The Royal College of Ophthalmologists:
Guide for delivery of Ophthalmic Specialist Training (OST)
Version 2.2
February 2009

www.rcophth.ac.uk
Please give feedback with comments and suggestions to the College

Note this guide remains an interim document and further change is inevitable. If you consult the other documents and sources of information mentioned in this guide make sure you are looking at the most up-to-date version of that source.

Contents:

The (College) Regional Adviser
The College Tutor
The Consultant Trainer

1. Introduction

1.1 The term Ophthalmic Specialist Training (OST) refers to the new scheme of postgraduate training in ophthalmology, which started across the UK for new entrants in August 2007. It is planned that this guidance from The Royal College of Ophthalmologists will evolve and improve in the light of our experience with the new form of specialist training. Feedback and suggestions to the College are encouraged.

1.2 The scheme is described as seamless or run-through training and has been developed by the College in response to the overall changes in medical postgraduate training developed by the NHS organisation "Modernising Medical Careers" (MMC).

The key features of the new approach to training are:

- Basic specialist training and higher specialist training are combined into one continuous programme
- The new curriculum for OST is based on specific identified learning outcomes
- Much of the assessment of competency will occur in the workplace
- A new examination structure has been developed for OST

For more information see www.mmc.nhs.uk

1.3 Another change in the training environment that has occurred at the same time is the replacement of the Specialist Training Authority (STA) by a new body the Postgraduate Medical Education and Training Board (PMETB). This new body was established by the Government to be responsible for the standards of medical postgraduate training (see Annexe A).

1.4 PMETB have established generic standards of training for specialist training programmes, and the OST programme in each Deanery should conform to these standards .

1.5 These standards cover the following domains:

Domain 1: Patient Safety
Domain 2: Quality Assurance, Review and Evaluation
Domain 3: Equality, Diversity and Opportunity
Domain 4: Recruitment, selection and appointment
Domain 5: Delivery of curriculum including assessment
Domain 6: Support and development of trainees, trainers and local faculty

Domain 7: Management of Education and Training
Domain 8: Educational resources and capacity
Domain 9: Outcomes

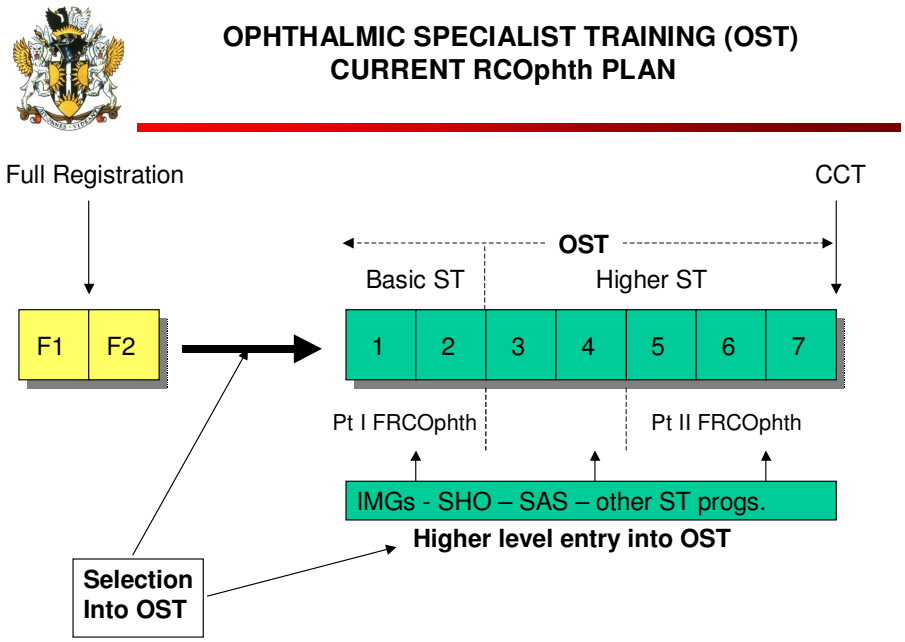
1.6 Standard of patient care. It is essential that both trainees and trainers maintain a good standard of patient care and make the care of patients their first concern. Particular issues for the training environment are the proper supervision of the trainee, the level of competence of the trainee, and good communication with the patient.

The duties of a doctor in respect of patient care are clearly set out in the General Medical Council (GMC) document "Good Medical Practice" (latest version of this document 13th November 2006).

Standards relating to patient safety are specified in Domain 1 of the PMETB generic standards for training mentioned above.

The RCOphth curriculum for OST specifies defined learning outcomes many of which relate directly to providing good patient care. See the web-based Curriculum for more details

1.7 The basic structure of OST is a 7-year continuous programme of postgraduate ophthalmic training leading to the successful candidate who completes the whole programme being awarded a CCT and thus being placed on the Specialist Register. A diagrammatic representation of the scheme is shown below:



1.7 It is thus apparent that basic specialist training occurs during Years 1 and 2 (approximately equivalent to the old Basic Specialist Training), higher specialist training occurs during Years 3 to 7 (approximately equivalent to the old curriculum of Higher Specialist Training), and more focussed training in the form of Trainee Selected Components may occur in Year 6 or 7.

