Ophthalmology Local Training (OLT) Programme Guidance

Version 1.0

June 2020

Ophthalmology Local Training Programme (OLT)

This is a guide document and future changes are inevitable. If you consult other documents and sources of information mentioned in this guide, please ensure that you are looking at the most up-to-date version.

Contents

1. Introduction

1.1 Traditionally training in Ophthalmology is within a recognised training programme Ophthalmic Specialist Training (OST) which started across the UK for new entrants in August 2007. This was developed by the College in response to the overall changes in medical postgraduate training developed by the NHS organisation 'Modernising Medical Careers' (MMC). At the time a new curriculum was written based on specific learning outcomes and the examination structure was updated in line with this. These have been reviewed continuously since then with alterations approved by the GMC (General Medical Council).

Now it is clear there is a need for increased numbers of Ophthalmology Consultants and many doctors choose to apply for entry to the Specialist Register through the Equivalence of Training Route. A number of Trusts offer new additional "training programmes" for Trust employed doctors to gain competencies for the Certificate of Equivalence of Training (CESR).

This is most likely to be successful in developing consultants with good clinical and practical ophthalmology skills and generic professional capabilities if training for this is undertaken prospectively and in a parallel way to current OST training. This guide promotes good practice in developing an alternative pathway.

1.2 The GMC now regulates all stages of a doctor's training. Promoting excellence: standards for medical education and training explicitly puts patient safety, quality of care and fairness at the heart of the learning environment for both undergraduates and postgraduates (January 2016).

1.3 Promoting excellence contains five themes around:

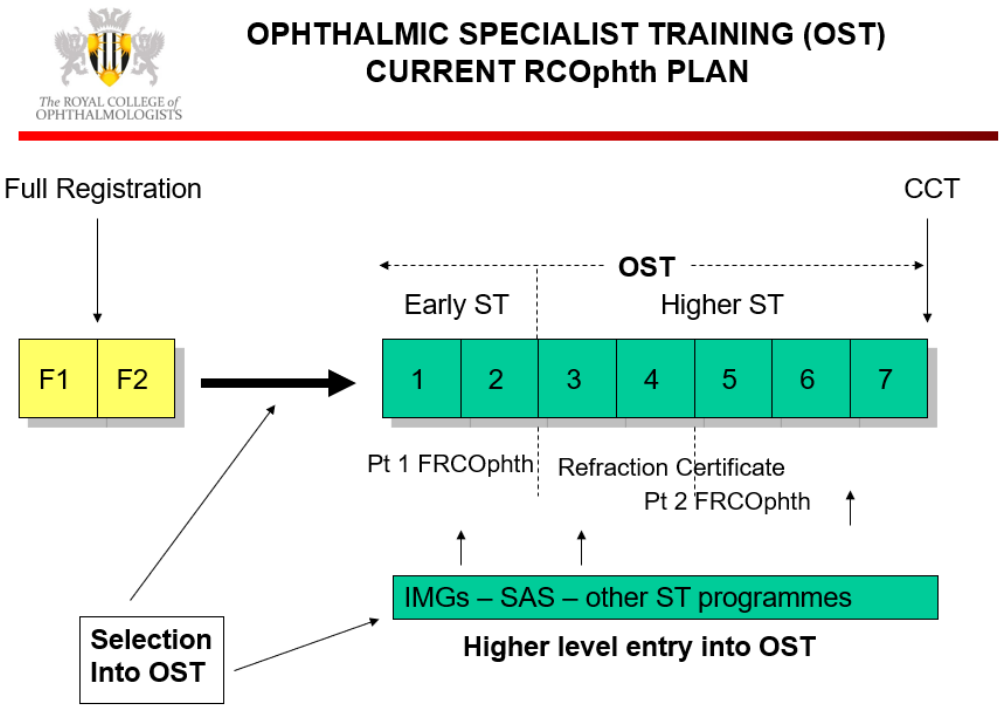
Learning environment and culture
Educational governance and leadership
Supporting learners

Supporting educators
Developing and implementing curricula and assessments

The duties of a doctor in respect to professional values, skills and behaviours required of all doctors working in the UK are clearly set out in the GMC document Good Medical Practice (April 2013).

The RCOphth curriculum for OST specifies defined learning outcomes which relate directly to providing safe and high-quality patient care. See the web-based OST Curriculum for more details. A new curriculum is being developed, incorporating the Generic Professional Capabilities Framework from the GMC and information about this will be on the website.

1.4 The basic structure of OST is a seven-year continuous programme of postgraduate ophthalmic training leading to the candidate who completes the whole programme successfully being awarded a CCT and thus being placed on the Specialist Register. Trust trainees entering the alternative pathway with no prior experience would expect to take the same length of time to acquire the necessary competencies of the curriculum.



1.5 It is thus apparent that early specialist training occurs during Years 1 and 2; higher specialist training occurs during Years 3 to 7, and more focussed training in the form of Trainee Selected Components (TSCs) may occur in Year 6 or 7 with preparation for the consultant role. Good practice would see Trust trainees offered a mirrored programme including the opportunity for special interest training of a TSC and consultant preparation in the same way.

1.6 However the endpoint for the alternative training programme would be the award of CESR and so an individual trainee who acquires competencies more rapidly and demonstrates the development of generic professional capabilities at an accelerated rate may be able to submit for CESR in a shorter time frame, just as OST trainees may apply for acceleration of training. This may particularly relate to Trust trainees appointed with significantly more previous ophthalmology experience.

2. Other relevant guidance

2.1 This guidance should be read in conjunction with the following sources of information:

The RCOphth curriculum for OST

The RCOphth on-line e-Portfolio for OST contains the workplace based assessments required.

The RCOphth examinations for OST

The GMC 'Good Medical Practice' (2013)

The GMC 'Promoting excellence: standards for medical education and training' (2016)

The Gold Guide – 8th Edition (March 2020)

International Medical Graduates (IMGs) should consult the specific information for IMGs on the RCOphth and GMC website.

