NHS
Leeds
Clinical Commissioning Group

Eye Procedures Policy

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Ratified by:	NHS Leeds Clinical Commissioning Group Quality and Performance Committee – 13 March 2019
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Name of responsible committee/individual:	Dr Simon Stockill Medical Director, NHS Leeds CCG Governing Body
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Target audience:	Primary and secondary care clinicians, individual funding request panels, and the public
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Produced on behalf of NHS Leeds Clinical Commissioning Group

Executive Summary

This policy applies to all Individual Funding Requests (IFR) for people registered with General Practitioners in Leeds

This policy does not apply where NHS Leeds CCG is not the responsible commissioner.

The policy updates all previous policies and must (where appropriate) be read in association with the other relevant Leeds Clinical Commissioning Group commissioning policies, which are to be applied across Leeds , including but not limited to policies on cosmetic exceptions and non-commissioned activity.

All IFR and associated policies will be publically available on the internet for the CCG.

This policy relates specifically to :

Eye procedures including: Toric Lens Insertion, Laser Vitreolysis, Blepharoplasty, Congenital Ptosis

Contents

1 Introduction

The Clinical Commissioning Groups (CCGs) (NHS Leeds West CCG, NHS Leeds North CCG and NHS Leeds South and East CCG) were established on 1 April 2013 under the Health and Social Care Act 2012 as the statutory bodies responsible for commissioning services for the patients for whom they are responsible in accordance with s3 National Health Service Act 2006. As at 1 April 2018 these three CCGs have merged to become NHS Leeds Clinical Commissioning Group

As part of these duties, there is a need to commission services which are evidence based, cost effective, improve health outcomes, reduce health inequalities and represent value for money for the taxpayer. NHS Leeds CCG is accountable to their constituent populations and Member Practices for funding decisions.

In relation to decisions on Individual Funding Requests (IFR), NHS Leeds CCG has a clear and transparent process and policy for decision making. They have a clear CCG specific appeals process to allow patients and their clinicians to be reassured that due process has been followed in IFR decisions made by the Non Commissioned Activity Panel, Cosmetic Exclusions and Exceptions Panel, or Non NICE Non Tariff Drug Panel (the IFR panels).

Due consideration must be given to IFRs for services or treatments which do not form part of core commissioning arrangements, or need to be assessed as exceptions to Leeds CCG Commissioning Policies. This process must be equitably applied to all IFRs.

All IFR and associated policies will be publically available on the internet for the CCG. Specialist services that are commissioned by NHS England or Public Health England are not included in this policy.

2 Purpose

The purpose of the IFR policy is to enable officers of NHS Leeds CCG to exercise their responsibilities properly and transparently in relation to IFRs, and to provide advice to general practitioners, clinicians, patients and members of the public about IFRs. Implementing the policy ensures that commissioning decisions in relation to IFRs are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of the CCG.

The policy outlines the process for decision making with regard to services/treatments which are not normally commissioned by the CCG in Leeds, and is designed to ensure consistency in this decision making process.

The policy is underpinned by the following key principles:

- The decisions of the IFR panels outlined in the policy are fair, reasonable and lawful, and are open to external scrutiny.
- Funding decisions are based on clinical evidence and not solely on the budgetary constraints.
- Compliance with standing financial instructions / and statutory instruments in the commissioning of healthcare in relation to contractual arrangements with providers.

Whilst the majority of service provision is commissioned through established service agreements with providers, there are occasions when services are excluded or not routinely available within the National Health Service (NHS). This may be due to advances in medicine or the introduction of new treatments and therapies or a new cross-Leeds Clinical Commissioning Group statement. The IFR process therefore provides a mechanism to allow drugs/treatments that are not routinely commissioned by the NHS Leeds CCG to be considered for individuals in exceptional circumstances.

3 Scope

Policy development and review: consultation and engagement

The policy was developed to:

- ensure a clear and transparent approach is in place for exceptional/individual funding request decision making; and
- provide reassurance to patients and clinicians that decisions are made in a fair, open, equitable and consistent manner.

