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HealthHarmonie Limited

Glaucoma/OHT/IOP Services Guide

V1.0

2017

Contents

Introduction

This document is a guide for the delivery of glaucoma services within the Community. Guidance is based on information from Royal College of Ophthalmologists.

Qualifications of staff

Staff	Repeat Measures (IOP & Fields, Optic Disc Normal	Enhanced Case Finding (Repeat Measures plus)	Referral Refinement with Diagnosis of OHT/COAG suspect	Glaucoma Diagnosis
Community Optometrist (HCP) Core competence ***	✓	X	X	X
Community Optometrist (HCP) CoO Professional Certificate in Glaucoma (or equivalent)	✓	✓	X	X
Optometrist (HCP) with specialist training, competence and experience as specified by NICE. Care may be delivered in Community or Outreach setting. CoO Professional Higher Certificate in Glaucoma (or equivalent) ≈ Glaucoma Certificate A	✓	✓	✓	X
Optometrist (HCP) with highest level specialist training, competence and experience as specified by NICE. Care usually in HES (inc. outreach) and rarely in a Community Optometric setting. CoO Professional Diploma in Glaucoma (or equivalent) ≈ Glaucoma Certificate B	✓	✓	✓	X
Consultant Ophthalmologist	✓	✓	✓	✓

Courtesy of the Royal College of Ophthalmologists 2016

Experience, Qualifications and Competencies

The term competence implies proficiency, i.e. familiarity based on regularly performing and interpreting an examination or procedure.

Local foundation level or core competence refresher training as provided by LOCSU/WOPEC is widely undertaken in current schemes for some low risk subgroups of patients. Joint College Guidance allows for defined low risk subgroups who do not require treatment to not be referred. Similarly, people not requiring treatment who have been monitored for a period and who have been found to be stable are advised by NICE to attend their optometrist for annual visits (e.g. people with mild OHT and increased CCT). A repeat measures scheme may provide a useful context for observation of these subgroups of low risk individuals who do not require formal monitoring.

Consultant supervision should be in line with the joint college guidance in relation to glaucoma-related care by optometrists.

	Level 1	**Level 2**	**Level 3**	**Level 4**
Type of Care	Case finding; Repeat measures (IOP/Fields only, optic disc appearance normal) * Observation of individuals not requiring referral (Joint College Guidance) and stable individuals off treatment discharged to annual optometric visits (CG85).	Enhanced Case Finding (IOP and other measures); Monitoring (but not altering the treatment of) people with an established diagnosis and management plan for OHT or suspected glaucoma (Level 1 activities also permitted)	Diagnosis of OHT/COAG suspect; Management of OHT and suspected glaucoma (Level 1 & 2 activities also permitted)	Management of established glaucoma where a diagnosis has been made by a consultant ophthalmologist (or someone working under their supervision) (Level 1,2 & 3 activities also permitted)
Experience/ qualification/ supervision	Core competence for optometrists	CoO Professional Certificate in Glaucoma, or equivalent. (Prior to this CoO qualification local refresher training and accreditation in common use.)	Specialist qualification (CoO Professional Higher Certificate in Glaucoma, or equivalent, or Glaucoma Certificate A), or working under supervision of a consultant ophthalmologist**	Specialist qualification (CoO Professional Diploma in Glaucoma, or Glaucoma Certificate B), or equivalent, or working under supervision of a consultant ophthalmologist**
Competency and familiarity in performing and interpreting	Goldmann type applanation tonometry • standard automated perimetry • central suprathreshold perimetry	As per Level 1, and: • experience and ability to detect a change in clinical status from normal to abnormal • slit lamp mounted Goldmann	As per Level 2, and: • medical and ocular history • differential diagnosis • gonioscopy • CCT Measurement NB. Optometrists working at Level III	As per Level 3, and should be trained and able to make management decisions on: • risk factors for conversion to glaucoma • coexisting pathology

	• anterior segment examination	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 ophthalmoscopy	who in addition have prescribing rights (Independent prescribing / supplementary prescribing / patient group directions) may themselves prescribe or supply (initiate or alter) topical treatment for people with OHT / COAG Suspect (fields and discs normal or equivocal). Those without prescribing rights can do so in conjunction with a prescriber.	• risk of sight loss • monitoring and clinical status change detection • pharmacology of IOP lowering medications • Advise treatment changes for COAG, COAG suspect status and OHT (with consideration given to relevant contraindications and interactions) NB. Optometrists working at Level 4 who in addition have prescribing rights may themselves prescribe topical treatment for people with an established diagnosis of COAG

Be aware that holding an independent or non-medical prescribing qualification alone (without a specialist qualification relevant to the case complexity of glaucoma being managed) is insufficient for managing glaucoma and related conditions.

