



The ROYAL COLLEGE of  
OPHTHALMOLOGISTS

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Postgraduate Medical Training

# Assessment Strategy

Programme of Assessment for OST Curriculum 2024

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## Contents

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<b>Section</b>	<b>page</b>
1 Executive Summary	3
2 Purpose of the Programme of Assessment	3
Ensuring Validity	4
3 How to use the Programme of Assessment	5
4 RCOphth Examinations	5
Part 1 FRCOphth	5
Refraction Certificate	5
Part 2 FRCOphth Written	6
Part 2 FRCOphth Oral	6
5 Assessment of Performance (AoP)	6
Entrustable Professional Activity (EPA)	6
Objective Assessment of Surgical and Technical Skills (OSATS)	8
Direct Observation of Procedural Skills – Biometry (DOPSBi)	8
Generic Skills Assessment Tool (GSAT)	8
Multi-Assessor Report (MAR)	9
Multi-Source Feedback (MSF)	9
Surgical logbook	10
Audit	10
6. Supervised Learning Events (SLEs)	10
Clinical Rating Scale (CRS)	10
Case-based Discussions (CbDs)	11
Direct Observation of Procedural Skills (DOPS)	11
7 Guidance for Annual Review of Competency Progression (ARCP)	12
Satisfactory completion of Level 1 training requirements	12
Satisfactory completion of Level 2 training requirements	13
Satisfactory completion of Level 3 training requirements	14
Satisfactory completion of Level 4 training requirements (CCT)	15
8 Feedback and Reflection	16
Giving feedback	16
What makes feedback more effective?	16
Feedback tools	17
Reflective practice	17
9 Ensuring Quality	17
10 Ensuring Equality, Diversity and Inclusion in Assessment	18

## 1 Executive Summary

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This Assessment Strategy contains the rationale for, and content of, the Programme of Assessment, which is defined by the GMC as “the integrated framework of exams, assessments in the workplace and judgment made about a learner during their approved programme of training”. This strategy will apply to all ophthalmologists in training due to start on, or transition to, OST Curriculum 2024.

This represents a move away from the previous programme of assessment, which employed many granular assessments of competencies, to one with fewer summative assessments. Entrustable Professional Activity (EPA) tools will be used to assess high-level, clinical Learning Outcomes in the Patient Management domain of the curriculum. A Generic Skills Assessment Tool (GSAT) will be used to assess the high-level, non-clinical Learning Outcomes in the remaining six domains. Named Clinical Supervisors (NCSs) and Educational Supervisors (ESs) will make a professional judgement as to whether the ophthalmologist in training has achieved each Learning Outcome, which will be based on the evidence provided and mapped to the outcomes.

Assessment tools that worked effectively in the previous programme have been adapted and retained. Feedback will be framed around the seven curriculum domains, which incorporate the GMC’s [Generic Professional Capabilities \(GPCs\) framework](#).

This document must be read in conjunction with the OST Curriculum 2024, which describes the scope of practice of an ophthalmologist completing the curriculum, as well as the level of performance expected at four advancement points. All assessments are mapped to the Learning Outcomes, which define such critical points: three during the training programme and one before obtaining the Certificate of Completion of Training (CCT). The supplementary syllabi provide the descriptors for the activities that will be assessed.

This document outlines the purpose of each assessment and the mechanisms by which their validity will be ensured. It also outlines the principles by which feedback should be provided and received.

## 2 Purpose of the Programme of Assessment

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The GMC defines the purpose of the Programme of Assessment as being “to robustly evidence, ensure and clearly communicate the expected levels of performance at critical progression points, and to demonstrate satisfactory completion of training as required by the approved curriculum”. The RCOphth’s aim is to provide a comprehensive Programme of Assessment that:

- Ensures that doctors in training have acquired the full range of knowledge, understanding, skills, attitudes and behaviours that are required of an ophthalmologist, including the generic professional capabilities that meet the requirements of Good Medical Practice (GMP).
- Provides robust evidence for decisions that are made about a doctor’s readiness to progress to the next stage of training, whilst supporting trainers and assessors so that they feel confident and empowered to make consistent, transparent and evidence-based decisions.

- Supports doctors in their learning by providing feedback at all stages and encouraging reflection.
- Identifies doctors in training who are struggling to achieve competence or are in difficulty, enabling appropriate, structured and targeted support.
- Reassures the public, employers and the regulatory body that safe decisions are made about a doctor's competence to perform in practice and thereby assures high quality care for patients.

The underpinning rationale to achieve these aims will reflect:

- Assessments that support both practical and theoretical models of assessment methodologies and include formative and summative elements.
- Assessment criteria that are clear and explicit, and an assessment process in which doctors in training can be confident.
- That all assessments will be carried out by assessors with the relevant skills, knowledge, training and support to do so effectively, making fair and consistent judgments.
- An engagement in reflective practice, actively encouraging independent and trainee-led learning.
- The promotion of equality, diversity and respect, ensuring that assessments are fair and equitable for all doctors in training.

