



Appendix 9c

Cataract Surgery Task and Finish Group meeting, 15 May 2018

Notes of key discussion points

Task and Finish Group members

Attendees:		
Susanne Althausen	Consultant Ophthalmologist, Clinical Director North Central London Diabetic Eye Screening Programme	NCL
Poonam Sharma	Optometrist, Clinical Advisor to NHSE, Clinical Lead Waltham Forest CCG	NEL
Alison Davies	Consultant paediatric ophthalmologist	SWL
Anthony Brzezicki	GP, London Choosing Wisely Steering Group	SWL
Sushanta Bhadra (Chair)	GP, SEL 111 Clinical lead, IFR lead Bexley	SEL
Anju Gupta	GP, Clinical Director, Barking, Havering and Dagenham CCG	NEL
Waqar Shah	GP, Clinical Director, Wandsworth CCG	SWL
Rashmi Agrawal	Trustee, Heathwatch UK and Patient Representative, Lambeth CCG group	SEL
Parul Desai	Consultant Ophthalmologist, Chair of the Clinical Council for Eye Health Commissioning for England; Public health consultant	London
Apologies		
Clare Jarman	GP, Clinical Lead Hammersmith and Fulham CCG	NWL

Also in attendance:

Jane Halpin	Director	Deloitte
Nikita Patel	Senior Consultant	Deloitte
Danny Batten	Acting Director of Transformation and Delivery (NEL)	NHSE (London)
Mandip Korotana	Programme Manager	Healthy London Partnership
Kunle Awosanya	Project Manager	Healthy London Partnership

1. Welcome from Sushanta Bhadra, Chair of the Task and Finish Group

The Chair welcomed members and outlined the purpose of the meeting. The Chair confirmed:

- the meeting was quorate
- there were no conflicts of interest

2. Presentation of the evidence review from Nikita Patel and Jane Halpin

Colleagues from Deloitte presented the draft evidence review which was circulated in advance to Task and Finish Group members. They confirmed that the purpose of the evidence review is to present the available evidence to the Task and Finish Group in order to support informed decision making regarding the commissioning policy. The evidence review will be further updated following discussions at Task and Finish Group meetings as required.

A general introduction was given for cataracts and cataract surgery. This included a definition and some key risk factors. Cataract was defined for the group. Some key issues were highlighted in terms of requirement for cataract surgery, including an ageing population and therefore increasing demand, potentially earlier treatment currently taking place and increasing waiting times in the NHS, bringing about the question of sustainability. Barking, Havering and Redbridge (BHR), South West London and North West London CCGs have policies on cataract surgery. The key similarities and differences between these policies are as follows:

- i. They all include visual acuity.
- ii. They all include some quality of life – impact statement.
- iii. Some of the policies have different criteria for the first or second eyes.
- iv. Some have specific criteria for comorbidities such as glaucoma, retinopathy etc.
- v. One policy specifically mentions driving separately.

The exclusions for the search strategy were highlighted as they were an issue of online discussion preceding the meeting.

3. Discussion on the evidence: is it robust and of high quality?

Key points of discussion were as follows:

- Whilst there are variations in existing CCG policies, the evidence demonstrates that cataract surgery is clinically effective and cost effective for both first and second eye.
- There is high quality evidence suggesting that cataract surgery improves the quality of life. NICE references that it reduces the risk of falls, anxiety and depression, although Deloitte noted the sources of these statements are not stated.
- NICE guidance suggests that visual acuity alone should not be used as a referral criterion and recommends a shared decision making approach.
- It was noted that examples of decision aids can be found on the HealthWise and RightCare websites.
- The risk of complications can vary, the commissioning guide states that this could vary more than 10 fold depending on the presence of comorbidities.
- There were questions over the NHS Atlas of Variation data presented in the evidence review. Task and Finish Group members questioned that rates of activity per CCG vary by >100,000 across London. The 2012/13 Atlas of Variation indicated that there was a two-fold variation in London. Deloitte will recheck this data and amend accordingly.

