Optical Confederation and Local Optical Committee Support Unit College of Optometrists' Consultation: Glaucoma and Low Vision Higher Qualifications

Optical Confederation and Local Optical Committee Support Unit

The Optical Confederation represents the 13,000 optometrists, 6,000 dispensing opticians, 7,000 optical businesses and 45,000 ancillary staff in the UK, who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of the five optical representative bodies: the Association of British Dispensing Opticians (ABDO), the Association of Contact Lens Manufacturers (ACLM), the Association of Optometrists (AOP), the Federation of Manufacturing Opticians (FMO) and the Federation of Opticians (FODO). As a Confederation, we work with others to improve eye health for the public good.

The Local Optical Committee Support Unit (LOCSU) provides quality, practical support to Local Optical Committees (LOCs) in England to help them to develop, negotiate and implement local objectives in respect of primary ophthalmic services.

Consultation general comments

We have some general comments to make for both low vision and glaucoma and then answers in response to the questions. Please see below for our general comments on each qualification:

General comment on Low Vision: Professional Certificate in Low Vision

Our main concern with the College's Higher Qualifications for Low Vision is that these do not become expected or required for the Low Vision Primary Care Service.

General comments on the combined Glaucoma Higher Qualifications

Our main comment on the combined Glaucoma Higher Qualifications is that NICE is currently reviewing the Clinical Guidelines (CG) on Glaucoma CG:85 and all current evidence, which could impact upon the content of these qualifications. The scope of

the new CG will include referral as well as diagnosis, treatment and monitoring of ocular hypertension (OHT), suspect glaucoma and chronic open angle glaucoma (COAG). This should be out for consultation in May or June. We question the appropriateness of the timing of the College of Optometrists' consultation given this. Furthermore, when seeking the pragmatic professional expansion of higher qualifications all considerations should be taken into account – with these not being restricted to clinical opinion alone.

The Royal College of Ophthalmologists (RCOphth) produced NICE accredited Commissioning Guidance on Glaucoma in June 2016; wording and definitions used in the qualification documents should reflect this.

We have an issue with the current wording relating to the potential involvement of optometrists in the training process which is as follows:

> Training should also incorporate a structured clinical placement in an appropriate ophthalmic care setting under the direction of a sub-specialist ophthalmologist mentor (although it is anticipated that specialist optometrists could be involved in the training process).

Our concern is that this makes the qualification almost out of reach of the large majority of community optometrists and places an immediate cap due to the lack of available hospital positions and consultant supervision. To help alleviate these problems, we pose the following questions:

1. Could training be predominantly under the supervision of a higher qualified glaucoma optometrist to allow for cascade?
2. Could problem-based learning make up a percentage of the total case load?

We also challenge the levels of cases for portfolios, which we consider to be too high. In addition, we consider that the requirements of the accreditation panel are too onerous for some course providers. There is the clear risk that such onerousness may preclude participation and thus potentially constrain professional development. Lastly, any patient discharged (e.g. treated for acute angle-closure glaucoma) will not require anyone to be accredited in order to manage (as they are discharged).

General comment on Professional Certificate in Glaucoma

In addition to monitoring patients with diagnosed OHT and Suspect COAG who have an established management plan, add *'those with primary angle closure (PAC) who have been successfully treated & have been demonstrated to have non-occludable angles.'*

General comments on Professional Higher Certificate in Glaucoma

We are concerned over the lack of availability of courses for the Professional Higher Certificate in Glaucoma despite these being drafted more than five years ago.

The text 'Programme to prepare optometrists to diagnose OHT and COAG and to monitor patients with diagnosed OHT (on treatment or in the absence of a management plan) (Higher Certificate Level)' should change to 'Programme to prepare optometrists to diagnose OHT and suspect glaucoma and to *manage* patients with OHT & suspect glaucoma'.

General comments on Professional Diploma in Glaucoma

As with the Professional Higher Certificate in Glaucoma we are concerned over the lack of availability of courses for the Professional Diploma in Glaucoma despite these being drafted more than five years ago.

Consultation question responses

Please see below for our response to the specific consultation questions, broken down into qualification types:

1. What, if any, are the significant changes in the knowledge or treatment of the condition which may require a change in content of the qualification? Please reference any source documents you would like us to review.

Low Vision: Professional Certificate in Low Vision

We do not have any particular comments on the content. The main 'changes in knowledge or treatment' will be emerging treatments for AMD and advances in fields such as gene therapy and in technology such as 'bionic eyes'; however, most of these are still at the research stage.

Professional Certificate in Glaucoma

This should be in the new NICE Clinical Guideline which will hopefully be available in the Autumn.

Professional Higher Certificate in Glaucoma

This should be in the new NICE Clinical Guideline which will hopefully be available in the Autumn.

Professional Diploma in Glaucoma

Monitoring of patients with treated angle closure glaucoma who have been successfully treated and have been demonstrated to have non-occludable angles does not require the Diploma in Glaucoma: see Royal College of Ophthalmologists Commissioning Guide on Glaucoma.

2. Are there any specific learning outcomes or parts of the indicative content that are out of date? If so, please state them, referencing the learning outcome number and the item of indicative content.

