Standard Clinical Specification

*This standard clinical specification provides for a **Community Minor and Urgent Eye Care Service** delivered from a network of optical practices, to assure, support and enhance access to minor and urgent eye care locally. The specification review and upgrade was led by the Local Optical Committee Central Support Unit (LOCSU) and the Clinical Council for Eye Health Commissioning (CCEHC) at the request of the Department of Health and Social Care.*

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The specification is based on the COVID-19 Urgent Eyecare Service Specification - CUES. Developed by NHS England, LOCSU and the CCEHC and published in April 2020, to *support the immediate and recovery phase of Coronavirus Pandemic.*
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Service Name	**Community Minor and Urgent Eye Care Service – CUES Version 2 Updated February 2024**
Specification Number	
Commissioner Lead	
Provider Lead	
Period	April 2024 -
Date of Review	

1.	**Population Needs**

1.1 National context and evidence base

The clinical specification for the *community minor and urgent eye care service* aims to reduce pressure on General Practice and Hospital Eye Service (HES) and help meet the growing eye health need, by delivering more care locally through existing expertise in primary eye care.

Context:

Published in April 2020, the Covid-19 Urgent Eyecare Service provided for the triage, assessment and management of urgent eye care in the community, remote consultation, support for self-care and access to care close to home so that only high-risk patients are appropriately referred into hospital eye services. The specification was initially designed to address the immediate response to and recovery phases of the coronavirus pandemic. The specification has now been updated based on local implementation and service delivery experience.

This clinical specification aims to improve consistency, reduce unwarranted variation, and address inequities in access, by building on established good practice. Commissioning is recommended across integrated care systems or regional geographies to ensure a standardised approach.

Key areas of consideration:

- **Sector Collaboration and Endorsement:** The specification was developed through wide sector collaboration with clinical endorsement by the College of Optometrists and Royal College of Ophthalmologists.
- **Service availability:** As of October 2023, 75% of the population of England has access to minor and urgent eye care through local optometric practices. This access has been stable since 2021, following increased commissioning in response to the pandemic (1).
- **Technology Integration:** Improved connectivity between primary eye care and ophthalmology is needed to enable direct referral, remote consultation, advice and guidance and clinical co-management with a view to streamlining and enhancing patient care.
- **Greener NHS:** Efficiency is associated with low carbon care - ensuring the right care is delivered at the right time in the right place is key to reducing carbon emissions associated with health care.
- **Patient Benefit:** The approach outlined aligns with the NHS Long Term Plan and is expected to reduce the burden on patients, improve service availability, and deliver timely accessible care locally.

Through a network of optical practices, and utilisation of technology, patients will be able to gain prompt access to a consultation and, in most cases, a care plan for the patient to either self-manage their ocular condition (with access to appropriate topical medications where appropriate), be managed with advice, guidance and remote prescribing as necessary by hospital eye service or be appropriately referred to ophthalmology services. The use of technology will allow virtual consultations allowing people to receive their consultation from their home, or place of work, where clinically appropriate, with associated environmental benefits anticipated. The community minor and urgent eye care service is intended to

complement and integrate with a single point of access, where they exist, to deliver seamless interaction along the care pathway.

In summary, the initiative represents a comprehensive strategy to address minor and urgent eye care needs in the community, leveraging collaboration, technology, and regional coordination to ensure standardised and accessible services for the population.

Need:

Primary eye care delivers almost 20 million sight tests across England each year, of which approximately 70% are NHS funded. In 2019-20 13.4 million NHS-funded sight tests were carried out, an increase of 38% since 2002-03. (2, NHS Digital & sector data). Practice teams (optometrists, opticians and their support staff) are increasingly delivering enhanced care through local commissioning arrangements, more fully recognising the valuable contribution to the health system delivered by primary eye care (3).

Ophthalmology is already one of the busiest specialities in secondary care with nearly 10% of all outpatient appointments and 6% of surgeries being performed by the HES (4).

Demand for all eye care is rising, in 2017 the Royal College of Ophthalmologists reported an expected 40% increase in hospital eye care over the next 20 years if no action is taken (5). Studies have indicated demand may rise faster still, particularly in an ageing population and with advancements in diagnostic and treatment options. (6). Referrals to ophthalmology from primary care rose by 12% from 2013/14 to 2017/18 (7). Following diagnosis, chronic ophthalmic disease requires regular and timely monitoring and management.

