Curriculum FAQs

Introduction

This document aims to aid trainees in obtaining the best learning experience from the curriculum and in resolving disputes about how to be assessed for the core curriculum items. It is hoped that trainees and assessors will be able to refer to this document to aid development of a standardised training between different LETBs/Deaneries.

Questions and Answers

	Question	Answer
1	There is an increasing emphasis on simulation from the RCOphth and my Deanery, but there is no local access to an EyeSi. What can I do?	Please remember that simulation training can be high-fidelity or low-fidelity, each providing differing validity. Simulation training does not necessarily need to be on an EyeSi and could also include suture boards, plastic eyes or even practice at home with grapes / tomatoes and a pair of rhexis forceps! As emphasis increases on this valuable learning tool, it will be necessary for departments to invest in simulation materials. Bookable simulation resources are available at college and commercial venues. The document 'Surgical Skills Simulation' (dated 24 September 2014) gives advice and resources to aid development of simulation.
2	When can simulation be used to complete WpBAs?	Simulation is only acceptable for 1 of the 2 cases required for each of 'PS16 – Corneal glueing' and 'SS13 – Eye removal'. It should not be used for both of the assessments required for each of these outcomes, and is not acceptable to be used anywhere else in the curriculum for formal sign off. Of course, simulation can and should be used to aid learning and surgical experience throughout the curriculum.

3	What counts as simulation in 'PS16 – Apply corneal glue'?	A simulated procedure can be carried out in any model that represents the human eye (including human cadaveric, mammal and plastic eyes and other tissue models). The model for simulation must be as close to performing an in vivo procedure as possible.
4	What counts as simulation in SS13 – 'Remove the eye when indicated'?	For this competence one simulated procedure may be done in a human or mammal cadaver orbit.
5	Can simulation be used to assess SS8 – 'Ocular surface protection'?	This learning outcome must be performed and assessed in patients. It is recognised that, where such procedures are performed out of hours, it may be difficult to be observed by an assessor. It would be acceptable for a satisfactory OSATS to be completed based on assessment of the post-operative appearance of a patient, providing your technique has been assessed in a simulated environment.
6	Can 'SS13 – Remove the eye when indicated' include 2 enucleations or 2 eviscerations or must there be one of each?	This outcome should be assessed using at least one enucleation and one evisceration.
7	Why is enucleation / evisceration required? It is only ever done by oculoplastic surgeons in our unit.	You may be required to use these skills when a specialist oculoplastic surgeon is not available. This may be required as an emergency in a trauma case where you are the on call surgeon and have to proceed yourself.
8	Does eyelid laceration repair count towards 'SS6 – Perform surgical repair of ocular and adnexal tissues after trauma'?	This outcome must include one globe repair (including traumatic – not surgical – corneal lacerations and scleral wounds). The second case can include a globe or a lid repair. The following conditions must be met: ○ Globe repair – must be on a living patient. ○ Lid repair – must be on a living patient and must include the lid margin (but it is not required to involve the canaliculus). ○ The operation must only have a "minor contribution from the consultant or other team members" as documented in the medical notes.

9	What level of involvement is required in squint surgery to be classed as 'PS'?	A trainee must have performed the entire operation of at least 1 muscle under supervision from the consultant or senior trainee. If a case involves multiple muscles, but a trainee is not completing all the muscles, then this will still be able to be counted as PS (Performed under supervision) as long as a minimum of 1 muscle is completed in entirety by the trainee. "In entirety" would be from and including opening the conjunctiva to closing the conjunctiva. The supervising surgeon should not take an interventional role during the surgery, although "non-touch" advice is acceptable. Remember that this outcome is to aid trainees in developing the necessary skills for dis-inserting and reattaching a muscle in a trauma situation.
10	What counts as a case for squint surgery numbers?	○ Each patient where at least one complete muscle is undertaken by the trainee counts as a case. Note that the minimum of 20 surgical cases should include a mix of muscles (a minimum of lateral and medial recti, preferably including obliques and superior / inferior recti), and a mix of techniques (recession / resection / myectomy / dis-insertion). ○ Botulinum toxin is not a valid procedure for squint numbers. This has a separate learning outcome and is assessed by a DOPS. It is important to remember that this outcome is to aid trainees in developing the necessary skills for dis-inserting and reattaching a muscle in a trauma situation. ○ Where it is agreed squint surgery is difficult to attain locally, up to 5 cases of the indicative 20 can be undertaken in supervised simulation.
11	Can I include laser peripheral iridotomies in my glaucoma surgery numbers?	Laser iridotomy should not be counted as glaucoma surgery for SS5, however it can count in the total number of glaucoma procedures for your log book.

