QUARTERLY BULLETIN OF ROYAL COLLEGE OF OPHTHALMOLOGISTS

College NEWS

Winter
2008

Message from the President

Throughout the 20th Anniversary year of the College there has been a great mood of celebration. We have been very pleased to welcome members of the founding Steering Committee and the first Council to various notable College events and we now look forward to the next 20 years.

The College is in good shape, efficient, effective and looking ahead as well as financially sound. By the time you read this edition of College News we will know who will take office in May as the 8th President. It is a very healthy sign that six good candidates would like to serve the College in this way and I hope Fellows and Members exercised their new responsibility to take part in the ballot.

2008 has seen the bedding down of the new run-through training programme after the turbulence of the MTAS year. "Teething" problems are being sorted out and trainers are getting to grips with work-place based assessments (WBAs) and the e-portfolio.

In 2009 we will be re-licensed by the General Medical Council and enter a new era of regulation. The College has big projects on the go identifying ways of assessing ophthalmologists for revalidation. These need to be robust but readily delivered. The advent of the ophthalmic electronic care record for patients will underpin this.

In April, with other professionals in the voluntary sector, we helped to launch the UK Vision Strategy for the next 5 years: to deliver the aims of Vision2020 UK (to eliminate avoidable blindness) and to ensure the inclusion of visually impaired people in the community. The impetus is gathering pace and I was pleased to visit Leeds in October to help launch their Vision Strategy Challenge at the Civic Hall – an event hosted by the Strategic Partnership Team Leeds, jointly serving NHS Leeds and the City Council. *(See report on Page 13)* I look forward to similar initiatives in other parts of the country.

The College is looking outward too, increasing collaboration with the ophthalmic community internationally. We had a significant presence at the World Congress in Hong Kong in July and are participating in the organisation of the 24th Asia Pacific Academy of Ophthalmology congress next May. We are also working more closely with the Vision 2020 Links Programme, the International Council of Ophthalmology and the European Society of Ophthalmology (SOE). I was privileged to visit Eastern Africa in September to help launch the strategy of the fledgling Eastern Africa College of Ophthalmologists.

As the year concludes with the Christmas festivities we have a programme in place and plans afoot for 2009. Your College will strive to serve you and the public even better in 2009.

I wish you all a Happy Christmas and good opportunities in 2009.

Brenda Billington

The Steering Group and First Council at the 2008 Admissions Ceremony

BIKE RIDE

Anyone wanting to take part in a Sponsored Bicycle Ride – London to Birmingham, arriving on the eve of Congress, 18 May, should contact events@rcophth.ac.uk by 15 January '09

Articles and information to be considered for publication should be sent to: kathy.evans@rcophth.ac.uk and advertising queries should be directed to: Robert Sloan 020 8882 7199 rsloan@rsa2.demon.co.uk

Copy deadlines

Spring	5 February 09
Summer	5 May 09
Autumn	5 August 09
Winter	5 November 09

The Royal College of Ophthalmologists Annual Congress

19 – 21 May 2009

International Convention Centre, Birmingham

We are pleased to announce that the Optic UK Lecture will be delivered by a world renowned speaker, Professor Alfred Sommer, of the Bloomberg School of Public Health in Baltimore. Professor Anthony Moore of Moorfields Eye Hospital and Great Ormond Street Hospital has been invited to deliver the Duke Elder Lecture and the Edridge Green Lecture will be delivered by Professor Irene Gottlob of the University of Leicester.

Updates to the Congress 2009 scientific programme include sessions chaired by Richard Harrad on 'Clinical Leadership' and 'How to peer review and get a paper published'. Isabelle Russell-Eggitt has been invited to chair a session on 'The child with impaired vision and normal eye examination', and a session on 'Wavefront Laser Refractive Surgery' will be organised by David Gartry. We are pleased to welcome Dr Richard Spaide, a specialist in diseases of the retina and vitreous from Vitreous-Retina-Macula Consultants of New York, who will speak during the session on 'Intravitreal Therapies and off label drugs – perspectives from three experts'.

Carole Jones has put together an appealing programme for her session on 'Management of Periocular Tumors'. The guest speakers, internationally recognised oculoplastic surgeon, Jeff Nerad from Iowa, dermatologist, Cameron Kennedy, and local oculoplastic surgeon John Beare, will present a range of management options for tumours around the eye. Nick Astbury and Andy Cassels-Brown promise to deliver a lively debate on 'Ophthalmology in the community – are we facing extinction?' exploring the pros and cons around eye care in the community to inform, as well as amuse, delegates.

A highlight of Congress 2009 will be the UCAN concert, which will include a selection of songs, dance and a small sketch by visually impaired young people. UCAN Productions is a 'not for profit' cooperative which aims to increase opportunities for visually impaired young people to participate in the arts. More information is on *www.ucanproductions.org*

Registration is from Friday 23rd January 2009 and there are more details on the College website *www.rcophth.ac.uk/scientific/*. If you have any further queries, please contact the Scientific Department by email *events@rcophth.ac.uk.*

Winfried Amoaku, Chairman, Scientific Committee
Gabriella Saunders, Scientific & Events Co-ordinator

The RCOphth Research Fund

The College is delighted to launch the RCOphth Research Fund to assure a stable mechanism to enhance the conduct and dissemination of research in ophthalmology and visual sciences. It will allow the College to meet new challenges and promote innovation in eye research. Particularly, it will provide seed money to encourage young researchers to establish themselves on the research ladder to enable them to apply for other grants.

We seek to raise £1.5 -2.0 million by The Royal College of Ophthalmologists' 25th Anniversary celebrations in 2013. Disbursements will commence in that year as part of Silver Jubilee celebrations and continue on a regular basis thereafter.

It is hoped that moneys will be raised through the generosity of individual donors, key supporters from industry, and wills and legacies.

So far we have received some handsome donations (totalling £67,000) to the Fund from a pharmaceutical company (Novartis), and from our senior members.

It is hoped that especially as Christmas approaches, the membership of the College – young and old, home or abroad, as well as well wishers will contribute generously to the Fund.

You can support the RCOphth Research Trust in several ways including:

1. Complete a gift aid form available from the website or from the College with your details and attach a cheque payable to 'The Royal College of Ophthalmologists' to the value of your donation. Please mark the reverse of the cheque 'Research Fund'.

Alternatively, you may make:

2. Regular donations by standing order to the RCOphth.
3. A bequest in your will to the RCOphth.

Every little bit counts! Please give freely to this cause.

