clinical governance in optometric practice

Quality in Optometry in Wales

A toolkit for clinical governance in optometric practice

www.qualityinoptometry.co.uk

Version 1.0 August 2007

Optometry Wales

ABDO

AOP Association of Optometrists

The College of Optometrists

FODO Federation of Ophthalmic and Dispensing Opticians

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A toolkit for clinical governance in optometric practice

This document explains what clinical governance means and its relevance to optometry in Wales. It comprises an introduction, a checklist to be used for a quick assessment of your current position and a lengthy table that shows how the various aspects of clinical governance in optometry in Wales fit with NHS Wales thinking. Finally, it describes the use of the electronic toolkit, available on the internet at **www.qualityinoptometry.co.uk**, which will assist in meeting all aspects of clinical governance. (See "How to use this toolkit.")

This document will be regularly reviewed and updated. Any future updates will be placed on the website version of the toolkit and therefore the electronic version will always contain the most up-to-date information.

Contents

Introduction

Clinical Governance is all about maximising quality of care, patient safety and service delivery on an on-going basis. It covers many aspects of practice from Health and Safety to clinical interactions. It is not new to optometry since many aspects of clinical governance are enshrined in legislation or regulation as well as in the College of Optometrists' code of Ethics and Guidance on Professional Conduct and in other guidance documents. In some ways it might be analogous to the quality control exerted by a major supermarket chain on its suppliers, or by airlines and railways to ensure passenger safety, all of which most people would regard as good things. Although originating within the NHS, clinical governance is a quality framework and, as such, is clearly applicable to both NHS and private practice. Given the current trends for litigation and fraud investigation, operating an effective clinical governance framework can provide a safer working environment for the practice owner and staff as well as the patient.

The concept of clinical governance in the NHS began in 1998 with the publication by the Department of Health of the document "A First Class Service: Quality in the NHS" which provided the following and now widely used definition of clinical governance:

"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."

Initially clinical governance in Wales was seen to consist of a series of five themes for improving quality and ensuring that professionals were accountable for their practice. These themes were patient experience; quality improvement; staff focus; use of information; and leadership, strategy and planning.

The focus of clinical governance has since changed significantly in the light of reports such as the Kennedy report on the Bristol Children's Hospital (2001) and "Building a Safer NHS for Patients" (2001). These reports and the launch of the National Patient Safety Agency in September 2001 mapped out the quality agenda in terms of the objective of creating world-class health and social care for Wales in the twenty-first century mapped out in "Design for Life" (2005).

Thus, from the perspective of the National Assembly for Wales and local health boards, the focus on standards has moved on from the clinical governance themes approach and is now detailed by more recent thinking in "Healthcare Standards for Wales" (2005). (There is a similar document for England.) Local health boards are required to engage in clinical governance with, amongst others, all their contractors and they are monitored on their performance by the Healthcare Inspectorate Wales.

The standards cover the following areas, known as "domains:"

- Patient experience
- Clinical outcomes
- Healthcare governance
- Public health

The standards within the domains have been organised so that they can be directly mapped across to existing clinical governance guidance in Wales as illustrated in the table opposite:

Standard Number	Domain	Clinical Governance Theme
1-10	Patient experience	Patient experience
11-13	Clinical outcomes	Processes for quality improvement
14-19	Healthcare governance	
20-24		Staff focus
25-26		Use of information
27-28		Leadership, strategy and planning
29-32	Public Health	

When commissioning new services, LHBs expect service providers to meet or be working towards the standards outlined in "Healthcare Standards for Wales." It is likely that this requirement will extend to any new additional services provided by optometrists in the future.

In September 2002 the Welsh Assembly Government published "The Future of Optometric Services in Primary Care in Wales" outlining its vision for the future role of optometry in the provision of eye care. "Quality in Optometry in Wales" now shows the quality optometric practices can offer when providing these future services. Indeed quality in optometry is very high: Optometrists and dispensing opticians are very highly trained; practices respond to the market environment by offering high quality services; and LHBs already know that there are very few patient complaints about optometry services.

In this clinical governance toolkit we have worked down the list of standards and identified where and how they apply to optometry. As stated above, this covers many aspects of practice. Many of these relate to activities that are either a legal requirement or are simply good clinical practice. This means that most practices should be compliant with many aspects of clinical governance without any new effort.

Funding

At the time of writing, the Welsh Assembly Government is emphatic that there is no requirement within the current GOS contract for optometrists to comply with clinical governance standards. Consequently there is no national funding for it and yet LHBs are obliged to engage with and collect information from their contractors in respect of clinical governance. So while some degree of clinical governance is something that most optometry practices will be engaging in as a matter of course, there is no requirement to inform LHBs of what your practice is doing.

LHBs and the Welsh Assembly Government are entitled to make clinical governance reporting a condition of participation in local or national schemes such as shared-care schemes that are funded outside GOS and this should be reflected, through negotiation, in the fees paid. In some areas LHBs have engaged in "light touch" clinical governance in conjunction with their local or regional optometric committee. Where this has been viewed as having two-way benefits, practices have generally co-operated, often for little or no fee. Other LHBs have paid for particular aspects of clinical governance such as audit or attendance at meetings.

Clinical governance is generally a good thing, many aspects of which you are already familiar with. Nevertheless, information about clinical governance in your practice is something that you own. Collecting, collating and passing on such information takes time and thus has a price. It may be that you are or have been paid fees for such information and some aspects of clinical governance may be a requirement of a service outside GOS that you participate in through local agreement. Perhaps your practice has a healthy and productive relationship with the LHB and considers it reasonable to meet modest requests for information as a gesture of goodwill. Whatever the case, you are entitled to expect something in return for providing information and assisting LHBs in meeting their responsibilities on clinical governance.

Where clinical governance is developed locally, it should be done as a co-operative venture between the LHB and LOC or ROC, as well as the LHB's optometry adviser, if one is in post.

Reporting

The Freedom of Information Act is being used increasingly to request information from LHBs, NHS Trusts and the Welsh Assembly Government. Some of the information contained in a clinical governance assessment may be considered confidential by the practice and practitioners involved. If a clinical governance report or questionnaire is being supplied to an NHS body such as a local health board, the following wording should be appended to the report:

The information contained within this report contains personal information relating to optometrists and dispensing opticians and commercial information relating to the practice. It is supplied in confidence and may not be disclosed outside the LHB other than in an anonymous and aggregated form, without the express permission of the practice, whether in its original form or as part of a summary practice report.

How to use this toolkit

There are three main parts to this toolkit:

Part 1 is a list of questions you can quickly run through to determine standards you already meet and where you may need additional help.

Part 2 uses tables to show how the standards, optometry and the questions in part one all relate to each other.

Part 3 is available on the internet at *www.qualityinoptometry.co.uk*. Here the questions are provided as an interactive toolkit that will help you develop all aspects of clinical governance in your practice. There is a series of hyperlinks to take you forwards and backwards through the document. Clicking a hyperlink next to a question will take you to an action point giving advice on how to deal with that particular aspect of clinical governance. The action points have many external web links to a vast array of resources and documents available online. In the longer term, this toolkit will be developed in to a tool that will also allow you to print a completed questionnaire.

