Association of Optometrists

Hospital & Specialty Optometrists Conference

at

Novotel London West
Hammersmith
LONDON

8th & 9th November 2025

Link to Contents

THE
HOSPITAL AND SPECIALTY OPTOMETRISTS CONFERENCE
IS ORGANISED BY

THE ASSOCIATION OF OPTOMETRISTS ALONGSIDE
THE HOSPITAL OPTOMETRISTS COMMITTEE
Association of Optometrists
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Conference Handbook
Edited by
Andrew Tompkin

The Chairman of the Hospital Optometrists Committee

On behalf of the Hospital Optometrists Committee, I am pleased to welcome you to the 2025 Hospital and Specialty Optometrists Conference. We return to London for our 51st Annual Conference - the main opportunity each year for the gathering of Hospital and Specialty Optometrists.

Many of us eagerly anticipate conference to keep abreast with advances in our profession through a full schedule of events. Most delegates, above all, look forward to meeting up with fellow professionals, reconnecting with old acquaintances but equally importantly making new connections.

The event has been a continuing success. This year looks to be no exception with a full and varied programme attended by a healthy number of delegates. The Committee, along with the AOP Education and Events Teams, have endeavored to provide something of interest for everyone.

Keynote lectures are a particular highlight. This year we warmly welcome four high caliber speakers: Prof. Augusto Blanco, John Buchan, and Prof Rachel Pilling will share expertise in their own fields. We are particularly pleased that our very own Andrew Tompkin will be delivering the Woodward Memorial Medal Lecture. Over many years, Andrew has made an immeasurable contribution to our profession, and worked tirelessly to ensure the high standard & continuing development of conference. It is very fitting that he will be delivering this memorial lecture to share some his extensive knowledge.

Alongside these and other didactic talks, there will opportunities to attend workshops, peer review sessions, and poster presentations, as well as the Trade exhibition. For those with a specific interest, the four streams: Anterior Eye, Contact Lenses, Glaucoma and Medical Retina, provide a targeted experience, which many will have decided to pick and choose between the streams. Either way, it is the committee's sincere wish that everyone has the experience that you hope for. We always welcome feedback, which will be requested formally after conference. Since the latest committee elections, we are now proud to have members from all four nations of the United Kingdom. You may wish to get to know a representative from your nation during conference!

Special mention must go to Vijay Anand who, as previous HOC Chair, oversaw the majority of the preparation for this event. Vijay has been a ubiquitous and reassuring presence at conference for several years, and I am pleased that this will extend into this event, particularly for those who attend his lecture. I am also very grateful to all members of the committee, committee secretary and the AOP for their essential contributions and ensuring a supportive and collaborative atmosphere within the Committee.

Finally, I would like to extend the committee's gratitude to all the speakers, poster presenters and judges, other contributors and delegates for committing their time and effort to making these such great experiences. Thanks, must also go to our sponsors and exhibitors. I know I am not alone in finding that engaging with the exhibitors often provides some of the most invaluable benefit of the weekend. I therefore strongly encourage you to visit as many exhibits as you can.

I look forward to speaking to many of you over the weekend and wish you all a beneficial and, above all enjoyable conference.

SAM COMELY
HOC Chair

51 YEARS OF HOSPITAL OPTOMETRISTS ANNUAL CONFERENCE

1	2nd October 1975	Oxford	Oxford
2	19th September 1976	London	Moorfields Eye Hospital
3	23rd October 1977	London	Moorfields Eye Hospital
4	8th October 1978	London	Moorfields Eye Hospital
5	21st October 1979	Coventry	Coventry & Warwick Hospital
6	19th October 1980	Birmingham	Birmingham & Midland Eye Hospital
7	8th October 1981	London	London Refraction Hospital
8	10th October 1982	London	London Refraction Hospital
9	9th October 1983	London	London Refraction Hospital
10	14th October 1984	London	London Refraction Hospital
11	20th October 1985	London	Strand Palace Hotel
12	19th October 1986	Bristol	Unicorn Hotel
13	18th October 1987	London	Moorfields Eye Hospital
14	23rd October 1988	London	Guys Hospital
15	22nd October 1989	Glasgow	Glasgow Eye Infirmary
16	28th October 1990	London	Royal Overseas League
17	21st/22nd September 1991	Nottingham	University Hospital QMC
18	25th October 1992	London	Royal Overseas League
19	2nd/3rd October 1993	Birmingham	Arcadian / Ibis Hotel
20	1st/2nd October 1994	London	Moorfields Eye Hospital
21	30th Sept./1st Oct. 1995	Manchester	Weston Centre UMIST
22	14th/15th September 1996	London	The City University
23	12th-14th September 1997	Glasgow	Royal Scottish Academy Music & Drama
24	4th- 6th September 1998	Bradford	Bradford University
25	3rd - 5th September 1999	Oxford	Eynsham Hall

51 YEARS OF HOSPITAL OPTOMETRISTS ANNUAL CONFERENCE

26	3rd - 5th November 2000	Warrington	De Vere Daresbury Park
27	21st - 23rd September 2001	Derbyshire	Marriott Renaissance
28	4th - 6th October 2002	Newcastle	Marriott Gosforth Park
29	26th- 28th September 2003	Bristol	Four Pillars Tortworth Court Hotel
30	19th - 21st November 2004	Chester	Chester Moat House Hotel
31	28th - 30th October 2005	Kenilworth	Chesford Grange Hotel
32	10th - 12th November 2006	Chester	Crowne Plaza Hotel
33	26th - 28th October 2007	Kenilworth	Chesford Grange Hotel
34	21st - 23rd November 2008	Kenilworth	Chesford Grange Hotel
35	27th - 29th November 2009	Harrogate	Barcelo Majestic Hotel
36	5th - 7th November 2010	Heathrow	Park Inn
37	4th - 6th November 2011	Kenilworth	Chesford Grange Hotel
38	21st -23rd September 2012	Chester	Crowne Plaza Hotel
39	22nd - 24th November 2013	Stratford-upon-Avon	Holiday Inn
40	19th - 21st September 2014	Stratford-upon-Avon	Holiday Inn
41	3rd - 4th October 2015	Glasgow	Hilton Grosvenor Hotel
42	7th - 9th October 2016	Stratford-upon-Avon	Crowne Plaza Hotel
43	6th - 7th October 2017	Leeds	The Queens Hotel
44	19th - 21st October 2018	Stratford-upon-Avon	Crowne Plaza Hotel
45	8th - 10th November 2019	Belfast	Crowne Plaza Hotel
46	3rd – 24th November 2020	COVID Pandemic	A Series of Virtual Events
47	25th September 2021	COVID Pandemic	A Day of Virtual Events
48	5th November 2022	COVID Recovery	A Day of Virtual Events
49	4th – 5th November 2023	Coventry	Warwick University
50	21st – 22nd September 2024	Manchester	Emirates Old Trafford
51	8th – 9th November 2025	London	Novotel London West

THIS CONFERENCE IS SUPPORTED BY THE FOLLOWING WHO'S ASSISTANCE WE GRATEFULLY ACKNOWLEDGE.

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PLEASE BE SURE TO VISIT THE EXHIBITION

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Saturday Morning

08:30 Delegate Registration

SESSION ONE **Session Chair: LUCY ANDREWS**

09:00 **Short Paper Presentations**

1. "Mental Health and Wellbeing in Inherited Disease."
   Michael Crossland, Moorfields Eye Hospital, City Road, London, EC1 V2PD, UK
2. "Development of a Patient Centered Toolkit to Support Glaucoma Medication Adherence."
   Peter Campbell, Guys and St Thomas' NHS Foundation Trust, London, SE1 7EH
3. "Comparing the Diagnostic Value of Visual Field Test Locations for Detecting Early Glaucomatous Field Loss in Myopic and Non-myopic Eyes.
   Pádraig Mulholland, Moorfields Eye Hospital, City Road, London, EC1V 2PD, UK
4. "The VISION Project: Validation of Scheimpflug Tomography Designed Lenses."
   Dan Ehrlich, Moorfields Eye Hospital, City Road, London, EC1V 2PD, UK

Q&A Panel Discussion

SESSION TWO **Session Chair: DIEDRE BURNS**

10:05 Conference Opening Address - *HOC Chair Sam Comely*

10:10 "Glaucoma Treatment Beyond IOP: Alternative Therapies and Neuroprotection."
Prof. Augusto Azuaro Blanco, Queen's University Belfast, Northern Ireland, UK
Consultant Ophthalmologist, Belfast Health & Social Care Trust, Belfast, NI, UK

11:10 Refreshments

SESSION THREE **Session Chair: TIM HUNTER**

11:45 "Delivering Eye Health for Everyone, Everywhere, Forever.
John Buchan, International Centre for Eye Health, LSHTM, London, UK
Consultant Ophthalmologist, Leeds Teaching Hospitals NHS Trust, Leeds, UK

12:45 Lunch

PLEASE REMEMBER TO VISIT THE EXHIBITION & POSTER AREAS

SESSION FOUR (Lunch Session)

13:10 - 13.40 "Adventures in Eye Shapes: From the Cornea to the Sclera, Why Shape and Elevation Matter When Fitting Scleral Lenses."
Cindy Tromans, Consultant Optometrist,
Manchester Royal Eye Hospital, Manchester, UK

Saturday Afternoon (Parallel Sessions)

Anterior Eye Stream	Contact Lens Stream	Glaucoma Stream	Medical Retina Stream
Théa let's open our eyes	BAUSCH+LOMB	Newmedica Eye Health Clinics | Surgical Centres	Association of Optometrists

SESSION FIVE 13:50 – 14:50

Session 5A Peer Review for Specialty Optometrists	Session 5B Peer Review	Session 5C Peer Review for General Optometrists	Session 5D Lecture with Discussion Workshop
Room: Mancy	**Room: Bourgogne**	**Room: Avize**	**Room: Bourg**
Anterior Eye	**Contact Lenses – Basic Principles for Complex Cornea**	**Glaucoma or not Glaucoma? That is the Question**	**The Regulation of Time – Implications for Patients with Sight Impairment**
Diedre Burns & Jenny Lindsey	Elizabeth Dinsdale & Katie Etherton	Lucy Andrews	Ian Beasley

SESSION SIX 14:55 – 15:55

Session 6A Discussion Workshop	Session 6B Lecture with Discussion Workshop	Session 6C Discussion Workshop
Room: Mancy	**Room: Bourgogne**	**Room: Avize**
Tough Tears – Managing Ocular Surface Challenges	**NHS – Navigating Harmonising Sclerals in the NHS System**	**From Minimum Invasiveness to Maximum Impact – MIGS and MIBS in Glaucoma Care**
Navneet Gupta	Aneel Suri & Cindy Tromans	Richard Stead
Thea	Bausch + Lomb	Newmedica

Refreshment Break

SESSION SEVEN 16:30 – 17:30

Session 7A Peer Review for General Optometrists	Session 7B Peer Review	Session 7C Peer Review for Specialty Optometrists	Session 7D Peer Review for General Optometrists
Room: Mancy	**Room: Bourgogne**	**Room: Avize**	**Room: Bourg**
Anterior Eye	**Contact Lenses (Advanced Level)**	**Glaucoma**	**Medical Retina**
Alison Weston	Shreeti Lakhani & Emma Irwin	Angela Whitaker	Janice Oster & Anitta Sharma

Saturday Evening (For Ticket Holders)

Evening Sponsor

CANTOR BARNARD

19:15 Drinks Reception

20:00 Conference Dinner and Entertainment

Charity Collection with proceeds to: Keratoconus Group

Midnight Close

Sunday Morning

08:30 Morning refreshments

SESSION EIGHT **Session Chair: ELIZABETH HUNT**

09:00 **Short Paper Presentations**

5. "Enhanced Macular Referral Pathway at Bristol Eye Hospital."
   Ben Phipps, Bristol Eye Hospital, Lower Maudlin Street, Bristol, BS1 2LX
6. "Safety and Efficacy of Large Volume Medical Retina Digital Clinics."
   Alice Sidorowicz, Moorfields Eye Hospital, 162 City Road, London, EC1V 2PD, UK
7. "Management of Paediatric Refractive Error in the Community:
   Early Insights from Hospital Referrals of Children Aged 2-10 Years."
   Megan Casey, Moorfields Eye Hospital, 162 City Road, London, EC1V 2PD, UK
8. "The Evolution of Moorfields Eye Hospital Glaucoma Service Clinic Criteria & Optometrist Delivered Care.
   Emma Laber, Moorfields Eye Hospital, 162 City Road, London, EC1V 2PD, UK