Please Contact
Mr. Winfried Amoaku / Mrs. Heidi Booth-Adams
Scientific Department
www.rcophth.ac.uk
The Royal College of Ophthalmologists
17 Cornwall Terrace, London NW1 4 QW

Tel: 020 7935 0702
heidi.booth-adams@rcophth.ac.uk

Medical Futures

The Medical Futures Innovation Awards were established in 2003 and this year it was extended to ophthalmology. The first judging day was held at the College in September. Applications had been sought from all areas of development, from services and educational tools, through to therapies and diagnostics. The results are:

Winners
Mini Slit-Lamp – Mr Roger Armour
Sight-Sim – Professor Gordon Dutton and Team
MediSoft – Mr Rob Johnston
Retinal Oximetry – Professor Andrew McNaught and Team

Commendations
Central Electronic Design of Hospital Referral – Roshini Saunders, Shyamanga Borooah and Team

College judges, from left to right, standing: Simon Keightley, John Marshall, Peter McDonnell
Seated: Miles Stanford, Winfried Amoaku, Larry Benjamin

Congratulations to the **Hasanali Tobaccowala Eye Centre of the Rotary Club of Bombay**. This began in 1978 and, under the chairmanship of Dr Rahim Muljiani, has flourished and now celebrates its pearl anniversary. For a detailed account see www.rotary clubofbombay.org

Obituaries

We note, with regret, the deaths of the following members:
Dr Sajjad Ahmad, Lahore, Pakistan
Dr David Staig, Reading, Berkshire
Mr Geoffrey Gibson Bisley, Ipswich, Suffolk.
Professor M Aslam Khan Malik, Islamabad, Pakistan.

Members' news

Consultant Appointments

Mr Austin McCormick	University Hospital Aintree, Merseyside
Mr Glynn Baker	Cheltenham General Hospital, Gloucestershire
Mr Jonathan Bhargava	Countess of Chester Hospital, Cheshire
Mrs Archana Bhargava	Pinderfields General Hospital, West Yorkshire
Mr Sunildath Cazabon	Countess of Chester Hospital, Cheshire
Mr Narendra Dhingra	Pinderfields General Hospital, West Yorkshire
Mr Bruce Dong	William Harvey Hospital, Kent
Mrs Yvonne D'Souza	Calderdale Royal Hospital, Halifax, West Yorkshire
Mr Robin Hamilton	Moorfields Eye Hospital, London
Mr Edward Hughes	Sussex Eye Hospital, East Sussex
Mr Aby Jacob	Southampton General Hospital, Southampton
Mr Brian Little	Moorfields Eye Hospital, London
Mr Maharatnam Logendran	Northampton General Hospital, Northamptonshire
Mrs Samantha Mann	St Thomas's Hospital, London
Mr Tristan McMullan	Northampton General Hospital, Northamptonshire
Mr Mohammed Musadiq	University Hospital of North Staffordshire, Staffordshire
Dr Carmel Noonan	University Hospitals Aintree, Merseyside
Mr Say Aun Quah	Macclesfield Hospital, Cheshire
Mr Yashin Danjay Ramkissoon	Royal Hallamshire Hospital, Sheffield
Miss Sandra Rayner	Cheltenham General Hospital, Gloucestershire
Miss Jayashree Nair Sahni	Royal Liverpool University Hospital, Merseyside
Mr Michael Smith	Royal Devon and Exeter Hospital, Devon
Mr Deepak Tejwani	Royal Alexandra Hospital, Refrewshire

Regional Advisers

Regional Advisers are appointed by Council to act on behalf of the College. They must be:

- Fellows of the Royal College of Ophthalmologists registered with the College for Continuing Professional Development (CPD).
- NHS consultants with an established or honorary contract in active practice. Advisers must stand down on retirement from their NHS post.

The table below shows those post holders who will complete a three year term of office in 2009. In most cases they are eligible to stand for re-election for a second and final term. Any person wishing to stand should contact *Hon.Sec@rcophth.ac.uk*

REGION	CURRENT POST HOLDERS	DATE OF RETIRE-MENT	ELIGIBLE FOR RE-ELECTION
Northern Ireland	Mr Gerard McGinnity	March 09	Yes
Scotland East	Mr Nicholas George	March 09	No
Scotland East	Mr Jaswinder Singh	June 09	No
Wales	Mr Chris Blyth	September 09	Yes
Yorkshire	Mr Ian Simmons	December 09	Yes
Wessex	Miss Anne Denning	December 09	Yes
Oxford	Miss Susan Downes	December 09	Yes

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1. Based on an average cataract patient. **2.** Artal P, Alcon E, Villegas E. Spherical Aberration in Young Subjects with High Visual Acuity. Presented ESCRS 2006. Paper 558. **3.** Artal P, Berrio E, Guirao A, Piers P. Contribution of the cornea and internal surfaces to the change of ocular aberration with age. *J Opt Soc Am A.* 2002;19:137-143

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THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

Focus

Winter
2008

An occasional update commissioned by the College. The views expressed are those of the author.

Visual rehabilitation of patients with macular diseases

Michael D. Crossland PhD MCOptom FAAO
NIHR Research Fellow, UCL Institute of Ophthalmology, London
Specialist Optometrist, Moorfields Eye Hospital NHS Foundation Trust, London

Despite new treatment, macular diseases remain the leading cause of severe sight impairment in the UK. For untreatable macular diseases such as geographic atrophy or Stargardt macular dystrophy, visual rehabilitation provides the only means by which visual function can be improved.

Table 1 summarises some of the most frequent complaints of people with macular disease and suggests possible mechanisms for ameliorating them. Whilst some of these rehabilitation options will require referral to a low vision clinic or local society for the blind, useful advice can be provided in a clinical setting or by advising the patient to visit their own optometrist.

Optical aids for low vision

Spectacle refraction should not be overlooked in people with poor vision. Even when the distance visual acuity cannot be improved significantly, it is important to have the best possible optical correction for intermediate or near tasks. Any spectacle prescription with more than a +4.00DS addition (i.e. one which focuses closer than 25cm from the eye) will provide magnification and can be issued on loan from some hospital low vision clinics.

Optical alternatives to high reading addition spectacles include hand and stand magnifiers such as those illustrated in the top left panel of the Figure. As magnification increases, the lens diameter and field of view gets smaller: therefore, the lowest magnification consistent with best vision is generally the level prescribed. As a rule, hand magnifiers are held just above the object of interest and can be used with any refractive correction, whilst stand magnifiers rest against the page and require reading spectacles to be worn by presbyopes. LED illumination is now widely used in these magnifiers due to its increased brightness and better battery life compared to tungsten bulbs.

Hand-held telescopes can be used for spot-reading tasks such as looking at airport departure boards or street names. Telescopes of up to about 4x magnification can also be spectacle mounted for prolonged tasks such as watching a play or football match, although they

Figure. Top left: A selection of optical magnifiers. Top right: CCTV magnifiers. Bottom left: Samples of normal and giant print. Bottom right: Portable electronic magnifier.

cannot be used when walking due to their effect on the vestibulo-ocular reflex: small head or body movements are magnified by telescopes such that they appear much larger, severely affecting the patient's balance.