3. Induction programme for training

Guidance on the recommended induction programme for **Ophthalmology Local Trust Trainee (OLTT)** is the same as new starters for OST and is on the RCOphth website. All ST1 equivalents should have an introductory week to ophthalmology as well as undertake the Trust mandatory induction. The induction is a starter guide to examination and assessment of the ophthalmic patient, with an introduction to some main specialty interests and the acquisition of practical skills to ensure that early clinical exposure is enhanced. The guidance covers the main principals and suggested programme content.
https://www.rcophth.ac.uk/training/resources-and-support-for-trainees/
https://www.rcophth.ac.uk/professional-resources/eye-site/

4. Curriculum and Assessment during training

4.1 The curriculum for OST is described as a set of learning outcomes.

4.2 Workplace based assessments (WpBAs) are used formatively, to deliver feedback and aid development, and summatively, to demonstrate competence in the area of each learning outcome of the OST curriculum.
The WpBAs required is defined in the descriptor for the learning outcome.

In some learning outcomes a judgment of competence will be made from the evidence submitted. For OST this may be made by an Educational Supervisor. It would be good practice for the **Ophthalmology Local Trust Trainee (OLTT)** to have similarly an assessment in the same way. This is particularly the case for generic professional capabilities. Suggested evidence can be found in the portfolio section of the curriculum.

Assessment and good practice is discussed in Section 4 of the Gold Guide. The assessments should be carried out and assessed in the same way that they are for OST trainees. It is recommended that Trust trainees undertake mirrored assessments to those required for OST trainees at the same stage of training.

4.3 The FRCOphth examination is required to demonstrate appropriate knowledge. In order to progress through the Ophthalmology Local Training (OLT) Programme it is recommended that, the mandatory College examinations must be passed. In the same time scale. Details of examinations and requirements for examination pass at a given stage of training can be found on the Examinations section of the College website.

It is advised that this is completed in the same way in the mirrored pathway with Part 1 achieved by the end of year 2 (6 attempts allowed), the Refraction Certificate by the end of Year 3 (6 attempts allowed). The Part 2 Fellowship is decoupled with separate written and clinical components. This can be attempted once the Refraction Certificate has been

attained and must be passed by the end of year 7 (4 attempts are allowed per section). https://www.rcophth.ac.uk/examinations/candidate-tips/

4.4 A Local Assessment equivalent to the Annual Review of Competence Progression (ARCP) should take place each calendar year to assess that competencies are being achieved at the expected rate and the trainee is ready to move to the next stage. Evidence is provided by the trainee in their Portfolio for the ARCP panel to consider. Preparation of the evidence for the local ARCP process should take place throughout the preceding year.

The assessment evidence required for each level ARCP is described on the curriculum and can be used as guidance.

The ARCP process is fully described in Section 4 of the Gold Guide. This can be used to ensure local processes are equivalent.

5. The Portfolio/e-Portfolio

5.1 OLT Trainees entering training should document their progress using a Portfolio. As Affiliate members they have access to the e-portfolio for the WpBAs and relevant supervisor forms. However they do not currently have the same access as OSTs so should ensure that in their portfolio they keep their details, those of the hospitals they are based in, their timetables, study leave, personal development plan (PDP), as agreed with their Educational Supervisor, WpBAs and all further evidence of their learning and achievements. In 2022 when the new e-portfolio is released it is envisaged there will be full access to the e-portfolio.

5.2 In addition to the annual clinical and practical skills WpBAs completed, OLT Trainees should collect evidence of research, audit and quality improvement, teaching and training, management and leadership activities. These can be associated with appropriate learning outcomes. The evidence contained in the Portfolio will then be viewed by the Educational Supervisor (ES) to complete a report at the end of each 6 months. Clinical and Educational Supervisor reports should be completed at each 6 month period in the same way that OSTs do so as this can then be reviewed by the local ARCP panel.

6. Years 1 and 2 (early specialist training)

6.1 OLT Trainees entering at Year 1, with no prior experience, will require closely supervised training in basic examination methods and techniques and should rapidly be introduced to the elements of surgery and the management of general outpatients and accident and emergency ophthalmic patients. In their second year, they will be expected to take a larger role in both theatre and outpatients, where they will benefit from special clinics. The training units should therefore provide a broad-based training in general ophthalmic medicine and surgery and exposure to the common subspecialties.

6.2 The detailed learning outcomes which must be achieved in Years 1 and 2 of OST are set out in the curriculum, as are the assessment methods that must be used. Many of these assessment tools are based in the work place and trainers for Ophthalmology Local Training Programme should also need to be recognised Clinical Supervisors who have been trained in

such assessments. OLT Trainees may be familiar with these assessment methods as they are used in the Foundation Programme, however they may require training in how to undertake them, if they have come from overseas. In addition, the OST Curriculum gives supplementary information that will be helpful to both the OLT Trainee and trainer.

OLT Trainees on the Ophthalmology Local Training Programme will be aware that for CESR evidence of the last 5 years is given priority by the GMC in assessing equivalence of training. However it takes 7 years to train an ophthalmologist so if they have no prior experience it would be expected that it would take the seven years. The spiral nature of training and learning means that early competencies are often included in or covered by higher later assessments.

6.3 Ophthalmology Local Training Programme may be based in one unit or potentially may be associated with other smaller units rotating trainees to allow them to acquire all the relevant experience and competencies. Units providing training for Years 1 and 2 should normally have a minimum of three Consultants with a major sessional commitment to that ophthalmic training unit. The unit should provide a broad programme of experience in which OLT Trainees may develop their skills progressively.

6.4 All Consultants acting as trainers should be trained Clinical Supervisors. Trainers should actively pursue their own as well as their trainees' medical education and must enrol for a Continuing Professional Development programme.

Locum Consultants may only be involved in training if they are registered as e- Portfolio assessors and fulfil the requirements to be a suitable trainer, as assessed by the unit's College Tutor, which would normally involve having completed recognised Clinical Supervisor Training and have an understanding of the curriculum and its assessment.

More senior trainees in Years 3 to 7 have an important supportive role in training Years 1 and 2 trainees and may be of benefit to the OLT Trainee during the early stages of training.

6.*5* Other medical and allied health professional staff (for example, nurses, orthoptists, and optometrists) may make significant contributions to the training of OLT Trainees. Non-consultant career grade doctors (SAS) may make a valuable contribution to training and assessment, provided that a consultant who acts in an overall supervisory capacity delegates this role. Any medical or paramedical staff who assist in delivery of training should be competent to train.

It is important that the multidisciplinary team and staff such as phlebotomists undertake routine tasks to ensure that the OLT Trainee does not become overburdened with non-educational duties which do not add value to their training as for OST trainees.

