The RCOphth's response to the Health and Social Care Committee's budget and NHS long-term plan inquiry

August 2019

Introduction

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 welcome the opportunity to respond to this inquiry, having submitted responses to NHS England's draft plan consultation in September 2018[1], and HEE's workforce strategy consultation in March 2018[2].

Below are our responses to the topics set out in the Committee's inquiry: funding, impact on LTP implementation and economic impact.

Response to questions

1. Funding

NHS Capital

Chapter one of the NHS Long Term Plan calls for a new service model by which patients will receive properly joined-up care at the right time in the optimal care setting.

Ophthalmology is ideally positioned to take a leading role in delivering this new model of care. Ophthalmologists in England service 7.6 million outpatient appointments per year[3]. The majority of these are for monitoring and treatment of chronic diseases, such as glaucoma, so many patients with these conditions do not need to be seen in a large hospital setting.

According to reports from our members, most eye hospital departments in the United Kingdom are critically constrained by the space they have to work in. Eye departments rapidly outgrow the space available well before the hospital becomes too old or is too small for all the other medical subspecialties. There are many more treatments available now for eye conditions (e.g. for AMD) that were not available 15 years ago which has changed the way we care for patients, and meant it is possible to successfully treat greater numbers than

[1] https://www.rcophth.ac.uk/wp-content/uploads/2019/08/RCOphth-response-to-NHS-England-10-year-plan-consultation.pdf
[2] https://www.rcophth.ac.uk/wp-content/uploads/2018/03/RCOphth-response-to-HEE-Workforce-Strategy.pdf
[3] https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2017-18

ever before. However, because so many eye conditions are age-related, this demand is set to keep increasing at a faster rate than we have capacity for. This reflects a historic failure to expand infrastructure in line with the growing demands for service.

As examples, the departments in Southampton and Bristol have far too few operating theatres for their population. This has reduced their ability to provide enough operating sessions for consultants to maintain their skills and impacted on their ability to recruit new staff. This is also limiting training opportunities for ophthalmologists in training. Investment in Independent Surgical Treatment Centres has been at the expense of the hospital eye service.

However, new delivery models are possible, that ensure the efficient use of both medical and technical staff time, and the expensive equipment required to properly assess patients. The RCOphth believes that, in an urban setting, this is best delivered by the development of small eye units strategically located in the catchment area of the main hospital, that are set up to deliver high volume services. Repeated small capital investments in such departments would allow capacity to keep pace with demand.

Our series of reports The Way Forward provides detailed examples of these delivery models for each of the high-volume subspecialties of ophthalmology[4].

Education and Training

Ophthalmologists have long recognised the huge potential for allied health professionals, such as optometrists, nurses and orthoptists, to contribute to the monitoring and treatment of patients. Examples include the widespread adoption of nurse injectors to deliver treatment for medical retinal diseases, and a recently completed joint project between RCOphth and HEE project to develop a training programme for allied health professionals interested in gaining additional, higher level ophthalmic skills. We are also seeking to review the evidence on further opportunities for each major ophthalmic subspecialty to ensure highest quality care is delivered by the most appropriate person.

Despite these developments, our workforce data show that we need more ophthalmologists, both to deliver high-level diagnostic and treatment services, and to supervise allied health professionals[5]. At present, the number of ophthalmologists in training is not sufficient to replace those that are retiring, let alone being enough to address the increasing demands for ophthalmology services from an aging population. The situation is likely to get worse post Brexit as around 25% of our current consultant workforce originally trained in Europe, and they are less likely to come to UK in future. Therefore, The Royal College of Ophthalmologists is calling for an immediate increase in the number of ophthalmology training posts.

[4] https://www.rcophth.ac.uk/standards-publications-research/the-way-forward/
[5] https://www.rcophth.ac.uk/wp-content/uploads/2019/02/RCOphth-Workforce-Census-2018.pdf

Social Care and Public Health

The NHS Long Term Plan recognises the particular challenges of elderly patients with multi-morbidities. Maintaining independence is vital for quality of life and greatly reduces the cost of social care. In this context, health spending on eye services must be prioritised. Being able to see well allows people to exercise, to avoid falls, and to manage their various medical conditions. This is discussed in further detail in relation to economic impact.

To reduce unwarranted variation and improve public health, we must champion evidence-based medicine, including greater investment in clinical audits and better use of service data to make improvements. We must also ensure that we do not create barriers to cataract surgery and prevent patients from accessing this highly clinically and cost-effective treatment[6].

2. Potential impact on implementation of the Long-Term Plan, of failing to provide necessary funding

Chapter one of the LTP relates to delivering a new service model for the 21st century. This has recognised the growing and ageing population, and the need to support people to age well. Most major eye conditions and sight threatening disease are associated with the ageing process, so investing in services that preserve and restore eye health must be central to a 21st century NHS.

Evidence of the link between capacity and sight loss:

- BOSU Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome[7]
- Between June 2005 and May 2009, the National Patient Safety Agency (NPSA) received reports of 44 glaucoma patients who experienced deterioration of vision, including 13 reports of total loss of vision, attributed to delayed follow up appointments with a further 91 incidents related to delayed, postponed or cancelled appointments for patients with glaucoma.[8]

3. Potential impact on wider economy and other public services of investing in the four areas

The importance of investing in the four areas, to enable implementation of the LTP has been discussed above. The value for the wider economy of investing in eye care and preserving our vision has been assessed through two economic analyses:

[6] https://www.rcophth.ac.uk/2019/04/rcophth-follow-up-survey-finds-continued-cataract-rationing-imposed-by-ccgs-despite-nice-guidance/
[7] https://www.nature.com/articles/eye20171
[8] https://www.rcophth.ac.uk/wp-content/uploads/2015/01/NPSA_RRR_on_glaucoma_2009_supporting_info.pdf

RNIB and Deloitte Access Economics 2013 report: The economic impact of sight loss and blindness in the UK adult population. The results of the study indicated that sight loss and blindness in the adult population cost the UK economy £28.1 billion in 2013, including direct costs to the health care system (£2.99 billion), indirect costs to the system (£5.65 billion) and an estimated reduction in stock of health capital (£19.47 billion).

The economic impact of sight loss and blindness in the UK adult population 2018. Sight loss and blindness from age-related macular degeneration (AMD), cataract, diabetic retinopathy, glaucoma and under-corrected refractive error are estimated to affect 1.93 (1.58 to 2.31) million people in the UK. Direct health care system costs were £3.0 billion, with inpatient and day care costs comprising £735 million (24.6%) and outpatient costs comprising £771 million (25.8%). Indirect costs amounted to £5.65 (5.12 to 6.22) billion. The value of the loss of healthy life associated with sight loss and blindness was estimated to be £19.5 (15.9 to 23.3) billion or £7.2 (5.9 to 8.6) billion, depending on the set of disability weights used.[9]

Loss of vision has been associated with reduced quality of life and mental health conditions, including anxiety and depression[10][11][12].

We live in a sight-dependent society and often take our vision for granted. However, the economic, societal and personal impact of sight loss must not be underestimated. By investing in eye care, we invest in our independence, productivity and quality of life.

We have an opportunity to deliver this to scale, for all patients, through the NHS Long Term Plan. The RCOphth would be happy to provide further information and guidance on how we can achieve this.

[9] https://www.ncbi.nlm.nih.gov/pubmed/29382329
[10] https://www.ncbi.nlm.nih.gov/pubmed/9565052
[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1857044/
[12] https://jamanetwork.com/journals/jamaophthalmology/article-abstract/2733451