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Vision, Healthy Ageing and Frailty

Primary Care Optometry as a Partner in Prevention, Frailty Management and Neighbourhood Care

June 2026
Version 1

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Table of Contents

Summary of Position

Vision and eye health should be recognised as core components of healthy ageing, frailty prevention and neighbourhood care. Primary care optometry is an accessible, clinically relevant and underused neighbourhood asset that can support earlier intervention, reduce avoidable deterioration, improve functional independence and contribute to more coordinated care for older people and those living with, or at risk of, frailty, reduced mobility or loss of independence.

The case for action is strong. National public health and clinical guidance **identify visual impairment as an important contributor** to falls, reduced mobility, loss of confidence and avoidable loss of independence in older age.

Key Takeaway

National public health and clinical guidance **identify visual impairment as an important contributor** to falls, reduced mobility, loss of confidence and avoidable loss of independence.

NHS England states that **more than one in three people over 65 fall each year**, increasing to **50% in people aged 80 years and over**, while current NICE guidance highlights the distress, injury, loss of confidence and loss of independence associated with falls. Nearly two million people in England live with sight loss affecting daily life, with prevalence projected to rise significantly as the population ages.

Primary care optometry is a neighbourhood asset within prevention-focused models of care. It has regular contact with older people, people living with long-term conditions, care home residents and housebound populations, and can contribute to early identification, falls prevention, maintenance of visual function, support for self-management and referral into wider

services.

We therefore call on integrated care systems, NHS commissioners, local authorities and neighbourhood teams to **make vision explicit within healthy ageing, falls, frailty and ageing well strategies**; establish effective referral and collaboration mechanisms between optometry and other community services; strengthen access for care home and housebound populations; and commission service models that support prevention, functional outcomes, frailty management and equity of access.

This position statement focuses on **five priorities** for system action:

5
key priorities
for system action

1. Recognise vision and eye health as **core components** of healthy ageing, frailty and prevention strategies.
2. **Embed primary care optometry** in falls prevention and neighbourhood care pathways.
3. **Improve access** for care home residents, housebound people and other underserved groups.
4. Support **functional independence** through prevention, early intervention and low vision pathways.
5. Commission integrated, evaluated service models that **reduce avoidable deterioration** and inequality.

Primary care optometry does not seek to duplicate existing services for older people. Rather, its role is to strengthen prevention, support mobility and functional independence, provide clinically relevant support on visual function and eye health, and act as a practical partner within integrated, person-centred neighbourhood models of care, including services focused on frailty identification, management and support for living independently.

Position Statement

Vision and eye health should be treated as **integral** to healthy ageing, frailty prevention and the maintenance of functional independence. In many systems, however, vision is recognised only after deterioration has already affected mobility, confidence, communication or self-management.

This creates avoidable risk, weakens prevention efforts and limits the effectiveness of person-centred care for older people, including those living with frailty.

Key Takeaway

Vision and eye health should be treated as **integral** to healthy ageing, frailty prevention and the maintenance of functional independence.

Primary care optometry should be embedded within neighbourhood, multidisciplinary and population health pathways, particularly where systems are seeking to reduce falls, delay functional decline, improve frailty management, support people to remain at home and reduce inequality.

Primary care optometry is already embedded within local communities through both high street practices and domiciliary services delivering care in patients' homes and residential care settings.

Key Takeaway

Commissioners and system leaders should therefore ensure that **vision is visible** within local healthy ageing, frailty, falls prevention and population health strategies.

It has the capacity to contribute if system leaders **establish formal referral pathways, local partnerships, governance arrangements and resourced service models** that make effective use of this resource. Given that people living with frailty may be vulnerable and have complex needs, optometry's role should be designed into pathways as an active and appropriately supported partner, with training, clear escalation routes and safety-netting arrangements, rather than relying on informal signposting or assuming additional activity can be absorbed within the existing General Ophthalmic Services (GOS) sight test.

Commissioners and system leaders should therefore ensure that vision is visible within local healthy ageing, frailty, falls, prevention and population health strategies; commission services that support timely access, earlier intervention, mobility and functional outcomes; and ensure that people at highest risk of poor eye health and avoidable sight loss are **not excluded** from neighbourhood care or frailty pathways.

Why This Matters Now

England's population is ageing, and more people are living longer with complex health needs, multimorbidity and disability. At the same time, sight loss and visual impairment remain major public health issues.

