

NEWSLETTER

Question Time

AOO to hold the third of its question time series at UKISCRS, Leeds



The AOO is proud to announce that the next in its question time series will be on the very topical issue of "Quality & CQC-What will it mean for you?" by Baroness Barbara Young, the Chairman of the Care Quality Commission, with opportunities for questions from the audience.

We look forward to welcoming you at 17.20 hours on Thursday 8th October at the Bury Theatre Royal Armouries, Leeds.

DILEMMAS FOR THE MODERN OPHTHALMOLOGY TRAINEE

'Phaco surgeon' or "more-than-phaco surgeon"?

Most school careers departments offer courses, books, and lectures to students about potential vocations. Many medical schools stage careers fairs, where senior medical students learn the pros and cons of various medical careers.

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Dear Colleagues

It gives me great pleasure to write to you to introduce our latest AOO Newsletter. As you can see this edition covers a range of different subjects of importance to all of us in one way or another.

The NICE Glaucoma Guidelines have arrived this year and due to the referral criteria have already led to many patients arriving in our clinics without detectable disease. One of our articles analyses the implications of this document.

The article 14 approach to achieving CCT is discussed in the context of a new type of post in Gloucestershire.

The changes taking place in the independent sector are highlighted. Not only how insurers and hospitals are behaving but also the result of the Cooperation and Competition Panel review of conflict of interest between NHS consultants and their Trusts.

Finally and possibly most importantly, the issue of clinicians taking destiny into their own hands by becoming leaders in management in hospitals. It seems we should be able to do a better job than professional managers.

Over the next year or so profound changes will take place in your lives as enhanced appraisal and re-validation are rolled out. Inherent in this will be quality in the way you practice and how it is measured. For those of you attending the UKISCRS meeting we shall be hearing from the Care Quality Commission about this issue.

The AOO is here to be your representative in ways that the RCO cannot. However we are nothing without your support. If you are not already a member please fill in the form attached to this newsletter.

With best wishes

Richard Packard
Chairman of AOO

LEADERSHIP BY CLINICIANS: THE KEY TO MAKING THINGS BETTER

Management in relation to healthcare is a concept, which has been featuring very prominently in recent public-sector reform efforts in the UK and as clinicians we have become increasingly aware of the need to formally develop these skills. Traditionally, however many clinicians have been content with their management responsibilities being confined to "clinical management".

Whilst clinicians may have representation in the Executive and Non-Executive management teams of the Hospital, their proportional representation remains small. It is therefore of particular interest that a new research conducted jointly by McKinsey and the London School of Economics and Political Science (LSE) points to a link between key management practices, on the one hand, and better health care and higher hospital productivity, on the other. The study, based on an assessment of 126 Hospitals (104 NHS & Foundation Trusts and 22 private hospitals) across the UK, strongly suggests that improved operational effectiveness, performance management, and talent management are associated with lower rates of infections in hospitals, lower readmission rates, more satisfied patients and more productive staffs, and better financial margins. Moreover, the study indicates that stronger leadership by doctors in the way hospitals are managed could play a particularly significant role in improving them.

The joint McKinsey-LSE research, which sought to explore the drivers of productivity in the field of health care delivery involved interviewing 170 general managers and heads of clinical departments about whether and how they have implemented a number of proven management practices in their hospitals. The hypothesis that the direct involvement of doctors in the management of a hospital helps to improve its performance was examined by way of "double blind" interviews, whereby neither the interviewer nor interviewee knew what hypothesis were being tested. Good, average and poor practices for 27 dimensions of management across four categories were defined. These four categories were: Lean management (a hospital's operational effectiveness), performance management, talent management (the recruitment, development, rewarding, and retention of high-performing staff), and clinical leadership.

The study identified a considerable gap between the management scores of NHS hospitals and those of private hospitals and UK industrial companies. This gap was larger in the performance management scores, primarily because NHS facilities tend to focus on a narrower set of short-term measures and largest in managing talent.

A clear association was detected between the level of involvement of doctors in running the business side of their hospi-

tals, lean management and performance management. Furthermore, hospitals whose general managers have a clinical background had overall management scores higher than other hospitals.

The above suggests that helping clinicians become better leaders, should improve the overall management of NHS hospitals, which would reflect in the quality and productivity of health care provided. Good practice in talent management i.e. proactively, identifying top talent, nurturing it, retaining high performers, and, shedding low performers are areas where NHS hospitals can improve on by looking at the private-sector hospitals or industry.

