



*The* ROYAL COLLEGE *of*  
OPHTHALMOLOGISTS

## **Guide for delivery of Ophthalmic Specialist Training (OST)**

**Version 3.5**

June 2018

---

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

## Contents

<b>1. Introduction</b> .....	<b>3</b>
<b>2. Other relevant guidance</b> .....	<b>4</b>
<b>3. Induction programme for OST</b> .....	<b>5</b>
<b>4. Curriculum and Assessment during OST</b> .....	<b>5</b>
<b>5. The e-Portfolio</b> .....	<b>6</b>
<b>6. OST Years 1 and 2 (early specialist training)</b> .....	<b>7</b>
<b>7. OST Years 3 to 7 (higher specialist training)</b> .....	<b>11</b>
<b>8. Trainee Selected Components (TSCs)</b> .....	<b>15</b>
<b>9. Teaching / Audit / Quality Improvement / Research in OST</b> .....	<b>15</b>
<b>10. Generic Professional Capabilities (GPCs)</b> .....	<b>17</b>
<b>11. Consultant Preparation</b> .....	<b>18</b>
<b>12. Facilities for OST</b> .....	<b>18</b>
<b>13. Simulation for OST</b> .....	<b>20</b>
<b>14. Acute Services Training</b> .....	<b>22</b>
<b>15. Quality assurance and inspection process for OST programmes</b> .....	<b>22</b>
<b>16. OST for Academic Trainees</b> .....	<b>23</b>
<b>17. Research counting towards CCT</b> .....	<b>24</b>
<b>18. National recruitment</b> .....	<b>25</b>
<b>19. Medical Ophthalmology</b> .....	<b>26</b>
<b>20. Flexible (less than full time) training</b> .....	<b>26</b>
<b>21. Locum Appointment for Training (LAT)</b> .....	<b>27</b>
<b>22. Post-CCT training</b> .....	<b>28</b>
<b>23. Preparing for ARCPs</b> .....	<b>28</b>
<b>24. Preparing for CCT</b> .....	<b>31</b>
<b>25. Acceleration of Training</b> .....	<b>32</b>
<b>26. Effects on training of 2016 Junior Doctors Contract</b> .....	<b>32</b>

---

## **1. Introduction**

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

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

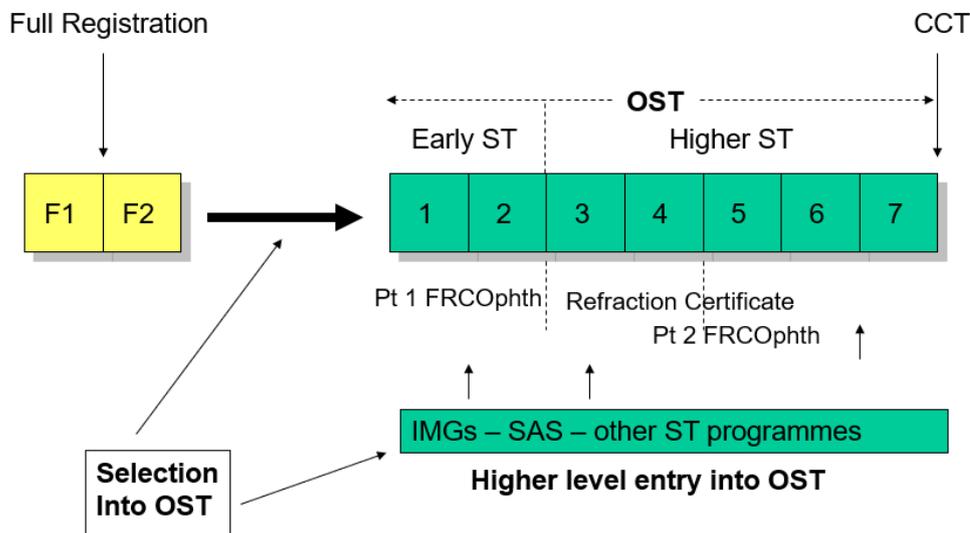
1.3 Promoting excellence contains five themes around:  
Learning environment and culture  
Educational governance and leadership  
Supporting learners  
Supporting educators  
Developing and implementing curricula and assessments

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

The RCOphth curriculum for OST specifies defined learning outcomes which relate directly to providing safe and high-quality patient care. See the web-based OST Curriculum for more details.

