NATIONAL HEALTH SERVICE (SCOTLAND)

GENERAL OPHTHALMIC SERVICES

THE STATEMENT

The Scottish Ministers, in exercise of powers conferred by sections 28A and 28B of the National Health Service (Scotland) Act 1978 and regulation 17 of the National Health Services (General Ophthalmic Services) (Scotland) Regulations 2006, after consultation with such organisations as appear to them to be representative of contractors providing General Ophthalmic Services, make the following determination (referred to as the "Statement") -

Application

1. This determination applies to all primary eye examinations and supplementary eye examinations carried out on or after 1 April 2023.

2. This determination applies to all claims for CPD allowance or IPCPD allowance submitted to the Agency on or after 25 September 2023.

Interpretation

3. In this Statement:

> "the 2006 Regulations" means The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006 (SSI 2006/135), as amended;
>
> "CPD" means continuing professional development (previously named continuing education and training or CET);
>
> "CPD allowance" means the sum of £654;
>
> "Goldmann type tonometer" includes a Perkins type tonometer;
>
> "IP optometrist" means an optometrist who is an optometrist independent prescriber as defined in the 2006 Regulations;
>
> "IPCPD" means independent prescriber continuing professional development (previously named independent prescriber continuing education and training or IPCET);
>
> "IPCPD allowance" means the sum of £979;
>
> "optometrist" includes an optician as defined in the 2006 Regulations;

"professional registration" means, for optometrists, registration with the General Optical Council and, for ophthalmic medical practitioners, registration with the General Medical Council.

4. Any other terms defined in regulation 2 ('Interpretation') of the 2006 Regulations are to be given the same meaning in this Statement.

Fees Payable

5. The fees payable to an optometrist or ophthalmic medical practitioner for undertaking eye examinations are set out in Appendix A.

6. Appendices B to E set out conditions which must be met before fees are payable:

   (a) Appendix B sets out the frequencies of primary eye examinations by patient category for which fees will be payable, and the circumstances in which the use of early re-examination codes is permitted;

   (b) Appendix C sets out conditions on the conduct of a primary eye examination;

   (c) Appendix D sets out conditions on the conduct of a supplementary eye examination;

   (d) Appendix E sets out:

      (i) practice equipment that must be provided in accordance with paragraph 6 of Schedule 1 to the 2006 Regulations, as a condition of the fees payable under appendices A to D; and

      (ii) records that must be kept in accordance with paragraph 8 of Schedule 1 to the 2006 Regulations, as a condition of the fees payable under appendices A to D.

Allowances Payable

7. Appendix F sets out the conditions which must be met before the CPD allowance and IPCPD allowance are payable.

APPENDIX A

FEES PAYABLE TO OPTOMETRISTS AND OPHTHALMIC MEDICAL PRACTITIONERS FOR EYE EXAMINATIONS

PRIMARY EYE EXAMINATION

1. Fees payable for each primary eye examination carried out in accordance with appendices B and C by an optometrist or ophthalmic medical practitioner for a patient aged under 60 years: £42.21

2. Fees payable for each primary eye examination carried out in accordance with appendices B and C by an optometrist or ophthalmic medical practitioner for a patient aged 60 years and over:

   (a) no digital photograph taken - £45.63

   (b) digital photograph taken - £51.35

SUPPLEMENTARY EYE EXAMINATION

3. Fees payable for each supplementary eye examination carried out in accordance with Appendix D by an optometrist or ophthalmic medical practitioner:

   (a) standard supplementary eye examination - £27.96

   (b) enhanced supplementary eye examination - £43.35

DOMICILIARY VISITING FEE

4. The additional fees payable to an optometrist or ophthalmic medical practitioner for visits to a place where the patient normally resides for the purpose of carrying out NHS eye examinations under General Ophthalmic Services are:

   (a) for a visit to one establishment or location to undertake an NHS eye examination, for each of the first and second patients - £42.86

   (b) for each of the third and subsequent patients at the same establishment or location - £10.73

5. A payment made under paragraph 1, 2, 3 or 4 above to an ophthalmic medical practitioner who is participating in the National Health Service Superannuation Scheme, is subject to adjustment in respect of superannuation by deduction of the appropriate contribution.

APPENDIX B

THE FREQUENCY OF PRIMARY EYE EXAMINATIONS FOR THE PURPOSE OF REGULATION 22B OF THE 2006 REGULATIONS

1. A primary eye examination must not be carried out more frequently than the frequency set out in Table A of this Appendix, except in the circumstances (and using the relevant reason code) set out in Table B of this Appendix.

