

# Primary Eyecare in the Community

What  
**Optometrists**  
can offer Healthcare Commissioners and Patients

**“Optometrists have the skills and resources to provide radical patient-centred eye care. They can help healthcare commissioners to meet the requirements of the NHS Plan to deliver shorter waiting lists, shorter waiting times and easily accessible services through community-based co-management schemes.”**

**CONTENTS**

<b>Introduction</b>	<b>1</b>
<b>Optometry: An Overview</b>	<b>1</b>
<b>Sight Tests &amp; Eye Examinations</b>	<b>2</b>
<b>Referral Procedures</b>	<b>3</b>
<b>Specialist Skills</b>	<b>3</b>
<b>Infrastructure</b>	<b>4</b>
<b>Co-Management</b>	<b>4</b>
<b>Costs &amp; Pricing</b>	<b>5</b>
<b>Cataract</b>	<b>5</b>
<b>Glaucoma</b>	<b>7</b>
<b>Diabetes</b>	<b>10</b>
<b>Low Vision</b>	<b>10</b>
<b>Contact Lenses</b>	<b>11</b>
<b>Minor Acute Eye Problems</b>	<b>11</b>
<b>Paediatrics</b>	<b>12</b>
<b>Summary</b>	<b>12</b>

## INTRODUCTION

**Optometrists** are graduates who have undertaken a three or four-year degree course in optometry followed by a period of at least a year in supervised practice before taking professional qualifying examinations which lead to registration with the General Optical Council.

Optometrists (previously known as ophthalmic opticians) test sight and prescribe glasses; they also screen patients for signs of ocular disease and refer them to medical practitioners for treatment when necessary. They are skilled in monitoring patients suffering from eye disease. Optometrists provide eyecare in the community and by doing so they often relieve the burden on hospital ophthalmologists. Optometrists are also qualified to dispense spectacles, fit contact lenses and prescribe low vision aids.

**Dispensing Opticians** provide spectacles on the basis of a prescription produced by an optometrist or ophthalmic medical practitioner. Some dispensing opticians dispense low vision aids and some are qualified to fit contact lenses under instruction from an optometrist.

**Ophthalmic Medical Practitioners** are medical doctors who undertake eye examinations as part of the General Ophthalmic Services. They work to the same terms of service as optometrists.

**Ophthalmologists** are doctors who specialise in diseases of the eye and most also undertake eye surgery. In general they work within hospital eye departments.

**Orthoptists** treat disorders of binocular vision and work in eye departments under the supervision of ophthalmologists. They may also undertake visual screening of children in the community.

Good vision is essential to the development of life and educational skills in an individual's formative years. As a person matures, good vision and health influence their quality of life and ability to earn a living. In later years, good vision and health continue to play an important role in maintaining a person's independence. Preventing eye disease – a key role of optometry - rather than treating it, saves money in the long run.

## OPTOMETRY: AN OVERVIEW

Optometrists mainly work in community-based practices at primary care level, although some work in hospitals alongside ophthalmologists, in the secondary care sector. Community optometrists provide a range of services including sight tests and eye examinations, either through the General Ophthalmic Services or privately; they dispense contact lenses and spectacles and undertake clinical procedures through co-managed or shared care arrangements.

Optometrists are trained to perform sight tests, which include refraction and detection of signs of injury, disease or abnormality in the eye; most referrals to the hospital eye departments are initiated following a routine sight test by an optometrist. Greater accuracy of referrals can be achieved by optometrists carrying out more detailed examinations.

Optometrists are able to provide a range of services within primary care, usually in conjunction with GPs and ophthalmologists, in order to screen for and monitor eye disease e.g. glaucoma and diabetic retinopathy. They can also provide treatment e.g. low vision aids, and soon for anterior segment eye disease. Schemes involving optometrists in the pre-and post-surgical assessment of patients with cataract have been shown to be a particularly effective way of helping to deliver the targets required under the Government initiative “Action on Cataracts”. Optometrists can also examine patients referred by GPs and advise on the best course of action. Primary care optometry is a thoroughly patient-centred service.

All of these services ensure that the maximum amount of eyecare is provided in a primary care setting by someone trained to detect, manage, and treat eye disease (independent prescribing rights will shortly be granted to optometrists). Optometrists provide a quality service to patients, at a reasonable cost to healthcare commissioners and use a range of sophisticated equipment, which is not available in most GP surgeries. They offer GP’s the best advice on the necessity, or otherwise, of ocular referrals to the Hospice Eye Service (HES). The primary eyecare of the patient is improved, unnecessary referrals to ophthalmologists are minimised, costs are therefore contained and the waiting time for urgent hospital appointments is reduced.

