The ROYAL COLLEGE of OPHTHALMOLOGISTS

Ophthalmic Services Guidance

Quality, safety and clinical governance in ophthalmology: an overview

July 2016

18 Stephenson Way, London, NW1 2HD T. 020 7935 0702
contact@rcophth.ac.uk rcophth.ac.uk @RCOphth

Contents

Date of review: July 2018

1. Introduction

All doctors need to understand and follow the principles of quality, safety and clinical governance in modern healthcare. In the General Medical Council's (GMC's) Good Medical Practice[1] a doctor's duties are subdivided into four domains of which Domain 2 is Quality and Safety which describes how doctors must:

- Contribute to and comply with systems to protect patients
- Respond to risks to safety
- Protect patients and colleagues from any risk posed by your health.

This document aims to provide a simple overview of the principles and systems which currently exist in the UK for quality and safety (Q&S), and how they have evolved. It is supplemented by other more detailed documents on specific areas. References are, where possible, web-based, to allow members to more easily access them for further reading if interested.

2. Definition of quality and safety and clinical governance

Clinical governance is defined by the Department of Health as follows:

Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

It is the *process* by which organisations achieve high quality care.

High quality care essentially describes care which achieves good outcomes for patients through the provision of evidence based healthcare delivery, which minimises harm and which provides the patient with a positive, personal experience of care.

The modern NHS definition of quality centres around the three arms defined by Lord Darzi in 2008[11]:

Clinical effectiveness: Care which provides good outcomes, that is good results or success of care for patients. This can be assessed both through clinical outcome measures, such as mortality/survival rates, complication rates, and through patient reported outcome measures (PROMs) such as a patient's assessment of their own symptoms and quality of life measures.

Patient safety: First we do no harm. This is about minimising avoidable healthcare related harm such as reducing healthcare associated infections, falls or medication errors.

Patient experience: This describes personal and caring healthcare, so that patients are treated with compassion, dignity and respect and in a way that increases the patient's satisfaction with their care.

3. History of governance and quality in healthcare in England

The concept of clinical governance developed on the back of corporate governance, which emerged in response to concerns on standards of accountability and financial reporting in public companies and which was formalised in 1992. From the mid 1990s onwards, concerns began to emerge in the NHS of variations in clinical quality and a number of well publicised serious clinical failures (such as cervical cancer screening services at Kent and Canterbury Hospital[3], paediatric heart surgery at the Bristol Royal Infirmary[4], organ retention at the Alder Hay Hospital[5]) led to calls for action. Clinical governance was proposed as a method of ensuring that NHS organisations gave as much weight to quality performance as they did to service performance and financial control, and to create a vehicle for continuous quality improvement. Clinical governance was defined and statutory duties for providers presented, with the creation of two new external agencies the Commission for Health Improvement, CHI (the forerunner of the current CQC), and the National Institute for Clinical Excellence, NICE, in 1991 (renamed the National Institute for Health and Care Excellence in 2013).

CHI produced the original seven pillars of clinical governance, which were:

- Patient involvement
- Risk management
- Clinical audit
- Staffing and management
- Education and training
- Research and effectiveness
- Use of information

The regulatory functions and names changed over time: Star ratings and then the Annual Health Check for hospitals were introduced, and CHI changed to the Healthcare Commission (2004) which was superseded by the Care Quality Commission (CQC) in 2009.

The government introduced in 2000 the NHS Plan, which looked to increase funding and also to modernise and reform the NHS. To help move this further forward, Lord Darzi was asked to conduct a consultative review which concluded that, although the modernisation plan had improved efficiency and reduced waiting times, there was further work required to improve outcomes. In 2008 the so-called Darzi report was published. This document aimed to put quality at the heart of the NHS and introduced sweeping changes including greater emphasis on prevention of disease, a new NHS constitution setting out patients' rights especially in choice of provider, and ensuring that healthcare outcomes would be measured, published and that funding for providers would be dependent on achievement of quality in care. It also moved away from the seven pillars to the three modern domains of quality, that is patient safety, clinical effectiveness and patient experience.

