THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

Response to the AoMRC regarding the NHS England 10-year plan

The Royal College of Ophthalmologists (RCOphth) is the professional body for eye doctors. The Royal College of Ophthalmologists believes that all patients should receive equal access to high quality eye care. Ophthalmology accounts for nearly 9 million outpatient appointments in all four nations[1]. Ophthalmologists save and restore sight, the sense that people fear losing the most.

Poor vision affects health, economic well-being and productivity of individuals, families and society as a whole. The risk of mortality and morbidity from other chronic conditions (both physical and mental) increases significantly with loss of sight. The direct and indirect costs of loss of sight is estimated at £28billion pa[1]. People with vision impairment are twice as likely to have falls, experience increased levels of depression and anxiety and this can lead to earlier dependency on care homes and care support[2].

The eye care workforce is already employing flexible and innovative ways of working to meet the increasing demand set to increase by 50% over the next 20 years[3]. We are moving away from traditional roles and divisions of labour to work in more flexible ways in hospitals and the community to maximise capacity. Ophthalmologists are already working with artificial intelligence (AI), virtual clinics and genomics to maximise improvements in patient care.

Despite all this, hospital eye services continue to struggle to deliver timely care due to gaps in the workforce and variable commissioning practice – we need help to do more to meet the increasing demand. The latest RCOphth workforce census shows that 93% of eye units are using locum consultants to cover consultant ophthalmologist posts and 25% of eye units have unfilled consultant posts.

Attached are recommendations from The Royal College of Ophthalmologists that are essential to long-term planning to achieve high quality patient care, improve service delivery and efficiencies. Workforce planning remains at the heart of a sustainable approach to meet the demand placed on hospital eye services. This approach also supports the NHS's ability to attract and retain highly experienced and motivated ophthalmic medical and non-medical health care professionals.

This is an opportunity to invest in the future, listen to those on the frontline of patient care and patients themselves to ensure that our health service is fit for purpose for the long term.

Mike Burdon

President

The Royal College of Ophthalmologists

1. CLINICAL REVIEW OF STANDARDS

End cataract rationing

The NICE Guideline on Cataracts states:

'Cataract surgery is the most commonly performed elective surgery in the UK, with over 400,000 operations performed in England each year over recent years. The clinical and cost effectiveness of cataract surgery (at a population level) is well established in both people with and without ocular comorbidities. In spite of this, there is concern that there is wide variation across the country in commissioning policies for cataract surgery. In some areas, restriction of access to cataract surgery has been introduced by referral thresholds, based only on visual acuity. In England this has led to a reported threefold variation in the number of people having cataract surgery between different areas.'[2]

- NICE is sponsored by the DHSC to develop sound clinical recommendation for patient care using the best available evidence and a robust process with input from experts and service users.
- NICE has determined that first and second eye cataract surgery is probably the most cost-effective operation performed by the NHS and should be made available when patients' quality of life is affected by their eyesight.
- Cataract intervention has wide reaching benefits. Good vision not only provides a better quality of life, it also reduces dependence on social services through lessening the risk of falls and mental health issues. Cataract surgery intervention reduces costs elsewhere in the NHS by allowing patients to better comply with medical treatment and retain independent living.
- Clinical Commissioning Groups (CCGs) are mistakenly rationing cataract surgery because they are concerned about costs. However, the effects of rationing are only to delay surgery and increase the chances of falls. They only way CCGs can save money by rationing is if patients die whilst waiting for surgery.

Recommendation

- ***NHS England to mandate national adoption of NICE guidance by for all specialties.***

The benefit

- ***National adoption of NICE recommendations that support NHS England clinical priorities and enables best efficiencies for resources and funding.***
- ***Enhances the eye health of the nation by ensuring patients retain optimal vision to continue to lead independent lives***
- ***Reduces the financial and resources burden on health and social services.***

Continued funding of the National Ophthalmology Database

- UK Ophthalmology is leading the way, not only in the NHS but also internationally, in the use of big data to improve patient safety and quality of care.
- An increase of around 50% in cataract operations is predicted over the next 20 years (25% increase over the next 10 years - RCOphth Way Forward), plan services
- The National Ophthalmology Database (NOD) currently audits 180,000 cataract operations a year and is planning to expand to include all 400,000 operations performed annually. Data gathered so far has allowed patients to be risk-stratified, ensuring experienced surgeons

operate on the most complex cases. **The NOD has documented a 30% reduction in complications over the last seven years**, improving outcomes for patients and reducing costs to the NHS[3].

