Written evidence submitted by The College of Optometrists (CBP0037)

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1. The College of Optometrists

1.1 The College of Optometrists is the professional body for optometrists in the UK; representing the interests of our members and the profession to government, policy makers and patients. The College qualifies the profession and delivers the guidance, development and training to ensure optometrists provide the best possible care. We recognise excellence through the College's affixes, by building the evidence base for optometry, and by raising awareness of the profession with the public, commissioners, and health care professionals.

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

1.3 The College is a member of the Clinical Council for Eye Health Commissioning (CCEHC) and holds joint-secretariat of the CCEHC with The Royal College of Ophthalmologists. The CCEHC is an independent advisory body providing evidence-based national clinical leadership, advice and guidance to policy makers in health, social care and public health, and those commissioning and providing eye health services in England.

1.4 The College is directly involved with the work of NHS England/Improvement's National Eye Care Recovery and Transformation (ECRT) Programme in England, contributing to all workstreams.

2. Executive summary

2.1 There are approximately 13,000 optometrists registered in England, and they are a key part of the NHS workforce, playing a vital role in the screening, monitoring and treatment of eye health (and other) conditions. They work across both primary and secondary care, as well as in community and domiciliary settings, and in academia and research. Optometrists provide over 13 million NHS sight tests in primary and domiciliary settings each year.

2.2 Even before the pandemic began, demand for NHS eye care services had exceeded capacity; and a 40% increase in demand for eye services is predicted over the next 20 years.

2.3 During the pandemic, optometrists played an essential role in taking the pressure off hospital eye care services, and made a significant contribution to reducing avoidable sight loss.

2.4 As the UK emerges from the pandemic, it is more important than ever to develop more integrated eye care between all organisations across the hospital eye service, the independent sector, community settings and primary eye care. This must be the key priority in order to address

not only the pre-existing capacity issues in the system, but now also in clearing the additional backlog resulting from the pandemic.

2.5 A focus must be on equitable access for all patients no matter where they live, in a way that is sustainable within the limited resources of the NHS, and making full use of the skilled eye healthcare professional workforce, particularly optometrists.

2.6 From the start of the pandemic the College has worked with partners and stakeholders in the sector - including NHS England/Improvement - to help optometrists adapt their practice to the ever-changing situation, and to ensure the continuation of safe and effective eye care, ensuring the preservation of vision and the prevention of avoidable sight loss.

2.7 Via initiatives such as the COVID-19 Urgent Eyecare Service (CUES), optometrists have already played a key role in supporting hospital ophthalmology and GP primary care teams in reducing existing burden and dealing with the backlog of patients due to the pandemic by:

- safely delivering urgent eye care in the community;
- making use of higher qualifications, skills and competencies to treat and manage eye conditions in the community;
- making use of existing and new technologies to reduce patient–practitioner contact time;
- reducing the burden on the rest of primary care (such as GP practices) and reducing pressures on ophthalmology departments within secondary care;
- maintaining local access to quality eyecare services for local populations.

2.8 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 via College higher qualifications and training. 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.

3. Recommendations

3.1 Eye care services need to incorporate innovative models to improve patient care and outcomes in a way that is sustainable and within the limited resources of the NHS.

3.2 We have an opportunity to build on the existing new clinical pathways and innovations introduced at pace during COVID-19, making full use of the skills and competencies of optometrists in primary and secondary care.

3.3 We need to develop more integrated eye care between all relevant organisations across the hospital eye service, the independent sector, community settings and primary care optometry, through the work of the National Eye Care Recovery and Transformation (NECRT) Programme.

3.4 Direct patient contact should take place with a clinician capable of making appropriate management decisions, and make full use of the eye care workforce. This will require a greater recognition across primary and secondary care of the core capabilities of optometrists - which go beyond performing routine sight tests.

3.5 There should be better utilisation of optometrists with appropriate independent prescribing (IP) and/or other higher qualifications. Optometrists who have completed higher qualifications can work

with a greater degree of autonomy and provide a wider range of care.

3.6 Pathways and services should be integrated at geographies larger than single hospital level, where possible, and long-term improvement plans put in place; with a joint lead optometrist and lead ophthalmologist for the pathways. There should be equity of access to enhanced services developed on the basis of population need, rather than on an historical basis.

3.7 Eye care services need to be appropriately and equitably funded to meet growing patient needs in both the hospital eye service and primary eye care.

