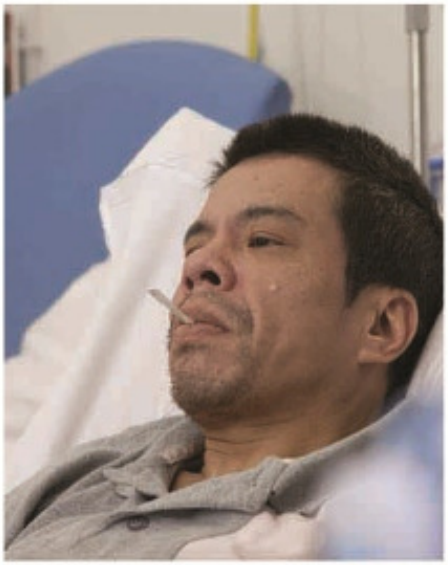
NHS England

Framework for managing performer concerns:

NHS (Performers Lists) (England) Regulations 2013

Consultation



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Contact Details for further information	Kate Rogers NHS England medical revalidation PMO c/o Skipton House 80 London Road, London SE1 6LH kate.rogers@rst.nhs.uk n/a

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Framework for managing performer concerns:

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Consultation document

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Prepared by David Geddes, Head of Primary Care Commissioning

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Introduction

1. The NHS (Performers Lists) (England) Regulations 2013 details NHS England's responsibility for holding and maintaining the England performer list in respect of primary medical, dental and ophthalmic performers. The aim of the regulations are to ensure that performers may not deliver NHS primary care services in England unless they are included on the performers lists. The performers list system provides NHS England with powers to manage these performers and protect the public from any performers who is not suitable or that fall below the required standards.

2. Since 1 April 2013, NHS England has followed a single process for the commissioning of primary care services. To support this, a suite of policy and procedure documents was produced with the aim of ensuring consistency in the management of the four primary care contractor groups (medical, dental, ophthalmic and pharmaceutical) including holding and maintaining the England performers lists in respect of medical, dental and ophthalmic performers. It was always intended that these would be refined in light of feedback from users and other relevant stakeholders.

3. Following extensive consultation with area teams, the National Clinical Assessment Service (NCAS), local representative committees and other stakeholders, a new set of documents are being drafted covering inclusion onto the performers lists and management of concerns in performers on the list. This will include a new, high level framework and supporting guidance for use by area teams. The framework, entitled 'Framework for managing performer concerns: NHS (Performers Lists) (England) Regulations 2013', hereafter referred to as 'the framework', is presently in draft form. We would now like to make specific elements of the draft framework available for broader consultation and are seeking feedback on whether these elements of the proposals are practical and proportionate so that the documents can be developed in further detail.

4. The consultation will run from 20th February to midnight on Thursday 20th March. Primarily, this will be an online consultation via CitizenSpace. Respondents are strongly advised to use this method in order that feedback can be collected and analysed in a thorough manner. The online consultation can be accessed via http://www.engage.england.nhs.uk/ listed under *Framework for managing performer concerns: NHS (Performers Lists)(England) Regulations 2013.*

   Note that the framework is presently in a draft format and will be further developed to incorporate the principles discussed in this document following consultation.

Background

5. Medical, dental and ophthalmic performers are required to be named on the performers lists. The performers lists provide NHS England with powers over inclusion, suspension and removal, responsibility for the movement of performers between area teams and the maintenance of the performers lists. It thus enables NHS England to assure the suitability of all general practice doctors, dentists and ophthalmic practitioners who undertake primary care services in England and provides protection for patients from any performer who is not suitable, or whose efficiency to perform those services may be impaired.

6. The underpinning legislation to enable NHS England to manage the list is set out in the *National Health Service (Performers Lists) (England) Regulations 2013*, which came into force in April 2013. This legislation provides for responsibility of England's performer list to be managed by a national body and enacts legislative changes arising from the recommendations made by the Performers Lists Review and the Out-of-Hours Services Review. The framework is also informed by recommendations from these reviews that did not require new legislation, the *Medical Profession (Responsible Officer) Regulations 2010* and the results from the 2009 consultation on the role of the responsible officer.

