Three Steps to sustainable patient care: RCOphth view on the independent sector and the delivery of NHS cataract surgery

November 2021

Independent sector providers are now playing a major role in the delivery of NHS ophthalmology services in England, especially cataract surgery where they are undertaking almost half of NHS funded procedures. The RCOphth recognises this has helped to increase much-needed capacity to deliver patient care, particularly during the pandemic. It has also presented new challenges in how to ensure a well-trained workforce and a sustainable comprehensive ophthalmology service.

The Royal College of Ophthalmologists is committed to working with all stakeholders, including the independent sector, to:

1. Rapidly increase access to surgical training in the independent sector
2. Level the playing field for cataract providers to ensure equitable patient access and stability for the whole service
3. Safeguard patient safety and standards of service delivery.

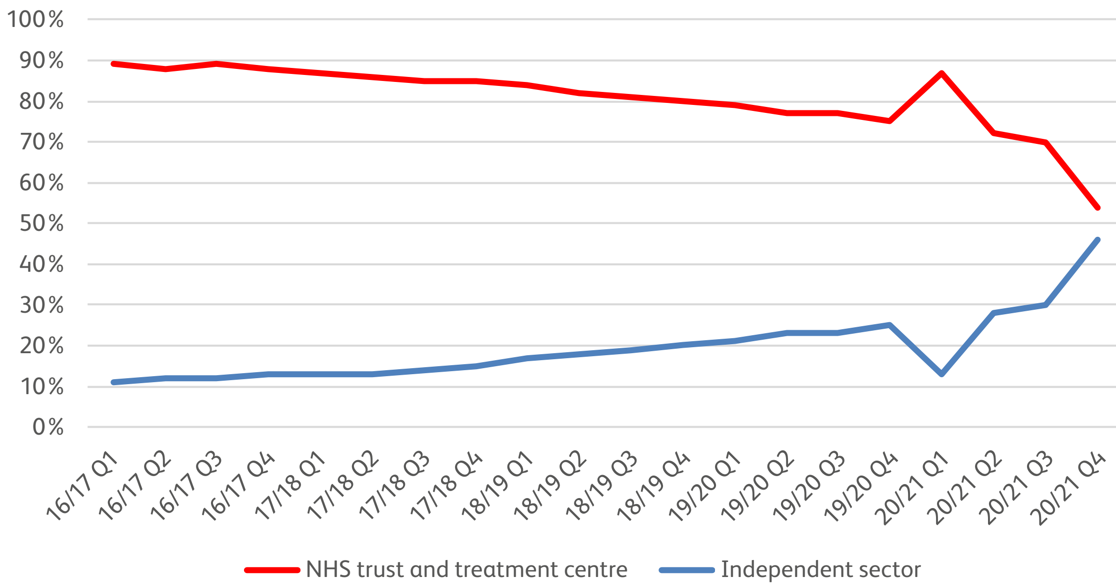
Changes in the setting for NHS cataract surgery

There has been a huge shift over the last five years in what type of provider delivers NHS funded cataract procedures. According to NHS England data, in 2016 11% of NHS cataract procedures in England were delivered in the independent sector (IS) and 89% by NHS trusts and treatment centres. By April 2021 there was almost a 50/50 split, with 46% in the IS and 54% in NHS trusts and treatment centres.

Chart 1 shows that the pandemic has been a key driver of a particularly rapid shift since 2020 – when the independent sector helped provide some of the capacity that was not available in the NHS. But the trend was clearly visible before COVID-19 too, as NHS ophthalmology units struggled to provide capacity for cataract procedures. This is primarily due to a lack of investment, at both the national and local level, in appropriate infrastructure and workforce despite rising demand.

