The Eyes Have It: Response to the 10 Year Plan Consultation

The Eyes Have It (TEHI) is a partnership of the Macular Society, Fight for Sight, Royal National Institute of Blind People (RNIB), Association of Optometrists, Royal College of Ophthalmologists and Roche Products Ltd. Roche has funded the activities of the partnership.

What does your organisation want to see included in the 10-Year Health Plan and why?

The Eyes Have It (TEHI) is a partnership of the Macular Society, Fight for Sight, Royal National Institute of Blind People (RNIB), Association of Optometrists, Royal College of Ophthalmologists and Roche Products Ltd. Roche has funded the activities of the partnership. We work collaboratively across the eye care sector to advocate for and champion improvements to patient care and outcomes. Our ambition is for everyone to have access to the right care, where and when they need it, and to prevent avoidable sight loss.

In light of the significant impact of eye health conditions on people affected, the NHS and wider economy, our top priority is to ensure that eye care is recognised within the upcoming 10 Year Plan for Health.

High-street optometry, general practice, secondary care and the independent sector all have a role in ensuring the public has access to high-quality and timely eye care. The sector has effective prevention measures, innovative technologies and significant expertise, and we believe that eye care already represents a significant opportunity area to deliver on the Government's proposed 'big shifts' from analogue to digital, from hospital to community and from sickness to prevention. If mobilised in a strategic and coordinated way, there is potential to improve ill health, move care closer to home, improve outcomes for people living with eye health conditions, deliver substantial cost savings and provide a powerful blueprint for the NHS and wider economy.

The pressures on eye care and the health and economic impact

Lord Darzi's investigation into the NHS in England found a system in crisis, and this is particularly true of secondary care services for people with eye health conditions and sight loss. Extensive waiting lists in ophthalmology, variations in clinical pathways resulting in a postcode lottery of care for patients, and ophthalmology workforce capacity constraints are putting people at risk of experiencing avoidable and irreversible sight loss, which not only has profound wellbeing impacts, but is also a significant cost burden for the NHS and wider economy.

There are already 2.2 million people living with some form of sight loss in the UK and this is anticipated to double to over four million by 2050 due to the effects of an ageing population – with the number of people aged 85 and over expected to double in the next 25 years.[1,2] As the prevalence of sight loss rises, Fight for Sight has also estimated that the total cost associated with sight loss will reach £33.5bn in 2032, representing a 26% increase since 2020.[3] A large proportion (just under half) of this financial burden is due to refractive disorders (i.e. those that can be corrected with glasses or other interventions). However, on a per person basis, prevalent eye conditions, including glaucoma, cataract, wet age-related macular degeneration (AMD) and diabetic retinopathy, are significantly more costly for the NHS. Taken together, the prevalence of these conditions is expected to grow by around 25% in the next decade, which is seven times faster than predicted population growth.[3]

Even at current incidence and prevalence rates, ophthalmology is the busiest outpatient specialty in the NHS and there are over 600,000 people waiting for their first appointment with an ophthalmologist.[4] Just over 35% of these patients have been waiting over 18 weeks, despite NICE quality standards which recommend patients should start treatment within 14 days of referral for some serious eye conditions such as AMD.[5] This also varies significantly across the country, with 58% of patients on the ophthalmology waiting list in the East of England being seen within 18 weeks, compared to 71% in London.[4] This is one of the several harmful inequalities associated with eye health across the country, with people in the most disadvantaged populations going blind or experiencing sight deterioration at a greater rate than people in the most advantaged areas.

On top of this, while follow up appointment data is not routinely published by the NHS England, analysis by think tank Reform found that ophthalmology had the highest number of people waiting for a follow up appointment in 2023 – the highest number out of any specialty - during which time patients are nine times more likely to suffer irreversible damage to their sight compared to new patients.[6,7]

Every delay to care and treatment risks the irreversible progression of an eye health condition, with potentially devastating consequences for the patient, as well as avoidable impacts and costs for the health system and economy.

