Cataract Referrals and Professional Liability – Optical Confederation Guidance

PCTs in England have recently been imposing blanket visual acuity thresholds on referrals for cataract surgery despite a Ministerial Statement that such bans should have been discontinued from March 2012.[1]

Blanket thresholds are clinically inappropriate and have been an issue of concern for optometrists, optical practices and ophthalmologists as well as patients and their families.

As a result the Royal College of Ophthalmologists, the College of Optometrists, the Optical Confederation, and LOCSU have issued a statement to clinicians, commissioners, government and the public. The joint statement is reproduced at Annex 1.

This additional Optical Confederation guidance is intended to support optometrists and optical practices in fulfilling their professional and statutory duties in the interests of patients in line with the joint statement.

Professional Duty

The General Optical Council Codes of Conduct for individual and business registrants make clear that registered clinicians and practices must "make the care of the patient [their] first and continuing concern".[2] This duty is absolute and clinicians must always do what they feel is in the best interests of the individual presenting patient.[3]

As far as referrals are concerned, the NHS General Ophthalmic Services Contract Requires practices "to have regard to all relevant guidance issued by the PCT".[4] This of course means simply to "have regard to" but not "to follow slavishly" in all circumstances.

It is the circumstances of the individual patient that are paramount.

Referrals

Clearly it would not be sensible to refer a patient who was obviously outside locally agreed referral guidelines unless there was an exceptional reason for intervention in their case. The last thing anyone wants is patients being required unnecessarily to attend hospital only to have their case rejected, when it was quite clear that there were no exceptional circumstances to justify a referral in the first place.

In the case of cataract surgery, the attached statement recommends that clinicians should always refer or accept patients for treatment on the basis of

- functionality and impairment to tasks of daily living
- the patient's fitness and willingness for surgery.

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[1] Andrew Lansley takes firm action to protect patient choice, Nov 14 2011. http://mediacentre.dh.gov.uk/2011/11/14/andrew-lansley-takes-firm-action-to-protect-patient-choice/

[2] GOC Code of Conduct for Individual Registrants http://www.optical.org/goc/filemanager/root/site_assets/codes_of_conduct/code_registrants.pdf

[3] See also College of Optometrists *Code of Ethics and Guidelines for Professional Conduct* and the ABDO *Advice and Guidelines*

[4] *NHS England General Ophthalmic Services Contract Regulations (2008)* Regulation 53 and *General Ophthalmic Mandatory Services Model Contract* and *General Ophthalmic Mandatory Services Model Contract (*2008) Clause 100

Good Practice

In a clinically-led and patient-focussed NHS as the government intends, it is good practice for referral guidelines to be agreed locally between hospital clinicians, community optometrists and optical practices via the Local Optical Committee and commissioners. These should be on the basis of the statement in Annex 1 and not on the basis of visual acuities alone. Visual acuities are only one indicator (albeit an important one) of the need for cataract surgery.

Referring optometrists and practices should then abide by those local guidelines unless there are exceptional circumstances which would indicate the need for surgery for example where a patient falls the wrong side of the local threshold, her vision cannot be improved by vision correction and her quality of life and daily living is affected.

As always the referring optometrist should note in the referral letter why, in such a case, the patient is being referred outside the locally agreed guidelines.

If the receiving ophthalmologist then considers that the patient should not undergo surgery, that is a legitimate clinical decision, however this should be on the basis of the patient's individual circumstances and clinical need, not on the basis of a blanket threshold.

Advice

Adherence to this advice should ensure that

- the maximum number of patients benefit according to clinical need and priority
- clinicians are practising safely within clinical guidelines, their professional codes of conduct and the legal requirements of their NHS contracts.

