London Region

Primary Care Optometrists' Pathways & Referral Guide

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Endorsed by the London Ophthalmology and Eye Care Board

1. Overview

This guide has been compiled to support optometrists providing General Ophthalmic Services (GOS) in the London region. It is especially important for locum, newly qualified and 'new to area' optometrists prior to commencement, including those delivering domiciliary eye care. The expectation is for GOS contractors/ NHS optometrist performers to align their practice accordingly.

This guide does not replace optometrists' professional judgement or remove optometrists' professional responsibility to act in the best interests of their patients, who should be dealt with on an individual basis and in accordance with General Optical Council (GOC) Standards. Patients who are monocular or have other risk factors may constitute a higher risk.

Optometrist supervisors retain clinical responsibility for patients under their student's care including all referral decisions and content [GOC Standard 9].

Core extended primary care/ community urgent eyecare services requiring Integrated Care Board (ICB) commissioning are shown in *light blue italics.* Please check Local Optical Committee (LOC) and primary eye care provider websites for information on participating practices and service requirements.

This document is intended to be actively updated over time. Proposed ICB and Trust changes to referral pathways should be agreed with LOCs and only then, information cascaded to all primary care optometrists and practices by the responsible organisation prior to initiating changes. Failsafe should be in place before the original pathway option is considered safe to be removed.

Guide information for GOS contractors engaging optometrists, especially locums, newly qualified, and those new to area:

- Please ensure availability of a practice information pack with current pathway and referral guidance for home ICB and neighbouring ICBs (keep updated).
- If providing ICB extended primary eye care services – consider internal practice protocols for managing patients (if not seen by an accredited practitioner) requiring cataract assessments/ glaucoma filtering and access to urgent eye care.
- Consider practice referral audits and peer review, e.g., recording and reviewing referral decisions and outcomes.

Guide information for all optometrists:

- Read this pathway and referral guide thoroughly to inform your decision-making and safe use of pathways e.g., do not refer suspect wet AMD patients via the GP.
- Be aware of the range of ophthalmology services, extended primary eye care provision and local protocols in the areas you work.
- Consider Guidance for Professional Practice: **Links: Guidance for Professional Practice - College of Optometrists, and Clinical Management Guidelines - College of Optometrists (college-optometrists.org)**, NICE guidance for Cataract, Glaucoma, and AMD **(Links in text).**
- If your practice is subcontracted for ICB extended primary eye care services, and you are not accredited or acting as a locum, consider referral to the accredited optometrist for managing patients requiring cataract assessment, glaucoma repeat measures and urgent eye care, with instructions to manage outcome, or
- Become accredited for ICB extended services and use locally agreed criteria and practice protocols as per service specifications.
- Keep a personal refinement/ referral audit log to track if patients miss appointments to recheck results and ensure recording of any advice and guidance, subsequent referral decisions and outcomes in the patient record.

2. Opticians Act and General Ophthalmic Services

Optometrists must meet all 19 GOC Standards of Practice **Link: Standards of practice for optometrists and dispensing opticians | GeneralOpticalCouncil** A sight test must include a refraction that may result in a spectacle prescription. It must include 'such examinations of the eye for the purpose of detecting injury, disease or abnormality in the eye or elsewhere' [The Opticians Act, 1989]. The Act also makes it clear that the patient shall not be required to purchase an optical appliance as a condition of having a sight test. The optometrist has a duty to inform the GP if there are signs of injury, disease or abnormality of the eye or elsewhere, and can manage certain eye conditions if within scope of practice and expertise [GOC rules 1999].

GOS sight test provision has:

- set eligibility criteria,
- requirements for early recall, ensuring appropriate use of early retest codes, **Link: OFNC Statement: Clinical Priority Codes - LOCSU** and
- no funding for follow up or repeating tests to manage uncertainty and risk based on a single episode of care, cataract assessment, or a needs-led review for urgent eye presentations.