6.6 The employment of a nurse practitioner or another allied health professional is recommended in any unit to carry out pre-operative biometry will prevent the OLT Trainee becoming unduly occupied with excessive routine clerking. Complete competence in the performance of biometry is now a specific learning outcome for ophthalmology trainees, hence they are expected to have done enough biometry to interpret it correctly and to understand the limitations and potential problems with the technique. Biometry

assessment is undertaken though learning outcomes and DOPs so the opportunity for this must be provided.

Where anaesthetic assessment is required for suitability for General Anaesthesia, the decision and tests required should be decided by a suitable qualified anaesthetist. Likewise, the assistance of anaesthetic colleagues in the pre-operative assessment of patients requiring general anaesthesia should, where possible, be sought.

6.7 The Ophthalmology Local Training Programme
There should be a clear commitment by all the ophthalmic consultants to the education of the OLT Trainee as for an OST. There should be an appointed Unit OLT Lead/Tutor (or other appointed Educational Supervisor) should monitor the trainee's progress in attaining the required learning outcomes set out in the curriculum through the educational appraisal process and the ARCP process with information from WpBAs and the trainee's portfolio. The OLT Lead should be a CESR Assessor for the RCOphth, having attended their training programme and undertaking regular CESR assessments (at least 2 per year). This will ensure the OLT Lead is familiar with the process of CESR applications to advise the OLT Trainees.

6.8 Guidance on the Weekly Timetable
Years 1 and 2 OLT trainees should undertake no more than eight clinical sessions a week. The weekly timetable should include the same pattern of sessions that an OST trainee would undertake:
General clinics 3 (maximum) †
Acute Services/Eye Care 2 (maximum) †
Theatre 2 (protected sessions
Other* 1

† There should be no more than 5 general sessions, including acute services and primary care.
*Laser, consultant supervised pre-assessment clinic (see 6.7), special clinic, etc.

There should be 1 session for Teaching
There should be 1 session for Research / Study / Audit /Quality Improvement

Each OLT trainee should have access to training in refraction, which could be organised for one of the above session prior to the refraction certificate.

6.9 The OLT trainee should have some exposure to special clinics, particularly those which offer training in methods of examination and assessment. They should not be routinely added to the numbers of patients seen until they have acquired sufficient skill to assess patients efficiently to contribute positively to throughput in the clinic. This will then offset the time required by the trainer to provide teaching, supervision and performing WpBAs.

Sometime could be allocated for ward work, supervised case documentation and inpatient investigation; however, the OLT trainee should not be overburdened with routine ward work or clerking duties including pre-operative assessment clinics. Pre- operative ward rounds or clinics, when supervised by a consultant, may be a valuable training resource.

6.10 OLT trainees should have the opportunity to assist in theatre and learn minor/extraocular procedures and gradually progress to those of a more complex nature towards the end of the first year depending on the aptitude of the OLT trainee.

All OLT trainees must attend the RCOphth Introduction to Phacoemulsification Course and have completed the EyeSi courseware A and B training , as required for OSTs, before they are allowed to undertake intraocular procedures on patients. This may take place at any time during the first six months of OST, preferably near the start, It may even occur before entry into a training programme.

In the meantime, OLT trainees may undertake surgical simulation locally in a wet/dry lab to be able to start supervised extraocular surgery and assist in intraocular procedures. The Introduction to Phacoemulsification Course will then be supplemented by further simulation experience (see Section 13).

Trainees entering with prior surgical experience may not require to undertake the RCOphth Introduction to Phacoemulsification Course (if they are entering as the equivalent of an ST3 in OST training) if they have previously completed ST1/2 competencies. For other OLT trainees with prior surgical experience but not completed ST1 and 2 competencies then the unit should consider the timeliness of their surgical experience and whether they should recommend undertaking the national mandatory course for the UK held by RCOphth.

6.11 More experienced Years 1 and 2 OLT trainees should be actively involved in supervised intraocular surgery – further guidance is given in the curriculum. They should also continue to supplement these skills with simulation to enhance the acquisition and consolidation of their surgical skills.

6.12 It is essential for the OLT trainee to perform sufficient numbers of surgical cases (particularly cataract procedures) to experience a full range of clinical situations ((e.g. white cataract, small pupil) so that the OLT trainee learns techniques to manage a range of cases and becomes competent in managing complications. It is expected that at the end of Year 2 the OLT trainee will typically have completed approximately 50 phacoemulsification cataract procedures. Years 1 and 2 OLT trainees should be allocated to operating lists with suitable patients for the level of their skills as year 2 OLT trainees are unlikely to have developed sufficient skills to manage complex situations at this stage of training. OLT trainees should be taught how to manage the complications of cataract surgery in simulation. In most units post-operative review of cataract surgery patients is undertaken by other members of the multidisciplinary team. It is important that OLT trainees should be allowed to review their own cataract surgery cases post-operatively, or at least a proportion of them, so that they are able to understand the pattern of healing and recovery and the positive impact of surgery on the patients' lifestyle.

Surgical progress must be recorded using a logbook so it is recommended that the Eye Logbook is used (see guidance on format on RCOphth website), which will form part of the OLT trainee's portfolio.

6.13 OLT Trainees are expected to attend two protected operating lists a week, which implies that the OLT trainee will have hands on surgical experience during this session and preferably be the only doctor other than their trainer for that session. The OLT trainee should be undertaking his/her own surgical procedures under supervision on these lists.

As senior trainees are required to supervise other trainees undertaking cataract, and potentially specialist surgery, they may provide supervision for year 1-2 trainees, with consultant oversight and additional input. Where there is a division of surgery into service and training lists, there is in general little training value for the trainee to attend the service list. Where there is more than one trainee allocated to a surgical list they should be at a different stage and not be competing for cases i.e. it is acceptable for a senior trainee to be paired with a year 1-2 trainee, but the junior trainee would be given priority for non-complex cases.

6.14 The OLT Leads/Tutors should supervise and facilitate the handover of trainees from one eye department to another in a rotation, if this in undertaken in the region (local arrangement), in the same way as would happen with College Tutors and OSTs. This handover should include, amongst other issues, communication between trainers so that a seamless process of supervision, ensuring a progressive learning environment for surgery, can be achieved.

