



Hertfordshire LOC: Demonstrating Clinical Need for a Minor and Urgent Eye Care Service in Optometry Through Dual-Audit Evidence

At a Glance

Challenge: No commissioned MECS or CUES in Hertfordshire despite local demand

Objective: To provide clinical evidence supporting the need for a minor and urgent eye care service

Action: Dual audits across primary and secondary care settings to provide evidence of need

Result: High volume of cases suitable for optometry service identified in both settings, including unmet need

Introduction

Acute red eye and similar minor and urgent ocular presentations are not eligible for GOS, do not require a refraction or sight test and must be managed through alternative pathways. Hertfordshire and West Essex Integrated Care Board (ICB) remains one of the few areas in England without a commissioned Minor Eye Conditions Service (MECS) or COVID-19 Urgent Eyecare Service (CUES) to manage these conditions. Despite repeated advocacy efforts from Hertfordshire LOC, a perceived lack of need and limited funding have delayed service development. To address this, a collaborative audit approach was initiated, aiming to provide robust clinical evidence and highlight the impact of operating without a commissioned urgent eyecare pathway utilising optometry.

Led by LOCSU and the Clinical Council for Eye Health Commissioning, the national CUES specification was developed through wide sector collaboration using an evidenced-based approach, learning from established local minor and urgent primary eye care services, as well as expert opinion from across the eye care sector – the specification provides an endorsed clinical model.

The updated specification was published in February 2025 and aims to:

- Support local commissioning and enhance access to minor and urgent eye care locally across England
- Improve consistency, reduce unwarranted variation and aim to help relieve capacity pressures in general practice, hospital eye casualty and A&E
- Inform local delivery and support a consistent level of high-quality care for patients

This service aligns with the government’s first strategic shift – moving more care from hospitals into the community – by enabling urgent eyecare to be delivered closer to home, reducing pressure on secondary care and improving access for patients.

Methods

A dual-audit approach was undertaken between January to March 2025.

Primary Care Audit: Four optometric practices across Hertfordshire recorded non-GOS patient encounters over a four-week period in March 2025. Practices included both independent and multiple providers to reflect a broad patient demographic.

Secondary Care Audit: A concurrent hospital-based audit, led by a hospital optometrist and Hertfordshire LOC committee member, reviewed eye casualty attendances over a three-week period in February 2025. Cases were selected with appointment times spread throughout the day to capture a representative mix of cases.

The dual audits captured presenting symptoms, patient demographics, and whether presentations could be managed under a primary care CUES pathway. Particular attention was paid to cases in primary care where patients declined care due to cost, highlighting potential health inequalities in access.

Results

Patient Demographics

The primary care audit recorded 67 urgent eye presentations within 4 optical practices. The secondary care audit recorded 85 urgent eye presentations within a hospital eye casualty clinic.

Table 1 describes the patient demographics of the presentations and shows the broad demographic accessing urgent eye care in both settings.

Table 1: Patient demographics accessing urgent care in primary and secondary care settings

	Primary Care	Secondary Care
Age range (years)	4 to 88	1 to 92
Mean (average) age (years)	59.7	50.9
Gender	22 male, 45 female	45 male, 40 female

Presenting Symptoms

Figure 1 shows the spread of primary symptoms that presented in primary care. The most common presenting symptoms in primary care were ocular pain or discomfort, followed by red eye, blurry or reduced vision, watery or dry eyes, flashes and floaters, ingrowing eyelashes and foreign body sensation.

Figure 1: Presenting symptoms in primary care (some patients reported multiple symptoms)