The Office for Health Improvement and Disparities (OHID) Vision profile provides local indicators on sight loss outcomes, eye care activity and risk factors to support commissioning and planning, while the RNIB Sight Loss Data Tool is widely used to understand current and projected need. Together, these resources underline the importance of local intelligence in service design and prevention planning.

The demographic trends driving frailty are also driving rising demand for eye care. PA Consulting's Key Interventions to Transform Eye Care & Eye Health reported that some major eye conditions are **projected to increase by around 25% by 2032,** substantially outpacing overall population growth.

25%

A number of major eye conditions are **projected to increase by around 25%** by 2032.

The report also modelled **significant** NHS capacity and cost benefits from expanding primary care optometry pathways, reinforcing the wider strategic case for using optometry as part of prevention-focused, neighbourhood-based care.

This direction is reinforced by NHS England's Best Practice Guide for NHS Frailty Pathways, published in May 2026, which sets out actions for ICBs and providers to improve frailty pathways ahead of the forthcoming Modern Service Framework for Frailty and Dementia.

The guide emphasises the need for improved frailty identification and assessment, linked data, personalised care planning, neighbourhood-level frailty plans, integrated pathways, enhanced support for care homes and a frailty-attuned workforce. Vision and eye health should be considered within this agenda because they affect mobility, confidence, falls risk, communication, self-management and the ability to remain independent.

Falls are a particularly important part of this picture. NHS England states that **more than one in three people over 65 experience a fall each year**, and NICE's updated guideline on falls aims to reduce the associated distress, pain, injury, loss of confidence, loss of independence and mortality.

OHID's national falls guidance also identifies visual impairment as one of the key modifiable and interacting risk factors that should be addressed in prevention work.

For older people, the consequences of visual impairment are not limited to eyesight alone.

Vision affects balance, depth perception, navigation, communication, medication management, confidence and participation in daily life. As visual function deteriorates, people may reduce activity, become less confident leaving home and experience greater dependence on health and social care support.

The Case for Action

The relationship between vision, healthy ageing and functional independence is both clinical and practical. **Visual impairment contributes to falls risk**, but it also affects wider determinants of independence, including safe movement around the home, confidence on stairs and uneven surfaces, reading, communication, self-care, social participation and the ability to manage other health conditions.

Eye health is therefore not peripheral to healthy ageing; **it is part of the same prevention, mobility and independence agenda**.

Key Takeaway

Eye health is therefore not peripheral to healthy ageing; **it is part of the same prevention, mobility and independence agenda**.

Many causes of visual deterioration are **preventable, treatable or manageable**, including refractive error, cataract, glaucoma and diabetic eye disease. Recent OHID profile updates continue to track preventable sight loss from age-related macular degeneration, glaucoma and diabetic eye disease, while RNIB data projects further growth in major eye conditions as the population ages.

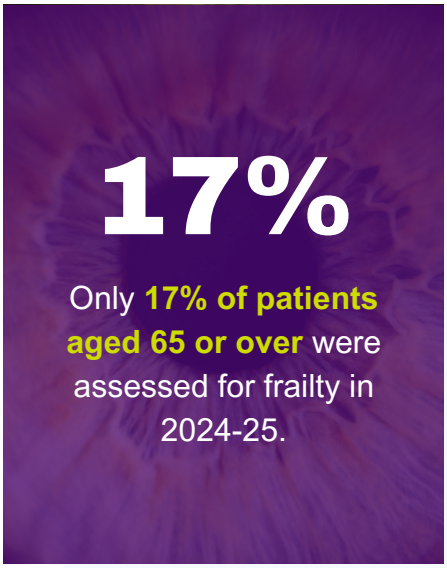
Key Takeaway

Many causes of visual deterioration are **preventable, treatable or manageable**, including refractive error, cataract, glaucoma and diabetic eye disease.

This makes eye care especially relevant to prevention policy: timely examination, appropriate correction, early detection and referral can help reduce avoidable deterioration and protect functional ability.

The recent Public Accounts Committee (PAC) report on supporting people with frailty outside hospitals adds a strong system-level rationale for this agenda. It highlights major shortcomings in current frailty identification and falls prevention, noting that in 2024–25 **only 17% of patients aged 65 or over were assessed for frailty**, **while among people diagnosed with severe frailty, only 18% received a falls risk assessment and 16% a medication review**, despite these being expected elements of care.

