NHS
Herefordshire and Worcestershire
Clinical Commissioning Group

Cataract Extraction Surgery

July 2021

Commissioning Summary

NHS Herefordshire & Worcestershire CCG (also termed "the Commissioner" in this document) routinely commissions cataract extraction surgery on either 1st or 2nd eyes which have been diagnosed with a best corrected visual acuity of:

- 6/12 or worse (in the affected eye) OR
- better than 6/12 when there are special indications (as defined in section 6)

Referrers should ensure that:

1. Ocular co-morbidities and other relevant information is clearly documented and shared with the provider/clinicians caring for the patient
2. Following a discussion of the risks and benefits of surgery, the patient is willing to undergo surgery if clinically appropriate
3. There is documented evidence that the patients lifestyle is affected by disabling visual symptoms attributable to cataracts (see section 6)

Post-operative Follow-Up Arrangements: The commissioner supports a single follow-up by the patients referring optometrist at 3-6 weeks post-operatively. Further follow-ups are only supported where there are clinical issues of concern identified in the initial follow-up appointment.

Further definition of the circumstances is provided in section 6.

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Please contact the Communications Team: 01905 681956

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Author(s)	Fiona Bates - Specialist Medicines and Clinical Policy Adviser Helen Bryant – Head of Acute Contracts
Directorate Responsible	Contracting
Directorate Lead	Ruth Lemiech – Director of Strategy
Ratified by	Herefordshire & Worcestershire Clinical Commissioning Executive Committee
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Version No	Description of change	Reason for Change	Author	Date
1.0	Minor	Documents from previous CCGs reviewed and ratified to provide a single policy for the new CCG	Fiona Bates & Helen Bryant	1st July 2020
1.1	Minor	Application of new commissioning policy template, no change to policy statement, no requirement to update Clinical Commissioning Executive Committee as Template already approved. Change of Executive Lead to Ruth Lemiech	Helen Bryant & Jennie Hammond Helen Bryant	July 2021

Key individuals involved in developing the document:

Name	Designation	Version Reviewed
Paul Ryan	Associate Director of Contracting & Procurement	V1.0
Fiona Bates	Specialist Medicines and Clinical Policy Adviser	V1.0 & V1.1
Helen Bryant	Head of Acute Contracts	V1.0 & V1.1
Cathie Hatherall	IFR Manager, Prior Approval and Contracts Manager	V1.0 & V1.1

Circulated to the following individuals/groups for comments:

Name	Date	Version Reviewed
Policy Alignment Task & Finish Group	Various	Version 1.0
Herefordshire Local Optometrist Committee and Ophthalmologists at Wye Valley NHS Trust [1]	Various	Version 1.0
Worcestershire Local Optometrist Committee and Ophthalmologists at Worcestershire Acute Hospitals NHS Trust[2]	Various	Version 1.0
Patients and the Public across Herefordshire Worcestershire via Public Engagement exercise	Closed 25th May 2020	Version 1.0
Herefordshire & Worcestershire Clinical Commissioning Groups – Clinical Commissioning Executive Committee	1st July 2020	Version 1.0

[1] Via the Herefordshire Eye Health Care Group Meetings

[2] Via the Worcestershire Eye Health Care Group Meetings

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1. Definitions

1.1 **Exceptional** - refers to a person who demonstrates characteristics, which are highly unusual, uncommon or rare.

1.2 **Exceptional clinical circumstances** are clinical circumstances pertaining to a particular patient, which can properly be described as exceptional, when compared to the clinical circumstances of other patients with the same clinical condition and at the same stage of development of that condition (i.e. similar patients). A patient with **exceptional clinical circumstances** will have clinical features or characteristics which differentiate that patient from other patients in that cohort and result in that patient being likely to obtain significantly greater clinical benefit (than those other patients) from the intervention for which funding is sought.

1.3 A **Similar Patient** is a patient who is likely to be in the same or similar clinical circumstances as the requesting patient and who could reasonably be expected to benefit from the requested treatment to the same or a similar degree. The existence of more than one similar patient indicates that a decision regarding the commissioning of a **service development** or commissioning policy is required of the Commissioner.

1.4 An **individual funding request (IFR)** is a request received from a provider or a patient with explicit support from a clinician, which seeks exceptional funding for a single identified patient for a specific treatment.

1.5 An **in-year service development** is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the Commissioner agrees to fund outside of the annual commissioning round. Such unplanned investment decisions should only be made in exceptional circumstances because, unless they can be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.

1.6 The term "**where appropriate"** within this document means that clinical judgement is exercised in determining which aspects of the policy guidance can be applied to individual patients depending on their condition; ability to tolerate the listed treatment; and whether they have already undergone that treatment.

1.7 A **cataract** is a clouding of the eye's natural lens, which lies behind the iris and the pupil. Cataracts are the most common cause of vision loss in people over age 40 and is the principal cause of blindness in the world. There are 3 types of cataract:

- **Nuclear cataracts** are the most common and are normally age related because they are primarily caused by the hardening and yellowing of the lens over time.
- **Cortical cataracts** develop in the lens cortex, which is the outside edge of the lens. People with diabetes are at risk for developing cortical cataracts.
- **Subcapsular cataracts** begins as a small opaque or cloudy area on the back surface of the lens. It is called "subcapsular" because it forms beneath the lens capsule, which is a small "sac," or membrane, that encloses the lens and holds it in place. Subcapsular cataracts can develop rapidly and symptoms can become noticeable within months.