Clinical assessment of first attendance as suspect

The clinical staff member is responsible for determining the level of examination as per the clinical information provided. If only IOP raised by NCT (fields normal from community optom) – IOP refinement only and proceed only if IOP raised. Otherwise protocol as below

History and symptoms

The clinician should:

- Ask the patient specific questions relating to their condition.
- Take history of the patient, including personal medical and ocular history, including medications and eye drops
- Take details of any family ocular history

Anterior Segment

- Slit lamp examination, including, Cornea, iris, lens (check for PDS and pseudo exfoliation)
- Anterior chamber angle examination – van Herick
- Intra-ocular pressure by GAT (or Perkins) – if raised perform visual fields
- Pachymetry
- Central corneal thickness (CCT) measurement.

OCT

All patients should have an OCT image taken as part of their diagnostics – peripapillary rnfl and anterior chamber angle if raised IOP

Visual Fields

Full threshold testing should be undertaken on those patients with high pressures and/or suspect/abnormal scans.

Optic disc assessment

Dilated 78D examination

At the time of diagnosis of ocular hypertension (OHT), assess risk of future visual impairment, taking account of risk factors such as:

- level of IOP
- CCT
- family history
- life expectancy

Outcomes

- Discharge with education
- Follow up for monitoring
- Onward referral (this will be reviewed by consultant, unless onward referral is for cataract surgery)
- After referral, consider an early assessment appointment when there is clinical concern based on the information provided.

All patients should be provided with:

- Education
- Discussion of lifestyle changes and self-management plans
- Information on support and further guidance
- Advice on returning or seeking advice

Diagnosis

From their appointment a patient may have the following diagnoses:

Normal – No current OHT or COAG

OHT – Elevated eye pressure with open angle but no damage to visual field or optic nerve head.

Likely COAG or secondary glaucoma – raised IOP, visual field loss and corresponding optic disc/rnfl damage + or – signs of secondary glaucoma

Suspected COAG –Typical visual field loss and/or related optic nerve damage/OCT abnormality

A diagnosis of Glaucoma can only be made following review from a Consultant Ophthalmologist

Transfer of patients to the Secondary Care

In the following situations a patient should be transferred to secondary care for treatment

If a patient presents with very high pressure (>35mmHg) and is in immediate risk refer urgently to eye casualty.

A patient should be referred on to secondary care if

- Their IOP cannot be reduced to acceptable levels using prescribed treatments – Ensure that eye drop instillation technique is reviewed
- There is progression of optic nerve head damage
- There is progression of visual field defect
- They are intolerant of the drug
- There is ocular comorbidity identified
- The patient does not have capacity (as defined by the mental capacity act)

Transfer of patients out of the Secondary Care

Patients will be eligible for transfer into the Community Ophthalmology Service if they meet the below criteria:

- Patients 50 years plus
- No deterioration optic disc and visual field over 2 year period
- Patients to be on no more than 2 different eyedrop medications, only one of which can a combined drop
- Not on Acetazolamide
- Vision 6/18 or better in both eyes
- Visual field MD <10dB on 24/2 field
- The patient has capacity (as defined by the mental capacity act)
- Diabetic with risk of Diabetic Retinopathy

Patients Returning to Secondary Care (Post Discharge)

At times there will be a need for a patient to return to hospital post discharge.

- There is ocular comorbidity identified
- There is progression of optic nerve head damage
- There is progression of visual field defect
- There pressures have raised above 35

Minimum Data Set

This defines the required data / information that is required to transfer a patient from the acute setting.