TABLE A

Category of patients	Frequency
Patients: • aged under 16 years; • aged 60 years or over; • with diabetes; • who are sight impaired or severely sight impaired, as set out in Annex B to this Statement.	Annually
All other patients	Biennially

TABLE B

Early Re-Examination Codes For Primary Eye Examination
7 - This code is only to be used in the following scenarios: (a) the patient is new to the practice and the optometrist or ophthalmic medical practitioner does not have access to the patient's clinical records; or (b) the patient is not new to the practice but the optometrist or ophthalmic medical practitioner does not have access to the patient record created as a result of a primary eye examination carried out at another practice within the relevant primary eye examination frequency as defined in Table A.
8 - This code is to be used when the patient has turned 16 years of age (and does not have diabetes and/or is not sight impaired or severely sight impaired), resulting in a change in frequency between primary eye examinations from annually to biennially. Annex A to this Statement provides a guide chart which should be used by optometrists and ophthalmic medical practitioners when determining a patient's eligibility for an early re-examination under this code.

APPENDIX C

PRIMARY EYE EXAMINATION

1. A primary eye examination carried out by an optometrist or ophthalmic medical practitioner shall consist of all appropriate tests or procedures relevant to the presenting signs, symptoms and needs of the patient for the purpose of that examination (including the tests and procedures of an eye health assessment as defined in the Table below), unless:

   (a) the optometrist or ophthalmic medical practitioner considers that the patient has a physical or mental condition which would make the carrying out of a specific test or procedure clinically inappropriate;

   (b) in the judgement of the optometrist or ophthalmic medical practitioner, a specific test or procedure is clinically inappropriate for any other reason; or

   (c) the patient has refused to undertake a specific test or procedure.

2. Following a primary eye examination, if the patient is being referred they should be referred directly to an IP optometrist, ophthalmic medical practitioner, ophthalmic hospital or to the patient's General Practitioner.

3. Clinically appropriate equipment must be used for each test or procedure carried out under a primary eye examination.

4. Where –

   (a) the patient has refused to consent to the use of a particular piece of equipment; or

   (b) the patient has a physical or mental condition which would make the use of a particular piece of equipment clinically inappropriate or not reasonably practicable;

   alternative equipment may be used which, despite not being a direct equivalent to any suggested examples in professional guidance for that particular test or procedure in terms of clinical thoroughness, will enable the required test or procedure to be carried out.

TABLE

THE TESTS AND PROCEDURES INVOLVED IN AN EYE HEALTH ASSESSMENT REQUIRED FOR THE PURPOSES OF A PRIMARY EYE EXAMINATION

The tests and procedures involved in an eye health assessment required for the purposes of a primary eye examination should be in accordance with guidance laid out in the College of Optometrists Guidance for Professional Practice and Scottish Intercollegiate Guidance Network 144: Glaucoma Referral and Safe Discharge, and must include (unless any of grounds (a), (b) and (c) set out in paragraph 1 of Appendix C apply):

Tests and procedures
Taking a record of any relevant history and symptoms, which includes relevant medical, family, and ocular history.
An eye health assessment appropriate to the patient's presenting signs, symptoms and needs.
A refraction and an assessment of the patient's visual function.
In keeping with the requirements of the Opticians Act 1989 'to perform such examinations of the eye for the purpose of detecting injury, disease or abnormality in the eye or elsewhere'.
An external examination of the eye using slit lamp biomicroscopy.
An internal examination of the eye using slit lamp biomicroscopy and a condensing lens.
The communication of the clinical findings, advice, results and diagnosis to the patient and, where appropriate, the patient's carer and other health professionals. This may include a referral letter and clinical reports.
To capture and record a digital image of the retina for all patients aged 60 years or over.
Primary eye examinations involving dilation: Patients aged 60 years or over should have a dilated internal eye examination.
Primary eye examinations carried out in a place where the patient normally resides: Use of a head mounted indirect ophthalmoscope and a direct ophthalmoscope may be appropriate for an internal examination of the eye. Use of a loupe and illumination may be appropriate for an external examination of the eye.