This should serve to encourage ophthalmologists to reaffirm their desire to further develop their management skills and actively engage the support of their NHS Trust in doing so, so that they can assume a more influential role in the management of their local eye services. As a stepping stone in this regard the establishment of local eyecare groups of interested stakeholders is a first and important move.

Reference

Castro PJ, Drogan SJ, Richardson B. A healthier healthcare system for the United Kingdom. *Mckinseyquarterly.com*, February 2008.

Hooman Sherafat
Editor of AOO Newsletter

RESPONSE TO NICE GLAUCOMA GUIDELINES

The Association of Ophthalmologists (AOO) welcomes NICE Guideline 85, on the Diagnosis and Management of Chronic Open Angle Glaucoma (COAG) and Ocular Hypertension (OHT).

We note in particular the following Key Priorities for Implementation:

1. At diagnosis of OHT or COAG, all patients should receive:
 - a. Corneal pachymetry
 - b. Gonioscopy
 - c. Optic nerve head imaging

2. At follow up visits, the following should all be available to the clinician:
 - a. Previous notes and tests
 - b. Previous images

In addition, we note the public information document, which details to patients the tests which they should receive, as well as a number of questions, which they should, rightly, expect to be able to talk about at each visit. We agree with the above-mentioned Key Priorities for Implementation for diagnosis and monitoring of these conditions, which now set out best practice in these areas, and we feel that a service, which is able to achieve these KPIs, will better serve our patients with OHT or suspected or actual COAG.

However, we are concerned that the NHS will not be able to meet these KPIs without a substantial increase in funding to NHS eye departments. We hypothesize that, due to overbooked clinics reducing time available with each patient, poor access to equipment such as pachymeters and gonioscopes (especially in outreach or community clinics), poor access to optic nerve head photographs in clinic (either in hospital notes or on networked computers next to doctors' slit-lamps, where they exist), and frequent outpatient visits where the notes are missing, the standard of care required will simply not be possible without a large increase in investment to hospital eye clinics and their community counterparts. We set out here some more details on areas of particular concern.

1. Gonioscopy

A. *Gonioscopy quality and availability*

It is generally acknowledged that gonioscopy is under-performed, and this has also been found in the United States where, in a rare study published on this topic, almost 50% of patients with COAG failed to receive this assessment at presentation.¹ Clearly, if all UK patients referred to busy NHS clinics with OHT or possible COAG are now to receive this test, then each doctor in eye clinic needs instant access to a gonioscope, rather than having to go and search around the clinic for one. Based on our collective experiences, this will require a large increase in the number of gonioscopes available in NHS eye clinics. Furthermore, we are aware of eye units, which do not possess the more expensive 4-mirror style indenting gonioscopes. Without these lenses, doctors assessing closed iridocorneal angles will be unable to differentiate between appositional and synechial angle closure. Provision of such gonioscopes in adequate numbers will be mandatory if NHS eye departments are realistically expected to comply with this aspect of the Guideline.

B. *Provision of care as it relates to gonioscopy*

The Guidelines rightly suggest that patients with OHT and suspected or actual COAG will be looked after by a variety of health care professionals, both in the community and, where relevant, in a hospital eye clinic. But the Guidelines state further "diagnosis [of OHT or COAG] by healthcare professionals other than ophthalmologists could be cost-saving" (section 10.3.5). Given that diagnosis requires performing and interpreting the large range of tests mentioned in the Guideline, the implication is that those tests would also be performed and interpreted by healthcare professionals other than ophthalmologists, in the interests of cost saving.

The emphasis on gonioscopy is clearly aimed at detecting angle closure, and the Guideline refers frequently to gonioscopy being used to check that the angle is open.

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RESPONSE TO NICE GLAUCOMA GUIDELINES
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We appreciate that the Guideline itself concerns primary open angle glaucoma rather than secondary glaucomas. But during the Provision of Care discussions, which touch on non-ophthalmological health care professionals diagnosing these conditions, the Guideline fails to make clear that in patients with raised intraocular pressure or glaucomatous optic nerve damage, assessment of the iridocorneal angle should absolutely not be limited to deciding whether or not the angle is open.

