NHS0015

Written evidence submitted by Royal College of Ophthalmologists

About The Royal College of Ophthalmologists

1. The Royal College of Ophthalmologists (RCOphth) provides training, professional development and clinical guidance for our 4,000 members who include ophthalmologists in training, consultants, SAS doctors and other eye care professionals such as optometrists. We ensure high standards of patient care in the prevention and treatment of eye diseases and other eye conditions.

Summary of response

2. Of all medical specialties across the NHS, ophthalmology has the highest number of outpatient appointments, and one of the longest treatment backlogs. In 2021/22 alone, there were over 7.5 million ophthalmology outpatient appointments in England. Latest data on waiting lists highlights an extremely concerning picture. As of September 2022, 656,814 people in England were waiting for treatment or diagnosis by an ophthalmologist. This is almost 10% of the entire NHS backlog but even these stark figures underplay the scale of the backlogs in ophthalmology.

3. That is because these published figures only include those waiting for a first appointment with a consultant ophthalmologist, not subsequent follow-up appointments. Given follow-up appointments accounted for 69% of ophthalmology outpatient appointments in 2021/2022, we know there is a huge hidden backlog here not accounted for in NHS England statistics. Permanent harm from delays to care, in terms of avoidable visual loss, is 9 times more likely to happen in follow-up patients than in new patients.

4. A range of innovative measures are being taken to tackle the situation across the country, supported by the National Eye Care Recovery and Transformation Programme, RCOphth and other eye care organisations. These include surgical hubs, virtual and digital clinics, community diagnostic centres and increased integration of primary care optometrists . There has also been a dramatic increase in the use of independent sector providers, with almost half of NHS-funded cataract procedures now delivered in the independent sector. These innovations are however inconsistently resourced and implemented, and further action will be needed to bring these backlogs down and prevent a tide of avoidable blindness.

5. Our response highlights the need to:

- **Ensure that NHS England's National Eye Care Recovery and Transformation Programme (NECRTP) is supported to bring down the long ophthalmology backlogs** through national coordination and consistent implementation of services, appropriate direction of transformation funding locally for proven innovations, upskilling of the existing workforce to meet current and future patient need, and support for the implementation of integrated pathways across primary and secondary care.

- **Effectively use the additional capacity offered by independent sector providers, while addressing the risks its widespread use in ophthalmology is already posing** for training the next generation of ophthalmologists and the sustainability of NHS eye units delivering comprehensive care.

- **Focus recovery efforts on the diagnostic and follow-up delays, not just surgical backlogs**. Publishing more granular data on outpatient waiting lists including risk stratification and follow-up delays - as Wales does – would help eye services plan better and prevent more avoidable blindness. As an image and data-reliant speciality, relatively modest investments from NHS England and DHSC in roles such as ophthalmic image graders and technicians, would also help to rapidly expand diagnostic capacity in ophthalmology.

Ensuring the National Eye Care Recovery and Transformation Programme is supported to bring down ophthalmology backlogs: national coordination & locally directed funding

6. RCOphth has been involved in shaping the National Eye Care Recovery and Transformation Programme (NECRTP) with NHS England since it began in 2021 and is determined to see it make a real difference as we emerge from the pandemic. NECRTP represents a welcome shift away from short-term thinking and siloed improvement programmes, towards a co-ordinated, whole pathway approach. By bringing together the various national programmes for eye care improvement - such as the national outpatient transformation programme, Getting It Right First Time (GIRFT) and digital improvement under one governance structure - guidance and support can be co-ordinated to help reduce waiting lists and put ophthalmology services on a sustainable footing.

7. Ophthalmology is the highest volume outpatient specialty. Almost 10% of the NHS backlog is in eye care, with over 650,000 patients on the waiting list to start ophthalmology treatment in England, and many more patients affected by delays to their ongoing treatment. Many patients continue to undergo worsening quality of life and the profound trauma of sight loss as a result of avoidable delays, with knock-on financial burden for the wider health and social care system.

Developing appropriately designed care pathways

8. It is crucial to the aim of the Programme that modern care pathways are designed by experienced clinicians to provide the best quality care tailored for their patients. There is clear consensus across all key eye care stakeholders on the innovations and improvements which should now be implemented across England, with a huge range of practical resources to help on NHS England's Eye Care Hub which have been co-produced with regions and systems.

