Welcome to the UKOA June Quarterly Meeting

Wednesday 13th June 2018
Housekeeping

• Fire
  • There is no alarm test today
  • If the alarm sounds it is not a drill and you should leave via the front entrance

• Toilets: to the left/2nd left

• Phones & laptops
  • Please can these be off or silent/closed during the presentations unless needed for the workshop

• Breaks
  • Refreshments will be served mid-morning and mid-afternoon just help yourself as no formal ‘breaks’ are built in - apart from lunch
  • Lunch break (20 mins) food/drinks will be served

• Wi-Fi – select FH Conferencing – Password: FH_Quakerism!

• Evaluation forms- please give us your feedback!
## Introduction & Agenda

<table>
<thead>
<tr>
<th>Item</th>
<th>Speakers</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrival and refreshments</td>
<td></td>
<td>10.00 - 10:30</td>
</tr>
<tr>
<td>Introduction/UKOA update</td>
<td>Melanie Hingorani, UKOA</td>
<td>10:30 - 11:10</td>
</tr>
<tr>
<td>Procurement &amp; IVT packs update</td>
<td>Oleksandr Lyubych, North of England Commercial Procurement Collaborative</td>
<td>11:10 - 11:40</td>
</tr>
<tr>
<td>Procurement: Cataract</td>
<td>Melanie Hingorani, UKOA</td>
<td>11:40 - 12:10</td>
</tr>
<tr>
<td>Patient Standards</td>
<td>David Galloway, RNIB</td>
<td>12:10 - 12:40</td>
</tr>
<tr>
<td>Lunch break</td>
<td></td>
<td>12:40 - 13:00</td>
</tr>
<tr>
<td>Scan for Safety</td>
<td>Adam Parsons, Scan4Safety</td>
<td>13:00 - 13:30</td>
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<tr>
<td>High Impact Intervention in Ophthalmology</td>
<td>Kate Branchett, National Elective Care Transformation Programme</td>
<td>13:30 - 14:10</td>
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<td>Outpatient Clinics</td>
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<td>Wrong IOL’s: National Investigation</td>
<td>Keely Galloway, National Investigator HSIB</td>
<td>14.10 – 14.50</td>
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<tr>
<td>Summary</td>
<td>Melanie Hingorani, UKOA</td>
<td>14:50 - 15:00</td>
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<td>Close</td>
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<td>15:00</td>
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UKOA Update

Melanie Hingorani: UKOA Board Member & Moorfields Consultant
& Gill Salter: UKOA
UKOA Update

- Launched the UKOA Website: www.uk-oa.co.uk
  - Members area live - end of June
- 12 new members since the last meeting with more in progress (39 members to date)

  - Buckinghamshire Healthcare NHS Trust
  - Derby Hospital NHS FT
  - Imperial College Healthcare NHS Trust
  - King’s College Hospital NHS Foundation Trust
  - Milton Keynes Hospital NHS Foundation Trust
  - North West Anglia NHS Trust
  - Plymouth Hospitals NHS Trust
  - Salisbury NHS Foundation Trust
  - Sheffield Teaching Hospitals NHS Foundation Trust
  - Sherwood Forest Hospitals NHS Foundation Trust
  - Southend University Hospital NHS Foundation Trust
  - The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
UKOA Update

- New stakeholders IGA & Macular Society
- Appointed a Board:
  - Mary Freeman, Consultant Nurse, Sheffield
  - Penelope Stanford, Lead of RCN Ophthalmic Nursing Forum
  - Stephanie Hartley, Nurse Consultant, Stoke Mandeville, Bucks Healthcare
  - Sean Briggs, Deputy COO, Moorfields Eye Hospital
  - Helen Rolle, Head and neck/ophthalmology General Manager, Leeds
  - John Ashcroft, CEO, Manchester Royal Eye Hospital
  - Veronica Greenwood, Chair of BIOS
  - Bill Newman Medical Director Manchester Royal Eye Hospital
  - Melanie Hingorani, Consultant Moorfields Eye Hospital

- Launched a quarterly newsletter
- Supporting GIRFT webex 4-5pm 15th June – Don’t forget to Register to join this – via the UKOA email link sent
UKOA Update:
Best practice/management & leadership days

- First two meetings Manchester and London
- Over 30 delegates attended both sessions – sample agenda shown

**Agenda**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker(s)</th>
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<tbody>
<tr>
<td>09.10</td>
<td>The extended workforce – orthoptics</td>
<td>Veronica Greenwood</td>
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<tr>
<td>09.40</td>
<td>The extended workforce – optometry in practice</td>
<td>Cecilia Fenerty &amp; Amanda Harding</td>
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<tr>
<td>10.10</td>
<td>Working in regional networks</td>
<td>Mary Masih</td>
</tr>
<tr>
<td>10.30</td>
<td>My professional development as a HCA</td>
<td>Steve Bewley</td>
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<tr>
<td>10.50</td>
<td>Group discussion and reflection</td>
<td>Glyn Wood</td>
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<td></td>
<td>Part 2: Quality and safety in ophthalmology:</td>
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<td>Chairs: Melanie Hingorani &amp; Sean Briggs</td>
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<tr>
<td>11.20</td>
<td>How do I know my ophthalmology service is safe?</td>
<td>Melanie Hingorani</td>
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<td>11.40</td>
<td>Safe networked care – principles and examples</td>
<td>Sean Briggs</td>
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<td>11.50</td>
<td>Moorfields approach to quality across the network</td>
<td>Anne Cooke</td>
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<td>12.00</td>
<td>MREH approach to quality across the network</td>
<td>Melanie Hingorani</td>
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<td>Vanguard learning on Q&amp;S in networked services</td>
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<td>12.20</td>
<td>Preventing Never Events and Wrong IOLs</td>
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<tr>
<td>12.10</td>
<td>Group discussion— sharing examples of how wrong IOLs occurred in delegates’ and speakers’ own units</td>
<td>Laura Steeple &amp; Melanie Hingorani</td>
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<tr>
<td>12.20</td>
<td>The new never event framework and the UKOA IOL quality standard</td>
<td>Melanie Hingorani</td>
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<tr>
<td>12.40</td>
<td>Human factors training</td>
<td>Laura Steeple</td>
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UKOA Update:
Best practice/management & leadership days

