The safety and effectiveness of community urgent eye care services in England 2025

A policy review

The College of Optometrists
42 Craven Street, London, WC2N 5NG
T +44 (0)20 7839 6000 Registered charity number: 1060431

Executive Summary

The demand for eye care in England has risen sharply, outpacing the capacity of hospital eye services (HES) and leading to delays in treatment [1, 2]. Ophthalmology now accounts for nearly 9% of all NHS outpatient appointments[3], and acute eye problems are increasingly burdening emergency departments with 1–6% of all A&E attendances being ocular emergencies[4]. Historically, patients with eye symptoms turn first to GPs, yet most GPs lack specialist ophthalmic training and equipment[5]. Up to 70% of eye-related A&E cases could be managed in primary care by specially trained GPs or optometrists[6, 7], indicating a significant opportunity to shift care closer to home. The consequence of the status quo – overloaded hospitals and GPs – is delayed care, which risks avoidable sight loss[2]. With an ageing population and tight health service budgets, it is imperative to adopt new models of care that improve access and outcomes[1, 8].

Optometry-led urgent and emergency eye care services – exemplified by the Minor Eye Conditions Service (MECS) and COVID-19/Community Urgent Eyecare Service (CUES) – offer an effective solution. These services enable patients with urgent ocular problems to be seen promptly by primary care optometrists, and specially trained contact lens opticians* in some pathways, with the necessary expertise and equipment. Evidence from across England shows that optometrists can safely manage the majority of acute eye cases in the community, delivering timely care while reducing unnecessary hospital visits[8, 9]. The national roll-out of Community Minor and Urgent Eye Care Service has been predicted to reduce HES, A&E and GP appointments by 200,000, 240,000 and 425,000 per year respectively. Timely access to these schemes is an important patient benefit as sight threatening conditions with similar symptoms to non-sight threatening conditions can be identified early, which helps prevent avoidable sight loss.

Patient outcomes are excellent, and satisfaction is very high, as patients receive immediate specialist attention rather than waiting for GP or hospital appointments. Crucially, these schemes operate within optometrists' core competencies – additional qualifications beyond standard optometry training are not required for delivering urgent eye care safely[10, 11]. Despite their proven benefits, MECS and CUES are not yet uniformly commissioned across all regions, and awareness among the public and some health professionals remains limited.

> Up to 70% of eye-related A&E cases could be managed in primary care by specially trained GPs or optometrists

Policy action is needed now to expand and fully integrate optometry-led urgent eye care services across England. This brief presents key findings from the latest evidence and offers recommendations to capitalise on this under-used capacity in primary care. By commissioning and scaling up these services, policymakers and commissioners can alleviate pressure on GPs and hospital eye departments, reduce health inequalities in eye care access, and improve patient safety and experience. This aligns with the Westminster government's ten year health plan to move more services from hospital to community settings, where patients can access the right care closer to home[8, 9, 10].

The College of Optometrists
42 Craven Street, London, WC2N 5NG
T +44 (0)20 7839 6000 Registered charity number: 1060431

Key Findings

High burden of acute eye conditions on GP and hospital services:

Eye-related issues comprise about 1–2% of all GP consultations[5] and a significant share of A&E attendances[4, 6, 7]. However, many of these cases do not require hospital-based intervention. Studies estimate that approximately 70% of patients attending emergency departments for ocular problems could instead be managed in primary care by optometrists or specially trained GPs[6, 7]. Many patients who present at hospital eye casualty are discharged without needing any follow-up, suggesting that hospital care may not have been necessary in those instances[12]. This misallocation of care pathways contributes to unnecessary workload for overstretched ophthalmology departments and GPs, and leads to delays for patients who genuinely need specialist or emergency care[8, 13]. Without change, rising demand will continue to strain the system, increasing the risk of avoidable vision loss in patients with more serious conditions, due to longer waits and delayed treatment[1, 2, 14].

Optometry-led urgent care services are effective and efficient:

Primary care optometrists have the training, experience, and equipment to diagnose and manage most acute eye conditions that would otherwise go to GPs or hospitals. Comprehensive evaluations of locally commissioned MECS and CUES schemes in England show that between 75% and 97% of acute eye cases are fully managed by optometrists in primary care, without need for onward referral[12, 15, 16, 17, 18, 19].

