Glaucoma: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
19/11/2021 to 03/12/2021

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Bausch+Lomb UK Ltd	Guideline	General	General	After careful review of the draft and then examining the evidence that underpins the recommendation for SLT in ocular hypertension or COAG, we have made the following observations that we feel may require further discussion: **The recommendations appear to be heavily reliant on the findings presented in the LiGHT RCT authored by Gazzard et al., 2019.[1]** ○ The LiGHT study does provide evidence that primary selective laser trabeculoplasty is a cost effective alternative to drops when compared over 3 years, however, the time horizon used in this trial does not provide accurate analysis for costs incurred beyond that period should a patient require additional pharmacological care ○ It may also be fair to suggest that this study might not reflect current practice, such as the medication group using a four line treatment algorithm (PGA –> BB –> CAI –> AA). Guidelines suggest using SLT earlier than this, so the costs incurred by the medication group might not be accurate. ○ IOP reduction was the main endpoint, but absolute IOP levels are not always the only indicator for risk. Another study by Kiddee and Atthavuttisilp (2017) looked at the effects of	Thank you for your comment, and you are correct that the LiGHT trial (and the modelling conducted around it) was a key source of evidence to inform the recommendations. Gazzard et al. used a combination of the LiGHT study and published data to extrapolate the costs and benefits beyond the 3 years to the lifetime of the patient in the HTA. This included additional pharmacological care after 3 years. Therefore, if a patient required further pharmacological treatment after 3 years, then this was included in the economic model, and SLT was found to be cost saving. The committee noted that, while there will always be uncertainties in any extrapolation, the consistency of results between the within trial and lifetime analyses increased their confidence in the robustness of the conclusions overall. Regarding your comment on the second bullet point, this issue has been discussed by the committee. It was acknowledged that the pathway modelled by the LiGHT trial in the medication group was not current treatment within the NHS. However, the committee felt this was not a significant limitation and the comparison of SLT and eye drops as a first-line treatment was valid. The costs of PGA (including people taking multiple PGAs)

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				travoprost vs SLT on IOP reduction and diurnal IOP fluctuations, and found that travoprost was more successful in reducing fluctuations (whereas mean IOP reduction was similar).[2]	treatment were included in the analysis cost by the LiGHT trial. The study by Kiddee and Atthavuttisilp (2017) was excluded because participants received treatment for glaucoma before entering the study which was an exclusion criterion in the protocol for this review. Additionally, the aim of the study by Kiddee and Atthavuttisilp (2017) was to evaluate the effect of 360° SLT and 0.004% travoprost on the 24-hour circadian IOP of patients with primary open-angle glaucoma and normal-tension glaucoma in habitual positions. The aim of the current update of the guideline was to evaluate the effectiveness and cost-effectiveness of SLT as a first line treatment compared to intraocular pressure-lowering eyedrops in OHT or COAG adult patients.
Bausch+Lomb UK Ltd	Guideline	General	General	**What if patients require more than one SLT treatment?** ○ Page 21 lines, 22-25 of the Evidence review document acknowledges that 15% of patients will require second arm treatment in the first year. It is good to see that this has been taken into account in the analysis. That being said, what is the economic impact of treating patients who may require further treatments beyond the first 3 years following SLT treatment? ○ A retrospective study by Ansari et al (2021) identifies that 60% of patients are likely to	Thank you for your comment. The economic model does take into account patients who need a further SLT over a year after their first treatment. The model shows patients having one or two SLT treatments before progressing on to eye drops, it does not stipulate that the second SLT must be within a certain time frame. At three years the model has 26% of patients receiving a second SLT. Even if significantly higher numbers of patients receive a second SLT (such as the 60% number reported) it still finds that SLT is cost effective compared to eye drops. It should also be noted that over a 10 year horizon it would be expected that some people in the "eyedrop" arm of the model would also

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				need an additional SLT treatment within a 10 year follow-up following their first procedure. If over half of patients are required to receive multiple treatments over 10 years, there should be questions raised about the long term cost effectiveness of this treatment.[3]	receive SLT, meeting criteria later in the guideline (such as no longer being controlled with pharmacological treatments). The retrospective study by Ansari et al (2021) was not included in the update of this guideline because it did not match the protocol for this review which states that randomised controlled trials would be considered for inclusion. However, the committee noted that with the base-case analysis showing SLT to be cost-saving, because of considerable reductions in the costs of eye drops, even if the number of repeat SLT procedures did occur at an increased amount, this would be unlikely to change the overall conclusions.
Bausch+Lomb UK Ltd	Guideline	General	General	**Patients are still likely to use of Pharmacological treatments** ○ Many patients still require IOP lowering treatment following SLT. Conflicting results from studies about average number of medication needed after SLT – some show similar to non-SLT, some show lower than non-SLT groups.[4,5]	Thank you for your comment. The model allows for patients to still receive pharmacological treatment after SLT, the cost of these are included and were obtained from the number of patients receiving eye drops after SLT in the LiGHT trial and SLT is still found to be cost saving. The committee agreed the LiGHT trial was the best source of evidence available to estimate the likely medication use for people after SLT in the UK. Reference 4 (Francis et al 2005) is a non-randomised study and therefore did not match the protocol for this review which states that randomised controlled trials would be considered for inclusion.

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					Reference 5 (Tufan et al 2017) was excluded because participants received first line treatment for glaucoma which was an exclusion criterion in the protocol for this review. The aim of the current update of the guideline was to evaluate the effectiveness and cost-effectiveness of SLT as a first line treatment compared to intraocular pressure-lowering eyedrops in OHT or COAG adult patients.
Bausch+Lomb UK Ltd	Guideline	General	General	**Economic analysis is robust for SLT in the identification of small financial savings but detailed analysis on the indirect costs on the impact of practice appears to have been overlooked** ○ Gazzard et al., (2019) calculates that the cost of eye drops for a patient at £4,228 over a 3 year period with SLT costing £4,119 by comparison.[1] Is the saving of £36.40 a year significant enough to justify SLT being positioned as first line therapy for all patients? ○ The health technology assessment of Gazzard et al., (2019) goes further to suggest that there would be a ~£3009 saving per patient over a lifetime.[6] It may be fair to question whether a 3 year model is robust enough to be extrapolated over a lifetime?	Thank you for your comment. We are uncertain of the calculations for the costs of eye drops that you cite. The Gazzard Lancet paper states "Over the 36 months of the trial, drops for OAG and ocular hypertension cost an additional £465 (95% CI 440 to 491) for patients assigned to the eye drops group", which the committee agreed was a substantial difference. Different numbers were estimated in the different analyses undertaken, but in each case showed a substantial reduction in eye drop costs. The health technology assessment of Gazzard et al. (2019) modelled a lifetime (30 years) time horizon which they used both the LiGHT trial and published data for transition probabilities after 3 years. This cost effectiveness study (lifetime time horizon) also found that SLT is cost saving and therefore it was felt to be strong evidence for SLT to be the preferred first line treatment. When uncertainty in the data was taken in to account, the probability of SLT being cost-effective over

