



THE COLLEGE OF OPTOMETRISTS

House of Commons Public Bill Committee Call for evidence on the Health Bill

Written evidence submitted by *The College of Optometrists*

22 June 2026

1. The College of Optometrists

- 1.1. The [College of Optometrists](#) is the professional body for optometry in the UK. It 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. We represent over 19,000 optometrists, trainees and students across primary and secondary care, education, research, and academia.
- 1.2. There are almost 15,000 optometrists registered as health professionals in England, 80% of whom work in primary eye care settings¹. Optometrists are a core pillar of NHS primary care, acting as the “front door” of the NHS² for most patients with eye concerns. 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. Through a network of 7,000 local practices in England, optometrists provide over 13 million NHS-funded sight tests in primary and domiciliary settings each year and increasingly deliver urgent eye care, glaucoma monitoring, medical retina services and shared-care pathways³.

2. Executive summary and recommendations

- 2.1. The College of Optometrists welcomes the opportunity to provide evidence on the Health Bill. We welcome the overall direction of the Bill, particularly its ambition to strengthen integrated care, improve data sharing through a single patient record and support the shift of appropriate services from hospital settings into the community.
- 2.2. The Health Bill introduces significant changes to the governance, accountability and commissioning structures of the NHS in England. These reforms create opportunities to support greater integration and local delivery of care. However, the transition must be carefully managed to avoid disruption to existing services and to ensure that patients continue to benefit from safe, accessible and high-quality care.
- 2.3. We have [consistently advocated for greater use of community-based eye care services](#) to improve patient access, reduce pressure on hospital eye services and make better use of the clinical skills of the NHS optometric workforce. Optometrists are highly trained healthcare professionals who are well placed to contribute to these objectives through providing earlier diagnosis, management of long-term eye conditions such as

¹ <https://optical.org/static/0dd3bdca-cac3-4531-bc03c1a82e147c21/GOC-Registrant-Workforce-and-Perceptions-Survey-2025-Research-Report-final-2608.pdf>

² <https://www.england.nhs.uk/get-involved/get-involved/how/primarycare/>

³ <https://www.nhsbsa.nhs.uk/ophthalmic-data/general-ophthalmic-services-gos-activity-data>

glaucoma, urgent eye care services and the prevention of avoidable sight loss. We hope that this legislation will recognise the value of optometrists in delivering timely and effective eye care in line with the three key shifts in the 10 Year Health Plan.

- 2.4. The College's submission focuses on areas of the Bill that are particularly relevant to the delivery of eye care services.
- 2.5. The new Bill should enable the NHS to make maximum use of the full clinical skills of primary care health professionals, including optometrists, helping to relieve pressure on hospitals for the benefit of patients.
- 2.6. Hospital eye services continue to face significant capacity pressures, with growing demand and long waiting times:
 - Eye care accounts for nearly 9% of all outpatient appointments in England⁴
 - Demand is rising faster than hospital capacity^{5,6}
Ocular emergencies constitute 1-6% of A&E attendances⁷, with up to 70% manageable in primary care^{8,9}
- 2.7. 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.

3. Ophthalmic Services – Schedule 1 – Clauses 26-29

- 3.1. The College of Optometrists recognises the Government's intention to simplify NHS structures and create clearer lines of accountability by bringing NHS England's functions into the Department of Health and Social Care. While there may be benefits from reducing organisational duplication and strengthening ministerial accountability, the success of these reforms will depend on maintaining continuity and avoiding disruption during implementation.

⁴ <https://www.college-optometrists.org/category-landing-pages/models-of-eye-care/urgent-emergency-eye-care-services-england-review>

⁵ Rawlings, A., Hobby, A. E., Ryan, B., Carson-Stevens, A., North, R., Smith, M., ... & Acton, J. H. (2024). The burden of acute eye conditions on different healthcare providers: a retrospective population-based study. *British Journal of General Practice*, 74(741), e264-e274.

⁶ Foot, B., & MacEwen, C. (2017). Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome. *Eye*, 31(5), 771-775.

⁷ Royal College of Ophthalmologists. <https://www.rcophth.ac.uk/wp-content/uploads/2021/01/Emergency-eye-care-in-hospital-eye-units-and-secondary-care-Copy.pdf>

⁸ Rehan, S. M., Morris, D. S., Pedlar, L., Sheen, N., & Shirodkar, A. L. (2020). Ophthalmic emergencies presenting to the emergency department at the University Hospital of Wales, Cardiff, UK. *Clinical and Experimental Optometry*, 103(6), 895-901.