## SIGHT TESTS & EYE EXAMINATIONS

**Optometrists carry out sight tests and eye examinations, which may encompass some or all of the following procedures:**

- Patient details, for example personal details and visual needs;
- Reasons for visit;
- History & symptoms including previous ocular history and current medication;
- Ocular status including the aided and / or unaided vision of each eye, ocular motility and binocular vision assessment, pupil reflexes;
- Screening for gross visual field defects;
- An internal and external examination of the eye;
- Objective refractive findings;
- Subjective refraction;
- Intraocular pressure measurement;
- Visual field assessment;
- Other vision tests where appropriate for example, colour vision;
- On completion of tests, advice on the findings and the prescription for a corrective appliance, or signed statement, will be given to the patient.

Certain groups of patients, for example, children, those aged 60 and over, people on some income-related benefits and those at risk of defined eye diseases are entitled to have a sight test paid for by the NHS through the General Ophthalmic Services (GOS). Those who are not entitled to a GOS sight test are seen privately.

The GOS sight test is a legally defined procedure for a defined purpose and GOS fees should not be used for other purposes, for example, to finance a co-management scheme.

## REFERRAL PROCEDURES

**When an optometrist detects an abnormality of the eyes there are two possible courses of action:**

- To refer the patient
- To monitor the situation over a period of time.

In the past, the “Rules on Referral” from the General Optical Council restricted the choices available to the optometrist. If any sign of eye disease was found the optometrist was required to inform or refer a medical practitioner. In 2000 this was changed to allow the optometrist to use clinical judgement on whether to refer or to monitor the situation by a re-examination of the patient at a later date.

In effect this means that when a patient has a condition, for example an early cataract, the optometrist is permitted by law to monitor the position until referral is appropriate.

In many areas, shared care referral protocols have been drawn up by agreement between the Local Optometric Committee, the Local Medical Committee and local ophthalmologists to identify under what circumstances certain categories of patients should be monitored by community optometrists. This ensures that only those patients who need to be seen at the hospital are referred at the appropriate time.

## SPECIALIST SKILLS

**Optometrists can provide the following services:**

- detection of ocular pathology and referral for medical treatment if appropriate;
- monitoring of pathological conditions in support of the medical profession (shared or co-managed care);
- detailed referral information and grading the urgency of such referrals;
- the therapeutic treatment of certain eye conditions;
- diagnostic and other specific services, such as the visual assessment of the over 75s, examinations and tests carried out at the request of GPs to assist them when diagnosing patients’ ocular problems;
- the care of children’s eyes, including advice on education and career implications of sight defects;
- provision and advice on the use of low vision aids;
- provision and advice on the use of contact lenses; correction of visual defects by refraction and the dispensing of appropriate optical appliances;
- advice on vision and eye wear for sport; occupational eyecare including safety spectacles and those for use with visual display screen equipment;

## INFRASTRUCTURE

In general, community optometrists work from premises that are more easily accessed by patients; more conveniently located than hospital eye departments and open for longer hours. Optometric practices usually offer appointments six days per week, including Saturdays and sometimes in the evening.

Practices are well equipped with most of the general equipment found in ophthalmology clinics. Increasingly, this will include digital retinal imaging equipment.

Most optometric practices have sophisticated computerised recall systems, ample administrative staff and are situated in almost every locality.

Some optometrists have specialist skills, for example in contact lenses, low vision or paediatrics and these skills can be utilised in the care of patients who would otherwise need to be seen in the secondary sector.

## CO-MANAGEMENT

Co-management, or shared care, is the process by which optometrists undertake specified clinical procedures, usually working to an agreed protocol. This is designed to relieve the burden on GPs and the hospital eye service, and to move patient care into the community.

### This may include:

- **Cataract:** optometrists can manage the patient to the stage where surgery is necessary, and assess the patient before surgery and afterwards;
- **Glaucoma:** optometrists can improve the accuracy of referrals by undertaking further clinical investigation and monitoring patients who have ocular-hypertension or whose disease is stable;
- **Diabetes:** optometrists can deliver a highly effective monitoring service for diabetic retinopathy, using either slit-lamp biomicroscopy, digital imaging, or both;
- **Low Vision:** optometrists can extend the routine sight test and dispensing function to provide aids for the registered blind and partially sighted;
- **Contact Lenses:** optometrists who have the relevant contact lens skills can provide medically indicated contact lenses in a community setting;
- **Minor Acute Eye Problems:** optometrists can work with GPs to manage and treat minor eye conditions;
- **Paediatrics:** optometrists can refract children referred from a screening service, provide spectacles or binocular vision therapy and refer children to the hospital eye service, as appropriate.
- **Therapeutics:** At the time of going to press (November 2001) optometrists are expected to be granted independent prescribing rights within the next eighteen months.

