



Ophthalmic Specialist Training (OST)

Curriculum Handbook

August 2024

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| Version number | Date issued | Summary of changes |
|----------------|------------------|---|
| 1.0 | 1 August 2024 | |
| 1.1 | 8 September 2025 | Levels 3 and 4 requirements for: Cornea and Ocular Surface Disease; Glaucoma; Vitreoretinal Surgery; Neuro-ophthalmology; Ocular Motility |
| 1.2 | 2 December 2025 | Content review and removal of EPA examples |

1 Introduction

This document must be read in conjunction with the [OST Curriculum 2024](#), which describes the scope of practice of an ophthalmologist completing the curriculum – divided into domains of professional skills and knowledge – as well as the level of performance expected at advancement points. Assessments are mapped to high-level, overarching Learning Outcomes which define such critical points, three during training (Levels 1-3) and one (Level 4) before completion of the programme. Competence against all the Learning Outcomes at the four critical points will allow training advancement and lead to the Certificate of Completion of Training (CCT). A suite of supplementary syllabi provides detailed descriptors for all the activities that will be assessed during training.

This document:

- describes the overall approach to assessment.
- provides guidance on the usage of assessment tools.
- forms the basis of other guidance materials about assessment.

The [Assessment Blueprint](#) provides a handy summary of the assessment requirements. The [Matrix of Progression](#) outlines the annual requirements for progression for ARCP.

2 Programme of assessment purpose

A programme of assessment is defined as the integrated framework of exams, assessments in the workplace and judgment made during an approved programme of training.

A comprehensive programme of assessment:

- Ensures that training doctors acquire the full range of specialty knowledge, skills, attitudes and behaviours, as well as the generic professional capabilities that meet the requirements of Good Medical Practice (GMP).
- Provides robust evidence for decisions that are made about readiness to advance to the next stage of training.
- Supports doctors in their learning by providing feedback at all stages of their progression and encourages reflection.
- Identifies training doctors who are struggling to achieve competence or are in difficulty, enabling appropriate, structured and targeted support.
- Reassures stakeholders that safe decisions are made about competence to perform in practice.

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

An effective programme of assessment should:

- Include formative and summative tools that support both practical and theoretical models of assessment methodologies.
 - Have assessment criteria that are clear and explicit, and a process in which stakeholders have confidence.
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- Ensure that all assessments are carried out by assessors with the relevant skills, knowledge, training and support to make fair and consistent judgments.
- Actively encourage resident-led training, with full engagement in reflective practice.
- Promote equality, diversity and inclusion to ensure that assessments are fair and equitable.

Some assessments are formative, ensuring training doctors receive immediate feedback, and these can be employed to help to identify areas for development, guide learning, reassure about knowledge and skills, prompt reflection and nurture appropriate attitudinal responses. These assessments may also be collated and used to give a rounded view of a doctor's performance, contributing to summative judgements.

Other assessments are summative and utilised to make an overall judgment regarding competence, fitness to practice or qualification for progression to higher levels of responsibility.

Central to the programme of assessment is the professional, accountable judgement by trainers to ensure training doctors have met the Learning Outcomes and expected levels of performance set out in the curriculum.

3 Curriculum structure

OST Curriculum 2024 aims to prioritise resident-led evidence to show competence in all the domains that make up a consultant ophthalmologist's practice. Its key objectives are:

- To describe specific professional capabilities that incorporate the knowledge, skills and attitudes needed to practice ophthalmology at consultant level.
- To set the expected standards of knowledge and performance of professional skills for each stage of training through a series of high-level, overarching Learning Outcomes.
- To define the critical points at which the required standards must be achieved.

The significant differences between this and earlier curricula are:

- **Focus** – Resident doctors can choose what evidence to present to display competence. It is no longer required to evidence individual learning outcomes (previously, 180) and all numbers of procedures or Workplace-based Assessments (WpBAs) have been removed at the request of the GMC. Any such numbers given in this document are indicative only. It is for the trainer and the resident to determine if competence has been achieved with the evidence provided. Residents are expected to carry out a much greater degree of self-assessment, which is embedded within the summative assessment tools.
 - **Flexibility** – The curriculum has been designed to be more flexible as it is competency-based, as opposed to time-based. However, the constraints of a structured national training programme puts some limitations. An [Implementation Note](#) issued in 2025 clarifies key flexibility principles.
 - **Structure** – The curriculum is structured according to Levels and Domains of practice, with detailed descriptors underpinning high-level, overarching Learning Outcomes. The [Concise Curriculum Guide](#) outlines key features of the four-level structure.
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- **Domains of practice** – The curriculum is divided into seven Domains of clinical practice, which are framed around the Generic Professional Capabilities (GPCs). These Domains are areas against which residents must demonstrate capability through achievement of all Learning Outcomes before being awarded the CCT.
- **Levels** – Residents will advance from Level 1 to 4, completing all Learning Outcomes required for each Level before moving to the next. For the Patient Management domain:
 - Level 1 is management of low complexity patients.
 - Level 2 is management of low complexity patients at appropriate rate.
 - Level 3 is management of moderate complexity patients (of the type expected from a consultant not specialising in that area) and surgical treatment of low complexity patients.
 - Level 4 is management of uncertainty and complexity of specialty patients as expected of a consultant with a special interest in that area.
- **Special Interest Areas (SIAs)** – The curriculum has twelve SIAs in the Patient Management domain. Residents must complete all Learning Outcomes at Level 3 in all seven Domains, after which they will choose to specialise in two of the twelve Level 4 SIAs for the last 18 months of training (indicative times, ranges apply to some SIAs to make rotas manageable).
- **Learning Outcomes and descriptors** – The syllabi include descriptors designed to guide residents and trainers in what must be evidenced to demonstrate achievement of the Learning Outcomes. The curriculum has a dedicated [microsite](#) (embedded within the main RCOphth website) to learn about which Learning Outcomes are required per Level and to view accompanying descriptors. The ePortfolio has links to facilitate navigation to individual Learning Outcomes pages and lists of descriptors. The evidence is reviewed through the ePortfolio by Named Clinical Supervisors Educational Supervisors and panels taking part in the Annual Review of Competency Progression (ARCP) process.
- **Assessment tools** – Entrustable Professional Activity (EPA) tools are used to assess Learning Outcomes in the Patient Management domain, whereas a level-specific Generic Skills Assessment Tool (GSAT) is used to assess Learning Outcomes in the six generic Domains. EPA forms rely on the completion of at least one Multi-Assessor Report (MAR), the number of which is decided by the NCS at the outset. WpBA forms focus on formative narrative, as opposed to a granular assessment of competencies. Supervised Learning Events (SLEs) are designed to help residents to develop and improve their clinical and professional practice, and to set targets for future achievements. Repeated SLEs allow them to demonstrate skills development over time. The [Concise Curriculum Guide](#) outlines key features of the assessment tools.

Assessor role

Resident doctors may request any colleague to complete a WpBA if the latter has the skills and knowledge necessary to make a competent assessment as appropriate to the procedure under review. In general, resident assessors should be at least two Levels above the resident being assessed, e.g. Level 2 WpBAs or MAR should only be signed off by a consultant, suitably experienced specialty and specialist grade (SAS) doctor or a Level 4 resident. However, the NCS can advise as to who is appropriate to supervise and feedback on WpBAs, and residents should ensure this is discussed with the NCS prior to getting any forms signed off. They may recommend suitable non-medical health professionals within the team to sign off some

Clinical Rating Scale (CRS) forms. Professional hospital/Trust emails, as opposed to personal addresses, must be used to request completion of WpBAs through the ePortfolio.

Supervisor roles

- **Named Clinical Supervisors** (NCSs) are trainers responsible for overseeing clinical work and providing constructive feedback to their residents during a training placement. NCSs should complete EPAs after consultation with other supervisors (Assessors). There should only be one NCS responsible for each EPA. Thus, there will be one NCS required for every six months in Levels 1 and 2. More than one NCS may be required every six months in Level 3 and 4 if more than one SIA is being covered in that six-month rotation.

The NCS should:

- Be familiar with the requirements of the curriculum, particularly those set out in the Patient Management syllabi.
- Oversee clinical training and ensure the resident is given the opportunity to meet the clinical requirements as set out in the relevant syllabus, as appropriate for the Level of training.
- Meet the resident in the first two weeks of their rotation to:
 - Agree the number of MARs to be completed in that post.
 - Agree if any additional WpBAs, over and above what specified in the EPA, are required to be completed in that post.
- Meet the resident at the end of the post to complete the relevant EPA by checking the mandatory and additional WpBAs and reviewing any completed MARs.
- Liaise as appropriate with the ES.

Educational Supervisors are trainers responsible for the overall supervision and management of the educational progress during a clinical training placement, or a series of placements. There should be one ES per post. The ES should:

- Understand role by:
 - Being familiar with the structure of the training programme.
 - Being aware of local and regional policies for trainee support.
 - Understanding own role in the ARCP process and the resident's revalidation.
- Meet their resident in the first two weeks of their post to:
 - Ensure the resident understands the curriculum requirements and develops a personal developmental plan that considers individual needs and learning opportunities.
 - Ensure that the resident is aware of and has contacted their NCS.
- Meet the resident regularly to review progress with their personal learning plan, reviewing the ePortfolio, ensuring it is maintained and encouraging reflection on the curriculum and GMC's GMP.
- Liaise with the NCS as appropriate, using information from EPA(s), MAR(s) and the MSF to provide honest and constructive feedback.
- Sign off GSATs, although the latter is primarily resident-driven.
- Complete the Educational Supervisor Report (ESR) in preparation for the ARCP, including noting any serious incident or complaint involvement and making a global assessment recommendation to the ARCP panel. The ES must indicate if any Level of training has been completed during the period covered by the ESR.

- Have career discussions with the resident and ensure they have access to specific advice and support.
- Identify residents in difficulty and provide support as necessary, in line with local and regional policies.
- Encourage residents to undertake the annual GMC National Trainee Survey.

NCSs and ESs consider the evidence to make a professional judgement as to whether the resident has achieved each Learning Outcome and is ready to be signed off at a Level. Supervisors who hold either of these roles are trainers recognised by the GMC. The RCOphth strongly supports the provision of adequate, equivalent time in their job plan for the ES and NCS to carry out their duties. **The RCOphth advises a minimum of 0.25 PA per resident per role (for both NCS and ES).**

It is recommended to consult the [end-of-rotation checklist](#) for ePortfolio tips.

