Royal Cornwall Hospitals
NHS Trust

Ophthalmic Science Diagnostic Testing Procedures

V7.0

November 2025

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Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

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1. Introduction

1.1. Diagnostic testing information supports many clinical decisions both in the identification of new conditions and the monitoring and treatment of existing ones. As such it sits within the overall patient clinical pathway. The diagnostic pathway begins when a test is indicated such that a request is generated, progresses via the diagnostic process, and ends when a report is received by the requester and acted upon. Failures at any point in this pathway may lead to delays in the care of the patient, sometimes with serious clinical consequences.

1.2. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

2.1. This policy sets out an approved documented process whereby the risks associated with ophthalmic science tests within the Ophthalmology Department are managed through the provision of local policies and procedures that are implemented and monitored. It has been developed to ensure these risks are minimised and give assurance to external bodies, specifically the NHSLA (Standard 5 – Criterion 7: Diagnostic Testing Procedures). No patient's treatment should be delayed because of delays in the availability of Diagnostic information and the objective of this document is to ensure that this does not happen, recognising that communication problems are often the root of such delays; there is an absolute need for clear pathways that identify how, when and to whom the results should be communicated. This policy is aimed at those who provide and those who request ophthalmic science tests within the Ophthalmology Department.

3. Scope

This policy applies to all those who request Ophthalmic Science tests and those who receive, process, or need to act on the results of these.

4. Definitions/Glossary

- National Health Service Litigation Authority.
- GP: General Practitioner.
- RCHT: Royal Cornwall Hospitals NHS Trust.

5. Ownership and Responsibilities

The strategic and operational roles responsible for the development, management and implementation of the policy are shown below:

5.1. Role of the Managers

Line managers are responsible for:

- Conduct stringent recruitment checks to ensure that only appropriately qualified and registered staff undertake and authorise test results and ongoing checks of professional registration.

- Ongoing checks of Training and competence to perform those tests within the scope of activity of individual staff.

- Ensuring that staff follow those processes and procedures described in the Standards and Practice section relevant to the part they play in the diagnostic pathway.

5.2. Role of the Surgical Divisional Governance Management Board

The Surgical Division Governance Committee is responsible for:

- The Surgical Divisional Governance Management Board is responsible for the development, approval and communication of this policy and monitoring compliance with it.

5.3. Role of Individual Staff

All staff members are responsible for:

- The diagnostic pathway begins when a request is generated, and the required procedure is undertaken; it progresses via the diagnostic testing process and ends when a report is received by the requester and when necessary, acted upon. Various healthcare staff are involved in this pathway including Doctors, Nurses, Healthcare Assistants/Support workers and Allied Health Professionals.

- Administrative staff in Ophthalmology have a role to play in ensuring diagnostic testing appointments are booked and appropriate preparation instigated in accordance with agreed operating policies.

5.4. All staff members are responsible for:

All staff members are responsible for:

- Being aware of this policy and any documents referred to within it pertaining to their part in the diagnostic pathway.

- Adhering to any requirements described within this policy and documents described in the standards and practice section pertaining to their role in the diagnostic pathway.

6. Standards and Practice

6.1. Content

The content of this section takes account of the information provided in the overarching Trust-wide policy which in turn is informed by the document and template provided by the NHSLA (amended to incorporate revisions to the Standards in January 2012) for Standard 5 – Criterion 7: Diagnostic Testing Procedures, and is used to provide details and information describing the practices, systems, and processes staff are expected to follow in order to comply with this document.

6.2. Diagnostic tests provided by the service, including but not exclusively

- Refraction.
- Corneal Topography.
- Diagnostic Ultrasonography.
- Fluorescein Angiography and Indocyanine Green Angiography.
- OCT and OCTA.
- Colour Photographsext Paragraph.

6.3. How diagnostic testing procedures are risk assessed

Departments need to focus on the degree of intervention required, the consequence of missed diagnosis and the impact for the trust. Information sources include a trawl of the complaints, claims and incidents data to see if there are common themes as this would also indicate an area of increased risk for the organisation.

6.4. Measures that need to be in place for the diagnostic test to enable any preparation of the patient (e.g., fasting) required

For fluorescein angiography (FFA) and Indocyanine Green Angiography (ICG), specific information is posted to the patient with the appointment letter. For OCT, colour photographs and other ocular images, the patient appointment letter states that dilating eye drops may be required on the day and that these will be instilled at the clinic. For refraction, the parents/guardians are provided with the dilating drops along with a patient information sheet by the Orthoptist when the Optometry appointment is made. On occasions when the drops are instilled on the day of the appointment, the parents are advised, verbally that the drops take 30 mins for them to be fully effective.

