Written evidence from The College of Optometrists (PCC0065)

HOUSE OF LORDS INTEGRATION OF PRIMARY AND COMMUNITY CARE SELECT COMMITTEE INQURY

House of Lords
Special Inquiry Committee on the Integration of Primary and Community Care

Written evidence submitted by *The College of Optometrists*

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1. Introduction.

1.1. The College of Optometrists welcomes the Inquiry on the Integration of Primary and Community Care. At this time of great challenges and

opportunities for NHS England, it is essential to make sure that patients continue to receive effective, quality care.

2. About us: The College of Optometrists.

2.1. We are the professional body for optometry in the UK. The College champions optometrists and the role they play by developing their knowledge and skills, defining good optometric practice, supporting optical research and innovation, and educating and advising the public on eye health. Further information can be found at www.college-optometrists.org.

2.2. As well as providing public health advice, we also encourage the public to look after their eyes and make regular appointments with their local primary care optometrist, via our Look after Your Eyes website.

2.3. There are approximately 13,000 optometrists registered as health professionals in England. They work across both primary and secondary care, as well as in community and domiciliary settings, and in academia and research.

2.4. Optometrists are a key part of the NHS workforce, providing over 13 million NHS sight tests in primary and domiciliary settings across England each year[1]. They play a vital role in the screening, diagnosing, monitoring and treatment of eye conditions, including cataract (pre and post treatment) and glaucoma.

3. Executive summary.

3.1. **Hospital eye-care services (HES) are under increasing demand**, which is expected to increase by 40% of the next 20 years. Ophthalmology now accounts for 8% of outpatient appointments[2].

3.2. The current lack of capacity in hospital eye services **must be addressed through effective eye care pathways into and out of hospital,** ensuring that all available capacity in primary and community care, including those of optometrists and dispensing opticians, is used effectively.

3.3. The COVID-19 crisis has showcased **the role of primary and community care optometrists as 'first contact' healthcare providers for eye health**, taking the pressure off hospital eye care

[1] General Ophthalmic Services Activity Statistics England, year ending 31 March 2020 https://digital.nhs.uk/data-and-information/publications/statistical/general-ophthalmic-services-activity-statistics/england-year-ending-31-march-2020

[2] NHS Digital, *Hospital Outpatient Activity, 2021-22, Main Specialty*. Available at: https://files.digital.nhs.uk/D1/C9B503/hosp-epis-stat-outp-main-spec-2021-22-tab.xlsx

services, and we have a unique opportunity to build on these achievements to address the capacity issues in HES and build a cost-effective, joined up, clinically safe and sustainable eye care service.

3.4. We believe that optometrists should be at the heart of patient-centred eye care in England. The **core capabilities of optometrists create a flexible and ready workforce**, who can contribute to effective, integrated multidisciplinary patient care in primary, community and secondary care.

3.5. At a time of great challenges and opportunities for the NHS, it is essential to make sure we deliver cost effective quality care to all patients in England. The College of Optometrists supports the recent structural changes to the NHS in England. Commissioning **more enhanced eye care services at ICB level** covering larger geographical areas:

- will **enable the provision of consistent, coordinated eye health services** appropriate to the patients' clinical risk across primary, community and secondary care.
- will better **address health inequalities and unwarranted variation** in the delivery of healthcare.
- will enable NHS England to **make maximum use of the clinical skills of primary and community care health professionals, including optometrists**, helping to relieve pressure on hospitals for the benefit of patients.

3.6. However, one of the main barriers to better integration between primary and community care is the **lack of digital/IT connectivity between and within primary, community and secondary care.** Currently, primary and community eye care services are not universally digitally connected to secondary care services. For example, in many places this means that optometrists cannot easily make digital referrals, sometimes having to go through a GP to do so. This continues to cause issues for patient outcomes and also for efficiency of the system through unnecessary clinical and administrative burden. Lack of connectivity can lead to delayed diagnosis, unnecessary referral and lack of up-to-date patient records when the patient returns to primary care. It also hinders the safe transfer of care between professionals. New e-referral systems are being developed and we are ready to work with NHS England to develop a solution which can be funded and rolled out at scale to benefit patients, the NHS and taxpayer.

3.7. As the Fuller stocktake report recognised[3], a major delivery challenge for ICBs is how actively to involve primary and community care in

[3] Next steps for integrating primary care: Fuller stocktake report, NHS England, 2022 https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

strategic service planning. **All primary care providers, including optometrists, should be directly involved in the design, delivery and leadership of more integrated services** for local populations in every ICS area. Having optometric representation would ensure all patients' needs are considered. It would ensure eye health is effectively included in general health decisions and would improve opportunities for more integrated and mutually supportive service provision. It would also ensure the entire workforce is taken into account and that decision-makers understand what eye care professionals can deliver to patients, and how the primary eye care workforce can increase capacity across systems.

3.8. Optometrists play an important role in providing joined-up healthcare services for patients between primary and community care, such as **glaucoma filtering and monitoring scheme, domiciliary eye care**, **school vision services and special school eye care**, or to signpost into other types of services, such as **falls prevention services, smoking cessation or weight loss and alcohol services**. Optometrists play also an important role to improve joint working with social care, including **mental health services**, which are crucial for people experiencing sight loss, or to improve the quality of life for **people living with dementia.**

4. The main challenges facing primary and community health services as well as possible solutions within the current framework.

