Don’t turn back the clock:

Cataract surgery – the need for patient-centred care

RNIB supporting blind and partially sighted people

The Royal College of Ophthalmologists

Contents

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Barbara McLaughlan, Policy and Campaigns Manager, RNIB
Steve Winyard, Head of Policy and Campaigns, RNIB
Larry Benjamin, Consultant Ophthalmologist, Chair of the RCOphth Cataract Guideline Committee
Andy Cassels-Brown, Chair of the RCOphth Public Health Subcommittee
Richard Smith, RCOphth, Chair of the Revalidation Subcommittee.

1. Overview

- Cataract operations are proven to be safe, clinically and cost effective interventions for both eyes.
- The Department of Health "Action on cataract" best practice guidance introduced three criteria that need to be met for a cataract to be removed:
  - the cataract affects the individual's sight
  - the reduction in the patient's sight has a negative impact on their quality of life
  - the patient understands the risks and agrees to having surgery.
- These criteria constitute best practice guidance and should be implemented consistently.
- PCTs introducing visual acuity thresholds to restrict access to cataract surgery do so without being able to demonstrate that they will not harm patients, while it is clear that they will increase health inequalities of access across their populations.
- It is estimated that consistent application of the national cataract guidelines recently published by the Royal College of Ophthalmologists combined with a standardised cataract pathway have the potential to reduce the costs of cataract surgery by five per cent.
- Where PCTs consider cost saving measures in the area of ophthalmology they should be guided by the Royal College focusing on non sight-threatening eye diseases rather than restricting access to treatment that could result in people living with avoidable sight loss.

Call to action

We call on Commissioners to engage in a constructive dialogue with the Royal College and RNIB to review current and planned cataract policies and reverse those that are not in line with Action on cataract best practice guidance.

Most importantly, PCTs must refrain from trying to solve cash-flow problems by simply cancelling all cataract surgery in the run-up to a new financial year, in breach of their own cataract policy.

Patient stories

"For me it was a life-changing operation"

Norma Marriott, 64, from Dorset, had a detached retina in 2009 and developed a cataract as a result. Her sight deteriorated quite quickly and became extremely blurred. Initially, glasses and a contact lens helped but she became increasingly concerned about driving and walking down steps or on uneven ground. "I never realised how problems in one eye can affect your depth perception and make things like walking down stairs and many day-to-day activities really difficult."

Mrs Marriott was told that she could continue to drive but she started to avoid driving because of the restricted field of vision from not being able to see out of her left eye and also because she experienced glare. "Driving at night became quite frightening." Having the operation gave her back the life she knew, and that is why Mrs Marriott believes firmly that nobody should be denied the operation when they need it.

"I do need that second operation to retain my independence. I don't want to wait any longer"

Dennis Sleigh is a 69-year-old singer, song-writer and poet from Derby who had an early cataract in his right eye that was successfully removed. He has now developed a cataract in his left eye that causes him problems with glare when driving, and also when writing his songs and poetry. However, because the operation on his right eye was successful and his visual acuity in his second eye still appears to be good he has been told that he cannot have the cataract in his left eye removed.

"I have told them that I am struggling with my writing and with driving. I think that's what should count, not an artificial rule based on visual acuity. After all, there is all this talk about a patient-centred NHS. For me that means that they should fix my eye so I don't have to rely on other people for transport and I can continue doing what I love most."

2. Background

Benefits of cataract surgery to patients

In 2008/9 the NHS carried out approximately 330,000 cataract operations. The increase in surgery from approximately 201,000 in 1998/9 is likely to be a reflection of better access and the increase in the elderly population but also the widely recognised benefit surgery brings to patients (1).

Cataracts affect individuals in different ways. The impact on daily activities such as driving, undertaking work that requires fine detail or recognising faces will depend on the type of cataract and on the ability of the individual to adjust. For some people even a small change to their sight in one eye is a problem. Others take longer before they seek help.