- Excellent feedback received on the sessions with more to be planned
- Looking for Member organisations to host future sessions – let us know
- Anyone interested in participating in these sessions – let us know
- Some of the subjects we’ve been asked to cover are below:
  - Audits - Protocols development
  - Recognising the expanding footprints of MREH & Moorfields. Engagement and building relationships/working with the community/services provided etc.
  - Look at joint training qualifications of nurses/optometrist/ optoms in extended roles
  - Shared benchmarking - templates for clinics etc.
  - Consultant Job planning
  - More on extended roles in practice
  - Emergency care models
  - ROP Screening models
  - Using case studies/examples from DGH’s where resources are a lot less than at centres
  - IT services - EPR
UKOA Update: Coding

• Over 30 delegates attended our Coding Workshop in May
• Draft clinician guide to costing and coding to be consulted shortly
• Followed by gradual development of detailed coding advice in areas of uncertainty, supported by NCO and coding classification advice centre
• Further workshops to be run regionally or locally
• Agenda covered:
  • Introduction to the NCO, HRGs, grouping and clinical coding
  • The ophthalmology Expert Working Group and ophthalmic issues
  • Contracting & costs basics
  • Coding and coders in practice
  • Coding practical & feedback
  • Working together to improve coding
  • Shared Guidelines
  • Shared guidelines practical & feedback
UKOA Update

- Glaucoma patient standards
- Extended roles for ophthalmic nurses
- Giant cell arteritis
  - Raise awareness in the population and supporting the patient journey including managing steroids, red flags for steroid side effects
  - Related tools or materials for GPs - raise awareness, initial investigations, dealing with steroids
  - Pathways between ophthalmologists, rheumatologists, primary care
  - BSR and PMR-GCA patient charity agreed to be involved

- Pathway development case studies from Sunderland/cataract surgery and MEH on IVT
- Claims study
- RightCare – draft measures, now need 1st stakeholder meeting
UKOA Update: Efficiency app

- **EyeEfficiency**, initially developed with members College sustainability group for worldwide research
- NHS version available for android and i-phone via app store
- Cataract
  - allows you to enter factors which affect throughput e.g. trainee grade, complexity patient and eye, anaesthetic
  - Based on College guidance and GIRFT work
  - Enter key time points to see productivity and where the time is spent/wasted
  - Benchmark internally and with others on a website
  - Also shows carbon waste
  - Demo-ed to NHSI, Supported by GIRFT
- IVT version planned
**INSTRUCTIONS**  

EyeEfficiency performs a time-and-motion study for your cataract operating list. The banner at the top of the screen can be used to navigate through the study — pressing the word on the right of the screen takes you forward, pressing the word on the left takes you backwards.

Before your study starts, you will be asked a few questions about your unit, and how your list is set up.

Before each case, we will ask you about the type of operation you’re going to perform, whether it’s expected to be a simple case, and the training level of the surgeon.

During a case, you will use the banner to record when a certain event has happened (e.g. patient has entered the theatre, incision closed). If you have made a mistake, for example you have recorded an event too early, you can use the banner to go back (the last event will be on the left of the banner).

At the end of your operating list, you will see a breakdown of your time and motion study. Old studies are stored for later review.

When you’re ready to start, press on “preferences” in the banner at the top of the screen.

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**PREFERENCES**  

**NUMBER OF BEDS**  

**ONE**

**UNITS**  

**KG**

**MEASURE WASTE AFTER**  

**FULL SESSION**

**INTENDED LIST START TIME**  

**08:30**

**INTENDED LIST END TIME**  

**12:30**

**NAME OF UNIT**  

Eye department

**CITY**  

A hospital

**COUNTRY**  

ANTARCTICA

EyeEfficiency is part of a global, not-for-profit research program to investigate best practice in cataract surgery sustainability and efficiency.
UKOA Update: Efficiency app
## ANALYSIS

### UNIT DETAILS
- **Name of Unit:** Eye Department
- **City:** A Hospital
- **Country:** Antarctica
- **Number of Beds:** 1

### LIST STATISTICS
- **Number of Patients:** 1
- **Percentage of Straightforward Patients:** 100.00%
- **Planned Length of List:** 04:00:00
- **Actual Length of List:** 02:08:39
- **List Over or Under:** UNDER 02:59:21
- **Cases Per Hour:** N/A
- **Average Case to Case Duration:** N/A

### OPERATIONS
- **Average Operating Time:** 00:00:04
- **Percentage of Time Spent Operating:** 10.18%
- **Percentage with Complications:** 0.00%

