LOCSU

Primary Care Optometry CVD Case-Finding Service Blueprint

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LOCSU

1.0 Introduction 3
1.1 Cardiovascular Disease in England 3
1.2 Primary Eyecare in England 4
1.3 CVD and Primary Care Optometry 5
1.3.1 Healthy Living Optical Practices 6
1.3.2 Other CVD Pilots and Services in Optical Practices 6
1.4 NHS England Phase Two Case-Finding in Optometry Pilots 7
1.4.1 Summary of Pilots 10
2.0 Blueprint 16
Aims and Objectives 16
2.1 Setup 16
2.1.1 Define Objectives and Scope 16
2.1.2 Regulatory and Legal Considerations 17
2.1.3 Collaboration and Stakeholder Engagement 17
2.1.4 Equipment and Resources 18
2.2 Implementation 18
2.2.1 Patient Identification and Recruitment 18
2.2.2 Patient Pathways 20
2.2.3 Workflow Integration 22
2.2.4 Staff Engagement and Training 23
2.3 Evaluation 24
2.3.1 Record Keeping, Data Collection and Analysis 24
2.3.2 Stakeholder Feedback 24
2.3.3 Cost-Benefit Analysis 25
2.4 Key Challenges to Consider 25
2.4.1 Patient Participation 25
2.4.2 Integration of Systems 25
2.4.3 Capacity and Resources 25
2.4.4 Reporting 26
2.5 Recommendations 26
2.5.1 Recommendations for Commissioners 26
2.5.2 Recommendations for LOCs 27
2.5.3 Recommendations for Optometry Practices and Professionals 28
3.0 Developing the Service 29
4.0 Summary 30
Appendices 31
Appendix A - Pathway 31
Glossary 33
References 33

1.0 Introduction

1.1 Cardiovascular Disease in England

Cardiovascular disease (CVD) is a major cause of premature mortality in England. The 2025 Fit for the Future: 10 Year Health Plan for England committed to reducing lives lost to the biggest killers, including CVD (1).

Hypertension or high blood pressure (HBP) is the major risk factor for CVD. HBP is also a major risk factor for the development of atrial fibrillation (AF), where the heart beats with an irregular rhythm. AF increases the risk of stroke by five times.

Non-modifiable risk factors for HBP include family history, race and age. Modifiable risks include lack of physical activity, obesity, high alcohol intake, high salt intake, high cholesterol and smoking. Those living in the most deprived areas of England are around 30% more likely to have HBP that those living in the least deprived areas. Nationally, there are thought to be around 5.5 million people with undiagnosed hypertension.

At present there are no nationwide screening programmes for AF or hypertension. The NHS Screening Committee currently does not recommend a screening service for either condition (2, 3). Case finding and opportunistic screening differ from formal screening programmes.

In formal screening programmes, such as the diabetic retinopathy or bowel cancer screening programme, invitations are issued and screening of those who agree to attend are undertaken. While case finding is similar to screening in that its purpose is to detect potential disease indicators, the aim differs slightly, as it is intended to identify missed risk groups or to target resources at those at higher risk of disease.

While the NHS Screening Committee does not recommend a formal screening programme, it does recognise the need for a cardiovascular risk programme such as the NHS Health Check (4). The NHS Health Check, introduced in 2009, is aimed at identifying unknown health issues in people aged 40 to 74 years who have no pre-existing conditions such as heart disease, hypertension, diabetes, AF or kidney conditions. Attending the NHS Health Check is linked to reduced incidence of a number of diseases, which can be attributed to earlier detection and management of hypertension and cholesterol (5).

Uptake of the NHS Health Check has been found to be around 50% nationally, with some regions having as low as 25% uptake (6). A study found that women (54.7% attendees) and those over 55 years of age were more likely to attend. Deprivation had a limited effect on attendance, with slightly more attendees from the most affluent areas and slightly fewer from the most deprived areas as defined by the index of multiple deprivation spectrum (6).

There are many reasons people do not attend the Health Check when invited, including lack of awareness or knowledge and difficulties in accessing general practice (7).

This suggests that other primary healthcare providers, other than GPs, could have an important role in offering CVD investigations such as hypertension and AF testing, to those people who are not accessing current CVD services. Utilising the wider primary care workforce also supports the national Making Every Contact Count (MECC) initiative developed by Public Health England for public facing workforce (8).

In 2021, NHS England expanded CVD case finding into community pharmacy services through the Community Pharmacy Blood Pressure Check Service. This allows trained, non-registered staff to undertake blood pressure checks under supervision from a pharmacist (9).

Individuals found to have elevated blood pressure measurements are offered ambulatory monitoring to confirm diagnosis under National Institute for Health and Care Excellence (NICE) guidance (10). While it has been acknowledged that conversion rates have been lower than expected, this may reflect the variable uptake of ambulatory monitoring and challenges in following up patients (11).

Public health interventions to prevent CVD aim to tackle the modifiable risks, such as lack of physical activity, obesity, high alcohol intake, high salt intake, high cholesterol and smoking. Many of these risks are linked to risks of developing sight threatening diseases such as glaucoma, diabetic retinopathy, macular degeneration and cataract. Therefore, optometry can encourage MECC opportunities and help identify those at risk of developing CVD as well as ocular conditions.

The NHS medium-term planning framework talks about tackling inequalities, shifting from sickness to prevention and sets an aim to reduce CVD-related premature mortality by 25% over 10 years (12). Case finding for CVD in optometry practices can play a role in this process.

1.2 Primary Eyecare in England

There are over 5,000 optical practices in England (13), many located in easily accessible high street locations. 12,790,385 NHS sight tests were carried out in 2022/23 (14). A significant percentage of the population of England do not meet eligibility for NHS funded sight tests and fund their own tests. The estimated total number of sight tests a year is over 19 million (15).

As part of the sight test, an optometrist must ask questions relating to general health, medication, family history and assess a patient's lifestyle (16). As a result, optometrists can gain a good understanding of a patient's risk of cardiovascular disease along with ocular health.

Sight tests are recommended every two years, with certain groups of people being eligible for more frequent sight tests (14). Due to high visual demands of the digital world we live in and the natural aging changes within the eye, where the focusing lens becomes less adjustable, many people start attending for sight tests in their 40s. These sight tests are often private tests, funded either by the individual or via their employer for the assessment of driving standards,

safety glasses or VDU use.

As well as delivering sight tests, the teams in optical practices provide other health interventions, such as contact lens checks, low vision support, DVLA assessments and enhanced eye care services, for example minor and urgent eye care (MECS/ CUES) (16) or enhanced glaucoma care (16).