In more recent times there has been a flurry of further safety concerns which have led to more change. Following a huge public outcry over standards of care at the Mid Staffordshire NHS Foundation Trust, Robert Frances QC produced two reports, the final one released in 2013[12] with a staggering 290 recommendations to improve care and safety. Of particular note was the suggestion, following this report, to potentially prosecute staff and organisation leaders if serious harm or death arose because care fell well below the fundamental standards expected. Another important change after this report was the introduction of the Duty of Candour, that is telling patients and families openly if things has gone wrong leading to harm. This report was followed in rapid succession by two more

reports on safety: one examining quality and safety in 14 hospitals with apparently high mortality by the Medical Director of the NHS in England, Bruce Keogh, the Keogh mortality review[13]. Recommendations included better response to early warning signs in sick patients, clearer national quality and safety data provision, greater involvement of patients and peer review in regulation, better response to patient feedback, guidelines for nursing staff levels and skill mix, involving junior doctors in running healthcare, engaging staff. The Berwick review[14] highlighted previous issues on delivering safe care with respect to blaming staff and a climate of fear, targets with the wrong priorities, failing to recognise warning signs of problems in hospitals, and unclear lines of responsibility and made 10 recommendations which centre on common sense themes such as meaningfully engaging patients in the running of hospitals, embracing learning and transparency, simple safety and regulatory systems and proper staff resourcing for care.

During this time, in 2012, the new Health and Social Care Act[15] was passed into law. This introduced far reaching changes to the way the NHS is run, introducing greater competition including potential provision by so-called Any Qualified Providers, commissioning by multiple GP-led clinical commissioning groups (CCGs) supported by a NHS Commissioning Board, a more hands off Secretary of State who would not directly manage but instead direct by providing objectives and with the power to intervene in the event of failure. In terms of driving the quality agenda, the Act outlined the full regulatory powers of the CQC for quality and of Monitor for efficiency and competition; it also cemented the concept of an implementation framework based around delivery of quality and outcomes.

In response to the changes described above, the strategy of the CQC has changed the way it now undertakes its regulatory role. In particular, the inspections have become more intensive, comprehensive and demanding of providers.

The latest major changes in the NHS are not primarily focussed on safety alone. It aims to address a fundamental shortfall in resources for current and future demand by working towards new models of care, particularly creating networks of providers across traditional boundaries (networks across primary and secondary care, across health and social care, between secondary providers) as described in the Dalton Review[17] and the Five Year Forward View (FYFV)[18]. However, the FYFV did aim to “re-energise the NHS quality board” (see below).

4. Overall structure within NHS England for quality

NHS England leads the NHS in England and commissions care from within its budget. Simon Stevens is currently the NHSE Chief Executive and other NHSE Board members include the Chief Nursing Officer, the National Medical Director, the National Director for Commissioning Operations, the National Director for Commissioning Strategy, the National Director for Transformation and Corporate Operations and the Chief Financial Officer. There are also a number of non-executive directors.

The organisation of quality and who is in charge of it in England is a complex thing and is probably best outlined by trying to understand the plethora of bodies and agencies which contribute.

5. Key national bodies and their functions in England

It is worth bearing in mind that the names and functions of many of the bodies described below change regularly and were correct at the time of writing.

NHS Improvement/Monitor

From the 1st April 2016, NHS Improvement took over the functions of a number of NHS bodies including Monitor and the Trust Development Authority (financial and operational sustainability for trusts, avoiding competition), patient safety and the National Reporting and Learning System (NRLS). The body's goal is to "support foundation trusts and NHS trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable"[19]. NHS Improvement intends to work closely with providers and with other regional and national bodies such as the CQC to support providers and to create a single framework for of success that encompasses quality, financial, operational, leadership and improvement and strategic change elements.

NHS Improvement also oversees NHS Patient Safety, taking over the work of the National Patient Safety Agency. This work involves issuing national patient safety alerts, work on reducing never events, and undertaking large programs for improving safety. This includes patient safety collaborations which, in conjunction with the academic health sciences networks, aim to tackle leading causes of harm to patients such as pressure ulcers and acute kidney injury. In addition, NHS Improvement has incorporated the Sustainable Improvement Team (formerly NHS Improving Quality) which aims to be "the driving force for improvement across the NHS" by supporting and building capability in leading transformational change to allow the design and implementation of new service models more rapidly: piloting, implementing what works and abandoning what does not quickly.