7. Admittance to the performers lists and management of performers on the list have significant consequences both for patients, who have a right to high quality, effective and safe care, and for clinicians, for whom entry to the list is an important step in their career. It is therefore essential that the framework enables NHS England employees to act effectively and with consistency, fairness and transparency both over initial admissions to the list and over the processes leading to possible suspension or removal from the list. The framework should also provide the means for early intervention and the support and remediation for practitioners whose performance is beginning to fall below the required standards.

8. Since April 2013, area teams have used standardised policies and standard operating procedures governing the inclusion, movement and maintenance of performers on the performers lists and separate policies and procedures governing the identification, management and support of primary care performers and contractors whose performance gives cause for concern. NHS England has sought extensive feedback on how these have been applied in practice through informal discussions with area teams, members of performance screening groups (PSG) and performers lists decision panels (PLDP), NCAS, local representative committees, medical defence organisations and legal advisers to NHS England. Revisions to the policies and procedures have been drafted and circulated among stakeholders to provide further opportunity for feedback, and the responses are reflected in this document, which is now being made available for wider consultation.

9. The framework has been reduced both in length and in number from the original suite of documents produced in April 2013. This single document now covers consideration of applications for inclusion onto the performers lists, movement between area teams and the procedure for responding to concerns. In line with the need for a consistent approach across primary care, the framework applies to all three disciplines (general practice doctors, dentists and ophthalmic practitioners) with key differences in the application of the framework highlighted in separate appendices. Further guidance materials will be developed to support for area team staff in applying the framework locally.

10. Pharmacists are not on a performers list therefore a separate policy will be developed for community pharmacy and dispensing appliance contractors that adheres to the principles of the framework.

<u>Respondent questions</u>

1. **Name**

2. **Email address**

3. **Job title/role**

4. **Organisation**

5. **Is this a personal response to the consultation or are you submitting on behalf of your organisation?**

   Please highlight your response or delete as appropriate:

   Personal response Organisation response

6. **Brief explanation of your involvement with regards to performers lists and managing concerns of performers:**

Part 1 – Admittance to the performers lists

Knowledge of the English language necessary for the work which those included in the relevant performers lists perform or could reasonably be expected to perform

11. Feedback from area teams has highlighted concerns about a lack of consistency in assessing whether applicants are able to demonstrate sufficient knowledge of the English language necessary for the work which those included in that performers list perform or could reasonably be expected to perform. The revised EU directive on the recognition of qualifications provides a legal basis for regulatory bodies to check health professionals' language competence and test it where necessary, on the grounds of patient safety, before allowing them to practise. In addition, for medical performers, the Department of Health recently consulted on proposals to amend the Medical Act which will enable the General Medical Council (GMC) to apply language controls after registration but before a licence to practice is issued. At the same time, the GMC consulted on how this should work in practice. However, as legal powers are currently not in force for additional language testing by regulators pending the outcome of the consultation, it is important that NHS England is able to satisfy itself that applicants to the lists have sufficient knowledge of the English language in line with the performers lists and responsible officer regulations.

12. The framework will be strengthened to provide greater clarity on testing the English language of applicants who do not have a certificate of graduation or postgraduate training from a recognised medical or dental school or university optometry department in the UK or Ireland. These changes are in line with the proposals set out in the GMC consultation. For applicants who have not studied in the UK or Ireland, applicants will have to provide the following evidence:

    - A certificate of a pass within six months of one of the current accepted language tests at the required level
      or
    - A certificate of graduation or postgraduate training within the past two years from a recognised medical or dental school or university optometry department taught and examined in English

      and

    - Evidence of three months full time professional employment from the past two years in a country where English is the first language and current English language capabilities necessary for the work which those included in the list could reasonably be expected to perform are documented in the references submitted as part of the application form

or

- Agreement to submit to face to face oral assessment of English language skills in a clinical context with a clinician nominated by the medical director

13. The oral assessment will be carried out by a clinician with experience of regular contact with patients and follow a consistent process. A fee will be introduced to cover the administrative cost of the face-to-face oral assessment up to a maximum of £150. This will be met by the performer and submitted with the completed application form.

7. Do you agree that the evidence to be supplied by applicants to the performers list provides a sufficient basis to demonstrate their knowledge of the English language necessary for the work which those included in that performers list perform?

Please highlight/delete as appropriate: YES / NO

8. To whom should the oral language testing regime apply?

a. Applicants who do not have recent evidence of working for a period in a country where English is the first language and a reference of their English language skills

OR

b. All applicants who do not have a recent certificate of graduation or postgraduate training which was taught and examined in English?

