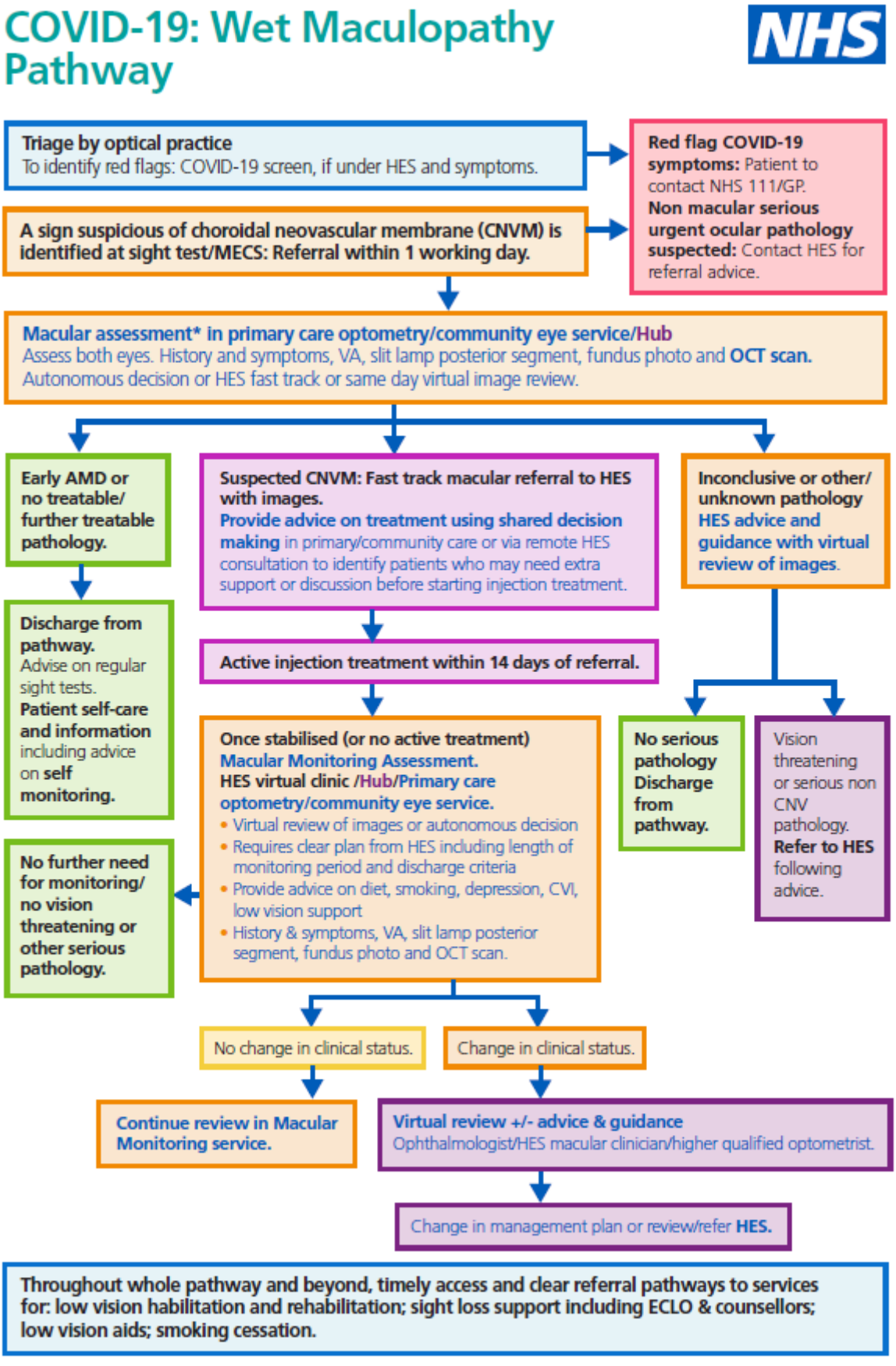
COVID-19 Wet Maculopathy Pathway
Sample Protocol



Blue font indicates elements not covered by GOS. *Macular assessment could be done under CUES. Macular assessment must be done in timescale to allow HES to deliver treatment within 14 days if required.