Electronic aids for low vision

Electronic magnifiers offer a high and variable amount of magnification over a relatively large field of view, and the contrast, colour and brightness of the observed text can be manipulated to suit the observer. Conventional desktop closed circuit television systems (CCTV) (Figure, top right panel) consist of a camera mounted above a moveable table, whilst a screen displays an enlarged image of whatever is placed on the table. The advent of flat panel LCD screens means that these systems are less bulky than before, but they are still reasonably heavy and difficult to move around. All-in-one desktop CCTV magnifiers generally cost in excess of £1,000. A cheaper alternative is to use a camera which plugs directly into an existing television or computer monitor, such as the Monomouse (Figure, top right panel, left hand screen). In this system, the camera is mounted within a computer mouse and is moved over

the page of text by the user. The Monomouse is available in two fixed magnification levels and provides either normal or reversed contrast. It costs around £100 (plus the cost of the television).

Computer users can use Accessibility Options in Windows (or Universal Access Preferences on a Mac) to magnify or reverse the contrast of the computer screen. Third-party software such as Zoomtext, JAWS or Magic can be added to read text aloud or to provide advanced magnification and contrast manipulation options. A simple approach for people with minor vision loss is to buy a larger monitor, and to ensure that the correct refractive correction is worn for the screen distance.

Most CCTV manufacturers now offer portable, hand-held CCTV systems (Figure, bottom right) which exploit new developments in screen and battery technology to provide portable magnification in systems which are often aesthetically pleasing, looking like a personal digital assistant or games console rather than a rehabilitative device. These devices vary in their ability to cope with text on a non-flat surface (such as a price label on a supermarket shelf) but the best of them can be used for a variety of everyday tasks. They cost around £300-£600.

Head-mounted electronic magnifiers have been available for some years yet remain unpopular, perhaps due to their cost, weight and cosmetic appearance. They also suffer from the same problems as head-mounted telescopes in that they cannot be worn whilst walking. Current research in head-mounted devices includes the augmented presentation of an enhanced image over a correctly sized background image, to avoid balance difficulties if worn whilst mobile.

All types of electronic magnifiers can present text in reversed contrast (white on black) or altered contrast formats (e.g. blue on yellow) formats. Whilst people with corneal or media opacities frequently find reversed contrast text more useful, there is no general rule as to which format is preferred by people with macular disease.

Non-optical advice for patients

Having good lighting for detailed tasks is extremely important. As luminance decreases exponentially with increasing distance from the light source, using a simple desk lamp is of far more benefit for reading than increasing the power of a ceiling light. There is no clear evidence that any particular type of light bulb is any better than any other, so general advice should be to use whatever bulb gives the most light on the task at hand.

Contrast manipulation is also of benefit: for example, it is far easier to cut fish when it is placed on a dark chopping board than against a white background. Similarly, telephone numbers and notes will be easier to read when written in a thick black ink on plain white paper, rather than in a blue biro on purple writing paper.

Large print and giant print books are readily available from public libraries and can significantly improve reading speed even in those who are still able to discern smaller writing. Examples of these are shown in the bottom right panel of the Figure, with a standard magazine for comparison. Utility companies and banks are obliged to issue correspondence in large print on request, and for people who have difficulty entering their PIN when shopping "chip and sign" bank cards are available.

A multitude of non-optical aids to help with daily living tasks are available from the Royal National Institute of the Blind and local partially sighted societies.

Eccentric viewing

Eccentric viewing refers to the technique of observing a scene with the peripheral retina, by moving the damaged fovea away from the object of interest. Due to the lower density of photoreceptors and greater number of photoreceptors per ganglion cell in the peripheral retina, visual acuity will be far worse as that in the fovea. This strategy can, however, provide an unobstructed view of the scene.

To improve patients' ability to make this adaptation, eccentric viewing training is widely used in Scandinavia and some centres in the USA. The benefit of this training remains controversial: although some authors have reported encouraging results, no rigorous randomized controlled trials have yet been performed in the use of eccentric viewing training. It is known that many patients use eccentric viewing techniques without any intervention, and often without being aware of using non-central viewing.

Vision rehabilitation following anti-VEGF therapy

The widespread use of anti-VEGF therapy for neovascular AMD will have significant effects on low vision rehabilitation strategies for macular disease. Some preliminary evidence suggests that patients are less likely to be referred to low vision services if they have received anti-VEGF treatment. Anecdotal experience suggests that even people with relatively good visual acuity who had received anti-VEGF therapy often have large regions of relative scotoma. They require very large amounts of lighting to perform visual tasks. The potential benefit of low vision rehabilitation in this patient group should not be underestimated.

The management of patients with macular disease is one of the key challenges in modern ophthalmology. Co-ordinated, multidisciplinary vision rehabilitation provides an important adjunct to clinical therapies to maximize the quality of life in this group of people.

Table 1

Presenting complaint	Possible rehabilitation options
Difficulty in reading	Refraction; Lighting; High reading add spectacles;Hand/stand magnifiers; CCTV; Large print/talking books
Difficulty in recognizing faces	Refraction; Fixation advice/training; Lighting
Difficulty in watching TV	Refraction; Changing viewing distance; Fixation advice/training; Telescopic magnifiers
Difficulty in navigation/mobility	Orientation and mobility training; Refraction; Telescopic magnifiers (for street signs)
Difficulty in using computer screens	Text enlargement software; Screen reading software; Refraction
Difficulty in kitchen/household tasks	Lighting; Contrast advice ; Hand magnifiers
Difficulty in shopping	Hand magnifiers; Portable lighting; Handheld CCTVs
Difficulty in hobbies (reading music, gardening, painting)	Refraction; Galilean telescopes; Text enlargement

General reading
1. Dickinson C. Low Vision: Principles and practice. Oxford: Butterworth Heinemann; 1998.
2. Wolffsohn JS, Peterson RC. A review of current knowledge on Electronic Vision Enhancement Systems for the visually impaired. Ophthalmic Physiol Opt 2003; 23(1): 35-42.
3. Culham LE, Chabra A, Rubin GS. Clinical performance of electronic, head-mounted, low-vision devices. Ophthalmic Physiol Opt 2004; 24(4): 281-90.
4. Nilsson UL, Frennesson C, Nilsson SEG. Patients with AMD and a large absolute central scotoma can be trained successfully to use eccentric viewing, as demonstrated in a scanning laser ophthalmoscope. Vision Res 2003; 43:1777-87.
5. Crossland MD, Culham LE, Kabanarou SA, Rubin GS. Preferred retinal locus development in patients with macular disease. Ophthalmology 2005; 112:1579-85.
6. Schartz RB, Thompson JT, Sjaarda R, Sunness JS,. Patterns of referral of AMD patients for low vision intervention in the anti-VEGF era. Investigative Ophthalmology & Vision Science 2008; 49: ARVO E-abstract 4116.

Museum Piece

GEORG BARTISCH 1535–1607

Georg Bartisch, surgeon and oculist, is best known for his Ophthalmodouleia or Augendienst, that is "The Service of the Eyes" published in 1583.

This book was the first to be written in the vernacular German and is remarkable for its illustrations, many drawn by the author himself.

Born in 1535 near Dresden, Bartisch, from the age of 13, was the pupil of several barber-surgeons and his book was the result of 36 years of surgical experience travelling throughout Saxony, Silesia and Bohemia by horse and covered cart. He operated on hernias, cataracts and stones and was sufficiently successful to come to the notice of the Elector of Saxony to whom he became Court Oculist in 1588.