Assessments take place throughout the training programme, providing continuous formative feedback and evidence of learning.

### **Ensuring Validity**

Validity and reliability of assessment methods are considered the two most important characteristics of a well-designed assessment process. Validity refers to the degree to which a method assesses what it claims or intends to assess. Reliability refers to the extent to which an assessment method or instrument measures consistently the performance of the learner.

Any programme of assessment must be supported by a comprehensive approach to ensure the validity and reliability of its constituent assessments. This is important in the development, implementation and ongoing review of the programme.

This Assessment Strategy has been developed to ensure that the assessment tools used are the most appropriate for their intended purpose. All new tools have been piloted and evaluated.

The Learning Outcomes to be assessed in are high level, making an integrated approach, with a range of methodologies and sufficient evidence, necessary to ensure reliability.

While Postgraduate Deaneries and local NHS England offices will be responsible for ensuring that the NCSs acting as supervisors are properly trained, they will also receive training and support via a planned training cascade utilising the established RCOphth Training the Trainers (TTT) programme and the Regional Education Teams. Training will be cascaded to ESs and NCSs through Training Programme Directors (TPDs) and College Tutors. A comprehensive Curriculum 2024 Handbook will articulate the approach and standards required for robust and fair assessments. In the pilot year of the curriculum introduction (2023-24), members of the RCOphth Training Committee (Heads of School and TPDs) will canvas and survey local assessors for feedback on the guidance and training given.

The Programme of Assessment will be reviewed and continually improved in subsequent years by the RCOphth Curriculum Sub-committee, with input from all stakeholders. Future curricular changes will trigger adjustments of all associated assessment tools.

The RCOphth will use its established Annual Review of Competency Progression (ARCP) External Adviser programme, which reports to its Training Committee, to have oversight on the decisions that are made about assessments and advancement. This will ensure the application of published standards for assessment in each Postgraduate Deanery and NHS England local office, as well as provide shared learning opportunities to refine the Programme of Assessment or the guidance around it.

### 3 How to use the Programme of Assessment

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The Programme of Assessment must be read in conjunction with the OST Curriculum 2024, its supplementary syllabi and the Curriculum 2024 Handbook. It describes the range of assessment methods used to assess capability in relation to the curriculum Learning Outcomes.

A separate Assessment Blueprint summarises the assessment requirements at each critical advancement point.

The type of assessment must be appropriate to the purpose. Some assessment tools are formative and ensure that doctors in training receive immediate feedback. They can be employed to identify areas for development, guide learning, reassure about knowledge and skills, prompt reflection and nurture appropriate attitudinal responses. They may also be collated and used to give a rounded view of a doctor's performance, contributing to summative judgements.

Other assessment tools are summative and used to make an overall judgment regarding competence, fitness to practice or qualification for advancement to higher levels of responsibility.

Central to the Programme of Assessment is the professional judgement by trainers in ensuring learners have met the Learning Outcomes and expected levels of performance set out in the curriculum. Assessors will make accountable, professional judgements.

### 4 RCOphth Examinations

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#### Part 1 FRCOphth

This examination must be passed **by the end of Level 1** of ophthalmic specialist training. It comprises theoretical papers based on the curriculum Learning Outcomes for the first two years of training. This includes basic sciences, theoretical optics and pathology. There are two 2-hour multiple choice question papers of 90 questions each, consisting of one best answer out of four options.

#### Refraction Certificate

The Part 1 FRCOphth, which tests theoretical knowledge, must be passed before taking the practical Refraction Certificate examination. The latter must be passed **by the end of Level 2**

of ophthalmic specialist training to test, at that level, the ability to refract before progressing to practice the acquired skill at Level 3.

### Part 2 FRCOphth Written

This exam may only be taken after having passed the Part 1 FRCOphth. It is the first component of the Part 2 examination, which is required **by the end of Level 3**. It comprises theoretical papers based on Level 1, 2 and 3 Learning Outcomes. There are two multiple choice question papers of 90 questions each, each consisting of one best answer out of four choices.

### Part 2 FRCOphth Oral

This exam may only be taken after having passed the Part 1 FRCOphth, the Refraction Certificate and the Part 2 FRCOphth Written component. Ophthalmologists in training must pass this examination to complete their FRCOphth, which is required **by the end of Level 3** of ophthalmic specialist training. It comprises a structured viva and an objective structured clinical examination (OSCE) based on Level 1, 2 and 3 Learning Outcomes.

## 5 Assessment of Performance (AoP)

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### Entrustable Professional Activity (EPA)

An Entrustable Professional Activity (EPA) is a unit of professional practice, defined as a “task or responsibility that a trainee is entrusted to perform unsupervised once they have attained sufficient competence in the activity” (ten Cate, 2013). An EPA requires simultaneous proficiency in multiple competencies and is a more suitable focus for assessment than separate competencies.

