Serious eye disorders

NICE National Institute for Health and Care Excellence

Consultation on draft quality standard – deadline for comments 5pm on 08/10/18 **email:** QSconsultations@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on these questions: 1. Does this draft quality standard accurately reflect the key areas for quality improvement? If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.
Organisation name – stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	The Royal College of Ophthalmologists, submitting jointly with The College of Optometrists and Vision UK
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	N/A
Name of commentator person completing form:	Beth Barnes

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Supporting the quality standard - Would your organisation like to express an interest in formally supporting this quality standard? More information.		Yes	
Type		[office use only]	
Comment number	**Section**	**Statement number**	**Comments** Insert each comment in a new row. Do not paste other tables into this table because your comments could get lost – type directly into this table.
Example 1	Statement 1 (measure)		This statement may be hard to measure because…
1	**Statement 1**	1a	The denominator should be amended to 'the number of adults who are referred for cataract surgery'. This is because only those patients with visually significant cataract will be referred to see the ophthalmologist. Many people have a small bit of cataract and do not have any problems at all and are successfully managed in primary care without surgery. Doctors will have a discussion with those who may benefit from surgery.
2	**Statement 1 Quality measures**	1b	The denominator will be impossible to measure, as many patients have a small bit of cataract which causes them no problems. They are successfully managed in primary care without being referred for surgery. This standard will give no indication as to the quality of care, as there is no need to refer people who have cataracts unless they are having visual problems. We therefore feel this standard should be deleted.
3	**Statement 1**	1c	The quality measure should be amended to 'Proportion of patients with significant/operable cataract refused

	Quality measures		surgery based on visual acuity alone.' Numerator should be 'the number in the denominator for which surgery is refused based on visual acuity alone.' Denominator should be 'the number of adults with significant/operable cataract who have cataract surgery performed.'
4	**Statement 1 Quality measures**	1d	The quality measure should be 'Proportion of referrals for cataract surgery who do not undergo cataract surgery (ie conversion rate).'
5	**Statement 3 Outcome**	3a	The outcome loss of vision (should be defined as loss of 15 letters) and should have gain of vision (gain of 15 letters)
6	**Statement 4 Outcome**	4b	Add the outcome of the 25% delay target for follow up from the national elective care transformation programme. https://future.nhs.uk/connect.ti/ECDC/view?objectId=12183216&exp=e1 Elective care community of practice. Ophthalmology Failsafe Prioritisation. Access can be granted to relevant NHS applicants by application to England.electivecare@nhs.net
7	**Statement 5 Quality measure**	5a	Amend the statement to 'Proportion of adults with COAG and related conditions who have reassessment at specific intervals related to their risk of progression as stated by NICE guidance for glaucoma'. Similarly amend the numerator to say 'the number in the denominator who have reassessment at specific intervals related to their risk of progression as stated by NG81.
8	**Statement 5 Outcome**	5a	Add the outcome of the 25% delay target for follow up from the national elective care transformation programme.
9	**Statement 6 Quality statement**	6	Reword the statement to 'Adults with late age-related macular degeneration (AMD) or chronic open angle glaucoma (COAG) are offered certification as soon as eligible.' Certification is voluntary on the part of the patient and consent is required. Patients may refuse to be certified entirely or may decline in the first instance and change their mind later. The text in the standard on page 19 also needs amending to reflect that it is the process of being offered CVI which is most important rather than given to them.

10	**Statement 6 Structure**	6	Reword the structure to 'evidence of local arrangements to ensure that adults with late AMD/COAG are given information about the certificate and those meeting the eligibility criteria are offered a CVI.' In addition, you should add "in a format appropriate to them as detailed in the accessible information standard. It would be ideal to add "in conjunction with support of an ECLO (eye clinic liaison officer)" where possible.
11	**Statement 6 Process**	6a	Reword the process statement to 'Proportion of adults with late AMD that meet the eligibility criteria for a CVI who are offered a CVI.'
12	**Statement 6 Numerator**	6a	Reword the numerator to 'the number in the denominator who are offered a CVI.'
13	**Statement 6 Process**	6b	Reword the process statement to 'Proportion of adults with COAG that meet the eligibility criteria for a CVI who are offered a CVI.'
14	**Statement 6 Numerator**	6b	Reword the numerator to 'the number in the denominator who are offered a CVI.'
15	**Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement**	Whole document	It reflects the key areas for quality improvement. Adoption of the suggestions above will ensure the quality standards more accurately reflect these key areas.
16	**Question 2 Are local systems and structures in place to collect data for the proposed**		All indicators are possible to collect but do require local work in trusts and between trusts and commissioners to produce. For instance, the delay in follow ups (25%) may need some adaptation of trust PAS IT systems to generate a report but is possible. Proportions of eligible patients offered CVI would need local trust audit as will conversion rate for cataract referrals. Number of letters visual acuity loss and gain is straightforward to measure if units have an ophthalmic specific EPR but without that requires manual audit.

	quality measures, if not, how feasible would it be for these to be put in place?		
17	**Question 3 Do you think each of the statements in this QS would be achievable by local services given the net resources needed to deliver them?**		Statements 3-6 are going to be challenging to meet. This is because the whole hospital eye service is over stretched and under-resourced. However, this is even more reason to set reasonable quality standards to measure to demonstrate more funding may be needed for patient safety. The other statements are achievable currently.
18	**Question 4 Do you have any examples for practice of implementing NICE guidelines that underpin this quality standard?**		There are examples in the RCOphth document The Way Forward and available via the NHS National Elective Care Transformation programme Ophthalmology High Impact Intervention and Ophthalmology Failsafe Prioritisation . https://future.nhs.uk/connect.ti/ECDC/view?objectId=12183216&exp=e1 Elective care community of practice. Ophthalmology Failsafe Prioritisation. Access can be granted to relevant NHS applicants by application to England.electivecare@nhs.net There are also quite a number of publications in the literature of innovative pathways to achieve the standards e.g. the Huntingdon and Bristol and similar cataract and glaucoma shared community schemes and a few examples are cited here but there are more: 1. Ratnarajan G, Newsom W, Vernon SA, et al. The effectiveness of schemes that refine referrals between primary and secondary care—the UK experience with glaucoma referrals: the Health

			Innovation & Education Cluster (HIEC) Glaucoma Pathways Project. BMJ Open 2013;3: e002715. doi: 10.1136/bmjopen-2013-002715 2. Shared care of patients with ocular hypertension in the Community and Hospital Allied Network Glaucoma Evaluation Scheme (CHANGES). A Mandalos, R Bourne, K French, W Newsom, and L Chang. Eye . 2012 Apr; 26(4): 564–567. 3. Gray SF, Spry PGD, Brookes ST, et al. The Bristol shared care glaucoma study: outcome at follow up at 2 years. British Journal of Ophthalmology 2000; 84:456-463. 4. C Park, J & Ross, AH & Tole, Derek & Sparrow, John & Penny, J & V Mundasad, M. (2008). Evaluation of a new cataract surgery referral pathway. Eye. 23. 309-13. 5. LOCSU http://www.locsu.co.uk/community-services-pathways/

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include section number of the text each comment is about eg. introduction; quality statement 1; quality statement 2 (measure).
- If commenting on a specific quality statement, please indicate the particular sub-section (for example, statement, measure or audience descriptor).
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons). We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance and quality standards that we have produced on topics related to this quality standard by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are

too long, or publication would be unlawful or otherwise inappropriate.

Comments received from registered stakeholders and respondents during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.