HSE Primary Care Eye Services Review Group

Submission by the Irish Medical Organisation

18th December, 2014

Sir Patrick Dun's Hospital, Dublin

Terms of Reference of the Review Group

The terms of reference of the Primary Care Eye Services Review Group are as follows:

- Examine and document the primary care eye services currently provided to children and adults nationwide including HSE directly provided services and contracted primary care services.
- Determine and document the needs of the population for primary care eye services.
- Review the current primary care eye services in terms of quality, safety and consistency and identify issues for action.
- Set out a clear blueprint with recommendations for delivery of primary care eye services which will ensure a high quality, safe and consistent service for patients.
    a) Put in place an action plan to address immediate primary care paediatric eye services issues in the Dublin area.

The Irish Medical Organisation (IMO) was invited to engage with the Review in early September 2014, with a subsequent invitation to make a submission to Review personnel in December 2014.

Current Community Based Services

It is Government policy that ninety to ninety five percent of an individual's health and social care needs be met in a community or primary care settings. The ongoing difficulties in the public finances, and difficulties in addressing hospital outpatient waiting lists, make this policy aim not just desirable but essential. Accordingly, there is a need to ensure that the State maintains and supports a specialist eye doctor service in community and primary care settings.[1]

The medical treatment of the eye is known as Ophthalmology. It has been recognised that there are two branches of ophthalmology, the surgical and the medical. The majority of traditional surgical ophthalmology takes place in hospitals, and is under the care and supervision of Consultant Surgeon Ophthalmologists. However, as recognised in the National Eye Care Plan, the majority of medical eye treatment can be delivered in community, or primary care, settings and it is there that this submission will focus.

Medical eye care and treatment is delivered by Ophthalmologists; these doctors are entered on the Specialist Register by the Irish Medical Council and are may practice independently, may be consulted by their colleagues, and will assume full and continuing clinical responsibility for those aspects of patient care on which they have been consulted. In this level of expertise and specialism, they are unique in the delivery of non-hospital eye care. As independent specialist practitioners, Ophthalmologists are the only professionals working in non-hospital eye care that may, under current legislation, make medical diagnoses of and prescribe treatments of medical eye conditions.

[1] For a discussion of waiting lists for eye care services in Ireland, see 'National Eye Care Plan' Health Service Executive, National Clinical Programme in Eye Care, pp 9 - 10

Accordingly, the IMO would contend that a community, or primary care based eye service must be specialist led and practice evidence based medicine of the highest standard. To do otherwise would not be in the best interests of patients, and may result, despite the best of intentions, in flawed diagnoses which require later specialist intervention.

In terms of actual service delivery, ophthalmologists provide services to patients on behalf of the State either as direct employees of the HSE, or as contractors for service. The submission will now briefly examine these roles and their responsibilities.

Community Ophthalmic Physicians

Community Ophthalmic Physicians (COPs) are HSE employees and they are charged, primarily, with providing medical eye care to a range of identified groups comprehended within screening programmes; school based screening programmes being the most widely known. Among the conditions presenting for treatment by COPs are strabismus, amblyopia, refractive errors and congenital eye disease. The COP service receives referrals from nurses, optometrists, other eye care professionals and, of course, General Practitioners. However, it has been observed that "[I]n many cases the health care professionals carrying out this range of vision screening checks are inadequately trained to identify vision problems." This leads to the appearance of high false positive rates and "consequently very long waiting lists for specialist review in the local health clinics." These waiting lists can, in some cases, run as long as four years.

There can be no doubt that these waiting lists are too long, especially if one is dealing with a referred child and an anxious parent. This is exacerbated by the fact that the specialist care that is delivered is often provided in "poorly resourced clinics with inadequate diagnostic equipment."[2]

Nonetheless, despite the small number of COPs in the health service, the long waiting lists, and the less than optimal working conditions, the COP service is the only specialist and diagnostic community based eye service delivered by HSE employees.

Contracted Ophthalmological Services

In recognition of the constraints placed on both hospital based ophthalmology services and the COP service, the State has contracted for ophthalmological services with ophthalmologists who are not State employees. This is done via the Community Ophthalmic Services Scheme (COSS) and, latterly, the Community Ophthalmic Services Medical Treatment Scheme (COSMTS).

The first of these, the COSS, is delivered by approximately twenty private practices and provides medical card holders with a biennial eye test, and facilitates the provision of the necessary spectacles and appliances, as required. It was felt that this Scheme was, by its nature, cumbersome, and insufficiently clinical to enable participating eye doctors to respond

[2] There are twenty two Whole Time Equivalent (WTE) Community Ophthalmic Physicians employed by the HSE. 'National Eye Care Plan' (pp. 12 - 14)

adequately to acute conditions once detected. As a result, in 2004, the COSMTS was launched as a pilot scheme taking in four contractors providing diagnosis and treatment in six practice sites. Unlike the COSS, Ophthalmologists participating in the Medical Treatment Scheme could accept referrals from General Practitioners and Optometrists (for example) and diagnose and treat acute conditions. The Medical Treatment Scheme was rolled out on a 'pilot' basis only and despite Ministerial approval to make it more widely available, no further roll out has occurred.