1.8 However the endpoint for the training programme of OST is the successful completion of the learning outcomes set out in the Curriculum, rather than time served in a training programme. Thus an individual trainee may take either a shorter time or a longer time than the seven years indicated in the Diagram and referred to in this guidance.

2. Other relevant guidance:

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

- The RCOphth curriculum for OST
- The RCOphth study guide for OST
- The RCOphth on-line portfolio for OST
- The RCOphth examinations of OST
- The GMC document "Good Medical Practice"
- The PMETB generic training standards
- Other relevant publications from MMC and PMETB
- The Gold Guide for ST First Edition June 2007

Detailed information on these key areas is available on the College website at www.rcophth.ac.uk

International Medical Graduates (IMGs) should consult the specific information for IMGs on the MMC, RCOphth, and other relevant websites.

3. Induction programme for OST:

3.1 An induction programme, with supporting documentation should occur at the start of OST. The initial induction should have input from the Deanery and should cover the features of the OST programme.

3.2 In addition part of the induction will relate to the particular Trust or Unit at which the programme starts, and this element of the induction will need to be repeated with each move to a new Hospital during the OST programme. This local component of the induction process should include both ophthalmology and generic parts. For example: being shown facilities of hospital, meet key members of staff, given copies of care pathways, practice guides, unit or hospital handbook.

3.3 The Trainee will be allocated an Educational Supervisor. There will be a Learning Agreement that sets out specific aims and learning outcomes for the training placement. See para 7.16 to 7.23 of the Gold Guide for more information.

3.4 See also para 6.1 and 6.2 of Domain 6 of PMETB Generic Standards for Training.

4. Assessment during OST:

4.1 Workplace based assessments of learning outcomes as set down in the curriculum. See also Section 7 of the Gold Guide.

4.2 Examinations as specified by the College (see the Examinations part of the College website for current guidance or contact the Examinations department at the College). In order to progress in OST, the mandatory examination requirements (for those trainees following the new examination format from the beginning) are to pass Part 1 FRCOphth by the end of OST Year 2, to pass the Refraction Certificate by the end of OST Year 3, and to pass the Part 2 FRCOphth by the end of OST Year 7.

4.3 Annual Record of In-Training Assessment (RITA) has been replaced (for trainees following the new curriculum) by the Annual Review of Competence Progression (ARCP) as specified in the Gold Guide for ST (see the Gold Guide Section 7 and Appendices for detailed information about the ARCP process).

5. OST Years 1 and 2 (Basic specialist training (BST))

5.1 Doctors entering OST will require closely supervised training in basic examination methods and techniques, and should rapidly be introduced to the elements of surgery and the management of general outpatients and accident and emergency ophthalmic patients. In their second year, they will be expected to take a larger role in both theatre and outpatients, where they will benefit from special clinics. In general, therefore, the training units should provide a broad-based training in general ophthalmic medicine and surgery and exposure to the common subspecialties.

5.2 The detailed learning outcomes, which must be achieved in year 1 and year 2 of OST, are set out in the curriculum, as are the assessment methods that must be used. Many of these assessment tools are based in the work place and trainers will need to be trained in the use of these methods. Trainees will be familiar with these assessment methods as they are used in the Foundation programme. In addition the RCOphth Study Guide gives supplementary information that will be helpful to the trainee and trainer.

5.3 In terms of examinations required to progress through OST, part 1 FRCOphth must be passed by the end of year 2. The refraction certificate must be passed by the end of Year 3. There is specific guidance in relation to examinations and

the transition period for the implementation of OST. For more information see the examinations guide produced by the College.

5.4 Units providing training for Year 1 and Year 2 OST should normally have a minimum of three Consultants with a major sessional commitment to that ophthalmic training unit. The unit should provide a broad programme of experience in which the trainee may develop his/her skills progressively.

5.5 All Consultants acting as trainers should be competent to train and would normally have completed a Training the Trainers course. Trainers should actively pursue their own as well as their trainees' medical education and must enrol for a Continuing Professional Development programme.

More senior trainees in OST (Years 3 to 7) have an important supportive role in training Year 1 and Year 2 trainees and may be of particular benefit to the trainee during the early stages of his or her training.

5.6 Other medical and paramedical professional staff (for example nurses, orthoptists, and optometrists) may make significant contributions to the training of OST trainees. Non-consultant career grade doctors may make a valuable contribution to training, provided that a consultant who acts in an overall supervisory capacity delegates this role. Any medical or paramedical staff who assist in delivery of training should be competent to train.
Associate specialists and staff grade doctors, and nurse practitioners may help with the outpatient work or with what traditionally have been regarded as 'clerking duties' of the trainee, in order that the trainee may not become overburdened with such duties to the detriment of his or her training.

