



The ROYAL COLLEGE of
OPHTHALMOLOGISTS

Guidance Document

Preparing for Revalidation and Appraisal as an Ophthalmologist

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1 Introduction

This document aims to help ophthalmologists when selecting supporting information for appraisal and revalidation and ensure that appraisal can be carried out to a standard which meets the General Medical Council's requirements.

It is intended to be read alongside the accompanying document [Supporting information for appraisal and revalidation: guidance for ophthalmology](#) developed in collaboration with the other Medical Royal Colleges and Faculties.

2 Definition of Revalidation

The General Medical Council (GMC) defines revalidation as "...the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field and able to provide a good level of care. This means that holding a licence to practise is becoming an indicator that the doctor continues to meet the professional standards set by the GMC". The process leading to renewal your [Licence to Practise](#) is based on local evaluation of your performance through annual appraisal. You are expected to participate in annual appraisal and to maintain a portfolio (in paper or electronic form) of supporting information to bring to your appraisal as a basis for discussion. You will report to a Responsible Officer who makes a five-yearly recommendation to the GMC based on your appraisals on which the GMC will base its decision to renew your Licence to Practise.

3 The Standard for Revalidation

The "gold standard" against which the practice of all doctors is compared is the GMC's [Good Medical Practice](#).

To demonstrate your practice meets the standards of *Good Medical Practice*, you must provide items of *Supporting Information* about your practice for appraisal. For each area of practice and its accompanying supporting information, you must demonstrate you have reflected and, where necessary, taken or plan actions for improvement. You will need to demonstrate you have progressed against your previous personal development plan and generate a new plan for the next year in discussion with your appraiser.

The GMC has published guidance on [Supporting information for appraisal and revalidation](#) that all doctors are required to provide. As medical practice is very diverse, the Academy of Medical Royal Colleges, its constituent Colleges and Faculties have worked closely with the GMC to develop additional guidance to assist doctors in choosing supporting information for appraisal and revalidation which is relevant and appropriate to their scope of practice. The 2014 document: [Supporting information for appraisal and revalidation: guidance for ophthalmology](#) provides a specialty context to the GMC's generic guidance and is supported by this document which offers more detailed and regularly updated guidance.

4 Expected or optional?

Where supporting information is **expected**, and it is relevant to your scope of practice, you should provide it care unless there is a good reason why you cannot, or it can be demonstrated that alternative supporting information provides an equivalent level of assurance. In general, items of supporting information that are **expected** relate to patient safety, or have gained wide acceptance as important indicators of good clinical care.

Supporting information defined as **optional** can provide further insight into the safe and effective function of you as an individual practitioner, or of a clinical service to which you contribute.

In other aspects of ophthalmology, it is reasonable for you to exercise discretion in the choice of supporting information, providing the GMC's general expectations can be satisfied. Your Responsible Officer may sometimes require you to include specific items of supporting information.

5 Scope of Work

Scope of work includes anything that you do in your capacity as a medical practitioner. This includes not only clinical work in all the main subspecialties in which you practise but also on-call or emergency work, research, teaching, managerial and leadership commitments, medico-legal activities, locum work, private work, voluntary work and medical work outside the UK.

You are revalidated against the actual scope of your work. There is no requirement for you to demonstrate competence in areas which fall outside your scope of work. However, you are expected to demonstrate you are maintaining your professional skills, and supply supporting information for, all major aspects of your work as a doctor during the five-year cycle.

The description of your scope of work should include details of:

- Weekly timetable
- Workload including surgical numbers
- On call and other emergency commitments
- Sub-specialty interests
- The nature and frequency of surgical and other interventional procedures undertaken
- Areas of practice or skills which are used occasionally
- Private work
- Research and participation in any areas of innovative or emerging practice
- Teaching roles
- Management and leadership roles

- Locum or voluntary work
- Work undertaken outside the UK
- Any other work undertaken as a medical practitioner

Surgical numbers and occasional practice: The Royal College of Ophthalmologists makes several recommendations about the number and type of operations that ophthalmologists in training should complete to achieve the competencies required for a Certificate of Completion of Training in Ophthalmology. It does not make any recommendations about the minimum number of procedures per year that ophthalmologists who are not in training programmes should undertake to maintain their skills.

Although it is generally acknowledged that proficiency in an area of clinical practice is likely to increase with the regularity of exposure to it, it may sometimes be necessary for you to maintain a skill which will only be used occasionally e.g. an emergency. Where this is the case, you have a responsibility to weigh up the benefits and risks of continuing to practise in that area and to demonstrate you have taken reasonable steps to maintain the necessary level of knowledge and skill.

6 Supporting information

Continuing Professional Development (CPD) and Mandatory Training

It is important to include evidence of continuing professional development for revalidation. You must remain competent and up to date in all areas of your practice and your CPD activities should aim to maintain and improve the standards of your own practice and also those of any teams in which you work. You must reflect on what you have learnt through your CPD and record any impact (or expected future impact) on your performance and practice. The College strongly supports the use of the online CPD diary and the associated report function, which is easier for appraisers to assess than presenting multiple attendance certificates. The College scheme follows a 5-year cycle of CPD activity in which ophthalmologists should accumulate 250 credits at approximately 50 credits per annum spread over the following categories:

CATEGORY A: CLINICAL AND ACADEMIC: INTERNAL (Minimum 10 Points)

CATEGORY B: CLINICAL AND ACADEMIC: EXTERNAL (Minimum 20 Points)

CATEGORY C: CLINICAL AND ACADEMIC: SELF DIRECTED (Minimum 5 Points)

CATEGORY D: PROFESSIONAL & MANAGERIAL (Minimum 5 Points)

However, this is only a guide and your CPD activities should be shaped by assessments of both your professional needs and the needs of the service and the people who use it

The organisations(s) in which you work might set specific training requirements e.g. trust mandatory training such as annual fire training or infection control. These are not necessarily requirements for revalidation and may be requirements to demonstrate your continued fitness for purpose in a role, and/or staying on a Performers List. In many areas, responsible officers (ROs) have asked doctors to include additional training requirements in their portfolio of supporting information for appraisal, for convenience, and to ensure that organisational requirements are understood by every doctor. This does not automatically make them part of the GMC requirements for revalidation. However, any mandatory

training requirements which are required to ensure you are safe and up to date within your scope of practice, or for professional development, could be encompassed by revalidation.

You should ensure you are aware of any training required by the organisation in which you work, and ensure you demonstrate you are fit for purpose as well as fit to practise. However, it is important to recognise the difference between the requirements for revalidation and training requirements for other purposes, and that their appraisers and ROs do not allow the two to become confused.

Quality improvement activities

The GMC requires doctors to participate in quality improvement activities relevant to their work. Information on quality improvement activities relevant to each ophthalmic subspecialty is provided at the end of the document.