EPAs have been developed to map to all Learning Outcomes for each level of the OST Curriculum 2024 in the Patient Management domain. The Learning Outcomes of a given level in this domain can therefore be assessed in an integrated way in the context of meaningful clinical activity to make summative entrustment decisions for that level. The EPAs can be employed to inform decisions taken by the ARCP panel relating to training progression at critical advancement points.

The EPAs will be completed by the NCS and will replace the Clinical Supervisor Report (CSR) from the previous curriculum. It is recommended that an ophthalmologist in training will have one EPA every six months for Level 1 and 2; one for every SIA in Level 3 (minimum of one every 6 months); two out of twelve for Level 4 SIA (minimum of one every six months).

The EPA form includes a self-assessment to be completed by the ophthalmologist in training at the start of the process. This is designed to facilitate professional insight on completion of the assessment, and reflection on the formative feedback.

While longitudinal, periodic observation of performance is a key aspect on which to base the entrustment decision, NCSs must consider some mandatory pieces of evidence. This varies between each EPA and may include Clinical Rating Scales (CRSs), Case-based Discussions (CbDs), Objective Assessment of Surgical and Technical Skills (OSATS), Direct Observation Practical Skills (DOPS) and Multi-Assessor Reports (MARs). Nested EPAs are employed at Level 4, with the EPA for ‘Managing an Operating list’ – which has been retained from the current programme of assessment – being considered as part of the summative evidence used to make an entrustment decision about the Learning Outcomes. Elective evidence may also be included (e.g. further OSATS and DOPS) and such inclusions are mandatory wherever the

assessor has indicated that the ophthalmologist in training is not achieving the expected level. This ensures focused, formative feedback is given.

After reviewing and considering the evidence, assessors make and document a decision about the degree of independence a doctor in training can safely work with in relation to the relevant Learning Outcomes. The degree of entrustment is described as below:

- Observing
- Needs Direct Supervision
- Needs Indirect Supervision
- Competent to Level

Longitudinal development of the doctor in training is captured: a) as they move up through the entrustment descriptors within the level at which they are working and b) as they reach competence for the Learning Outcomes of a level and move through the advancement point.

Feedback is given for each piece of evidence. As well as a confirmation statement (Yes or No) about whether the evidence presented confirms entrustment to practice independently in the area under consideration, a narrative to support that decision and suggested areas for further development is required.

Furthermore, where the entrustment level is below competent, a narrative is required to include the evidence that is needed to increase the entrustment recommendation.

The form concludes with further space for feedback about what was particularly good and actions that have been agreed between the supervisor and the doctor in training for further development.

As well as recording within the tool, feedback must be given directly to the doctor in training, and the assessment therefore requires a specific feedback meeting.

The EPAs will be used by ESs, along with the other evidence signposted in the Assessment Blueprint, to make a recommendation at the end of the training year and inform the ARCP process.

### *Ensuring validity*

Regarding content validity, the EPAs for this Programme of Assessment have been developed through an iterative process, and piloted and supported by trainers and doctors in training. The fact that the EPAs map directly to the Learning Outcomes in the Patient Management domain means they align completely to the curricular requirements of an ophthalmologist working at the level being assessed.

Explicit criteria enhance both the validity and reliability of the assessment process. The high-level Learning Outcomes included in the EPA tool will link directly to the relevant descriptors once in electronic format. This means ophthalmologists in training and supervisors will be able to easily assure themselves of the competencies that must be included in their assessment.

HPAC (2016:44) suggests entrustment formats may have advantages over other summative assessment formats in terms of authenticity and rigour, as the assessor's judgement is more closely aligned to their own duties in this context to uphold standards. This gives some assurance about the conduct of assessors.

The EPA format encourages reflection on the evidence used to reach the judgement, and this is mandated wherever the doctor in training is judged not to be attaining the expected standards, increasing transparency of the decision making.

The EPA includes evidence from MARs, which introduces multiple judgments to this single assessment as well as an opportunity of incongruence and potential unfairness to be noticed and remediated.

Clear guidance regarding the approach and standards for the EPAs will be articulated in the Curriculum 2024 Handbook.

### **Objective Assessment of Surgical and Technical Skills (OSATS)**

This assessment is being retained from the current programme of assessment, where it has been utilised for several years and found to be useful and valid. It is used to assess ocular surgery and can be applied at any level of training and to any procedure. Descriptors are given to describe ‘very good trainee’ and ‘poor trainee’.

For this iteration, the four-point rating scale ‘Poor, fair, good and very good’ previously used for the criteria that make up the assessment has been replaced with ‘Major concerns, Minor concerns, Meets expectations’. Doctors in training, trainers and external assessors taking part in the consultation process had fed back extensively regarding the perceived unreliability associated with the term ‘fair’, which many saw as having a wide range of interpretation.

An overall assessment is then made as to whether the trainee meets or does not meet expectations.