6.15 Experience should be provided in acute services/emergency ophthalmology and OLT trainees should be involved in the management of ophthalmic casualties, under supervision although they should not attend more than two emergency sessions per week. There should be a regular on-call commitment although this should not necessarily mean that post holders must be resident. It is not necessary for ophthalmic accident and emergency to be open throughout the 24 hours to deliver appropriate training for OST. Further guidance on supervision of acute services training is given in section 14.

6.16 Where WpBAs are available for more specialised competencies, these can be undertaken and assigned to a later stage of training than they are currently undertaking. The trainer assessing the competency should be made aware that they are assessing the OLT trainee at a more senior level and the learning outcomes that should be achieved to sign off as competent at this level.

7. Years 3 to 7 (higher specialist training)

7.1 The detailed learning outcomes which must be achieved in Years 3 to 7 are set out in the curriculum, as are the assessment methods that must be used. Many of these assessment tools are based in the work place and trainers will need to be trained Clinical Supervisors. OLT trainees will be familiar with these assessment methods as they are used in the Foundation Programme. In addition, the RCOphth Curriculum gives supplementary information that will be helpful to the OLT trainee and trainer.

7.2 OLT *t*rainees entering a recognised training programme at year 3 level or higher should have been able to demonstrate equivalence of training for the OST1-2 competencies, or higher.

7.3 Guidance on Rotations
The OLT trainee's level of clinical responsibility in any part of the rotation should increase progressively according to the seniority of the trainee, their level of competence and any guidance from the School of Ophthalmology.

7.4 A Year 3 OLT trainee should receive a good general educational grounding, although the firms to which they are allocated should also provide a specialty interest. During this year there should be a consolidation of skills so that OLT trainees can efficiently examine and assess ophthalmic patients in outpatients and acute services. They should make a step up in cataract surgery, be able to undertake a greater proportion of cases on operating lists and develop their skills.

An OST programme should provide training in the 7 main ophthalmic specialty interests, which underpin the curriculum:

Oculoplastic, Adnexal and Lacrimal Surgery

Cornea and External Diseases
Cataract (and Refractive Surgery*)

Glaucoma

Retina, Vitreous and Uvea (including Ocular Oncology)

Neuro-Ophthalmology
Paediatric Ophthalmology and Strabismus

(*Although Refractive Surgery will not be undertaken as usually falls outside the NHS, a basic level of knowledge and ability to manage referred complications must be covered.)

Access to teaching in ocular pathology is important. Continued training in acute services /emergency ophthalmology is essential throughout the training period.

The OLT programme should be sufficiently flexible to allow OLT trainees to take out of service leave without disrupting the rotation unduly.

7.5 The employing programme should ensure that all OLT trainees have a suitably balanced rotational programme.

7.6 It is important that every OLT trainee has access to appropriate Educational Supervision with regular meetings and support. They should also know who the OLT Lead/Tutor is for the unit, the Regional CESR/OLT Lead, the Regional Education Adviser (REA), the Trust Postgraduate Education team such as the Director of Medical Education and be aware of any supportive or pastoral structures within the Trust.

7.7 Guidance on Weekly programme
In general, every session should be appraised for its value as a training resource. Those

sessions which cannot be made to fit this criterion should not be part of OLT trainees' timetables and other staff should be employed to provide the service.

There should be no more than 7 clinical sessions per week, whose content should be flexible within the following guidance:
2 acute services or general clinics maximum
2 special clinics minimum

1 treatment session such as laser or minor operations or further special clinic
2 theatre sessions minimum
In some parts of the rotation, such as medical retina, less surgery may be allowed provided the School is satisfied that a balanced training can be achieved.

The remaining weekly sessions should include:
1 (minimum) fully protected research (R)
1 individual study, to include time for undergraduate teaching and personal audit (STA)
1 postgraduate teaching

The weekly programme should indicate the timing of these RSTA sessions. The RSTA sessions are as much a part of the timetable as an operating list or clinic and are not for non-educational use.

Where on call commitments mean that zero-hour days or sessions impact on the training experience to limit adequate training opportunities, an RSTA session may be used to deliver the missing components of training. However, this should be individualised to optimise the OLT trainees' experience as in the OST programme.

7.8 Outpatients
The OLT trainee should see sufficient patients in a clinic to develop competency and fluency in managing patients in an outpatient setting but the number seen must not be excessive to the extent that training is impaired. The actual number of patients seen should be appropriate to the competency of the OLT trainee and the complexity of the clinical condition of the patient. In all clinics, OLT trainees should see new patients and should be able to present them to the consultant. The clinic numbers should be controlled to ensure time for the trainer to provide teaching, supervision and completion of WpBAs with contemporaneous face to face feedback.

A special clinic is a clinic in which patients with a single diagnosis or group of related diagnoses are seen exclusively, and to which there are internal referrals. Ideally there should not be a mixture of patients in such a session, but if there is, there should be 2/3 specialist patients bias towards one specialty interest, in order not to dilute the OLT trainees' experience.

7.9 All clinics should be timetabled to be supervised by a consultant and it is important that a consultant should always be available, especially during designated laser and minor operations sessions, and acute services. The degree of supervision of OLT trainees should be judged according to their seniority, experience and competence.

OLT trainees should never be timetabled to do outreach clinics alone, although it is permitted for the OLT trainee to attend outreach sessions with the consultant. It is not acceptable for a consultant doing an outreach clinic to leave the OLT trainee undertaking unsupervised clinical sessions in the base hospital.

7.10 No OLT trainee should undertake timetabled clinical sessions, such as acute services or laser photocoagulation, which do not necessarily need direct supervision, without a consultant being available in the hospital at the time.

It is important that OLT trainees should see the patients they operate upon pre and post-operatively as they rotate around the specialty interests. OLT trainees should be supported to follow up, post-operatively, any patients where there have been complications in surgery performed by the OLT trainee. They should also be encouraged to review a proportion of the 50 cases they document for their 50 consecutive cataract audit within the last 3 years of their training.

Pre-operative assessment clinics are to be encouraged, but should largely be run by nurses, with only a minor input from Years 1 and 2 OLT trainees and none from more senior OLT trainees, as these sessions are not valuable as training, unless they are part of a ward round with the consultant present.

