RCOphth response to NHS England's consultation on Developing the long-term plan for the NHS

September 2018

1. Life stage programmes:

Early life

1.2 How can we improve how we tackle conditions that affect children and young people?

Eye disease and visual impairment (VI) in childhood is usually very early onset, at birth or during infancy, and impacts on all aspects of development. The impact of childhood VI is carried through life, so prompt detection is critical to maintain eye health and improve outcomes later in life.

There is increasing evidence of higher rates of VI among children of lower socioeconomic status and in ethnic minorities, groups who often find it more difficult to access services due to financial, geographical or language barriers.

We would like to see Public Health England's new child vision screening recommendations adopted by every local authority to ensure all children are appropriately screened for early detection of vision defects[1].

1.4 How can we ensure children living with complex needs aren't disadvantaged or excluded?

Children with complex needs, particularly when from a disadvantaged background, should have a Key worker to co-ordinate care and support. The paediatric Eye Clinic Liaison Officer plays a very important role in facilitating support for families of VI children. Improving access to these individuals would be transformative for many families. Use of appropriate Patient Related Outcome measures (PROMS) in paediatric ophthalmology will help to quantify the perceived quality of service being delivered. Well-constructed and effective transition services are lacking in the UK and are very important for the delivery of best care in adolescents with complex disorders like uveitis and glaucoma.

Staying healthy

We urge NHS England to invest in preventing avoidable sight loss and its wider social costs.

[1] https://www.gov.uk/government/publications/child-vision-screening

Eye health and good vision underpin our general health, wellbeing and independence. Preserving eye sight reduces onset of other health issues that accompany frailty, such as falls, decreased mobility and mental health issues[2].

When our sight deteriorates we are at increased risk of falls and social isolation, which in turn impact on our wellbeing and mental health. People with vision impairment experience earlier dependency on care homes and are twice as likely to have falls, while sight loss has been found to have associations with depression and anxiety.

We want all children and adults to have equal access to care, whether emergency or long-term, initial or follow up review. Services must be designed with sufficient capacity to provide care in a way that patients can access. Ophthalmology has great potential to be significantly more efficient with some investment in the basics. Most eye care is now delivered in outpatient settings during follow up appointments, which is testament to progress, however basic infrastructure such as physical space and ICT has not kept pace to enable services to meet the growing demands placed on them.

Crucially we urge NHS England to support an end to rationing of effective treatments. NICE has found cataract surgery to be incredibly cost effective as a treatment, as well as reducing the social costs of sight loss including falls, mental health problems and dependency on social services. Lack of capacity has resulted in rationing of these treatments in some areas. We would welcome mandating NICE recommendations to provide these procedures based on patient benefit.

3. Enablers of improvement:

Workforce

3.1 What is the size and shape of the workforce that we need over the next ten years to help deliver the improvements in services that we would like to see?

We support development of a workforce that is working at the top of its licence; doctors taking the most complex decisions and procedures, supported by upskilled team members, such as optometrists and nurses who can manage an expanded range of clinical activities.

In Ophthalmology, speciality training is heavily oversubscribed, while consultant posts are being created but going unfilled in large numbers. Alternative training routes leading to equivalence are an opportunity to train more ophthalmologists for these posts but need formal recognition and support by HEE and Deaneries.

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[2] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/improving_later_life_for_people_with_sight_loss-full_report.pdf

It is unclear what the impact of Brexit will be. A quarter of those on the GMC register for Ophthalmology gained their primary medical qualification in the EEA, so it is important to ensure these professionals can continue to work here.

Where there are opportunities for non-medical workforce to deliver more, there needs to be a national drive to work with specialty colleges and experts to remove the barriers or establish the enablers. For example, in ophthalmology huge amounts of work could be done by non-medical staff and community opticians but does not occur wholesale as there needs to be a national training and accreditation programme; a tariff or payment structure that provides payment for these services; and access to NHS clinical IT systems by community opticians. These are having to be worked out across every CCG individually which limits uptake.

The relationship between service delivery and training must also be considered. The increasing number of Independent Treatment Centres (ISTCs) is beginning to impact on the availability of suitable 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.

Trusts must work with clinical directors in long-term workforce planning to ensure that training opportunities for NHS specialty doctors are not disproportionately affected and therefore risk a reduction in standards in training and patient care.

Planning a workforce to meet the needs of the population requires proper assessment of current and future patient need, changing pathways, new treatments, technology, roles, changing multidisciplinary team skills mix and the need to improve morale and retention rates. We need to train more staff, but the size and shape of the services they drive must be considered in the planning too. Our reports from The Way Forward project explore this complex picture and detail a range of approaches to service and workforce design[3]. We would strongly welcome investment in NHS workforce planning staff, software and data, informed by specialty-specific clinical and workforce knowledge.

3.2 How should we support staff to deliver the changes and ensure the NHS can attract and retain the staff we need?

Staff need to feel valued. The impact that negative press about the NHS and its staff causes must be recognised and mitigated where possible. For example, national contract disputes, regulatory action against health care professionals and poor Trust performance.