4.1. Hospital eye services and general practice in England are under increased pressures. Demand for NHS eye care services had exceeded capacity. Ophthalmology is the largest outpatient specialty in the NHS, with 7.5 million appointments in England in 2021-22[4], and a 30-40% increase in demand for eye services is predicted between 2018 and 2038[5]. Patients are not being seen within clinically appropriate timeframes, which leaves them at risk of avoidable and irreversible sight loss.

4.2. This is exacerbated by low public awareness and understanding of the importance of eye health and how it can be maintained.

4.3. Furthermore, locally commissioned primary and community care services are currently fragmented, creating unwarranted variation across England in terms of patient access to eye care.

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[4] NHS Digital, *Hospital Outpatient Activity, 2021-22, Main Specialty*. Available at: https://files.digital.nhs.uk/D1/C9B503/hosp-epis-stat-outp-main-spec-2021-22-tab.xlsx

[5] The Royal College of Ophthalmologists, *Workforce census 2018*. Available at: New RCOphth Workforce Census illustrates the severe shortage of eye doctors in the UK | The Royal College of Ophthalmologists

4.4. Tackling these challenges requires effective collaboration between systems and health professionals across primary, community and secondary care.

4.5. The College of Optometrists and The Royal College of Ophthalmologists have developed a joint vision to support our workforce and the commissioning of safe and sustainable eye care services that meet the needs of all patients, improving patient care and outcomes during and beyond the pandemic[6].

4.6. Our vision for the future is to provide eye care pathways that ensure patients are prioritised based on their clinical need and to receive care that is appropriate and accessible. Multidisciplinary professionals should provide that care, working collaboratively in primary care, community and hospital settings.

4.7. Our vision is underpinned by four key principles:

- Reducing the risk of visual loss due to delayed eye care, in an equitable, appropriate and accessible way.
- Multidisciplinary professionals working collaboratively in primary care, community, and hospital settings to provide care.
- Direct patient contact taking place with a clinician capable of making appropriate management decisions including, where required, support by a senior decision-maker e.g. an optometrist with higher qualifications or the independent prescribing (IP) certificate, or the hospital eye service.
- All pathways led by the highest standards of joint optometry and ophthalmology clinical governance, applied equitably to all who are providing care, and underpinned by patient-centred outcome measures.

5. The main barriers preventing improved integration and how they could be overcome.

5.1. Lack of digital/IT connectivity.

5.1.1. Good patient care requires effective communication to support improved patient experience and outcomes, for example to enable effective referrals and shared care provision between and within primary, community and secondary care. Digital/IT connectivity is a key enabler to transform eye care service delivery, such as allowing electronic referrals, but a major barrier to achieving this is a lack of IT connectivity provided to primary eye care.

[6] The College of Optometrists and The Royal College of Ophthalmologists, *Joint statement on our vision for safe and sustainable patient eye care services*, 2021. Available at: Joint statement on our vision for safe and sustainable patient eye care services - College of Optometrists (college-optometrists.org)

5.1.2. The College of Optometrists, together with our main partners in the sector, fully supports the need for effective, two-way IT connectivity between primary and community care and with hospital eye services and GPs. This would not only ensure timely, secure and effective communication to improve patient care, but would also facilitate feedback between multidisciplinary professionals to aid learning and improve clinical decision making.

5.1.3. We are aware that there are currently a number of proof-of-concept projects running in various regions, including electronic eye-care referral systems (EeRS) between primary and community care practices and hospital eye-care services. However, it is unclear how these will link into the national electronic referral system (eRS) programme that NHS England are developing.

5.1.4. We support the need for a joined-up, national approach to electronic referral systems across eye care. However, it must be implemented in a planned and systematic fashion with appropriate levels of funding to ensure roll-out is safe and effective and does not put patient safety at risk. These risks include potential digital isolation of patients and practitioners and lack of safety-netting – which is essential in case of IT failure - such as retaining acceptance of paper referrals where appropriate.

5.1.5. While we recognise that funding arrangements and timescales for implementation should be agreed collaboratively with local stakeholders, national engagement and coordination and involvement of stakeholders such as the College and other optical sector organisations is important to achieve optimal primary eye care IT connectivity.

5.1.6. In addition to IT connectivity, there is the need for ensuring digital clinical image interoperability (standardisation). Currently, there are several digital systems to review and analyse clinical images within eye care that are supplied by different manufacturers and purchased by trusts and practices. However, the historical lack of agreed interoperability standards means most of these systems and image files are incompatible with one another.

5.1.7. Clinical images are increasingly offered in primary and community eye care settings to detect and monitor eye disease. They can also help improve referrals to secondary care and improve patient outcomes within shared care pathways.

However, as a result of incompatible systems, images often need to be taken repeatedly – this means time and resources are wasted, causing delays in diagnosis and access to timely treatment. Multiple visits may result in increased stress and anxiety to patients and contributes to waiting time delays. Any delay in diagnosis can lead to avoidable sight loss.

5.1.8. Standardisation of digital imaging in eye care will allow:
- Seamless sharing and viewing of patient images digitally across systems and between primary, community and secondary care settings.
- Improved ability to make swift and efficient diagnosis, referral and treatment decisions.
- Seamless interface with technology for joined-up patient care.
- Facilitated use of artificial intelligence through deep learning to enhance clinical decision making.

5.1.9. A collaborative approach with all relevant stakeholders is vital to enable implementation of these standards by device manufacturers and the development of IT systems with image viewing capability. The College of Optometrists and the Royal College of Ophthalmologists are leading a digital imaging Task and Finish group with NHS England. This brings together healthcare professionals, the manufacturing industry and sector stakeholders to develop a set of DICOM standards[7] that will drive interoperability of digital systems.