6.5. Identifying the process for ensuring that informed consent is obtained prior to a diagnostic test

Consent for investigations is assumed consent, by way of the patient attending for the appointment for the test procedure. For Fluorescein Angiography verbal consent is taken on the day and this is recorded in the patients' hospital notes.

6.6. How the diagnostic test is requested

6.6.1. It is important that requests are generated, received, and processed correctly in order for the diagnostic process to be initiated in the first place.

6.6.2. Requesting Ophthalmic diagnostic procedures is currently actioned from the appointment outcome form for follow up patients and referral letters for new patients. Verbal requests may be made on the day by a clinician direct to the team. The request will also be documented on

MediSIGHT for the follow up patients. The process for fluorescein angiography and indocyanine green angiography is documented in the department protocol. Both documents are available on the Document Library.

6.7.3. It is the responsibility of the requesting Clinician to complete the appointment outcome form and record the request on MediSIGHT or referral letter accurately clearly indicating the diagnostic procedure requested.

6.7.4. The professional expectation is that anyone requesting a test should have the training, experience, and authority to explain the result to the patient. The examiner has a duty to carry out reasonable tests on the assumption that they have been legitimately requested. Some specialised tests may only be performed if requested by a consultant.

6.7. Ensuring that diagnostic tests are received within agreed time frames

It is the responsibility of the Ophthalmology Department to ensure that patients present for testing within any cut-off times quoted in published User information or Policies.

6.8. How the clinician treating the patient is informed of the result, including timescales

6.8.1. All results from Ophthalmic diagnostic tests are recorded/documented on MediSIGHT and uploaded to the viewing platformOphthalsuite/Heyex/Imagenet) and are available for the patient's Consultation with the Doctor. It is the examiners responsibility to ensure that the patient has an appointment with the Doctor.

6.8.2. If the request has been received from a doctor from another department e.g., the Stroke team, Neurology then a copy of the results will also be sent directly to the referrer.

6.8.3. If appropriate the results will be given to the patient by the examiner at the time of undergoing the test.

6.9. How the patient is informed of the result, including timescales

6.9.1. Patients must be made aware of the reason for tests being requested and the approximate timescale for availability of the results so that they may request an update on results as necessary. Results which have significant implications for the patient must be discussed with them in the appropriate timescale.

6.9.2. There is an expectation that patients are informed of results by the requesting clinician in a timely fashion.

6.9.3. The mechanisms and timescales for informing patients of results are the responsibility of the requesting clinician but may include, according to the nature of the test, availability of result and the significance of the result:

- Telling patients.
- Writing to patients.
- Discussing with patients at Outpatient or pre-op assessment clinics.
- Writing to their GP.

6.9.4. Every opportunity should be taken to check for/flag outstanding results at Outpatient and GP appointments.

6.10. Actions to be taken by the clinician, including timescales

6.10.1. The person receiving the results should ensure the results are brought to the attention (urgently if necessary) of the clinical team currently caring for the patient. The referrer will take responsibility for ALL investigations requested by them or in their name, but the responsibility for signing off a result can be appropriately delegated. It does not have to be the responsible clinician who signs off the result. Ultimately though the responsibility will fall back on the responsible clinician if nobody else accesses the result.

6.10.2. A person with clinical responsibility for the patients should review and interpret the results and ensure a management plan is recorded as required.

6.11. How the minimum requirements for are recorded

6.11.1. **Requesting:**

Requests for Ophthalmic diagnostic tests/procedures are recorded on MediSIGHT or via a referral letter/form.

6.11.2. **Informing the Clinician**

At present there is no record of clinicians being informed of the result other than the printing of reports and those that are telephoned. Practices vary as to what the requester records and where.

Communication of test results between clinical staff who have received results and other healthcare staff, or patients must be recorded in the notes.

6.11.3. **Informing the patient**

Records are kept of any written correspondence with the patient or their doctor in the notes. Records are kept of discussions (in person or over the telephone) in the notes.

6.11.4. **Actions taken**

Actions taken are documented in the notes.

6.11.5. When recording results within the patient's record the minimum information which must be included is:

- Forename and surname.
- NHS/Hospital number.
- For unknown patients a coded identifier may be used.
- Test or procedure.
- Date investigation was performed.
- Interpretive comments made/conclusion reached may be recorded.

