



City Research Online

City, University of London Institutional Repository

Citation: Amin, M., Edgar, D. F, Parkins, D. and Hull, C. (2014). A Survey of Local Optical Committees (LOCs) involved in Cataract Pathways within the London Region. *Optometry in Practice*, 15(1), pp. 29-36.

This is the accepted version of the paper.

This version of the publication may differ from the final published version.

Permanent repository link: <http://openaccess.city.ac.uk/4858/>

Link to published version:

Copyright and reuse: City Research Online aims to make research outputs of City, University of London available to a wider audience. Copyright and Moral Rights remain with the author(s) and/or copyright holders. URLs from City Research Online may be freely distributed and linked to.

City Research Online:

<http://openaccess.city.ac.uk/>

publications@city.ac.uk

A Survey of Local Optical Committees (LOCs) involved in Cataract Pathways within the London Region

Mitesh Amin¹, David F Edgar², David Parkins³, Christopher C Hull²

¹ The Neville Chappell Research Clinic, The Institute of Optometry, 56-62 Newington Causeway, London

² Applied Vision Research Centre, City University London, Northampton Square, London

³ NHS Bexley Clinical Commissioning Group

Disclosure: MA (none), DFE (none), DP (none), CCH (none).

Word count: 4333 (excluding abstract, references and tables)

Running head: cataract pathways in London

Key words: cataract, enhanced services, direct referral, choose and book, survey, London

Abstract

Purpose: Cataract enhanced service (direct referral) schemes have been in existence for over 12 years. Such schemes make better use of the primary care practitioner's professional expertise and have the potential to reduce costs and provide an improved patient pathway. Surprisingly little has been published about these schemes, hence there is a lack of evidence to inform local decision making about existing and future services. The aim of this study was to provide more evidence by surveying the Local Optical Committees (LOCs) to obtain their views on their involvement or lack of involvement in cataract enhanced service schemes in the London region. Secondary aims were to compare how schemes operate and determine why schemes do not exist in some areas.

Method: A structured survey of London's 14 LOCs was carried out on two occasions (2007 and 2012). LOCs were contacted via e-mail, telephone or written letter. Some supporting information was obtained from PCTs. All data were analysed qualitatively.

Results: In 2007, only two out of the 10 LOCs that had participated in the 2005 Cataract Choose and Book scheme were involved in running a full direct referral scheme. This had risen to six by 2012 with a total of 11 LOCs having participated in a trial/pilot scheme by that date. The remaining three LOCs have never participated in a scheme. Although there are similarities across schemes (e.g. requirement for accreditation, a referral fee etc), marked differences were found in patient booking arrangements, requirements during initial assessment and post-operative assessment. The percentage of LOCs involved in full schemes in the London region (43%) is lower than for the rest of England (69%). Where trial/pilot schemes had run

but no full scheme had been implemented the major reasons reported were: lack of central funding; the schemes were only feasibility studies; and the requirement for a Unique Booking Reference Number (UBRN) for the Choose and Book process.

Conclusions: Enhanced cataract service schemes do not always develop into full schemes even if the trial/pilot scheme has been deemed successful. Schemes may have a more prominent role in future with requirements on Clinical Commissioning Groups to provide an improved patient experience within tighter financial constraints. The co-ordinating activity across England of the Local Optical Committee Support Unit (LOCSU) and the newly formed Local Professional Networks for Eyecare should help increase uniformity of approach. All established cataract schemes will need to be re-procured during 2013/14 if they are to continue without interruption.

Introduction

Cataract continues to be a major cause of visual impairment in the UK. Demographic changes over the past 14 years show that there are now 10.8 million people in the UK over the age of 65 (most recent data for mid 2011 to mid 2012) compared to 8.3 million in 1998, with a corresponding increase in the numbers affected by age-related cataract.¹ In a sample of British people aged 75 years or older, it was estimated that 12.4% had visual impairment (defined as binocular VA of worse than 6/18 when wearing their habitual correction) and that cataract was the cause of the visual impairment in 36% of this group.² Hence cataract services remain a priority for the NHS.

