

Ophthalmic Services Guidance

Primary Eye Care, Community Ophthalmology and General Ophthalmology

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1 Summary

This document concentrates on the commissioning and provision of eye health and ophthalmology services in England. It is intended to provide an overview of what should be in place across the eye health service system.

Ophthalmology accounts for 8% of the 94 million hospital outpatient attendances and is the busiest outpatient attendance specialty.¹ With demand already overwhelming many hospital eye services (HES), addressing the challenge of an ageing population and delivering new treatments is a problem for which we must find a solution. More innovative approaches for the management of acute and chronic eye disease are necessary to provide safe and sustainable services.

To improve patient flow across an eye health system, it is important to investigate the extent of unwarranted variation in clinical decision-making, develop efficiencies across pathways, and devolve some of the low-risk activity to free up capacity within the HES for those who really need specialist expertise. Good places to start are the referral and follow-up pathways. However, despite this concept being widely supported by all relevant stakeholders, implementation of a risk-stratified approach across the pathways has been slow in England. In addition, there is recognition that increasing subspecialisation in ophthalmology may have created difficulties with providing comprehensive services in smaller units, and in the management of low-risk or multimorbidity care within hospitals or in partnership with community or primary care.

This document aims to outline the current roles of primary eye care and community ophthalmology, the related development of general ophthalmology as a specialty, and how ophthalmic services could be better reconfigured through risk-stratification - thereby enabling a more comprehensive service by 'the right person, in the right place' appropriate for that patient's condition.

2 Definitions

The distinction between General Ophthalmic Services (NHS sight test), primary eye care, community ophthalmology, primary care ophthalmology, and general ophthalmology services is often misunderstood by commissioners and professionals.

In England, **General Ophthalmic Services (GOS)**² are commissioned by NHS England. These services cover the provision of the NHS sight test and optical appliances (mandatory services), and domiciliary services (additional services). The GOS contract (which varies in Scotland) specifies that the contractor (or the ophthalmic practitioner employed by it) must ensure that the patient's sight is tested to determine whether an optical appliance is required and fulfil duties imposed under section 26 of the Opticians Act 1989 (duties to be performed on sight testing) as amended by Statutory instrument 2005/848.

Where it is found that a patient a) shows on examination signs of injury, disease or abnormality in the eye or elsewhere which may require medical treatment; or (b) is not likely to attain a satisfactory standard of vision notwithstanding the application of corrective lenses, the optometrist or ophthalmic medical practitioner shall, if appropriate, and with the consent of the patient³:

- refer the patient to an ophthalmic hospital, which includes an ophthalmic department of a hospital;
- inform the patient’s doctor or GP practice that they have done so; and
- give the patient a written statement that they have done so, with details of the referral (GOS 18 form or referral letter).

In 1999, under powers in the Opticians Act, the General Optical Council issued rules relating to injury and disease of the eye⁴ which allowed optometrists to manage certain eye conditions rather than make a referral if within their scope of practice.

Publications by the **Clinical Council for Eye Health Commissioning (CCEHC)** have helped to clarify the roles of **primary eye care**⁵, **community ophthalmology**⁶ and **low vision, habilitation and rehabilitation services**.⁷ The role of the HES has been clearly set out in ‘The Way Forward’ reports.⁸ The CCEHC have developed a **System and Assurance Framework for Eye-health (SAFE)**⁹ which provides a sustainable, consistent and coordinated approach to delivering efficient eye health and sight loss pathways within a **service system**. Eye-health conditions covered so far in SAFE are the main adult chronic conditions (glaucoma (Figure 1) and age-related macular degeneration), a high-volume condition (cataract), and emergency and urgent eye care but can be applied to any eye condition.