Q&A Panel Discussion

SESSION NINE **Session Chair: MARTIN RUBINSTEIN**

10:05 **Woodward Memorial Medal Lecture**
"Professionalism - Leadership and Accountability.
Why it matters and how it all fits together."
Andrew Tompkin, Consultant Optometrist, Head Ophthalmology Support Services, St. Paul's Eye Unit, Liverpool University Hospitals NHS Group, Liverpool, UK

11:05 Refreshments

SESSION TEN **Session Chair: CHARLOTTE HAZEL**

11:40 "Do You See What I See? Neurodivergence and Vision."
Prof Rachel Pilling, Consultant Paediatric Ophthalmologist, University of Bradford, Richmond Road, Bradford, UK
Bradford Teaching Hospitals NHS Foundation Trust, Bradford, UK

12:45 Prize Giving and Closing Remarks – HOC Chair Sam Comely

12:55 Lunch

Pre-Booked Parallel Sessions continue after Lunch

Sunday Afternoon

Anterior Eye Stream	Contact Lens Stream	Glaucoma Stream	Medical Retina Stream
Théa let's open our eyes	BAUSCH + LOMB	Newmedica Eye Health Clinics | Surgical Centres	Association of Optometrists

SESSION ELEVEN 14:00 – 15:00

Session 11A	Session 11B	Session 11C	Session 11D
Peer Review for Speciality Optometrists	Discussion Workshop	Peer Review for General Optometrists	Peer Review for General Optometrists
Room: Mancy	**Room: Bourgogne**	**Room: Avize**	**Room: Bourg**
The Cornucopia of External Eye Diseases	**Scleral Contact Lenses**	**Glaucoma (Advanced Level)**	**Medical Retina (Advanced Level)**
Vijay Anand & Hemesh Jethwa	Shreeti Lakhani & Mathew Carter	Emma Minchin & Neil Nathwani	Ashish Choksi & Anita Sharma

END OF EVENT
***

SHORT PAPER PRESENTATION 1

MENTAL WELLBEING IN INHERITED DISEASE

Michael Crossland,[2] Marc Tibber, [3] and Michel Michaelides[1,2]
1. Moorfields Eye Hospital NHS Foundation Trust
2. UCL Institute of Ophthalmology
3. UCL Research Department of Clinical, Educational and Health Psychology

Purpose
People with vision impairment have lower mental wellbeing than people without eye disease, but the reasons for this are not clear. Here we determined the effect of multiple demographic, clinical and psychosocial factors on mental wellbeing for a group of adolescents and adults with inherited macular disease.

Method
Thirty-six people with inherited macular disease and a broad range of age and disease severity were recruited. Demographic data (age, sex, ethnic origin, socioeconomic status) and clinical history (visual acuity, duration of disease) were obtained from hospital records. Validated age-appropriate questionnaires were used to measure loneliness, vision-related health utility, level of function and disability, mental wellbeing, depression and anxiety.

Results
On average, participants' wellbeing was not significantly different to the reference population (this study: mean: 50.9, sd: 9.68; reference population; mean=51.4; sd: 9.42; ANOVA, F = 0.099, p = 0.75), but there were significant associations between wellbeing and loneliness (r = -0.59, p < 0.001), vision-related health utility (r = 0.64, p < 0.001), level of disability (r = -0.54 p < 0.01) and participation (r = 0.74, p < 0.01).

Conclusion
Loneliness, reduced vision-related health utility, and higher levels of disability were associated with lower individual wellbeing. Interventions such as social prescribing, cognitive behavioural therapy, low vision rehabilitation and the provision of assistive technology may help maximise wellbeing in people with inherited macular disease.

Funding
This work was supported by Macular Society research grant 22-RG-1.

Michael Crossland

SHORT PAPER PRESENTATION 2

DEVELOPMENT OF A PATIENT CENTRED TOOLKIT TO SUPPORT GLAUCOMA MEDICATION ADHERENCE

Peter Campbell[1,2], Deborah Bott[2], Ahalya Subramanian[2], David Edgar[2], and John Lawrenson[2]

1. ***Guy's and St Thomas' NHS Foundation Trust, London, SEI 7EH, UK***
2. ***Dept Optometry & Vision Scienc, City St George's, University of London, EC1V 0HB, UK***

Purpose: To develop a patient-focused toolkit of resources designed to support adherence to glaucoma medication, using a theory-driven behaviour change approach combined with input from key stakeholders.

Methods: A multi-stage, mixed-methods approach was adopted:

- **Systematic Review**: Key modifiable determinants of glaucoma medication adherence were identified, categorised using the Theoretical Domains Framework (TDF).
- **Qualitiative Interviews**: Interviews were conducted with patients and practitioners, insights were analysed using the TDF to explore real-world barriers and enablers to adherence.
- **Toolkit Development:** Findings from above studies were synthesised to identify what needs to change to improve adherence targeted, patient-focused resources were investigated with stakeholder involvement.

Results: Systematic review and interviews identified multiple modifiable influences on adherence operating across patient, practitioner, and healthcare system levels.

- Three key patient-level barriers emerged: limited understanding of glaucoma and its treatment, difficulties with drop administration, and challenges obtaining medication.
- These barriers were mapped to evidence-based Behaviour Change Techniques to generate potential strategies, which were integrated into development of a practical, patient-focused toolkit

Discussion: Evidence has shown that providing people living with glaucoma with the appropriate skills and resources improves medication adherence and thereby better self-management and improved health outcomes. The next stage will be to refine and operationalise the prototype toolkit, and assess its feasibility in real-world clinical practice.

Conclusion: Ensuring treatment adherence for people with glaucoma is crucial for improving clinical, social, and economic outcomes for both patients and society. This toolkit has the potential to support healthcare professionals in delivering personalised, effective support for glaucoma patients at risk of non-adherence.

Peter Campbell

SHORT PAPER PRESENTATION 3

COMPARING THE DIAGNOSTIC VALUE OF VISUAL FIELD TEST LOCATIONS FOR DETECTING EARLY GLAUCOMATOUS VISUAL FIELD LOSS IN MYOPIC AND NON-MYOPIC EYES

Pádraig J. Mulholland,[1 2] Caitlín S. Campbell,[1,2] Victoria Stapley,[1] David M. Wright,[3] David F. Garway-Heath,[2] Giovanni Montesano,[2] Roger S. Anderson,[1,2] and Tony Redmond,[4]

[1] Centre for Optometry & Vision Science, Biomedical Sciences Research Institute, Ulster University, Coleraine, Northern Ireland, UK
[2] NIHR Biomedical Research Centre at Moorfields Eye Hospital NHS Foundation Trust and UCL Institute of Ophthalmology, London, UK
[3] School of Medicine, Dentistry and Biomedical Sciences, Queen's University Belfast, UK
[4] School of Optometry and Vision Sciences, Cardiff University, Cardiff, UK

Purpose: To compare the diagnostic value of 24-2 visual field test locations (n=52) for detecting early glaucomatous visual field loss in myopic and non-myopic eyes.

Method: Visual field data (Humphrey VFA SITA-Standard 24-2) from 94,579 eyes of 48,617 patients (GRIP study database) with suspected or diagnosed glaucoma were analysed. Eyes were classified on the Brusini staging system as normal (Stage 0: 20,664 myopes, 12,718 non-myopes) or defective (Stages 2/3: 13,042 myopes, 10,551 non-myopes). Visual field data were resampled using a Bootstrap method, with the positive predictive value (PPV) of each location calculated where locations with a pattern deviation probability (PDP) <0.01 were classified as defective. The location with the most frequently highest PPV across samples was selected for the PPV-optimised grid. Eyes in which this location was defective were then removed and PPVs recalculated for the residual sample until all locations were selected. This was repeated for the full cohort and separately for myopes and non-myopes. Sensitivity and specificity for detecting glaucomatous field loss (PDP <0.01 at any location) in myopic eyes were compared between general and myopia-specific PPV-optimised grids.

Results: Good diagnostic accuracy (sensitivity, specificity) for the detection of glaucoma related visual field loss in the full cohort was achieved with as few as 20 (90.6%, 86.2%) or 30 (96.5%, 72.1%) test locations. Diagnostic performance of the general and myopia-specific PPV-optimised grids did not differ in detecting glaucomatous field loss in myopes (20 locations: 89.9%, 87.3% vs. 90.1%, 87.3%).

Conclusion: An equivalent reduced number of PPV-optimised test locations provide good diagnostic accuracy for detecting glaucomatous field loss in both myopic and non-myopic eyes. The outcomes of this work

Pádraig Mulholland

This short paper is also supported with a poster presentation.

LINK TO POSTER

SHORT PAPER PRESENTATION 4

THE VISION PROJECT: VALIDATION OF SCHEIMFLUG TOMOGRAPHY LENSES USING A REFERENCE STANDARD OF THE PATIENT'S OWN CONTACT LENS

McVeigh EM[1], Low WS[1], Anand V[1], Leucci M[1], Clarke B[1,2], Mulholland PJ[1,3,4], Shah N[1], Ehrlich DP[1]
[1] Optometry Department, Moorfields Eye Hospital NHS Foundation Trust, London, UK
[2] Optometry Department, Belfast Health and Social Care Trust, Belfast, UK
[3] National Institute for Health Research (NIHR) Biomedical Research Centre, Moorfields Eye Hospital NHS Foundation Trust and UCL Institute of Ophthalmology, London, UK
[4] Centre for Optometry and Vision Science, School of Biomedical Sciences, Ulster University, Northern Ireland, UK

This presentation will give a VISION project update, progress in which has been reported at SOC 2023 and HSOC 2024. Please use link below to the supporting poster for details.

Dan Ehrlich

This short paper is also supported with a poster presentation.

LINK TO POSTER

SHORT PAPER PRESENTATION 5

ENHANCED MACULAR REFERRAL PATHWAY AT BRISTOL EYE HOSPITAL

Ben Phipps, and Clare Bailey
Bristol Eye Hospital, University Hospitals Bristol & Weston NHS Foundation Trust

Purpose: In response to mounting pressures on hospital eye services and inefficiencies in macular referral processes, Bristol Eye Hospital (BEH) has implemented an innovative, digitally enhanced macular referral pathway in collaboration with community optometrists, Primary Eyecare Services (PES), and the local optical committee (LOC). A grant from NHS England supported the development of this pathway. This novel system enables community optometrists to submit macular referrals (whether urgent or routine) complete with full DICOM OCT and fundus images, via the OPERA platform, and with remote clinical review by the BEH team within one working day of receipt of the referral.

Method: The referrals are processed by Primary Eye Care Services who hold a contract with the ICB. There is a bespoke macular referral form with mandatory fields completed by the referring optometrists, and the images are attached to this referral via OPERA software. Referral via ERS which books a patient straight into a BEH 'remote consultation clinic' the same/next working day. Patient's Summary care record is attached. The patient's GP is sent a record of the referral/and outcome but does not need to process a referral, saving GP time. PES arrange payment to the community optometrist. The pathway was not for known vitreomacular pathology such as known macular holes or ERM. A clinical audit of this service was carried out on the first 424 patients assessed.

Results: 373 referrals were appropriate for the pathway. For these, 73.4% of patients avoided a hospital visit, significantly reducing strain on clinical capacity, carbon footprint, and patient/carer travel burdens. Patients with a remote diagnosis of wet AMD were contacted over the phone and booked straight into one stop treatment clinics, giving faster access to care, with a median time of 8 days between receipt of referral and the first treatment 89% of these patients began therapy within 14 days. This compares to the national benchmark of 40.3% (NOD AMD Audit). Feedback from optometrists has been overwhelmingly positive, citing enhanced education, diagnostic confidence, and professional satisfaction.