4 RCOphth Examinations

Part 1 FRCOphth

Resident doctors are required to pass this examination **by the end of Level 1**. It comprises theoretical papers based on the Learning Outcomes for the first two years of training. This includes basic sciences, theoretical optics and pathology.

Refraction Certificate

Resident doctors are required to have passed the Part 1 FRCOphth examination, which tests theoretical knowledge, before taking the practical Refraction Certificate. They are required to pass the Refraction Certificate examination **by the end of Level 2**.

Part 2 FRCOphth Written

Resident doctors are required to have passed the Part 1 FRCOphth examination before taking the first component of the Part 2 examination. It comprises theoretical papers based on the Learning Outcomes from Level 1, 2 and 3.

Part 2 FRCOphth Oral

Resident doctors are required to have passed the Part 1 FRCOphth, the Refraction Certificate and the Part 2 FRCOphth Written examinations before taking the final component of the Part 2 examination. It comprises a structured viva and an objective structured clinical examination (OSCE) based on the Learning Outcomes from Level 1, 2 and 3. Completion of all examinations is required **by the end of Level 3**.

5 Summative assessment tools

Entrustable Professional Activity (EPA)

EPAs have been mapped to the Learning Outcomes for each Level in the Patient Management domain. The purpose of the EPA is to assess the level that a resident doctor can be entrusted with independent practice in the context of meaningful clinical activity. The EPA allows the NCS to make and document a decision about the degree of independence a doctor can safely work with. This decision is made about a relatively wide area of practice, which is described by high-

level, overarching Learning Outcomes. The EPA requires simultaneous proficiency in multiple competencies and is a more suitable focus for assessment than separate competencies.

The ePortfolio allows the NCS to make summative entrustment decisions and select the degree of entrustment using the following scale:

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

Longitudinal development is captured as the resident doctor:

- moves up through the entrustment scale within the Level at which they are working.
- reaches competence for the Learning Outcomes of that Level and advances to the next Level.

The EPA form includes a self-assessment element to facilitate professional insight and reflection on the evidence to be used to reach the judgement. ESs review EPAs when completing the ESR to inform decisions taken by the ARCP panel at the end of each training year or at critical advancement points. 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. Additional evidence may be supplied by the resident doctor to demonstrate competence across all the requirements for each Level. See the Level Guides ([1](#), [2](#), [3](#), [4](#)) prior to preparing the EPA. Elective evidence requesting focused, formative feedback may also be included wherever the NCS has indicated that the resident is not achieving the expected degree of entrustment.

As well as confirming whether the evidence presented corroborates entrustment to practice independently in the area under consideration, it is required to provide a narrative to support that decision, feedback about what was particularly good and suggested areas for further development. Where the degree of entrustment is below competent, a narrative is required and must include the evidence that is needed to increase the entrustment recommendation.

How to complete an EPA

- The resident should complete the self-assessment prior to review by the NCS.
- The resident should link ePortfolio evidence to the EPA to demonstrate that they have met each requirement. It is about quality, not quantity, and **one piece of evidence may be used for more than one Learning Outcome.**
- If the first piece of evidence gives a clear indication that the required standards have been met, it is up to the NCS to decide how thoroughly to review other evidence provided for that requirement. A common-sense approach would be to link only good quality example(s), and the NCS could then decide whether to go further. The resident doctor should not link large numbers of documents with weak evidence (e.g. anonymised patient letters) in the hope that it will be acceptable when summated.
- NCSs should note who has supervised and signed off WpBAs and alert ES if there are any concerns regarding the appropriateness of supervisors chosen by the resident.
- The ‘other mandatory requirements’ are necessary evidence for the NCS to consider when making their decision as to the level of entrustment for the relevant EPA. These

requirements are not subject to mandatory quantitative expectations such as set numbers of CbDs or durations of periods of observation.

- Some of the mandatory WpBAs in Level 1 are required to be repeated at higher Levels (e.g. CRS1). It is thus important for the resident doctor to demonstrate development of the skills required over time, and to be able to apply and tailor them to the SIA. Other mandatory WpBAs do not need to be repeated and therefore the Level required to be demonstrated is that expected of a competent independent practitioner (i.e. a newly qualified consultant).
- Competence in the EPA should be benchmarked to the Level of the assessment. Where the final entrustment on the scale is below the maximum possible, the NCS will need to add a narrative about the evidence that is needed to increase the entrustment recommendation. Where a resident has not yet had the experience or opportunity for a higher degree on the scale to be attained, this can be indicated without an exhaustive list of all areas to be developed. However, where a resident might have been expected to achieve a higher degree on the scale, it is imperative that the narrative is detailed and specific to help them understand what is required.
- NCSs should view any completed MARs (there is no mandated number) as part of the evidence to be used to make the entrustment decision.
- Some competencies may appear in an EPA of more than one SIA (see Table 1). Where a competence has already been signed off in one EPA, this can be taken as evidence of competence and transferred to the other EPA. **The competency assessment does not need to be re-assessed.**

Table 1 – Examples of competences that appear in more than one EPA

| Level | Competence | SIA |
|---------|--|--|
| Level 3 | Local anaesthesia (<i>theatre</i>) | Cataract, Oculoplastics & Orbit, Cornea, Vitreoretinal |
| Level 3 | Aqueous / vitreous biopsy (<i>clinic or theatre, depending on SIA</i>) | Cataract Surgery, Vitreoretinal Surgery, Urgent Eye Care |
| Level 3 | Interpretation of FFA and ICG (<i>clinic</i>) | Medical Retina, Uveitis |
| Level 3 | Interpretation of orthoptic assessment/examination (<i>clinic</i>) | Neuro-ophthalmology, Ocular Motility, Paediatric Ophthalmology |
| Level 3 | Periocular and intraocular drug delivery (<i>theatre</i>) | Cataract Surgery, Uveitis |
| Level 3 | Corneal gluing (<i>clinic</i>) | Cornea & Ocular Surface, Urgent Eye Care |

| Level | Competence | SIA |
|---------|---|--|
| Level 4 | Temporal artery biopsy (<i>theatre</i>) | Neuro-ophthalmology, Oculoplastics & Orbit |

- Where a WpBA is not completed for a specific requirement, the resident doctor must provide other evidence to demonstrate that they have met that requirement. There are few mandatory DOPS across all SIAs in the curriculum; however, the relevant practical skills must be evidenced for the EPA.
- A feedback meeting should be arranged if the resident doctor and NCS disagree about the level of entrustment. The ePortfolio will only mark an EPA as complete if the chosen degree of entrustment is the same.
- The EPA may need to be repeated if the NCS decides that it is inadequate, and extra time might be needed. This should be highlighted to the ES.
- The resident doctor is signed off by the NCS as competent to a Level only when **all** the Learning Outcomes of the SIA for that Level have been achieved.

Generic Skills Assessment Tool (GSAT)

GSATs have been mapped to the Learning Outcomes for each Level in the six non-clinical domains. This tool is used to make a global professional judgement of a range of different skills and behaviours to make decisions about advancing to the next Level of the training programme and eventually to consultant practice at CCT. Whilst the Learning Outcomes 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.

The GSAT is, first and foremost, a self-assessment by the resident doctor. It is used by the ES to make a recommendation and inform the ARCP process. Two assessments should be undertaken in any training year, one at the mid-point and one towards the end of the year, in advance of the ARCP.

Evidence can come from multiple different sources: case-based discussions; undertaking mandatory Trust training, e.g. on Health and Safety; passing exam(s); personal audits; departmental audits; attending teaching sessions. Examples of evidence are listed in each Level Guide (1, 2, 3, 4) and are not mandatory. The emphasis should be on the quality of evidence, and it may be that one piece of evidence can demonstrate achievement against more than one Learning Outcome. It may not be possible at times to provide evidence for every Learning Outcome, and a subjective judgement may need to be made.

There is a GSAT for each Level of training that covers the same six non-clinical domains, and for each Level there are different Learning Outcomes, which are specified on the GSAT forms.

How to complete a GSAT

- The resident doctor should pre-populate the GSAT for their current Level with the relevant supporting information.
- The resident should link to ePortfolio evidence to demonstrate that they have met each requirement. It is about quality, not quantity, and **one piece of evidence may be used more for more than one Learning Outcome.**

- Unlike the EPA, the GSAT does not mandate any WpBAs. It is up to the resident to identify the evidence they think will best demonstrate achievement of a learning outcome.
- If there is no specific evidence but a resident can demonstrate they have achieved a Learning Outcome – or, if they consider they have not, offer a plan as to how they will acquire the evidence – the same comment box may be used.
- After reviewing the self-assessment and links to evidence, the ES indicates whether, in their view, the resident meets or does not meet expectations for each Learning Outcome.
- If the first piece of evidence gives a clear indication that the required standards have been met, it is up to the ES to decide how thoroughly to review other evidence provided for that Learning Outcome. A common-sense approach would be for the trainee to link only to good quality example(s), and the ES could then decide whether to go further. The resident doctor should not link large numbers of documents with weak evidence (e.g. anonymised patient letters) in the hope that it will be acceptable when summated.
- The ES should comment on the Level achieved overall in each domain. Both resident and ES should agree whether there are areas that need work before advancing to the next Level. Comments in specific boxes, after each domain is considered, are especially important if the resident does not meet the expected requirements for the Level.
- The GSAT may need to be repeated if the ES decides that it is inadequate, and extra time might be needed.
- All Learning Outcomes must be completed in all non-clinical domains across the Level to advance to the next Level.

Multi-Assessor Report (MAR)

This summative assessment tool reflects the multi-professional working environment and has been designed to capture the opinions of other consultants, senior residents and other colleagues such as orthoptists, optometrists, advanced clinical practitioners and senior technicians, and nursing staff, who have supervised the resident and are able to comment on 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. There are several professional practices, competencies and skills that the contributor(s) is asked to comment on. They should indicate whether the resident meets or does not meet expectations in each of the areas that are relevant to their experience with the resident.

The responses contribute to EPAs and a list of appropriate respondents is agreed with the NCS at the outset. The ES will also view these assessments and reflect them in their ESR. This tool is not specific to a particular case or cases, nor is it specific to a Level. It allows contributors to comment on the clinical knowledge and skills of the resident and supports the completion of the EPA. There is no requirement to check formal evidence on the ePortfolio.

The NCS reviews the MAR(s) before completing the EPA. Free comments are encouraged to allow the NCS to gain a better understanding of how the resident is progressing, as well as the ES to reflect them in their report. The free comments are visible to the resident and can be useful to receive constructive feedback. The ES will also review the MAR(s) and consider whether there are any issues to follow up or areas of concern.