1.8 Visual **Acuity (VA)** – VA commonly refers to the clarity of vision. Visual acuity is dependent on optical and neural factors, i.e., (i) the sharpness of the retinal focus within the eye, (ii) the health and functioning of the retina, and (iii) the sensitivity of the interpretative faculty of the brain.

1.9 **Best Corrected Visual Acuity (BCVA)** – BCVA refers to the clarity of vision that is achieved when an individual is wearing corrective lenses (spectacles or contact lenses).

1.10 **What does 6/9 or 6/12 Vision Mean?** A standard eyesight chart is always placed 20 feet (or 6 meters) away from the person being tested. If an individual can see the last line on a visual test chart (without corrective lenses), this is defined as having 6/6 vision and is considered to be “normal sight”. If your eyesight is diagnosed as being 6/9, it means you can only see the text in the line above the bottom (which has a slightly bigger text size), therefore, 6/12 would mean you could only see the text in the line second from bottom and so on. If an individual does not have 6/6 vision without corrective lenses, they will be prescribed glasses or contact lenses to bring their vision as close to normal (6/6) as possible.

2. Scope of Policy

2.1 This policy is part of a suite of locally endorsed Commissioning Policies. Copies of these Commissioning Policies are available on the following website address: www.herefordshireandworcestershireccg.nhs.uk

2.2 This policy applies to all patients for whom Herefordshire & Worcestershire CCG has responsibility including:

- People provided with primary medical services by GP practices which are members of the CCG and
- People usually resident in the area covered by the CCG and not provided with primary medical services by any CCG.

2.3 The clinical responsibility for applying this policy to a presenting patient rests with the clinician who is responsible for the patient at that point in the treatment pathway and should be done in consideration of the patient's individual clinical circumstances, their place on the management pathway and following discussion with the patient.

2.4 Where a patient's clinical presentation does not clearly meet the requirements for secondary care referral within the context of this policy, and where a GP is uncertain or concerned about the appropriate treatment/management pathway, referral for Advice & Guidance should be considered as an alternative to a referral for clinical assessment.

2.5 There may be occasions when a GP referral is made for specialist assessment which appears to meet the policy requirements, but which on specialist clinical examination either does not meet the clinical criteria for intervention or is not considered clinically suitable for intervention. Such patients should be discharged without intervention.

2.6 For patients who do not fall within the eligibility criteria set out in the policy but where there is demonstrable evidence that the patient has exceptional clinical circumstances, an Individual Funding Request may be submitted for consideration. The referring clinician should consult the Commissioner's "Operational Policy for Individual Funding Requests" document for further guidance on this process.

For a definition of the term "exceptional clinical circumstances", please refer to the Definitions section of this document.

2.7 This policy applies to people with visual impairment as a result of cataract formation.

3. Background

3.1 The NHS Constitution, which details the principles and values that guide the NHS, has been applied in the agreement of this policy.

3.2 NHS Herefordshire & Worcestershire Clinical Commissioning Group consider all lives of all patients whom they serve to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability except where a difference in the treatment options made available to patients is directly related to a particular patient's clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.

3.3 NHS England/Improvement launched their Evidenced Based Interventions (EBI) programme in 2018 which aims to ensure that interventions routinely available on the NHS are evidence-based and appropriate. Adoption of published EBI guidance is mandated in the NHS standard contract; commissioners have the freedom to implement criteria with local variations, provided that the decision to adopt varying criteria reflects the requirement to have regard to the national guidance. Where EBI guidance is available, this has been accommodated within the policy criteria.

3.4 Besides funding healthcare interventions that tackle ill health and save lives there is a growing demand for a range of ophthalmic procedures, some of which are considered to be less efficacious when it comes to allocating limited NHS resources. However, the Commissioner recognises that in some cases the purpose of a procedure will be to meet an appropriate and justifiable clinical need. This commissioning statement sets out eligibility criteria for funding of cataract extraction surgery.

3.5 Cataract is a common and important cause of visual impairment world-wide. The term "cataract" as used here includes those that are not congenital or secondary to other causes. Cataract extraction accounts for a significant proportion of the surgical workload of most ophthalmologists and cataract surgery continues to be the commonest elective surgical procedure performed in the UK.

3.6 Since the level of visual acuity that an individual requires to function without altering their lifestyle varies, measurements of visual acuity do not necessarily reflect the degree of visual disability patients may experience as a result of cataracts. The criteria within this policy attempt to explicitly take this into account.

4. Relevant National Guidance and Facts

4.1. A recent Worcestershire County Council Public Health Department Joint Strategic Needs Assessment indicates that cataracts are the most common cause of blindness worldwide and occur most commonly in older people. There are different classifications of cataract depending upon which part of the lens is affected, including nuclear, cortical and sub-capsular (NICE, 2010).