12	What level of involvement is required in glaucoma surgery to be classed as 'PS' in the logbook?	The trainee should perform all the steps of the procedure. The consultant/supervisor should only make minor contributions to the operation, although they may offer guidance throughout. This is the case for trabeculectomy, drainage tube surgery, bleb needling, MIGS, non-penetrating surgery, iridectomy and bleb refashioning, etc. If a trainee is able to perform a part of the surgery demonstrating transferable skills (e.g. creation of a scleral flap, releasable suture, scleral patch graft, conjunctival closure) these would be good examples for completing 'SS1 - Surgical Skills'. This should be recorded as A (Assisted) in the logbook.
13	What procedures are considered appropriate for assessment of 'SS5 – Surgery to lower IOP' and 'SS15 – Laser for IOP'?	○ SS5 – This could include performing **complete** trabeculectomy, non-penetrating surgery, tube surgery, bleb needling, MIGS procedures, iridectomy, goniosynechiolysis (usually with cataract surgery) and cyclodiode laser (a maximum of one case). Where only part of one of these procedures is performed, this can be usefully used for an assessment for SS1. Other laser for IOP is not appropriate for this outcome. A single cyclodiode must not be counted as both a laser procedure and a surgical procedure. ○ SS15 – This should include a minimum of two different forms of laser, e.g. peripheral iridotomy, selective laser trabeculoplasty (SLT), Argon laser trabeculoplasty (ALT), iridoplasty and can include cyclodiode. Progression to more complex cases with increasing seniority should be demonstrated, e.g. laser iridotomy with argon pre-treatment.
14	Is Incision and curettage of chalazion appropriate to list under the Tx count for Oculoplastic and Lacrimal surgery?	Incision and curettage of chalazion would not be considered sufficient to demonstrate competence of common oculoplastic procedures, although it would be appropriate to use a few cases in the portfolio of evidence.

15	What procedures are appropriate when completing an OSATS1 assessment, particularly for SS1, SS5 and SS15? Is it acceptable to use cataract surgery to complete an SS1 assessment?	For SS1, the appropriate procedures will change throughout training as trainees become more experienced. For instance, a minor lid procedure may be an appropriate procedure for an ST1-3, but would not be appropriate for an ST7. Therefore the aim is to demonstrate development of skills over training. It is appropriate to complete this for transferable skills from any surgical area without it meaning the entire operation has been completed by the trainee. Examples include: fashioning a scleral flap, creating an ostium, completing an iridectomy, releasable suture placement in a scleral flap, conjunctival closure, suturing a scleral patch, reforming the anterior chamber, performing compression sutures, exploring a conjunctival laceration, suturing a conjunctival/corneal laceration, performing an EUA, syringing and probing, pterygium excision, conjunctival graft/rotation, suturing a penetrating keratoplasty, performing a core vitrectomy, iris prolapse repair. Any other surgical operation performed that does not require a specific OSATS – e.g. trauma/oculoplastics/muscle surgery, particularly when this shows advancement of skills – may also be used. Routine phacoemulsification surgery should not be used for this assessment although management of significant complications, such as anterior vitrectomy, can be used. Please see FAQ13 for an answer to which procedures are appropriate for SS5 and SS15.
16	Should I use medical record numbers in my portfolio?	Whilst record numbers are required in the logbook, they should not be used in the portfolio.
17	How am I going to be assessed for Biometry? The doctors do not do biometry in my Trust.	It is important that you understand the technical procedure to obtain biometry measurements as this aids with interpreting the results, and can be essential when nurses are unable to perform biometry for any number of reasons. We suggest that, where doctors are not routinely involved in biometry, this could be a practical session at a regional Postgraduate teaching session at which all trainees would be able to complete this outcome. This outcome can be assessed by a technician or nurse who regularly performs biometry as long as they are trained in assessments.

