LOCSU Enhanced Services

Service Specification

Primary Eyecare Assessment and Referral Service (PEARS) North Hampshire CCG

Issued by
Local Optical Committee Support Unit
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LOC SUPPORT UNIT
SUPPORT FOR PRIMARY EYE CARE DEVELOPMENT

Service Specification – Primary Eyecare Assessment and Referral Service (PEARS)

Key Service Outcomes

The introduction of a Primary Eyecare Assessment and Referral Service will alter the pathway of care to reduce waiting times and increase access for patients & provide value for money. This will be achieved by:

- Providing timely and effective triage of all new ophthalmic referrals to the service.
- Providing timely access to clinical expertise in primary care. Providing timely access to a comprehensive range of diagnostic and treatment services in primary care.
- Providing clear and unencumbered referral pathways for those patients who require intervention from other specialties or secondary care.
- Providing high quality performance information as defined by the specification to commissioners at prearranged and agreed intervals

1 Service outline

1.1 The service provides for the assessment and treatment of a number of eye care conditions in the community.

1.2 The service is provided by accredited local *ophthalmic practitioners* who have a range of equipment to facilitate detailed examination of the eye, as well as the specialist knowledge and skill.

1.3 The service is accessed by *patients* direct from the local *ophthalmic practitioner* by referral from:

- a GP or Allied Health Professional within the North Hampshire Clinical Commissioning Group who recommends attendance and treatment ("GP referral")
- another ophthalmic practitioner who does not provide the service
- a secondary care consultant where it is considered appropriate for those patients to be managed within the community
- the GP out of hours service on a Saturday
- patients will not be able to self-refer to the service unless the condition requires an urgent assessment

1.4 The service is available to all persons registered with a GP practice located within the geographical area of North Hampshire CCG.

2 Service aims

2.1 The service aims to improve eye health and reduce inequalities by providing increased access to eye care in the community.

2.2 The service utilises the knowledge and skills of primary care ophthalmic practitioners to triage, manage and prioritise patients presenting with an eye condition

2.3 Access to eye care for the conditions described in paragraph 4.1 will enable more *patients* to receive treatment closer to their homes.

2.4 The service is expected to reduce the number of unnecessary referrals from primary care to secondary care, supported by the provision of more accurate referral information if a referral is made.

2.5 Relationships between *ophthalmic practitioners*, GPs and the Clinical Commissioning Group will be further developed

3 Service provision

3.1 The service shall be provided during normal opening hours Monday to Saturday, 9.00-5.30 as a minimum

3.2 Referrals to the service shall be made in accordance with paragraph 4.9.

3.3 An *ophthalmic practitioner* or other person employed or engaged by the Contractor in respect of the provision of the services under the Contract ("other responsible person") may refuse to provide the service if an *ophthalmic practitioner* is unavailable to provide the service within the timescale provided for in paragraph 3.4.

3.4 On receipt of a referral, the *ophthalmic practitioner* or *other responsible person* shall arrange for the assessment and, where appropriate, the treatment of the *patient*, within twenty four (24) working hours of such referral. NB: Please note that Flashes and Floaters would need to be seen within 24 hours whereas ‘routine’ cases can be treated within a longer time frame.

4 Service specification and criteria

4.1 Symptoms at presentation included in the service

4.1.1 This service provides for the assessment and management of *patients* presenting with any of the following:

- Blurred vision providing the patient has had a sight test within the previous year
- Ocular pain or discomfort
- Systemic disease affecting the eye eg throid dysfunction, rheumatoid arthritis
- Differential diagnosis of the red eye
- Dry eye
- Epiphora (watery eye)
- Trichiasis (in growing eyelashes)
- Differential diagnosis of lumps and bumps in the vicinity of the eye
- Flashes/floaters
- Retinal lesions
- Non specific field defects
- GP referral

4.2 Symptoms at presentation not included in the service

4.2.1 The following conditions require the *patient* to attend an ophthalmic hospital (which includes an ophthalmic department of a hospital) casualty or accident and emergency department ("hospital eye services"):

- Red painful eye requiring immediate attention
- Suspect Retinal detachment
- Retinal artery occlusion
- Chemical injuries
- Penetrating trauma
- Orbital cellulitis
- Temporal arteritis
- Ischaemic optic neuropathy
- Sudden loss / dramatic reduction in vision in *one* eye
- Patients identified to have severe eye conditions which need hospital attention eg. orbital cellulitis, temporal arteritis
- Eye problems related to herpes zoster
- Removal of suture

4.2.2 The treatment of long term chronic conditions is not included within the service. Conditions excluded from the service include:

- Diabetic retinopathy

- Long standing adult squints
- Long standing diplopia
- Patient's reported symptoms indicate that a sight test is more appropriate than this service

4.2.3 An NHS sight test shall not be performed concurrently with assessment or treatment for this acute service. Please note that the ophthalmic practitioner will need to prioritise the urgency of the conditions presented. For example Flashes and Floaters will need to be seen within 24 hours.

4.3 Procedures

4.3.1 Such procedures shall be undertaken as deemed clinically necessary by the relevant *ophthalmic practitioner* after assessment of the *patient's* History and Symptoms

4.3.2 All tests undertaken and results obtained must be recorded on the *Optometric Patient Record,* even if the results are normal.

4.3.3 Any drugs or staining agents used during the examination or prescribed must be recorded on the *Optometric Patient Record*.