> GP referrals to ophthalmology dropped by 27% and hospital follow-up appointments fell by 13% in the first year of MECS operation

In practice, optometry-led urgent care services in primary care settings address a wide range of presentations, predominantly acute red eye, painful eye, vision changes, flashes/floaters, and other non-sight-threatening conditions. Across multiple regions, the majority of patients (often 80% or more) are treated and discharged after a single visit in optometry practices[12, 15, 16, 17, 18, 19]. Only a small fraction require escalation: for example, in a London based MECS, about 19% of patients needed referral to hospital eye clinics[12, 16], and in a recent enhanced CUES site, only ~10–14% required referral to GPs or HES[18]. This is in addition to the patients already routinely managed solely in primary eye care, where only around 3-5% of patients from over 19 million sights tests in England require onward referral per year[20].

These numbers demonstrate a substantial reduction in unnecessary hospital attendances. Notably, many areas that implemented MECS saw a significant drop in hospital workload – one study found GP referrals to ophthalmology dropped by 27% and hospital follow-up appointments fell by 13% in the first year of MECS operation[12, 16]. Similarly, during the rollout of CUES in 2020, a Manchester evaluation reported emergency eye department attendances fell by ~38% per month compared to the prior year[17]. Such outcomes confirm that diverting patients to optometry-led primary care services effectively frees up capacity in secondary care and general practice.

The College of Optometrists
42 Craven Street, London, WC2N 5NG
T +44 (0)20 7839 6000 Registered charity number: 1060431

Safe and high-quality care, comparable to hospital standards:

Evidence consistently shows that urgent eye care provided by primary care optometrists is clinically safe and of high quality. Independent case reviews and audits report that the vast majority of cases managed by optometrists are deemed appropriate and in line with best practice[12, 16, 21]. For example, in the Lambeth & Lewisham MECS, 95% of patient records audited met appropriate management standards, and only 2 out of 220 cases reviewed were considered to have been managed sub-optimally, but none of which resulted in serious adverse outcomes[12, 16]. Inappropriate referrals from optometrists are rare, and when they occur they are usually due to being overly cautious (referring more urgently than necessary, or referring cases that turned out not to require specialist care)[12, 16, 17, 21].

This cautious approach, while resulting in some false alarms, is inherently safe – studies found that the vast majority of referrals from MECS/CUES are appropriate (approximately 80–90%), and the small proportion that are deemed unnecessary pose minimal risk[12, 15, 16, 17]. Importantly, missed diagnoses (false negatives) are exceedingly low: a follow-up study in Greater Manchester found only 0.23% of cases not referred by the CUES service turned out to have sight-threatening issues on later review[21]. In other words, primary care optometrists are effectively triaging and managing urgent eye conditions with an accuracy and safety profile comparable to (and in some aspects better than) traditional hospital or GP settings[1, 5, 21]. Additionally, optometrists provide thorough documentation and communication in their referrals when escalation is needed, aiding seamless handover to HES[17, 18].

High patient satisfaction and improved access:

Patients strongly favour primary care optometry-led services. Surveys from MECS pilots indicate over 95% of patients rated their experience as "excellent," with 100% expressing confidence in the optometrist's care[15]. By accessing care on the high street, patients are seen faster and closer to home, avoiding long waits at GP surgeries or hospital A&E. In the West Suffolk MECS audit, a large majority of patients reported that if the service hadn't been available, they would have sought care from their GP or an emergency department[15] – highlighting that MECS/CUES directly reduce those attendances. Patients appreciate the immediacy and specialist attention: they receive timely diagnosis, treatment (including on-site minor treatments or prescriptions) and advice for self-management when appropriate. This positive patient experience leads to greater trust in primary eye care and encourages people to present with symptoms to their optometrist as first contact and at an earlier stage, rather than delaying until problems worsen. Research from Healthwatch England also shows strong public support (85% of patients surveyed) for expanding the role of optometrists in delivering specialist eye care, including as First Contact Practitioners, reflecting widespread trust in local optometrists and their ability to deliver comprehensive primary eye care services closer to home[22].