However, large, well conducted observational studies consistently provide evidence for the clinical effectiveness of cataract extraction in routine practice, and demonstrable improvement in patient reported outcomes (in patients with and without additional ocular conditions) (2).

Importantly, this is not restricted to surgery in the first eye. Randomised trials and rigorously conducted observational studies provide evidence for the benefit of second eye surgery based on clinical and patient reported outcomes (3).

Crucially in terms of outcomes and costs for the NHS, patients who have early access to second eye surgery may experience fewer falls (18 per cent versus 25 per cent); and fewer fractures (three per cent versus 12 per cent) in the 12 months following surgery, compared to those who had routine second eye surgery at 12 months (4).

Cataract surgery has a low complication rate and is successful in 97 per cent of cases. Most of the complications experienced in three per cent of cases can be dealt with and usually do not affect sight in the long term (5).

It is important to note that access to cataract surgery is also a health inequalities issue and higher rates of cataracts have been linked with ethnicity and deprivation status. The former because of the link between cataracts and diabetes, which is more prevalent in Asian and African/African Caribbean populations (6). The latter because of the association between cataracts and lifestyles (smoking, obesity, diet) (7). Any cataract policy should therefore consider the impact on these population groups.

What current guidance says about eligibility criteria for cataract surgery

It is 10 years since the Government decided that a major effort was needed to ensure that eligible patients were able to access cataract surgery without experiencing undue waiting times. Up to that point it was not unusual to hear stories about people with cataracts waiting up to two years for an operation.

To address the problem with cataract waiting times the Government organised the Action on cataract campaign and issued good practice guidance (8) to improve access. This guidance establishes some straight forward eligibility criteria which, if implemented fully, should prevent situations where people experience falls, loss of mobility and independence, and a reduction in their quality of life due to operable cataracts. It should also ensure that people with cataracts do not undergo surgery unless it is necessary and the risk that is associated with any operation is justified.

In short the criteria are that a referral to a hospital eye clinic is appropriate if the person with a cataract:

1. has reduced vision from the cataract
2. experiences a negative impact on their quality of life (due to inability to drive or carry out day-to-day activities)
3. is in principle willing to have the cataract removed and aware of the risks involved, recognising that some people will need a detailed discussion with their consultant ophthalmologist before making a final decision.

These basic premises are explained in more detail in this and other guidance (including the Royal College of Ophthalmologists cataract guidelines (9) and the Department of Health commissioning toolkit for community-based eye care services (10)).

In addition, Action on cataract best practice guidance establishes that treatment of the second eye is included in the patient journey and second eye surgery should be scheduled within two to three months of the initial surgery to avoid the need for new glasses between operations and reduce the likelihood of deteriorating general health. As a rule, Action on cataract guidance recommends that an appointment for the operation on the second eye should be made at the post-operative review for the first eye. However, some patients may need their two operations much closer together if for example they have a large difference in visual acuity between the two eyes after the first operation (such as in the case of a very long or very short-sighted person).

Action on cataract did not establish a visual acuity threshold that patients should reach before they are eligible for treatment. The increasing number of PCTs that are introducing such thresholds are doing so without a robust evidence base. Therefore, PCTs imposing such restrictions cannot be sure that they are providing optimum care

or even protecting patients from avoidable harm. In fact it is clear that certain types of cataract can enable patients to read the eye chart without any problem, yet find that the cataract interferes significantly with their vision whilst driving – clearly a dangerous situation.

While we recognise that some PCTs introduce thresholds with numerous exceptions, for instance to cater for situations where a person with good visual acuity has problems driving, we believe that it is inappropriate to put a threshold in place that will act as a barrier to access to treatment since any patient with better visual acuity will first have to prove that they are an exception.

Evidence gathered for this report was used at an event in Parliament, when we raised our concerns with MPs and other decision-makers.

3. Balancing the books – are cataracts an easy target?

The cost-effectiveness of cataract surgery

We recognise the financial pressures that PCTs are currently experiencing due to the efficiency savings they are expected to make.

