Labour National Policy Forum – Securing first class NHS eyecare services that meet future patient need

Royal College of Ophthalmologists submission: March 2023

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.

Strategic reform of eyecare services

2. To secure first class eyecare services for all, the ophthalmology sector should be supported by Government to expand capacity through reform coupled with targeted investment which modernises the workforce, makes full use of technology to integrate primary and secondary care, and ensures the sustainable use of independent sector provision.

3. To secure first class NHS ophthalmology services that meet patient need, The Royal College of Ophthalmologists is calling for:

    a. **Matching increased medical school places with increased training places** to ensure there is an effective pipeline for medical school graduates to become NHS consultants where patient need is greatest. Long-term certainty on workforce planning can be achieved through the regular publication of workforce plans which include projections on the number of medical school places and specialty training places needed, alongside a commitment to providing the investment to deliver these projections.

    b. **A single national Electronic Eyecare Referral System for England** – as is being developed in Wales – which allows optometrists to directly refer patients to hospital eyecare services without needing to refer via a GP, improving the efficiency of services, providing a seamless patient experience, and saving money

    c. **Effective use of independent sector provider (ISP) capacity through targeted commissioning and the provision of training opportunities** to ensure independent sector provision genuinely boosts capacity to meet local patient need and ISPs provide sufficient training opportunities to help secure the next generation of doctors

    d. **Reform of regulation and investment in the wider multidisciplinary eyecare team** to ensure we maximise our ability to tackle backlogs and provide high-quality patient care. This should include reform of the General Ophthalmic Services contract to bring optometry into the wider NHS system by mandating HEE oversight of the optometry training programme – as is done in Wales. Alongside reform, additional

funding of non-medical staff and allied health professionals would provide important additional capacity within a short time frame.

Background to NHS ophthalmology challenges

4. Ophthalmology is the busiest outpatient specialty in the NHS, with over 7.5 million ophthalmology outpatient appointments in 2021/22 in England. In December 2022 in England, there were over 628,000 patients on ophthalmology waiting lists – almost 10% of the entire NHS backlog – 27,000 of whom were waiting over a year. These challenges come as demographic shifts drive ever-increasing patient need from an ageing population at a time when significant workforce shortages are set to worsen.

5. Like many other specialties, NHS ophthalmology services face significant capacity pressures, with 82% of eye units not having enough consultants to meet current need. With patient demand for cataract services alone set to increase by 25% between 2017 and 2027 and current workforce shortages getting worse as 22% plan to retire over the next five years, current capacity challenges are set to intensify in the near future.

6. These capacity pressures mean that potential reductions in the availability of secondary eyecare services will disproportionately impact older people. The chances of developing many eye diseases increases with age, such as cataracts, age-related macular degeneration, and glaucoma. Therefore, action must be taken across the board – from workforce, technology and commissioning – if we are to secure capacity that reduces current backlogs and meets future patient need.

7. As well as working closely with primary care optometry services to diagnose and prevent eye disease, a key part of ophthalmology services is to treat conditions after the point at which they have crossed the threshold for treatment, to prevent and slow the further deterioration of vision. While we strongly welcome measures that boost prevention, such as optometry screening services, it is imperative that we invest in capacity 'downstream' to treat patients when prevention is no longer possible.

Establishing a single national Electronic Eyecare Referral System

8. A single national Electronic Eyecare Referral System (EERS) should be developed in England – as is being developed in Wales – which allows optometrists to refer into secondary care without having to go through a GP.

9. A key reason why many primary to secondary eyecare referrals go via a GP is due to incompatible referral systems between optometry and ophthalmology units in an area. Where primary eyecare services do not have access to electronic referrals, they must go via the GP as the local ophthalmology unit may not accept paper or other forms of referral. Aside from referrals, ophthalmologists also need access to patients' medical records, which are held by GP services.

10. In 2019-20, RCOphth and NHS England jointly conducted modelling on the impact direct referrals between primary care optometry and secondary eye care services would have on GP time and costs. This modelling estimated that a **direct referral system could save over £2**

million by reducing unnecessary GP involvement, equivalent to a reduction of over 76,000 eyecare referrals processed by GPs.

11. In this model, optometry is the first point of contact for any patient seeking support or care for eyecare issues (both routine and urgent) and makes referrals directly to hospital eye service as required. This model would be underpinned by access to information between primary and secondary services with agreed timings for redirection and access.

