NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Serious eye disorders

NICE quality standard

Draft for consultation

September 2018

This quality standard covers the diagnosis and management of cataracts, glaucoma and age-related macular degeneration (AMD). It describes high-quality care in priority areas for improvement.

It is for commissioners, service providers, health, public health and social care practitioners, and the public.

This is the draft quality standard for consultation (from 10 September 2018 to 8 October 2018). The final quality standard is expected to publish in February 2019.

Quality statements

Statement 1 Adults with cataracts are not refused surgery based on visual acuity alone. **[new 2019]**

Statement 2 Adults have case-finding tests in primary care before referral for further investigation and diagnosis of chronic open angle glaucoma (COAG) and related conditions. **[2011, updated 2019]**

Statement 3 Adults with late age-related macular degeneration (AMD) (wet active) start treatment within 14 days of referral to the macular service. **[new 2019]**

Statement 4 Adults with late AMD (wet active) have ongoing monitoring for both eyes. **[new 2019]**

Statement 5 Adults with COAG and related conditions have reassessment at specific intervals. **[2011, updated 2019]**

Statement 6 Adults with AMD or COAG are given a certificate of vision impairment as soon as they are eligible. **[new 2019]**

In 2019 the quality standard for glaucoma in adults (QS7) was updated and replaced by this new quality standard on serious eye disorders. Some statements from QS7 prioritised in 2011 were updated (2011, updated 2019). New statements (new 2019) were added on cataracts, AMD and support for people with vision impairment. For more information, see update information.

Statements from the 2011 quality standard for glaucoma in adults that may still be useful at a local level, but are no longer considered national priorities for improvement:

- People are referred to a consultant ophthalmologist for further assessment and definitive diagnosis if the optometrist or other healthcare professional suspects COAG. There are local agreements in place for referral refinement.

- People with elevated IOP alone are referred to an appropriately qualified healthcare professional for further assessment on the basis of perceived risk of progression to COAG. There are agreements in place for repeat measures.
- People with COAG, suspected COAG or with OHT are diagnosed and have a management plan formulated by a suitably trained healthcare professional with competencies and experience in accordance with NICE guidance.
- People with COAG, suspected COAG or with OHT have a regular review of management options with their healthcare professional, taking into account comorbidity and other changed circumstances, including a discussion of the benefits and risks of stopping treatment for those at low risk of progressing to visual impairment.
- Healthcare professionals involved in the care of a person with COAG, suspected COAG or with OHT have appropriate documentation and records available at each clinical encounter in accordance with NICE guidance.
- People with COAG who are progressing to loss of vision despite treatment or who present with advanced visual loss are offered surgery with pharmacological augmentation (MMC) as indicated and information on the risks and benefits associated with surgery.
- People with COAG, suspected COAG or with OHT are given the opportunity to discuss their diagnosis, prognosis and management, and are provided with relevant and accessible information and advice at initial and subsequent visits in accordance with NICE guidance.
- People with suspected COAG or with OHT who are not recommended for treatment are discharged from formal monitoring with a patient-held management plan and their discharge summary is sent to their GP and primary eye care professional.

The 2011 quality standard for glaucoma in adults is available as a pdf.

NICE has developed guidance and a quality standard on patient experience in adult NHS service (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside these quality statements.

A full list of NICE quality standards is available from the quality standards topic library.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?

Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Questions about the individual quality statements

Local practice case studies

Question 4 Do you have an example from practice of implementing the NICE guidelines that underpin this quality standard? If so, please submit your example to NICE local practice case studies on the NICE website. Examples of using NICE quality standards can also be submitted.

Quality statement 1: Referral for cataract surgery

Quality statement

Adults with cataracts are not refused surgery based on visual acuity alone.

Rationale

The decision to refer an adult for cataract surgery should be based on discussions with the person about the effect of cataracts on their quality of life, the risks and benefits of surgery and what may happen if they choose not to have surgery. Measurement of visual acuity often fails to detect vision problems that may benefit from cataract surgery (for example, glare and loss of colour vision). Restricting access to surgery based on visual acuity alone has an impact on quality of life for some people with cataracts.

