Glaucoma Repeat Readings & OHT Monitoring Community Service Pathway

Issued by
Local Optical Committee Support Unit
May 2009

[Revised May 2016, Version 3.3]
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>Background</td>
<td>4</td>
</tr>
<tr>
<td>NICE Guidance and Quality Standards</td>
<td>4</td>
</tr>
<tr>
<td>IOP referrals</td>
<td>4</td>
</tr>
<tr>
<td>Tonometry methods</td>
<td>5</td>
</tr>
<tr>
<td>Outline of Service</td>
<td>5</td>
</tr>
<tr>
<td>Key Drivers</td>
<td>6</td>
</tr>
<tr>
<td>Description</td>
<td>7</td>
</tr>
<tr>
<td>Level 1a: Goldmann style applanation tonometry</td>
<td>7</td>
</tr>
<tr>
<td>Level 1b: Visual field repeat readings</td>
<td>9</td>
</tr>
<tr>
<td>Level 1c: Non-participating practices</td>
<td>10</td>
</tr>
<tr>
<td>Level 2: OHT &amp; suspect COAG Monitoring</td>
<td>11</td>
</tr>
<tr>
<td>Patient Records</td>
<td>12</td>
</tr>
<tr>
<td>IT System</td>
<td>12</td>
</tr>
<tr>
<td>Special requirements - equipment</td>
<td>13</td>
</tr>
<tr>
<td>Patient information</td>
<td>13</td>
</tr>
<tr>
<td>Appendix 1: IOP and Visual Field Pathway</td>
<td>14</td>
</tr>
<tr>
<td>Appendix 2: Non-Participating Practices</td>
<td>15</td>
</tr>
<tr>
<td>Appendix 3: OHT Monitoring Pathway</td>
<td>16</td>
</tr>
<tr>
<td>Appendix 4: Clinical Management Guideline Level 1</td>
<td>17</td>
</tr>
<tr>
<td>Appendix 5: Clinical Management Guideline Level 2</td>
<td>19</td>
</tr>
<tr>
<td>Appendix 6: Core Competencies for Optometry</td>
<td>20</td>
</tr>
</tbody>
</table>
Executive Summary

In order to facilitate a reduction of referrals of suspect glaucoma to the Hospital Eye Service and to increase “care in the community” for glaucoma related conditions LOCSU recommends the implementation of care pathways for Glaucoma Repeat Readings and Ocular Hypertension (OHT) Monitoring.

The aim of a glaucoma repeat readings pathway is to reduce false positive referrals to the hospital eye service, reducing patient anxiety and increasing capacity within the overburdened hospital glaucoma clinics. This should provide a more cost-effective service with a greater number of patients managed within the primary care setting. Evaluation of data in Stockport\(^1\), Bexley\(^2\) and North of Tyne\(^3\) CCGs shows that a reduction in referrals of up to 76% can be expected following implementation of a Glaucoma Repeat Readings service provided by community optometrists.

The pathway allows accredited optometrists to repeat diagnostic tests to confirm the risk of disease and thus improve the accuracy of referrals and deflect unnecessary referrals. The first two Quality Statements of the NICE Quality Standards for glaucoma recommend local agreements for referral refinement & repeat measurements.

http://www.nice.org.uk/guidance/qualitystandards/glaucoma/Home.jsp

The aim of an OHT monitoring pathway is to reduce the number of secondary care consultations for the cohort of patients who are diagnosed as having OHT i.e. consistently high intra-ocular pressures (IOP) but no glaucoma. Currently, patients who are considered to have a greater chance of developing glaucoma due to elevated IOP or other suspicious signs are generally retained in secondary care and reviewed there on an annual basis, following referral in.

The OHT monitoring service allows patients with diagnosed OHT to be discharged back into primary care for monitoring by community optometrists. Patients would only be referred back into secondary care if there was a change in clinical status.