The method of communication of the actions must be recorded, i.e., face to face contact, phone call, letter, email, fax, etc.

Hospital discharge summaries should record confirmed diagnosis and any outstanding investigations.

7. Dissemination and Implementation

The document will be placed on the RCHT Documents Library with notification of all users via email. It will also appear on the Ophthalmology A-Z of Services Intranet pages.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	1. Informing the clinician treating the patient of the result; ensuring they are looked at/acknowledged. 2. Reporting timescales. 3. Acting on, documenting, and informing the patient of the result that part of the process, do you intend to monitor (you may intend or need to monitor all of it).
Lead	Ophthalmology Consultant.
Tool	Documentation audit using a word or excel template.
Frequency	Annually.
Reporting arrangements	Reports will be reviewed by the Ophthalmology team. Each report should contain a summary and action points to enable these to be readily identified; these should be discussed and recorded in meeting minutes.

Information Category	Detail of process and methodology for monitoring compliance
	The lead or committee is expected to read and interrogate the report to identify deficiencies in the system and act upon them.
Acting on recommendations and Lead(s)	The Committee which reviews the report will delegate recommendations and action planning, for any or all deficiencies and recommendations within reasonable timeframes, to the appropriate committee, department, or lead. Required actions will be identified and completed in a specified timeframe.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within the minimum achievable timescale. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

9. Updating and Review

This policy will be reviewed every three years or sooner if circumstances suggest this may be necessary.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Ophthalmic Science Diagnostic Testing Procedures V7.0.
This document replaces (exact title of previous version):	Ophthalmic Science Diagnostic Testing Procedures V6.0.
Date Issued/Approved:	November 2025.
Date Valid From:	November 2025.
Date Valid To:	November 2028.
Author/Owner:	Faye Gibson, Head Orthoptist.
Contact details:	01872 253287.
Brief summary of contents:	This policy sets out an approved documented process whereby the risks associated with diagnostic testing procedures for Ophthalmic Science are managed.
Suggested Keywords:	Ophthalmology, Diagnostic, Testing, Eyes.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer.
Approval route for consultation and ratification:	Julia Hale, Clinical Lead for Ophthalmology. Salem Murjaneh, Clinical Governance Lead for Ophthalmology.
Manager confirming approval processes:	Ian Moyle-Browning, Head of Nursing (HoN).
Name of Governance Lead confirming consultation and ratification:	Michele Reed.
Links to key external standards:	NHSLA Risk Management Standards, Criterion 5.6.
Related Documents:	Organisation Wide Policy for The Management Of Diagnostic Testing Procedures.
Training Need Identified:	No.

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/Ophthalmology.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
May 2012	V1.0	Initial issue.	Faye Gibson, Head Orthoptist.
May 2013	V2.0	Amended version.	Faye Gibson, Head Orthoptist.
June 2015	V3.0	Amended version.	Faye Gibson, Head Orthoptist.
August 2017	V4.0	Amended version.	Faye Gibson, Head Orthoptist.
February 2020	V5.0	Minor changes regarding MediSIGHT and Ophthalsuite as an electronic way of storing and viewing the test results.	Faye Gibson, Head Orthoptist.
January 2023	V6.0	Minor changes regarding MediSIGHT and the imaging platforms.	Faye Gibson, Head Orthoptist.
December 2025	V7.0	Minor change MediSIGHT is replacing Medisoft.	Faye Gibson, Head Orthoptist.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy/policy/proposal/service function to be assessed:	Ophthalmic Science Diagnostic Testing Procedures V7.0.
Department and Service Area:	Ophthalmology.
Is this a new or existing document?	Existing.
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Faye Gibson, Head Orthoptist.
Contact details:	01872 253287.

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Sets out an approved documented process whereby the risks associated with diagnostic testing procedures are managed through the provision of local policies which are implemented and monitored.
2. Policy Objectives	The risks associated with diagnostic testing procedures are minimised; compliance with NHSLA Standard 4 – Criterion 4: Diagnostic Testing Procedures is achieved.
3. Policy Intended Outcomes	To ensure that the diagnostic process contributes the maximum benefit to the treatment of patients.
4. How will you measure each outcome?	As described in Section 8.
5. Who intends to benefit from the policy?	All patients.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/visitors: No • Local groups/system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Ashish Patwardhan, Clinical Lead for Ophthalmology - Care Group Governance Meeting.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	

Protected Characteristic	(Yes or No)	Rationale
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Faye Gibson, Head Orthoptist.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis