Scottish Government – Future Medical Workforce call for evidence

Please provide evidence, case studies, or proposals addressing one or more of the following themes:

1. **Prevention and Early Intervention**

• How can innovation support early detection and management of long-term conditions?

• What new models or tools will support doctors to provide care and improve health outcomes?

• What would support a move towards preventative care, and how might prevention-focused workforce differ from our current model?

It is estimated that 50% of sight loss in the UK is avoidable and can be prevented by tackling the risk factors associated with eye disease and poor eye health (for example smoking, obesity, diabetes and poor diet) and ensuring early diagnosis of eye health conditions that can lead to sight loss without treatment.

Clinical research is also vital in supporting prevention for conditions where sight loss cannot yet be avoided. Despite the significant potential benefits that increased investment into eye health research could generate, there is currently a significant gap in funding compared to conditions such as dementia. At present, just £9.60 per year is invested in eye research for each person with sight loss, which is around one tenth of the funding available for dementia research (£97 per person, per year).

Integration of health research across the NHS will require protected time for clinicians to participate, as well as dedicated infrastructures that supports access to data, collaboration between researchers and patient participation.

Ophthalmology has a vital role to play in preventing avoidable irreversible sight loss through prompt diagnosis and treatment, working closely with primary eye care.

Once patients are referred to an ophthalmologist for treatment it is crucial they are seen quickly. Data from Public Health Scotland however shows that there are over 68,000 patients waiting for a first outpatient appointment with an ophthalmologist. There is significant variation across health boards regarding how long these patients wait – in Tayside the median wait is 7 weeks, while for Golden Jubilee it is 39 weeks. To prevent avoidable irreversible sight loss, it is also vital to focus on patients waiting for follow-up appointments, particularly for conditions such as complex glaucoma and wet age-related macular degeneration.

Ensuring we have the right workforce in place (see Q6), backed by the right facilities in terms of adequate clinic and theatre space, innovative models of care (see Q3) and IT interoperability is essential in improving this situation.

2. Person-Centred and Value-Based Care

• What is the role of a medical professional in supporting individuals to manage their own health and care, and how might technology influence this?

• What innovations can support services to move towards person-centred care?

In our response to question three, we outline a number of models of care that are more person-centred as well as improving efficiency.

One positive example where Scotland has led the way are the efforts to pioneer high-volume bilateral cataract surgery in Tayside. This has seen the waiting times for a consultant decision cut by 94%, surgical efficiency doubled from 12-14 cases per day to 30, and improved patient experiences with faster recovery and fewer visits to the hospital required. As well as strong leadership, team cohesion, and effective planning, this innovative model requires fit-for purpose clinic space.

3. Community-Based Service Delivery

• What approaches have shifted/could successfully shift care from acute settings to communities and what does this mean for our medical workforce?

• How will technology/innovation support the shift of care from hospital to community?

• How can technology or service redesign improve access to medical care services in rural and island areas?

There are many successful examples of ophthalmology-led care being shifted from hospital to community settings, leading to efficiency gains, cost savings and an improved patient experience. Our 2025 position statement – Shifting ophthalmology-led care from hospital to community settings – outlines three models that can drive this shift across the UK:

- diagnostic centres in the community with virtual review
- enhanced optometry services
- surgical hubs.

These models require consultant ophthalmologist oversight, but other roles will play a more prominent role in delivering care too. For example, in diagnostic centres in the community (like that pioneered by Moorfield's Eye Hospital at Brent Cross shopping centre), tests are undertaken in-person, typically by trained ophthalmic technicians, with results reviewed later virtually by a clinician, such as a consultant, speciality and associate specialist ophthalmologist or suitably trained optometrist, in a separate setting. Technological developments, such as the increasing use of artificial intelligence (AI) and video examinations,

are likely to further increase the use and efficiency of this model. Diagnostic centres will help facilitate the introduction of AI, supported by effective oversight and governance. This can help quickly tackle follow-up backlogs in certain areas of ophthalmic care.

Likewise, an important part of the surgical hub model is the use of nurse-led pre-operative clinics. Optometrists and orthoptists will continue to play a vital role in the delivery of ophthalmology-led care and should be supported to further develop their clinical skills and experience. Following a pilot undertaken in 2023-2024 into the use of physician assistants (PAs) in ophthalmology, we 'recommend investment in established allied health professions within ophthalmology and additional training numbers for ophthalmologists rather than a new role of PA with an interest in ophthalmology'.

