Cataract care

Cataract care is mobile

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Is the direction correct?

Ophthalmologists found themselves in the vanguard of recent government policy to deploy overseas clinical teams (OCTs) in three mobile cataract treatment units touring England. These were announced in the first of two Department of Health (DoH) initiatives in England, titled Wave 1 and Wave 2, to augment clinical capacity. Since 2004 independent sector treatment centres (IS-TCs) have been mostly, but not exclusively, in schemes approved by the National Implementation Team (NIT), which is composed of special advisers to the Commercial Directorate of the DoH. Non-NIT schemes involving OCTs date back to 2002. The Royal College of Ophthalmologists (RCOphth), and others, raised concerns at the outset of the scheme when it was announced that 44 000 cataract operations would be undertaken in the mobile units over 5 years. Clinical and conceptual concerns (box) were mostly ignored. Implementation rather than consideration of policy has been the mantra. Some concerns have been realised.

CATARACT CAPACITY CONSIDERATIONS

Many observers thought that the use of OCTs in mobile IS-TCs undertaking cataract surgery only was not the optimal method of enhancing or increasing ophthalmic services. The RCOphth favoured expansion and upgrading of local National Health Service (NHS) hospital eye service (HES) units. While the underfunding of medical services in England has a deep rooted history, examples of how local HES units have improved following investment, modernisation, and local clinical leadership have been illustrated to ministers. Excellent progress has been made with the commissioning of dedicated day care cataract facilities within *Action on Cataracts*,[1] an initiative undertaken long before "modernisation" became contemporary. Ophthalmologists in established NHS settings currently carry out more than 300 000 cataract operations per annum in NHS care in England and NHS waiting time targets are being achieved.[2] Observers suspected that investing in mobile cataract units, staffed by overseas teams, was fiscally flawed. There were concerns that such schemes might be more costly than conventional NHS care because of central subsidies in the form of incentives to attract overseas providers and with the setting up of guaranteed contracts. True costs remain opaque. Local primary care trusts (PCTs) had to commit to IS-TCs whether they wished to or not, and "top slicing" of local PCT funds to the IS-TCs has been experienced. Contracts have had to be paid for regardless of whether the work was done. Resignations were required from PCT leaders who dissented with dogma.[3] Curtailment of previously planned expansion of NHS ophthalmic services and the inhibition of NHS consultant ophthalmologist expansion have been made known to the NIT, though largely ignored. Policy makers trumpet the successes of the mobile units. Erroneous claims of greater productivity in the mobile units appeared from government[4 5] and were refuted by the profession.[6 7]

PATIENT SAFETY CONCERNS

The DoH's requirement was for a mobile cataract solution in the initial IS-TC contract invitations and in the procurement exercise undertaken by the NIT in 2003. The contract was awarded to the South African organisation Netcare. While the concept of a mobile, "field hospital-like," facility might appear superficially attractive, most ophthalmologists and the college had concerns from the outset as to what would happen to patients when the mobile unit left town? Who would look after patients with postoperative problems when the unit was operational at St Elsewhere's? The advice from the NIT was that "sponsors,"—that is, PCT or strategic health authority (SHA) managers should make robust local arrangements for such foreseeable, often serious, urgent clinical risks. The RCOphth had published guidelines for commissioning cataract surgery, which strongly recommended clinical issues should be agreed in advance of contracting.[8] However, this guidance was largely ignored. Implementers of policy took a one dimensional view that local ophthalmology services should provide backup for the mobile units, without the initial engagement or agreement of local ophthalmology staff. Lack of engagement between local ophthalmologists and IS-TCs has been a feature of Wave 1 schemes. There were concerns over the lack of risk assessment for treatment of postoperative complications for patients in general and those with co-morbidity, such as glaucoma and diabetic retinopathy. Complex medical cases would also be excluded from the mobile units.

These initially theoretical fears have been realised with evidence of poor arrangements for the management of postoperative complications coming to attention in a number of incidents. As clinical governance in all of the early schemes, not just ophthalmic schemes, is somewhat opaque and little understood by those at the front line the RCOphth recently updated its guidance on how patient safety incidents should be reported.[9] Safety in cataract surgery, including risk assessment of plans and policy, remains the priority.[10]

Early concerns about Wave 1 mobile units

(Summarised from material on www.rcophth.ac.uk with permission)

- Adverse clinical or patient safety incidents
- Adverse impact on finances or services at local eye units
- Adverse impact on local medical staff morale
- Adverse impact on local medical training
- Destabilisation of ophthalmic staff planning

INTEGRATION OF PROFESSIONAL NETWORKS LACKING

Commitment to multidisciplinary research and development (R&D) is a key policy objective for both healthcare and general economic policy development. UK leaders favour innovation in NHS care including service delivery and technological innovation. Participation in clinical audit and peer reviewed presentations are vital but may not be compatible with the short term nature of rotating teams. A long awaited completed audit of cataract surgery undertaken by an OCT at a hospital in the north west of England in 2002 remained outstanding following presentation of initial outline results in January 2003 until circulated in the summer of 2005. (Unpublished

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company report; Netcare UK, *Operation Cataract 2002—Outcome Analysis—V7*, updated 31 March 2005, further details on request.) No audit of the mobile unit outcomes has been presented to the profession or published in the literature at the time of writing.

