QUARTERLY BULLETIN OF THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

College NEWS

Winter
2012

Clinical Excellence Awards
(CEA) – 2013 ROUND

Since the publication of the Autumn edition of College News, ACCEA has informed us that it will not open any 2013 Round until after the results of the 2012 Round are published in 'early spring' 2013. In view of this, the College has put back the timetable for the College processes by several months which means that the revised schedule for consultants wishing to apply for a College ranking will be:

- Applications to be considered for College ranking to be emailed to *accea@rcophth.ac.uk* and to be received by **9am on Monday, 11 March 2013** at the latest;
- CEA Committee to convene in mid-April.

Consultants wishing to submit applications for the 2013 Round are urged to check that their names and details are correct on the ACCEA Nominal Roll and to have their application ready by early March. Consultants who need to renew their awards are reminded that the onus is on them to apply for renewal in the fourth year after their last award. A new feature is that renewal applications may now be supported by College citation. Any consultant wishing to apply for a citation to support their renewal application will need to adhere to the timetable above.

Part 1 FRCOphth

The Examinations Committee is delighted to announce that from 2013 the Part 1 FRCOphth examination will be held in partnership with the British Council in Kuala Lumpur. It is also planned to hold the Refraction Certificate examination at a centre in Malaysia from 2014 and discussions are underway with potential venues. Further details on this will be available in due course.
Please visit *www.rcophth.ac.uk/examinations* for further information.

Emily Beet,
Head of the Examinations Department

The British Ophthalmological Surveillance Unit: Electronic Reporting Update

The BOSU is currently developing an email/ internet based reporting system. This will be piloted and introduced in the New Year. Once available it will allow reporting ophthalmologists to make their monthly report online, saving both time and the cost of postage. We hope that this will make reporting easier and more efficient. However, we will of course continue to send out the yellow monthly report cards to those who favour the current method.

Please tell us if you move
database@rcophth.ac.uk

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
robertsloan@virginmedia.com

Copy deadlines
Spring
5 February 2013
Summer
5 May 2013
Autumn
5 August 2013
Autumn
5 November 2013

Global Burden of Diseases, Injuries and Risk Factors (GBD) study

- vision impairment and blindness results to be launched

A UK-based team at the Vision & Eye Research Unit (VERU; Postgraduate Medical Institute) of Anglia Ruskin University, Cambridge led by Professor Rupert Bourne has been coordinating for the past four years a global collaboration of 79 ophthalmologists and optometrists with an interest in the epidemiology of vision impairment and blindness. This Vision Loss Expert Group has produced a global database of the prevalence of vision impairment and blindness that has become the principal repository for this information at the World Health Organisation.

The contribution of vision loss to the global burden of disease will be published in four papers in the Lancet in December this year. This is the first time an issue of the Lancet has been devoted entirely to one study, and the results will be launched at The Royal Society on 14 December 2012. The GBD project is funded by the Bill and Melinda Gates Foundation, while a Fight for Sight grant has been used for the statistical modelling of temporal trends of blindness over the past 30 years.

Recently, the Brien Holden Vision Institute has generously agreed to fund a visualisations project that will both update the database with prevalence data from future studies (over the next five years) but also fund the creation of an internet portal to allow users worldwide to search and download region and country-specific data. It is anticipated this will greatly assist efforts by commissioners and providers in planning distribution of resources and also serve as an important advocacy tool in pursuing the aims of Vision2020.

Prof Bourne's team is seeking a motivated, UK-based trainee ophthalmologist to work intermittently with the team over the next five years to update and maintain this database/website, working with health informatics colleagues in Geneva. This work could continue alongside the suitable individual's full-time clinical post as a research project. For further information regarding this post, please contact Rupert Bourne via *rb@rupertbourne.co.uk*

For further information regarding the project:

1. *www.who.int/evidence/bod/*

2. Bourne R, Price H, Stevens G. Global Burden of Visual Impairment and Blindness. Arch Ophthalmol. 2012; 130 (5): 645–647.

3. Bourne R et al. New Systematic Review Methodology for Visual Impairment and Blindness for the 2010 Global Burden of Disease Study. Ophth Epidemiol. 2012 (accepted September 2012).

4. The Lancet, December 14 2012.

Macular Disease Society

– new year, new name, new look!

In January 2013, the Macular Disease Society will launch its new name and a fresh new look. A major review of the organisation's reputation and communications revealed that whilst its patient information, support services and research funding were valued by patients and professionals alike, more people need to hear about the help on offer from the experts on living with macular disease. Patients surveyed also revealed their overwhelming dislike of the word 'disease', which deterred many from seeking the Society's help. From January the Society will become simply, the Macular Society. The Society will also be making it easier for eye clinics to order its FREE information leaflets as well as launching a professional members' scheme. For information go to *www.maculardisease.org/professionals.*

New logo

Top Doctors 2013

The Macular Disease Society and the Royal College of Ophthalmologists are working together again in 2013 to present a UK-wide series of talks for patients with macular degeneration. Following the success of eight sell-out seminars held this year to mark the Society's 25th anniversary, they are visiting six different locations in 2013. Each seminar includes talks from the local consultant ophthalmologist leading the wet-AMD service, a researcher in the field and a low vision specialist. Seminars are being held in Perth, York, Chester, Cardiff, Peterborough and Exeter in April and May.

Pocklington Project
Please contact Amy Burton at Aston University if you are interested in a project on communication with patients. Emal: *a.burton@aston.uk.*

Wolverhampton PCT are looking for a National Ophthalmic Expert to advise their Ophthalmology Peer Review which is a paid role. Email: *desiree.lichtman l@nhs.net*

Members' News and Appointments

Consultant Appointments

We rely on medical personnel departments to confirm consultant appointments. Please contact *aac@rcophth.ac.uk* if you notice an error or omission.