## COSTS & PRICING

Optometrists can provide a range of services within primary care as part of locally agreed and funded co-management (shared care) schemes. Those involved in establishing these schemes should be aware that it is not, in general, legally possible to use the GOS sight test fee to fund, or part-fund, such schemes. Nor should the GOS fee be used as an indicator of the cost of providing other optometric services as it is widely recognised that this fee is unrealistically low.

**Co-managed schemes can deliver great value for money, bringing four key benefits:**

- **shorter waiting lists;**
- **shorter waiting times;**
- **greater patient convenience;**
- **more efficient use of secondary care resources.**

## CATARACT

Cataract co-management is one of the most straightforward shared-care systems to implement; it is well liked by patients; in audit it has been shown to be effective and to reduce the number of hospital visits from five to one or two. In a well-managed system it is likely that for every three outpatient ophthalmologist appointments saved, one extra cataract extraction can be undertaken.

Cataract is almost entirely an age-related condition. The UK has an aging population and the proportion of those over 80 years of age will increase significantly in the coming years. Older people are demonstrating an increasing desire to be independent, and with this goes the need to see adequately.

Cataract is the largest preventable cause of visual reduction in the over 70s, yet can be remedied in most people with day-case surgery involving an operation which takes approximately 20 minutes under local anaesthetic. However the UK has one of the lowest rates of cataract surgery in the western world, along with some of the longest waiting lists for this procedure. This problem was addressed in the document “Action on Cataracts” which proposed a 50% increase in surgery between 1999 and 2003, but present systems of patient care cannot deliver this target without either a reduction in the care of patients with other eye disease, or a change to procedures of service delivery.

Eight patient/clinician procedures are involved from when the optometrist first diagnoses the condition to when the optometrist examines the patient for post-operative spectacles. Through co-management, this process can, at best, be reduced to three procedures, although this may not be suitable for all categories of patients.

The following are some of the care pathways for cataract co-management:

### **Direct referral**

It is accepted by both GPs and ophthalmologists that optometrists are able to diagnose cataract more accurately than GPs, so a direct referral from the optometrist to the hospital is a more sensible use of resources, cuts down on unnecessary GP appointments, and is more convenient for the patient. It is, however, essential that the GP is able to add useful clinical information to the referral, and so all correspondence from the optometrist to the hospital and vice versa is copied to the GP.

### **Streamline hospital appointments**

All of the procedures undertaken at the hospital outpatient visit are within the clinical skills of the optometrist, who can work to a locally agreed protocol and refer patients who require surgery to an ophthalmologist appointment. It has been found that when this regime is adopted the outpatient appointment time is reduced by about 50%, allowing a higher volume of patients to be seen.

### **Two stop system**

In most cases it is possible for the patient to be seen at the hospital for confirmation by the ophthalmologist that surgery is appropriate and to have some further tests e.g. biometry, at the same visit. This simple measure will save one out-patient visit per patient, but will require either that surgery follows shortly afterwards, or that biometry in some patients may need to be repeated at the time of surgery. It is advisable for either the cataract co-ordinator, or preferably the ophthalmic nurse, to telephone the patient a week or two before the operation to confirm all of the details.

### **One stop system**

In some patients, mostly those with straightforward cataract, no major co-morbidity and in moderate general health, the outpatient appointment can be dispensed with entirely. The patient is assessed by the optometrist and telephoned by the hospital, as in the two stop system, but is then placed directly on the surgical list. Enough information is given to the patient at this stage for informed consent to be assumed. On the day of surgery the patient is seen by the ophthalmic nurse and briefly by the ophthalmologist, who further explains the procedure; informed consent is then confirmed or formalised. The patient has surgery within that session. Audits in areas which operate this system show no increase in the number of patients who do not undergo surgery on the same day.

This approach may require some reorganisation of operative procedures, but can result in a dramatic increase in surgery rates per ophthalmologist.

