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 Evidence Based Interventions (EBI) 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 e.g. with glasses, lenses, surgery is 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:
Cataract surgery in the second eye will not be funded unless at least one the following criteria are met:

- **The second eye** has an uncorrectable loss of acuity that renders vision worse than 6/24 with the first eye corrected
  OR
- **The first eye,** with refractive correction**,** does not achieve an acuity of 6/9 or better.
  OR
- **If the patient** has diabetes or a retinal condition and requires clear views of their retina to monitor their disease or treatment
  OR
- **If the patient** has glaucoma and requires cataract surgery to control intraocular pressure
  OR
- **If there is anisometropia** (a large refractive difference between the two eyes) after the first eye operation, which would result in diplopia (double vision)

Additional Notes:

- **Bilateral cataract surgery can be undertaken for patients with diabetes, retinal conditions or glaucoma.**
- **A report from a recent sight test should in included in 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.

Prioritisation of cataract surgery is based on the ability to benefit and affordability. Hence the criteria for second eye surgery are stricter.

The first eye policy criteria has been reviewed over time to address inequalities ensuring fair assessment for both drivers and non-drivers. Key considerations include:

- Absolute acuity – correctable visual impairments (.e.g glasses, lenses, surgery)
- Medical conditions – prioritising cases where delays could exacerbate health risks (e.g. diabetes, glaucoma)
- Functional ability – recognising the challenges faced by those unable to care for others, at risk of losing employment due to driving restrictions or unable to manage their self-care

(e.g. stoma care) due to severe visual impairment

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.
This decision should be based on shared decision making and holistic assessment of the patient's needs.

Intraocular lenses for cataract surgery (IOL) Monofocal IOLs are the current standard IOL design used for cataract surgery in the NHS. Toric Intraocular Lenses for astigmatism correction in patients undergoing cataract surgery is not normally funded by ICBs. This is due to a lack of quality evidence regarding the long term clinical effectiveness of this procedure. NHSE commissions other services for astigmatism and refractive errors that are effective, safe and cost effective, such as wearing glasses or contact lenses

4. Personalised Care

Personalised care simply means that people have more control and choice when it comes to the way their care is planned and delivered, considering their individual needs, preferences and circumstances. It includes supporting shared decision making and self-management.
Shared decision-making means people are supported to:

- *understand the care, treatment and support options available and the risks, benefits and consequences of those options*
- *decide on a preferred course of action, based on evidence based, good quality information and their personal preferences.*

Supported self-management means increasing the knowledge, skills and confidence a person has in managing their own health and care. This involves using self-management education, peer support, and health coaching.
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

- BRAN leaflet – Shared decision making supports individuals to make the right decision for them. This easy-to-use leaflet supports this people to consider their treatment options
- Cataracts in adults: Management https://www.nice.org.uk/guidance/ng77 [Accessed 30/07/24]
- NICE Clinical Knowledge Summaries:Cataracts 2020 https://cks.nice.org.uk/topics/cataracts/ [Accessed 30/07/24]
- NICE NG197: Shared decision making. Published June 2021. 3. NHS England. Decision support tools: making a decision about cataracts. Published July 2022. https://www.england.nhs.uk/publication/decision-support-tools-making-a-decisionabout-a-health-condition/
- Academy of Medical Royal Colleges. Evidence based Interventions: List 3 Guidance. Shared decision making for cataract surgery. Published 2023

6. References

- Immediate-Sequential-Bilateral-Cataract-Surgery-Guidance (2020) https://www.rcophth.ac.uk/resources-listing/immediate-sequential-bilateral-cataract-surgery-guidance/ [Accessed 30/07/24]
- 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 (Accessed 30/07/24)
- 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
Local Optical Committee	August 2024
Chair, Local Eye Health Network (LEHN)	August 2024
Director of Public Health Derby City	January 2025
Consultant Ophthalmologist (UHDBFT)	January 2025
Consultant Ophthalmologist (CRHFT)	January 2025
Clinical Policy Advisory Group (CPAG)	February 2025

Appendix 2 - Document Update

Document Update	**Date Updated**
Version 5.0 • Reference to Personalised Care added • Clarification on the provision of Toric lenses added • Rationale included for prioritisation of 1st eye cataract surgery • Definition of refractive correct included • 2nd eye cataract criteria has been reworded to make the policy easier to read and understand and reflect the commissioning stance of bilateral cataracts • Rationale updated for safety concerns related to undertaking of sequential bilateral cataracts.	February 2025