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

## OPHTHALMIC SPECIALIST TRAINING (OST) CURRENT RCOphth PLAN



1.5 It is thus apparent that early specialist training occurs during Years 1 and 2; higher specialist training occurs during Years 3 to 7, and more focussed training in the form of Trainee Selected Components (TSCs) may occur in Year 6 or 7 with preparation for the consultant role.

1.6 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, if granted acceleration of training, 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 <https://www.rcophth.ac.uk/curriculum/ost/>

The RCOphth on-line e-Portfolio for OST  
<https://eportfolio.rcophth.ac.uk/login>

The RCOphth examinations for OST  
<https://www.rcophth.ac.uk/examinations/>

---

The GMC 'Good Medical Practice' (2013)

<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice>

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

[https://www.gmc-uk.org/-/media/documents/promoting-excellence-standards-for-medical-education-and-training-0715\\_pdf-61939165.pdf](https://www.gmc-uk.org/-/media/documents/promoting-excellence-standards-for-medical-education-and-training-0715_pdf-61939165.pdf)

The Gold Guide – 7th Edition (2017)

<https://www.copmed.org.uk/gold-guide-7th-edition/the-gold-guide-7th-edition>

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

<https://www.rcophth.ac.uk/training/working-in-britain-for-non-uk-doctors/dual-sponsorship-scheme/>

### **3. Induction programme for OST**

Guidance on the recommended induction programme for OST is on the RCOphth website. All ST1s should have an introductory week to ophthalmology as well as undertake the Trust mandatory induction. The induction is a starter guide to examination and assessment of the ophthalmic patient, with an introduction to some main specialty interests and the acquisition of practical skills to ensure that early clinical exposure is enhanced. The guidance covers the main principals and suggested programme content.

<https://www.rcophth.ac.uk/training/resources-and-support-for-trainees/>

<https://www.rcophth.ac.uk/professional-resources/eye-site/>

### **4. Curriculum and Assessment during OST**

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

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

The WpBAs required is defined in the descriptor for the learning outcome.

<https://www.rcophth.ac.uk/curriculum/ost/learning-outcomes>

In some learning outcomes a judgment of competence will be made by the Educational Supervisor, on reviewing evidence in the e-Portfolio. Suggested evidence can be found in the portfolio section of the curriculum.

<https://www.rcophth.ac.uk/curriculum/ost/assessments/workplace-based-assessments/portfolio/>

Assessment is discussed in Section 4 of the Gold Guide.

---

4.3 In order to progress through OST, the mandatory College examinations must be passed. Details of examinations and requirements for examination pass at a given stage of training can be found on the Examinations section of the College website. <https://www.rcophth.ac.uk/examinations/>

The first part of the FRCOphth must be passed by the end of ST2 (6 attempts allowed). The Refraction Certificate must be completed by the end of the ST3 year (6 attempts allowed). The Part 2 Fellowship is decoupled with separate written and clinical components. This can be attempted once the Refraction Certificate has been attained and must be passed by the end of year 7 (4 attempts are allowed per section). <https://www.rcophth.ac.uk/examinations/candidate-tips/>

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

The assessment evidence required for each level ARCP is described on the curriculum. <https://www.rcophth.ac.uk/curriculum/ost/assessments/annual-review-of-competence-progression-arcp-guidance/>

The ARCP process is fully described in Section 4 of the Gold Guide.

## **5. The e-Portfolio**

5.1 Doctors entering OST will document their progress using the RCOphth e-Portfolio. They are required to enter their details, those of the hospitals they are based in, their timetables, study leave, personal development plan (PDP), as agreed with their Educational Supervisor, WpBAs and all further evidence of their learning and achievements.