The case for a national plan recognising eye health as a long-term health priority

In light of this, TEHI believe that the development of a National Eye Care Plan – drawing on the overarching priorities and improvement areas that are set out within the 10 Year Health Plan - is the single biggest opportunity for transforming eye health in this country. It is an approach that the entire sector is unified behind and in the current environment, represents a low-cost, high-return policy driver, providing

the much needed detail and strategic direction for how the Government's three shifts can be implemented across this significant sector.

The scale of the challenges we are faced with calls for a joined-up system-wide approach to the provision of eye care in every part of the country.

In the context of the recent announcement that the Government will move forward with the development of a national cancer strategy, we argue that there is an equivalent need in eye health. There is considerable and broad expertise available within TEHI partnership and we stand ready to provide support and resource to work directly with colleagues across the DHSC and NHS England to inform the development of a plan. This approach represents the best opportunity to address the significant and growing impact that the eye care backlog currently places upon the NHS, and to help prevent avoidable sight loss in the coming years.

Implementation of the Accessible Information Standard

Underpinning everything in the upcoming 10 Year Plan, it is critical that information and support is provided in an accessible format, in line with NHS England's Accessible Information Standard (AIS). Missed medical appointments, delayed test results, misunderstood treatment instructions, unread medication labels and letters from doctors are all consequences of inaccessible health information.

In light of evidence from recent patient surveys indicating only 11% of patients covered by the AIS have equitable access to the NHS, it is vital that the findings from this review are published without delay and plans are put in place to ensure people with blindness and visual impairment have access to information and support.[8,9]

References

1. RNIB. Key information and statistics on sight loss in the UK. Available: https://www.rnib.org.uk/professionals/health-social-care-education-professionals/knowledge-and-research-hub/key-information-and-statistics-on-sight-loss-in-the-uk/
2. Health Foundation. Our ageing population. Available: https://www.health.org.uk/publications/our-ageing-population
3. PA Consulting (commissioned by the Association of Optometrists, Fight for Sight, Primary Eyecare Services and Roche Products Ltd). Key interventions to transform eye care and eye health. November 2024. Available: https://www.aop.org.uk/our-voice/policy/consultations/2024/11/29/key-interventions-to-transform-eye-care-and-eye-health
4. NHS England. Consultant-led Referral to Treatment Waiting Times Data 2024-25 – September 2024. Available: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2024-25/

5. NICE. Serious eye disorders. Quality Standard [QS180]. Available: https://www.nice.org.uk/guidance/qs180/chapter/Quality-statement-3-Treatment-late-age-related-macular-degeneration-wet-active
6. Reform. The hidden waiting list: the growing follow up backlog. Available: https://reform.uk/wp-content/uploads/2023/10/Reform-The-Hidden-Waitlist-Embargoed.pdf
7. Royal College of Ophthalmologists. Scale of the ophthalmology follow-up backlogs and need for better data collection highlighted by thinktank. Available: https://www.rcophth.ac.uk/news-views/scale-of-ophthalmology-follow-up-backlogs-and-need-for-better-data-collection-highlighted-by-thinktank/
8. The Deaf Health Charity: SignHealth. Review of the NHS Accessible Information Standard. Available from: https://signhealth.org.uk/resources/research/aisreview/
9. Healthwatch. Our policy position on accessible information. July 2023. Available from:https://www.healthwatch.co.uk/news/2023-07-10/our-policy-position-accessible-information

What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

The eye care sector is uniquely placed to deliver on the Government's ambition of moving care closer to home, and away from hospitals.

The workforce within primary eye care is stable. Data from the Association of Optometrists (AOP) has indicated that there are over 5,300 optometry practices in England and around 8,223 full-time equivalent (FTE) optometrists – based on 13,705 registered optometrists working an average of 0.6 FTE.[3,10] The optometry sector already plays a well-established role in delivering General Ophthalmic Services for the NHS, and the overall benefits in England for the delivery of these services are estimated to be £2.09 billion (on a total cost of £525 million).