APPENDIX D

SUPPLEMENTARY EYE EXAMINATION

1. A supplementary eye examination carried out by an optometrist or ophthalmic medical practitioner shall consist of all appropriate tests or procedures relevant to the presenting signs, symptoms and needs of the patient for the purpose of that examination (including the tests and procedures of an eye health assessment as defined in Table A of Appendix D), unless:

   (a) the optometrist or ophthalmic medical practitioner considers that the patient has a physical or mental condition which would make the carrying out of a specific test or procedure clinically inappropriate;

   (b) in the judgement of the optometrist or ophthalmic medical practitioner, a specific test or procedure is clinically inappropriate for any other reason; or

   (c) the patient has refused to undertake a specific test or procedure.

2. Table B of Appendix D lists the reason codes to be used in accordance with the carrying out of a supplementary eye examination. Only one reason code per supplementary eye examination is required.

3. Following a supplementary eye examination, if the patient is being referred they should be referred directly to an IP optometrist, ophthalmic medical practitioner, ophthalmic hospital or to the patient's General Practitioner.

4. Clinically appropriate equipment must be used for each test or procedure carried out under a supplementary eye examination.

5. Where:

   (a) the patient has refused to consent to the use of a particular piece of equipment; or

   (b) the patient has a physical or mental condition which would make the use of a particular piece of equipment clinically inappropriate or not reasonably practicable;

   alternative equipment may be used which, despite not being a direct equivalent to any suggested examples in professional guidance for that particular test or procedure in terms of clinical thoroughness, will enable the required test or procedure to be carried out.

TABLE A

THE TESTS AND PROCEDURES INVOLVED IN AN EYE HEALTH ASSESSMENT REQUIRED FOR THE PURPOSES OF A SUPPLEMENTARY EYE EXAMINATION

The tests and procedures involved in an eye health assessment required for the purposes of a supplementary eye examination should be in accordance with guidance laid out in the College of Optometrists Guidance for Professional Practice and Scottish Intercollegiate Guidance Network 144: Glaucoma Referral and Safe Discharge, and must include (unless any of grounds (a), (b) and (c) set out in paragraph 1 of Appendix D apply):

Tests and procedures
Taking a record of any relevant history and symptoms, which includes relevant medical, family, and ocular history.
An eye health assessment appropriate to the patient's needs and any presenting signs and symptoms.
Whenever an external examination of the eye is required, it should be carried out using slit lamp biomicroscopy.
Whenever an internal examination of the eye is required, it should be carried out using slit lamp biomicroscopy and a condensing lens. A head mounted indirect ophthalmoscope may also be appropriate for some patients.
The communication of the clinical findings, advice, results and diagnosis to the patient and, where appropriate, the patient's carer and other health professionals. This may include a referral letter and clinical reports.
Enhanced Supplementary Examination with dilation/cycloplegia: If, in the judgement of the optometrist or ophthalmic medical practitioner, the patient requires a dilated internal examination or cycloplegia, then the reason must be recorded.
Supplementary eye examinations carried out in a place where the patient normally resides: Use of a head mounted indirect ophthalmoscope and a direct ophthalmoscope may be appropriate for an internal examination of the eye. Use of a loupe and illumination may be appropriate for an external examination of the eye.

TABLE B

SUPPLEMENTARY EYE EXAMINATION - REASON CODES

If a supplementary eye examination is carried out on the same day as a primary eye examination, full details of the reasons why must be provided in the patient's records.

A supplementary eye examination cannot be claimed on the same day as a primary eye examination, for the same patient, using the 2.1, 2.7, 4.1, 4.6 and 4.7 reason codes.

Reason codes 2.5, 2.8, 4.5 and 4.8 should only be claimed on the same day as a primary eye examination, for the same patient, where the supplementary eye examination is an emergency eye examination.

A supplementary eye examination undertaken using remote facilities must:

- **only be claimed using one of reason codes 2.5, 2.8 or 2.9;**

  and

- **involve all the elements of an eye examination undertaken in person with the patient, except tests and procedures which require the physical presence of the patient. Any advice and recommendations should be issued and clearly documented in the patient's record.**

  A supplementary eye examination cannot be claimed where remote facilities are only used to ask the patient a series of questions to explore their concerns more fully and make a decision regarding whether the patient requires an eye examination.

Standard Supplementary Eye Examination
2.0 - Cycloplegic Refraction Following Routine Primary Eye Examination On A Child This code is to be used when a child requires a cycloplegic refraction following a routine primary eye examination.
2.1 - Paediatric Review (without dilation/cycloplegia that does not follow a primary eye examination) This code is to be used to review a child within 12 months of a primary eye examination, as judged clinically necessary, and dilation/cycloplegia is not required.