Part 1 – Quality in Optometry – Healthcare Standards for Wales

Checklist for the standards

First Domain: .....Patient experience
Second Domain: .....Clinical outcomes
Third Domain: .....Healthcare governance
Fourth Domain: .....Public health

The document, Healthcare Standards for Wales, is available from the Health of Wales Information Service (HOWIS) website. Go to **www.wales.nhs.uk** and search for "Healthcare Standards for Wales."

Using the questions in this checklist, you can quickly determine which standards you already meet and where you may need additional help. The Welsh Assembly Government concluded that there was a need for each individual standard to have both a 'core' and 'developmental' element – the 'core' part to be the basic standard of care to be achieved immediately and the 'developmental' part to be achieved over a longer time period and to a higher level. Precisely how the line will be drawn between the 'core' and 'developmental' elements of each standard will be considered as part of the development of assessment criteria work and will be the subject of a further consultation exercise. In the meantime, the questions are grouped in order of priority in levels from one to four.

Priority Level 1	legal or mandatory requirement	Core standards
Priority Level 2	good clinical practice	
Priority Level 3	aspirational (higher priority)	Developmental standards
Priority Level 4	aspirational (lower priority)	

Standards in Levels 1 and 2 are considered 'core,' representing the standards a good quality practice might be expect to meet for involvement in additional services outside GOS. Standards in Levels 3 and 4 are considered 'developmental,' representing standards of quality to aspire to. Within the NHS, some developmental standards may be expected to become core standards over time.

There will be some questions that appear to relate only to larger practices, such as, "Does the practice hold regular staff meetings or do members of staff have regular one-to-one meetings with their manager?" If your practice is small, don't be put off; simply mark that question as not applying to your practice if that seems to be the case. Similarly for the question asking if the practice has a named clinical governance lead; for a practice with a sole practitioner they will be the clinical governance lead almost by default, unless they have delegated the function to a member of their support staff.

Priority Level 1 - Core Standards - legal or mandatory requirements

First Domain: The Patient Experience

Standard	Questions	Yes	No	Don't know
2	Does the practice offer patients equal access to services as required by the Disability Discrimination Act?			
2	Has the practice recently reviewed access? If no:			
	Has it done so in the past?			
	Is the practice DDA compliant? If no:			
	Is there a system in place to ensure reasonableness of access?			
3	Do optometrists and dispensing opticians in the practice understand and comply with the GOC rules on referral?			
4 (c) 4 (d)	Does the practice have policies on mandatory Health and Safety requirements?			
6(a)	Does the practice have information on GOS sight test entitlement?			
6(a)	Does the practice have information on WECI entitlement?			
6(a)	Does the practice have information on GOS voucher entitlement?			
6 (b)	Does the practice have a contact lens specification form? If yes:			
	Does it include the expiry date, re-examination date and your GOC number?			
8(b)	Does the practice operate equal opportunities and equal employment policies for staff?			
10	Does the practice operate equal opportunities and access policies for people accessing healthcare?			

Second Domain: Clinical Outcomes

Standard	Questions	Yes	No	Don't know
11 (b)	Is a supervising optometrist present in the practice at all times? If no:			
	Are systems in place to ensure that delegated functions are not carried out without supervision?			

Third Domain: Healthcare Governance

Standard	Questions	Yes	No	Don't know
15 (b)	Does the practice have a formal complaints procedure? If yes:			
	Is it available in writing for members of staff to access?			
	Does the practice have patient information material describing the procedure?			
15 (c)	Does the practice complaints procedure give information about complaints advocacy support provided by Community Health Councils in Wales?			
15 (d)	Have you been informed of a policy for managing poor performance in your area: If yes:			
	Has the practice been provided with a copy of the policy?			

Priority Level 1 - Core Standards - legal or mandatory requirements				
Third Domain: Healthcare Governance				
Standard	Questions	Yes	No	Don't know
18	Does the practice have a computer system? If yes:			
	Is a systematic backup policy in place?			
	Is the policy available for staff to reference?			
19 (a)	Does the practice have glazing facilities? If yes:			
	Has the practice completed an RG2 document and submitted it to the MHRA?			
	Does the practice display a certificate of conformity?			
19(a)	Is equipment decontaminated before inspection, service, repair or disposal?			
19(d)	Do you dispose of POMs by incineration?			
19(d)	Does your practice have a refuse collection contract with your landlord, local authority or other suitable service provider?			
19(d)	Does your practice undertake any blood tests? If yes:			
	Are sharps and contaminated products disposed of using a sharps and clinical waste collection service?			
26	Does the practice have a data-management policy?			
26	Are patient records/data secured, e.g. by locks, passwords, access rights?			
26	Is the practice registered under the Data Protection and Freedom of Information Acts?			
26	Does the practice have a registered Freedom of Information publication scheme?			
27(b)	Does the practice undertake POS checks?			
27(d)	Is a member of staff responsible for assessing risks and acting on any findings?			
27(d)	Have risk assessments been undertaken?			
27(d)	Does the risk management policy include the reporting of patient safety incidents?			

Priority Level 2 - Core Standards - good clinical practice				
First Domain: The Patient Experience				
Standard	Questions	Yes	No	Don't know
2	Does the practice provide domiciliary services? If no:			
	Does the practice refer patients to a domiciliary provider?			
3	Are optometrists in the practice conversant with emergency treatment pathways operating locally?			
3	Is written information on local emergency care arrangements available to locums working in the practice?			
3	Does the practice provide information for out of hours care of contact lens patients?			
4(b)	Is there sufficient privacy for patients during dispensing, POS checks and any diagnostic tests that are performed outside the consulting room?			
5(a)	Are the reception areas and consulting rooms clean?			
5(c)	Are hand-washing facilities or alcohol-based gel available in the consulting room?			
5(c)	Does the practice have hand-washing facilities and/or access to alcohol-based gel for staff and patients?			
5(c)	Does the practice have disposable towels for hand drying?			
6(b)	Does the practice have patient literature on a range of ocular conditions?			
6(b)	Does the practice offer copy referral letters to the patient?			
6(c)	Do you give patients opportunities to discuss and agree options relating to their care?			
7	Does the practice participate in WECI or co-management schemes? If yes:			
	Are patients encouraged to contribute to their care plans?			
	Are patients provided with opportunities and resources to develop competence in self-care?			
8(d)	Do members of staff have a confidentiality clause in their contracts of employment?			
8(d)	Is the record storage area accessible to the public?			
Second Domain: Clinical Outcomes				
Standard	Questions	Yes	No	Don't know
11(c)	Does the practice record the CET and/or CPD achievements of optometrists and dispensing opticians?			
12(b)	Are systems in place to ensure that professional notifications and guidance is disseminated to all optometrists working in the practice?			
12(b)	Are practitioners aware of the reasons and the codes for 'early' sight tests?			
12(b)	Do all practice staff have access to sight test frequency information?			