The Rationale for a Specialist Eye Care Service in the Community

As observed in the National Eye Care Plan

> "Increasing patient numbers and the growing incidence of chronic diseases are placing an enormous strain on the current model of eye care. Hospital centres are overburdened by chronic diseases, most of which could be appropriately diagnosed, treated and managed in the community by eye doctors in a decentralised model."[3]

To ease the burden on overstretched hospital based eye care will require a careful and gradual re-balancing of eye care services and delivery in Ireland. As greater amounts of this type of care are delivered in community settings, so the balance of funding can be brought into a new alignment. In order for a specialist community based eye doctor service to assume its full share of the patient workload, it must attain sufficient scope and scale itself. Notwithstanding the necessary up-skilling of other professionals working in this field, in order to ensure community based eye care makes a significant difference in terms of keeping patients from having to attend hospital, it must be specialist led, and to the greatest extent possible, specialist delivered.

As referenced above, the community based Ophthalmologist, whether a HSE employee or a contractor for service, is the only professional in that setting who can assume complete and continuous responsibility for their patients care. To ensure that the migration of eye care services from hospitals to the community is not to be accompanied by any diminution in service, the IMO would submit that the Ophthalmologist must be at the centre of the delivery of care and have a continuing relationship with the patients under their care.

Enabling Specialist Eye Care in the Community

It has been noted above, that a feature of the COP service is long waiting lists, brought about, in large part, by inappropriate referrals. To offset this situation, a refined screening service is required. This would include fully trained nurses and orthoptists working with an enhanced COP cohort to ensure that only those patients who need specialist care, receive that care. Shorn of the need to act as their own screening service, COPs could, increasingly focus on chronic care, particularly in respect of adults who may otherwise end up on hospital waiting lists. This is a double financial benefit for the State, in terms of keeping patients off waiting lists

[3] National Eye Care Plan (p.21)

and out of hospitals, but also in terms of deriving the full benefit of the specialist skills of the COPs.

The dictates of the Moratorium on Recruitment have hit the COP workforce hard; each loss and subsequent non replacement of a doctor is keenly felt in such a small group. The IMO contends that increasing COP manpower is a key step in ensuring that specialist eye care in the community attains critical mass. It has been mooted that the COP service be clustered into a small number of centres per hospital region. In terms of the need for COP clinics to function as effectively as possible in terms of support teams and infrastructure, there may be some merit to this suggestion.

The Expansion of the Community Ophthalmic Services Medical Treatment Scheme

It has been noted in the National Eye Care Plan that the COSMTS "is an enhanced medical version of Community Ophthalmic Services Scheme (COSS) for medical card holders requiring medical diagnostic and treatment services provided by eye doctors." As noted above, Ministerial approval to extend the Medical Treatment Scheme beyond the 'pilot' practices was given in 2007. With the severe deterioration in the public finances since 2008, this project has, unfortunately, been stalled for some years now. This is despite the best efforts of the IMO and of the participating Ophthalmologists to have the Scheme extended. [4]

However, in the context of re-appraising non-hospital eye care services, the case for the expansion of the Medical Treatment Scheme is worth re-stating. In the first instance, the Medical Treatment Scheme provides value for money; using the most recent figures available, the IMO has calculated that the average cost to the State per specialist consultation was €80, which is between sixty and one hundred percent less than a consultation in the hospital sector.

To better understand the effectiveness of the Medical Treatment Scheme it is worth assessing the results of audits recently conducted by practices that participate in the Scheme. In one instance, one practice, with surgeries in Ranelagh (Dublin) and Naas (Kildare), took one hundred and sixty two referrals from the eye care waiting list in Adelaide Meath National Children's Hospital (AMNCH). Of those, only fifteen (nine percent of the total) were subsequently referred back to AMNCH. The vast majority were treated in community settings, either in the Medical Treatment Scheme practices, or referred to other community based service providers. Similarly, another audit took five hundred patients from the waiting list at Cork University Hospital (CUH), the vast majority of whom were treated just as effectively in community settings without the need for them to endure long waiting lists with the attendant strains and stresses, and at lower cost to the State.

In one final instance, Our Lady's Children's Hospital Crumlin referred a group of patients to a Medical Treatment Scheme practice in Bray (Wicklow) and Fairview (Dublin) in late November 2013; it was requested that the patients, all of whom were under sixteen years of age, should be seen before the end of 2013. This group consisted of eighty three referrals of which sixty accepted appointments and were examined by two paediatric ophthalmologists over a four week period. Over half of these children were discharged by the practice with the remainder referred for appropriate follow up. (Appendix A).