### TURNOVER
- **Average Turnover Time:** N/A
- **Percentage of Time Spent in Turnover:** N/A

### PERCENTAGE OF SURGEON TYPES
- **Senior Surgeon:** 100.00%
- **Trainee <2 Years:** 0.00%
- **Trainee 2-4 Years:** 0.00%
- **Trainee > 4 Years:** 0.00%

### PERCENTAGE OF SURGERY TYPES
- **Phacoemulsification:** 100.00%
- **NSICS:** 0.00%
- **ECCE:** 0.00%
- **Femtosecond Assisted:** 0.00%
- **Bilateral:** 0.00%

### WEIGHT OF WASTE (KG)
- **Total:** 0

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**UK Ophthalmology Alliance**
Procurement Workshop

Oleksandr Lyubych & Melanie Hingorani
Tower 4 – Orthopaedic & Ophthalmology

- NHS CPP Awarded contract by DH 8 November 2017
- 6 months to transition
- Live since 8 May 2018 as NHS National Procurement organisation
- DH objective to on-board Trusts to transact via NHSSC route
  - From circa 20% currently for ophthalmology to 80% within 3 years
  - Whist ensuring clinical engagement and approval to nationally recommended products
  - To deliver cost savings to the NHS
  - To reduce variation and risk
- DH working to novate CPP frameworks to CTSP
- Team of 35 across the tower
- Engaging with market on a 1-2-1 basis since February
- Meetings held at UK Ophthalmology Conference
- Market appear keen to work with us and recognise UKOA support for our national strategy
Complete Ophthalmology Solutions

- Lot 1 Intraocular Lenses
- Lot 2 Surgical Instruments
  - 2.1 Single Use
  - 2.2 Re-usable
- Lot 3 Procedure Packs
- Lot 4 Solutions & Gases
- Lot 5 General accessories & consumables
- Lot 6 Ophthalmic Equipment
  - 6.1 phacoemulsification
  - 6.2 vitreoretinal machines
  - 6.3 ophthalmic microscopes
  - 6.4 diagnostic equipment
  - 6.5 ophthalmic lenses
  - 6.6 additional ophthalmic equipment
- Lot 7 Combination specific lots
- Lot 8 Managed Service
Tower 4 Ophthalmology Team

Category Tower Director – Kath Ibbotson
National Category Manager – Khalid Shihadah
Senior Category Manager – Vacant
Clinical Engagement & Implementation Manager - Vacant
Category Manager – Oleksandr Lyubych (Procedure Packs)
Category Manager – Adele Hancox (IOL’s)
Category Manager – Nicola Atkinson (Instruments)
Category Manager - Rob Rae (Equipment)
Procurement Specialist - Vacant
Procurement Contract Support – Alison Higson
Procurement Contract Support – Abby Gay
Ophthalmic Procedure Packs

- Intravitreal (IVT)
- Phacoemulsification (Cataract)
- Instrument sets
Data analysis, Evaluation and Procurement

- Data collection
- Data analysis
- Samples
- Evaluation
- Procurement
IVT Packs

- IVT Pack Samples Evaluation
- Fill in Evaluation forms
- Provide feedback
- Discussion – final ‘Best IVT procedure pack’
Procurement: Cataract

Melanie Hingorani
Patient Standards

David Galloway: Head of UK Eye Clinic Support RNIB
Patient Standards

Project Purpose
To develop specific standards; enable measurement of the quality of patients’ experience when receiving hospital eye services; identify areas for improvement

Approach
Involvement of patient representative organisations
RNIB; IGA and the Macular Society – testing identified issues with patients
Literature review

SOURCES OF EVIDENCE
• Existing patient standards published by NICE and other health sector bodies
• Research carried out by the Macular Society in 2013 (BMJ Open)
• RNIB Patient Survey for Westminster APPG 2018
• BMJ Literature Review
• Northern Ireland Public Health Agency Report – Hospital Eyecare Service 2016-17
Patient Standards

Outputs
UKOA Patient Quality Standard – Melanie Hingorani

Patient Experience Survey
9 core questions; 4 additional questions for patients with low vision/sight impairment
• Welcome on arrival
• Staff introductions
• Dignity and Privacy
• Accessibility and adequacy of information – eye condition, prognosis and treatment
• Understanding what will happen next
• Where to find sources of practical help with sight loss and/or emotional support
• Ability of staff to greet and guide persons with sight loss
• Clinic Environment – lighting, signage etc...
• Accessibility of check-in procedures
Patient Standards

Next Steps

• Finalise paperwork for the Patient Experience Survey
• Disseminate to UKOA members with guidance in July

Today’s Decision

• Members are asked to agree to adopt Patient Experience Survey with an expectation that each UKOA member will conduct a survey within 12 months
• Agree to share results
Patient Standards

Northern Ireland report link

www.publichealth.hscni.net/sites/default/files/Eyecare%20Services%20Regional%20Final%20Report.pdf
Lunch Break

30 minutes
Scan 4 Safety

Adam Parsons: Patient ID and Product Recall Lead Scan4Safety
Scan4Safety
Implementation and Ophthalmology

UKOA Quarterly Meeting
13th June 2018
Programme Objectives

**Right Patient**
Setting standards to make sure we always have the right patient and know what product was used with which patient, when.