However, it is the Government's stated policy that cuts to frontline services should be avoided. Cataract surgery is a particularly inappropriate target due to the benefits to patients, demonstrated in section 2, and importantly, its proven cost-effectiveness.

A recent cost benefit analysis used the English Longitudinal Survey of Ageing (ELSA) to explore the self-reported effect of cataract operations on eyesight (11). The sample was drawn from previous respondents to the Health Survey of England in 1998, 1999 or 2001, and respondents were interviewed every two years in three waves between 2002–03 to 2006–07. The survey did not distinguish between first and second operations. The cohort included 4,308 people who provided complete records of their experience with cataracts in all three waves, together with records on their self-assessed eye-sight. Overall the results indicated that cataract surgery is good value in terms of benefits to costs.

"The average expected welfare gain from surgery is valued at £1,110 in the year after surgery costing £672, but the benefits probably continue for the whole of the patient's life. Only in the case of very elderly patients reporting excellent eye-sight ahead of surgery does it seem likely that the costs exceed the benefits. This finding does not rule out the possibility that some patients are operated on unnecessarily although these cannot be identified from ELSA. Identification of any such patients would, of course, be helpful but the magnitude of the average expected life-time gain in welfare relative to the cost of surgery suggests that, overall, the widespread provision of cataract surgery is easily justified (12)."

Similar results are suggested for second eye surgery. A cost-utility analysis using data and costs from the USA, reported that second-eye cataract surgery, at $2,727 per Quality-Adjusted Life Year (QALY) gained, seemed to be nearly as valuable as initial cataract surgery, at $2,023 per QALY gained. It concluded that patients with good vision in one eye and visual loss from cataract in the fellow eye derive substantial benefit from cataract extraction (13).

A more recent, smaller UK-based study including females of 70 years or over, with minimal dysfunction at baseline reported cost-effectiveness of second-eye cataract surgery in excess of the £20,000-30 000 threshold value used by NICE (at the time

of writing). However, in the longer term – that is, over the remaining lifetime of the women, surgery was shown to be cost-effective at a threshold of £20,000 from a health and social services perspective. Furthermore, the fact that the women studied had minimal dysfunction before surgery may suggest that at least some of them did not meet the Action on cataract criteria for surgery. They may not have reported significant benefits from surgery since they had not experienced any negative impact to start with.

Significantly, a recent survey of ophthalmologists conducted by the Royal College of Ophthalmologists for this report indicates that restricting access to cataract surgery can have unintended negative consequences for hospital trusts. Depending on the criteria used, restrictions can result in theatre lists having to be cancelled as fewer patients meet the criteria used, wasting valuable resources. At the same time, the restrictions are likely to result in excessive demand on services once the patients whose surgery has been delayed become eligible or restrictions imposed towards the end of a financial year are lifted. Unless patients have opted in significant numbers to seek private treatment or waiting times are so long that a large number of patients die before accessing surgery, restricting access may ease cash flow problems but it will not reduce overall costs. Furthermore excessive variations in the utilisation of services will create capacity and financial problems for Trusts.

Alternative solutions to improve efficiency that do not harm patients

We recognise the large number of operations that need to be carried out and the fact that the number has been increasing over the years due to the ageing of the population. However, this does not justify choosing high volume cataract services as an easy target for cuts to ophthalmology budgets.

The Royal College of Ophthalmologists has been working on proposals for efficiency savings under the Government's Quality, Innovation, Productivity and Prevention (QIPP) and Right Care agendas. The proposals are based on the following principles:

1. Prioritisation of pathways that prevent visual impairment over non sight threatening conditions.
2. User centred perspectives, improved patient journeys, access to services closer to home.
3. Clinical effectiveness and cost effectiveness but decreasing costs along with improved quality where possible.
4. Identifying and raising awareness of the need to target inequalities and high risk groups.

