London Assembly Health Committee review into eye health and preventing sight loss in London: Optical Confederation and Local Optical Committee Support Unit response

Optical Confederation and Local Optical Committee Support Unit

The Optical Confederation represents the thirteen thousand optometrists, six thousand dispensing opticians, seven thousand optical businesses and forty-five thousand ancillary staff in the UK, who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of the five optical representative bodies: the Association of British Dispensing Opticians (ABDO), the Association of Contact Lens Manufacturers (ACLM), the Association of Optometrists (AOP), the Federation of Manufacturing Opticians (FMO) and the Federation of Opticians (FODO). As a Confederation, we work with others to improve eye health for the public good.

The Local Optical Committee Support Unit (LOCSU) provides quality, practical support to local optical committees (LOCs) in England to help them to develop, negotiate and implement local objectives in respect of primary ophthalmic services.

1. Why should eye health be a priority for London?

Eye health should be a priority for four main reasons:

- because poor vision and poor eye health can have a severe impact on people's wellbeing
- to address inequality—poor eye health disproportionately affects vulnerable and disadvantaged individuals

- to improve London's economic performance
- because many of the potential means to effectively promote and address eye health have the added benefit of also addressing the pressures on GPs and hospitals, both in A&E and capacity problems in the Hospital Eye Service (HES) itself.

Firstly, wellbeing: adults are more afraid of losing their sight than they are of developing serious conditions such as Alzheimer's, Parkinson's, or heart disease, or of having to use a wheelchair.[1] Prioritising eye health outcomes can reduce the incidence of sight loss: over thirty per cent of sight loss can be avoided through early identification of sight-threatening pathologies and even more through correcting refractive error.[2] What is good for eye health is good for general health, including eating a balanced diet and avoiding smoking and excessive alcohol consumption.

Secondly, addressing inequality: prioritisation of eye health across the capital is required to ensure equitable treatment outcomes. London is a world city of unparalleled diversity but with major contrasts of wealth and opportunity and health outcomes. Nine London boroughs are in the UK's five per cent most deprived local authority areas, while forty per cent of the capital's population are from non-white backgrounds.[3] The Mayor's strategy to promote the reduction of health inequalities among Londoners must take into account the impact that socio-economic deprivation has on people not attending vital eye examinations and presenting late

[1] 'Blindness feared more than Alzheimer's, Parkinson's and heart disease,' RNIB. 2014. http://www.rnib.org.uk/blindness-feared-more-alzheimer%E2%80%99s-parkinson%E2%80%99s-and-heart-disease.

[2] 'Future of Sight Loss UK (1): The economic impact of partial sight and blindness in the UK adult population,' Access Economics (RNIB). 2009. http://www.rnib.org.uk/sites/default/files/FSUK_Report.pdf

[3] The nine boroughs are Hackney, Newham, Tower Hamlets, Islington, Waltham Forest, Barking and Dagenham, Haringey, Lambeth, Lewisham. 'Eye Health Network for London: Achieving Better Outcomes,' NHS England. 2015. http://www.londonsenate.nhs.uk/wp-content/uploads/2015/07/Item-5-2015-07-21-LCSC-Final-London-Eye-Health-Network-Achieving-Better-Outcomes.pdf;
'Ethnicity and National Identity in England and Wales: Census 2011,' Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandnationalidentityinenglandandwales/2012-12-11

with treatable conditions, as well as the greater prevalence of diabetic eye disease and glaucoma in particular ethnic minority populations. At Question Ten, we suggest ways to achieve this.

Thirdly, London's economy: poor eye health is detrimental to economic output. London continues to drive the wider UK economy, accruing a net fiscal surplus in the financial year ending 2016 (£26.6bn), raising a total revenue of £136.7bn, and equating to over one-fifth of UK gross domestic product.[4] However, research has shown that the total cost of sight loss to the UK economy is £28bn per year, or £6.4bn to London.[5] This is a figure which can be reduced by proactive strategies to lower the risk of sight loss in London. These include encouraging regular eye examinations, particularly among at risk groups, through driving greater health care integration and services signposting.