The MAR can be used at any time to record any concerns with a resident. There is no mandatory number of MARs, although normally they will be completed twice a year to support the EPA.

How to complete a MAR

- The NCS determines at the outset the number and likely contributors to the MAR for every rotation on a six-month rolling basis.
- Each contributor should consider whether the resident meets or does not meet the expectations in each area, from their own experience with that resident. If the contributor has no evidence or experience in that area, they should choose N/A. Comments are encouraged but not mandatory.

6 WpBAs

Objective Structured Assessment of Technical Skills (OSATS)

This tool is used to assess ocular surgery and can be applied at any Level of training and to any procedure. Descriptors of ‘very good trainee’ and ‘poor trainee’ are given, and longitudinal development is captured by progression through a three-point rating scale per each criterion: major concerns, minor concerns, meets expectations. An overall assessment is then made as to whether the resident 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. Residents are strongly encouraged to use OSATS regularly in a formative manner to collect high-quality, recorded feedback.

Direct Observation of Procedural Skills (DOPS)

This tool is used to assess procedural skills. Longitudinal development is captured by progression through a three-point rating scale per each criterion: major concerns, minor concerns, meets expectations. An overall assessment is then made as to whether the resident 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 – Biometry (DOPSBi)

This assessment tool is used to assess biometry skills and achieve the best refractive results after cataract surgery. Longitudinal development is captured by progression through a three-point rating scale per each criterion: major concerns, minor concerns, meets expectations. An overall assessment is then made as to whether the resident 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.

Clinical Rating Scale (CRS)

These tools are used to assess clinical skill competencies, principally around ophthalmic examination and use of equipment, skills few doctors have achieved prior to OST1. Their purpose is to provide feedback on skills essential to providing good clinical care. There are fourteen specific forms for different skills:

- CRS1 Consultation skills
- CRS2 Assess vision
- CRS3 Assess visual fields

- CRS5 External eye examination
- CRS6 Assess pupils
- CRS7 Assess ocular motility
- CRS8 Assess intra-ocular pressure
- CRS9 Slit lamp
- CRS10a Fundus assessment – direct ophthalmoscope
- CRS10b Fundus examination using slit lamp condensing lenses e.g. 90D/78D or equivalent
- CRS10c Fundus assessment – diagnostic contact lenses
- CES10d Fundus assessment – indirect ophthalmoscope
- CRSgon Gonioscopy
- CRSret Cycloplegic refraction

The forms provide descriptors of ‘very good trainee’ and ‘poor trainee’. They may be repeated with longitudinal development captured by progression through the scale of each criterion. The standard for competence is that of a newly qualified consultant, an independent practitioner. Once considered competent, the assessment does not need to be repeated, except for CRS1 (Consultation skills). The latter must be tailored and focussed appropriately to the subject of the individual SIA and show advancement between Levels, as well as further advancement by Level 4.

Although all CRS tools are formative, they are listed as mandatory evidence, especially for EPA Level 1. The NCS must summate the evidence within the ePortfolio to determine competence in these clinical examination skills. Where the NCS has directly observed the resident performing these skills, it is suggested to state that the required standard has been reached. Where areas have not been directly observed by the NCS, they can consider evidence from other practitioners through the MAR to make the decision.

Case-based Discussion (CbD)

This tool is intended to assess aspects of patient management, communication (written and verbal) and clinical reasoning, judgement and decision-making, and additionally leadership and management skills. They complement the assessment of these skills which takes place in the Part 2 FRCOphth examination.

Cases should be chosen if they have created challenge, doubt or difficulty to maximise the learning opportunity. Discussion should be structured and in-depth and trainers should encourage residents to discuss clinical problems regularly. The expectation is to be able to manage a range of clinical scenarios, which may involve referrals from other health professionals, patient self-referrals or screening for ophthalmic disease. Below is a list of typical problems that may present to an ophthalmologist.

Table 2 – list of typical problems

| Symptoms | Signs |
|--|--|
| Decreased Vision <ul style="list-style-type: none"> • Transient • Sudden • Gradual • Painful | Ametropia Corneal Opacities Conjunctival Pigmentation Dysgenesis/Colobomata Lens Opacities |
| Diplopia | Lid Lumps |
| Distortion | Lid Malposition |

| Symptoms | Signs |
|--------------------|-----------------------------|
| Dry Eyes | Macular Exudation |
| Floaters | Nystagmus |
| Headache | Ocular Tumours |
| Night Blindness | Optic Disc Atrophy/Swelling |
| Pain | Proptosis |
| • Ocular | Pupil Abnormalities |
| • Periocular | Raised Intraocular Pressure |
| Red Eye | Retinal Haemorrhages |
| Trauma | Retinal Pigmentation |
| Visual Disturbance | Strabismus |
| Watery | Visual Field Defects |
| | Visual Handicap in a Child |
| | Vasculature abnormalities |

Using these commonly encountered scenarios enhances the value of on-the-job learning, increasing learning efficiency and relevancy.

During an out-patient clinic: trainers and residents may wish to allocate 5-10 minutes to discuss the management of the patient. The resident should have had some direct clinical role with the patient, e.g. history taking, clinical examination, investigations ordered or interpreted, management decisions, management of complications, critical incidents.

At the end of an out-patient clinic: trainers and residents may wish to allocate some time at the end of clinic to review a small number of case notes where the resident has had a significant role in the management of the patient.

Case presentations during postgraduate teaching: residents are often asked to present cases at local or regional postgraduate teaching sessions. A nominated trainer should complete a CbD form with the resident after the presentation.

During a designated teaching session: Trainers and residents may wish to allocate a period of one-to-one teaching or small group teaching where cases are discussed and a CbD form has been completed.

How to complete a CbD

The purpose of the CbD is to give residents the opportunity to demonstrate achievement of Learning Outcomes in relation to an individual case they were involved in. In particular, the resident should be able to demonstrate how they approach their practice. That is, application of medical knowledge, rationale for clinical decision making and the ethical/legal framework of their practice, if appropriate.

The resident should present the case and detail their involvement. The discussion should start from the resident’s own entry in the case record which may, in part, be used to demonstrate appropriate information handling.

Longitudinal development of resident is captured by progression through a three-point rating scale per each topic: major concerns, minor concerns, meets expectations. An overall assessment of the specific case-based discussion is then made as to whether the resident 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.

Multi-Source Feedback (MSF)

The MSF assesses professional competence within a team-working environment, where the resident's performance is assessed by a range of peers and colleagues covering different professions, grades and environments (e.g. outpatients, theatre, administration). The resident selects a minimum of 11 assessors (up to 15) who can be approached to give feedback. The recommended combination of assessors, where applicable, should include:

- 2 consultant clinical supervisors
- 2 more senior residents
- 1 senior nurse in the operating theatre (if the resident has been performing surgery)
- 1 senior nurse in the out-patient department
- 1 other member of the out-patient staff (nurse/optometrist/orthoptist)
- 1 member of the administrative or secretarial team who regularly deals with the resident's work

The resident selects those who can be approached to give feedback in accordance with the recommended combination of assessors. The resident and ES must discuss and agree the list before starting the process electronically. Care should be taken to use only professional hospital/Trust emails, not personal addresses. Feedback is provided in the form of a table generating collated scores and anonymised written comments. The anonymised summary report that is generated after an MSF has closed will only be visible to the ES in the first instance. The ES should meet with the resident 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.

7 Annual Review of Competency Progression (ARCP)

The ARCP is a formal Statutory Education Body (SEB) process overseen on their behalf by a TPD. It is used each year to review progression against standards set down in the curriculum for their training programme. These standards are set down in the [Matrix of Progression](#). It is incumbent on the resident doctor to provide portfolio evidence to demonstrate that all curriculum requirements have been met. ARCP panels expect the following evidence to be included in portfolios:

- Educational and clinical supervision – documentation of meetings and outcomes
- Regular participation in the mandated programme of assessment (EPAs, GSATs, MARs, WpBAs, MSF)
- Surgical logbook
- Audits as required
- Examination outcomes
- Professional Development Plan (PDP)
- Reflective entries
- Record of training and teaching events

- Teaching resources
- Clinical governance/quality improvement activities
- Presentations/research/publications
- Evidence of Continual Professional Development (CPD)

The ES should utilise much of this evidence when completing the ESR as this will be used to inform the ARCP panel. The decision regarding the appropriate Level of training should be reached unanimously before the ARCP and recorded in the ESR. There will be no right to appeal at any point. The ARCP panel makes the final summative decision determining whether the resident has progressed at the appropriate rate to be able to move to the next OST stage, as well as the next Level of training if at a critical point, before being awarded the CCT at the end of the programme.

A resident may not have yet demonstrated to the ARCP panel that they are ready to move to the next Level; however, they must show that they are making appropriate progress towards it as laid out in the [Matrix of Progression](#). Residents will be expected to upload the relevant evidence to their portfolio for the Level they are working towards, even if their NCS or ES cannot yet sign them off at that Level.

Surgical logbook

A surgical logbook allows competence that has been measured using various assessment tools to be placed in the context of experience. Although not a formal assessment, resident doctors are mandated to use the [Eye Logbook](#) platform 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. During Level 4, the supervision of more junior residents must be documented, and it is important to demonstrate maintenance of skills as well as new procedures undertaken in Level 4 SIAs.

Audit

Training ophthalmologists are expected to keep and present a continuous complications audit of their cataract surgery. This allows reflection and developmental planning with their supervisors. Benchmarking against peer norms enables outliers to be highlighted, and early appropriate action to be taken in the interest of patient safety.

As resident doctors approach the end of training, they need to undertake a prospective audit of 50 consecutive cataract cases where the surgery is performed within three calendar years of achieving Level 4 Cataract Surgery. Post-operative refractive data must be provided on at least 10% of cases.

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.

Level 1 training requirements

During this stage (usually spanning the OST1-2 years), training ophthalmologists develop clinical and procedural skills which are essential for both acute care and general ophthalmology. They also develop values and behaviours in all non-clinical curriculum domains, including reflective practice and communication, and acquire the basic science

knowledge essential for the practice of ophthalmology, which is assessed by the Part 1 FRCOphth examination.

Assessments supporting the Level 1 Learning Outcomes focus on acquiring the knowledge base required to be a safe and effective ophthalmologist. **Trainees have an indicative maximum of two years to be signed off in all Level 1 competences**, although it is expected that many will achieve competence by the end of OST1.