Formative feedback is captured in free-text boxes around aspects of the assessment that were particularly good, suggestions for development and an agreed action plan.

Some OSATS are mandatory in some EPAs and are embedded in those assessment tools; in addition, doctors in training are strongly encouraged to use OSATS regularly in a formative manner to collect high quality recorded feedback.

### **Direct Observation of Procedural Skills – Biometry (DOPSBi)**

This single DOPS assessment tool has been retained to assess biometry skills. This procedure requires a high degree of accuracy and is essential to achieve the best refractive results after cataract surgery. Failure to do so could result in patient morbidity following this most common of procedures. The summative element has proved valid and helpful in the previous programme of assessment.

For this iteration, the four-point rating scale ‘Poor, fair, good and very good’ previously used for the criteria that make up the assessment has been replaced with ‘Major concerns, Minor concerns, Meets expectations’.

An overall assessment is then made as to whether the trainee meets or does not meet expectations.

Formative feedback is captured in free-text boxes around aspects of the assessment that were particularly good, suggestions for development and an agreed action plan.

### **Generic Skills Assessment Tool (GSAT)**

The assessment of progression against the Learning Outcomes of the non-clinical domains requires a global professional judgement of a range of different skills and behaviours to make decisions about a doctor’s suitability to take on specific responsibilities and advance to the next level of the training programme, and eventually to consultant practice at CCT. Whilst the

Learning Outcome statements in the Patient Management domain describe activities that meet the criteria for consideration of entrustment, those in the other six domains are competencies rather than activities and are not suitable for EPAs.

As an alternative tool for these domains, to capture and document a global summative judgment, the RCOphth have adopted and adapted the Plastic Surgery Curriculum Multi Consultant Report. This followed a short iterative process involving doctors in training and trainers who are members of the RCOphth Curriculum Sub-committee.

The doctor in training will self-assess and enter a narrative to describe the evidence they are presenting, and practice that has been observed by the assessor to evidence competence against the relevant Learning Outcome. The assessor will then review and assess the evidence to make a summative, global statement as to whether, based on their observations and the evidence presented, they consider that the doctor in training has achieved the competencies required to complete the given Level in the six non-clinical, generic domains. The formative feedback will highlight areas of excellence and guide further development.

Two assessments should be undertaken against each curricular domain in any training year. One at the mid-point and one towards the end of the year, in advance of the ARCP.

Different assessors might be selected for the different curricular domains, although often a single supervisor will be able to complete several. The assessor may be involved with an ophthalmologist in training in one of several capacities, for example as ES, CS or academic/research supervisor. The GSAT must be signed off by the trainee's ES and will be used by the ES to make a recommendation at the end of the training year and inform the ARCP process. As with other tools, wide discrepancy between the two assessments will allow identification of over or under confidence and support further trainee reflection for insight.

### **Multi-Assessor Report (MAR)**

This summative assessment tool has been directly adapted from the JRCTB Multiple Consultant Report. It has been altered to 'multiple assessor' to reflect the multi-professional working environment of ophthalmology and the value of capturing the opinions of colleagues such as orthoptists, optometrists, advanced clinical practitioners and senior technicians, and nursing staff. The form is designed to capture the opinions of senior colleagues who have supervised the doctor in training and are able to comment on various important aspects of clinical performance.

The form is additional to the Multi-Source Feedback (MSF), as it is intended to focus specifically on clinical performance. Assessors rate the doctor in training on a range of criteria using the scale 'Major concerns, Minor concerns and Meets expectations'. The responses contribute to the EPA and a list of appropriate respondents is agreed with the NCS. In most Special Interest Areas (SIAs) two-four respondents per 6-month post should be obtained. The ES will also view these assessments and reflect them in their ESR.

### **Multi-Source Feedback (MSF)**

The MSF is a tool that has been used for several years in the current programme of assessment. It assesses professional competence within a team working environment with assessments of the doctor's performance from a range of peers and colleagues, covering different professions, grades and environments (e.g. out-patients, theatre, administration). The doctor in training selects their assessors and this list is approved by the ES before the process is carried out electronically in an anonymised fashion. Feedback is provided in the form of a table providing collated scores and anonymised written comments. This is released

first to the ES, who should meet with the doctor in training to discuss the feedback on their performance. As well as providing feedback for reflection, the MSF enables any serious concerns to be highlighted to the ES in confidence, allowing appropriate action to be taken.

The ES will consider this evidence in writing their ESR and making a recommendation to the ARCP panel.

### **Surgical logbook**

The surgical logbook allows the doctor's competence as assessed by the OSATS, DOPS and EPAs to be placed in the context of experience. Although not a formal assessment, ophthalmologists in training are required to keep a log of all operative procedures in which they have been involved, including the level of supervision (A-Assisting, PS-Performed supervised, P-Performed independently, SJ-Supervising a junior). The logbook demonstrates the breadth of experience, particularly essential for the assessment of Level 4 Learning Outcomes.