System and Assurance Framework for Eye-health (SAFE) - GLAUCOMA SERVICE SYSTEM

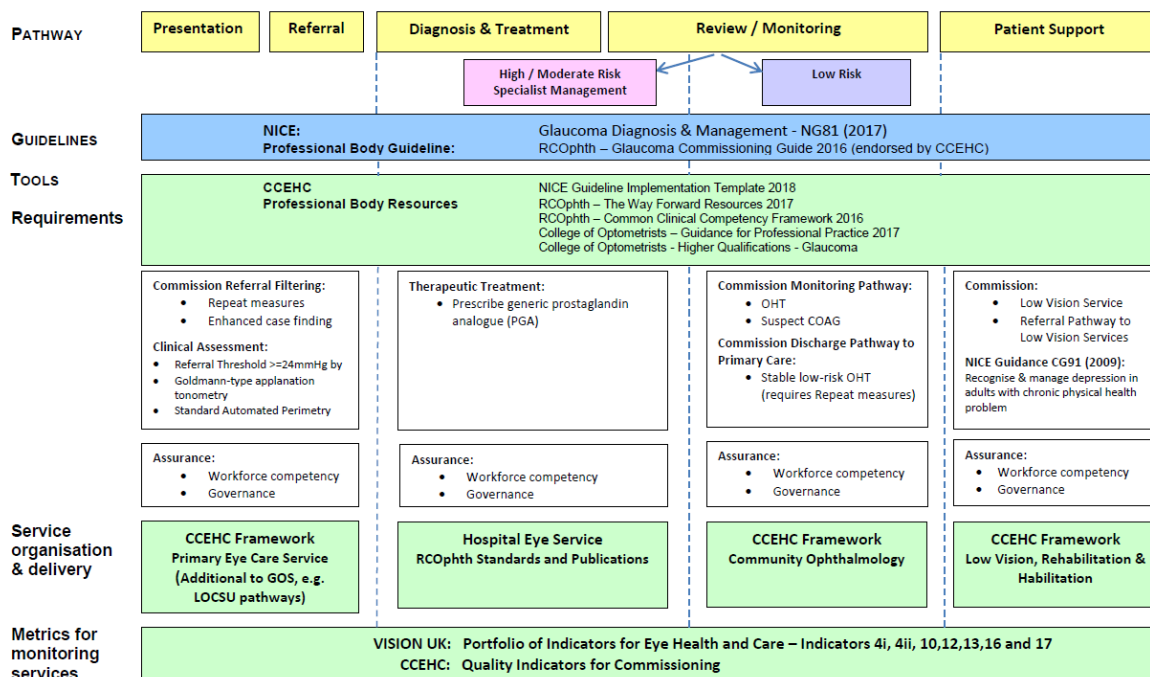


Figure 1 SAFE Glaucoma

Primary Eye Care Services (PECS)⁵ are commissioned by Clinical Commissioning Groups (CCGs) and are in effect add-on to a NHS sight test (contracted by NHS England) or a private eye examination. Previously, these were known as enhanced services. They are most commonly delivered in optical practices as services which precede referral decisions. The Local Optical Committee Support Unit (LOCSU) has developed national specifications for these services.¹⁰ Typically, these will include the ability to:

- conduct supplementary checks to confirm abnormal test results (detected by an NHS eye test / eye examination) e.g. repeat measures as outlined in NICE Glaucoma Guideline NG 81¹¹
- further refine the decision to refer e.g. where risks and benefits are discussed with the patient prior to referral for cataract surgery
- address the needs of a patient presenting with an acute eye condition (first contact) and manage a range of low-risk minor eye conditions (MECS)

Community Ophthalmology Services (COS)⁶ are commissioned by CCGs. These may involve the assessment and management of patients whose eye conditions are at low-risk of deterioration who are either referred by primary care for further assessment or discharged from secondary care for monitoring. COS may have some or all the following characteristics:

- the ability to make definitive diagnoses to manage and treat most of cases referred into it
- be effective as a monitoring service for patients at risk of their condition deteriorating asymptotically (e.g. ocular hypertension, stable age-related macular degeneration)
- provide an access point for patients with recurrent symptomatic disease

Low Vision, Habilitation and Rehabilitation Services⁷ are commissioned across the eye care pathways by both CCGs and Social Services. These should focus on:

- improving the process for certification of sight impairment and the associated data flows across the health and care system
- providing practical and emotional support post diagnosis e.g. through Eye Clinic Liaison Officers (ECLOs) and counsellors
- providing timely assessments of visual function and provision of appropriate assistive aids and relevant training

The service previously known as ‘**Primary Care Ophthalmology**’¹² describes general ophthalmology provided within the HES and should be re-termed **General Ophthalmology**. Currently, this service is provided in most trusts, with general patients mixed into specialist clinics or seen in dedicated general clinics. Larger tertiary referral centres may have dedicated general ophthalmology services led by consultants with a special interest in general ophthalmology.