Mr Peter Addison	Moorfields Eye Hospital, London
Mr Amar Alwitry	Jersey General Hospital, St Helier
Ms Nishani Amerasinghe	Worthing Hospital, Worthing
Mrs Rina Bhatt	New Cross Hospital, Wolverhampton
Mr John Buchan	St James's University Hospital, Leeds
Mr James Church	Altnagelvin Area Hospital, Londonderry
Mr Bryn Davies	St James's University Hospital, Leeds
Mr Sumit Dhingra	Peterborough City Hospital, Peterborough
Mr Haralabos Eleftheriadis	King's College Hospital, London
Mr Daniel Ezra	Moorfields Eye Hospital, London
Miss Emily Fletcher	Gloucestershire Royal Hospital, Gloucester
Miss Devina Gogi	Calderdale Royal Hospital, Halifax
Mr Graham Hay-Smith	Luton and Dunstable Hospital
Mrs Helen Herbert	Taunton and Somerset Hospital, Taunton
Mr Badrul Hussain	Moorfields Eye Hospital, London
Mr George Kalantzis	St James's University Hospital, Leeds
Mr Inayat Khan	Hillingdon Hospital, Uxbridge
Mr Nonavinakere Manjunatha	University Hospital, Coventry
Mr Fayyaz Musa	Calderdale Royal Hospital, Halifax
Mr Abdul Rauf	Betsi Cadwaladr University Health Board, Wrexham
Mr Kashif Qureshi	Conquest Hospital, St Leonards-on-Sea
Mr Sukumaran Ramanathan	Pilgrim Hospital, Boston
Miss Suhair Twaij	South Tyrone Hospital, Dungannon
Mr Sherif Wasfy Ragheb	City General Hospital, Stoke on Trent

High Holborn Reunion

The photograph above was taken at the Reunion Lunch held on 26 October 2012. The hospital closed 24 years ago and there will be a campaign to keep the name 'High Holborn' in the public eye. More details to follow.

20th Year Alumni planned for Southampton

Please contact *susan.cousens@uhs.nhs.uk* if you are interested in this event to be held in 2014.

Obituaries

We note with regret the death of:

Dr Christopher Joseph Earl
Ealing, London

Mr Howard Fyfe Harper
Islington, London

Mrs Una Kathleen Goddard
Beverley, North Humberside

Mr John Robin Pyne
Shotesham, Norfolk

Honorary Fellowship

Professor Carrie MacEwen has been awarded an Honorary Fellowship by the Faculty of Sport and Exercise Medicine. Carrie represented the College on the Shadow Intercollegiate Academic Board of Sport and Exercise Medicine, then the Intercollegiate Academic Board and ultimately the Faculty.

Addenbrooke's Abroad
Cambridge University Hospitals

Ophthalmologist needed for a technical advisor role in Botswana

Nascent diabetic retinopathy screening services (DRSS) have been established in Botswana. An ophthalmologist with experience of providing these services is needed for a three-month technical advisor role.

The technical advisor will review what has been established and will work with government and key stakeholders to develop and agree a long-term plan for DRSS throughout Botswana. The role will also involve providing training to ophthalmic staff.

This is a voluntary role but all costs will be covered including a living allowance. To register interest and for more information please contact *evelyn.brealey@addenbrookes.nhs.uk*

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THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

Focus

Winter
2012

Mike Harris, *Communications Lead*
NHS Adult Screening Programmes
5th Floor, Victoria Warehouse,
The Docks, Gloucester GL1 2EL
Email: mike.harris@nhs.net

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

The NHS Diabetic Eye Screening Programme: New Common Pathway.

The success of the NHS Diabetic Eye Screening Programme depends upon ensuring the early identification and appropriate treatment of patients with sight-threatening retinopathy. Crucial to this is the relationship between screening and ophthalmology. Hence, ophthalmologists working in medical retina clinics need to know how the screening programme works and be aware of the forthcoming changes to the common pathway for diabetic eye screening.

Background: The four UK nations were the first countries in the world to introduce systematic national screening programmes for diabetic retinopathy. The implementation of screening in England was announced in the 2003 Delivery Strategy for the National Service Framework for Diabetes and, by 2008, local retinal screening programmes covered the whole country. Four years on, annual screening for diabetic retinopathy is an established and essential component of effective healthcare for all people with diabetes aged 12 and over across the UK.

Collaboration between the screening programmes for diabetic retinopathy in England, Scotland, Wales and Northern Ireland is an integral part of the UK National Screening Committee's strategy. The four UK nations continue to work together closely in a number of areas, including a current evaluation project to determine the optimal screening intervals, particularly for low risk patients who have no diabetic retinopathy.

Retinal screening in England is overseen by the NHS Diabetic Eye Screening Programme (NDESP) and delivered by more than 80 local programmes. England has over 2.5 million people aged 12 and over with diabetes with a 5% (120,000) increase every year. NDESP has a challenge to ensure a consistent high quality annual screening service as well as to ensure a smooth and safe transition for diabetic eye screening into the new commissioning structures in England following the NHS reforms effective from April 2013.

Significant changes are being made to the service – most importantly, new grading criteria and a development of a new common pathway to be implemented in a phased roll-out across England. These changes will have implications for everyone involved in the service, from ophthalmologists and optometrists to screening providers and commissioners.

Screening delivery: Diabetic retinopathy is the most common cause of sight loss in the working age population[1] and it is estimated that screening has the potential to save more than 400 people per year in England from blindness[2].

All people with type 1 or type 2 diabetes are at risk of developing sight-threatening retinopathy. The most at risk are those with long duration and/or poorly controlled diabetes and hypertension.

Screening using digital photography facilitates timely treatment of patients by detecting sight-threatening retinopathy early. It also gives patients and GPs information about very early micro-vascular damage so as to prompt optimum control of diabetes to help reduce progression of retinopathy as well as other morbidities related to diabetes.

