Humber Coast and Vale

Cataract Surgery Commissioning Policy

Intervention	Elective Eye Surgery for the treatment of Cataracts in adults
OPCS codes	C62 Incision of iris C621 Iridosclerotomy C622 Surgical iridotomy C623 Laser iridotomy C624 Correction iridodialysis NEC C628 Other specified incision of iris C629 Unspecified incision of iris C71 Extracapsular extraction of lens C711 Simple linear extraction of lens C712 Phacoemulsification of lens C713 Aspiration of lens C718 Other specified extracapsular extraction of lens C719 Unspecified extracapsular extraction of lens C72 Intracapsular extraction of lens C721 Forceps extraction of lens C722 Suction extraction of lens C723 Cryoextraction of lens C728 Other specified intracapsular extraction of lens C729 Unspecified intracapsular extraction of lens C74 Other extraction of lens C741 Curettage of lens C742 Discission of cataract C743 Mechanical lensectomy C748 Other specified other extraction of lens C749 Unspecified other extraction of lens
Background	Current DVLA guidance states that the minimum eyesight standard for driving is a Best Corrected Visual Acuity (BCVA) of at least 6/12 measured on the Snellen Scale (with glasses or contact lenses, if necessary) using both eyes together (or, in the only eye, if monocular)[1].
Commissioning position	This policy covers direct referral for cataract surgery by optometrists and referral by GPs and by any other method to ophthalmologists. Prior to referral for cataracts, the referral should be made using the agreed referral form and should only be made where the patient has been provided with approved information in a suitable format (e.g. Royal College of Ophthalmologists leaflet 'Understanding Cataracts') and is willing to undergo surgery. Humber Coast and Vale CCGs will only fund elective surgery for cataract extractions for patients whose visual impairment is mainly attributable to cataract and who, **after correction** (e.g. with glasses or other adjustments): • Have a best corrected visual acuity of 6/12 or worse with both eyes open

AND
have significant effects on daily living e.g. with mobility (difficulty with steps, risk of falls, ability to drive), independent living, or reading

OR

- have diabetes and removal of the cataract is necessary to facilitate effective retinal screening

OR

- have glaucoma and / or narrow drainage angles and cataract surgery is required to control intra-ocular pressure

If referral for surgery is being considered (simple cataracts, sole pathology)[3]:

- Consider whether the person has the capacity to co-operate with eye examinations, surgery, and postoperative eye drop treatment.
- Frail people with mental health problems such as dementia may be unfit for general anaesthesia and unable to lie still for surgery under local anaesthetic.
- Discuss the risks and benefits of surgery.
- Give advice on what to expect before, during, and after surgery
- Optometrists should provide generic literature to inform the patient regarding the risks and benefits of surgery Optometrists should ensure patients are happy to be referred for surgery before referral is made.
- Decisions by optometrists on behalf of patients should be communicated to the GP.

It is expected that patients who have BCVA better than 6/12 with both eyes open, and who report substantial visual impairment, such as glare, anisometropia or anisekonia will be advised, as part of their optometric consultation, on suitable adjustments.

Second eye surgery

This will be offered, after post-operative review, if there is resultant significant anisometropia (difference in refractive error between the two eyes of more than 1.00D) which would result in poor binocular vision or diplopia.

Patients who do not meet the threshold, but the referrer feels that there are exceptional circumstances should be referred to the CCG Individual Funding Request (IFR) panel for consideration of exceptional circumstances.