5.2 Trainees will be expected to familiarise themselves with the system and update it regularly to demonstrate their progression towards completing the curriculum requirements. Guidance for the use of the e-Portfolio is contained within it.

5.3 In addition to the annual stage of training grid (“traffic-light”) displaying the WpBAs completed, trainees should upload evidence of research, audit and quality improvement, teaching and training, management and leadership activities. These can be associated with appropriate learning outcomes and will also be viewable within the generic professional capabilities grid within the e-Portfolio. The evidence contained in the e-Portfolio will then be viewed by the Educational Supervisor (ES) to complete a report at the end of each 6 months. Clinical and Educational Supervisor reports are completed online ensuring all documentation is viewable electronically by the ARCP panel.

---

## **6. OST Years 1 and 2 (early specialist training)**

6.1 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. The training units should therefore provide a broad-based training in general ophthalmic medicine and surgery and exposure to the common subspecialties.

Doctors entering OST who have had previously undertaken ST1 OST in another LETB/Deanery must indicate to their Training Programme Director (TPD) that they would like this time counted on entry into the new LETB/Deanery programme. The trainee must have evidence of adequate progression with an outcome 1 at ARCP and a letter of support from the TPD/Head of School at the previous LETB/Deanery detailing their previous progress. Evidence of the ARCP outcome must be included within their e-Portfolio.

6.2 The detailed learning outcomes which must be achieved in Years 1 and 2 of OST are set out in the curriculum, as are the assessment methods that must be used. Many of these assessment tools are based in the work place and trainers will need to be recognised Clinical Supervisors who have been trained in such assessments. Trainees will be familiar with these assessment methods as they are used in the Foundation Programme. In addition, the OST Curriculum gives supplementary information that will be helpful to both the trainee and trainer.

6.3 Units providing training for Years 1 and 2 of 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 trainees may develop their skills progressively.

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

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

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

---

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

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

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

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

#### 6.7 The 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 ARCP process with information from WpBAs and the trainee's portfolio.

#### 6.8 Guidance on the Weekly Timetable

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

The weekly timetable should include:

General clinics 3 (maximum) †

Acute Services/Eye Care 2 (maximum) †

Theatre 2 (protected sessions)

Other\* 1

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

\*Laser, consultant supervised pre-assessment clinic (see 6.7), special clinic, etc.

There should be 1 session for Teaching

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

---

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

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

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

6.10 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 must attend the RCOphth 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.

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

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

6.12 It is essential for the 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. It is expected that at the end of Year 2 the trainee will typically have completed approximately 50 phacoemulsification cataract procedures. Years 1 and 2 trainees should be allocated to operating lists with suitable patients for the level of their skills as OST2 trainees are unlikely to have developed sufficient skills to manage complex situations at this stage of training. Trainees should be taught how to manage the complications of cataract surgery in simulation. In most units post-operative review of cataract surgery patients is undertaken by other members of the multidisciplinary team. It is

---

important that trainees should be allowed to review their own cataract surgery cases post-operatively, or at least a proportion of them, so that they are able to understand the pattern of healing and recovery and the positive impact of surgery on the patients' lifestyle.

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

<https://www.rcophth.ac.uk/training/ost-information/logbook/>

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

As senior trainees are required to supervise other trainees undertaking cataract, and potentially specialist surgery, they may provide supervision for OST1-2 trainees, with consultant oversight and additional input. Where there is a division of surgery into service and training lists, there is in general little training value for the trainee to attend the service list. Where there is more than one trainee allocated to a surgical list they should be at a different stage and not be competing for cases i.e. it is acceptable for a senior trainee to be paired with an OST1-2 trainee, but the junior trainee would be given priority for non-complex cases.