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					the lifetime time horizon was found to be 90%, which the committee agreed was robust evidence.
Bausch+Lomb UK Ltd	Guideline	General	General	**The guidelines fail to acknowledge the substantial pressure already on the NHS and the impact this may have on healthcare professionals and their patients** o The waiting times for ophthalmological procedures are among the worst affected by the covid pandemic.[7] It may be fair to suggest that the expectation that consultant ophthalmologists and other healthcare professionals have the capacity to carry out even more procedures at this moment in time may be unrealistic. An surge in the number SLT procedures routinely carried out can only be achieved through with a correlated surge in the availability of qualified personnel. If demand for SLT exceeds the capacity for NHS practitioners to carry out this procedure, a group of vulnerable patients are going to find themselves on another NHS waiting list. o Should a patient face a significant waiting time for their first SLT procedure, disease progression could occur. To mitigate disease progression, pharmacological treatment could be an option upon diagnosis. However, the initiation of pharmacological treatment first line, may then defeat the purpose of putting	Thank you for your comment. The committee acknowledged the pressures posed on the NHS due to the covid pandemic, but they highlighted that the new recommendations were developed to be applicable to the post pandemic period too. The committee agreed that there could be service delivery issues, but they highlighted that based on evidence, new recommendations are likely to improve efficiency in service delivery. The committee agreed that there might be a delay in delivering SLT to some people. To ensure people are receiving treatment, the committee did recommend PGA to be used as an interim treatment while waiting for SLT. The committee have acknowledged that this may result in additional visits upfront, but based on the economic findings SLT does demonstrate cost savings in the long run.

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				SLT as first line treatment for cost efficiency reasons.	
Bausch+Lomb UK Ltd	Guideline	General	General	**We propose a new suggestion for the guideline:** o In reviewing the recommendations, we feel that there may still be a lack of data and resources to make such a significant change in practice. o We agree that some patient groups, as mentioned in the draft, can significantly benefit from first-line SLT. For example, the elderly, where adherence due to cognitive issues and polypharmacy is an important concern. Furthermore, we support the recommendation that pregnant/breastfeeding women can significantly benefit from first line SLT, where side effects of medication can be a concern. o For these reasons, we propose limiting the new first-line SLT treatment guidelines to the above subset of patients as a 'pilot' approach, and observe and collect more data to expand into the general glaucoma patient population.	Thank you for your comment. Robust evidence from the LiGHT trial was used to inform recommendations, and this trial included the general population. Therefore, first-line SLT is recommended for people with newly diagnosed OHT or COAG. The committee have acknowledged that older people, people with cognitive and physical impairment, people with learning disabilities, people with dementia and people who are pregnant, or breastfeeding would benefit from the new recommendations. This is captured in the evidence review in section 1.1.11.5.
Bausch+Lomb UK Ltd	Guideline	General	General	1. Gazzard G, Konstantakopoulou E, Garway-Heath D, Garg A, Vickerstaff V, Hunter R, Ambler G, Bunce C, Wormald R, Nathwani N, Barton K, Rubin G, Buszewicz M; LiGHT Trial Study Group. Selective laser trabeculoplasty versus eye drops for first-line treatment of	Thank you for providing these references. Responses have been added to comments where each reference is mentioned.

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				ocular hypertension and glaucoma (LiGHT): a multicentre randomised controlled trial. Lancet. 2019 Apr 13;393(10180):1505-1516. doi: 10.1016/S0140-6736(18)32213-X. Epub 2019 Mar 9. Erratum in: Lancet. 2019 Jul 6;394(10192):e1. PMID: 30862377; PMCID: PMC6495367. 2. Kiddee W, Atthavuttisilp S. The effects of selective laser trabeculoplasty and travoprost on circadian intraocular pressure fluctuations: A randomized clinical trial. Medicine (Baltimore). 2017 Feb;96(6):e6047. doi: 10.1097/MD.0000000000006047. PMID: 28178150; PMCID: PMC5313007. 3. Ansari E. 10-year outcomes of first-line selective laser trabeculoplasty (SLT) for primary open-angle glaucoma (POAG). Graefes Arch Clin Exp Ophthalmol. 2021 Jun;259(6):1597-1604. doi: 10.1007/s00417-021-05098-z. Epub 2021 Feb 12. PMID: 33576857. 4. Francis, B.A.; Ianchulev, T.; Schofield, J.K.; Minckler, D.S. Selective laser trabeculoplasty as a replacement for medical therapy in open-angle glaucoma. Am. J. Ophthalmol. 2005, 140, 524–525. 5. Tufan, A.K.; Onur, I.U.; Yigit, F.U.; Agaçhan, A.; Asık Nacaroglu, S. Selective Laser Trabeculoplasty vs. Fixed Combinations with	

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				Timolol in Practice: A Replacement Study in Primary Open Angle Glaucoma. Turk. J. Ophthalmol. 2017, 47, 198–204 6. Gazzard, Gus; Konstantakopoulou, Evgenia; Garway-Heath, David; Garg, Anurag; Vickerstaff, Victoria; Hunter, Rachael; Ambler, Gareth; Bunce, Catey; Wormald, Richard; Nathwani, Neil; Barton, Keith; Rubin, Gary; Morris, Stephen; Buszewicz, Marta; Selective laser trabeculoplasty versus drops for newly diagnosed ocular hypertension and glaucoma: the LiGHT RCT.; Health technology assessment (Winchester, England); 2019; vol. 23 (no. 31); 1-102 7. National Audit Office. 2021. NHS backlogs and waiting times in England. Accessed 3rd December 2021 from: https://www.nao.org.uk/wp-content/uploads/2021/07/NHS-backlogs-and-waiting-times-in-England.pdf	
College of Optometrists	Guideline	007	026	We very much welcome this recommendation.	Thank you for your comment.
College of Optometrists	Guideline	009	016	1.4.9 We welcome this recommendation, as it recognises many health care professionals (HCP) in a variety of settings (including optometrists in the community) are responsible decision makers and recognises community settings for the delivery of SLT.	Thank you for your comment.