Priority Level 2 - Core Standards - good clinical practice				
Standard	Questions	Yes	No	Don't know
12(b)	Does your practice participate in local shared care or co-management systems? If yes:			
	Are the relevant protocols available for reference in the practice?			
	Are all staff to whom these are relevant aware of the location of these protocols?			
12(b)	Is your practice aware of NICE guidelines relating to PDT and Refractive Surgery?			
12(d)	Do you have a patient consent policy for issuing duplicate spectacle or contact lens prescriptions to colleagues?			
Third Domain: Healthcare Governance				
Standard	Questions	Yes	No	Don't know
17	Does the practice have a chaperone policy?			
19(a)	Are instruments regularly wiped with disinfectant?			
19(a)	Do you check all prescriptions before dispensing?			
19(a)	Do you have your equipment regularly serviced and keep a log of equipment maintenance checks?			
19(a)	Do you calibrate your equipment regularly?			
19(b)	Does the practice use a contact tonometer or any other instrument which contacts the eye? If yes:			
	Are the College of Optometrists' guidelines for decontamination or disposability followed?			
19(b)	Does the practice use any special diagnostic hard or RGP contact lenses? If yes:			
	Are these decontaminated according to the College of Optometrists' Guidelines?			
19(c)	Are ophthalmic drugs stored safely and in accordance with the manufacturer's recommendations?			
19(c)	Are all single-dose drugs (e.g. minims) used once and then discarded?			
21(a)	Has the practice checked registration details of all professional staff, including locums?			
21(b)	Does the practice have professional guidance and codes of conduct available for reference by professional staff?			

Priority Level 3 - Developmental Standards - aspirational

First Domain: The Patient Experience

Standard	Questions	Yes	No	Don't know
2	Does the practice have wheelchair access?			
3	Does the practice have access to local waiting times for ophthalmology appointments?			
4(b)	Does the practice have procedures in place to ensure confidentiality?			
4(b)	Does the practice have a named individual responsible for patient confidentiality issues?			
4(c) 4(d)	Can staff store their possessions safely while working?			
4(c) 4(d)	Does your practice have members of staff who work alone? If yes:			
	Does the practice have a lone working policy?			
5(c)	Does the practice have guidance on hand-washing?			
6(c)	Do you provide patients with a choice of provider when you refer them? If yes:			
	Does the LHB keep you up to date with their preferred providers?			
8(a)	Do staff members have the required skills to treat all patients with respect and empathise with their needs?			
8(a)	Do staff members have any deeply-held beliefs or convictions which may compromise their ability to deal sympathetically with all patients?			
8(d)	Do you have protocols in place to ensure security of patient records at all times?			
8(d)	Has your LHB supplied you with leaflets or posters to explain to patients how their information may be used?			

Second Domain: Clinical Outcomes

Standard	Questions	Yes	No	Don't know
11(a)	Does the practice encourage optometrists and dispensing opticians to base clinical decisions on evidence based practice? If yes:			
	Is this through provision of peer-review?			
	Is this through provision of access to journals and up-to-date reference sources?			
	Is this through allowing attendance at conferences?			
	Is this through provision of CET?			
11(b)	Is there written guidance in the practice on which staff are able to undertake delegated functions?			
11(b)	Does the practice have information on the completion of NHS forms and record card entries for all staff?			

Priority Level 3 – Developmental Standards – aspirational				
Third Domain: Healthcare Governance				
Standard	Questions	Yes	No	Don't know
15(a)	Does the practice have a feedback procedure? If yes:			
	Is it available in writing for members of staff to access?			
	Does the practice have patient information material describing the procedure?			
15(d)	Does your LHB have an optometry adviser? If yes:			
	Do you know how to contact him/her?			
16(a)	Does the practice record adverse incidents? If yes:			
	Does the practice feed back to the staff?			
	Does the practice assess risks from this process?			
16(b)	Does the LHB include the practice in adverse incident reporting procedures?			
16(b)	Does the practice report adverse incidents to the NPSA and LHB in line with existing guidance?			
16(c) 16(d)	Does the LHB include the practice in the circulation of patient safety notices, alerts and related communications? If yes:			
	Does the practice acknowledge their receipt?			
	Does the practice have a system in place or named person to deal with such notices, alerts and communications?			
17	Has the LHB notified your practice of procedures for reporting concerns about children and vulnerable adults?			
19(a)	Do practice staff have easy access to instructions on the use of equipment?			
22(a)	Does the practice carry out CRB checks on professional staff?			
23(b)	Do all members of staff have personal development programmes?			
27(a)	Does the practice have a named clinical governance lead?			
27(c)	Are staff encouraged to share near misses and solutions?			
27(c)	Does the practice hold regular staff meetings or do members of staff have regular one-to-one meetings with their manager?			
Fourth Domain: Public Health				
Standard	Questions	Yes	No	Don't know
30(b)	Does your practice receive information on new policies and knowledge regarding public health from the LHB, e.g. the Annual Report of the Public Health Director?			

Priority Level 4 – Developmental Standards – aspirational

First Domain: The Patient Experience

Standard	Questions	Yes	No	Don't know
2	Does the practice survey patients for feedback on the services it provides? If yes:			
	Are the views expressed used to determine practice policy and service delivery?			
2	Does the practice have a hearing aid loop?			

Second Domain: Clinical Outcomes

Standard	Questions	Yes	No	Don't know
11(b)	Does the practice have a formal training programme for optical assistants or others carrying out delegated functions? If yes:			
	Is the programme reviewed regularly?			
11(d)	Does the practice undertake or plan to undertake clinical audit?			
11(d)	Can the practice demonstrate an audit framework exists?			
11(d)	Are results of any specific audits available?			

Third Domain: Healthcare Governance

Standard	Questions	Yes	No	Don't know
18	Does the practice have an emergency recovery plan?			
19(d)	Do you segregate healthcare and general waste?			
19(d)	Has your LHB offered you a clinical waste collection service for your practice?			
23(a)	Does the practice have a whistle-blowing policy?			
23(b)	Does the practice have an appraisal system for all staff?			
23(b)	Does the practice have an organisational development programme?			
23(b)	Does the practice have a designated member of staff responsible for training and appraisal?			
27(d)	Is there a procedure in the practice for raising concerns about staff performance? If yes:			
	Are all staff aware of this and encouraged to use it?			

Fourth Domain: Public Health

Standard	Questions	Yes	No	Don't know
29(a)	Does the practice encourage staff to adopt healthier lifestyles and encourage health improvement?			
30(a)	Has your LHB asked the practice to participate in local disease prevention and/or health promotion projects? If yes:			
	Which programmes?			
	Do you have information in your practice to give to patients, e.g. on smoking cessation?			

Part 2 – Quality in Optometry – Healthcare Standards for Wales

How the standards relate to optometry

First Domain:	Patient experience
Second Domain:	Clinical outcomes
Third Domain:	Healthcare governance
Fourth Domain:	Public health

The document, Healthcare Standards for Wales, is available from the Health of Wales Information Service (HOWIS) website. Go to **www.wales.nhs.uk** and search for "Healthcare Standards for Wales."

The following four tables (one for each domain) show how the questions in Part 1 relate to quality in optometry and where that fits in to NHS Wales thinking. Presented in a three-column layout, they show the NHS Wales definition of the particular standard in the left-hand column. The centre column then indicates the ways in which that standard may relate to optometry. The right-hand column then lists the questions from the first section so that you can see how it all fits together. The purpose of this section is to show how the standards, optometry and the questions all relate to each other.

First Domain: The Patient Experience

Standards to support the provision of healthcare in partnership with patients, service users, their carers and relatives and the public will be based on plans and decisions that respect diverse needs and preferences. Services will be user friendly and patient centred. Healthcare will be provided in environments that promote patient and staff wellbeing and respect for individual patients' needs and preferences in that they will be designed for the effective and safe delivery of treatment and care and are well maintained and cleaned to optimise health outcomes for patients.