The **Level 1 Guide** lists which evidence is required to demonstrate meeting all Level 1 Learning Outcomes. In addition, trainees must:

- Have a satisfactory ARCP Outcome
- Pass the Part 1 FRCOphth examination
- Provide a surgical logbook with details of A/PS/P
- Ensure that one MSF is completed for each 12-month training period
- Maintain a cataract complications audit
- Complete Form R for each 12-month training period (or a SOAR declaration if training in Scotland)

Level 2 training requirements

The theme of general ophthalmology continues at this stage with training ophthalmologists adopting spiral learning and demonstrating increasing independence and efficiency. They continue to use skills of reflection and self-awareness to recognise their own achievements and limitations. They begin supervision of more junior residents where appropriate.

At the end of this stage the Refraction Certificate examination must have been passed to progress further. This test of knowledge involves an understanding of theoretical principles of optics, refraction and the related clinical skills, essential for higher practice.

All Level 2 competences must have been signed off by the end of OST3.

The **10 Level 2** Guide lists which evidence is required to demonstrate meeting all Level 2 Learning Outcomes. In addition, trainees must:

- Have a satisfactory ARCP Outcome
- Pass the Refraction Certificate examination
- Provide a surgical logbook with details of A/PS/P
- Ensure that one MSF is completed for each 12-month training period
- Maintain a cataract complications audit
- Complete Form R for each 12-month training period (or a SOAR declaration if training in Scotland)

Level 3 training requirements

During this stage (usually spanning the OST3 to mid-way OST6 years), training ophthalmologists rotate through posts to receive mandatory training in the specific clinical skills related to the twelve SIAs. Residents develop transferable surgical skills as they move between these specialty posts and continue to consolidate their cataract surgical skills. Progression in cataract surgery is demonstrated by the completion of more complex procedures, a continuous cataract complications audit and formative assessments. Other surgical and procedural skills are also assessed formatively. Clinical knowledge is assessed by the final Part 2 FRCOphth examination.

- Level 3 will generally range between 2.5 to 3.5 years.
- **Trainees have an indicative maximum of 5 ½ years to be signed off in all Level 3 competences.**
- Cataract Surgery, Urgent Eye Care and Community Ophthalmology SIAs will not need dedicated postings because competencies are acquired simultaneously.

The **11 Level 3** Guide lists which evidence is required to demonstrate meeting all Level 3 Learning Outcomes. In addition, trainees must:

- Have a satisfactory ARCP Outcome
- Pass the Part 2 FRCOphth examination (both Written and Oral components)
- Provide a surgical logbook with details of A/PS/P
- Ensure that one MSF is completed for each 12-month training period
- Maintain a cataract complications audit
- Complete Form R for each 12-month training period (or a SOAR declaration if training in Scotland)

Level 4 training requirements (CCT)

During the final stage of the programme (which may vary in duration), training ophthalmologists develop Level 4 skills of at least two SIAs within the Patient Management domain.

Residents planning to work in localities where it is necessary to provide a more generalist ophthalmology service could continue to develop their skills in Urgent Eye Care and/or Community Ophthalmology along with their cataract expertise.

- A minimum of two Level 4 SIAs are required to be recommended for CCT.
- **Level 4 training cannot start until completion at Level 3 of all 12 SIAs plus six non-clinical domains.**
- **In addition, Level 4 entry criteria for Cornea & Ocular Surface Disease, Glaucoma and Vitreoretinal Surgery SIAs is to have been signed off in Level 4 Cataract Surgery.** This may well be achieved by the time Level 3 is completed in all other SIAs. In exceptional circumstances, this condition may be waived in consultation with the Chairs of the Training Committee and Curriculum Sub-committee.

The **12 Level 4** Guide lists which evidence is required to demonstrate meeting Level 4 Learning Outcomes. Residents must:

- Provide EPA Level 4 Managing Operating List for each surgically based SIA (Oculoplastics & Orbit, Cornea & Ocular Surface Disease, Cataract Surgery, Glaucoma, Vitreoretinal Surgery, Ocular Motility and Paediatric Ophthalmology)
- Provide a surgical logbook indicating the expected breadth of surgical experience and indicating supervision of juniors at Level 3 in the chosen SIA
- Complete a cataract complications audit where Level 4 Cataract Surgery training is undertaken
- Complete an audit of surgical outcomes for each surgically based SIA undertaken (Oculoplastics & Orbit, Cornea & Ocular Surface Disease, Cataract, Glaucoma, Vitreoretinal Surgery, Ocular Motility and Paediatric Ophthalmology)

In addition:

- Have a satisfactory ARCP Outcome
- Ensure that one MSF is completed for each 12-month training period

- Complete Form R for each 12-month training period (or a SOAR declaration if training in Scotland)

Level 1 Guide

Essential ePortfolio evidence

1. EPA Level 1 – one for every six months until final one signed off by NCS as ‘Competent’ in Level 1 Patient Management domain. Level 1 EPA requirements are summarised in **Table A** Level 1 EPA requirements.
2. GSAT Level 1 – one every six months until final one signed off by ES as achieving Level 1 competencies in the six non-clinical domains. Examples of evidence that can be used in the Level 1 GSAT are summarised in **Table B** Examples of GSAT Level 1 evidence.
3. ESR – one every six months and final one indicating that Level 1 competencies have been achieved in all seven domains
4. Pass Part 1 FRCOphth examination
5. Logbook
6. PDP
7. MSF – one per calendar year
8. Cataract Complications Audit
9. Form R or SOAR declaration
10. Satisfactory outcome at ARCP

Level 1 requirements are summarised the [web version](#) of this Handbook.

Table A Level 1 EPA requirements

*A formative tool should be used if the resident is not achieving the expected level. These requirements can be demonstrated by DOPS, OSATS, direct observation or observation by another team member.

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Can be achieved either in Outpatients or Theatre | Other mandatory requirements |
|--|--|--|---|
| CRS1 Consultation skills CRS2 Assess vision CRS3 Assess visual fields CRS5 External eye examination CRS6 Assess pupils CRS7 Assess ocular motility CRS8 Assess intra-ocular pressure CRS9 Slit lamp CRS10a Fundus assessment – direct ophthalmoscope | OSATS Microsurgical skills OSATS Cataract Surgery OSATS Lid surgery Operating microscope* | Removal of sutures* | Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible Longitudinal observation by consultant assessor in the theatre and simulation setting Review of record keeping and letters CbDs |

| | | | |
|---|--|--|-----------------------|
| <p>CRS10b Fundus examination using slit lamp condensing lenses e.g. 90D/78D or equivalent</p> <p>CRS10c Fundus assessment – diagnostic contact lens</p> <p>CRSGon Gonioscopy</p> <p>Corneal scrape*</p> <p>Use an exophthalmometer*</p> <p>Assess lacrimal function*</p> <p>Punctal plug insertion*</p> <p>Interpretation of automated visual fields*</p> | | | Multi Assessor Report |
|---|--|--|-----------------------|

Table B Examples of GSAT Level 1 evidence

CbDs and reflections can be used to demonstrate evidence.

| Learning Outcome | Examples |
|---|--|
| Domain: Health Promotion | |
| Provide appropriate lifestyle advice. | <ul style="list-style-type: none"> • Promote immunisation • Avoidance of allergens • Diet and Nutrition • Advice on sources of information • Smoking cessation • AREDS supplementation in advanced AMD |
| Adopt local and national guidelines of prevention of infection. | <ul style="list-style-type: none"> • Use/create eye local eye casualty guideline • Audits • Infection control protocols • Endophthalmitis prevention • Contact lens guidance • Hand hygiene • PPE guidance for appropriate respiratory diseases |
| Advise appropriately about the systemic side-effects of drugs. | <ul style="list-style-type: none"> • Systemic side-effects of antimuscarinics, beta blocker eye drops, doxycycline administration • Make recommendations for bone protection |
| Know the principles of screening. | <ul style="list-style-type: none"> • Principles of screening (e-LFH) • Examples include hydroxychloroquine; diabetic retinopathy; retinopathy of prematurity; fungaemia in immunocompromised patients. • Part 1 FRCOphth |
| Use and promote means of eye injury protection. | <ul style="list-style-type: none"> • Blunt and penetrating eye injury and foreign bodies – reiterate the importance of protective glasses to prevent eye injury working with high velocity machinery or patients with corneal susceptibility (Ehlers Danlos, High myopia) |

| Learning Outcome | Examples |
|--|---|
| | <ul style="list-style-type: none"> • Avoidance of fireworks in blast injury cases • High velocity machinery to wear protective goggles • DOPS – removal foreign body • OSATS – lid repairs • Eye protection advice/driving advice for patients on cycloplegia |
| Domain: Leadership and Team Working | |
| <p>Know about leadership competencies in the nine behavioural dimensions as defined by the NHS Leadership Academy: inspiring shared purpose; leading with care; evaluating information; connecting our service; sharing the vision; engaging the team; holding to account; developing capability; influencing the results.</p> | <ul style="list-style-type: none"> • Go through the https://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/nine-leadership-dimensions/ • Certificate of learning • 01_01 Introduction to Leadership and LeAD • https://portal.e-lfh.org.uk/Component/Details/510250 • Attend leadership courses • Rota co-ordinator |
| <p>Know the principles of leadership and identify areas for own development.</p> | <ul style="list-style-type: none"> • Completion of self-learning • https://portal.e-lfh.org.uk/Component/Details/511042 |
| Domain: Patient Safety and Quality Improvement | |
| <p>Know the principles, recognise the contribution to improved practice, and take part in clinical governance, audit and quality improvement activities.</p> | <ul style="list-style-type: none"> • Clinical governance • Quality Improvement • Portfolio • Part 2 FRCOphth • Undertake a QIP project; supervise another team member in a project; demonstrate management of a complaint with report and be involved in the investigation; investigate an incident. |
| <p>Identify appropriate information from a variety of data sources.</p> | <ul style="list-style-type: none"> • <i>Evidence-based approach</i> • Quality Improvement • Sources of Information Epidemiology/ Evidence-based medicine • Portfolio • Part 2 FRCOphth • MSF • Research/publication |
| Domain: Safeguarding and Holistic Care | |
| <p>Understand and promote professional responsibility of safeguarding.</p> | <ul style="list-style-type: none"> • Involvement in safeguarding case • Non-accidental Injury – screening • Portfolio Part 2 FRCOphth • Adult Safeguarding Level 1 • https://portal.e-lfh.org.uk/Component/Details/510406 |

