PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	A qualitative study of stakeholder views regarding participation in locally commissioned enhanced optometric services
AUTHORS	Konstantakopoulou, Evgenia; Lawrenson, John; Harper, Robert; Edgar, David

VERSION 1 - REVIEW

REVIEWER	Isabelle Jalbert Senior Lecturer, Deputy Head of School School of Optometry and Vision Science University of New South Wales Australia
REVIEW RETURNED	07-Mar-2014

GENERAL COMMENTS	This is a qualitative study aiming to explore stakeholder views regarding the development and organisation of two distinct community-based enhance optometric services, a Minor Eye Conditions Scheme based in South London and a Glaucoma Referral Refinement Scheme based in Manchester. The study included a particular focus on reasons for optometrists' non participation in the schemes. It is unclear how stakeholders were identified and how the authors ensured that key stakeholders were not ignored. For example, could the investigators justify why patients accessing the community-based enhanced service schemes were not sampled. It would have been good to explore their views of the enhanced service schemes. Similarly, clarify or specify who the external stakeholders consulted where in the sentence "A topic guide was developed by the research team, in consultation with external stakeholders" on page 6. The limitation of not having sampled patients certainly needs to be acknowledged in the discussion. I would have liked to hear how many enhanced service schemes now exist in the UK and why these particular two services were chosen. I would also like to hear some justification for the investigators' decision to include two disparate enhanced service schemes in their analysis. In addition, how have the investigators ensured that any themes identified were common to both schemes? How have they identified and presented any differences between the two schemes? A potentially major limitation of the study is the perhaps poor generalizability of the results to any other existing enhanced service schemes in the UK; a discussion on this is required. I was unclear how the results as currently presented related to the thematic analysis described in the methods section. It would be nice to hear how many themes were identified in total for example and

	whether these are in fact the sub-headings currently included in the results section. Additional small recommendations: Bias introduced by not including ophthalmologists not involved in the scheme is acknowledged. A strength of the study is the sample size which includes most of the practitioners involved in the schemes. Explain what the “previous Manchester GRRS” scheme mentioned on page 10 is. I recommend that a copy of the topic guide and online questionnaires be provided as online appendices. I recommend that the checklist from the COREQ for supplementary reporting by included. The views of ophthalmologists presented at the end of page 11 under the “3.1 Participating community optometrists” tab would be better placed under the heading of “3.3 Medical Views”. Provide a reference and an explanation of what they are for the NICE guidelines for managing glaucoma mentioned on page 13. Clarify the meaning of “High Street setting” in the last sentence for non UK readers.

REVIEWER	Paul GD Spry Bristol Eye Hospital England
REVIEW RETURNED	19-Mar-2014

GENERAL COMMENTS	General Comments This paper describes a well-designed piece of high quality research with appropriate content relevant to the eye care community and particularly those interested in evolving models of eye care service provision, and specifically the border between primary and secondary care. The paper is well written, appropriately referenced and well presented. Use of qualitative methodology is uncommon but appropriate given the subject content, and as such is novel and pleasing to read. Specific Comments 1. Methodology. Whilst I entirely understand the use of qualitative methodology I wonder whether inclusion of a frequency table for each of the themes identified in the qualitative research may give the reader a better idea of how often any of the views expressed occurred amongst the sample? I appreciate that this may not be possible and/or may represent the next stage of a programme of research that the authors may have yet to present, in which case this comment can be disregarded. 2. Page 7. One of the groups surveyed were “glaucoma specialist optometrists.”Tthe criterion for inclusion in this group should be defined. 3. Page 8, results, table 2 and also discussion section 4.4, strengths and limitations. Although the overall response rate was high, this was biased towards those who actively involved in the schemes, specifically participating optometrists, ophthalmologists and GPs. The authors should therefore comment on whether they consider that the low proportion of responses from non-participating