### **Streamline hospital post-operative assessments**

There is agreement amongst many surgeons that two appointments post-operatively are not necessary e.g. the one at 24 hours rarely identifies any complication which, if severe, could not have been picked up by a telephone call to the patient, and if not severe could not have been left until a later appointment. Thus one further outpatient appointment can be saved.

### Optometrist post-operative assessment

As with the pre-operative assessments, the community optometrist is capable of examining the cataract patient post-operatively and referring back to the ophthalmologist those patients found to have complications.

In some cases it may be possible to combine the post-operative assessment and refraction in one visit, but in general, the former should take place at about 2-3 weeks after surgery and the latter 4-6 weeks afterwards.

Like all co-management schemes it is necessary to look at each stage of the pathway and decide if that stage is necessary, if so, where it should be undertaken and by whom. A patient-centred approach is essential.

## GLAUCOMA

Optometrists can improve the accuracy of referrals to the Hospital Eye Service (HES) by undertaking additional confirmation tests before the patient is sent to the hospital. They can also monitor patients who have been diagnosed as having ocular hypertension, or who have glaucoma that has remained stable for two years.

Like cataract, glaucoma is an eye condition that is more prevalent in the elderly. While the visual effects of cataract can be “cured” by surgery, there is no cure for glaucoma. A patient with glaucoma will be using medication for life, even when the condition is stable. Most glaucoma is initially detected by a community optometrist and diagnosed by an ophthalmologist in the secondary sector, who initiates treatment.

### The referral process

A problem often encountered is the referral of patients to the secondary sector who are found not to have glaucoma. This can be due to a number of factors.

Glaucoma is not always easy to diagnose and even ophthalmologists can disagree with each other on this. It is complicated by the fact that some patients with higher than “normal” pressure in the eye do not have glaucoma - they have ocular hypertension, but they can go on to develop glaucoma; on the other hand, some patients with glaucoma have pressures which are within the normal range e.g. normal tension glaucoma.

In an ideal world, every referral from the primary sector for glaucoma would be as a result of an initial finding of abnormalities, with further tests repeated on at least one occasion for confirmation. Unfortunately the funding of the General Ophthalmic Services (GOS) sight test makes no allowance for repeat tests, so patients will generally be referred to the secondary sector on the basis of any anomalies found at the first visit.

**The usual patient pathway at the moment is that the patient would be seen by the ophthalmologist, who would then make the diagnosis:**

Once treatment has been initiated the patient would be reviewed at frequent intervals until the condition had been stabilised, then put onto a routine monitoring programme (see below) for the rest of their life.

**Optometrists can develop services to improve the accuracy of referrals, through formal, co-managed schemes, in two ways:**

No disease	>	Discharge
Uncertain diagnosis	>	Review in 6 months
Ocular Hypertension	>	Discharge or Monitor every 12 months
Glaucoma	>	Instigate treatment & review (4-6 months)

- Repeat tests for patients who fall into defined categories such as suspect visual fields or intraocular pressure.
- The establishment of a group of accredited optometrists, who will undertake extended examinations on patients referred by other community optometrists, in order to refine those referrals. They will be trained and accredited by the hospital consultant and will work to strictly defined protocols. Patients not found to have suspect glaucoma within the specified criteria of the protocol would be referred back to the community optometrist for routine eye care. Patients within the defined criteria would be referred to the secondary sector for confirmation of diagnosis and treatment.

These care pathways would reduce the number of unnecessary referrals to the secondary sector and provide the initial referral refinement within primary care, with all of the advantages which this has for the patient.

### **Routine monitoring of the diagnosed patient**

Once the patient has been stabilised, i.e. once the pressure in the eyes is within a target range and there is no further significant loss of visual field, the patient will be subject to routine reviews to ensure that this situation is maintained. Routine review also applies to many with ocular hypertension.

Review will consist of a visual field analysis and an examination by the ophthalmologist, who will look at the optic nerve head with an ophthalmoscope and measure the intra-ocular pressure, comparing the readings with previous visits. In essence these are the same procedures as those used by the optometrist in making the initial decision to refer. There is, therefore, no clinical reason why stable patients cannot be transferred back to the primary sector optometrist, to be monitored. Ideally these checks should occur at intervals of about six months, although at least one leading authority has suggested that three months is more appropriate. Due to pressures on ophthalmology departments, checks are generally on an annual basis and some may even slip beyond this.

In a community monitoring service it is usually considered advisable for the patient to be seen in the secondary sector on a routine basis every few years and this would be included in the agreed protocol.