5. Developing community capacity whilst decongesting but also sustaining Hospital Eye Services, training and research.
6. The need to reduce variation in provision of care for longer term conditions (for example, New to Follow Up ratios) by developing locally agreed health economy protocols.

A full set of detailed proposals is likely to be published later in the year.

In relation to cataracts, the Royal College of Ophthalmologists estimates that consistent application of the Action on cataract criteria for cataract surgery, combined with a standardised cataract pathway, has the potential to reduce the costs of cataract surgery by five per cent.

To illustrate what a five per cent reduction means we have chosen a number of PCTs from across the country using population data from the Office for National Statistics (14) and NHS Atlas of Variation data on the rate of expenditure on cataract surgery per 1,000 population (15). This data illustrates the wide range of costs associated with cataract surgery in different parts of the country and in line with this variation the range of savings that could be achieved.

The potential for savings will obviously depend on the population profile and current referral practice. Where Action on cataract criteria are applied consistently and the level of unnecessary referrals is low Commissioners should accept the need to seek efficiency savings in other areas. The point is that savings in cataract surgery budgets should not be made by restricting access to treatment for patients who might suffer harm by having to wait for treatment. Also, in some PCT areas low cataract surgery rates may be a reflection of health inequalities (people from minority ethnic and low income communities, those with learning disabilities, people with dementia, and older people who are housebound not presenting for treatment) that should be explored and addressed as they may even require an increase in surgery, not a decrease.

Name of PCT and SHA	Population	Rate of expenditure per 1,000	Total	Five per cent potential savings
London				
Brent	255,000	£7,635	£1,927,000	£96,350
Kensington and Chelsea	169,000	£2,574	£435,000	£21,750
Kingston	167,000	£7,076	£1,181,000	£59,050
Sutton and Merton	398,000	£5,349	£2,130,000	£106,500

Name of PCT and SHA	Population	Rate of expenditure per 1,000	Total	Five per cent potential savings
South East				
Surrey	1.1 million	£5,881	£6,470,000	£323,500
Brighton and Hove	256,000	£4,024	£1,030,000	£51,500
South Central				
Hampshire	1.3 million	£5,900	£7,670,000	£383,500
Portsmouth City	203,000	£4,707	£955,500	£47,775
South West				
Devon	747,000	£4,636	£3,463,000	£173,150
Torbay	134,000	£3,925	£526,000	£26,300
East of England				
Norfolk	757,000	£5,042	£3,817,000	£190,850
Peterborough	171,000	£4,585	£784,000	£39,200
West Midlands				
Heart of Birmingham	280,000	£5,009	£1,402,000	£70,100
South Staffordshire	609,000	£2,873	£1,750,000	£87,500
East Midlands				
Derbyshire County	726,000	£4,865	£3,530,000	£176,500
Nottingham City	300,000	£3,895	£1,170,000	£58,500
Yorkshire and Humber				
Calderdale	201,000	£3,571	£718,000	£36,900
Leeds	787,000	£4,590	£3,612,000	£180,600
North West				
Manchester	484,000	£3,566	£1,726,000	£86,300
Warrington	198,000	£3,307	£655,000	£32,750
North East				
County Durham	506,000	£4,024	£2,036,000	£101,800
Hartlepool	91,000	£3,830	£348,000	£17,400

4. Examining the variations in cataract policies across England's PCTs

As the table in the previous section illustrates, current spending on cataract surgery and the associated potential for savings vary considerably from PCT to PCT. To gain a full picture of the way cataract surgery is currently being dealt with at local level we issued a Freedom of Information request to all PCTs in England asking them to tell us what, if any, policies they have put in place to control access to cataract services.

We received responses to our request from 133 PCTs. We grouped the responses received into three different groups: green, red and grey.

Green group

- No policy. Clinicians decide in discussions with their patients whether an operation is needed or
- A policy applying the Action on cataract criteria without a visual acuity threshold.

Red group

- Any threshold in first or second eye.

Grey group

- No policy but work on policy underway or planned.
- Review of policy underway.

