ABDO Draft 10 Year Plan Response.

Priorities

The government has promised to put in place a 10-Year Health Plan to fix the NHS in England. We want to hear what your priorities are for this plan as interested organisations.

Tell us what your organisation wants to see in the 10 Year Health Plan, and why this is important.

The Association of British Dispensing Opticians (ABDO) is the professional body for dispensing opticians in the UK, representing over 8000 dispensing opticians and student dispensing opticians. Most dispensing opticians are employed within primary care settings, although a number are employed within secondary care as well as in professional services and other roles in eye care.

Dispensing opticians are healthcare professionals educated to degree level and registered, along with our optometrist colleagues, with the General Optical Council (GOC). The GOC is the regulatory body responsible for setting the standards of practice for dispensing opticians and optometrists and the same standards apply to each profession. Dispensing opticians form the second biggest workforce within primary eyecare and for most patients are the first clinicians they will encounter on entering a High Street optical practice. As the professional body for dispensing opticians, provides the qualification that enable students to qualify and register as dispensing opticians ABDO, as well as providing evidence-based guidance and continuing professional development for dispensing opticians.

Dispensing opticians are the experts in the medical devices needed to optimise patients' vision, principally spectacles and contact lenses. They analyse prescriptions to ensure patients receive the best visual outcomes by providing recommendations around correctly fitting frames and appropriate lenses. They advise patients across a range of eye care issues including acute eyecare, paediatric eyecare, myopia management and low vision. With further advanced training, dispensing opticians can become qualified to prescribe contact lenses and fit the majority of contact lenses supplied within the UK

The overall eyecare workforce includes around 16,000 optometrists and 7000 dispensing opticians. Optometrists and dispensing opticians work together as part of the primary eye care team to provide over 28 million primary care appointments per year across a network of around 5000 optical practices- the majority within their patient's locality. By comparison, within secondary care, there are around 3500 ophthalmologists based across around 220 general acute hospitals.

Q1:What does your organisation want to see included in the 10 Year Health Plan and why?

Our members work with patients to preserve and optimise their vision with the long-term goal of preventing avoidable sight loss for all. Eye care professionals have the skills to deliver this in primary care, along with the capacity, infrastructure and equipment, but need to see firm commitments within the 10-year plan to make this happen.

We are committed to help the NHS and government deliver a 10 year plan that recognises the value and potential of primary eyecare and addresses the challenges we, and our patients, have faced over the last 14 years.

The 10-Year Health Plan must address the long-standing systemic challenges and inefficiencies within the commissioning and delivery of eye care services across England, including the hospital eye service. The varied and inequitable approach to the provision of eye care across the country, beyond the success of the national eye testing service, has caused significant delays and contributed to preventable sight loss, particularly in areas of deprivation as highlighted by the RNIBs

To create a sustainable, equitable and patient-centred system, the NHS must reduce its reliance on overstretched hospital services and refocus on strengthening and promoting locally based primary eye care.

To achieve this, we propose the following key priorities for the 10 Year Plan:

1. **Delivering the Government's Three Big Shifts:**

   - **From Hospital to Community:** Expand access to enhanced services in primary eye care across the whole of England rather than just in pockets of "primary care excellence", allowing hospitals to focus on critical and emergency cases and fully utilize the skills of the locally based optometric workforce to undertake more routine and urgent work. Examples of this include services such as delivered in "Community Urgent and minor Eyecare Service (CUES) and Minor Eye Condition Services (MECS) as well as diagnostic tests, scans and monitoring of existing stable, eye conditions such as glaucoma.

   - **From Sickness to Prevention:** Prioritise the earliest interventions to preserve sight, support independence, and improve patient outcomes. Every day incidences of avoidable sight loss occur, affecting patients and their families' lives and the preventative approach will have a huge impact both positively on patients, and on the wider healthcare infrastructure and national economy.

   - **From Analogue to Digital:** digital systems and the data they capture live in silos within eye health to the detriment of our patients. Investment to improve connectivity between primary and secondary care, reducing unnecessary hospital visits, streamlining referrals, and ensuring efficient and safe patient management will improve patient outcomes as well as reduce the need for them to attend hospital eye departments.

