The Royal College of Ophthalmologists' response to Health Education England's consultation on the draft health and care workforce strategy for England to 2027

March 18

INTRODUCTION

1. The RCOphth is the professional body for ophthalmologists and trainees in the UK. We work closely with clinical leaders across the sector to help shape eye services and the workforce for the benefit of patients.

2. We welcome the opportunity to respond to this consultation and participate in future conversations about the workforce.

OVERALL COMMENTS

3. We welcome this document and the willingness of HEE and NHS leadership to initiate an open and honest conversation with the sector about the challenges facing the workforce and how we can work together to resolve them.

4. Recognising the impact that the UK's changing demographic is having on healthcare is a positive step. Eye care is particularly sensitive to the ageing population since most eye conditions are associated with ageing. This means demand is steadily increasing and outstripping capacity, necessitating new ways of delivering care.

5. Chapter 6 crucially addresses future demand and attempts to quantify required staffing levels. Our research into how eye services are changing, The Way Forward, concluded that over the next 20 years:

   - cataract operations needed will increase by 50%;
   - glaucoma cases will rise by at least 44%;
   - age-related macular degeneration will rise by nearly 60%; and
   - diabetic retinopathy will increase by *a minimum* of 20% over the next 20 years. Other studies predict 50-80%.

6. We would welcome further work to predict changes in demand and discussions to identify what appropriate staffing levels look like for ophthalmology and the wider care team.

7. As we gain more information about how eye units are adapting to capacity and staff shortages, we are exploring what an effective eye care workforce looks like, including the mix of different roles. While solutions to the capacity issue depend on many local factors and the populations being served, we would strongly welcome national guidance on different ways of working. We wish to work with HEE and the NHS to explore these issues and develop a strategy for delivering the eye care workforce that patients need.

CONSULTATION QUESTIONS

Do you support the six principles proposed to support better workforce planning; and in particular will the principals lead to better alignment of financial, policy, and service planning and represent best practice in the future?

8. Yes. Overall, we agree that the six proposed principles outline the basic requirements for delivering an effective and sustainable workforce. Whether they will lead to better aligned financial, policy and service planning depends on how they are implemented.

9. We welcome greater emphasis on self-supply of staff across the health and care system to ensure its long-term sustainability. New roles and flexible training routes are key to facilitating this and ophthalmology has been one of the leading specialties for upskilling non-medical staff to take on greater responsibility for patient care.

10. We are pleased to see that Ophthalmology is used as a case study for innovative multidisciplinary working. Upskilling non-medical eye care professionals to take on additional responsibility for patient care is a successful approach used in many units which is delivering benefits that go beyond filling staffing gaps. Developing the MDT is an important strategy for addressing capacity issues in the eye service. However, the significant vacancy rates acknowledged within ophthalmology must also be addressed.

11. We note that ophthalmology is recognised as one of the specialities with above average vacancy levels. This was just under 10% in 2016. However, ophthalmology is not included in NHS England's Five Year Forward View priority specialities and there are no proposed steps to address this problem in the present consultation document.

12. Identifying the extent to which enhanced MDT working can address workforce gaps is complex. Many factors are involved, such as availability of suitable staff to

be upskilled, capacity to train and supervise them, support from management to develop and integrate new roles into the service, patient expectations and physical space for them to practise.

13. Non-medical professionals may fall into two groups; those who are and are not willing to take on the greater responsibilities and risk of extended clinical roles. How many individuals fall into either group remains to be seen. There also needs to be planning to back fill their traditional roles so that other parts of the workforce are not undermined.

14. Optometrists and dispensing opticians are not included in the range of professions referred to in the document, which reflects the general view that they are not widely seen as healthcare professionals. If more clinical eye care is to be delivered by non-medical eye care professionals, we would expect this to be recognised within the workforce strategy.

15. The document briefly notes the need to review the role of SAS doctors and how we ensure they are supported and used to their full potential. SAS ophthalmologists play a vital role delivering eye care and represent a source of expertise that could be better used to address our workforce gaps. We are exploring how SAS doctors work, what support they need and how we could maximise their role. For example, suitable individuals could be supported through the CESR process so that they are eligible to take up consultant posts. We would be happy to share our findings as part of wider discussions about how we maximise this important section of the workforce.

16. There is, however, a limit to the extent to which responsibilities and clinical decision making can be delegated to staff who have not completed medical training. There is still a shortage of medical staff who can safely manage this activity, which increasing the supply of non-medical staff will not be able to address. Finding the right balance between training more UK ophthalmologists, upskilling our healthcare professional and employing ophthalmologists from overseas will be critical for delivering an effective and sustainable workforce.

17. NHS ophthalmology has historically been well supported by doctors from India and Pakistan who are equipped with the skills and experience needed to deliver quality eye care services, where we lack the available staff. Therefore, we ask HEE to clarify the extent to which overseas staff can continue to contribute where we cannot train and recruit within the UK. We would welcome further discussions to ensure we find the best way to deliver this principle in a way that ensures patient care is maintained at a high level of quality and safety.

