Commissioning Policy

Cataract Extraction Surgery

November 2012

This commissioning policy applies to patients within:
South Worcestershire Clinical Commissioning Group (CCG)
Redditch & Bromsgrove Clinical Commissioning Group (CCG)
Wyre Forest Clinical Commissioning Group (CCG)

Version:	1.1
Ratified by (name and date of Committee):	09/02/2013 - NHS Worcestershire Clinical Senate 1st April 2013 – this policy was formally adopted by: NHS South Worcestershire Clinical Commissioning Group NHS Redditch & Bromsgrove Clinical Commissioning Group NHS Wyre Forest Clinical Commissioning Group
Date issued:	1st April 2013
Expiry date: **(Document is not valid after this date)**	Any revisions to the policy will be based on local and national evidence of effectiveness and cost effectiveness together with recommendations and guidelines from local, national and international clinical professional bodies. Minimum 3 yearly.
Review date:	April 2016
Name of originator/author:	Mrs Anita Roberts/ Mrs Fiona Bates
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Distribution:	NHS Trusts, Independent Providers, GP's, optometrists, patients, Worcestershire MP's, Public & Patient Involvement Forum
Equality & Diversity Impact Assessment	Undertaken 29th November 2012 Endorsed 13th December 2012

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Contribution list

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Circulated to the following individuals/groups for comments

Name	Designation
Ophthalmology Service Review Group	Various staff including: • Commissioners for both Primary and Secondary Care services • Public Health representatives • General Practitioners • Specialist Clinicians • Optometry representatives • Provider General Management

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Commissioning Statement:

NHS Redditch & Bromsgrove Clinical Commissioning Group, NHS South Worcestershire Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group (also termed "the Commissioner" in this document) will routinely fund 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).

The Commissioner does not normally fund cataract extraction surgery on an eye (1st or 2nd) with a best corrected visual acuity of better than 6/12, unless there are special indications*.

All patients referred for cataract surgery should have evidence of significant impairment of lifestyle and patients should be ready and willing to undergo surgery.

** For further information regarding special indications please see section 5.3 of this document.*

1. Definitions

1.1 ***Exceptional clinical circumstances*** are clinical circumstances pertaining to a particular patient, which can properly be described as exceptional. This will usually involve a comparison with other patients with the same clinical condition and at the same stage of development of that clinical condition and refer to features of the particular patient which make that patient out of the ordinary, unusual or special compared to other patients in that cohort. It can also refer to a clinical condition which is so rare that the clinical condition can, in itself, be considered exceptional. That will only usually be the case if the NHS commissioning body has no policy which provides for the treatment to be provided to patients with that rare medical condition.

1.2 A ***Similar Patient*** refers to the existence of a patient within the patient population 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. When the treatment meets the regional criteria for supra-CCG policy making, then the similar patient may be in another CCG with which the Commissioner collaborates. The existence of one or more similar patients indicates that a policy position is required of the Commissioner.

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

1.4 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. 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.

2. Scope of policy:

2.1 This policy should be considered in line with all other Worcestershire Commissioning Policies. Copies of these Commissioning Policies are available on the Commissioner's website at the following address:
http://www.worcestershire.nhs.uk/policies-and-procedures/commissioningindividual-funding-requests-ifr/

2.2 Referrals into secondary care for consideration for cataract surgery should only be made after an assessment by an optometrist unless there are exceptional reasons why this is not possible. When considering referral into secondary care, optometrists should take account of the referral thresholds below.

3. Background:

3.1. NHS principles have been applied in the agreement of this policy.

3.2. 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.

3.3. This policy informs the service specification for Elective Ophthalmology Services.

4. Relevant National Guidance and Facts

4.1. 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.

4.2. 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 set out below attempt to explicitly take this into account.

4.3. 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 below will not render the majority of people unable to drive.

4.4. 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. Commissioning Policy

5.1 The Commissioner considers all lives of all patients whom it serves 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 the patient's clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.

5.2 The Commissioner routinely funds cataract extraction surgery on either 1st or 2nd eyes with a best corrected visual acuity of 6/12 or worse (in the affected eye). A copy of the agreed

Worcestershire Cataract Surgery Treatment Pathway flowchart is attached to this document as Appendix 1 to ensure clarity regarding Commissioner expectations.