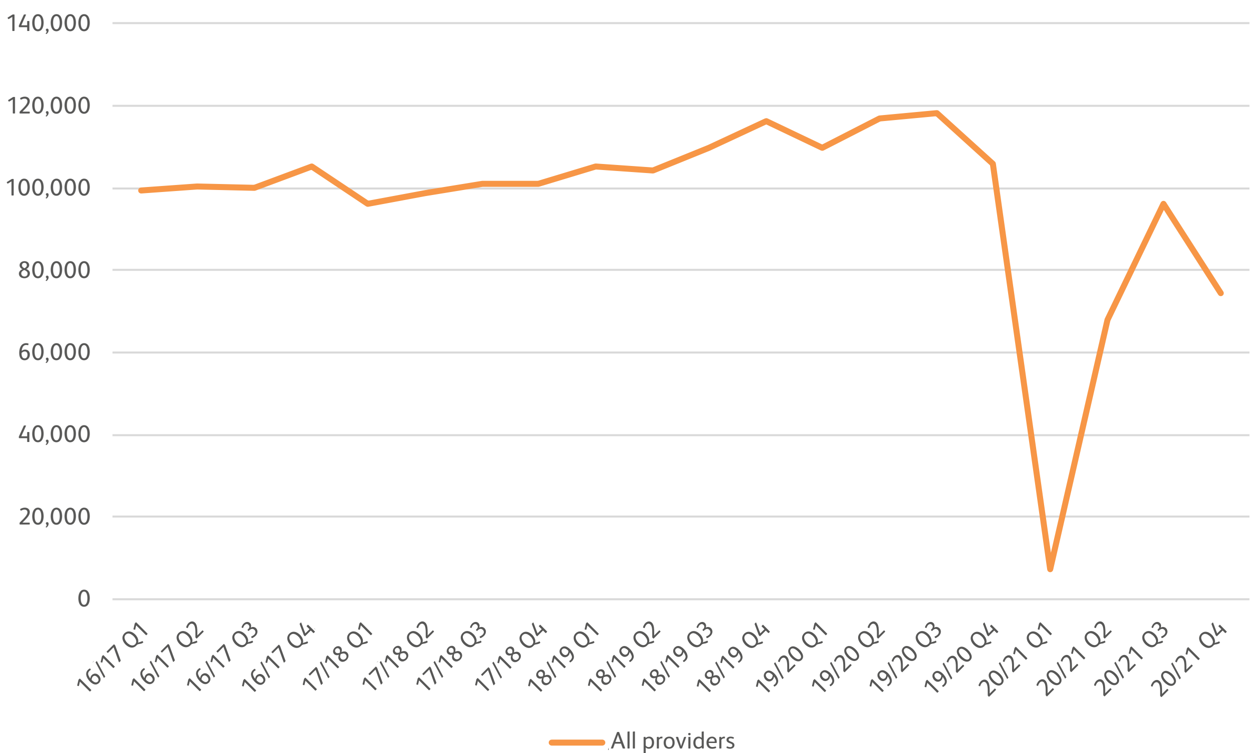
The August 2021 Atlas of Variation report by Public Health England confirms these systemic pressures highlighting that *'rising outpatient activity has posed significant and increasing pressure on capacity for timely service provision'* and the *'shortage of consultant and specialty training posts required to meet the increasing demand for specialist ophthalmic care'*.

Chart 1: Delivery of NHS funded cataract procedures in England by setting



The backlogs we are now facing, both in access to outpatient care and to sight-restoring cataract surgery, are now overwhelming and are only going to make these challenges more acute. Cataract procedures fell by over 40% in 2020 as services were paused or patients did not come forward for treatment, despite what we know is ever-rising patient need. Chart 2 shows the sharp fall in procedures in the spring of 2020, the partial recovery in the second half of 2020 followed by another fall, as the second wave of the pandemic hit services again in late 2020 and early 2021.

Chart 2: Number of NHS funded cataract procedures in England



Investment to increase capacity, alongside service transformation, is the key long term solution to improving patient care, and the RCOphth will continue to make the case for this – including through the National Eye Care Recovery and Transformation Programme. NHS providers are innovating to improve services to tackle the backlogs, including through cataract hubs and high flow cataract lists and often are collaborating locally with independent sector providers (ISPs), but there are many barriers to change.

Investment is urgently required to support the transformation process and to expand capacity to the level needed to meet population need. Some of the additional £5.9 billion capital funding announced at the 2021 Spending Review to support tackling NHS backlogs needs to be specifically targeted to deliver the investment that eye care services sorely need.

Given how rapidly the cataract landscape has shifted in the last five years, we now need to take stock and develop a more strategic approach to the role played by ISPs to ensure sustainable patient care and eye services. The RCOphth will support such an approach by working collaboratively, with ISPs and other key stakeholders, to achieve the following three aims:

1. Rapidly increase access to surgical training in the independent sector

Ophthalmologists in training must complete 350 cataracts, be able to manage intra- and post-operative complications and complete an entire cataract list. They must be able to manage complex cases, show they can supervise junior trainees and be able to deliver high volume lists in their future consultant role.

These requirements are proving difficult to meet as regional training programmes report reduced surgical opportunities, especially of "routine" cataracts. These cases are now often undertaken in the IS, leaving more complex cases, which are less suitable for training, to be delivered by NHS providers. This is making it more difficult for trainees to successfully complete training and, most importantly, more difficult to develop the skilled and experienced surgeons our patients need.

In an RCOphth survey of ophthalmologists in training in 2020, over two thirds (72%) said they did not achieve all their training objectives in their most recent placement, with over half (55%) of these citing lack of surgical opportunities. A significant proportion (29%) of those not achieving their training objectives felt further placement would be required. This could lead to an extension in training, adding to the workforce capacity challenge.

Steps are being taken to tackle this problem. The framework to provide training agreed in October 2020 between NHS England, Health Education England (HEE), the Independent Healthcare Providers Network (IHPN) and the Confederation of Postgraduate Schools of Surgery was a welcome step forward. For this framework to be effective, the right governance arrangements need to be in place and ISPs, the RCOphth, the local eye unit and the relevant deanery need to work together.