Screening in England is organised and delivered by a range of providers as per local commissioning arrangements. The local programmes organise the call and recall process. Various models of screening exist e.g. screening in static units using cameras in a hospital or diabetes centre or mobile clinics (GP surgeries, screening vans), or optometry-based services by accredited optometrists. All four UK nations use the training and accreditation package for screeners offered in conjunction with City and Guilds[3], which awards a Level 3 Qualification in Diabetic Retinopathy Screening that consists of nine learning units.

Each of the four nations has some variation in screening protocol and grading, but in general, the photographs are graded and the results sent to the patient and their GP within six weeks. Depending on the results, patients are either recalled for annual screening, invited back for more frequent surveillance or referred on to hospital eye services. During 2011–12, NDESP invited 2,362,000 people in England for screening and 1,911,000 of these attended[4] – an overall uptake rate of over 80%.

Quality assurance: Local programmes in England deliver screening in line with NDESP's national service objectives and quality assurance standards[5]. These standards were revised in 2010–11 to improve the quality, collection and comparison of data so as to reduce variability and to facilitate identification of local issues and to improve standards.

All programmes carry out their own internal quality assurance checks by regularly monitoring their screening data. Programmes are also held accountable through external quality assurance (EQA) visits and the submission of key performance indicators (KPIs) and annual reports. EQA visits play a key role in monitoring local programme's performance and provide clear action plans after each visit to address any issues. The national QA team provides support and advice to programmes and liaises with SHA screening leads whenever there are patient safety concerns.

New common screening pathway: The NDESP has identified that significant variation currently exists between programmes in terms of grading and referral processes as well as commissioning as to what activities are part of screening and what activities are part of diagnostic and treatment services. To address these issues, a new grading criteria and common pathway for diabetic eye screening[6] will be implemented in phases across England during 2013–14.

The new pathway and grading criteria will ensure a consistent approach to the commissioning and delivery of screening. From April 2013, national screening programmes will be commissioned by the NHS Commissioning Board (NHS CB) on behalf of Public Health England while diagnostic and treatment services will be commissioned by clinical commissioning groups (CCGs). The NHS CB and CCGs will have separate budgets, so it is vital there is clarity about who is commissioning which part of the service.

NDESP will support local programmes during the implementation of the new pathway and grading criteria to ensure patient safety is not compromised. The roll-out of a consistent pathway nationwide will also reduce variation in data reporting and enable the quality of screening services to be monitored and compared more effectively and consistently.

Key elements of the new common screening pathway include:

- All local programmes to provide primary, secondary and arbitration grading
- Annual recall patients will be the only patients retained in the screening service
- It will be possible to manage patients who:
  - require more frequent monitoring, (e.g. three/six monthly) or screening in pregnancy photography during pregnancy, in new photographic surveillance clinics (out of routine screening pathway)
  - have unassessable images in slit lamp biomicroscopy surveillance clinics
- All programmes will move to features-based grading. Graders will not be able to override a grade derived from correctly identified features.

Some clinicians have found that the current R1M1 referral threshold leads to unnecessary referrals and pressures on hospital eye services. The new pathway will enable many of these patients to be kept in a surveillance service delivered by the screening programme without the need for a referral. A consultant ophthalmologist with medical retina experience will supervise patients within these surveillance clinics according to local protocols and based on best evidence. In future, the NHS CB will commission both photographic and SLB surveillance as part of the screening pathway but this activity will be recorded separately from the annual screening recall activity.

Provision of optical coherence tomography (OCT) is not part of the new pathway but can be added to the photographic surveillance screening service if commissioned by the local CCGs. Guidance on how surveillance clinics should be set up and run will be provided to local programmes and commissioners once finalised.

The new pathway changes clarify circumstances in which patients can be suspended or excluded from screening. Patients under care of ophthalmology for diabetic retinopathy should be suspended and not be invited for annual screening. The local programme's clinical lead or a designated clinician will assess patients who are considered to have an ungradable image according to NDESP's exclusions and suspensions guidance.

New grading criteria: The introduction of features-based grading will emphasise the relationship between features and screening outcomes.
The changes to the grading criteria include:

- Defining the R2 pre-proliferative level
- Defining groups of exudates
- Introduction of a stable treated R3 grade (R3s)
- Simplification of image quality into adequate and inadequate.

All programmes will have to provide primary, secondary and arbitration grading. All images with referable disease should be reviewed by the clinical lead or designated senior grader, to decide a Referral Outcome Grade that provides the referral outcome.

NDESP is working closely with software providers to ensure that new screening software to be installed will be fit for purpose enabling local programmes to implement the new pathway and grading criteria. Each programme will be given an individual timeline for the software and pathway implementation. Until that time, NDESP has instructed local programmes to continue to provide their existing 'steady state' service affirming patient safety to be the top priority.

For information on NDESP visit:
www.diabeticeye.screening.nhs.uk or
email: *dr.screening@nhs.net.*

References
1 Bunce C, Wormald R (2006) Leading causes of certification for blindness and partial sight in England & Wales. BMC Public Health 6: 58.
2 Scanlon PH (2008) The English national screening programme for sight-threatening diabetic retinopathy. J Med Screen 15 (1): 1–4.
3 www.diabeticeye.screening.nhs.uk/training
4 Department of Health Integrated Performance Measures Monitoring Report 2011–12
5 www.diabeticeye.screening.nhs.uk/standards
6 www.diabeticeye.screening.nhs.uk/pathway
7 Future operations for screening and immunisation services www.dh.gov.uk/health/2012/08/screening-immunisation-programmes/

IDA MANN

1893-1983. An incomparable pioneer

On 5 September this year, an English Heritage plaque in memory of Dame Ida Mann was unveiled on the building in West Hampstead where she had spent most of the first 39 years of her life.

It is perhaps little wonder that only one word, Ophthalmologist, is used on the plaque to describe her. It is the dilemma of anybody writing about this extraordinary woman who achieved so many varied goals in her career to encapsulate just one outstanding achievement. Some have emphasised her achievements as a woman in a man's world. Some have concentrated on her many 'firsts'. Others pay tribute to her career as a researcher and yet others write about her second career when she moved to Australia.