Optical Confederation
August 2012

Annex 1

Monday 13th August 2012

Royal College of Ophthalmologists, College of Optometrists, Optical Confederation and Local Optical Committee Support Unit issue joint statement on cataract surgery

London, August 13 The Royal College of Ophthalmologists, College or Optometrists, Optical Confederation and LOSCU have expressed their concern over reports that patients in more than half of PCTs in England are being denied cataract surgery unless their ability to read the optometrists' test chart (visual acuity) falls below a certain level - by which time they might not be able to lead their normal lives. In addition, there are reports that patients with cataracts in both eyes are being told their PCT will only treat one, despite substantial evidence in favour of treating both[1]. Therefore, they have urgently issued the following joint statement:

We strongly advise that it is clinically unsound to determine access to cataract surgery on the basis of visual acuity alone. Patients should be offered treatment for cataract if:

- **cataract is adversely affecting their daily living;**
- **they fully understand the risks and benefits of surgery; and,**
- **they want to have, and are fit enough, for surgery.**

We urge commissioners, clinicians and patient groups to work together to implement this advice as a matter of urgency.

Context for the advice

The bodies issuing this statement support the Department of Health's strong stance against rationing access to cataract surgery through blanket visual acuity criteria, which ignore patients' individual circumstances, such as the impact on their ability to work, drive or look after themselves.

Despite the commitment by Secretary of State for Health, Rt Hon Andrew Lansley MP to ban "caps on operations that do not take account of the healthcare needs of individual patients" by March 2012[2], new evidence shows that many commissioners are still imposing unfair restrictions on cataract surgery[3,4]. This is not clinically justified. Visual acuity is just one symptom of cataract. Measuring visual acuity is only part of an assessment of visual performance and does not take into account other elements that impact on the quality of life of patients. Patients with cataract can experience other serious symptoms, such as double vision or disabling glare from lights, even though their visual acuity is relatively unaffected. These symptoms have a serious impact on patients' quality of life and they need access to treatment.

Second eye surgery

We are also concerned by reports that patients with cataracts in both eyes are being told their PCT will treat only one, despite substantial evidence in favour of treating both. Unless both eyes are treated, patients lose their ability to judge distances so it is more likely they will suffer accidents. Health Minister Simon Burns MP has rightly branded such blanket restrictions that ignore clinical judgements as "unacceptable"[5].

We understand the financial pressures the NHS faces but cataract surgery is a highly cost effective treatment that improves sight loss and preserves patients' ability to live independent lives. Using visual acuity thresholds to impose limits on cataract surgery is economically counterproductive when it leads to higher health and social care costs because patients' vision deteriorates. For example, a driver with a cataract that makes them very sensitive to glare might have to stop working before they

reach the visual acuity threshold. An older person with reduced vision from cataract is more likely to fall and cataract surgery can reduce falls[6].

NHS best practice tariff

Best practice tariffs are one way for the NHS to improve quality, by reducing unexplained variation and making best practice universal. Our advice, including allowing for second eye surgery, is consistent with the NHS best practice tariff for cataract surgery[7].

Access to cataract surgery and patient-centred care

The "no decision about me without me" principle means patients should have the opportunity to discuss the pros and cons of surgery with a health professional. Visual acuity thresholds prevent many patients who could benefit from treatment reaching a shared decision about their care.

Further information and contacts

NHS Choice has helpful information on cataract surgery: http://www.nhs.uk/conditions/Cataract-surgery/Pages/Introduction.aspx

NHS Direct has produced a decision aid to help patients decide if they want to proceed with cataract surgery, which is available from their website:
https://www.nhsdirect.nhs.uk/DecisionAids/PDAs/PDA_Cataracts.aspx

A Cochrane review into further evidence for second eye cataract surgery is underway and should report by the end of 2012.

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[2] Andrew Lansley takes firm action to protect patient choice, Nov 14 2011. Available from http://mediacentre.dh.gov.uk/2011/11/14/andrew-lansley-takes-firm-action-to-protect-patient-choice/

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[4]GP. Exclusive: 90% of PCTs are now rationing care, available from http://www.gponline.com/channel/news/article/1136671/exclusive-90-pcts-rationing-care/

[5] Mr Simon Burns MP. Simon Burns: PCT rationing is 'unacceptable' - 19 June 2012, available from http://www.simonburnsmp.com/index.php?option=com_content&view=article&id=400:simon-burns-pct-rationing-is-unacceptable-19-june-2012&catid=34:latest-press-releases&Itemid=53

[6] The College of Optometrists and the British Geriatric Society. The importance of vision in preventing falls, available from http://snipurl.com/244ko2a. 2011

[7] Department of Health. Confirmation of Payment by Results (PbR) arrangements for 2011-12.