IN CONVERSATION WITH

Prof Carrie MacEwen, Chair of The Way Forward and President, The Royal College of Ophthalmologists

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Scope for optimising capacity within the Hospital Eye Service (HES)?

The demand for ophthalmic care continues to grow with no increase in capacity. In order to be able to continue to deliver adequate care ophthalmologists have devised new ways of working that involve patient pathway re-design, better use of technology and improved multidisciplinary working. There is considerable opportunity for greater multidisciplinary learning and in harnessing expanded roles of non-medical eye healthcare professionals (HCPs) within ophthalmology. The right option will depend on staff availability, available IT links across sites and with community practitioners, geographical issues and degree of engagement, for example with local optometrists.

An essential part of the process is ensuring quality of ophthalmic care, and this requires standardisation of competency and training requirements. The Ophthalmology Common Clinical Competency Framework identifies the competences and skill sets that non-medical ophthalmic HCPs – qualified optometrists, orthoptists, ophthalmic nurses and ophthalmic clinical scientists – need to possess in order to safely and successfully undertake expanded roles. As well as ensuring trained staff, there must also be local audit and governance in place.

Overall aims of The Way Forward project?

The ultimate aim is to improve the patient experience. We want to reduce false positive referral rates, for example by making sure there is good glaucoma referral refinement, and ensure effective cataract protocols so that 90% or more of referrals actually go on to have cataract surgery. In some areas the conversion rate for cataract surgery is as low as 50%, representing a huge waste of patient time. This will allow more patients with genuine eye pathology to access appropriate and continuing care. Once in a hospital setting, the goal is to make sure that the patient journey is as efficient as it can be. That means optimising the multidisciplinary team and utilising virtual review clinics if indicated or dedicated clinics structured according to risk grading. Shared care opportunities may also be utilised for discharged patients, with clear re-referral criteria.

Barriers to change?

One of the barriers to change in England is the tariff system. There are often disincentives to make change, for example with reduced income from virtual clinics and funding constraints that limit the scope to construct integrated teleophthalmology care models. Other major issues are workforce shortages with a lack of trained personnel and oftentimes inadequate space. Some ophthalmology departments have been shoehorned into tight spaces.

Key learnings?

Ophthalmologists have proven to be resourceful in overseeing their own delivery of care for the benefit of patients and also prepared to learn from each other. All of the newer models of care adopted have been driven largely by medical doctors, not by commissioners or hospital managers. As far as service delivery is concerned, I was impressed by the approaches being taken to update oversight of diabetic retinopathy screening, increasingly using virtual OCT-based clinics for referral refinement to reduce unnecessary hospital appointments. Some of the proposed newer models of care require additional resources but may nonetheless facilitate higher patient throughput.

We have to service redesign. It is already known from the BOSU Study published in January 2017 that 22 patients per month in the UK are going blind because they are not getting adequate hospital follow-up [1]. Preventable harm due to health service initiated delay indicates a lack of capacity within the HES. So we have to protect patients by ensuring timely follow-up or review. But we also need to continue to push for more medical doctors and consultant ophthalmologists. I believe The Way Forward represents a highly positive piece of research that College members will be able to use as a valuable resource in tackling service redesign to improve service capacity and maintain high-quality ophthalmic care.

References

1. Foot B, MacEwen C. Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome. *Eye* (Lond) 2017;[Epub ahead of print].

INTERVIEWED BY

Rod McNeil

is an independent journalist and consultant.

E: rod.mcneil@icloud.com