2. **Strengthening NHS Eye Care:**

   - Focus on expanding and funding services appropriately within primary eye care, positioning optical practices as the first point of contact for eye health needs. Optician practices should serve as the "gatekeepers" of eyecare, delivering comprehensive interventions directly to patients and referring to secondary care only when specialised expertise is essential. This approach maximises the use of skilled eye care professionals, improves patient access, and ensures secondary care resources are focused on the most complex cases.

   - Commit to addressing the long-standing funding gap for the NHS sight-testing service to ensure the viability of primary eye care and the clinical teams

employed within it. Develop a long-term plan that will allow contractors within primary care to invest in workforce, training and equipment to deliver the clinical services that can be provided in optical practices.

- Expand national access to enhanced services within primary eye care, based on clinical need and delivered to consistent standards, making the best use of available resources and capacity in primary care.

3. **Rebalancing Care and Investment:**

   - Shift care closer to home by expanding NHS-funded enhanced eye care services such as Community Urgent and minor Eyecare Services (CUES), glaucoma monitoring and low vision pathways, which already exist in some areas, to reduce pressure on hospital services, and address growing patient needs.
   - Fully utilise the clinical skills of the registered eye care workforce based in primary care, including dispensing opticians, along with existing diagnostic technologies and infrastructure in primary care settings across England, to deliver safer and more efficient services.
   - Instigate a "Darzi-style" review of investment in both primary and secondary eye care to ensure that funding truly sits where it can have the most immediate impact on the government's "Three big shifts".
   - Establish an enforceable national commissioning framework to ensure patients are not affected by regional variation in the commissioning of enhanced eye care pathways and ensure that where possible commissioned eye health is delivered within primary care settings.

2. **Introducing the 3 shifts**

The next questions relate to 3 'shifts' – big changes to the way health and care services work – that doctors, nurses, patient charities, academics and politicians from all parties broadly agree are necessary to improve health and care services in England:

- *Shift 1: moving more care from hospitals to communities*
- *Shift 2: making better use of technology in health and care*
- *Shift 3: focussing on preventing sickness, not just treating it*

In answering the following questions on the 3 shifts, we'd welcome references to specific examples or case studies. Please also indicate how you would prioritise these and at what level you would recommend addressing this at, i.e. a central approach or local approach.

Shift 1: Hospital to Community

This means delivering more tests, scans, treatments and therapies nearer to where people live. This could help people lead healthier and more independent lives, reducing the likelihood of serious illness and long hospital stays. This would allow hospitals to focus on the most serious illnesses and emergencies.

More health services would be provided at places like GP clinics, pharmacies, local health centres, and in people's homes. This may involve adapting or extending clinics, surgeries and other facilities in our neighbourhoods, so that they can provide things that are mostly delivered in hospitals at the moment. Examples might include:

- urgent treatment for minor emergencies
- diagnostic scans and tests
- ongoing treatments and therapies.

Q2: What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

High Street optical practices are already undertaking clinical work beyond the NHS sight testing service. These "enhanced services" include caring for patients with acute eye problems via MECS & CUES pathways, supporting patients with pre and post-cataract services, monitoring and managing glaucoma patients outside of secondary care, providing low vision assessments and dispensing of low vision aids and undertaking specialised contact lens fitting amongst other services. However, although all of these services have huge benefits for patients in primary care, none of them are available in their entirety across the whole of any ICB area.

Challenges

- **Inconsistent or non-existent ICB Commissioning**
  Efforts to shift care from hospitals to the "High Street" have often lacked a coordinated, strategic approach supported by any national, enforceable guidelines. Instead, they have been disjointed, sometimes influenced by concerns within the Hospital Eye Service (HES), where there is a fear that reducing patient numbers could result in decreased ICB funding, a legacy from the old "payment by results system". . This has led to piecemeal implementation rather than a unified local, regional or national strategy. The variation in local contracts and care pathways across and even within Integrated Care Board (ICB) boundaries, compounded by inconsistent funding, short-term contracts, and the absence of long-term planning, has created confusion, inefficiencies, and inequalities in eye care delivery. Without clear, enforceable national guidelines combined with sustainable long-term funding, the shift to primary care-based services will remain challenging, preventing the effective reduction of pressure on hospital eye care services and avoidable sight loss.