Enhanced services are locally commissioned, enabling care to be delivered within optical practices beyond a sight test and to meet local population need, alleviating pressures on general practice and hospital services. Enhanced services cover care and management that are not included as part of a sight test as defined by the Opticians Act (1989) (17).

Local Optical Committees (LOCs) are instrumental in the commissioning of enhanced services. LOCs are recognised by the NHS as the representative organisations for Primary Care Optometry locally. LOCs were established by the NHS (Amendment) Act 1949 as the optical Local Representative Committee (LRC) whose primary care counterparts are Local Medical Committees, Local Pharmaceutical Committees and Local Dentistry Committees. Therefore, they are bodies created by statute and have an important and defined legislative role. They represent, support and communicate with local practices and their eye health professionals (optometrists and dispensing opticians) to ensure the effective delivery of eye care services across the whole of the area and play an important role in local contract development.

1.3 CVD and Primary Care Optometry

Every sight test requires an external and internal assessment of the eye, so optometrists always make an assessment of the ocular component of the CV system during a sight test (18). The eye is the only place in the body where blood vessels can be viewed without invasive procedures, providing an opportunity to assess a patient's vascular health. Changes to all the small peripheral blood vessels in the body can occur over time due to hypertension, high cholesterol (hyperlipidaemia) and diabetes. These changes can be viewed in the blood vessels in the eye. All are common examples of conditions that may be identified during a sight test.

Currently, any concerning findings, such as recurrent subconjunctival haemorrhages (19) or retinal abnormalities such as vessel changes, emboli, retinal haemorrhages or retinal vein occlusions (20) would result in onward referral from an optometrist, contact lens optician or dispensing optician to the GP to investigate the possibility of underlying undiagnosed hypertension.

While not a prerequisite for an NHS-funded General Ophthalmic Services (GOS) sight test, many practices now own diagnostic equipment which enables digital retinal photography. Retinal photography has already made routine diabetic retinopathy screening possible in those people already identified as having diabetes.

Retinal photography can be used to provide a record of arteriosclerotic vessels and retinal haemorrhages, both which can be precursors to stroke and can indicate undiagnosed hypertension.

1.3.1 Healthy Living Optical Practices

The Healthy Living Optical Practice framework (HLOP) was co-designed between LOCs and LOCSU to enable a structured approach for Optometry practices to deliver health and wellbeing support for their local population and aiming to be part of the neighbourhood solution to reduce health inequalities.

Through the pioneering work of Dudley LOC, a number of the HLOP services were commissioned by Dudley Council's Public Health in 2015. This stemmed out of conversations around preventing sight loss due to age related macular degeneration and thyroid eye disease by reducing smoking in the population.

The local service involves training optometrists and optical practice teams on a new approach to care, changing the practice environment and hence the delivery of public health services as a result. Eight optical practices became accredited as Healthy Living Optical Practices and implemented the services between May 2015 and April 2017.

During the pilot, optical practices provided alcohol awareness information and brief advice on 12,345 occasions, recruited 36 people into the smoking cessation service, and performed 316 NHS Health Checks. The service was well received by patients and the optical practice staff highlighting the importance of ophthalmic public health awareness (21).

1.3.2 Other CVD Pilots and Services in Optical Practices

Before the recent NHSE injection of funding to enable the hypertension case finding in optometry and dentistry, there had a been a few local pilots within England utilising primary care optometry practices, specifically targeting cardiovascular health. Through a LOCSU and LOC co-ordinated approach, success and early learning from the local innovators led to the wider investment from NHS England.

Local innovators include NHSE Phase 1 blood pressure pilots in Humber and North Yorkshire and an AF pilot in Cheshire. The East Cheshire AF pilot ran from November 2020 to August 2023 and was funded by NHS England, in conjunction with Cheshire East Integrated Care Partnership (ICP) and Cheshire LOC.

The aim of the study was to identify people with undiagnosed AF who would then be at a higher risk of related stroke, with the long-term aim of reducing the rates of stroke in over 60's, across East Cheshire.

Five optometry practices completed the pilot. Each practice received a Kardia Mobile Heart Monitor and training. Patients aged 60 years and over, with no pre-existing heart problems were tested. Around 10% of patients screened had abnormal results.

Anyone found to have an abnormal reading was given a pre-printed slip and was told to contact their GP within two days. Optical practices found it an easy and quick extra service to support caring for older patients making every contact count. Anecdotal feedback from patients indicated their gratitude and that they had started anti-coagulants because of the intervention at the optical practice (22).

A hypertension case-finding service was implemented in 36 optical practices in Humber and North Yorkshire ICB. Over a one-year period in 2022/23, 728 patients had a blood pressure check with nearly half being referred on to community pharmacies for further follow-up. These previous small-scale pilots show that primary care optometry can be effective in reaching people with undiagnosed hypertension and AF, especially among those who are less likely to attend GP appointments, however there are no long-term evaluations to date.

1.4 NHS England Phase Two Case-Finding in Optometry Pilots

The NHS 10-Year Plan highlights the shift to preventative health care which in turn means that those at risk of health conditions will need to be identified earlier. This puts the whole of primary care at the forefront of community-based prevention strategies and the delivery of neighbourhood health services. This is reiterated in the release of the medium-term planning framework 2026/27 to 2028/29 (9).

Evidence from earlier localised pilots in England indicated that there may be potential to offering a hypertension case finding service in optical practices. This aligns to the 10-Year Plan's three key shifts of hospital to community, analogue to digital and sickness to prevention described in **Table 1.**

Additionally, providing services in community-based optical practices can help address health inequalities by reaching people who may not seek help elsewhere. Evidence from case finding services in optical practices for other conditions, such as type 2 diabetes, shows that many people would not seek out the test elsewhere and find optical practices to be an acceptable and convenient location for a test (23).

NHS England's CVD prevention programme earmarked approximately £1 million for hypertension case finding within dental and optometry settings for 2024/25. Funding allocation was based on selected proposals submitted by ICBs to the National Team using an Expression of Interest (EoI) template pack. The funds were designated for pilots in dental settings for hypertension case finding and in optometry settings for hypertension and atrial fibrillation (AF) case finding, building on the work that had already been done. These pilots were to offer blood pressure and/or AF checks to eligible patients in optical practices to gauge the impact on case finding and diagnosis. Assessment criteria for bids included a description of local need, planning and engagement.