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[4] National Eye Care Plan (p.27)

While the long held view of the IMO is that the Medical Treatment Scheme ought to be expanded, it is accepted that there are qualifying criteria in terms of the need for the participating doctor to demonstrate that they are available on a full time commitment, have sufficient IT and other facilities and have the requisite indemnity and insurance. However, as most, if not all, of these costs must be met by the participating eye doctor, these should not work against the gradual roll out of the Medical Treatment Scheme. Indeed, the IMO is aware of four eye doctors who could join the Medical Treatment Scheme within a short time frame. Furthermore, it should be borne in mind that as practices join the Medical Treatment Scheme, they would depart the COSS, which would yield a saving to State. (Appendix B).

Two further points are worth making in this regard. Firstly, as knowledge of the Medical Treatment Scheme increases, in line with its expansion, it can reasonably be expected that participating practices will be required to hire additional staff, including specialist eye doctors. Secondly, the Scheme is funded through the Primary Care Reimbursement Service (PCRS) of the HSE. This funding arrangement has worked well since its inception and would allow for the Medical Treatment Scheme to be easily adaptable to a 'Money Follows the Patient' funding model.

Conclusion

The IMO is grateful for the opportunity afforded to us to set out the benefits of a specialist community based eye doctor service. We believe that there is a compelling logic in ensuring that patients can avail of a specialist service as close to their home as possible without the automatic need to attend a hospital. When considered from the point of view of a patient, it is preferable to have an ongoing relationship with "their" eye doctor as opposed to having to attend, unfortunately impersonal, hospital outpatient departments.

However, while community based care is very often preferable to hospital care, it must still be considered to be, and valued as, specialist care. Under the current legislation, Ophthalmologists are the only eye care professionals who are entitled to make medical diagnoses and practice independently. Patients can reasonably expect to be treated by recognised specialists and this should be the case, whenever possible. We would caution against allowing 'light touch regulation' of eye care without first seriously considering the potential consequences.

In the view of the IMO, both aspects of community based Ophthalmology, whether delivered by HSE employees, or contracted specialists, need to be enhanced and while the two may be complimentary, they are not in conflict. Both services offer the taxpayer an excellent value proposition and, while we acknowledge the scarcity of resources, we would urge that we invest now to reap the benefits later.

Appendix A

Tallaght OPD Referrals 2013-2014 *Ranelagh/ Naas*

Total no of referrals **162**

Total number discharged/removed from Tallaght OPD: **147** **91%**

*** Total DNA** **44 (27%)** **3 consecutive appointments given to patients in Ranelag appointments but failed to attend**

Total patients seen **112** **procedure 7 done in Ranela paediatric 2 cases**

Discharged from Tallaght **147** **91%**

followed up in the community under HBCOSS scheme or GP/Optician as required

RVEEH cataract referrals: **20 = 13%**

Referred back to Tallaght **15 = 9%**

(reason for referral back as below)

* orthoptic	5
*YAG	1
* dermatology	1
*OPD	4
*diabetic	2
* Other:	2

6 referrals did not attend for other reasons:

2 seen in the RVEEH

1 no need for apt.

1 to stay with Tallaght , has MND

2 Passed away.

CUH Waiting List Initiative Final Figures (2014)

Total Number of Patients Seen: (by Dr Traynor, not Dr Mark James or Dr Ann Collins)	501
Total Appointments Scheduled: (For Dr Traynor)	574 (+8 for patients who previously DNA'c
Total DNA's:	76 (+5 of those given second appointment) (13% of total scheduled appointments)
Total Discharged:	394 (78% of total number seen)
Total Referred for Cataract Surgery: (1 or 2 cataracts)	87 (17% of total number seen)
Total Referred for CUH Follow Up:	20 (5% of total number seen)
Total Needing OCT Scan of Macula/Disc:	37 (7% of total number seen)
Total Needing Visual Field Testing:	34 (6% of total number seen)

Appendix B

Questionnaire for inclusion in the:

Community **O**phthalmic **S**ervices **M**edical **T**reatment **S**cheme

(COSMTS)

1. Can you please confirm that you are an active participant in the current community ophthalmic services scheme (COSS)?

2. How many sessions per week do you spend in your own practice premises? - A session is a morning. afternoon or evening clinic.

3. Do you hold a part-time hospital or COP post, if so what is your session of commitment?

4. Do you practice ophthalmology exclusively? If not, please state your other specialty commitments.

5. Please state the location or locations at which you see COSS patients.

6. Please state which of the following management facilities you have available in your practice premises:

a). Administrative support staff such as secretary/receptionist

B). A recognized electronic patient record system (EPR)

7. Please list the practice equipment at each of your practice locations on a separate sheet.

8. Do you have professional indemnity insurance?

Does this indemnification cover you in each of your practice premises?

9. Do you have public liability insurance cover at each of your practice premises?

10. Do you have employers' liability insurance cover at each of your practice premises?