  Research consistently points to the lack of cohesive planning as a barrier to integrating primary and secondary care effectively[1] and is noted as a significant obstacle to reducing unnecessary hospital visits and improving patient outcomes in eye care. Local variations, along with both local and national financial challenges, contribute to these

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[1] **The King's Fund**: *Closing the Gap: Key Areas for Action on the Health and Care Workforce* (2019)
Health Foundation: *Data-Driven Approaches to Integrated Care*.

inefficiencies, as highlighted in recent policy reviews and studies on NHS service delivery. [2]

- **Under prioritization of Eye Care in NHS Planning**
  Eye care, and in particular primary eye care, despite its potential for impactful change, has been consistently given insufficient weight in NHS England plans and this has led to inaction by local commissioners. The overwhelming demand on hospital services has contributed to backlogs, which in turn delay essential treatments and diagnoses and lead to avoidable sight loss. This situation underscores the need for a more balanced approach, with greater emphasis on utilising primary eye care to alleviate pressure on hospitals and prevent further harm to patients. By enabling more care within "High Street" optician practices it will become possible to deliver quicker, more accessible interventions, ongoing patient monitoring delivered without delay, and ultimately reduce the risk of sight loss caused by the systemic delays within the Hospital Eye Service.

- **Lack of engagement with or understanding of primary eye care**.
  Many ICBs are under huge system pressures - the National Oversight Framework (NOF) means for some they can look no further than the "acutes and ambulances". This means they have disengaged from primary care, which has particularly impacted eyecare, where perhaps the biggest opportunities exist to support the systems back to normality. Some ICB leaders have limited understanding of eyecare contracts, enhanced service pathways or the skills of the existing workforce, including dispensing opticians and optometrists. This is a highly skilled, regulated group of clinicians willing and able to support the wider healthcare sector. The structure of Integrated Care Boards (ICBs) often includes representatives from secondary care, reflecting their significant role in service delivery. However, primary eye care typically lacks equivalent representation, despite its critical role in preventative care. This disparity can affect the development of integrated pathways and undermine the contribution of primary eye care to managing the present eye health challenges.

  Inadequate IT and Communication Systems
  The absence of a standardized, interoperable IT system creates significant barriers to communication between primary and secondary care in eye health. This disconnect leads to delays in patient care, duplication of diagnostic tests, and widespread inefficiencies. In some cases, even enabling basic access to NHS Mail for dispensing opticians and optometrists remains a challenge, hindering their ability to send secure referrals efficiently.

  Furthermore, many primary eyecare clinicians are forced to navigate multiple disjointed systems to manage referrals, which complicates patient referral and increases the risk of errors. This lack of streamlined, interconnected IT infrastructure not only wastes clinical time but also undermines patient safety and continuity of care.

- **Inequality and deprivation.**
  Current contractual arrangements for NHS-funded eyecare often rely on some level of cross-subsidisation from private work. However, this approach has become increasingly

[2] https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf

difficult to sustain, particularly in areas of deprivation where NHS sight tests make up the majority of a practice's workload. The NHS sight testing fee of £23.53 is notably below the cost of delivering these tests, creating challenges in maintaining service viability, especially in less affluent areas. Analysis carried out by the Ophthalmic Fee Negotiating Committee (OFNC) put the cost of delivery of an NHS sight test at around £50 which reflects the actual costs involved, including clinical expertise, practice overheads, staff, and equipment. We do not wish to see "deserts" where no practices can remain viable commercially and patients are deprived of the basic NHS eye testing service and access to any enhanced services, should they be commissioned in the area in question. Eye health in such areas would be seriously impacted, meaning more patients becoming economically challenged and deprivation increasing. There would also be increased pressure on the already stretched eyecare services within secondary care as they would be left to deal with the inevitable impact on patients' visual health.