18. Hospital eye services see large numbers of patients each year, with eye care accounting for around 10% of all outpatient activity. Every member of staff involved in delivering care and administering the service is a valuable member of

the team. We would welcome more training and development of non-clinical staff; managers, administrators and receptionists. This could improve the efficient running of services, allowing clinical staff to focus on the tasks they have been trained for.

What measures are needed to secure the staff the system needs for the future; and how can actions already under way be made more effective?

19. The number of ophthalmologist trainees must be better aligned with demand for consultants to reduce gaps in the workforce. Nearly 10% of consultant posts were vacant in 2016, despite all trainee posts consistently being filled each year.

20. Sufficient capacity is needed to upskill non-medical eye care professionals so they can play a greater role in clinical care. This requires appropriate training of professionals, namely optometrists, orthoptists, ophthalmic nurses and ophthalmic clinical scientists. We have set out the required competencies in our Common Clinical Competency Framework[1] and been working with HEE on developing a scheme of assessment to deliver them and provide staff with transferable qualifications.

21. There is a lack of clarity about who will hold responsibility and provide resource for this training, providing qualifications and CPD. If it is to become embedded for the long-term, this needs to be agreed and supported nationally with guidance.

22. Having clear career progression is key to retention. Also crucial for recruitment and retention is staff feeling valued and supported. There must be recognition of the negative impact caused by national or political messaging that the NHS is poor or that staff are not committed to seven-day care. Failure to honestly admit resource gaps also reduces morale and drives staff away from the NHS.

How can we ensure the system more effectively trains, educates and invests in the new and current workforce?

23. More joined up working between professional bodies is required to support training a multidisciplinary workforce. We would welcome support for sharing good practice in training and education across specialties and allied professions. Staff need to be supported to attend College, Academy and wider cross-organisational events.

24. Trainers and Educators must be given adequate paid time in their job plans to carry out their role and be recognised for their excellence. We struggle to recruit doctors

[1] https://www.rcophth.ac.uk/professional-resources/new-common-clinical-competency-framework-to-standardise-competences-for-ophthalmic-non-medical-healthcare-professionals/

to undertake important roles that are vital to the sustainability of high quality services and training, such as examining. Without being given the time by Trusts to undertake these roles, we will be unable to fulfil our requirement to educate, assess and support the future workforce. Many members cite capacity issues in their employing organisation as a barrier to undertaking this crucial work.

25. Quality improvement, efficiency and cost effectiveness are essential to the sustainability of the NHS. It is important to ensure the workforce is aware of these issues. Understanding NHS management, structure and function is important for navigating and bringing about change. Making staff aware of these subjects during their training would allow them to more effectively engage with management and participate in service improvement throughout their careers.

26. Artificial intelligence and future medical applications are relevant across specialties and could be explored during training and education. Discussing new and potential technologies is important to inspire and encourage innovation by our future workforce.

27. Gamification could be helpful for teaching. Ophthalmology is a very visual subject that uses a variety of imaging techniques that lend themselves to interactive ways of learning. Exploring how gamification could be used for support learning is to be welcomed.

How does the system ensure it spends what is needed on individual CPD and gets the most effective outcomes from it?

28. Documenting individuals' training and CPD through their appraisals and job plans can help to ensure that the outcomes are aligned with organisational and NHS needs. National toolkits on key topics, such as upskilling non-medical staff or implementing innovative new models of service delivery would also be useful. Resources could include training materials, competency frameworks, case studies and template protocols and policies.

What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?

29. Clinicians are increasingly required to take on responsibility for non-clinical activities such as service design, managing budgets and developing business cases. However, many of our members report insufficient SPA time to cover this substantial work and lack of available training to support them with it. To ensure the attractiveness of the career, there must be proper recognition of this activity

as part of the role of a consultant and for many SAS doctors, and adequate support and training.

How can we better ensure the health system meets the needs and aspirations of all communities in England?

30. It is vital we recruit and train staff who are willing to work where there is patient need. There is currently significant difficulty recruiting medical staff to work in rural locations such as areas of the North of England. Employers need to be supported to be more attractive to potential recruits. Staff often tend to take up posts near to where they have trained, so relocating education providers closer to areas that struggle to recruit may be a way to resolve this.

31. Financial restraints in the health system mean that patient choice cannot be always be accommodated and staff need to make difficult decisions about how to use limited resources to best serve their local population. Raising awareness and educating patients and carers about the system, how to access it and what they can realistically expect from it would support effective use and collaboration between staff and users. This should include empowering patients to self-manage their health where possible to decrease unnecessary demand for care.

What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?

32. We consider that a model employer is accessible and engaged with its workforce. Managers should have a good understanding of the services provided and pressures faced by the clinical staff delivering them. There is a widespread feeling among clinical staff that managers do not understand or effectively work with them to solve problems and improve services.

33. Model employers effectively recognise and address capacity issues, such as staffing shortages, which impact on front line staff and patients. Recognising quality of work more effectively would also make the NHS more attractive and encourage retention.

If you have any questions or need more information, please contact Laura Coveney, Policy Researcher at laura.coveney@rcophth.ac.uk