REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

Oxfordshire Eyecare Services

Report by: Dr Omid Nouri, Health Scrutiny Officer, Oxfordshire County Council

Report to:
- Matthew Tait (Chief Delivery Officer, BOB ICB)
- Hannah Mills (Director of Delivery – UEC and Elective, BOB ICB)
- Sharon Barrington (Associate Director Acute Provider Collaborative, BOB ICB)

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on eyecare services in Oxfordshire during its public meeting on 11 September 2025. The report provided a summary of the commissioning, delivery, and geographical spread of eyecare service activity.

2. The Committee would like to thank Matthew Tait (Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board [BOB ICB Chief Delivery Officer); Hannah Mills (Director of Delivery – Urgent Emergency Care and Elective, BOB ICB); and Sharon Barrington (Associate Director Acute Provider Collaborative, BOB ICB) for attending the meeting and answering questions from the Committee in relation to eyecare services. The Committee also wishes to thank Veronica Barry (Executive Director, Healthwatch Oxfordshire) and Peter Burke (Chair, Thames Valley Faculty Board, Royal College of General Practitioners) for their attendance and participation in the discussion.

3. The topic of eyecare services is of significant interest and concern by the HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by the NHS to not only deliver eyecare services promptly and efficiently, but to explore how to address rising demand for these services and for eyecare procedures.

4. Upon commissioning the report for this item, some of the insights the Committee sought to receive were as follows:

   - How eye care services are commissioned and managed.
   - The geographical distribution of eyecare facilities in Oxfordshire.
   - Whether there are sufficient numbers of eyecare professionals (ophthalmologists, optometrists, and support staff) to meet the demand?
   - Waiting times for routine and urgent eyecare appointments.

- Were there any barriers to accessing eye services, such as transportation issues, financial constraints, or lack of awareness?

- Were there standard protocols and guidelines in place for the diagnosis and management of eye conditions?

- How the quality of eyecare was measured and monitored?

- What was the level of patient satisfaction with the services provided?

- What referral pathways existed for patients requiring specialised eye care?

- Details on the sustainability of NHS eye care departments.

SUMMARY

5. During the 11 September 2025 meeting, the BOB ICB Chief Delivery Officer confirmed the ICB's support for sustainable secondary care. The Chief Delivery Officer also highlighted challenges between NHS and private providers, and stated that they were adhering to national policy on provider choice and tariffs.

6. It was also discussed as to what mechanisms were in place to ensure that private eyecare providers adhered to the same rigorous standards as the NHS; as well as what contractual authority were exercised over private suppliers, and the processes for addressing instances of provider failure and patient complications. The Director of Delivery stated that private providers were subject to the NHS standard contract and accreditation checks, with quality monitored through contractual mechanisms and feedback.

7. There were also concerns raised about the destabilising impact of independent service providers (ISPs) on NHS ophthalmology pathways and training. It was explained that the growth of ISPs providing low complexity cataract care had reduced the number of suitable cases for NHS trainees, leading to the loss of trainees and affecting the quality of training.

8. It was enquired as to how NHS trainees in eyecare were being trained, and what support the ICB provided for retaining ophthalmologists and optometrists, and the challenges faced around staff retention. Officers indicated that recruitment and retention were key to service sustainability, with positive developments seen through closer collaboration among NHS Trusts in the region, such as offering opportunities to work across different sites and services. However, it was acknowledged that further details on ophthalmologist recruitment would need input from the Trust, and that retention remained a significant challenge, especially in specialties like ophthalmology.

9. The discussion also addressed whether there were any geographical differences in the provision of eyecare services and how such differences were

measured. Officers explained that general optometry services were available across the area, including domiciliary options for housebound patients, and that onward referrals included arrangements for patient transport if needed. It was noted that the single point of access system allowed patients to choose from a range of providers, including those outside the immediate area, and that contracts existed with providers beyond the local footprint to ensure coverage for rural and cross-border patients.