Table 1: NHS 10-Year Plan and Case Finding in Optical Practices

NHS Plan Objective	How it enables CVD case finding in optical practices
Hospital → Community	Neighborhood health services prioritise community-led, accessible care. GOC registered professionals and optical practice staff, embedded in local settings, are ideally positioned to offer routine checks like BP/AF checks.
Sickness → Prevention	Preventative measures are central. BP checks in optical practices aligns with early intervention goals to detect asymptomatic high-risk individuals.
Analogue → Digital	Digitally connected optometry practices could share BP checks data with GP and pharmacy systems, feeding into NHS systems, reducing duplication and enabling timely follow-up.
Additionally *Equity and Health Inequalities*	Community-based checks reach people less likely to seek routine checkups - helping close gaps in cardiovascular care.

The key aims and objectives of the pilot were:

- **Expansion of previous pilots**: To expand case finding efforts for cardiovascular diseases, particularly atrial fibrillation (AF) and hypertension, across various regions, aiming to reach a larger population for early detection and intervention.
- **Standardisation and knowledge sharing**: Facilitate regular meetings between different regions to encourage the standardisation of protocols, share best practices, and promote a coordinated approach to CVD prevention within optometry.
- **Stakeholder engagement**: Engage with key stakeholders to gather support and expertise for the development and implementation of CVD prevention programs within optometry.
- **Securing funding for evaluation**: Secure funding for the evaluation of existing pilots and the development of sustainable delivery models, aiming to inform future CVD prevention efforts and ensure the effective allocation of resources.
- **Integration into broader healthcare frameworks**: Integrate optometry into broader healthcare frameworks by presenting updates to relevant oversight groups and seeking

representation within key decision-making bodies, highlighting the sector's role in comprehensive healthcare delivery.

14 ICBS were selected. Six were dental only, four were optometry only and four involved optometry and dental.

- Bath and North East Somerset, Swindon and Wiltshire (Dental)
- Birmingham and Solihull (Dental)
- Buckinghamshire, Oxfordshire and Berkshire (Dental)
- Cheshire and Merseyside (Optometry)
- Gloucestershire (Optometry)
- Greater Manchester (Optometry)
- Hertfordshire and West Essex (Optometry and Dental)
- Humber and North Yorkshire (Optometry and Dental)
- Kent and Medway (Dental)
- Lancashire and South Cumbria (Optometry)
- Lincolnshire (Optometry and Dental)
- Mid and South Essex (Dental)
- North East London (Dental)
- North Central London (Optometry and Dental)

Heath Innovation South West (HISW) were commissioned by NHS England to undertake an evaluation of the pilots in dental and optometry pilots.

LOCSU were commissioned by NHS England to produce a blueprint for CVD case finding in optometry practices. A CVD team was appointed by LOCSU in May 2025 to support and share learning with the LOCs involved, provide representation on the steering group and attend the community of practice meetings for the pilot sites.

The team worked with LOCs to gain a deeper understanding of the pilots and how they were developed and implemented.

1.4.1 Summary of Pilots

The NHS England funded optometry pilots are summarised in **Tables 2-4**. Further details can be found in **Appendices B-I**.

Each pilot site is carrying out an evaluation. These will be published in 2026.

Table 2: Summary of Pilot Projects

Pilot and Case Study Link	Summary	Note and Challenges
Cheshire and Merseyside ICB (LOCs: Cheshire; Wirral; Central Mersey; Liverpool; Sefton)	60 practices offered CVD case finding service, built on previous pilot to identify AF, started June 25	Finding suitable patients - many already identified as having CVD and on medication or older than the inclusion criteria.
Greater Manchester (LOCs: Greater Manchester East; Ashton, Leigh & Wigan; Bolton; Manchester, Salford & Trafford)	This pilot was commissioned and delivered at scale across the ICB. Over 3,000 hypertension checks were offered since it started in Nov 2024. Clinical protocols were aligned with community pharmacy practices, emphasising consistency across primary care providers.	For ongoing evaluation of the impact, GP data capture and coding accuracy were challenges; manual review was resource intensive.
Gloucestershire (LOC: Gloucestershire)	Pilot started in June 2025 aimed to identified people with hypertension and irregular pulse.	Start date delayed due to sourcing equipment. People with time constraints, such as parking time limits, were not eligible to be included as BP had to measured same day as sight test.

Table 2: Summary of Pilot Projects (continued)

Pilot and Case Study Link	Summary	Note and Challenges
Hertfordshire and West Essex (LOC: Hertfordshire; Essex)	Small pilot run in 4 optometry practices (and 6 dental practices) commissioned directly with the ICB, targeted area of poorer deprivation. Over 10% of people who agreed to have their blood pressure checked required an onward referral.	Requirements like an NHS mail shared mailbox and direct contracting with the ICB created some challenges for practices.
Humber and North Yorkshire (LOCs: North & Northeast Lincolnshire; North Yorkshire; East Yorkshire)	Pilot commissioned directly with the ICB and linked closely to the pharmacy pilot already running. Much of the project management support was provided by the three LOCs within the ICB footprint	Service required a pharmacy to refer to for 24-hour blood pressure monitoring - several optometry practices did not have a local participating pharmacy. Difficult to identify people who had not had BP check in last 5 years or who wasn't already diagnosed with hypertension.
Lancashire and South Cumbria (LOCs: Lancashire & Morecombe Bay; Pennine Lancs)	Pilot led on from work the Local Eye Health Network and ICB had been doing to deliver CVD awareness training to optical practices across Lancashire and South Cumbria ICB. Pilot included a specific target group of South Asians aged 30 year plus.	Cross-Border Issues Data Integration - there was no direct GP integration. Updates regarding ongoing clinical care was obtained via NHSmail but time consuming. Referral completion data could not be consistently verified due to lack of a standardised GP feedback mechanism.

Table 2: Summary of Pilot Projects (continued)

Pilot and Case Study Link	Summary	Note and Challenges
Lincolnshire (LOC: Lincolnshire)	Small pilot of 2 Optometry practices (and dental practices) commissioned directly with the ICB.	Minimum activity threshold applied: Payment to practices required a certain number of tests to be performed
North Central London (LOC: North Central London)	Small pilot of 5 Optometry practices commissioned directly with the NHS Foundation Trust.	Paper based data collection. 5 practices selected based on area.