When Ida died at the age of 90, still working at her desk at her home in Perth, she left behind a formidable list of scientific papers and publications. For instance, there are 46 papers on embryology, anatomy and developmental abnormalities, 29 on pathological conditions of the eye and experimental pathology, 13 on chemical warfare agents and industrial hazards, 10 on cytology and cancer research and 20 on geographical ophthalmology and ophthalmic surveys. There were also papers on endocrine diseases and historical notes and she wrote six books including her autobiography, *The Chase.*

In her autobiography she states of her early medical training, 'I had no vision of myself as a ministering angel, or indeed even as a practising doctor. I saw only the enchanted avenue of ever-expanding knowledge down which one sped, rejoicing, to the ultimate reaches of speculation and discovery.' One of her early mentors was the distinguished anatomist Professor J Ernest Fraser who sparked her interest in anatomy.

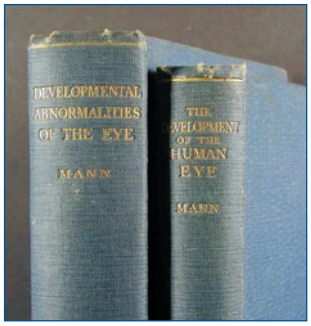
Ida qualified as a doctor in 1920 and was given the post of ophthalmic house surgeon at St Mary's Hospital; a year later she enrolled as a Junior Clinical Assistant at Moorfields Eye Hospital where her rival Stewart Duke Elder was also an assistant. The eye soon fascinated her and another mentor Townley Paton suggested she might specialise in ophthalmology. She told Professor Fraser who replied, 'Now you can use your interest in embryology to further your career. There is no English textbook on the embryology of the eye, and only one good one in German. Here (Fraser had a famous collection) is the finest collection of embryos in England. Get down to it.'

In 1927 Ida applied for and won the consultant post at Moorfields over Duke Elder, much to his fury. Ida started to travel and became aware of the work of that Josef Dallos was doing in Budapest on a moulding technique for fitting contact lenses. It was she who persuaded Dallos to come to England in 1937 to set up a laboratory and the first Contact Lens Centre in the West End of London.

On learning that the Margaret Ogilvie Readership at the Oxford Eye Hospital had become vacant, she applied and was duly appointed in 1941. Ida later became the first Professor of Ophthalmology in 1942 and the first woman professor, in any subject, at Oxford University.

1948 was a momentous year for Ida. At the age of 55 she married Professor William Gye FRS, Director of the Imperial Cancer Research Fund Laboratory and was appointed Senior Surgeon to Moorfields Eye Hospital.

This appointment was not to last long as in 1949 Ida and her husband, who was in poor health, decided to move to Australia. Sadly, Bill Gye died three years later but a new career beckoned for Ida when she answered the call for an ophthalmologist to report on eye disease in an aboriginal population in the Kimberleys, Western Australia. It was intended to be a few weeks' work but it turned out to be the catalyst for years of research and travelling.



Two works by Ida Mann

English Heritage plaque

Although Australia was at this time officially free of trachoma, Ida found 38 cases of children with the disease in Darwin.

In 1966 she published the first textbook of geographical ophthalmology as a result of her incessant pursuit for the trachoma agent Chlamydia trachomatis all over the world. Ida was created a Dame of the British Empire in 1980 just three years before she died. She had never lost her vision of an 'enchanted avenue of ever-expanding knowledge' realising from the very beginning that she had been blessed with the intellect to fulfil this ambition.

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

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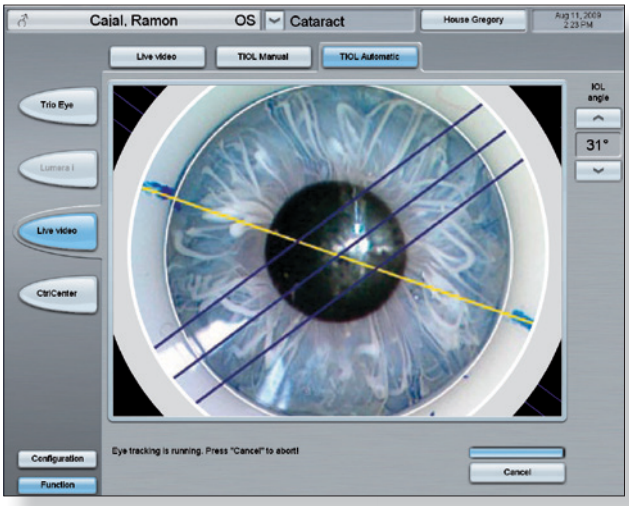

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Specialised commissioning

The Patient perspective:

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…..They want to feel that their clinicians will see them as *'people' rather than 'patients'. They do not want a 'career' as a 'patient'".*

Patient and Public Engagement Representative,
CRG for Ophthalmology May 2012

What is specialised commissioning?

Commissioning in the NHS is the process of ensuring that health services meet the needs of the population. As a result of the Health and Social Care Act 2012 the majority of services will be commissioned by Clinical Commissioning Groups (CCGs). The NHS Commissioning Board (NHSCB) has been established to commission 'prescribed' services which will include specialised services.

The four factors used to define specialised services:

- No. of individuals who require the provision of the service or facility
- The cost of providing the service or facility
- No. of persons able to provide the service or facility
- The financial implications for CCGs required to arrange for the provision of the service or facility.

How is Ophthalmology involved?

Specialised ophthalmology will be commissioned by the NHSCB. The Clinical Reference Group (CRG) for Ophthalmology was set up, together with 58 other CRGs, covering a range of clinical specialities, to provide clinical advice as specialised commissioning developed. From the outset, the College has had significant involvement; specialised commissioning is discussed at College Council, Professional Standards Committee and Paediatric Subcommittee. The CRG for Ophthalmology currently has 22 members[1] including representatives for patients, geographical areas, national groups and subspecialties. The CRG will be developed to ensure a fair representation that will formally engage with the new NHSCB governance structures which, for ophthalmology, will enable us to have balanced representation from smaller and larger units. The chair, Alison Davis, will continue in the role for two further years.