N.B. A clinical pathway using remote refraction as a separate process to an eye health examination is not permissible as part of a GOS sight test (NHS England Statement 2022).

3. GOS18 referral information

Please ensure your name, NHS performer/ GOC number, and practice name and address are clear on the referral. Some GOS18 and practice referral letters do not include the name of the optometrist but just an illegible signature. Referral letters without adequate source information do not encourage an ophthalmology reply. Similarly, ensure the patient's name, address and contact details are correct. Providing more referral content than the minimum reduces the possibility of the referral being delayed, rejected, or returned for more information by clinical triagers.

4. NHS Patient Choice requirements (extract from NHS letter to practices 10 July 2024)

A provider operating under the GOS contract, when deciding to refer a patient for NHS services, must do so without regard to its own financial interest and ensure that patient choice conversations are carried out. This is confirmed by the General Optical Council Joint Statement on Conflicts of Interest, which sets out the Council's expectation that professionals should avoid, declare and manage actual or potential conflicts of interest across healthcare settings.

The legal right to a choice of five providers applies to referrals made by optometrists as well as GPs [as described in section 3 of the NHS Choice Framework and set out in legislation]. The GOS contract requires optometrists to "comply with all relevant legislation and have regard to all relevant guidance issued by NHS England or the "Secretary of State".

Provider obligations in the GOS contract include a specific contractual requirement to ensure patients are not misled about the availability of services.

5. Safeguarding

Consider GOC Safeguarding Standard 11. If you need to report concerns or seek advice, please search your local ICB website for contact details of your children and young people, and adult safeguarding leads. Also, consider using the NHS England Safeguarding Guide **Link: Safeguarding - NHS Safeguarding** which provides information on how to report a safeguarding concern.

6. Eye Emergencies (same day to hospital eye casualty/ rapid access clinic)

What to refer? The following Red Flag examples are not exhaustive: <24 hours requires clinical discussion.

- Chemical injury to eye or lids,
- Injury involving severe trauma or penetrating injury to the eyeball, lids or socket. by severe traumatic injury or retrobulbar bleed,
- Sudden onset of painful eye with severe reduction or loss of vision, or suddenly blind, or painful eye which causes sickness and general malaise (e.g. acute glaucoma, severe uveitis),
- After an eye operation, an unexpectedly painful, red, or swollen eye with reduced vision (e.g., endophthalmitis, severe post-operative uveitis),
- Unexpected symptoms following corneal graft surgery (graft rejection),
- Recent onset of shadows or 'curtaining' in the field of vision, typically associated with flashing lights or an increase in seeing floaters (retinal tear/ detachment),
- Sudden onset of a red and painful eye, particularly if associated with wearing contact lenses (e.g., corneal ulcer with or without hypopyon),
- Sudden loss of vision with no other symptoms (e.g., retinal or optic nerve vascular or inflammatory event),
- Swollen, painful, red eye with blurred or double vision and malaise, especially in a child (orbital cellulitis),
- Ptosis, headache and sudden diplopia – (third nerve palsy posterior communicating artery aneurysm),
- Severe head pain, scalp tenderness, jaw pain with or without loss of vision (giant cell arteritis).
- Sudden or recent onset of double vision (see 13. Neuro-ophthalmology section).

Link: Urgency of referrals table - College of Optometrists (college-optometrists.org)

Access - In Hours Emergencies (hours may vary).

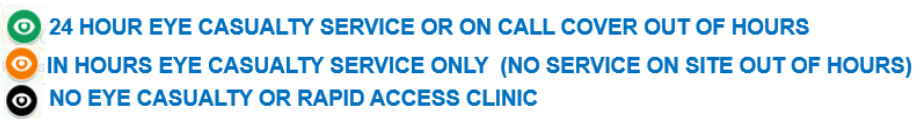
Referral should be made to your local eye casualty/ rapid access clinic. Please contact them (by telephone or email) to discuss the referral before sending the patient, as most units triage before accepting the referral.