- Exclusions in the search strategy were discussed, particularly patients with co-morbidities such as glaucoma, retinal conditions and diabetes. It was noted that 33-40% of the cataract operations taking place in England will be in patients with these co-morbidities.
- Numerous exclusions can make the policy more difficult for Trusts to implement.

It was agreed that the evidence review was thorough and of high quality and also captured the key points from the NICE guidance. The Group confirmed they were happy to proceed to drafting a London policy.

4. Drafting the London policy

In terms of **content of the London policy**, the key discussions were as follows:

- A significant volume of cataract surgery includes patients with ocular comorbidity, and increasingly clinicians will be managing patients with multiple co-morbidities given the ageing population.
- It was agreed that these patients should receive routine treatment and it should be made clear that this policy does not apply to this group of patients. Rather than 'exclusion criteria', the policy wording should be as follows, 'This policy does not apply to patients with the following conditions.....'.
- NICE guidance includes a full list of ocular co-morbidities (see point above). It was agreed that the NICE list should be cross referenced with existing London CCG policies, with the final list to be agreed via virtual discussion between members of the Task and Finish Group, or at the next meeting.
- Visual acuity was discussed and whether this should be within the commissioning criteria given that NICE guidance states that this alone should not form part of referral criteria.
- Following discussions, with a range of views on this point, it was agreed that overall, having guidance on visual acuity was useful. Currently, SWL, NWL and Moorfields (earlier pan-London criteria agreed with oversight from the London Senate) criteria include patients who have symptomatic cataracts, with visual acuity of 6/9 or worse.
- It was felt that including a visual acuity criterion was useful for commissioners and also in terms of guidance for secondary care clinicians, to address any unwarranted variation in practice.
- It was discussed that criteria should be the same for first and second eyes because the evidence suggests they are both clinically and cost effective.
- Impact on quality of life was discussed and the Greater Manchester policy that had been circulated by a member of the Group was reviewed. Some members of the Group felt that the wording in the Moorfields version was more straightforward and easy to follow on this aspect.
- It was agreed that the London policies are a good starting point to build upon.
- There was much discussion on whether there should be an 'AND' or 'OR' between the criterion of visual acuity of 6/9 or worse, and impact on daily life. There was a discussion that patients may have visual acuity of 6/9 or worse, but this may not impact on their daily life and vice versa, patients with visual acuity better than 6/9, where there is an impact on daily life.
- Linked to this, there was discussion on how patients with a visual acuity that is better than 6/9, who are experiencing symptoms that impact on their daily life, should be managed. Around 50% of the group felt that that these patients should go through the Individual Funding Request (IFR) process, as it would be for a minority of patients. Others preferred that these patients are

routinely treated, and this part of the commissioning criteria is reviewed after a year or so following an audit process.

- There were differing views on the logistics of the IFR process, and differing views on whether additional audits were required beyond measuring the number of patients going through the IFR process. It was also noted that the IFR process varies from CCG to CCG.
- There were conversations on available resources in CCGs across London. In SWL for example, IFRs are saving the STP patch approximately £500k.
- The Group agreed that policy should address variation and protect patients from inappropriate treatment and poor practice.
- Looking at the National Ophthalmology Database Audit (NOD), figures extrapolated for London, patient numbers that fall in this category would be approx. 300 in London per month, at most. (This high level estimate was based on operative rates of 3000 per 100,000 population aged over 65 years; that this cohort comprises around 18% of the total population; that London has circa 13% of the national population and that NOD data suggests around 8% of eyes undergoing cataract surgery have acuity better than 6/9).
- Given the divergent views, it was agreed to re-visit the 'AND' / 'OR' point between visual acuity of 6/9 and worse, and impact on daily life, at the next meeting.
- The Group agreed that shared decision making (SDM) was important to include in the policy, to be used by both primary (GPs and optometrists) and secondary care clinicians to support conversations with patients and to ensure patients want to consider surgery. This would further help to support informed consent.
- Whilst NICE recommends SDM, it does not refer to any particular SDM tools. It was agreed that Deloitte would circulate some examples of SDM tools to the Group for review, with Parul, Susanne and Alison testing and pulling together a tool(s) (if appropriate) for this policy to present at the next meeting.
- It was agreed that the Moorfields criteria would be the criteria used for a London policy, and this will be fine-tuned by the Group over email and at the next meeting.

