Effective Commissioning of Elective Procedures: The Royal College of Ophthalmologists' response to NHS London and the QIPP Programme – Right Care Workstream, 2 September 2011

Introduction

The Royal College of Ophthalmologists (RCOphth) is pleased to be able to respond to the questions posed by Dr Andy Mitchell and Professor Sir Muir Gray in their letter of 5 August 2011.

The College wishes to point out that although Ophthalmology is a surgical speciality, much of the work of an Ophthalmologist is concerned with the outpatient management of patients with potentially blinding diseases such as Glaucoma, Age-related Macular Degeneration (AMD) and Diabetic retinopathy. These conditions are expensive to treat and require lifelong follow up. There have been recent advances in the treatment of AMD and NICE has approved treatment with anti-VEGF agents. The English National Diabetic Retinopathy Screening Programme (ENDRSP) provides standards and guidelines for the delivery of a quality assured diabetic retinopathy screening service.[1] Screening for diabetic retinopathy provides timely detection of potentially sight-threatening disease enabling earlier more effective delivery of sight saving laser treatment. The Screening Programme is currently identifying diabetic individuals with early stage retinopathy who previously would not have been seen in the Hospital Eye Services (HES) until later in the course of their retinopathy progression. Furthermore, NICE criteria for referral of patients with glaucoma have increased referral to HES. AMD is another blinding eye disorder for which NICE and Royal College guidance to the NHS now exists. [2] These developments have led to tangible improvements to such patients with early glaucoma, AMD and diabetic retinopathy but have increased the workload of HES and expenditure on eye disease by Commissioners.

Cataract Surgery is the commonest and one of the most effective surgical procedures carried out in the UK with 350,000 procedures annually, but surgical procedures are also required for the management of serious conditions such as Retinal Detachment (Vitreo-retinal surgery), glaucoma, oculo-plastic and orbital diseases, paediatric eye conditions, strabismus, ophthalmic trauma and corneal diseases (e.g. corneal grafting). Any strategy for safe and effective surgical commissioning for ophthalmic patients must consider the provision of these essential services.

Cataract surgery is a highly effective procedure which provides rapid improvement in vision-related as well as non-vision-related outcomes as well as being very cost

effective. [3] Benefits to patients are life-long. The principal causal factor of adult cataract is ageing, and demand for services for cataract and other diseases of the ageing eye is expected to increase as the UK population ages. The indications for surgery as recommended in the consensus guidelines from the College, simply stated, are: failing vision attributable to lens opacity (despite optimal optical correction) or ocular co-morbidity and patient willingness and fitness to undergo cataract surgery. The last issue is not problematic, as surgery is almost always carried out under day care and local anaesthesia. While we know there is variation in cataract surgical uptake, there is no evidence that we are aware of, to suggest that patients are having 'inappropriate' cataract surgery in the UK. [4]

If ophthalmic elective procedures are considered in isolation, there is probably not much scope for funding more of one by funding fewer of another without introducing arbitrary rationing (as we are seeing with some of the cataract thresholds). However, if we look at ophthalmology as a whole, there are more possibilities. We suggest that what is needed is to look more closely at the reasons why existing commissioning practice may not be as effective as it could be.

The College has published evidence based guidelines for the treatment of many ophthalmological conditions. Some of the key treatments in widespread use in ophthalmology have had the benefit of appraisal by NICE. Most patients do benefit from the eye surgery and medications in use in NHS ophthalmology. Specifically, much of ophthalmic surgery is dedicated to restoration of vision and reduction of the burden of blindness.

QUESTIONS & RESPONSES

1. What are the main issues and concerns in the commissioning of surgical procedures and interventions that the Federation of Surgical Specialist Associations (FSSA) and surgical Royal Colleges believes need to be addressed and how do these impact on quality and outcomes?

ANSWER

- There is often, in our opinion, an inadequate understanding by commissioners of the services being commissioned. Ophthalmology is a topic inadequately covered in many medical schools and many lay people and some NHS managers are unaware even of the distinction between optometrists (of which there are many, mainly prescribing spectacles and contact lenses on the high street) and ophthalmologists (of which there are fewer, concerned with the diagnosis and management of eye disease). High street optometrists are, however, the main source of referral of persons with eye diseases to Hospital Eye Services and the Royal College has established a joint working group with the College of Optometrists (COptom) to address the issues which are the main reasons for ineffective commissioning of eye care services. Sir Muir Gray and the Right Care team have developed a Wiki type tool which will be used as the vehicle for providing accessible guidance to commissioners on what effective commissioning of eye care services should look like. The team

cast the net wider than elective surgery and the first two topics are glaucoma and 'minor' eyelid (oculoplastic) conditions. We believe that this work will lead to effective commissioning with savings and positive impact on quality and outcomes.