Quality measures

Structure

Evidence of local agreements detailing criteria, which are not based on visual acuity alone, to be used for referrals and access to cataract surgery.

Data source: Local data collection, for example, service specifications, local commissioning agreements and local protocols and pathways for cataract surgery referrals.

Process

a) Proportion of adults with cataracts who have a discussion about having surgery.

Numerator – the number in the denominator who have a discussion about having surgery.

Denominator – the number of adults with cataracts.

Data source: Local data collection, for example, patient records.

b) Proportion of adults with cataracts who are referred for cataract surgery.

Numerator – the number in the denominator who are referred for cataract surgery

Denominator – the number of adults with cataracts.

Data source: Local data collection, for example, patient records, referral records.

c) Proportion of referrals for cataract surgery for which surgery is performed based on visual acuity alone.

Numerator – the number in the denominator for which surgery is performed based on visual acuity alone.

Denominator – the number of referrals for cataract surgery.

Data source: Local data collection, for example, patient records, referral records.

d) Proportion of referrals for cataract surgery which are refused surgery.

Numerator – the number in the denominator for which surgery is refused.

Denominator – the number of referrals for cataract surgery.

Data source: Local data collection, for example, patient records, referral records.

Outcomes

Health-related quality of life for adults with cataracts.

Data source: Local data collection, for example, a questionnaire or patient reported outcome measure on self-reported improvement from surgery.

What the quality statement means for different audiences

Service providers (such as community optometry practices, referral management centres and NHS hospital trusts) ensure that referral pathways for cataract surgery for adults are not based on visual acuity alone.

Healthcare professionals (such as GPs, ophthalmologists, optometrists, orthoptists and advanced nurse practitioners) base decisions to undertake or refer adults for cataract surgery on discussion with the person about the impact of cataracts on quality of life and the risks and benefits of having, and not having, surgery.

Commissioners (clinical commissioning groups and NHS England) provide access for adults to cataract surgery based on factors other than visual acuity alone. They monitor services to ensure that this is happening.

Adults with cataracts are involved in discussion of how cataracts affect their everyday life, how they affect their vision, the risks and benefits of surgery, and what would happen if they chose not to have surgery. Referral for cataract surgery is based on this discussion, and not on the clarity and sharpness with which they can see objects (particularly fine details) alone.

Source guidance

Cataracts in adults: management (2017) NICE guideline 77, recommendations 1.2.1 and 1.2.2.

Definitions of terms used in this quality statement

Based on visual acuity alone

The decision to refer an adult with cataracts for surgery should be based on a discussion of the issues listed below, not on visual acuity alone:

- how the cataract affects the person's vision and quality of life
- whether 1 or both eyes are affected
- what cataract surgery involves, including possible risks and benefits
- how the person's quality of life may be affected if they choose not to have cataract surgery
- whether the person wants to have cataract surgery.

[Adapted from NICE's guideline on cataracts in adults: management, recommendation 1.2.1 and cataracts in adults: management (full guideline), indicators for referral, glossary].

Quality statement 2: Referral – chronic open angle glaucoma and related conditions

Quality statement

Adults have case-finding tests in primary care before referral for further investigation and diagnosis of chronic open angle glaucoma (COAG) and related conditions.

Rationale

Accurate diagnosis of COAG and related conditions is important because they can lead to irreversible damage to the optic nerve and sight loss. Case-finding tests support more accurate referrals for further investigation and diagnosis. They ensure that adults with COAG and related conditions have prompt diagnosis and treatment and people who do not need referral avoid unnecessary anxiety and investigations.

Quality measures

Structure

a) Evidence of the availability of equipment for case-finding tests.

Data source: Local data collection, for example, service specifications.

b) Evidence of the availability of staff trained to perform case-finding tests.

Data source: Local data collection, for example, staff rotas, staff training records, records of services providing referral filtering.