Conclusion: This pathway represents a game-changing shift toward integrated, image-based, and rapid-response care, empowering optometrists, easing hospital burden, and delivering faster access to care for patients with macular diseases.

Ben Phipps

This short paper is also supported with a poster presentation.

LINK TO POSTER

SHORT PAPER PRESENTATION 6

SAFETY AND EFFICIENCY OF LARGE VOLUME MEDICAL RETINA DIGITAL CLINICS

Alice Sidorowicz, Megan Casey, Sharon Heng and Bahar Demir
Moorfields Eye Hospital, 162 City Road, London, EC1V 2PD, UK

Purpose: The Medical Retina Digital Clinic at Moorfields Eye Hospital was established to address rising demand for medical retina services, ensuring timely patient review and optimising clinic capacity. The advancement of imaging modalities has allowed a vast majority of safe diagnosis via digital pathways. Digital review pathways aim to reduce unnecessary face-to-face (F2F) appointments while prioritising patients requiring treatment.

Method: We conducted a retrospective service audit of 7,032 patients reviewed across all Moorfields Medical Retina digital sites between July and August 2023. Data was extracted from SQL reports and electric paper record system. All patients with scheduled appointments were included, including those who did not attend (DNA).

Results: Of the 7,032 patients, 5,614 attended their appointment, with a DNA rate of 20.3%. Optometrists performed 36% of all reviews. 100% (n=700) of new patients were reviewed within 7 days, and 100% (n=4914) of follow-up patients were reviewed within 14 days.

The majority of patients (70%) remained within the digital pathway, 6% were discharged, and 24% had a F2F follow-up appointment. Of the patients that were brought back for F2F review following their digital clinic appointment, 35% received treatment.

Conclusions: The Medical Retina Digital Clinic is effective in reviewing high volumes of patients safely across digital hubs. Reducing unnecessary F2F visits, streamlining treatment pathways for patients with urgent pathologies who need it the most. The significant contribution of Allied Health Professionals and Optometrists demonstrates potential to further optimise resources by freeing consultant time.

References: The Royal College of Ophthalmologists. The Way Forward: Executive Summary. January 2017.

Alice Sidorowicz

SHORT PAPER PRESENTATION 7

MANAGEMENT OF PAEDIATRIC REFRACTIVE ERROR IN THE COMMUNITY: EARLY INSIGHTS FROM HOSPITAL REFERRALS OF CHILDREN AGED 2-10 YEARS

Megan Casey,[1] Saleha Humayun,[2] Ankit Patel,[1] Katherine Anguige,[1] Riccardo Cheloni,[1,3] and Vijay TailorHamblin[2,4,5]

[1] Department of Optometry, Moorfields Eye Hospital NHS Trust, London, UK
[2] Department of Orthoptics, Moorfields Eye Hospital NHS Trust, London, UK
[3] School of Optometry and Vision Science, University of Bradford, Bradford, UK
[4] NIHR Moorfields Biomedical Research Centre, Moorfields Eye Hospital, London, UK
[5] Institute of Ophthalmology University College London, , London, UK

Purpose: Refractive amblyopia develops when significant refractive errors remain uncorrected during childhood, representing a leading cause of visual impairment in children and young people (CYP). Timely spectacle correction is crucial to prevent amblyopia and strabismus, thereby reducing long-term psychosocial impacts on CYP and their families. Refractive error prescribing is a routine part of community optometrists' work. All CYP are eligible for NHS Funded Sight Tests up to age 16, yet previous studies have reported barrier and limitations in accessing community eye care for CYP.[1-3] Delay in access to eyecare for CYP may lead to poorer visual and developmental outcomes. We reviewed referral patterns of children from community to Hospital Eye Services (HES) as an insight into paediatric refractive error management.

Method: We retrospectively reviewed the clinical notes and referral letters of all newly referred children (2–10 years) to Moorfields Eye Hospital, and its outreach clinics. Data collection spanned the time between January and March 2024. Data collected included the referral source, referral reason, HES diagnosis, and patient discharge rates.

Results: Of 402 referrals identified, 66 were excluded due to repeat referrals (n=32), awaiting appointments (n=18), or lost to follow-up (n=16), leaving 336 for analysis. Most referrals came from community optometrists (37.5% via general practitioners [GP], 22.3% direct), followed by GPs (28.9%), school screening (6.8%), and other sources (4.6%). The 5-year-olds formed the largest age group (22.3%), and children referred by GPs were younger than those referred by optometrists (4.2±2.1 vs 5.6±1.7 years, $p<0.001$). Most common reasons for referral were suspected strabismus (31.9%), amblyopia (16.7%) and reduced vision (13.7%). Ninety children (26.8%) were discharged at the first visit; and a further 48 (14.2%) at the second visit. For those discharged (n=138), the most common HES diagnosis was refractive error (43.5%). The rate of discharge at the first visit increased significantly with age (OR: 1.23, 95% CI: 1.08-1.40; $p=0.002$), but appeared unrelated to the referral source (i.e., optometrists or GP, $p>0.05$).

Discussion: Most CYP's referrals into HES were initiated by optometrists and GPs, with strabismus and reduced vision representing most common reasons. CYPs are referred by GP at slightly younger age than optometrists. Up to 40% of referrals were discharged after one or two visits, with 43.5% of these due to refractive errors, often manageable in the community.

Conclusion: Most CYP's referrals were initiated by optometrists and GPs, and up to 40% were discharged after one or two visits, with a diagnosis of refractive errors. These referrals, combined with limited HES resources, may delay care and worsen outcomes for CYP.

Megan Casey

This short paper is also supported with a poster presentation.

LINK TO POSTER

SHORT PAPER PRESENTATION 8

THE EVOLUTION OF MOORFIELDS EYE HOSPITAL GLAUCOMA SERVICE CLINIC CRITERIA AND OPTOMETRIST DELIVERED CARE

Emma Laber, Stephanie Figg and Emily Minchin
Optometry Department, Moorfields Eye Hospital NHS Foundation Trust, London, UK

Purpose: Optometrists have worked in an extended role within the Moorfields Glaucoma service for over 30 years, with specific optometrist-led Clinic protocols being first developed in 2011. As the complexity and autonomy of optometrists' practice has significantly increased, protocol updates underpinned by quality and safety audit results and the emergence of higher-level qualifications have been necessitated. This review described the evolution of the protocol and gives a summary of the current Moorfields Glaucoma service workforce.

Method: Iterative versions of the Glaucoma Service Criteria and Optometrist-Led clinic protocol from 2011, 2017/18 (service expansion), 2021 (introduction of virtual reviews in response to COVID pandemic) and 2025 were reviewed. At each stage, the complexity of patients seen was critiqued as changes based upon safety and management audits were implemented. The increase in number of optometrists in Independent Prescribers and those holding higher qualifications in glaucoma was also considered.

Results: Currently nearly 100 optometrists provide around 150 sessions per week of glaucoma activity across all types of glaucoma clinics. The scope of their autonomous clinical practice has greatly increased; 66% hold the Independent Prescribing qualification; 91% the College of Optometrists Professional Certificate in Glaucoma; 56% the Higher Certificate and 30% the Diploma. Audit results show excellent agreement between optometrist and consultant decision making (2017: 83%; 2021: 88%; 2023: 93%) and follow up intervals (2017: 82%; 2021: 73%). Safety in management and adherence to protocols is high.

Discussion: The scope of optometrists in extended role continues to expand. The model of care adopted in Glaucoma clinics has been successful and is being replicated across other Moorfields services and Trusts.

Conclusion: Through sharing our experience, it is hoped we can support Optometrist colleagues at other Trusts build similar models of care and learn from each other's experiences for the benefit of glaucoma patients.

Emma Laber

This short paper is also supported with a poster presentation.

LINK TO POSTER

GLAUCOMA TREATMENT BEYOND IOP: ALTERNATIVE THERAPIES AND NEUROPROTECTION

Prof. Augusto Azuaro Blanco, Queen's University Belfast, Northern Ireland, UK
Consultant Ophthalmologist, Belfast Health & Social Care Trust, Belfast, NI, UK

This lecture will review current evidence of alternative therapies for glaucoma. The session will begin with a brief description of evidence synthesis methodology, and why non-IOP related treatments, including neuroprotection, are important.

The mechanism of action of non-IOP related treatments will be appraised with a particular focus on evidence from randomised clinical trials. The following treatments will be considered:

- NMDA-receptor antagonists,
- Alpha-2 agonists,
- Neurotrophins,
- Glucagon-like peptide 1 receptor agonists,
- Micronutrients, antioxidants,
- Nicotinamide,
- Citicoline,
- Metformin,
- Marijuana, cannabinoids,
- Gingko biloba,
- Acupuncture, meditation, exercise.

A critical appraisal of the literature describing the effectiveness of the above interventions will be included.

Augusto Blanco

Learning Outcomes

- Optometrists and dispensing opticians will recognise the merits and limitations of alternatives therapies for glaucoma (s.5).

DELIVERING EYE HEALTH FOR EVERYONE, EVERYWHERE, FOREVER

Prof. John Buchan, International Centre for Eye Health, LSHTM, London, UK
Consultant Ophthalmologist, Leeds Teaching Hospitals NHS Trust, Leeds, UK

This lecture will cover the following topics:

- Triple bottom line sustainability in UK and global eye health care provision,
- Service delivery pressures, demographic shifts and projections in the UK and internationally,
- Clinical and research workforce disparities between richer and poorer communities,
- Carbon footprint of health care, and specifically eye health care in the UK with international comparators,
- Sustainability promotion interventions available in UK eye departments.

John Buchan

Learning Outcomes

- Demonstrate an understanding of international eye health service provision workforce requirements and human resource sustainability issues (s.5)
- Evaluate current sustainability of UK hospital eye care services (using cataract surgical services as a case study) (s.11)
- Synthesise evidence around aspects of sustainability of UK hospital eye care service provision using international comparators (s.10)
- Recognise what intervention options exist for reducing carbon footprints of hospital eye care services (using examples of intravitreal injection services and cataract services but applying these principles to other service areas) (s.11).

Bausch + Lomb Lunch Session

ADVENTURES IN EYE SHAPE: FROM CORNEA TO THE SCLERA, WHY SHAPE AND ELEVATION MATTER WHEN FITTING SCLERAL LENSES

Cindy Tromans, Consultant Optometrist
Manchester Royal Eye Hospital, Manchester, UK

Cindy Tromans

BAUSCH + LOMB

WOODWARD MEMORIAL MEDAL LECTURE

PROFESSIONALISM – LEADERSHIP AND ACCOUNTABILITY. WHY IT MATTERS AND HOW IT ALL FITS TOGETHER

Andrew Tompkin, BSc, DOpt, PGCertOptom, MBA, CMgr FCMI
Consultant Optometrist, Divisional Head Ophthalmology Support Services,
St. Paul's Eye Unit, Liverpool University Hospitals NHS Group, Liverpool, UK

In this session, aspects of leadership, in a governed professional healthcare context, at individual, team, organisational, and system-wide levels will be considered. Benefits including motivation factors, competence, relatedness, autonomy, health and wellbeing, outcomes and patient safety will be explored.

Elements of professional behaviours will be considered including, personal integrity, ability to manage patients with empathy, sympathy and compassion, initiate informed consent and appreciate links to patient safety.

This lecture will consider typical management processes within a financial and capacity challenged hospital environment to deliver a governed system, which is also responsive, both reactively and proactively, to the inevitable change that occurs in the NHS.
The development of roles through the learning journey from "consciously incompetent" to "unconsciously competent" will be considered in relation to advancing hospital optometry activities.

Andrew Tompkin

Learning Outcomes

- Practitioners will recognise the development of roles through the learning journey (s.9)
- Practitioners will identify a range of professional behaviours that impact patient safety (s.11).