2.2 - Follow-Up / Repeat Procedures (without dilation and not associated with glaucoma)

This code is to be used for additional or repeat procedures not requiring dilation and which are required to refine a diagnosis or clinical outcome in order to determine whether the patient needs referral or can be retained for ongoing care in the community. This code can be used for a refraction, on a separate day, that could not be undertaken at the primary eye examination.

2.3 - Suspect Glaucoma (without dilation)

This code is to be used specifically for suspect glaucoma review, in keeping with SIGN 144 guidance for diagnosis and referral for glaucoma, and which does not require dilation. This includes ocular hypertension.

2.4 - Patients Aged Under 60 Requiring Dilation Following Primary Eye Examination

This code is to be used, following a primary eye examination, for a supplementary eye examination of a patient aged under 60 that requires to be dilated.

2.5 - Anterior Eye Condition (without dilation)

This code is to be used for a supplementary eye examination of a patient (in person or using remote facilities) with a suspect or diagnosed anterior eye condition within the normal interval between primary eye examinations, and which does not require dilation.

2.7 - Post-Operative Cataract Examination (without dilation)

This code is to be used for a post-operative cataract examination of a patient, which includes refraction, an ocular examination and (if required) a feedback report, but does not require dilation.

This code should not be used for a post-operative cataract examination of a patient where a General Ophthalmic Services provider has, is or will receive remuneration outwith General Ophthalmic Services arrangements for undertaking the appointment. Such examinations do not form part of General Ophthalmic Services.

2.8 - Unscheduled Appointment (without dilation)

This code is to be used for a supplementary eye examination for a patient (in person or using remote facilities) who presents with symptoms for an unscheduled appointment within the normal interval between primary eye examinations, and which does not require dilation.

2.9 - Cataract Referral Advice and Counselling

This code is to be used when providing advice and counselling to a patient (in person or using remote facilities) following an eye examination which has resulted in the patient being considered for referral. This may include providing prognosis or counselling and preparation for consent for cataract surgery, including risk factors.

3.0 – Additional or Significantly Longer Appointment To Complete Primary Eye Examination For A Patient With Complex Needs

This code can be used for each additional appointment (whether or not on the same day as the first appointment), or a significantly longer single appointment, required to complete a primary eye examination in practice premises for a patient with complex needs, when more time to complete the examination is needed. This code should be claimed in addition to the relevant primary eye examination fee. This code must not be used more than once per day for the same patient.

A patient with complex needs is a patient who has a physical or mental condition and, as a result of that condition, the patient's primary eye examination must be conducted significantly more slowly than that of a typical patient who does not have a physical or mental condition. This includes circumstances where a sign-language interpreter is required because of the patient's physical or mental condition. A patient must not be treated as having complex needs solely due to their age.

Enhanced Supplementary Eye Examination

An enhanced supplementary eye examination should be conducted where it is deemed clinically appropriate to support the care of the patient.

4.1 - Paediatric Review (with dilation/cycloplegia that does not follow a primary eye examination)

This code is to be used to review a child within 12 months of a primary eye examination, as judged clinically necessary, and dilation/cycloplegia is required.

4.2 - Follow-Up / Repeat Procedures (with dilation and not associated with glaucoma)

This code is to be used for additional or repeat procedures requiring dilation and which are required to refine a diagnosis or clinical outcome in order to determine whether the patient needs referral or can be retained for ongoing care in the community.

4.3 - Suspect Glaucoma (with dilation)

This code is to be used specifically for a suspect glaucoma review, in keeping with SIGN 144 guidance for diagnosis and referral for glaucoma, and which requires dilation. This includes ocular hypertension.

4.5 - Anterior Eye Condition (with dilation)

This code is to be used for a supplementary eye examination of a patient with a suspect or diagnosed anterior eye condition within the normal interval between primary eye examinations, and which requires dilation.

4.6 - Cycloplegic refraction of a child referred from the hospital eye service

To facilitate the cycloplegic refraction of a child aged under 16 referred from the hospital eye service. The supplementary eye examination must include an internal and external examination of the eye.

4.7 - Post-Operative Cataract Examination (with dilation)

This code is to be used for a post-operative cataract examination of a patient, which includes refraction, an ocular examination and (if required) a feedback report, and also requires dilation.

