NHS
Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

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Via email to:

18th July 2018

Julie Shaw
Project Manager - Specialty Collaborative Working
Ophthalmology Managed Clinical Network
Working Together Vanguard Partnership

Dear Julie

Senate Review of Ophthalmology Out of Hours On Call Model for the Working Together Vanguard Partnership

Thank you for the opportunity to review your out of hours model for Ophthalmic Emergencies.

The objectives of the clinical review are to provide you with an independent clinical view of the model which has been in operation since 20th November 2017. You have requested a view from us of whether we have any safety concerns with this model. The members of the clinical review panel who reviewed the proposals through email and teleconference discussion are listed within the Terms of Reference enclosed with this letter.

The questions you asked us to consider are:

- Can the Clinical Senate advise on whether they have any safety concerns on the out of hours model. If so, can the senate specify those concerns and the recommended actions to ensure the service is fit for purpose?
- Does this model best serve the whole population of South Yorkshire and Bassetlaw given the consideration that the current situation is neither sustainable nor resilient?
- Does our approach over the last few years and the new model address the concerns expressed by the RCOphth two years ago about the negative impact on District General Hospitals unilaterally closing out of hours services with no regard for neighbouring Trusts?

Due to the late submission of both the second and third questions and the supporting additional information a later response date of 8th June was agreed with you.

There have been differing versions of the out of hours model since it commenced and we understand that Mid Yorkshire only recently joined as a hub. Please note that in our report the model we have considered is the 3 hub model with Mid Yorkshire, Sheffield and Doncaster acting as the hubs. We understand that there is one consultant on-call for each hub at a time and one middle grade/trainee at each hub. You have stated that there are no plans in place to move to a 2 hub service of Sheffield and Mid Yorkshire in line with your original plans. You asked us to

consider the out of hours handover time of 5.30 pm and also 9 pm as both have been used since the model started. We understand that you are currently trialling the later handover time.

I hope this letter provides a constructive summary of our comments and advice. Please find below our comments on each of the questions asked.

- **Can the Clinical Senate advise on whether they have any safety concerns on the out of hours model. If so, can the Senate specify those concerns and the recommended actions to ensure the service is fit for purpose?**

1. The Senate agrees that the out of hours model is a sensible and reasonable solution to the staffing issues which have been evident in the Network for some time. There are, however, currently too many unknowns in the operation of the model for the Senate to state that this model is currently safe. These concerns primarily relate to the triage, handover, transport and follow up arrangements between the hub and non-hub resulting in our concerns with the continuity of care for the patient. Our comments are detailed below. More robust arrangements need to be put in place to ensure that these processes are robust.

2. In terms of the model of care we fully recognise that there are safety issues with managing some emergency ophthalmic conditions without ophthalmic emergency care on site and we understand the safety concerns that have been highlighted by clinicians in the near miss incidents which you shared with the Senate. Due to these concerns, and concerns with already stretched out of hours services, we are aware that not all clinicians are fully committed to this model. It is clear that failure to commit clinically will manifest itself in problems for the patient and until there is full clinical commitment this model will not be safe. It is equally clear however that the individual Trusts cannot sustain the services on their own. We are pleased that there is Network wide recognition that the Barnsley service needs support and as a Network you have agreed to ensure that they are sustainable. This hub model needs to provide that solution. All clinicians need to recognise their duty of care to work together to make this model work effectively. The data suggests that the additional workload to the hubs is minimal with only 5 patients transferred in the first quarter which should address the concerns regarding the stretched on call at the hubs (although we do recognise that this audit may not have comprehensively captured all emergency attendances).

Recommendation: *We recommend that the clinicians within the Network now commit fully to the implementation of the model and work together to address the triage and communication issues we raise to ensure this model provides a safe and effective solution.*

Safety Concerns

Emergency Department

3. The current model relies on main Emergency Department (ED) staff to firstly identify and then triage eye diseases correctly. The Network produced Ophthalmology Guidance for the Primary Eye Carer is excellent but for those with very little ophthalmic knowledge (most non-ophthalmic clinicians) it is difficult to triage easily between a microbial keratitis needing immediate management and a viral keratitis requiring outpatient care for example. The delays in care in the near miss cases detailed were due to the performance of ED.

Unsurprisingly a patient with visual loss and a red eye may not receive priority assessment in ED when frail elderly patients are queuing for care. It is vital therefore that referral criteria is easily understood by ED clinicians and a diagnosis driven protocol, which needs an ophthalmic specialist to interpret, may not be the right document to achieve this. We recommend that there is opportunity to improve this document into a signs and symptoms decision tree with more easily recognised "red flags" for referral which the ED staff can describe well to the hub. The communication of a potential "red flag condition" should enable appropriate equity of care when the patient attends the acute service in the hub ie. the staff know that the patient should not be left waiting and be assessed rapidly. Of course both parties also need to be professional and refer/accept outside of the defined criteria if deemed clinically appropriate.