6.14 College Tutors should supervise and facilitate 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.

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

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

---

## **7. OST Years 3 to 7 (higher specialist training)**

7.1 The detailed learning outcomes which must be achieved in Years 3 to 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 Clinical Supervisors. Trainees will be familiar with these assessment methods as they are used in the Foundation Programme. In addition, the RCOphth Curriculum gives supplementary information that will be helpful to the trainee and trainer.

7.2 Trainees entering a recognised training programme at ST3 level should have been able to demonstrate equivalence of training for the OST1-2 competencies. If the early training was undertaken in its entirety in GMC-approved training posts with an ARCP assessment, they will be eligible for Certificate of Completion of Training (CCT). If previous training did not have ARCP outcomes or was not undertaken in the UK, the trainee will be granted a Certificate of Equivalence of Specialist Training – Combined Programme (CESR CP) at the completion of training.

<https://www.gmc-uk.org/registration-and-licensing/the-medical-register/a-guide-to-the-medical-register/specialist-and-gp-application-types>

### 7.3 Guidance on Rotations

The role of the trainee in all parts of the rotations, including District General Hospitals, 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, their level of competence and any guidance from the School of Ophthalmology.

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

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

Oculoplastic, Adnexal and Lacrimal Surgery  
Cornea and External Diseases  
Cataract (and Refractive Surgery\*)  
Glaucoma  
Retina, Vitreous and Uvea (including Ocular Oncology)  
Neuro-Ophthalmology  
Paediatric Ophthalmology and Strabismus

---

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

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

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

7.5 The School 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.

7.6 It is important that every trainee knows the identity of, and has access to, the Head of School, the Regional Education Adviser (REA), the TPD and the College Tutor.

#### 7.7 Guidance on Weekly programme

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

There should be no more than 7 clinical sessions per week, whose content should be flexible within the following guidance:

2 acute services or general clinics maximum

2 special clinics minimum

1 treatment session such as laser or minor operations or further special clinic

2 theatre sessions minimum

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

The remaining weekly sessions should include:

1 (minimum) fully protected research (R)

1 individual study, to include time for undergraduate teaching and personal audit (STA)

1 postgraduate teaching

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

Where zero-hour days or sessions impact on the training experience to limit adequate training opportunities, an RSTA session may be used to deliver the missing components of training. However, this should be individualised to optimise the trainees' experience.

---

### 7.8 Outpatients

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

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

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

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

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

Pre-operative assessment clinics are to be encouraged, but should largely be run by nurses, with only a minor input from Years 1 and 2 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.

7.11 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.

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

#### 7.13 Specialty interest clinical experiences

There will be further guidance on this in the appropriate sections of the Curriculum. <https://www.rcophth.ac.uk/curriculum/ost/>

#### 7.14 Theatre

Surgical experience should develop as indicated by the learning outcomes in the curriculum. 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 have completed a minimum of 350 phacoemulsification cataract procedures.

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

<https://www.rcophth.ac.uk/training/certification-of-training-and-specialist-training/award-of-the-cct/>

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

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

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

---

7.15 A logbook should be kept (<https://www.rcophth.ac.uk/training/ost-information/logbook/>) 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. This logbook forms part of the trainee's portfolio. Additionally, a continuous complications audit of cataract surgery outcomes should be maintained throughout training.

In preparation for obtaining a consultant post, OST6-7 should demonstrate evidence of supervising junior (SJ) colleagues. This should take the form of supervising juniors during surgical and laser cases. A minimum of 20 SJ cases should be documented. The majority should be during cataract surgery; up to 10 full cases can be in simulation but must be the entire operation performed in the wet/dry-lab, not just on the EyeSi simulator.

7.16 All junior 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 latter 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 training a trainee should be competent to undertake cataract ophthalmology theatre lists unsupervised.

#### 7.17 On-call

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

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

### **8. Trainee Selected Components (TSCs)**

OST Year 6 or Year 7 – see the separate College guidance on TSCs and Out of Programme Training.

<https://www.rcophth.ac.uk/training/ost-information/out-of-programme-training/>

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

9.1 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 training grade staff, or by speciality or trust doctors if available

---

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

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

9.4 OST trainees should take an active part in teaching undergraduates, other trainees and paramedical staff. Where possible, OST trainees should be supported if they wish to develop their own teaching/training skills.

