The Royal College of Ophthalmologists

Macular Society

AMD Services Survey 2013 Report

In September 2013 The Royal College of Ophthalmologists and the Macular Society sent a joint survey to medical retinal consultants seeking their opinions on the current state of wet AMD and other medical retinal services in the UK. We were particularly interested in the view of clinicians providing these services and will compare the results with a similar survey conducted by the Macular Society in July 2012 to see if we can detect any changes.

The survey was sent to 226 consultants across the UK and received a 31% response rate.

Findings

There is the significant insufficiency of resources to deliver adequate contemporary AMD Services. Only 12.9% of respondents described their service as excellent (where patients received a high level of care). Another 28.6% described their service as 'good' (patients receive an appropriate level of care), whilst 45.7% said their service was 'quite good' (could be improved – some patients do not receive an appropriate/optimal level of care). The service was reported as 'Poor' (significant numbers of patients do not receive appropriate/optimal care, and some may be losing more sight than necessary as a result) by 11.4% whilst 1.4% felt their service was 'very poor' (significant numbers of patients may be losing more sight than is necessary).

Respondents thought that the barriers to good or excellent services were medical staff shortages (69.4%), and support staff shortages (69.4%) followed by insufficient clinic time (57.1%). Other reasons included inadequate prioritisation of AMD Services by Hospital Trust managers (46.9%), inadequate theatre/clean room facilities (30.6%), insufficient service commissioning (24.5%), low tariffs (18.4%) or inadequate tariff for follow-ups (14.3%), poor referral pathways (18.4%) and no fast track macular clinics (12.2%). In addition, patients presented too late for treatment in 12.2%, or individual funding requests were required by commissioners in 6.1%.

Aflibercept (Eylea, Bayer) was available (for wet AMD) to 24.3% pre-NICE guidance, whilst 32.9% had access post-NICE guidance. However, at the time of the survey,

42.9% of respondents had no access to aflibercept. Amongst those who had access to aflibercept, only 6.4% thought that it had contributed to resolving their capacity issues, 27.7% said not, whilst 66% thought it was too early to say.

The waiting time for initial treatment was less than 2 weeks in 42.6%, between 2 to 4 weeks in 42.6%, more than 4 weeks in 11.8% and more than 8 weeks in 2.9%. 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%. Extra clinics are being run at weekends by 42.2% of services, and evenings in 14.1%, whilst 43.8% do not run extra clinics to meet AMD demand.

For Diabetic macular oedema (DMO) services, 71.8% of respondents had a service in place or had business cases agreed, whilst 11.3% were not treating patients with DMO as recommended by NICE. Another 11.3% had to apply for individual funding in order to treat DMO patients. The DMO service was described as good (patients received appropriate level of care) in 36.2%, whilst 33.3% thought their services were quite good but could be improved (as some patients did not receive optimum care), and 18.8% thought their service poor (significant numbers of patients not receiving appropriate care; another 5.8% described their services as poor (significant numbers may be losing vision). Commonly, the expected waiting time for the initial treatment in DMO was 2-4 weeks (41.8%), more than 4 weeks (28.4%, more than 8 weeks (7.5%), more than 12 weeks (7.5%), and less than 2 weeks (6.0%). Extra clinics were being run at weekends (12.1%) or in the evenings (3.0%) in order to meet demand.

Retinal vein occlusion (RVO) services were in place in for 70% of respondents, whilst 14.3% had to apply for individual funding, and 7.1% were not yet treating RVO patients (8.6% didn't know). The RVO service was described as quite good in 50.7%, good in 31.9%, excellent in 8.7% and very poor in another 8.7%. Waiting times for the initial treatment varied from 2-4 weeks (35.8%), >4 weeks (35.85%), more than 8 weeks (10.4%), less than 2 weeks (10.4%) and more than 12 weeks (7.5%). Extra clinics were being run in the evenings (7.7%) or weekends (6.2%) of cases to meet demand for treating RVO patients.

Respondents felt that capacity in NHS AMD/ Medical Retina Clinics could be improved by increasing the assessment capabilities by adopting multidisciplinary teams (81.4%), administration of intravitreal injections by non-medical personnel in line with College statement (70%), employing more doctors (47.1%) or administering intravitreal injections by non-medical retina ophthalmologists (31.4%), or outsourcing services to non-NHS providers (11.4%).

Comments

This survey provides evidence that AMD Services in many areas across the UK are generally functioning below the required capacity 5-6 years following NICE Guidance

TA 155 which recommended ranibizumab as a treatment option in all types of wet AMD. Evidence continues to support increasing prevalence of nAMD in the UK population. The recent introduction of aflibercept (Eylea, Bayer) is expected to make only a small contribution to capacity issues. Furthermore, as there are no immediate longer-acting treatments, the burden of follow-ups in our AMD Clinics are unlikely to ease. The burden of regular follow-up visits for nAMD patients is likely to continue for some time.

The recent addition of treatments for other retinal vascular diseases, including macular oedema secondary to retinal vein occlusions, and diabetic macular oedema, as predicted, has increased the burden of treatment.

The capacity and logistical issues identified in the earlier survey by the Macular Society in July 2012 have unfortunately not been adequately rectified, and may have been aggravated by the introduction of new therapies. More medical retina specialists now believe that capacity issues may be relieved by the administration of intravitreal injections by non-medical personnel, or other ophthalmologists (compared to 2012).

Significant increase in capacity is required to be able to deliver services that are sufficient, as well as efficient, for needs in order to optimise treatment outcomes.

Clinicians are advised to engage with managers, and actively participate in the planning and development of services and contract negotiations.

The new Clinical Commissioning Groups (CCGs) should prioritise treatments of retinal diseases so as to reduce levels of visual impairment that go with optimisation of contemporary services.

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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)