5.2. Lack of primary and community care representation at ICB level.

5.2.1. The lack of representation of the full range of primary and community care health professions, including optometrists, at ICB level to inform commissioning decisions is another major barrier preventing improved integration between primary, community and secondary care.

5.2.2. We have developed this point in more detail in point 8.5 below.

6. Examples of successful or innovative models of integrated care, either in the UK or internationally.

6.1. Covid-19 Urgent Eyecare Service (CUES) and Optometry First

6.1.1. During the pandemic, the College contributed to the development of the Covid-19 Urgent Eyecare Service (CUES)[8]. This enabled

[7] DICOM standards: DICOM (dicomstandard.org)

[8] https://www.college-optometrists.org/news/2020/april/covid-19-urgent-eyecare-service_cues_england

patients to gain prompt access to a remote consultation, and to have access to a care plan to:

- Self-manage their ocular condition (with access to appropriate topical medications where appropriate); or
- Be managed by their optometrist, with advice, guidance and remote prescribing as necessary by a hospital ophthalmology service; or
- Be referred into secondary care if necessary.

6.1.2. This service has informed the evolution of "Optometry First" pathways in three areas in England[9], where primary care optometrists are locally commissioned to diagnose, treat and manage a variety of commonly occurring eye conditions. These services are delivered in patients' local communities in familiar surroundings. They enable rapid care and reduce demand on GP services and HES.

6.1.3. In February 2022 it was reported that 74% of the population had access to urgent and emergency eye care services delivered by primary eye care[10].

6.1.4. However, these service are not as efficient as they could be. The NHS 2021-22 planning guidance annex recommended that all optometrists with Independent Prescribing qualifications working within an urgent eye care service should have access to NHS prescription forms (FP10)[11]. Despite this, members of the profession report that there is still considerable variation across England as to the number of optometrists prescribers who can write NHS prescriptions. This contrasts with Scotland and Wales where there is a high level of FP10 access for all optometrist prescribers, benefiting local communities and further reducing pressure on GP practices.

6.2. **Glaucoma filtering and monitoring.**

6.2.1. The lack of capacity in the hospital eye services for glaucoma patients has been highlighted in a recent report from the Healthcare Safety Investigation Branch[12]. An estimated 22 people a month suffer severe or permanent loss of sight due to delays in

[9] Optometry First toolkit, NHS England https://future.nhs.uk/NationalEyeCareHub/view?objectId=29549904

[10] https://locsu.co.uk/coverage-of-cues-and-mecs-continues-to-increase-but-more-gaps-to-fill/

[11] https://www.rcophth.ac.uk/wp-content/uploads/2021/06/Eye-Care-Planning-Implementation-Guidance-2021-22-Summary-Annexe-1.pdf

[12] Healthcare Safety Investigation Branch, Lack of timely monitoring of patients with glaucoma, 2020. Available at: hsib_report_lack_timely_monitoring_patients_glaucoma.pdf (hsib-kqcco125-media.s3.amazonaws.com)

follow-up appointments, and this has also been attributed to insufficient capacity within HES[13].

6.2.2. The Cambridge community Optometry Glaucoma Scheme[14] (COGS) was initiated in 2010, where new referrals for suspected glaucoma are evaluated by community optometrists with a special interest in glaucoma, with virtual electronic review and validation by a consultant ophthalmologist. Of the patients, 46.6% were discharged at initial assessment and 5.7% following virtual review. Evaluation of the scheme demonstrated it was a safe and effective way of evaluating glaucoma referrals in the community and reducing false-positive referrals to HES. The scheme was subsequently extended to include the review and management of patients who needed long term glaucoma care.

6.2.3. Such schemes now have an established safety record and there are other long standing and well reported schemes in Manchester, Bristol. However the majority of citizens in England do not have access to community based schemes to manage their lifelong glaucoma care, unlike in Scotland where there has recently been a nationwide implementation of an optometry led glaucoma service[15].

6.3. **Domiciliary eye care.**

6.3.1. Domiciliary eye care is provided to people who are unable to visit a practice unaccompanied due to a mental, physical or learning disability. For this patient group, many of whom are vulnerable adults, good eye care can have an enormous impact on their independence and wellbeing.

6.3.2. Eligible patients who cannot leave home unaccompanied are entitled to a free sight test in their home. This domiciliary service can be provided both by high street optometrists and specialist mobile service providers. Domiciliary services are an essential part of primary ophthalmic services and a lifeline for many eligible people. However, we believe that many people are unaware that the service exists.

6.3.3. There is a need for improved awareness of its existence and sufficient support to ensure that services remain sustainable. This is vital to:
- optimise vision and quality of life

[13] Foot B, MacEwen C. Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome. Eye (Lond). 2017;31(5):771-775.
[14] Keenan J, Shahid H, Bourne RR, White AJ, Martin KR. Cambridge community Optometry Glaucoma Scheme. Clin Exp Ophthalmol. 2015;43(3):221-227.
[15] PCAO20226-Memorandum.pdf (optometryscotland.org.uk)

- preserve sight for as long as possible, especially for groups who may not be able to report symptoms of sight loss, such as people effected by learning difficulties or dementia.
- reduce the number of falls
- maintain individuals' independence (see section 9 for further details)

6.4. School Vision Services.

6.4.1. Since 2015, local authorities have been responsible for delivering a screening service to detect reduced vision in children at school entry (age 4-5yrs) as part of the government's Healthy Child Programme[16].