"DO YOU SEE WHAT I SEE?" – NEURODIVERSITY AND VISION

Prof Rachel Pilling, Consultant Paediatric Ophthalmologist,
University of Bradford, Richmond Road, Bradford, UK
Bradford Teaching Hospitals NHS Foundation Trust, Bradford, UK

This session will offer insights into the different ways in which neurodivergent (those with atypical neurodevelopment / autism / ADHD) people use their vision. It will introduce the concept of ViBes (visual behaviours), how these manifest in daily activities and strategies to maximise visual function.

Rachel Pilling

Learning Outcomes

- Practitioners will be able to identify techniques that can support visual assessment in special needs/neurodivergent patients and recognise how sensory processing disorders can impact visual function (s.5).

ANTERIOR EYE STREAM

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ANTERIOR EYE STREAM - 1

PEER REVIEW FOR SPECIALTY OPTOMETRISTS (AS/SP/IP)

Deidre Burns and Jenny Lindsay
Royal Victoria Hospital, Belfast, Northern Ireland, UK

This session will present a range of anterior segment cases encountered by the presenters in their clinics. Cases will be drawn from both adult and paediatric corneal clinics as well as eye casualty and will cover both acute and more chronic presentations. Cases will stimulate round table discussions around differential diagnosis, appropriate investigations and therapeutic options.

Deidre Burns

Learning Outcomes

- Specialty optometrists will be able to recognise and manage a range of anterior eye conditions (s.7).

Jenny Lindsay

ANTERIOR EYE STREAM - 2

DISCUSSION WORKSHOP: TOUGH TEARS – MANAGING OCULAR SURFACE CHALLENGES

Navneet Gupta, Professional Education Lead,
Théa Pharma UK, Keele, ST5 5NT, UK

This discussion workshop will cover three cases of ocular surface disease that can present to practice, requiring therapeutic management beyond just ocular lubricants. From eyelid disorders affecting the ocular surface, to inflammatory factors, this session will get you thinking about more challenging situations and the management options available, including prescribing decisions.

Specifically, this session will cover a case of ocular surface disease related to meibomian gland loss, recurrent corneal erosions, and inflammatory dry eye which is unresponsive to traditional management.

The session is suitable for optometrists and specialty optometrists, who are likely to encounter such patients and manage in practice.

Navneet Gupta

Learning Outcomes

- Practitioners will identify how to assess, diagnose and manage patients presenting with challenging ocular surface disease, relative to their scope of practice (s.5, s.7)
- Practitioners will recognise when it is appropriate to work collaboratively with colleagues to manage challenging cases of ocular surface disease (s.10).

ANTERIOR EYE STREAM - 3

PEER REVIEW FOR GENERAL OPTOMETRISTS: ANTERIOR EYE

Alison Weston, Principal Optometrist
Leeds Teaching Hospitals NHS Trust, Leeds, UK

This session will review the diagnosis and management of a selection of anterior eye cases including corneal and conjunctival disorders, anterior uveitis and cataract. The use of different anterior segment imaging techniques to aid diagnosis and monitoring will be reviewed and therapeutic/surgical management options explored.

Alison Weston

Learning Outcomes

- Optometrists will recognise the clinical characteristics of a range of anterior eye conditions to aid diagnosis and patient management (s.7)
- Dispensing opticians will recognise the clinical characteristics of a range of anterior eye conditions and how they are managed in practice (s.5).

ANTERIOR EYE STREAM - 4

PEER REVIEW FOR SPECIALITY OPTOMETRISTS (AS/SP/IP): THE CORNEACOPIA OF EXTERNAL EYE DISEASES

Vijay Anand and Hemesh Jethwa
Moorfields Eye Hospital NHS Foundation Trust, City Road, London, EC1V 2PD, UK

This session will discuss a series of cases from external disease and keratoconus clinics, looking in particular at history taking, signs and symptoms, diagnosis, management and monitoring of corneal disease. Using a range of patients from infectious disease, keratoconus, transplants and traumatic injuries, delegates will be involved in case-based discussion to broaden their knowledge in corneal disease and treatments.

Vijay Anand

Learning Outcomes

- Practitioners will identify key aspects of history and symptom taking that can support diagnosis and management of a range of anterior eye diseases (s.2)
- Practitioners will recognise how to assess a range of anterior eye diseases to enable diagnosis and management relative to their scope of practice (s.7).

Hemesh Jethwa

CONTACT LENS STREAM

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CONTACT LENS STREAM - 1

PEER REVIEW:
CONTACT LENSES – BASIC PRINCIPLES FOR COMPLEX CORNEAS

Elizabeth Dinsdale and Katie Etherton
Moorfields Eye Hospital NHS Foundation Trust, City Road, London, EC1V 2PD, UK

This peer review will present cases which explore the core principles of fitting medical contact lenses, including RGPs, specialist soft lenses and mini-scleral lenses. Delegates will consider how these lenses help manage corneal ectasias and other complex corneal pathologies, with a focus on improving vision and patient comfort.

Elizabeth Dinsdale

Learning Outcomes

- Practitioners will identify the core principles of fitting contact lenses for complex corneas (s.7).

Katie Etherton

CONTACT LENS STREAM -2

DISCUSSION WORKSHOP:
NHS – NAVIGATING HARMONISING SCLERALS IN THE NHS SYSTEM

Aneel Suri[1] and Cindy Tromans[2]
1. Moorfields Eye Hospital NHS Foundation Trust, City Road, London, UK
2. Manchester Eye Hospital, Oxford Road Manchester, UK

Join us for an engaging session where you'll discover how scleral lens fitting can significantly enhance patient satisfaction across a wide range of ocular pathologies. Through real-world case studies and collaborative discussion, you'll gain practical insights and learn from your peers' experiences. By the end of the lecture, you'll understand how a systematic approach to scleral lens fitting can streamline your workflow and improve outcomes. Stay ahead of the curve by exploring the latest trends and tools in scleral lens fitting – while connecting with fellow eye care professionals.

Aneel Suri

Learning Outcomes

- Practitioners will recognise the indications for using scleral contact lenses and how to take a systematic fitting approach to streamline workflow and optimise patient outcomes (s.7).

Cindy Tromans

CONTACT LENS STREAM - 3

PEER REVIEW: CONTACT LENSES (ADVANCED LEVEL)

Shreeti Lakhani and Emma Irwin
Moorfields Eye Hospital NHS Foundation Trust, London, EC1V 2PD, UK

This session will consider the use of medical contact lenses for managing anterior eye conditions, including paediatric cases, found in a tertiary care setting and is aimed at practitioners with a subspecialty in contact lenses.

Shreeti Lakhani

Learning Outcomes

- Practitioners will recognise the use of medical contact lenses for managing a range of anterior eye conditions (s.7).

Emma Irwin

CONTACT LENS STREAM - 4

DISCUSSION WORKSHOP: SCLERAL CONTACT LENSES

Shreeti Lakhani and Matthew Carter
Moorfields Eye Hospital NHS Foundation Trust, London, EC1V 2PD, UK

This interactive workshop will consider:

- Scleral contact lens indications and applications
- Anterior segment shape and the importance of scleral alignment when fitting scleral contact lenses
- Complications associated with and the signs of a suboptimal scleral alignment
- Scleral lens assessment techniques
- Scleral lens designs and their different approaches to providing lens/ocular alignment.

Shreeti Lakhani

Learning Outcomes

- Practitioners will recognise the use of medical contact lenses for managing a range of anterior eye conditions (s.7).

Matthew Carter

GLAUCOMA STREAM

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GLAUCOMA STREAM - 1

PEER REVIEW FOR GENERAL OPTOMETRISTS: GLAUCOMA OR NOT GLAUCOMA THAT IS THE QUESTION

Lucy Andrews, Lead Optometrist
Wirral University Hospitals NHS Foundation Trust, Merseyside, UK

This session will present a range of cases from the glaucoma clinic aimed at a basic level, suitable for general optometrists without a subspecialty in glaucoma. Delegates will discuss presenting signs and symptoms, investigation, diagnosis and management.

Lucy Andrews

Learning Outcomes

- Optometrists will identify how to investigate, diagnose and manage a range of glaucoma clinic cases relative to their scope of practice (s.7).

GLAUCOMA STREAM - 2

DISCUSSION WORKSHOP: FROM MINIMAL INVASIVENESS TO MAXIMUM IMPACT – MIGS AND MIBS IN GLAUCOMA CARE

Richard Stead, Consultant Ophthalmologist
The Queens Medical Centre, Nottingham, UK
Newmedica Nottingham, Nottingham, UK

This interactive discussion workshop is specifically tailored for optometrists looking to deepen their understanding of minimally invasive glaucoma surgery (MIGS) and minimally invasive bleb surgery (MIBS) in the context of glaucoma care.

Through a series of case discussions, delegates will engage with real-world cases to identify when MIGS and MIBS are appropriate treatment options. The session will also include discussions on patient selection criteria, balancing surgical risk and efficacy, and managing patient expectations. The discussion will highlight long-term results and strategies to optimise patient care for sustained intraocular pressure control and visual outcomes.

Additionally, the session will highlight future directions in glaucoma care with a focus on emerging technologies that will shape the future of minimally invasive surgery. By the end of this workshop, optometrists will have a comprehensive understanding of MIGS and MIBS, enabling them to make informed decisions about patient referrals, collaborate effectively with glaucoma consultants, and enhance the overall care of glaucoma patients.

Richard Stead

Learning Outcomes

- Practitioners will recognise the indications for minimally invasive glaucoma surgery (MIGS) and minimally invasive bleb surgery (MIBS) (s.5)
- Practitioners will identify opportunities to collaborate effectively with consultants to enhance the care of glaucoma patients (s.10).

GLAUCOMA STREAM - 3

PEER REVIEW FOR SPECIALTY OPTOMETRISTS (AS/SP/IP) GLAUCOMA

Angela Whitaker
Moorfields Eye Hospital NHS Foundation Trust, London, UK
Royal Gwent Hospital, Newport, Gwent, Wales, UK
Bristol Eye Hospital, Bristol, UK

This peer review session will give specialty optometrists an opportunity to discuss real-life glaucoma cases with their peers led by facilitators with experience working in glaucoma clinics. The format will be small round-table discussions, with overall summary reviewed collectively after each case. Patient history, clinical findings, disc imaging, visual fields, diagnosis and therapeutic treatment options will be considered by each group.

Angela Whitaker

Learning Outcomes

- Specialty optometrists will identify how to manage a range of glaucoma cases relative to their scope of practice (s.7).

GLAUCOMA STREAM - 4

PEER REVIEW FOR GENERAL OPTOMETRISTS: GLAUCOMA (ADVANCED LEVEL)

Emily Minchin and Neil Nathwani
Moorfields Eye Hospital NHS Foundation Trust, London, EC1V 2PD, UK

This session is designed for experienced clinicians working in secondary and tertiary care glaucoma services and will provide a platform for critical discussion and collaborative learning around complex glaucoma cases encountered in clinical practice.

Through case-based discussions, participants will explore diagnostic challenges, treatment decision-making, and the integration of diagnostic tests in the management of advanced disease. Emphasis will be placed on the role of optometrists and orthoptists in risk stratification, laser interventions, and long-term management within multidisciplinary teams. Attendees will have the opportunity to share insights and reflect on practice during the session. The session will also aim to highlight emerging research, with a focus on evidence-based practice influencing the decision-making process in glaucoma care.

Emily Minchin

Learning Outcomes

- Practitioners will identify strategies to aid diagnosis and management of patients with glaucoma (s.5).

Neil Nathwani

MEDICAL RETINA STREAM

Sponsor

Association of Optometrists

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MEDICAL RETINA STREAM - 1

LECTURE WITH DISCUSSION WORKSHOP: THE REGULATION OF TIME – IMPLICATIONS FOR PATIENTS WITH SIGHT IMPAIRMENT

Ian Beasley, AOP Head of Education & Clinical Editor Optometry Today
Association of Optometrists, Woodbridge Street, London, UK

Ordinarily, we are oblivious to the complex neurological interactions involved in sleep-wake regulation; we passively accept that these processes happen – until, that is, they do not.