4.3.4 All advice given to the *patient* (verbal or written) must be recorded on the *Optometric Patient Record*.

4.3.5 All detailed retinal examinations shall be undertaken under mydriasis using either 0.5% or 1.0% Tropicamide from a single dose unpreserved unit (Minim) unless this is contraindicated. The reason for not dilating must be recorded on the *Optometric Patient Record*.

4.3.6 The level of examination should be appropriate to the reason for referral. All procedures are at the discretion of the ophthalmic practitioner; however the following guidelines should be adhered to:

- Fundus examination should be through a dilated pupil when required or appropriate using slip-lamp with Volk type lens or head mounted indirect.
- Examination of an uncomfortable red eye must involve a slit-lamp examination used in conjunction with a staining agent and checking for anterior chamber cells/flare
- Visual field examination results must be in the form of a printed field plot rather than a written description.
- Symptoms of a sudden reduction in vision should be investigated by the examination of the macula and retina using a Volk or similar lens

- Symptoms of sudden onset flashes and floaters should be investigated by an examination of the anterior vitreous and peripheral fundus with a Volk or similar lens and relative afferent pupil defect (RAPD) testing is essential.
- Epilation of eyelash capability is essential.

4.4 Clinical Management Guidelines (See appendices 2 & 4)

http://www.college-optometrists.org/en/professional-standards/clinical_management_guidelines/index.cfm

4.4.1 Clinical Management Guidelines for specific conditions should be adhered to unless this is contraindicated. All clinical decisions and advice given to *patients* must be recorded on the *Optometric Patient Record*.

4.5 Equipment

4.5.1 The Contractor shall have the following equipment:

- Slit lamp
- Contact Tonometer
- Threshold field equipment to produce a printed field plot
- Ophthalmoscope
- Amsler charts
- Epilation equipment
- Diagnostic drugs (mydriatics, stains, local anaesthetics etc)
- Volk type lens
- Ishihara / other colour vision plates
- Internet access

4.6 Medication

4.6.1 *Ophthalmic practitioners* may sell or supply all pharmacy medicines (P) or general sale list medicines (GSL) in the course of their professional practice, including 0.5% Chloramphenicol antibiotic eye drops in a 10ml container.

4.6.2 *Ophthalmic practitioners* may give the patient a written (signed) order for the patient to obtain the above from a registered pharmacist, as well as the following prescription only medicines (POMs):

- Chloramphenicol
- Cyclopentolate hydrochloride

- Fusidic Acid
- Tropicamide

4.6.3 In making the supply to the patient the ophthalmic practitioner must ensure:

- Sufficient medical history is obtained to ensure that the chosen therapy is not contra-indicated in the patient
- All relevant aspects, in respect of labelling of medicine outlined in the Medicine Act 1968 are fully complied with
- The patient has been fully advised on the method and frequency of administration of the product

4.6.4 In general, supply via a pharmacist is preferred. The College of Optometrists has produced guidelines on the use & supply of drugs as part of its 'Code of Ethics &Guidelines for Professional Conduct' section 2.40.

If the patient is exempt from prescription charges, supply of appropriate treatments could be covered by Group Prescribing Directives and/or by Minor Ailment Services in accordance with The National Pharmacy Enhanced Service Plan already in existence.

4.7 Accreditation – education and training

4.7.1 The Contractor and all *ophthalmic practitioners* employed or engaged by the Contractor in respect of the provision of the *enhanced services* shall satisfy the accreditation criteria detailed in this section 4.7.

4.7.2 To become accredited, *ophthalmic practitioners* must be able to identify a range of ocular abnormalities and must demonstrate proficiency in the use of the above mentioned equipment. Participating Ophthalmic practitioner s must be registered with the General Optical Council.

4.7.3 Participating *ophthalmic practitioners* must complete the Cardiff (WOPEC)/LOCSU PEARS Distance Learning modules (Part 1) and the associated Practical Skills Demonstration (Part 2). Part 1 must be completed before Part 2.
An ophthalmic practitioner who has a relevant higher qualification and experience may be exempt from the PEARS Distance Learning and/or the Practical Skills Assessment at the discretion of the WOPEC Clinical Lead. Please note that the clinical lead would have to look at the time elapsed since the qualification and experience. Over 5 years since the qualification would not be sufficient for example.

4.7.4 *Ophthalmic practitioners* will be required to attend a training session run by the LOC and CCG, primarily to cover the admin procedures and protocols involved in providing the *enhanced service.* The training session will cover:

- An introduction to the service
- Administration of the service including protocols, processes and paperwork

4.7.5 *Ophthalmic practitioners* will be required to successfully complete a re-accreditation process every three (3) years.

4.7.6 *Ophthalmic practitioners* will be required to undertake appropriate Peer Review Activity in the third year of the Contract term.

4.77 The CCG will provide GPs and optometric practices with a regularly updated list of contractors providing the primary eye care service.

4.7.8 The Contractor shall be responsible for ensuring that all persons employed or engaged by the Contractor in respect of the provision of the services under the Contract are aware of the administrative requirements of the service.

4.8 Patient eligibility

4.8.1 The service is available to all persons registered with a GP practice located within the North Hampshire Clinical Commissioning Group.

4.8.2 The Contractor shall ensure that the *patient* is an *eligible person* by verifying the patient's GP before providing the enhanced service.

