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Transforming Eye Care for Tomorrow's NHS: From Vision to Action

A REPORT FROM THE EYES HAVE IT PARTNERSHIP

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

Roche Products Ltd is a pioneer in pharmaceuticals and diagnostics, focused on advancing science to improve people's lives. Roche believes that more can and should be done to improve and protect vision.

The Royal College of Ophthalmologists is the professional body for ophthalmologists in the UK, committed to developing and promoting the highest standards of patient care.

Fight for Sight is the only independent UK-wide funder changing lives through grant investment in ground-breaking scientific research and innovative services for people with sight loss.

The Association of Optometrists (AOP) is the voice of the optical profession, representing over 80 percent of practising optometrists. The AOP elevates the work of its members, safeguards their interests and champions eye health across the UK.

The Royal National Institute of Blind People (RNIB) is the UK's leading sight loss charity. We want to change our world so there are no barriers to people with sight loss.

Macular Society is the charity dedicated to beating the fear and isolation of macular disease, by funding world-class research, and providing the best advice and support to those affected by macular conditions.

Marsha de Cordova MP

Foreword from Marsha de Cordova MP

Marsha de Cordova

Member of Parliament for Battersea and Chair of the All-Party Parliamentary Group for Eye Health and Visual Impairment

As the NHS embarks on a decade of reform, the urgency and opportunity to embed eye care at the heart of a future-ready health system has never been clearer. **With over two million people in the UK currently living with sight loss, and numbers projected to rise considerably in the coming years, the need to act is urgent.**

As Chair of the APPG on Eye Health and Vision Impairment and having lived with Nystagmus – an involuntary movement of the eyes causing severe short-sightedness – my whole life, I understand first hand just how critical it is to get eye care right. I know that poor eye health can not only have a devastating impact on the wellbeing and health of people affected, but it also places additional pressures on the health-care system and negatively affects our wider economic productivity. **Many of these impacts are ultimately avoidable.**

Over the past few years, I've had the privilege of working closely with The Eyes Have It (TEHI) partnership to push for much-needed change, including calling for the development of a national eye health strategy. Together, we've made the case for better services, smarter policy, and a stronger voice for people affected by sight loss. **Now, with the Government having published its 10 Year Health Plan, the opportunity to realise this transformation and truly deliver for the nation's sight is in front of us.**

In this context, the following report provides a practical and ambitious blueprint for transformation. Crucially, it demonstrates just how well positioned the eye care sector is to deliver on the commitments in the Plan. From high street optometrists to specialist ophthalmology teams, each part of the system is central to achieving the Government's three strategic shifts for creating an NHS fit for the future: hospital to community, analogue to digital, and sickness to prevention. By improving outcomes and preventing avoidable sight loss, eye health truly can play a central role in strengthening population health and reducing future demand on the NHS.

At the same time, the UK benefits from an excellent eye health research and innovation environment, and there are significant opportunities to capitalise on this heritage to advance the way we treat eye health conditions, and ultimately prevent avoidable sight loss.

The time to act is now. The eye health sector is already strongly aligned with the Government's ambitions for reform, and this report demonstrates the sector's capacity to deliver against them. With the right investment, leadership, and collaboration, there is enormous potential to build on these foundations and ensure eye care remains a cornerstone of a modern, person-centred health service.

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Executive Summary

The **Government's 10 Year Health Plan** presents a significant opportunity to improve eye health and care across England, with the potential to reduce avoidable sight loss, enhance patient outcomes and experience, and alleviate pressure on NHS services. With over **1.8 million people currently living with sight loss in England** – and numbers expected to rise – the need for timely, accessible, and integrated eye care has never been greater.

The eye care sector is ready to deliver on the three strategic shifts outlined in the Plan: moving care from hospital to community, from analogue to digital, and from sickness to prevention. **These shifts are already underway across parts of the sector and have demonstrated clear benefits in improving outcomes, streamlining services, and supporting broader productivity gains.** By expanding community-based models, investing in and embracing innovation, and embedding prevention into services, the sector can play a leading role in realising the ambitions of a future-ready NHS.

Summary of Recommendations

Care closer to home through consistent and expanded use of primary eye care, available nationally, for suitable patients: Commission enhanced primary eye care services consistently across all regions, with appropriate ophthalmology specialty oversight and two-way digital connectivity, to shift care into the community and reduce pressure on hospital services.

Scale up cost-effective diagnostic centre models of community eye care, that complement primary eye care services: Increase the use of diagnostic and management centres in community settings, overseen by hospital eye services, to cut waiting times, ease pressure on hospital services and deliver further care in the community.