Process

Proportion of adults referred for further investigation and diagnosis of COAG and related conditions who have case-finding tests in primary care.

Numerator – the number in the denominator who have case-finding tests for COAG and related conditions in primary care.

Denominator – the number of adults referred for further investigation and diagnosis of COAG and related conditions.

Data source: Local data collection, for example, referrals received from providers, patient records.

Outcomes

a) Rates of false-positive referrals from primary care for COAG and related conditions.

Data source: Local data collection, for example, patient records, referral records, the number of referrals to referral filtering schemes.

b) Levels of satisfaction of adults with COAG and related conditions with referral for further investigation and diagnosis.

Data source: Local data collection, for example, a patient or carer survey.

What the quality statement means for different audiences

Service providers (such as community optometry and GP practices) ensure that equipment, staff training and local referral pathways support case-finding for adults with suspected COAG and related conditions.

Healthcare professionals (such as optometrists, orthoptists and GPs with a special interest in ophthalmology) perform case-finding tests when they suspect glaucoma and related conditions and refer on the basis of the results.

Commissioners (clinical commissioning groups and NHS England) ensure that services have agreed protocols to support accurate referral into hospital eye services for adults with suspected COAG and related conditions. They monitor referrals.

Adults with suspected glaucoma and related conditions have a range of tests before they are referred for further investigation. This means that only people needing further investigations are referred, which may reduce waiting times and anxiety.

Source guidance

Glaucoma: diagnosis and management (2017) NICE guideline 81, recommendation 1.1.1.

Definitions of terms used in this quality statement

Case-finding tests

Case finding tests are:

- central visual field assessment using standard automated perimetry (full threshold or supra-threshold)
- optic nerve assessment and fundus examination using stereoscopic slit lamp biomicroscopy (with pupil dilatation if necessary), and optical coherence tomography (OCT) or optic nerve head image if available
- intraocular pressure (IOP) measurement using Goldmann-type applanation tonometry
- peripheral anterior chamber configuration and depth assessments using gonioscopy or, if not available or the person prefers, the van Herick test or OCT.

[Adapted from NICE's guideline on glaucoma: diagnosis and management, recommendation 1.1.1].

COAG and related conditions

- COAG: a disease of the optic nerve with characteristic changes in the optic nerve head (optic disc) and typical defects in the visual field with or without raised IOP. There is an open anterior chamber angle (trabecular meshwork visible on gonioscopy).
- Suspected COAG: when, regardless of the level of IOP, the optic nerve head (optic disc) and/or visual field show changes that suggest possible glaucomatous damage, and there is an open anterior chamber angle (trabecular meshwork visible on gonioscopy).
- Ocular hypertension: consistently or recurrently elevated IOP (greater than 21 mmHg) in the absence of clinical evidence of optic nerve damage or visual field defect.

[NICE's guideline on glaucoma: diagnosis and management (full guideline), glossary].

Quality statement 3: Treatment – late age-related macular degeneration (wet active)

Quality statement

Adults with late age-related macular degeneration (AMD) (wet active) start treatment within 14 days of referral to the macular service.

Rationale

Late AMD (wet active) can deteriorate rapidly. Any delay to starting treatment may lead to a worsening of outcomes over the long term. Minimising delays in starting treatment increases the chances of preserving vision and so quality of life.

Quality measures

Structure

Evidence of local arrangements and clinical protocols to ensure that adults with late AMD (wet active) start treatment within 14 days of referral to the macular service.

Data source: Local data collection, for example, referral pathways.

Process

Proportion of adults with late AMD (wet active) who start treatment within 14 days of referral to the macular service.

Numerator – the number in the denominator who start treatment within 14 days.

Denominator – the number of adults with late AMD (wet active) referred to the macular service.

Data source: Local data collection, for example, patient records, referral records, appointment systems.

Outcome

a) Loss of vision (changes to visual acuity) of people with late AMD (wet active).