	optometrists may have led to incomplete ascertainment of views representative of a generalised population of optometrists who chose not to participate in enhanced schemes. 4. Page 9, penultimate sentence. GGRS should be GRRS. 5. Page 17, section 4.5 Conclusion. The first sentence of this section may require re-wording because optometrists can work both in primary care and secondary environments. Furthermore, because this paper has been submitted to BMJ Open rather than eye specific journal, in which readers are familiar with the role of optometrists, I am uncertain whether the authors may consider being more specific about the terms Primary and Secondary Care as, for non-eye care practitioners, and readers not familiar with UK NHS eyecare service design, the term primary care may serve to confuse.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1.
Reviewer Name Isabelle Jalbert
Institution and Country Senior Lecturer, Deputy Head of School
School of Optometry and Vision Science
University of New South Wales Australia

This is a qualitative study aiming to explore stakeholder views regarding the development and organisation of two distinct community-based enhance optometric services, a Minor Eye Conditions Scheme based in South London and a Glaucoma Referral Refinement Scheme based in Manchester. The study included a particular focus on reasons for optometrists' non participation in the schemes.

1. It is unclear how stakeholders were identified and how the authors ensured that key stakeholders were not ignored. For example, could the investigators justify why patients accessing the community-based enhanced service schemes were not sampled. It would have been good to explore their views of the enhanced service schemes. Similarly, clarify or specify who the external stakeholders consulted where in the sentence "A topic guide was developed by the research team, in consultation with external stakeholders" on page 6. The limitation of not having sampled patients certainly needs to be acknowledged in the discussion.

Response: Thank you for pointing out the importance of sampling patients who accessed the scheme. We had neglected to draw attention to the fact that the views of patients would form the basis of a further qualitative paper investigating these two schemes. We have included the following sentence towards the end of our revised submission (page 19):
"Patients are also important stakeholders and their views of these ESS are currently under investigation and will form the basis of a subsequent publication."

The aim of the current paper was to seek the views of healthcare professionals. With this aim in mind we feel that the key stakeholders within this group of professionals were sampled. However, the inclusive nature of our sampling of healthcare professionals involved in these schemes has not perhaps been sufficiently emphasised in the paper. We have attempted to remedy this by including the following sentence on page 6:
"The sampling strategy was designed to be inclusive and capture the views of healthcare professionals participating in community schemes and their associated care pathways. These included: all MECS and GRRS optometrists, as well as other key stakeholders (participating ophthalmologists, specialist hospital optometrists and GPs). The views of non-participating optometrists, who had been invited to join the schemes but chose not to, were also sought.

The evaluation of these two schemes is part of a larger project which is overseen by a multidisciplinary Steering Group. They were fully consulted on the development of the topic guide. This has been clarified by a modification of the original sentence (page 7) relating to this point which now reads:
"A topic guide was developed by the research team, in consultation with the Enhanced Scheme Evaluation Project (ESEP) Steering Group (a multidisciplinary group consisting of optometrists, ophthalmologists and methodologists). The guide formed the basis for open-ended questions used in questionnaires and telephone interviews. The topic guide covered the following broad subject areas…"

2. I would have liked to hear how many enhanced service schemes now exist in the UK and why these particular two services were chosen. I would also like to hear some justification for the investigators' decision to include two disparate enhanced service schemes in their analysis. In addition, how have the investigators ensured that any themes identified were common to both schemes? How have they identified and presented any differences between the two schemes? A potentially major limitation of the study is the perhaps poor generalizability of the results to any other existing enhanced service schemes in the UK; a discussion on this is required.

