We would like to hear your views on the draft recommendations presented in the short version and any comments you may have on the evidence presented in the full version. We would also welcome views on the Equality Impact Assessment.

We would like to hear your views on these questions:

1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.

Streamlining and standardising the cataract pathway to embed community optical practices in the pre-referral and post op stages will deliver a more person-centered service with fewer hospital visits and care closer to home. It will make best use of available resources by taking advantage of optometrists' clinical skills to reduce pressure on HES clinics. In the traditional model of HES-based post-op follow ups, the majority of people need an appointment with their primary care optometrist for refraction for presbyopic correction in addition their HES follow up. A single post op appointment in primary care therefore will reduce the total number of appointments a person needs.

The Local Optical Committee Support Unit has developed a national model for primary care based cataract pre-referral and post op services, and locally commissioned services have already been successfully implemented in some areas.[1] Where pre-cataract referral services are in place, 98% of patients are listed for surgery, as opposed to 62% where not.[2] At the other end of the pathway, 40% of CCGs have now commissioned post-operative cataract services.[3] 98% of patients using this service express satisfaction with only 2% dissatisfied.[4]

The greatest challenge to implementation will be overcoming cultural resistance to changing current ways of working within the HES. It is in the interest of patients and the future sustainability of the NHS that this challenge is successfully met.

2. Would implementation of any of the draft recommendations have significant cost implications?

There is no national follow-up tariff for extended primary eye care. However, local tariffs are typically 25% less than HES follow-up. Therefore, there should be, in fact, minor cost benefits to commissioning these services.

In order to achieve a fully integrated pathway, a one-off investment by NHS England is required to enable primary care optical practices to connect with NHS IT infrastructure.

	This investment will provide wider transformational strategic benefits across all eye care pathways. 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice. Easy read factsheets, such as those produced by the charity, SeeAbility, will help users with learning disabilities overcome challenges.[5] 1. [Insert any specific questions about the recommendations from the Developer, or delete if not needed] See section 3.9 of Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	**Optical Confederation and Local Optical Support Unit (LOCSU)**
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	**[Insert disclosure here]**
Name of commentator person completing form:	**Katrina Venerus (Clinical Director, Local Optical Committee Support Unit)**
Type	[office use only]

Comment number	Document (**full** version, **short** version or the **appendices**	Page number Or **'general'** for comments on the whole document	Line number Or **'general'** for comments on the whole document	Comments Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.

Example 1 Example 2 Example 3	Full Full Full	16 16 16	45 45 45	We are concerned that this recommendation may imply that …….. Question 1: This recommendation will be a challenging change in practice because …… Question 3: Our trust has had experience of implementing this approach and would be willing to submit its experiences to the NICE shared learning database. Contact……..
1	Short	2 3	8 – 19 1 – 9	There is a time and cost implication to providing written and oral information. Information needs to be tailored to the individual person's needs and in addition to general information about cataracts and cataract surgery. We recommend that there should be information on local providers of surgery. This requirement is beyond the requirements of a GOS sight test and should be part of a commissioned pre-referral service.1
2	Short	3	16 – 18	Individual's risk will be better informed if primary care optometrists are involved in the overall pathway through a commissioned pre-referral service.1
3	Short	4	18	'when it is appropriate to get new spectacles and how to do so' should be moved to 1.1.5 'on the day of surgery, after the operation,' because the first appointment after surgery will not necessarily be with the surgery provider; it may be in the community.3
4	Short	 5	23-28 1 – 4	There is a time and hence cost implication for discussions with patients and their family members or carers. This requirement is beyond the requirements of a GOS sight test and should be part of a commissioned pre-referral service.1
5	Short	5	4	We strongly support this statement. Currently many CCGs/commissioners are restricting access to cataract surgery on the basis of visual acuity alone, so we are very pleased that this NICE guideline states clearly that they should not be doing so.
6	Short	10	2 – 3	We strongly support this statement. Currently some commissioners are applying more restrictive access criteria to second eye surgery.
7	Short	12	12	"processes to ensure" should be changed to "a commissioned service to ensure" Providing electronic postoperative data for the UK Minimum Cataract Dataset for National Audit should be a requirement of a commissioned cataract post-operative service in primary care.1
8	Short	12	18-19	Primary care optometrists are ideally situated to collect patient visual function and quality of life data as part of a commissioned cataract post-operative service community service pathway.1

9	Short	13	8	• Patient choice – the process would be streamlined if primary care optometrists had access to the NHS e-referral service and hence up to date information on waiting times and capacity of service providers of cataract surgery. • Shared electronic patient records would facilitate full integration of primary and secondary care services. • Direct referral by primary care optometrists to cataract services should be considered. • Direct listing by community optometrists such as the service provided in Bedford should be considered.[6]
10	Short	13	16 – 17	"General Optical Council" should be added to emphasise that primary care optometrists play an essential role in the cataract pathway.
11	Short	14	9 – 10	Add "Local Optical Committee" after "health and social care organisations" as Local Optical Committees represent all local ophthalmic contractors and performers i.e. primary care optical practices and practitioners.
12	Short	15	17	As are some systemic medications such as cortico steroids.
13	Short	16	12	Add "People should have a recent sight test and up-to-date spectacle prescription before referral for cataract extraction. A pre-referral service should be commissioned to ensure further relevant social and clinical information is provided.

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include page and line number (not section number) of the text each comment is about.
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons). We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The

comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.