In this session, we'll discuss the implications of sight loss on circadian rhythm regulation and consider the role optometrists can play in supporting patients affected by these issues.

Ian Beasley

Learning Outcomes

- Practitioners will be able to explain to patients about the implications of sight impairment on sleep-wake regulation (s.2)
- Practitioners will recognise the implications of sight impairment on sleep-wake regulation (s.7).

MEDICAL RETINA STREAM - 3

PEER REVIEW FOR GENERAL OPTOMETRISTS MEDICAL RETINA (BASIC LEVEL)

Janice Oster and Annita Sharma
Moorfields Eye Hospital NHS Foundation Trust, London, EC1V 2PD, UK

This peer review session will go through medical retina cases, from diagnosis to management. These are set to a level suitable for those who have little experience within the subspecialty of medical retina to enable delegates to develop their skills at interpreting clinical information and managing medical retina conditions.

Janice Oster

Learning Outcomes

- Practitioners will be able to interpret clinical imaging techniques to allow diagnosis and management for a range of medical retina conditions, while recognising their limits of competence (s.5, s.6, s.7).

Anitta Sharm

MEDICAL RETINA STREAM - 4

PEER REVIEW FOR GENERAL OPTOMETRISTS: MEDICAL RETINA (ADVANCED LEVEL)

Ashish Chokshi and Anitta Sharma
Moorfields Eye Hospital NHS Foundation Trust, London, EC1V 2PD, UK

This peer review session will go through several medical retina cases, from diagnosis through to management. These are set to an advanced level for optometrists to develop their skills at interpreting clinical information and managing complex medical retina conditions.

Ashish Chokshi

Learning Outcomes

- Practitioners will identify how to manage a range of medical retina cases relative to their scope of practice (s.7).

Anitta Sharm

POSTER PRESENTATION 1

POST OPERATIVE CATARACT, OPTOMETRIST-LED SERVICE: CLINICAL OUTCOMES

Zahra Jessa, Riccardo Cheloni, Katie Etherton, and Sonal Rughani
Moorfields Eye Hospital NHS Foundation Trust, London, UK

Purpose: Increasing prevalence of cataracts is projected to lead to a rise in the number of people requiring surgeries, resulting in longer waiting times and higher demand for postoperative care. The Post Operative Cataract, Optometrist Led Service manages low-risk patients following uncomplicated cataract surgery. Guidelines have been developed to ensure consistent management of patients seen by optometrists working in independent Optometrist led postoperative clinics. This audit will report on the clinic outcomes of these patients. The purpose of this audit was: To report on the effectiveness of the Optometrist Led Post Operative Cataract Clinic. To report on whether post operative complications are being appropriately managed. To highlight areas of improvement. To report on the onward journey of the patient

Methods: 200 cases were retrospectively reviewed by an experienced Optometrist. The inclusion criterion was any patient booked and seen in the Post Operative Cataract, Optometrist Led Service between January 2023 and July 2023.

Results: 94% of patients were managed by the optometrist with only 6% onwards referral for a consultant opinion. 6 patients were incorrectly booked in to the service, of these: 3 were managed in the Optometrist led Clinic and 3 were referred into the consultant led clinic. The review of notes showed 100% adherence with guidelines indicating appropriate management of patients seen in this service.

Discussion: Extending the number of Post Operative Cataract, Optometrist led clinics to reduce waiting times and increase capacity of the cataract service.

Conclusions: The Post Operative Cataract, Optometrist Led Service is an effective way of managing high numbers of low-risk patients that have had routine cataract surgery, with only a small percentage needing onward referral. Most patients (81%) attending the clinic are listed to have surgery in the fellow eye or discharged.

Disclosures

Financial Disclosure: Declared as none.
Prior presentation: Governance Session, Moorfields Eye Hospital.

POSTER PRESENTATION 2

THE EFFECTIVENESS OF OPTOMETRY LED YAG LASER CLINICS

Zahra Jessa, Riccardo Cheloni, Katie Etherton, and Sonal Rughani
Moorfields Eye Hospital NHS Foundation Trust, London, UK

Purpose: YAG laser capsulotomy is a medical procedure used to treat posterior capsule opacification (PCO), a common complication of cataract surgery which develops when the lens capsule becomes cloudy, resulting in blurred or hazy vision. With increasing rates of cataract surgery performed, allied health professionals are delivering YAG capsulotomy to meet growing demand. Nurses have been performing YAG capsulotomy since 1997 but there is limited data on the safety of this procedure being performed by Optometrists. Moorfields Eye Hospital has established an Optometrist Led YAG Laser Clinic (June 2023) and the aim of this work is to report preliminary findings of an audit evaluating the safety and effectiveness of this service.

Method: This audit undertakes a retrospective review of clinical notes of patients referred to the Optometrist Led YAG Laser Clinic at Moorfields between August 2023 to February 2025. Preliminary results are presented based on data collected to date. Routine follow-up appointments are currently not arranged in the YAG Laser Clinic hence surrogate measures of safety and effectiveness are extracted from hospital notes, A&E access and overall medical records. In particular, we report on the safety of the procedure and the improvement in visual function where any visual acuity (VA) record was available on electronic records within 6 months of the procedure.

Results: Data extracted so far from 101 patients, out of a target sample size of 380, with a mean age of 74.4 ± 8.4 years, and slightly higher proportion of females (41% vs 59%). There was an equal split between internal referrals (46%) and external referrals (54%); the latter originating from GPs, community optometrists and diabetic retinal screening services. Out of the 101 patients referred, 80 (79%) underwent YAG Capsulotomy. 11 of the 80 patients (14%) had subsequent clinical encounters after the procedure, with the following outcomes noted: acute anterior uveitis (n=3), residual posterior capsule opacification (n=3), steroid response (n=1), corneal graft rejection episode, which fully resolved with treatment (n=1), myopic CNV which went on to be treated (n=1), referral for YAG laser in the fellow eye (n=1), post YAG laser floaters (n=1). VA data following the procedure was available for 43 (54%) patients who received YAG, and 30 of 43 (70%) exhibited VA improvement of at least 1 line.

What useful information will the study provide: The audit will provide surrogate measures of the safety and effectiveness of optometrist-delivered YAG Capsulotomy, enabling comparison with expected complication rates and visual outcomes. Findings will guide potential improvements to the clinical pathway and help identify high-risk patients who may need routine follow-up

Conclusion: Preliminary analysis suggests that optometrist-delivered YAG capsulotomy is largely effective, with a low but not negligible incidence of post-procedural complications. Most patients with available VA data demonstrated meaningful improvement following treatment. Ongoing data collection will help validate these early findings and further inform any further development of the Optometrist Led YAG Laser Clinic.

Disclosures

Financial disclosure: Declared as none.
Prior presentation: Declared as none.

POSTER PRESENTATION 3

THE VISION PROJECT: VALIDATION OF SCHEIMFLUG TOMOGRAPHY LENSES USING A REFERENCE STANDARD OF THE PATIENT'S OWN CONTACT LENS

McVeigh EM[1], Low WS[1], Anand V[1], Leucci M[1], Clarke B[1,2], Mulholland PJ[1,3,4], Shah N[1], Ehrlich DP[1]
[1] Optometry Department, Moorfields Eye Hospital NHS Foundation Trust, London, UK
[2] Optometry Department, Belfast Health and Social Care Trust, Belfast, UK
[3] National Institute for Health Research (NIHR) Biomedical Research Centre, Moorfields Eye Hospital NHS Foundation Trust and UCL Institute of Ophthalmology, London, UK
[4] Centre for Optometry and Vision Science, School of Biomedical Sciences, Ulster University, Northern Ireland, UK

Purpose: To our knowledge, no previous work has evaluated the outputs of the contact lens selection tool within the Pentacam-HR tomographer in participants with keratoconus. Such knowledge is necessary to provide a firm evidence base for the use of this decision support tool in keratoconic contact lens fitting, the Pentacam-HR being one of the most commonly used topographers in medical contact lens practice settings. This study aims to (i) evaluate the fit of RGP contact lenses selected using the virtual fitting module on the Pentacam-HR device, comparing it to the patients habitually worn lens, and (ii) verify whether predictable changes in lens edge-clearance are observed when changes to lens axial edge lift are made to the optimal lens selected using the virtual fitting tool on the Pentacam-HR device.

Method: 53 participants diagnosed with keratoconus (median age 47 years, range 24 – 78) attending a specialist medical contact lens clinic were recruited into each of the following BOZR ranges; (i) 5.50 to 5.80; (ii) 5.90 to 6.20; (iii) 6.30 to 6.60; (iv) 6.70 to 7.10; (v) 7.20 to 7.50; (vi) 7.60 to 7.90. Pentacam HR topographic scans were collected in one eye & selection of optimal 'virtual' lens selected using in-built software undertaken. Participants were fitted with 4 lenses in a randomised order: "optimal" lens design as specified by the virtual fitting module, lenses one step flatter and steeper axial edge lift compared to optimal virtual lens and the participants current CL correction. In all instances a single RGP lens design was selected using the virtual fitting tool. This new lens design was developed by linking data-rich corneal tomography scans with historical records of what contact lens specifications worked in individual patients. For each CL, images were captured using slit lamp photography and lens fit classified according to the standardised method of Wolffsohn et al. (2013) by a masked grader.

Results: Validation of the virtual lens design. No statistically significant difference in clinical grading was observed between participants' own lenses (median edge clearance grading -0.63, IQR -1 to 0) and the optimal virtually selected lens (P=0.55). **Changes in AEL.** There was a statistically significant difference in global edge clearance grading between the edge clearance gradings for the optimal virtually selected lens (median -0.50, IQR -0.25 to 0.25) and virtual lenses with +1 AEL (median 0.00, IQR -0.25 to 0.25, P=0.03) and -1 AEL steps (median -1.5, IQR -2 to -1, P<0.001). Changes in edge clearance with alterations in AEL were uniform in the superior, nasal and temporal meridians (i.e., ~1 step for both AEL+1 and AEL-1 lenses), but there was a minimal effect of increasing AEL by one step in the inferior quadrant. By comparison a reduction of AEL by one step also reduced edge clearance grading by ~1 step in the inferior quadrant. There were statistically significant differences between the magnitude of edge clearance grading change in the inferior and superior quadrants (P<0.001), in addition to the inferior and temporal quadrants (P=0.02). No differences in the magnitude of edge clearance changes across quadrants were observed for the AEL+1 lens design when compared to the optimal virtually selected lens.

POSTER 3 Continued

Discussion: To our knowledge, no previous work has evaluated the outputs of the contact lens selection tool within the Pentacam-HR tomographer in participants with keratoconus. VISION project work packages 2 and 3 also found that Topography-guided software can reduce the number of trial lenses and fitting time required for RGP fitting, while improving patient satisfaction and experience.

Conclusion:
(i) The RGP contact lenses selected using the virtual fitting module on the Pentacam-HR device was found to have no statistical difference to the fit of to the patients habitually worn lens.
(ii) Predictable changes in lens edge-clearance were observed when changes to lens axial edge lift are made to the optimal lens selected using the virtual fitting tool on the Pentacam-HR device.
(iii) Further work is needed to determine if virtual lens selection provides health economic benefits over traditional lens fitting techniques.

Disclosures

Financial Disclosure: Moorfield Charity, NIHCR and UCL.
Prior presentation: HSOC 2023 - Preliminary data in two posters from VISION study WP1&3.
VISION Project work package 2 results Poster at HSOC 2024 and 2025 BCLA clinical conference

POSTER PRESENTATION 4

MANAGEMENT OF PAEDIATRIC REFRACTIVE ERROR IN THE COMMUNITY: EARLY INSIGHTS FROM HOSPITAL REFERRALS OF CHILDREN AGED 2-10 YEARS

Megan Casey[1], Saleha Humayun[1], Ankit Patel[1], Katherine Anguige[1], Riccardo Cheloni[1,2] and Vijay Taylor-Hamilton[1,3,4]

1. ***Moorfields Eye Hospital, 162 City Road, London, EC1V 2PD, UK***
2. ***School Optometry Vision Science, University of Bradford, Bradford, UK***
3. ***NIHR Moorfields Biomedical Recearch Centre, London, UK***
4. ***University College London, London, UK***

Purpose: Refractive amblyopia develops when significant refractive errors remain uncorrected during childhood, representing a leading cause of visual impairment in children and young people (CYP). Timely spectacle correction is crucial to prevent amblyopia and strabismus, thereby reducing long-term psychosocial impacts on CYP and their families. Refractive error prescribing is a routine part of community optometrists' work. All CYP are eligible for NHS Funded Sight Tests up to age 16, yet previous studies have reported barrier and limitations in accessing community eye care for CYP.[1-3] Delay in access to eyecare for CYP may lead to poorer visual and developmental outcomes. We reviewed referral patterns of children from community to Hospital Eye Services (HES) as an insight into paediatric refractive error management.

