Submit an organisational response

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FODO – The Association for Eyecare Providers

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

Previous NHS plans overlooked structural issues and system failures in the hospital eye service. As a result, patients have continued to suffer avoidable sight loss due to delays in hospital eye services.

The NHS now needs to urgently address its unsafe and unsustainable dependence on the hospital eye service if it is to tackle the root cause of system failures and meet growing need in a sustainable and safe way.

To achieve this, the NHS must re-balance investment by meeting more patient needs closer to home through primary eye care. This will make best use of the regulated eye care workforce, advanced diagnostics and infrastructure across England; and most importantly help prevent avoidable harm.

The 10 Year Health Plan should therefore clearly set out how the NHS will address the crisis in the hospital eye service by delivering the government's three big shifts:

- **Hospital to community** – improve access to NHS funded enhanced primary eye care services for all, allowing hospitals to focus on the most serious illnesses and emergencies
- **Sickness to prevention** – help preserve sight and keep people independent for longer, with all the benefits that this brings to individuals, the NHS and economy through greater productivity and by reducing costs associated with avoidable sight loss
- **Analogue to digital** – invest in safe frictionless connectivity between primary eye care and hospitals, reducing the need for patients to visit hospital and avoiding the need for repeat diagnostic tests.

To deliver the Government's three big shifts, the focus needs to be on fixing primary eye care - only by investing in primary eye care will the Government find solutions to the problems in secondary care. Therefore, the 10 Year Health Plan must commit to transforming hospital eye services by investing in sustainable NHS primary eye care services outside of hospital, on the strong foundation provided by the national sight-testing service. The three key priorities for primary eye care are:

1. **Restore the NHS sight testing service** – to protect NHS primary eye care infrastructure for the benefit of patients, work with the sector to agree a sustainable plan towards fee restoration. Following 15 years of real terms cuts to NHS primary eye care, work together so that NHS eye care providers are funded fairly for the clinical work they do.

2. **Prevent avoidable sight loss –** work with primary eye care to achieve national coverage of enhanced community eye care for all based on clinical need, delivered to national specifications. Making optimal use of the workforce, diagnostic capacity and infrastructure already in place in primary eye care settings across England.
3. **Digital innovation** – work with eye care providers to maximise the use of technology to treat and retain more patients in primary eye care, streamline referrals and hospital access and meet growing patient needs in a sustainable way.

We set out evidence to support the case for change in response to shift 1: hospital to community, as this is the planning shift on which everything else (including prevention) depends.

We would be pleased to answer any questions about our submission, facilitate a meeting with eye care providers and to supplement our response with further evidence if this would be helpful. Please email healthpolicy@fodo.com

Background information – see
https://www.fodo.com/downloads/managed/Information_1.pdf

About us

FODO is the leading national association for eye care providers working in primary and community care settings. Our members provide more than 80% of all NHS primary eye care services each year. Our members include the full range of large and small employers who are the main workforce and infrastructure investors in NHS primary eye care.

Shift 1: Hospital to Community

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

We agree with the King's Fund analysis that the NHS in England has experienced 30 years of policy and implementation failure in moving care closer to home. We also agree with its analysis that to address this, the NHS must shift its focus to primary and community health "across the domains of leadership, culture, and implementation" [1]. We also agree with Lord Ara Darzi's insightful independent investigation of the NHS in England, which reached the same conclusions. In our view

Challenges

- The biggest challenge in shifting care out of hospital has been the NHS commissioning system's misplaced focus on hospital care. Successive NHS England plans and local commissioners have overlooked services with the biggest opportunities, like eye care, and as a result, the NHS hospital eye service has become overwhelmed and unsafe with people suffering sight loss due to delays in care.
- Where commissioners have tried to affect a shift from hospital to community, this has been on a piecemeal, local and non-strategic basis with multiple variants of local contracts and pathways and often short-term funding.
- The NHS too often prioritises the hospital model of care rather than services designed around patient needs and preferences. As a result, the NHS internal market has driven hospital growth even when those patients could be treated equally well elsewhere.