\(^1\) Repeating pressures- an electronic reporting system. T J Warburton. Optometry Today, 17th September 201
\(^2\) Comparison of the effectiveness of two enhanced glaucoma referral schemes David J Parkins and David F Edgar. Ophthalmic & Physiological Optics 31 (2011) 343–352
\(^3\) Local audit data, NHS North of Tyne
Background

Affecting an estimated 480,000 people in England, Chronic Open Angle Glaucoma (COAG) is a common condition involving optic nerve damage and loss of the visual field that can lead to blindness if it’s not diagnosed early and treated promptly. Around 14% of UK blindness registrations are due to glaucoma. However many people won’t know that their eyesight is at risk – there are usually no symptoms until the later stages when their vision is already seriously damaged. OHT (raised pressure in the eye) is a major risk factor for developing COAG, although COAG can occur with or without raised eye pressure. Glaucoma is more common with increasing age, and people of African descent or with a family history of glaucoma may be at greater risk of developing the condition. With changes in population demographics the number of people affected by the condition is expected to rise.

NICE guidance and quality standards

NICE clinical guideline 85 (Diagnosis and management of chronic open angle glaucoma and ocular hypertension) issued 22 April 2009 sets out how best to diagnose COAG and OHT, how people with COAG, OHT or at risk of COAG, should be monitored, and which treatments should be considered.


IOP referrals

Currently due to the constraints of a GOS sight test, and recent NICE guidelines, optometrists are referring all cases of suspect glaucoma and OHT to secondary care for confirmation of the diagnosis and treatment where necessary. This works well when the diagnosis is positive. However, there is no simple single test for glaucoma and this, coupled with the low prevalence of the condition, makes it difficult to detect with certainty in the early stages.

Referral refinement has been shown to reduce onward referrals by as much as 77%. OHT is defined in the NICE guidance as repeatable intra-ocular pressure over 21 mmHg as measured by Goldmann applanation tonometry (GAT). By defining the criteria and procedures for diagnosis, NICE have, by implication, created a referral threshold.
Previously the threshold for OHT was set by local ophthalmologists and in many cases was around 25 mmHg. This lowering of the effective threshold has increased the number of referrals by community optometrists who are now following the NICE guideline.

**Tonometry methods**

Most optometrists measure the pressure using an air-puff tonometer. These are considered by NICE to be less accurate, and so repeating the pressures using Goldmann style tonometry will reduce the number of false positive referrals. The use of Goldmann style tonometry is not a requirement of a GOS sight test, although it is a core competency of optometrists.

Only a small number of practices have a slit lamp Goldmann applanation tonometer (GAT) but a greater number may have a Perkins which is a hand held applanation tonometer based on the Goldmann prism principle. Maximum participation is very important for the success of a repeat IOP scheme and it would be correct to say that NICE only insist on slit lamp GAT for diagnosis and monitoring. The entire guideline is silent on referral but it is covered by the first two Quality Statements. IOP refinement requires accurate repeat readings; therefore repeat measures using either slit lamp GAT or Perkins will be acceptable. It should be stressed that the use of any other type of tonometer for repeat measures in an NHS funded community service should be avoided.

**Outline of Service**

The proposed Level 1 service would provide primary care repeat readings to deflect unnecessary referrals to secondary care and is within the basic competency of community optometrists.

The proposed Level 2 service would provide primary care monitoring for patients diagnosed with OHT that does not require treatment.

Some refreshment of skills may be required depending on the service. Both services would be below secondary care PbR tariff.
National Key Drivers

The national key drivers include:

- NHS Standard Contract 2016-17 (March 2016)
- HM Treasury Spending Review and Autumn Statement (November 2015)
- NHS Commissioning for Quality and Innovation (CQUIN) Guidance for 2015/16 (March 2015)
- NHS Serious Incident Framework (March 2015)
- NHS Standard Contract 2015-16 (March 2015)
- NHS England Business Plan (March 2015)
- National Information Board Personalised Health and Care 2020 (November 2014)
- NHS Five Year Forward View (October 2014)
- NHS Outcomes Framework 2015 to 2016 (Dec 2014)
- NHS Constitution (March 2013)
- Safeguarding Vulnerable People in the Reformed NHS (March 2013)
- The Information Governance Review (March 2013)
- Commissioning Better Care: Urgent Care (Feb 2013)
- NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013
- Everyone Counts: Planning for Patients 2013/14 (Dec 2012)
- Securing excellence in commissioning primary care (June 2012)
- Health & Social Care Act 2012
- Equity & Excellence: liberating the NHS (2010)
- Right Care: Increasing Value – Improving Quality (June 2010)
- NHS 2010-15; from good to great (Jan 2010)
- Quality Innovation Productivity & Prevention (QIPP) agenda
- Implement care closer to home; convenient quality care for patients (April 2007)
- The UK Vision Strategy 2013-2018
Description

Level 1a: Goldmann style applanation tonometry repeat readings

A first level community service for IOP refinement where other signs of glaucoma are not present will reduce unnecessary referrals to the hospital eye service, reducing patient anxiety and minimising capacity issues within the already overburdened hospital glaucoma clinics. The service will be cost effective with a greater number of patients managed within the primary care setting.