4.9 Referral and patient pathway

4.9.1 Accredited ophthalmic practitioners will receive referrals from GPs/Allied Health Professionals using a standard referral form (Appendix 1a).

4.9.2 If patients are referred into PEARS via the accredited PEARS ophthalmic practitioner, the referral form (shown in Appendix 1b) must be used.

4.9.3 Each *patient* requiring an assessment and/or treatment under the service will be provided with an *Information Leaflet* describing the service and including a list of contractors (as drafted by the CCG).

4.9.4 *Patients* shall make a mutually convenient appointment with the Contractor, and shall be encouraged to telephone the *practice premises*.

4.9.5 If the Contractor is unable to provide for the assessment and where appropriate, the treatment of the *patient* within the timescale described in paragraph 3.4, the Contractor, *ophthalmic practitioner* or *other responsible person* shall direct the *patient* to an alternative provider of the services, by way of the list of contractors supplied by the CCG.

4.9.6 If urgent onward referral to *hospital eye services* is required, in accordance with paragraph 4.2.1, the *ophthalmic practitioner* shall advise the relevant *hospital eye service* by telephone and a copy of the *Optometric Patient Record* shall be given to the *patient* to present on attendance.

4.9.7 Where a sight test/routine eye examination is required, the Contractor, *ophthalmic practitioner* or *other responsible person* shall direct the *patient* to their usual community ophthalmic practitioner.

A copy of the *patient's Optometric Patient Record* shall be faxed (where possible) to such community ophthalmic practitioner within twenty four hours or given to the *patient* to present on attendance.

4.9.8 The Contractor, *ophthalmic practitioner* or *other responsible person* shall provide the *patient* with a paper copy of their *Optometric Patient Record Card*, if requested.

4.9.9 The Contractor, *ophthalmic practitioner* or *other responsible person* shall send a copy of each *patient's Optometric Patient Record* to the *patient's* GP, where a prescription is required, (unless they have the relevant qualification and can issue an NHS prescription if appropriate) within twenty four working hours.

4.9.10 The Contractor shall provide all appropriate clinical advice and guidance to the *patient* in respect of the management of the presenting condition.

4.9.11 Where appropriate, the Contractor, *ophthalmic practitioner* or *other responsible person* shall provide the *patient* with an Information Leaflet on his/her eye condition.

4.9.12 Should a patient fail to arrive for an appointment, the ophthalmic practitioner must contact the patient within 24 working hours, informing them that they have missed their appointment, and ask them to arrange a further appointment.

4.9.13 Should a patient fail to re-arrange an appointment within 7 working days of contact being made (or fails to attend their re-arranged appointment) then the ophthalmic practitioner will inform the patient’s GP.

4.10 Follow-up processes

4.10.1 Treatments shall not routinely attract a follow-up appointment. All follow-up appointments must be clinically justified.

4.11 Record keeping and data collection

4.11.1 The *ophthalmic practitioner* shall fully complete, in an accurate and legible manner, an *Optometric Patient Record* in the format provided by the CG for each *patient* managed.

4.11.2 The *Optometric Patient Record* will provide for:

- The urgent referral of *patients* by an *ophthalmic practitioner* to the *hospital eye services*
- The referral of *patients* to their GP for joint management
- The referral of *patients* to their usual community ophthalmic practitioner for a sight test/routine eye examination
- The management of *patients* by the *ophthalmic practitioner*

4.11.3 The Contractor, *ophthalmic practitioner* or *other responsible person* shall also maintain a summary of:

- The number of *patients* for whom an appointment was booked and the source of the referral (as set out in paragraph 1.3)
- The number of appointments booked for *patients* who did not attend ("DNAs")

4.12 Performance reporting and audit

Reporting requirements and timescales

4.12.1 A report on activity and patient outcomes shall be forwarded by the Contractor to the CCG's payments agency by the 25th day of the month following the month in which the *patients* received the service.

4.12.2 Clinical Governance issues shall be reported by the Contractor to the CCG by exception, in accordance with paragraph 5.5.

4.12.3 Complaints shall be reported quarterly by the Contractor to the CCG.

4.12.4 Other relevant information required from time to time by the CCG shall be provided by the Contractor in a timely manner.

4.13 Service review

4.13.1 The Contractor shall co-operate with the CCG as reasonably required in respect of the monitoring and assessment of the services, including:

- Answering any questions reasonably put to the Contractor by the CCG
- Providing any information reasonably required by the CCG
- Attending any meeting or ensuring that an appropriate representative of the Contractor attends any meeting (if held at a reasonably accessible place and at a reasonable hour, and due notice has been given), if the Contractor's presence at the meeting is reasonably required by the CCG

5 Clinical governance

5.1 Quality in Optometry: http://www.qualityinoptometry.co.uk/

5.1.1 The Contractor must complete Level One and Level Two of Quality in Optometry within one year of the *Enhanced Service commencement date* and provide evidence of this to the commissioner if requested to do so.

5.2 Significant Incident reporting

5.2.1 A record of all significant incidents (SIs), near misses and potential incidents must be maintained. SIs must be reported to the designated quality lead within 24 hours.

5.2.2 All complications resulting from a PEARS examination or treatment must be recorded on the patient record.

5.3 Infection control

5.3.1 Premises must be kept clean; this includes all areas of public access.

5.3.2 In all consulting and screening rooms used, hard surfaces should be regularly cleaned using appropriate hard surface solution / wipes.