6.4.2. Currently school vision screening is available in 94% of local authorities in England[17]. Vision screening allows the detection of reduced vision in one or both eyes at an age when treatment has the potential to improve vision. The target condition is amblyopia, where the vision in one or both eyes does not develop properly. It is estimated that 1 in 50 children will develop this condition, but often younger children are unaware there is anything wrong with their vision, as they have grown up with and become used to it[18].

6.4.3. School vision screening helps identify and refer patients at risk of eye issues to the relevant eye care services in primary and secondary care.

6.5. Special Schools Eyecare.

6.5.1. The College of Optometrists and other sector bodies co-wrote the Framework for provision of eye care in special schools in England[19] which describes a framework whereby all children and young people in special schools in England gain equitable access to regular eye care.

6.5.2. Children with learning disabilities are 28 more times more likely to have a serious eye problem. Over four in ten pupils we have seen had no history of eye tests or eye care, and yet half of the

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[16] https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning#history

[17] Freedom of Information request (FOI), British and Irish Orthoptic Society (BIOS), on behalf of the Clinical Council for Eye Health Commissioning (CCEHC), 2019. Available at: Child Vision Screening - FOI Results Published - British and Irish Orthoptic Society

[18] Freedom of Information request (FOI), BIOS, 2019. Available at: Child Vision Screening - FOI Results Published - British and Irish Orthoptic Society.

[19] Framework available at: Framework-for-Proposed-Special-Schools-Service-Final-ABDO-BIOS-College-of-Optometrists-LOCSU-RcOphth-and-SeeAbility.pdf

children have a problem with their eyes or vision, and at least a third need glasses[20].

6.5.3. At present, there is a pilot service in special schools in some parts of England which aims to ensure that all children are able to access eye care and their eye care needs are met to reduce inequalities. The service is currently under review by NHS England.

6.5.4. SeeAbility have published a survey[21] from the parents of the Special Schools Eye care service users and found that:
- 97% of parents are happy with the NHS-funded eye care service.
- 98% would recommend this service to other parents.
- 98% were happy with the glasses their child had received.
- 93% said they understood more about their child's vision after receiving the service.

6.6. Falls and vision.

6.6.1. Across the UK, falls are the most common cause of hospitalisation for people aged over 65, and of accidental death in those aged over 75[22]. Undetected and untreated visual impairment plays a significant role in the high incidence of falls among older people[23]. Vision is fundamental to coordinating our movement; balance and postural stability are directly affected by vision. In addition, vision is fundamental to adapting gait to enable safe travel through the environment, avoiding obstacles and negotiating steps and stairs.

6.6.2. Optometrists are in a good position to identify people who are at an increased risk of falling due to vision problems and can help to reduce that risk by offering advice on prevention to patients and carers (e.g. signposting them to services for crucial strength and balance exercise training to prevent falls), and colleagues in other medical and care professions. The College of Optometrists

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[20] Donaldson LA, Karas M, O'Brien D, Woodhouse JM (2019) Findings from an opt-in eye examination service in English special schools. Is vision screening effective for this population? PLoS ONE 14(3): e0212733. https://doi.org/10.1371/journal.pone.0212733

[21] SeeAbility, Survey on eye care services in special schools, 2023. Available at: Parents support 'lifechanging' eye care in special schools | SeeAbility.

[22] Lord SR SC, Menz HB, Close J. *Falls in older people: risk factors and strategies for prevention*. 2nd ed. Cambridge: Cambridge University Press; 2007.

Tinetti ME, Speechley M, Ginter SF. *Risk factors for falls among elderly persons living in the community*. N Engl J Med. 1988;319(26):1701-7.

Rubenstein LZ, Josephson KR. *The epidemiology of falls and syncope*. Clin Geriatr Med. 2002;18(2):141-58.

[23] Black A, Wood J. *Vision and falls*. Clin Exp Optom. 2005;88(4):212-22.

Elliott DB. The Glenn A. *Fry award lecture 2013: blurred vision, spectacle correction, and falls in older adults*. Optom Vis Sci. 2014;91(6):593-601.

has published detailed recommendations, endorsed by Age UK, The Royal College of General Practitioners and British Geriatrics Society, about how optometrists can help to prevent their older patients from falling[24].

6.6.3. Other community healthcare professionals, including community nurses (district nurses), social care workers and physiotherapists, also have a role in identifying patients who have fallen and who have poor vision and signposting them to primary eye care services.

6.6.4. Awareness of the links between falls and vision among relevant primary and community care healthcare professionals is fundamental and better integration between all these services should be established:
- Methods of reciprocal referral between optometry and falls services should be explored.
- Vision should be a consideration in all aspects of a patient pathway through falls services – including prevention and rehabilitation programmes.

6.6.5. A vision screening project (VISIBLE) to improve balance and prevent falls has been developed as a simple stepped approach to implement vision screening in community settings[25]. It combines resources for all organisations who are in contact with older adults with the aim of increasing knowledge of the link between vision, balance and falls prevention.

6.7. Prevalence of visual impairment in dementia.

6.7.1. Around 900,000 people are living with dementia in the UK[26]. The risks of visual impairment and dementia both increase with age, and the UK's ageing population will lead to many more people living with both dementia and sight loss. The impact on quality of life of having both sight loss and dementia are much more severe than those resulting from either dementia or sight loss alone[27].

