

**House of Commons
Public Bill Committee's call for evidence
on the Health and Care Bill**

Written evidence submitted by *The College of Optometrists*

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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. There are approximately 13,000 optometrists registered as health professionals in England with around 10,000 working in primary care. They are a key part of the NHS workforce, playing a vital role in the screening, monitoring and treatment of eye conditions, including cataract (pre and post treatment) and glaucoma. Many

optometrists also have further [higher qualifications](#) enabling them to prescribe medicines for eye conditions where appropriate, and provide an advanced level of eye care. Optometrists provide over 13 million NHS sight tests in primary and domiciliary settings each year.

2. Executive summary and recommendations

- 2.1. The College of Optometrists supports the Government's reform plan for the NHS in England, as it will enable more joined-up working between primary, secondary and community services. The new bill could enable NHS England to make maximum use of the clinical skills of primary care health professionals, including optometrists, helping to relieve pressure on hospitals for the benefit of patients. 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.
- 2.2. **We welcome the proposal to move local commissioning of eye care services from Clinical Commissioning Groups (CCGs) to larger statutory Integrated Care Boards (ICBs).**
 - 2.2.1. This will help tackle the unwarranted variation (postcode lottery) caused by the small footprints of Clinical Commissioning Groups.
 - 2.2.2. That should pave the way for more consistent commissioning of enhanced eye care services delivered by optometrists in primary and secondary care.
- 2.3. **We call on the Public Bill Committee to ensure wider primary care services have a seat on Integrated Care Boards and can feed into commissioning decisions.**
 - 2.3.1. As it stands, the Bill only requires that each ICB includes a member nominated by General Practice, with no insight from any of the other primary health care professions (such as optometrists, pharmacists and dentists). Optometrists and other specialist primary care providers are vital to population health and care, and need an equal voice at all levels of the NHS in England.
- 2.4. **We call on the Public Bill Committee to maintain public scrutiny of government actions.**
 - 2.4.1. We remain concerned by the Secretary of State's new powers of control over the daily running of the NHS, and the possibility of abolishing a regulator or deregulating a profession without an Act of Parliament. This change will remove public scrutiny of government actions. Such greater central intervention might also undermine the Bill's focus on giving power to local leaders to improve population health.
 - 2.4.2. We do not support this proposal as it would mean very limited parliamentary scrutiny of matters of significant public interest. Healthcare regulators exist to uphold professional standards and therefore directly impact patient care.
 - 2.4.3. Parliament should maintain its role to properly examine any proposals to abolish a regulator or deregulate a profession, otherwise the Bill could jeopardise public confidence in the NHS and in healthcare professions.
- 2.5. **The new Bill should maintain and support the progress and achievements of the National Eye Care Recovery and Transformation (NECRT) Programme led by NHS England / NHS Improvement.**

- 2.5.1. Developing new models of care is critical 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.
- 2.5.2. 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 consistently commissioned and appropriately funded.
- 2.5.3. The NECRT Programme will enable and support 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. New integrated eye care pathways covering cataract, glaucoma and medical retina will be a key part of the NECRT.
- 2.5.4. We call on the Public Bill Committee to ensure the progress and achievements of the NECRT are maintained and consistently implemented by the new Integrated Care Boards.

3. We welcome the proposal to replace Clinical Commissioning Groups (CCGs) with larger statutory Integrated Care Boards (ICBs).

- 3.1. The College of Optometrists supports a model that would allow more collaboration, integration and partnerships across traditional boundaries, with organisations, groups and individuals coming together to collectively plan and deliver services and interventions in the best interest of patients. The proposal to move to ICBs covering larger areas, with CCG functions being folded into ICBs, is going to the right direction.
- 3.2. The strengths of the proposals, in relation to eye care, is in their aim to integrate health and social care providers. This should enable providers to manage patient care more collectively and efficiently. We expect this will address inequalities and unwarranted variation in the delivery of healthcare. 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 services, such as smoking cessation or weight loss and alcohol services. It will also improve joint working with social care, including mental health services, which are crucial for people experiencing sight loss.
- 3.3. Commissioning at ICB level covering larger geographical areas would enable the provision of consistent, coordinated eye health services appropriate to the patients' clinical risk across primary and secondary care, making the best use of all available expertise and resources.
- 3.4. The benefits of enhanced primary eye care such as the [Minor Eye Conditions Service \(MECS\)](#) and most recently the [COVID-19 Urgent Eyecare Services \(CUES\)](#) are recognised, but to date these have been locally commissioned by CCGs, resulting in inconsistency in terms of availability and fragmented services across England. CUES provides a recent example of how optometrists can take on wider clinical roles and relieve pressure on other parts of the NHS. The delays in commissioning this new service in some parts of England, because of fragmented commissioning at CCG level,

have further demonstrated the need for extended eye care services to be commissioned across a wider footprint.