3 General Ophthalmology

The nature of ophthalmology training and practice has changed over the last twenty years to become much more subspecialised. Currently, consultant ophthalmologists tend to have a subspecialist interest, although all will have extensive experience and competencies across a variety of different ophthalmic subspecialties covered during their RCOphth approved training.¹³ Subspecialty expertise in Accident and Emergency, Neuro-ophthalmology, Medical Retina, Glaucoma and External diseases are especially useful as a general ophthalmologist.

General ophthalmology is provided differently in different units, but overall constitutes a large volume of ophthalmic activity within the HES. Many units are finding it increasingly difficult to find ophthalmologists interested in leading and delivering general ophthalmic practice at consultant level, as it is not regarded as having the same kudos as a subspecialty role.

However, there is increasing need for high quality general ophthalmologists for the management of:

- patients with multiple comorbidities who do not fit neatly within one subspecialty (e.g. those sent for evaluation of suspicious discs, cataract and macular evaluation in a single referral)
- patients referred from primary care with non-subspecialty specific concerns (such as repeatable visual field loss and uncertain fundus findings)
- Accident and Emergency (A&E) and urgent care ophthalmology, especially out of hours
- patients requiring follow-up after an A&E visit e.g. trauma cases, those evaluated for unexplained visual loss, those needing evaluation after ancillary testing (e.g. orthoptic assessment)
- patients with visual impairment needing support such as counselling, sight registration and/or low vision assessment
- patients whose care requires generic expertise (such as ocular assessment in those with learning disabilities)
- in larger units, general ophthalmology clinics may have a subspecialty aspect to triage out lower risk patients who require minimal ongoing specialist input (e.g. blepharitis, dry eye, evaluation of benign choroidal naevi, myopic retinal degeneration, geographic atrophy, pterygia)

There is increasing recognition that there is a need for more general ophthalmology services to provide:

- greater flexibility within ophthalmology units as they struggle to cope with rising demand
- the growing push for ophthalmic care to be delivered closer to the patient's home
- the Shape of Training¹⁴, supporting the development of more 'generalists' with the skills, aptitudes and competencies to care for those with chronic disease and multiple co-morbidities in all specialties

In addition, the general ophthalmologist is particularly well placed to oversee community ophthalmology services and interact with primary eye care services, support non-medical healthcare professionals, co-ordinate better control of the flow of patients into and out of the HES and provide leadership and clinical accountability for innovative pathways. Currently general ophthalmologists manage a broad spectrum of patients and redirect those needing more subspecialist expertise or ongoing clinical input, to the appropriate clinic. This allows best use of resources. This can be expanded further by appropriate risk-stratification of patients, so that moderate or lower-risk conditions could be managed in non-medical or virtual HES clinics, thereby making best use of resources. This risk stratified approach with optimal use of the multidisciplinary team (MDT) across boundaries is supported by the National Elective Care Transformation and associated High Impact Intervention for ophthalmology.¹⁵ The resulting change of patient flow would require re-commissioning to

reflect the new caseload and complexity, so that both HES and community services remain financially viable and collaborative.

There is a strong argument that general ophthalmology should be developed as a subspecialty to attract more high-quality consultant and staff grade, associate specialist, and specialty doctor (SAS) candidates. Training by the RCOphth in time may reflect this changing need in the development of a Trainee Selected Component (TSC) in General Ophthalmology.

The training of general ophthalmologists of the future should include a focus on developing leadership and teaching skills, to optimise their potential role in innovating pathways and to support, train and supervise other allied healthcare professionals as part of an effective multidisciplinary team.

4 Traditional Service Model and the Changing Role of Optometrists and Other Professionals in Eye Health Services

Primary care pathways rely on a multi-professional workforce covering both urgent and routine care. GPs and pharmacists can provide non-specialist eye care including initial assessment and treatment of common low-risk conditions not requiring specialist expertise or equipment (e.g. conjunctivitis), but first contact eye care is a small part of their routine workload. There are also GPs with a special interest in ophthalmology (GPSI), ophthalmic medical practitioners (OMPs), nurse practitioners, orthoptists, and ophthalmologists delivering services in primary care.

However, the majority of primary eye care is provided by optometrists in high street optical practices using their skills and specialist equipment. This is supported by the availability of NHS funded sight tests and the increasing coverage of MECS and other schemes.