3. **Population Planning and Equity**

    • How can we improve the use of data and evidence to plan services based on population need?

    • What innovations address health inequalities and improve access for underserved groups?

Improving the delivery and accessibility of paediatric ophthalmology care will make an important difference in tackling inequalities in vision loss and eye health.

National Services Scotland and National Specialist Screening Department developed a joint situation-background-assessment-recommendation (SBAR) in 2020 on the paediatric ophthalmology service, which highlighted the 'ongoing problems with recruitment and staffing levels, which is resulting in a sub-standard service delivery nationally in Scotland'.

Many of these problems are still present in 2025, and we support a renewed focus on the recommendations made in the report including a long-term workforce strategy, centralisation of retinopathy of prematurity (ROP) screening and training for paediatric ophthalmology fellowships.

4. **Digital Transformation and AI**

    • What digital tools or platforms have improved care co-ordination and outcomes?

    • How can AI be safely and ethically used to support diagnosis, triage, or resource planning?

    • What are the barriers and enablers to digital inclusion in health and social care? What skills will our workforce require to support this?

5. Workforce Enablement/impact

• What innovations support workforce wellbeing, efficiency, and collaboration?

• How can training and development be adapted to support new models of care?

• How will technology/innovation impact the role of the doctor over the next 20 years?

6.For Royal Colleges/expert advisors

• In your specialty, how will or could the role of the consultant/general practitioner change in the next 20 years? what will be required to enable that change?

The unique role that ophthalmologists play, gained through training and experience, in consistently delivering and coordinating high quality care for complex surgical and clinical decisions will remain crucial. This will become even more important as more people have complex and multiple health conditions.

The prevalence of eye disease will continue to rise with an ageing population in the coming years. In 2017 we estimated that the number of people with glaucoma and neo-vascular age-related macular degeneration would rise by 44% and 59%, respectively, by 2035.

When we surveyed clinical leads in NHS ophthalmology departments across the UK in 2024, just a quarter feel able to deliver a service that generally met the needs of patients in their area, with our 2022 census finding that 76% of units did not have enough consultants to meet current patient need.

There will need to be increases in the ophthalmologist workforce to meet growing need. Our 2024 position statement on a sustainable ophthalmology workforce identified that Scotland requires:

- An additional 37 ophthalmology training places, phased by 2031.
- Expansion of ongoing initiatives such as the Portfolio Pathway, Ophthalmic Local Training Programme, and Ophthalmic Practitioner Training Programme.
- A drive to improve the retention of ophthalmologists, including by better supporting SAS doctors in their career development and progression.

Ophthalmologists will also continue to play a multi-faceted leadership role in driving improvements in care across their team, organisation, and specialty. This will include overseeing the delivery of care by the multidisciplinary team, leading on service redesign and

improvements, driving forward a research-active NHS and supporting medical education and the development of the future workforce.

They should be empowered to perform this leadership by national policymakers and their local NHS organisation, including through carving out appropriate time in job plans. Local approaches to job planning should seek to ensure a balanced portfolio, and be based around flexible delivery and appropriate variation.

• How will AI/digital technology impact the current role/workload of doctors in this specialty?

AI-enabled tools will supplement the expertise of ophthalmologists to strengthen patient care, streamline processes and advance research. As an image-focused specialty, there are huge opportunities to use AI to improve diagnostic accuracy, personalise treatment plans and broaden access to care. These are detailed further in our position statement on artificial intelligence in ophthalmology.

A focus on education and training will be needed to equip ophthalmologists with the knowledge and skills to leverage AI tools effectively and safely.

Sufficient workforce capacity will also be required to ensure efficiencies gained by the introduction of AI tools are not restricted due to a demand-capacity bottleneck elsewhere in the clinical pathway. The workforce itself must also have the knowledge and willingness to implement and critically review AI-enabled tools in their service.

Digital technology also has the potential to support more at-home testing, monitoring and remote consultations in some sub-specialties. Appropriate planning and governance processes will need to be in place to realise benefits of better patient experience and significantly improved service efficiency.