RCOphth response to 10 Year Workforce Plan

Section 1: the 3 shifts

The NHS must change. Our 10 Year Health Plan makes clear our ambition to move from a centralised system to one where patients have greater control over their care, and frontline staff are empowered to shape and improve services. We know that those working closest to patients understand best how local services can be delivered.

We want to hear from organisations, clinicians, staff groups and partners who are already driving change at a local level.

We are seeking evidence on how the 3 shifts are being implemented locally, and the impact on your workforce. Where possible, please support your submission with data and measurable outcomes, so we can learn from what is working well and apply those lessons across the NHS.

In this section, please submit evidence of:

- where you have delivered or observed new digital initiatives that improved patient care
- where you have already seen or begun to deliver a shift from hospital-based care to community care
- where you have already seen or begun to deliver preventative care services
- which professions, roles and skills were critical to successful implementation for each example
- any barriers to ensuring the right professions, roles and skills were involved, and how you overcame these barriers

Implementing the hospital to community shift

Ophthalmology is the largest outpatient specialty in the NHS, with 9.7 million appointments in 2024/25, a 9% annual increase. This scale and rate of growth demand urgent attention to ensure access and patient safety. The Royal College of Ophthalmologists (RCOphth) has identified three existing scalable models for shifting appropriate pathways from hospital to community settings, under consultant ophthalmologist oversight and underpinned by a single point of access (SPoA) model and adequate resources.

These are:

1. **Diagnostic centres in the community** – Diagnostic centres enable tests to be undertaken in community settings, typically by trained technicians, with ophthalmologist review of the results then taking place virtually.

A significant portion of patients with chronic conditions, such as glaucoma and age-

related macular degeneration (AMD), are particularly well-suited to diagnostic centres in community settings. This approach has delivered significant gains, including:

- Moorfields Eye Hospital's diagnostic centre in Brent Cross shopping centre created an additional 38,500 appointments per year and an immediate reduction in the waiting list of 8.1 days per week.

- NHS Nightingale Hospital Exeter's virtual glaucoma and medical retina pathways, reduced the glaucoma waiting list from 807 patients in 2023 to 55 in 2024, cutting average waiting times from nine months to under six weeks.

  Integration with the hospital eye service (HES) ensures continuity of care and minimises the risk of duplication. Diagnostic centres also provide an ideal foundation for the safe introduction of AI-enabled image analysis and virtual triage. There is also potential to integrate diabetic eye screening programmes into diagnostic centres, which could help reduce did not attends.

2. **Enhanced optometry services** - Primary care optometry services have a crucial role to play in managing low and suitable medium-risk patients and preventing unnecessary referrals into ophthalmology service. This is dependent on having two-way digital connectivity and image sharing with the HES, robust governance and commissioning arrangements, appropriate funding, and clear routes for professional development and upskilling.

   In Gloucestershire*, the Community Ophthalmic Link Project enables optometrists to access hospital imaging and clinic letters in real time. It is estimated this has prevented 2,5000 unnecessary referrals.*

3. **Surgical hubs -** Surgical hubs in ophthalmology are dedicated facilities that deliver planned procedures efficiently and at high volume. They can be located in a range of settings, separate from the main HES, such as standalone high-volume low-complexity units and modular units with mobile theatres.

   One of the major benefits is expanded surgical capacity. At Sussex Eye Hospital, cataract services were redesigned by stratifying patients, converting clinical rooms into theatres, and introducing nurse-led pre-operative clinics. This freed up 19 additional theatre sessions each week and is forecast to save £1.37 million, while reducing the cataract backlog. At a smaller scale, Cardiff and Vale deployed modular units and mobile laminar flow theatres to rapidly increase capacity, from 138 each month to more than 400. In this model, there is no need for patients to visit the main hospital building.

Expansion of these models depends on the wider ophthalmic workforce: technicians, nurses, orthoptists, and optometrists performing enhanced roles supported by the *Ophthalmic Practitioner Training Programme*. For example, technicians have a crucial role to play in operating diagnostic centres in the community. Nurses are also vital in leading pre-operative clinics as part of surgical hubs. Optometrists and orthoptists can also perform enhanced clinical roles, when supported to gain the appropriate experience and skill.

Ophthalmologists' roles will increasingly focus on delivering complex care, virtual review, and overseeing multidisciplinary pathways and service redesign. Job planning must evolve to reflect these responsibilities.

Digital initiatives in ophthalmology

Significant benefits have been seen in ophthalmology through implementing a single point of access (SPoA) model – financial, efficiency, patient experience and for genuine informed patient choice. This involves a central hub of expert clinical staff who review and triage all eye care referrals in a defined area to ensure that patients are referred to the right care setting first time. In 2023, a North Central London pilot for wet AMD reduced avoidable referrals from 62% to 29% and cut average triage times from 11 days to one day, and earlier this year RNIB estimated that a national rollout of SPoA could save the NHS £170m annually.