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College of Optometrists	Guideline	019	002	1.6.6 We welcome this recommendation. It provides clarity to training providers and local systems commissioning OHT and glaucoma pathways.	Thank you for your comment.
College of Optometrists	Guideline	019	016	1.6.7 This recommendation puts considerable burden on the responsible ophthalmologists and may have the unintended consequence of delaying access to SLT, based on the relativity small number of consultant ophthalmologists with a glaucoma specialty. We recommend to acknowledge the potential for virtual review and option to delegate this responsibility within local systems to appropriately trained and experienced HCPs, including optometrists with supporting governance. NICE should look to Joint statements issued by The Royal College of Ophthalmologists and The College of Optometrists to provide the clinical leadership for delivery collaborative care for people with OHT or COAG.	Thank you for your comment. The rationale for new recommendations mentions that healthcare professionals such as associate specialists, specialist nurses, optometrists and allied health professionals can perform SLT with support from a consultant ophthalmologist. The committee also noted the importance of establishing a multidisciplinary team where the responsible consultant ophthalmologist could discuss and delegate SLT procedures to trained staff. Therefore, it is not expected that new recommendations will add considerable burden to responsible ophthalmologists. The committee also noted that virtual reviews already take place in practice and new recommendations do not stop virtual reviews occurring. The set up of SLT services is a local implementation issue but as these recommendations are intended to be implemented over time, it does give units time to make the change. The committee also highlighted that in practice, many units have started to make the change over to SLT in anticipation of new evidence.

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					The NICE Resource Impact Assessment team has produced resource impact assessment tools to help organisations to plan for the impact of implementing the new recommendations. To access the tools, see https://www.nice.org.uk/guidance/ng81/resources
College of Optometrists	Guideline	028	001	We welcome this recommendation.	Thank you for your comment.
College of Optometrists	Guideline	028	011	The College of Optometrists supports transformative eye care for all, and where the widespread rollout of SLT will result in a significant change of practice, the guidance should not restrict innovative care delivery or create barriers that prevent people accessing the most appropriate treatment.	Thank you for your comment.
College of Optometrists	Guideline	030		**Table 1** 1.5.10 We welcome these changes to table 1.	Thank you for your comment.
College of Optometrists	Guideline	031		**Table 2** 1.5.7 and 1.4.9 The change to table two may inadvertently create a challenge to local community services who do not offer SLT, creating additional referrals to systems that provide SLT.	Thank you for your comment. The committee acknowledge that there will be an impact on local community services that do not offer SLT but new recommendations will result in a more efficient care pathway compared to the current model of care. The impact and improvement of the care pathway will depend on how new recommendations are implemented locally.

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					The committee also noted the importance of establishing a multidisciplinary team where the responsible consultant ophthalmologist could discuss and delegate SLT procedures to trained staff.
College of Optometrists	Guideline	033		**Table 2** 1.6.6 and 1.6.6 We welcome this update.	Thank you for your comment.
Fight for Sight	Guideline	General	General	Fight for Sight is pleased to see the current guidelines updated from 2017 to include the outcomes of the LiGHT trial so that issues surrounding compliance and ability to comply, due to additional barriers is addressed. Fight for Sight would state that we funded early research that led up to the trial, but not the trial directly.	Thank you for your comment.
Fight for Sight	Guideline	General	General	Q1 - As noted in the evidence and draft, SLT offers a greater chance to help with non-compliance of eye drops, as well as harder to reach populations. With an aging population, increased dementia, and co-morbidities such as arthritis, and difficulty with administration of eye drops, a single procedure, or at most 2-3, should help reduce the burden. However, it is important to note and provided in the recommendation that drops will not necessarily be stopped, so this may only be marginal in benefit. In spite of the new recommendations, hard to reach patients may not benefit from SLT because of the late presentation of glaucoma	Thank you for your comment. The committee acknowledged that late presentation of glaucoma in hard-to-reach patients is a public health issue. Late presentation of glaucoma issue has been captured in the evidence review under section 1.1.11.5. The committee noted that new recommendations were unlikely to have an impact on late presentation of glaucoma because surgery is the main treatment option for advanced glaucoma, and this is stated in existing recommendations. Section 1.1.11.5 also includes a discussion about people who might find it difficult to administer eye drops including those who have

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					dementia or physical impairment. Arthritis has been added as an example of a physical impairment.
Fight for Sight	Guideline	General	General	Q2 - Nothing to add	Thank you for your comment.
Fight for Sight	Guideline	General	General	Q3 - As outlined in lines 31-45 on page 20 of the Evidence Review, it is good to see this expanded to other healthcare professionals with appropriate training.	Thank you for your comment.
Fight for Sight	Guideline	General	General	Q4 - The wording as in the draft is appropriate.	Thank you for your comment.
Fight for Sight	Guideline	General	General	In a survey that Fight for Sight commissioned as a part of the Time to Focus report, published in 2020, for those with severe sight loss, a majority of people said that a treatment that improved their condition so that they would need less assistance would make the biggest difference to their lives. This highlights the importance of reducing the treatment burden on individuals, which this recommendation update seeks to address.	Thank you for your comment.
Fight for Sight	Guideline	008	004 - 008	Good list of information provided to inform patients of SLT. Especially good to manage expectations regarding eye drops as they may still be necessary.	Thank you for your comment.
Fight for Sight	Guideline	030	016	**Table 1** Agree with the removal of this line.	Thank you for your comment.

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Fight for Sight	Guideline	037	019 - 021	A long-term study of 5 -10 years would be appropriate. It would be interesting to know if those who had only one or multiple SLTs behaved differently over a longer observation period.	Thank you for your comment.
Glaucoma UK	Guideline	007	027	We are concerned that a lack of sufficient laser machines and trained staff to perform laser treatment in some areas may create or exacerbate health inequalities. It may be worth identifying the minimum number of machines and staff able to be able to provide this to a given population.	Thank you for your comment. The number of laser machines and trained staff to perform laser treatment is a local implementation issue but as these recommendations are intended to be implemented over time, it does give units time to make the change. The committee also highlighted that in practice, many units have started to make the change over to SLT in anticipation of new evidence. The NICE Resource Impact Assessment team has produced resource impact assessment tools to help organisations to plan for the impact of implementing the new recommendations. To access the tools, see https://www.nice.org.uk/guidance/ng81/resources Regarding your point about creating or exacerbating health inequalities, the new recommendations have been assessed as not increasing health inequalities. Based on the new evidence, we are recommending units to move to an efficient care pathway. The committee is aware that there may be delays in treatment but have recommended PGA as interim treatment to people waiting for an SLT procedure. This