Meanwhile, workforce pressures are a significant challenge in ophthalmology. The latest workforce census coordinated by the Royal College of Ophthalmologists has indicated that increasing demand for eye care is vastly outstripping capacity, with over three quarters (76%) of secondary eye care units reporting that they don't have enough consultants to meet existing levels of demand.[11]

In addition to this, over half of NHS ophthalmology units (52%) have found it more difficult to fill consultant and specialty and associate specialist doctor vacancies over the last 12 months, and a quarter of consultants (25%) plan to leave the ophthalmology workforce over the next five years.[11] Delivering on the ambitions within the NHS Long-Term Workforce plan will be a key enabler for realising the Government's shifts. Alongside this, the Royal College is calling for a phased

introduction of 285 additional training places in England by 2031 to ensure the long-term sustainability of the NHS ophthalmology services.[12]

Unlike ophthalmology, there is no workforce shortage in optometry, and the profession has a reliable and established training and recruitment pipeline – representing a key enabler for moving care closer to home. It is clear that the optometry sector has both the willingness and the capacity to reduce the pressure on secondary care services and provide much needed eye care and support in the community, where patients need it.

Expanding optometry-led, out-of-hospital services such as Minor Eye Care Services (MECS) and Community Urgent Eye Care Services (CUES) has already demonstrated improved access to timely care, refine referrals, alleviate downstream pressures on secondary care, and ultimately improve patient experiences and outcomes. These services can be strengthened by consistent commissioning of services by Integrated Care Boards (ICBs).

As an immediate priority, minor eye conditions and cataract aftercare should be moved from hospitals to high-street optometry, allowing partners across optometry and ophthalmology to work together efficiently to intervene at the most appropriate time within the patient journey.

The transfer of appropriate responsibilities to high-street optometry has the potential to result in significant cost savings and economic benefit. A recent analysis commissioned by the Association of Optometrists, Fight for Sight, Primary Eyecare Services and Roche Products Ltd recently found for example, that through the delivery of four key interventions (including the national roll-out of Community Urgent Eye Services, integrated glaucoma and cataract pathways and the transformation of Optical Coherence Tomography (OCT) use across all settings), the NHS could save an estimated 1.9 million appointments and achieve an overall net saving of £98 million – assuming national roll-out of all four interventions. These four interventions are also estimated to shift 752,867 appointments from hospital eye services to high-street optometry, which would represent just 92 additional appointments per optometrist per year, or around two per working week.[3]

A key concern however, which has been highlighted by Lord Darzi in his recent review, is that shifting care into the community has been an ambition since the 2000s, yet spending has "drifted towards the acute sector" – meaning the NHS has in fact implemented the inverse of its strategy.[13]

Improving connectivity between primary and secondary care providers
To ensure that the Government's ambitions are deliverable, and to provide a blueprint for other areas on how to deliver them, we therefore urge recognition of the

role of optometry and the value of high-street practices as diagnostic hubs and treatment centres, which may be based on an 'Optometry First' model. To deliver on this it is critical to address some of the longstanding issues that are preventing the delivery of best-practice, integrated care between community and secondary providers. This includes the lack of basic IT connectivity, access to advice and guidance and a way to seamlessly share data between primary and secondary care providers. This, in turn, is having a significant impact on sector performance.

Poor IT connectivity and limited digital clinical image interoperability is causing significant inefficiencies in the patient pathway, creating barriers to sharing data such as images and patient information, resulting in avoidable referrals and patients not receiving the right care at the right time.

A recent survey of ophthalmology clinical leads in NHS departments in the UK found that less than 10% felt that shared electronic patient record (EPR) systems functioned well, while almost two fifths (39%) said that interoperate imaging standards did not function well.[14] However, it is essential to roll out universal EPRs in order to enable eye care professionals in primary, community and hospital settings to be able to share critical information about a patient's medical history, diagnosis and treatment with one another.