The CRG for Ophthalmology has written a scope of services which covers the majority of subspecialties[2] and will be used in the regulations. It is based on the Specialised Services National Definition Set (SSNDS) 2010 with input from national subspecialty groups; we are grateful for the additional comments from many colleagues.

The specifications for specialised ophthalmology state the more generalised requirements for specialised service delivery and include reference to quality standards, measurement of clinical outcomes, audit, continuous professional development for all staff groups, training and research. The specifications will be launched by the NHSCB for public consultation during November aiming for the final specification to be in place for January 1 2013. The next stage for the CRG for Ophthalmology will be to consider how to develop QIPP[3], CQINN[4] and clinical policies to support specialised commissioning.

How will specialised ophthalmology be delivered?

The initial requirement of 50 specialist centres for adult and 20 specialist centres for children was based on service provision per million population. However, we have agreed that ophthalmic specialised services will be delivered in networks. The regulations state that, 'specialist ophthalmology services will include services provided by specialist ophthalmology centres including out-reach when delivered as part of a provider network. The service will include management of rare conditions and complex or high risk procedures only.' Specialised ophthalmology will be provided in operational delivery networks. The details, including the financial arrangements for these networks, are yet to be published.

However, networks will allow us to develop pathways of care with equitable access for all patients. This will also ensure that existing good local services will continue so that, wherever possible, patient care is delivered close to home. We strongly encourage members to consider how they might work with colleagues in the same geographical area. The local area teams for specialised commissioning have not been appointed and the CRG would like to know of any established or planned networks.

Innovation Fund

The Specialised Services Commissioning Innovation Fund (SSCIF) will be launched in the New Year. It will assess the clinical and cost effectiveness of new technologies and accelerate the introduction of those that can deliver significant improvements in quality or value to the NHS. *www.specialisedcommissioning.com/products/innovation-portfolio/*

Next steps for specialised commissioning

The on-going development of specialised ophthalmology will continue to be challenging but there is the opportunity for us, as clinicians to shape how it will build on our current best practice. If you are interested in joining the CRG for Ophthalmology and would like to discuss informally please contact Alison Davis via *beth.barnes@rcophth.ac.uk*. In addition, the College President, Chair of the CRG and CRG members[1] are happy to discuss specific issues with College members.

Alison Davis, Chair of the Specialised Ophthalmology CRG
Sarah Watson, Commissioning Lead for Specialised Ophthalmology

References and Glossary

1. CRG for Ophthalmology membership (available in the members are of the College website *www.rcophth.ac.uk/page.asp?section=683&sectionTitle=Specialised+Commissioning*)
2. Scope of Specialised Ophthalmology (Adult and Paediatric) membership (available in the members are of the College website *www.rcophth.ac.uk/page.asp?section=683&sectionTitle=Specialised+Commissioning*)
3. QIPP - Quality, Innovation, *www.evidence.nhs.uk/qipp* Productivity and Prevention, an NHS programme
4. CQUINN - Commissioning for Quality and Innovation, a payment framework

The difference is in the detail.

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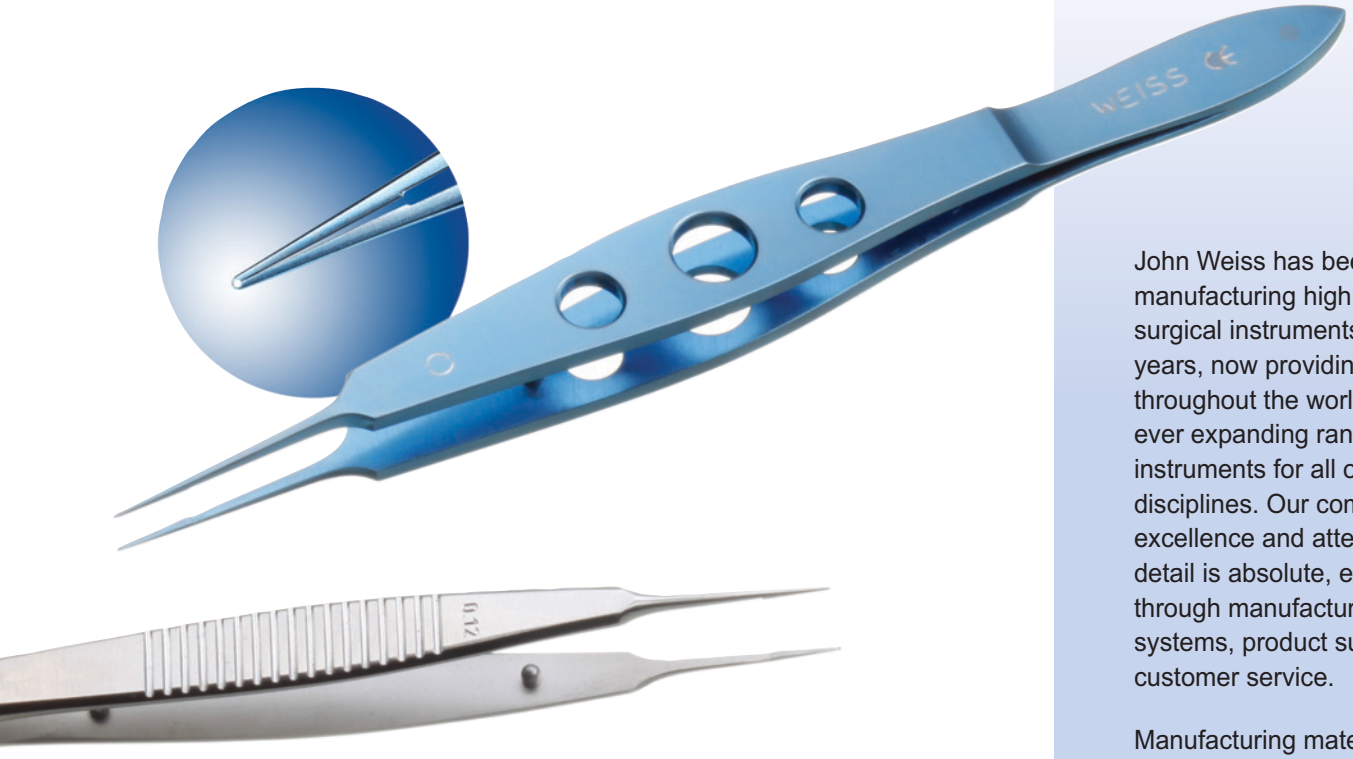
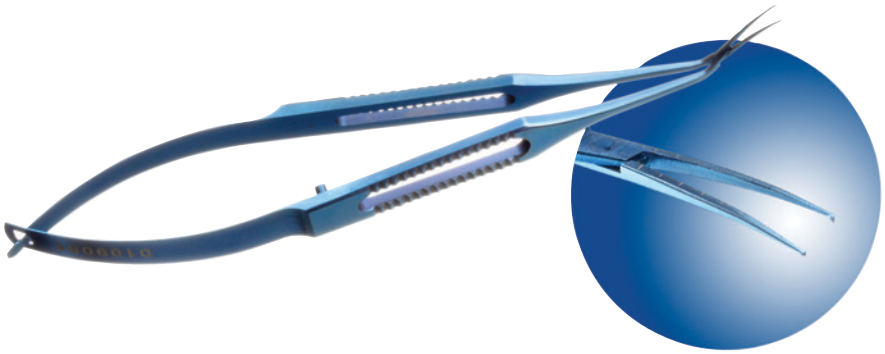
225 Years John Weiss