Impact: Commissioning enhanced primary community eye care services and ophthalmology-led models of community care have demonstrated success in easing pressure on GPs, reducing waiting times, and ensuring faster, fairer access to sight saving treatment and care.

Prioritise early intervention and prevention of sight loss: Improve uptake of regular sight testing and early intervention services, particularly for at-risk groups, and strengthen secondary prevention to reduce avoidable sight loss.

Impact: Improving uptake of regular sight tests and early intervention – especially for those most at risk – helps prevent avoidable sight loss, supports public health goals, and reduces the emotional and financial burden on those affected and wider society.

Enable improved, two-way communication between primary and secondary eye care: Enable universal adoption of NHS.Connect.net and mandate the standardisation of electronic health records (EHRs) to support seamless information sharing and clinical collaboration.

Impact: Standardising electronic health records and adopting NHS. Connect.net will enable seamless, two-way communication between primary and secondary eye care - improving continuity for patients, reducing duplication, and supporting more efficient collaboration using tools already in place.

Deliver personalised, person-centred eye care support: Embed co-created care plans for people with complex needs, integrating clinical and social support, and promote models such as the RNIB eye care support pathway.

Impact: Embedding co-created care plans and support pathways will improve patient outcomes and experience, while strengthening collaboration between health and social care services.

Embed eye health needs assessments in local planning: Require local systems to incorporate eye health data and needs assessments into service design and commissioning decisions to reduce health inequalities.

Impact: Incorporating eye health needs assessments into local planning enables data-driven commissioning, reduces health inequalities, and lays the groundwork for meaningful, long-term improvements in care.

Ensure accessibility of the NHS App: Improve the NHS App's usability for people with sight loss and ensure it functions as an inclusive digital front door to NHS services and ensure access to eye care via digital platforms.

Impact: Improving the NHS App's accessibility ensures it serves as an inclusive digital front door to care, helping to reduce digital exclusion and better support people with sight loss.

Support artificial intelligence (AI) innovation and adoption: Invest in research, guidance, and training to enable safe and effective use of AI in ophthalmology, including predictive analytics and diagnostic tools.

Impact: Investing in AI innovation and adoption in ophthalmology unlocks major future potential to transform early detection of eye disease and other health conditions through advanced diagnostics and predictive tools.

Publish service performance and patient-reported data: Include eye care services in national transparency measures, with routine publication of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) to drive quality improvement and accountability.

Impact: Publishing performance and patient-reported data for eye care services will enhance transparency and accountability, helping to improve both access to and the quality of care.

Establish a dedicated eye care policy team at the Department of Health and Social Care: Ensure prioritisation of eye health through the establishment of a dedicated policy function within new national structures, reflecting all elements of the eye care pathway across primary and secondary care and incorporating clinical expertise with the authority to implement changes.

Impact: Creating a dedicated eye care policy team within the Department of Health and Social Care will ensure sustained focus on eye health, helping the system meet rising demand from an ageing population, with opportunity to align with the ongoing restructure of national leadership.

Introduction

Over **1.8 million people live with sight loss in England**, and with the effects of an ageing population, this number is expected to reach **over 2.2 million by 2032** – bringing significant costs to the NHS and the wider economy.[1]
The impact of poor eye health extends beyond vision alone. Without the right care and support, sight loss can have broad implications on independence, mental and emotional wellbeing, and the ability to participate in daily life.

However, the scale of the challenge is also matched by the opportunity: timely intervention and effective service design can prevent avoidable sight loss, reduce pressure on the NHS, and support broader economic and social wellbeing.

The Government's 10 Year Health Plan sets out a bold vision for reform, centred on delivering care that is more personalised, preventative, and community-based.[2] These ambitions align closely with the priorities of the eye care sector, which has long advocated for transformation in how services are commissioned, delivered, and integrated across primary and secondary care to improve patient experience and outcomes, and ultimately preserve the nation's sight.

This is a pivotal moment for the NHS, and the eye care sector is well positioned to deliver on the Government's vision for the health service over the coming decade. With a strong foundation of clinical expertise, community reach, and a track record of innovation, the sector offers a compelling model for future NHS delivery.