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					recommendation is on the third bullet point of recommendations 1.4.6 and 1.4.17. Health inequalities have been addressed as SLT might be more suitable for people with memory loss, dementia, and arthritis. Some people may also find it difficult to pay prescription charges and SLT can reduce this burden. This has been captured in the evidence review in section 1.1.11.5.
Glaucoma UK	Guideline	008	020	If a very long wait for SLT involves a patient's OHT being treated by eye drops, robust monitoring systems need to be in place to ensure the planned treatment is not overlooked	Thank you for your comment. The committee acknowledged that there might be additional visits for people on interim PGA to reassess them. Therefore, the committee have added signposts to recommendations on reassessment for further advice on when the next appointment should take place to assess the impact of any new treatments started which includes interim treatment with PGA. Additionally, new recommendations are intended to be implemented over time, and planning of services should consider robust monitoring systems.
Glaucoma UK	Guideline	010	016	Again, we are concerned that a lack of sufficient laser machines and trained staff to perform laser treatment in some areas may create or exacerbate health inequalities.	Thank you for your comment. The number of laser machines and trained staff to perform laser treatment is a local implementation issue but as these recommendations are intended to be implemented over time, it does give units time to make the change. The committee also highlighted that in

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					practice, many units have started to make the change over to SLT in anticipation of new evidence. Regarding your point about creating or exacerbating health inequalities, the new recommendations have been assessed as not increasing health inequalities. Based on the new evidence, we are recommending units to move to an efficient care pathway. The committee is aware that there may be delays in treatment but have recommended PGA as interim treatment to people waiting for an SLT procedure. Moving away from medication will help the system because fewer review clinics will be needed. The committee noted that this move may help people that may find it difficult to pay prescription charges and SLT can reduce this burden.
Glaucoma UK	Guideline	011	009	If a very long wait for SLT involves a patient's OHT being treated by eye drops, robust monitoring systems need to be in place to ensure the planned treatment is not overlooked	Thank you for your comment. The committee acknowledged that there might be additional visits for people on interim PGA to reassess them. Therefore, the committee added signposts to recommendations on reassessment for advice on when the next appointment should take place to assess the impact of any new treatments started, which includes interim treatment with PGA.
Glaucoma UK	Guideline	012	013 - 022	We welcome this guidance.	Thank you for your comment.

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Glaucoma UK	Guideline	012	016	Glaucoma UK consulted members in November 2021, asking for patients' views on this proposed change in guidance. Ten out of thirteen respondents who had been on eye drops for some time said that they would have liked SLT as an initial treatment and are happy that SLT is still available to them should they need it, so welcomed the guidance. Lots of people mentioned that even 18 months relief from eye drops would have been a bonus.	Thank you for your comment.
Glaucoma UK	Guideline	019	016 - 024	We welcome this guidance and would like to see the equivalent for eye drops and surgery.	Thank you for your comment. The equivalent evidence for eye drops and surgery was outside the scope of this update.
Glaucoma UK	Guideline	024	022	We would urge NICE to include age and ethnicity in this research as a priority.	Thank you for your comment. Ethnicity is an important risk factor for glaucoma that the committee already identified as an important subgroup. Therefore, ethnicity is listed as a subgroup to analyse in the PICO table for the new research recommendation. This is also captured in section 1.1.11.5 of the evidence review. Age was not included as a subgroup because it has already been acknowledged that older age is a risk factor for glaucoma and its progression.
Guy's & St Thomas' NHS Foundation Trust	Guideline	008	009	Consider providing guidance on best time frame for repeat SLT re-treatment	Thank you for your comment. The committee added further clarification to the rationale about the repeat SLT procedure. They recommended that a second 360° SLT could be needed if the effect of an initial successful SLT has subsequently reduced over time. This means that the

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					IOP level has gone up and clinicians need to decide if there is risk of progression of COAG or conversion of OHT to COAG. The second SLT should be given at the discretion of the treating consultant ophthalmologist. This follows the procedure used in the main UK randomised trial (the LiGHT trial). This is captured in the section 1.1.11.3 of the evidence review. The committee also added signposts to recommendations on reassessment for advice on when the next appointment should take place to assess the impact of any new treatments started (a second SLT is included under those sections).
Guy's & St Thomas' NHS Foundation Trust	Guideline	025	020 - 021	This wording a little confusing: "This is because the additional costs of SLT were outweighed by reduced costs of eye drops." Consider changing to "This is because the additional upfront costs of SLT were outweighed by the costs of eye drops accumulating over time."	Thank you for your comment, this has been changed as suggested.
Guy's & St Thomas' NHS Foundation Trust	Guideline	025, 026	023 - 024, 001 - 002	"This improved quality of life (although no direct benefit on quality of life was found in the trial, the cost-effectiveness analysis incorporated additional data on the natural history of glaucoma)." This statement is very confusing. One assumes that natural history data was used to infer improved quality of life in the trial. Consider changing wording to "Although no direct benefit on quality of life was found in the trial, additional data on the natural history of glaucoma, which was incorporated in to the cost-effectiveness	Thank you for your comment, this has been changed as suggested.

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				analysis, suggests that quality of life was likely to be improved."	
Guy's & St Thomas' NHS Foundation Trust	Evidence Review A	008	010	Link to 'Evidence review A: Glaucoma diagnosis and management' is non-functional, resulting in a 'We can't find this page' message	Thank you for your comment. The link has been fixed.
Medicom Healthcare Ltd.	Guideline	General	General	*In response to Question 1 posed above by NICE relating to: 'Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.'* Given current NHS directives around the Covid-19 recovery agenda perhaps the most immediate impact would be to actively consider SLT for COAG patients who are trending towards a surgical intervention. This workload may be manageable with existing SLT trained resources and would immediately reduce surgical waiting lists and allow for prioritisation of more urgent ophthalmology cases. It is then a priority to deliver SLT for all new OHT and COAG patients to get the best health gain over the patient's lifetime – i.e., deliver the outcomes modelled in the HTA and Evidence Review. This will require a coherent plan to be developed to increase capacity for SLT delivery – the plan will need local patient audit data to define potential SLT patient capacity based on incidence and existing treated OHT and COAG patient populations, a training plan for identified staff, a local implementation process that maximises SLT delivery capacity per defined session, potential capital	Thank you for your comment. Regarding your point about COAG patients who are trending towards a surgical intervention, surgery was outside the remit of this review as the question focused on SLT compared to eyedrops. However, it should be noted that current recommendations only recommend surgery in people with advanced COAG (1.4.13) and if a patient is at risk of sight loss despite treatment (1.4.21). There is also a recommendation (1.4.24) where we have said if surgery is not suitable, SLT can still be an option. Regarding your point about delivering SLT for all new OHT and COAG patients, that is in line with recommendations that SLT should be delivered to newly diagnosed OHT and COAG patients. The NICE Resource Impact Assessment team has produced resource impact assessment tools to help organisations to plan for the impact of implementing the new recommendations. To access the tools, see https://www.nice.org.uk/guidance/ng81/resources