**Right Product**
Setting standards to make sure our staff have what they need, when they need it.

**Right Place**
Setting standards to make sure that patients and products are in the right place.

**Right Process**
Setting standards and implementing common ways of working to deliver better and more easily repeatable patient care.
Patient

Improved Care
• Releasing clinical staff time
• Wristband scanning for PPID

Protection
• Safer process through wristband scanning
• Tracing products directly to patient
• 13,055 Procedures and 231,244 Products
Product

Traceability
- POU scanning in Theatres
- Accurate stock through live system

Improved Catalogue
- Control and coverage of products
- Recording of implantable devices
- Rationalisation through visibility (£150K to date)
- Efficient payment through e-invoicing
Place

Accurate Locations
• All trust locations assigned (3,925)
• Increased knowledge of all areas

Patient Safety
• Recording of theatre location through POU scanning
• Trust-wide GLN’s create possibility of tracking patients
Process

Increased Safety
• Wristband scanning
• POU scanning alerts

Refined Supply Chain
• Managed service Mat-Man provide accurate product data

Improved Understanding
• New product recall process defines roles and responsibilities
POU Scanning

Patient & Procedure
- Wrist band scanned & Procedure selected

Staff
- All levels included

Products
- Including expiry date/lot number

Time
- Theatre Time
Implementation Timeline

Cardiology – October 2016
Trauma and Orthopaedics – March 2017
Main Theatres – October 2017
  • Plastic Surgery, Gynaecology, Urology, General Surgery, Maxillofacial, ENT, Oral Surgery, Obstetrics, Anaesthetics
Day Surgery – February 2018
  • Ophthalmology
Radiology and ERCP – March 2018

20 Operating Theatres Live (All Inpatient)
## Surgery History

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<thead>
<tr>
<th>Reference</th>
<th>Procedure Code</th>
<th>Procedure Name</th>
<th>Surgeon</th>
<th>Theatre</th>
<th>Duration</th>
<th>Patient ID</th>
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<td>Timelapse</td>
<td>8 June 2018</td>
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Surgery Report

![Surgery Report Software Interface]

## Details
- **Surgeon:** 2498216 - MR ROGER HUMPHREY
- **Reference:** PL0032843
- **Procedure:** OPHTH01 - CATARACT
- **Theatre:** 5055222183417 - Day Surgery E
- **Patient ID:** D187101
- **Created By:** Theatre E Theatre E
- **Created On:** 7 June 2018 10:54
- **Surgery Duration:** 00:30:09

## Surgery Items

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*All changes are automatically saved.*

Subtotal: **£316.17**
VAT: **£6.00**
Total: **£316.17**
Safety Alerts

Attention!

97.16.00 | 97.16.00
Item has expired 10 months ago (01/09/2017).

CANCEL  CONTINUE  DISCARD

Attention!

31146063 | 31146063
A Product Recall has been issued for:
- Item 31146063 | Lot Number: 0211974254

CANCEL  CONTINUE  DISCARD
Safety Development

- Ophthalmology Electronic Medical Record
- Lens Size Chosen
- Lens Size Match or Alert
- POU Scan / Inventory Management System
Future

Continue Improvement Areas
- Product Recall
- Catalogue Management
- Purchase to Pay
- Inventory
- Communication
- Patient ID
- New Development Areas
- Pharmacy
- Medical Devices
- Instrumentation
- Systems
- Analytics
- Staff ID
Questions?

Scan4Safety@salisbury.nhs.uk

@SFTScan4Safety
#scan4safety
Ophthalmology Modelling: High Impact Intervention

Kate Branchett: National Elective Care Transformation Programme
Elective Care Transformation Programme
Ophthalmology High Impact Intervention 2018/19

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Right person, right place, first time

www.england.nhs.uk/elective-care-transformation
Background

- Approximately 8 million people are treated annually in Hospital Eye Services (HES), accounting for 8% of all outpatient appointments across the UK. A lot of the outpatient visits are for timed treatment and monitoring for Acute Macular Degeneration and for Glaucoma.
- There is rising, unmet demand for ophthalmology services and the gap between demand and capacity continues to grow.
- One of the main causes of avoidable sight loss in patients within HES is patients not receiving follow–up appointments within the clinically indicated (safe) timeframe.
- Hospital Eye Services have not previously been required to report or monitor delays for follow up appointments, therefore the scale of any backlog is not immediately evident.
- 200 patients per year are losing their sight due to health service initiated delays – people with sight loss are twice as likely to have falls and more likely to suffer from anxiety and depression.
- The total estimated indirect cost of sight loss is around £5.5 billion.
Background contd

- **Thousands** of patients are being ‘lost to follow up’ every year due to health initiated delays

Moorfields Review of Ophthalmic Patient Episodes Lost to Follow–up: Summary of results
Davis, A. et al., 2017. ‘A review of 145234 ophthalmic episodes lost to follow up.’ Eye, 31, pp. 422-42

Moorfields initially identified a total of 145234 ‘lost to follow up’ patient episodes

- **Step 1 Administrative Review and Discharge:** 79,562
  - Remaining lost to follow – up episodes: 65,672

- **Step 2 & 3 Clinical Records Review and Discharge:** 50,519
  - Remaining lost to follow up episodes requiring review appointments: 15,153

- **Step 4 Patient Clinical Review and management:** 12,316 (16 serious incidents)
  - Remaining lost to follow up episodes and records not available: 2,837
Introduction to the intervention

• The Elective Care Transformation Programme has been working with key national stakeholders (including the Royal College of Ophthalmologists) to produce a specification outlining the key actions necessary to improve safety in elective ophthalmology pathways.