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Revalidation

On 19 October, the Secretary of State for Health confirmed, as expected, that revalidation of doctors will start on 3 December 2012. Senior medical leaders and responsible officers will be the first to revalidate, between that date and 31 March 2013. The great majority of doctors who currently have a Licence to Practise will be required to revalidate at some point between April 2013 and March 2016.

Readiness for revalidation checklist:

1. Do you need a Licence to Practise? If you are engaged in clinical practice in the UK in any capacity, you need to maintain a Licence to Practise and will be required to revalidate. If your practice is entirely outside the UK or if you have retired completely from clinical practice, you can remain on the GMC's medical register without the need to revalidate.

2. Have you identified your Designated Body for revalidation? The GMC provides guidance (*www.gmc-uk.org/doctors/revalidation/12387.asp*) on making a connection to an organisation that will be responsible for making a recommendation for your revalidation, but if you are unable to identify a connection, you need to notify the GMC of this and await its further instruction.

3. If you have not already done so, start to collect the supporting information that you will need to provide for appraisal and revalidation. Do not leave this until your revalidation date is imminent. The documents on the College website Supporting information for appraisal and revalidation: guidance for ophthalmology and Preparing for Revalidation as an Ophthalmologist (May 2012) will help you. *www.rcophth.ac.uk/revalidation*

4. Book your annual appraisal. Even if the date for your first revalidation is in 2016, you must have annual appraisals (the 'appraisal year' starts on 1 April), and all appraisals from now on must meet standards set by the GMC in terms of their format and the supporting information that must be provided. If you are unsure about how to arrange an appraisal, the document Interim advice on obtaining an appraisal provides guidance. *www.rcophth.ac.uk/revalidation*

If you have further questions about revalidation, which are not adequately covered by this advice, the College has a dedicated confidential email address for individual enquiries (*revalidation@rcophth.ac.uk*) which will be answered by one of the College's specialty advisers for revalidation.

Richard Smith, Chairman
Revalidation Sub-committee

National recruitment

The first round of national recruitment into ophthalmic specialty training for ST1 occurred earlier in the year, in February 2012. The process was a success on many levels as the competition ratios demonstrate:

Total number of applications to ST1 ophthalmology in 2012	287
Total number of applications that progressed through initial long-listing checks	262
Total number of applications that achieved a minimum shortlist score and above and were invited to interview	203
Total number of specialty training run-through posts	80
Total number of fixed term training appointments	14
Number of offers declined	16
Number of unfilled positions following round 1	0
Competition ratio – run-through posts	4 applications to each post
Competition ratio – overall	3 applications to each post

The Severn Deanery will again co-ordinate recruitment in 2013 and the process will extend to ST3 posts.

New shared decision making resource centre

The Health Foundation has developed a shared decision making resource centre for healthcare professionals and managers.

It pulls together practical tools, best practice strategies, personal accounts and evidence in one place. The information it contains is open to everyone to explore and adapt, and it's completely free to use.

Visit the resource centre at *http://shareddecisionmaking.health.org.uk*

The new building update

The College has engaged Bennetts Associates as architects to refurbish its new building at 18 Stephenson's Way and appointed Jackson Coles as the project manager.

Plans have been submitted as part of a pre-planning application to the London Borough of Camden and once they have been approved they will appear on the College website.

In the coming months, the College will develop plans to encourage sponsorship to fund elements of the building such as the new seminar room and skills centre.