Standard	Relevance to Optometry	Questions
1. The views of patients, service users, their carers and relatives and the public are sought and taken into account in the design, planning, delivery, review and improvement of health care services and their integration with social care services.	When planning area wide services for optometry and ophthalmology, e.g. shared care schemes, LHBs should take in to consideration the needs and views of all stakeholder groups, including patients and optometrists, and should consult the ROC or LOC for its views. In doing so, the LHB should take in to consideration any relevant national guidance, e.g. National Service Frameworks and NICE guidelines, and also WAG guidelines and strategy documents.	
2. The planning and delivery of healthcare: a) reflects the experiences, views and preferences of patients and service users. b) reflects the health needs of the population served. c) is based on nationally agreed evidence and best practice. d) ensures equity of access to services.	Practices should consider patients and practitioners views on, for example, access and delivery, using a questionnaire or by other means. A practice should never assume it knows what its patients want. Using feedback from patients makes good business sense. The requirements of the Disability Discrimination Act will determine how accessible a practice can reasonably be made. Practices should from time to time review accessibility and take steps to improve access where this is possible. An LHB may from time to time wish to gather information about which practices have, for instance, wheelchair access or steps, whether practices have a hearing loop system, someone who can sign or protocols dealing with the hearing impaired and advice for those who are visually impaired. Similarly LHBs may wish to establish which practices provide domiciliary services, or, for a practice that does not, how it directs a patient to one that does. Not every practice will provide every service or total accessibility, but the LHB will want to establish that there is adequate provision across its area. The LHB should have access to a translation service which practitioners can use and should ensure that practices are aware of its existence.	Does the practice survey patients for feedback on the services it provides? If yes: • Are the views expressed used to determine practice policy and service delivery? • Does the practice offer patients equal access to services as required by the Disability Discrimination Act? Has the practice recently reviewed access? If no: • Has it done so in the past? Is the practice DDA compliant? If no: • Is there a system in place to ensure reasonableness of access? Does the practice have wheelchair access? Does the practice have a hearing aid loop? Does the practice provide domiciliary services? If no: • Does the practice refer patients to a domiciliary provider?

Standard	Relevance to Optometry	Questions
3. Patients with emergency health needs access appropriate care promptly and within national time-scales set annually by the Welsh Assembly Government.	When referring a patient, an optometrist must adhere to the rules relating to injury or disease of the eye. It is the duty of all optometrists to ensure that they understand and comply with the rules which are available on the GOC website. The College of Optometrists also has guidance on referrals. Optometrists must be aware of the emergency referral routes in their area and be able to offer alternatives if the local hospital trust cannot provide assessment or treatment within an appropriate timescale. There should be written information in every practice to ensure that locums and other staff are aware of local procedures for referral of patients with conditions requiring emergency care. The College of Optometrist's guidelines on emergency patient care should be used to inform the decision making process. Advice should be in place for contact lens patients who develop problems out of hours, including suitable referral pathways for symptoms suggesting an immediately sight-threatening problem. The access times for treatment routes are the responsibility of each individual LHB. It is helpful to patients and beneficial to good clinical care if optometrists are made aware of local waiting times for secondary care.	Do optometrists and dispensing opticians in the practice understand and comply with the GOC rules on referral? Are optometrists in the practice conversant with emergency treatment pathways operating locally? Is written information on local emergency care arrangements available to locums working in the practice? Does the practice provide information for out of hours care of contact lens patients? Does the practice have access to local waiting times for ophthalmology appointments?
4. Healthcare premises are well-designed and appropriate in order to: a) promote patient and staff well-being.	Practices should promote patient and staff well-being through good design and maintenance.	
b) respect different patients' needs, privacy and confidentiality.	Patient consultations should be conducted in private. If diagnostic tests are performed outside the consulting room this should not be in view of other patients. There should be sufficient privacy for procedures taking place outside the consulting room, such as dispensing and point of service checks. Patient details both written and on computer should not be accessible to members of the public and should be securely stored. The LHB will have a policy on patient confidentiality and use of records. They should make contractors aware of how to contact the LHB's Caldicott Guardian for advice on confidentiality issues. Practice staff should have a confidentiality clause in their contracts. See also Standard 8(f).	Does the practice have procedures in place to ensure confidentiality? Is there sufficient privacy for patients during dispensing, POS checks and any diagnostic tests that are performed outside the consulting room? Does the practice have a named individual responsible for patient confidentiality issues?

Standard	Relevance to Optometry	Questions
c) have regard for the safety of patients, users and staff.	Basic Health and Safety Executive (HSE) regulations require a practice to have policies dealing with hazardous substances; cross-infection control; toilet/washroom facilities; as well as clothing, changing, eating facilities. If you have staff who work alone you should have procedures in place for their safety and security. Your LHB will have its own policy for lone workers, some of which may apply. You may wish to install an alarm and keep records of any incidents.	Does the practice have policies on mandatory Health and Safety requirements? Can staff store their possessions safely while working? Does your practice have members of staff who work alone? If yes: • Does the practice have a lone working policy?
d) provide a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation.		
5. Healthcare services are provided in environments, which:		
a) are well maintained and kept at acceptable national levels of cleanliness.	The practice should be clean.	Are the reception areas and consulting rooms clean?
b) minimise the risk of healthcare associated infections to patients, staff and visitors, achieving year on year reductions in incidence.	This principally applies to hospitals, but optometry practices may have patients attend with known or unknown cases of MRSA. The College of Optometrists has advice on infection control, as does the Royal College of Nursing.	
c) emphasise high standards of hygiene and reflect best practice initiatives.	Simple procedures, such as respiratory and hand hygiene, help prevent the spread of everyday diseases as well as MRSA and will be especially important in the event of a flu pandemic. Where frequent hand-washing is impractical or undesirable, alcohol-based disinfectant hand gel is an acceptable alternative.	Are hand-washing facilities or alcohol-based gel available in the consulting room? Does the practice have guidance on hand-washing? Does the practice have hand-washing facilities and/or access to alcohol-based gel for staff and patients? Does the practice have disposable towels for hand drying?
6. Healthcare organisations, in recognising different language, communication, physical and cultural needs:		
a) make information available and accessible to patients, service users, their carers and relatives and the public on their services.	Posters should be displayed and leaflets available in public areas regarding GOS, WECI and other NHS services. These should be available from the LHB.	Does the practice have information on the following: • GOS sight test entitlement • WECI entitlement • GOS voucher entitlement