Recommendation: *We recommend that the Network undertakes further work with the non-hub ED departments to ensure that they have absolute clarity on the referral criteria and to use their feedback on the model to make improvements to the guidance.*

Patient Transport

4. We recommend that Inter-hospital transport requires further consideration. Whilst most patients presenting to ophthalmology out of hours will have arrived by private car or taxi and could transfer in a contract taxi the agreements with the ambulance service need to be clear. We understand that the non-hubs have liaised with Yorkshire Ambulance Service (YAS) and YAS have confirmed that they will transfer patients to the hubs if and when required and that they will monitor the numbers. What is not clear however is how ophthalmic emergencies are prioritised by YAS and this requires clarification.

Recommendation: *To obtain clarity on how YAS prioritises ophthalmic emergencies.*

Handover Documentation and Follow Up

5. Any hub and spoke model such as this requires clear and effective handover procedures. There is a lack of confidence in the Senate that there is a robust and comprehensive handover process (via secure email) behind the hub/ non hub pathway. The email handover can work well, however, we noted the lack of email addresses in the Memorandum of Understanding (MoU) handover procedure and we are not clear who in the non-hub accesses that secure email (administrative or clinical responsibility) and ensures the follow up the following morning. We are also not clear whether the imaging, blood tests and surgery notes for example follow the patient back to the non-hub.

6. The process for ensuring the hub records the telephone advice by email and how this is added to the patient record is also not clear.

Recommendation: *To provide greater clarity to all parties to ensure that the process for the patient to be followed up in the non-hub after emergency care in the hub is robust and comprehensive.*

Patient Records

7. Ophthalmology is very dependant on imaging to document diagnosis and the Senate has concerns as to how images and records of previous investigations can be handed over

between the ophthalmic teams in the hub and non-hub.

8. Patients presenting out of hours in the Trust where they receive their usual care are safer to manage as a full medical/surgical/ocular history can be obtained either from the notes or electronic patient records. The Senate is unclear how the Network is addressing this issue of data transfer. There is reference to Medisoft within the documents which would certainly be a help but there are limitations to this as it is both expensive and doesn't solve all the issues of different sites being able to access all of the patient notes including the imaging. There are other options available like the increased use of teleophthalmology to share images between the hub and non-hub.

Recommendation: *The Senate recommends that the Network have further discussions about how this model manages the information flows between referring hospital and hub and invests in the technology to improve the communications.*

The handover cut off time.

9. You asked the Senate to consider the differing implementation times for the model of both 5.30 and 9pm. The Senate advises that this decision should be based upon what is best for the hubs/ non hubs and whether the non-hubs can staff their services up until the later time and whether this impacts on the hub rota. The overriding factors in both cases is that there needs to be a robust system of triage/ transfer and follow up as discussed in this letter. We also recommend that the Network reaches some agreement around patients with complex issues presenting near the cut off time at the non-hub when the patient will need 2- 3 hours of surgery for example.

- **Does this model best serve the whole population of South Yorkshire and Bassetlaw given the consideration that the current situation is neither sustainable nor resilient?**

10. We agree that from the workforce data presented, retaining out of hours emergency ophthalmology services in all Trusts within the Network is not sustainable. This hub model has the potential to be an effective solution to the provision of out of hours emergency ophthalmology care in South Yorkshire and Bassetlaw but to operate safely we recommend that the Network addresses the points we raise about triage and communication

- **Does our approach over the last few years and the new model address the concerns expressed by the RCOphth two years ago about the negative impact on District General Hospitals unilaterally closing out of hours services with no regard for neighbouring Trusts?**

11. The Royal College of Ophthalmologists published their Ophthalmic Service Guidance in August 2017 entitled "Emergency Eye Care in Hospital Eye Units and Secondary Care". The Senate is agreed that the South Yorkshire and Bassetlaw model is one of the acceptable models discussed in this document (page 4). We agree that the geography of the South Yorkshire and Bassetlaw model fits with their recommendations of acceptable distances between hubs and non-hubs. The document comprehensively describes the requirements for the provision of emergency eye care and discusses the audit and governance framework required and communication channels. From the documentation presented we have not seen the

evidence that at this point in time the South Yorkshire and Bassetlaw model fully addresses the Royal College recommendations on the guidelines for referral, transfer, governance and communication between hub and non-hub which is required to make such models of networked care work effectively. If the model described for SYB is implemented well then it will address the concerns raised in the report.

12. We recommend that the Network considers the Royal College of Ophthalmologists Guidance entitled "The Way Forward Emergency Care 2017" which overlaps with the above guidance but gives greater information of all aspects of emergency eye care. This guidance also references smaller services joining forces with larger services for the provision of out of hours care and again emphasises the need for excellent communications, follow up and explicit and meticulous handover which we have not seen comprehensive evidence of in the South Yorkshire and Bassetlaw model. It probably is not possible to pre-empt or protocol every potential scenario and therefore common sense and professionalism will be required. Within your network framework it would be helpful for the units to hold joint governance meetings to discuss issues as they arise, share their perspectives and look for ways to improve their own services.