- The NOD could, with some adaptation, be used to link variations in intraocular lens implants with outcomes (visual symptoms, quality of life, need for laser intervention later) to improve cost efficiency of device procurement.
- The Royal College of Ophthalmologists believes that the scope of the audit should be expanded to include other major ophthalmology sub-specialties such as age-related macular degeneration (ARMD) and glaucoma. By doing so, NHS England will be able to identify and address variations in quality and services to prevent costly avoidable visual loss and drive efficiencies.

Recommendation

- ***Auditing of national clinical data is proven to raise clinical safety standards and enhance learnings and training to improve patient outcomes. National ophthalmic funding for three years for each of the sub-speciality areas (Cataract, ARMD and Glaucoma) would cost a total of £0.9m over a three-year period.***
- ***Providers can use NOD data to plan for the predicted demand.***
- ***Other branches of medicine can adopt principles as data is uniquely collected via Electronic Medical Record (EMR) systems.***

The benefit

- ***NOD enables comprehensive and meaningful comparisons to be made between providers of cataract surgery, driving up standards and providing patients genuine reassurance of the quality of the care that they are receiving in any eye unit.***
- ***Reduced associated costs to health and social care costs from complications of surgery and visual loss from inadequate chronic disease care.***
- ***Continued professional learnings and improved patient satisfaction.***

2. WORKFORCE, TRAINING AND LEADERSHIP

Workforce and Multidisciplinary Teams

- There is good evidence to show that we are not training enough ophthalmologists to meet current demands, let alone the rapidly increasing demands of an aging population. The current cap on ophthalmology training imposed by HEE appears to be financially driven rather than based on an understanding of workforce needs.
- The RCOphth 2018 Workforce survey shows 93% of units are using locum consultants to cover consultant ophthalmologist posts and 25% of have completely unfilled consultant posts. UK Ophthalmology is leading the way, not only in the NHS but also internationally, in the use of big data to improve patient safety and quality of care.
- A number of Trusts are providing training programmes for ophthalmologists outside the conventional training pathway, in SAS and non-numbered posts. These doctors will be applying for equivalence of training via the CESR route. These posts fill essential rota gaps and will potentially increase the number of consultants. This alternative training route needs to be actively explored as an alternative and, if there are not enough numbered training posts funded nationally, the alternative route should be recognised and supported by HEE and the Deaneries.

- Ophthalmologists recognise that there is huge scope for non-medical clinical professionals such as optometrists, orthoptists and nurses to support the work they do through advanced practice. The RCOphth is working with HEE to develop appropriate training programmes for these staff in hospital settings; the Ophthalmic Common Clinical Competency Framework[4]. Care can also be delivered in community settings but needs consistent training funded and clear clinical governance links with ophthalmologists and secondary care.
- Current payment systems do not support nor incentivise the use of community and non-face to face or IT supported (virtual) care. Payments for community optometrist expanded role care has to be negotiated separately for every single CCG.

Recommendations

- ***National infrastructure investment in local clinical space planning and joined up multidisciplinary risk stratified service and pathway design to meet demands.***
- ***Investment in ophthalmology specialty training places to ensure there are enough doctors qualified in ophthalmology to meet the predicted 30-40% increase in demand over the next 20 years.***
- ***National workforce planning expertise and resource to work with clinical specialty experts and Colleges to produce clear picture of ideal workforce for medical, non-medical clinical and community staff provision for predicted demand.***
- ***HEE funded support to provide national training programme for all non-medical professionals to deliver care safely in regional community and secondary care networks with ophthalmologists.***
- ***Appropriate national consistent arrangements for funding of safe networks of care including in the community.***

The benefits

- ***A workforce to meet the needs of the population, now and in the future.***
- ***A workforce that is working at the top of its licence, with improved morale and increased retention rates.***
- ***A cohesive workforce with clear clinical governance structures safely expanding the capacity for patient care.***

Arbitrary increased use of Independent Sector Treatment Centres

- The increasing number of Independent Sector Treatment Centres (ISTCs) and Any Qualified Providers (AQPs) is beginning to impact on the availability of suitable surgical cases for ophthalmologists in training. Routine cases are often sent to the ISTCs with more complex cases remaining in the Hospital Eye Service.
- This means that training ophthalmologists are not exposed to enough routine cases to enable learning, confidence in patient diagnosis and lack of surgical practice. It reduces training at a time when more trainees are required to deliver more work for the rapidly increasing demand.
- Removal of high volume straightforward work fragments care and destabilises NHS hospital units.