This code should not be used for a post-operative cataract examination of a patient where a General Ophthalmic Services provider has, is or will receive remuneration outwith General Ophthalmic Services arrangements for undertaking the appointment. Such examinations do not form part of General Ophthalmic Services.

4.8 - Unscheduled Appointment (with dilation)

This code is to be used for a supplementary eye examination for a patient who presents with symptoms for an unscheduled appointment within the normal interval between primary eye examinations, and which requires dilation.

APPENDIX E

PRACTICE EQUIPMENT THAT MUST BE PROVIDED IN ACCORDANCE WITH PARAGRAPH 6 OF SCHEDULE 1 TO THE 2006 REGULATIONS

1. An optometrist or ophthalmic medical practitioner must provide proper, sufficient and appropriate equipment in good working order for the provision of General Ophthalmic Services. This must include, but is not limited to:

   (a) For practice premises:

   (i) Distance test chart (e.g. Snellen chart)
   (ii) Trial frame, trial lenses and accessories or phoropter head
   (iii) Condensing lens for indirect retinal viewing with slit lamp biomicroscope (60-120D)
   (iv) Slit lamp biomicroscope
   (v) Reading test type
   (vi) Automated visual field analyser, capable of full threshold analysis of the central 30 degrees
   (vii) A Goldmann type contact applanation tonometer
   (viii) Digital retinal imaging apparatus with a minimum resolution of 2 megapixels and capable of taking a clear retinal image under normal circumstances
   (ix) Distance binocular vision test
   (x) Near binocular vision test
   (xi) Retinoscope
   (xii) Direct ophthalmoscope
   (xiii) Colour vision test chart
   (xiv) Stereoacuity test
   (xv) Macula assessment test
   (xvi) Pachymeter
   (xvii) Appropriate hand disinfection product
   (xviii) Ophthalmic drugs required for tonometry, dilation, corneal examination and other necessary ophthalmic procedures.

   (b) For mobile practices:

   (i) Distance test chart (e.g. Snellen chart)
   (ii) Trial frame, trial lenses and accessories or phoropter head
   (iii) Appropriate equipment for binocular internal eye examination (e.g. slit lamp and condensing lens or a head-mounted indirect ophthalmoscope)
   (iv) Appropriate equipment for external eye examination (e.g. slit lamp / loupe and illumination)
   (v) Reading test type
   (vi) A Goldmann type contact applanation tonometer
   (vii) Distance binocular vision test
   (viii) Near binocular vision test

(ix) Retinoscope
(x) Direct ophthalmoscope
(xi) Colour vision test chart
(xii) Stereoacuity test
(xiii) Macula assessment test
(xiv) Pachymeter
(xv) Appropriate hand disinfection product
(xvi) Ophthalmic drugs required for tonometry, dilation, corneal examination and other necessary ophthalmic procedures.

RECORDS THAT MUST BE KEPT IN ACCORDANCE WITH PARAGRAPH 8 OF SCHEDULE 1 TO THE 2006 REGULATIONS

2. An optometrist or ophthalmic medical practitioner must keep appropriate clinical records as relevant to any eye examination conducted.

3. The information recorded should follow professional guidance. In addition, the record should include:

   (a) A record of any relevant history and symptoms, to include relevant medical, family, and ocular history;

   (b) CHI number if available;

   (c) All relevant clinical details; and

   (d) A digital image (or reference to) of the retina when taken.

APPENDIX F

CONTINUING PROFESSIONAL DEVELOPMENT ALLOWANCE

1. Subject to paragraph 4, a CPD allowance shall be payable to an optometrist other than a body corporate if:

   (a) that optometrist's name was included on the Ophthalmic List of a Health Board for a period of at least six months during the previous calendar year;

   (b) the optometrist has maintained their professional registration;

   (c) the optometrist has undertaken appropriate CPD during the previous calendar year; and

   (d) the optometrist complies with paragraphs 5 and 6.

2. Subject to paragraph 4, a CPD allowance shall be payable to an ophthalmic medical practitioner if:

   (a) during the previous calendar year that practitioner's only remunerated medical or optical activity was the conduct of General Ophthalmic Services;

   (b) the practitioner's name was included on the Ophthalmic List of a Health Board for a period of at least six months during the previous calendar year;

   (c) the practitioner has maintained their professional registration;

   (d) the practitioner has undertaken appropriate CPD during the previous calendar year; and

   (e) the practitioner complies with paragraphs 5 and 6.

