Sandwell and West Birmingham Hospitals NHS
NHS Trust

Ophthalmology Specialist Trainee Induction Booklet

Birmingham and Midland Eye Centre
City Hospital
Dudley Road
Birmingham
B18 7QH

Where EVERYONE Matters

February 2015

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Trust Profile

The Trust is one of the largest teaching Trusts in the United Kingdom with a reputation for excellent, friendly staff who provide high quality care from City Hospital in Birmingham and Sandwell General in West Bromwich. Both are busy acute hospitals providing many specialist services and a broad range of emergency services, including Accident & Emergency at both sites. In addition, the Trust provides comprehensive community services to the Sandwell area, including from Rowley Regis Community Hospital, Leasowes Intermediate Care Centre and the Lyng Centre for Health and Social Care.
The Trust has an income of £418 million and employs around 7000 WTE staff. It has circa 900 beds and serves a population of over 500,000.

The Trust is a key partner along with the local Clinical Commissioning Group, PCTs and local authorities in the "Right Care Right Here" programme which seeks to deliver an ambitious redevelopment of local health services. Following a very successful public consultation, implementation of the programme is underway with a wide range of secondary care services now being provided via new models of care in community locations. The programme includes one of the largest investments in the UK in new facilities in both the acute and community sectors. Included within this is a new single site acute hospital for which business case approval is currently being sought.

The Trust has reconfigured a number of services between its acute sites so as to ensure their quality and sustainability. This programme of change will continue over the coming period. Alongside this, the Trust has embarked on a 5 year Transformation Plan, designed to ensure that the quality and safety of our services can be maintained and enhanced whilst at the same time responding to national requirements for increased efficiency. The plan takes in all of the Trust's key clinical and non-clinical work streams. In the light of its strategic, operational and financial strength the Trust is applying to become a NHS Foundation Trust, which is expected to be achieved by April 2014.

The Trust is a pioneer in developing new and more effective approaches to staff engagement through its "Listening into Action" programme which harnesses the energy and ideas of front line staff to improve services. This is the largest programme of its kind in the NHS and has received widespread national recognition. These techniques are also increasingly used to obtain the view of patients and carers.
The £35m Birmingham Treatment Centre on the City Hospital site provides state of the art facilities for one-stop diagnosis and treatment. It includes an Ambulatory Surgical Unit with six theatres, extensive imaging facilities, an integrated breast care centre and teaching accommodation.

The £18m Emergency Services Centre on the Sandwell site incorporates a comprehensive A&E facility, Emergency Assessment Unit and Cardiac Care Unit.

The Trust hosts the Birmingham and Midland Eye Centre which is a supra-regional specialist facility, as well as the Pan-Birmingham Gynaecological Oncology Centre, Birmingham Skin Centre, Sickle Cell and Thalassaemia Centre and regional base of the National Poisons Information Service.

Aside from being one of the largest providers of patient services in the Midlands, the Trust also has a substantial teaching and research agenda with several academic departments including rheumatology, ophthalmology, cardiology, gynaecological oncology and neurology.

Ophthalmology in Birmingham

Ophthalmology services in Birmingham are provided on a hub and spoke principle. The main operating facilities, as well as most of the specialist clinics, the Academic Unit and A&E services are provided at the BMEC. The more general outpatient facilities are located locally at hospitals around the city. Major developments have taken place at these other centres to improve local access to high quality ophthalmology services. The main partnership hospitals are Good Hope, Heartlands and Solihull Hospitals at Heart of England NHS Foundation Trust, Birmingham Children's Hospital, University Hospital Birmingham NHS Trust and Dudley Group of Hospitals NHS Trust. Many consultant staff at these partnership hospitals also work at the BMEC. All these hospitals and the BMEC share junior staff on training rotation, rotating through the spoke hospitals and the BMEC.

Ophthalmology at Sandwell and West Birmingham Hospitals NHS Trust

Services are provided at three hospital sites:

- City Hospital, which accommodates the BMEC
- Sandwell General Hospital, which includes outpatients and day case surgery
- Rowley Regis Hospital, where outpatient activity is undertaken.

At Sandwell Hospital, the eye theatre is in the Day Unit. It is equipped with an Alcon Phaco emulsification machine and a Zeiss microscope. There are six patient chairs on the Day Unit, with dedicated ophthalmic nursing staff. Almost all surgery is done on a day case basis.

Services provided include:

- Paediatric refraction
- Photo dynamic therapy
- Lucentis injection service
- Visual field testing
- Medical photography
- Biometry
- B-scan ultrasound

Birmingham and Midland Eye Centre

Birmingham and Midland Eye Centre (BMEC) is one of the largest specialist eye hospitals in Europe. The centre has 35 consultants, each sub-specialising in particular areas of ophthalmic practice. The centre is the main site for eye surgery and A&E in Birmingham and Sandwell. In the year ending December 2013, the overall attendances in the outpatient department were 142759, and there were 10491 surgical attendances. The total number of BMEC A&E attendances in 2013 was 24626.

The BMEC treats both common and rare eye disorders, including cataract, glaucoma, diabetes-related eye diseases, uveitis, inherited genetic conditions, neuro-ophthalmology, age related macular degeneration, oculoplastics, complex orbital surgery, vitreo-retinal, immunosuppression patients and much more. All aspects of eye surgery are also carried out by the 35 consultants working at the trust, either substantively or as visiting consultants. Along with state of the art laser and diagnostic equipment, the centre provides the full range of general and specialist outpatient services:

- Cornea and external eye diseases
- Ocular surface diseases
- Inflammatory eye diseases and immunosuppression
- Oculoplastics, lacrimal and orbit
- Glaucoma
- Uveitis clinic
- Behçet's Syndrome Centre of Excellence
- Medical retina
- Diabetic retinopathy
- Macula clinic
- Intravitreal injections
- Vitreo-retinal
- Laser clinics
- Neuro-ophthalmology and adult strabismus
- Paediatric ophthalmology
- Genetics
- Cataract clinics
- Community clinics
- General ophthalmology and primary care clinics
- A&E and Urgent Care Clinics
- Optometry and contact lens
- Low vision aid clinic
- Visual function and electrodiagnostics
- Orthoptics
- National Artificial Eye Centre
- Medical illustration
- Fluorescein angiography
- Indocyanine green angiography

The present consultant and academic staff includes (with an indication of their special interest):

1. Mr S Aggarwal	Glaucoma
2. Mr J Ainsworth	Genetic Eye Disease
3. Mr J Al-Ibrahim	Medical Retina
4. Mr A Aralikatti	Cornea and A&E/primary care
5. Mr H El-Defrawy	Paediatric Ophthalmology
6. Miss L Butler	Paediatric Ophthalmology
7. Mr D Cheung	Oculoplastics
8. Mr B Das (Locum)	Medical Retina
9. Mr S Elsherbiny	Medical Retina
10. Mr Y Ghosh	Oculoplastics and A&E/primary care

11. Mr A Jacks	Neuro-ophthalmology
12. Mr K S Lett	Vitreo-retina and A&E lead
13. Miss P Lip	Medical Retina
14. Mr P McDonnell	Cornea
15. Mr I Masood	Glaucoma
16. Mr T Matthews	Neuro-ophthalmology
17. Mr A Mitra	Vitreo-retina, Medical Retina and A&E/Primary Care
18. Mr A Murray	Oculoplastics
19. Professor P Murray	Uveitis
20. Mrs B Mushtaq	Medical Retina
21. Mr M Nessim	Glaucoma and A&E/Primary care
22. Mr M Quinlan	Cornea
23. Miss S Rauz	Ocular Surface and Inflammatory Eye Diseases
24. Professor R Scott	Vitreo-retina
25. Professor P Shah	Glaucoma
26. Professor S Shah	Cornea
27. Mr A Sharma	Vitreo-retina
28. Miss E Damato	Medical Ophthalmology / Uveitis
29. Miss C Sullivan	Oculoplastics
30. Mr V Sung	Glaucoma and Group Director
31. Mr A Tyagi	Vitreo-retina
32. Miss F Mellington	Oculoplastics (Locum)
33. Mr R Chavan	Medical Retina
34. Mr P Pandey	Glaucoma

The Birmingham and Midland Eye Hospital transferred from a city centre site in 1996 to be re-established as the BMEC at the then City Hospital NHS Trust. The BMEC was purpose built for ophthalmology and includes:

- Academic Department
- Outpatient suite
- Three main operating theatres
- Visual Function Department
- Refraction Service
- Orthoptic Department
- Artificial Eye Service
- Ophthalmic ward with 10 inpatient beds
- Paediatric inpatient facility
- Day Surgery Unit for adults
- A self-contained day case operating theatre suite (theatre four) adjacent to the daycase unit

At the same time and linked with this move, there was a major development of outpatient ophthalmology provision at the other main hospitals around Birmingham. The BMEC, in partnership with the other hospital eye departments around Birmingham, aims to build on its established reputation as a Centre of Excellence in Ophthalmology.

Children are admitted to the paediatric area adjacent to the inpatient ward at the BMEC as necessary. Dedicated one stop cataract clinics are also running across the trust. All pre-operation patients are assessed by nursing staff, with medical staff obtaining informed consent.

BMEC Website

A new website for the Birmingham and Midland Eye Centre was launched in June 2013. The website contains useful information both for patients and staff working at BMEC. The Healthcare Professional section of the site is password protected and contains a number of guidelines and other useful resources that trainees will benefit from. Trainees are requested to visit the site and take part in the discussion forum. Please email arijit.mitra@nhs.net for your password.

Visit the BMEC website today at http://bmec.swbh.nhs.uk/

The Academic Unit of Ophthalmology

The Academic Unit of Ophthalmology, School of Immunity and Infection, University of Birmingham is housed in the BMEC on the City Hospital site. It consists of:

- Professor Philip Murray
- Clinical Senior Lecturer, Miss Saaeha Rauz
- Non-clinical Senior Lecturers, Dr Graham Wallace and Dr John Curnow
- NIHR Clinical Lecturer
- Clinical Lecturer
- Clinical Research Fellows
- Academic Clinical Fellows
- Research Nurse
- PhD students
- Research Associates
- Two secretaries

Although some laboratory-based research is undertaken on site in two purpose-built laboratories, much of this work takes place at the newly formed Centre for Translational Inflammation Research based in the Queen Elizabeth Hospital, Birmingham (part of the Medical School). The main research area of the unit is centred on immune mechanisms in the ocular environment. Major research interests include:

- understanding of the immunological mechanisms underlying intraocular inflammation
- ocular surface inflammation and severe infections.

A particular interest is the endocrine control of immune regulation and inflammation.

Professor Murray and Miss Rauz are also academic tutors for the West Midlands Deanery Postgraduate School of Ophthalmology. Anyone contemplating out of programme leave for research should discuss their plans with the tutors.

Academic Unit of Ophthalmology seminars

The Academic Unit of Ophthalmology runs research seminars on the fourth Thursday of the month (8-9 am) for academic, clinical and non-clinical staff. All trainees and trainers

are welcome. These seminars are particularly suitable for anyone wishing to undertake research with the unit leading to higher degrees. The session is awarded one Category A CPD point from the Royal College of Ophthalmologists.

West Midlands Postgraduate School of Ophthalmology

Postgraduate Training Programme

There is a regular Wednesday afternoon postgraduate training sessions in ophthalmology currently based at the Postgraduate Medical Centre, City Hospital, but with "out and about sessions" at Coventry, Wolverhampton and other sites. The postgraduate training programme committee is developing new concepts for learning. Sessions will include a diverse programme such as mini-symposia, grand rounds, journal clubs, conference reports, audits, case presentations and a bespoke ophthalmology induction programme for year one specialist trainees.

The programme can be found at:
http://www.westmidlandsdeanery.nhs.uk/SpecialtySchools/Ophthalmology/PostgraduateTrainingProgramme.aspx.

