The ROYAL COLLEGE of OPHTHALMOLOGISTS

External Service Reviews

Local Support, National Learning

October 2018

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Date of issue	October 2018
Review date	October 2021
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Approved by	Professional Standards Committee 5 October 2018
Document Owner	The Royal College of Ophthalmologists

1. Summary

The Royal College of Ophthalmologists (RCOphth) analysed findings from the last five years of external service reviews. In many cases issues had continued for prolonged periods which made finding solutions harder than if earlier input had been requested. The key themes for issues nationally are:

- A lack of capacity
- Difficulty recruiting and retaining ophthalmologists resulting in unfilled posts
- An over-reliance on locum consultants
- A failure to provide adequate subspecialty expertise
- Lack of senior support for an investment in the department
    - Lack of investment in space and IT
    - Lack of enough, dedicated, consistent, experienced management staffing resource for ophthalmology
    - Clinical leaders were not resourced or developed to do the job and not joined up effectively to trust decision systems.
    - Fragmentation or absence of expert nursing leadership
- Under-use of the skills of the multidisciplinary team and innovative ways of working
- SAS doctors often felt poorly supported
- Lack of transparent supportive culture and poor communication with the organisation
- A need to strengthen links with local commissioners
- Lack of team-working, positive behaviour and consistent clinical decision making between consultants. This was compounded by a failure to have difficult conversations or robust performance management e.g. by the medical director at an early stage
- Failure to have administration and clinical IT systems suitable for ophthalmology
- Services partially delivered by private providers

The report identifies that one of the key problems is the **national shortage of ophthalmologists and that, so far, there is no willingness from policy makers to expand ophthalmology training numbers** but does make some broad recommendations about how trusts and eye department staff can act to avoid or mitigate frequently occurring issues.

Feedback from the reviews was very positive and the RCOphth is exploring plans to broaden the scope of the review service to include analysis for individual clinicians. We would strongly encourage units to invite a review where objective advice is welcomed to improve and develop.

2. Introduction

The RCOphth provides an external review facility to support ophthalmology units to improve their services through independent and objective expert assessment of practice and performance, with provision of recommendations for improvement. The process is based on

recommendations from the Academy of Medical Royal Colleges (AoMRC), incorporates elements of Care Quality Commission (CQC) methodology, and is described in detail in the External Review Process Guide. We have undertaken a retrospective review of the performance and findings of this service since our last report in 2013, to highlight any common or recurring issues in ophthalmology services and identify themes for learning and improvement. We hope this will support the RCOphth and ophthalmologists to raise concerns regionally and nationally with NHS commissioners and leaders and can help trusts and eye departments to learn from others and take proactive steps to protect and improve their own service.

The RCOphth published 'Our ophthalmology service is failing please help' in 2013 which summarised the lessons learnt from the first seven years of our external service reviews. It concluded that 'Immediate triggers for the requests have included complaints, adverse events, staffing problems, difficult relations between clinicians or between clinicians and managers and problems meeting waiting time targets. However, a very common finding has been that, underlying the stated reason for the request, there is a chronic mismatch between capacity and demand within the service.'

It concentrated on the need for organisations to undertake:

1. Population needs assessment
2. Use of the quality assessment tools provided by the RCOphth to self-evaluate the service and identify areas for improvement
3. Workforce planning and training for the whole department team.

We will examine whether this has changed in the last five years.

3. Activity and reasons for the Review

From 2014 to mid-2018, the RCOphth has assisted 21 organisations with formal review services. It has provided informal advice, assessments and recommendations to many more, such as review and advice on concerns from clinical audit and outcome results, assessments of surgical performance via video reviews, telephone and face to face advice.

The formal reviews consisted of:

- 17 service reviews – 16 involved a two day visit and the other a one day visit to the site. The process is more than just the visit. Reviewers discuss the issues and requirements on the phone with trust leaders several times prior to the visit, and develop specific terms of reference, to plan the team and methods. Information and evidence are gathered from public sources and from the trust, collated and analysed before, during and after the visit.

- Seven case note reviews, of which three received a service review as well, either at the time or after.

