



ROYAL COLLEGE OF OPHTHALMOLOGISTS

**GUIDANCE FOR REVALIDATION AND APPRAISAL IN
OPHTHALMOLOGY**

CRITERIA, STANDARDS AND EVIDENCE

May 2003

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ROYAL COLLEGE OF OPHTHALMOLOGISTS

DRAFT GUIDANCE FOR REVALIDATION AND APPRAISAL IN OPHTHALMOLOGY CRITERIA, STANDARDS AND EVIDENCE

INTRODUCTION

Ophthalmologists, like all other doctors in the UK, will be required on a regular basis to demonstrate their fitness to practise by taking part in the process of revalidation. This will involve all ophthalmologists who need a licence to practise.

The gathering of evidence of good practice for revalidation in the form of a portfolio has much in common with the process required for annual appraisal*. The GMC believe that 'full participation in annual appraisal with completed supporting documentation, during the revalidation cycle, is a powerful indicator of a doctor's current fitness to practise'. It is likely therefore that no additional documentation will be necessary for revalidation.

The aim of this guidance is to:

- describe the events leading up to revalidation and appraisal
- to explain clinical governance and its relevance to ophthalmology
- to list the attributes of 'good ophthalmological practice'
- to draft criteria from these attributes
- to define the standards against which the ophthalmologist's performance for each criterion will be assessed
- to suggest categories and examples of evidence that can be submitted both for local appraisal and for the purpose of revalidation

HISTORICAL BACKGROUND

In 1998, NHS reforms were centred around the concept of **clinical governance** which is essentially a mechanism for ensuring that organisations are accountable for improving their quality of care. This became a legally binding requirement with the introduction of the Health Act.

In 1999, the General Medical Council (GMC), responding to public concerns following several high profile medical negligence cases, decided that "all doctors must be able to demonstrate regularly that they continue to be fit to practise in their chosen field" and termed this process **revalidation**.

Both clinical governance and revalidation require **evidence** to demonstrate that quality standards are being achieved, either by a Health Authority or Trust in a corporate sense with respect to governance, or by an individual ophthalmologist in the form of a portfolio.

* An appraisal scheme for consultants was launched in April 2001 (MD) 05/01, and for all non-consultant career grade doctors in September 2002 (MD) 05/02.

We have always had a duty to provide the best care for our patients; this duty has become a legal requirement which must be supported by evidence to demonstrate our fitness to practise.

CLINICAL GOVERNANCE

Clinical Governance is defined as “a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”.

Put in simpler terms, clinical governance is a ‘duty of quality’ which we all share in our responsibilities to patients and these characteristics are embodied in the GMC’s ‘Good Medical Practice’ and referred to as ‘good ophthalmological practice’ in this document.

Good clinical governance requires a partnership between clinicians and managers. Clinicians are expected to maintain high standards through professional self-regulation (revalidation and appraisal), keep up to date (with continuing professional development) and use evidence-based medicine wherever possible. Managers are expected to provide systems and support, monitor performance and outcomes and take action where standards fall.

Clinical governance should be positively concerned with good practice rather than bad practice and should avoid a culture of blame.

In essence it should involve good communication and teamwork between managers and clinicians with the best interests of patients as the common goal.

PUTTING CLINICAL GOVERNANCE INTO OPHTHALMOLOGICAL PRACTICE

The main elements of clinical governance are:

1. clinical audit
2. clinical effectiveness - guidelines, protocols
3. evidence based practice
4. risk management - including adverse event reporting
5. education and training - continuing professional development
6. openness - to public scrutiny and lay involvement

All of the above are concerned with good practice and every ophthalmologist is expected to participate in these areas. Evidence of involvement will provide essential material for the portfolio. Audit areas relevant to ophthalmology are listed in *Appendix 1*.

REVALIDATION

Revalidation is the regular demonstration by doctors that they remain up to date and fit to hold a licence to practise. This licence will normally be granted by the GMC following a formal 5-yearly assessment supported by interim annual appraisals.

The type of practice may vary considerably and so it is important that local context and the working environment are taken into account. Ophthalmologists will be asked to specify their fields of practice in the information submitted for revalidation and these may include non-clinical activities such as medical management, teaching or research for which evidence can be submitted.

Revalidation, like registration, will be generic. It should be flexible enough to allow ophthalmologists to change their field of practice or to undertake new procedures or activities throughout the revalidation cycle. However, all ophthalmologists should bear in mind the requirement to ensure that they work only within the limits of their professional competence, and that revalidation will require them to demonstrate that they are *continually fit to practise in all areas they undertake*.

Ophthalmologists in training who have been qualified for five years will need to provide evidence for revalidation. This evidence will normally be gathered as part of the Record of In-Training Assessment (RITA) scheme. Full participation in the RITA process with retention of the supporting documentation will be considered to be equivalent to appraisal for the purposes of revalidation.