Attendance is monitored and circulated to the Postgraduate School of Ophthalmology through a sign-in attendance register and via return of feedback forms. Traffic light RAG status audits are conducted periodically. 70% attendance rate is mandatory to ensure a successful ARCP and for final authorisation of study leave.

If you have ideas of how to improve the programme, please feedback to the committee. Details can also be found on the website (you will need to register to gain access to the restricted areas).

The Birmingham Eye Foundation Roper-Hall Prize Medal Award is open to any member of the junior medical staff within the West Midlands Deanery School of Ophthalmology Specialist Training Scheme, junior research fellows and more senior clinical trainees undertaking specialty fellowships at the BMEC. The medal is awarded for a clinical case presentation in which the trainee must have been personally involved in the management of the patient during their training.

Special consideration is given to case presentations which improve clinical practice particularly if there is a message to be learnt from the case scenario. The winner will receive the hallmarked solid silver Roper-Hall Prize Medal which will be engraved with the winner's name, a £100 cheque donated from the Birmingham Eye Foundation, and will have their name added to the Birmingham Eye Foundation Roper-Hall Honours Board. All trainees are encouraged to submit a case. For more information, please contact Miss Rauz.

Website

The School of Ophthalmology website hosts a wealth of information, such as programme rotations, ARCP information, Head's Headlines and Director's Directions. A large proportion of the site is secure. You must register in order to have access to these pages. Please visit: http://www.westmidlandsdeanery.nhs.uk/SpecialtySchools/Ophthalmology/.

The registration link is found in the top left hand corner of the page. Your registration will require authorisation before access is granted. If you have comments regarding the website content, please feed these back to Miss Rauz.

RSTA sessions

The School of Ophthalmology is monitoring the quality of RSTA sessions using a points based system to ensure activity in all aspects of research, study, teaching and audit (**Appendix A**, Check West Midlands Deanery website for updates).

Outpatient Department

Sandwell and West Birmingham Hospitals NHS Trust undertakes general ophthalmic outpatient activities at Sandwell and Rowley Regis Hospital, as well as community venues in south Birmingham. It also undertakes a mix of general and specialist ophthalmic outpatient services within BMEC. We also outreach our orthoptic and optician services across the west Birmingham and Sandwell locality.

Documentation

Clinical notes are a legal document. It is therefore imperative that for all entries the following information is documented legibly:

- Date
- Time the patient is seen
- Full name and grade of doctor is printed (the trust provides a stamp – contact Bhajan Kaur)
- Signature

Your name stamp should be used during documentation.

Please be aware that notes will be audited from time and feedback provided where failures are noted.

Outpatient outcome/18 week form

Every time a patient attends OPD, doctors, nurses and other healthcare professionals are all responsible to ensure that whatever happens to the patient is all recorded on the trust's outpatient/18 week form. Failure to do this will create two serious problems:

- we might not get paid
- we won't be able to monitor the patients waiting time against the national 18 week target.

Productivity

The specialty is keen to ensure that it optimises its outpatient resources to deliver a service that meets patients' needs and delivers on both local and national targets. From time to time, process and start/finish time reviews are undertaken to facilitate this.

The specialty is currently making a concerted effort to:

- Reduce its level of DNAs (patients who did not attend for their appointment). We ask that you play your part by publicising the importance of attending clinic appointments. The trust's policy on DNAs requires that patients who fail to attend their appointment be referred back to their GP, unless there is exceptional clinical need.
- Reduce its new to follow up rate to align it closer to the national average. We therefore ask that you assist by avoiding unnecessary follow ups.

Transport

All patients must be advised that hospital transport is not routinely available. It is only available for patients who have a medical requirement for an ambulance.

Clinical Sharps Safety

When we refer to clinical sharps, we include items such as needle sticks, punctum plugs inserters, forceps and any other sharp disposable instruments used in the course of clinical work. You must ensure the safety of both yourself and others by disposing of sharps via the yellow sharps bin located in each clinical area. Where failures or near misses occur, they must be reported immediately to the departmental manager. **Appendix B** of this document provides further important information in regards to sharps safety.

Orthoptic Department

Orthoptics is the study of visual development, eye co-ordination and binocular vision which is the ability to use both eyes together as a pair. Orthoptists are university-trained allied health professionals who assess the movement of the eyes and determine how well people can see. They are clinicians who diagnose and provide non-surgical management of disorders of eye movements and associated vision defects. Common examples of problems relating to vision are:

- Lazy eye (amblyopia), which occurs when one or both of the eyes are underdeveloped. This results in a reduction of vision and can be caused by a presence of a squint and/or a difference in the need for glasses between the two eyes.
- Defective binocular vision, which is the inability to use the two eyes together in the correct way, can lead to impaired visual viewing.
- Diplopia (double vision) resulting from abnormal eye movements or strabismus (squint). A squint is when one eye turns away from the normal position and occurs when there is an imbalance between the muscles that move the eyes.
- An injury or disease affecting the eye muscles or the nerve supplying the muscles will cause abnormal eye movements or a physical restriction to eye movement.

The orthoptists at BMEC also work within community providing school screening throughout the centre of Birmingham including special schools and a child development centre offering support and treatment for patients' visual needs.

In addition, the orthoptic team is also responsible for glaucoma monitoring by testing fields of vision, and with the orthoptist's expanding role they are now working alongside glaucoma specialist surgeons assisting with eye pressure measurements and recording the health of the eye.

Clinically, orthoptics involves investigating, diagnosing and treating defects of binocular vision and abnormalities of eye movements in patients of all ages from infants to the elderly. The orthoptists see people with a wide range of conditions and play a vital role for follow up of patients for their best care. They work with ophthalmologists, ophthalmic nurses, optometrists and visual function technicians that form part of the eye care team. There are specialised clinics for children with a paediatric consultant and neuro-ophthalmology clinics for adults that are led and managed by highly specialised orthoptists.

Orthoptic Manager: Rosie Auld, extension 6852

Rapid fast track service for wet AMD and retinal vein occlusion

Patients are screened throughout the area via local optometrists and local eye A&E department. Those patients who are suspected to have wet age related macular degeneration (AMD) are referred via fax to the Medical Retina Administration team. The referral is then triaged for appropriateness for this clinic. The patient will then be registered and sent an appointment within two weeks of the date of the referral.

Please note that there is a Medical Retina tray in the Eye Casualty, which is cleared by the Medical Retina clerk every morning. Please leave the Eye Casualty sheet in the Medical Retina tray for any patient presenting with wet AMD or RVO. Please DO NOT send these notes to the Medical Retina consultant to avoid unnecessary delay.

Optometry – Patients are seen by our in-house optometrists, where they will receive a full refraction.

Diagnostics – An OCT or FFA will be performed depending on clinical requirement. This involves a medical technical officer plus nursing grade.

Assessment – Patient is then assessed by an associate specialist, who will recommend the appropriate management of the patient's condition.

Treatments

Lucentis: Lucentis is an injection given into the eye (a procedure known as intravitreal Lucentis, or IVL for short) and prevents the new, weak blood vessels from growing and leaking, and in some cases has even repaired some of the damage that has occurred. To maintain a patient's vision with Lucentis they will require regular diagnostic and refraction tests in conjunction with monthly injections of this drug.

The patient will be booked for a course (loading dose) of injections with a four week review following the third injection.

Photo dynamic therapy: We currently provide photo dynamic therapy to patients with wet AMD. The aim of Visudyne, the drug used in the process, is to reduce the potential

for loss of central vision caused by wet AMD. Visudyne works by destroying abnormal blood vessels that grow behind the retina at the back of the eye. Visudyne is a non-thermal laser, as the light produced by this type of laser does not burn the retina.

The patient is then booked an appointment to receive laser. This will be one week, or may even be on the same day as the fast track appointment if there is time. In total, patients are identified and treated within a maximum of three weeks, but more usually within two weeks.

Ozurdex: Ozurdex has now been approved by NICE (National Institute for Health and Clinical Excellence) for all CRVO and BRVO patients with macular haemorrhage or those that have been unresponsive to laser should all be funded.

- Dexamethasone intravitreal implant is recommended as an option for the treatment of macular oedema following central retinal vein occlusion.

- Dexamethasone intravitreal implant is recommended as an option for the treatment of macular oedema following branch retinal vein occlusion when treatment with laser photocoagulation has not been beneficial, or treatment with laser photocoagulation is not considered suitable because of the extent of macular haemorrhage.

The service is managed by the Medical Retina Services Manager, Charlotte Hill (extension 6714) and supported by administrative staff, secretaries and clerks.

Community Ophthalmology Service

The award-winning Sandwell and West Birmingham Hospitals NHS Trust community ophthalmology service provides regular ophthalmology check-ups and services. It is provided locally, in a more familiar and comfortable setting, for patients within south Birmingham.

The service has regularly received excellent feedback from service users, GPs and optometrists alike since becoming operational in January 2009. The service represents a great opportunity to encourage the forging of stronger links between primary and secondary care in the effort to improve ophthalmic services for the population of south Birmingham.

The community ophthalmology service is operational from two venues within south Birmingham:

Area	Venue	Clinical Lead	Date opened
Harborne	Lordswood House Medical Practice, 54 Lordswood Road, Harborne, Birmingham, B17 9DB **Tel - 0121 426 2030**	Mr O Durrani	May 2009
Selly Oak	River Brook Medical Centre, 3 Riverbrook Drive, Stirchley, Birmingham B30 2SH **Tel – 0121 451 2525**	Mr A Aralikatti	June 2010

The service is provided by consultants from the BMEC and has been commissioned to provide high quality care within a setting which is local and convenient for service users. Benefits of this service include:

- Consultant delivered expertise at a convenient local venue
- Specialist nursing support
- Swift and efficient referral management – centralised, with one point of contact for both venues
- Seamless integration with secondary care
- Prompt appointment service from a dedicated team – patients contacted within five days of referral
- A convenient local venue with smaller, less busy clinics
- A direct telephone number and named point of contact
- Short waiting times: maximum waiting time is five weeks
- Letters to referring GP/optometrist within five working days
- Smaller, less busy clinics
- A comfortable environment
- State of the art equipment
- Free parking and good access to public transport, pharmacies etc.
- Care closer to home
- One-stop service, doing away with numerous visits into hospitals
- Centre of excellence
- If patients require surgery, they will have their pre-op during initial consultation, and leave knowing the date and time of their operation

Referral process

GPs and optometrists may refer into the service, and at this point the patient may choose their preferred location for treatment. As with the BMEC itself, appointments can also be made via the Choose and Book system. All referrers will be given feedback after the patient's appointment, including any notifications of non-attendance.

The dedicated support line for information and assistance is 0121 507 6705 and the dedicated fax number for referrals is 0121 507 6444.

Key service standards

- Patients will wait no longer than five working days to be sent their appointment (this may obviously be quicker if Choose and Book is used)
- Patients will be offered an appointment date within five weeks of the date that they were referred
- A clinical letter will be sent to the referring GP or optometrist within five days
- Patients requiring surgery at the BMEC will have their pre-operation assessment during their initial consultation, and will leave the appointment with a date for their surgery

For further information regarding the Community Ophthalmology Service, please contact Sherminder Sanghera, Community Manager, on 0121 507 6754 or sherminder.sanghera@nhs.net.

Behcet's Syndrome National Centre of Excellence.

This is a national specialised commissioned service . The centre provides a one stop comprehensive clinic to allow patients to obtain rapid access to diagnosis and treatment. The aims of the service are :

- To ensure that patients of all ages with Behcets Syndrome receive an accurate diagnosis in a timely manner and optimal clinical management delivered on a shared-care basis with centres acting as hubs.
- Provide an excellent continuity of medical and nursing care
  The service includes:
- Clinical consultation with experts representing multidisciplinary specialities at each clinic
- Rapid referral to other related specialists where required
- Telephone access to a specialist nurse
- Funding for Biologic therapies.
- Psychological assessment

Clinics run on a Thursday PM 2-5 and Friday AM 8.30-1 The Centre is located on D46 Sheldon Block , Birmingham and West Midland Eye Centre.

