DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UPDATE ON OPHTHALMOLOGY		
DATE OF DECISION:		27 FEBRUARY 2020		
REPORT OF:		DIVISIONAL DIRECTOR OF OPERATIONS - UHS		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Duncan Linning-Karp**	**Tel:**	**023 8120 8605**
	E-mail:	**Duncan.Linning-Karp@uhs.nhs.uk**		
Director	**Name:**	**Duncan Linning-Karp**	**Tel:**	**023 8120 8605**
	E-mail:	**Duncan.Linning-Karp@uhs.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

Ophthalmology services both locally and nationally have been under significant and sustained pressure for a number of years. There is evidence nationally that 88% of trusts have backlogs in diabetes and glaucoma and there are over 80 consultant vacancies in England. The reasons for this are well-rehearsed, but include an aging population (10% of the population over the age of 75 will develop glaucoma) and an increased ability to maintain sight for longer and better in patients with chronic eye conditions.

At UHS, significant backlogs in diabetes and glaucoma were first widely understood as a result of several incidents in 2017. An oversight board chaired by the Medical Director and Director of Nursing / OD was set up and a comprehensive action plan developed with the service. The majority of the diabetes backlog was quickly addressed but the glaucoma backlog remained a significant and ongoing risk. General patients in Lymington have also been booked out of time. The introduction of an insourcing firm in October 2019 has finally allowed the majority of patients in glaucoma to be seen.

Further work is needed across the system to ensure adequate longer-term capacity within hospital eye services, as well as better access to out-of-hospital services.

RECOMMENDATIONS:

(i) That the Panel considers the notes the report.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the committee to effectively scrutinise the issues impacting on hospital eye services in Southampton.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. University Hospital Southampton, along with most trusts in the country, has been unable to meet demand in the glaucoma and diabetes eye services. This problem has been driven by increasing demand (approximately 7% per

annum), improved treatments, an inability to recruit, and the fragmentation of pathways.

4. The problem has been recognised since at least 2017 and the Trust and wider system has taken a number of steps to try to address this, including:
    - Expanding the operating available to attract further consultant ophthalmologists (by an additional theatre, or 50%)
    - Multiple rounds of recruitment for consultant ophthalmologists (2 appointed in glaucoma, one who has started and one starting later in 2020). We are out to recruit further if possible
    - Appointing additional nurses and optometrists
    - Reviewing pathways, including West Hampshire CCG commissioning a community eye service for stable glaucoma pathways (Southampton City already has one)
    - Risk stratifying all patients
    - Using high cost locums where possible.

5. The Healthcare Safety Investigation Branch recently published an investigation into delays in glaucoma nationally and highlighted the significant problems. The Royal College of Ophthalmologists commented on the report, stating:

    "…because the same severe capacity issues are present in every ophthalmology department in the country and, unfortunately experience is by no means unique.

    The investigation has correctly identified a fundamental lack of capacity within hospital eye services to deliver glaucoma monitoring and treatment, exacerbated by inappropriate referrals, risk adverse behaviour, lack of glaucoma specialists and lack of continuity of care caused by locums"

    Source: https://www.rcophth.ac.uk/2020/01/rcophth-responds-to-hsib-report-on-lack-of-timely-monitoring-for-patients-with-glaucoma/