- 3.5. This will also support the ongoing work under the [National Outpatient Transformation Programme](#) to move more eye healthcare into the community in line with the [NHS Long Term Plan](#). We have provided more details about this initiative in section 7 below.
- 3.6. However, the Bill lacks detail on governance, process and accountability. The ICS model should provide greater transparency by establishing the basis for the responsibilities of ICSs, including clear and consistent processes for governance, and reporting on service implementation, quality and outcomes, at all levels. Having these processes in place across all ICSs would allow clearer responsibility for regular scrutiny and review of the impact of health services (and their related budgets).
- 3.7. ICSs cover large geographical areas so it is important to give them the right statutory basis to effectively design and deliver services that meet the needs of their local populations. While the ICS approach builds on existing local areas and relationships, there is uncertainty around what the final structures will be, and a localised approach may create unwarranted variation across the country. We believe that appropriate legislative changes that incorporate the required operating, governance and decision-making arrangements will help strike a balance between providing sufficient clarity on the core functions and responsibilities of ICSs while enabling flexibility to adapt to local needs.

4. The Health and Care Bill must give all primary care professions, including optometrists, equal opportunity to inform commissioning decisions

- 4.1. Currently, the Health and Care Bill requires ICBs to have a number of 'ordinary members' including representatives from local NHS trusts, local authorities and a member nominated by general practice. These requirements leave no space for insight from primary health care professions, such as optometrists, pharmacists and dentists, beyond general practice.
- 4.2. It is reasonable that ICSs should have the flexibility to shape their governance to meet local needs. However, we think it is vital that ICS membership should always give a voice to the full range of primary care professionals, including optometrists. This is because the care that primary care optometrists provide is and will be a core part of NHS service provision in every ICS area. There should be minimum national standards to ensure this representation for primary care, with additional local flexibility to allow systems to fine-tune their governance arrangements.
- 4.3. Having optometric 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 what eye care professionals can safely deliver to patients, and how the primary eye care workforce can increase capacity across systems.
- 4.4. Primary care optometrists should be involved in place-based initiatives from the start, to avoid missed opportunities and the difficulties that affect Clinical Commissioning Groups.

- 4.5. The crucial contribution of non-medical primary care professionals for the benefit of patients and the NHS must be recognised and reflected within Integrated Care Boards. As the Bill progresses through Parliament, we are calling for an amendment which would include an extra ICB member nominated by clinicians providing non-medical NHS primary care services, such as primary care optometrists. This must be supported by fully integrated Primary Care Networks that effectively involve and represent all primary care specialities.
- 4.6. It is essential that wider primary care can input at a strategic level in order to create real transformation, reduce pressure on the secondary care, and deliver robust and sustainable care for all.

5. We remain concerned by the Secretary of State's new powers of control over the daily running of the NHS, and the possibility of abolishing a regulator without an Act of Parliament.

- 5.1. The Bill gives wide ranging new powers to the Secretary of State for Health (SoS), with unclear consequences for the NHS, for regulators and for patients.
- 5.2. These new powers strengthen the SoS's control over the daily running of the NHS in relation to almost all its functions. They also include powers to intervene at any stage in service reconfigurations, such as decisions about merging or closing hospitals. Such greater central intervention might undermine the Bill's focus on giving power to local leaders to improve population health.
- 5.3. The SoS also gains the power to abolish a regulator or deregulate a profession through an Order in Council instead of going through an Act of Parliament, as it is currently the case. We do not support this proposal, as it would mean very limited parliamentary scrutiny of matters of significant public interest. Healthcare regulators exist to uphold professional standards and therefore directly impact patient care. Parliament should maintain its role to properly examine any proposals to abolish a regulator or deregulate a profession.
- 5.4. Public scrutiny of government actions needs to be maintained, otherwise the Bill could jeopardise public confidence in the NHS.

6. The new Bill should maintain and support the progress of the National Eye Care Recovery and Transformation Programme

- 6.1. NHS England / NHS Improvement 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. The objectives of the NECRT programme are to develop highly efficient eye care pathways to join up whole-system services and offer better outcomes for patients. Ultimately, it aims to reduce the number of people losing their sight while on an outpatient waiting list, by establishing integrated eye care pathways across primary, community and secondary eye care, supported by digital systems.
- 6.2. This programme 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 in the NECRT programme, contributing to all areas of work.

- 6.3. The programme aims to 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.
- 6.4. New integrated eye care pathways covering cataract, glaucoma and medical retina will be a key part of the NECRT. As part of this, we are supporting NHS England to develop an 'Optometry First' scheme. Optometry First is a first contact provider service to help manage the growing demand for eye care in a sustainable way, reducing pressure on the hospital eye service (HES) and benefiting patients and the wider NHS.
- 6.5. 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.
- 6.6. 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.
- 6.7. 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.
- 6.8. 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.
- 6.9. 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.
- 6.10. 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.
- 6.11. The new Bill should maintain and support the progress of this National Eye Care Recovery and Transformation Programme. While we welcome this Government's proposal, it is not clear whether this could be achieved without another wholesale NHS structural reorganisation, which would distract commissioners, managers and health professionals from achieving these much-needed improvements.

7. Further information

- 7.1. For further information on this submission, please contact Dr Olivier Denève, Head of Policy & Public Affairs, The College of Optometrists: olivier.deneve@college-optometrists.org