Key Staff:
Dr Deva Situnayake, Consultant Rheumatologist and clinical lead for the Centre
Dr David Carruthers, Consultant Rheumatologist
Professor Philip Murray , Ophthalmologist
Miss P Stavrou , Consultant Ophthalmologist
Mr John Hamburger, Consultant in Oral Medicine
Miss Andrea Richards, Consultant in Oral Medicine
Debbie Mitton, Lead Nurse/Centre Manager
Vicky Sewell, Centre Administrator

Inpatient ward and Day Surgery Unit

The inpatient ward has 10 adult beds. In addition there are five Ophthalmic Paediatric beds in the children's part of the eye ward. If children need to stay overnight, they are transferred to D19 / PAU or sometimes Sandwell Hospital. The Paediatric Nurse is Angela Alwright, who can be contacted on extension 6875 or angela.alwright@nhs.net.

The day surgery unit consists of six beds and 15 reclining chairs. The pre-operative assessment clinics are also held on the unit Monday to Friday, working towards being totally nurse-led. The trust is also working towards reducing in-patient stays.

The Eye Ward and Day Surgery Unit ward Manager is Sarah McCay who can be contacted on 0121 507 6875/6866. The Matron for the Division of Surgery B is Laura Young, who can be contacted on 0121 507 6289.

Ward cover

Each trainee is responsible for their consultant's patients on the ward. When on leave, you must make clear arrangements as to who will see your team's patients and let the ward, your consultant and their secretary know.

Daytime ward cover by FY2/GPST

Hours of duty (weekdays***):*** 9am – 5pm

1. They shall produce a rolling weekly rota forward cover (including bleep/contact number), email it to the RSO, sarah.mccay@nhs.net and Bhajan Kaur and print a copy and give it to the ward. When on leave, ensure that they cover each other's leave period and keep everyone informed.

2. Between the hours of 9am – 5pm, they are responsible for ward patients, under the direction of the various teams. They may be requested to review patients by the nursing staff. If there are any ophthalmic queries that are beyond their expertise, ask the ward to contact the team responsible for the patient. If a patient is unwell and/or requires transfer off the ward, inform the responsible team.

3. Before leaving at 5pm, ensure that there is no routine ward work left for the on call team (drug charts, bloods, clerk-ins etc).

The FY2 has bleep free teaching from 2 – 5pm on Tuesdays, so the GPST will cover during these hours. When the GPST is away, the FY2 does the jobs before teaching.

Emergency ward cover

The following instructions relate to inpatients on the eye ward who are unwell and need urgent medical (non-ophthalmic) attention and none of the patient's team members are contactable or able to attend (e.g. team under c/o Selly Oak Hospital, Heartlands Hospital).

The Eye Ward staff will need a named doctor to contact, who will carry a ward cover bleep (5865). When a doctor on the following escalation list is on leave, they must hand the bleep to the next person down the list. This list is updated by management.

The ward should contact:

GP trainee; if on leave, they must hand the bleep to:
1. FY2; if on leave, they must hand the bleep to:
2. BMEC 1 ophthalmology trainee; if on leave, they must hand the bleep to:
3. BMEC 2 ophthalmology trainee.

Should emergency/immediate ophthalmic assessment be required, the following contacts should be attempted

1. Patient's own team
2. Take patient to BMEC A&E
3. Call a doctor up from BMEC A&E
4. BMEC 1 ophthalmology trainee, then BMEC 2 trainee (depending on their availability)

Antibiotic Prescribing on the Ward

Please make sure that you provide the following information on the drug charts especially when you are prescribing antibiotics:

1. Complete the allergy status of all drug charts (if there is no allergy history, write down ‘nil’ in the allergy box).
2. Antibiotics Stop/review date on drug charts (encircling the box on the charts when the continuation of the antibiotics needs to be reviewed e.g. after 48 hours).
3. IV antibiotics must be reviewed in 48 hours and oral antibiotics must be reviewed on the 5th days.
4. Write down the indications for the use of the antibiotics under the name of the drug e.g. corneal ulcer.
5. Make sure that the use and choice of antibiotics are in line with the trust and departmental guidelines.

VTE assessments

1. All patients admitted from BMEC A&E should have a VTE assessment as soon as possible. It is technically not possible to do this before the patient's name appears on iCM as inpatient, so ask the ward clerk/A&E staff to add the patient on iCM as inpatient. Undertake VTE assessment in BMEC A&E if possible before sending the patient to the ward (unless other clinical priorities). All GA patients must also have a VTE assessment before surgery.
2. The admitting doctor shall specify in the notes the name of the doctor who shall be doing the clerking and VTE assessment (so that the ward can contact the named doctor if necessary)
3. If the casualty is busy or if there are other clinical priorities, the named doctor should inform the ward about the "Time when VTE assessment would be undertaken". This should not NOT be left for the next day
4. If the doctor has any IT difficulties, they can contact the on-call IT technician by ringing Ext 4050

Ophthalmic theatres

Theatres are one of our most expensive resources and the trust policies require all lists to start on time and endeavour to utilise the full list.

There are three theatres, plus one ambulatory cataract/minor ops theatre. The Theatre Managers are Kevin Mitchell and Brett Thornewell and they can be contacted on 0121 507 6825.

Where necessary, issues around the order of operating lists can be managed in conjunction with the Elective Surgical Booking Team. Lists and their order should be determined wherever possible at least 48 hours in advance. On the day of surgery, any adjustment in the order of a planned operating list should be communicated and agreed at Theatre Team Brief, and the staff of the admitting ward/area must be advised of such changes as early as possible.

Cataract operations must be documented in the Medisoft IT system with a brief summary in the notes.

The following protocol has been developed to outline the correct process for ensuring that intraocular lenses are correctly selected prior to their implantation. Many of the control measures included within this document are agreed outcomes following recent table-top review of untoward incidents.

Roles and responsibilities

The responsibility for ensuring that the appropriate lens type and power is selected, prepared and implanted is shared by the peri-operative team, but ultimately lies with the operating surgeon.

The availability of the usual consignment stock is ensured by the operating theatre personnel and the Operating Theatre Manager(s).

In the event of any particular consignment lens type/lens power being unavailable, this must be effectively communicated by the operating theatre personnel at the Team Brief prior to the commencement of the operating list.

The individual operating theatres hold a stock of lenses which is maintained and replenished by the staff dedicated to each theatre.

Selection of intraocular lenses

There is a standard operating procedure (SOP) for cataract surgery in BMEC and Sandwell eye theatres (**Appendix C**). It is extremely important that you follow the SOP for IOL implantation so as to reduce/eliminate the risk of wrong IOL implantation. As you are aware, implantation of wrong IOL is counted as a never event and has to be reported.

Although there are many persons/processes involved in IOL implantation and therefore should be seen as a 'Team Approach'. It is ultimately the surgeon's responsibility.

In summary, apart from the normal WHO time-out checklist, surgeons require to select the IOL power from biometry on Medisoft. Once the surgeon has picked out the IOL from the lens store, the surgeon is required to double check with another person in the theatre (another doctor or a registered nurse) in front of the biometry screen on the Medisoft. They have to confirm the name of patient, laterality of operation, lens power and model, aiming refraction and finally double checking that the IOL box for the correct model and power of the IOL then place it on top of the phaco machine.

If an alternative IOL must be used during the operation, the new IOL choice must be selected on the biometry screen of Medisoft. Nurses can collect new IOL from lens store, a second double checking procedure must be performed before opening the IOL for use.

This is an extremely important process and we expect everyone following the same process for every cataract operation. Some theatre nurses will do the double checking on behalf of the surgeons, but this do not replace the double reading and checking process by the surgeons.

Also, all IOLs should be stored outside the theatre, therefore there should be only one IOL with the correct power for the patient in the theatre to avoid mistake.

We cannot emphasize enough how important it is to avoid IOL implant mistake, any wrong IOL implant will automatically categorised as "Never Event" and trigger an investigation process and table-top review. For the surgeons, a mistake like this will be discussed at appraisal and the ARCP for juniors.

Traceability of intraocular lenses

In order to ensure satisfactory recording and traceability of intraocular lenses and other implantable devices, it is essential that product identification labels are affixed within the:

- Theatre register
- Surgeon's operation record
- Medical continuation notes (healthcare records)
- Intra-operative care plan
- Medicines batch/lot number record

Visitors and company representatives

The presence of any visitor(s) within the operating theatre must be highlighted at the Team Brief prior to the operating list.

The selection and preparation of ophthalmic implants of all types must be managed exclusively by the operating surgeon and operating theatre personnel. Any team member that participates in this process must be occupationally competent and sufficiently familiar with the specified process. Company representatives including salespersons, product specialists or any other visiting individual(s) must not be involved in the selection and preparation of lens implants.
Any concerns relating to the correct selection and preparation of implants must be highlighted and addressed immediately. Any discrepancies or untoward occurrences must be reported as they arise in order that any rectifications may be undertaken as soon as is appropriate.

Emergency cases

To book emergency cases within normal hours, the theatre co-ordinator can be contacted on extension 6825. It is also necessary to contact the on-call anaesthetist if required.

When booking emergency cases out of hours, all emergency surgery should be undertaken as soon as possible after discussing with the on-call consultant and liaising with the theatre team. Emergencies admitted after 8pm should be booked to the theatre list for the following morning, after informing the on-call consultant and liaising with the theatre team. One of the BMEC theatres shall be made available by rotation for such emergency surgery. The rota for this emergency morning theatre is displayed in the BMEC A&E notice board, inpatient ward and by the theatre office. There is also an afternoon BMEC theatre nominated for emergencies that arise earlier the same day.

Ophthalmic accident and emergency

The lead consultant for A&E is Mr K Lett. There is a consultant in A&E from Monday to Friday:

Monday	Mr P Pandey (am), Mr B Das, Miss Damato (pm)
Tuesday	Mr Y Ghosh (am), Miss R Ford (pm)

Wednesday	Mr K Lett (am), Mr A Mitra (pm)
Thursday	Mr A Aralikatti (am), Mr M Nessim (pm)
Friday	Mr Chavan (am), Mr. H. El Defrawy (pm)

The A&E nurse in charge is Alison Hynes. She can be contacted on 0121 507 6780 or alison.hynes@nhs.net.

A&E opening hours

Monday to Saturday	9am – 7pm
Sunday and bank holidays	9am – 6pm

A&E sessions

Morning session	9am – 1pm
Afternoon session	1.30 – 5pm
Evening session	5pm onwards (on-call team - there is a dedicated on-call team after 5pm on Monday to Friday, and on weekends and bank holidays)

Guidelines for A&E sessions

- All doctors must report punctually for their sessions. If you are unable to do so, you may be required to work over.
- You should not assume that if you arrive early to suit your own circumstances that you can leave the department early unless this has been previously agreed by the A&E consultant.
- On-call doctors are expected to be present at 5pm. Those working in spoke hospitals must inform them about on-calls well in advance to be able to leave the spoke hospitals early and reach A&E by 5pm.
- In the event of unforeseen delay, the A&E sister and A&E senior medical staff must be informed
- All doctors should check the monthly A&E rota and inform Bhajan Kaur and RSO about any errors related to their sessions. Any changes due to annual leave, study leave or general swaps should be notified in appropriate time.

Guidelines for managing patients

- Access to the A&E system is via Smart Card. All doctors must both bring and use their smart cards in every casualty session.
- Patients should be managed according to the A&E protocols. These are held in a folder in the A&E and the ward (also see **Appendix D**)
- In addition, there are detailed guidelines on the hospital intranet, Connect.
- The use of investigations should be kept to a minimum and only in cases of uncertain diagnosis or where their use will affect patient management on that day. In particular OCT is currently massively overused when a diagnosis is quite evident

on clinical examination, eg. wet and dry AMD, macular oedema, epiretinal membrane, macular hole. Develop and rely on clinical skills more than technology.