Data source: Local data collection. National Ophthalmology Database Audit – National Electronic Age-related Macular Degeneration (AMD) Audit: feasibility report.

b) Health-related quality of life of adults with late AMD (wet active).

Data source: Local data collection, for example, a questionnaire.

What the quality statement means for different audiences

Service providers (NHS hospital trusts) have agreed protocols to ensure that adults with late AMD (wet active) start treatment within 14 days of referral to the macular service.

Healthcare professionals (such as ophthalmologists, advanced nurse practitioners, orthoptists) treating late AMD (wet active) in adults adhere to local protocols and start treatment within 14 days of referral to the macular service.

Commissioners (clinical commissioning groups) monitor providers to ensure that treatment for adults with late AMD (wet active) starts within 14 days of referral to the macular service.

Adults with late age-related macular degeneration (wet active) start their treatment within 14 days of being referred to the specialist service so that they have the best possible chance of keeping their sight.

Source guidance

Age-related macular degeneration (2018) NICE guideline 82, recommendation 1.4.10.

Quality statement 4: Monitoring late age-related macular degeneration (wet active)

Quality statement

Adults with late age-related macular degeneration (AMD) (wet active) have ongoing monitoring for both eyes.

Rationale

Monitoring of late AMD (wet active) is important for identifying changes in the eye associated with the condition. Monitoring supports treatment planning, which helps to avoid under-treatment, which could result in loss of vision, and over-treatment (unnecessary anti-VEGF injections), which could be associated with harm and affect quality of life.

Quality measures

Structure

Evidence of local arrangements and clinical protocols to ensure that adults with late AMD (wet active) have ongoing monitoring for both eyes.

Data source: Local data collection, for example, service specifications and local protocols for monitoring appointments for adults with late AMD (wet active).

Process

a) Proportion of adults with late AMD (wet active) who have a monitoring appointment scheduled.

Numerator – the number in the denominator who have a monitoring appointment scheduled.

Denominator – the number of adults with late AMD (wet active).

Data source: Local data collection, for example, patient records and appointment systems.

b) Proportion of scheduled monitoring appointments for late AMD (wet active) that are cancelled or delayed by the hospital.

Numerator – the number in the denominator that are cancelled or delayed by the hospital.

Denominator – the number of scheduled monitoring appointments for late AMD (wet active).

Data source: Local data collection, for example, patient records and appointment systems.

Outcome

Loss of vision (changes to visual acuity) in adults with late AMD (wet active).

Data source: Local data collection. National Ophthalmology Database Audit – National Electronic Age-related Macular Degeneration (AMD) Audit: feasibility report.

What the quality statement means for different audiences

Service providers (NHS hospital trusts) ensure that they have agreed protocols for adults with late AMD (wet active) to have monitoring of both eyes at clinically appropriate intervals.

Healthcare professionals (such as ophthalmologists, advanced nurse practitioners, optometrists) monitor both eyes in adults with late AMD (wet active) at clinically appropriate intervals to plan and optimise treatment.

Commissioners (clinical commissioning groups) ensure that services provide monitoring of both eyes for adults undergoing active treatment for late AMD (wet active) at clinically appropriate intervals.

Adults with late age-related macular degeneration (wet active) have both their eyes monitored regularly so that treatment can be planned to preserve their sight and quality of life.

Source guidance

Age-related macular degeneration (2018) NICE guideline 82, recommendation 1.7.8.

Quality statement 5: Reassessment – chronic open angle glaucoma and related conditions

Quality statement

Adults with chronic open angle glaucoma (COAG) and related conditions have reassessment at specific intervals.

Rationale

Reassessment is important for identifying clinically significant changes in adults with COAG and adults at risk of conversion from OHT or suspected COAG to COAG. Reassessment also supports maintaining a consistent intraocular pressure (IOP). Providing tailored treatment in response to disease progression and maintaining IOP levels reduces the risk of significant sight loss, and reduced quality of life.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with COAG and related conditions have reassessment appointments scheduled at specific intervals.

Data source: Local data collection, for example, service specifications, local protocols.