KEY POINTS OF OBSERVATION:

10. This section highlights four key observations and points that the Committee has in relation to eyecare services in Oxfordshire. These four key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

Monitoring contract outcomes and patient satisfaction: Effective oversight of healthcare services requires not only robust data collection but also the ability to interpret and act on that data in a way that is responsive to local needs. In the context of eyecare services commissioned by the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB), adopting this in the form of a dashboard would serve as a vital tool for transparency, accountability, and continuous improvement. The report submitted to the Committee for this item outlines a complex landscape of eyecare provision; spanning primary optometry, intermediate care, and secondary hospital services. While contract management arrangements exist, including the use of the Quality in Optometry (QiO) toolkit and periodic reviews, there is little indication of a unified, real-time system that tracks performance across providers or captures patient satisfaction in a systematic way. This fragmentation risks obscuring service gaps, delays in referrals, and variations in patient experience.

There are key benefits to having a localised dashboard, as it could allow the ICB and stakeholders to:

- *Track contract outcomes*: Including service delivery against agreed metrics, referral efficiency, and adherence to clinical pathways.
- *Monitor patient satisfaction*: Using real-time feedback mechanisms to identify trends, concerns, and areas for improvement.
- *Support place-based decision-making*: By enabling granular analysis at the district or neighbourhood level, the dashboard would help tailor interventions to local needs.
- *Enhance transparency and public trust*: Making performance data accessible to patients and the public would reinforce accountability and support informed choices.

Other regions have successfully implemented dashboards that demonstrate the feasibility and impact of such tools: Mid and South Essex ICB developed a series of comprehensive outcomes and performance dashboards as part of a stewardship programme. These dashboards enabled easy monitoring of delivery against the NHS Triple Aim—improving population health, service quality, and resource efficiency—while addressing health inequalities[1]

Furthermore, academic literature supports the use of comprehensive and adaptable dashboards in healthcare settings. A study by Dowding et al. (2015) in *BMC Medical Informatics and Decision Making* found that dashboards improve clinical decision-making by presenting data in a user-friendly format. Similarly, research by Cresswell et al. (2020) in *BMJ Health & Care Informatics* emphasised that dashboards enhance organisational learning and responsiveness when integrated into routine workflows.

Moreover, to be effective, such a dashboard should:

- Integrate data from multiple sources, including contractors, Independent Service Providers, and NHS Trusts.
- Include both quantitative metrics (e.g., appointment wait times, referral rates) and qualitative feedback (e.g., patient satisfaction surveys).
- Be co-designed with stakeholders, including clinicians, commissioners, and patient representatives.
- Be updated regularly and made accessible to both professionals and the public.

Therefore, the recommendation to establish a localised dashboard for eyecare services in Oxfordshire is not merely a technical suggestion—it is a strategic imperative. It aligns with national best practices, responds to local service challenges, and supports the broader goals of the NHS to deliver high-quality, equitable, and patient-centred care. By investing in such a tool, the ICB would demonstrate its commitment to transparency, responsiveness, and continuous improvement, ultimately enhancing outcomes for patients across Oxfordshire.

Recommendation 1: *For the ICB establish a localised dashboard to monitor contract outcomes and patient satisfaction across Oxfordshire.*

Raising awareness of services: The report submitted to the Committee for this item highlighted that NHS-funded sight tests and optical vouchers are available under General Ophthalmic Services (GOS) contracts, with eligibility determined nationally. However, the report also notes that these

[1] [ardengemcsu.nhs.uk]

services are delivered by private optical businesses, which rely on commercial promotion and patient self-referral. This model inherently disadvantages individuals who are less engaged with high street optometry, including older adults, people with disabilities, and those living in rural or economically deprived areas.

Healthwatch Oxfordshire's 2024 findings, referenced in the report, reveal that while patients generally had positive experiences with eye care appointments, they also faced challenges related to transport, costs, and accessing services locally. Some patients expressed frustration at not being able to receive outpatient eye care at their local health facility, and others struggled with early appointment times and busy waiting areas. These barriers are compounded by a lack of awareness about entitlements to NHS-funded sight tests and optical vouchers, particularly among those who may benefit most.