Artificial intelligence (AI) is also increasingly being used in ophthalmology to improve patient care, as outlined in Artificial intelligence in ophthalmology. A focus on education and training will be needed to equip ophthalmologists with the knowledge and skills to leverage AI tools effectively and safely. Sufficient workforce capacity will also be required to ensure efficiencies gained are not restricted due to other demand-capacity bottlenecks. The workforce must also have the knowledge and willingness to implement and critically review AI-enabled tools in their service. Other digital innovations like at-home testing, monitoring and remote consultation are also likely to become common in some areas of ophthalmology care, with appropriate planning and governance processes needed to help the workforce successfully deliver these changes.

Given there is great potential to deliver more care remotely in ophthalmology, the launch of NHS Online could have significant implications for clinical care in ophthalmology and the way ophthalmologists work. It will be important that NHS England works closely with the ophthalmology community to get the design of this new initiative right. Likewise, plans to make greater use of the NHS APP need to ensure it conforms to accessibility standards so that patients with vision loss can fully benefit.

Supporting prevention

Half of sight loss in the UK is avoidable through early detection and management of risk factors such as smoking, obesity, diabetes and poor diet. Yet, almost 600,000 patients await a first appointment with an ophthalmologist, and ophthalmology leads all specialties for follow-up waits, at 10,000 per trust. Follow-up appointments in ophthalmology are crucial for managing chronic, sight-threatening eye diseases like complex glaucoma and wet age-related macular degeneration.

To mitigate this, RCOphth recommends requiring trusts to report risk rating, as Wales does, alongside Latest Clinically Appropriate Date (LCAD) data. This would increase accountability and help prioritise patients at greatest risk of irreversible sight loss.

Greater investment in eye health research is also essential. Despite its burden, only £9.60 per person with sight loss is spent on eye research annually, compared with £97 for dementia. Integration of health research across the NHS will require protected time for clinicians to participate, as well as dedicated infrastructures that supports access to data, collaboration between researchers and patient participation.

Improving the accessibility of paediatric ophthalmology care will make an important difference in ensuring good eye health from a young age and preventing conditions worsening too. This will

need a focus on investing in paediatric ophthalmology services, including the workforce needed to deliver care.

Section 2: modelling assumptions

The workforce we build today will determine whether we can deliver the ambitions of the 10 Year Health Plan. That means challenging old assumptions, testing new ideas and being honest about what the future demands.

Big changes are coming. Artificial intelligence, breakthroughs in genomics and an ageing population will transform the way care is delivered. We need to capitalise on these shifts now or the NHS risks being left behind.

We need the insight of those who see, every day, what really works for staff and citizens - be that in the NHS, in other sectors or in other healthcare systems around the world. Your evidence will help us build a workforce that is ready, resilient and capable of delivering world-class care.

In this section, please submit evidence of:

- specific assumptions you use in workforce modelling - for example, how service redesign such as new community services or digital models of care might affect the numbers, deployment and/or skill mix of staff
- how that impacts on workforce supply and demand, including career and training pathways

Please provide clear examples and, where possible, support them with data.

Current workforce challenges

The UK lags behind nearly all other European nations in the number of ophthalmologists per population head. We published an analysis showing that to reach 3 ophthalmologists per 100,000 population head we would need an additional 285 ophthalmology training places by 2031. Competition ratios for ophthalmology training places are one of the highest for any training programme, reaching 21.54 in the 2025 recruitment round. These additional training places would therefore certainly be filled, although resourcing for trainers and additional clinic and theatre space will be needed to accommodate this increase.

Modelling future need

RCOphth is in the process of undertaking work to model the optimum composition of the multi-disciplinary workforce for each ophthalmology sub-specialty, based on incidence and prevalence data and the models of care needed to meet this patient need. This shows, for example, that for medical retina we need 2,868 medical retina ophthalmologists across the UK based on a model that encompasses ophthalmologists, resident doctors, ophthalmic nurses and optometrists. For specialised ophthalmology care, there will need to be coordinated workforce planning to ensure services that need to be implemented at a regional level are effectively supported, and there is equity of access across the UK.

This takes into account the rising demand on ophthalmology services. In 2024/25, there were 9.7 million outpatient attendances in ophthalmology, a 9.4% increase on the previous year. When we surveyed NHS ophthalmology departments in 2024, just a quarter felt able to deliver a service that generally met the needs of patients in their area. Demand is set to rise further in the coming years as our population ages. in 2017 we estimated that the number of people with glaucoma and neo-vascular age-related macular degeneration would rise by 44% and 59%, respectively, by 2035.

Service redesign and workforce implications

As we outline in our response to Section 1, there is scope to move more care out of the hospital. This does not negate the urgent need for more ophthalmologists though. Given demand will increase significantly in the coming years, ophthalmologists have a crucial role to play in models such as diagnostic centres and enhanced optometry services by overseeing the design and delivery of services and conducting virtual reviews. Hospital-based ophthalmology care will of course need to be effectively staffed to account for rising demand too – especially for complex care and surgery and emergency care.