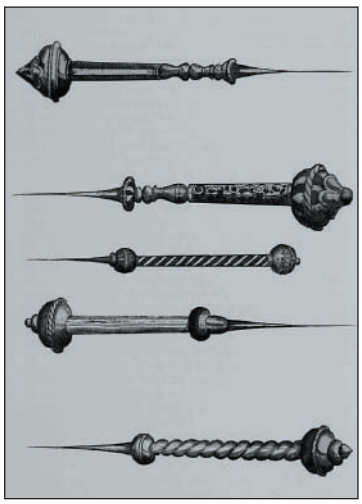
This book, which he published himself, was a kind of vade mecum for all oculists. It covers many deformities and defects of the eyes, including squint and short sight. There are several chapters on cataract and the needling procedure which shows the instruments he used. Lengthy chapters are also given over to the potions and remedies used in a wide variety of diseases of the eye. Bartisch was the first to describe the successful removal of the total eye with cancer in a living human.

This publication has been referred to as the first book on modern ophthalmology and its author as "the father of ophthalmology".

A second edition, in quarto, was published over 100 years later in 1686. It is virtually the same as the original but a number of the illustrations have been re-drawn to reflect the dress of the period. There are fewer plates which are printed in the reverse to the original.

A copy of this rare second edition may still be available at the time that this newsletter is published. Would those who would like more details or to pledge a sum of money (£250-£500) to purchase this important and fascinating book for the Library, please email me by 20 December.

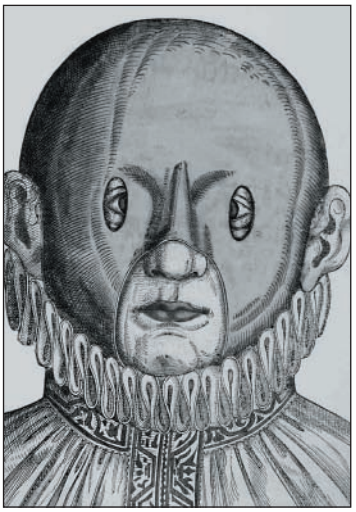
Richard Keeler, Museum Curator
rkeeler@blueyonder.co.uk



Gold plated needles for cataract operations

Georg Bartisch

Eye lid operation



Mask for curing squint

Operating for cataract

Method of cataract operation

Education News

Association of Health Professions in Ophthalmology (AHPO)

Manijet Wishart has been appointed as the College representative on AHPO.

Curriculum Subcommittee - new member required

A new member is required for this Subcommittee which reports to the Education Committee. The new Curriculum is up and running but the project must be evaluated and the content reviewed, refined and updated on an on-going basis.

We seek an active trainer in the UK who can put forward the views of the typical busy ophthalmologist. No specific educational qualification is required.

The Subcommittee meets according to demand, currently 3 – 4 times per year. The new member would also be expected to play an active role in e-correspondence and in drafting and refining proposed curricular developments.

Expressions of interest, along with a relevant CV and a 400-word supporting statement should be sent to *beth.barnes@rcophth.ac.uk*. Applications will be reviewed by the chairman of the Subcommittee and two other members of the Education Committee. **Closing date 07 January 2009**.

CPD Audit shows 21% of participants are failing to keep adequate records

Every two years the College audits Continuing Professional Development activity to ensure that members are able to produce evidence of attendance at Group B activities (external meetings) which they have recorded in their on-line diaries. Ten per cent of those registered for CPD are randomly selected and regional CPD co-ordinators perform the audit. 'Evidence' is defined as a certificate of attendance, receipt, name badge or similar. In 2008, 77 registrants were audited; 52 (67%) responded by sending some proof of their activity.

Of those responding, only 44 (79%) could produce over 75% evidence and 3 (6%) produced 25% or less evidence. Clearly a sizeable minority of CPD participants are failing to keep adequate evidence of their CPD activity. This will become increasingly important as revalidation comes on-stream; members are encouraged to avoid putting themselves at risk of accusations that CPD activity has been claimed but not actually undertaken.

The college strongly advises members to keep careful records of their CPD activities so that evidence is readily available to support the on-line diary declarations.

The next College CPD audit will take place in 2010.

Travel Awards and Fellowship

Information and application forms for all awards are available on the College website: *www.rcophth.ac.uk/education/travelawards*

AWARD	AMOUNT	CLOSING DATE
International Glaucoma Association Fellowship 2009	Two awards of up to £50,000	20 February 2009
Fight For Sight Award 2009	One award of £5,000	13 February 2009

The Map of Medicine Editorial Office is looking for reviewers. For more details please contact *editorial@mapofmedicine.com*

EIDO Healthcare is seeking authors for their patient information leaflets. These have input from the Lay Advisory Group. For more details please contact *owain.tudor@eidohealthcare.com*

Revalidation News

Appointment of a project lead for revalidation

Mr Robert Johnston, consultant ophthalmologist at Gloucestershire Hospitals NHS Foundation Trust, has been appointed to this post following competitive interview. One of his main tasks will be to consult widely with ophthalmologists, covering all the sub-specialties of ophthalmology, to determine the best and most practical measures of good clinical care. The process of revalidation must also be accessible to ophthalmologists who work entirely outside the hospital eye service.

Mr Johnston has a long standing interest in medical informatics and has previously been a contributor to the NHS 'Do Once and Share' project from which the College's cataract data set was developed. He has a financial interest in an ophthalmic clinical information system which is in use in a number of trusts in the UK. The College does not believe that conflicts of interest are likely to arise from Mr Johnston's appointment to this post, but in order to avoid any future potential conflicts of interest in the course of this project, two measures will be put in place:

1. Mr Johnston will be accountable during the period of the project to the College's Revalidation Committee which is chaired by the chairman of the Professional Standards Committee and includes all the College officers and the chief executive.
2. The existing ophthalmic data sets (cataract, glaucoma, diabetic eye disease) and any future data sets covering other areas of ophthalmology will be in the public domain and will be accessible via the College website. Companies which wish to design and market clinical information systems for ophthalmology will have free access to the data sets as a standard for software development.

Although the College believes that electronic clinical records will play an increasingly important part in ophthalmology in the future, the revalidation of ophthalmologists will not depend on access to clinical information systems.