At the same time, the eye care sector is one of significant innovation in both digital and treatment terms, and in the future is due to form a key pillar of predictive, preventative healthcare. **Emerging research in ophthalmic imaging and diagnostics – and the increasing use of artificial intelligence (AI) – is presenting new, non-invasive ways to identify cardiovascular, metabolic, and neurological risks through retinal scans – positioning eye care as a gateway to broader preventative health.**

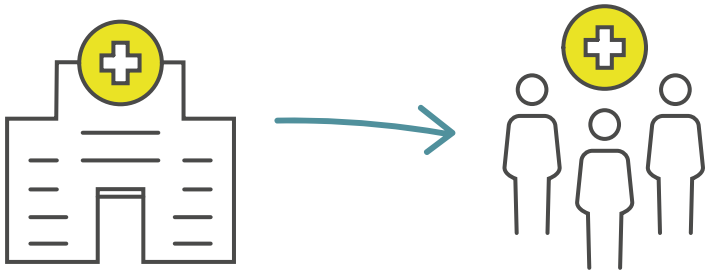
However, to realise this vision, several longstanding challenges must be addressed. There remain significant variation in commissioning practices and outcomes across the NHS, workforce shortages, fragmented data systems, and barriers to integration between services. Without targeted action, these barriers risk undermining progress and widening inequalities in access to eye care.

The Eyes Have It (TEHI) partnership is driven by its purpose to advocate for improvements to patient eye care and outcomes, working to ensure that everyone affected by eye health conditions and sight loss has access to the right care, when and where they need it.

To deliver on this, the following report sets out how the 10 Year Health Plan can be applied across the eye care sector, offering practical recommendations to improve outcomes, reduce avoidable sight loss, and build a more sustainable and equitable system for the future.

Delivering the Three Shifts in Eye Care

From Hospital to Community



With ophthalmology remaining the busiest outpatient specialty in the NHS, shifting care from hospital to community presents a significant opportunity to improve patient outcomes, reduce pressure on hospital eye services, and enhance system efficiency. This has never been more important than now, against the backdrop of the UK's ageing population and the growing numbers of people with risk factors such as obesity and diabetes, which is leading to eye health conditions becoming more prevalent. **With specialist eye care having a waiting list of over 590,000 cases as of August 2025**, it is similarly critical that the full ecosystem of hospital and community care is utilised to address chronic waiting lists for specialist eye care.[3]

A key element of this ecosystem is community-based optometry, with Healthwatch England's recent report emphasising strong public support for greater utilisation of optometry to increase timely access to eye care.[4] Expert high street optometrists and dispensing opticians are already embedded into communities via over **6,000 opticians in England**, and are well-placed – with appropriate training, governance and funding arrangements – to support delivery of care closer to home by being one of the first ports of call for the public when it comes to their eye care.[5]

Enhanced primary eye care service pathways have been shown to be both clinically and cost-effective, and are further evidence that this approach is effective in reducing the chronic backlog of patients waiting for specialist eye care.[6,7]

Recent research commissioned by the Association of Optometrists, Fight for Sight, Primary Eyecare Services and Roche Products Ltd found that through NHS General Ophthalmic Services, optometrists deliver at least **£2.1 billion of benefits for a cost to the NHS of £525 million**. If expanded to include enhanced primary eye care services this research suggests that an additional **£98 million in net direct cost savings could be achieved**, alongside a projected reduction of up to **1.9 million appointments across traditional NHS settings.**[8]

However, variation in commissioning practices remains a key barrier to realising this potential. While enhanced optometry services have been proven to be clinically effective, with high levels of patient satisfaction – and have been recognised within the 10 Year Health Plan itself such as those implemented in Gloucestershire – they are not currently uniformly commissioned across regions.[9,10] As a result, patients are facing avoidable barriers to care, including the expense and time away from work required to attend hospital appointments that could be delivered in the community. Addressing this inconsistency is essential to ensure equitable access and unlock the full potential of community care.

Ophthalmology-led models of community care have similarly been established and have demonstrated success in reducing waiting times for secondary care services. This includes ophthalmology-led diagnostic hubs in the community – for example, based in retail settings – whereby diagnostic tests are undertaken in-person, and results reviewed virtually in a separate setting. These hubs similarly present the opportunity to monitor patients virtually, enabling them to stay at home rather than travel to hospitals; for example, patients with diabetic retinopathy and stable retinal vein occlusions after treatment.[11]

As the Government seeks to implement its 'Neighbourhood Health Service', it is critical to consider the full range of opportunities to improve access and convenience of care for patients, while ensuring sustainable funding for hospital and emergency eye services for people living with serious and complex eye health conditions.