5.3 The Commissioner does not normally fund cataract extraction surgery on an eye (1st or 2nd) with a best corrected visual acuity of better than 6/12, unless there are special indications. Special indications include:

- Patients who are still working in an occupation in which good acuity is essential to their ability to continue to work (e.g. watchmaker) OR
- Patients with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in daylight or bright conditions OR
- Patients who need to drive at night who experience significant glare due to cataracts which affects driving OR
- Difficulty with reading due to lens opacities OR
- Patients with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field OR
- Significant optical imbalance (anisometropia or anisekonia) following cataract surgery on the first eye OR
- Patients with glaucoma who require cataract surgery to control intra-ocular pressure OR
- Patient with diabetes who require clear views of their retina to look for retinopathy OR
- Patients with 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)

Note: No driver should be left without the necessary binocular visual acuity for the DVLA standard, (which is about 6/10 but has no actual Snellen equivalent).

5.4 For all patients referred for cataract extraction surgery:

1. There should be evidence of significant impairment of lifestyle such as:
   - The patient is at significant risk of falls; **OR**
   - The patient's vision is substantially affecting their ability to work; **OR**
   - The patient's vision is substantially affecting their ability to undertaken leisure activities such as reading, recognising faces or watching television;

AND

2. The patient is ready and willing to undergo cataract surgery.
   - The referring optometrist or GP must have discussed the risks and benefits of surgery prior to referral and is assured that the patient understands and is willing to undergo surgery if required.

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

5.5 Where referrals are not of a good quality, the Provider will reserve the right to return to the referring organisation for greater clarity.

5.6 The commissioner expects all Providers within the cataract surgery treatment pathway for clinically appropriate Worcestershire 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. Clinically Exceptional Circumstances

6.1 If there is demonstrable evidence of a patient's clinically exceptional circumstances, the referring practitioner should refer to the commissioner's "Individual Funding Request Policy" document for further guidance on the process for consideration.

