

COMMISSIONING CATARACT SURGERY – AN OUTLINE OF GOOD PRACTICE

Background

The NHS Plan¹ set out a ten year strategy aimed at building a more responsive and more patient-centred NHS with more uniform standards of care and access. Central to the strategy was a staged reduction in the time that patients wait for surgery down to six months in 2005 and eventually, three months. Similar targets have also been introduced for waiting times for routine outpatient appointments.

The government initiative: Action on Cataracts (Department of Health 1999) made an attempt to address the issue of capacity for cataract surgery by investment in infrastructure (though not manpower) in NHS ophthalmic units across the country, aimed at increasing throughput. The NHS Plan recognized that a considerable expansion in the consultant workforce would also be required if the targets for waiting times for elective surgery in the NHS Plans were to be met. Despite an increase in the number of UK Medical School places, it will be a number of years before this translates into a corresponding increase in the number of fully trained specialists emerging from surgical training programmes.

A further Government paper² paved the way for a rapid increase in elective surgical capacity by commissioning overseas surgical teams to perform elective surgical procedures either within NHS premises or in independent facilities. A number of contracts have since been awarded to independent providers (mostly but not exclusively from outside the UK) to undertake elective cataract surgery. Primary Care Trusts will be required to offer patients who have been referred for cataract surgery a choice of provider.

In the days of general practice fund-holding, the “outsourcing” of cataract surgery to distant NHS providers or the private sector was not uncommon, but was normally instigated by the GP in discussion with the patient. Since the end of GP fund-holding, block contracts between commissioning agencies and providers have become the norm, and the College has received a number of reports of cases where the care of patients already on the waiting list of a local consultant ophthalmologist has been transferred to an alternative provider without the knowledge of the local consultant, and sometimes without the prior knowledge of the patient. In some cases, patient care has been compromised either because of inappropriate selection of cases for transfer, or because of inadequate arrangements for post-operative follow-up (especially where complications have occurred).

Potential problems of “outsourcing” cataract surgery

Leaving aside the political controversies surrounding the outsourcing of surgical procedures (especially from the private sector and abroad), there are a number of practical problems which may arise from this practice. A number of examples of these problems have been brought to the attention of this College in recent years;

Problems for the patient:

- Travel to a more distant provider may be difficult, and adequate follow up care may be difficult to arrange.
- There may be little or no opportunity for the patient to discuss their operation with the surgeon before the day of surgery, and the patient may feel an obligation to proceed if they feel that special arrangements have been made for their treatment.

Problems for the provider

- It may be difficult to obtain relevant information about the patient's previous history (eg adverse reactions to previous treatment, ongoing medical or ophthalmic problems), leading to unexpected difficulties with surgery.
- If complications occur, it may be difficult to provide treatment or adequate follow up if the patient lives some distance away.

Problems for the local eye unit

- If a significant proportion of cataract surgery is “cherry picked” by other providers, the workload of the local unit may be distorted, with potential adverse effects on training, skill-retention, recruitment and retention of staff
- The local unit may have to make urgent arrangements to deal with postoperative complications from surgery performed by a distant provider, without adequate background information. This poses a threat to patient safety.

Problems for the commissioning agency

- The commissioning agency has a duty of care to the patient when placing a contract for their surgery and may share legal liability with the provider for failings in the standard of care, particularly if monitoring of the contract is shown to be inadequate, or if the provider is based outside British legal jurisdiction
- It may be difficult to obtain or validate information on standards of care and outcomes from providers prior to placing a contract.

Purpose of this document

General guidelines for NHS employers who plan to commission and use overseas clinical teams have recently been circulated in the form of a consultation document³. The primary purpose of this document is not to deter commissioning agencies from placing contracts for cataract surgery with providers other than their local NHS eye unit, but rather to provide guidance on the standards which commissioning agencies should expect of any provider of ophthalmic care, whether in the NHS, in Independent Sector Treatment Centres or abroad, with whom they plan to place contracts for cataract surgery.