| Learning Outcome | Examples |
|--|--|
| | <ul style="list-style-type: none"> • Evidence of generic skill courses and essential courses like fire safety, information governance, infection control, etc. • https://www.e-lfh.org.uk/ - contains several links that could be used to support this learning, there are too many to list so the trainee can look and see if any are appropriate to undertake if they have seen a case they may relate to recently. • e.g. safeguarding adults, supporting children and young persons with learning difficulties, dementia etc |
| <p>Demonstrate familiarity with local safeguarding procedures and contacts.</p> | <ul style="list-style-type: none"> • Use RCOphth NAI proforma • Laser safety course • Adult Safeguarding Level 1 • https://portal.e-lfh.org.uk/Component/Details/510406 • Evidence of generic skill courses and essential courses like fire safety, information governance, infection control, etc. <p>Portfolio Part 2 FRCOphth</p> |
| <p>Demonstrate awareness of possibility of non-accidental injury in vulnerable patients.</p> | <ul style="list-style-type: none"> • Adult Safeguarding Level 1 • https://portal.e-lfh.org.uk/Component/Details/510406 • Child Safeguarding Level 1 • https://portal.e-lfh.org.uk/Component/Details/510412 • CPD from teaching/meetings |
| <p>Document safeguarding concerns accurately and refers to senior staff.</p> | <ul style="list-style-type: none"> • Safeguarding • M+M meeting • Refer to appropriate safeguarding personnel, ECLO, seniors • Adult Safeguarding Level 1 • https://portal.e-lfh.org.uk/Component/Details/510406 • Child Safeguarding Level 1 • https://portal.e-lfh.org.uk/Component/Details/510412 • MSF • Case relating to vision/visual field and driving • Case relating to Amaurosis/TIA/Stroke and advice regarding driving • Case relating to CVI registration and ECLO/low visual aid referral • Reflective piece on breaking bad news on condition and effect on driving |
| <p>Domain: Education and Training</p> | |

| Learning Outcome | Examples |
|---|---|
| Ensure patient safety is paramount in all training and learning events. | <ul style="list-style-type: none"> • Use EyeSi simulation and wetlab • Courses – simulation training • Record of discussion with supervisor of an adverse outcome • reflective piece on how patient safety was included in a training or learning event and why important • M&M meeting, • Reflective entry from complications log where supervisor was sought to help fix a complication |
| Actively participate in own induction and training. | <ul style="list-style-type: none"> • Use EyeSi simulation and wetlab • Evidence of participation in local departmental induction and training • evidence of attendance in hospital and departmental post-graduate teaching • MSF |
| Deliver teaching activities under guidance. | <ul style="list-style-type: none"> • MDT teaching/medical student training • Contribution to local teaching session that is supervised • Medical Student teaching; • evidence of oral/poster presentation in regional teaching, national, international meeting • Present at regional trainees research symposium |
| Deliver patient education. | <ul style="list-style-type: none"> • Evidence of participation in patient education event, support groups meeting, developing patient information leaflets, videos • MSF |
| Domain: Research and Scholarship | |
| Adopt an evidence-based approach to clinical practice. | <ul style="list-style-type: none"> • Personal/departmental audits • Evidence of involvement in journal club, local teaching, presentation/research publications • Research Agreement |
| Critically appraise existing published research. | <ul style="list-style-type: none"> • Evidence of involvement in journal club, local teaching, presentation/research publications • Research Agreement |
| Understand research and deliver oral presentations. | <ul style="list-style-type: none"> • Local PG teaching/journal club • Regional teaching • Research publication/oral or poster presentation in local, regional, national and international meetings • Research Agreement |

10 Level 2 Guide

Essential evidence on ePortfolio evidence

1. EPA Level 2 – one for every six months until final one signed off by NCS as ‘Competent’ in Level 2 Patient Management Domain Level 2. Level 2 requirements are summarised in **Table A** Level 2 EPA requirements.
2. GSAT Level 2 – one every six months until final one signed off by ES as achieving Level 2 competencies in the six non-clinical domains. Examples of evidence that can be used in the Level 2 GSAT are summarised in **Table B** Examples of GSAT Level 2 evidence.
3. ESR – one every six months and final one indicating that Level 2 competencies have been achieved in all seven somains
4. Pass in Refraction Certificate examination
5. Logbook
6. PDP
7. MSF – one per calendar year
8. Cataract Complications Audit
9. Form R or SOAR declaration
10. Satisfactory outcome at ARCP

Level 2 requirements are summarised the [web version](#) of this Handbook.

Table A Level 2 EPA requirements

*A formative tool should be used if the resident is not achieving the expected level. These requirements can be demonstrated by DOPS, OSATS, direct observation or observation by another team member.

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Other mandatory requirements |
|--|---|--|
| CRS1 Consultation skills CRS10d Fundus assessment – binocular indirect ophthalmoscope CRSret Cycloplegic refraction Use a pachymeter* Insertion of bandage contact lens* Remove of corneal foreign body* Laser to lens capsule* Laser for raised IOP* Laser retinopexy* Interpret orthoptic assessment* Interpret FFA* | OSATS Microsurgical skills OSATS Cataract Surgery OSATS Lid surgery Lateral canthotomy/cantholysis* Interpret biometry* | Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible Longitudinal observation by consultant assessor in the theatre and simulation setting Review of record keeping and letters Multi-assessor report |

Table B Examples of GSAT Level 2 evidence

CbDs and reflections can be used to demonstrate evidence.

| Learning outcome | Examples |
|---------------------------------|----------|
| Domain: Health Promotion | |

| Learning outcome | Examples |
|--|---|
| Be aware and respect the impact of social, economic, cultural and religious factors on health. | <ul style="list-style-type: none"> • Evidence of community ophthalmology attachment • Cultural: corneal donations/retrievals and its implications. • Social and economic: deprivation and transport. Evidence of detailing examples of people with limited means of transport and being remote. Booking Taxis. Late presentation of cataract and advanced disease secondary to socioeconomic deprivation. • Religion: drops in Ramadan – educational element. Fasting |
| Have detailed knowledge of National Screening Programmes especially with reference to Ophthalmic diseases. | <ul style="list-style-type: none"> • Placements in paed (ROP), Med ret (diabetic screening), or glaucoma • Demonstrate understanding of UK visual screening for children. An example could be including familial retinoblastoma cases, or cases who have been referred as a part of hydroxychloroquine screening or diabetic retinopathy screening |
| Domain: Leadership and Teamworking | |
| Document and evidence leadership behaviours. | <ul style="list-style-type: none"> • Reflective practice • Courses – e.g. TTT • Certificate of learning • 01_01 Introduction to Leadership and LeAD • https://portal.e-lfh.org.uk/Component/Details/510250 • Completion for Level 1 also counts towards Level 2 evidence • https://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/ • Audit / QIP project/or evidence of research project • Write a reflective piece about own attributes and skills in communication, handling feedback, coping with stress, developing resilience, leadership styles that fit your strengths and stretching oneself to develop further |
| Practice within a multidisciplinary team to develop leadership projects. | <ul style="list-style-type: none"> • Manage rota • Human factors training • Certificate of course • Evidence of practice within a multidisciplinary team • Chairing a meeting • Learning appraisal skills • Training on team building • Undertaking patient improvement activity |
| Domain: Patient Safety and Quality Improvement | |
| Apply clear and appropriate clinical reasoning to make safe decisions. | <ul style="list-style-type: none"> • Portfolio • Part 2 FRCOphth • MSF |
| Practice in line with latest evidence. | <ul style="list-style-type: none"> • Portfolio • Part 2 FRCOphth • MSF |
| Maintain appropriate audits of practice. | <ul style="list-style-type: none"> • Portfolio • Part 2 FRCOphth • Surgical logbook; details of complications; Cataract Complications Audit • MSF |
| Apply quality improvement methods. | <ul style="list-style-type: none"> • Portfolio • Part 2 FRCOphth • QI project, Audit • MSF |
| Domain: Safeguarding and Holistic Care | |

| Learning outcome | Examples |
|--|---|
| Recognise where specialised management techniques may be necessary for those with special needs. | <ul style="list-style-type: none"> • CBDs • Refer to ECLO • Consent and capacity training • Adult Safeguarding Level 2 • https://portal.e-lfh.org.uk/Component/Details/510406 CbD re: patient with special needs attending clinic or theatre • Evidence of knowledge in sight impaired registration, DLVA requirements • CBD or reflection on support needed/referral to ECLO • DVLA:https://portal.e-lfh.org.uk/Component/Details/506969 • ECLO and wider visual support: • https://portal.e-lfh.org.uk/Component/Details/506975 • Case relating to vision/visual field and driving • Case relating to Amaurosis/TIA/Stroke and advice regarding driving • Case relating to CVI registration and ECLO/low visual aid referral • CBD/reflection relating patient with dementia/learning difficulties needing consent |
| Domain: Education and Training | |
| Plan and provide education and training activities for medical trainees and other professionals. | <ul style="list-style-type: none"> • Evidence of medical student teaching, nurses, optometrist or junior trainee • Evidence of developing a teaching session • contribution to regional teaching session or to medical students or other professionals • Reflect on teaching • Feedback |
| Give constructive feedback on learning activities. | <ul style="list-style-type: none"> • Feedback form completed at end of teaching session with own constructive feedback • MAR from a non-clinical supervisor • Feedback on regional teaching |
| Domain: Research and Scholarship | |
| Implement an evidence-based approach to shared decision making and enhancing patient outcomes | <ul style="list-style-type: none"> • Involvement in MDT • CbD • Undertake a literature review to answer a clinical question • Research Agreement |
| Demonstrate competencies for commencing clinical research. | <ul style="list-style-type: none"> • GCP course – online/in person • Research ethics course • Collect evidence of research skills; evidence of a publication is strong evidence or research project undertake • Good Clinical Practice training • Carry out lit search on topic • Evidence of discussions with supervisor on research projects e.g a project proposal • Write ethics application • eLearning/courses on research skills e.g GCP training, research skills modules from MSc course, Trust R+D training courses • Research Agreement |
| Distil research, deliver poster presentations and improve oral presenting. | <ul style="list-style-type: none"> • Journal club • Regional teaching • Research publication/oral or poster presentation in local, regional, national and international meetings |

| Learning outcome | Examples |
|------------------|--|
| | <ul style="list-style-type: none"> Critical appraisal clinical trial presented at regional meeting/journal club Research Agreement |

11 Level 3 Guide

Level 3 ePortfolio evidence

- EPA Level 3 – one for each of the Level 3 SIAs (overall requirement of minimum of one every six months) until final one signed off by NCS as ‘Competent’ in Level 3 Patient Management domain. Level 3 EPA requirements are summarised in **Table A** Level 3 EPA requirements for each SIA.
- GSAT Level 3 – one every six months until final one signed off by ES as achieving Level 3 competencies in the six non-clinical domains. Examples of evidence that can be used in the Level 3 GSAT are summarised in **Table B** Examples of GSAT Level 3 evidence.
- ESR – one every six months and final one indicating that Level 1 competencies have been achieved in all seven domains
- Pass in Part 2 FRCOphth examination
- Logbook
- PDP
- MSF – one per calendar year
- Cataract Complications Audit
- Form R or SOAR declaration
- Satisfactory outcome at ARCP

Level 3 requirements are summarised the [web version](#) of this Handbook.

Table A Level 3 EPA requirements for each SIA

*A formative tool should be used if the resident is not achieving the expected level. These requirements can be demonstrated by DOPS, OSATS, direct observation or observation by another team member.

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Other mandatory requirements |
|--|--|--|
| OCULOPLASTICS | | |
| CRS1 Consultation skills in oculoplastics | OSATS Lid surgery | Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible |
| Assessment and detailed interpretation of lacrimal function (syrringing / sac wash-out)* | OSATS Lateral canthotomy and cantholysis | Longitudinal observation by consultant assessor in the theatre and simulation setting |
| Botulinum toxin injection for induction of ptosis* | Local anaesthesia* | Review of record keeping and letters |
| Initial management of sight-threatening orbital emergencies (e.g. orbital cellulitis)* | Tarsorrhaphy* | CbDs |
| | Eyelid laceration repair* | |
| | Eyelid lesion biopsy* | |

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Other mandatory requirements |
|--|--|---|
| | | Multi-assessor report |
| CORNEA & OCULAR SURFACE DISEASE | | |
| <p>CRS1 Consultation skills in cornea and ocular surface disease</p> <p>Corneal gluing*</p> | <p>OSATS Microsurgical skills - cornea and ocular surface disease</p> <p>Corneal trauma repair (may be as part of larger globe repair)*</p> <p>Corneal graft suture removal*</p> <p>Local anaesthesia*</p> | <p>Ocular surface protection (e.g. Botox, Amniotic membrane, tarsorrhaphy)* - either Outpatients or Theatre</p> <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| CATARACT SURGERY | | |
| <p>CRS1 Consultation skills in cataract surgery</p> <p>DOPSBi Perform and interpret biometry</p> | <p>OSATS Cataract Surgery</p> <p>Local anaesthesia*</p> <p>Aqueous / vitreous biopsy*</p> <p>Anterior chamber paracentesis*</p> <p>Periocular and intraocular drug delivery*</p> | <p>Logitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of continuous audit of complications of cataract surgery</p> <p>Review of logbook</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| GLAUCOMA | | |
| <p>CRS1 Consultation skills in glaucoma</p> | <p>OSATS Cataract Surgery</p> | <p>Longitudinal, periodic observation by consultant assessor in the</p> |

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Other mandatory requirements |
|---|--|---|
| <p>Laser for IOP (including YAG PI and SLT)*</p> <p>Acute management of angle closure glaucoma*</p> | <p>OSATS Microsurgical skills – glaucoma surgery</p> <p>Local anaesthesia*</p> | <p>outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| UVEITIS | | |
| <p>CRS1 Consultation skills in uveitis</p> <p>Interpretation and use of ICG and FFA*</p> <p>Interpretation of electrophysiology*</p> | <p>DOPS Periocular and intraocular drug delivery</p> | <p>Aqueous and vitreous sampling* - either Outpatients or Theatre</p> <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| MEDICAL RETINA | | |
| <p>CRS1 Consultation skills in medical retina</p> <p>Interpretation of FFA, ICG, OCT, AF, electrophysiology *</p> <p>Interpretation of electrophysiology*</p> <p>Retinal laser treatment*</p> | <p>OSATS Intravitreal injections</p> <p>Sub-tenon’s injection*</p> | <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| VITREORETINAL SURGERY | | |

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Other mandatory requirements |
|---|---|---|
| <p>CRS1 Consultation skills in vitreoretinal surgery</p> <p>Ultrasound of the vitreous cavity, retina and choroid*</p> | <p>OSATS Cataract Surgery</p> <p>OSATS Microsurgical skills – vitreoretinal surgery</p> <p>Local anaesthesia*</p> <p>Vitreous biopsy*</p> | <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| OCULAR MOTILITY | | |
| <p>CRS1 Consultation skills in ocular motility</p> | <p>DOPS Forced duction test</p> <p>OSATS Surgical skills – extraocular muscle surgery</p> <p>Interpretation of orthoptic exam*</p> | <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| NEURO-OPHTHALMOLOGY | | |
| <p>CRS1 Consultation skills in neuro-ophthalmology</p> <p>Use of neuroimaging*</p> <p>Liaison with other medical and surgical specialties as needed*</p> <p>Interpretation of orthoptic assessment*</p> | | <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| PAEDIATRIC OPHTHALMOLOGY | | |

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Other mandatory requirements |
|--|--|---|
| <p>CRS1 Consultation skills in paediatric ophthalmology</p> <p>Indirect ophthalmoscopy with indentation (ROP screening)*</p> <p>Examination for suspected NAI*</p> <p>Referral for genetic counselling*</p> <p>Interpretation of the orthoptic examination*</p> <p>Refract and provide glasses prescription*</p> | <p>OSATS Surgical skills – extraocular muscle surgery</p> <p>DOPS Assessment of lacrimal function, including probing in children</p> | <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| COMMUNITY OPHTHALMOLOGY | | |
| <p>Knowledge of community ophthalmology commissioning frameworks, local community ophthalmology provision and referral pathways*</p> <p>Knowledge of screening programmes*</p> <p>Application of improvement methodologies*</p> | | <p>Longitudinal, periodic observation by consultant assessor in the outpatient and community setting where possible (consider handling of referrals, communication with primary care, virtual clinics, teleophthalmology, etc.)</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| URGENT EYE CARE | | |
| <p>CRS1 Consultation skills in urgent eye care</p> <p>Corneal gluing*</p> | <p>OSATS Microsurgical skills – urgent eye care</p> <p>Lateral cantholysis*</p> | <p>Vitreous biopsy* - either Outpatients or Theatre</p> <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |

Table B Examples of GSAT Level 3 evidence

CbDs and reflections can be used to demonstrate evidence.

| Learning outcome | Examples |
|---|--|
| DOMAIN: HEALTH PROMOTION | |
| Demonstrate leadership in the promotion of eye and general health in the wider community. | <ul style="list-style-type: none"> • M+M meetings – present any cases of endophthalmitis • Reflective piece following involvement with Integrated care system pathways (regional) for eye disease e.g. dry eye disease • Patient information leaflets for general eye health (e.g. contact lens wear guidance) • QIP in a community ophthalmology clinic e.g in virtual access clinics. |
| Promote immunisation. | <ul style="list-style-type: none"> • Recommend tetanus in trauma cases • Recommend flu vaccine and covid vaccine to elderly and immunosuppressed. |
| DOMAIN: LEADERSHIP AND TEAMWORKING | |
| Demonstrate the authority, capacity and motivation to implement change. | <ul style="list-style-type: none"> • Undertake management course • Certificate of learning • CLE 04 - Managing Services • https://portal.e-lfh.org.uk/Component/Details/393939 • https://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/ • Examples of training undertaken covering 9 leadership behaviours: <ul style="list-style-type: none"> ○ Undertake management training course with reflective notes or ○ shadow senior manager or ○ visit hospital or community service scheme and write reflective notes. • Ability to manage and lead teams when on call: MSF/CS/ ESR • Participation in committees e.g., RCOphth role/ trust working parties/ HEENE roles such a Doctors in Training representative |
| Design own projects related to leadership and management with outcomes predetermined to reflect on success. | <ul style="list-style-type: none"> • QIPs • Examples include: <ul style="list-style-type: none"> ○ writing a business case e.g., for a piece of equipment. ○ Learning about finance or commissioning within the NHS to share the knowledge with others, introducing a new guideline or piece of equipment |
| DOMAIN: PATIENT SAFETY AND QUALITY IMPROVEMENT | |
| Design and implement quality improvement programmes to improve clinical effectiveness, patient safety and patient experience. | <ul style="list-style-type: none"> • Portfolio • Part 2 FRCOphth • QI project • Audit |
| Analyse and critique published research. | <ul style="list-style-type: none"> • Portfolio • Part 2 FRCOphth • Journal club attendance • PG teaching |
| DOMAIN: SAFEGUARDING AND HOLISTIC CARE | |
| Take responsibility for safeguarding of children and vulnerable adults, | <ul style="list-style-type: none"> • Adult Safeguarding Level 2 - https://portal.e-lfh.org.uk/Component/Details/511209 • Child Safeguarding Level 2 – |

| Learning outcome | Examples |
|---|--|
| referring and taking appropriate action. | <ul style="list-style-type: none"> • https://portal.e-lfh.org.uk/Component/Details/510418 • CBD re: • Performing an NAI screening in a child • Involving/initiating a safeguarding incident • Portfolio • Part 2 FRCOphth |
| Apply mental capacity legislation in clinical practice. | <ul style="list-style-type: none"> • Undertake Mental Capacity Act (MCA) training and demonstrate booking best interests meeting • Hold best interests meeting with supervision • Trust Deprivation of Liberty training • MCA: https://portal.e-lfh.org.uk/Component/Details/598749 • Best interest: https://portal.e-lfh.org.uk/Component/Details/597891 |
| Apply appropriate equality and diversity legislation in clinical practice. | <ul style="list-style-type: none"> • Trust equality and diversity training • Reflective piece/CBD of case involving issues of equality and diversity |
| DOMAIN: EDUCATION AND TRAINING | |
| Create learning opportunities for others. | <ul style="list-style-type: none"> • Supervise juniors – logbook • CSR • Thank you note for teaching or learning support from junior trainee or other professional • Feedback from medical students |
| Provide objective assessment. | <ul style="list-style-type: none"> • Objective feedback on teaching or training received • reflective piece • OSCE examiner for medical school |
| Design and contribute to patient education | <ul style="list-style-type: none"> • Evidence of participation in patient education events, patient support group meetings etc • Design or revise patient information leaflets or videos • Involvement in other forms of patient education |
| DOMAIN: RESEARCH AND SCHOLARSHIP | |
| Implement service improvement by revision and development of guidelines, treatments and practical procedures using current clinical research and contemporary evidence. | <ul style="list-style-type: none"> • Involvement in QI project, audit, evaluation, writing business case • Developing departmental guidelines, • Developing teaching handbook • Evidence of participation in the NIHR Associate Principal Investigator Scheme |
| Lead research / teaching sessions and critically appraise oral presentations. | <ul style="list-style-type: none"> • Chair local postgrad teaching • Chair simulation course • Evidence of presentation in local and regional teaching • Evidence of feedback given • Evidence of organising teaching session • Publications |