9.5 The regional teaching programme could include the following:

Case presentations

Topic teaching

Journal club

Fluorescein conference

Ocular pathology

Audit

Invited speakers (ophthalmologists and non-ophthalmologists)

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

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

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

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

---

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

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

### 9.9 Research

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

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

## **10. Generic Professional Capabilities (GPCs)**

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

[https://www.gmc-uk.org/-/media/documents/generic-professional-capabilities-framework--0817\\_pdf-70417127.pdf](https://www.gmc-uk.org/-/media/documents/generic-professional-capabilities-framework--0817_pdf-70417127.pdf)

Trainees will not be signed off as competent in clinical skills if they have not mastered the necessary professional skills, such as good communication, required for an assessment. Evidence of acquisition of these skills should be uploaded to the e-Portfolio and assigned to the relevant curriculum outcomes to be evident in the generic professional capabilities grid of the e-Portfolio.

10.2 There are 9 domains:

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

- 
- capabilities in research and scholarship

## **11. Consultant Preparation**

11.1 Trainees are expected to undertake Consultant Preparation for the last six months of their programme. It is accepted that the in-depth subject of a specialty interest adds hugely to the trainees' development and it is important for them to get the opportunity for a TSC, but this should be balanced with the time for Consultant Preparation. It is expected that the trainee will return to programme to compete this aspect of their ST7 requirements. However, it may be acceptable for them to continue in an area of specialty interest as long as the requirements of Consultant Preparation are prioritised and specific attention is paid to this in their timetable.

11.2 The trainee must have the following opportunities:

Refresh and maintain general ophthalmic skills including acute services provision; to be ready to be the senior opinion on-call.

Be given the opportunity to supervise more junior trainees in all these areas: on-call, in clinics and particularly in surgical practice.

If the trainee has already undertaken cataract surgery supervision of a more junior trainee, they should be given the opportunity of supervising specialist surgery; if not, then cataract surgery supervision must take place in this time.

Be trained as a clinical supervisor, if not previously accredited, as this is a curriculum requirement.

Develop skills in running a service. It is acceptable for them to act up as a consultant for up to 3 months during this period.

<https://www.rcophth.ac.uk/training/ost-information/out-of-programme-training/>

Otherwise they should take more responsibility in the unit and have the opportunities for management experience.

## **12. Facilities for OST**

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

<https://www.rcophth.ac.uk/standards-publications-research/ophthalmic-services-guidance-2/>

### **12.2 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, slit lamp, direct and indirect

---

ophthalmoscope, retinoscope and trial lenses and the necessary indirect lenses. There must be appropriate examination facilities for retinal diseases, such as a couch or reclining chair. There should be easy access to the consultant.

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

12.4 Ancillary equipment that should be available should include:

Portable slit lamp

Goldman tonometer and other portable tonometer

Fields equipment

Fundus camera / retinal angiography / OCT

Argon laser

YAG laser

Auto-refractor

IOL Master or Lenstar

Keratometer and A-scan ultrasound for biometry

Focimeter

Orthoptic instruments such as prism bar, Hess chart/Lees screen

Corneal pachymeter

12.5 In a teaching hospital, it would be expected that additional equipment would include:

B-scan ultrasound

Anterior segment camera

Electrophysiology equipment

Corneal topography / tomography

Advanced retinal imaging equipment e.g. HRT, OCT

Routine radiological investigations with access to CT and MRI scanning should be available.

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

### 12.6 Theatre facilities

In most cases the theatre will be dedicated to ophthalmology, but in small units this may not be possible. The layout and instrumentation must be designed with training in mind. The equipment should include, as appropriate:

Operating microscope with teaching side arm and video camera and recorder Coaxial assistant's microscope

Phacoemulsifier

Automated anterior vitrectomy (even in units in which no vitreous surgery is undertaken, to deal with complications of cataract surgery)

---

### 12.7 Ward

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

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

### 12.8 Electronic Patient Record

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

### 12.9 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 and online resources available in the Eye Department that cover all the principal specialty interests.