7.11 Laser photocoagulation should be fully supervised at the start of training although, thereafter, OLT trainees who have demonstrated the appropriate level of competence can manage patients without supervision. OLT trainees should be able to see their patients both before and after treatment. An appropriate laser teaching attachment, such as a sidearm or video, should be available.

7.12 Year 3 to Year 6 OLT trainees should see acute services patients, but usually no more than two weekly sessions of acute services, primary care or general clinics should be timetabled. Senior supervision and advice must always be available. It is not necessary for ophthalmic accident and emergency to be open throughout 24 hours to be approved for training.

7.13 Specialty interest clinical experiences
There will be further guidance on this in the appropriate sections of the Curriculum.

7.14 Theatre
Surgical experience should develop as indicated by the learning outcomes in the curriculum. It is essential for the OLT trainee to perform sufficient numbers of surgical cases (particularly cataract procedures) to experience a full range of clinical situations (e.g. white cataract, small pupil) so that the OLT trainee learns techniques to manage a range of cases and becomes competent in managing complications. For example, it is expected that by the end of Year 7/ submission of CESR the OLT trainee will have completed a minimum of 350 phacoemulsification cataract procedures.

OLT trainees' portfolios must show documented evidence of having undertaken a personal assessment by audit of these cataract procedures. This should include a full audit of at least 50 consecutive cases performed in the last three years of training, measured against the

Royal College Cataract Audit data. https://www.rcophth.ac.uk/training/certification-of-training-and-specialist- training/award-of-the-cct

The OLT trainee should also have performed and/or assisted at sufficient numbers of surgical cases in the other surgical specialty interest areas (oculoplastic, cornea, glaucoma, retina, paediatric and squint). A trainee should typically have the following surgical experience by the end of OST:

- performed 20 squint procedures
- performed 40 oculoplastic procedures (excluding ptosis)
- assisted at 3 ptosis procedures
- performed 30 procedures for glaucoma (including laser)
- assisted at 6 corneal transplants
- assisted at 20 retinal / vitreo-retinal procedures
- performed 40 retinal laser procedures

  It is recognised that OLT trainees wishing to acquire specialty interest knowledge and skills will be expected to undertake more procedures in the field of their interest, usually in Year 6 or 7 as a TSC.

7.15 A logbook should be kept and should be up to date and available for inspection at any time. It should contain an audit of the outcomes of the OLT trainee's cataract surgery. This logbook forms part of the OLT trainee's portfolio. It is recommended that the EyeLogbook is used. Additionally, a continuous complications audit of cataract surgery outcomes should be maintained throughout training, including follow-up of the patient and reflection and learning. A template for this is available https://www.rcophth.ac.uk/wp-content/uploads/2014/07/Example-model-50-case-cataract-audit-1.pdf *)*

In preparation for obtaining a consultant post, Years 6-7 should demonstrate evidence of supervising junior (SJ) colleagues. This should take the form of supervising juniors during surgical and laser cases. A minimum of 20 SJ cases should be documented. The majority should be during cataract surgery; up to 10 full cases can be in simulation but must be the entire operation performed in the wet/dry-lab, not just on the EyeSi simulator.

7.16 All junior OLT trainees should be timetabled to have supervision by a consultant in every session. The nature of supervision will vary with the level of competence of the OLT trainee. In the latter part of training, in keeping with the trainee's competence, one weekly theatre session may be undertaken without the physical presence of a consultant in the operating theatre, provided consultant assistance is available in an adjacent theatre or within the unit. By the end of training a OLT trainee should be competent to undertake cataract ophthalmology theatre lists unsupervised.

7.17 On-call
There should be a regular on-call commitment, although this should not necessarily mean that post holders must be resident. It is not necessary for ophthalmic accident and emergency to be open throughout the 24 hours to deliver appropriate training.

On-call cover for neighbouring eye departments is allowed, but only to fulfil statutory limits on junior doctors' hours.

8. Trainee Selected Components (TSCs)

Year 6 or Year 7 should undertake a specific time for 6-12 months of special interest training as OSTs do. See the separate College guidance on TSCs and Out of Programme Training.

9. Teaching / Audit / Quality Improvement / Research in OST

9.1 All OLT trainees should have one session per week protected to attend a regional half-day teaching programme. Any essential activities, such as accident and emergency, during this period should be covered on rotation by training grade staff, or by speciality or trust doctors.

9. Where attendance in person is not possible, teleconferencing facilities for peripheral units should be explored. Local teaching arrangements may be offered where a regional training programme is not available.

9.3 In some regional teaching hospitals the study half-day session is arranged during university terms only. OLT trainees should attend 75% of arranged teaching sessions. Most programmes will offer study days which will be relevant to certain stages of training. OLT trainees should attend all of these, where possible. All units should organise at least an hour of formal in-house teaching on a weekly basis, not only to supplement the regional teaching programme but also to capitalise on local consultant expertise. Informal teaching should be regarded as routine during outpatient and theatre sessions.

9.4 OLT trainees should take an active part in teaching undergraduates, other trainees and paramedical staff. Where possible, OLT trainees should be supported if they wish to develop their own teaching/training skills. They should also acquire the skills necessary to become a Clinical Supervisor.

9.5 The regional teaching programme could include the following:

Case presentations
Topic teaching
Journal club

Fluorescein conference
Ocular pathology
Audit
Invited speakers (ophthalmologists and non-ophthalmologists)

The programme organiser(s) should consider the RCOphth OST curriculum during planning and reflect its content in delivery.

The programme might include symposia, update sessions, surgical masterclasses, managerial and leadership workshops and regional speciality interest meetings. Trainees, particularly senior colleagues, should be encouraged to contribute to curriculum delivery.

Combined teaching with other specialities such as neurosurgery, neurology, endocrinology, oncology and radiology are valuable. All OLT trainees should be encouraged to attend management courses, either coordinated by their regional health education organisation or by the training programme. It is useful for OLT trainees to understand the workings of Multidisciplinary Team (MDT) partners such as Eye Clinic Liaison Officers and Visual Impairment Support Teachers.

9.6 Consultants, from both the teaching hospital and surrounding units, should attend and participate in the teaching programme whenever possible, as part of their Continuing Professional Development (CPD) programme. It is appreciated that consultant job plans now commonly include service commitments on the regional teaching half day, which will make attendance difficult.