3. Subject to paragraph 4, an IPCPD allowance shall be payable to an optometrist other than a body corporate if:

   (a) that optometrist's name was included on the Ophthalmic List of a Health Board for a period of at least six months during the previous calendar year;

   (b) the optometrist has maintained their professional registration and has been registered as an IP optometrist during the previous calendar year;

   (c) the optometrist has been registered with a host Health Board as an IP optometrist for a period of at least six months during the previous calendar year;

   (d) the optometrist has undertaken appropriate IPCPD during the previous calendar year; and

   (e) the optometrist complies with paragraphs 5 and 6.

4. Only one CPD allowance or IPCPD allowance may be paid in respect of any one person for each calendar year in which appropriate CPD or IPCPD was undertaken by that person.

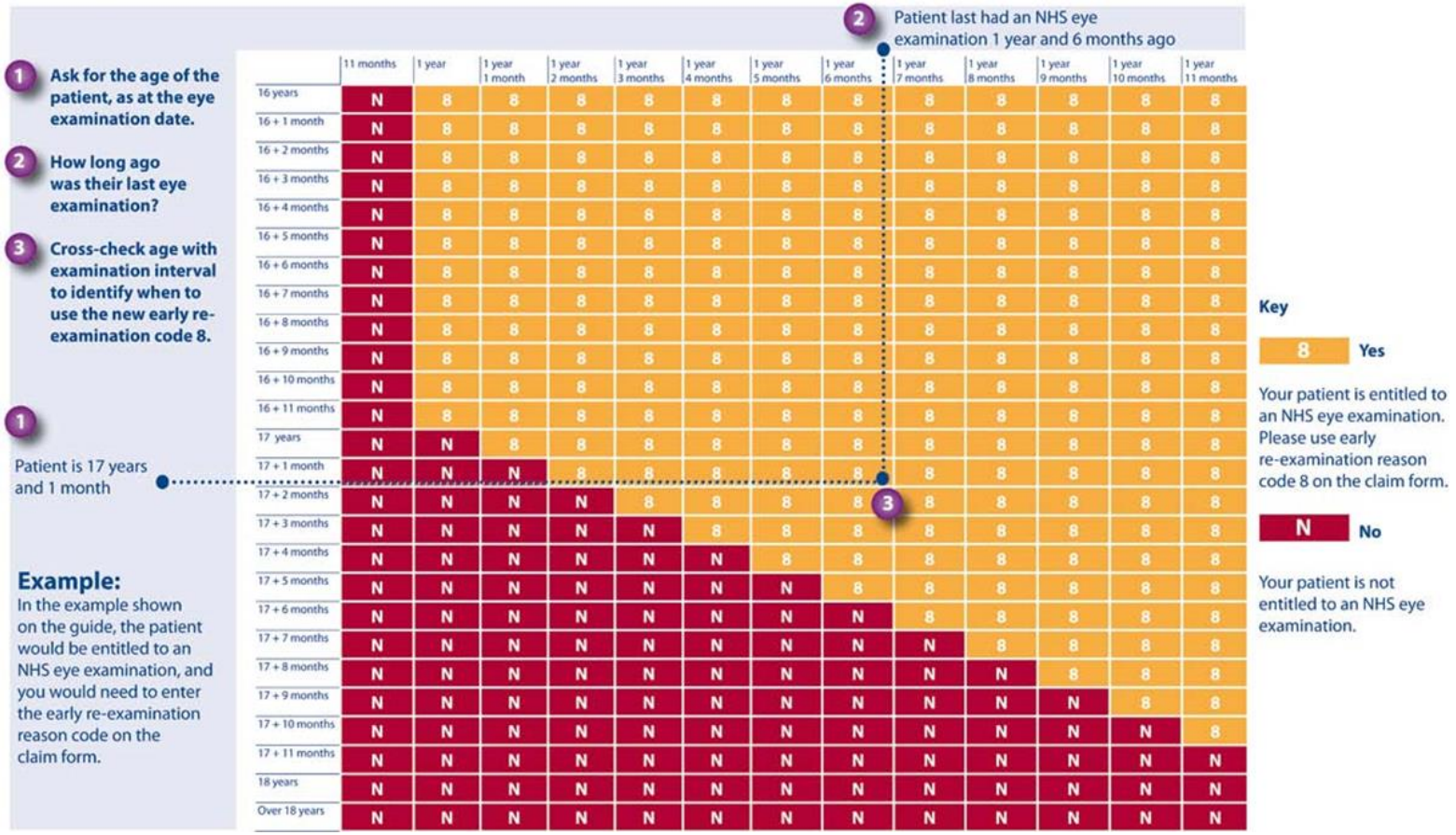
5. A claim for a CPD allowance or IPCPD allowance shall be made in writing on the form provided for this purpose by the Agency.

