Cataract Services Workforce Guidance Stakeholder Feedback and Changes

The ROYAL COLLEGE of OPHTHALMOLOGISTS

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Introduction

The RCOphth made workforce planning one of the priorities in its 2020-2022 strategic plan. This consultation was part of the first project, to develop guidance to support workforce planning for cataract services.

We set up a guidance development group to provide perspectives and expertise from key stakeholder groups. We also gathered feedback on the draft guidance at a stakeholder webinar in November and ran a consultation between December 2020 – January 2021.

74 people attended the webinar and gave feedback, and five written responses were received.

Overall, respondents welcomed the guidance, in particular the calculator tool. There were a range of comments and suggestions for improvement, which we carefully considered and used to revise the guidance being published.

The following pages provide a summary of feedback and changes to the guidance.

1. Primary care optometrists

We were glad that the feedback welcomed recognition of primary care staff within the workforce guidance.

We noted comments about co-developing with optical bodies a complementary primary care cataract workforce calculator and felt this was a good idea to be explored in future. We decided to retain primary care optometrist workforce in the calculator for now, with more explanation about the intention in the calculator instruction sheet.

2. Post-Covid

A few comments asked whether the guidance should be for Covid or post-Covid service and workforce development. Given the impact of the pandemic on cataract services, we felt it was important to base the guidance on the current context, and review it when Covid precautions are no longer necessary.

3. Integrated pathways

We received a lot of feedback about integrated pathways.

Some felt that since much more integrated models of care are being used in areas, the guidance should be based on these for future proofing.

While we recognise this, we wanted to use models that can be applied to a wide range of local configurations, and support the process of integration. However we agree that this will need to be reviewed as services change and become more integrated.

We agreed with feedback that the guidance should be applicable to all cataract surgery providers including the independent sector, and have now indicated this in the document.

A few comments were received about the need to address barriers to integration, such as IT and siloed commissioning. We appreciate this and continue to advocate for improved and integrated IT and commissioning, but this is outside the scope of this guidance.

4. Post-operative assessment

We were pleased to see that our message on ensuring nursing continuity within the pathways was welcomed, as we recognise this is important to both nursing staff and patients. We noted a request for a similar statement that post-operative assessment should be delivered by the referring optometric practice where possible.

While returning to the referring optometric practice for post-operative assessment could improve continuity of care, we feel that this is primarily a matter of patient choice.

5. Workforce calculator

We were really pleased that the calculator was welcomed as a useful tool to plan staffing. We will make it accessible via the RCOphth website following publication of the guidance.

We considered the comments about the supporting information and made the following changes:

- Adding a statement that referral refinement would be applied in 100% of cases where commissioned. We are unable to recommend a target for referral refinement due to the variety of potential ways a patient can come into the cataract service.
- Amended the introductory wording to make it clear that the objective for the calculator refers to calculating the future demand and future supply.

6. Training

We have considered the comments regarding possible impact on trainees, especially ST1 and ST2. We have been clear there is a need for trainees to attend cataract clinics. We will work with Heads of School and Training Programme Directors to ensure there is not a negative impact on training and to ensure the required training can be delivered locally in their Deanery.

We received a suggestion to add a statement that primary care optometric practices are suitable sites for training junior doctors and AHPs. We recognise it can be beneficial for trainees to attend a practice to see how the system works. There are specific requirements for recognition of training sites, which is out of the scope of this work. However, we will consult the Training Committee to consider this as the systems evolve.

7. Surgical throughput

Concerns were raised buy some respondents about setting minimum numbers of surgical cases that should be completed.

The RCOphth does not set a standard for the minimum number of cases that should be completed on a list. We recognise the impact that complex cases, DNAs, training and facilities have on throughput. We have used the recommended number of cases, and time per case set out in the GIRFT guidance for the purpose of modelling, with the caveat that the above factors often cannot be controlled or changed, and therefore the GIRFT numbers are recommendations, not expectations. We reviewed the wording to make sure this message is clear.

8. Surgeons meeting patients before the day of surgery

A few people expressed concerns about the surgeon meeting the patient for the first time on the day of surgery, while others did not consider this to be a problem.

Meeting patients before the day of surgery ensures good communication and shared decision making, and, ultimately the best clinical outcomes and patient safety. In our refractive surgery guidance we have stated that this is necessary. However, cataract surgery is supported by well-established systems of local and national audit that are used to inform local policies, such as this. The RCOphth's view is that local cataract services should decide this policy based on local and national audit data.

9. Language

We received some feedback about the language used in the guidance and have amended the following:

- Replace 'community optometrist' with 'primary care optometry teams' to reflect the wider team involved.
- Rephrasing the introduction to reflect the significant amount of work being done by others to develop and improve cataract services, which this guidance follows.

10. Guidance development process

We were pleased that the project was welcomed overall and so many gave us their feedback.

A couple of comments were received about the breadth of input and asked whether it was wide enough. We agree that guidance should be developed with input from all the key stakeholders, while being a manageable process. We formed a guidance development group with representatives of the key stakeholder groups as a way to achieve this, alongside carrying out an open consultation.

We are grateful to all those who responded and we will be evaluating the process to identify improvements for future projects.