Method: We retrospectively reviewed the clinical notes and referral letters of all newly referred children (2–10 years) to Moorfields Eye Hospital, and its outreach clinics. Data collection spanned the time between January and March 2024. Data collected included the referral source, referral reason, HES diagnosis, and patient discharge rates.

Results: Of 402 referrals identified, 66 were excluded due to repeat referrals (n=32), awaiting appointments (n=18), or lost to follow-up (n=16), leaving 336 for analysis. Most referrals came from community optometrists (37.5% via general practitioners [GP], 22.3% direct), followed by GPs (28.9%), school screening (6.8%), and other sources (4.6%).
The 5-year-olds formed the largest age group (22.3%), and children referred by GPs were younger than those referred by optometrists (4.2±2.1 vs 5.6±1.7 years, $p<0.001$). Most common reasons for referral were suspected strabismus (31.9%), amblyopia (16.7%) and reduced vision (13.7%). Ninety children (26.8%) were discharged at the first visit; and a further 48 (14.2%) at the second visit. For those discharged (n=138), the most common HES diagnosis was refractive error (43.5%). The rate of discharge at the first visit increased significantly with age (OR: 1.23, 95% CI: 1.08-1.40; $p=0.002$), but appeared unrelated to the referral source (i.e., optometrists or GP, $p>0.05$).

Discussion: Most CYP's referrals into HES were initiated by optometrists and GPs, with strabismus and reduced vision representing most common reasons. CYPs are referred by GP at slightly younger age than optometrists. Up to 40% of referrals were discharged after one or two visits, with 43.5% of these due to refractive errors, often manageable in the community.

Conclusion: Most CYP's referrals were initiated by optometrists and GPs, and up to 40% were discharged after one or two visits, with a diagnosis of refractive errors. These referrals, combined with limited HES resources, may delay care and worsen outcomes for CYP.

Disclosures

Financial disclosure: None declared.
Prior presentation: BCOVS Glasgow September 2025.

POSTER PRESENTATION 5

AN UNUSUAL CASE OF ESOTROPIA IN A PAEDIATRIC PATIENT: SIXTH NERVE PALSEY & IIH

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Purpose: This case study is of a paedatric patient who presented with RE esotropia and double vision and initially thought to be decompensating esophoria. However, careful examination revealed a 6th nerve palsy and bilateral disc swelling. The purpose of this poster is to educate the delegates on the high incidence of sixth cranial nerve (CN VI) palsy in patients with idiopathic intracranial hypertension (IIH) and describe the theory on their close association.

Presentation & Diagnosis: A 15-year-old Caucasian female presented to eye emergency with horizontal double vision for past 2 days. Patient is known to have high hyperopia and large esophoria which is controlled by her glasses. Hence, initially thought to be decompensating phoria. Careful ocular examination including an orthoptic assessment & dilated examination reveals 6th nerve palsy and bilateral disc swelling. Patient was referred to neurology and was diagnosed with IIH.

Discussion: Idiopathic intracranial hypertension (IIH), is elevated intracranial pressure in the absence of intracranial mass lesions or cerebrospinal outflow obstruction. The usual presentation is headache, pulsatile tinnitus, papilledema, visual disturbances and in some cases diplopia due to cranial nerve involvement. Studies have shown that Abducens (6th) nerve palsy is the most common nerve palsy associated with IIH, citing prevalence of between 12% in adults but in children can be as high as 30%.

The sixth cranial nerve is unique as it is a pure motor nerve, entirely dedicated to supplying the lateral rectus muscle. This poster explains how the remarkable course of this nerve makes is more vulnerable to intra-cranial pressure changes.

Conclusion: This important association reminds us that all clinicians who are presented with suspected optic nerve swelling should examine the ocular motility to see if there is any cranial nerve involvement. Those with double vision & esotropia must have their optic nerves examined carefully to rule out bilateral disc swelling too.

Disclosures

Financial disclosure: Declared as none.
Prior presentation: Internally within UHL Trust.

POSTER PRESENTATION 6

REFERRAL OF ADULT PATIENTS WITH GLAUCOMA TO THE LOW VISION SERVICE AT MOORFIELDS EYE HOSPITAL.

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Purpose: Glaucoma is the second leading cause of Sight Impairment (7.6%) and Severe Sight Impairment (11%) registrations[1] in the UK. It is a chronic, progressive disease that irreversibly affects functional vision by reducing visual acuity (VA), constricting visual fields (VFs), decreasing contrast sensitivity and dark adaptation, and/or increasing glare.[2] This can significantly impact activities of daily living, emotional well-being and social function.[2,3,4] Furthermore, individuals with bilateral disease may experience 2 to 3 times more difficulty with daily tasks.[5] Low vision rehabilitation aims to reduce the negative impact of visual impairment. At Moorfields Eye Hospital, adult glaucoma clinics operate 5 days a week across multiple sites, delivering over 2,500 appointments weekly, including both virtual and face-to-face consultations. It is anticipated that many patients seen in the glaucoma service may benefit from referral to the Low Vision (LV) service. The purpose of this audit was to identify the proportion of adults under the glaucoma service who qualify for a referral to the LV service and: 1. have been referred (i.e. an existing patient or newly referred to the LV service), 2. have not been referred (missed referral – i.e. no past or future LV service appointments). Additional analysis examined whether: any demographic or clinical factors were associated with likelihood of referral to the LV service.

Method: This audit consisted of a retrospective chart review of a random selection of 555 adult patients seen in the glaucoma service at the City Road Division and Hoxton Diagnostic Hub sites between 01/01/2024 and 30/06/2024. The clinical data available on OpenEyes were analysed by 2 Optometrists, with data recorded in Excel. Patients were considered suitable for referral if they met any of the following criteria: a. VA worse than 6/12, b. Significant VF loss, defined as: binocular defects involving 2 or more quadrants, defects, volving 2 or more quadrants in 1 eye if uniocular, or significantly global VF constriction. The proportions of patients eligible for referral, those referred and those not referred were calculated. Logistic regression was used to assess whether the likelihood of being appropriately referred was associated with demographic and clinical factors including patient age, clinician (medic vs non-medic), clinic (virtual vs face-to-face), VA and VF mean deviation of the better eye, sight registration status, and patient reported visual problems.

Results: Of 555 patients reviewed, 100 were found to be eligible for referral to the LV Service. The two most common types of glaucoma in this cohort were primary open-angle glaucoma (38%), and secondary glaucoma (37%). Thirty-five percent of patients met the referral criteria based solely on VA, 42% based solely on VF loss and 23% on both VA and VF criteria. Twenty-six percent of patients were seen in a virtual clinic and 74% in a face-to-face clinic.
Of the 100 patients eligible for referral, 35% were either referred to or already known to the LV service. The remaining 65% were not referred or known to the service, indicating missed referral opportunities. The likelihood of referral when eligible was significantly higher with any form of sight impairment registration (OR = 15.6, 95% CI: 5.9 to 45.4, $p<0.0001$) and was significantly lower with improving VA in the better eye (OR = 0.96, 95% CI: 0.93 to 0.97 $p<0.0001$). Borderline statistical significance was found between the likelihood of referral when eligible and the clinic type that the patient was seen in i.e. virtual vs face-to-face clinic (OR = 0.35, 95% CI: 0.11 to 0.97, $p = 0.056$), such that patients seen in the virtual clinic were 65% (95% CI: 3% to 89%) less likely to be referred or known to the LV service. Patient age, clinician type (medic Vs non-medic), VF mean deviation of the better eye and patient reported vision problems were not associated with the likelihood of referral (all $p>0.05$).

Discussion: At the time of review, 100 out of 555 (18.0%) of adult glaucoma patients met our criteria for referral to the LV service, yet a substantial proportion (65%) were not referred or known to the service. The strong association between sight impairment registration and appropriate LV referral indicates formal registration may act as a prompt for referral, however functional need should be considered irrespective of registration status. There was no clear evidence of a systematic referral bias based on clinician type, suggesting under-referral is likely a service-wide issue. These findings highlight the need to increase clinician awareness of LV referral criteria and the benefits of early rehabilitation interventions. The possibility that patients seen in virtual clinics were less likely to be referred warrants further investigation. Future audits across other Moorfields divisions are planned to explore this.

Conclusion: This audit highlights that patients with glaucoma who have visual impairment are under referred to the low vision service. Further work is required to ensure clinicians in glaucoma clinics appropriately refer patients to the LV service.

Disclosures
Financial disclosure: Declared as none.
Prior presentation: Declared as none.

POSTER PRESENTATION 7

THE EVOLUTION OF THE MEH GLAUCOMA SERVICE CLINIC CRITERIA & OPTOMETRIST DELIVERED CARE

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Purpose: Optometrists have worked in an extended role within the Moorfields Glaucoma service for over 30 years, with specific optometrist-led Clinic protocols being first developed in 2011. As the complexity and autonomy of optometrists' practice has significantly increased, protocol updates underpinned by quality and safety audit results and the emergence of higher-level qualifications have been necessitated. This review described the evolution of the protocol and gives a summary of the current Moorfields Glaucoma service workforce.

Method: Iterative versions of the Glaucoma Service Criteria and Optometrist-Led clinic protocol from 2011, 2017/18 (service expansion), 2021 (introduction of virtual reviews in response to COVID pandemic) and 2025 were reviewed. At each stage, the complexity of patients seen was critiqued as changes based upon safety and management audits were implemented. The increase in number of optometrists in Independent Prescribers and those holding higher qualifications in glaucoma was also considered.

Results: Currently nearly 100 optometrists provide around 150 sessions per week of glaucoma activity across all types of glaucoma clinics. The scope of their autonomous clinical practice has greatly increased; 66% hold the Independent Prescribing qualification; 91% the College of Optometrists Professional Certificate in Glaucoma; 56% the Higher Certificate and 30% the Diploma. Audit results show excellent agreement between optometrist and consultant decision making (2017: 83%; 2021: 88%; 2023: 93%) and follow up intervals (2017: 82%; 2021: 73%). Safety in management and adherence to protocols is high.

Discussion: The scope of optometrists in extended role continues to expand. The model of care adopted in Glaucoma clinics has been successful and is being replicated across other Moorfields services and Trusts.

Conclusion: Through sharing our experience, it is hoped we can support Optometrist colleagues at other Trusts build similar models of care and learn from each other's experiences for the benefit of glaucoma patients.

Disclosures

Financial Disclosure: Declared as none.
Prior presentation: Declared as none.

POSTER PRESENTATION 8

COMPARING THE DIAGNOSTIC VALUE OF VISUAL FIELD TEST LOCATIONS FOR DETECTING EARLY GLAUCOMATOUS VISUAL FIELD LOSS IN MYOPIC AND NON-MYOPIC EYES

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Purpose: To compare the diagnostic value of 24-2 visual field test locations (n=52) for detecting early glaucomatous visual field loss in myopic and non-myopic eyes.