5.7 The employment of a nurse practitioner or another paramedical professional to carry out pre-operative biometry will prevent the trainee becoming unduly occupied with excessive routine clerking. Although complete competence in the performance of biometry is not a specific learning outcome for ophthalmology trainees, they are expected to have done enough biometry to interpret it correctly and to understand the limitations and potential problems of the technique. Likewise, the assistance of anaesthetic colleagues in the pre-operative assessment of patients requiring general anaesthesia should, where possible, be sought.

5.8 The Training Programme
There should be a clear commitment by all the ophthalmic consultants to the education of the trainee. The College Tutor (or other appointed Educational Supervisor) should monitor the trainee’s progress in attaining the required learning outcomes set out in the curriculum through the educational appraisal process and the Annual Review of Competence Progression (ARCP) process with information from work place based assessments and the trainee’s portfolio.

5.9 Guidance on the Weekly Timetable

Year 1 and 2 OST trainees should undertake no more than eight clinical sessions a week.

The weekly timetable should include:

- General clinics 3 (maximum)†
- Accident and Emergency 2 (maximum)†
- Theatre 2 (minimum of 1 protected session)
- Other* 1

† There should be no more than 5 general sessions, including accident and emergency and primary care.

*Laser, consultant supervised pre-assessment clinic (see 4.7), special clinic, etc.

There should be 2 sessions for Teaching / Study / Research / Audit

Each trainee should have access to training in refraction.

5.10 The trainees should have some exposure to special clinics, particularly those which offer training in methods of examination.

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

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

All trainees should attend a Royal College of Ophthalmologists basic microsurgical skills course before they are allowed to undertake intraocular procedures on patients. This may take place at any time during the first six months of OST, preferably near the start, and may even occur before entry into a training programme. Nevertheless, until they have attended such a course, they are expected to start supervised extraocular surgery and assist in intraocular procedures.

5.12 More experienced year 1 and year 2 trainees should be involved in supervised intraocular surgery. Further guidance is given in the curriculum and associated study guide**.**

5.13 It is essential for the trainee to perform sufficient numbers of surgical cases (particularly cataract procedures) to experience a full range of clinical situations (e.g. white cataract, small pupil) so that the trainee learns techniques to manage a range of cases, and becomes competent in managing complications. For

example it is expected that at the end of year 2 the trainee will typically have completed approximately 50 phacoemulsification cataract procedures.

Surgical progress should be recorded using a logbook (see guidance on format on RCOphth website), which will form part of the trainee's portfolio.

5.14 Trainees are expected to attend at least one protected operating list a week, which implies that the trainee will have hands on surgical experience during this session. The trainee should be undertaking his/her own surgical procedures under supervision on these lists. Where there is a division of surgery into service and training lists, there is in general little training value for the trainee to attend the service list.

5.15 College Tutors should supervise the handover of trainees from one eye department to another in a rotation. This handover should include, amongst other issues, communication between trainers so that a seamless process of supervision, ensuring a progressive learning environment for surgery, can be achieved.

5.16 Experience should be provided in emergency ophthalmology and trainees should be involved in the management of ophthalmic casualties, although they should not attend more than 2 accident and emergency sessions per week. There should be a regular on-call commitment although this should not necessarily mean that post holders must be resident. It is not necessary for ophthalmic accident and emergency to be open throughout the 24 hours to deliver appropriate training for OST.

6. OST Years 3 to 7 (higher specialist training (HST)):

6.1 The detailed learning outcomes, which must be achieved in year 3 to year 7 of OST, are set out in the curriculum, as are the assessment methods that must be used. Many of these assessment tools are based in the work place and trainers will need to be trained in the use of these methods. Trainees will be familiar with these assessment methods as they are used in the Foundation programme. In addition the RCOphth Study Guide gives supplementary information that will be helpful to the trainee and trainer.

6.2 In terms of examinations required to progress through OST, the refraction certificate must be passed by the end of Year 3, and the part 2 FRCOphth must be passed by the end of year 7 of OST. For more information see the examinations guide produced by the College.

6.3 Guidance on Rotations
The role of the trainee in all parts of the rotations, including the District General Hospital, is in a training capacity, which should never be subordinate to the service commitment.

The trainee's level of clinical responsibility in any part of the rotation should increase progressively according to the seniority of the trainee, his/her level of competence and any guidance from the STC.

6.4 A Year 3 trainee should receive a good general educational grounding, although the firms to which he/she is allocated should also provide a subspecialty interest.

An OST programme should provide training in the 7 main ophthalmic subspecialties, which underpin the curriculum.
These are:

1. Oculoplastic, Adnexal and Lacrimal Surgery
2. Cornea and External Diseases
3. Cataract and Refractive Surgery
4. Glaucoma
5. Retina, Vitreous and Uvea (including Ocular Oncology)
6. Neuro-Ophthalmology
7. Paediatric Ophthalmology and Strabismus

Access to teaching in ocular pathology is important.

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

6.5 The STC will ensure that all trainees have a suitably balanced rotational programme including a satisfactory balance in the programme between Teaching Hospital and District General Hospital experience.

6.6 It is important that every trainee knows the identity of, and has access to, the Chairman of the STC, the Regional Adviser, the Programme Director and the College Tutor.