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				investment in terms of equipment and fitting out the actual SLT 'delivery units'.	
Medicom Healthcare Ltd.	Guideline	General	General	*In response to Question 2 posed above by NICE relating to: 'Would implementation of any of the draft recommendations have significant cost implications?'* The physical setting up of a service from scratch – i.e., SLT device purchase, insurance and commissioning: geographically defining where service will be delivered within the CCG/ICS and then finding the available space to set up the SLT delivery suite or suites depending upon local patient capacity needs: identification and training/validation of staff (as this will divert resource away from immediate service delivery across the Trust)	Thank you for your comment. The physical set up of a service from scratch is a local implementation issue but as these recommendations are intended to be implemented over time, it does give units time to make the change. The committee also highlighted that in practice, many units have started to make the change over to SLT in anticipation of new evidence. The NICE Resource Impact Assessment team has produced resource impact assessment tools to help organisations to plan for the impact of implementing the new recommendations. To access the tools, see https://www.nice.org.uk/guidance/ng81/resources
Medicom Healthcare Ltd.	Guideline	General	General	*In response to Question 3 posed above by NICE relating to: 'What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)* i. A national contract for supply plus the maintenance of the of SLT equipment. ii. A national insurance contract for the SLT equipment. iii. An accredited national module for staff undergoing training on delivery of SLT plus the associated patient pre/post SLT engagement process. iv. A detailed local patient audit of new patient incidence, of existing patients who	Thank you for your response. The NICE Resource Impact Assessment team has produced resource impact assessment tools to help organisations to plan for the impact of implementing the new recommendations. To access the tools, see https://www.nice.org.uk/guidance/ng81/resources

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				may benefit from SLT and those who may have exhausted currently available options and are candidates for surgery so that staff capacity, session numbers etc can be defined to enable the most appropriate and accurate block contract tender to be submitted. v. An agreed national prioritisation plan on which patients need most urgent SLT whilst overall SLT capacity is being built. vi. Focus SLT delivery within limited geographies across the ICS – audit where patient population need is greatest and look to place SLT delivery sites accordingly (and with good patient public transport access). vii. Can recruitment of staff who can be trained to deliver SLT include those who have taken early retirement but would be prepared to work on a part-time basis delivering one form of care consistently? viii. New or updated Quality Standards from NICE on implementation. An awareness that generic pharmaceuticals are not always the least expensive option and hence branded prescribing may be more cost efficient for the NHS whilst being equally effective clinically. National contracting for supply of pharmaceuticals may be a consideration?	

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Medicom Healthcare Ltd.	Guideline	012	008	*In response to Question 4 posed above by NICE relating to wording of recommendation 1.4.19 – 'the clinical pathway for people with COAG who are at risk of progressing to sight loss despite treatment with a generic PGA.'* Would it be helpful to consider which generic PGA molecule had been used as initial treatment as there is evidence, albeit from short-term clinical studies, from a recent systematic review which suggests that there is a hierarchy of clinical effectiveness in that bimatoprost 0.03% had a greater cumulative probability of being the most effective treatment compared to tafluprost and latanoprost. Harasymowycz P, *et al*. Br J Ophthalmol 2021;0:1–8. If this evidence is considered robust, would it be worth adding into the written guideline as an additional option to consider alongside the existing 3 options suggested between lines 13 and 17? With regard to recommendation 1.4.20, whilst surgery may be the best treatment option if it is not suitable or not preferred perhaps the existing recommendation 1.4.23 can be inserted as part of 1.4.20 or as a reordering of the existing recommendations so that it sits alongside whatever final content of 1.4.20 is.	Thank you for your comment. Effectiveness of different generic PGA molecule as initial treatment was outside the scope of this review. Regarding your comment on recommendation 1.4.20, a visual summary has been developed to show the pathway to treat people with COAG at different stages of disease.
Medicom Healthcare Ltd.	Evidence Review A	017	005	Please confirm an assumption we are making about the costs in Table 13; that the costs included have been amended to reflect 2021 costs from the original 2019 costs used in the original HTA?	Thank you for your comment. The costs in table 13 have been uprated to 2021 cost using https://eppi.ioe.ac.uk/costconversion/default.aspx

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Medicom Healthcare Ltd.	Evidence Review A	017	005	Please confirm an assumption we are making about the costs in Table 13; that the costs included reflect the clinical appointment costs that will apply in the 'block contract' commissioning process that comes into formal practice in April 2022 as opposed to the existing 'payment by results' tariff process? This will improve the robustness of an excellent health economic model.	Thank you for your comment. We assume this is referring primarily to the costs of staff and appointment time, and if so these were based on a standard source used in economic evaluations (Unit Costs of Health and Social Care 2020 | PSSRU). These are based on microcosting exercise for the true staff time for various appointments, as opposed to tariff payments, and are therefore designed to represent the full economic cost associated with staff time. It would be hoped that any tariff or payment systems designed would accurately reflect these true underlying costs, but that is outside of NICE's remit to assess.
Medicom Healthcare Ltd.	Evidence Review A	022	011	In the sentence it contains the phrase '..or preservative drops' ought this to be written as '.. or preservative-free drops'?	Thank you for your comment. Correction has been made.
Medicom Healthcare Ltd.	Evidence Review A	131		**Appendix H** Please confirm an assumption we are making about the costs in Table 14; that the costs included have been amended to reflect 2021 costs from the original 2019 costs used in the original HTA?	Thank you for your comment. The costs in this table are directly sourced from the papers and have not been uprated to 2021 costs. The uprated costs are in the main body of the text, in section 1.1.8, and it was these costs (uprated to 2021) that the committee used when making decisions.
Royal College of Ophthalmologists	Guideline	General	General	Overall, we are pleased to see the clinical recommendations for treatment. However, there is a need to clarify several aspects of the recommendations to differentiate between appropriate treatment for patients and the way the treatment s delivered and by whom. We will expand on this in our comments below.	Thank you for your comment.