Requirement	Minimum Data Set	Ideal Data Set
Patient identifiable Data	✓	✓
Recall Appointment Type	✓	✓
Original Referral	☒	✓
Last Consultant Report	✓	✓
Last Diagnostic Test HRT/OCT/VF	x1	x2
Recall Date	✓	✓

Reassessment

Reassessment tests

At each assessment, offer the following tests to people with COAG, people suspected of having COAG and people with OHT:

- Goldmann applanation tonometry (slit lamp mounted)
- Anterior segment slit lamp examination with van Herick peripheral anterior chamber depth assessment when clinically indicated.

When clinically indicated, repeat gonioscopy, for example, where a previous examination has been inconclusive or where there is suspicion of a change in clinical status of the anterior chamber angle.

When clinically indicated, repeat visual field testing using standard automated perimetry (central thresholding test) for people with COAG and those suspected of having visual field defects who are being investigated for possible COAG (see tables 2 and 3 for recommended reassessment intervals).

When clinically indicated, repeat visual field testing using either a central thresholding test or a supra-threshold test for people with OHT and those suspected of having COAG whose visual fields have previously been documented by standard threshold automated perimetry (central thresholding test) as being normal (see tables 1 and 2 for recommended reassessment intervals).

When a visual field defect has previously been detected, use the same measurement strategy for each visual field assessment.

When clinically indicated, repeat assessment of the optic nerve head (for example, stereoscopic slit lamp biomicroscopy or imaging).

When a change in optic nerve head status is detected by stereoscopic slit lamp biomicroscopy, obtain a new optic nerve head image for the person's records to provide a fresh benchmark for future assessments.

When an adequate view of the optic nerve head and surrounding area is unavailable at reassessment, people should have their pupils dilated before stereoscopic slit lamp biomicroscopy or optic nerve head imaging is repeated.

When to reassess

People with COAG, suspected COAG and OHT

At each assessment, re-evaluate risk of conversion to COAG and risk of sight loss to set time to next assessment.

At each assessment, ask about general health and, if appropriate, factors affecting adherence to treatment, including cognitive impairment and any treatment side effects.

People with treated OHT (baseline IOP 24 mmHg or more) and a normal optic nerve head and visual field at most recent assessment

For people with treated OHT (baseline IOP of 24 mmHg or more) and a normal optic head and visual field at the most recent assessment:

- Use clinical judgement to assess control of IOP and risk of conversion to COAG, and reassess according to table 1.

Table 1: Time to next assessment for people being treated for OHT

Conversion from OHT to COAG	Control of IOP	Time to next assessment
Not detected or uncertain conversion	No	Review management plan and reassess between 1 and 4 months
Uncertain conversion	Yes	Reassess between 6 and 12 months
No conversion detected	No	Reassess between 18 and 24 months
Conversion	No or yes	See recommendations on the diagnosis and reassessment of COAG
Use clinical judgement to decide when the next appointment should take place within the recommended interval. Uncertain conversion includes having insufficient accurate information (perhaps because the person was unable to participate in the assessment).		

People with suspected COAG

For people with suspected COAG:

- Use clinical judgement to assess control of IOP and risk of conversion to COAG (optic nerve head damage and visual field defect), and
- Reassess according to table 2.

Table 2 Time to next assessment for people with suspected COAG

Conversion to COAG	Control of IOP	Time to next assessment
Not detected or uncertain conversion	No	Review management plan and reassess between 1 and 4 months
Uncertain conversion	Yes	Reassess between 6 and 12 months
No conversion detected	Yes	Reassess between 12 and 18 months
Conversion	No or yes	See recommendations on the diagnosis and reassessment of COAG
Use clinical judgement to decide when the next appointment should take place within the recommended interval. Uncertain conversion includes having insufficient accurate information (perhaps because the person was unable to participate in the assessment).		

People with COAG

For people with COAG:

- Use clinical judgement to assess risk of COAG progression to sight loss, and
- Reassess according to table 3.

Table 3 Time to next assessment for people with COAG

Progression of COAG	Control of IOP	Time to next assessment
Not detected	No	Review treatment plan and reassess between 1 and 4 months
Uncertain progression or conversion	No	Review treatment plan and reassess between 1 and 2 months
No progression detected and low clinical risk	Yes	Reassess between 12 and 18 months
No progression detected and high clinical risk	Yes	Reassess between 6 and 12 months
Uncertain progression or progression	Yes	Review treatment plan and reassess between 2 and 6 months

Use clinical judgement to decide when the next appointment should take place within the recommended interval.