In the hypertensive eye, pathologies such as angle recession in eyes with previous trauma, trabecular hyperpigmentation in eyes with pigment dispersion, angle neovascularisation in eyes with previous retinal vein occlusions, or Sampaolesi lines in eyes with pseudoexfoliation are all important gonioscopic signs which add to the clinical picture and further inform diagnosis. Familiarity with these and other important, but not necessarily common, gonioscopic pathologies are usually accrued over many years of training in hospital eye services. Importantly, much of the above-mentioned gonioscopic experience is gained through the management of patients whose primary presentation was totally unrelated to raised intraocular pressures (for example, noting angle recession when assessing ocular trauma in eye casualty), and who therefore are only likely to have been seen by ophthalmologists. The AOO does not, therefore, see it as currently likely that healthcare professionals other than ophthalmologists would become skilled or experienced enough in gonioscopy to safely be able to reach diagnostic decisions in such patients – unless large changes are made to the structure, location, and length of training of non-ophthalmological healthcare professionals.

1. Optic Nerve Head imaging

While many new optic disc imaging modalities have been developed in recent years, and continue to evolve rapidly in design and performance, the technology of optic nerve photography has been here for decades, and will continue to be so. The doctor seeing a new patient with glaucoma today is wise to record photographs of the disc, so that another doctor seeing that nerve in 25 years' time can have an idea of what it used to look like today. But when monitoring patients with glaucoma, doctors should be able

to bring up optic nerve images from previous visits on a computer next to their slit-lamp. This facilitates comparison with more recent photographs, allows the patient to see their nerve, and quickens the photographer's list by not requiring printing of every image. We hypothesize that very few NHS eye clinics currently have computers by each slit-lamp, which are networked to the clinic's image database so that doctors can easily view and compare previous optic nerve images.

2. Outreach clinics

Many NHS eye units run clinics in community hospitals, in order to prevent excessive patient travel. We are concerned that, where new patient referrals are accepted, many such 'outreach' clinics are poorly equipped with facilities for optic nerve imaging, gonioscopy, and corneal pachymetry.

3. Availability of previous notes, test results (eg. perimetry) and images

According to recent estimates, some 1.2 million patients are seen annually in the UK without their notes; the National Patient Safety Agency received almost 40,000 incident reports in 2007 regarding inadequacy of hospital notes.² Unfortunately, many NHS Trusts now encompass several sites or hospitals, and appear to have difficulty in arranging for all notes to be available to doctors seeing patients in clinic across different sites. This is clearly a long-standing problem, and inherent with paper notes. Following years of delay and uncertain efficacy of specialist clinic implementation, eye doctors and eye departments are not expecting the NPfIT project to deliver a decent outpatient ophthalmic record system. But many eye departments are still being told they cannot purchase third party patient record software because of the pending national IT programme changes. Unless hospital eye units are now given permission and funding to invest in some of the many dedicated ophthalmic electronic patient record systems on the market, the service's ability to comply with those parts of the Guideline dealing with monitoring and follow-up will be severely compromised owing to frequent absence of hospital notes.

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DILEMMAS FOR THE MODERN
OPHTHALMOLOGY TRAINEE:
"PHACO SURGEON" OR "MORE-THAN-PHACO
SURGEON" continued from front page

But as the specialties themselves become more subspecialised, I argue that formal careers advice and support is just as important for the specialty trainee, who may be struggling to decide which, if any, subspecialty to aim for – often at an age where heightened family responsibilities make geographically peripatetic training an extremely demanding affair.

The increasing sub-specialisation of ophthalmology, combined with expanding volumes of specialty operations, has led to interesting developments for current consultants (for example, some subspecialists giving up cataract surgery). But the impact of these changes on modern training is perhaps more profound. Many current senior consultants were trained to become competent in a wide array of surgical procedures. Some may still perform cataract extractions, trabeculectomies, pterygium excisions, squint repairs, and ptosis surgery all on a day's list. Despite increasing overall numbers of some such operations, a similar situation is difficult to foresee in the future, for a number of reasons.

First, Modernising Medical Careers and the European Working Time Directive have significantly reduced the total number of hours' training received before becoming a consultant. Second, many new trainees find it difficult to gain experience in anything other than cataract surgery. Particularly in tertiary centres, it is no longer the case that ophthalmology registrars can expect to be trained in techniques such as penetrating keratoplasty, strabismus surgery, filtration surgery, or basic vitreoretinal techniques. Third, patient expectations and litigation

risks in the NHS have increased significantly in recent years, and there may be a feeling among some consultants that complications arising from trainees' operations may be medicolegally indefensible if it later transpired that the trainee had not harboured a strong interest in pursuing that specialty. Fourth, the advent of Payment by Results, together with the 18 week target, has led to a strong managerial drive to increase tariff income by increasing the number of operations carried out per unit time. Since the training of junior surgeons is more time-consuming, it has become a low priority for departmental managers who are struggling to break even and meet government targets. Finally, certain Royal Colleges have begun to suggest minimum numbers of operations that should be carried out per year in order for a surgeon to acceptably continue to perform them. Surgeons in more rural areas may therefore be required to refer all patients needing less common operations to subspecialist surgeons.