> ...over 95% of patients rated their experience as "excellent

Moreover, commissioning these services can address health inequalities: without NHS-funded urgent eye care schemes, those who cannot afford private fees may delay care or overload NHS secondary care emergency pathways[1, 2, 13, 14]. MECS and CUES ensure that all patients, regardless of income, have prompt access to eye care professionals for urgent

The College of Optometrists
42 Craven Street, London, WC2N 5NG
T +44 (0)20 7839 6000 Registered charity number: 1060431

needs, which is particularly beneficial for vulnerable groups who suffer the greatest burden of eye disease[23, 24].

Efficient use of workforce and resources:

Shifting urgent eye care to optometrists makes better use of NHS resources. Optometrists are highly trained in eye health and equipped with slit lamps and diagnostic tools that most GPs lack[5, 13]. By utilising optometrists' skills, patients receive a more accurate diagnosis on first contact, often avoiding unnecessary prescriptions or referrals. For instance, GPs tend to prescribe medications (notably antibiotics) in up to 70% of acute eye cases they see, whereas optometrists prescribe in roughly 35% of cases[25, 26], managing many conditions with conservative measures or simple remedies[12, 16, 17, 18]. This suggests optometry-led care can reduce unnecessary antibiotic use, supporting antimicrobial stewardship.

Furthermore, optometrists can provide immediate treatments (like removing superficial foreign bodies or initiating topical therapeutics) and issue timely referrals only for genuine emergencies. The result is fewer duplicative appointments and less overall cost: one visit to a community optometrist often replaces multiple GP visits or an A&E visit followed by a hospital clinic appointment[12, 16, 17, 18, 19]. Several evaluations note that including a follow-up visit within the service (when needed) allows optometrists to ensure resolution of the condition, which prevents patients bouncing back to GPs or hospitals[8, 9, 15]. Overall, MECS/CUES leverage an existing workforce of optometrists and their accessible high street practices to deliver faster care, increase system capacity, and potentially lower NHS expenditures through avoidance of more expensive hospital-based care.

No additional qualifications needed for optometrists:

A critical finding is that community optometrists can deliver urgent eye care safely without needing new formal qualifications beyond their core training. MECS and CUES providers are typically required to undergo an accreditation process (often a short online course and practical assessment) to reaffirm skills, but this is essentially a review of competencies they already possess[9, 11, 15]. Research has shown no significant differences in clinical outcomes based on optometrists' experience level or postgraduate qualifications in these schemes – indicating that the core competencies of a qualified optometrist are sufficient to manage acute presentations[15, 26]. In fact, during the pandemic, CUES was rapidly rolled out with no mandatory accreditation refresh, yet delivered safe and effective care nationwide[14, 17, 18, 21]. The notion that extra credentials (beyond standard optometry registration and continuing professional development and education) are needed has been called into question, where such requirements may be unnecessary for clinical safety[27].

The evidence suggests that, given appropriate support and clear protocols, all optometrists can capably provide urgent eye care. This means there is a large and ready workforce to expand these services and removing onerous accreditation barriers could accelerate commissioning. While additional training such as Independent Prescribing (IP) can enhance an optometrist's scope to manage more complex cases (and indeed studies show IP-trained optometrists achieve even higher primary care retention rates)[17, 18, 19, 29], these are enhancements rather than prerequisites. The priority is to activate the existing network of primary care optometrists to perform urgent care roles that they are already trained for, which is both feasible and safe. While further research is needed to assess their impact, specially trained contact lens opticians can also provide urgent eye care services to further increase capacity in primary care[30].

The College of Optometrists
42 Craven Street, London, WC2N 5NG
T +44 (0)20 7839 6000 Registered charity number: 1060431

Recommendations

Commission optometry-led urgent eye care services across all regions

Remove unnecessary barriers and additional qualification requirements

Ensure adequate funding and support within service specifications

Strengthen integration, clinical governance and collaboration

Increase awareness and encourage appropriate use of services

To realise the benefits of optometry-led urgent and emergency eye care at scale, the following actions are required:

1. Commission optometry-led urgent eye care services across all regions:

Every part of England should have a commissioned service enabling patients to access acute eye care from primary care optometrists. Integrated Care Boards (ICBs) and NHS commissioners must ensure that the Community Minor and Urgent Eye Care Service[30] (evolved from MECS and the original CUES specification) is funded and available universally, so no patient is disadvantaged by their location[8, 9, 14]. This includes maintaining the Community Minor and Urgent Eyecare Service as a permanent service, with a consistent service specification nationally. Commissioning urgent eye care services fills a critical gap between routine sight tests and hospital emergency care. By embedding optometry-led urgent care into NHS pathways (including NHS 111 and GP referral protocols), patients with acute eye symptoms can be directed straight to a participating primary eye care practice. This significantly reduces unnecessary GP and A&E visits and frees up hospital clinicians to focus on true ocular emergencies and complex cases. ICBs should review current service provision and act to expand or establish contracts to achieve 100% geographic coverage.

2. Remove unnecessary barriers and additional qualification requirements:

Commissioners should review existing accreditation processes for optometrists in urgent eye care schemes. Given evidence that reaffirmation courses do not necessarily improve safety outcomes[27], the requirement for additional entry qualifications beyond core optometry training should be dropped or minimised. Optometrists' standard competencies (as assessed by their registration and continuing professional development requirements) are sufficient to deliver MECS/CUES safely. Therefore, policies should trust and utilise the existing workforce without imposing extra courses or certifications that delay service rollout. Where some form of orientation or induction is needed for local protocols, it should be brief and focused on familiarisation rather than testing competency. Removing these barriers will encourage more optometrists to participate, rapidly increase capacity, and save administrative costs. Commissioners can look to the COVID-19 CUES deployment – which operated without mandatory re-accreditation and achieved excellent outcomes – as a model for simplifying requirements[10, 14, 17, 18, 21]. Relevant professional body guidance[29] (e.g. from The College of Optometrists) supports eye health professionals to provide

The College of Optometrists
42 Craven Street, London, WC2N 5NG
T +44 (0)20 7839 6000 Registered charity number: 1060431

clinical care. Existing service specifications[30] should be followed, which emphasise that core competency optometrists and specially trained contact lens opticians should work within their scope of practice, reinforcing confidence among providers and commissioners alike.

3. Ensure adequate funding and support within service specifications:

For urgent eye care services to succeed and be sustainable, commissioning contracts must provide appropriate funding and resources. These services are not part of the GOS sight test. Tariffs should reflect the complexity of urgent eye examinations and include funded follow-up appointments where clinically necessary[8, 9, 15]. Including follow-ups in the service model has been shown to improve outcomes and reduce onward referrals by allowing issues to fully resolve under optometric care.

Commissioners should also enable optometrists to provide treatments that prevent the need for GP involvement – for non-prescribing optometrists, mechanisms like Patient Group Directions or NHS-funded signed order arrangements for antibiotic and anti-inflammatory eye drops (within optometrists' existing exemptions) should be in place[12, 15, 17, 18]. Where optometrists with Independent Prescribing (IP) qualifications are available, the service should maximise their utility by permitting them to prescribe and manage a broader range of conditions funded by the NHS (for instance, issuing NHS prescription pads or electronic prescribing codes to IP optometrists)[18, 19, 21]. This was successfully achieved in a Herefordshire CUES scheme, where enabling IP optometrists to prescribe independently kept an additional 23% of cases within primary care that would otherwise have required referral for medication[19, 21]. By investing in proper resourcing – adequate fees, remote consultation infrastructure, and medication supply pathways – commissioners will ensure optometry-led services can handle the majority of cases from start-to-finish, delivering both patient convenience and system cost savings.

4. Strengthen integration, clinical governance and collaboration:

A primary care optometry-led acute eye care pathway should be fully integrated into the broader healthcare system. This means developing robust clinical governance frameworks to ensure patient safety, facilitate clinical audit and improve service quality to safeguard high standards of care. Commissioners should also facilitate ongoing mentorship, feedback, and case discussion between community optometrists and ophthalmologists[12, 15, 16, 17]. Evidence shows that schemes with regular multidisciplinary shared learning (e.g. hospital clinic sessions for optometrists, referral feedback, and shared continuing education) yield higher clinical quality and allow optometrists to manage more complex cases confidently[12, 15, 16, 17, 31, 32]. Therefore, each commissioned service should include arrangements for improved communication, building relationships through local training events, e.g. designated HES liaison sessions or periodic joint meetings to review cases, local protocols and professional guidelines. In addition, advice and guidance should be formally commissioned to support clinical decision making and enable co-management where appropriate, to further prevent onward referral.

