The Royal College of Ophthalmologists
Cataract surgery: current limitations to patients accessing treatment

The Royal College of Ophthalmologists (RCOphth) has undertaken a survey of ophthalmic clinical leads to understand how the current situation of visual acuity thresholds and other imposed restrictions are affecting access to cataract surgery.

Summary

- Of 140 leads contacted in England and Northern Ireland, 87 replied, a response rate of 62%[1]
- 66% of responding eye units confirmed restricted access to surgery
- For access to first eye surgery:
    - approximately 34% of eye units have no restriction to access
    - 62% of eye units have thresholds of moderate visual acuity[2] reduction (vision of 6/9 or 6/12 or worse)
    - 4% of those clinics surveyed have thresholds of marked acuity reduction that is 6/18 or worse
- For second eye surgery
    - the access requirements are often stricter and further restrict those in need of cataract surgery
    - approximately one third of eye units have no restriction
    - 45% have thresholds of moderate acuity reduction but for 20% of units there is a requirement for marked visual acuity reduction (6/18 or 6/24 or worse)
- 73% of units have no specific monitoring of adherence
- In 22% of units, clinicians are required to fill in a short form usually with tick boxes for each criterion
- In 5% of units, clinicians use lengthy individual funding request[3] (IFRs) forms which is estimated to be affecting thousands of patients' access to surgery
- 20% of units have no alternative access route to offer surgery to patients who do not meet the restriction criteria
- Of the 80% who do have alternative routes, two thirds are simply based on other symptoms or clinical requirements (such as glare, inability to work or drive, surgery needed to manage other conditions eg glaucoma or diabetic retinopathy screening)
- There was considerable feedback in the survey that any monitoring or refusal by CCGs was minimal and that most patients who required surgery did obtain it once the process had been followed

Conclusions

- These findings show that the majority of units are being asked by commissioners to restrict access to surgery based on visual acuity thresholds
- The use of criteria is variable and seems to have no clear logic behind it

- The survey supports the view that clinicians are already having appropriate, shared decision-making discussions with patients and are not over providing surgery to patients with minimal visual effects or symptoms
- Whilst most patients who required surgery did obtain it once the process had been followed, the imposed use of IFR forms adds an additional burden to the already stretched hospital eye services

This survey provides evidence that the use of visual acuity restrictions to access cataract surgery places an unnecessary burden on the NHS, creates barriers for patients and clinicians and is not justified as the restrictions do not seem to achieve the aim of limiting surgical numbers. The results of the survey provide a baseline for comparison as we determine how well commissioners take up the recommendations of the new NICE guidelines.

Working together to achieve the best outcomes for patients and the NHS
As demand for surgery is predicted to rise by 25% over the next 10 years and by 50% over the next 20 years, it is crucial that commissioners act now to ensure sustainable and equitable cataract services. The RCOphth wishes to work actively with commissioners and providers to ensure optimum use of resources.

Download the full report

Notes

1. Data has been rounded up
2. Visual Acuity Explained
   As a simple guide, we refer to the standards for driving. The minimum eyesight standard for driving is to have a visual acuity of at least decimal 0.5 (6/12) (with glasses or contact lenses, if necessary) using both eyes together or, if you have sight in one eye only, in that eye; and have an adequate field of vision.
   https://www.gov.uk/driving-eyesight-rules
3. Individual funding request forms (IFRs) can be made by a clinician (doctor or other health professional) if they believe that a particular treatment or service that is not routinely offered by the NHS is the best treatment for the patient, given individual clinical circumstances