**Norfolk and Waveney ICB**

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**CATARACT SURGERY**

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**Document Control Sheet**

This document can only be considered valid when viewed via the ICB’s intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

Approved documents are valid for use after their approval date and remain in force beyond any expiry of their review date until a new version is available.

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| **Name of document** | **Cataract Surgery >18 years** |
| **Version** | V3 |
| **Date of this version** | July 2023 |
| **Produced by** | NWICB Clinical Policy Development Group |
| **What is it for?** | Clinical Threshold Policy |
| **Evidence base** | NICE, GIRFT, RCOphth |
| **Who is it aimed at and which settings?** | Secondary Care |
| **Consultation** | Tom Butler, Consultant Ophthalmologist, NHS James Paget Hospital, Tom Eke, Consultant Ophthalmologist, NHS Norfolk & Norwich University Hospital  Norfolk and Waveney Local Optical Committee, NWICB Eye Care Team, |
| **Impact Assessment:** |  |
| **Other relevant approved documents** |  |
| **References:** |  |
| **Monitoring and Evaluation** | Review annually |
| **Training and competences** | Reviewed by Clinicians appointed by NWICB and Public Health Consultant |
| **Reviewed by:** | NWICB Planned Care Medicines Management Working Group |
| **Approved by:** | NWICB Planned Care Medicines Management Working Group |
| **Date approved:** | 24th August 2023 |
| **Signed:** |  |
| **Dissemination:** | NWICB Contracts Team, NWICB Knowledge Anglia, NWICB Communications Team |
| **Date disseminated:** | 6th September 2023 |
| **Review Date:** | July 2024 |
| **Contact for Review:** | NWICB Clinical Policy Development Group |

**Version Control**

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| **Revision History** | **Summary of changes** | **Author(s)** | **Version**  **Number** |
|  | The revised policy responds to NICE and EBI guidance of removing the visual acuity threshold, whilst having wording that prevents inappropriate operations on asymptomatic patients. | NWICB Eye Care Team | V3 |
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|  | The potential to benefit from cataract surgery depends on several factors including the patient’s visual acuity, whether they have any visually disabling symptoms such as glare and the severity of the symptoms, the impact of any visual disability on the patient’s ability to function, maintain independence and remain safe, and the impact on their ability to conduct any activities which are important to them and/ or which require particularly good vision.  The benefits of second eye surgery have been demonstrated and patients with bilateral cataract should be offered second eye surgery provided they meet the criteria.  **Patients may benefit from cataract surgery in the first or second eye when:**   1. They have evidence of significant cataract on assessment. 2. **AND** any of the following (but not limited to): 3. Visual disability: can no longer undertake their usual activities such as reading, watching television, or particular activities relating to their employment (if applicable). 4. Where the presence of cataract is preventing a patient from meeting the DVLA visual requirements for their current form of driving licence. 5. Significant glare and dazzle in daylight or difficulties with night vision, due to the lens opacity. This may particularly affect patients who need to drive at night. 6. The patient has difficulty with activities of daily living or self-care, and/or are at increased risk of falls due to impaired vision. 7. They are a carer for their partner or other dependent adult and the cataract limits their ability to provide care. 8. The patient has significant optical imbalance between the two eyes (anisometropia) which will be reduced or resolved by removal of the cataract (this may be the result of cataract surgery on the first eye). 9. The patient has a refractive error / myopic shift which is primarily due to the presence of the cataract. 10. To treat existing angle closure glaucoma or prevent future angle closure glaucoma (in eyes with cataract deemed at significant risk of future angle closure). 11. To improve intraocular pressure control in eyes with glaucoma and inadequate intraocular pressure control. 12. To treat lens-induced ocular disease (e.g., phacolytic glaucoma, phacomorphic glaucoma, phaco-anaphylactic uveitis, etc.) 13. The patient has corneal or conjunctival disease where cataract removal would reduce the risk of losing corneal clarity or reduce the risk of complications.      1. The patient has a co-existing eye condition, and the removal of the cataract is required to enable better surveillance or management of the condition, for example diabetic and other retinopathies, age-related macular degeneration, glaucoma, inflammatory eye disease or neuro-ophthalmological conditions. 2. The patient has post-vitrectomy cataracts which hinder the retinal view or result in a rapidly progressing myopia.   **Note**: NICE NG77 recommends that access to cataract surgery should not be restricted based on visual acuity.  **NOTE**: Surgeons may elect to insert toric lenses provided that this is the most appropriate implant at a cost equal to standard lenses.  **Cases for Individual Consideration**  On a case-to-case basis, patients might be eligible for surgical intervention, in consideration of their exceptionality. The requesting clinician must provide information to support the case for being considered an exception, by submitting an individual funding request.  **Feedback**  This is a new Cataract Threshold Policy for Norfolk and Waveney that will be reviewed 12 months after implementation. If you wish to share any feedback, please contact Norfolk and Waveney Clinical Policy Development Group at [nwicb.cpdg@nhs.net](about:blank) . |  |
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| **Appendix A** | **Equality Impact Assessment** |  |
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**APPENDIX A: EQUALITY IMPACT ASSESSMENT**

