The ROYAL COLLEGE of OPHTHALMOLOGISTS

Process Guide

External Review of Ophthalmology Services

October 2017

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1. Introduction

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

1.2 This document defines the indications and the operational and governance processes for Royal College of Ophthalmologists (College) led service reviews, and should be used by ophthalmologists, trusts and healthcare provider organisation as a guide to the services the College is able to provide.

1.3 The College 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 where the terms of their contracts allow for this.

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'. The College agrees with the Academy that the primary aim of external reviews is to ensure patient safety and improve patient care.

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 organisations than by the College before an approach to the College is made:

The Care Quality Commission (CQC) registers, regulates and inspects healthcare services to ensure quality and safety of care in England, there are equivalent bodies in Northern Ireland, Scotland and Wales.

The National Clinical Assessment Service (NCAS) assesses and advises provider organisations on individual medical practitioners where there are concerns about their performance and supports 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 set limits on their practice or remove the doctor from the medical register if necessary.

2.2 The College can provide specific expertise in assessing the quality of ophthalmic care and services. It is important to understand that **College reviews have no formal statutory or regulatory role, status or function** and the College has no formal power to compel the healthcare organisation concerned to act on their advice.

Requests for a review by the College may relate to:

- Issues arising from a CQC inspection
- Issues arising from an NCAS assessment of an individual ophthalmologist
- The performance of an ophthalmology department/service which is giving cause for concern

- When there are disagreements between the hospital management/commissioners and the ophthalmology department/service (manpower, performance, workload, resources, safety and governance)
- When the provider organisation 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 postoperative complications or poor outcomes, a run of serious incidents or never events.

College reviews are not suitable for assessing the performance of an individual ophthalmologist which should be 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 provider organisation 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 will aim to provide rapid, expert, informed, and objective advice, in the form of a report against a standardised template, with reference to standards such as:

- Publications by the GMC, the CQC and other national regulators
- The requirements of clinical governance
- The requirements for revalidation
- Published College, NICE and similar standards and clinical guidelines

2.4 The College works within an ethos of openness and encourages sharing the findings of the review whenever appropriate and helpful e.g. with regulators. 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 of the information and results of the review outside of the participants should be agreed by the College, the ophthalmology department and the provider organisation first, unless there is a clear and serious risk to patient safety which requires immediate escalation. 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, if required, the relevant regulatory body (CQC, GMC etc) will be informed by the provider organisation. If 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.

The College reserves the right to produce anonymised thematic learning reports arising from reviews and to monitor the methodology and outcome of the review to inform future review policy.

3. The initial contact

3.1 When a request is made to the College, the Medical Director or Chief Executive of the provider organisation should in the first instance contact the College to hold a preliminary telephone conversation with the Chairman of the Professional Standards Committee (PSC) or the Chair of External Reviews to explore the request. If the problem appears to be one that the College can help with, the Medical Director or nominated deputy (e.g. Clinical Lead for ophthalmology) should:

- Complete the College request form (appendix) to:
  - Clearly define in writing the problem and the reason for the request
  - Indicate (a) whether a referral has been made to NCAS, the GMC or other organisation (b) 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 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
- Agree reimbursement of direct expenses and appropriate recompense for the members of the review team (see section 3.7)
- 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
- Provide detailed guidance on the processes to be followed during the course of a review

4. The review team

4.1 Responsibility for establishing the membership and lead of the review team will reside with the Chair of External Reviews and the Chair of the PSC. The review team will usually comprise members of the PSC, clinical reviewers (medical, ophthalmic nurses, orthoptists and optometrists) including any required subspecialty interest, lay reviewers, and may include trainees, managers or other professionals as appropriate. Any conflicts of interest will be identified prior to appointment to the review team.

4.2 The Chair of External Reviews, 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.

4.3 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.

4.4 Once a review team has been identified, the names, addresses 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 Head of Professional Support will act as the point of contact for queries relating to the arrangements for the review but the lead reviewer should also make introductory contact with the Medical Director /Chief Executive or their nominated deputy.

4.5 The provider organisation must liaise directly with the lead reviewer to make the necessary administrative arrangements for the review. This should include arrangements for accommodation, travel and subsistence. The organisation should confirm directly with the lead reviewer the contact details for key personnel in the referring organisation – usually the Medical Director and Clinical Lead for Ophthalmology.

4.6 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 provider organisation. The reviewers' employing organisations 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.

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

4.8 The review lead will advise the provider 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 publicly available information about the provider and its ophthalmic services such as publications on the trust website, the CQC website, Hospital Eye Service (HES) data and media publications where relevant.

5. 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.

