Improving the visibility of paediatric ophthalmology: A workforce report

Introduction

Ophthalmology services across the UK face a significant capacity challenge, and paediatric ophthalmology is no exception. Capacity shortages in the sub-specialty are driven by difficulties in the recruitment and retention of staff, significant patient backlogs, and the impact on ways of working adopted during the COVID pandemic. Alongside these broader challenges facing ophthalmology, paediatric ophthalmology also faces a range of unique pressures relating to the delivery of paediatric care. As a result, paediatric ophthalmology services are particularly vulnerable to the capacity pressures in the system.

To help give voice to the paediatric ophthalmology sub-specialty and ensure issues are addressed, The Royal College of Ophthalmologists' Paediatric Subcommittee undertook a series of interprofessional focus group sessions in November 2022 where colleagues from across the sector explored the challenges facing paediatric ophthalmology, .

This briefing details the main challenges facing paediatric ophthalmology as outlined by the focus groups:

1. **Patient backlogs and consultant workload**
2. **COVID ways of working**
3. **Training, recruitment and retention**

To meet these challenges, a set of policy recommendations have been submitted in separate documents to the Education Committee, Training Committee and Quality and Standards Committee respectively, to be taken forward, developed, and implemented by representatives of each committee through several cross-committee task and finish groups. It is hoped by outlining a range of solutions alongside the challenges detailed below, paediatric ophthalmology can be supported to deliver more high quality, timely patient care.

Overview of the challenges facing paediatric ophthalmology

Capacity pressures through backlogs, workforce issues, and hangovers of new ways of working developed during the COVID pandemic are prevalent in paediatric ophthalmology and must be addressed. The challenges outlined throughout the sessions – many of which were present in the years prior to the pandemic – are impacting the quality and availability of patient care, with 31% of eye units naming paediatric ophthalmology as a subspecialty with the most concerning backlogs in their unit according to the 2022 workforce census.

Eye units continue to struggle to fill posts advertised for ophthalmologists with a specialist interest in paediatric ophthalmology and strabismus. As a result, units are resorting to either filling posts with temporary locums, re-employing recently retired consultants or simply ceasing to provide a paediatric ophthalmology service, resulting in paediatric patients being diverted to adjacent units that retain paediatric consultants.

Shifting the workload from a declining pool of consultants to other parts of the workforce and neighbouring ophthalmology departments is no longer proving to be a long-term solution, as the capacity of MDTs, AHPs, and those consultants in adjacent units is also becoming restricted, reducing their ability to manage the additional workload.

While there are many new ways of working developed during the COVID pandemic which have led to greater efficiencies and improvements in patient experience, there remain several that create additional pressures in the system, such as the inconsistent implementation of virtual consultations.

Ultimately, the various challenges facing paediatric ophthalmology will damage the long-term sustainability of services across the UK as well as lifelong outcomes for patients, unless action is taken now.

1. Patient backlogs and consultant workloads

1.1. Significant ophthalmology-wide backlogs are putting huge pressure on paediatric services. Latest data shows that England has over 630,000 patients on ophthalmology outpatient waiting lists, Scotland has almost 60,000, Wales has over 142,000, and Northern Ireland has over 40,000. Throughout the focus groups, participants highlighted how these sizable backlogs continue to place additional pressure services as patient volume has increased and they are unable to find natural breaks in patient flow.

1.2. Units increasingly rely on MDT, AHPs, and locums

1.2.1. To help deal with patient backlogs, many units are increasing their reliance on the wider multidisciplinary team (MDT), allied health professionals (AHP), and locums.

1.2.2. A large majority (80%) of units are increasing their reliance on the multidisciplinary team – including ophthalmic nurses, orthoptists, and qualified optometrists – working in extended roles over the last 12 months, according to the 2022 workforce census. This increased reliance is further emphasised by the fact that 74% of units are reporting they rely 'to a large extent' on non-medical professionals working in extended roles. Over three quarters (76%) cite funding for additional posts as a barrier to further increasing the capacity of non-medical professionals working in their unit.

1.2.3. Alongside an increased reliance on the MDT and AHPs, many paediatric units are relying on locums to fill vacancies, particularly for consultant roles. 65% of units report in the recent RCOphth workforce census using locums to fill consultant vacancies, while 24% use locums to fill SAS vacancies and 20% use locums to fill trainee vacancies. Use of locums is not a temporary measure either, with 57% of units reporting that where they were using locums for over 12 months to fill consultant posts. The majority of eye units in London, the North West, Northern Ireland and East of England have been using locums for over 12 months to fill consultant vacancies.[1]

1.3. Upskilling ACPs has let to unintended challenges

1.3.1. While the extension of advanced clinical practitioners (ACPs) roles has been a welcome addition to paediatric ophthalmic capacity and should be encouraged, there have been incidents of some ACP roles being extended without their previous workload being appropriately backfilled. When this occurs, rather than extended ACP roles being genuinely additional to capacity, it sees overall workforce shortages being shifted internally rather than filled.

1.4. Ophthalmology unit theatre and outpatient space constraints are particularly acute for paediatric ophthalmology

1.4.1. National service frameworks for children need to have separation of children from adult clinics – discrete clinical areas are allocated. This inherently builds in limited capacity and flexibility. Many ophthalmology units report a lack of theatre and outpatient space, with little support from their Trust or Health Board, exacerbating capacity pressures by not having adequate infrastructure to see a sufficient volume of patients.