Richard Smith,
Vice President and Chairman of Professional Standards Committee

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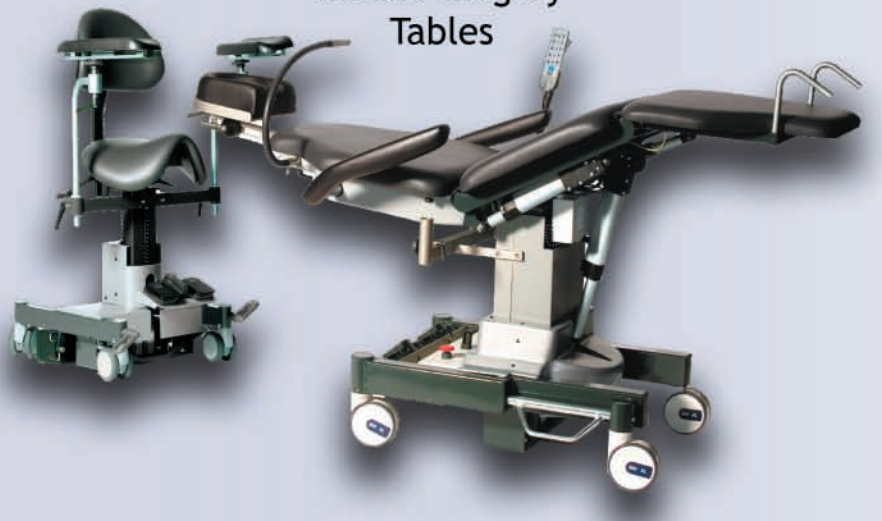

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Choose and Book

All members should have had some experience of "Choose and Book", a system intended to give GPs' patients the opportunity to book or change appointments on line.

The initial system was commissioned by the Department of Health from Connecting for Health. There does not seem to have been a great deal of consultation about the fundamental design, but subsequently a consultative body was formed. All Royal Colleges and professional bodies were invited to nominate representatives to what is now called the National Speciality Reference Group (NSRG).

Choose and Book comprises a structure of Specialty (e.g. Ophthalmology) – Clinic Type (e.g. Glaucoma) – Service (defined by provider). The GP has to identify the correct service for the booking. Most GPs do so by following this tree structure.

Note:
The name given to a service should describe it effectively and thus ensure that it is chosen appropriately.
Providers should provide specific booking guidance for each service.
Providers should make sure that they carefully "proof read" how they have mapped Clinic Types to services – if an error is present then patients may end up in the wrong clinic.

GPs can also search a list of keywords, but this is not used extensively, and can also filter by Consultant name. It is proposed that SnoMed codes be made available, but this is not yet functional.

The Ophthalmology Clinic Type list has been modified several times - sometimes against advice, such as the transfer of ophthalmology paediatric services to the Specialty "Children and Adolescent". Nevertheless, the current list is intended to accommodate the operational priorities of providers (e.g. to ensure that squints are referred to an orthoptic supported service) whilst not expecting too much of the average GP's knowledge of ophthalmology, albeit augmented by an optometrist's letter.

I would welcome comments and invite suggestions for changes to the clinic type list.

Specifically:
- Are some conditions invariably mapped to General Clinics, and hence are redundant?
- Is the Clinic Type "Oculoplastic/orbits/lacrimal" too broad?

The Ophthalmology Clinic Type list is available at *www.chooseandbook.nhs.uk/staff/implement/dos/ specialty-and.xls*

If any members would like to be on a mailing list to be consulted or updated please e-mail me with the subject header "RCOphth CaB".

Nick Strong
IT and Audit Subcommittee
Nick.Strong@nuth.nhs.uk

Quality and Safety Note; Avoiding IOL errors

A review of the National Reporting and Learning System (NRLS) database at the National Patient Safety Agency (NPSA) identified 88 incidents where the 'wrong' or incorrect intra ocular lens (IOL) was inserted during cataract surgery or a similar near miss occurred. A theme contributing to the selection of wrong/incorrect IOLs in operating theatres includes incorrectly writing the dioptric power of the IOL required on theatre 'swab/white' boards. Furthermore, this practice, according to reports received, appears to be detracting from safety checks for individual patients. 16 incidents were due to incorrect biometry or keratometry readings. Other issues included: transcription errors, late/undetected changes to operating lists, wrong power selection because of inadequate documents and poor IOL stock availability. Such themes are similar to other correct IOL safety, or error, reviews and alerts.[1,2]

Suggested preventative measures for staff include: careful pre-operative verification of the correct IOL power and type required, and the vigilant transcription of IOL power/type required. Circling/highlighting the IOL power required on the biometry print out as well as carefully writing the power required in the records and cross checking is also prudent. Beware of the danger of similar appearing (when hand written) or sounding numbers/abbreviations, such as '11' and '17' or '14' and '19' or '20' and '2D'. Mixing up decimal points or full stops with zero numeral such as '2.' and '20' has caused problems. In another report '-5D' was confused with '+5D'. Use the most accurate biometer and software. When low or high IOL powers are needed, give adequate pre-operative notice for stocking and check appropriate formulae were used. Be wary when significant differences in fellow eyes calculations or when IOL power calculation and spectacle powers do not chime. Avoid rushing surgery and peri-operative distractions. Vigilance and cross checking including a 'time out' prior to surgery commencement, as is advised in the WHO's 'Safe Surgery Saves Lives' (SSSL)[3] initiative, is prudent. Focus on quality not just high volume cataract surgery.

The NPSA's 'Correct Site Surgery Alert' and checklist will be refreshed in the light of the SSSL initiative for a re-launch in 2009. The College will contribute to this project.

Comments from College members on these matters are requested and will be of value in revising the College's Cataract Surgery Guidelines in 2009. The College remains committed to quality in ophthalmology, which includes reporting and learning from errors and maintaining safety. The updated *Patient Safety in Ophthalmology*[4] document, from the Quality and Safety (QaS) Committee, and now available on the Ophthalmic Services section of the College website, provides further guidance.

References
1. American Academy of Ophthalmology. Minimizing wrong IOL placement. Patient safety bulletin. 2005. http://one.aao.org/CE/PracticeGuidelines/Patient.aspx
2. Jin G, Crandall A, Jones J. Intraocular lens exchange due to incorrect lens power. Ophthalmology. 2007; 114: (3),417-424
3. World Alliance for Patient Safety. Implementation manual – surgical safety checklist. World Health Organisation. 2008. http://www.who.int/patientsafety/safesurgery/
4. Royal College of Ophthalmologists. Patient Safety in Ophthalmology. 2008. http://www.rcophth ac.uk/standards/ophthalmicservices

Simon Kelly, Quality and Safety Subcommittee.
Larry Benjamin, Cataract Surgery Guidelines Working Party.

18 Weeks Treatment Standard Update

Ophthalmology services have helped the NHS reach its commitment to treat patients within 18 weeks of referral, where clinically appropriate and convenient to the patient.

The target, set for December 2008, was for 90% of those who need admission and 95% of patients whose treatment ends as an outpatient to be treated within 18 weeks. Yet by August 2008, 92% of admitted ophthalmology patients and 96% of outpatients began treatment within 18 weeks. A year earlier, just 40% of ophthalmology patients requiring admission entered hospital within 18 weeks.