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Royal College of Ophthalmologists	Guideline	General	General	**Cost implications** The recommendations indicate a significant change in practice for most glaucoma services. Cost implications relate to: 1. Infrastructure costs and/or availability of appropriate laser rooms to deliver selective laser trabeculoplasty SLT as well as other laser treatments, in large organisation one laser room shared between different services is unlikely to suffice and could result in long waiting lists/unsafe delays to treatment 2. Equipment costs – most glaucoma services do not offer routine SLT treatment and there are upfront capital costs to purchase the equipment. These might be recouped as part of the tariff for treatment overtime. 3. Could result in inequity of access to care	Thank you for your comment. The committee agree the recommendations would increase the number of patients receiving SLT and therefore there would be an increase in service capacity. The cost of buying and maintaining a SLT machine was included in the cost effectiveness study conducted alongside the LiGHT trial and SLT still came out to be cost saving over a longer time horizon, and therefore the committee were confident that that although there will be larger upfront costs, investment in SLT will be worthwhile and cost-effective. The committee were aware that there may be delays in implementation of these recommendations (especially because of COVID 19) and therefore made a recommendation to ensure no patients were left without treatment because of a lack of access. Specifically, they recommended a generic prostaglandin analogue should be offered to people "as interim treatment if they are waiting for an SLT procedure", and they were therefore confident no individual should end up receiving worse care as a result of the recommendation. Infrastructure costs and/or availability of appropriate laser rooms to deliver SLT is a local implementation issue but as these recommendations are intended to be implemented over time, it does give units time to make the change. The committee also highlighted that in practice, many units have started to make the change

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					over to SLT in anticipation of new evidence. The committee further noted that larger centres may see an increase in number of referrals, resulting in an increase in new clinics a week, but the committee highlighted that there should not be a significant increase. It is acknowledged that any increase means that there has to be different organisation of care. This text has been added to the rationale and to the evidence review. The NICE Resource Impact Assessment team has produced resource impact assessment tools to help organisations to plan for the impact of implementing the new recommendations. To access the tools, see https://www.nice.org.uk/guidance/ng81/resources
Royal College of Ophthalmologists	Guideline	General	General	Challenges 1. Lack of appropriately trained workforce currently available to deliver and existing workforce shortages – services competing for nursing staff etc. 2. Responsiveness/appropriateness of the regulatory environment and governance arrangements 3. Responsiveness/appropriateness of the commissioning requirements Solutions 1. Need appropriate workforce plan and funded Multi-Disciplinary Team (MDT) training to agreed standards	Thank you for your comment. The committee acknowledged that more staff might need to be trained over time to deliver SLT procedures. They also considered that there may be issues with job plans that may not allow trained staff to have sufficient sessions to deliver SLT. However, the committee noted that with the introduction of new recommendations future planning could be done by trusts to include the number of SLT sessions needed to offer SLT as first-line treatment. This planning can allow more trained staff to have sufficient time to deliver SLT. Additional staff are likely to be needed and with the new recommendations there should be opportunities to train

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				2. It will be key to ensure the multidisciplinary team have suitable training and time to build relationships across primary and secondary care – this includes providing information on appropriate qualifications in line with patient risk – see joint The Royal College of Ophthalmologists (RCOphth) and UK and Eire Glaucoma Society (UKEGS) Risk Stratification Tool https://www.rcophth.ac.uk/wp-content/uploads/2020/08/Glaucoma-Risk-Stratification-Tool-1.pdf Commissioning of services needs to be undertaken on this basis 3. Real time collection of data on harm is important and should be recommended. Commissioning requirements should include this in service specifications and ensure suitable General Data Protection Regulation (GDPR) arrangements are in place.	staff. The rationale for new recommendations mentions that healthcare professionals such as specialty doctors, associate specialists, specialist nurses, optometrists and allied health professionals can perform SLT with support from a consultant ophthalmologist. The committee also noted the importance of establishing a multidisciplinary team where the responsible consultant ophthalmologist could discuss and delegate SLT procedures to trained staff. This has been captured in the evidence review and rationale in the guideline.
Royal College of Ophthalmologists	Guideline	004	020	The referral guidelines should state 'Do not refer patients only on the basis of RNFL- OCT findings without other clinical reasons for referral.	Thank you for your comment. Recommendations on case-finding were outside the scope of this update.
Royal College of Ophthalmologists	Guideline	005	014	The panel should explain why they are using a threshold of 24 or more rather than more than 24.	Thank you for your comment. Recommendations on case-finding were outside the scope of this update.
Royal College of Ophthalmologists	Guideline	007	028	The implication here is that a intra ocular pressure (IOP) of 24 or more should trigger a treatment decision requires evidence. The ocular hypertension (OHT) algorithms do not offer sufficient precision to make a good estimate of lifetime risk of visual loss.	Thank you for your comment. As you mention, the recommendation is for people with IOP of 24 mmHg or more if they are at risk of visual impairment within their lifetime. The recommendation is

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				They give (very rough) estimate of the risk developing subtle disc or field changes in 5 years. However, many of these changes may merely be aging not disease. The median life expectancy at the median age (70) of presenting for glaucoma or OHT is 12 years and the overwhelming majority of untreated OHT patients will progress to the (asymptomatic) trial end points, let alone to a risk of visual loss which typically will not be evident for at least 10-15 years after diagnosis (of glaucoma with field loss). SLT should only be offered to those with an IOP of 30 (subject to discussion etc.) or more unless they have structural abnormality or similar. This statement as currently expressed will create a large problem with over treated OHT. The excess requirement for SLT in people with a miniscule risk of visual loss who could be monitored without taking on the burden of treatment will be unsustainable. 1:500- 1:10000 patients having SLT will have corneal failure, often, but not always temporary. For someone who has an indeterminate (but definitely low) risk of glaucoma and an unknown but low risk of visual loss, to offer treatment is irresponsible. The recommendation is mistaken in terms of equating SLT with Prostaglandin analogs (PGA) treatment in terms of risk for lowish risk OHT treatment. They are not the same.	based on strong evidence and follows the procedures and the inclusion criteria used in the main UK randomised trial (the LiGHT trial). The LiGHT trial based treatment threshold on existing NICE thresholds, which we retained in the new recommendations. Baseline data from the LiGHT trial shows that IOP mean and standard deviation (SD) were 24.5 (SD 5.2) and 24.4 (5.0) for the SLT and eye drops arms respectively. This has been detailed in the committee discussion section of the evidence review. Recommendation 1.4.3 states that treatment should not be offered to people with OHT who are not at risk of visual impairment within their lifetime. Therefore, people with OHT and low risk of visual loss should not be treated with SLT. We have included 'complications' to the third bullet point of recommendation 1.4.4 and 1.4.15. We have added the risk of corneal failure as a rare event to the rationale related to the new recommendations of SLT for people with OHT.