The lack of connectivity between primary and secondary care is having a direct impact on the optometry sector's availability to support secondary care providers in managing demand and reducing avoidable sight loss. At present – for example – different providers are unable to share data with each other (including for example images or patient information). This means some patients are having to have repeat OCT scans because original results can't be shared by primary eye care providers.

TEHI therefore highlight the importance of realising increased IT connectivity and digital clinical image interoperability within and between primary and secondary care providers, which can be achieved through the deployment of a single, consistent mechanism for image sharing. This would facilitate timely, secure and effective communication to improve patient care, streamline referral pathways, facilitate quality improvement and aid learning.

Alongside this, we also highlight the opportunities that can be realised through the implementation of a Single Point of Access (SPoA) referral pathway model for eye care. Whilst there is a need to establish a clearly defined SPoA model that works for all parts of the eyecare pathway, and which maintains the critical role of primary-based eyecare settings, recent examples of SPoA models being deployed across the NHS demonstrate how these approaches can support meaningful system benefits and ultimately, help to strengthen patient outcomes.

References
10. Data provided by the Association of Optometrists.
11. Royal College of Ophthalmologists. Facing workforce shortages and backlogs in the aftermath of COVID-19: the 2022 census of the ophthalmology consultant trainee and SAS workforce. Available: https://www.rcophth.ac.uk/wp-content/uploads/2023/03/2022-Ophthalmology-census-Facing-workforce-shortages-and-backlogs-in-the-aftermath-of-COVID-19.pd
12. Royal College of Ophthalmologists. Position Statement: A sustainable ophthalmology workforce. Available: 240520-Position-statement-training-places.pdf
13. The Rt Hon Professor Lord Darzi. Independent Investigation of the National Health Service in England. Available: https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf
14. The Royal College of Ophthalmologists. Summary of 2024 clinical leads survey. Available: https://www.rcophth.ac.uk/wp-content/uploads/2024/05/Summary-of-RCOphth-2024-clinical-leads-survey.pdf

What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Addressing IT connectivity

As outlined in the previous question, there are longstanding issues that are preventing the delivery of best-practice, integrated care between primary, community and secondary providers.

TEHI therefore highlight the importance of realising increased IT connectivity and digital clinical image interoperability within and between primary and secondary care providers, which can be achieved through the deployment of a single, consistent mechanism for image sharing. This would facilitate timely, secure and effective communication to improve patient care, streamline referral pathways, facilitate quality improvement and aid learning.

Consistent roll-out of Optical Coherence Tomography (OCT)

As an immediate opportunity area, NHS England should also fund a service that utilises OCT in primary care optometry practices, supported by appropriate training where required, to further improve diagnosis and appropriate onward referral. For example, utilising OCT to complement glaucoma repeat measures can help reduce 'false positive diagnosis', while use of OCT to grade diabetic maculopathy cases can provide a more accurate understanding of disease progression, both of which would help reduce avoidable referrals. Delivering more diagnostic activity (for example diabetic retinopathy screening) in primary care optometry can also provide clinicians

with a more holistic picture of overall eye health and widen access to screening services in some areas.

Implementation of new technologies
New models of care, technologies and treatment models have the potential to deliver better care, reduce the burden of treatment and improve patient outcomes. For example, opportunities exist to support greater use of OCT to transform detection and monitoring of eye conditions, telehealth to support greater patient access to services, and Artificial Intelligence (AI) to analyse imaging and detect signs of eye disease.

However, a clear and collective approach to innovation such as AI and robotic automation process applications, which can support screening, diagnosis and monitoring for the whole population, is also essential.

With potential for strengthening patient care, streamlining processes and advancing research, AI undoubtedly has an important role to play in transforming eyecare delivery in the UK.

We believe that AI tools should be adopted via an iterative process, with ophthalmology services conducting regular audits, quality assurance and inclusive patient engagement to ensure safe, equitable and effective implementation of these tools.