Ophthalmologists will therefore increasingly focus on:

- The delivery of complex and emergency care
- Virtual review
- Governance and oversight of AI-enabled and diagnostic pathways delivered by other members of the multidisciplinary team
- Service redesign

Job planning and training pathways will need to evolve to reflect these responsibilities.

Retention, retirement and independent sector impact

Further challenges for ensuring a sufficient ophthalmologist workforce in England, that need to be built into modelling assumptions, are retention, retirement and the number of ophthalmologists increasingly working in independent sector providers.

GMC's 2024 workforce report found that 28% of ophthalmologists joining the specialist register left within five years – the highest of any specialty. Our 2023 workforce census also found that a quarter of consultant ophthalmologists planned to leave the workforce over the next five years, the vast majority through retirement.

The census also found that 14% of consultant ophthalmologists worked for an independent sector provider (ISP), mostly supplementary to their NHS role where they worked the majority of their time. This is likely to become a growing trend – when asked about their career intentions over the following five years, 21% planned to work a balance between the NHS and ISPs and that rose to 30% for those under 40. The government's drive to deliver more care in the independent sector, signalled by the 2025 NHS and Independent Sector Partnership Agreement, is likely to further accelerate this trend. This will mean the ophthalmology workforce becomes more fragmented, with increasing challenges for workforce and service planning.

Section 3: productivity gains from wider 10 Year Health Plan implementation

In his independent investigation of the NHS in England, Lord Darzi said:

"Falling productivity doesn't reduce the workload for staff. Rather, it crushes their enjoyment of work. Instead of putting their time and talents into achieving better outcomes, clinicians' efforts are wasted on solving process problems, such as ringing around wards desperately trying to find available beds."

To deliver transformational change we must improve productivity. This does not mean asking staff to work harder, it means changing the way we deploy staff in response to other developments, making it easier for them to do their jobs and bringing back their enjoyment of work.

In this section, please provide evidence of:

- the top digital initiatives you have delivered - in the NHS, other sectors, or internationally - that have successfully increased workforce productivity or reduced demand
- actions taken to identify and address gaps in training (pre or post-registration) that support delivery of the 3 shifts
- policies or initiatives that have enabled the NHS to play a bigger role in local communities (for example, widening access, creating opportunities, or supporting underserved groups)
- where you have managed changing expectations and increased patient participation in their care through digital tools and, where applicable, you have adjusted workforce planning to reflect this (for example, increased training to deliver new approaches to diabetes management to reflect new digital tools)

Please provide specific examples, supported by data where available.

Section 4: culture and values

The 10 Year Health Plan made it clear that great culture and great leadership go hand in hand with better quality care. When staff feel valued and supported, patients see the benefits.

We are committed to empowering leaders and managers at every level of the NHS to do better - to focus relentlessly on access, experience and outcomes for patients and communities. We know the best ideas often come from those already driving change on the ground.

We want your evidence and experiences on what works in building a positive culture where leadership is strong, the quality of care is high and staff are supported to thrive - and what must change to make that the norm everywhere.

In this section, please provide evidence of:

- policy interventions that have directly improved workforce outcomes and patient outcomes (for example, retention, staff wellbeing, reducing sickness absence, as well as better quality care)
- approaches that have successfully embedded strong core values into everyday leadership, decision making and service delivery
- systems or practices that ensure leaders at all levels actively listen to staff feedback - particularly from underrepresented groups - and act on it

Please provide specific examples, supported by data where available

Section 5: any additional comments

Please include any other comments, information or evidence you would like to share as part of this call for evidence that you think would help deliver the ambitions of the 10 Year Health Plan. (Optional)

Maximum 250 words.

Standardising electronic health records (EHR) in eye care is essential in delivering new and efficient models of care in ophthalmology and allowing the workforce to operate more flexibly. Current fragmentation – characterised by data silos and poor interoperability – compromises patient safety and care continuity. In England alone, NHS trusts use at least 21 different EHR systems, many of which are unable to share critical information. Additionally, primary care optometrists face challenges accessing and updating EHRs and NHS IT systems.

RCOphth recommends urgent implementation of a national EHR standard for eye care, ensuring interoperability between hospital and primary eye care systems, and embedding image and data sharing by default. This is a prerequisite for safe expansion of community diagnostic centres, virtual clinics, and AI-assisted triage.

A strengthened commissioning framework that ensures better control and oversight of scarce resources and enforcement of contracts is also vital. In a May 2025 open letter to the Care Minister calling for a review into the use and oversight of independent sector providers (ISPs) in ophthalmology, we highlighted concerns we and NHS England officials had following the moving of the majority of NHS Cataract surgery to ISPs around "value for money, unnecessary operations, impacts on workforce and training, poor follow-ups and patient safety".