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| **Step 1: Aims and purpose of the proposal / policy being assessed**  (This should reflect what the policy is intending to achieve and how it seeks to achieve, it is this intention that the assessment seeks to measure, consider who benefits and how and who doesn’t and why, also consider the impact of associated aims). |
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| **Step 2: Screening process for relevance to equality & diversity issues** | | |
| **Does this proposal / policy have any equality & diversity relevance in the following areas?** (This should be considered in relation to the formulation and application of the policy. As far as possible engagement with the relevant staff network groups should take place to identify any potential areas of relevance). | |
| **A Age** | This policy relates to clinical conditions which are commonly found in older patients. However, the policy relates to the clinical symptoms and findings. Therefore, an older patient with the same set of circumstances is as likely to receive treatment as a younger patient. |
| **B Disability** | This policy relates to clinical conditions which are more commonly found in people with disabilities.  We consider the impact of the condition on a person’s daily life. The policy relates to clinical symptoms and signs. Therefore, the patient with disability but the same presentation is as likely to receive treatment as a patient without disability. |
| **C Gender reassignment** | **No impact identified** |
| **D Marriage and Civil Partnership** | **No impact identified** |
| **E Pregnancy and maternity** | **No impact identified** |
| **F Race** | The policy relates to clinical symptoms and signs and therefore ethnicity would not impact adversely on treatment. |
| **G Religion or belief** | **No impact identified** |
| **H Sex** | **No impact identified** |
| **I Sexual orientation** | **No impact identified** |
| **J Other issues** | **No impact identified** |
| **Step 3: If you have answered, “Yes”, to any of the protected characteristic boxes in Step 2, a full impact assessment is required** | | |
| **Are any of the protected characteristic boxes in Step 2 marked “Yes”?** |  |

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| **Step 4: Examination of available information (sources can include but are not restricted to – ESR data; MI relating to Recruitment /Employee Relations/Attrition; Industry best practice; legal overview; research articles; matters arising from judgements tested during consultation; consider four-fifths rule to assess difference).** |
| This policy was impact assessed by Norfolk and Waveney ICB clinicians, appointed to support Clinical Policy Development Group. The clinical threshold policy was reviewed against impact and evidence criteria and no impact identified. |

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| **Step 5: Full Impact Assessment Process** | | | | | | | |
| **Step 5a: Consultation Log** | | | | | | | |
| **Where are the consultation records stored? – No consultation records, as consultation was not undertaken** | | | | | | | |
| **Step 5a: Consultation Log** | | Step 5a: Consultation Log | | Step 5a: Consultation Log | | Step 5a: Consultation Log | |
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| **Step 5b: EIA Action Plan: Workforce Impacts (internal)** | | | | | | | | |
| **Potential issues or impacts**  **(positive and negative)** | | |  | |  | |  | |
| **None identified** |  | |  | |  | |  | |
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| **Step 5c: EIA Action Plan: Service Delivery Impacts (external)** | | |
| **Potential issues or impacts**  **(positive and negative)** | | |
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| **Step 6: Monitoring and review arrangements** |
| **How will the implementation of the proposal / policy be monitored, and by whom?** |
| Clinical Policy Development Group undertake reviews of policies, where there is new clinical evidence e.g. NICE, EBI or as and when clinically required**.**  A data requirement will be CV’d into provider contracts to require reporting on the Age and Visual Accuity of patients operated on to monitor if there are any unusual trends suggesting asymptomatic patients are being operated on inappropriately. |
| **What is the timetable for monitoring, with dates?** |
| Annual review, unless otherwise (as stated above) |
| **Step 7: Public availability of reports / result** | |
| Once policy has been formally approved by PCMMWG, the policy will be available to view via Knowledge Anglia | |