Community settings also offer significant potential for delivering research and innovation. **Embedding clinical research and trials within primary and community eye care services can accelerate the adoption of new technologies, generate real-world evidence, and support the development of more responsive models of care.** This approach can also help ensure that innovation reaches underserved populations and contributes to reducing health inequalities.

Improved utilisation of the full range of community-based eye care services is critical to enabling hospital eye care services to focus on timely treatment for patients with serious and complex conditions. This shift represents a strategic opportunity to build a more efficient, patient-centred system that delivers care in the right setting, at the right time.

Case Study

How optometry can support the eye care needs of older people[12]

Gloucestershire Integrated Care Board (ICB) was one of the first in the country to develop diabetic eye screening, commission out-of-hospital follow-up care for cataracts and one of the first to commission COVID Urgent Eyecare Services.

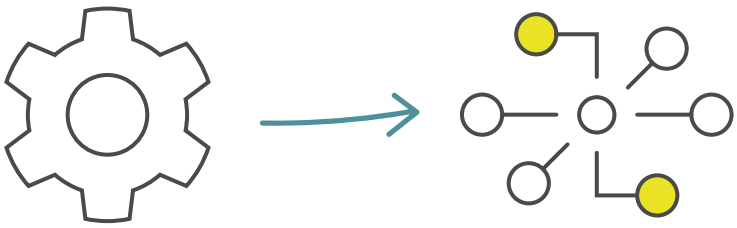
Following funding and central support as part of the NHS England Eyecare Transformation Programme, Gloucestershire ICB has made significant progress in designing and commissioning services that support older people in the area with significant eye care needs. This has included piloting a Low Vision Service for patients who are not in easy reach of the hospital services, and commissioning Eye Care Liaison Officers (ECLOs) to provide urgent provision of spectacles, emotional help, and help with aids and adaptations and fast-tracked onward referral.

The ICB has also supported a 'Community Ophthalmic Link' project enabling eye care collaboration through IT Connectivity – with phase 1 of the programme resulting in a **24% reduction in e-referrals** for Gloucestershire registered GP patients compared to 2022/23, thereby reducing the number of patients placed on NHS waiting lists.

Recommendations

Care closer to home through consistent and expanded use of primary eye care, available nationally, for suitable patients: Commission enhanced primary eye care services consistently across all regions, with appropriate ophthalmology specialty oversight and two-way digital connectivity, to shift care into the community and reduce pressure on hospital services.

From Analogue to Digital



The Government's 10 Year Health Plan puts digital transformation at the core of its vision for change. As it rightly recognises, creating a more digitally enabled and better-connected system has the potential to improve system efficiency, put patients at the centre of their care and free-up much needed capacity in secondary care settings.

Across the eye care sector, digital and technological innovation has a truly transformative potential. This includes everything from creating a more seamless pathway for the patient, to ensuring patients benefit from the application of AI innovations which have shown potential to enable more predictive and personalised models of care.

As a speciality where services are typically delivered across multiple providers – including both high-street optometrists and ophthalmology services – improvements are needed in the way information is shared between teams.

At present, poor interoperability and connectivity across primary and secondary eye care remain persistent challenges. For example, patient eye health data often exists in silos, limiting opportunities for clinicians across disciplines to collaborate and share vital patient information. In turn, this creates unnecessary referrals – either because clinicians cannot collaborate, or in many cases simply because previous history or status that has been captured in one place is inaccessible in another place – and raises the risk of misdiagnoses, referral and treatment errors. These silos prevent new ways of working, contribute to waiting lists, hinder patient care and limit the transformation of eye care services.

The creation of a Single Patient Record (SPR) is a critical step toward resolving these issues and would bring patient information into one place. Alongside this, it is critical that electronic health records (EHRs) are standardised. At present, EHR vendors are not required to align their software with national standards – such as Digital Imaging and Communications in Medicine (DICOM) – which causes inconsistency in the data fields used.

In England alone, NHS trusts use at least **21 different EHR systems**, many of which are unable to share critical information. This, in turn, means information cannot be shared between providers, as it may be incompatible with other systems.[13] To develop and implement these improvements and ensure effective integration, it will be vital that primary care providers, including optometry, receive funding support.

There are also practical steps that the Government can take to make collaboration easier for eye care providers. This includes consistent roll out of NHS e-mail access (via NHS Connect.net) to all primary eye care providers. A recent cost benefit analysis commissioned by the Royal National Institute of Blind People estimated that the NET benefit to the NHS of ensuring all primary care providers have an NHS e-mail address could equal over **£19 million per year**. This includes benefits from reductions in duplicated testing and saved GP time.[14]

As the Government similarly seeks to deliver on its commitment to an expanded NHS App to act as the 'front door' to the health service, it is vital that accessibility is recognised and embedded as a foundational design principle. Ensuring that people with visual impairments and other access needs can fully engage with these platforms is critical for equity and usability.