NHS staff inability to deliver the right care due to lack of capacity or resource, creates a negative message about the value of the NHS. This undermines staff motivation to keep investing their skills and time in the NHS. A credible plan to gather evidence, understand and address these issues will also demonstrate recognition of the challenges NHS staff face,

[3] https://www.rcophth.ac.uk/standards-publications-research/the-way-forward/

demonstrating that their concerns are taken seriously. Retention will result as staff feel supported to meet demand.

Primary Care

3.4 How can the NHS help and support patients to stay healthy and manage their own minor, short term illnesses and long-term health conditions?

We would welcome a drive to improve national messaging and information to help patients and the public understand NHS resource, responsible use and the importance of following clinical recommendations, for example attending appointments as advised, limiting unnecessary visits and overuse of antibiotics. Helping patients to understand the concepts of risk in healthcare would enable them to be more informed and careful consumers.

Improving how health care addresses psychological and social issues could help patients whose disease may not be serious but who struggle to accept this.

3.5 How could services like general practice and pharmacy, work with other services like hospital services to better identify and meet the urgent and long-term needs of patients?

In ophthalmology, the key primary care professionals are optometrists and orthoptists. To enable them to significantly contribute to long term patient care we must properly integrate them, through two-way communication between community and hospital services, consistent national training and sustainable national payment systems.

3.6 What other kinds of professionals could play a role in primary care, what services might they be able to deliver which are currently delivered elsewhere and how might they be supported to do so?

In ophthalmology many conditions which are low to medium risk could be managed in part by extended health care roles in the community with hospital oversight. Many unnecessary referrals could be avoided if the necessary systems were in place to facilitate shared care.

3.7 How could prevention and pro-active strategies of population health management be built more strongly into primary care?

Preventing deterioration of eye health requires patients to access primary care staff who can accurately assess and decide when to refer to secondary care. Up to 50% of glaucoma is undiagnosed in the community and identification and early treatment is needed to prevent visual loss. Improved uptake of regular eye tests, particularly among hard to reach groups is crucial for proactive population health management.

Digital Innovation and Technology

3.8 How can digital technology help the NHS to:

a) Improve patient care and experience?

Digital technology can improve patient care and experience in a number of ways.

Ophthalmology has made use of virtual clinics for many years. Supported by appropriately trained non-medical staff, virtual clinics release consultants to take on the more complex patient cases. This enables greater flexibility for service delivery, how and where patients receive care.

To develop this further, basic IT systems both within ophthalmology departments and those linking primary and secondary care need urgent improvement. Internal hospital systems in some areas are outdated and impede efficient working. Importantly there is a lack of ICT which prevents sharing of patient information between the hospital eye service, GP and optometric establishments, within and external to the hospital setting. A joined-up network between hospital EPS and optometric systems is required much like the GP-Pharmacy join up.

UK Ophthalmology is taking a leading role in the development of artificial intelligence (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. However, there must also be recognition that where aspects of AI will greatly enhance efficiency and diagnostic accuracy it may also lead to an increase in service demand.

3.11 How do we ensure we don't widen inequalities through digital services and technology?

Adopt a population-based approach that recognises disadvantaged groups who require support to access new digital services and technology.

Research and Innovation

3.11 How can we increase opportunities for patients and carers to collaborate with the NHS to inform research and also encourage and support the use of proven innovations (for example new approaches to providing care, new medical technologies, use of genomics in healthcare and new medicines)?

We need more funding for translational and population science research. It is also important to ensure that opportunities are accessible and taken up by disadvantaged groups.

3.12 What transformative actions could we take to enable innovations to be developed and to support their use by staff in the NHS?

Investing in implementation science to identify methods and strategies to promote the uptake of new interventions. Patient and public involvement

3.14 How can we increase research in topics that have traditionally been under-examined?

Funding needs to be made available. We must also encourage young researchers through local networks and flexible training.

3.15 What should our priorities be to ensure that we continue to lead the world in genomic medicine?

Funding for both discovery and translation into practical interventions that improve patient outcomes. Ophthalmology is at the forefront of UK genomics and the RCOphth recently began to work up its approach for supporting development. We would welcome support from NHS England to take this forward in due course.

Engagement

3.17 How can the NHS improve the way it feeds back to people about how their input is shaping decisions and demonstrate that the NHS is the world's largest learning organisation?

We are committed to working together to improve patient care and would welcome more engagement with NHS England to codesign and implement solutions. In an environment of poor STP engagement and lack of NHS accountability it is really important to invest in better, meaningful engagement. This means allowing sufficient time to gather information, discuss and respond. We hope this consultation forms just the beginning of a wider and meaningful process of engagement and collaboration.

General questions

3. What do you think are the barriers to improving care and health outcomes for NHS patients?

There is insufficient data and evidence on hospital performance to fully understand the capacity problems and implement meaningful long-term solutions. Measuring the challenges our hospitals face is the first step toward managing them. Clinical audit of patient outcomes is a proven means of driving up quality through improvements such as risk stratification of patients and better use of resource. Measuring the capacity issues that lead to dangerous delays would enable us to identify the improvements needed to improve care for NHS patients. We urge NHS England to work with us to overcome this barrier.