It was originally developed in line with NICE or equivalent guidance where this was available or based on a review of scientific literature. This included engagement with hospital clinicians, general practice, CCG patient advisory groups, and the general public cascaded through a range, mechanisms.

The policy review was undertaken using any updated NICE or equivalent guidance, and input from clinicians was sought where possible. Engagement sessions with patient leaders were undertaken and all policies individually reviewed. Patient leaders were satisfied with the process by which the policy was developed, particularly in light of the robust process (including extensive patient engagement) by which NICE guidance are developed, and acknowledging their own local role in providing assurance. No concerns were raised with regard to the policy

NHS Leeds CCG has established the processes outlined in this policy to consider and manage IFRs in relation to the following types of requests:

Eye procedures including: Toric Lens Insertion, Laser Vitreolysis, Blepharoplasty, Congenital Ptosis

NHS Leeds CCG *does not routinely commission* aesthetic (cosmetic) surgery and other related procedures that are medically unnecessary.

Providing certain criteria are met, the CCG will commission aesthetic (cosmetic) surgery and other procedures to improve the functioning of a body part or where medically necessary even if the surgery or procedure also improves or changes the appearance of a portion of the body.

Please note that, whilst this policy addresses many common procedures, it does not address all procedures that might be considered to be cosmetic. The CCG reserve the right not to commission other procedures considered cosmetic and not medically necessary. This policy is to be used in conjunction with the Individual Funding Requests (IFR) Policy for NHS Leeds CCG and other related policies.

NHS Leeds CCG routinely commission interventional procedures where National Institute for Health and Care Excellence (NICE) guidance arrangements indicate “normal” or

"offered routinely" or "recommended as option(s)" and the evidence of safety and effectiveness is sufficiently robust.

NHS Leeds CCG *do not* routinely commission interventional procedures where NICE guidance arrangement indicates "special", "other", "research only" and "do not use".

The commissioning statements for individual procedures are the same as those issued by NICE. (www.nice.org.uk).

An individual funding request (IFR) may be submitted for a patient who is felt to be an exception to the commissioning statements as per the Individual Funding Request Policy.

The CCG accept there are clinical situations that are unique (five or fewer patients) where an IFR is appropriate and exceptionality may be difficult to demonstrate.

Whilst the CCG is always interested in innovation that makes more effective use of resources, in year introduction of a procedure does not mean the CCG will routinely commission the use of the procedure.

An individual funding request is not an appropriate mechanism to introduce a new treatment for a group or cohort of patients. Where treatment is for a cohort larger than five patients, that is a proposal to develop the service, the introduction of a new procedure should go through the usual business planning process. CCG will not fund interventional procedures for cohorts over 5 patients introduced outside a business planning process.

Endpoints

Following completion of the agreed treatment, a proportionate follow up process will lead to a final review appointment with the clinician where both patient and clinician agree that a satisfactory end point has been reached. This should be at the discretion of the individual clinician and based on agreeing reasonable and acceptable clinical and/ or cosmetic outcomes.

Once the satisfactory end point has been agreed and achieved, the patient will be discharged from the service.

Requests for treatment for unacceptable outcomes post treatment will only be considered through the Individual Funding Request route. Such requests will only be considered where a) the patient was satisfied with the outcome at the time of discharge and b) becomes dissatisfied at a later date. In these circumstances the patient is not automatically entitled to further treatment. Any further treatment will therefore be the Clinical Commissioning Group's discretion, and will be considered on an exceptional basis in accordance with the IFR policy.

NHS Leeds CCG are committed to supporting patients to stop smoking in line with NICE guidance in order to improve short and long term patient outcomes and reduce health inequalities. Referring GPs and secondary care clinicians are reminded to ensure the patient is supported to stop smoking at every step along the elective pathway and especially for flap based procedures (in line with plastic surgery literature: abdominoplasty, panniculectomy, breast reduction, other breast procedures).