Finally, capacity problems: an overburdened HES is resulting in patients losing their sight unnecessarily due to delayed follow up appointments.[6] However, transformation of eye services do not feature as a priority in any of the London STP plans.

The 2015 '*Eye Health Network for London: Achieving Better Outcomes*' report described a more coordinated approach to the commissioning and delivery of eye health and sight loss services to support the integration between services and

[4] 'Country and regional public-sector finances: Financial year ending March 2016,' Office for National Statistics. https://www.ons.gov.uk/economy/governmentpublicsectorandtaxes/publicsectorfinance/articles/countryandregionalpublicsectorfinances/2015to2016;
'Regional gross value added (income approach), UK: 1997 to 2015,' Office for National Statistics. https://www.ons.gov.uk/economy/grossvalueaddedgva/bulletins/regionalgrossvalueaddedincomeapproach/december2016

[5] This proportional figure reflects London's share of GDP at twenty three percent. London's greater economic performance may mean this is higher in reality. 'The State of the Nation: Eye Health 2016,' RNIB. http://www.rnib.org.uk/knowledge-and-research-hub-research-reports/prevention-sight-loss/stateofthenation.

[6] B. Foot and C. MacEwen, 'Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome,' *Eye*. 27 January 2017. http://www.nature.com/eye/journal/v31/n5/full/eye20171a.html?foxtrotcallback=true

pathways. This would provide a better service for patients and would ensure more effective use of limited NHS resources. But to date this extremely valuable piece of work has been largely ignored by commissioners.[7] The approach to commissioning has remained piecemeal and there has been a focus on preserving boundaries rather than developing shared solutions across boundaries. Making eye health a priority for London is an essential policy driver to achieve the objectives set out in this report and the wider objectives of ensuring that NHS services meet the needs of patients, are safe and are cost effective.

2. What are the key factors that affect eye health? Which groups are particularly affected?

The major factor affecting eye health is age. Changes in vision and sight-threatening eye conditions become more common as people age— cataracts and macular degeneration are both examples of age-related eye health issues—so Britain's ageing population therefore means demand for eye services will continue to increase.[8] Although London has a younger age profile than the rest of the country, there are still almost one million people aged sixty-five or over in the capital.[9]

Another factor affecting eye health is deprivation. People aged sixty or over, or under sixteen, living in the least deprived quintile are seventy-one and twenty-

[7] 'Eye Health Network for London,' NHS England. http://www.londonsenate.nhs.uk/wp-content/uploads/2015/07/Item-5-2015-07-21-LCSC-Final-London-Eye-Health-Network-Achieving-Better-Outcomes.pdf. The accompanying document produced by the LEHN on working at STP levels, and also sent to NHS England London features three priorities: 1) acknowledging that HES capacity issues are real, and requires shared solutions across boundaries. Commissioning and procurement for the delivery of eye care services needs to be done at a larger scale to have greater impact and save costs. Resource needs to go to front line services; 2) to develop / commission a set of STP-wide system pathways, focussed on risk stratification, and step down from HES, thus improving patient flow. Alignment of existing schemes where practical, streamlining processes and delivering on efficiencies. The pathways should reflect new NICE guidance when available; 3) the urgent and essential need for better data

[8] J. Buchan, 'The Way Forward Resources,' Royal College of Ophthalmologists. February 2017. www.rcophth.ac.uk/standards-publications-research/the-way-forward

[9] 'Eye Health Network for London,' NHS England. http://www.londonsenate.nhs.uk/wp-content/uploads/2015/07/Item-5-2015-07-21-LCSC-Final-London-Eye-Health-Network-Achieving-Better-Outcomes.pdf

three per cent respectively more likely to have an NHS-funded eye examination than someone in that age group in the most deprived quintile, even though all are equally entitled.[10] In addition, incidences of smoking, excessive alcohol consumption, obesity and mental health problems are more common in areas of deprivation, all of which are detrimental to both eye and general health.[11]