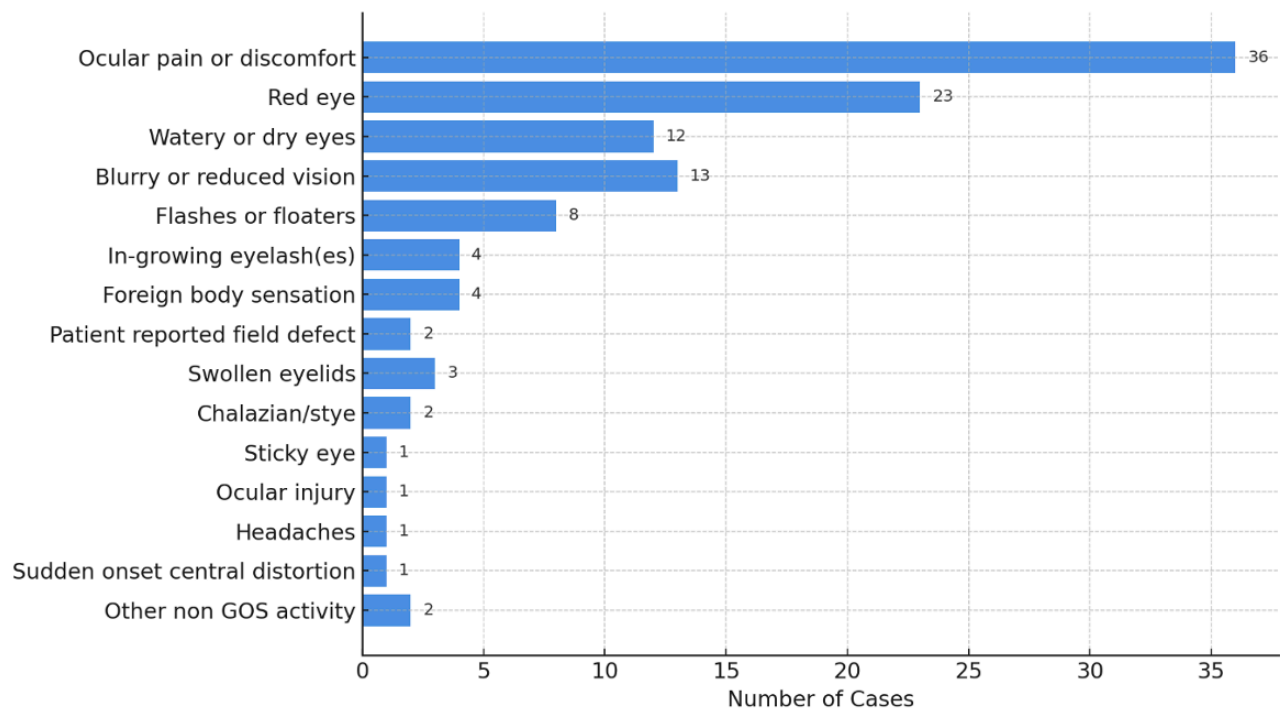
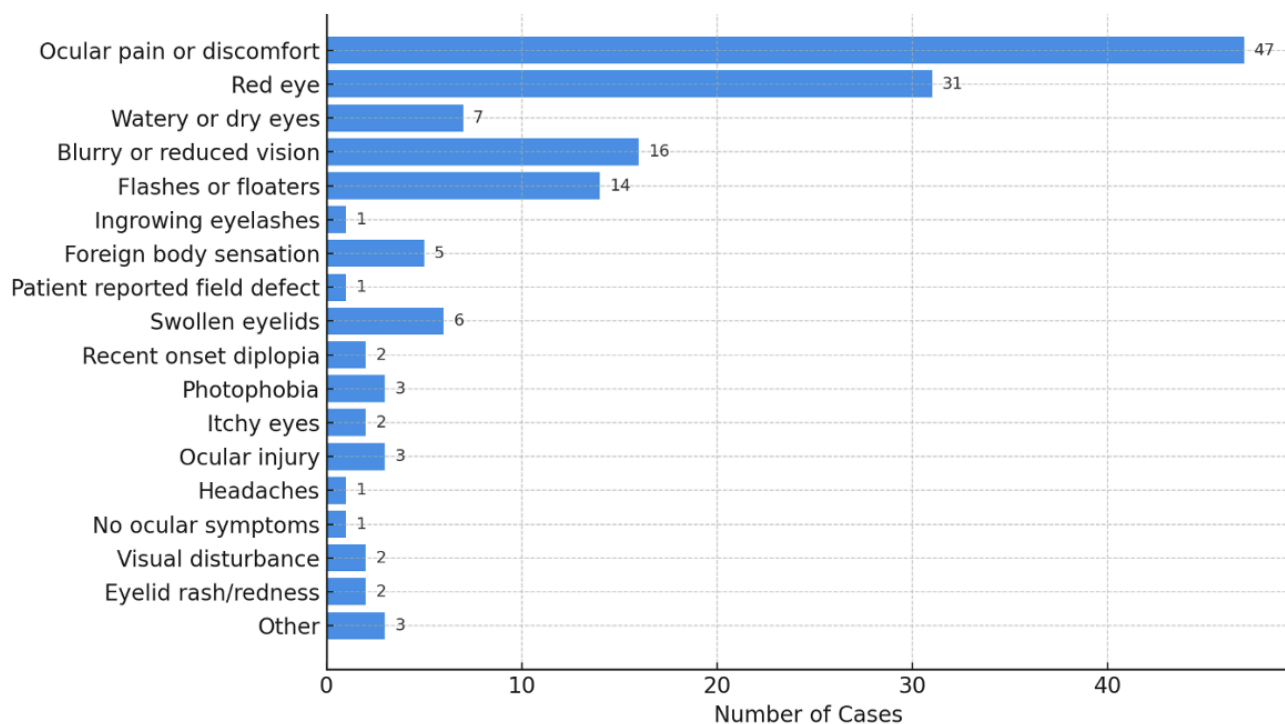


