The Royal College of Ophthalmologists

Ophthalmology Specialty Training

Workplace Based Assessment (WpBA) Handbook for OST

Curriculum Sub-Committee April 2014

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Introduction

This handbook is intended to complement formal training in assessment provided by the Royal College of Ophthalmologists (RCOphth) and others, for those involved in postgraduate training in the UK. It should be read in conjunction with the RCOphth curriculum for OST.

Assessment

Assessment, in the context of postgraduate medical education is a judgement made about the knowledge, practical skills or attitudes and behaviours of a trainee compared to a known standard. Assessment is often referred to as **formative**, if the main purpose is to provide feedback for a trainee as part of their personal learning and professional development, or **summative** if the outcome is used to make decisions about progress. There are many ways to assess the competence of a trainee doctor. In order to be fit for purpose an assessment should be reliable and valid.

A **reliable** assessment will produce the same result if the assessment is re-applied (Test/retest reliability). Ideally the same trainee should achieve the same result from an assessment if a different assessor observes them (inter-observer reliability).

A **valid** assessment should sample the curriculum or syllabus widely and to an appropriate depth (content validity) and address the important attributes required for practice as an ophthalmologist (construct validity). A trainee passing an assessment should be competent and an incompetent trainee should fail the assessment (predictive validity).

In practice no single assessment scores highly on all of the above and so it is appropriate for a reliable and valid assessment system to utilise more than one assessment tool.

Assessment tools

Some methods of assessment are well known and are used most often in examinations. A few examples are:

- Multiple choice examinations (MCQs).
- Long cases and short cases
- Essays and 'write short notes' (often referred to as constructed response questions or CRQs)
- Objective structured clinical examinations (OSCEs)

As part of the formal postgraduate examination system for OST the new FRCOphth examination will consist of a combination of MCQs, CRQs a structured viva and OSCEs.

Formal examinations, if wellstructured and designed, are reliable and valid but unfortunately cannot cover all aspects of training. They are also 'snap shots' of a trainee's performance and may not truly reflect their performance in the workplace.

Workplace based assessment (WpBA)

The early years of training after medical school, foundation years 1 and 2 (F1, F2), are assessed using a variety of WpBA. Briefly these are:

- Mini-CEX: Clinical Evaluation eXercise. This requires observation of a trainee during a clinical encounter with a patient.
- Mini-PAT: Peer Assessment Tool. This is a form of 360 degree assessment (or "multi-source feedback", MSF).
- CbD: Case based Discussion. This requires review of case notes and discussion of management with a trainee.
- DOPS: Direct Observation of Procedural Skill. This requires observation of a trainee performing a practical procedure on a patient.

The accumulation of several of these assessments during F1 and F2 in their portfolio enables a reliable and valid assessment of a trainee. Each tool is generic and can be applied to any trainee during F1 and F2. Trainees are responsible for ensuring that trainers complete these assessments.

WpBA and OST

The F1 and F2 WpBA tools have been adapted for use in OST. Trainees are responsible for the preparation and organisation of the appropriate WpBAs for their stage of training, as described in the curriculum.

The WpBA are designed to cover most of the curriculum so that by completion of training a trainee will have a **portfolio** of evidence that supports their application for a CCT and complements the evidence obtained by passing FRCOphth.

Each WpBA is designed to assess one part of the curriculum. This is described in the curriculum itself together with the target year/stage of achievement. Progress from one stage of OST to the next is determined by the accumulation of evidence of acceptable performance in the trainee's portfolio.

The WpBAs that are used in OST are:
- Clinical Rating Scales (CRS). These are the equivalent of the mini-CEX for F1 and F2 trainees. They have been adapted from the rating scales used in the Part 2 MRCOphth examination, which has largely been replaced by WpBA. CRS are used to assess achievement of the clinical assessment (CA) learning outcomes of the curriculum. There are 11 CRS forms, one for each CA learning outcome and one for PS2 Cyclopegic refraction (CRSret).
- Direct Observation of Procedural Skills (DOPS). These are are used to assess a trainee's practical skills.
- Objective assessment of technical skills. (OSATS). These are used for the assessment of surgical skills. There are three OSATS in total. 2 are used early on in training for aseptic technique and use of the operating microscope; the third (OSATS1) is used for all of the surgical skills in the curriculum.

All of these WpBA require the assessor to observe the trainee performing an examination or procedure with a patient in the context of clinical supervision.

- Multi-source feedback (MSF). This assessment is carried out remotely and summarises a trainee's performance over an extended period time. Opinions are sought form a variety of the trainee's colleagues (doctors, nurses, orthoptists, technicians, clerical, secretarial and managerial staff) regarding their communication skills and their attitudes and professional behaviours.
- Case-based discussion (CbD). This assessment covers a trainee's decision-making skills, case note writing, and clinical management by reviewing a small set of case notes where they have been involved with the management of patients. It can also be used to assess a trainee after a case presentation as part of a formal teaching session.