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Royal College of Ophthalmologists	Guideline	008	010	**Rationale** The rationale is not about the treatment threshold, rather about why SLT not just drops.	Thank you for your comment. The remit of the review question focused on the effectiveness of SLT when compared to eye drops, therefore the committee did not review evidence on treatment threshold. The LiGHT trial was included in the evidence, and this study based treatment threshold on existing NICE thresholds, which we retained in the new recommendations. The evidence review includes a longer version of what the committee discussed when making these recommendations (see the discussion in the evidence review under section 1.1.11 The committee's discussion and interpretation of the evidence).
Royal College of Ophthalmologists	Guideline	008	013	As before, in comment three, the suggestion that IOP treatment should be considered at an IOP of 24 is not sufficiently explained.	Thank you for your comment. The recommendation is for people with IOP of 24 mmHg or more if they are at risk of visual impairment within their lifetime. The recommendation is based on strong evidence and follows the procedures used in the main UK randomised trial (the LiGHT trial). This study based treatment threshold on existing NICE thresholds, which we retained in the new recommendations.
Royal College of Ophthalmologists	Guideline	008 - 009	027 - onwards	Section 1.4.4 the Lancet paper Selective laser trabeculoplasty versus eye drops for first-line treatment of ocular hypertension and glaucoma (LiGHT): a multicentre randomised controlled trial, Gus Gazzard, FRCOphth , Evgenia Konstantakopoulou, PhD;, Prof David Garway-Heath, MD, Anurag Garg, FRCOphth, Victoria Vickerstaff, MSc, Rachael Hunter, MScet al. VOLUME 393,	Thank you for your comment. People with pseudoexfoliation have not been excluded from recommendations. The LiGHT trial included people with pseudoexfoliation but the numbers were very low (less than 2% of participants had pseudoexfoliation at baseline). The committee opted to not explicitly highlight

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				ISSUE 10180, P1505-1516, APRIL 13, 2019 https://doi.org/10.1016/S0140-6736(18)32213-X could not establish a different in treatment in relation to pigmentation dispersion. We suggest insert 'and care with pseudo exfoliation' and offer SLT to establish patients who may wish to switch.	the condition in the recommendation because the evidence based was relatively small.
Royal College of Ophthalmologists	Guideline	009	014	consider non treatment or managed under statement as a valid option when combined with appropriate monitoring	Thank you for your comment. Recommendation 1.4.8 was out of scope for this review.
Royal College of Ophthalmologists	Guideline	009 and general	016 - 019 and general	When referring to who is qualified to treat these patients, rather than specifying the grade of treater – in this case the recommendation mentions a consultant ophthalmologist – it would be more useful to specify the levels of qualification for the care professional relevant to the patient scenario. Glaucoma Risk Stratification Tool published by the RCOphth and the UKEGS. Patients can find it confusing to know who they should talk to regarding different aspects of their care. Laser treatment of any kind can cause significant harm and there is a difference between the qualifications required to initiate treatment and those required to undertake the treatment.	Thank you for your comment. The committee acknowledged that different stages of disease would require different management techniques. The committee further highlighted that a number of different qualifications would need to be listed in the recommendations which would not be useful for users. Instead the committee were keen to highlight the importance of establishing a multidisciplinary team where the responsible consultant ophthalmologist could discuss and delegate SLT procedures to trained staff. Additionally, there are separate recommendations about the training that health care professionals should have when they are involved in monitoring and treating people with OHT, suspected COAG and established COAG.
Royal College of Ophthalmologists	Guideline	012	008 - 022	If the recommendation is meant as written this is a significant change to current practice. It reads patients should be offered surgery if only one drug treatment has been tried (line 12). This does not differentiate	Thank you for your comment. The recommendation was amended to provide further clarity as there were three important messages being

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				between partial and non-partial responders. We also request clarification on the threshold for surgical intervention as lines 19-22 say after two drug treatments are tried. The wording is ambiguous, and we feel unable to comment further as we do not understand what is meant by 'trying drugs' (line 19).	conveyed across two recommendations. The 2017 recommendations (1.5.16 and 1.5.17) were split into 3 separate recommendations. The first recommendation highlights that clinician should check treatment adherence and eye drop instillation technique in people with COAG whose IOP has not been reduced sufficiently to prevent the risk of progression to sight loss, despite pharmacological treatment with a generic PGA. The second recommendation highlights the treatment options that can be offered to people in whom eye drop instillation technique is satisfactory and IOP has not been reduced. As the evidence identified in the current review focused specifically on SLT, the committee noted it was important that all recommendations in the guideline are in line with the evidence and new recommendations. As SLT is the type of laser trabeculoplasty currently used in clinical practice this recommendation was also updated to specifically highlight SLT as a treatment option for people in whom adherence and eye drop instillation technique are satisfactory. The third recommendation offers surgery with pharmacological augmentation (MMC) as indicated to people with COAG who are at risk of progressing to sight loss despite treatment with medicines from 2 therapeutic classes. The text 'trying drugs' is no longer

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					mentioned in the recommendations and it was replaced with the text 'despite treatment with medicines from 2 therapeutic classes'. It should also be noted that the committee suggested to change the term 'surgery' to 'glaucoma surgery' because the term 'surgery' is more general, and it can include other types of eye surgery which are not glaucoma surgery. This change was also made across the guideline. Regarding your comment about differentiation between partial and non-partial responders, the committee highlighted that the wording of recommendation 1.4.20 does indeed cover both partial and non-partial responders. For partial responders clinicians may choose to offer additional medical treatment (that may be a switch of medication or adding another medication) or to offer 360° SLT or surgery. For non-partial responders clinicians may consider a switch to a different class of medication or alternatively consider 360° SLT or surgery. The list of options is presented with the wording 'or' between each option. This is because the committee did not try to be prescriptive but recognise clinical decision-making will be based on the characteristics and risk factors of individual patients. Recommendation 1.4.21 (which follows rec 1.4.20) advises that surgery or 360° SLT should be considered (over additional medical therapy) if treatment with two drug classes has already been tried.

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Royal College of Ophthalmologists	Guideline	013	008 - 014	We question if cyclodiode is different from more surgery. It is a potentially blinding treatment and we question the justification for the potential lowering of the threshold for cyclodiode. There is more nuance needed in this recommendation.	Thank you for your comment. The committee highlighted that cyclodiode is different from surgery because it can be delivered as an outpatient procedure which is why the distinction was made in the recommendation.
Royal College of Ophthalmologists	Guideline	013	015 - 020	We question if cyclodiode is different from more surgery. It is a potentially blinding treatment and we question the justification for the potential lowering of the threshold for cyclodiode. There is more nuance needed in this recommendation.	Thank you for your comment. The committee highlighted that cyclodiode is different from surgery because it can be delivered as an outpatient procedure which is why the distinction was made in the recommendation.
Royal College of Ophthalmologists	Guideline	014	009	Why is supra threshold testing for OHT being recommended for OHT? As the disc / retinal nerve fibre layer (RNFL) is being examined and by definition, these were previously normal, the chance of a supra threshold test picking up conversion is minimal unless the patient has advanced field loss, in which case it is incredibly unlikely that the anatomy will not be obviously abnormal, triggering the need for a threshold test. This seems to be unevidenced. Suprathreshold visual field (VF) will create the burden of a VF workload in overstretched clinics (the differential opportunity cost between threshold and suprathreshold is small) with no tangible benefit. I suggest that the guidelines support the restriction of the use of our stretched and precious VF testing	Thank you for your comment. Recommendations on reassessment tests were outside the scope of this update.