While we welcome the ambition to transition appropriate services from analogue to digital, it is equally important to recognise that digital transformation must not come at the expense of accessibility or inclusion. In eye health particularly, maintaining high-quality non-digital pathways remains vital for individuals who cannot access or engage through the NHS App or other digital services. Without this, there is a risk of exacerbating digital exclusion and widening existing health inequalities.

Case Study

How improved connectivity can support greater efficiency, and improve outcomes[15]

Since July 2024, Bristol Eye Hospital has been piloting an Enhanced Macular Referral Service designed to streamline the process for routine macular referrals and reduce unnecessary GP involvement and hospital visits. Developed in collaboration with the Avon Local Optical Committee, the Integrated Care Board (ICB) and NHS England, the pathway uses bespoke software that enables community optometrists to send full clinical details, DICOM Optical Coherence Tomography (OCT) scans, and summary care records directly to the hospital's retinal team for remote assessment. This innovative approach by-passes the need for GP referrals and significantly improves the patient journey.

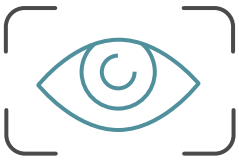
The pilot has delivered notable improvements in clinical efficiency, patient experience, and environmental impact. **Over 74% of patients have avoided unnecessary hospital visits, and urgent cases, such as suspected wet age-related macular degeneration (wAMD) are now triaged virtually, with confirmed cases booked into treatment clinics within a week.**

Recommendations

Enable improved, two-way communication between primary and secondary eye care: Enable universal adoption of NHS.Connect.net and mandate the standardisation of electronic health records (EHRs) to support seamless information sharing and clinical collaboration.

Ensure accessibility of the NHS App: Improve the NHS App's usability for people with sight loss and ensure it functions as an inclusive digital front door to NHS services and ensure access to eye care via digital platforms.

The future of AI in eye care



Looking to the future, AI presents one of the most significant opportunities for long-term transformation in eye care. **Ophthalmology is widely recognised as a specialty where AI is already having a tangible impact and where its future potential is especially promising.**[16] From automating administrative functions such as appointment scheduling, waiting list management, patient communications and staff rotas, to enhancing diagnostic and screening capabilities, AI is actively reshaping service delivery across the eye care pathway.

Several AI tools are already in use across ophthalmology and are continuing to demonstrate their impact.[17] Studies have shown AI algorithms demonstrating diagnostic accuracy comparable to human experts in detecting conditions like diabetic retinopathy, enabling faster and more consistent identification of disease. This has the potential to free up time and clinical capacity for more complex cases, and creates opportunity to bring down ever growing waiting lists.[18]

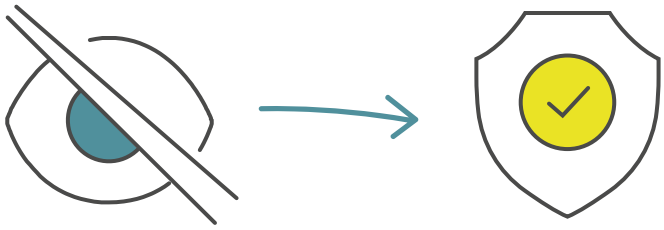
In parallel, the emerging field of **'oculomics'** (the study of the eye as a window to overall health) is leveraging AI to analyse retinal scans and uncover unique disease "fingerprints" linked to cardiovascular and neurodegenerative conditions, positioning ophthalmology as a gateway to broader preventative healthcare.

However, **it is vital that the adoption of AI continues to be underpinned by robust guidance, comprehensive training**, and **clear regulatory frameworks**. Ensuring that clinicians are equipped to use AI safely and effectively and that systems are designed with transparency, accountability, and accessibility in mind will be critical to embedding AI in a way that enhances care and reduces inequalities.

Recommendations

Support artificial intelligence (AI) innovation and adoption: Invest in research, guidance, and training to enable safe and effective use of AI in ophthalmology, including predictive analytics and diagnostic tools.

From Sickness to Prevention



The shift to prevention is one that is strongly aligned with the priorities of the eye care sector, where preventative interventions have the potential to deliver substantial benefits to the public, the NHS, and the wider economy.