Since the publication of *Action on Cataracts* in 2000³ there has been a marked expansion in provision of cataract procedures: from 237,507 in 2000-2001 to 343,782 in 2010-2011, an increase of 44.7%.⁴ This expansion has been accompanied by a significant reduction in median waiting time for surgery from 164 days to 57 days.⁴ Although this expansion in provision has produced positive media publicity, the increase in availability of cataract surgery could come at a cost. Sparrow⁵ argued that better patient reported outcome data and health gain data are needed to avoid waste and potential harm since the expansion in cataract surgery has led to the procedure being portrayed as quick, easy and risk free. However, Black *et al.*,⁶ in a prospective cohort study, while agreeing that the risk of unnecessary surgery was present, were less certain that there was overutilization of cataract surgery in the UK because of methodological difficulties in measuring the effect of cataract surgery on visual function and quality of life.

As a result of the expansion in cataract surgery provision, capacity is no longer the driver that it was in 2000. However, there remains a requirement to strive for best practice throughout the whole cataract pathway, part of which is the referral pathway for cataract surgery. *Action on Cataracts* recommended setting up direct referral schemes under locally agreed protocols to streamline the process for the patient.³ The Department of Health's National Eye Care Steering Group proposed that this should be the preferred referral method.⁷ These schemes, which make better use of primary care practitioners, are supported by both ophthalmologists⁸ and optometrists.⁹ With increasing financial pressures on the NHS and the need to take some of the loading off the Hospital Eye Service, such schemes have the potential to deliver an improved patient referral pathway with fewer steps and to reduce costs without affecting quality. The recently introduced Clinical Commissioning Groups may help drive this development by requiring services to be cost-effective and achieve continuous improvements in the quality of patient services and outcomes.¹⁰

In 2005, the Association of Optometrists listed 37 cataract referral schemes. It is therefore surprising that few reports are available on the development and results of such enhanced pathway/direct referral schemes; a systematic review of UK Eye Care Services commissioned by the College of Optometrists and published in 2011 found only 10 papers in the black literature that covered cataract management with 6 specifically referring to direct referral.¹¹ Although there have been a number of papers which describe successful schemes,^{12–20} there remains a need to gain a better understanding of the outcomes from cataract enhanced services. Hence, the primary aim of this study is to provide more evidence by surveying the LOC's in the London area to obtain their views on their involvement or lack of involvement in

cataract enhanced schemes within the London region. Secondary aims were to compare how schemes operate and to determine why schemes do not exist in some areas. We also wished to determine why some trial/pilot schemes had not been developed into full schemes and the reasons why this should have occurred.

Methodology

Information regarding direct cataract referral schemes within the London region was obtained by contacting members of London's Local Optical Committees (LOC) via phone, email or written letter with the help of the Association of Optometrists (AOP) and the Local Optical Committee Support Unit (LOCSU). Some supporting information was obtained from PCTs.

London was chosen for several reasons: Firstly, the range for the Overall Index of Multiple Deprivation in London is from 1.7 to 66.2, which is similar to the rest of England (0.53 to 87.8) hence, based on this measure, London as a whole is fairly representative of the rest of England; secondly the London region has had a number of LOCs involved in negotiations to set up trial/pilot schemes; and thirdly, London is a densely populated region with 31 Primary Care Trusts (PCT) prior to the NHS reorganisation, which would allow for a comparison of how different schemes operate within the same geographical region.

The following information was requested from the LOCs:

- Has the LOC ever been part of a local direct referral scheme?
- If yes, was the scheme still current?
- If no, but a scheme had been established, why did the scheme cease?
- If no scheme was operating at present, was such a scheme being considered?

LOCs which had been involved in a direct referral scheme in the past were requested to provide a copy of the proforma agreed with their PCT. This is the form

completed by an optometrist when referring a patient into the direct cataract referral scheme.

LOCs with a current scheme were contacted again and asked to provide further information which included:

- How much were optometrists paid for each referral?
- Was a dilated fundus examination mandatory?
- Was referral direct regardless of any ocular/systemic co-morbidity?
- Was booking made directly into the hospital/treatment centre or via an intermediate booking service?
- The number of hospitals/treatment centres available?
- Were post-operative assessments carried out within the Hospital Eye Service (HES) or by accredited optometrists in community practice?
- If a post-operative assessment was provided, what was the optometrists' fee for this service?

Local research and ethics approval was obtained from City University London and the tenets of the Declaration of Helsinki were followed throughout the study. All data gathered were analysed and assessed qualitatively.