Enablers

- **Proven Effectiveness of primary care extended services**
  Evidence demonstrates that enhanced primary eyecare pathways can successfully manage patients outside hospitals.[3] Over 5,000 optician practices are equipped with the regulated clinical workforce and infrastructure to deliver outpatient-level services sustainably.

- **Successful Initiatives**
  Programmes such as the transformation of primary eyecare services in Scotland in 2006 show that shifting care to primary settings reduces pressure on hospitals while maintaining quality.[4] .

  Analysis by our sector colleagues at FODO (The Association for Eyecare Providers- a national organization in the UK that supports eye care providers) showed that between 2013 and 2017 there was a 13% reduction in ophthalmology activity in Scotland compared to an increase of 18% in England. Building on this approach to eye care across England can ensure equity and consistency for patients as well as reducing demands on the Hospital Eye Service (HES) and GPs.

- **Support for Workforce Development and Engagement**
  Recognising and investing in the skills of optometrists and dispensing opticians through continuous professional development can expand the scope of care they deliver. ABDO's role as an End Point Assessment Organisation for the primary eye care Dispensing Optician apprenticeship and experience in Continuing Professional

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[3] https://www.city.ac.uk/news-and-events/news/2017/12/enhancing-primary-eye-care-services-in-the-uk
https://www.rcophth.ac.uk/wp-content/uploads/2022/02/Primary-Eye-Care-Community-Ophthalmology-and-General-Ophthalmology-2019.pdf

[4] Public Health Scotland, 2020, General Ophthalmic Service Statistics https://www.publichealthscotland.scot/media/4679/2020-10-13-ophthalmic-report.pdf

Development (CPD) provision is just one example of the eyecare sector's focus on developing a skilled workforce ready to adapt to evolving healthcare needs. However, this could be further advanced by allowing NHS funding for CPD to be extended to dispensing opticians rather than the existing scheme which funds only optometrists. Both dispensing opticians and optometrists have to meet the requirements of the CPD scheme operated by the sector regulator, the General Optical Council (GOC), in order to remain registered and deliver patient care as part of the primary eyecare team. Alongside this we call for the inclusion of dispensing opticians on the "Ophthalmic performers lists" to recognise that they now play a vital role in delivery of eye care services to patients within primary care.

- **IT Systems**
  Access for dispensing opticians and optometrists to a fully interoperable IT system would enable seamless communication and data sharing between primary and secondary care, reducing delays and duplication and positively impact patient's visual outcomes.

- **Education and Awareness**
  National campaigns aimed at the public to promote NHS sight tests and enhanced services would have a positive impact on the population's eye health. This could be improved even further when combined with awareness training for colleagues in ICB/HES around the positive patient benefits of an expanded role for primary eyecare.

- **Environmental and Accessibility Benefits**
  Delivering care through local opticians' practices not only enhances patient access and clinical efficiency but also contributes significantly to reducing the ecological impact of healthcare. By minimizing patient travel, and lowering hospital resource usage by removing duplication of tests or unwarranted referrals, the use of primary care based local optical practices helps advance the NHS sustainability agenda and its **commitment to Net Zero emissions by 2040**.

Shift 2: Analogue to Digital

Improving how we use technology across health and care could have a big impact on our health and care services in the future.

Examples might include better computer systems so patients only have to tell their story once; video appointments; AI scanners that can identify disease more quickly and accurately; and more advanced robotics enabling ever more effective surgery.

Q3: What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Challenges

- **Lack of digital connectivity across different healthcare settings**.
  The lack of seamless digital communication between optical practices in primary care, patients GPs, and the NHS Hospital Eye Service (HES) creates barriers that delay referral and prompt treatment, risk loss of patient data and often result in tests being repeated within HES when they have already been or could have been delivered at the patient's local opticians practice. Undertaking this diagnostic work within a primary care based optical practice and being able to seamlessly share this with colleagues within secondary care would not only increase the quality of referrals that could be made but also contribute to a reduction in hospital attendance.