### **Audit**

Ophthalmologists in training are required to keep and present a continuous complications audit of their cataract surgery. This allows reflection and developmental planning with their CSs and ESs. Benchmarking against peer norms enables outliers to be highlighted and early appropriate action to be taken in the interest of patient safety.

As doctors approach the end of training, they are required to present audits of outcomes of their surgical procedures. Accepted national or international standards are used as benchmarks and this information is an important consideration for an ARCP panel in deciding that a doctor has reached the standard of competency required for CCT.

## **6. Supervised Learning Events (SLEs)**

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A Supervised Learning Event (SLE) is an interaction between a doctor in training and a trainer which leads to immediate feedback and reflective learning. They are designed to help doctors in training develop and improve their clinical and professional practice, and to set targets for future achievements.

Workplace-based assessments from the previous programme of assessment have been adapted to include both summative elements and a formative narrative.

There is no minimum number of SLEs and quality will be of more value than quantity. A useful SLE will stretch the doctor in training, act as a stimulus and mechanism for reflection, uncover learning needs and provide an opportunity for them to receive developmental feedback.

### **Clinical Rating Scale (CRS)**

These are tools retained from the existing programme of assessment. They were initially adapted from the mini-CEX assessments used in Foundation Training. They are used to assess clinical skill competencies, principally around ophthalmic examination and use of equipment, skills few doctors have achieved prior to OST1. There are fourteen specific forms for different skills. Their purpose is to provide feedback on skills essential to providing good clinical care. The forms provide descriptors of 'very good trainee' and 'poor trainee'.

For this iteration, the four-point rating scale 'Poor, fair, good and very good' previously used for the criteria that make up the assessment has been replaced with 'Major concerns, Minor concerns, Meets expectations'.

Formative feedback is captured in two free-text boxes around aspects of the assessment that were particularly good, suggestions for development and an agreed action plan.

### **Case-based Discussions (CbDs)**

These are tools retained from the existing programme of assessment. The assessment covers a doctor's clinical judgement, decision making skills, case-note writing and clinical management. This is a formative assessment, and cases should be chosen that have created challenge, doubt or difficulty in order to maximise the learning opportunity. Discussion should be structured and in-depth. It should allow the assessor to explore how the doctor in training compiles, prioritises and applies knowledge. Discussion can be extended to other scenarios or situations, for example to encompass ethical frameworks of practice.

Case-based discussions can take place during or at the end of a clinical session such as an out-patient clinic, focussing on a patient the doctor in training has had a significant role in managing. They could also reflect a case presentation a doctor in training has made at a post-graduate meeting or where cases are discussed as part of one-to-one or small group teaching.

For this iteration, the four-point rating scale 'Poor, fair, good and very good' previously used for the criteria that make up the assessment has been replaced with 'Major concerns, Minor concerns, Meets expectations'.

An overall assessment of the specific case-based discussion is then made as to whether the trainee meets or does not meet expectations.

Formative feedback is captured in free-text boxes around aspects of the assessment that were particularly good, suggestions for development and an agreed action plan.

### **Direct Observation of Procedural Skills (DOPS)**

This tool has been adapted from the previous summative tool. It is used to assess procedural skills and gain formative feedback.

For this iteration, the four-point rating scale 'Poor, fair, good and very good' previously used for the criteria that make up the assessment has been replaced with 'Major concerns, Minor concerns, Meets expectations'.

An overall assessment is then made as to whether the trainee meets or does not meet expectations.

Formative feedback is captured in two free-text boxes around aspects of the assessment that were particularly good, suggestions for development and an agreed action plan.

### *Ensuring validity*

Workplace-based assessments have been in routine practice for several years and are an embedded part of assessment strategy across medical specialties, reflecting their value to day-to-day supervision for both doctor in training and trainers. There is, however, limited evidence supporting their validity and reliability, which is reflective of their heterogeneous nature, difficulty in identifying measurable behavioural change and a diverse population of doctors in training and trainers employing them.

This programme of assessment employs the principal that a range of assessment tools is preferable to give a rounded view of a doctor in training across many domains.

The RCOphth will continue to evaluate the performance of these assessment tools and refine the guidance to use them as indicated.

## 7 Guidance for Annual Review of Competency Progression (ARCP)

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The ARCP is a formal Statutory Education Body (SEB) process overseen on their behalf by a TPD. It scrutinises the doctor's suitability to progress through the training programme and it is incumbent on the doctor in training to provide evidence in their portfolio on which the panel can make this decision. Throughout training there should be engagement with the GMC's GMP framework and the learning process (curriculum, formative and summative assessment) by regular participation in SLEs and AoPs. The ePortfolio is utilised to demonstrate that the requirements of the GMC-approved curriculum and associated assessment system have been met.

