Please find below a joint response to the Public health workforce consultation submitted jointly by The College of Optometrists, the Optical Confederation and the Local Optical Committee Support Unit.

It is signed by:

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Annex B: Consultation questions and responses

Question 1 (Para 1.7): Do you agree that a public health workforce strategy should be reviewed regularly? If so, should this be every three years or every five years?

No response.

Question 2 (Para 2.5): Are these four groups a useful way of describing the public health workforces?

Yes. We would see most optometrists fitting in to the third category, 'practitioners with some public health component to their work' due the central role regular sight tests play in preventing and early detection of eye disease as well as other conditions such as diabetes. We would like to see community optometrists listed on the table beside community pharmacists, dentists and GPs. As optometrists carry out 17.5 million sight tests a year in England[1], there is the potential for optometrists and dispensing opticians to do more to make 'every contact count' by expanding their role in health promotion, for example smoking cessation which is a major risk factor in age-related macular degeneration, the biggest cause of blindness in the UK.

In addition, we would very much like to see optometrists and dispensing opticians undertaking public health training with a view to taking up public health consultant and specialist positions. This would strengthen the understanding of ophthalmic public health across the board. See question five, below.

Question 3 (Para 2.12): Do you agree that methods of enumeration of the public health consultant and practitioner workforces should be scoped and piloted at a national level? Or do you think that workforce planning can take place effectively at a more local level eg LETBs working with local partners?

No response.

Question 4 (Para 3.7): Would these values, combined with the features of public health in Box 2, serve to bind together dispersed public health workforces?

We feel these values and features of public health are appropriate and underpin the central importance of the public health outcomes framework as the single set of shared objectives that should drive public health across the country.

Question 5 (Para 3.14): What further actions would enhance recruitment and retention of truly representative public health workforces?

[1] Optical Confederation (2011) Optics at a glance. Available from http://www.fodo.com/downloads/Optics-at-a-glance_Dec2011_web.pdf

We would support some effort to monitor the extent to which the diversity of the public health workforce reflects the populations it serves. Within ophthalmic public health, there are health inequalities especially in relation to certain ethnic groups and lower socio-economic groups, both of which are more likely to have problems with their eyes but less likely to access treatment. The biggest barrier to a "truly representative" workforce of course is that most professionals in eye health will always be considerably younger than their patients.

To encourage optometrists and dispensing opticians to train for public health specialists and consultant positions, we would very much welcome a public health career path for specialists of all clinical backgrounds, setting out the training routes and career options, including research roles.

Question 6 (Para 3.25): Are there workforce challenges and opportunities we have not identified? What support could be put in place to help meet these challenges?

We would like to add further detail to the challenges of the aging population and rising prevalence of long term conditions. Furthermore, tackling health inequalities should be added as a major challenge. We believe that successfully embedding the public health outcomes framework in to the work of all public health commissioners offers the best hope of tackling these challenges.

The aging population is of huge significance in ophthalmic public health as the main eye conditions are strongly associated with aging. For example, 2.5% of over 50s in the UK have late stage age-related macular degeneration, rising to 4.8 in over 65s and 12.4 in those over 80[2]. The prevalence of open angle glaucoma increases from 0.3% in people aged 40 to 3.3% in people aged 70 years[3]. There are two million people with sight loss in the UK and, without action, that figure is set to rise by 22% by 2020 and double to approximately 4 million people by the year 2050.

Early detection from regular sight tests and efficient treatment are the keys to avoiding what are what worrying projections for health and social care budgets. The programme budget for eye care is £2.17bn and set to expand rapidly. The 12 million NHS sight tests are the gateway to 6 million outpatient appointments a year. The economic cost to the UK of sight loss has been estimated at £22bn a year. Sight loss also impacts on other public health challenges, for example older patients with sight loss are at much greater risks of from falls and depression.

Looking specifically at long term conditions, AMD, glaucoma and diabetic retinopathy are the main causes of sight loss and challenging long term conditions. The direct healthcare costs per 100,000 of the population for AMD is around £514,000, and £439,000 for glaucoma. AMD alone accounts for 3.2% (£129m) of NHS drugs bill and there are 40,000 new cases a year[4]. Around half a million people are currently affected

[2] Owen et al (2012) The estimated prevalence and incidence of late stage age related macular degeneration in the UK, Br J Ophthalmol. 2012 May; 96(5): 752–756.

[3] Burr JM, Mowatt G, Hernández R, Siddiqui MAR, Cook J, Lourenco T, et al. *The clinical effectiveness and cost-effectiveness of screening for open angle glaucoma: a systematic review and economic evaluation*. Health Technol Assess 2007;11(41).

