|  |  |
| --- | --- |
| Intervention | **076. Cataract Surgery in Adults** |
| For the treatment of: | Cataract |
| Commissioning position | This intervention is routinely commissioned and does not require prior approval.  The person should be referred by a primary care optometrist, who should formally document shared decision making with the patient and/or their family and carers if appropriate. As a minimum, referral should include:   * How the cataract affects the person’s vision and quality of life * Whether one or both eyes are affected * What cataract surgery involves, including possible risks and benefits? * How the persons quality of life may be affected if they choose not to have cataract surgery * Whether the person wants to have cataract surgery.   In line with NICE guidance, surgery for cataract extraction is not restricted on the basis of visual acuity.  Providers should have processes in place to provide regular feedback to referrers; for example, Fife utilised biannual meetings with their optometrists to support better referrals and shared understanding of the pathway.  **Second Eye Cataract Surgery**  Second eye surgery will follow the same criteria. The eye with the worse visual acuity should normally be operated on first. |
| Summary of Rationale | Cost-utility analyses of cataract surgery, and second eye surgery have shown it to be good value, and cataract surgery also has indirect societal and health-economic advantages in improving well-being, reducing isolation and premature need for care while also reducing falls and road traffic accidents  Patients who are referred need to be reasonable candidates for surgery and have a desire to undergo the operative procedure. Historically, referred patients often, when they have had an informed discussion, do not wish to undergo surgery, which has produced huge variability in conversion rates (from direct cataract referral to undergoing surgery) nationwide, with rates ranging from 40-92%. The reason for poor conversion rates can be due to many factors including commissioning of services, incomplete training, and lack of engagement of primary care staff on shared decision making. The ideal conversion rate to cataract surgery is not agreed, but rates of more than 80% can be achieved by referral guidelines and efficient forms, as recommended by the Royal College of Ophthalmologists.  Shared decision-making tools have been proven to improve conversion rates and lead to better patient experience and clinical outcomes. Their use is endorsed by the Department of Health policy ‘Equity and Excellence: liberating the NHS’ highlighting the importance of the patient’s opinion and choice with regards to their care. This guidance uses evidence to propose that all referral pathways for cataract surgery should include shared decision-making tools.  NICE guidance has clearly stated since 2017 that referrals for cataract surgery should not be restricted purely on the basis of a measure of visual acuity, and this is strongly endorsed by the Royal College of Ophthalmologists. |
| References | [EBI Shared decision making for cataract surgery (AOMRC)](https://ebi.aomrc.org.uk/interventions/shared-decision-making-for-cataract-surgery/)  [NHS\_Cataracts\_decision\_tool](https://www.england.nhs.uk/wp-content/uploads/2022/07/Making-a-decision-about-cataracts.pdf)  [NG77 Cataracts in adults (NICE)](https://www.nice.org.uk/guidance/ng77)  [The Way Forward-Cataract (RCOphth)](https://www.rcophth.ac.uk/wp-content/uploads/2021/12/RCOphth-The-Way-Forward-Cataract-300117.pdf)  [Cataract Commissioning Guide January 2018 (RCOphth)](https://curriculum.rcophth.ac.uk/wp-content/uploads/2018/02/Cataract-Commissioning-Guide-January-2018.pdf)  [High Flow Cataract Surgery\_V2 (RCOphth)](https://www.rcophth.ac.uk/wp-content/uploads/2022/02/High-Flow-Cataract-Surgery_V2.pdf) |
| Effective from: | January 2025 |
| Policy Review Date | January 2028 |