The increased workload alongside the impact of the pandemic, ophthalmology workforce pressures (8) and lack of national focus has resulted in extended waiting times (9) and inequitable access for patients seeking ophthalmic care.

Prior to the pandemic, investigations from British Ophthalmological Surveillance Unit and the RCOphth highlighted the substantial incidence of sight loss in the UK tied to delayed follow-up appointments, reporting up to ***22 cases per month*** (10). Post pandemic, NHS England reported the pandemic and infection control measures had increased the issue, with “enormous numbers of new and follow up patients now at risk due to delays.” (11)

It is likely that increasing capacity pressures in general practice will have an impact on A&E departments, which are already experiencing increasing demand, up 13% up between 2010/11 and 2018/19. (12). GP surgeries are not usually equipped to undertake detailed eye examinations and, in most instances, GPs do not have the specialist knowledge to manage eye conditions. As a result, most GPs have little choice but to refer patients presenting with eye problems to the local A&E department or hospital eye service.

In a survey conducted by the GOC in 2023, 34% of the public said they would speak to their GP practice first if they woke with an eye problem, 30% would contact their optometrist/opticians practice, 10% pharmacy and 16% hospital (eye hospital or A&E). Back in 2019, only 20% reported that they’d contact their optometrist/optician first (13).

In their delivery plan for recovering access to primary care, NHS England has recognised that in general practice demand is greater than capacity and made a commitment to make access easier for patients, with general practice now delivering more than a million appointments every day (14).

Evidence base:

The eye care sector has long recognised the opportunity in addressing lack of capacity, optimising the skills and expertise available with multidisciplinary working across primary and secondary eye care and increasing the scope of care delivered within optometric practice. The NHS Long-Term Plan emphasises the pivotal role of primary care including optometry in advancing out-of-hospital care (15).

Public confidence in primary eye care remains strong, with 92% of respondents to the GOC public 2023 survey either “fairly” or “very confident” in the standard of care provided by opticians/optometrists practice, higher than that seen for other primary care professionals (13).

The long-term trend for those who would speak to their optometrist/optician first if they woke with an eye problem has increased year on year, now 30% in England (36% for UK) rising from 20% in 2019. By contrast, there’s been a reducing trend for contacting general practice, falling from 54% in 2015 to just 33% across the UK. Other nations have seen more significant shift most likely due to their approach to national commissioning (13).

There are long-established services and local (many unpublished) audits and service evaluations to build on:

Service evaluation in Manchester in 2021 and 2022 strongly supports the ongoing commissioning of CUES in primary care, supporting the view that the service is clinically safe, reporting a reassuringly low false-negative rate of 0.23% for moderate-to-high risk of sight loss cases in the cohort reviewed and a reduced footfall into the hospital’s emergency eye department following the introduction of the optometry service (16,17).

A retrospective analysis of activity and outcome data (for the period before the service started i.e. April 2011 to March 2013; and after i.e. April 2013 to March 2015) for 2,123 patients who accessed a MECS over a 12-month period in Lewisham and Lambeth, in April 2013, demonstrated (18):

- Patients presented with red eye (36.7%), painful white eye (11.1%), flashes and floaters (10.2%) and loss of vision (9.2%).
- 64.1% of patients were managed in optometric practice and 18.9% were referred on to the HES; of these 88.9% had been appropriately referred.
- Two thirds (67.5%) were signposted from general practice.
- A 26.8% [95% CI -40.5% - 13.1%] reduction in GP referred first attendances to hospital ophthalmology outpatient services, compared with a neighbouring area; *the reduction in first attendances was impressive given that the average England growth for the same comparison period was 13.1%.*

Primary Eyecare Services Limited (PES), the largest prime provider of CUES contracts, reported for the period Oct-2022 – Sep-2023 covering 247,556 patient episodes from all 7 NHS regions; 78.9% of people were fully managed within the Optometry service (ranging from 70% in North Central London to 82% in Southwest London). Of the referrals, 4.6% were to the GP, 16.5% to HES (12% urgent, 4.5% routine).