This is a significant achievement and one due to the hard work and dedication of College members. Trusts have improved ophthalmic services access in different ways and to sustain such improvement members are invited to share best practice via *contact@rcophth.ac.uk*

The College has consistently argued that clinical priorities must not be distorted to achieve the 18 week target. College concerns centre on inter-professional transfers and on some Trusts 'overlooking' long term patients, such as glaucoma cases, in favour of treating new patients swiftly to meet targets. Philippa Robinson, National Implementation Director for 18 Weeks, said that the Department would work with staff on such concerns

More information available at *www.18weeks.nhs.uk.*

From the Medicines and Healthcare Products Regulatory Agency (MHRA)

Manufacturer's recall of silicone oil used in retinal surgery

Oil manufactured by Fluoron GmbH has been subject to a worldwide recall. It is a highly pure silicone oil tamponade sold under the name of SILURON 1000 supplied in either a vial or a pre-loaded syringe. The manufacturer became aware of some reports from Portugal of the SILURON 1000 becoming opaque.

There were no reports of harm to patients e.g. emulsification, inflammation or changes to the retina.

Reported problem: the coating on power cables of AMO handpieces

There appear to be small holes or cracks on the surface which may be deep enough to either be a hazard to the cable beneath, or harbour debris which may compromise the decontamination process. The manufacturer has examined the cables and found them to be surface features only but the hospital has continued to find them on new cables. Users are asked to check AMO handpiece cables and report any similar incidents.

User error

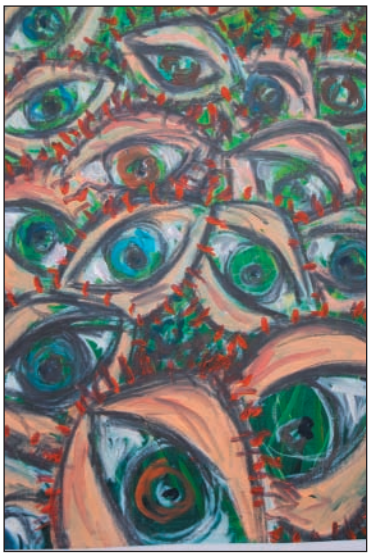
A surgeon had to undertake a vitrectomy during a phaco procedure and changed the handpiece in mid surgery. When he returned to using the phaco handpiece he incorrectly connected the irrigation and vacuum lines leading to the collapse of the lens bag. The manufacturer's instructions clearly state to test the handpiece prior to use to ensure correct function. It should not be easy to incorrectly connect in this manner as the two connectors are clearly different, but testing would have stopped the incident altogether.

Charles Bonnet Syndrome

The College and The Macular Disease Society held an event on 12 November at 17 Cornwall Terrace to raise awareness of Charles Bonnet Syndrome. It was attended by journalists from national newspapers, the BBC, Sky television and magazine contributors.

Patients with sight-destroying conditions such as macular degeneration should be advised, on or around the time they are diagnosed, that they might develop visual hallucinations. These can often be disturbing and can lead patients to believe they are suffering from psychosis or dementia.

Each ophthalmologist will want to use their own judgement and knowledge of the patient, to judge how best to break the news about the possibility that patients may develop visual hallucinations.



Mr Cecil Riley [c]

The Macular Disease Society has been interviewing members in detail about their experiences of Charles Bonnet Syndrome. Of 35 patients who approached the Society, none was informed by their doctor or optician of the possibility that they might develop Charles Bonnet Syndrome before they experienced visual hallucinations.

Dr Dominic ffytche, a senior lecturer at the Institute of Psychiatrists, said: "There is no evidence that being forewarned would cause unnecessary anxiety, people prefer to be told. At least 10% of people with Age Related Macular Degeneration (AMD) get Charles Bonnet Syndrome. The small number of studies conducted in eye clinics show around a 10-20% prevalence of Charles Bonnet Syndrome. One study looked at patients with severe visual loss [caused by a range of different eye conditions] and this figure was closer to 50-60%."

The presentation included an image by artist and AMD sufferer, Mr Cecil Riley, who painted his hallucinations.

The White Paper "Trust, Assurance and Safety" called for clinical audit to be revitalised. In response, in April 2008 the Department of Health appointed the Healthcare Quality Improvement Partnership (HQIP) to manage the National Clinical Audit and Patient Outcomes Programme and support local clinical audit activity.

HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and the Long-Term Conditions Alliance and its purpose is to promote better healthcare by providing support and advice to those responsible for managing quality improvement work.

HQIP has three immediate priorities: to manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), to support and enable clinical audit staff on a local level, and to promote clinical audit as the engine that drives quality improvement.

For more information, visit *www.hqip.org.uk.*

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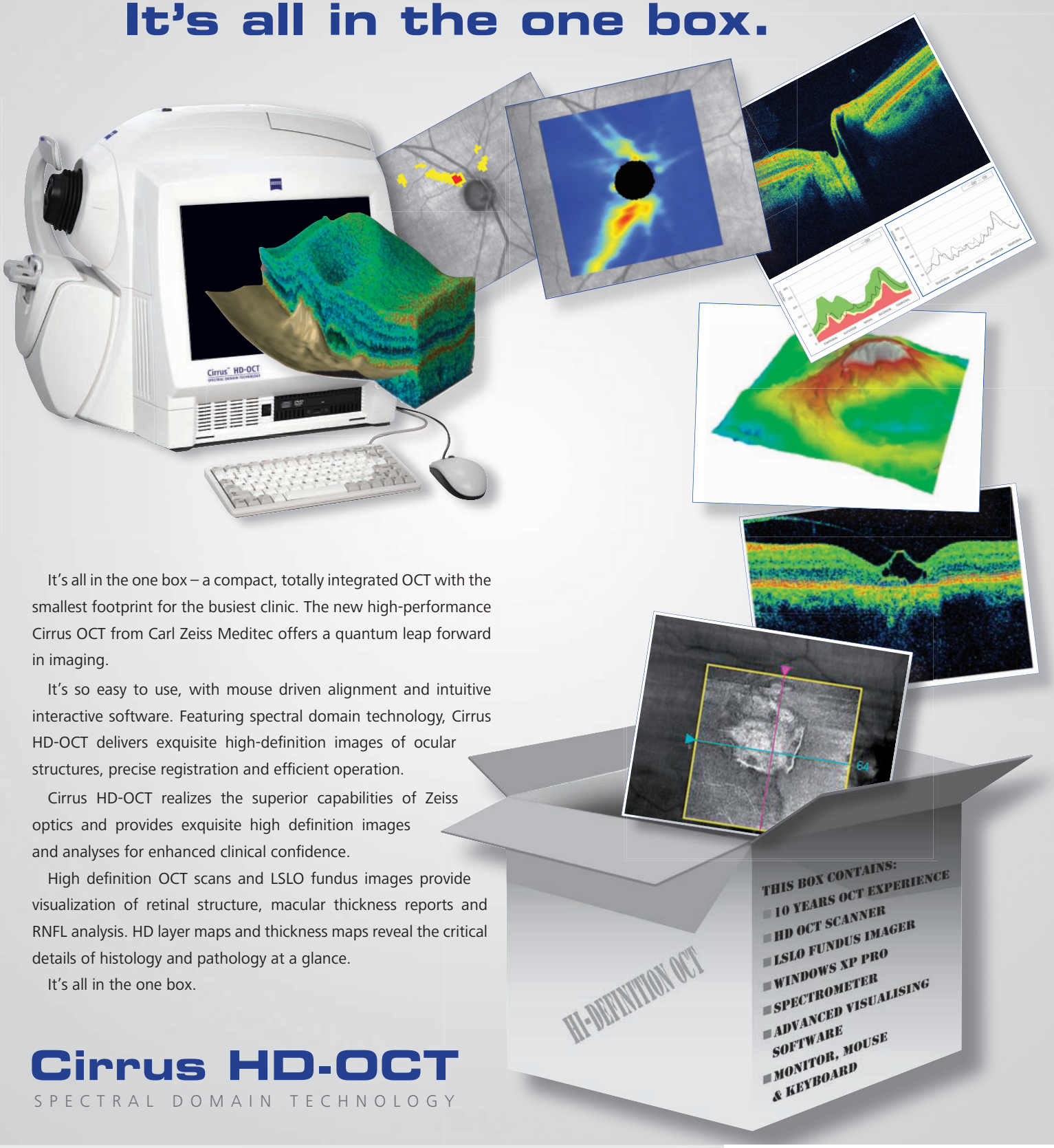

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We make it visible.