Method: Visual field data (Humphrey VFA SITA-Standard 24-2) from 94,579 eyes of 48,617 patients (GRIP study database) with suspected or diagnosed glaucoma were analysed. Eyes were classified on the Brusini staging system as normal (Stage 0: 20,664 myopes, 12,718 non-myopes) or defective (Stages 2/3: 13,042 myopes, 10,551 non-myopes). Visual field data were resampled using a Bootstrap method, with the positive predictive value (PPV) of each location calculated where locations with a pattern deviation probability (PDP) <0.01 were classified as defective. The location with the most frequently highest PPV across samples was selected for the PPV-optimised grid. Eyes in which this location was defective were then removed and PPVs recalculated for the residual sample until all locations were selected. This was repeated for the full cohort and separately for myopes and non-myopes. Sensitivity and specificity for detecting glaucomatous field loss (PDP <0.01 at any location) in myopic eyes were compared between general and myopia-specific PPV-optimised grids.

Results: Good diagnostic accuracy (sensitivity, specificity) for the detection of glaucoma related visual field loss in the full cohort was achieved with as few as 20 (90.6%, 86.2%) or 30 (96.5%, 72.1%) test locations. Diagnostic performance of the general and myopia-specific PPV-optimised grids did not differ in detecting glaucomatous field loss in myopes (20 locations: 89.9%, 87.3% vs. 90.1%, 87.3%).

Conclusion: An equivalent reduced number of PPV-optimised test locations provide good diagnostic accuracy for detecting glaucomatous field loss in both myopic and non-myopic eyes. The outcomes of this work

Disclosures

Financial disclosure: None Declared.
Prior presentation: British Congress of Optometry & Vision Science, Glasgow, September 2025.

POSTER PRESENTATION 9

EVALUATION OF THE PATIENT EXPERIENCE IN THE VIRTUAL DIAGNOSTIC GLAUCOMA HUB AND PERCEPTION OF MONITORING GLAUCOMA IN THE COMMUNITY

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Method: New glaucoma patients were recruited from a diagnostic hub at a UK tertiary ophthalmic centre between January and April 2023. A structured questionnaire with 10-point Likert scales was provided that asked: journey time, costs, time taken for tests, difficulty of tests, satisfaction, follow-up modality, as well as their initial referral and thoughts of community monitoring

Results: 98 patients completed survey, mean age 56.2 years, 95% CI (53.0-59.4 years), 60 were female (61.2%). Public transport was the most popular 75 (76.5%), where 40 (40.8%) of all participants had to travel more than 1 hour. 45 (45.9%) patients took time off work and 63 (64.3%) paid for travel. 74 (75.3%) patients found all the tests easy and were 87 (89%) reported they were very happy with their appointment, 48 (55.2%) preferred a virtual follow-up. 88 (90%) were seen within 8 weeks of their initial referral. 49 (50%) were referred by a community-based optometrist, 76 (83.5%) would be happy with an optometrist to monitor their risk and refer them when their risk was identified as moderate.

Discussion: Glaucoma diagnostic hubs were developed to accommodate the growing need for examination and monitoring of patients to support the resources available to see higher volume patients compared to the traditional face-to-face clinician-patient examination. Patients reported that the diagnostic hub tests were easy, and they were happy with their experience in having all their tests completed in one sitting, where the wait time was acceptable. Most travelled by public transport, where almost half had to travel over an hour and the majority had to wait up to 8 weeks for a diagnostic appointment. In addition, almost a half would prefer to see a clinician at their follow-up. Community-based optometric/neighbourhood care could help mitigate the travel time and retain face-to-face contact if referral could be avoided; three-quarters of respondents would be happy for their optometrist to monitor them if they were at low risk of disease development, providing there were guidelines to advocate this.

Conclusion: The virtual diagnostic hub is an accessible portal for new diagnostic care that accommodates a high volume of patients. Patients were satisfied with the tests, waiting times and ease to complete them; however for some, their travel time was significant and half desired to see a clinician at follow-up. Half of referrals were from CBO. The provision of further training and guidance could reduce the need for further referral and facilitate additional community pathways to monitor those at low-risk of glaucoma. This will require funding but aligns with the NHS long-term plan for community-based care.

Disclosures

Financial disclosure: Declared as none.
Prior presentation: Declared as none.

POSTER PRESENTATION 10

IS THERE A ROLE FOR OPTICAL PRACTITIONER TRAINING (OPT) IN GLAUCOMA CLINICS

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Purpose: Outline the stages of completing OPT Levels 1-3 and reflect on the challenges and benefits of this education and training framework for glaucoma practitioners.

Methods: OPT Training was completed by over the course of 4 years by the author. Training involved documenting and reviewing the following competencies: Core ophthalmic assessments and clinical reasoning, History taking and ocular examination techniques, Shared decision-making and multidisciplinary working. Assessment was via Worked based assessments (WBAs) Case-based discussions (CBDs) and Direct observation of procedural skills (DOPS)

Results: Completion of Levels 1-3 OPT in glaucoma were successfully rewarded in April 2025 • A key challenge was the requirement for extensive assessment of WBAs, placing a considerable burden on the small number of educational supervisors particularly if only working part-time in hospital setting. A clinical audit on glaucoma management decision-making was undertaken and a literature review on the efficacy and safety of Rho kinase inhibitors was completed as part of Level 3. These findings were received positively by the assessors and the fed back to the glaucoma team at the Trust aiming to improve knowledge and skills in glaucoma management by team members

Discussion: The structured mentorship and feedback of the OPT programme provides a strong foundation for improving clinical skills and knowledge across a wide range of health care practitioners including nurses and orthoptists. The requirement to provide evidence for clinical skills already in use by experienced optometrists may feel redundant and burdensome. The challenge of completing mostly paper-based documentation could be eased by utilisation of digital systems.

Conclusion: OPT has a valuable place in enabling autonomous and clinically capable health care practitioners within a hospital setting providing an ophthalmic practitioner workforce rather than rotating resident doctors. It also provides a base for lifelong learning for ophthalmic nurses and other registered ophthalmic professionals. There is however limited in recognition of prior learning particularly when the curriculum overlaps with existing optometrist clinical competencies including relevant post-graduate qualifications.

Disclosures

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Prior presentation: Declared as none.

POSTER PRESENTATION 11

OUTCOMES FOR PATIENTS ATTENDING NI DIABETIC RETINOPATHY SCREENING PROGRAMME (NIDESP) FOR OPTOMETRIST-LED SLIT LAMP BIOMICROSCOPY

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2. Queens Universiy, Belfast, Northern Ireland, UK

Purpose: To ascertain the range of final outcomes with slit-lamp based screening for Diabetic Retinopathy (DR) and examine the reasons for urgent referrals from Northern Ireland Diabetic Retinopathy Screening Programme into Hospital Eye Service (HES). The UK National Screening Committee (UK NSC) state that annual SLB appointments are offered for as long as gradable retinal images continue to be unobtainable with standard digital photography and set standards for this surveillance pathway. Timely consultation in SLB should be sought within 13 weeks of the last digital screen, which resulted in an ungradable outcome.[1]

Method: A retrospective review of patient records taken from all optometrist-led slit-lamp based screening appointments with the NIDESP, during the month of June 2025. Report building technology built in to Optimize (DESP capture, grading and reporting software) was utilised. HES appointment information was gathered from EPIC (electronic patient record system).

Results: There were 658 slit-lamp based screening appointments carried out in June 2025 across the entire programme, of which 370 patients were male (56.2%) and 288 patients were female (43.8%). Age ranged from 14 years and 100 years, with the mean age being 74.2 years. As our diabetic population in Northern Ireland (NI) increases, as do the number of patients attending SLB screening clinics. However, the number of patients requiring SLB screening is increasing each year, beyond the expected rate. This pressure on the SLB screening clinics is a direct impact of the long waiting lists for cataract assessment and surgery in NI. In the month of June 2025, the time between the digital screening event and first attended consultation in SLB surveillance was within 13 weeks in 24.73% of cases. The range of final grade outcomes were as follows: Refer to slit-lamp screening to be seen in 12 months 69.9%; return to annual recall/routine screening 9.7%; refer to slit-lamp screening to be seen in 6 months 7.1%; refer to HES for non-DR 5%; refer to HES for urgent non-DR 3.3%; refer to HES for DR 1.7%; refer to HES for urgent DR 1.5%; digital surveillance to be seen in 6 months 1.5%; digital surveillance to be seen in 12 months 0.2%. Further analysis of 22 (3.3%) cases referred to HES urgently, when non-DR conditions were suspected, was carried out, and the following reasons for referral were found: dense cataract (no adequate fundal view) 40.9%; suspicious pigmented lesion on fundus 18.1%; possible CNVM/PPM 18.1%; suspect advanced glaucoma 9.0%; corneal scar (no adequate fundal view) 4.5%; possible macular RVO 4.5%; suspicious lid lesion 4.5%.

Conclusion: A notable subset of patients who present for DR screening are found to have comorbid non-DR pathologies, highlighting the value of optometrist-led slit lamp-based examination within diabetic eye screening programmes. The most common non-DR finding in June 2025, requiring urgent referral, was dense cataract.

1. www.gov.uk/government/publications/diabetic-eye-screening-programme-standards/nhs-diabetic-eye-screening-pathway-standards-from-1st-october-2024-public-facing-guidance-information

Disclosures

Financial disclosure: Declared as none.
Prior presentation: Declared as none.

POSTER PRESENTATION 12

THE MEDICAL RETINA VIRTUAL CLINIC PATHWAY AT BRISTOL EYE HOSPITAL

Ketan Kapoor, Ben Phipps, Clare Bailey and Serena Salvatore
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Purpose: To evaluate and showcase the impact of the Medical Retina Virtual Clinic pathway at Bristol Eye Hospital (BEH), which integrates a multidisciplinary team performing high volume tele-ophthalmology, reducing in-person visits and streamlining medical retina clinical activity.

Method: This is primarily a service description, incorporating a retrospective study completed after institutional review board approval by the audit department at BEH: Diagnostic imaging hub equipped with OCT, ultra-widefield imaging (Optos), Fundus autofluorescence, ETDRS VA charts and iCare tonometer. Asynchronous image and data review by trained optometrists, with escalation to ophthalmologists for teleconsultation if necessary. Service evaluation over two-week period in July 2022: 298 cases, 15% DNA (Did Not Attend) rate. Data quality and SOP adherence assessed.

Results: Service description including a flow diagram of the patient pathway. Patient volume: 20,000+ patients assessed since 2021; 4,611 (2021) → 6,958 (2022) → 8,569 (2023). Service audit (July 2022, n=298): 99.2% of images were of adequate quality. Teleconsultations (n=45): 97.7% completed within 4 weeks. DNA SOP followed in 93.3% cases. 73.4% of patients avoided hospital visits. Clinical impact: Median 8 days from referral to wet AMD treatment, 89% treated within 14 days (vs 40.3% national benchmark).

Conclusion: The BEH virtual retina pathway demonstrates high efficiency, excellent data quality (99.2%), and strong adherence to SOPs (77.2%), while significantly reducing hospital burden and reducing carbon footprint. Up to 18 patients are reviewed per session (36 per day) which significantly increases capacity and reduces waiting times for patients. There was 91.5% agreement between trained optometrists and consultants when sent through for second opinion.

Disclosures

Financial disclosure: Bayer PLC.
Prior presentation: Bristol Eye Hospital audit meeting.

POSTER PRESENTATION 13

REAL WORLD VISUAL AND ANATOMIC OUTCOMES OF DUAL INHIBITION OF VEGF-A ad ANG-2 WITH FARICIMAB IN TREATMENT NAÏVE NEOVASACULAR AGE_RELATED MACULAR DEGENERATION OVER A 24-MONTH PERIOD: EXPERIENCE FROM A SINGLE TERTIARY CENTRE IN THE UK.

Emma Dixon, Heather Thompson, Romi Chhabra, and Nicola Cassels
Manchester Royal Eye Hospital, Manchester, UK

Purpose: To evaluate the efficacy and safety of intravitreal Faricimab for neovascular age-related macular degeneration (nAMD) in treatment naïve eyes.