- **Fragmented and incompatible IT systems**.
  The current IT landscape for primary eye care is unnecessarily complex, with various referral systems commissioned across England that often lack compatibility with an opticians' practice management system (PMS). This creates inefficiencies and challenges in integrating care pathways effectively. Streamlining these systems to improve compatibility could enhance communication, reduce administrative burdens, and ensure smoother patient referrals. Practitioners can find themselves using three different systems to facilitate a routine referral (their own PMS, their equipment suppliers' IT and an external referral platform) which is burdensome and presents risks to the accurate and timely transfer of patient data. Some of these challenges stem from previous NHS England IT infrastructure projects, which were perceived by the primary eye care sector as costly and inefficient. The sector had raised concerns that these initiatives might not be well-suited to the specific needs of primary eye care, leading to difficulties in integration and functionality. More careful planning and alignment with sector needs could help address these issues in future IT developments. There seems to be no clear direction of travel now, with different ICBs commissioning different legacy systems from the NHSX EeRS project, and an urgent review of this situation is essential.

Enablers.

- **Universal access to NHS mail for primary eye care.**
  At present, only part of the eye care workforce has access to NHS mail, with domiciliary providers in primary care, many dispensing opticians, and other clinical colleagues lacking

automatic access, although all of these clinicians have equal duty to refer. Dispensing Opticians have a duty to refer, where appropriate – it is laid out by their regulatory body the General Optical Council[5] – and yet many do not have access to a secure IT system in which to undertake this. A "quick win" would be to allow all of these clinicians immediate access to NHS mail and the benefits this brings.

- **Collaborative development of a national IT solution.**
  Evidence of the challenges posed by "stand-alone IT projects" within eye care can be seen in recent initiatives like the NHSX EeRS project, which faced issues with integration and compatibility across different systems. These problems highlighted the difficulties of implementing isolated digital solutions without broader sector alignment. However, there is growing interest within primary eye care in collaboration to develop a national IT model that could work seamlessly with existing practice management systems, improving patient care and system efficiency. Optical practices utilise advanced diagnostic equipment daily and have an existing IT literate workforce who would support and help with the development and effective utilisation of IT platforms to improve eye health and achieve efficiencies across primary and secondary eyecare.

Shift 3: Sickness to Prevention

Spotting illness earlier and tackling the causes of ill health could help people stay healthy and independent for longer, and take pressure off health and care services.

Q4: What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Challenges.

- **Culture**
  Both ICBs and secondary care systems have traditionally been oriented toward treatment, focusing on acute and emergency care, shaped by the historical frameworks within which they operate. This has made it challenging for them to fully adopt a preventative approach. Consequently, their engagement with and understanding of primary care, where prevention is a key focus, can be limited, and their awareness of primary eye care commissioning is often minimal - it is only recently that they have taken over responsibilities for commissioning the delivery of GOS sight testing. The present reality is that ICB priorities naturally focus on areas of higher expenditure and therefore primary eye care has not been seen as a necessary priority

- **Understanding of present sight testing provision**.

[5] https://optical.org/en/standards/standards-of-practice-for-optometrists-and-dispensing-opticians-effective-from-1-january-2025/6-recognise-and-work-within-your-limits-of-competence/
https://optical.org/en/standards/standards-of-practice-for-optometrists-and-dispensing-opticians-effective-from-1-january-2025/10-work-collaboratively-with-colleagues-in-the-interest-of-patients/

The NHS General Ophthalmic Services (GOS) sight test is sometimes seen primarily as a mechanism for prescribing spectacles or, at best, a chance appraisal of general eye health, rather than being recognised for its broader potential as an early intervention tool in various aspects of patient health. An NHS sight test plays a critical role in preventing health concerns, as it not only identifies vision problems but also serves as a screening tool for a range of serious conditions, some of which may not be immediately apparent. The early detection of eye disease such as glaucoma, macular degeneration and cataracts is a critical part of the sight test. It can also enable the identification of other systemic health conditions such as diabetes, hypertension, and high cholesterol. Sight testing of children can identify vision issues that can have a profound impact on their learning and development if not treated and it is this type of "prevention" that is often overlooked when sight tests are considered.