The majority of patients (64%) self-presented to the service with 17% care-navigated from general practice (appointment avoided) and a further 7.5% referred following an appointment in general practice. Patients presented with sore/painful eye (64%), loss of vision (13%), flashes and floaters (20%) and foreign body (4%). (note: patients reported multiple symptoms e.g. Sore eye with loss of vision).

16% (2,366 of 14,703 respondents) of people seen within CUES contracts delivered by PES during 2022 & 2023 said they'd go to A&E if there was not a CUES service locally, whilst 42% (6216) said they'd visit their GP. Others reported they'd have called NHS 111 (3%), done nothing (3%), paid privately (14%), attended a local walk-in centre (7%), sought advice from Pharmacy (7%) and 8% said they didn't know or left the question unanswered.

Where services are not commissioned patients unnecessarily attend A&E and general practice:

In 2014/15, there were 372m GP consultations in England (National Audit office 2015) and it has been estimated that 1.5 – 2% (i.e. 5.6m – 7.4m appointments) of these are eye related (based on Sheldrick et al 1992 & 1993 1992) suggesting that the traditional pathway unnecessarily relies on GP capacity.

In November 2023, the BMA reported that GP practices across England are experiencing significant and growing strain with declining GP numbers, rising demand and struggles to recruit and retain staff (19).

Increasingly, pathways of care-navigation from general practice and eye casualty to optometry are helping patients to receive their care in the right place first time. NHS England has invested in a national care navigation training programme with the aim to redirect 15% of activity from GP practice to alternative provision to better meet patient need (20). Through care-navigation to optometry, there is potential to ease general practice capacity pressures.

Data made available by Hampshire and Isle of Wight ICB shows that following the introduction of CUES on the Isle of Wight, 85% of people presenting to the service were managed within the service, emergency department activity decreased (71% of the pre-pandemic level) and cases seen in the ED were more urgent/ appropriate, with 53% considered urgent compared with only 45% in 2019/20. As a result, the HES were able to redirect resources to address other care pathways (21).

Recent retrospective analysis of eye casualty presentations in Hereford found that (22):

- 92% of referrals to eye casualty by GP could have been seen in optometric practice.
- Of these, 57% could have been managed within core optometric skills with an additional 13% managed by using additionally qualified Independent Prescriber (IP) optometrists.
- 83% of self-referrals to eye casualty were eligible for the local minor eye conditions service.

Efficiency is associated with low carbon care - ensuring the right care is delivered at the right time in the right place is key to reducing carbon emissions associated with health care. Due to the reduction in patient travel, an optometry appointment could have significant environmental benefits (23).

1.2 Local context and evidence base *Insert local context and evidence base.*

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 Local defined outcomes

The expected benefits of the Service include:

- Optimised first contact care
- Reduction in the number of eye-related GP appointments
- Reduction in the number of ophthalmology attendances for low complexity acute care
- Improve the appropriateness of presentations to hospital ED, by managing low complexity minor and urgent care outside of the hospital.
- Release hospital workforce for more complex ophthalmic care
- Minimise patient travel providing care closer to home
- Delivery of a rapid, safe, high quality service for patients
- Improve referral information and referral pathway
- Improve access to patient information, advice and practical support to help patients self-manage, where appropriate
- Improve quality of life
- Provide accurate data about outcomes and patient satisfaction across multiple providers
- Provide outcome data to providers to enable quality improvement
- Improve communication along the care pathway, including between primary and secondary care clinical teams to streamline care
- Enhance practitioner experience, making best use of existing skills

3. Scope

3.1 Aims and objectives of service

The primary aim of the Service is to ensure people can access urgent and minor eyecare within primary care, utilising the established trained workforce and specialist equipment in optical practices.

This is essential to reduce demand on wider primary care including general practice and pharmacy, and pressures on the hospital eye services, especially their urgent and emergency care services.