Process

a) Proportion of adults with COAG and related conditions who have reassessment at specific intervals.

Numerator – the number in the denominator who have reassessment at specific intervals.

Denominator – the number of adults with COAG and related conditions.

Data source: Local data collection, for example, patient records, appointment systems.

b) Proportion of scheduled monitoring appointments for COAG and related conditions that are cancelled or delayed by the provider.

Numerator – the number in the denominator that are cancelled or delayed by the provider.

Denominator – the number of scheduled monitoring appointments for COAG and related conditions.

Data source: Local data collection, for example, patient records and appointment systems.

Outcomes

a) Loss of vision for adults with COAG and related conditions (visual field loss, changes to visual acuity).

Data source*:* Local data collection (for example, patient records, appointment system, local records of patient safety incidents) National Ophthalmology Database Audit – National Electronic Glaucoma Surgery and Visual Field Preservation Audit: Feasibility report.

b) Health-related quality of life of adults with COAG and related conditions.

Data source: Local data collection, for example, a questionnaire.

What the quality statement means for different audiences

Service providers (NHS hospital trusts and community optometry practices) have agreed protocols to ensure adults with COAG, suspected COAG and OHT have reassessment at specific intervals, according to their risk of sight loss.

Healthcare professionals (for example, ophthalmologists, advanced nurse practitioners, optometrists and orthoptists) carry out reassessment for adults with COAG, suspected COAG and OHT adhering to local protocols, so that adults are reassessed at specific, clinically appropriate intervals according to their risk of sight loss.

Commissioners (clinical commissioning groups) ensure that services provide reassessment for adults with COAG, suspected COAG and OHT at specific intervals according to their risk of sight loss.

Adults with glaucoma, suspected glaucoma and ocular hypertension have regular assessments to minimise their risk of sight loss.

Source guidance

Glaucoma: diagnosis and management (2017) NICE guideline 81, recommendations 1.4.9, 1.4.11, 1.4.12 and 1.4.13.

Definitions of terms used in this quality statement

Specific intervals for reassessment for COAG, suspected COAG and OHT.

Reassessment depends on the risk of progression to sight loss, as recommended in NICE's guideline on glaucoma: diagnosis and management, recommendations 1.4.11 to 1.4.13. Tables 1 to 3 outline assessment intervals; clinical judgement is to be used to decide when the next appointment should take place within the recommended interval.

COAG and related conditions

- COAG: a disease of the optic nerve with characteristic changes in the optic nerve head (optic disc) and typical defects in the visual field with or without raised IOP. There is an open anterior chamber angle (trabecular meshwork visible on gonioscopy).
- Suspected COAG: when, regardless of the level of IOP, the optic nerve head (optic disc) and/or visual field show changes that suggest possible glaucomatous damage, and there is an open anterior chamber angle (trabecular meshwork visible on gonioscopy).
- Ocular hypertension: consistently or recurrently elevated IOP (greater than 21 mmHg) in the absence of clinical evidence of optic nerve damage or visual field defect.

[NICE's guideline on glaucoma: diagnosis and management (full guideline), glossary].

Quality statement 6: Supporting adults with visual impairment

Quality statement

Adults with age-related macular degeneration (AMD) or chronic open angle glaucoma (COAG) are given a certificate of vision impairment (CVI) as soon as they are eligible.

Rationale

A certificate of vision impairment allows easier access to services and support for adults with AMD or COAG. The certificate is usually completed in secondary care. This includes a formal referral for a social care needs assessment due to vision impairment, and discussion of the additional benefits of registration. Completing and submitting the form as soon as a person is eligible, rather than waiting for treatment to finish, allows earlier access to services and support, which can help people retain or regain their independence and improve their wellbeing and quality of life.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with AMD are given information about the certificate and those meeting the eligibility criteria are given a certificate of vision impairment.

Data source: Local data collection, for example, a service protocol.

Process

a) Proportion of adults with AMD that meet the eligibility criteria for a CVI who are given a CVI.