- No corneal PCR should be requested from Eye Casualty unless discussed with the Corneal team (within hours) or the on-call Consultant (out-of-hours)
- For adults with suspected intercranial hypertension, refer to medics at the main City Hospital site (please see protocol on Connect)
- For children with suspected optic disc swelling, always consider drusen and arrange B-scan ASAP. Consider seeking the advice of a paediatric ophthalmologist early on, as well as involving the paediatricians if necessary.
- Paediatric orbital cellulitis is jointly managed with the paediatric and ENT team (refer to A&E protocols).
- Clinical records must be complete and legible. All doctors must sign their entries with name and designation. Identification stamps should be obtained from Bhajan Kaur.

Lasers

- Urgent laser treatment (e.g. retinopexy) for A&E patients should be undertaken when these patients present to A&E. During the day, this can be undertaken by the daytime A&E team only if the number of waiting patients allows, or if there is no suitable doctor to undertake the laser, all efforts should be made to add the patient to available laser lists during the day. Failing this, the patient can brought back at 5pm for the on call to perform the laser. Out of hours PRP should only be performed in exceptional cases and most should be booked onto a daytime laser list.
- Please refer to the recently updated Laser Rule Book.
- Any laser procedure done outside a dedicated laser clinic, or undertaken out of hours, must be recorded in the laser register present in the room where the procedure was done, and a clerk must be informed (at a later time if necessary if the procedure was out of hours). If the clerks do not know what to do, please ask them to inform Manjit Purewal, Medical Records Team Leader.

Endophthalmitis - Minor Procedures Room in A&E

All patients with acute postoperative endophthalmitis need urgent vitreous biopsy and intravitreal antibiotics. This can be performed within the BMEC A&E urgently with the help of staff nurse/sister in A&E. Intravitreal antibiotics are stored in the BMEC A&E refrigerator and need to be injected according to the endophthalmitis protocol which is available in the procedures room. These patients need to be discussed with senior doctor/consultant on call and admitted after the procedure has been performed.

Corneal cases

Corneal emergencies should be dealt by the on-call team on the same day. For corneal cases needing consultant opinion (that can wait more than 10 days), please place the notes for vetting by Mr Aralikatti. He may decide some cases can be seen in the primary care clinics.

Follow up arrangements

Please note that no follow ups are allowed in BMEC A&E unless authorised by the consultant or nominated senior doctor in BMEC A&E**.** All junior trainees and speciality doctors are urged to discuss patients with their senior colleague in BMEC A&E who may be the consultant, senior registrar or associate specialist. This will ensure that only appropriate follow ups will be brought back in a timely fashion. (**Appendix D**). Regular audits are carried out in A&E.

A&E handover

- It is essential that on leaving A&E, you have appropriately handed over any patients that remain in the department and for whom you are responsible.

- **A&E handover book**: There is a handover book in A&E. During the day, details of any patient who needs to be handed over to the on-call team must be recorded in this book**.** In addition, details of the person entering the information and relevant clinical information shall be entered (emergency admissions during the day, pending investigations and procedures, outstanding tasks, etc). The same information should also be entered in the patients' hospital records. See **Appendix E** for a copy of this handover information.

- **A&E handover meeting:** A handover meeting should take place between 5pm and 5.30pm in the A&E staff room. All on-call doctors and the senior nurse in charge of A&E should be present unless there is a medical emergency. The 4th on-call should be the handover leader. If the 4th on-call is unable to attend (e.g. if attending to an emergency in a spoke hospital), this responsibility can be delegated to the 2nd on-call who should then brief the 4th on-call as soon as possible.

Urgent care clinics

Urgent care clinics are for patients who are not accidents or emergencies, but need to be seen sooner rather than later. These clinics operate every Monday to Friday (morning, afternoon and evening) and on weekends. A list of conditions that can be seen in these clinics has been given to the A&E nurses who triage the patients. These clinics run parallel to A&E, and are staffed by A&E nurses and doctors. Please note that GP letters need to be typed on ICM for all urgent care clinics.

Primary care follow up clinics

Primary care clinics are for A&E patients who need a follow-up appointment (e.g. acute anterior uveitis) that have been approved by the consultant. These clinics have been set up in the outpatient department on Monday evening, Tuesday afternoon, Wednesday afternoon and Friday afternoon. They are undertaken by A&E doctors with the help of the outpatient nurses. A short letter should be dictated to the GP with diagnosis, vision and management plan.

On call

Day SpR for A&E

- There is an on-call SpR to cover each daytime A&E session during the week. The role of the day SpR is to give advice to the junior A&E colleagues and to see patients needing admission. The day SpR needs to ensure that the switchboard and the junior colleagues can contact them throughout their session.

- **Handover of patients admitted during daytime working hours**: Patients must be seen by the on call day registrar or admitting team and discussed with the admitting consultant. Between them (admitting consultant and registrar) they must agree ongoing follow up and care arrangements and document a plan in the notes. Any acute issues that day must be handed over to the 2nd or 4th on call for that evening who should communicate with each other. The admitting consultant's registrar/SHO must be briefed the following day.

  It is not appropriate for the admitting registrar to provide ongoing care for patients not under their own consultant or for the patient to wait for the on call team to see them in the evenings; however, until care is handed over, the admitting consultant and registrar must remain responsible for the patient.

Out-of-hours on call

- When you are on call you are part of a team. All on call doctors must be available and contactable by other team members and switch-board.

- Each doctor should sort out his or her own swap; there should be no RSO involvement. Each person swapping informs switchboard/A&E/Management Office (Bhajan Kaur/Marion Butler) and the RSO. If the person you have swapped with fails to attend, unfortunately you will not be paid.

- All emergency admissions must be discussed with the on call consultant that evening/night. When informing about an emergency admission, the 4th on-call should clarify with the on-call consultant about the future management plan (including subspecialty referral, and any preference for a named consultant referral) and document a plan in the notes. If possible and where this is agreed, the referral for this transfer can be made the evening before the next working day (e.g. Sunday evening). The point of contact will be the Fellow, ASTO and specialist trainee in that order. However, until the subspecialty team has seen the patient the next day and taken over, the care of the patient shall be with the admitting consultant. See **Appendix F** for a copy of ward handover.

- Vitreo-retinal patients: There is a pathway for management of vitreo-retinal patients over the weekend (**Appendix G**). The on call team is responsible for the pre-operative and post-operative work-up of admitted vitreo-retinal patients out-of-hours. The vitreo-retinal fellows can be contacted for advice should any queries or problems arise.

- Emergency operations: For patients admitted to BMEC with corneo-scleral perforations / lid laceration / any other condition requiring emergency operation the following day, please follow the SOP as outlined in Appendix H.

Worcester and Kidderminster patients: Emergencies during daytime (Monday to Friday 9 am – 5pm) are to be seen by local eye services and not at BMEC A&E. Emergencies out-of-hours should be discussed with the 4th on call and only urgent cases that cannot

wait until next day to be seen at BMEC A&E. Non-urgent patients are to attend local eye services next day.

1st on call

Hours of duty (weekdays): 5pm until start of next normal working day (9am)
Hours of duty (weekend): 9am Saturday until Sunday morning (9am), 1pm Sunday until Monday morning (9am)

During these hours they are responsible for seeing patients in A&E and on the ward and for taking referrals from City Hospital A&E. In addition, they can be tasked by the 2nd and 4th on call.

They should usually expect to leave casualty at 7pm and go up to the ward to do all remaining jobs there before returning to A&E. If A&E is busy, this may not be possible, but it is then good etiquette for the 2nd on to help with ward work later.

Overnight, the hospital at night team is the first port of call for non-ophthalmic issues.

2nd on call

Hours of duty (every day) 5pm until start of next normal working day (except weekends)

During these hours they are responsible for seeing patients in BMEC A&E and on the ward, covering the first on call, performing emergency lasers (retinopexy, PRP) in A&E and seeing patients at City Hospital who cannot come to the BMEC A&E or ward. They are also responsible for taking referrals from other hospitals and taking calls throughout the night. In addition, they can be tasked by the 4th on call at any time.

After a Friday night on call (i.e. Saturday morning) they are expected to assist the 4th on call in ward round from 9 to 10pm and then see patients in the BMEC A&E till 1pm.

After a Saturday night on call (i.e. Sunday morning), they are expected to see patients in the BMEC A&E from 9am – 1pm.

4th on call

Hours of duty (weekdays) 5pm until the start of the next normal working day (9am)
Hours of duty (weekend) 9am Saturday until Monday morning (9am)

During these hours they are responsible for seeing patients in peripheral hospitals and emergency operations in theatre. They also cover the 2nd on call in A&E/on the ward and assist when necessary. They should take ownership of patients and are responsible for ensuring appropriate handover of admissions.

On Saturday and Sunday mornings, they do the ward rounds.

Leave

Please note when applying for leave you need approval from all hospitals you work at. Medical staffing and the Deanery have the right to refuse any leave, even if sanctioned by the consultant, if the minimum period of eight weeks' notice is not given. Each individual

is responsible for their own on call swap. When doing this it is best to send an email to switchboard and Bhajan Kaur in Medical Staffing to notify of any change. A summary of leave is sent to colleagues bi-weekly, so please check that your absences have been correctly reflected and advise Bhajan Kaur in the event of error.

Authorisation of annual leave

This should be booked through the Management Office at the BMEC through Bhajan Kaur. Leave forms should reach the office eight weeks in advance, with appropriate consultant signatures to ensure leave will be granted, and then to the RSO for approval and checking. You need to know the reply in writing before making any holiday plans. If your base hospital is not BMEC, you still need to give eight weeks' notice to BMEC for BMEC clinics and the appropriate consultant needs to sign your leave form. Forms will not be accepted without consultant signatures.

Study leave

There is a detailed study-leave process for trainees of the West Midlands Programme. This process is being changed to an online process

For all other trainees (and employees of the trust), the process requires an additional online submission. These trainees include pre and post CCT fellows (that do not fall into Deanery regulations):

- Study leave duration: 10 working days per annum
- Study leave maximum: £500
- Leave process:
    - Doctors should obtain sessional sign-off from trainers using hardcopy of the SL form (as per Deanery trainees).
    - Once obtained, the dates should be entered onto the trust online doctors' leave request system.
    - Submission of the online request is sent for approval.
    - Hardcopies are handed to the Capacity Manager.
    - The Capacity Manager will approve leave electronically only if the electronically requested dates match the clinic sign off dates.

Sickness and compassionate leave

If you are taken ill, you must contact Bhajan Kaur/Marion Butler by 8am on the first day of your absence and if possible give an approximation of how long you expect to be off. It is important that you keep in touch during the period of your sickness absence, so that we can ensure that all clinical commitments are appropriately covered. It is the trainee's responsibility to ensure that Bhajan is informed on return back from sick leave. Bhajan will organise a sickness return to work interview in line with the trust policy.

You are also responsible for notifying the hospital you are working at, as this has a major impact on covering clinics and on calls; therefore the relevant people should be notified immediately:

Queen Elizabeth Hospital	Tracey Allen on 0121 627 1627 ext 53112
Good Hope Hospital	0121 378 2211
Children's Hospital	0121 333 9469

Dudley Group of Hospitals	01384 456111 ext 3264

Please note all annual leave, study leave, travel expenses and additional session forms are obtainable from the Doctors' Training Room at BMEC.