3.8 Referral systems should be electronic, and support assessment and improvement of referral quality and activity. Referrals should be supported by a digital system that provides virtual review; and primary care optical practices must have access to appropriate secure NHS electronic referral systems and email.

4. Context

4.1 Optometrists are health professionals who are qualified to examine the eyes to detect defects in vision, signs of injury, ocular diseases or abnormality and problems with general health, such as high blood pressure or diabetes. They make a health assessment, offer clinical advice and treatment recommendations, prescribe spectacles or contact lenses and refer patients for further treatment, when necessary.

In addition they may also treat a range of eye conditions, and can manage and provide care for cataract patients (pre and post treatment) as well as managing conditions such as glaucoma in the community. Some also have further qualifications enabling them to prescribe medicines for eye conditions where appropriate, and provide an advanced level of eye care.

They work across both primary and secondary care, as well as in community and domiciliary settings, and in academia and research.

4.2 All optometrists practising in the UK must be registered with the General Optical Council - there are approximately 13,000 optometrists registered in England, with around 10,000 working in primary care. Many optometrists will divide their clinical practice between primary and secondary care.

4.3 Many optometrists will undertake further qualifications and develop their interests in specialist areas of practice such as independent prescribing. The College offers a range of higher qualification courses, developed and delivered by universities and hospitals, and accredited by The College of Optometrists. These include glaucoma, low vision, medical retina and paediatric eye care. However, due to a lack of appropriately funded and commissioned services, many optometrists are not able to use these additional skills and competencies.

4.4 General Ophthalmic Services (GOS) in England are contracted and funded at a national level. GOS fees are paid by NHS England. Under the current system, Clinical Commissioning Groups (CCGs) are responsible for the planning and commissioning of health care services for their local area. They have control over the allocation of funding for Hospital Eye Services (HES) and for extended primary eye care services. The latter deliver services above and beyond the remit of the basic GOS sight test (e.g. minor eye condition schemes).

4.4.1 With the introduction of Integrated Care Systems in 2022, we have called for enhanced eye care services to be commissioned at integrated care system level, but primary eye care service (GOS) commissioning should remain national and not delegated to ICS bodies. We strongly recommend that commissioners include optometrists and other eye care professionals in the planning of more integrated services.

4.5 The General Ophthalmic Services (GOS) currently commissioned by NHS England provide over 13 million NHS sight tests in primary and domiciliary settings each year. These services are delivered by the majority of primary care optical practices in England, which provides a standardised and equitable eye healthcare offer across the country.

4.6 Harmful delays to the screening, monitoring and treatment of eye health conditions were well recognised before the pandemic. The measures put in place to protect people from acquiring COVID-19, reluctance by patients to attend secondary and primary care appointments, together with reduced resource with Hospital Eye Service (HES) staff being redeployed away from ophthalmology, resulted in *further* capacity reduction and will have undoubtedly led to vision loss that, in normal circumstances, should have been preventable.

4.7 The Royal College of Ophthalmologists (RCOphth) workforce census figures confirm that there are not enough ophthalmologists to safely cope with rising demand.

- Nearly 10% (9 million annually) of all outpatient appointments are for eye clinics;
- 85% of units are dependent on waiting list initiatives and out-of-hours sessions;
- A 40% increase in demand for eye services is predicted over the next 20 years;
- 22 patients per month lose vision from hospital initiated system delays;
- The overall economic burden of sight loss is estimated to be £28 billion in the UK.

4.8 There is an urgent need to address not only the pre-existing backlog of patients, but also the additional backlog due to the pandemic, and the predicted burden on the NHS in the future.

4.9 This needs to be achieved by adopting and accelerating new models of care, utilising the full core skills and competences of optometrists, both in primary and secondary care. Services must also be commissioned and funded which make full use of the higher qualifications that many optometrists hold, which in many cases are not being deployed to their full potential.

5. A collaborative approach to integrated eye care: optometry and ophthalmology working together

5.1 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.

5.2. 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.

Our vision for safe and sustainable eye care is underpinned by four key principles:

1. Reducing the risk of visual loss due to delayed eye care, in an equitable, appropriate and accessible way.
2. Multidisciplinary professionals working collaboratively in primary care, community, and hospital settings to provide care.
3. 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.
4. 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.

6. We need to learn from services developed rapidly during the pandemic

6.1 During the COVID-19 pandemic, hospital ophthalmology departments reduced all routine out-patient and surgical activity, providing services only for high risk patients and emergency care. As a consequence, there was a risk that patients with urgent eye health issues would find it difficult to access care, with potential implications for their sight and long-term eye health.