Level 1a (Part 1)

Patients who are identified as having IOP > 21 mmHg and no other signs of glaucoma during a GOS or private sight test will have immediate slit lamp GAT or Perkins tonometry assuming the optometrist is contracted to provide the service. This service falls within core competencies for optometrists. Set up costs of purchasing tonometers should be considered.

Outcomes

Guidance from the College of Optometrists and the Royal College of Ophthalmologists recommends that the outcome should be dependent on the patient’s age and they define certain groups who may not need referral. However, pressures should still be repeated on these groups to ensure that decisions are made based on reliable readings.

There are four possible outcomes from this first repeat of pressures:

1. All patients with IOP > 31mmHg should be referred for OHT diagnosis without further IOP refinement
2. Other patients with a pressure of 22 - 31 need to proceed to Part 2 (2nd repeat pressure)
3. Pressures which differ between the eyes by 5 mmHg or more should proceed to Part 2 (2nd repeat pressure)
4. All other IOP results are within normal limits and the patient can be discharged.

At risk groups should be monitored at appropriate intervals.
Level 1a (Part 2)

Patient attends for repeat Goldmann or Perkins applanation tonometry on a separate occasion.

Outcomes

There are four possible outcomes from repeating this test:

1. Patients who need to be referred for OHT diagnosis based on confirmed IOP result:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>&lt; 65 years</th>
<th>65 – 79 years</th>
<th>80 years +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure</td>
<td>&gt; 21 mmHg</td>
<td>&gt; 24 mmHg</td>
<td>&gt; 25 mmHg</td>
</tr>
</tbody>
</table>

2. Patients who can be referred direct to the OHT monitoring service assuming there is a service in place:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>65 – 79 years</th>
<th>80 years +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure</td>
<td>22 - 24 mmHg</td>
<td>22 - 25 mmHg</td>
</tr>
</tbody>
</table>

NB: The Joint RCOphth/COptom’s advice suggest that optometrists might “consider not referring” this group of patients as under the NICE Guidelines they will never need treatment. Whilst this is true, these patients however do still have OHT and need careful monitoring to pick up any signs of progression towards COAG. It is not appropriate to monitor these patients under GOS.

These patients are not really in any of the groups specifically covered by NICE but the most appropriate way to deal with them is to make the assumption that the College’s advice constitutes the establishment of a "management plan" as per para 1.5.6 of NICE CG85 and monitor these patients as having diagnosed OHT.

3. Where repeat applanation measurements show a consistent difference in pressure of 5 mmHg or more, practitioners may wish to consider whether referral may be appropriate, or whether there is a reasonable explanation (e.g. surgery to one eye).

4. The results are within normal limits and the patient can be discharged. At risk groups should be monitored at appropriate intervals.
The criteria for inclusion of patients in level 1a:

- IOP > 21 mmHg as measured at the sight test following College guidance on technique where NCT is used (4 readings), and no other signs of glaucoma are present.

Level 1b: Visual field repeat readings

A first level community service for visual field refinement will reduce unnecessary referrals to the hospital eye service, reducing patient anxiety and minimising capacity issues within the already overburdened hospital glaucoma clinics. The service should be cost effective with a greater number of patients managed within the primary care setting.

Patients who are identified as having suspicious visual fields during a GOS or private sight test will have visual fields repeated on a separate occasion assuming the optometrist is contracted to provide the service. This service falls within core competencies for optometrists.

Outcomes

There are three possible outcomes from these tests:

1. The results are within normal limits and the patient can be discharged. At risk groups should be monitored annually under GOS. (This would include the case where there is a defect on the repeat but NOT in the same areas of the visual field as the original defect. Such inconsistent defects are usually due to the patient finding the test difficult and should not, as a rule, lead to referral and further repeats/monitoring may well just add further confusion.)