Uncertain conversion includes having insufficient accurate information (perhaps because the person was unable to participate in the assessment).

Discharge back to primary care

Discharge people back to primary eye care services if:

- They were referred for OHT but do not need treatment
- They were referred for suspected COAG but this is no longer suspected.

Advise people that they should continue with regular visits to their primary eye care professional, at clinically appropriate intervals.

Give a discharge summary to people who have been assessed and discharged to primary care. Send a copy to their GP and, with patient consent, copy the relevant information to the primary eye care professional nominated by the patient. Advise people to take their discharge summary with them when attending future sight tests.

Treatment

Treatment for OHT

Offer a generic prostaglandin analogue (PGA) to people with IOP of 24 mmHg or more (OHT) if they are at risk of visual impairment within their lifetime.

Do not offer treatment to people with OHT who are not at risk of visual impairment in their lifetime. Advise people to continue regular visits to their primary eye care professional, at clinically appropriate intervals.

Offer another pharmacological treatment to people with an IOP of 24 mmHg or more who cannot tolerate their current treatment. The first choice should be an alternative generic PGA, if available, and if this is not tolerated, offer a beta‑blocker. If none of these options are tolerated, offer non-generic PGA, carbonic anhydrase inhibitors, sympathomimetics, miotics or a combination of treatments.

Offer a drug from another therapeutic class (beta-blocker, carbonic anhydrase inhibitor or sympathomimetic) to people with an IOP of 24 mmHg or more whose current treatment is

not reducing IOP sufficiently to prevent the risk of progression to sight loss. Topical drugs from different therapeutic classes may be needed at the same time to control IOP

Refer people whose IOP cannot be reduced sufficiently with pharmacological treatment to prevent the risk of progression to sight loss to a consultant ophthalmologist to discuss other options.

Offer preservative-free eye drops to people who have an allergy to preservatives or people with clinically significant and symptomatic ocular surface disease, but only if they are at high risk of conversion to COAG.

Treatment for suspected COAG

Do not offer treatment to people with suspected COAG and IOP less than 24 mmHg. Advise people to continue regular visits to their primary eye care professional, at clinically appropriate intervals.

Offer a generic PGA to people with suspected COAG and IOP of 24 mmHg or more, in line with the recommendations on treatment for people with OHT.

Treatment for COAG

Offer a generic PGA to people with COAG.

Offer people with advanced COAG, surgery with pharmacological augmentation (MMC) as indicated. Offer them information on the risks and benefits associated with surgery.

Offer people who present with advanced COAG and who are listed for surgery, interim treatment with a generic PGA.

Encourage people to continue with the same pharmacological treatment unless:

- their IOP cannot be reduced sufficiently to prevent the risk of progression to sight loss
- there is progression of optic nerve head damage
- there is progression of visual field defect
- they cannot tolerate the drug.

Ask about adherence to treatment and check the eye drop instillation technique in people with COAG who's IOP has not been reduced sufficiently to prevent the risk of progression to sight loss despite pharmacological treatment. If adherence and eye drop instillation technique are satisfactory offer 1 of the following:

- a drug from another therapeutic class (a beta-blocker, carbonic anhydrase inhibitor or sympathomimetic); topical drugs from different therapeutic classes may be needed at the same time to control IOP
- Secondary care referral for surgical treatment

If the drug treatment option is chosen, after trying drugs from 2 therapeutic classes, consider offering surgery with pharmacological augmentation (MMC) as indicated or laser trabeculoplasty.

Offer surgery with pharmacological augmentation (MMC) as indicated to people with COAG who are at risk of progressing to sight loss despite treatment. Offer them information on the risks and benefits associated with surgery.

Consider offering people with COAG who cannot tolerate a treatment:

- a drug from another therapeutic class (a beta-blocker, carbonic anhydrase inhibitor or sympathomimetic) or
- preservative-free eye drops if there is evidence that the person is allergic to the preservative or has clinically significant and symptomatic ocular surface disease.
- After trying drugs from 2 therapeutic classes, consider offering surgery with pharmacological augmentation (MMC) as indicated or laser trabeculoplasty.