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

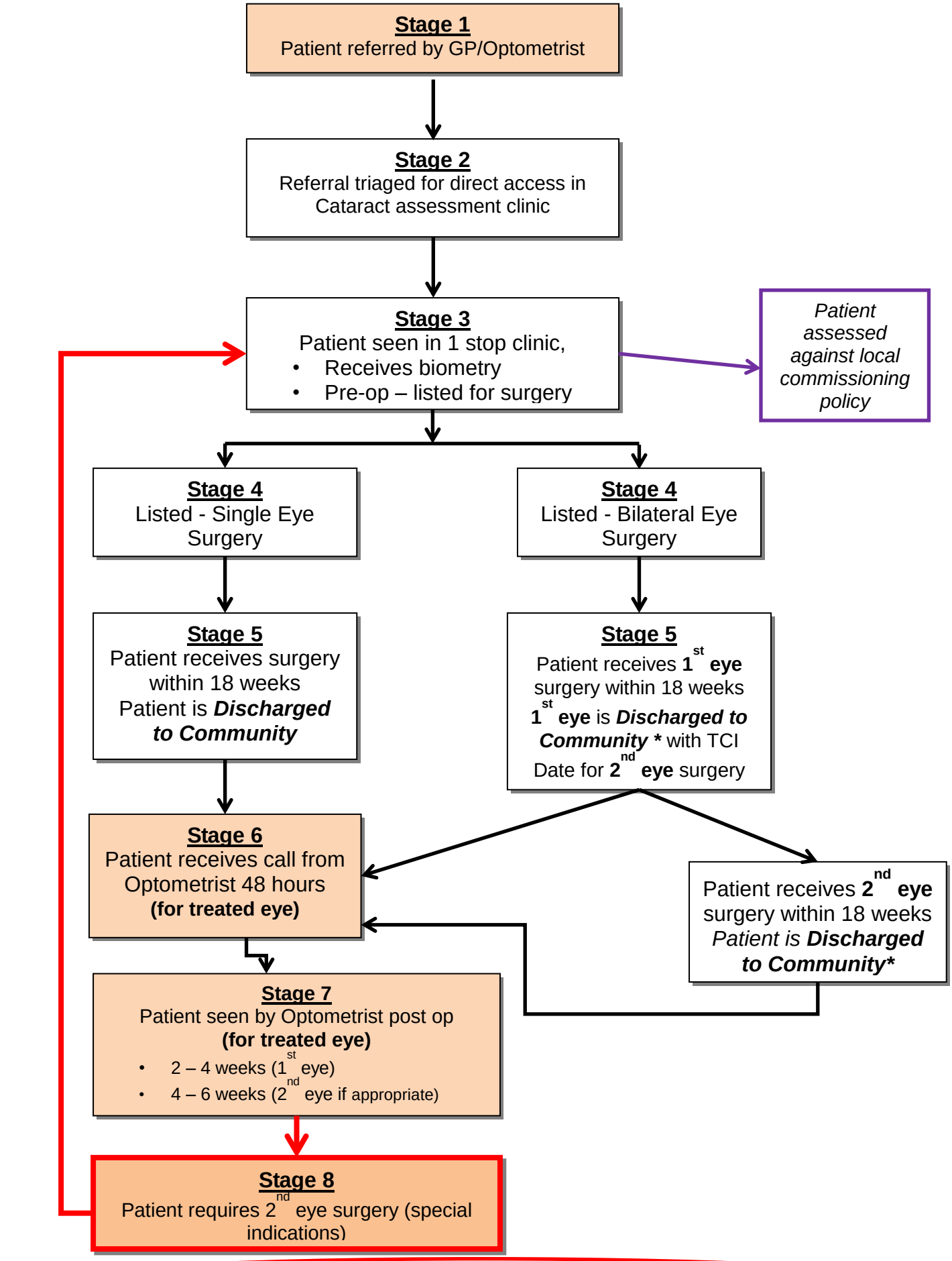
7. References

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

8. Documents Which Have Informed This Policy

- NHS Worcestershire: Individual Funding Request Policy
- NHS Worcestershire: Prioritisation Framework for the Commissioning of Healthcare Services
- West Midlands Strategic Group Commissioning Policy 1: Guiding principles and considerations to underpin priority setting and resource allocation within collaborative commissioning arrangements
- West Midlands Strategic Group Commissioning Policy 4: Use of cost-effectiveness, value for money and cost effectiveness thresholds
- West Midlands Strategic Group Commissioning Policy 16: Prior Approval
- West Midlands Strategic Group Commissioning Policy 9: Individual funding requests
- NHS Herefordshire Low Priority Treatment Policy 2011
- 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

Appendix 1 COUNTY WIDE CATARACT PATHWAY



AT ALL TIMES -Patient has access to Provider services for Emergencies

COUNTY WIDE WAHT 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 2-4 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 of 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 post operative eye drops 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 the 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**.**

Equality Analysis Report Template

Your Equality Analysis Report should demonstrate what you do (or will do) to make sure that your function/policy is accessible to different people and communities, not just that it can, in theory, be used by anyone.

1. Name of policy or function:
   Cataract Extraction Surgery Commissioning Policy

2. Responsible Manager:
   Helen Bryant, Commissioning & IFR Manager

3. Date Equality Analysis completed: **29th November 2012**

4. Description of aims of function/policy:
   To provide clear referral information for GPs and Optometrists to use when assessing a patient's need for cataract surgery.

   The policy has been updated to further clarify the clinical indications for NHS funded cataract surgery for Worcestershire patients and also any special clinical indications to be considered when assessing a patient's need for surgery.

   The policy also provides an updated referral and treatment pathway for patients, which has been agreed by the Commissioner and by the Provider in consultation with patient and public representatives and optometry advisors.

5. Brief summary of research and relevant data:

   This policy has been developed in line with:

   - **the NHS Executive "Action on Cataracts" Good Practice Guidance, published January 2000**
   - **the Department of Health National Eye Care Plan 2004**
   - **the Royal College of Ophthalmologists "Cataract Surgery Guidelines", published September 2010.**

6. Methods and outcomes of consultation:
   Meetings with secondary care clinicians and management, optometry advisors, patient and public representatives and the Policy Working Group to review the treatment pathway previously employed with a view to consolidating service provider's understanding whilst taking note of the public feedback to improve the service and update the policy.

7. Results of Equality Analysis

Equality Analysis	
Protected Characteristics	**Assessment of Impact**
Age:	None
Disability:	Positive
Gender reassignment:	None
Marriage and Pregnancy:	None
Marriage and Civil Partnership:	None
Race:	None
Religion or Belief:	None
Sex:	None
Sexual Orientation:	None
Any other groups:	None

8. Decisions and or recommendations (including supporting rationale)
   To update the policy and ensure that, once endorsed, it is published on the internet and distributed to all clinicians involved in the treatment pathway to ensure compliance.

9. Equality action plan (if required)
   None

10. Monitoring and review arrangements (include date of next full review)

Department	**Commissioning & Redesign**
Directorate	**As above**
Director	**Chris Emerson**
Report produced by and job title	**Helen Bryant, Commissioning & IFR Manager**
Date report produced	**29th November 2012**
Date report published	**29th November 2012**