Care Quality Commission

The CQC monitors, inspects and regulates healthcare providers including NHS and independent hospitals, GP practices and community healthcare services and care homes, mental health trusts adult social care and dentists, to ensure they meet fundamental standards of quality and safety. It publishes performance ratings for organisation. Where it finds poor care it can take action. Providers must be registered with the CQC before they can begin to provide care. Inspections include a period of "intelligent data gathering" before the visit, an announced formal inspection with some short extra unannounced visits by a team including CQC staff and national experts, peer reviewers (NHS quality, managerial and clinical staff), and patients and users. Services are judged against five key lines of enquiry or KLOEs:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

For each area services will be rated against these criteria to provide an overall rating of outstanding, good, requires improvement or inadequate. Actions taken to address poor care can include issuing requirement or warning notices, placing limits on their registration (limiting services), issuing cautions or fines, undertaking prosecutions and placing services in special measures where the CQC usually in conjunction with another provider, work closely

with the service or hospital to improve with a defined period. The CQC also will act on whistle-blowing and complaints raised to them.

General Medical Council

The GMC's stated aim is to "help to protect patients and improve medical education and practice in the UK by setting standards for students and doctors. We support them in achieving and exceeding those standards, and take action when they are not met". The GMC sets out the standards for doctors and their duties in Good Medical Practice, oversees doctors' education and training, manages the UK's medical register, investigates and acts on concerns about doctors and helps to raise standards through revalidation.

The Professional Standards Authority

The Professional Standards Authority for Health and Social Care was established within the Health and Social Care Act 2012 and takes over from the Council for Health Care Regulatory Excellence (previous to that the Council for the Regulation of Health Professionals) as the regulator of the clinical professions' regulators, which include the GMC, the NMC (Nursing and Midwifery Council) and the GOC (General Optical Council) amongst others.

It scrutinises and oversees the work of the various professional regulators, audits their work on fitness to practice cases and can take action if regulators are unduly lenient, investigate regulators practice and report on it to parliament.

NHS Litigation Authority, Clinical Negligence Scheme for Trusts and the National Clinical Assessment Service

The NHS Litigation Authority (NHSLA) manages negligence and other claims again the NHS in England and helps to ensure disputes are resolved fairly. It aims to share learning about risks and safety standards in the NHS and to improve safety for patients and staff. It also advise on human rights case law and equal pay claims. Their latest campaign is Sign up to Safety, a drive by the Secretary of State to listen and learn from staff and patients to reduce avoidable harm by 50% and save 6000 lives. The NHSLA run the CNST, the Clinical Negligence Scheme for Trusts, which handles all clinical negligence claims for trusts including payment for the defence and the cost of claims. The body's costs are met by provider contributions which vary based on risk. In other words, the CNST /NHSLA is the negligence insurer for the NHS.

NCAS (the National Clinical Assessment Service) is an operating division of the NHSLA. It helps to resolve concerns about the professional practice of doctors, dentists and pharmacists, providing expert advice and support, clinical assessment and training where required for doctors working in the NHS.

National Reporting and Learning System

This function now falls under NHS Improvement. The National Reporting and Learning System (NRLS) is a central database of patient safety incident report and receives copies of all reported incidents in the NHS. Since the NRLS was set up in 2003, over four million incident reports have been submitted. The information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care. Organisations can upload incidents, and see how they compare with other providers.

NRLS data can identify national safety themes which individual providers might not appreciate are significant if only few events occur locally. A prime example of this was that NRLS first identified the problem with loss of vision due to delays in glaucoma follow ups which lead to the national safety alert to all trusts in 2009.

National Institute for Health and Care Excellence

The National Institute for Health and Care Excellence's (NICE) role is to improve outcomes for people using the NHS and other public health and social care services. It does this by producing evidence based guidance and developing quality standards and performance metrics for those providing and commissioning health, public health and social care services, taking into account clinical and cost effectiveness. NICE produces guidelines on clinical topics, technology appraisal guidance, medical technology and diagnostics guidance and interventional procedures guidance. NICE also produces quality standards, quality outcomes frameworks and outcomes indicators for commissioners.

Medicines and Healthcare products Regulatory Agency

The Medicines and Healthcare products Regulatory Agency (MHRA) regulates medicines, medical devices and blood components for transfusion in the UK. MHRA is an executive agency of the Department of Health. Some of its important roles are to ensure that medicines, medical devices and blood components for transfusion meet standards of safety, quality and efficacy, that the supply chain for medicines, medical devices and blood components is safe and secure, to educate the public and healthcare professionals about the risks and benefits of medicines and devices and to influence regulatory frameworks so that they are risk-proportionate and effective at protecting public health.