6.7.2. The Government-funded PrOVIDe Prevalence of Visual Impairment in Dementia project, led by The College of Optometrists, found that the prevalence of visual impairment in

[24] The College of Optometrists, *The importance of vision in preventing falls*, 2020. Available at: the-importance-of-vision-in-preventing-falls.pdf (college-optometrists.org)

[25] https://healthinnovationnetwork.com/visible/

[26] Alzheimer's Society 2023 https://www.alzheimers.org.uk/about-us/news-and-media/facts-media

[27] Bowen M, Edgar DF, Hancock B, Haque S, Shah R, Buchanan S, et al. (2016) *The Prevalence of Visual Impairment in People with Dementia (the PrOVIDe study): a cross sectional study of 60-89 year old people with dementia and qualitative exploration of individual, carer and professional perspectives*. Health Serv Deliv Res 2016;4(21).

those with dementia is generally higher than for the overall population, indicating that the lives of many people with dementia could be improved by regular eye examinations and taking appropriate action[28]. Prevalence is up to 2.5 times higher in people with dementia living in residential care homes, suggesting that concurrent dementia and visual impairment may lead to increased need for residential care.

6.7.3. Awareness on how good vision will help people with dementia live better, and possibly slow their decline, should be increased. Meeting the social care and support needs of people living with concurrent sight loss and dementia could be improved. People with dementia and sight loss would benefit from increased joint working, and sharing of skills by different groups of primary and community care practitioners.

7. Possible impacts of the Government's long-term workforce plan for the NHS on primary and community care staffing.

7.1. The College of Optometrists is disappointed that that the Government's long-term workforce plan did not include optometrists and dispensing opticians, despite these two professions being a key part of NHS primary, community and secondary eye care.

7.2. We believe optometrists should be at the heart of patient-centred eye care in the UK, making full use of their skills, being given opportunities to develop new skills, and playing a central role in leading and delivering new models of care to improve patient outcomes.

7.3. As the provision of eye care in the UK is rapidly changing, our Workforce Vision sets out how we will ensure that optometrists remain at the forefront of eye care provision, and continue to be valued and recognised as a key healthcare profession[29].

7.4. Primary and community care optometrists are well-placed to provide enhanced and shared care services closer to home and to reduce the backlog of delayed outpatient appointments through both referral refinement and autonomous management of certain eye conditions, without additional training. Many optometrists also have higher and independent prescribing qualifications that enable them to provide autonomous diagnosis and management of low- and suitable

[28] https://www.college-optometrists.org/category-landing-pages/clinical-topics/research/provide-prevalence-of-visual-impairment-in-dementi

[29] https://www.college-optometrists.org/about/who-we-are/optometry-2030-a-workforce-vision-for-the-uk

medium-risk patients alongside medical colleagues. These skills should be recognised and utilised.

7.5. Primary and community care optometrists should be involved locally in co-developing and leading the workforce planning required for effective care pathways. Where there are common development or training areas across primary and community care pathways e.g. governance, audit, service evaluation, it would make best sense for this training to be made available to all primary care professionals, including optometrists.

8. The impact of recent structural changes to the NHS in England (enacted through the Health and Care Act 2022) on integration between primary and community care services.

8.1. At a time of great challenges and opportunities for the NHS, it is essential to make sure we deliver cost-effective quality care to all patients in England. The College of Optometrists supports the recent structural changes in the NHS in England as they will enable:

- more joined-up working between primary, secondary and community services coming together to collectively plan and deliver services and interventions in the best interest of patients.
- NHS England to make maximum use of the clinical skills of primary and community care health professionals, including optometrists, helping to relieve pressure on hospitals for the benefit of patients.

However, we are disappointed with the lack of lack of representation of the full range of primary and community care professions, including optometrists, at ICB level to inform commissioning decisions.

8.2. We welcome the proposal to move local commissioning of eye care services from Clinical Commissioning Groups (CCGs) to larger statutory ICBs as it will allow better integration between primary and community care.

8.2.1. This will help tackle inequalities and unwarranted variation caused by the small footprints of Clinical Commissioning Groups in the delivery of healthcare.

8.2.2. This should pave the way for more consistent, coordinated eye health services commissioning appropriate to the patients' clinical risk across primary, community and secondary care, making the best use of all available expertise and resources.

8.2.3. It will improve joint working with public health services, giving opportunities for primary care professionals such as optometrists

to provide more joined-up services for patients, or to signpost into other types of community services, such as smoking cessation or weight loss and alcohol services.

8.2.4. It will improve joint working with social care, including mental health services, which are crucial for people experiencing sight loss.

8.3. More optometry-led eye care services should be commissioned, funded and promoted to patients and the public.

8.3.1. Optometrists working in primary care are well-placed to provide routine, enhanced and shared eye care services closer to home, and to reduce the backlog of delayed outpatient appointments, without additional training. With additional higher qualifications, they can offer an even wider range of specialist eye care services and treatments for managing patients with more complex needs, either autonomously or within shared care pathways with secondary care colleagues.

8.3.2. In many parts of the UK, optometrists already play an essential role in taking the pressure off HES, and make a significant contribution to reducing sight loss by:

- Providing first contact care for eye conditions, and routine eye examinations and sight tests.
- Delivering urgent eye care in the community.
- Making full use of their core competences, as well as independent prescribing and higher qualifications, to safely and effectively treat and manage more eye conditions in primary, community and secondary care settings.
- Making use of existing and new technologies to reach patients and deliver joined-up care.
- Reducing the burden on the other strands of primary care (such as GP practices) and reducing pressures on ophthalmology departments within secondary care.
- Maintaining access to quality eye care services for local populations.