THE ROUTES TO REVALIDATION AND THE ROLE OF THE GMC

The GMC will require all doctors to demonstrate that they have followed the standards within 'Good Medical Practice' that are relevant to their speciality and practice. They stress that this is the individual's responsibility and it is not up to the GMC to prescribe what information should be collected and retained.

The routes to revalidation may either be through **appraisal** or an **independent** route.

Most ophthalmologists will participate in annual appraisal as part of their trust's clinical governance programme. Alternatively some ophthalmologists may use the independent route which means that they must demonstrate that they are adopting the standards of 'Good Medical Practice' and undertaking appropriate continuing medical education (CME) or professional development. Suitable evidence will need to be provided as outlined in this document.

The intended **timetable** for revalidation is that by the end of 2004 the GMC will give all doctors (except those that opt out) a licence to practise*. By 1st January 2005, by law, any doctor who wants to practise must hold such a licence. In Spring 2005 the GMC will 'invite' doctors to be revalidated. They expect that it will take up to 5 years for all doctors to be revalidated for the first time. In 2010 the second round of revalidation will start. It is

* Further details are available on the GMC websites www.revalidationuk.info and www.gmc-uk.org

planned that invitations for first revalidation will be on a **random basis**. The first revalidation will cover the period between April 2003 and the date of invitation to take part.

It remains the individual ophthalmologist's responsibility to satisfy the GMC of their fitness to practise. The system described in this document is a method for securing revalidation through the appraisal process. Participation in quality assured annual appraisal should be, for the vast majority of ophthalmologists, all that is necessary to ensure revalidation.

The GMC will not normally want to see all the information that is collected (although it should be retained as from time to time samples of doctor's evidence will be scrutinised in more detail).

Communication with the GMC is likely to be, for the most part, via the Internet. The Revalidation Groups (referred to in the first edition of this document) are now not mentioned although medical and lay members of the GMC Council will monitor operation of the system.

REVALIDATION FOR LOCUM OPHTHALMOLOGISTS

Locum ophthalmologists will also be required to submit a folder of information to demonstrate their fitness to practise when their revalidation is due. NHS Professionals, which was commissioned by the Department of Health in November 2002 to provide a range of services to support temporary and flexible working in the NHS, and will be the primary supplier of all temporary staffing requirements, will provide support for appraisal leading to revalidation*.

REVALIDATION FOR OPHTHALMOLOGISTS IN THE INDEPENDENT SECTOR

Revalidation and appraisal may pose particular problems for those who undertake private practice particularly when it is entirely independent and there is no association with a health authority or trust who might provide an appraisal mechanism or performance data.

The same principles of clinical governance apply to all ophthalmologists[†] and evidence of competency, as outlined in this document, will similarly be required for revalidation. The 'independent' route to revalidation (described above) will apply instead.

It would clearly be advantageous for ophthalmologists in private practice to collaborate in order to create a formal structured opportunity to discuss professional roles and clinical practice. Alternatively, liaising with a neighbouring trust would help foster good relations and be of practical benefit.

The GMC is in discussion with the main independent sector organisations to determine the extent to which they will be able to help. It is anticipated that a 'whole-practice' appraisal concept, proposed by the Independent Healthcare Association Revalidation Group, will be implemented for NHS doctors with an independent practice, in order to

* <http://www.nhsprofessionals.nhs.uk/doctors/index.asp>

[†] As described in the Principles for a Private Medicine Clinical Quality Framework – Private Practice Forum of the Academy of Medical Royal Colleges, April 1999

avoid duplication of appraisal and revalidation across the independent sector and the NHS.

REVALIDATION FOR RETIRED OPHTHALMOLOGISTS

Retired ophthalmologists no longer in active practice have the option to remain on the Register but not hold a licence to practise in which case there is no need for them to be revalidated.

Those who want to continue to practise (for example as an ophthalmic medical practitioner or as a locum) will need a licence and must take part in the revalidation process. They will have to draw on what they have actually done over the revalidation period and provide suitable evidence covering each heading of good medical practice.

THE ROLES OF THE PERFORMANCE-REVIEWING ORGANISATIONS

The **Commission for Health Audit and Improvement (CHAI)** assesses clinical governance in all NHS organisations and will review systems in health authorities and trusts for identifying and handling poor performance

The **National Clinical Assessment Authority (NCAA)** assesses the contribution of individual doctors to the local service by addressing individual performance issues

The **National Care Standards Commission (NCSC)** regulates independent health care providers

The **General Medical Council (GMC)** 'protects patients and guides doctors' by keeping up to date the register of qualified doctors and maintaining standards of good medical practice. The GMC investigates serious misconduct, health or performance issues of individual doctors which call into question the doctor's fitness to remain on the medical register.