Access - Out of Hours (OoH) Emergencies (hours may vary)

Use local guidance (e.g. ICB referral directory) and practice information/ protocols for your closest eye unit providing OoH services.

If information is not readily available in the practice, use the eye casualty referral map **Link: http://bit.ly/EyeCas** to locate your nearest and most appropriate eye unit, and details of how to contact them according to their published eye unit guidelines. The bit.ly map also provides information on eye emergency access for neighbouring systems outside London ICB boundaries. Please note that this information is only for referring optometrists - the link should not be given to patients.

Bit.ly coding



7. Suspect Wet AMD (active) (next working day)

What to refer?

Signs and symptoms:

Visual loss and visual acuity in affected eye – 6/96 or better, with…

- Recent sudden onset of central distortion/ scotoma in central vision of affected eye (usually less than 3 months), or
- Fundal appearance suggestive of choroidal neovascularisation, such as subretinal haemorrhages (not microaneurysms) and exudation, or
- Distortion of vision in only remaining good eye (fellow eye blind from AMD or another cause).

If VA is worse than 6/96 in the affected eye – send non-urgent referral to local eye department for assessment and consideration of low vision aids.

If using a practice referral letter or template, please mark in capitals
'SUSPECT WET AMD REFERAL URGENT NEXT WORKING DAY'

Information to include:

Rx, BCVA, Symptoms, Duration of symptoms, Signs: macular haemorrhage? drusen? exudate? sub/intra-retinal fluid? any other relevant features? History: e.g., previously known to HES, diabetes. etc. Provisional diagnosis.

Consider NICE guideline [NG82] **Link: Overview | Age-related macular degeneration | Guidance | NICE**

1.4.3. Do not refer people with asymptomatic early AMD to hospital eye services for further diagnostic tests (characterised by drusen (small and large) and/ or retinal pigmentary changes).

1.4.5. Refer people with late AMD (dry) to hospital eye services only:

- for certification of sight impairment, or
- if this is how people access low-vision services in the local pathway, or
- if they develop new visual symptoms that may suggest late AMD (wet active), or
- if it would help them to participate in research into new treatments for late AMD (dry)

Access

Refer to the nearest Trust or to the patient's preferred Trust using the Trust's dedicated AMD NHS email – referral to be received by the next working day (ICB referral directory).
All London Trusts now have a dedicated NHS mail referral pathway and should offer an alternative option. However, access via eye casualty may involve telephone triage and take more time.

DO NOT REFER PEOPLE WITH SUSPECTED WET AMD VIA THE GP. This creates significant delay in patients being seen and may result in permanent sight loss.

The Wet AMD pathway expectation is 2 weeks from referral to treatment [NICE NG82]. Please advise patients to contact you if they do not receive an appointment notification within 10 days, so you can chase their referral.

Suspect Wet AMD referral failsafe:

Learning from recent optometrist performance cases around referral delays has highlighted the importance for the following failsafe measures to be in place**:**

1) All optometry/ optician practices to have details of local referral pathways, and mechanisms to assist the practitioner in referring directly using a fast-track wet AMD pathway (next working day).
2) All practices, with no access to electronic referral systems as used by ICB commissioned eyecare services, to use a dedicated secure NHS email to refer directly to the local trusts (or use an alternative option as NHS mail is not accessible to some optometry/ optician practice groups).
3) ICBs, Trusts and LOCs to agree and clearly communicate local ICB referral pathways to all optometry/ optician practices in their area as well as practices in neighbouring ICBs.
4) ICB, Trust and LOC websites to have accessible and updated information on optometrist referral pathways.

8. Urgent Ophthalmology (not within 24 hours, or one working day)

What to refer? Examples include:

- Suspicious recent onset persistent floaters/ suspect Schaeffer's especially with photopsia and/ or IOP decrease in that eye, even if no visible break on dilated view. N.B. clinical examination requires mandatory dilated BIO to assess urgency.
- Vitreous haemorrhage in a non-diabetic patient.
- Elevated IOP in eye with narrow Van Herick but normal pupil and clear cornea.