Routine sight testing, alongside timely intervention and treatment, represents one of the most effective preventative tools. **Early detection of common eye conditions – such as glaucoma, cataracts and age-related macular degeneration – can delay or halt disease progression, thereby reducing the need for more intensive interventions and prevent avoidable sight loss.**

As well as an eye health check, a sight test has the potential to detect signs of underlying general health conditions, such as diabetes, high cholesterol and high blood pressure, enabling timely referral and intervention across care pathways. Embedding routine sight testing firmly within NHS prevention strategies and population health planning should, therefore, be a priority in the delivery of the Plan's vision for proactive and community-based care, supported by timely referrals where necessary to enable early treatment.

Despite their benefits, **survey data suggests that an estimated 19 million Britons do not attend their regular eye test** – based on a sample of 2,000 UK adults in which 36% said they had not had an eye test in the last two years.[19] Evidence also demonstrates that rates of sight loss are higher in more deprived areas of England, due to a number of reasons, including lifestyle factors and reduced engagement with and access to eye care services. For example, in a survey of 2,000 UK adults, 55% of respondents living in households with an annual income of less than £10,000 had not had an eye test in the last two years, compared to one third (33%) of those living in households with an annual income of more than £90,000.[19]

The inclusion of eye health needs assessments within local population health management planning would help ensure services are designed around local needs and that preventative interventions reach those populations most likely to benefit.

Secondary prevention – this is, facilitating intervention and treatment to reduce the progression of a condition – plays a crucial role in reducing the burden of sight loss. **For patients already diagnosed with eye conditions, timely intervention – whether through treatment, ongoing monitoring, or referral – can significantly improve patient outcomes.** Strengthening referral pathways between primary and secondary care pathways, supported by integration through the development of the Single Patient Record, will be central to delivering on
this ambition.

A stronger focus on prevention within eye health has the potential to deliver benefits that extend far beyond the health system. **Preventable sight loss has been associated with loss of independence, poorer mental health and reduced workforce participation – factors that drive higher social care costs and affect overall quality of life.**

Against the backdrop of an ageing population and the growing numbers of people with risk factors such as obesity and diabetes, the burden of eye disease will continue to rise. This makes the case for embedding preventative approaches more urgent than ever. **Ensuring greater awareness and uptake of regular sight testing, alongside equitable access to these services in the communities where they are needed most, will be essential to protecting the vision of the population.**

Recommendations

Prioritise early intervention and prevention of sight loss: Improve uptake of regular sight testing and early intervention services, particularly for at-risk groups, and strengthen secondary prevention to reduce avoidable sight loss.

Embed eye health needs assessments in local planning: Require local systems to incorporate eye health data and needs assessments into service design and commissioning decisions to reduce health inequalities.

Personalised, Person-Centred Eye Care

TEHI welcome the Government's emphasis on improving patient experience and delivering care that is personalised and centred around individual needs. Within the eye care sector, this ambition aligns with ongoing efforts to ensure that services are not only clinically effective but also responsive to the lived experiences of people with eye conditions and sight loss.

This is critically important for people living with sight loss, where impact is felt across a broad range of areas. Research by Fight for Sight for example revealed that **76% of people living with sight loss or visual impairment said they felt lonely some or all of the time** compared to **25% of the general population, and 44% scored an 8 or 9 on the loneliness scale.**[20]

The 10 Year Health Plan sets out a commitment that **by 2027, 95% of people** with complex needs **will have a care plan co-created with patients, addressing holistic needs beyond clinical treatment.**[21] For people living with sight loss, this represents a critical opportunity to embed support that reflects both clinical and social dimensions of care, and to ensure that care planning is inclusive of rehabilitation, emotional wellbeing, and practical support.

The Royal National Institute of Blind People's eye care support pathway offers a best practice example of how this can be achieved.[22] **The pathway identifies people's needs at four key stages of their eye care journey – from initial diagnosis to living well with sight loss – and integrates emotional, psychological, and practical support during and after diagnosis into the patient pathway alongside clinical care.** This includes providing tailored support such as emotional counselling, vision rehabilitation, and access to assistive technologies. This model demonstrates the value of coordinated, person-centred approaches that extend beyond the clinical setting and respond to the broader challenges faced by patients.

Delivering personalised care for people living with sight loss will require collaboration across multi-disciplinary teams and sectors, ensuring that care plans are meaningful, inclusive, and accessible. It will similarly require close consideration as part of local system planning, with eye health and care needs assessments embedded into these processes.