Enhanced digital integration, adequate workforce capacity and robust governance frameworks are needed to facilitate such efforts, and clinicians must remain central to patient care, with AI-enabled tools supplementing – not replacing – their expertise and judgement.[15]

To enable this, there needs to be the underlying infrastructure and processes in place to support consistent roll out and application of new technologies and treatment models across the country. This should include setting out clear commissioning requirements, with a minimum standard of evidence alongside analysis of clinical and cost effectiveness, to support correct implementation. Adequate staff training and resourcing is also needed to deliver new technologies and treatment models, and evolving professional practice should be continually reflected in workforce planning and training.

What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

It is estimated that at least half of sight loss in the UK is avoidable and can be prevented by tackling the risk factors associated with poor eye health (for example

smoking, obesity and poor diet), providing corrective eye care (e.g. glasses), and ensuring early diagnosis of eye health conditions that can lead to sight loss without treatment (for example glaucoma, cataract, wet age-related macular degeneration and diabetic retinopathy).[16]

Reducing the prevalence of eye health conditions by just 1% each year could save the UK economy around £9.5 billion by 2050.[17]

Sight test and screening programmes

The availability and provision of routine sight tests is excellent across the country, however there are opportunities to improve uptake, particularly among at-risk groups.

For example, despite research indicating that sight is the most valued sense among UK adults, research by Eye Health UK and Thomas Pocklington Trust found that just one in four people rated routine eye tests as important for maintaining good eye health.[18,19] More recent research found significant inequalities in uptake of routine sight tests, with people in affluent areas being 5 times more likely to access a General Ophthalmic Service (GOS) sight-test than those in more deprived areas.[20]

To ensure prevention of avoidable sight loss across the country there is a need to promote the availability of sight tests to increase uptake among groups at higher risk of eye conditions (e.g. due to comorbidities or genetic factors).

One way to deliver on this is to encourage and support Integrated Care Partnerships (ICPs) to undertake an eye health needs assessment of their population – as part of Joint Strategic Needs Assessments – to feed into public health plans and inform local commissioning and pathway development. Where possible, this should be informed by new sources of data and real-world evidence.

At the same time, it is important to ensure that pathway development processes do not inadvertently disadvantage patients, for example by ensuring that screening pathways continue to recognise the unique role of optometrists in joining up different elements of eye care and supporting high quality patient experience.

Waiting list prioritisation

There are over 600,000 people waiting for an ophthalmology appointment in England, many of whom have been waiting over 18 weeks.

To ensure early and effective intervention for people with serious eye conditions that will likely lead to sight loss if left untreated, better prioritisation of patients on the waiting list is urgently needed in order to identify those that are at the highest risk of preventable, avoidable damage to their sight. This will require appropriate

investment in data capture and data accessibility, to support NHS organisations to accurately identify care needs within their local populations, and develop strategies to address them.

To further understand local population eye health needs, TEHI believes that NHS England should publish detailed statistics on the number of people currently waiting for a follow-up appointment, alongside the routine Referral To Treatment (RTT) publication. While this is an important component in informing local assessments of clinical risk across all specialties, it is especially important in ophthalmology, where the risk of permanent harm from avoidable sight loss is nine times more likely in follow-up patients than in new patients.

Sustainable use of independent sector providers (ISPs)

ISPs have an increasing role in providing additional capacity to the NHS, and now deliver over half of NHS cataract operations, with the number of procedures up 40% compared to pre-pandemic.[21]

While this has helped to bring down cataract waits, some ophthalmologists are concerned that resources are being diverted towards treating cataracts – a relatively low risk condition – at the expense of rising follow-up waits for potentially blinding eye diseases like glaucoma and age-related macular degeneration. It is important that the government considers how best we commission and deploy independent sector capacity, with a view to prioritising patient need and best use of scarce resources.

