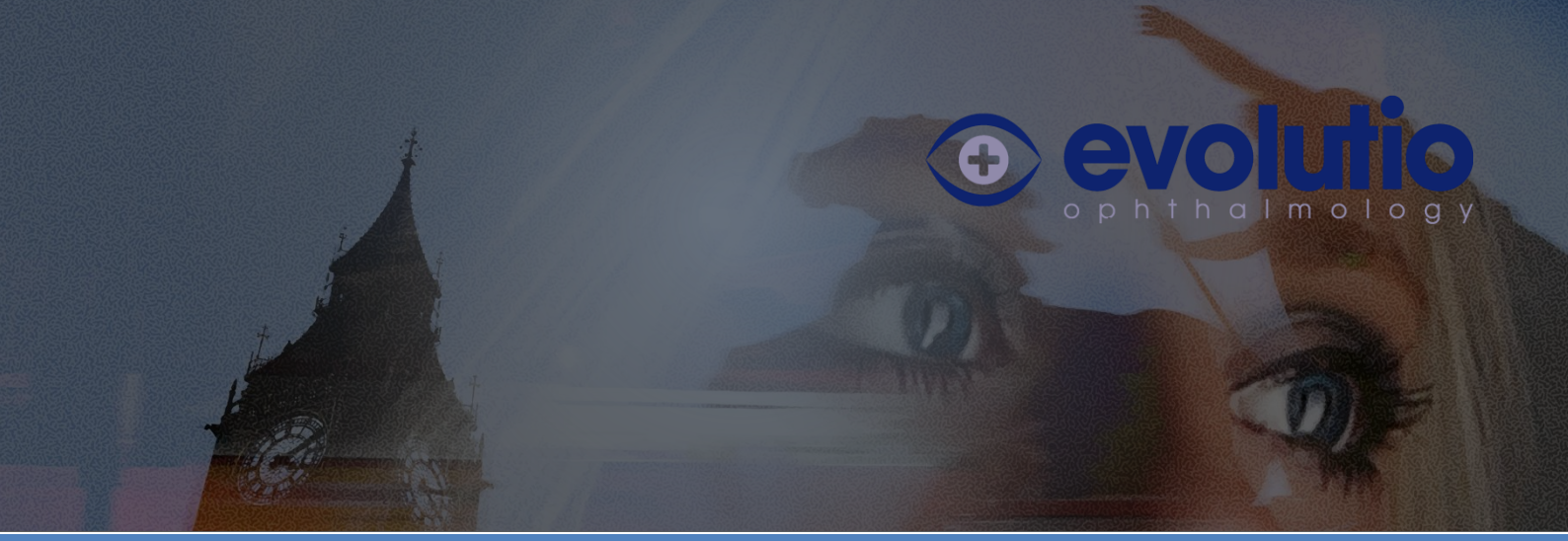

Evolutio Ophthalmology Service Handbook

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Evolutio Ophthalmology Service Handbook

This handbook outlines the clinical and operational policies and procedures followed by Evolutio Service Providers.

The contents of this handbook are subject to change but represent our best effort to encourage compliance with good practice and national guidance. We welcome feedback on any aspect of this handbook.

Service Providers must initial each section of the contents table below to indicate you have read and understood them (return a copy to *support@evolutio-ophthalmology.co.uk* or send to Owen Thom at the address overleaf). New sections or updates will be issued periodically along with a revised contents page to confirm your receipt and understanding of the updates. Service Providers have a contractual obligation to ensure that anyone who delivers Evolutio services on behalf of the service provider is suitably qualified and accredited and has read and understood each of these policies and protocols.

Practice Name			
Practice Address			
Lead Optometrist			
Telephone		**Email**	

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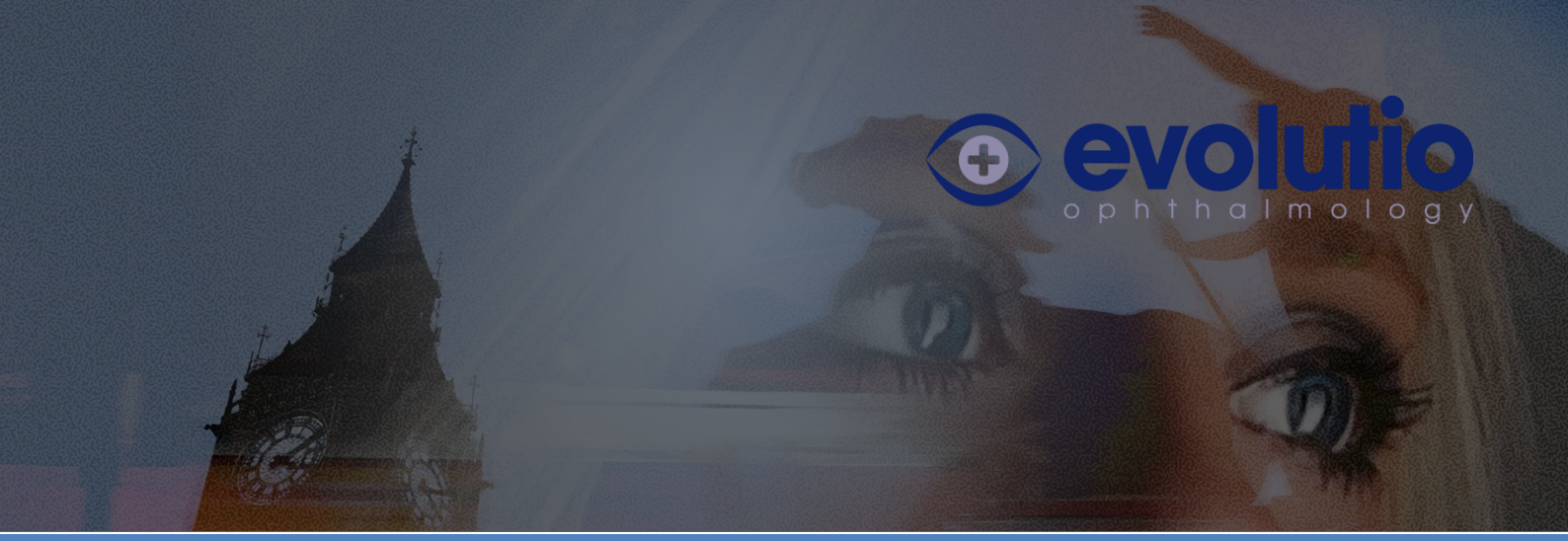
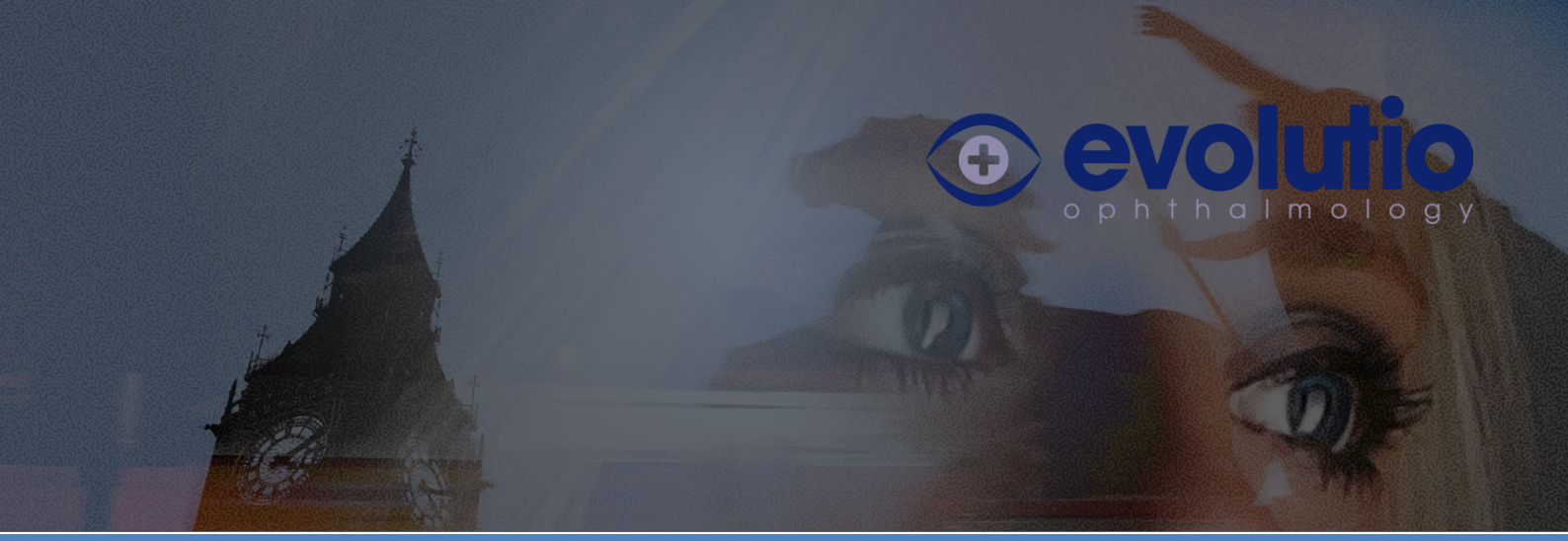


Evolutio Ophthalmology Handbook

Section 1: LEGAL & GOVERNANCE



1.1 Information Governance Overview

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Lyn Price		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Why is it necessary?

NHS 'information' includes all the information produced by all employees of, or contractors to an NHS organisation. It includes corporate or business information such as finance, estates and personnel records, and all health records. The information produced by the NHS is important as it allows organisations to make decisions about the allocation of resources, manage their future performance, support clinical governance, plan for new services and more importantly to make care and treatment decisions based on what is recorded in patient health records.

All NHS organisations are subject to statutory and regulatory obligations which require that information is presented and centrally submitted in particular formats. This information assists the public to make decisions about choice of service provider, it assists the Healthcare Commission to audit current services and it helps the Government to make decisions about existing and future services.

Peter Price-Taylor
CEO

What is information governance?

Information governance provides a framework to bring together all the requirements, standards and best practice that apply to the handling of information, so that the way that the NHS holds, obtains, records, uses and shares information is:

- Held securely and confidentially
- Obtained fairly and efficiently
- Recorded accurately and reliably
- Used effectively and ethically
- Shared appropriately and lawfully

The requirements and standards which are currently part of information governance are:

- Information Governance Management
- Data Protection and Confidentiality Assurance
- Information Security Assurance
- Information Quality including Records Management

Why is information governance important?

Information governance allows organisations and individuals to ensure that all NHS information is handled in accordance with the law and best practice. It encourages patients and the public to have greater confidence in the service provided and it provides a legal framework for inter-agency working.

Individual responsibility for information governance

Everyone who handles NHS information is responsible for compliance with information governance requirements. All employees complete mandatory information governance training and must comply with policies and procedures put in place by the NHS organisation. Organisations must have a process for the reporting of actual and potential breaches of information governance policies and procedures so that lessons can be learned, and, where necessary, more robust policies/procedures can be implemented. Individuals must ensure they comply with the reporting process and with any recommendations made as a result of an actual or potential breach.

Providing a confidential service

Patients' health information and interests must be protected through a number of measures:

- Procedures to ensure that all staff, contractors and volunteers are at all times fully aware of their responsibilities regarding confidentiality
- Recording patient information accurately and consistently
- Keeping patient information private
- Keeping patient information physically secure
- Disclosing and using information with appropriate care

Patients must be made aware that the information they give may be recorded, may be shared in order to provide them with care and may be used to support clinical audit and other work to monitor the quality of care provided. Consider whether patients would be surprised to learn that their information was being used in a particular way – if so, then they are not being effectively informed.

Patients have different needs and values; this must be reflected in the way they are treated both in terms of their medical condition and the handling of their personal information. What is very sensitive to one person may be casually discussed in public by another. Just because something does not appear to be sensitive does not mean that it is not important to an individual patient in his or her particular circumstances.

Best practice is achieved as part of a learning process which requires practice. Staff must:

- Be aware of the issues surrounding confidentiality and seek training or support where uncertain in order to deal with them appropriately
- Report possible breaches or a risk of breaches

What information is confidential?

A duty of confidence arises when one person discloses information to another (e.g. patient to clinicians) in circumstances where it is reasonable to expect that the information will be held in confidence. It is a legal obligation that is derived from case law, rather than an Act of Parliament, built up over many years and often open to different interpretations. It is also a requirement established within Professional Codes of Conduct.

It is generally accepted that information provided by patients to the health service is provided in confidence and must be treated as such so long as it remains capable of identifying the individual it relates to. This is an important point, as once information is effectively anonymised it is no longer confidential.

When an individual has died it is unlikely that information relating to that individual remains legally confidential. However, an ethical obligation to the relatives of the deceased exists and health records of the deceased are public records and governed by the provisions of the Public Records Act 1958. This permits the use and disclosure of the information within them only in limited circumstances. The Access to Health Records Act 1990 permits access to the records of the deceased by those with a claim arising out of the death; this right of access is negated however if the individual concerned requested that a note denying access be included within the record prior to death (this might be part of a formal advance directive).

The information that must be held as confidential is any information item or combination of information items by which a person's identity may be established, including but limited to:

- First name
- Surname
- Date of birth
- Gender
- Address
- Postcode

Local Confidentiality Code for staff

All employees with access to confidential patient information are subject to the common law duty of confidence. This law provides that information given in confidence must not be disclosed without the consent of the giver of that information. There are two exemptions to this basic fact:

- An organisation will be compelled to disclose information on the production of a valid court order; or
- An organisation is permitted to disclose information where there is a greater public interest in doing so than there is in maintaining the confidentiality of the giver of the information

Employees may be subject to Professional Codes of Conduct setting out ethical behaviour and should be bound by confidentiality clauses within their contracts.

All organisations have a duty to ensure that their employees are aware of the law so that the risk of a breach of confidentiality are minimised. To discharge this duty each organisation should develop local confidentiality codes of conduct based on legal requirements, national guidelines and best practice, which are tailored to the needs of different staff groups. However, it is not sufficient merely to develop the codes of conduct; organisations must ensure they have informed all employees of the existence of the codes and of the duty to comply with them.

When should confidential information be disclosed?

Patients generally have the right to object to the use and disclosure of confidential information that identifies them and need to be made aware of this right. Sometimes if patients choose to prohibit information being disclosed to other health professionals involved in providing care, it might limit the care that can be provided and in extremely rare circumstances it may not be possible to offer certain treatment options. Patients must be informed if their decisions about disclosure have implications for the provision of care or treatment. Clinicians cannot usually treat patients safely nor provide continuity of care without having relevant information about a patient's condition and medical history.

Explicit consent is not usually required for information disclosures needed to provide healthcare where patients have been informed of:

- The use and disclosure of their information associated with their healthcare; and

- The choices that they have and the implications of choosing to limit how information may be used or shared

Opportunities to check that patients understand what may happen and are content should be taken with special attention paid to the issues around child consent. Additional consent is generally required where the purpose of the disclosure is not directly concerned with the healthcare of a patient.

There are situations where consent cannot be obtained for the use or disclosure of patient identifiable information yet the public good outweighs the duty of confidentiality. Section 60 of the Health and Social Care Act 2001 currently provides an interim power to ensure that patient identifiable information needed to support a range of important work such as clinical audit, record validation and research, can be used without the consent of patients.

An organisation will be compelled to disclose confidential information on the production of a valid court order and organisations are permitted to disclose information where there is a greater public interest in doing so than there is in maintaining the confidentiality of the giver of the information.

Caldicott Guardian

Each NHS organisation is required to have a Caldicott Guardian, a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing. Evolutio's Caldicott Guardian is Clinical Lead (Optometry) Lyn Price.

What is information security all about?

The NHS uses a wide variety of information concerning patients, personnel, the organisation, its systems and practices, other organisations and other people. Much of this information is highly sensitive and all of it is important to the organisation and the people concerned. The information is communicated through a number of media; spoken, audio, video, X-ray, digital, computerised, paper records, etc. Staff, contractors and students working at the organisation all have an obligation to use this information responsibly and should receive training and guidance on how to do this.

Information security is the term used to describe the systems used by the organisation to protect information; it has three broad principles:

1. Confidentiality - Staff should always ensure that only those authorised to access information are able to do so
    - You should know what to do if you suspect someone without authorisation is accessing information. This will normally involve reporting the matter. Ensure you know how to do this.
    - You should only discuss, show or otherwise share information with other authorised users
2. Integrity - Staff should ensure that all information they create, or use is accurate and complete
    - Accurate and complete information is essential to ensure patient safety, legal compliance and reliability for use. You should know what to do if you think information is inaccurate or incomplete.
3. Availability - Staff should ensure they have access to information they are authorised to use when they need it
    - Your line manager should ensure you have access to particular systems or records. If you don't, then discuss it with your line manager.
    - Information is susceptible to interruption or destruction from a number of threats. If you can't get access to the information you need due to a system failure make sure you report the fault, even if others have already done so. Find out what alternative means there are of getting the information or what you need to do instead.
    - Non-electronic information is susceptible to being lost, misplaced or retained for longer than necessary. Ensure you know how to report missing information or what to do with it when you no longer need it.

A key to maintaining information security is training and awareness. Find out what training is available, read appropriate documentation (policies, procedures, training materials) and know what to do when using information.

Good security practice

Good security practice comes with familiarity of knowing what you should do when dealing with information and information systems. Many examples of good security practice are generic such as not sharing passwords or keeping information confidential. However, each organisation has its own particular rules and regulations that you should follow.

- Read any policies or procedures related to security in the organisation. There may be paper copies in your department or copies stored on the organisation's intranet. If you don't understand anything seek clarification.
- If the organisation has a security manager find out their contact details
- Find out how to report a security incident
- If you use a workstation, make sure you use a password-protected screensaver when you leave it unattended. Log out and switch off at the end of each day.
- Lock paper and other portable records away when they are not being used
- Choose a good password (at least 8 characters long, mixture of letters and numbers)
- Don't let others know your password
- Only discuss information with those authorised to know about it
- Look after portable information-processing equipment
- Find out how to report missing, lost, damaged or stolen information and information-processing equipment

Poor security practice

Examples include:

- Not reading or following policies or procedures related to security in the organisation
- Not knowing how to report a security incident
- Neglecting to report a security incident
- Leaving a workstation unattended without securing it
- Leaving paper and other portable records in places where unauthorised people can have access to them
- Letting others know your password
- Writing your password down and leaving it where others can read it
- Leaving portable information-processing equipment unattended in places where it is in danger of being stolen, such as public areas, cars or public transport
- Not knowing how to report missing, lost, damaged or stolen information and information-processing equipment
- Unattended equipment/information being left unprotected and subject to unauthorised use
- Incomplete or inaccurate data in systems
- Non-electronic records being misplaced, not returned for storage or lost
- Theft of information processing equipment. To help prevent this staff should lock portable devices away when they are not being used. In offices, cupboards and drawers should be used
- If taking equipment on public transport, always keep it in sight and nearby
- It is best to store portable equipment out of sight in cars (preferably the boot)
- Malicious code (viruses, Trojans, etc) being introduced through emails, web site or portable storage devices.
- Misusing information or systems e.g. sending threatening emails, selling records for financial gain, using systems to find out information for personal purposes not related to work.
- Power failures making electronic systems unavailable
- Software failure resulting in systems unavailability or data corruption
- Staff shortages resulting in work being delayed or curtailed

Threats and incidents

Threats

Threats are "A potential cause of an unwanted incident, which may result in harm to a system or organization [sic]" (ISO/IEC 13335-1:2004).

Information and information processing facilities face a number of threats from a variety of sources. Theft, destruction, misuse, unauthorised access and inaccuracy are all common threats and may originate within the organisation or from external sources. The organisation should ensure that an assessment has been carried out for all information and information processing facilities; remember that new threats emerge all the time. Staff should report all threats.

Incidents

An information security incident is defined as "…indicated by a single or a series of unwanted or unexpected information security events that have a significant probability of compromising business operations and threatening information security." (ISO/IEC TR 18044:2004).

Each organisation should have a procedure for reporting incidents and staff should be trained on how to do this. In many cases, staff may feel that an incident is trivial or that someone else may have reported it. However, staff should work on the assumption that each incident is important and that no-one else has reported it.

Why is effective records management important?

An effective records management service ensures that information is accurate, up to date and accessible whenever and wherever there is a justified need for that information and in whatever media it is required. Information may be needed to:

- Support care and continuity of care
- Support day-to-day business which underpins the delivery of care
- Support evidence-based clinical practice
- Support sound administrative and managerial decision making as part of the knowledge base for NHS or Social Care services
- Meet legal requirements, including requests from patients / service users under the access provisions of the Data Protection Act 1998 or the FOI Act 2000
- Assist clinical and other types of audits
- Support improvements in clinical effectiveness through research and support archival functions by taking account of the historical importance of material and the needs of future research
- Support choice and control over treatment and services designed around patients / service users

Amongst other benefits, effective records management allows organisations to:

- Have knowledge of the type / categories of records held
- Know where records are held to enable retrieval when and where required
- Provide appropriate storage that protects the information within records and frees up under-utilised space
- Make savings in administration costs, e.g. time spent locating missing records
- Provide continuity in the event of a disaster
- Comply within the statutory timescales when responding to requests for information under the Data Protection Act 1998 and the Freedom of Information Act 2000
- Make decisions about retention of records and future storage requirements
- Take decisions in reliance on accurate information

Freedom of information

The Freedom of Information Act lays down requirements for public bodies (including the NHS) to keep and make information available on request. The new rights of access in the Freedom of Information Act signal a new recognition of and commitment to the public interest in openness about government. They are additional to other access rights, such as access to personal information under the Data Protection Act 1998 and access to environmental information under the Environmental Information Regulations 2004.

The main features of the FOI Act are:

- A general right of access to recorded information held by public authorities, regardless of the age of the record/document
- A duty on every public authority to adopt and maintain a scheme which relates to the publication of information by the authority and is approved by the Information Commissioner

Section 46 of the Act placed a duty on the Lord Chancellor to issue a Code of Practice on records management. The Code has been published and although compliance is not obligatory, it provides guidance to all public authorities as to the practice which it would, in the opinion of the Lord Chancellor, be desirable for them to follow in connection with the discharge of their functions under the FOI Act 2000. Additionally, the Code will be used by the Information Commissioner when deciding whether a public authority has properly dealt with a case (in the event of a complaint).

General right of access

The Act confers two rights on the general public:

- The right to be informed whether a public body holds certain information
- The right to obtain a copy of that information

However, the Act recognises that there can be valid grounds for withholding information and provides a number of exemptions from the right to know, some of which are absolute, and some are subject to a public interest test.

As regards exemptions subject to the public interest test, organisations must weigh up whether the public interest in maintaining the exemption in question outweighs the public interest in disclosure.

The request for information must be:

- In writing
- State the name of applicant and an address for correspondence
- Describe the information requested

The applicant can request that information be communicated by:

- A copy in permanent form (or other form acceptable to them, e.g. on CD-ROM or audio tape)
- Inspection of records
- A summary or digest of the information held

Organisations may charge a fee for reasonably incurred costs to inform the applicant whether it holds the information and communicate the information to the applicant. However, they are not obliged to charge a fee, and the Department for Constitutional Affairs suggests that where the costs incurred are minimal the fee should be waived. If a fee is required, this should be notified to the applicant and paid within 3 months of receipt of the notice, otherwise the public authority need not comply with the request.

Subject access requests

Section 7 of the Data Protection Act 1998 gives individuals a right to access personal information held about them by organisations such as NHS organisations.

Access encompasses:

- The right to obtain a copy of the record in permanent form
- The right to view a record without obtaining a copy
- The right to have information explained where necessary (e.g. medical abbreviations)

Under the DP Act the request must be complied with within 40 days of an organisation receiving it, or in any case within 40 days of receipt of any further information required to identify the correct individual. However, the Government has indicated that where possible information should be provided within 21 days.

To facilitate this obligation to provide information within the time limits, organisations must ensure that all employees are aware of how a subject access request should be made and of the requirement to respond to requests quickly.

The right of access is exercisable by the individual:

- Making a written application to the organisation holding the records, including via email
- Providing such further information as the organisation may require to sufficiently identify the individual
- Paying the relevant fee

The fee for providing the individual with a copy of a computerised record is £10. For healthcare records held partially or entirely on paper, the maximum amount that can be charged is £50.

There are several circumstances under which access may be denied or restricted, however the two most relevant to healthcare are:

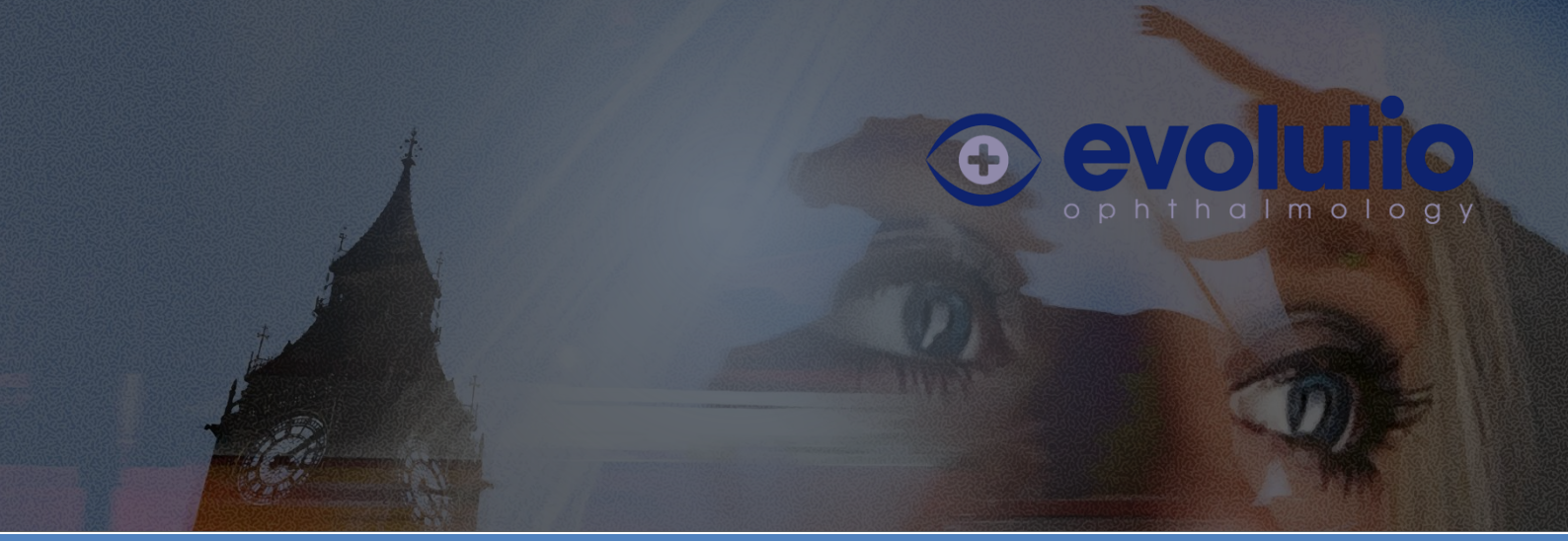
- If the record contains third party information where that third party is not a health care professional and has not consented to their information being disclosed. If possible, the individual should be provided with access to that part of the record which does not contain the third-party identifier.
- If access to all or part of the record will seriously harm the physical or mental well-being of the individual or any other person. If possible, the individual should be provided with access to that part of the record that does not pose the risk of serious harm.

Complaints and appeals

The organisation should ensure that its procedures set out the patient's right to appeal against a decision to refuse access to their information and the way in which an appeal or a complaint about the subject access procedures should be made.

The organisation should assign responsibility for dealing with complaints and appeals, for example, initial complaints about the organisation's Data Protection procedures and appeals against decisions not to allow access to information could be handled by the Data Protection Lead. If the DP Lead is unable to resolve the issue the complaint/appeal should be referred to a more senior person e.g. the organisation's IG forum (or equivalent) or if appropriate to a senior medical professional for consideration.

The complaints and appeals procedure should inform individuals how to contact the Information Commissioner.



1.2 Privacy & Dignity Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Why is it necessary?

Evolutio is committed in ensuring privacy and dignity continues to be a key priority in the provision of care to patients and service users.

It is essential that patients and service users are treated as individuals with courtesy and respect, in any setting in which their care is delivered or they have contact with Evolutio. Privacy and Dignity for the purpose of this Policy covers all settings where any kind of care is carried out or a patient or service user has contact with Evolutio.

The aim of this policy is to provide Evolutio staff with guidance and procedures to support and assist best practice in the delivery of care and services which can impact on patients', service users' and carers' privacy, dignity and modesty.

Peter Price-Taylor
CEO

Dignity in care

This Policy is underpinned by the Social Care Institute for Excellence (SCIE, 2010) campaign, Dignity in Care which includes "A clear statement of what people can expect from a service that respects dignity" in their 'Stand up for dignity – the Dignity Challenge' document.

This identifies ten standards that people can expect from the Evolutio service that supports dignity:

a) Have a zero tolerance of all forms of abuse
b) Support people with the same respect you would want for yourself or a member of your family
c) Treat each person as an individual by offering a personalised service
d) Enable people to maintain the maximum possible level of independence, choice and control
e) Listen and support people to express their needs and wants
f) Respect people's right to privacy
g) Ensure people feel able to complain without fear of retribution
h) Engage with family members and carers as care partners
i) Assist people to maintain confidence and a positive self-esteem
j) Act to alleviate people's loneliness and isolation

There are eight main factors that promote dignity in care and contribute to a person's sense of self-respect.

These factors, listed below, guide staff to ensure that care and treatment are provided in a collaborative way to which privacy and dignity remain central and which indicate best practice in terms of culture and attitude:

a) Choice and control - Enabling people to make choices about the way they live and the care they receive
b) Communication - Speaking to people respectfully and listening to what they have to say; ensuring clear dialogue between workers and services
c) Pain management - Ensuring that people living with pain have the right help and medication to reduce suffering and improve their quality of life
d) Personal hygiene - Enabling people to maintain their usual standards of personal hygiene
e) Practical assistance - Enabling people to maintain their independence by providing 'that little bit of help'
f) Privacy - Respecting people's personal space, privacy in personal care and confidentiality of personal information
g) Social inclusion - Supporting people to keep in contact with family and friends, and to participate in social activities

A person's right to respect means 'having the right to live one's own life with such personal privacy that is reasonable, whilst taking into account the rights and freedoms of others'. It includes the freedom for every individual to choose:

- How they look
- How they dress
- Their religious beliefs
- Who they socialise with
- Their sexual identity
- To express personal opinions

These rights should be acknowledged by Evolutio staff and where appropriate should be included within any process undertaken.

All Evolutio staff and those contracted to undertake work on behalf of Evolutio are personally accountable for ensuring that they promote and protect service user's well-being and their attitude and behaviour should reflect this.

Staff should recognise and prevent any barriers to access and support because of stereotyping, or stigma associated with age, ethnicity, disability, faith, sexual orientation and gender.

Patients have the right to:

- Be treated with dignity at all times
- To have their modesty protected
- To remain autonomous and independent wherever possible

Best practice

a) Staff should introduce themselves (name and role) on initial contact with the service user and their carer, this includes phone conversations.
b) Service users should have the opportunity to discuss with staff if they have any objections to health professionals (not directly related to their care) being present. These wishes should be adhered to as required.

c) Staff should ask each service user how they wish to be addressed e.g. Mr, Mrs, Reverend and should avoid lapsing into over familiarity.
d) Staff should ensure service users and carers (if appropriate) are equal partners in any care decisions being made. They should have clear opportunities to contribute to care planning and should be actively encouraged to identify their aspirations for well-being.
e) Staff should ensure that a service users request is dealt with promptly, where there is an unavoidable delay an apology should be given.
f) Staff should respect the individual patient's cultural, religious and ethnic beliefs and make arrangements as required.
g) Staff should be aware of how their body language may be interpreted by a service user or carer. Staff should be aware of healthcare users' sensitivities with regard to personal contact/touch and personal boundaries. In particular, these issues might arise as a result of gender, culture and ethnicity.
h) Staff should not assume that a patient's partner is of the opposite sex or that their partner is married to them. Staff need to recognise that same sex couples may also have a civil partnership. If it is not clear what sex the partner is, gender neutral words must be used such as "they" rather than making assumptions.
i) For those service users whose knowledge and understanding may be limited, their diagnosis, care and treatment must be explained to them in a manner that promotes understanding.

Confidentiality

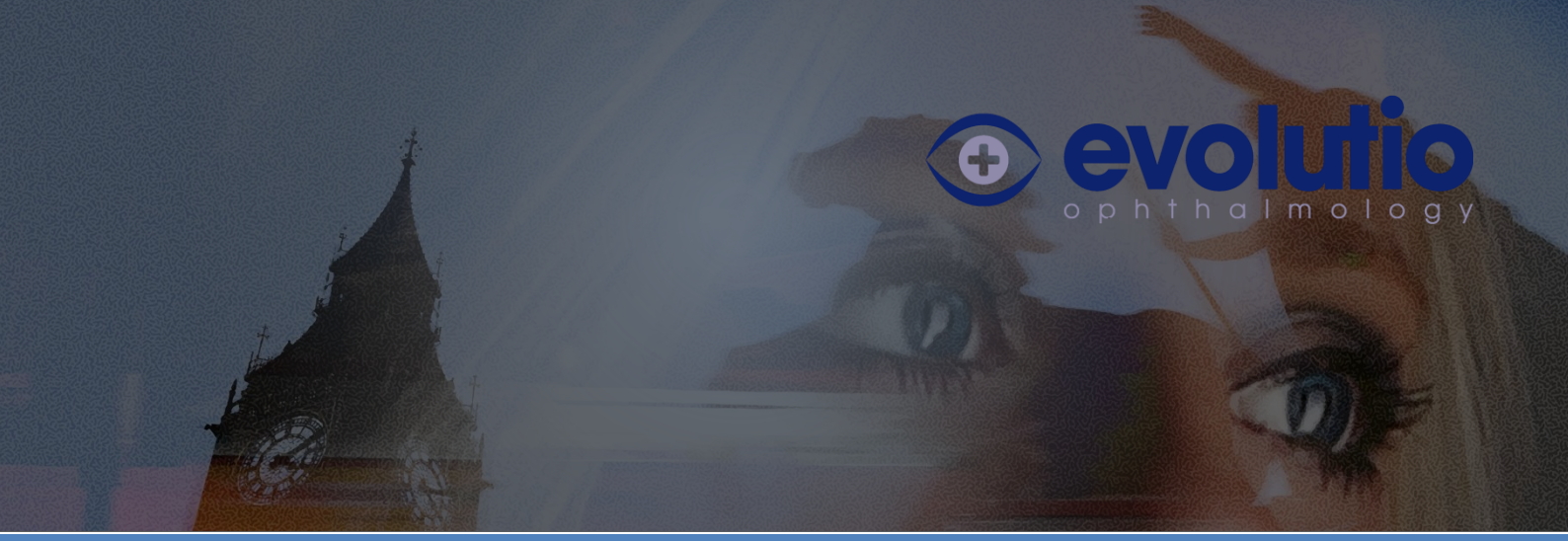
Patients have a right to expect that information is shared to enable care, with their consent.

Best practice

a) Only sharing information that a service user discloses, with staff who are directly involved in their care and with the service users verbal consent.
b) Staff asking for personal and demographic details ensure they cannot be overheard.
c) Obtaining service user consent before disclosing information to family, carers and friends.
d) Being aware of and alert to anyone who may overhear staff conversations. It is not acceptable to discuss clinical information in public areas even if a service users name is not used.
e) Ensuring written service user information which contain confidential details are disposed of correctly and are not left in public places.
f) Precautions are taken to prevent information being shared inappropriately, e.g. computer screens being viewed and white boards being read.
g) Staff follow Evolutio policy in relation to confidentiality and disclosure – Information Quality and Records Management Policy, Pseudonymisation and Anonymisation Policy, Secure Transfer of Information Policy & Information Governance Policy.

Monitoring

Aspect of compliance or effectiveness being monitored	Method of Monitoring	Individual responsible for the monitoring	Monitoring Frequency	Group or committee who receive the findings or report	Group or committee of individual responsible for completing any actions
Non-compliance with the principles and best practice identified will be monitored.	Via service User complaints, feedback, datix, Serious Investigations and Whistle blowing concerns	Individual Managers via complaint/ serious investigation feedback and action planning.	As required based on complaint, serious incidents investigations.	Commissioning NHS CCG & Evolutio Board	Evolutio Board and individual managers



1.3 Consent & Capacity Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	4.0

Why is it necessary?

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to care and treatment is therefore absolutely central in all forms of healthcare, from providing intimate care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health professionals and patients.

Staff should ensure the patient is able to understand the information given to them and are able to give their valid consent. This may necessitate the use of a professional interpreter and the translation of written information. A capacity assessment should be considered for those patients who are unable to consent to the procedure and reference should be made to the relevant Trust policy.

Peter Price-Taylor
CEO

Seeking consent

For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question (this will be the patient or someone with parental responsibility for a patient under the age of 18, someone authorised to do so under a Lasting Power of Attorney (LPA) or someone who has the authority to make treatment decisions as a court appointed deputy). Acquiescence where the person does not know what the intervention entails is not 'consent'.

Does the person have capacity?

The Mental Capacity Act 2005 defines a person who lacks capacity as a person who is unable to make a decision for themselves because of an impairment or disturbance in the functioning of their mind or brain. It does not matter if the impairment or disturbance is permanent or temporary. A person lacks capacity if:

- They have an impairment or disturbance (for example a disability, condition or trauma or the effect of drugs or alcohol) that affects the way their mind or brain works, and
- That impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made

An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general. A person is unable to make a decision if they cannot do one or more of the following things:

- Understand the information given to them that is relevant to the decision
- Retain that information long enough to be able to make the decision
- Use or weigh up the information as part of the decision-making process
- Communicate their decision – this could be by talking or using sign language and includes simple muscle movements such as blinking an eye or squeezing a hand.

People may have capacity to consent to some interventions but not to others or may have capacity at some times but not others. Under the Mental Capacity Act, a person must be assumed to have capacity unless it is established that they lack capacity. If there is any doubt, then the healthcare professional should assess the capacity of the patient to take the decision in question. This assessment and the conclusions drawn from it should be recorded in the patient's notes.

A person's capacity to consent may be temporarily affected by factors such as confusion, panic, shock, fatigue, pain or medication. However, the existence of such factors should not lead to an automatic assumption that the person does not have the capacity to consent.

Capacity should not be confused with a healthcare professional's assessment of the reasonableness of the person's decision. Under the Mental Capacity Act and the common law, a person is not to be treated as unable to make a decision merely because they make an unwise decision. A person is entitled to make a decision which may be perceived by others to be unwise or irrational, as long as they have the capacity to do so.

However, if the decision that appears irrational is based on a misperception of reality, as opposed to a different value system to that of the health practitioner – for example a patient who, despite the obvious evidence, denies that his foot is gangrenous, or a patient with anorexia nervosa who is unable to comprehend their failing physical condition – then the patient may not be able to comprehend, weigh or make use of the relevant information and hence may lack the capacity to make the decision in question.

The Mental Capacity Act also requires that all practical and appropriate steps are taken to enable a person to make the decision themselves. These steps include the following:

- Providing relevant information. For example, if there is a choice, has information been given on the alternatives?
- Communicating in an appropriate way. For example, could the information be explained or presented in a way that is easier for the person to understand?
- Making the person feel at ease. For example, are there particular times of the day when a person's understanding is better?
- Supporting the person. For example, can anyone else help or support the person to understand information and to make a choice?

Is consent given voluntarily?

To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the person either to accept or refuse treatment. Such pressure can come from partners or family members, as well as health or care practitioners. Practitioners should be alert to this possibility and where appropriate should arrange to see the person on their own in order to establish that the decision is truly their own.

The test of capacity is set out in the Mental Capacity Act. Once it has been determined that a person has the capacity to make a particular decision at a particular time, a further requirement (under the common law) for that consent to be valid is that it must be given voluntarily and freely, without pressure or undue influence being exerted upon them.

When people are seen and treated in environments where involuntary detention may be an issue, such as prisons and mental hospitals, there is a potential for treatment offers to be perceived coercively, whether or not this is the case. Coercion invalidates consent, and care must be taken to ensure that the person makes decisions freely. Coercion should be distinguished from providing the person with appropriate reassurance concerning their treatment or pointing out the potential benefits of treatment for the person's health. However, threats such as withdrawal of any privileges, loss of remission of sentence for refusing consent or using such matters to induce consent may well invalidate the consent given and are not acceptable.

Has the person received sufficient information?

To give valid consent, the person needs to understand the nature and purpose of the procedure. Any misrepresentation of these elements will invalidate consent. Where relevant, information about anesthesia should be given alongside information about the procedure itself.

In March 2015 the United Kingdom Supreme Court ruled that healthcare professionals:

- Must make sure that their patients are both aware of and understand the risks of any treatment or procedure that they offer
- Must ensure patients are aware of any reasonable alternatives

It is particularly important that a person is aware of the situation when students or trainees carry out procedures to further their own education. Where the procedure will further the person's care – for example taking a blood sample for testing – then, assuming the student is appropriately trained in the procedure, the fact that it is carried out by a student does not alter the nature and purpose of the procedure.

It is therefore not a legal requirement to tell the person that the clinician is a student, although it would always be good practice to do so. In contrast, where a student proposes to conduct a physical examination that is not part of the person's care then it is essential to explain that the purpose of the examination is to further the student's training, and to seek consent for that to take place.

Although informing people of the nature and purpose of procedures enables valid consent to be given as far as any claim of battery is concerned, this is not sufficient to fulfil the legal duty of care to the person. Failure to provide other relevant information may render the practitioner liable to an action for negligence if a person subsequently suffers harm as a result of the treatment received.

In considering what information to provide, the health practitioner should try to ensure that the person is able to make an informed judgement on whether to give or withhold consent. Case law on this issue is evolving. It is therefore advisable to inform the person of any 'material' or 'significant' risks or unavoidable risks, even if small, in the proposed treatment; any alternatives to it; and the risks incurred by doing nothing.

The expected standard is now that healthcare professionals must "take reasonable care to ensure that the patient is aware of any material risks involved in any treatment, and of any reasonable alternatives".

A 'material risk' is defined as one which a reasonable person in the same position, would be likely to attach significance to, or that the healthcare professional should reasonably be aware that the particular patient would be likely to consider significant. An example of this would be the loss of sight following a refractive surgery procedure.

Who should seek consent?

The clinician providing the treatment or investigation is responsible for ensuring that the person has given valid consent before treatment begins, although the consultant responsible for the person's care will remain ultimately responsible for the quality of medical care provided. Guidance states that the task of seeking consent may be delegated to another person, as long as they are suitably trained and qualified. In particular, they must have sufficient knowledge of the proposed investigation or treatment, and understand the risks involved, in order to be able to provide any information the patient may require.

The practitioner who eventually carries out the investigation or treatment must also be able to determine whether the person has the capacity to make the decision in question and what steps need to be taken if the person lacks the capacity to make that decision. Inappropriate delegation (for example where the clinician seeking consent has inadequate knowledge of the procedure) may mean that the 'consent' obtained is not valid. Clinicians are responsible for knowing the limits of their own competence and should seek the advice of appropriate colleagues when necessary.

Talking to patients

Importantly patients cannot simply be given the percentage chance of something going wrong: instead the impact, or significance of the risk must be explained. It is also important to explain the risk in terms that the patient can understand, and to avoid using technical terms and jargon that the patient is unlikely to understand.

Factors to consider include:

- What impact would something going wrong have on the patient's life?
- How important is the potential benefit of the procedure to the patient?
- What are the other options and what are the risks of those options?
- If you were in the patient's position, what would you want to know?

These discussions must be recorded carefully so that it is clear that not only was the patient provided with the relevant information, but also that they understood the risks. If this is not recorded, a court will assume that you did not provide this advice.

When should consent be sought?

The seeking and giving of consent is usually a process, rather than a one-off event. For major interventions, it is good practice where possible to seek the person's consent to the proposed procedure well in advance, when there is time to respond to the person's questions and provide adequate information. Clinicians should then check, before the procedure starts, that the person still consents. If a person is not asked to signify their consent until just before the procedure is due to start, at a time when they may be feeling particularly vulnerable, there may be real doubt as to its validity. In no circumstances should a person be given routine pre-operative medication before being asked for their consent to proceed with the treatment. You must respect the rights of patients to be fully involved in decisions about their care, including onward referral. Explicit consent is when a patient gives specific permission to do something, either oral or written. Implied consent is when consent can be assumed from a patient's actions. You must use your professional judgement to decide what type of consent is required.

Form of consent

The validity of consent does not depend on the form in which it is given. Written consent merely serves as evidence of consent: if the elements of voluntariness, appropriate information and capacity have not been satisfied, a signature on a form will not make the consent valid.

Where there is any doubt about the person's capacity, it is important, before the person is asked to sign the form, to establish both that they have the capacity to consent to the intervention and that they have received enough information to enable valid consent to be given. Details of the assessment of capacity, and the conclusion reached, should be recorded in the case notes.

If the person has capacity, but is unable to read or write, they may be able to make their mark on the form to indicate consent. It would be good practice for the mark to be witnessed by a person other than the clinician seeking consent,

and for the fact that the person has chosen to make their mark in this way to be recorded in the case notes. Similarly, if the person has capacity, and wishes to give consent, but is physically unable to mark the form, this fact should be recorded in the notes. Or, the person can direct someone to sign the form on their behalf, but there is no legal requirement for them to do so. If consent has been given validly, the lack of a completed form is no bar to treatment, but a form can be important evidence of such consent.

Consent may be expressed verbally or non-verbally: an example of non-verbal consent would be where a person, after receiving appropriate information, holds out an arm for their blood pressure to be taken. However, the person must have understood what examination or treatment is intended, and why, for such consent to be valid. It is good practice to obtain written consent for any significant procedure, such as a surgical operation or when the person participates in a research project or a video recording (even if only minor procedures are involved).

When consent is refused

If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment (whether contemporaneously or in advance), this decision must be respected, except in certain circumstances as defined by the Mental Health Act 1983). This is the case even where this may result in the death of the person (and/or the death of an unborn child, whatever the stage of the pregnancy).

Withdrawal of consent

A person with capacity is entitled to withdraw consent at any time, including during the performance of a procedure. Where a person does object during treatment, it is good practice for the practitioner, if at all possible, to stop the procedure, establish the person's concerns and explain the consequences of not completing the procedure. At times, an apparent objection may in fact be a cry of pain rather than withdrawal of consent, and appropriate reassurance may enable the practitioner to continue with the person's consent. If stopping the procedure at that point would genuinely put the life of the person at risk, the practitioner may be entitled to continue until that risk no longer applies.

Assessing capacity during a procedure may be difficult and, as noted above, factors such as pain, panic and shock may diminish capacity to consent. The practitioner should try to establish whether at that time the person has capacity to withdraw a previously given consent. If capacity is lacking, it may sometimes be justified to continue in the person's best interests, but this should not be used as an excuse to ignore distress.

Advance decisions to refuse treatment

A person may have made an advance decision to refuse particular treatment in anticipation of future incapacity (sometimes previously referred to as a 'living will' or 'advance directive'). A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision to refuse treatment. This is a well-established rule of common law, and the Mental Capacity Act 2005 now puts advance decisions on a statutory basis. The Act sets out the requirements that such a decision must meet to be valid and applicable. Further details are available in chapter 9 of the Mental Capacity Act (2005) Code of Practice, but in summary these are:

- The person must be 18 or over
- The person must have the capacity to make such a decision
- The person must make clear which treatments they are refusing if the advance decision refuses life-sustaining treatment, it must be in writing (it can be written by someone else or recorded in healthcare notes), it must be signed and witnessed and it must state clearly that the decision applies even if life is at risk
- A person with capacity can withdraw their advance decision at any time

Healthcare professionals must follow an advance decision if it is valid and applicable, even if it may result in the person's death. If they do not, they could face criminal prosecution or civil liability. The Mental Capacity Act 2005 protects a health professional from liability for treating or continuing to treat a person in the person's best interests if they are not satisfied that an advance decision exists which is valid and applicable. The Act also protects healthcare professionals from liability for the consequences of withholding or withdrawing a treatment if at the time they reasonably believe that there is a valid and applicable advance decision. If there is genuine doubt or disagreement about an advance decision's existence, validity or applicability, the case should be referred to the Court of Protection. The court does not have the

power to overturn a valid and applicable advance decision. While a decision is awaited from the courts, healthcare professionals can provide life-sustaining treatment or treatment to stop a serious deterioration in the patient's condition.

Patients should always be offered measures that are essential to keeping them comfortable. This is sometimes referred to as 'basic' or 'essential' care, and includes warmth, shelter, actions to keep a person clean and free from distress and the offer of food and water by mouth. The BMA's guidance advises that basic care should always be provided unless it is actively resisted by a patient, and that 'refusals of basic care by patients with capacity should be respected, although it should be continued to be offered'. Advance decisions made under the Mental Capacity Act cannot refuse actions that are needed to keep a person comfortable. The Act allows healthcare professionals to carry out these actions in the best interests of a person who lacks capacity. An advance decision can refuse artificial nutrition and hydration.

Adults without capacity

The Mental Capacity Act 2005 came fully into force in October 2007 and applies in England and Wales to everyone who works in health and social care and is involved in the care, treatment or support of people over 16 years of age who may lack capacity to make decisions for themselves. It is largely based on previous common law and creates a single, coherent framework for decision-making, including decisions about treatment. This chapter summarises the main provisions of the Mental Capacity Act. Detailed guidance is provided in the Code of Practice,35 which has statutory force. The Act imposes a duty on health professionals (and other healthcare staff) to have regard to the Code of Practice.

Under English law, no one is able to give consent to the examination or treatment of an adult who lacks the capacity to give consent for them self, unless they have been authorised to do so under a Lasting Power of Attorney or they have the authority to make treatment decisions as a court appointed deputy. Therefore, in most cases, parents, relatives or members of the healthcare team cannot consent on behalf of such an adult. However, the Mental Capacity Act sets out the circumstances in which it will be lawful to carry out such examinations or treatment.

In general, the refusal to an intervention made by a person when they had capacity cannot be overridden if the advance decision is valid and applicable to the situation (see chapter 1, paragraph 47). There are certain statutory exceptions to this principle, including treatment for mental disorder under the Mental Health Act 1983, which are set out briefly in chapter 5.

The legal requirements in the Mental Capacity Act are underpinned by five statutory principles. One of these key principles is that any act done for, or any decision made on behalf of, a person who lacks capacity must be done, or made, in that person's best interests. This principle applies to health professionals as it does to anyone working with and caring for a person who lacks capacity. The Act also creates a new offence of ill treatment or wilful neglect of someone who lacks capacity by someone with responsibility for their care or with decision-making powers.

The Mental Capacity Act provides healthcare professionals with protection from civil and criminal legal liability for acts or decisions made in the best interests of the person who lacks capacity. The Act makes it clear that when determining what is in a person's best interests a healthcare professional must not make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour.

The Act requires that a healthcare professional must consider all the relevant circumstances relating to the decision in question. These are described as factors that the healthcare professional is aware of and which are reasonable to take into account.

In considering the relevant circumstances, the Act rules that the healthcare professionals must take the following steps:

- Consider whether the person is likely to regain capacity and if so whether the decision can wait
- Involve the person as fully as possible in the decision that is being made on their behalf
- As far as possible, consider:
    - The person's past and present wishes and feelings (in particular if they have been written down)
    - Any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question, and any other relevant factors, and
    - The other factors that the person would be likely to consider if they were able to do so
- As far as possible, consult other people if it is appropriate to do so and take into account their views as to what would be in the best interests of the person lacking capacity, especially:
    - Anyone previously named by the person lacking capacity as someone to be consulted
    - Anyone engaging in caring for or interested in the person's welfare
    - Any attorney appointed under a Lasting Power of Attorney
    - Any deputy appointed by the Court of Protection to make decisions for the person
- For decisions about serious medical treatment, where there is no one appropriate other than paid staff, healthcare professionals have to instruct an IMCA

- If the decision concerns the provision or withdrawal of life-sustaining treatment, the person making the best interests decision must not be motivated by a desire to bring about the person's death

The Mental Capacity Act (2005) Code of Practice makes it clear that the steps set out in the Act should form the starting point for considering all the relevant circumstances of each case, and often other factors will be important.

Healthcare professionals should demonstrate in their record-keeping that the decision has been based on all available evidence and has taken into account any conflicting views. What is in a person's best interests may well change over time. This means that even where similar actions need to be taken repeatedly in connection with the person's care or treatment, the person's best interests should be reviewed regularly.

In cases of serious doubt or dispute about an individual's mental capacity or best interests, an application can be made to the Court of Protection for a ruling. The duty officer of the Official Solicitor can advise on the appropriate procedure if necessary. See also chapter 8 of the Mental Capacity Act (2005) Code of Practice for further information.

Children and young people

The legal position concerning consent and refusal of treatment by those under the age of 18 is different from the position for adults. For the purposes of this guidance 'children' refers to people aged below 16 and 'young people' refers to people aged 16–17.

Young people aged 16-17

By virtue of section 8 of the Family Law Reform Act 1969, people aged 16 or 17 are presumed to be capable of consenting to their own medical treatment, and any ancillary procedures involved in that treatment, such as an anesthetic. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed young person capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent person aged 16–17 may in certain circumstances be overridden by either a person with parental responsibility or a court.

Section 8 of the Family Law Reform Act 1969 applies only to the young person's own treatment. It does not apply to an intervention that is not potentially of direct health benefit to the young person, such as blood donation or non-therapeutic research on the causes of a disorder. However, a young person may be able to consent to such an intervention under the standard of Gillick competence, considered below.

In order to establish whether a young person aged 16 or 17 has the requisite capacity to consent to the proposed intervention, the same criteria as for adults should be used. If a young person lacks capacity to consent because of an impairment of, or a disturbance in the functioning of, the mind or brain then the Mental Capacity Act 2005 will apply in the same way as it does to those who are 18 and over. If, however they are unable to make the decision for some other reason, for example because they are overwhelmed by the implications of the decision, then the Act will not apply to them and the legality of any treatment should be assessed under common law principles. It may be unclear whether a young person lacks capacity within the meaning of the Act. In those circumstances, it would be prudent to seek a declaration from the court. More information on how the Act applies to young people is given in chapter 12 of the Mental Capacity Act (2005) Code of Practice.

If the 16/17-year-old is capable of giving valid consent, then it is not legally necessary to obtain consent from a person with parental responsibility for the young person in addition to the consent of the young person. It is, however, good practice to involve the young person's family in the decision-making process – unless the young person specifically wishes to exclude them – if the young person consents to their information being shared.

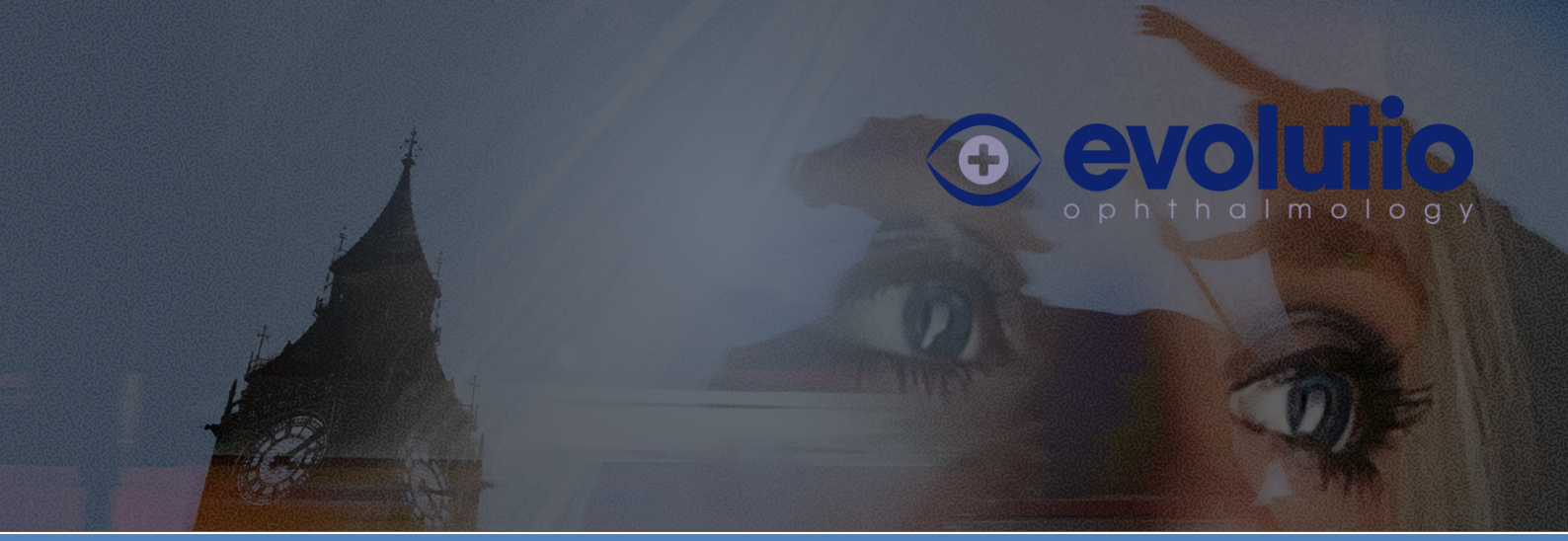
Children under 16

In the case of Gillick, the court held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention. This is sometimes described as being 'Gillick competent'. A child of under 16 may be Gillick competent to consent to medical treatment, research, donation or any other activity that requires their consent.

The concept of Gillick competence is said to reflect a child's increasing development to maturity. The understanding required for different interventions will vary considerably. Thus a child under 16 may have the capacity to consent to some interventions but not to others. The child's capacity to consent should be assessed carefully in relation to each decision that needs to be made.

In some cases, for example because of a mental disorder, a child's mental state may fluctuate significantly, so that on some occasions the child appears Gillick competent in respect of a particular decision and on other occasions does not. In cases such as these, careful consideration should be given as to whether the child is truly Gillick competent at the time that they need to take a relevant decision.

If the child is Gillick competent and is able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required. It is, however, good practice to involve the child's family in the decision-making process, if the child consents to their information being shared.



1.4 Chaperone Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	3.0

Why is it necessary?

This policy is intended to safeguard patients and staff of all ages, both genders and race, from misinterpretation of actions taken as part of consultation, examination, treatment and care.

Patients can find some consultations, examinations, investigations or procedures distressing and may prefer to have a chaperone present in order to support them. It is good practice to offer all patients a chaperone for any consultation, examination or procedure where the patient feels one is required.

Any consultations or procedures involving the need to undress, the use of dimmed light or intimate examinations involving the breasts, genitalia or rectum may make the patient feel particularly vulnerable. The intimate nature of many medical interventions, if not practised in a sensitive and respectful manner, can lead to misinterpretation and occasionally allegations of sexual assault or inappropriate examinations.

In these circumstances a chaperone can act as a safeguard for both patient and clinician. All patients have the right, if they wish, to have a chaperone present during an examination, procedure, treatment or any care irrespective of organisational constraints or settings in which they are carried out.

This policy sets out guidance on the use of chaperones within Evolutio and is based on recommendations from the General Medical Council and NHS Guidance.

This policy has been developed with the aim of producing a co-ordinated approach to the use of chaperones during consultations, examinations or procedures carried out within a service provided by Evolutio. It should be used in conjunction with existing guidance from Professional Bodies and with reference to:

- Consent to Examination and Treatment Policy
- Clinical Record Keeping Policy
- Whistle Blowing Policy
- Mental Capacity Act 2005

This policy applies to all staff working in for Evolutio who may be involved in examining or undertaking clinical procedures as well as those who may be asked to chaperone patients.

Peter Price-Taylor
CEO

Chaperone definition

There is no common definition of a chaperone and the role varies according to the needs of the patient, the healthcare professional, and the examination or procedure being carried out. It is acceptable for a friend, relative or carer to be present during a procedure if that is the wish of the patient but it is recommended that staff make use of a formal chaperone for all intimate examinations.

The role of the chaperone may vary according to the clinical situation and can include:

- Providing the patient with physical and emotional support and reassurance
- Ensuring the environment supports privacy and dignity
- Providing practical assistance with the examination
- Safeguarding patients from humiliation, pain, distress or abuse
- Providing protection to healthcare professionals against unfounded allegations of improper behaviour
- Identifying unusual or unacceptable behaviour on the part of the healthcare professional
- Providing protection for the health care professional from potentially abusive patients

Chaperones should be:

- Sensitive and respectful of the patient's dignity and confidentiality
- Be familiar with the procedures involved in routine intimate examinations
- Be prepared to ask the examiner to abandon the procedure if the patient expresses a wish for the examination to end. Be prepared to raise concerns if misconduct occurs and report it.

Responsibility and duties

All Evolutio professionals should be aware of and comply with the chaperone policy. Staff also are responsible for reporting any incidents or complaints related to the use of chaperones.

Guidance from the Royal College of Nursing (RCN) (2002) states that all patients should have the right, if they wish, to have a chaperone present during an examination or procedure, treatment or care irrespective of organisational constraints or settings in which they are carried out.

The General Medical Council (GMC) (2003) recommends that whenever possible medical practitioners should offer the patient the security of having an impartial observer (a "chaperone") present during an intimate examination even if you are the same gender as the patient.

Process

It is good practice to offer all patients a chaperone for any consultation, examination or procedure where the patient feels one is required. Evolutio does not perform intimate examinations, procedures or treatments. That does not preclude patients the opportunity to request a chaperone for an examination and all requests must be treated as though the examination falls under the definition of 'intimate' as out-lined below.

If a patient prefers to undergo an examination/procedure without the presence of a chaperone this should be respected and their decision documented in their clinical record. In order for patients to exercise their right to request the presence of a chaperone, a full explanation of the examination, procedure or treatment to be carried out should be given to the patient. This should be followed by a check to ensure that the patient has understood the information and gives consent.

Clinicians are advised to request a healthcare professional to act as a chaperone when undertaking any intimate examinations or procedures. An intimate examination is defined as an examination of the breast, genitalia or rectum and applies to both female and male patients.

To protect the patient from vulnerability and embarrassment consideration should be given to the chaperone being of the same sex as the patient wherever possible.

Facilities should be available for patients to undress in a private undisturbed area. There should be no undue delay prior to examination once the patient has removed any clothing.

Examinations should take place in a closed room or well screened bay that cannot be entered without consent while the examination is in progress. Do not enter or Examination in progress signs must be used when possible.

During the examination the examiner should:

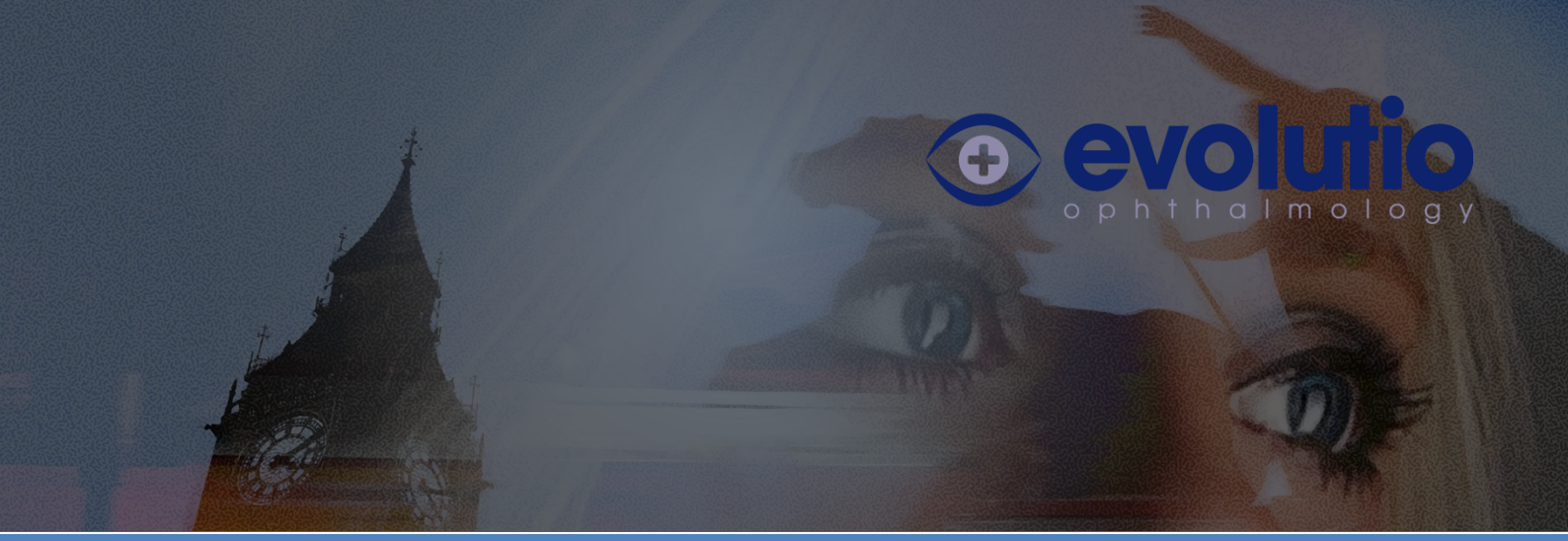
- Be courteous at all times Offer reassurance
- Keep all discussion relevant to the examination and avoid unnecessary personal comments
- Remain alert to any verbal and non-verbal signs of distress from the patient
- Respect any requests for the examination to be discontinued

Training and awareness

While individual professionals have a responsibility to ensure that they are aware of the contents of this policy and apply them, it is the responsibility of lead clinicians to identify any training needs and to organise appropriate workplace instruction.

Workplace instruction should involve discussion and demonstration of an understanding of the following:

- What is meant by the term Chaperone?
- Confidentiality
- What is an intimate examination?
- Why chaperones need to be present
- The rights of the patient
- The chaperone's role and responsibility
- An understanding of the diverse needs of patients
- A working knowledge of the incident reporting procedures
- Instruction on the role of the chaperone should be included in clinical induction programmes for new members of staff.



1.5 Adult Safeguarding Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Why is it necessary?

All of us have a responsibility and none of us have the excuse not to take action. For Adult at risks, our commitment is more than a strategy, however robust; and can mean the difference between safety and danger. Our commitment is that "on our watch" with the help of our partners, safeguarding is an active part of how we do our job and we can be held to that promise.

Health services have a duty to safeguard all patients and to provide additional measures for patients who are less able to protect themselves from harm, abuse and neglect.

The implementation of the Care Act 2014 in April 2015 put in place the statutory framework for Adult Safeguarding. The statutory guidance for Adult Safeguarding (HM Government 2014) replaced the 'No secrets' guidance (Department of Health 2000). The legislation places statutory duties on the NHS, Local Authorities and Police for Safeguarding Adults at risk, however, emphasises that Adult Safeguarding is everyone's business.

Safeguarding is 'everyone's business'. This policy sets out Evolutio's responsibilities under the Care Act 2014 to ensure adult at risks are kept safe from harm.

Peter Price-Taylor
CEO

Purpose

The purpose of this policy and the associated procedures is to protect and promote the welfare adults using or receiving services provided by Evolutio, its employees and sub-contractors in fulfilling their statutory responsibilities.

All employees and contracted service providers have a clear responsibility to take action when they suspect or recognise that an adult at risk may be a victim of significant harm or abuse.

This policy demonstrates how Evolutio will meet its legal obligations and reassure members of the public, service users, employees and customers:

a) What they can expect Evolutio to do to protect and safeguard adult at risks
b) That they are able to safely voice any concerns through an established procedure
c) That all reports of abuse or potential abuse are dealt with in a serious and effective and timely manner
d) That there is an efficient recording and monitoring system in place
e) That Members, employees, volunteers and contractors receive appropriate training
f) That robust 'safer' recruitment procedures are in place

Legal duties

The Care Act 20141 sets out statutory responsibility for the integration of care and support between health and local authorities. NHS England and Clinical Commissioning Groups are working in partnership with local and neighbouring social care services. Local Authorities have statutory responsibility for safeguarding. In partnership with health they have a duty to promote wellbeing within local communities.

What is safeguarding adults and why it matters

Safeguarding adults means protecting a person's right to live in safety, free from abuse and neglect.

An adult at risk is any person who is aged 18 years or over and at risk of abuse or neglect because of their needs for care and or support. Where someone is over 18 but still receiving children's services and a safeguarding issue is raised, the matter should be dealt with as a matter of course by the adult safeguarding team.

The aims of adult safeguarding are to:

- Stop abuse or neglect wherever possible
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- Safeguard adults in a way that supports them in making choices and having control about how they want to live
- Promote an approach that concentrates on improving life for the adults concerned
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect
- Provide information and support to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well- being of an adult
- Address what has caused the abuse or neglect

Six key principles underpin all Adult Safeguarding work

- Empowerment – people being supported and encouraged to make their own decisions and informed consent
- Prevention – it is better to take action before harm occurs
- Proportionality – the least intrusive response proportionate to the risk presented
- Protection – support and representation for those in greatest need
- Partnership – Public services working with their communities and partners
- Accountability – accountability and transparency in delivering safeguarding.

'Safeguarding is everyone's business'

Further information

The Suffolk Safeguarding Adults Board (SAB) is a multi-agency partnership that promotes the development of adult safeguarding work throughout Suffolk. The Board consists of senior officers nominated by each of the main agencies who will be responsible for developing and maintaining strong and effective inter agency protocols to safeguard vulnerable adults from abuse. Further information can be found on *https://www.suffolkas.org/*

Policy

Evolutio is committed to safeguarding adult at risks from abuse when they are engaged in services organised and provided by Evolutio or any sub-contractor providing services on behalf of Evolutio.

Evolutio will:

a) Endeavour to keep patients and service users safe from abuse. Suspicion of abuse will be responded to promptly and appropriately. Evolutio will always act in the best interests of the adult
b) Proactively seek to promote the welfare and protection of all children, young people and adult at risks
c) Ensure that unsuitable people are prevented from working with adult at risks through robust 'safer recruitment' procedures
d) Deal with any concern raised by an employee, contracted service provider, or member of the public appropriately and sensitively
e) Safeguarding referrals made by an employee or contracted service provider cannot be anonymous and should be made in the knowledge that, during the course of enquiries, the referrer may be required as a prosecution witness
f) Not tolerate harassment of any employee contracted service provider or adult at risk who raises concerns of abuse or neglect
g) Prevent abuse by using good practice to create a safe and healthy environment and avoid situations where abuse or allegations of abuse could occur
h) Establish an appropriate governance structure, made up with delegates from appropriate departments across the business to monitor activity and make necessary improvements around this agenda, led by the CEO and board

This policy covers all Members, employees and volunteers at Evolutio, including contracted service providers.

While employees and contracted services providers are likely to have varied levels of contact with adult at risks as part of their duties and responsibilities for the company, everyone should be aware of the potential indicators of abuse and neglect and be clear about what to do if they have concerns. Responsibilities are limited and it is important to remember the following:

It is not the responsibility of any Evolutio employee or contracted service provider to determine whether abuse is actually taking place.

However,

It is the responsibility of the an Evolutio employee or contracted service provider to take the actions set out in the procedure, if they are concerned abuse is taking place

Roles, responsibility and governance

Chief Executive and the Board

The Chief Executive and the Senior Management Team are responsible for ensuring that this policy and related procedures are implemented, monitored, and consistently reviewed and make up the Safeguarding Board.

Employees

All employees are responsible for carrying out their duties in a way that actively safeguards and promotes the welfare of children, young people and adult at risks. They must also act in a way that protects them from wrongful allegations of abuse as far as possible. They must bring safeguarding concerns to the attention of the CEO and the Senior Management Team / Line Manager.

Contractors, sub-contractors or other organisations funded by or on behalf of Evolutio

Contractors, sub-contractors or other organisations funded by or on behalf of Evolutio are responsible for applying the appropriate CRB checks, delivering safeguarding training commensurate with their level of contact with children, young people and adult at risks; and ensuring their employees comply with their organisational Safeguarding Policy and Procedures.

Safeguarding procedures

The procedure for reporting a concern or allegation informs all employees and those contracted service providers that have accepted this policy of what actions they should take if they have concerns or encounter a case of alleged or suspected child, young person or adult at risk abuse or neglect.

Even for those experienced in working with adult abuse it is not always easy to recognise a situation where abuse may occur or already has taken place. Whilst it is accepted that staff are not experts at such recognition all staff have a duty to act if they have any concerns and discuss with an appropriate Safeguarding representative within Evolutio.

An adult at risk is someone who:

- Has needs for care and support and;
- Is experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

There are many types of abusive behaviour, some of which are difficult to spot. Abuse can include:

- Domestic violence – abuse that takes place between family members or intimate partners regardless of gender or sexuality. It can include psychological, physical, sexual, financial, emotional abuse and so called 'honour' based violence.
- Sexual abuse – any sexual act that a person does not agree to
- Psychological or emotional – this is when someone makes threats of harm, abandonment, humiliation, intimidation or verbal abuse
- Financial - this include stealing someone's money or denying them access to their money, property or possessions
- Neglect or acts of omission – this can be both physical and emotional. It could be failing to keep an adult at risk clean or warm, not promoting optimum health, not providing adequate nutrition or medication. It could also mean preventing someone from making their own choices.
- Discriminatory - abusive remarks or actions relating to a person's age, race, religion, sex or abilities
- Organisational abuse - this happens when the routines in use force residents or service users to sacrifice their own needs, wishes or preferred lifestyle to the needs of the institution or service provider
- Modern slavery – such as human trafficking, forced labour and domestic servitude
- In adult safeguarding cases additional categories include financial, institutional and discriminatory abuse

Who could be an abuser?

Anyone can carry out abuse or neglect including:

- Spouses/partners
- Other family members
- Neighbours
- Friends
- Acquaintances
- Local residents
- People who deliberately exploit adults they perceive as vulnerable to abuse
- Paid staff or professionals
- Volunteers
- Strangers

Institutions and services can be guilty of abuse if they persistently fail to take account of the needs of the people using that service or do not provide the staffing or equipment to enable people's needs to be met adequately and safely.

Professional status or title does not guarantee safety. There are many recent examples of professionals being responsible for abuse.

More than one person may abuse an adult at risk and some sources of risk will abuse more than one alleged victim.

It can be difficult to understand why anyone would want to abuse an older person, someone with a physical or learning disability, or someone who is unwell. In some instances, the abuse may not have been deliberate, malicious or premeditated. It can happen when people are trying to do their best but are unaware of what is the right thing to do.

Raising concerns and duty of care

Mental Capacity Act Code of Practice

People working with or caring for adults who lack capacity to make decisions for themselves have a legal duty to consider the Code of Practice.

The Mental Capacity Act 2005 covers people in England and Wales who can't make some or all decisions for themselves. The ability to understand and make a decision when it needs to be made is called 'mental capacity'.

The code of practice gives guidance to people who:

- Work with people who can't make decisions for themselves
- Care for people who can't make decisions for themselves

It says what you must do when you act or make decisions on behalf of people who can't act or make those decisions for themselves.

The Mental Capacity Act 2005 (MCA) says certain people must think about the code of practice when they act or make decisions on the other person's behalf.

Capacity

Capacity describes a person's ability to make a specific decision at a specific time. An individual is deemed to lack capacity if at the time, a decision is required, and he/she is unable to make that decision because of an impairment or disturbance in the functioning of the mind or brain. This may be temporary or permanent.

The following 5 principles apply for the purposes of this Act:

1. A person must be assumed to have Capacity unless it is established that he/she lacks Capacity
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success
3. A person is not to be treated as unable to make a decision merely because he/she makes an unwise or bad decision.
4. An act done or decision made, under the Act for or on behalf of a person who lacks Capacity must be done, or made, in his/her best interests
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action

You should always treat every individual with dignity and respect to ensure that they feel safe in services and empowered to make choices and decisions.

Ensure that significant others, i.e. family member, friend, or advocate, are involved to support the individual where appropriate.

It is important to recognise that though an individual with capacity has the right to refuse care for themselves. Such a refusal may give raise a safeguarding concern in respect of others.

Duty of care

All staff employed by Evolutio have a duty to act promptly and report concerns if they think that a patient in their care is being abused, or that their concerns about standards of care suggest there is a risk of abuse or neglect to adults using the service. The seriousness, or the extent of the abuse, is often not clear. It is therefore important that staff report incidents immediately so that the matter can be investigated further, and that staff approach such allegations with an open mind.

It is the responsibility of the staff caring for the patient to ensure there is in no immediate danger. If deemed necessary, the medical team caring for the patient may be required to examine the patient and instigate any clinical investigations needed.

Staff must make sure that they assure the person raising the concerns that their concerns will be taken seriously and that they, and we, have a duty to report incidents of this nature. It should be explained to the person raising the concern that

in order to safeguard an individual information will need to be shared with others, or with safeguarding teams, who have a part to play in protecting them. Do not give promises of complete confidentiality.

When a child, young person or adult at risk makes an allegation of abuse or bullying, you should:

- If you believe the person is 'at risk' of immediate significant harm, which includes situations which any employee would reasonably believe requires the emergency services, then you must contact the relevant emergency service and notify the CEO, COO or Line Manager
- Ensure the safety and wellbeing of the individual
- Listen carefully to what is said and allow the person to talk at their own pace, being careful not to compromise potential evidence
- Establish their wishes and feelings
- Find an appropriate opportunity to explain it is likely that information will need to be shared with other responsible people, do not promise to keep secrets
- Only ask questions for clarification, the use of open questions e.g. what, where, when, who is advisable, do not ask leading questions (that suggest certain answers as this could compromise evidence)
- Reassure the child, young person or adult at risk that they have done the right thing in telling you
- Seek consent to share information if patient has capacity and if this does not place you, them or others at an increased risk
- You may share information without consent if it is in the public interest in order to prevent a crime or protect others from harm
- Tell them what you will do next and who you will inform
- Immediately report to and inform the CEO, COO or Line Manager
- Record all details you are aware of on the Safeguarding Incident Record Form (SIRF) as soon as possible

When allegations or concerns are expressed about an employee or contracted service provider, you should:

- Take the allegation or concern seriously
- Immediately inform the CEO/COO or Line Manager if they are not implicated in the allegation
- If you believe the child, young person or adult at risk is 'at risk' of immediate significant harm, which includes situations which you would reasonably believe requires the emergency services, then you should contact the relevant emergency service and then notify the CEO/COO or Line Manager
- Record all details you are aware of on the Safeguarding Incident Record Form (SIRF) as soon as possible

In situations where there has been or may have been a crime, it is important that forensic or other evidence is preserved, or can be collected, as part of the police investigation. Try not to disturb evidence or potential evidence and seek advice about what you need to do to preserve evidence.