Please highlight/delete as appropriate

9. Do you agree that the administrative costs of the face-to-face oral language assessment should be met by the applicant?

Please highlight/delete as appropriate: YES / NO

10. Please use this space to record any further comments regarding the 'knowledge of English language' section of the consultation document.

Occupational health clearance to join the performers lists

14. The *National Health Service (Performers Lists) (England) Regulations 2013* do not require occupational health (OH) clearance for admittance to the list. However, we propose that an OH clearance certificate should be required to ensure that practitioners are able to undertake exposure prone procedures and that they do not pose a risk to patients. In order to obtain OH clearance, the performer should complete information on clinical history and provide evidence of their immunisation status taking into account the services that they shall provide or could reasonably be expected to provide as a performer in line with guidance and the law. A list of the relevant checks for applicants is provided at Annex 2.

15. If, on the basis of the information provided, there is a need for further assessment, this will be undertaken by an OH specialist arranged through NHS England. If, following this assessment the OH specialist concludes that a performer does not meet all the criteria in the assessment, the specialist will make a recommendation to the responsible officer so that an appropriate decision can be made about voluntary undertakings, refusal to the list or inclusion with conditions.

16. There is no need for OH clearance for practitioners who have previously received OH screening when starting work in the NHS and have been working under the supervision of a postgraduate dean as a trainee without a break in training.

17. The cost for OH screening should be met by the applicant. However, on the rare occasion where there is a need to seek additional assessment in relation to assessing or investigating a concern, this would be funded by NHS England.

18. As the 2007 Department of Health guidance and 2013 NHS employment check standards apply also to ophthalmic practitioners (except with regard to exposure prone procedures), ophthalmic practitioners also require an OH clearance certificate for acceptance onto the performers list.

11. Do you agree with the provisions to include ophthalmic practitioners under the arrangements for occupational health clearance?

Please highlight/delete as appropriate: YES / NO

12. Do you have any other comments on arrangements for occupational health clearance in the framework?

References

19. The *National Health Service (Performers Lists) (England) Regulations 2013* state that applicants to the performers lists should provide two clinical references relating to two recent posts or medical school or, where this is not possible, a full explanation as to why that is the case and the names and addresses of two alternative referees. A number of area teams have reported that it is often not possible to provide two impartial clinical references in particular for newly trained dentists and requested a consistent application of the regulations.

20. Under the new proposals, where obtaining two clinical references proves difficult, a 3 month allowance should be built into the process whereby the applicant can obtain a second clinical reference from their new employer within 3 months of joining the list. One satisfactory reference would still be required. In these circumstances, a performer should be included on the lists with conditions.

13. Do you agree with the policy of conditional inclusion for performers where performers are only able to obtain one satisfactory reference, with an additional reference to be provided within three months of joining the lists?

Please highlight/delete as appropriate: YES / NO

14. Please use this space to record any further comments regarding the 'references' section of the consultation document.

Inclusion on the list – child protection training

21. The *National Health Service (Performers Lists) (England) Regulations 2013* do not require child protection training for admittance to the list. However, for medical practitioners the General Medical Council's *Good medical practice*[1] places a duty on all doctors to protect and promote the health and well-being of children and young people. Information about the level of child protection training that is needed for different roles, and how often doctors should receive that training, is provided in *Safeguarding children and young people:*

[1] General Medical Council (2013) *Good medical practice*, General Medical Council

roles and competences for health care staff[2]. This states that all clinical staff, including dental and ophthalmic practitioners, who have any contact with children, young people and/or parents/carers should have child protection training at level 2. Medical performers should have child protection training at level 3.

15. **Do you agree that applicants to the dental and ophthalmic performers lists should be required to provide evidence of child protection training at level 2 and applicants to the medical performers list should be required to provide evidence of child protection at level 3?**

    Please highlight/delete as appropriate: YES / NO

16. **Please use this space to record any further comments regarding the 'child protection training' section of the consultation document.**

Application of the induction and refresher programme (returners scheme) for general medical practitioners

22. Although there is no requirement in legislation for performers to undergo a period of induction or refresher / returner training, the Department of Health, the Committee of General Practice Education Directors (COGPED) and the Royal College of General Practitioners (RCGP) all recommended in 2008 a period of induction and adaptation for all European Union and International Medical Graduate doctors new to the NHS and for GPs who want to return to general practice after lengthy career breaks. This is usually through a specific induction and refresher programme. Concerns have been expressed that this is being applied inconsistently across the NHS with consequences for performers being readmitted onto the performer list. The RCGP will shortly be undertaking an evaluation of the barriers to re-entry onto the performer list following a career break. However, there is a need to ensure a consistent process in advance of any recommendations arising from the report.