Any incident involving medications or medical devices should involve notification of the MHRA.

Healthcare Quality Improvement Partnership

The Healthcare Quality Improvement Partnership (HQIP) is an independent organisation led by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices, established in April 2008 to promote quality, and in particular to increase the impact that clinical audit has on healthcare quality improvement. The aim of HQIP is to improve health outcomes by enabling those who commission, deliver and receive healthcare to measure and improve healthcare services. HQIP commissions, manages, supports and promotes national and local quality improvement and audit. This includes the National and Local clinical audit programmes, the Clinical Outcome Review Programmes and the National Joint Registry on behalf of NHS England and other healthcare departments and organisations. The Royal College of Ophthalmologists' National Ophthalmology Audit[28] of NHS funded cataract surgery in England and Wales is funded and supported by HQIP.

National Quality Board

This Board, relaunched in 2015, is composed of the six partner organisations who developed the Five Year Forward View (CQC, NHS England, NHS Improvement, Public Health England, NICE and Health Education England) together with the Department of Health. This is a forum for these organisations to come together regionally and nationally to share intelligence, agree action and monitor overall assurance on quality. The National Quality Board includes the senior clinicians (chief medical and nursing officers / medical and nursing directors / chief inspectors / heads of profession) of each of the national NHS leadership bodies alongside CCG leaders, providers, regulators and patient and lay representatives.

Patient safety expert groups

The patient safety expert groups have been established by NHS England and have a core multi-professional membership which includes representation from relevant colleges and associations in England, patient and carer groups, NHS England and CCGs. Wider

membership for individual groups includes relevant organisations in a position to promote learning and provide data on patient safety priorities.

The existing patient safety expert groups are Children and young people, Medical specialties, Mental health, Primary care, Surgical services (which includes ophthalmology) and Women's health.

The Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. The Foundation's aim is a healthier population, supported by high quality health care that can be equitably accessed. The charity provides grants to front line staff and carries out research and policy analysis and works with NHS organisations and bodies, policy makers, managers, clinicians, other charities and patient bodies. It also co-owns the BMJ Quality and Safety journal.

6. Arrangements in other areas of the UK

The descriptions above describe in detail the arrangements in England and vary elsewhere. It is fair to say that other areas of the UK are somewhat less complex, with less frequent change, in terms of the number of bodies and agencies involved in quality, safety and regulation. The arrangements for other UK areas are summarised below.

Wales

NHS Wales run healthcare, and quality and safety requirements are described in the NHS Wales governance e-manual. All Welsh health organisations work to a shared quality assurance framework. NHS Wales has a five-year strategy to work more productively with limited resources, to utilise community care more effectively and to place prevention, better patient experience and better quality and safety leading to improved health outcomes at the heart of the service. This is described within the publication Together for Health and details are outlined in supporting documents all available at Health in Wales, the NHS Wales website.

The 1000 Lives quality improvement program[35] is run by Public Health Wales in conjunction with all health boards and trusts and its guide describes methods and ongoing work for quality improvement with special editions of the publication directed at different clinical professional groups.

The healthcare regulator/inspectors of care is the Healthcare Inspectorate Wales and it differs from the CQC in that most of its inspections are unannounced and it have not so far changed to the more detailed pre and post inspection data collection and comprehensively detailed reporting and ratings system the English regulators have adopted in recent years.

Scotland

NHS Scotland runs healthcare and has a five-year strategy "A fairer healthier Scotland"[37] which, in addition to aiming to improve health of the whole population, has a particular emphasis on addressing health inequalities. The Scottish government's 2011 Vision 2020 strategy[40] outlined sustainability plans which included the integration of for health and social care and a focus on community care, prevention and quality. There is also a Healthcare Quality Strategy which builds on this and focusses on three quality ambitions: safety and avoidance of harm; person centred (mutually beneficial partnerships between professionals/providers and patients); and effective (right treatment at the right time to

reduce waste and variation). This is supported by a quality measurement framework and outcomes. There is a Quality Improvement Hub[39] online with lots of relevant resources for professional to bring to their practice.

The regulator is Healthcare Improvement Scotland which also has a slightly different remit from the English CQC with a more explicit remit to actively drive healthcare improvement, producing evidence based guidelines and standards. It oversees bodies such as the Healthcare Environmental Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group and the Scottish Intercollegiate Guidelines Network.