Recommendations

Deliver personalised, person-centred eye care support: Embed co-created care plans for people with complex needs, integrating clinical and social support, and promote models such as the RNIB eye care support pathway.

Enabling Delivery

Workforce Fit for the Future

A strong and sustainable ophthalmology workforce is essential to delivering the transformation and innovation ambitions set out in the Government's 10 Year Health Plan.[23] As the busiest outpatient specialty in the NHS, ophthalmology faces growing demand driven by an ageing population and increasing prevalence of chronic eye conditions.[24] Future-proofing the workforce is, therefore, critical to ensuring timely access to care and maintaining high standards of service delivery.

TEHI partnership welcomes the Government's commitment to create **1,000 additional specialty training places and urges that ophthalmology be prioritised within this expansion and that the sector is consulted as part of the 10 Year Workforce Plan.** To realise the full benefit of this investment, it will be important to ensure that sufficient infrastructure, supervision capacity, and resources are in place to support the training of new ophthalmologists.

In addition, the development of streamlined career pathways for Specialty and Associate Specialist (SAS) doctors must include locally employed doctors with more than two years' experience. These professionals represent a valuable and experienced segment of the workforce and should be supported to progress within the system.

Insights from The Royal College of Ophthalmologists' latest workforce census reinforce the urgency of action. The data highlight persistent workforce shortages, regional variation in staffing levels that impact on waiting lists and the backlog, and the need for targeted investment to address capacity gaps.[25]

Delivering the transformation set out in the 10 Year Health Plan will require not only a well-resourced ophthalmology workforce, but also one that is empowered to lead innovation. This means adopting new models of care that help relieve pressure on hospital eye services. For example, community-based ophthalmology-led diagnostic hubs have proven effective in increasing hospital capacity and reducing patient waiting times. By coordinating diagnostic tests in the community and reviewing results remotely, these hubs minimise the need for patients to travel to hospital settings and support efficient review of results for specialist clinicians.

Case Study

Asynchronous review and innovative ways of delivering care in the community[26]

An increasing number of patients with chronic eye conditions – such as glaucoma, age-related macular degeneration (AMD), and diabetic retinopathy – are benefiting from ophthalmology-led community diagnostic centres. These centres bring care closer to patients by operating in accessible community locations, such as shopping centres, and by adopting innovative asynchronous review models. In this approach, patients attend in-person diagnostic tests carried out by trained ophthalmic technicians, while specialist clinicians review the results remotely at a later stage, ensuring timely and efficient clinical oversight.

A leading example of this model is the Moorfields Eye Hospital pilot at Brent Cross shopping centre in north London. Initially focused on stable glaucoma, AMD, and diabetic retinopathy, the service later expanded to include epiretinal membranes, vein occlusions, keratoconus, and cataracts. Newly recruited and trained ophthalmic technicians performed the diagnostic assessments, with scans then uploaded to the hospital network's secure online system and later reviewed remotely by specialist clinicians, who decided on appropriate next steps for the patient.

The outcomes have been highly positive. The Brent Cross diagnostic centre increased capacity across the hospital network, delivering **38,500 additional appointments per year** and achieving an **8.1-day weekly reduction in waiting lists**. As these centres are fully integrated with hospital eye services, patient records are shared seamlessly across systems – reducing duplication, preventing unnecessary visits, and supporting continuity of care.[27]

Clinical time must be carved out within workforce planning to support research, service redesign, and the adoption of new technologies. Without protected time and structured support to enable the adoption of innovation, the sector risks missing opportunities to improve care pathways, integrate digital tools and new treatments, and accelerate progress towards a more preventative and personalised model of eye care.

Embedding innovation into clinical roles will be essential in delivering the three shifts and ensuring that change is driven from within the system.

This would support the UK's position as a leading research destination, and, coupled with investment in early career researchers and clinical research networks, would continue to build the UK's long-term capacity and leadership.

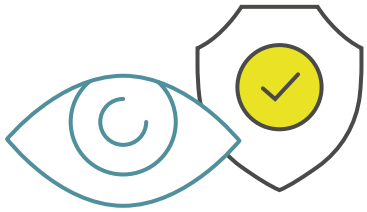
It is critical that ophthalmology is recognised as a strategic priority in workforce planning and that the necessary enablers are in place to support training, retention, and progression across the sector.

Recommendations

Scale up cost-effective diagnostic centre models of community eye care, that complement primary eye care services: Increase the use of diagnostic and management centres in community settings, overseen by hospital eye services, to cut waiting times, ease pressure on hospital services and deliver further care in the community.