ETHICAL CONCERNS WERE SORTED OUT

There were some early ethical criticisms about the arrangements potentially denuding South Africa of scarce clinical staff resources. However, a new government memorandum of understanding between South African and UK governments was signed to facilitate benefit for the South African healthcare system by offering South African and English healthcare professionals the chance to go on time limited placements to each other's countries.[11]

DIFFERENCES IN CLINICAL PRACTICE AND GOVERNANCE EMERGE

Members of overseas teams should be supported by dedicated personnel within the host commissioning organisation to make the transition required to work within local policies and the UK healthcare system. However, on occasion, teams have simply arrived and have been expected to proceed with complex clinical tasks without the benefit of induction and familiarisation with equipment vital in providing safe patient care. One example has been the failure to use preoperative povidone-iodine which resulted in an increased frequency of postoperative endophthalmitis.[12] When the problem was spotted and when povidone-iodine was used in later cases, the endophthalmitis frequency returned to baseline. There were some blockages by healthcare management and inspectors to investigate or learn from this matter. In another example overseas management staff, perhaps unfamiliar with UK Caldicott guidelines concerning patient confidentiality, breached these in publications on an IS-TC website. Basic lessons that are long established in conventional units in England are now being learned by IS-TC providers, such as the need for robust on-call rotas for postoperative emergencies. The resignation of the ophthalmic medical director for England of the overseas cataract chain, allegedly in this context, was noteworthy.

DIFFERENCES IN THE SYSTEMS

Patterns of medical practice vary internationally, while a whole systems approach to health care exists in the United Kingdom in NHS care, office based services provided by independent physicians predominate in western Europe and North America. There is a potential for visiting OCTs not to be fully appraised of these systems variations or understand the potential implications of them for patients. An example occurred in relation to visiting European ophthalmologists and an overseas management provider in the Midlands in England recently. Patients with both cataract and co-morbidities of glaucoma and diabetic retinopathy were transferred by the sponsor health authority to the overseas IS-TC provider without consideration of the need for postoperative treatment of the latter co-morbidities. It appears that neither the visiting ophthalmic surgeons nor their overseas business managers were aware that glaucoma care and diabetic retinopathy care are predominantly hospital eye clinic based in the United Kingdom. The visitors assumed, it appears, that the patients' general practitioners and or optometrists would attend to such postoperative care, perhaps reflecting the practice that postoperative ophthalmic care transfer in the visitors' homeland is returned to community based or office based ophthalmologists (Dr Sarah Wilson, unpublished communication 2005). No such system is routine in the United Kingdom and as a result some such patients experienced some adverse problems with glaucoma and retinopathy management following cataract surgery. The matter was further compounded in that many of the patients on the health authority's electronic waiting list management database for cataract extraction were, in fact, glaucoma patients attending a leading glaucoma department. Furthermore, as the cataract facility concerned was not registered with the competent authority, the Healthcare Commission investigation of root causation may prove problematic.[13]

APPOINTMENT OF SPECIALISTS

The more the ''market'' in health care is deregulated, the more important it is that patients can be assured that they will be cared for by properly trained and appointed consultants. Paradoxically, therefore, deregulation of health care in the broad sense makes tight regulation in the appointment of specialists even more important. Concerns about the appointment of IS-TC specialists compared with the robust NHS advisory appointment committees' mechanisms have been drawn to the attention of the NIT. Some progress was made by the medical royal colleges in securing agreement that IS-TC medical staff should be on the UK General Medical Council's specialist register as a minimum requirement, as initially sponsors did not require such restrictions.

IMPACT ON TRAINING AND FUTURE SPECIALISTS

The ''cherry picking'' of the straightforward surgical procedures has implications for surgical training. Local NHS units may be left with more complex cases that are not suitable for the training of junior surgeons. The residual complicated cases may incur a greater cost, yet NHS hospitals will only receive a set unbundled national tariff fee per case, which, at present, does not embrace risk stratification or complexity. This is likely to put significant cost pressures on local services. Research is needed to gauge impacts. Similar concerns have been raised by other specialties. With alterations to capacity, a potential destabilisation of central ophthalmology staff planning for the NHS, despite the availability of UK trained ophthalmology specialist registrars, is feared.