Particular ethnic groups are more susceptible to certain eye health problems. For instance, people of south Asian and African-Caribbean origins are more at risk of diabetic eye disease and glaucoma. In some London boroughs such as Tower Hamlets or Lewisham, this should have a major bearing on planning eye health care provision. In addition, people with learning disabilities, those with mental health problems and homeless people also face higher incidences of eye health problems. It is important that work is undertaken with communities to develop targeted education to raise awareness of the importance of sight tests and diabetic eye screening.

3. How aware are people of the importance of maintaining eye health? What are the main barriers to raising awareness?

Unfortunately, many people are unaware of the importance of maintaining their eye health, including those most at risk such as the elderly.[12] Only just over half of the population (fifty-two per cent) view sight tests as 'very important.'[13]

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[10] 'Geographical inequalities in uptake of NHS-funded eye examinations: small area analysis of Leeds, UK,' *Journal of Public Health*, June 2015. Volume 37, Issue 2, 337-345. https://academic.oup.com/jpubhealth/article/37/2/337/1591677/Geographical-inequalities-in-uptake-of-NHS-funded

[11] 'Deprivation and Inequalities,' Public Health Wales. http://www.wales.nhs.uk/sitesplus/888/page/43764 'Obesity and sight loss.' http://www.rnib.org.uk/eye-health-looking-after-your-eyes/obesity-and-sight-loss; 'Obesity and vision are directly linked,' The Macula Center. https://maculacenter.com/eye-news-tampa-bay/obesity-and-vision/; Canadian Association of Optometrists. https://opto.ca/health-library/the-link-between-obesity-and-eye-health

[12] 'Future of Sight Loss UK (1),' Access Economics (RNIB). http://www.rnib.org.uk/sites/default/files/FSUK_Report.pdf

[13] 'Britain's Eye Health in Focus: A snapshot of consumer attitudes and behaviour towards eye health,'

Overcoming this lack of awareness is a fundamental challenge for the whole health sector, including the commissioners of eye health care. Initiatives such as National Eye Health Week aim to increase public awareness but it remains the case that eye health in general requires greater prioritisation.[14] For example, while the diabetic eye screening programme is vital, particularly given the increase in people with diabetes, and demonstrates what can be achieved in eye health through a national strategy, this is the only cross-population eye health success story.

The major barrier to greater awareness is that eye health has unfortunately not historically been a public health priority—despite the existence of the eye health Public Health Outcomes Framework indicator. The absence of funding for eye health campaigns is the major barrier to raising awareness. The level of competition from other disease areas to catch the public's attention is another key issue.[15]

4. How can eye health be integrated with other public health and social care activity at local or London-wide levels?

Sustainable Transformation Plans (STPs) have been designed in large part to drive through the prevention and integration agenda of the NHS Five Year Forward View and break down barriers in health care provision. We support this initiative. But for it to succeed, it is essential that all parties are fully on board; for this to happen consistent communication explaining the necessary role of STPs in meeting health needs across wider geographies is necessary to address concerns. Central to the challenge is ensuring that the various bodies maintain focus on shared objectives; particularly so given that London's health care provision is so fragmented. We quote from the *Eye Health Network for London: Achieving Better Outcomes* report below

College of Optometrists. 2013. https://www.college-optometrists.org/

[14] 'National Eye Health Week.' http://www.visionmatters.org.uk/

[15] 'Campaign Resource Centre,' Public Health England. https://campaignresources.phe.gov.uk/resources

which we believe correctly outlines the problem and partial solutions to eye health integration:

> The commissioning and delivery of eye health and sight loss services is complex; pathways cut across borough boundaries and can involve many providers in a network of care. In London, the landscape includes over 30 NHS hospital ophthalmology departments / sites, private ophthalmology providers offering NHS services, several community provider organisations and nearly 900 optical / optometry practices and nearly 900 providers holding contracts to deliver primary care domiciliary services. In addition, there are borough based social care services for people with visual impairment, and a range of charity and voluntary organisations involved in sight loss services.
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> Pathways rely on a multi-professional workforce, which include: optometrists, ophthalmic medical practitioners, ophthalmologists, orthoptists, ophthalmic nurses, dispensing opticians, ophthalmic technicians, and GPs with special interest. For the vast majority of GPs and pharmacists in primary care, simple eyecare is considered to be a small part of their routine workload.
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> The commissioning process needs to ensure that eye care is delivered safely, by an appropriately trained workforce and compliant with NICE guidance. It should be evidenced-based and audited for outcomes and value for money. Roles and responsibilities in the processes of commissioning and provision of care do need to be clear, to ensure safe and effective care based on clinical need.[16]

[16] 'Eye Health Network for London,' NHS England. http://www.londonsenate.nhs.uk/wp-content/uploads/2015/07/Item-5-2015-07-21-LCSC-Final-London-Eye-Health-Network-Achieving-Better-Outcomes.pdf

We would add the importance of utilising existing networks of professionals. In particular, the London-wide Local Eye Health Network and London's local optical committees are well placed to improve outcomes. These bodies bring key stakeholders together and offer leadership in achieving eye health goals.

5. What impact do poor eye health and sight loss have on wider health and wellbeing?

Poor eye health, which can lead to sight loss, has a very significant impact on wider health and wellbeing; it can reduce independence, reduce the ability to be economically active and increase the risk of social isolation. Poor vision and poor eye health can impact on the ability to undertake every day activities, such as driving, or watching television. Falls, which are linked with age-related eye problems, are the most common cause of hospitalisation for people aged over sixty-five and the biggest cause of accidental death in people aged over seventy-five.[17] Poor eye health can often also lead to depression or other mental health issues, especially when a patient is already suffering from loneliness or isolation. In such situations, optical professionals can assist a patient by ensuring correct and appropriate eye health care.[18] In addition, community optical professionals can play an important role by detecting the risk of falls and informing GP to enrol patients in a falls prevention programme.[19]

Healthy life styles are good for eye health, and good eye health supports general wellbeing but the opposite is also the case. There is work in the eye health sector underway currently to demonstrate the linkages between eye and general

[17] 'Falling standards, broken promises: report of the national audit of falls and bone health in older people,' Royal College of Physicians. 2011. https://www.rcplondon.ac.uk/projects/outputs/falling-standards-broken-promises-report-national-audit-falls-and-bone-health

[18] S. Hodge, W. Barr and P. Knox, 'Evaluation of Emotional Support and Counselling within an Integrated Low Vision Service-Final Report,' RNIB. 2010. https://www.rnib.org.uk/sites/default/files/ESaC_final.doc

[19] 'Focus on Falls,' College of Optometrists. 2014. http://www.college-optometrists.org/filemanager/root/site_assets/commissioning/falls/focus_on_falls_report_240414.pdf.

health. The Vision 2020 UK Ophthalmic Public Health Committee has developed population indicators for eye health and care designed to support the national eye health indicator as feeders and to enable the review and monitoring of wider population eye health, care and wellbeing (at national and local level).[20] This is a useful resource for policy makers exploring this question.

6. What are the main challenges around improving screening and eye test uptake, in both adults and children?

The main challenge around improving screening and eye test uptake in adults and children is in increasing the understanding through information campaigns (both NHS and privately organised) that eye examinations and screening programmes can prevent sight loss. This message should be promoted in tandem with the promotion of optical practices as the first port of call for eye health.