Clinical Audit and Review of Clinical Outcomes

General principles:

- Audits must be conducted with appropriate methodology and use recognised standards and benchmarks including, where available, those from NICE and the Royal College of Ophthalmologists,
- Some audits for appraisal and revalidation are simple quality assurance audits to ensure minimum standards are achieved, and some are quality improvement audits with action plans and re-audit to demonstrate improvement. It is **expected** that you participate in at least one quality improvement audit in a five-year cycle involving a review of practice and re-audit.
- Over a five-year cycle, it is **expected** you provide supporting information which is representative of your scope of clinical practice. It is not necessary to audit every aspect of your practice exhaustively, but there should be no major areas of your practice on which no supporting information is provided. Agreement should be reached with your appraiser on what it is reasonable to include or exclude. If your practice is varied, you may need to provide a wider range of supporting information than those with a limited scope of practice. If your scope of practice is largely confined to one sub-specialty you are likely to need more detailed supporting information from that sub-specialty than the minimum expected items.
- In some areas of ophthalmology (e.g. medical retina, glaucoma, neuro-ophthalmology), clinical audit is likely to be undertaken collaboratively and reflect the performance of a clinical team, rather than that of individual practitioners. It is acceptable to include this type of audit as supporting information but you should provide an explanation of your role in the team and contribution to conducting the audit and the results.
- Where several ophthalmologists in a unit are undertaking similar types of clinical practice or procedures where outcome measures can be attributed to individual ophthalmologists, it may be more efficient to review outcome measures

collaboratively as a unit, rather than requiring individuals to audit their own practice separately but results should still be presented as attributable to individual performance where possible.

- It is desirable that at least one audit in a five-year cycle should include an analysis of the quality of record keeping. However, generally an audit of record keeping should not be only form of audit provided (see <https://www.rcplondon.ac.uk/projects/outputs/generic-medical-record-keeping-standards>).
- If you need to maintain skills which you use occasionally, you should, where appropriate, include an analysis of outcomes and quality.
- What if my practice provides little scope for clinical audit?
- If your practice is limited in scope and you see relatively few patients, you may find it difficult to undertake a meaningful clinical audit cycle.

Examples include:

- Ophthalmic medical practitioners whose work consists mainly of sight testing of clients whose only problem is refractive error.
- Ophthalmologists who undertake limited volumes of private practice outside managed care environments following retirement from the NHS.
- Ophthalmologists whose work consists mainly of the writing of medico-legal reports.

In these situations, it may be reasonable, by agreement with your appraiser, to limit the scope of audit to an audit of record keeping and/or to provide case reviews (e.g. request a peer or senior colleague to assess quality of your practice from a review of a sample of records or reports) as alternative supporting information.

Significant events

It is **expected** that doctors provide supporting information for significant events which have involved them and discuss these at appraisal. A significant event is defined as “any unintended or unexpected event, which could or did lead to harm of one or more patients” and may include incidents and complaints. A summary of the event should be included, with your reflection and learning, and you may include incident root cause analysis reports, complaint letters and replies in your supporting information. It is particularly important to include any serious incidents or a “[never events](#)” e.g. “wrong site/eye surgery or implantation of an intraocular lens other than the one intended.

Events such as the certification of a patient as sight-impaired or severely sight-impaired is not necessarily an indication of any failure in care, but may provide an opportunity to look back at whether there are any opportunities to improve aspects of the service.

Other quality improvement activities

Other useful activities which can be included are attendance at and involvement in clinical governance meetings and involvement in quality and service improvement projects and you can include relevant supporting evidence such as clinical governance meeting minutes, new service guidelines or patient information leaflets you have authored etc.

Peer and patient feedback

The GMC provides [peer and patient questionnaires](#) which can be downloaded from its website, and has published [guidance for organisations](#) which wish to develop their own questionnaires for this purpose. The questionnaires should normally be administered and collated independently of the doctor about whom the feedback is provided, and the appraiser. In February 2016, the GMC launched a set of [case studies and a leaflet for patients](#), to better support doctors with collecting feedback for revalidation. It is **expected** that you undertake a formal analysed assessment of patient feedback through questionnaires once during the five-year cycle.

When seeking feedback from patients, it is necessary to consider the needs of patients with visual impairment. Reproduction of the questionnaire in a larger font on good quality paper may allow many visually impaired people to complete it without assistance, but for patients with more severe degrees of visual impairment, it may be necessary to enlist the help of an accompanying person or a member of staff such as an Eye Clinic Liaison Officer (ECLO).

The GMC also requires you to discuss complaints as a form of patient feedback at appraisal. It defines a complaint as “...a formal expression of dissatisfaction or grievance. It can be about an individual doctor, the team or about the care of patients where a doctor could be expected to have had influence or responsibility”. The purpose of discussing complaints at appraisal is not to apportion blame, but to reflect on the reasons behind the complaint and opportunities for professional development and service improvement. It is also important to discuss compliments, because they also represent patient feedback.

Many organisations have a system to obtain “360 degree” colleague feedback so that a representative sample of your multiprofessional team can provide feedback, often with a benchmark or scoring process for analysis. It is **expected** that formal colleague feedback is sought once in the five-year cycle.

Research and innovative practice

The arrangements for appraisal of doctors who hold clinical academic appointments should follow the principles set out in the [Follett Report \(2001\)](#).

In [Good Medical Practice](#), the GMC sets out the following requirements of doctors who take part in research:

- 7 You must be competent in all aspects of your work, including management, research and teaching.
- 11 You must be familiar with guidelines and developments that affect your work.
- 12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.
- 67 You must act with honesty and integrity when designing, organising or carrying out research, and follow national research governance guidelines and our guidance.

The GMC provides further guidance on the ways in which these principles can be put into effect: http://www.gmc-uk.org/guidance/ethical_guidance/5992.asp

Participation in innovative or emerging practice refers to the evaluation of new techniques, medications or technology, or the extension of existing technology to new indications. Revalidation should encourage and support your involvement in innovative practice, within an appropriate clinical governance framework. If your scope of practice includes areas of innovative or emerging practice, this should be documented in the supporting information, whether or not it is formal research.

Training and Educational Supervision

The skills required to be a competent clinical teacher and trainer must be learned and maintained through practice and appropriate continuing professional development activities. Paragraphs 39-43 of *Good Medical Practice* set out the GMC's expectations of doctors in relation to training and educational supervision http://www.gmc-uk.org/guidance/good_medical_practice/teaching_training.asp

The GMC is introducing a system for the recognition and approval of trainers <http://www.gmc-uk.org/education/10264.asp>

Postgraduate deaneries often require clinical and educational supervisors to attend specific training courses and refresher training as a condition of holding these roles.