Table 3: Inclusion Criteria

	Inclusion Criteria				
	40 Years and Over				Under 40 Years
	Max Age	No Hypertension Diagnosis	Time Since Last BP Measurement	Registered with GP in Area	Suspected Hypertension from Eye Exam Finding
Cheshire and Merseyside	79 Years	✓	6 Months	✓	
Gloucestershire	No	✓	Recent Past	✓	✓
Greater Manchester	No	✓	6 Months	✓	
Herts and West Essex	No	✓	3 Months		
Humber and North Yorkshire	No	✓	5 Years		✓
Lancashire and South Cumbria	No	✓ (1)	12 Months (15 months if treated hypertension but not followed up)	✓	✓ (2)
Lincolnshire	No	✓	2 Years		✓
North Central London	No	✓	N/A	✓	

(1) 30yrs + South Asian
(2) Exceptions: patients from outside the area could only be included if hypertensive signs were found in the eye exam and there was a safe onward pathway.

Table 4:
Referral Pathways

	Normal BP (between 90/60 and 139/89mmHg)			**Very High Blood Pressure** (180/120mmHg or higher)	**Raised Blood Pressure** (between 140/90 mmHg and 179/119mmHg)	**Low Blood Pressure** (89/59mmHg or lower)		**AF**
	Provide healthy living resources	**Give BP measurement**	**Recheck advised**	**Onward refferal**	**Onward referral**	**Symptomatic**	**Asymptomatic**	**Onward Referall**
Cheshire and Merseyside	Y	Y	5yrs	NHS 111	GP	GP		NHS 111
Gloucestershire	Y	Y	5yrs	Urgent NHS 111	Community Pharmacy	GP		Urgent NHS 111
Greater Manchester	Y	Y	5yrs	A&E (over 220/120) or NHS 111	GP	GP same day	GP within three weeks	Urgent NHS 111
Herts and West Essex	Y	Y		Urgent Care or A&E	Community Pharmacy	GP same day	No further action	GP
Humber and North Yorkshire				A&E or same day GP	Community Pharmacy	GP Informed		GP
Lancashire and South Cumbria				A&E, urgent walk-in centre or same day GP	Community Pharmacy	GP within 48 hours	GP within two weeks	GP within 48 hours
Lincolnshire	Inform GP within seven days			Same day GP or NHS 111	Community Pharmacy	GP within 48 hours	GP within two weeks	GP
North Central London				A&E	Community Pharmacy	GP within 48 hours	Community pharmacist repeat within two weeks	A&E with symptoms GP or NHS 111 within 48 hours if no symptoms

Key findings from the evaluation (24):

- Conducting blood pressure and AF measurements in dentistry and optometry settings increases the diagnosis of patients with hypertension and AF and can help prevent CVD and premature deaths. The pilot sites had a detection rate of 3% for hypertension, which is likely to be an underestimate given the challenges of collecting follow-up data. HISW calculated that if the pilots were rolled out into all practices in the participating ICBs, the intervention would prevent over 718 CVD events and avoid 58 premature deaths over a 20-year horizon. Over the longer term, CVD related savings were calculated to be between £11.7 million and £112.9 million, mainly due to reduced hospitalisations and long-term social care needs.
- The intervention is considered acceptable by many patients, with high take up by those offered it.
- Optometry and dental staff feel that their roles are undervalued by the wider primary care system and felt that the pilots created opportunities for collaboration across primary care.
- Setting may influence the outcomes – the proportion of patient with blood pressure outside the normal range was higher in dental practices than optometry practices, possibly due to 'white coat hypertension', the increase in blood pressure found in medical setting and could be associated with anxiety in patients attending dental appointments.
- A quarter of patients tested were signposted to other services for further investigation (26.1% in dental, 20.4% in optometry). The majority were found to have normal blood pressure and reassured and given appropriate lifestyle advice
- Dental and optometry practices do not have direct digital referral functionality across all the services involved. Current digital platforms allow electronic referrals to some services, but it is not always clear if the referral is acted on or a diagnosis made.

2.0 Blueprint

Aims and Objectives

The aim and objective of this blueprint is to:

- Provide a recommended model for CVD case-finding in optometry practices

The aims and objectives of a CVD case-finding service in optometry are to:

- Identify patients at risk of CVD
- Improve early detection rate for patients with CVD
- Increase accessibility to blood pressure testing in wider community settings
- Promote healthy behaviour
- Provide a service free of charge to eligible patients

2.1 Setup

2.1.1 Define Objectives and Scope

Commissioners should consider the local population and local data in order to define the need for hypertension case finding and to inform the scope of the service.

Local health data intelligence should be used to define the local need in terms of unmet hypertension needs. Understanding the local unmet needs allow the service to be adapted as needed. Inclusion criteria (described in 2.2.1) and referral pathways (described in 2.2.4) can be further informed and implemented to meet the needs of the local population once the unmet need is understood.

An understanding of the local population demographics accessing local optometry services, held by the ICBs, is important. Those who may benefit from the CVD case finding in optical practice may not meet GOS eligibility criteria for sight test. Those aged between 40 and 60 years and not claiming any benefits or having health or ocular conditions (e.g. diabetes, family history of glaucoma) will not be eligible for GOS sight tests. Patients eligible for the case finding service will be seen in practices for GOS sight tests or private sight tests as well as for other services such as contact lens checks and enhanced service appointments.

Some CUES/MECS criteria eye complaints, such as recurring conjunctival haemorrhages, may be caused by raised BP and it is important that these patients are eligible for blood pressure measurement. Similarly, patients attending for enhanced glaucoma assessments may benefit from blood pressure measurements as hypertension is known to increase the risk of open angle glaucoma (26). There are also many patients who received GOS sight tests who would benefit from CVD case finding services, such as people with diagnosed diabetes who are not regularly attending their GP for CVD reviews.

The patient base of an optical practice is much more fluid and flexible than a primary care network (PCN) or neighbourhood footprints.

Patients are not registered to a particular practice and often travel across NHS boundaries to access eye care services from optometry. Therefore, commissioning across a wider geographical footprint, for example, ICB wide or across an NHS region (covering multiple ICBs) rather than at neighbourhood or place, will enable a more consistent service and prevent confusion over who is able to benefit from the service.

2.1.2 Regulatory and Legal Requirements

Service Provider Requirements

Optical practices must:

- Deliver NHS sight testing and/or enhanced eye care services, or, if a private practice, meet the same governance requirements as a GOS contractor and maintain compliance with Quality in Optometry to demonstrate this
- Maintain the appropriate clinical governance toolkits with Quality in Optometry
- Have appropriate Practice and Clinical Indemnity Insurance
- Comply with data protection legislation
- Have workforce and estate capacity to provide the service (see 2.1.4)

As this service is outside of normal practice, individual practices must check with their indemnity provider that they are covered and, if not, arrange appropriate cover before commencing the service.

2.1.3 Collaboration and Stakeholder Engagement

The service must fully integrate and work with other providers and organisations within the area. Relationships will need to be developed and maintained with all health and/or social care providers.