Results

Analysis of schemes

There are 14 LOCs within the London region and table 1 summarises the availability of direct cataract referral/enhanced cataract services involving these LOCs as of July 2012. London has had a number of schemes for direct cataract referral (11 out of 14 or 79% of LOCs have participated). At July 2012 only Hillingdon; Ealing, Hammersmith & Hounslow; and Kensington, Chelsea & Westminster have not participated in a scheme and, although all three LOCs have been involved in discussions regarding possible enhanced cataract schemes, none was aware of any plans yet for a scheme.

Of the 11 LOC areas in which trial/pilot schemes have run in the past, 6 (43% of the total of 14 LOC areas) had full schemes running as of July 2012 (table 1). Croydon was one of the first LOCs to participate in a referral scheme for cataract, which began in 2004 as part of the wider South West London scheme, but the scheme ceased due to lack of funding. Audit information collected from the pilot stated a successful referral rate of 93.3%. A successful referral in this context is defined as a patient who is referred and is then listed for surgery. A local scheme was re-launched in Croydon in 2006, but with patients referred via a Clinical Assessment Service to Croydon University Hospital Eye Unit rather than offering any choice of service provider. Under the Croydon scheme, patient choice is available only via referral to the patient's GP. Optometrists are paid £20 for each direct referral and £20 for a post-operative assessment. Within the first year Croydon optometrists had referred approximately 170 patients through the scheme.

Barnet (part of Barnet, Enfield & Haringey) LOC participated in a successful pilot scheme that ran for over a year. A full scheme is currently in place in Barnet and optometrists are paid £25 per assessment, which must include a dilated fundus examination. Post-operative assessments are not carried out by optometrists. Optometrists in Barnet are also connected to the NHS.net and the possible implications of this are discussed later in this paper. Neighbouring Enfield & Haringey have not had a scheme in the past but it was reported that Haringey was about to procure a new scheme.

In Southwark and Lambeth (part of Lambeth, Southwark & Lewisham LOC) a direct referral scheme was re-introduced in July 2009. An earlier successful trial as part of the South East London Choose and Book scheme ceased at the end of 2006 when centralised funding ended. The Southwark pilot had a successful referral rate of 79% while Lambeth had a successful referral rate of 71%. The re-launched scheme pays accredited optometrists £25 for each direct referral and dilation is a requirement. Patient referrals are faxed directly to the treatment centre of choice. Post-operative assessments are carried out within the Hospital Eye Service (HES). Optometrists within the catchment area were also due to receive NHS.net addresses in the near future to facilitate referral.

The direct cataract referral scheme involving London (East) & The City LOC was re-launched in 2007 and optometrists are paid £30 for an assessment that includes a dilated fundus examination.

Information regarding the remaining two current schemes, involving Camden & Islington and Bexley, Bromley & Greenwich, is tabulated for ease of comparison (table 2) to highlight some key similarities and differences between typical schemes. Although these are two of the longest running schemes in London (a scheme began in Bexley, Greenwich & Dartford as early as 2002), they employ different methods throughout the process from initial referral to post-operative assessment.

Brent (part of Brent & Harrow LOC), Kingston (part of Kingston, Richmond & Twickenham LOC) and Merton LOCs (part of Merton, Sutton & Wandsworth LOC) have all participated in successful pilot schemes, and a report on the Kingston pilot was published in the *Optician* in 2003¹⁴. It was notable that patients referred via the “fast track” scheme in Kingston had an average waiting time from optometrist referral to pre-assessment of 21.6 days compared with 12 weeks for patients referred in the usual way via the patient’s GP. However, none of these LOCs are currently involved in any direct referral schemes at present. Merton, Sutton & Wandsworth PCT commissioned a service that assesses all ophthalmic referrals, including cataract. It is a consultant-led scheme, which has no optometric involvement. All cataract referrals have to go through this scheme.

In 2009 Redbridge & Waltham Forest optometrists had two referral pathways for patients with cataracts. The first pathway involved a single PCT area which offered direct referral into the ophthalmology department. There was no fee for referral via this route. A second pathway was introduced in October 2008. A treatment centre was shared with Barking & Havering. Two PCTs within the Redbridge & Waltham

Forest catchment area commissioned a number of cataract procedures at the centre. The proforma was shared with Barking & Havering and is an enhancement of the *Action on Cataracts* proforma layout. Optometrists were paid a fee for a dilated fundus examination, which is mandatory. A pilot scheme for direct cataract referral was launched at a later date (2011), for which there was no fee offered to optometrists. Consequently, this scheme ceased due to poor uptake.