New Patients Protocol

This service allows suitably qualified and experienced primary care optometrists to assess patients with suspected acute choroidal neovascular membrane (CNVM) macular conditions, particularly age-related macular degeneration (AMD), in their practice.

Patients may self-present or be referred from another health care professional. The patient may have suspicious symptoms or signs of active CNVM. This includes new patients and known AMD patients with new acute symptoms who will be assessed:

- to identify those with acute CNVM who need urgent referral
- to arrange non-urgent referral for those with non-neovascular maculopathy or other non-urgent sight-threatening or treatable conditions
- to discharge patients with no sight-threatening or treatable pathology, avoiding unnecessary referrals.

Decisions can be:

- autonomous by experienced optometrists with support available through virtual assessments and advice and guidance (A&G) from the hospital eye service (HES)
- made by the HES based on clinical data and images obtained by the optometrist in a virtual clinic model.

Assessments and practice will be in compliance with NICE guideline NG82 with further detail supplied by advice / management plan from the HES face to face (F2F) or virtual assessment.

Patients for new or ongoing care require information provision in line with NICE and other national guidance (appendix).

Macular Assessment in Primary care optometry/ Community eye service/ Hub

History and symptoms

Visual symptoms

- General blur/reduced vision
- Loss of central part of field of vision
- Distortion of straight lines
- Difficulty with specific tasks especially reading or recognising faces

Previous ophthalmic history

Medical history

- Record all medical conditions, ask patient to bring print out from GP

Medication

- Record all systemic and ocular medication – ask patient to bring prescription or print out from GP

Allergies

Family history (macular conditions or other major eye conditions)

Social history

- Occupation especially driver, HGV driver or drives for work
- Lives alone, dependents or carer status.

Visual acuity (VA)

- VA, pinhole if necessary
- VA best corrected distance.

Ophthalmic assessment

Slit lamp dilated fundus examination

- Macula – signs of pathology eg AMD, diabetic retinopathy, epiretinal membrane
- Fundus – any abnormalities.

Dilated macular imaging including photography and OCT

OCT requirements

OCT is adequate if:

- artefacts are not present and signal strength appears optimal for interpretation of the image set
- artefacts are present or signal strength is reduced, but there is still enough intensity to distinguish major features across the entire scan
- the grader is confident the quality of the OCT scan is sufficient.

OCT is inadequate if:

- severe artefacts are present (for example, significant deviations in retinal contour) or the signal strength is so reduced across the scan that you cannot identify major features
- the OCT quality fails to meet definition of adequate above.

If required

Slit lamp examination of anterior segment

Intraocular pressure

Outcomes:

1. No significant or sight-threatening abnormalities or treatable disease detected: **Discharge**.
2. People with AMD but no signs of wet active: **Discharge and Self-monitoring advice.** Consider referral to low vision and Eye Clinic Liaison Officer (ECLO) services for patients with visual impairment. Eligible patients should be offered referral for certification.
3. If active wet maculopathy is confirmed or suspected:
    a. The autonomous optometrists make the decision, with virtual assessment of images and data or Advice and Guidance as required from the HES**: Urgent Direct Referral to the HES –** a fast-track referral is made directly to the hospital macular clinic. The referral should normally be made within 1 working day but does not need emergency referral; the referral must be timed to ensure the HES can deliver treatment within 14 days if required.
    b. **Non-autonomous optometrists or there is diagnostic uncertainty or virtual assessment pathway –** If there is any uncertainty on the clinical findings or the optometrist is not accredited for autonomous decision-making, the HES will undertake a fast-track virtual assessment of the images and data collected to inform on need for arranging an urgent macular or injection appointment, other referral, discharge or advice to patient.
4. **Referral –** If another pathology requiring referral has been identified, local referral protocols should be followed and appropriate advice given to the patient. Decisions supported, where required, by A&G or virtual assessment of clinical data and images by the HES.

NICE guidance states that suspected wet active AMD should normally be referred within 1 working day and treatment started within 14 days of referral. In this pathway, the community macular assessment should usually be within 1 further working day of receiving the original referral. There can however be different locally applied targets if agreed with the lead for the macular service. This is most likely to occur when the images are available to the HES and shared decision-making takes place in advance of the HES appointment so as to facilitate treatment at the first visit and within the 14 day target.