This may include (but is not limited to):

- Local Optical Committees (LOC)
- Other Local Representative Committees (Medical, Dental, Pharmacy)
- Local Primary Care Collaborative, or equivalent
- Local Neighbourhood Health Service provider (including PCN & GP Federations)
- Primary Eye Care Company or local prime provider organisations
- NHS 111
- Emergency Departments and/or teams for acute CVD
- Community pharmacies offering hypertension services
- Diabetic Retinopathy Screening
- IT platform providers
- Patient groups
- ICB and regional CVD leads and/or planned care leads

Learning from the optometry pilots indicates the need for a primary eye care company (or other prime provider organisation) to provide clinical expertise, practical support and digital solutions to connectivity. The lack of this arrangement will inevitably have an impact on the practice participation and service sustainability, as well as the ICB and LOCs ability to evaluate the service impact/outcomes. ICBs need to consider how to appropriately resource contract management and practice support for implementation and for the duration of the service.

2.1.4 Equipment and Resources

Practices participating in the service must have the following equipment and resources:

- BIHS approved BP monitor with a range of cuff sizes, appropriately calibrated
- Access to and funding for licences for any IT platforms that are used for data collection, referrals, recording of results etc (e.g. OPERA, PharmOutcomes, NHS mail)
- Patient information (posters, leaflets etc)
- Available private space for the duration of the BP assessment and lifestyle conversation. For example, a spare testing room, pre-screening area or dispensing area where a confidential conversation can be held
- Workforce capacity to undertake consent, BP and AF, data recording, discussion of results with patients and referral if required
- Suitably trained members of staff to undertake the procedure
- Optometry Health Champion with robust links to the LOC, at either an ICB or neighbourhood level to support optical providers and practice teams, sharing best practice, advice and encouragement

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2.2 Implementation

2.2.1 Patient Identification and Recruitment

The service should be available and actively promoted within optical practices to eligible people.

Inclusion Criteria

- Able to give informed consent

AND

- Aged 40 years and over OR aged under 40 years with findings suggestive of hypertension

AND

- No hypertension diagnosis or not taking regular hypertensive medication.

AND

- Blood pressure has not been measured by a health care provider in the recent past as reported by the patient (Last 12 months)

The service should be offered based off the information given by the patient.

If a patient reports that they do not have a diagnosis of hypertension and have not had a check in that recent past, then the check should be offered. If a patient is unsure if they have hypertension or do not know if they are receiving treatment, the National Summary Care Record can be checked if the practice has access, but there is no requirement to check and the blood pressure test can still be offered.

Exclusion Criteria

- Unable to give consent
- With treated hypertension
- Under the age of 40 years (unless findings suggestive of hypertension found)
- Blood pressure has been measured by a health care provider in the recent past (in the last 12 months)

People who are not registered with a GP, but live in the area, should not be excluded from the service. If patients are not registered with a GP, they should be given written copies of their results, including actions to be taken and the reasons why follow up is important. Patients should be provided with information and support on how to register with a GP.

Identification of Patients

The whole practice team needs to proactively identify potential patients who meet the inclusion criteria. Commissioners and practices should consider promoting the service though a variety of methods, both within the practice and across the service footprint.

This may include:

- Social media campaigns
- NHS websites, ICB communication channels and websites
- Displaying posters with the practice
- Providing a patient information leaflet
- Proactively identifying eligible patient when arranging or confirming appointments.

The service can be offered to patients who are in the practice for a sight test or other eye care appointments. It can also be offered to people who are in the practice for other reasons (such as accompanying a friend or family member). A patient does not have to have a sight test to be able to be eligible for the service. However, they do have to fulfil the inclusion criteria and there must be a way to record the blood pressure measurements, advice given and action taken.

Example: Lancashire and South Cumbria

The service pathway states that “No patient will be refused”. This is clarified by stating that anyone attended for a sight test/eye health check and anyone attending with them should be tested if eligible. Walk-ins who have no need for eye care services should be advised of blood pressure checking service (BPCS) available at a pharmacy in the first instance. If it is not possible, then they can be tested within the service.

Patients who are eligible and wish to participate but where the smallest/largest cuff does not fit and so an accurate BP measurement cannot be recorded, should be directed to their GP.

Patients should be signposted to register with a GP if they have not already done so.

2.2.2 Patient Pathways

An example of a patient pathway is shown in **Appendix A**.

The service structure can be thought as having four process elements.

1. Eligibility check and service offer
2. Explanation and assessment
3. Outcome and signposting
4. Post-service administration and follow-up

Eligibility and Offer Process

Patients could be identified as meeting the inclusion criteria through three routes:

- At booking: During an appointment scheduling or reminder call, practice staff can complete a pre-test questionnaire with the patient. If eligible, the service can be offered as part of the appointment. A note can be made on the patient record to indicate they are eligible for the service.
- On arrival: When a patient (or accompanying person) arrives for an appointment, they can complete a pre-test questionnaire. If eligible, they can be offered the service.
- During the consultation: If the GOC registered professional identifies signs associated with high blood pressure during the course of the consultation (e.g. sight test, CUES/MECS appointment or contact lens check) they can offer the service to the patient

If patients are not eligible for the service, no record is required and no further action needs to be taken. A record of the number of people who are eligible but decline the service should be kept so that the take up rate can be calculated.

If they are eligible and refuse the service, a record should be made that they declined.

If they are eligible and would like to be tested, then a trained member(s) of the team will:

- Explain what is involved, the process and outcomes
- Obtain and record verbal consent

Explanation and Delivery of the Check

Trained members of staff, such as optical assistants can deliver the BP and AF tests. It is for the practice to determine how the tests best fit within their business model, but flexibility is encouraged.

The service can be delivered prior to the consultation as part of the pre-test screening process or after the consultation.

The timing of the check will depend on the way a patient is identified as being eligible. For example, patients who are identified as being eligible when booking or arriving for an appointment may be tested prior to the sight test. Patients who are identified as being eligible during the course of a consultation will receive the test after the appointment is completed.

Test Procedure

- The test should be carried out in quiet, private area.
- The test will be carried out by appropriately trained staff, using an approved and validated BP machine. Blood pressure should be measured in line with NICE guidelines NG136 (21).
- If the BP machine measures pulse, this should be checked first. If pulse irregularity is found (for example, due to AF) blood pressure may not be recorded accurately. The patient should be referred for investigation for AF and notes recorded in the patient records
- Blood pressure measurements should be recorded in the patient's optical practice record and discussed with the patient.
- A copy of the results, and advice provided, should be given to the patient.