- Although we believe savings in elective surgery can be made by adherence to College guidelines and hence increased efficiency, we wish to point out that we believe economies could also be made in other disciplines in Ophthalmology, for example, community eye care. Many commissioners have invested in community-based primary eye care services on the grounds that a consultation costs less than the NHS tariff for a hospital consultation. That may be true, but there is no evidence that the development of community eye services has led to the reduction of hospital eye accident and emergency visits as a result. A& E departments act as a fall-back for what the community service either cannot, or does not want, to provide. Because it is available, GPs, optometrists and patients frequently exercise their discretion to bypass the community service and refer directly to ophthalmic emergency departments in an unpredictable fashion. The reason this duplication is allowed to persist is that commissioners fail to understand the differences between urgent eye conditions (which require timely assessment and intervention) and complex eye conditions (which require hospital assessment and intervention) and the chronic nature of several major ophthalmic disorders (e.g. diabetic retinopathy and AMD). We believe there could be rationalisation of community eye care so that it provided routine follow up care for some chronic conditions. It should also be possible for Community eye care to see new patients with some routine conditions (e.g. glaucoma suspects, cataracts) Community eye care is not well placed to deal with emergencies. All of these schemes need very considerable investment in training but, if successful, the HES would have more capacity for complex cases. For these developments to work well, commissioners need to engage with ophthalmologists to develop care pathways that best use the strengths of both HES and community services

- Of major concern to the College is the apparent lack of concern about training of future ophthalmologists which is a vital role for the National Health Service. Time, money and facilities must be available for this activity to continue. At present the UK has the lowest number of ophthalmic specialists per 100,000 population in the EU and including the recent accession eastern European economies. [5]

- Cataract surgery is, as mentioned above, a frequently performed operation with very low complication rates and excellent clinical and patient reported outcomes. The College is very concerned that it is repeatedly and inaccurately put forward in some circles as '*a procedure of lesser value'* which is currently leading to rationing of the procedure by some purchasers. This error must stop.

  The College does not agree with any proposal which limits access to cataract surgery on the grounds of visual acuity alone (e.g. surgery to be denied if acuity 6/9 Snellen acuity or better) because patients with certain types of

cataract (e.g. posterior sub-capsular) may have serious impairment of visual function in differing lighting conditions. This may mean that a patient with 6/6 Snellen acuity (apparently normal visual acuity) is extremely dazzled due to glare when driving or in the workplace and is a danger to him/herself and others. Patients in this group are often in active employment and excluding them from surgery may render them unable to work. By restricting referral of these patients into the Hospital Eye Service they will be denied an opportunity to discuss the relative merits of surgery. Please refer to the College statement on Access to Cataract Surgery from 29 July 2011.

The College Cataract Surgery Guidelines 2010, if followed, will optimise the efficiency of provision of cataract surgery to those who need it whilst achieving the best quality and outcomes. The College has worked with *NHS Choices* on patient decision aids in cataract surgical choice.

AMD is a blinding condition affecting predominantly the ageing eye. Ranibizumab (Lucentis) was designed specifically for intravitreal use, and, in addition to AMD, is approved for the treatment of diabetic macular oedema in the European Union (EU) and macular oedema secondary to retinal vein occlusion in the EU and the USA. NICE has approved Ranibizumab for treatment of wet AMD. There are very high medication costs because of the high cost of this main licensed treatment. There is also an alternative treatment for AMD, Bevacizumab (Avastin), which is unlicensed in Europe and the USA for this indication. The UK government and NHS should consider exerting pressure on the manufacturer of the existing licensed product to substantially reduce the price of this medication to the NHS. The UK government, the NHS and NICE should also assess whether the alternative and less expensive but similar agent Bevacizumab could receive market authorisation for use in AMD and other retinal conditions. A principle underpinning the regulations governing the production, distribution and use of medicines is the safeguarding of public health. For this reason, EU legislation requires a Marketing Authorisation to be granted for the purposes of placing a medicinal product on the market.[6] The medicines regulatory system in the UK was developed following the thalidomide tragedy and exists to protect the public from exposure to unsafe drugs. We are aware Bevacizumab is in widespread use in other EU economies despite EU regulations.