- **Funding**
- Where funding is focused on sickness it can be to the detriment of prevention. Evidence from various reports, such as those from The King's Fund and the Health Foundation, indicates that underinvestment in primary care can lead to a higher burden on secondary care services, as patients may bypass primary care entirely. This imbalance of resources ultimately affects patient outcomes, as care becomes less preventive and more reactive. Therefore, the increase in healthcare spend in secondary care to the detriment of investment in primary care needs to be reversed in order to achieve the ambitions of the 10 year plan.

- **Commissioning**
  Local systems, particularly those under special measures, tend to focus solely on deficit reduction by curtailing innovative commissioning, even when it can bring tangible savings through efficiencies and delivering a preventative agenda. This focus on deficit reduction at the expense of innovative commissioning has become so embedded in system priorities that it seems difficult to imagine that the culture change required to move from sickness to prevention can be delivered without it being mandated centrally.

Enablers.

- **Rebalancing of the primary/secondary care spend.**
  Generally, healthcare works well when the funding follows the patient and likewise for the preventative agenda to be delivered the money needs to sit where prevention can take place. In the case of eye health, this should be within the budget for services delivered from within primary care which should move to deliver more diagnostic testing and management of less complex eye conditions, as well as an expanded role in the monitoring of more complex conditions outside of HES.
- **Training and education**.
  ABDO has led the sector in the delivery of the first level 6 apprenticeship for eyecare practitioners and similar opportunities should be enabled across the complete primary eyecare workforce. Continuing professional development (CPD) for eye care professionals is at present inequitable, with only public funding available for optometrists, which creates a barrier for dispensing opticians, the second biggest clinical workforce within primary eyecare, to expand their skills and knowledge, and enhance patient care. This should be addressed to allow all primary eye care clinicians to work 'at the top of their licence'.

- **Incentives & deterrents.**
  ICBs should be incentivised to move funding to primary eye care to drive a prevention agenda with early detection, advice and signposting delivered to patients by eye care professionals located closer to patients' homes. At the same time, there should be a tighter framework put in place to discourage the continual use of secondary care resources for routine monitoring or other services which could take place in primary care.

Ideas for change

We're inviting everyone to share their ideas on what needs to change across the health and care system. These could be:

- Ideas about how the NHS could change to deliver high quality care more effectively.
- Ideas about how other parts of the health and care system and other organisations in society could change to promote better health and/or improve the way health and care services work together.
- Ideas about how individuals and communities could do things differently in the future to improve people's health.

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

(optional)

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:

- Widen availability of acute eyecare pathways such as the Community minor and Urgent Eyecare Service (CUES) and Minor Eye Conditions Services (MECS)so that they are available across the whole of England to improve patient care and reduce pressure on GPs and A&E. At present these pathways manage around 80% of all the patients seen without onward referral
- Enable access to NHS mail for all primary care clinicians (including dispensing opticians) to facilitate safe onward referral of patients and secure transfer of data.
- Enable access to CPD funding for dispensing opticians to support primary care workforce development, enhancing patient care and supporting the Government's prevention agenda

- Mandate referral refinement in primary care optical practices to reduce false positive referrals to the Hospital Eye Services – this would be better for patients and provide cost savings for hospitals.
- Add dispensing opticians to the Ophthalmic Performers List (OPL) so a true reflection of the registrant clinical workforce across England can be obtained and better inform a national primary eyecare workforce strategy.
- Ensure that primary eye care has representation at ICB Board level alongside GP, pharmacy and dentistry colleagues to ensure that eye care services are integrated into broader healthcare strategies and recognize the role primary care has within the country's health care system.

  - In the middle, that is in the next 2 to 5 years
  - Address the long term underfunding of the NHS GOS sight testing service to ensure its future viability in all areas across England, and thereby remove its reliance on cross-subsidy from private work.
  - Deliver integrated IT connectivity between optical practices, GPs and secondary care.
  - Undertake a review of the clinical work that takes place in HES with the purpose of reallocating any work that can take place in primary care settings. This could include low vision, routine glaucoma follow up appointments and low vision work.
  - Long term change, that will take more than 5 years
  - Support practices to deliver the NHS Green agenda and become net zero in advance of the 2040 target.