Parents need to receive clear messages about the importance of looking after their children's eye health, including regularly accessing NHS funded sight tests. It is important that the London Assembly, Greater London Authority and Mayor, GPs and secondary care, local authorities, schools, and all other public-sector bodies give the message that as eyesight is usually fully developed by the age of eight, children must have their vision checked before then, even if there are no obvious signs of anomalies. In addition, among teenage children, the huge growth of myopia worldwide—shown by researchers to reflect reduced time spent outdoors—makes regular sight tests particularly important.[21] In a multi-cultural city such as London this worrying trend is something that policy makers should be aware of.

[20] 'Portfolio of Indicators,' Vision 2020. 2015.http://www.vision2020uk.org.uk/download/Portfolio%20of%20Indicators%20for%20Eye%20Health%20and%20Care-2015.xlsx

[21] 'The Myopia Boom,' 18 March 2015. *Nature*, volume 519, Issue 7543. http://www.nature.com/news/the-myopia-boom-1.17120

It is also important that the successful national diabetic eye screening programme is maintained and fully supported across government and NHS. There are nearly four million people living with diabetes in the UK—an increase of one hundred and seventy per cent since 1996. By 2025, it is estimated that five million people will have diabetes in the UK.[22] Diabetes is the leading cause of blindness in people of working age in the UK and with this level of growth, public information programmes explaining the importance of screening are essential. [23] As diabetes is more prevalent in African-Caribbean and south Asian communities, in London there is a particular challenge to increase uptake.

7. What impact is the rising prevalence of eye health problems having on the health care system in London?

Eye health problems certainly are rising in prevalence: from 2015-2025 it is predicted that the number of people in the UK with glaucoma will increase by twenty-two percent, demand for cataract surgery will grow by twenty-five per cent and age-related macular degeneration will surge by twenty-nine per cent.[24] HES in the UK are currently struggling with serious capacity issues. Over the five years to 2016 the number of attendances in specialist secondary eye care services has risen by more than thirty per cent and currently ophthalmology outpatients constitute the second largest number by speciality.[25] There are almost two and a half million ophthalmology outpatient attendances in London itself.[26] The pressures created by this demand for care is compounded by the fact that too many patients have little

[22] Diabetes, NHS Choices. http://www.nhs.uk/Conditions/Diabetes/Pages/Diabetes.aspx
[23] Diabetes UK. https://www.diabetes.org.uk/Diabetes-the-basics/Myths-and-FAQs/
[24] J. Buchan, 'The Way Forward Resources.' www.rcophth.ac.uk/standards-publications-research/the-way-forward
[25]C. McEwan, 'Increasing demand on hospital eye services risks patients losing vision,' Royal College of Ophthalmologists. 2016. https://www.rcophth.ac.uk/2016/03/increasing-demand-on-hospital-eye-services-risks-patients-losing-vision/;
'Hospital Outpatient Activity - 2015-16,' NHS Digital.
http://www.content.digital.nhs.uk/catalogue/PUB22596/hosp-epis-stat-outp-all-atte-2015-16-tab.xlsx
[26] 'Eye Health Network for London: using STPs for Achieving Better Outcomes,' London Eye Health Network. March 2017.

choice but to attend HES and GPs for eye health concerns that could be treated more appropriately, conveniently and more cost effectively by community optometrists and dispensing opticians. When seventy-eight per cent of incidences of minor eye conditions are non-serious and can be treated by community optometrists, and there are over two and half million eye-related GP appointments as well as two hundred and seventy thousand A&E departments for acute eye problems annually, the present situation is inefficient to the NHS and inconvenient for the patient when more suitable alternatives exist.[27]

While certain groups are more susceptible to certain eye health issues, it is the case that anyone of any age or background can suffer eye health problems. Minor eye conditions, for example, affect many of us from time to time and cover a wide range of problems including red eye, painful white eye, dry eye, 'floaters' in the vision and so on. However, services to treat these conditions (known as extended primary care services, and of which the minor eye conditions service is one) are not commissioned nationally, or indeed, regionally, and nor are they universally commissioned at a local level. Due to the piecemeal nature of health care commissioning, some clinical commissioning groups (CCGs) have commissioned these sorts of services, but others have not, meaning that patients suffer from inequitable healthcare (postcode lotteries). However, while commissioning varies, demand across areas of similar demographic profiles is broadly similar.