The RCOphth and its Training Committee have also been speaking directly to ISPs and HEE, and secured agreement from four large ISPs to deliver training. The provision of cataract training by ISPs has disappointingly been very limited to-date though, with few trainees involved. It is imperative to make much quicker progress. We must ensure we are providing the next generation of ophthalmologists with the surgical skills they will need to meet rising patient demand.

The RCOphth is committed to working with independent sector providers, NHS England and the devolved health bodies, statutory training and education bodies and deaneries to rapidly increase access to high quality surgical training opportunities in the independent sector.

2. Level the playing field for cataract providers to ensure equitable patient access and stability for the whole service

NHS ophthalmology units are grappling with long backlogs, and winter pressures will likely place another brake on elective recovery. Chronic underinvestment in NHS eye care units' estate and their workforce also exacerbate this capacity challenge.

It is therefore clear that the independent sector will need to continue to play an important role in cataract surgery delivery. Patient access must however be equitable.

There are currently significant differences in some areas between the waiting times on NHS hospital list and those on an ISP waiting list. Notable variations also exist in waiting times within and between different geographical areas. The greatest patient need is often in rural areas where capacity is lacking and waiting lists are longest, and these areas also face particular challenges in recruiting and retaining staff. The whole system must do more to address these issues, which contribute to worsening health inequalities across the country.

Variations also exist in the type of case complexity accepted into ISPs. Although it is widely accepted that patients with the greatest complexity are likely to need surgery in NHS eye units, high volume efficient cataract care should be available in all settings to a wider group of patients. This will mean that those with multiple or complex eye conditions, multiple health conditions or patients with physical disabilities or mental health illnesses are not disadvantaged and health inequalities are not widened further.

Some ISPs do not offer urgent and emergency 24 hour care or treat surgical complications (such as endophthalmitis or a dropped nucleus). In these situations, nearby NHS providers must care for these patients. As the RCOphth's cataract commissioning guidance makes clear, these arrangements should be agreed as part of the commissioning process with 'clear, documented and agreed contingency arrangements' with the provider of out of hours emergency care being appropriately funded.

If less complex cataract cases are increasingly referred to the independent sector, while more complex cases, and complications from IS procedures, are managed in NHS units, this could have significant implications for the financial viability of NHS eye care units which deliver comprehensive care, including out of hours and subspecialty work.

ISPs need to contribute to the delivery of a comprehensive ophthalmic service for all patients.
The management of cataracts, while very important, should not be at the expense of other services such as glaucoma and age-related macular degeneration (AMD) which are essential to protect patients from permanent sight loss.

It is crucial that better contracting and funding mechanisms, which appropriately reimburse costs across all providers fairly, are designed to promote safe, equitable and patient-centred pathways.

The RCOphth is determined that patients can access the best possible timely care, irrespective of how complex their case is or where they live. We will work with NHS England and the devolved health bodies, ISPs, commissioners, primary care, NHS organisations and patient groups to ensure that the whole system, including funding and contracting, works coherently to deliver the best possible care to patients.

3. Safeguard patient safety and standards of service delivery

Cataract surgery is safe and effective and as NICE guidance has concluded, is cost-effective for both first and second eye surgery. Complications do arise infrequently though and require prompt assessment and management.

The RCOphth is working to further improve standards of cataract care. Working jointly with GIRFT, we have produced guidance on high volume cataract surgery. We have also published guidance on Immediate Sequential Bilateral Cataract Surgery and, with the College of Optometrists, recommendations on discharging patients following cataract surgery.

We work closely with the NHS England National Eye Care Recovery and Transformation Programme, and the transformation programmes in Scotland, Wales and Northern Ireland, to support the delivery of this guidance. We will also, working with the independent sector, soon be publishing guidance on training in high volume lists and managing more complex cases. This will help ISPs to manage complex cases to support regional systems in providing more accessible comprehensive eye care to all patients.

Patient care continues to be provided by a fragmented service delivery system across multiple providers, where patients with ocular co-morbidities managed by NHS eye units might have their surgery delivered by ISPs. We therefore need to take additional steps to safeguard patient safety and the quality of service delivery. All patients need clear guidance and access to urgent care at all times.

The National Ophthalmology Database (NOD) Audit has helped to drive quality improvement and patient safety by providing national benchmarking for cataract surgery and evidence-based recommendations for service improvement. Given almost half of cataract procedures are now performed in the IS, it is important that ISPs contribute to the NOD Audit so we can drive standards of patient care even higher and ensure safety performance is visible for every NHS patient who receives cataract surgery, as well as all providers, surgeons and commissioners.

The RCOphth will work closely with ISPs, NHS England and devolved health bodies, and NHS organisations to ensure that we maintain the highest standards of patient safety and service delivery. An important aspect of this will be ensuring all providers of NHS funded cataract services contribute to NOD, mandating this where appropriate.

If you would like to be involved in RCOphth's work on any of the areas outlined in this statement, or have comments or suggestions please contact our policy team on **policy@rcophth.ac.uk**

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