Examples of evidence include:

- Educational and clinical supervision – documentation of meetings and outcomes
- Regular participation in EPAs, SLEs and AoPs
- Examination outcomes
- Professional Development Plan (PDP)
- Reflective entries
- Surgical logbook
- Record of training and teaching events
- Teaching resources
- Audits
- Clinical governance/quality improvement activities
- Presentations/research/publications
- Evidence of Continual Professional Development (CPD) and educational meetings attended

The ES should utilise much of this evidence when completing the Educational Supervisor Report (ESR) as this will be used to inform the ARCP panel.

The ARCP panel makes the final summative decision determining whether the doctor in training is making the appropriate progress and can move to the next stage of training, or is awarded a CCT.

### **Satisfactory completion of Level 1 training requirements**

Assessments supporting the Level 1 Learning Outcomes focus on acquiring the knowledge base required to be a safe and effective ophthalmologist. An ophthalmologist working at Level 1 will be able to perform a patient assessment and basic investigation independently. They will be able to identify, describe and interpret clinical findings. They will be able to arrive at differential diagnoses, using their basic clinical science knowledge. They will be able to suggest management plans for low complexity patients. They will work effectively with the multi-professional team.

Doctors in training must demonstrate they have achieved the Level 1 Learning Outcomes through:

- Up to date ePortfolio
- One ESR every 6 months
- Part 1 FRCOphth examination
- One EPA from each 6-month post
- CRS assessments (CRS1-10, CRSGon)
- CbDs
- OSATS1 for Cataract Surgery and Lid Surgery
- Surgical logbook with details of A/PS/P procedures
- MAR(s) as requested by NCS
- Satisfactory evidence, using the appropriate assessment tool, to demonstrate:
  - Operating microscope
  - Removal of sutures
  - Corneal scrape
  - Use of the exophthalmometer
  - Assessment of lacrimal function
  - Punctal plug insertion
  - Interpretation of automated visual fields
- One MSF for each 12-month training period
- Cataract complications audit (from each 12-month training period)
- GSAT (one from each 6-month post) for each non-clinical curriculum domain
- Form R for each 12-month training period (SOAR declaration in Scotland)

### **Satisfactory completion of Level 2 training requirements**

An ophthalmologist working at Level 2 will be able to independently manage low complexity patients at an appropriate work rate employing the most appropriate clinical examination and investigation modalities. They will refine differential diagnoses and management plans by application of their clinical knowledge. They will be aware of public health issues relevant to ophthalmology.

Doctors in training must demonstrate they have achieved the Level 2 Learning Outcomes through:

- Up to date ePortfolio
- One ESR every 6 months
- Refraction Certificate examination
- One EPA from each 6-month post
- CRS assessments (CRS1, CRS10d, CRSRet)
- CbDs
- OSATS1 for Cataract Surgery, Lid Surgery and other transferable microsurgical skills
- Surgical logbook with details of A/PS/P procedures
- MAR(s) as requested by NCS
- Satisfactory evidence, using the appropriate assessment tool, to demonstrate:
  - Lateral canthotomy
  - Lateral cantholysis
  - Interpret biometry
  - Use of a pachymeter
  - Insertion of a bandage contact lens
  - Removal of corneal foreign body

- Laser to lens capsule
- Removal of ocular surface sutures
- Laser for raised intraocular pressure (IOP)
- Laser retinopexy
- Interpret orthoptic assessment
- Interpret fundus fluorescein angiography (FFA)
- One MSF for each 12-month training period
- Cataract complications audit (from each 12-month training period)
- GSAT (one from each 6-month post) for each non-clinical domain
- Form R for each 12-month training period (SOAR declaration in Scotland)

### **Satisfactory completion of Level 3 training requirements**

An ophthalmologist working at Level 3 will be able to independently assess and manage moderate complexity patients demonstrating an understanding of appropriate procedures and selecting the most appropriate treatment. They will work at the level expected of a consultant general ophthalmologist, i.e. not a specialist in the area. They will recognise when specialist expertise is required and refer appropriately. They will independently perform low complexity procedures relevant to the specialty.

Doctors in training must demonstrate they have achieved the Level 3 Learning Outcomes through:

- Up to date ePortfolio
- One ESR every 6 months
- Part 2 FRCOphth examination
- One EPA Level 3 for each of the Level 3 SIAs (minimum of one every 6 months)
- CRS assessment (CRS1)
- DOPSBi assessment
- CbDs
- OSATS1 for Cataract Surgery, Lid Surgery and other transferable microsurgical skills, as appropriate to each SIA
- Surgical logbook with details of A/PS/P procedures
- MAR(s) as requested by NCS
- Satisfactory evidence, using the appropriate tool, to demonstrate:
  - Anterior chamber paracentesis
  - Anterior orbital biopsy
  - Aqueous and vitreous sampling
  - Assessment of lacrimal function
  - Botulinum toxin injection
  - Corneal gluing
  - Corneal trauma repair
  - Corneal graft suture removal
  - Examination for suspected non-accidental injury (NAI)
  - External dacryocystorhinostomy
  - Eyelid laceration repair
  - Eyelid lesion biopsy
  - Indirect laser to the retina
  - Indirect ophthalmoscopy with indentation (screening of retinopathy of prematurity)