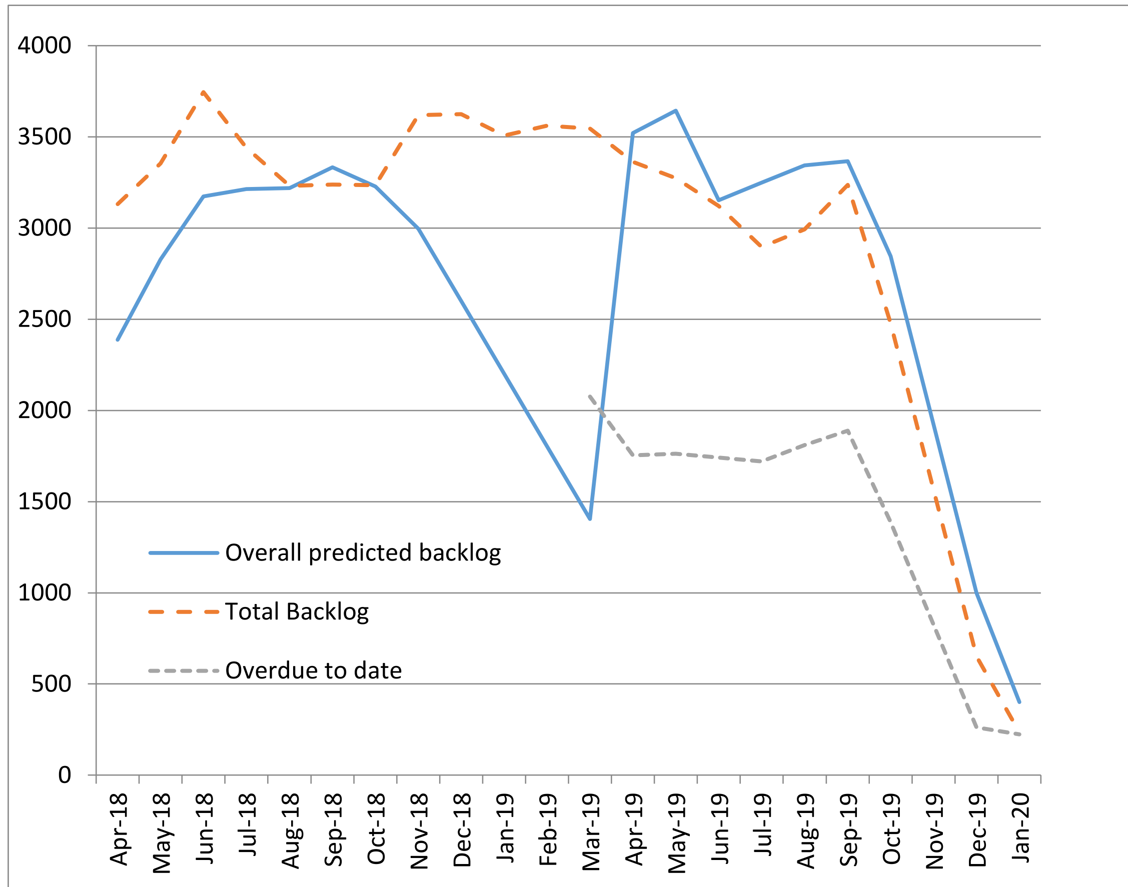
6. While UHS has had delays for a number of years, over the last few months we have made significant progress in addressing these, reducing the overall backlog of patients from 3,500 to 200.

7. The backlog has been addressed largely through an insourcing company as we have an ongoing inability to recruit enough staff in glaucoma, and existing staff have been affected by the tax and pension issue and are therefore unwilling to take on additional sessions.

8. Seeing so many patients has inevitably meant that more have been listed for surgery, leading to potential delays in glaucoma surgery. We have tried to mitigate this by putting on additional operating at Lymington, moving our glaucoma surgeons from clinics to theatre and asking commissioners to identify other centres with surgical capacity, which to date they have been unable to.

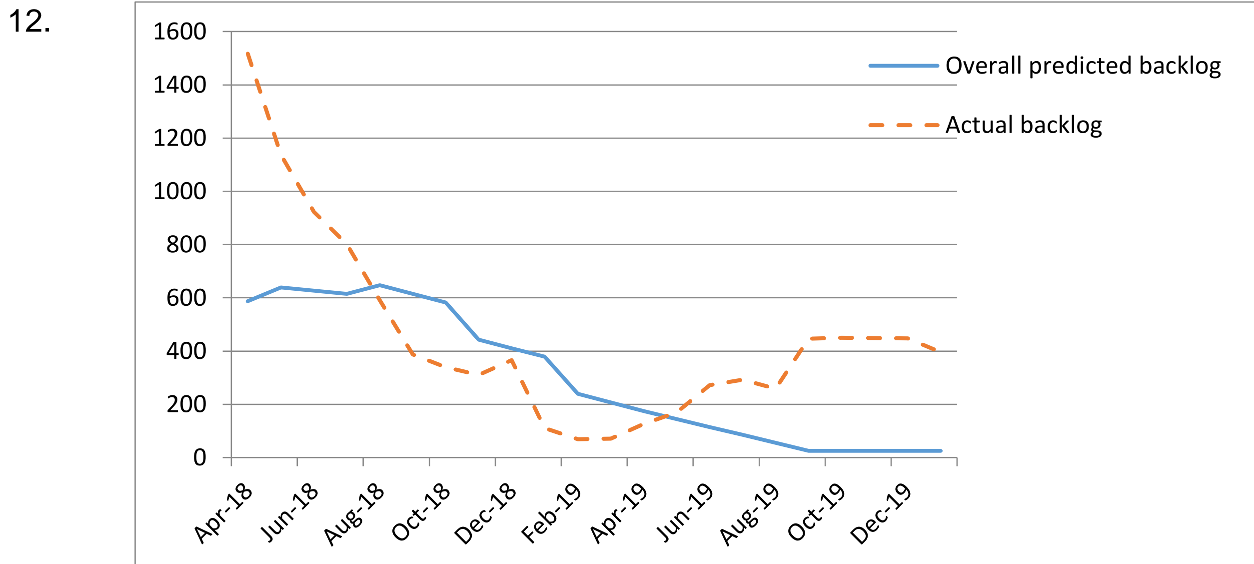
9. While the longer term plan has to be to recruit more substantive staff, UHS will need to continue using insourcing for the foreseeable future.