This can be a confusing area as optometrists and ophthalmologists often differ in what they mean by an 'urgent ' or 'soon' (up to 4 weeks) referral.

Urgent referrals are not the same as eye emergencies (same day), and what constitutes an urgent or soon referral varies considerably between optometrists and ophthalmologists as well as the time expected for patients to be seen.

Where there is any level of urgency, referral letters must include a detailed history and full clinical findings to support the need for the case to be seen more urgently.

Waits may vary depending on the assessed urgency of the condition as determined by the triager based solely on your referral letter content.

Access

Options may include:

- Traditional route via patient's GP practice (may involve a delay)
- Direct secure NHS mail
- Direct referral using prime primary eye care providers own software
- NHS eRS direct referral (used by some ICB commissioned services)
- Direct referral to ICB commissioned urgent eye care services.
- Single Point of Access (SPoA) for urgent and routine referrals.

Extended/ Enhanced Primary Eye Care Services

If no SPOA is in place and condition appropriate, consider signposting patient to a CUES/ MECS practice or practitioner for further investigation rather than default to secondary care.

N.B. The NHS sight test is not an emergency or urgent eye care service.

Eye conditions typically managed and/ or referred under MECS/ CUES/ CES when an NHS sight test cannot be provided under GOS regulations include:

- *Sudden or recent reduction or distortion of vision in one or both eyes.*
- *Recent onset or sudden increase in floaters and /or flashes in one or both eyes.*
- *Red eye(s) or red lids.*
- *Pain and /or discomfort in the eyes, around the eye area or temples .*
- *Swelling, itching or irritation of lids or conjunctiva.*
- *Mild trauma e.g., scratched cornea.*
- *Suspected foreign body, lost contact lens in the eye or in turning eye lashes.*
- *Significant recent discharge from or watering of the eye.*

Single Point of Access .

Direct referral to a Single Point of Access (SPoA) model has been introduced in several London ICB areas. e.g., SEL, NCL, inner NEL. If a SPoA operates in your ICB area, check for local guidance and protocols. Ophthalmology responses regarding patient and clinical information require use of secure systems such as NHS mail.

- Optometrist direct referral requires use of NHS mail **Link: Registering Optometrists (GOS Contractors) – NHS mail Support** or Egress **Link:**: **GOS contractors can apply for an NHS Egress account | NHSBSA** to receive confirmation and an ophthalmology outcome letter.
- Please use the separate dedicated NHS mail for suspect Wet AMD referrals, unless advised otherwise.
- SPoAs must not be used for eye emergencies. Refer direct to your nearest eye emergency or rapid access service, telephoning or emailing first. However, triagers may escalate a referral to eye emergency or de-escalate as required.
- SPoAs should not be used for letters for GP information or for referrals for GP actions only. Send direct to the GP practice.
- Please highlight urgency, subspecialty, choice of provider, and consider including all essential information and where appropriate any relevant visual fields/ photos/ scans.
- Some SPoAs may offer Advice and Guidance with the option of image and scan transfer, but use of this service is not part of GOS. An NHS sight test has a binary outcome of 'referred' and 'not referred'.

Advice and Guidance (A&G) Failsafe

Learning from optometrist performance cases around referral delays has highlighted the need for the following practice failsafe measures to be in place:

1) *Need for practice procedures/ protocols when the optometrist seeks A&G.*
2) *Confirm A&G request has been sent on software/ NHS mail.*
3) *Trusts to provide A&G response within an agreed timeframe (typically up to 48 hours).*
4) *Practice to regularly monitor software/ NHS mail for reply.*
5) *Default referral if no Trust review or response within the agreed A&G timeframe.*

9. Routine Cataract

London Choosing Wisely cataract guidance.
Links: Appendix-9a-Cataract-Surgery-Policy.pdf (transformationpartners.nhs.uk) and
[NG77] **Overview | Cataracts in adults: management | Guidance | NICE**

Consider your decision to refer a person with cataract for surgery on a discussion with them (and a family member or carer as appropriate) as part of history and symptoms that includes:

- Does the cataract affect the person's vision?
- Whether one or both eyes are affected?
- Is the cataract bad enough for the person to want to have cataract surgery?
- Consider NHS England choice guidance if deciding to refer.