Northern Ireland

Health and Social Care in Northern Ireland (HSCNI) oversees health and social care. The Department of Health funds care and has a 10-year strategy (Quality and Safety Strategy 2020) to improve quality and safety of care and has published frameworks and standards for safety and quality. The regulator is the Regulation and Quality Improvement Authority (RQIA) which was established under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It oversees inspections of health and social care organisations against minimum standards. Adverse events are reported to the Northern Ireland Adverse Incident Centre (NIAIC).

It is beyond the scope of this document to describe in complete detail all the arrangements all over the UK, and readers are encouraged where more information is required to begin with the governmental and NHS websites of other areas for details.

7. Role of The Royal College of Ophthalmologists

Medical Royal Colleges

The medical royal colleges are charitable organisations representing the main medical professional bodies whose actions, which involve the promotion of the relevant specialty field of practice and maintaining relevant education and standards, are determined by royal charter. The Academy of Medical Royal Colleges (AoMRC) promotes, facilitates and co-ordinates the colleges and related specialty faculties, and was established in 1974 and renamed in 1996. The AoMRC aims to “provide a collective, clear and sure voice for the benefit of patients and healthcare professionals across the four nations of the UK.” The Academy of Royal Colleges Quality Improvement Committee brings together representatives from the colleges and faculties, including from the RCOphth, to jointly tackle quality and safety issues with widespread relevance, to achieve improvement in quality of care and to provide a method of communicating with government and other national stakeholders for cross-cutting quality issues. Recently tackled issues include seven-day care and mismatches between demand and capacity for follow up care.

The Royal College of Ophthalmologists: charter and strategic plan

The RCOphth Royal Charter outlines the objects and activities of the College and the stated objectives are to:

- advance the science and practice of ophthalmology;
- educate medical practitioners in the science and practice of ophthalmology;
- maintain proper standards in the practice of ophthalmology for the benefit of the public;

- promote study and research in ophthalmology and related subjects and publish the useful results of such study and research;
- further instruction and training in ophthalmology both in the United Kingdom and overseas;
- educate the general public in all matters relating to vision and the health of the human eye

The RCOphth, which has relevance to all the devolved UK nations, champions excellence in the practice of ophthalmology and, in its strategic plan 2015-9, one of the three strategic aims is "to influence and uphold standards in eye health through proactive leadership and expertise in the field of ophthalmology for the benefit of patients".

Committees and groups

The College has a number of committees. The Professional Standards Committee (PSC) oversees most of the work which could be said to pertain both directly and in the wider sense to quality and safety in ophthalmic practice. The term "professional standards" encompasses a very wide range of matters which impinge on the professional lives of ophthalmologists and the workload of the Professional Standards Committee is very diverse.

The PSC has a number of sub-committees including: Revalidation, Paediatric, Information and Audit, Quality and Safety, Ocular Tissue Transplantation Standards Advisory Group, Workforce and the Primary Care Group. The PSC oversees audit and clinical effectiveness in ophthalmology, revalidation for ophthalmologists, provides advice and answers question on specific issues or safety concerns, takes proactive action where quality and safety issues arise, works to influence national bodies and policies around standards and quality in ophthalmology and writes and approves supporting documents. It also supports the Scientific Committee in producing clinical guidelines.

The Quality and Safety Group, which is responsible for this document, is a multidisciplinary group which reports to the PSC. Its strategic aims are:

- To help define the characteristics of high-quality clinical care across the breadth of ophthalmology in terms which are readily understood and agreed by clinicians and the lay public.
- To support the provision of high quality and safe ophthalmic care
- To support the development and use of valid and reliable measures of quality and safety in ophthalmic care.
- To ensure that standards and recommendations produced by the QSG are consistent with other guidelines and good practice statements produced by The Royal College of Ophthalmologists and that they conform to the requirements of the national guidance and standards.
- To support the Revalidation Sub-committee where required on quality standards for the revalidation of ophthalmologists.
- To maintain liaison with NHS and other healthcare-related organisations with common interests in quality of clinical care, for instance: the CQC, MHRA, NICE, AoMRC, the Department of Health and charities related to vision

The work involved in achieving these can be summarised as:

- Review at request any relevant issue of quality and safety including technical and device issues.
- Disseminate best practice in quality and safety
- Proactively review and provide advice and guidance on new quality and safety issues
- Advise the College officers and the Chairman of the Scientific Committee on any queries or issues regarding quality and safety and help provide advice, responses and statements on these
- A representative will sit on the committee of the AoMRC's Quality Improvement Committee, the NHS National Surgical Patient Safety Experts Group and other similar committees as required and will feedback to the RCOphth

The group welcomes enquiries from ophthalmologists who might wish to join the group or support its activities.