Out of the responses received 56 were green (42 per cent), 70 red (53 per cent) and 7 were grey (five per cent). Interestingly, none of the policies we received included an impact assessment to ascertain whether the thresholds they established were likely to lead to increased health inequalities.

5. Policies versus reality

To interpret this information we checked whether there was an association between cataract treatment rates and restrictive or non-restrictive policies. The Atlas of Variation issued in January 2011 shows considerable variation in the provision of cataract surgery services across England. The period covered is 2008/9 and at the time the lowest rate of cataract surgery was in North Staffordshire with, on average, 28.5 out of every 10,000 people having a cataract operation. The highest was in Newham where 80.4 in every 10,000 people had a cataract operation.

Our responses suggest that the policies in place do not always correspond with respective higher or lower rates of surgery. For instance NHS Kensington and Chelsea have one of the lowest surgery rates in England (28.8 operations per 10,000 population) yet their policy is rated green. This is probably a reflection of the affluence of the population and correspondingly higher up-take of private treatment.

At the other extreme, Waltham Forest has a policy that is labelled as red with a cataract surgery rate of 77 in every 10,000 people. In this case, the policy may be restrictive but still result in high up-take simply because there are more people with cataracts from ethnic minority populations.

While local population profiles (age, ethnicity and deprivation) will impact on cataract surgery rates it is interesting to note that out of the 10 PCTs with the lowest surgery rates seven had red policies, one was under review and only two were green. Out of the 10 PCTs with the highest surgery rates two had green policies, two had red policies, one was reviewing its policy and the remaining five did not respond to the Freedom of Information request.

Since it was not possible to judge from this data whether low surgery rates are a result of restrictive policies or of local population profiles the Royal College of Ophthalmologists decided to conduct an online survey of its consultant ophthalmologist members working in England to obtain further information about the situation in different parts of the country.

The online survey took place between 4 and 8 April and contained three questions about cataract surgery. Responses were received from 111 PCT areas. (See Annex 1 for combined results of Freedom of Information request and RCOphth survey).

1. Restrictions to cataract surgery

Question: Have commissioners in your area placed any restrictions on who can be listed for cataract surgery? If yes, please give details.

Number of responses: 242
Yes: 55.6 per cent
No: 44.4 per cent

2. Representations to Commissioners

Question: Have you made any personal representations to commissioners on behalf of patients who are not eligible for cataract surgery because of such restrictions?

Number of responses: 219
Yes: 20.1 per cent
No: 79.9 per cent

3. Patients being disadvantaged by restrictions

Question: Have you encountered any situations where, in your opinion, a patient has been disadvantaged because of restrictions on cataract surgery?

Number of responses: 231
Yes: 38.1 per cent
No: 61.9 per cent

In addition to simple "Yes/No" answers, respondents were able to leave comments. This has allowed us to provide a more precise interpretation of the results. Additional comments were received from 47 PCT areas. Comments from 33 areas described the impact these restrictions were having on patients and hospital eye services. Comments from five areas suggested that it was too early to judge the impact of restrictions that had come in at the beginning of the financial year (2011/12) and comments from nine areas stated that policies were under review or that restrictions had been proposed.

The description of restrictions and their impact can be grouped as follows:

Cashflow

- All cataract operations stopped in the run-up to the new financial year, in one instance from October to March.
- Patients booked for surgery, which was delayed. They were then told that they no longer qualified.

- Several patients opted for private treatment because they were no longer willing to wait for surgery.
- Cataracts were temporarily classified as procedures of limited clinical value causing the hospital to discontinue one-stop direct referral cataract clinics because of uncertainty about the new rules. This policy was lifted in April 2011.

Reduction in number of referrals

- Number of referrals reduced due to use of point scoring system.
- Attempts to impose minimum waiting time and bar smokers from treatment unless they have completed a smoking cessation course.
- Stated PCT objective to reduce cataract surgery activity by 514 cases per year.