[2] Royal College of Paediatrics and Child Health, et al (2010) *Safeguarding children and young people: roles and competences for healthcare staff: intercollegiate report*, Royal College of Paediatrics and Child Health

23. An I&R assessment typically costs £850, which is to be met by the performer and is consistently applied for all applicants. The scheme itself is modular with the individual components to be taken dependent on the needs of the individual performer.

17. Do you agree that all medical performers should automatically be referred for assessment to the scheme after 2 years of absence from UK general practice for admission to the list?

Please highlight/delete as appropriate: YES / NO

18. If not, what should the threshold be?

19. Should the I&R scheme apply differently to doctors trained in the UK who have been out of practice for more than 2 years compared to doctors who are moving to the UK having trained abroad?

Please highlight/delete as appropriate: YES / NO

Please explain your response:

20. The costs of the induction and refresher programme are not routinely funded by NHS England. Should there be circumstances under which NHS England should provide funding for the programme, for example, to encourage applications to under-doctored areas?

Please highlight/delete as appropriate: YES / NO

Please explain your response:

21. Is there value in introducing similar schemes for other performers to be paid for by the performers themselves?

Please highlight/delete as appropriate: YES / NO

Please explain your response:

22. Please use this space to record any further comments regarding the 'induction and refresher programme (returners scheme) 'section of the consultation document.

Entry onto the performers lists for GP registrars and dental foundation trainees

24. Currently GP registrars and dental vocational trainees go through the application to join the performers lists as all other performers. On inclusion to the lists performers must give undertakings that they only provide services under the supervision of the trainer. As applicants already have to apply to the deanery for their training placement and undergo checks as part of this application, we propose that a successful application to the deanery should suffice for application to join the lists. This also means that trainee performers should be aligned to the area team of the deanery where their application is made and that they remain with that area team throughout their training.

23. Do you agree that a successful application to the deanery for trainee performers provides sufficient assurance about fitness for purpose/suitability for an application to the performers lists?

Please highlight/delete as appropriate: YES / NO

24. If so, do you agree that trainee performers should be aligned to the area teams of the deanery where their application is made?

Please highlight/delete as appropriate: YES / NO

25. **Please use this space to record any further comments regarding the 'trainee entry' section of the consultation document.**

Part 2 – Responding to concerns about primary care performers

Investigating and decision making-bodies

25. In order to maintain a separation of responsibilities between the identification and analysis of performance issues and the responsibility for the final decisions regarding primary care performers, the original performance policy set out arrangements for two separate bodies in each area team: a performance screening group and a performer list decision panel. Feedback from members of these bodies has highlighted significant differences in the way that these are run with implications for the workload, governance arrangements and the skillsets required to manage the bodies. We have therefore proposed the following key changes:

Process for responding to concerns

26. The framework confirms that concerns will be considered by a Performance Advisory Group (PAG) and Performers Lists Decision making Panel (PLDP) with an arrangement for an alternative PLDP where there is a conflict of interest or perception of bias. The role of the PAG is different to that of the PLDP. The PAG's role is investigative and advisory; the role of the PLDP is to make decisions under the performers lists regulations. There will be a need for the two separate functions within each area team plus arrangements for alternative PLDPs to take place, for example through area teams agreeing to work together to provide PLDP members outside their regional footprint. Both bodies should be fair and transparent in the way that they handle concerns.

27. The PAG considers all complaints or concerns that are reported about a named performer and can carry out an initial investigation. Any issues related to the delivery of the contract are considered under the contractual regulations. The framework will clarify and strengthen the role of PAG in making provision for 'voluntary undertakings', provided the performer demonstrates insight and consents and where the risk to patient safety is considered to be low. This is a signed agreement between the performer and the PAG about future practice and can be a useful mechanism for resolving concerns if the performer has insight regarding the concern being considered and is in agreement with the proposed remediation. The decisions taken should still be formally noted and there must be sound monitoring and reporting in place by the PAG to provide the necessary assurance. Voluntary undertakings can also be used as part of initial entry to the performers lists.