9.7 OLT *t*rainees should be actively involved in clinical audit. At least one closed loop audit should be completed during training. OLT trainees should audit their own specialty interest outcomes in addition to the personal cataract audit (see paragraph 7.14 above). OLT trainees should be involved in Quality Improvement (QI) projects and should have completed at least one project within training. They should be able to access training in QI methodology.

9.8 Evidence of attendance at teaching sessions, feedback from delivered sessions and audits should be presented in the Portfolio.

9.9 Research
All OLT trainees are expected to undertake at least one fully protected Research/Study/Teaching/Audit (RSTA) session a week. OLT trainees will be expected to demonstrate how they have used this time in their Portfolio (assessed by their Educational Supervisor and the local ARCP panel).

Research is an important element of the training programme. There may be more opportunities in teaching units than in district general hospitals to perform National Institute for Health Research-approved research. Each teaching unit or rotation will have a local research network coordinator who is the best person to contact for advice. OLT trainees should be able to access training in research methodology.

The College continues to support and encourage trainees who wish to conduct research. All OLT trainees must undertake research as part of their training. Should they wish to undertake full time research they should consider this in relation to the application time for CESR.

9.10 Study leave should be available to OLT trainees as to OST trainees. They should be supported to attend meetings that are suitable learning opportunities for them. They should be encouraged to submit and poster and oral presentations.

10. Generic Professional Capabilities (GPCs)

10.1 All OLT trainees should pay attention to demonstrating that they have acquired all the generic professional capabilities required to become an independent practitioner and obtain CCT. These are mandated by the new curriculum from the GMC.

OLT trainees will not be signed off as competent in clinical skills if they have not mastered the necessary professional skills, such as good communication, required for an assessment. Evidence of acquisition of these skills should be included in the Portfolio and assigned to the relevant curriculum outcomes.

10.2 There are 9 domains:

- professional values and behaviours
- professional skills
- professional knowledge
- capabilities in health promotion and illness prevention
- capabilities in leadership and team working
- capabilities in patient safety and quality improvement
- capabilities in safeguarding vulnerable groups
- capabilities in education and training
- capabilities in research and scholarship

11. Consultant Preparation

11.1 OLT *t*rainees are expected to undertake Consultant Preparation for at least the last six months of their programme. It is accepted that the in-depth subject of a specialty interest adds hugely to the OLT trainees' development and it is important for them to get the opportunity for a TSC, but this should be balanced with the time for Consultant Preparation. It is expected that the OLT trainee will return to programme to compete this aspect of their requirements. However, it may be acceptable for them to continue in an area of specialty interest as long as the requirements of Consultant Preparation are prioritised and specific attention is paid to this in their timetable.

11.2 The OLT trainee must have the following opportunities:

Refresh and maintain general ophthalmic skills including acute services provision; to be ready to be the senior opinion on-call.
Be given the opportunity to supervise more junior trainees in all these areas: on-call, in clinics and particularly in surgical practice.

If the OLT trainee has already undertaken cataract surgery supervision of a more junior trainee, they should be given the opportunity of supervising specialist surgery; if not, then cataract surgery supervision must take place in this time.
Be trained as a clinical supervisor, if not previously accredited, as this is a curriculum requirement.

Develop skills in running a service. It is acceptable for them to act up as a consultant for up to 3 months during this period. https://www.rcophth.ac.uk/training/ost-information/out-of-programme-training/ Otherwise they should take more responsibility in the unit and have the opportunities for management experience.

12. Facilities for training

12.1 Each training centre should have sufficient facilities and adequate patient throughput to provide appropriate experience in ophthalmic surgery and medicine. The training centre should be fully resourced and equipped as recommended in the Ophthalmic Services Guidance from the College.

12.2 Outpatient facilities

There should be a dedicated, fully equipped ophthalmic outpatient department.

Each OLT trainee, whatever the grade, should have a room in which to examine patients, or a separate examination area where the layout is based on a modular system. Every OLT trainee must have access to his/her own test type, slit lamp, direct and indirect ophthalmoscope, retinoscope and trial lenses and the necessary indirect lenses. There must be appropriate examination facilities for retinal diseases, such as a couch or reclining chair. There should be easy access to the consultant.

12.3 Teaching aids should be available wherever possible, such as side-arms or video cameras on slit lamps and lasers, and teaching mirrors or video cameras on indirect ophthalmoscopes.

12.4 Ancillary equipment that should be available should include: Portable slit lamp
Goldman tonometer and other portable tonometer
Fields equipment

Fundus camera / retinal angiography / OCT Argon laser
YAG laser
Auto-refractor

IOL Master or Lenstar
Keratometer and A-scan ultrasound for biometry
Focimeter
Orthoptic instruments such as prism bar, Hess chart/Lees screen Corneal pachymeter

12.5 In a teaching hospital, it would be expected that additional equipment would include:
B-scan ultrasound
Anterior segment camera

Electrophysiology equipment
Corneal topography / tomography
Advanced retinal imaging equipment e.g. HRT, OCT
Routine radiological investigations with access to CT and MRI scanning should be available.

There should be close liaison with other disciplines such as neurology, neurosurgery, plastic and faciomaxillary surgery, metabolic medicine, etc.

12.6 Theatre facilities
In most cases the theatre will be dedicated to ophthalmology, but in small units this may not be possible. The layout and instrumentation must be designed with training in mind. The equipment should include, as appropriate:
Operating microscope with teaching side arm and video camera and recorder Coaxial assistant's microscope
Phacoemulsifier
Automated anterior vitrectomy (even in units in which no vitreous surgery is undertaken, to deal with complications of cataract surgery)

12.7 Ward
Most eye surgery is now performed as a day case procedure. It is however expected that, except for paediatrics, beds will be available to ophthalmology emergency admissions.

There must be adequate examination facilities for OLT trainees' use in a ward side room, equipped with a slit-lamp, indirect ophthalmoscope, test type and trial lens set.

12.8 Electronic Patient Record
It is expected that most units will have or are in the process of considering implementation of EPR in most specialty interest areas, especially cataract and medical retina, as well as electronic systems to review ophthalmic investigations such as OCT and FFA images. This is important to facilitate audit and appraisal for OLT trainees.

12.9 Library
All OLT trainees should have access to a medical library, which is open outside weekday and daytime working hours. There should also be reference books and online resources available in the Eye Department that cover all the principal specialty interests.