12. Parameters for a national EERS should be created in coordination between NHS England, optometry services, ophthalmology services, and system manufacturers to ensure it functions effectively. A national EERS should also facilitate shared imaging standards across both primary and secondary care, enabling higher volume, efficient patient data sharing.

Effective use of independent sector capacity through targeted commissioning and provision of training opportunities

13. ISPs are now playing a major role in the delivery of NHS-funded ophthalmology services in England. This is focused on cataract surgery, where they are undertaking almost half of NHS-funded procedures. Significant regional differences exist. The North West, Midlands, South West and North East and Yorkshire were all delivering at least half of their NHS-funded cataract procedures through ISPs in November 2021. The South East meanwhile was delivering a third (34%) through ISPs, while for London the figure was a quarter (25%). While this increased capacity to help tackle the backlogs is welcome, there are two measures that can be taken to ensure it genuinely increases NHS capacity and does not undermine the sustainability of NHS services.

14. First, **a national commissioning structure** should be established – in partnership with RCOphth, NHSE, ISPs, integrated care boards and trusts – that prioritises the deployment of independent sector provision in areas where the need is greatest, either where NHS capacity cannot meet demand or where patient need is projected to grow beyond existing NHS capacity.

15. Local NHS ophthalmology units can face sustainability challenges given the funding from delivering simpler 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 unable to access timely care, leading to permanent loss of vision. More targeted commissioning of ISPs would ensure that provision for patients is increased and reduces any sustainability challenges to NHS services.

16. Independent sector provision of NHS services can also affect staffing of local NHS services. With a limited number of ophthalmologists working in England, both NHS and ISPs draw on the same pool of staff. 14% of consultant ophthalmologists work in either a full or part-time role at an independent sector provider, with increasing numbers planning to undertake more work in ISPs in the coming years. This is likely to have implications for health inequalities unless action to increase workforce capacity is taken, given we know there is

correlation between areas with the worse staffing shortages and where patient need is greatest (more rural, coastal areas of the country where the population is older). Therefore, commissioning of ISPs must also take into account their impact on the availability of staff for NHS services.

17. Second, **national and local contractual mechanisms to provide training opportunities** should be built into NHS England and ICB contracts respectively. These should ensure 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.

18. 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 sustainability of NHS ophthalmology services. 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.

19. To date, ISP capacity has been deployed in an uncoordinated way across England, with increasing concerns about the destabilisation of some local NHS services and worsening regional health inequalities. By securing a more targeted system of commissioning that incorporates better access to training opportunities, ophthalmology service capacity can be increased, providing better care for patients while securing the workforce of the future.

Reform of regulation and investment in the wider multidisciplinary eyecare team

20. As well as consultant ophthalmologists, NHS eye care services rely on nurses, optometrists and orthoptists and many more professions that comprise the multi-disciplinary eyecare team (MDT). 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, and there are several strands to achieving this.

21. First, **focused reform of and investment in training for the wider eyecare MDT**, including through an expansion of ophthalmic practitioner training (OPT) programmes to assist hospital-based ophthalmic nurses, optometrists and orthoptists who wish to develop their skills further to deliver patient care. The OPT programme should also be brought within the remit of HEE, expanding capacity in the workforce within a short time-frame – particularly in the context of community diagnostic centres, surgical hubs, and high-volume cataract hubs given their reliance on the MDT. This aligns with Labour's announcement of an expansion in medical school places that will help expand capacity in the longer term. With help from NHS England, the Ophthalmic Practitioner Training (OPT) programme should be expanded, assisting hospital-based ophthalmic nurses, optometrists and orthoptists who wish to develop their skills further to deliver patient care.

22. Increasing the number of MDT roles within ophthalmology provides a quick and cost-effective way to enable high throughput surgical and diagnostic hubs – which rely heavily on the MDT – to treat more patients. This will need to go hand-in-hand with expanding the number of consultant ophthalmologists, who oversee the delivery of care by the MDT alongside their diagnostic and surgical responsibilities.

23. Second, **reform of the General Ophthalmic Services (GOS) contract to bring primary eyecare into the NHS ecosystem with a standardised payment system** should be undertaken. GOS reform should also bring optometry into the wider NHS system by mandating Health Education England (now within NHSE) oversight of the optometry training programme. There is a good practice example of reform of the GOS contract in Wales.

24. Optometrists must become decision makers and disease managers if we are to improve the interface between primary and secondary care. RCOphth supports the proposal in the recent GOC call for evidence to potentially allow dispensing opticians (under the oversight of an optometrist or registered medical practitioner) to undertake refraction.