4 Definitions

The CCG is not prescriptive in their definitions. Each IFR will be considered on its merits, applying this Policy.

Routinely commissioned – this means that this intervention is routinely commissioned as outlined in the relevant policy, or when a particular threshold is met. Prior approval may or may not be required, refer to the policy for more information.

Exceptionality request – this means that for a service which is not routinely commissioned, or a threshold is not met, the clinician may request funding on the 'grounds of exceptionality' through the individual funding request process. Decisions on exceptionality will be made using the framework defined in the overarching policy 'Individual Funding Requests (IFR) Policy for the Clinical Commissioning Group in Leeds'.

5 Duties

The CCG will delegate its decision making in relation to IFRs to a delegated decision maker/s in accordance with its own scheme of delegation.

A delegated decision maker will attend the relevant IFR panel and will also have responsibility for approving the triage process. The triage process is the process of screening requests to see whether the request meets the policy criteria and which referrals need to be considered by an IFR panel; see sections on IFR panels for more information. This will be detailed in the CCG Scheme of Delegation

6 Main Body of Policy

Exceptionality funding can be applied for in line with the overarching policy through the IFR process if you believe your patient is an exception to the commissioning position. Please refer to the overarching policy for more information.

6.1 Toric Lens Insertion

Status: routinely commissioned in specific circumstances

Toric and phakic intraocular lenses refer to astigmatism correcting intraocular lenses used post corneal graft surgery and for certain stable keratoconic patients to prevent the patient from experiencing visual confusion or double vision.

Routinely commissioned if one of the following circumstances are met, prior approval is not required:

- If the patient has not already had cataract surgery this can be a phakic lens implant. (An intraocular phakic lens implant will only be used if there is significant astigmatism) OR
- If the patient has already had a cataract op in the past they need a 'piggyback' intraocular lens which slides in behind the pupil over the top of the existing lens implant OR
- If the patient has a cataract, the procedure will seek to treat the patient's cataract and an intraocular lens will be used instead of a standard lens to complete the procedure OR
- In some rare cases stable keratoconic patients are also eligible. These will be patients with high prescriptions who cannot achieve adequate visual function using contact lenses or spectacles. Their suitability will be assessed via a refraction test.

AND

In addition, the following must apply to all patients:

(a) Patient has > 3D astigmatism
OR
Patient has > 3D difference in spectacle prescription between the two eyes

(b) Patient is intolerant to contact lenses

(c) Intraocular lens surgery will be considered as second line treatment only after corrective laser surgery is attempted first.

6.2 Laser Vitreolysis

Status: not routinely commissioned

Floaters are small shapes that some individuals see floating in their vision and can vary in perceived shape. They are caused by pieces of debris which float in the vitreous humour and can cast shadows on the retina. Prior to a small case series being published in 2000 (Schiff, et al., 2000), these were considered to be a normal consequence of the aging process, or as a complication of another condition (Schulz-Key, et al., 2011).

The surgical interventions carried out for vitreous floaters are vitrectomy or laser vitreolysis (Schulz-Key, et al., 2011). Vitrectomy refers to the surgical removal of some of the vitreous fluid in the eye and the filling of the void with an inert substance. Laser vitreolysis refers to the use of a laser to either disrupt the floater itself or to disrupt the fibres that are maintaining the position of the floater to allow it to float out of the field of view.

6.3 Blepharoplasty, ptosis and brow lift

Status: ophthalmology opinion and intervention is routinely commissioned in specific circumstances

Blepharoplasty is a surgical procedure which removes excess tissue from the eyelid. Excess tissue can accumulate through normal ageing as the skin loses its elasticity and muscles slacken. This can lead to the appearance of folds in the upper eyelid and protrusion of the tissue. For the most part, this excess skin is purely a cosmetic problem, however, if the skin is hanging too low it may affect the individuals vision.