2. Visual field is suspicious and requires monitoring at appropriate intervals

3. Visual field defect is confirmed and the patient is referred to consultant ophthalmologist.

The criteria for inclusion of patients in level 1b

- Visual field defect which may be due to glaucoma and requires further investigation, and no other signs of glaucoma are present. (Defects caused by old pathology or lens rim artefacts should be excluded.)
Level 1c: Patients from non-participating practices

It is anticipated that the majority of optometrists will participate in the Level 1a or 1b pathway if it is commissioned, assuming refresher training is available and funding is appropriate. However a small minority of practices may decide not to sign up to the pathway. Commissioners may look to accredited practitioners to provide referral refinement for patients from non-participating or out-of-area practices.

In this case it should be emphasised that the second optometrist assumes clinical responsibility for the detection of the patient suffering from glaucoma or ocular hypertension. Therefore assessment of the optic disc, anterior angle and where appropriate, visual field is necessary.

These additional examinations required will take more time and will require a greater level of funding than Level 1a or 1b. (Please see guidance from the Association of Optometrists and the Optical Confederation on insurance issues.)

The criteria for inclusion of patients in level 1c

- IOP > 21 mmHg as measured at the sight test following College guidance on technique where NCT is used (4 readings), and no other signs of glaucoma are present or visual field defect which may be due to glaucoma and requires further investigation, and no other signs of glaucoma are present.

NB: Glaucoma is a very slow developing disease and there is very little risk to the patient in delaying the repeat tests. The reason for repeating the tests on a different occasion is to ensure that factors that may have influenced the patient responses the first time round, particularly in the fields test, will be different.

Level 1 accreditation

The procedures and skills required for level 1 are core competency. That doesn’t necessarily mean that every practitioner is completely up-to-date in those areas and/or has any recent experience of the techniques. LOCSU would expect most areas to introduce repeat IOP and fields, with no accreditation requirement at all beyond a refresher for those who require it. Others may require some form of accreditation. However it should be noted that, for Level 1a in particular, a very high level of participation is the key to successful referral deflection. Placing barriers to participation at core competency level may affect the success of the scheme.
If accreditation at this level is required, it must be available rapidly to new practitioners in an area. Typical professional staff turnover within an area can be around 10% per year. A LOCSU training and accreditation package for Level 1 IOP repeat readings and Level 2 OHT monitoring has been developed in conjunction with the Welsh Optometric Post-graduate Education Centre (WOPEC), and is available to optometrists in England and Wales via their LOC or ROC.

Level 2: OHT and suspect COAG monitoring

Patients who have a confirmed diagnosis of OHT or suspect COAG and who do not require treatment should follow the OHT or suspect COAG monitoring pathway and be monitored at regular intervals as specified by NICE. Patients will be referred to this pathway from the community OHT diagnostic clinic or secondary care with an individual management plan.

It is further recommended that patients falling into the 2 groups that the Colleges suggest may not need referral should be directed straight into this service rather than refer them for diagnosis.

The skills required for this pathway are covered by the core competencies for optometrists. Training and accreditation for optometrists would include knowledge of the NICE guidelines, referral criteria, interpretation of results and the disease process. If a change in clinical status is found, the patient should be referred to a specialist community optometrist or hospital eye department for further investigation, depending on local protocol. This service will reduce unnecessary hospital eye service consultations and minimise capacity issues in secondary care.

Set up costs of purchasing slit lamp mounted Goldmann tonometers should be considered.

The accredited optometrist will carry out slit lamp mounted Goldmann tonometry, suprathreshold perimetry, Van Herick’s test, and dilated slit lamp biomicroscopic examination of the optic nerve head.

Outcomes

There are two possible outcomes from these tests:

1. No change in clinical status. Next appointment as per protocol.
2. Change in clinical status. Patient referred to specialist optometrist or hospital clinic depending on local arrangement.
The criteria for inclusion of patients may include the following:

- Diagnosed ocular hypertension discharged from hospital eye service (HES) or specialist practitioner
- Diagnosed suspect COAG discharged from HES or specialist practitioner

**Level 2 accreditation**

With OHT monitoring, although the skills are still core competencies, LOCSU would expect most areas to require accreditation in the form of a validation of knowledge and skills. A LOCSU training and accreditation package for Level 1 referral refinement and Level 2 OHT monitoring has been developed in conjunction with the Welsh Optometric Post-graduate Education Centre (WOPEC), and is available to optometrists in England and Wales via their LOC or ROC. This package includes distance learning via CD–Rom and a template for practical skills assessment in slit lamp GAT, disc assessment and Van Herick’s technique. A number of Lead Assessors have been trained at WOPEC so that the practical assessments can be organised locally when required.