Outcomes and Signposting Routes

Referral pathways and actions for very high, high, normal and low blood pressure and AF need to be established following local procedures and aligned with national guidance (10). Actions for when it is not possible to obtain a reading should be determined, for example signposting to GP or pharmacy.

Suggested actions are shown in **Table 5**. The actions should be established following discussions with local providers to determine what the local protocol should be. Local referral pathways need to be agreed, communicated in advance and hosted on LOC websites. Periodically reminder communications should be sent to help ensure new practice staff are informed.

Table 5: Suggested Referral Pathways

Finding	Suggested Actions
Very high blood pressure ≥ 180/120 mmHg	Walk-in centre, A&E. NHS 111, contact GP same day with a copy of results
High blood pressure <180/120 mm ≥ 140/90 mmHg	Sign-post to community pharmacy blood pressure checking service or GP for further testing or ambulatory blood pressure monitoring, give copy of results

Table 5: Suggested Referral Pathways (continued)

Finding	Suggested Actions
Normal blood pressure <140/90 mm ≥ 90/60 mmHg	Given advice on healthy behaviours, copy of results, recommend retest within 5 years
Low blood pressure <90/60 mmHg	**Symptomatic** – refer to GP within 24-48 hrs **Asymptomatic** – refer to GP with 2-3 weeks or repeat testing at community pharmacist Give copy of results
Irregular heartbeat	Refer to GP within 48 hrs or urgent NHS 111 call Give copy of results
Unable to obtain a reading	Sign-post to GP or pharmacy to obtain a reading

Referral pathways should take into account the local area and provisions across the region.

It may be appropriate to have alternative options to ensure that a patient can access appropriate care. An example of this is in a rural area where there may be limited access to community pharmacies and alternative provisions may need to be identified.

Example: Humber & North Yorkshire

The service required people with high blood pressure to go to community pharmacy for further testing. For one practice there was limited access to community pharmacy in the area making follow up difficult for some patients.

2.2.3 Workflow Integration

The pathway for service delivery recognises that practices operate in different ways, with different staffing levels and patient throughput. In the pilot areas all practice staff were involved in the process. Staff carrying out the blood pressure measurements do not need to be clinical members of the team, but they do need to have received appropriate training to perform the assessment and communicate the results.

Eligible patients may be identified by reception staff or optical assistants when booking or attending for appointments. Blood pressure measurements could be carried out by optical assistant as part of the pre-checks undertaken prior to the consultation.

Patients may also be identified at eligible by an optometrist, CLO or DO during the course of a consultation. In these cases, the optometrist, CLO or DO could carry out the blood pressure measurement or ask a trained optical assistant to do the test once the consultation is complete.

In practices where there are optical assistants already performing pre and post eye examination tests, such as intra-ocular pressures, retinal photography, OCT scans and fields tests, the most efficient and cost-effective way of carrying out the blood pressure measurements would be for optical assistants to add them to tests they are already trained to do. In some smaller practices, where optometrists carry out these tests themselves, it may be more appropriate for them to undertake the service.

These decisions can be made by the practice teams to best meet their business model.

Practices understand their workforce capacity and patient's needs. Ideally patients should be offered the service on the day of the appointment. However, there may be occasions when it is appropriate to invite patients to return on another day if they do not have the time to stay or if the practice capacity means it is not possible to deliver the service.

This could be done when a patient returns to collect glasses or attend a follow up appointment. Ideally all testing will be done on the same day to minimise inconvenience to patients and reduce the risk of patients not attending the second appointment.

2.2.4 Staff Engagement and Training

The whole optical workforce can be involved in the process of checking eligibility, offering and carrying out the service. In the pilots, this included dispensing opticians, optical assistants, optometrists, practice managers and receptionists. Both clinical and non-clinical staff can be involved in delivering the service if they are appropriately trained.

Training packages for the whole workforce need to be flexible and available to be undertaken at any time to ensure that new members of staff can access training, thereby preventing disruptions to delivery caused by staff turnover and loss of trained staff. Training requirements should be accessible and proportionate for the optical practice workforce.

Training packages need to ensure that staff are:

- Familiar with NICE guidelines NG136: Hypertension in adults
- Familiar with the service specification and understand the operation process
- Trained to use the blood pressure monitoring equipment

Training packages should include:

- Easy to read operating procedure, including referral pathways
- ·ommonly used hypertension medications
- Details of what hypertension is and how is it defined and measured
- Signs and symptoms of hypertension

2.3 Evaluation

2.3.1 Record Keeping, Data Collection and Analysis

In the pilots, some results were shared with GPs either via digital platforms (PharmOutcomes or OPERA) or by email.

New services need to establish how results will be shared and referrals made. If digital platforms are to be used, all practices involved need to have access and appropriate licences.

The following information needs to be collected and recorded.

- Blood pressure measurement and pulse (if recorded) recorded in patient records and given to patient
- Actions taken following blood pressure/pulse measurement, including the information and advice given to the patient
- Referrals made, recorded in patient notes and made through the appropriate platform.

Take up of the service by eligible patients can then be determined at a practice level, this can also be collected and analysed on a neighbourhood, LOC or ICB level.

This can allow for targeted promotion in areas where take up may be lower.

Understanding how many referrals are made and who to is important in understanding the extent of undiagnosed hypertension in the area and if there are implications for other services.

2.3.2 Stakeholder Feedback

All involved stakeholders (see 2.1.3) need to be involved at all stages of development of the service.

Feedback via surveys for patients, staff and other stakeholders (such as pharmacists and GPs receiving referrals) can be used to determine effectiveness of the service and monitor quality.

Any patient surveys need to be offered in digital and hardcopy form to ensure that digital exclusion does not affect the findings.

2.3.3 Cost-Benefit Analysis

In the pilots, a fee of £15 was received for each completed patient episode.

While the evaluation showed that the fee was not the main driving force for providing the service, the fee was appropriate to sustain the service. On a practice level, the service is most cost effective if it was carried out by non-clinical staff, such as trained optical assistants.

At an ICB level, the evaluation found that the cost involved in setting up and running the intervention and of management of diagnosed CVD would be offset by the avoided long-term costs of disease management and social care.

2.4 Key Challenges to Consider

2.4.1 Patient Participation

Patient Not Registered with GP in Area

Pathways need to be identified to ensure any patient tested can be referred on for further testing and management as needed.

If patients are not registered with a GP, they should be given written copies of their results, including actions to be taken and the reasons why follow up is important. Patients should be provided with information and support on how to register with a GP.