Offer people with COAG who prefer not to have surgery or for whom surgery is not suitable:

- pharmacological treatment; topical drugs from different therapeutic classes may be needed at the same time to control IOP
- Laser trabeculoplasty or cyclodiode laser treatment.

Contacting HealthHarmonie

When sending patient information to HealthHarmonie, please use the following NHS email account.

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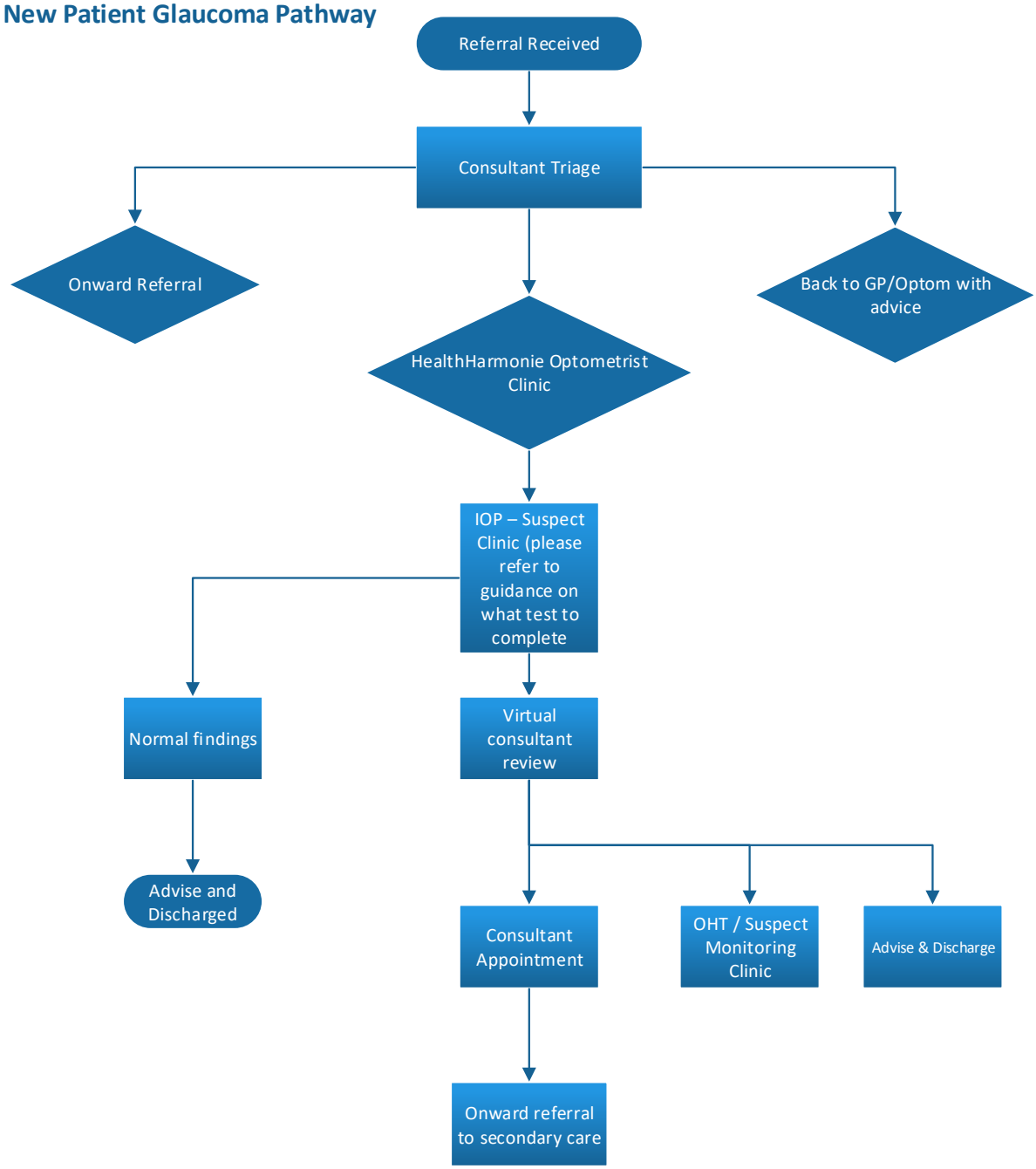
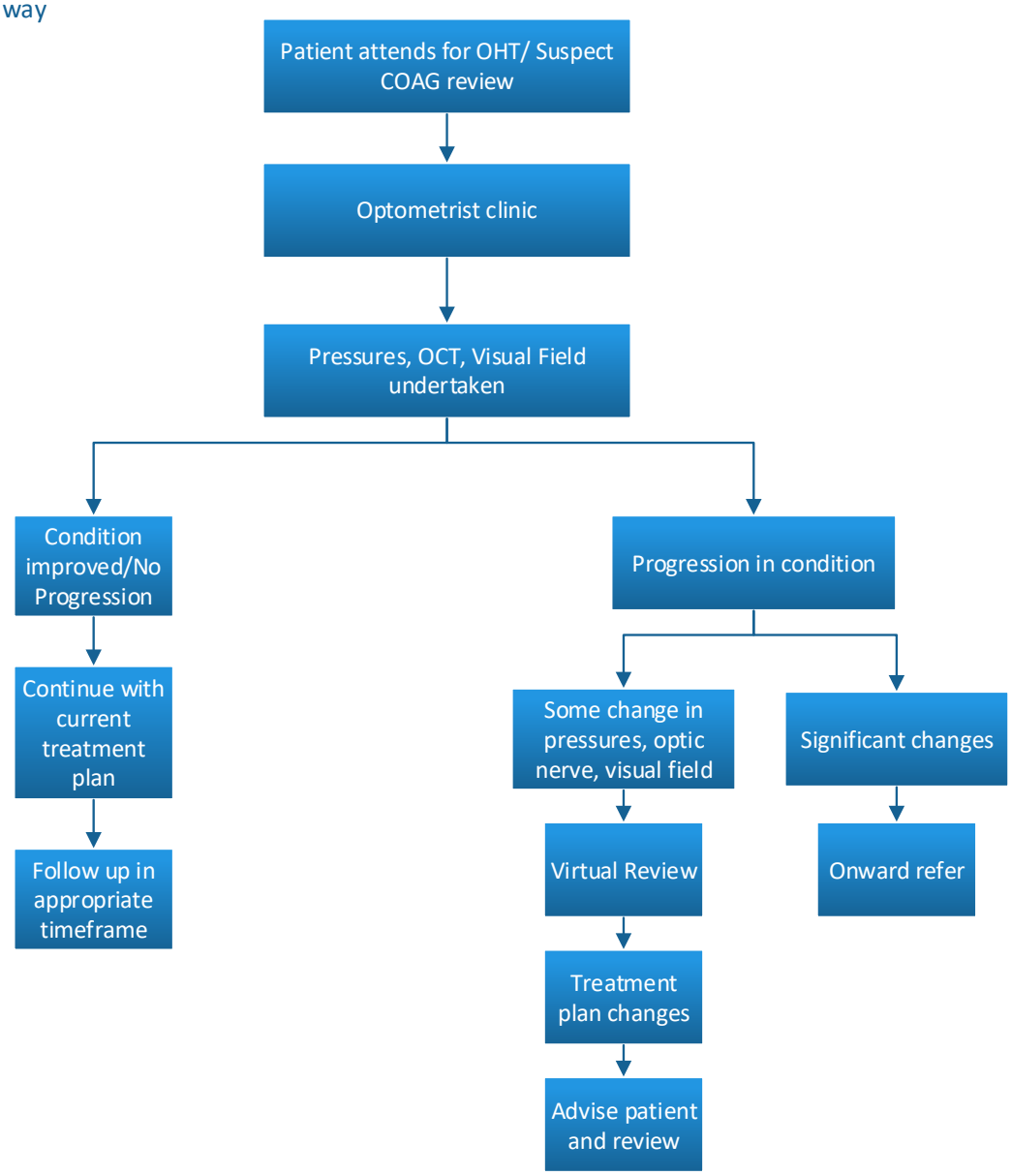
Pathway for Community Ophthalmology