Extended/ Enhanced Primary Eye Care Services
Pre- and post-cataract assessments require ICB commissioning. These would include more detailed and protocol-led assessments e.g.,

- *Assessment of how the person's quality of life may be affected*
- *Explaining what cataract surgery involves*
- *Dilation if clinically indicated*
- *Discussion of possible risks and benefits.*

N.B. Cataract with suspicion of glaucoma is a glaucoma referral, not cataract referral.

10. Routine Glaucoma

Patients to refer? examples include:

- Chronic open angle glaucoma suspect
- Ocular hypertension (OHT) suspect
- Primary angle closure suspect (PACS)

Consider The College of Optometrist's guidance for professional practice.

A269 'It is good practice to follow up equivocal results from non-contact tonometry with contact applanation tonometry. If you are using non-contact tonometry, before considering referral you should take four readings per eye and use the mean as the result. In the absence of other signs of glaucoma, you should refer the patient for further assessment only when the mean is 24mmHg or above. You should advise people with IOP below 24mmHg to continue with their routine eye examinations'.

Consider NICE [NG81] guideline to inform referral decisions and content:
1.1.Case finding **Link: Overview | Glaucoma: diagnosis and management | Guidance | NICE**

Do not refer on a single borderline suspect reading.

Extended/ Enhanced Primary Eye Care Services
Services for glaucoma repeat measures (IOP and visual fields) and enhanced case finding using contact applannation tonometry require ICB commissioning. If you are working in a practice which performs glaucoma repeat measures and as a locum or non-accredited optometrist are unable to comply, consider referral to an accredited optometrist within the practice to have this measured, with clear instructions to manage either outcome.

Primary Angle Closure Suspect (PACS)

Consider PACS PLUS / MINUS guidance: **Link: The-Management-of-Angle-Closure-Glaucoma-Clinical-Guidelines-Executive-Summary.pdf**

Only **PACS PLUS** should trigger a referral for suspected occludable angles to the HES:

- Angle characteristics: **either** – a Van Herick grade <¼ **or** – an anterior segment OCT showing irido-trabecular contact.

PLUS - with one of the following criteria:

- People with only one "good eye" in which deterioration of vision may threaten independent living or livelihood,
- Vulnerable adults who may not report ocular or vision symptoms,
- Family history of significant angle closure disease,
- High hypermetropia (>+6.00D),
- Diabetes or another condition necessitating regular pupil dilation,
- Those using antidepressants or medication with an anticholinergic action,
- People either living in remote locations (such as foreign aid workers, armed forces stationed overseas or oil rig workers etc.) where rapid access to emergency ophthalmic care is not possible.

PACS MINUS - If an individual has the angle-characteristics specified above but none of the "PLUS" criteria, and does not meet NICE glaucoma referral guidelines, they should be advised to seek an annual NHS sight test.

