Macular Services Survey 2014 Report

In September 2013 and again in August 2014 the Royal College of Ophthalmologists and the Macular Society undertook a survey of Consultant Ophthalmologists with sub-speciality interest in medical retinal disorders. The survey sought their opinions on the current state of medical retinal services in the UK.

2013 Survey
The survey was sent to 226 consultant ophthalmologists across the UK and received a 31% response rate.

2014 Survey
The survey was sent to 234 consultants ophthalmologists across the UK and received a 28% response rate. We do not know if respondents from the 2014 survey are the same individuals who responded to the 2013 survey.

Results

We analysed the 2013 and 2014 findings for change. The findings for 2014 show some changes to those from the 2013 survey. In 2014 15.8% of respondents described their service as excellent (where patients received a high level of care) compare to 12.9% in 2013. Another 26.3% described their service as 'good' (patients receive an appropriate level of care) in 2014 compared to 28.6% in 2013. In 2014 49.1% said their service was 'quite good' (could be improved – some patients do not receive an appropriate/optimal level of care) compared to 45.7% in 2013.

In 2014 8.7% stated that their service was 'Poor' (significant numbers of patients do not receive appropriate/optimal care, and some may be losing more sight than necessary as a result) compared to 11.4% stating so in 2013. No respondents in 2014 felt their service was 'very poor' (significant numbers of patients may be losing more sight than was necessary) whereas 1.4% had stated so in 2013. The results suggest a small improvement in the perception of the quality of services by clinicians.

The top 3 barriers to good or excellent services remain and a great percentage of respondents identified them as the main areas for improvement.

1. Medical staff shortages (76.3% in 2014:69.4% in 2013)
2. Support staff shortages (71% in 2014: 69.4% in 2013)
3. Insufficient clinic time (52.6% in 2013:57.1% 2013)

The fourth main barrier for both surveys was also the same; however a larger percentage of respondents ranked it in fourth place in 2014:

4. inadequate prioritisation of AMD Services by Hospital Trust managers (52% in 2014: 46.9% in 2013)

In addition a slightly larger percentage of patients were perceived as having presented too late for treatment in 2014 (13.7 compared to 12.2% in 2013). Requirement for individual funding requests by commissioners was perceived as less of a problem in 2014 (5.3% compared to 6.1% in 2013).

Manpower issues appear to the main barriers to improving access to treatment in 2014. (See Table 1 below).

The survey results show a good improvement in the access to aflibercept for patients most likely due to the NICE Technology Appraisal 'Aflibercept solution for injection for treating wet age-related macular degeneration'. Aflibercept (Eylea, Bayer) was only available (for wet AMD) to 12% of ophthalmologists in 2014 (24.3% in 2013) prior to relevant NICE guidance, and became available to 69% (32.9% in 2013) following such relevant NICE guidance. Only 1.7% of respondents had no access to aflibercept in 2014 compared to 42.9% in 2013. Amongst those who had access to aflibercept, only 19.3% (6.4% in 2013) thought that it had contributed to resolving their capacity issues, 31.6% said not (27.7% in 2013), whilst 49% thought it was too early to say (66% in 2013).

Table 1

If your service is not good or excellent what are the barriers to a good or excellent service (pick as many options as relevant)		
Answer Options	**Response Percent**	**Response Rank**
Medical staff shortages	76.3%	1
Support staff shortages Please state which category: nursing, imaging, other	71.1%	2
Insufficient clinic time	52.6%	3
Trust managers don't give it a high enough priority	52.6%	4
Inadequate tariff for follow up	10.5%	4
Theatre/clean room facilities	34.2%	5
Tariffs set too low	15.8%	6
Patients presenting too late for treatment	13.2%	7
Poor referral pathways from primary care	13.2%	7
Insufficient services commissioned	10.5%	9
No fast track macular clinic	10.5%	9
Commissioners require individual funding applications	5.3%	12
Patients presenting too early for treatment	0.0%	13

The waiting time for initial treatment remains similar between the 2013 and 2014 results. The majority of patients are still not being seen for their first appointment within the 2 week target recommended by the College (Reference College AMD GUIDELINES) This is clinically relevant in a time sensitive condition and this capacity issue does need to be addressed.

AMD Expected waiting time for initial treatment	**2013**	**2014**
<2 weeks	42.6%	42.1%
2-4 weeks	42.6%	43.8%
<4 weeks	11.8%	10.5%
>8 weeks	2.9	3.5%

In 2013 we asked: '**What is the expected time between follow up appointments for your AMD patients?**' Time between follow ups was 4-6 weeks in 62.3%, 6-8 weeks in 18.8%, 4 weeks in 14.5% and more than 8 weeks in 4.3%.

For 2014 the survey was modified and we asked for expected waiting times for follow AMD patients being treated with Eylea and separately asked for information on expected waiting times for follow AMD patients being treated with Lucentis. Waiting times appear to have reduced for follow-up appointments.