Support and discussion:
Whatever the clinical outcome of the macular assessment, a discussion regarding AMD will be needed. The discussion should be tailored to the person's individual needs and current level of knowledge, allowing for enough time to discuss the person's concerns and questions.

Information should also be provided in an accessible format (e.g. written in large print and easy to understand) for the patient to take away. If the patient is being referred, this information should include:

- information about AMD and treatment pathways, including likely timescales
- information as required on COVID-19 infection control processes and any requirements for action by the patient or effect on timescales of non-urgent assessments
- key contact details – for example, who to contact if appointments need to be altered
- advice about what to do and where to go if vision deteriorates.
- patients should be provided with advice in primary/community care or via remote HES consultation as per local protocol on: AMD, treatment using shared decision-making, diet and nutritional supplements, smoking, depression, certificate of visual impairment (CVI), Amsler grid advice, Macular Society booklets / contacts webpage, DVLA visual standards for driving, ECLO/ local support services.

Self-monitoring advice:
Advise all people with AMD to self-monitor their condition. Monitoring strategies can be discussed and agreed depending on the person's preference. They should be encouraged to attend routine sight-tests with their usual optometrist.

Information about the AMD referral filtering service should be made available, so the person understands how to self-refer into the service if their vision changes.

They should be advised to self-refer as soon as possible, if they notice:

- blurred or grey patch in their vision
- straight lines appearing distorted
- objects appearing smaller than normal.

Ongoing Care Protocol

This service allows suitably qualified and experienced primary care optometrists to assess, monitor and treat patients in their practice with late active or inactive AMD. Patients considered suitable for community monitoring by their referring ophthalmologist will be provided with an individual management plan, to include a date for the monitoring assessment and the length of the monitoring period, discharge criteria and criteria for re-referral.

Patients considered suitable for self-monitoring by NICE may also be referred for community monitoring if the referring ophthalmologist considers self-monitoring unreliable for the individual.

Decisions can be made:

- autonomously by optometrists, with support available for decisions and management where required through virtual assessments of clinical data and images, and advice and guidance from the HES
- by the HES based on clinical data and images obtained by the optometrist in a virtual clinic model.

Patients may also be seen in diagnostic hubs and virtual HES clinics.

Macular Monitoring Assessment in HES virtual clinic/ Hub/ Primary care optometry/ Community eye service

Dilated macular imaging including photography and OCT

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Slit Lamp examination of anterior segment

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INFORMATION to provide for virtual assessment or onwards referral:

- Visual symptoms
- Any relevant positive findings in previous ocular history, medical history, family history social history
- Current medication list
- Medication allergies
- Current corrected VA
- Current spectacle prescription
- Macular assessment findings
- Macular imaging OCT +/- photography
- Other relevant ocular / slit lamp findings

The appointment offers an opportunity to address the patient's condition with them and answer any questions appropriately.

Where the practitioner is an autonomous decision-maker, they will undertake the decision on outcome, seeking advice or virtual assessment from HES where required.

Where the practitioner is a data gatherer, they will not discuss the outcome from the assessment with the patient but will advise on next steps and offer general support and advice relating to AMD. To support professional development, the practitioner may provide a tentative outcome for the ophthalmologist to ratify.

Outcomes:

- **No further need for monitoring/ no vision-threatening or serious pathology.** Discharge
- **No change in clinical status - OCT stable & VA as expected**. Recall under current management plan and reiterate advice on self-care and low vision support available locally.

- **Possible change in clinical status - OCT inconclusive, or OCT stable but with reduced VA and/or patient reported decline in visual function.** Refer for consultant or specialist opinion by virtual review as required
- **Confirmed change in clinical status – Confirmed signs of wet maculopathy on OCT requiring an urgent direct referral** - a fast-track referral directly to the hospital macular clinic is indicated if active wet maculopathy is confirmed. The referral should normally be made within 1 working day but does not need emergency referral.

Advise on the need for a sight-test if the patient is complaining of reduced vision but there is no change in their maculopathy clinical status.