Discussions we have had with NHS Trust CFOs show that they also agree that hospitals are not the best place for all this care and change is needed, but they do not have the capacity make change happen.
- There have been cases of professional protectionism in hospitals (often expressed as non-evidence-based concerns about quality or loss of medical control in the community) and a strong system bias to an outdated and unsustainable outpatients model of hospital care which depends on large numbers of repeat appointments.
- Eye care conditions have traditionally been given low priority in NHS thinking as they are not immediately life-threatening (despite falls and their associated health risks) and mainly affect the population in older age.

Enablers

- The biggest enabler is the existing infrastructure provided by primary eye care (over 5000 community-based facilities, the workforce and advanced diagnostics) to deliver outpatient services out of hospitals in a sustainable way. Evidence shows the shift from secondary to primary eye care can work. (See evidence below).
- The second enabler is central leadership - to date, the missing piece of the jigsaw has been the lack of political leadership to make change happen. We have seen time and time again that only via a central approach has it been possible to reduce the level of unwarranted variation in NHS care - e.g. most recently via a national mandate to rollout direct referral from primary eye care to the hospital eye service. There have been attempts to effect change over the past decade, but overly hospital based clinical leadership combined with perpetual reorganisations and disorganisation within NHS England means they have failed to deliver on the big issues.
- To finally deliver "hospital to community", the NHS needs to follow the evidence to transform NHS eye care for all. Given the low priority afforded to primary eye care services in recent decades, and little evidence this will change if left to ICBs, place or locality decision-making, a central approach is needed to rigorously challenge solutions which are mainly hospital-led triage systems and shift care closer to home once and for all.

The evidence to support the case for change is set out in the section below. This is followed by a list of services that could be prioritised to help shift care from hospitals to community.

Evidence to support the case for change

Transforming eye care must be a priority in the NHS 10 Year Health Plan. This is because ophthalmology (the hospital eye service) is the busiest NHS outpatient speciality in England, with more than 8.8 million attendances in 2023-24, accounting for 8.5% of all outpatient attendances [2]. Fixing eye care will therefore go a long way towards making shift 1 a reality. This can only happen through investment in primary eye care.

For example, 79% of patients attending ophthalmology are 50 and older [3]. This is driven by the fact that the most common eye conditions are age-related cataract, glaucoma and macular degeneration. As a result of our ageing population, demand for each of these services is expected to grow significantly by 2037 – e.g. demand for cataract operations alone will increase by 50% between 2017-2037 [4]. Many of these patients can in fact have their ongoing needs met out of hospital.

The hospital eye service has also struggled for many years to meet needs safely and at a significant cost to individuals, the NHS and care system and economy. Without action things will get worse and more unsafe. For example, as far back as 2009 the National Patient Safety Agency reported that patients with glaucoma had suffered vision loss due to delays in hospital care [5]. In 2017 researchers concluded that people continued to suffer vision loss because of delays in care due to a lack of capacity in the hospital eye service [6]. In 2019, the NHS GIRFT team raised concerns that people continued to suffer harm due to delays and medical malpractice insurance costs had increased [7]. In 2020, before the pandemic, the Healthcare Safety Investigation Branch again found that people with glaucoma were suffering harm due and irreversible sight loss due to delays in care [8].

Despite this repeated evidence of avoidable harm, the NHS hospital eye care service has failed to transform and meet needs safely. As a result, it is now estimated that more than 20 people a month continue to suffer avoidable sight loss due to delays in hospital care [9] and that clinical negligence claims caused by delays in hospital eye care are rising [10].

While each case of avoidable sight loss due to delays in NHS hospital care is a tragedy, it also imposes a significant cost on individuals and economy, with Deloitte estimating that the annual cost of somebody living with sight loss is £16,800 and that delays in eye care might cost an additional £50.4 million annually compared to pre-Covid [11].

In addition, research by the Royal College of Ophthalmologists shows that over 76% of ophthalmology departments do not have enough consultants to meet current patient demand and lack physical capacity to meet patient needs, and that many ophthalmologists report growing concerns about how long patients are having to wait for care – especially "due to backlogs in glaucoma and medical retina sub-specialties largely focused on follow-up patients" [12].

Clearly without transforming eye care services, more patients will go blind due to delays in the hospital eye service with massive impacts on patients, their families and economy.