Figure 2 shows the spread of primary symptoms that presented in secondary care eye casualty. The most common presenting symptoms in secondary care were ocular pain or discomfort, followed by red eye, blurry or reduced vision, flashes and floaters, watery or dry eyes, swollen eyelids and foreign body sensation.

Figure 2: Presenting symptoms in secondary care (some patients reported multiple symptoms)



The urgent eyecare symptoms patients presented with closely align with the inclusion criteria for CUES, and the findings from secondary care mirror those observed in the primary care audit, which demonstrates consistency in clinical need across both settings.

Referral Sources

Referral sources indicate how patients initially sought help for their eye condition – whether they self-referred or were signposted/referred to primary care optometry by a healthcare provider. Table 2 and Figure 3 summarise how patients accessed primary care practices and show that the majority of patients (83.6%) accessed primary eyecare through self-referral directly to an optical practice.

Table 2: Referral sources to primary care

Primary Care Referral Source	Number of Patients	Percentage
General Practice (GP)	5	7.5%
Self-referred	56	83.6%
Pharmacist	3	4.5%
Hospital Eye Service (HES)	1	1.5%
Optometrist/Other Optical Practice	1	1.5%
GP Receptionist	1	1.5%

Figure 3: Referral sources to primary care

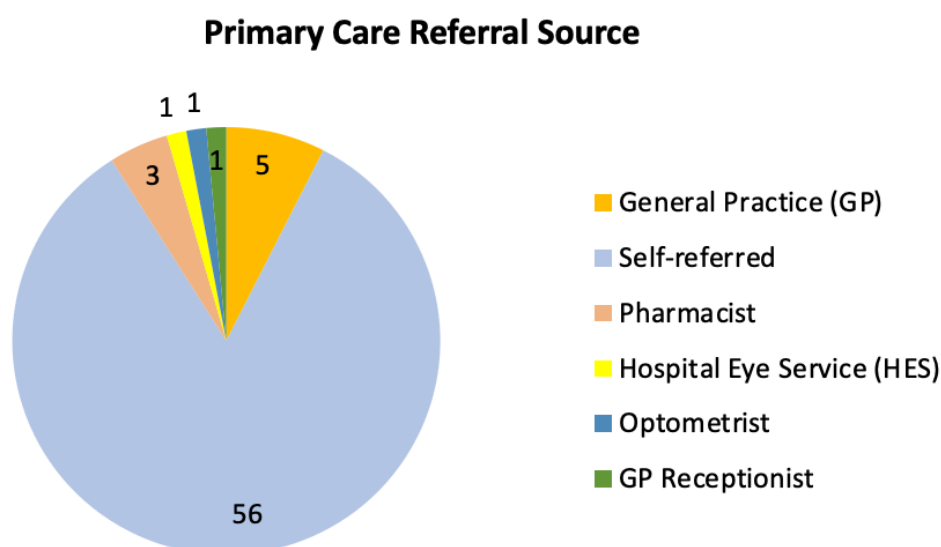
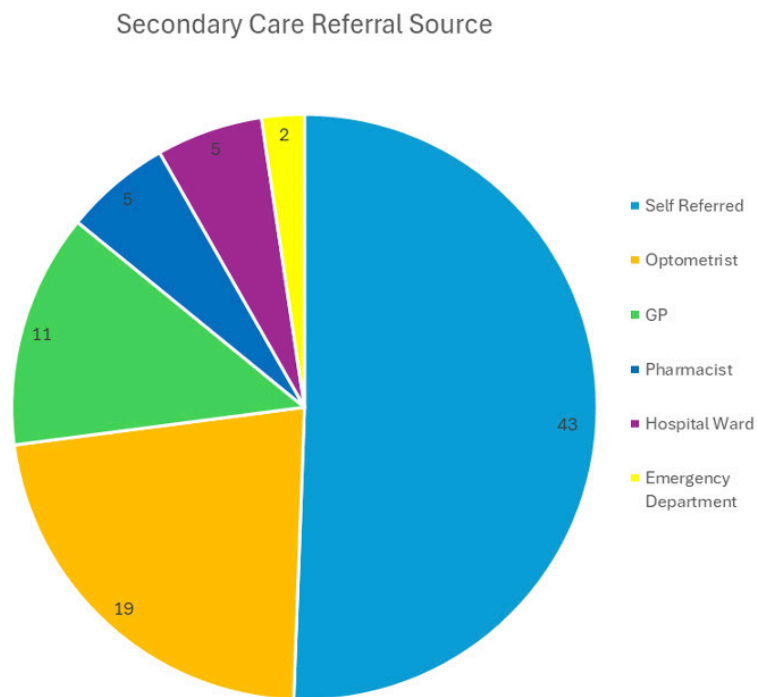