4.2. A study by Reidy et al (1997) provides evidence of the prevalence of cataracts in adults – as might be expected it varies with age, with an average of 30% amongst people aged 65+. Prevalence can be as high as 59% in people aged 80 years and over. It is estimated that there are around 33,000 Worcestershire people with the condition (30% of the 65+ population). By 2021, the number of people with cataract could increase to 42,000 as the number of older people in the resident population increases.

4.3. Cataracts in children are much less common, estimated to be around 3 in every 10,000 at the age of 3, increasing to 4 in every thousand by the age of 15 (Rahi et al, 2001). This approximates to only around 40 children in Worcestershire.

4.4. Apart from ageing, other causes of cataract include family history (accounting for 50% of cortical cataracts), diabetes mellitus, high alcohol intake and smoking.

4.5. The legal visual requirement for driving falls somewhere between 6/9 and 6/12 (strictly speaking it is based on the number plate test), and it is anticipated that the thresholds set out in this document will not render the majority of people unable to drive.

4.6. NICE National Guideline NG77 “Cataracts in adults: management” published in October 2017 recommends that the decision to refer for cataract surgery should be made after discussions with the patient or their family/carers if more appropriate. The discussion should include:

- How the cataract affects the person’s vision and quality of life.
- Whether one or both eyes are affected
- What cataract surgery involves, including possible risks and benefits
- How the person’s quality of life will be affected if they choose not to have surgery
- Whether the person wants to have cataract surgery.

Access to cataract surgery should not be restricted based on visual acuity.

4.7. The Royal College of Ophthalmologists formally adopted the NICE NG77 in their press release of 26th October 2017. A link to this document is included in the Supporting Documents section of this policy.

4.8. The Royal College of Ophthalmologists – Commissioning Guide – Adult Cataract Surgery document, published January 2018, recommended that the commissioning of cataract care should encompass the whole cataract care pathway from initial assessment and treatment planning to final postoperative review.

4.9. The Royal College of Ophthalmologists – Commissioning Standards, published March 2018, recommends that referrals for one eye disorder, particularly cataract surgery, should not occur without appropriate consideration of other ocular co-morbidities and without full information sharing between, and involvement of, providers caring for the co-morbidities

4.10. The Royal College of Ophthalmologists – Sustainable Ophthalmic Guidelines document, published April 2018 recommendations are all covered by our local policy requirements.

4.11. This policy also recognises the increasing body of evidence that second eye surgery does benefit patients. Over one third of all National Health Service cataract operations are performed on the second eye. Second eye surgery confers significant additional gains in visual function in everyday activities and quality of life above and beyond those achieved after surgery to the first eye. Functional improvement in visual symptoms after second eye surgery has been demonstrated. Surgery for cataract on the second eye also enables a greater proportion of patients to meet the DVLA driving standard. These benefits of surgery are recognised clinically, and its value should not be overlooked in the management of cataract.

5. Evidence Review

5.1 Cooper K, Shepherd J, Frampton G et al. The cost-effectiveness of second-eye cataract surgery in the UK. Age and Ageing 2015; 44: 1026–1031. Concluded that second-eye cataract surgery is generally cost-effective based on the best available data and under most assumptions. However, there are only a small number of clinical trials for second-eye cataract surgery, and these have not been conducted in recent years.

5.2 Technology Assessment 2014 Nov 18;18(68). Available from: http://journalslibrary.nihr.ac.uk/hta/hta18680 published the results of a Systematic review, which concluded that second-eye cataract surgery is generally cost-effective based on the best available data and under most assumptions. However, more up-to-date data is needed. A well-conducted RCT that reflects current populations and enables the estimation of health state utility values would be appropriate. Guidance is required on which vision-related, patient-reported outcomes are suitable for assessing effects of cataract surgery in the NHS and how these measures should be interpreted clinically.

5.3 Iftikhar M, Woreta FA. Preoperative evaluation for cataract surgery. Curr Opin Ophthalmol. 2019 Jan;30(1):3-8. Concluded that Visual acuity alone is a poor gauge of cataract disability. Rising patient expectations and a growing number of surgical choices have expanded the cataract preoperative evaluation. A systematic and comprehensive examination which includes identifying any ocular comorbidity is essential for surgical planning and counselling on visual prognosis. New technologies will continue to inform, but not replace, sound clinical judgment.

6. Patient Eligibility

6.1 **Referral for Consideration of Cataract Surgery**
Before referring a patient for cataract surgery, the optometrist (or GP) must:

1. take appropriate consideration of other ocular co-morbidities and therefore, share all relevant information with the Provider undertaking the surgery and clinicians who are caring for the co-morbidities.

2. discuss the risks and benefits of surgery so that there is assurance that the patient (and/or their family member/carer if this is required) understands these and is willing to undergo surgery if this is clinically indicated.

3. ensure there is documented evidence that the patient lifestyle is affected by disabling visual symptoms attributable to cataracts, such as:
   - Reduced mobility including difficulty with steps or uneven ground; **OR**
   - Difficultly continuing to work, give care or live independently; **OR**
   - Difficulty carrying out everyday tasks such as recognising faces, reading, watching TV, cooking, driving and playing sport; **OR**

The reasons why the patient's vision and lifestyle are adversely affected by the cataract and the likely benefit from surgery, or other exceptional circumstances, must be clearly documented in the clinical records and on the referral form.