It is foreseeable then, that the product of pre-fellowship specialty training in ophthalmology will essentially be a cataract surgeon, and that small district general hospitals are staffed by surgeons who are only able to offer cataract surgery and 'minor' procedures. Other operations would require patients to travel greater distances to tertiary centres, albeit to see surgeons more experienced in those procedures. But if this scenario evolves as anticipated, then decisions about which subspecialty to choose – if any – will become both more important and more difficult to make. Thus, it may be just as important for the modern ophthalmology trainee to have constant access to sound and unbiased careers advice as it is for the school leaver, medical student, and house officer.

Anish N Shah
Secretary of AOO

TRENDS IN INDEPENDENT PRACTICE:
RECENT CHANGES - NOT ALL FOR THE BEST

Senior consultants look back with nostalgia to a simpler age of private practice when they worked as sole traders at relatively unrestricted but acceptable and accepted fees and without interference from regulators or insurers. The young consultant now feels so hemmed in on all sides that private practice is losing its attraction. What has changed?

Regulatory: There is increasing regulation both from the Care Quality Commission and the GMC. Hospital practising privileges, once simply granted

by the MAC and hospital manager, are now a constant hassle with extensive documentation such as CRB, clinical assessments and appraisals all being required and renewable at frequent intervals.

Revalidation is looming and will certainly add a cost and complexity to private practice. The majority of consultants have an NHS attachment and will come under the purview of their Trust Responsible Officer for Revalidation but they will need to bring to this person all their private practice data from every hospital they work in.

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TRENDS IN INDEPENDENT PRACTICE

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Independent consultants will report to a Responsible Officer in their main private hospital or group. Specialty driven and strengthened appraisals will be required and organisations like FIPO (Federation of Independent Practitioner Organisations) are planning to provide this service for hospital based private consultants.

Acute Independent Hospitals: When Barbara Castle attacked private practice by attempting to close NHS private wings it led, paradoxically, to a boom and many more independent hospitals. Patients had increased access and consultants were seen as customers by the hospital and enjoyed freedom from NHS demands. In recent years the private equity purchase of certain groups has led to various cutbacks by hospitals culminating this year in BMI and Nuffield Hospitals reducing fees for radiologists. This is the first time such a strategy has been enforced and is a reflection of what may happen if a specialty or a group of consultants are packaged by the insurer in to the hospital charge. Anaesthesia would be a prime target but so far, despite some backroom proposals by insurers to hospitals this has gone nowhere. Hospital groups are increasingly wary of other competitors and have attempted to lure in consultants with financial inducements. Some find this strategy disconcerting particularly if it becomes interwoven with specific care pathways. Another trend is for consultants to become involved in hospital development, a policy that has brought some in to direct conflict with established hospitals.

NHS contract work: The previous clear line separating NHS and private work has been fudged with privatisation and many would say to the detriment of both the NHS and the independent sector. Whilst the concept of choice for NHS patients cannot be challenged and the objective is perhaps as yet unfulfilled the impact on the private hospital can be deleterious. Some hospitals, however, see this as a means of survival as traditional private practice has declined in many areas. Although some consultants benefit from this NHS work the opposition to privatisation by the BMA is understandable. We now have the long awaited report from the Competition and Cooperation Committee which states that there are no potential conflicts of interest between consultants and their Trusts in performing this work.

Insurers: The change in attitude by insurers over the last fifteen years has been dramatic with the attempts by certain insurers to develop network products as we all know. There is an economic argument which suggests that the market will be polarised into traditional more expensive private practice and, at the other extreme, a commoditised service with restrictions of choice of consultant and hospital and to some extent treatment. Whether this network package would be acceptable to large numbers of subscribers is unclear and certainly this model has largely failed in the United States.

Some insurers seem intent on breaking the consultant / patient contract and to drive patients into the arms of networked (cheaper) consultants irrespective of the patient's wishes. The BUPA attempt to impose changes on us as ophthalmologists failed because of our professional resolve. However, BUPA was successful in the "paramedical" issue of MRI (mainly a hospital matter) whilst more recently the physiotherapy network seems unresolved. BUPA's suggestion to certain orthopaedic groups for the surgeon to take the whole fee and buy in the anaesthetist and physiotherapist has failed due to wholly inadequate funding and more importantly as a matter of principle. PPP have tried to impose networks by not involving consultants but going to hospitals directly and also restricting subscriber choice. This has caused aggravation for patients and their surgeons but to a considerable extent has failed.

