Outcomes of Cataract Surgery Training amongst Trainees between NHS and Independent Sector: A Comparative Study

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Introduction

The Royal College of Ophthalmologists recently published a position statement and training guidance setting out the college's commitment to rapidly increase access to cataract surgery training in the independent sector (IS).(1) Despite this, there has been limited data reported on training outcomes on high volume training lists within the IS, and how this compares to NHS training lists.

Method

Two trainees (ST5 and ST3) undertook supervised cataract training within IS high volume lists and simultaneously within the local NHS lists. Prospective data collection on case number, RCOphth risk stratification score (2), intraoperative and postop complication rates as well as visual outcome were obtained and compared. This project was considered a clinical audit therefore ethical approval was not required.

IS high-volume training list set up

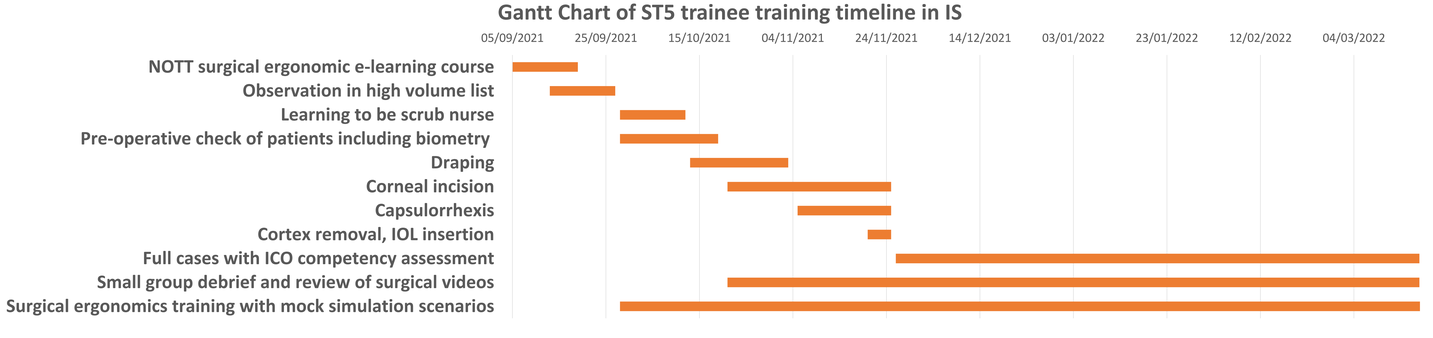
A structured comprehensive training programme was followed for the IS high volume list, which consists of 12 patients per session of varying complexity. Trainees were lead through modular cataract training with gradual progression to more complex full cases, with regular feedback and assessment using ICO competency assessment framework (3). Training on all aspects of cataract surgery including surgical ergonomics were incorporated.

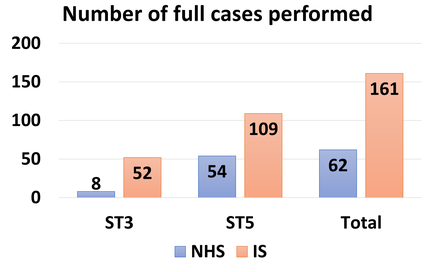
Placement details	ST3		ST5		Total	
Area of placement	NHS	IS	NHS	IS	NHS	IS
Duration of placement (months)	5	5	6	6	11	11
Number of lists attended	4	11	27	21	31	32
Average % of cases operated by trainee/ list	36%	42%	45%	49%	41%	46%
Number of assisted cases	0	20	0	23	0	43
Number of full cases	8	52	54	109	62	161