1.4.2. Theatre capacity is dependent on availability of paediatric trained staff (anaesthetists, operating department practitioners (ODAs) recovery etc). These are additionally pressurised workforces. Limitation of some hospitals in the lower age cut off that they are able to operate on (under the age of 3) resulting in routine cases going to specialist centres.

2. COVID ways of working

2.1. During the COVID pandemic, many paediatric eye units – along with the wider health system – adopted new ways of working to help meet the particular stresses of the time. While some of these measures have seen benefits that should be kept (such as risk stratification) there are others (such as remote consultation) that continue to be in place to the detriment of paediatric ophthalmology capacity and patient care, if not adequately implemented with careful case selection and safety measures in place.

2.2. Referral and triaging reforms are impacting capacity and patient care

2.2.1. To deal with backlogs, many eye units are reviewing their protocols to have a lower threshold for discharge, as well as having longer periods between seeing patients. In addition, many ophthalmologists have had to become more active in triaging referrals as many referrals from other parts of the eyecare system can be poor quality, adding unnecessary burdens on administrative and consultant time.

2.2.2. Poor quality referrals from primary eyecare and GPs often have little information for the ophthalmologist to work with and has led to some mis-referrals. An over-use of virtual appointments by GPs – adopted during the COVID pandemic – means some diseases are not being identified that would otherwise be picked up by an in-person appointment.

2.3. Virtual consultations can add to capacity but are not a panacea

2.3.1. Experience with virtual consultation within paediatric ophthalmology is mixed. While in some instances it is a useful tool to see a greater volume of patients – particularly taking into account the frequent lack of theatre and outpatient space within units – if not utilised correctly it can lead to missed or inaccurate diagnoses.

2.3.2. Virtual consultation also poses particular challenges in relation to paediatric ophthalmology, with instances of parents or guardians finding it challenging to keep the child's attention on the camera in a way that allows the consultant to effectively and accurately assess the eye.

2.3.3. Several examples were highlighted in the focus group sessions detailing how virtual consultations – whether by an ophthalmologist or a GP – missed certain signs that would otherwise be picked up by an in-person appointment leading to poor life outcomes for the patients.

2.4. Remuneration for new ways of working has been lacking

2.4.1. In instances where new ways of working led to increased capacity or additional unrecognised activity, remuneration for this additional work has sometimes been lacking from unit management. This lack of associated remuneration for increased productivity can undermine innovation and demoralise consultants working to improve the availability and quality of patient care delivered.

2.4.2. In addition, new ways of working may have been implemented without adequate recognition of the time and resources required, which must be recognised in job planning processes.

3. Training, recruitment and retention

3.1. Challenges relating to the training, recruitment and retention of ophthalmologists are prevalent across the specialty. However, paediatric ophthalmology faces particularly acute pressures, especially in the trainee pipeline.

3.2. Uptake of paediatric ophthalmology as a subspecialty by graduates is low

3.2.1. The particular conditions associated with working with children in paediatric ophthalmology has been noted as a driving factor behind a relatively small workforce pool, with only 12% of trainees responding to the recent RCOphth workforce census indicating their intention to work within paediatric ophthalmology.[1]

3.2.2. Throughout the course of the focus groups, an apprehension from trainees about working with children and anxious parents was highlighted. Exposure to paediatric ophthalmology in training programmes comes a few years into the training programme, often meaning that trainees have already decided their preferred subspecialty by the time they experience paediatric ophthalmology and have already grown accustomed to working withing adult ophthalmology. The position in which exposure to paediatrics is provided to trainees within the wider training programme therefore may be another cause in the lack of uptake of paediatric ophthalmology as a subspecialty by trainees.

3.3. Retention of staff remains challenging and may deteriorate in coming years

3.3.1. Retention-side paediatric workforce pressures will continue in coming years unless action is taken now, with 26% of paediatric consultants set to leave the ophthalmology workforce over the next five years due to retirement, leaving the ophthalmology workforce or leaving medicine entirely.

3.3.2. This means that even when recruitment of paediatric staff is relatively high in an area, overall workforce trends such as retirement means attrition is high and the number of new staff hired often does not replace the number of staff leaving.

3.4. Morale is suffering as a result of pressures

3.4.1. Morale across paediatric ophthalmology is also suffering as a result of these capacity pressures, with 31% of consultants having found their role becoming less fulfilling over the previous 12 months, the overwhelming majority of those pointing toward capacity pressures such as a shortage of ophthalmologists and allied health professionals, increasing patient demand and a lack of work-life balance as the cause.[1]

3.4.2. Ophthalmologists want to be able to deliver the highest quality of patient care in a supportive environment, and while the myriad workforce capacity pressures continue they will affect morale which itself may impact the decision for trainee ophthalmologists to choose paediatric ophthalmology as a subspecialty.

3.5. ROP screening and treatment are particularly concerning

3.5.1. All areas of paediatric ophthalmology are under stress as adult ophthalmology specialists are now much less confident about managing children than they were in the past. However, a subspecialty of particular concern is Retinopathy of Prematurity (ROP) screening and, to a lesser extent, ROP treatment. The latter tends to be consolidated within regional centres, which are somewhat less vulnerable to complete loss of paediatric workforce, but which can still become pressurised due to capacity issues. Screening is the bigger workload and the requirement for dedicated ophthalmologists, generally paediatric ophthalmologists, to undertake this role remains a significant workforce pressure.