Optometrists work in a variety of roles; primary care in the delivery of GOS, community services and the HES. The role of the optometrist has evolved rapidly with increasing involvement in care traditionally delivered by ophthalmologists. For example, their traditional role in glaucoma case finding is known, but optical practices are now investing in more specialist equipment and optometrists are becoming accredited for new services or are undertaking higher qualifications to upskill to a standard to diagnose and manage more conditions independently.¹⁶

With NHS ophthalmic provision increasingly struggling to meet demand, RCOphth commissioning guides for cataract¹⁷ and glaucoma¹⁸, and sustainable ophthalmic pathways – cataract¹⁹ also highlight the potential involvement of optometrists to deliver high quality services.

Recent NICE guidance for glaucoma¹¹, cataract²⁰ and age-related macular degeneration (AMD)²¹ has explicitly set out greater responsibility for optometrists in referral filtering and managing low-risk and/or stable disease themselves.

School vision and diabetic eye screening programmes are included here as they are provided in within primary and community care and feed referrals into the HES.

School vision screening programmes are commissioned by local authorities as part of the healthy child programme. Although recommended by Public Health England²², it is non-mandatory. Orthoptists may lead on screening 4/5-year-old children for amblyopia and strabismus in their area, but their main role is in the HES specialising in diagnosing and

treating visual problems involving eye movement and alignment. Increasingly, their roles are extending into the management of glaucoma, AMD and low vision as part of a MDT.

Diabetic eye screening programmes (DESP) are commissioned by Public Health England embedded with NHS England regional teams.²³ The DESP team includes ophthalmologists, optometrists, and screener/graders. Retinal photography and slit-lamp biomicroscopy identify patients with maculopathy (M1), pre-proliferative (R2) and proliferative retinopathy (R3) for referral to HES diabetic retina clinics. Optical Coherence Tomography (OCT) surveillance clinics can reduce the number of low-risk M1 referrals to the HES that do not require treatment, but the OCT component must be separately commissioned by CCGs.

5 Primary Eye Care Services

Primary eye care (PEC) services⁵ provide the opportunity for optometrists to manage more eye care problems within primary care relieving pressure on the HES. The current NHS England funded sight test provides for one appointment with a minimum recall interval which must include a refraction for glasses. The decision to refer might often be based on a single atypical result at that one appointment. The NHS sight test is not an emergency or urgent care service. If the CCG has funded optometrists to manage patients who present with minor eye conditions, or to see a patient again to monitor their condition or recheck suspect results, this reduces unnecessary referrals and eases the capacity pressures faced by the HES. Research evidence suggests that optometrists involved in these services are three times less likely to make false-positive referrals²⁴ When practitioners must make the right decision on the results from one appointment and may not have seen that patient before, they may play safe and refer. When not locally commissioned in England, these options can only be offered privately to the patient.

PEC services may also include assessments to support people with learning disabilities²⁵ and post-cataract surgery follow-up care.²⁶

The development of Primary Eyecare Companies with the support of Local Optical Committee Support Unit (LOCSU) has enabled optical practices to collaborate and bid for services. However, participation in local schemes is not mandatory for optical practices and this can lead to variation in referral outcomes. In some areas, triage is used to identify low-risk referrals and direct them back into other primary eye care practices.

Delivery of the main primary eye care schemes are within the core-competencies of an optometrist, but assurance of competency in the form of skill assessments (e.g. WOPEC training²⁷) may be sought as part of the service specification and contractual agreement. To support more integrated working, it is important that there are close links with local HES colleagues to support consistent pathways, initial training, targeted CPD, mutually agreed guidelines and clinical governance, although these will have resource implications for trusts.