Pharmacy at BMEC

There is an in-house pharmacy based at BMEC. The opening times for the pharmacy are 9am to 4.45pm and is closed between the hours of 1 – 2pm for lunch. If you have an urgent query, please contact the pharmacy department at City Hospital on 0121 507 5263. We would ask you to plan ahead and ensure that the discharge paperwork is written up in advance for patients whom you wish to discharge between 1 – 2pm.

During opening hours, the pharmacy department can be contacted on 0121 507 6716/ 6717. Members of the pharmacy team are:

- Anar Meghji, Clinical Pharmacist Advanced Level – bleep 5796
- Ilka Fisher, Chief Pharmacy Technician Specialist Sector
- Geraldine Attwood, Senior Technician Specialist Sector
- Sharman Niber, Senior Technician Specialist Sector
- Other rotational pharmacy staff from across the site

Please remember that pharmacy does require a signature sample from you and will require you to complete a mini tutorial on how to use pharmacy-related trust resources. Please pre-arrange a time with the pharmacy team for when you can do this.

Prescribing

Please note the following arrangements for prescribing:

- **A&E prescriptions:** internal prescriptions (prescriptions marked as: *This prescription can only be dispensed at the Pharmacy Departments of Sandwell and West Birmingham Hospitals NHS Trust.)*
- **Post-laser topical steroids:** internal prescriptions
- **Out-patient clinics:** FP10HP prescriptions, except ophthalmic specials (must be prescribed on internal prescriptions only). The pharmacist can provide you a list of ophthalmic specials when you leave your signature sample. The pharmacy does not dispense prescriptions for outpatients, except for ophthalmic specials, or an acute emergency supply in extreme situations. In an emergency situation whereby you require pharmacy to dispense an internal prescription, please ring the pharmacy first to inform them of this and check that the item is in stock. The pharmacy will dispense an acute supply to initiate treatment, hence be mindful to give the patient an FP10HP.

Please be mindful of prescribing non-formulary items on FP10 prescriptions; BMEC gets charged by the CCG for all non-formulary prescribing (even if the items have been prescribed on an FP10).

The formulary status of all drugs can be checked by accessing the eBNF on the Connect intranet home page. However, should you have any queries, contact the pharmacy team for advice regarding formulary status, prescribing specials and whether drugs are available or not.

Medical Records Department

Medical Records is housed on the ground floor of the Eye Centre. The department prepares all records for clinics, organises and manages appointments and ensures that all reception services are covered.

All hospital notes must be appropriately tracked to an easily accessible BMEC location. If you need to retain notes for a specific period of time, please let either your team secretary or a receptionist know and they will track the notes on your behalf. This will allow their retrieval more easily should the patient be seen for a scheduled visit or as an emergency. Failure to do this can be a risk issue and will be dealt with accordingly.

Notes must not be taken off site for any reason.

The Manager of medical records is Trish Kehoe, and the Team Leader is Manjit Purewal. They can be contacted on extension 6781.

Mess President

The Mess President post is currently vacant .

Essential contact numbers and email addresses

Name/role	Email	Extension
RSO Aditi Gupta contact through switchboard		
Bhajan Kaur, Medical Staffing & Capacity Manager	bhajan.kaur@nhs.net	6879
Marion Butler, Administration Support Manager	marionbutler@nhs.net	6784
Saira Hamid, Assistant Medical Staffing Manager	saira.hamid@nhs.net	4827
Hilary Lemboye, Deputy Divisional Manager	hilary.lemboye@nhs.net	6786

BMEC ophthalmology consultants and secretaries

Consultant	Speciality	Secretary	Extension
Mr A Aralikatti	Corneal	Lucy Johnson	6855
Mr J Ainsworth	General	Natasha Thompson	6742
Mr R Chavan	Medical Retina	Veronica Campbell	6800
Mr N Motwani	General Ophthalmology	Anna Beckett	6833
Mr S Elsherbiny	Medical retina	Angela Swainsbury	6799
Miss F Mellington	Oculoplastics	Marie Grubb	6894
Mr Y Ghosh	Oculoplastics	Anna Beckett	6833
Mr A Jacks	Neuro-ophthalmology	Debbie Jones	6787
Mr K Lett	Vitreo-retinal	Esther Sterling	6807

Miss P Lip	Medical Retina	Parul Begum	6808
Mr P McDonnell	Corneal	Julie Noak	6801
Mr I Masood	Glaucoma	Charlotte Harris	6854
Mr T Matthews	Neuro-ophthalmology	Debbie Jones	6787
Mr S Aggarwal	General	Debbie Jones	6787
Mr A Mitra	Vitreo-retinal	Esther Sterling (VR) Natasha Thompson (MR)	6807 6742
Mr A Murray	Oculoplastics	Julie Noak	6801
Professor Murray	Uveitis	Jenny Hudson	6851
Miss B Mushtaq	Medical retina	Parul Begum	6808
Mr M Nessim	Glaucoma	Marie Grubb	6894
Miss S Rauz	Ocular surface / inflammatory eye disease	Kate Martin	6849
Mr R Scott	Vitreo-retinal	Veronica Campbell	6800
Prof S Shah	Corneal	Julie Noak	6801
Prof Y Yang	Medical retina	Veronica Campbell	6800
Mr A Sharma	Vitreo-retinal	Esther Sterling	6807
Miss E Damato	Medical/retina/diabetes/uveitis	Charlotte Harris	6854
Miss C Sullivan	Oculoplastics	Parul Begum	6808
Mr V Sung	Glaucoma	Lucy Johnson	6855
Mr A Tyagi	Vitreo-retinal	Angela Fall	6806
Mr H El-Defrawy	Paediatric		
Mr B Das	Medical Retina	Naina Champaneri	6794

Sandwell ophthalmology consultants and secretaries

Consultant	**Speciality**	**Secretary**	**Extension**
Mr S Aggarwal	Glaucoma	Patricia Masih	3296
Mr Al-Ibrahim	Medical retina	Julie Lukic	3139
Mr D Cheung	Oculoplastics	Jayne Evitts	3165
Mr Y Ghosh	Oculoplastics	Jean Gibbs	2812
Miss B Mushtaq	Medical retina	Jayne Evitts	3165
Mr M Nessim	Glaucoma	Julie Lukic	3139
Mr M Quinlan	Corneal	Jayne Evitts	3165
Mr A Tyagi	Vitreo-retinal	Trudy Edmunds	3207

Appendix (A) - RSTA Sessions

POSTGRADUATE SCHOOL OF OPHTHALMOLOGY
(West Midlands Deanery Workforce)

Educational Agreement for Ophthalmology Specialty Trainees
(Quality Assurance for Research, Study, Teaching & Audit (RSTA) Sessions)

Target	**Points**	
Trainees with two half-day RSTA sessions per week	12 annually	
Trainees with one half-day RSTA session per week	6 annually	
Point Allocations	**First Author/ Principal Investigator**	**Co-author/ Co-Investigator**
1) Research (2 sessions= Min 4; 1 session= Min 2)		
Paper in peer-reviewed journal	6	3
Chapter in book	4	2
Case report	2	1
Exit exam case	2	-
IRAS/Grant application submission	3	1
Involvement in a clinical trial	-	1
2) Audit (2 sessions= Min 2; 1 session=Min 1)		
Completed local audit	2	1
Completed regional audit	3	1
3) Presentations / Posters (2 sessions=Min 3; 1 session=Min 2)		
At local meeting	1	-
Oral presentation at a regional meeting	2	1
Poster presentation at a regional meeting	1	1
Oral presentation at a inter/national meeting	3	1
Poster presentation at a inter/national meeting	2	1
4) Teaching/Training (Min 2)		
Instructing or organising a regional course	1	-
Instructing or organising a national course	2	-
Contribution to formal course material	1	-
Formal teaching or courses (surgical skills etc…)	1	-
5) Completion of a College examination		
	3	-

6) Other		
use of research periods to be discussed with educational supervisor, where research periods may be used for	• attending extra specialist clinics or laser / theatre sessions • other opportunities (ECDL, MBA or MSC, BOSU, medical journalism, etc…)	

Appendix (B) - Risk Focus alerts

JANUARY 2012
ISSUE NO.8

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Focus

FOCUS ON..... "Sharps and Splash injuries; Everybody's problem!".

What is safeguarding Children?

In recent times we have moved away from the phrase needlestick injury, and are now using the phrase sharps or splash injury. Such injuries are still a major problem within the healthcare workplace, with over 250 injuries sustained last year in this trust alone. With any sharps or splash injury there is a risk of transmission of blood borne viruses, including Hepatitis B and C and HIV. If 1000 people have a sharps injury that punctures the skin from a source infected with HIV, 3 of these people would go on develop HIV. This is compared with 1000 people that have a sharps injury that punctured the skin from a source infected with Hepatitis B; 300 of these people would go on develop Hepatitis B.

Anyone is at risk of pricking their finger on a used sharp left amongst some dirty bed sheets or thrown carelessly into a bin, therefore, it is important that everyone is aware of what to do if they sustain a sharp or splash injury, and that team members are supportive and helpful, to ensure swift delivery of appropriate care.

If you do your part, what does Occupational Health do?

If you sustain a sharps or splash injury out of hours, attend A&E, who will risk assess you and treat as needed. Contact Occupational Health as soon as you can, leave a message on the answer phone and we'll get back to you.

Sharps and splashes injuries can be very distressing for the person injured. In order to reduce alarm in these cases, all enquiries relating to you should be directed to the occupational health team, not via direct contact with you, and any enquiries regarding the source patient should be directed to the attending medical team.

Join the campaign to improve the immediate management of sharps and splash injuries. You can make a difference!

B leed the wound

W ash the wound thoroughly

I nform: **Your line manager/perso in charge**
- Occupational Health (in-hours) or A&E (out of hours, and leave a message with Occupational Health)

S ource: **think about potentially high risk sources**

E very incident must be reported and any sharps disposed of safely

B-WARE !

You may require **urgent treatment** if you have an injury from a source that is known or highly suspected to be:

- HIV positive
- Hepatitis B positive
- Hepatitis C positive
- TB positive
- Suffering from Lymphoma

Take Home message:

- Dispose of your sharps correctly
- If you have a sharps injury – report it
- Seek assessment

The incidents reported since May 2011 were graded as follows:

Incident Grade	May	Jun	Jul	Aug	Sept	Oct	Nov	Trend
Green	407	407	431	341	306	358	309	↓
Yellow	618	801	688	695	671	864	651	↑
Amber	142	164	158	149	163	125	163	↑
Red	24	32	27	26	17	17	11	↓

Where EVERYONE Matters

OCTOBER 2017
ISSUE NO.7

Sandwell and West Birmingham Hospitals NHS

Risk Focus

FOCUS ON..... "Clinical Administrative Systems".

What are 'Clinical Administrative Systems'?

The phrase 'Clinical Administrative System' is a general term which describes the work that we do in the back-office, to support the delivery of patient care. It can include booking outpatient appointments, updating patient notes, ordering tests, discharging patients, sending letters to GPs and everything in between.

What's the risk?

Generally, it is rare for a single clinical administrative systems failure to cause immediate and significant harm to a patient. More commonly, these isolated failures result in the less serious (but still important) 'service failure' – an occasion when the patient's experience and the standard of clinical care is not quite as high as it could have been. Serious risks arise when a patient experiences a catalogue of clinical administrative systems failures, often in quick succession. These failures combine and create what is known as a snowball effect that culminates in an incident that causes immediate and significant harm to a patient.

What can we do?

If we break serious incidents down it is possible to see them as the products of actions and inactions of people and teams. In very simple terms, they arise because simple tasks are done differently by different people (sometimes even by the same people), and because there is little clarity (or consistency) with **who** does **what**, **where**, **when**, **how** and **with what tools**. Complex systems are underpinned by very simple, even mundane, tasks which need to be done well.