Who should complete the Safeguarding Incident Report Form (SIRF)?

It is the responsibility of the person who directly observes or witnesses the event (e.g. living situation) that is being recorded or who has participated in the meeting/conversation, to complete the record. Where this is not possible and records are completed or updated by other people, it must be clear from the record which person provided the information. Preferably, the person with first-hand knowledge should read and sign the record. There must be clear differentiation between opinion and fact. Records of decisions must show who has made the decision, the basis for it, the date and time.

Recording concerns

If any employee has concerns about the welfare of an adult at risk, or has concerns about the behaviour of an employee, it is vitally important to record all relevant details regardless of whether or not the concerns are shared with the Police or other emergency service. A Safeguarding Incident Record Form (SIRF) must be completed (even if no referral is subsequently made).

Records may be used for: Evidence for investigations and inquires; Court Proceedings; Monitoring Quality Assurance; and Disciplinary procedures. The CEO will then manage the process and follow established guidance on information sharing, confidentiality, consent and the making of appropriate referrals.

Who to go to

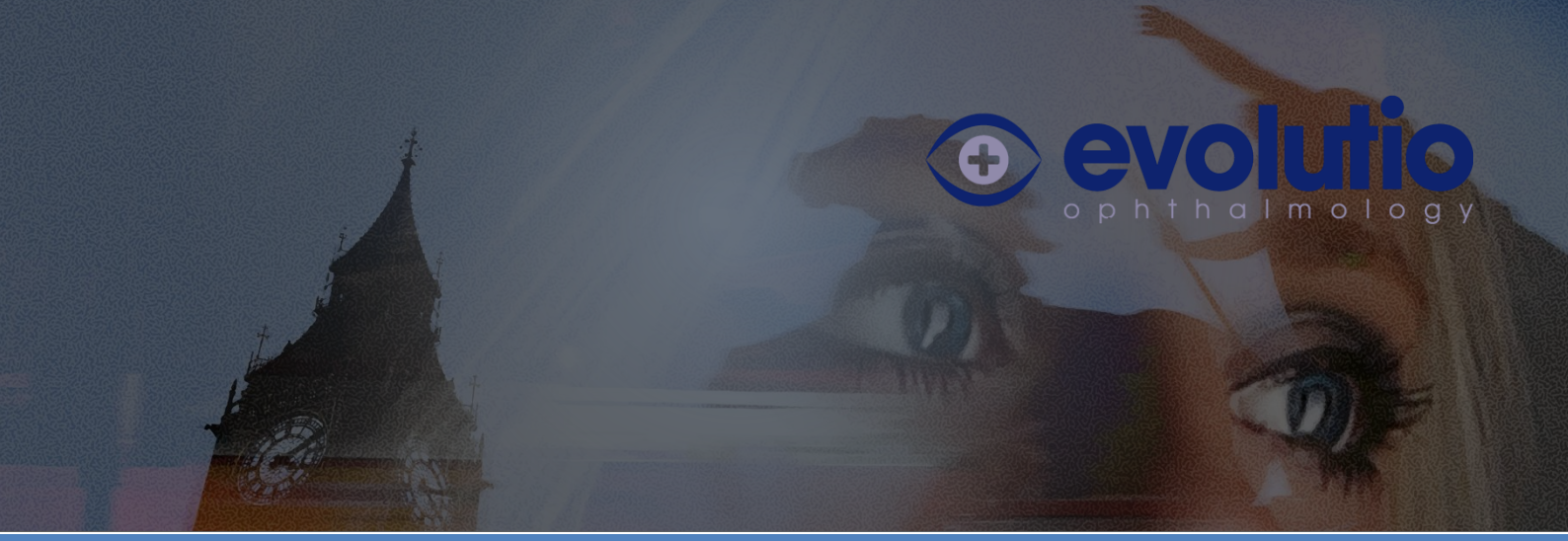
The Safeguarding Contract Contacts document available on SharePoint outlines where you should report concerns depending on the Local Authority area the concern has originated. You may feel that you would prefer to approach the patient's GP in the first instance or request assistance from the patient's Local Authority. Both are acceptable when reporting a safeguarding incident. We would encourage you, however, to follow the Local Authority's process. If in doubt, then approach a board member for help and guidance.

Allegations against staff

Where abuse is alleged against an employee, this must be reported immediately to your line manager and the COO of the company. Consideration should be given to whether a crime has been committed and the duty to report to the Police.

The procedure remains the same as if you were reporting an external party. In addition, the following procedure applies.

1. Where the alleged perpetrator of abuse or neglect is a member of staff an immediate risk assessment needs to be undertaken to decide if the staff member will be immediately removed from their work area. The decision will need to involve a Director of the company and Human Resources department.
2. The decision to suspend a member of staff pending an investigation will be made by the Human Resources Department. If the allegation is against a member of medical staff the Medical Director will be involved.
3. The disciplinary or workforce procedures will be instigated as soon as possible
4. The Police must be involved if a crime has believed to have been committed. Contact with the police should be via the Director of Nursing, Deputy Director of Nursing or the Executive on call, unless it is an emergency.



1.5 Children's Safeguarding Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Why is it necessary?

All of us have a responsibility and none of us have the excuse not to take action. For children at risk, our commitment is more than a strategy, however robust; and can mean the difference between safety and danger. Our commitment is that "on our watch" with the help of our partners, safeguarding is an active part of how we do our job and we can be held to that promise.

Health services have a duty to safeguard all patients and to provide additional measures for patients who are less able to protect themselves from harm, abuse and neglect.

Safeguarding is 'everyone's business'. This policy sets out Evolutio's responsibilities under the Children Act 2004 to ensure children, young people are kept safe from harm.

Peter Price-Taylor
CEO

Purpose

The purpose of this policy and the associated procedures is to protect and promote the welfare of the children and young people using or receiving services provided Evolutio, its employees and sub-contractors in fulfilling their statutory responsibilities.

All employees and contracted service providers have a clear responsibility to take action when they suspect or recognise that a child or young person may be a victim of significant harm or abuse.

This policy demonstrates how Evolutio will meet its legal obligations and reassure members of the public, service users, employees and customers:

a) What they can expect Evolutio to do to protect and safeguard children and young people
b) That they are able to safely voice any concerns through an established procedure
c) That all reports of abuse or potential abuse are dealt with in a serious and effective and timely manner
d) That there is an efficient recording and monitoring system in place
e) That Members, employees, volunteers and contractors receive appropriate training
f) That robust 'safer' recruitment procedures are in place

Legal duties

The Children Act 1989 states that the child's welfare is paramount and that every child has a right to protection from abuse, neglect and exploitation. Statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 10, 11 and 13 of the Children Act 2004 and specifies what is required of Evolutio.

This includes:

- The Boards commitment to the importance of safeguarding and promoting children's welfare
- A clear statement of Evolutio's responsibilities to children
- Clear lines of accountability for work on safeguarding and promoting well being
- Using the views of children and young people to help shape services
- Safer recruitment procedures for those coming into contact with children and young people
- Appropriate training for staff
- Effective working relations within Evolutio and with other organisations to safeguard and promote well-being and to share information effectively

What is Safeguarding Children and why it matters

We have a duty of care to safeguard the welfare of children and young people while they are under our care. We do this by:

- Providing all clinical staff with child protection awareness training. We continually aim to meet recommended training levels and we report on this monthly.
- Ensuring all staff are given information about the importance of child safeguarding and how they can support the needs of vulnerable children and young people
- Working with GPs, social services and other professionals to ensure the needs of vulnerable children and young people are met

The aims of children and young people safeguarding are to:

- Stop abuse or neglect wherever possible
- Prevent harm and reduce the risk of abuse or neglect to children and young people
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect
- Provide information and support to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well- being of an children and young people
- Address what has caused the abuse or neglect

Policy

Evolutio believes Safeguarding is committed to the following principles for children:

- Their welfare is paramount
- Whatever their background and culture, parental or pregnancy status, age, disability, gender, racial origin, religious belief, sexual orientation and/or gender identity, they have the right to participate in society in an environment which is safe and free from violence, fear, abuse, bullying and discrimination
- They have the right to be protected from harm, exploitation, abuse, and to be provided with a safe environment.
- Working in partnership with them, alongside their parents or carers and other agencies, is essential to the promotion of their welfare

Evolutio is committed to safeguarding children and young people at risks from abuse when they are engaged in services organised and provided by Evolutio or any sub-contractor providing services on behalf of Evolutio.

Evolutio will seek to keep children and young people safe by:

a) Endeavour to keep patients and service users safe from abuse. Suspicion of abuse will be responded to promptly and appropriately. Evolutio will always act in the best interests of the children and young people.
b) Proactively seek to promote the welfare and protection of all young people and children
c) Ensure that unsuitable people are prevented from working with children and young people through robust 'safer recruitment' procedures
d) Deal with any concern raised by an employee, contracted service provider, or member of the public appropriately and sensitively
e) Safeguarding referrals made by an employee or contracted service provider cannot be anonymous and should be made in the knowledge that, during the course of enquiries, the referrer may be required as a prosecution witness
f) Not tolerate harassment of any employee contracted service provider children or young person who raises concerns of abuse or neglect
g) Prevent abuse by using good practice to create a safe and healthy environment and avoid situations where abuse or allegations of abuse could occur
h) Establish an appropriate governance structure, made up with delegates from appropriate departments across the business to monitor activity and make necessary improvements around this agenda, led by the CEO and board

This policy covers all Members, employees and volunteers at Evolutio, including contracted service providers.

While employees and contracted services providers are likely to have varied levels of contact with children and young people as part of their duties and responsibilities for the company, everyone should be aware of the potential indicators of abuse and neglect and be clear about what to do if they have concerns. Responsibilities are limited and it is important to remember the following:

It is not the responsibility of any Evolutio employee or contracted service provider to determine whether abuse is actually taking place.

However

It is the responsibility of the an Evolutio employee or contracted service provider to take the actions set out in the procedure, if they are concerned abuse is taking place.

Roles, responsibilities and governance

Chief Executive and the Board

The Chief Executive and the Senior Management Team are responsible for ensuring that this policy and related procedures are implemented, monitored and consistently reviewed and make up the Safeguarding Board.

Employees

All employees are responsible for carrying out their duties in a way that actively safeguards and promotes the welfare of children and young people. They must also act in a way that protects them from wrongful allegations of abuse as far as possible. They must bring safeguarding concerns to the attention of the CEO and the Senior Management Team / Line Manager.

Contractors, sub-contractors or other organisations funded by or on behalf of Evolutio

Contractors, sub-contractors or other organisations funded by or on behalf of Evolutio are responsible for applying the appropriate CRB checks, delivering safeguarding training commensurate with their level of contact with children and young people; and ensuring their employees comply with their organisational Safeguarding Policy and Procedures.

Safeguarding procedures

The procedure for reporting a concern or allegation informs all employees and those contracted service providers that have accepted this policy of what actions they should take if they have concerns or encounter a case of alleged or suspected of a child or young person at risk of abuse or neglect.

Even for those experienced in working with children and young people, it is not always easy to recognise a situation where abuse may occur or has already has taken place. Whilst it is accepted that staff are not experts at such recognition, all staff have a duty to act and to discuss concerns with an appropriate Safeguarding representative within Evolutio.

Child specific abuse can take different forms. The main types of abuse are:

- Neglect – can mean the persistent lack of essential care for a child including enough love, stimulation, safety, food, clothing, shelter, medical care or education. It can also mean leaving a child alone and at risk. Neglect may occur during pregnancy as a result of maternal substance abuse.
- Emotional abuse – can mean repeatedly rejecting a child, constantly threatening or putting a child or young person down so that they feel unloved and worthless. It may involve the child seeing or hearing the ill-treatment of another (like a parent or sibling being deliberately hurt in front of them). It may involve serious bullying (including cyber bullying), causing the child to feel frequently frightened or in danger, or it can also be the exploitation or corruption of children.
- Physical abuse – can mean any form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child
- Sexual abuse – can mean forcing or enticing a child or young person to take part in any kind of sexual activity, whether or not they are aware of what is happening. It can include inappropriate touching, kissing or sexual intercourse. It can also involve causing a child to look at, or be involved, in pornographic material or videos, or grooming a child in preparation for abuse (including via the internet). Both women and men can commit acts of sexual abuse.

Who could be an abuser?

Anyone can carry out abuse or neglect including:

- Parents/Carers (including foster carers)
- Other family members
- Neighbours
- Friends
- Acquaintances
- Local residents
- People who deliberately exploit children and young people they perceive as vulnerable to abuse
- Paid staff or professionals
- Volunteers
- Strangers

Institutions and services can be guilty of abuse if they persistently fail to take account of the needs of the people using that service or do not provide the staffing or equipment to enable people's needs to be met adequately and safely.

Professional status or title does not guarantee safety. There are many recent examples of professionals being responsible for abuse.

More than one person may abuse children and young people at risk and some sources of risk will abuse more than one alleged victim.

Raising concerns and duty of care

Duty of care

All staff employed by Evolutio have a duty to act promptly and report concerns if they think that a patient in their care is being abused, or that their concerns about standards of care suggest there is a risk of abuse or neglect to children and young people using the service. The seriousness, or the extent of the abuse, is often not clear. It is therefore important that staff report incidents immediately so that the matter can be investigated further, and that staff approach such allegations with an open mind.

It is the responsibility of the staff caring for the patient to ensure there is in no immediate danger. If deemed necessary, the medical team caring for the patient may be required to examine the patient and instigate any clinical investigations needed.

Staff must make sure that they assure the person raising the concerns that their concerns will be taken seriously and that they, and we, have a duty to report incidents of this nature. It should be explained to the person raising the concern that in order to safeguard an individual information will need to be shared with others, or with safeguarding teams, who have a part to play in protecting them. Do not give promises of complete confidentiality.

When a child or young person at risk makes an allegation of abuse or bullying, you should:

- If you believe the person is 'at risk' of immediate significant harm, which includes situations which any employee would reasonably believe requires the emergency services, then you must contact the relevant emergency service and notify the CEO, COO or Line Manager
- Ensure the safety and wellbeing of the individual
- Listen carefully to what is said and allow the person to talk at their own pace, being careful not to compromise potential evidence
- Establish their wishes and feelings
- Find an appropriate opportunity to explain it is likely that information will need to be shared with other responsible people, do not promise to keep secrets
- Only ask questions for clarification, the use of open questions e.g. what, where, when, who is advisable, do not ask leading questions (that suggest certain answers as this could compromise evidence)
- Reassure the child or young person that they have done the right thing in telling you
- Seeking consent to share information if patient has capacity and if this does not place you, them or others at an increased risk is best practice but not always required for safeguarding concerns
- You may share information without consent if it is in the public interest in order to prevent a crime or protect others from harm
- Tell them what you will do next and who you will inform
- Immediately report to and inform the CEO, COO or Line Manager
- Record all details you are aware of on the Safeguarding Incident Record Form (SIRF) as soon as possible

When allegations or concerns are expressed about an employee or contracted service provider, you should:

- Take the allegation or concern seriously
- Immediately inform the CEO/COO or Line Manager if they are not implicated in the allegation
- If you believe the child or young person is 'at risk' of immediate significant harm, which includes situations which you would reasonably believe requires the emergency services, then you should contact the relevant emergency service and then notify the CEO/COO or Line Manager
- Record all details you are aware of on the Safeguarding Incident Record Form (SIRF) as soon as possible

In situations where there has been or may have been a crime, it is important that forensic or other evidence is preserved, or can be collected, as part of the police investigation. Try not to disturb evidence or potential evidence and seek advice about what you need to do to preserve evidence.

Who should complete the Safeguarding Incident Record Form (SIRF)?

It is the responsibility of the person who directly observes or witnesses the event (e.g. living situation) that is being recorded or who has participated in the meeting/conversation, to complete the record. Where this is not possible and records are completed or updated by other people, it must be clear from the record which person provided the information.

Preferably, the person with first-hand knowledge should read and sign the record. There must be clear differentiation between opinion and fact. Records of decisions must show who has made the decision, the basis for it, the date and time.

Recording concerns

If any employee has concerns about the welfare of a child or young person at risk, or has concerns about the behaviour of an employee, it is vitally important to record all relevant details regardless of whether or not the concerns are shared with the Police or other emergency service. A Safeguarding Incident Record Form (SIRF) must be completed (even if no referral is subsequently made).

Records may be used for: Evidence for investigations and inquires; Court Proceedings; Monitoring Quality Assurance; and Disciplinary procedures. The CEO will then manage the process and follow established guidance on information sharing, confidentiality, consent and the making of appropriate referrals.

Who to go to

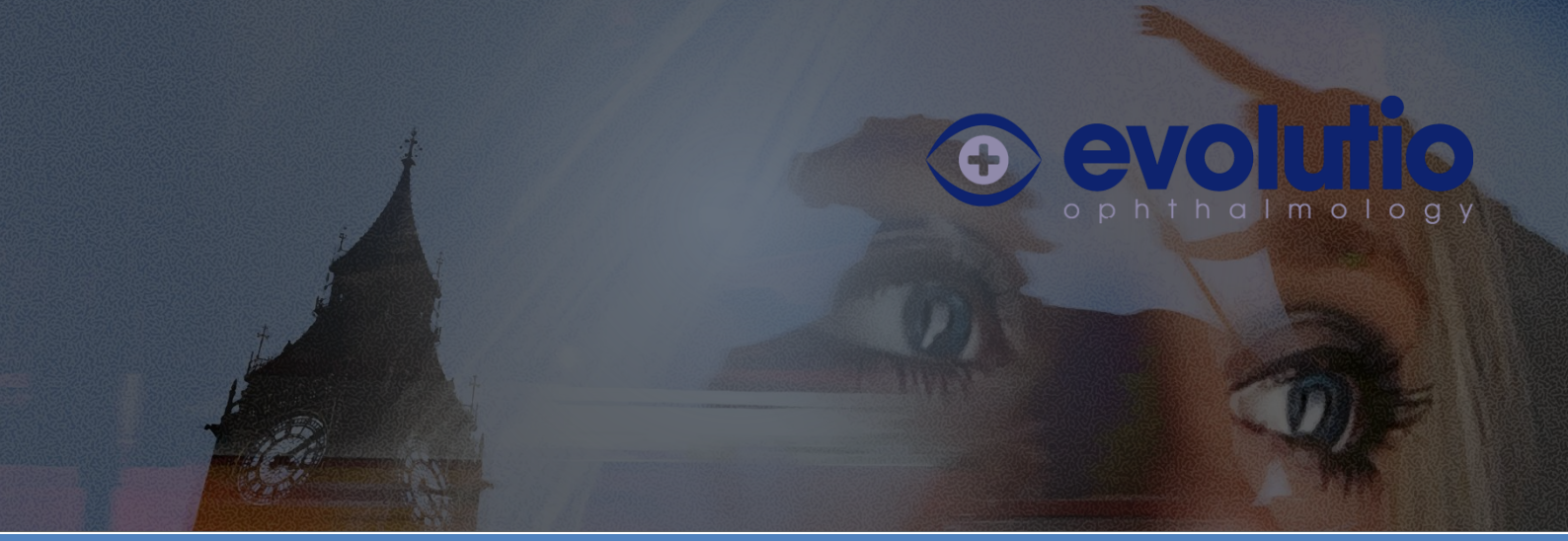
The Safeguarding Contract Contacts document available on SharePoint outlines where you should report concerns depending on the CCG area the concern has originated. If in doubt, then approach a board member for help and guidance.

Allegations against staff

Where abuse is alleged against an employee, this must be reported immediately to your line manager and the COO of the company. Consideration should be given to whether a crime has been committed and the duty to report to the Police.

The procedure remains the same as if you were reporting an external party. In addition, the following procedure applies.

1. Where the alleged perpetrator of abuse or neglect is a member of staff an immediate risk assessment needs to be undertaken to decide if the staff member will be immediately removed from their work area. The decision will need to involve a Director of the company and Human Resources department.
2. The decision to suspend a member of staff pending an investigation will be made by the Human Resources Department. If the allegation is against a member of medical staff the Medical Director will be involved.
3. The disciplinary or workforce procedures will be instigated as soon as possible
4. The Police must be involved if a crime has believed to have been committed. Contact with the police should be via the Director of Nursing, Deputy Director of Nursing or the Executive on call, unless it is an emergency.



1.6 Complaints Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	4.0

Why is it necessary?

Evolutio is committed to dealing with any complaint made about its services equitably, comprehensively, and in a timely manner.

Evolutio are dedicated to high quality care for all as a core principal of our vision and purpose. This includes the provision for any user of the organisation and its associated services, their family, carers, or members of the public, with the opportunity to seek advice, raise concerns or make a complaint, about any of the services it commissions, or policies and procedures it has developed and implemented.

The complaints policy aims to clarify how the public can make a complaint. The policy seeks to create a positive approach to complaints where they are valued as a means of continuously reviewing and improving the services we offer.

The 'Errors, Concerns & Continuous Service Improvement' policy (section 3.4 of this handbook) offers service providers information and support when investigating or reporting an error, concern or complaint.

Peter Price-Taylor
CEO

Aims

A complaint or concern is an expression of dissatisfaction about an act, omission or decision of Evolutio, either verbal or written, and whether justified or not, which requires a response and/or redress.

When dealing with complaints we aim to adhere to NHS England's organisation principles and follow the 'Good Practice Standards for NHS Complaints Handling' (Sept 2013) outlined by the Patients Association:

- Openness and Transparency - well publicised, accessible information and processes, and understood by all those involved in a complaint
- Evidence based complainant led investigations and responses. This will include providing a consistent approach to the management and investigation of complaints.
- Logical and rational in our approach
- Sympathetically respond to complaints and concerns in appropriate timeframes
- Provide opportunities for people to offer feedback on the quality of service provided
- Provide complainants with support and guidance throughout the complaints process
- Provide a level of detail appropriate to the seriousness of the complaint
- Identify the causes of complaints and to take action to prevent recurrences
- Effective and implemented learning - use 'lessons learnt' as a driver for change and improvement
- Ensure that the care of complainants is not adversely affected as a result of making a complaint
- Ensure that Evolutio meets its legal obligations
- Act as a key tool in ensuring the good reputation of Evolutio

The complaints system also incorporates the Parliamentary and Health Service Ombudsman Principles of Good Complaints Handling (2009) and the NHS Constitution which includes a number of patient rights relating to complaints. In summary, these include patients' rights to:

- Have their complaint acknowledged and properly investigated
- Discuss the manner in which the complaint is to be handled and know the period in which the complaint response is likely to be sent
- To be kept informed of the progress and to know the outcome including an explanation of the conclusions and confirmation that any action needed has been taken on
- Take a complaint about data protection breaches to the independent Information Commissioners Office (ICO) if not satisfied with the way Evolutio has dealt with this
- Make a claim for judicial review if the patient thinks that they have been directly affected by an unlawful act or decision
- Receive appropriate redress if the patient has been harmed by medical negligence.

Who can make a complaint?

Anyone can complain, including young people. A family member, carer, friend, or your local MP, can complain on your behalf with your permission.

A complaint can be made about any aspect of Evolutio as long as you:

- Receive or have received services from Evolutio, or
- Are someone who is affected, or likely to be affected, by the action, omission or decision of Evolutio

You can complain on behalf of someone else if the person who has grounds to complain:

- Has died, or
- Is a child, or
- Can't make the complaint themselves because of physical or mental incapacity, or
- Has asked you to act on their behalf

In the case of a third party pursuing a complaint on behalf of the person affected we will request the following information:

- Name and address of the person making the complaint,
- Name and either date of birth or address of the affected person; and
- Contact details of the affected person (if not deceased) so that we can contact them for confirmation that they consent to the third party acting on their behalf

This will be documented in the complaint file and confirmation will be issued to both the person making the complaint and the person affected.

If the Board is of the opinion that a representative is not acting in the affected person's best interests, we will notify the representative in writing stating the reasons.

Children and young people

The regulations provide that a child means an individual who has not attained the age of 18.

A parent can make a complaint on their behalf, but only if the Board thinks the child can't make the complaint themselves. If the Board thinks the child can make the complaint themselves, you can still make the complaint on their behalf, as long as the child gives you permission to make a complaint on their behalf.

How to complain

If a person has concerns relating to an Evolutio service, then the first step is usually for concerns to be addressed with the Chief Operations Officer.

If the person decides it is not appropriate to raise a concern informally, or where informal resolution fails to achieve a satisfactory outcome, a person has the right to raise a complaint to the Board.

A complaint or concern can be received by mail, electronically or by phone on the below:

Mail: complaints@evolutio-ophthalmology.co.uk
Tel: 0203 7807860
Post: Evolutio Care Innovations Ltd.
Newtown House,
Newtown Road,
Henley on Thames,
Oxon,
RG9 1HG

Complaining to the NHS

You have the right to make a complaint about any aspect of NHS care, treatment or services, and this is firmly written into the NHS Constitution.

NHS guidance

If you are unhappy with an NHS service, it is often worthwhile discussing your concerns early on with the provider of the service, as they may be able to sort the issue out quickly. Most problems can be dealt with at this stage, but in some cases you may feel more comfortable speaking to someone not directly involved in your care.

If you are making or thinking of making a complaint, someone from the independent NHS Complaints Advocacy service can help you. An advocate will also be able to attend meetings with you and review any information you are given during the complaints process.

You can seek advice from an NHS complaints advocate at any stage of the process. If you decide you need some support, it is never too late to ask for help.

Your local council will be able to tell you who the advocacy provider is in your area. Find details for your local council on the GOV.UK website.

Your local Healthwatch can also provide information about making a complaint.

How to complain to the NHS

Everyone who provides an NHS service in England must have their own complaints procedure. You can often find information in waiting rooms, at reception, on the service provider's website, or by asking a member of staff.

You can either complain to the NHS service provider directly – such as a GP, a dentist surgery, or a hospital – or to the commissioner of the services, which is the body that pays for the NHS services you use. You cannot apply to both. See the information below on How to find the commissioner.

In the event of a complaint about more than one organisation – perhaps a complaint that includes issues about your GP, local hospital and ambulance service – you'll only need to make one complaint. The organisation that receives your complaint must then co-operate with the others to ensure you receive a co-ordinated response.

How do I find the commissioner?

Contact NHS England for complaints about primary care services (GPs, dentists, opticians or pharmacists). NHS England also commissions military health services and some other specialised services. To contact NHS England:

- Email *england.contactus@nhs.net* with "For the attention of the complaints team" in the subject line
- Phone 0300 311 22 33
- Use the British Sign Language service

For more detailed information, visit NHS England's website.

Contact your local clinical commissioning group (CCG) for complaints about secondary care, such as hospital care, mental health services, out-of-hours services, NHS 111 and community services – district nursing, for example.

Every CCG will have its own complaints procedure, which is often displayed on its website.

Contact your local authority if your complaint is about public health organisations, which provide services that prevent disease, promote health and prolong life.

The complaints process

Complaints can be made twelve months from the date on which the matter that is the subject of the complaint came to the notice of the complainant. If there are good reasons for not having made the complaint within the above timeframe and, if it is still possible to investigate the complaint effectively and fairly, the Board may decide to still consider the complaint.

All complaints will be acknowledged no later than three working days after the day the complaint is received (the acknowledgement will be made either by telephone, email or letter) and an offer will be made, as appropriate, to discuss with the complainant the following:

- An action plan for handling the complaint
- Timescales for responding
- The complainants' expectations and desired outcome.
- Consent for the Board to handle the complaint in the event that your complaint requires input or investigation from parties or organisations outside of Evolutio
- Where appropriate outline the complainant's rights as set out by the NHS Constitution

The complainant can expect that:

- They will be kept up to date with the progress of their complaint
- Their complaint will be investigated by specially trained members of staff and, where appropriate, they will receive an explanation based on facts
- They can expect to receive a quality response with assurance that action has been taken to prevent a recurrence
- To be informed of any learning
- A remedy will be made where appropriate

Our response to a complainant will be wherever possible by their preferred method of communication (email correspondence will only be responded to by email when the complainant has expressly requested this as their method of communication and security measures will be implemented in line with office policy to protect personal information sent via email).

On receipt of the investigation report a response to the complaint will be prepared and the Board will include information on the next stages of the complaints procedure should the complainant wish to take matters further.

As soon as it is reasonably possible after completing the investigation, and within the timescale agreed with the complainant, the Board will send a formal response in writing to the complainant which will be signed by the Chief Executive Officer or delegated deputy.

The response will include:

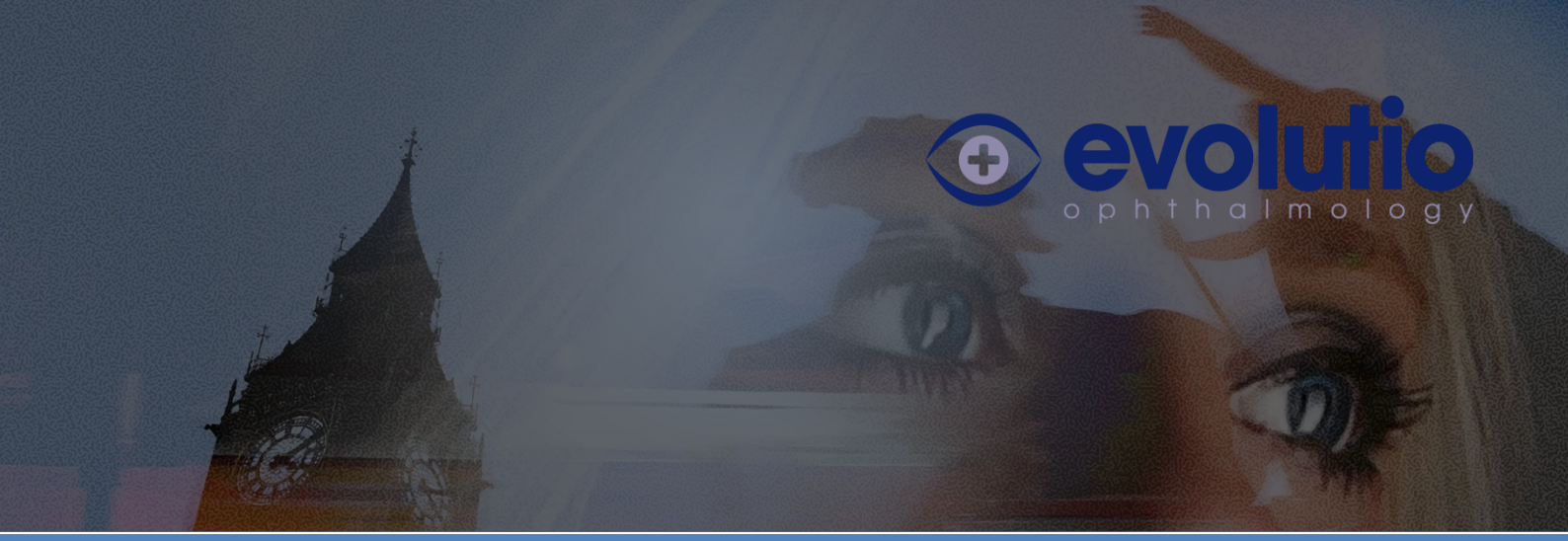
- An explanation of how the complaint has been considered
- An apology if appropriate
- An explanation based on facts
- Whether the complaint in full or in part is upheld
- The conclusions reached in relation to the complaint and remedial action that the organisation considers to be appropriate.
- Confirmation that the organisation is satisfied any action has been or will be actioned
- Where possible, we will respond to people about any lessons learnt

Confidentiality

Complaints will be handled in the strictest of confidence in accordance with Evolutio's Confidentiality Policy and will be kept separately from patient medical records.

Care will be taken that information should only be disclosed to those who have a demonstrable need to have access to it. Suitable arrangements are in place for the handling of patient identifiable data to meet the compliance of the Data Protection Act and other legal obligations such as the Human Rights Act 1998 and the common law duty of confidentiality.

The Caldicott Report sets out a number of general principles that health and social care organisations should use when reviewing its use of patient or client information. The designated Caldicott Guardians are responsible for ensuring that confidentiality is maintained. Confidentiality will be maintained in such a way that only managers and staff who are leading the investigation know the contents of the case. Anyone disclosing information to others who are not directly involved in this may be dealt with under disciplinary procedures



1.7 Duty of Candour

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Why is it necessary?

This policy sets out the appropriate processes for communicating with a patient and/or family/carer following a reportable patient safety incident and should be followed in conjunction with the Evolutio Incident Reporting Policy.

This document outlines Evolutio's duty of candour and the processes by which openness will be supported.

This will support Evolutio to meet its obligations to patients, relatives and the public by being open and honest about any mistakes that are made whilst Evolutio employees care for and treat patients.

This document is aimed at all Evolutio employees and service providers and sets out the infrastructure which is in place to support openness between healthcare professionals and patients, their families and carers, following a patient safety incident.

This policy aims to improve the quality and consistency of communication when incidents involving patients, staff or visitors occur and/or in situations which give rise to complaints. The policy will make sure that if mistakes are made the patient and/or their carer, staff member or visitor will be given an opportunity to discuss what went wrong, that they will receive and apology and be informed of the action Evolutio will take to prevent it happening again.

Peter Price-Taylor
CEO

Duty of Candour

The Duty of Candour is contained within the Care Quality Commission regulations under the Health and Social Care Act. It applies to all Trusts in England from 27th November 2014 and all GPs, social care providers and other practitioners registered with the CQC from April 2015.

The regulations set out that each healthcare provider should comply with the following:

- Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered
- Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators
- Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it

To meet these requirements health care providers have been told they have to:

- Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity
- Tell the relevant person as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred and provide support to them in relation to the incident, including when giving the notification
- Provide an account of the incident which, to the best of the health service body's knowledge, is true of all the facts the body knows about the incident as at the date of the notification
- Advise the relevant person what further enquiries the health service body believes are appropriate
- Offer an apology
- Follow this up by giving the same information in writing and providing an update on the enquiries
- Keep a written record of all communication with the relevant person

Scope

This policy relates to incidents, complaints and claims and details arrangements for communication with patients and/or their carers who have suffered harm within the care of Evolutio. The same principles and process should be applied if a member of staff or visitor suffers harm as a result of an incident within Evolutio's property. It is aimed at any healthcare staff member, clinical or non-clinical, responsible for making sure that the infrastructure is in place to support openness between healthcare professionals and patients and/or their carers following an incident, complaint or claim.

It describes the processes of Being Open and the Duty of Candour with patients and gives advice on the 'dos and don'ts' of communicating with patients and/or their carers following harm. Evolutio's Incident Reporting and Investigation policy encourage staff to report all patient safety incidents, including those where there was no harm, or it was a 'near miss'.

This policy relates to those incidents that cause moderate harm, severe harm or death on the risk consequence grading scale below, incidents that are no harm/near miss are not within the scope of this policy.

Roles and responsibilities

The Board

Evolutio Care Innovations Limited is committed to the provision of high-quality health care in all aspects of its services to patients, visitors, local community and staff. Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. The Board therefore supports this policy and culture of openness and honesty.

Chief Executive

The Chief Executive is responsible for making sure that the infrastructure is in place to support openness between healthcare professionals and patients and/or their carers, staff and visitors. In conjunction with the Board, the Chief Executive is responsible for actively championing the Being Open and Duty of Candour culture and process by promoting an open, honest and fair culture that fosters peer support.

Executive Directors

Executive Directors are responsible for promoting an open, honest and fair culture within the organisation.

All staff

All staff working within Evolutio will be expected to adhere to this policy and promote an open, honest and fair culture within the organisation. All staff have a responsibility for making sure that incidents or complaints are acknowledged and reported as soon as they are identified as per the Serious Incident Policy. In cases where the patient and/or carers inform healthcare staff when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all healthcare staff.

Being open and duty of candour process

Ten Principles of "Being open as identified in the National Patient Safety Agency's document "Being open": communicating patient safety incidents with patients and their carers' (NPSA, 2005).

Being open is a process rather than a one-off event. With this in mind, the following principles have been drawn up to support the policy.

1) Principle of acknowledgement

All patient safety incidents should be acknowledged and reported as soon as they are identified. In cases where the patient and/or their carers inform healthcare staff when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all healthcare staff. Denial or trivialisation of a patient's concerns will make future open and honest communication more difficult.

2) Principle of truthfulness, timeliness and clarity of communication

Information about a patient safety incident must be given to patients and/or their carers in a truthful and open manner by an appropriately nominated person. Patients want a step-by-step explanation of what happened, that considers their individual needs and is delivered openly.

Communication should also be timely: patients and/or their carers should be provided with information about what happened as soon as practicable. It is also essential that any information given is based solely on the facts known at the time. Healthcare staff should explain that new information might emerge as an incident investigation is undertaken, and patients and/or their carers should be kept up to date with the progress of an investigation.

Patients and/or their carers should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff. Medical jargon, which they may not understand, should be avoided.

3) Principle of apology

Patients and/or their carers should receive a sincere expression of sorrow or regret for the harm that has resulted from a patient safety incident. This should be in the form of an appropriately worded apology, as early as possible. Both verbal and written apologies should be given. The decision on which staff member should give the apology should consider seniority, relationship to the patient, and experience and expertise in the type of patient safety incident that has occurred. Verbal apologies are essential because they allow face-to-face contact between the patient and/or their carers and the healthcare team.

Although an apology should be given as soon as staff are aware an incident has occurred, it is essential that the episode is planned, and some preparation undertaken. It is important not to delay for any reason, including setting up a more formal multidisciplinary "Being open" discussion with the patient and/or their carers, fear and apprehension, or lack of staff availability. Delays are likely to increase the patient's and/or their carer's sense of anxiety, anger or frustration. A written apology, which clearly states the healthcare organisation is sorry for the suffering and distress resulting from the incident, must also be given. An apology is not an admission of liability.

4) Principle of recognising patient and carer expectations

Patients and/or their carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident and its consequences in a face-to-face meeting. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times.

Patients and/or their carers should also be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include a patient requiring additional support, such as an independent patient advocate or a translator. When appropriate, information on accessing the Patient Advisory and Liaison Service (PALS) and other relevant support groups like Cruse Bereavement Care and Action against Medical Accidents (AvMA) should be given to the patient as soon as it is possible.

5) Principle of professional support

Evolutio's ethos of openness and fairness creates an environment in which all staff, whether directly employed or independent contractors, are encouraged to report patient safety incidents. Managers should ensure that staff feel supported throughout the incident investigation process as they too may have been traumatised by being involved. They should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration. To ensure a robust and consistent approach to incident investigation, the NPSA's Incident Decision Tree (IDT) has been developed as an aid to improve the consistency of decision-making about whether human error or systems failures contributed to an incident.

It is designed for use by anyone who has the authority to exclude a member of staff from work following a patient safety incident (including medical and nursing directors, chief executives and human resources staff). More details can be found in Seven Steps to Patient Safety and on the NPSA website: www.npsa.nhs.uk Where there is reason for Evolutio to believe a member of staff has committed a punitive or criminal act, the company will take steps to preserve its position, and advise the member(s) of staff at an early stage to enable them to obtain separate legal advice and/or representation. Staff will also be encouraged to seek support from relevant professional bodies such as the General Medical Council, Royal Colleges, the Medical Protection Society, the Medical Defence Union and the Nursing and Midwifery Council.

6) Principle of risk management and systems improvement

Root cause analysis (RCA) should be used to uncover the underlying causes of a patient safety incident. Investigations should focus on improving systems of care, which will then be reviewed and audited for their effectiveness.

7) Principle of multidisciplinary responsibility

This policy applies to all staff who have key roles in the patient's care. Most healthcare provision involves multidisciplinary teams and communication with patients and/or their carers following an incident that led to harm, should reflect this. This will ensure that the "Being open" process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

8) Principle of clinical governance

Being open" has the support of patient safety and quality improvement processes through the clinical governance framework, in which patient safety incidents are investigated and analysed, to find out what can be done to prevent their recurrence. It also involves a system of accountability through the Chief Executive to the Board to ensure these changes are implemented and their effectiveness reviewed.

The findings are disseminated to staff so that they can learn from patient safety incidents through managers' feeding back locally and via the mortality and morbidity agenda of the Clinical Improvement Group. These actions are monitored to ensure that the implementation and effects of changes in practice following a patient safety incident.

9) Principle of confidentiality

Full respect should be given to the patient's and/or their carer's and staff's privacy and confidentiality. Details of a patient safety incident should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. Where this is not practicable or an individual refuses to consent to the disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the incident have statutory powers for obtaining information. Communications with parties outside of the clinical team should also be on a strictly need-to-know basis and, where practicable, records should be anonymous. In addition, it is good practice to inform the patient and/or their carers about who will be involved in the investigation before it takes place and give them the opportunity to raise any objections.

10) Principle of continuity of care

Patients are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.

Detecting and recognising an incident

The being open and Duty of Candour process begins with the recognition and acknowledgement that a patient has suffered moderate harm, major harm, or has died, as a result of a patient safety incident.

In all cases relating to incidents, Evolutio's Incident Reporting and Investigation policy must be followed. As soon as a patient safety incident is identified the actions required are:

First priority: prompt and appropriate clinical care with prevention of further harm. If additional treatment is required, it should happen as soon as reasonably practicable after a discussion with the patient (or carer if the patient is unable to participate in discussion) and with appropriate consent.

Incidents must be reported through the incident reporting system in accordance with the Serious Incident Policy.

Where an incident is reported and identified as moderate, severe or death a flag will direct the reporter to inform a Board Member as soon as possible of the incident.

An initial investigation will be carried out to validate the harm caused prior to informing the patient or their relatives/carer.

The following actions are the responsibility of a Board Member and the Clinician responsible for the episode of care during, or as a result of which, the incident happened. It is not appropriate for others to give information to the patient.

The initial notification of the incident must be verbal (face-to-face, where possible) unless the patient or their family/carer decline notification or cannot be contacted in person. A sincere expression of apology must be provided verbally. This must be recorded. At that time, an initial apology and explanation must be given. The patient and/or carer must be offered written notification (including a sincere apology) of the incident.

A step-by-step explanation of the facts (in plain English) must be offered as soon as practicable. This may just be an initial view pending investigation. Full written documentation of any letters, discussions and meetings must be maintained. It does not need to be a verbatim record of the discussions.

The response of the patient/carers should also be recorded. If meetings are offered but declined this must be recorded. Any emerging information (whether during the investigation or after the investigation) must be offered.

Within 10 working days of the report of the investigation being signed off as complete by the Board it should (together with action plans) be signed off by the COO and shared with the patient/relatives. It is important that patients and/or their relatives receive a meaningful apology. An apology does not constitute an admission of liability.

Patients and the relatives increasingly ask for detailed explanations of what led to adverse outcomes and they frequently say that they derive some consolation from knowing that lessons have been learned for the future.

Explanations should not contain admissions of liability.

Completion of the process

After completion of the incident investigation, the patient/carer must be provided with the written report of the investigation and action plan (unless the offer has been refused and recorded as such).

The Report should include:

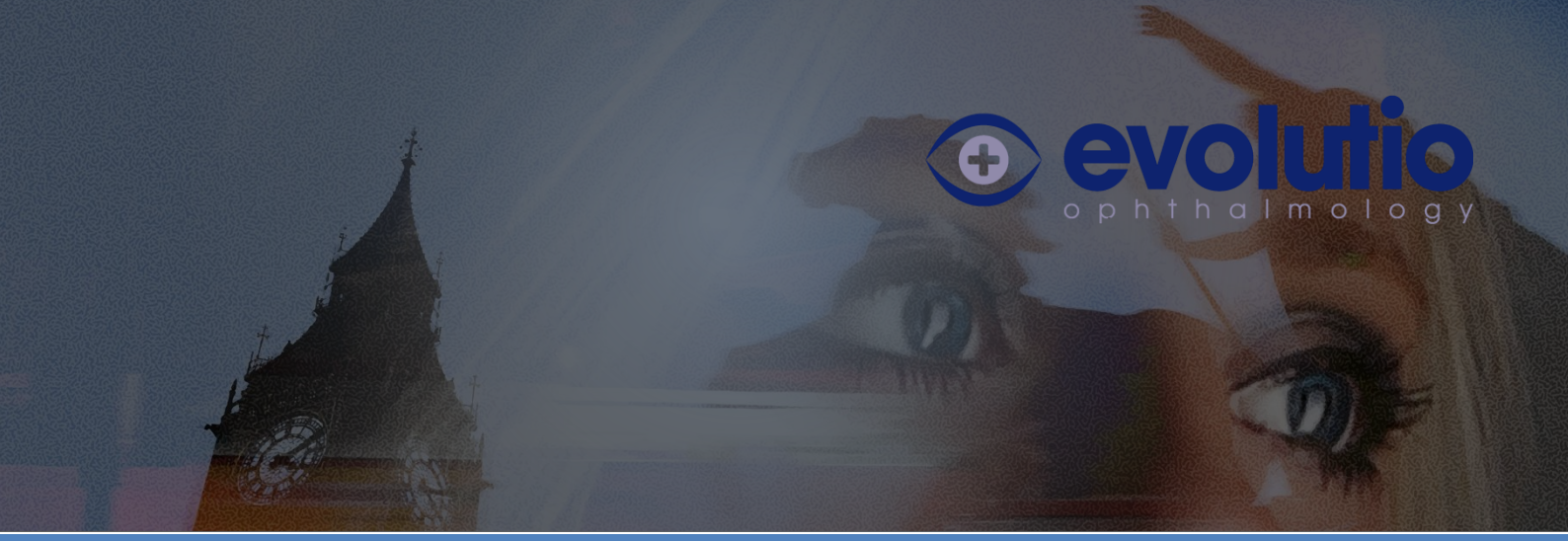
- A summary of the factors that contributed to the incident
- Information on what has been and will be done to reduce the risk of a similar incident in the future
- Information about how these improvements will be monitored

- A repeated apology for the harm suffered and any shortcomings in delivery of care that led to the patient safety incident
- And in most cases, there will be a complete discussion of the findings of the investigation and analysis. In some cases, information may be withheld or restricted, for example, where communicating information will adversely affect the health of the patient; where investigations are pending coronial processes, or where specific legal requirements preclude disclosure for specific purposes. In these cases, the patient and/or their carers will be informed of the reasons for the restrictions.

Continuity of care

When a patient has been harmed during the course of treatment and requires further management or rehabilitation, they should be informed of the ongoing clinical management plan. This may be included in discharge documentation addressed to designated individuals such as the referring GP or healthcare organisation if the patient is being transferred.

Patients and/or their carers should be reassured that they will continue to be treated according to their clinical needs even in circumstances where there is a dispute between them and the healthcare team. They should also be informed that they have the right to continue their treatment elsewhere if they have lost confidence in the healthcare team involved in the patient safety incident.



1.8 Disclosure of Abuse & Bad Practice Policy (Whistle blowing)

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	4.0

Why is it necessary?

The term 'whistle blowing' is used to describe the action of raising concerns, or giving information, to the appropriate authorities about any 'wrongdoings' within an organisation which fall into one of the following categories:

- A criminal offence
- A miscarriage of justice
- The endangering of an individual's health and safety (Safeguarding)
- An act causing damage to the environment
- Deliberate concealment of information relating to any of the above

Examples of such actions may include the physical abuse of people using our services; clinical malpractice or dangerous patient care / practice which compromises patient safety; financial impropriety, such as the falsification of claims, records or accounts; putting others at serious risk by failures to act or withholding information on known dangers to health and safety.

Staff must be able to raise concerns about wrongdoing at an early stage and in the right way. Only by being made aware, can Evolutio correct any wrongdoing before it becomes a serious problem or causes harm. Evolutio believes that a responsible attitude to raising concerns and whistle blowing helps to promote a healthy workplace culture and built on openness and accountability.

Peter Price-Taylor
CEO

Raising a concern

If you decide to raise any concerns then you should follow one of the current procedures in place for incident reporting in the first instance, as detailed in the following policies Incident Reporting Policy.

If your concern relates to one of the following:

- A criminal offence
- A miscarriage of justice
- The endangering of an individual's health and safety
- An act causing damage to the environment
- Deliberate concealment of information relating to any of the above
- A safeguarding issue relating to an Adult or Child

or does not clearly fit within any of the existing policies, or you have previously raised a concern via one or more of these routes, which you feel has not been dealt with appropriately or has failed to correct the wrongdoing, then you should report your concerns using the Disclosure of Abuse and Bad Practice Policy.

All of us at one time or another have concerns about what is happening at work. Usually these concerns are easily dealt with and resolved through the normal line management structures. However, when the concern feels serious because it is about a possible danger, professional misconduct or financial malpractice that might affect patients, colleagues or the company itself, it can be difficult to know what to do.

You may be worried about raising such an issue and may think it best to keep it to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may feel that raising the matter would be disloyal to colleagues, to managers or to Evolutio. You may have said something but found that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

Evolutio is committed to running the organisation in the best way possible and to do so we need your help. We have introduced this policy to reassure you that it is safe and acceptable to speak up and to enable you to raise any concern you may have at an early stage and in the right way.

If you feel unable to raise your concern internally, we advise that you contact the Public Concern at Work (PCaW) on 0207 404 6609 - *http://www.pcaw.org.uk/*.

Anonymity and confidentiality

All concerns raised under the whistle blowing policy must be treated confidentially by all parties, including the person who has initially raised the concern. Information relating to the specific concerns raised will only be shared on a 'need to know' basis, with those people directly involved in the process of investigation or reporting and those outlined in this policy as having a key role in assisting the whistle blowing process.

If you wish to remain anonymous and ask us not to disclose your identity, we will not do so without your consent unless we are required to do so by law. You should understand that there may be times when we are unable to resolve a concern without revealing your identity, for example where your personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

Please remember that if you do not tell us who you are it will be much more difficult for us to look into the matter. We will not be able to protect your position or to give you feedback. Accordingly, you should not assume that we can provide the assurances we offer in the same way if you report a concern anonymously.

Procedure

Wherever possible, you should report any concerns you have, verbally or in writing, to your line / department manager in the first instance (Stage 1).

Where the concern involves that manager, or you feel, for whatever reason, that your manager is not the appropriate person, you should take your concerns directly to a more senior Divisional / THQ Manager (Stage 2) as outlined:

Your Line Manager
Chief Operations Officer
CEO

It will be the responsibility of the senior managers above to investigate your concern appropriately and to escalate it to the next line of senior management where necessary. If your concern relates to one of the issues described in the introduction of the policy, or if you have previously raised concerns using any of the existing Evolutio policies (Incident Reporting Process) and do not consider that your concerns have been dealt with appropriately or have failed to rectify the wrongdoing, then you can use this policy to escalate your serious concern to a more senior level of management for action.

Raising concerns openly and professionally is acknowledged as being the best way to deal with such incidents to ensure speedy and appropriate responses and actions to your concern.

If you wish to remain anonymous and ask us not to disclose your identity, we will not do so without your consent unless we are required to do so by law.

Once you have raised your concern formally through one of the above channels, you can expect to receive written acknowledgement within 5 working days of you formally raising the incident.

The investigation

It is the responsibility of the COO to establish as many facts about the case as possible and for making a judgement about the potential severity and scale of the case and the subsequent investigation required.

This should be done by grading the case according to the likely risks associated and the level of investigation required:

Potential Impact	Risk Grading	Level of investigation
Minimal risk to patients, staff or the company. No one in immediate danger.	Low	Local departmental
Some low level risk. No one in immediate danger.	Medium	Local departmental or divisional
High risk to patients, staff or the company. Potential immediate danger.	High	Divisional or corporate
Patients or staff in immediate danger. Potential reputational damage for the company.	Catastrophic	Corporate

The preliminary investigation may identify the need to involve third parties to provide further information, advice or assistance; for example, the involvement of other members of staff, legal or HR advisors, the police, or other appropriate external body.

Records will be kept of work undertaken and actions take throughout the investigation. The investigating officer(s) will consider how best to report the findings and what (if any) corrective action needs to be taken. This may include some form of disciplinary action or third-party referral.

Within 14 working days of a concern being received, the investigating officer will write to the worker, if known, and in accordance with the communications channel agreed with the worker, who raised the issue:

- Acknowledging that the concern has been raised
- Indicating how it is proposed to deal with the matter
- Where possible, giving an estimate of how long it will take to provide a final response, and
- Whistleblowing Policy
- Telling the individual whether further investigations will take place, and if not, why not

The amount of contact between the investigating officer considering the issue and the person who has raised the issue will depend on the nature of the matters raised, the potential difficulties involved, and the clarity of the information provided. If necessary, further information will be sought from the individual.

When any meeting is arranged with the individual, he or she will be given the right to be accompanied by a trade union or professional association representative or a work colleague who is not involved in the area of work to which the concern relates.

Evolutio accepts that individuals need to be assured that the matter has been properly addressed. Thus, subject to legal or contractual constraints, individuals will receive appropriate information about the outcomes of any investigations.

Raising unfounded or malicious concerns

If an allegation is made but is not confirmed by the investigation, no action will be taken against the individual raising the concern and the Council will endeavour to protect the individual from reprisals or victimisation.

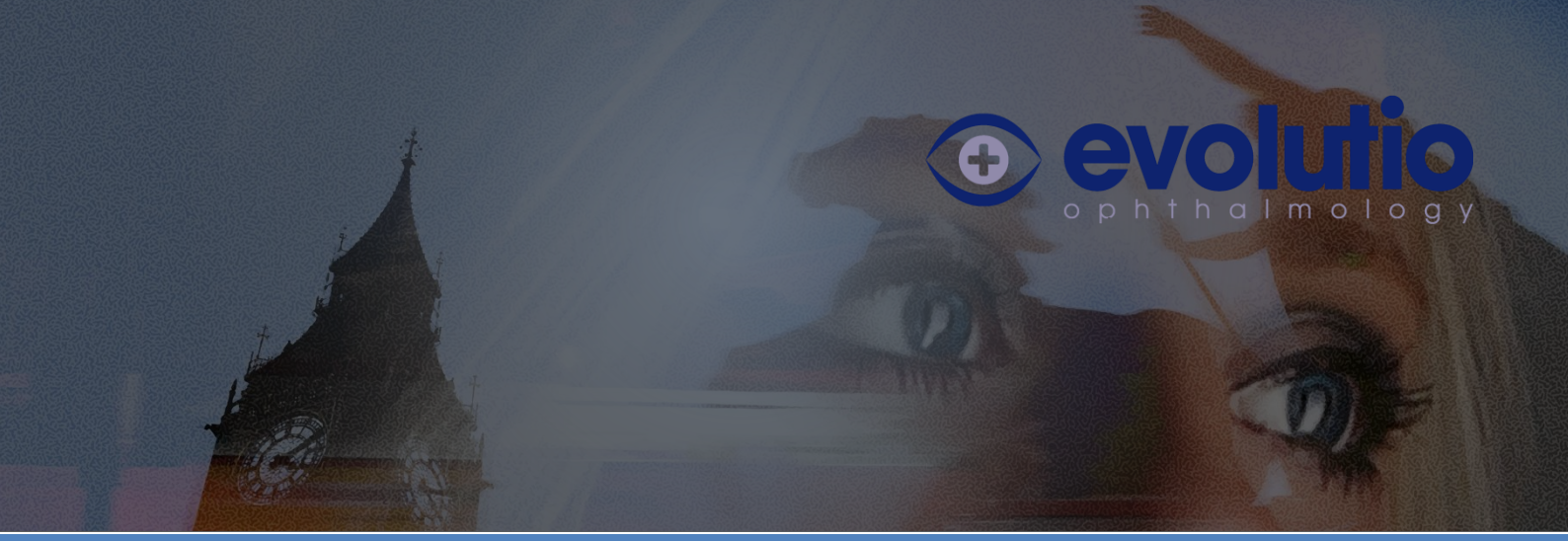
However, if an employee makes an allegation which–through the internal investigation process - is found to be malicious, mischievous or vexatious, or a disclosure made for personal gain, such actions will be considered as disciplinary offences and are likely to result in disciplinary action being taken against the employee.

Whistle blowers making untrue allegations may expose themselves to actions for libel or slander which together make up the civil wrong of defamation. This is a complex area of law. In essence a person puts themselves at risk of being sued for damages if, without justification, they publish or communicate a false statement about someone which may injure his or her reputation in the eyes of ordinary members of society.

Dissatisfaction with a response

This policy is intended to provide individuals with an avenue to raise relevant concerns within the company. If the individual is dissatisfied with the resolution of the matter or has genuine concerns that the matter has not been dealt with appropriately, these concerns should initially be raised with the investigating officer.

Where the concern is of a particularly serious nature, the employee may feel that it is more appropriate to take the matter outside of the company. If you would like independent advice about how to raise serious concerns constructively, then you should contact Public Concern at Work.



1.9 Medical Emergency Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	1.0

Why is it necessary?

At some point, most people will either witness or be involved in an accident or experience a medical emergency. Knowing what to do next and who to call can potentially save lives.

The purpose of this policy is to ensure that where there is a need for staff to respond to any crisis within any of the Evolutio buildings and this response is coordinated and effective as possible.

Examples of this would be where extra staff are required quickly to manage incidents and to provide assistance to maintain a safe environment or to support a life-threatening event for example a cardiopulmonary arrest.

A medical emergency is usually, though not always a life-threatening event for example a cardiopulmonary arrest. Although the action taken will be fundamentally the same, the process will inevitably change slightly depending upon which area of the business the emergency occurs. By definition, a medical emergency is obviously an 'adverse incident'; therefore, an incident form MUST be completed every time the medical emergency procedure is instigated.

Peter Price-Taylor
CEO

First aid

The first aid kit is located behind the reception desk on the first floor along with the first aid book.

When to call an ambulance

Life-threatening emergencies

Call 999 in a medical emergency – when someone is seriously ill or injured and their life is at risk.

Medical emergencies can include:

- Loss of consciousness
- An acute confused state
- Fits that are not stopping
- Persistent, severe chest pain
- Breathing difficulties
- Severe bleeding that cannot be stopped
- Severe allergic reactions
- Severe burns or scalds

Call 999 immediately if you or someone else is having a heart attack or stroke. Every second counts with these conditions. Also call 999 if you think someone has had a major trauma. Major trauma is often the result of a serious road traffic accident, a stabbing, a shooting, a fall from height, or a serious head injury.

Non-life-threatening emergencies

If it is not a life-threatening emergency and you or the person you are with does not need immediate medical attention, please consider other options before dialling 999:

- Self-care at home
- Calling NHS 111
- Talking to a pharmacist
- Visiting or calling your GP
- Going to a local NHS walk-in centre
- Attending an urgent care centre or minor injuries unit
- Making your own way to your local A&E department – arriving in an ambulance does not mean you will be seen any quicker

Choose the best service for your needs, as this will ensure the ambulance service is able to respond to the people who need help the most.

What happens when you call 999?

If it is a genuine emergency, where someone is seriously ill or injured and their life is at risk, call 999 and don't panic.

You can contact emergency services via SMS if you are deaf, hearing impaired or have a speech impediment. Visit the emergency SMS website for more information or to register your phone.

1. Answer the questions

Once you are connected to a call handler, you'll have to answer a series of questions to establish what's wrong, such as:

- Where are you (including the area or postcode)?
- What is the phone number you are calling from?
- Exactly what has happened?

This will allow the operator to determine the most appropriate response as quickly as possible.

Dialling 999 does not necessarily mean an ambulance will be dispatched. The call handler will decide what is appropriate. It may be safe enough for you to be seen elsewhere, or you can be given telephone advice by a medically trained clinical adviser. An ambulance will be sent if it is a life-threatening emergency.

Response units that could be dispatched include:

- An emergency ambulance
- A rapid response vehicle or motorbike
- A cycle response unit
- A community first responder
- A combination of the above

2. Don't hang up yet

Wait for a response from the ambulance control room, as they might have further questions for you, such as:

- What is the age, gender and medical history of the patient?
- Is the person awake or conscious and breathing?
- Is there any serious bleeding or chest pain?
- What is the injury and how did it happen?

The person who handles your call will let you know when they have all the information they need. You might also be instructed on how to give first aid until the ambulance arrives.

How you can assist the ambulance crew

There are a number of things you can do to assist the ambulance service:

- If you are in the street, stay with the patient until help arrives
- Call the ambulance service back if the patient's condition changes
- Call the ambulance service back if your location changes
- If you are calling from home or work, ask someone to open the doors and signal where the ambulance staff are needed
- Lock away family pets
- If you can, write down the patient's GP details and collect any medication they are taking
- If you can, inform the paramedics about any allergies the patient has
- Stay calm

If appropriate, you may want to call the patient's doctor. The doctor may meet you at the A&E department, or call with important information about the patient.

How to provide first aid

If someone is injured in an incident, first check that you and the casualty are not in any danger. If you are, make the situation safe. When it's safe to do so, assess the casualty and dial 999 or 112 for an ambulance (if necessary). You can then carry out basic first aid.

It's important to stay calm and then try get an overview of the situation. See if you can identify what the most serious problem is. The most obvious problem is not always the most serious. Treat the most life-threatening problems, such as lack of breathing, bleeding or shock, first. Check for broken bones and other injuries afterwards.

If a person is unconscious but is breathing and has no other life-threatening conditions, they should be placed in the recovery position. If a person is not breathing normally after an accident, call for an ambulance and start CPR straight away if you can.

Unresponsive and not breathing adult – CPR

If an adult is unresponsive and not breathing, you'll need to do CPR (which is short for cardiopulmonary resuscitation). CPR involves giving someone a combination of chest compressions and rescue breaths to keep their heart and circulation going to try to save their life. If they start breathing normally again, stop CPR and put them in the recovery position.

- To check if someone is unresponsive and not breathing, you need to assess the casualty using the Primary Survey.
- If you find they're unresponsive and not breathing, then you'll need to call 999/112 for emergency medical help.

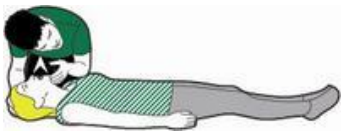
If an adult is unresponsive and not breathing, you'll need to do CPR (which is short for cardiopulmonary resuscitation). CPR involves giving someone a combination of chest compressions and rescue breaths to keep their heart and circulation going to try to save their life. If they start breathing normally again, stop CPR and put them in the recovery position.

- To check if someone is unresponsive and not breathing, you need to assess the casualty using the Primary Survey.
- If you find they're unresponsive and not breathing, then you'll need to call 999/112 for emergency medical help.

Step 1 of 5: Open their airway

- If they are unresponsive, open their airway
- Place one hand on the casualty's forehead and two fingers under their chin. Gently tilt their head back and lift the chin.

Step 2 of 5: Check their breathing



Maintain the head tilt and chin lift and look for chest movement. Listen for the sounds of normal breathing and see if you can feel their breaths on your cheek.

If they are not breathing, you need to start CPR (cardiopulmonary resuscitation – a combination of chest pressure and rescue breaths) straight away.

Step 3 of 5: Call for help and start CPR

Call 999 or 112 for an ambulance or get someone else to do it.

Next, you'll need to perform CPR - cardiopulmonary resuscitation. This involves giving someone chest compressions and rescue breaths to keep their heart and circulation going.

If they start breathing normally again, stop CPR and put them in the recovery position.

Step 4 of 5: How to give a rescues breath

- Ensure the casualty's airway is open.

- Pinch their nose firmly closed.
- Take a deep breath and seal your lips around their mouth.
- Blow into the mouth until the chest rises.
- Remove your mouth and allow the chest to fall.

Repeat once more.
Carry on giving 30 chest compressions followed by two rescue breaths for as long as you can, or until help arrives.
If the casualty starts breathing normally again, stop CPR and put them in the recovery position.

Unresponsive not breathing child

What to look for – Unresponsive and not breathing child

If your child is not responding to you and you think they are unresponsive, ask loudly 'What's happened? or say to them: 'Open your eyes!'. Place one hand on their shoulder and tap gently. If they still do not respond, it's likely that they're unresponsive.

Open their airway and check to see if they are breathing normally by looking for chest movement, listening for the sounds of normal breathing and seeing if you can feel their breaths on your cheek.

If they are not breathing, you need to start CPR (cardiopulmonary resuscitation – a combination of chest compressions and rescue breaths) straight away.

What you need to do – Unresponsive and not breathing child

If someone is with you, get them to call 999 or 112 for emergency help.
If you're on your own, you need to give one minute's worth of CPR – cardiopulmonary resuscitation - before you call for help. This involves giving chest compressions and rescue breaths to keep the child's circulation going.

How to perform CPR on a child

Kneel down beside the child on the floor, level with their chest.

Give five initial rescue breaths before starting the sequence of 30 chest compressions and two rescue breaths.

How to give a rescue breath

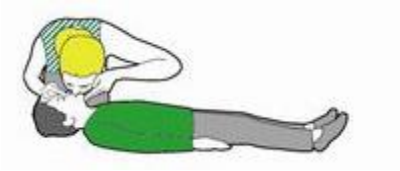
Step 1 of 7

- Ensure the child's airway is open.

Step 2 of 7:

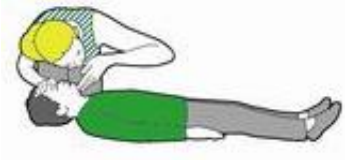
- Pinch their nose firmly closed.

Step 3 of 7:

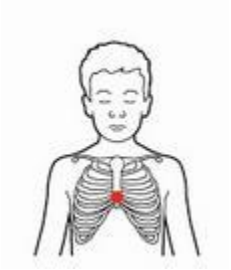


- Take a deep breath and seal your lips around their mouth.
- Blow steadily into the mouth until the chest rises.

Step 4 of 7:



- Remove your mouth and allow the chest to fall
- Repeat this four times more
- Now Give 30 chest compressions



- Place the heel of one hand towards the end of their breastbone, in the centre of their chest, making sure you keep the fingers off the ribs

Step 5 of 7:

- Lean over the child, with your arm straight, pressing down vertically on the breastbone, and press the chest down by at least one-third of its depth
- Release the pressure without removing your hand from their chest. Allow the chest to come back up fully – this is one compression.
- Repeat this 30 times, at a rate of about twice a second or the speed of the song 'Staying Alive'
- Now give two rescue breaths

Step 6 of 7:

- Release the pressure without removing your hand from their chest. Allow the chest to come back up fully – this is one compression.

- Repeat this 30 times, at a rate of about twice a second or the speed of the song 'Staying Alive'
- Now give two rescue breaths

Step 7 of 7:

- Remember to call for emergency help after about a minute if you are on your own
- Carry on giving 30 chest compressions followed by two rescue breaths for as long as you can, or until help arrives. If the child starts breathing normally again, stop CPR and put them in the recovery position.

Emergency first aid

Control of bleeding

1. Apply direct pressure to wound – use your hand(s) (wear gloves)
2. Elevate (raise) the limb
3. Apply a pad and firm bandage
4. If necessary, use clean rags or clothing

Remember

- Always check circulation below the bandage
- If there is tingling, numbness or blueness, loosen the
- Bandage

Poisoning

1. Seek medical advice or call an ambulance

Remember

- Do not make the person vomit without advice from a medical professional
- Do not give fluids without advice from a medical
- Professional

Management of minor wounds

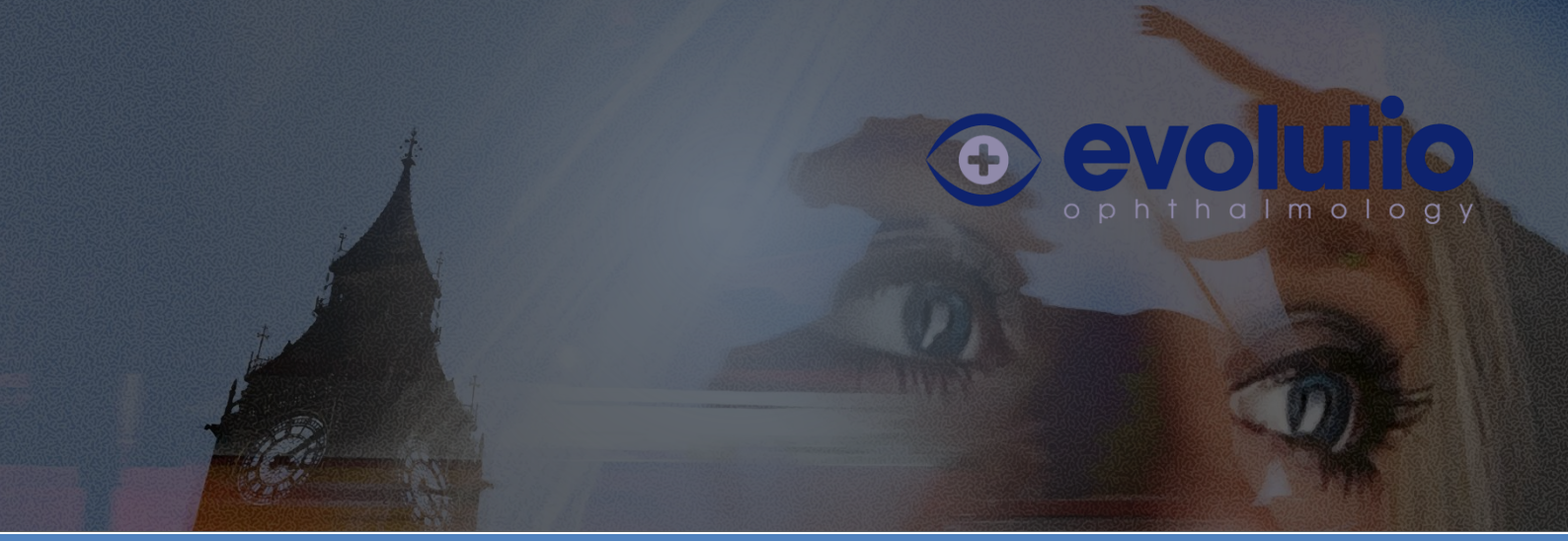
1. Clean the wound with soap and water
2. Cover lightly with clean dressing
3. Seek medical help, if necessary

Management of burns

1. Cool the burnt area with cool water for 10-15 minutes
2. If necessary, cover the burn with a clean dressing or plastic wrap before removing person to medical aid

Remember

- Do not burst blisters
- Do not remove clothing that is stuck
- Do not apply creams



1.9.1 Clinical Emergency Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1TR
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

There are 4 main level of urgency to consider when making HES referrals:

- Emergency – needs action within hours (high risk of imminent blindness/loss of life)
- Rapid access – needs management within a few days
- Urgent – typically seen within a few weeks
- Routine – typically seen with 18 weeks

Service Providers are reminded of their responsibilities under the GOC Standards when managing referrals, particularly emergency and rapid access cases; Standard 7.2 states that you must 'provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care'.

Emergency referrals

A true ophthalmic emergency, if not treated, can cause blindness or loss of life overnight. Symptomatic categorisation (e.g. sudden painless loss of vision) is of limited use when establishing urgency so accurate management does require a measure of diagnosis. The following conditions are highly likely to need an emergency referral to A&E/HES:

- Post ocular trauma / surgery
    - Chemical injury
    - Penetrating eye injury and lid laceration
    - Severe pain or loss of vision within 2 weeks of surgery / intravitreal injection
        - e.g. flat/shallow AC and/or possible infection (e.g. hypopyon)
    - Painful loss of vision after glaucoma surgery or corneal graft surgery at any time

- Systemic
    - Giant cell arteritis (including other causes of a pale swollen disc)
    - Malignant hypertension
    - Retinal emboli in the young (includes new CRAO due to embolus)
    - Dissecting carotid aneurysm
    - Acute 3rd nerve palsy (intracranial aneurysm)

- Ophthalmic
    - Orbital cellulitis
    - Bacterial keratitis
    - Acute angle closure
    - Acute retinal detachment (because needs planning)

- Other signs & symptoms which the RCOphth suggest might need emergency referral:
    - Sudden onset diplopia
    - Sudden painful loss of vision
    - Sudden painless loss of vision (e.g. TIA)
    - Painful loss of vision in contact lens wearer
    - Severe lid swelling with pyrexia
    - Eye pain keeping the patient awake at night

Process

When referrals from primary care pass through Evolutio's triage service, potential emergencies are rejected to the referrer (for reassignment to the HES/A&E) following a robust system. It is therefore unlikely that service providers will receive referrals which require emergency care. Evolutio have a reporting structure to NHS England's Professional Advisory Group (and the Clinical Directors of the various retail chains) for cases of inappropriately managed ophthalmic emergencies.

It is possible that an ophthalmic emergency may be identified during the course of your examination. **Due to the high risk of imminent blindness/loss of life, the majority of these cases will need to attend A&E to be seen immediately. Depending upon the presentation and local protocols, some cases would require a telephone conversation with the duty eye doctor to arrange for the patient to be seen immediately (record doctor's name and advice given).**

1. Complete your clinical record in Evonnect

2. Instruct the patient to attend A&E immediately (or where indicated contact the duty eye doctor). Keep clear notes about how the patient is being managed (name, role and hospital of person you spoke to, their advice to you and your advice to the patient)
3. Hand the patient a printed referral including relevant details from your visit. This will be done by choosing an outcome of 'discharge and refer on' and printing a copy locally. Ensure your visit notes and the referral make it clear how the patient is being managed.
   e.g. Spoke to Dr X on 01/01/2021 13:00 at X HES who asked me to send patient to eye casualty immediately. Given copy of referral to patient.
4. If telemedicine is mandated you will not be able to wait for a response so you will need to 'create new referral' and manage the patient's referral yourself without telemed input; you can accept the telemed outcome in the coming days. Make it clear in your notes to telemed what's happened.
   e.g. Spoke to Dr X on 01/01/2021 13:00 at X HES who asked me to send patient to eye casualty immediately. Given copy of referral to patient. Telemed mandated so sending this on to you to complete the audit trail

   Any duplicate referral which is subsequently generated can be deleted with an explanatory note
   e.g. Px referred directly to A&E on X date with a copy of referral ID xxx. This is a duplicate referral post-telemed so can be deleted

   The print GP Report button will allow you to print a local copy with your visit conclusion if required

Any electronic referrals passing through Evonnect for emergencies can ONLY be for patients who have already received a printed copy of their referral and been sent directly to eye casualty/A&E. The referral MUST be clearly annotated as such.

Rapid access referrals

Rapid Access was introduced during the C19 crisis to arrange access to eye casualty clinics, typically run by a junior doctor in a general ophthalmology clinic. Rapid access cases usually require management within a few days, i.e. some action will be taken immediately at HES.

As with emergency referrals, symptomatic categorisation is of limited use when establishing urgency so accurate management does require a measure of diagnosis. There is some overlap with the College of Optometrists '24 hour emergency' conditions, and, unlike emergency conditions, not all rapid access referrals are HES restricted (e.g. anterior uveitis or potential swollen disc requiring further investigation). The following are examples of conditions which might be suitable for a rapid access referral:

- Acute onset severe pain – includes scleritis
- IOP 40+ without pain
- Vitreous/pre-retinal haemorrhage
- Sudden onset diplopia (if not III palsy)
- Acute dacrocystitis – if severe or in children
- Uveitis
- Hyphaema (in the absence of trauma)
- Hypopyon (in the absence of recent surgery or severe anterior uveitis)
- Pink swollen disc (malignant hypertension is an emergency)

Process

Please note that the following are NOT indications for a rapid access appointments:

- Not being sure of the diagnosis
- Wanting your patient to be seen sooner due to HES backlog
- Patient requires a subspeciality (e.g. OMR) – they are reviewed by eye casualty
- Hospitals which don't offer rapid access pathways (will default to 'urgent' in those cases)

It is possible that a case requiring rapid access referral to HES may be identified during the course of your examination. Depending upon the presentation and local protocols, some cases would require a telephone conversation with the duty eye doctor to arrange for the patient to be seen. Follow local protocols if your HES does not have a rapid access pathway (might have a dedicated email address or phone line):

1. Complete your clinical record in Evonnect
2. Keep clear notes about how the patient is being managed, including, if you speak to someone I the HES, their name, role, hospital, advice and your advice to the patient. This should be reflected in any referral and telemed notes.
3. Choose an outcome of 'discharge and refer on' and send the referral immediately with an action required/urgency of Rapid Access (NB if the hospital does not have a rapid access pathway it will be treated as 'urgent') – include a

note advising the HES to make arrangements to see patient immediately. Remind the patient to contact you again if they haven't heard from the HES within, for example 24-48 hours.