- Initial management of orbital emergencies
  - Interpretation and use of indocyanine green angiography (IGA) and FFA, optical coherence tomography (OCT), autofluorescence (AF) and electrophysiology
  - Interpretation of electrophysiology
  - Interpretation of orthoptic examination
  - Interpretation of scan ultrasound
  - Laser for IOP, including laser iridotomy (YAG PI) and selective laser trabeculoplasty (SLT)
  - Lateral canthotomy and cantholysis
  - Local anaesthesia
  - Nasal endoscopy
  - Ocular surface protection
  - Periocular and intraocular drug delivery
  - Referral for genetic counselling
  - Refraction and glasses prescription
  - Retinal laser treatment
  - Sub-tenon's injection
  - Surgical management of oculoplastic adnexal and lacrimal conditions
  - Tarsorrhaphy
  - Ultrasound of the vitreous cavity, retina and choroid
  - Use of neuroimaging
  - Vitreous biopsy
- One MSF for each 12-month training period
  - Cataract complications audit (from each 12-month training period)
  - GSAT (one from each 6-month post) for each non-Patient Management domain
  - Form R for each 12-month training period (SOAR declaration in Scotland)

### **Satisfactory completion of Level 4 training requirements (CCT)**

An ophthalmologist working at Level 4 will demonstrate the advanced clinical management and surgical skills expected of a consultant with a special interest in this area. They will be able to manage the complexity and uncertainty of the SIA. They will be an effective teacher and trainer.

Doctors in training must demonstrate they have achieved the Level 4 Learning Outcomes through:

- Up to date ePortfolio
- One ESR every 6 months
- Two EPAs out of twelve (minimum of one every 6 months)
- EPA Level 4 Operating List for each surgically based SIA (Oculoplastics, Cornea, Cataract Surgery, Glaucoma, Vitreoretinal Surgery, Ocular Motility and Paediatric Ophthalmology)
- CRS assessment (CRS1)
- CbDs
- OSATS1 for microsurgical skills where a surgically based SIA is undertaken (Oculoplastics, Cornea, Cataract Surgery, Glaucoma, Vitreoretinal Surgery, Ocular Motility and Paediatric Ophthalmology)
- Satisfactory DOPS/OSATS or other evidence (e.g. managing an operating list) to demonstrate competence in the areas described in the EPA L4 of the chosen SIA.

- A logbook indicating the described breadth of surgical experience (see Patient Management Level 4 syllabi)
- A logbook indicating supervision of juniors (up to Level 3) in the chosen SIA (Oculoplastics, Cornea, Cataract Surgery, Glaucoma, Vitreoretinal Surgery, Ocular Motility and Paediatric Ophthalmology) and supervision of juniors (up to Level 4) in Cataract Surgery (only where Cornea, Glaucoma and Vitreoretinal Surgery have been chosen as Level 4 SIAs)
- MAR(s) as requested by NCS
- One MSF for each 12-month training period
- Cataract complications audit (from each 12-month training period where Cataract Level 4 SIA is undertaken)
- Audit of surgical outcomes for each surgically based SIA undertaken (Oculoplastics, Cornea, Cataract Surgery, Glaucoma, Vitreoretinal Surgery, Ocular Motility and Paediatric Ophthalmology)
- GSAT (one from each 6-month post) for each non-clinical Management domain
- Form R for each 12-month training period (SOAR declaration in Scotland)

## 8 Feedback and Reflection

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Reflection and feedback are an integral component to all assessments, and they should therefore take place regularly throughout each year of the training programme. Every clinical encounter can provide a unique opportunity for reflection and feedback and this process should occur frequently. Feedback should be of high quality and should include an action plan for future development. Reflection and feedback should take place as soon as possible after an event to maximise benefit. Both doctors in training and trainers should recognise and respect cultural differences when giving and receiving feedback.

### Giving feedback

Feedback is sometimes seen as merely providing a commentary on what the doctor in training has achieved, or what corrections need to be made. When performed well, feedback:

- Improves the doctor's awareness of their strengths and areas for development.
- Boosts the doctor's confidence, self-esteem and motivation, thereby leading to greater progress.
- Can be used for developmental activity to develop generic skills and a greater dialogue between the doctor in training and the assessor/supervisor.

To provide high-quality feedback the assessor/supervisor should devote adequate professional time.

### What makes feedback more effective?

Effective feedback has the following characteristics:

- Feedback is timely and provided as near as possible to the activity or assessment.
- Feedback must be focussed on the behaviour / capability and not on the person, ensuring that the Learning Outcome achievement is the primary focus.
- Feedback must be understandable and useful to the doctor in training.
- Feedback must be constructive. It must also consider how future developments and assessments can be supported, e.g. where does this fit with generic skills?