Reasons for and background to the reviews

Organisations have differing reasons for requesting a review. However, the overriding aim is common: to improve the quality of care for ophthalmology patients.

Usually it was the trust that initially contacted the RCOphth to discuss a review, at the level of divisional manager or chief operating officer, or divisional clinical director or medical director. One request originated from a clinical commissioning group (CCG) but, with full agreement with the trust; and one arose from the RCOphth contacting a trust after anonymous concerns were raised (whistleblowing).

Scope

Sometimes the remit of the review requested was very clearly linked to a particular subspecialty, service or area of practice. This was the case in approximately 40% of reviews, of which the commonest areas were medical retina/age related macular degeneration (AMD) / intravitreal injections, cataract especially wrong intraocular lenses (IOLs) and endophthalmitis cases, and glaucoma. In the other 60%, the review concerned the whole service.

Sometimes the trust was uncertain how widespread the problem was within the department, and this can be difficult to tease out before the visit. In general, the RCOphth tried to remain within the requested remit but would make as much comment as the reviewers felt appropriate where the issue went beyond the area of request or was linked to issues across the whole ophthalmology service.

Areas of concern

Common concerns or areas to investigate for the review team included:

- A desire to prevent continuation of serious incidents or never events and to ensure high quality investigations and robust preventative actions had been achieved
- Recruitment problems, or capacity issues
- Skill-mix and use of the multidisciplinary team (MDT)
- Medical subspecialisation and job planning issues
- Potential service redesign/reconfiguration
- Single handed subspecialty consultant provision
- Performance against externally accepted standards
- Consistent use of evidence-based guidelines, clinical outcomes
- IT and administration processes
- Team working, behaviour and culture
- Leadership issues
- Estates and facilities.

Triggers

It was common for there to have been awareness of significant issues, and internal attempts to address them, for a considerable time before the RCOphth was invited, which tended to make finding solutions more difficult, as chronic problems can create stresses and difficulties which impact negatively on staff relationships and behaviour. There was often a trigger event which finally led the trust to move externally for support and these were:

- Cluster of serious incidents and never events
- Cluster of endophthalmitis
- Poor CQC inspection report
- Discovery of a large number of delayed or lost to follow up patients
- Whistleblowing internally or externally by staff
- Breakdown of working relationship between consultants
- Introduction of external (independent) providers to supplement capacity
- Poor trainee survey results
- Administrative meltdowns

4. What are the key issues affecting ophthalmology services?

The single most important recurring issue was that there is a **lack of capacity** to deliver enough care to meet the eye care needs of the local population and this is creating issues and delays in scheduling appointments for follow up patients. Delays in care were not only creating more work (e.g. fielding queries from patients and external professionals, administrative and clinician time spent trying to find fixes or identify at risk patients) and leading to distress and anxiety for patients and staff, but also leading to serious incidents of visual loss in chronic conditions such as glaucoma and retinal problems. This is strong confirmation of the work from the British Ophthalmological Surveillance Unit (BOSU), the Royal National Institute for Blind People (RNIB) and the All Party Parliamentary Group (APPG) for Eye Health and Visual Impairment demonstrating continuing patient harm from a severe national shortage of ophthalmology capacity in the face of continually rising demand.

Another key, and linked, theme was **the difficulty of recruiting and retaining staff, especially consultants, with unfilled posts, an over-reliance on locum consultants and a failure to provide adequate subspecialty expertise in key areas.** The lack of substantive consultants and subspecialty care being delivered by non-subspecialists often exacerbated the capacity problem through an increased propensity to follow up patients who might otherwise have been discharged, given definitive treatment or given longer follow up intervals. In addition, it led to substandard care or care that was not evidence based and up to date.

Lack of senior support for and investment in the department. Many of the departments complained of the factors listed below contributing to their failure to develop, expand capacity to match increasing demand, or address ongoing problems. Staff often told us that it was only when the College arrived that senior trust leaders would recognise or admit this as a contributory factor to the failure to solve their issues:

- Lack of investment in infrastructure e.g. clinic space and information technology
- Lack of investment in management. The units often had frequently changing managers or no managers, or an overstretched manager shared between several different specialisms with not enough time to dedicate to ophthalmology, or to junior management input. There was a lack of enough, dedicated, consistent, experienced management staffing resource for ophthalmology.
- Lack of investment in leadership for the eye service. Clinical leaders were not given the time and support in terms of help from admin and management staff, training and personal

development to deliver their job. They were often not joined up effectively to trust decisions making processes and felt isolated.