6.2 **Referral for Cataract Surgery**
The Commissioner will support the routine NHS funding of cataract extraction surgery on either 1st or 2nd eyes with a best corrected visual acuity of:

1. 6/12 or worse (in the affected eye)

OR

2. better than 6/12 providing they meet one of the following clinical circumstances:

   - Difficultly continuing to work, give care or live independently **OR**
   - Reduced mobility including difficulty with steps or uneven ground; **OR**
   - Difficulty carrying out everyday tasks such as recognising faces, reading, watching TV, cooking and playing sport; **OR**
   - Experience of glare or reduction in acuity in daylight or bright conditions (if you have posterior subcapsular cataracts and those with cortical cataracts) **OR**
   - Significant optical imbalance (anisometropia or anisekonia) following cataract surgery on the first eye **OR**
   - Diagnosis of Glaucoma and require cataract surgery to control intra-ocular pressure **OR**
   - Diagnosis of Diabetes who require clear views of their retina to look for retinopathy **OR**
   - Diagnosis of Wet Macular Degeneration or other retinal conditions who require clear views of their retina to monitor their disease or treatment (e.g. treatment with anti-VEGFs) **OR**
   - Difficulty with driving due to cataracts e.g:
     - Experience of significant glare due to cataracts which affects driving at night; **OR**

- Borderline visual field defects that impacts on driving, in whom cataract extraction would be expected to significantly improve the visual field

A copy of the agreed Cataract Surgery Treatment Pathway flowchart is attached to this document as Appendix 1 to ensure clarity regarding Commissioner expectations.

Notes:

i. No driver should be left without the necessary binocular visual acuity to meet the DVLA standard, (which is about 6/10 but has no actual Snellen equivalent).
ii. Patients and, where appropriate, their family/carer, must be made aware that there is a risk of worsening visual acuity post surgery if their original best corrected visual acuity is good (better than 6/12) before intervention.
iii. The patient's best corrected visual acuity and, where appropriate, the adverse impact on lifestyle made by the cataract must be clearly documented in the clinical records.
iv. Where referrals are not of a good quality, the Provider will reserve the right to return to the referring organisation for greater clarity.
v. The commissioner expects all Providers within the cataract surgery treatment pathway for clinically appropriate patients to ensure that patient safety is maintained at all times during that pathway. These expectations have been documented in Appendix 2 for ease of reference.

6.3 **Post-Operative Follow-Up Arrangements**

The commissioner supports a single follow-up by the patients referring optometrist at 3-6 weeks post-operatively. Further follow-ups are only supported where there are clinical issues of concern identified in the initial follow-up appointment.

7. Supporting Documents

References:

1. Castells X, Comas M, Alonso J, Espallargues M, Martinez V, Garcia-Arumi J, Castilla M. In a randomised controlled trial, cataract surgery in both eyes increased benefits compared to surgery in one eye only. J Clin Epidemiol. 2006 Feb;59(2):201-7. http://www.jr2.ox.ac.uk/bandolier/band57/b57-4.html
2. Laidlaw DA, Harrad RA, Hopper CD, Whitaker A, Donovan JL, Brookes ST, Marsh GW, Peters TJ, Sparrow JM, Frankel SJ. Randomised trial of effectiveness of second eye cataract surgery. Lancet. 1998 Sep 19;352(9132):925-9.
3. Busbee BG, Brown MM, Brown GC, Sharma S. Incremental cost-effectiveness of initial cataract surgery. Ophthalmology 109 (3): 606-612 MAR 2002
4. B. Busbee Cost-utility analysis of cataract surgery in the second eye. Ophthalmology, Volume 110, Issue 12, Pages 2310-2317
5. Tobacman JK, Lee P, Zimmerman B, Kolder H, Hilborne L, Assessment of appropriateness of cataract surgery at ten academic medical centers in 1990. Ophthalmology. 1996 Feb;103(2):207-15.
6. Choi YJ, Hong YJ, Kang H. Appropriateness ratings in cataract surgery. Yonsei Med J 2004;45:396-405
7. Mangione CM, Oray EJ, Lawrence MG et al. Prediction of visual function after cataract surgery. A prospectively validated model. Arch Opthal. 1995;113:1305-1311.
8. Brogan C, Lawrence D, Pickard D, Benjamin L. Can the use of visual disability questionnaires in primary care help reduce inequalities in cataract surgery rates?–a long term cohort study. In press
9. Reidy et al (1997)
10. Cooper K, Shepherd J, Frampton G et al.
11. Technology Assessment 2014 Nov 18;18(68)
12. Iftikhar M, Woreta FA. Preoperative evaluation for cataract surgery. Curr Opin Ophthalmol. 2019 Jan;30(1):3-8.