[4] Owen et al (2012) The estimated prevalence and incidence of late stage age related macular degeneration in the UK, Br J Ophthalmol. 2012 May; 96(5): 752–756.

by chronic open angle glaucoma in England, around 70% of whom are undetected[5] but there are around 300,000 first outpatient attendances for glaucoma in the Hospital Eye Service every year[6].

Recommendation
Tackling health inequalities should be seen as a major public health challenge. As noted above, older people are far more likely to suffer poor eye health and certain ethnic groups and lower socio-economic groups are at higher risk from eye conditions. Furthermore, children and adults with learning difficulties are ten times more likely to have eye problems[7] and much less likely to receive treatment[8].

We believe focusing on the outcomes in the public health outcomes framework offers the best chance of meeting public health challenges presented by an aging population, long term conditions and health inequalities. Support should be targeted on helping commissioners, health and well being boards and the public health workforce improve performance against the public health outcomes framework.

Within eye care, that means focusing on preventable sight loss:

- ensuring the National Screening Committee policies on children's visual screening and diabetic retinopathy are implemented universally;
- ensuring joint strategic needs assessments include plans to reduce preventable sight loss; and
- tackling health inequalities by commissioning specific services for the most vulnerable groups, for example, the community eye care pathway for adults and young people with learning difficulties produced by LOCSU in partnership with Mind and Mencap[9].

Question 7 (Para 4.7): How can local people be encouraged to develop their skills for public health in the new system?

No response

Question 8 (Para 4.11): How can the public health element of GP training and continued professional development be enhanced?

No response

Question 9 (Para 4.18): Would it be helpful to describe the potential career pathways open to public health practitioner workforces?

We would welcome more information about how the career options could be open to experts in ophthalmic public health.

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[5] Burr JM, Mowatt G, Hernández R, Siddiqui MAR, Cook J, Lourenco T, et al. *The clinical effectiveness and cost-effectiveness of screening for open angle glaucoma: a systematic review and economic evaluation*. Health Technol Assess 2007;11(41).

[6] NICE. Services for people at risk of developing glaucoma. Available from http://publications.nice.org.uk/services-for-people-at-risk-of-developing-glaucoma-cmg44/1-commissioning-services-for-people-at-risk-of-developing-glaucoma

[7] Emerson, E. & Robertson, R. (2011) *The estimated prevalence of visual impairment among people with learning disabilities in the UK*. RNIB and SeeAbility Learning Disabilities Observatory.

[8] Kerr, A.M (2003) Medical needs of people with intellectual disability require regular reassessment, and the provision of client- and carer-held reports, *Journal of Intellectual Disability Research*, p134-145, February 2003.

[9] http://www.locsu.co.uk/communications/news/?article=39

Question 10 (Para 5.14): What benefits would multi-disciplinary training bring to the public health workforces?

No response

Question 11 (Para 5.24): How can LETBs best support flexible careers to build extended capacity in public health?

No response

Question 12 (Para 5.25): Is the healthcare Education Outcomes Framework appropriate for public health education and training? If not, how could it be adapted?

No response

Question 13 (Para 5.31: How can flexible careers for public health specialists best be achieved?

No response

Question 14 (Para 5.38): What actions would support the development of strong leadership for public health?

To develop strong leadership, it is vital that organisations and individual practitioners can access the clinical expertise they need to solve the problems they face. We would urge commissioners and leaders shaping ophthalmic public health services at national and local level to take advantage of our shared expertise in eye health. We would be delighted to explore with you how we this could work in practice and how we work together to make a real difference to the country's eye health.

Question 15 (Para 5.43): What actions can be taken, and by whom, to attract high-quality graduates into academic public health?

No response.

Question 16 (Para 5.50): Are these the right actions to develop and strengthen the public health information and intelligence function? Who should be responsible for delivering these actions?

The NHS currently collects a vast amount of data on eye health, which could be used to inform needs assessments and improve care, but far too much is wasted. As part of our Optical sector strategy to improve ophthalmic public health[10], we are undertaking a critical evaluation of ophthalmic data to highlight areas for improvement. We also recently launched an NHS network for ophthalmic public health to share intelligence. Again we would be delighted to work with you to explore how ophthalmic public health data and intelligence could be improved.

Question 17 (para 6.3): Do you have any evidence or information that would help analyse the impact of these proposals?

No response

[10] College of Optometrists (2011) An optical sector strategy to improve ophthalmic public health, available from http://www.college-optometrists.org/en/knowledge-centre/PublicAffairs/optical-sector-strategical-documents.cfm