Derby and Derbyshire
Integrated Care Board

CLINICAL POLICY ADVISORY GROUP (CPAG)

Cataract Surgery Policy

Statement

Derby and Derbyshire ICB, in line with its principles for procedures of limited clinical value has deemed that Cataract Surgery should not routinely be commissioned unless the Criteria listed for First Eye or Second Eye Cataract Surgery are met.

These commissioning intentions will be reviewed periodically. This is to ensure affordability against other services commissioned by the ICB.

1. Background

A cataract is an opacity (cloudy area) that forms within the lens of an eye that can reduce transparency of the lens gradually and painlessly over a period of time. The symptoms manifest themselves in gradual difficulty reading, recognising faces, trouble with bright lights or seeing at night. A cataract may form in one or both eyes and at any age, although most commonly in people aged over 60 years. Other causes of cataracts include eye disease, trauma, systemic disease and congenital risks in children. Risk factors include a family history, corticosteroid treatment, smoking and prolonged exposure to Ultraviolet B Light.

Most cataracts are progressive, although the decline in visual function may be variable and unpredictable. The natural history of cataracts depends on the type and severity of the cataract and the presence of comorbid ocular conditions. In severe, untreated cases, cataracts can lead to significant reduction in vision, which is reversible with cataract surgery, although some level of visual impairment may persist.

There are no medicines or eye drops that have been proven to improve cataracts or stop them getting worse. Cataract surgery is the removal of the natural lens of the eye where the cataract has developed and its replacement with an intraocular lens. Cataract surgery has a high success rate in improving visual function, with low morbidity and mortality and a usual recovery time of 2-6 weeks following surgery.

2. Recommendation

The ICBs will only fund cataract surgery as described below:
(NB: These criteria also apply to secondary care and community optometrists)

FIRST EYE:
Cataract surgery will be funded where the visual acuity after refractive correction is worse than 6/9 or worse in the worst eye (the eye to be treated) or the patient has one of the following (with correction):

- Reduced mobility, experiencing difficulties in driving, for example, due to glare, or experiencing difficulty with steps or uneven ground OR the ability to work, give care or live independently is affected.
- **OR**
  The patient has diabetes, or retinal condition, and requires clear views of their retina to monitor their disease or treatment
- **OR**
  The patient has glaucoma and requires cataract surgery to control the intraocular pressure
- **OR**
  The patient has posterior subcapsular or cortical cataracts and experiences problems with glare and a reduction in acuity in bright conditions
- **OR**
  The patient's visual field defects are borderline for driving, and cataract extraction would be expected to significantly improve the visual field.

This information, together with a report from a recent sight test, should form the minimum data on the referral form.

SECOND EYE:
(NB These criteria apply to Secondary Care ONLY once referral for First Eye Surgery has been met)

Cataract surgery will not be funded in the second eye if the first eye has achieved a visual acuity of 6/9 or better, with refractive correction, and the acuity of the second eye is 6/24 or better with refractive correction. These patients should be reviewed by their optometrist annually or earlier if there is any deterioration in vision.

Cataract surgery in the second eye will be funded if:

- The first does not achieve an acuity of 6/9 or better, with refractive correction, and the procedure is clinically indicated for the patient's individual circumstances
- **OR**
  The patient has diabetes, or retinal condition, and requires clear views of their retina to monitor their disease or treatment
- **OR**
  The patient has glaucoma and requires cataract surgery to control the intra ocular pressure
- **OR**
  There is, after first eye operation, resultant anisometropia (a large refractive difference between the two eyes) which would Secondary result in diplopia (double vision)
- **OR**
  There is uncorrectable loss of acuity in the second eye (with first eye corrected) that effectively renders the second eye vision worse than 6/24

This information, together with a report from a recent sight test, should form the minimum data on the referral form.

3. Rationale for Recommendation

There are no medicines or eye drops that have been proven to improve cataracts or stop them getting worse with surgery being the only intervention. In severe, untreated cases, cataracts can lead to significant reduction in vision, which is reversible with cataract surgery, although some level of visual impairment may persist.