Expected waiting time between follow ups for AMD patients having:	**Eyelea**	**Lucentis**
4 weeks	10.9%	25.8%
4-6 weeks	23.6%	58.6%
6-8 weeks	52.7%	12.1%
>8 weeks	12.7%	3.4%

Consultants continue to run extra clinics to meet demand for AMD services.

Are you running extra clinics to meet demand for AMD patients?	**2013**	**2014**
No	43.8%	44.23%
Yes in the evenings	14.1%,	7.7%
Yes at weekends	42.2%	48.1%
Yes in the private sector	0%	0%

Diabetic macular oedema (DMO) services

Guidance from NICE on treatment of DMO was published in April 2013. For DMO services, 91.4% of respondents had a service in place or had business cases agreed in 2014 and which is an encouraging increase from 71.8% in 2013 (although we did not ask about effectiveness in dealing with demand). This tells us there has been an improvement following NICE guidance on DMO in April 2013. However close to one in 10 of respondents do not have a service in place in 2014

None of the 2014 respondents stated that there were not treating DMO patients as recommended by NICE compared to 11.3% who stated they were not doing so in 2013.

There was a significant reduction in the level of responses stating that consultants had to apply for individual funding in order to treat DMO patients (69% in 2014 compared to 11.3% in 2013).

Service quality:

Which description best fits your service for DMO?	2013	2014
Excellent (my patients receive a high level of care)	5.8%	7%
Good (my patients receive an appropriate level of care)	36.2%	36.8%
Quite good (could be improved)	33.3%	36.8%
Poor (significant numbers of patients do not receive appropriate/optimal care and some may be losing more sight than is necessary)	18.8%	19.3%
Very poor (significant numbers of patients may be losing more sight than is necessary)	5.8%	0%

Waiting times for initial treatment remains very similar between the 2013 and 2014 results for DMO services although there has been some improvement in waiting times.

DMO Expected waiting time for initial treatment	2013	2014
<2 weeks	6%	10.5%
2-4 weeks	41.8%	47.4%
<4 weeks	28.4%	24.5%
>8 weeks	7.5%	14%
> 12 weeks	7.5%	3.5%

There has been a large increase in the number of extra clinics being run at weekends 44.2% compared to 12.1% in 2013 in order to meet demand.

Retinal vein occlusions (RVO)

In 2013 70% of respondents reported they had services were in place in for RVO treatment; this has increased to 89.6% in 2014. Although the number of respondents having to apply for individual funding has decreased from14.3% in 2013 to 6.9% in 2014 it is still worrying that guidance has not been fully implemented across the UK. Access to services for RVO patients appears to have increased with only one respondent stating their service is not treating RVO patients compared to 7.1% so stating in 2013.

Encouragingly there was decrease in responses which suggested consultants are concerned that significant numbers of RVO patients may be losing more sight (0% in 2014 compared to 8.7% in 2013). However, over half of the respondents stated that services still needed improvement before they would rate the services as delivering appropriate standards of care to patients. This closely matches the results from the 2013 survey (53.6% in 2014 and 50.7% in 2013).

Waiting times for the initial treatment appear to have improved slightly with a smaller percentage of respondents answering that patients can expect to wait longer than 4 weeks for treatment.

RVO Expected waiting time for initial treatment	2013	2014
<2 weeks	10.4%	10.5%
2-4 weeks	35.8%	52.6%
<4 weeks	35.8%	19.3%
>8 weeks	10.4%	10.5%
> 12 weeks	7.5%	7%

A majority of respondents stated that they are running extra clinics at weekends to meet demand compared to 2013.

Are you running extra clinics to meet demand for RVO patients?	2013	2014
No	86.2%	66.7%
Yes in the evenings	7.7%	3.7%
Yes at weekends	6.2%	29.6%
Yes in the private sector	0%	0%

Solutions Suggestions

Ophthalmologists were asked their opinion on potential solutions to medical retina capacity issues in 2013 and 2014. The 2014 responses differ to those of 2013 in attitudes to potential solutions. There was a decrease in respondents suggesting that that an increase in number of doctors delivering the service or outsourcing the service was a solution of merit. A third of respondents still agree that developing non-medical staff to undertake intravitreal injections was a potential solution, although only 37% believe that such a change will increase capacity in NHS Medical Retina Clinics. Nurses were the most popular choice of professional to undertake this role. This is in keeping with the concept of local solutions for local issues and it is reassuring that ophthalmologists continue to look for innovative solutions in meeting concerns about capacity in eye care services.