**Patient records**

All advice given to the patient, and procedures undertaken should be recorded on a patient card or electronic device, and stored in a safe retrieval system.

On conclusion of an IOP repeat readings or OHT monitoring assessment the optometrist must complete the appropriate report form, entering the information on the IT system for audit purposes (where applicable) and report to the referring GP, and to the hospital eye service, should an onward referral be necessary. For full NICE compliance there should be disc images taken close to the time of discharge to the monitoring scheme which are available as a baseline measure.

**IT system**

LOCSU has developed an electronic patient record for Level 1 which is currently in use in areas such as Stockport. This IT platform will standardise data collection and will ensure audit data is readily available. It can generate paper referrals or can provide for electronic referral via a referral management centre. Work on extending the Level 1 IT platform to support the Level 2 pathway is nearing completion.
Special requirements – equipment

All practices participating in the Level 1 IOP repeat readings service and the Level 2 OHT monitoring service will be expected to employ an accredited optometrist and have the following equipment available:

- Access to the Internet
- Slit lamp and fundus viewing lens
- Goldmann applanation tonometer (Perkins acceptable for IOP refinement)
- Threshold fields equipment capable of producing a printed report
- Distance test chart
- Appropriate ophthalmic drugs (Mydriatic, Anaesthetic, Staining agents)

Patient information

Patient information leaflets as recommended by NICE will be available to patients.
Appendix 1
Glaucoma Repeat Readings Pathway

LOCSU Glaucoma Repeat Readings & OHT Monitoring Pathway. [Rev 14.03.16, v3.3].
Copyright © LOC Central Support Unit. May 2009. All Rights Reserved.
Appendix 2
Patients from Non-Participating Practices

Patient attends for GOS or private eye test at a non-participating practice

IOP > 21 mmHg
Optic nerve head normal
Visual field normal

Patient referred to community optometrist enhanced service provider for referral refinement

Any other signs of glaucoma (regardless of IOP)

Patient referred to consultant ophthalmologist

Examination to include:
Assessment of IOP by Goldman or Perkins tonometry,
Assessment of optic nerve head
Standard automated perimetry
Van Herick’s assessment

IOP ≤ 21 mmHg

Discharge

IOP 22-31 mmHg

Repeat Goldmann or Perkins tonometry 1-2 weeks later

IOP > 31 mmHg or other sign of glaucoma

Refer to consultant ophthalmologist

IOP ≤ 21 mmHg

Discharge

Age < 65 IOP > 21 mmHg
Age 65-79 IOP > 24 mmHg
Age ≥ 80 IOP > 25 mmHg

Refer to secondary care for OHT diagnosis

Ages 65-79 IOP 22-24 mmHg

Refer to OHT monitoring
Appendix 3

OHT Monitoring Pathway

Patient diagnosed with OHT (no treatment required)

- CCT 590 micrometres
  - IOP 22–32 mmHg
  - Age - any

- CCT 555–590 micrometres
  - IOP 22–25 mmHg
  - Age - any

- CCT 555–590 micrometres
  - IOP 26–32 mmHg
  - Age > 60
  - Or
  - CCT < 555 micrometres
  - IOP 22–25 mmHg
  - Age > 65
  - Or
  - CCT < 555 micrometres
  - IOP 26–32 mmHg
  - Age > 80

Referral for monitoring by accredited optometrist at intervals specified by NICE

Examination to include:
- Suprathreshold perimetry
- IOP measured by Goldmann applanation tonometry
- Van Herick’s assessment
- Slit lamp biomicroscopic examination of the optic nerve

No change in Clinical status

- Arrange next appointment as per protocol

Change in Clinical status

- Refer to specialist accredited optometrist or hospital clinic
- CCT measurement
  - Gonioscopy assessment
  - Image capture of the optic nerve

No change in Clinical status

- Evidence of optic nerve damage and/or visual field changes
  - Refer to consultant ophthalmologist

NB: All combinations of CCT, IOP and age not listed above should be referred to the treatment pathway
Appendix 4
Clinical Management Guideline for Glaucoma Repeat Readings (Level 1)

1. **Intra-ocular pressure alone (i.e. normal fields and disc appearance)**
   
   IOP > 21 mmHg by non-contact tonometry at GOS or private sight test and IOP refinement by Goldmann or Perkins tonometry is carried out by the optometrist.

