NICE National Institute for Health and Care Excellence

NICE quality standard

# Serious eye disorders

Quality standard

Published: 12 February 2019

www.nice.org.uk/guidance/qs180

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This standard replaces QS7.

This standard is based on NG81, NG77 and NG82.

This standard should be read in conjunction with QS109 and QS15.

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In 2019, the quality standard for glaucoma in adults (QS7) was updated and replaced by this new quality standard on serious eye disorders.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 2017). New statements (new 2019) were added on cataracts, AMD and support for people with vision impairment. For statements from the 2011 quality standard for glaucoma in adults that are still supported by the evidence may still be useful at a local level:

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

- People with elevated intraocular pressure 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 ocular hypertension (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.

# Quality statement 1: Referral – chronic open angle glaucoma and related conditions

## Quality statement

Adults with signs of possible glaucoma or related conditions on a routine sight test have additional tests before they are referred for a diagnosis.

## Rationale

Accurate diagnosis of chronic open angle glaucoma (COAG) or related conditions is important because they can lead to irreversible damage to the optic nerve and sight loss. As well as the routine sight test, additional tests are needed for people with possible glaucoma to support more accurate referrals for further investigation and diagnosis. They ensure that adults with COAG or related conditions have prompt diagnosis and treatment and people who do not need referral avoid unnecessary investigations.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

a) Evidence of the availability of equipment for performing the additional tests needed before referral for further investigation and diagnosis of COAG or related conditions.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service specifications.

b) Evidence of the availability of staff trained to perform the additional tests needed before referral for further investigation and diagnosis of COAG or related conditions.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, staff rotas and staff training records.

### Process

Proportion of adults with signs of possible glaucoma on a routine sight test who had additional tests before referral for further investigation and diagnosis of COAG or related conditions.

Numerator – the number in the denominator who had additional tests before referral for further investigation and diagnosis of COAG or related conditions.

Denominator – the number of adults with signs of possible glaucoma on a routine sight test referred for further investigation and diagnosis of COAG or related conditions.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records and referral records.

### Outcome

Rates of false-positive referrals for further investigation and diagnosis of COAG or related conditions.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records and referral records.

## What the quality statement means for different audiences

**Service providers** (such as community optometry services) ensure that equipment, staff training and local referral pathways support adults with possible glaucoma to have

additional tests after the routine sight test and before referral for further investigation and diagnosis of COAG or related conditions.

**Healthcare professionals** (such as community optometrists) ensure additional tests are performed when signs of possible glaucoma are detected on a routine sight test and refer on the basis of these results.

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

**Adults with possible glaucoma** have a range of tests after the routine sight test and before they are referred to hospital eye services. This means that only people needing further investigations are referred, which may reduce waiting times.

# Source guidance

Glaucoma: diagnosis and management. NICE guideline NG81 (2017, updated 2022), recommendation 1.1.1

# Definitions of terms used in this quality statement

## Possible glaucoma or related conditions

Signs of possible glaucoma or related conditions include:

- a glaucomatous-type visual field defect
- visible structural damage to the optic nerve head
- an intraocular pressure of 24 mmHg or more.

[Adapted from NICE's guideline on glaucoma, recommendation 1.1.5; and expert opinion]

## Additional tests

If a routine sight test suggests signs of possible glaucoma, all of the following additional

tests should be undertaken before referral:

- 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 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.

[NICE's guideline on glaucoma, recommendation 1.1.1]

# Quality statement 2: Referral for cataract surgery

## Quality statement

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

## Rationale

The decision to undertake cataract surgery should be based on discussions with the person about the effect of cataract 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). The decision should include consideration of a patient's quality of life and symptoms such as difficulty with reading, night driving, work or home activities, glare and loss of contrast, despite appropriate optical correction. Restricting access to surgery based on visual acuity alone has an impact on quality of life for some people with cataracts. The decision to undertake cataract surgery should be made on the same basis for first and second eyes.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

Evidence of local agreements to include vision difficulties affecting quality of life in the criteria for referral and access to cataract surgery. The same criteria should be used for first- and second-eye cataract surgery.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and

provider organisations, for example, service specifications and local commissioning agreements for cataract surgery.

## Process

a) Proportion of presentations of cataract where the person has a discussion about how their vision affects their quality of life.

Numerator – the number in the denominator where the person has a discussion about how their vision affects their quality of life.

Denominator – the number of presentations of cataract.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records.

b) Proportion of presentations of cataract that are refused referral for surgery based on visual acuity alone.

Numerator – the number in the denominator that are refused referral for surgery based on visual acuity alone.

Denominator – the number of presentations of cataract.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records or referral records.

c) Proportion of referrals for cataract surgery that are not accepted based on visual acuity alone.

Numerator – the number in the denominator that are not accepted based on visual acuity alone.

Denominator – the number of referrals for cataract surgery.

**Data source:** No routinely collected national data for this measure has been identified.

Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records or referral records.

### Outcome

Health-related quality of life for adults with cataracts.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, results from a questionnaire or patient-reported outcome measure on self-reported improvement after surgery, such as the Cat-PROM5 questionnaire.

## 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 are based on criteria that include vision difficulties affecting quality of life, and not just visual acuity alone. The decision to undertake cataract surgery should be made on the same basis for first and second eyes.

**Healthcare professionals** (such as ophthalmologists, optometrists, orthoptists and advanced nurse practitioners) base decisions about cataract surgery on a discussion with the person of the impact of the cataract(s) on their quality of life and the risks and benefits of having, and not having, surgery. Visual acuity should not be used as the sole basis for deciding to refer for or perform surgery. The decision to undertake cataract surgery should be made on the same basis for first and second eyes.

**Commissioners** (clinical commissioning groups and NHS England) commission services that provide access for adults to cataract surgery based on criteria other than visual acuity alone. The other criteria include vision difficulties affecting quality of life. They monitor services to ensure that this is happening. The decision to undertake cataract surgery should be made on the same basis for first and second eyes.

**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 only on the clarity and sharpness (particularly fine details) with which they can see objects. The decision to perform cataract surgery on the second eye should be made on the same basis.

# Source guidance

Cataracts in adults: management. NICE guideline NG77 (2017), 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 with the person 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.

[NICE's guideline on cataracts in adults, recommendation 1.2.1]

# 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### 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:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, 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:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records, referral records and appointment systems.

### Outcome

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

**Data source:** Database audit – National Electronic AMD Audit feasibility report contains: mean change in visual acuity between baseline and month 12 (figure 7) and percentage of eyes losing ≥3 LogMAR lines between baseline and month 12 (figure 8). Data, collected from 40 centres dating from January 2012 to December 2013 (8 had low numbers and the data were excluded), were last collected in 2016. Available from the Royal College of Ophthalmologists' National Ophthalmology Database Audit.

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

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, 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, optometrists and orthoptists working in secondary care) 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 AMD (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. NICE guideline NG82 (2018), 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 monitoring for both eyes.

## Rationale

Monitoring of late AMD (wet active) in both eyes is important for identifying changes that are 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. The interval between appointments should be determined by the healthcare professional responsible for planning the person's care.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

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

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, 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:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records and appointment systems.

b) Proportion of scheduled monitoring appointments for adults with 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 adults with late AMD (wet active).

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records and appointment systems.

c) Proportion of hospital appointments for adults with late AMD (wet active) that occur within 25% of their intended monitoring period, including rescheduling of hospital cancellations and non-attendance by adults with late AMD (wet active).

Numerator – the number in the denominator that occur within 25% of their intended monitoring period.

Denominator – the number of monitoring appointments scheduled, including those rescheduled after hospital-initiated cancellation and non-attendance by adults with late AMD (wet active).

**Data source:**NHS England's Elective care transformation programme: Transforming

elective care services: ophthalmology includes an indicator in this area. Local data collection, for example, clinic attendance and cancellation records.

### Outcome

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

**Data source:** Database audit – National Electronic AMD Audit feasibility report contains: mean change in visual acuity between baseline and month 12 (figure 7), percentage of eyes losing ≥3 LogMAR lines between baseline and month 12 (figure 8), visual acuity change from month 3 to month 12 (figure 10) and percentage of patients retaining visual acuity of 70 letters/LogMAR visual acuity of 0.3 or better (at 1 year; figure 11). Data, collected from 40 centres dating from January 2012 to December 2013 (8 had low numbers and the data were excluded), were last collected in 2016. Available from the Royal College of Ophthalmologists' National Ophthalmology Database Audit.

## 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 determined by the healthcare professional responsible for planning their care.

**Healthcare professionals** (such as ophthalmologists, advanced nurse practitioners, optometrists and orthoptists working in secondary care) monitor both eyes of adults with late AMD (wet active) at intervals determined by the healthcare professional responsible for planning their care.

**Commissioners** (clinical commissioning groups) ensure that services provide monitoring of both eyes for adults with late AMD (wet active) at intervals determined by the healthcare professional responsible for planning their care.

**Adults with late AMD (wet active)** have both their eyes monitored regularly so that treatment can be planned to preserve their sight and quality of life. The time between appointments is determined by the healthcare professional responsible for planning their care.

# Source guidance

Age-related macular degeneration. NICE guideline NG82 (2018), recommendation 1.7.8

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

## Quality statement

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

## Rationale

Reassessment is important for identifying clinically significant changes in adults with COAG or adults at risk of conversion from ocular hypertension (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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

Evidence of local arrangements to ensure that adults with COAG or related conditions have reassessment appointments scheduled at specific intervals, according to their risk of conversion to COAG or progression to sight loss.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service specifications and local protocols.

## Process

a) Proportion of adults with COAG or 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 or related conditions.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records and appointment systems.

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

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

Denominator – the number of scheduled reassessment appointments for COAG or related conditions.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records and appointment systems.

c) Proportion of hospital appointments for adults with COAG or related conditions that occur within 25% of their intended reassessment period, including rescheduling of hospital cancellations and non-attendance by adults with COAG or related conditions.

Numerator – the number in the denominator that occur within 25% of their intended reassessment period.

Denominator – the number of reassessment appointments scheduled, including those rescheduled after hospital-initiated cancellation and non-attendance by adults with COAG or related conditions.

**Data source:**NHS England's Elective care transformation programme: Transforming

elective care services: ophthalmology includes an indicator in this area. Local data collection, for example, clinic attendance and cancellation records.

### Outcome

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

**Data source:** Database audit – National Electronic Glaucoma Surgery and Visual Field Preservation Audit feasibility report contains: rates of visual field loss in the worst eyes (figure 44), speed of visual field progression (figure 45), and loss of sight years (table 11). Data were last collected in 2015 from 5 major glaucoma centres. Available from the Royal College of Ophthalmologists' National Ophthalmology Database Audit.

Local data collection, for example, patient records and local ophthalmology records of patient safety incidents.

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

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, a questionnaire.

## What the quality statement means for different audiences

**Service providers** (NHS hospital trusts and community optometry services) have agreed protocols to ensure that adults with COAG or related conditions have reassessment at specific intervals, according to their risk of progressive sight loss.

**Healthcare professionals** (such as ophthalmologists, advanced nurse practitioners, optometrists and orthoptists) carry out reassessment for adults with COAG or related conditions at specific, clinically appropriate intervals, according to their risk of progressive sight loss.

**Commissioners** (clinical commissioning groups) ensure that services provide reassessment for adults with COAG or related conditions at specific intervals, according to

their risk of progressive sight loss.

**Adults with glaucoma, suspected glaucoma or ocular hypertension** have regular assessments to minimise their risk of sight loss. How often they have an assessment will depend on how well the treatment seems to be working.

# Source guidance

Glaucoma: diagnosis and management. NICE guideline NG81 (2017, updated 2022), recommendations 1.5.9, 1.5.11, 1.5.12 and 1.5.13

# Definitions of terms used in this quality statement

## Specific intervals for reassessment of COAG or related conditions

Specific intervals for reassessment depend on the risk of progression to sight loss, as set out in tables 1 to 3 in NICE's guideline on glaucoma. Clinical judgement is used to decide when the next appointment should take place within the recommended interval.

# Quality statement 6: Certificate of vision impairment

## Quality statement

Adults with serious eye disorders are given a certificate of vision impairment (CVI) as soon as they are eligible.

## Rationale

A CVI allows easier access to services and support for adults with serious eye disorders. Making a person aware of the benefits associated with a CVI, and giving them the choice of having a CVI as soon as they are eligible, rather than waiting for treatment to finish, allows earlier access to services and support. This can help people retain or regain their independence and improve their wellbeing and quality of life.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

Evidence of local arrangements to ensure that adults with serious eye disorders are given information about the CVI and those meeting the eligibility criteria are given a certificate.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, a service protocol.

### Process

Proportion of adults with serious eye disorders 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 serious eye disorders that meet the eligibility criteria for a CVI.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records.

### Outcome

Health-related quality of life for adults with serious eye disorders.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, a questionnaire.

## What the quality statement means for different audiences

**Service providers** (NHS hospital trusts and community optometry practices) have systems in place to ensure that adults with serious eye disorders are given information about the support and services associated with certification. They ensure that adults can engage in the process as soon as they meet the eligibility criteria, including while they are having treatment. Services make sure people know about the benefits of certification, and know that they have a choice to have a CVI or not.

**Healthcare professionals** (optometrists, and ophthalmologists, orthoptists and nurses working in secondary care) make sure that people with serious eye disorders know about the benefits of certification and that they can have a CVI if they choose as soon as they are eligible. This includes while they are having treatment. Professionals give information about the support and services associated with certification. Ophthalmologists sign the certificate to formally certify adults with serious eye disorders as visually impaired.

**Commissioners** (clinical commissioning groups) ensure that providers have the capacity

and resources to give information about the support and services associated with certification to adults with serious eye disorders as soon as they meet the eligibility criteria.

**Adults with serious eye disorders** are given a certificate of vision impairment 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 improve or regain their independence and wellbeing.

# Source guidance

- Age-related macular degeneration. NICE guideline NG82 (2018), recommendation 1.6.4
- Glaucoma: diagnosis and management. NICE guideline NG81 (2017, updated 2022), recommendation 1.7.2

# Definitions of terms used in this quality statement

## 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, executive summary, sections 4, 9, 21, 29 to 34 inclusive.

# Equality and diversity considerations

Healthcare professionals should adapt their communication to the needs of adults with sight difficulties so that they have the opportunity to be involved in decisions relating to certification of vision impairment. This includes being made aware of the benefits associated with having a CVI.

Physical or learning disabilities, hearing problems and difficulties with reading or speaking English, which may affect the patient's involvement in the consultation, should also be considered.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information

Standard.

# Update information

**February 2019:** This quality standard updates and replaces the quality standard on glaucoma in adults (QS7) and also includes other eye disorders. Some statements from QS7 prioritised in 2011 were updated (2011, updated 2019). New statements (new 2019) were added on cataracts, age-related macular degeneration 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 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.

**Minor changes since publication**

**January 2022:** We made changes to align this quality standard with the updated NICE guideline on glaucoma: diagnosis and management. Links, definitions and source guidance references have been updated throughout.

# 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 our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

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 guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to 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:

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

## Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard 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.

ISBN: 978-1-4731-3267-2

# Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

# Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Royal National Institute of Blind People
- Royal College of Ophthalmologists

- Glaucoma UK
- Macular Society
- Asthma and Lung UK