12.10 A collection of ophthalmic journals should be available on the rotation such as:

British Journal of Ophthalmology

Eye Journal

American Journal of Ophthalmology

Archives of Ophthalmology

Survey of Ophthalmology

Investigative Ophthalmology

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

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

### 12.11 Additional facilities

Trainees should have a room for study and should have access to a computer. A surgical skills simulation laboratory is an essential ancillary training resource. Appropriate instrumentation and a microscope should be available, and trainees encouraged to use the facility. The facility may be provided at unit or regional level.

## **13. Simulation for OST**

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

---

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

13.1 Microsurgical Skills Course – it is mandatory for all UK ophthalmic specialist trainees to complete a College-run Microsurgical Skills Course at the state-of-the-art Skills Centre before undertaking intraocular surgery.

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

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

[https://portal.e-lfh.org.uk/myElearning/Index?HierarchyId=0\\_35&programmeld=35](https://portal.e-lfh.org.uk/myElearning/Index?HierarchyId=0_35&programmeld=35)

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

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

These surgical skills would also be appropriate for all ophthalmic surgeons. They would be of benefit particularly for those returning to work after time out of programme, a career break, illness, parental leave, etc. Increasingly, dry and wet lab experience before commencing new surgical techniques is appropriate for all grades of surgeons.

---

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

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

#### **14. Acute Services Training**

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

<https://www.rcophth.ac.uk/training/resources-and-support-for-trainees/>

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

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

#### **15. Quality assurance and inspection process for OST programmes**

*15.1 Local health education offices undertake monitoring visits to quality assure educational environments. In England these no longer occur to a regular schedule, but in accordance with the HEE Quality Framework and are triggered through a risk-based approach. Generally, visits are trust-based, but processes vary, and local offices may ask for programme reviews if there are concerns. In these instances, they may ask for College representation. Visits are preceded by a detailed process of information gathering and are now multi-professional when conducted at trust level.*

---

In trust-based visits, ophthalmology will only be visited if there is a specific concern, which may have been highlighted via the GMC survey, or directly by the Director of Medical Education (DME) or TPD.

15.2 Visits involve examination of educational and quality data provided by the organisation, and interviews with the Trust Board, as well as multi-professional trainees and trainers. Questions will be mapped to the HEE Quality Framework which in turn maps to the five themes of the GMC Promoting Excellence document. Reports are provided noting any requirements for action, which the Trust will then respond to as needed.

15.3 In addition, it is expected that local education offices will have in place their own robust quality strategies, which will include information gathering in relation to specialty training programmes. These may include sources such as GMC surveys, locally collected feedback at Trust and programme level, trainee fora, minutes of STC meetings, monitoring of allegations of bullying and harassment or incidents involving trainees, annual specialty reports and local intelligence from Trust DMEs, Guardians and TPDs.

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

<https://www.rcophth.ac.uk/about/college-roles/regional-advisors/>

15.5 The College aims to provide representation at ARCP panels on a rotating basis and will provide written feedback to the Dean on the ARCP process, in addition to supporting feedback on the quality of clinical and educational supervisor reports.

## **16. OST for Academic Trainees**

### **16.1 The NIHR Integrated Academic Training Programme**

There are excellent opportunities for trainees to enter an academic career track through this scheme. Academic trainees are appointed to Academic Clinical Fellow (ACF) schemes either early on in their training (i.e. OST1-3 level) or later (OST3 and above), which may include those returning to academia post-PhD/MD. This gives them the opportunity to take 25% of time out of clinical training to undertake research or educationalist training over 3 years. The aim is to develop an application for a fellowship to go out of programme and undertake a PhD after completing the ACF scheme or establish their research programme again toward development of future intermediate fellowships. Following on from the PhD trainees can come back into programme and continue to develop their academic career as Academic Clinical Lecturers (ACLs) where part-time clinical training continues in conjunction with further academic development.