If you are involved in training and educational supervision it is **expected** that you should include feedback on your clinical supervision and teaching from peers and from those you teach or supervise in the supporting information you provide for appraisal. This can include communications which include feedback (e.g. emails), and ideally also formal scoring assessments (e.g. from attendees of your teaching lectures) where possible.

Leadership and Management

Many doctors have informal and formal leadership and management roles and it is **expected** that they provide relevant supporting evidence. The [Faculty of Medical Leadership and Management](#) provides guidance on the principles for selecting supporting information. FMLM launched the [Leadership and management standards for medical professionals](#) in February 2015. These set out the competences and expected behaviours needed for leadership and management practice across the UK health sector.

The GMC has also issued [guidance on the professional attributes of doctors in positions of leadership](#) which covers the leadership responsibilities that all doctors carry, as well as the additional responsibilities of those who hold formal positions of leadership.

Medicolegal Practice

The sections of *Good Medical Practice* '[Record your work clearly, accurately and legibly](#)', '[Contribute to and comply with systems to protect patients](#)' and '[Openness and legal or disciplinary proceedings](#)' summarise the GMC's expectations of doctors in relation to writing reports, giving evidence and signing documents. If you undertake work as an expert witness but are not engaged in clinical practice (for instance, following retirement from clinical practice) advice is available from [Faculty of Forensic and Legal Medicine](#) regarding the necessity to maintain a Licence to Practise. This advice also deals with the issues which

should be considered if medico-legal reports are used as supporting information for appraisal.

7 Revalidation in specific employment situations

Work as a Locum

If you practice as a locum doctor in the UK, you are required to have an annual appraisal and to maintain a Licence to Practise with the GMC. Your Designated Body and Responsible Officer depends on whether you are employed directly by a health care provider or are contracted to work via a locum agency. The GMC provides guidance on making a connection with a Designated Body <http://www.gmc-uk.org/doctors/revalidation/12387.asp>.

The principles for [selecting supporting information](#) for appraisal if you are working as a locum are the same as if you are working in a substantive post.

There may be challenges in maintaining an appraisal portfolio, particularly if your work consists mainly of short term locum contracts. These difficulties should not be insurmountable. It may be possible to undertake simple prospective audit projects which can be transferred from one post to another based on groups of patients that you are likely to encounter in every post. Permission to gather data in this way should be sought at the beginning of each post, and local guidance on the handling of patient identifiable information must be followed. It should also be possible to write up case reports of patients who have presented particular diagnostic or therapeutic challenges and include these in your appraisal portfolio.

You should attempt to find out the outcome of any significant events or complaints that occur during your locum post by actively maintaining contact with the department. Leaving contact details, or take the contact details of a mentor or educational supervisor at the end of each post should improve the likelihood of receiving details of any significant events, complaints or compliments notified after the end of the post.

Your clinical supervisor or line manager (and, if possible, other members of staff who will be able to provide feedback) should be approached at the beginning of your locum attachment and asked to provide feedback using a questionnaire approved by the GMC towards the end of the post. It should also be possible to request feedback from patients during a locum post using a questionnaire approved by the GMC. Your designated body should help with administering and collating the questionnaire.

Practice Outside of the UK

The requirement for doctors to have a Licence to Practise and to revalidate applies only to practice in the UK. If you are on the GMC's medical register but do not work in the UK you can remain on the medical register and in "good standing" but should not need to maintain a Licence to Practise in order to satisfy the requirements of the regulatory authority in the country in which you work.

If you are registered with the GMC but are working entirely outside the UK and do not plan to work in the UK soon, the general advice is to relinquish your Licence to Practise. If you later return to work in the UK, the GMC will issue a Licence to Practise once the regulatory

authority in the country or countries in which you have been working since relinquishing the Licence to Practise have provided evidence that you are in good professional standing there.

Relinquishing and restoring a Licence to Practise are applications that a doctor must make to the GMC.

The GMC has published [frequently asked questions guidance on revalidation](#) for overseas regulators.

Ophthalmic Medical Practitioners

OMPs are required to maintain a Licence to Practise and to undergo revalidation. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 connect doctors on an optical performers' list (i.e. OMPs) to [NHS England](#) and the Responsible Officer will usually be based in the [Area Team](#) in the area in which the OMP practises.

Ophthalmologists in training

The progress of ophthalmologists in training against the learning outcomes and competencies of the curriculum is reviewed in detail annually during the training programme by the bodies responsible for the training rotation. This review is referred to as the Annual Review of Competence Progression (ARCP). This is used as the basis for the revalidation of doctors in training.

Designated bodies for ophthalmologists in training are the Local Education and Training Board (LETB), NHS Education for Scotland, the Wales Deanery and the Northern Ireland Medical and Dental Training Agency.

More information about the process of revalidation of doctors in training can be found on the GMC website '[Information for doctors in training](#)'

Return to Practice

If you have taken a period of significant leave from practice the factors likely to influence the speed and facility your re-entry to clinical practice include the duration of leave, age and experience, preparation for the period of leave, measures taken to maintain knowledge during the period of leave and quality of re-induction (including measures for supervision).

The Royal College of Ophthalmologists endorses the principles contained the Academy of Medical Royal College's [Return to Practice](#) document. The guidance suggests that a career break of longer than three months is likely to require some formal planning for re-entry to clinical practice. Although this is an arbitrary figure, the College's experience suggests that this is probably correct for ophthalmology. There is also anecdotal information to suggest that skills in intraocular surgery are particularly vulnerable to attrition with disuse, and that it may become increasingly difficult to resume intraocular surgery with advancing age following a break from practice. Re-entry to this area of practice is therefore likely to require particularly careful planning.

8 Gathering data for supporting information for appraisal

At first sight, the task of gathering data for supporting information may seem intimidating, but there are several ways to ensure that it is a manageable task.

Collect information as you go along. Wherever possible, remember to collect and keep (on paper or electronically) any potential evidence as you go along rather than trying to collect everything at the end of each appraisal year.

Make a five-year plan: Revalidation is a five-year process, not a fifth-year process. Plan your data collection across the whole of the cycle. Some items of supporting information, having been provided once, only need to be updated if something changes (e.g. scope of work). Some items are best recorded and reflected on as they occur, then summarised in preparation for each annual appraisal (e.g. CPD, complaints, accolades). Clinical audit and clinical outcomes data may either be collected continuously or as part of discrete projects, depending on the subject. By making a five-year plan, it should be possible to divide the work reasonably evenly across the five-year revalidation cycle.

Collect clinical audit and clinical outcomes data prospectively wherever possible: It is generally more efficient and effective to collect clinical audit data prospectively. Retrospective data collection is often time-consuming and frustrating because care records are not usually structured with the needs of audit in mind, and the quality of data may be seriously compromised by missing data items or unavailability of records.

Embed the collection of data into the routine activity of the department or practice: Where particular items of supporting information will be required for appraisal on a recurrent basis, it should be possible to plan for the necessary data to be collated and reviewed as part of the routine work of the department or practice, preferably within the structure of a formal clinical audit and governance programme where patient safety incidents, near-misses, complaints and clinical audit findings are discussed and recorded in the minutes, with regular review of action points.

Share the work of gathering supporting information for appraisal with colleagues where appropriate: Where several doctors in a department undertake similar procedures, it may be more efficient for one individual to collate and review clinical outcome data on behalf of the group.

It is a common misconception that only supporting information which is attributable to the individual doctor can be used for that doctor's appraisal. Most doctors work in clinical teams where other doctors and other health care professionals share responsibility for clinical outcomes. In some sub-specialties, there are few clinical outcome measures which can currently be used to compare the performance of individual doctors. It is permissible to use clinical audit or clinical outcomes data which reflects the performance of a team or a clinical service as supporting information for appraisal, though it should be accompanied by an explanation of the ophthalmologist's role in the team. It is also important that team-based clinical audit is structured in a way that any unacceptable variations in practice within the team are likely to be detected and acted upon, should they exist.

The purpose of audit (individual or team-based) is not to show the doctor or team in the best possible light, but rather to ensure an acceptable level of quality and safety, and to identify areas for improvement and take action for improvements. By acting as an advocate for patient safety and high-quality care, you are demonstrating attributes of Good Medical Practice.

Make use of information technology where possible: Electronic medical records should include reporting functions that can be configured to meet the needs of departments and individual ophthalmologists. The [National Ophthalmology Database Audit](#) is under development and will provide a mechanism for comparing outcomes of cataract surgery and several other procedures with those of a large group of peers. However, items of supporting information for the ophthalmic subspecialties which are designated as **expected** have been chosen so that ophthalmologists who do not have access to electronic medical records can collate them manually.

Use your organisation. It is expected that your employing organisations should help provide clinical governance information to assist you in preparing for appraisal such as data on activity and outcomes, the outcome of investigations of significant incidents, complaints and compliments.

Make use of external resources: There is already a great deal of information in the public domain which can help ophthalmologists evaluate their own practice and provide supporting information for appraisal.

9 Quality improvement in the ophthalmology subspecialties

Cataract Surgery

Surgeons in training are also expected to complete a minimum of 50 cataract operations per year from the third year of training onwards and there is evidence that this frequency of exposure to surgery is important to acquire the necessary skills. Whether a similar minimum frequency of exposure is necessary for cataract surgeons to maintain their skills after completion of training is less clear, but there is evidence that surgical complication rates tend to be lower in surgeons who undertake larger numbers of cataract operations.

If you undertake cataract surgery in the UK it is **expected** that you will provide the following information for appraisal:

- Once in each five-year revalidation cycle: a detailed audit of at least 50 consecutive cataract operations where you are the primary surgeon, to include preoperative and postoperative visual acuities, rates of good postoperative visual acuity, actual refractive outcome vs intended refractive outcome, intraoperative complications including posterior capsular rupture rate, with a reasonable degree of completeness of data and assessment against recognised benchmarks.
- In audit of cataract surgery, an explanation should be sought for situations where the final best-corrected postoperative visual acuity is worse than the preoperative visual acuity.
- An annually-updated record of the total number of cataract operations you have performed in the revalidation cycle including a record of all cases which were complicated by posterior capsule rupture, endophthalmitis, or other operative or postoperative complications which resulted in additional interventions or a poor visual outcome.

- Surgeons working in units which submit returns to the National Ophthalmology Audit should include outcome data from the audit.
- If you regularly use multifocal or toric lenses, outcomes should be audited on these patient groups assessing refractive outcomes, unplanned return to theatre and lens adjustments or exchanges and rates of post-op optical symptoms such as dysphotopsias, glare and halos.

You may also wish to consider the following **optional** topics for audit:

- Perceptions by patients and carers of the quality of care provided by the service
- Patient reported outcomes measures (PROMs)
- Accuracy of biometry
- The development of optically significant posterior capsule opacification
- Correct use of the [WHO checklist](#) (Note: The College has developed a modified ophthalmic version of the WHO “Safer Surgery” [checklist](#)).

The items of information expected for appraisal should be achievable even if you are entirely reliant on paper records and manual data collection methods. If you have access to an electronic clinical record system for cataract care you will usually be able to provide more extensive and detailed supporting information.

Ophthalmologists may wish to include case reviews of individual complex patients as supporting information for appraisal.

Significant events in cataract care

- “Wrong site” (e.g. wrong eye) or wrong patient surgery or implantation of an intraocular lens other than the one intended i.e. “**never events**”
- Other significant adverse events related to cataract surgery should be included, particularly if action was, or may be required to prevent a recurrence – for example, if a patient was cancelled or a complication occurred because of a significant omission in the preoperative assessment process.

Resources:

[RCOphth Quality Standards for Cataract Services](#)

[National Ophthalmology Database Audit](#)

[RCOphth Cataract Surgery Guidelines](#)

Glaucoma

If you perform glaucoma surgery procedures, it is **expected** that you participate in audit of your procedures including outcomes, each main procedure to be audited at least once in the five-year cycle. Important outcome measures in glaucoma surgery are:

- Achievement of a sustained reduction in intraocular pressure and a reduced need for anti-glaucoma medications

- Stabilisation of visual field loss
- Occurrence of early complications (eg persistent hypotony, aqueous misdirection, visual field “wipe-out”, endophthalmitis, choroidal haemorrhage, or the need for additional surgeries)
- Occurrence of late complications (eg failure of the drainage site requiring further surgery, bleb infection)

Collecting one year trabeculectomy data will allow evaluation of outcomes at year one, three and five etc. so that one year of data can be used in an ongoing process.

A different approach is required when choosing supporting information for non-surgical aspects of glaucoma care. The initial diagnosis of glaucoma and subsequent monitoring of a patient usually involves many health care professionals over a long period and it is likely to be difficult to separate your contribution from that of others in a systematic way. Audit in this area is therefore likely to relate to a team rather than to an individual doctor.

If you provide care for patients with glaucoma it is **expected** that you audit in the five-year cycle:

- Compliance with the NICE quality standards for glaucoma

You may also wish to consider the following **optional** topics for audit:

- Compliance with The Royal College of Ophthalmologists Quality Standards for Glaucoma Services
- Perceptions by patients and carers of the quality of care provided by the glaucoma service including communication and education in eye-drop instillation technique.
- Quality of record keeping in the glaucoma service

Ophthalmologists may wish to include case reviews of individual complex patients as supporting information for appraisal.

Significant events in glaucoma care include:

- Occurrence of significant delays in follow up appointments leading to avoidable deterioration in vision
- Registration of a patient as sight impaired or severely sight impaired due to glaucoma. This does not necessarily imply any shortcomings in standards of care, but it provides an opportunity to review the factors which led to that degree of visual disability to see if any lessons could be learned.
- Severe adverse reaction to glaucoma medication (e.g. asthma or heart failure precipitated by beta blocker eye drops)
- Severe visual loss following glaucoma surgery
- Bacterial endophthalmitis after drainage surgery especially a cluster of cases

Resources

[RCOphth glaucoma quality standard](#)

[NICE glaucoma quality standard](#)

Kirwan JF, Lockwood AJ, Shah P, MacLeod A, Broadway DC, King AJ, McNaught AI, Agrawal P, Trabeculectomy Outcomes Group Audit Study Group, *Trabeculectomy in the 21st century: am multicentre analysis*, *Ophthalmology*. 2013 Dec;120(12): 2532-9.

<https://www.ncbi.nlm.nih.gov/pubmed/24070811>

Medical Retina

If you perform intravitreal injections or laser treatment for medical retina conditions, it is **expected** that you audit the procedures you have undertaken once in the five-year cycle including:

- Appropriateness of treatment selection on clinical diagnosis and criteria
- Timeliness of initial assessment, treatment, further assessments and retreatments
- Effect of treatment (visual acuity and central macular thickness outcomes)
- Adverse events (e.g. endophthalmitis following intravitreal injection, macular burns after laser treatment).

If you provide care for patients with medical retinal disorders, you may also wish to consider the following **optional** topics for audit:

- Perceptions by patients and carers of the quality of care provided by the service
- Perceptions by patients and carers of the quality of care provided by the diabetic retinopathy treatment service
- Compliance with the standards of national screening programme for diabetic retinopathy
- Compliance with Royal College of Ophthalmologists quality standards for medical retina disease services and Quality Standards for diabetic retinopathy services
- Results of performance in the diabetic retinopathy grading test sets (for ophthalmologists who grade retinal screening images)
- Outcome of the most recent External Quality Assurance visit by the national diabetic screening programmes and progress against any action points identified.
- Local audits of quality of clinical record keeping

Ophthalmologists may wish to include case reviews of individual complex patients as supporting information for appraisal.

Significant events in Medical Retina Treatment include

- “Wrong eye” or “Wrong patient” and wrong drug events (**never events**) involving intravitreal injections or lasers
- Post intravitreal injection bacterial endophthalmitis especially a cluster of cases.
- Occurrence of significant delays in assessment, treatment or follow up appointments leading to avoidable deterioration in vision
- The occurrence of a foveal burn during laser photocoagulation .

Resources:

[RCOphth quality standards for diabetic retinopathy services](#)

[RCOphth quality standard on AMD services](#)

[RCOphth Age-related Macular Degeneration treatment guideline 2009](#)

[Diabetic retinopathy screening, preferred practice 2010](#)

[RCOphth Guideline for Diabetic Retinopathy 2005](#)

[Managing an outbreak of postoperative endophthalmitis](#)

NICE guidance related to Macular Degeneration

Vitreoretinal surgery

If you undertake vitreoretinal surgery it is **expected** that you audit your surgery including outcomes. The College's Informatics and Audit Sub-committee and the [British and Eire Association of Vitreoretinal Surgeons](#) (BEAVRS) have developed data sets for audit of the following commonly performed procedures and recommend their use for this purpose:

- [retinal detachment data set](#)
- [macular hole surgery data set](#)

If you undertake primary retinal detachment surgery there is a requirement you undertake an audit of a consecutive series of 50 primary retinal detachment procedures, once in each five-year revalidation cycle. Important outcomes are:

- Retinal reattachment rates
- Reoperation rates
- Visual outcomes
- Complications of surgery

It is recommended that you perform continuous audit of results of your retinal detachment surgery and can present data at annual appraisal.

If you undertake macular hole surgery, it is expected that you undertake an audit of procedures once in each five-year cycle. Important outcomes are:

- Closure rates for primary macular hole
- Complications of surgery
- Reoperation rates

You may also want to consider the following **optional** topics for audit:

- Compliance with the RCOphth Quality Standard for VR surgery
- Perceptions by patients and carers of the quality of care provided by the vitreoretinal service
- Timeliness of primary surgery for retinal detachment
- Outcomes of macular hole and epiretinal membrane surgery

- Outcomes of vitreoretinal surgery for diabetic retinopathy (stabilisation of retinopathy, visual function)
- Patient reported outcome measures (PROMs) following primary retinal detachment surgery or for macular hole and epiretinal membrane surgery

Ophthalmologists may wish to include case reviews of individual complex patients as supporting information for appraisal.

Significant events in vitreoretinal surgery are:

- Significant events relating to the operation of the service such as significant delays in treatment which may have affected visual outcome adversely.
- Infective endophthalmitis especially if a cluster of cases
- “Wrong site” (eg wrong eye) or wrong patient surgery is a **“never event”**

Resources:

[RCOphth Clinical Data Sets](#)

[RCOphth guidance: Management of acute retinal detachment 2010](#)

[RCOphth VR quality standard](#)

[British and Eire Association of Vitreoretinal Surgeons http://beavrs.org/](http://beavrs.org/)

Corneal and external eye disease

If you perform corneal transplantation procedures using human donor material it is **expected** that you participate in the ongoing national audit of corneal transplantation outcomes run by NHS Blood and Transplant, and will make reasonable efforts to ensure that data returns to NHSBT are timely and complete. This data, or equivalent locally collected data, should be provided as supporting information. Important outcomes are:

- Graft survival/failure
- Rejection
- Complications
- Visual outcomes
- Refractive outcomes

You may also want to consider the following **optional** topics for audit:

- Compliance with the RCOphth Quality Standards for cornea services
- Perceptions by patients and carers of the quality of care provided by the corneal/external eye disease service
- Outcomes of management of sight-threatening corneal infections
- Outcomes of management of ocular surface disease or scleritis requiring systemic immunosuppression or new topical/systemic technologies
- Progress of patients presenting with episodes of graft rejection.

Ophthalmologists may wish to include case reviews of individual complex patients as supporting information for appraisal.

An example of a patient reported outcome measure which is used in some units is the [Ocular Surface Disease Index](#) provided to patients on long term immunosuppressive treatment or novel topical technologies for dry eye disease.

Significant events in corneal and external eye disease include

- Delay in provision of an appointment or delay in treatment which resulted in irreversible deterioration in vision (for instance, a delay in treatment for a graft rejection episode resulting in irreversible graft failure)
- Certification of a patient as sight impaired or severely sight impaired due to corneal or external eye disease. This does not assume any shortcomings in the standards of care, but may provide opportunities to review the factors which led to this degree of visual impairment to see if any lessons could be learned.
- Unplanned return to theatre following corneal surgery
- Any suspected occurrence of transmission of infection or prion disease from donor to recipient or any lapse of protocol which could have increased the risk of transmission.