⁹ Hau, S., Ioannidis, A., Masaoutis, P., & Verma, S. (2008). Patterns of ophthalmological complaints presenting to a dedicated ophthalmic Accident & Emergency department: inappropriate use and patients' perspective. *Emergency Medicine Journal*, 25(11), 740-744.

- 3.2. Schedule 1 – Clause 28 amends the NHS Act 2006 to include duties for Integrated Care Boards (ICBs) to arrange primary ophthalmic services including securing provision of the national sight-testing service.
- 3.3. The current national sight testing service is one of the NHS's most effective preventative services, delivering more than 13 million NHS-funded sight tests each year¹⁰ through a network of 7,000 community-based practices. These services play a vital role in supporting early diagnosis, prevention and population health by identifying sight-threatening conditions such as glaucoma, age-related macular degeneration and diabetic eye disease, as well as wider health conditions including diabetes, hypertension and, on occasion, neurological disease.
- 3.4. The College welcomes the written reassurances from the Department of Health and Social Care and the Minister of State for Care in Parliament that, although responsibility will formally rest with ICBs as a result of the abolition of NHS England, NHS sight testing services will continue to operate within a national regulatory and contractual framework, with contract terms set in regulations and fees set nationally through Directions and that the Bill will not affect patient eligibility for NHS sight tests. This should provide great reassurance to the public.
- 3.5. Community optometry services have demonstrated their ability to safely manage increasing numbers of patients outside hospital settings through urgent eye care services¹¹, glaucoma pathways¹², medical retina services, post-operative care and other shared-care models.
- 3.6. The Public Bill Committee may therefore wish to seek assurance that patient eligibility for NHS sight testing services will remain unchanged. We have included specific amendments in 3.7.
- 3.7. Suggested amendments:
- 3.7.1. New amendment – under Clause 28 – insert “The Secretary of State must ensure that access to sight tests under the GOS arrangement is protected and not subject to variations by locality”.
- 3.7.2. Accept amendment NC32 – extending patient choice to non-consultant-led community services including optometry-led low risk glaucoma management and Community Urgent Eyecare Services (CUES or MECS). This is vital to do: as more care is shifted from hospital into the community, the ability for patients to choose how their care is delivered must follow.
- 3.8. **The Public Bill Committee may wish to explore ways in which the Bill can ensure:**

¹⁰ General Ophthalmic Services Activity Statistics England, year ending 31 March 2023.

<https://www.nhsbsa.nhs.uk/ophthalmic-data/general-ophthalmic-services-gos-activity-data>

¹¹ <https://www.college-optometrists.org/category-landing-pages/models-of-eye-care/urgent-emergency-eye-care-services-england-review>

¹² <https://www.college-optometrists.org/category-landing-pages/clinical-topics/glaucoma/safety-and-effectiveness-of-glaucoma-services>

- existing primary eye care commissioning arrangements will remain stable throughout the transition;
- effective enhanced community eye care pathways will be expanded consistently across England where evidence demonstrates improvements in access, outcomes and efficiency; and
- specialist expertise relating to eye care commissioning, workforce development and service transformation currently held within NHS England will be retained.

4. Changes to the statutory duties and role of Integrated Care Boards

- 4.1. The College of Optometrists has consistently supported the principles underpinning Integrated Care Systems (ICSs) and believes they have an important role in improving population health, reducing health inequalities and delivering more integrated care.
- 4.2. Primary eye care aligns closely with these objectives. Community optometry services improve access to care, support earlier diagnosis, reduce avoidable sight loss and help deliver care closer to home.
- 4.3. Evidence from enhanced primary eye care services such as Community Urgent Eyecare Services (CUES), Minor Eye Conditions Services (MECS) and other optometry-led pathways demonstrates that effective collaboration between commissioners, hospital eye services and community optometrists can improve patient outcomes while reducing pressure on secondary care^{10,11}.
- 4.4. The transfer of primary care commissioning responsibilities from NHS England to ICBs largely formalises arrangements that already operate through delegation. However, substantial variation remains in the commissioning and availability of enhanced eye care services across England, resulting in unequal access to care for patients.
- 4.5. The College also believes that further action is required to reduce unwarranted geographical variation in access to community enhanced eye care services, ensuring that patients can access high-quality eye care services regardless of where they live.
- 4.6. The College supports greater local integration but is concerned that changes to ICB governance arrangements will reduce opportunities for engagement with primary care professionals or weaken local clinical leadership. Successful community eye care pathways have often emerged through collaboration between local commissioners, hospital eye services and community optometrists, and future governance arrangements should preserve this flexibility and innovation.
- 4.7. The College believes that neighbourhood health services will only succeed if all parts of primary care are fully integrated into local planning and service delivery. Optometry should therefore be recognised as a core component of neighbourhood health services and fully incorporated into workforce planning, prevention strategies, population health initiatives and integrated care pathway development.
- 4.8. The Committee may wish to seek assurance that optometry will be recognised as a core component of neighbourhood health services and integrated care pathways. We have included specific amendments in 4.9.
- 4.9. Suggested amendments:

- 4.9.1. New amendment – under Clause 21 Membership of integrated health boards – Insert a section that ICBs include members of the community primary care sector including optometry.
- 4.9.2. New amendment – under Clause 7 Education and training – Insert “Workforce planning must take into consideration the requirements of primary eye care, including community optometry and enhanced primary eye care services”.

5. Creation of a Single Patient Record

- 5.1. The College of Optometrists strongly supports the Government's ambition to improve information sharing across health and care services and welcomes the proposed development of a Single Patient Record. This is a landmark development which holds the potential to support safer, joined-up care by ensuring access to the right information at the right time.
- 5.2. Effective digital connectivity is essential to delivering the Government's objectives of prevention, integrated care and care closer to home. However, a lack of interoperability remains one of the most significant barriers to integrated eye care. Optometrists frequently experience difficulties accessing and sharing information with general practice, hospital eye services and other healthcare providers. In many areas, primary eye care providers remain excluded from core NHS digital infrastructure, shared care records and interoperable referral systems.
- 5.3. These barriers create inefficiencies, duplication and delays in patient care. They can result in unnecessary referrals, repeat testing, reduced opportunities for shared care, delays in diagnosis and treatment, and increased administrative burden for clinicians.
- 5.4. The College has long supported national efforts to improve interoperability, including the development of national shared data standards, electronic referral systems and imaging standards that enable clinical information to be exchanged safely and effectively across care settings. Improved digital connectivity is a critical enabler of eye care transformation and is essential to making best use of the primary eye care workforce.
- 5.5. To realise these benefits, primary eye care providers must be fully integrated into the design, implementation and governance of the programme from the outset.
- 5.6. The College recommends that:
- Optometrists, as regulated healthcare professionals, are granted appropriate access to relevant patient information;
 - optometry clinical systems are fully interoperable with NHS digital infrastructure and the Single Patient Record;
 - national standards are adopted for electronic records, referrals and diagnostic imaging to enable seamless information sharing across care settings;
 - primary eye care providers are represented within governance and implementation arrangements;
 - robust safeguards protect patient confidentiality, data security and public trust;
 - patients are provided with clear information about how their data are used, including for research and service improvement; and
 - adequate investment is provided for digital infrastructure, workforce training and implementation across all care settings, including primary eye care.

- 5.7. Digital transformation should support clinical care and reduce administrative burden rather than create additional complexity for healthcare professionals. The College believes that digital inclusion of primary eye care should be regarded as an essential part of NHS infrastructure and a prerequisite for delivering integrated neighbourhood health services.
- 5.8. Suggested Amendment:
- 5.8.1. Schedule 1, Clause 47 Single Patient Record – Subsection (7) include:
“optometry”. Include optometrists and all forms of provider of primary ophthalmic service providers.
- 5.8.1.1. “primary care” includes primary eye care providers and all forms of providers who provide care in the community.
- 5.9. Subject to the provision of sufficient funding, implementation support and appropriate sector consultation, and recognising that these requirements should not create additional unfunded burdens for primary eye care providers and practice owners, the **Committee may wish to seek that the Bill ensures:**
- optometrists will have appropriate access to relevant patient information through the Single Patient Record and associated NHS digital systems;
 - optometry systems will be fully interoperable with wider NHS records, referral systems and shared care platforms;
 - primary eye care providers will be represented in the design, implementation and governance of the Single Patient Record;
 - national standards for digital records, referrals and ophthalmic imaging will support consistent information sharing across organisational boundaries;
 - universal digital connectivity across primary eye care will be implemented; and
 - robust governance arrangements will protect patient confidentiality, maintain public confidence and provide transparency regarding secondary uses of health data.

6. Further information

- 6.1. 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