6.7 <u>Guidance on Weekly programme</u>

In general, every session should be appraised for its value as a training resource. Those sessions, which cannot be made to fit this criterion, should not be part of trainees' timetables and other staff should be employed to provide the service.

There should be no more than 7 clinical sessions per week, whose content should be flexible within the following guidance:
2 general clinics maximum (which may include 1 accident and emergency or primary care clinic and should include a minimum of 1 general clinic)
2 special clinics minimum
1 treatment session such as laser or minor operations (may be replaced by a further special clinic if no suitable treatment session can be devised)
2 theatre sessions minimum

In some parts of the rotation, such as medical retina, less surgery may be allowed provided the STC is satisfied that a balanced training can be achieved.

The remaining weekly sessions should include:
1 (minimum) fully protected research
1 individual study, to include time for undergraduate teaching and personal audit (STA)
1 postgraduate teaching
The weekly programme should indicate the timing of these RSTA sessions. These RSTA sessions are as much a part of the timetable as an operating list or clinic and are not for non-educational use.

6.8 Outpatients
The trainee should see sufficient patients in a clinic to develop competency in managing patients in an outpatient setting but the number seen must not be excessive to the extent that training is impaired. The actual number of patients seen should be appropriate to the competency of the trainee and the complexity of the clinical condition of the patient. In all clinics, trainees should see selected new patients and should be able to present them to the consultant.

A special clinic is a clinic in which patients with a single diagnosis or group of related diagnoses are seen exclusively, and to which there are internal referrals. There should not be a mixture of patients in such a session, even if the bias is towards a particular subspecialty, because this dilutes the trainees' experience.

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

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

6.10 No trainee should undertake timetabled clinical sessions, such as accident and emergency or laser photocoagulation, which do not necessarily need direct supervision, without a consultant being available in the hospital at the time.
It is important that trainees should see the patients they operate upon pre and post-operatively.
Pre-operative assessment clinics are to be encouraged, but should largely be run by nurses, with only a minor input from Year 1 and Year 2 trainees and none from more senior trainees, as these sessions are not valuable as training, unless they are part of a ward round with the consultant present.

6.11 Laser photocoagulation should be fully supervised at the start of training, although thereafter, trainees who have demonstrated the appropriate level of

competence can manage patients without supervision. Trainees should be able to see their patients both before and after treatment. An appropriate laser teaching attachment, such as a sidearm or video, should be available.

Additional experience is valuable, for all grades, in other hospital departments, notably neurology, neurosurgery, plastic surgery, rheumatology, maxillofacial surgery, paediatrics, endocrinology, diabetes and clinical genetics. Trainees should have access to radiological imaging facilities.

6.12 Year 3 to Year 6 trainees may see accident and emergency patients, but usually no more than one weekly session of accident and emergency or primary care should be timetabled. If an accident and emergency session is included in the timetable, it should be substituted for a general clinic. Senior supervision and advice must always be available. It is not necessary for ophthalmic accident and emergency to be open throughout 24 hours to be approved for training.

6.13 Sub speciality clinical experiences

There will be further guidance on this in the appropriate sections of the Study Guide of the new RCOphth curriculum.

6.14 Theatre

Surgical experience should develop as indicated by the learning outcomes in the curriculum and the associated study guide.
It is essential for the trainee to perform sufficient numbers of surgical cases (particularly cataract procedures) to experience a full range of clinical situations (e.g. white cataract, small pupil) so that the trainee learns techniques to manage a range of cases, and becomes competent in managing complications. For example it is expected that by the end of year 7 the trainee will typically have completed approximately 350 phacoemulsification cataract procedures.
To show documented evidence of having undertaken a personal assessment by audit of these cataract procedures; this should include a full audit of at least 50 consecutive cases performed in the latter part of training, measured against the Royal College Cataract Audit data.

The trainee should also have performed and/or assisted at sufficient numbers of surgical cases in the other surgical sub-speciality areas (oculoplastic, cornea, glaucoma, retina, paediatric and squint). Typically a trainee should have the following surgical experience by the end of OST:

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

It is recognised that trainees wishing to acquire sub specialist knowledge and skills will be expected to undertake more procedures in the field of their interest, usually in Year 6 or 7 of OST (TSCs).

6.15 A logbook should be kept (see guidance on format on RCOphth website) and should be up to date and available for inspection at any time. It should contain an audit of the outcomes of the trainee's cataract surgery, as indicated in the study guide. This logbook forms part of the trainee's portfolio.

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

6.17 On call
There should be a regular on-call commitment although this should not necessarily mean that post holders must be resident. It is not necessary for ophthalmic accident and emergency to be open throughout the 24 hours to deliver appropriate training for OST.
On-call cover for neighbouring eye departments is allowed, but only to fulfil statutory limits on junior doctors' hours.

7. Trainee selected components (OST Year 6 or Year 7):

See the separate College guidance on TSCs and Out of Programme Training.

8. Teaching / Audit / Research in OST:

8.1 All trainees should have one session per week protected to attend a regional half-day teaching programme. Any essential activities, such as accident and emergency, during this period should be covered on rotation by all non-consultant career and training grade staff in the department.