Website and publications

The College had many documents on quality and safety both in its quality and safety pages and within other areas and all are available on the website. Helpful documents relevant to quality include:

- Quality standards for services e.g. Quality standards for corneal services, Quality standards for people with sight loss and dementia in an ophthalmology department
- Ophthalmic services guidance e.g. Managing an outbreak of endophthalmitis, Primary care ophthalmology
- Commissioning guidelines e.g. Cataract and Glaucoma commissioning guidance, commissioning better eye care: age related macular degeneration
- Surgical safety information documents e.g. World Health Organisation checklist for cataract surgery, National safety standards for invasive procedures
- Clinical guidelines e.g. Retinal vein occlusion guidelines, Abusive head trauma in infancy guidelines
- National datasets and audit e.g. The national ophthalmology database, retinal detachment dataset, British Ophthalmological Surveillance Unit

and many others. Members are encouraged to share on the website relevant local quality and safety documents, protocols and checklists to disseminate good practice examples.

Curriculum

Education and training is another crucial way in which the RCOphth supports and promotes quality in ophthalmic practice. Many of the core learning outcomes include aspects which are key to high quality care and some learning outcomes, such as "information handling" and "role in the health service" are particularly focussed around promoting quality and safety in care; in addition, one of the trainee selected components is clinical governance for those trainees with a particular interest in this area.

Invited Service Reviews

An important part of the PSC's work is to provide advice to providers or commissioners of ophthalmology services where something has gone wrong with a clinical service, where concerns have been raised about the clinical care provided, or where an eye department is

in dispute with its host trust. Although the College has no statutory right to inspect or accredit clinical services, it aims to provide rapid, high quality specialist advice when requested to do so.

The College can provide an independent review of the structure, organisation and departmental practices to ensure quality care is provided in an ophthalmology department/service. The College works within an ethos of openness in the conduct of its work. However, the nature of some reviews means that the College and any review team will take pains to ensure that information specific to the review is treated as strictly confidential by all parties involved in order to promote participation by all in an open, equal and fair way.

Immediate triggers for service review requests can include complaints, adverse events, staffing problems, difficult relations between clinicians or between clinicians and managers and problems meeting waiting time targets. There are many reasons why an ophthalmology service may struggle to meet the demands placed upon it, although a very common finding has been that there is a chronic mismatch between capacity and demand within the service. Some of the recurrent themes identified over the last decade are described in the College's document "Our ophthalmology service is failing, please help" and should be considered by organisations whose ophthalmology service appears to be in difficulty.

The College's Invited Review system operates in accordance with the Academy of Medical Royal College's Framework of operating principles for managing invited reviews within healthcare.

Confidential Reporting System for Surgery

The Confidential Reporting System for Surgery (CORESS) was set up in 2005 by the Association of Surgeons of Great Britain and Ireland, and it now encompasses all the surgical specialties in UK and Irish practice and the surgical Royal Colleges. The purpose of CORESS is to extract the lessons from mistakes, mishaps and near-miss events and disseminate that learning, with a particular interest in the role of human factors. The main difference between CORESS and the NRLS is to ensure there is widespread feedback to the surgical community in a manner which is effective, but preserves the anonymity of the reporter and his/her institution of origin. The mechanism of feedback for ophthalmologists is mainly via College News, carrying 'learning points' of interest to ophthalmologists whether from ophthalmology or, where relevant, from other surgical specialties.

Ophthalmologists are encouraged to report adverse events to CORESS, via the website and on-line reporting is quick and simple, and all reports are then anonymised. Reporting a problem (and the resultant learning points) will assist colleagues, and reporters will get an acknowledgement which can be used for appraisal/revalidation supporting evidence.