“Wrong site” (eg wrong eye) and wrong patient is a “[never event](#)” and must always be reported and investigated fully using root case analysis techniques.

Strict protocols for selection of donors, retrieval of eyes, screening of donor eyes for infection and the storage of ocular tissue in preparation for transplantation minimise the likelihood of transmission of infection or prion disease to recipients of ocular tissue transplants. Although extremely unlikely to occur, any suspected occurrence of transmission of infection or prion disease from donor to recipient or any lapse of protocol which could have increased the risk of transmission must be reported via the appropriate channels.

Significant events relating to misdiagnosis or delayed follow up of a patient with inflammatory or ocular surface disease should be reported via local reporting mechanisms and discussed at appraisal.

Ophthalmologists with an interest in medical cornea frequently prescribe unlicensed medications (e.g. serum eye drops) or licensed medications outside the terms of their product licenses (e.g. immunosuppression, biologics). Suspected adverse reactions should be reported using the [Medicines and Healthcare products Regulatory Agency’s reporting system](#).

Serious corneal infections caused by or associated with contact lens wear (Class ii medical devices) should be reported using the [Medicines and Healthcare products Regulatory Agency’s reporting system](#).

Resources:

[Ocular Tissue Advisory Group website](#)
[Standards for the retrieval of ocular tissue used in transplantation, research and training](#)
[NHS Blood and Transplant Ocular Advisory Group](#)

Refractive surgery

It is **expected** that ophthalmologists who perform refractive surgery participate in audits of their procedures using the refractive surgery dataset outcomes. Important outcomes include:

- Uncorrected visual acuity results
- Loss of best corrected visual acuity
- Complications
- Refractive outcomes

Many refractive surgeons already collect comprehensive outcome data, but audits should as a minimum include the outcomes specified by George Waring et. al. in "[Standardized graphs and terms for refractive surgery results](#)" (Journal of Refractive Surgery, 27:7-9, 2011). Alternative data sets which meet or exceed this minimum requirement are also acceptable as supporting information for appraisal.

Ophthalmologists who undertake refractive surgery may also consider the following **optional** topics for audit:

- Adherence to the RCOphth professional standards for refractive surgery
- Perceptions by patients of the quality of care provided by the refractive surgery service
- Retreatment or treatment enhancement following refractive surgery
- Complication rates

Ophthalmologists may wish to include case reviews of individual complex patients as supporting information for appraisal.

Significant events in refractive surgery include

"Wrong site" (e.g. wrong eye) or wrong patient i.e. a "[never event](#)"

Serious malfunctions of laser or refractive surgery equipment leading to harm to patients (note these need to be reported to the Medical Devices section of the [Medicines and Healthcare products Regulatory Authority](#) if they occur).

Serious incidents such as the incorrect entry of treatment parameters leading to a laser correction other than the one intended.

Resources

[RCOphth Professional Standards for Refractive Surgery](#)

[RCOphth Certificate in Laser and Refractive Surgery](#)

Paediatric ophthalmology

Paediatric ophthalmology is unique amongst the sub-specialties of ophthalmology in that its boundaries are defined primarily by the age of the patient rather than by groups of clinical conditions that it treats.

- It is **expected** that if you perform examinations or treatments for ROP you undertake an audit on the **timeliness** and outcomes of examinations/treatment of premature neonates for retinopathy of prematurity once in the five-year cycle
- If you undertake strabismus surgery in children, it is **expected** that you undertake an audit of this surgery once in the five-year cycle to include serious complication rates and rates of reoperation as a minimum.
- If you undertake cataract surgery in children it is **expected** that you audit this once in the five-year cycle to examine similar outcomes to adult cataract surgery. However, note the surgery and its results are more complex in the growing eye
- If you undertake lacrimal probing it is **expected** that you audit success and the rate of reoperations

Other potential topics for audit:

- Audit of compliance for the College [Quality Standards & Quality Indicators for Ophthalmic Care and Services for Children and Young People](#)
- Perceptions by patients and parents of the quality of ophthalmic care provided for children and their families
- The provision of care for children and young people with visual impairment
- PROMs for strabismus surgery in children and young people
- Outcomes for the treatment of amblyopia
- The provision of care and CVI registration for children and young people with visual impairment

Paediatric ophthalmologists who participate in the multidisciplinary care of children with multi-system disorders may wish to include case discussions in the supporting information.

Significant events in paediatric ophthalmology include

- Events such as significant delays which may have affected visual outcome adversely e.g. delayed referral, screening or follow up for amblyopia
- Visual loss from aggressive retinopathy of prematurity
- Failure to detect serious pathology in child vision screening programmes.
- “Wrong site” (e.g. wrong eye, wrong muscle, wrong procedure) or wrong patient surgery

Strabismus Surgery

It is **expected** that ophthalmologists who perform surgery for strabismus participate in audit of the outcomes of their surgery. However, there is not yet widespread agreement amongst strabismus surgeons on a standard definition for successful outcomes of strabismus surgery. As a minimum, a comparison of preop and postop deviation measurements, rates of reoperation and serious complications should be included.

It is **expected** that ophthalmologists who perform botulinum toxin injections for strabismus participate in audit of the outcomes of their treatment. As a minimum a comparison of

preop and postop deviation measurements, rates of reoperation and serious complications should be included

Ophthalmologists whose practice includes paediatric ophthalmology and strabismus surgery may also wish to consider the following **optional** topics for audit:

- PROMs for strabismus surgery
- Satisfaction/subjective assessment of good outcome rates for clinicians and patients/parents on results of strabismus surgery
- Perceptions by patients and parents of the quality of ophthalmic care provided

Ophthalmologists may wish to include case reviews of individual complex patients as supporting information for appraisal.

Significant events in the care of strabismus include

- Significant events relating to the operation of the service such as significant delays in treatment which may have affected visual outcome adversely.
- Serious complications of strabismus surgery such as visual loss or a “lost” muscle.
- “Wrong site” (e.g. wrong eye, wrong muscle, wrong procedure) or wrong patient surgery

Resources:

[RCOphth quality standard on services for children and young people Guidelines for the Management of Strabismus in Childhood 2012](#)

Oculoplastics, Lacrimal and Orbital Surgery

(unless their practice is confined to minor procedures such as removal of simple benign eyelid lesions)

It is **expected** that ophthalmologists who undertake major surgery in this sub-specialty should participate in audit of oculoplastic, lacrimal and orbital surgical procedures they have performed, assessing as a minimum complication rates, unplanned reoperation rates and some assessment of patient or clinician perception of success. The following areas should be audited once every five-years for those who perform this surgery:

- Outcomes of ptosis surgery
- Outcomes of surgery for entropion and ectropion
- Outcomes of surgery for dacryocystorhinostomy

Optional topics for audit:

- Completeness of excision and recurrence or metastasis following removal of periocular tumours
- Compliance with the RCOphth quality standard for adnexal services
- Outcomes of treatment of thyroid eye disease
- PROMs

- Visual function following orbital surgery
- Anatomical and functional outcomes of orbital decompression
- Patient perceptions of the quality of care provided by the orbital service

In terms of success, it is difficult to translate what constitutes an “excellent”, “good”, “fair” or “poor” outcome of many aspects of oculoplastic and lacrimal surgery into objective measurements because the appearance of the periorcular tissues varies widely from one individual to another and changes with natural ageing processes. However, from the patient’s perspective, important considerations include sustained relief of symptoms, comfort, symmetry, eyelid position and contour and scarring.