The service objectives are to:

- Improve access to local timely care for patients with urgent ocular presentations, reducing the need to travel to the hospital.
- Improve access to local timely care for patients with minor eye conditions.
- Deliver clinical triage, assessment, treatment, follow-up and advice by telephone or video to reduce the need for in person appointments, where appropriate, avoiding the need for some patients to leave their home.
- Facilitate urgent and emergency eye referrals, where necessary, following local referral protocols, supported with diagnostic data (including Optical Coherence Tomography (OCT) as needed.
- Ensure the knowledge and skills of the optical practice workforce (Optometrists, Ophthalmic Medical Practitioners, Dispensing Opticians, Contact lens Opticians and support staff) are utilised as primary health care providers.
- Services should include the provision of a home visiting service, where practicable and appropriate, availability of a home visiting service should not prohibit wider service delivery.
- Provide access to specialist ophthalmic advice and guidance and remote prescribing when required to support practitioner clinical decision making and treatment.
- Provide optimal first contact care, with care navigation into the service and referral management away from other services to help meet demand and ensure right place, first time.
- Deliver personalised care and provide reassurance and support for patient self-management (self-care), as appropriate.
- Work with the NHS to help reduce patient and environmental cost.

3.2 Service description/care pathway

The Service will provide initial contact, triage, remote consultations and/or in-person assessments, follow-up, and management, with appropriate support, for recent onset symptomatic minor or urgent ocular presentations.

The Service will streamline the patient pathway by:

- supporting effective care navigation from other services e.g. general practice, NHS111, pharmacy, minor injuries units(MIUs).
- adopting remote consultation where clinically appropriate
- triage to the most appropriate practitioner/practice if a face to face appointment is indicated.
- optimising each consultation with ophthalmologist, or optometrist with independent prescribing advice & guidance, where appropriate, in line with locally agreed protocols.
- Providing follow-up assessments where clinically indicated.

Initial contact and access to triage – access to the Service via telephone booking is encouraged, to:

- Manage practice and service capacity and appointment prioritisation.
- Offer telephone/ video consultation and selfcare advice, where appropriate.
- Triage to the appropriate practitioner and/or appropriate practice to best manage presenting symptoms, in line with locally agreed clinical protocols.
- Direct to emergency services, as appropriate.
- Signpost to another service, where appropriate.

The Service might typically include people presenting with a red or sore/painful eye or eyelid, foreign body, sudden change in vision, or flashes and floaters which might suggest retinal detachment, who would otherwise present to general practice, hospital services and A&E.

Risk Stratification Conditions and Service Pathway Table

Patients can self-present (by telephone or walk-in) or be referred / redirected from other services for clinical assessment and management. The service will:

- Utilise current clinical capability within an optical practice
- Avoid patients being repeatedly redirected by accepting patients referred or signposted into the service following triage within another service (e.g. NHS111, MIU, GP care navigation) and sharing learning with other services to continually enhance care navigation/triage.
- Accept referrals from the Hospital Eye Service for assessment / continued care.
- Recognise that where available, optometrists with higher qualifications and experience (independent prescribing and higher qualifications from the College of Optometrists e.g. glaucoma qualifications) will be able to manage a broader scope of eye conditions, initiate treatment and deliver care as necessary, as well as supporting other practitioners with advice and guidance as required. Note: Access to FP10 prescription pads is essential to independent optometrist prescribing and to enable this broader scope of care.
- Optometrists without higher qualifications can be supported in decision making and providing treatment through advice, guidance and remote prescribing from the hospital eye service and/or primary care Optometrists with higher qualification and experience.
- Some referrals to ophthalmology may require prior clinical discussion with an ophthalmologist (by email if not urgent) to explore alternative management options thereby reducing the need to attend hospital, or to receive advice and guidance to, determine the appropriate timing for attendance or to agree a collaborative approach for patient management. Local protocols should be co-developed by primary and secondary eye care clinicians.

Implementation

In providing this standard clinical specification, the main priority is to assure, enhance and improve existing provision, reducing unwarranted variation and address inequity of access across England.

There should be a trajectory for these services to be commissioned ideally on an ICS footprint using existing commissioning relationships and mechanisms. Where appropriate,

larger regional groupings may wish to commission at a larger scale. In health communities where a prime provider is already involved in the delivery of locally commissioned optometric services, commissioners should expect to continue using this mechanism to deliver and manage the Community Minor and Urgent Eye Care service. Commissioners without such relationships should consider their use to deliver the service across a network of optical practices.