How do you think capacity in the NHS AMD/Medical Retina Clinics can be increased? (pick all options you feel are relevant)	2013	2014
Increase assessment capabilities by employing more doctors	47.1%	5.6%
Increase assessment capabilities by adopting multidisciplinary teams	81.4%	53.7%
Administration of intravitreal injections by non-medical retina Ophthalmologists	31.4%	3.7%
Administration of intravitreal injections by non-medical personnel in line with the College statement	70.0%	37%
Outsourcing services to non-NHS providers	11.4%	0%

In addition the 2014 survey asked consultants which type of staff currently undertook intravitreal injection treatments in their ophthalmology departments. All ophthalmic departments responding stated ophthalmology medical staff continued to undertake this procedure and 33% stated nursing staff also undertake intravitreal injection treatments. One respondent stated orthoptic staff delivered such treatments.

In 2014, 88.5% of respondents stated they were considering developing non-medical staff to undertake intravitreal injection treatments. Only 12.3% of respondents stated they were opposed to the concept of intravitreal injections by non-medical staff.

Please indicate which type of staff you are currently developing to undertake intravitreal injections in your department?	
Nursing staff	100%
Orthoptic staff	8.3%
Optometry staff	2.1%

Considering your views on intravitreal injections by non-medical staff are you….	
Supportive of the concept	80.7%
No opinion	7%
Against the concept	12.3%

How is your department coping with intravitreal injection requirements?	
Coping very well with demand	12.1%
Just about coping	48.3%
With great difficulty	31%
Not able to meet demand	8.6%

Concerning progress at your department with gaining management approval for non-medical staff injections, has your department made a request for approval for intravitreal injections by non-medical staff?	
Yes	63%
No	37%

If you answered yes to the question above has the request for approval for intravitreal injections by non-medical staff been supported?	
Yes	88.6%
No	11.4%

Comments

The picture that has emerged from this second survey, is of a service in 2014 under continued stress, where over half the respondent consultant ophthalmologists recognise that the medical services could be improved. The major hurdles, absinthe 2013 survey, continue to be related to resources; medical and support staff shortages, insufficient clinic time, and a perceived inadequate prioritisation by NHS Trusts for these services.

To meet these challenges ophthalmologists have been at the forefront of promoting innovative solutions such as training non-medical injection and assessment staff, and promoting the adoption of new NICE guidance.

Despite these steps there remains a need to address the issue of increasing the capacity for the medical retina services if the delivery of these sight-saving medications, in a timely and cost-effective fashion, is going to remain effective.

Ophthalmologists are therefore encouraged to continue to work with managers, and actively participate in the planning and development of services and to actively involved in relevant contract negotiations.

September 2014

Annex A: Resources

- Age-related Macular Degeneration clinical commissioning guidance from The College of Optometrists and The Royal College of Ophthalmologists (November 2013)
- Maximising capacity in AMD services from The Royal College of Ophthalmologists (July 2013)
- Commissioning and Value for Money for AMD services section of the College website
- New to Follow Up Ratios for Ophthalmology Appointments from The Royal College of Ophthalmologists (2011)
- National Institute for Health and Care Excellence
- Half of eye clinics failing to meet guidance on waiting times from Macular Society Press Release (2012)

Annex B: Commissioning Groups Covered by the Respondents

1 respondent is in full time private practice

England CCGs covered by the response

- NHS Bath And North East Somerset CCG
- NHS Bexley CCG
- NHS Bolton CCG
- NHS Brighton And Hove CCG
- NHS Birmingham Crosscity CCG
- NHS Bristol CCG
- NHS Bromley CCG
- NHS Cambridgeshire And Peterborough CCG
- NHS Camden CCG
- NHS Coventry And Rugby CCG
- NHS Eastern Cheshire CCG
- NHS East Leicestershire And Rutland CCG
- NHS East And North Hertfordshire CCG
- NHS Enfield CCG
- NHS Gloucestershire CC
- NHS Great Yarmouth And Waveney CCG
- NHS Harrogate And Rural District CCG
- NHS Herefordshire CCG
- NHS Hillingdon CCG
- NHS Hull CCG
- NHS Ipswich And East Suffolk CCG
- NHS Kernow CCG
- NHS Lancashire North CCG
- NHS Leeds North CCG
- NHS Lincolnshire West CCG
- NHS Newcastle North And East CCG
- NHS Northern, Eastern And Western Devon CCG
- NHS North Manchester CCG
- NHS North Somerset CCG
- NHS Nottingham West CCG
- NHS Portsmouth CCG
- NHS Sheffield CCG
- NHS Solihull CCG
- NHS Stockport CCG
- NHS Surrey Heath CCG
- NHS Waltham Forest CCG
- NHS Wandsworth CCG
- NHS Warrington CCG
- NHS West Essex CCG
- NHS Wiltshire
- NHS Wolverhampton CCG

Northern Ireland

- Belfast Local Commissioning Group
- Western Local Commissioning Group

Wales

- Betsi Cadwaladr University Health Board
- Cwm Taf University Health Board

Scotland

- NHS Borders
- NHS Fife
- NHS Highland
- NHS Greater Glasgow and Clyde