Public information campaigns are a proven tool in addressing health inequalities and improving service uptake. According to a study published in the *Health Promotion International Journal*, health literacy is a key determinant of health outcomes, and effective public health communication must go beyond information provision to empower individuals to act[2]. A targeted campaign can help bridge the gap between entitlement and access by clarifying eligibility criteria, demystifying the process of obtaining sight tests and vouchers, and signposting individuals to local providers.

National Eye Health Week, coordinated by Eye Health UK, offers a successful model of how targeted campaigns can raise awareness. In 2023, the campaign highlighted that 4.7 million NHS sight tests were lost due to pandemic-related disruptions, and cost concerns led 1 in 5 people to cancel or postpone appointments[3]. The campaign used localised data to identify hotspots of avoidable sight loss and tailored messaging to encourage uptake. Similarly, the Eyecare Trust's campaigns have used a mix of national advertising, local events, and media engagement to promote eye health among specific demographics[4].

To be effective, the campaign must be tailored to the needs of vulnerable and underserved populations. This includes:

- *Older adults and people with disabilities*: who may face mobility challenges and digital exclusion.

- *Residents of rural areas:* where transport options are limited and local services may be sparse.

[2] Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century | Health Promotion International | Oxford Academic
[3] Vision Matters - National Eye Health Week
[4] NEHW 2023: raising awareness of eye health

- *Economically deprived communities:* where cost concerns and competing priorities may deter individuals from seeking care.

The campaign should use multiple channels, including print, radio, community outreach, and digital platforms. It should be co-designed with community representatives to ensure cultural relevance and accessibility also. Trusted intermediaries such as GP practices, schools, libraries, and voluntary organisations can play a key role in disseminating information and assisting individuals in navigating eligibility criteria.

The recommendation to involve local authorities and voluntary sector partners is both pragmatic and strategic. These organisations have deep roots in their communities and are well-positioned to deliver culturally sensitive and locally relevant messaging. For example, Age UK, Citizens Advice, and local disability networks can help disseminate information and assist with navigating eligibility criteria. The ICB's existing commissioning infrastructure can be leveraged to coordinate messaging across providers and ensure consistency. Local authorities can support the campaign through their public health teams, while voluntary sector partners can provide outreach and engagement in hard-to-reach communities. Collaboration with local Healthwatch organisations can also prove useful in this regard. In Surrey, the County Council and Surrey Heartlands and Frimley ICBs collectively worked with Healthwatch Surrey to boost awareness of NHS-funded sight tests; which allowed for more effective outreach[5].

Furthermore, academic literature supports the role of targeted health communication in improving service uptake. A 2015 study in the *British Journal of General Practice* found that lower health literacy was associated with reduced use of preventive services, including eye care[6]. In rural settings, outreach must also address geographic isolation. A 2020 study by Smith et al. in *Health & Place* found that community-based interventions, including mobile clinics and local champions, significantly improved access to care in rural England[7].

In addition, policy frameworks such as the NHS Long Term Plan and the Health Inequalities Strategy emphasise the importance of targeted interventions to reduce disparities in access and outcomes. The proposed campaign aligns with these priorities and supports the broader goals of the NHS to deliver equitable, patient-centred care.

Therefore, launching a targeted public information campaign to raise awareness of NHS-funded sight tests and optical vouchers is a necessary and evidence-based intervention. It addresses a clear gap in service utilisation, aligns with national best practices, and supports the broader goals of health equity and prevention. By working with local

[5] Sight (eye) tests for children and young people | Healthwatch Surrey
[6] A mismatch between population health literacy and the complexity of health information: an observational study - PMC
[7] Spatial Lifecourse Epidemiology Reporting Standards (ISLE-ReSt) statement - ScienceDirect

authorities and voluntary sector partners, the ICB can ensure that the campaign reaches those who need it most—residents in rural and deprived areas who are currently underserved. This recommendation is not only justified but urgent, and its implementation will be a meaningful step toward reducing avoidable sight loss and improving population health in Oxfordshire.