ICSs should agree with their LOC the most appropriate way to implement this specification reflecting the distribution of interested optometric practices and the needs of the local population. All optometric practices meeting the clinical specification requirements should be invited to participate, there should be no barriers to optometric practices becoming involved.

This clinical specification is not intended to interfere with locally agreed arrangements where they are working well. However, the patient pathway, and the risk stratification conditions, and service pathway may serve as a guide to optimise existing services to the standards laid out in this clinical specification.

Clinical leadership

Any service requires clinical leadership in enabling and assuring the delivery of high-quality care. The Service will therefore provide effective clinical leadership using the principles of multidisciplinary and organisational collaboration, training, clinical governance, and clinical audit.

A locally based clinical lead optometrist will oversee the implementation and performance management of the Service and will work in partnership with the Trust clinical lead ophthalmologist(s) to agree local pathways; revisions to local ophthalmology triage guidelines, joint care protocols and support responsive service co-developments, as required.

Service innovation and development

The standard clinical specification provides a minimum standard and should not limit local service innovation and improvement. A cycle of continuous improvement, informed by local and national audit, evaluation, and published research, should be adopted and appropriately resourced.

The detailed Service delivery model and supporting documents are provided below:

- **Patient pathway flow diagram**
- **Risk Stratification, Conditions and Service Pathway Table**

3.3 Population covered / geographic coverage/boundaries

The service should be accessible to all adult and child patients presenting with an urgent eye condition, or minor symptomatic eye condition, although it is envisaged that the majority of users will be registered with a GP within the relevant ICS boundary.

The Service will accommodate those who are not registered with a GP but are resident and eligible for NHS care e.g. members of travelling communities, homeless people, asylum seekers not yet resident in the UK.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance:

People self-presenting with an urgent or minor symptomatic eye condition requiring consultation (telephone booking preferrable)

Patients referred / directed to the Service by another service.

Following a sight test, patients who require further diagnostic assessment or treatment to confirm or avoid the need for referral. (example: OCT to exclude or confirm wet AMD following suspicious findings on BIO)

Exclusion:

People with an asymptomatic minor eye condition or long-term condition who already have an appropriate management plan.

People with an eye care need that is best met within General Ophthalmic Services

3.5 Interdependence with other services/providers

- Ophthalmology providers
- Local Optical Committees
- GPs and their practice staff / Local Medical Committees
- Pharmacists and their practice staff / Local Pharmacy Committees
- Primary optical practice staff
- Other local urgent care provision e.g. A&E, MIUs, NHS 111
- Complementary services such as third sector providers

3.6. Data Protection

All Providers are expected to maintain secure patient records, and when required, cooperate, and securely share (e.g. NHS mail, eRS) information with others involved in a patients' clinical care, treatment and support while having regard to the patients' right to confidentiality.

3.7. Registration

Health professionals delivering services must be registered with the regulatory body for their profession (e.g. General Optical Council, General Medical Council) as appropriate to their profession and must adhere to the professional standards and codes of practice set by that body.

4. Applicable Service Standards

4.1 Service Standards. The Provider will ensure all aspects of the service are delivered where applicable within:

- NICE Guidelines
- The College of Optometrists Guidance for Professional Practice https://guidance.college-optometrists.org/home/
- The College of Optometrists Clinical Management Guidelines. https://www.college-optometrists.org/guidance/clinical-management-guidelines.html
- Local guidelines between primary eyecare and ophthalmology with a reasonably comprehensive list of conditions /urgency/setting for care (NB guidelines will need to be agreed for the service and not for each and every local Trust).

4.2 Governance: The provider will demonstrate that there are clear organisational and clinical governance systems and structures in place, with clear lines of accountability and responsibility. The provider will ensure clinical and corporate governance processes are in place to include:

- Full recording of clinical notes
- Infection control
- Quality assurance
- Patient confidentiality
- Clear policies to manage risk and procedures to identify and remedy poor professional performance
- Patient safety incident reporting
- Mechanisms for joint reporting/management of patient safety incidents and complaints, clinical audit and learning across whole pathway including primary eyecare and HES teams.
- Escalation routes are set out clearly with problems being solved as early as possible
- Storage and use of FP10s (by independent prescribing optometrists in primary care)
- Communication and sharing information take place with all partners at the appropriate level
- Continuous cycle of improvement with clinical audit and evaluation embedded.