In essence it means that once the patient has been stable for two years, he/she is transferred to the care of the accredited optometrist of their choice, who would see them at intervals agreed with the ophthalmologist before they would return to the hospital for evaluation. If all were still satisfactory, the patient would then be transferred back into the community optometrist loop. At any stage, if the condition changed, the patient would be referred back into the hospital eye department on a fast-track basis.

This system of care would fulfil the desired goal of cutting down on unnecessary visits to the secondary sector; bring care to the community and increase the number of available hospital outpatient appointments.

## DIABETES

Optometrists have been shown to be efficient and cost-effective at delivering a system of diabetic retinopathy monitoring in the community. In the UK there are upwards of 60 schemes in which people with diabetes are seen by community-based optometrists, who work within agreed protocols to examine the retina and refer the patients for ophthalmological evaluation and treatment at the appropriate time.

A guidance document for optometrists involved in diabetic co-management, produced by the College of Optometrists, the Royal College of Ophthalmologists, the Royal College of General Practitioners, and the British Diabetic Association (now Diabetes UK), with the support of the Department of Health, is available. Thus it can be seen that the involvement of optometrists in the care of the diabetic patient is well supported by all of the relevant professional and special interest groups.

Alternative schemes involving patients attending hospital for assessment, either by clinical staff or for retinal photography, have been shown to be the most expensive care delivery system and do not fit in with Government requirements for care to be moved to the community whenever possible.

The National Screening Committee accepts that accredited community-based optometrists can deliver the standards required, but has suggested that the long-term aim should be to use retinal photography as the mode of delivery to ensure that audit is straightforward.

### **Retinal cameras based in optometrists' practices have the following advantages:**

- Most patients already attend an optometrist for routine eye care;
- The screening can be provided at a time and place which is more convenient for the patient;
- Most optometrists would be prepared to accept a grant towards the purchase of a retinal camera on the basis that they will be able to use the cameras for other clinical purposes. This would mean that more cameras could be supplied in an area for the same financial outlay.
- Optometrists have been shown to have the necessary clinical skills for grading and, therefore, diabetic patients can be informed of the outcome of the screening at the same visit;
- If an image is found to be inadequate for grading, the optometrist can view the retina immediately using the "traditional" gold standard method of slit lamp bio-microscopy;
- Co-existing morbidity, such as cataract, can be detected.

## LOW VISION

Currently, in most areas, an optometrist who believes that the vision of a patient would benefit from a low vision aid must refer that patient to the Hospital Eye Service (HES). There is often a considerable delay before the patient is seen and assessed. Some hospitals have no LVA service at all and rely on the voluntary sector. If an aid is issued, this will be on a loan basis, but there is frequently no follow-up to see if this approach has been successful.

Patients with low vision are often one of the most disadvantaged groups in society. They are usually elderly and require a dedicated team-approach to their needs. Frequently their social needs are catered for on the basis that their vision cannot be improved but often this is not the case and the provision of low vision aids can dramatically improve their quality of life and independence.

The examination of the patient with low vision is an extension of the normal procedures undertaken as part of a routine sight test. The provision of low visual aids is a clinical skill, which is well within the remit of optometrists. By working with other agencies, such as the Hospital Eye Service, GPs, Social Services and the voluntary sector, the lifestyle of the low vision patient can be improved significantly, thereby reducing the dependence of that person on others.

Low vision services can be provided with reference to a framework drawn up by a multi-disciplinary working group on low vision, which recommended that each Primary Care Group/Trust set up a Local Low Vision Services Committee to help those members of the community with low vision.

### **It also recommended:**

- A person with low vision should be able to use low vision services at any stage after low vision has been identified;
- Access should not be exclusively determined by clinical parameters such as visual acuity;
- That the person's GP should be kept informed;
- That a full eye examination by an ophthalmologist or optometrist has been carried out.
- There should be re-examination annually by an optometrist or ophthalmic medical practitioner (OMP);
- Services should be provided as close to the person's own home as practicable;
- Mechanisms should ensure inter-agency referral and information exchange to ensure a seamless service;
- Those supplying low vision aids should ensure that the user is trained in the optimal use of their vision and the low vision aids provided.

This type of approach to the care of the patient fits in well with the closer cooperation envisaged between Primary Health Care and Social Services.