COLLEGE TRAVEL AWARDS AND FELLOWSHIPS

AWARD	CLOSING DATE
International Glaucoma Association Research Awards Total prize fund of £100,000 to be divided between multiple recipients	Thursday 31 January 2013
Pfizer Ophthalmic Fellowship Total prize fund of £50,000 to be divided between multiple recipients	Wednesday 6 February 2013
Fight for Sight One award of £5,000	Wednesday 6 February 2013
Patrick Trevor Roper Award Two awards of £550	Wednesday 5 June 3013
Dorey Bequest & Sir William Lister Travel Awards Multiple awards of £300–£600	Wednesday 25 September 2013
Ethicon Foundation Fund Multiple awards of £300–£1000	Wednesday 30 October 2013

Please note that these closing dates may be subject to minor amendment. Please check the website for the confirmed date. Information and application forms for all awards are available on the College website: *www.rcophth.ac.uk/awardsandprizes*

The Daniel Turnberg UK/Middle East Travel Fellowship Scheme

The fifth round of funding for the Daniel Turnberg Travel Fellowship Scheme is now open for applications. The fellowship scheme aims to encourage and foster collaborations between biomedical researchers in the UK and the Middle East. It provides opportunities for short-term exchange of researchers, offering them the chance to gain further research experience, learn new techniques and to foster scientific collaboration. Grants will be awarded to early and mid-career medical researchers and bioscientists from the UK to spend time in laboratories and hospitals in Egypt, Israel, Jordan, Lebanon and the Palestinian Territory or for researchers in those countries to come to the UK. The grant will cover the Fellow's travel expenses and will provide a subsistence allowance for a period of up to four weeks.

Contact: *grants@acmedsci.ac.uk*
Closing date: Monday 7 January 2013.

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 shortly complete a three year term of office. Any person wishing to stand should contact *training@rcophth.ac.uk*

NAME	REGION	DATE OF APPOINTMENT	DATE OF REAPPOINTMENT	DATE OF RETIREMENT
Miss Susan Downes	Oxford	December 2006	December 2009	December 2012
Mr Gerard McGinnity	Northern Ireland	March 2006	March 2009	December 2012
Dr Chris Scott	Scotland North East	December 2003	March 2007/ March 2010	March 2013 by special agreement
Miss Anne Gilvarry	South West Thames	March 2007	March 2010	March 2013
Mr Roger Humphry	Wessex	June 2010		June 2013
Mr Timothy Matthews	West Midlands	June 2010		June 2013
Dr Donald Montgomery	Scotland West (Glasgow)	June 2010		June 2013
Mr Christopher Hammond	South East Thames	March 2007	September 2010	September 2013 by special agreement
Miss Dilani Siriwardena	Moorfields	September 2010		September 2013

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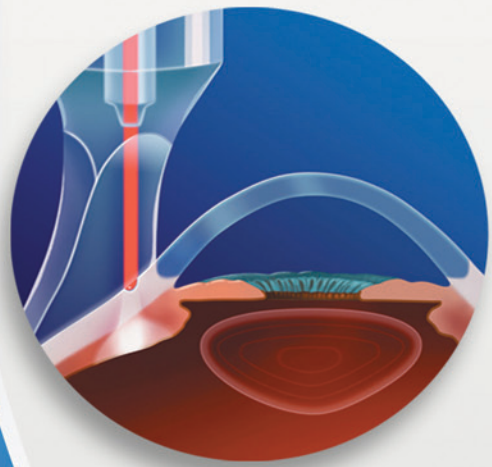
Making light work

Control Uncontrolled Glaucoma

G-PROBE GLAUCOMA DEVICE OFFERS A NON-INVASIVE SURGICAL DAYCASE SOLUTION



Transscleral cyclophotocoagulation (TSCPC) using the G-Probe device is a long-term, effective IOL lowering procedure.[1]

TSCPC has been proven effective with many types of glaucoma patients, including those with good vision.[1-3]

IRIDEX

1. Wilensky JT, Kammer J. Long-term visual outcome of transscleral laser cyclotherapy in eyes with ambulatory vision. *Ophthalmology.* 2004;111(7):1389-1392.
2. Egbert PR, Fiadoyor S, Budenz DL, et al. Diode laser transscleral photocoagulation as a primary surgical treatment for primary open angle glaucoma. *Arch Ophthalmol.* 2001;119:345-350.
3. Roctchford AP, Jayasawi R, Madhusuhan S, et al. Transscleral diode laser cycloablation in patients with good vision. *Br J Ophthalmol.* 2010;94(9):1130-1183.

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Honorary Fellowship

At the Admissions Ceremony in September 2012, an Honorary Fellowship was awarded to Professor Alistair Fielder. This is an edited version of the citation given in his honour.

Alistair was born in Lancashire to a Methodist minister. From the age of seven to 14 he lived in Northern Rhodesia. Perhaps medicine was in his blood, as he was the great grandson of Queen Victoria's oculist, Sir Jonathan Hutchinson. In 1966 he qualified from St George's Hospital Medical School, and completed his training at Moorfields Eye Hospital, including a research fellowship at Great Ormond Street.

As a male born to a Methodist minister, Alistair is by definition a Son of the Manse. Traditionally these individuals are high achievers, showing dedication and discipline. He also shows excellent leadership, coupled with complete honesty and humility.

When appointed to his first consultant post in Derby in 1977 he was a generalist, but soon he was captured by the excitement of working with children, and had a real ability to communicate with them. He strongly believed in the link between clinical work and research, and in 1982 snapped up an academic position in Leicester. Wanting to give his research team the best opportunities, he became a professor in Birmingham in 1988, Imperial College London in 1995 and City University in 2005.

He was fascinated by the development of the visual system. He published over 200 papers on related subjects and co-founded the Child Vision Research Society and the UK Children's Eye Group. This naturally led to interests in retinopathy of prematurity and amblyopia. Whilst Alistair was researching the natural history of ROP, a vitreoretinal surgeon, Mr Edmund Schulenburg, was studying the treatment. The two came together to crystallise their thinking, and produced the first ever ROP Guidelines in 1990. They embarked on a series of national 'Band-waggon Tours', encouraging neonatologists to refer babies for screening. Alistair co-chaired the 1995 and 2008 revisions, bringing together the key parties and revolutionising visual outcomes in preterm infants.

In 2006 he was granted the highest accolade at The Royal College's Annual Congress, and delivered the Bowman Lecture on 'The Sharpening of Blunted Sight'. This was 120 years after his great grandfather had delivered the first ever Bowman Lecture on 'The Relation of Eye Diseases to Gout'.