4.3 Leadership

There will be a locally based clinical lead optometrist for the Service who will support local implementation of the service pathway working closely with the Trust clinical lead ophthalmologist, as necessary. The clinical lead optometrist and the clinical lead ophthalmologist will also act as their respective service clinical governance leads. Working collaboratively across the system, as governance leads, they should review and recommend updates to the clinical specification, subject to commissioner approval, considering performance and clinical governance data and to manage safety issues detected after initial implementation. If there are multiple Trust clinical leads for ophthalmology wherever practicable, one will act as the single lead ophthalmologist to liaise with the service clinical lead optometrist and facilitate interactions with, and agreement from, other Trust ophthalmology leads. Changes in clinical leadership will be communicated to all involved in service delivery.

4.4 Learning

Once the service is in place, there should be remote updates to provide a learning forum for all practitioners delivering care, including those involved in the urgent care pathway, where practicable. This could be organised by the clinical leads and delivered by subject matter experts, local optometrists/opticians and/or ophthalmologists via webinar or in-person. Provider to consider email groups or regular telecalls to support reflective learning and anonymised case discussions, feedback learning on good practice, incidents etc.

4.5 Key Performance Indicators / Metrics: A short list of high-level KPIs are offered below.

Areas	**Measure**	**Achievable Standard**
Access *(access to the service in a timely way)*	Number and percentage of people triaged within 4 hours of presentation (within usual working hours, Monday to Saturday)	80%
	Number and percentage of people seen in accordance with triage outcome timescales	
Activity	Number of people presented to the service	
	Number and percentage of people care navigated to another service / selfcare at triage	
	Number and percentage of people per consultation type (remote/in-person)	
	Number and percentage of people DNA (including those who cancelled) for their initial consultation	<20%
	Number and percentage of people required follow-up assessment (remote/in-person)	
Outcomes	Number and percentage of people managed within the service	
	Number and percentage of people referred urgently (GP/ HES)	
	Number and percentage referred routinely (GP/HES)	
Patient satisfaction/ PROMs	e.g. Friends and Family test	

Also, Patient safety incidents, complaints and patient equality monitoring as required within the NHS Standard contract.

Retrospective audit examples for local consideration:

- Where would the patient have gone if this service had not been available?
- How was the patient directed into the service?
- Outcome of the referral to GP
- Outcome of the referral to HES, to include percentage of patients referred back to CUES for management following initial HES appointment.
- Presenting symptoms and clinical diagnosis
- Outcome of the follow-up assessments by diagnosis
- Audit of clinical appropriateness for service/hospital urgent care service
- Overall patient experience and satisfaction e.g. % of patients who received information about their condition, reported that they found this information helpful to
    - better understand their condition and the service pathway delivering its management
    - manage their condition when directed to self-care
- Audit of people “fully managed” within the service but who return to the service or elsewhere (e.g. HES ED) within 3 months.

4.6 Applicable National Standards

Clinical Council for Eye Health Commissioning guidance & frameworks
Clinical Council for Eye Health Commissioning (CCEHC) - College of Optometrists (college-optometrists.org)

Professional Body Guidance
- Association of British Dispensing Opticians

ABDO Extended services for contact lens opticians https://www.abdo.org.uk/extended-services-for-contact-lens-optician/

College of Optometrists

- Guidance for Professional Practice - College of Optometrists (college-optometrists.org)
- Annex 1 Equipment list for the routine eye examination - College of Optometrists (college-optometrists.org)
- Annex 4 Urgency of referrals table - College of Optometrists (college-optometrists.org)
- Guidance for therapeutics and non-medical optometric prescribers. https://www.college-optometrists.org/clinical-guidance/guidance-for-therapeutics
- Clinical Management Guidelines, evidence-based management and treatment tool (60 common conditions updated once every two years using GRADE. https://www.college-optometrists.org/guidance/clinical-management-guidelines.html