Ptosis is the drooping of the upper eyelid. It can be congenital or can develop, sometimes as a result of problems with the nerves or muscles supplying the eyelid. If the eyelid is hanging low enough over the eye it may cause a visual impairment. Surgery to correct ptosis usually involves shortening the muscles or tendons leading to a rise in the eyelid.

A brow lift is a surgical procedure in which the brow is surgically lifted. This may be performed because of brow ptosis – the drooping of the eyebrow. This procedure is often performed cosmetically but may also be performed if the brow is sagging to such an extent that the individual's vision is obscured.

For all conditions:

- Demonstrated superior visual field defect on Humphry 24-2 visual field test (this test can be performed by either an ophthalmologist or an optometrist)

AND

- To correct prosthesis difficulties in an anophthalmia socket OR
- To repair the following defects predisposing to corneal or conjunctival irritation:
- Entropion (eyelid turned inward)
- Pseudotrichiasis (inward misdirection of eyelashes caused by entropian)
- To treat periorbital sequelae of nerve palsy
- To relieve painful symptoms of blepharospasm

AND

- Marginal reflex distance (vertical distance between the top of the pupil and the midline of the pupil) of no more than 2mm shown in photographs of straight gaze.

Note: The surgical removal of fatty tissue within the eyelid which does not result in a visual field defect (as defined above) is NOT routinely commissioned.

All exceptionality requests must also submit medical photographs.

The commissioning of all thyroid ophthalmopathy is the responsibility of NHS England.

6.4 Congenital ptosis

Status: routinely commissioned in certain circumstances

Leeds CCGs consider surgical correction of congenital ptosis medically necessary to allow proper visual development and prevent amblyopia in infants and children with moderate to severe ptosis interfering with vision. Surgery is considered cosmetic if performed for mild ptosis that is only of cosmetic concern. Photographs must be available for review to document that the skin or upper eyelid margin obstructs a portion of the pupil.

6.5 Chalazia Removal

Status: routinely commissioned in the following circumstances[1]:

Incision and curettage (or triamcinolone injection for suitable candidates) of chalazia should only be undertaken if at least **one** of the following criteria have been met:

- Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks
- Interferes significantly with vision
- Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy
- Is a source of infection that has required medical attention twice or more within a six month time frame
- Is a source of infection causing an abscess which requires drainage
- If malignancy (cancer) is suspected eg. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions

7 Equality Impact Assessment (EIA)

This document has been assessed, using the EIA toolkit, to ensure consideration has been given to the actual or potential impacts on staff, certain communities or population groups, appropriate action has been taken to mitigate or eliminate the negative impacts and maximise the positive impacts and that the and that the implementation plans are appropriate and proportionate.

[1] https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf (accessed 05.02.19)

Include summary of key findings/actions identified as a result of carrying out the EIA. The full EIA is attached as Appendix A.

8 Implications and Associated Risks

This policy and supporting frameworks set evidence based boundaries to interventions available on the NHS. It may conflict with expectations of individual patients and clinicians.

9 Education and Training Requirements

Members of the panels will undergo training at least every three years, particularly in relation to the legal precedents around IFRs. Effective policy dissemination is required for local clinicians.

10 Monitoring Compliance and Effectiveness

Each IFR panel will maintain an accurate database of cases approved and rejected, to enable consideration of amendments to future commissioning intentions and to ensure consistency in the application of the CCGs in Leeds Commissioning Policies.

The financial impact of approvals outside of existing Service Level Agreements will be monitored to ensure the Leeds CCGs identify expenditure and ensure appropriate value for money. Member Practice clinicians need to be aware that all referrals will ultimately be a call on their own CCG budgets.

11 Associated Documentation

This policy must be read in conjunction with the underpinning Leeds CCGs decision making frameworks.