The offer of cataract surgery depends both upon the risks of surgery and the impact of the cataract on the patient's quality of life. NICE Guidance (NG77), published in October 2017, advises that the decision to refer, a person with a cataract, for surgery should be based on a discussion with the individual patient.

In summation only patients who would be likely to agree to and benefit from surgery should be referred for cataract surgery, although NG77 notes that no relevant studies were identified to create a distinct tool or set of criteria that could be used to determine a threshold for cataract surgery.

Although surgery for the second eye is usually done 6-12 weeks apart to allow recovery one eye at a time - the Policy is not intended to preclude Immediate Bilateral Sequential Cataract Surgery if DDICB criteria have been met.

4. Shared Decision-Making

Shared decision-making ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment.

Decision support tools, also called patient decision aids, support shared decision making by making treatment, care and support options explicit. They provide evidence-based information about the associated benefits/harms and help patients to consider what matters most to them in relation to the possible outcomes, including doing nothing.

5. Useful Resources

- Cataracts in adults: Management https://www.nice.org.uk/guidance/ng77 [Accessed Sept 2021]
- NICE Clinical Knowledge Summaries:Cataracts 2020 https://cks.nice.org.uk/topics/cataracts/ [Accessed Sept 2021]
- NHS England » Decision support tool: making a decision about cataracts

6. References

- Immediate-Sequential-Bilateral-Cataract-Surgery-Guidance (2020) https://www.rcophth.ac.uk/wp-content/uploads/2020/07/Immediate-Sequetial-Bilateral-Cataract-Surgery-Guidance-2.pdf
- The Royal College of Ophtalmologists: The Way Forward Cataract (2018): https://www.rcophth.ac.uk/wp-content/uploads/2018/10/RCOphth-Way-Forward-Cataract.pdf
- The Royal College of Ophthalmologists Commissioning Guide (Adult Cataract Surgery) 2018. https://www.rcophth.ac.uk/wp-content/uploads/2018/02/Cataract-Commissioning-Guide-January-2018.pdf
- FOCUS (Jan 2021) https://www.rcophth.ac.uk/wp-content/uploads/2021/03/FOCUS-January-2021-Cataract-Service-during-and-after-COVID-19-pandemic.pdf
- Cataract surgery guidelines for Post COVID-19 pandemic: https://www.rcophth.ac.uk/wp-content/uploads/2020/05/RCOphth-UKISCRS-COVID-cataract-surgery-restoring-services-070520.pdf
- Cooper et al. (2015) “The cost-effectiveness of second – eye cataract surgery in the UK”
- Kessel et al. (2016) “Indication for cataract surgery. Do we have evidence of who will benefit from surgery? A systematic review and meta-analysis”

7. Appendices

Appendix 1 - Consultation

All relevant providers/stakeholders will be consulted via a named link consultant/specialist. Views expressed should be representative of the provider/stakeholder organisation. CPAG will consider all views to inform a consensus decision, noting that sometimes individual views and opinions will differ.

Consultee	**Date**
Local Optical Committee	September 2021
Director of Public Health Derby City	October 2021
Consultant Ophthalmologist (CRHFT)	October 2021
Clinical Policy Advisory Group (CPAG)	October 2021
Clinical Lay Commissioning Committee (CLCC)	November 2021
Chair, Local Eye Health Network (LEHN)	March 2024
Consultant Ophthalmologist (UHDBFT)	March 2024

Appendix 2 - Document Update

Document Update	**Date Updated**
Version 4.0 • Policy has been re-worded and reformatted to reflect the DDCCG clinical policies format. This includes the addition of background information, useful resources, references and consultation • Separate Cataract Surgery First Eye and Cataract Surgery Second Eye Policies have been merged into a single policy for ease of use • A single referral form has been developed to use by both GPs and Community Optometrists • Addition of comment is "The Policy is not intended to preclude Immediate Bilateral Sequential Cataract Surgery if DDCCG criteria have been met"	September 2021
Version 4.1 • Review date extended by 12 months in agreement with clinical stakeholders	March 2024
Version 4.2 • Reference to Prior Approval removed	June 2024
Version 4.3 • Reference to shared decision making added	September 2024