2.4.2 Integration of Systems

Digital platforms were used in a number of pilots and they can provide an effective way to manage referrals. However, at present there is no one platform that links all NHS services.

2.4.3 Capacity and Resources

Onward Referral

The pathways should take into account local facilities, on an ICB, a neighbourhood and on an individual optical practice level, while meeting national guidelines.

In the pilots, patients who were found to have raised blood pressure were referred on to different locations or services.

These included the GP or pharmacy for either repeat testing or 7-day monitoring. National guidelines for onward referral need to be followed, but an understanding of the local area is needed to ensure patients have easy access to appropriate services, for example if there are no local pharmacies offering 7-day testing an alternative service needs to be available.

2.4.4 Reporting

Data needs to be recorded and reported in a way that is manageable by the practice and useful for practice, neighbourhood and ICB reporting.

The following data is recommended to be recorded and reported at a minimum:

- Number of eligible patients identified
- Number of eligible patients consenting to the service
- Number of patients being referred for further investigations in each category (e.g. very high blood pressure, high blood pressure, low blood pressure and AF)

2.5 Recommendations

2.5.1 Recommendations for Commissioners

Commissioners need to ensure they understand the local community and population needs. NHS funded sight testing, while a significant part of the work done in an optical practice, does not highlight the true extent of the whole patient cohort seen by primary care optometry.

Relying on this data will not help the ICB understand the full picture of the population attending optical practice, who would benefit from a CVD case finding service. GOS eligibility for funding toward sight tests (excluding those under 19 and 60 years and over) is based on several different criteria. Considering GOS tests alone will underestimate the number of potential people passing through optical practices as this does not take in to account private tests and people attending practices for other services.

These other services may include, but are not limited to:

- Minor and urgent eye care services
- Glaucoma pathways
- Maculopathy pathways
- Contact lens appointment
- Low vision assessment

Other locally commissioned service and pathways may also be in operation.

ICBs should consider commissioning across the whole ICB areas, encompassing multiple neighbourhoods. This will aid both patient engagement and optometry workforce participation. Collaboration between ICBs would help widen the service reach and avoid problems where patients attend optical practices in a different ICB area from the one their GP is in.

Early engagement with LOCs is vital as they know the local practices and area and should be involved in any service from the start. Running initial engagement sessions for the LOC and interested workforce is helpful to understand the local interest, identify potential challenges to

implementation and develop the enthusiasm and buy in to drive the service forward.

Appointing CVD champions for area or neighbourhood can also help drive forward the service and support practices in implementing a blood pressure service. Communities of practice or other ways of sharing good practice can be set up to allow practices to support each other and share learning.

When developing the service, there must be some consideration of the data capture process involved. Compared to sight testing, this will be a lower volume service and therefore utilising IT provision that the majority of optical practices are already familiar with and use within other services will be important.

Service sustainability needs to be considered and succession planning needs to be built in. There needs to be ways for new practices to join the service, e.g. training needs to be available on an ongoing basis and alternative provisions if other services change, e.g. if there is no longer a pharmacy in the area who offered the 7-day blood pressure monitoring.

2.5.2 Recommendations for LOCs

LOCs need to be involved at all stages of the development of the service. Early engagement with neighbourhood hub discussions is vital to highlight the important role optometry can play in supporting health initiatives in the area.

For many optical practices this will be a completely new type of service, even if other enhanced optometry services are commissioned. It is likely that project support will be required beyond the initial set up of the service to ensure that service is effective.

Where the service is contracted directly with practices, adequately resourced project management support for practice teams should be considered. Where a prime provider is contracted, they should have experience in project managing service implementation and be able to provide support to optometry practices.

All committee members need a solid understanding of why CVD identification is important to the local and regional population and the impact CVD-related issues have on their population's health, along with the aim of preventing avoidable sight loss.

LOCs should be advocating that CVD identification could be part of wider primary care preventive role, for example as part of Healthy Living Optical Practices. They can consider the potential of neighbourhood accreditation to encourage practice sign up and participation.
LOCs should be encouraged to identify a lead and working group to support the first few years of this service development as the pilot experience has found that practices benefit from ongoing reassurance and support beyond initial implementation.

Providing clinical leadership to the commissioner project management team and supporting the appointment of a CVD champion (HLOP champion) can help in developing a service that is effective and fit for purpose. LOCs should consider leadership development for a health champion network.

LOCs should share information about the service and referral pathways on their websites.

Collaboration with LOCSU is recommended to ensure that local innovation is reflected in national guidance and LOCSU resources updated to help ensure an England-wide consistent approach.

2.5.3 Recommendations for Optometry Practices and Professionals

Engagement

Optical practice staff need to feel engaged and involved in the services.

The evaluation of the pilots showed that staff felt positive about their role and felt it was important work that should be done and felt it added value to their job role. For the service to be effective, all staff members need to be involved and understand the processes involved.

Integration into Workflow

Practices need to identify the best way to implement the pathway in their individual practice. This will depend on the practice size, set up and workforce. For most practices, it will be most effective to have trained optical assistants carrying out the blood pressure measurements.

However, it is recognised that in some small practices it may be necessary for a clinical member of staff, such as an optometrist or DO to perform the service.

The evaluation showed that once the process has been established, practice staff find the processes to be straightforward.

3.0 Developing the Service

This CVD case finding service provides a way of demonstrating the role primary care optometry has in wider primary care. The role of optometry is expanding, and the profession needs to demonstrate the skills and expertise it has.

The eye is the only part of the body that hypertensive and organ damage can be observed directly, and it is natural that the profession is involved in prevention of CVD. CVD case finding sits naturally alongside work that is already being done in optical practices. There is software currently in use in some practices that uses AI to predict cardiovascular risk from retinal photography (26). As technology advances, the optical sector can push forward their role in CVD case-finding and management.

There are also other opportunities in the public health arena, such as case finding for diabetes (23), smoking cessation (27) and alcohol interventions (21), that could be developed alongside CVD case finding.

The recommendation for age groups to be tested is in line with other CVD case finding services such as NHS Community Pharmacy case finding service (9). People under 40 years of age can be offered the service if there are finding that are suggestive of hypertension. If the lower age limit for CVD case finding is recommended to be lowered for other services, such as community pharmacy or the NHS Health Checks, it is suggested that the lower age limit in optical practice be changed in line.

Further Audit and Research Suggestions

Further audit is required to understand service uptake in optometry. In the pilot, take up of the service by eligible patients was between 70 and 100%. However, in some areas with 100% take up it was not clear if this was an accurate reflection of all patients who were offered the service. Further audits are recommended to confirm take up rates remain high.