The good news is that this can be readily resolved. The 8.8 million hospital attendances are in the main driven by an ageing population who currently need to attend hospitals multiple times for monitoring and repeat tests. For example, just 3.2 million patients account for these 8.8 million attendances [13] and of these 2.6 million attendances are for eye care scans, many of which could be delivered closer to home [14].

In addition, while hospitals do not have the infrastructure or staff to meet needs safely, primary eye care has the largest regulated eye care workforce and access to advanced diagnostic equipment close to where people live [15]. This highly skilled workforce can therefore care for a wide range of clinical needs within their core competencies (see https://www.fodo.com/downloads/managed/Competencies-Table_2.pdf)

We do not need any pilot to make the case for change. We know from the NHS in Scotland which transformed primary eye care services in 2006/7 that it has been possible to reduce pressure on the hospital eye service, with Public Health Scotland stating that "Community optometry is now established as the first port of call for patients with eye problems, reducing pressures on GPs and the HES and the need for patients to travel to hospital to access eye care"[16].

Our own analysis has also shown that between 2013 and 2023, ophthalmology activity in Scotland reduced by 12% compared to an increase in England of 18%, controlling for changes in population size, recorded demand for ophthalmology services in Scotland reduced by 14% compared to an increase of 11% in England [17]. Given both populations have similar eye care needs, the main difference between both countries is that Scotland invests more in primary eye care and patients can access more care closer to home.

Other advantages of improving access to a wider range of NHS primary eye care services will include:

1. A potential 20% reduction in first outpatient appointments for cataracts and up to 85% of all cataract surgery follow up, more than a 30% reduction in first outpatient appointments for glaucoma care and a significant reduction in follow-up glaucoma care and a 30% reduction in medical retina visits [18]
2. Reducing pressure on GPs. For example, it is estimated that 1.5-2% of GP appointments are eye related [19]. Commissioning enhanced primary eye care services will result in more people seeing their optometrist rather than their GP when they have an eye problem
3. Reducing pressure on A&E departments. For example, it is estimated that c 3.2% of Accident and Emergency diagnoses are ophthalmology related [20]. National access to Community Minor and Urgent Eye Care Service (CUES), will help reduce pressure on A&E, GPs and hospital eye departments [21].

Despite the urgent need for action and shifting more eyecare out of hospital being strongly supported by professional bodies and Wes Streeting [22], progress remains agonisingly slow for patients, many of whom are still losing their sight unnecessarily. Hence the need to prioritise change from the centre.

Priorities for reform

Primary eye care teams, using advanced technology, are ideally placed to be the eye care ‘front door’, providing the right care in the right place at the right time. They can offer new solutions to the prevention of sight loss, hospital avoidance, and care delivery in all communities, including for patients unable to leave home unaided. This is best achieved by ensuring everybody in England has access to the following enhanced NHS primary eye care services based on clinical need:

1. Community Minor and Urgent Eye Care Service (CUES)
2. Referral refinement services – including access to advanced diagnostics
3. Cataract – pre/post operative support pathway
4. Glaucoma care – including referral filtering and a monitoring service for patients diagnosed with glaucoma
5. Medical retina care – including referral filtering and a monitoring service for patients diagnosed with retinal disease

Doing so will provide these four benefits:

1. Significant reductions in demand for hospital ophthalmology and associated savings;
2. Patients on hospital waiting lists are seen sooner;

3. Ophthalmology sees only those who genuinely need consultant-led care;

4. An end to avoidable sight loss due to delays in care.

Reference list accessible here –
https://www.fodo.com/downloads/managed/Evidence_1.pdf

Shift 2: Analogue to Digital

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

As we set out in our response to Shift 1 above, the hospital eye service is unsafe and unsustainable.

While it is widely recognised that ophthalmology (hospital eye service) is the busiest NHS outpatient speciality in England, it is less well understood that a large proportion of this activity does not have to take place in secondary care. Much more care can be delivered closer to home in primary eye care (opticians' practices). For example, many eye care scans that currently take place in secondary care could be undertaken in primary eye care and sent electronically to the hospital eye services provided there was a suitable digital solution funded in a sustainable way.