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				resource to those that need it. I would suggest that VF testing is not required on every visit for a patient with controlled OHT and normal anatomy. I appreciate this is a 'grey zone' comment but the suprathreshold VF recommendation is not logical.	
Royal College of Ophthalmologists	Guideline	015		**Table 1** We feel it is important to retain this table in the guideline as it provides clarity on recommended follow up intervals	Thank you for your comment. Table 1 will be retained in this guideline.
Royal College of Ophthalmologists	Guideline	019	002 – 015	We feel this recommendation mixes up the requirements for monitoring and for treating, as with comment 5 the mix of skills/qualifications required for monitoring and treatment are different and should be separated out and clarified. As written the recommendation implies monitoring and treatment are the same. Monitoring does not include initiating therapeutic change.	Thank you for your comment. Recommendation 1.6.6 was outside the scope of this update. We only added SLT to the list because it is a new treatment recommended from this update. The committee noted that recommendations 1.6.2 and 1.6.5 have a list of qualifications for different aspects of care.
Royal College of Ophthalmologists	Guideline	019	016 - 024	As with our previous comments we are concerned about the lack of clarity regarding the term health care professional in the context of the different qualifications required for monitoring vs treating patients with glaucoma. All Healthcare Professional (HCPs) in the pathway need to be part of a proper governance process. It is unclear who is ultimately responsible for patient care. The recommendation needs to be reworded to be clearer. This is key as there are implications for indemnity liability, training, competence sign off etc. The issues of regulation and	Thank you for your comment. The rationale for new recommendations mentions that healthcare professionals such as specialty doctors, associate specialists, specialist nurses, optometrists and allied health professionals can perform SLT with support from a consultant ophthalmologist. The committee highlighted the importance of establishing a multidisciplinary team where the responsible consultant ophthalmologist could discuss

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				appropriate treatment for patients are being confused in this guideline update.	and delegate SLT procedures to trained staff. The recommendation has been amended to state that the responsible ophthalmologist will retain ultimate clinical responsibility of the treatment. Additionally, recommendation 1.6.7 is about the training that health care professionals should have when they are involved in monitoring and treating people OHT, suspected COAG and established COAG.
Royal College of Ophthalmologists	Guideline	027	020 - 028	There is no mention of Specialty Doctors or Specialists doctors to perform SLTs, throughout the guidance mentions associate specialists and all other AHPs expected to take up this responsibility in near future as SLT workload is expected to increase with updated guidance. Currently most of the places, after associate specialists, major SLT workload is carried out by Specialty Doctors who will be the future candidates for Specialists. If NICE guidance mentions Specialty Doctors and specialists along with the above list of AHPs, it will encourage Specialty doctors to come forward to share this responsibility and managers will be also assured while redesigning the service, especially as per the contract update in 2008, there will not be many ongoing opportunities to increase associate specialists	Thank you for your comment. Specialty doctors have been added as requested.

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				positions to cope up with the increasing SLT service demands.	
Royal National Institute of Blind People (RNIB)	Guideline	007	015	After 1.3.3, add a recommendation to certify the patient as sight impaired or severely sight impaired, should this be warranted by clinical judgement during an assessment, and not to wait for the outcome of a treatment or surgery to do so. There should also be a recommendation for a referral to an Eye Clinic Liaison Officer (ECLO) and a supportive conversation to discuss the benefits of registration with their local authority, should certification be warranted. Diagnosis of sight loss is recognised as a life-changing, potentially traumatic event. After 1.3.3 add a reference to diagnostic tools in CG91 (Depression in adults with a chronic physical health problem: recognition and management) as part of all assessments.	Thank you for your comment. Recommendations on standard practice for all assessments were outside the scope of this update. Therefore, a reference to diagnostic tools in CG91 was not added. Recommendation 1.7.2 includes advice on practical information about how to contact the eye clinic liaison officer (ECLO) and what information and assistance they can provide.
Royal National Institute of Blind People (RNIB)	Guideline	012	008	Add "Demonstrate, and observe that eye drop installation technique is correct when first prescribed." As a new sentence before "Ask about adherence to treatment"	Thank you for your comment. We have added a sentence under recommendations 1.4.6 and 1.4.17 to state that eye drops instillation technique should be demonstrated and observed when eye drops are first prescribed.

Glaucoma: diagnosis and management

Consultation on draft guideline - Stakeholder comments table
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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Royal National Institute of Blind People (RNIB)	Guideline	017	General	Within "Organisation of Care", the Guideline does not place glaucoma management within the setting of the Vision UK Adult UK eye health and sight loss pathway or CCEHC's Systems and Assurance Framework for Eye Health (SAFE) Glaucoma guideline, focussing on the clinical management of an individual, rather than the holistic care needs that an ICS should consider in its planning. Commissioners need to be aware of the value of and need for ECLO support within an eye clinic, specialist NHS mental health services, NHS low vision services, and LA vision rehabilitation services as part of an integrated range of services that are essential for optimum patient outcomes and maintenance of independence.	Thank you for your comment. Recommendations on organisation of care were outside the scope of this update. Recommendation 1.7.2 includes advice on practical information about how to contact the eye clinic liaison officer (ECLO) and what information and assistance they can provide.
Royal National Institute of Blind People (RNIB)	Guideline	017	General	Add in new paragraph after 1.5.15 to include a referral to NHS low vision services for aids and equipment to enable patients to maximise their vision.	Thank you for your comment. Recommendations on discharge back to primary care were outside the scope of this update.
Royal National Institute of Blind People (RNIB)	Guideline	017	General	Add in new section "Referral into local authority sensory services" to include the decision triggers and process for a referral for local authority adult social care vision rehabilitation services.	Thank you for your comment. Recommendations on referral were outside the scope of this update.
Royal National Institute of Blind People (RNIB)	Guideline	017	General	The support services offered by an ECLO should form a central part of the process outlined for the organisation of wider care and support for a patient. The role as an information source is referenced briefly on p31, line 17, which does not reflect the range of	Thank you for your comment. Recommendations on organisation of care were outside the scope of this update. Recommendation 1.7.2 includes advice on practical information about how to contact the eye clinic liaison

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				support offered to patients – this should be made explicit within section 1.6.	officer (ECLO) and what information and assistance they can provide.
Royal National Institute of Blind People (RNIB)	Guideline	021	024	Add a section referring to the need to record a patient's preferred format, and necessity for adherence to the Accessible Information Standard (DCB1605 Accessible Information) in correspondence and information provided to them.	Thank you for your comment. Recommendations on providing information were outside the scope of this update. While recommendations do not state adherence to the Accessible Information Standard, this is a legal duty set out in the HSC act 2012, therefore all organisations that provide NHS care and/or publicly-funded adult social care are legally required to follow it.

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*