12 Additional References and Background

Toric Lens

Astigmatism correction with toric intraocular lenses: wavefront aberrometry and quality of life (2013), Menucci, Giordano, Favuzza et al

Toric intraocular lenses for correcting astigmatism in 130 eyes (2000), Sun, Viscary, Montgomery et al

Cataract surgery with toric intraocular lens implantation in keratoconus: A case report (20111), Visser, Gast, Bauer et al

Phakic intraocular lens implantation for the correction of myopia: a report by the American Academy of Ophthalmology (2009), Huang, Schallhorn, Sugar, Farjo et al

Toric intraocular lens implantation: 100 consecutive cases (2002), Till, Yoder, Wilcox, Speilman et al

Laser Vitreolysis

Brod, R. D., 2009. Surgery for Diseases of the Vitreous and Retina. *The Journal of Lancaster General Hospital,* 4(1), pp. 4-9.

Delaney, Y. M., Oyinloye, A. & Benjamin, L., 2002. Nd:YAG Vitreolysis and pars plana vitrectomy: surgical treatment for vitreous floaters. *Eye,* Volume 16, pp. 21-26.

Martínez-Sanz, F., Velarde, J. I., Casuso, P. & Fernández-Cotero, J. N., 2009. Solución Quirúrgia al Problmea Visual de los Cuerpos Vítreos Flotantes [Surgical Solution to Vitreous Floaters Visual Problem]. *Arch Soc Esp Oftalmol,* Volume 84, pp. 259-262.

Roth, M., Trittibach, P., Koerner, F. & Sarra, G., 2005. Pars-plana-Vitrektomie bei idiopathischen Glaskörpertrübungen [Pars Plana Vitrectomy for Vitreous Floaters]. *Klin Monatsbl Augenheilkd,* 222(9), pp. 728-732.

Schiff, W. M., Chang, S., Mandava, N. & Barile, G. R., 2000. Pars plana vitrectomy for persistent, visually significant vitreous opacities.. *Retina,* 20(6), pp. 591-596.

Schulz-Key, S., Carlsson, J.-O. & Crafoord, S., 2011. Longterm follow-up of pars plana vitrectomy for vitreous floaters: complications, outcomes and patient satisfaction. *Acta Ophthalmologica,* Issue 89, pp. 159-165.

Stevie Tan, H., Mura, M., Lesnik Oberstein, S. Y. & Bijl, H. M., 2011. Safety of Vitrectomy for Floaters. *American Journal of Ophthalmology,* 151(6), pp. 995-998.

Vandorslaer, T., Van de Velde, F. & Tassignon, M. J., 2001. Eligibility Criteria for Nd-YAG Laser Treatment of Highly Symptomatic Vitreous Floaters. *Bull. Soc. belge Ophtalmol.,* Volume 280, pp. 15-19.

Wagle, A. M. et al., 2011. Utility values associated with vitreous floaters. *American Journal of Ophthalmology,* 152(1), pp. 60-65.

Blepharoplasty

http://baaps.org.uk/procedures/eyelid-surgery accessed 29/06/2016

Background

Blepharoplasty refers to surgery to remove excess skin and fatty tissue around the eyes. Blepharochalasis is a term used to refer to loose or baggy skin (dermatochalasis) above the eyes, so that a fold of skin hangs down, often concealing the tarsal margin when the eye is open. In severe cases, excess skin and fat above the eyes can sit on the upper eyelid and may obstruct the superior field of vision. Blepharochalasis may cause pseudoptosis (false ptosis), where the patient has a normal ability to elevate the eyelid, but bagging skin above the eye overhangs the eyelid margin, resembling ptosis. In some cases, excess skin around the eye may cause the eyelashes to turn in and to irritate the eye, or turn outward, resulting in exposure keratitis.

Surgical removal of these overhanging skin folds may improve the function of the upper eyelid and restore peripheral vision. Blepharoplasty is also performed for cosmetic reasons to improve a sagging, tired appearance, and is the second most common aesthetic procedure performed by plastic surgeons. For coverage of this

procedure, photographs in straight gaze should show sagging tissue above the eyes that is resting on or pushing down on the eyelashes.