18	What counts as 'managing complications' for 'SS4 – Cataract surgery'?	By the end of training it is important that senior trainees are able manage any complication that occurs within the operating theatre or in the post-operative period for cataract surgery. This may include loss of vitreous, displaced lens or implant during the procedure or a post-operative refractive surprise or infection. Managing complications involves being able to safely complete surgery even if the intended outcome is not reached. It would be expected that trainees will develop the skills to maintain the eye in a stable state, perform anterior vitrectomy and be able to insert a sulcus lens. Trainees should be aware of how to manage a supra-choroidal haemorrhage. However, retrieval of lens fragments from the vitreous or inserting a scleral fixated or iris clipped lens would not be required, as they are typically carried out as a secondary procedure in the UK. Where a senior trainee has not been able to demonstrate this skill either on their own or supervised cases, they should do so in simulation.
19	How do I record % rupture & % take over?	This should be recorded as a raw number and also as a percentage (%). ○ % PC rupture and number of PC ruptures / (PS Phaco + P Phaco) ○ % of your own complications handed over to a senior to deal with.
20	How do I record a procedure when I take over from a junior to manage a complication?	In this situation you record the procedure twice. The first part of the case would count towards SJ and the second part, the management of the complication, would count as P.
21	I have performed most but not all of a procedure – how do I correctly record surgical cases in my logbook using A, PS, P, SJ? What happens when I have had a complication and my surgical supervisor has taken over?	For the correct recording of supervision for surgical procedures please refer to the letter 'Terminology when recording surgery' dated (11 July 2016).

22	What are the current guidelines for when a trainee is able to operate independently with a clinical supervisor in the adjacent theatre? What surgical competencies must they have before this is acceptable?	A trainee should only operate independently when a clinical supervisor deems that it is safe to do so. There are no competencies that must be specifically gained before this is acceptable, although it would be considered advisable for the supervisor to have assessed and documented such an assessment of the trainee's competence with generic surgical skills and any skills specific to the procedure. The trainee's surgical logbook will also aid a supervisor in assessing the trainee's experience and suitability to practice unsupervised. It may be appropriate to use an EPA (Entrustable Professional Activity) where available (e.g. managing a cataract operating list) before a trainee operates unsupervised.
23	Can my Deanery require their trainees to undertake specific training not required in the rest of the country (e.g. use of EyeSi, or particular training courses)?	The RCOphth defines the curriculum which is the requirement for all trainees to obtain CCT. How the curriculum is delivered is largely determined by the "Deanery" (HEE) leads. Therefore if a Deanery requires a specific outcome (e.g. EyeSi training, evidence of leadership), then as long as it is made clear that this a requirement for ARCP and the resources are made available to trainees to allow completion, then trainees will be required to complete this for a successful outcome at ARCP.
24	Why do I need to be assessed on my knowledge of refractive surgery when I would require further certification to be allowed to perform the surgery?	It is increasingly common to be asked about refractive surgery by patients, and it is therefore important to have a basic understanding of the techniques, risk and benefits. The curriculum has been re-worded in 2016 to clarify this requirement. Additionally patients who have had refractive surgery in the private sector may present to the NHS with complications and require urgent or long term management.
25	Do I need supervision for a CbD or can I discuss a case from the medical notes where the clinical encounter was not directly supervised by a consultant?	A CbD does not require any supervision of the consultation by the assessor, and can be done retrospectively from the medical notes. This particularly facilitates cases seen on-call being discussed and assessed.

26	CRS10 assessment – there are 4 modalities listed for testing the fundus listed, i.e. direct ophthalmoscope, indirect ophthalmoscope, 78/90 lens and contact lens. Do all 4 methods need to be demonstrated? If so, do all 4 methods need to be used on both of the 2 required assessments – or do all 4 methods need to be demonstrated between the 2 assessments?	Each of the four modalities of examination must be assessed twice. Although it may be possible to complete this using only two forms (subjecting two patients to examination using each of a direct, indirect, 90D/78D and contact lens), it is more likely that you will need to complete several assessments, e.g. the first assessment may assess direct ophthalmoscope, the second assessing indirect and 78/90 and the third assessing use of a contact lens. If these 3 assessments were repeated a second time that would complete this outcome. It is intended that you use appropriate cases for the assessments with findings in the retina that can be particularly identified/viewed by each method.
27	Are temporal artery biopsies considered a "hard to acquire" competency such that I can use simulation to complete an assessment?	It is not acceptable to use simulation for this WpBA and it is considered achievable to obtain both assessments in routine clinical practice. However, opportunities for this on your programme may be limited to certain rotations so you should find out and plan ahead.
28	What are the current guidelines for when a trainee does a vitreous biopsy and intravitreal injection of antibiotics under supervision for a case of endophthalmitis? Would it be allowed to obtain a DOPS for 'PS19 – Vitreous sampling' and a second for 'PS3 – Drugs', given that it was one patient, or would it be necessary to choose which is more desirable?	One procedure/patient interaction is used for one single assessment. In the example given PS19 can be challenging to obtain where there are many possibilities for PS3.