In terms of **the purpose of the policy**, key discussions were as follows:

- It was agreed that the purpose of this policy is to set commissioning criteria for cataract surgery.
- It was agreed that the policy was not seeking to restrict cataract surgery, but ensuring equitable access across London for the right patient at the right time.
- The policy presents an opportunity to reinforce NICE recommendations and include SDM tools.
- It was agreed that the policy needs to be easy to manage and implement.
- It was confirmed that the policy is not seeking to change pathways across London.

5. Next Steps

- Deloitte will re-check the NHS Atlas of Variation data presented in the evidence review and update as necessary.
- A draft policy will be circulated by email for comment.
- Task and Group members will give comment over email promptly, also noting where they agree with comments of others.
- Deloitte will circulate some examples of SDM tools and Parul, Susanne and Alison will review these and pull together a tool(s) (if appropriate) for this policy to present at the next meeting.

- Given low attendance at the next scheduled meeting, it was agreed to cancel this, with conversations taking place over email instead, to support further drafting of the policy
- The next meeting will therefore take place on 19 June.
- A provisional additional meeting to be arranged after 19 June, although it was noted that 6 week notice will need to be given.

Cataract Surgery Task and Finish Group meeting, 19 June 2018

Notes of key discussion points

Task and Finish Group members

Attendees:		
Poonam Sharma	Optometrist, Clinical Advisor to NHSE, Clinical Lead Waltham Forest CCG	NEL
Alison Davies	Consultant paediatric ophthalmologist	SWL
Anthony Brzezicki	GP, London Choosing Wisely Steering Group	SWL
Sushanta Bhadra (Chair)	GP, SEL 111 Clinical lead, IFR lead Bexley	SEL
Anju Gupta	GP, Clinical Director, Barking, Havering and Dagenham CCG	NEL
Rashmi Agrawal	Trustee, Heathwatch UK and Patient Representative, Lambeth CCG group	SEL
Parul Desai	Consultant Ophthalmologist , Chair of the Clinical Council for Eye Health Commissioning for England; Public health consultant	London
Laurence Whitefield (deputising for Susanne Althausser)	Consultant Ophthalmologist	NCL
Apologies		
Clare Jarman	GP, Clinical Lead Hammersmith and Fulham CCG	NWL
Susanne Althausser	Consultant Ophthalmologist, Clinical Director North Central London Diabetic Eye Screening Programme	NCL
Waqaar Shah	GP, Clinical Director, Wandsworth CCG	SWL

Also in attendance:

Jane Halpin	Director	Deloitte
Nikita Patel	Senior Consultant	Deloitte
Danny Batten	Acting Director of Transformation and Delivery (NEL)	NHSE (London)
Mandip Korotana	Programme Manager	Healthy London Partnership
Kunle Awosanya	Project Manager	Healthy London Partnership

6. Welcome from Sushanta Bhadra, Chair of the Task and Finish Group

The Chair welcomed members and outlined the purpose of the meeting. The Chair confirmed:

- the meeting was quorate
- there were no conflicts of interest

7. Agreement and sign off on notes of previous meetings

The notes of the meeting on 15 May 2018 were reviewed and agreed as an accurate and a true reflection of the meeting. There were no comments or amendments.

8. Presentation of the draft policy for cataract surgery: Nikita Patel and Jane Halpin

Colleagues from Deloitte presented the revised draft policy showing the online comments received from Task and Finish Group members. This had been circulated in advance to the Task and Finish Group members.