Recommendations

- 1. Communication.** The provider should inform the patient's general practitioner at the points when the patient is listed for surgery, when the surgery occurs and when the patient is discharged. Where a patient is under the ongoing care of another ophthalmologist, he/she should also be copied into the correspondence. The provider is responsible for arranging handover of care to another ophthalmologist where this is necessary (eg for management of a complication or where ongoing monitoring of another eye condition is required). Where a commissioning agency arranges transfer of patients already on the waiting list of a consultant ophthalmologist to an alternative provider, the agency is responsible for obtaining the consent of the patient, and should inform the consultant from whose list the patient is being removed, and the patient's general practitioner (L Donaldson, personal communication, 14 November 2001).
- 2. Case selection and preoperative preparation.** The provider must perform a detailed preoperative assessment to ensure that case selection is appropriate to the level of expertise of the operating team and the clinical facilities. In particular, it is vital to take adequate account of ocular or systemic co-morbidity which might increase the technical difficulty of the procedure, or increase the risk of complications. The provider should also ensure that adequate account is taken of the patient's social circumstances (availability of transport, help at home etc) when planning the episode of care.
- 3. Patient information and consent.** The provider is responsible for providing adequate verbal and / or written information about cataract and cataract surgery to allow the patient to give informed consent to the procedure. Informed consent must be taken by someone who has the knowledge and competence to explain the benefits and risks of the procedure and to provide accurate answers to questions. Although NHS patients do not have a right to choose their surgeon, they have a right to expect that their surgeon has the experience and skill to perform their operation. It is reasonable that the patient should have the opportunity to know the identity and status of the operating surgeon and to meet him / her prior to entering the operating theatre. It is the final responsibility of the operating surgeon (or the supervising surgeon where the operating surgeon is a trainee) to ensure that the patient has been adequately assessed, prepared and consented prior to the start of the operation.
- 4. Hotel Facilities.** The commissioning agency and the provider have a joint responsibility for ensuring that the adequate facilities are available for the patient to be accommodated for the duration of the episode of care. This is particularly important where the provider unit is too distant from the patient's home to allow a return journey in the same day.
- 5. Clinical facilities.** The commissioning agency and the provider have a joint responsibility to ensure that the premises and equipment in the provider unit is adequate for performing modern small incision cataract surgery safely, and

that the unit complies with relevant legislation.

6. **Anaesthesia and perioperative care.** Most cataract surgery is carried out under local anaesthesia, and has a very low mortality and systemic morbidity, especially considering that a high proportion of patients are elderly and would be graded as 2 or worse on the American Society of Anaesthetists (ASA) scoring system. However, the provider has a responsibility to ensure that resuscitation facilities are readily available, and that an appropriately qualified person is readily available to undertake resuscitation should the need arise. Contingency plans should be in place for emergency transfer of patients who suffer a life-threatening complication. The National Confidential Enquiry into Perioperative Deaths (NCEPOD) has criticized the practice of undertaking ophthalmic surgical procedures on very unfit patients in isolated units. Provider units which are geographically isolated from accident and emergency or intensive care facilities should give particular consideration to contingency planning for life-threatening emergencies and to case selection.
7. **Postoperative care and contingency planning for complications.** The provider is responsible for arranging routine postoperative care following cataract surgery, in order to monitor for postoperative complications and for the collection of information on outcomes. The patient must be provided with any necessary postoperative medication and instructions, and a discharge summary. The provider unit must have adequate arrangements for handling urgent enquiries from patients who have had surgery. It is not acceptable for patients merely to be told to go to their local accident and emergency department or to contact their GP if they have a problem. If operative or postoperative complications occur, the provider unit should either manage them, or arrange direct referral to another specialist, keeping the general practitioner informed. The commissioning agency should ensure that there is a funded agreement in place with a suitably equipped NHS facility with adequate capacity for dealing with any early or late post-operative complications which cannot be managed by the provider.
8. **Clinical Governance.** The commissioning agency should ensure that the provider unit follows the requirements of Clinical Governance, whether the provider is within the NHS or the private sector. In particular, medical staff should undergo annual peer appraisal, there should be evidence of ongoing audit of outcomes and complications in relation to national comparators, there should be a robust mechanism for recording and acting on complaints and clinical incidents, and there should be facilities for monitoring the progress of staff in training.
9. **Accreditation of private healthcare providers.** From 31st March 2002, it became a requirement that doctors and establishments engaged entirely in private practice must register with the National Care Standards Commission. On 1st April 2004, these functions of the NCSC were taken over by the Healthcare Commission. The commissioning agency has a responsibility to ensure that a private healthcare provider with whom they contract is registered, or can demonstrate exemption.

References:

1. The NHS Plan, a plan for investment, a plan for reform. Department of Health, July 2000.
2. Growing Capacity: a new role for external healthcare providers in England. Department of Health, June 2002.
3. Code of Practice and Guidance for NHS employers commissioning and using overseas teams. Department of Health, February 2004.

Further sources of information:

Cataract Surgery Guidelines. Royal College of Ophthalmologists, 2004.

Department of Health website: www.dh.gov.uk

Seeking patients' consent: the ethical considerations. General Medical Council
November 1998

Good Medical Practice. General Medical Council. May 2001.

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