12.10 A collection of ophthalmic journals should be available on the rotation such as: British Journal of Ophthalmology
Eye Journal
American Journal of Ophthalmology

Archives of Ophthalmology
Survey of Ophthalmology
Investigative Ophthalmology
This list should not be seen as proscriptive and, in large units, it is frequently supplemented by specialist journals.

There should be access to computer search / internet facilities. Electronic journal subscription may provide a satisfactory alternative to paper subscription.

12.11 Additional facilities
OLT trainees should have a room for study and should have access to a computer. A surgical skills simulation laboratory is an essential ancillary training resource. Appropriate

instrumentation and a microscope should be available, and OLT trainees encouraged to use the facility. The facility may be provided at unit or regional level.

13. Simulation for training

13.1 Simulation has become a key tool in the training of doctors and to maintain patients' safety and it has become essential part of many surgical training programmes. The main goal of simulation training is to have a competent surgeon who can provide a safe, quality, cost-effective, and efficient surgical service.

13.2 Simulation training in Ophthalmology can be broadly divided into six subgroups: Introduction to Phacemulsification Course ; OST1 Induction; Laser Simulation; Ocular (Intra / Extraocular) Surgery; Simulation Situational Awareness; Communication Skills

13.1 Introduction to Phacemulsification Course – it is mandatory for all UK ophthalmic specialist trainees to complete. at the state-of-the-art Skills Centre before undertaking intraocular surgery. This must also be undertaken by OLT trainees starting ophthalmology. Those commencing with equivalent ST1 and 2 competencies may be exempt.

13.2 ST1 Induction – the College has produced detailed guidance on the recommended induction for ophthalmology for those entering OST1. And should be the same for all OLT trainees in year 1. It is expected that OLT trainees will practice basic examination skills and that opportunities for practical sessions and particularly simulation will be included. This should include the sign off of basic competencies in simulation to facilitate the sign off in real life scenarios earlier in training. Practicing removal of a corneal foreign body or undertaking a corneal scrape can be performed in simulation. Introduction to the EyeSi simulator, cataract surgery in wet/dry labs, suturing practice and wound construction can be included.

The College also provide e-learning that OLT trainees can undertake once they take up their OST1 post up.

13.3 Laser Simulation – Laser Simulation courses can be held in any eye unit where there is a Laser Suite with all the different types of laser machines. All OLT trainees should be encouraged to practice on model eyes before performing the commonly performed laser procedures such as YAG laser capsulotomy, YAG laser peripheral iridotomy, Argon Laser treatment for retinal pathology, Selective Laser Trabeculoplasty and Cyclodiode laser treatment on patients.

13.4 Ocular Surgery Simulation – All LETBs/Deaneries have at least one EyeSi simulator with the Cataract module and all OLT trainees should have access to it.
The list of intra / extraocular surgical skills that can be simulated in a wet lab has been growing steadily as newer model eyes are becoming available in the market. All training units should have access to these model eyes and heads where OLT trainees can access basic surgical skills.

These surgical skills would also be appropriate for all ophthalmic surgeons. They would be of benefit particularly for those returning to work after time out of programme, a career break,

illness, parental leave, etc. Increasingly, dry and wet lab experience before commencing new surgical techniques is appropriate for all grades of surgeons.

13.5 Situational Awareness/immersive simulation – While some aspects of this will overlap with the communications skills and intraocular skills courses, hands-on simulation training on how to handle situations which happen rarely such as PC rupture is of immense importance so that the acute situation is handled appropriately for the best possible outcome to the patient. Some regions have already been running simulation training for PC rupture, which includes situational awareness, and may be used for the wider theatre team, for example, and these examples could be rolled out. It is envisaged that this area would be developed more in future as techniques for practicing immersive simulation that are more affordable and more practical are also developed in other medical specialties.

13.6 Communication Skills – The GMC has published the Generic Professional Capabilities Framework, which stresses the importance of good communication and interpersonal skills and dealing with complexity and uncertainty. This supports the OST curriculum outcomes. It is expected that every trainee should demonstrate evidence of these skills, whilst maintaining appropriate situational awareness, professional behaviour and judgement. Simulation is also important for practicing these skills as it can allow feedback and development in a supportive environment. This can be developed initially in a low-tech way with sharing scenarios and techniques for set up. Members of the College Lay Group have written scenarios to help set up a bank for all trainers to use.

14. Acute Services Training

The College website has guidance on supervision and training in Acute Services.

All OLT trainees should undergo training in managing Acute/Emergency Ophthalmology presentations with adequate support and supervision and be able to manage an acute ophthalmology on-call. However, it is important that OLT trainees are properly trained and supervised in Acute Services sessions and are supported by Advanced Nurse Practitioner Roles. OLT trainees should not be left to manage whole clinics of acute presentations without support and feedback.

Acute Services Training should be undertaken throughout the programme, demonstrating enhanced clinical decision making and responsibility in later training years. As OLT trainees become more senior they should be able to assist in teaching and training more junior trainees.

15. Quality assurance and inspection process for training programmes

15.1 Local health education offices undertake monitoring visits to quality assure educational environments. In England these no longer occur to a regular schedule, but in accordance with the HEE Quality Framework and are triggered through a risk-based approach. In comparison the Ophthalmology Local Training Programme will need to self-declare to the Royal College that they meet the criteria for the training pathway, treating OLT trainees in the same way as OST trainees, and uphold the standards set by the College. The College will not be visiting departments directly, however the Regional team network: Regional

educational Advisor (REA) and Regional CESR/OLT Lead may be able to provide feedback or advice.

15.2 In addition, it is expected that the employing Trust will have in place their own robust quality strategies, which will include information gathering in relation to Ophthalmology Local Training Programme,. These may include sources such as GMC surveys, locally collected feedback at Trust and programme level, trainee fora, minutes of STC meetings, monitoring of allegations of bullying and harassment or incidents involving trainees, annual specialty reports and local intelligence from Trust DMEs, Guardians and CESR Leads/Tutors.

15.3 The Regional Education Adviser has a very important role in acting for the College in helping local offices to provide high quality ophthalmic training. For more information on the role of the College Regional Education Adviser see the College website.

16. Recruitment

16.1 Recruitment to the Ophthalmology Local Training Programme for CESR is a local process. Advertisement of these posts will occur as per other Trust/Healthboard posts and appointment be with the local recruitment/Human Resources team. The interview panel should include the local OLT Lead/Tutor and other Educational or Clinical Supervisors.