Response: The majority of enhanced service schemes in England follow the Local Optical Committee Support Unit (LOCSU) models. In the 2012/13 LOCSU annual report it states that there was a total of 246 LOCSU enhanced schemes in England in July 2013
http://www.locsu.co.uk/communications/news/?article=106
The geographical distribution of these schemes can be found at:
http://www.locsu.co.uk/enhanced-services-pathways/enhanced-services-map

Our study is limited to England as different approaches to eyecare services apply elsewhere in the UK. In addition to these LOCSU schemes there are an unknown number of schemes which have been initiated by secondary care.
Insert refs to annual report and LOCSU atlas
Two of the most common types of enhanced scheme are minor eye conditions schemes (MECS) (sometimes referred to as Primary Eye Care Acute Referral Schemes (PEARS)) and Glaucoma referral refinement schemes (GRRS) and we wished to include in our suite of schemes evaluated under ESEP one example of each main type of scheme. We specifically chose these two schemes (MECS and GRRS) for geographical and temporal reasons. The ESEP team are split between London and Manchester, therefore choosing one scheme in each centre was logistically sound, allowing team members to attend key meetings related to both schemes. Another aim was to identify newly established schemes such as MECS and GRRS. This would allow us to investigate each scheme both in the early months of their existence and again once the schemes have become more established.

Themes emerged organically from each scheme and we have described in section 2.4 the iterative process by which responses were analysed. This process involved four of the authors. Themes were identified as common on the basis of being reported repeatedly by participants in both schemes. We have identified and discussed these common themes in the course of the article.
Differences between schemes emerged from the same qualitative research process. We have presented these differences by highlighting when a theme is exclusive to one or other scheme. For example, for MECS "Communication between ophthalmologists/GPs and optometrists was reported to be poor before the commencement of the MECS. The vast majority of optometrists stated they rarely received feedback on their referrals or the diagnosis of referred patients; where feedback was provided it generally came from patients." While for GRRS "In terms of the GRRS, good communication between specialist optometrists working in the glaucoma clinic and community

optometrists appeared to be well established. Most respondents reported that hospital specialist optometrists provided detailed clinical feedback on their referrals." Another example related to training "Almost all participating optometrists in the MECS and GRRS expressed an interest in doing more clinical training and had a number of suggestions in terms of their areas of interest. Additional distance learning, gonioscopy, hospital placements and peer review groups were most popular amongst MECS optometrists, while GRRS optometrists suggested training in gonioscopy, visual field assessment, unusual glaucoma cases and optic nerve head assessment. "

The issue of generalisability of the results is an interesting one. We have referred in our Discussion to the representative nature of these two schemes, for they are typical examples of their type. We believe our results to be as generalisable to other ESS in England as could be expected from any such study of one scheme of each type .

3. I was unclear how the results as currently presented related to the thematic analysis described in the methods section. It would be nice to hear how many themes were identified in total for example and whether these are in fact the sub-headings currently included in the results section.

Response: Thank you for pointing this out. We have inserted the following sentence on Page 8:
"The results of the qualitative analysis for each group of healthcare professionals are presented below using sub-headings to reflect each thematic domain.

Additional small recommendations:
Bias introduced by not including ophthalmologists not involved in the scheme is acknowledged.

Response: Agreed. We have inserted the following sentence into the Strengths and Limitations Section (Page 18):
"The poor response rate for optometrists who chose not to participate and the lack of the views of non-participating ophthalmologists may also have been a source of bias."

A strength of the study is the sample size which includes most of the practitioners involved in the schemes.
Response: Thank you.

4. Explain what the "previous Manchester GRRS" scheme mentioned on Page 10 is.

Response: We have inserted the following sentence on Page 5. "The GRRS was initially launched in 2000 and was recently updated to include measurement of central corneal thickness.

5. I recommend that a copy of the topic guide and online questionnaires be provided as online appendices. I recommend that the checklist from the COREQ for supplementary reporting by included.

Response: Our reporting of the study complied with COREQ. We have added the following sentence on Page 8:
'The study was designed and reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist and was approved by the Research and Ethics committee of the School of Health Sciences, City University London.'
We will, of course, be very happy to comply with the reviewer's to supply a completed COREQ checklist should the Editor prefer it.