Barking & Havering had an established scheme for cataract referral, however at present the scheme no longer exists as the contract with their local independent treatment centre has ended. Referral is currently via the patient's GP.

Information collected in scheme proforma

The second part of this review investigates the information gathered by optometrists for referrals on their respective proforma. Proforma were obtained from all LOCs involved in a direct referral scheme. Some information required, such as the details of the chosen treatment centre, is common to every proforma (table 3), however, there are also notable variations between the proforma, for example whether dilated fundus examination is mandatory or recommended, and these are summarised in table 4.

Discussion

The 6 schemes running in the London area at the time of the second survey in 2012 involved 43% of the 14 London LOCs, which is a lower percentage than figures reported by LOCSU for the rest of England in a short survey conducted in 2010.¹⁹ These latter data were collected using an online survey sent to LOC chairs over a 4-week period. Although the response rate was a healthy 58%, LOCs involved in schemes may be more likely to respond to the survey which could introduce some bias. Only 25% of LOCs in England (excluding London) have a post-operative cataract surgery follow-up pathway involving community optometrists. This finding is similar to London, where 1 out of the 6 schemes for which we had definitive data had a local scheme for post-operative follow-up. Perhaps unsurprisingly, there is no standardisation of the proforma used across schemes that are currently running and therefore no standardisation of the information requested. Similarities between proformas are reported in Table 3. Perhaps of greater interest are the differences between proformas highlighted in Table 4. Only Barking & Havering included a health questionnaire, which is to be completed by the patient. An audit in Avon and South Gloucestershire comparing cataract referrals via a direct referral scheme with referrals using the GOS18 referral form via the GP showed that direct referrals provided better information regarding visual acuity/reading speed/contrast sensitivity while referral via the GP resulted in better information about the patient's medical, personal and drug history.¹⁷ Inclusion of a standard health questionnaire in direct referral schemes could help to reduce these differences and is recommended by LOCSU⁹. The Bexley, Bromley & Greenwich patient information sheet makes reference to an online cataract decision aid to help the patient decide if surgery is right for them. It is also available as a mobile phone application. Performing a dilated

ocular fundus examination is a requirement in 5 out of the 6 full schemes running in the London region for which we have definitive data. Examination of the fundus under dilation could be regarded as essential in order to reveal any potential co-morbidity which may influence the outcome of surgery, and allows patients to make a more informed decision regarding management. It also allows the optometrist to re-assess the urgency of referral should examination of the macula reveal that VA is reduced as a result of wet AMD. On the other hand, direct referral regardless of co-morbidity may result in an improved quality of life because of improved navigational vision, contrast sensitivity, increased brightness, and improved colour rendition, even though surgery may not improve the overall level of visual acuity. Grading of cataracts may also be of benefit in helping hospital eye clinics identify those more “difficult” cataracts on which to operate. Evaluation of the impact of the referral proforma employed in direct referral schemes on the quality of the outcome for the patient does not seem to have taken place. The results of an evaluation and identification of key features of an exemplar proforma could lead to further sharing of good practice. LOCSU has published proforma to support LOCs negotiating with commissioners for enhanced service pathways and this should help achieve more uniformity.⁹

Reasons given for schemes folding

LOC's that have participated in a direct referral scheme have generally commented in their survey responses that their scheme had been quite successful. Although such reports are open to bias there is audit evidence from the London boroughs of Barnet, Southwark & Lambeth, and Bexley, Bromley & Greenwich to support this view based on successful referral rates, and from the high rates of successful