8.2 Where attendance at a regional half day teaching session is not possible, trainees should attend a local approved half day teaching programme, but the Training Committee should be consulted before such arrangements are made.

8.3 In some regional teaching hospitals the study half-day session is arranged during university terms only. It is nevertheless expected that trainees should attend a minimum of 30 such sessions a year.
All units should organise at least an hour of formal in-house teaching on a weekly basis, not only to supplement the regional teaching programme but also to

capitalise on local consultant expertise. Informal teaching should be regarded as routine during outpatient and theatre sessions.

8.4 OST Trainees should take an active part in teaching undergraduates, other trainees and paramedical staff.

8.5 The regional teaching programme should include:
Case presentations
Topic teaching
Journal club
Fluorescein conference
Ocular pathology
Audit
Invited speakers (ophthalmologists and non-ophthalmologists)

In addition, combined teaching with neurospecialties and radiology sessions are valuable. All trainees should attend management courses, usually organised within their own deaneries. Similarly, it is valuable for trainees to undergo training in communication skills and the management of visual impairment.
All staff should undergo regular CPR training.

8.6 Consultants, from both the teaching hospital and surrounding units, should attend and participate in the teaching programme whenever possible, as part of their CPD programme.

8.7 Regular audit should take place, with active participation by all grades of staff. As with any audit programme, there should be evidence that conclusions from audit sessions have been properly documented and acted upon.

8.7.1 Personal audit should include the outcome of cataract surgery (see paragraph 6.14 above)

8.8 Evidence of all these training activities should be recorded in the trainee's portfolio.

8.9 Research
All OST trainees are expected to undertake at least one fully protected research session a week.
Research is an important element of the training programme. There should be an identified research supervisor who will not only be able to assist the trainee in finding appropriate projects but also ensure that the work is carried through.
In many rotations, it will be possible to undertake all the research in the teaching centre, but in some it is necessary to initiate research in DGHs. A heavy service load in such departments must not inhibit research.
Trainees' research output should be accountable, recorded in their portfolio and will be reviewed during the ARCP.

9. Facilities for OST:

9.1 Each training centre should have sufficient facilities and adequate patient throughput to provide appropriate experience in ophthalmic surgery and medicine. The training centre should be fully resourced and equipped as recommended in the Ophthalmic Services Directory from the College. See the College web site for more details.

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

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

9.3 Teaching aids should be available wherever possible, such as sidearms or video cameras on slitlamps and lasers, and teaching mirrors or video cameras on indirect ophthalmoscopes.

9.4 Ancillary equipment that should be available should include:
Fields equipment
Fundus camera / retinal angiography
Argon laser
YAG laser
Keratometer and A-scan ultrasound for biometry
Focimeter
Orthoptic instruments such as prism bar, Hess chart/Lees screen
Corneal pachymeter

9.5 In a teaching hospital, it would be expected that additional equipment would include:
B-scan ultrasound
Anterior segment camera
Electrophysiology equipment
Corneal topography
Advanced retinal imaging equipment e.g. HRT, OCT

Routine radiological investigations with access to CT and MRI scanning should be available. There should be close liaison with other disciplines such as neurology, neurosurgery, plastic and faciomaxillary surgery, metabolic medicine etc.

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

9.7 Ward
It is expected that, with the exception of paediatrics, beds will be dedicated to ophthalmology.
There must be adequate examination facilities for trainees' use in a ward side room, equipped with a slitlamp, indirect ophthalmoscope, test type and trial lens set and, where not available in outpatients, biometry equipment. The side room is often the site, in addition, for informal teaching and ward rounds.

9.8 Daycase unit
The advent of large-scale daycase surgery should not be allowed to be a barrier to teaching in theatre, nor to trainees' surgical experience. It is expected that trainees will have gained the necessary preliminary training in most procedures carried out in daycase units during Year 1 and Year 2 of OST and that consequently surgery under local anaesthetic will not be a bar to teaching.

9.9 Library
All trainees should have access to a medical library, which is open outside weekday and daytime working hours. There should also be reference books available in the Eye Department.
The library should contain books that cover all the principal subspecialties, as well as major ophthalmic texts, and there should be a demonstrable active purchasing policy for new books.

9.10 Ophthalmic journals available on the rotation should include:

British Journal of Ophthalmology
Eye
American Journal of Ophthalmology
Archives of Ophthalmology
Ophthalmology
Survey of Ophthalmology
Investigative Ophthalmology

This list should not be seen as prescriptive and, in large units, is frequently supplemented by specialist journals.
There should be access to computer search / internet facilities. Electronic journal subscription may provide a satisfactory alternative to paper subscription.

Isolated eye hospitals should stock principal general medical texts.

9.11 Additional facilities
Trainees should have a room for study, and should have access to a computer.

A surgical skills laboratory is a valuable ancillary training resource. Appropriate instrumentation and a microscope should be available, and trainees encouraged to use the facility. The facility may be provided at unit or regional level.