So, despite the complexity of our systems what we can do is surprisingly simple: **we need to get the basics right**. That is, we need to be clear about how our systems should work, what processes people should follow and what critical information needs to be recorded consistently and accurately. Specifically:

1. The Imaging and Pathology departments need to define referral protocols that will include:
   - Who can order tests
   - The process for ordering tests (electronically and using paper)
   - The process for escalating a request for an urgent test
   - Time to test
   - Time to report back to clinician
   - What happens if a test is rejected
   - The protocol that will be followed to escalate urgent/abnormal results to the attention of the ordering clinician
2. All clinicians need to use ICM to order tests electronically
3. Patients need to be kept informed about their tests (including what service they can expect to receive from the trust) either verbally or through a documented management plan or letter.
4. Clinical specialities need to ensure there are clear protocols to indicate who is responsible for tracking, checking, acting on and acknowledging test results in inpatient and outpatient situations.
5. The results of tests which are clinically significant; any action needs to be recorded (where possible electronically) in the patient's notes.

Take home message:

It's hard to get excited about administrative systems, but getting them right really matters. So,

1. Ask you manager about your department's operational protocols
2. Use ICM to request tests electronically
3. Always acknowledge your results
4. Act on the results
5. Communicate to each other and to the patient
6. Document what you have done

For further information contact:
Robin Burrow (Phd) 07816275381

Where EVERYONE Matters

MARCH 2011
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Sandwell and West Birmingham Hospitals NHS
NHS Trust

Risk Focus

FOCUS ON ..... Needlestick Injuries.

What is a needlestick injury?

An injury caused by a used sharp instrument that breaks the skin. The sharp could have been used in a clinical procedure or by an unknown person to take illicit drugs.

What is the risk?

The main risk is that of infection by a blood-borne virus, in particular Hepatitis B (HVB), Hepatitis C (HBC) and Human Immunodeficiency Virus (HIV).

The risk of transmission from an infected person to a member of staff from a sharps injury is thought to be 1 in 3 for Hep B when patient is 'e' antigen +, around 1 in 30 for Hep C and 1 in 300 for HIV.

Who is at risk?

Predominantly healthcare workers but other staff (e.g. Ward Services, Security, Waste Management, Estates) may encounter used sharps in the course of their duties.

How do they happen?

The unexpected movement of a patient during a procedure can result in an injury but this can usually be avoided with careful planning and completion of the procedure.

Wholly preventable are those injuries caused by a sharp that has not been disposed of properly. This could be a healthcare worker who fails to put it in the correct sharps bin; either leaving it unattended or placing it into a normal waste bin.

We also have patients that may self-medicate (e.g. diabetics) and fail to dispose of the sharp correctly leaving sharps that have been discarded in public places by persons unknown.

What are the best ways to avoid these injuries?

During use:

- Never pass sharps from hand to hand. They must be passed via a neutral zone (e.g. kidney dish)
- Needles must not be bent or broken prior to use
- Avoid resheathing needles. In the rare case of resheathing being necessary, the procedure must avoid direct handling (i.e. via a piece of equipment)

Disposal:

- Syringes/cartridges and needles should be disposed of intact. Where it is necessary to remove (e.g. a disposable needle from a reuseable syringe), needle forceps or other suitable devices should be readily available and staff trained in their use
- Sharps must be disposed of at the point of use in a suitable container. The use of small sharps bins taken to a patient's bedside will assist with this
- Remember that sharps contaminated with cytotoxic substances must be segregated from regular sharps waste and the purple-lidded bins must be used
- Only use approved sharps bins obtained through the Trust's usual supply lines
- Always close apertures on sharps bins when not in use
- Sharps bins should not be left unattended in public areas and in particular should be out of reach of children while remaining as near to points of use. They should not be left on the floor. The use of small sharps bins taken to a patient's bedside will assist with this
- Do not fill sharps bins above the manufacturer's marked line
- Lock the used sharps bin when ready for final disposal, in accordance with the manufacturer's instructions
- Sharps bins must be disposed of when the manufacturer's marked line has been reached, or earlier at specified times as per local procedures. It is essential that the containers are identified by ward/dept and are signed/dated so that they can be traced back to their source
- Always carry sharps bins by the handle
- Always dispose of sharps in sharps bins (i.e. not bags)
- If sharps are found outside the waste stream (e.g. on a floor), do not handle them by hand. Use needle forceps/ similar to dispose of them directly into a suitable sharps bin.

What should I do in the event of a needlestick injury?

- Immediately encourage the wound to bleed for a few seconds by gently squeezing the surrounding skin. Do not suck the wound
- Wash (but do not scrub) the affected area using soap & water and cover the injury with a waterproof dressing
- Dispose of the sharp in a suitable container. Do not take the sharp anywhere
- Contact Occupational Health (out-of-hours: contact A&E)
  - If possible, obtain the name, hospital number and location of the source patient. It may be necessary to obtain a blood sample from the patient in order to assess the risk of infection. However, this must not be done by the person who sustained the injury.
  - It is vital to seek expert advice immediately where the source patient is known or strongly suspected to be HIV+ as treatment must begin within one hour of the injury
- Report the injury on the Trust Incident/Hazard Report form to be managed by the department responsible for the area

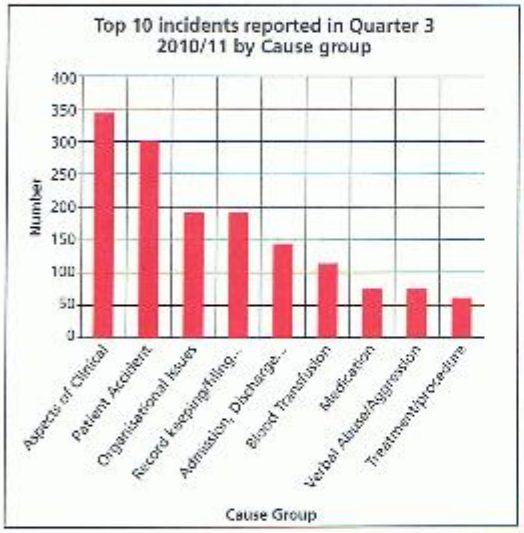
Where EVERYONE Matters

What should I do if a sharp is discovered in a waste bag?

- Quarantine the bag locally – do not dispose of it
- Contact the domestic services manager/supervisor on duty
- Domestic Services will safely search the bag to establish risk information
- Ward/dept managers will investigate accordingly
- Domestic Services will arrange for safe disposal of the bag and the sharp

Where can I find out more about this subject?

You can contact either the Infection Control or Occupational Health Department and also see the relevant policies on the intranet.



When we receive the incident forms we load them onto the Safeguard system (incident database) and categorise them into "cause groups" which are an overview group of the issue. Underneath each of these cause groups is a long list of reasons why an incident occurred or nearly occurred. Here we have identified the top 10 cause groups for incidents reported between 1 October – 31 December 2010 (Q3).

COMING SOON

to a computer near you!

Testing of the new electronic reporting forms began in October in some selected areas. Training will be available across the Trust to support roll out which will begin in earnest in January and continuing until we have complete Trust cover.

The top cause groups have changed slightly from Q3 2010/11 with Organisational Issues replacing admission/discharge:

Aspects of clinical care - Failure to provide planned care - 167

Patient accident - slip/trip/fall - 200

Record keeping/filing/missing records - missing/illegible/inadequate documentation - 144

Organisational Issues - Unsafe staffing levels - 67

Record keeping/filing/missing records - missing/illegible/inadequate documentation - 102

The incidents reported during the third quarter of 2010/11 were graded as follows:

Grade of Incidents Q3 2010-2011			
Incident Grade	Total Number	Percentage	Variance to Q2
Green	696	33.3%	☐
Yellow	967	46.3%	☐
Amber	320	15.3%	☐
Red	104	5%	☐

Root Cause Analysis (RCA)Training

The training session is being held on 19th & 20th May. To book a place please email our generic email address (swb-tr.RiskManagement@nhs.net) and we will send you a registration form.

Confirmation of your place will be sent to you.

Hurry **ONLY 3** places left for May

The Risk Management Team	
Allison Binns Head of Risk Management	Ext. 4974
Heather Arscott Risk Facilitator	Ext. 4850
Jacqui Camsell Risk Facilitator	Ext. 5064
Sue Espley Risk Facilitator	Ext. 4899
Fran Carapinha Standards Compliance Officer	Ext. 4332
Chris Robbins Risk Administrator	Ext. 5712
Harjeet Kaur Data Support Assistant	Ext. 4883
Fax: 5753 Team email: swb-tr.RiskManagement@nhs.net	

Appendix (C) : Theatre IOL checking SOP

Ophthalmology Theatres
Protocol for the Selection and Management of Implantable Lenses

The following protocol has been developed to outline the correct process for ensuring that Intraocular Lenses are correctly selected prior to their implantation.
Many of the Control Measures included within this document are agreed outcomes following a “Table-Top Review” of recent serious clinical incidents.

Roles and Responsibilities

The responsibility for ensuring that the appropriate lens type and power is selected, checked and implanted is shared by the Peri-operative Team, but ultimately lies with the Operating Surgeon.

The availability of the usual consignment stock is ensured by the Operating Theatre Personnel and the Operating Theatre Manager(s).

In the event of any particular consignment lens type / lens power being unavailable, this must be effectively communicated by the Operating Theatre Personnel at the Team Brief prior to the commencement of the operating list.

The individual Operating Theatres hold a stock of lenses which is maintained and replenished by the staff dedicated to each theatre.

Protocol for the Selection of Lenses

Item	Detail	Whom
1	The process of selecting the correct lens begins with appropriate documentation at the pre-op ward round. The printed biometry’s must always be used and this must be book-marked by the Ward Nurses in the patient’s medical notes.	Operating Surgeon
2	As per usual practice, a positive patient identification must be performed by the Surgeon at the pre-op ward round and this must include confirming the ID checks on the printed biometry. This, cross-check with the printed biometry must be made before lens selection is made.	Operating Surgeon

3	The desired lens must be circled, signed and dated by the Surgeon at the pre-op ward round. Any subsequent amendments must be made clearly and must be written out below the biometry with the Surgeon's signature and dated. Alternative lens implants can be determined on the biometry calculation page within the Medisoft EPR system, but a paper copy must be printed, circled and signed prior to the patient arriving in theatre. Before implementation, robust ID checks must be made to ensure the correct patient file has been called up.	Operating Surgeon
4	If it is the second eye of the patient being operated on, the biometry column for the first eye must be struck through to avoid any confusion.	Operating Surgeon
5	The paper Healthcare Records containing the marked current biometry results have to be checked at handover by the receiving Theatre Personnel confirming that the selected IOL has been checked circled and signed by the Surgeon.	ODP
6	The **"Sign in"** section of the WHO checklist will be carried out in the Anesthetic Room. It is the responsibility of the Surgeon who will be performing the operation to select the correct lens from the lens cupboard or lens room.	Anesthetist ODP and Operating Surgeon
7	Once the patient has arrived in theatre and the IOL has been selected, the Surgeon must carry out a positive ID check using the **patient's wristband**. The Surgeon and Scrub Nurse will double check the biometry to confirm the patient's ID details, the eye to be operated on, the predicted refractive result and that the correct IOL has been selected.	Operating Surgeon and Scrub nurse
8	The IOL must be placed on top of the Phaco machine and communicated to all theatre staff.	Operating Surgeon
9	At **'Time Out'** when completing the WHO Surgical Safety Checklist, all Theatre Staff must pay attention. The Surgeon must **supervise** the positive patient identification process. This will include the wrist band check against the consent form and notes, confirming the procedure and the correct IOL has been selected and double checked. The rest of the WHO Surgical Safety Checklist must be completed prior to the start of the operation.	All Theatre Team

10	Before opening the IOL in preparation of lens implantation, the Theatre HCA/Nurse must check the paper biometry again with the Scrub Nurse that the correct IOL make and power is being opened. The Scrub Nurse must confirm the IOL power on the internal IOL packaging with the Surgeon.	Runner, Scrub Nurses and Surgeon
11	In the event the selected IOL is not implanted for whatever reason the Surgeon has to re-select the most suitable IOL from the printed biometry in the notes. Once the IOL has been selected the label on the IOL box with the biometry must be shown to the Surgeon and Scrub Nurse before implantation. At the conclusion of surgery the biometry should be amended, with reasons and re-signed by the Surgeon.	Runner, Scrub Nurse and Surgeon
12	On completion of the operation the team must perform the "**Sign-out**" process of the WHO Surgical Safety Checklist confirming that the correct operation has been performed and the correct IOL has been implanted.	All Theatre Team
13	The surgical details must be entered into Medisoft. A positive ID check must be performed when patient data is opened on Medisoft.	Surgeon

Traceability

In order to ensure satisfactory recording and traceability of intraocular lenses and other implantable devices, it is essential that the product identification labels are affixed within the;

Theatre register
Surgeons operation record
Medical continuation notes (Healthcare Records)
Intra-operative care plan

Visitors and Company Representatives

The presence of any visitor(s) within the operating theatre must be highlighted at the Team Brief prior to the operating list (please refer to Visitors in Theatre Protocol).