2. Of the issues and concerns highlighted what do you see as the highest priorities to address and why?

ANSWER

- Priority and funding should be given so that hospital clinicians, commissioners and other interested parties can meet so as to understand the requirements for a given clinical service so that it can meet the needs of patients.

- Cataract surgery must stop being seen as a procedure of “lesser value” and recognised as the outstanding surgical success it undoubtedly is. This will allow those who need it to see well during their lifetime. Refinement of referral

pathways and efficient surgery will make savings more significant than the imposition of arbitrary referral thresholds.

- In the UK, GMC guidance does not allow physicians to factor in the cost of a medicine.[7] [8]Rather, physicians must be satisfied that an un-licensed medication would better serve the patient's needs than an appropriately licensed alternative and be satisfied that there is a sufficient evidence base and/or experience of using the medicine to demonstrate its safety and efficacy. This contradicts current DH emphasis encouraging hospital doctors to be involved in 'population health' and be aware of 'programme expenditure' implying that the cost of treatment and the number of patients it benefits should be a factor in management decisions. The College would like to see such GMC guidance relaxed to better serve the NHS rather than serve the individual patient.

- The government, NHS, NICE and the GMC should review use of anti-VEGF agents in the treatment of AMD and other retinal conditions to see if savings (which could amount to millions of pounds) can be made either by the reduction in the price of Ranibizumab, or the use of the, currently unlicensed, Bevacizumab. On a global basis, across the developed and developing world it is estimated that more clinicians use the latter over the former for the treatment of the same conditions.

- As diabetic retinopathy is a disease that often falls between the Trust and PCT providers, the lines of responsibility, project management and funding have often not been clearly demarcated. The forthcoming 'vertical integration' of many Trust and PCT provider arms within Transforming Community Services (TCS) may be a key to improvement and leadership in this regard.

- In relation to laser treatment of diabetic retinopathy the relatively new, PASCAL laser enhances laser delivery with less pain, improved tolerability and greater patient compliance. In addition, its batch delivery of treatment provides greater ease of use for the laser operator, saving considerable time and effort. The PASCAL laser system and other similar systems have been a significant safety step forward in the last 10 years and are now in use in several eye clinics in the UK. If more were in use productivity gains may be forthcoming.

- Advanced diabetic eye disease (vitreous haemorrhage and tractional retinal detachment) is treated by surgical vitrectomy. Such tertiary care provided may salvage eyes with severe visual loss. However, improved primary and secondary care of diabetic retinopathy by screening, laser treatment, improved control of systemic risk factors and use of antiVEGF agents will lead to less cause for referral to tertiary care and chimes with the Quality, Innovation, Productivity and Prevention (QIPP) Programme.

3. What would you recommend as the optimal solution to addressing the priorities identified? What do you see are the barriers to implementation and how could these be overcome?

ANSWER

- If it could be decided what the commissioning of common surgical procedures should look like (as in Q2 above) on a national basis, then 'post code lotteries' would be avoided. A barrier to this is the government's insistence that commissioning is to be devolved to a local level.

- We are aware that some Primary Care Trusts are attempting to "demand manage" cataract surgery to certain thresholds of patient visual impairment. Such decisions, if simply based on Snellen visual acuity levels, are likely to disadvantage elderly patients, drivers and those whose occupation and activities of daily life are vision dependent. Cataract surgery should be removed from the list of procedures of lesser value and College guidelines for treatment should be followed. Barriers to that is the apparently entrenched notion that Snellen visual acuity thresholds are a valid method to ration surgery.

4. How would these recommendations assist commissioners to commission high quality, cost-effective care and to improve outcomes for patients?

ANSWER

- By working directly with the specialists who will provide the service that is being commissioned it will naturally follow that all stakeholders will understand each others' position and, more importantly, the commissioners will gain an insight into what is being offered and why it is important for the patients and for maintenance and improvement of quality of outcome.