Primary eye care already has advanced diagnostics and is digital, so this is not the barrier to much needed change in England. The issue is that fragmented, costly and complex NHS IT systems create barriers to making the most of all that primary eye care has to offer. If the NHS can help get IT connectivity right, then this will help:

- Reduce referrals to secondary care;
- Reduce the need and cost associated with repeat diagnostic tests;
- Streamline and improve the quality and experience of care for patients;
- Save the NHS money.

That is why we have long supported safe frictionless interconnectivity between primary and secondary eye care (and ideally GPs). This needs to be co-produced with the major IT suppliers and avoid resource-wasting double entry by using co-produced application programming interfaces (APIs) to support interconnectivity.

The other barrier is that too often NHS IT projects are rushed, imposing massive and unfunded costs on primary care providers, and in the end deliver suboptimal outcomes. NHS X's e-ERS programme in eye care was a case in point with the unit being abandoned before the programme had even started wasting the better part of £20m NHS funds without counting the significant on costs for practices. Worse still, this was an entirely preventable waste as primary eye care warned NHS colleagues about the risk but were ignored and "end of year spending" rushed through.

To deliver transformational change the NHS therefore needs to collaborate with primary eye care providers on a partnership basis and agree pragmatic and sustainable funding to help achieve the government's three big shifts.

The primary eye care sector has been at the forefront of digitalisation of systems, records, and retinal imaging, for some time. Throughout the Covid pandemic, most optical practices were able to stay open with a committed clinical and support workforce, effective infection and prevention control (IPC) and personal protective equipment (PPE) when hospital departments closed doors to anything other than urgent and emergency care. As a result, we learned to manage a far wider range of care in new ways including in digital ways and remote consultations for those isolating and unable to leave home. This has put primary eye care in a very strong position to help the wider NHS modernise and digitalise.

As FODO members deliver the majority of NHS funded primary eye care, we, along with sector partners, stand ready to support the NHS with this work.

Shift 3: Sickness to Prevention

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

A major barrier here is that the NHS has failed to prioritise preventative services, with local commissioners often more focused on in year budget control rather than lasting economic efficiency and health benefits. For example, despite hospital eye services being under pressure and people going blind while they wait for care, many NHS regions have failed to commission enhanced primary eye care services, despite NICE guidelines and other evidence supporting it for many years (see evidence provided in answer to shift 1: hospital to community).

Both the government's instruction to NHS England and NHS England's planning guidance for ICBs must reprioritise growth spending to reduce the curve of accelerating spending on avoidable illness and invest in prevention to reduce long-term expediture instead.

Providing more eye care out of hospital and closer to home must be a key priority if the NHS is serious about shifting from sickness to prevention. In doing so expediture must be re-balanced, with greater share of NHS funding going to all of primary care, not just GPs. While general medical practice rebuilds and recovers, in eye care at least, primary eye care can expand services to identify, monitor and treat eye care patients earlier to reduce risk as well as participating in wider local health promotion schemes such as blood pressure and well-being monitoring.

Ideas for change, Please use this box to share specific policy ideas for change.

The main change the NHS must make to deliver the government's three shifts is to establish more professional and evidence-based relationships with the primary care sector (including primary eye care, dentistry, pharmacy and audiology) and the organisations within that sector who can make change happen. For too long primary care has been neglected and underinvested in, with hospital waiting lists and services taking priority over all else.

Without rebalancing investment, it will not be possible to fix the NHS front door, and therefore there will be no way of reducing pressure on hospitals, with all the consequences that brings for individuals, the NHS, social care and wider economy.

In eye care, we would ask the government to focus on the following priorities:

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

1. Ensure NHS Community Minor and Urgent Eye Care Service (CUES) is available in every location for all who need it.
2. Ensure all primary eye care practices can offer referral refinement based on clinical need to reduce false positive referrals.
3. Start national rollout of enhanced primary eye care services for glaucoma care.

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

1. Work collaboratively to restore NHS sight testing fees, so provider costs are fairly covered, and primary eye care services remain sustainable.
2. Sustainability funded safe and frictionless IT connectivity between primary eye care, secondary care and GPs to maximise benefits of integrated care.
3. Secure nationwide-wide access to glaucoma and medical retina care, out of hospital and closer to home for all patients who meet agreed clinical criteria.
4. End avoidable sight loss due to delays in hospital care by year 5.

End