For virtual assessments, the assessment information will be reviewed virtually by an ophthalmologist (or their delegated specialist reviewer) and the results communicated to the patient and copied to the community macular service, their GP and the original optometrist referrer.

Patients considered suitable for continued community monitoring will be advised on their next appointment due date and asked to book within the community macular monitoring service.

The optical practice will book the appointment within 25% of the recommended follow up interval in line with national guidance on ophthalmic follow-ups. For example, a recommended follow up interval of 4 months could be booked between 3 and 5 months.

Any patients who fail to attend their monitoring assessment will be referred back to the referring ophthalmologist.

Record keeping

Complete and accurate records need to be held for each patient in either paper or electronic format and stored securely. Information within records should be processed in compliance with the Data Protection Act 2018.

Records need to clearly state where a remote consultation (telephone or video consultation) has occurred and any significant limitations which arose due to use of this modality. Records should also include details of advice and guidance sought and given and the outcome and advice given following virtual review. Where patients are moved from the HES into a primary or community monitoring pathway, the community or primary care health care professionals must be provided with access to full records or sufficient clinical information and images to allow comparison to detect change for autonomous decision makers and, where required by the pathway, with a clear management plan with criteria for action, seeking HES support or review, and discharge criteria or timing.

Appendix sources and standards for patient information and support

RCOphth RNIB Understanding Diabetes Booklet 2017
https://www.moorfields.nhs.uk/sites/default/files/DVLA%20licence%20FAQ%E2%80%99s-vision%20and%20driving.pdf
https://www.macularsociety.org/sites/default/files/downloads/Accessible%20MS020%20Nutrition.pdf
https://www.rnib.org.uk/sites/default/files/Sight_loss_what_we_needed_to_know.pdf
https://www.nhs.uk/conditions/vision-loss/
https://www.rnib.org.uk/recently-diagnosed/coming-terms-sight-loss
Someone to talk to (PDF)
Starting Out - Emotional Support (PDF)
RCOphth RNIB Understanding Charles Bonnet Syndrome 2017
https://www.nice.org.uk/guidance/ng28/ifp/chapter/Diet-and-lifestyle
https://www.nice.org.uk/guidance/ng28/ifp/chapter/Sources-of-advice-and-support
https://www.macularsociety.org/sites/default/files/downloads/Macular%20Society%20Protecting%20your%20eyes%20accessible%20pdf%20JUN%2017.pdf
https://www.macularsociety.org/sites/default/files/downloads/Macular%20Society%20Smoking%20and%20sight%20loss%20accessible%20pdf%20JUN17.pdf
UKOA Patient Standards

Smoking cessation advice

Smoking is the main cause of illness and early death in the UK. People who smoke are at higher risk of serious conditions like heart and lung disease, stroke and cancer. If people quit early enough they can prevent smoking-related health problems or at least stop them getting worse. So it's important that health and social care workers in community and primary settings can identify people who need information and support to help them quit.

We want this guideline to help everyone who smokes, but especially those people who smoke heavily or who find it most difficult to stop, by making sure:

- people are asked about their smoking and encouraged to stop every time they see a health or social care worker
- extra help to quit is targeted at people with the highest risk of harm from smoking, such as people in hospital or with serious health conditions like heart or lung disease, pregnant women, mothers with young children and their families, and people in prisons
- people are given help to decide which stop smoking aids would suit them best and can be offered the option they prefer
- people using, or interested in using, a nicotine-containing e-cigarette to quit smoking are advised about these products
- services with trained staff are available to help people quit, including stop smoking services and telephone quitlines, and these are promoted widely to people who need them.

Whenever they talk to you about stopping smoking, health and social care professionals should give you clear information, talk with you about the different options and listen carefully to your views and concerns. They should also:

- talk to you about your smoking in a way that is sensitive to your needs and circumstances
- ask you about any other smoking aids you have tried before
- encourage you to quit in the future if you are not ready to stop yet, and give you advice about ways to reduce harm from smoking.

If you can't understand the information you are given, tell your health and social care professional.

Read more about making decisions about your care.

https://www.nhs.uk/live-well/quit-smoking/10-self-help-tips-to-stop-smoking/?tabname=advice-and-support