Increasingly, optometrists are gaining additional qualifications such as independent prescribing (IP), and a range of College of Optometrists higher qualifications (professional certificate, higher certificate and diploma) in medical retina, glaucoma, low vision, paediatric eye care or contact lens practice.¹⁶

Minor eye condition schemes have been successful in helping to manage patients without the need for attendances at hospital A&E and outpatient departments, or to ensure only clinically appropriate referrals are made, so reducing false positives.^{28,29,30} Cataract referral

pre-assessment has been shown to dramatically reduce the number of patients who do not want or do not need cataract surgery from attending hospital.³¹

Evidence suggests that up to 40% of first attendance patients for suspected glaucoma are false positive.^{32,33} Referral filtering in form of repeat measures been shown to reduce this significantly.³⁴ Patient satisfaction is high as care is close to home. A glaucoma repeat measures scheme was evaluated for savings, quality, and evidence of change by NICE and published as a Quality and Productivity: Proven Case Study on NHS Evidence.³⁵ NICE glaucoma guidance [NG81] has set out that repeat measures (additional to the GOS) should be commissioned as part of the glaucoma referral filtering pathway.¹¹

Unlike Scotland (Scottish GOS)³⁶ and Wales (Eye Health Examination Wales)³⁷ where there are nationally commissioned schemes, uptake and impact can be variable across England. This might be because of limited CCG resource or experience, the non-mandatory aspect that enables optical practices to opt out or the lack of support from local eye units who struggle to take on extra service development work whilst trying to maintain already stretched services.

6 Community Ophthalmology

Community Ophthalmology Services⁶ are intermediate services that are starting to be commissioned by CCGs and are distinct from Primary Eye Care Services. In most of these services, a multidisciplinary approach is used to deliver specific types of care in community settings. These can be community or HES led.

Instead of being primarily aimed at reducing referrals into the HES, community ophthalmology can undertake a greater range of care, including not only managing some patients in the community without the need for any hospital care but also monitoring or managing lower-risk patients in step down care from hospital. This care is separate to the provision of sight tests and optical appliances, and has the following characteristics:

- the ability to make definitive diagnoses to manage and treat most of cases referred into it
- be effective as a monitoring service for patients at risk of their condition deteriorating asymptotically
- provide an access point for patients with recurrent symptomatic disease

Potentially, there are a wide range of conditions that can be diagnosed, treated and managed in the community if the right skill set, space, resource, communication network and equipment are available. Conditions can be as diverse as anterior uveitis, pterygia, lid lumps, benign choroidal naevi, stable AMD, low-risk glaucoma, and OHT suspects. Staffing may include any of the wider ophthalmic team, i.e. optometrists, orthoptists, nurses, GPSIs, technicians, but there is usually senior doctor involvement, whether seeing patients, supervising or supporting practitioners.

Key to the success of a community ophthalmology service is its ability to link into HES and primary eye care. As such there should be:

- collaboration between with primary eye care services, and HES e.g. through agreed guidelines of management for step-up or step-down care for certain eye conditions

- clear lines of communication to help manage referrals and allow advice to be sought and escalation protocols for urgent cases
- a discharge summary or letter conveying discharge details to all those involved in the patient's care
- clear referral protocols and signposting between providers in all sectors of eye care to prevent duplication, delay or confusion for patients
- clear governance systems for the sharing of clinical data, dealing with complaints and incidents, and means of sharing outcomes across all providers
- appropriately trained health professionals who are accredited, have recorded competencies and involved in ongoing CPD to maintain their skills
- regular participation in audit to show continued collaboration between providers, patient satisfaction, incidents, effective management of patients to avoid over referrals to HES, discharge rate and standard of clinical care

Community ophthalmology services are starting to increase but currently there is a deficit of uptake from NHS trust providers for a variety of possible reasons including the lack of sufficient staffing, lower tariffs and concerns about cost effectiveness, including start-up costs. Thus, independent sector companies bidding under 'Any Qualified Provider' (AQP) arrangements have stepped in to provide much of this care. A RCOphth list of commissioning standards and guidance has been published.³⁸

7 Networked Ophthalmology

The use of technology is increasingly a crucial factor in providing and evidencing a high standard of care. Ophthalmology is particularly reliant on huge data requirements due to the high number of attendances, the need to analyse change over time to make management decisions and the heavy reliance on imaging and visual field data. When attempting to join up care pathways and audit vertically across primary, community and HES and horizontally between different providers, the requirement to share this data appropriately whilst maintaining information governance can be challenging.

Shared clinical communication networks between providers, such as electronic medical records (EMR), summary care records and NHS emails using secure IT systems would facilitate effective and appropriate sharing of clinical data and images. This would facilitate communication, feedback on referrals and better collaboration for the safe delivery of high-quality care that spans traditional boundaries of healthcare provision. Sharing of clinical data is vital for collecting ongoing outcome data, such as post-operative cataract refraction data for the National Ophthalmology Database audit. In addition to paper feedback options, there are now electronic data solutions available which feed directly into the hospital electronic patient record. An NHS productivity report by Monitor³¹ highlights the use of optometry schemes in delivering post-operative cataract follow-up care after uncomplicated surgery.