Alistair was not always very keen on committees, but he saw it as the only way to get anything done beyond the local level. He started on the Council of the Royal College of Ophthalmologists in 1988, joined the Education Committee, then became Vice President and Chairman of the Scientific Committee from 1995–99.

Alistair has performed ground-breaking work in the field of visual impairment. He has been Chairman or Trustee of at least of seven charities, bringing together many groups and professions. He chaired a first-rate Grant Assessment Panel for Fight for Sight, spending many hours considering how to make it fairer and better. He was Vice Chairman of VISION 20/20 for four years.

Whilst making major contributions nationally and internationally, Alistair always went the extra mile for his local team. His famous 7am teaching sessions showed he was passionate about stimulating the grass roots, and he has inspired generations of medical students and trainees.

Alistair says the secret of his productivity is to get a good day's work done before coming to work. But no man could have achieved what Alistair has done without being a great leader. He gets the best out of others, by providing support and encouragement. He has huge insight and uses thought and discussion to question dogma, solve problems and develop ideas. He is immensely loyal and generous to colleagues, giving credit where due. His humility enables him to value everyone, regardless of status. Whilst working hard, Alistair manages to maintain a sense of fun, and is always great company.

I am sure that Alistair would agree that such achievements are not possible without great support from home. Gill has been by his side throughout, and they are both very proud of their four children and five grandchildren.

It might be considered for Alistair that life has gone a full circle. As a trainee, he lived on a houseboat in Paddington Basin, and recently he has built a canal boat. This is not evidence of regression, but a passion supressed during the priorities of work, and allowed to flourish again in retirement.

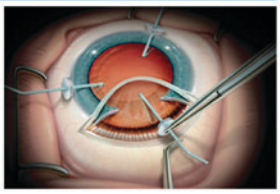
We can now see the influence the Methodist preacher must have had on his son, Alistair, with his honesty and humility. He has certainly shown the dedication and discipline necessary to become a truly high achiever. These qualities, together with his leadership skills, make him a good role model for the new generation of ophthalmologists that we have before us today. I am sure that his great grandfather, Sir Jonathan Hutchinson would have been proud of him too. On his own epitaph he described himself as 'A man of hope and forward looking mind', which is also a good description of Alistair.

Miss Melanie Corbett, Professor Alistair Fielder and the President, Professor Harminder Dua

Miss Melanie Corbett

delivering surgical innovation

New Capsule Retractors



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College 2013 Seminar Programme

All College seminars and events take place at 17 Cornwall Terrace.

The Vitreo-(Medical) Retinal Interface
6 February
Chaired by: Mr David Steel

Emergency Ophthalmology
20 March
Chaired by: Professor Carrie MacEwen

Skills in Retinal Imaging, Diagnosis & Therapy
20 & 21 June 2013
The Institute of Physics, London
Chaired by: Professor Heinrich Heimann & Professor Yit Yang

New Frontiers in Management of Glaucoma
16 September 2013
Chaired by: Mr Keith Martin

Management of Incomitant Strabismus
23 September 2013
Chaired by: Mr John Ferris

Revalidation
11 November 2013
Chaired by: Mr Richard Smith

Please visit *www.rcophth.ac.uk/seminars* for further details

College Skills Centre Programme 2013

Details are on the website at *www.rcophth.ac.uk/bmscourse*

The Training the Trainers
4 February
What to teach and How to teach

12 February
Trainees in Difficulty

30 April
Assessment

20 May
Appraisal and How to teach practical skills

Other events 2013

5 day course:
28 - 30 January and 7 - 8 March
5th Ophthalmic Public Health Short Course
University of Leeds (15 Masters level credits)
This is an opportunity for eye health professionals to better understand the links between eye health and public health and epidemiology.
Some funding is available to cover course fees.
public_health_cpd@leeds.ac.uk

7 - 10 March
International Symposium on Ocular Pharmacology and Therapeutics
Paris, France.
www.isopt.net

13 March
5th Annual Meeting of the UK Neuro-Ophthalmology Special Interest Group
Royal College of Physicians and Surgeons Glasgow
www.uknosig.com

14 March
The Medical Ophthalmology Society of the UK
Royal College of Physicians and Surgeons Glasgow
lindy.gee@mosuk.co.uk

4 - 7 April
The 4th World Congress on Controversies in Ophthalmology
Budapest, Hungary
www.comtecmed.com/COPHY/2013/

28 June
22nd Annual Salisbury course in Ophthalmic Plastic Surgery
liz.fenwick@salisbury.nhs.uk

30 June - 3 July
Oxford Ophthalmological Congress
Oxford Playhouse Theatre, Beaumont Street, Oxford
CALL FOR PAPERS
Abstracts should be received ONLINE by the Editor, Prof A D Dick,
NO LATER THAN 25 January 2013.
www.oxford-ophthalmological-congress.org.uk
Click onto Conference and scroll down to Abstract Box.
Enquiries to the Conference Organiser by e-mail: o_o_c@btinternet.com

Annual Congress

Celebrating the 25th anniversary of the College 21–23 May 2013, Liverpool

Registration opens: 15 February 2013

The Edridge Green Lecture 2013.
Delivered by Professor David Williams, William G. Allyn Chair of Medical Optics, Director, Center for Visual Science, Professor of Optics, Ophthalmology, Biomedical Engineering & Brain Cognitive Sciences, University of Rochester, USA

The Duke Elder Lecture 2013.
Delivered by Professor Phil Murray, Professor of Ophthalmology, University of Birmingham and Honorary Consultant, Birmingham & Midland Eye Centre, City Hospital, Birmingham

The Optic UK Lecture 2013.
Delivered by Dr Gerrit Melles, Ophthalmic Surgeon, Director, Netherlands Institute of Innovative Ocular Surgery, Rotterdam, The Netherlands

Membership information

Please contact *database@rcophth.ac.uk* if you get a new email address so that we can keep in touch with you. This is particularly important if your NHS Trust changes its name.

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