referrals reported in other schemes in the UK (Table 5)¹¹⁻¹⁷. This raises the question why 5 of the 11 pilot schemes run in London ceased after the initial trial/pilot periods? One reason given by PCT's was that the pilot schemes were only intended to judge feasibility, and as some of these schemes ceased abruptly no clinical audit data were available to judge their success. Also, audit information was harder to obtain as the PCTs were being abolished under the NHS reorganisation. In some boroughs there was insufficient uptake by local practices and schemes were not actively managed. However, the main reason was a lack of central funding which led to the cessation of the majority of the trial/pilot schemes. Funding streams within the NHS can often come to an abrupt end; for example, central NHS funding of Choose and Book stopped in December 2006 and all the existing cataract referral schemes ceased at that time. Funding has always been an issue with any form of service or treatment. For direct cataract referral schemes, PCTs and now CCGs may also incur additional costs for a team to administer the referral process. On the other hand, accreditation of individual optometrists should improve the quality of cataract referrals as only those patients who satisfy the criteria set out in the proforma, criteria consistent with the recommendations in *Action on Cataracts*³, will be referred via the scheme, and this should reduce over-referral of patients for possible cataract extraction, with cost savings to the CCGs. Evidence provided for UK schemes in table 5 indicates that a large percentage of patients who were referred via direct referral schemes went on to be listed for cataract surgery.

Another approach which is intended to save costs and release capacity in the HES is the use of 'best practice tariff'. This is a single price that covers the HES cataract pathway. This approach is designed to improve quality in the NHS by reducing

unexplained variation in the provision of services and by universalising best practice; this can be achieved in the management of cataract when the number of visits required by a cataract patient to the eye clinic is reduced, with assessments taking place on the same day. The provision of post-operative assessment by community optometrists in uncomplicated surgery could help release capacity and free up clinic time as well as offering more convenient local access for patients. The Royal College of Ophthalmologists' Cataract Surgery Guidelines note that the final review can be carried out by a range of staff within the unit or by accredited optometrists²¹. At the time of the survey Croydon is the only scheme in the London region where accredited optometrists are able to provide post-operative assessments. Arguments against community based post-operative assessments in the London area include access within the region to a large number of hospitals and treatment centres, hence most patients are being accommodated within the HES. Assessment within the HES can also make listing for second eye surgery easier as the patient could be pre-assessed and listed at the same time, allowing for a true one-stop referral. However, in some areas, GP prior approval is required before second eye treatment can proceed. Furthermore, if post-operative assessments are seen within the eye clinic, any complications can be reviewed by a consultant on the day without requiring a patient to be referred back into the eye clinic.

The evidence-base for post-operative management of cataract patients is scant²² since most studies report on referral and not follow-up. However, Newsom *et al.*²³ reported on a shared care cataract pathway in Huntingdon which incorporates post-operative assessment by community optometrists. The pathway has demonstrated that optometrists can generate accurate and comprehensive post-operative

information on VA, refractive error, complications etc. Such information is invaluable when negotiating with CCGs and when demonstrating that NHS targets have been met. The pathway has reduced the average number of visits made by each patient to the hospital, allowing the HES to focus resources on other eye conditions. Two surveys have reported patient satisfaction with the service to be very high. Further evidence from other schemes would allow a stronger business case to be put forward in future procurements of cataract schemes. Options open to CCGs may include 'Any Qualified Provider (AQP)' schemes, in which patients are able to choose from a range of approved providers. However, in reality, schemes such as cataract assessment and repeat measurements would only be applicable to optometrists as these schemes are supplementary to the NHS sight test or a private eye examination.

Another reason cited by LOCs why successful Choose and Book trial/pilot schemes had failed to stimulate the development of full schemes was the requirement for each patient to have a Unique Booking Reference Number (UBRN) as part of the patient choice agenda. This number can only be provided by uploading the referral onto the Choose and Book System, mostly via the General Practitioner (GP). Some areas use an intermediate booking service which is able to provide the UBRN. Bexley Referral Management and Booking Service (RMBS) provides a Central Booking Service (CBS) for the Bexley, Bromley & Greenwich scheme. Referrals are faxed to the CBS and patients can then select the hospital eye department of their choice. Each referral is also individually screened to ensure that all the required information is provided as outlined in the protocol. Other schemes, such as Camden & Islington, have a different process whereby the referrals are sent directly to the patient's

desired treatment centre, where the appointment is then made and a booking number provided. The requirement of a UBRN for each referred patient can only be satisfactorily addressed at the optometrist level if community optometrists are allowed to connect to the NHS booking system via a N3 internet gateway. Referral schemes have adapted to this situation either by providing an intermediate booking service or having the patients referred directly to their chosen eye department. As more optometrists gain connection to NHS.mail this may in turn allow for alternative booking routes. Electronic referrals can be emailed to the booking centre or treatment centre of choice.