- When we talk of "improving outcomes for patients" we must take the perspective of current and future patients. Some of the current proposals and practices around commissioning are very short sighted and cost motivated in that they have jeopardised the quality of treatment that will be on offer to future patients. For example, in some centres, cataract surgery has been diverted to 'alternative' providers, such as Independent Sector Treatment Centres (ISTCs) (but often at greater cost) with no provision being made for inclusive training. We are almost at the point now that in some NHS hospital departments there are not enough cataract operations being undertaken to train junior doctors or for consultants to maintain their surgical skills. If this trend is not reversed promptly we will pay a heavy price for short term financial gains. If commissioners work together with providers and gain an understanding of the requirements of training, this will be built into commissioning with consequent long term gains.

5. How would commissioners and providers need to be supported to implement these solutions to ensure that high quality and cost effective care is consistency and reliably delivered?

ANSWER:

- Commissioners must be mandated to consult with all stakeholders and providers before issuing commissioning contracts. Commissioners should follow guidelines on world class commissioning and take into account the impact of their actions on all aspects of NHS activity e.g. patient treatment, surgical and medical; training, research, innovation and prevention. Commissioning should not just be the cheapest means to get a procedure undertaken.

- Providers should be supported to reduce unnecessary variation in surgical practice. The College has worked with the Department of Health and with the NHS in such matters in the past within the *Action on* schemes and has had particular success in modernising cataract surgical productivity. The College is willing to work on other service improvements and modernisation in other areas of clinical activity. Some variation and flexibility is both essential and desirable.

- Commissioners and providers must be encouraged to work together with mutual trust and co-operation. The culture of pitching provider against provider under the guise of 'competition' must be discouraged.

- The term "*patient choice"* should be replaced with "*informed patient choice*". The current system is such that often patients can be made to choose what the commissioner desires. Moreover, patients often make their choice on factors other than quality of outcome. They are so used to quality service in the NHS that they automatically presume that what is on offer on the NHS will be of the same quality. With 'any willing provider' being allowed to join the competition, sadly this is not the case. Patient education and participation in the commissioning process is imperative. Only by allowing patients an informed decision about the choice on offer, will the aspiration of 'patient choice' be achieved.

6. Thinking about broader opportunities to improve QIPP (quality, innovation, productivity and prevention): What improvements in surgical pathways (either in general or related to specific pathways) would you recommend as likely to have the most significant impact? (b) What would be the key considerations for commissioners and providers?

ANSWER

- Please see at annex A, our document already sent to Andrew Mitchell with regard to cataract pathway and cataract commissioning in London. This clearly shows that there is more saving to be made by streamlining the pathway without compromising quality.

- Care of NHS cataract patients has improved as a result of better technology and improved access to care, much of which followed the *Action on Cataract* (AoC) initiative. [9] Now could be the time for a second "Action on Cataract" and other similar initiatives. Across the country AoC produced considerable improvements in productivity and efficiency, but it was not uniform and not all the gains have been sustained in the long term because the initiative ran out of steam. Some units are undertaking 5 cataracts on an operating list when the College is of the view that more can often be undertaken given correct conditions. Many NHS units are still reliant on chaotic, inefficient paper records. Some are still unable to implement nurse-led consent or prescribing because they have high levels of bank or agency staffing – and so on. The electronic medical record cataract audit suggest that there are still some ophthalmologists who are not in training who are undertaking less than 50 cataract operations per year.

- Another possible initiative is to build on data comparing PCTs with the highest uptake of cataract surgery and those with the lowest by commissioning research to explain such variations. It could look at referral patterns, waiting times, decision-making processes, productivity as well as looking for demographic differences which are not obvious. An initial attempt at such was undertaken within *Focus on Cataract* by the NHS Institute.[10] We are of the opinion that the NHS Institute should commission further projects in ophthalmic care provision and not just restricted to cataract.

7. Are there examples of these solutions (priority areas or broader QIPP opportunities) being commissioned and delivered in the UK to learn from?

ANSWER

- Ophthalmology has a huge advantage over most other specialities in that the pathology is often visible and can be imaged using photography and other imaging techniques. These, combined with high quality image capture and transmission, opens the way to local imaging and remote expert assessment of patients. In Scotland, photographic triage of referrals from optometric practices to eye departments has reduced unnecessary referrals and enabled rapid treatment for those who need it. [11] The savings in Fife alone amounted to £600,000 per annum. This, extrapolated to the whole of the Scotland is projected to save £25 million per annum. If used UK wide, the savings would run to more than £100 million. In some units, there are nurse-led oculoplastic clinics where patients are photographed and allocated a management plan remotely by the consultant on the basis of clinical images (e.g. Stoke Mandeville). Similar innovations are in use for diabetic retinopathy screening referrals in some departments (e.g. Bristol, Birmingham). In Salford telemedicine consultations are reducing referrals to retinal services in Bolton. In Sheffield 'virtual clinics' are being undertaken. In York a mobile unit is in use for outreach clinics for AMD patient treatment. In Exeter nurses have been trained in safe intravitreal injection technique. The College would like to see these local pathfinder projects receiving greater recognition to inform intelligent commissioning nationally. The College is deeply committed to quality and safety improvements and provides an innovation prize to