10. The current trajectory for glaucoma is:



11. The original backlog in diabetes was addressed quickly, with only those patients who we could not contact / would not accept a different appointment left. A high level of vacancies has seen a small increase in the last month, however a locum consultant has started and this should be addressed in February. The current trajectory for diabetes is:

12.



13. Patients being booked out of time in Ophthalmology had been on the Trust's risk register since 2014. However, the full scale of the problem was not appreciated until 2017.

14. University Hospital Southampton NHS Foundation Trust conducts a robust review of all patients identified to have potentially come to harm as a result of delays in their treatment. This is triggered by the patient's clinician completing an adverse event report (AER) any time they review a patient who has been delayed and has experienced deterioration in their vision during this period. A patient safety review meeting will then be held which will be attended by the care group management team including an ophthalmic consultant, the organisation's patient safety team, and the divisional governance team. They will review the length of delay, the patient's history and the current clinical picture, to determine whether the deterioration in vision is likely to be as a result of the delay. This will be recorded on a bespoke investigation template (designed for this purpose in consultation with the Trust executives and local Clinical Commissioning Group) which includes an assessment of the extent of the impact to the patient, which in turn determines whether or not any harm caused fulfils the criteria to be reported as a SIRI (Serious Incident Requiring Investigation) in line with the national serious incident (SI) framework. Patients fulfilling any of the criteria below would be reported as a SIRI:
    - Lost complete vision in one or both eyes as a direct consequence of the delay
    - Been registered severely vision impaired as a direct consequence of the delay
    - Have lost their driving licence and/or employment as a direct consequence of the delay.

15. If patients do not fulfil the criteria above but it is identified that the patient has come to harm, their individual circumstances will be assessed in further detail including whether or not they have needed to make amendments to their daily living activities; whether there has been any impact on their next of kin or dependents (i.e increased care needs or inability to fulfil existing caring responsibilities); and, whether the deterioration in vision is in line with natural disease progression. If it is ascertained that the harm or impact does not fulfil the SIRI criteria under the SI framework, but moderate/significant harm (for example partial sight loss) has been sustained as a result of the delay, this would be classified as an SEC (Significant Event Clinical). These incidents are subject to the same level of scrutiny as SIRIs within the organisation and are reviewed at the Trust's monthly SISG (Significant Incident Scrutiny Group) meeting to ensure that all appropriate learning has been identified and that actions are in place to mitigate against further incidents. This would include any incidental learning identified through review of individual patients. The group also review the SIRI/SEC classification as an additional level of scrutiny independent to the initial patient safety review meeting.

16. The investigation templates including the assessment of harm and SIRI/SEC determination are shared with patients as part of the organisation's commitment to be open and honest with patients, and fulfil duty of candour.

17. A breakdown of incidents to date is:

Number of patients reviewed as part of cohort	Glaucoma	Diabetes	AMD*	Total
	67	24	3	94
SEC	11	9	1	21
SIRI	26	6	0	32
No Harm	30	9	2	41

*Age-related Macular Degeneration

Conclusion

18. Ophthalmology has finally and successfully addressed the vast majority of delayed patients in glaucoma and diabetes. Because of a national shortage of ophthalmologists this has taken significantly longer than we would have wished.

19. However, as this is a lifelong condition all the patients will require follow up appointments in the future. These are currently being booked in time, but this is dependent on the continued use of insourcing. A further expansion of both staff and space is needed. There is also a need to review the current fragmented commissioning pathways.

RESOURCE IMPLICATIONS

Capital/Revenue

20. None.

Property/Other

21. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

22. The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.

Other Legal Implications:

23. None

RISK MANAGEMENT IMPLICATIONS

24. None.

POLICY FRAMEWORK IMPLICATIONS

25. None

<table>
<tr><td colspan="2">KEY DECISION</td><td colspan="2">No</td></tr>
<tr><td colspan="3">WARDS/COMMUNITIES AFFECTED:</td><td>None directly as a result of this report</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4"><u>SUPPORTING DOCUMENTATION</u></td></tr>
<tr><td colspan="4">Appendices</td></tr>
<tr><td>1.</td><td colspan="3">Risk Stratification Pathway</td></tr>
<tr><td>2.</td><td colspan="3">Patient Information Leaflet</td></tr>
<tr><td colspan="4">Documents In Members’ Rooms</td></tr>
<tr><td>1.</td><td colspan="3">None</td></tr>
<tr><td colspan="4">Equality Impact Assessment</td></tr>
<tr><td colspan="3">Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out?</td><td>No</td></tr>
<tr><td colspan="4">Data Protection Impact Assessment</td></tr>
<tr><td colspan="3">Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?</td><td>No</td></tr>
<tr><td colspan="4">Other Background Documents
Equality Impact Assessment and Other Background documents available for inspection at:</td></tr>
<tr><td colspan="2">Title of Background Paper(s)</td><td colspan="2">Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)</td></tr>
<tr><td>1.</td><td colspan="2">None</td><td></td></tr>
</table>