10. Quality assurance and inspection process for OST programmes:

10.1 PMETB currently perform Deanery based visits taking place every 5 years. They will be preceded by a detailed process of information gathering both at the Deanery level and the individual Hospital level. More than one specialty is involved in the PMETB-lead Deanery visits.

10.4 PMETB also envisage there may be the need for additional visits in between the regular 5 year Deanery visits: these would be if there were any serious concerns about the standards of training in a particular Hospital or in a Deanery as a whole. These are called “Triggered Visits”.

10.5 In addition it is expected that the Deanery itself will have in place its own robust procedures of information gathering in relation to its ST programmes, and may also where appropriate perform its own inspections on units in the Deanery. These inspections may also involve members of the Training Committee of the RCOphth.

10.6 The College Regional Adviser has a very important role in acting for the College in helping the Deanery to provide high quality ophthalmic training. For more information on the role of the College Regional Adviser see Annexe A.

10.7 The College is developing a process of College Faculty Support to aid and provide guidance locally to the College Faculty of Regional Adviser, College Tutors, and the Deanery STC.

10.8 This guidance may change as PMETB further develops and refines its procedures. See PMETB website for the current guidance and standards.

11. OST for Academic trainees:

11.1 As part of the MMC changes there are new plans for academic medical training.

In brief these consist of specific academic training programmes, with a new post of Academic Clinical Fellow for new entrants to the start of specialist training, and a more senior post of Clinical Lecturer. The programme combines academic research work with a clinical programme, which ultimately leads to the CCT. The

Deanery, the host Trust, and the participating University will run these programmes jointly. The National Coordinating Centre for Research Capacity Development coordinates and partly funds these programmes.

More information is available from:

www.mmc.nhs.uk and www.nccrcd.nhs.uk

11.2 It is recognised that academic trainees may have a lighter clinical load than their non-academic colleagues, but in general, provided that the sessional commitment is not radically different, a prolonged training may not be necessary.

Where it is important for an academic trainee to undertake less than 5 clinical sessions per week, he/she should consider a flexible programme of training.

Academic trainees like all trainees on OST programmes progress by achieving the competences set down in the curriculum and their total time in training, as for all trainees, will depend on how they progress through the curriculum.

11.3 Academic trainees must be prepared to rotate as flexible trainees do and to include a minimum period of 6 months in a DGH. It is recognised that, in some centres, this might put constraints upon the research programme and that, for this reason, some centres may not be able to train junior academic staff within the OST programme. Similarly, academic trainees must participate in all parts of the training programme and care should be exercised by the designated training supervisor and STC that such individuals have experienced a balanced training by the time they apply for the CCT.

11.4 See also Gold Guide 6.81 to 6.90 and 6.103 to 6.108.

12. Research counting towards CCT:

12.1 The College continues to support and encourage trainees who wish to conduct research as part of OST. Any plans must first have the full support of the Deanery. See also the separate College guidance on TSCs which includes advice on Out of Programme Training.

12.2 Up to 6 months time counting towards CCT arising from research may be recommended for approval by the Training Committee of the RCOphth.

12.3 The maximum total time that may count towards CCT arising from all research and Out of Programme Training in the form of a TSC is 12 months. Thus if 6 months time arising from research is granted then only an additional 6 months arising from a TSC can be counted towards CCT.

12.4 Prospective approval must be sought from the STC, the Postgraduate Dean, the Training Committee of the College, and PMETB.

12.5 The application to the Training Committee for recognition of a research period to count towards CCT must be accompanied by a research protocol and a timetable, or job description and timetable as well as written evidence of support from the Chairman of the STC and/or the Programme Director. More detailed information on the paperwork required is available from the Department of Education and Training at the College. The recommendation of the Training Committee will then be passed to PMETB for their formal approval. The Training Committee on completion of the research period or out of programme training requires a brief report.

12.6 See also Gold Guide 2007 para 6.88 to 6.108.

13. Flexible (Less than full time) training:

13.1 Supervision of flexible training is the responsibility of the Regional Postgraduate Dean and the STC, but the Training Committee is available to give advice to trainees and trainers.

The balance of training must be the same for those training flexibly as for those in full-time training. There can be no exceptions to the necessity to rotate, or to the requirement to achieve the learning outcomes laid down in the curriculum.

13.2 The STC will calculate the expected date for the award of the CCT and inform the College through the ARCP process.

In general the College encourages Postgraduate Deans to allow the trainee to work as many weekly sessions as he/she needs, and not to be forced into a half-time programme to facilitate back-to-back training with another flexible trainee.

13.3 More detailed guidance is included in the Gold guide for ST (in particular: para 6.70 to 6.80, and para 7.112)

14. Locum Appointments:

14.1 Guidance is available from the Gold Guide to ST (para 5.35 to para 5.46)

15. Post CCT training:

15.1 Some trainees may wish to acquire additional training outwith the CCT envelope. Such posts are only relevant to the College Training Committee in as much as they may impact on the existing OST programmes and consequently on trainees in post. Training that does not count towards CCT does not need PMETB approval.

15.2 However procedures for post CCT training are likely to be developed in a more formal way particularly in some of the sub-speciality areas of Ophthalmology and the Education Committee of the College is leading this work.

Peter McDonnell FRCP FRCS FRCOphth
Vice President
Chairman - Training Committee

ANNEXE A

The Postgraduate Medical Education and Training Board (PMETB):

On the recommendation of the Council of The Royal College of Ophthalmologists, PMETB awards the Certificate of Completion of Training (CCT) to ophthalmic trainees who have successfully completed a full UK programme of OST. PMETB also ensures that the duration and standards of training comply with their established standards and requirements, and it approves overall programmes of training, curricula of training, and training post inspection processes undertaken by the College.

For more information see www.pmetb.org.uk

The Postgraduate Dean:

OST is organised and coordinated within Deaneries which are based around university medical schools (and number twenty-one in the UK). The Postgraduate Dean has overall responsibility for the appointment and training of trainees in OST and for establishing training contracts with NHS Trusts in accordance with national guidelines (see 'A Guide to Specialist Registrar Training', known as 'The Orange Book', and "The Gold Guide" for ST). The Postgraduate Dean provides a variable proportion of the basic salaries of trainees in OST programmes. The Postgraduate Dean must give his/her approval before posts in OST can be re-advertised. The Deanery, usually through an Associate Postgraduate Dean, also advises trainees interested in part-time training and on educational issues for doctors in difficulties. The Postgraduate Dean also appoints the Programme Director for Postgraduate Ophthalmic Training ('Programme Director') in the Deanery and sits on the Deanery Specialty Training Committee (STC) in Ophthalmology, which oversees the OST programme in the Deanery.

For more information see: www.copmed.org.uk where there are links to individual Deanery websites.

The Royal College of Ophthalmologists:

The Royal College of Ophthalmologists recommends the educational standards required for entry into OST and for the award of the CCT at the end of OST. It determines the curriculum of OST through the Education Committee and formally assesses standards of professional education and training through examinations organised by the Examinations Committee. The Training Committee monitors educational standards through reports received on individual trainees in OST following their Annual Review of Competence Progression (ARCP) by a panel of the Deanery Specialty Training Committee (STC); following receipt of outcome 6 of the ARCP and review of a trainee's logbook, the Training Committee proposes to the Council of the College that it should recommend to PMETB the

award of the CCT. The College also appoints Regional Advisers and College Tutors who, with the Programme Directors, are responsible for the day-to-day management of OST programmes.

The Training Committee of the Royal College of Ophthalmologists:

The Training Committee is a committee of The Royal College of Ophthalmologists.

Its members include nominees from the RCOphth and the surgical Royal Colleges of London, Scotland and Ireland and the armed services as well as RCOphth officers, a legal adviser and the Lead Dean for ophthalmology. The Training Committee reports directly to Council.

The principal functions of the committee include:
a. The supervision of Ophthalmic Specialist Training in the UK.
b. Setting the curriculum for Basic and Higher Specialist Training in liaison with the Education Committee.
c. Recommendation for Educational approval of OST programmes by working with the College Regional Adviser and the Deanery, and by inspection of the programme working with PMETB.
d. Recommendation for Educational approval for Trainee Selected Components, and any out of programme training.
e. Making recommendations to PMETB for the award of the CCT. The Training Committee receives copies of the ARCP forms which are the outcome of Regional assessments and which, together with the Portfolio and success in the College's examinations, form the basis for the decision to award the CCT.
f. To give general advice to trainers and trainees regarding trainees' careers in ophthalmic specialist training.

The award of the NTN and the ARCPs are the responsibility of Postgraduate Deans and the STCs.

The Speciality Training Committee in Ophthalmology:

The STC in each Deanery represents the focus of liaison, co-operation and co-ordination between the Postgraduate Dean and The Royal College of Ophthalmologists. The membership of the STC should include: the Programme Director, the Regional Adviser, the Postgraduate Dean (or alternate), College Tutors from all ophthalmic units participating in OST in the Deanery, two trainee representatives (possibly including one from Years 1 to 2 of OST, and the other from Years 3 to 7 of OST), the College regional representative and the head of the university department of ophthalmology in the medical school if he/she is not already included in the STC membership. It is recommended that the full committee of the STC meets at least twice per year, with additional meetings of STC panels for trainee appointments to OST, and for the ARCPs. The Chairman of the STC is usually the Programme Director but may be the Regional Adviser or another member of the STC.

The STC may be organised as part of a post-graduate specialty School of the Deanery. Such arrangements may vary from Deanery to Deanery: for example ophthalmology may be a school on its own or be part of a larger school with other specialities. The College encourages Deaneries to have single schools of ophthalmology, so that the specialty is fully represented and supported at Deanery level.

The Director of Postgraduate Ophthalmic Training (Programme Director):

The Programme Director is responsible to the Postgraduate Dean for the overall delivery of OST in the Deanery in accordance with College guidelines. The Programme Director's remit includes preparation and publication of the prospectus of OST, the devolution of elements of the College OST Curriculum to individual training units through College Tutors, the equitable allocation of trainees to individual training placements, and direct involvement in trainee appointments and the ARCPs as a regular member of the STC panels charged with these responsibilities. The Programme Director is appointed by the Postgraduate Dean in liaison with the College through the STC. The appointment process involves nominations of eligible Consultant Ophthalmologists (usually from the teaching hospital) either by the Postgraduate Dean to the STC or to the Postgraduate Dean from the STC; the appointment is subject to confirmation by the STC. The duration of appointment is three years (renewable), and frequently coincides with the Chairmanship of the STC.