- Fragmentation or absence of expert nursing leadership. The reduction in availability of the old style "ophthalmic nursing courses" and failure of trusts to invest in training up non-ophthalmic nurses in ophthalmic skills and knowledge meant nurses leading the ophthalmic team, and their line reporting seniors, were not knowledgeable enough about in ophthalmology. They were therefore less equipped to take on leadership in the department or challenge senior ophthalmologist colleagues. This was often compounded by fragmentation of the ophthalmology staff structure, especially for nursing and other non-medical clinical staff in the multidisciplinary team (MDT) – so that clinic staff reported to an outpatient nurse lead or manager, theatre staff to a theatre lead, day case to another whilst the surgeons reported to an elective care directorate. There was frequently no holistic ophthalmology team structure or leadership.

Under-use of the skills of the multidisciplinary team and innovative ways of working. There is a significant shortfall of trainee posts nationally to fulfil the required consultant numbers (see RCOphth workforce census), a reduction in those applying for Staff and Associate Specialist (SAS) doctor posts and an increasing demand for services. To try and address the demand/capacity deficit, modern ophthalmic units are increasingly relying on non-medical clinical staff delivering a wider skill set through advanced practice and extended roles (see RCOphth Way Forward Resources). This includes, activities such as nurse led intravitreal injections, use of health care assistants (HCAs) and technicians for imaging and diagnostic tests, optometrists with prescribing rights managing low risk patients in clinics, and schemes for referral refinement and shared care for low risk disease with community optometrists. This had often not been pursued to the degree required. It was not always due to lack of willingness or commitment from clinical leads and the eye team, but that the staffing situation meant all their energies were directed at keeping the clinical service afloat rather than service improvement and development, which takes time, and effort and access to training. Consultants did not receive any time in their job plans to effect these changes.

SAS doctors often felt poorly supported and saw themselves as the unappreciated workhorses of the department. They sometimes did not have full access to training and Continuing Professional Development (CPD) and were not being effectively supported to develop professionally nor take on subspecialty roles for greater departmental expertise or non-clinical roles to support the clinical lead.

Culture and communication with the organisation. Units in difficulty often had poor frequency and quality of communication between the clinical team, the clinical lead and manager and the senior management team. Staff often felt they did not know what was going on nor could they raise concerns or discuss issues openly and in a spirit of learning. They wanted better communication, openness and transparency in the decision-making process, and to feel included in decisions about the department and service. This was often an issue where there was uncertainty about the future shape of the ophthalmology service e.g. rumours of service development plans or major change were casting a shadow over the department. Staff often said that, until the RCOphth had visited, they had never seen the trust leaders nor had those leaders taken any convincing interest in the ophthalmology service.

There was a surprising lack of awareness at senior trust level of the importance of ophthalmology as being responsible for the commonest operation (cataract), the second busiest outpatient specialty, and that, run well, it can be an income generator for the trust.

When things went wrong, there were frequent complaints of a blame culture and a failure to address the real root causes. Staff felt unsupported and some had been excluded as a default from any investigation.

A need to strengthen links with local commissioners. There were often straightforward ways to improve or change pathways which required interaction between commissioners and the ophthalmology department but neither side was certain how to achieve the right forum to interact; and trust support for this was missing of opaque. In addition, where ophthalmologists were being excluded from service reconfigurations, often there were potential safety issues not being addressed.

L**ack of team-working, positive behaviours and consistent clinical decision making between consultants.** Where the consultants in an eye unit could not work together and communicate professionally, as senior leaders of the service, the whole unit was seriously negatively impacted. Poor relationships between consultants, an unwillingness to reform the service and modernise, to agree consistent evidence based clinical practices or to avoid unhelpful criticism and undermining was seen in some units. However, it is worth noting that sometimes relationships had deteriorated due to the impact of other factors described above.