5.1 Estates and environment

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

5.2 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

5.3 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 or benchmarks
- Timetable
- 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

5.4 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

5.5 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

5.6 Management and leadership arrangements

- Local management structures
- The process of line management for dissemination of information and decision-making
- Management and leadership style / culture 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

5.7 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

5.8 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

5.9 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

5.10 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.

5.11 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

5.12 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

5.13 Children's ophthalmology

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

6. Individual performance

6.1 The College will not normally accept instructions from providers 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)

6.2 The review team will bring such matters to the attention of the relevant people and, in the first instance, this would be to the Medical Director; 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.

7. Arrangements for reviews involving visits

7.1 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.

7.2 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.

7.3 The provider organisation 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.

7.4 The provider organisation 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. Organisations 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 this should be by a secure means.

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

7.6 Tour of inspection. The reviewers should receive a guided tour of the facilities and other areas as deemed relevant or necessary. The reviewers should be allowed where possible to examine equipment and areas. In agreement with the provider organisation and with patient consent, reviewers may observe care and staff-patient interactions. The reviewers may also take photographs of the environment and equipment for the report.

7.7 **Interviews**: Reviews may include interviews or informal discussions with patients, clinical user groups, staff and representative(s) of management. The reviewers and the provider organisation 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.

7.8 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.

7.9 **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 provider organisation and the review team in advance. It is the responsibility of the provider organisation to make the detailed 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 can present their views and discuss them with the reviewers.

7.10 **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.

7.11 The review team may not be able to consider documentation submitted during or after the review visit unless there are good reasons why it could not be submitted in advance and they accept this. However the review team may request documentation whilst on site.

8. Reviewing a service without a visit

8.1 In some cases, the review team will be asked to undertake a review of documents without a visit, although sometimes this process will lead to a later visit being requested. Documents which require review are most commonly patient case notes, but sometimes also documents such as serious incident reports, protocols and guidelines, audit reports and other safety and quality related information.

As for a visit, a request form will require completion and the Chairs and/or reviewers will need to decide what information is required and, if this goes beyond case notes, will need to provide a list of required documentation and the parameters of these. If case notes are involved, a decision will be required between the unit and the reviewers on how to select records (e.g. the records of those where there are safety concerns or incidents, a random selection, a selection relating to certain professionals or certain subspecialties).

8.2 There needs to be a practical approach to how many case records are requested to be reviewed in terms of a reasonable time commitment of reviewers. Most commonly reviewers would expect to be asked to look at no more than 30 records each. On occasion more may be agreed but requests to examine more than 100 sets of notes are usually impractical.

8.3 On occasion, other ‘remote’ review processes may be possible or appropriate, such as telephone discussions, and these should be discussed with the Chair of External Reviews.

8.4 For reviews without a visit, reviewers may also request other information from the unit, as they would for a visit, to provide the necessary background to the local practice and context. The report process will be the same as for a review involving a visit. In some cases, the lead reviewer may request from the College some independent or expert second opinion in a particular area of the review for support or objectivity which the College will facilitate.

9. The review team's recommendations

9.1 In many cases, the review team will be willing to provide informal feedback and early recommendations to the provider team at the end of the visit.

9.2 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.

9.3 The review report will usually be structured as per the template format but 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.

9.4 The College will contact the provider organisation 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 organisation provides feedback to the College. Follow up visits may be arranged at request. Such visits will be subject to additional charges.

10. Quality assurance process

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

10.2 The QA check considers:

- Is the report readable with a clear flow and logical order?
- Does the report follow the recommended College format or where it deviates, this is appropriate?
- 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?
- Are judgements and conclusions based on the gathered evidence?
- Does the review sufficiently identify relevant standards e.g. College, Nice?
- Is the information gathered and presented clearly against the standards?
- Are there clear judgements links to standards or College positions or recognised benchmarks?
- Do the recommendations flow from 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?

11. Learning from reviews

11.1 The College will learn from experience in performing external reviews. Feedback will be routinely sought from reviewed provider organisations and College reviewers on the methodology, the experience, any issues, any suggestions for improvement and these will be regularly collated and used to improve the external review service and policy and to inform training.

11.2 At least annually, anonymised themes and issues from external reviews will be examined and a report generated by the Chair of External Reviews in conjunction with the Chair of Professional Standards to be shared in the College and, where appropriate, externally potentially triangulated with other national quality and safety evidence to provide an overarching quality and safety in ophthalmology review.