In addition, the BMA has highlighted challenges with the NHS's ISP selection regime, especially in the case of high value, low complexity (HVLC) procedures, sometimes at the expense of the NHS.[22]

Getting It Right First Time (GIRFT) has published a wide range of resources to address potential issues in these collaborations and it is important to explore how these pathways and best practice guidance could help all providers to ensure the ongoing provision of high quality care across all settings.[23]

Clinical research and investment

While early diagnosis and intervention is critical to prevent avoidable sight loss, there are still some conditions (such as macular and inherited eye health conditions) where sight loss cannot yet be avoided and as such we need to continue to focus on researching the next generation of solutions.

In eye health, integrated research into health and care across the NHS is vital not only in supporting improvements in our understanding of the causes, diagnostics and treatments for disease, but also in ensuring the UK remains an attractive

proposition for the next generation of discovery and clinical researchers. A majority (54%) of ophthalmology trainees want to be more involved in research than they are currently. 44% of SAS doctors also want to be more research active, while 39% of consultants do.[11]

The opportunity to be involved in research is similarly important for patients, particularly those that are currently living with untreatable conditions, as well as trainees, 54% of which recently reported that they want to be more involved in research activity in the NHS.[11] Transitioning to research opportunities within eye health should become a more routine component of eye care in the community, as should being provided with opportunities to consent for participation in relevant trials.

Despite the significant potential benefits that increased investment into eye health research could generate, there is currently a significant gap in funding compared to conditions such as dementia. At present, just £9.60 per year is invested in eye research for each person with sight loss, which is around one tenth of the funding available for dementia research (£97 per person, per year).[17]

Integration of health research across the NHS will also require dedicated infrastructures that support access to data, collaboration between researchers and enable patient participation.

In addition, new and effective treatment options for eye health conditions are emerging and there is an increasing need to be able to effectively compare modalities, which could be supported by a central tool for comparison and recording health outcomes research.

References

15. Royal College of Ophthalmologists. Position Statement on Artificial Intelligence. May 2024. Available: https://www.rcophth.ac.uk/wp-content/uploads/2024/05/240521-Position-statement-artificial-intelligence.pdf
16. Thomas Pocklington Trust. Preventing Avoidable Sight Loss. Available: https://www.pocklington.org.uk/health/prevention/
17. Fight for Sight. Time to Focus. Available from: https://www.fightforsight.org.uk/media/3302/time-to-focus-report.pdf
18. Enoch J, McDonald L, Jones L, Jones PR, Crabb DP. Evaluating Whether Sight Is the Most Valued Sense. *JAMA Ophthalmol.* 2019;137(11):1317–1320. doi:10.1001/jamaophthalmol.2019.3537
19. Eye Health UK, Thomas Pocklington Trust. Testing the Nation’s Eye Q. Available: https://www.pocklington.org.uk/wp-content/uploads/2022/09/Eye-Q-Report.pdf

20. Optometry Today. UK research finds lower rate of GOS sight test activity in areas of deprivation. Available: https://www.aop.org.uk/ot/science-and-vision/research/2024/09/18/uk-research-finds-lower-rate-of-gos-sight-test-activity-in-areas-of-deprivation
21. Guardian. Boom in cataract surgery in England as private clinics eye huge profits. June 2024. Available: https://www.theguardian.com/society/article/2024/jun/16/boom-in-cataract-surgery-in-england-as-private-clinics-eye-huge-profits
22. British Medical Association. Privatisation of the NHS. Available: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/commissioning/privatisation-of-the-nhs
23. Getting It Right First Time. Ophthalmology Academy Resources. Available: https://gettingitrightfirsttime.co.uk/surgical_specialties/ophthalmology/#Ophthal

Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

Quick to do, that is in the next year or so

- **Commit to developing a National Eye Care Plan:** TEHI urge the Government to commit to developing a National Eye Care Plan at its earliest opportunity, to help deliver transformative change as soon as possible. This should include an analysis of the cost saving opportunities presented by new technologies and innovations, and a plan for their implementation. Development of a plan should be informed by engagement with system, sector and patient experts – including through roundtable meetings and a formal, 12-week public consultation on a draft plan. We recommend that a draft plan is developed with joint working between representatives across the patient and clinical pathway (primary, secondary and independent care) with Department of Health and Social Care and NHS England’s National Clinical Director for Eye Care. A final plan should then be published within six months of the consultation.