Recommendation*: In order to make progress with the issues highlighted we recommend that the Network appoints a lead in each hub to oversee these governance and process issues and holds regular joint governance meetings.*

Conclusion

13. In summary the Senate agrees that the out of hours model is a sensible and reasonable solution to the staffing issues which have been evident in the Network for some time. Not all Trusts within the Network can sustain the out of hours emergency ophthalmology services on their own and this hub model needs to provide the solution to that issue. There are, however, currently too many unknowns in the operation of the model for the Senate to state that this model is currently safe. These concerns primarily relate to the triage, handover, transport and follow up arrangements between the hub and non-hub resulting in our concerns with the continuity of care for the patient.

14. We recommend that the clinicians within the Network now commit fully to the implementation of the model and work together to address the triage and communication issues we raise to ensure this model provides a safe and effective solution.

Yours sincerely

Chris Welsh
Senate Chair
NHS England – North (Yorkshire and the Humber)

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Ophthalmology Out of Hours On Call Model, Working Together Vanguard Partnership

Sponsoring Organisation: Working Together Vanguard Partnership

Terms of reference agreed by: Julie Shaw, Project Manager - Specialty Collaborative Working and Joanne Poole, Senate Manager, Yorkshire and the Humber Clinical Senate
Date: 1st May 2018

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Jon Ausobsky, Consultant [General] Surgeon from Bradford Teaching Hospitals and Regional Advisor to the General College of Surgeons and Training Programme Director for General Surgery for Yorkshire and Humber.

Citizen Representatives: Not on the panel

Senate Review Clinical Team Members:

David Spokes	Consultant Ophthalmologist	Norfolk and Norwich University Hospitals
Pnt Laloe	Consultant Anaesthetist and Council member	Calderdale & Huddersfield NHS FT
Louise Downey	Consultant Ophthalmologist, Hull and East Yorkshire Trust	Hull and East Yorkshire NHS FT
Edward Doyle	Consultant Ophthalmologist and Clinical Director	South West Senate
Amar Alwitry	Consultant Ophthalmologist and Clinical Lead for Community Ophthalmology,	Alliance, Leicestershire
Richard Allen	Head of Optometry and Independent Prescriber Qualified Optometrist	Colchester Hospital University

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:

- Can the Clinical Senate advise on whether they have any safety concerns on the out of hours model. If so, can the senate specify those concerns and the recommended actions to ensure the service is fit for purpose?
- Does this model best serve the whole population of South Yorkshire and Bassetlaw given the consideration that the current situation is neither sustainable nor resilient?
- Does our approach over the last few years and the new model address the concerns expressed by the RCOphth two years ago about the negative impact on District General Hospitals unilaterally closing out of hours services with no regard for neighbouring Trusts?

Objectives of the clinical review (from the information provided by the commissioning sponsor):

The clinical review advice provided by the Senate will be used in local clinical discussions to consider the future of the model.

Scope of the review: The Clinical Senate will focus their review on the above questions based on

the information provided in the documentation. The clinical panel will supplement their understanding of the model through discussion with commissioners.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: N/A

Agree the Terms of Reference: May 2018

Receive the evidence and distribute to review team: Initial evidence received on 8th March and additional evidence received 15th March and distributed to the panel on the same dates. Additional questions received 21st March when also notified of change to the model hours of operation. The Senate requested clarification and supporting information on these questions on 22nd March. The information we requested to support these additional questions was received on 25th April and distributed on 26th April

Teleconferences: The first Clinical Panel discussions w/c 19th March. Unable to arrange teleconference with commissioners and Q and A completed by email. A series of teleconferences was held with the panel members in mid-May

Draft report submitted to commissioners: 8th June. Report will be by Chair's letter.

Commissioner Comments Received: within 10 working days of the draft report being received

Senate Council ratification; at the July Council meeting

Final report agreed: end July

Publication of the report on the website: to be agreed with commissioners

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

1. The On – Call Monitoring excel spreadsheet
2. The Ophthalmology Out of Hours On Call Model
3. Additional Questions and Answers following an email exchange with our Senate Chair, Chris Welsh and Senate Manager, Joanne Poole
4. Geographical information (post code hub)
5. Model Memorandum of Understanding
6. Pathway guidance for ophthalmic emergencies
7. Ophthalmology workforce data
8. The previous Senate review on the proposed model
9. Royal College of Ophthalmologists "Eye Care in Hospital Eye Units and Secondary Care" August 2017

The review team will review the evidence within this documentation and supplement their understanding with a clinical discussion.

6. REPORT

The draft clinical senate report will be in the form of a letter from the Chair. It will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor, provider, NHS England (if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

9. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

Clinical senate council and the **sponsoring organisation** will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical senate council will:

i. appoint a clinical review team; this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialising during the review.

END