• This intervention is a joint initiative between the NHS England Elective Care Transformation Programme and the Getting It Right First Time Programme. For the intervention to be successful, it will require local systems to work together to support the necessary transformation of ophthalmology services.

• The three key actions are intended to ensure the timely assessment and follow up of those most at risk of sight loss due to chronic eye conditions.

• This intervention complements current key policy documents, guidance and recommendations, building on the work of the Royal College of Ophthalmologists and their three step plan. It is also supported by NICE guidance and reflects the recommendations of the former National Patient Safety Agency, the RNIB and the Clinical Council for Eye Health Commissioning, in their System and Assurance Framework for Eye-health (SAFE).
The aims of the intervention

The intervention aims to bring local systems together to develop new approaches to ophthalmology outpatient services and to fully understand:

- **How to minimise the risk of significant harm** to patients by prioritising the review, treatment, and care of those at greatest risk of irreversible sight loss.
- **What the current demand and levels of risk to patients actually are** within the HES.
- **Which challenges exist and what action needs to be taken** across the local system to manage capacity effectively, deal with demand safely, and prevent risk of harm to patients in the future.
Ophthalmology High Impact Intervention Specification 2018/19

1. Actions necessary
## Actions necessary

<table>
<thead>
<tr>
<th>Owner</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action 1</strong></td>
<td>Trusts responsible for Hospital Eye Services (HES)</td>
</tr>
<tr>
<td><strong>Action 2</strong></td>
<td>Trusts responsible for HES</td>
</tr>
<tr>
<td><strong>Action 3</strong></td>
<td>CCGs/STP/ICS leaders</td>
</tr>
</tbody>
</table>
Actions 1 and 2: Essential resource

- Ophthalmic Service Guidance for safe and efficient processes in ophthalmology outpatients published by The Royal College of Ophthalmologists.
- Relates directly to Actions 1 and 2 in the specification.
- Highlights the importance of failsafe prioritisation, along with the robust mechanisms necessary to manage non-attendance, cancellations and the rebooking of appointments.
## Ophthalmology Intervention Timeline

<table>
<thead>
<tr>
<th>What?</th>
<th>When?</th>
<th>Who?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publish Specification</td>
<td>May 2018</td>
<td>National ECTP Team</td>
</tr>
<tr>
<td>Webinars for Specification</td>
<td>May 2018</td>
<td>National ECTP/GIRFT Team</td>
</tr>
<tr>
<td>Co-ordinate baseline audit</td>
<td>Quarter 1 2018/19</td>
<td>National ECTP Team</td>
</tr>
<tr>
<td>Develop local ophthalmology transformation plan for eye health capacity review</td>
<td>May/June 2018</td>
<td>STPs/CCGs/ICS</td>
</tr>
<tr>
<td>Assure local ophthalmology transformation plans for eye health capacity review</td>
<td>June 2018</td>
<td>NHSE Regional Teams</td>
</tr>
<tr>
<td>Local NHSE/GIRFT/NHSI Ophthalmology Workshops</td>
<td>Quarter 1 2018/19</td>
<td>National ECTP/Local NHSE &amp; GIRFT Teams</td>
</tr>
<tr>
<td>Quarterly reporting (informed by GIRFT feedback on uptake of actions 1 &amp; 2 and direct monitoring of action 3)</td>
<td>Quarterly during 2018/19</td>
<td>NHSE Regional Teams</td>
</tr>
<tr>
<td>All Trust Hospital Eye Services have developed failsafe prioritisation processes and policies (action 1)</td>
<td>By March 2019</td>
<td>Hospital Eye Services, supported by GIRFT Regional Teams</td>
</tr>
<tr>
<td>All Trust Hospital Eye Services have undertaken clinical risk and prioritisation audit (action 2)</td>
<td>By March 2019</td>
<td>Hospital Eye Services, supported by GIRFT Regional Teams</td>
</tr>
<tr>
<td>All CCGs/STPs/ICSs undertake eye health capacity review (Action 3)</td>
<td>By March 2019</td>
<td>CCGs/STPs/ICSs supported by local NHSE teams</td>
</tr>
</tbody>
</table>
Ophthalmology High Impact Intervention Specification 2018/19

2. Working together locally

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Implementation – National and regional support

This is a joint initiative between the NHS England Elective Care Transformation Programme (ECTP) and the Getting It Right First Time Programme (GIRFT).
Implementation – National and regional support

The national elective care transformation programme will:

- Provide specification and support materials, including key lines of enquiry (KLOEs) for assurance and launch webinars/events.
- Co-ordinate an initial baseline audit against the key actions.
- Work with all stakeholders and provide support throughout 2018/19.
Implementation – National and regional support

GIRFT regional implementation teams will:

• Support HES to develop local plans to address the key actions taking into account the baseline position.
• Support local HES to implement these plans, helping to report and feed back to the national team.
Implementation – National and regional support

Local NHS England regional teams will assure that for each locality (incorporating CCG/STP/ICS and HES):

- A baseline is documented against each of the three actions.
- A local ophthalmology transformation plan is in place to address each of the three actions, taking into account the baseline position. The footprint for these plans will be determined locally, but regional teams must ensure each Trust and CCG is covered.
- Appropriate progress is made against these plans.
Implementation – National and regional support

STPs/ICSs/CCGs will:

• Lead on the review of capacity and demand locally, working closely with Hospital Eye Services, GIRFT and Regional teams.
• Develop local ophthalmology transformation plans to address each of the three actions, taking into account the baseline position.
• Report progress against these plans on a quarterly basis.
Implementation – National and regional support

Trusts responsible for hospital eye services will:

• Ensure that HES develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients.
• Ensure that a clinical risk and prioritisation audit of existing ophthalmology patients is undertaken in each hospital eye service.
• Provide appropriate input for actions 1 and 2 into local ophthalmology transformation plans.
Elective Care Transformation Programme

Implementation timeline

- **Jan - Mar 17/18**
  - Publication of specification

- **Apr-Jun 18/19**
  - Webinars for specification
  - Implementation workshops
  - Baseline audit

- **Jul-Sep 18/19**
  - Local systems developing optimisation transformation plan

- **Oct-Dec 18/19**
  - HES develop failsafe prioritisation processes and appoint failsafe officers

- **Q2 submission**
  - HES undertake clinical risk and prioritisation audit
  - GIRFT to support HES to implement both actions 1 and 2

- **Q3 submission**
  - STPs/CCGs/ICSs undertake eye health capacity review

- **Q4 submission**
  - GIRFT to incorporate the HII specification and recommendations as part of their work
  - NHS Digital to develop information standards to support system changes

NHSE National Team
- GIRFT
- CCGs/STPs
- NHSE Region Teams
- Hospital Eye Services
Related work

The Elective Care Transformation Programme will be working in partnership with other national programmes to help local systems implement this intervention:

- GIRFT will be incorporating the High Impact Intervention (HII) specification and recommendations as part of their work, ensuring essential and efficient clinic management processes are embedded within the services they work with.

- NHS Digital are developing an information standard to support system changes.
3. Where are we now? Local baseline audit

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Assurance and monitoring progress

A baseline audit will be co-ordinated by the national team during Q1 to inform discussions at the local implementation workshops.

- This audit builds on existing data and intelligence from GIRFT visits so far.
- An audit tool has been developed to enable this to be undertaken across the seven GIRFT regions.
- NHSE colleagues report on the progress of implementation overall. This will need to be informed by updates from GIRFT colleagues regarding HES implementation of actions 1 & 2 and related timescales.
Ophthalmology Baseline Audit

The Baseline Audit has been developed to allow the programme to evaluate the current status of HES in relation to actions 1 & 2 for the Ophthalmology HII.

Actions so far include:

✓ Baseline audit tool developed by ECTP
✓ Distributed by national GIRFT team to HES for submission to ECTP (Early May 18)
✓ Reminders sent to providers with follow-up calls and information on provider returns shared with regional NHSE leads.
✓ Completed audits evaluated by ECTP with findings shared with GIRFT and NHS England regional colleagues, including any good practice information

Action 3 will be monitored through the NHS England Regional teams. Webinar scheduled for 8th June with regional NHSE leads.
Ophthalmology Baseline Audit

The Audit will provide a baseline on:

- Policies and procedures linked to failsafe systems
- IT system capabilities to capture patient categorisation and delays
- Clinical risk and prioritisation
- Number of patients categorised as 'lost or delayed follow up'

Baseline data will support a review of progress against actions for ECTP and GIRFT, providing assurance and allow regional GIRFT teams to evaluate and prioritise support for HES and regions.
# Ophthalmology Baseline Audit

## Action 1. Failsafe prioritisation processes

<table>
<thead>
<tr>
<th>Question</th>
<th>Y/N</th>
<th>Evidence/ detail</th>
<th>Y/N</th>
<th>Evidence/ detail</th>
<th>Y/N</th>
<th>Evidence/ detail</th>
<th>Y/N</th>
<th>Evidence/ detail</th>
<th>Y/N</th>
<th>Evidence/ detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a written policy or protocol in place, agreed between clinicians and admin/managerial staff, which adheres to RCOphth guidance on outpatient operational processes?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are patients stratified by clinical risk and a range of review options in place using the whole MDT?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a dedicated failsafe officer or function in post? Please provide detail.</td>
<td>Failsafe officer?</td>
<td></td>
<td>Senior clinical lead for failsafe?</td>
<td>Evidence/det</td>
<td>Can your PAS system collect planned follow up dates for patients?</td>
<td>Y/N</td>
<td>Are follow up dates for patients routinely completed?</td>
<td>Y/N</td>
<td>Is this broken down to high / low risk patients</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

## Action 2. Clinical risk and prioritisation audit

<table>
<thead>
<tr>
<th>Question</th>
<th>Y/N</th>
<th>Evidence/ detail</th>
<th>Y/N</th>
<th>Evidence/ detail</th>
<th>Y/N</th>
<th>Evidence/ detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a clinical risk and prioritisation audit of ophthalmology patients taken place?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there an action plan in place to deal with any LDFU patients?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start date</td>
<td>Finish date</td>
<td>Status</td>
<td>Y/N</td>
<td>If yes, what is the number of LDFU patients?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Region</th>
<th>Number of contact details provided</th>
<th>Number of Completed Returns</th>
<th>Total Number of HES *</th>
<th>% Completed Returns</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Midlands</td>
<td>17</td>
<td>17</td>
<td>22</td>
<td>77%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>17</td>
<td>12</td>
<td>16</td>
<td>75%</td>
</tr>
<tr>
<td>South East</td>
<td>14</td>
<td>14</td>
<td>19</td>
<td>74%</td>
</tr>
<tr>
<td>South West</td>
<td>9</td>
<td>10</td>
<td>17</td>
<td>59%</td>
</tr>
<tr>
<td>London</td>
<td>17</td>
<td>8</td>
<td>19</td>
<td>42%</td>
</tr>
<tr>
<td>North-East &amp; Yorkshire</td>
<td>20</td>
<td>9</td>
<td>21</td>
<td>43%</td>
</tr>
<tr>
<td>North West</td>
<td>20</td>
<td>13</td>
<td>21</td>
<td>62%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>114</strong></td>
<td><strong>83</strong></td>
<td><strong>133</strong></td>
<td><strong>62%</strong></td>
</tr>
</tbody>
</table>

* Includes sub contracted or hub and spoke model services
Can your PAS system collect planned follow up dates for patients?