It is known that where extended primary care services are not commissioned by the NHS, patients are more likely to turn to secondary care (i.e. visit A&E

[27] S. Hau; A. Ioannidis; P. Masaoutis; S. Verma, 'Patterns of ophthalmological complaints presenting to a dedicated ophthalmic Accident & Emergency department: inappropriate use and patients' perspective,' *Emergency Medicine Journal*. October 2008, Volume 25 Issue 11. http://emj.bmj.com/content/25/11/740;
J.H. Sheldrick; A.D. Wilson; S.A. Vernon; C.M. Sheldrick, 'Management of ophthalmic disease in general practice,' *British Journal of General Practice.* Nov 1993, Volume 43 Issue 376. http://europepmc.org/articles/PMC1372484;
J.H. Sheldrick; S.A. Vernon; A. Wilson, 'Study of diagnostic accord between general practitioners and an ophthalmologist.' *British Medical Journal*. April 1992 Volume 304 Issue 6834. http://europepmc.org/articles/PMC1881924

departments). As an illustration of this, a recent study in south east London has shown that in Lambeth and Lewisham where MECs is commissioned, first attendances to secondary care as referred by GPs were reduced by nearly twenty-seven per cent, as compared to neighbouring Southwark where MECs is not commissioned.[28] We would therefore like to see a London-wide commissioning programme of minor eye conditions services (MECs), and other extended primary care programmes to ensure consistent treatment across the capital, that benefits patients and ensures more effective use of limited NHS resources.[29] We urge the London Assembly Health Committee and the Mayor to encourage health commissioners across the London boroughs of the merits of such London-wide programmes. Given the major changes in the health care environment with the forthcoming deployment of STPs, which look likely to assume commissioning responsibilities, this is the ideal time to make provision for all of London's eye health needs.

There is also a clear role for public health teams in the London boroughs to commission Healthy Living Optical Practices across London, as are already in place in other parts of the country. These optical practices become community public health resources by capitalising on their interactions with patients, thus supporting the national policy of 'Making Every Contact Count.' These practices can conduct a variety of NHS health checks, as required by local public health teams, to identify people at risk of developing cardiovascular disease, stroke, diabetes, kidney disease and dementia. They can also conduct health interventions on smoking cessation,

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[28] E. Konstantakopoulou; D.F. Edgar; A. Harper; H. Barker; M. Sutton; S. Janikoun; G. Larkin; J.G. Lawrenson, 'Evaluation of a minor eye conditions scheme delivered by community optometrists,' *British Medical Journal Open*. Aug 2016, Volume 6, Issue 8. http://bmjopen.bmj.com/content/6/8/e011832;
A further study by the same researchers corroborated these findings as well as the higher GP sign-up in Lewisham demonstrating the importance of GP engagement. E. Konstantakopoulou; D.F. Edgar; A. Harper; H. Barker; M. Sutton; S. Janikoun; G. Larkin; J.G. Lawrenson, 'Retrospective economic analysis of the transfer of services from hospitals to the community: an application to an enhanced eye care service,' British Medical Journal Open. March 2017. http://bmjopen.bmj.com/content/bmjopen/7/7/e014089.full.pdf

[29] Such as those developed by the not-for-profit Local Optical Committee Support Unit. http://www.locsu.co.uk/community-services-pathways/primary-eyecare-assessment-and-referral-pears/

weight management, alcohol consumption and physical activity. They can provide advice on oral health, men's health, travel health, breastfeeding, and nutrition, which can also be related to eye health. They may help raise awareness of issues such as mental health, cancer, and the benefits of falls assessment and support for older patients.[30] In addition, optical professionals can refer patients to other experts and services as required.