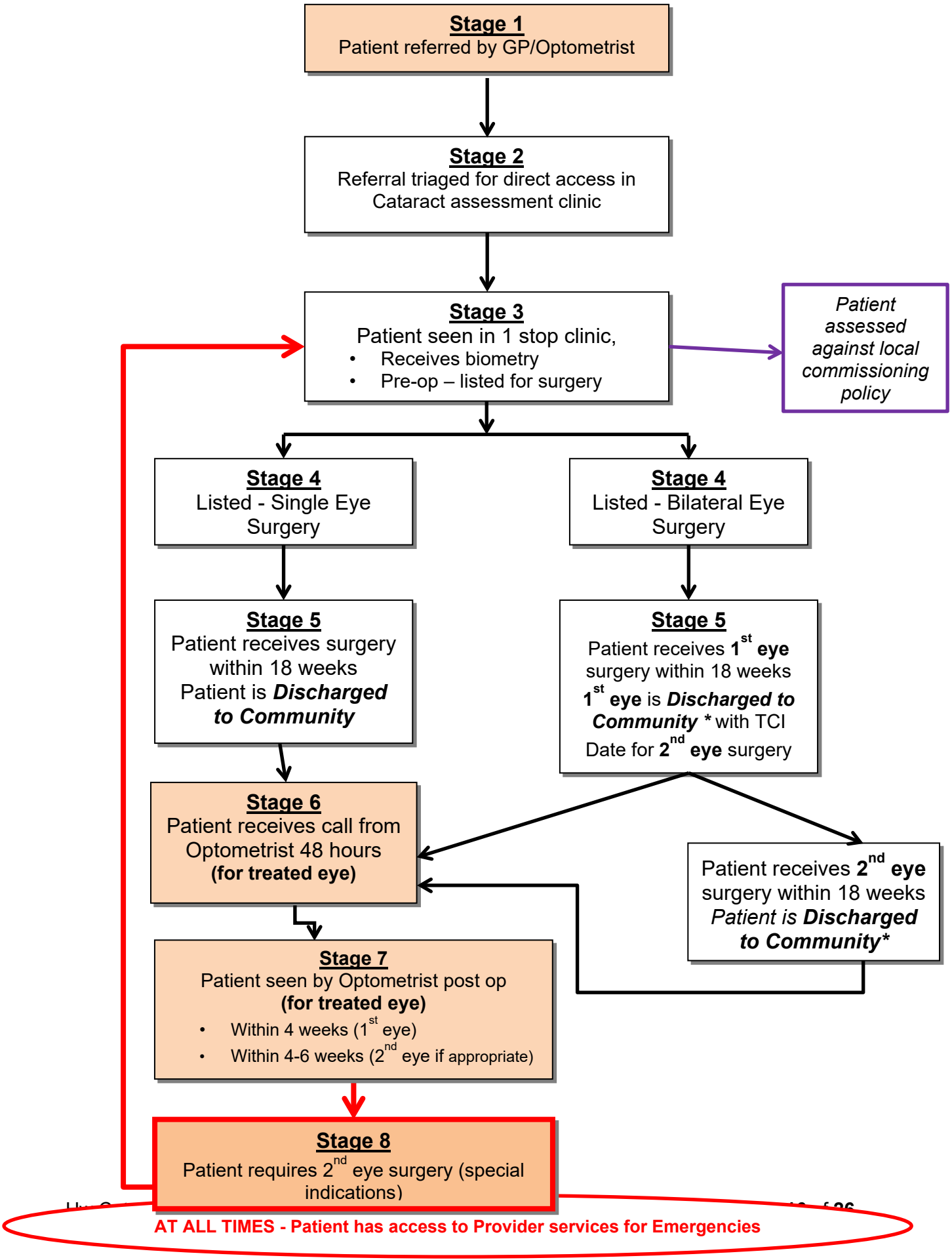
Policies:

- NHS Herefordshire & Worcestershire: Individual Funding Request Operating Procedure
- NHS Herefordshire & Worcestershire: Prioritisation Framework for the Commissioning of Healthcare Services
- WM01 – Ethical Framework
- WM02 – Orphan Drugs
- WM03 – Patients Leaving Industry Sponsored Trials
- WM05 – NICE Guidance
- WM07 – Choice
- WM08 – In Year Service Developments
- WM09 – Individual Funding Requests (to be read with local process document)
- WM10 – Patients Leaving Non Commercially Funded Trials

- WM11 – Patients Leaving a CCG Funded Trial
- WM12 – Patients Changing Responsible Commissioner
- WM13 – NHS Private Interface
- WM14 – Experimental Treatments
- WM15 – Trial of Treatment
- NHS Constitution, updated 27th July 2015
- NHS Executive, Action on Cataracts, Good Practice Guidance, January 2000
- Department of Health: National Eye Care Plan 2004
- Royal College of Ophthalmologists: Cataract Surgery Guidelines. September 2010
- The Royal College of Ophthalmologists – Commissioning Guide – Adult Cataract Surgery document, published January 2018
- The Royal College of Ophthalmologists – Commissioning Standards, published March 2018
- The Royal College of Ophthalmologists – Sustainable Ophthalmic Guidelines document, published April 2018

8. Appendices

Appendix 1 – Cataract Pathway



Cataract Pathway Supporting Information

- **Stage 1** – Patient is seen by GP or Optometrist in Primary Care, decision made to refer to Secondary Care for consideration of surgery

- **Stage 2** – Referral is triaged by Specialty Doctor in Ophthalmology Department