5.3.3 Hand washing facilities must be provided in, or near, to consulting / screening rooms.

5.3.4 Hot and cold water should be available, and liquid soap and paper towels provided.

5.3.5 All equipment that comes into contact with patients must be cleaned after each patient. This may be by using antiseptic wipes (or similar) for head / chin rests or by using disposable chin rests.

5.3.6 Disposable heads should be used for Tonometer prisms.

5.3.7 Epilation equipment must be sterilised between patients.

5.4 Waste management

5.4.1 In accordance with College of Optometrists' guidelines used tissues and paper towel can be disposed of in your normal 'black bag' waste.

5.4.2 Part-used (or out of date) minims need to be disposed of appropriately.

5.4.3 Chloramphenicol is regarded as hazardous waste and requires specialist incineration.

5.5 Clinical audit

5.5.1 The Contractor shall participate in any clinical audit activity as reasonably required by the CCG, and maintain appropriate records to evidence and support such activity, including an electronic spreadsheet showing patient outcomes.

5.6 Patient experience

5.6.1 The Contractor will participate in a patient survey by engaging *patients* in the completion of a patient questionnaire, if required by the CCG.

6 Payment

6.1 Payment for the service is on a cost per case arrangement. The CCG shall pay the Contractor £50 for each first *patient* appointment and £25 for each follow-up appointment. (For the avoidance of doubt, though, no payment shall be made by the CCG in respect of DNAs.)

6.2 Payment will be made to the Contractor monthly based on activity reports submitted by the Contractor to the CCG to be received by the [insert date day of the month following the month in which the *patient*s received the service]. Payment shall be paid by the CCG to the Contractor on the [insert date] day (or, where such day is not a working day, the next working day) of the following month.

7 Participating accredited ophthalmic practitioners

The *ophthalmic practitioners* named below have successfully undertaken accreditation and will provide the acute community eye care service for *patients* presenting at the *practice premises*.

The *ophthalmic practitioners* named below declare that they have read and understood this service specification.

Name

Signature Dated

Name

Signature Dated

Name

Signature Dated

Appendix 1a
PEARS – First Attendance

Patient's Details	Optometrist / Practice
First name:	*Optometrist:*
Last name:	*OPL number:*
DOB:	*Practice:*
NHS number:	
Address:	*Phone:*
Phone:	**Patient's GP**
Mobile:	*GP name:*
Email:	*Practice:*

Referral info	*Date referred:*			*Date seen:*			
Referred by		*GP*		*Patient*		*Optometrist*	
Sight test		*Carried out*		*Not carried out*		*Not carried out but advised*	
Reason for referral	*Headache*		*Loss of vision*		*Ocular discomfort*		*Other (specify):*
	Flashes/floaters		*Red eye*		*Trauma*		

Diagnosis

Eyelid lumps and bumps	*Resolved*		**Conjunctiva**	*Resolved*		**Anterior uveitis**	*KP*		*?Melanoma*	
	Concretions			*Pinguecula*			*Flare*		*Naevus*	
	Papilloma			*Allergic*			*CL injection*		**Retinal lesions**	*BRVO/CRVO*
	Cyst			*Bacterial*			*Synechiae*			*CRAO/BRAO*
	Stye			*Viral*		**Macular degeneration**	*Drusen*			*Isolated haem*
	?Malignant			*Tumour*			*Dry*			*Other (specify below)*
Tear Dysfunction	*Dry eye*			*Episcleritis*			*Wet*		**Field defects**	*Physiological*
	Conjunctivitis			*Scleritis*		**Maculopathy**	*Serious ret*			*Artefact*
	Tear duct		**Cornea**	*Foreign body*			*Cellophane*			*Longstanding*
	Lid laxity			*Pterygium*			*Macular hole*			*Glaucoma*
	Ectropion			*Keratoconus*		**Flashes/ floaters**	*Weiss ring/PVD*			*Neurological*
Lid and Lash problems	*Trichiasis*			*Marginal keratitis*			*Tobacco dust*		**Diplopia**	*Resolved*
	Entropion			*Dystrophy*			*Retinal hole/tear*			*Recent onset*
	Blepharitis			*Herpes keratitis*			*Ret.Detachment*			*refractive*
				Microbial keratitis			*non-PVD floaters*		**Systematic disease affecting eye**	*Hypertension*
				Other keratitis						*Diabetes*
										MS
										Thyroid
										Arteritis

Other diagnosis / comments:

Dist. VA	*Right:*		*Discharged*	
	Left:		*Epilated*	
Smoker?	*Yes*		*Foreign body removed*	
	Recent ex		*Lubricated*	
	No		*Lid hygene*	
Dilated?	*Yes*		*Rx requested by GP (specify)*	
	No		*Follow up (specify interval)*	
Tonometry	*Right:*		*Refer back to GP*	
	Left:		*Refer to secondary care (specify routine, urgent, emergency)*	

Action taken

Additional comments:

Signature:	*Date:*

STATEMENT: The reason for this referral has been explained to the patient or guardian who agrees to it.