Recommendation 2: *To launch a targeted public information campaign to raise awareness of NHS-funded sight tests and eligibility for optical vouchers, especially among vulnerable and underserved populations. It is recommended that the ICB works with local authorities and voluntary sector partners to improve outreach in rural and deprived areas.*

Shared digital records: Shared digital records between providers is a forward-looking and necessary step toward improving the quality, efficiency, and equity of care across the county. In a health system increasingly characterised by complexity, fragmentation, and rising demand, the ability to share patient information seamlessly across organisational boundaries is no longer a luxury—it is a foundational requirement for safe, effective, and person-centred care.

The Committee understands that as with many other systems around the country, Oxfordshire's health system experiences challenges including duplication of services, gaps in continuity of care, and inefficiencies in referral pathways. These problems are particularly acute in areas such as ophthalmology, where patients often move between primary optometry, intermediate care, and secondary hospital services. Without shared digital records, each provider may rely on incomplete or outdated information, leading to repeated tests, missed diagnoses, and delays in treatment. NHS England encourages the use of shared digital records for eyecare services, and is promoting a blueprint that could help to set the foundations for this[8].

The NHS Long Term Plan and the "What Good Looks Like" framework from NHS England both emphasise the importance of shared care records in achieving integrated, data-driven care. The Connecting Care Records programme, which succeeds the Shared Care Records initiative, also aims to ensure that authorised professionals have secure access to person-centred information across settings[9]. The Health Foundation's April 2025 analysis stresses that while most NHS trusts now have electronic patient records (EPRs), many are not using them to their full potential. The report calls for a national strategy to unlock the benefits of EPRs, including improved care quality, productivity, and safety[10].

[8] NHS England » Blueprinting
[9] NHS England » Connecting Care Records programme
[10] Electronic patient records: why the NHS urgently needs a strategy to reap the benefits - The Health Foundation

Moreover, academic literature supports the role of shared digital records in improving continuity of care. A study by Cresswell et al. (2020) in *BMJ Health & Care Informatics Journal* found that integrated digital systems reduce duplication, enhance communication, and support better clinical outcomes[11]. Similarly, Greenhalgh et al. (2017) in *The Lancet* argued that shared records are essential for managing complex, multi-morbidity cases in community settings. Additionally, the Health and Social Care Committee's 2023 report on digital transformation in the NHS emphasises that digitising services and enabling data sharing are critical to personalising care, reducing disparities, and improving system performance[12].

To be successful, the development of shared digital records in Oxfordshire must:

- *Ensure interoperability:* across NHS Trusts, GP practices, optometry providers, and voluntary sector organisations.
- *Address digital exclusion*: by providing alternative access routes and support for those without digital literacy or connectivity.
- *Protect data privacy and security:* with robust governance frameworks and consent protocols.
- *Be co-designed with stakeholders*: including patients, clinicians, and community representatives.
- *Include evaluation metrics:* such as reductions in duplicated tests, improved referral times, and patient satisfaction scores.

The Oxfordshire Health & Wellbeing Board Neighbourhood Health Workshop held on 24th October 2025 also discussed the importance of vertical and horizontal integration, data-driven decision-making, and reducing duplication in resource allocation—all of which align with the goals of shared digital records.

Recommendation 3: *To explore the development of shared digital records between providers to reduce duplication and improve continuity of care.*

Workforce recruitment and retention: The report submitted to the Committee for this item highlights that while General Ophthalmic Services (GOS) contractors have not reported shortages of optometrists for routine sight tests, there are systemic pressures affecting sustainability. Independent Service Providers (ISPs) delivering low-complexity cataract surgery have inadvertently destabilised NHS ophthalmology training pathways, reducing opportunities for trainees and

[11] Investigating the use of data-driven artificial intelligence in computerised decision support systems for health and social care: A systematic review - Kathrin Cresswell, Margaret Callaghan, Sheraz Khan, Zakariya Sheikh, Hajar Mozaffar, Aziz Sheikh, 2020

[12] Digital transformation in the NHS - Health and Social Care Committee

increasing reliance on experienced staff for complex cases. This has created knock-on effects for eye casualty and other specialist services, stretching workforce capacity and impacting service resilience.
Moreover, the report notes that acute ophthalmology departments remain challenged by high demand and long waiting lists, despite collaborative efforts across the Buckinghamshire, Oxfordshire and Berkshire West (BOB) system. These pressures underscore the need for a proactive workforce strategy that addresses recruitment, retention, and training across community and hospital settings.