Integrating IT systems is also crucial – optometrists should have access to (and training in) secure two-way referral systems, shared patient records, and the ability to share clinical data and imaging studies with secondary care[32]. Improved IT connectivity would streamline referrals and enable hospital clinicians to easily triage or redirect appropriate cases back to

The College of Optometrists
42 Craven Street, London, WC2N 5NG
T +44 (0)20 7839 6000 Registered charity number: 1060431

community care (a process that CUES has piloted with success), and feedback on the outcomes of referrals[17, 18, 19, 33]. By cementing collaboration and data-sharing, this can further reduce unnecessary referrals and prevent duplication of imaging studies and other clinical investigations that may otherwise delay access to care. Standard national protocols should underpin the service to maintain high and consistent clinical standards across England.

Commissioners should also monitor outcomes (clinical audits, patient feedback and referral patterns) as part of governance, to support optometrists to continually refine the service and address any issues promptly. Such data should also be used to assess the impact of specially trained contact lens opticians providing urgent eye care and fill this crucial evidence gap. An overall integrated approach will build trust in the service, further solidifying its role in the urgent care pathway.

5. Increase awareness and encourage appropriate use of services:

Even where MECS or CUES are commissioned, under-utilisation can occur due to low public or professional awareness[12, 15, 16]. A concerted effort is needed to promote these services as the first port of call for any urgent eye problem. National and local commissioners should implement public information campaigns so that the local community know they can directly attend or self-refer to participating optometrists for ocular symptoms such as red and/or painful eyes, flashes and floaters and sudden vision changes. Clear messaging (through NHS websites, 111 operators, GP practice communications, pharmacies, and media campaigns) can shift patient behaviour to seek care from optometry practices for eye issues in the first instance[8, 9, 15].

Equally important is engagement with other healthcare professionals: GPs, pharmacists, and NHS 111 staff should be regularly updated and reminded about the availability of these services and should be encouraged to redirect patients with eye symptoms to local commissioned urgent eye care services. This requires confidence that the service will deliver: collection and dissemination of positive outcomes and patient satisfaction data can help convince clinicians to trust the scheme. Local Optical Committees and GP federations could collaborate on simple referral pathways, for example, a direct booking system or advice line between GPs and optometrists. Moreover, professional bodies should include modules on optometry-led urgent eye care in GP and pharmacy training, to increase recognition of and referral to such services. As more patients and providers become aware, these services should see higher uptake, leading to a greater impact on reducing hospital attendance. Such cultural change, supported by policy, will be key to unlocking the full potential of optometry-led schemes.

The College of Optometrists
42 Craven Street, London, WC2N 5NG
T +44 (0)20 7839 6000 Registered charity number: 1060431

Conclusions

England faces a critical opportunity to improve urgent and emergency eye care by leveraging the untapped capacity of its community optometrists. The evidence is clear and compelling: primary care optometry-led services like MECS and CUES deliver safe, effective care for the majority of acute eye conditions, achieving outcomes on par with hospital care while dramatically easing the burden on GPs and eye casualty departments. The national roll-out of Community Minor and Urgent Eye Care Service can reduce HES, A&E and GP appointments by 200,000, 240,000 and 425,000 per year respectively while also releasing financial benefits to the NHS[34]. Patients benefit through quicker access, expert management, and excellent experiences, all within their local community. Importantly, these benefits have been realised by utilising the core skills of optometrists – a testament to the high level of skill already present in the workforce. In a time of NHS workforce shortages and secondary care backlogs, expanding these services offers a timely solution to increase system capacity, reduce waits, and prevent harm from delayed ophthalmic care. It aligns with broader health system goals of delivering care closer to home and improving integration between primary and secondary care. Perhaps most critically, adopting optometry-led care ubiquitously will foster a more resilient eye health care system able to meet the growing demands of our ageing population.