6. The views of ophthalmologists presented at the end of Page 11 under the "3.1 Participating

community optometrists" tab would be better placed under the heading of "3.3 Medical Views".

Response: Agreed. We have moved these to Section 3.3

7. Provide a reference and an explanation of what they are for the NICE guidelines for managing glaucoma mentioned on Page 13.

Response: Thank you for pointing out this omission. We have added a footnote and reference on Page 13 of the resubmission. This reads as follows:
" The introduction of the NICE glaucoma guideline in 2009 (http://www.nice.org.uk/guidance/CG85) had significant impact on optometrist' referral behaviour with a reported a doubling of referrals post-NICE which was not associated with an increase in the absolute numbers of positive diagnoses.

8. Clarify the meaning of "High Street setting" in the last sentence for non UK readers.

Response: This has been altered to "convenient community setting".

Reviewer: 2
Reviewer Name Paul GD Spry
Institution and Country Bristol Eye Hospital
England
General Comments
This paper describes a well-designed piece of high quality research with appropriate content relevant to the eye care community and particularly those interested in evolving models of eye care service provision, and specifically the border between primary and secondary care. The paper is well written, appropriately referenced and well presented.

Response: Thank you.

Use of qualitative methodology is uncommon but appropriate given the subject content, and as such is novel and pleasing to read.

Response: Thank you.

Specific Comments

9. Methodology. Whilst I entirely understand the use of qualitative methodology I wonder whether inclusion of a frequency table for each of the themes identified in the qualitative research may give the reader a better idea of how often any of the views expressed occurred amongst the sample? I appreciate that this may not be possible and/or may represent the next stage of a programme of research that the authors may have yet to present, in which case this comment can be disregarded.

Response: The reviewer raises a most interesting point for discussion. There is a temptation to present qualitative research using a quantitative approach. However, quantitative analysis, even something as straightforward as a frequency table, is not conventionally reported in qualitative papers. However, should any reader wish to carry out a simple quantitative analysis based on our data, this would be a trivial matter as the data are available online through the Dryad repository .

10. Page 7. One of the groups surveyed were "glaucoma specialist optometrists" The criterion for inclusion in this group should be defined.

Response: Agreed. We have made it clear on Page 7 that these are hospital-based optometrists.

11. Page 8, results, table 2 and also discussion section 4.4, strengths and limitations. Although the overall response rate was high, this was biased towards those who actively involved in the schemes, specifically participating optometrists, ophthalmologists and GPs. The authors should therefore comment on whether they consider that the low proportion of responses from non-participating optometrists may have led to incomplete ascertainment of views representative of a generalised population of optometrists who chose not to participate in enhanced schemes.

Response: Agreed. We have added the following sentence to the Discussion (Page 18).
"The poor response rate for optometrists who chose not to participate and the lack of the views of non-participating ophthalmologists may also have been a source of bias." We recognise that there is a wide range of views in the ophthalmology community regarding the adequacy of NHS sight tests for glaucoma and/or OHT referrals. A recent example is BMJ 2014;348:g2084 "NHS sight tests include unevaluated screening examinations that lead to waste.

12. Page 9, penultimate sentence. GGRS should be GRRS.

Response: Corrected

13. Page 17, section 4.5 Conclusion. The first sentence of this section may require re-wording because optometrists can work both in primary care and secondary environments. Furthermore, because this paper has been submitted to BMJ Open rather than eye specific journal, in which readers are familiar with the role of optometrists, I am uncertain whether the authors may consider being more specific about the terms Primary and Secondary Care as, for non-eye care practitioners, and readers not familiar with UK NHS eyecare service design, the term primary care may serve to confuse.

Response: We have deleted the term Primary care' from the first sentence of the Conclusion.

VERSION 2 – REVIEW

REVIEWER	Isabelle Jalbert UNSW Australia
REVIEW RETURNED	15-Apr-2014

GENERAL COMMENTS	Both reviewers comments and suggestions have been satisfactorily addressed.