12. Appointing, training and supporting reviewers

Ophthalmologist reviewers will be recruited from members of the Professional Standards Committee, the Quality and Safety Committee, College Officers and Chairs of standing committees and groups, or by an open recruitment process for other reviewers through advertisement to members on the College website. Open appointments will be through completion of an application form and face to face or telephone/skype interview supported by references. For ophthalmologists, there should be a reference from their Medical Director or equivalent and another from their College Regional Representative. For clinical reviewers from associated professions, recruitment will occur via professional links of College Committee members and from advertisement through professional bodies such as the Ophthalmic Forum of the Royal College of Nursing, the British and Irish Orthoptic Society and the College of Optometrists. Non-ophthalmologist clinical reviewer applicants will require two professional references, at least one from their clinical lead, line manager or senior colleague. Lay reviewers will be recruited by working with the RCOphth Lay Advisory Group, with completion of a short application form and face to face interviews. For lay reviewers who are not part of the College Lay Group, they will need to submit two references from suitable professional colleagues such as clinical professionals, teachers, lawyers or similar. Selection for all reviewers will be made by an agreed appointment panel.

Existing experienced reviewers will continue on grandfather rights.

The Chair of External Reviews will provide day to day support and guidance and will run annual workshops for new and current reviewers, which may be supplemented by further training sessions as required. This will ensure training is received, and reviewers are up to date and can be supported and share experiences and resources and work together to improve the review process and contribute to the annual external review report. Lay reviewers will also be supported by the Chair of the Lay Advisory Group.

13. Contacting the College

All enquiries regarding external reviews should be directed to the Professional Support Department at the College.

Professional Support Department

The Royal College of Ophthalmologists

18 Stephenson Way

London

NW1 2HD

Telephone: 020 7935 0702

Email: beth.barnes@rcophth.ac.uk

Website: www.rcophth.ac.uk

Appendix 1 External service review request form

<table>
<tr><th colspan="3">For completion by the Chief Executive/Medical Director of requesting healthcare organisation</th></tr>
<tr><td>Name of organisation requesting review</td><td colspan="2"></td></tr>
<tr><td>Subspecialties to be reviewed</td><td colspan="2">Please select from the list below as relevant, more than one option can be chosen

Cataract ☐
Medical retina ☐
Vitreoretinal ☐
Adnexal (lid, orbital, lacrimal) ☐
Glaucoma ☐
Paediatrics and or strabismus ☐
Cornea/external disease ☐
Refractive ☐
Other (state what) ☐
Whole service ☐</td></tr>
<tr><td rowspan="2">What has triggered the review?

Please select from the list as relevant, more than one option can be chosen</td><td>☐ Concerns raised by staff
☐ Serious incident(s)
☐ Patient complaint(s)
☐ Internal review
☐ External review</td><td>☐ Commissioner or regulator concern
☐ Audits/outcome data
☐ Recent changes to service delivery
☐ Planned changes to service delivery</td></tr>
<tr><td colspan="2">Other (please comment)</td></tr>
<tr><td>What areas need review?

Please select from the list as relevant, more than one option can be chosen</td><td>☐ Service delivery, productivity or efficiency
☐ Workforce issues
☐ Interpersonal behaviours
☐ Multidisciplinary clinical team working
☐ Clinical workload
☐ Protocols and patient pathways</td><td>☐ Clinical leadership
☐ Trainees
☐ Clinical governance/safety
☐ Interaction with patients
☐ Facilities and resources
☐ Clinician/management relationship</td></tr>
</table>

	Other (please comment)	
Comments / background / description of problems		
What steps have already been taken? Please select from the list as relevant, more than one option can be chosen	☐ Discussions with staff ☐ Clinical record reviews ☐ Internal audit ☐ Internal investigation ☐ External peer review ☐ Pathway or protocol redesign	☐ Restrictions on practice ☐ Contact with GMC, CQC, NCAS
Give brief details especially on any other agencies involved		
Add any other information, or any specifics on what you are asking the College to do		

Contact details for the Chief Executive/Medical Director:	
Name	
Post	Chief Executive ☐ Medical Director ☐ Other please specify: ☐
Address	
Telephone number	
Email	
Name and contact details of clinical lead for ophthalmology	

Fees: Please provide the name and contact details to which the invoice for the review should be sent along with a purchase order number for the review	
Name	
Role	
Contact Details	
Purchase Order Number for Invoice	

Declaration: I have read and agree to the review conditions set out in the College's External Review Guidance Document (October 2017)	
Name and designation (Chief Executive/ Medical Director)	
Signed	
Date	

Please send to: Professional Support Department, The Royal College of Ophthalmologists, 18 Stephenson Way, London, NW1 2HD

beth.barnes@rcophth.ac.uk

Appendix 2 Review Charges as of April 2017

External 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). Above 30 sets, the full fee will apply.

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

Expenses for review team

The College fee may reimburse each review team member (or their employing organisation)

- Ophthalmologists £650 for each team member per day on site
- Non-ophthalmologist clinical reviewers £300 per day on site
- Lay reviewers £200 per day on site and per day for offsite analysis of data and work on the report.

If any review team members are also Trustees of the College, they are not acting as a Trustees when part of the review team.

All charges are subject to V.A.T. at 20%