Standard	Relevance to Optometry	Questions
b) provide patients and service users with timely information on their condition; the care and treatment they will receive as well as after-care and support arrangements.	Patient literature should be available regarding common eye conditions and their treatment. Sources include: the RNIB; College of Optometrists; Stockport LOC website; and the Eye Care Trust. All patient literature should be easy to understand. Ease of reading can be assessed by organisations such as the Plain Language Commission. Patients must be given a completed prescription form or statement about the outcome of their sight test. A copy of the contact lens specification must be issued when fitting is completed or the specification is modified or confirmed at an after-care examination. If a patient is referred they should be given a written statement of the reasons for referral or a copy of their referral letter.	Does the practice have patient literature on a range of ocular conditions, such as: • cataract; • diabetic retinopathy; • macular degeneration; • glaucoma; • flashes and floaters; • children's vision; • colour vision; • blepharitis; and • low vision. Does the practice have a contact lens specification form? If yes: • Does it include the expiry date, re-examination date and your GOC number? Does the practice offer copy referral letters to the patient?
c) provide patients and service users with opportunities to discuss and agree options relating to their care.	Patients should be provided with opportunities to discuss and agree options relating to their care, such as choice in referral and treatment options.	Do you give patients opportunities to discuss and agree options relating to their care? Do you provide patients with a choice of provider when you refer them? If yes: • Does the LHB keep you up to date with their preferred providers?
7. Patients and service users, including those with long-term conditions, are encouraged to contribute to their care plan and are provided with opportunities and resources to develop competence in self-care.	Where an optometrist or dispensing optician has a role in formulating a patient's care plan, such as the management of patients under the Wales Eye Care Initiative or under local co-management schemes, the patient should be encouraged to contribute to the plan and provided with opportunities and resources to develop competence in self-care.	Does the practice participate in WECI or co-management schemes? If yes: • Are patients encouraged to contribute to their care plans? Are patients provided with opportunities and resources to develop competence in self-care?
8. Healthcare organisations ensure that:		
a) staff treat patients, service users, their relatives and carers with dignity and respect.	All patients and their carers should be treated equally, regardless of socio-economic, racial, religious or other background. An optometric practice should enable an adequate level of privacy for the patient during all aspects of their care; preferably a room available for one-to-one attention.	Do staff members have the required skills to treat all patients with respect and empathise with their needs? Do staff members have any deeply-held beliefs or convictions which may compromise their ability to deal sympathetically with all patients?

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b) staff themselves are treated with dignity and respect for their differences.	All staff should be treated equally. Practices should ensure that members of staff are not unfairly discriminated against on the grounds of age, gender, disability, ethnicity, race, religion, or sexual orientation by other members of staff or by patients. Practices should comply with relevant legislation such as the Disability Discrimination Act, Sex Discrimination Act, Equal Pay Act, Race Relations Act, Human Rights Act and the Employment Equality (Age) Regulations	Does the practice operate equal opportunities and equal employment policies for staff?
c) informed consent is obtained appropriately for all contacts with patients and service users and for the use of confidential patient information.	Practices should ensure that all patients are adequately informed and able to give consent to any procedures undertaken. The practice should have a Chaperone Policy. See also Standard 17.	
d) patient information is treated confidentially, except where authorised by legislation to the contrary.	Confidential patient information should not be accessed, discussed or transferred unless in circumstances directly relevant to patients' care. Practice staff should have a contractual obligation to maintain confidentiality. Guidance and a model contract of employment is available on the AOP website. Patient record cards should be stored safely and be inaccessible to anyone other than practice staff at all times. Records should not be shown, copied or given to other parties unless it is clearly in the patient's interest, or the patient gives explicit consent to do so. A patient may request copies of his or her record cards. Practices may make a small administration charge to cover the cost of copying only. The LHB should have a document advising practitioners what information they can share and under what circumstances. It should include information on how to decide who is competent to make informed consent, including Gillick competent children. You should seek advice before disclosing patient information to a third party. It is unlikely this will occur very frequently in optometric practice. It is unreasonable to expect practitioners to know exactly what they can and can not do, and to keep up to date with regulations. In certain rare circumstances information can and should be disclosed even if it is not in the interests of the patient. Contact the AOP or the LHB Caldicott Guardian for advice before taking action.	Do members of staff have a confidentiality clause in their contracts of employment? Is the record storage area accessible to the public? Do you have protocols in place to ensure security of patient records at all times? Has your LHB supplied you with leaflets or posters to explain to patients how their information may be used?

Standard	Relevance to Optometry	Questions
9. Where food is provided there are systems in place to ensure that:		
a) patients and service users are provided with a choice of food which is prepared safely and provides a balanced diet.	Not relevant to optometry.	
b) patients and service users' individual nutritional, personal, cultural and clinical dietary requirements are met, including any necessary help with feeding and having access to food 24 hours a day.	Not relevant to optometry.	
10. Healthcare organisations ensure that people accessing healthcare are not unfairly discriminated against on the grounds of age, gender, disability, ethnicity, race, religion, or sexual orientation.	All people accessing healthcare should be treated equally. Practices should ensure that patients are not unfairly discriminated against on the grounds of age, gender, disability, ethnicity, race, religion, or sexual orientation by members of staff or by other patients. Practices should comply with relevant legislation such as the Disability Discrimination Act, Sex Discrimination Act, Race Relations Act, and Human Rights Act.	Does the practice operate equal opportunities and access policies for people accessing healthcare?

Second Domain: Clinical Outcomes

Healthcare decisions and services will be based on what appropriately assessed research evidence has shown will provide an effective outcome for patients and service users taking account of their individual needs and preferences. Patients and service users will receive services as promptly as possible, and will not experience unreasonable delay at any stage of service delivery or of their care pathway.

Standard	Relevance to Optometry	Questions
11. Healthcare organisations ensure that:	Evidence based practice is an approach to health care that promotes the collection, interpretation, and integration of valid, important and applicable patient-reported, clinician-observed, and research-derived evidence. The best available evidence, moderated by patient circumstances and preferences, is applied to improve the quality of clinical decision making. Practices should encourage optometrists and dispensing opticians to base clinical decisions on evidence based practice.	Does the practice encourage optometrists and dispensing opticians to base clinical decisions on evidence based practice through: provision of peer-review; provision of access to journals and up-to-date reference sources; allowing attendance at conferences; and/or provision of CET?
b) clinical care and treatments are carried out under appropriate clinical supervision and leadership.	Where tasks within the sight test or other clinical procedures, such as dispensing, are delegated to others, practitioners must ensure that those undertaking the delegated tasks are appropriately trained. Practitioners must be aware that delegation of certain functions is not permitted, e.g. any part of a WECI Eye Health or PEARS examination. At all times a supervising optometrist or dispensing optician (as appropriate) must be present in the practice. Guidance as to which members of staff can or cannot carry out specific delegated tasks and under what circumstances should be available in writing in the practice. Where the completion of NHS forms is undertaken by non-professional staff, the practice should ensure those staff understand the GOS and other relevant regulations and are able to complete forms and any associated record card entries accurately and in compliance with the regulations. Guidance on the application of GOS regulations and WECI is available in the publication "Making Accurate Claims." Any changes to the regulations should be communicated to the relevant staff members.	Does the practice have a formal training programme for optical assistants or others carrying out delegated functions? If yes: • Is the programme reviewed regularly? Is a supervising optometrist present in the practice at all times? If no: • Are systems in place to ensure that delegated functions are not carried out without supervision? Is there written guidance in the practice on which staff are able to undertake delegated functions? Does the practice have information on the completion of NHS forms and record card entries for all staff?
c) clinicians continuously update skills and techniques relevant to their clinical work including peer reviews..	It is a requirement of registration that practitioners attain sufficient CET points as determined by the GOC. It is a good idea for the practice to keep a log of permanent staff members' CET points achievements in order to ascertain how staff members are fairing when appraisals are carried out. This can be achieved by professional staff providing a print out of their CET points record from the CET website. Attendance at all CET or CPD should be traceable and logged. Local protocols may require optometrists working in co-management or shared care schemes to achieve and maintain agreed standards of practice for participation. It is a good idea to keep a record of all such local training for each member of staff participating in any such scheme.	Does the practice record the CET and/or CPD achievements of optometrists and dispensing opticians?