The (College) Regional Adviser:

The main remit of the Regional Adviser is to promote high standards of Ophthalmology by acting on behalf of the College and maintaining a College presence in each Deanery. The Regional Adviser is a senior member of the STC and regularly participates as a member of STC panels for trainee appointments to OST and the ARCPs. In keeping with the Regional Adviser's specific role in maintaining standards of training in the Deanery, the Regional Adviser has responsibilities in monitoring OST programmes between formal PMETB Deanery visits and in providing a focus for the receipt, assimilation and dissemination of feedback on the quality of training in individual units as reported by trainees in OST after such placements. The Regional Adviser will also have a crucial role in representing the College locally in the process of recommendations to PMETB for educational approval for individual posts and whole programmes in a Deanery. It is important that the Regional Adviser liaises closely with the Training committee in this work. Up to three nominations having been sought from the STC (and thus subject to the approval of the Postgraduate Dean), the Council of The Royal College of Ophthalmologists appoints the Regional Adviser from among the STC nominations; the process is informed by a short Curriculum Vitae and a personal statement from each of the nominated Consultant Ophthalmologists. The duration of appointment is three years (renewable for one further term of three years). Along with Programme Directors, Regional Advisers

meet twice yearly in the College to review educational standards and the training curricula.

The College Tutor:

College Tutors are responsible to the Programme Director for the delivery of formal teaching and of specified elements of the OST curriculum within their units; they also have specific responsibility for the quality of training locally (in liaison with the Trust Postgraduate Clinical Tutor) of those trainees in Years 1 and 2 of OST. The College Tutor is by default the educational supervisor for all of the trainees in their unit, but it is expected that this role may be shared with other consultant trainers, particularly in larger units. See the Gold Guide (para 4.15 to 4.27) for more information about the role of the educational supervisor and the clinical supervisor. They are responsible for the informal appraisal of, and for ensuring the induction and formal assessment of, trainees on OST placements within their units; to aid assessment, College Tutors agree training objectives for each placement with Consultant trainers. College Tutors also have a pivotal role in liaising with the Regional Adviser who will monitor training standards in the unit.

There is generally one College Tutor for each training unit/Trust, although Co-Tutors may be required in the larger teaching centres in view of the wide range of duties involved; in such teaching units, however, some of the duties of the College Tutor will inevitably be undertaken by the Programme Director. College Tutors should sit on the STC, and they should be closely involved in the arrangements for placement of OST trainees in their units and they may be involved in appointments to the OST programme, and ARCPs through the Postgraduate Dean's department.

College Tutors are nominated by their Consultant colleagues in the training unit and the nomination is forwarded by the Chairman of the STC to the Education Committee in the College before being approved by the College Council. College Tutors are appointed for three years (renewable).

College Tutors must conform to the RCOphth person specification, attend a College Tutor Induction Day and are required to have training in appraisal, teaching methods and equal opportunities. They are responsible (from 1 August 2007) for providing the RCOphth with a yearly updated list of non-member/fellow assessors for Workplace-based Assessments.

The Consultant Trainer:

The remit of most Consultant Ophthalmologists includes the provision and supervision of postgraduate ophthalmic training; the training objectives/curricular priorities during such training placements should be agreed in advance between the Consultant Trainer and the College Tutor/Programme Director on the one hand, and between the Consultant Trainer and trainee on the other.

The Consultant Trainer is responsible for maximising the learning opportunities (or informal teaching) arising out of his/her day-to-day practice (in clinics, operating sessions etc.), for ensuring an appropriate balance between a trainee's

service workload and teaching, and for monitoring the extent to which trainees exploit these opportunities.

The Consultant Supervisor/Trainer also has a key role in the workplace based assessment of trainees using the techniques specified by the Education Committee of the College. Through these assessments the Consultant Trainer ensures the relevant learning outcomes laid down in the curriculum of OST are achieved. Such assessment not only forms a basis for a Consultant delegating clinical care to a trainee but also, by certifying/documenting progress against learning outcomes in the trainee's Portfolio, contributes to the ARCP. Validation of entries to the Portfolio such as assessment results, audit results and log-book entries (both clinics/surgeries undertaken and essential experiences) is another aspect of the role.

The Consultant Trainer is also required to respond to feedback on the training content/quality of his/her placement as reported by successive trainees during their ARCPs and as communicated to the Trainer by the Regional Adviser.

A Deanery may wish to consider the concept of appointing a specific Consultant Trainer to act as educational supervisor to a trainee for the whole of his/her time on an OST programme (this is a matter for local arrangement). See the Gold Guide (para 4.15 to 4.27) for more information about the role of the educational supervisor and the clinical supervisor.