LACK OF HOLISTIC CARE; FOCUS ON THE CATARACT!

Continuity and consistency of care for patients are essential. This is especially the case for patients with chronic diseases. It is self evident that a consistent holistic service is not possible when rotating clinical teams are deployed. It is unsatisfactory to focus on one (surgically treatable) aspect of the patient's condition—that is, cataract, and ignore chronic ocular co-morbidity, such as glaucoma or retinopathy in the same eye. The tradition of treating patients as individual people rather than targets on waiting lists has long been recognised. Investment in integrated local multidisciplinary care for patients with both acute and chronic eye conditions is preferred. It may be the case that a commissioning error was made by the recent focus on a relatively small percentage of cataract surgery in England. The DoH has partially conceded this and has made efforts to address access to the more problematic ophthalmic areas by extra investment in chronic eye disease pathways in response to pressures from the profession.

STAFF MATTER AND STAFF MATTERS

The DoH's tender documents required Wave I bidders to exclude, from IS-TCs, NHS clinical staff if employed by the NHS in any clinical capacity within the previous 6 months. This is known as the ''additionality'' rule, or A-word, which had the effect of favouring overseas bidders. Busy ophthalmic surgeons mostly in independent practice, often, but not exclusively, based in South Africa staff the mobile cataract caravans on their travels. Staff benefit from currency earned during tours of duty

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in England and the motivation of the visitors and their employing corporations is, we presume, mostly fiscal. It was suggested that UK consultants were opposed to overseas teams and IS-TCs because of potential adverse effects on their NHS units and their own independent (private) practice. This criticism was ill placed; as the evidence is that the majority of NHS consultants work over and above their contracted duties, on fixed salaries, for NHS employers. There are codes of practice in NHS hospitals to ensure that staff comply with their job plans. Arguably, if visiting or overseas clinicians were primarily committed to improving UK health care they would be better deployed into expansion of the current UK resident clinical workforce with local NHS or independent employers. In fact, significant numbers of clinical staff currently in NHS employment are overseas individuals, doctors and nurses, who have chosen to migrate to the United Kingdom and work in the NHS for either professional and or economic reasons. These immigrant clinicians have historically made a significant contribution to UK health care. Overarching these matters is a basic tenet that there is a need for all people, including healthcare employees, to be motivated to deliver their employing organisation's strategy. Here, an overall sense of purpose and ethos are crucial, such as the mission of improving the health of the local population, or the healthcare facilities for local residents, as is the case of the NHS. This aspirational policy, generally close to many NHS clinical staff's philosophy, and in keeping with successful human resources policy, may perhaps be being eroded by the current policy of expansion of diverse IS-TCs staffed by a plurality of overseas/short term staff. The morale of ophthalmologists is thought, from anecdote only, to be suffering. This is occurring just at a time when it is recognised internationally that deep seated culture change and embedding of whole systems modernisation is needed to improve health care. Long established NHS teams with great clinical expertise and leadership may be broken up if local units do close. Perversely, UK healthcare costs may rise as markets evolve. The traditional ''ethos'' of the NHS could disappear to be replaced by a more modern ''commercial'' mentality. The risks are obvious.

THE ''A-WORD'' DROPPED

As the NHS is by far the major source of UK secondary healthcare employment some concern might surround the calibre, competency, or motivation of staff not recently employed within the umbrella of the NHS. Perhaps this may have been part of the reason why the newly appointed Secretary of State for Health for England announced that the earlier strict ''additionality rules'' would now be dropped. The minister's about turn of policy is for Wave 2 procurement only, by then advertised by the health ministry.[14] Staff employed by NHS organisations in England will now be permitted to work in Wave 2 IS-TCs after they have completed their job plans and if their NHS employer does not object to them doing so, as long as they are not deemed to be in ''shortage'' specialties Ms PatriciaHewitt (the health secretary) announced to delegates attending a BMA conference in June 2005. More detail is awaited of these new rules. Forthcoming rules for Scotland, which is now following the English path of IS-TC procurement, are also awaited.

IS ANYONE LISTENING?

Unfortunately, there still remains little engagement between central capacity planners and clinicians in the United Kingdom. Gaps are widening. This is acknowledged by the policy implementors at NIT. Hearing aids are suggested for those who have difficulty understanding policy directions (unpublished personal verbal communication from NIT advisers, 2005.) Some UK clinicians, NHS managers, and others fear that the ambitious commissioning policy for the wide ranging independent sector procurement, currently being extended in Wave 2, may result in the destabilisation of local NHS hospitals.[15 16] Doubts about policy direction are being increasingly voiced by many, including some longstanding parliamentarians.[17] Will they be heard?

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