Falls and fragility fractures also create a substantial financial burden for the NHS and wider care system. Falls in older people are estimated to cost the NHS **over £2.3 billion each year**, while the total annual cost of fragility fractures to the UK has been estimated at **around £4.4 billion**, including social care costs. Visual impairment is recognised within national falls guidance as one of several modifiable and interacting risk factors.



Falls are multifactorial, and not all falls related to poor vision are preventable, but the scale of clinical harm and system cost strengthens the case for ensuring that vision is routinely considered within frailty, falls and healthy ageing pathways.

Further local evaluation should seek to quantify how often visual impairment, uncorrected refractive error, cataract, glaucoma, poor lighting or other vision-related factors are present in falls and fragility fractures, and whether earlier identification and management of visual problems can reduce avoidable deterioration, falls-related harm, loss of confidence and demand on urgent, community and hospital services.

Taken together, these findings suggest that current models, reliant largely on general practice, are not consistently delivering preventive intervention at scale. In this context, primary care optometry should be seen not as a peripheral service but as an additional, underused point of contact with older adults that can support earlier identification of visual impairment, functional decline, falls risk and emerging frailty within neighbourhood care pathways.

Why Primary Care Optometry?

Primary care optometry is **uniquely positioned** within neighbourhood health systems because it combines clinical expertise, accessibility and regular contact with populations at increased risk of falls, visual impairment, frailty and functional decline.

Unlike many episodic healthcare interactions, optometry practices often maintain **long-term relationships** with patients and can identify gradual deterioration, changing functional needs and barriers to independence over time.

Recent service model examples also demonstrate the wider system value of using primary care optometry more effectively. The Specsavers Access to Care 2025 report highlights how commissioned primary care delivered glaucoma and urgent eye care pathways can improve access, reduce avoidable hospital activity and support care closer to home.

While these models are not frailty services in themselves, they demonstrate that primary care optometry has the **clinical infrastructure, workforce and community footprint** to contribute to wider neighbourhood care ambitions when appropriately commissioned and connected into local pathways.

What Primary Care Optometry Contributes

Primary care optometry is an **accessible, neighbourhood-based clinical service** with established contact with populations central to healthy ageing, frailty and prevention pathways, including older adults, people living with long-term conditions, care home residents and housebound patients. Care can be delivered in high street practices or in patients' homes through domiciliary services.

This matters because sight loss is **concentrated in later life**, and evidence from RNIB and care home research indicates that visual impairment is common among care home residents and among people living with dementia and sight loss.

Its contribution includes timely eye examination, optimisation of refractive correction, detection of causes of sight loss, support for functional vision, access to low vision pathways, practical advice to help people adapt safely to changing vision, and escalation or referral where wider concerns are identified.

In this way, optometry can support both clinical care and the everyday outcomes that matter to patients, including confidence, mobility, communication and independence.

Key Takeaway

Primary care optometry is an **accessible**, **neighbourhood-based clinical service** with established contact with populations central to healthy ageing, frailty and prevention pathways.

Low vision services deserve **particular attention** within this agenda. A low vision assessment, supported by appropriate magnification, practical advice and adaptation can make an immediate

difference to a person's confidence, independence, communication and ability to manage daily life. This is especially relevant for people living with frailty, dementia, reduced mobility or housebound status, where loss of functional vision can compound falls risk, social isolation, reduced activity and dependence on others.

Primary care optometry can also **strengthen neighbourhood working** by creating reciprocal referral routes with falls services, frailty services, rehabilitation teams, primary care, community nursing, sensory support services, care homes and the voluntary sector. This is particularly important as systems develop anticipatory care, integrated neighbourhood teams and population health approaches for older people.

Recommendations for Commissioners and System Leaders

Integrated care systems and commissioners **should explicitly include vision and eye health within healthy ageing, frailty, prevention and falls strategies**. This should be reflected in local policy, pathway design, service specifications and population health planning, rather than treated as a peripheral issue.

Key Takeaway

Integrated care systems and commissioners **should explicitly include** vision and eye health within healthy ageing, frailty, prevention and falls strategies.

Commissioners should **embed** primary care optometry within neighbourhood and multidisciplinary pathways for falls prevention, frailty management, anticipatory care, rehabilitation and support at home.

In practice, this should include **formal referral and communication routes between frailty, falls, rehabilitation, care home, primary care and optometry services, with clear expectations about roles, responsibilities, escalation and safety-netting**. Where local systems want optometry to support identification, referral or wider frailty-related activity, this should be underpinned by appropriate training, pathway design and commissioning arrangements.