## CONTACT LENSES

For some medical conditions, contact lenses are the only possible or practicable method of sight correction. The fitting of contact lenses in such clinical situations is currently undertaken, if at all, within the secondary sector i.e. in hospital-based clinics which are often staffed by part-time, experienced contact lens practitioners, and following a consultant access appointment. These practitioners, because they have a special interest in contact lenses, usually offer the same service from their community based practices on a private basis i.e. to non-NHS patients. It seems difficult to justify the allocation of relatively expensive, hospital-based specialist clinics, for this purpose, when community optometrists can provide the service.

Basing such services in the community, where premises, equipment and skills are already established, offers patients the advantages of convenience and continuity, as well as the potential of much reduced costs to the provider.

## MINOR ACUTE EYE PROBLEMS

Minor eye problems, such as red eye, floaters, minor trauma, dry eyes, extra-ocular foreign bodies, are often treated by GPs. Many GPs will admit that they have neither the experience nor the equipment to make a confident diagnosis and give suitable treatment.

Optometrists have both the training and equipment necessary to provide this service.

Pilot schemes have demonstrated that this can be operated efficiently and cost effectively. They have shown that fewer prescriptions are issued, there are fewer referrals to hospital for minor conditions and serious conditions are referred earlier than would otherwise have been the case if the GP had managed the condition.

At the moment, optometrists do not have prescribing rights, although this is to change in the near future. It is currently possible for arrangements to be made between the GP, optometrist and pharmacist to produce a system which will allow the issue of these drugs on the recommendation of the optometrist with the prescription being signed by the GP.

The final report of the Crown Review (1999) into the prescribing, supply and administration of medicines, recommended that optometrists should be given leave to apply for independent prescribing rights. Primary legislation (Health & Social Care Act 2001) is now in place to allow optometrists to apply for prescribing rights and it is expected that these will be granted within eighteen months from the time of going to press (Nov 2001).

When optometrists have prescribing rights, they will be able to diagnose and treat non-sight-threatening eye conditions (initially), independent of GP or hospital involvement.

## PAEDIATRICS

Children should be screened for visual defects by a suitably trained person at age 4-5, or earlier if there is a family history of ocular-related problems. In many areas, if a defect is indicated, the child is referred to the secondary sector to be seen by an ophthalmologist. This can involve a wait of many months at a time when the visual system is at its most vulnerable. If a squint (strabismus) or lazy eye (amblyopia) is identified, treatment would be initiated and reassessed at regular intervals.

Where screening is carried out by an orthoptist rather than an optometrist, pre-school children with vision which appears to be below normal, or with binocular vision problems, should then be seen for examination by a community-based optometrist. Refraction, the provision of spectacles where indicated, and commencement of therapy could be initiated swiftly. Pathological conditions causing strabismus or amblyopia are rare, but would be detected at this eye examination.

Where amblyopia shows no improvement within three months, or where a refractive strabismus does not respond within this timescale, “fast track” referral to ophthalmology could be initiated. In all of these cases this would ensure that children were seen by an ophthalmologist when necessary, and within a shorter waiting time than most current systems.

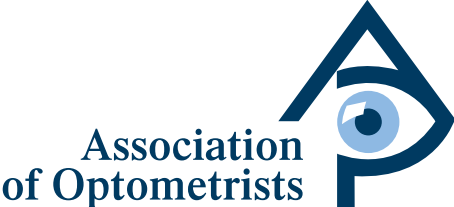
## SUMMARY

Optometrists have the skills and resources to provide radical patient-centred eye care. They can help healthcare commissioners to meet the requirements of the NHS Plan to deliver shorter waiting lists, shorter waiting times and easily accessible services through community-based co-management schemes.

**Healthcare commissioners interested in exploring the benefits that optometrists can bring to patients and the NHS should contact:**

Patricia O’Sullivan  
 Head of Professional Services  
 Association of Optometrists  
 61 Southwark Street  
 London SE1 OHL

Tel: 020 7261 9661 ext 28  
 Direct Line: 020 7207 2195  
 Fax: 020 7261 0228  
 email: [patriciaosullivan@assoc-optometrists.org](mailto:patriciaosullivan@assoc-optometrists.org)





**Healthcare commissioners interested in exploring the benefits that optometrists can bring to patients and the NHS should contact:**

Patricia O'Sullivan  
Head of Professional Services  
Association of Optometrists  
61 Southwark Street  
London SE1 OHL

Tel: 020 7261 9661 ext 28  
Direct Line: 020 7207 2195  
Fax: 020 7261 0228  
email: [patriciasullivan@assoc-optometrists.org](mailto:patriciasullivan@assoc-optometrists.org)