ophthalmologists for such work. We believe that more can be achieved by rewarding innovation and multi-disciplinary teamwork and clinical leadership. We commend such an approach to addressing the QIPP Programme.

- In relation to prevention there is room for action. For example AMD is causally linked to oxidative damage in the retina. In relation to AMD prevention both smoking cessation and diet supplements are of merit. The original Age Related Eye Disease Study (AREDS) formulation provides the best evidence for reduction of incidence of advanced AMD for patients presenting with either large drusen or extensive intermediate drusen (category 3) or advanced AMD in one eye (category 4).[12] The safety profile of such products is good for at least 7 years but should be avoided in smokers or recent ex-smokers. The Rotterdam Study [13] reported a statistically significant (35%) reduction in incident AMD risk with supplementation, even greater than that observed in AREDS study. Provision of correct advice to case find those individuals with AMD category 3 or 4 is a long term cost releasing exercise and importantly will avoid use of supplements by people/patients who may not need them. Savings are envisaged by only those individuals with AREDS 3 or 4 retinal signs receiving such supplements.

- The College has been active in promoting smoking cessation as a tool to reduce the burden of AMD in the community and is seeking changes to EU regulations on tobacco product warnings.

8. Are there any other points relevant to these issues that you would like to raise?

ANSWER

- The College is aware of the National Hip Fracture Database (NHFDB). The NHFDB was compiled by orthopaedic surgeons, anaesthetists and geriatricians who decided the fields in the database that constituted good care. These were largely process based, e.g. waiting time for surgery, whether reviewed by a geriatrician etc. Payment is made if the data is entered and if the targets are met (in the case of fractured hip repairs say surgery within 48 hours of admission). The system is already up and running successfully. Those units who do not contribute to the NHFDB do not get paid.

- The data fields would be different for elective surgery such as cataract, but a set of standards could be set using existing fields from the National Cataract Data Set, involving both process and outcome: for example, biometry recorded; refractive outcome recorded; surgery within the time frame set by commissioners; two or more post operative visits made by the patient to be considered as an adverse quality outcome and factored into the overall outcome quality.

- We believe Ophthalmologists may be able to learn lessons from this work and apply them to our own National Cataract Data Set (NCDS). This is a repository for data on 225,000 cataract operations (and is being added to all

the time). We believe implementation of such a system could drive up standards whilst reducing costs.

- Ophthalmology is a unique service, in the demands it has for digital imaging and the storage/recall of information from multiple instrument sources. All patient digital information should be available with one system. Long-term service planning for the IT challenges in ophthalmology needs to be hastened. Greater proactive engagement is needed with IT Departments at hospital Trust to provide solutions to the clinical IT challenges. Resources are required and project management of the ophthalmology digital imaging issues need to be given high priority. The use of imaging has increased massively in the last five years and it is no longer acceptable to simply react to IT problems/failures as they happen as is currently often the case in ophthalmic IT. A proactive response is required for future proofing the clinical service. With the development of Transforming Community Services the integration of IT systems in the hospital and community are a possibility for enhancing productivity and safety in ophthalmic care across primary and secondary care.

SUMMARY

The College recommends that:

- Commissioners and Ophthalmologist should work together to develop care pathways that provide high quality care for all.

- Emphasis should be shifted from individual procedures to pathways. Greater efficiency and cost savings can be had from focusing on the entire pathway rather than on a single operation in isolation.

- Cataract surgery should be removed from the list of “procedures of lesser value” and should be available to all who need it to see well enough to fulfil their visual requirements, irrespective of the measured Snellen visual acuity.

- Although cataract surgery is very important, it is only part of Ophthalmology and that there is an essential requirement for other branches of ophthalmic medicine and surgery to be included in the fold.

- The “*action on” strategic* initiative might usefully be revisited both for cataract surgery and other ophthalmic conditions.

- The essential requirement to train the Ophthalmologists of the future must be incorporated in any commissioning strategy.