- Yes: 68.83%
- No: 31.17%

Are follow up dates for patients routinely completed?

- Yes: 52.64%
- No: 47.36%

Is this broken down to high / low risk patients?

- Yes: 52.64%
- No: 47.36%
Join our community of practice on the FutureNHS Collaborative (Kahootz)

- Visit https://future.nhs.uk/connect.ti (email Sian.greenley@nhs.net for access)
- Visit our website at https://www.england.nhs.uk/elective-care-transformation/
- Share learning from elective care innovation
- Discuss challenges and solutions
Thank you for coming to the workshop today

Contact us:

Email: england.electivecare@nhs.net

Website: https://www.england.nhs.uk/elective-care-transformation
Wrong IOL’s: National Investigation

Keely Galloway: National Investigator HSIB
Agenda

• Introduction to HSIB
• Investigation in insertion of an incorrect intraocular lens
• Reference case overview
• Methods
• Investigation findings
• Examples of variation in practice
  • Lens selection
  • WHO time out
• Discussion
• Potential recommendations
• Questions
Who are HSIB?

*Improve Patient Safety* through *Effective* and *Independent National Investigations* that do not *Apportion Blame* or *Liability*

Determine the *causes* of clinical incidents

Encourage *safety action* and make *safety recommendations* to prevent recurrence
What to investigate

Outcome Impact
- Impact on people, service
- Physical and emotional harm
- Loss of confidence

Systemic Risk
- How common is the issue
- Does it span different areas or locations

Learning Potential
- What work is ongoing or has been done
- Can we produce new safety information and lead to improvements
- Can we bring a new perspective to the issue
<table>
<thead>
<tr>
<th>Case</th>
<th>SAN date</th>
<th>Web notification</th>
<th>Bulletin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac and vascular pathways</td>
<td>April 17</td>
<td>July 17</td>
<td>3 July 17</td>
</tr>
<tr>
<td>Wrong site interventions</td>
<td>June 17</td>
<td>Sept 17</td>
<td>27 Nov 17</td>
</tr>
<tr>
<td>Provision of mental health services in the ED</td>
<td>June 17</td>
<td>Sept 17</td>
<td>11 Jan 18</td>
</tr>
<tr>
<td>Recognising and responding to critically unwell patients</td>
<td>July 17</td>
<td>Oct 17</td>
<td>27 Nov 17</td>
</tr>
<tr>
<td>Transition from child and adolescent mental health services to adult mental health services</td>
<td>July 17</td>
<td>Oct 17</td>
<td>19 Jan 18</td>
</tr>
<tr>
<td>Wrong route administration of an oral drug into a vein</td>
<td>Sept 17</td>
<td>Nov 17</td>
<td>19 Feb 18</td>
</tr>
<tr>
<td>Insertion of an incorrect intraocular lens</td>
<td>Oct 17</td>
<td>Nov 17</td>
<td>27 Feb 18</td>
</tr>
<tr>
<td>Implantation of the wrong prosthesis</td>
<td>Oct 17</td>
<td>Dec 17</td>
<td>20 Dec 17</td>
</tr>
<tr>
<td>Safe delivery of oxygen</td>
<td>Oct 17</td>
<td>Jan 18</td>
<td>29 Mar 18</td>
</tr>
</tbody>
</table>
Safety issues on initial review

- Equipment design/use
- Diagnostic failure
- Communication failure between organisations
- Medication administration
- Transfer issues
Investigation into insertion of an incorrect intraocular lens
Evaluation Against HSIB Criteria

Outcome Impact
- Moderate harm – patients rarely require further surgery and instead have a change in the prescription of their glasses
- Older patients, often nervous about procedure, can need two surgeries, separately – loss of confidence in service
- Errors continue to occur, despite numerous safety initiatives and reviews – systems could be more user friendly
- International issue – International Association of Eye Hospitals – 2018 challenge

Systemic Risk

Learning Potential
- Development of software – simplification of process of selection and checking
- Barcode scanning of lens (overlap with I2017/010)
- Organisations have taken learning as far as they are able – now all they see is training as an option
Reference case

• 86 year old female, listed for Left Eye Cataract Surgery
• Target visual outcome -0.25
• Also had measurements for Right Eye and this was planned to be undertaken at a later date (Target 0.0)
• Using an EPR in theatre
• During surgery, the biometry for the right eye was used to select the lens for the left eye (difference 0.5 dioptres)
• Error picked up after surgery
• Not having a further operation to correct lens power
Key lines of Enquiry