Royal College of Ophthalmologists

- https://www.rcophth.ac.uk/standards-and-guidance/
- https://www.rcophth.ac.uk/wp-content/uploads/2017/08/Emergency-eye-care-in-hospital-eye-units-and-secondary-care.pdf
- Designing Glaucoma Care Pathways using GLAUC-STRAT-FAST | The Royal College of Ophthalmologists (rcophth.ac.uk)
- Emergency Eye Care Commissioning Guidance | The Royal College of Ophthalmologists (rcophth.ac.uk)
- Management of Angle-Closure Glaucoma Guideline | The Royal College of Ophthalmologists (rcophth.ac.uk)
- Retinal Vein Occlusion (RVO) Guidelines | The Royal College of Ophthalmologists (rcophth.ac.uk)
- Primary Eye Care, Community Ophthalmology and General Ophthalmology | The Royal College of Ophthalmologists (rcophth.ac.uk)

NICE Clinical Knowledge Summaries

Blepharitis | Health topics A to Z | CKS | NICE
Conjunctivitis - allergic | Health topics A to Z | CKS | NICE
Conjunctivitis - infective | Health topics A to Z | CKS | NICE
Corneal superficial injury | Health topics A to Z | CKS | NICE
Dry eye disease | Health topics A to Z | CKS | NICE
Red eye | Health topics A to Z | CKS | NICE
Retinal detachment | Health topics A to Z | CKS | NICE
Meibomian cyst (chalazion) | Health topics A to Z | CKS | NICE
Styes (hordeola) | Health topics A to Z | CKS | NICE
Uveitis | Health topics A to Z | CKS | NICE

Other Guidance

- Conditions for which over-the-counter items should not routinely be prescribed in primary care otc-guidance-for-ccgs.pdf (england.nhs.uk)
- Eye Care Support Pathway report – https://www.rnib.org.uk/your-eyes/the-eye-care-support-pathway/

4.7 Applicable local standards

Consider inclusion of local referral protocols

4.8 Reference list

1. LOCSU Case Studies Minor and Urgent Eye Care
2. General Ophthalmic Services activity statistics - NHS Digital
3. LOCSU Services Directory
4. Hospital Episode Statistics (HES) - NHS Digital
5. The Way Forward | The Royal College of Ophthalmologists (rcophth.ac.uk)
6. Ophthalmology Programme National Speciality Report GIRFT December 2019
7. Ophthalmology-elective-care-handbook-v1.1.pdf (england.nhs.uk)
8. Workforce census | The Royal College of Ophthalmologists 2022
9. Statistics » Referral to Treatment (RTT) Waiting Times (england.nhs.uk)
10. BOSU report shows patients losing sight to follow-up appointment delays | (rcophth.ac.uk)
11. Eye Care Hub - FutureNHS Collaboration Platform access via nhsi.eyecare-transformation@nhs.net
12. NHS pressures in England: Waiting times, demand, and capacity December 2019 (parliament.uk)
13. Public perceptions reports | General Optical Council
14. NHS England » Delivery plan for recovering access to primary care 2023
15. NHS England » The NHS Long Term Plan 2019
16. Williams, E., Craven, W., Wilson, H. et al. Reassurance on false negatives in the Manchester COVID19 Urgent Eyecare Service (CUES). Eye 36, 12–14 (2022).
17. Kanabar R, Craven W, Wilson H, Rietdyke R, Dhawahir-Scala F, Jinkinson M. et al. Evaluation of the Manchester COVID-19 Urgent Eyecare Service (CUES). Eye. 2021
18. Konstantakopoulou E, Harper RA, Edgar DF, Larkin G, Janikoun S, Lawrenson JG. Clinical safety of a minor eye conditions scheme in England delivered by community optometrists. BMJ Open Ophthalmol. 2018
19. Pressures in general practice data analysis (bma.org.uk)
20. Guidance: Care Navigation How to Improve care navigation in general practice 2023
21. LOCSU Isle of Wight Optometry First Evaluation 2023
22. MacIsaac JC, Naroo SA, Rumney NJ. Analysis of UK eye casualty presentations. Clin Exp Optom. 2022
23. The Annual Carbon Footprint of NHS Sight Tests (sustainablehealthcare.org.uk)

Developed by Local Optical Committee Support Unit and the Clinical Council for Eye Health Commissioning at the request of the Department of Health and Social Care.

Clinically endorsed by: The College of Optometrists and The Royal College of Ophthalmologists