8.3.3. In order to improve eye care services and patient outcomes, we believe that health services must utilise the full core skills and competences of all optometrists in all settings. Services must also be commissioned and funded which make full use of the higher and independent prescribing qualifications that many optometrists hold, which in many cases are not being deployed to their full potential.

8.4. Primary care optometrists should be established as first contact practitioners.

8.4.1. The COVID-19 crisis has showcased the role of primary care optometrists as 'first contact' healthcare providers for eye health, and accelerated the role of advanced optometric practice. We have a unique opportunity to build on these achievements to address the backlog, and build a cost-effective, clinically safe and sustainable eye care service for the benefits of patients.

8.4.2. Primary care optometrists as first contact service providers, can help manage the growing demand for eye care in a sustainable way, reducing pressure on the HES and benefiting patients and the wider NHS. Many patients with eye conditions could be appropriately managed within primary care optometry and only referred to the hospital eye service if clinically necessary. This includes patients who are currently on regular follow-up plans within hospital, but who can be transferred be managed within a service closer to home.

8.4.3. The benefits of enhanced primary eye care such as the Minor Eye Conditions Service (MECS) and CUES are recognised[30], but to date these have been locally commissioned, resulting in inconsistency in terms of availability and fragmented services across England. MECS and CUES provides a good example of how optometrists can take on wider clinical roles as first contact providers of eye care services, and relieve pressure on other parts of the NHS. See section 6.1. for further detail.

8.5. There is a lack of representation of all primary and community care professions, including optometrists, at ICBs level to inform commissioning decisions.

8.5.1. It is vital that all primary care providers, including optometrists, are directly involved in the design, delivery and leadership of more integrated services for local populations. ICSs and commissioners should work closely with NHS England's Local Eye Health networks (LEHNs) and Local Optical Committees (LOCs) to facilitate integrated eye care services in primary and community settings.

8.5.2. Eye care has not been integrated into current Primary Care Networks, and so involvement must be actively sought. There cannot be an assumption that representation from a Primary Care Network will effectively represent all pillars of primary care (i.e. that a PCN includes eye care, dentistry and pharmacy).

[30] Konstantakopoulou E, Harper RA, Edgar DF, et al *Clinical safety of a minor eye conditions scheme in England delivered by community optometrists* *BMJ Open Ophthalmology* 2018;**3:**e000125. doi: 10.1136/bmjophth-2017-000125.

8.5.3. We strongly recommend that commissioners include optometrists and other eye care professionals – not just GPs – in the planning of new integrated services, as well as their delivery. Primary care optometrists can help commissioners deliver additional eye healthcare capacity in accessible locations, rather than relying on overstretched hospital eye services – thus supporting the delivery of out of hospital services in local communities, as recommended in the NHS Long Term Plan.

8.5.4. Having primary eye care representation would ensure all patients' needs are heard and understood. It would ensure eye health is connected and related to general health at the point of decision-making and would further develop the opportunities for more integrated and mutually supportive service provision. It would also ensure workforce issues are part of the discussions, and that decision-makers understand which additional or enhanced services eye care professionals can safely deliver to patients, and how the primary and community eye care workforce can increase capacity across systems.

9. Examples of the role of primary and community care in addressing health inequalities and prevention.

9.1. Optometrists carry out over 13 million NHS-funded sight tests in England each year, of which 3.5% are domiciliary (i.e. sight tests carried out at a patient's home if they are unable to attend an optical practice due to physical or mental disability).[31] NHS-funded sight tests are available for a number of different groups of people, including those who are aged 16 or under, or aged 19 and under in full-time education; those aged 60 and over; people registered blind or partially sighted; people with diabetes or glaucoma (or at risk of glaucoma) and people who claim certain benefits[32]. This means that optometrists are able to provide NHS-funded eye care and additional health advice to people who are at greater risk of health inequalities and poor health due to their age, physical or mental health or other wider factors, such as low income.

9.2. When it comes to eye health, prevention is key. Although the risk of developing many eye conditions such as cataracts and age-related macular degeneration (AMD) increases with age, worse eye health is also linked with indicators of inequality such as ethnicity and deprivation[33].

[31] General Ophthalmic Services Activity Statistics England, year ending 31 March 2020 https://digital.nhs.uk/data-and-information/publications/statistical/general-ophthalmic-services-activity-statistics/england-year-ending-31-march-2020

[32] https://www.nhs.uk/nhs-services/opticians/free-nhs-eye-tests-and-optical-vouchers/

[33] Atlas of variation in risk factors and healthcare for vision in England, PHE, 2021

9.3. 50% of moderate to severe vision impairment across Western Europe is preventable[34] and changes in lifestyle can reduce the risk of developing poor eye health and sight loss[35]. The complex links between eye health and the broader public health agenda are strong but overlooked. Sight loss has a significant impact on all aspects of life, and more still needs to be done by the Government and the NHS to reduce preventable sight loss.

9.4. More than two million people in the UK live with sight loss that is severe enough to have a significant impact on their daily lives, such as not being able to drive, find employment and suffer increased social isolation[36]. They also require additional support from community and social services. Up to 22 people per month experience unnecessary and irreversible sight loss because of hospital-initiated appointment delays [37].