Appendix 1b
PEARS – Referral to Optometrist

Referral to Optometrist Form
First name:
Last name:
Address:
DOB:
Phone:
Mobile:
NHS number:

GP details
GP name:
Practice:

Referral details
Date of referral:

Reason for referral *(Please tick all that apply or write in comments box)*

Reduction or disturbance of vision including transient *(sudden severe loss of vision - refer to A&E)*		*Yes*	
Ocular pain / discomfort *(Red very painful eye – refer to A&E)*		*Yes*	
Differential diagnosis of red eye		*Yes*	
Foreign body / contact lens removal *(chemical / penetrating injuries - refer to A&E)*		*Yes*	
Dry eye		*Yes*	
Epiphora (watery eye)		*Yes*	
Trichiasis (ingrowing eyelashes)		*Yes*	
Eyelid lumps and bumps		*Yes*	
Recent onset diplopia		*Yes*	
Flashes / floaters		*Yes*	
Glaucoma suspect *(sudden onset acute glaucoma – refer to A&E)*		*Yes*	
Field defects		*Yes*	
Systematic disease affecting the eye		*Yes*	
Retinal lesions		*Yes*	
Other reason	*Please specify:*	*Yes*	

Additional comments:

Patient details

Current medication:	
Significant past medical history:	
Social situation if relevant:	
Signature:	*Date:*

Appendix 2

Guidelines for Flashes and Floater Management

Terminology

The following terms are important in this text:

Retinal break

This is a retinal hole or tear

Retinal detachment

This is any type of retinal detachment including rhegmatogenous, traction or exudative

Optometric Assessment

History and symptoms

A full and thorough history and symptoms is essential. In addition to the normal history and symptoms, careful attention must also be given to the following:

History

- Age
- Myopia
- Family history of retinal break or detachment
- Previous ocular history of break or detachment
- Systemic disease
- History of recent ocular trauma, surgery or inflammation

Symptoms

- Loss or distortion of vision (a curtain / shadow / veil over vision)
- Floaters
- Flashes

For symptoms of floaters these additional questions should be asked:

- Are floaters of recent onset?
- What do they look like?
- How many are there?
- Which eye do you see them in?
- Any flashes present?

For symptoms of flashes these additional questions should be asked:

- Describe the flashes?
- How long do they last?
- When do you notice them?

For symptoms of a cloud, curtain or veil over the vision these additional questions should be asked:

- Where in the visual field is the disturbance?
- Is it static or mobile?
- Which eye?
- Does it appear to be getting worse?

Symptoms of less concern:

- Long term stable flashes and floaters
- Symptoms >2 months
- Normal vision

Clinical examination

All patients presenting for a PEARS examination with symptoms indicative of a potential retinal detachment should have the following investigations (in addition to such other examinations that the ophthalmic practitioner feels are necessary):

- Tests of pupillary light reaction including swinging light test for Relative Afferent Pupil Defect (RAPD), prior to pupil dilation
- Visual acuity recorded and compared to previous measures
- Contact tonometry, noting IOP discrepancy between eyes
- Visual Field examination at discretion of ophthalmic practitioner
- Slit lamp bio microscopy of the anterior and posterior segments, noting:
    - Pigment cells in anterior vitreous, 'tobacco dust' (Shafer's sign)
    - Vitreous haemorrhage
    - Cells in anterior chamber (mild anterior uveitic response)

- Dilated pupil fundus examination with slit lamp binocular indirect ophthalmoscopy using a Volk or similar fundus lens (wide field fundus lens optimal) asking the patient to look in the 8 cardinal directions of gaze and paying particular attention to the superior temporal quadrant as about 60% of retinal breaks occur in that area.

- Noting:
    - Status of peripheral retina, including presence of retinal tears, holes, detachments or lattice degeneration
    - Presence of vitreous syneresis or Posterior Vitreous Detachment (PVD)

Management

If local protocols for the referral of retinal detachment are in place, then these should be followed. If not, you should note that some HES ophthalmology departments will not have RD surgery facilities. In these cases it is best to telephone the department first to find out what procedures to follow.

Symptoms requiring assessment within 24 hours:

1. Sudden increase in number of floaters, patient may report as "numerous", "too many to count" or “sudden shower or cloud of floaters” Suggests blood cells, pigment cells, or pigment granules (from the retinal pigment epithelium) are present in the vitreous. Could be signs of retinal break or detachment present
2. Cloud, curtain or veil over the vision. Suggests retinal detachment or vitreous haemorrhage – signs of retinal break or detachment should be present

Signs requiring assessment within 24 hours:

1. Retinal detachment with good vision unless there is imminent danger that the fovea is about to detach i.e. detachment within 1 disc diameter of the fovea especially a superior bullous detachment, when urgent surgery is required.
2. Vitreous or pre-retinal haemorrhage
3. Pigment 'tobacco dust' in anterior vitreous
4. Retinal tear/hole with symptoms

Signs requiring referral ASAP next available clinic appointment:

- Retinal detachment with poor vision (macula off) unless this is long standing Retinal hole/tear without symptoms
- Lattice degeneration with symptoms of recent flashes and/or floaters

Require discharge with SOS advice (verbal advice and a leaflet):

1. Uncomplicated PVD without signs and symptoms listed above
2. Signs of lattice degeneration without symptoms listed above

Explain the diagnosis and educate the patient on the early warning signals of further retinal traction and possible future retinal tear or detachment:

- Give the patient a Retinal Detachment warning leaflet
- Instruct the patient to return immediately or go to A&E if flashes or floaters worsen