Capacity

- Theatre lists being cancelled due to reduced numbers creating inefficiencies and risking under-capacity in the future when delayed patients become eligible for treatment.
- Patients having to return several times to hospital to establish whether they have reached the treatment threshold causing frustration and waste of resources.

Driving/work

- Non-drivers being denied surgery.
- Commissioners questioning "difficulty driving" as a justification for surgery.
- A patient who needs to drive for his job was denied surgery although he experiences glare and can no longer drive in the evening during the winter.
- Patients denied surgery despite problems with driving or with their favourite pastimes.
- A patient being denied surgery even though his job as a forklift driver was at risk.
- A patient being denied surgery although he needs good sight in his job as a welder.

Second eye surgery

- Patients being denied second eye surgery because their binocular vision is "too good".
- Patients being denied second eye surgery even though they have suboptimal binocular vision.

Management of additional eye conditions

- A patient being denied surgery even though this jeopardised his treatment for another eye condition (uveitis).
- A patient with diabetes being denied surgery despite having a cataract that makes it difficult for his consultant to check his retina for signs of diabetic retinopathy.

Other

- Restriction on choice of provider.

6. Don't turn back the clock – our call to action

"They are asking us to turn back the clock to the '60s". (Comment received in response to the RCOphth cataract survey)

This report demonstrates the impact that the efficiency savings expected from the NHS has had on the provision of cataract surgery in England. The introduction of a wide variety of different treatment policies has added another layer to the already complex picture of variation in cataract surgery rates that is partly due to different population profiles (variations in age, ethnicity and deprivation).

Where previously best practice has been to focus on the impact a cataract has on a patient's quality of life, policies are now being introduced that are not evidence-based, causing problems not only for individual patients but also for hospital eye clinics.

As organisations representing patients and clinicians, we believe that Commissioners must not abandon evidence-based medicine to achieve the efficiency targets they have been set. Instead they should work with clinicians and patients to identify ways of improving productivity so that the growing number of people with cataracts can expect to access surgery when they and their consultants agree it is necessary.

The Royal College proposals to improve ophthalmology services in line with the QIPP agenda should be used as a basis for commissioning decisions.

We call on Commissioners to engage in a constructive dialogue with the Royal College and RNIB to review current and planned cataract policies and reverse those that are not in line with Action on cataract best practice guidance.

Most importantly, PCTs must refrain from trying to solve cash-flow problems by simply cancelling all cataract surgery in the run-up to a new financial year, in breach of their own cataract policy.

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8. About us

RNIB

RNIB is a membership organisation with over 10,000 members who are blind, partially sighted or the friends and family of people with sight loss. 80 per cent of our Trustees and Assembly Members are blind or partially sighted. We encourage members to be involved in our work and regularly consult with them on Government policy and their ideas for change.

As a campaigning organisation of blind and partially sighted people, we fight for the rights of people with sight loss in each of the UK's countries. In addition, under our Royal Charter, we are committed to preventing avoidable sight loss and this is one of our three priorities under our current strategy (2009-2014). It is in this context that we have joined the Royal College of Ophthalmologists in a campaign to tackle unjustified restrictions to access to cataract surgery in England.

Royal College of Ophthalmologists

The College is a charity set up by Royal Charter to champion excellence in the practice of ophthalmology for the benefit of patients and the public. We are also the professional association for 4,000 eye doctors.

We set the examinations and the curriculum for medical graduates who wish to be eye surgeons and we provide elements of surgical skills training.

We set the standards for professional practice through clinical guidelines and ophthalmic service guidance. The continuing professional development (CPD) programme is designed to help ophthalmologists maintain and increase their knowledge and expertise.

We have a role in promoting ground-breaking research; we organise a seminar programme and an annual scientific congress and produce the scientific journal, EYE, to disseminate that research.

We are also a member of VISION 2020, an umbrella group of organisations across the ocular section, which strives to eliminate avoidable sight loss by the year 2020.