9.5. We know that eye health is linked to several public health issues, including smoking, obesity, alcohol use, mental health, and disease prevention. For example:

- Smokers are up to four times more likely than non-smokers to develop age-related macular degeneration (AMD). AMD is a major cause of vision loss and can lead to blindness[38].
- Poor diet, obesity and type 2 diabetes have been identified as heightened risk factors for a range of sight-limiting eye conditions including glaucoma, cataracts, AMD and diabetic retinopathy[34].
- Visual issues can exacerbate co-morbidities with other long-term health conditions, such as dementia[39] and depression[40] (see section 9.12).
- Sight loss can also cause social isolation, increase a person's risk of falling and create a fear of movement, which can in turn increase frailty. Older people with eye diseases are three times more likely than those with good vision to limit activities due to fear of falling[41].

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https://fingertips.phe.org.uk/documents/VisionAtlas_v1.1_20210817.pdf

[34] Bourne RRA, Jonas JB, Bron AM on behalf of the Vision Loss Expert Group of the Global Burden of Disease Study, et al Prevalence and causes of vision loss in high-income countries and in Eastern and Central Europe in 2015: magnitude, temporal trends and projections British Journal of Ophthalmology 2018;102:575-585.

[35] https://www.pocklington-trust.org.uk/supporting-you/about-sight-loss/looking-after-your-sight/

[36] Key statistics about sight loss, RNIB (2021) https://www.rnib.org.uk/documents/1073/Key_stats_about_sight_loss_2021.docx

[37] British Ophthalmological Surveillance Unit (BOSU), *Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome*, 2017. Available at: BOSU report shows patients losing sight to follow-up appointment delays | The Royal College of Ophthalmologists (rcophth.ac.uk)

[38] https://www.macularsociety.org/support/daily-life/practical-guides/healthy-living/smoking/

[39] https://www.scie.org.uk/dementia/living-with-dementia/sensory-loss/sight-loss.asp

[40] https://www.dovepress.com/visual-impairment-and-mental-health-unmet-needs-and-treatment-options-peer-reviewed-fulltext-article-OPTH

[41] https://www.college-optometrists.org/coo/media/media/documents/falls/the-importance-of-vision-in-

9.6. Optometrists play a critical role in primary and preventative healthcare and are in a good position to deliver important public health services to patients attending for regular eye examinations who may not be in regular contact with other healthcare professionals. Optometrists can identify both eye problems and other wider systemic diseases through regular eye examinations, and provide advice, treatment, referral, signposting and support to manage these. For example, as well as identifying eye conditions, eye examinations can identify high blood pressure, high cholesterol and patients that may have diabetes or are pre-diabetic.

9.7. A good case study is the Healthy Living Optical Practice initiative, which started in Dudley. Through the scheme, optometrists and colleagues in primary eye care offer a range of health-related advice, including NHS health checks, smoking cessation services, alcohol screening and weight management. Patients can also receive lifestyle advice and, if necessary, referral into other support services. Initial results from the pilot proved to have a positive effect[42] and the scheme was rolled out in Manchester, Nottinghamshire and Derbyshire.

9.8. A pilot stroke prevention study was set up in East Cheshire, to determine if primary eye care practices could identify patients with undiagnosed atrial fibrillation. Patients aged 60 and over who were already attending for a sight test were screened. Five practices took part and in 12 months 329 patients were screened and 31 patients were referred for further investigation at their GP. The pilot demonstrated that low cost screening in primary eye care reduced the burden on GPs and identified a number of people at risk of stroke, enabling them to seek appropriate treatment and reducing the negative impact a stroke could have on their lives and to the wider health and social care system[43].

9.9. It is vital for the public to understand the importance of eye examinations, which are crucial in detecting early signs of eye disease and signs of other health problems. We would like to see more interventions that encourage people to attend for regular eye examinations with an optometrist as an important healthy lifestyle behaviour, and to prevent worsening eye (and systemic) health.

9.10. Although 17% of the population live in rural areas[44], a workforce survey indicates that only approximately 11% of the optical workforce

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preventing-falls.pdf

[42] Dyoss M and S Asif "HEALTHY LIVING OPTICAL PRACTICE REPORT of a pilot" 2017

[43] https://locsu.co.uk/wp-content/uploads/2021/10/LOCSU-CS-Cheshire-Stroke-Prevention.pdf

[44] Statistical Digest of Rural England, DEFRA, 2022 Edition https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/110

(optometrists and dispensing opticians) work in non-urban areas[45]. This indicates that there is a disparity in the location of primary eye care services in non-urban areas, compared to the size of population that lives there.

9.11. There is also evidence that people living in socio-economically deprived areas face more barriers to accessing primary eye care and regular eye examinations, and therefore present later to hospital eye services[46]. It is important that primary eye care services in non-urban and more deprived areas are commissioned, and local residents supported to access both regular eye examinations and enhanced eye care services, to help prevent sight loss and improve vision and related wider health outcomes.

9.12. **Low vision and mental health.**

9.12.1. Visual issues can exacerbate co-morbidities with other long-term health conditions, such as depression. Sight loss can also cause social isolation[47], increase a person's risk of falling and create a fear of movement, which can then lead to poor muscle growth. This in turn increases frailty which leads to more social isolation - a vicious circle.

9.12.2. A 2015 study[48] found that the prevalence of depressive and anxiety disorders were significantly higher in visually impaired older adults compared to their normally sighted peers, with agoraphobia and social phobia being the most commonly found. In addition, a 2016 study[49] found that three quarters of low vision patients with clinically significant depression were not receiving any treatment. Alarmingly, the prevalence of clinically significant depressive symptoms was found in 43% of those

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0175/07_Statistical_Digest_of_Rural_England_2022_August_edition.pdf

[45] The Optical Workforce Survey, The College of Optometrists et al 2015 https://www.college-optometrists.org/coo/media/media/documents/research/research%20projects/optical-workforce-survey-full-report.pdf

[46] Shickle D, et al. Addressing inequalities in eye health with subsidies and increased fees for General Ophthalmic Services in socio-economically deprived communities: a sensitivity analysis. Public Health. 2015 Feb;129(2):131-7.