Numerator – the number in the denominator who are given a CVI.

Denominator – the number of adults with AMD who meet the eligibility criteria for a CVI.

***Data source**:* Local data collection, for example, patient records.

b) Proportion of adults with COAG that meet the eligibility criteria for a CVI who are given a CVI.

Numerator – the number in the denominator who are given a CVI.

Denominator – the number of adults with COAG who meet the eligibility criteria for a CVI.

Data source*:* Local data collection, for example, patient records.

Outcomes

a) Health-related quality of life for adults with AMD.

Data source: Local data collection, for example, a questionnaire.

b) Health-related quality of life of adults with COAG.

Data source: Local data collection, for example, a questionnaire.

What the quality statement means for different audiences

Service providers (NHS hospital trusts) have systems in place to ensure that adults with AMD or COAG are given a CVI and associated information about support and services as soon as they meet the eligibility criteria, including while they are having treatment.

Healthcare professionals (consultant ophthalmologists) give a CVI and associated information about support and services to adults with AMD or COAG as soon as they meet the eligibility criteria, including while they are having treatment.

Commissioners (clinical commissioning groups) ensure that providers have the capacity and resources to give a CVI and associated information about support and services to adults with AMD or COAG as soon as they meet the eligibility criteria.

Adults with age-related macular degeneration or glaucoma are given a certificate of vision impairment (CVI) as soon as they are eligible. This may be while they are still having treatment. They are also told about support and services which can help them enhance or regain their independence and wellbeing.

Source guidance

Age-related macular degeneration (2018) NICE guideline 82, recommendation 1.6.4.

Glaucoma: diagnosis and management (2017) NICE guideline 81, recommendation 1.7.1.

Definitions of terms used in this quality statement

Eligibility criteria for a certificate of vision impairment

See the Department of Health and Social Care's Certificate of vision impairment: explanatory notes for consultant ophthalmologists and hospital eye clinic staff in England, sections 29 to 34 inclusive.

Update information

This quality standard updates and replaces the quality standard for glaucoma in adults (QS7) and includes additional eye disorders. Some statements from QS7 prioritised in 2011 were updated (2011, updated 2019). New statements (new 2019) were added on cataracts, AMD and support for people with vision impairment.

Statements are marked as:

- **[new 2019]** if the statement covers a new area for quality improvement
- **[2011, updated 2019]** if the statement covers an area for quality improvement included in the 2011 quality standard on glaucoma in adults and has been updated

Statement numbers 3, 5, 6 and 8 from QS7 have been updated and are included in this quality standard, marked as **[2011, updated 2019]**.

Statements numbered 1, 2, 4, 7, 9, 10, 11 and 12 from QS7 are no longer considered national priorities for improvement, but may still be useful at a local level. These are listed in the quality statements section.

The 2011 quality standard for glaucoma in adults is available as a pdf.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See quality standard advisory committees on the website for details of standing committee 1 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the quality standard's webpage.

This quality standard has been included in the NICE Pathway on eye conditions, which brings together everything we have said on a topic in an interactive flowchart. Pathways are available for cataracts, glaucoma and age-related macular degeneration.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those

countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- Avoidable sight loss in adults with serious eye disorders
- Health-related quality of life for people with serious eye disorders
- Patient safety incidents reported for adults with serious eye disorders
- Social isolation of people with serious eye disorders.

It is also expected to support delivery of the Department of Health and Social Care outcome frameworks:

- Adult social care outcomes framework
- NHS outcomes framework
- Public health outcomes framework for England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact products for the source guidance to help estimate local costs:

costing report and template for the NICE guideline on cataracts
resource impact report for the NICE guideline on cataracts
costing report and template for the NICE guideline on glaucoma
resource impact report for the NICE guideline on glaucoma
costing report and template for the NICE guideline on age-related macular degeneration

resource impact report for the NICE guideline on age-related macular degeneration

Diversity, equality and language

During the development of this quality standard, equality issues were considered and equality assessments are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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