- The government, NHS, NICE and the GMC should review use of anti-VEGF agents in the treatment of AMD and other retinal conditions to see if savings (which could amount to millions of pounds) can be made either by the reduction in the price of Ranibizumab, or the use of the, currently unlicensed, Bevacizumab. Across the developed and developing world it is estimated that

more clinicians use the latter over the former for the treatment of the same conditions.

- Existing Community and Primary Care Ophthalmology schemes should be examined to determine those that are most effective in the use of resources with a view to promulgating the best of these on a national basis.

- Schemes combining local assessment of patients using digital media with centralised assessment by specialist ophthalmologists should be expanded.

References

[1] National Screening Committee (NSC) for Diabetic Retinopathy. Essential elements in developing a diabetic retinopathy screening programme. England: NSC; 2009.

[2] National Institute for Health and Clinical Evidence. NICE Technology Appraisal Guidance TA155, Ranibizumab and pegaptanib for the treatment of age-related macular degeneration. National Institute for Health and Clinical Evidence, London 2008. http://www.nice.org.uk/nicemedia/pdf/TA155guidance.pdf

[3] Walker JG, Anstey KJ, Hennessy MP, et al. The impact of cataract surgery on visual functioning, vision-related disability and psychological distress: a randomized controlled trial. *Clin Exp Ophthalmol* 2006;34:734–42

[4] Kelly SP and Billington B. Cataract surgery in England. *Br J Ophthalmol* 2008;**92**:722-723

[5] European Union of Medical Specialities. www.uems.net

[6] Directive 2001/83/EC of the European Parliament and of the Council of 6 November 2001 on the community code relating to medicinal products for human use. *Official Journal L* - 311, 28/11/2004, p. 67 - 128.

[7] General Medical Council. Consent: patients and doctors making decisions together. June 2008. http://www.gmc-uk.org/static/documents/content/Consent_0510.pdf.

[8] General Medical Council. Good practice in prescribing medicines – supplementary guidance. September 2008. http://www.gmc-uk.org/static/documents/content/Good_Practice_in_Prescribing_Medicines_0911.pdf

[9] Department of Health. Action on cataracts—good practice guidance. NHS Executive. Feb 2000. *http://www.dh.gov.uk/assetRoot/04/01/45/14/04014514.pdf*

[10] *Focus on Cataract.*
http://www.institute.nhs.uk/quality_and_value/high_volume_care/cataracts.html

[11] Cameron JR Ahmed S, Curry P, Forrest G, Sanders R. Impact of direct electronic optometric referral with ocular imaging to a hospital eye service. *Eye*. 2009 ;**23**:1134-40.

[12] Age-Related Eye Disease Study Research Group. *Arch Ophthalmol* 2001; 119: p1417

[13] van Leeuwen R et al. *JAMA* 2005; 294: p3101

THE ROYAL COLLEGE OF OPHTHALMOLOGITS
CATARACT COMMISSIONING GUIDELINES

This statement has been prepared following meetings with NHS London and it draws on the paper by Miss Parul Desai on the London Criteria.

BACKGROUND

Cataract refers to a clouding of the natural lens of the human eye. Cataract can cause a wide range of visual symptoms (see appendix). When symptoms due to cataract affect the patient's lifestyle, intervention is often required. Treatment is essentially surgical, wherein the opaque lens material is removed and replaced with a prosthetic synthetic lens implant of a predetermined power, guided by the patient's need. Cataract surgery is regarded as the "best value for money" procedure performed on the human body. It is the high volume of cataract operations required to meet demand that makes it an expensive item in the context of population health.

In the current economic situation, of immense financial pressures, the challenge is to enhance value by achieving savings from rationalising and improving efficiency in the cataract pathway whilst maintaining standards and quality, and access for those who need it.

Principles underlying the guidelines

- The guidelines should be based on the clinical evidence.
- They should be unambiguous and simple to implement.
- They should not be prescriptive. Although referral, intervention and follow up should largely be within the framework of the guidelines, clinical judgement

based on the interaction between patient and clinician should be exercised in the best interest of the patient.

- Adoption of these guidelines should show demonstrable gains in value.
- The effectiveness of the guidelines in achieving added value should be amenable to evaluation by appropriate audit.
- The guidelines should address the three components of the cataract pathway: referral, intervention and follow-up.
- The guidelines should be rolled out uniformly through the country. Individual PCTs should be discouraged from introducing ad hoc local guidelines and setting arbitrary thresholds for cataract surgery. This would create a postcode lottery and encourage cross PCT movement of patients, thus adding to the administrative workload.