Table 3 and Figure 4 summarise how patients accessed the secondary care eye casualty clinic and show that approximately half of patients self-referred and the next most common referral routes were referral from an optometrist and then from General Practice (GP).

Table 3: Referral sources to secondary care

Secondary Care Referral Source	Number of Patients	Percentage
Self-referred	43	50.6%
Optometrist	19	22.4%
General Practice	11	12.9%
Pharmacist	5	5.9%
Hospital Ward	5	5.9%
Emergency Department	2	2.4%

Figure 4: Referral sources to secondary care



The relatively high proportion of patients who self-referred to secondary care eye casualty highlights a key potential opportunity to redirect appropriate cases to primary care through enhanced community triage or management/referral schemes, such as CUES.

Primary Care Triage Results Summary

- 61 of the 67 patients (91%) reporting with urgent eye care needs in primary care were assessed by an optometrist.
 - **54 patients (80.6%)** paid for a private urgent eyecare assessment due to the absence of a commissioned NHS-funded service
 - **7 patients (10.4%)** were able to be seen by an optometrist through an alternative route such as GOS sight test, Private sight test or other appointment type
- 6 patients (9%) declined to pay and did not book an appointment with an optometrist
 - 3 patients stated they would contact their GP
 - 1 person planned to visit another optical practice
 - 1 intended to consult a pharmacist
 - 1 planned to attend A&E
- One person explicitly stated their decision to decline optometrist care was directly due to cost

Table 4: Outcomes following primary care triage for urgent eyecare needs

Primary Care Triage Outcomes	Count	Percentage
Private urgent care assessment	54	80.6%
GOS sight test	3	4.5%
Private non-urgent care assessment	1	1.5%
Seen via contact lens scheme	1	1.5%
Private sight test	1	1.5%
Seen without charge	1	1.5%
Patient declined: Not seen by an optometrist	6	9.0%

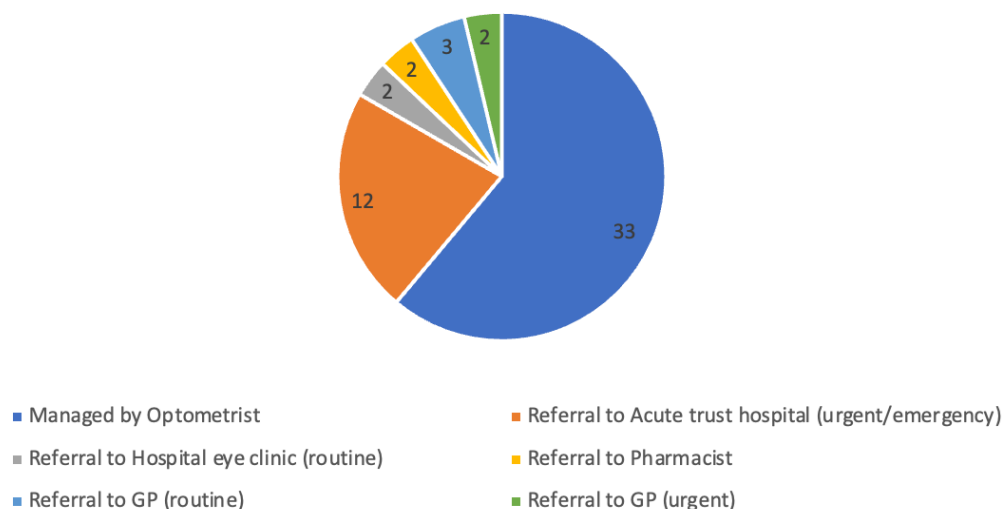
Primary Care Management Outcomes following private urgent optometric assessment (54 patients)