Professional Certificate in Glaucoma

Following completion of the programme, an optometrist should be able to demonstrate (our amendments in italics):

[a] an ability to take a comprehensive ophthalmic history in a patient with diagnosed OHT or suspect COAG *or treated PAC.*

[b] an awareness of demographic, ocular and systemic risk factors for COAG *and primary angle closure glaucoma (PACG).*

[k] an awareness of timescales for follow-up of patients with diagnosed OHT and suspect OHT *and treated PAC.*

Professional Higher Certificate in Glaucoma (our amendments in italics)

[c] an ability to make appropriate management decisions in a patient with OHT and *suspect glaucoma.*

[d] an ability to monitor the response to treatment in a patient with OHT or *suspect glaucoma* and modify the management plan or refer if necessary.

(c) Secondary glaucomas:

We think that this should be in the Higher Certificate as it is required for differential diagnosis of OHT.

•Exfoliation syndrome and exfoliative glaucoma (PXF)

•Pigmentary glaucoma (PDS)

•Other causes of secondary glaucoma

(e) Principles of management of primary angle closure and PACG:

Again, this (e) should come under the Certificate, as treated PAC can be monitored with a lower level of qualification.

3. Are there any comments you wish to make about the assessment requirements in the qualification?

Professional Higher Certificate in Glaucoma

The current requirements states:

> During the placement, the trainee should have an active involvement in each patient episode. It is anticipated that the complexity of the case mix should gradually increase as clinical experience develops. From experience of existing training programmes for optometrists with a specialist interest in glaucoma, it is recognized that the number of patient episodes required to achieve competence varies considerably. However, at least 150 patient episodes of varying diagnosis and complexity are required for an individual to become competent at higher certificate level. As a guide, placements are likely to need to be of approximately 6 months' duration on a one session per week basis in order to achieve the necessary experience, case exposure and patient numbers.

In our view this seems overly onerous and difficult for most optometrists to achieve. There is the possibility for accreditation of prior learning (APL) as follows:

> APL may be awarded to candidates as appropriate. It should be noted that the APL must be specific to the units and certificates already held by candidates. APL can count for no more than one third of the programme.
>
> Candidates may be eligible for exemption from the clinical placement through accreditation of prior learning. The criteria for exemption are:
>
> 1. Candidates must be current practitioners with relevant experience in glaucoma management within a hospital, clinic or other appropriate setting
> 2. Candidates must present a portfolio of at least 150 patient episodes; patients should be seen within a hospital, clinic or other appropriate setting
> 3. The portfolio evidence must include details of relevant, specific workplace assessments which directly match the clinical skills learning outcomes in the College of Optometrists' Glaucoma professional higher certificate
> 4. Items of evidence within a portfolio have a currency of two years.

The course provider must ensure that this portfolio is assessed by at least two assessors, using a formal process which is explicit, reliable, and valid and fits into the quality assurance framework of their course.

<u>Professional Diploma in Glaucoma</u>

Again, the patient number requirement makes the delivery of courses very expensive hence only Moorfields/UCL have been able to provide the course for this, and this took a period of years to establish. Presently, the assessment requirements are:

> From experience of existing training programmes for optometrists with a specialist interest in glaucoma, it is recognized that the number of patient episodes required to achieve competence varies considerably. However, at least 250 patient episodes of varying diagnosis and complexity are required for an individual to become competent at diploma level. As a guide,

placements are likely to be of approximately 12 months duration on a one session per week basis in order to achieve the necessary experience, case exposure and patient numbers.

Thus, the requirement is fifty-two sessions – a huge undertaking.

We have a further comment on the passage below:

> Accreditation of prior learning (APL) may be awarded to candidates as appropriate. It should be noted that the APL must be specific to the units and certificates already held by candidates. APL can count for no more than one third of the programme.
>
> Candidates may be eligible for exemption from the clinical placement through accreditation of prior learning (APL).
>
> The criteria for exemption are:
>
> 11. candidates must be current practitioners with relevant experience in glaucoma management within a hospital, clinic or other appropriate setting
>
> 12. candidates must present a portfolio of at least 250 patient episodes; patients should be seen within a hospital, clinic or other appropriate setting
>
> 13. the portfolio evidence must include details of relevant, specific workplace assessments which directly match the clinical skills learning outcomes in the College of Optometrists' Glaucoma professional diploma
>
> 14. items of evidence within a portfolio have a currency of two years.
>
> The course provider must ensure that this portfolio is assessed by at least two assessors, using a formal process which is explicit, reliable, and valid and fits into the quality assurance framework of their course.

To put this in perspective, the requirement for the IP clinical placement is a minimum of twenty-four sessions of not less than three hours (twelve days).

Conclusion:

We would like to reiterate our primary concern regarding the lack of availability of courses for the Higher Certificate and Diploma in Glaucoma, despite these being over five years' old. Impediments to availability must be addressed.

There has been very little demand for glaucoma qualifications over the last few years and we consider that if there is no relaxing of requirements this is unlikely to change. There is the risk that the qualifications in their current format will be seen as agreed/approved by the profession and therefore be incorporated into the next NICE review, resulting in minimum practitioner participation.

With regards to low vision there is already a recognised shortage of available services. Future expansion of services should not be tied to holding College qualifications.

We would appreciate a response to our concerns and/or a meeting to discuss them before the Optical Confederation can support or recommend these proposals to members.

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