Prioritise ophthalmology as part of specialty training expansion: Ensure ophthalmology is recognised as a priority specialty within the 1,000 additional training places, supported by adequate infrastructure and trainer capacity.

Transparency and Quality of Care



Improving transparency and quality of care is central to delivering a more accountable, patient-centred eye care system. **The 10 Year Health Plan set out welcome commitments to system-wide transparency and the prioritisation of patient experience as a core measure of success.** To achieve this, it is critical that eye care service data is included in national assessments of provider performance to enable accurate monitoring of service provision and to inform, where necessary, interventions that can improve outcomes and experience.

Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) provide a **significant opportunity to capture the lived experience and outcomes of those accessing eye care services, and should be utilised to a greater extent across the system**, particularly in the eye care sector. To achieve system-wide consistency and meaningful comparison, central guidance and support are needed to select and adopt appropriate PROMs/PREMs, including which tools to use, how to integrate them into workflows, and how to act on the findings.

The Royal College of Ophthalmologists' National Ophthalmology Database Audit also provides a blueprint for how real-world data can be utilised to improve service quality and safety, reduce unwarranted variation and make savings for the NHS by reducing risks and supporting continued professional learning. However, not all units submit their data and broader adoption of such databases offers a significant opportunity to drive improvements in patient care, benchmark standards, and support continuous quality improvement.[28]

It is also important to recognise that for some eye health conditions, delays in treatment can lead to rapid deterioration. For example, National Institute for Health and Care Excellence's (NICE) Quality Standards for age-related macular degeneration (AMD) recommend treatment within 14 days of referral.[29] This highlights the need for more granular data to monitor whether patients at higher risk of sight loss are being seen within the clinically appropriate timeframes.

Currently, NHS England's Referral-to-Treatment (RTT) data publication lacks the detail needed to track these patients effectively. It only monitors newly-referred patients awaiting treatment, omitting those who have already been seen and are waiting for follow-up care. Analysis from think tank Re:State (formerly Reform) found ophthalmology has the highest average number of patients waiting for follow-up appointments per NHS Trust, with consistently high backlogs since 2019.[30] Publication of this information would have benefits across all specialties within the NHS but is particularly urgent within ophthalmology given the risk of permanent harm from avoidable sight loss is nine times more likely in follow-up patients than in new patients.[31]

To address this issue, specific eye care measures were introduced by NHS Wales in 2019 to provide a 'maximum waiting time' framework for new and follow-up patients, based on the urgency of care required, and are reported in addition to the existing RTT waiting times. These measures have been developed for patients referred for an ophthalmology appointment, with corresponding waiting times based on a clinical assessment of their condition and well-being. Patients who require regular ongoing review or treatment will be seen within 'clinically indicated intervals', which are also based on their condition and well-being.[32]

Monitoring and publication of this data would offer the potential to more accurately prioritise the ophthalmology waiting list, and by extension, reduce the prevalence of avoidable sight loss in England.

Together, these measures will help embed transparency, accountability, and patient voice into the fabric of eye care delivery – ensuring that services are not only clinically effective but also responsive to the needs and experiences of those they serve.

Recommendations

Publish service performance and patient-reported data: Include eye care services in national transparency measures, with routine publication of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) to drive quality improvement and accountability.

Establish a dedicated eye care policy team at the Department of Health and Social Care: Ensure prioritisation of eye health through the establishment of a dedicated policy function within new national structures, reflecting all elements of the eye care pathway across primary and secondary care and incorporating clinical expertise with the authority to implement changes.

Glossary and Definitions

- AI – Artificial Intelligence
- AMD – Age Related Macular Degeneration
- DICOM – Digital Imaging and Communications in Medicine (the international standard to transmit, store, retrieve, print, process, and display medical imaging information)
- ECLO – Eye Care Liaison Officer
- EHRs – Electronic Health Record
- ICB – Integrated Care Board
- NICE – National Institute for Health and Care Excellence
- OCT – Optical Coherence Tomography (a non-invasive eye scan that uses light waves to take high-resolution, cross-sectional images of the retina and other eye structures)
- Oculomics – The study of the eye as a window to overall health
- PREM – Patient Reported Experience Measure
- PROM – Patient Reported Outcome Measure
- RTT – Referral to Treatment
- SAS – Specialty, Associate Specialist and Specialist doctors (includes specialty doctors and specialist grade doctors with at least four years of postgraduate training, two of which are in a relevant specialty)
- SPR – Single Patient Record
- wAMD – Wet Age Related Macular Degeneration

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