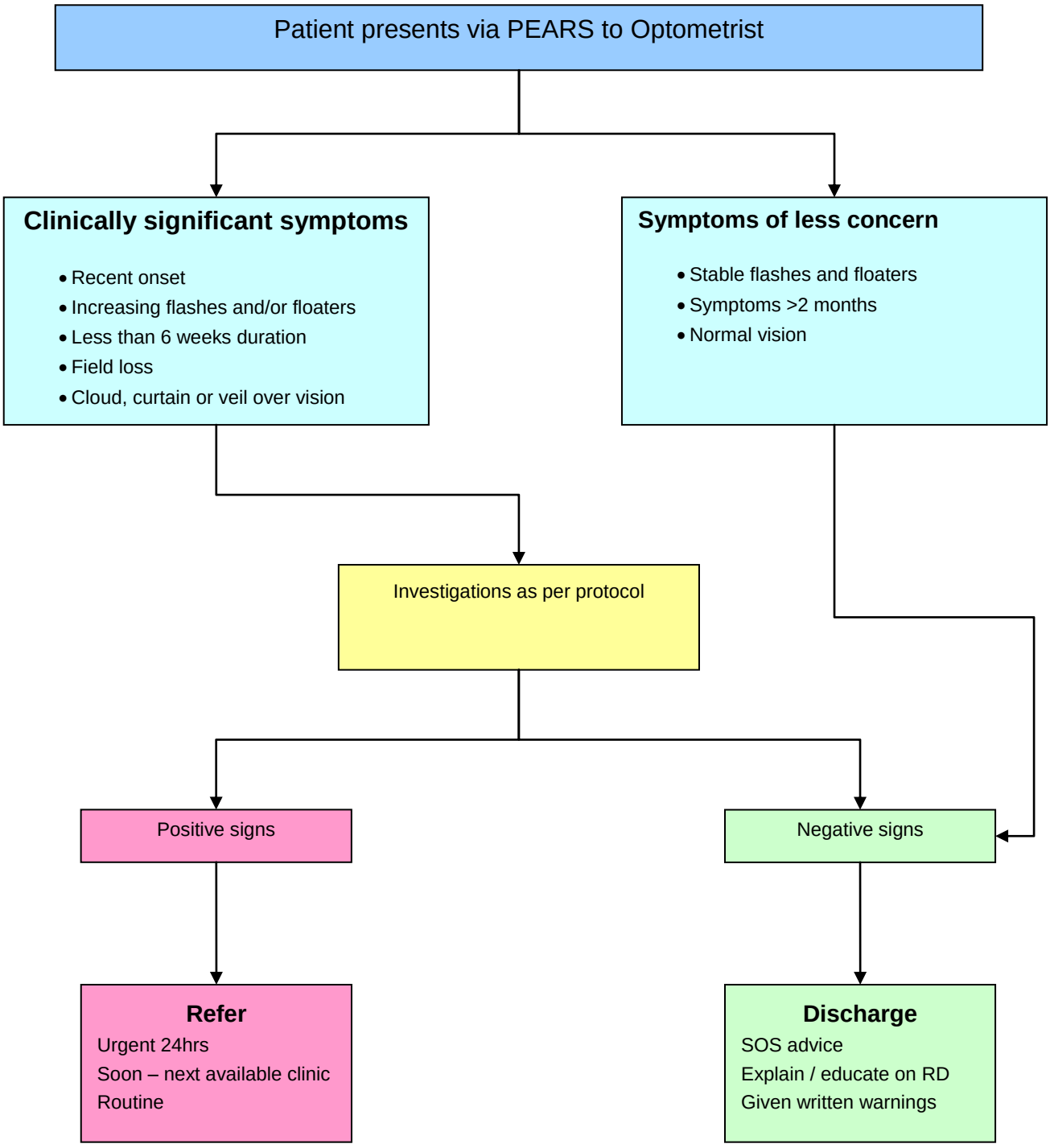
Referral letters

Patients requiring referral for retinal breaks or detachment must have the following noted on the referral form to the ophthalmologist. Letters should be typed whenever possible and may be faxed or sent with the patient in urgent cases.

- A clear indication of the reason for referral. e.g. Retinal tear in superior temporal periphery of Right eyeA brief description of any relevant history and symptoms
- A description of the location of any retinal break / detachment / area of lattice
- In the case of retinal detachment whether the macula is on or off.
- The urgency of the referral

Appendix 3

Flashes and Floaters Patient Pathway



Appendix 4

Age-related Macular Degeneration Management Guidelines

Terminology

The following terms are important in this text & for differential diagnosis:

Wet (exudative) AMD
This can progress very rapidly causing loss of central vision & metamorphopsia (distortion). It is characterised by sub retinal neovascular membrane, macular haemorrhages & exudates.

Dry (atrophic) AMD
A slowly progressive disease characterized by drusen & retinal pigment epithelial changes

Optometric Assessment

History and symptoms

A full and thorough history and symptoms is essential. In addition to the normal history and symptoms, careful attention must also be given to the following:

History

- Age
- Family history of maculopathy
- Previous ocular history
- Systemic disease eg hypertension, diabetes
- History of ocular surgery- cataract extraction, retinal detachment repair
- Myopia
- Medication e.g. chloroquine derivatives, tamoxifen
- Smoking status
- Excessive exposure to sunlight/UV

Symptoms

- Loss of central vision
- Spontaneously reported distortion of vision

These additional questions should be asked:

- Is loss of vision of recent onset?
- In which eye are symptoms present?
- Has the loss of vision occurred suddenly or gradually?