The selection and preparation of ophthalmic implants of all types must be managed exclusively by the Operating Surgeon and Operating Theatre Personnel. Any team member that participates in this process must be occupationally competent and sufficiently familiar with the specified process. Company Representatives including Sales Persons, Product Specialists, or any other visiting individual(s) must not be involved in the selection and preparation of lens implants. In circumstances where this may be

necessary, it must be arranged by strict prior agreement and within a set of defined protocols.

Any concerns relating to the correct selection and preparation of implants must be highlighted and addressed immediately. Any discrepancies or untoward occurrences must be reported as they arise in order that any rectifications may be undertaken as soon as is appr

Appendix (D) - Follow up of patients from A&E & Urgent Care Clinics

Patients are being brought back inappropriately to A&E for follow up resulting in unnecessary long delays for all patients and increased workload for doctors & nurses which can be avoided. **Only genuine emergencies need to be dealt with in eye casualty and it should not be used as a follow up clinic**.

Patients requiring short term follow up (one visit) may be seen in Primary Care Follow Up Clinics running from Monday to Friday in outpatients. However, it is not acceptable to say to patients "please do not turn up for appointment if you feel better". This results in valuable appointment slots being wasted and high DNA rates with loss of revenue to the trust. If you think the patient is likely to get better please discharge with advice to contact us if the condition persists or worsens. For patients who may require more than one follow up, please send notes to consultants attention.

No follow ups will be arranged in eye casualty without approval from a senior clinician in A&E. Please document clearly as to which clinician you have discussed with as we will audit notes on regular basis and action may be taken against individuals who fail to do this. There is a finite number of Casualty FU slots per day and all CFUs must attend first thing in the morning so that they have been seen before the day's new patients have started to build up.

For this purpose, I have drawn up a rota of senior doctors in A&E without whose approval follow ups cannot be booked in eye casualty. In their absence, the next senior doctor who may be the senior SPR / Associate specialist in A&E may be involved. For out of hours please discuss with 4th or 2nd on call registrar (or if indicated the on call consultant).

Rota of senior doctors in eye casualty

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Mr. Pandey	Mr. Ghosh	Mr. Lett	Mr. Aralikatti	Mr Chavan
PM	Mr. Das	Ms Mellington	Mr. Mitra	Mr. Nessim	Mr H El-Defrawy

The pathway for patients in Primary Care Clinics is as follows:

1. Most patients will be expected to be discharged back to GP or optometrists.

2. A few patients may need to be seen in general clinic routinely eg. Have suspicion of glaucoma or have a significant cataract. These non urgent patients will require a letter to the GP requesting them to refer to Eye Consultant General Clinic routinely as per patient's choice which usually is at the hospital nearest to patient.

3. Patients may occasionally require sub-speciality clinic appointments soon eg. Cornea / med ret / uveitis / VR / Neuro etc. These patients may be discussed with the consultant under whose care the primary care clinic is booked, or placed in the sub-specialty tray for the appropriate fellow to vet. The consultant may then generate a consultant to consultant referral in cases which need to be seen soon or urgently or see the patient in their own

subspecialty clinic if appropriate. For all non urgent conditions the GP is requested to do a new referral to appropriate sub speciality clinic as per patient's choice.

Under no circumstances should you arrange repeated follow ups in primary care clinics as it may be unsafe to leave patient without consultant supervision or input.

Rough guide to follow up of Eye Casualty patients

Aim: To reduce unnecessary follow ups in A&E. Patients who need one follow-up may be booked into Primary Care Clinics which are held in out-patients. Patients requiring more than one visit may be referred for vetting by clearly documenting in the notes "Notes to consultant".
For corneal patients who require urgent follow up and consultant opinion, the notes should be marked for Mr Aralikatti's attention so he can decide further action.

Blepharitis / Viral / Bacterial / Allergic Conjunctivitis: Patients with the above diagnoses do not need follow up arranged. Patients are asked to phone and book into urgent care clinic only if symptoms are worsening or not resolving after 2 weeks.

Corneal Abrasion / Recurrent Corneal Erosions: Prescribe Oc Chloramphenicol qds for 5 days then Occ Lacrilube nocte long term if recurrent erosions. No follow up is required in eye casualty.

Recurrent anterior uveitis: It is important to ensure the fundus has been checked and there are no sight threatening complications such as posterior segment inflammation, raised eye pressure and macular oedema. Patients with recurrent anterior uveitis without complications should be prescribed intensive topical steroids such as G. Dexamethasone or G. Predforte 1 % and G. Cycloplentolate 1%. Patients should be given instructions to taper the steroids gradually. One follow up may be arranged in the Primary Care Clinic in 2-3 weeks time.

Herpes Simplex Keratitis: Patients with epithelial keratitis (Dendritic ulcer) may be prescribed Occ. Acyclovir 3 % 5 times a day for 10 days. Review is not routinely necessary. Patients with disciform keratitis need clinic follow up and notes should be sent to consultant for clinic follow up. Please start the patient on topical steroids + Occ. Acyclovir and advise slow tapering of steroids. If the IOP is raised patient will need one follow up in Primary Care FU Clinic before referral to consultant clinic.

Bacterial Keratitis: Perform corneal scrapes / send contact lenses for microbiology unless there is a good reason not to do so. Patients need intensive hourly eye drops such as G. Ofloxacin. Most of these patients need admission but smaller ulcers may need to be followed up in A&E. Patients requiring senior opinion may be referred for Mr Aralikatti's opinion after starting treatment.

Herpes Zoster Ophthalmicus: Patients with no ocular complications may be discharged. Patients with complications such as posterior uveitis, secondary glaucoma and cranial nerve palsy need to be seen in consultant clinic. Patient with mild corneal involvement or anterior uveitis may be followed up in Primary Care Clinic.

Lid abscess or lacrimal abscess: Incision and drainage in eye casualty procedures room if pointing. Oral antibiotics may be prescribed and follow up arranged in one week in PCFU clinic.

Preseptal cellulitis: Prescribe a course of oral antibiotics and review in 5 to 7 days. Orbital cellulitis needs admission for IV antibiotics and investigations.

Laser Retinopexy for breaks: If satisfactory laser coverage, PCFU in 2-3 weeks. If patient has vitreous haemorrhage with poor view of fundus, multiple breaks, small amount of subretinal fluid or other complicating factors please refer for vitreo-retinal follow up.

Vitreous haemorrhage: If vitreous haemorrhage is dense with poor fundal view please arrange urgent ultrasound in visual function to ensure retina is flat. Diabetic vitreous haemorrhages may need laser and intravitreal Avastin and should be referred urgently to the appropriate medical retina consultant. Vitreous haemorrhage due to posterior vitreous detachment needs ultrasound and vitreoretinal clinic appointment soon. Patients with retinal tear or detachment with poor view should be referred for urgent VR opinion.

Optic Neuritis: Typical optic neuritis patients (age 20 to 40, acute unilateral visual loss with painful eye movements, reduced colour vision, RAPD, no proptosis) need reassurance and need follow up in general clinic in a few weeks time (Notes to consultant). Atypical optic neuritis patients need to be discussed with senior doctor and if available please get neuro-ophthalmology opinion. Do not arrange follow up in A&E.

CRVO / BRVO / CSR: Refer to consultant clinic. No follow up in A&E or PCFU clinic.

CRAO: Start on Aspirin if no contraindications and refer to TIA clinic. Control risk factors such as hypertension and advise to quit smoking. Refer to medical retina clinic by saying notes to Consultant.

Wet AMD: Refer to FAST TRACK MACULAR CLINIC at BMEC urgently.

Proliferative diabetic retinopathy: If possible first session of Argon laser panretinal photocoagulation should be performed during visit to eye casualty. Notes should be sent to medical retina clinic (at pt's base hospital) urgently for further laser and follow up.

Rubeosis / Neovascular Glaucoma: Long standing established patients do not require any urgent laser or Avastin. Acute cases require emergency laser photocoagulation during casualty visit if cornea is clear. Patient should be discussed with a medical retina consultant so that intravitreal Avastin can be requested urgently from DTC as a non formulary drug. Start topical steroids / cycloplegics / antiglaucoma medication if eye inflamed. Follow up will be arranged in medical retina clinic.

Retinal Detachment: All patients to be discussed with VR team (fellow / Co-ordinator / consultant) and their advice followed. Do not accept referrals from outside Birmingham without discussing with VR team. See Emergency VR pathway appendix.

3rd Cranial Nerve Palsy: This may be a medical emergency. Patients with painful (headaches), pupil involvement, partial or evolving 3rd nerve paresis need urgent referral to RMO for admission and neuro-imaging. Please discuss with neuro-ophthalmology team if unsure. Ischaemic 3rd nerve palsy needs referral to clinic.

6th Nerve Palsy: If ischaemic palsy (microvascular risk factors such as hypertension, diabetes in an older patient) needs orthoptic assessment and routine clinic review. If in a younger patient or any other cranial nerve involved needs referral to medics. Please discuss with neuro-ophthalmology team if unsure.

4th Nerve Palsy: Please arrange orthoptic assessment and follow up in clinic.

Acute Glaucoma: These patients need emergency management as per protocol and admission. It is good practice to involve glaucoma team at an early stage. Do not arrange follow up in eye casualty after emergency treatment.

Mr KS Lett, Consultant Ophthalmologist and Vitreo-Retinal Surgeon, Service Director for Eye Emergency Department

Appendix (E) - Handover to out-of-hours on-call team (outstanding work at BMEC A&E + referrals/visits to other hospitals)

Patient details and location Contact details of their hospital/ward (Patient ID label if available)	**Contact details of referring doctor**	**Clinical information:** • **In-patient in Other Peripheral hospital** • **Emergency admission at BMEC** • **Pending Ix results (ESR, imaging)** • **Outstanding tasks (laser, surgery)**	**Time / Name & Designation of person entering information**
Eg. Mr Emergency St Elsewhere Hospital, Ward 200 RXNo.000000000, DOB: 9/9/2000 Direct phone number: 012101210121	Eg Dr Anonymous SpR Neurology Ph: 0121 4444444 Ext / Bleep 1111	Eg. Road traffic accident with multiple fractures, Rt traumatic hyphaema. Advised CT Orbit. Check pt has not gone for CT scan before making the trip	Eg 4.30 pm Anil Aralikatti Consultant

- **Requests by other hospitals during daytime working hours to be dealt by Local Eye Unit**
- **Please ask for outside referrals to be FAXED and attach it to this page**
- **Handover meeting: All entries noted and actioned by on-call team**
- **Place a cross over the page if there are no tasks to handover.**

Date & Time:_____ **Handover Lead:** _____**Signed:** _____

Appendix (F) - BMEC Ward Handover

Instructions:

1. The on-call team when informing the on-call consultant about emergency admissions must check about plans for patient care for the following working day. In particular, check if the patient needs to be transferred to a subspecialty team.