This was compounded by a failure to have difficult conversations or robust performance management e.g. by the medical director at an early stage to resolve issues.

Failure to invest in administrative and clinical IT systems suitable for ophthalmology measuring important information e.g. ophthalmic suitable electronic patient records (EPRs), networked imaging systems for all clinical rooms, and admin systems which could not measure key data in ophthalmology, especially follow up delays, was a recurring theme. In addition, there was often a failure to actively measure and manage follow ups.

Services partially delivered by private providers not properly integrated into the NHS service created risks in some cases because of differences in care protocols, a tendency for patients to have too many appointments (duplication or over frequent returns), unfamiliarity with each other's processes, difficulties in joint ownership and solution of clinical governance issues. In some instances, this diverted leaders from working on establishing a sustainable long-term solution. It needed very careful management to work safely.

5. Recommendations and solutions

In most reviews, it was clear that ophthalmology department staff were committed to high standards of patient care and making improvements and welcomed the support and recommendations the RCOphth provided. The RCOphth was often simply providing confirmation that the staff already knew many of the solutions and providing a formality and completeness to their ideas.

RCOphth reviewers made numerous recommendations for organisations to consider enacting, ranging from long term business planning to develop new hospital sites/facilities/buildings, to achievable short-term objectives e.g. make MDT meetings truly MDT and attendance mandatory. They are too many to list in detail.

6. What did the reviews tell us are the key recommendations for keeping eye services safe?

There is a national shortage of ophthalmologists and trusts have no power over this factor. So far, despite efforts at national level, there has been no willingness from policy makers to expand ophthalmology training numbers. However, there are some actions trusts can take to mitigate difficulties as follows:

- Ensure, as far as possible, that enough consultant posts are funded. If necessary, for hard to fill subspecialties consider working in networks with local and regional trusts through shared posts or arrangements**.**

- Deliver much of the care in subspecialist teams. There must be access to subspecialist consultant expertise for key areas such as glaucoma, MR etc. They may not see every patient in that subspecialty in their own clinics, but they need to have oversight of patients in their unit and be available to advise. Ideally, the MDT also develop areas of subspecialty expertise.

- Agree evidence based consistent guidelines of care in key areas, informed by NICE, RCOphth and similar guidance.

- Develop extended roles and innovative working practices for the whole MDT, with regular skill mix reviews. Ensure these staff receive internal and external training, and record competencies. Have protocols for this work. Provide enough protected time in job plans for consultants to be able to develop these pathways and associated documents and to train and supervise.

- Provide plenty of managerial time for ophthalmology and, if the unit is struggling, provide a dedicated manager with enough seniority to effect improvement. Provide the clinical lead with enough time and training in leadership and management skills to do their job, and ensure they are well supported by and joined up with the trust leadership structure. Work actively to break down “them and us” barriers between clinicians and managers.

- Ensure all staff providing the ophthalmology service are within the same organisational team and directorate and function as a team in the clinical and non-clinical arena, across different sites, including admin. Ensure ophthalmic senior nurses receive ophthalmic training and ophthalmic lead nurses have management and leadership training. Provide some professional development and education to staff in multidisciplinary teams.

- Trust leaders should not take decisions about the ophthalmology service restructure or major changes without input and communication with the eye team. The whole eye team should meet regularly in team or clinical governance meetings to communicate and solve issues together. Trust leaders need to meet at times with the clinical lead for ophthalmology and the manager and nurse lead, even if there is no crisis. Listen to staff if they say there is a problem and listen to their ideas for solutions. Do not wait for a serious incident or a crisis before you do this. Everyone involved needs to work together to proactively plan your sustainable ophthalmology service of the future.

- Trusts should help ophthalmic leads and managers contact commissioners and all should work together to solve capacity issues and reconfigure pathways across the region, including looking at community-based care.

- Use the space you already have innovatively and reconfigure it – divide rooms and areas into vision lanes, review room usage during the week, change how sessions are divided up in the day or week. If after that there is not enough space, the trust needs to provide more or work to ensure that some patients are seen in the community. You cannot see increasing numbers of patients in the same space for ever.