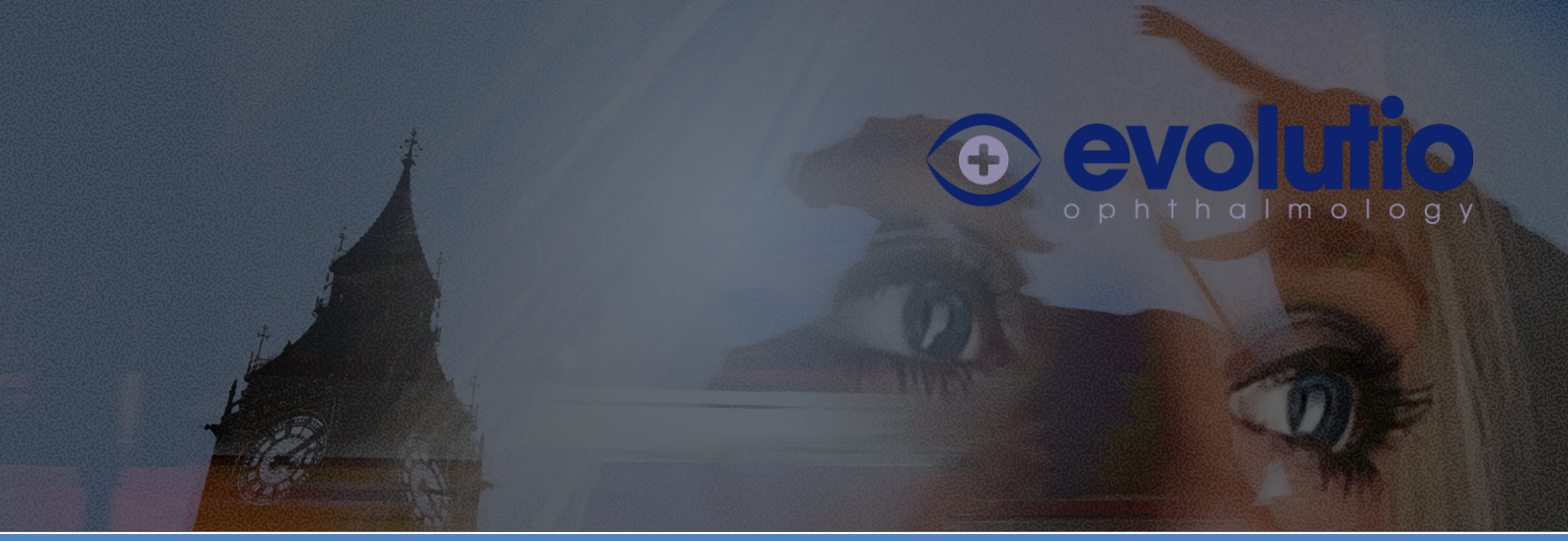
4. If telemedicine is mandated, you should flag it to them as a priority by clicking on 'Rapid access'. As soon as you receive the case back from telemedicine, submit the referral immediately (NB if the hospital does not have a rapid access pathway it will be treated as 'urgent').
5. When the referral is received by Evolutio's triage service it will be processed as a priority case

References

Royal College of Ophthalmologists (Feb 2020): Commissioning Guidance – Emergency Eye Care

College of Optometrists: Guidance for Professional Practice - Annex 4 Urgency of referrals table

General Optical Council: Standards for Optometrists and Dispensing Opticians



1.9.2 Consulting Room Iatrogenic Events - Clinical Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	4.0

Overview

Iatrogenic effects/responses are outcomes inadvertently induced by a physician or surgeon or by medical treatment or diagnostic procedures.

Ophthalmic patients may be exposed to a range of diagnostic drugs, therapeutic medicines, chemicals and allergens. Some of these have the potential to cause harm to susceptible patients. Some potential side effects and actions to take are listed in this policy.

- Service providers must be aware of the indications, cautions, contraindications and side effects of any drugs they instil or supply
- Service providers must tell patients what to do in the event of an adverse incident following instillation of eye drops or supply of a drug
- Service providers should tell a patient to attend the local Accident and Emergency department if they are not available to deal with an emergency or adverse reaction following the instillation of eye drops or supply of a drug
- Service providers should report adverse reactions to medicines or medical devices using the appropriate reporting schemes

Acute angle closure following pharmacological mydriasis

The risk of precipitating acute angle closure after diagnostic pharmacologic mydriasis is very low, approximately 1 in 20,000. The risk of inducing acute glaucoma following mydriasis with tropicamide alone is close to zero.

- Dilation increases the sensitivity of the detection of retinal disease, for example it doubles the sensitivity of detecting diabetic retinopathy. Expert opinion is that the benefits of confirming a diagnosis, and timely delivery of treatment, outweigh the risks, therefore mydriasis should be advised in all patients when thorough retinal examination is indicated.
- The Diabetic Retinal Screening Service do not perform screening tests to assess AAC risk before dilation
- Some patients are at an increased risk of AAC when inducing pharmacological mydriasis, specifically women and those with shallow anterior chambers (measure with Smith's technique, 0.2mm asymmetry is also significant)
- A cause should be sought for a significantly raised pre-dilation IOP before dilating. Patients with anterior chamber lens implants should not be dilated, particularly if the implant is supported by the iris
- Several studies have identified that the risk of precipitating acute angle closure is extremely low, approximately 1 in 20,000.
    - 0.006% - Systematic review of 33 studies (n=600,000)
    - 0.03% - Rotterdam study (n=6,760)
    - 0% - Baltimore survey (n=4,870)
    - 0% - Blue Mountains study (n=3,654)
    - 0.003% - Northern Ireland Diabetic Retinopathy Screening Programme (n=31,755)
  - In patients at an increased risk of acute angle closure (glaucoma, flat anterior chamber, East Asian ancestry)
    - 0% - COAG patients (n=1,000 with COAG)
    - 0.7% - Rotterdam study (n=149 with flat A/C)
    - 0% - Baltimore (n=38 potentially occludable angles on gonioscopy)
    - 0% - Chinese Singaporeans (n=1,232)
    - 0.04% - Malay Singaporeans (n=2,400)
  - Study authors concluded that warning patients to seek immediate treatment if symptoms of acute angle closure develop would be more effective than screening for potentially occludable angles

- Where there is a risk of angle closure, tropicamide 0.5% appears to be the safest mydriatic agent. Pre and post-dilation IOP measurements in narrow angles is advisable.

ACTION:

Patients experiencing AAC should be directed to eye casualty/A&E immediately. Initial management is usually oral or IV acetazolamide (excluding those with known allergies) with topical beta blockers and alpha agonists. Pilocarpine is NOT indicated as an initial treatment because it may hold the pupil in a mid-dilated position (and the high IOP is likely to reduce blood flow to the iris sphincter, hence the iris will be unresponsive).

Toxic corneal epitheliopathy

Some patients exhibit an immediate toxic reaction to topically applied diagnostic drugs in the consulting room; this is sometimes incorrectly labelled as a 'corneal melt'.

ACTION:

Advise patient that they've had a reaction to the drops which sometimes occurs, it is very likely to settle without treatment, but it might be a bit sore for the day.

1. Check monocular VA
2. Establish depth of damage, including fluorescein stain
3. Advise patient to use frequent preservative free tear supplements and issue SOS advice (pain, redness, reduced VA)
4. Review cornea in 24-48 hours if required

Conjunctivitis medicamentosa

Conjunctivitis medicamentosa, a delayed hypersensitivity response to a range or irritants including topical drugs and their preservatives, commonly brimonidine, atropine, neomycin, Bk-Cl, PMN or lanolin.

ACTION:

Advise patient that they're becoming sensitive to the eye drops, possibly the preservatives.

1. Check monocular VA
2. Establish depth of damage, including fluorescein stain
3. Where possible, withdraw the offending medication/preservative (require prescriber's consent)
4. Consider unpreserved alternative where possible
5. Cold compress and unpreserved tear supplements for symptomatic relief
6. Occasionally require a short course of non-penetrating topical steroid

Chemical injury

Chemical injuries are rare in optometric practice but should be logged as an adverse event. The commonest causative agents are:

- Sodium hypochlorite (Milton/disinfectant)
- Hydrogen Peroxide (contact lens solution)
- Ethanol/Alcohol (cleaning wipes)

ACTION:

Hypochlorite is a strong alkaline so has the potential to cause serious ocular injury.

1. Immediate copious irrigation for at least 5 minutes (might require topical anaesthetic to allow adequate irrigation)
2. Following copious irrigation, check monocular VA and extent of injury then refer immediately to eye casualty/A&E

Peroxide and alcohol injuries will usually heal. *Advise patient that they've had a reaction to the procedure so the eye might be sore for the rest of the day.*

1. Irrigation where indicated
2. Check monocular VA
3. Establish extent and depth of damage, including fluorescein stain – in any doubt (or there are signs of limbal ischaemia) refer to A&E/eye casualty
4. Some cases might require a prophylactic short course of topical broad-spectrum antibiotic (e.g. g./oc. Chloramphenicol)
5. Review cornea in 24-48 hours

Corneal abrasion (post GAT/gonioscopy/pachymetry)

Corneal abrasion may be caused by a range of ophthalmic procedures including contact tonometry, gonioscopy and pachymetry. Usually they are small and superficial requiring no treatment. Significant corneal abrasions should be logged as an adverse event.

ACTION:

Advise patient that the procedure has left a small imperfection, which is common, so the eye might be sore for the rest of the day, but it should be healed by tomorrow.

1. Record a careful history outlining how the abrasion occurred
2. Check monocular VA
3. Record size, depth, edge quality and any oedema below the abrasion
4. Consider unpreserved tear supplements/ointment for symptomatic relief, possibly coupled with oral NSAID/painkiller
5. Some cases might require a prophylactic short course of topical broad-spectrum antibiotic (e.g. g./oc. Chloramphenicol) and possibly a cycloplegic to control ciliary spasm
6. Review cornea in 24-48 hours as required

Vasovagal syncope (Faint)

The vasovagal syncope is a common condition which causes a sudden drop in heart rate and blood pressure resulting in reduced blood flow to the brain and a brief loss consciousness. Patients might exhibit jerky/abnormal movements and a slow/weak pulse. Vasovagal syncope is often due to an overreaction to certain triggers, for example:

- Standing for long periods of time
- Heat exposure
- Seeing blood
- Having blood drawn
- Fear of bodily injury (including foreign body removal or contact lens insertion/removal)

Before fainting, patients might experience:

- Feeling warm
- Light-headedness
- Pale skin
- Tunnel vision
- Nausea
- A cold, clammy sweat
- Blurred vision

ACTION:

Patients who think they might faint are at risk of injury so should:

1. Sit on the floor (while you get help)
2. Lie down and elevate legs (keeps blood flowing to the brain)
3. If unable to lie down, sit down with their head between their knees until they feel better
4. Recovery after a vasovagal episode generally begins in less than a minute
5. Wait 15 minutes before standing and get up slowly and gently (risk of another faint)

Patients should be advised to contact their GP for routine tests to rule out more-serious causes of fainting, such as heart disorders.

Anaphylaxis

Anaphylaxis is a severe and potentially life-threatening allergic reaction affecting more than one body system such as the airways, heart, circulation, gut and skin. Symptoms can start within seconds or minutes of exposure to the allergen and usually will progress rapidly.

The common causes of anaphylaxis include:

- Foods
    - Peanuts, tree nuts, sesame seeds, milk, eggs, shellfish, fish, kiwi fruit

- Wasp/bee stings
- Natural latex (rubber)
- Drugs
    - Antibiotics (penicillin and cephalosporin) and nonsteroidal anti-inflammatory drugs (NSAIDs)

The common signs and symptoms:

- Airway
    - Persistent cough
    - Hoarse voice
    - Difficulty swallowing
    - Swollen tongue

- Breathing
    - Difficult/noisy breathing
    - Wheezing (like an asthma attack)

- Consciousness/circulation
    - Feeling lightheaded/faint
    - Clammy skin
    - Confusion
    - Unresponsive/unconscious due to drop in BP

- Other
    - Skin flushing
    - Nettle rash
    - Skin swelling (e.g. lips/face)
    - Abdominal pin/nausea/vomiting

ACTION:

1. Anaphylaxis is potentially life-threatening, and always requires an immediate emergency response – dial 999
2. If a patient has an adrenaline pen, they should use it
3. If a patient has an inhaler, they should use it if their airway is at risk
4. Antihistamines might help in more mild cases

References

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College of Optometrists Clinical Management Guidelines – conjunctivitis medicamentosa

College of Optometrists Clinical Management Guidelines – trauma (chemical)

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British National Formulary

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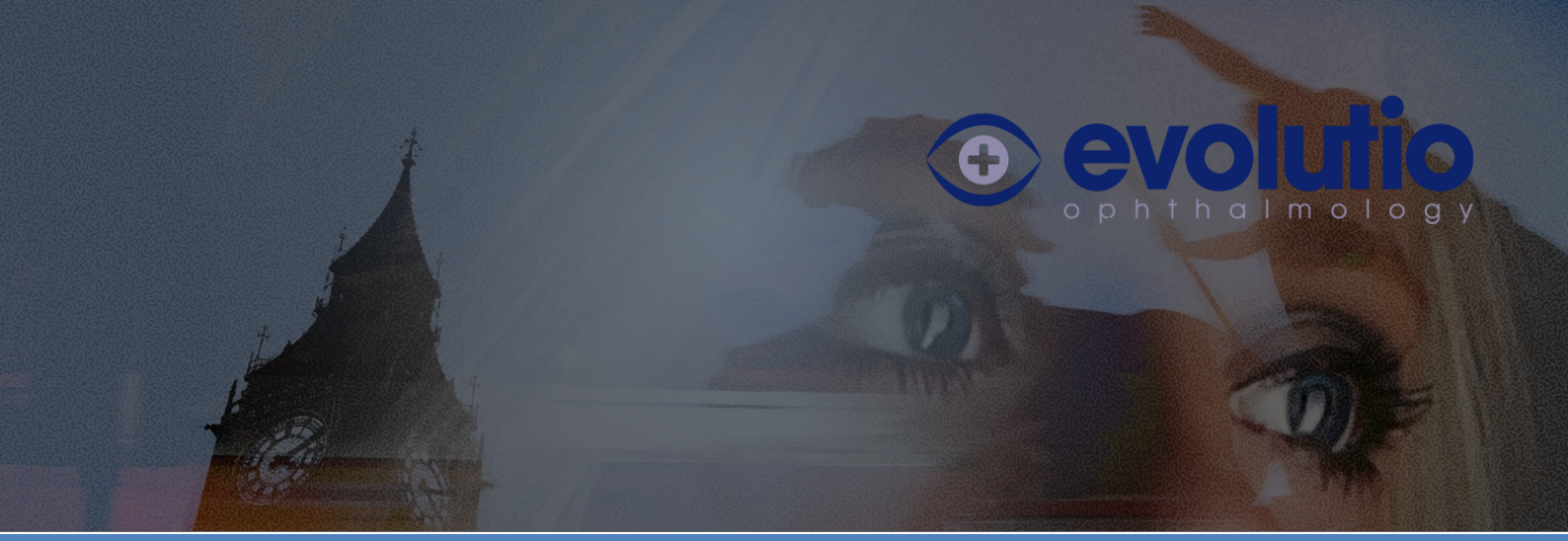


1.10 Code of Conduct Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	4.0

Why is it necessary?

Evolutio recognises its responsibilities as a care provider and NHS sub-contractor and is committed to being a responsible corporate employer, having regard to the NHS code of conduct and UK legislation.

Evolutio believes that it is not only required to abide by the national laws in each country in which it operates, but that it must also conduct its business in accordance with internationally accepted practices and procedures. These core principles, which the board and senior management of Evolutio are committed to upholding, are enshrined in Evolutio's values, and encapsulated in this Corporate Code of Conduct and Ethics Policy.

Evolutio believes that these principles extend to all workers producing or providing products or services for Evolutio, whether or not they are co-workers of Evolutio.

All employees working in the NHS are bound by a legal duty of confidence to protect personal confidential information they may come into contact with during the course of their work. This is not just a requirement under their contractual responsibilities but also a requirement within the common law duty of confidence and the Data Protection Act 1998 and continues to exist after employment has terminated. It is also a requirement within the NHS Care Record Guarantee produced to assure patient regarding the use of their information.

It is important that staff protect personal confidential/sensitive and corporately sensitive information at all times and must therefore ensure that they are aware of and comply with all information governance policies and complete their statutory and mandatory information governance training.

Evolutio expects its contractors, their sub-contractors, principal suppliers and licensees to observe these standards when providing services to Evolutio.

Peter Price-Taylor
CEO

Principles

These principles of conduct set out how the Evolutio expects you to behave when doing your job. We have expanded on some of them in later sections.

- Leading by example - promote this principle by behaving in a way that gives people complete confidence in Evolutio. Uphold the law - you have a responsibility to uphold the law, and to act in line with the Evolutio, the public and patients it serves, places in you.
- Constituency - you have a responsibility to help Evolutio to act in the interests of the whole community that it serves, as far as possible
- Public interest - you must never use your position to make gains for yourself, family, friends or others. This includes financial benefits, preferential treatment or any other advantage.
- Honesty, integrity and propriety - you must not get in a position where your integrity could be questioned by a financial or any other obligation. As well as avoiding actual impropriety, you must be seen to avoid it so that your honesty and integrity is beyond question.
- Gifts and hospitality – the golden rule is that you shouldn't accept gifts or hospitality. Even with the best of intentions, people could think gifts or hospitality might influence, or be intended to influence, your judgement.
- Objective decisions – any decision you make in your job must be made solely on merit, including appointing someone, awarding contracts or recommending people for rewards or benefits
- Accountability - you are accountable for your actions and for your part in making decisions, so you must cooperate with whatever scrutiny is appropriate to your post
- Openness - you must be as open as possible about your actions and your part in reaching decisions and seen to be open so that people are confident there is nothing underhand about your conduct
- Confidentiality - you must make sure that you handle anything confidential, including information about others, in accordance with the law and other relevant Evolutio policies; you must not use it for private purposes
- Evolutio resources - you have a responsibility to make sure that Evolutio uses its resources prudently and in accordance with the law
- Declarations - you have a legal duty to declare any private interests relating to your employment and to resolve any conflicts that may arise
- Relations with colleagues and patients - respect colleagues and patients, treating them with mutual respect at all times

Complying with written guidelines, laws and regulations

- Make sure that you comply with, the laws and regulations relevant to your job which you are aware of or are told about. If in doubt, get advice.
- Make sure that you understand the conditions of service under which you are employed. The details are in the Employee Handbook and outlined in other Evolutio policies and protocols. Ask your manager for clarification about anything you're not clear about.
- You must also comply with corporate guidance and governance protocols, such as clinical regulations and Information Governance, as well as any specific departmental guidelines
- You, together with all employees, have a responsibility to contribute to developing new procedures and to respect them when they are in place
- If you are a member of a professional institute or clinical association, you are also obliged to comply with the professional code and standards of practice relating to that organisation

Bribery Act 2010

Under the Bribery Act 2010, a bribe is a 'financial or other advantage' offered, promised or given to induce a person to perform a relevant function or activity improperly, or to reward them for doing so. The Act makes it a criminal offence to:

- Offer, promise or give a bribe
- Request, agree to receive or accept a bribe
- Bribe a foreign public official to obtain or retain business or a business advantage
- (by an organisation) fail to prevent bribery by those acting on its behalf ('associated persons') to obtain or retain business or a business advantage for the organisation.

Small payments made to government officials or others to make something happen, or happen sooner, (commonly called facilitation payments) are likely to be bribes and unlawful under the Act.

Under the Bribery Act, individuals can be prosecuted for accepting bribes or offering bribes. In addition, the University can be prosecuted for failing to prevent bribery committed to obtain or retain business or a business advantage for the University by an employee or other individual or organisation performing services for the University.

Confidentiality and patient information

In your job you will come across confidential information. You must maintain the privacy and confidentiality of such information at all times, unless you are expressly authorised to divulge it, or are required to do so by law. Please refer to the Information Governance Policy and your line manager if you are unsure.

You must not supply information about another employee's private affairs to anyone without the consent of the employee.

You must Evolutio contracts or purchasing arrangements for personal benefit or to benefit any external function or organisation, unless you get approval from your line manager beforehand.

You must not divulge any business information, for example rates, unit costs, work plans, quality assurance documents and so on to any third party or use it other than for the purpose of furthering the interests of Evolutio.

You must not disclose the proceedings of any committee meeting unless you are legally required, or have been authorised, to do so. If you are obliged to disclose information, you must make sure that it is accurate.

If you have any reservations about any request to supply information, refer it immediately to your line manager.

All staff must ensure that the following principles are adhered to:

- Personal confidential information and corporately confidential information must be effectively protected against improper disclosure when it is received, collected, created, stored, transmitted or disposed of
- Access to personal confidential information or corporately confidential information must be allocated on a need-to-know basis
- Disclosure of personal confidential information or corporately confidential information must be limited to that purpose for which the disclosure is required
- Recipients of disclosed information must respect that it is given to them in confidence and treat it accordingly
- If the decision is taken to disclose information, that decision must be justified and documented
- Where services which need to regularly or routinely share confidential information in order to provide the service must
- Have an information sharing agreement in place, including service user information leaflets and a process to obtain consent for sharing
- Any concerns about disclosure must be discussed with either your Line Manager or the Information Governance Team

The NHS Constitution

The NHS belongs to the people.

It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science

– bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

This Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions. References in this document to the NHS and NHS services include local authority public health services, but references to NHS bodies do not include local authorities. Where there are differences of detail these are explained in the Handbook to the Constitution.

Principles that guide the NHS

The NHS provides a comprehensive service, available to all

1. Access to NHS services is based on clinical need, not an individual's ability to pay
2. The NHS aspires to the highest standards of excellence and professionalism
3. The patient will be at the heart of everything the NHS does
4. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
5. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources
6. The NHS is accountable to the public, communities and patients that it serves

NHS Values

- Working together for patients.
- Respect and dignity.
- Commitment to quality of care.
- Compassion
- Improving lives.
- Everyone counts.

Treating confidential information with respect

Everyone using health and social care services in England is entitled to expect that information they entrust to care providers will be treated in strictest confidence. The promise of confidentiality has been a cornerstone of medical practice for centuries and the relationship of trust between a doctor and patient depends on it. The patient needs to be able to tell the truth about intimate matters, knowing that this information will not be improperly disclosed. This is equally important in social care, for example when a social worker is making arrangements for an individual's care and wellbeing.

People using services deserve a lot more than just information security. Individuals need the teams of professionals who are responsible for their care to share information reliably and effectively. Confidential information about an individual must not leak outside the care team, but it must be shared within it in order to provide a seamless, integrated service.

What are the confidentiality rules?

Rule 1

Confidential information about service users or patients should be treated confidentially and respectfully.

Rule 2

Members of a care team should share confidential information when it is needed for the safe and effective care of an individual.

Rule 3

Information that is shared for the benefit of the community should be anonymised.

Rule 4

An individual's right to object to the sharing of confidential information about them should be respected.

Rule 5

Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed

For more information on treating confidential information with respect, visit the *digital.nhs.uk* website or download a copy from the intranet.

Disclosing confidential information

To ensure that information is only shared with the appropriate people and in appropriate circumstances, care must be taken to check those people have a legal basis for access to the information before releasing it.

It is important to consider how much confidential information is needed before disclosing it and only the minimal amount necessary is disclosed.

Information can be disclosed:

- When effectively anonymised
- When the information is required by law or under a court order. In this situation staff must discuss with their Line Manager and obtain approval of the Caldicott Guardian
- In identifiable form, when it is required for a specific purpose, with the individual's written consent or with support under the Health Service (Control of patient information) regulations 2002, obtained via application to the Confidentiality Advisory Group (CAG) within the Health Research Authority1.
- In Vulnerable Adults and Child Protection proceedings if it is considered that the information required is in the public or child's interest. In this situation staff must discuss with their Line Manager and obtain approval of the Caldicott Guardian.
- Where disclosure can be justified for another purpose, this is usually for the protection of the public and is likely to be in relation to the prevention and detection of serious crime. In this situation staff must discuss with their Line Manager and obtain approval of the Caldicott Guardian.

Care Record Guarantee

The NHS Care Record Guarantee for England sets out the rules that govern how patient information is used in the NHS and what control the patient can have over this. The Guarantee was first published in 2005 and was reviewed annually by the NIGB. The Social Care Record Guarantee - published in 2009 - explains to service users how the information they provide to social care staff is used and what control they can have over this. It complements the NHS Care Record Guarantee for England.

It includes information on:

- Your access to your own records their content and security
- How NHS Staff access will be monitored and what controls are in place to prevent unauthorised access
- Options you have to limit further access by NHS or contracted Staff
- What happens if you are unable to make decisions for yourself

Confidentiality dos and don'ts

Dos

- Do safeguard the confidentiality of all personal confidential information or corporately confidential information that you come into contact with. This is a statutory obligation on everyone working on or behalf of NHS.
- Do clear your desk at the end of each day, keeping all portable records containing personal confidential information or corporately confidential information in recognised filing and storage places that are locked at times when access is not directly controlled or supervised
- Do switch off computers with access to personal confidential information or corporately confidential information, or put them into a password protected mode, if you leave your desk for any length of time

- Do ensure that you cannot be overheard when discussing confidential matters
- Do challenge and verify where necessary the identity of any person who is making a request for personal confidential information or corporately confidential information and ensure they have authorisation to access, and a legitimate need to know the information
- Do share only the minimum information necessary
- Do transfer personal confidential information or corporately confidential information securely, i.e. use an nhs.net email account to send confidential information to another nhs.net email account or to a secure government domain e.g. gsi.gov.uk
- Do seek advice if you need to share personal confidential information without the consent of the patient/identifiable person's consent and record the decision and any action taken
- Do report any actual or suspected breaches of confidentiality
- Do complete statutory and mandatory training and other training as appropriate

Don'ts

- Don't share passwords or smart cards or leave them lying around for others to see or use
- Don't share information without the consent of the person to which the information relates, unless there are statutory grounds to do so
- Don't use personal confidential or corporately confidential information unless absolutely necessary, anonymise the information where possible
- Don't collect, hold or process more information than you need, and do not keep it for longer than necessary
- Don't attempt to obtain access to personal confidential information or corporately confidential information unless you have a legitimate reason to do so

NHS Code of Practice

The guidelines contained in the Code of Practice draw on advice and published guidance available from UK Government security authorities, the British Standards Institute, the Information Security Forum, and from best information security management practices followed by a wide range of organisations in the Government, public and private sectors.

The guidelines provide a framework for consistent and effective information security management that is both risk and standards-based and is fully integrated with other key NHS Information Governance areas.

Evolutio need robust information security management arrangements for the protection of our patient records and key information services, to meet the statutory requirements set out within the Data Protection Act 1998 and to satisfy their obligations under the Civil Contingencies Act 2004.

The Caldicott Guardian Principles

The Principles were devised by the Caldicott Committee, which reported in 1997 following a review of patient-identifiable information. They represent best practice for using and sharing identifiable personal information and should be applied whenever a disclosure of personal information is being considered.

Principle 1: Justify the purpose for using the information
Principle 2: Only use identifiable information if absolutely necessary
Principle 3: Use the minimum that is required
Principle 4: Access should be on a strict need to know basis
Principle 5: Everyone must understand their responsibilities
Principle 6: Understand and comply with the law

Offers of gifts, hospitality, or sponsorship

Evolutio employees should exercise caution concerning the acceptance of gifts or hospitality from external suppliers and contractors; and any involvement in sponsorship events, or endorsement of a product or service, where there may be a conflict of interest.

Employees must be aware that it is a criminal offence for them corruptly to receive any gift, loan, fee, reward or advantage for doing, or not doing anything, or showing favour, or disfavour, to any person in their official capacity. The acceptance of gifts and hospitality (including sponsorship of a local government activity) must be treated with extreme caution.

The receipt of minor articles, for example, diaries and calendars will not be regarded as the acceptance of a gift, although employees should not accept significant personal gifts from contractors and outside suppliers. Offers of hospitality should be accepted only if there is a genuine need to impart information or represent Evolutio.

All gifts and hospitality should be properly recorded. In particular any offer over the value of £25 should be recorded and can only be accepted if agreed by your line manager. Where an employee receives a series of gifts or hospitality from the same person or organisation in one year with a cumulative value of £100 or over, must be registered.

No employee should continue to accept gifts or hospitality after the cumulative value of items reached in a single financial year reaches £200 or more. Managers should ensure that all of their staff are aware of the arrangements.

Where the Evolutio wishes to sponsor an event, no employee must benefit in a direct way without their full disclosure to an appropriate manager of any such interest.

Outside interests

Your life away from work is your own concern but you must not put yourself in a position where your job and your personal interests conflict. This includes behaviour which, because of the nature of your employment, would undermine the organisation's confidence or trust in you.

An example would be if you are facing criminal charges, regardless of whether these were incurred on or off duty. You must tell your manager immediately if the charges are in any way relevant to your employment, such as drug offences, crimes of violence, dishonesty or driving offences if your job involves the use of a car or Evolutio vehicle. If you are in any doubt about this, consult your line manager.

Additional employment

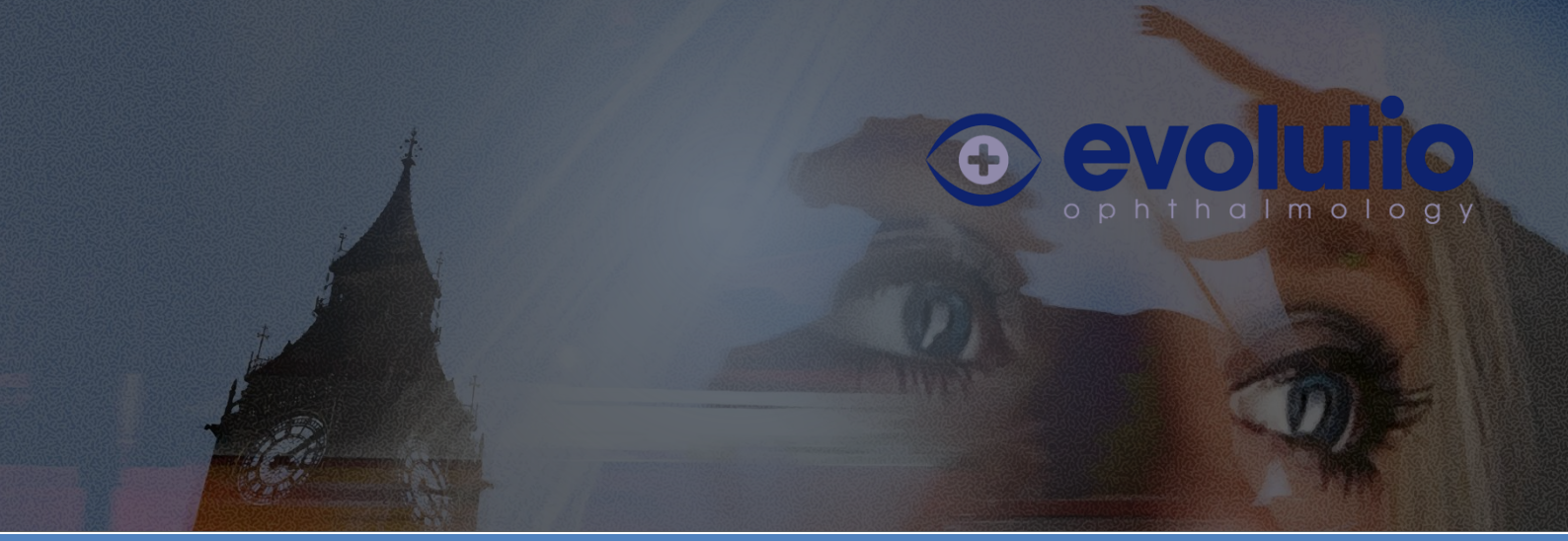
Evolutio will not stop you taking additional employment as long as it does not affect your duties and responsibilities or conflict with the interests of, or weaken, public or patient confidence in Evolutio.

If you are thinking of taking on additional work, you must get permission from your manager beforehand and we will maintain a record of approval. This conduct rule applies to any employment, paid or unpaid, for example taking up office in an outside organisation. This would include charities such as local community associations.

If you are paid for work which arises principally as a result of your work-related skills, you must not use assets or information belonging to Evolutio, without getting prior permission from your line manager.

You must also make sure that any customer realises the private nature of the work you are doing, which is in no way connected to the business of Evolutio.

You must declare any income received to Inland Revenue, but you do not have to inform Payroll as well.



1.11

Equality & Diversity Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	3.0

Why is it necessary?

We believe in providing equity in its services, in treating people fairly with respect and dignity and in valuing diversity both as a health services provider and as an employer.

Our equality and diversity aims are to:

- Provide the best possible healthcare services we can that are accessible and are delivered in a way that respects the differing needs of the individual
- Employ staff who are motivated because they feel valued for the contributions they make and the diversity they bring, who are well trained and who reflect at all levels the diversity of the population we service
- Embed our equality and diversity values into our policies and procedures and our everyday practice
- Regularly monitor and report on our Equality Objectives, on patient and workforce information and on Equality Impact Assessments to evaluate how we are doing and to set goals and actions in response
- Ensure that all services providers working for us understand and support our commitment to promoting equality and diversity in everything we do

Peter Price-Taylor
CEO

Executive summary

We aim to promote equal opportunities, eliminate discrimination and eliminate harassment through the following:

- Opposing all forms of unlawful and unfair discrimination
- All employees and patients will be treated fairly and with respect
- Employment will be open to all
- Access to services will be open to all
- All vacancies will be advertised internally and externally simultaneously and will include a statement on equal opportunities
- Selection for employment, promotion, training or any other benefit will be on the basis of aptitude and ability. All selection/rejection decisions will be recorded.
- All employees will be helped and encouraged to develop their full potential and the talents and resources of individuals will be fully utilised to maximise the efficiency of the organisation
- All employees have a legal and moral obligation not to discriminate and to report incidents of discrimination against any individual or group of individuals to the Operations Manager

Our commitment

- Creating an organisation that actively promotes equality of opportunity for all and ensuring that no- one receives less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race (including nationality or culture), religion or belief, sexual orientation, caring responsibilities in any aspect of their employment
- Creating a workplace in which people feel valued; treating people fairly and with dignity and respect at all stages of the employment process from recruitment to termination of employment
- Embedding values and behaviours that highlight treating others as we would wish to be treated ourselves
- Evolutio is opposed to all forms of unlawful and unfair discrimination and victimisation. We expect its staff to treat each other and all patients, visitors and service users with dignity and respect, in a non-discriminatory manner and in accordance with their individual needs.

The successful implementation of this policy depends on the awareness and commitment of all staff. Hence, all new staff will be made aware of its existence and on joining the organisation and reminded they must conform to it on a regular basis.

Responsibilities

All staff have a responsibility to guard against any form of discrimination and avoid any action which goes against the spirit of this policy. Thus, staff at all levels must ensure that there is no discrimination in any of their decisions or behaviour. This includes the provision that all staff must:

- Report any suspected discriminatory acts or practices
- Not induce or attempt to induce others to practice unlawful discrimination
- Co-operate with any measures introduced to ensure equality of opportunity
- Not victimise anyone as a result of them having complained about, reported or provided evidence of discrimination
- Not harass, abuse or intimidate others

However, whilst all staff have a collective responsibility to ensure this policy is successfully implemented, there are also specific responsibilities within this.

The Board

1. Provide leadership on the equality and diversity strategy and policy, acting as overall champions to ensure the policy is implemented
2. Communicate the strategy and policy, internally and externally
3. Manage Strategic engagement with and be accountable to company employees and the public

Employees

1. Develop an understanding of the Equal Opportunity Policy objectives for both employment and service delivery. This should be done with managers and colleagues to establish what it means for each individual employee.
2. Treat each other fairly in accordance with the policy and standards
3. Tell colleague(s) where their conduct is causing offence to them or another colleague
4. Provide support to an individual receiving less favourable treatment and, if necessary, inform another member of staff who is able to take the appropriate action.
5. Act in ways that are in accordance with this policy and with our values
6. Act fairly and compassionately
7. Treat other people as individuals responding to their needs
8. Respect others' privacy and dignity
9. Ensure they do not discriminate, harass or intimidate others or encourage other people to do so
10. Use communication methods that other people understand when carrying out duties
11. Take account of their own behaviour and its effects on others
12. Undertake relevant equality and diversity training
13. Inform their manager if they become aware of any behaviour that undermines equality and diversity

Managers

1. Ensure that all their employees are aware of the policy objectives and standards and understand how to apply them day to day
2. Ensure that these are discussed as part of the induction process
3. Ensure that all employees have the opportunity to improve their job skills and develop skills to meet the wider needs of the service or organisation
4. Ensure that all personnel procedures are carried out in accordance with the policy and standards
5. Take action when standards of conduct and behaviour do not comply with the policy
6. Take prompt action to stop discriminatory treatment as soon as it is identified. This will include using the disciplinary procedure where an employee knowingly commits a discriminatory act, induces others to commit such an act or victimises those who have complained of harassment.
7. Before acting, consider the most appropriate way. Challenge behaviour in a sensitive way proportionate to the nature of the conduct identified.

Discrimination

Discrimination may take seven main forms and is defined in law along with the protective characteristics associated with each provision as listed below:

Direct discrimination

Occurs when someone is treated less favourably than another person because of a protected characteristic. Relevant protected characteristics include age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage & civil partnership, pregnancy and maternity. For example, a manager does not select a pregnant woman for promotion even though they meet all of the competencies because they are pregnant. This is probably direct discrimination and cannot be justified.

Associative discrimination

Occurs when someone discriminates against someone because they associate with another person who possesses a protected characteristic. Relevant protected characteristics include age, disability, gender reassignment, race, religion or belief, sex, sexual orientation. An example of this is when a manager does not give a job-applicant the role, even though they have met all of the competencies for the role, just because the applicant tells the employer they have a disabled partner. This is probably associative discrimination because of disability by association.

Discrimination by perception

Occurs when someone discriminates against an individual because they think they possess a particular protected characteristic. It applies even if the person does not actually possess that characteristic. Relevant protected characteristics include age, disability, gender reassignment, race, religion or belief, sex, sexual orientation. An example of this is when a manager selects a person for redundancy because they incorrectly think they have a progressive

condition (i.e. that they are a disabled person). This is probably discrimination by perception because they believe the individual is disabled.

Indirect discrimination

Occurs when a seemingly neutral provision, criterion or practice that applies to everyone places a group who share a characteristic e.g. type of disability at a particular disadvantage. Indirect discrimination may be justified if it can be shown that the provision, criterion or practice is a proportionate means of achieving a legitimate aim. An example of this is when an employer decides to apply a "no hats or headgear" rule to staff. If this rule is applied in exactly the same way to every member of staff, then staff who may cover their heads as part of their religion or cultural background (such as Sikhs, Jews, Muslims and Rastafarians) will not be able to meet this requirement of the dress code and may face disciplinary action as a result. Unless the employer can objectively justify using the rule, this will be indirect discrimination. Relevant protected characteristics include age, marriage and civil partnership, race, religion or belief, sex and sexual orientation. In addition, the Act extends protection against unjustified indirect discrimination to gender reassignment and disability.

Dual discrimination

Occurs when someone is treated less favourably because of a combination of two relevant protected characteristics. This means that it will be possible for an applicant to claim that they have been treated less favourably not just because of their race but also because of their gender. For example, because the individual is an Asian woman. Relevant protected characteristic include age, disability, gender reassignment, race, religion or belief, sex and sexual orientation. (At present this new concept has not been implemented).

Detriment arising from a disability

Arises when you treat a disabled person unfavourably because of something connected with their disability. This type of discrimination is unlawful where the employer or other person acting for the employer knows, or could reasonably expected to know, that the person had a disability. This type of discrimination is only lawful if the action can be justified and the employer can show that is a proportionate means of achieving a legitimate aim. An example of this when an employer imposes a "no beards" rule as a part of a dress code and tells staff they will be disciplined if they do not comply. The employee is a disabled person who has a skin condition which makes shaving very painful. They have been treated unfavourably (threat of disciplinary action) because of something arising from their disability (their inability to shave). Unless the employer can objectively justify the requirement, this may be a detriment arising from a disability. It may also be a failure to make a reasonable adjustment.

Victimisation

Occurs when an employer is treated unfavourably, disadvantaged or subjected to a detriment because they have made or supported a complaint of discrimination or raised a grievance under the Equality Act, this policy or the Harassment, Bullying and Discrimination policy or because they are suspected of doing so. (However, an employee is not protected from victimisation if they have maliciously made or supported an untrue complaint). An example, of this is when an employee requests to work flexibly and their manager refuses their request because they supported a colleague in a complaint of discrimination.

Third party harassment

Occurs when an employee is harassed by someone who does not work for the employing organisation such as a customer, visitors, client, contractor or visitors from another organisation. The employer will become legally responsible if they know an employee has been harassed on two or more occasions by someone and it may also be different individuals each time and fails to take reasonable steps to protect the employee from further harassment.

Complaints of discrimination

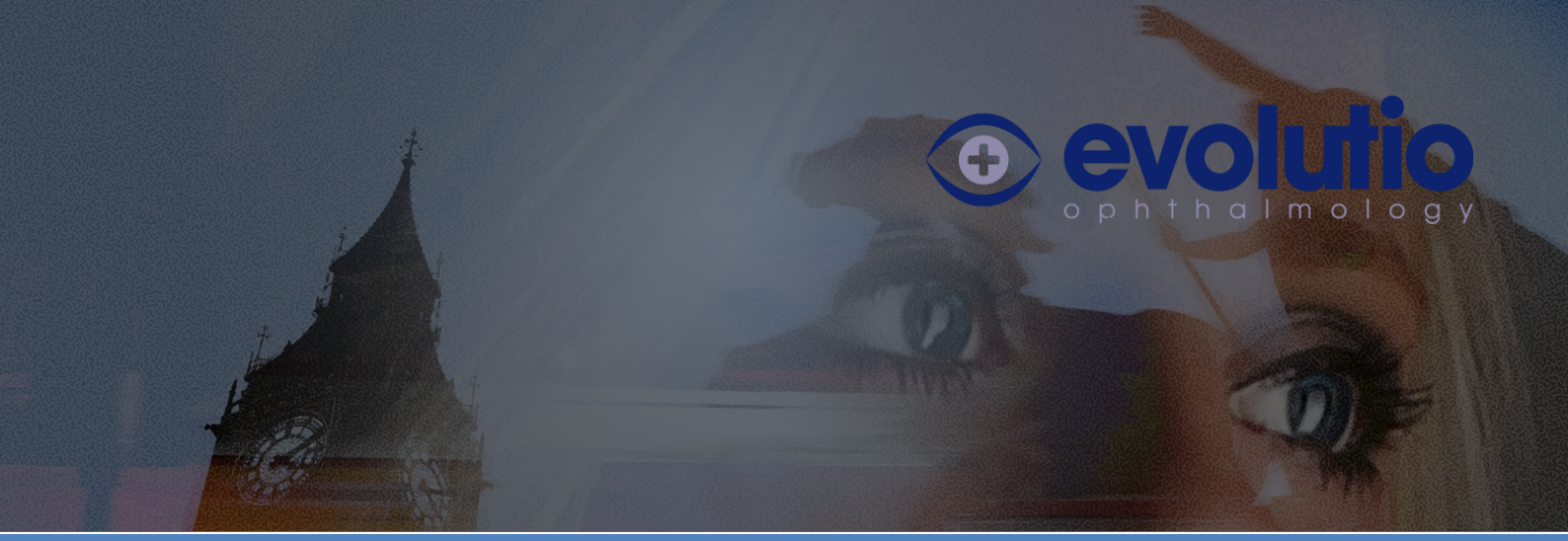
Evolutio takes all claims of discrimination very seriously and will take appropriate action against those concerned. Discrimination occurs when someone directly or indirectly treats a person or a group of people unfavourably because of a protected characteristic of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. This covers all behaviour including remarks and insinuation, both verbal and non-verbal, which cause offence.

Any member of staff or service user who is subject to harassment, bullying or discrimination is encouraged to refer to Evolutio's policy on Harassment, Bullying and Discrimination. This provides details of the steps that can be taken to deal with such an issue. In addition, staff are reminded that they can obtain external, confidential help if they so wish.
If a worker (engaged through, or by, an employment agency or bureau) considers they have been discriminated against they should raise their complaint directly with their employer.

Any member of public that feels they have been discriminated against should raise their concerns via Evolutio's Complaints Policy.

This policy should be read in conjunction with the:

- Recruitment and Selection Policy and Procedure
- Retirement Policy
- Flexible Working Policy and Procedure
- Maternity, Adoption and Maternity Support (Paternity) Leave Policy and Procedure
- Managing Sickness Absence Policies
- Whistleblowing Procedure
- Patient Privacy and Dignity Policy



1.12 Health & Safety Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	3.0

Introduction

Evolutio Care Innovations Ltd. recognises and accepts its legal responsibilities to provide a safe and healthy work and social space for all its members, employees and visitors to its premises. Evolutio will take all steps within its power to meet this responsibility and will ensure no person is exposed to health and safety hazards so far as is reasonably practicable. It will provide adequate resources to meet the requirements of the Health and Safety at Work etc. Act 1974 and to its specific regulations for all its activities.

Evolutio requires management at all levels to display a positive attitude and commitment to health and safety and to ensure compliance with the Health and Safety Policy within their areas of authority. Managers have a responsibility to consider the health and safety implications of their decisions and to ensure that appropriate resources are allocated.

Our statement of general policy is:

- Provide and maintain safe working environments without risk to health and safety
- Set standards that comply with all relevant statutory requirements relating to health, safety and the environment with regard to their effect on employees, customers, contractors and the public
- Safeguard employees and others from foreseeable hazards with regard to health, safety or the environment in existing processes and working systems
- Ensure that when new substances, plant, machinery, equipment, processes or premises are introduced, adequate guidance, instruction and supervision will be provided for safe methods of work to be developed
- Ensure all employees are aware of their own responsibilities in respect of relevant health, safety and environmental matters
- Aim to achieve the commitment and active involvement of all staff, in order that safety awareness and positive attitudes are fostered and continuous efforts made to improve safety performance
- Ensure that contractors carrying out work are informed of relevant standards; are trained in procedures as necessary; and that systems are established for monitoring compliance, without detracting from the contractor's legal responsibilities, to ensure that requirements are met
- Promote good health and be concerned with the prevention of occupational and non-occupational disorders and diseases using health counselling and health education
- Co-operate with appropriate authorities and technical organisations, both to ensure that policies are updated and to contribute to the formulation of standards and means of compliance
- Retain, and review as necessary, existing

Peter Price-Taylor
CEO

The policy

In accordance with our health and safety duties, we are responsible for:

- Assessing risks to health and safety and identifying ways to overcome them
- Providing and maintaining a healthy and safe place to work and study and a safe means of entering and leaving our premises, including emergency procedures for use when needed
- Providing information, instruction, training and supervision in safe working methods and procedures as well as working areas and equipment that are safe and without risks to health.
- Ensuring that equipment has all necessary safety devices installed, that equipment is properly maintained and that appropriate protective clothing is provided
- Promoting co-operation between members of staff to ensure safe and healthy conditions and systems of work by discussion and effective joint consultation
- Regularly monitoring and reviewing the management of health and safety, and thereafter making any necessary changes and bringing those to the attention of all staff and students, as appropriate

Personnel

The Board of Directors has overall responsibility for health and safety and the operation of this policy and have nominated the CEO to have day-to-day responsibility for health and safety matters.

The CEO is responsible for:

- The implementation of this policy statement and keeping it under review
- Safety inspections
- Ensuring that legal requirements are met, for example notifying any accidents reportable under RIDDOR; and
- Ensuring that any necessary health and safety risk assessments are undertaken regularly, and any recommendations are recorded and implemented.

All members of staff have a duty to look after their own and others' health and safety.

All employees have a responsibility to:

- Take reasonable care of their own health and safety and that of others who may be affected by what they do or do not do
- Co-operate with the Trust on Health and Safety issues
- Not interfere with or misuse anything provided for their or other's health, safety or welfare
- Use any equipment, Personnel Protection Equipment (PPE), and procedures provided by the company, take reasonable care of it and to report any accidents, defects, damage, unsafe acts or conditions, near misses, or loss as soon as reasonably possible
- Be aware that wilfully or intentionally interfering with or misusing equipment, procedures or safe systems of work will be subject to disciplinary action
- Ensure they report immediately any ill health, stress or other medical condition which may be work related or affect their ability to work safely
- Ensure they attend any Health and Safety induction, or training courses provided for them

As such it is the responsibility of members of staff to ensure that the CEO is informed of any hazards present in the workplace. In practice, this means 'if you see something which you consider to be a hazard' report it. Do NOT assume that someone else will. These reports should be confirmed in writing.

There are several Acts of Parliament covering safety in the workplace including the Health and Safety at Work Act 1974 (HAS), and the regulations under that Act, in particular the Management of Health and Safety at Work Regulations 1999 and the Control of Substances Hazardous to Health Act 2002 (COSHH).

Health and Safety law requires the employer to assess the risks to health and safety. This does not mean that a separate written risk assessment is required for every activity as long the business has undertaken a common sense and proportionate approach.

In practice

A clean and orderly environment is essential for staff of the business. Staff have a particular responsibility for ensuring that the working environment is neat and tidy in order that cleaning staff may undertake their duties. It is not the duty of the cleaning staff to tidy up the personal belongings staff.

Periodic checks of the contents and layout of the office should be made by the CEO and other board members. Defective equipment, fittings and furniture should be reported immediately to the CEO.

Key guidelines:

- Make sure that all doors are unlocked daily, and that all doors including fire doors are easy to open and free from obstruction
- Ensure that free-standing furniture is not placed in such a position that it can be pushed over
- Avoid storing heavy equipment, materials etc. on top of tall cupboards and high shelves
- Ensure that all floor areas are kept clear of obstructions other than furniture so that cleaning staff are able to work safely and efficiently
- Make sure that all furniture is in a good state of repair. Take out of use, and report as necessary, any defective item of furniture or equipment
- Keep all sinks and wash basins free from obstruction so that they can be kept clean and hygienic
- As far as practicable, keep working surfaces clear so that cleaners can wipe down as necessary
- Report any insecure wall-mounted units
- Make sure that light sockets are not left without a bulb, to avoid the possibility of electric shock
- Do not leave electric power cables, leads etc. trailing across the floor
- Switch off and un-plug electrical equipment after use
- Edged or pointed tools (such as scissors, knives) should be regularly checked for damage and stored safely
- Aerosol containers should be kept in a safe, cool place to which they should be returned after use. They should never be left in direct sunlight
- Hazardous, toxic or flammable materials (bleaches, polishes, paint etc.) should also be stored securely

All staff (whether temporary or permanent) will receive adequate training in health and safety to ensure that all staff are competent to undertake their work safely and efficiently. The CEO will ensure that all new staff receive this training.

Accidents or injury

In the event of an accident or medical emergency contact a member the CEO or COO.

IF NEITHER IS AVAILABLE then the member of staff on duty should continue to deal with problem as follows:

1. Seek medical advice directly, either
   (i) By ringing 111 (NHS Direct).

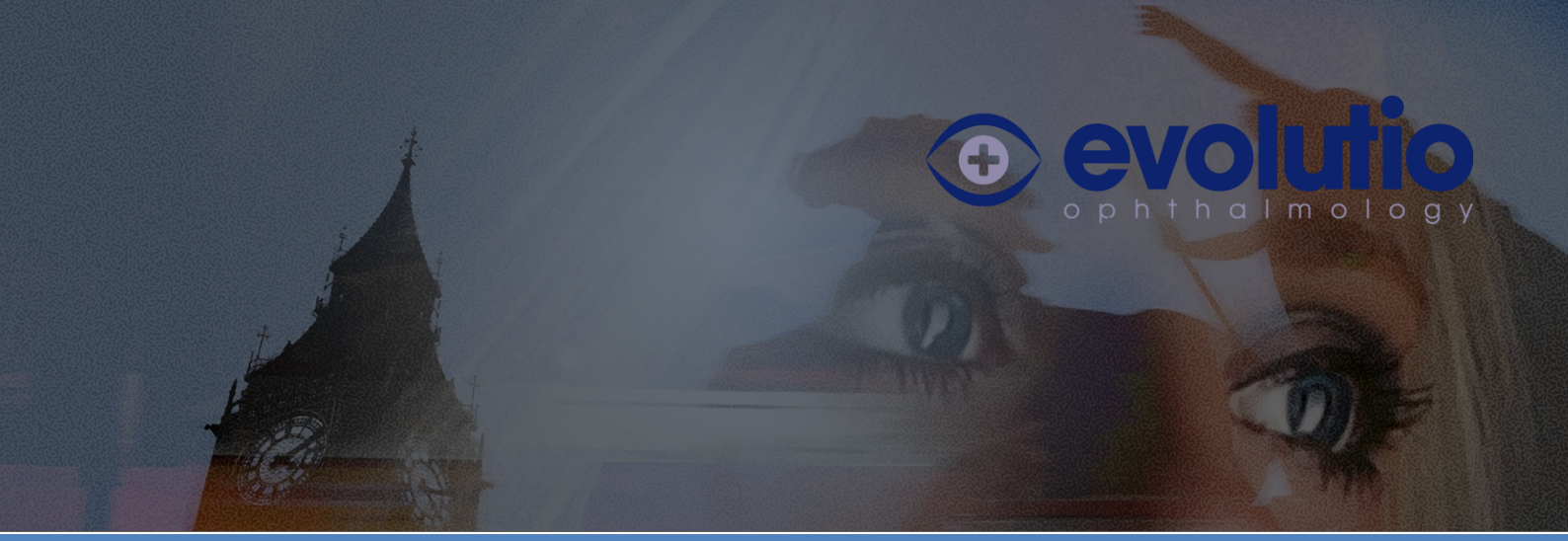
   (ii) In extreme cases, by dialling 999 to call an ambulance.

At this stage inform the CEO of the incident.

(iii) If a member of staff is taken to hospital by ambulance another member of staff MUST accompany them, either in the ambulance or following in their own car. Next of kin must be informed. Details can be found in the employees file held by the CEO or COO.

(iv) If treatment is given in casualty and the member of staff is discharged, ensure that full instructions are obtained about follow-up treatment (eg further appointment).

(v) Write a full account of the incident and all subsequent treatment and send to the CEO and COO.



1.13
Lone Worker Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	3.0

Why is it necessary?

Evolutio has a duty to ensure, as far as is reasonably practicable, the health, safety and welfare of its staff and others who may be affected by the work of organisation.

Under health and safety legislation (see section 4), employers have a legal duty to ensure, so far as is reasonably practicable, the health, safety and welfare at work of their employees.

Evolutio acknowledges that there may be an increased risk to the health and safety of its employees, clinicians and third parties when working alone and is committed to making adequate provision for the health and safety of lone workers.

The key requirement of responsible persons is to carry out a risk assessment to identify risks to lone workers and to ensure that control measures are implemented to minimise the risks wherever practicable. These requirements are applicable to all work situations/activities and in particular where staff, patients and visitors are working alone or outside normal working hours.

This policy gives information about lone working risks, sets out the responsibilities of Evolutio and others for the managing the safety of lone workers and gives guidance on the lone working risk assessment process.

Peter Price-Taylor
CEO

Lone workers

The HSE defines lone workers as those who 'work by themselves without close or direct supervision'. In this the term 'lone workers' means any person meeting the HSE's definition who are working or practicing on behalf of Evolutio, whether they are working in a clinic or at Head Office. Third parties (not patients or employees) working at a clinic or at Head Office may also be lone workers.

Lone working can take place when people:

- Work as individuals at a fixed site but are separated from others e.g. working alone in buildings or interviewing patients alone in interview rooms
- Work in a remote location, including outdoors
- Work alone away from base e.g. home visiting
- Work outside normal working hours such as on-call staff required to respond to clinical or non-clinical emergencies in isolated buildings (e.g. clinicians) or working alone in the community
- Travel alone as part of their work e.g. traveling to meetings or traveling to patient's homes
- Provide services to the public e.g. community nurses
- Work on other employers' premises or working from home
- Those who open (or reopen) and close buildings either early in the morning or late at night

Aims

This policy aims to:

- Increase staff awareness of safety issues relating to lone working
- Make sure that the risk of working alone is assessed in a systematic and ongoing way, and that safe systems and methods of work are put in place to reduce the risk so far as is reasonably practicable
- Make sure that appropriate training is available to staff in all areas, that equips them to recognise risk and provides practical advice on safety when working alone
- Make sure that appropriate support is available to staff who have to work alone
- Encourage full reporting and recording of all adverse incidents relating to lone working
- Minimise the number of incidents and injuries to staff related to lone working

Responsibilities

The Board

- Making sure that there are arrangements for identifying, evaluating and managing risk associated with lone working
- Ensuring that reasonable resources are provided to support the implementation of this policy and procedures
- Making sure that there are arrangements for monitoring incidents linked to lone working and that the Board regularly reviews the effectiveness of the policy

Service/Line managers

- The operational management of health and safety in their service lines/localities
- To promote, support and ensure understanding of the aims and objectives of this policy
- To ensure that suitable lone working risk assessments are carried out and reviewed annually or following any serious incident involving lone workers
- To ensure that staff are aware of the risks of lone working, and the arrangements/protocols in place locally to reduce risks to lone workers
- To put procedures, safe systems of work and, if deemed necessary, lone worker devices into practice which are designed to eliminate or reduce to an acceptable level, risks associated with working alone
- To ensure that staff receive the appropriate induction, instruction and training, including updates and refresher training as required by Evolutio
- To ensure that incident reporting procedures are followed, and accurate records maintained in accordance with the Incident Reporting Policy
- To ensure that systems are in place to account for and trace the whereabouts of lone workers and that these systems are regularly checked

- To ensure operational arrangements to minimise risks where there are specific concerns about staff safety (known risk of violence and aggression from individuals or in specific environments). These could include visiting in pairs, liaising with police officers or arranging to see service users on Evolutio premises etc.

Employees identified as lone workers

- To take reasonable care of themselves and other people who may be affected by their actions
- To familiarise themselves with relevant health and safety policies and procedures
- To co-operate by following protocols and procedures designed for safe working
- To consider and assess potential risks to their health and safety
- Where appropriate, to carry a personal alarm, mobile phone, Lone Working Device or other form of emergency communication device as deemed suitable for the particular service
- To report all incidents, difficulties or risks, including near misses, raised from lone working, however minor to their manager
- To ensure that all risk information about service users, particularly if there is a risk of violence and/or aggression is shared with relevant parties/agencies and recorded in patient notes
- To attend and utilise all training designed to meet the requirements of the policy
- To maintain an up to date diary of their appointments that is accessible to others whilst they are out working alone
- To be certain of 3 important things:
    - That they are aware of any hazards or risks to which they may be exposed
    - That they know what to do if something goes wrong
    - That someone knows their whereabouts, what they are doing and when they are due back

Risk assessment

The requirement to carry out suitable and sufficient risk assessments is a statutory obligation on all employers within Regulation 3 of the Management of Health and Safety Regulations. Evolutio is required to assess the safety risks associated with lone working activities.

Line Managers are responsible for ensuring that these assessments have been completed for their teams. In line with Regulation 3, an assessment is required for any activity where there is a significant risk of harm occurring. An assessment should, therefore, be completed for any situation, where members of staff may become lone workers.

This assessment will evaluate the existing control measures and determine whether further action is needed to protect staff. Managers are required to ensure the findings from any assessment are communicated to their teams. Significant risks can also be escalated up to board level using the risk registers.

As part of the risk assessment, the line manager is responsible for reviewing the acceptability of lone working in isolated premises, the length of time where members of staff work alone, the cover for breaks and hand-over etc. They will also review how members of staff respond to a violent incident, whilst maintaining adequate levels of care for others.

Prevention

Prevention is essentially about using all available information to ensure that the risk of future incidents can be minimised.

This includes lessons learned from operational experience on previous incidents and adopting an inclusive approach that involves staff and stakeholders. It is, therefore, essential that staff must report identified risks to managers as well as incidents that have or may have occurred, so that the appropriate action can be taken.

The key to preventive action is a profound understanding of how and why incidents occur in lone working situations and to learn from that understanding. In order to achieve this, the following factors should be considered:

- The type of incident for example, physical assault/theft of property or equipment
- The severity of incident
- The cost to the organisation (human and financial)
- The individuals and staff groups involved
- The weaknesses or failures that have allowed these incidents to take place, for example, procedural, systems or technological

- A review of measures and technology in place to manage risk and to aid in the protection of lone workers (this would need to be identified by the Local Security Management Specialist)

Physical Measures:
- Mobile phone
- Personal audible or screech alarm
- Radios
- Electronic lone work systems

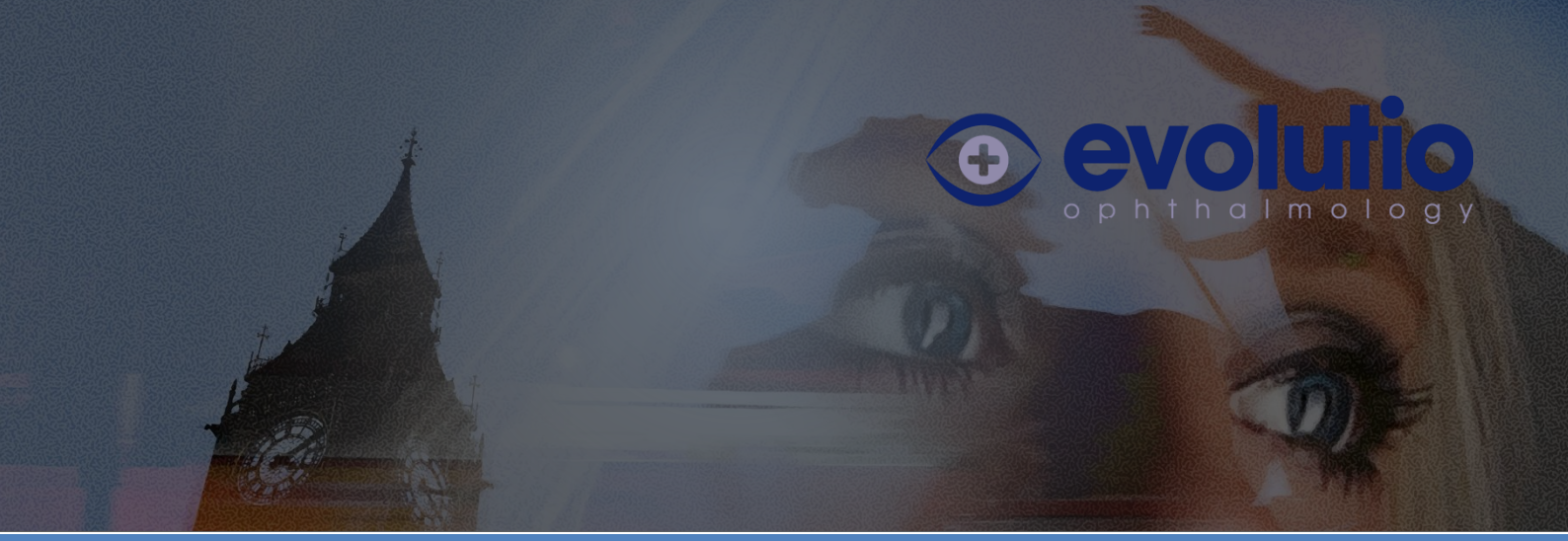
Practical Measures
- Buddy System
- Removal from situation
- Ensure building security e.g. shutting doors, understanding locking mechanisms in emergency situations etc.
- Keep possessions close
- Be aware of body language
- Where practical individuals should not be left working on their own in buildings or offices outside of normal working hours
- Managers should ensure that whenever possible at least two workers are on the premises and that they are able to leave together
- The working environment must be made as safe as is possible and all doors and windows should be checked and secure
- If part of the building that is not in use can be covered by a burglar alarm, then it should be set to isolate that part of the building
- Always treat threats of violence seriously
- Be perceptive and read situations
- Be constantly alert to signs of frustration, tension or aggression in an individual, e.g. heightened respiration, perspiration, pitch and speed of voice, invasion of personal space, flushed skin, increased muscle tension, pacing, restlessness, agitation and uncomfortable sustaining of eye contact

Reporting

All violent or abusive behaviour must be reported to your line manager and recorded on an incident form.

If the assailant is a patient/client, then the incident should also be recorded in their notes (a second copy of notes can be kept at base) and in the risk assessment form.

Where actual bodily harm has been incurred, a medical examination and statement of injury should be obtained as soon as possible after the event. The main purpose of recording the incident is:
- To provide an information base for further preventative measures
- To provide information necessary for any legal action which you may wish to take
- To ensure that the incident is highlighted to future providers of care



1.14 Infection Prevention & Control Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	4.0

Why is it necessary?

Prevention and control of healthcare associated infection is part of the overall clinical governance and risk management strategy within the healthcare setting. Evolutio is committed to improving the quality of care throughout the organisation and promoting high standards of infection prevention and control practice.

Evidence suggests that up to 30% of healthcare associated infections are preventable through adherence to good infection control procedures. The Hygiene Code (2006) requires all staff/visitors/contractors to adhere to infection control practice at all times.

All staff must possess an appropriate awareness of their role in the prevention and containment of infection control in their area of work. Not only is this part of their professional duty of care to the patients with whom they are involved, but it is also their responsibility to themselves, to other patients and members of staff under the Health and Safety at Work Act (1974). The Control of Substances Hazardous to Health (COSHH) Regulations (2002), require actions to be taken to control the risk of hazardous substances, including biological agents.

Peter Price-Taylor
CEO

Scope

This policy applies to all staff employed Evolutio in a permanent or temporary capacity, volunteers and staff working in a contracted capacity and anyone working in a training capacity. This policy will set out the roles and responsibilities of staff to infection prevention and control within the organisation.

Information will be provided to patients, carers and visitors to the company on public involvement with infection prevention and control as well as information on communicable diseases, infectious conditions and good infection prevention and control practice. Support and advice are available to all staff and members of the public.

This is an overarching policy intended to outline the company's approach to the broad and complex issues relating to infection prevention and control. This overarching policy confirms Evolutio's commitment to the prevention and control of infection. It is supported by documents including other policies and guidelines to ensure that healthcare provision within Evolutio complies with good standards of infection prevention and control.

Roles and responsibilities

This policy will ensure that:

- Responsibility for infection prevention and control is embedded at all levels of the organisation
- Effective arrangements are in place for the provision of a full infection prevention and control service including policy production, surveillance, education and training, and audit
- Infection control advice is provided by a suitably qualified and resourced person(s), which includes an Infection prevention and Control Lead, with administrative and information technology support
- All healthcare personnel working within the scope of this policy are aware of the rationale and responsibility to maintain high standards of infection control at all times

CEO

The Chief Executive is the accountable officer and holds responsibility for infection prevention and control. The CEO is responsible for the organisation's infection prevention and control strategy, implementation of the annual infection prevention and control programme and for providing assurance on infection prevention and control to the Board and general public. The focal point for the integration of infection prevention and control into the clinical governance systems and for ensuring the safety of patients from infection is not forgotten.

The Chief Executive as accountable officer will chair the Infection Prevention and Control Committee meeting and be a strong and visible advocate for infection prevention and control.

Infection prevention and Control committee

The Infection Prevention and Control Committee consists of the executive board and clinical leads.

The purpose of the committee is to:

- Ensure that Evolutio can demonstrate ongoing compliance with the Hygiene Code of Practice (DH, 2009)
- Ensure that Infection Prevention and Control policies, procedures and additional guidance are endorsed, implemented and reviewed on a rolling programme
- Ensure that relevant national guidance is reviewed/implemented, and assessment completed as necessary
- Ensure that documents relevant to Infection Prevention and Control are received, discussed interpreted and disseminated across the company
- Ensure that the Chief Executive and the Clinical Governance Group are alerted to any serious risks, problems or hazards relating to Infection Control Prevention and Control and make recommendations
- Review reports on Healthcare Associated Infection and other infection prevention and control issues
- Commission and approve policies for all aspects of Infection Prevention Control and review their implementation
- Advise on the most effective use of available resources for the implementation of the Infection Prevention and Control programme
- Recommend amendments to local policies and procedures to ensure compliance with all relevant legislation, Health Service guidelines etc
- Promote best practice in infection prevention and control within the organisation

Healthcare personnel

- All healthcare staff have a duty to act on, and report at the earliest opportunity, conditions or incidents that may be deemed infectious or potentially infectious to others
- All healthcare staff are required to adhere to the policies, guidelines and procedures pertaining to the prevention and control of healthcare associated infection which provide a framework for safe and best practice

Training requirements

Evolutio will work towards all staff being appropriately trained in line with the organisation's Staff Training Matrix (training needs analysis).

- Staff Induction – Standard Infection Control Precautions
- Hand Hygiene Training
- Medical Devices
- SI Event Reporting

Monitoring

The Infection Prevention and Control Committee will produce a quarterly report to the board. The Team provides the Infection Prevention and Control Lead with Quarterly Untoward Events reporting of outbreaks which are discussed as a Standing Agenda Item at each bi-monthly Infection Prevention and Control Group meeting and action plans developed for any issues of concern.

- The Group will regularly discuss and monitor the measures within the CQC registration standards
- Infection prevention and control related Patient Safety Alerts from CAS, SABS, Public Health Alert, MRSA and Medical Devices will be discussed and recorded within the Minutes of each bi-monthly meeting with detail of any action taken
- New UER's, Significant Risks and Lessons Learnt relating to infection prevention and control will be discussed at each monthly board meeting
- The Infection Prevention and Control Committee will review this policy at least every two years, in accordance with any National Guidance or update legislation

Audit results will be presented to the Infection Prevention and Control Committee for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring improvements, where necessary, are implemented. A briefing of the audit will be provided to staff to raise awareness.

Infection and cross-infection

Infection is the pathological state that results from the invasion of the body by pathogenic micro-organisms. Cross-infection (or nosocomial infection) is infection contracted during the course of clinical care in a hospital or other healthcare facility (such as an optical practice).

Cross-infection is a common but partly avoidable complication of healthcare provision. A patient may present at a clinic or practice with an infectious illness, which may be either symptomatic or asymptomatic, and pose a risk of infecting the practitioner or passing on the infection to other patients either directly or through the use of medical devices. Practitioners themselves may also be harbouring infectious disease, which they may be at risk of passing on to their patients. In addition, the clinic or practice environment may pose a microbiological hazard and present an infection risk to both staff and patients.

The risk of the accidental transmission of infection in optical practice is low compared with that encountered in some other healthcare disciplines, Nevertheless the direct transmission of skin infections, respiratory infections and enteric infections does occur, and ophthalmic infections such as bacterial and viral conjunctivitis may also be transmitted if there are inadequate infection control measures. The close proximity (< 1m) between staff and patients in optical practice poses special risks which must always be borne in mind.

Contagious diseases

Infections transmitted by physical contact

Physical contact can be directly between individuals, for example hand-eyelid contact during the course of an examination or contact lens fitting. It can also be indirect, between objects or surfaces and individuals. Examples of such indirect contact are soiled tissue wipes and trial rigid contact lenses.

Viruses that can be transmitted by direct and indirect physical contact include adenovirus, herpes virus, papilloma virus and molluscum contagiosum.

Bacteria that can be transmitted in this way include methicillin resistant Staphylococcus aureus (MRSA).

Fungal infections can also be transmitted through contact. Examples are athlete's foot (Tinea pedis) and Ringworm (Tinea corporis).

Infections borne in the blood and other body fluids

Blood-borne and other body fluid-borne infections are transmitted by contamination by blood or body fluids. The commonest examples are HIV, hepatitis B and C and viral haemorrhagic fever. These are all viral diseases. Other diseases, including TSEs (transmissible spongiform encephaolopathies, also known as prion diseases] have been transmitted by the transfusion of blood and blood products. There is a small degree of risk to practitioners, support staff and patients from cross-infection with such diseases Infection may be transmitted via contaminated instruments and devices including contact lenses. It is necessary to be aware of this possibility and to observe strict infection control procedures in the course of clinical practice. No case has yet been identified of the transmission of a prion disease during optical practice, but there is a theoretical risk.

Airborne infection

Potentially infectious respiratory aerosols are generated when an individual sneezes, coughs, or talks. A single cough can transmit up to 100,000 particles and a sneeze 20 times this number. Particles over 5 microns in diameter do not normally travel more than 1m while smaller particles can travel longer distances and remain airborne for longer. Large particles are deposited in the vulnerable mucous membranes (nose, eyes, mouth). Small particles can reach the respiratory tract including its lower parts. Environmental conditions, including temperature, humidity and airflow, influence the transmission of disease by droplet infection. Infections that can be transmitted in this way include a number of respiratory diseases such as the common cold, influenza and COVID-19.

Because of their professionally necessary proximity to the patient's nose and mouth, optical practitioners (along with other healthcare workers such as ophthalmologists, rhinolaryngologists and dentists) are at special risk of airborne infection and of infecting their patients in the same way.

The risk of airborne infection can be minimised in a number of ways. Persons with signs and/or symptoms of a respiratory infection of any type should be instructed:

- To cover the nose and mouth when coughing
- To use disposable tissues to contain respiratory secretions
- To dispose of tissues in the nearest receptacle after use
- To perform hand hygiene after contact with respiratory secretions and contaminated objects or materials

Patients who are symptomatic of COVID-19 (high temperature, new continuous cough and loss/change in sense of smell or taste) or those who have been in contact with someone infected with C-19 must not be seen in face-to-face Evolutio clinics under any circumstances.

CJD / vCJD

The theoretical transmission of prion proteins, implicated in Creutzfeld Jacob Disease (CJD) and variant CJD (vCJD), through re-useable ophthalmic devices and trial contact lenses has been identified as a risk by the Department of Health (DH). These untreatable diseases affect the central nervous system and some other tissues and are invariably fatal.

The entire population of the UK currently above the age of ten years has been identified as having been exposed to beef or beef products contaminated with the bovine spongiform encephalopathy (BSE) agent. This agent has caused disease (vCJD) in 162 individuals since 1990.

In addition to the general risk of vCJD, certain patient groups have been identified as being at greater than normal risk (which is one per million per annum) of developing classical CJD:

- Recipients of pituitary derived hormones such as human growth hormone or gonadotrophins
- People known or assumed to have had human dura mater implanted, including people who have had brain surgery before August 1992, and people who have had an operation for a tumour or cyst of the spine before August 1992
- People diagnosed of suffering from CJD of any type or with a family history of CJD
- People with degenerative neurological diseases of unknown causation

As a precautionary measure, patients in any of these groups who require ocular interventions of any kind should be referred to the Hospital Eye Service.

Immunisation

You should keep up to date with immunisation, including:

- Tetanus
- Polio
- Tuberculosis, and
- Hepatitis B

Principles of infection control

Routine infection control precautions

There are routine infection control procedures which can be used to minimise the transmission of infection [summarized in the table below]. Although contact with body fluids and use of sharps is quite rare within optical practice, it is important that the practitioner understands how to minimise the risk of infection and uses the appropriate techniques to ensure both clinician and patient safety. Sharps e.g. needles may be used in optical practice for the removal of foreign bodies and the metallic caps from contact lens bottles may also cause a sharp injury.

Immunisation	Keep up to date with tetanus, polio, tuberculosis Hepatitis B
Hand hygiene	Before and after contact with all patients (see below for more detail) After contact with body fluid
Maintain integrity of skin	Cover cuts to skin with waterproof dressing. Dry skin properly with paper hand towels. Use hand cream as appropriate
Protective clothing	Use to protect against direct contact with body fluid
Sharps safety	Use equipment with safety devices Use safe handling and disposal procedures
Decontamination of equipment	Decontaminate equipment after use(see below) Disinfect used linen by laundering Use protective clothing whilst handling and cleaning
Decontamination of the environment	Keep environment clean and free from dust Disinfect spills of body fluid

Personal protection

Immunisation - All practitioners and support staff should be up to date with immunisations against infectious diseases including tetanus, polio, hepatitis B and tuberculosis.

Barrier Techniques - All cuts and abrasions should be covered with waterproof sticking plasters. Although HIV has been isolated in tears it is considered unlikely that this would lead to a risk of cross-infection between patient and practitioner.

Hand hygiene

Good hand hygiene practice is now widely acknowledged as being the single most effective intervention for reducing the risk and preventing the spread of infection. It is a means of removing transient micro-organisms and significantly reducing resident microorganism [also called skin commensals] to a level which is not harmful to patients. Hand hygiene also removes blood, body fluids and any other infectious or hazardous agents.

It is recommended that sinks with warm water used only for hand washing are available in all clinical areas and that they are easily accessible.

The National Institute for Health and Clinical Excellence (NICE) recommends that hands must be decontaminated immediately before each and every episode of direct patient contact or care and after any activity or contact that could potentially result in hands becoming contaminated.

There is no set frequency for washing your hands, this is determined by actions that are completed and those that are about to be performed. Hand hygiene should always be performed:

- Before and after contact lens insertion/removal
- After going to the toilet
- Before [and after as appropriate] contact with ocular surfaces/adnexa in each and every episode of patient contact /care
- Before and after administering medication e.g. eye drops
- After any possible microbial contamination (e.g. contact with body fluids, wounds, clinical waste)
- After handling soiled / contaminated materials
- When hands are visibly dirty
- Before wearing and after removing gloves

This technique is usually all that is required for most procedures performed in the clinical setting -

- Wet hands under running water.
- Dispense soap/antiseptic into cupped hand.
- Rub hands vigorously and thoroughly for 10-15 seconds without adding more water.
- Ensure all surfaces of the hands are covered.
- Rinse hands thoroughly under warm running water.
- Dry hands with a disposable paper towel. The use of non-disposable towels is not good practice.

During times of heightened infection risk (e.g. COVID-19 pandemic), more comprehensive handwashing is indicated (see https://www.nhs.uk/live-well/healthy-body/best-way-to-wash-your-hands/):

You should wash your hands for the amount of time it takes to sing "Happy Birthday" twice (around 20 seconds):

1. Wet your hands with water
2. Apply enough soap to cover your hands
3. Rub your hands together
4. Use 1 hand to rub the back of the other hand and clean in between the fingers. Do the same with the other hand.
5. Rub your hands together and clean in between your fingers
6. Rub the back of your fingers against your palms
7. Rub your thumb using your other hand. Do the same with the other thumb.
8. Rub the tips of your fingers on the palm of your other hand. Do the same with other hand
9. Rinse your hands with water
10. Dry your hands completely with a disposable towel
11. Use the disposable towel to turn off the tap

Hand washing agents

Soap

Handwashing with soap and water is effective in removing most transient micro-organisms and is usually all that is necessary in most situations to prevent cross infection. In clinical areas, soap should be preferably supplied as liquid soap in disposable containers or containers that are washed and dried before refilling. The containers should not be "topped up".

