



## **The Royal College of Ophthalmologists' response to the All-Party Parliamentary Group (APPG) on Eye Health and Visual Impairment's Call for Evidence on capacity problems in NHS eye care services and avoidable sight loss in England**

September 17

### **INTRODUCTION**

The Royal College of Ophthalmologists (the RCOphth) is the professional body for ophthalmologists and trainees in the UK. We work to ensure quality of patient care through the maintenance of high standards in ophthalmology and the wider eye service.

We work closely with leaders across the sector to help shape eye services for the benefit of patients. This includes providing commissioning guidance and identifying solutions to the capacity issues faced by ophthalmic services.

The RCOphth welcomes the opportunity to respond to this call for evidence. We have set out our response below to Section 5 of the consultation document which calls for evidence from health professional bodies with an interest in eye health commissioning and planning.

### **CONSULTATION QUESTIONS**

**Q1. How effective are the following at assessing the eye health needs of their local populations?**

**Q2. Compared to other areas of health and social care what priority do you consider the following give to eye health services?**

**Q3. How effective are (a) CCGs at commissioning and (b) STPs at planning eye health services to meet local patient demand? Please explain why.**

We have serious concerns about widespread gaps between available services and the eye health needs of local populations which suggests inadequate assessments, planning and prioritising of resource at both local and national level for the current and developing population needs for ophthalmic care. Our evidence falls within the following areas.

#### **Patient harm**

The British Ophthalmological Surveillance Unit (BOSU) study published in January 2017 concluded there are up to an estimated 22 patients per month permanently losing sight due to hospital-initiated delays in care. Delayed follow-up or review appointments were the cause in most cases. This indicates insufficient capacity in the service.

National Reporting and Learning System (NRLS) data showed that between April 2011-March 2014 there were 577 delayed glaucoma appointments, 58 resulting in severe harm and 118 in moderate harm.

NRLS data also showed that between August 2011 – September 2013, around 500 incidents of severe (130) and moderate (350) vision loss occurred due to delayed review appointments in ophthalmology outpatients. This was mostly in glaucoma, macular degeneration and retinal conditions including diabetic retinopathy.

The National Patient Safety Agency (NPSA) issued a rapid response safety alert in 2009 on managing glaucoma follow up delays. This followed NRLS data that showed 44 glaucoma patients experienced deterioration of vision between June 2005 and May 2009, including 13 reports of total loss of vision, attributed to delayed follow up appointments.

### **Cataract Rationing**

We are receiving increasing reports from patients and our members of cataract surgery being rationed, eligibility being based on arbitrary thresholds rather than clinical need. In some cases, patients have only qualified for surgery after sight loss has occurred in their second eye.

Our members are regularly having to complete Independent Funding Requests for cataract surgery, which causes delays to treatment and uses up significant clinician time. This is a highly inefficient method of funding patient care. We are currently carrying out a survey with members to quantify the extent of this issue.

### **Workforce issues**

We have evidence of significant deficiencies in the workforce. Our 2016 workforce census show that Trusts are struggling to fill consultant posts<sup>1</sup>. The figures show:

- 51% of units in the UK have unfilled consultant posts (73% in Scotland)
- There are at least 73 unfilled consultant posts in the UK
- 47% of units in the UK have unfilled SAS doctor posts
- 42% of units are using locums to cover unfilled consultant posts
- 66 locums are being used in responding units to cover unfilled consultant posts
- 91% of units are undertaking waiting list initiatives
- 71% of waiting list initiatives are undertaken by responding units rather than by other independent providers

We also have concerns about the absence of standardised training for non-medical ophthalmic practitioners in expanded roles. If this part of the workforce is to be developed further, there must be assurances that their skills and knowledge are sufficient to deliver safe

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<sup>1</sup> <https://www.rcophth.ac.uk/wp-content/uploads/2017/03/RCOphth-Workforce-Census-2016.pdf>

and effective care. We provided a framework for developing non-medical ophthalmic staff in the hospital eye service within our Common Competency Framework<sup>2</sup>.