9. Further work is needed through NECRTP to support systems to now implement the agreed standardised integrated care pathways across primary care and hospital eye services. This will, for example, involve ensuring consistent commissioning mechanisms are implemented

for optometrists acting as the first point of contact and managing low risk patients in the community. NECRTP also has plans to help link optometry to hospital ophthalmology electronically through Electronic Eyecare Referral Systems (EERS). These improvements will both help to make eye care more efficient, bringing down waiting times for patients.

Developing high-volume surgical and diagnostic hubs

10. To help address some of these challenges in diagnostic capabilities, NECRTP with the GIRFT programme is supporting the development of high-volume community diagnostic centres (CDCs). This is a welcome step, increasing ophthalmology capacity by maximising the use of primary care workforce and the non-medical multi-disciplinary team within accessible community sites which support efficient patient journeys.

11. NCRTP with GIRFT has also supported the development of high-volume surgical hubs and procedure pathways for ophthalmology, which can improve productivity and reduce the backlog of cases. RCOphth produced updated guidance this year on high flow cataract surgery and released a joint statement with the College of Optometrists on discharging patients to an optometrist sight test (with outcome data return) after uncomplicated cataract surgery.

12. NECRTP needs to be supported and resourced to continue delivering this work. Further consideration should also however be given to how areas of high demand in ophthalmology, such as paediatric care, can be better incorporated into service improvements such as CDCs.

Focusing NECRTP on developing the workforce

13. NECRTP can further enable the reduction in ophthalmology backlogs by supporting enhanced roles for the wider multi-disciplinary team (MDT) in eyecare. As well as consultant ophthalmologists, NHS eye care services rely on nurses, optometrists and orthoptists. The continuing upskilling of these professions to provide services that were traditionally delivered by doctors, with increasing use of other roles such as technicians to provide diagnostics and the care traditionally delivered by nurses, is vital in providing more capacity in the system to deliver patient care. Ophthalmology is a specialty which has clear and proven opportunities for improvement and productivity through all team members practising at the top of their licence.

14. RCOphth helps to provide Ophthalmic Practitioner Training (OPT). This is a training programme for hospital-based ophthalmic nurses, optometrists and orthoptists who wish to develop their skills further to deliver patient care. With the support of NHS England, the OPT programme could be expanded to help increase capacity.

15. Non-graduate roles such as technicians and image graders can also be quickly trained, increasing the capacity to deliver eye care services. This is particularly relevant in the context of the rollout of CDCs, where large volumes of diagnostic data will need to be collected and analysed quickly to help clear the backlogs.

16. We are already working with NHS England to collate information for NHS trusts on how to train technicians, but investment in these roles by trusts and NHS England could provide a quick boost to capacity. The RCOphth's Cataract Services and Workforce Calculator Tool provides an example of how to plan the delivery of services across a MDT. It enables accurate MDT workforce planning, using a workforce calculator to plan the staff needed to deliver cataract services using community or hospital-based pathways.

17. Thinking beyond the immediate backlogs, it is clear that more robust mechanisms are needed to ensure that long-term workforce needs are identified and backed by investment by the government. RCOphth and other sectors of the health and care workforce have articulated for some time what their respective workforce needs are, but these analyses are disparate and are not assessed by the Treasury in a joined-up way.

18. To tackle this problem, it is essential that regular independent workforce assessments are delivered by DHSC or NHS England. This would increase the likelihood that rational decisions are made about the workforce needed in future and help prevent worsening backlogs. We are therefore encouraged by the announcement in the Autumn Statement that a comprehensive workforce plan will be published in 2023, which will include 'independently-verified forecasts for the number of doctors, nurses and other professionals that will be needed in 5, 10 and 15 years' time'. The question of whether these independent forecasts will be underpinned by the funding needed to deliver the workforce needed is crucial.

The role of the National Clinical Director for eyecare in addressing key strategic challenges

19. A major milestone for the NECRTP has been the approval and funding of a new senior leadership role for eye care in NHS England, the first National Clinical Director (NCD) for eye care – currently held by Louisa Wickham. The establishment of the NCD is a hugely welcome step, providing a lead point of contact for the profession, so that issues and challenges can be escalated quickly within NHS England, as well as being a champion for the importance of eye care within the wider health system. However, the NCD must be properly resourced and empowered in order to make a meaningful impact in the role.