Recommendations

- ***Recognition by NHS England, Commissioners and Trusts on the negative impact on training and professional standards by taking routine cases out of the Hospital Eye Service and ensure training must be protected in service transformation or changes in provider.***
- ***National and regional long-term workforce planning with appropriate training provision to meet local population demands and reduce dependency on ISTCs and AQPs.***

The benefits

- ***All ophthalmologists in training receive fit for purpose and sustainable training in all aspects of patient care and surgical practice to meet demand.***
- ***No destabilisation or fragmentation of care for patients.***
- ***Sustainable number of ophthalmologists trained for future demand and sustainable stable integrated networks of eye care.***

3. SYSTEM ARCHITECTURE

Infrastructure – moving out of the traditional HES environment

- The greatest limiter of service development in most ophthalmology departments is a lack of space. New, efficient ways of working such as a team of non-medical clinical professionals working under the leadership of a consultant can only be developed if there is enough room for them to work.
- Ophthalmology needs to expand out of major hospitals into the community. Doing so will provide more local accessible care for many elderly patients and allow planned increases in service provision in line with increasing demands. Such expansion requires access to relatively small amounts of funding for new clinics.
- Community settings can deliver high volume, high efficiency pathways for procedures equivalent to that achieved by ISTCs and can also act as hubs for clinical /diagnostic data and imaging capture to allow remote review by clinicians for virtual clinics with cost savings and avoidance of hospital attendances.
- Ophthalmology is a cost effective and efficient specialty best delivered in specifically designed facilities.

Recommendation

- ***National infrastructure investment in local clinical space planning and national transformative service design to meet demands.***

The benefits

- ***Enabling more surgical procedural output, such as increasing the numbers of cataract surgery and intravitreal injections by providing more clinical pace in a community setting.***
- ***Enabling more chronic care for conditions such as glaucoma and retinal disease to be delivered rapidly with minimal patient pathway time whilst still allowing expert assessment of disease status.***

4. DIGITAL AND INFORMATION TECHNOLOGY

- Basic IT systems both within ophthalmology departments and those linking primary and secondary care need urgent improvement. Internal hospital systems in some areas are

archaic and can impede efficient working. Optometrists cannot communicate directly electronically with hospitals for advice and guidance (to prevent unnecessary attendances), for shared care schemes and for electronic referrals.

- Importantly there is a lack of communications/technology which prevents sharing of patient information between the HES, GP and optometric establishments, within and external to the hospital setting.
- Ophthalmology electronic patient records (EPRs) are very different from EPRs for other specialties but generate huge benefits in terms of providing efficient care in networks and assessing the quality of care.
- UK Ophthalmology is taking a leading role in the development of AI to process the vast numbers of images now being generated in both primary and secondary care. From the back of the eye to the front, AI is expected to give ophthalmologists new automated tools for diagnosing and treating ocular diseases.

Recommendations

- ***A joined-up network between hospital clinical and administrative IT systems and optometric systems is required much like the GP-Pharmacy join up.***
- ***National support for ophthalmology-suitable electronic patient records (EPR) solutions which fulfil College standards in all providers.***
- ***Recognition that where aspects of AI will greatly enhance efficiency and diagnostic accuracy it may also lead to an increase in case identification and service demand.***

The benefits

- ***Unnecessary hospital attendances will be reduced.***
- ***Referral and follow-up care routinely delivered more efficiently by sharing patient information, monitoring and follow up***
- ***Virtual imaging and virtual clinics will release consultants to take on the more complex patient cases***
- ***Allows follow-ups to be routinely assessed or audited under supervision of an ophthalmologist.***
- ***Establishes the IT infrastructure for AI to eventually deliver some automated care decisions.***

SUMMARY

The RCOphth welcomes NHS England's wish to involve clinicians in shaping the strategy for the next decade. We continue to work collaboratively across the NHS and our eye health sector partners, charities, industry and patients to optimise services to reduce the incidence of sight loss.

Ophthalmology is well-placed to meet the government's five financial tests of:

1. Improving productivity and efficiency
2. Eliminating provider deficits
3. Reducing unwarranted variation in the system so people get the consistently high standards of care wherever they live

4. Getting much better at managing demand effectively
5. Making better use of capital investment

Eye units are one of the more effective and high income generating areas for trusts. The recommendations outlined in this report could be established if providers worked with commissioners and clinicians to develop five-year strategic plans to meet the increasing demand and this would support long-term workforce planning.

We look forward to taking our recommendations forward in partnership with the Department of Health and NHS England.

September 2018

References

1. RNIB APPG Report : See the Light - Improving capacity in NHS eye care in England
2. The Royal College of Ophthalmologists Three Step Plan
3. The Royal College of Ophthalmologists The Way Forward
4. NICE guideline [NG77] Published date: October 2017: Cataracts in adults: management
5. The National Ophthalmic Audit Database
6. The Royal College of Ophthalmologists - Ophthalmic Common Clinical Competency Framework