Clinical examination

All patients presenting for a PEARS examination with symptoms indicative of a potential macular degeneration should have the following investigations (in addition to such other examinations that the ophthalmic practitioner feels are necessary):

- Tests of pupillary light reaction including swinging light test for Relative Afferent Pupil Defect (RAPD), prior to pupil dilation
- Visual acuity recorded and compared to previous measures
- Refraction as a hyperopic shift can be indicative of macular oedema
- Amsler grid or similar assessment of central vision
- Dilated pupil fundus examination with slit lamp binocular indirect ophthalmoscopy using a Volk or similar fundus lens noting:
    - Status of macula, including presence of drusen(&size), haemorrhages, pigment epithelial changes ie hyper or hypo pigmentation, exudates, oedema, signs of sub retinal neovascular membrane

Management

If local protocols for the referral of AMD are in place, then these should be followed. If not, you should note that some HES ophthalmology departments will not have the facilities to deal with wet age related macular degeneration. In these cases it is best to telephone the department first to find out what procedures to follow.

Symptoms requiring referral ASAP next available clinic appointment:

1. Sudden deterioration in vision + VA better than 3/60 in affected eye
2. Spontaneously reported distortion in vision + VA better than 3/60

Signs requiring referral ASAP next available clinic appointment:

1. Sub retinal neovascular membrane
2. Macular haemorrhage
3. Macular oedema

Requiring routine referral:

1. Patient eligible & requesting certification of visual impairment
2. Patients requesting a home visit from Social Services to help them manage their visual impairment in their home.
3. Patients who require an assessment for LVA
4. Patients likely to benefit from an intra-ocular Galilean telescope system

Low Vision Aids may be available in the community or hospital eye service - this varies in different areas.

Requires routine follow up but provide an Amsler chart, verbal advice and a leaflet (see sheet appended).

- Dry AMD, drusen &/or pigment epithelial changes
- Explain the diagnosis and educate the patient on the early warning signs of wet AMD.
- Give stop smoking advice via leaflet if appropriate + advice on healthy diet + protection from blue light
- Use 4 point scale to assess risk of AMD progression. Count one point for large drusen of 125 microns or larger (about the size of a vein at the disc margin) and one point for any pigmentary change. Score each eye separately and then add them together for a score out of 4. A full score of 4 points means a 50% chance of progressing to advanced AMD in the next 5 years. 3 points gives a 25% chance, 2 points a 12% chance and with 1 point the risk is just 3%.
- For those at intermediate risk of AMD progression give information on AREDS findings & leaflet on anti-oxidant supplements
- Give information on local services for the visually impaired- public and third sector.
- Give appropriate information on national voluntary agencies e.g. RNIB, Macular Disease Society
- Instruct the patient to inform the practice or GP immediately if vision suddenly deteriorates or becomes distorted.

Referral letters

Patients requiring referral for macular degeneration must have the following noted on the referral form to the ophthalmologist. Letters should be typed whenever possible and may be faxed or sent with the patient in urgent cases. The Royal College of Ophthalmologists fast track referral form for AMD can be used www.college-ophthalmic practitioners.org/en/utilities/document-summary.cfm/docid/81143450-07B2-4A16-BA3ED6F3F7A86D7

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- A clear indication of the reason for referral. e.g. macular haemorrhage
- A brief description of any relevant history and symptoms
- A description of the type of macular degeneration or signs of drusen, pigment epithelial changes, sub retinal neovascular membrane, haemorrhages, exudates, macular oedema.
- The urgency of the referral

Differential diagnosis

Macular hole

This is a hole at the macula caused by tangential vitreo-retinal traction at the fovea. Causes impaired central vision & typically affects elderly females

Macular epiretinal membrane

Can be divided into cellophane maculopathy & macular pucker

Central Serous Retinopathy

Typically sporadic, self-limited disease of young or middle-aged adult males. Unilateral localised detachment of sensory retina at the macula causing unilateral blurred vision.

Cystoid Macular Oedema

An accumulation of fluid at the macula most commonly due to retinal vascular disease, intra-ocular inflammatory disease or post cataract surgery.

Myopic Maculopathy

Chorio retinal atrophy can occur with high myopia, usually > 6.00D, which can involve the macula.

Solar Maculopathy

Due to the effects of solar radiation from looking at the sun causing circumscribed retinal pigment epithelium mottling or a lamellar hole at the macula.

Drug Induced Maculopathies

Antimalarials eg chloroquine, hydroxychloroquine
Phenothiazines eg thioridazine (melleril), chlorpromazine (Largactil)
Tamoxifen

Red Eye Guidelines

Optometric Assessment

The College of Optometrists have produced Clinical Management Guidelines (CMGs) to provide an evidence based information resource on the diagnosis and management of various eye conditions[1]. There are currently 60 of these CMGs, 57 of which could apply to red eyes. These Clinical Management Guidelines were originally intended for specialist therapeutic prescribers but they are valuable to all optometrists.

