Two-Minute Briefing

Vision, Healthy Ageing and Frailty

LOCSU

Why Primary Care Optometry Should be Part of Neighbourhood Frailty and Prevention Pathways

Core Message

Vision **should** be part of frailty prevention, falls prevention and healthy ageing.

It affects how older people move, manage medication, remain socially connected, maintain confidence and stay safely at home. Primary care optometry is **an existing neighbourhood clinical asset** that can help systems identify and respond to visual impairment earlier.

Why This Matters

Frailty prevention is often framed around falls, mobility, medicines and support at home. Vision is **directly relevant** to each of these.

Poor vision can affect balance, depth perception, confidence, medication management, communication, social participation and the ability to remain safely at home. **Many causes of visual deterioration are identifiable, treatable or manageable** — including refractive error, cataract, glaucoma, diabetic eye disease and low vision needs.

The scale of the challenge is significant:

- **More than one in three people over the age of 65 fall each year**, rising to **around 50% of people aged 80 and over**.
- Falls in older people cost the NHS **over £2.3 billion each year**.
- Fragility fractures cost the UK **around £4.4 billion annually**, including social care costs.
- **Nearly two million people in England live with sight loss** affecting daily life.
- In 2024–25, **only 17% of patients aged 65 or over were assessed for frailty**; among those with severe frailty, **only 18% received a falls risk assessment**.

These figures point to a **prevention gap**. Vision will not explain or prevent all frailty, falls or fractures, but it is a recognised, modifiable and often overlooked factor that should be built into local pathways.

Why Vision Belongs in This Agenda

Visual impairment is a **recognised, modifiable risk factor** that can affect mobility, balance, confidence, medicines management and independence.

Addressing vision is, therefore a practical prevention issue, not simply an eye care issue.

What Primary Care Optometry Contributes

Primary care optometry is **already embedded** in local communities through high street and domiciliary services. It has regular contact with older people, care home residents, housebound patients and people living with long-term conditions.

Optometry can contribute to:

- **Earlier identification** of visual impairment and eye disease
- Optimising visual correction and functional vision
- Falls prevention and mobility support
- Low vision assessment, magnification and **practical adaptation**
- Referral into wider services where concerns are identified
- **Better support** for care home residents and housebound people
- More joined-up **neighbourhood care** for people living with frailty

This is not about duplicating frailty services. It is about using an existing neighbourhood clinical asset more effectively.

The Opportunity for Systems

Integrated care systems, commissioners, local authorities and neighbourhood teams **should make vision explicit** within:

- Frailty strategies
- Falls prevention pathways
- Healthy ageing and ageing well plans
- Care home support models
- Anticipatory care and neighbourhood team development
- Low vision and domiciliary care provision

The starting point does not need to be large-scale redesign. Systems could begin by mapping current eye care, falls, frailty, rehabilitation and low vision provision; identifying gaps; and agreeing practical referral routes.

Closing Line

If we are serious about helping older people remain mobile, confident and independent, then vision cannot sit at the margins of frailty and prevention work. Primary care optometry is already firmly embedded within communities; the opportunity now lies in fully integrating it into local frailty and prevention pathways.

The Ask

We are asking integrated care systems, commissioners and neighbourhood teams to **bring vision and primary care optometry into local conversations on frailty, falls prevention, healthy ageing and care closer to home.**

A practical next step would be **a focused discussion** with local frailty, falls, community, primary care and commissioning leads to map current provision, identify gaps and agree referral routes.