Table 5 and Figure 5 summarise the outcomes of patients seen for a private urgent care optometric assessment in a primary care setting. Almost two thirds of patients were fully managed by the optometrist within primary care and did not require onward referral. Just over one third of patients required signposting or referral to other healthcare providers for further care, most of which were directed to an acute hospital trust.

Table 5: Management outcomes following private urgent assessment in primary care

Management Outcome Following Urgent Assessment	Number of Patients	Percentage
Managed by Optometrist within primary care	33	61.1%
Referral to Acute trust hospital (urgent/emergency)	12	22.2%
Referral to Hospital eye clinic (routine)	2	3.7%
Referral to Pharmacist	2	3.7%
Referral to GP (routine)	3	5.6%
Referral to GP (urgent)	2	3.7%
Total Referrals	21	38.9%

Figure 5: Management outcomes following private urgent assessment in primary care



Primary Care Management Outcomes following other optometric appointment types (7 patients)

Management Outcome for other appointment types	Number of Patients
Managed by Optometrist within primary care	4
Acute trust referral after GOS sight test	2
Acute trust referral after contact lens scheme test	1

Secondary Care Triage & Urgency

- 71 (83.5%) patients were triaged to be seen within 24 hours
- 13 (15.2) patients were triaged to be seen within 2 weeks
- Of the reviewed cases, 17 patients (20%) were seen by a hospital optometrist within the eye casualty team, while the remainder 68 patients (80%) were seen by an ophthalmologist

Suitability for CUES Service

Figure 5 shows that suitability of primary care cases for primary care management.

- **63 (94%)** of the 67 patients presenting to primary care with urgent eyecare needs were deemed clinically appropriate for management under a CUES pathway (CUES inclusion criteria met)
- 4 patients (6%) were considered not appropriate for CUES