DEFINITIONS USED IN THIS GUIDANCE

This guidance is intended to explain the revalidation process and give advice on how each section will be assessed so that the most relevant evidence and information can be collated, using, wherever possible, data that has already been gathered by trusts.

Attributes of good ophthalmological practice (based on the GMC's 'Good Medical Practice') are cited in section 3 – these are not exhaustive, but give a general view of behaviour that should underlie the expected level required for revalidation.

Criteria have been drafted from these attributes. A criterion is a statement of a test that can be applied to an ophthalmologist to determine whether he or she has or does not have the required attributes.

Standards define the level of performance against which an ophthalmologist's performance in a criterion will be assessed.

The standards will be based on generally accepted levels of good ophthalmic practice as identified in this document, College guidelines and the College Quality Development Programme.

The generic standards of revalidation will be the GMC's fitness to practise procedures – seriously deficient performance, serious professional misconduct and serious impairment on the grounds of physical or mental health.

Evidence will be needed to inform the appraisal process or support revalidation. Examples are given for each criterion. For the most part the evidence acquired for annual appraisal can be summated for five yearly revalidation.

PRIORITIES

The culture of appraisal is now becoming part of our working lives. Time and resources need to be made available for it to reach its full potential as a supportive mechanism for everyone.

In order for revalidation to be meaningful and effective, in the way that has been envisaged, the process must be kept straightforward and achievable.

At present the GMC revalidation folder requires evidence of good medical practice in the seven areas outlined in section 3 and this document addresses them all. However, some sections are clearly more relevant to the theme of *patient safety* and bearing in mind that the main purpose of revalidation is to ensure that patients are practised upon by competent ophthalmologists, we should concentrate on the components of clinical governance which will provide *essential core evidence* for appraisal and revalidation, namely participation in the following:

- a) Regular audit including adverse event reporting (Section 3.1)**
- b) Continuing Professional Development (Section 3.2)**
- c) Complaints monitoring (Section 3.3)**

Data collected on these areas is likely to be more robust and easier to quantify than other forms of evidence when it comes to practical assessment. Nevertheless, this guidance also covers criteria, standards and evidence for **all** the sections in the GMC revalidation folder.

THE APPRAISAL / REVALIDATION FOLDER

The documentation for both appraisal and revalidation contains the following sections:

Section 1: Your personal and registration details

Section 2: What you do

Section 3: Information about your practice

1. Good Professional Practice
2. Maintaining Good Medical Practice
3. Relations with Patients
4. Working with Colleagues
5. Teaching and Training
6. Honesty
7. Health

SECTION 1 - YOUR PERSONAL AND REGISTRATION DETAILS

This section of the folder (or appraisal document) asks for:

- Personal details
- GMC registration details including any breaks in registration

SECTION 2 - WHAT YOU DO

This section of the folder covers what you do and where you practise. The following details are required:

- Your job plan including:
 - Obligatory professional requirements
 - Teaching commitments
 - Non fixed session commitments (including emergency, administrative, research and on-call)
 - Management roles and functions
 - Details of any private practice undertaken

Revalidation is intended to be directed towards the activities that you declare - these may have a variable clinical content.

Criterion: The ophthalmologist defines what he or she does

Standard: The statement covers all important areas of the ophthalmologist's work, taking into consideration the context in which he or she practises. The contents of this statement forms the basis of the evidence given in the subsequent sections of the folder

Evidence: A statement of the ophthalmologist's activities

SECTION 3 – INFORMATION ABOUT YOUR PRACTICE

Section 3.1: good professional practice

Section 3.2: maintaining good ophthalmological practice

Section 3.3: relations with patients

Section 3.4: working with colleagues

Section 3.5: teaching and training

Section 3.6: honesty

Section 3.7: health

SECTION 3 – INFORMATION ABOUT YOUR PRACTICE

This section applies to all ophthalmologists undertaking clinical work. In this section you can identify any data which you think demonstrates the quality of your practice

SECTION 3.1: GOOD PROFESSIONAL PRACTICE

The following is a synopsis of aspects of care that relate to good ophthalmological practice. The list of these attributes is not exhaustive and should be read in conjunction with the GMC's "Good Medical Practice"

Attributes:

CLINICAL CARE

An Ophthalmologist should:

- take time to listen to patients and allow them to express their own concerns
- use clear language appropriate to the patient
- have access to up-to-date equipment and be skilled in its use
- be aware of all relevant investigations and understand the results
- make sound management decisions which are based on good practice guidelines and evidence
- maintain his or her knowledge and surgical skills and be aware of his or her limitations

RECORD KEEPING

An Ophthalmologist should:

- record appropriate information for all consultations and procedures
- ensure legibility
- only use abbreviations where they are in common use
- accept responsibility for the record by signing and dating it
- communicate regularly with the GP (or Optometrist where appropriate), conveying all relevant information in a clear and concise way
- respect the patient's right to confidentiality