Trainees are encouraged to undertake assessments of their competence early in each stage and well before they are due to be submitted to an ARCP panel so they can receive valuable feedback about their performance and progress. It is therefore entirely expected for trainees to have a number of poor or fair areas of performance in the relevant WpBA forms. Under normal circumstances, these weaker areas will be addressed and subsequent assessments will be satisfactory. If a trainee has not satisfactorily completed a given stage's WpBA by the time specified by the local deanery (usually, but not necessarily, the ARCP for that stage of OST), then this must be addressed by an appropriate ARCP outcome.

Each deanery's ophthalmic ARCPs occur at approximately the same time every year. Whatever the local arrangements, setting a fixed date for ARCPs so that this can be determined years in advance, and making this well known to ARCP panel members, educational supervisors and trainees is essential. ARCP arrangements vary from deanery to deanery. Some deaneries arrange the ARCPs quite early in the year when trainees may not be expected to have all the

required learning outcomes (LOs) for that stage. The ARCP panel certify that that the trainee is achieving their LOs at the expected rate and will be given a favourable ARCP outcome. Satisfactory completion of any remaining LOs will then need to be checked for at a subsequent ARCP. Other deaneries set the ARCP at a date towards the end of the year and make it very clear to trainees that all the stage's LOs need to be acquired by the time of the submission to the ARCP panel.

The most relevant ARCP outcomes are, therefore:

1. Satisfactory progress; achieved/achieving learning outcomes and competencies at the expected rate; may pass on to next stage of training
2. Not progressing satisfactorily; targeted training required; repeated LOs/WpBAs may be required; no additional training time necessary; may pass on to next stage of training
3. Not progressing satisfactorily; targeted training required; repeated LOs/WpBAs may be required; additional training time required
4. Trainee released from OST with or without specific competencies
5. Incomplete evidence presented; written explanation required from trainee within 5 days; additional training with or without extra training time may be required
6. Satisfactory completion of training programme; recommendation for CCT
7. Completion of FTSTA post (it is useful for FTSTA ARCP documents to have a suffix to show the full outcome e.g. 7.1 for an FTSTA who completes all the OST1 LOs; 7.5 for an FTSTA who fails to submit the appropriate information)
8. Completion of out-of-programme experience (will need a suffix as above)
9. Completion of Article 14 top-up training (will need suffix as above)

The ARCP panel must have access to each trainee's ARCP on their e-portfolio for the length of time prior to the ARCP that is required for deliberation. When the panel meet, each trainee is discussed and an outcome decided upon. If the trainee is invited to meet the panel, the ARCP outcome MUST be decided first; the decision must be taken on the submitted evidence only and not altered as a result of any face-to-face meeting that follows. If a favourable outcome is expected, there is no necessity to meet with the trainee after the formal outcome decision. However, it is recommended that a minimum of 10% trainees are seen in person. If it looks as though a trainee might be given an unfavourable outcome, they must be invited to attend the ARCP.
For full details, see Gold Guide (www.specialtytraining.hee.nhs.uk)

Using the WpBA tools

Clinical Rating scales
There are 10 different CRS, one for each of the clinical assessment learning outcomes.

CRS	Learning Outcome		Target Year (TYA)[#]	Assessor*
CRS1	CA1	Consultation	Year 1 and Year 2 then once per subspecialty during Years 3-7	Cons, Sen. OST, SAS
CRS2	CA2	Vision	1	Cons, Sen. OST, AHP, SAS
CRS3	CA3	Fields	1	Cons, Sen. OST, SAS
CRS4	CA4	Amsler	1	Cons, Sen. OST, SAS
CRS5	CA5	External eye	1	Cons, Sen. OST, SAS
CRS6	CA6	Pupil	1	Cons, Sen. OST, SAS
CRS7	CA7	Ocular motility	2	Cons, Sen. OST, SAS
CRS8	CA8	IOP	1	Cons, Sen. OST, AHP, SAS
CRS9	CA9	Slit lamp	1	Cons, Sen. OST, SAS
CRS10	CA10	Fundus	2	Cons, Sen. OST, SAS
CRSret	PS2	Retinoscopy (Paeds)	3	Cons, Sen, Optometrist, SAS

Standards
There are two sections for all the WpBA forms (except the MSF); the first is there to aid feedback given to the trainee, the second is to grade the assessment overall. The feedback section comes first. Each assessor makes a judgement about each component of the assessment. Each component has detailed descriptors of a trainee allowing the assessor to grade the trainee's performance as poor, fair, good or very good. These standards should be made against what would be expected of a newly qualified consultant

In general each term has the following meaning and implication:
Poor: The performance in this area was not acceptable and the trainee requires further instruction in this area.
Fair: The performance in this area might be acceptable in an inexperienced trainee who should aim to improve this part of their examination; they may seek another assessment as part of their personal development
Good: The performance in this area is acceptable and a trainee can be considered to be competent in this part of the assessment.
Very good. The performance was to a standard that would be expected of a senior and more experienced trainee ready to become a consultant.

