Glaucoma (update)

Consultation on draft scope – deadline for comments 5.00pm on 16 June 2016
email: glaucomaUpdate@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly or arrive after the deadline. We would like to hear your views on these questions: 1. Which interventions or forms of practice might result in cost saving recommendations if included in the guideline? Developing NICE guidance: how to get involved has a list of possible areas for comment on the draft scope.
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	**Optical Confederation + LOC Support Unit**
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	**None**
Name of person completing form:	**Sophie Pavlovic**
Type	[for office use only]

Comment No.	Page number or **'general'** for comments on the whole document	Line number or **'general'** for comments on the whole document	Comments Insert each comment in a new row. Do not paste other tables into this table, as your comments could get lost – type directly into this table.
Example	3	55	The draft scope currently excludes people who have already been diagnosed. We feel this group should be included because….

1	General	General	We are very pleased that the vital role that community optometrists play in glaucoma case finding & their potential role for ongoing monitoring has been recognised. As the scope of the review of the NICE guidelines for Glaucoma has been expanded to include the important role that community optometrists have to play in glaucoma care it is essential that there is adequate representation from community optometrists on the Glaucoma guideline committee. NICE are in the process of recruiting members for this committee & we see that there are 4 consultant ophthalmologists, 2 community optometrists with an interest in glaucoma & 1 glaucoma trained optometrist so the balance is more towards hospital eye services rather than community. The range of community IOP and glaucoma practice is very wide - having evolved to meet the requirements of different hospital and commissioner models. To ensue this is captured we would strongly advise that there be three community optometrists, as well as a hospital optometrist (different type of clinician), with experience of the range of community service models in the community as well as straightforward referral, on the working group to ensure the full scope of community practice, model options and future possibilities is considered.
2	General	General	It is important for NICE to recognise that NHS capacity for addressing the rising and unidentified levels of glaucoma in the population includes not only hospitals but also community ophthalmic services (commissioned locally just as hospital services are). They are both part of a continuum and need to be considered together, especially as the community sector has fewer workforce and facilities constraints than the hospital sector and can flex more easily to meet demand.
3	General	General	Although the tone of the surveillance report still reads as if the main issues are about hospital capacity, it is nevertheless reassuring to see that, this time round, the important role that community optometry plays in glaucoma case finding, pressure checking and ongoing monitoring has been recognised and included within the scope.
4	General	General	NICE should also be aware of the wider roles that optometry can play both within core skills and with higher training and qualifications to help the NHS respond to growing demand and unidentified need.

Please add extra rows as needed

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5	General	General	From our perspective it is therefore essential that, this time, there is adequate involvement of community optometry on the guideline committee including optometrists engaged in glaucoma care with both core and advanced skills.
6	4	1-4	LOCSU has developed a Glaucoma repeat readings & OHT monitoring pathway http://www.locsu.co.uk/community-services-pathways/glaucoma-and-oht/ We also collated all the evidence as part of our response to the Call to Action for Eye Health 2 years ago: http://www.locsu.co.uk/uploads/call_to_action/copy_of_community_services_summary_september_2014_3.pdf
7	12	19-23	The reason that recommendations for repeat measures & referral refinement in the NICE QS7 didn't fully resolve the problem is due to many CCGs not commissioning repeat readings services as advised in the NICE Commissioning Guide. Any possible amendments will still need resourcing to solve the problem.
8	13	6	Instead of 'clarify the role of optometrists' we suggest 'take account of the role of community optometrists'
9	13	8-13	It gives us no pleasure to note that, as we warned NICE in 2008, "an unintended consequence of publication of CG85 in 2009 was high levels of false-positive referrals to hospital eye services". This was entirely predictable but the influence of the community sector in CG85 was limited and the warnings ignored. We now face a situation in which the Royal College of Opthalmologists are warning (March 2016) that patients are losing their sight because of capacity pressures in hospitals. It is important that the work on these guidelines does not increase those pressures without evidence to justify referrals to hospital. Our exact response to the consultation is in the cell below;

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10			Currently a very large number of patients with intraocular pressure greater than 21 mm Hg, but with no other signs of glaucoma, are being successfully monitored by optometrists in the community with no evidence of visual loss occurring as a result. One of the recommendations of the draft guidance is that OHT should be formally diagnosed for intraocular pressure greater than 21 mm Hg; a diagnosis requiring assessment of the anterior chamber angle by gonioscopy. Currently few optometrists are competent to perform gonioscopy (although all could be) and in order to conform with their legal and ethical obligations they will have no option but to refer all of these patients for a formal diagnosis before continuing to monitor them in the community. Unless the introduction of the guidelines is properly managed over a realistic timeframe many thousands of patients will be referred for a diagnosis over a very short period of time, overwhelming hospital eye departments with many false positive patients. We fear this sudden influx of very low risk, visually normal, patients will potentially disrupt the care of existing diagnosed patients, with a serious risk of unnecessary disease progression and visual impairment. If implemented we believe this guideline should be phased in, preferably over a 3 to 5 year timescale
12			
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Checklist for submitting comments

- Use this form and submit it as a **Word** document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include page and line number (not section number) of the text each comment is about.
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, do not include attachments such as research articles, letters or leaflets. We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.

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