16.2 It would be good practice to use a methodology similar to and/or including the assessments of OST trainees.

There should be an assessment of the candidate's portfolio, where application is for a stage higher than year 1 this should include the relevant ophthalmic competencies. Clinical questions can be included, for Year 1 trainees this may involve those with a more general medical background but more ophthalmological for later years. Critical appraisal and questions around audit and service show analytical skills and initiative. Communication skills are so important it is recommended that these are considered within the interview process.

16.3 Trusts will need to consider whether to offer a one year contract renewable, on completion of a local ARCP process and evidence of progression, or longer contracts. They will be mindful that employees' rights are different if on longer than 2 year contracts. Shorter contracts than a year are not suitable.

17. Flexible (less than full time) training

17.1 A OLT trainee wishing to train flexibly should discuss this with their employer.

17.2 The trainee should also discuss this with the OLT Lead/Tutor and the effect this will have on acquiring competencies for their CESR application. The requirements from the GMC are such that evidence is primarily from the last 5 years and must be seen that competencies are current and maintained. This may be difficult to achieve with a period of time spent as less than full time and should be carefully considered as to whether the programme/timetables can be altered to accommodate this and permit acquiring competencies.

18. OLT Trainees in difficulty

Any OLT trainee with difficulties identified by the Clinical and Educational Supervisors should be highlighted to the unit OLT Lead and remedial training identified and implemented in the same way as would be undertaken for an OST Trainee. To satisfy College standards there should be a willingness to engage with HR and potentially outside support to enable the OLT trainee to progress.

19. Preparing for Local ARCPs

18.1 The Local ARCP should be a mirror of the process for OST trainees. It is a review of all the evidence that the OLT trainee has collected over the preceding year to demonstrate their progress and achievements. It is an objective and rigorous process, so that the panel can assess that the OLT trainee may progress to the next stage of training. It is also an opportunity to flag up areas for development to ensure and set targets for the trainee. The panel reviews the evidence within the Portfolio and triangulates this with the Clinical and Educational Supervisor reports. It is up to the OLT trainee to ensure that their Portfolio is complete.

18.2 An Educational Supervisor should be allocated to each OLT trainee and meet with them at the beginning of each attachment, half way through and at the end. Progress should be reviewed against the curriculum and the annual requirements whilst in training, depending on the OLT trainee's stage to ensure that overall development in generic professional capabilities are progressing alongside the clinical and practical skills.

18.3 Preparation for the Local ARCP should start with the first meeting with the ES, setting the requirements for the year, and subsequent appraisals should ensure that the Portfolio is completed in a timely manner throughout the training year. The evidence that the panel will look at comes under the following headings:

Evidence	Guidance
Educational Supervisor Reports (ESR)	Two signed ESRs should be completed, one for each 6-month attachment. Ensure that all the boxes have been completed, and that the ES has included free-text comments.
Clinical Supervisor Reports (CSR)	Four signed CSRs should be completed as a minimum. There must be 2 for each 6-month attachment. However, if a OLT trainee spends clinical time regularly with additional supervisors, they should also complete a report. There should be free-text comments included rather than just tick boxes.
PDP/Appraisals	A PDP should be populated and assigned to the appropriate local ARCP. Any targets set at the previous ARCP should be included in the PDP. Further goals are discussed with the ES, and SMART objectives completed. Trainees should have collected evidence that they have completed the previous year's PDP goals or include comments on progress towards completing them.
Eye Logbook	The Eye Logbook summary must be included in the Portfolio, including the cataract surgery complication rate (which should also

	be documented in the ESR). Year 6-7 trainees should have evidence of supervising juniors (they need approximately 20 SJ before end of training) and managing the complications of cataract surgery such as vitreous loss. Year 6-7 trainees should also have completed an audit of 50 consecutive cataract operations with refractive outcomes. There should be a continuous audit of cataract surgery complications throughout training with the outcomes. Evidence of surgical simulation should be documented, e.g.: the Excel spreadsheet from the EyeSI simulator.

Research/Audit/Quality Improvement/ Publications /Teaching	Quality improvement projects or audit; publications and presentations should be submitted with evidence of the trainee's involvement. These should be included in the ESR. Some Schools use a scoring system to rate productivity in RSTA sessions. If used in the region this should also be used by the OLT trainee and should be included in or with the ESR. Attendance record at postgraduate teaching should be collected. Teaching and Training should be collected, including feedback.
WpBAs	All WpBAs included in the Portfolio for the trainee's 'Stage of Training' should be completed. For Years 4-7 there must be a proportionate completion of the cumulative requirements. Trainees can complete competences ahead, completing the WpBA for a later Stage of Training. The free-text boxes must be completed for the WpBA to be valid. There must be a majority of consultant assessors for the WpBAs. If another trainee is used as an assessor, then the assessor must be a minimum of 2 years senior to the trainee. There should be no clustering of WpBAs, which indicates lack of engagement in the educational process. Trainees should complete WpBAs throughout the year, preferably about one per fortnight.
MSF	There should be at least one MSF per year. The MSF takes time to organise and get signed off, so the trainee should initiate this at least three months before the ARCP.
CPD diary	This should be populated and up to date, with evidence of appropriate reflection on learning events. It is not enough for the trainee to state that they attended a conference. The diary should indicate what was learned, and how it will affect their practice.
Exams	The results from RCOphth should be included. For unsuccessful attempts, the College feedback should be included as a resource.
Significant events/ complaints	These should be summarised in the ESR, but there should be appropriate reflective evidence with lessons learnt, included in the

	Portfolio, or in the CPD diary. This may be in the form of a 'Case Review', 'Significant Events' or 'Complaints' or using a structured reflective template. http://www.aomrc.org.uk/statements/interim-guidance-on-reflective-practice/

20. Preparing for CESR

24.1 CESR is awarded by the GMC and confirms that a doctor is eligible for entry onto the specialist register. The Royal College of Ophthalmologists will be asked to review the evidence and make a recommendation to the GMC.

24.2 OLT *t*rainees should prepare well in advance for their submission, ensuring their whole portfolio is up to date with no outstanding requirements and triangulation of evidence where possible.

Fiona Spencer DM FRCS (Glas) FRCOphth FCOptom
Chair – Training Committee

June 2020