12 Level 4 Guide

Level 4 ePortfolio evidence

1. EPA Level 4 – two EPAs out of twelve (minimum of one every six months). Level 4 requirements per SIA are summarised in **Table A** Level 4 EPA requirements for each SIA.
2. EPA Level 4 Managing Operating List - for each surgically based SIA ((Oculoplastics & Orbit, Cornea & Ocular Surface Disease, Cataract Surgery, Glaucoma, Vitreoretinal Surgery, Ocular Motility and Paediatric Ophthalmology).
3. GSAT Level 4 – one every six months until final one signed off by ES as achieving Level 4. competencies in the six non-clinical domains. Examples of evidence that can be used in the Level 4 GSAT are summarised in **Table B** Examples of GSAT Level 4 evidence.
4. ESR – one every six months and final one indicating that Level 4 competencies have been achieved in all seven domains.
5. Logbook indicating the described breadth of surgical experience (see Patient Management Level 4 [syllabi](#)) and supervision of juniors at Level 3 in the chosen SIA.
6. Cataract complications audit where Level 4 Cataract Surgery training is undertaken.
7. Audit of surgical outcomes for each surgically based SIA undertaken (Oculoplastics & Orbit, Cornea & Ocular Surface Disease, Cataract, Glaucoma, Vitreoretinal Surgery, Ocular Motility and Paediatric Ophthalmology).
8. Logbook
9. PDP
10. MSF – one per calendar year
11. Form R or SOAR declaration
12. Satisfactory outcome at ARCP

Level 4 requirements are summarised the [web version](#) of this Handbook.

Table A Level 4 EPA requirements for each SIA

*A formative tool should be used if the resident is not achieving the expected level. These requirements can be demonstrated by DOPS, OSATS, direct observation or observation by another team member.

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Other mandatory requirements |
|--|---|--|
| OCULOPLASTICS | | |
| CRS1 Consultation skills in oculoplastics | OSATS Surgical skills – eyelid and adnexal surgery | Nasal endoscopy* - either Outpatients or Theatre |
| Independent management of the oculoplastics clinic* | OSATS Temporal artery biopsy | Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible |
| Management of thyroid eye disease* | OSATS Removal of eye (enucleation and evisceration) | Longitudinal observation by consultant assessor in the theatre and simulation setting |
| Participation in MDT meetings* | EPA L4 Managing an oculoplastics operating list | Review of logbook |
| Ability to supervise and train trainees and other health professionals in oculoplastic | Surgical management of oculoplastic adnexal and | |
| Surgery to Level 3 in a clinic setting* | | |

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Other mandatory requirements |
|--|--|--|
| | lacrimal conditions including complex entropion, Ectropion, ptosis, surgical excisions, and peri-ocular reconstruction* Anterior orbital biopsy* External dacryocystorhinostomy* | Review of personal audit of surgical outcomes Review of record keeping and letters CbDs Multi-assessor report |
| CORNEA & OCULAR SURFACE DISEASE | | |
| CRS1 Consultation skills in cornea and ocular surface disease Independent management of the cornea and ocular surface clinic* Management of complex corneal, ocular surface and anterior segment disease including use of systemic immunomodulators* Management of post refractive surgery complications e.g. ectasia, epithelial in growth* Ability to supervise and train trainees in corneal and ocular surface disease to Level 3 and other health professional in a clinic setting* | OSATS Surgical skills – cornea and ocular surface OSATS Cataract surgery EPA L4 Managing a corneal and ocular surface operating list Complex cataract surgery, pre-existing corneal abnormalities, absence of capsular support, etc.* Corneal grafting* Ocular surface biopsy* Pterygium surgery and amniotic membrane graft* Conjunctival manipulation* Collagen crosslinking* Supervise and provide objective assessment of cataract surgical competency at Level 3 (e.g. WpBAs such as DOPS or OSATS)* | Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible Longitudinal observation by consultant assessor in the theatre and simulation setting Review of logbook Review of personal audit of surgical outcomes Review of record keeping and letters CbDs Multi-assessor report |
| CATARACT SURGERY | | |
| CRS1 Consultation skills in cataract surgery Independent management of the cataract clinic* Perform and interpret biometry in complex cases* | OSATS Managing range of complex cataract surgery cases and different IOL types EPA L4 Managing a cataract operating list Performance of anterior vitrectomy* Placement of secondary IOL* | Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible Longitudinal observation by consultant assessor in the theatre and simulation setting Review of logbook |

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Other mandatory requirements |
|--|--|---|
| | <p>Management of complication including capsule tears and iris complications*</p> <p>Ability to supervise and train trainees in cataract surgery to Level 3 and other health professionals in a theatre setting*</p> | <p>Review of ‘continuous audit of complications of cataract surgery’ and evidence of ability to manage complications</p> <p>Review of ‘Outcomes 50 consecutive cataract surgery’ personal audit (to be completed within 3 years of achieving Level 4 Cataract Surgery)</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| GLAUCOMA | | |
| <p>CRS1 Consultation skills in glaucoma</p> <p>Independent management of the glaucoma clinic*</p> <p>Ability to supervise and train trainees in glaucoma surgery to Level 3 and other health professional in a clinic setting*</p> | <p>OSATS Microsurgical skills – glaucoma surgery</p> <p>OSATS Cataract surgery</p> <p>EPA L4 Managing a glaucoma operating list</p> <p>Complex cataract surgery: shallow anterior chamber, poor dilation, pseudoexfoliation, previous glaucoma surgery, etc.*</p> <p>Supervise and provide objective assessment of cataract surgical competency at Level 3 (e.g. WpBAs such as DOPS or OSATS)*</p> | <p>Medical and surgical management of glaucoma patients including trabeculectomy or non-penetrating glaucoma surgery and cyclodestructive procedures* - either Outpatients or Theatre</p> <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of logbook</p> <p>Review of personal audit of surgical outcomes</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| UVEITIS | | |
| <p>CRS1 Consultation skills in uveitis</p> <p>Independent management of the uveitis eye care clinic*</p> | | <p>Longitudinal, periodic observation by consultant assessor in the</p> |

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Other mandatory requirements |
|--|-----------------------------------|---|
| <p>Advanced interpretation of electrophysiology and multi-modal imaging modalities: e.g. FFA/ICG/Blue light autofluorescence and EDI-OCT*</p> <p>Prescribe steroid sparing agents and/or biologic therapies*</p> <p>Liaise with physicians for systemic management of patients*</p> <p>Ability to supervise and train trainees and other health professionals in uveitis to Level 3 in a clinic setting*</p> | | <p>outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| MEDICAL RETINA | | |
| <p>CRS1 Consultation skills in medical retina</p> <p>Independent management of the medical retina clinic*</p> <p>Advanced interpretation of multi-modal imaging*</p> <p>Use of appropriate pharmacological and laser therapies*</p> <p>Indirect laser and subthreshold laser treatment*</p> <p>Photodynamic therapy*</p> <p>Order appropriate genetic testing and interpret results*</p> <p>Ability to supervise and train trainees in intravitreal injections and laser techniques up to Level 3 and other health professional in a clinic setting*</p> | | <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of personal audit of treatment outcomes</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| VITREORETINAL SURGERY | | |

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Other mandatory requirements |
|--|---|--|
| <p>CRS1 Consultation skills in vitreoretinal surgery</p> <p>Independent management of vitreoretinal clinic*</p> <p>Management of endophthalmitis, vitreous haemorrhage, sub-retinal haemorrhage, uncomplicated rhegmatogenous retinal detachment, vitreo-macular traction, epiretinal membrane, macular hole*</p> <p>Indirect laser to the retina*</p> <p>Ability to supervise and train trainees in vitreoretinal surgery to Level 3 and other health professional in a clinic setting*</p> | <p>OSATS Cataract surgery</p> <p>OSATS Microsurgical skills - vitreoretinal surgery</p> <p>EPA L4 Managing a vitreoretinal operating list</p> <p>Complex cataract surgery, post vitrectomy, posterior polar cataract, etc.*</p> <p>Management of complications of cataract surgery*</p> <p>Supervise and provide objective assessment of cataract surgical competency at Level 3 (e.g. WpBA such as DOPS or OSATS)*</p> | <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>Review of logbook</p> <p>Review of personal audit of surgical outcomes</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| OCULAR MOTILITY | | |
| <p>CRS1 Consultation skills in ocular motility</p> <p>Independent management of the ocular motility clinic*</p> <p>Complex strabismus assessment and management*</p> <p>Ability to supervise and train trainees and other health professionals in ocular motility disease surgery to Level 3 in a clinic setting*</p> | <p>OSATS Surgical skills (extraocular muscle surgery)</p> <p>DOPS Botulinum toxin injection to extraocular muscles</p> <p>EPA L4 Managing an ocular motility operating list</p> | <p>DOPS Botulinum toxin injection - either Outpatients or Theatre</p> <p>Management of complications of strabismus surgery and re-do surgery* - either in Outpatients or Theatre</p> <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>Review of logbook</p> <p>Review of personal audit of surgical outcomes</p> <p>CbDs</p> <p>Multi-assessor report</p> |