[47] Lee SP, Hsu YW, Andrew L, Davis T, Johnson C. Fear of falling avoidance behavior affects the inter-relationship between vision impairment and diminished mobility in community-dwelling older adults. Physiother Theory Pract. 2022 May;38(5):686-694. doi: 10.1080/09593985.2020.1780656. Epub 2020 Jun 16. PMID: 32543314; PMCID: PMC8212668.

[48] Hilde P. A. van der Aa, Hannie C. Comijs, Brenda W. J. H. Penninx, Ger H. M. B. van Rens, Ruth M. A. van Nispen; Major Depressive and Anxiety Disorders in Visually Impaired Older Adults. *Invest. Ophthalmol. Vis. Sci.* 2015;56(2):849-854. doi: https://doi.org/10.1167/iovs.14-15848.

[49] Claire L. Nollett, et al. (2016). High Prevalence of Untreated Depression in Patients Accessing Low-Vision Services. Ophthalmology, Volume 123, Issue 2, 2016, Pages 440-441, ISSN 0161-6420. doi: https://doi.org/10.1016/j.ophtha.2015.07.009

seeking help for sight loss in Britain. This suggests that it is an unrecognised high-risk group.

9.12.3. We would recommend that patients attending low vision services should be screened regularly for depression and signposted to appropriate support.

10. The potential benefits of technology and data sharing in improving patient access and experiences.

10.1. There is an urgent need to improve and streamline the process for the collection and sharing of data within NHS systems. There is currently no shared understanding or consistency of the data that is collected, which metrics are useful and how data is used for performance monitoring, evaluation and research.

10.2. Better quality data across eye care pathways is essential. Commissioners cannot make strategic decisions on eye care or properly understand its importance when they have too little data. This crucial evidence will help commissioners understand local demand for eye care and identify any unmet need. Without high quality data, developing innovative approaches to preventing sight loss will be severely hampered.

10.3. We need to have an accurate understanding of the population's needs in order to plan effective and appropriate eye care services. As a first step, the existing data in the General Ophthalmic Services (GOS) payments systems and hospital clinical systems needs to be collated and used to best inform ICS planning and commissioning. We would then like to see a move towards better quality and more comprehensive data collection at ICS level, which can be used to inform both local and national primary care service provision.

10.4. There is also an urgent need to understand eye care workforce requirements now and in the future, in order to meet patient need and improve outcomes.

10.5. As part of our Workforce Vision[50], the College of Optometrists is working with partners to commission an analysis of current and future population eye care need, and the development of a workforce data model, to fully understand eye care workforce supply and demand.

10.6. A data-driven, multi-professional approach to understanding eye care workforce supply and demand is needed to inform decision-making

[50] https://www.college-optometrists.org/about/who-we-are/optometry-2030-a-workforce-vision-for-the-uk

and interventions relating to workforce planning, investment, training, and deployment. However, there is a lack of up-to-date data on both current population need and granular workforce capacity.

11. Recommendations for key changes to facilitate effective and efficient integration in the delivery of primary and community care services.

11.1. Optometrists as first contact healthcare practitioners.

11.1.1. Commissioners should recognise and utilise the full core skills and competences of primary care optometrists, as well as those with independent prescribing and higher qualifications, to reduce unnecessary referrals to secondary care, and increase capacity to manage low risk patients with long-term eye conditions.

11.1.2. Commissioners should establish primary care optometrists as 'first contact' practitioners for eye health, providing routine, enhanced and shared eye care services closer to home, and managing more eye conditions in primary and community care settings without referral to secondary care.

11.1.3. The current lack of capacity in hospital eye services must be addressed through effective eye care pathways into and out of hospital, ensuring that all available capacity in primary and community care, including those of optometrists and dispensing opticians, is used effectively.

11.1.4. All primary care providers, including optometrists, should be directly involved in the design, delivery and leadership of more integrated services for local populations in every ICS area. Having optometric representation would ensure all patients' needs are considered. It would ensure eye health is effectively included in general health decisions and would improve opportunities for more integrated and mutually supportive service provision.

11.2. Eye care services and prevention.

11.2.1. Primary and community eye care services should be commissioned to provide prevention and healthy living services in communities at highest risk.

11.2.2. Commissioners should ensure that primary and community eye care services are available and accessible across England, particularly ensuring access in non-urban and more deprived areas.

11.3. Digital/IT connectivity.

11.3.1. Digital/IT connectivity is a key enabler to transform eye care service delivery, such as allowing electronic referrals, but a major barrier to achieving this is a lack of IT connectivity provided to primary and community eye care.

11.3.2. Local funding arrangements and timescales for implementation of electronic referral systems should be agreed collaboratively between commissioners, primary, community and secondary care providers, to facilitate coordinated, safe and effective roll-out.

11.3.3. IT systems should support two-way communication and allow image sharing across devices and software.

11.3.4. NHS England, healthcare professionals, manufacturing industry and sector stakeholders should continue to develop and implement digital imaging standards that will enable seamless image sharing between and within primary, community and secondary care settings.

12. Contact details.

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