More information is available from:

---

<https://www.nihr.ac.uk/funding-and-support/funding-for-training-and-career-development/training-programmes/integrated-academic-training-programme/>

16.2 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, they 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.

16.3 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 Ophthalmology School Board that such individuals have experienced a balanced training by the time they apply for the CCT.

16.4 See also Gold Guide, section 3 (para: 3.105, 3.106, 3.107, 3.108, 3.109, 3.110, 3.111).

## **17. Research counting towards CCT**

17.1 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 LETB/Deanery. See also the separate College guidance on TSCs which includes advice on Out of Programme Training.

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

17.3 The maximum total time that may count towards CCT arising from all research, and in conjunction with 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.

17.4 Prospective approval must be sought from the STC/Ophthalmology School Board, the Postgraduate Dean, the Training Committee of the College and GMC.

17.5 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 as well as written evidence of support from the Chair of the STC and/or the TPD. More detailed information on the paperwork required is available from the Education and Training Department at the College. The recommendation of the Training Committee will then be passed to the GMC for their formal approval. The Training Committee requires a brief report on completion of the research period or out of programme training.

17.6 See also Gold Guide, section 3 (para: 3.112, 3.113).

## **18. National recruitment**

18.1 Recruitment to all OST1 and OST3 posts in England, Scotland, Wales and Northern Ireland is via the National Recruitment process, which is co-ordinated by the recruitment team in Health Education South West (Severn). Candidates who have achieved a high enough score in the Specialty Recruitment Assessment (SRA) test will be invited to the interviews in Bristol and candidates will be able to choose a time slot on a first-come-first-served basis.

For detailed information about the recruitment process see the Severn Deanery website <http://www.severndeanery.nhs.uk/recruitment> . Links to the Applicant Guide, Person Specification for both OST1 and OST3, Guidance on the interview format, advice on portfolio, sample MSF and details of the posts available is all included on the site.

18.2 For OST1 recruitment, the interviews include registration with Deanery staff, a de-brief with senior member of the team and ID check. The format includes:

a) Preparation station

Watching a video explaining the interview process followed by 40 minutes to read the critical appraisal paper, the communication scenario, and any other material related to the other two questions.

b) Interviews

There are two interview stations. Station A consists of a Critical Appraisal question and a more general question about Health Care. Station B consists of a Communication scenario, followed by a series of clinical questions, which will be of a general medical background, but with an ophthalmological theme.

In the communication scenario team an actor will play the role of a patient or relative, according to a tightly written “script”.

The marking scheme is published, as is the appointable score.

18.3 For OST3 recruitment, the requirements to demonstrate equivalence of OST1 and 2 competencies are detailed, including the cataract surgical requirements. The interviews include registration with deanery staff, a de-brief with senior member of the team and ID check. The format is similar to that for OST1, including a preparation

---

station and similar interview stations A and B. An additional station C is added testing clinical examination skills.

18.4 There is detailed information about the training provided in each LETB/Deanery on the College website <https://www.rcophth.ac.uk/training/national-recruitment-ophthalmic-specialist-training/national-recruitment-deanery-proforma-information/> and on the Severn Deanery site.

Candidates can rank all the LETBs/Deaneries they would be prepared to work in. Once the run-through posts have been offered to higher ranking candidates, lower ranking candidates with an appointable score will be offered LAT posts in Scotland, Wales or Northern Ireland.

## **19. Medical Ophthalmology**

19.1 There are opportunities for OST trainees to switch to Medical Ophthalmology Specialty Training at OST3. Medical Ophthalmologists, or Ophthalmic Physicians, are trained in the management of medical disorders affecting eyes and vision, which includes ocular and orbital inflammatory disease, neuro-ophthalmology and medical retina disorders. The training programme consists of two years of internal medicine and three years of higher medical ophthalmology. There are medical modules in relevant medical specialties such as rheumatology, neurology, infection and clinical genetics.