20. On top of immediate backlogs, pressure on ophthalmology services continues to grow given the UK has an ageing population and greater prevalence of co-morbidities such as diabetes. The number of people with eye disease is expected to rise sharply to 2.8 million by 2030. RCOphth believes that a National Strategy for Eye Care should be developed – with the National Clinical Director for eyecare – that targets key strategic challenges such as workforce shortages and integrated pathways. It should focus on implementation and delivery of the many innovations which are evidenced and agreed by eye care stakeholders and endorsed by the NECRTP and GIRFT.

Effectively use independent sector capacity while tackling sustainability risks

21. Independent sector providers (ISPs) are now playing a major role in the delivery of NHS ophthalmology services in England. This is focused on cataract surgery, where they are undertaking almost half of NHS-funded procedures. According to NHS England data, in 2016 11% of NHS cataract procedures in England were delivered in the independent sector and 89% by NHS trusts. By April 2021 there was almost a 50/50 split, with 46% in the

independent sector and 54% in NHS trusts and treatment centres.

22. While this increased capacity to help tackle the backlogs is welcome, ophthalmology has two key concerns regarding the unintended consequences of this huge shift. Local NHS ophthalmology units can face sustainability challenges given the resourcing brought in by simple cataract surgery helps support NHS units to deliver comprehensive care for more complex and chronic conditions, like glaucoma and age-related macular degeneration. This more complex care has not traditionally been delivered by ISPs. This could mean that units start to be unable to continue delivering more complex chronic care, with patients having to travel further for more complex treatments, or are not able to access timely care, leading to permanent loss of vision.

23. Secondly, without training opportunities in the independent sector, it is becoming more difficult for trainees to build up the experience required to become skilled surgeons, threatening the long term continued delivery of ophthalmic surgery to patients. According to GMC data, of the three quarters of ophthalmology trainees who needed access to training opportunities in ISPs, 86% disagreed that they were easily able to access these – just 6% agreed.

24. While RCOphth continues to work with NHS England, commissioners, and ISPs to address these challenges, including through the joint development of a service specification for cataract surgery and a blueprint to support the delivery of cataract surgical training in the independent sector, independent sector capacity cannot be a long-term substitute for properly funding and resourcing NHS ophthalmology units.

25. To ensure an increased reliance on ISPs does not undermine the sustainability of NHS ophthalmology services, NHS England at the national level, and integrated care bodies (ICB) at the local level, need to build into their contractual requirements mechanisms that ensure those ISPs delivering NHS-funding cataract surgery are able to train NHS ophthalmology trainees on at least 11% of all NHS cataracts within two years, as detailed in NHS England's March 2022 cataract service specification.

Focus recovery efforts on the diagnostic and follow-up delays, not just surgical backlogs

26. In England, the number of patients waiting for all consultant-led ophthalmology treatment in September 2022 was 656,814 - up by 44% since 2019. The outpatient backlog has increased by 56%, while the surgical backlog is up only 13%. It is therefore clear that action must be taken to reduce outpatient and follow-up appointments to avoid more avoidable blindness, just as attention is rightly being focused on reducing surgical backlogs.
27. The Welsh Government publishes monthly data, broken down by Health Board, which lists the number of patients waiting for an ophthalmology outpatient and includes both new and follow-up patients. Importantly, it lists patients categorised as "Risk Factor R1" - those at risk of irreversible harm or significant adverse outcome if their target date for an outpatient appointment is missed.

28. This type of granular data enables Health Boards and eye units in Wales to more accurately understand the risk to patients of delaying outpatient appointments and take necessary actions which can be targeted to protect high risk patients. Mandating similar data be regularly published in England would likewise support better planning and outcomes for patients and prevent many cases of preventable vision loss.

29. Reducing the outpatient backlog will have a knock-on effect of reducing surgical backlogs. The longer a patient waits for a first or follow-up appointment, the greater the risk of otherwise manageable conditions developing into something more severe that requires surgery. By identifying and treating more patients earlier – before a condition deteriorates – we can reduce the number of patients falling into surgical backlogs later down the line.

30. High-volume diagnostic hubs are a cost- and time-effective measure to work through outpatient appointment backlogs by using more of the MDT workforce. As outlined earlier, non-graduate roles such as technicians and image graders can be quickly trained and deployed in these diagnostic hubs, increasing efficiency and reducing the demands on ophthalmologists, freeing them up to undertake more surgeries and deal with more complex cases. Therefore, relatively small investments in expanding the non-graduate MDT workforce for deployment in efficient new ways of working such as diagnostic hubs is an effective measure to tackle both outpatient and surgical backlogs within a short period of time.

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