IMPORTANT

A previous version of the WpBA handbook suggested that if there were two "fairs" in a WpBA form, the trainee should fail the WpBA ("does not meet expectations for the stage of training" or "fail"). This was not the College's intention. The sections scored on the 4 point scale (poor, fair, good and very good) are formative only and only recorded to provide detailed feedback to the trainee. It is then up to each individual assessor, taking an overview to decide whether a trainee either "meets" or "does not meet expectations" for the stage of training or "passes" or "fails" (depending on the WpBA).

 The first part of the form is formative only. In other words, it is there to help the assessor give feedback to the trainee. Each domain should be regarded as an aide memoire for the assessor suggesting areas of the trainee's performance that should be checked. Completing this section of the form allows detailed and specific feedback to be given to the trainee at the end of the WpBA. There follows a global assessment of the trainee in the above four categories. This is an overall impression of the trainee's performance.

The next section of the WpBA form may be unique to ophthalmology. This is the pass/fail part of the WpBA and determines whether the assessment can count towards their ARCP. This sort of assessment is known as **summative assessment**. For pass/fail WpBAs, the assessor should ask him/herself the question "Is this trainee good enough never to have to do this formal assessment again?" If the answer is "yes", then the trainee should pass. If "no", the trainee should fail, be given detailed feedback and asked to repeat the WpBA at a later date.

Other curricula avoid mixing feedback with pass/fail elements and as a consequence, their ARCPs can be extremely lengthy because all a trainee's WpBAs need to be scrutinised as part of a summative assessment performed by the ARCP panel. The use of a mixture of formative and summative assessment makes the ARCP process much easier.

There are two sorts of WpBA. The first is the pass/fail type and is typical of the early clinical methods WpBAs done by trainees in OST1. It includes assessment of visual acuity, pupil examination, confrontational visual fields and the like. These WpBAs, once passed, do not have to be repeated (although they can be assessed in the part 2 Fellowship examination). There is only one standard for such a WpBA and that is the standard of a newly qualified consultant ophthalmologist. There is no lesser standard. In line with the Tooke report, we are looking for all trainees to show excellence.

The second type is "meets expectations/fails to meet expectations for the stage of training". These are common in WpBAs designed to be repeated yearly (e.g. history-taking, cataract surgery). For these WpBAs a trainee's performance is expected to improve as they progress through their training and so the standard is judged against their stage of training. A complicating factor is when a trainee attempts to accelerate their training. Pass/fail WpBAs can be done at any time and have a set standard (that expected of a newly qualified consultant ophthalmologist). But if a trainee manages to acquire so many WpBAs in advance that they can complete OST in 6 years rather than the more usual 7, any final yearly assessed WpBA must be judged as if the trainee were an

OST7, not an OST6 and all the required Case-based Discussions (CbD) need to have been completed.

DOPS   Direct observation of procedural skills

The DOPS is intended for use when assessing the performance of a practical skill. The OST curriculum lists 23 practical skills as follows:
(PS2 (practical refraction) is assessed by the refraction certificate examination.
PS4 (venepuncture) and PS20 (blood cultures) are expected to have been completed by all foundation trainees but may need to be completed by trainees joining OST who have not completed Foundation Training. DOPS is derived from the foundation training assessment tool of the same name.

DOPS is also used for laser skills SS14, SS15 and SS16.

Learning Outcome (LO)		Target Year (TYA)*
PS11	Ocular surface FB	1
PS22	Ocular irrigation	1
PS8	Lacrimal function	2
PS10	Corneal scrape	2
PS13	Removal of sutures	2
PS18	Perform/teach lid hygiene	2
PS5	Local anaesthesia	3
PS14	Fit a bandage contact lens	3
SS14	Laser to the lens capsule	3
SS15	Laser for raised intraocular pressure	3 (plus 6 assessments during OST4-7)
SS16	Laser for retinal problems	3 (plus 6 assessments during OST4-7)
PS3	Intraocular/periocular drugs	7
PS6	Diathermy	7
~~PS7~~	~~Cryotherapy~~(removed from curriculum in 2011)	~~7~~
PS9	Paracentesis	7
PS12	Occlude puncta/canaliculi	7
PS15	Botulinum toxin injection	7
PS16	Corneal glue	7

PS17	Ocular /orbital ultrasound	7
PS19	AC/vitreous tap	7
PS23	Prepare biopsy	7
PS24	Forced duction test	7

Ideally each DOPS should be completed by two independent assessors as this increases the reliability of the tool. Most of the procedures that require a DOPS would naturally be observed in the early part of training and so the use of this assessment tool will not add much time overall. The incorporation of the assessment into the trainee's portfolio will greatly enhance communication as a trainee moves around a training rotation.

OSATS   Objective Structured assessment of technical skills

Ophthalmology is a surgical specialty and trainees are expected to take the opportunity of accumulating surgical experience throughout their training. Whilst surgical and practical skills will be recorded in a logbook (and included in their portfolio) the use of a standardised tool for assessing competence will add to the ability of a RITA panel to judge the progress and final competence of a trainee.

The OST curriculum lists surgical skills as follows:

OSATS		Learning Outcome (LO)	Target Year (TYA)*
OSATS2	SS2	Operating microscope	1
OSATS3	SS3	Aseptic technique	1
OSATS1	SS1	Microsurgical skills	2 (annual review)
OSATS1	SS7	Lid surgery	2 (plus 6 assessments during OST4-7)
OSATS1	SS4	Cataract surgery	3 (annual review)
OSATS1	SS11	Temporal artery biopsy	7
OSATS1	SS5	Procedures to lower IOP	7
OSATS1	SS6	Ocular and adnexal trauma	7
OSATS1	SS8	Ocular surface protection	7
OSATS1	SS9	Lateral canthotomy/cantholysis	7
OSATS1	SS10	Biopsy ocular and adnexal tissue	7
OSATS1	SS12	Extraocular muscle surgery	7
OSATS1	SS13	Removal of the eye	7

There are 3 OSATS forms to help assess trainees in their surgical skills.
OSATS 2 and 3 are for the very specific and basic skills of use of the operating microscope and skills in aseptic technique. Both of these skills must be acquired before progressing to actual surgery. OSATS1 is for use with all surgical procedures.

The overall standard of pass is for the individual assessor to decide. As a trainee proceeds through training they will accumulate a number of these OSATS forms which will allow a more valid and reliable assessment of competence than a single form.

Most of these surgical procedures will be performed under observation and so the completion of the OSATS form and the associated feedback will add little time overall. Trainees who are advanced in training and who still require OSATS for procedures that are either rarely performed or require advanced assessment (e.g. cataract surgery, which requires at least an annual OSATS1)) will need to ask an assessor to observe.

MSF Multisource feedback

All doctors must practise with appropriate attitudes, ethics and responsibility and possess excellent communication skills. Assessment of these areas has been lacking and although communication is still an important part of the Part 2 FRCOphth examination it is important that trainees adopt high standards in these important areas throughout training, not just in an examination.

Each trainee must arrange an annual survey of the opinions of their peers, colleagues and trainers utilising a form of multi-source feedback or MSF.

This will be collected electronically as follows:

1. It is the trainee's responsibility to arrange to obtain feedback well in advance of the annual ARCP, it is recommended this takes place at least 8 weeks in advance of the ARCP deadline.
2. The trainee will identify 11-15 people who are in a position to answer most, but not necessarily all, of the questions on the questionnaire. These people must have access to email and be prepared to complete the form.
3. The trainee should email their proposed assessors asking them to agree to complete the MSF, this should help identify any incorrect email addresses. Email addresses entered into the MSF incorrectly won't be delivered and this will delay the whole process.
4.
5. The list of names will be approved by the trainee's ES so that there is a balance of doctors, nurses, orthoptists admin and clerical staff, managers and any other members of the team of people who observe the doctors practice. The assessors selected must include:
   2 consultant clinical supervisors
   2 other trainees
   1 senior nurse in the operating theatre (if the trainee has been performing surgery)

        1 senior nurse in the out-patient department
        1 other member of the out-patient staff (nurse/optometrist/orthoptist)
        1 medical secretary who has been dealing with the trainee's work.

6. When the ES approves the list the e-portfolio system sends emails to each person allowing them to gain access to the questionnaire and make their responses on-line. The system automatically sends up to 2 further reminders to anyone who has not completed it.
7. When all the assessors have responded or 4 weeks have passed the MSF will close and a summary report is generated, this is entirely anonymous.
8. The system alerts both the trainee and ES that the MSF has been completed and they can both view it in their portfolios. It is recommended strongly that the report is opened in the presence of the ES so that any criticism can be discussed. This must be done well in advance of the ARCP submission date so that the ES has time to produce and agree their report with the trainee.

The MSF report is confidential between the ES and the trainee. The ARCP process just requires that MSF has been performed and the results discussed. MSF does not result in a pass or fail outcome. Most trainees will receive excellent feedback and possibly some useful comments for further development. Such trainees will be happy to disclose their MSF report. If a trainee receives criticism from a minority of respondents this may be cause for concern but may just represent an individual personality clash. Negative feedback from the majority of respondents requires action and evidence of improvement, (ideally from the same people if the trainee is working in the same unit at the time of the next MSF, but this is at the discretion of the ES), must be seen by the next ARCP. Failure to progress after several MSF exercises may result in a negative ES report leading to failure to proceed onto the subsequent year of training. This will be determined by the ARCP panel.

The learning outcomes assessed in the MSF questionnaire are:

Learning Outcome (LO)		Typical question	Feedback likely from*
PS21 SS3 HPDP2	Hand hygiene Asepsis X-infection	Follows local guidelines on general cleanliness and avoidance of cross infection	MS, AHP
C1	Rapport	Establishes a trusting clinical relationship with patients	MS, AHP
C2	Listen	Listens effectively to patients	MS, AHP
C3	Deliver	Provides information to patients in an appropriate and sensitive manner	MS, AHP
C5	Consent	Obtains valid consent in an appropriate manner	MS, AHP
C6	Breaking bad news	Communicates potentially upsetting information in an appropriate and sensitive manner	MS, AHP
C7	Language	Makes allowances for difficulties in communication that may affect the patient	MS, AHP

C8	Body language	Uses body language to good effect in communication	MS, AHP, S&C
C10	Professionals	Communicates well with clinical and non-clinical colleagues	MS, AHP, S&C
C11 C12	Written Letters	The doctor writes notes and dictates letters clearly	MS, AHP, S&C
C14	leave	Complies with local policies for the approval of leave and makes appropriate arrangements for cover	MS, AHP, S&C
AER1	Compassion	Has a compassionate approach to patient care	MS, AHP
AER2	Autonomy	Respects the patient's wishes when making clinical decisions	MS, AHP
PS1 and AER3	Considerate	Behaves in a considerate and sensitive manner towards all patients	MS, AHP, S&C
AER4	Empathy	Shows appropriate empathy with patients	MS, AHP, S&C
AER5	Confidentiality	Respects the confidential nature of clinical information obtained from patients	MS, AHP, S&C
AER6	Limits	Works within the limits of her/his clinical competence	MS, AHP
AER7	Help	Seeks help and advice from clinical colleagues when appropriate	MS, AHP
AER10	Equality	Treats all patients equally, avoiding discrimination	MS, AHP, S&C
AER12	Legal	Practises according to the GMC's "Duties of a doctor"	MS
AER16	Prioritise	Prioritises tasks appropriately, ensuring urgent and important matters are dealt with promptly	MS, AHP, S&C
AER16	Stress	Copes well when under stress	MS, AHP, S&C

CbD case based discussion

Trainees spend a lot of time discussing cases with their trainers. Trainers should encourage trainees to discuss clinical problems regularly. Case presentations of challenging or interesting patients are a common part of postgraduate medical education meetings. (The old Fellowship (Exit) Assessment was an extended case based discussion based upon a formal written casebook.)

The CbD is intended to assess aspects of patient management, communication (written and verbal) and clinical reasoning, leadership and management skills. They complement the assessment of these skills that takes place in the part 2 FRCOphth examination.

Most core ophthalmic knowledge can be covered by managing around 40 clinical scenarios, combined with the associated review of evidence and reflection. It is expected that trainees will ask for an assessment of their competence in managing most, if not all, of these scenarios, through CbD.

CbD can be completed for a trainee in the following situations:

During an out-patient clinic: Trainers and trainees may wish to allocate 5-10 minutes to discuss the management of a patient seen during an out-patient clinic. Case selection would be determined by either the trainee or trainer. The trainee 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 etc.

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

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

During a designated teaching session: Trainers and trainees may wish to allocate a period of one-to-one teaching or small group teaching where cases are discussed and a CbD form completed with the trainee.

Purpose: To give trainees the opportunity to demonstrate achievement of OST learning outcomes in relation to an individual case they were involved in.

In particular, the trainee should be able to demonstrate how they approach their practice i.e. application of medical knowledge, rationale for clinical decision making and the ethical/legal framework of their practice if appropriate.

The trainee should present the case and detail their involvement.
The discussion should start from the trainees own entry in the case-notes which may, in part, be used to demonstrate appropriate information handling. Following the case presentation, relevant learning outcomes to the case are discussed focussing on the ophthalmologists approach to practice:

- With an understanding of basic and clinical science
- With appropriate attitudes, ethics and legal responsibilities
- With appropriate decision making skills clinical reasoning, judgement and management and leadership skills.

Other outcomes may also be discussed e.g. Patient investigation, however, it is not necessary to cover all 12 outcomes in relation to the case.

The trainer should complete the outcome rating form by ticking the box that most accurately reflects the trainees level of achievement in that outcome as demonstrated by the case-based discussion. Specific mention of strengths, areas that need development should be outlined at the end of the form.

Time taken for WpBA

When considering the time involved for trainers in carrying out the WpBA described in this document it is important to consider the following:

- It is the trainee's responsibility to arrange assessments. It is not the trainer's job to chase trainees. Trainers must make every effort to support trainees however, and respond to requests for assessments in a timely manner.

- The number of trainees involved in detailed WpBA will be fewer than are currently in training at present. It is anticipated that 80-90 trainees per year will be involved in OST across the UK.

- The most time intensive WpBA are the CRS assessments which are conducted early on in training (during ST1). These trainees would already be under close supervision anyway.

- Not all WpBA need to be completed by a consultant ophthalmologist. Other trainees and health professionals can provide assessments where appropriate

- Practical and surgical skills should already be supervised before a trainee can go solo.

- Formal teaching sessions can be used for case based discussions.

- Time allocated to the trainee for study can be used for assessments as it they form an important part of a trainee's learning

With the above taken into consideration the time involved in WpBA need not be excessive. The modernisation agency suggest the following time allocation for WpBA:

- CRS 15 minutes plus 5 minutes for feedback
- DOPS 15 minutes plus 5 minutes for feedback
- CbD 20 minutes in total (for 2 cases)
- MSF 10 minutes to complete form
- OSATS Variable depending upon procedure, 5 minutes for feedback

Estimated total time taken for assessors per trainee **each year** for WPBA:

Stage of OST	Number of WPBA					Est. total time (hours)	Est. total time for consultant trainer per week (mins)*
	CRS	DOPS	OSATS	MSF	CbD		
1	16	4	4	15	10	15	15
2	5	10	4	15	10	13.5	12
3	1	6	10	15	10	13.8	20
4	1	6	7	15	10	13.8	20
5	1	6	7	15	10	13.8	20
6	1	6	7	15	10	13.8	20
* Based upon 60% of assessments done by consultant trainer in Y1 and Y2, 90% in Y3-6 and an average 42 week year							

Guidance for different stage of OST follows:

OST Stage 1

Trainees entering Stage 1 will have passed foundation training or completed the equivalent period training outside a foundation programme. They may or may not have any previous ophthalmology experience.

Some OST learning outcomes should have been achieved during foundation training:
- CA11 general medical examination
- CA12 paediatric and developmental examination
- CA13 neurological examination
- CA14 neck examination
- CA15 skin and joint examination

If some of these learning outcomes have not been achieved, trainees should be assessed using the foundation mini-CEX rating scale.

Specific WpBA are required during Stage 1 as follows:

Clinical rating scales (CRS)

Trainees are expected to achieve competence in the following clinical assessment learning outcomes during OST Stage 1*:
- CA1   Conducting a consultation
- CA2   assess vision
- CA3   visual fields
- CA4   amsler chart
- CA5   external eye examination
- CA6   pupils
- CA8   IOP
- CA9   slit lamp

It is important therefore not to leave the assessments to the end of the clinical placement. Suggested timings are October/November and April/May.

Total CRS in Stage 1   16

Trainees are required to be assessed using the appropriate clinical rating scales and so will need to be observed on 2 occasions with completion of the forms by 2 different assessors. If a trainee does not achieve a pass on both occasions, more assessments will be required.

* if a trainee has completed CRS during foundation training or has gained part 2 MRCOphth during transition they can be considered as exempt from some of these assessments at the discretion of the training Programme Director and the local STC.

Direct observation of practical skills (DOPS)

Trainees are expected to achieve competence in the following practical skills before the end of Stage 1*:
- PS4   intravenous cannulation
- PS20 blood culture
- PS21 hand hygiene
- PS11 removal of foreign bodies
- PS22 irrigation and debridement

*if a trainee has completed DOPS in some of these skills during foundation training or the equivalent during transition they can be considered as exempt from some of these assessments at the discretion of the training programme director and the local STC

Total DOPS in Stage 1   10

Objective structured assessment of technical skills (OSATS)

Trainees are expected to achieve competence in the following surgical skills before the end of Stage 1:

- SS2   operating microscope
- SS3   aseptic surgical technique

Total OSATS in Stage 1   4

Case based discussion (CbD)

Trainees are expected to undergo a case based discussion with a trainer at least once per month with the completion of a CbD form. At least 2 assessors should complete these forms.

Total CbD in Stage 1   10

Multi-source feedback (MSF)

Trainees are expected to arrange for MSF at least annually. This is an entirely electronic process and the supervisor's role is just to approve the list of names from the trainee and discuss feedback during appraisal.

Total MSF in Stage 1   1

TOTAL NUMBER OF WpBA REQUIRED IN STAGE 1: 41

http://curriculum.rcophth.ac.uk/assessments/quick_links

OST Stage 2

Trainees entering Stage 2 will have passed the Stage 1 ARCP or may have specific competencies to achieve without extra time required (outcome 2).

Specific WpBA are required during Stage 2 as follows:

Clinical rating scales (CRS)

Trainees are required to be assessed in consultation skills on an annual basis and so will need to be observed on 2 occasions during Stage 2 with the completion of 2 CRS1 forms by 2 different assessors. If a trainee does not achieve a pass on both occasions, more assessments will be required.

In addition, trainees are expected to achieve competence in the following clinical assessment learning outcomes during OST Stage 2:
- CA7   ocular motility
- CA10 fundus examination

It is important therefore not to leave the assessments to the end of the clinical placement. Suggested timings are October/November and April/May.

Total CRS in Stage 2   6

Direct observation of practical skills (DOPS)

Trainees are expected to achieve competence in the following practical and laser skills before the end of Stage 2:
- PS8   assess lacrimal function
- PS10 corneal scrape
- PS13 removal of sutures
- PS18 lid hygiene

Total DOPS in Stage 2   8

Objective structured assessment of technical skills (OSATS)

Trainees are expected to achieve competence in the following surgical skills before the end of Stage 2:

- SS1   basic microsurgical skills
- SS7   lid surgery

Total OSATS1 in Stage 2   4

Case based discussion (CbD)

Trainees are expected to undergo a case based discussion with a trainer at least once per month with the completion of a CbD form. At least 2 assessors should complete these forms.

<u>Total CbD in Stage 2</u>   10

Multi-source feedback (MSF)

Trainees are expected to arrange for MSF at least annually. This is an entirely electronic process and the supervisor's role is just to approve the list of names from the trainee and discuss feedback during appraisal.

<u>Total MSF in Stage 2</u>   1

<u>TOTAL NUMBER OF WpBA REQUIRED IN STAGE 2: 29</u>

Progress on to Stage 3

Trainees must have gained part 1 FRCOphth in order to proceed to OST Stage 3.

Although the number of procedures performed does not define competence, it is expected that by the end of Stage 2 trainees will have completed 50 cataract operations and a proportionate number of the surgical procedures listed in *a guide to delivery of OST*
- It is expected that by the end of Stage 7 the trainee will typically have completed approximately 350 phacoemulsification cataract procedures.
- 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

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OST Stage 3

Trainees entering Stage 3 will have completed the Stage 2 learning outcomes or may have specific competencies to achieve without extra time required (ARCP outcome 2).

Specific WpBA are required during Stage 3 as follows:

Clinical rating scales (CRS)

In ST3-7trainees are required to be assessed in consultation skills at least once in each subspecialty.
They must also achieve competence in clinical refraction (PS2) in 2 ways:
- Completion of CRSret (cycloplegic refraction)
- RCOphth Refraction certificate

It is important therefore not to leave the assessments to the end of the clinical placement. Suggested timings are October/November and April/May.

Total CRS in Stage 3   3-5

Direct observation of practical skills (DOPS)

Trainees are expected to achieve competence in the following practical and laser skills before the end of Stage 3:
- PS2   Practical refraction (see clinical rating scales above)
- PS5   Local anaesthesia
- PS14 Fit a bandage contact lens
- SS14 laser to lens capsule
- SS15 Laser to control IOP
- SS16 Laser to retina

Total DOPS in Stage 3   10

Objective structured assessment of technical skills (OSATS)

Trainees are expected to have achieved the expected level of competence in the following surgical skills before the end of Stage 3:

SS1   Microsurgical skills
SS4   Cataract surgery

Total OSATS1 in Stage 3   4

Case based discussion (CbD)

Trainees are expected to undergo a case based discussion with a trainer at least once per month with the completion of a CbD form. At least 2 assessors should complete these forms.

Total CbD in Stage 3   10

Multi-source feedback (MSF)

Trainees are expected to arrange for MSF at least annually. This is an entirely electronic process and the supervisor's role is just to approve the list of names from the trainee and discuss feedback during appraisal.

Total MSF in Stage 3   1

TOTAL NUMBER OF WpBA REQUIRED IN STAGE 3: 29

Progress on to Stage 4

Although the number of procedures performed does not define competence, it is expected that during Stage 3 trainees will have completed 50 cataract operations and a proportionate number of the surgical procedures listed in *a guide to delivery of OST*
- It is expected that by the end of Stage 7 the trainee will typically have completed approximately 350 phacoemulsification cataract procedures.
- 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

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OST Stages 4- 7

Trainees entering Stages 4-7 will have passed the Stage 3 ARCP which includes completion of the RCOphth refraction certificate, or may have specific competencies to achieve without extra time required (outcome 2).

Specific WpBA are required during Stage 4-7 as follows:

Clinical rating scales (CRS)

In ST3-7 trainees are required to be assessed in consultation skills at least once in each subspecialty.

Total CRS in each Stage (4-7)   1-2

Direct observation of practical skills (DOPS)

Trainees have until Stage 7 to gain competence in the following practical skills:
- PS3   Intraocular/periocular drugs
- PS6   Diathermy
- PS9   Paracentesis
- PS12 Occlude puncta/canaliculi
- PS15 Botulinum injection
- PS16 Corneal glue
- PS17 Ocular/orbital ultrasound
- PS19 AC/vitreous tap
- PS23 Prepare biopsy
- PS24 Forced duction test

They may have already achieved some of these during OST1-3 if the opportunities have arisen, however these will only be picked up in the e-portfolio ARCP review progress 'traffic lights' page if they have been entered as Stage 4, 5, 6 or 7.. During Stages 4-7 trainees should aim to achieve a proportionate number of PS (by observation of performance on 2 occasions each with the completion of a DOPS form) i.e. 5 or 6 on average per Stage.

In addition they must be assessed on at least 6 occasions in SS15 laser to lower IOP and SS16 laser to retina (by observation of performance with the completion of a DOPS form).

Total DOPS in each Stage (4-7)   Average 9-10 (minimum 4, possible 24)

Objective structured assessment of technical skills (OSATS1)

Trainees have until Stage 7 to gain competence in the following surgical skills:
- SS5   Procedures to lower IOP
- SS6   Ocular and adnexal trauma
- SS7   Common Lid Surgery (NB minimum total of 6 assessments for this)

- SS8   Ocular surface protection
- SS9   Lateral canthotomy/cantholysis
- SS10 Biopsy ocular and adnexal tissue
- SS11 Biopsy of the temporal artery
- SS12 Extraocular muscle surgery
- SS13 Removal of the eye

They may have already achieved some of these during OST1-3 if the opportunities have arisen. During Stages 4-7 trainees should aim to achieve a proportionate number of SS (by observation of performance on 2 occasions each [6 for SS7] with the completion of an OSATS1 form) i.e. 2 or 3. In addition they must be re-assessed (annually) in SS1 microsurgical skills and SS4 cataract surgery (by observation of performance on 2 occasions each Stage with the completion of an OSATS form).

Total OSATS1 in each Stage (4-7)   Average 10-11 (minimum 4, possible 26)

Case based discussion (CbD)

Trainees are expected to undergo a case based discussion with a trainer at least once per month with the completion of a CbD form. At least 2 assessors should complete these forms.

Total CbD in each Stage 4-7   10

Multi-source feedback (MSF)

Trainees are expected to arrange for MSF at least annually. This is an entirely electronic process and the supervisor's role is just to approve the list of names from the trainee and discuss feedback during appraisal.

Total MSF in each Stage 4-7   1

TOTAL NUMBER OF WpBA REQUIRED IN STAGE 4: Av 34-36 (min 21, poss. 67)
TOTAL NUMBER OF WpBA REQUIRED IN STAGE 5: Av 34-36 (min 21, poss. 67)
TOTAL NUMBER OF WpBA REQUIRED IN STAGE 6: Av 34-36 (min 21, poss. 67)
TOTAL NUMBER OF WpBA REQUIRED IN STAGE 7: Av 34-36 (min 21, poss. 67)

Exit from training

Trainees must pass the Part 2 FRCOphth examination in order to meet many of the curriculum leaning outcomes and therefore be eligible to exit training with a CCT (or CESR CP) recommendation. Trainees must also have complete documentation from the outcome of their ARCP. Copies of these must be forwarded to the College as part of the assessment for recommendation of CCT/CESR from the College to the GMC.

Although the number of procedures performed does not define competence, it is expected that during Stages 4-7 trainees will have completed around 100 cataract operations during each Stage and a proportionate number of the surgical procedures listed in *a guide to delivery of OST*

It is expected that by the end of Stage 7 the trainee will typically have completed at least 350 phacoemulsification cataract procedures.

- 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

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