History & Symptoms

A full and thorough history & symptoms is essential. Careful attention must be given to the following:

History

- Previous ocular history
- Systemic disease, especially diabetes, thyroid dysfunction and inflammatory disease e.g. rheumatoid arthritis, ankylosing spondylitis, inflammatory bowel disease
- Recent cold, flu or infections
- Acne rosacea
- History of contact lens wear
- History of recent ocular trauma, pay particular note to hammer & chisel i.e. risk of penetrating injury and to possible chemical contamination
- History of recent ophthalmic surgery
- History of recent UV exposure e.g. sunlamp, welding
- Atopia e.g. hayfever, asthma, eczema
- Recent foreign travel
- Instillation of any eye drops, if so what are they?
- Systemic medication
- Allergies to drops, preservatives, medications
- Family history

Symptoms

- Discomfort, gritty sensation
- Itchiness
- Pain- sharp or aching on a scale of 1-10
- Discharge- watery, purulent, mucoid
- Unilateral or bilateral
- Duration of onset
- Acute, recurrent or chronic
- Photophobia
- Reduced vision
- Any predisposing factors

Clinical Examination

Include the following as appropriate according to symptoms & history

- Visual acuity
- Pupil reactions- particularly check for RAPD (relative afferent papillary defect)

[1] http://www.college-optometrists.org/en/professional-standards/clinical_management_guidelines/index.cfm

- Ocular motility
- Exophthalmos
- Eyelids- inflammation, incomplete closure, ptosis, position & size of any lumps & bumps, misdirected eyelashes, lid margin disease (blepharitis, meibomianitis, phthiriasis i.e. crab louse, punctae (normal, occluded, absent, stenosed or plug inserted).
- Tears- quality & quantity + tear break up time
- Discharge- serous, watery (viral toxic), mucopurulent (bacterial) or stringy (allergic)
- Bulbar conjunctiva- redness (use grading scale eg CCLU) note depth of vessel injection (conjunctival, episcleral, sclera) and location (perilimbal, sectoral, diffuse, localized) subconjunctival haemorrhage, pigment, raised areas
- Palpebral conjunctiva- evert upper & lower lids to look for foreign bodies, scarring, membranes, papillae, follicles & concretions.
- Corneal epithelium- note any defects (size, location, pattern eg superficial punctate keratitis, dendritic, geographic) FBs, infiltrates (pattern, size, location, depth), oedema, deposits (location, pattern, material eg iron, calcium, filaments)
- Corneal stroma- size, location & depth of opacities- infiltrates, scars, oedema. Note any vessel infiltration- ghost or active vessels
- Corneal endothelium- thickening guttatae, folds or breaks in Descemets' membrane, location, pattern & type of any deposits (KPs, pigment, blood)
- Anterior chamber- depth & Van Herrick assessment of anterior angles. Any cells, flare or blood
- Iris- heterochromia, atrophy, nodules, pigment dispersion, posterior synechiae, new vessels (note is not unusual to see vessels in light coloured irides), peripheral iridotomy

Management[2]

Practitioners should recognise their limitations and where necessary seek further advice or refer the patient elsewhere

Symptoms requiring emergency referral

- Sudden severe ocular pain
- Severe photophobia
- Unexplained sudden loss of vision
- Painful red eye in CL wearer ,unless due to FB/torn CL, (retain CLs, case & solutions for culture)
- Severe trauma

Signs requiring emergency referral (to eye casualty, ophthalmic outpatient clinic or accident & emergency)

- Circumcorneal flush
- IOP>45mmHg
- Chemical injury

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[2] http://www.college-optometrists.org/en/utilities/document-summary.cfm/docid/729FE39F-3048-216E-804AA6284C06A348
http://www.college-optometrists.org/en/professional-standards/clinical_management_guidelines/index.cfm

- Hyphaema
- Hypopyon
- Penetrating injury or deep corneal foreign body
- Corneal ulcer unless small & marginal
- Cells or flare in anterior chamber
- Dendritic ulcer in CL wearer (possible acanthamoeba)
- Deep corneal abrasion
- Corneal abrasion contaminated with foreign material
- Proptosis, restricted eye movements, pain with eye movement, pyrexia (fever >38c)
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Signs requiring urgent referral (within one week)

- Rubeosis (new iris vessels)
- IOP >35mmHg (and ,<45mmHg) unless due to acute closed angle glaucoma
- New case of facial palsy or those with loss of corneal sensation
- Pyrexia (fever >38c), with lid oedema, warmth, tenderness & ptosis

Symptoms requiring routine referral

- **Slow developing, non-resolving lesion of eyelid skin**
- Epiphora causing symptoms

Signs requiring routine referral

- Non-resolving lid lump
- Severe ectropian with symptoms
- Entropian
- Obstructed naso lacrimal duct
- Pterygium threatening vision or associated with chronic inflammation

Referral Letters[3]

Urgent & emergency referral letters may be faxed or sent with the patient. Telephone the ophthalmic casualty unit or ophthalmic unit to arrange for the patient to be seen. Routine referral letters should be typed whenever possible and sent to the GMP unless there are other local arrangements in place eg referral centres. All referral letters/forms should include the following:

- Date
- Full name of referring optometrist & practice address
- Full details of patient including name, address, telephone number, date of birth, reason for referral, supporting signs and symptoms; reports of relevant tests / investigations, including copies of any supplementary data
- A clear indication of the reason for referral
- Provisional diagnosis
- Indication of urgency
- Clearly state if the report is for information only

http://www.college-optometrists.org/en/professional-standards/clinical_management_guidelines/index.cfm

[3] http://www.college-optometrists.org/en/utilities/document-summary.cfm/docid/729FE39F-3048-216E-804AA6284C06A348