Supporting primary care optometry to be more visible within local pathways and referral mechanisms will help ensure that patient care is delivered in a joined-up way. Commissioning services, including low vision services within primary care optometry, will help ensure that care is delivered locally, in familiar settings, and supports patients to maintain independence.

Systems should **improve access** for groups at highest risk of poor outcomes, including care home residents, housebound patients, people living with dementia and people experiencing deprivation or barriers to eye care. Equity should be built into commissioning design, outreach arrangements and service monitoring from the outset. People living in care homes face a **substantially higher risk of falls** and are often more vulnerable because of older age, greater frailty and reduced mobility.

Equity of access should include specific consideration of low vision and domiciliary provision. Access to primary care delivered low vision services remains inconsistent across England, meaning that support for functional independence may depend on geography rather than need.

Rurality, poor transport access, frailty, housebound status and caring responsibilities can all make hospital-based or high street appointments difficult. Commissioners should therefore ensure that low vision pathways **include appropriate domiciliary provision** and are designed around the needs of people who are least able to travel.

Commissioned service models should prioritise functional and system outcomes alongside clinical activity. For older people, relevant outcomes include confidence, mobility, communication, self-management and the ability to remain independent. Service design and evaluation should therefore assess real-world function, patient experience, avoidable deterioration and contribution to wider prevention objectives.

Key Takeaway

Commissioners should ensure that low vision pathways **include appropriate domiciliary provision** and are designed around the needs of people who are least able to travel.

Commissioners should support workforce development, shared protocols, governance arrangements and evaluation. Integrated service models require staff confidence, local leadership, clear accountability and agreed outcome measures that capture prevention, functional benefit, patient experience and reduced avoidable deterioration.

Implementation Priorities

Unlike many contributors to frailty and falls, visual impairment is often **identifiable, treatable or manageable**.

Timely examination, appropriate refractive correction, cataract management and low vision support therefore represent **important opportunities for prevention**, support for frailty management, improved mobility and reduction of avoidable deterioration.

Key Takeaway

Unlike many contributors to frailty and falls, visual impairment is often **identifiable, treatable or manageable**.

As an initial step, local systems should map existing eye care, falls, frailty, rehabilitation and low vision provision; identify current gaps in referral, access and pathway integration; and agree a small number of shared delivery priorities that can be implemented through neighbourhood teams and provider partnerships. Early priorities may include reciprocal referral arrangements, improved access for care homes and housebound patients, workforce development on vision and falls, and locally agreed measures for monitoring impact.

Local systems should treat domiciliary and care home eye care as **core infrastructure for frailty and healthy ageing**, not as an optional add-on, particularly for people with dementia, reduced mobility, advanced frailty or caring needs that make attendance at high street services difficult.

Implementation does not require large-scale redesign at the outset. In many areas, progress can begin through **targeted pathway improvement**, pilot activity and clearer service interfaces. The immediate priority is to ensure that vision is consistently included in prevention planning and that primary care optometry is commissioned and used as a practical delivery partner within neighbourhood care.

As systems implement NHS England's best practice guide for frailty pathways and prepare for the forthcoming Modern Service Framework for Frailty and Dementia, local frailty plans should explicitly consider how vision, eye health, low vision support and domiciliary eye care are reflected in pathway design, linked data, workforce development, care home support and outcome measures.

Systems should also support evaluation of the relationship between visual impairment, falls, frailty and healthcare utilisation, helping to strengthen the evidence base for future commissioning decisions.

Conclusion

Vision should no longer sit at the margins of healthy ageing, frailty and prevention policy. It affects how people move, manage, communicate and live independently, and it has material implications for outcomes that matter both to patients and to the wider health and care system.

Primary care optometry is already present in local communities and can make a practical contribution to earlier identification, falls prevention, functional support and more coordinated neighbourhood care.

The policy opportunity now is to embed that contribution more consistently through commissioning, pathway design, service specifications and local partnership working.

We therefore call on integrated care systems, NHS commissioners, local authorities and neighbourhood teams to **make vision explicit within local strategies**, establish practical referral and collaboration mechanisms, and commission service models that improve access, reduce avoidable deterioration and strengthen support for frailty management and living independently.

The case for action is clear: primary care optometry should be embedded within healthy ageing, frailty and falls pathways so that vision is recognised as a core component of prevention, functional independence, mobility and living independently.

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Version 1: 06/26

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