NHS North West London CCGs will fund cataract surgery for either or both eyes if the following thresholds are met:

1. Cataract surgery to be considered for patients with a best corrected visual acuity of 6/9 (LogMAR 0.18) or worse in the affected eye(s).

AND

2. Have impairment in lifestyle such as significant effect on activities of daily living, leisure activities, and risk of falls

OR the following threshold alone

3. Surgery is indicated for management of ocular comorbidities e.g. management of glaucoma OR in diabetes where the view of the retina is obscured in retina screening

Revision cataract surgery is not in scope of this policy

Where the criteria are not met, funding may be considered via the IFR route if there are exceptional reasons present.

These polices have been approved by the eight Clinical Commissioning Groups in North West London (NHS Brent CCG, NHS Central London CCG, NHS Ealing CCG, NHS Hammersmith and Fulham CCG, NHS Harrow CCG, NHS Hillingdon CCG, NHS Hounslow CCG and NHS West London CCG).

Cataracts are cloudy patches or areas in the eye lens that are very common in the elderly population and cataract surgery is a fast, safe and effective treatment. Referral depends on reduced visual acuity, impairment of activities of daily living and a willingness to have surgery. Impairment of activities of daily living may include the following:

- The patient is at significant risk of falls
- The patient’s vision is substantially affecting their ability to work
- The patient’s vision is substantially affecting their ability to undertake leisure activities such as reading, recognising faces or watching television

Although there is significant improvement in vision from mono- to binocular vision (35% of cataract operations are in the second eye), there is debate around whether second cataract surgery is cost effective. There is also debate around whether cataract surgery in both eyes should occur simultaneously. The risk of bilateral intra-ocular complications is generally perceived to be too important to warrant simultaneous treatment and if second surgery occurs it is usually delayed after the first operation.
First Eye Cataract Surgery
First eye cataract surgery is recommended by NICE and the Department of Health. Surgery can involve either accommodating or non-accommodating intraocular lenses as they both improve visual acuity. Compared with monofocal lenses, multifocal lenses reduce dependence on spectacles (OR 0.17 – 0.12, 0.24) but do increase the risk of halos and glares (OR 3.55 – 2.11, 5.96). Key efficacy outcomes from surgery are spectacle independence, uncorrected near and distance vision, postoperative refractive error, contrast sensitivity and quality of life. Referral should not be based only on the presence of the cataract but also on the presence of reduced visual acuity, impairment of lifestyle and willingness to have surgery.

Second Eye Cataract Surgery
The Royal College of Ophthalmologists released guidance on cataract surgery in 2004 stating that second eye surgery is warranted given the significant gains in visual function and quality of life compared with single surgery alone. Multiple randomised studies have shown improved clinical and functional benefit from surgery in the second eye, in terms of visual acuity, contrast sensitivity, stereoaucuity, and visual disability however second surgery does not improve the risk of falling in the elderly. At the population level, maximum utility is obtained from increasing access to first eye surgery in the first instance. However where first surgery rates are high then second-eye surgeries should be performed to maximise quality of life to as many as possible.

Cost-benefit of Second Cataract Surgery
Modelled cost-benefit analysis has shown that second eye surgery yields an additional 0.92 QALYs over a 12 year life expectancy, with each additional QALY gained costing between $2045 to $3649 2001. Compared with first eye surgery ($2023 per QALY) this is only slightly less cost-efficient and represents good cost-effectiveness when compared with other procedures. However, these estimates may not be generalisable to the UK because they are based on US studies where healthcare costs and systems are different from the NHS.

Immediate Sequential Cataract Surgery (ISCs)
Simultaneous surgery in both eyes results in improved visual function compared to single eye surgery, however this is not a long-lasting effect and its value is mostly to avoid suboptimal vision while waiting for second-eye surgery. Simultaneous bilateral surgery minimises the use of local and general anaesthesia, ensures only one-step visual rehabilitation is required, leads to fewer hospital visits, and a more efficient use of hospital time, shorter waiting lists and less demand on hospital services. Including all surgical costs, delayed second-eye surgery is 14% more expensive than ISCS. ISCS leads to 15-30% greater efficiency in the numbers of eyes that can be operated on per day, given that the second operation adds only 12 minutes on average to the operating time, compared to delayed surgery.

Theoretically, there is no risk arising from ISCS additional to that from monocular cataract surgery itself. The perceived threat of binocular complications occurring simultaneously underpins the concern around simultaneous bilateral surgery. However, evidence suggests that the risk of bilateral complications in ISCS (which includes catastrophic and non-catastrophic complications) compares favourably to unilateral surgery complication rates Smith and Liu (2001). In general, the risk of a complication in the second eye is the same as in the first eye. The chance of complications occurring in both eyes is the same as in the unilateral operations of two consecutive patients. The principal exclusion criteria for ISCS should be for patients that have specific underlying co-morbidities or experiences with previous cataract surgery that indicate an increased risk of post-operative complications.
References

6. Castells X, Cornas M, Alonso J et al 2006 – In a randomised trial, cataract surgery in both eyes increased benefits compared to surgery in one eye only. Journal of Clinical Epidemiology 59(2):201-7