Blepharoplasty to remove excess tissue either above or below the eyes may also be medically necessary and covered to correct prosthesis difficulties in an anophthalmia socket, to repair defects caused by trauma or tumor-ablative surgery, to correct an entropion (inward turned eyelid) or extropion (outward turned eyelid), to treat periorbital sequelae of thyroid disease and nerve palsy, and to relieve painful blepharospasm.

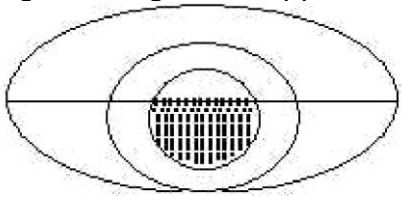
Ptosis (also called blepharoptosis) is the term for drooping of one or both upper eyelids. This may occur in varying degrees from slight drooping to complete closure of the involved eyelid. In the most severe cases, the drooping can obstruct the visual field and cause positional head changes. There are two types of ptosis, acquired and congenital. Acquired ptosis is more common. Congenital ptosis is present at birth. Ptosis may occur because the levator muscle's attachment to the lid is weakening with age. Acquired ptosis can also be caused by a number of different things, such as disease that impairs the nerves, diabetes, injury, tumours, inflammation, or aneurysms. Congenital ptosis may be caused by a problem with nerve innervation or a weak muscle. Drooping eyelids may also be the result of diseases such as myotonic dystrophy or myasthenia gravis.

The primary symptom of ptosis is a drooping eyelid. Adults will notice a loss of visual field because the upper portion of the eye is covered. Children who are born with a ptosis usually tilt their head back in an effort to see under the obstruction. Some people raise their eyebrows in order to lift the lid slightly and therefore may appear to be frowning.

Diagnosis of ptosis is usually made by observing the drooping eyelid. Ptosis is usually treated surgically. For minor drooping, a small amount of the eyelid tissue can be removed. For more pronounced ptosis the approach is to surgically shorten the levator muscle or connect the lid to the muscles of the eyebrow. Or, the aponeurosis can be reattached to the tarsal plate if it had separated. Correcting the ptosis is usually done only after determining the cause of the condition.

Ptosis (blepharoptosis) repair for laxity of the muscles of the upper eyelid causing functional visual impairment is covered when photographs in straight gaze show the eyelid margin across the midline or at the most 1 or 2 mm above the midline of the pupil (see Figure).

Figure: Diagram of upper lid margin crossing the pupil



Brow ptosis refers to sagging tissue of the eyebrows and/or forehead. In extreme cases, brow ptosis can obstruct the field of vision. Brow ptosis is caused by aging changes in the forehead muscle and skin, which leads to weakening of these tissues and sagging of the eyebrows. Brow ptosis is treated surgically with the specific operation being based on the amount and location of the brow ptosis.

Often brow ptosis coexists with eyelid ptosis and dermatochalasis; in these cases, ptosis surgery and blepharoplasty may be performed at the time of the brow ptosis surgery. The medical necessity of each surgical procedure may need to be demonstrated with separate photographs: one photograph should show the eyebrow below the supraorbital rim, a second photograph with the sagging forehead lifted up in order to see the sagging tissue above the eye resting on the eyelashes, and then a third with the sagging tissue lifted off of the eyelid in order to see the persistent lid lag (ptosis).
Visual field testing is not necessary to determine the presence of excess upper eyelid skin, upper eyelid ptosis, or brow ptosis. A patient could cause a visual field defect by lowering their lids during the test. Photographs that document eyelids crossing the pupils provide a practical indication for the need of surgery.

If visual field tests are performed, the tests should show loss of two-thirds or greater of a visual field in the upper or temporal areas documented by computerised visual field studies, with visual field restored by taping or holding up the upper lid.