Standard	Relevance to Optometry	Questions
d) clinicians participate in regular audit and review of clinical services.	Audit is a fundamental part of clinical governance. It is a tool by which quality can be assessed, improvements instituted and their effectiveness monitored. All practices should have a framework of audit or review work within their systems. Practices should be able to demonstrate such a framework exists and be able to evidence audit work being, or recently having been, carried out. Guidance on undertaking clinical audit has been produced by the College of Optometrists	Does the practice undertake or plan to undertake clinical audit? Can the practice demonstrate an audit framework exists? Are results of any specific audits available?
12. Healthcare organisations ensure that patients and service users are provided with effective treatment and care that:		
a) conforms to the National Institute for Clinical Excellence (NICE) technology appraisals and interventional procedures, and the recommendations of the All Wales Medicines Strategy Group (AWMSG).	This is the responsibility of any organisation to which NICE guidelines and AWMSG recommendations relate. Primarily this will be larger NHS organisations such as LHBs and NHS Trusts. LHBs must ensure that various parts of their organisations conform to NICE technology appraisals.	
b) is based on nationally agreed best practice and guidelines, as defined in National Service Frameworks, NICE clinical guidelines, national plans and agreed national guidance on service delivery	Optometrists in practice need to be aware of nationally agreed best practice and guidelines when planning and delivering treatment and care, including the College of Optometrists' Guidelines for Professional Conduct. Guidance on sight test intervals is agreed nationally. Information on the intervals and acceptable reasons for 'early' sight tests are available from the AOP, College of Optometrists and FODO websites and in the publication, "Making Accurate Claims in Wales." Optometrists should also be aware of locally agreed guidance when it is relevant to shared care or co-managements systems they may be involved with. Literature on such systems should be available in participating practices. Practices should be aware of NICE guidelines relating to these organisations that are relevant to optometry including PDT and Refractive Surgery guidelines.	Are systems in place to ensure that professional notifications and guidance is disseminated to all optometrists working in the practice? Are practitioners aware of the reasons and the codes for 'early' sight tests? Do all practice staff have access to sight test frequency information? Does your practice participate in local shared care or co-management systems? If yes: • Are the relevant protocols available for reference in the practice? • Are all staff to whom these are relevant aware of the location of these protocols? Is your practice aware of NICE guidelines relating to PDT and Refractive Surgery?

Standard	Relevance to Optometry	Questions
c) takes account of patients' physical, social, cultural and psychological needs and preferences.	Practices should take account of patients' physical, social, cultural and psychological needs and preferences in providing their treatment and care. See also Standards 6 and 7.	
d) is integrated to provide a seamless service across all organisations that need to be involved, including social care organisations.	From time to time you may be asked to provide information to fellow practitioners or other professionals. The College of Optometrists' Guidelines include guidance on inter- and intra-professional relationships and transferring of information. It is the responsibility of the LHB to ensure that a seamless service is provided across all practices through negotiation with your LOC/ROC.	Do you have a patient consent policy for issuing duplicate spectacle or contact lens prescriptions to colleagues?
13. Healthcare organisations, which either lead or participate in research, have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.	Practices participating in research should apply the principles and requirements of the research governance framework.	

Third Domain: Healthcare Governance

Providers and commissioners of healthcare will have in place systems that support both managerial and clinical leadership and accountability centred on patient and service user needs and preferences. Working practices will be in place to enable probity, quality assurance, quality improvement and patient safety to be the central components of all routines, processes and activities.

Standard	Relevance to Optometry	Questions
14. Healthcare organisations continuously and systematically review and improve all aspects of their activities that directly affect the safety and health of patients, service users, staff and the public. They will not only comply with legislation, but apply best practice in assessing and managing risk.	Practices should have systems in place to review and improve their activities that affect the health and safety of patients, staff and the public. They should comply with legislation and assess and manage risk. See also Standards 4(c), 4(d), 16, 19 and 27(d).	
15. Healthcare organisations, recognising different language and communication needs, ensure that patients, service users, relatives and carers:		
a) can provide feedback on their experiences and the quality of services.	The practice should have a policy and procedure for patients to provide feedback on their experiences and the quality of the services they receive. This may be integrated with the practice's complaints procedure and may include patient surveys. See also Standard 2(a).	Does the practice have a feedback procedure? If yes: • Is it available in writing for members of staff to access? • Does the practice have patient information material describing the procedure?
b) have their complaints looked at promptly and thoroughly in accordance with complaints procedures.	The practice must have a formal written complaints policy and a named complaints manager (even a practitioner working alone). The AOP has a draft complaints procedure available.	Does the practice have a formal complaints procedure? If yes: • Is it available in writing for members of staff to access? • Does the practice have patient information material describing the procedure?
c) are given information about complaints advocacy support provided by Community Health Councils in Wales.	The practice complaints procedure must give information about complaints advocacy support provided by Community Health Councils in Wales	Does the practice complaints procedure give information about complaints advocacy support provided by Community Health Councils in Wales?

Standard	Relevance to Optometry	Questions
d) receive assurance that organisations act on any concerns and make appropriate changes to ensure improvements in service delivery.	The LHB should have developed a policy for managing poor performance in conjunction with the ROC or LOC. A model policy is available on the AOP website. The LHB may offer training to primary care staff on how to deal with difficult patients. The LHB should have an optometry adviser to assist in dealing with complaints, concerns and issues	Have you been informed of a policy for managing poor performance in your area: If yes: • Has the practice been provided with a copy of the policy? Does your LHB have an optometry adviser? If yes: • Do you know how to contact him/her?
16 Healthcare organisations have systems in place:		
a) to identify and learn from all patient safety incidents and other reportable incidents.	Practices should record adverse incidents which occur within the practice. Practices should feed back to their staff. Practices may wish to assess their practice for risks.	Does the practice record adverse incidents? If yes: • Does the practice feed back to the staff? • Does the practice assess risks from this process?
c) to demonstrate improvements in practice based on shared local and national experience and information derived from the analysis of incidents.	LHBs should ensure that optometric practices are included in the circulation of patient safety notices, alerts and related communications from national and local sources and that practices are aware of how to acknowledge these.	Does the LHB include the practice in the circulation of patient safety notices, alerts and related communications? If yes: • Does the practice acknowledge their receipt? • Does the practice have a system in place or named person to deal with such notices, alerts and communications?
d) to ensure that patient safety notices, alerts and other communications concerning safety are acted upon within required time-scales.		
17. Healthcare organisations comply with national child protection and vulnerable adult guidance within their own activities and in their dealings with other organisations.	Optometric practices should have a chaperone policy. Further information is included in the College of Optometrists' Guidelines, particularly the section on dealing with Children and Vulnerable Adults. LHBs should ensure that optometric practices know how and where to report concerns about children and vulnerable adults. Practitioners should keep careful records of their actions and observations.	Does the practice have a chaperone policy? Has the LHB notified your practice of procedures for reporting concerns about children and vulnerable adults?