The connection to the NHS booking system and the use of a single shared proforma would help to embed the schemes within the cataract pathway, to standardise the fees claimed by optometrists, to standardise the tests carried out during the initial assessment, and streamline further the current booking system. Optometrists diagnose many patients with cataract who may be London residents but who are not registered with a GP practice within the CCG's coverage area. In this situation the patient has to be referred routinely via their GP. If the whole of the London region were to implement a direct referral scheme using the same criteria, all cataract patients could be referred directly to their treatment centre of choice either directly or through Choose and Book depending on local arrangements. This could be facilitated through the work of a Local Professional Network (LPN) for Eyecare whose initial focus may be on local needs assessment, quality assurance and improving services in line with national eye health pathways. The LPN feeds into both the CCGs and Health and Wellbeing Boards.

Accreditation of optometrists

All schemes include the requirement for individual optometrists to be accredited. Only an accredited optometrist may refer directly, and non-accredited optometrists within the same practice are required to refer routinely. It would be possible for non-accredited optometrists to refer the patient on to an accredited optometrist within the same practice increasing the number of patients passing through the scheme. Such an approach would be beneficial to the CCG. The optometrists' fees for direct referrals are claimed either by being sent to the CCG's payment agency along with the forms submitted for General Ophthalmic Services (GOS) as provided through the NHS, or via NHS Shared Business Services (SBS) which may also process the fees. The amount claimed for each referral was negotiated between each LOC and their respective PCT and varies between schemes (Table 2). Under AQP, CCG's now have a set of pricing principles they will need to follow to set a fixed price e.g. benchmarking and ensuring an efficient model of delivery.

The requirements for an optometrist to join an accredited scheme can vary from attending a lecture to gaining some hospital-based experience. There is the view that all that is required is to introduce a distance learning pack outlining the screening and referral process, after which an optometrist would acknowledge, via their signature, the terms of service. In reality, distance learning is useful in providing basic knowledge about the scheme for new participants, with practical experience provided by shadowing a consultant in the cataract clinic for post-operative cataract schemes.

Limitations of the study

The study is limited to the London region which may not be representative of the rest of England. We have argued reasons for the choice and the demographic included within the sample but it remains to carry out a larger survey covering a wider geographical area. We were unable to obtain audit information for all London-based trial/pilot schemes. This was, in part, because restructuring within the NHS made it more difficult to obtain audit data and because some schemes ceased abruptly with no clinical audit data being made available. As the NHS restructures and the process of commissioning of services changes, cataract schemes will undoubtedly be affected. The current system of enhanced services will not exist in the new NHS. As a result, all enhanced schemes, including direct cataract referral, will have to be re-procured by the CCG during the first year of the restructured NHS.

Summary and conclusions

In summary, enhanced cataract service schemes do not always develop into full schemes even if the trial/pilot scheme has been deemed successful. The main reasons reported were: lack of central funding; the schemes were feasibility studies; and the requirement for a Unique Booking Reference Number (UBRN) for the Choose and Book process. Schemes may have a more prominent role in future, with the requirements on Clinical Commissioning Groups to provide improved patient outcomes within tighter financial constraints. There is a lack of uniformity of approach between current schemes in the London region which should be improved by the increasing involvement of the Local Optical Committee Support Unit (LOCSU) and the setting up of a London-wide Local Professional Network for Eyecare (LPN). Further studies are required to provide an evidence base to support the development

of cataract scheme provision. All established cataract schemes will need to be re-procured by CCG's during 2013/14 if they are to continue.

Acknowledgements

The views expressed in this publication are those of the authors and not necessarily those of any funding organisation. We are most grateful to Nick Taylor for his comments on the manuscript. Special thanks are given to the AOP, LOCSU and all those members of the LOC's contacted whilst gathering information.