- Provide networked ophthalmology suitable IT for imaging and patient records. Ophthalmology patient record requirement are very different to most other specialty requirements. Have a proper plan for ophthalmology equipment and device replacement.

- Support and use SAS doctors to their full potential. Provide targeted training and CPD for them to develop more skills, more subspecialty expertise and to take on non-clinical roles such as clinical governance, audit, management, training.

- When things go wrong, undertake an open blame free investigation looking at the real root causes. Do not punish or exclude as a default. Never undertake a root cause analysis (RCA) into an ophthalmology incident without an ophthalmologist's input.

- Tackle behavioural problems or disagreements especially between consultants early and at a senior level. Actively but fairly performance manage. Have the difficult conversations. Ensure appropriate job planning is undertaken to underpin this. Do not tolerate consultants failing to respect basic trust and professional rules and requirements.

7. Feedback

Overall, around 50% of organisations have responded to requests for follow-up information on implementation of the recommendations. However, the response rate has improved over the last two years.

Some representative comments from those feeding back on the process:

'The review report highlighted shortcomings within the service and other safety issues. All recommendations taken on board and implemented. No safety or service related problems

have since been identified. A well run system is in place with high level of patient satisfaction. Extremely valuable for safe and efficiently running service meeting all national standards for care.'

'I feel that the support and effort provided by the…ECAT system was very welcome, effective and positive in resolving a long standing local issue. The team here are now facing the future with a renewed sense of team-spirit and cohesion, a more effective clinical environment for our patients, and a more enjoyable place to work for our staff.'

'The review has been a very useful exercise in terms of getting an external opinion on the service. It has instigated discussion within the team and enabled us to formulate our own action plan to take forward the recommendations. This has coincided with a change in the management team, which has had a positive impact, in terms of enabling change.

'The comprehensive list of recommendations enabled us to focus on issues that had been highlighted. We drew up an action plan to deliver the recommendations; and positive improvements to the service have already been realised. We also have a vision going forward. Communication is much better within the team, and there is a willingness to accept the changes that have been suggested.'

'I was not personally involved in the review process. I arrived in post around the time that the review was published. The review had obviously been requested because the service was under major pressure. Many pressures still remain, but the team feels in a much better position to respond to this and implement the necessary changes. The objective, balanced, professional and discrete manner in which the ECAT team conducted their process was very helpful in identifying the key issues….this lead directly to further work which was key to an ultimate resolution to the issues we were having.'

'On behalf of the department, we found the review extremely helpful. In particular, it highlighted many areas that required increased input with a big emphasis on the development of allied health professional roles – something we've taken on board and have also in turn highlighted at our internal specialty review process.

The estate issues highlighted by the report has also helped us escalate on going issues and finally we're beginning to see action at a senior level on this with engagement that we've just not seen before.

We have created an action plan in relation to the Review and have been steadily working through these.'

'In general, it is always useful to have an external light shone on a department and there have been many areas which the clinicians have readily enacted, not least the standardised clinical pathways. Some, such as the recommendations that require significant capital investment, are less easy to implement but efforts are being made. The department is undoubtedly more functional and happier at this current time. The review met expectations and overall has been extremely useful in the development of the department.'

8. The future of RCOphth reviews

The review service seems to be well received and able to support units to improve. Recently, it has been expanded to include more consultants and nurses, orthoptists, optometrists, SAS doctors, trainees and lay and patient representatives. The methodology has matured beyond the traditional interviews in an office and tour of the department, to include going out to observe practice and talk informally to all levels of staff and to patients. We are exploring establishing a service which can also review individual doctors' practices.

We hope to be equipped to offer more reviews and with a more holistic approach to the issues and how to solve them.

We would like units not to leave calling in the RCOphth until the last moment or when all else has failed. By this stage, problems can be so chronic and relationships so soured that it is difficult to solve the problems. We welcome units asking us in much earlier and even where there is no crisis but where objective advice is welcomed to improve and develop.

Informal advice is always available from the RCOphth's Professional Support Team, committee chairs, and from the regional College team such as regional representatives and regional education advisors. In addition, do not forget that local and regional colleagues are often willing to help and advice.