Implementing the UK Vision Strategy

Leeds, October 2008

Over 100 representatives of the eye health, sight loss and adult social care sectors convened to discuss the implementation of the UK Vision Strategy (UKVS) in Leeds. National guest speakers included College President Brenda Billington, Vision 2020 UK Chief Executive Mike Brace and RNIB Chief Executive Lesley-Anne Alexander. The day began with a Leeds Vision Strategy Challenge Event at the Civic Hall, followed by a lively symposium hosted by NHS Leeds.

The Leeds Vision Strategy aims to address the needs of the 750,000 strong population of Leeds in line with the UKVS timescale. The key priority areas of the Leeds Vision Strategy are closely linked to the priority areas of the UKVS:

- awareness of, education about eye health and prevention of sight loss
- correction and high-quality treatment of visual impairment and improving the eyecare journey
- support to people with sight loss for independent living
- empowerment of people with sight loss and the development of an inclusive society.

One of the strengths of the symposium resulted from the eclectic mix of backgrounds of the participants ranging from service users (and their dogs!) to representatives from Leeds City Council/Adult Social Care, NHS Leeds (Leeds PCT)/Teaching Hospitals Trust, the Local Optometric Committee and ophthalmologists from across Yorkshire. The meeting was chaired by Mick Ward, Head of Strategic Partnerships (NHS Leeds /Leeds City Council) who with James Woodhead (NHS Leeds/ Leeds City Council /UK Vision Strategy Team) has led the development of the Leeds Vision Strategy.

After a showing of the emotive UKVS launch DVD, the afternoon ended on a positive note with an address by our President emphasising the role of the College and its members in national and local UKVS implementation. She touched on the many roles of the College such as education, training and independent review. Through these areas, the College will continue to set standards in line with the expectations of the UKVS. This will safeguard the College's position, to quote the President, as the "Guardian of Excellence".

For more information about the UKVS, visit *www.vision2020.org.uk* or *www.rnib.org.uk*

Kanchan Bhan & Andy Cassels-Brown

Thrive – The National Blind Gardeners' Club

Members might like to tell patients about this joint project with the RNIB. The Club brings together gardeners who are blind or partially sighted to share information, tips and techniques. Members receive a quarterly magazine (in a variety of formats) and regular e-bulletin on events and seasonal gardening tips. Specific gardening advice is also available.

Contact *info@thrive.org.uk* or 0118 988 5688

Help Sought

A College representative for the British Standard Institute. Contact: *penny.jagger@rcophth.ac.uk*

A College representative on the European Board of Ophthalmology. Contact: *beth.barnes@rcophth.ac.uk*

SAS Members or Fellows willing to be examiners in the Refractive Certificate.

Applicants must have been in post for a minimum of 3 years, active in the NHS and experienced in refraction. Contact *emily.beet@rcophth.ac.uk*

Clinical Excellence Awards 2009 Round

The Clinical Excellence Awards recognise and reward NHS consultants and academic GPs who perform 'over and above' the standard expected of their roles. The Scheme is administered by the Advisory Committee on Clinical Excellence Awards (ACCEA). It is managed on the Committee's behalf by a full-time secretariat that is currently part of the Department of Health.

It seeks nominations for national awards from this College but final decisions rests with ACCEA and the Secretary of State. The number of applications that the College can support is determined by ACCEA and relates to the size of the consultant body. There are always more applications than slots and several applicants are always disappointed.

Over the years, the College has tried to make the system more equitable and our Clinical Excellence Awards Committee met on 6 November 2008 under the chairmanship of the Lay Advisory Chairman, Tim Battle.

Northern Ireland and Eire do not participate in the system but all other Council regional representatives had been asked to nominate a member for the Committee. In addition to a good geographical spread, there was a spread from those consultants holding no awards, to those holding Bronze through to Gold.

All applications were sent out to the committee members in advance of the meeting to score across the domains using the scoring structure laid down by ACCEA. The arithmetic mean, the standard deviation of scores and the ranking of rankings was then calculated. However, this exercise was a springboard to discussion and not a substitute for discussion. The Committee has put forward 4 applications for Gold, 7 for Silver and 12 for Bronze.

It was felt that some applicants had not completed the form correctly and the College has updated its guidance for applicants. Please see *www.rcophth.ac.uk/finance-membership/members/accea-tips*

The results for the 2008 Round are available on *www.advisorybodies.doh.gov.uk/accea/annual.htm*

Honorary Fellows

At the Admissions Ceremony in June 2008, an Honorary Fellowship was awarded to ***Dr Jeffrey Jay***

This is an edited version of the citation given in his honour.

Madam President, Members of Council, ladies and gentlemen,

Jeffrey is a true son of the city of Glasgow. He went to the Glasgow High School, followed by the University of Glasgow. He qualified firstly with an Honours degree in Physiology, and in 1970 with an MBChB also with Honours, one of the few to achieve this, and he won the Brunton Memorial Prize for the most distinguished medical graduate of his year.

After his house jobs, he spent a year in Pathology, before joining the Tennent Institute of Ophthalmology, under the mentorship of Wallace Foulds, the first President of our College. Within 6 years, he had been appointed a consultant in the Department, with a special interest in external eye disease and glaucoma.

As a clinician, he has an encyclopaedic knowledge of every ophthalmic sub-specialty and his opinion was sought, not only from his immediate colleagues, but from the entire Scottish Ophthalmic community. During his career, he has helped to train a generation of ophthalmologists. He has shown them how to analyse a clinical problem and refine their clinical judgment to make a logical treatment plan for the patient as a whole. In ophthalmic surgery, he taught them his meticulous technique, exquisite tissue handling, and most importantly, a profound understanding of the anatomical and scientific principles underlying each procedure.

He has been an editorial writer for "Eye" and the British Journal of Ophthalmology, and authored almost one hundred scientific papers on general ophthalmology, external eye disease and glaucoma in all its forms. Amongst his best known contributions are his papers on early trabeculectomy for glaucoma, a controversial subject in it's time, but explained with the great precision and clarity for which he is renowned.