28. If action is considered to be necessary under the performers lists legislation, the case is referred to a PLDP. If conditions are imposed by the regulator these are also automatically referred to PLDP. Where there are concerns about a conflict of interest or perception of bias that may influence the outcome, it may be necessary for concerns to be considered by an alternative

PLDP. The costs of handling concerns are to be met by NHS England. This includes OH assessments arising from PAG or PLDP recommendations.

Membership of PAG and PLDP

29. Feedback from area teams has reinforced the need to balance appropriate expertise and representation with concerns that decisions cannot always be taken because of lack of quoracy under the current arrangements. We are now seeking views on a suitable quorate membership for both groups. It is important to note that increasing quoracy has implications not just in terms of ensuring members are present but also in terms of funding the bodies, as only quorate members will be funded.

30. Membership of the PAG: The PAG will be a repository of expertise provided by individuals with in-depth knowledge of performance procedures and professional standards and able to provide advice on handling individual cases. Quorate membership should comprise three individuals. These are:

    1. An appropriately experienced clinician nominated by the medical director with recent clinical practice;

    2. A senior NHS manager with a performance role;

    3. i) A senior manager from the operations or nursing directorate who will bring expertise in patient safety and patient experience **or**
       ii) A lay member who will act as the patient / public advocate **or**
       iii) A discipline specific practitioner.

31. We do not intend to specify in all cases whom the third quorate member of the PAG should be, as this may differ depending on the nature of the cases being discussed.

32. Membership of the PLDP: The PLDP will take overall responsibility for the management of performance, to decide on actions required on individual performance cases, in line with statutory regulations, and to make referrals to other regulatory bodies where appropriate. Membership of the PLDP should be competence-based and comprise the following people:

    1. A lay member who will act as the patient / public advocate;

    2. A discipline-specific practitioner;

3. A senior manager / director with responsibility for patient safety / experience

4. The medical director for an area team or their nominated deputy.

33. A number of current PLDP lay chairs have suggested that their role would be strengthened if they did not take part in any voting as this would support them in overseeing a process that should be fair and transparent. We would like to take further views on this as part of the consultation.

Training and competencies for PAG and PLDP

34. Current members of performance panels gave clear feedback that members should be properly trained for their roles. In response to this, a core competency framework for members of the PAG and PLDP is being developed, in addition to clear job descriptions and recruitment criteria.

26. Do you agree that the proposed membership of the PAG provides a fair and transparent process for the performer?

Please highlight/delete as appropriate: YES / NO

27. In terms of the membership of PAG, should one of the members be of the same clinical discipline as the performer who is under discussion?

Please highlight/delete as appropriate: YES / NO

28. Please use this space to record any further comments on the PAG proposals.

29. Do you agree that the proposed membership of the PLDP provides a fair and transparent process for the performer?

Please highlight/delete as appropriate: YES / NO

30. In terms of the membership for <u>PLDP</u>, do you agree that recruitment should be based on competency rather than individuals nominated?

Please highlight/delete as appropriate: YES / NO

31. Should the LRC member attend

a) as a quorate member, nominated as the discipline-specific practitioner?

Or

b) by standing invitation?

Please highlight/delete as appropriate.

32. Do you agree that the lay member should act as chair for PLDP?

Please highlight/delete as appropriate: YES / NO

33. Should the PLDP chair have voting rights:

a) In all circumstances

Or

b) Only if a casting vote is required?

Please highlight/delete as appropriate.

34. Please use this space to record any further comments regarding PLDP proposals.

National disqualification

29. The *National Health Service (Performers Lists) Regulations 2004* provided the opportunity for Primary Care Trusts (PCTs) to apply to the First Tier Tribunal (FTT) for a national disqualification of a performer for a minimum period of 2 years, which could be extended to five years on application. The FTT could impose the same after considering a PCT decision to remove from the list or refuse inclusion on the list.

30. The national disqualification provided two purposes, firstly to prevent the performer from applying to join another performers list in England or Wales. The second was to prevent the performer from being able to work in primary care for two years. With the introduction of national performers lists under the *National Health Service (Performers Lists) (England) Regulations 2013*, this provision has been removed. However, this also means that there are now no restrictions on a performer reapplying to join the lists immediately after being removed or immediately after being refused inclusion. To address this, we are seeking views on amending the framework so that no application should be considered from a performer who has been removed from the lists on the grounds of suitability or fraud until at least a period of time has passed.