New Patient Glaucoma Pathway



OHT/COAG Follow Up Pathway



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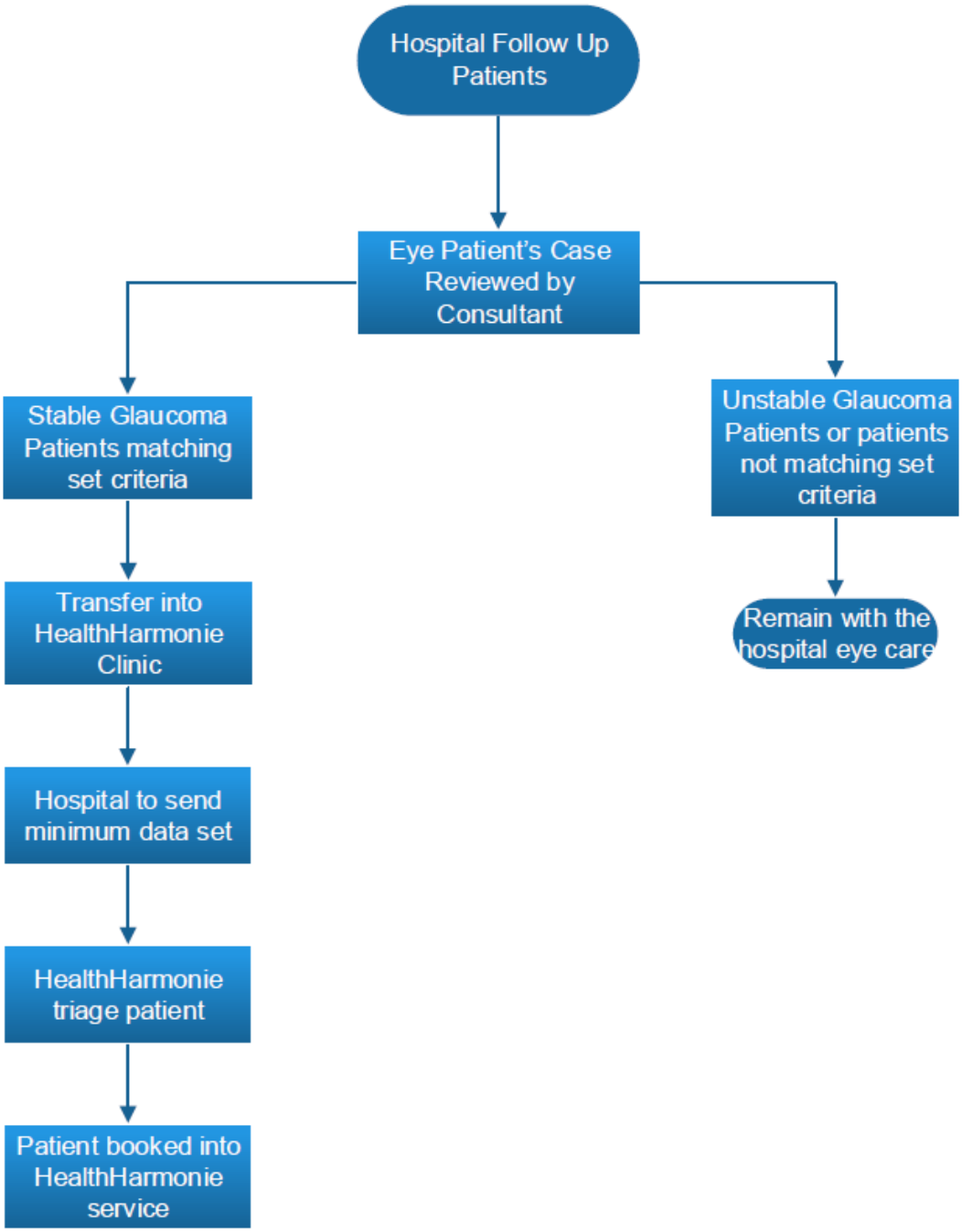

Version Control

Version	Date	Amendment(s)	Approved By
Draft F	Nov 10th 2017	We have added a flow chart for the discharge process.	Steve Vernon