LOCSU and Optical Confederation Response to the RCOphth Glaucoma Commissioning Guidance Consultation

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Dear Beth

Many thanks for giving our organisations the opportunity to respond to this Commissioning Guidance on Glaucoma. This is a joint response from the Optical Confederation and LOCSU as members of the Clinical Council for Eye Health Commissioning with whose full support the Royal College is developing this guidance.

Overall we found this to be very comprehensive and fully support the view that a high value care pathway for glaucoma needs to include providers in the community as well as the hospital eye service.

We would like to make the following comments:

1. We agree with section 3 p7 in the short version of the Guide that 'commissioners of glaucoma care should work in partnership with a range of stakeholders including service users and carers, community optometry services, general practitioners, health and wellbeing boards, the HES, community pharmacy services, established local networks, social care, rehabilitation officers for the visually impaired, voluntary organisations, and adjacent clinical commissioning groups'.

   Local Eye Health Networks are a formal part of the structure of NHS England and should be recognised in this document, so we suggest replacing the words 'established local networks' with 'Local Eye Health Networks (LEHNs) and any other established local networks' for clarity. We suggest replacing 'community optometry services' with 'community optical and optometry services'.

   We would also suggest on p14, Box 1 adding to the final bullet under condition "tested for free under the NHS at an optical practice".

2. We have some concerns about the requirements for higher glaucoma qualifications in Tables 1a and 1b p9/10 and Table 2 p18, particularly when compared with qualifications and competencies required for the national eye care services in Scotland and Wales. We also note that the Scottish Intercollegiate Guidelines Network (SIGN) have recently published a national clinical guideline SIGN 144 'Glaucoma Referral and Safe Discharge'.[1] The NHS Scottish General Ophthalmic Services (GOS) have been different from those in England since 2006 and include a more comprehensive range of additional tests and procedures to be undertaken as a part of a primary eye examination, depending on the signs and symptoms of the patient.

[1] SIGN 144 Glaucoma referral mand safe discharge March 2015: http://www.sign.ac.uk/guidelines/fulltext/144/index.html

This has particular relevance to glaucoma case finding; these additional tests would currently need to be commissioned locally as an enhanced community service by CCGs in England to provide a similar level of service.

In Wales there is a National Wales Eye Care Service (WECS).[2] This service was launched in January 2013 and replaced the previous 'Welsh Eye Health Examination' (WECI) which was first introduced in 2002 and fully evaluated in 2006, and again in 2009[3].

Neither the Scottish GOS, supported by SIGN 144, nor WECS require higher glaucoma qualifications for enhanced case finding (repeat measures plus) or monitoring of OHT/suspect glaucoma. Thus Tables 1a and 1b on pp 9/10 of the Commissioning Guidance are inequitable with requirements in both Scotland and Wales and we believe should be reconsidered.

These tables also state that 'optometrists or HCPs with the highest level of specialist training, competence and experience as specified by NICE' usually deliver care in the HES and rarely in the community. This may be true at the present but should not limit future opportunities for such practitioners to work in any setting. The only reason that most currently work in the HES is due to the current requirements for a large number of case histories to attain the qualification.

Finally, we suggest that since all registered optometrists have the competencies to level 1 and in most cases level 2 functions in table 2, having a list of optometrists with a higher qualification (ie level 3 and 4) may only serve to create confusion for patients who could attend any optometrist for level 1 and 2 functions.

3. As the Commissioning Guidance correctly states in Table 2 p18, such services already commissioned in England have 'local refresher training/accreditation in common use'. LOCSU (LOC Support Unit), in association with WOPEC (Wales Optometry Postgraduate Education Centre), developed a distance learning package for such glaucoma community services which is in alignment with the requirements of WECS with a practical skills assessment. This is an accepted national level of training and accreditation. We therefore do not support any requirement for community optometrists to have the College of Optometrists Professional Certificate.

4. Regarding the levels of competency in Table 2 p18 of the Commissioning Guidance, it is our strong opinion that:

'Monitoring (but not altering the treatment of) people with an established diagnosis and management plan for OHT or suspected glaucoma'

should be Level I not II.

In addition, the following competencies are core competencies for optometrists ie Level I rather than Level II

[2] Wales Eye Care Services; http://www.eyecare.wales.nhs.uk/eye-health-examination-wales

[3] Br J Ophthalmol. 2009 Apr;93(4):435-8. Epub 2008 Nov 21. Novel optometrist-led all Wales primary eye-care services: evaluation of a prospective case series. Sheen NJ, Fone D, Phillips CJ, Sparrow JM, Pointer JS, Wild JM.
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- slit lamp mounted Goldmann applanation tonometry
- stereoscopic slit lamp biomicroscopic examination of the anterior segment
- Van Herick's peripheral anterior chamber depth assessment
- examination of the posterior segment using slit lamp binocular indirect

This opinion is supported on p24-25 of the Guidance: 'The specific tests which identify a person to have primary angle-closure rather than open-angle disease are slit lamp examination with Van Herick's peripheral anterior chamber depth assessment and gonioscopy. The skills and associated equipment for gonioscopy are not routinely available in every community optometric practice, but every practice should have a slit lamp, and clinical examination of the anterior ocular segment and assessment of the risk of angle closure are part of core competence for all optometrists (Table 2, Level I).'

CCT measurement is Level I or II rather than Level III and it is considered a core competency in Scotland and for WECS accredited optometrists in Wales. 2 of the 7 Health Boards in Wales have issued optometric practices with pachymeters to use as part of WECS and NHS Scotland is currently considering this in Scotland as they also regard it as core competency.

5. A requirement to have the College Certificate in Glaucoma for enhanced case finding plus monitoring of OHT/suspect glaucoma would act as a barrier for any such future services due to the extra time and cost involved in attaining the extra qualification. It would also mean that those services already commissioned and working perfectly safely would be at risk.

6. We are concerned that there is no declaration of conflict of interest from the College of Optometrists representatives on the working group in section 10.6 on p 47 of the long version of the Guidelines given that the Higher Qualifications developed by the College of Optometrists are promoted in the document. We feel that this omission has the potential to compromise the independence of the Group as a whole.

7. It is important that all Health Care Professionals are expected to have similar minimum levels of competence, experience and qualifications, ie orthoptists, ophthalmic nurses as well as GPs with a specialist interest in ophthalmology.

8. We understand the reasoning for the risk stratification approach that has been adopted within the guidance for management of patients with various classes and stages of conditions but are concerned about the ramifications of this because patients may not fit neatly into such boxes. In our opinion there are cases when a patient with COAG could be of low risk of visual impairment in their lifetime, for example a 90 year old with early COAG (minimal field loss) and no change in clinical status or management for 10+ years. Such patients could be safely monitored in the community and would be less likely to be lost to follow up and to have follow-up appointments postponed or cancelled than in the hospital eye service. Even some patients with secondary glaucomas which are classified within the guidance as always being high risk, for example neovascular glaucoma secondary to CRVO or diabetic retinopathy with a blind eye, can have in the past been safely discharged from the hospital eye service providing the eye is comfortable.

9. We note that pp 20 and 24 reference GOS 18. We believe this may be an error and the number should be deleted: it is GOS that does not allow for additional testing, GOS 18 is simply a general referral form.