11. Medical Retina - diabetic retinopathy

- Check that patients with diabetes are seen by the local NHS Diabetic Eye Screening Programme (DESP) and record the date of their last screening.
- Note DESP grading definitions for referrable disease **Link: NHS Diabetic Eye Screening Programme: grading definitions for referable disease - End date September 30 - GOV.UK (www.gov.uk)**
- There is no need to refer to ophthalmology for R1M0 background diabetic retinopathy (DR) if the patient is already under screening by the DESP.
- Refer to GP if new R1M0 background DR found and request referral to DESP only, not to hospital ophthalmology.
- If informing the GP when changes in background DR changes are noted and under DESP, please state in bold that the patient **does not require referral to ophthalmology**.
- For patients under the DESP, sight test recall should be the same as for patients who do not have diabetes e.g., 2 years. (College of Optometrists guidance).
- DESP referral urgency is provided here for information

  - R2 Pre-proliferative DR: venous beading, reduplication, multiple blot haemorrhages, IRMA - routine referral and seen with 13 weeks .
  - R3A Proliferative DR: active neovascularisation (including active new vessels), pre-retinal or vitreous haemorrhage - urgent referral and seen within 6 weeks.
  - R3S Proliferative DR - stable neovascularisation and evidence of peripheral retinal laser treatment. A referral should be made as R3A in any case where there is doubt.
  - M1 Maculopathy: exudate within macula - routine referral and seen within 13 weeks.

12. Medical Retina - pigmented fundus lesions

Pigmented lesions are a common finding - reported prevalence between 2% and 7%.
Links: Oxford Eye Hospital guidelines for management of patients with melanocytic choroidal tumours and Pigmented fundus lesions - College of Optometrists

Consider 'Signs of pigmented fundus lesions' and use 'Management Category' or 'MOLES scoring system' (absent = 0, unsure or suspect = 1, definite or significant = 2, score >2 = probable melanoma).

- Mushroom shape
- Orange pigment
- Large size
- Enlargement
- Subretinal fluid

Consider 'Management by Optometrist' section and refer appropriately on a 2-week pathway when the need is evidenced using Management Category or MOLES scoring.
If appropriate referral software is available, please consider including an image with the referral.

13. Neuro-ophthalmology

This section is taken from the new London lean neuro-ophthalmology pathway, and the signs and symptoms are provided here for information to help inform referral urgency. As yet, a dedicated single point of access for neuro-ophthalmology referrals has not been put in place in London.

Essential information/ test results - past ocular and general health including any heart attack or stroke in last 3 months, signs (pupils, ptosis, ocular muscles) and symptoms (date of onset, visual disturbances? persistent or episodic?), VAs, visual fields, IOPs, Ishihara, optic nerve examination.

Desirable results for disc swelling - optic nerve photos and OCT scans, and copies of visual field plots if available.

P1 Emergency	**< 24 hours and requires clinical discussion**
P2a	**within one week (see specific guidance)**
P2b	**within 1-3 months (see specific guidance)**
P3	**next available**

Red Flag P1 Disc swelling – refer direct to eye emergency/ casualty <24 hours as requires clinical discussion – telephone or email first.

- Obvious optic disc swelling in both eyes.
- "Blurred" or "indistinct" optic disc margins with no frank disc swelling test and SUDDEN ONSET RECENT headache / pulsatile tinnitus / transient visual obscurations.
- Presence of disc swelling in association with sudden or recent onset of reduced visual acuity in one or both eyes with reduced/ absent colour vision and no visible macular lesion +/- pain on eye movement/headache. Plus pupil RAPD if unilateral.
- Refer urgently to eye casualty for assessment within 24 hours.

P2a Suspect disc swelling – if not sure, discuss with eye emergency / casualty - telephone or email first.

- Blurred" or "indistinct" optic disc margins with no frank disc swelling noted during sight test + symptoms for >MONTH of headache / pulsatile tinnitus / transient visual obscuration OR unexplained signs of visual field defect / reduced visual acuity / reduced colour vision.
- Refer for diagnostic testing or consultant triage **within one week.**

P2b Suspect disc swelling – refer as urgent for diagnostic tests or triage.

- Blurred" or "indistinct" or "mildly swollen" or swollen" optic disc margins noted incidentally during routine sight test with NO symptoms and NORMAL visual function (visual acuity and field of vision).
- Refer for urgent diagnostic testing to refine referral, or 'urgent triage' to be seen in clinic **within 1-3 months**.