### **Impeded service improvement**

While our members have been conceiving local solutions to the growing capacity crisis for many years, uptake and development of them is patchy and slow. Our research, *The Way Forward*, identified and collated solutions for managing hospital demand for four key eye conditions, as a tool to support clinicians, managers and commissioners identify ways to manage demand. There does not appear to have been a significant improvement, which suggests that greater strategic input is needed to enable real transformation.

### **Assessment of need**

As far as we are aware, there is a worrying lack of systematic and consistent assessment of local eye health needs. The College has only seen two examples of local frameworks shared by members. The evidence of delays in care and patchy uptake of and support for innovative pathways and multidisciplinary care suggests assessments are either not taking place or they are not translating into effective change for patients and services.

### **STPs**

Most STPs do not reference or prioritise ophthalmology services. There is little evidence of engagement with clinical professionals, patients and professional bodies. The RCOphth has not been approached for input on any STP and would welcome the opportunity to work with leads to ensure eye services are effectively planned.

Feedback from our invited service reviews strongly indicates that engagement between clinicians and STP leads is missing. Similarly, our recent membership survey identified ophthalmologists feel disengaged from commissioning and regional reconfigurations.

### **Q4. Do you think the priority of eye health should be raised at the local area to meet existing and/or future patient demand? Yes or no, please explain why?**

Yes. Patients are coming to harm as result of inadequate planning and coordination. Solutions will depend on local patient population needs, and the configuration and availability of local staff and ophthalmic healthcare facilities, therefore the priority of eye health must be raised at local level, but supported also by national action.

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<sup>2</sup> <https://www.rcophth.ac.uk/professional-resources/new-common-clinical-competency-framework-to-standardise-competences-for-ophthalmic-non-medical-healthcare-professionals/>

**Q5. Please tell us about examples which are currently meeting demand for eye health services and/or which are enabling them to improve as a result of:**

- (a) commissioning by CCGs and/or
- (b) planning by STPs.

We presently do not have evidence of demand being met as a result of commissioning or STPs. However, our The Way Forward document has multiple examples of units who are taking action with innovative services and models to meet demand.

**Q6. How do you think the commissioning, planning and delivery of eye care services can be improved at?**

- (a) the local level, and
- (b) the national level

Commissioning, planning and delivery of care requires better engagement with all stakeholders, including patients and professionals at local level, and nationally with professional bodies and patient groups. This should involve all groups of ophthalmic healthcare professionals, including ophthalmologists, optometrists, ophthalmic nurses and healthcare science practitioners.

There should be a more consistent and systematic approach to local health needs assessment and planning that takes into account capacity and innovative solutions. This should align with nationally agreed principles for effectively commissioning, planning and delivering eye care, including those within guidance produce by the Clinical Council for Eye Health Commissioning (CCEHC). CCGs and STPs should make better use of College and CCHEC commissioning guidance and be more aware of key recommendations by NICE.

Commissioning must support development of innovative service delivery models and pathways developed by professionals. This includes local and regional networked solutions across primary, community and secondary care, with horizontal links within primary and secondary settings and supportive regulatory and financial systems supporting collaboration not competition. Stakeholders and those who need to make changes to services, such as clinicians, need to be given the time and resource to allow them to do so. Networked or reconfigured regional solutions to care must be commissioned so that:

- some providers are not unfairly adversely affected or adhering to different clinical standards and governance requirements; so that conflicts of interest are managed;
- clinical safety, adherence to key standards and cost effectiveness can be managed and monitored across the whole network; and
- patient pathways are joined up not fragmented in networks of care.

Commissioning and planning should support national solutions to monitoring follow up delays, which is a significant cause of delayed care and therefore risk to patient sight. There

is currently no usable IT system which can monitor differences between planned or clinically appropriate follow up time scale and actual follow up date, and a system is required which can do so at a national level.

Commissioning for chronic eye disease must have realistic new to follow up ratios and other appropriate contracting agreements so that key safety areas such as glaucoma and retinal conditions can deliver timely follow up reviews and treatments without penalisation.