Standard	Relevance to Optometry	Questions
18. Healthcare organisations have planned and prepared, and where required practised, an organised response to incidents and emergency situations, which could affect the provision of normal services.	It is sensible for a practice to assess its vulnerability to incidents and situations, such as fires and floods. Contingency plans should be drawn up to enable the practice to minimise the effects of such events; the preservation and recovery of patient records should be a high priority. Data held on computer systems should be backed up regularly and systematically, especially if patient records are stored electronically. Back up procedures should be documented and available for practice staff to reference. The College of Optometrists has guidance on record keeping which includes guidance on electronic records.	Does the practice have an emergency recovery plan? Does the practice have a computer system? If yes: • Is a systematic backup policy in place? • Is the policy available for staff to reference?
19. Healthcare organisations ensure that:		
a) all risks associated with the acquisition and use of medical devices are minimised.	It is good practice to wipe down instruments, e.g. chin and head rests and trial frames, with disinfectant. Alcohol- or chlorhexidine-based disposable wipes can be used for this. If the practice has glazing facilities, it must conform to the Medical Devices Regulations and must register with the Medicines & Healthcare products Regulatory Agency (MHRA). All devices issued to patients should be checked to ensure they are as ordered and safe to use. Dispensing (including contact lenses) should only be done by competent persons, bearing in mind the restriction of dispensing to certain groups of patients to registered practitioners. Consulting room equipment should be safe to use, properly maintained and fit for purpose. A log should be kept detailing all maintenance checks. All members of staff who use equipment should be properly trained and have access to instruction and other manuals. Equipment needing maintenance or repair must be decontaminated before and after.	Are instruments regularly wiped with disinfectant? Does the practice have glazing facilities? If yes: • Has the practice completed an RG2 document and submitted it to the MHRA? • Does the practice display a certificate of conformity? Do you check all prescriptions before dispensing? Do you have your equipment regularly serviced and keep a log of equipment maintenance checks? Do you calibrate your equipment regularly? Do practice staff have easy access to instructions on the use of equipment? Is equipment decontaminated before inspection, service, repair or disposal?
b) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.	One of the contaminant hazards of particular concern to optometry is vCJD as it requires stringent decontamination procedures. Risks are also posed by a variety of bacterial and viral contaminants. Procedures should be in place in the practice to ensure that devices are effectively decontaminated so that cross-contamination from any hazardous agent does not occur. Advice is available for the College of Optometrists covering disinfection procedures and on when single use devices are appropriate.	Does the practice use a contact tonometer or any other instrument which contacts the eye? If yes: • Are the College of Optometrists' guidelines for decontamination or disposability followed? Does the practice use any special diagnostic hard or RGP contact lenses? If yes: • Are these decontaminated according to the College of Optometrists' Guidelines?

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c) quality, safety and security issues of medicines are managed.	Any pharmaceutical agents used in the practice should be stored according to the manufacturer's recommendation in a secure location. Note that some ophthalmic drugs require storage in a refrigerator.	Are ophthalmic drugs stored safely and in accordance with the manufacturer's recommendations? Are all single-dose drugs (e.g. minims) used once and then discarded?
d) the prevention, segregation, handling, transport and disposal of waste are managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.	The practice should have a refuse collection contract with its landlord, local authority or other suitable service provider. Clinical waste has, by definition, to be hazardous, e.g. it is material which is toxic or infectious. Waste from clinical activities in an optometric practice, e.g. used contact lenses are unlikely to be hazardous and might be termed "healthcare" waste. Such healthcare waste may be disposed of in the normal refuse, providing it is in small quantities. Large quantities should be segregated and disposed of separately. POMs used by optometrists are not considered hazardous, but must be disposed of by incineration. This facility is unlikely to be available in an optometric practice; a local pharmacy or GP surgery may be prepared to accept these for disposal. The collection and disposal of hazardous waste is the responsibility of the waste producer, however this may be organised by the LHB on behalf of contractors in its area. They may choose to provide optometric practices with a collection service for clinical or healthcare waste. A few practices may undertake blood tests, e.g. for diabetes. They should ensure that they are included in a sharps and clinical waste collection service.	Does your practice have a refuse collection contract with your landlord, local authority or other suitable service provider? Do you segregate healthcare and general waste? Do you dispose of POMs by incineration? Has your LHB offered you a clinical waste collection service for your practice? Does your practice undertake any blood tests? If yes: • Are sharps and contaminated products disposed of using a sharps and clinical waste collection service?
20. Healthcare organisations work to enhance patient care and to continuously improve staff satisfaction by providing best practice in human resources management.	Good human resources management will maintain staff satisfaction and encourage good patient care. Practice recruitment and staff management processes must not adversely impact on minority groups. Policies and procedures should be developed and reviewed with this in mind. See also Standards 8(b), 21(a), 22 and 23.	
21. Healthcare organisations:		
a) undertake all necessary employment checks and ensure that all employed or contracted professionally qualified staff are registered with the relevant bodies.	Practices should check registration details of all professional staff at the start of their employment and ensure that registration does no lapse (either by paying registration fees for staff or checking registration details annually in April on the GOC website).	Has the practice checked registration details of all professional staff, including locums?

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b) require that all employed professionals abide by their published codes of professional practice and conduct.	Practice staff should be familiar with the College of Optometrists' Code of Ethics and Guidelines for Professional Conduct and other professional guidance or codes of conduct, such as the AOP sigh test protocol or the GOC code of conduct.	Does the practice have professional guidance and codes of conduct available for reference by professional staff?
c) address where appropriate under-representation of minority groups.	Practices should, where appropriate, address under-representation of minority groups.	
22. Healthcare organisations ensure that staff:		
a) are appropriately recruited, trained and qualified for the work they undertake.	Recruitment processes should be appropriate to the position available and should include verification of identity, work permits and qualifications. The LHB or BSC may undertake a CRB check in relation to an ophthalmic list application. If they do not, you may feel it is something the practice should do, particularly if the practice sees child patients.	Does the practice carry out CRB checks on professional staff?
b) participate in induction and mandatory training programmes.	Professional staff should undertake basic CET as a requirement of continued registration with the GOC.	
c) participate in continuing professional and occupational development.	Practices should encourage professional development.	
23. Healthcare organisations ensure that staff are supported by:		
a) processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management.	A whistle-blowing policy should be in place in the practice.	Does the practice have a whistle-blowing policy?
b) organisational and personal development programmes which recognise the contribution and value of staff.	Practices should have personal development programmes for staff (agreed between individual members of staff and their line-managers). Practices should have an organisational development programme to which all staff have input.	Does the practice have an appraisal system for all staff? Do all members of staff have personal development programmes? Does the practice have an organisational

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		development programme? Does the practice have a designated member of staff responsible for training and appraisal?
24. Healthcare organisations work together with social care and other partners to meet the health needs of their population by:		
a) having an appropriately constituted workforce with appropriate skill mix across the community.	The LHB is responsible for working with social care and other partners, including optometric practices, to meet the health needs of their population. They may seek to meet this responsibility through discussions with the LOC / ROC and practices to try to develop an appropriately constituted optometric workforce with an appropriate skill mix across the community and may provide support and/or incentives to practices to achieve and maintain this. Practices are responsible for ensuring the continuous improvement of the services they provide through better ways of working. The LHB may provide support and/or incentives to practices to do so. See also Standards 1, 2, 11(c) and 11(d).	
b) ensuring the continuous improvement of services through better ways of working.		
25. Healthcare organisations use effective information systems and integrated information technology to support and enhance patient care, and in commissioning and planning services.	LHBs are responsible for the integration of information technology to support and enhance patient care and in commissioning and planning services. They may seek to meet this responsibility through discussions with the LOC / ROC and practices to try to connect optometry practices to the NHS computer network to support secure, accurate and timely referral and co-management of patients; good communications between the LHB and practices, such as dissemination of patient safety notices and alerts; and future developments, such as electronic claims and payments, and appropriate access to electronic patient records.	
26. Healthcare organisations have effective records management processes in place to ensure that:		
a) from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the	Practices should have a data-management policy including details on appropriate record keeping, access to and security of records, data back up and disposal of records. Practices should comply with statutory requirements under the Data Protection and Freedom of Information Acts. All practices should have a publication scheme	Does the practice have a data-management policy? Are patient records/data secured, e.g. by locks, passwords, access rights? Is the practice registered under the Data Protection and Freedom of