Antiseptic

Antiseptic agents are more effective in reducing both transient and resident micro-organisms (e.g. Chlohexidine, Povidine -iodine). Chlorhexidine (4%) preparations have shown to be more effective as they have shown a residual effect against transient organisms influencing the survival time on hand surfaces. The use of an antiseptic agent is recommended

- Before and after direct contact with patients in clinical settings where there is an outbreak of antimicrobial resistant organisms (e.g. Residential /Nursing Homes)
- Where there is heavy microbial contamination
- Before performing invasive procedures/minor operations

Alcohol-based hand rub

Alcohol based hand rubs are effective antiseptic agents which rapidly destroy microorganisms on the skin surface. It is indicated that, when used correctly, alcohol hand rubs reduce microbial load and increases compliance with hand hygiene. However, they are not a cleaning agent and should not be used if hands are visibly dirty or contaminated with blood, bodily fluids or other potentially infectious agents. To be effective against MRSA hand rubs must contain 70% of either ethyl or isopropyl alcohol. They are especially useful in situations where handwashing and drying facilities are inadequate e.g. domiciliary visits.

Whilst the efficacy of alcohol hand rubs has been proven, they are not to be used as a substitute for good handwashing technique using soap and water when available.

Handwashing technique

A rapid decontamination of the hands can be achieved by rubbing the whole surface with an alcoholic solution e.g. Hibisol.

Frequent hand washing and the use of alcohol preparations can cause damage to the skin and contact dermatitis. Cracked skin may harbour more bacteria and increase the risk of the transmission of infection. Soap should always be applied to wet hands to minimise irritation to the skin. Regular use of hand creams may help to prevent skin damage. If contact dermatitis is suspected, employees should seek medical advice and advise their line manager.

Cleaning, disinfecting and decontamination

There are numerous pieces of equipment and appliances with which patients regularly come into contact, e.g. trial frames, chin rests, refractor heads, hand held occluders and rulers, as well as ophthalmic devices which come into direct contact with ocular tissues e.g. tonometer heads, pachymeters, gonio lenses and other contact lenses. It is essential that they are all appropriately decontaminated, for example by wiping headrests and/or chin rests with a disinfectant wipe, to reduce the risk of transmission of infection.

Decontamination is defined as the process of cleansing to remove microorganisms or foreign matter from contaminated materials. There are three levels of decontamination:

- Cleaning – The removal of organic and inorganic debris from a surface which might support micro-organisms and provide insulation that reduces the efficiency of disinfecting or sterilisation procedures. Detergents and ultrasonic cleaners are frequently used for cleaning purposes.
- Disinfection – A treatment that reduces the number of viable micro-organisms but not necessarily bacterial spores or some viruses. Disinfection can be achieved by physical methods such as heat or by the use of chemical disinfecting agents. Chemical disinfection can be an uncertain procedure as it involves an integration between the chemical used, the micro-organism and exposure time.
- Sterilisation – A treatment, which completely kills or removes all kind of microorganisms including spores. Sterilisation can be achieved by ionising radiation, by gaseous ethylene oxide, by low pressure steam and formaldehyde, by filtration by dry heat (hot air oven) or by moist heat (autoclave).

To be effective all items must be physically clean before being exposed to any sterilisation or disinfection process. Not all equipment, however, needs to be sterile before use and the following is a general guideline:

- Sterile - Equipment introduced into a sterile body area or is in contact with a break in the skin or mucous membrane
- Disinfected - Equipment in close contact with body surfaces of intact mucous membranes, such as the ocular surface e.g. tonometer head, gonioscopes
- Clean - Equipment not coming into close contact with mucous membranes or sterile body areas e.g. trial frames, refractor heads.

All surfaces used as a preparation area for dealing with patients and disinfected/sterile appliances must also be cleaned and disinfected regularly. Surfaces should be cleaned with detergent and water unless contaminated with body fluids, then a chlorine-based disinfectant should be used. It is considered good practice for the consulting room to contain a wash hand basin and for the practitioner to maintain good hand hygiene between patients and certain procedures as necessary.

Protective clothing

Wear protective clothing:
- to protect against direct contact with body fluid, or
- while handling and cleaning decontaminated equipment.
- Where there is an increased infection risk (e.g. COVID-19 pandemic)

During the 2020/2021 COVID-19 pandemic, Public Health England issued specific advice on the type of PPE to use in various situations, see:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/925605/PHE_PPE_illustrated_guide_for_community_and_social_care_settings_OCT_2020.pdf

For healthcare workers in direct contact with patients they advise:
- Apron
- Gloves
- Fluid repellent Type IIR surgical mask
- Eye protection, either a visor or goggles, can be used (prescription glasses are not eye protection), subject to risk assessment such as if the person has a cough

The following advice in this section is superseded by PHE advice (above) until such time that COVID-19 is no longer a significant risk. Patients who are symptomatic of COVID-19/in contact with an infected person must not be seen in face-to-face Evolutio clinics under any circumstances.

Masks

You do not have to routinely use a mask, unless there is a serious respiratory risk involved. Ordinary surgical masks are not effective protection. In these cases, you should wear specialised respiratory protection

Gloves

You should wear gloves where you consider there is a risk from:
- Invasive procedures
- Contact with:
    - Non-intact skin, or
    - Mucous membranes
- Exposure to:
    - Blood
    - Bodily fluids, including tears
    - Secretions
    - Excretions
    - Sharp or contaminated instruments, or
    - Other contaminated material, for example dressings.

You should consider the following factors when deciding to wear gloves:
- Whether the patient has an overt infection, such as ulcerative blepharitis or acute viral or bacterial conjunctivitis
- The degree of contact with bodily fluids or infected tissue, and
- The consequences of infection.

You do not have to wear gloves to:
- Carry out a normal eye examination
- Perform minor procedures where there is no likelihood of cross-inoculation with bodily fluids, or
- Fit contact lenses.

You should practise thorough hand hygiene before wearing, and after removing, gloves, as they may not provide complete protection.

Gloves should fit correctly and must only be used once. Put them on immediately before the activity and remove them as soon as it is completed. Dispose of contaminated gloves in a clinical waste bin.

You can use non-sterile disposable examination gloves. However, if you undertake a procedure which requires a sterile environment you must use sterile surgical gloves. You must not use polythene gloves for clinical interventions. Powdered gloves should not be used due to the risk of airborne allergens. If you choose to use latex gloves you should be aware

that these might cause allergic reactions such as asthma or contact dermatitis in sensitised individuals therefore nitrile gloves should be the first choice in all cases.

The table below summarises agents recommended for cleaning, disinfection and decontamination procedures.

AGENT	PREPARATION	EXAMPLES OF USE
Liquid soap	As supplied	Handwash
Chlorhexidene Gluconate 4% skin cleanser	500 ml bottles with pump dispenser e.g. Hibiscrub	Antiseptic handwash
Chlorhexidene 5% in 70% Isopropyl Alcohol	500 ml bottles with pump dispenser e.g. Hibisol	Antiseptic handwash for clean hands
Detergent	General purpose detergent Detergent impregnated wipes e.g. Cutan Multisurface wipes	Cleaning of hard surfaces
Isopropyl alcohol	Isopropyl alcohol 70% Impregnated swabs e.g. Mediswabs or wipes e.g.Mediwipes	Disinfection of hard surfaces, chinrests etc.
Hypochlorite solution (1,000 ppm available chlorine)	Available from pharmacies e.g. Milton or own brand 'sterilising solution' (dilute to concentration required)	General disinfection
Hypochlorite solution (10,000 ppm available chlorine)	Available from pharmacies e.g. Milton or own brand 'sterilising solution' (dilute to concentration required)	Disinfection of body fluid spills
Hypochlorite solution (20,000 ppm available chlorine)	Available from pharmacies e.g. Milton or own brand 'sterilising solution' (dilute to concentration required)	Decontamination of trial contact lenses and tonometer heads

Contact lenses and ophthalmic devices

Contact lens solutions

Contact lens care products used during the examination must be carefully maintained and discarded prior to their expiry date. As recent studies have demonstrated, varying levels of contamination exist in the plastic bottles containing contact lens solutions. Clinicians should note when these bottles are opened and discard them in accordance with manufacturer's guidelines, which vary depending on the product and its use. All solutions run the risk of infection during the time that caps are removed, they must therefore be replaced immediately after each application.

Chlorine/sodium hypochlorite and hydrogen peroxide are toxic to the eye. Should either solution come into contact with the eye, irrigate with sterile normal saline, check the ocular area for inflammation and for damage using fluorescein, and if there are any clinically significant signs, refer/manage as appropriate.

Contact lens practice

General points

All surfaces used for preparation prior to contact lens fitting or aftercare should be disinfected regularly. All containers used for temporary storage, whilst the patient is undergoing an examination, should be cleaned and disinfected before and after use.

The re-use of trial contact lens fitting sets ceased in 1999, following advice from SEAC [the Spongiform Encephalopathy Advisory Committee] to the Medical Devices Agency. Since that time single patient use contact lenses have been considered to be best practice. However, it was agreed that special complex diagnostic contact lenses might be re-used and decontamination was recommended after each use.

Re–use of contact lenses and ophthalmic equipment

Decontamination

All surgical instruments (e.g. forceps, dilators etc.), tonometer probes, goniolenses and pachymeter probes should be single use (disposable) wherever possible; this is particularly important in cases where a patient has a known transmissible disease (e.g. HIV/Hepatitis B/C).

Examples of suppliers include Malosa Medical (forceps), Tomey (SP100 pachymeter), Keeler (Tonomate tonometer probes) and Sensor Medical Technology (goniolens). Evolutio do not have a commercial interest in these companies and they are given simply as examples.

Where this is not possible, the following decontamination process should be followed as recommended by the joint Colleges:

1. The item should not be allowed to dry following use
2. Rinse in saline for at least 30 seconds
3. Clean by rubbing with liquid soap or detergent
4. Soak in 1% (10,000ppm) sodium hypochlorite solution for 10 minutes
5. Thoroughly rinsed with water for irrigation BP/sterile normal saline for at least 10 minutes with 3 changes of water/saline
6. Shake off excess, dry with tissue, reuse immediately or store dry - the item may then be safely used

'Tristel Duo Oph' is a relatively new product described as 'high level disinfectant foam for ophthalmology.' This is an acceptable alternative for routine disinfection where there is no obvious active infection or other risk factors.

Safe disposal of waste

Under section 34 of the Environmental Protection Act 1990 any person who '…imports, produces, carries, keeps, treats or disposes of…' controlled waste has a duty of care to take all reasonable steps to deal with it appropriately. Controlled waste is defined as being waste from households, commerce or industry. Optometrists and Dispensing Opticians therefore have a responsibility to dispose of the waste that they produce responsibly. This applies to producers of both non-hazardous and hazardous waste.

The Hazardous Waste Regulations 2005, which came into force in July 2005 have reclassified waste to fall in line with European legislation.

The separate category of 'special waste' (pharmaceutical waste) has been removed. POMs are now either hazardous (which depends upon their toxicity and concentration) or not. The POMs commonly used by optometrists and dispensing opticians are not of a sufficient concentration to be classed as hazardous and so are not subject to the consignment regulations that used to apply to special waste.

POMs that are not classed as 'hazardous' do not need a consignment note, or special transportation arrangements. However, as 'medicinal waste', the POMs may possess hazardous properties and therefore require appropriate disposal.

Under their duty of care, optometrists and dispensing opticians must identify any medicines in their waste to their waste disposal company, to ensure they are able to dispose of them properly. It is recommended that best practice is to have a waste transfer note system with the waste contractor to ensure that the waste is incinerated at high temperature. Waste medicines should as far as possible be disposed of in their original packaging.

Clinical waste is defined in the Controlled Waste Regulations 1992. It means any waste which consists wholly or partly of:

- Human or animal tissue
- Blood or bodily fluids
- Excretions
- Drugs or other pharmaceutical products
- Swabs or dressings
- Syringes, needles or other sharp instruments. Which unless rendered safe may prove hazardous to any person coming into contact with it.
- Any other waste arising from medical, nursing, dental, veterinary, pharmaceutical or similar practice, investigation, treatment, care teaching or research, or the collection of blood for transfusion, being waste which may cause infection to any person coming into contact with it

Waste is considered to be hazardous if it is amongst other things irritant, harmful or infectious.

The 'soft' healthcare waste produced by most optical practices (e.g. used contact lenses, tonometer probes, tissues etc) is unlikely to be considered hazardous, and as such is not classed as clinical waste. This can be disposed of in the normal refuse unless it is of large quantities in which case it can be considered as 'offensive waste'. For non-hazardous healthcare waste, DEFRA and the RPSGB recommend the separate packaging of large quantities of offensive wastes under the heading 'Does the quantity of waste produced affect its classification?', but this is good practice rather than a requirement.

If the waste is likely to be infectious it is classed as hazardous (and it is therefore within the definition of clinical waste) and must not be mixed with non-hazardous waste. Advice from the DH states that where a patient in the community has been diagnosed with MRSA and is being cared for by a healthcare worker, the healthcare waste generated is not necessarily infectious.

Clinical waste should be segregated from other types of waste and be treated/disposed of appropriately in suitably permitted, licensed or exempt facilities on the basis of the hazard it poses.

Contact lenses and solutions do not normally fall within any of the categories of Hazardous Waste and should be classified as non-infectious healthcare waste.

Sharps are defined as items that could cause puncture wounds. These would include needles, broken glass ampoules, scalpels etc. Sharps should be disposed of in sharps boxes. They are considered to be Hazardous Waste if their collection and disposal is 'subject to special requirements to prevent infection' (SI 895 of 2005 18.01.03). Sharps which are classed as non-hazardous will be treated differently for transport and disposal, but they should still be in sharps boxes. A separate box should be used for 'hazardous' and non-hazardous sharps. Practitioners who use sharps should contact their waste contractor who will be able to advise on the most appropriate form of disposal.

In England and Wales details of the premises at which hazardous waste is produced or from which it is removed must be notified to the Environment Agency. There is an exemption for various types of premises, which we have been assured includes optometrists and dispensing opticians, providing that they produce less than 200kg of hazardous waste in any 12 month period. It is extremely unlikely that any optical practice will produce this quantity of hazardous waste, if any, so they will not need to notify the Agency. In Scotland and Northern Ireland premises do not have to be registered. Instead of registration the relevant authorities must be notified of any movement of hazardous waste at least 3 days in advance. Further details of the consignment regulations can be found at:
www.ehsni.gov.uk/pubs/publications/Hazardous_Waste_leaflet_2005.pdf.

In Scotland Hazardous Waste is termed 'Special Waste' but is defined as that waste which is hazardous waste as defined by Article 1(4) of the Hazardous Waste Directive.

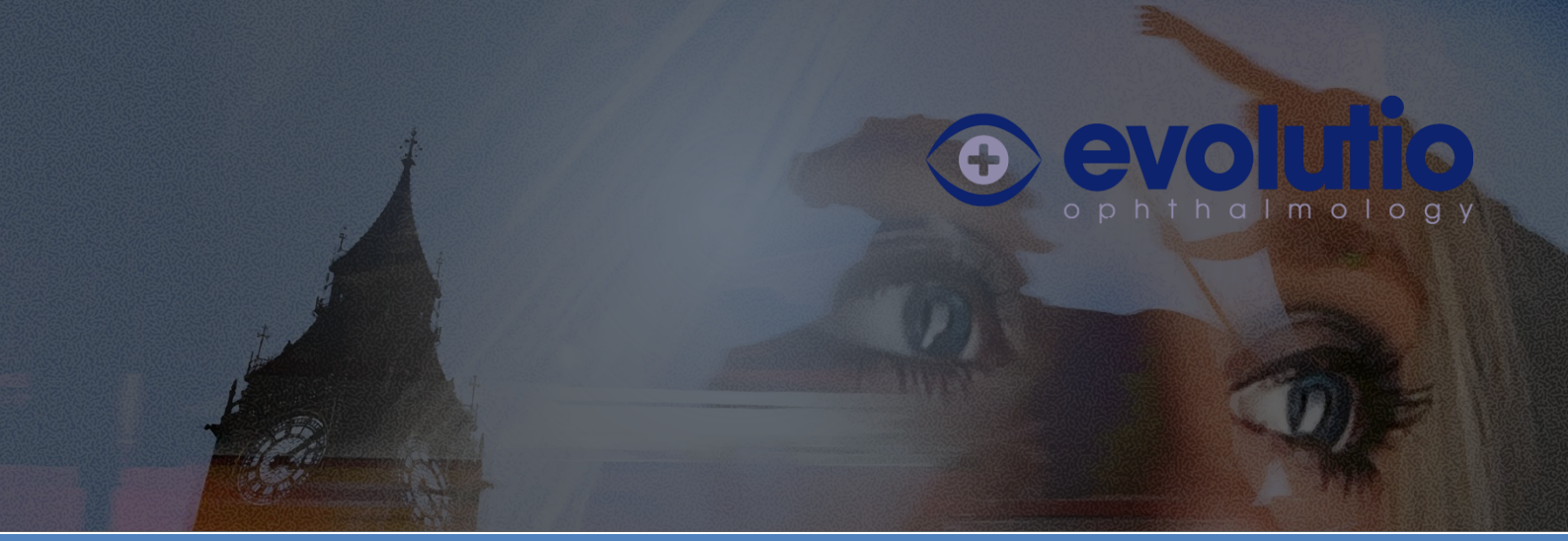
Further information for those classified as waste producers can be found in the Department of Health's guidance on the Safe Management of Healthcare Waste (Health Technical Memorandum 07-01). This guidance also applies to offensive/hygiene and infectious waste produced in the community from non-NHS healthcare sources. The producers of waste should complete and sign a waste transfer note (or consignment note for hazardous waste) prior to waste being transferred to another party. Prior to waste being disposed of, it should be stored securely on site.

A summary of the different types of waste and their disposal is tabulated:

Item	Classification	Disposal method	Responsible person	Legislative information
DRUGS / PHARMACEUTICAL PRODUCTS Ophthalmic – POMs	Non-hazardous	Incineration *	Contractor	No consignment note required No special transportation Waste contractor must be informed of nature of waste under 'duty of care'.
** Best practice - Have a waste transfer note system with a waste contractor to ensure high temperature incineration*				
GENERAL OPHTHALMIC HEALTHCARE WASTE - used contact lenses, blunt tonometer probes, tissues etc	Non-hazardous healthcare waste	Small quantities –normal refuse disposal Large quantities - are considered 'offensive waste'	Contractor	DEFRA Advice RPSGB Advice DH Guidance See *text*
Contact lens solutions and cases	Non-hazardous	Normal refuse disposal		
Infectious healthcare waste is classed as CLINICAL WASTE	Hazardous	Must be packaged separately to non-hazardous waste	Contractor	Consignment note required for hazardous waste1
SHARPS Anything able to cause a puncture wound. This would include soft CL glass bottles and their metal caps,	Non hazardous -unless infected	Sharps box Separate Sharps box if infected		See text

A national colour coding system has been suggested. This is not mandatory but may help to aid the identification and segregation of waste to aid appropriate treatment and disposal. The colours that would apply to optometrists are:

Suggested colour coding	Description
Yellow bin	Waste which requires disposal by incineration such as POMs
Yellow bin marked 'sharps' with orange lid	Sharps not contaminated with medicinal products
Yellow/black striped bag	Offensive/hygiene waste
Orange bin/bag	Infectious waste or potentially infectious waste (must be treated prior to disposal).
Black	Domestic (municipal) waste. Clear/opaque receptacles may also be used for domestic waste.



1.15 Drugs Management Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	3.0

Why is it necessary?

The Department of Health requires that healthcare organisations establish, document and maintain an effective and economical system to ensure that medicines are handled in a safe and secure manner.

- Professional practices concerning the use of medicines have developed and continue to develop
- Healthcare practitioners are dealing with medicines as a routine part of their day-to-day work
- The use of new information technology to assist the medicine use process requires new policies and procedures
- The concepts of patient focused care and patient empowerment require a fresh approach to some long-established practices
- Clinical governance and risk management are high on the company's agenda

Peter Price-Taylor
CEO

Key points

- You must act in accordance with the current legislation controlling the use and supply of drugs
- Drugs should normally be supplied by a pharmacist
- You should take particular care when using or supplying drugs to patients from at risk groups
- You should be aware of the indications, cautions, contraindications, and side effects of any drugs you instil or supply
- You should inform patients how to use the drug you supply and what to do in the event of an adverse incident following instillation or supply of a drug
- You should instruct a patient to attend the local Accident and Emergency department if you are not available to deal with an emergency or adverse reaction following the instillation of a drug
- You may delegate the instillation of eye drops to another trained member of staff, but you remain responsible for the patient
- You should not treat yourself or someone close to you or prescribe or prepare written orders for POM drugs for yourself or someone close to you, except in the cases of minor ailments or emergencies
- You may supply or administer drugs under a Patient Group Direction (PGD)
- You may supply drugs not in the exemptions list under the authority of a PGD
- You should store all drugs according to the manufacturer's instructions
- You should report adverse reactions to medicines or medical devices using the appropriate reporting schemes

Principles on the use and supply of drugs and medicines

You must always act in accordance with the current legislation controlling the use and supply of drugs in optometric practice.

You should only supply drugs when it is appropriate to do so. Drugs supply must not be delegated. Topical anaesthetic drops must not be sold nor supplied to patients.

Registered optometrists are exempt from some of the rules in the Medicines Act. Provided it is in the course of professional practice, you may **sell** or **supply** the following medicinal products to a patient:

a) All medicinal products on the General Sales List (GSL). Under medicines legislation, products which are for use as eye drops or eye ointments are excluded from the GSL category
b) All pharmacy (P) medicines, and
c) In an emergency, prescription only medicines (POMs) which are not for parenteral administration and which are eye drops and contain no more than 0.5% chloramphenicol, eye ointments and contain no more than 1% chloramphenicol, or contain the following substances: cyclopentolate hydrochloride, fusidic acid or tropicamide

A signed order for the above POM's may be written for supply by a pharmacist (e.g. in non-emergency cases). Signed orders must include:

- Date
- The optometrist's name, address and GOC number
- The name and address of the patient (if applicable)
- The name of the drug, quantity, pharmaceutical form and strength
- Labelling directions
- An original signature of the optometrist
- Standard prescription abbreviations

A wider range of POM's are available to Additional Supply optometrists for emergency supply or to issue a signed order for pharmacist supply; these are primarily topical anti-allergy and anti-inflammatory drugs.

Independent prescribers may prescribe any POM relevant to their scope of practice (excluding CD's and drugs for parenteral use). They are able to prescribe privately and, where suitable arrangements have been made, write an NHS prescription. They may also supply drugs from the additional supply list in an emergency. See Evolutio's FP10 Management policy.

Evolutio's telemedicine service allows an ophthalmologist to send a prescription request to the patient's GP.

All clinicians should maintain their knowledge and skills to use the drugs encountered in practice. Your knowledge should include:

a) Actions
b) Interactions

c) Cautions
d) Contraindications, and
e) Side effects

You should take particular care when using or supplying drugs to at risk groups such as very young or very old patients, those with renal or hepatic impairment or who are pregnant or breastfeeding.

Instilling eye drops

Checking risks

You should consider the cautions and contraindications for each drug you use in practice.

There is potential for interaction with some systemic drugs, in particular phenylephrine may interact with systemically administered monoamine-oxidase inhibitors and anti-hypertensive drugs.

Making the appointment

If pupils are likely to be dilated, tell patients when they make an appointment that they might not be able to drive after the examination. Suggest that they bring sunglasses with them.

Administering drugs

When you use drugs that dilate the pupil, you should consider whether to:
a) Check the depth of the anterior chamber, for example using the van Herick technique, for the possibility of angle closure, and
b) Measure intra-ocular pressures as appropriate, for example before and/or after dilation.

You should check corneal integrity, if appropriate.

You should ask the patient if they:
a) Have experienced adverse reactions to eye drops in the past
b) Have a history of drug-induced adverse incidents
c) Have any relevant medical conditions, or
d) Take any systemic drugs

You should check for possible interactions with any systemic medication the patient may be taking.

You should check:
a) That you are administering the correct drug and dosage, and
b) The expiry date

You should record all drugs used, including the batch number and expiry date, on the patient record.

You may keep a logbook of which drugs are used on each patient. This will help you if you need to recall patients.

You should explain to the patient:
a) Why you are instilling the drug
b) What effects the drops might have
c) How long the effects might last
d) The side effects they might experience
e) If you are dilating their pupils, that they might not be able to drive and must not undertake any activity which is not advised after dilation, and for how long
f) If you are using anaesthetic drops, that they should avoid wearing contact lenses for an appropriate period of time after anaesthesia, and
g) What to do if they experience an adverse reaction

You should give the patient an information sheet (e.g. College of Optometrists leaflet on tropicamide, topical anaesthetic etc.)

You should instruct the patient to attend the local Accident and Emergency department if you are not available to manage any emergency or adverse reaction that may arise following the instillation of the drug.

You should inform the patient's GP of any suspected adverse reaction and report using the Yellow Card Scheme (see below).

Delegating the instillation of eye drops

There is no legal restriction on who can instil eye drops to a person as the law only restricts supply of the drops.

The clinician is responsible for the instillation and if you decide to delegate this to another member of staff you should be on the premises whilst this is being done so you can intervene if necessary. You are responsible for the management of the patient and the work of the person to whom you have delegated the procedure.

Supply of drugs in optometric practice

The drugs that are covered by the Medicines Act exemptions, P and some POM medicines, can only be supplied to patients by a registered optometrist or dispensing optician. There is no provision for you to delegate or supervise this supply.

Therapeutic drugs should normally be supplied by a pharmacist. You should not supply therapeutic drugs unless it is in the patient's best interests.

As with the use of drugs above, you should be aware of the indications, cautions, contraindications, and side effects of any drugs you supply.

You should ask patients about any drug-induced adverse incident and known drug allergies before supplying them with drugs.

You should inform patients how to use the drug and what to do in the case of an adverse incident.

Prescribing yourself and others close to you

You should not treat yourself or someone close to you or prescribe or prepare written orders for POM drugs for your own personal use or for anyone with whom you have a close personal relationship unless:

a) You are treating minor ailments, or
b) It is an emergency

If you prescribe for yourself or someone close to you, you should:

a) Record it in the patient notes, including your relationship to the patient and the reason for the necessity of prescribing, and
b) Tell the patient's GP and others treating the patient, if relevant, what you have prescribed and other information required for continuity of care, unless the patient objects

Patient group directions and co-management schemes

Optometrists may supply or administer drugs to patients under a Patient Group Direction (PGD). PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. You must ensure you meet the criteria in the PGD. You should work to local protocols.

You may be involved in community services or be co-managing patients, such as those who have had surgical procedures, and need to supply or administer an ocular medication that is not on the list of drugs you can use or supply under the exemptions above. You may do this under the authority of a PGD.

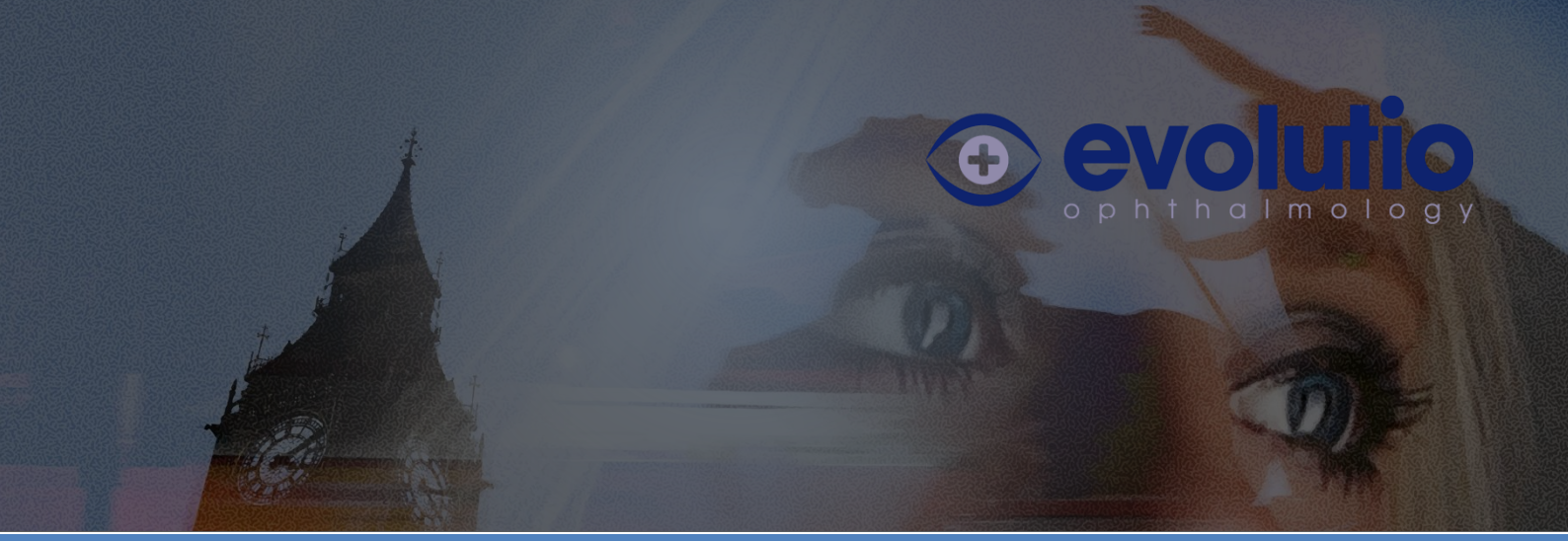
Storage and disposal of drugs

You should:
a) Store all diagnostic and therapeutic drugs according to the manufacturer's instructions, and
b) Keep drugs out of patients' reach

You must follow the current legislation on the disposal of hazardous waste. You must ensure drug waste is disposed of in accordance with the regulations. See section on Infection control.

Reporting adverse drug reactions

All suspected adverse drug reactions (ADRs) should be reported using a Yellow Card. A Yellow card is a standard form used to report a suspected ADR. The card can be submitted online via the MHRA Yellow Card website or by post.



1.15.1 FP10 Management Policy

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	James Syrett		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	6.0

Why is it necessary?

This document has been developed to ensure the security of FP10s against theft and abuse and to record the movement of FP10s at every stage from their ordering to their destruction.

This document details a number of measures to prevent and address the problem of prescription theft and misuse. It further recommends action to be taken when an incident occurs.

The safe and effective management of FP10s, including their ordering, storage and their access by authorised prescribers and administration staff represents a high priority within Evolutio and necessitates appropriate security procedures and systems. All staff need to be security conscious, whereby they treat FP10s as controlled stationery and manage their use effectively.

FP10's must be accounted for at all times, to demonstrate organisational effectiveness and fraud prevention. The misuse of FP10 is a criminal offence, hence full accountability is required.

Peter Price-Taylor
CEO

Introduction

The safe and effective management of FP10 forms, including their ordering, storage and access by authorised prescribers and administration staff represents a high priority for Service Providers who are Independent Prescribers (IP), and necessitates appropriate security procedures and systems. All staff need to be security conscious, treating FP10s as controlled stationery and managing their use safely and effectively.

FP10s must remain protected and secure at all times. Individuals need to be aware of their responsibility to ensure the security of FP10s in their possession. Theft of prescription forms and their subsequent misuse is an area of concern due to the financial costs and public safety which can be associated with fraudulent misuse.

Stolen FP10s can be used illegally to obtain controlled drugs or other medicines either for illegal personal use or for the purpose of selling them on. A clinical incident could then result.

Scope

This document applies to all directly and indirectly employed staff within the service provider's. In particular, this document applies to all authorised prescribing staff, and those non-prescribing staff who manage or administer FP10s across all areas and at all levels within the company. For the purpose of this document the term "prescriptions" refers to the prescribing stationery (typically FP10SS) which may be presented at a community pharmacy.

Role and responsibilities

Evolutio ophthalmology clinics

Evolutio's Clinical Responsible Officer (CRO) is responsible for overseeing the ordering, receipt, storage, transfer, access to and overall security of prescription stationery. Evolutio's Compliance Lead clinician will act as a deputy or second point of contact in the absence of the CRO.

Evolutio's CRO's responsibilities are to:

- Maintain a signed record that the named responsible clinician (NRC) and all other prescribers within each practice has read and understood this policy
- Assist in the assignment of prescribing staff to the appropriate budget code and the setting up of prescribing codes for clinics and units
- Maintain records of FP10s ordered and issued to authorised prescribers
- Order prescription "pads" (via the NHS forms site) when required and ensure that staff are appropriately registered to prescribe
- Ensure prescribers are appropriately registered with the NHSBSA and conduct regular checks to ensure all prescriber details are up to date
- Verify prescribing qualifications and ensure all documentation relating to non-medical prescriber registration is completed and filed
- Ensure the safe keeping of prescription forms in their possession at all times, and for maintaining records
- Regular auditing of prescription pad stock and usage

Evolutio service providers

Each contracted service provider must have a named responsible clinician (NRC) who is an employed independent prescriber within their practice, usually a practice owner/co-owner (Appendix 1).

The NRC's broad responsibilities, as described within this document, are to:

- Conduct a risk assessment to establish practice security, and therefore eligibility to have FP10 forms on site (Appendix 1)
    - Ensure the safe keeping of prescription forms in their practice and possession at all times
- Inform Evolutio's CRO of any clinicians who prescribe within the practice (Appendix 2):
    - Signed record that each prescriber has read and understood this policy
    - Verify prescribing qualifications (copy of relevant certificate)
    - Verify prescribing registration (annual lookup on GOC register)
- Communicate closely with Evolutio's CRO:

  - When a new supply of FP10s are required (Appendix 3)
  - To confirm receipt of the delivery of FP10s (Appendix 3)
  - Where any incidents or concerns are identified
- Maintain records:
  - FP10s received/on site (Appendix 3/4/5)
  - FP10s issued to each authorised named prescriber (Appendix 4)
  - FP10s issued to patients (Appendix 5)
  - Includes regular audit of prescription pad stock and usage

Random checks will be undertaken by Evolutio's compliance team. Additionally, an annual audit will be undertaken by the Evolutio Clinical Lead for Ophthalmology, supported by the Clinical Lead for Optometry.

All staff are responsible for ensuring the security of FP10s, reporting of incidents to the CRO and prescribing appropriately. The CCG will be provided with assurance that this policy is being adhered to.

Security

All FP10 prescription forms must be handled as controlled stationery. Each stage (ordering, receipt, storage and use) must be accounted for and records kept as detailed in this document. FP10 prescription forms must be stored securely and must only be accessible by authorised members of staff.

Theft of FP10 prescription forms can lead to service users, colleagues or members of the public illegally obtaining medication or selling the forms on to a third party for profit. To assist with the security of FP10 prescription forms, it is mandatory that Evolutio and its subcontracted service providers maintain clear and unambiguous records relating to prescription stationery.

A risk assessment (Appendix 1) should be carried out by the NRC to identify potential security threats at locations where FP10 prescription forms are stored. Suitable physical security measures that address identified risks should be put in place. Physical measures include CCTV, alarms and access control systems with a physical lock (where appropriate). Access to the room or area where FP10 prescriptions are stored should be restricted to authorised individuals. Keys or access rights should be strictly controlled, and a record made of keys issued or an authorisation procedure implemented regarding access to the controlled area.

There must be an audit trail for all FP10 prescription forms:

- The serial numbers issued by the Medicines Management department which are received by the NRC (Appendix 3)
- The serial numbers issued by the NRC to individual prescribers within that practice (Appendix 4)
- The serial numbers issued by each prescriber to each patient (Appendix 5)

Where treatment is prescribed following a virtual consultation, a photograph of the prescription will be sent via NHS.net to the designated pharmacy with a physical copy sent within 72 hours (local processes will be agreed with the CCG and Local Pharmacy Committee).

Management of FP10 stock

Ordering

Evolutio's Clinical Responsible Officer is responsible for the ordering, receipt, safe storage and distribution of the FP10 prescription forms. The NRC and individual prescribers are responsible for the security of FP10 prescription forms after they have been issued to them.

Requests for FP10 prescription forms can only be made by the Clinical Responsible Officer via the PCSE portal. All requests must include (as a minimum):

- Address
- Quantity required
- Date of request
- Staff signature

Receipt

Upon receipt of the FP10 prescription forms at the prescribing location and before the delivery driver leaves, a full check should be made against the delivery note to ensure the correct forms and the correct quantity of forms have been received. Any discrepancies should be noted on the delivery note and queried with PCSE as soon as possible. The delivery note should only be signed once satisfied the order is correct and the delivered packaging is sealed and unbroken.

The following details must be recorded in the FP10 record folder upon receipt of the FP10s at each location (see Appendix 3):

- Date of receipt
- Name of person receiving FP10s
- What has been received (quantity and serial numbers)
- Where it is being stored and who stored them
- The copy of the FP10 Prescription Order Form / Delivery Note should be filed and kept for a minimum of five years
- Records of serial numbers received should be kept for at least five years

Storage

Each practice is responsible for the security of FP10 prescription forms once they have been issued to them. Each prescriber also has a responsibility for security once FP10s have been issued to them. FP10 prescription forms must be securely locked away when not in use in a designated lockable filing cabinet, secured with a digital lock. Access rights to the cabinet should be strictly controlled and access to the room where FP10 prescription forms are stored should be restricted to authorised individuals.

Use of FP10 prescription forms

When issuing FP10 prescription forms to prescribers, the following information should be recorded in the FP10 record log (Appendix 4):

- When it was issued (date and time)
- To whom they were issued
- Serial numbers of the prescriptions issued
- Name and signature of the prescriber

Usually a small number of FP10 forms would be issued to a prescriber at a time (e.g. 5). These must be stored in a locked drawer/cupboard when not being used. Service users, temporary staff and visitors should never be left alone with prescriptions forms or be allowed into secure areas where forms are stored.

Prescription for controlled drugs

Prescribers must comply with all the relevant legal requirements when writing prescriptions for controlled drugs. Optometrist therapeutic prescribers are unable to (and therefore must not) issue a prescription for controlled drugs.

Duplicate and spoiled prescriptions

If an FP10 is duplicated, spoiled or no longer required, it should be securely destroyed or returned to the prescriber as soon as possible. If an error is made during prescribing, the prescriber should do one of the following:

- Put a line through the script and write 'spoiled' on the form
- Cross out the error, initial and date the error, then write the correct information
- Destroy the form and write a new prescription

A record must be made in the FP10 Destruction Record (Appendix 6) before any duplicated / spoiled / incorrect forms are destroyed. The forms should be securely destroyed by shredding or by tearing into at least four pieces before being put into confidential waste, appropriate records of these actions should be kept by the destroying location. The person who destroys the forms should make a record of the serial number of the forms destroyed along with the reason for destruction. The destruction of the forms should be witnessed by a second member of staff. Records of forms destroyed should be kept for at least five years.

Reporting NHS prescription form incidents

Any incidents involving FP10 prescription forms, fraud, loss or theft should be reported by the prescriber or the manager at the prescribing location to the NHSCFA (NHS Counter Fraud Authority) through the NHS Fraud and Corruption Reporting Line 0800 028 4060 or online at *https://cfa.nhs.uk/reportfraud*. For details of how to make an online report see 'NHS Counter Fraud Agency Management and control of prescription forms 'A guide for prescribers and health organisations March 2018 Version 1.0'An Evolutio Incident Form must be completed, and the following people informed; Clinical Lead, Senior NHS Services Manager, Chief Operations Officer and the police (if criminal activity is suspected).

The Evolutio Chief Executive Officer/Board should be notified if fraud / suspected fraud has occurred. Any report must include the following details:

- Date and time of fraud, loss or theft
- Date and time of reporting fraud, loss or theft
- Place where fraud, loss or theft occurred
- Type of prescription stationery
- Serial numbers
- Quantity
- Details to whom the incident has been reported

The location whose FP10 prescription forms are lost / stolen should instruct all prescribers at that location to write and sign all newly issued prescriptions in RED ink for a period of TWO months.

Less serious incidents (e.g. misplace a single completed FP10 by a patient or a request for an early repeat prescription) should be raised with the patient's GP as it may be a sign of deteriorating mental capacity or drug misuse.

Appendix 1: Application to Evolutio to become a Named Responsible Clinician (NRC) for FP10 purposes

This form must be completed in full by the person applying to be the NRC. The NRC must be a therapeutic optometrist and own/co-own the practice.

PART 1 – Your details

Practice name:

Practice address:

Your full name:

Your GOC number:

Your role in the practice (e.g owner):

Attach copy of your prescribing qualifications (e.g. IP certificate)
Attach copy of your prescribing registration (printout/screenshot of entry on GOC register showing IP speciality)

PART 2 - Security Risk Assessment

Physical security measures within practice: CCTV / alarms / lockable access control systems

Where will the FP10 pads be stored? Lockable Room / cupboard / drawer / safe / other ……..

Security measures in room/area where FP10 stored: CCTV / alarms / lockable access control systems

Is the room/area where FP10 stored accessible to the NRC only? Yes / No

If not, please list the name and role of all staff/individuals who will have access:

I confirm that I have read, understood and agree to strictly adhere to this policy (Evolutio Ophthalmology Handbook section 1.15.1 FP10 Management Policy). I agree to undertake the responsibilities of the NRC and agree to raise any concerns relating to FP10 forms/prescribing to Evolutio's Clinical Responsible Officer immediately.

Name:

Signature:

Date:

Please return a copy of this completed form (scan/photo/hard copy) to Evolutio's Compliance Team at *support@evolutio-uk.com*

Appendix 2: Request for access to FP10 for a therapeutic optometrist within a practice with existing Evolutio FP10 access

Name of applicant (therapeutic optometrist):

I confirm that I have read, understood and agree to strictly adhere to this policy (Evolutio Ophthalmology Handbook section 1.15.1 FP10 Management Policy). I agree to raise any concerns with the NRC (listed below) or Evolutio's Clinical Responsible Officer immediately.

Signature of applicant: Date of signature:

Named Responsible Clinician (NRC) completing this form:

Practice name and address:

Attach copy of applicant's prescribing qualifications (e.g. IP certificate)
Attach copy of applicant's prescribing registration (printout/screenshot of entry on GOC register showing IP speciality)

I agree to check this applicant's prescribing registration each year.
I have given the applicant a copy of this policy.
I accept responsibility for logging the supply of FP10 forms to this prescriber and making them aware of their obligations concerning FP10 use.
I agree to notify Evolutio if this clinician no longer works at this practice, is no longer eligible to prescribe or if any concerns are identified around their handling of FP10 forms/prescribing practice.

Signature of NRC: Date of signature:

Please return a copy of this completed form (scan/photo/hard copy) to Evolutio's Compliance Team at *support@evolutio-uk.com*

Appendix 3: Request to Evolutio to organise FP10 batch order (and for NCA to confirm receipt)

	ORDER 1	ORDER 2	ORDER 3	ORDER 4	ORDER 5
Practice name & address:					
ORDER					
Named Responsible Clinician:					
Date request made to Evolutio:					
RECEIPT					
Date FP10 forms received:					
FP10 serial number – from:					
FP10 serial number – to:					
Received by – name:					
Received by – signature:					
NRC signature to confirm receipt (if not directly received by NRC from courier)					
Where are the FP10 forms stored?					

Whenever additional entries are made, please send a copy of this completed form (scan/photo/hard copy) to Evolutio's Compliance Team at *support@evolutio-uk.com*

Appendix 4: Distribution of FP10 forms by NRC to Evolutio-approved prescribers within the practice

RECORD OF FULL FP10 PRESCRIPTION PAD/FORM ISSUED TO PRESCRIBERS	PRACTICE NAME & ADDRESS:

FP10 PAD/FORM SERIAL NUMBER (not including last digit)		DATE ISSUED	TIME ISSUED	ISSUED BY (NRC)		RECEIVED BY	
From	To			Print Name	Signature	Print Name	Signature

Appendix 5: FP10 prescribing log

Date	Clinician	Evolutio ID	FP10 serial number	Condition	Drugs prescribed

Appendix 12: FP10 destruction record

PRACTICE NAME:						
Date	Prescriber name and code	Reason and method of destruction	QTY	Serial numbers		Sign & print name	Witness (Sign & print)
				From	To		

Appendix 7: FP10 incident reporting form

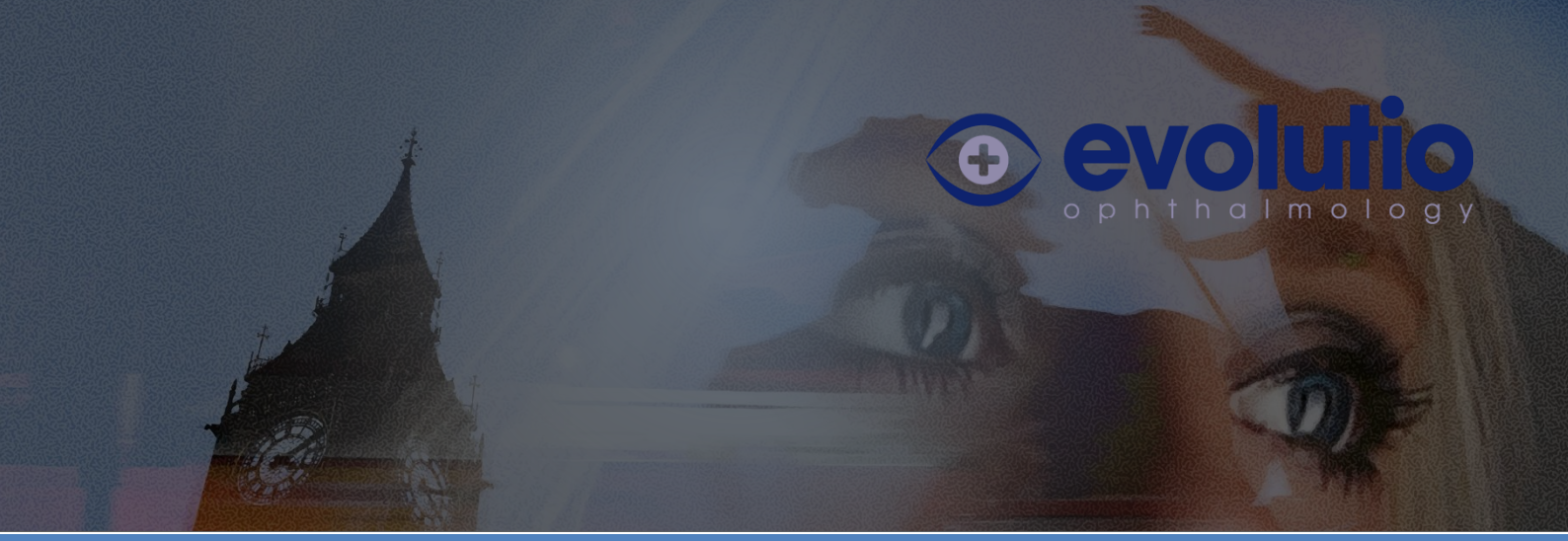
In cases of suspected fraud, loss or theft of FP10 forms must be reported by the NRC to the NHSCFA (NHS Counter Fraud Authority) through the NHS Fraud and Corruption Reporting Line 0800 028 4060 or online at *https://cfa.nhs.uk/reportfraud*.

An Evolutio Incident Form must be completed (see Section 3.4 of this handbook)

Classification of incident	Fraud / loss /theft / other ……
Date of occurrence	
Time of occurrence	
Location where incident occurred	
Type of prescription stationery	
Serial numbers	
Quantity	
Who has this been reported to?	
Any other information	
Name of person completing this form	
Role of person completing this form	
Practice name and address	
Date of form completion	
Time of form completion	
Signature	

In cases of loss or theft, all prescribers at that location must write and sign all newly issued prescriptions in RED ink for a period of TWO months.

A copy of this completed form (scan/photo/hard copy) AND an incident form must be sent immediately to Evolutio's Compliance Team at *support@evolutio-uk.com*



1.15.2 Treatment & Prescribing Guidance

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Lyn Price	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	1.0

Overview

As an NHS service, Evolutio pathways are FREE at the point of access. This policy will support providers when recommending conservative measures and medications to their patients. The policy is underpinned by several key documents referenced below.

Evolutio appointment or sight test?

Service providers and patients must clearly understand the difference between a sight test and an Evolutio appointment. If you receive a referral, you should address the reasons for referral and advise the patient to consult their regular practitioner for their routine sight test. Patients must not be encouraged to change from their regular optometrist to the Evolutio service provider for their sight test or spectacle purchase. If a patient, without encouragement (e.g. discussion, recommending, handing leaflets etc.) requests to attend the service provider for their sight test or spectacles then you may accept them as a sight test/spectacle patient and clarify in the notes 'patient independently and without encouragement elected to attend this practice for their sight test/spectacles, having made an informed choice'.

Private products and services

If a patient requires a product or service which is not covered/funded by Evolutio's service (e.g. demodex medication, Lipiflow treatment, keratoconic contact lens fitting, punctal plugs etc.) and assuming that there are no alternatives which are available within the service (e.g. conventional lid hygiene measures initially in the case of Demodex/MGD) then the patient should be clearly informed that the next step in their NHS-funded care is a referral to an alternative pathway (may be community or HES).

Private services must NOT be offered to patients within the context of an Evolutio appointment. Should a patient enquire about private services (without provider encouragement/pressure) then the NHS pathways mentioned above must be reiterated and it must be made very clear that any private services are outside the scope of the Evolutio service they were referred in for. If the patient elects private care then you must clearly annotate the notes 'patient expressly declined onward referral for further NHS-funded care and without encouragement elected to undertake private care at this practice; they are aware that all private services are outside the scope of the Evolutio service'.

Conservative measures and ancillaries

There are numerous over-the-counter (OTC) ophthalmic medicines and ancillaries, particularly in the context of blepharitis and dry eye.

Patients must be given the option to make an informed choice about their NHS-funded care. Wherever possible, and in alignment with the NHS 'free at the point of access' philosophy, patients should be made aware of DIY options as an alternative to commercial products (e.g. hot facecloth and boiled salt water for eyelid hygiene). No patient should feel compelled to purchase ancillaries from the service provider; they must be made aware that such products may be purchased from a range of outlets, including online. Furthermore, service providers should only offer ancillaries to Evolutio patients if they are sold at a similar price to the local pharmacy. Your notes should be annotated with 'discussed DIY vs commercial products and patient aware these may be purchased from any supplier'. Some patients might require onward referral to HES if their condition cannot be managed within the service.

Tear supplements (dry eye drops) are commonly available over the counter (OTC) and NHS England's 'Conditions for which over the counter items should not routinely be prescribed in primary care' alongside local CCG formularies strongly advocate 'self-care' (i.e. patient purchases OTC).

There are some General Exceptions to the Guidance (where patients should continue to have their treatments prescribed):

- Patients prescribed an OTC treatment for a long-term condition (which dry eye often is)
- For those patients that have symptoms that suggest the condition is not minor (i.e. highly symptomatic dry eye patients)
- Patients prescribed OTC products to treat an adverse effect or symptom of a more complex illness (e.g. Sjogrens syndrome or as a result of medications e.g. diuretics)
- Patients with a minor condition suitable for self-care that has not responded sufficiently to treatment with an OTC product

Evolutio's position is as follows:

1. Where dry eye is identified we specify severity (mild/moderate/severe) and conduct investigations to identify the cause (evaporative/aqueous tear deficiency, primary/secondary)

2. Where eyelid hygiene is a contributory factor, we give patients an informed choice by suggesting 'DIY' self-help measures (e.g. hot flannel soaked in dilute baby shampoo/bicarbonate of soda) and making them aware of products they might wish to purchase as an alternative (e.g. heat masks such as Blephamask and cleansers such as Blephasol, LidCare etc.)
3. Where tear supplements are required patients are advised that there are a large number of preparations and typically a product will be suggested on the basis of aqueous vs lipid layer deficiency and severity. Cases of mild to moderate dry eyes are often amenable to OTC tear supplements. Moderate to severe cases (and those discussed in the scenarios above) might benefit from a prescription in view of the long-term nature and risk to the cornea.
4. Environmental factors are discussed with patients (e.g. humidity/air conditioning, protective wrap-around glasses, hydration, diet, VDU use, blink rate etc.) as well as options such as punctal plugs

Exceptions and low income

The general exceptions state that "Individual patients where the clinician considers that their ability to self-manage is compromised as a consequence of medical, mental health or significant social vulnerability to the extent that their health and/or wellbeing could be adversely affected, if reliant on self-care.

Note that being exempt from paying a prescription charge does not automatically warrant an exception to the guidance. Consideration should also be given to safeguarding issues.

Thus, although it isn't feasible to make a full financial assessment of our patients, wherever possible we are mindful of patients' individual circumstances and needs, particularly groups who are financially and socially vulnerable.

Glaucoma medications

We have several treatment algorithms for glaucoma depending on risk of clinical progression, beta blocker intolerance and preservative intolerance.

In accordance with NICE NG81, a generic PGA (latanoprost) would usually be a first line intervention. Branded products would be used if this was not effective (as suggested by NG81) or if there was no alternative (e.g. Tiopex gel). When a patient has been on a treatment for considerable time with stable control and there is no generic alternative or other compelling reason (e.g. the formulation sensitivities) we would generally not modify medication, although we do look to change patients to generic medications where appropriate.

CCG Formulary

Local Formularies are for use by local prescribers and healthcare professionals. The contents are based on clinical evidence as well as consultant and GP opinion. The formulary aims to provide information on medicines available to prescribers, reflecting safe, evidence-based, cost-effective choices.

Formularies often follow a similar layout to the BNF but with each drug categorised as formulary or non-formulary. Additionally, formulary drugs may be classified according to a traffic light system:

- Green - May be initiated, stabilised and maintained in primary, secondary or tertiary care
- Amber - May be with or without shared care guideline
- Red - For secondary or tertiary care initiation and long-term maintenance of prescribing
- Black - Not recommended

References

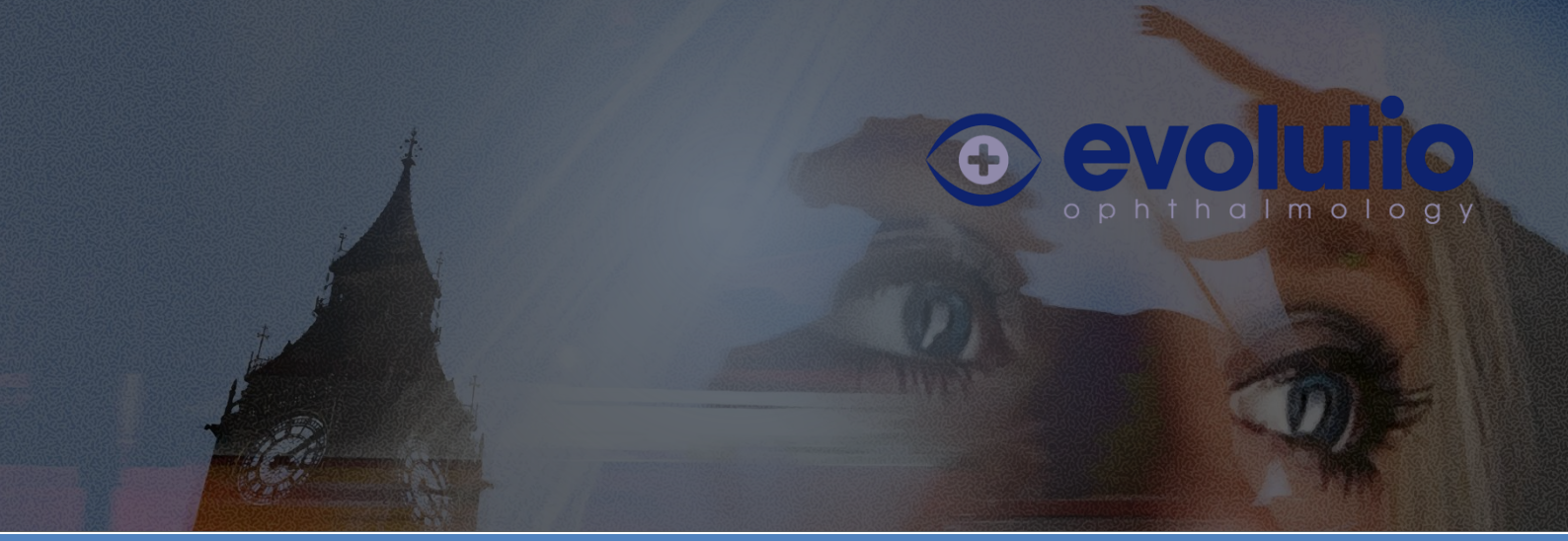
All clinicians must be aware of and have reviewed following documents:

NHS England's 'Conditions for which over the counter items should not routinely be prescribed in primary care: Guidance for CCGs'

NICE CKS: Dry eye syndrome

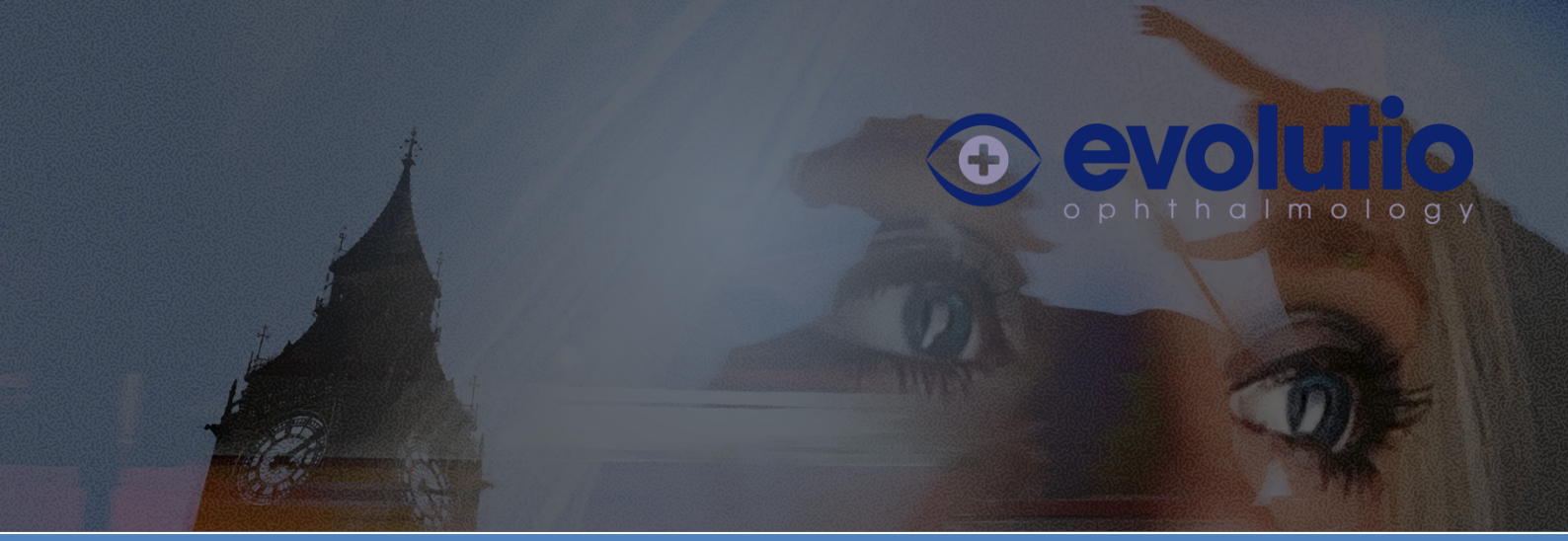
Local CCG Formulary (& other relevant publications e.g. medicines advisory group directive/prescribing guidelines for dry eye)

NICE NG81 (https://www.nice.org.uk/guidance/ng81)



Evolutio Ophthalmology Handbook

Section 2: CLINICAL PROTOCOLS & RECORD KEEPING



2.1 Record Keeping & Evonnect

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

In accordance with GOC Standards and College of Optometrists Guidance, all records must be made contemporaneously and must be complete, sufficiently detailed, legible and accurate.

High quality records enhance the safety and effectiveness of the care system. They are the only way to demonstrate what happened during an episode of care and might provide protection against any subsequent complaints from patients or their representatives. Any conversation with a patient or their representative relating to their care must also be recorded. All queries relating to record keeping standards should be directed to the Clinical Lead (Optometry).

Evolutio's clinical protocols provide a recommended structure for the clinical examination. Appropriate clinical tests must be undertaken and the results recorded comprehensively for the purposes of patient care, safety, clinical audit and for our telemedicine team to make informed decisions when reviewing clinical cases.

Evonnect is Evolutio's NHS Digital compliant platform for processing referrals and recording clinical findings (Electronic Medical Record), including additional practice management functionality such as calendar and patient recall. Some pathways include telemedicine oversight/functionality.

Patients seen within the Evolutio service have NOT consented to their personal information (name address, contact details etc.) nor their clinical information being stored on your existing practice management system. All information relating to Evolutio patients seen within the Evolutio service must only be kept on Evonnect (i.e. no local copies).

System requirements

Evonnect is available for download for the following platforms: Windows, macOS, iOS and Android.

Internet/firewall

Evonnect requires users to download and upload clinical data so application speed may be affected by download speed, upload speed, latency (ping) and bandwidth. Although internet requirements may vary with new releases, as a guide user require a minimum of 4MBPs download speed and 1MBPs upload speed. You can check your speed at the following site: *https://speedof.me/*.

Larger organisations will need to contact their IT department to whitelist the connection to Evonnect (this can be checked by visiting https://evonnectapp.evonnect.com/ECOLB/ping which will return the word 'Hi' if access has been granted) – see 'Networking Requirements' below.

Operating system/resolution

Windows

Evonnect works with Win7 onwards, we recommend resolution 1280x1024 or higher but can work on 1024x768.We also recommend minimum of 4GB of RAM for any PC running Windows but can run on lower (about 2GB) as the app tends to use about 500MB of RAM.

Mac

We recommend resolution 1280x1024 or higher but can work on 1024x768.
We also recommend minimum of 4GB of RAM when running on Mac but can run on lower as the app tends to use about 400MB of RAM.

Networking requirements

The app uses HTTPS to communicate with server, so the port is 443. As it will be working on a corporate network, it will be communicating with servers, there are two server locations that will need to be whitelisted by your IT people, these are *https://ereferserver.evolutio-uk.com* and *https://www.erefer.co.uk*.

Other dependencies

There are no Java or active X or other DLL dependencies.

Where to download Evonnect

Windows

https://www.erefer.co.uk/erefer-downloads/eEvonnect/Win32/Latest/Evolutio_Evonnect.exe

Mac

https://www.erefer.co.uk/erefer-downloads/eEvonnect/MAC/Latest/Evonnect.pkg

Installing and updating Evonnect:

When installing on windows, it is really important that the software is NOT installed using any Elevated Rights or logging in as Admin - it is important that it is installed using the user account that will run the software and WITHOUT choosing to "Run As Administrator".

2.2 Evolutio contingency electronic/paper record

May be use in the event of a software/internet failure and transcribed when resolved.

Date			
Name		DOB	
Phone		GP	

H&S	
Symptoms	
PMH	
Meds	
POH	
FH	
Smoker	

RX	R		VA		PH	
	L		VA		PH	

	Right		**Left**
Visual Function		Colour	
		Amsler	
		Pupils	
		Fields	

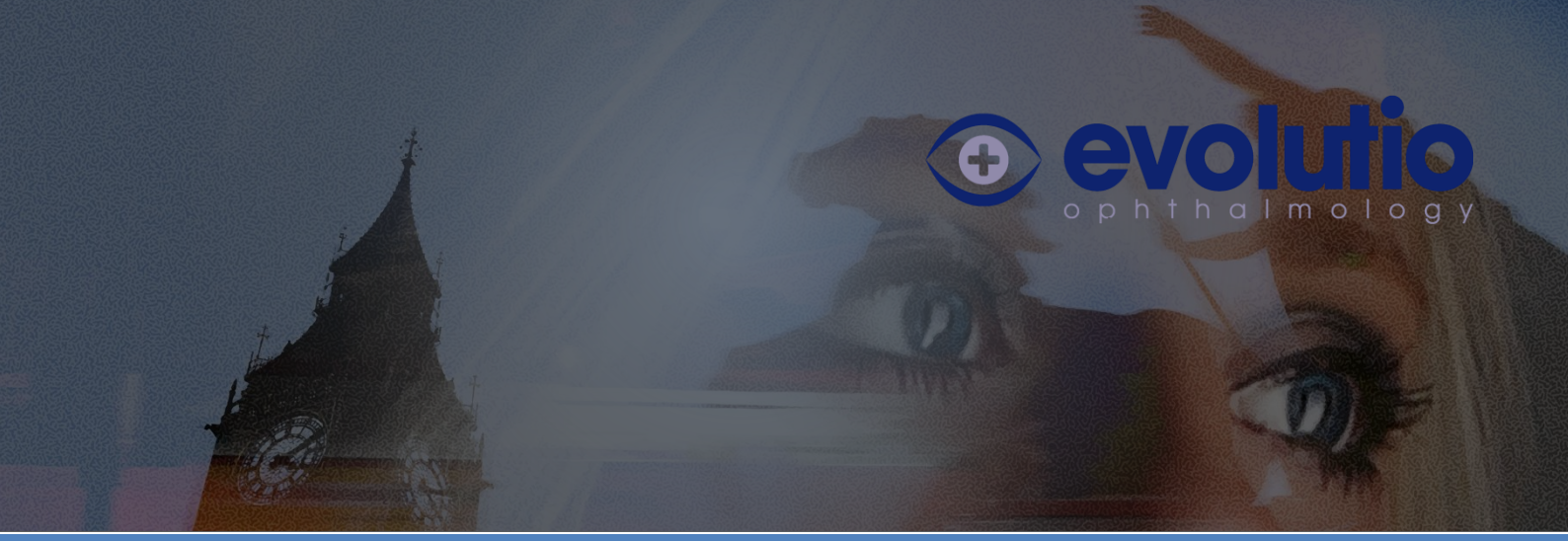
	Right		**Left**
Anterior Segment		Lids/Lashes	
		Tear Film	
		Conj.	
		Cornea	
		Iris	
		Lens	
		AC	

Dilated?	Reason why not:	
Drops used		

	Right		**Left**
Posterior Segment		Vitreous	
		Vessels	
		Macula	
		Periphery	

	Right		**Left**
Discs, angles & Tonometry		IOP	
		CCT	
		A/C Angles	
		CD Ratio	
		Depth	
		ISNT?	
		Highest IOP	

Conclusion	
Clinical impression	
Care plan	
Suggested meds	
Recall	
Other	



2.3 Clinical Protocols – Evolutio Service & Telemedicine

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This document provides a high-level overview of Evolutio's service specification and introduces the clinical protocols. Commissioned services vary by Clinical Commissioning Group (CCG) so Service Providers are advised to consult their local Evolutio CCG handbook for any local service variations/requirements.

Evolutio continuously work with local hospitals and key stakeholders to establish and implement local referral/inclusion/exclusion criteria. We also welcome feedback on our clinical protocols and policies.

The NHS has a strategic vision to ensure that patients receive high quality, sustainable and cost-effective care to meet the increasing health needs of an expanding elderly population. Current pressures on eye care services, especially within secondary care, are already substantial and demographic changes will significantly impact on this already overloaded service model of care.

Many patients with eye problems do not require the expertise offered within a specialist secondary care setting and instead, could be seen and treated in the community closer to their own home. With oversight from consultant ophthalmologist-led asynchronous telemedicine, utilisation of the large optometrist resource working within defined pathways and under a clear clinical governance framework, allows for the safe and cost-effective delivery of community ophthalmology services. This enables the HES to treat patients requiring high end specialist care, ensuring that the limited number of hospital consultant ophthalmologists are used effectively and cost efficiencies across the local healthcare economy are realised.

Patient management will be maintained within the community for as many patients as possible, thus avoiding unnecessary referrals to hospital services. Where non-invasive treatment is required, this will usually be performed in the initial outpatient appointment, or where a Prescription Only Medication (POM) is required then a prescription request will be raised with the patient's registered GP. Where referral to HES is required it will be made directly to a suitable sub-specialist with appropriate urgency and diagnostic information.

Evolutio's community service pathways diagnose and manage patients presenting with an eye condition and will improve outcomes by:

- Improving access
- Reducing false positives
- Increasing capacity within the eye department
- Maximising care in the community
- Signposting to other appropriate services
- Reducing costs to the greater health economy
- Supporting the system to GIRFT

Although all clinical procedures are at the discretion of the clinician, Evolutio's clinical protocols specify the recommended safe minimum level of care which Providers are expected to deliver. The clinical protocols are intended to support clinicians by providing a structure to their consultation both in terms of questions to ask, tests to undertake and management options. If providers deviate from the clinical protocol, there should be a valid clinical reason and this should be recorded.

Clinical governance

Pathway Entrance Decision Affirmation - all Evolutio pathways are operated on an electronic real time check by a two-decision affirmation process, ensuring patients are referred onto the most appropriate care pathway and the receiving clinician can see the patient. All cases follow these key steps into a care pathway:

- Decision
    - A central referral clinical management (triage) team assess suitability for a community pathway
- Decision Peer Affirmation
    - Service Provider accepts the case by electronic acknowledgement (accept/reject), before care is transferred to the Evolutio pathway

Additional governance is provided though clinical audit and data analysis comparing like for like decision repeatability and deviations, or whistle blowing events, resulting in immediate suspension of a login to the Evonnect central records system, thus suspending an affected clinician from providing any further care until a full assessment is completed by the clinical leadership team.

Patient liability and insurance

All patients referred to and under the care of Evolutio Care Innovations Limited are covered under the Company's Professional Indemnity and Medical Malpractice insurances to a cover value of £5,000,000 per case. All patients remain the clinical responsibility of the Evolutio Care Innovations Ltd board of directors and registered clinicians until the point of a confirmed transfer to another care provider or clinician.

Please see section 3.2 of this handbook (Provider Responsibilities) for more information.

Training, accreditation and equipment requirements

Please see section 3.1 of this handbook (Equipment, Consumables & Accreditation) for more information

- Service Providers are encouraged to participate in our peer review cycle and may be offered placements (including IP) in our clinics with one of our ophthalmologists
- All optometrists working within our pathways undergo an initial Training Needs Analysis to highlight any additional training requirements
- Equipment requirements vary by Provider Tier

Pathway inclusion criteria

Age restrictions may apply in some CCGs (e.g. under 18's excluded). Some pathologies are excluded from the community service in some CCGs (e.g. new floaters in a high myope). See your local CCG handbook for details.

Time to care (TTC)

Service Providers are required to review, grade and prioritise all referrals (using the accept/reject silo) within one working day of entering an Evolutio pathway. Contractual requirements vary by CCG and presenting signs/symptoms (see your local handbook for more information). Typical timescales:

- Routine – appointment offered within 1 week, for clinic review within 4 weeks
- Urgent - appointment offered within 48 hours, for clinic review within 2 weeks
- Rapid Access - appointment offered within 24 hours, for clinic review within 1-5 days (depending on presentation)

Record keeping

To ensure maximum efficiency and safety, and govern minimum standards of record keeping, all Evolutio pathways operate on a single electronic medical record (EMR) and Patient Administration System (PAS). It is mandatory for all clinicians to have an active logon, current clinical accreditation and a minimum standard of record data field entry is mandated to each pathway before a case can be discharged from the system.

A list of acceptable ophthalmic clinical abbreviations may be found in Appendix A.

Therapeutic supply/Prescribing of medicines

- Appropriate self-care medicines will be recommended where indicated
- Appropriate POMs will be prescribed where local arrangements exist, or a request will be made for the same from the patient's GP

Asynchronous telemedicine

Evolutio have 2 main types of pathway:

- Ophthalmology-led (e.g. glaucoma monitoring)
- Optometry-led (e.g. MECS)

Ophthalmology-led pathways are operated under the training, guidance and real time telemedicine oversight of an Evolutio ophthalmologist. This service is overseen by the lead consultant ophthalmologist (clinical service director).

1. Service provider completes visit in accordance with clinical protocol, including images
2. Asynchronous telemedicine clinician reviews record
   - Finalises impression and care plan
   - Generates prescription requests
   - Returns record to Service Provider's 'from Telemed' silo
3. Service Provider accepts telemed clinician's plan (and contacts patient with an update if required)
4. Report sent to GP (including prescription request where applicable)

Tips for working with the asynchronous telemedicine team are included in Appendix B.

Visit outcomes

In ALL cases, patient information is offered to aid and support early detection and prevention planning through:

- Written guidance as appropriate
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Following an Evolutio appointment, there are 3 outcome options:

Discharge

There are no abnormalities found requiring further investigation or treatment

- Select 'choose outcome'
- Select 'discharge'
- Enter visit outcome notes
  - Include a high-level overview of the case (typically 1 or 2 sentences summarising reason for visit, diagnosis and management plan)
- Choose 'assign outcome'

Retain (for follow-up)

Where safe to do so patients should be discharged. In some CCGs follow-up visits are not funded. Evolutio report % of follow-ups to the CCG as they are a key metric.

- Select 'choose outcome'
- Select 'retain'
- Choose time to care (and appointment type if applicable)
- Select 'choose outcome'
- Enter visit outcome notes
  - Include a high-level overview of the case (typically 1 or 2 sentences summarising reason for visit, diagnosis and management plan)
- Choose 'assign outcome'
  - This will go into the 'retained' silo after Telemed (if applicable)

Onward referral

To refer the patient on to another pathway (could be HES or community) and therefore discharge the patient from the service for this referral reason. Evolutio report % of HES referrals to the CCG as they are a key metric.

- Select 'choose outcome'
- Select 'discharge and refer on'

- Select action (urgent or routine)
- Select pathway
- Select provider
- Select 'choose outcome'
- Enter visit outcome notes
    - Include a high-level overview of the case (typically 1 or 2 sentences summarising reason for visit, diagnosis and management plan)
- Choose 'assign outcome'
    - This will discharge this referral and spawn a new referral to be completed and sent on to the new provider (new referral can be found in drafts)

Create new referral for patient

To create a new referral for an unrelated incidental finding requiring further investigation (e.g. macular problem during a blepharitis assessment). This process takes place as a separate standalone process within the current visit. After completion/submission of this new referral the Provider is able to complete the current visit (discharge/retain/refer).

This process and all visit outcomes are demonstrated within the Eloomi training platform.

- Select 'choose outcome'
- Select 'Create new referral for patient'
- Complete the GOS18-style form and submit
- Complete original visit and assign outcome of discharge/retain/refer on (as above)

Outcome reports

A visit summary report is automatically sent to the patient's registered GP after each visit. Where available this is sent electronically via NHS.net, otherwise it is sent by post. In the case of ophthalmology-led pathways, this happens after the record has been reviewed by the telemedicine team and the Service Provider has accepted the telemedicine team's management plan.

Copies of patient visit records may be printed locally at the provider's discretion. Evolutio are currently developing a secure electronic platform for patients to access their clinical records.

Referring clinicians can view their referrals and the provider's clinical record/management plan by logging into Evonnect. Evolutio are currently developing a secure electronic platform for direct feedback to referrers.

Appendix A: Acceptable Evolutio ophthalmic clinical abbreviations

Right eye must be written as OD or Right eye (not R or RE)
Left eye must be written as OS or Left eye (not L or LE)

A/C	Anterior chamber
AAU	Acute anterior uveitis
ACG	Angle closure glaucoma
AION (AAION NAAION)	Anterior ischaemic optic neuropathy (arteritic/non arteritic)
ALL	Allergies
AMD	Age related macular degeneration
b.d. / b.i.d.	Twice a day
BP	Blood pressure
BRAO/CRAO	Branch/central retinal artery occlusion
BRVO/CRVO	Branch/central retinal vein occlusion
C:D	Cup:disc ratio
CCT	Central corneal thickness
CHRPE	Congenital hypertrophy of the retinal pigment epithelium
CLPU	Contact lens associate peripheral ulcer
CMO	Cystoid macular oedema
conj	Conjunctiva/conjunctivitis
CSR/CSCR	Central serous retinopathy/chorioretinopathy
CVA	Cerebrovascular accident
CWS	Cotton wool spot
DR	Diabetic retinopathy
EOM	Extraocular muscle
ERM	Epiretinal membrane
F/U	Follow up
FB	Foreign body
FH	Family history
g.	Eye drops
GCA	Giant cell arteritis
GCC	Ganglion cell complex
HA	Headache
Haem	Haemorrhage
HES	Hospital eye service
HSK	Herpes simplex keratitis
HTN	Hypertension
HZO	Herpes zoster ophthalmicus
IRF/SRF	Intra/sub retinal fluid
KP	Keratic precipitate
MA	Microaneurysm
mane	In the morning
MD/PSD	Mean deviation / pattern standard deviation
Meds	Medications
MGD	Meibomian gland dysfunction

nocte	At night
Non-tol	Non tolerance
NRR	Neuroretinal rim
NS/PSC	Nuclear sclerosis/posterior subcapsular cataract
NTG	Normal tension glaucoma
o.d.	Once a day
oc.	Ointment
OCT	Optical coherence tomography
OD	Right eye **[Please do NOT write R or RE]**
ONH	Optic nerve head
ONL/INL/EZ/ILM/RPE	Outer/inner nuclear layer, ellipsoid zone/inner limiting membrane/retinal pigment epithelium
OS	Left eye **[Please do NOT write L or LE]**
OU	Both eyes **[Please do NOT write BE]**
p.r.n.	Use as required
PAC	Primary angle closure
PAS	Peripheral anterior synechiae
PCO	Posterior capsular opacification
PDS/PG	Pigment dispersion syndrome/pigmentary glaucoma
PMH	Personal medical history
POAG	Primary open angle glaucoma
POH	Personal ocular history
PPA	Peripapillary atrophy
PS	Posterior synechiae
PVD	Posterior vitreous detachment
Px / Pt	Patient
PXS/PXF	Pseudoexfoliation syndrome / pseudoexfoliative glaucoma
q.d.s. / q.i.d.	Four times a day
RAPD	Relative afferent pupillary defect
RD	Retinal detachment
RFV	Reason for visit
RNFL	Retinal nerve fibre layer
RUL/RLL/LUL/LLL	Right/left upper/lower lid
SOT/XOT	Eso/exo tropia
SRNVM/CNVM	Subretinal/choroidal neovascular membrane
ST/EE/LEE	Sight test/eye examination/last eye examination
Sub-conj haem	Sub conjunctival haemorrhage
t.d.s. / t.i.d.	Three time a day
TBUT	Tear breakup time
TM	Trabecular meshwork
Trop	Tropicamide
V/H	Van Herrick
VDD	Vertical disc diameter
VMA	Vitreomacular adhesion
VMT	Vitreomacular traction
WNL	Within normal limits **[ONL is NOT acceptable for outside normal limits]**

Appendix B: Working with our Telemedicine Consultants

Our panel of ophthalmologists, led by Consultant Mr. Simon Hardman-Lea, share some tips on how to produce informative records which facilitate safe and effective remote management for our patients and clear GP outcome reports.