ACCESS & AVAILABILITY

An Ophthalmologist should:

- aim to provide a polite, responsive and accessible service within the resources allocated
- make it clear how, where and when he or she can be contacted
- ensure that it is easy for GPs to arrange immediate and urgent referrals

EMERGENCY AND OUT OF HOURS COVER

An Ophthalmologist should:

- have a policy for the organisation and management of emergencies and ensure that all members of the team are aware of them
- always be easy to contact when on duty
- always be prepared to come into the hospital to support his or her team

Criterion: Regular review of clinical practice demonstrates the achievement of acceptable standards of care

Standard: Reviews of clinical practice show a willingness to be involved in local audit and demonstration of a commitment to and achievement of acceptable standards of care. Comparison with national statistics (where available)

Evidence: Reports on clinical audits^{*}, including adverse event auditing, in which the ophthalmologist has been involved

Additional evidence that *may* be relevant:

- Record of how results of audit have resulted in changes to practice
- Results of clinical outcomes as compared with College guidelines
- Evidence of any resource shortfalls which may have compromised clinical outcomes
- Indicative information regarding annual workload (providing that systems for gathering such data are in place)

Examples of **Audit Projects in Ophthalmology** are given in *Appendix 1*

^{*}Clinical Audit provides evidence for both clinical governance and revalidation, indicates what changes are needed and highlights resources required

SECTION 3.2: MAINTAINING GOOD OPHTHALMOLOGICAL PRACTICE

The purpose of this section is to record Continuing Professional Development (CPD) and Continuing Medical Education (CME). If there have been problems in attending these activities, they should be identified.

Attributes:

CLINICAL CARE

An Ophthalmologist should:

- maintain his or her knowledge and skills and be aware of his or her limits of experience
- keep up-to-date with developments in clinical practice
- have a personal development plan* (PDP)

Criterion: An awareness of learning needs, activities to meet those needs and changes in clinical practice as a result

Standard: Registration and participation in CME to the RCOphth standard. Satisfactory annual appraisal

Evidence: Evidence of College CME registration. Annual summary of CPD/CME activity. Personal development plan. Annual appraisal certification

Additional evidence that *may* be relevant:

- Details of any particularly relevant work such as involvement in the production of papers, articles, guidelines, protocols, instigation of new techniques or treatments etc.
- Record of attendance and contributions to local departmental meetings
- Record of attendance at conferences etc.
- A list of membership of professional societies

* A Personal Development Plan (PDP) will form part of the appraisal process outlined in Section 4. The two fundamental components of the PDP are a) the requirements of an individual's Job Plan and b) the aspirations for professional career development. Details of PDPs in ophthalmology are available from the Education and Training Department

SECTION 3.3: RELATIONS WITH PATIENTS

This section is intended to demonstrate that you interact appropriately with patients and have good communication skills. You are required to give details of any substantiated complaints about you that have been made by members of the public.

Attributes:

CLINICAL CARE

An Ophthalmologist should:

- respect the patient's right for confidentiality
- ensure good communication with patients whether face to face, by letter or by telephone
- treat patients politely and with consideration
- give patients the information that they need to understand their condition
- involve patients in decisions about their care
- obtain informed consent to treatment
- treat all patients equally

Criterion: An assessment of the ophthalmologist's communication skills and reflection on the results

Standard: Good ophthalmological practice as outlined above

Evidence: Submission of a patient survey*
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IF THINGS GO WRONG

An Ophthalmologist should:

- contact the patient immediately if a mistake has occurred
- fully inform the patient of any significant complication of surgery
- tell the patient what has happened and whether or how it can be put right
- inform the patient's relatives (if appropriate)
- co-operate with any investigation arising from a complaint
- try to maintain a relationship with the patient or family after the mistake has occurred

Criterion: An effective complaints procedure is in place and being used
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Standard: Compliance with the formal trust / hospital complaints procedure

Evidence: A summary of substantiated complaints received and any subsequent changes in practice
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* Patient Surveys should be organised by trust Human Resources Departments

SECTION 3.4: WORKING WITH COLLEAGUES

This applies to all those with whom you work – ophthalmologists, nurses, orthoptists, technicians, clerical staff and other professionals as well as lay people.

