East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**QUALITY AND SAFETY COMMITTEE**
REPORT TITLE:	**OPHTHALMOLOGY SERIOUS INCIDENTS AND RISK**
MEETING DATE:	**MAY 2022**
BOARD SPONSOR:	**CHIEF MEDICAL OFFICER**
PAPER AUTHOR:	**[Redacted]; CARE GROUP HEAD OF NURSING & PROFESSIONS**
APPENDICES:	**Appendix 1** Ophthalmology Serious Incidents reported September / October 2022 **Appendix 2** Ophthalmology Serious Incidents reported November 2022 to April 2023

Executive Summary:

Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion

Purpose of the Report:	This report provides and update on the ophthalmology serious incidents involving moderate or above patient harm reported between 07.09.22 and 27.04.23. This report outlines what actions have been taken and mitigations have been put in place and the longer-term plan.
Summary of Key Issues:	Ophthalmology is the largest outpatient specialty in the organisation. It has and continues to be challenging for the specialty to manage the high number of patients with lifelong conditions and the number and frequency of follow ups required. The specialty is working in line with the HII, GIRFT and NICE to reduce the risk of harm to patients. The ophthalmology specialty had 4 serious incidents involving moderate or above patient harm reported between 07.09.22 and 13.10.22. Since this time (14.10.22 to 27.04.23) there have been two further incidents reported, although one has a downgrade request. The report provides an update on the progress against previous recommendations identified. Access to services is being supported by ongoing work with the ICB to introduce REGO single point of access for all pathways but there remain challenges with information governance and IT systems. Internal improvements are focussed on equipment, staffing and capacity.
Key Recommendation(s):	The Quality and Safety Committee is asked to receive the report and support the ongoing work within the specialty to reduce the risk of harm.

Implications

Links to 'We Care' Strategic Objectives:

Our patients	Our people	Our future	Our sustainability	Our quality and safety

Link to the Board Assurance Framework (BAF):	*BAF 32-There is a risk of potential harm to patients if high standards of care and improvement streams are not delivered.*

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Link to the Corporate Risk Register (CRR):	*NA*	
Resource:	N	
Legal and regulatory:	Y	*CQC responsive*
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	Patient Safety Committee December 2022	

REPORT TITLE: Ophthalmology Serious Incidents

1. Purpose of the report/ Situation

1.1 To brief the patient safety committee on the 4 serious incidents (SIs) appendix 1, involving moderate or above patient harm reported within the Ophthalmology Specialty between 07.09.22 and 13.10.22, and the 2 further incidents reported between 14.10.23 to 27.04.23 (although one has been sent the ICB for a downgrade).

2. Background

Date	Care Group	Ophthalmology
April 2022 to March 2023	12	8
April 2021 to March 2022	11	5
April 2020 to March 2021	9	5
April 2019 to March 2020	16	11

2.1 The table above shows the number of Ophthalmology Sis that have been reported over the last 4 years.

2.2 The current ophthalmology outpatient undated follow up backlog is 12,030 with 2,607 waiting over a year past their target date.

2.3 The backlog was cleared during 2019-2020 reaching 300 in March 2020. The impact of the Covid pandemic on capacity has seen the backlog rise.

2.4 The current monthly Ophthalmology follow up activity is 4.579 for 130 ophthalmology, 162 for 216 Paediatric Ophthalmology, and 864 for 655 clinics - giving us a grand total of 5,605 per month.

2.5 The specialty has 18 consultants and provides an urgent service with on-call, serving a mixed cohort across 6 Trust sites making up 13% of Trust outpatient activity.

2.6 There are a number of different clinical staffing groups within the specialty including; Doctors, Nurses, Optometrists, Orthoptists and Healthcare Scientists resulting in additional complexity.

2.7 In 2018 as a response to multiple harm events in Ophthalmology across the country, NHS England supported by the Royal College of Ophthalmology

(RCOph) suggested 2 High Impact Intervention actions designed to reduce the risk of harm to patients in follow up backlogs. EKHUFT has implemented failsafe officers and specialty risk stratification in response to these recommendations.

2.8 Clinicians have been enabled to report harm with additional support from the governance team as required. The specialty work to the GIRFT recommendations, and assess NICE guidance as released and implement as appropriate.

Assessment

2.9 A number of risk areas where the SIs have occurred within the specialty were identified;

(a) Multiple referral and access points
(b) IT systems and interfaces
(c) Sub-specialty complexities
(d) Backlog
(e) Equipment
(f) Staffing
(g) Capacity

2.10 The SI's received for this initial period (07.09.22 and 13.10.22) were themed by category, 2 categorised by to access to services, 1 by individual clinical decision making and 1 an IT issue.
Since this (14.10.23 to 27.04.23) there have been 2 further incidents reported. One regarding individual clinical decision making [Redacted], and one regarding a possible missed opportunity to diagnose earlier – however, this has been investigated and a downgrade sought as no omissions in care identified.

2.11 Duty of Candour was delivered for all incidents within the required timeframe, 100% compliance for all applicable incidents. All RCA's have been completed and submitted within expected time frames. Learning and action plans have been developed and shared with the Care group and organisation via the OWL newsletter and Risk wise newsletter with any updates sent to the governance team, with evidence of completion to be uploaded to the Datix system.

2.12 Reduction of the Ophthalmology follow up backlog was one of the Surgery, Head, Neck, Breast & Dermatology care group driver metrics due to the risk of harm.

3. Recommendation / Plan

3.1 Executive support has been provided to deliver an Ophthalmology task and finish recovery plan. Output is incomplete and handed over to the ops team for completion.

3.2 Access to services ongoing work with ICB to introduce REGO single point of access for all pathways. It has been rolled out to some but not all providers, it has proved difficult to get the bigger providers using it eg Boots, Specsavers onboard, due to information governance and IT systems issues.

3.3 IT systems; continuing work with IT to develop the Open eyes system in line with clinical requirement. Latest update on 29.04.23

3.4 Sub-specialty complexity; the new clinical lead has recruited sub-specialty leads at 0.5 PA's to enable improved clinical engagement and accountability across a variety of sub-specialties. Non-medical clinical groups are developing a workforce plan to support clinicians and patients in a more innovative way.

3.5 The subspecialty leads will undertake a risk stratification exercise for their subspecialties in line with the latest Royal College of Ophthalmologists recommendations. Clinical lead and management to have meetings with subspecialty leads.

3.6 Backlog; High risk patients are categorised as urgent to enable booking within an appropriate timescale. Failsafe officers have been introduced to monitor the patient tracking list (PTL) and highlight high risk patients for additional capacity to be provided. Clinical validation needs to be added to job plans and manpower identified. Virtual diagnostics clinics have been introduced (diabetic monitoring, choroidal naevus monitoring, AMD imaging, and glaucoma monitoring).

3.7 The clinical harm policy is followed for elective patients waiting in excess of 52 weeks.

3.8 Equipment; Aging equipment is risking the sustainability of the service. The risks have been added to the risk register. Business cases have been completed and are awaiting Medical Devices Group (MDG) slippage but have been agreed as priorities.

3.9 Staffing; The care group are being pro-active with recruitment and skill mixing across professions to enable continuity of service. A review is underway to ensure that the sickness management policy is being followed.

3.10 Capacity; New clinical lead and newly recruited sub-specialty leads will review job plans and scheduling to ensure job plans match activity.

3.11 The specialty continues to work with the ICB to utilise community pathways and capacity.

Conclusion

3.12 Ophthalmology is the largest outpatient specialty in the organisation. It has and continues to be challenging for the specialty to manage the high number of patients with lifelong conditions and the number and frequency of follow ups required.

3.13 The specialty is working in line with the HII, GIRFT and NICE to reduce the risk of harm to patients.

3.14 The Quality and Safety committee is asked to receive the report and support the ongoing work within the specialty to reduce the risk of harm.

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Appendix 1 Ophthalmology Serious Incidents reported September / October 2022

Ref & Site	Summary	Learning outcome and actions
[Redacted] **On time** Sent to CCG [Redacted] **Closed by ICB** [Redacted]	Treatment Delay – Glaucoma This incident was reported as an SI due to treatment delay of a **[Redacted]** resulting in potentially avoidable harm.	The investigation team have concluded that the delay in the patient being urgently reviewed by the Glaucoma team was as a result of human error. The doctor incorrectly chose the wrong person to send the email request to. It has been identified that had the correct user (Failsafe Officer) received the message they would have reviewed the PTL and picked up the un booked appointment. • Review of Open Eyes user list • Review of the Failsafe system • Review of the validation process when removing duplicate partial booking entries • Raise awareness that any delays should be escalated and reported on Datix and the importance of double checking details when managing lists and sending emails
[Redacted] **On time** Sent to CCG [Redacted] **Closed by ICB** [Redacted]	This incident relates to the potential risk to patients as a result of delays in sending clinical correspondence to GPs. This was due to a functioned being manually disabled in error.	• Send communication to GP practices alerting them to delays in correspondence and how to report any harm identified. • All documents affected resent via the file monitor and therefore triggering the electronic sending to GP for those since the last sent. • Immediately implement bi-weekly manual and system generated checks to ensure mailer technology is operational and to identify any failed transfers. • Harm review of 100 urgent patients undertaken to identify any missed / delayed treatment as a result of missed correspondence and requiring priority review. • All Ophthalmology clinicians have been made aware of this incident and have been asked to remain extra vigilant, any issues are to be reported on Datix.
[Redacted] **On time** Sent to CCG [Redacted] **Closed by ICB** [Redacted]	Treatment Delay- UES triage error MR patient This incident was declared an SI due to a delay in treatment of a **[Redacted]** resulting in the patient experiencing a loss of vision.	• UES triage guidelines updated with UES lead clinician, with addition of diabetic guidelines. • IT report requested to identify individual for support and training. • Explore the introduction of a flagging system when patients are re-directed and DNA that appointment. • Further training for remaining staff who triage. • Update OpenEyes system to version 7, which will initiate and automatic copy of the patient correspondence to DESP for all diabetic eye patients.

[Redacted]
On time
 	
Sent to CCG
[Redacted]
 	
Closed by ICB
[Redacted]
	Treatment Delay – Medical Retina –
	
	This was declared as a serious incident due to a delayed review appointment of an **[Redacted]** resulting in sight loss.
		• Introduce a safety net process to identify high/medium risk ophthalmology patients.
		  ○ Weekly meeting held to discuss management of backlog.
		  ○ Failsafe officer monitoring PTL for risk of harm.
		  ○ Risk stratification within sub specialties (GIRFT)
		  ○ Harm reviews undertaken when patients present to clinic
		  ○ Review how the service use the follow up label.
		• Engaging with Getting it Right First Time (GIRFT) programme. This is about the sub specialty risk stratification- this will mean that we will be able to identify the patients at the highest risk of harm due to breaching their follow up target date and therefore ensure that those with a greater risk are booked first.
		• Engaging Royal College of ophthalmology, to understand how to use the latest clinically appropriate date (LCAD) to identify the patients at risk.
		• Task and Finish group to support ophthalmology achieve activity plans.
		• Engaging with the community, who are currently setting up more capacity in the community.

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Appendix 2 Ophthalmology Serious Incidents reported November 2022 to April 2023

Ref & Site	Summary	Learning outcome and actions
[Redacted]	Delayed recognition and management of wet AMD	Findings: There were no abnormalities identified by the Consultant Medical Retina Specialist on [Redacted] from the examination of the patient's fundus (back of the eye) or the OCT scan. Therefore, a referral to the AMD clinic was not made. The consultant no longer works for the Trust; the clinical director has been unable to contact the consultant; therefore, it has not been possible to ascertain why this occurred. Recommendations: Incident feedback to Ophthalmology team at the Ophthalmology audit meeting on [Redacted] to raise awareness of the issue and reiterate the importance of all necessary and thorough checks as per the national guidelines. [Redacted] Incident escalated to care group clinical director and Ophthalmology clinical lead (consultant no longer employed by the Trust). • [Redacted] Incident escalated to Ophthalmology lead: Kent & Medway, NHS Kent and Medway ICB. SM sent to Mr [Redacted] to discuss with [Redacted] – SIIAP [Redacted]
[Redacted]	Delayed Treatment - Glaucoma	• [Redacted] scheduled for [Redacted] - SIIAP [Redacted] • **Downgrade sent to ICB [Redacted]** On review by the ophthalmology clinical lead and two glaucoma consultants it does not appear that there were omissions in care or treatment which led to the deterioration in the patient's vision. The downgrade is requested on the basis that there were no acts or omissions in care / treatment which have led to serious harm.