2. If a transfer is necessary, the eye ward has a list of Subspecialty Consultants and contact numbers for their team. The first point of contact is the Fellow, ASTO / TSC, ST in that order. Although they may be happy to receive a text the previous evening about a handover, no patient identifiable details must be sent in the text message. It is important to confirm and exchange detailed information by a two-way process (e.g. telephonic conversation the next day before 9 am).

3. The first 5 columns of the handover sheet must be completed by the on-call team. In addition, the information should be documented in the patient's records.

4. The handover is complete when the last column is filled by the team "taking over" care of the patient. Until this happens, the patient shall be under the care of the on-call consultant.

5. The nursing staff on the eye ward shall facilitate the handover process, but the primary responsibility shall be with the on-call team.

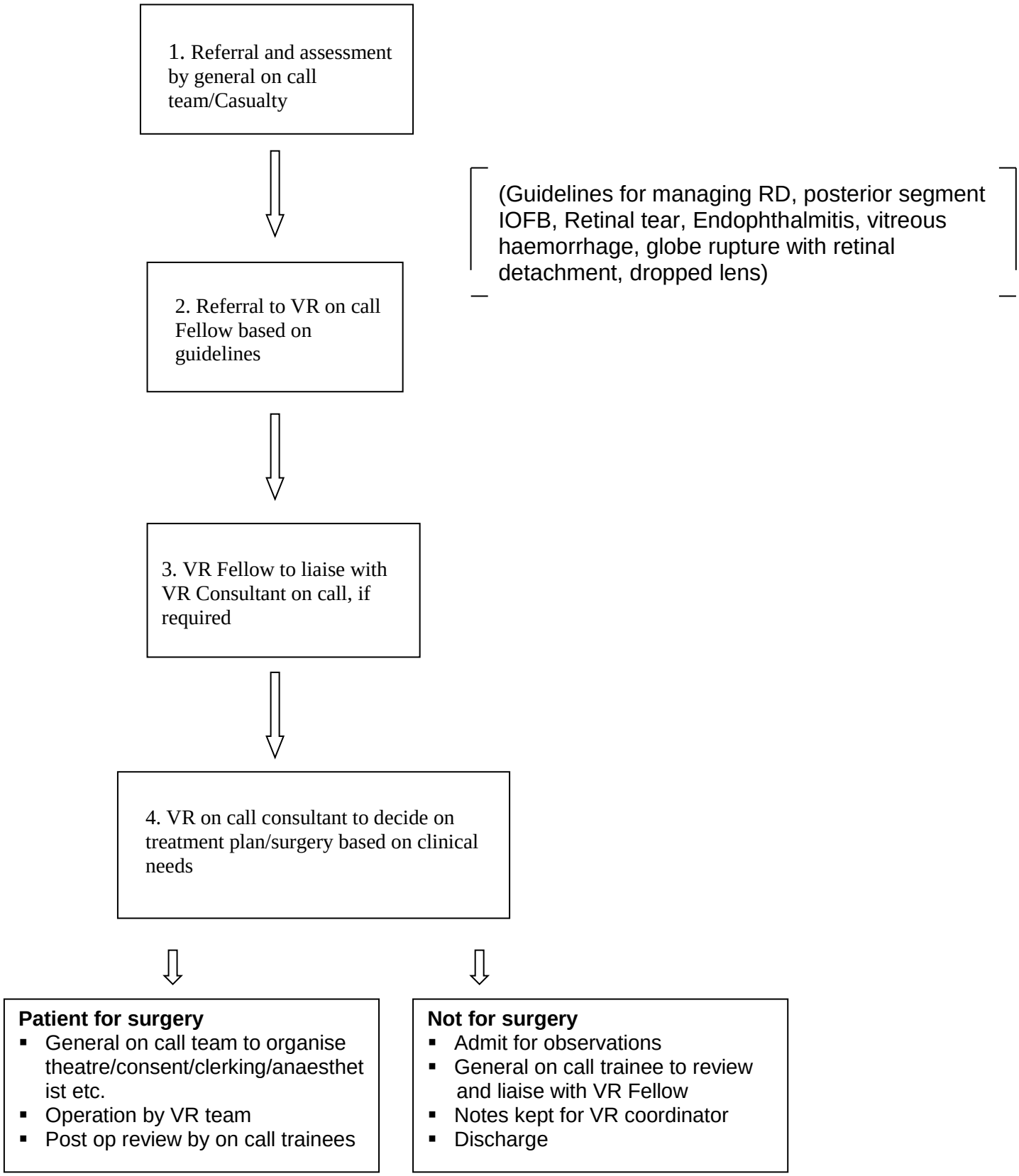
6. The handover sheet must be filled for all ward patients that need to be handed over, including the following:

    - Emergency admissions that need to be transferred to another named Consultant Team
    - Existing in-patients who have any clinical / non-clinical problems out-of-hours
    - Existing in-patients who have investigations / test results / change of treatment out-of-hours

Date: _____ **BMEC Ward Handover Sheet**

Patient details (or label)	Printed Name, Time, Designation of person entering information	On-call consultant (initials)	Information for hand-over (Diagnosis, relevant clinical / non-clinical information) Outstanding tasks (pending investigation, tasks, surgery, etc)	NAMED New Consultant / team member who has agreed to take-over future care of patient	On completion of handover: Date, Time, Name and Signature of New Consultant / Team member

Appendix (G) - VR Weekend On call pathway



Ward activities such as clerking, investigations, review etc. are to be carried out by the general on call team

Guidelines

1. Retinal detachment - Macula *off* – notes to VR Coordinator

- *Macula on* – discuss with VR Fellow (+/- assessment)
- VR fellow to discuss with consultant VR On Call and discuss management

Surgery (Nyree Duffy) | Admit | Notes to VR Coordinator

2. Posterior segment IOFB → discuss with VR Fellow (+/- Assessment) → Discuss with VR Consultant

Surgery for primary repair Admit (general on call team) | Surgery for posterior segment (VR Team) | IOFB (General on call team to Review and liaise with VR Fellow

3. **Endophthalmitis**

Managed by on call team based on published guidelines

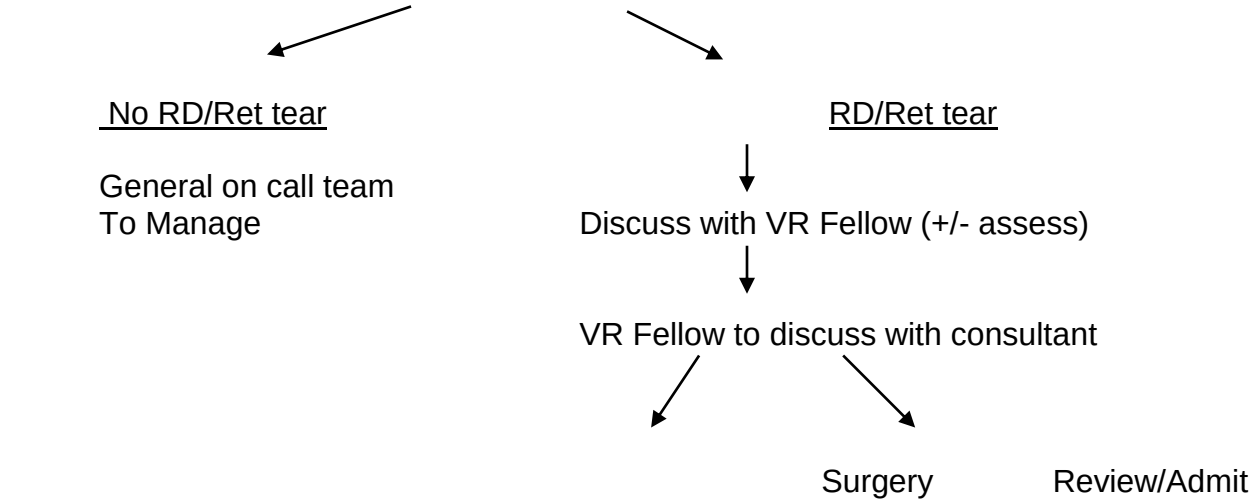
Contact VR Fellow only if guidelines met for Vitrectomy

VR Fellow to consultant

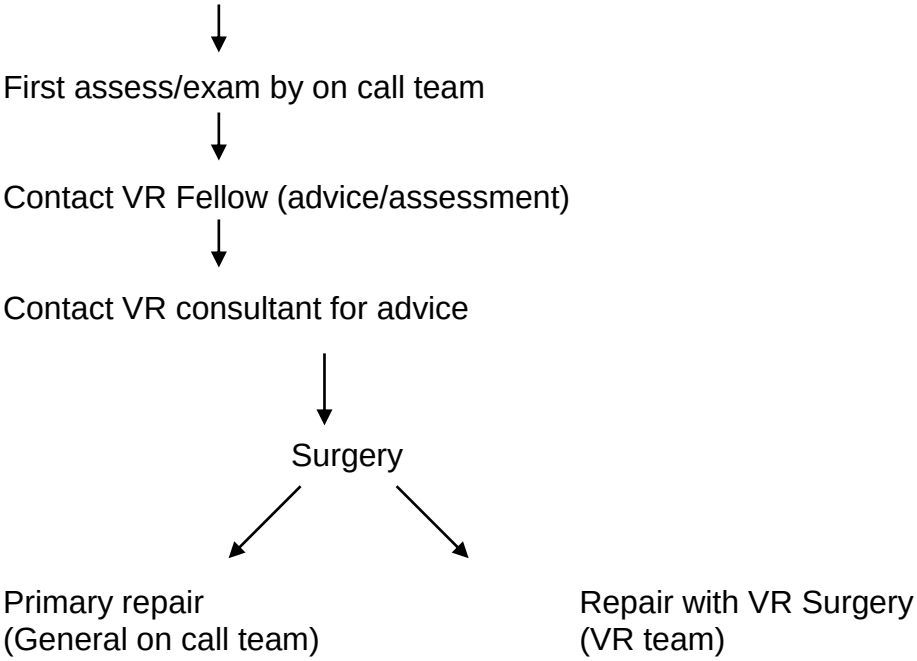
No Vitrectomy (General on call team to manage) | Vitrectomy (VR team to manage)

4. Retinal tear → 4th on call to perform laser/(direct/indirect laser/theatre etc)

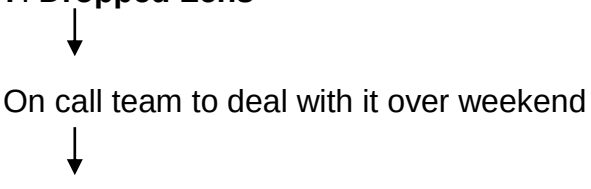
5. Vitreous haemorrhage – General on call team to assess and do B scan



6. **Open globe with vitreous haemorrhage RD**



7. **Dropped Lens**



Appendix H

SOP FOR PERFORATING INJURY PATIENTS

1. Theatre timetable are displayed on a monthly basis on the Theatre corridor opposite the Theatre office. Each working day has one designated theatre in the morning and in the afternoon.
2. All patients admitted with corneo-scleral perforations should be seen by the second / fourth on-call and discussed with the on-call consultant.
3. The fourth on-call should hand over the patient by 8.30 am to the consultant team allotted for the emergency list. Once the morning theatre starts at 9.00 am, it becomes very difficult to cancel / reschedule patients onto other lists.
4. Depending on the urgency of the other cases on the emergency list, the perforation should get priority – phacos and other cases that can be done on other lists should be distributed accordingly with the permission of the operating surgeon.
5. If the emergency case cannot be done in the morning list, due to delay in getting scan reports or for any other reason, the case should be done in the afternoon list.