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Editorial

Shifting left for getting it right: lessons from primary care optometry developments in Scotland

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Court et al's paper¹ is prescient, providing an encouraging indicator of developments in the community optometry workforce in Scotland, contemporaneous with common ground within the eyecare sector on the need for an expanded primary care optometry role throughout the UK. Recent recommendations^{2,3} and the joint Colleges' vision⁴ highlight common themes of direct relevance to optometry, including improving referral quality, developing discharge policies and shared care protocols, and enhancing working practices within the eyecare community. It is acknowledged that making progress on these themes depends upon digital integration, adequate recruitment and retention, and appropriate training and up-skilling, processes well in-hand in Scotland. Court et al¹ conclude that improved utilisation of Scotland's optometry workforce is enabled by upskilling and the use of the national electronic patient record. They also highlight the potential role of 'controlled' undergraduate intake in optometry facilitating closer workforce monitoring, to better manage demand. Notably, Court et al. observe that their findings help provide *'insight into the wider UK challenge'* while *'building a sustainable eyecare solution to deliver eyecare will support patients receiving the right care at the right time.'* It is timely to consider this broader UK challenge, contrasting the divergent primary eyecare models across the UK, just as the government and NHS England (NHSE) focus on three key shifts: moving care from hospital to the community (the 'shift left'); from analogue to digital; and from sickness to prevention⁵.

In comparison to England, the Scottish General Ophthalmic Service (GOS) contractual framework provides for more clinical and comprehensive eye examinations⁶, with financial support for education targeting the whole workforce through NHS Education for Scotland⁷. Furthermore, optometrists must pass GOS competencies to practise in Scotland and must

undertake annual training. As Court et al. point out, with the majority of ophthalmic accident and emergency care in Scotland now closed to walk-in patients, upskilling for Independent Prescribing (IP) has had a significant impact, with optometrists in Scotland being the first 'port of call' for eye problems within the community. Recent developments in the Welsh GOS include an expanded primary care contract (for glaucoma filtering and monitoring, for example), where optometrists with higher qualifications examine and manage to include follow-up or referral, with a separate fee applicable for those prescribing⁸. In Northern Ireland, patients with ocular hypertension can now be monitored by their optometrist^{9,10}. In contrast, enhanced services in England are not mandatory for commissioners, and although numbers of enhanced service schemes have increased¹¹, practices do not have to participate. In contractual terms, compared with Scotland and Wales, there are few clinical requirements in the English GOS mandatory services contract¹² to drive enhanced levels of service. Recent analysis of registration data shows Scotland has a greater proportion (29%) of optometrists with an IP qualification, compared with England (7%), Wales (10%) and Northern Ireland (10%)^{13,14}. In England, primary care optometrists typically self-fund IP training and anecdotally face greater difficulties arranging clinical placements. Further, once qualified, while IP is being incorporated within some commissioned urgent eyecare services, many optometrists in England cannot easily use their new skills within funded NHS service contracts. More generally, enhanced service provision in England varies widely, from pockets of best practice to areas where no or few services are commissioned. Even where commissioned, some practices within an area may not participate, or, alternatively, even when offered by most practices within one area, there may be service specification differences compared to neighbouring areas, resulting in

inequity of access. Consequently, there is uneven implementation of the drive from hospital to community.

The second shift in the NHSE long-term plan, from 'analogue to digital', necessitates digital connectivity across the interface of primary and secondary eyecare, areas where Scotland, Wales, and Northern Ireland have made progress. Across England, variation in referral processes exists between and within different regions, with access to electronic pathways often linked to enhanced services. Other issues include that some GOS contractors in England cannot obtain NHS mail if comprising more than 10 practices, and the rate of replies to referring optometrists following new ophthalmology consultations remains disappointingly low^{15,16}.

The third NHSE shift, 'sickness to prevention', arguably mandates challenging the underpinning GOS model. This model provides eye examinations free of charge to the population of Scotland (in addition to enhanced GOS regulations delivering management of more eye conditions in the community), versus more restricted entitlement arrangements (and a contractually referenced 'sight-testing' model) within the English GOS. In England, there are stark differences between areas of deprivation and areas of affluence in both the number of practices holding GOS contracts¹⁷ and the number of GOS sight-tests undertaken¹⁸. In contrast, some evidence from Scotland suggests that the distribution of practices¹⁹ and activity levels²⁰ show less variation than in England in relation to their respective indices of multiple deprivation. These differences in primary eyecare provision between England and Scotland, where the latter has been argued to provide value for

money²¹, illustrate the much greater challenge ahead for the NHS in England in terms of an eyecare 'sickness to prevention' shift.

Arguably the key learning from Scotland is that cohesive and widespread service change comes through a single contract for core requirements (supplementary to a sight-test) with providers, and with clinical education available through ring-fenced funding. In England, GOS and core enhanced services for primary care optometry should be considered as part of the same continuum of first contact care. Further, Court et al's analyses¹ serve as a reminder that improved arrangements for sharing routine NHS primary eyecare data are essential, facilitating researchers to explore the cost-effectiveness of eyecare pathways across all UK nations. Finally, in relation to the underpinning GOS model versus enhanced services per se, Shickle et al²² previously concluded that the GOS contract may be contrary to public health interests, proposing that different approaches were needed to address eye health inequalities, thereby reducing preventable sight loss. Ten years later, divergent systems in both GOS and enhanced services across the UK's nations confer variations; variations necessitating change to ensure more equitable and sustainable eyecare in future decades for all UK nations.

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