8. References and links

1. Good Medical Practice. General Medical Council 2016. http://www.gmc-uk.org/guidance/index.asp,
2. Report of the committee on the financial aspect of corporate governance. "The Cadbury Report" Gee, 1992. http://www.ecgi.org/codes/documents/cadbury.pdf
3. Acceptable mistakes at scandal hospital. BBC News 1999. http://news.bbc.co.uk/1/hi/health/515733.stm
4. Learning from Bristol "The Bristol Inquiry" Department of Health 2002. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273320/5363.pdf
5. The Royal Liverpool Children's Enquiry Report, House of Commons 2001. https://www.gov.uk/government/publications/the-royal-liverpool-childrens-inquiry-report
6. An organisation with a memory. Dept of Health 2000. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006902
7. Clinical governance and the drive for quality improvement in the new NHS in England. Scall G, Donaldson LJ. British Medical Journal 1998;317:61-5. http://www.ihrdni.org/315-021.pdf
8. A first class service. Quality in the new NHS. Department of Health 1998. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006902
9. Regulation and system management. Bevan G. The Kings Fund 2011. http://www.kingsfund.org.uk/sites/files/kf/chapter-7-regulation-system-management-new-labours-market-reforms-sept11.pdf
10. The NHS plan. HMSO 2000. http://1nj5ms2lli5hdggbe3mm7ms5.wpengine.netdna-cdn.com/files/2010/03/pnsuk1.pdf
11. High Quality Care for All: the next stage review final report. "The Darzi report" Crown Copyright 2008 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf
12. Report of the Mid Staffordshire NHS foundation trust public inquiry. "The Frances Report". House of Commons 2013 http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report
13. Review into the quality of care and treatment provided by 14 hostpial trusts in England, "The Keogh mortality review" 2013. http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf
14. A promise to learn, a commitment to act. Improving the safety of patients in England. "The Berwick review."

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf
15. The Health and Social Care Act 2012. http://services.parliament.uk/bills/2010-12/healthandsocialcare.html
16. The CQC website. http://www.cqc.org.uk/
17. Examining new options and opportunities for providers of NHS care "The Dalton Review" 2014. https://www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care
18. The NHS Five year forward view 2014. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
19. NHS Improvement website. https://improvement.nhs.uk/about-us/who-we-are/
20. Professional Standards Authority. http://www.professionalstandards.org.uk/
21. NHSLA website. http://www.nhsla.com/Pages/Home.aspx
22. CNST. http://www.nhsla.com/claims/pages/clinical.aspx
23. NCAS. http://www.ncas.nhs.uk/
24. NRLS: https://report.nrls.nhs.uk/nrlsreporting/
25. NICE website. https://www.nice.org.uk/
26. MHRA website. https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency
27. HQIP website. http://www.hqip.org.uk/
28. National Ophthalmology Database Audit https://www.nodaudit.org.uk/
29. NHS patient safety. https://www.england.nhs.uk/patientsafety/
30. The Health Foundation. http://www.health.org.uk/
31. Overall structure of the NH England senior management structure. https://www.england.nhs.uk/wp-content/uploads/2016/01/nhse-senior-mngmnt-strcture-2016.pdf
32. NHS Wales. http://www.wales.nhs.uk/
33. Healthcare Improvement Wales. http://www.hiw.org.uk/
34. Together for health. Health in Wales. http://www.wales.nhs.uk/ourservices/strategies
35. 1000 lives program. http://www.1000livesplus.wales.nhs.uk/qi-guide
36. NHS Scotland. http://www.ournhsscotland.com/
37. NHS Scotland quality strategy. http://www.gov.scot/Topics/Health/Policy/Quality-Strategy
38. Healthcare Improvement Scotland. http://www.healthcareimprovementscotland.org/
39. NHS Scotland Quality Improvement Hub. http://www.qihub.scot.nhs.uk/default.aspx
40. Vision 2020 strategy. http://www.gov.scot/Topics/Health/Policy/2020-Vision
41. Northern Ireland Department of Health. https://www.health-ni.gov.uk/
42. RQIA. http://www.rqia.org.uk/home/index.cfm
43. Academy of Medical Royal Colleges. http://www.aomrc.org.uk/
44. RCOphth charter. https://www.rcophth.ac.uk/wp-content/uploads/2015/03/RCOphth-1988-College-Charter.pdf
45. CORESS. https://www.rcophth.ac.uk/professional-resources/coress/ , www.coress.org.uk

9. Authors

The Royal College of Ophthalmologists Quality and Safety Group, Chair Mrs Melanie Hingorani FRCOphth.

July 2016.