<table>
<thead>
<tr>
<th>The IOL process and human factors considerations</th>
<th>Design and procurement of software</th>
</tr>
</thead>
<tbody>
<tr>
<td>- How do organisations structure their IOL process</td>
<td>- How is software for ophthalmology procured?</td>
</tr>
<tr>
<td>- Staffing</td>
<td>- How is software for ophthalmology implemented in an organisation?</td>
</tr>
<tr>
<td>- Use of technology</td>
<td>- What considerations are given to the design of software for use in ophthalmology?</td>
</tr>
<tr>
<td>- Checking processes</td>
<td>- How is software for use in ophthalmology qualified?</td>
</tr>
<tr>
<td>- Training</td>
<td>- What involvement does MHRA have?</td>
</tr>
<tr>
<td>- Governance</td>
<td></td>
</tr>
<tr>
<td>- To identify if technical solutions may limit the reliance on human factors</td>
<td></td>
</tr>
</tbody>
</table>
Investigation approach

- Interviews with all staff involved and managers
- Observation of practice in main theatre
- Observation of practice in other organisations and discussions with staff
- Meeting with Scan4Safety programme
- Meeting with Royal College Ophthalmologists
- Visit to EPR to understand design, testing and implementation
- Review NRLS and StEIS data against literature
- Discussion with National Ophthalmology Audit lead
- Discussion with organisations using Scan4Safety
- Process mapping
Analysis Model for Analysis –
Australian Transport Safety Bureau

- **Organisational Influences**
  - What could have been in place to minimise problems with the risk controls?

- **Risk Controls**
  - What could have been in place to reduce the likelihood of or severity of problems at the operational level?

- **Local Conditions**
  - What aspects of the local environment may have influenced the individual actions/technical problems?

- **Individual Actions**
  - What individual actions increased safety risk?

- **Occurrence Events** (including technical problems)
  - What events best describe the occurrence?

- **Regulation/law/systemic factors**
  - Factors beyond a Trust’s control

- **Risk Controls**
  - Rules/guidance/policies/systems/processes

- **Trust factors**
  - Culture, local systems, equipment availability

- **Consultant/theatre staff**
  - Perspective, thoughts, feelings

- **Insertion of wrong IOL**
  - Objective description of what happened
What did the data tell us?
Findings - Themes

1. Technology
   1. Presentation of information
      1. Lens selection using source biometry
      2. Usability of the EPR in the theatre environment
   2. Safety and usability assessments of EPR
   3. Record management and scanning/barcoding

2. Lens selection
   1. When to select the lens
      1. Pooled lists

3. WHO 5 steps to safer surgery
   1. Variation in delivery of team brief
   2. Variation in delivery of time out
   3. Adequacy of Time out to prevent wrong IOL

Local conditions
Management of service delivery and risk mitigation
Findings - Themes

1. Technology
   1. Presentation of information
      1. Lens selection using source biometry
      2. Usability of the EPR in the theatre environment
   2. Safety and usability assessments of EPR
   3. Record management and scanning/barcoding

2. Lens selection
   1. When to select the lens
      1. Pooled lists

3. WHO 5 steps to safer surgery
   1. Variation in delivery of team brief
   2. Variation in delivery of time out
   3. Adequacy of Time out to prevent wrong IOL

Local conditions
Management of service delivery and risk mitigation
Variation in practice – When to select the lens

- In theatre, just prior to the team brief
- One week before with paper record available
- At pre-assessment clinic (pooled lists)
- In theatre, just before the patient is brought in
- One week before on EPR – double checked on day of surgery against paper biometry
- In pre-op assessment

**Question**
- Which of these (if any) is the safest?
- Which of these is the most practicable?
  - Can you agree on the best way?
  - What would affect your decision?
Variation in practice – WHO Time Out

- **Ophthalmologist leads team in check indicating the target, formula, AL, which eye**
- **Scrub nurse and ophthalmologist only participate**
- **Adoption of WHO Cataract surgical checklist**
- **Biometry isn’t available in theatre, only lens selected and target – challenged if not between 0 and -0.5**
- **Lens is opened and placed on scrub trolley after WHO time out completed**
- **Lens is placed on phaco machine ready for pre-insertion check**

- **Starts without ophthalmologist involvement**
- **The selection is made on the EPR then cross referenced with paper biometry, paper biometry is used to check lens in theatre**
- **The target is written on consent form and target from operation screen is checked against target and lens power from same screen checked against box**
- **Lens is circled on source biometry, transcribed onto a second sheet where the sticker is placed – the checks confirm the lens in theatre, the source biometry and the transcribed lens selection**

- **Minimum scrub nurse, ophthalmologist and anaesthetic practitioner participate**
- **Takes place after patient is draped**
- **Takes place before patient is draped**
Variation in practice – WHO Time Out

Question
• Which of these (if any) is the safest?
• Which of these is the most practicable?
  • Can you agree on the best way?
  • What would affect your decision?

Considerations:
• Purpose of the WHO checklist
• Participation
• What should be checked
• When should the checks happen
• What information should be used
• How should the checks be done?
1. Agree, evaluate, implement standardised practice, supported with training
2. Utilise barcoding and scanning functionality to alert mismatches between the patient and selected lens*
3. Ensure EPRs are assessed for human factors/design/usability
4. Include ‘wrong IOL’ with National Ophthalmology Audit
Questions?
Healthcare Safety Investigation Branch
Investigation into insertion of an incorrect intraocular lens

Keely Galloway
National Investigator

Keely.Galloway@hsib.org.uk
www.hsib.org.uk
Summary & Close

Melanie Hingorani