- **Balancing local and national commissioning:** Eye care is one of several service areas where commissioning responsibility has been delegated to Integrated Care Boards (ICBs), in recognition that they should account for the specific needs of their local populations. However, given the complexity of the eye care pathway and the range of providers working together across the country to deliver eye care and treatment to patients, TEHI believe a national framework is needed to provide accountability for local systems, with supporting actions provided on how they can improve local services and tackle long-standing challenges in the system.

- **Publish more granular waiting times data:** A lack of regularly published data on follow-up waits has contributed to a worrying focus on the number of patients waiting for care, rather than prioritising who is most at risk of adverse outcomes. Alongside NHS England's Referral to Treatment (RTT) publication, publish data on the number of people waiting for a follow up appointment, by specialty, to inform prioritisation of patients at risk of avoidable sight loss. This is an important component in informing local assessments of clinical risk across all specialties, and is especially important in ophthalmology, where the risk of permanent harm from avoidable sight loss is nine times more likely in follow-up patients than in new patients.

- **Recognise the role of high-street optometry in reducing pressure on hospital eye services:** As an immediate priority, minor eye conditions and cataract aftercare should be transferred from hospitals to high-street optometry, allowing partners across optometry and ophthalmology to intervene at the most appropriate part of patient journeys, and ensure ophthalmology can focus on the specific care it is best placed to provide in the hospital eye service.

- **Review the NHS tariffs for delivery of hospital-based procedures** including how tariffs influence activity, to better align resource to patient need and risk.

- **Ensure equitable access to NHS mail for 100% of high-street optometrists,** to support effective communication between primary and secondary eye care providers.

- **Commit to publishing an updated and improved NHS Accessible Information Standard,** and prioritise implementation, to ensure that blind and partially sighted people have access to health and care information.

In the middle, that is in the next 2 to 5 years

- **Address the lack of connectivity between primary and secondary eye care:** Increased IT connectivity and digital clinical image interoperability within and between primary and secondary care providers through the deployment of a single, consistent mechanism for image sharing. One option for facilitating this could be through wider adoption of a consensus-based Single Point of Access (SPoA) referral pathway model, which have the potential to support more effective joint working between primary and secondary care eyecare services.

- **Commitment to increase eye health research investment:** Research and innovation have the potential to transform eye care services through enabling a better understanding of sight loss and finding the next generation of diagnostics and innovative treatments. This is particularly critical given the scale and

significance of society's ageing population, combined with the fact that prevalence of sight loss increases with age. There is a clear need to accelerate research into how to reduce preventable sight loss within wider healthy ageing and economic growth initiatives. TEHI believe that the Government needs to urgently double funding for sight loss research, taking total public investment to at least £50 million per year by 2030 (for common and rare diseases), and continuing to expand research funding sustainably thereafter.

- **Review training needs for Allied-Healthcare Professionals:** Alongside measures to increase utilisation of optometrists and Eye Care Liaison Officers (ECLOs) and ensure the sustainability of the ophthalmology workforce, NHS England should review training needs, as well as the audit and regulation of allied-healthcare professionals, and develop a comprehensive development plan for implementation over the coming years.

Long term change, that will take more than 5 years

- **Address the current shortfall in the ophthalmology workforce:** Building on commitments in the NHS Long Term Workforce Plan, DHSC and NHS England should increase the number of ophthalmology specialty training places in line with current and future patient need and fully resource trainers to deliver this expanded programme. Specifically, we believe a phased increase of 285 training places in England by 2031 is essential to ensure the long-term sustainability of NHS ophthalmology services.[12]