Start you record ('the beginning')

- Begin your record with the patient's age, gender and reason for visit to frame the record.
  e.g. 85yr M, RFV – right eye sudden onset reduced vision 1/12

- Clarify which eye is affected and use 'right eye', 'left eye' or 'both eyes' rather than RE/LE/BE (which are frowned on medicolegally). We have attached a list of accepted abbreviations.

- Describe the patient's symptoms; if they are asymptomatic then please record it. Ensure you explain/refer/address all symptoms in your conclusion.

- Provide a compact, targeted history, including negative findings (*e.g. 'no FH glaucoma'*). Our clinical protocols will guide you through relevant questions to ask for a range of presentations.

Conducting the assessment ('the middle')

- Provide a complete set of relevant observations. These will vary by condition and the clinical protocols will support you. Amsler testing and monocular colour vision are underutilised.

- Ensure fields, anterior eye photos, fundus photos and OCT images are attached (where indicated/specified) and of good resolution – please don't send photos of screen displays.

- Comment on the reliability of your results, particularly fields and OCT. Ensure masks are well fitted/taped to avoid lens fogging and the patient receives clear instructions.

Completing the record ('the end')

- When requesting prescriptions, record any relevant contraindications.
  e.g. 'no breathing/heart problems' when requesting beta blockers

- It is acceptable to refer (to yourself or elsewhere) for unrelated ocular pathologies. Please clarify how the other conditions are being managed to reassure telemed.
  e.g. on a glaucoma pathway where suspected wetAMD is discovered you should record 'I have made a separate rapid access referral for wetAMD'.

- Provide your impression (with differential diagnosis) for each eye. This box is unique so please don't copy and paste.
  e.g. 1. Right eye blepharitis 2. Left eye ocular hypertension

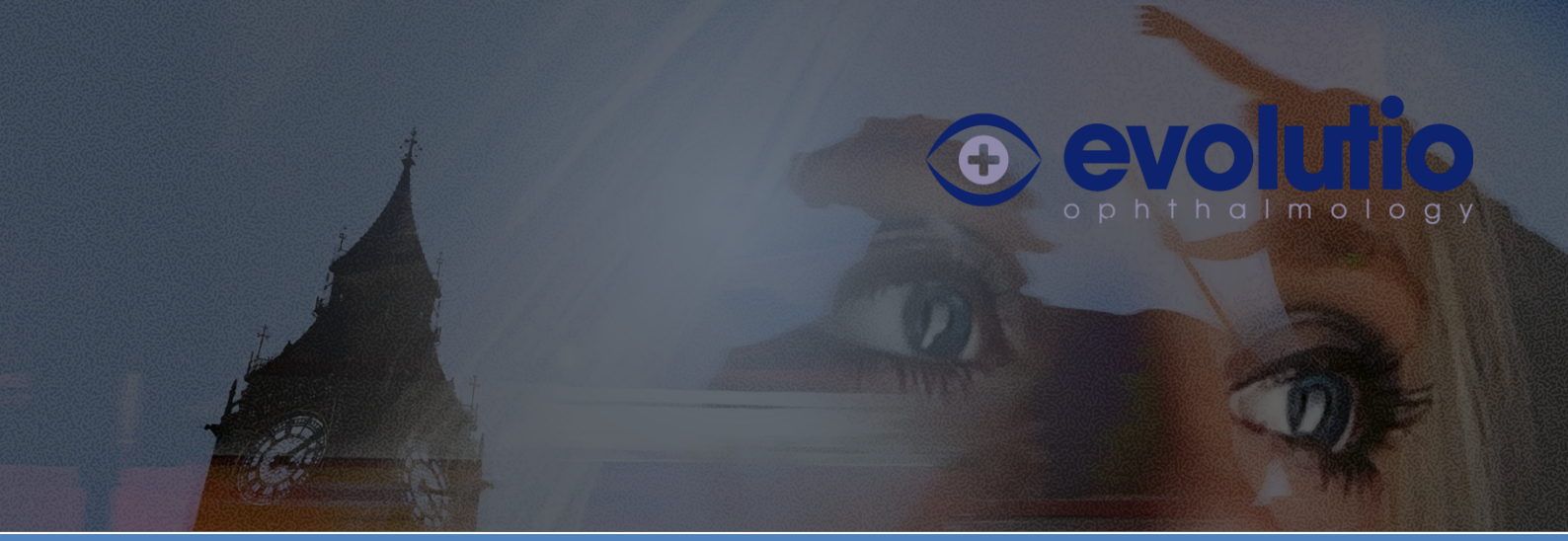
- Provide your management plan. This box is unique so please don't copy and paste.
  e.g. 1. Commence g. latanoprost 1 drop left eye nocte 2. Lid hygiene instructions and warm compress o.d. 2/52 3. Leaflets issued

- Provide a short conclusion in the 'notes to clinician' box. The telemed doctor will usually read this first then review your record.
  e.g. 63-year-old lady, no risks for glaucoma, IOP 25 corrected, normal disc / OCT / field = OHT

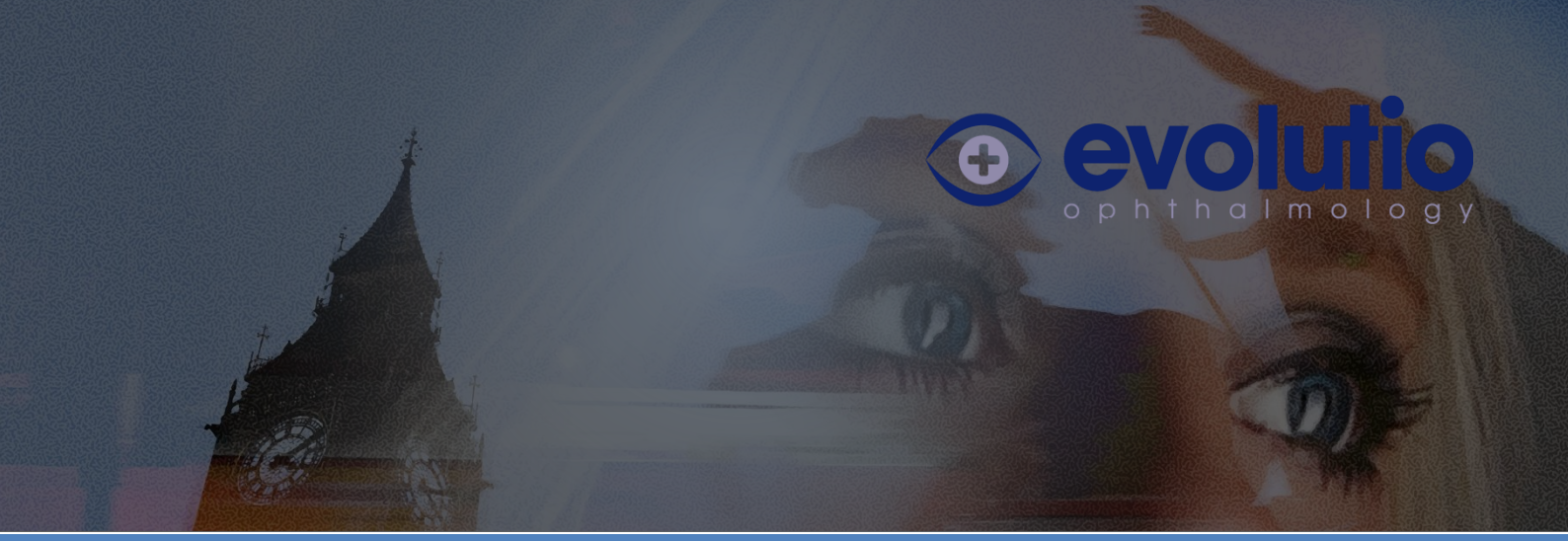
In the context of a glaucoma record, please also record any past glaucoma damage (MD on fields) and risk factors for future development/progression (e.g. thin CCT, FH, DM, young age, poor compliance).

The pre-treatment IOP/discs/fields are also helpful for baseline comparison.

You can then propose to continue / increase / decrease treatment and a recall date.



Section 2.3.1:
Tier 1 Pathways



1.3.1.1 Minor Eye Conditions - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 1 clinicians when assessing/managing a patient with anterior/posterior ophthalmic signs/symptoms which warrant investigation under a minor eye conditions pathway.

The sub-protocols in section 2.3.4 offer some helpful additional guidance for the assessment of maculopathy, vitreoretinal symptoms (flashes & floaters) and pigmented fundus lesions.

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment

History and symptoms

- Record age and gender
- Synopsis of referral / reason for visit
- Symptoms / asymptomatic
    - Including onset, duration, frequency
- Specific questions relevant to the presenting condition
- Personal medical history (including medications and allergies)
- Family medical history
- Personal ocular history
- Family ocular history

Initial tests

- Visual acuity (distance and near) with refraction where indicated
- Where indicated:
    - Visual fields
    - Monocular colour vision
    - Amsler
    - Pupil reactions
    - Ocular motility
- Intra-ocular pressure (IOP) and time
    - Goldmann Applanation Tonometry is the gold standard, iCare acceptable

Anterior segment

- Slit-lamp examination (with photos where clinically indicated)
    - Lids, lashes, tear film, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens
        - Staining where indicated
- Anterior chamber and angle examination

Posterior segment

- Slit lamp binocular indirect ophthalmoscopy (SL-BIO)
    - With dilation where indicated
    - Vitreous, retina, macula, disc, choroid
- Fundus imaging where indicated
- Post-dilation IOP review as appropriate

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established. 'Minor eye conditions' cover a wide range of ophthalmic conditions therefore there are a wide range of possible treatment options including eyelid hygiene, tear supplements, anti-histamines, anti-inflammatories, painkillers, antibiotics etc. depending on the diagnosis and the clinician's prescribing status.

If a prescription is required, a request can be made to the GP to prescribe. Where commissioned, therapeutic optometrists (independent prescribers) may issue a prescription to a patient directly. Registered Optometrists may supply all pharmacy medicines (P) or general sale list medicines (GSL) in the course of their professional practice, including 0.5% Chloramphenicol antibiotic eye drops or 1% eye ointment.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. College of Optometrists leaflet on blepharitis, AOP leaflet on dry eye etc.)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

References

NICE CKS Red Eye

College of Optometrists Guidance – examining patients who present as an emergency

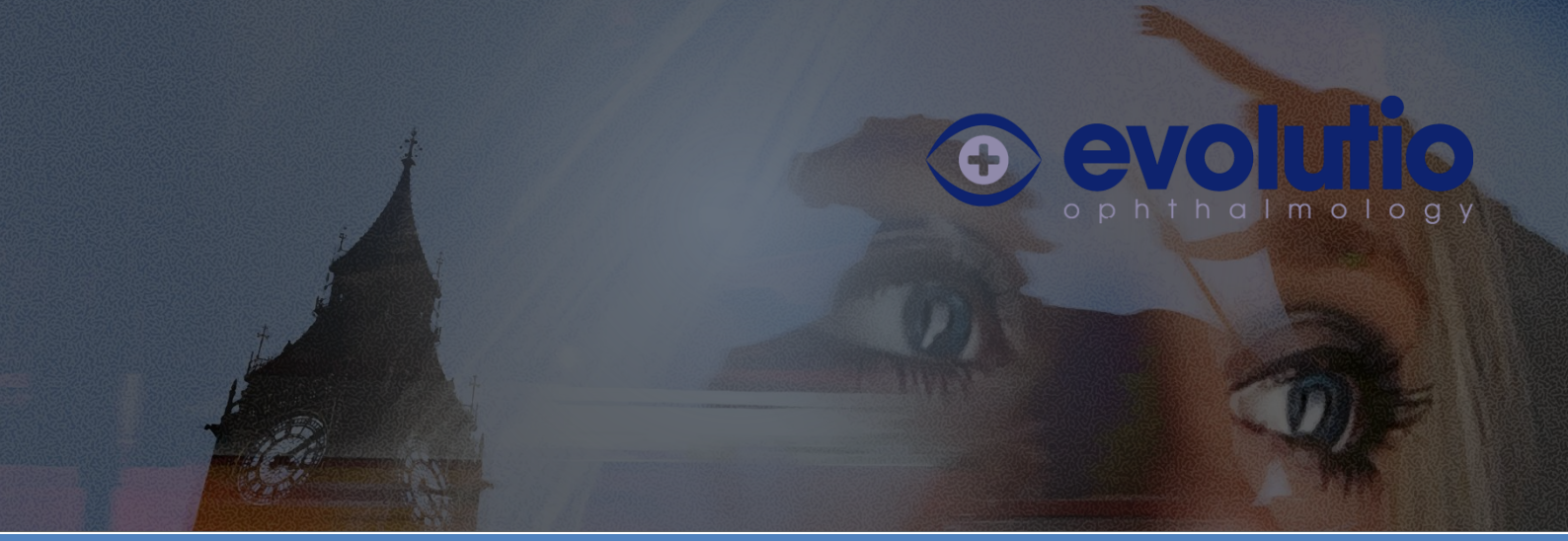
College of Optometrists Guidance – examining patients who present with flashes & floaters

College of Optometrists Clinical Management Guidelines – ALL

College of Optometrists - Guidance for optometrist prescribers

College of Optometrists – Optometrists Formula

British National Formulary



2.3.1.2 Virtual Consultations - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
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Overview

The COVID-19 pandemic of 2020 resulted in a temporary suspension of routine HES care, reduced access to eye casualty and in many cases a fear or inability for patients to leave their homes. This identified a clear need for virtual consultations within primary and secondary care, including ophthalmology. The continuation of virtual consultation through covid recovery and beyond serves both patient need and choice into the future.

Virtual consultations may take place via telephone or video. Video consultations are preferable because of the additional information provided and Evolutio have developed a bespoke secure platform for this.

- Virtual consultations should take place in the practice
    - I.G/patient confidentiality
    - Professional environment without potential household interruptions
    - Stable business broadband with adequate download/upload speeds and fewer bandwidth issues
- Full clinical records must be added to eVonnect in all cases
- Video calls must be made using the NHS-approved secure eVonnect system only
    - **Instructions for use and link to access the platform: *https://www.evolutio-uk.com/virtual-consult/***
- Some virtual consultations will identify a need to see patients face-to-face (F2F) within the community therefore clinicians offering this pathway must also be available for F2F appointments where clinically indicated within an appropriate timescale

This protocol provides some structure to the consultation for clinicians in terms of screening questions, medicolegal considerations, clinical prompts and possible management options.

Initial considerations

Telephone consultation

- If the patient is describing their signs/clinical test results, then a magnified mirror (make-up/shaving type) and good lighting will help
- If the patient has a representative/carer/friend helping, then that person will need good vision and good light. A magnifying glass might help them. It is often helpful to put the telephone on speakerphone so there is a 3-way conversation – remember to gain consent and record the name of the 3rd person.

Video consultation

- Require good lighting – ask patient to face the window or have local directional light/lamp
- Require good magnification/resolution – on a modern mobile phone, the 'selfie' camera is lower resolution than the rear-facing camera so it might be helpful for a friend/relative to hold the mobile phone and point it towards the patient. If there is no-one available to help and you require the additional resolution, the patient could hold the phone in this manner themselves but they would need a mirror to help them to see the reflection of the phone screen so they know the phone is pointed in the correct place.
- If the patient does not have steady hands or good manual dexterity, then it is advisable to ask a friend/relative to hold the device or ask them to securely mount it at an appropriate height/angle

1. Introductions, overview of process and consent

A. Verify patient/their representative's identity. Provide your name and role
e.g. *Px given my name and role. Verified patient identity.*

B. Provide an overview of the nature of a virtual consultation and its limitations
e.g. Nature of the telephone/video consultation explained and px understands the limitations

- A standard disclaimer is presented to the patient and they must agree to it before being able to join the video platform
- For telephone consultations the following disclaimer must be read to the patient/representative:
  Any clinical judgement will be based on the symptomatic responses only and cannot take account of any asymptomatic findings or anatomical changes that would normally be assessed in a traditional consultation. To

undertake a virtual consultation, we can only make a clinical assessment and working diagnosis on the basis of your symptoms and the responses you provide to my questioning. This is reliant on an honest description of your symptoms, and full transparency of your lifestyle and medical history, to enable reasonable clinical judgement.

C. Establish capacity and consent to proceed
e.g. Px not considered vulnerable, has capacity, consents to this virtual consultation and is happy to proceed.

2. Ask standard screening questions, as clinically indicated

The following prompts might be helpful, depending upon the presentation:

RFV & description:	Laterality / onset / duration / stability / severity
Symptoms:	Pain / photophobia / diplopia / reduced vision / feeling unwell / headache / floaters / photopsiae
Signs:	Redness / eyelid swelling
Other:	Aggravating / relieving factors / measures tried so far
POH:	Trauma / surgery / CL wear
PMH:	Medications / allergies / general health
FH:	Relevant medical and ocular history

3. Ask condition specific questions, as clinically indicated

Where a patient is unable to attend F2F, a virtual assessment may still provide useful clinical information (albeit more limited than F2F), for example a comprehensive history, compliance check, risk analysis and/or opportunity to offer advice and arrange a subsequent F2F review when the patient is able. This might include patients with glaucoma (assessment or follow-up), AMD, vitreoretinal symptoms, headaches etc, conditions which might not normally be associated with virtual assessment.

4. Assess visual function

Undertake relevant investigations within the context and limitations of a virtual consultation. In some cases the patient may be instructed to download a specific app or directed to a particular website during the consultation. Examples of record keeping phrases are included for your consideration.

Visual Acuity

- Px given advice on how to conduct monocular VA check at home ('EyeChart – Vision Screening' app or equivalent)
- Asked to check each eye individually at far distance / normal book/newspaper reading with the appropriate correction and stated …

Pupils

- With permission, take photos/screenshots wherever necessary to record positive and negative findings
- Pupils appear to react normally and appear to be a normal size, round and equal

Motility

- With permission, take photos/screenshots wherever necessary to record positive and negative findings
- Patient was able to look in 9 positions of gaze without pain/discomfort and without gross over/underaction or diplopia.

Fields

- Px given advice on how to conduct visual field test at home (www.eyesage.org/?lang= us or equivalent)

- A gross confrontation test was within normal limits in both eyes.

Amsler

- The Amsler grid was shown to the patient on the examining clinician's PC screen / The patient was directed to a Google search for 'Amsler grid' (click 'images' tab) / Px given advice on how to conduct monocular Amsler check at home ('Eyecare- Amsler Grid Eye Test' app or equivalent) / The patient was instructed on how to draw a basic Amsler grid
- Amsler was full in both eyes monocularly (no distortion/scotoma)

Colour vision

- Ishihara plates were shown to the patient on the examining clinician's PC screen / The patient was directed to a Google search for 'Ishihara colour vision extended' (click 'images' tab) / Px given advice on how to conduct monocular colour vision test at home ('PseudoChromatic ColorTest' app or equivalent)
- Monocular colour vision was full and quick in both eyes

5. Assess anterior eye

WITH PERMISSION, TAKE PHOTOS/SCREENSHOTS WHEREVER NECESSARY TO RECORD POSITIVE AND NEGATIVE FINDINGS

Lids & lashes

- Position (upper and lower, right and left) / swelling / margin inflammation / lesions / lower lid eversion

Conjunctiva & sclera

- Hyperaemia / chemosis / lesions

Cornea

- Eye colour / grossly clarity / limbus

Regional lymph nodes

Due to the limitations of the video consultation (magnification, lighting, stability) I was unable to adequately assess the anterior chamber for activity, the A/C depth nor the IOP. Examination of the posterior eye was also not possible.

Due to the limitations of the telephone consultation I was unable to assess the anterior nor posterior eye.

6. Assess posterior eye

Although there are smartphone apps for this function, some of which do not require any additional hardware/lenses, we acknowledge that a posterior eye assessment is unlikely to be possible in the context of a virtual consultation.
e.g. veterinaryvision.co.uk/retinal-photography-with-an-iphone.html

7. Impression and management

Impression

Consider prefixing your diagnosis with 'suspected' or 'likely' if uncertain and it is good practice to include your differential diagnoses, particularly in the context of a virtual consultation.

Management plan

1. Treatment, for example:
   - Lid hygiene / hot compresses / lid massage
   - Tear supplements (self-care / prescribed)
   - Lid taping
   - Cold compress
   - Oral painkillers
   - Oral / topical antihistamines
   - Oral / topical antibiotics
   - Hand hygiene measures

2. Literature:
   - Signpost patient to appropriate literature (record if declined), for example the AOP, Moorfields, Glaucoma UK etc.

3. Outcome:

(i) Discharge

- Advise patient they are being discharged and you will write to their GP
- Provide relevant SOS advice

e.g. Based on the data I was able to gather I felt that this patient could be safely discharged to their optometrist/GP. Px given SOS advice, specifically if signs/symptoms worsen (e.g. pain/reduced vision) to contact our telephone triage line or 111. Px understands advice given and consents.

(ii) Virtual review

- Advise patient they are being retained for virtual review, you will write to their GP and they'll be contacted in due course
- Provide relevant SOS advice

e.g. Based on the data I was able to gather I recommended a virtual review in …... Px given SOS advice, specifically if signs/symptoms worsen (e.g. pain/reduced vision) to contact our telephone triage line or 111). Px understands advice given and consents.

(iii) Face to face review (community or HES)

- Establish COVID-19 status
- Consider risk of contracting / transmitting C19
- Set a safe and sensible timeframe
- Ensure the patient is able to make an informed decision (understand importance of attending)

e.g. Based on the data I was able to gather, I recommended a face to face review in community/HES in …... Px given SOS advice, specifically if signs/symptoms worsen (e.g. pain/reduced vision) to contact our telephone triage line or 111. They do not have any specific age or health risk factors, they are asymptomatic and have not been in close contact with anyone with confirmed/likely Covid-19.

- These patients will need an outcome of 'discharge and refer on' to put them on a suitable F2F pathway
- Patients requiring urgent/rapid access F2F review should be referred into a suitable clinic and the importance of attending clearly explained (including a note on their coronavirus status/risk)
- Patients requiring same/next day HES care should be sent along the agreed eye casualty pathway for the area

If the patient requires F2F review but declines then keep clear notes and consider whether a virtual review in (e.g. a few days) might be appropriate.

e.g. I recommended a face to face review in community/HES in ….. but patient declined. Patient is aware that medical appointments are essential for maintaining visual health and helping to prevent sight loss. They are aware that community and HES facilities are meticulously cleaned regularly and that employees pose a minimal risk to patients. I therefore advised: the patient to contact 111 for further advice / routine/urgent/rapid access HES referral / /the px to consult their GP/local pharmacy ASAP / telephone/video review in …..

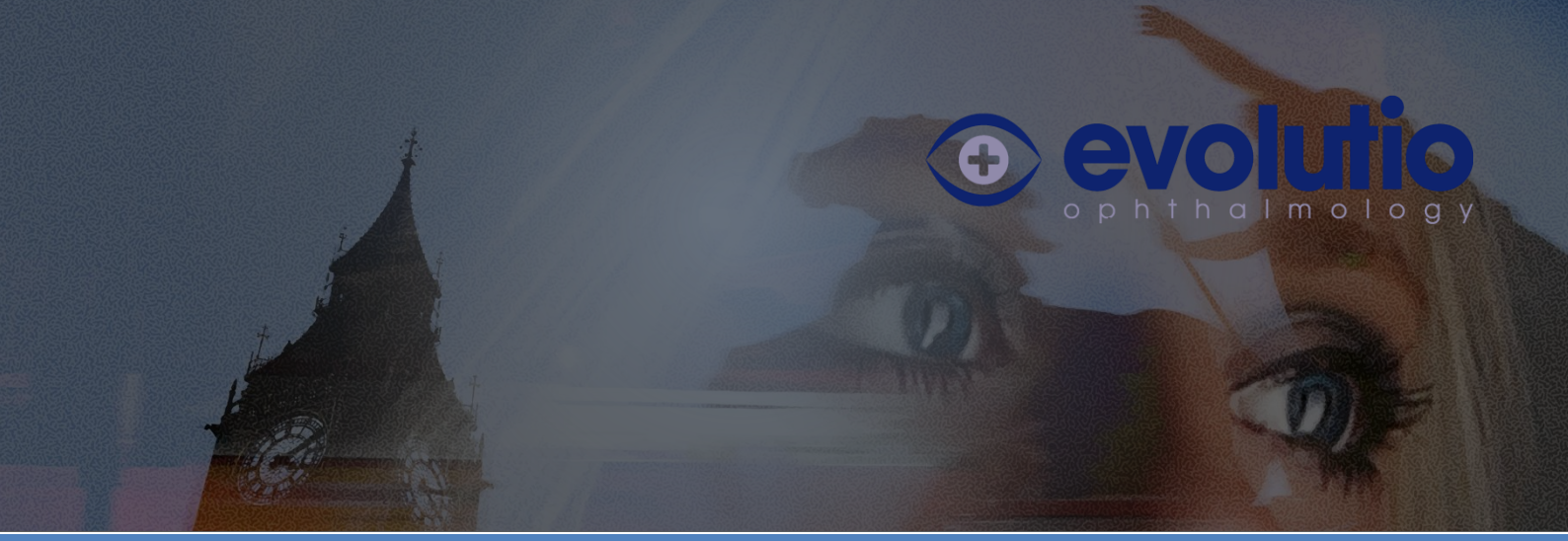
References

Please review Government and Professional websites for up to date information (e.g. PHE, NHSE, GOC, CoO, AOP)

Royal College of Ophthalmologists - Glaucoma Management Plans during COVID-19)

Moorfields Risk Stratification Process

How to conduct written online consultations with patients in primary care, BMJ 2021;372:n264



2.3.1.3 Trichiasis - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 1 clinicians when assessing/managing a patient with trichiasis.

Trichiasis is defined as a misdirection of one or more eyelashes toward the globe. There are many causes including aging changes to the lids/lid margins, scarring of the lid (from trauma, infection or inflammation) and entropion. Where the cornea is involved, there is the potential for microbial keratitis and corneal scarring.

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment

Some patients will enter this pathway following transfer from an incumbent provider. It is important to review the clinical notes provided so you have a clear understanding of the patient's clinical status; this is especially relevant at the first visit. ***Please transcribe the CCT measurement, the pre-treatment (presenting) IOP and target pressure from the clinical notes provided*** *so the telemedicine consultant has all the required information in 1 place. These values will be automatically carried over at subsequent visits.*

History and symptoms

- Record age and gender
- Onset
- History of lid surgery/trauma
- Effect on Quality of Life

Initial tests

- Pre and post visit monocular VA

Anterior segment

- Slit-lamp examination (with photos where clinically indicated)
    - Lids, lashes, tear film, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens
    - Important to rule out other causes of eye irritation.
- Comment on corneal status (including staining)
- Record where the lashes are and how many etc. are they causing corneal involvement

Posterior segment

- As clinically indicated

Management

Providers should be familiar with national and local guidance including those referenced below.

Mild cases might only require lubrication therapy (ointments or high viscosity drops/gels).

Mechanical epilation is usually the first-line treatment, especially for a few isolated lashes. Topical anesthetic eye drops are generally instilled. Some practitioners also use an anesthetic-soaked cotton bud applied to the base of the lash. The procedure is generally carried out at the slit lamp. Patient safety is paramount therefore the patient must be suitably positioned (on a stable slit lamp) with steady fixation. When removing lower lid lashes, the patient is asked to look upwards and the lower lid is gently pulled down. For upper lashes, the upper eyelid is held against the orbital rim with the thumb and the patient is asked to look downwards. Lashes are pulled out with epilation forceps (single use or sterile) as close as

possible to the base of the lash in the direction of root growth, being careful not to break the lash and leave a sharp 'barb'. Between each epilation the lashes are wiped off the forceps.

If the trichiasis has caused epithelial breakdown, it might be appropriate to fit a bandage contact lens.

Where safe to do so, patients should be encouraged (and taught) to manage their trichiasis using suitably disinfected tweezers, good lighting and a suitably magnified mirror.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. University Hospitals of Leicester leaflet on trichiasis)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

Generally, if no recurrence after epilation and/or patient can safely self-epilate.

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

For patients attending for recurrent trichiasis, discuss and record in the clinical notes:

1. Self-management (e.g. magnified mirror and tweezers by self or carer/relative) – declined/unable (with reason)
2. HES referral for more definitive treatments (e.g. electrolysis/cryo/laser) -if declined include reason
3. If applicable, evidence to justify epilation more frequently than 6 weekly (e.g. documented lash growth from epilation to corneal abrasion/symptoms is x days/weeks - see visit on x and x dates)

Follow-up intervals and target pressures will be set by the consultant-led telemedicine ophthalmologist depending upon severity, duration and co-morbidity risk factors. As a guide, NICE NG81 suggests:

Onward referral to another pathway

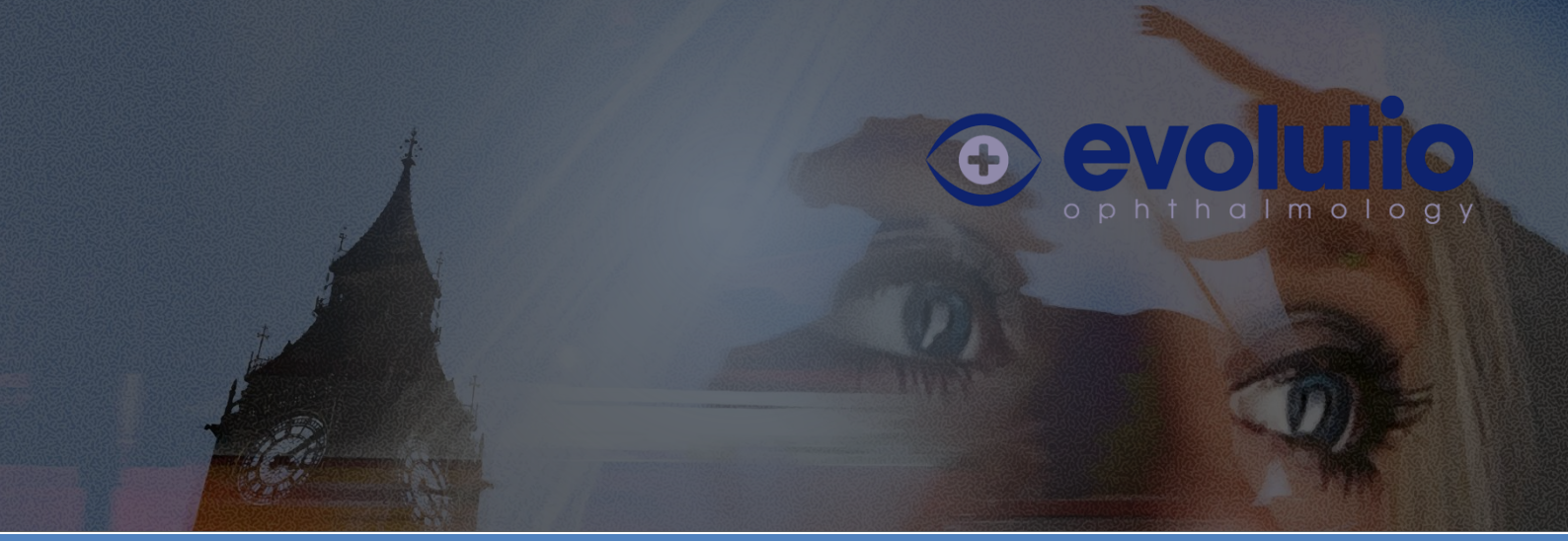
The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

Lashes tend to grow back to full length in 4-6 weeks. In cases of ongoing recurrent trichiasis a more definitive treatment may be sought for patient convenience (and long-term CCG cost). Cases of extensive trichiasis may also be more appropriately managed by an ophthalmologist.

Electrolysis or Argon laser may be suitable for a small number of lashes but often require multiple treatments. Cryotherapy is more effective for large, confluent areas of trichiasis although the risk of side effects is higher. Very extensive trichiasis may be treated surgically by a variety of methods.

References

College of Optometrists Clinical Management Guidelines – Trichiasis



2.3.1.4 IOP/Field Repeat Measures - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 1 clinicians when assessing a patient with suspected raised IOP (usually 22-30) or an unconfirmed minor/anomalous visual field defect (which might be associated with glaucoma).

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment

History and symptoms

- Visual symptoms
    - Visual field loss, haloes or visual disturbance
- Risk factors
    - Age & gender
    - Ethnicity
    - Family history of OHT/glaucoma (first/second degree)
    - Previous ocular history
    - Medical history, including:
        - Topical and systemic medications
        - Prolonged steroid usage (topical or systemic)

Initial tests

- Visual acuity (distance and near)
- Visual fields
    - Full threshold test (SITA, ZATA and other algorithms acceptable)
    - Comment on reliability, describe any pattern
- Pupil reactions

Anterior segment

- Slit-lamp examination
    - Cornea, iris, lens
- Anterior chamber angle examination (including peripheral depth)
    - Indicate method of assessment used e.g. Van Herrick
- Intra-ocular pressure (IOP)
    - Contact applanation tonometry and time
        - Goldmann is the gold standard, Perkins acceptable.
        - iCare if patient declines or can't tolerate GAT/PAT (annotate clearly)

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established. Clinicians are not expected to initiate treatment within this pathway.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. College of Optometrists leaflet on glaucoma, Glaucoma UK's leaflet on OHT)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitor

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

Typically, if IOP and visual fields are found to be within normal limits.

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

In borderline cases a patient might be recalled for repeat readings to confirm the diagnosis.

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

If the IOP is over 23, there is an IOP asymmetry (usually 4mmHg or more) or a confirmed visual field defect, patients are referred onto another pathway such as a community glaucoma assessment pathway (where commissioned) or HES for further investigation.

References

NICE NG81- Glaucoma: diagnosis and management

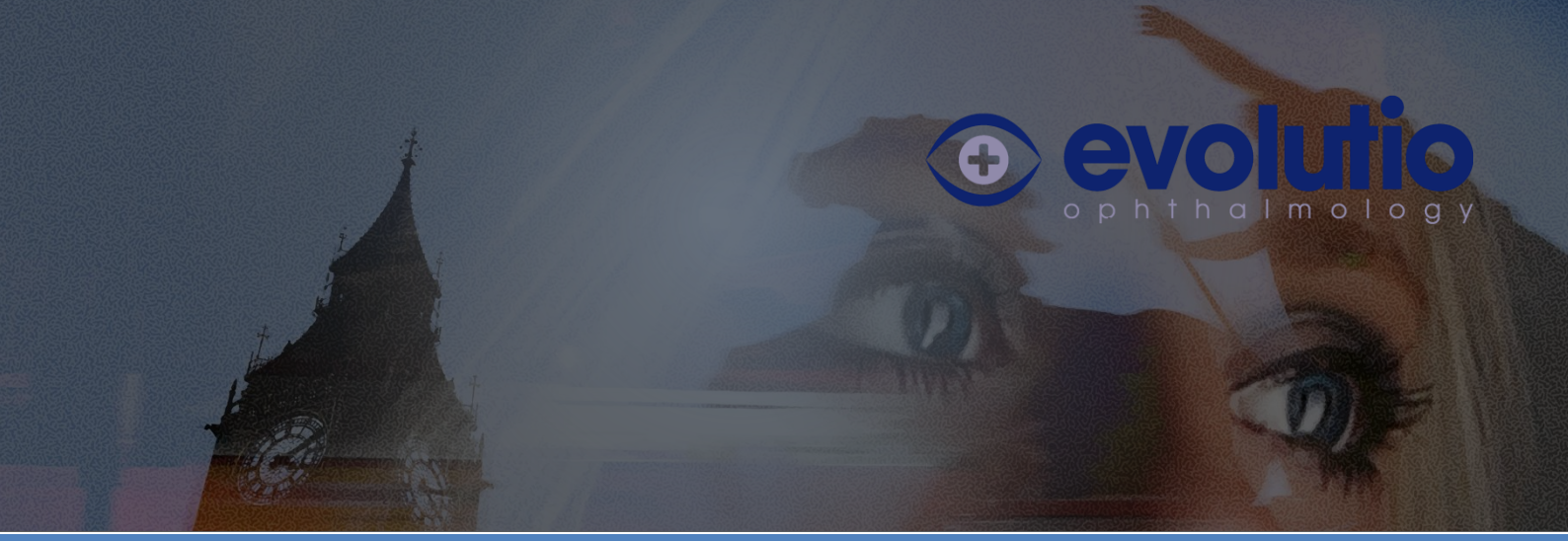
College of Optometrists Guidance – assessing patient with raised IOP

College of Optometrists Clinical Management Guidelines (glaucoma, OHT)

Joint RCOphth and UKEGS Glaucoma Risk Stratification Tool (July 2020)

The Royal College of Ophthalmologists Commissioning Guide: Glaucoma (Recommendations) June 2016

NICE Quality standard [QS180] – Serious Eye Disorders



2.3.1.5 Cataract Pre-op Assessment - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 1 clinicians when assessing a patient with cataracts to establish eligibility for onward referral for the consideration of cataract surgery.

A cataract pre-op assessment will usually follow a sight test although in some cases it might result from a request from a GP or an optometrist who is not accredited to undertake the pre-op assessment.

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment

THIS PATHWAY WOULD USUALLY FOLLOW A FULL GOS SIGHT TEST

History and symptoms

- Specific questions relevant to the presenting condition
- Personal medical history (including medications)
- Personal ocular history (including history of amblyopia, refractive surgery, glaucoma, AMD, corneal disease, diabetic retinopathy)
- Smoking status
    - Must be a non-smoker or must be advised to contact a smoking cessation service
- Quality of life questions
    - The patient is at significant risk of falls
    - Significantly impaired ability to drive
    - Significantly impaired ability to work
    - Significantly impaired ability to undertake leisure activities (e.g. read, watch TV or recognise faces)
    - Significant glare and dazzle in daylight or having difficulties with night vision
    - There is significant anisometropia causing BV problems / marked refractive non-tolerance
    - Other significant impact on QOL as a result of visual symptoms

Initial tests

- Visual acuity (distance and near) with refraction
- Pupils (e.g. small, not mobile)
- Amsler (where indicated)
- Intra-ocular pressure (IOP) and time
    - Goldmann Applanation tonometry is the gold standard

Anterior segment

- Slit-lamp examination
    - Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, iris, lens
        - Specify the type of cataract (e.g. NS, PSC, cortical, mixed) and density
        - Presence/absence of pseudoexfoliation, corneal endothelial dystrophy
- Anterior chamber angle examination

Posterior segment

- Slit lamp binocular indirect ophthalmoscopy (SL-BIO)
    - With dilation **where clinically indicated**
    - Vitreous, retina, macula, disc, choroid
- Post-dilation IOP review as appropriate

Patient discussion

- Confirm that the patient has sufficient cataract to account for the visual symptoms
- Confirm that the patient is interested in being referred for surgery and is willing to undergo surgery if offered
- Confirm that you have discussed the risks and benefits of cataract surgery with the patient and issued an approved cataract information booklet
- Confirm that the patient understands they are being referred for assessment of surgery initially and that surgery must be approved by the surgeon
- Specify which eye you are requesting surgery for and whether the patient has had cataract surgery previously
- Confirm that the patient has waited 7 days to consider their decision to undergo referral for surgery ('cooling off' period)
    - Before completing a cataract pre-op form the patient will be aware that they have cataract and will have expressed an interest in having surgery therefore it is rare for a patient to decline surgery following a pre-op assessment. Patients are given an optional 7 days to reflect on their diagnosis of cataract and the risks and benefits of the procedure.
    - If patients are confident on the day that they wish to proceed with surgery it is acceptable to submit the form and ask the patient to contact the referrer within the next 7 days if they change their mind (the referrer can then contact the RM organisation to cancel the referral)
    - If patients are uncertain on the day and wish to fully utilise the 7 day 'cooling off' period, the referral should be held (in the drafts silo) and the patient asked to call back in 7 days with their decision. We suggest that the provider or a delegated member of staff contacts the patient in 10 days if there has been no contact. In rare instances the provider will need to speak to the patient again directly (by phone or in person).

Management

Providers should be familiar with national guidance and local CCG guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established regarding eligibility and desire to be referred for consideration of surgery.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway
    - In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:
    - Written guidance as appropriate (e.g. College of Optometrists leaflet on cataracts)
    - Education about disease prognosis
    - Discussion of lifestyle changes
    - Information detailing available support/rehabilitation services
    - Advice to return/seek advice (with appropriate urgency) if new symptoms develop
    - Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

A patient is discharged back to the referring clinician if they decline to proceed with onward referral/surgery. Patients who do not meet the criteria for cataract surgery are usually discharged, unless an exceptional need is identified in which case an 'Individual Funding Request' would be made (often via the GP but in some CCG's this may be completed by the optometrist).

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back

to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

Borderline cases might be followed up to reassess eligibility in, for example, several months however this is expected to be uncommon.

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

In most cases the clinician will refer the patient to a qualified provider (AQP) of cataract surgery with an appropriate level of urgency (almost always routine).

References

NICE NG77 'Cataracts in adults: management'

CATARACT PRE-OP ASSESSMENT

Date of Referral: _____

PATIENT DETAILS:

Title: _____ First Name: _____ Surname: _____

Date of Birth: _____

Address: _____ Postcode: _____

Mobile Phone No.: _____ Home Phone No.: _____

GP Name & Address: _____ Postcode: _____

CLINICAL DETAILS:

Is surgery requested for the first or second eye? ☐ First Eye ☐ Second Eye

Which eye are you requesting surgery for? ☐ Right Eye ☐ Left Eye

What is the refractive error and VA?

Right:						
	Sph.	Cyl.	Axis	VA	Add	Near VA
Left:						

IOP: R_____ L_____ GAT / PAT / iCare / NCT
Previous refractive surgery No / R / L / Both

Dilated fundus assessment revealed the following co-morbidities (specify reason if not dilated):
AMD No / R / L / Both
Diabetic Retinopathy No / R / L / Both
Glaucoma No / R / L / Both
Amblyopia No / R / L / Both
Corneal opacity No / R / L / Both

Any additional relevant information?

Unless all 7 primary boxes are ticked, the patient may not be considered for surgery:

☐ Patient has sufficient cataract to account for the visual symptoms
☐ Patient is interested in being referred for surgery and is willing to undergo surgery if offered
☐ The cataract is affecting the person's vision and quality of life [tick all that apply and **at least one**]:
- ☐ The patient is at significant risk of falls
- ☐ Significantly impaired ability to drive
- ☐ Significantly impaired ability to work
- ☐ Significantly impaired ability to undertake leisure activities (e.g. read, watch TV or recognise faces)
- ☐ Significant glare and dazzle in daylight or having difficulties with night vision
- ☐ There is significant anisometropia causing BV problems/marked refractive non-tolerance
- ☐ Other significant impact on QOL as a result of visual symptoms (please list)

☐ Patient is a non-smoker or has been advised to contact a smoking cessation service
☐ Referrer has discussed the risks and benefits of cataract surgery with the patient and issued an approved cataract information booklet
☐ Patient understands they are being referred for assessment of surgery initially and that surgery must be approved by the surgeon
☐ Patient has waited 7 days to consider their decision to undergo referral for surgery ('cooling off' period)

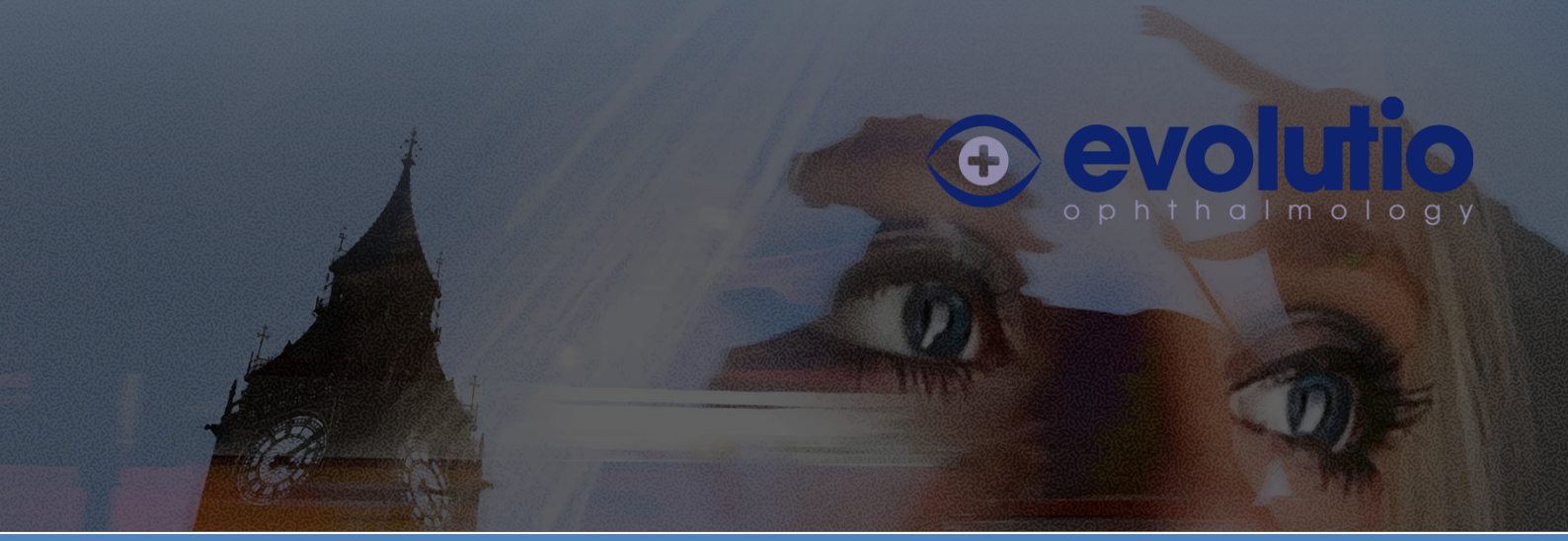
REFERRER DETAILS:

First Name: _____ Surname: _____

GOC: _____

Practice Address: _____ Postcode: _____

The reason for this referral has been explained to the patient or guardian who agrees to it. The patient or guardian also consents to information being exchanged between the Hospital Eye Service, their General Medical Practitioner, and optometrist or ophthalmic medical practitioner (delete any not consented to).



2.3.1.6 Cataract Post-op Assessment - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 1 clinicians when assessing a patient following cataract surgery (typically after 4 weeks).

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment

THIS PATHWAY WOULD USUALLY FOLLOW A FULL GOS SIGHT TEST

History and symptoms

- Specific questions relevant to the presenting condition
- Which eye was treated, when, where and by whom
- Symptoms e.g. post-operative pain, intolerable refractive error
- Record refractive target and expected VA, if available

Initial tests

- Monocular visual acuity (distance and near) with refraction (full refraction, not solely autorefraction)
- Amsler (where indicated)
- Intra-ocular pressure (IOP) and time
    - Goldmann Applanation tonometry is the gold standard

Anterior segment

- Slit-lamp examination
    - Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, iris, lens
    - Record the presence or absence of abnormal wound healing, reduced corneal clarity, A/C cells, posterior synechiae, posterior capsular thickening (PCO), vitreous activity

Posterior segment

- Slit lamp binocular indirect ophthalmoscopy (SL-BIO)
    - With dilation **where clinically indicated**
    - Vitreous, retina, macula, disc, choroid
- Post-dilation IOP review as appropriate

Patient discussion

- Summarize your findings and advise the patient regarding a spectacle update where appropriate
- Establish whether patient is satisfied, dissatisfied or neither as regards the outcome of their cataract surgery

Management

Providers should be familiar with national guidance and local CCG guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. College of Optometrists leaflet on cataracts)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

We do not actively encourage dispensing at the practice which provides the post-op assessment (if it isn't the patient's regular optometric practice) however patients do have the right to exercise choice as to if, when and where they purchase their new spectacles (if required).

At the end of the visit you record on Evonnect whether the outcome is satisfactory or unsatisfactory. The surgeon requires the report to be returned to them for audit purposes. This is achieved by selecting an outcome of 'satisfactory outcome' or 'Unsatisfactory outcome'. In the case of unsatisfactory outcomes an additional new referral must be generated for the new pathology (e.g. OMR for CMO).

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration, and co-morbidity risk factors with consideration of national guidelines and local protocols.

Borderline cases might be followed up to reassess eligibility in, for example, several months however this is expected to be uncommon.

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

Guidance on urgency of referral (always check local protocols and use your own judgment in each individual case):

- Emergency/Rapid Access
  - Severe pain
  - Sudden reduction in vision where previously good
  - Endophthalmitis/vitritis/hypopyon/severe anterior uveitis
  - Raised IOP (40 or more)
  - Retinal detachment/vitreous haemorrhage
  - Retained lens fragment
  - Iris prolapse
  - Wound leak - Siedel sign positive
  - Shallow A/C

- Urgent
  - Pain (not severe)
  - VA not as good as expected
  - Abnormal/poor wound healing
  - Corneal issues (epitheliopathy, infiltrates, epithelial defect, melt, oedema)

  - Mild to moderate A/C activity
  - Raised IOP (24-39)
  - IOL malposition
  - Cystoid macular oedema
  - Large/multiple retinal haemorrhage
  - Flashes/floaters/PVD
  - Ocular surface/conjunctival toxicity/allergy

- Routine
  - Posterior capsular thickening (often treated no sooner than 6 months after surgery)
  - Small retinal haemorrhage (outside macula)

References

NICE NG77 'Cataracts in adults: management'

CATARACT POST-OP ASSESSMENT (4 Weeks)

Date of Review: _____

PATIENT DETAILS:

Title: _____ First Name: _____ Surname: _____

Date of Birth: _____

Address: _____ Postcode: _____

Mobile Phone No.: _____ Home Phone No.: _____

GP Name & Address: _____ Postcode: _____

CLINICAL DETAILS:

Date of Procedure: _____ Consultant Name: _____

Address: _____

Which eye was treated? ☐ Right Eye ☐ Left Eye

IOP: R_____ L_____ ☐ Goldman ☐ Perkins ☐ iCare ☐ NCT

Pain	☐No ☐R ☐L ☐Both	Incision not healing/abnormal	☐No ☐R ☐L ☐Both
Unexplained reduced VA	☐No ☐R ☐L ☐Both	Reduced corneal clarity	☐No ☐R ☐L ☐Both
A/C cells	☐No ☐R ☐L ☐Both	Posterior capsular thickening	☐No ☐R ☐L ☐Both
Posterior synechiae	☐No ☐R ☐L ☐Both	Intolerable refractive error	☐No ☐R ☐L ☐Both
Vitreous activity	☐No ☐R ☐L ☐Both		

What is the refractive error and VA?

Right:						
	Sph.	Cyl.	Axis	VA	Add	Near VA
Left:						

Any additional relevant information?

Patient is: ☐ Satisfied ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied (tick one with supporting comments)

Plan: ☐ Discharge

☐ Optometrist Review/Follow-up (Specify timescale: _____)
☐ Refer back to ophthalmologist for complication related to surgery*
☐ Refer to ophthalmologist for a condition unrelated to recent cataract surgery*

*NB This form does NOT constitute a referral – a separate referral must be made with appropriate urgency

CLINICIAN DETAILS:

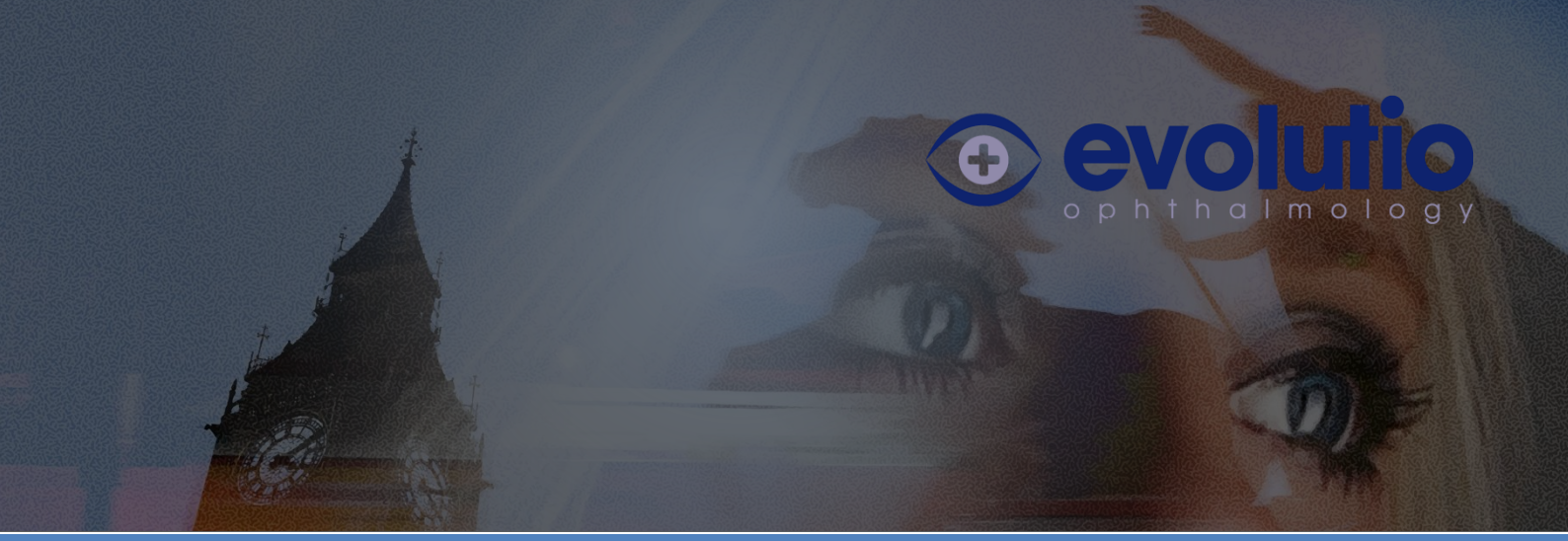
First Name: _____ Surname: _____

GOC: _____

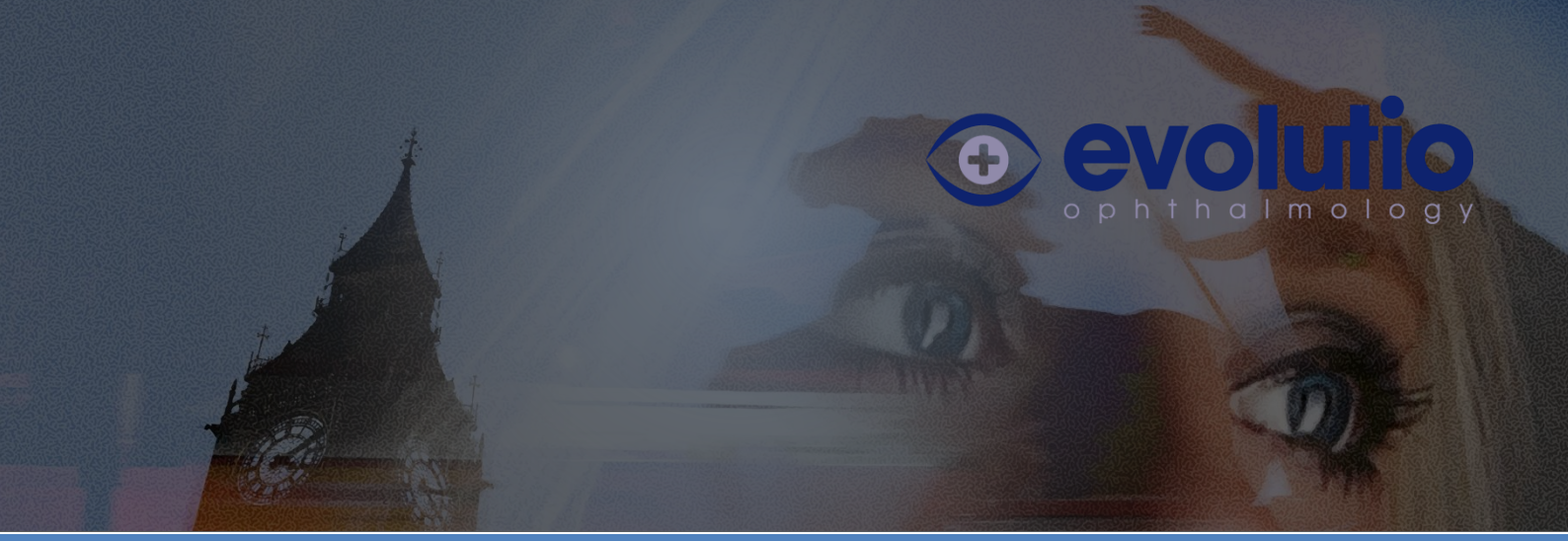
Practice Address: _____ Postcode: _____

Email Address: _____ Phone Number: _____

The reason for this referral has been explained to the patient or guardian who agrees to it. The patient or guardian also consents to information being exchanged between the Hospital Eye Service, their General Medical Practitioner, and optometrist or ophthalmic medical practitioner (delete any not consented to).



Section 2.3.2: Tier 2 Pathways



2.3.2.1 Glaucoma/OHT Monitoring - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.1

Overview

This protocol provides guidance to TIER 2 & 3 clinicians when assessing/managing a patient with OHT/suspect glaucoma/glaucoma as diagnosed by a 'suitably qualified clinician' (RCOphth, 2016). The Tier 3 pathway mandates OCT whereas the tier 2 pathway does not. Evolutio's clinical team will assign patients to the appropriate tier having considered clinical risk.

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment

Some patients will enter this pathway following transfer from an incumbent provider. It is important to review the clinical notes provided so you have a clear understanding of the patient's clinical status; this is especially relevant at the first visit. ***Please transcribe the CCT measurement, the pre-treatment (presenting) IOP and target pressure from the clinical notes provided*** *so the telemedicine consultant has all the required information in 1 place. These values will be automatically carried over at subsequent visits.*

History and symptoms

- Record age and gender
- Glaucoma history (for each eye):
    - Existing diagnosis (OHT/COAG suspect/COAG/Secondary glaucoma/Angle closure)
    - Pre-treatment (presenting) IOP
    - Target pressure
- Visual symptoms
    - Visual field loss, haloes or visual disturbance
- Compliance & QOL
    - Treatment compliance, including any side-effects
    - Quality of life (tolerating treatment, any visual loss, ability to drive)
- Risk factors
    - Age & gender
    - Ethnicity
    - Refractive error (approximate)
    - Family history of OHT/glaucoma (first/second degree)
        - If yes, did they lose sight or receive glaucoma surgery
    - Previous ocular history, including:
        - Refractive surgery
        - Trauma
        - Inflammation
    - Medical history, including:
        - General health
        - Allergies
        - Heart / breathing problems
        - Topical and systemic medications (including frequency for glaucoma medications)
        - Prolonged steroid usage (topical or systemic)
        - Circulation
            - Acute blood loss or transfusion
            - Raynaud's disease
            - Migraine
            - Low diastolic blood pressure

Initial tests

- Visual acuity (distance and near) with refraction where indicated
- Monocular colour vision
- Visual fields
    - Full threshold test (SITA, ZATA and other algorithms acceptable)

    - Progression analysis were available
    - Comment on reliability, describe any pattern and change
    - Record Mean Defect and classify as early if up to 6dB / moderate if 6-12dB / advanced over 12dB

Anterior segment

- Slit-lamp examination
    - Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens
        - Presence/absence of iris transillumination, corneal endothelial pigment, pseudoexfoliation
- Anterior chamber and angle examination
    - Peripheral depth (Van Herrick)
    - Central depth (e.g. Smith) where indicated (e.g. shallow limbal AC depth)
    - Gonioscopy where clinically indicated (e.g. previously inconclusive or changing)
- Central corneal thickness (CCT)
    - Ultrasound pachymetry is the gold standard. OCT measurement of CCT acceptable
    - Transcribe previous value if it is unlikely to have changed
- Intra-ocular pressure (IOP)
    - Contact applanation tonometry and time
        - Goldmann is the gold standard, Perkins acceptable.
        - iCare if patient declines or can't tolerate GAT/PAT (annotate clearly)

Posterior segment

- Slit lamp binocular indirect ophthalmoscopy (SL-BIO)
    - Dilation where indicated (including post-dilation IOP review as appropriate)
    - Lens, vitreous, retina, macula, choroid
    - Optic nerve head
        - Disc size (vertical disc diameter)
        - Vertical C:D ratio
        - Neuroretinal rim notches/loss
        - 'ISNT' rule obeyed?
        - PPA
        - Disc haemorrhages
        - Vessel changes (baring, bayonetting, nasalisation)
        - RNFL defects

Imaging

- Tier 2
    - Colour fundus photographs (showing disc and macula)
    - OCT (cRNFL and GCC) is **OPTIONAL** but desirable
- Tier 3
    - Colour fundus photographs (showing disc and macula)
    - OCT (cRNFL and GCC) is mandated on the Tier 3 'Glaucoma/OHT Monitoring with OCT' pathway
        - Progression analysis where available
    - Anterior segment OCT (or equivalent) anterior chamber angle scan for potentially occludable angles

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established. Monitoring and management must be undertaken by a 'suitably qualified clinician' (Appendix B). Evolutio's glaucoma pathways have mandated consultant-ophthalmologist-led telemedicine.

A 4-point summary should be included at the end of the consultation:

1) Diagnosis

- There should be a diagnosis attached to each record for each eye
- e.g. primary, secondary, open angle, narrow angle, glaucoma risk/suspect etc.

2) An assessment of past glaucoma damage

- Based on discs, fields and OCT
- Classify as early if field MD up to 6dB / moderate if 6-12dB / advanced over 12dB

3) A judgement about future risk

- Estimate risk of future disc damage, taking into account all the relevant risk factors
    - Thin CCT, young age, ethnicity, FHG etc.
- Classify as low / moderate / high

4) A decision whether the patients status is stable or not

- Consider whether IOP at/below target, progression (disc/OCT/field), drop compliance etc.
- Classify as stable/satisfactory or unsatisfactory

Taking into account the past damage, future risk and present status, a decision can be made about treatment/management.

If a prescription is required and not already arranged, it will be issued by the consultant-ophthalmologist-led telemedicine team to the patient's registered GP and may include a range of topical medications including prostaglandin analogue, beta blocker, carbonic anhydrase inhibitor, sympathomimetic, alpha 2 adrenergic agonist or combinations.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. College of Optometrists leaflet on glaucoma, Glaucoma UK's leaflet on OHT/Glaucoma/Eye Drops and Dispensing Aids/Glaucoma and Your Relatives/Glaucoma and Driving)
- Education about disease prognosis
    - Must inform DVLA if (see regulations):
        - Glaucoma with field defect in both eyes (car/motorbike)
        - Glaucoma with field defect in 1 eye and other problem causing reduced VA/field loss in other eye (car/motorbike)
        - Glaucoma in 1/both eyes (PCV/HGV)
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

Usually low risk OHT or COAG suspect no longer considered 'suspect', typically after 3-5 years of 'stability':

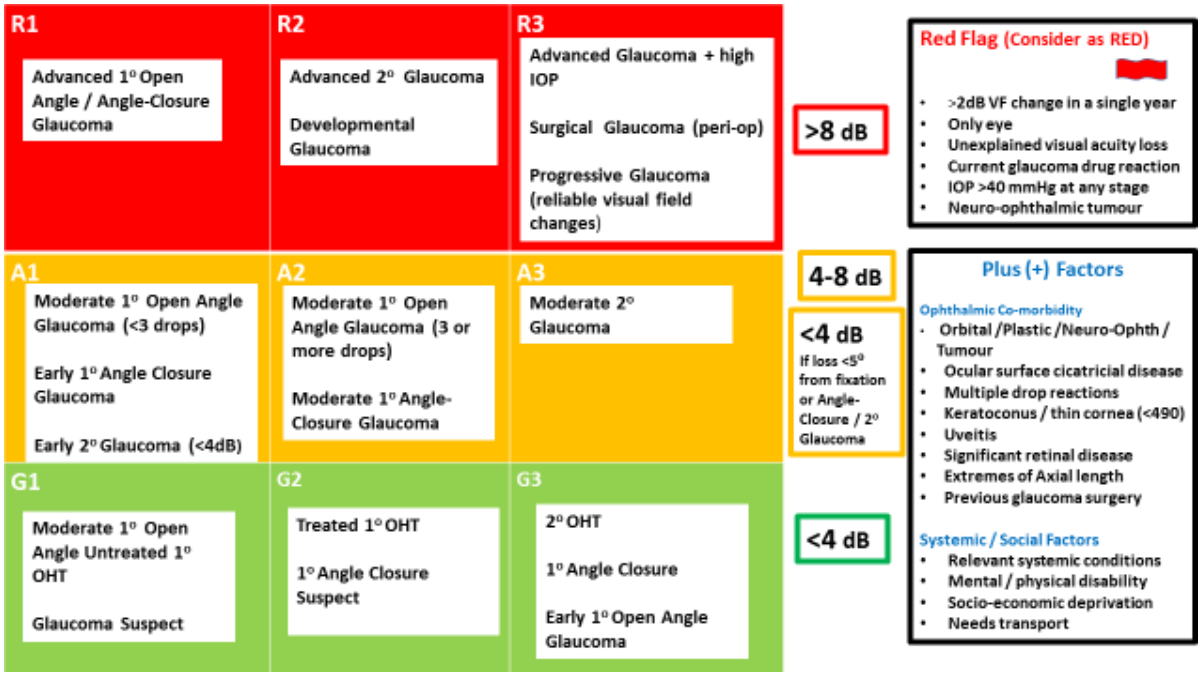
- Anterior chamber angle is not occludable
- Treatment not recommended/no longer required according to NG81 table 5 (based on CCT, IOP and age)
- No glaucomatous or progressive visual field loss
- Disc/OCT assessment shows no glaucomatous abnormalities

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

The majority of patients on this pathway are expected to be retained for ongoing follow-up. The RCOphth/UKEGS Glaucoma Risk Stratification Tool (July 2020) is shown below. Patients in categories G1, G2, G3 and A1 are suitable for community monitoring:

- Untreated/treated primary ocular hypertension (OHT)
- Secondary ocular hypertension (OHT)
- Glaucoma suspect (COAG suspect)
- Early primary open angle glaucoma (POAG)
- Moderate primary open angle glaucoma <3 drops (POAG)
- Early secondary glaucoma
- *Primary angle closure suspect (PACS) – seen on the 'narrow angle monitoring' pathway*
- *Primary angle closure (PAC) – seen on the 'narrow angle monitoring' pathway*
- *Early primary angle closure glaucoma (PACG) – seen on the 'narrow angle monitoring' pathway*



Follow-up intervals and target pressures will be set by the consultant-led telemedicine ophthalmologist depending upon severity, duration and co-morbidity risk factors. As a guide, NICE NG81 suggests:

Treated OHT

- Conversion to COAG uncertain:
  - 1-4/12 (and review treatment plan) if IOP not controlled
  - 6-12/12 if IOP controlled
- No conversion to COAG:
  - 18-24/12

Suspected COAG

- Conversion to COAG uncertain:
  - 1-4/12 (and review treatment plan) if IOP not controlled
  - 6-12/12 if IOP controlled
- No conversion to COAG:
  - 12-18/24

COAG

- Progression uncertain: 1-2/12 (and review treatment plan) if IOP not controlled else 2-6/12
- No progression: 1-4/12 (and review treatment plan) if IOP not controlled else 6-12/12 if high risk or 12-18/24 if low risk

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

The RCOphth/UKEGS Glaucoma Risk Stratification Tool (July 2020) is shown above. Patients in categories R1, R2 and R3 are restricted to HES-delivered care. In most cases patients in categories A2 and A3 would be onward referred for HES-delivered care, particularly those with 'plus' and other risk factors.

- Moderate primary open angle glaucoma on 3 or more drops
- Moderate/advanced primary angle closure glaucoma
- Moderate/advanced secondary glaucoma
- Advanced primary open angle glaucoma
- Developmental glaucoma
- Surgical glaucoma (peri-op) e.g. trabeculectomy within the last 12/12
- **** Progressive glaucoma ****

The following signs/symptoms may also require onward referral to HES:

- A 2db visual field change in a single year
- Unexplained visual acuity loss
- Current glaucoma drug reaction
- IOP of higher then 40mmHg at any stage
- Patients requiring SLT/surgery
- NTG with plus factors (particularly in category A1 and above)

Some patients will require an alternative non-HES pathway:

- Diagnostic uncertainty – consider the OHT/Glaucoma Assessment pathway
- OCT indicated but currently on Tier 2 monitoring pathway – consider the Tier 3 OHT/Glaucoma Monitoring pathway
- Narrow/occludable angles – consider the OHT/Glaucoma Assessment pathway or narrow angle monitoring pathway

References

NICE NG81- Glaucoma: diagnosis and management

College of Optometrists Guidance – assessing patient with raised IOP

College of Optometrists Clinical Management Guidelines (glaucoma, OHT)

Joint RCOphth and UKEGS Glaucoma Risk Stratification Tool (July 2020)

DVLA - Glaucoma and driving

The Royal College of Ophthalmologists Commissioning Guide: Glaucoma (Recommendations) June 2016

NICE Quality standard [QS180] – Serious Eye Disorders

Appendix A: Diagnosed glaucoma/OHT patients – a quick reference guide

	1. Introduction
HISTORY & SYMPTOMS	**2. Overview of why they're here (referring clinician's perspective)** **3. Are they having any problems with their eyes?** **4. Glaucoma history:** • Diagnosis, presenting IOP, target pressure **5. Compliance & QOL** **6. Risk factors** • Age, gender, ethnicity • Refractive error • Family history • Previous ocular history (refractive surgery, trauma, inflammation) • Medical history (including medications): o General health (including heart/breathing problems) o Allergies o Steroid use o Circulation (Acute blood loss or transfusion, Raynaud's, migraine, low BP)
INITTAL TESTS	**7. Visual acuity (distance and near) with refraction and pinhole where indicated** **8. Monocular colour vision** **9. Visual fields (full threshold)**
CLINICAL EXAMINATION	**10. Anterior segment slit-lamp examination** • Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens • Iris transillumination, corneal endothelial pigment **11. Anterior chamber angle examination** **12. L/A instil (plus leaflet)** **13. GAT with time** **14. Central corneal thickness (if using ultrasound pachymeter and not previously measured)** **15. Instil tropicamide (plus leaflet)** **16. Colour fundus photography and where mandated/possible posterior OCT scans (cRNFL and macular GCC)** **17. Slit lamp binocular indirect ophthalmoscopy (SL-BIO)** • Vitreous, retina, macula, choroid • Disc (VDD, C:D, NRR status, PPA, haemorrhages, vessels) • Post-dilation IOP review as appropriate
CONCLUSION	**18. Impression (4 point summary)** • Diagnosis • Past glaucoma damage (early if field MD up to 6dB / moderate if 6-12dB / advanced over 12dB) • Future risk (low/moderate/high depending on risk factors e.g. CCT, age, ethnicity, F/H) • Present status (stable or unsatisfactory depending on IOP vs target, disc/field progression, compliance) **19. Proposed management plan and recall** **20. Discussion with patient** **21. Telemedicine review** **22. Letters sent**

Appendix B: 'Suitably Qualified Clinicians' for monitoring and managing OHT/Glaucoma

ALL OHT/GLAUCOMA PATIENTS ARE MANAGED BY EVOLUTIO'S CONSULTANT-OPHTHALMOLOGST-LED TELEMEDICINE TEAM

The following table is reproduced from The Royal College of Ophthalmologists Commissioning Guide: Glaucoma (Recommendations) June 2016. It shows the necessary qualifications to monitor/manage OHT/COAG suspect/COAG.

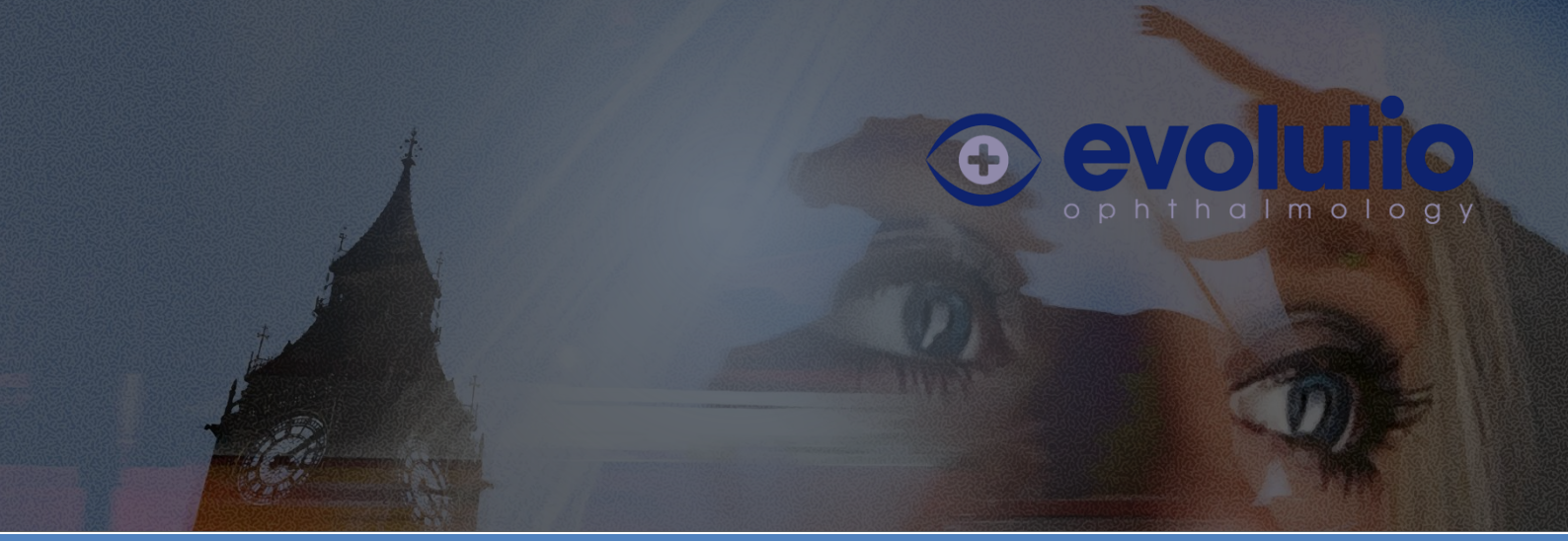
'Low Risk' is defined as "COAG suspect or OHT with or without suspicious features, i.e. equivocal optic disc or visual field, and those with PAC who have been successfully treated and have been demonstrated to have non-occludable angles."

'Medium Risk' is defined as "Early to moderate established apparently 'stable' glaucoma"

'High Risk' is defined as "Complex glaucoma (inc. COAG, PACG, secondary glaucoma and rare glaucomas). Patients at high risk of significant visual loss and those under active management or requiring or having recently undergone glaucoma surgery."

Table 1b: Risk Stratified Management by Perceived Risk of Progression to Blindness **

Case setting options	*Low Risk (monitoring only)*	*Low Risk (monitoring & management)*	*Medium Risk*	*High Risk*
Care setting only				
Community Optometrist (HCP) Core competence***	x	x	x	x
Community Optometrist (HCP) CoO Professional Certificate in Glaucoma (or equivalent)	✓	x	x	x
Optometrist (HCP) with specialist training, competence and experience as specified by NICE. Care may be delivered in Community or Outreach setting. CoO Professional Higher Certificate in Glaucoma (or equivalent) ≈ Glaucoma Certificate A	✓	✓	x	x
Optometrist (HCP) with highest level specialist training, competence and experience as specified by NICE. Care usually in HES (inc. outreach) and rarely in a Community Optometric setting. CoO Professional Diploma in Glaucoma (or equivalent) ≈ Glaucoma Certificate B	✓	✓	✓	x
Hospital or Consultant Supervised (may include outreach)				
Consultant Ophthalmologist delivered and supervised HES care. HCPs participating in such supervised services** may be medically qualified (e.g. trainee ophthalmologists) or non-medically qualified HCPs (e.g. optometrists, nurses, orthoptists)	✓	✓	✓	✓



2.3.2.2 Children's Community Eye Service - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 2 clinicians when assessing the refractive status and ocular health of children who require further investigation (e.g. cycloplegic refraction) following a sight test or Public Health England's school vision screening service.

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment

Providers should offer a service which allows access for children with a broad range of mental and physical developmental requirements, for example wheelchair access, flexible appointment times and a flexible and pragmatic approach to the clinical visits. A basic understanding of communication methods such as Makaton would be preferable.

THIS PATHWAY WOULD USUALLY FOLLOW A FULL GOS SIGHT TEST

History and symptoms

- Record age and gender
- Introductory questions
    - Do you have any concerns about the child's health or vision?
    - Do the child's eyes look straight, or do you think one eye tends to turn or wander?
    - Do the eyes have a tendency to wobble, rather like dancing eyes?
    - Does the child complain of headaches or blurred vision?
- Birth history
    - Premature/forceps/difficult birth/delayed or rapid delivery/oxygen needed/birth weight
- General health
    - Developmental concerns/any regular medications/learning difficulties
- Previous eye treatments
    - If yes, where/when/what happened?
- Family history
    - Any family history of eye turn, glasses or patching from a young age?

Initial tests

- Monocular (and binocular) unaided vision (crowded logMAR)
- Cover test (distance & near)
- Stereopsis
- Cycloplegic refraction (exclude occludable angles and issue appropriate leaflet e.g. CoO)
- Monocular (and binocular) visual acuity

Anterior segment

- Slit-lamp examination

Posterior segment

- Slit lamp binocular indirect ophthalmoscopy (SL-BIO)
    - Vitreous, retina, macula, disc, choroid
- Fundus imaging where indicated
- Post-dilation IOP review as appropriate

Management

A clinical impression (tentative diagnosis) is made and a management plan established. Spectacles may be prescribed where clinically indicated and providers should prescribe in line with current evidence and guidance.