   **Outcomes:**
   - All patients with IOP > 31mmHg should be referred for OHT diagnosis without further IOP refinement.
   - Any patients with IOP ≤ 21mmHg should be discharged
   - If IOP result is 22 - 31mmHg, or if there is a difference in IOP of ≥ 5 mmHg between the eyes then Goldmann (or Perkins) is repeated on a separate occasion.
     
     **Second repeat of Goldmann or Perkins tonometry** (on a separate day)

   **Outcomes:**
   - Any patients with IOP ≤ 21mmHg should be discharged
   - If there is a difference in IOP of ≥ 5 mmHg between the eyes then practitioners may wish to consider whether referral may be appropriate, or whether there is a reasonable explanation (e.g. surgery to one eye)
   - The following patients are referred for OHT diagnosis:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>&lt; 65 years</th>
<th>65 – 79 years</th>
<th>80 years +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure</td>
<td>&gt; 21 mmHg</td>
<td>&gt; 24 mmHg</td>
<td>&gt; 25 mmHg</td>
</tr>
</tbody>
</table>

   - The following patients are referred to the OHT monitoring service if it exists or for OHT diagnosis otherwise:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>65 – 79 years</th>
<th>80 years +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure</td>
<td>22 - 24 mmHg</td>
<td>22 - 25 mmHg</td>
</tr>
</tbody>
</table>
2. **Visual Field alone (i.e. normal IOP and optic disc appearance)**

   Visual field defect which may be due to Glaucoma found at GOS or private sight test and visual field refinement is carried out by the optometrist on a separate occasion.

   **Outcomes:**
   - Field defect consistent on two occasions, patient is referred to consultant ophthalmologist for differential diagnosis or specialist optometrist as per local protocol.
   - Field defect inconsistent or not repeatable patient should be discharged

3. **Optic Disc indications**

   **Suspicious optic nerve head found at GOS or private sight test.** Patient is referred to a consultant ophthalmologist or specialist practitioner as per local protocol

4. **Narrow Angle**

   **Suspicious anterior chamber angle found at GOS or private sight test.** If suspect narrow angle, refer to consultant ophthalmologist if symptoms of sub-acute attacks or IOP > 21 mmHg or greater (Van Herick grade 2 or less)
Appendix 5
Clinical Management Guideline for OHT Monitoring (Level 2)

1. **No change in clinical status**

   No change in clinical status found at OHT monitoring assessment.
   - Next appointment is arranged as per protocol.

2. **Change in clinical status**

   Change in clinical status found at OHT monitoring assessment.
   - Patient is referred to hospital clinic or specialist optometrist depending on local protocol.

   Further diagnostics carried out by specialist optometrist/healthcare professional.
   - Change in clinical status confirmed. Patient is referred to consultant ophthalmologist.
   - No change in clinical status. Patient is referred back to OHT monitoring
## Appendix 6
The General Optical Council Core Competencies for Optometry

<table>
<thead>
<tr>
<th>Core Subject 1:</th>
<th>Communication Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>The ability to communicate effectively with the patient and with professional colleagues</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Subject 2:</th>
<th>Professional Conduct</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>An understanding of professional conduct and the legal aspects of professional practice</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Subject 3:</th>
<th>Visual Function</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>An understanding of and the ability to assess visual function</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Subject 4:</th>
<th>Optical Appliances</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>The ability to prescribe and to dispense appropriate optical appliances</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Subject 5:</th>
<th>Ocular Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>The ability to perform an examination of the eye and related structures</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Subject 6:</th>
<th>Ocular Abnormalities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>The ability to identify and manage ocular abnormalities</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Subject 7:</th>
<th>Contact Lenses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>The ability to manage patients with contact lenses</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Subject 8:</th>
<th>Binocular Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>The ability to assess and manage patients with anomalies of binocular vision</em></td>
</tr>
</tbody>
</table>