Figure 5: Suitability of primary care cases for CUES management

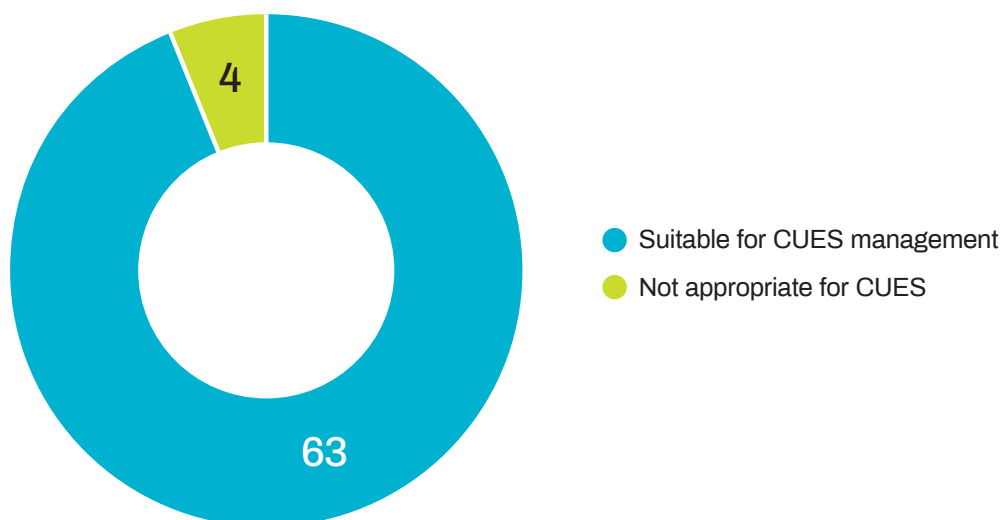
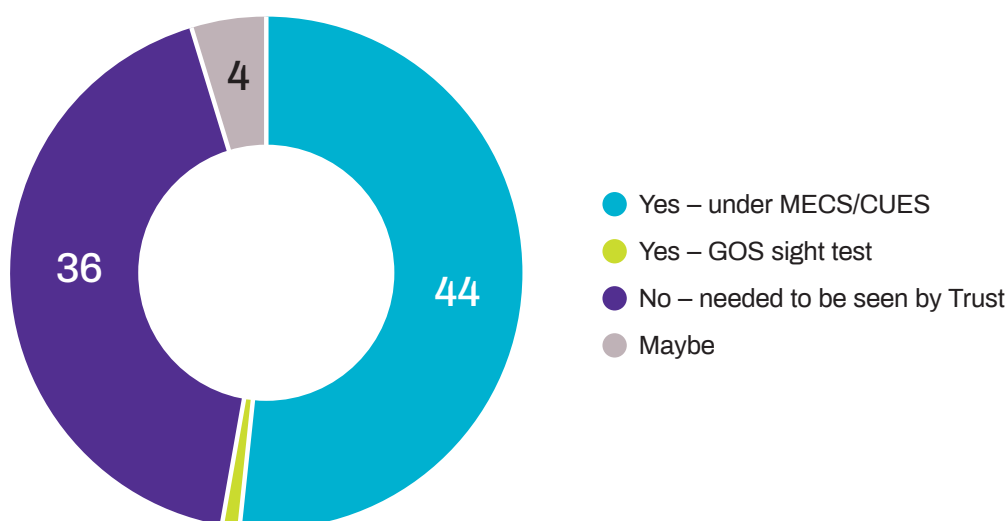


Figure 6 shows that suitability of secondary care cases for primary care management.

- **45 (52.9%)** of the 85 patients seen in secondary care eye casualty were recorded as suitable for management in primary care:
 - **44 (51.8%) patients were suitable for management within a primary care CUES service**
 - 1 patient was suitable for a sight test
- **36 patients (42.3%)** seen in secondary care eye casualty were deemed not suitable for primary care management and required hospital-based management due to case complexity
- **4 cases (0.05%)** were uncertain and marked as “maybe” suitable depending on follow-up needs

Figure 6: Suitability of secondary care cases for primary care management.



Key insights from this audit include the finding that ophthalmologists within eye casualty managed 68 of the 85 urgent care cases (80%). Notably, 45 patients (52.9%) were suitable to be managed in the community by primary care optometrists, including 44 who were suitable for care under a CUES service.

Implementing an urgent eyecare pathway within primary care would free ophthalmologist and secondary care team capacity, allowing them to focus on more complex, hospital-appropriate cases, and thereby reducing hospital workload and patient waiting times.

Conclusion

The dual audit clearly demonstrates a significant volume of patients presenting with urgent eyecare needs who are suitable for management in a primary care optometric setting. The absence of a commissioned optometry service risks delays in care, inequities due to private charges, and inappropriate reliance on specialist hospital services where primary care have the skills and capacity. Hertfordshire LOC will use this audit to support a formal business case for CUES commissioning, recognising it as a feasible and impactful step toward equitable, accessible urgent eyecare.

The primary care audit highlights the demand in primary care, currently only available to people who can afford or are willing to pay. The hospital audit highlights that over half of the patients attending hospital eye casualty services could have been safely managed within a commissioned primary care urgent eyecare service.

This data reinforces the need for a minor and urgent eyecare pathway in optometry to:

- Improve patient access and equity
- Reduce unnecessary hospital attendances
- Support more efficient use of NHS resources
- Deliver care closer to home, in line with the government's ambition to shift appropriate services from hospital to community settings

By working collaboratively across primary and secondary care, and introducing care navigation and triage processes, we can ensure patients are seen in the **right place, first time** – improving outcomes, reducing delays, and enhancing the patient experience.

LOC Case Study – Hertfordshire Local Optical Committee

Supporting Information:

MacIsaac, J.C., Naroo, S.A. and Rumney, N.J., (2022). Analysis of UK eye casualty presentations. *Clinical and Experimental Optometry*, 105(4), pp.428-434.
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