Standard	Relevance to Optometry	Questions
purpose it was collected for and disposes of the information appropriately when no longer required. b) patient confidentiality is maintained.	which sets out what information will be made available to the public which must be registered with the Information Commissioner.	Information Acts? Does the practice have a registered Freedom of Information publication scheme?
27. Governance arrangements representing best practice are in place which:		
a) apply the principles of sound clinical and corporate governance.	Practices should be able to demonstrate application of these principles, e.g. promoting high standards of clinical care and ensuring the effective use of public funds.	Does the practice have a named clinical governance lead?
b) ensure sound financial management and accountability in the use of resources	Practices should ensure efficient use of NHS resources, e.g. by undertaking POS checks and working to sight testing and prescribing guidelines such as the "Memorandum of Understanding on Sight Test Intervals."	Does the practice undertake POS checks?
c) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.	Practices should promote a "no-blame" culture. Staff should have regular opportunities for one-to-one discussions with their line manager. Practices should audit financial processes to promote accountability and to monitor the use of resources.	Are staff encouraged to share near misses and solutions? Does the practice hold regular staff meetings or do members of staff have regular one-to-one meetings with their manager?
d) include systematic risk assessment and risk management.	Practices should undertake risk assessments and manage perceived risks. Guidance is available from the College of Optometrists. Statutory requirements exist making risk assessments in Health and Safety, COSHH mandatory for all businesses. For more information visit the HSE website. A risk management policy should also include the reporting of patient safety incidents locally (to agreed protocols) and/or to the National Patient Safety Agency (NPSA). The College of Optometrists has published advice on the NPSA and reporting adverse incidents. If you have concerns about the safety of a regulated product, such as a drug, contact lens solution or device then it should be reported to the Medicines & Healthcare Products Regulatory Agency (MHRA).	Is a member of staff responsible for assessing risks and acting on any findings? Have risk assessments been undertaken? Is there a procedure in the practice for raising concerns about staff performance? If yes: • Are all staff aware of this and encouraged to use it? Does the risk management policy include the reporting of patient safety incidents?

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e) are integrated across all health communities and clinical networks.	LHBs are responsible for disseminating best practice in governance arrangements across all health communities and clinical networks, including optometric practices.	
28. Healthcare organisations:		
a) ensure that the principles of clinical governance underpin the work of every team and every clinical service.	Practices should ensure that all members of staff are aware of clinical governance and incorporate it in their work. NB The Welsh Assembly Government is emphatic that there is no requirement within the current GOS contract for optometrists to comply with clinical governance standards. Consequently there is no national funding for it. While some degree of clinical governance is something that most optometry practices will be engaging in as a matter of course, there is no requirement to inform the LHB of what your practice is doing in relation to clinical governance and GOS work. LHBs are responsible for ensuring that clinical governance is incorporated in clinical services and may make clinical governance (and reporting of it) a requirement of practices' participation in shared-care and co-management schemes. This will be reflected in the fee negotiations between the LHB and the LOC/ROC. See also Standard 27(a).	
b) have a cycle of continuous quality improvement, including clinical audit.	Practices should have a framework of audit or review work within their systems. See also Standard 11(d).	
c) ensure effective clinical and managerial leadership and accountability.	Practices should ensure effective clinical and managerial leadership and accountability by ensuring they have an appropriate staffing structure with clearly defined roles, areas of responsibility and areas of accountability for all staff documented in staff contracts and job descriptions. See also Standards 11(b), 22(a), 23(a) and 23 (b).	

Fourth Domain: Public Health

Healthcare organisations will collaborate with relevant organisations and local communities to ensure the design and delivery of programmes and services to promote, protect and improve health, and which will tackle health inequalities and help people to live healthy and independent lives.

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29. Healthcare organisations promote, protect and demonstrably improve the health of the community served and reduce health inequalities by:		
a) collaborating and working in partnership with local authorities and other agencies in the development, implementation and evaluation of health, social care and well being strategies.	The LHB is responsible for the development and implementation of strategies which ensure that the health and social care of the local population is maintained and improved. All employers are obliged to encourage health improvement among staff members by encouraging them to stop smoking, reduce alcohol consumption etc by suitable means, such as displaying posters and other materials.	Does the practice encourage staff to adopt healthier lifestyles and encourage health improvement?
b) ensuring that needs assessment and sound public health advice informs their policies and practices.	National and local advice is produced detailing the current health status and needs of the national and local population.	
30. Healthcare organisations:		
a) have systematic and managed disease prevention and health promotion programmes, which include staff, which meet the requirements of the National Service Frameworks, national plans and health promotion and prevention priorities.	It is the LHB's responsibility, with the guidance of the Public Health Director, to devise and implement disease prevention and health promotion programmes. In developing these, the LHB will take in to account relevant national guidance and standards. Your practice may be asked to join a local project to help the LHB to meet its objectives, for example by participating in a smoking cessation campaign. It is normal for participating practices to receive financial support.	Has your LHB asked the practice to participate in local disease prevention and/or health promotion projects? If yes: • Which programmes? • Do you have information in your practice to give to patients, e.g. on smoking cessation?
b) take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health	It is the LHB's responsibility, with the guidance of the Public Health Director, to disseminate new policies and knowledge regarding public health issues and to take these in to account in the development of public health programmes, health promotion and prevention services, and in the commissioning and provision of services. See also Standard 30(a).	Does your practice receive information on new policies and knowledge regarding public health from the LHB, e.g. the Annual Report of the Public Health Director?

Standard	Relevance to Optometry	Questions
promotion and prevention services, and the commissioning and provision of services.		
31. Healthcare organisations:		
a) have plans in place to mobilise resources to protect the public in the event of significant infectious disease outbreaks and other health emergencies.	Each LHB has an Emergency Planning Officer and makes detailed plans for the management of emergencies, disasters and other critical incidents. Plans concentrate primarily on the provision of medical services.	
b) identify and act upon significant public health problems and health inequality issues, with Local Health Boards taking the leading role.	LHBs will take a leading role in identifying and acting upon significant public health problems and health inequality issues. The LHB will implement programmes to address these and may ask your practice to participate. See also Standard 30(a).	
c) implement effective programmes to improve health and reduce health inequalities; and protect their populations from identified current and new hazards to health.		
d) encourage and support individuals to recognise their own responsibilities in maintaining their health and well being.	Practices and practitioners should encourage staff and patients to recognise their own responsibilities in maintaining their health and well being. See also Standards 6(b), 29(a) and 32.	
32. Healthcare organisations achieve the Corporate Health Standard, the national quality mark for workplace health, moving to a higher level on reassessment.	The Corporate Health Standard is the national mark of quality for health and well-being in the workplace. Any workplace that has adopted practices to improve employee health and well-being can apply, although the criteria are more suited to larger organisations (of fifty or more employees). Further information is available from the National Assembly for Wales's website (www.wales.gov.uk).	

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