- Feedback should be encouraging and supportive, building on strengths but also identifying areas for development and supporting the doctor in training to produce clear action plans to address these.
- Feedback supports the doctor in training in becoming self-aware and forming their own judgements about their own performance and level of work.

### Feedback tools

AoPs and SLEs – each assessment tool included in this programme of assessment includes free-text boxes to document the narrative of the feedback given. This is divided into sections to include the acknowledgment of what was particularly good, identification of areas for development and an agreed plan to address the identified developmental needs.

MSF – this is a method used to assess common skills including behaviours, team working and communication skills. It is described in more detail further above.

### Reflective practice

Reflective practice is strongly encouraged and is the underpinning concept of the whole curriculum. Identifying the many approaches and opportunities to learn from experiences will require ophthalmologists in training to consider the impact of actions and the outcomes. Learning from experiences, both positive and negative, is a powerful learning tool.

## 9 Ensuring Quality

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A robust quality assurance and improvement framework is required to support an effective assessment strategy. The framework to support this programme of assessment will comprise several quality improvement tools and processes that impact on the overarching aspects of assessment.

**Effective recruitment mechanisms.** It is important that the right person is recruited into the ophthalmology programme and that doctors in training are not set up to fail before they have begun. The RCOphth recruitment process includes testing of aptitude and attributes along with any existing skills and knowledge specific to ophthalmology.

**Support for induction periods and review of induction.** The RCOphth provides guidance through online workshops and resources.

**Gathering and responding to trainee feedback.** Analysis of the GMC National Trainee Survey (NTS), as well as other surveys carried out directly by the RCOphth and / or its committees, will be key to identifying both concerns and good practice.

**Quality assurance of examinations.** This takes a variety of forms during the development, delivery, standard setting and review stages.

**Quality of assessors and supervisors.** This is supported by a well-established RCOphth Training the Trainers (TTT) programme.

**Monitoring and support for ARCP.** There is an externality process to ensure that the Gold Guide requirements are met across all Postgraduate Deaneries and NHS England local offices. Improvement aspirations include additional training and standardisation activities.

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Along with these mechanisms, there will be scheduled review points for the evaluation of the effectiveness and impact of this strategy. By applying the framework processes outlined above, the RCOphth will ensure that assessment is monitored and reviewed in a structured, planned and risk-based manner.

## 10 Ensuring Equality, Diversity and Inclusion in Assessment

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The RCOphth has considered any actual or potential adverse effects of implementation on those with protected characteristics (as defined in the Equality Act, 2010), including consideration of any likely effect on Less Than Full Time (LTFT) doctors in training. The RCOphth seeks to address issues of equality, diversity, inclusion and fairness in a range of ways, including:

- Examination and assessment content authored, implemented and reviewed by a diverse range of individuals. Equality and diversity data are gathered regularly from clinicians involved in the work of RCOphth committees with responsibility for examinations and assessment.
- Training for examiners and assessors includes consideration of potential adverse effects and how to ensure these are removed or mitigated when designing, authoring and administering examinations and assessments.
- Feedback is gathered from candidates following centrally administered examinations and assessments, and from the entire trainee cohort through the GMC NTS and RCOphth-led surveys.
- The RCOphth provides reasonable adjustments where evidence supporting a request exists, and use online examination and assessment systems which can be adjusted (e.g. text, font size and colour) where necessary to meet specific access needs.
- Outcomes for examinations and assessments are monitored to identify any trends that may pose a concern with regards to equality, diversity, inclusion or fairness.

Additional consideration regarding the implementation of this programme of assessment have been:

- A planned TTT programme, which will be cascaded through the regions for CSs and ESs, as well as the Curriculum 2024 Handbook will both draw attention to the barriers faced by specific groups of doctors.
- Including multiple judgements mapped to each set of Learning Outcomes will reduce the impact of disadvantage from interpersonal interactions and any local context that may put some groups of doctors in training at a disadvantage.
- The inclusion of clear, useable assessment criteria contributes to the openness and accountability of the whole process.
- The Curriculum 2024 Handbook will encourage ESs to explore the underlying reasons where there is incongruence between doctor in training self-assessment and trainer assessment.

The RCOphth is committed to the following actions to enhance its existing work in relation to ensuring equality, diversity, inclusion and fairness in assessment:

- To continue to review the nominations and appointment process to positions responsible for examinations and assessments, ensuring equality of opportunity and access.
- To increase the number of characteristics for which examination data is routinely reviewed.
- To implement a range of measures to improve the quality and quantity of the data set that the RCOphth holds related to protected characteristics for all those involved in training and assessment, enabling more comprehensive analysis and reporting.
- To develop improved training related to equality and diversity for all clinicians with a role in the examinations and assessments.
- To implement improvements to the review of the complaints log, ensuring that any issues and / or trends are identified promptly and acted on accordingly.