Method: We carried out a prospective, non-randomized, observational study of 220 eyes from 196 patients with treatment naïve nAMD. Patients received their first intravitreal injection of Faricimab (6.0 mg) between November 2022 and December 2023. Inclusion criteria were a confirmed diagnosis of treatment naïve nAMD and completion of a loading dose of Faricimab injections (minimum four). Exclusion criteria were having had any previous intravitreal injections and other macular pathology. Clinical data was collected at baseline and at each subsequent visit. The treatment protocol involved an initial loading dose of four injections at monthly intervals. Treatment interval was then personalised on a treat and extend basis. Treatment interval extension was considered when no biomarkers of active nAMD were present, with stable or improved visual acuity or if visual acuity loss was not considered to be due to nAMD. Patient demographic data including age, sex and ethnicity was collected. Functional and anatomical outcomes were analysed between baseline (1st injection) and month 24. Best corrected visual acuity (BCVA) was initially recorded as logMAR values and then converted to Early Treatment Diabetic Retinopathy Study (ETDRS) letters. ETDRS letter scores for eyes greater than 1.68 logMAR were recorded as zero. The data was analysed using Excel.

Results: Results were analysed from 215 eyes from 193 patients. Two eyes were excluded due to previous alternative anti-VEGF treatment and three eyes were excluded due to a diagnostic dilemma. The mean age of our cohort was 79.5 ± 7.5 years, with 86% of patients being Caucasian. In this study, 66% were females, 56% were right eyes, 56% were pseudophakic and 89% had unilateral injections. Mean BCVA at baseline was 56.64 ± 16.63 letters, there was a statistically significant increase in BCVA of 4.75 letters ($p< 0.01$) by Visit 4 (month 3). Mean BCVA further improved up to month 24 (6.68 letters, $p< 0.001$). At month 24, 50% of eyes gained ≥ 5 BCVA letters, with a further 31% maintaining stable vision (within 5 BCVA letters). After a single intravitreal injection 40% of eyes were dry, while a further 59% showed anatomic improvement. Mean central retinal thickness (CRT) at baseline was 307.35 ± 87.77µm. After a single injection CRT reduced by 69.08 µm ($p<0.001$), by month 12 this reduction was enhanced to 82.55 µm ($p<0.001$), with a maximal decrease of 90.52 µm ($p<0.001$) at month 24. Patients received on average of 10.45 ± 2.55 injections over the course of the study, with a mean follow up of 100.43 ± 6.62 weeks. Mean treatment interval at 24 months was 15.68 ± 9.48 weeks (n=134 eyes), with 70% of patients being on a treatment interval of ≥10 weeks, including 43% of eyes on a treatment interval of 16 weeks. At month 24, 65% eyes remained inactive (n= 134 eyes).
Intraocular inflammation was noted in three eyes. One eye had anterior uveitis (AAU) after the 7th IVI, one eye had a known history of iritis and experienced AAU at visit 4. AAU was noted in one eye at visit 6 post cataract surgery. Retinal pigment epithelium (RPE) tears were noted in seven eyes (3.18%), all of which were recorded as having large pigment epithelial detachment (PEDs) >400µm at baseline.

Discussion: This real-world prospective study over a 24-month period demonstrates that intravitreal Faricimab is both effective and well-tolerated in treatment-naïve nAMD. Functional and anatomic gains were sustained throughout the study period, indicating robust functional efficacy. Clinically meaningful improvements in both BCVA and CRT were observed early in the treatment course and sustained over 24 months. By month 24, 46% of eyes were within driving standard (≥70 letters) which was an increase from 26% at baseline allowing more patients to maintain independence. Notably the high number of eyes at the maximum treatment interval of 16 weeks reflects a meaningful reduction in treatment burden. By Week 12, 73% of eyes treated with Faricimab were inactive compared to 50% with Aflibercept in the PRECISE study[1] suggesting it is superior. It was found to be safe to use as there was a low incidence of serious adverse events particularly intraocular inflammation, in line with that reported in Phase 3 clinical trials[2].

Conclusion: This real-world audit conducted at Manchester Royal Eye Hospital (MREH) demonstrates Faricimab is an effective and durable first-line treatment for in treatment-naïve nAMD eyes in real-world settings. It has shown a superior drying effect, allowing more patients to be monitored and treated at extended intervals within our service. Using Faricimab as a first line agent in this cohort has had a significant positive impact in service delivery creating capacity in the busy NHS macular clinics as well as notable cost savings. Reduction in treatment burden has also been shown to have a positive impact on patient well-being overall.

Disclosures:
Financial disclosure: Advisory boards/education speakers /travel support: Alimera Science, Bayer, Novartis, Roche.
Prior presentation: EURetina Congress Paris, Sept. 2025 as 8-slide E-poster.

POSTER PRESENTATION 14

ENHANCED MACULAR REFERRAL PATHWAY AT BRISTOL EYE HOSPITAL

Ben Phipps, and Clare Bailey
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Purpose: In response to mounting pressures on hospital eye services and inefficiencies in macular referral processes, Bristol Eye Hospital (BEH) has implemented an innovative, digitally enhanced macular referral pathway in collaboration with community optometrists, Primary Eyecare Services (PES), and the local optical committee (LOC). A grant from NHS England supported the development of this pathway. This novel system enables community optometrists to submit macular referrals (whether urgent or routine) complete with full DICOM OCT and fundus images, via the OPERA platform, and with remote clinical review by the BEH team within one working day of receipt of the referral.

Method: The referrals are processed by Primary Eye Care Services who hold a contract with the ICB. There is a bespoke macular referral form with mandatory fields completed by the referring optometrists, and the images are attached to this referral via OPERA software. Referral via ERS which books a patient straight into a BEH 'remote consultation clinic' the same/next working day. Patient's Summary care record is attached. The patient's GP is sent a record of the referral/and outcome but does not need to process a referral, saving GP time. PES arrange payment to the community optometrist. The pathway was not for known vitreomacular pathology such as known macular holes or ERM. A clinical audit of this service was carried out on the first 424 patients assessed.

Results: 373 referrals were appropriate for the pathway. For these, 73.4% of patients avoided a hospital visit, significantly reducing strain on clinical capacity, carbon footprint, and patient/carer travel burdens. Patients with a remote diagnosis of wet AMD were contacted over the phone and booked straight into one stop treatment clinics, giving faster access to care, with a median time of 8 days between receipt of referral and the first treatment 89% of these patients began therapy within 14 days. This compares to the national benchmark of 40.3% (NOD AMD Audit). Feedback from optometrists has been overwhelmingly positive, citing enhanced education, diagnostic confidence, and professional satisfaction.

Conclusion: This pathway represents a game-changing shift toward integrated, image-based, and rapid-response care, empowering optometrists, easing hospital burden, and delivering faster access to care for patients with macular diseases.

Disclosures

Financial disclosure: Declared as none.
Prior presentation: ARVO 2025 Poster.

POSTER PRESENTATION 15

EVALUATION OF PRESCRIBING PRACTICE BY INDEPENDENT PRESCRIBING OPTOMETRIST AT MOORFIELDS EYE HOSPITAL

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Moorfields Eye Hospital, Moorfields Eye Hospital NHS Foundation Trust, London, UK

Purpose: The aim of this audit is to evaluate the prescribing practice of IP optometrists working at Moorfields Eye Hospital. To assess the prescribing practice and adherence to the non-medical prescribing protocol of IP optometrists at Moorfields Eye Hospital. At present, there is a lack of published data on prescribing practice by Hospital IP optometrists including what drugs are commonly prescribed, number of prescriptions issued by IP optometrists, prescribing errors, and what sub-specialties they work within.

Method: 3-month retrospective audit of prescribing practice by 92 IP optometrists starting 01/07/2024 to 30/09/2024 at Moorfields Eye Hospital City Road, London. A list of prescriptions written by each IP optometrist over the defined audit period were requested from the Performance & Information department. Obtained internal records from the pharmacy team and the incident reporting platform to collate data regarding any prescribing errors by IP optometrists. Descriptive statistics were used to summarise the findings.

Results: Total number of IP qualified optometrists = 92, Average years qualified as IP = 4.87, Total number of drugs prescribed over the 3-month period of 01/07/2024 to 30/09/2024 by optometrists = 8871, Majority prescribed within the glaucoma service. No significant correlation between number of years qualified and number of drugs prescribed. 63 (68.5%) IP optometrists completed a prescription during this 3-month period. 8% (2.489) prescriptions were written by IP optoms out of a total of 31,013 prescriptions written by all clinicians over the audit period. 2,489 prescriptions (8871 drugs prescribed), which equates to a mean of 3.6 drugs per prescription. Mean number of drugs prescribed per week = 682. Most prescribed drug Latanoprost 50micrograms/ml eye drops0 .2ml unit dose preservative free (n= 622). Top 3 services IP optoms working within over audit period: Glaucoma (n=46, 24.9%), External (n=30, 16.2%), MR & A&E (n=24, 13.0%)

Discussion: Currently, 92 independent prescribers work at Moorfields constiting the largest number of optometrist prescribers working in a single Hospital Trust in the UK. The most common sub-speciality service worked in was glaucoma with preservative free latanoprost being the commonly prescribed drug. Limitations of this audit include the retrospective design and the short duration of the audit period, which may not account for prescribing variation throughout the whole calendar year. Additionally, only prescribing data from the main City Road hospital was evaluated, therefore variations in prescribing trends and errors across different Moorfields sites were not evaluated.

Conclusion: The vast majority of medication prescribed by optometrists was within their scope of practice. All of the unlicensed prescriptions were done under the direct supervision of a consultant. The intravitreal injections were prescribed with no mention of consultant supervision on records – this needs to be addressed to ensure optometrists are aware that only doctors are able to prescribe intravitreal injections. Relative to the number of drugs prescribed there were few prescribing errors with 4 no harms and 1 near miss. There were no never events.

yDisclosures

Financial disclosure: Declared as none.
Prior presentation: Declared as none.

POSTER PRESENTATION 16

EFFECT OF A HEAD STRAP ON THE FUNCTION OF THE BLEPHA EYEBAG® EYELID WARMING DEVICE

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Purpose: Warming eye masks, provide relief from symptoms of dry eye associated with meibomian gland disease along with other related eye conditions such as blepharitis, hordeolum and Meibomian cysts. Certain eye mask designs use head straps, to potentially improve mask retention on the face and heat transfer to the eyelids. Straps may increase ocular pressure, raise the risk of tissue damage from direct heating, or pose a visual hazard if the user moves while wearing the mask. This study investigated whether the presence of a strap clinically influences the performance of such eye masks.

Methods: The surface temperature decline of the ocular area following application of the Blepha EyeBag® eye mask (Théa Pharmaceuticals, Clermont-Ferrand), positioned on the facial region of a composite mannequin head, was recorded using a thermographic camera. Prior to measurement, the mask was heated in a domestic microwave oven for 30, 45, or 60 seconds at a power setting of 800 watts. Thermographic images were analyzed based on scale intensity using ImageJ software, and variations in facial temperature were plotted. The process was repeated for a Blepha EyeBag® eye mask which was modified to include a head strap. Repeated-measures analysis of variance (ANOVA) was performed to compare temperature profiles.

Results: Using a strap significantly decreased the temperature of the manikin upper eyelid by on average 1.4 ± 1.9 °C, and lower eyelid by 2.5 ± 2.2 °C ($F=40.451$, $p<0.001$). The upper and lower eyelids heated to a similar temperature (on average 31.1 ± 5.1 °C vs 31.2 ± 5.4 °C, respectively; $F=0.064$, $p=0.805$), with temperate systematically increasing with Blepha EyeBag® heating time ($F=74.027$, $p<0.001$). The temperature dropped with time following heating ($F=56.483$, $p<0.001$) in a similar manner with and without the strap in place $F=1.949$, $p=0.221$).

Conclusion: The temperature transference to the eyelid surfaces was higher without the strap (on average by 1.9 ± 2.2°C) probably because the mask could conform to the contours of the face better when it wasn't pulled tight.

Disclosures

Financial disclosure: Thea Pharmaceuticals.
Prior presentation: None.

END PIECE

NEXT YEARS MEETING

52nd HOSPITAL AND SPECIALTY OPTOMETRISTS CONFERENCE

1st CALL FOR POSTERS AND PRESENTATIONS

Any colleague interested in presenting
a paper, poster or interactive is invited to contact: -

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