Attributes:

WORKING IN TEAMS

An Ophthalmologist should:

- have effective systems for communication within the team
- participate in regular meetings with members of the team
- encourage and facilitate all members of the team to play their full role and support their development
- attempt to ensure that deficiencies in the team are addressed effectively

COLLEAGUES PERFORMANCE

An Ophthalmologist should:

- be aware when a colleague's performance, conduct or health may be putting patients at risk
- ascertain the facts of the case, take advice from colleagues, and if appropriate refer the colleague for medical advice or local remedial action
- if appropriate provide positive support to colleagues who have made mistakes or whose performance gives cause for concern
- put the safety of patients first at all times

<p>Criterion: A demonstration by the ophthalmologist of his or her willingness to work as part of a team and having a professional working relationship with colleagues for the benefit of patients</p>
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<p>Standard: Good ophthalmological practice as above. Satisfactory peer review*</p>
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<p>Evidence: Peer review (feedback from staff as part of 360 degree survey*)</p>

* Ramsey (for reference see page 30) developed a peer-rating model with the objective of assessing the feasibility of evaluating the performance of practising physicians. The Ramsey model has been referred to by the Revalidation Leads Group of the Academy of the Royal Medical Colleges (1 April 2000) as providing suitable evidence towards the 'fitness to practice' element of revalidation.

Ramsey concludes that using this model, it is feasible to obtain peer assessments in areas such as clinical skills, humanistic qualities and communication. It is recommended that eleven responses provide sufficient reliability. It remains to be seen whether peer surveys are going to prove useful in assisting the process of revalidation. An 'acceptable standard' of response has yet to be agreed

SECTION 3.5: TEACHING AND TRAINING

This section deals with the above activities which may form part of an ophthalmologist's work to a greater or lesser degree. Any difficulties arranging cover whilst undertaking teaching and training should be recorded.

Attributes:

TEACHING AND TRAINING

An Ophthalmologist should:

- have a personal commitment to teaching and learning and show a willingness to develop further through education, audit and peer review
- ensure that patients are not put in danger when being seen by students or doctors in training
- ensure that the patient's dignity is respected during teaching or training

Evidence that *may* be relevant:

- Brief description of teaching and training activity
- Courses attended such as 'Teaching the Teachers'
- Brief description of supervision or mentoring duties
- Methods employed for teaching surgery
- Recorded feedback from those taught

SECTION 3.6: HONESTY*

Paragraphs 47-57 of the GMC's 'Good Medical Practice' are concerned with

- providing information about your services
- writing reports, giving evidence and signing documents
- research
- financial and commercial dealings with patients
- conflicts of interest
- financial interests in hospitals, nursing homes etc.

In this section you may be required to sign a declaration of past findings related to any convictions, findings against you or disciplinary action and also that you accept the professional obligations placed upon you in the above paragraphs of 'Good Medical Practice'.

Attributes:

PROFESSIONAL PRACTICE

An Ophthalmologist should:

- be honest and open regarding financial or commercial dealings and when providing professional documentation
- ensure that research is carried out to a high standard
- protect patient's rights
- preserve patient's confidentiality

PROVIDING REFERENCES

An Ophthalmologist should:

- take care with references and bear in mind his/her responsibility to a doctor's future patients
- be honest and objective in comments made in references and not to miss out relevant information

Criterion: Professional honesty
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Standard: The attributes for 'good ophthalmological practice'
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Evidence: A statement* signed by the ophthalmologist that he or she practises honestly

* The GMC's documentation on revalidation and Department of Health documentation on appraisal relate to 'Probity'. The GMC may require all doctors to sign a declaration covering a range of issues such as criminal convictions, determinations by regulatory bodies and disciplinary procedures. Self declarations regarding honesty do not constitute proof but may have more standing if and when they are required by law

SECTION 3.7: HEALTH

During the revalidation process, the GMC encourages you to reflect on your own health, seek professional advice if necessary and to consider whether, if you feel your health is affecting your work, you should modify your professional activities.

In this section you are required to state whether or not you have:

- any illness that is affecting your work
- been subject to any regulatory or voluntary proceedings related to your health

Attributes:

HEALTH

An Ophthalmologist should:

- not allow ill health to affect his or her fitness to practise

<p>Criterion: The self-confirmation that an ophthalmologist's fitness to practise safely is not compromised by health</p>
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<p>Standard: The attribute described above</p>

<p>Evidence: A statement signed by the ophthalmologist that health issues do not affect his or her fitness to practise*</p>
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* The same comments (footnote page 17) with respect to honesty apply to a self declaration concerning health

SECTION 4: APPRAISAL

The national scheme for appraisal of consultants was introduced by the Department of Health in April 2001 and for non-consultant career grade doctors in September 2002, and is now a contractual requirement.

The appraisal process is the vehicle through which the GMC's revalidation requirements will be delivered⁺ and every ophthalmologist being appraised should prepare an appraisal folder as outlined in this document, which should include information, evidence and data which can be updated as necessary.

Appraisal covers all areas in Section 3 of the revalidation folder. The appraiser and appraisee will sign to confirm the accuracy of the summary of the appraisal discussion, agreed action and agreed personal development plan. These certificates will form a key element of the revalidation folder.

Whereas revalidation is concerned with standards measured against the GMC's good practice guidelines, appraisal takes a broader look at an ophthalmologist's work and service delivery.

The appraisal process should:

- be a professional process which gives ophthalmologists regular feedback on past performance and continuing progress and identifies educational and developmental needs
- not be related to promotion or discipline
- be supportive to the appraisee and which may help to identify signs of poor performance at an early stage or to recognise factors, such as ill health or stress

Appraisal and revalidation

Appraisal discussions and evidence gathering should be sufficient to cover the essential requirements of revalidation based on the following headings in the GMC's 'Good Medical Practice'.

1. good professional practice
2. maintaining good ophthalmological practice
3. relations with patients
4. working with colleagues
5. teaching and training
6. honesty
7. health

⁺ See combined GMC and Departments of Health website: www.revalidationuk.info

Appraisal documentation

Appraisal follows a standardised format in order to ensure consistency and to provide a written record. Guidance on appraisal has been issued and can be downloaded from the GMC and Department of Health Appraisal and Revalidation website at:

<http://www.revalidationuk.info/article.cfm?area=3&art=13&sub=42&gc=44>

and further information relating to non-consultant career grade doctors on:

<http://www.revalidationuk.info/article.cfm?area=3&art=13&sub=41&gc=116>

APPRAISAL

A successful appraisal system may have the following elements

Appraisal Framework Overview

- Step 1 Trust Office notifies consultant that appraisal is due using Appraisal Preparation Form (see *Appendix 2*)
- Step 2 Ophthalmologist ensures that he/she has a current Job Plan - this is a prerequisite for appraisal and selects Appraiser from local bank of trained appraisers and makes an appointment
- Step 3 Ophthalmologist prepares portfolio of collected evidence. Appraiser (assisted by trust) organises 360 degree survey (see footnote on page 14)
- Step 4 Appraisal interview takes place (approximately 60 minutes)
Appraisal Summary Form completed
- Step 5 Appraiser forwards Summary Form to Clinical Director (if not the appraiser) for forwarding on to Medical Director indicating completed Appraisal. The Summary Forms may form the basis of ophthalmic speciality self-appraisal

Organisational Structure

- Each consultant to choose his or her (trained) appraiser*
- An annual cycle of evidence gathering to be collected in a portfolio
- An appraisal preparation form (*Appendix 2*) will provide a framework for the interview
- Responsibility of the appraisee to gather evidence (data relating to clinical practice) for appraisal
- An annual appraisal interview to be held to review the year's activities based on the evidence collected
- Summary form completed and targets established for following year's cycle
- Summary forms collated for speciality team appraisal and used by trust to identify and apply resource needs to appraisal outcomes

* The choice of appraiser may vary with different schemes and may not be left up to the individual. Hierarchical appraisal may not be practical in terms of workload. Ideally the appraiser should have an adequate grasp of the speciality but need not necessarily be an ophthalmologist. On occasions a two-on-one system is employed whereby two appraisers (one an ophthalmologist) conduct the appraisal interview.

Evidence

The amount of evidence relating to clinical practice and gathered for appraisal will depend upon the extent to which data is collected and made accessible by the trust and the resources made available to support audit and appraisal. Ideally every ophthalmology department should have their own audit co-ordinator. It should be stressed that until adequate resources and time are made available, evidence that *already exists* should be used for appraisal.

The appraisal interview

At appraisal, the discussion regarding Clinical Practice seeks to establish what has gone well and what difficulties have been encountered over the preceding year. The discussion is centred around the appraisee's personal development and also identifies involvement in management, education and training, clinical governance and research. Appraisal may be supported by a 360 degree feedback or Ramsey Peer Assessment suitably modified for ophthalmology (see footnote page 15).

Criterion: Regular review of performance and activities

Standard: Annual appraisal demonstrates, as far as can be determined, that the ophthalmologist is eligible for revalidation

Evidence: A Statement by an appropriately trained appraiser that each regular review has been satisfactory

Additional evidence that *may* be relevant:

- Summary of the appraisal discussion, agreed action and agreed personal development plan

REVALIDATION IN RELATION TO ACTIVITIES OTHER THAN CLINICAL OPHTHALMOLOGY

When completing the revalidation folder, there will be opportunities for listing other activities such as management and research. For ophthalmologists who do not undertake clinical work revalidation seeks to demonstrate competency in other areas.

Management activity*

Appropriate documentation

- Information about your formal management commitments
- records of any noteworthy achievements
- any recorded feedback available

Research

Attributes:

An ophthalmologist should:

- ensure that research is carried out to a high standard
- protect patients' rights
- preserve patients' confidentiality

Appropriate documentation

- Evidence of formal research commitments
- Record of any research ongoing or completed in the past year
- Record of funding arrangements for research
- Confirmation of ethical approval

<p>Criterion: Review of all activities undertaken as an ophthalmologist outside the scope of 'clinical ophthalmology'</p>
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<p>Standard: Performance to the required standards in each field of practice against the relevant sections of 'Good Medical Practice'</p>
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<p>Evidence: A list of all significant activities not included in the standard options. For each activity there should be: a brief description of the activity, evidence of initial training and competency, evidence of continuing professional development and evidence of regular review</p>
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*For information on standards in medical management see the British Association of Medical Managers (BAMM) website at : www.bamm.co.uk

SUMMARY

Both appraisal and revalidation require evidence of good practice in the form of a portfolio. Despite the revalidation timetable not presenting an immediate threat to an individual's licence to practise, it would be unwise for anyone to hope that this requirement will somehow go away. Therefore collecting evidence should become part of everyone's working life so that they can be prepared for appraisal, and by default for revalidation.

The basic categories and evidence required are:

'Good Medical Practice' heading:	Evidence:
1. Good Professional Practice	Job Plan Summary of activity (if available) Participation in clinical audit and adverse event reporting
2. Maintaining Good Medical Practice	CME registration Summary of CPD activity Personal Development Plan Annual appraisal certification
3. Relations with Patients	Summary of any substantiated complaints
4. Working with Colleagues	Peer review (Reference or 360 ⁰ survey)
5. Teaching and training	Summary of activity (and feedback)
6. Honesty	Statement if required
7. Health	Statement if required

APPENDIX 1

Ophthalmic audit

Revalidation requires ophthalmologists to demonstrate to the public that they are competent and have up-to-date clinical skills. Ophthalmic clinical audit is one way of providing this evidence for both clinical governance and revalidation. It indicates what changes are needed and highlights resources required.

Personal audit

With increasing work pressures it is easy to carry out day to day activities without auditing clinical practice or patient outcomes. This is in part due to the lack of information technology systems for collecting data and the lack of audit department support. Until these are properly in place it is unreasonable to expect all ophthalmologists to perform continuous meaningful audit of all areas of their clinical practice.

Where resources are available, ophthalmologists should collect audit data on the two most commonly performed procedures (which may include laser treatment) that they undertake. Data collection needs to be standardised so that valid comparisons with national audit data can be made.

Department audit

There are a number of aspects of ophthalmic care which are particularly amenable to review and which reflect the effectiveness of a department's work and address the question:

How well are we doing?

1. Routine audit of clinical outcomes

- Record of surgical complication rates
- Surgical outcomes
- Endophthalmitis management
- Visual field loss in glaucoma
- Detection and management of diabetic retinopathy
- Outcome of children's vision screening
- Detection rates for FFAs, CT or MRI scans
- Accuracy of preoperative biometry etc.

2. Continuous professional development

- Consultant audit involvement in areas of high activity or risk
- CME up to date
- Study leave taken
- Completion of annual appraisal

3. Risk management

- Monitoring of adverse events
- Equipment replacement

4. Departmental organisation

- Individual's workload
- Communication within the department
- Day case cataract service
- Emergency referral service etc.

5. Treatment protocols and local guidelines, eg:

- Uveitis
- Acute glaucoma
- Screening for Retinopathy of Prematurity
- Harvesting donor material etc

6. Service quality

- Waiting times
- Complaints analysis / actions

APPENDIX 2

Outline of Draft Consultant Appraisal Preparation Form

A PRELIMINARY DETAILS

- Name
- Appraisal Period (year)
- Speciality / Other Formal Roles
- GMC Number
- Appraisal Date
- Appraiser

B YOUR JOB AND ROLE

- Is the Job Plan current? Yes/No
- If No – Comment describing the major changes
- Does it accurately describe your duties and responsibilities? Yes/No
- If No – Comment describing the major changes

C LAST APPRAISAL

- To what extent were your objectives achieved?
- Were 'Issues Raised' responded to? If Yes - how specifically

D YOUR PRACTICE (Professional, Clinical, Managerial, Personal)

1. What has gone well and given you the greatest satisfaction (over the last 12 months)
2. What difficulties have you encountered (over the last 12 months) and why?
3. What issues would you like to address over the next 12 months?
4. What help do you need to address any of these?
5. What are the Clinical Standards (eg College or other guidelines, evidence based practice) introduced within your clinical area over the past 12 months
6. Tick any of the following areas in which you have been involved over the past 12 months
 - Developing standards of pathways and protocols
 - Clinical Governance programmes
 - Education of medical, nursing and other staff
 - Use of IT in developing service, education teaching
 - Service Research and Development
7. What clinical audit programmes including national programmes have you been involved with?

E CME / CPD

1. What opportunities have there been to undertake CPD (including CME)? Please list activity during last 12 months
2. How was this funded?
3. What areas of CPD and service development are of particular importance to you?
4. How do you envisage progressing the above (say over the next 2 years)

F ADDITIONAL COMMENTS OR ISSUES YOU WISH TO RAISE AT APPRAISAL

APPENDIX 3

Unacceptable Ophthalmological Practice

To be read in conjunction with the GMC's 'Good Medical Practice'. This list is not comprehensive but paints a picture of an individual who leaves a lot to be desired and who would put both his/her patients at risk as well as his/her own prospects for revalidation.