The evidence base indicates that:

- Visually impairing cataract is common in persons of 65 yrs and over
- The effectiveness of cataract surgery (first and second eye) is established
- Up to one third of cataract operations are for second eye surgery
- Delay in second eye surgery is associated with poorer quality of life and functioning
- Surgery is offered for *symptomatic* cataract and is not based on visual acuity
- There are no patient related outcome measures that are currently suitable for use in *routine* clinical practice

THE CATARACT PATHWAY

Referral guidelines

It is recognised that this is one part of the pathway where much value can be extracted by improving the referral to intervention ratio. Currently this ranges from 50% to 85% and fluctuates from time to time. Savings can be achieved by reducing

the gap between referrals for cataract surgery and the surgeries performed. This would require informing and training both general practitioners and optometrists and continuously auditing referrals and providing constructive feedback.

First contact: At the first contact between the patient and the primary care personnel the following questions should be asked:

1. Does the patient have cataract? Yes/No
2. Does the patient have symptoms than can be attributed to the cataract? Yes/No
3. Does the patient need and want cataract surgery? Yes/No

If the answer to all questions is 'Yes', a referral should be made.

Intervention guidelines

Second contact: At the second contact between the patient and the ophthalmologist, the clinician will assess the patient and ask the following questions;

1. Is the answer to the above 3 questions still 'Yes' and, if so,
2. *Does the patient understand the procedure and the risks? Yes/No

If answer is 'Yes'' The patient will be consented and listed for surgery and subsequently operated upon.
*With appropriate training this question can also be covered at the "first contact" so that patient who do not wish to proceed to surgery after understanding the risks may not be referred, thus adding value to the cataract pathway.

Follow-up guidelines

Third contact: The third contact will be between the patient and the health care worker (cataract nurse, optometrist, community ophthalmologist, HES ophthalmologist) based in the community or in a hospital.

Optometrists should be able to send data on refraction to the surgeon in a stamped addressed envelope provided to the patient on discharge after surgery. This will capture data required for audit purposes for both consultants and trainees.

APPENDIX on AUDIT

From a commissioning perspective it will be important to deliver tangible savings whilst ensuring that quality of service is not compromised. From the patient's perspective it will be important to ensure that access is not denied to those who need it.
The number of patients dealt with at each contact point will be recorded as part of the pathway requirements.

The numbers at the "first contact" will demonstrate the ***Initial Demand*** on the service.

The numbers at the "second contact" will demonstrate the ***Effective Demand*** on the service as some patients who need cataract surgery may not want it. The numbers at the "second contact" going on to surgery will demonstrate the ***Clinical Demand*** on the service. The difference between Effective and Clinical Demand (ED – CD) will illustrate the efficiency/inefficiency of the pathway. The closer the Effective Demand is to the Clinical Demand, the more will be the value added to the pathway.

The number of patients at the "third contact" who are satisfied with the outcome and discharged will indicate the ***Quality*** of the outcome. The numbers referred back to the HES (subsequent contact(s)) for "dissatisfaction" (post-operative complications or outcome not meeting patients' expectations) will also be an indicator of Quality of outcome. This number will indicate to the commissioner the Quality of surgical intervention. The cost of "subsequent contacts" will detract from value and can be used to monitor value together with the other parameters.

The ED-CD difference and the “subsequent contact” numbers will lend themselves to appropriate targeted intervention (additional training, identify poor performing units/surgeons) to enhance value.

Referral Data

The capture of the following dataset at the “first contact” will allow more sophisticated audit.

Symptoms (attributed to cataract) can be explored at the “first contact” and recorded:
Impairment of vision e.g.: Blurring, mistiness, cannot see road signs or bus numbers, cannot recognise faces

Night vision problems e.g.: Difficulty seeing at night, glare, haloes (rainbow), starburst. Difference in vision between day and night.

Double or multiple vision e.g. Uniocular diplopia, polyopia, ghosting, shadowing. Frequent change in glasses.

Visual Acuity: Snellen or Log Mar, Each eye unaided and best corrected. Distance vision and near vision

Refraction: Spectacle refraction

Signs: Cataract - cortical, nuclear, posterior sub-capsular.

Any other finding including those relating to the fundus