Many optical practices have invested in high quality visual field analysers, fundus cameras, anterior segment cameras and OCT machines. These have the potential to provide better examination options for optometrists and deliver earlier diagnoses for patients, thus expanding the optometrists' role and responsibilities. The ability to share images and receive advice and guidance over secure IT connections cannot be underestimated. The use of these technologies provides an infrastructure to devolve more care into the community, but also increases the possibility of over-referral because of uncertain interpretation of these newer

technologies. Training for optometrists on the use and interpretation of new diagnostic results would help to reduce inappropriate referrals.

Triaging of referrals can now be done electronically using the Referral Assessment Service (RAS) within NHS e-Referral Service (e-RS). Triage has traditionally been performed in the HES to direct internally to different clinics but is increasing being used to avoid unnecessary referrals and to take advantage of community skills. Triage may also be performed by independent organisations, either to simply direct referrals or as part of a wider community care scheme to divert low-risk referrals into community care. All triaging should be clinically robust to channel the right patient, to the right place, with the skills, expertise and equipment to deal with their condition effectively and without delay. It also needs to be cost effective across the whole pathway. It is crucial for referrers and those triaging that there is clear signposting of the services delivered to avoid patient and referrer confusion, duplication, and unnecessary delay.

Virtual ophthalmology: The provision of virtual clinics, where diagnostic test results are captured in a separate location with a view to obtaining a clinician opinion later, is being explored by some HES departments to manage stable or low-risk disease more efficiently to address some of the HES capacity issues. These clinics are increasingly being used to manage glaucoma conditions (low-risk glaucoma, OHT and glaucoma suspects) and medical retinal conditions (e.g. stable AMD, diabetic maculopathy and stable treated proliferative diabetic retinopathy).^{39,40} Virtual clinics may be operated by HES trained non-medical practitioners, with some clinics provided in a community setting. More novel virtual clinics could also be developed to screen those with suspected wet AMD and hydroxychloroquine toxicity. Success and safety are highly dependent on the ability to share clinical information, as described previously with shared EMR and images over a secure IT connection.

8 Collaborative Commissioning

This describes the vision for an integrated eye health and ophthalmology service model, incorporating the whole MDT of primary, community and secondary care clinicians, with patients offered risk-stratified care and where clinicians can share information and obtain advice and training.

The development of eye health and sight loss pathways that span primary, community and secondary care should be done in collaboration and not in isolation. All providers should agree on clearly defined whole pathways, and there must be clear lines of responsibility, mechanisms for referral feedback, referral escalation policy, fluid communication between care providers and evidence-based guidelines for maintaining high standard of care. Such data should be audited on a regular basis to ensure high quality outcomes (such as timely appointments, safety and patient satisfaction).⁴¹

The **SAFE** framework (Figure 1 - glaucoma given as an example) provides for a sustainable, consistent and coordinated approach to the delivery of efficient eye health and sight loss pathways in England. While SAFE provides the overall architecture for how pathways of care should be organised and monitored, the exact model and how pathways are commissioned and who provides them needs careful planning between commissioners and all providers. The workforce should have the necessary skills and appropriate training to deliver safe and effective care based on clinical need specific to their part of the pathway. It is hugely

important that cost effectiveness should be demonstrated across the whole pathway. Cost effectiveness has been demonstrated with glaucoma repeat measures³⁴ and minor eye conditions⁴¹, but this can be difficult to achieve in practice when each service within a system is commissioned separately. With HES under pressure, such schemes support RightCare and GIRFT (Get it Right First Time) and serve to reduce unnecessary referrals and shorten waiting lists. SAFE also includes Eye Specific Indicators⁴² as metrics for quality outcomes and Quality Indicators for Commissioning⁴³.

There is no national tariff or mandate for primary eye care and community ophthalmology services, they rely heavily on new funding and the drive from local commissioners to reconfigure services and break down the traditional barriers between different parts of the eye care sector and different providers.