- **Stage 3** – Patient attends Cataract One Stop Clinic for:
  - Assessment by Consultant
  - Visual assessments with Nurse
  - Biometry with an Orthoptist.
  - Where patient meets local commissioning policy criteria the patient will be provided with information on the procedure to be provided and will sign all consent forms.
    The patient will be requested to select the Primary Care Optician they wish to receive post operative appointments with, unless, for medical reasons, the patient needs to remain under WAHT care.
    Nursing staff will fax patient information to the selected Optometrist

- **Stage 4** – Patient is listed on Provider's waiting list for either Bilateral or Unilateral Surgery

- **Stage 5** – Provider Booking Administrator agrees date for the procedure (any declines or holiday days will be recorded appropriately:
  - 1st (or only) eye – within 18 weeks RTT
  - 2nd eye – within 18 weeks RTT***
- The **Treated Eye** is discharged back to Primary Care for follow up unless it is clear that there are medical reasons meaning that the patient needs to remain under WAHT care.
- If patient assessed as requiring Bilateral surgery, the "To Come In" Date is confirmed on discharge and communicated to the patient, the GP and follow up Optometrist/Optician

- **Stage 6 –** Patient receives call from Primary Care Optometrist within 48 hours of discharge

- **Stage 7** – Patient receives post operative assessment with Primary Care Optometrist
  - 1st (or only) eye – within 4 weeks following surgery
  - 2nd eye – within 4-6 weeks following surgery

- **Stage 8** – Patient in receipt of unilateral cataract surgery is identified as needing 2nd eye surgery due to special indications (see Appendix 2) , then patient is referred into Secondary care at **Stage 3**

ALL Patients MUST have access to Secondary Care Emergency Service for any post operative conditions.

Appendix 2 – Patient Safety, Pathways and Equipment

The Commissioner expects the Provider shall ensure that any cataract clinic used is adequately equipped to ensure the safe and efficient treatment of Herefordshire and Worcestershire patients.

This will include ensuring that all standard equipment is up to date including**:**

- Ultrasound equipment
- Laser measuring devices (for example, the IOLmaster or equivalent) for pre-operative biometry.

Pre-operative Assessment:

All of the following tests will be undertaken at the **first (and only)** pre-operative visit, in accordance with the Commissioner's agreed patient pathway.

- Laser measuring for pre-operative biometry
- Indirect ophthalmoscopy,
- Slit lamp bio-microscopy
- Gonioscopy

The formulae used must be as recommended in the Royal College of Ophthalmology Cataract Guidelines (i.e. 3rd or 4th generation)

Providers should not use SRK and SRK II specifically as these are considered outdated.

If patients have astigmatism over 1.00 dioptre in magnitude, Providers should use Topography

During the pre-operative assessment, the following information should be discussed with the patient and recorded in the patient's file:

- The pre-operative current refraction
- The target spherical equivalent
- The intended target refraction.
- The A-constant for the type of lens implant to be used. If this is not "factored" for the unit and surgeon, the surgeon must record a specific reference to the "origin" of the A-constant figure used
- Confirmation that the types of local anaesthetic that are appropriate for surgery have been discussed. The patient's wishes must be considered foremost in the decision as to the type of local anaesthetic to be administered prior to surgery being undertaken.
- Confirmation of the patient's chosen optometrist to ensure smooth discharge planning

Providers must ensure that patients have sufficient time to consider these complex issues, and decisions such as post-operative target refraction should be determined and agreed with the patient well in advance of the scheduled surgery date.

Surgical Intervention:

The Provider shall ensure that all surgery is be undertaken within a modern fully equipped ophthalmic operating theatre, and that modern phacoemulsification equipment is available.

It is accepted that the majority of cases will be undertaken under local anaesthesia; the approach for each surgeon should be consistent with their usual practise and should reflect the discussions held with the patient at the pre-operative assessment.

Additional equipment within theatre will include:

- Small pupil surgical devices of the surgeon's preference along with a full range of viscoelastic devices (such as Healon 5) to manage the eventuality of "small pupil" surgery
- Theatre equipment must be available to manage vitreous loss at the time of cataract surgery

Both surgical complications and post-operative posterior capsule rates (PCRS) must be recorded contemporaneously by the clinician for future reference and be made available to the commissioner annually or on request.

Discharging The Treated Eye:
On discharge, the Provider must ensure that the following information is reported in the discharge letter to both the GP and to the patient:

- Any complications experienced during surgery
- Confirmation that the full course of post operative eye drops (2 bottles) and instructions, together with the emergency contact number have been given to the patient on discharge (in the form of a patient information leaflet)

The Commissioner expects the Provider to send sufficiently detailed discharge letters to the GP and to the patient's identified Optometrist within 48 hours of the patient being discharged.

In addition, the Provider must ensure that patients have direct and IMMEDIATE access to the surgical team if they experience any problems following discharge from surgery. If this is level of post-operative care is not possible **the surgeon** should formally approach (and make arrangements for such urgent care) with other local providers.

Post Operative Review:
The patient's identified optometrist will undertake a full review of the patient's treated eye between 3-6 weeks post surgery. The Commissioner expects the Provider will ensure that they have access to the surgical team to discuss any complications identified at the post-operative optometry review clinic.