The College of Optometrists
42 Craven Street, London, WC2N 5NG
T +44 (0)20 7839 6000 Registered charity number: 1060431

References

1. Rawlings, A., Hobby, A. E., Ryan, B., Carson-Stevens, A., North, R., Smith, M., ... & Acton, J. H. (2024). The burden of acute eye conditions on different healthcare providers: a retrospective population-based study. *British Journal of General Practice*, *74*(741), e264-e274.
2. Foot, B., & MacEwen, C. (2017). Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome. *Eye*, *31*(5), 771-775.
3. NHS England (2024). Hospital outpatient activity 2023-24. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2023-24. (Accessed 18/03/25)
4. Royal College of Ophthalmologists. (2024). Ophthalmic service guidance: emergency eye care in hospital eye units and secondary care. Available at: https://www.rcophth.ac.uk/wp-content/uploads/2021/01/Emergency-eye-care-in-hospital-eye-units-and-secondary-care-Copy.pdf. (Accessed 18/03/25).
5. Sheldrick, J. H., Wilson, A. D., Vernon, S. A., & Sheldrick, C. M. (1993). Management of ophthalmic disease in general practice. *British Journal of General Practice*, *43*(376), 459-462.
6. Rehan, S. M., Morris, D. S., Pedlar, L., Sheen, N., & Shirodkar, A. L. (2020). Ophthalmic emergencies presenting to the emergency department at the University Hospital of Wales, Cardiff, UK. *Clinical and Experimental Optometry*, *103*(6), 895-901.
7. Hau, S., Ioannidis, A., Masaoutis, P., & Verma, S. (2008). Patterns of ophthalmological complaints presenting to a dedicated ophthalmic Accident & Emergency department: inappropriate use and patients' perspective. *Emergency Medicine Journal*, *25*(11), 740-744.
8. Baker, H., Ratnarajan, G., Harper, R. A., Edgar, D. F., & Lawrenson, J. G. (2016). Effectiveness of UK optometric enhanced eye care services: a realist review of the literature. *Ophthalmic and Physiological Optics*, *36*(5), 545-557.
9. Wilson, H., Bhogal-Bhamra, G. K., Dhawahir-Scala, F., Tromans, C., & Harper, R. A. (2024). A review of UK primary care pathways for acute ophthalmic conditions. *Eye*, 1-12.
10. The College of Optometrists. COVID-19 Urgent Eyecare Service (CUES) in England. Available at: https://www.college-optometrists.org/news/2020/april/covid-19-urgent-eyecare-service_cues_england. (Accessed 13/03/25).
11. LOCSU. (2022). Competencies and qualifications summary table - primary care optometrist. Available at: https://locsu.co.uk/wp-content/uploads/2022/10/LOCSU-Competencies-Table.pdf. (Accessed 18/03/25).
12. Konstantakopoulou, E., Harper, R. A., Edgar, D. F., Larkin, G., Janikoun, S., & Lawrenson, J. G. (2018). Clinical safety of a minor eye conditions scheme in England delivered by community optometrists. *BMJ Open Ophthalmology*, *3*(1).
13. Pooley, J. (2018). Treating minor eye conditions in optometry practices: is this a viable model for the future? *Eye News, 25(1).*
14. Desai, P., Parkins, D., & Richmond, Z. (2021). A catalyst for change. *Eye*, *35*(4), 1037-1040.

The College of Optometrists
42 Craven Street, London, WC2N 5NG
T +44 (0)20 7839 6000 Registered charity number: 1060431