References

1. Office for National Statistics. Population estimates available at <http://www.statistics.gov.uk/hub/population/population-change/population-estimates/index.html> (accessed 16th October 2013)
2. Evans JR, Fletcher AE, Wormald RP. Causes of visual impairment in people aged 75 years and older in Britain: an add-on study to the MRC Trial of Assessment and Management of Older People in the Community. *Br J Ophthalmol* 2004;88:365-70.
3. Department of Health. Action on Cataracts. Good practice guidance. UK:NHS Executive, 2000. Available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014514.pdf (accessed 15th October 2013)
4. Hospital Episode Statistics. Headline Figures from 2000-1 to 2010-11. <http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=193> (accessed 16th October 2013)
5. Sparrow JM. Cataract surgical rates: is there overprovision in certain areas? *Br J Ophthalmol* 2007; 91: 852-853
6. Black N, Browne J, van der Meulen J *et al*. Is there overutilization of cataract surgery in England? *Br J Ophthalmol* 2009; 93: 13-17
7. Department of Health. National Eye Care Services Steering Group – First Report 2004. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014514.pdf

- [gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4080998](http://www.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4080998) (accessed 26th October 2013)
8. Royal College of Ophthalmologists. Clinical Guidelines: Cataract Surgery Guidelines 2010. Available at <http://www.rcophth.ac.uk/page.asp?section=451§ionTitle=Clinical+Guidelines> (accessed 16th October 2013)
 9. Local Optical Committee Support Unit. Pre and Post-operative Cataract Pathway. 2008 (revised June 2012). Available at <http://www.locsu.co.uk/enhanced-services-pathways/cataract-referral-and-post-op/> (accessed 15th October 2013)
 10. Department of Health. The functions of GP commissioning consortia: a working document 2011. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124979 (accessed 15th October 2013)
 11. College of Optometrists. UK Eye Care Services Project. Phase One: Systematic Review of the Organisation of UK Eye Care Services. 2011. Available at <http://www.college-optometrists.org/en/research/commissioned-research-2/uk-eye-care-services-project.cfm> (accessed 15th October 2013)
 12. Gaskell A, McLaughlin A, Young E and McCristal K (2001) Direct optometrist referral of cataract patients into a pilot 'one stop' cataract surgery facility. *J Roy Coll Surg Edin.* 46, 133-137
 13. Sharp J, Moriarty A, Warburton T, Dixon J. Cataract assessment and direct referral. Stockport optometrists take the initiative. *Optom Today* 2003; 25: 16–17.

14. Wong R, Horgan SE, Gammon S, Haig-Brown G. Direct referrals for cataract surgery. *Optician* 2003; 226: 20-22.
15. Newsom W, Gibbons H, Flanagan D, Hingorani M. Direct referral of cataracts in Huntingdon. Sharing good practice. *Optom Today* 2005; 22: 21–24.
16. Lash SC, Prendiville CP, Samson A, Lewis K, Munneke R, Parkin BT. Optometrist referrals for cataract and 'Action on Cataracts' guidelines: are optometrists following them and are they effective? *Ophthal Physiol Opt* 2006; 26: 464–467.
17. Park JC, Ross AH, Tole DM *et al.* Evaluation of a new cataract surgery referral pathway. *Eye (Lond)*. 2009; 23: 309-13
18. Holmes K, Park J, Tole D. Improving the operative rate for cataract surgery. *J Cataract Refract Surg* 2013;39(5):712-715.
19. Venerus K. Enhancing Local Services. *The Optician*, 8th October 2010
20. Eye Care Services Steering Group. Report of the Cataract Sub-Group. Vision 2020 UK, 2004. Available at <http://www.vision2020uk.org.uk/library.asp?libraryID=264§ion=> accessed 16th October 2013)
21. The Royal College of Ophthalmologists. Cataract Surgery Guidelines, September 2010. Available at www.rcophth.ac.uk/core/core_picker/download.asp?id=544 (accessed 17th October 2013)
22. Muthucumarana DJ, Rimmer TJ. Cataract surgery and the optometrist. *Eye (Lond)*. 2000; 14: 777-778.

23. Newsom W, Hussain U, Stephenson C, Hingorani M. Community optometry working with hospital ophthalmology: the benefits of working together in a shared care cataract pathway. An audit of postoperative refractive outcomes. *Optometry in Practice*. 2013; 55-60

Table Captions

Table 1: List of LOCs and their involvement in cataract direct referral schemes in the London region (2012).

Table 2: Comparison of two full cataract direct referral schemes currently running in Greater London.

Table 3: Information required on all direct referral forms (proforma) for cataract.