Although myopia control is outside the scope of this pathway, providers are expected to have an understanding of current developments (e.g. http://www.myopiacontrol.org/) and make appropriate informed prescribing decisions or referrals where indicated.

Providers should be familiar with national and local guidance including those referenced below:

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. Myopia leaflet from College of Optometrists)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

Typically VA would be logMAR 0.2 or better in each eye with no pathology or uncorrected strabismus identified.

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

Where indicated, a 6 week check might include the following clinical tests:

- Monocular unaided vision (crowded logMAR)
- Visual acuity (if spectacles were prescribed)
- Cover test (distance & near)
- Stereopsis
- Cycloplegic refraction (if clinically indicated)

Where indicated, a further check 12 weeks later (18 week check) might be undertaken to review monocular visual acuity and to conduct a GOS sight test (where clinically indicated).

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

Children would typically be referred on to secondary care in the following cases:

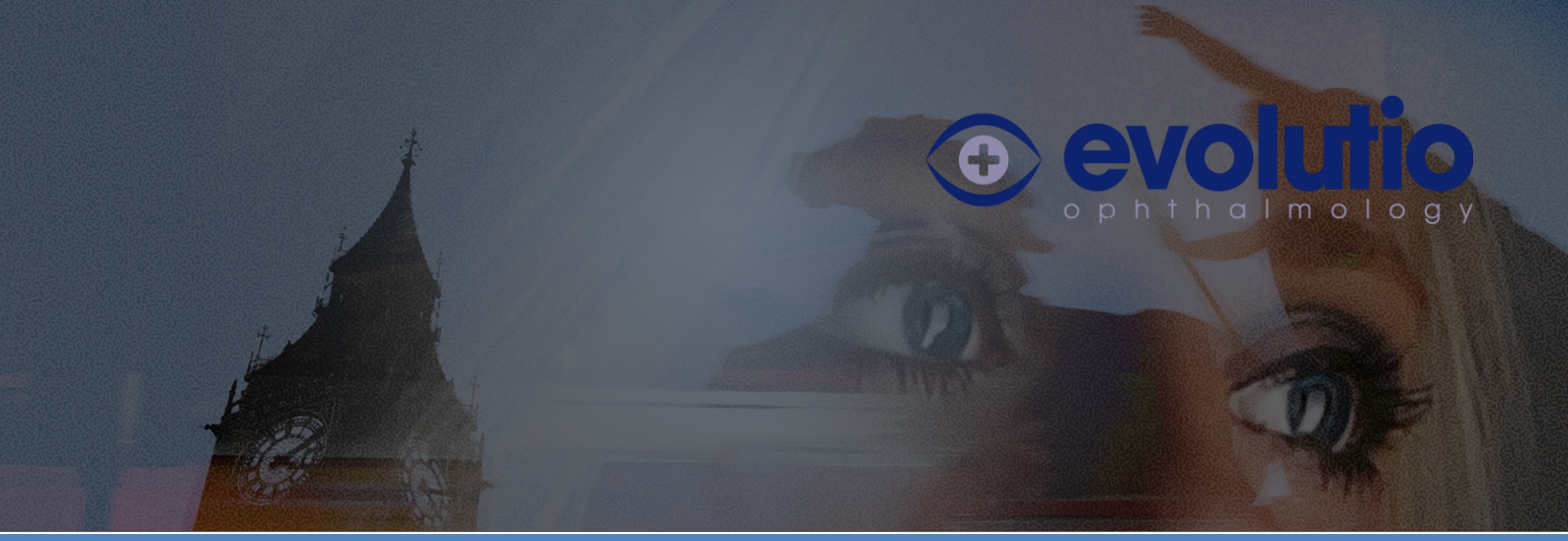
- Non-accommodative strabismus (strabismus not fully corrected by spectacles)
- Ocular pathology

- Visual acuity logMAR 0.5 or worse
- Visual acuity logMAR worse than 0.2 but not improving at 6 week check
- Visual acuity logMAR worse than 0.2 (or more than 1 line of difference between the eyes) at 18 week check

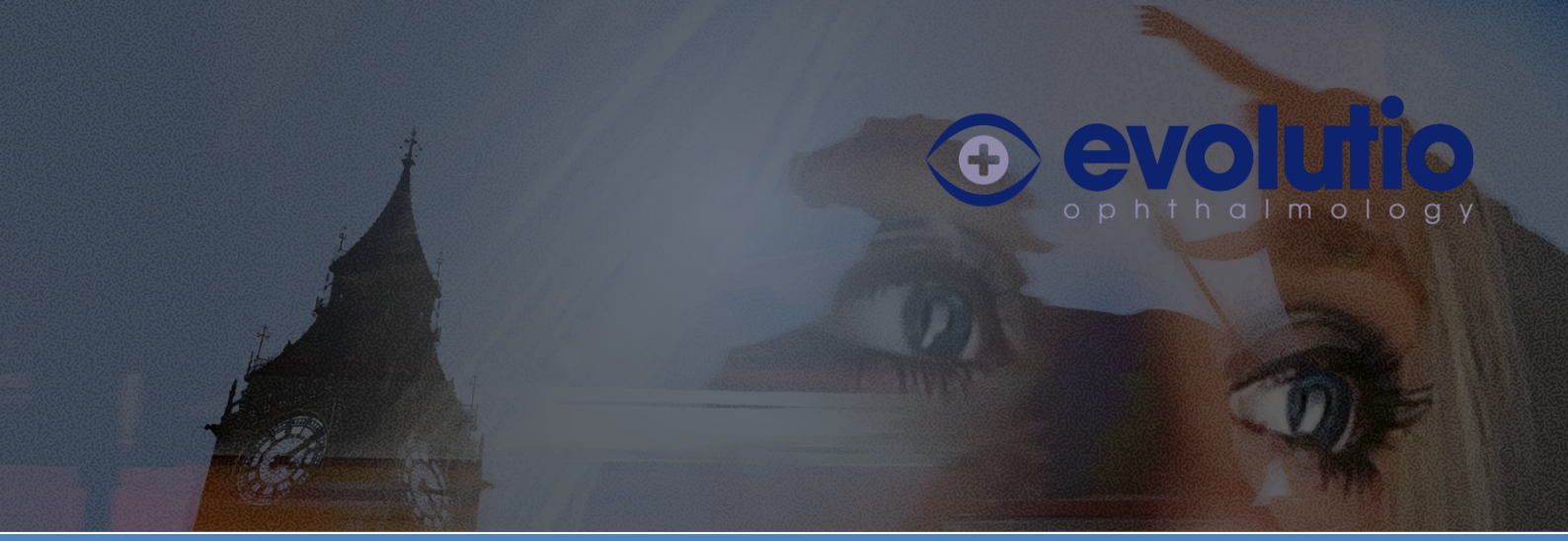
References

College of Optometrists (2019) Guidance - Examining younger children. Available at: guidance.college-optometrists.org/guidance-contents/knowledge-skills-and-performance-domain/examining-younger-children/#open:

Leat, S. (2011) To prescribe or not to prescribe? Guidelines for spectacle prescribing in infants and children. Clinical and Experimental Ophthalmology; 94(6): p.514-527. Available at: onlinelibrary.wiley.com/doi/full/10.1111/j.1444-0938.2011.00600.x



Section 2.3.3: Tier 3 Pathways



2.3.3.2 Glaucoma/OHT Suspect Assessment (OCT & Gonio) - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 3 clinicians when assessing a patient with a suspicion of OHT/suspect glaucoma/glaucoma/narrow angles. The RCOphth (2016) define which 'suitably qualified clinician' can make the diagnosis (see Appendix B). All OHT/glaucoma diagnoses are made/confirmed by Evolutio's consultant-ophthalmologist-led telemedicine team.

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical Assessment

A small cohort of patients with limited clinical data will enter this pathway following transfer from an incumbent provider. It is important to review the clinical notes provided so you have a clear understanding of the patient's clinical status; this is especially relevant at the first visit. ***Please transcribe the CCT measurement, the pre-treatment (presenting) IOP and target pressure from the clinical notes provided*** *so the telemedicine consultant has all the required information in 1 place. These values will be automatically carried over at subsequent visits.*

History and symptoms

- Record age & gender
- Where applicable (transferred patients):
    - Glaucoma history (for each eye):
        - Existing diagnosis (OHT/COAG suspect/COAG/Secondary glaucoma/Angle closure)
        - Pre-treatment (presenting) IOP
        - Target pressure
    - Compliance & QOL
        - Treatment compliance, including any side-effects
        - Quality of life (tolerating treatment, any visual loss, ability to drive)
- Visual symptoms
    - Visual field loss, haloes or visual disturbance
- Risk factors
    - Ethnicity
    - Refractive error (approximate)
    - Family history of OHT/glaucoma (first/second degree)
        - If yes, did they lose sight or receive glaucoma surgery
    - Previous ocular history, including:
        - Refractive surgery
        - Trauma
        - Inflammation
    - Medical history, including:
        - General health
        - Allergies
        - Heart / breathing problems
        - Topical and systemic medications (including frequency for glaucoma medications)
        - Prolonged steroid usage (topical or systemic)
        - Circulation
            - Acute blood loss or transfusion
            - Raynaud's disease
            - Migraine
            - Low diastolic blood pressure

Initial tests

- Visual acuity (distance and near) with refraction where indicated
- Monocular colour vision
- Visual fields
    - Full threshold test (SITA, ZATA and other algorithms acceptable)

  - Progression analysis where available
  - Comment on reliability, describe any pattern and change
  - Record Mean Defect and classify as early if up to 6dB / moderate if 6-12dB / advanced over 12dB

Anterior segment

- Slit-lamp examination
  - Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens
  - Particularly iris transillumination, corneal endothelial pigment, pseudoexfoliation
- Anterior chamber angle examination (including peripheral depth)
- Central anterior chamber depth (where indicated)
- Gonioscopy
  - Use an established system (e.g Shaffer) to record as a minimum the most posterior visible angle structure without indentation in each of the 4 quadrants (superior/temporal/nasal/inferior)
- Central corneal thickness (CCT)
  - Ultrasound pachymetry is the gold standard. OCT measurement of CCT acceptable
- Intra-ocular pressure (IOP)
  - Contact applanation tonometry and time
    - Goldmann is the gold standard, Perkins acceptable.
    - iCare if patient declines or can't tolerate GAT/PAT (annotate clearly)

Posterior segment

- Slit lamp binocular indirect ophthalmoscopy (SL-BIO)
  - Dilation where indicated (including post-dilation IOP review as appropriate)
  - Lens, vitreous, retina, macula, choroid
  - Optic nerve head
    - Disc size (vertical disc diameter)
    - Vertical C:D ratio
    - Neuroretinal rim notches/loss
    - Disc haemorrhages
    - RNFL defects
    - PPA
    - 'ISNT' rule obeyed?
    - Vessel changes (baring, bayonetting, nasalisation)

Imaging

- Colour fundus photographs (showing disc and macula)
- OCT (cRNFL and GCC)
  - Progression analysis where available
- Anterior segment OCT (or equivalent) anterior chamber angle scan for potentially occludable angles

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established. Evolutio's glaucoma pathways have mandated consultant-ophthalmologist-led telemedicine.

A 4 point summary should be included at the end of the consultation:

1) **Diagnosis**
   - There should be a diagnosis attached to each record for each eye
   - e.g. primary, secondary, open angle, narrow angle, glaucoma risk/suspect etc.
2) **An assessment of past glaucoma damage**
   - Based on discs, fields and OCT
   - Classify as early if field MD up to 6dB / moderate if 6-12dB / advanced over 12dB
3) **A judgement about future risk**
   - Estimate risk of future disc damage, taking into account all the relevant risk factors
     - Thin CCT, young age, ethnicity, FHG etc.
   - Classify as low / moderate / high

4) A decision about whether the present status is stable or not

- Consider whether IOP at/below target, progression (disc/OCT/field), drop compliance etc.
- Classify as stable/satisfactory or unsatisfactory

Taking into account the past damage, future risk and present status, a decision can be made about treatment/management.

If a prescription is required and not already arranged, it will be issued by the consultant-ophthalmologist-led telemedicine team to the patient's registered GP and may include a range of topical medications including prostaglandin analogue, beta blocker, carbonic anhydrase inhibitor, sympathomimetic, alpha 2 adrenergic agonist or combinations.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. College of Optometrists leaflet on glaucoma, Glaucoma UK's leaflet on OHT/Glaucoma/Eye Drops and Dispensing Aids/Glaucoma and Your Relatives)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

- Anterior chamber angle is not occludable
- Treatment not recommended or required according to NG81 table 5 (based on CCT, IOP and age)
- No glaucomatous or progressive visual field loss
- Disc/OCT assessment shows no glaucomatous abnormalities

Follow-up and monitoring

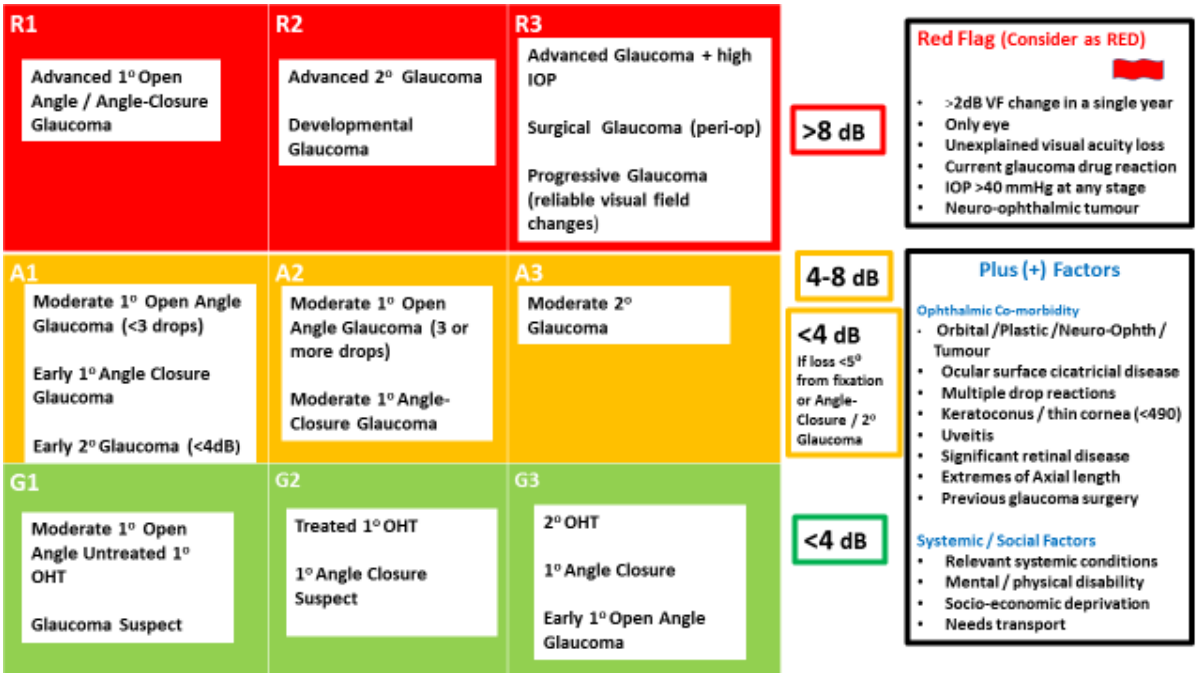
A patient may require a follow-up appointment to confirm the diagnosis, if any, or suitability to discharge back to the referring clinician. The follow-up interval will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

This purpose of this pathway is to perform the necessary tests to establish a diagnosis so a decision can be made on the most appropriate pathway for ongoing care (e.g. community monitoring, HES assessment or even discharge). In the majority of cases a patient would have 1 (or possibly 2) visits on this pathway.

A second visit would typically be because either the discs or fields or IOP are borderline with no other significant risk factors.

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.



The RCOphth/UKEGS Glaucoma Risk Stratification Tool (July 2020) is shown above. Patients in categories G1, G2, G3 and A1 are suitable for community monitoring.

- The following diagnoses may be suitable for the 'Glaucoma/OHT Monitoring pathway' (section 2.3.2.1):
    - Untreated/treated primary ocular hypertension (OHT)
    - Secondary ocular hypertension (OHT)
    - Glaucoma suspect (COAG suspect)
    - Early primary open angle glaucoma (POAG)
    - Moderate primary open angle glaucoma <3 drops (POAG)
    - Early secondary glaucoma

- The following diagnoses may be suitable for the 'Narrow A/C Angles Monitoring pathway' (section 2.3.3.5):
    - Primary angle closure suspect (PACS)
    - Primary angle closure (PAC)
    - Early primary angle closure glaucoma (PACG)

Patients in categories R1, R2 and R3 are restricted to HES-delivered care. In most cases patients in categories A2 and A3 would be onward referred for HES-delivered care, particularly those with 'plus' and other risk factors:

- Moderate primary open angle glaucoma on 3 or more drops
- Moderate/advanced primary angle closure glaucoma
- Moderate/advanced secondary glaucoma
- Advanced primary open angle glaucoma
- Developmental glaucoma
- Surgical glaucoma (peri-op) e.g. trabeculectomy within the last 12/12
- **** Progressive glaucoma ****

The following signs/symptoms may also require onward referral to HES:

- A 2db visual field change in a single year
- Unexplained visual acuity loss
- Current glaucoma drug reaction
- IOP of higher then 40mmHg at any stage
- Patients requiring SLT/surgery
- NTG with plus factors (particularly in category A1 and above)

References

NICE NG81- Glaucoma: diagnosis and management

College of Optometrists Guidance – assessing patient with raised IOP

College of Optometrists Clinical Management Guidelines (glaucoma, OHT)

Joint RCOphth and UKEGS Glaucoma Risk Stratification Tool (July 2020)

DVLA - Glaucoma and driving

The Royal College of Ophthalmologists Commissioning Guide: Glaucoma (Recommendations) June 2016

NICE Quality standard [QS180] – Serious Eye Disorders

Appendix A: Suspected glaucoma/OHT assessment – a quick reference guide

	1. Introduction
HISTORY & SYMPTOMS	**2. Overview of why they're here (referring clinician's perspective)** **3. Are they having any problems with their eyes?** 4. Glaucoma history: • Diagnosis, presenting IOP, target pressure 5. Compliance & QOL 6. Risk factors • Age, gender, ethnicity • Refractive error • Family history • Previous ocular history (refractive surgery, trauma, inflammation) • Medical history (including medications): o General health (including heart/breathing problems) o Allergies o Steroid use o Circulation (Acute blood loss or transfusion, Raynaud's, migraine, low BP)
INITTAL TESTS	**7. Visual acuity (distance and near) with refraction and pinhole where indicated** **8. Monocular colour vision** **9. Visual fields (full threshold)**
CLINICAL EXAMINATION	**10. Anterior segment slit-lamp examination** • Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens • Iris transillumination, corneal endothelial pigment **11. Anterior chamber angle examination** **12. L/A instil (plus leaflet)** **13. GAT with time** **14. Central corneal thickness (if using ultrasound pachymeter and not previously measured)** **15. Gonioscopy** **16. Instil tropicamide (plus leaflet)** **17. Colour fundus photography and posterior OCT scans (cRNFL and macular GCC)** **18. Slit lamp binocular indirect ophthalmoscopy (SL-BIO)** • Vitreous, retina, macula, choroid • Disc (VDD, C:D, NRR status, PPA, haemorrhages, vessels) • Post-dilation IOP review as appropriate
CONCLUSION	**19. Impression (4 point summary)** • Diagnosis • Past glaucoma damage (early if field MD up to 6dB / moderate if 6-12dB / advanced over 12dB) • Future risk (low/moderate/high depending on risk factors e.g. CCT, age, ethnicity, F/H) • Present status (stable or unsatisfactory depending on IOP vs target, disc/field progression, compliance) **20. Proposed management plan and recall** **21. Discussion with patient** **22. Telemedicine review** **23. Letters sent**

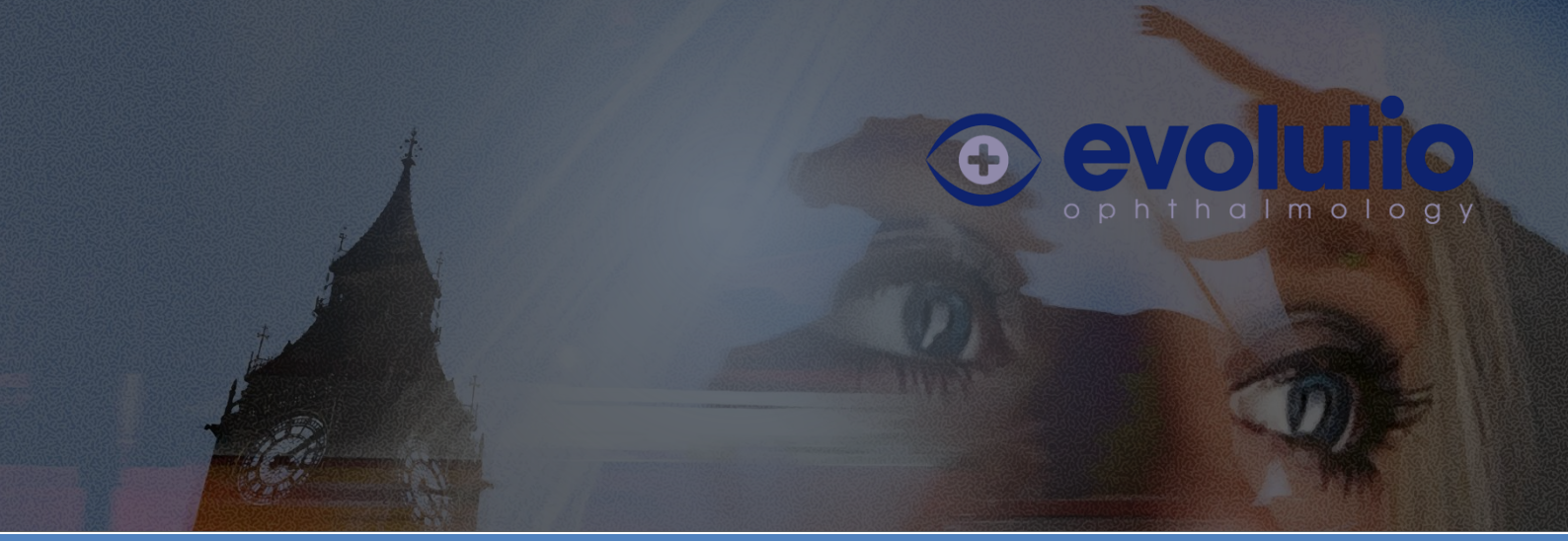
Appendix B: 'Suitably Qualified Clinicians' for diagnosing OHT/Glaucoma

ALL OHT/GLAUCOMA DIAGNOSES ARE MADE/CONFIRMED BY EVOLUTIO'S CONSULTANT-OPHTHALMOLOGST-LED TELEMEDICINE TEAM

The following table is reproduced from The Royal College of Ophthalmologists Commissioning Guide: Glaucoma (Recommendations) June 2016. It shows the necessary qualifications to diagnose OHT/COAG suspect/COAG.

Table 1a: Case finding & diagnostic services for newly identified patients

Case setting options	*Repeat Measures (IOP & Fields, Optic disc normal)*	*Enhanced Case Finding (Repeat Measures plus)*	*Referral refinement with Diagnosis of OHT/COAG suspect*	*Glaucoma Diagnosis*
Community				
Community Optometrist (HCP) Core competence ***	✓	×	×	×
Community Optometrist (HCP) CoO Professional Certificate in Glaucoma (or equivalent)	✓	✓	×	×
Optometrist (HCP) with specialist training, competence and experience as specified by NICE. Care may be delivered in Community or Outreach setting. CoO Professional Higher Certificate in Glaucoma (or equivalent) ≈ Glaucoma Certificate A	✓	✓	✓	×
Optometrist (HCP) with highest level specialist training, competence and experience as specified by NICE. Care usually in HES (inc. outreach) and rarely in a Community Optometric setting. CoO Professional Diploma in Glaucoma (or equivalent) ≈ Glaucoma Certificate B	✓	✓	✓	×
Hospital or Consultant Supervised (may include outreach)				
Consultant Ophthalmologist delivered and supervised HES care. **HCPs participating in such supervised services**** may be medically qualified (e.g. trainee ophthalmologists) or non-medically qualified HCPs (e.g. optometrists, nurses, orthoptists)	✓	✓	✓	✓



2.3.3.3 Hydroxychloroquine Retinopathy Screening - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 3 clinicians when providing retinal screening for a patient taking/planning to take chloroquine or hydroxychloroquine for over 5 years.

Hydroxychloroquine (HCQ) is an antimalarial agent that is also commonly used as a treatment for a variety of rheumatological and dermatological conditions (e.g. Rheumatoid Arthritis (RA) and Systemic Lupus Erythematosus (SLE). Hydroxychloroquine Retinopathy (HCQR) can result in retinal pathology that reduces visual acuity. The prevalence of HCQR after 5 years of HCQ treatment is approximately 7.5%, rising to 20-50% after 20 years of HCQ therapy.

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment: Baseline

A baseline assessment should be undertaken within 6 months of starting treatment and ideally before starting treatment.

The risk of HCQR increases with:

- Duration of HCQ use more than 5 years (assuming no other risk factors)
- Drug dosage (patients taking more than 5mg/kg/day)
- Concomitant Tamoxifen use
- Renal impairment (defined as reduced, typically eGFR <60 indicates impaired renal function)
- Macular disease

History and symptoms

- Record age and gender
- Ancestry in particular East Asian, Southeast Asian and Filipino
    - At risk of wider/pericentral (rather than parafoveal) damage
- Reason for taking the drug
- Dose (e.g. 400 mg/day)
- Approximate weight in kg
- Date treatment commenced
- Symptoms
- Do you exceed the recommended dose (and if so, how often?)

Initial tests

- Visual acuity (distance and near) with refraction where indicated
- Visual fields
    - 10-2 threshold visual field test in cases of existing macular pathology

Anterior segment

- Anterior chamber angle examination pre-dilation

Posterior segment

- Dilated colour retinal photograph showing disc, macula and arcades
- Dilated SD-OCT macula
- Post-dilation IOP review as appropriate

Clinical assessment: Annual monitoring

If a patient continues on treatment, then **annual monitoring** is indicated after 5 years for HCQ (or sooner in the above high-risk groups). For those patients taking chloroquine (which is more retinotoxic than HCQ) annual monitoring is indicated from the baseline measurement date. Clinical tests (particularly visual fields) should be repeated if the results are unreliable.

History and symptoms

- Ancestry (in particular East Asian, Southeast Asian and Filipino)
- Reason for taking the drug
- Dose (e.g. 400 mg/day)
- Approximate weight in kg
- Date treatment commenced
- Symptoms
- Do you exceed the recommended dose (and if so, how often?)

Initial tests

- Visual acuity (distance and near) with refraction where indicated
- Visual fields
    - 10-2 threshold visual field test
    - 30-2 visual field if
        - Widefield FAF anomalies
        - Suspected peri-central changes
        - Racial risk factors for peri-central disease (East Asian, Southeast Asian and Filipino)

Anterior segment

- Anterior chamber angle examination pre-dilation

Posterior segment

- Dilated colour retinal photograph showing disc, macula and arcades
- Dilated SD-OCT macula
    - Widefield SD-OCT volumetric macular scans with raster/detailed scans in areas of interest (or mosaic to cover macula and extra-macular areas around arcades) if:
        - Widefield FAF anomalies
        - Suspected peri-central changes
        - Racial risk factors for peri-central disease
- Widefield FAF (or mosaic to cover macula and extra-macular areas around arcades)
    - Mosaic would typically comprise 4 images to cover circa 50 degrees (macula centre, superior, inferior, temporal)
- Post-dilation IOP review as appropriate

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established. Providers are not expected to treat suspected HCQ retinopathy, nor should they advise a patient to stop taking the drug.

If a patient is found to have hydroxychloroquine retinopathy, they should be discharged from the screening programme, however we would recommend that they continue to be reviewed in the hospital eye service to determine disease stability/rate of progression.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. Macular Society's 'Eye screening for patients taking hydroxychloroquine' - see references for link)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

Patients may be discharged if the HCQ/CQ treatment is stopped

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

Patients who are clinically suitable to be retained within the service will typically be recalled annually although this will depend on the clinical presentation. Higher risk/borderline cases (e.g. renal impairment, Tamoxifen use, high doses of hydroxychloroquine 5mg/kg or any patient taking Chloroquine >2.3mg/kg may be recalled sooner and monitored annually from baseline.

Results will be sent to the prescribing doctor (usually a rheumatologist), the patient and the GP. Results are classified as:

- Normal
- Possible HCQR
    - One imaging test result typical of HCQR
- Definite HCQR
    - Two test results (one subjective and one objective) typical of HCQR – usually referred to HES

The recall period (1 or 5 years) is managed by the central ophthalmology team. Where a patient is retained within the service for follow-up (annual monitoring), the referral is managed through a number of in-built and automated processes within our system:

- Referral is placed in the 'retained silo' with appropriate follow-up timeframe i.e. 12 months, 5 years
- When an appointment is due, the referral moves to 'appointment to book silo'
- Patient is contacted to book their appointment
- Appointment reminder sent by SMS or email

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. If a patient is found to have hydroxychloroquine retinopathy they should be discharged from the screening programme, however we would recommend that they continue to be reviewed in the hospital eye service and undergo annual testing for a few years to determine whether there is stabilization or progression of their disease.

The clinician should also refer cases which they are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

When referring it is good practice to specify disease severity (as defined by RCOphth, 2018).

1. Referral for an Electroretinogram (mfERG) if there are persistent and significant visual field defects consistent with HCQR but normal OCT/FAF
2. Referral for an Electroretinogram If there are OCT/FAF changes consistent with HCQR
3. Referral for further assessment and establish eligibility to drive if there is 'definite HCQR'
4. Referral in cases of diagnostic uncertainty

Severity	Visual field (10-2)	Fundus autofluorescence	Spectral domain OCT
Mild	Non-specific visual field deficits/ focal visual field loss PSD <3bD	Subtle increase signal in parafovea or pericentral distribution	Subtle outer retinal changes
Moderate	Incomplete ring scotoma PSD 3-10dB	Significant increase in signal in parafovea or pericentral distribution. RPE loss (reduced signal) may also be present in less than 2 quadrants.	Significant outer retinal structural changes with thinning
Severe	Complete ring scotoma with or without loss of sensitivity at fixation PSD >10dB	Reduced signal in more than 2 quadrants indicative of RPE damage	Disruption of outer retina and RPE, with diffuse retinal thinning and outer retinal debris. Epiretinal membrane and cystoid macular oedema may be present.

It is the prescribing doctor's responsibility to ensure their patients are adequately assessed and to act on the results of monitoring. Do **NOT** advise the patient to stop taking their medication solely because HCQR is detected.

Patient should be made aware of appropriate support when hydroxychloroquine retinopathy is detected. Support can include low vision clinics, eye clinic liaison officer (ECLO) services, certification of visual impairment and referral to local and/or national charities.

Consider the patient's eligibility to drive. Ask the patient to inform the DVLA of HCQ use and advise the patient not to drive if they do not meet the driving standard. They should not drive until an Estermann visual field test confirms it is legal to do so. It is the patient's responsibility to inform the DVLA.

References

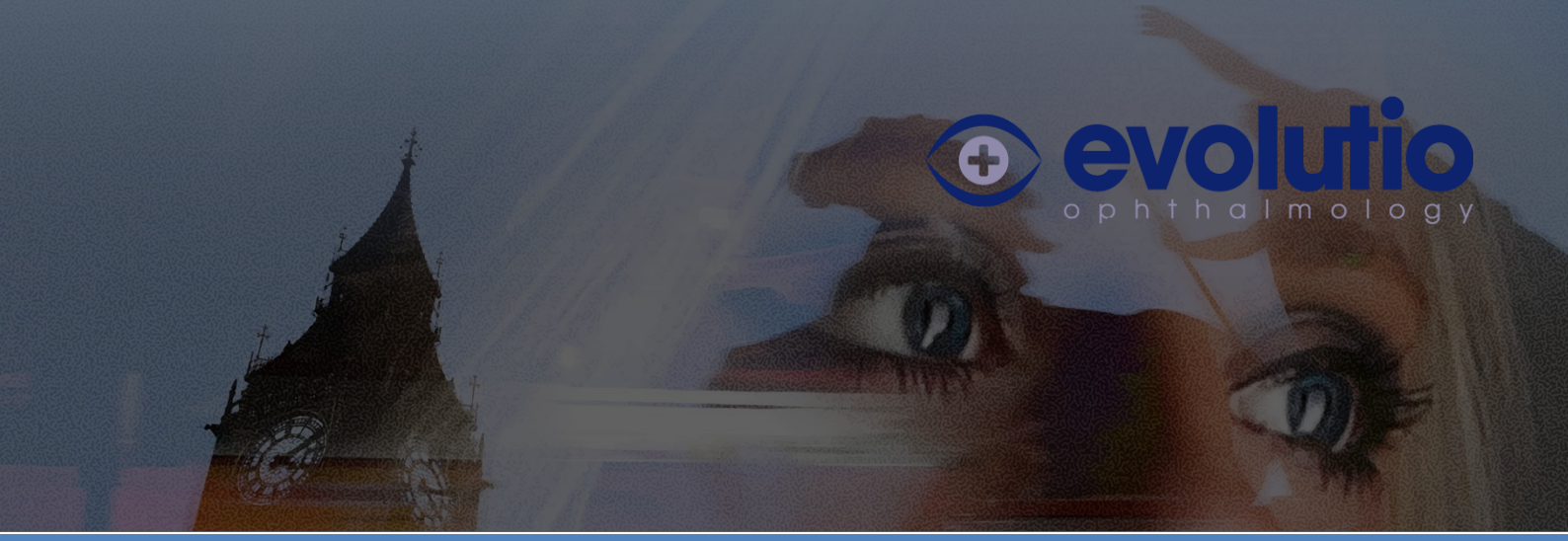
Yusuf, I. Sharma, S. Luqmani, R. & Downes, S. (2017) 'Hydroxychloroquine retinopathy' Eye, 31 pp. 828–845 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5518824/ (Accessed 13-06-19)

Melles, R. Marmour, M. (2015) 'Pericentral Retinopathy and Racial Differences in Hydroxychloroquine Toxicity' Ophthalmology, 122 (1) pp. 110 – 116 https://www.aaojournal.org/article/S0161-6420(14)00622-8/pdf (Accessed 13-06-19)

RCOphth (2018) - Hydroxychloroquine and Chloroquine Retinopathy: Recommendations on Screening Clinical Guidelines, February 2018 https://www.rcophth.ac.uk/wp-content/uploads/2018/07/Hydroxychloroquine-and-Chloroquine-Retinopathy-Screening-Guideline-Recommendations.pdf

RCOphth (Jan 2020) Hydroxychloroquine and Chloroquine Retinopathy: Recommendations on Monitoring - Clinical Guidelines

Macular Society leaflet "Eye screening for patients taking hydroxychloroquine" available at: https://www.macularsociety.org/sites/default/files/resource/Hydroxychloroquine%20-%20access_0.pdf)



2.3.3.4 Foreign Body Removal (Sub-tarsal/corneal) - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 3 clinicians when assessing/managing a patient with a corneal/sub-tarsal foreign body.

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Practitioners should recognise their limitations and where necessary seek further advice or refer the patient elsewhere

Clinical assessment

History and symptoms

- Record age and gender
- When did it happen?
- What happened?
- What is it likely to be? Metal / vegetation / lime
    - Metal FB - high energy (metal striking e.g. chiselling)
        - Assume an intraocular FB if not visible on the surface (globe penetration)
    - Metal FB – low energy (dropped in the eye, including grinding wheels)
        - Very unlikely to penetrate globe
    - Lime/old mortar must be removed and thoroughly irrigated before sending the patient to eye casualty

Initial tests

- Monocular VA
- Assess motility
- Assess pupils (size, shape, reflexes)

Anterior segment

- Examine the eye for deflation of the globe or anterior chamber (perforation)
- Instil 1 drop of topical anaesthetic
- Check for Seidel sign
    - Instil fluorescein and look for a hypofluorescent stream of aqueous (since it is irrigating the fluorescein away in that area of leakage)
    - Seidel positive indicates globe perforation and warrants immediate referral to eye casualty

- Check A/C for flare and/or cells
- Check entire cornea and conjunctiva for foreign body(ies)
    - Evert both lids and ask patient to look in at least 4 positions of gaze
    - Remember the potential for multiple particles
    - If double eversion is indicated consider onward referral (challenging technique, rarely performed, patient anxiety)
    - Where there is any suspicion of a penetrating injury, carry out dilated fundus examination

- Assess the FB
    - depth (optical section)
        - Stromal penetration carries an increased risk of scarring
    - Establish likely material (metal/organic/other)

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established.

Foreign body removal

Equipment required:

- Needle (21 gauge, green), 40mm
- Syringe (small, e.g. 3ml)
- Sterile saline
- Sterile buds
- Topical anaesthetic
- Fluorescein (Fluorette strip)

IF no FB and simple/no corneal abrasion visible:

- Swab the upper and lower fornices with a moistened cotton-tipped applicator
- Irrigate the eye
- Ask for a second opinion if there is another clinician on the premises

IF superficial FB:

- Lubricate the eye
- Ask the patient to fixate a distant object
- Moistened (sterile) cotton-tipped applicator, with a rolling motion, to gently lift the FB

IF embedded FB:

- Prepare/lay out your equipment
    - Including a moistened cotton bud to remove the dislodged FB
    - Attach the needle to the syringe and hold like a pencil (or just hold the needle without a syringe if you prefer)
- Ask the patient to fixate a distant object in the most helpful direction
- Approach with the needle parallel to the cornea and from the periphery
    - Most people use their dominant hand, but preferences vary
    - Approach in 2 steps
        - With permission, rest your hand in a comfortable, stable position against the patient's face (zygomatic arch or nasal bridge)
        - Position the needle/bud to a position near the corneal periphery
        - Under magnification with the tool still parallel to the cornea, slowly and carefully approach the FB, proceeding inward from the corneal periphery
- Remove the FB
    - Needle bevel should be facing up
    - Use the tip to pick or scoop the FB up and away from the cornea
    - Several of these 'scrapes' may be required to remove all of the FB and some of the superficial rust ring
    - If the FB has been dislodged but remains on the surface of the eye, use the moistened cotton bud to remove it

It takes a fair amount of effort to perforate the cornea if you follow the above steps.

Post removal

Rust Ring:

- Metallic (ferrous) FB's start to form a rust ring within 8-10 hours (around and underneath the FB). This can cause scarring and potential visual loss. If the rust ring does not fully come out at the time of removing the FB (despite a few additional scrapes):
    - Option 1. A burr (e.g. Alger Brush) may be used by those who are suitably trained/experienced. These must be sterile. NOT IN CURRENT USE IN EVOLUTIO
    - Option 2. Alternatively, use chloramphenicol ointment tds to lubricate/soften it and arrange for a follow-up with the HES in 2-3 days (rapid access)

Assess size and depth of remaining epithelial defect (so that healing can be monitored).

- Repeat Seidel test where indicated to exclude post-procedure perforation

- It is uncommon to see Seidel sign post-removal even in a deep FB. If it does leak, consider a bandage CL and refer for corneal glue

Check VA

Usually the eye is not padded. If there is a clear indication to stop the eye from opening/blinking, then consider a Vaseline gauze to seal the eye shut.

Prescribing

Pain:

- Oral painkillers may be taken if required, typically for 24-48hrs e.g. paracetamol/ibuprofen
- A large epithelial defect (usually abrasion) can cause a pupil spasm so consider g. cyclopentolate bd/tds for 2-3 days

Infection:

- Chloramphenicol is licensed as a POM for prophylaxis following minor ocular trauma
  - Unless the FB is organic it is unlikely to get infected, so chloramphenicol ointment is more useful as a lubricant than a (bacteriostatic) antibiotic.
  - Tears will pool in the defect and it will naturally heal very quickly
  - For organic FB, use oc. chloramphenicol 1% nocte for 2/12. Then move on to oc. NaCL 5% (draws fluid out from under the epithelium so it can bed down and it lubricates).
- In a contact lens wearer prescribe a course of antibiotics effective against gram negative organisms e.g. g.levofloxacin qds for 5 days

Other:
Do not prescribe topical NSAID/steroid/topical anaesthetic.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate
- Education about disease prognosis
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop or symptoms persist
- Use suitable eye protection in future
- In contact lens wearers, cease wear
- Increased risk of recurrent corneal erosion due to epithelial instability
- Warn of the potential for visual problems in a central deep FB with a rust ring (doesn't heal well, might perforate and might require a transplant)

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

Clinical findings:

- No associated or progressive visual loss
- Simple superficial FB

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

Review after 24-48 hours if there are any concerns (e.g large FB, edges uneven following removal, contact lens wear).

Onward referral to another pathway

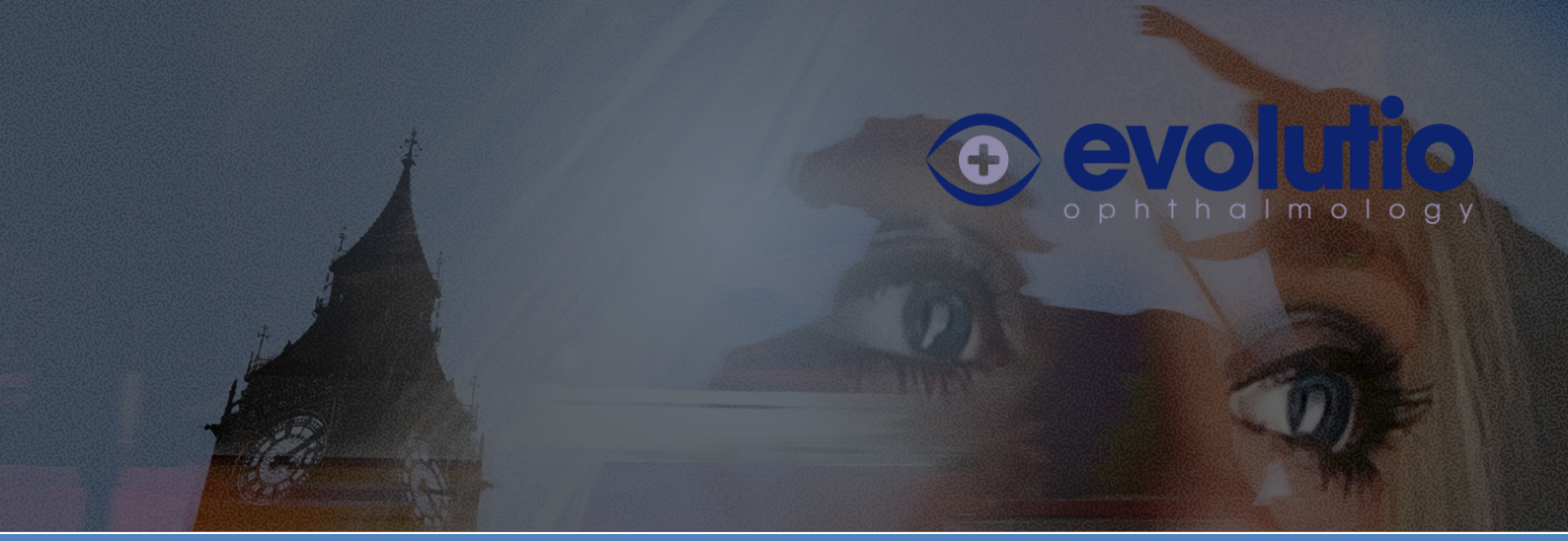
The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

- Refer to eye casualty if globe perforation is suspected
- Refer on Rapid Access pathway to HES if a FB can't be removed in community
- Refer to HES for review in 2-3 days if the rust ring can't be removed
- If a telemed opinion is sought/mandated, then follow their advice

References

College of Optometrists Clinical Management Guidelines – corneal foreign body

College of Optometrists Clinical Management Guidelines – sub-tarsal foreign body



2.3.3.5 Narrow Anterior Chamber Angles Monitoring - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 3 clinicians when assessing a patient with diagnosed or treated narrow anterior chamber angles. Patients will enter this pathway in 2 possible ways:

- Following assessment on the 'Glaucoma/OHT suspect assessment' pathway, having identified narrow angles which require and are suitable for ongoing community monitoring (glaucoma risk and occludability)
- Following a request from the HES for the monitoring of treated (laser peripheral iridotomy) narrow angles

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment

History and symptoms

- Where applicable (transferred patients):
    - Glaucoma history:
        - Existing diagnosis (OHT/COAG suspect/COAG/Secondary glaucoma/Angle closure)
        - Pre-treatment (presenting) IOP
        - Target pressure
    - Compliance & QOL
        - Treatment compliance, including any side-effects
        - Quality of life (tolerating treatment, any visual loss, ability to drive)
- Visual symptoms
    - Visual field loss, haloes or visual disturbance
    - Pain, redness, nausea, intermittent blurring of vision
    - Symptoms might reduce in the supine position
- Risk factors
    - Age & gender
    - Ethnicity
    - Refractive error (approximate)
    - Family history of OHT/glaucoma (first/second degree)
        - If yes, did they lose sight or receive glaucoma surgery
    - Previous ocular history, including:
        - Refractive surgery
        - Trauma
        - Inflammation
    - Medical history, including:
        - General health
        - Allergies
        - Heart / breathing problems
        - Topical and systemic medications
            - Adrenergic agents (e.g. phenylephrine)
            - Anticholinergics (e.g. atropine, tropicamide, cyclopentolate)
            - Drugs with anticholinergic effects (e.g. tricyclic antidepressants such as amitriptyline)
            - Drugs that cause ciliary body oedema (e.g. topiramate, sulphonamides)
            - Selective serotonin reuptake inhibitors (e.g. citalopram, sertraline, fluoxetine)
            - Recreational drugs (e.g. amphetamines, cocaine, MDMA)
        - Prolonged steroid usage (topical or systemic)
        - Circulation
            - Acute blood loss or transfusion
            - Raynaud's disease
            - Migraine
            - Low diastolic blood pressure

Initial tests

- Visual acuity (distance and near) with refraction where indicated
- Monocular colour vision

- Visual fields – only necessary if disc damage is suspected
    - Full threshold test (SITA, ZATA and other algorithms acceptable)
    - Progression analysis were available
    - Comment on reliability, describe any pattern and change
    - Record Mean Defect and classify as early if up to 6dB / moderate if 6-12dB / advanced over 12dB

Anterior segment

- Slit-lamp examination
    - Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens
    - Particularly iris transillumination, corneal endothelial pigment, pseudoexfoliation
- Anterior chamber angle examination (including peripheral depth)
- Central anterior chamber depth (Smith's technique)
- Gonioscopy
    - Use an established system (e.g Shaffer) to record as a minimum the most posterior visible angle structure without indentation in each of the 4 quadrants (superior/temporal/nasal/inferior)
- Central corneal thickness (CCT)
    - Ultrasound pachymetry is the gold standard. OCT measurement of CCT acceptable
    - Transcribe previous value if it is unlikely to have changed
- Intra-ocular pressure (IOP)
    - Contact applanation tonometry and time
        - Goldmann is the gold standard, Perkins acceptable.
        - iCare if patient declines or can't tolerate GAT/PAT (annotate clearly)

Posterior segment

- Slit lamp binocular indirect ophthalmoscopy (SL-BIO)
    - Dilation where indicated (including post-dilation IOP review as appropriate)
    - Lens, vitreous, retina, macula, choroid
    - Optic nerve head
        - Disc size (vertical disc diameter)
        - Vertical C:D ratio
        - Neuroretinal rim notches/loss
        - 'ISNT' rule obeyed?
        - PPA
        - Disc haemorrhages
        - Vessel changes (baring, bayonetting, nasalisation)
        - RNFL defects

Imaging

- Colour fundus photographs (showing disc and macula)
- OCT (cRNFL and GCC)
    - Progression analysis where available
- Anterior segment OCT (or equivalent) anterior chamber angle scan

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established. Evolutio's glaucoma pathways have mandated consultant-ophthalmologist-led telemedicine.

A 4-point summary should be included at the end of the consultation:

1. **Diagnosis**
    - There should be a diagnosis attached to each record
        - PACS: $>180^0$ iridotrabecular contact (Shaffer grade 1 or less), normal IOP, normal disc
        - PAC: $>180^0$ iridotrabecular contact (Shaffer grade 1 or less), raised IOP and/or PAS, normal disc
        - PACG: $>180^0$ iridotrabecular contact (Shaffer grade 1 or less), raised IOP and/or PAS, disc damage

2. **An assessment of past glaucoma damage**
   - Based on discs, fields and OCT
   - Classify as early if field MD up to 6dB / moderate if 6-12dB / advanced over 12dB

3. **A judgement about future risk**
   - Estimate risk of future disc damage, taking into account all the relevant risk factors
     - Present risk of angle closure
     - Thin CCT, young age, ethnicity, FHG etc.
   - Classify as low / moderate / high

4. **A decision about whether the present status is stable or not**
   - Consider whether IOP at/below target, progression (disc/OCT/field), drop compliance etc.
   - Classify as stable/satisfactory or unsatisfactory

Taking into account the past damage, future risk and present status, a decision can be made about treatment/management.

If a prescription is required and not already arranged, it will be issued by the consultant-ophthalmologist-led telemedicine team to the patient's registered GP and may include a range of topical medications including prostaglandin analogue, beta blocker, carbonic anhydrase inhibitor, sympathomimetic, alpha 2 adrenergic agonist or combinations.

Visit outcomes

Allowable outcomes resulting from the consultation are:
- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:
- Written guidance as appropriate (e.g. Glaucoma UK's leaflet on PAC)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitor

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment

- Non-occludable angles
  - Anterior chamber angle is not occludable
  - Treatment not recommended or required according to NG81 table 5 (based on CCT, IOP and age)
  - No glaucomatous or progressive visual field loss
  - Disc/OCT assessment shows no glaucomatous abnormalities
  - Patients with treated narrow angles (who meet the above criteria) are usually discharged after 3 years of annual follow-up post-YAG Peripheral Iridotomy

- Occludable angles
  - PACS (>180^0 iridotrabecular contact (Shaffer grade 1 or less), normal IOP, normal disc, normal field)
  - No other 'high risk' factors (e.g. not often dilated/no FH, no drugs which precipitate angle closure)
  - RCOphth suggested management: Does not need follow-up or laser PI
    - *The Zap Trial found that the risk of converting from PACS to PAC was very low which suggests that LPI is not required in all PACS*

Follow-up and monitoring

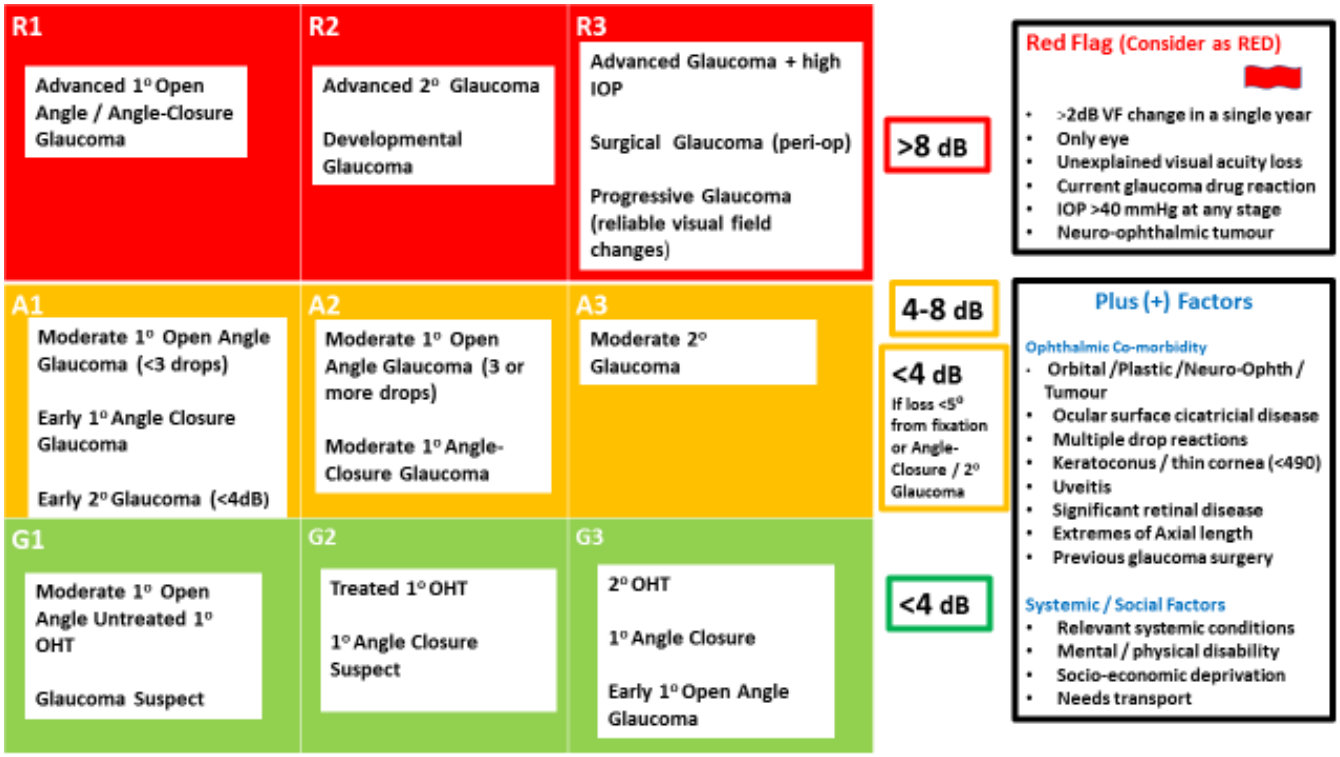
A patient may require a follow-up appointment to confirm the diagnosis, if any, or suitability to discharge back to the referring clinician. The follow-up interval will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

The majority of patients on this pathway are expected to be retained for ongoing follow-up. The RCOphth/UKEGS Glaucoma Risk Stratification Tool (July 2020) is shown below. Patients in categories G1, G2, G3 and A1 are suitable for community monitoring:

- *Primary angle closure suspect (PACS)*
    - *A cohort of low-risk PACS patients may be discharged, as described in the section above*
- *Primary angle closure (PAC)*
- *Early primary angle closure glaucoma (PACG)*

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.



The RCOphth/UKEGS Glaucoma Risk Stratification Tool (July 2020) is shown above. Patients in categories G1, G2, G3 and A1 are suitable for community monitoring.

Patients in categories R1, R2 and R3 are restricted to HES-delivered care. In most cases patients in categories A2 and A3 would be onward referred for HES-delivered care, particularly those with 'plus' and other risk factors:

- Moderate/advanced primary angle closure glaucoma
    - PACG with high IOP = urgent
        - *RCOphth suggested management: If IOP >30, offer lens extraction/LPI as a high-moderate priority*
    - PACG with moderate IOP = routine (advanced = urgent)
- **** Progressive glaucoma ****
- Other
    - PAC with high IOP might require HES referral
        - *RCOphth suggested management: If IOP is under 30 mmHg, offer LPI and treat IOP as one would otherwise. If IOP >30: Offer lens extraction/LPI as a high-moderate priority*
    - AAC/intermittent acute angle closure = HES (emergency/rapid access)

The following signs/symptoms may also require onward referral to HES:

- A 2db visual field change in a single year
- Unexplained visual acuity loss

- Current glaucoma drug reaction
- IOP of higher then 40mmHg at any stage
- Patients requiring SLT/surgery
- NTG with plus factors (particularly in category A1 and above)

References

NICE NG81- Glaucoma: diagnosis and management

College of Optometrists Guidance – assessing patient with raised IOP

College of Optometrists Clinical Management Guidelines (glaucoma, OHT, PAC)

The Royal College of Ophthalmologists Commissioning Guide: Glaucoma (Recommendations) June 2016

Joint RCOphth and UKEGS Glaucoma Risk Stratification Tool (July 2020)

DVLA - Glaucoma and driving

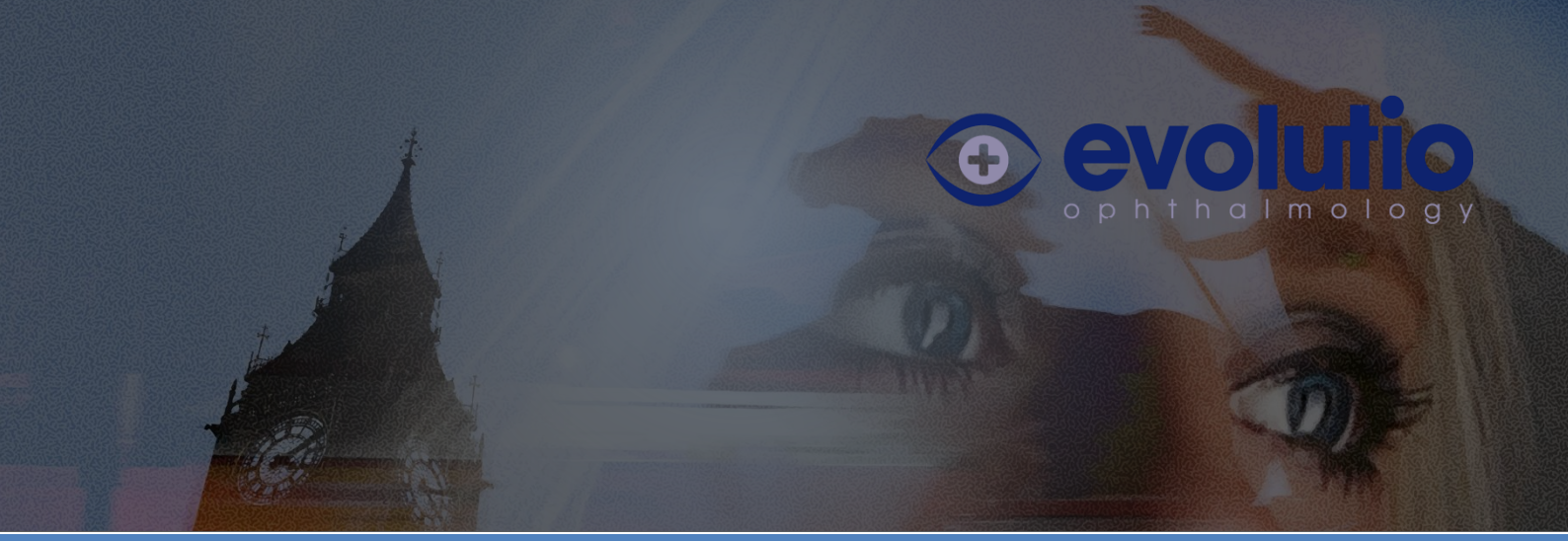
NICE Quality standard [QS180] – Serious Eye Disorders

The Royal College of Ophthalmologists 'Glaucoma Management Plans during Recovery Phase of COVID-19' (Sep 2020)

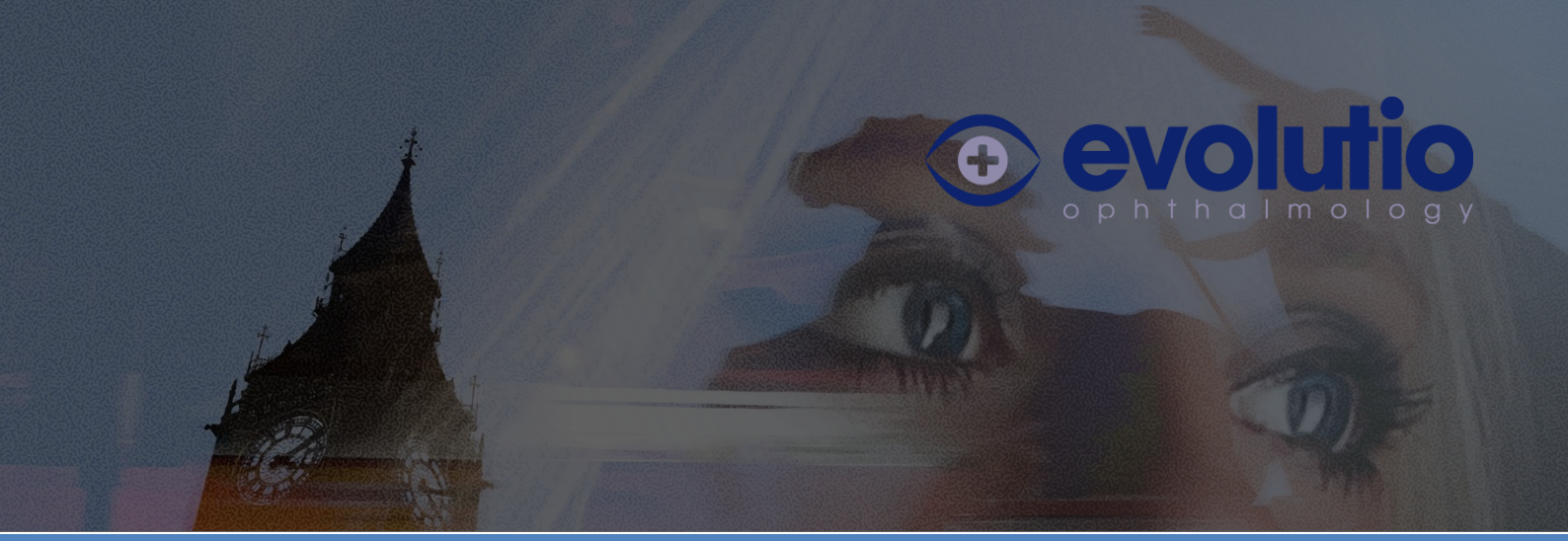
Jiang, Y. et al Longitudinal Changes of Angle Configuration in Primary Angle Closure Suspects: the Zhongshan Angle Closure Prevention Trial. Invest. Ophthalmol. Vis. Sci. 2014;55(13):4294.

Appendix A: Narrow A/C Angle Assessment – a quick reference guide

	1. Introduction
HISTORY & SYMPTOMS	**2. Overview of why they're here (referring clinician's perspective)** **3. Are they having any problems with their eyes?** **4. Glaucoma history:** • Diagnosis, presenting IOP, target pressure **5. Compliance & QOL** **6. Risk factors** • Age, gender, ethnicity • Refractive error • Family history • Previous ocular history (refractive surgery, trauma, inflammation) • Medical history (including medications): o General health (including heart/breathing problems) o Allergies o Steroid use o Circulation (Acute blood loss or transfusion, Raynaud's, migraine, low BP)
INITIAL TESTS	**7. Visual acuity (distance and near) with refraction and pinhole where indicated** **8. Monocular colour vision** **9. Visual fields (full threshold)**
CLINICAL EXAMINATION	**10. Anterior segment slit-lamp examination** • Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens • Iris transillumination, corneal endothelial pigment **11. Anterior chamber angle examination** **12. L/A instil (plus leaflet)** **13. GAT with time** **14. Central corneal thickness (if using ultrasound pachymeter and not previously measured)** **15. Gonioscopy** **16. If dilating, instil tropicamide (plus leaflet)** **17. Colour fundus photography and OCT scans (AS-OCT, cRNFL and macular GCC)** **18. Slit lamp binocular indirect ophthalmoscopy (SL-BIO)** o Vitreous, retina, macula, choroid o Disc (VDD, C:D, NRR status, PPA, haemorrhages, vessels) • Post-dilation IOP review as appropriate
CONCLUSION	**19. Impression (4 point summary)** • Diagnosis o Past glaucoma damage (early if field MD up to 6dB / moderate if 6-12dB / advanced over 12dB) o Future risk (low/moderate/high depending on risk factors e.g. CCT, age, ethnicity, F/H) o Present status (stable or unsatisfactory depending on IOP vs target, disc/field progression, compliance) **20. Proposed management plan and recall** **21. Discussion with patient** **22. Telemedicine review** **23. Letters sent**



Section 2.3.4:
Tier 4 Pathways



2.3.4.1 Oculoplastics Pre-op Assessment - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

The oculoplastics pre-op assessment protocols are a collection of protocols to guide TIER 4 clinicians when assessing/managing a patient with impaired lacrimal drainage, benign eyelid lesions, ptosis, dermatochalasis, entropion or ectropion.

The key points are:

1. Many oculoplastics conditions have funding restrictions imposed by the local CCG therefore a comprehensive community assessment is required to establish eligibility for treatment/onward referral. This will avoid hospital rejections, delays to patient care and potential complaints.

2. An oculoplastics pre-op assessment form is attached to this protocol and must be attached to any onward referral to secondary care for the named oculoplastics conditions. This will support clinicians in gathering the required clinical data to establish eligibility for onward referral/treatment.

3. A comprehensive community assessment and accurate diagnosis will allow many oculoplastics patients to be managed conservatively or, where indicated and commissioned, referred into a community oculoplastics minor surgery service (usually a GPwSI or ophthalmologist)

4. Cases of diagnostic uncertainty/suspected malignancy do not normally require funding and should be referred to secondary care with an appropriate level of urgency

Oculoplastic Pre-op Form

Referral ID	

Clinical Details

Which eye is affected?
RE upper eyelid ☐ RE lower eyelid ☐
LE upper eyelid ☐ LE lower eyelid ☐

Visual Acuity
RE
LE

Is this pathology affecting

Vision? Yes ☐ No ☐
Visual fields? Yes ☐ No ☐
Visual fields must be provided – are they attached? Yes ☐ No ☐
External eye images are required- Are they attached? Yes ☐ No ☐

How is this condition adversely affecting quality of life and activities of daily living?

Drive? Yes ☐ No ☐
Work? Yes ☐ No ☐
Hobbies? Yes ☐ No ☐
Carrying out vital domestic activities? Yes ☐ No ☐

Smoking cessation is recommended for all patients considering the possibility of a procedure.

Is this person a NON- smoker or have they been referred to a smoking cessation clinic?

Yes ☐ No ☐

Please provide any supporting clinical information of how vision, visual field and quality of life is affected?

Please tick the reason for the referral

Chalazion/ Benign lid lump ☐ (Please complete SECTION A)
Dermatochalasis / ptosis ☐ (Please complete SECTION A)
Ectropion ☐ (Please complete SECTION A)
Entropion ☐ (Please complete SECTION A)

Oculoplastic Pre-op Form

SECTION A: CHALAZION/BENIGN LID LUMP ASSESSMENT AND EXCISION

Prior approval is required.

The CCG will only consider funding excision of chalazion/ benign lid lump when the following criteria are met

The chalazion/ benign lid lump has been present for more than 6 months verified in clinical notes.	Yes ☐	No ☐
Has been chalazion/benign lid lump managed conservatively (e.g. hot compress, lid cleaning and massage for at least 3 months).	Yes ☐	No ☐
Chalazion/ benign lid lump has required medical attention twice or more within a six-month time frame. (e.g. antibiotics including name and duration for each episode).	Yes ☐	No ☐

In common with all types of lesions, the CCG will fund removal where malignancy is suspected.

Oculoplastic Pre-op Form

SECTION B: DERMATOCHALASIS/PTOSIS ASSESSMENT AND TREATMENT

Blepharoplasty and ptosis surgery. This procedure is not routinely funded and will only be considered for prior approval when there is:

Drooping of the tissue above the eyelid causes persistent impairment of visual fields in the relaxed, non- compensated state.	Yes	☐	No	☐
Documented evidence of encroaching of the central 20 degree of visual fields.	Yes	☐	No	☐

AND

Surgery will improve vision of the patient.	Yes	☐	No	☐

Supporting information where appropriate:

Oculoplastic Pre-op Form

SECTION C: ECTROPION ASSESSMENT AND TREATMENT

There is exposure of the cornea (e.g. in paralytic ectropion) and risk of keratopathy (urgent correction required). Yes ☐ No ☐

For symptoms relating to persistent and troublesome epiphora resulting in watery eyes:

The patient is experiencing constant daytime clear watering (indoors and outdoors). Causing tears to run down the face and severe enough to impair vision on a daily basis, causing smearing on glasses (if worn). Yes ☐ No ☐

3 episodes of infection or sticky discharge within 12 months. Yes ☐ No ☐

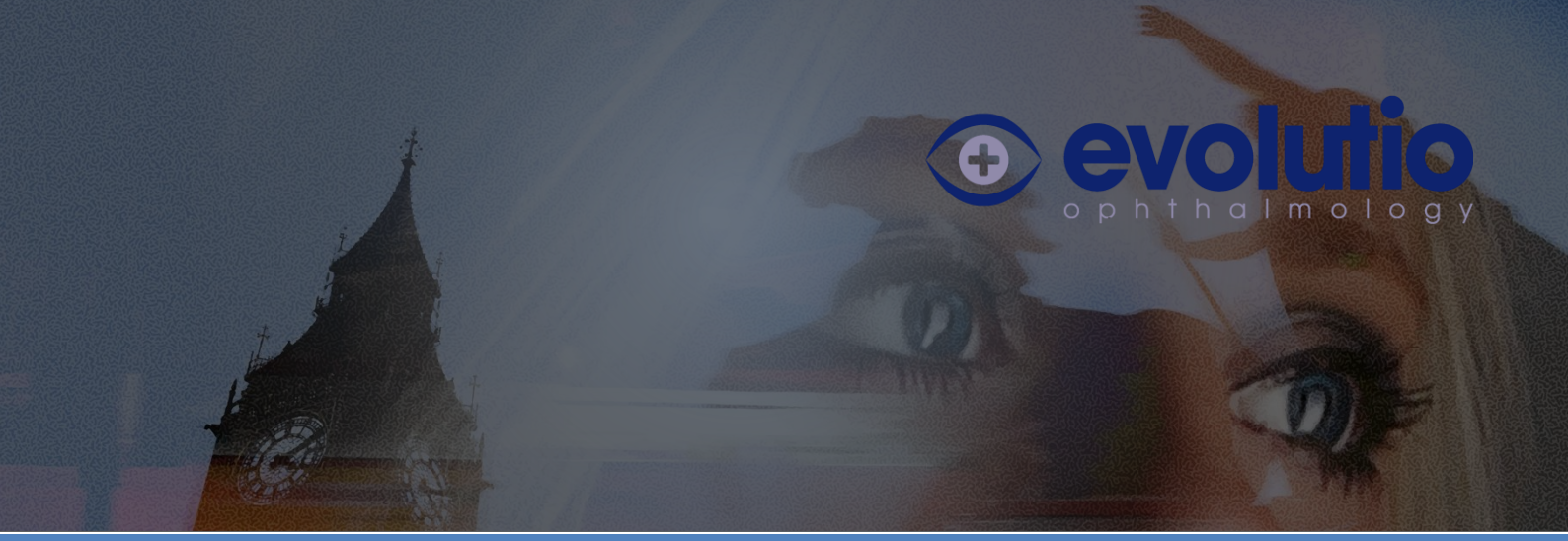
Supporting information where appropriate:

Oculoplastic Pre-op Form

SECTION D: ENTROPION ASSESSMENT AND TREATMENT

Eyelashes are causing persistent and on-going irritation to the eye risking trauma to the cornea. Yes ☐ No ☐

Supporting information where appropriate:



2.3.4.1.1 Epiphora & Lacrimal Drainage - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol is one of a subset of 'oculoplastics pre-op assessment' protocols. It provides guidance to TIER 4 clinicians when assessing/managing a patient with a watery eye.

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment

Some patients will enter this pathway following transfer from an incumbent provider. It is important to review the clinical notes provided so you have a clear understanding of the patient's clinical status; this is especially relevant at the first visit. ***Please transcribe the CCT measurement, the pre-treatment (presenting) IOP and target pressure from the clinical notes provided*** *so the telemedicine consultant has all the required information in 1 place. These values will be automatically carried over at subsequent visits.*

History and symptoms

- Record age and gender
- Duration & onset
- Symptoms
    - Presence/absence of true epiphora (nasal or temporal)
    - Aggravating/relieving factors (e.g. season, time of day, indoors/outdoors)
- Effect on activities of daily living (e.g. work, drive)
- Any previous eyelid/nasal surgery
- Discharge (e.g. mucus/mucopurulent)

Initial tests

- Visual acuity (distance and near) with refraction where indicated

Anterior segment

- Exclude/manage lid margin disease/foreign body/other ocular surface disease causes
- Lid position
- Punctal stenosis/position
- Corneal exposure
- Tear strip height
- Jones fluorescein dye test
    - Significant amount of fluorescein remaining in tear meniscus 2 mins+ after instillation indicates restricted drainage
    - Check for appearance of fluorescein in the nose
        - Examine tissue after nose blow - if fluorescein present, lacrimal system is patent
        - Enhanced with blue/UV light

Imaging

- Anterior images of both eyes showing natural lid and punctal position
- Lower lid eversion to image puncta (as indicated)

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established. Where a provider has the necessary training and experience, a range of treatments may be considered depending on the cause:

- Massage may help in some cases (stroking downwards from common cannaliculus)
- Punctal dilation
- Lacrimal syringe
- Probing
- Consider a broad-spectrum antibiotic in cases of infection
- Babies are commonly born with a tear duct that is not fully open in one or both eyes. This usually self resolves within the first 2 years of life.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. 'Blocked tear ducts in babies' by Moorfields, Epiphora leaflet from The Royal Bournemouth and Christchurch hospital)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

In some CCGs a community oculoplastics minor surgery service is commissioned (usually a GPwSI or ophthalmologist) so a cohort of cases may be treated (although cases with lid/punctal ectropion and/or very nervous patients are unlikely to be suitable). If a referral is made to the community surgical service, patients should be informed that the final decision to offer treatment will only be made after the surgeon has assessed the patient. Typical criteria for community treatment includes watery eye (particularly with true epiphora) due to punctal stenosis or restricted tear drainage. Typical exclusion criteria for the community service include (in addition to the cases requiring onward referral as listed below):

- Previous lacrimal drainage surgery
- Punctal/eyelid entropion/ectropion
- Other causes of watery eye (e.g. foreign body)

Other cases requiring onward referral include:
1. Any suspicion of malignancy or darcryocystitis
2. Cases of diagnostic uncertainty
3. Cases requiring treatment/investigation beyond your level of competency and experience

References

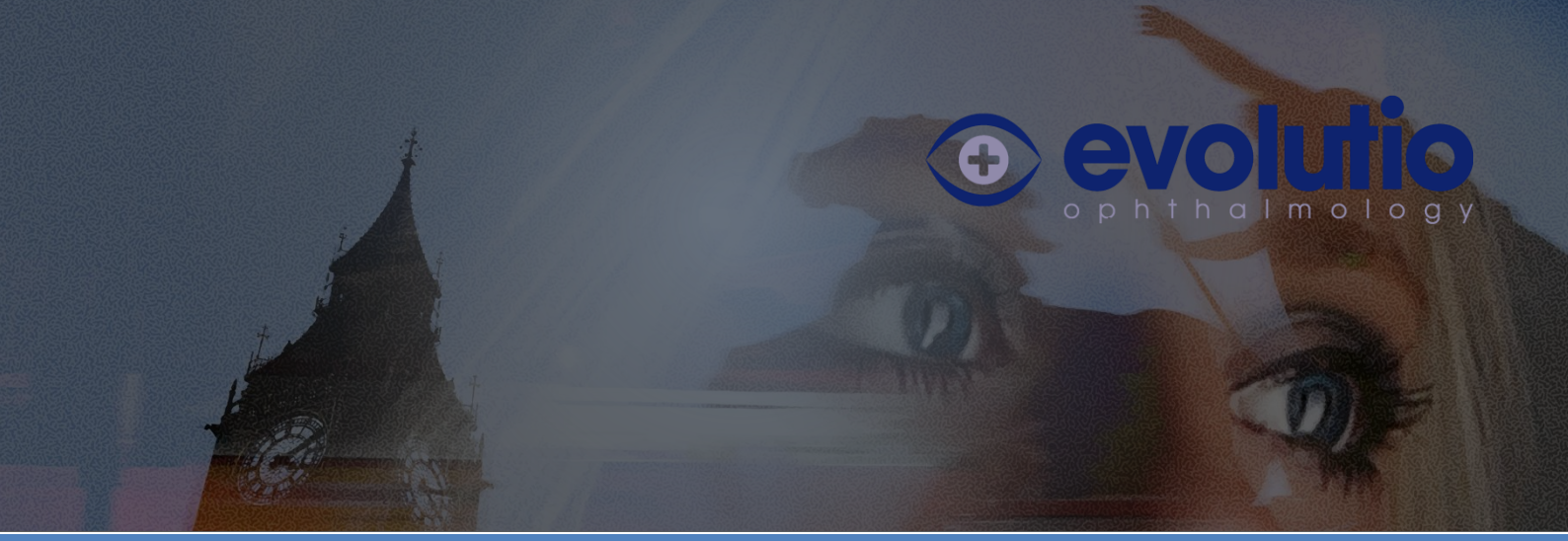
College of Optometrists CMG – Nasolacrimal duct obstruction

College of Optometrists CMG – Dacryocystitis (acute)

College of Optometrists CMG – Dacryocystitis (chronic)

Moorfields leaflet- 'Blocked tear ducts in babies'

Royal Bournemouth and Christchurch hospital leaflet – 'Epiphora'



2.3.4.1.2 Benign Eyelid Lesions - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol is one of a subset of 'oculoplastics pre-op assessment' protocols. It provides guidance to TIER 4 clinicians when assessing/managing a patient with a benign eyelid lump/lesion (including checking compliance with conservative treatment and assessing funding eligibility for HES treatment).