The profession must remain resolute to defend these principles of independent practice and choice for patients but this does not mean unreasonable or excessive fees. However, as you know insurance reimbursements to patients for their professional fees have not altered in 15 years. Considering that during this time the percentage take of the total insurance spend by consultants has fallen from around 28% to 22%, it seems hard to suggest that the main body of consultants are being unreasonable in their fee arrangements.

*Richard Packard
Chairman of AOO*

**CCT
VIA THE ARTICLE 14 ROUTE:
A new training programme**

In Gloucestershire a new training programme has just begun with the creation of a "Trust fellow rotation" post which is suitable for candidates pursuing their CCT via the article – 14 route. The Gloucestershire Eye Unit caters for a population of 600,000 with a team of 12 consultants, career grade staff and trainees linked to the South West rotation.

This programme extends for up to 3 yrs and rotates through all the subspecialties at 6 monthly intervals. Year – 1 comprises medical retina followed by glaucoma, Year – 2 oculoplastics and paediatrics and finally, cornea and viteroretina in year – 3. Timetables reflect the emphasis of the individual subspecialties and consist of 6 clinics, 2 theatre sessions and 1 – 2 study sessions. Laser lists, Botox and Lucentis clinics are all incorporated at various stages of the rotation. As with all training posts, attendance at teaching sessions is compulsory and we are actively encouraged to participate in research and audit projects.

I graduated from the University of Manchester Medical School and did both my medical and surgical house jobs at teaching hospitals in the Manchester area. My first ophthalmology SHO post was at Eastbourne district general hospital where I worked just over a year. To date I have

spent 3 years in ophthalmology at SHO level and have completed my MRCOphth. As my previous posts have all been in small district general hospitals, I needed some exposure to a teaching hospital or a large unit such as Cheltenham. This unit is very well equipped with a large team of supportive consultants and offers a training experience comparable to many teaching hospitals. Both my clinic and surgical skills have benefited greatly since moving to the department. As I rotate through the programme I hope to increase my competence clinically and surgically in all subspecialties. I have started working on a few projects within the unit with a view to publish in the future. Ultimately I see myself as a consultant with an interest in medical and surgical retina.

The transition from the old SHO system to the new ST system is challenging due to the limited number of FTSTAs and ST posts. This new rotational fellow post allows suitable candidates to continue ophthalmic training in a structured training program comparable to specialist trainees. Competencies can be acquired throughout the programme after which an application for CCT can be made via the article – 14 route. Regular appraisal and assessment is planned to match the training system available to specialist trainees. It is hoped this may be a model for other units to follow in the future.

*Martin Bennett MRCOphth
Trust Fellow
Gloucestershire Eye Unit*

AOO Registration Form

I accept membership of the AOO	Yes/no
Name	
GMC number	
Position	
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Please return completed form to:

The Association of Ophthalmologists, Lansdown Lodge, Lansdown Road, Cheltenham, GL5 6QL

Or alternatively register on line: www.aoo.org.uk

Or e-mail: info@aoo.org.uk

Please note that there is no membership fee

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Summary

The AOO commends NICE on setting out standards of best practice in this area in Guideline 85, and welcomes the present opportunity to consider a safe and cost-effective solution to the increased workload, which is likely to result from its implementation. As glaucoma is an optic nerve pathology, we strongly believe it to be in the best interests of our patients that medically trained ophthalmologists continue to be responsible for the diagnosis and classification of their condition, and the formulation of a management plan specific to their case. We welcome the fact that a cost-effective solution to the delivery of such management plans is likely to involve non-ophthalmological healthcare professionals, and look forward to reviewing schemes which can deliver care to the standards set out in the Guideline. There now needs to be a commitment for appropriate investment in infrastructure and equipment across NHS hospital eye clinics and their community clinic counterparts. Particularly where equipment provision is concerned, we call on the government to provide this extra funding without delay, in order to expedite the NHS' compliance with these guidelines and minimise the impact on the lives of our patients with OHT or suspected or actual glaucoma.

Anish Shah AOO Secretary**Bola Odufuwa AOO Web Co-ordinator****References**

1. Hertzog LH, Albrecht KG, LaBree L, Lee PP. Glaucoma care and conformance with preferred practice patterns. Examination of the private, community-based ophthalmologist. *Ophthalmology* 1996;103(7):1009-13.
2. Gainsbury S. Missing: the notes of more than a million outpatients. *Health Serv J* 2008;5

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