A dedicated workforce strategy would enable the ICB and Primary Eyecare Services to:

- *Identify and address geographic disparities:* Rural and deprived areas often struggle to attract and retain optometrists, leading to inequitable access to care.

- *Support continuity of care:* Stable staffing in community settings reduces reliance on hospital services for minor conditions and improves patient experience.

- *Future-proof the system*: By investing in training and career development, the strategy can mitigate the impact of national workforce shortages and policy changes.

The strategy should include measures such as flexible working arrangements, professional development opportunities, and financial incentives for newly qualified optometrists to work in underserved areas.

Furthermore, other regions have implemented successful workforce strategies that Oxfordshire can potentially learn from. For instance, on a national scale, NHS England's Workforce Plan emphasises the need for integrated workforce planning across primary and secondary care, including targeted recruitment campaigns and retention incentives for shortage specialties[13]. On a more regional scale, the Greater Manchester Health and Social Care Partnership introduced a "Grow Your Own" programme for optometry, offering bursaries and mentorship to encourage local recruitment[14]. Additionally, the North East and North Cumbria ICB piloted golden handshake schemes for newly qualified optometrists willing to work in rural practices, which had the effect of improving coverage in hard-to-reach areas[15]. These examples demonstrate that targeted incentives and collaborative planning can significantly improve workforce stability and service accessibility.

Research consistently shows that workforce shortages are a major determinant of health inequalities. A study by Buchan et al. (2022) in *Human Resources for Health* found that targeted recruitment and

[13] NHS England » NHS Long Term Workforce Plan
[14] Shifting left for getting it right: Lessons from primary care optometry developments in Scotland
[15] Shifting left for getting it right: Lessons from primary care optometry developments in Scotland

retention strategies, including financial incentives and career progression pathways, are effective in addressing shortages in community health services[16]. Similarly, Imison et al. (2016) in *The King's Fund report on workforce planning* emphasised that integrated approaches—linking education, commissioning, and service delivery—are essential for sustainable healthcare systems[17]. In ophthalmology specifically, a 2021 study in *Eye journal* highlighted that workforce constraints are a key barrier to reducing waiting times for cataract surgery and glaucoma management. The authors recommended expanding community-based optometry roles to alleviate pressure on hospital services—a goal directly aligned with this HOSC recommendation[18].

To succeed, an eyecare workforce strategy should consider the following points as part of its implementation:

- *Map current workforce distribution*: to identify priority areas for intervention.
- *Engage educational institutions:* to create pipelines for newly qualified professionals.
- *Offer incentives*: such as relocation packages, loan repayment schemes, and funded CPD opportunities.
- *Foster collaboration*: between NHS Trusts, ISPs, and community providers to ensure training opportunities are maintained despite shifts in service delivery models.

The strategy must also address retention by creating supportive working environments, promoting career progression, and recognising the contribution of eyecare support staff alongside optometrists.

Recommendation 4: *For the ICB and Primary Eyecare Services to collaborate on a workforce strategy to recruit and retain optometrists and support staff, particularly in areas with known shortages. It is recommended that incentives are explored for newly qualified professionals to work in Oxfordshire's community settings.*

Legal Implications

11. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
  - Power to scrutinise health bodies and authorities in the local area
  - Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions

[16] Leadership in HRH: remembering the future? | Human Resources for Health
[17] Reshaping the workforce to deliver the care patients need | Nuffield Trust
[18] The community optometry workforce in Scotland: supporting sustainable eye care delivery | Eye

 Duty of NHS to consult scrutiny on major service changes and provide feedback n consultations.

12. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

13. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

14. The recommendations outlined in this report were agreed by the following members of the Committee:

Councillor Jane Hanna OBE – (Chair)
District Councillor Dorothy Walker (Deputy Chair)
Councillor Ron Batstone
Councillor Judith Edwards
Councillor Gareth Epps
Councillor Emma Garnett
District Councillor Paul Barrow
District Councillor Katharine Keats-Rohan
District Councillor Elizabeth Poskitt
City Councillor Louise Upton
Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

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