He has delivered lectures at every important scientific forum in the United Kingdom, and also at many overseas symposia. There can be few Departments in the UK which have not welcomed him as guest speaker.

He has been a member of many Scientific Societies, including the British Eye Study Group, Arcus, the Oxford Congress (as Master 2002-04) the European Board of Ophthalmology and our own Scottish Ophthalmology Club, from which he has just stood down as President.

Jeffrey's other major contributions have been as an administrator and communicator. He has held numerous managerial positions in our Department as Chairman and the first Clinical Director. He turned his hand to different skills becoming the sole architect and interior designer of our new department at Gartnavel Hospital.

Jeffrey has been involved with this College from its earliest days. He was a Council Member from 1989 and Chairman of the Education Committee and Vice President from 1994. He was elected President (1997 – 2000) and he greatly enhanced the status and reputation of the College both within the specialty and also with our sister Royal Medical Colleges.

Amongst his greatest contributions is the "Action on Cataracts" document, published in 2000. The development and implementation of the "Action on Cataracts" Programme helped to streamline the management of this condition and greatly increased the number of procedures carried out in the UK annually.

Over the last 20 years, his wisdom and advice have been sought by the devolved Scottish Government's Health Department, and the Department of Health in London. He has chaired the Diabetic Retinopathy Screening Implementation Group and been Specialty adviser in Ophthalmology to the Chief Medical Officer of Scotland.

Since 1989 Jeffrey has served on the General Medical Council, bringing his analytical skills and formidable clinical experience to a number of roles in that organisation.

It is little wonder, therefore, that he received the C.B.E. for services to Ophthalmology in 2001, an honour richly deserved.

So much for the professional attributes; what about the man himself?

To those who know him well, Jeffrey is a true gentleman, a loyal and trusty friend, and is highly respected by all his colleagues on both sides of the border. Despite all the gravitas and worthiness to which I have alluded, as you might expect, Jeffrey has many other interests outside ophthalmology and is a pretty down-to-earth fellow. He's a keen sailor, skier, traveller, photographer, historian and family man.

I am delighted to present Dr Jeffrey Louis Jay CBE for the award of honorary fellowship.

Harold Hammer

The President, Brenda Billington, with Jeffrey Jay and Harold Hammer

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Annual Congress 2009

19 – 21 May
The largest ophthalmic meeting in the UK
ICC, Broad Street, Birmingham

College Seminar Programme 2009

All seminars take place at the College, unless otherwise stated

27 January
Commissioning Eye Care Services and Community Based Provision
Leeds PCT Community Eye Centre, Leeds
Chaired by: Mr Nick Astbury and Mr Andy Cassels-Brown

17 March
Retinopathy of Prematurity
Chaired by: Mr Ayad Shafiq,

19 June
IXth State of the Art Refractive & Cataract Surgery Symposium
The University of Hull, Cottingham Road, Hull
Chaired by: Mr Milind Pande

16 – 17 July
Retinal Imaging Course
Institute of Physics, 76 Portland Place, London
Chaired by: Mr Yit Yang

8 September
Use of glaucoma imaging in clinical practice – Who, when and how to scan your glaucoma suspects/patients
Chaired by: Professor Stephen Vernon

16 September
Advances in Keratoplasty – Layer by layer: How Selective Lamellar Corneal Surgery is the Shape of Things to Come
Chaired by: Mr David Anderson

2 October
Intravitreal Therapies
Chaired by: Professor Sue Lightman

13 October
Ocular Oncology – managing adult ocular tumours
Chaired by: Professor Bertil Damato and Miss Sarah Coupland

12 November
Shared Care Services in Ophthalmology – The provision of routine glaucoma management
Chaired by: Mr Jeremy Diamond

19 November
Shared Care Services in Ophthalmology – Review of current successful schemes
The Royal College of Surgeons, Edinburgh
Chaired by: Mr Augusto Azuara-Blanco

27 November
Elizabeth Thomas Seminar –Update on recent developments in macular disease
The East Midlands Conference Centre, Nottingham
Chaired by: Mr Winfried Amoaku

Training the Trainers

This course consists of 6 half-day modules to be run over 3 days and is particularly useful for Programme Directors, College Tutors and educational supervisors.

4 March and 29 September
What to teach / How to teach

7 April and 20 October
Improving teaching skills / Feedback and appraisal

22 June
Assessment / Problem Solving
Please note that day three will only be run once.

Please visit www.rcophth.ac.uk/education/traintrainers for further details.

College Skills Centre Programme 2009

Ten Basic Microsurgical Skills Courses are planned, details on the website at *www.rcophth.ac.uk/skillscentre/*.
Additional courses are listed below and these take place at the College.

2 February
Intermediate Phacoemulsification

6 February
Vitreoretinal HST/OST Study Day

28 April
Oculoplastics

7 May
Intermediate Phacoemulsification

7 December
Medical Retina

RSM Ophthalmology section

15 January
Consent, Capacity and Confidentiality
Chaired by: Mr Graham Kyle

12 February
New Frontiers in Paediatric Ophthalmology
Chaired by: Mr Ken Nishall

12 March
Laser 'Weapons' in Ophthalmology and in War
Chaired by: Prof John Marshall

14 May
Plastic and Oculoplastic
Chaired by: Miss Fiona Robinson

11 June
Trainees Meeting: Posters and Presentations

Other events 2009

Oxford Ophthalmological Congress - Call for papers
Abstracts should be submitted via:
www.oxford-ophthalmological-congress.org.uk
Closing date: 6 January

15 - 18 January
Asia ARVO, organised by the Indian Eye Research Group,
The Hyderabad International Convention Center, Hyderabad
asiaarvo@lvpei.org
www.asiaarvo2009.org

22 - 23 January
Trends in Ophthalmology Meetings
The Royal Society, 6-9 Carlton House Terrace, London
info@trendsinophthalmology.com
www.trendsinophthalmology.com

19th March
The Medical Ophthalmological Society (UK) - Annual Meeting
Governor's Hall, St. Thomas' Hospital, London
lindy.gee@mosuk.co.uk
www.mosuk.co.uk

27 March
MDA Annual Eye Surgery Update
County Hall, Cardiff, South Wales, U.K.
laservision@mdaclinic.co.uk
www.mdaclinic.co.uk

18 June
British Ophthalmic Anaesthesia Society
Manchester Conference Centre
roger.slater@cmmc.nhs.uk
www.boas.org

26 June
Stoke Mandeville – opening of new eye unit and reunion
Past employees most welcome to attend.
Please send your contact details to:
bruce.james@buckshosp.nhs.uk

5 - 8 July
Oxford Ophthalmological Centenary Congress
The Oxford Playhouse
To celebrate 100 years since it was founded by Robert W Doyne there will be a boat trip to mirror that taken at the first meeting and the Annual Dinner will be held in Blenheim Palace.
o_o_c@btinternet.com

26 - 27 November
Trends in Ophthalmology Meetings
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info@trendsinophthalmology.com
www.trendsinophthalmology.com

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