In order to undertake a full clinical review, the Commissioner expects the Optometrist to have access to diagnostic equipment such as Ocular Coherence Tomography (OCT) for the diagnosis of Cystoid Macular Oedema (CMO), which occurs in1-5% of patients post-operatively. Patients who are diagnosed with this condition will be referred back to Secondary Care for ongoing treatment as an emergency access.

In addition, the Commissioner expects the Secondary Care Provider to have an established treatment regimen for patients with CMO in place and available to Optometrists for escalation purposes.

Second Eye Surgery:
In most circumstances the Secondary Care Provider will confirm that 2nd eye cataract surgery is clinically appropriate for the patient (at the initial Pre-Operative Assessment).

Where this has not been confirmed, the Optometrist will review the patient's condition at the Post Operative Review and, where it is clear that the patient requires (and is clinically suitable for 2nd Eye Surgery) the Optometrist will refer the patient to the Secondary Care Provider clinic of the patients choice as a follow up referral, clearly indicating the change in clinical circumstances**.**

9. Equality Impact Assessment

Equality Statement

9.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on race equality. This obligation has been increased to include equality and human rights with regard to disability, age, gender, sexual orientation, gender reassignment and religion.

9.2. HWCCG endeavours to challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

9.3. All staff are expected to deliver services and provide care in a manner which respects the individuality of patients and their Carer's and as such treat them and members of the workforce respectfully, regardless of age, gender, race, ethnicity, religion/belief, disability and sexual orientation.

9.4. Providers are expected to use the appropriate interpreting, translating or preferred method of communication for those who have language and/or other communication needs. CCG staff and Providers will need to assess that the policy is applied fairly and equitably for all groups covered under the Equality Act 2010 and that they are implementing the Accessible Information Standard and have considered health inequalities.

9.5. HWCCG must meet its statutory duty to reduce inequalities of access and outcomes, as set out in the NHS Act 2006 (as amended). As a result, the CCG aims to design and implement policy documents that seek to reduce any inequalities that already arise or may arise from any new policy. Therefore, the CCG will consciously consider the extent to which any policy reduces inequalities of access and outcomes.

9.6. Any change to this policy will require a conscious effort from the HWCCG to actively consider the impact that this will have on any Protected group(s) and act due diligently. Where an impact on any of the Equality groups is realised after the implementation of this policy, HWCCG and the Providers, will seek to minimise such an impact and simultaneously carry out a full review.

9.7. HWCCG aims to design and implement policy documents that meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. This document has been designed to ensure that no-one

receives less favourable treatment due to their personal circumstances, i.e. the protected characteristics of their age, disability, sex, gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration has also been given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

Organisation	NHS Herefordshire & Worcestershire Clinical Commissioning Group		
Department	Transformation/Contracting/Public Health	Name of lead person	Jason Nash, Helen Bryant, Fiona Bates
Name of Policy being assessed	Cataract Extraction Surgery Commissioning Policy		
Aims of this Policy	To provide guidelines to patients and clinicians in both primary and secondary care on the medical/clinical requirements against which cataract surgery will be funded on the NHS by NHS Herefordshire & Worcestershire CCG		
Date of EIA	June 2018 (Worcestershire CCGs' policy) Updated April 2020 Reviewed June 2021 when updated commissioning policy template applied.	Other partners/stakeholders involved	Clinical Commissioning Policy Collaborative
Who will be affected by this Policy?	Individuals who wish to receive cataract surgery as part of an NHS pathway of care and the clinicians providing their eye health care.		
Did the Policy require Engagement or Consultation?	Version 1.0 of the Herefordshire & Worcestershire policy required a public engagement exercise to determine the impact of changes to the policy for Herefordshire patients. This was concluded in May 2020 and the information taken into account in the finalisation of the policy statement.		

Equality Group	Potential Positive Impact	Potential Neutral Impact	Potential Negative Impact	Baseline data and research on the population that this piece of work will affect. What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**
Age		Y		There is a large body of evidence that age is a factor in the development of cataracts, with County Council Public Health Department Joint Strategic Needs Assessments indicating that cataracts are the most common cause of blindness worldwide and occur most commonly in older people. Reidy et al (1997). Cataracts in children are much less common, estimated to be around 3 in every 10,000 at the age of 3, increasing to 4 in every thousand by the age of 15 (Rahi et al, 2001). This commissioning policy ensures that patients receive appropriate treatment based on their clinical presentation rather than on their age, although the treatment pathway for children may be more specialised in nature. Commissioners expect patients to be treated fairly and equitably with dignity.
Disability		Y		Cataracts are more prevalent in some conditions eg. Down's syndrome. Children with **Down's syndrome** have an increased risk of being born with **cataracts** or developing **cataracts** later in life. Cataracts are also associated with exposure to radiation from X-rays and cancer treatments. There does not appear to be other evidence that having a disability will have an impact on an individuals risk of developing cataracts. However, it is recognised that people who have cataracts may be at greater risk of falls and, if left untreated, cataracts can cause severe sight loss, even blindness. This commissioning policy ensures that patients receive appropriate treatment based on their clinical presentation rather than on whether they have disabilities. Commissioners expect patients to be treated fairly and equitably with dignity.
Gender Reassignment		Y		There does not appear to be any evidence that gender reassignment will have an impact on an individuals risk of developing cataracts.