6. A claim for a CPD allowance or IPCPD allowance must be received by the Agency by 30 November of the calendar year following the year in which the appropriate CPD or IPCPD was undertaken.

ANNEX A

PRIMARY EYE EXAMINATION EARLY RE-EXAMINATION CODE 8 – PATIENT TURNED 16 YEARS OF AGE

As set out in Table B of Appendix B, this Annex and the guide chart below is to be used by optometrists and ophthalmic medical practitioners when determining whether a patient who has turned 16 years of age (and does not have diabetes and/or is not sight impaired or severely sight impaired) is eligible to an early re-examination under code 8.



ANNEX B

PRIMARY EYE EXAMINATION ENTITLEMENT - SIGHT IMPAIRED AND SEVERELY SIGHT IMPAIRED PATIENTS

1. As set out in Table A of Appendix B, this Annex is to be used by optometrists and ophthalmic medical practitioners for the purposes of determining a patient's entitlement to an annual primary eye examination because they are sight impaired or severely sight impaired.

Sight Impaired

2. There is no legal definition of sight impaired. A person can be sight impaired if they are "substantially and permanently functionally impaired by defective vision caused by congenital defect or illness or injury".

3. As a general guide, people who have visual acuity of the following should be considered as being sight impaired:

   (a) 3/60 to 6/60 Snellen (or equivalent) with full field;

   (b) up to 6/24 Snellen (or equivalent) with moderate contraction of the field, opacities in media or aphakia;

   (c) 6/18 Snellen (or equivalent) or even better if they have a severe field defect, for example hemianopia, or if there is a contraction of the visual field, for example in retinitis pigmentosa or glaucoma.

Severely Sight Impaired

4. Although there is no legal definition of severely sight impaired, it is considered to be the same as the definition of "blind person" set out in section 64 of the National Assistance Act 1948 – "means a person so blind as to be unable to perform any work for which eyesight is essential".

5. The test is whether a person cannot do any work for which eyesight is essential, not just their normal job or one particular job. Only the condition of the person's eyesight should be taken into account - other physical or mental conditions cannot be considered.

6. Group 1: People who are below 3/60 Snellen (or equivalent)

   (a) Severely sight impaired: people who have visual acuity below 3/60 Snellen (or equivalent).

   (b) Not severely sight impaired: people who have visual acuity of 1/18 Snellen (or equivalent) unless they also have restriction of visual field. In many cases it is better to test the person's vision at one metre. 1/18 Snellen (or equivalent) indicates a

slightly better acuity than 3/60 Snellen (or equivalent). However, it may be better to specify 1/18 Snellen (or equivalent) because the standard test types provide a line of letters which a person who has a full acuity should read at 18 metres.

7. Group 2: People who are 3/60 but below 6/60 Snellen (or equivalent).

   (a) Severely sight impaired: people who have a contracted field of vision.

   (b) Not severely sight impaired: people who have a visual defect for a long time and who do not have a contracted field of vision. For example, people who have congenital nystagmus, albinism, myopia and other similar conditions.

8. Group 3: People who are 6/60 Snellen (or equivalent) or above.

   (a) Severely sight impaired: people in this group who have a contracted field of vision especially if the contraction is in the lower part of the field.

   (b) Not severely sight impaired: people who are suffering from homonymous or bitemporal hemianopia who still have central visual acuity 6/18 Snellen (or equivalent) or better.

9. Other points to consider: The following points are important because it is more likely that a person is severely sight impaired in the following circumstances:

   (a) How recently the person's eyesight failed: A person whose eyesight has failed recently may find it more difficult to adapt than a person with the same visual acuity whose eyesight failed a long time ago. This applies particularly to people who are in groups 2 and 3 above.

   (b) How old the person was when their eyesight failed: An older person whose eyesight has failed recently may find it more difficult to adapt than a younger person with the same defect. This applies particularly to people in group 2 above.