8. What impact does treatment delay have on patient outcomes and the wider health and care system?

Treatment delay has a negative impact on patients' outcomes and wellbeing. As a minimum, delays to treatment mean that a patient has to cope with the problems resulting from poor vision for longer than necessary—with all the risks for the general health and wellbeing as already described. However, as we have explained in response to Question 1, far too many patients are suffering a permanent loss or reduction of vision which would be entirely preventable were it treated promptly.

Treatment delay is to a large degree the result of under capacity within the HES and a failure to commission much greater provision of eye care services in the community.[31] As we have said in this consultation response, with ophthalmology outpatient appointments the second highest by speciality, a dual strategy to reduce unnecessary referrals to the HES and develop out of hospital care for monitoring patients with low risk eye conditions is required to address this problem.

[30]'Smoking in particular doubles the risk of age-related macular degeneration, one of the leading causes of blindness. 'Smoking and Sight Loss,' RNIB. http://www.rnib.org.uk/eye-health-looking-after-your-eyes/smoking-and-sight-loss

[31] B. Foot and C. MacEwen, 'Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome.' http://www.nature.com/eye/journal/v31/n5/full/eye20171a.html?foxtrotcallback=true

9. What additional challenges are there in supporting people who are homeless, in prison or have learning disabilities to maintain good eye health?

People with learning disabilities are ten times more likely to have eye problems, but are less likely to receive timely and appropriate care than the rest of the population.[32] The majority of people with mild learning difficulties should be able to attend a regular sight test. But for people with more complex learning disabilities a specialist service is required in all parts of the capital to ensure that they are seen in the same community setting as the rest of the population.[33]

There is also a high prevalence of untreated refractive error and eye health problems among homeless people. [34] This is influenced by a variety of factors, including poor awareness among many homeless people of the services that they are entitled to, an unwillingness among some to access healthcare in general, and unnecessary blocks created by NHS England. For example, while many people who are homeless may qualify for an NHS funded sight test (because of their age, specific health conditions or because they are in receipt of the relevant benefits), all too often they cannot claim a sight test or a voucher to cover the cost of spectacles because

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[32] E. Emerson and J. Robertson, 'The Estimated Prevalence of Visual Impairment among People with Learning Disabilities in the UK,' RNIB. 2011. https://www.rnib.org.uk/sites/default/files/Emerson%20report.pdf;
'Estimates of the number of adults in the UK with learning disabilities and visual impairment – summary report,' SeeAbility and RNIB. 2011. www.seeability.org;
D.L. McCulloch, P.A. Sludden, K. McKeown, A. Kerr, 'Vision care requirements among intellectually disabled adults,' *Journal of Intellectual Disability Research*. April 1996, Volume 40 Issue 2.
http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2788.1996.715715.x/abstract

[33] Such as that provided by the Local Optical Committee Support Unit. This pathway is designed to minimise stress and distress for people with learning disabilities when accessing essential eye health services.
http://www.locsu.co.uk/uploads/enhanced_pathways_2013/locsu_pwld_pathway_rev_nov_2013.pdf

[34] T.P. Baggett, 'The Unmet Health Care Needs of Homeless Adults: A National Study,' *American Journal of Public Health*. July 2010, Volume 100, Issue 7, 1326–1333;
C.W. Noel; H. Fung; R. Srivastava; G. Lebovic; S.W. Hwang; A. Berger; M. Lichter, 'Visual Impairment and Unmet Eye Care Needs Among Homeless Adults in a Canadian City,' *JAMA Ophthalmology*. April 2015, Volume 133, Number 4, 456-460;
J.B. Barnes, S.S. Barnes, C.R. Small, C.S. Otto, M.D. Bennett, 'Mobile eye screenings for Hawaii's homeless: results and applications,' *Clinical & Experimental Optometry*. 2010, Volume 2, 73-77;
J.H. Ho; R.J. Chang, N.C. Wheeler, D.A. Lee, 'Ophthalmic disorders among the homeless and nonhomeless in Los Angeles,' *Journal of the American Optometric Association*. 1997, Volume 68, Issue 9, 567-573.