Equality Group	Potential Positive Impact	Potential Neutral Impact	Potential Negative Impact	Baseline data and research on the population that this piece of work will affect. What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**
				This commissioning policy ensures that patients receive appropriate treatment based on their clinical presentation. Commissioners expect patients to be treated fairly and equitably with dignity.
Marriage & Civil Partnerships		Y		The application of this policy is based on an individual's clinical presentation against agreed criteria for treatment. Therefore, an individual's marital or civil partnership status would not be a deciding factor in the NHS funding of an intervention.
Pregnancy & Maternity		Y		There does not appear to be any evidence that pregnancy or maternity will have an impact on an individuals risk of developing cataracts. Congenital cataracts can be caused by infections caught by the mother or physical trauma eg car accident during pregnancy. This commissioning policy ensures that patients receive appropriate treatment based on their clinical presentation. Commissioners expect patients to be treated fairly and equitably with dignity.
Race including Travelling Communities		Y		The Birmingham University Study confirms that there is no UK evidence concerning cataracts in African-Caribbean populations in comparison to the White population. Several South Asian communities in the UK have been studied and in every case the prevalence of cataract has been found to be high. Cataracts are associated with high blood pressure which is more prevalent in African or African Caribbean populations and diabetes which is more prevalent in Africans, African Caribbeans and South Asians. Cataracts are also associated with sun exposure, so people who live in sunnier climates are at greater risk, but this risk is regardless of race. This commissioning policy ensures that patients receive appropriate treatment based on their clinical presentation rather than on their race. Commissioners expect patients to be treated fairly and equitably with dignity.

Equality Group	Potential Positive Impact	Potential Neutral Impact	Potential Negative Impact	Baseline data and research on the population that this piece of work will affect. What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**
Religion & Belief		Y		There does not appear to be any evidence that an individual's religion or belief system will have an impact on their risk of developing cataracts. This commissioning policy ensures that patients receive appropriate treatment based on their clinical presentation rather than on their religion or belief system. Commissioners expect patients to be treated fairly and equitably with dignity.
Sex		Y		There is evidence from epidemiological data that cataract is more common in women than men. https://pubmed.ncbi.nlm.nih.gov/24987869/ This commissioning policy ensures that patients receive appropriate treatment based on their clinical presentation rather than on their sex. Commissioners expect patients to be treated fairly and equitably with dignity.
Sexual Orientation		Y		There does not appear to be any evidence that an individual's sexual orientation will have an impact on their risk of developing cataracts. This commissioning policy ensures that patients receive appropriate treatment based on their clinical presentation rather than on their sexual orientation. Commissioners expect patients to be treated fairly and equitably with dignity.
Carers		Y		There does not appear to be any evidence that whether an individual is a carer will have an impact on their risk of developing cataracts. It is, however, recognised, that the development of cataracts may have an impact on their ability to act as a carer. This commissioning policy ensures that patients receive appropriate treatment based on their clinical presentation rather than on whether the patient is a carer for another individual. Commissioners expect patients to be treated fairly and equitably with dignity.
Care Leavers		Y		There does not appear to be any evidence that having been in care will have an impact on an individual's risk of developing cataracts.

Equality Group	Potential Positive Impact	Potential Neutral Impact	Potential Negative Impact	Baseline data and research on the population that this piece of work will affect. What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**
				This commissioning policy ensures that patients receive appropriate treatment based on their clinical presentation alone. Commissioners expect patients to be treated fairly and equitably with dignity.
Homeless		Y		There is evidence that there is a higher incidence of untreated visual impairment and ocular conditions in people who are homeless as they are less likely to attend health services if a health related issue arises. https://www.nature.com/articles/eye2016283 This results in patients presenting with a more complicated set of needs as their cataracts could be more developed as a result. However, this commissioning policy ensures that patients receive appropriate treatment based on their clinical presentation alone. Commissioners expect patients to be treated fairly and equitably with dignity.
Socio/Economic Deprivation		Y		There is some evidence that an individual's social deprivation status may be a factor in the development of cataracts, with recent Public Health Department Joint Strategic Needs Assessments that note that, apart from ageing, other causes of cataract include family history (accounting for 50% of cortical cataracts), diabetes mellitus, high alcohol intake, obesity and smoking. This commissioning policy ensures that patients receive appropriate treatment based on their clinical presentation rather than on their social deprivation status. Commissioners expect patients to be treated fairly and equitably with dignity.
Other Vulnerable and Disadvantaged Groups		Y		In producing the policy, the commissioner's intention was to provide clear clinical information to patients and their responsible clinician, therefore improving the option for equitable access to treatment for clinically eligible patients.

Equality Group	Potential Positive Impact	Potential Neutral Impact	Potential Negative Impact	Baseline data and research on the population that this piece of work will affect. What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**
Health Inequalities		Y		In producing the policy, the commissioner's intention was to provide clear clinical information to patients and their responsible clinician, therefore improving the option for equitable access to treatment for clinically eligible patients.
Does this policy impact on an individual's Human Rights?		Y		This policy does not seek to infringe on an individual's human rights.

Equality Impact Assessment Action Plan

Equality Group	Risk Identified	Action required to reduce/eliminate negative impact	How will you measure the outcome/impact	Timescale	Lead