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment

History and symptoms

- Record age and gender
- Duration & onset
- Evolution of the lesion
- Symptoms (tenderness, change in vision, discharge)
- Effect of lesion on activities of daily living (e.g. work, drive)
- Ask about skin cancer, immunosuppression, radiation therapy, excessive sun exposure
- Skin colour (fair skin is a risk factor for malignancies)

Initial tests

- Visual acuity (distance and near) with refraction where indicated
- Motility testing and VA to assess cranial nerves function
- Visual field plot in cases where the lesion might have an influence
- Keratometry readings if there is any indication of potential corneal pressure/distortion
- Assessment of regional lymph nodes

Anterior segment

- Lesion assessment
    - Location of lesion
    - Size of lesion
    - Surface of the lesion
    - Surrounding skin/adnexa
    - Palpation of the edges (is lesion fixated to deeper tissues?)
- Comment on lid/punctal position
- Associated eyelash loss
- Lid eversion and comment on tarsal conjunctiva

Imaging

- Colour photograph showing entire lesion (with eversion where indicated

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established. There are a wide range of benign lid lesions; many are self-limiting and only require observation. Depending on the cause, common first-line treatments include hot compress, lid massage and lid hygiene. In some cases topical (and possibly systemic) antibiotics are indicated.

Eyelid lesions may be categorised into inflammatory, infectious, or neoplastic.

Inflammatory lesions

- Internal (e.g. chalazion)
  - Chronic, localised swelling of the lid (meibomian glands/glands of Zeiss)
  - **Treatment** - warm compresses, sometimes topical steroids or incision and curettage
- External (e.g. stye/external hordeolum)
  - **Treatment** – epilation of associated lash(es), topical antibiotics, incision and cautery

Infectious lesions

- Molluscum contagiosum
  - Localised dermal infection caused by a poxvirus
  - It is common in children, especially in children between the ages of 1-4. It is also found in immunocompromised adults (e.g. HIV positive).
  - Skin nodule(s) (typically 2-3 mm diam), often with a central depression ('umbilicated')
  - Central core has cheese-like or waxy material which may discharge spontaneously
  - Can appear on anywhere else in the body and have more the one nodule on the lids.
  - **Treatment** - usually self-limiting. Else excision, cryotherapy or curettage

Other lid lesions – Benign

- Squamous cell papilloma
  - Pedunculated (narrow base/stalk), sessile (broad-base) or white and hyperkeratotic finger-like projections
  - **Treatment** – usually not required
- Xanthelasma
  - Yellow plaques, which are often associated with raised lipid levels
  - **Treatment** – usually not required, possible superficial excision

Neoplastic lesions – Malignant/pre-malignant

- Actinic keratosis
  - Round, scaly, hyper-keratotic plaques (texture like sandpaper)
- Keratoacanthoma
  - Flesh-colored papules usually on the lower eyelid
- Basal cell carcinoma
  - Firm, raised, pearly nodules with fine telangiectasias
- Squamous cell carcinoma
  - Usually males age 60+ with a history of other skin lesions requiring excision
- Sebaceous carcinoma
  - Can mimic blepharoconjunctivitis/chronic chalazia. Women aged 65+, upper lid
- Metastasis
  - Rare, usually widespread metastatic disease. Solitary/multiple nodules or diffuse eyelid swelling
- Melanoma
  - Rare, age 60+, pigmented and thickened area on the lower eyelid with irregular borders

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. Moorfields leaflet on chalazion, Moorfields leaflet on stye)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

In some CCGs a community oculoplastics minor surgery service is commissioned (usually a GPwSI or ophthalmologist) so a cohort of cases may be treated, for example narrow-based lesions, typically less than 3mm (e.g. pedunculated papilloma) which are likely to require cautery rather than sutures to close; generally not embedded in the lashes (requiring a section of eyelid to be removed) nor within 2mm of the puncta.

If a referral is made to the community surgical service, patients should be informed that the final decision to offer treatment will only be made after the surgeon has assessed the patient. Typical criteria for community-based minor surgery includes pedunculated/sessile papilloma or chalazion/chalazia (1-2mm clear of punctum). Typical exclusion criteria for community minor surgery include (in addition to the cases requiring onward referral as listed below):

- Any lesion considered to require excision biopsy
- Eyelid malposition (e.g. entropion, ectropion, ptosis, dermatochalasis)
- Broad based lesion / requirement for post-operative sutures

FOR ALL BENIGN LID LESIONS YOU MUST COMPLETE THE OCULOPLASTIC PRE-OP ASSESSMENT FORM TO ESTABLISH ELIGIBILITY FOR NHS-FUNDED TREATMENT

Other cases requiring onward referral include:

1. Cases of diagnostic uncertainty
2. Cases requiring non-cosmetic treatment/investigation beyond your level of competency and experience, including lesions not responding to diligent conservative measures (or affecting cornea).
3. Meibomian cyst recurring in same location (biopsy indicated on a 2 week wait pathway)
4. Any suspicion of malignancy, for example:
    - A change in appearance of the eyelid skin (e.g. loss of normal eyelid architecture or loss of cutaneous wrinkles, fine telangiectasia)
    - Swelling of the eyelid
    - Thickening of the eyelid
    - Chronic infection of the eyelid
    - Ulceration with crusting or bleeding / pearly edges with central ulceration
    - Irregular pigment or a spreading coloured mass on the eyelid

Benign lid lesions requiring excision must meet the criteria described where local CCG thresholds exists - information can be found on the CCG's website and in your local handbook. The pre-op assessment form must be completed and attached to your referral to establish eligibility for CCG-funded treatment – this is found at the start of this section.

References

College of Optometrists CMG – Chalazion

College of Optometrists CMG – Hordeolum

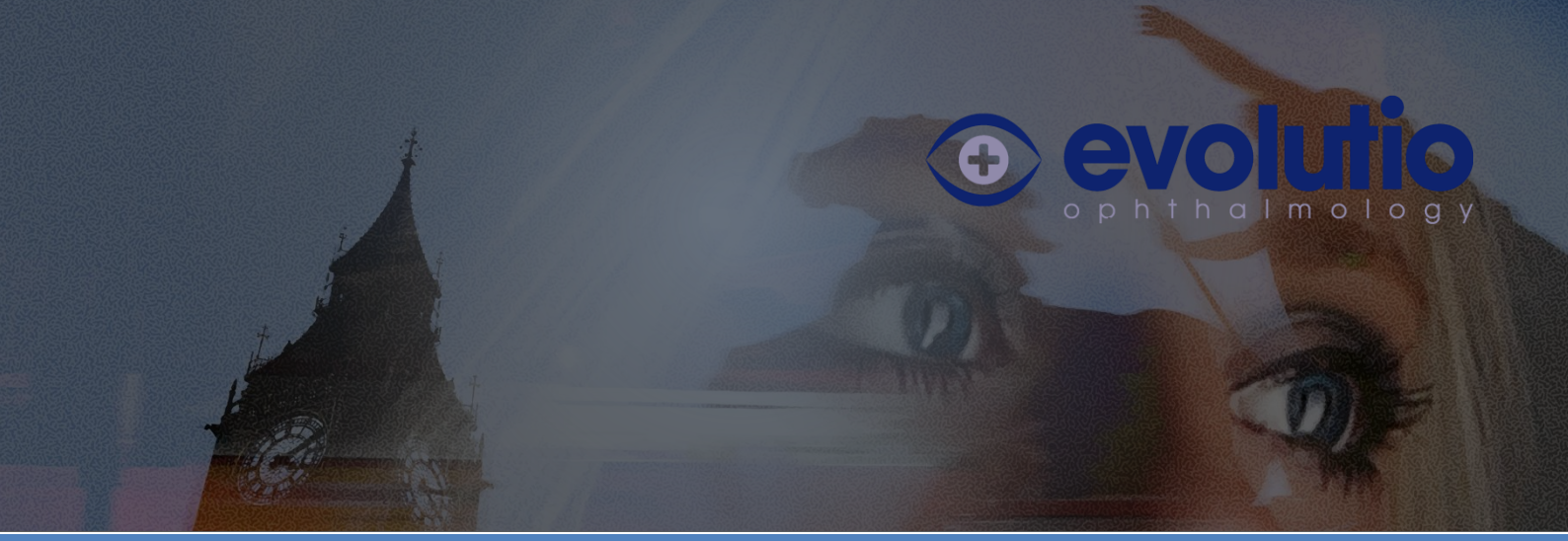
College of Optometrists CMG – Molluscum contagiosum

College of Optometrists CMG – Concretions

College of Optometrists CMG – Basal cell carcinoma

Moorfields patient leaflet – stye

Moorfields patient leaflet – chalazion



2.3.4.1.3 Ptosis & Dermatochalasis - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol is one of a subset of 'oculoplastics pre-op assessment' protocols. It provides guidance to TIER 4 clinicians when assessing/managing a patient with **non-acute** ptosis or dermatochalasis (including assessing funding eligibility for HES treatment).

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment

History and symptoms

- Record age and gender
- Duration & onset
- Symptoms
    - Diplopia
- Worsening or static
- Does it vary during the day
- One eye or both
- Effect on activities of daily living (e.g. work, drive)

Initial tests

- Visual acuity (distance and near) with refraction where indicated
- Field of vision plot taped and untaped (to demonstrate effect on visual field)
- Motility testing to assess the function of the cranial nerves
- Pupil testing (assess cranial nerves function)

Anterior segment

- Lid assessment
    - Location (which eye and which lid)
    - Cogan lid twitch (Myasthenia indicated if lid twitches after 10 seconds downgaze then returns to primary gaze)
    - Percentage of pupil covered
    - Presence/absence of secondary entropion with corneal involvement
    - Comment on lid/punctal position

Imaging

- Colour photograph showing both eyes in primary position
    - For both examination of lid height and for photos the correct technique is: Ask the patient to look to the floor. With the eyes in downgaze, stabilise the eyebrows with your fingers (index finger on one brow, thumb on the other), the get them to look in the primary position. This is the best way to eliminate brow overreaction and show the actual levator function.

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established. Any dry eye/lid margin disease should be treated. Temporary eyelid taping might be useful in some cases. Consider the effect of marked field restriction on driving (might need to inform the DVLA).

Acute neurological causes of ptosis must be excluded.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. Moorfields leaflet on ptosis or University Hospitals of Leicester leaflet on dermatochalasis)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

FOR ALL NON-ACUTE PTOSIS/DERMATOCHALASIS YOU MUST COMPLETE THE OCULOPLASTIC PRE-OP ASSESSMENT FORM TO ESTABLISH ELIGIBILITY FOR NHS-FUNDED TREATMENT

In some CCGs a community oculoplastics minor surgery service is commissioned (usually a GPwSI or ophthalmologist) although ptosis/dermatochalasis treatment is likely to require HES care.

Cases requiring onward referral include:

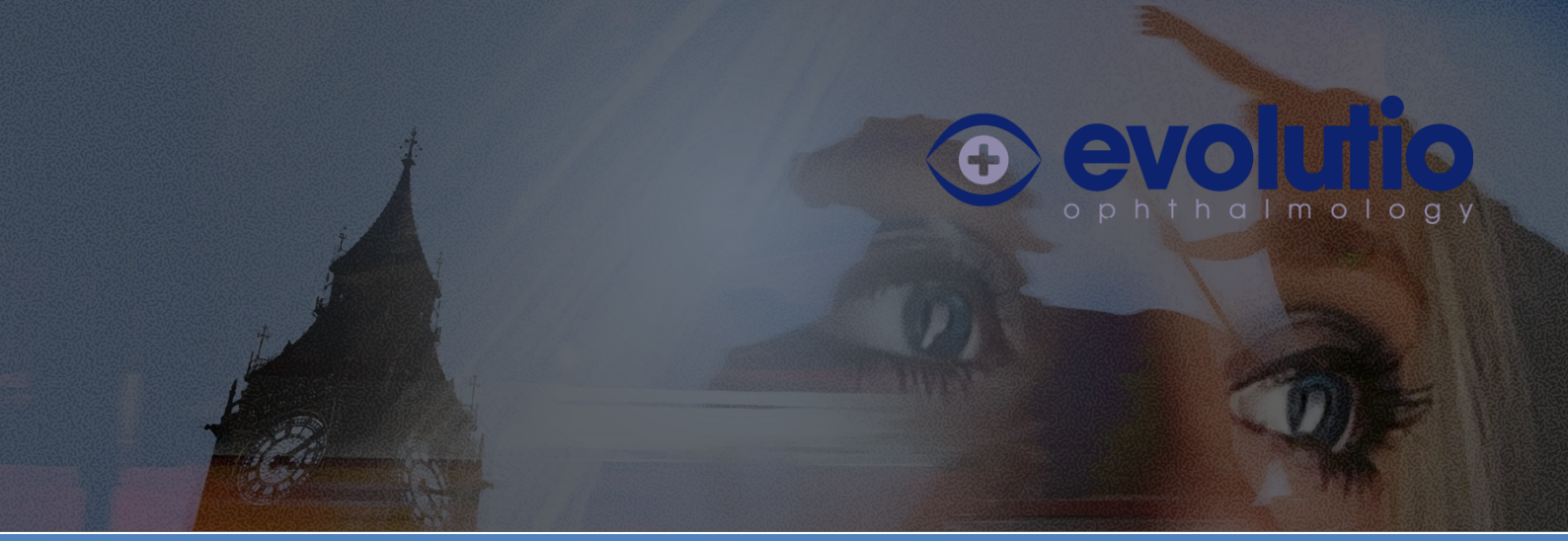
1. Cases of diagnostic uncertainty
2. Cases requiring functional (i.e. non-cosmetic) treatment which meet CCG inclusion criteria (if applicable)
3. Any suspicion of an acute neurological cause (urgent/emergency referral)

Non-acute ptosis/dermatochalasis must meet the criteria described where local CCG thresholds exists - information can be found on the CCG's website and in your local handbook. The pre-op assessment form must be completed and attached to your referral to establish eligibility for CCG-funded treatment – this is found at the start of this section.

References

Moorfields leaflet - ptosis

University Hospitals of Leicester leaflet - Dermatochalasis



2.3.4.1.4 Entropion/Ectropion - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol is one of a subset of 'oculoplastics pre-op assessment' protocols. It provides guidance to TIER 4 clinicians when assessing/managing a patient with entropion or ectropion (including assessing funding eligibility for HES treatment).

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment

History and symptoms

- Record age and gender
- Duration & onset
- Symptoms (including severity)
- Effect on activities of daily living (e.g. work, drive)
- Ask about previous lid/facial surgery

Initial tests

- Visual acuity (distance and near) with refraction where indicated

Anterior segment

- Lid assessment
    - Location (which eye and which lid)
    - Presence or absence of corneal involvement (with fluorescein stain)
    - Presence or absence of lagophthalmos

Imaging

- Colour photograph showing both eyes in primary position (and other positions as indicated)
- Request historic photos for comparison

Management

A clinical impression (tentative diagnosis) is made and a management plan established. Entropion and ectropion are commonly associated with age or previous eyelid/facial surgery. Depending on the cause, common first-line treatments include eyelid taping, bandage contact lenses and lubricants.

Ectropion

- Consider whether any active management is required; it often looks worse than the symptoms experienced
- Treat any existing blepharitis/lid margin disease
- Incomplete eye closure can threaten corneal integrity so consider:
    - Tear supplements/ ointment
    - Overnight lid taping (upper and lower lid taped together)
    - Consider a bandage soft contact lens
- Advise the patient to wipe the eye (if it is watering) upwards and towards the nose – this prevents the lid from being pulled down further

Entropion

- Treat any existing blepharitis/lid margin disease
- Tape lid to prevent lashes rubbing against cornea (place one end of the tape near your lower eyelashes, then

pull down gently and attach the other end of the tape to your upper cheek.
- Consider a bandage soft contact lens
- Consider epilation (where feasible)

Providers should be familiar with national and local guidance including those referenced below.

Visit outcomes

Allowable outcomes resulting from the consultation are:
- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:
- Written guidance as appropriate (e.g. Imperial College leaflet on Ectropion and Entropion)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

FOR ALL ENTROPION AND ECTROPION CASES YOU MUST COMPLETE THE OCULOPLASTIC PRE-OP ASSESSMENT FORM TO ESTABLISH ELIGIBILITY FOR NHS-FUNDED TREATMENT

In some CCGs a community oculoplastics minor surgery service is commissioned (usually a GPwSI or ophthalmologist) although entropion and ectropion are likely to require HES care. Secondary care treatment generally involves eyelid surgery. In the case of entropion there are some temporary treatments (Botox injection or suture).

Cases requiring onward referral include:
1. Symptomatic disease which is unresponsive to conservative measures (or conservative measures are not practical)
2. Consider sooner referral if there is corneal involvement
3. Any suspicion of systemic disease as the underlying cause

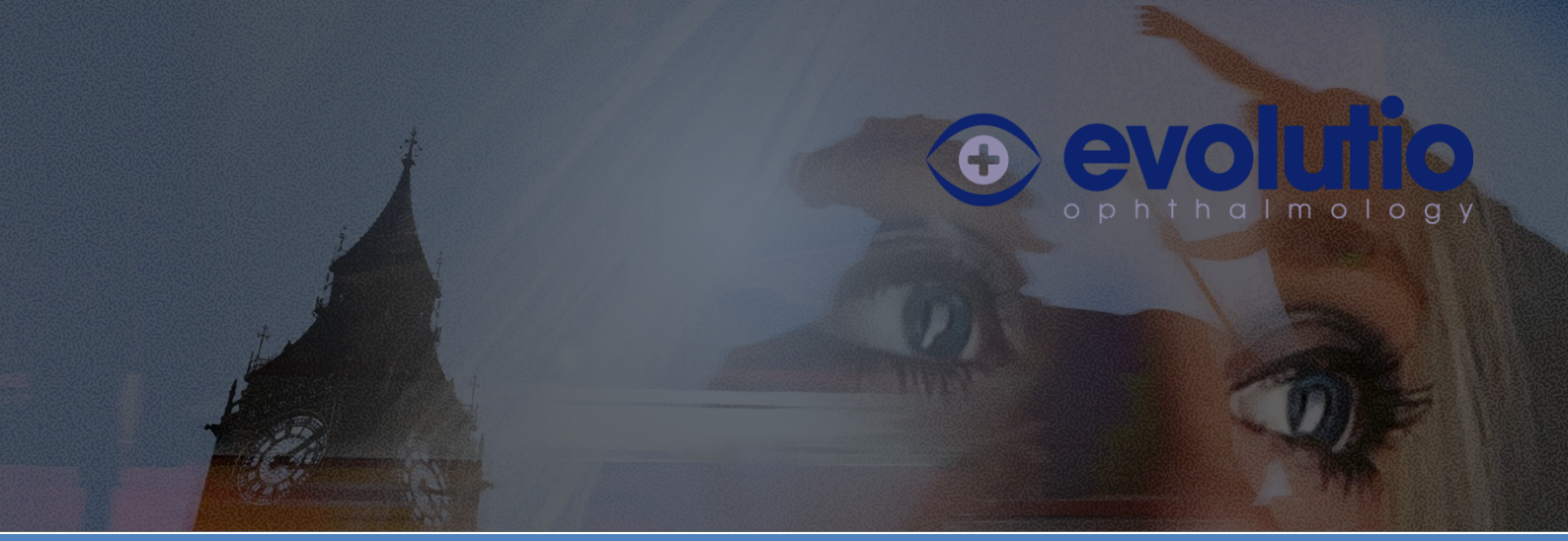
Entropion and ectropion must meet the criteria described where local CCG thresholds exists - information can be found on the CCG's website and in your local handbook. The pre-op assessment form must be completed and attached to your referral to establish eligibility for CCG-funded treatment – this is found at the start of this section.

References

College of Optometrists CMG – Entropion

College of Optometrists CMG – Ectropion

Imperial College leaflet - Ectropion and Entropion



2.3.4.2 Certification of Visual Impairment - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 4 clinicians when completing a Certificate of Visual Impairment (CVI).

The Certificate of Vision Impairment (CVI) form formally certifies someone as visually impaired, and also acts as a referral for a social care assessment if the individual is not yet known to social services. Its secondary purpose is to record data to be used for research into the underlying causes and the effects of visual impairment.

Sight loss can have a significant impact on a person's independence and wellbeing. If the person is not known to social services as someone with needs arising from their sight impairment, the CVI acts as a formal referral for a needs assessment. Consequently, the CVI should be seen as a significant step on the sight loss pathway, enabling people to access support to help them retain or regain independence. Certification should therefore not be seen as the end of the treatment journey for patients but as a gateway to support and services.

Clinical Assessment

This protocol solely covers the certification process. As a prerequisite to entering this pathway, a patient should have been investigated for their sight loss by a suitable person, have a confirmed diagnosis and have been offered appropriate treatment. If there is any diagnostic uncertainty or a recent change in vision/symptoms, a full Primary Assessment Service appointment should be completed (with onward referral if indicated) before entering this pathway. All patients must have a current sight test prescription before entering this pathway.

An electronic CVI form is provided in PDF for. Please save a copy as CVI_Evolutio ID number (e.g. CVI_765432) and complete this electronically. After completion, page 5 of 8 will need to be printed and signed by the patient.

History and symptoms

Ocular history

- Diagnosis(es) for each eye with approximate dates
    - Main cause of visual loss?
    - Visual loss recent?
    - Visual loss gradual or sudden?
- Still under HES/community review?
- Previous low vision assessment?
    - Requires review?
- Seen ECLO (see Appendix A)?
    - Requires ECLO?

Medical history

- Conditions which might increase the risk of falls
- Conditions related to mental health

Social history

- Lives alone?
- Any care support at home?
- Problems with physical mobility?
- Hearing difficulties?
- Learning disability?
- Dementia?
- Employed?
- Full-time education?
- Ever served in Armed Forces?
    - If so, signpost to Blind Veterans UK

Initial tests

Visual acuity

- Monocular and binocular (Snellen or logMAR)

Visual fields

- Monocular
- Supra-threshold test generally sufficient (confrontation might be required in extreme cases)
- Might be conducted in an HCA-delivered setting

Classification

Sight Impaired (SI, previously known as 'partially sighted')

- VA 3/60 - 6/60, full field
- VA 6/60 - 6/24, moderate field loss (e.g. superior or patchy loss)
- VA 6/18 or better, marked field loss (e.g. hemianopia)

SSI (Severely Sight Impaired, previously known as 'blind')

- VA worse than 3/60, full field
- VA 3/60 – 6/60, contraction of visual field (e.g. tunnel vision)
- VA 6/60 or better, clinically significant contracted field of vision which is functionally impairing the person e.g. significant reduction of inferior field or bi-temporal hemianopia

Ophthalmologist's details

- Name
- Signature (added at telemed)
- Date of assessment
- Clinic address

Communication needs

- Preferred method of contact
  - Phone / email / letter
- Preferred method of communication
  - British Sign Language / deafblind manual alphabet / Block / Visual Frame Signing / Hands on signing / Clear Speech / Tadoma / Braille / Moon
  - For more info: www.deafblinduk.org.uk/typesofcommunication.html
- Preferred format of information
  - Various print sizes / Easy-Read / Email / Audio CD / Other (free text box)
  - If the px is unsure there is an option to mark that
- Preferred language

Consent to share information

- Request consent to share the form with the GP
  - If declined, leave blank
  - If agreed, complete GP name and practice details (address, phone number)
- Request consent to share the form with the local council
  - If declined, leave blank
  - If agreed, complete local council name and details (address, phone number)
- Request consent to share the form with the RCOphth – they collect information to examine the causes of sight loss to help prevent others from losing their sight and to identify patterns in certain eye conditions for planning future services and research
  - If declined, strike through
  - If agreed, leave as is
- Remind the patient that they must not drive, and they must notify DVLA ASAP (page 8 of form)

Ethnicity

Select the patient's ethnicity (for epidemiological monitoring)

- It might be helpful to explain that we would like to make a note of the patient's ethnicity for several reasons. Firstly because some diseases are commoner in certain ethnic groups so we want to understand an individual's risk factors so we can offer them the best care. Secondly, capturing this data will help us to understand potential new links between certain eye conditions and ethnicity. Would you mind helping me to identify your ethnicity from this list please:

    - If necessary, read out the categories on the list
- Use 'Other ethnic group' if a patient's ethnicity does not align with any of the options presented

Management

A clinical impression (tentative diagnosis) is made and a management plan established regarding eligibility and desire to be certified as SI/SSI.

Providers should be familiar with national guidance and local CCG guidance including those referenced below.

Visit outcomes

Allowable outcomes resulting from the consultation are:
- Discharge and self-monitoring
- Complete and submit CVI form
- Onward referral to another pathway

In all cases patients should receive the following information:
- Appropriate leaflets relating to their condition (e.g. College of Optometrists/Macular Society/Glaucoma UK)
- Discussion of lifestyle changes (e.g. smoking cessation, diet, reduce stress and UV protection)
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician, without completing the CVI form, if they:
1. Do not meet the criteria for CVI:
    - Haven't met VA/field criteria
    - Sight loss isn't permanent
    - Already receiving treatment that could improve sight (await outcome)
2. Decline Certification - Advise such patients that that they can be reassessed at a later date

Complete and submit CVI form

- Print out page 5 of 8 (Part 4) for patient to sign. This will need to be scanned uploaded back into the CVI PDF before being sent on to telemed
- Suggest/give RNIB booklet – 'Sight loss: what we needed to know'
    - Website www.rnib.org.uk/sightlossinfo
    - 0303 123 9999
- Reminder that anyone certified SI/SSI must not drive and must inform the DVLA at the earliest opportunity
- If the patient has consented to council notification, advise that The Social Services Local Sensory Team should be in touch within 2/52 to:
    - Offer registration - It is your choice as to whether you choose to register but it is a proactive approach towards empowering you to be as independent as possible and to access any support you might need.
    - Identify any day-to-day support required such as vision rehabilitation (support or training to help you to maximise your independence, such as moving around your home and getting out and about safely) – it is your choice as to whether you wish to explore these.
    - Discuss eligibility for certain concessions such as discounted travel and TV licences, leisure concessions, tax allowances and welfare benefits such as PIP, AA and DLA - it is your choice as to whether you wish to explore these.
- Send to telemed
    - Insert ophthalmologist's signature if approved
- Distribute completed form to authorised stakeholders (with patient consent)
    - Patient
        - Entire form (large print if requested)
        - Post

- Local council
  - Pages 1-5 (within 5 working days)
  - Post
- GP
  - Pages 1-5
  - Nhs.net if available else post
- The Royal College of Ophthalmologists
  - Pages 1-6
  - c/o Certifications Office, Moorfields Eye Hospital, 162 City Road, London, EC1V 2PD
  - meh-tr.CVI@nhs.net

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

Where onward referral is required (e.g. HES/community low vision or macular/glaucoma/etc. clinic) an onward referral is created through Evonnect with an appropriate level of urgency.

References

Certificate of Vision Impairment for people who are sight impaired (partially sighted) or severely sight impaired (blind) – Updated September 2018

Certificate of Vision Impairment - Explanatory Notes for Consultant Ophthalmologists and Hospital Eye Clinic Staff in England (Aug 2017)

Seeing Beyond The Eyes – Resource Pack (2018, Visualise Training and Consultancy)

Appendix A: Step by step guide to completing the CVI

Part 1 – Certificate of Visual Impairment (PAGE 1)

Patient's details

- Name
- Address
- DOB
- Gender
- Contact details
- NHS number

Ophthalmologist's declaration

Classify

- Sight Impaired (SI, previously known as 'partially sighted')
  - VA 3/60 - 6/60, full field
  - VA 6/60 - 6/24, moderate field loss (e.g. superior or patchy loss)
  - VA 6/18 or better, marked field loss (e.g. hemianopia)
- SSI (Severely Sight Impaired, previously known as 'blind')
  - VA worse than 3/60, full field
  - VA 3/60 – 6/60, contraction of visual field (e.g. tunnel vision)
  - VA 6/60 or better, clinically significant contracted field of vision which is functionally impairing the person e.g. significant reduction of inferior field or bi-temporal hemianopia

Booklet

- Suggest/give RNIB booklet – 'Sight loss: what we needed to know'
  - Website www.rnib.org.uk/sightlossinfo
  - 0303 123 9999

ECLO

Eye Clinic Liaison Officers work closely with medical and nursing staff in the eye clinic, and the sensory team in social services. They provide those recently diagnosed with an eye condition with the practical and emotional support which they need to understand their diagnosis, deal with their sight loss and maintain their independence.

Unless the patient has seen an ECLO/Sight Loss Advisor within the HES, a HES referral can be made to access this service if required (NB only 50% of eye clinics offer this service). Else mark as 'not available' - the clinician completing this form will be expected to answer any outstanding questions the patient might have about their condition.

Ophthalmologist's details

- Name
- Signature
- Date of assessment
- Clinic address

Part 2 – Visual Function (PAGE 2)

Best corrected VA

- Snellen or logMAR
- Right eye
- Left eye
- Binocular

Fields

Is there 'extensive loss of peripheral field (including hemianopia)'?

Low vision service referral

- Yes – please arrange this through Evonnect as required

- Not required – if px declines LVA referral or is already under LV clinic or has been under LV clinic and nothing has changed
- No
- Don't know

Part 2a – Diagnosis AGE 18 OR OVER (Page 2 & 3)

These are arranged in logical groups (retina, glaucoma, cornea etc.) but there is a free text box at the bottom if the condition is not listed.

- Right eye - Select all conditions which apply
- Left eye - Select all conditions which apply
- Select the 'main cause' of the visual impairment
    - Most recent reason for CVI if different in each eye
    - Most significant contributor or multiple causes in the same eye

Part 3 – Patient Section (PAGE 4)

Additional information for local council

- Answer the 8 questions (mobility problems, hearing problems, employed etc.)
    - Yes / No
- There is also a free text box for any other relevant information, eg
    - Medical conditions
    - Emotional impact of sight loss
    - Risk of falls
    - Benefits of vision rehabilitation
    - Reason why urgent support might be required (e.g. recent rapid deterioration in vision)

Patient information and communication needs

- Preferred method of contact
    - Phone / email / letter
- Preferred method of communication
    - British Sign Language / deafblind manual alphabet / Block / Visual Frame Signing / Hands on signing / Clear Speech / Tadoma / Braille / Moon
    - For more info: www.deafblinduk.org.uk/typesofcommunication.html
- Preferred format of information
    - Various print sizes / Easy-Read / Email / Audio CD / Other (free text box)
    - If the px is unsure there is an option to mark that
- Preferred language

Part 4 – Consent to share information (PAGE 5)

- Request consent to share the form with the GP
    - If declined, leave blank
    - If agreed, complete GP name and practice details (address, phone number)
- Request consent to share the form with the local council
    - If declined, leave blank
    - If agreed, complete local council name and details (address, phone number)
- Request consent to share the form with the RCOphth – they collect information to examine the causes of sight loss to help prevent others from losing their sight and to identify patterns in certain eye conditions for planning future services and research
    - If declined, strike through
    - If agreed, leave as is
- Remind the patient that they must not drive and they must notify DVLA ASAP (page 8)
- Px signs

Ethnicity (PAGE 6)

- Select the patient's ethnicity (for epidemiological monitoring)
    - If necessary, read out the categories on the list
    - Use 'Other ethnic group' if a patient's ethnicity does not align with any of the options presented

Information sheet for patients (PAGE 7)

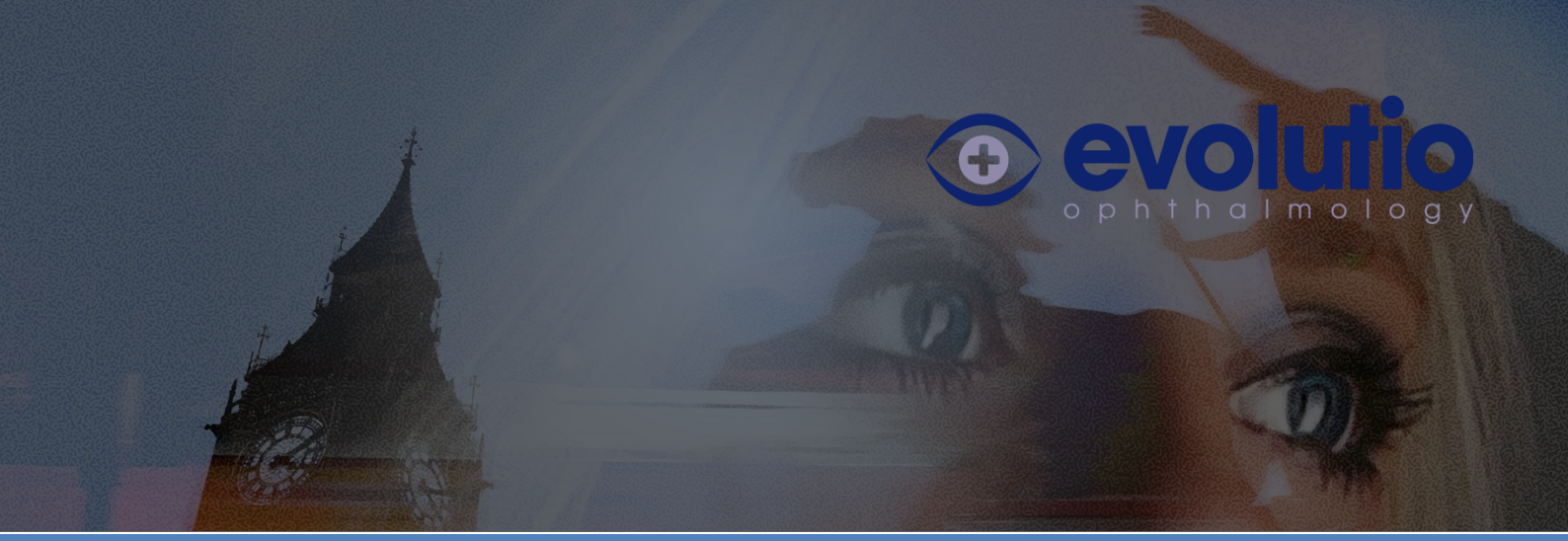
Draw the patient's attention to this section.

Functions of the CVI

- As well as capturing important information about the causes of sight loss in the UK for future planning and research, the CVI also shows that you qualify for registration with local council as SI/SSI.
- By making the council aware of your sight loss, they will be able to better understand your circumstances. The Social Services Local Sensory Team should be in touch within 2/52 to:
    - Offer registration - It is your choice as to whether you choose to register but it is a proactive approach towards empowering you to be as independent as possible and to access any support you might need.
    - Identify any day-to-day support required such as vision rehabilitation (support or training to help you to maximise your independence, such as moving around your home and getting out and about safely) – it is your choice as to whether you wish to explore these.
    - Discuss eligibility for certain concessions such as discounted travel and TV licences, leisure concessions, tax allowances and welfare benefits such as PIP, AA and DLA - it is your choice as to whether you wish to explore these.

Further information (PAGE 8)

- At the top of this page there is a reminder that you must not drive and must inform the DVLA at your earliest opportunity that you have been certified as SI/SSI.
- Various sources of additional information, advice and support are listed



2.3.4.3 Community Ophthalmology Service (COS) - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 4 clinicians when assessing/managing a patient with ophthalmic signs/symptoms under a community ophthalmology (outpatient) pathway.

The COS pathway is ophthalmology-led, usually through asynchronous telemedicine, and includes:

- Rapid access assessment
- Outpatient follow-up
- Eye casualty follow-up (where commissioned)
- Sub-protocols which provide additional specific guidance:
    - Maculopathy
    - Vitreoretinal symptoms (flashes & floaters)
    - Pigmented fundus lesions

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical Assessment

History and symptoms

- Record age & gender
- Synopsis of referral / reason for visit
- Symptoms / asymptomatic
    - Including onset, duration, frequency
- Specific questions relevant to the presenting condition
- Personal medical history (including medications and allergies)
- Family medical history
- Personal ocular history
- Family ocular history

Initial tests

- Visual acuity (distance and near) with refraction where indicated
- Where indicated:
    - Visual fields
        - Comment on reliability, describe any pattern and change, note M.D.
    - Monocular colour vision
    - Amsler
    - Pupil reactions
    - Ocular motility
    - Binocular vision assessment
    - Central corneal thickness

Anterior segment

- Slit-lamp examination
    - Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens
        - Staining
- Anterior chamber and angle examination
    - Peripheral depth (Van Herrick)
    - Gonioscopy where clinically indicated
    - Presence/absence of A/C cells
- Intra-ocular pressure (IOP) and time
    - Goldmann is the gold standard, Perkins acceptable
    - iCare if patient declines or can't tolerate GAT/PAT

Posterior segment

- Slit lamp binocular indirect ophthalmoscopy (SL-BIO)
    - Dilation where indicated (including post-dilation IOP review as appropriate)
    - Lens, vitreous, disc (C:D, and features), macula, retina, choroid

Imaging

- Anterior segment imaging for anterior eye disease
- Anterior segment OCT where clinically indicated
- Colour fundus photographs (showing disc, macula and lesion(s)) for posterior eye disease/reduced VA
- OCT with appropriate protocol (cRNFL, GCC, volume maps of disc/macula, radial/raster scan centred on lesion)

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established. This pathway covers a wide range of ophthalmic conditions therefore there are a wide range of possible treatment options including eyelid hygiene, tear supplements, oral/topical antihistamines, oral/topical anti-inflammatories, painkillers, oral/topical antibiotics/antivirals etc. depending on the diagnosis.

If a prescription is required and not already arranged, it will be issued by the consultant-ophthalmologist-led telemedicine team to the patient's registered GP. Some medicines may be supplied directly where there is an acute need. Where commissioned, therapeutic optometrists (independent prescribers) may issue a prescription to a patient directly.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. College of Optometrists leaflet on blepharitis, AOP leaflet on dry eye etc.)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen

by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

The consultant-led asynchronous telemedicine team will provide a diagnosis and management plan before onward referral to the Hospital Eye Service or any other commissioned pathway (can be undertaken retrospectively in emergency cases).

References

NICE CKS Red Eye

College of Optometrists Guidance – examining patients who present as an emergency

College of Optometrists Guidance – examining patients who present with flashes & floaters

College of Optometrists Clinical Management Guidelines – ALL

College of Optometrists - Guidance for optometrist prescribers

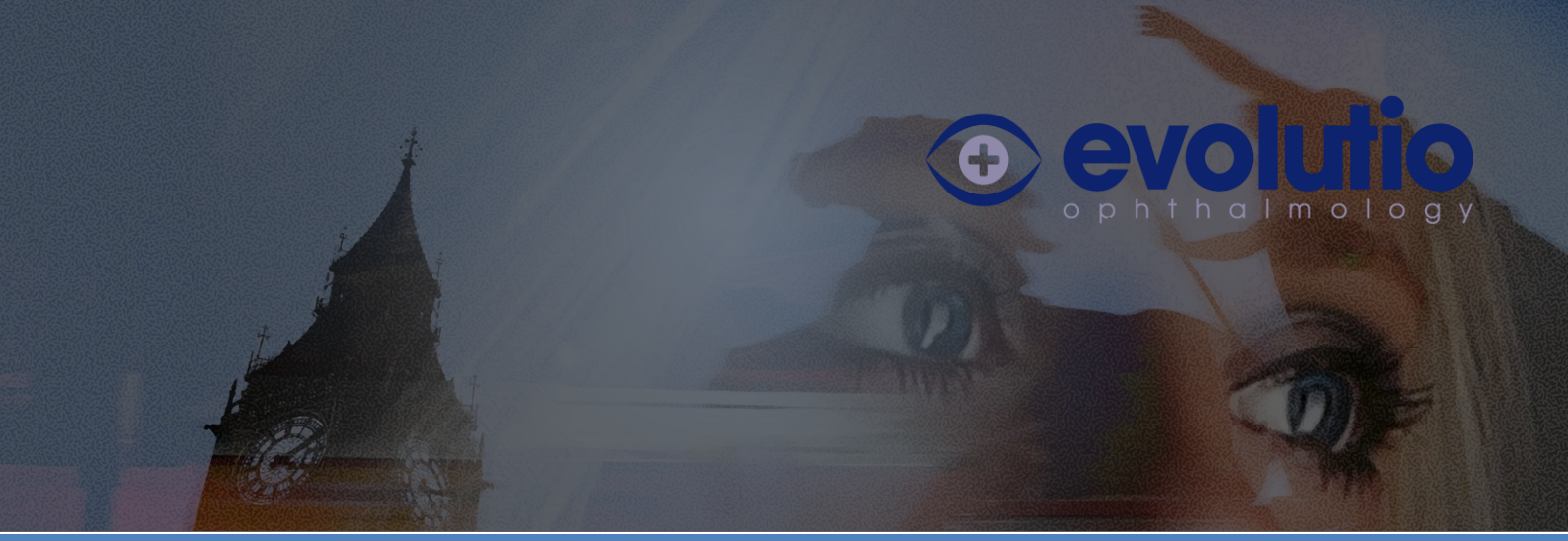
College of Optometrists – Optometrists Formulary

British National Formulary

Royal College of Ophthalmologists – Commissioning Guidance, Emergency Eye Care (Feb 2020)

Appendix A: COS Quick reference guide

	1. Introduction
HISTORY & SYMPTOMS	**2. Overview of why they're here (referring clinician's perspective)** **3. Are they having any problems with their eyes?** **4. Personal ocular history** • Specific questions relevant to the presenting condition (including risk factors) **5. Family ocular history** **6. Personal medical history (including medications)** **7. Allergies** **8. Family medical history**
VISUAL FUNCTION	**9. Visual acuity (distance and near) with refraction where indicated** **10. Monocular colour vision – where indicated** **11. Amsler – where indicated** **12. Pupil reactions – where indicated** **13. Ocular motility/BV assessment – where indicated** **14. Visual fields – where indicated**
CLINICAL EXAMINATIONS	**15. Anterior segment examination (with relevant imaging)** • Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens **16. Anterior chamber angle examination (including peripheral depth)** **17. Instill topical anaesthetic (and give leaflet)** **18. Contact applanation tonometry (e.g Goldmann) with time** **19. Central corneal thickness (if using ultrasound pachymeter)** **20. Instill mydriatic (and give leaflet)** **21. Posterior imaging (fundus photography, OCT)** **22. Posterior segment examination** • Dilated slit lamp binocular indirect ophthalmoscopy (SL-BIO) o Vitreous, retina, macula, disc (C:D, size & features), choroid • Post-dilation IOP review as appropriate
CONCLUSION	**23. Plan (impression, proposed management plan, proposed recall)** **24. Discussion with patient** **25. Telemedicine confirmation** **26. Letters sent**



2.3.4.3.1 Maculopathy Suspect Assessment - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 4 clinicians when assessing/managing a patient with suspected maculopathy, typically on a Community Ophthalmology Service pathway. This protocol might also be used as a helpful guide to clinicians assessing patients on other pathways/Tiers where maculopathy is identified.

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical Assessment

There are a wide range of maculopathies (e.g. AMD, ERM/macular hole, CSR, CMO, Telangiectasia, RAP) so the provisional diagnosis will determine the specifics of the assessment, particularly in terms of the *history* section.

History and symptoms

- Record age & gender
- Synopsis of referral / reason for visit
- Symptoms / asymptomatic
    - Including onset, duration, frequency
    - Metamorphopsia (note whether spontaneous), micropsia, macropsia, diplopia, aniseikonia
    - Reduced visual acuity (sudden or gradual)
    - Central scotoma
    - Charles Bonnet syndrome (CBS)
- Specific questions relevant to the presenting condition
- Personal medical history (including allergies)
    - Hypertension
    - Diabetes mellitus
    - Ischaemic heart disease
- Medications
    - Steroids
    - Anti-coagulant therapy
    - Nutritional supplements
- Family medical history
- Personal ocular history
    - Retinal vascular disease
    - Ocular inflammatory disease
    - Trauma
    - Intraocular surgery
    - Refractive error, including change
    - UV exposure
- Family ocular history
    - AMD/blindness/maculopathy
- Social history
    - Smoking
    - Alcohol consumption
    - Stress
    - Weight
    - Exercise
    - Varied diet (including fresh fruit/vegetables)

Initial tests

- Visual acuity (distance and near) with refraction where indicated
- Where indicated:
    - Visual fields
    - Monocular colour vision
    - Amsler

- Pupil reactions

Anterior segment

- Slit-lamp examination
  - Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens
- Anterior chamber and angle examination
- Intra-ocular pressure (IOP) and time
  - Goldmann is the gold standard, Perkins acceptable
  - iCare if patient declines or can't tolerate GAT/PAT

Posterior segment

- Slit lamp binocular indirect ophthalmoscopy (SL-BIO)
  - Dilation where indicated (including post-dilation IOP review as appropriate)
  - Lens, vitreous, disc (C:D, and features), macula, retina, choroid
    - Sub-retinal/sub-RPE neovascularisation
    - Serous detachment of the neurosensory retina
    - RPE detachment
    - Haemorrhages and/or oedema:
      - Sub-RPE
      - Sub-retinal
      - Intra-retinal
      - Pre-retinal
      - Breakthrough bleeding into the vitreous
    - Exudates (unrelated to other retinal disease)
    - Retinal angiomatous proliferations (RAP) and retinochoroidal anastomoses
    - Vitreomacular traction and ERM

Imaging

- Colour fundus photographs (showing disc, macula and lesion(s))
- OCT with appropriate protocol (usually macular volume map and radial/raster scan centred on lesions)

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established. This pathway covers a wide range of conditions, some of which might be suitable for topical or oral medication (usually steroid/NSAID) depending on the diagnosis.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. College of Optometrists leaflet on AMD, Macular Society leaflet on Macular Oedema, Moorfields leaflets on epiretinal membrane / macular hole / CSR)
- Education about disease prognosis
- Discussion of lifestyle changes (e.g. smoking cessation, improved diet, UV protection, reduce stress)
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

OCT assessment shows that the condition does not require active intervention nor serial monitoring.

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

The consultant-led asynchronous telemedicine team will provide a diagnosis and management plan before onward referral to the Hospital Eye Service or any other commissioned pathway (can be undertaken retrospectively in emergency cases).

The following points provide a guide on typical urgency of HES onward referral:

- Rapid access
    - Neovascular age-related macular degeneration ('Late AMD – wet active')
        - **Macular haemorrhage (any retinal level) is an important clinical indicator of likely SRNVM**

- Urgent (HES medical retina clinic), depending on presentation:
    - Inflammatory CNV
    - Central Serous Retinopathy (CSR)
    - Cystoid Macular Oedema (CMO)
    - CRVO/BRVO with macular involvement
    - Diabetic maculopathy
    - Idiopathic macular telangiectasia type 1 or 2 (MACTEL):
    - Pattern dystrophy (PD)
    - Uncertainty about disease diagnosis or stage

- Routine/Soon (HES OMR/vitreoretinal clinic), depending on presentation:
    - Macular hole (FTMH may require more urgent referral)
    - Epiretinal Membrane (ERM) affecting daily activities
    - Access low vision services or Certification as Sight Impaired (e.g. Late AMD – dry, Late AMD – wet inactive)

Some patients who are referred to the HES might be discharged to the community service (or remain under the care of the HES and undergo community diagnostics) for maculopathy monitoring on a dedicated pathway.

References

NICE NG82 - Age-related macular degeneration

Royal College of Ophthalmologists – Age Related Macular Degeneration Services: Commissioning Guidance (Jan 2021)

Moorfields patient leaflets – available at https://www.moorfields.nhs.uk/listing/conditions

Appendix A: Quick reference guide

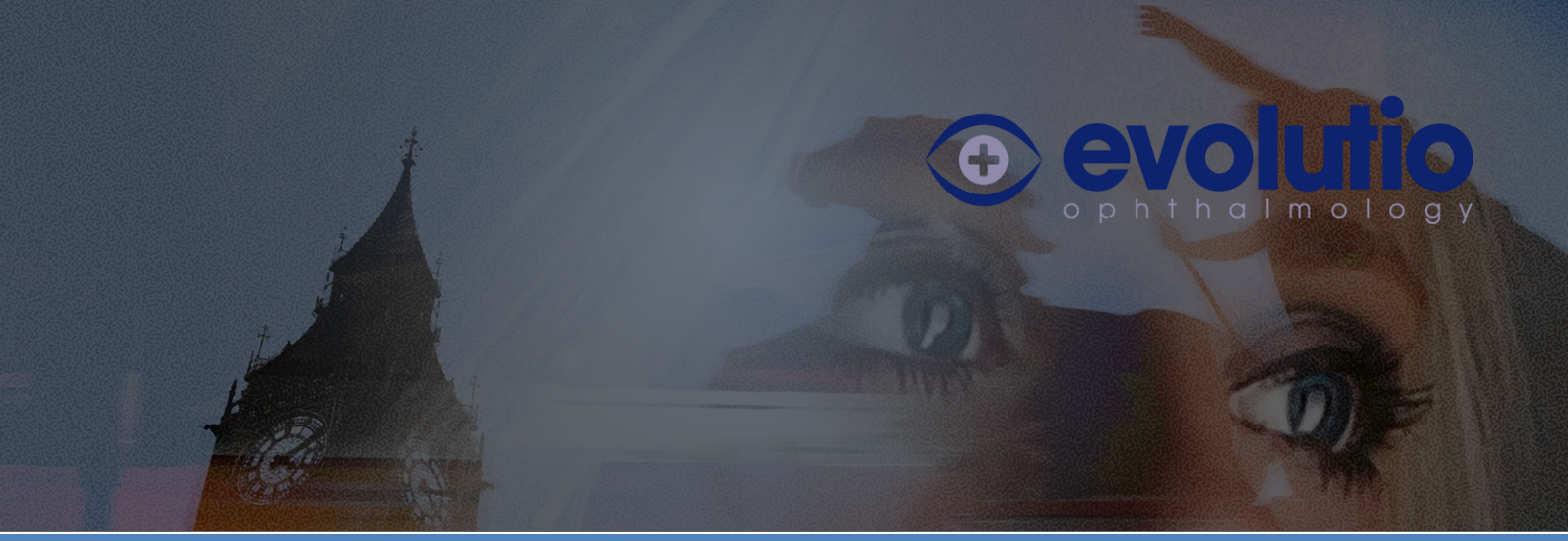
	1. Introduction

HISTORY & SYMPTOMS	**2. Overview of why they're here (referring clinician's perspective)**
	3. Are they having any problems with their eyes?
	4. Personal ocular history
	• Specific questions relevant to the presenting condition (including risk factors
	  ○ Symptoms:
	  ▪ Metamorphopsia, micropsia, macropsia, diplopia, aniseikonia
	  ▪ Reduced visual acuity
	  ▪ Central scotoma
	  ▪ Charles Bonnet syndrome (CBS)
	• Retinal vascular disease / Ocular inflammatory disease / Trauma / Intraocular surgery
	• Refractive error, including change
	• UV exposure
	5. Family ocular history
	6. Personal medical history (including medications)
	• Hypertension / Diabetes mellitus / Ischaemic heart disease
	• Steroids / Anti-coagulant therapy / Nutritional supplements
	• Social history
	• Smoking / Alcohol consumption / Stress / weight / exercise / diet
	7. Allergies
	8. Family medical history
	• First degree, second degree

VISUAL FUNCTION	**9. Visual acuity (distance and near) with refraction where indicated** **10. Monocular colour vision** **11. Amsler (digital where available)** **12. Pupil reactions**

CLINICAL EXAMINATION	**13. Anterior segment examination**
	• Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens
	14. Anterior chamber angle examination (including peripheral depth)
	15. Tonometry
	16. Instil trop (plus leaflet)
	17. Fundus photography and posterior OCT scans
	• Macular OCT scans, with attention to:
	  ○ Sub-retinal/sub-RPE neovascularisation
	  ○ Serous detachment of the neurosensory retina
	  ○ RPE detachment
	  ○ Haemorrhages and/or oedema:
	  ▪ Sub-RPE / Sub-retinal / Intra-retinal / Pre-retinal
	  ▪ Breakthrough bleeding into the vitreous
	  ○ Exudates (unrelated to other retinal disease)
	  ○ Retinal angiomatous proliferations (RAP) and retinochoroidal anastomoses
	  ○ Vitreomacular traction and ERM
	18. Posterior segment examination
	• Dilated slit lamp binocular indirect ophthalmoscopy (SL-BIO)
	  ○ Vitreous, retina, macula, disc (C:D, size & features), choroid, media
	• Post-dilation IOP review as appropriate

CONCLUSION	**19. Plan (impression, proposed management plan, proposed recall)** **20. Discussion with patient** **21. Telemedicine confirmation** **22. Letters sent**



2.3.4.3.2 Pigmented Fundus Lesion Assessment - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 4 clinicians when assessing/managing a patient with a pigmented fundus (chorioretinal) lesion, typically on a Community Ophthalmology Service pathway. This protocol might also be used as a helpful guide to clinicians assessing patients on other pathways/Tiers where a pigmented chorioretinal lesion is identified.

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical Assessment

History and symptoms

- Record age & gender
- Synopsis of referral / reason for visit
- Symptoms / asymptomatic
    - Including onset, duration, frequency
        - Floaters
        - Photopsiae
        - Reduced VA
        - Field loss
- Specific questions relevant to the presenting condition
- Personal medical history (including medications and allergies)
    - History of hypersensitivity reactions
    - UV exposure
    - Cancer / malignancy
    - Anorexia / weight loss / fatigue / malaise / illness
    - Systemic co-morbidities
- Family medical and ocular history
    - Family history of malignancy
- Personal ocular history
    - Previous lesion discussion/imaging
    - Previous ocular surgery / trauma
    - Any co-morbid conditions
- Family ocular history

Initial tests

- Visual acuity (distance and near) with refraction where indicated
- Where indicated:
    - Visual fields
        - Comment on reliability, describe any pattern and change
    - Monocular colour vision
    - Amsler
    - Pupil reactions
    - Ocular motility

Anterior segment

- Slit-lamp examination
    - Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens
- Anterior chamber and angle examination
    - Peripheral depth (Van Herrick)
    - Inflammation, iris rubeosis, dilated episcleral sentinel vessels
    - Iris colour and profile
- Intra-ocular pressure (IOP) and time
    - Goldmann is the gold standard, Perkins acceptable
    - iCare if patient declines or can't tolerate GAT/PAT

Posterior segment

- Slit lamp binocular indirect ophthalmoscopy (SL-BIO)
    - Dilation where indicated (including post-dilation IOP review as appropriate)
    - Lens, vitreous, disc (C:D, and features), macula, retina, choroid
        - Level of the lesion
            - Choroidal / sub retinal / intra-retinal / pre-retinal
        - Colour
            - Slate grey / brown / black / red / amelanotic
        - Size
            - Horizontal and vertical
        - Elevation (apical thickness)
            - Flat / minimally thickened (<2mm) / shallow dome / pronounced dome
        - Shape
            - Regular / irregular
            - Margins distinct / diffuse
        - Position
            - Any contact with the optic disc
            - Sub foveal
        - Surface features
            - Drusen (chronicity)
            - Orange lipofuscin (RPE dysfunction) – dusting or confluent clumps
            - Non pigmented areas (e.g. lacunae in CHIRPE)
            - Halo (ring of RPE atrophy surrounding a lesion)
        - Sub-retinal fluid
            - Absent / visible with OCT / visible with ophthalmoscopy
        - Vitreous haemorrhage or retinal detachment
    - A MOLES score should be included for all naevi (see below)

Imaging

- Colour fundus photographs (showing disc, macula and lesion(s))
- OCT with appropriate protocol (cRNFL, GCC, volume maps of disc/macula, radial/raster scan centred on lesion)
- Including comment on any changes from previous images

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established. There are no direct therapeutic options for conditions on this pathway.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. Oxford University Hospitals leaflet on 'mole at the back of the eye' or Moorfields leaflet on uveal melanoma)
- Education about disease prognosis (tactful and empathetic)
- Discussion of lifestyle changes (e.g. UV protection, smoking cessation)
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

- No associated or progressive visual or field loss
- OCT assessment and photos show the lesion to be stable
- MOLES Score of 0 – i.e. common naevus (see below)
- **No** *high-risk* features – high risk features include:
    - Naevus >1mm thick
    - Naevus 3DD or more in size
    - Mushroom shape (early/definite)
    - Orange pigment (lipofuscin)
    - Suspected change/growth
    - Sub-retinal fluid

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

- Lesion not recorded in previous examinations (without photographic evidence)
- Melanocytic lesions with a MOLES Score of 0 – i.e. common naevus (see below)
    - Usually reviewed at 6-12 months
    - May be eligible for discharge in due course if they meet the criteria shown above
- Common naevi with any of the following features may require ongoing monitoring:
    - Minimally raised (<1mm)
    - Within 3mm (or 2 disc diameter) of the optic disc
    - Sub foveal
    - Surrounding halo
        - Initially monitored in 3-6 months
        - Further follow-up as indicated ('significant' lesions are often reviewed at 3/12 then 6/12, 6/12, 12/12)
- CHRPE (congenital hypertrophy of retinal pigment epithelium)

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

The consultant-led asynchronous telemedicine team will provide a diagnosis and management plan before onward referral to the Hospital Eye Service or any other commissioned pathway (can be undertaken retrospectively in emergency cases).

The MOLES Scoring system (developed by Prof Bertil Damato) is shown below.

MOLES Scoring chart

Indicator	Finding	Score
Mushroom shape	0 = Absent 1 = Incipient (erosion through RPE/uncertain) 2 = Present (i.e. definitive mushroom shape with overhang)	
Orange pigment	0 = Absent 1 = Dusting/unsure 2 = Confluent (i.e. easily visible clumps of orange pigment)	
Large size	0 = Flat (<1mm thick) and less than 3 disc diameters (DD) wide 1 = Subtle dome shape (1-2mm thick) AND/OR 3-4DD wide 2 = Significant thickening (>2mm) AND/OR more than 4DD wide	
Enlargement	0 = None (or no baseline photography) 1 = Suspected change on comparing photographs 2 = Definite growth confirmed by sequential imaging	
Subretinal fluid	0 = Nil 1 = Trace (limited retinal detachment seen only with OCT) 2 = Definite subretinal fluid visible with ophthalmology	
	Moles total score =	

Recommended management

MOLES score	Management (i.e., in Oxfordshire)
0 = Common naevus	Advise usual self-care (i.e., with no surveillance other than usual visits to optometrists every 1-2 years). Follow B3 College of Optometrists Clinical Management Guidelines (CMG).
1 = Low-risk naevus	Refer NON_URGENTLY to the Oxford Eye Hospital by completing the Oxford Ocular Oncology Referral Form (downloadable from OEH website) and emailing it to OUH-tr.ocularmoles.oxon@nhs.net with attached image(s). [Follow B1 referral protocol of the College of Optometrists CMG]. Give patients the leaflet entitled 'Mole at the back of the eye', downloaded from the Oxford Eye Hospital website.
2 = High-risk naevus	
>2 = Probable melanoma	Refer URGENTLY by emailing the Oxford Ocular Oncology Referral Form to Pcc2wwoxford@nhs.net with attached image(s) of the lesion. [Follow A3 referral protocol if the College of Optometrists CMG and the NHS FastTrack pathway for suspected cancer. Encourage patient to accept the earliest appointment. Give them the FastTrack patient information sheet.

Local protocols should be followed in all cases. Referrals are typically graded as follows:

- 2 Week Wait:
  - Lesions with a MOLES score of 3 or more
  - Any primary intraocular tumour other than naevus
  - Any intraocular metastatic tumour
  - Suspected intraocular lymphoma
- Urgent
  - Lesions with a MOLES score of 2
  - Possible malignancy
  - Associated with symptoms of floaters or reduction in vision
- Routine
  - Lesions with a MOLES score of 1
- Urgency depends on presentation:
  - Diagnostic uncertainty
  - Unable to image entire lesion
  - 4 or more pigmented chorioretinal lesions
  - 2 or more large pigmented chorioretinal lesions

References

College of Optometrists Clinical Management Guidelines – Pigmented Fundus Lesions

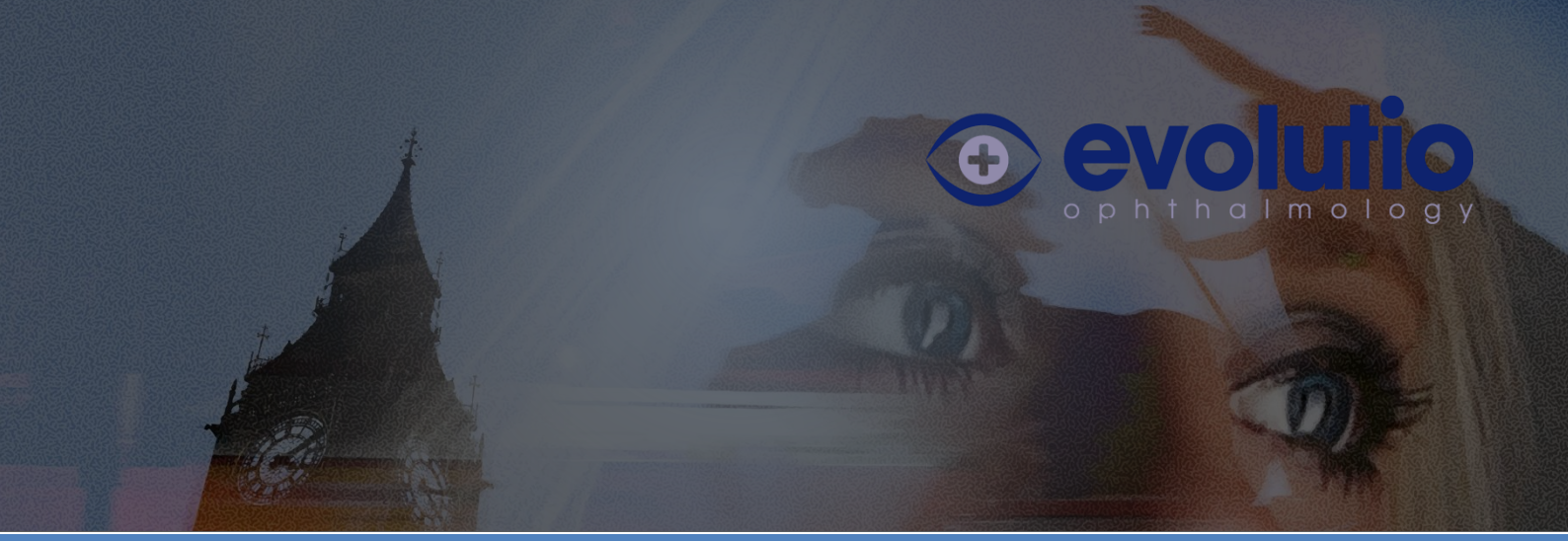
Oxford University Hospitals leaflet - Mole at the back of the eye

Oxford Eye Hospital guidelines for management of patients with melanocytic choroidal tumours

Moorfields Leaflets – available at https://www.moorfields.nhs.uk/listing/conditions

Appendix A: Quick reference guide

	1. Introduction
HISTORY & SYMPTOMS	**2. Overview of why they're here (referring clinician's perspective)** **3. Are they having any problems with their eyes?** **4. Personal ocular history** • Previous lesion discussion/imaging • Previous ocular surgery / trauma • Any co-morbid conditions • Specific questions relevant to the presenting condition (including risk factors o Systemic co-morbidities ▪ UV exposure ▪ Cancer / malignancy ▪ Anorexia / weight loss / fatigue / malaise / illness o Symptoms (usually asymptomatic): ▪ Floaters ▪ Photopsiae ▪ Reduced VA ▪ Field loss **5. Family ocular history** **6. Personal medical history (including medications)** • History of hypersensitivity reactions **7. Allergies** **8. Family medical history** • Including family history of malignancy
VISUAL FUNCTION	**9. Visual acuity (distance and near) with refraction where indicated** **10. Monocular colour vision (where indicated)** **11. Amsler (where indicated)** **12. Pupil reactions & motility (where indicated)**
CLINICAL EXAMINATION	**13. Anterior segment examination** • Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens o Anterior chamber – inflammation, iris rubeosis, dilated episcleral sentinel vessels o Iris colour and profile **14. Anterior chamber angle examination (including peripheral depth)** **15. L/A instil (plus leaflet)** **16. GAT with time** **17. Instil trop (plus leaflet)** **18. Visual fields (threshold)** **19. Fundus photography and posterior OCT scans:** • Level of the lesion — Choroidal / sub retinal / intra-retinal / pre-retinal • Colour — Slate grey / brown / black / red / amelanotic • Size — Horizontal and vertical • Elevation (apical thickness) — Flat / minimally thickened (<2mm) / shallow dome / pronounced dome • Shape — Regular / irregular, Margins distinct / diffuse • Position — Any contact with the optic disc, sub foveal • Surface features — Drusen (chronicity) Orange lipofuscin (RPE dysfunction) Non pigmented areas (e.g. lacunae in CHIRPE) Halo (ring of RPE atrophy surrounding a lesion) • Sub-retinal fluid — Presence or absence • Vitreous haemorrhage or retinal detachment **20. Posterior segment examination** • Dilated slit lamp binocular indirect ophthalmoscopy (SL-BIO) o Vitreous, retina, macula, disc, choroid, media • Post-dilation IOP review as appropriate • MOLES Score
CONCLUSION	**21. Plan (impression, proposed management plan, proposed recall)** **22. Discussion with patient** **23. Telemedicine confirmation** **24. Letters sent**



2.3.4.3.3 Flashes & Floaters Assessment - Clinical Protocol

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

This protocol provides guidance to TIER 4 clinicians when assessing/managing a patient with vitreo-retinal symptoms (primarily flashes and/or floaters), typically on a Community Ophthalmology Service pathway. This protocol might also be used as a helpful guide to clinicians assessing patients on other pathways/Tiers where patients present with flashes/floaters.

The level of examination should be appropriate to the reason for referral and all procedures are at the discretion of the clinician, however this pathway examination protocol is the recommended safe minimum level. Providers are advised to consult their Evolutio local CCG handbook for any local variations/requirements. Follow-up appointments should include investigations which are appropriate to the condition under review.

Clinical assessment

History and symptoms

- Record age and gender
- Synopsis of referral / reason for visit
- Symptoms / asymptomatic
- Loss or distortion of vision/field
    - Floaters – ask:
        - Which eye
        - Where in the visual field
        - Duration of onset
        - What they look like
        - How many
        - Are there 'tiny black dots'
        - Static or mobile
        - Getting better/worse/stable
    - Photopsiae – ask:
        - Which eye
        - Where in the visual field
        - Duration of onset
        - Duration of episode
        - Frequency
        - Description (arcuate vs point)
        - Getting better/worse/stable
- Personal medical history (including medications and allergies)
- Personal ocular history
    - Refractive error (particularly myopia >5D)
    - Previous retinal break/tear/detachment
    - Previous ocular surgery / **trauma** / inflammation
    - Any co-morbid conditions
- Family ocular history
    - Retinal break or detachment

Initial tests

- Visual acuity (distance and near) with refraction where indicated
- Visual fields
- Where indicated:
    - Amsler
    - Pupil reactions

Anterior segment

- Slit-lamp examination
    - Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens
- Anterior chamber and angle examination
    - Peripheral depth (Van Herrick)
- Intra-ocular pressure (IOP) and time
    - Goldmann is the gold standard, Perkins acceptable

- iCare if patient declines or can't tolerate GAT/PAT

Posterior segment

- Slit lamp binocular indirect ophthalmoscopy (SL-BIO) – dilated (including post-dilation IOP review as appropriate)
- Lens, vitreous, disc (C:D, and features), macula, retina, choroid
  - Anterior vitreous
    - Identification of pigment cells (Shafer's sign)
  - Posterior vitreous
    - Vitreo-retinal traction
    - PVD
  - Retinal integrity
    - Retinal / pre-retinal haemorrhages
    - Lattice degeneration
    - Retinal break
    - Operculum
    - Retinal detachment

Imaging

- Colour fundus photographs (showing disc, macula and any lesions)
- OCT with appropriate protocol (cRNFL, GCC, volume maps of disc/macula, radial/raster scan centred on lesion)

Management

Providers should be familiar with national and local guidance including those referenced below.

A clinical impression (tentative diagnosis) is made and a management plan established. There are no direct treatments for conditions on this pathway.

Visit outcomes

Allowable outcomes resulting from the consultation are:

- Discharge and self-monitoring
- Follow-up and monitor
- Onward referral to another pathway

In ALL cases, patient information should be provided to aid and support early detection and prevention planning through:

- Written guidance as appropriate (e.g. College of Optometrists leaflet on Flashes and Floaters)
- Education about disease prognosis
- Discussion of lifestyle changes
- Information detailing available support/rehabilitation services
- Advice to return/seek advice (with appropriate urgency) if new symptoms develop
- Home monitoring advice

Discharge and self-monitoring

A patient is discharged back to the referring clinician if no abnormalities are found requiring further investigation or treatment.

- No associated or progressive visual field loss
- No indications of retinal detachment, break or vitreous haemorrhage (confirmed with OCT)
- Previous mydriatic examination by a practitioner competent in the use of slit-lamp examination and indirect ophthalmoscopy (relating to this symptomatic episode)
- **No** *high-risk* features, such as:
  - Pigment in the anterior vitreous ('tobacco dust'/Schaefer's sign)
  - Operculum (free or attached)
  - Lattice degeneration (with symptoms)
  - Monocular/only one functioning eye

- Recent trauma
- Myopia over -6
- Family history of RD
- Previous RD or vitreoretinal investigations
- Previous intraocular surgery

Follow-up and monitoring

A patient may require a follow-up appointment to ascertain the rate of change, if any, and suitability to discharge back to the referring clinician. Follow-up intervals will be set dependent on severity, duration and co-morbidity risk factors with consideration of national guidelines and local protocols.

Depending on the signs, symptoms and risk factors, patients requiring a follow-up appointment may be reviewed within 1-6 weeks, possibly by a different practitioner; such patients are usually discharged after follow-up if none of the signs listed below are found.

Onward referral to another pathway

The clinician makes a provisional diagnosis and refers the patient into another care pathway within the CCG provider network with an appropriate level of urgency. This includes cases which you are unable to manage and incidental findings which need to be assessed further on a different pathway. Patients should be informed of when they are likely to be seen by an ophthalmologist/secondary care clinician and what they should do if they do not receive an appointment within a specified time.

The consultant-led asynchronous telemedicine team will provide a diagnosis and management plan before onward referral to the Hospital Eye Service or any other commissioned pathway (can be undertaken retrospectively in emergency cases).

Local protocols should be followed in all cases. Referrals are graded as follows:

- Emergency (call duty eye doctor):
  - Pigment in the anterior vitreous ('tobacco dust'/Shafer's sign)
  - Retinal break
  - Operculum (free or attached)
  - Retinal detachment (RD)
- Urgent (HES vitreoretinal clinic) depending on presentation:
  - Vitreal, retinal or pre-retinal haemorrhage
  - Lattice degeneration (with symptoms)
  - Monocular/only one functioning eye
  - Flashes and floaters with an onset within 2 weeks and a history of:
    - Trauma
    - Myopia over -6
    - Family history of RD
    - Previous RD or vitreoretinal investigations
    - Previous intraocular surgery

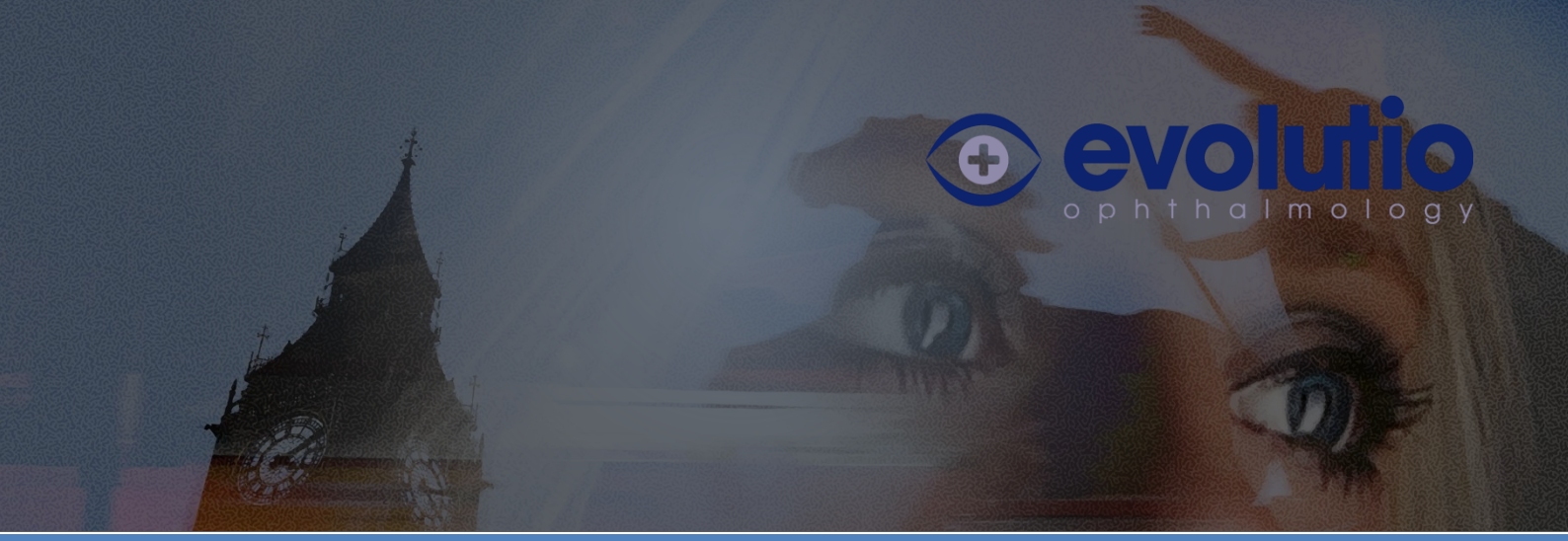
References

College of Optometrists guidance - Examining patients who present with flashes and floaters

NICE CKS: Retinal detachment

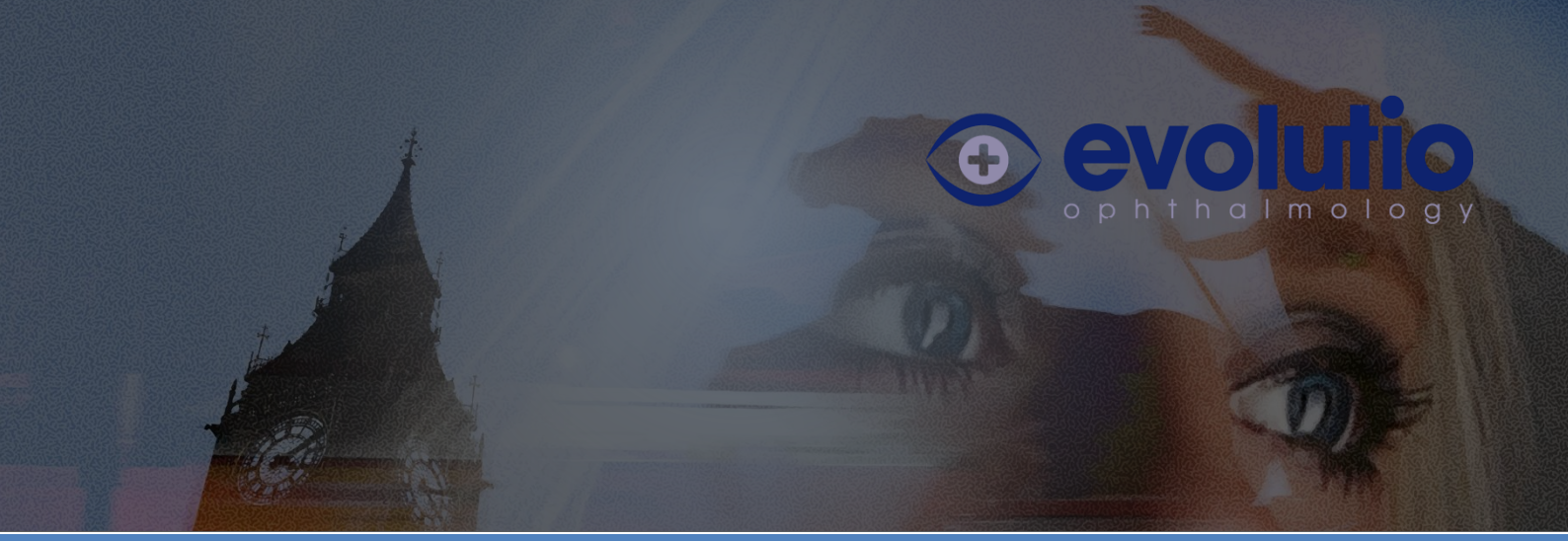
Appendix A: Quick reference guide

	1. Introduction
HISTORY & SYMPTOMS	**2. Overview of why they're here (referring clinician's perspective)** **3. Symptoms:** • Loss or distortion of vision o Floaters – ask: ▪ Which eye ▪ Where in the visual field ▪ Duration of onset ▪ What they look like ▪ How many ▪ Are there 'tiny black dots' ▪ Static or mobile ▪ Getting better/worse/stable o Photopsiae – ask: ▪ Which eye ▪ Where in the visual field ▪ Duration of onset ▪ Duration of episode ▪ Frequency ▪ Description (arcuate vs point) ▪ Getting better/worse/stable **4. Personal ocular history** • Previous ocular history of break or detachment • History of recent ocular trauma, surgery or inflammation o Refractive error **5. Family ocular history** • Family history of retinal break or detachment **6. Personal medical history (including medications)** **7. Allergies**
VISUAL FUNCTION	**8. Visual acuity (distance and near) with refraction where indicated** **9. Visual fields** **10. Amsler (where indicated)** **11. Pupil reactions (where indicated)**
CLINICAL EXAMINATION	**12. Anterior segment examination** • Lids, lashes, conjunctiva (bulbar and palpebral), sclera, cornea, limbus, iris, lens **13. Anterior chamber angle examination (including peripheral depth)** **14. L/A instil (plus leaflet)** **15. GAT with time** **16. Instil top (plus leaflet)** **17. Fundus photography and OCT scans** **18. Posterior segment examination** • Dilated slit lamp binocular indirect ophthalmoscopy (SL-BIO) o Vitreous, retina, macula, disc (C:D, size & features), choroid ▪ Anterior vitreous — Identification of pigment cells (Schaefer's sign) ▪ Posterior vitreous — Vitreo-retinal traction PVD ▪ Retinal integrity — Retinal / pre-retinal haemorrhages Lattice degeneration Retinal break Operculum Retinal detachment o Post-dilation IOP review as appropriate
CONCLUSION	**19. Plan (impression, proposed management plan, proposed recall)** **20. Discussion with patient** **21. Telemedicine confirmation** **22. Letters sent**



Evolutio Ophthalmology Handbook

Section 3: PRACTICE STANDARDS & ACCREDITATION



3.1 Equipment, Consumables & Accreditation

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

Evolutio offer a 3 tier structure to service providers so they can deliver the pathways which suit the needs of their business and their levels of equipment & experience. This policy outlines the requirements for service delivery at the various tiers including equipment, consumables, accreditation and compliance. Providers may apply to vary their tier should their circumstances or requirements change.