From the surgeon’s perspective, outcome measures will include “anatomical success” (i.e. intended change in measurement parameters versus actual change), occurrence of complications and recurrence. Incidence of recurrence following excision of periorcular tumours and improvement in visual field following correction of ptosis or brow ptosis are examples of objective measures that could be used as quality indicators.

Ophthalmologists may wish to include case reviews of individual complex patients as supporting information for appraisal.

Significant events in oculoplastic and lacrimal surgery

- Significant events relating to the operation of the service such as misdiagnosis or delayed follow up of a patient with a malignant periorcular tumour.
- Serious complications of oculoplastic and lacrimal surgery such as visual loss, major haemorrhage, CSF leak or serious infection.
- “Wrong site” (eg wrong side, wrong procedure) or wrong patient surgery
- Significant events relating to the operation of the service such as misdiagnosis or delayed treatment

Resources:

[British Oculoplastic Surgery Society \(BOPSS\)](#)
[RCOphth Quality Standard for Adnexal Services](#)

Uveitis

There are no **expected** items of supporting information in this sub-specialty now. Please refer to general principles for audit and clinical outcomes.

Optional topics for audit:

- Perceptions by patients and carers of the quality of care provided by the uveitis service
- PROMs
- Outcomes of treatment of sight-threatening ocular infections
- Outcomes of treatment of uveitis requiring systemic immunosuppression

- Adherence to monitoring requirements for systemic immunosuppression

Supporting information in this area of practice is likely to reflect the performance of the team or the service rather than the performance of an individual.

Ophthalmologists may wish to include case reviews of individual complex patients with uveitis as supporting information for appraisal.

Significant events in uveitis include

- Significant events relating to the operation of the service such as misdiagnosis or delayed follow up of a patient with uveitis
- Significant complications of treatment, or severe visual loss due to uveitis. These occurrences do not necessarily imply any failing in the standard of care, but can help to inform future treatment.

Neuro-ophthalmology

It is **expected** that ophthalmologists who undertake optic nerve sheath fenestration or surgery for nystagmus audit the outcomes of these procedures once in the five-year cycle.

There are no **expected** items of supporting information in this sub-specialty now. Please refer to general principles for audit and clinical outcomes.

Optional topics for audit:

- Perceptions by patients and carers of the quality of care provided by the neuro-ophthalmology service
- Management of giant cell arteritis
- Management of optic neuritis
- Access times to neuroimaging
- Retrospective review of the accuracy of imaging diagnosis

A significant proportion of patients in neuro-ophthalmological practice will require multi-disciplinary input to their diagnosis and management. Supporting information in this area of practice may therefore reflect the performance of the team or the service rather than the performance of an individual.

Ophthalmologists may wish to include case reviews of individual complex patients as supporting information for appraisal.

Significant events in neuro-ophthalmology include

- Significant events relating to the operation of the service such as misdiagnosis or delayed follow up of a patient with a neuro-ophthalmological disorder
- Significant complications of treatment
- Severe visual loss due to a neuro-ophthalmological disorder (for instance a late presentation of giant cell arteritis leading to bilateral blindness). These occurrences do not necessarily imply any failing in the standard of care, but can help to inform future treatment

- “Wrong site” (e.g. wrong side, wrong procedure) or wrong patient surgery

Ocular oncology

This is a highly-specialised area of practice, available in a limited number of centres in the UK. Ocular oncologists typically work in close liaison with other cancer specialists in multidisciplinary teams. There are currently no **expected** items of supporting information in this sub-specialty. Please refer to general principles for audit and clinical outcomes.

Optional topics for audit:

- Perceptions by patients and carers of the quality of care provided by the ocular oncology service

The multidisciplinary nature of ocular oncology means that supporting information for appraisal is likely to reflect the performance of the team as whole rather than individual performance. Nationally funded specialist services such as ocular oncology are required to provide regular detailed reports to the NHS on their activity, outcomes and patient feedback as a condition of continued funding, and it is ocular oncologists should draw on this data as supporting information for appraisal.

Significant events in ocular oncology include

- Significant events relating to the operation of the service such as loss to follow up or delayed follow up of a patient with an ocular tumour should be reported via local reporting mechanisms.
- “Wrong site” (eg wrong side, wrong procedure) or wrong patient
- Other serious events such as radiation under-treatment or over-treatment due to miscalculation of dose, or malfunction of equipment leading to harm of a patient

Resources:

[RCOphth Referral guidelines for adult patients with ocular tumours](#)

Primary care ophthalmology

This sub-specialty provides first-contact care for patients with eye problems in a variety of settings including community optometric practice (usually by Ophthalmic Medical Practitioners), general practice (usually by general practitioners with a specialist interest in ophthalmology) and hospitals. GPs with a special interest in ophthalmology should consult specialty guidance on revalidation provided by the Royal College of General Practitioners.

There are currently no **expected** items of supporting information in this sub-specialty. Please refer to general principles for audit and clinical outcomes.

Optional topics for audit:

- Perceptions by patients and carers of the quality of care provided by the primary care ophthalmology service
- Outcomes of referrals to the hospital eye service or sub-specialty services
- Record keeping audits
- Patterns of referral or outcomes of treatment.

Ophthalmologists may wish to include case reviews of individual complex patients as supporting information for appraisal.

Significant events in primary care ophthalmology include

Significant events relating to the operation of the service such as missed diagnosis or delayed treatment of a sight-threatening disorder

Resources:

[Primary Care Ophthalmology](#)

Emergency/Urgent eye care

For more than a decade there has been an increasing demand for urgent and emergency care in the UK, including ophthalmic care. Despite recent attempts to move towards a more community based ophthalmic care model, most hospital eye units will see and treat many urgent cases.

It is **expected** that ophthalmologists who contribute to emergency/urgent eye care will audit the one of the following at least once in the five-year cycle:

- Rate of patients who left the department before being seen for treatment
- Re-attendance rate
- Time to initial assessment
- Time to treatment
- Total time in A&E
- Measures of patient satisfaction (e.g. friends and family test)

Optional topics for audit:

- % of patients who should be discharged at first visit who were discharged at first visit
- % of patients diagnosed and managed accurately (consultant retrospective case note audit)

Ophthalmologists may wish to include case reviews of individual complex patients as supporting information for appraisal.