Recording a count of all eligible people who are offered the service and whether they accept or decline will allow take up rate to be determined.

The evaluation suggested that referral rates from optometry practices were lower than from dental practices, potentially due to ‘white coat hypertension’, where blood pressure is elevated due to anxiety associated with attending the dental clinic. Dental anxiety is well documented (28). However, this has been studied less in an optical setting (29) and further research could be undertaken as part of this pathway.

One of the aims of CVD case finding in optical practices is to increase accessibility in community settings and offer the service to people who may not be regularly accessing other services, such as GPs. Further research is required to show that there are patients presenting to optical practices who are not attending other healthcare providers.

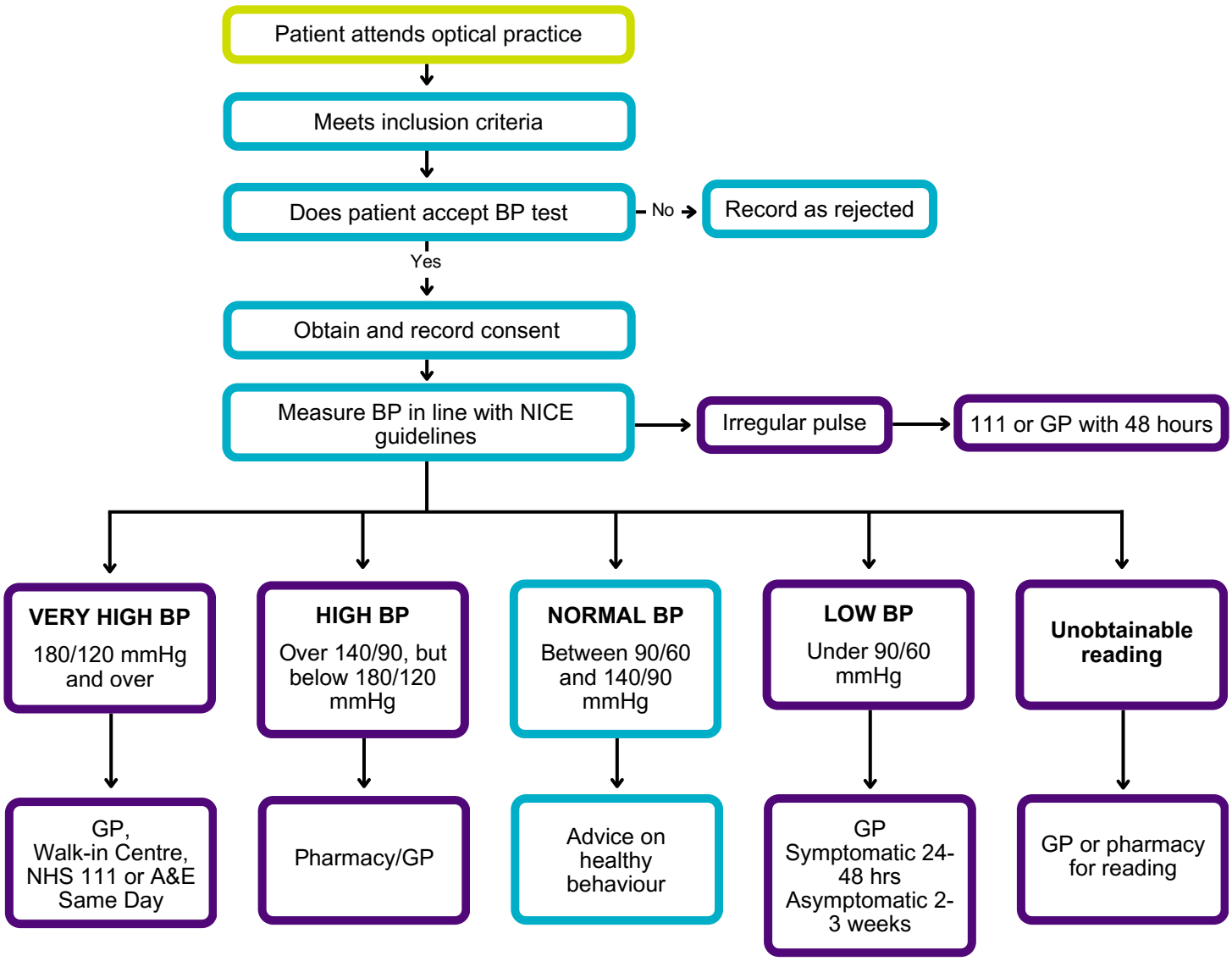
4.0 Summary

The CVD case finding pilots in England demonstrated that offering blood pressure and AF checks in Optometry is feasible, acceptable to patients and staff and can help in diagnosing undetected hypertension and AF, thereby reducing the risk of CVD events and premature deaths.

The initial evaluation indicates the service is financially viable; the cost involved in service set-up, delivery and management of diagnosed CVD would be offset by the avoided long-term costs of disease management and social care.

Appendices

Appendix A - Pathway



Key

- GOS/Core competency
- Extended Primary Care / referral filtering (Core Competency)
- Extended primary eye care, requires higher qualification and relevant experience (Care traditionally delivered in general practice)
- Referral to general practice for management

Inclusion Criteria

- Able to give informed consent

AND

- Aged 40 years or over **OR** aged under 40 years with findings suggestive of hypertension

AND

- No hypertension diagnosis or not taking regular hypetensive medication

AND

- Blood pressure has not been measured within last 6 months.

LOCSU CVD Pathway Diagram – December 2025. Review date: December 2028
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Appendices

Appendix B - I

Click on the case study for more information.

- Appendix B: **Cheshire and Merseyside**
- Appendix C: **Gloucestershire**
- Appendix D: **Greater Manchester**
- Appendix E: **Herts and West Essex**
- Appendix F: **Humber and North Yorkshire**
- Appendix G: **Lancashire and South Cumbria**
- Appendix H: **Lincolnshire**
- Appendix I: **North Central London**

Appendix J

Click on the case study for more information.

- Appendix J: **AI Powered Retinal Imaging**
- Appendix K: **Dudley**

Glossary

AF Atrial Fibrillation
BIHS British & Irish Hypertension Society
CCG Clinical Commissioning Groups
CLO Contact Lens Optician
CUES Community Minor and Urgent Eye Care
CVD Cardiovascular disease
DO Dispensing Optician
HBP High blood pressure
ICP Integrated Care Partnership
LOC Local Optical Committee
LOCSU Local Optical Committee Central Support Unit
MECC Making every contact count
NHSE NHS England

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