- As part of our structured on-boarding process, our Relationship Manager and an experienced clinical optometrist provide mentoring sessions and ongoing support as required

- All service providers must sign a Service Provider contract and are required to confirm they have read, understood and will adhere to the contents of this handbook by initialling every section in the index; Evolutio will keep a copy of this page on file. The contractor is responsible for ensuring that any clinicians delivering the service within their practice have read, understood and will adhere to the policies and protocols within this handbook.

- All service providers are registered with the General Optical Council / General Medical Council with no previous fitness to practice concerns

- Service providers must have 2 years of post-qualification clinical experience before accepting 'external' non-self referrals from another practice, or even from an experienced colleague within their own practice

- Pre-registration optometrists are able to see a cohort of patients on Tier 1 pathways within the service providing it is an incidental finding identified during their internal sight test and deemed clinically suitable by their supervisor (who will retain responsibility). Common examples would include dry/watery/red eyes and low risk floaters. This same cohort of patients may be examined by newly qualified optometrists following a sight test they've undertaken.

- Contact Lens Opticians with 2 years of post-qualification clinical experience may also see a cohort of patients on an anterior eye pathway and must make a suitable onward referral if investigations/management is indicated/required beyond their competency

Provider accreditation is managed through Eloomi. This platform contains a range of operational and clinical videos which will support providers in using our software and advancing clinical knowledge. Many service providers hold relevant higher qualifications and postgraduate certificates/diplomas (e.g. WOPEC for Tier 1 or IP/Glaucoma for Tier 3). Although these are not mandated, they may provide exemptions for aspects of the accreditation process if evidence is provided.

Synopsis of the tier structure:

Tier 1

- Referral type – Walk-in & self/internal referrals only
- Equipment – Core optometry
- Pathways - Minor eye conditions; Cataract pre/post op; IOP repeat readings
- Telemedicine Access - No

Tier 2 (in addition to Tier 1)

- Referral type – Walk-in, self/internal referral & **External referrals**
- Equipment – Anterior/posterior imaging
- Pathways - OHT/glaucoma monitoring (Low Risk); Children (cyclo)
- Telemedicine – Yes (Pathway defined)

Tier 3 (in addition to Tier 2)

- Referral type - Walk-in, self/internal referral, external referral & **Rapid access referrals**
- Equipment – OCT, gonioscopy
- Pathways - OHT/glaucoma monitoring (Medium Risk); OHT/glaucoma assessment; HCQR screening
- Telemedicine – Yes (Pathway defined)

Tier 1 providers – Requirements

Pathways (Where commissioned/see clinical protocol)

- Minor Eye Condition — *MECS-type walk-in service (red eye, floaters etc.)*
- Cataract Pre-op Assessment — *Establish eligibility for referral for cataract surgery (VA, lifestyle)*
- Cataract Post-op Assessment — *Post op assessment to establish if outcome is satisfactory*
- IOP Repeat Readings — *Contact tonometry and repeat fields*
- Trichiasis — *Epilation*

Additional equipment requirements

- Contact applanation tonometer (GAT preferable, PAT acceptable) with disposable heads
    - iCare acceptable for non-IOP/glaucoma pathways
- Disposable tweezers
- Equipment for superficial foreign body removal & cotton buds
    - Alger brush NOT required

Accreditation

- Safeguarding adults & children, capacity [e.g. DOCET]
- Infection control [e.g. AOP/DOCET]
- Eloomi
    - Evolutio provider compliance – copyright notice
    - Operational modules (video)
        - Data Protection
        - Evonnect training
            - Optional range of modules for various Evonnect functions
    - Processing cataract post-op assessments
        - Clinical modules (video)
        - Enhanced Optical Services [exemptions apply e.g. MECS/IP]
        - Acute eyecare [exemptions apply e.g. MECS/IP]
        - Cataract assessment [exemptions apply e.g. WOPEC cataract]
        - Virtual consultations

Compliance requirements

Tier 1 providers self-certify. F2F compliance/support visit is not mandated but we would aim to visit all tier 1 providers within each 3 year cycle.

- Evidence of a current General Ophthalmic Mandatory Services Model Contract
- Evidence of QiO Level 1
- Evidence of equipment – 1-3 photos of the consulting room and pre-screening area (if applicable)
- Evidence of a full range of diagnostic ophthalmic drugs stored appropriately and securely
- Evidence of Eloomi accreditation (or exemptions where applicable) for tier 1
- Agreement to see MEC self-referrals in an appropriate timescale (might need care within 48 hours)
- Agreement to deliver all pathways within this tier that are commissioned locally
- Participate in one of our education/training/peer review events at least once every 3 years

Tier 2 providers – Requirements

Pathways (Where commissioned/see clinical protocol)

All pathways for Tier 1 AND

- Children's Eye Service — *VA check and cycloplegic refraction*
- Glaucoma/OHT Monitoring (Low Risk) — *Review discs/fields/IOP with mandated telemed*
- Low Vision Aid — *Basic LVA assessment and signposting to services*

Additional equipment requirements

All equipment requirements for Tier 1 AND

- Anterior eye imaging

- Colour fundus imaging
- Visual field analyser capable of 24-2/30-2 threshold programs (smart algorithms such as SITA acceptable)

Accreditation

All accreditation requirements for Tier 1 AND

- Eloomi
    - Operational modules (video)
        - Optional range of modules for various Evonnect functions
    - Clinical modules (video)
        - Glaucoma modules [exemptions apply e.g. Prof Cert Glauc]
            - 2-part module (theory and clinical)
            - Managing glaucoma/OHT in the community
            - Glaucoma - a novel approach
        - Children's post vision screening [exemptions apply e.g. paediatric/orthoptics certificate]
        - A consultant's guide to telemed teamwork

Compliance requirements

All compliance requirements for Tier 1 AND

- Evidence of adequate infection control measures and waste disposal. Evolutio mandate a yellow bin for clinical waste in addition to the requirements of QiO subsections 26 (infection control) and 27 (waste disposal).
- Evidence of Eloomi accreditation (or exemptions where applicable) for tier 2
- Agreement to accept a minimum of 5 external referrals each week (if offered and clinically appropriate)
- Agreement to deliver all pathways within tiers 1 & 2 that are commissioned locally
- F2F compliance/support visit annually
- Participate in one of our education/training/peer review events at least once every 2 years

Tier 3 providers – Requirements

Pathways (Where commissioned/see clinical protocol)

- All pathways for Tier 2 AND
- Glaucoma/OHT Assessment (OCT & gonio) — *Glaucoma/OHT investigation with gonio*
- Glaucoma/OHT Monitoring (Medium Risk) — *Review discs/fields/IOP with mandated telemed*
- 112 Teletriage (Rapid Access) — *Acute cases with short TTC and optional telemed*
- HCQR Screening — *HCQ retinal screening with mandated telemed*

Additional equipment requirements

All equipment requirements for Tier 2 AND

- Visual field analyser capable of 10-2 threshold program (smart algorithms such as SITA acceptable)
- OCT
- Goniolens (disposable or with suitable consumables/process for disinfection)
- Pachymeter (ultrasound and/or AS-OCT with pachymetry functionality)

Accreditation

All accreditation requirements for Tier 2 AND

- Eloomi
    - Clinical modules (video)
        - HCQ Retinopathy screening [exemptions apply e.g. Prof. Cert Med Ret]
        - Emergency prescribing in the community [exemptions apply e.g. IP]

Compliance requirements

All compliance requirements for Tier 2 AND

- Evidence of Eloomi accreditation (or exemptions where applicable) for tier 3
- Agreement to accept rapid access referrals (who might need care within 48 hours)
- Agreement to deliver all pathways within tiers 1, 2 & 3 that are commissioned locally
- Participate in one of our education/training/peer review events at least once every year

Equipment and consumables

Evolutio service providers are required to have a specified minimum level of serviceable equipment and consumables, as defined by their tier level (above and Appendix A).

Service providers are responsible for ensuring that their equipment is maintained, serviced and calibrated according to manufacturer's guidelines. These items are checked at compliance visits, including equipment maintenance logs.

There must be a clearly defined process for equipment fault reporting and in the event of a fault affecting service delivery you are required to contact our Clinical Lead (Optometry) immediately.

Service providers are advised to consult their Evolutio local CCG handbook for any local equipment variations/requirements.

Adequate stocks of consumables must be maintained in order to deliver the service. In addition to the drugs and staining agents shown in Appendix A, the following consumables are required:

- Equipment for foreign body removal
    - e.g. 21 gauge 40mm green-collared needle and small (e.g. 3ml) disposable syringe
- Sterile cotton buds
- Regular cotton buds
- Disposable tonometer probes (e.g. Tonosafe / Easyton / Tonomate)
    - Disposable iCare probes (where applicable)
- Surgical tape for taping lids up for fields (e.g. Micropore tape)
- Sterile eye pad
- Epilation forceps (tweezers)
- Spare contact lens case

Ophthalmic drugs

Service Providers must stock a range of diagnostic drugs as shown in Appendix A. Drugs validity dates should be checked and a log kept. Drugs should be stored securely and in accordance with the manufacturer's instructions. Depending on the services being delivered, providers are also expected to stock the following for consulting room use:

- Sterile saline
- Single use tear supplements
- Coupling fluid (e.g celluvisc/viscotears/methylcellulose)

Using diagnostic drugs

- Advise patients (when booking) that they might not be able to drive after the examination and suggest that they bring sunglasses with them.
- Consider the cautions and contraindications. Check for any previous adverse reactions to eye drops or other drugs. Ask about relevant medical conditions and systemic drugs.
- Before instillation check the depth of the anterior chamber & corneal integrity. Measure IOP as appropriate (e.g. before/after).
- Check and record correct drug, dosage, expiry date and BN.

Advise patient (and give information leaflet):

1. Why you are instilling the drug
2. What effects the drops might have
3. How long the effects might last
4. The side effects they might experience
5. If you are dilating their pupils, that they might not be able to drive and must not undertake any activity which is not advised after dilation, and for how long
6. If you are using anesthetic drops, that they should avoid wearing contact lenses for an appropriate period of time after anesthesia, and
7. What to do if they experience an adverse reaction

Delegating the instillation of eye drops

- No legal restriction on who can instill eye drops to a person (law only restricts supply)

- Optometrist must be on the premises
- Delegated person must have the necessary skills and experience to undertake the procedure
- Patient should receive the same standard of care that the optometrist would provide
- Optometrist is responsible for the work of the delegated person
- If you choose to delegate, advise patient that you are delegating a particular part of their care to your colleague and that you will discuss any clinical findings with them

Practice hygiene

Service Providers are required to maintain high consulting room hygiene and infection control standards. Section 1.14 details the recommended infection control measures. Practice hygiene and infection control processes are checked at the initial and subsequent Compliance Visits.

Service Providers are responsible for ensuring that consulting room and practice hygiene standards are maintained including hand hygiene and the disinfection of equipment, work surfaces and patient areas. An effective cleaning rota should be followed (and evidenced).

Adequate stocks of consumables relating to hygiene must be maintained in order to deliver the service to an acceptable standard, including those shown below:

- Available bins (with lid)
- Yellow clinical waste bin
- Tissues
- Clinical surface wipes
- Alcohol wipes (e.g. Sterets)
- Clean sink with hot and cold water, soap and hand drying towels
- Alcohol hand gel
- Chin rest papers
- Adequate equipment sterilisation procedures (e.g. Milton/sodium hypochlorite sterilising fluid or Tristel Duo Oph)
- PPE (e.g. disposable nitrile gloves, apron, face mask)

Patient leaflets

Patients must be offered relevant literature to support their understanding and management of their eye condition. Patient leaflets are available from a wide range of sources, for example:

- Diagnostic drug information (tear-off pads)
    - CoO tropicamide
    - CoO anaesthetic
    - CoO cycloplegic
- Tear-off Amsler pad
- Ophthalmic conditions
    - Glaucoma UK (previously known as IGA)
        - OHT
        - PACG
        - POAG
        - Secondary glaucoma
        - Eye drops and dispensing aids
        - Glaucoma and driving
        - Glaucoma and your relatives
    - College of Optometrists
        - Glaucoma
        - Blepharitis
        - Flashes & floaters
        - Cataract
        - AMD
        - Dry eye
    - Association of Optometrists
        - AMD
        - Allergic conjunctivitis
        - Bacterial and viral conjunctivitis

- Blepharitis
- Cataracts
- Dry eye syndrome
- Flashes and floaters
- Glaucoma
- MGD
- Scratched cornea
- Smoking and eye health

Ancillaries

Service Providers may wish to stock a range of ancillaries (e.g. dry eye/blepharitis products) but the following points apply when recommending them to Evolutio patients:

- Patients must be made aware of 'DIY' as well as commercial products (where applicable) so an informed choice is made
- Inform patients that there are a wide range of products which will work differently for each individual
- Inform patients that they can purchase the product from any stockist
- Patients should NOT be charged more than the RRP in the local pharmacy
- Patients should be aware that although the Evolutio service is NHS-funded and therefore free at the point of access, local CCG guidance and formularies (which GP's also must follow) place a strong emphasis on self-care for dry eyes (i.e. purchase over the counter rather than prescribe), even in cases of low income

Ophthalmic imaging

High quality images are required for accurate disease monitoring (and diagnosis in the context of telemedicine). Images must be of sufficient resolution (typically at least 1MB) and you must not submit photographs of a screen/screenshot as this will be pixelated and of reduced quality/colour saturation.

Anterior eye imaging methods include:

1. Slit-lamp internally mounted camera/video
2. Modern digital camera (with appropriate lighting) – must be a non-personal 'practice owned' device and stored securely for GDPR reasons
3. Some fundus cameras/OCT machines (usually low magnification so less suitable)
4. iPhone/tablet adapter for slit-lamp mounting (e.g. Celestron NexYZ 3 Axis Universal Smartphone Adapter)
5. iPhone/tablet clip-on macro lens (e.g. Olloclip)

Posterior imaging methods include:

1. Digital fundus camera (must be provided in all posterior eye cases)
    a. Hand-held fundus cameras are available (e.g. Horus)
    b. iPhone/tablet adapters (described above) or a 20D condensing lens could provide an image.
2. OCT (some pathways also require anterior segment imaging with OCT/equivalent)
3. Optos widefield (e.g. Optomap image)

Appendix A

Some of the key requirements from the GOS contract and QiO Level 1 for service providers.

General Ophthalmic Mandatory Services Model Contract states that "The Contractor shall ensure that premises and equipment used for the provision of services under the Contract are:
25.1. Suitable for the delivery of those services; and
25.2. Sufficient to meet the reasonable needs of the Contractor's patients".

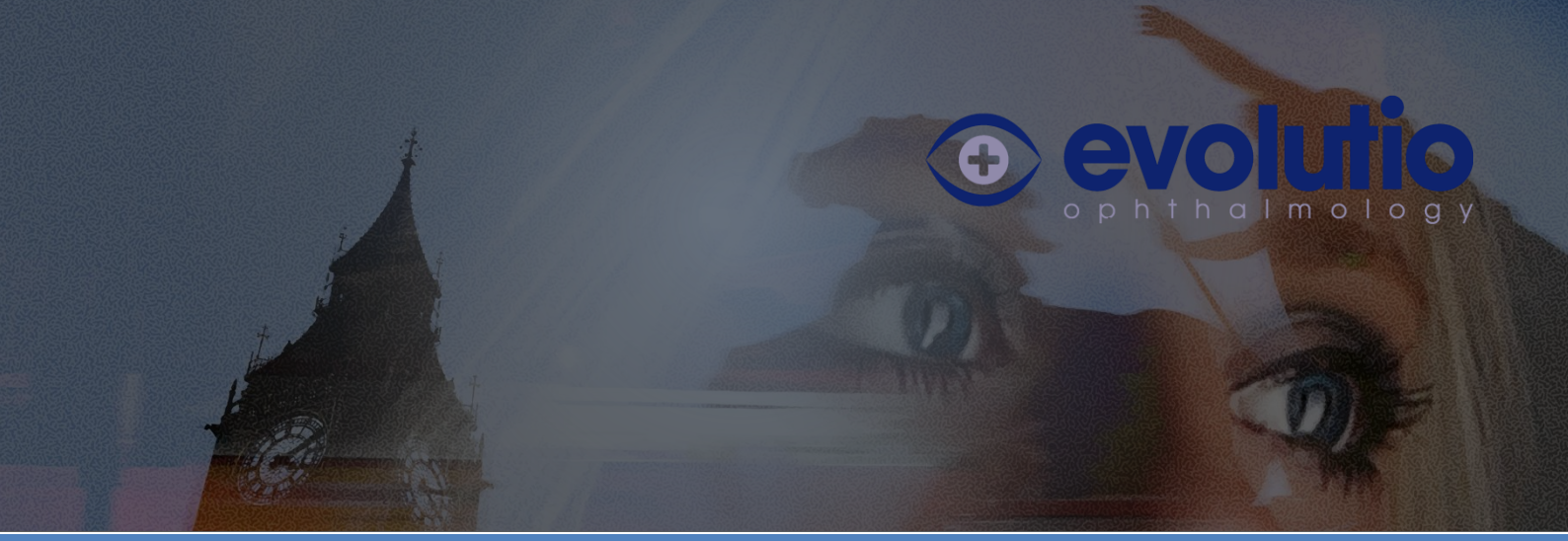
The QiO Contractor Checklist (Section B, subsection 24 'Clinical testing equipment') requires the following equipment to be in working order and be fit for purpose:

- Focimeter
- Frame ruler or similar
- Visual field test (Evolutio require the field analyser to have a working printer or method of exporting e.g. to PDF)
- Tonometer
- Distance test chart for adults
- Distance test chart for children/non-English/learning disability
- Trial lenses and accessories
- Trial frame (Evolutio will accept a phoropter as an alternative)
- Retinoscope
- Ophthalmoscope
- Distance binocular vision test
- Near binocular vision test
- Slit lamp
- Indirect ophthalmoscope or Volk lens
- Near reading chart
- Amsler grid
- Colour vision test
- Stereopsis test

The QiO Contractor Checklist (Section B, subsection 25 'Ophthalmic drugs') mandates the diagnostic drugs:

- Mydriatics
- Cycloplegics
- Staining agents (including at least fluorescein e.g. Biofluoro)

Evolutio also mandate topical anaesthetics



3.2 Medicolegal & Regulatory

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

- There are key differences between a sight test and an Evolutio community assessment. These must be clearly understood by the provider and patient.
- Evolutio Service Providers are required to follow a range of legal, regulatory and contractual obligations when assessing Evolutio patients, including the assessment of patients in a safe and appropriate timescale
- Service providers must maintain adequate indemnity insurance and understand the medicolegal differences between optometry-led and ophthalmology-led pathways

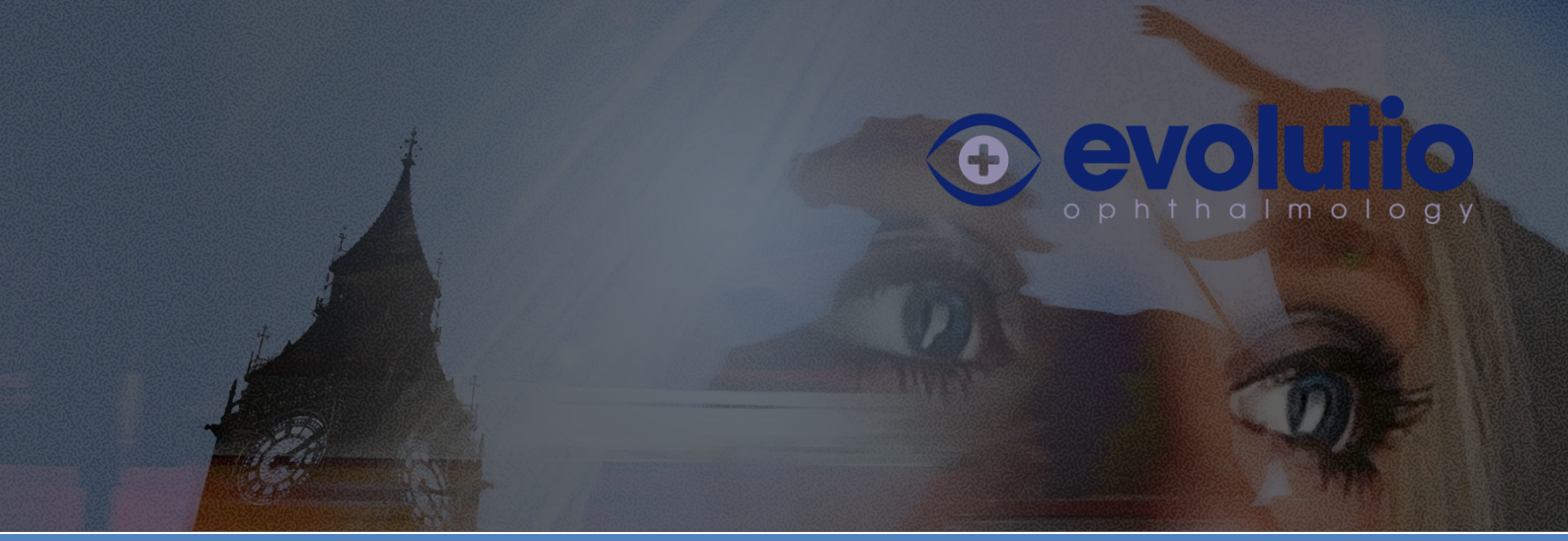
Key points

- Evolutio Service Providers are required to adhere to the Opticians Act (1989), GOC Standards, College of Optometrists Guidance and CMG's, NHS contractual requirements and Evolutio service contract
- This handbook defines Evolutio's expectations in terms of legal policies (section 1), clinical protocols and record keeping (section 2), clinical and practice standards (section 3) and appointment management (section 4)
- The provider and patient should understand that Evolutio's services are not a statutory sight test nor a full eye examination. College Guidelines state that "if you receive a referral, you should address the reasons for referral and advise the patient to consult their regular practitioner for routine eye care"; the appointment can be expedited where clinically indicated.
- Service providers may receive referrals from their colleagues for investigative procedures/treatment. College Guidance states that "when you refer a patient, you also transfer responsibility for the relevant part of the patient's care." It is therefore important for both practitioners to have a clear understanding of the extent of their responsibilities and to maintain a clear line of communication with each other and the patient.
- Service Providers are expected to be familiar with the College of Optometrists' Clinical Management Guidelines which provide information on "the diagnosis and management of a range of common and rare, but important, eye conditions that present with varying frequency in primary and first contact care."
- Service Providers require adequate insurance to practise in the UK; this indemnifies against allegations of clinical negligence. Service Providers should not practice outside the realms of their expertise or qualifications. Indemnity insurance usually covers any work done which is 'within the scope of normal optometric practice' but it is advisable to discuss your individual circumstances with your insurer if there is any uncertainty. In the event of a GOC complaint, you are judged against the standard of a reasonably competent optometrist; if the procedure is outside core competency you would be judged against the standard of an optometrist with whatever qualifications you currently hold (e.g. IP, Prof. Cert. etc.); opinions are usually provided by an experienced clinical optometrist known as an 'expert witness'.
- Optometry-led community enhanced optometry service appointments conducted in accordance with Evolutio's clinical protocols are at optometry core-competency; the College of Optometrist's Clinical Management Guidelines, relevant NICE guidelines and any local protocols should be followed. In cases of uncertainty the patient must be referred to a suitably qualified person with an appropriate level of urgency.
- Evolutio have a formal system of accrediting clinicians (and approved exemptions for some pathways). Your employer should be aware that you are carrying out this work. You should confirm with your insurer that you are adequately covered for this work.
- Service Providers who feel that they require additional training to meet their core competencies are responsible for making the necessary arrangements, usually as part of their PDP, and must only practice within the scope of their competency, skill and experience.
- If you have not been trained to undertake a particular procedure as part of a formal qualification, you should consider whether you have the necessary skill and competence. If not, you should undergo training and assessment, which is documented and signed off by an appropriate person.
- In terms of supervision, Evolutio have 3 pathways. In all cases patients must meet the pathway inclusion criteria:

1. Enhanced Optometry Services
   - Typical conditions: dry eye, watery eye, red eye, floaters
   - Led by: Optometry
   - Delivered by: Optometry
   - Competency: Optometric core competency for initial investigation (and management in many cases)

2. Community ophthalmology
   - Typical conditions: stable glaucoma monitoring, HCQR screening
   - Led by: Ophthalmology
   - Delivered by: Optometry
   - Competency: Clinical investigations are at optometric core competency (e.g. GAT, Volk, colour vision) and are listed in a clinical protocol. Monitoring/management is typically beyond optometric core competency, so Ophthalmologist sets diagnosis and management plan remotely

3. Intermediate pathways
   - Typical conditions: eyelid lump / OCT-commissioned OMR (low risk pigmented chorioretinal lesion / AMD)
   - Led by: Optometry with optional Ophthalmology input
   - Delivered by: Optometry
   - Competency: Clinical investigations are at optometric core competency (e.g. GAT, Volk, colour vision) and are listed in a clinical protocol. Many cases can be safely managed by optometry at core competency. Optional escalation to Ophthalmologist in cases of uncertainty.



3.3 Clinical Self-Reflection

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	James Syrett	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

Safe, appropriate clinical assessments and decisions, good quality record keeping and excellent patient service are the cornerstones of Evolutio's service:

- Legal and regulatory requirements (Opticians Act, GOC Standards, Evolutio Contract)
- Continuity of care (follow-up by yourself or another clinician internally or externally, including telemedicine)
- Patient safety (including appropriate onward referrals and safe discharge)
- Patient satisfaction (feedback, queries)
- Medicolegal (complaint, negligence)

Evolutio's Quality Team undertake a range of regular audit activities including provider decisions (via telemedicine and when working autonomously).

Service Provider contractors have a responsibility to ensure that all clinicians who deliver Evolutio's services within their practices adhere to the policies and protocols throughout this handbook, including proper accreditation, adequate record keeping in-line with our clinical protocols and good quality patient relations and communication.

Each clinician delivering Evolutio services is encouraged to reflect on at least 1 Evolutio case per month and keep a log, including their general approach to patient service. This process may be undertaken quarterly if necessary and aims to encourage self-reflection and continuous service improvement by reminding providers of their responsibilities.

Process

Using the spreadsheet at the end of this policy, randomly select at least 1 patient that you've seen each month, preferably on a variety of pathways:

- Insert Evolutio ID number
- Insert date seen
- Insert pathway
    - A = anterior
    - P = posterior
    - G = glaucoma/IOP
    - Other (specify e.g. HCQR)
- Score each section as either:
    - 0 (blank)
    - 1 (partially completed)
    - 2 (completed, including relevant positive and negative findings)
    - X (not indicated/not applicable

History and symptoms

1. Reason for visit
2. Symptoms (or asymptomatic)
3. Specific questions relevant to the presenting condition
4. Personal medical history (including medications and allergies)
5. Personal ocular history

Initial tests

6. Visual acuity (with pinhole if reduced)
7. Visual fields (where indicated)
8. Intra-ocular pressure
9. Other tests where indicated (e.g. colour vision, Amsler, pupils)

Anterior segment

10. Adequate slit-lamp examination of anterior eye structures

Posterior segment

11. Adequate slit lamp examination of posterior eye structures

Imaging

12. Anterior segment imaging (where indicated)
13. Colour fundus photographs (posterior pathways)
14. OCT (where mandated)

Management

15. Diagnostic impression (with no abbreviations)
16. Appropriate & clear management and advice (including treatment and recall)
17. Literature issued & SOS advice given

Patient service

Comment on the following behaviours (concerns must be reported to Evolutio immediately)

- Adequate infection control measures
- Introduces self by name/professional/puts patients at ease
- Patient seen on time
- Clear concluding summary (avoiding complex terms) with opportunity to ask questions
- Positive patient feedback
- Concerns

Outcomes

Providers are encouraged to discuss their findings with the contractor. Contractors may wish to discuss their reflections with their colleagues or Evolutio's Compliance Lead.

Any concerns or queries must be raised with Evolutio's Compliance Lead immediately.

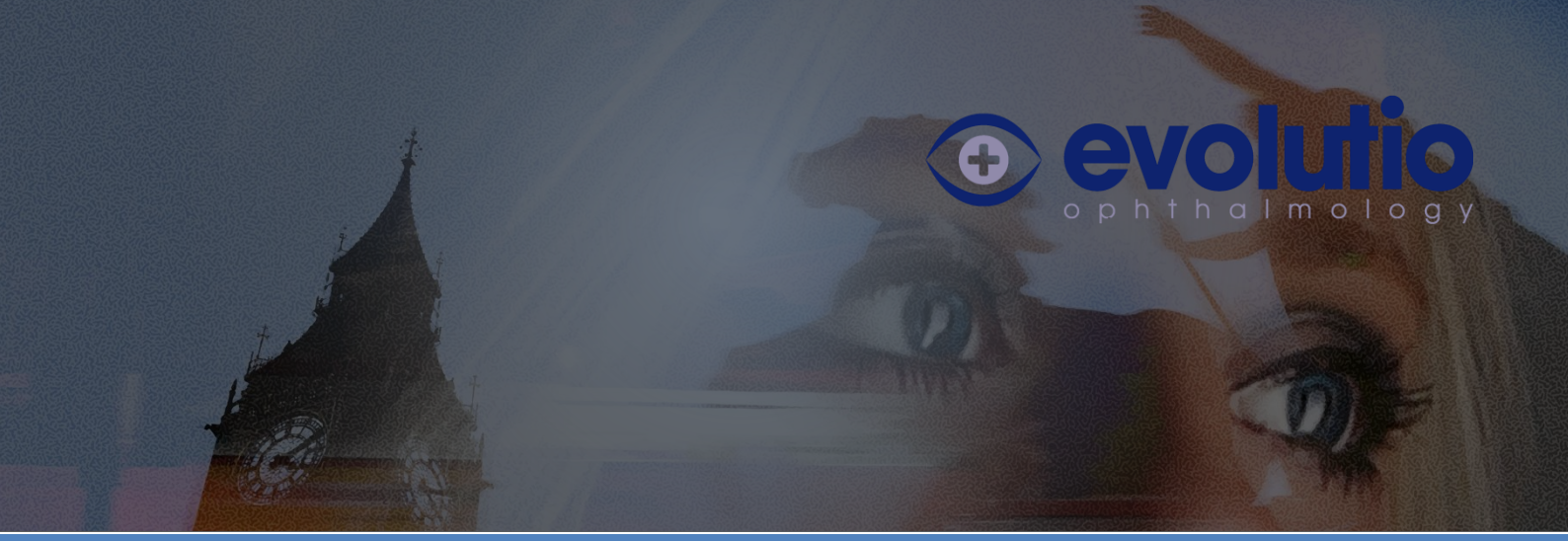
References

Quality in Optometry

College of Optometrists guidance for Professional Practice

Evolutio Clinical Self-Reflection Tool

Contractor name and practice							Clinician name					
Patient number	1	2	3	4	5	6	7	8	9	10	11	12
Evolutio ID												
Date seen												
Pathway (A / P / G / other - specify)												
History & symptoms												
1. Reason for visit												
2. Symptoms (or asymptomatic)												
3. Specific questions relevant to the presenting condition												
4. Personal medical history (with medications & allergies)												
5. Personal ocular history												
Initial tests												
6. Visual acuity (with pinhole if reduced)												
7. Visual fields (where indicated)												
8. Intra-ocular pressure (GAT for glaucoma pathways)												
9. Other tests where indicated (e.g. colour, Amsler, pupils)												
Slit lamp												
10. Adequate slit-lamp examination of anterior eye structures												
11. Adequate slit lamp examination of posterior eye structures												
Imaging												
12. Anterior segment imaging (where indicated)												
13. Colour fundus photographs (posterior pathways												
14. OCT (where mandated)												
Management												
15. Diagnostic impression (with no abbreviations)												
16. Appropriate & clear management and advice												
17. Literature issued & SOS advice given												
Patient Service (annual summary acceptable if no concerns)												
Adequate infection control measures												
Introduces self by name/professional												
Patient seen on time												
Clear summary and opportunity for questions												
Positive patient feedback or concerns												
Contractor comments and any actions taken												



3.4 Errors, Concerns & Continuous Service Improvement

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	James Syrett	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Overview

If you require support or clarification on any aspect of this policy, please contact Evolutio's Compliance Lead or Clinical Lead Optometrist.

Clinical Governance is a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Despite exemplary clinical governance, errors and complaints are inevitable in any healthcare service. Proactive organisations have a clearly defined process to capture, learn from and mitigate against a recurrence of complaints and errors. This process should encourage complaint/error reporting so all episodes may be captured, analysed and service improvements made with a focus on addressing the cause rather than attributing blame.

The Complaints Policy (section 1.6 of this handbook) describes how the public can make a complaint.

The Duty of Candour Policy (section 1.7 of this handbook) describes Evolutio's obligations to patients, relatives and the public by being open and honest about any mistakes that are made during patient care.

This 'Errors, Concerns & Continuous Service Improvement' policy offers service providers information and support when investigating or reporting an error, concern or complaint.

Key points:

- Each contractor practice must have a designated Complaints Manager (CM) and Deputy (DCM)
- All errors and complaints must be reported within 24 hours using the 'Error/Complaint Reporting Form' (see Appendix A)
- Any complaints made while the CM and DCM are not available in person must be briefed to the CM or DCM within 24 hours
- Evolutio's Clinical & Quality teams will review the report within 24 hours and, following further investigations as required alongside national guidelines, will classify the error and take the appropriate actions as dictated by Company Policy (including SI Policy and Near Miss Policy)
- See Section 1.6 'Complaints Policy' and Section 1.7 'Duty of Candour Policy' for more information

Complaints

Complaints may be verbal (in person or by phone) or written (letter, email, feedback form, solicitor). Complaints usually relate to one or more of 3 main aspects:

Clinical (issues relating to quality and safety of clinical care provided by healthcare staff)

- Quality: Clinical standards of healthcare staff
- Safety: Errors, incidents, and staff competencies

Management (issues relating to the environment and organisation within which healthcare is provided)

- Environment: Problems in the facilities, services, clinical equipment or staffing levels
- Institutional Processes: Problems in bureaucracy, waiting times or accessing care

Relationship (issues relating to the behaviour of a member of staff towards the patient or their family/friends)

- Listening: Healthcare staff disregard or do not acknowledge information from patients
- Communication: Absent or incorrect communication from healthcare staff to patients
- Respect and patient rights: Disrespect or violations of patient rights by staff

Errors

An error is an act of commission (doing something wrong) or omission (failing to do the right thing) which leads to an undesirable outcome or significant potential for such an outcome. Errors vary in severity based on the actual or potential harm experienced by a patient.

Patient harm includes injury, suffering, disability or death and may be classified as:

- None – whether impact prevented or not
- Low – required extra observation or minor treatment and caused minimal harm
- Moderate - required moderate increase in treatment, significant but not permanent harm
- Severe - resulted in permanent harm
- Death - directly resulted in death

The level of actual or potential patient harm informs the seriousness of the error. Errors are classified according to a traffic light system:

[RED] Serious incident (SI)

One or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened.

[AMBER] Potential adverse incident (Near miss)

These are indistinguishable from an adverse incident in all but outcome; the patient did not experience clinical harm, either through early detection or sheer luck. NB – classified as [RED] if there was the potential for it to be a SI.

[GREEN] Green occurrence

These are typically administrative errors which are unlikely to recur or result in patient harm but may provide useful learning opportunities to prevent recurrence and further improve service.

Provider process (Complaints and errors)

This should be managed by the Complaints Manager (or their deputy in their absence) and in a timely manner.

Verbal complaints

- Acknowledge the complaint, apologise
- Offer/undertake/arrange any necessary urgent clinical investigations/interventions
- Gather relevant information (see Appendix A)
    - Must be reported to Evolutio within 24 hours
- Advise patient that you or Evolutio will be in contact within 10 working days
    - Carefully log all conversations/communications/contact

Written complaints

- Offer/undertake/arrange any necessary urgent clinical investigations/interventions
- Gather relevant information (see Appendix A)
    - Must be reported to Evolutio within 24 hours
- Evolutio to issue standard letter acknowledging receipt of complaint and outlining next steps **(service providers must not send written communications to complainants without Evolutio's permission)**
    - If patient subsequently phones or attends in person, acknowledge the complaint and apologise and advise patient that you or Evolutio will be in contact within 10 working days from the date of the complaint
    - Carefully log all conversations/communications/contact

Errors (without complaint)

- Gather relevant information (see Appendix A)
    - Must be reported to Evolutio within 24 hours
- Offer/undertake/arrange any necessary urgent clinical investigations/interventions
- Carefully log all conversations/communications/contact

Overview of Evolutio's investigation process

Patient satisfaction is paramount to Evolutio and it is essential that patient concerns are taken seriously and investigated and addressed thoroughly. The overarching objective of the complaints process is to identify the cause and mitigate against a recurrence rather than focus on attributing blame.

The following is a high-level overview of the typical steps taken by Evolutio's Clinical and Quality Teams when investigating a complaint. See Section 1.6 'Complaints Policy' and Section 1.7 'Duty of Candour Policy' for more information:

1. Gather information
   - Interviews (for example cognitive interviewing)
   - Retrospective clinical records
   - Photographs

2. Map the incident
   - Narrative chronology
   - Timeline

3. Identify care and service delivery problems
   - Multidisciplinary review meeting including Clinical Team as required

4. Analyse problems to identify contributory factors and root causes
   - Fishbone analysis

5. Generate solutions and recommendations
   - Serious complaints are usually managed by Evolutio directly
   - In less serious cases Evolutio will support and advise the Provider in implementing the solution (e.g. patient communication)

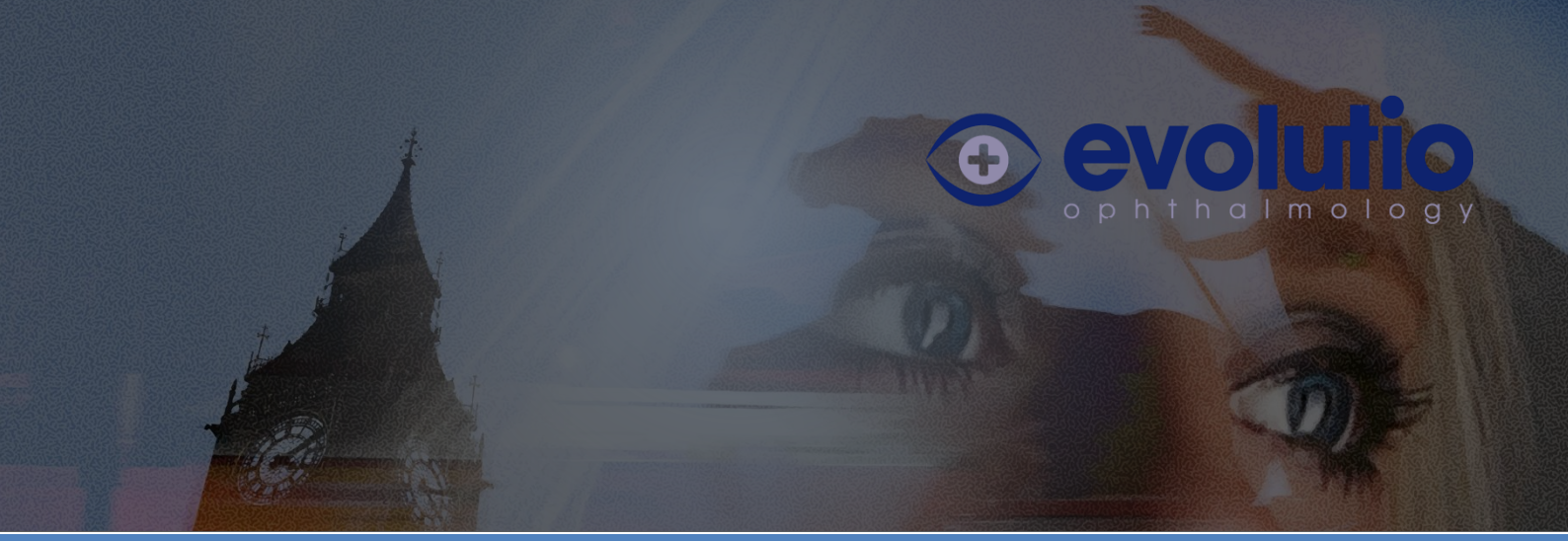
6. Disseminate learnings (internally and externally) and send appropriate reports (e.g. CCG)

Appendix A: Error/complaint reporting form

Please complete and forward this form to Evolutio's Clinical Lead Optometrist within 24 hours of the error being detected or the complaint being received – email to: ***complaints@evolutio-ophthalmology.co.uk***

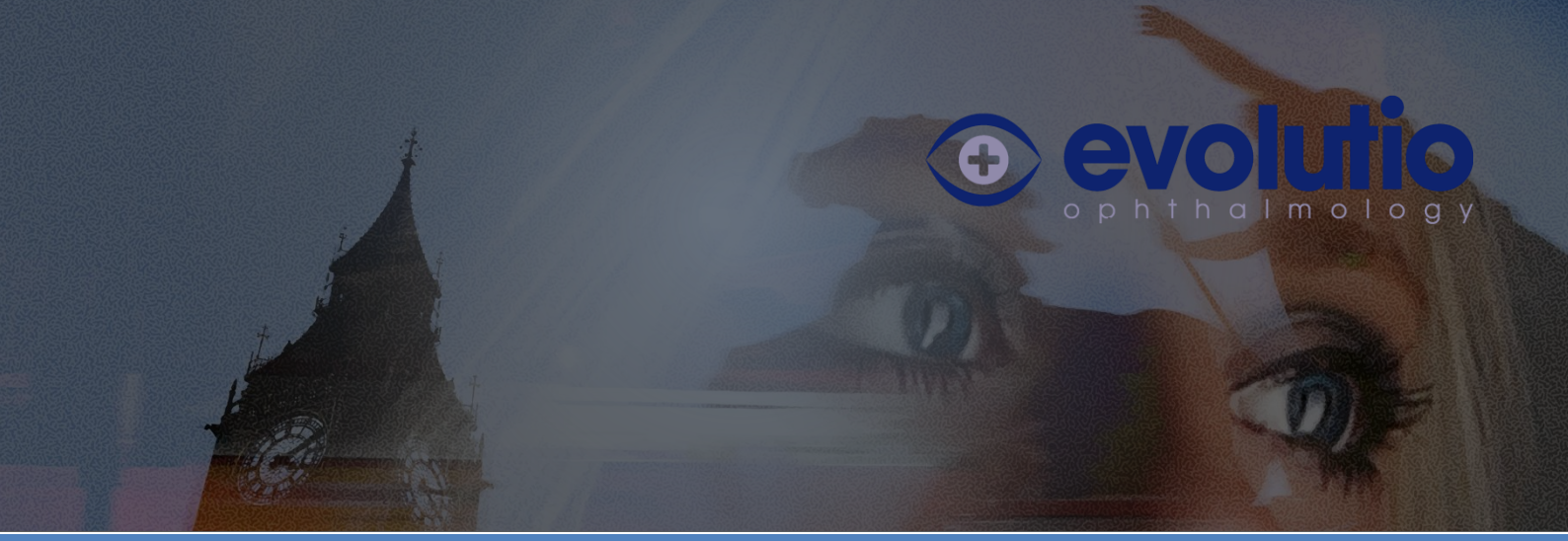
PLEASE DO NOT INCLUDE ANY PATIENT IDENTIFIABLE DATA ON THIS FORM, THE EVOLUTIO ID IS SUFFICIENT

Person completing this form:	
Your position (e.g. contractor, owner, optometrist etc.):	
Practice name:	
Today's date:	
Evolutio referral ID number:	
Incident date:	
Clinician name (if relates to a clinician):	
Brief incident description (timeline of what happened and why. Include comments made by others involved where relevant):	
How was the error detected (or complaint received):	
Actual effect on the patient and/or service (type of harm, if any, risk, financial loss):	
Action taken so far (including communications with patient):	



Evolutio Ophthalmology Handbook

Section 4: CLINICAL OPERATIONS & ADMINISTRATION



4.1 Appointment/Clinic Management

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Mr. Simon Hardman-Lea	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	3.0

Overview

This policy covers a range of operational responsibilities for Service Providers to ensure safe referral management, including timely acceptance, booking, rejection and telemedicine interaction; clinic optimisation tips are offered.

Providers must monitor their incoming referrals each day as well as cases received 'From Telemed' due to their responsibilities in actioning referrals, contacting patients for discussion and arranging follow-ups.

It is essential to maintain clear records regarding appointment arrangements and conversations with patients, particularly in cases of cancellations and DNAs.

Any rejections must be actioned promptly and with sufficient explanation.

Our Eloomi training platform offers a suite of training videos which illustrate Evonnect's various features as described in this policy.

Accept/Reject silo and appointment availability

Service Providers are required to review, grade and prioritise all referrals (using the accept/reject silo) within one working day of entering an Evolutio pathway. Contractual requirements vary by CCG and presenting signs/symptoms (see your local handbook for more information). Typical timescales:

- Routine – appointment offered within 1 week, for clinic review within 4 weeks
- Urgent - appointment offered within 48 hours, for clinic review within 2 weeks
- Rapid Access - appointment offered within 24 hours, for clinic review within 1-5 days (depending on presentation)

The patient **MUST** be accepted **BEFORE** contacting the patient to book an appointment/undertaking the examination. The only timescale exception would be if the patient has requested an alternative date which is clinically safe/appropriate, and this has been recorded in the notes.

Appointments must be offered between Monday and Saturday (inclusive), preferably with some appointments outside of 09:00-17:00 core hours. Where the Service Provider is unable to meet the time to care requirements, they must reject the referral within the timescales described in the 'rejections' section below, including a sufficient explanation.

Appointment duration and patient advice

Service Providers must allocate sufficient appointment time for accurate completion of the recommended tests to the required standard.

Many factors can influence the required appointment duration including patient mobility, communication, complexity and mental capacity; where possible, reasonable adjustments should be made to accommodate such needs and Evolutio recommend a minimum initial appointment duration of 20 minutes.

The initial appointment with a new patient often takes longer than subsequent follow-up/review appointments. Delegating functions (e.g. visual fields) to a trained clinical assistant can help to reduce appointment times.

Patients should not have to wait to be seen for more than 30 minutes beyond their booked appointment time.

Patients must be advised about the likely length of their appointment. Given that many patients will have a dilated examination, it is important to advise them of the effect this might have on their vision and ability to drive/work.

Walk-in service

Some patients will contact the Provider by phone or in person with acute signs/symptoms e.g. red eye, pain, floaters. Service Providers must, within reason, be able to offer an appointment within 2 working days (usually the next available appointment within that timescale depending on clinical presentation) for such patients.

A dedicated walk-in assessment form has been developed containing standardised questions (e.g. onset, presence/absence of pain, floaters, redness etc). This may be completed by a non-clinical member of staff and will assist in providing a basic history so urgency can be assigned by a clinician, using their clinical judgment with reference to professional guidelines.

Providers should select themselves as the providing practice (and mark as 'internal/self referral') so the referral bypasses Evolutio's central triage service and moves directly to your accept/reject silo.

Where the Service Provider is unable to meet the time to care requirements, they should advise the patient of the most suitable service and organise onward referral; for potentially sight-threatening signs and symptoms, this might be to advise attendance at eye casualty or a hospital eye clinic in accordance with agreed protocols. For non-emergency cases, Evonnect will assist the Provider in generating a referral which can be sent to Evolutio for urgent triage.

Cases which do not meet the criteria for the walk-in service (e.g. overdue glaucoma patient) should not enter the walk-in pathway.

Rejections

All rejections must be completed within the following timescales and with a sufficient explanation:

- Unsuitable for contractor - 2 working days
  - e.g. we do not offer lacrimal syringing
- Unable to contact routine patient – 3 different forms of communication over a 3 week period
  - e.g. unable to contact patient despite calls/SMS/email/letter on different days and at different times
- Unable to contact urgent patient – 3 calls/SMS at different times over 2 working days
  - e.g. unable to contact patient despite multiple calls/SMS at different times

Failure to adhere to these timescales may result in in a suspension of your contract pending further investigation (as specified in the patient safety clause in the Provider contract).

Unable to contact

Service Providers are advised to attempt to contact patients at least 3 times by telephone and at different times of day, keeping a record of each failed contact and whether a message was left. SMS messages may also be used inviting patients to make contact. For routine cases, it is acceptable to write to a patient to invite them to make contact if you have been unable to contact them by telephone.

Steps

1. Highlight the referral
2. Reject as 'unable to contact' with notes – "Unable to contact despite several attempts"

Cancellation

If a patient cancels an appointment and provides reasonable notice, the Service Provider must arrange another appointment. The timescale will be determined by the Provider's professional judgment with consideration given to the initial agreement from the time of receipt of the referral:

If a patient cancels 2 appointments, the Provider may at their discretion discharge the patient back to their GP, with appropriate correspondence e.g. *Dear GP, I am returning this patient to your care as they have cancelled several appointments. Please re-refer if the patient wishes to uptake care. Thank you.*

DNA's

If a patient fails to attend for their appointment, the Service Provider must mark the patient as 'DNA' in the Evonnect calendar using the 'DNA' button. You must then contact the patient within 2 working days, informing them that they have missed their appointment, and ask them to arrange a further appointment (with an appropriate level of urgency and with appropriate advice).

Should a patient fail to re-arrange an appointment within 7 working days of contact being made (or fails to attend their re-arranged appointment) then the Provider should discharge the patient back to their GP.

If a patient fails to attend for 2 appointments, the Provider may at their discretion discharge the patient back to their GP, with appropriate correspondence e.g. Dear GP, I am returning this patient to your care as they have failed to attend several appointments. Please re-refer if the patient wishes to uptake care. Thank you.

Steps

1. Highlight the missed appointment so the patient's contact card appears
2. Choose DNA booking at the bottom of the screen (this will bring up the "DNA communication" screen)
3. Choose the type of communication you require – this will move the referral into the DNA tab in the 'to book' silo
4. After 7 days -if no contact from px then reject using the DNA reason ("unable to contact, many attempts made"

If the Evonnect calendar is not used, then attempt contact via telephone. If after 7 days no contact from patient - discharge as above.

Silo management

- Daily review
    - Accept/reject silo – accept or reject incoming referrals
    - From telemed silo (especially urgent cases) – accept/reject telemed outcomes with patient contact as required

- Additional review (every 2-3 days)

- To action silo: follow-up contact (especially urgent cases) - contact to book/discharge
- To action silo: DNA tab (for calendar users) – contact to rebook/discharge
- Pending silo – investigate any cases dated before today
- Retained silo – contact patients who are overdue for follow-up

To Book silo

- 'To contact' tab
  - These referrals have only been accepted
  - Will have either had a text/email or they need to be contacted ASAP

- 'Follow up' contact tab
  - Had some form of contact but have not yet booked (need or missed appt)
  - Preferably 3 forms of contact before the TTC is needed
    - Different forms advised - text, voicemail, letter
    - Letter can be in the form of UTC button if all other contact been done first
  - If TTC reached (e.g. urgent 2/52, soon/routine 4/52) and still no contact from patient then discharge to GP with notes "Unable to contact, please discharge to GP, TTC reached."

Tips:

- Click the top of the TTC date column so these are now in date order (oldest at the top)
- Work through each referral and check the notes at the bottom of the contact card
  - When was the last contact?
  - How much contact?
  - If reached TTC do they now need to be rejected?
- Last Contact column (click to sort by date order) is a good indicator of when we last contacted the patient - work through to make more contact or discharge
- Contact frequency (do daily so you only have a few each day)
  - Soon/routines weekly
  - Urgent every 2-3 days
  - Generally there should not be any in this silo that have not had contact for more than 7 days

- 'DNA' tab - This silo is for patients that have missed their appointment and not yet re-booked.
  - They will only appear in here if we have DNA'd their appt on the calendar (i.e. if you don't use the calendar you won't have access to this function/tab – we strongly advise using the calendar)
  - Once the DNA button is pressed on the calendar you are prompted to contact the px via text message or letter
  - If the px calls to re arrange it will go back into Px exam pending
  - After 7 days you can discharge the px to the GP as a DNA (depending on urgency)

Patient Exams Pending silo

This silo should only consist of patients that have an upcoming (pending) appointment. It works differently depending on whether or not a provider is using the calendar function:

- Non-calendar users
  - Date and **time** must be entered when booking otherwise the 'next booking column' can't be sorted in date order. If only the date is inputted the software will show "none" so it will become very difficult to manage this silo.
  - If you put this column in date order, all should be upcoming appts. Any dated before today that have not had a visit should be investigated.
    - Could be that a visit was not created despite seeing the patient
    - Could be DNA
      - Need to contact patient, cancel appointment with note "DNA'd appt" then it will move back to the "to action silo"

- Calendar users
  - This silo will work in the same way as described above but once the appointment is booked on the system it will update the date and time so the 'next booking' column can be used
  - DNA's can be processed correctly from the calendar ensuring the patient gets a DNA letter/SMS and can easily be actioned from here (discharged or rebooked)
  - Using the calendar also allows you to send SMS/email confirmation of the appointment

Retained For treatment silo

This silo should only have the patients in that have been retained for follow-up.

- Can sort by 'follow-up due' column to highlight those overdue for recall
- Add notes if struggling to contact patient then easy to keep track of patients still to book vs discharge if unable to contact
    - Typically a non-urgent follow-up would be discharged after 3/12 of regular contact
- Once the appointment has been booked correctly these referrals will then move in to the 'Patients Exams Pending' silo

Drafts silo

Should be emptied every day (ideally by the end of each visit).

From Telemed silo

These should be checked and accepted/rejected every day and complete any action required.

Translation services

If an NHS patient requires a translation service (including sign language) for their NHS appointment, a translator will be provided by Evolutio. You can request a translator by emailing *support@evolutio-uk.com*, providing the nature of translation required, the date of any appointments that have been made and the referral ID of the patient. Please note that translators are not always available therefore it is advisable that you book an appointment with a patient only once a translator has been made available and the dates of availability have been confirmed.

Transport requests

Patients referred to hospital or other NHS premises for specialist NHS treatment or diagnostic tests by your doctor or another primary care health professional, may be able to claim a refund of reasonable travel costs under the Healthcare Travel Costs Scheme (HTCS).

To qualify for help with travel costs under the HTCS, patients must meet 3 conditions:

1. At the time of the appointment, the patient or the patient's partner (including civil partners) must receive one of the qualifying benefits or allowances listed on the link below, or meet the eligibility criteria for the NHS Low Income Scheme
2. The patient must have a referral from a healthcare professional to a specialist or a hospital for further NHS treatment or tests (often referred to as secondary care)
3. The appointment must be on a separate visit to when the referral was made. This applies whether the treatment is provided at a different location (hospital or clinic) or on the same premises as where your GP or another health professional issued the referral

Further information on the HTCS can be found at https://www.nhs.uk/using-the-nhs/help-with-health-costs/healthcare-travel-costs-scheme-htcs/

Please note that Evolutio don't manage the HTCS. Refunds must be organised directly with the NHS by completing a HC5 (T) claim travel charges (PDF, 35.5kb) and posting it to the address stated on the form.

Optimising clinic structure – Useful tips

Service Providers are experienced business owners and we are mindful of the need to offer sight tests as well as Evolutio appointments. We offer clinic management guidance for your consideration to help maximise efficiency and ensure the patients you see are due an appointment and require your services.

Evonnect does not currently integrate with all optometry practice management systems so Providers who elect not to use Evonnect's calendar might wish to create a 'dummy' patient within their practice management software named

'Mr. Evolutio' and include the 6 digit referral ID number in the associated booking notes to cross-reference the booking between the 2 systems. Some additional tips follow:

Clinic management

- Clinic preparation the night before – NHS forms, paper records
- Offer 'cold' clinic times to patients who are flexible

Delegate clinical and other duties to trained and validated assistants

- Pre-screening (including fundus photography, visual fields, OCT etc.)
- Instillation of eye drops

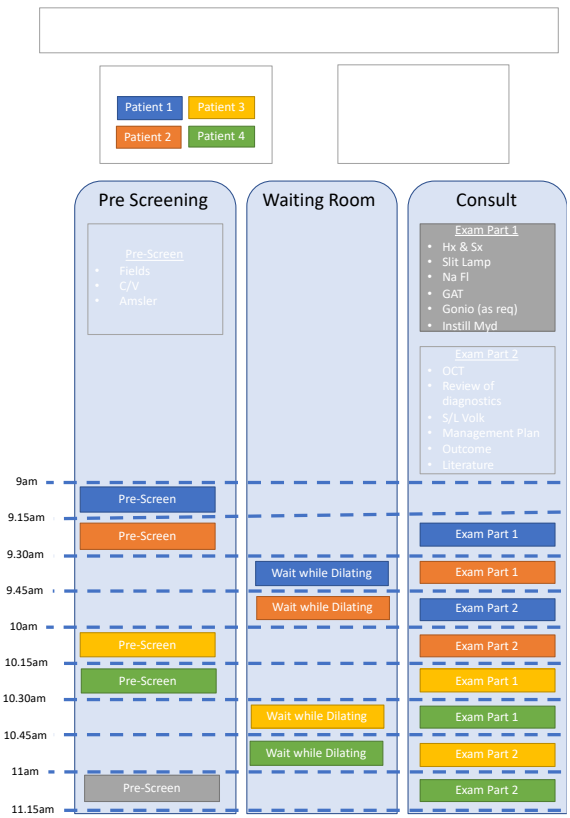
Minimise waster appointment slots

- Check they are due for an appointment
- Advise patients to bring their spectacles (and CL wearers to bring CL case)
- Ring and remind the night before (or SMS

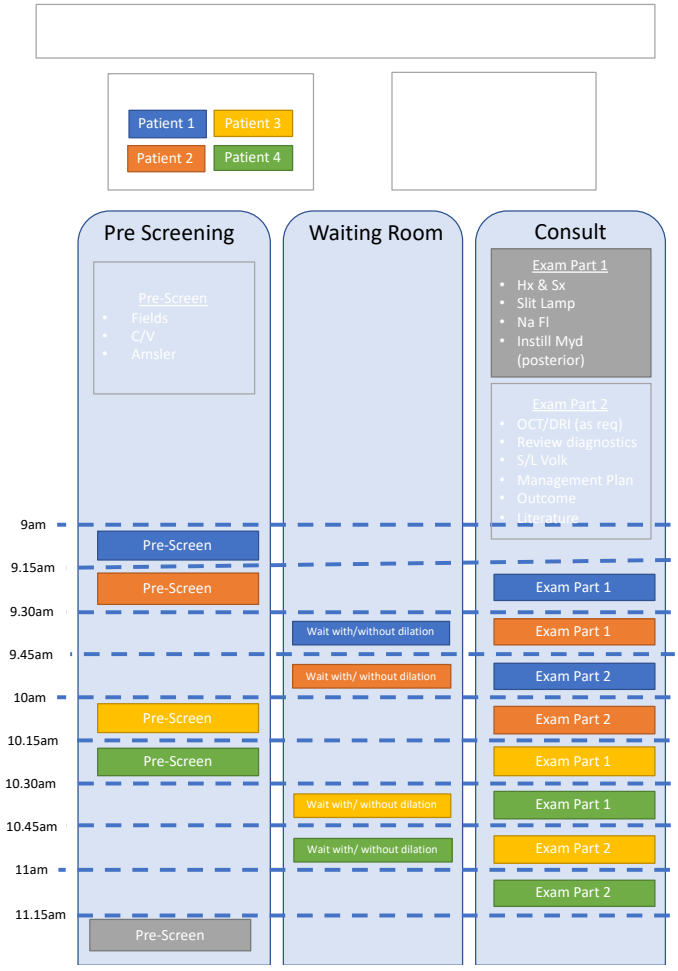
Managing walk-ins

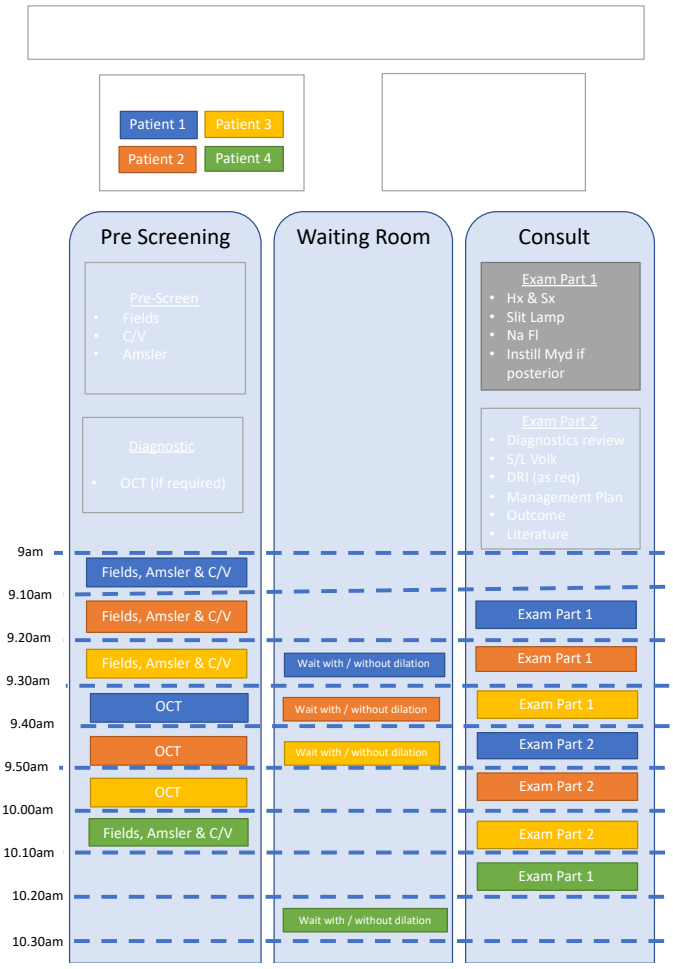
- Consider leaving a 15 minute slot mid-afternoon for emergencies – this can be scaled with changing demand. An unfilled slot can be used for a walk-in sight test, training or admin duties
- Emergencies may also be seen at the end of the clinic
- Clinicians may opt to see emergencies during their break (considering the urgent patient need and remuneration the service offers)
- Multiple rolling clinics allow greater flexibility

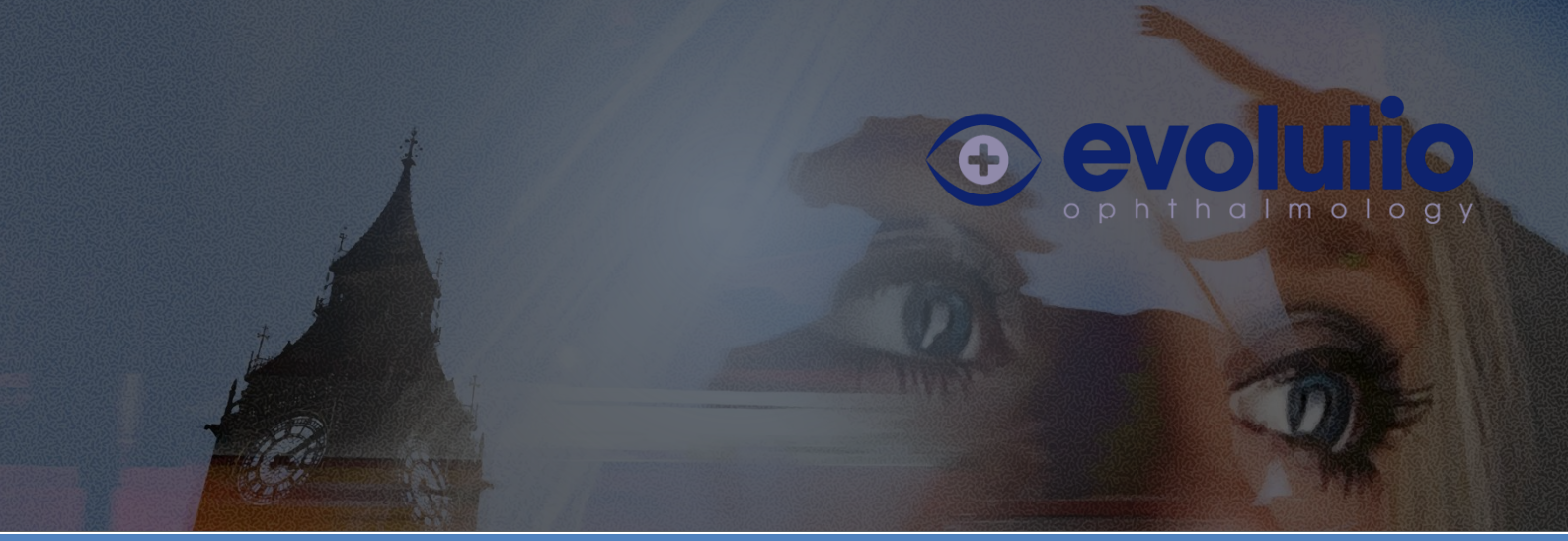
Sample structure for a glaucoma clinic with delegated diagnostics (20 or 30 minute appointments)



Sample structure for a general clinic with delegated diagnostics (20 or 30 minute appointments)







4.1.1 Provider-Patient Communication

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Christian Dutton		
Business Unit Head Sign Off	Lyn Price	**Date**	01/04/2021
Review Date	01/04/2023	**Version**	2.0

Describing the Evolutio Service

The following phrases are intended to help service providers and their staff when discussing the Evolutio service with patients. The first contact between a provider and patient is often the most important as it provides clarification about and therefore confidence in the service.

Why am I being booked into an optician's practice instead of the hospital?

We've received a referral from XX. We work alongside the hospital to deliver a specialist NHS medical eye service which is overseen by our lead consultant ophthalmologist – this is different to a normal sight test and is a separate part of our business. We find that people often prefer being seen in the community rather than in a busy hospital and we can usually offer shorter waiting times in a more familiar environment closer to your home.

Will I be seeing a consultant/eye doctor?

Optometry-led pathway: Your referral suggests that you can be safely seen by a specialist clinical optometrist first. Many eye conditions can be managed this way and it saves you waiting many months to see a hospital eye doctor. If necessary, the optometrist can ask one of Evolutio's eye doctors to review your case.

Ophthalmology-led pathway: You will be seen by a specialist clinical optometrist who works under the consultant's supervision. This is a common arrangement used in hospital clinics. All test results and the management plan will be reviewed and approved by the consultant team. The only conditions we don't handle are surgical and highly complex cases.

Are you an eye doctor?

Optometry-led pathway: I'm a specialist optometrist rather than an ophthalmologist. I have the necessary equipment and training to assess your eye condition. If necessary, I can ask one of Evolutio's eye doctors to review your case.

Ophthalmology-led pathway: I'm a specialist optometrist and I work under consultant supervision. This is a common arrangement used in hospital clinics. I will conduct the tests which the consultant has requested and discuss my findings with you. The consultant will then review my findings and finalise the management plan. The only conditions we don't handle are surgical and highly complex cases.

Starting the appointment

Optometry-led pathway: You've been referred into us because …. To save you a visit to the hospital we will conduct several standard tests then we'll discuss the results and next steps. A minority of patients still need to visit the hospital but it's usually less than 10%.

Ophthalmology-led pathway: You've been referred into us because …. To save you a visit to the hospital we will conduct several tests which have been requested by my consultant. We'll then discuss the results and next steps. A minority of patients still need to visit the hospital but it's usually less than 10%.

In cases of diagnostic uncertainty

Be decisive with your management plan wherever possible. If unsure:

- If the Ophthalmologist agrees, we will see you in XX months
- My feeling is … but I'm going to ask for my consultant's opinion and I'll give you a call next week to discuss

If the consultant's plan is significantly different to what you discussed with the patient, it is advisable to phone them to discuss.

Thanks for checking my eye health, what happens next?

Be decisive with recall:

- "You will get a call beforehand to arrange the appointment"
- "We'll send a report to your GP. Your optometrist can download our free app and register to read the report."

If there's any ambiguity at the end of the appointment (or if patient requests a copy):

- "After you case has been reviewed by the consultant team, we'll print a copy of the report for you to collect"

Post-Telemed discussion

When accepting a case which has been returned to you following telemed review, ensure that you (or a delegated member of your team) contact the patient to update them with any changes in the management plan, or if a prescription request is being issued. Common examples include:

- Change of follow up date (e.g. clinician advised 6/12 review, telemed reduced to 4/12 review)
- Change of outcome (e.g. clinician discharged but telemed chose to retain)
- Change of treatment (e.g. prescription request issued, prescription differs from that recommended during the visit)
- Change of diagnosis/impression (e.g. clinician proposed OHT, telemed set impression as POAG)

In many cases this task can be delegated to the 'Evolutio Champion' within your team however on occasions a call from the clinician will be necessary (e.g. clinical matter, particularly nervous patient, patient with some mental health/cognitive concerns).

When a prescription request is made (to the GP), please inform the patient that this process usually takes approximately 7 days:

1. The full record will be reviewed by the consultant-led telemedicine team, usually within 48 hours
2. Telemed will finalise the prescription request and send an electronic copy to the GP
3. The GP will need to review the request and issue the prescription before it can be collected
4. Patient collects the prescription as usual and takes it to the pharmacy (or follows the usual process for electronic prescriptions)
5. Patients are advised to read the associated literature carefully and report any concerns

Delivering unfavourable health information

Based on SPIKES – A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer, W. Baile et al, The Oncologist, 2019.

'Bad news' may be defined as "any information which adversely and seriously affects an individual's view of his or her future". Whilst it is uncommon for optometrists to deliver news about life or sight threatening disease, some of the techniques in this study should be borne in mid.

1. 'S' – Setting up the interview

- Privacy
- Involve significant others
- Sit down
- Make a connection with the patient (e.g. eye contact, touching the patient on the arm, if appropriate)
- Manage time constraints and interruptions

2. 'P' – Assessing the patient's perception

- Use open-ended questions to create a reasonably accurate picture of how the patient perceives the medical situation— what it is and whether it is serious or not
- Based on this information you can correct misinformation and tailor the bad news to what the patient understands

3. 'I' – Obtaining the patient's invitation

- Does the patient express a desire for full information about their diagnosis, prognosis, and details of their illness?
    - "How would you like me to give the information about the test results?
    - Would you like me to give you all the information or sketch out the results and spend more time discussing the treatment plan?"

4. 'K' – Giving knowledge and information to the patient

- Warning the patient that bad news is coming may lessen the shock and may facilitate information processing
    - "Unfortunately I've got some bad news to tell you" or "I'm sorry to tell you that…"
- Start at the level of comprehension and vocabulary of the patient

- Do not use overly blunt language

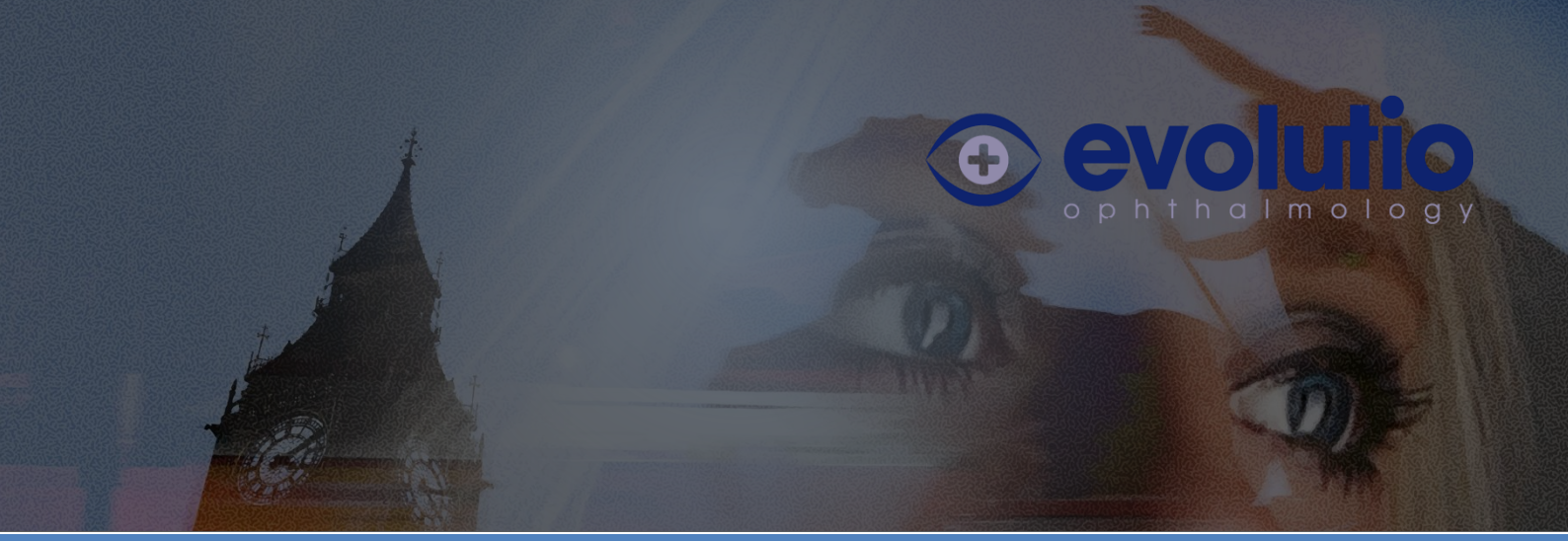
5. 'E' – Addressing patient emotion with empathic responses

Be empathetic to the patient's emotional needs:

- Observe patient for emotions (e.g. tearfulness, a look of sadness, silence, or shock)
- Name the emotion to yourself and use open questions to establish what they are thinking or feeling
- Identify the reason for the emotion (usually related to the bad news but ask if unsure)
- After a brief period of time, let the patient know that you have connected the emotion with the reason for the emotion by making a connecting statement.

6. 'S' – Strategy and summary

- Patients who have a clear plan for the future are less likely to feel anxious and uncertain
- Share responsibility for decision-making
- Clinician discomfort is often based on uncertainty about the patient's expectations, fear of destroying the
- patient's hope, fear of their own inadequacy in the face of uncontrollable disease, not feeling prepared to manage the patient's anticipated emotional reactions, and sometimes embarrassment at having previously painted too optimistic a picture for the patient
- Many patients already have some idea of the seriousness of their illness and of the limitations of treatment but are afraid to bring it up or ask about outcomes. Exploring the patient's knowledge, expectations, and hopes will allow the physician to understand where the patient is and to start the discussion from that point.
- Expressing fears and concerns will often allow the patient to acknowledge the seriousness of their condition



4.2 Invoicing Guidelines

Business Unit	Head Office	**Location**	Newtown House, Newtown Road, Henley on Thames, Oxon, RG9 1HG
Completed By	Karen Anderson		
Business Unit Head Sign Off	Peter Price-Taylor	**Date**	06/03/2021
Review Date	01/04/2023	**Version**	5.0

Invoicing guidelines

In accordance with the GOC's Standards of Practice (8.1), it is the clinician's professional obligation to maintain contemporaneous patient records, therefore the clinical record MUST be completed in full on the day of the examination (i.e. it is unacceptable to complete a record on Evonnect at a later date; this might also result in non-payment).

If you are legally contracted with Evolutio, you will be paid a fee for the clinical pathway that has been authorised by Evolutio's clinical triagers. If you do not feel that the pathway proposed is correct, then you should reject the case with supporting evidence (e.g. unexplained loss of vision so should be on MECS pathway not cataract pre-op pathway). If you choose to undertake investigations beyond those required in the authorised pathway you will not be paid an additional fee.

To ensure accurate and timely payment of appointments, Evolutio operates a monthly self-billing sales invoice system. We will raise a self-billed sales invoice based on the activity recorded in eVonnect. Further details are below:

For the purposes of this document, the 'Contractor' is Evolutio Care Innovations Ltd. and the 'Service Provider' is the sub-contractor who delivers Evolutio's services.

1. No fee shall be payable for an appointment unless the Evolutio service provider has undertaken a face to face appointment (or, where commissioned and clinically indicated, a virtual appointment) with the patient and the service provider has uploaded a completed Outcome Report of the clinical visit to eVonnect.

2. Payment of the fee to the Service Provider by the Contractor for the Services is subject to:
    a. NHS payment validation; and
    b. Completion of each Appointment. Appointments shall only be deemed completed by the Contractor when the Service Provider has uploaded an Outcome Report relating to the Appointment onto eVonnect; and
    c. Completion of the table below to ensure that the self-billing sales invoice is issued correctly:

Name of organisation:	
Name of invoicing contact in your organisation:	
Email address of invoicing contact in your organisation:	
Postal address that should appear on your invoice template:	
Your organisation's VAT number:	
Your organisation's bank details: *Sort code* / *Account Number*	/
Account Name	
Bank Name	
Email address to send remittances to:	

3. Around the 15th working day of the month after the service was provided, the Contractor will issue a self-billing sales invoice to the Service Provider based on activity generated by eVonnect. This will show:
    a. The number of completed appointments each Service Provider has conducted during the appointment month,
    b. The unique patient referral ID of each patient; and
    c. The financial amount due to the Service Provider based on the completed appointments.

    Payment will be made to the Service Provider's nominated bank account within 45 days following the month of activity. The Service Provider will be notified in advance of this settlement via the issuing of a standard remittance advice.

    If the Service Provider is late in completing appointments within the calendar month, as required in paragraph 1, this may result in appointments not being paid as it needs to be reconciled monthly with the relevant Contracting CCG.

Please direct invoicing queries to: *accounts@evolutio-uk.com*