Summary of evidence / rationale	Cataracts usually develop over a period of time, causing a gradual deterioration in eyesight. As it affects over a third of people aged over 65, cataract surgery continues to be the commonest elective procedure in day surgery performed in the UK. In the vast majority of cases the surgery involves local or topical anaesthesia, which markedly reduces operative and recovery time. Smoking and diabetes (associated with BMI > 30) are further risk factors for cataract[2]. 80-90% of patients report a benefit from surgery, which include improved clarity of vision and improved colour vision. This in turn has implications for a positive impact on other health and social care needs including a reduction in slips, trips and falls amongst the elderly[2]. There are risks associated with cataract surgery, some common and many very rare; however complications are usually treatable and reasonably good outcome s can be expected. There is currently no widely validated Patient Reported Outcome Measure (PROM) for cataract surgery[2]. Based on a systematic review and study of cataract PROMs, the Catquest-9SF questionnaire currently appears to be the most promising instrument. Catquest-9SF has been validated in a demographically matched population (Australia), but has not yet been validated in the UK. A National Institute for Health Research (NIHR) applied cataract research programme is currently funded to develop a short form cataract PROM suitable for routine use in the NHS. This will help to identify from the patient's perspective whether surgery is currently being over or under provided. NICE recommendations for cataract surgery are not due until June 2017, but the Royal College of Ophthalmologists published guidelines on the management of cataract last year – although these may not cover all the issues from a commissioning perspective[2]. Their guidelines recognise that “Visual acuity is the most common measurement of visual function as it can be quickly and easily measured” but goes on to point out that “ the sole use of visual acuity can underestimate visual disability because it does not take account of symptoms such as glare or reduced contrast sensitivity.” This can, however, be hard to quantify objectively. A best corrected visual acuity (BCVA) of better than 6/12 [Snellen], in the worse eye, normally allows a patient to function without significant visual difficulties. In population studies using BCVA as an indicator of morbidity, BCVA better than 6/12 is not considered a visually impairing cataract and acuity of 6/9 is considered a good outcome post-surgery. This applies to both first and second eye surgery[11].

	Significant improvements in visual symptoms and visual function may occur following cataract surgery even where the preoperative visual acuity is better than 6/12. However, the risk of worse visual acuity after surgery also increases where the preoperative visual acuity is very good, so surgery should be considered at this level of visual acuity only where the patient is experiencing significant symptoms attributable to cataract[2]. **Improving outcomes and cost-effectiveness** With such a common procedure, it is all the more important to seek improvements in cost-effectiveness, both with patient selection and the actual procedure. There is no set level of vision for which an operation is essential[3]. The rate at which cataracts progress is unpredictable. Reading glasses are usually needed after cataract surgery, and some people may require glasses for distance vision who did not previously require them[3]. With the current volume of cataract surgery and the increases in the future, it is critical to be able to optimise the safety, but also the cost effectiveness of this procedure. Most cataracts are age-related and therefore surgeries are performed on older individuals with correspondingly high systemic and ocular comorbidities. It is therefore more important to ensure the right balance of risk to benefit[4]. Cataract surgery does not always result in an improvement in visual acuity or patient satisfaction with visual function[5]. Despite the lack of evidence base to define thresholds bothfor initial referral to an ophthalmologist or for subsequent surgery, or to indicate cost-effectiveness, **over-provision** is recognised as a problem and thresholds are used to control access and resource use[6]. A recent study found significant reductions in cataract surgery, among other “low priority” procedures, as part of NHS efforts to implement spending cuts[7]. Improvement in visual acuity has often been used to judge the outcome of surgery. Surveys have shown that in 1990, 9% of eyes had a pre-operative visual acuity of 6/12 or better. By 2009, this had risen to 43%. Thus with the large increase in procedures over the last 20 years, it would appear that eyes with better acuity are now being operated on. The potential for benefit, from a visual acuity point of view, therefore, is decreasing and the impact of surgery may be becoming less cost-effective[8,9,10]. There is good data now which shows the risk of worse visual acuity after surgery is significant if you operate in milder cases; so there is a risk with overprovision of the threshold being too low[8,9,10].
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References:

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2. Royal College of Ophthalmologists Feb 2015 Commissioning Guide: Cataract Surgery Clinical Knowledge Summaries: Cataracts. Due during 2017
3. Routine pre-operative medical testing for cataract surgery Cochrane database 2012 Day A, Donachie PHJ, Sparrow JM, Johnston RL. The Royal College of Ophthalmologists' National Ophthalmology Database Study of Cataract Surgery: Report 1, Visual Outcomes and Complications. Eye. Feb 2015
4. Healthcare Improvement Scotland Technologies scoping report 9: What is the impact of using thresholds for first-eye cataract surgery on the delivery of the cataract service?
5. English National Health Service's Savings Plan May Have Helped Reduce The Use Of Three 'Low-Value' Procedures Sophie Coronini-Cronberg et al Health Affairs March 2015
6. Cataract surgical rates: is there overprovision in certain areas? Sparrow Br J Ophthalmol 2007 91: 852-853
7. Evidence review: cataract surgery Hampson and Briggs; Cheshire West and Chester public health collaborative service May 2014
8. Sophie Coronini-Cronberg, member of Royal College of Ophthalmologists working group commissioned by NICE to develop commissioning guidelines (see ref 2) and Honorary Research Fellow, Department of Primary Care and Public Health, Imperial College London (personal communication)
9. Cambridge and Peterborough CCG Cataracts policy March 2014.