6.2 In response, NHS England/Improvement (NHSE/I) regional teams worked with commissioners, health systems and primary eye care practices to ensure the availability of appropriate and adequate levels of urgent eye care commissioned and delivered through a contract with local commissioners. This was based on the COVID-19 Urgent Eyecare Service (CUES) – a service framework developed and endorsed by NHSE/I, The College of Optometrists, LOCSU, The Royal College of Ophthalmologists and the Clinical Council for Eye Health Commissioning.

6.3 Through a network of primary eye care practices, and better utilisation of technology, patients were able to gain prompt access to a remote consultation. Patients were able to:

- self-manage their eye condition (with access to appropriate topical medications where appropriate);
- be managed by their optometrist with advice, guidance and remote prescribing as necessary;
- be appropriately referred to hospital ophthalmology services.

6.4 The pandemic has showcased the role of optometrists as 'first contact' healthcare providers for eye health, and accelerated the role of optometrists in providing enhanced eye care within a primary care setting.

7. Developing new models of care is critical to addressing the backlog

7.1 NHS E/I is leading a National Eye Care Recovery and Transformation (NECRT) Programme, which enables and supports all local systems in England to deliver radical transformation of outpatient eye care services across primary, secondary and community care. This work also supports the NHS Long Term Plan which recommends moving more care outside the hospital and back to the community. The College of Optometrists is directly involved with the NECRT programme, contributing to all areas of work.

7.2 The programme aims to reduce face-to-face outpatient attendances and drive the development of innovative, integrated, safe and sustainable ways of working. This is to both reduce the impact of the COVID-19 pandemic on already over-stretched hospital eye services and to better manage the diagnosis and care of increasing numbers of patients with eye conditions in the future.

7.3 New integrated eye care pathways covering cataract, glaucoma and medical retina will be a key part of the NECRT. As part of this, we would like to see more of the case finding, diagnosis and risk-stratified management transferred to primary and community eye care professionals, and shared care and decision-making in place across primary and secondary care.

7.4 As part of the NECRT programme we would like to see an 'Optometry First' scheme established. Optometry First is a first contact provider service commissioning and design principle to help manage growing demand in a sustainable way, reducing pressure on the hospital eye service (HES) and benefiting patients and the wider NHS.

7.5 The fundamental shift at the heart of Optometry First would be that many patients with eye conditions can 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 to a service closer to home.

7.6 If rolled out nationally, Optometry First would help achieve transformation through care closer to home, and the best use of the existing 13,000 optometrists, 5,700 dispensing opticians and their teams in primary care. It would also bring a wider range of services to patients in a coordinated way across communities.

7.7 The Optometry First approach utilises the core competences of optometrists, supported by their practice teams, and higher-qualified primary care and secondary care colleagues where necessary.

7.8 Primary care optometrists are well-placed to provide enhanced and shared eye 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.

7.9 Many optometrists also have higher and independent prescribing qualifications that enable them to provide autonomous diagnosis and management of low- and suitable medium-risk patients alongside secondary care clinicians. These skills should be recognised and utilised.

7.10 The anticipated future pressures on the NHS eye care services are in addition to the immediate pressures due to the backlog from the pandemic. It will be essential that appropriate funding is made available now and in the medium and longer term to ensure that there is adequate investment in training, recruitment and development of optometrists to meet demand.

8. Future workforce requirements

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

8.2 A data-driven, multi-professional approach to understanding eye care workforce supply and demand is needed to inform decision-making 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 (i.e. the prevalence of vision-threatening conditions at a system level in England) and granular workforce capacity.

8.3 The College of Optometrists is developing a vision for the optometry workforce that is fit for the future. We will be working with partners to commission an analysis of current and future population need, and the development of a workforce data model, to achieve a full understanding of the eye care workforce supply and demand across the UK.

8.4 In the meantime, optometrists are ready and well positioned to play a wider role in transforming eye health delivery alongside other health professionals. Realising this potential and therefore the full benefits for patients and for the health and care system, can usefully be achieved by ensuring that optometry is linked into broader workforce transformation agendas.

8.5 With the introduction of Integrated Care Systems in 2022, primary 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 care pathways (e.g. governance, audit, and service evaluation), it would make best sense for this training to be made available to all primary care professionals, including optometrists.

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