An increase in the numbers of ophthalmologist posts must be considered if truly safe and effective eye care services are to be delivered. Even with empowered multidisciplinary staff, the need for ophthalmologists will continue and currently there is a significant lack to fulfil demand and to establish and deliver innovative services and training, supervision and clinical governance oversight for MDT working.

There also needs to be greater consideration of how the system enables adequate training and development of non-medical ophthalmic staff, both locally and improving consistency nationally. A nationally recognised and resourced curriculum and training system, with potential for CPD and updates, with buy in from all ophthalmic professional groups, is key to fulfilling demand and local teams and staff need to be resourced to access or deliver the training.

**Q7. What effect would raising the priority of eye health at a national/ strategic level (such as the NHS Mandate) have on improving commissioning across England and at the local level, and planning and delivery by STPs, to help meet current and future demand for services?**

We consider that raising the priority of eye health to a strategic level is essential because local and regional commissioning arrangements are currently ineffective and have not improved despite attempts by the College and other partners, such as patient charities and the College of Optometrists. Development of local clinician-led solutions have not lead to improved commissioning or STP planning, therefore strategic oversight is needed to ensure services are adequately delivered and patients do not come to harm. Increases in ophthalmologist numbers, national AHP training programmes and NHS digital monitoring of follow-up delays will only come from national support.

**Q8. The Public Health Outcomes Framework (PHOF) includes an indicator to highlight the rate of preventable sight loss in the population. The PHOF Data Tool shows significant variation in the rate of preventable sight loss for each local authority.**

- **At the national, CCG and STP-levels, how can the scrutiny of commissioning and planning of eye health services and eye health outcomes be improved?**

We call on commissioners to use agreed indicators and frameworks which are suitable for monitoring eye health and utilising for decision making on services. There are a range of resources available and we endorse the use of the following guidelines and frameworks.

- NICE-accredited commissioning guidance for cataract surgery<sup>3</sup> and glaucoma<sup>4</sup>.
- CCECH Community Ophthalmology Framework<sup>5</sup>, Primary Eye Care Framework for first contact care<sup>6</sup> and Low vision, habilitation and rehabilitation framework<sup>7</sup>
- VISION 2020 UK Portfolio of Indicators for Eye Health and Care. This portfolio provides a framework to review and monitor population eye health, care and well-being at national and local level. It has been designed to embed eye health in mainstream Outcome Frameworks including the PHOF.<sup>8</sup>
- We have produced a commissioning FAQs document on our website with further information about tariffs<sup>9</sup> and the College has multiple other quality assessment tools and guidelines.

We would be pleased to discuss any of the above views, points or evidence included in this submission.

**For more information please contact Laura Coveney – [laura.coveney@rcophth.ac.uk](mailto:laura.coveney@rcophth.ac.uk)**

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<sup>3</sup> <https://www.rcophth.ac.uk/wp-content/uploads/2015/03/Commissioning-Guide-Cataract-Surgery-Final-February-2015.pdf>

<sup>4</sup> <https://www.rcophth.ac.uk/wp-content/uploads/2016/06/Glaucoma-Commissioning-Guide-Long-June-2016-Final.pdf>

<sup>5</sup> <https://www.rcophth.ac.uk/wp-content/uploads/2015/07/Community-Ophthalmology-Framework.pdf>

<sup>6</sup> <https://www.rcophth.ac.uk/wp-content/uploads/2016/07/Primary-eye-care-framework-final-1.0.pdf>

<sup>7</sup>

<https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&cad=rja&uact=8&ved=0ahUKEwiJ6NmQ68fWAhVJKsAKHcgWBOAQFgyMAI&url=https%3A%2F%2Fwww.college-optometrists.org%2Fasset%2F2642D67C-96F9-4E12-AB4C402B2DF4E15C%2F&usq=AFQjCNELO7KOT4SA33inLTWqxITCLgRb3g>

<sup>8</sup> <http://www.vision2020uk.org.uk/vision-2020-uk-ophthalmic-public-health-committee-portfolio-of-indicators-for-eye-health-and-care/>

<sup>9</sup> <https://www.rcophth.ac.uk/standards-publications-research/commissioning-in-ophthalmology/local-tariff-variation-and-ophthalmology-commissioning/>