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Other mandatory requirements |
|--|---|---|
| NEURO-OPHTHALMOLOGY | | |
| <p>CRS1 Consultation skills in neuro-ophthalmology</p> <p>Independent management of the neuro-ophthalmology clinic*</p> <p>Forced duction test*</p> <p>Use and interpretation of appropriate neuroimaging*</p> <p>Use of and interpretation of appropriate electrodiagnostic testing*</p> <p>Ability to supervise and train trainees and other health professionals in neuro-ophthalmology to Level 3 in a clinic setting*</p> | <p>OSATS Temporal Artery Biopsy</p> <p>DOPS Botulinum toxin injection to extraocular muscles</p> | <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| PAEDIATRIC OPHTHALMOLOGY | | |
| <p>CRS1 Consultation skills in paediatric ophthalmology</p> <p>Independent management of the paediatric care clinic*</p> <p>Diagnosis and treatment of ROP*</p> <p>Collaborative working with tertiary and special interest teams*</p> <p>Ability to supervise and train trainees and other health professionals in paediatric ophthalmology to Level 3 in a clinic setting*</p> | <p>OSATS Surgical skills – paediatrics</p> <p>DOPS Laser for retinal problems (e.g. ROP)</p> <p>EPA L4 Managing a paediatric operating list</p> | <p>Complex strabismus and nystagmus assessment* - either Theatre or Outpatients</p> <p>Management of complications of strabismus surgery and re-do surgery* - either Theatre or Outpatients</p> <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of logbook</p> <p>Review of personal audit of surgical outcomes</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| COMMUNITY OPHTHALMOLOGY | | |

| Mandatory requirements in Outpatients | Mandatory requirements in Theatre | Other mandatory requirements |
|--|------------------------------------|---|
| <p>Understand local eye health needs, value of services and financial pressures</p> <p>Ability to supervise and train trainees in community ophthalmology to Level 3 and other health professionals</p> <p>Health services evaluation project/quality improvement project</p> | | <p>Longitudinal, periodic observation by consultant assessor in the outpatient and community setting where possible (consider handling of referrals, communication with primary care, virtual clinics, teleophthalmology, etc.)</p> <p>Review of record keeping and letters</p> <p>CbDs</p> <p>Multi-assessor report</p> |
| URGENT EYE CARE | | |
| <p>CRS1 Consultation skills in urgent eye care</p> <p>Independent management of the urgent eye care clinic*</p> <p>Ultrasound of the vitreous cavity, retina and choroid- performance and interpretation*</p> <p>Ability to supervise and train trainees in urgent eye care to Level 3 and other health professionals in a clinic setting*</p> | <p>OSATS Ocular/adnexal trauma</p> | <p>OSATS1 Vitreous biopsy and intravitreal injection in endophthalmitis* - either Theatre or Outpatients</p> <p>Longitudinal, periodic observation by consultant assessor in the outpatient and/or on call setting, where possible</p> <p>Longitudinal observation by consultant assessor in the theatre and simulation setting</p> <p>Review of record keeping and letters</p> <p>Review of logbook</p> <p>CbDs</p> <p>Multi-assessor report</p> |

Table B Examples of GSAT Level 4 evidence

CbDs and reflections can be used to demonstrate evidence.

| Learning outcome | Examples |
|--|---|
| DOMAIN: HEALTH PROMOTION | |
| <p>Develop special interest area specific guidance for health promotion.</p> | <ul style="list-style-type: none"> • New local guidelines • Develop or update patient information leaflet in SIA for health promotion |
| <p>Be an effective supervisor and guide in the area of health promotion.</p> | <ul style="list-style-type: none"> • Logbook, Audit, reflective practice • Evidence of supervision of more junior trainee in explaining health promotion strategy to patients |

| | |
|--|---|
| | <ul style="list-style-type: none"> • Evidence of involvement in patient engagement events • Evidence of supervision or providing training for other members of multidisciplinary team in health promotion in SIA |
| DOMAIN: LEADERSHIP AND TEAMWORKING | |
| Critically evaluate own skills in leadership, with particular reference to the quality of patient care. | <ul style="list-style-type: none"> • Audit, reflective practice • Examples include: <ul style="list-style-type: none"> ○ Audit of own or departmental outcomes with reflection ○ SIA audit ○ Audit of own surgical outcomes; cataract for example or ptosis if doing oculoplastics • Supervising, challenging, influencing and appraising colleagues and peers to enhance performance and to support development • Critically appraise performance of colleagues, peers and systems and escalate concerns • Attend and contribute to clinical governance meetings, e.g. confirmed log of meetings attended/evidence of participation in governance |
| Promote service improvement through: quality, innovation, productivity and prevention (QIPP); supervision of the multidisciplinary team; effective management of incidents and complaints. | <ul style="list-style-type: none"> • QIPP, M+M, SAI's involved in/ RCA meetings • Undertake a quality, innovation, productivity and prevention (QIPP) project • Supervision of the multidisciplinary team e.g., run a theatre list/ outpatient clinic • Effective management of incidents and complaints • Demonstrate management of a complaint with report and be involved in the investigation • Demonstrate training in root cause analysis • Demonstrate understanding of risk register and risk assessment • Provide proof of supervision ability • Simulation/clinical setting/theatre |
| DOMAIN: PATIENT SAFETY AND QUALITY IMPROVEMENT | |
| Share improved practice with others and be able to defend changes made. | <ul style="list-style-type: none"> • Portfolio • Part 2 FRCOphth • Research/publication |
| Critically evaluate own skills in quality improvement. | <ul style="list-style-type: none"> • Portfolio • Part 2 FRCOphth • QI Project/Audit; reflection piece on own work |
| Promote clinical governance and quality improvement in the wider organisation / NHS. | <ul style="list-style-type: none"> • Portfolio • Part 2 FRCOphth • QI project, Audit |
| DOMAIN: SAFEGUARDING AND HOLISTIC CARE | |
| Critically evaluate personal and wider organisational responses to safeguarding issues | <ul style="list-style-type: none"> • Adult and Child Safeguarding Level 3 https://portal.e-lfh.org.uk/Component/Details/510424 • Safeguarding Children: Level 3 – Parental Risk Factors https://portal.e-lfh.org.uk/Component/Details/510430 • Safeguarding Children: Level 3 – Unexplained Injuries https://portal.e-lfh.org.uk/Component/Details/510436 • Safeguarding Children: Level 3 – Disability and Neglect https://portal.e-lfh.org.uk/Component/Details/510442 • Safeguarding Children: Level 3 – Fabricated and Induced Illness https://portal.e-lfh.org.uk/Component/Details/510448 • Deprivation of Liberty Safeguards (DoLS) training • Audit/QIP in Safeguarding standards |

| | |
|--|---|
| | <ul style="list-style-type: none"> • Reflective piece/CBD in a more complex case involving support for visual impairment/additional needs |
| Supervise and support other professionals with regard to safeguarding. | <ul style="list-style-type: none"> • Teaching for colleagues • Supervising more junior trainee or members of multidisciplinary team; arranging best interests meeting or undertaking MCA training or arranging for patient with special needs to attend clinic/procedure/theatre. • Arranging teaching session on MCA/DOLS training etc |
| Demonstrate effective specialised management techniques for those with special needs. | <ul style="list-style-type: none"> • Undertaking best interests meeting; make specific enhancements to support patient in theatre, clinic, procedure undertaken • Audit/QIP in Safeguarding standards • Reflective piece/CBD in a more complex case involving support for visual impairment/additional needs • Creating or updating patient information leaflets |
| DOMAIN: EDUCATION AND TRAINING | |
| Demonstrate readiness to act as a clinical and educational trainer. | <ul style="list-style-type: none"> • Take on supervision roles, training skills, mentoring, supervising in theatre, logbook • Appropriate Training the Trainers course(s) to be a registered Clinical Supervisor • PG Cert or MSc in medical education • TTT course • College faculty for surgical courses/examiner |
| Balance service and training needs. | <ul style="list-style-type: none"> • Demonstrate ability to supervise or assist more junior trainees or other professionals in clinic but manage clinic in timely manner • CSR • Supervising juniors on theatre |
| Be able to identify and support a trainee experiencing difficulty. | <ul style="list-style-type: none"> • Supervise, support and encourage other trainees • Module on trainee in difficulty in Training the Trainers courses |
| DOMAIN: RESEARCH AND SCHOLARSHIP | |
| Understand the principles of research methods, research governance, application of ethics to research and the translation of research into practice. | <ul style="list-style-type: none"> • Research/publication, evidence of submission of application for funding for research project • Evidence of participation in the NIHR Associate Principal Investigator Scheme • Evidence of involvement in ethics submission for research project; use own or contemporary research to revise/develop local guidelines • GCP course |
| Promote innovation in ophthalmology. | <ul style="list-style-type: none"> • Publication – 1st author • Evidence review for own research project/publication; evidence of submission for funding for research project; complete and publish peer-reviewed paper • Evidence of participation in the NIHR Associate Principal Investigator Scheme |

13 Feedback and Reflection

Reflection and feedback are integral components to all assessments and should take place regularly throughout each year of the training programme. Every clinical encounter can provide a unique opportunity for reflection and feedback, which should take place as soon as possible after an event to maximise benefit. Feedback should be of high quality and should include an

action plan for future development. Both parties should recognise and respect cultural differences when giving and receiving feedback.

Giving feedback

Feedback should not be seen as merely providing a commentary on what the resident doctor has achieved, or what corrections need to be made. The trainer should devote adequate professional time to give high-quality feedback. When performed well, feedback:

- Improves awareness of both strengths and areas for development.
- Can be used for developmental activity to develop generic skills and a greater dialogue.

Effective feedback

Effective feedback has the following characteristics:

- Feedback is timely and provided as near as possible to the activity or assessment.
- Feedback is focussed on the behaviour / capability and not on the person, ensuring that achieving the Learning Outcome is the primary focus.
- Feedback is understandable and useful to the resident doctor.
- Feedback is 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 to produce clear action plans.
- Feedback supports the resident doctor in becoming self-aware and forming their own judgements about their own performance and level of work.

Feedback tools

Each assessment tool included in the programme of assessment provides 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. The MSF is a method used to assess common skills including behaviours, team working and communication skills.

Reflective practice

Reflective practice is strongly encouraged and is a key underpinning concept of the curriculum. Identifying the many approaches and opportunities to learn from experiences, both positive and negative, will require residents to consider the impact of actions and the outcomes.

Glossary of terms

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|------|---|
| ARCP | Annual Review of Competency Progression |
| CbD | Case-based Discussion |
| CCT | Certificate of Completion of Training |
| CPD | Continual Professional Development |
| CRS | Clinical Rating Scale |
| DOPS | Direct Observation of Procedural Skills |
| EPA | Entrustable Professional Activity |
| ES | Educational Supervisor |
| ESR | Educational Supervisor Report |

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| GMP | Good Medical Practice |
| GPCs | Generic Professional Capabilities |
| GSAT | Generic Skills Assessment Tool |
| MAR | Multi-Assessor Report |
| MSF | Multisource Feedback |
| NCS | Named Clinical Supervisor |
| OSATS | Objective Structured Assessment of Technical Skills |
| OST | Ophthalmic Specialist Training |
| PDP | Professional Development Plan |
| SEB | Statutory Education Body |
| SIA | Special Interest Area |
| SLE | Supervised Learning Event |
| WpBA | Workplace-based Assessment |