There is no strategic approach to the commissioning of eye health and sight loss pathways. This is often done piecemeal; for example, some CCGs commission primary eye care services and others not, some optical providers get involved and others not. This potentially increases service variation, decreases equity of access to eye care and encourages more HES referrals in areas without such services. In addition, it inhibits the ability to truly assess the value and impact of changes across the whole system. The development of **Sustainability and Transformation Partnerships (STPs)**⁴⁴ is leading to greater collaboration between CCGs to commission at a greater scale while **Integrated Care Systems (ICSs)**⁴⁵ may have the potential to achieve transformational change for their population. ICSs must agree a performance contract with NHS England to enable delivery of faster improvements in care and shared performance goals. ICSs are required to manage the funding for their defined population by taking responsibility for a system 'control total'. This would provide some consistency of funding arrangements across the wider area but would have the consequences of less dependence on an activity-based tariff if the control total is exceeded.

9 Potential Future Developments

With the increased use of sophisticated health technology, the advent of 'Artificial Intelligence' systems for early detection or identification of disease (such as diabetic retinopathy) and the increasing use of genomics, the traditional role of healthcare professionals will undoubtedly change. Non-medical eye health practitioners may be increasingly working from community settings, with more automated decision-making and remote consultations with ophthalmologists, reducing the need for face-to-face clinical evaluation. The use of telemedicine would be a vital tool to augment this fast-changing pathway and service redesign.

Systems that allow patient access and ownership of their own eye care data and images may not be far away, and this would facilitate patient-centred care without the need for paper records or joined up IT networks. Over time, care could be delivered nearer home and the healthcare workforce could concentrate more on disease prevention and disease modification and supporting patients to be engaged and active at managing their own health, as well as the traditional disease detection and treatment models.

10 Authors

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12 Glossary

Service System

A service system includes the range of pathways of care delivering services that may involve multiple providers and settings, to address the health needs of a defined patient population or condition.

Sustainability and Transformation Partnerships (STPs)

Sustainability and Transformation Plans were introduced in 2015 as a means for delivering the objectives of the NHS Five Year Forward View. STPs now operate across geographic areas, adopting a system-wide approach to transform the way that health and care is planned and delivered to their populations (average STP population = 1.2 million), whilst improving efficiencies in the services provided. It involves a collaborative approach within the NHS and between health and social care providers; and the development of new (increasingly integrated) models of care to meet changing population health needs. STPs have no basis in statute and are not legal entities; raising issues around their operational and financial governance, accountability and authority for policy and decision-making.

Integrated Care System (ICS)

This term has been developed from STPs, to provide an understanding of current accountability arrangements. Within an ICS, commissioners, health and care organisations, local authorities and other partners, voluntarily come together to provide system leadership for integrated services for a defined population, agreeing to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations. This facilitates system-based working whilst clarity on statutory authority for collaborative working is pending (or developed).

The term 'Integrated Care System' is now used by NHS England as a collective term for both devolved health and care systems and for those areas previously designated as 'shadow accountable care systems'¹.

The Royal College of Ophthalmologists (RCOphth)

The RCOphth is the only professional body for medically qualified eye doctors, who specialise in the prevention, treatment and management of eye disease, including surgery to optimise care for all patients.

The RCOphth acts as the voice of the profession and champions excellence in the practice of ophthalmology. We set the curriculum and examinations for trainee ophthalmologists, provide continued education and training, maintain professional standards and promote research and science in the specialty.

As an independent charity, we pride ourselves on providing impartial and clinically based evidence, putting patient care and safety at the heart of everything we do.

We are not a regulatory body, but we work collaboratively with government, health departments, charities and eye health organisations to develop recommendations and support improvements in the co-ordination and management of hospital eye care services both nationally and regionally.

The College of Optometrists

The College of Optometrists is the professional body for optometry. It promotes professional excellence in eye health by qualifying the profession through the Scheme for Registration and providing higher qualifications in a number of clinical areas. It produces guidance for professional practice, clinical management guidelines, guidance on using evidence in practice and runs a clinical advice service for its members. It provides continuing professional development and training through conferences, regional events, webinars, online learning and peer discussion, and develops research opportunities. And it provides an impartial voice for the profession through balanced contributions to debates about issues that are important to its ~~our~~ members, and by advocating high standards and an evidence-based approach to practice that puts patients at the heart.