Red Flag **P1 Double vision - refer direct to eye emergency <24 hours and requires clinical discussion – telephone or email first.**

- Sudden or recent onset of double vision, especially if also mid-dilated pupil and partial or full ptosis (i.e. possible third cranial nerve palsy), or if following head trauma (possible fourth cranial nerve palsy).
- Refer urgently to eye casualty for assessment **within 24 hours** to exclude/ manage cranial nerve palsy or myasthenia.

Double vision - refer urgently for triage.

- Gradual onset of persisting/ constant double vision with >3 months history.
- Refer for triage by neuro ophthalmologist within **1 month.**

Red flag **P1 Horner's - refer direct to eye emergency/ casualty <24 hours and requires clinical discussion – telephone or email first.**

- Smaller pupil with 1-2mm ptosis on same side noticed recently/ suddenly OR with neck pain.
- Refer urgently to eye casualty for assessment within 24 hours to exclude Horner's syndrome associated with carotid dissection.

P2b Horner's - refer urgently for triage, if not sure, discuss with eye emergency / casualty - telephone or email first.

- Smaller pupil + 1-2mm ptosis on same side noticed incidentally / longstanding with NO new neck pain or headache and NO sudden onset.
- Refer for triage by neuro ophthalmologist within **1 month.**

P3 Optic disc drusen – refer routinely, next available.

- Optic disc drusen seen and/or previously diagnosed with normal visual function (acuity, colour) and no significant visual field defect threatening driving-level vision, or no significant change in visual function as compared to a previous assessment.
- Refer routinely.

14. Children

Refraction in very young children may only be possible by objective means. For GOS, cycloplegic refraction is considered 'clinically necessary' to obtain an accurate result if subjective is not possible or variable. Consider prescribing for refractive amblyopia following cycloplegic refraction and reviewing visual acuity.

Consider College guidance for professional guidance sections on examining younger children, assessing and managing children with myopia, learning disabilities and autism. **Relevant sections Link: Knowledge, skills and performance - College of Optometrists (college-optometrists.org)**

15. Cornea

Keratoconus: Consider referral for suspected keratoconus (reduced VA with distortion on retinoscopy or keratometry mire images) for consideration of cross-linking. Corneal topography if available including thickness would be helpful.

16. External eye

Chalazion: Surgery to drain cyst may help but will only be considered if the chalazion has been present for at least 6 months, or it is having a serious impact on vision and after less invasive measures have been tried first. **Link: Surgery-to-remove-chalazia_19.pdf (aomrc.org.uk)**

17. Uveitis

Anterior Uveitis: **Link: College clinical management guidelines Uveitis (anterior) - College of Optometrists (college-optometrists.org)**

Symptoms: Onset usually sudden at first episode, gradual at subsequent episodes.
Usually unilateral (if bilateral, more likely to be associated with systemic disease and more likely to become chronic).

- pain (dull/ache)
- exacerbated on induced pupillary constriction (direct, near or consensual)
- photophobia
- redness
- decreased vision
- lacrimation

N.B. If condition is recurrent, eye may be asymptomatic and white despite presence of inflammation.

Signs:

- hyperaemia: that may be circumcorneal (‘ciliary injection’)
- keratic precipitates (KP) distribution – fine, stellate or ‘mutton fat’
- aqueous cells **(Consider grading system Link: Grading of ocular inflammation in uveitis: an overview | Eye News Table 4)**
- aqueous flare
- hypopyon/fibrin (severe cases)
- intraocular pressure commonly normal but raised in some cases
- posterior synechiae possibly causing pupil block and iris bombé
- iris nodules: koeppe (small, near pupil), bussaca (large, far from pupil)

Anterior vitreous cells may be seen in iridocyclitis but often will indicate intermediate ± posterior uveitis. Other signs include constricted or non-reactive pupil, iris atrophy, heterochromia, cataract, chronic corneal oedema including bullous keratopathy. N.B. If condition is recurrent, signs may be less apparent and will vary according to severity and the specific underlying disease.