CLINICAL CARE (Section 3)

The unacceptable ophthalmologist:

- fails to take time to listen to patients and prevents them from expressing their concerns
- does not explain his or her findings and the management options to the patient
- uses poor or out of date examination techniques and/or equipment
- does not make use of appropriate investigations and/or treatments
- fails to recognise and treat complications of surgery early and/or appropriately
- does not update skills (including surgical skills) and knowledge or fails to recognise his or her limitations

RECORD KEEPING (Section 3.1)

The unacceptable ophthalmologist

- fails to record appropriate information
- writes illegibly
- uses abbreviations which are not in common use
- fails to take ownership of the record by not signing it or indicating who saw the patient
- does not communicate regularly with the GP
- has little regard for the patient's right to confidentiality

ACCESS & AVAILABILITY (Section 3.1)

The unacceptable ophthalmologist:

- refuses to recognise his or her role in maintaining access to the service within given resource constraints
- makes it difficult for GPs or members of the team to contact him or her

EMERGENCY AND OUT OF HOURS COVER (Section 3.1)

The unacceptable ophthalmologist:

- leaves junior staff to handle emergencies without support
- is difficult to contact when on duty
- goes on leave without consulting colleagues or ensuring that there is emergency cover
- fails to treat emergencies appropriately and leaves colleagues to take over the management as soon as possible
- places little importance on the qualifications and competence of locums

RESEARCH (Page 22)

The unacceptable ophthalmologist:

- ignores the moral and ethical issues of research in pursuit of his/her own goals

IF THINGS GO WRONG (Section 3.3)

The unacceptable ophthalmologist:

- fails to contact the patient after a mistake or complication has occurred
- fails to explain or when necessary apologise to the patient when a mistake or complication has occurred
- fails to rectify the situation when there is an opportunity to do so
- hinders any investigation of a complaint either by lack of co-operation or by deliberately sabotaging it
- leaves any further contact with the patient or their relatives to other members of the team

WORKING IN TEAMS (Section 3.4)

The unacceptable ophthalmologist:

- either does not communicate with the team or does so through third parties
- uses memoranda or dictats rather than open discussion
- is reluctant to negotiate
- fails to consider the needs of other members of the team

COLLEAGUES' PERFORMANCE (Section 3.4)

The unacceptable ophthalmologist:

- fails to recognise when a colleague is putting patients at risk
- fails to take appropriate action when aware that a colleague may be putting patients at risk
- makes no effort to support an under performing colleague
- does not put the safety of patients first at all times

PROVIDING REFERENCES (Section 3.6)

The unacceptable ophthalmologist:

- gives little thought and time to the production of the reference
- supports doctors for reasons other than competence
- exaggerates competence
- fails to make important weaknesses clear

APPENDIX 4

Critical incident /Adverse Event Reporting (See also chapter in the College Hospital Eye Services Document – 2003)

The following are regarded as a **guide** to significant adverse events in ophthalmic practice. This list is intended to be practical and not exhaustive. These events should be recognised, analysed and reported, and they should provoke analysis with a view to both education and prevention. A blame free culture is needed for systems improvement. Action to reduce risks to future patients should take place both within the organisation (locally) and at national level (NHS wide). Ophthalmologists, nurses and paramedical staff are best placed to take ownership of these issues.

Theatre / Ward

1. Operation on the wrong eye
2. Wrong operation on the correct eye
3. Penetration or perforation of the globe during peri-ocular injection
4. Expulsive haemorrhage during surgery
5. Endophthalmitis following surgery
6. Patient collapse requiring resuscitation during surgery
7. Death, including death within 28 days of a surgical event regardless of cause
8. Open category for adverse incidents causing concern amongst staff or patients for whatever reason, e.g.
 - a) IOL miscalculation/wrong power
 - b) Dropped nucleus/fragment
 - c) Unplanned anterior vitrectomy
 - d) Lost muscle (squint surgery)
 - e) Perforated globe (squint surgery)
 - f) Laser to fovea
9. Unplanned re-admission or return to theatre within 28 days of surgery for treatment of the same eye. Includes transfer to or treatment in another hospital

Clinic

1. Delayed diagnosis of intra-ocular foreign body
2. Delayed diagnosis of intra-cranial tumour
3. Delayed diagnosis of retinal tear
4. Failure to screen ROP leading to visual loss

Drugs

1. Wrong drugs instilled
2. Prescribed drugs not instilled
3. Wrong prescription

General

1. Delay in referral leading to visual loss
2. Alteration of patient records
3. Missing case notes at surgery

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