Significant events in ocular oncology include

Visual electrophysiology

Electrophysiological testing is usually conducted by clinical scientists (eg neurophysiologists, medical physicists or optometrists) and the role of the ophthalmologist is usually to report the tests and provide clinical input to the care of the patient.

The [International Society for Clinical Electrophysiology of Vision](#) (ISCEV) sets and regularly reviews standards for the recording of all the common electrophysiological tests and these should be the benchmark for all visual electrophysiology services. It is expected that this is audited once in the five-year cycle for the service and included in supporting information.

Optional topics for audit:

- Perceptions by patients and carers of the care provided by the service
- Perceptions by referring clinicians of the efficiency and effectiveness of the service
- External audit of the calibration of equipment.

Electrophysiological responses can be affected greatly by factors such as stimulus parameters, electrode placement, suppression of sources of electrical interference, calibration of equipment, pupil diameter and the state of light or dark adaptation of the patient, so it is critical that these variables are controlled as much as possible.

Ophthalmologists may wish to include case reviews of individual complex patients as supporting information for appraisal.

Significant Events in visual electrophysiology include

- Significant events relating to the operation of the service such as misdiagnosis or delayed follow-up.
- Electrophysiological tests are non-invasive, but it is possible that a flicker stimulus could provoke photogenic epilepsy in a susceptible individual.

Resources:

The International Society for Clinical Electrophysiology of Vision (www.iscev.org)

The British Society for Clinical Electrophysiology of Vision (www.briscev.org.uk)

Ocular genetics

There are currently no **expected** items of supporting information in this sub-specialty.. Please refer to general principles for audit and clinical outcomes.

Ophthalmologists who participate in an ocular genetics service may also consider the following **optional** topics for audit:

- Perceptions by patients and carers of the quality of care and advice provided by the ocular genetics service
- Perceptions by referring clinicians of the efficiency and effectiveness of the ocular genetics service

Ophthalmologists may wish to include case reviews of individual complex patients as supporting information for appraisal.

Significant events in ocular genetics include

Significant events relating to the operation of an ocular genetics service might include inadvertent breaches of confidentiality, or the delivery of information that later proves to be incorrect.

Resources:

RCOphth Genetic testing and counselling in inherited eye disease (2011) (RCOphth Membership login required)

10 Examples

The following examples show the types of supporting information that ophthalmologists with different types of practice are likely to require to prepare for revalidation. The examples are illustrative, not prescriptive.

Case 1: A full time NHS consultant ophthalmologist in a district general hospital

An ophthalmologist holds a full-time NHS consultant post in a district general hospital which has eight consultant ophthalmologists. She also has consulting privileges at a local private hospital where she spends half a day per week. She trained as a general ophthalmologist but has a special interest in glaucoma. Her job plan consists of two glaucoma clinics per week, two general clinics per week, two operating lists per week one session where she reviews patient data from a network of community-based glaucoma clinics run by optometrists. Her scope of practice is similar in both places of work. She participates in a 1:8 on call rota. She is the clinical lead for glaucoma for the department. Her surgical practice includes about 300 cataract operations, 50 glaucoma drainage procedures, 10 squints, 30 cyclodiode laser treatments and a small number of minor oculoplastic procedures per year. She occasionally performs repairs of penetrating injuries and diagnostic vitreous taps when on call. She is a clinical supervisor to two specialist registrars. The unit does not have an electronic medical record, but it maintains a local register of patients with glaucoma and ocular hypertension. Her Responsible Officer is the trust's medical director.

Supporting information:

- *Personal details:* record once and update when necessary *Scope of work:* review annually and update if necessary. *Appraisal record and PDP:* review in preparation for appraisal
- *Probity and Health:* review statements annually and update when necessary
- *CPD:* Enter details of activities and reflective review into College electronic CPD database as they occur.
- *Audit / clinical outcomes:*

- Audit of cataract surgery complications: (updated by departmental cataract lead for all surgeons annually)
- Audit of 50 consecutive cataracts (personal, once in five years) Audit of trabeculectomy (continuous, entered into National Ophthalmology Audit, benchmarked against peers nationally) Audit of glaucoma service against NICE quality standards (once in five years, with assistance from registrar and trust clinical governance department)
- Audit of squint surgery (once every two years, collated by paediatric ophthalmology lead on behalf of all surgeons)
- Review of occasionally performed procedures: (Personal reflective review, every two years).
- *Significant events* (Personal reflective review, supplemented by departmental clinical governance minutes and action plan)
- *Peer review*: (Every five years. Trust-based electronic survey tool)
- *Patient feedback*: (Formal survey every five years, Trust-based paper survey tool)

Case 2: Full time Ophthalmic Medical Practitioner

An ophthalmologist works full time as an Ophthalmic Medical Practitioner. He is the senior managing partner in an optometric practice with two optometrists as the other partners in the business. They own two high street optometric premises in two towns in the same area and employ a dispensing optician and two receptionists. The ophthalmologist and his partners are on the central optical performers' list for NHS sight testing. The Area Team for NHS England conducts a rigorous review of the practice every two years, which includes financial audit, review of complaints, review of clinical record keeping and an inspection of the premises. The ophthalmologist conducts about 3000 NHS sight tests per year, of which about 200 result in referrals to the hospital eye service. He also conducts about 100 private sight tests per year. He enjoys good relations with consultants in the local hospital eye department, but he receives feedback on his referrals in the form of copies of letters to the GP in only about 30% of cases. He updates his clinical knowledge mainly via electronic learning resources and local update events organised by the Local Optical Committee and the local hospital. His Responsible Officer is the medical director of the Area Team for NHS England which covers his part of the country.

Supporting information:

- *Personal details*: record once and update when necessary
- *Scope of work*: review annually and update if necessary.
- *Appraisal record and PDP*: review in preparation for appraisal
- *Probity and Health*: review statements annually and update when necessary
- Summary of financial audit (every two years)
- *CPD*: Enter details of activities and reflective review into College electronic CPD database as they occur.
- *Audit / clinical outcomes*:
 - Audit of the quality of clinical records (practice-wide, every 2 years – already required by the Area Team of NHS England)
 - Audit of feedback received on referrals to the hospital eye service (reviewed with partners, updated annually)

- *Significant events:* Practice log of complaints and incidents (reviewed at quarterly practice meetings with action plans)
- *Peer review:* Every five years. Email survey tool. (Feedback requested from partners, reception staff, consultants in local hospital and local GP)
- *Patient feedback:* Clients are routinely asked to complete a feedback card at the end of appointments. Feedback reviewed at 3 monthly practice meetings. However, the routine feedback form does not meet the GMC standards for patient feedback tools, so once every five-years, a more detailed survey is conducted of 50 consecutive patients seeing the ophthalmologist, using an approved survey instrument.