the relevant forms require an address. These problems could and should be addressed by NHS England, for example, to make clear that a homeless shelter or 'no fixed abode' is acceptable in place of an address. However, in the interim, local commissioners should consider options such as commissioning services to be provided at homeless shelters.

It is also important that the relationship between dementia and eye health is understood. Sight loss among people with dementia can be caused by a variety of conditions including an eye condition such as cataract, another health condition, ageing of the eye, or the dementia itself. More than a quarter of a million people in the UK are living with both dementia and sight loss.[35] College of Optometrists' data shows that forty per cent of optometrists regularly, and fifty-eight per cent occasionally examine patients with dementia. A dementia eye care pathway should be considered to reduce the risks and prevalence of visual impairment among people with dementia.[36]

10. How could the Mayor and the GLA further support better prevention, detection and treatment of eye health issues in London?

The Mayor and GLA have the ability to provide the clear leadership for London, setting out a vision for the services they want all Londoners to be able to receive and how they would like to see them delivered. London would then provide a model for best practice in the delivery of eye care. Please see our recommendations below:

[35] RNIB. https://www.rnib.org.uk/eye-health-sight-loss-other-medical-conditions/dementia-and-sight-loss
[36] B. Hancock, R. Shah, D. Edgar, M. Bowen, 'A proposal for a UK Dementia Eye Care Pathway,' *Optometry in Practice*. 2015, Volume 16, Issue 2, 71-76. https://www.college-optometrists.org/asset/FE8B9C91-53B6-4D7C-8E20286C55135381/

1) Public information campaigns by the Mayor, assembly and GLA to stress the importance of regular eye examinations (sight tests). Eye health must be considered not in isolation but as part of wider public health. A full mayoral report into eye health needs and provision for the whole of London will go some way to achieving this.

2) We would like to see the Mayor and GLA support and encourage all London boroughs and CCGs (working at STP level) to take up the recommendations set out in the *Eye Health Network for London: Achieving Better Outcomes* report. These include the need for London-wide extended primary care services such as the minor eye conditions service.[37]

3) We would like to see further integration of primary and secondary eye care services, which can be facilitated by fostering dialogue and cooperation across all involved in the delivery of the wider eye care pathway. In particular, there must be a concerted emphasis on health and social care integration and the provision of support for people with sight loss, including emotional support and rehabilitation. People with sight loss must be properly supported so that barriers to care and social inclusion are overcome, both on equality grounds and to minimise downstream costs to the health and social care systems.

4) Support as required should be offered to local eye health networks and local optical committees to provide structure and leadership in eye health. These organisations work closely with CCGs, health and well-being boards, NHS England, local authorities, and all relevant bodies.

[37] 'Eye Health Network for London,' NHS England. http://www.londonsenate.nhs.uk/wp-content/uploads/2015/07/Item-5-2015-07-21-LCSC-Final-London-Eye-Health-Network-Achieving-Better-Outcomes.pdf

5) Eye health needs assessments must be completed and updated in order to identify where local eye health needs are not being met due to rising demand creating capacity problems.

6) London boroughs should commission as many as possible of London's optical practices as Healthy Living Optical Practices. These can improve both eye health and general health and well-being by taking health interventions in the form of targeted conversations, information dissemination, referral to other health care providers and more.

We applaud the London Assembly Health Committee for bringing these vital eye health matters to the fore. We would be delighted to provide further information on any of the issues we have raised. We would also be more than happy to work with the Committee to develop recommendations. Together we can make sure everyone in London gets the eye health care they need and deserve.