15. Hill, D., & Hanspal, I. (2020). A minor eye conditions pilot delivered by community optometrists. *Clinical Audit*, 1-9.
16. Konstantakopoulou, E., Edgar, D. F., Harper, R. A., Baker, H., Sutton, M., Janikoun, S., ... & Lawrenson, J. G. (2016). Evaluation of a minor eye conditions scheme delivered by community optometrists. *BMJ Open*, *6*(8), e011832.
17. Kanabar, R., Craven, W., Wilson, H., Rietdyke, R., Dhawahir-Scala, F., Jinkinson, M., ... & Harper, R. A. (2022). Evaluation of the Manchester COVID-19 urgent eyecare service (CUES). *Eye*, *36*(4), 850-858.
18. Amjad, H., & Rumney, N. (2021). Effect of the COVID-19 Urgent Eyecare Service on patient referrals to general practitioners and Hospital Eye Service. *Eye News*.
19. Ansari, E., Patel, M., & Harle, D. (2022). Acute community ophthalmology services provided by independent prescribing optometrists supporting hospital eye services during the COVID-19 outbreak. *Journal of Optometry*, *15*(2), 175-178.
20. FODO (2023). The future of primary eye care – principles and priorities. Available at: https://www.fodo.com/flipbooks/FODO-Strategy-Document-Full-2023/. (Accessed 17/04/25)
21. Williams, E., Craven, W., Wilson, H., Dhawahir-Scala, F., Jinkinson, M., Newman, W. D., & Harper, R. A. (2022). Reassurance on false negatives in the Manchester COVID19 Urgent Eyecare Service (CUES). *Eye*, *36*(1), 12-14.
22. HealthWatch (2025). A strain on sight: waiting for NHS specialist eye care. Available at: https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20250320_A%20strain%20on%20sight_Healthwatch%20England_0.pdf. (Accessed 29/04/25)
23. Cumberland, P. M., & Rahi, J. S. (2014). Visual health inequalities: findings from UK Biobank. *The Lancet*, *384*, S27.
24. Shickle, D., Davey, C. J., & Slade, S. V. (2015). Why is the General Ophthalmic Services (GOS) Contract that underpins primary eye care in the UK contrary to the public health interest?. *British Journal of Ophthalmology*, *99*(7), 888-892.
25. Hau, S., Ehrlich, D., Binstead, K., & Verma, S. (2007). An evaluation of optometrists' ability to correctly identify and manage patients with ocular disease in the accident and emergency department of an eye hospital. *British Journal of Ophthalmology*, *91*(4), 437-440.
26. Burns, D. H., Dart, J. K., & Edgar, D. F. (2002). Review of the Camden and Islington Anterior Segment Eye Disease Scheme. *Optometry in Practice*, *3*, 55-60.
27. Swystun, A. G., & Davey, C. J. (2022). A prospective evaluation of the clinical safety and effectiveness of a COVID-19 urgent eyecare service across five areas in England. *Ophthalmic and Physiological Optics*, *42*(1), 94-109.
28. Cottrell, P., North, R., Sheen, N., & Ryan, B. (2022). Optometry independent prescribing during COVID lockdown in Wales. *Ophthalmic and Physiological Optics*, *42*(6), 1289-1303.
29. The College of Optometrists. Clinical Management Guidelines. Available at: https://www.college-optometrists.org/clinical-guidance/clinical-management-guidelines. (Accessed 13/03/25).
30. LOCSU. (2024). Community minor and urgent eye care clinical specification. Available at: https://locsu.co.uk/what-we-do/pathways/community-minor-and-urgent-eye-care. (Accessed 18/03/25).

The College of Optometrists
42 Craven Street, London, WC2N 5NG
T +44 (0)20 7839 6000 Registered charity number: 1060431

31. Konstantakopoulou, E., Harper, R. A., Edgar, D. F., & Lawrenson, J. G. (2014). A qualitative study of stakeholder views regarding participation in locally commissioned enhanced optometric services. *BMJ Open*, *4*(5), e004781.
32. Baker, H., Harper, R. A., Edgar, D. F., & Lawrenson, J. G. (2016). Multi-stakeholder perspectives of locally commissioned enhanced optometric services. *BMJ Open*, *6*(10), e011934.
33. The College of Optometrists. (2022). Optical bodies fully support two-way IT connectivity for primary and secondary care. Available at: https://www.college-optometrists.org/news/2022/october/it-connectivity-primary-secondary-care. (Accessed 24/03/25)
34. PA Consulting (2024). Key interventions to transform eye care and eye health. Available at: https://primaryeyecare.co.uk/wp-content/uploads/2024/11/Key-interventions-to-transform-eye-care-and-eye-health_Full-Report_October-2024.pdf. (Accessed 20/05/25).

The College of Optometrists
42 Craven Street, London, WC2N 5NG
T +44 (0)20 7839 6000 Registered charity number: 1060431