35. Do you agree that no application should be considered by an applicant following removal from the performers lists on the grounds of suitability or fraud until a minimum period of time has passed?

Please highlight/delete as appropriate: YES / NO

36. If so, should that period be

a) 12 months?

Or

b) 24 months?

Or

c) at the individual discretion of the PLDP?

Please highlight/delete as appropriate.

37. **Please use this space to record any further comments regarding the 'national disqualification' section of the consultation document.**

Final questions

If completing a hard copy of the consultation, this page is to allow you the opportunity to comment on particular areas of the draft framework and annexes that earlier questions may not have permitted. When commenting, we would appreciate it if you could refer to page or paragraph numbers wherever possible so that your responses are clear.

38. **Do you have any further specific comments on the draft framework itself?**

39. **Do you have any further specific comments on annex 2 – PAG terms of reference?**

40. **Do you have any further specific comments on annex 3 – PLDP terms of reference?**

41. **Do you have any further specific comments on annex 5 – elements specific to medical performers?**

42. **Do you have any further specific comments on annex 6 – elements specific to dental performers?**

43. **Do you have any further specific comments on annex 7 – elements specific to ophthalmic performers?**

44. **Is there anything else that you wish to add?**

Annex 1 –Framework for managing performer concerns: superseded documents

Policy for the identification, management and support of primary care performers whose performance gives cause for concern. Published 27 March 2013, Gateway reference 00011.

Procedure for the identification, management and support of primary care performers whose performance gives cause for concern. Published 27 March 2013, Gateway reference OPS_2043

Policy and procedure governing the inclusion, movement and maintenance of medical, dental and ophthalmic performers in NHS England's national primary care performers lists. Published 5 August 2013, Gateway reference 313.

Annex 2 – Occupational health screening for applicants to the performers lists

All checks are in compliance with NHS employment check standards (NHS Employers July. 2013), the Equality Act (October 2010) and Health Clearance for tuberculosis, hepatitis B, hepatitis C and HIV: new healthcare workers (Department of Health, 2007).

Dental Practitioners

Hazard	**OH screening**
Direct patient contact	General immunisation - TB / VZV / MMR
Potential exposure to blood / body fluids	Hepatitis B protection
Exposure Prone Procedures	IVS sample Hep B surface antigen Hep B antibody Hep C antibody HIV antibody
Frequent hand washing and wearing gloves	Skin assessment via questionnaire
Lone Working / Shift work / On call	Via general health condition / disability section on questionnaire
Bending / stooping / reaching	Musculoskeletal assessment via questionnaire
Fine dexterity	Musculoskeletal assessment via questionnaire
Recording information - paper / electronic records	Via general health condition / disability section on questionnaire
High work demands	Psychological assessment via questionnaire

General Practitioners

Hazard	**OH Screening**
Direct Patient contact	General immunisation- TB / VZV / MMR
Potential exposure to blood / body fluids	Hepatitis B protection
Potential Exposure Prone Procedures *They should be screened against these as they <u>may</u> perform these in the course of their duties*	IVS sample Hep B surface antigen Hep B antibody Hep C antibody HIV antibody
Frequent hand washing and wearing gloves	Skin assessment via questionnaire
Lone Working / Shift work / On call	Via general health condition / disability section on questionnaire
Recording information - paper / electronic records	Via general health condition / disability section on questionnaire
High work demands	Psychological assessment via questionnaire
DSE work	Musculoskeletal assessment via questionnaire

Optometrist

Hazard	**OH Screening**
Direct Patient contact	General immunisation- TB / VZV / MMR
Potential exposure to blood / body fluids from	Tears - Hepatitis B protection recommended
Potential Exposure Prone Procedures	Not applicable
Frequent hand washing	Skin assessment via questionnaire

Recording information - paper / electronic records	Via general health condition / disability section on questionnaire
High work demands	Psychological assessment via questionnaire
DSE work	Musculoskeletal assessment via questionnaire
Bending / stooping / reaching	Musculoskeletal assessment via questionnaire
Fine dexterity (inserting / removing contact lens)	Musculoskeletal assessment via questionnaire