Table 4: Information required on certain (but not all) direct referral forms (proforma) for cataract.

Table 5: Summary of the reported percentages of patients 'successfully' referred by optometrists via direct cataract referral schemes. Data for Bexley, Greenwich & Dartford and for Southwark & Lambeth were obtained from audit. Other data obtained from Eye Care Services Steering Group, Report of the Cataract Sub-Group, Vision 2020 UK, 2004.²⁰

Table 1

Local Optometric Committee	Pilot Scheme	Full scheme currently running
Barnet, Enfield & Haringey	YES Barnet only.	YES Barnet only.
Barking & Havering	YES	NO
Bexley, Bromley & Greenwich	YES	YES
Brent & Harrow	YES	NO
Camden & Islington	YES	YES
Croydon	YES	YES
Ealing, Hammersmith & Hounslow	NO	NO
Hillingdon	NO	NO
Kensington, Chelsea & Westminster	NO	NO
Kingston, Richmond & Twickenham	YES	NO
Lambeth, Southwark & Lewisham	YES	YES Lambeth and Southwark only.
London (East) & City	YES	YES
Merton, Sutton & Wandsworth	YES	NO
Redbridge & Waltham Forest	YES	NO

Table 2

	BEXLEY, BROMLEY & GREENWICH	CAMDEN & ISLINGTON
Fee paid	£25.00 for Referral	£15.00 for Referral
Accreditation required	Yes	Yes
Number of Hospitals	Unlimited on C&B	3 (plus 2-3 additional sites*)
Booking	<ul style="list-style-type: none"> • Proforma faxed to RMBS (Referral Management and Booking Service). • Proforma assessed for completeness. • RMBS generates a UBRN (Unique Booking Reference Number) and an appointment request on “Choose & Book” which is then provided to the patient to complete their booking at their centre of choice. 	<ul style="list-style-type: none"> • Proforma faxed to patient centre of choice. • Patient information is then sent to the Appointments Centre. At the Appointments Centre, the patient’s details are logged on to the NHS PAS (Patient Administration System). New patients are registered and given a hospital number. • Patients are then sent an appointment for their chosen one-stop clinic.
Dilated fundus examination	Part of Protocol	Not required
Referral restrictions	Patients with co-morbidity which becomes apparent post-assessment and therefore the main reason for referral to be sent via the GP.	No restrictions regardless of any co-morbidity.
Post-op assessments	Carried out within the HES.	
Second eye referral	May need GP prior approval.	Normally on an individual basis. Second eye discussed on initial HES consultation/ post-op assessment.

*An additional site is one where a commissioning organisation may have bought treatment slots as, for example, occurs in Redbridge & Waltham Forest.

Table 3

Patient details
GP details
Optometrist details
Date of referral
Chosen treatment centre details
Spectacle prescription with acuities
Comments regarding additional relevant ocular/medical history
<p>Multiple Sections:</p> <ul style="list-style-type: none"> • Copy to booking centre/treatment centre • Copy to GP to provide any relevant medical history • Copy to patient • Copy for payment
<p>Confirmation of all of the following before referring:</p> <ul style="list-style-type: none"> • The patient has a problem with their vision caused by cataract • The patient's vision is affecting their lifestyle • The risks and benefits of surgery have been explained to the patient • The patient wishes to have cataract surgery • The patient has been provided with a leaflet on cataract referral to an eye clinic

Table 4

Requested information	Commentary
Dilated ocular assessment	Dilated fundus examination is not always mandatory but is recommended. This may be reflected in the fee paid for the referral.
Specific recording fields for information on proforma	Each area has its own proforma and the information gathered is recorded in different formats. The proforma used by Barking & Havering goes on to provide a further information sheet which contains a health questionnaire to be completed by the patient.
Need for additional services	Camden & Islington provides an additional box to request the presence of an interpreter for the assessment at the eye clinic.
Patient consent	Signed consent from the patient is required for referral in the Bexley, Bromley & Greenwich scheme. Schemes such as Camden & Islington only require verbal consent.

Table 5

Area	Percentage of patients
Peterborough	89
West Kent	80-90
Ayr	96.3
East Gloucestershire	97
Croydon	93.3
Bexley, Greenwich & Dartford (2003)	77 (88 after 1 follow up appointment)
Leeds	100
Southwark	79
Lambeth	71