Refer urgently to eye casualty/ rapid access clinic within 3 days for pharmacological treatment unless IP qualified.

18. Eye Care Support Pathway

The Eye Care Support Pathway aims to highlight people's needs at four key stages in their eye care journey:

- Having an initial appointment
- Having a diagnosis confirmed
- Support after a diagnosis
- Living well with my condition

For full information **Link: APDF-IN230702_Eye_Care_Support_Pathway_Report.pdf (rnib.org.uk)**

Most applicable to optometrists is the section on **'Understanding the information, advice and support people require' pages 18-23** This is about helping your patients understand about:

Having an initial appointment

- Understand who they are seeing.
- Know what tests will be undertaken and the initial results of those tests prior to the consultation, if appropriate.
- Know what will happen next and when.
- Understand why it is important to attend sight tests.
- Know how to access the most appropriate service if their eye condition changes.

Their eye condition

- Have access to specific eye health literature, from a trusted source.
- Receive information in a format that meets their communication needs.
- Be able to ask questions, in a safe and supported environment.

Emotional and practical support

- Know where to get support to manage any anxiety about what they have been told and what is planned next.
- Know where to get information, advice, and support to help with day-to-day activities such as employment, driving, benefits, care.
- Know how to speak to someone when they want to.
- Know how to access psychological support, if required.

19. Low Vision and Eye Clinic Liaison Officer (ECLO)

Optometrists considering making a referral to a low vision clinic can try high adds in appropriate circumstances.

Any patient referred direct to a low vision clinic/ ECLO should have:

- acuity of 6/12 or worse in BOTH eyes and/ or significant visual field loss, and
- a recent ophthalmological review confirming diagnosis and excluding treatable causes of visual loss.

People undergoing treatment should be seen concurrently in a low vision clinic especially if the acuity is likely to deteriorate. Sometimes this is overlooked and can be a reason for optometric referral to the appropriate hospital or community low vision service.

ECLOs, although not clinically qualified, provide advice and support to patients. They can alert medical staff to social issues, signposting agencies to help newly visually impaired people and provide some degree of support. They liaise directly with the borough social services, charities and rehabilitation officers. They also provide practical advice and emotional support in coming to terms with sight loss and maintaining independence. This can include applying for benefits and getting practical aids for the home.

20. Vision and Falls

Falls are the most common cause of hospital admission for people aged over 65. One in three people aged over 65 will fall each year, and one in two people over the age of 80 will fall each year. NICE Clinical Guideline 161 (updated 2017); “Falls in older people: assessing risk and prevention” recommends a multifactorial risk factor assessment, including a recommendation to check for visual impairment. **Link: VISIBLE - Health Innovation Network**

Consider visual fields and suitability of optical devices.

Access to community falls services varies across London. Please refer patients identified at risk of further falls through their GP.

21. ICB Referral Directory

ICBs now hold GOS Mandatory Services (NHS sight tests) and GOS Additional Services (domiciliary NHS sight tests) contracts for optometry and optician practices within their area, although GOS remains a national contract with terms, fees and grants negotiated nationally. The NHS Business Services Agency supports ICBs with contract management applications, terminations and variations for contractors based in England to help standardise the processes involved in applying for a GOS contract. **Link: GOS Contract Management | NHSBSA** .

ICBs commission and hold the contract(s) for extended/ enhanced primary eye care services. These are usually delegated to a prime provider to manage via a subcontractor model. These services are subject to separate protocols and referral guidance.

ICBs working with their Trusts, LOCs and primary eye care providers should agree their local referral pathways and share (in the form of an accessible online referral directory including site details, access, opening hours, contact telephone numbers and secure email addresses) with all ICB optometrists/ optician practices, and ensure this information is shared with bordering ICBs for cascading to their practices. This information needs to be kept up dated to ensure failsafe.