9. Drafting the London policy

The group discussed the comments received from members of the Group as follow:

- There were concerns expressed about the use of 'exclusion' criteria of patients. It was agreed to remove the word 'exclusion' and reword as 'this policy does not apply to'
- There were also concerns about the statement 'procedures will be commissioned with prior approval if'. It was acknowledged that CCG compliance processes vary and are not within the scope of this programme. In ensuring that the statement is applicable to all CCGs and standardising the wording used across the policies being developed in the London Choosing Wisely programme, it was agreed to remove 'prior approval' and change the statement to 'in ordinary circumstances, funding for cataract surgery is available for patients who meet the following criteria:'
- The Group discussed the use of 'AND' or 'OR' in the first two criteria – visual acuity and quality of life. It was agreed to use 'AND'.
- It was agreed to remove any 'AND' or 'OR' in the remaining commissioning criteria as it could lead to confusion and misinterpretation.
- In the criteria statement 'Surgery is indicated for management of ocular comorbidities....', the Group agreed to remove 'etc.' and use the table on page 40 of the current draft policy for a full list of ocular co-morbidities (SWL Group 2).
- The Group agreed that there is a need to be clear about the process for considering treatment for patients with a visual acuity better than 6/9, where there is a clear clinical indication or symptoms affecting quality of life. It was agreed that a statement about mutual agreement between the provider and the commissioner for the rationale for surgery should be added.
- It was noted that the Choosing Wisely UK programme (conference held on 15 June 2018) published a set of recommendations including those from the Royal College of Ophthalmologists which emphasised shared decision making (SDM) and it was agreed that SDM should feature prominently in the policy, in the commissioning criteria. The following statement was suggested 'all patients have been engaged in shared decision making to ensure they are well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration'. Whilst the programme shares a similar name to London Choosing Wisely, it was clarified that it was a completely separate programme.
- The conclusion of the Evidence Summary was discussed, as a member of the group did not feel that it reflected NICE guidance. Following discussion, it was understood that the conclusion reflected the wider context of cataract surgery in relation to the London Choosing Wisely programme itself and current pathways of care. It was also understood that the conclusion did reflect the NICE guidelines in that cataract surgery was considered clinically and cost effective. The group did not feel further clarification was needed.

- Coding was discussed and it was noted that whilst a long coding list is presented in the policy, only a small number of codes tend to be used for cataract surgery. Following discussion, it was agreed that the policy would state the preferred codes (C712 & C751) and then C718 and C719, and then the long list of codes.
- The SDM aides circulated (Rightcare and SWL) were discussed as well as the Healthwise SDM aide:
 - The SDM aides were similar but people may have preference on the contents and layout.
 - The patient representative felt the Healthwise aide was helpful from a patient perspective as it provided a scoring system and the patient could feel that they engaged collaboratively, and their views are being considered.
 - It was commented that the two SDMs circulated came across as information tools rather than decision making tools.
 - It was further agreed that there is a need to ensure that the right questions have been asked and the SDM discussion has taken place at all/any points in the pathway to cataract surgery.
 - It was noted that there is no validated SDM aid and NICE do not endorse or recommend any SDM aide.
 - SDM should support discussions and manage patient expectations of cataract surgery, for example, surgery is about vision that cannot be corrected by glasses and the patient may still require glasses following surgery.
 - It was noted that the group had not noted much evidence on the impact of SDM in cataract surgery, although it was felt that SDM was in its early days and is beneficial for the patient and clinician to ensure the right decision is made for treatment and thus, would be integral to include in the policy.
 - It was agreed that policy should signpost to all of the three SDM aides discussed and that it would be left to the clinician to decide which to choose based on the patient they were seeing.
 - The group highlighted that whichever SDM is used, it must enable the patient to have enough information, presented in a way in which they understand it, to make a decision about surgery.
 - The group agreed that a short statement similar to the SWL policy should be included in the policy to demonstrate that the patient has been involved in the shared decision making and the statement made in the commissioning criteria (as previously discussed) would pertain to this.

10. Review of the draft policy (statements above) against the ethical application sheet

The statements and process were reviewed against the key principles and considerations of the ethical framework. The group agreed that decisions were:

- Rational: within the limits of the available evidence
- Socially inclusive: the draft policy is inclusive and no particular group is treated differently
- Clear and open to scrutiny
- Economic factors: had been taken into account as NICE considers cataract surgery to be clinically and cost effective.

- Promotes health: is not relevant

11. Next steps

The draft policy and notes of the meeting will be circulated for final comment and sign off, ahead of the draft policy going out for 'sense check'. Feedback from the sense check will be discussed with the Chair, with any final amendments being made to the policy ahead of presentation to the Steering Group on 30 July.