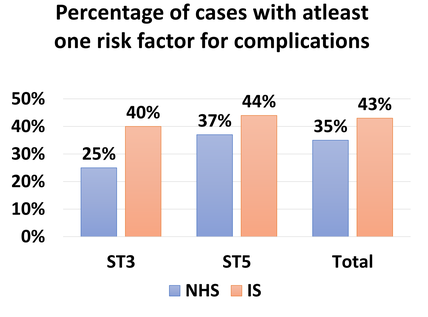
Operative details	ST3		ST5		Total		
Area of placement	NHS	IS	NHS	IS	NHS	IS	P-value
Case with atleast one risk factor (n, %)	2 (25%)	21 (40%)	20 (37%)	48 (44%)	22 (35%)	69(43%)	0.316
Mean RCOphth risk stratification score	1.28	1.48	1.43	1.57	1.36	1.53	0.125
Additional equipment used (n, %)	0 (0%)	3 (6%)	8 (15%)	19 (17%)	8 (13%)	22(14%)	0.881
Takeover rate (n, %)	1 (13%)	4 (8%)	3 (6%)	7 (6%)	4 (6%)	11 (7%)	0.919
Intraop complications incl. PCR (n, %)	1 (13%)	3 (6%)	2 (4%)	2 (2%)	3 (5%)	5 (3%)	0.533
Posterior capsule rupture (n, %)	0 (0%)	2 (4%)	0 (0%)	0 (0%)	0 (0%)	2 (1%)	0.378

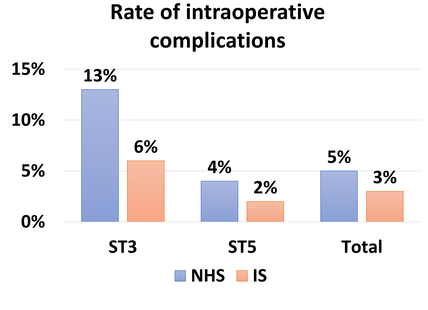
Postoperative outcomes	ST3		ST5		Total		
Area of placement	NHS	IS	NHS	IS	NHS	IS	P-value
Postop complication (n, %)	1 (13%)	1 (2%)	1 (2%)	5 (5%)	2 (3%)	6 (4%)	0.857
Comorbidity for guarded visual outcome (n, %)*	1 (20%)	13 (33%)	25 (57%)	28 (48%)	26 (53%)	41 (42%)	0.217
Available postop vision outcome (n, %)	5 (63%)	39 (75%)	44 (81%)	58 (53%)	49 (79%)	97 (60%)	0.008
Postop vision ≥ 6/12	4 (80%)	39 (100%)	32 (73%)	55 (95%)	36 (73%)	94 (97%)	<0.001

*calculated based on cases with available postop vision









Results

Overall, 161 and 62 full cataract cases were performed in the IS and NHS respectively. On average, trainees performed 46% of IS list compared to 41% of NHS list. Within IS list, 43% cases had atleast 1 complex risk factor which was comparable to 35% of cases of NHS cases (P=0.316). Overall intraoperative complication rate (3% IS vs 5% NHS, p=0.533) and postoperative complication rate (4% IS vs 3% NHS, p=0.857) were similar in both settings. In cases with available follow-up data, postoperative vision >6/12 was achieved in significantly higher proportion of IS cases compare to NHS cases, (97% IS vs 73% NHS, p<0.001), although NHS cases have a slightly higher proportion of comorbidity (44% IS vs 53% NHS, p=0.217) and more available follow up data (60% IS vs 79% NHS, p=0.008). All lists were completed within the 4 hour period as per GIRFT target.

Anonymised patient feedback surveys were conducted immediately postoperatively on total of 20 patients on both trainees' lists within the IS, 100% of patients agreed that it was a positive experience and they would be happy for the same doctor to operate on them again.

Conclusion

Our data has shown that following RCOphth guidelines, good quality cataract training is possible within IS high volume lists. Trainees gained exposure to many cases of varying complexity whilst ensuring patient safety and maintaining surgical efficiency, all comparable to NHS training lists.

A structured comprehensive training programme with regular assessment and feedback is essential to allow this to take place. We urge such training programme to be adopted within all high volume training lists in both IS and NHS settings.

References

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