



The ROYAL COLLEGE of
OPHTHALMOLOGISTS

Process Guide

Invited Review of Ophthalmology Services

March 2017

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Date of review: March 2018

1 Introduction and Purpose

1.1 On occasion healthcare organisations may have concerns regarding some aspects of delivery of an ophthalmology service.

1.2 This document defines the agreed indications for service reviews by the College and should be used by trusts* as a guide to the services the College is able to provide and information on the operational and governance process for service reviews. It should also assure ophthalmologists that there is an established mechanism for reviewing services.

1.3 The Royal College of Ophthalmologists will accept requests from healthcare organisations such as Foundation Trusts, NHS Trusts, Health Boards, independent ophthalmology centres and other service providers. It may also accept referrals from commissioners such as Clinical Commissioning Groups where the terms of their contracts allow for such escalation and referral.

1.4 The service covers the whole of the UK, including devolved nations.

1.5 This document should be read in conjunction with the Academy of Medical Royal College's 'A framework of operating principles for managing invited reviews within healthcare'

2. The Role of the College and Other Organisations

2.1 There are a number of other organisations who oversee governance and performance concerns. Consideration should be given as to whether a concern would be better dealt with by these organisation than the College before an approach to the College is made. The Care Quality Commission (CQC) monitors, regulates and inspects healthcare services to ensure quality and safety of care. The National Clinical Assessment Service (NCAS[†]) assesses and advises Trusts on individual medical practitioners whose performance give concerns and have a role in supporting practitioners to return to safe practice. The General Medical Council (GMC) is the independent regulator for doctors in the UK and sets professional standards (Good Medical Practice) for doctors to protect patients and improve medical practice. Where any doctor fails to meet those standards, the GMC can investigate and take action to remove the doctor from the medical register if necessary.

2.2 The College can provide specific expertise in assessing the quality of care and service provision provided by an ophthalmology service/department. Requests for a review by the College may relate to:

- Issues arising from a CQC investigation
- Issues arising from an NCAS assessment of an individual ophthalmologist

* While there are different types of health organisations within the devolved countries this document will refer to trusts for ease of reference.

[†] As of 1 April 2013 NCAS is an operating division of the NHS Litigation Authority (NHS LA).

- The performance of an ophthalmology department/service which is giving cause for concern
- When there are disagreements between the hospital management/commissioners of services and the ophthalmology department/service (manpower, performance, workload, resources, safety and governance)
- When the trust or department feels the service would benefit from an independent review or wishes to seek independent advice to optimise performance
- Quality and safety concerns such as a cluster of cases of post-operative endophthalmitis, an unexpectedly high rate of intraoperative complications or poor outcomes
- Invited Service Reviews are not suitable for assessing the performance of an individual ophthalmologist. Such matters are best referred to NCAS. However the College can provide links to independent advisors if necessary. Please note that arrangements for these reviews are directly between the Trust and that individual and outwith the College.

2.3 The College aims to provide an independent review of the structure, organisation, departmental practices, governance and outcomes in ophthalmology to ensure high quality and safe care is provided efficiently. The College works within an ethos of openness in the conduct of its work and encourages sharing of the findings of the review wherever appropriate and helpful. However, the sensitive nature of some reviews means that the data and information specific to the review should be treated as strictly confidential by all parties involved in order to promote participation by all in an open, equal and fair way. Any Sharing the data and results of the ISR outside of the participants should be agreed by the College, ophthalmology department and the trust first, unless there is a clear and serious risk to patient safety which requires alerting of an appropriate external regulator (see 2.6 and 2.7)

2.4 The Colleges will endeavour to provide rapid, expert, informed, and objective advice when a review is requested. To ensure a consistent process and approach by review teams a framework (Appendix 1) for reviews has been developed to reflect:

- Publications by the GMC which give clear advice on the responsibilities of doctors to ensure the maintenance of standards[†]
- The requirements of clinical governance
- The requirements for revalidation
- Published College documents
- National clinical guidelines

2.5 If a request is made to the College, the Medical Director or Chief Executive of the trust should in the first instance contact the College so that a preliminary telephone conversation with the Chairman of the Professional Standards Committee can be arranged. If the problem appears to be one that the College can help with then the Medical Director or nominated deputy e.g. the Clinical Lead for the ophthalmology department should:

[†] General Medical Council, *Good Medical Practice*. London: General Medical Council, 2013

- Clearly define in writing the problem as seen by the trust or department, and the reason for the request
- Indicate (a) whether a referral has been made to NCAS, the GMC or other organisation (b) indicate whether employment tribunals or other related legal processes are completed, in progress or are expected to begin during the service review
- Give details of the steps already taken to try and resolve the problem and their outcomes
- Inform all the involved local clinicians that an external review of the ophthalmology department/service has been requested
- Agree the Terms of Reference and methodology with the College[§]
- Indemnify the review team, the College and any clinical expert appointed to review cases
- Abide by the protocol on information governance and data management
- Agree the proceedings of the review and all related documentation will be treated as confidential by the trust and its employees
- Identify a single point of contact who should be a senior clinician or manager
- Reimburse direct expenses and recompense appropriately the members of the review team (see section 3.6)
- Agree to formulate an action plan in response to the review recommendations and to respond to the College's request for information on progress with any action points six months after the review.

2.6 The College will:

- Act promptly in accordance with guidance in the Terms of Reference with due regard for natural justice
- Appoint a review team which will:
 - Visit the department within a reasonable timescale (but bearing in mind that the review team is composed of practising clinicians who must give appropriate notice of absence to their employers)
 - Prepare a draft report according to the agreed terms of reference
 - Prepare the final report and recommendations for appropriate circulation
- Monitor the methodology and the outcome of the reviews to inform future policy
- Provide detailed guidance on the processes to be followed during the course of a review
- Please be aware that, due to duty of candour, any findings from a review that highlight areas where patients have come to harm or will potentially be harmed will be escalated immediately. There will be an expectation that the relevant regulatory body (CQC or GMC) will be informed if not by the trust then by the College.

[§] If, on arrival the reviewers believe the Terms of Reference have been altered by the referring organisation the lead reviewer is advised to contact the College before proceeding.

2.7 If, during the course of a review, the review team experiences any concerns in relation to serious and urgent aspects of patient care that are not being addressed, the College reserves the right to raise concerns directly with external regulatory agencies.

3. The Review Team and Initial Contact

3.1 Responsibility for establishing the membership and lead of the review team will reside with the Chairman of the Professional Standards Committee (PSC). The review team will usually comprise members of the PSC and the Chairman will ensure the team have the appropriate areas of expertise to address any specific concerns e.g. subspecialty interest. If any additional expertise is required, the Chairman of the PSC will seek reviewers outside of the Committee. This can include the help of allied health professionals such as ophthalmic nurses, orthoptists and optometrists, and ophthalmic administrators and managers; the presence of a multidisciplinary team is often very helpful. Any conflicts of interest will be identified prior to appointment to the review team.

3.2 The Chairman of the PSC, together with the review team leader will have responsibility for:

- Defining the process of the review
- The process of constructive informal feedback
- Report writing (normally done by the review team leader and approved by the Chairman of PSC) in accordance with College policy and format.

3.3 Training and updates for reviewers are provided as appropriate. Review team members are expected to be up to date with equality and diversity training and other mandatory training within their employing trust.

3.4 Once a review team has been identified, the names, and means of contact for the lead reviewer, along with the initial paperwork will be forwarded to the referring organisation's Medical Director or nominated deputy. The lead reviewer will act as the point of contact for queries relating to the arrangements for the review.

3.5 The trust must liaise directly with the lead reviewer and other members of the review team to make the necessary administrative arrangement for the review. This should include arrangements for accommodation, travel and subsistence. The trust should confirm directly with the lead reviewer the contact details for key personnel in the referring organisation involved in the review – usually the Medical Director and Clinical Lead for Ophthalmology.

3.6 Fees and expenses (see Annex 2 for the fee structure): In addition to the fee to the College, there will be a fee for the time spent performing the review, travel and subsistence expenses of the reviewers to be met by the trust. The reviewers' Trusts are also entitled to charge for the time the reviewers are away if they have been granted professional leave to perform the review. In these instances the reviewers themselves will not be paid.

3.7 It is the responsibility of the reviewer or the reviewers' employing Trust to invoice the referring Trust for financial reimbursement at the agreed rate once the final report has been submitted to the referring Trust.

3.8 The review lead will advise the trust contact on what data, documents and information are required in advance of any visit and how to transfer these, usually electronically. The review team may also examine publically available information about the trust and its

ophthalmic services such as publications on the trust website, the CQC website, Hospital Eye Service (HES) data and media publications where relevant.

4. Potential Review Topics

The following are topics that may require consideration during reviews depending on the circumstances of the request and the remit of the review team, but the list is not exhaustive. The review team should where possible use recognised standards (e.g. NICE guidelines, GMC standards, College guidance, national NHS performance standards, national audit results and scientific publications) for comparison or benchmark against similar units providing broadly comparable services. As with regulators such as the CQC, an element of judgement will be required by the reviewers in their assessments.

4.1 Estates and environment

- The size, suitability and state of estates and facilities in which ophthalmic services are delivered
- Patient focussed facilities e.g. availability toilets, refreshments etc.
- Theatre considerations including appropriate fittings and airflow

4.2 Equipment

- Sufficiency and appropriateness of the equipment
- Adequacy and efficiency of the equipment replacement programme, together with compliance with the programme
- Evidence of the proper equipment calibration and maintenance
- Arrangements for service development involving purchase of new equipment

4.3 Consultants: Job plans, workload and subspecialty provision

- Consultants expertise and area of practice
- Networks and arrangements for care outside of local expertise
- The nature and number of examinations or surgeries performed
- Suitability of subspecialist compared with general care
- Consultant supervision and availability for advice and opinions to others
- Workload, compared with College recommendations
- The involvement in teaching, on-call, CPD, appraisal, administration, management and other non-fixed commitments and time and resources allocated for these responsibilities
- Involvement in audit and quality improvement

4.4 Continuing Professional Development (CPD) and appraisal

- Opportunities for funded study leave
- Involvement in local education and training
- Personal development plans that are realistic and supported by management
- Regular revalidation standard appraisals

4.5 Non consultant staff

- Trainee ophthalmologists and training issues
- Non-consultant permanent medical staff
- Allied health professionals (orthoptists, optometrists, technicians, imaging)
- Secretarial staff
- Nursing staff
- Clerical and admin staff
- Management staff and management structure
- Skills mix and delegation, extended roles
- Shared care with community optometrists and clinics
- Interactions and communication between staff groups and with consultants

4.6 Management arrangements

- Local management structures
- The process of line management for dissemination of information and decision-making
- Management style and its effect of morale
- The involvement of ophthalmologists in trust management, clinical leadership and central decision-making processes and strategy
- Opportunities for management training for ophthalmologists
- Administrative support
- Relationship with commissioners

4.7 Organisational and administrative processes

- Adequacy of appointment system
- Handling and triage of referrals
- Capacity and performance
- Timeliness of new and follow up appointments
- Health records management and availability
- Management of admissions

4.8 Patient safety

- Clinical incidents and serious incidents
- Standards of care (including review of clinical notes)
- Claims
- Reporting and Learning from adverse events
- Risk assessments
- Safeguarding
- Consent
- Infection control
- Complaints

4.9 Patient experience

- The process for assessment of patient satisfaction
- Evidence from patient satisfaction surveys
- Any complaints and testimonials relating to individual ophthalmologists and the department/service, handling and learning from complaints
- Use of patient information leaflets
- Privacy, dignity and respect, compassion and caring

4.10 Clinical effectiveness

- The use of local and national guidelines
- Variation according to local practice
- The process of dissemination of information relating to protocols and policies
- Audit performance and use for improvement and to assess individual performance
- Issues with poor care outcomes
- Arrangements for involvement in clinical governance including meetings, leads etc.

4.11 Information technology

- The ability of existing information systems and hardware (administrative and clinical record and imaging systems) to facilitate safe, secure, reliable and efficient processes of care
- The ability of existing information systems to generate accurate and timely reports on performance and targets (e.g. RTT18), clinical activity, clinical outcomes (particularly in relation to nationally mandated quality standards), audit and research

4.12 Urgent care, on-call and continuity of care

- Arrangements for referring and seeing urgent cases in and out of hours
- Whether there is a robust on-call system
- Handover arrangements
- Whether the arrangements for leave, including notification and cover are clearly identified

4.13 Children's ophthalmology

- Suitable environment and toys
- Suitably trained and experienced staff
- Access to non-ophthalmic paediatric services and staff

5. Individual performance

5.1 The College will not normally accept instructions from trusts to undertake a review or an investigation of an individual ophthalmologist. If concerns have been substantiated by the organisation's own investigatory procedures and where further assessment of the ophthalmologist is required, it is recommended that the assistance of NCAS (or, where there is a potential fitness to practise issue, the GMC's Employer Liaison Adviser) is sought. However, in the course of an investigation of concerns about clinical standards or outcomes, it is possible that the review team may be presented with data which raises a concern about the performance or conduct of an individual ophthalmologist, such as:

- Clinical practice or outcomes which appear to fall outside accepted norms
 - Refusal or reluctance to acquire new skills
 - Inability to meet reasonable work requirements
-

- Poor communication with patients
- Poor communication with colleagues and staff
- Criminal activity (e.g. fraud)

5.2 The review team will bring such matters to the attention of the relevant authorities. In the first instance this would be to the Medical Director of the trust, however, the College reserves the right to inform the GMC or other relevant regulatory bodies of any conduct by individuals that is deemed to endanger patient safety.

6. Arrangements for reviews

6.1 The review process, though not formal, must observe basic rules of fairness and openness. The reviewers must approach the task with completely open minds. The reviewers must not exclude relevant evidence.

6.2 Documentation to be provided to the review team will be outlined in the terms of reference. Any information provided should not contain data which identifies individual patients unless this is unavoidable. If it is not possible to anonymise information the referring organisation should ensure that:

- Patient confidentiality is maintained and/or any necessary specific patient consent has been obtained
- Any obligations as data controller (in any applicable case) under the Data Protection Act 1998 have been taken into account

Reviewers must be up to date with information governance training.

6.3 The trust should ensure that **original** versions of documentation to be considered as part of the review are retained on its premises and not sent to reviewers or to the College in advance of the review.

6.4 The trust should ensure that as much of the documentation as possible is sent to the reviewers in advance of a visit no later than **three weeks** before the visit date. Trusts should ensure their Caldicott Guardian is aware of the review and that information shared is appropriately anonymised except where detail is pertinent. Where confidential or personal data is being sent then this should be by a secure means.

6.5 The Chief Executive or Medical Director/nominated deputy should make it clear to the reviewers whether the documentation should be returned to the trust or destroyed at the end of the review. The default position is that documents are returned to the trust.

6.6 Tour of inspection. The reviewers should receive a guided tour of the facilities and other trust areas as deemed relevant or necessary. The reviewers should be allowed where possible to examine equipment and areas. In agreement with the trust and with patient consent, reviewers may observe care and staff-patient interactions.

6.7 **Interviews:** Reviews may include interviews or informal discussions with patients, clinical user groups, staff and representative(s) of management. The reviewers and the trust will ensure as far as practical that those who will be directly involved in the review fully understand the aims and objectives of the review. Prior to interviews it should be made clear to interviewees (by the reviewers) that they are not obliged to provide information, but that, under normal circumstances, if they wish their views to be reflected in the final

report, they should be willing for those views to be attributable. Any interviewee concerned about his/her evidence being used should be given the opportunity to review the transcript of their evidence in draft form to ensure its accuracy. The reviewers may, at their discretion, agree to include evidence in the report in a form that is not attributable to an individual, though this is likely to reduce its impact. Verbatim comments will only be included where they are important and relevant to a clear understanding of the issues under review, and only where the interviewee has given permission for them to be included.

6.8 The Medical Director or nominated deputy should ensure that interviews take place in a comfortable environment. Room layouts should be such that the interviews are non-threatening to participants.

6.9 **Timetable for the review:** The majority of site visits will last for one or two days. Sufficient time will need to be factored into the timetable for review of documentation that cannot be removed from the premises or sent to reviewers in advance. The timetable should be agreed by the Trust and the review team in advance. It is the responsibility of the Trust to make the details arrangements. It is suggested the reviewers should meet the staff from the unit being reviewed at the start of the process. The meeting should ensure staff have the opportunity to present their views and discuss them with the reviewers.

6.10 **Confidentiality:** It is imperative that when confidential information is disclosed to the reviewers, that disclosure is authorised by the relevant people including the Caldicott Guardian. The reviewers will anonymise confidential information wherever possible. The Chief Executive or Medical Director must address this in advance of the review to avoid the possibility of confidential information being disclosed to the reviewers without consent.

6.11 The review team will not be able to consider documentation submitted during or after the review visit unless there are significant reasons why it could not be submitted in advance. However the review team may request documentation whilst on site.

7. The review team's recommendations

7.1 Usually 4-6 weeks after the site visit the draft text of the report will be sent to the referring organisation for factual checking. The comments will be sent to the reviewers for their consideration, The College will not normally forward reports until payment for the review has been received.

7.2 The review report will be structured broadly as per Annex 1 however the exact format details are at the discretion of the lead reviewer, dependent on the exact nature of the visit, the concerns and the findings.

7.3 The College will contact the Trust three to six months after the final report has been sent and request a progress report on the resolution of the problem and seek general feedback on the review process. It is a condition of the review that the Trust provides feedback to the College. Follow up visits may be arranged at the request of the Trust. Such visits will be subject to additional charges.

8. Quality Assurance Process

8.1 Once the factual checking has taken place by the trust, the report will be sent to a member of the Professional Standards Committee (usually the Chair unless they were part of the review team) and a member of the College's Lay Advisory Group for a quality assurance check.

8.2 The QA check considers:

- Is the report readable with a clear flow and logical order?
- Is there sufficient background to understand the context under which the review was established?
- Are the Terms of Reference easy to find and clear?
- Are the terms of reference clearly addressed?
- Does the review sufficiently identify relevant standards?
- Is the information gathered and presented clearly against the standards?
- Are there clear judgements links to standards of College positions?
- Does each judgement have evidence or triangulated information?
- Do the recommendations flow from the narrative?
- Are the recommendations cross referenced to the narrative?
- Are the recommendations achievable and realistic?
- Is the timescale for improvement clear?
- Are there any high-risk sections where opinion may be controversial?
- Anything else to add?

9. Contacting the College

9.1 All enquiries regarding invited reviews should be directed to the Professional Standards Department at the College.

Professional Support Department
The Royal College of Ophthalmologists
18 Stephenson Way
London
NW1 2HD

Telephone: 020 79350702

Email: beth.barnes@rcophth.ac.uk

Website: www.rcophth.ac.uk

Annex 1 Guidance for writing the service review report

This guidance template can be adapted for each service review report. It may not be exhaustive and not all headings will be relevant to every service review.

The Royal College of Ophthalmologists

Title

Date of review

The review team

- Name, job title, location (team leader)
- Name, job title, location
- Name, job title, location

1. Terms of reference
2. Introduction/background including brief outline of service and staff, population served, commissioners, nearby units, networks of care, trust situation (financial, CQC etc.), history of unit or trust if relevant
3. Description of the information provided to, or obtained by, the reviewers with sources
4. Details of tour of inspection and observation process
5. List of personnel interviewed and job titles (if relevant). Outline of patient or user interviews/discussions
Review findings: list topics and areas examined (see 4 above) and results and for each:
 - make sure ToR are addressed
 - ensure assessments and judgements are against identified relevant standards, College position or benchmark where possible
 - judgments should have evidence or triangulated information if possible
6. Summary of findings and judgement/assessment
7. Recommendations (should follow from narrative, cross referenced to narrative, be achievable and realistic and have a clear timescale)

(Suggested headings):

- Department and organisation structure
- Department culture and interpersonal relationships
- Subspecialisation
- Clinical governance
- On-call service
- Review of referral processes
- Skill mix, workload and workforce
- Equipment and physical facilities
- Private practice
- Miscellaneous

8. References

Document received and reviewed by College:

Document received and reviewed by referring organisation:

Date

Author(s)

Annex 2 Review Charges as of 1 April 2017**

Invited service review site visit

College administration fee of £15,000 plus V.A.T. at 20%

Document only review:

£5,000 plus V.A.T. at 20% (up to 30 sets of notes).

If the document review subsequently identifies a need for a site visit, a site visit charge will apply in addition to the document review charge.

The full fee must be received by the College prior to the report being released to the client organisation.

** Please note these charges will be reviewed annually and may be subject to change