Appendices

A Equality Impact Assessment (where applicable)

Title of policy	Eye Procedures	
Names and roles of people completing the assessment	Fiona Day Consultant in Public Health Medicine, Helen Lewis, Head of Acute Provider Commissioning	
Date assessment started/completed	26.6.16	25.7.16

1. Outline	
Give a brief summary of the policy	The purpose of the commissioning policy is to enable officers of the Leeds CCGs to exercise their responsibilities properly and transparently in relation to commissioned treatments including individual funding requests, and to provide advice to general practitioners, clinicians, patients and members of the public about IFRs. Implementing the policy ensures that commissioning decisions are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of the CCGs. This policy relates to requests for eye procedures.
What outcomes do you want to achieve	We commission services equitably and only when medically necessary and in line with current evidence on cost effectiveness.

2. Evidence, data or research	
Give details of evidence, data or research used to inform the analysis of impact	See list of references

3. Consultation, engagement	
Give details of all consultation and engagement activities used to inform the analysis of impact	Discussion with clinicians and patient representatives on the principles of decision making. Discussion with patient leaders relating to changes in the content of the policy and advice on proportionate engagement. The policy review was undertaken using any updated NICE or equivalent guidance, and input from clinicians was sought where possible. Engagement sessions with patient leaders were undertaken and all policies individually reviewed. Patient leaders were satisfied with the process by which the policy was developed, particularly in light of the robust process (including extensive patient engagement) by which NICE guidance are developed, and acknowledging their own local role in providing assurance. No concerns were raised with regard to the policy. Local clinical commissioning and clinical providers have had the opportunity to comment on the draft policies.

4. Analysis of impact			
This is the core of the assessment, using the information above detail the actual or likely impact on protected groups, with consideration of the general duty to; eliminate unlawful discrimination; advance equality of opportunity; foster good relations			
	Are there any likely impacts? **Are any groups going to be affected differently?** **Please describe.**	**Are these negative or positive?**	**What action will be taken to address any negative impacts or enhance positive ones?**
Age	Yes – congenital ptosis in children	Positive	
Carers	No		
Disability	Stop people being able to see.		
Sex	No		
Race	No		

Religion or belief	No		
Sexual orientation	No		
Gender reassignment	No		
Pregnancy and maternity	No		
Marriage and civil partnership	No		
Other relevant group	No		
If any negative/positive impacts were identified are they valid, legal and/or justifiable? **Please detail.**			

5. Monitoring, Review and Publication			
How will you review/monitor the impact and effectiveness of your actions	Annual report of IFR activity reported through relevant committees to Governing Bodies of the 3 CCGs. A limited equity audit is undertaken as part of this. Complaints and appeals monitoring.		
Lead Officer	Simon Stockill	**Review date:**	Dec 2019

6.Sign off			
Lead Officer			
Director on behalf of the 3 Leeds CCG Medical Directors	Dr Simon Stockill, Medical Director, Leeds West CCG	**Date approved:**	24.8.16

B Policy Consultation Process:

Title of document	Eye Procedures Policy
Author	F Day, M Everitt
New / Revised document	Revised
Lists of persons involved in developing the policy List of persons involved in the consultation process:	F Day Consultant in Public Health Medicine, M Everitt Public Health Registrar, Leeds City Council B Chang, Consultant Ophthalmologist LTHT See appendix A

C Version Control Sheet

Version	Date	Author	Status	Comment
1.0	7.7.16	F Day, M Everitt	draft	Blepharoplasty – Taken out two very rare indications on advice of Professor of ophthalmology (ectropian and corneal exposure). Still commissioned if there is visual impairment but method of impairment changed; now needs to have superior visual field defect on Humphrey 24-2 visual field test whereas in previous policy assessed only by photography of the eye. Clarification that thyroid eye disease is NHSE responsibility Extra section added to make it clear that removal of excess fat in the eyelid is only commissioned if it is causing visual field problems
2.0	5.2.19	F Day	Updated	Addition of position on chalazia in line with NHSE Evidence-Based Interventions : Response to the public consultation and next steps (November 28th 2018)