19.2 FRCOphth Part 1 and confirmation of satisfactory progress in OST1 and 2 are essential requirements for entry to the programme. The Medical Ophthalmology training programme is managed by the Joint Royal Colleges of Physicians Training Board.

More information is available from:

<https://www.jrcptb.org.uk/specialties/medical-ophthalmology>

<http://www.st3recruitment.org.uk/specialties/medical-ophthalmology>

## **20. Flexible (less than full time) training**

20.1 The Gold Guide – 7th edition (2017) uses the NHS employers document ‘Principles underpinning the new arrangements for flexible training’ (2005) and the GMC position statement (2017) to provide detailed guidance on flexible training including eligibility criteria (Section 3, para. 3.79 to 3.104). The BMA guide on the subject outlines the pros and cons including detail on pay related matters.

20.2 A trainee wishing to train flexibly should advise the TPD of their intention and then liaise with the Postgraduate Dean about an application.

20.3 Supervision of flexible training is the responsibility of the regional Postgraduate Dean and local school board; however, the Training Committee at the College 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.

20.4 The School will calculate the expected date for the award of the CCT and inform the College through the ARCP process. The balance of service and training is affected least by slot sharing trainees that wish to train flexibly and the College would generally support this but would encourage the Postgraduate Deans to allow trainees to work as many sessions as they wish, if this is possible.

20.5 The composition of timetables should generally be on a pro-rata basis compared with full-time training but note that issues like statutory mandatory training is not different. The period of grace after CCT is 6 months for both full-time and flexible trainees. Key issues are to plan ahead to avoid being penalised by loss of time or missing critical training opportunities, e.g. planning ahead for an attachment to be two 3-month blocks to offer all the opportunities on that timetable and ensuring child care can be flexible and later to accommodate that with sufficient notice.

20.6 Whilst the GMC statement allows for acceleration of training, the College would recommend the same stance as with full-time trainees that acceleration should only be contemplated for trainees who demonstrate exceptional progression in all domains of training.

## **21. Locum Appointment for Training (LAT)**

LAT posts are usually to provide for a gap in a training programme. Full guidance can be obtained from the Gold Guide, section 3 (para: 3.47 – 3.64).

LAT posts across all specialties ended in England in 2016, but continue to be available in Scotland, Wales and Northern Ireland.

LAT posts are normally for a year's duration and should be a minimum of three months.

LAT posts should be managed in the same way as a substantive training post. Specifically, the post should be identical in quality and educational opportunities as the substantive equivalent. The LAT should have the requisite supervision. i.e. clinical and educational.

The LAT post should be advertised with some detail of the training opportunities available and, prior to acceptance of the post, there should be an effort to tailor the training opportunities to the educational needs of the LAT.

---

Only the time in the LAT post should be assessed at an ARCP, which must be held at the end of the LAT post. As per para. 3.63 of the Gold Guide, an ARCP is not required if the post is less than 3 months, as this is too short a duration to count towards CCT. Previous ARCP outcomes should be taken into consideration at the time of the ARCP and prior to the offering or the acceptance into a LAT post. LAT posts should not provide immunity to failing to progress in training or failing to achieve exam success in the requisite times, as a substantive trainee would be subject to.

## **22. Post-CCT training**

22.1 Some trainees may wish to acquire additional training outwith the CCT envelope. Such posts are only relevant to the Training Committee of the College 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 GMC approval.

22.2 However, procedures for post-CCT training are being developed in a more formal way, particularly in some of the specialty interest areas of Ophthalmology and the Education Committee of the College is leading this work. Guidance is being developed for the location, structure and expected competencies of such post-CCT fellowships, and a process of College accreditation for such fellowships.

## **23. Preparing for ARCPs**

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

23.2 Where trainees are invited to attend, the panel will have agreed the outcome prior to meeting the trainee. They can then inform the trainee of the outcome. For outcomes 2-5 the trainee will need to meet the panel, potentially to provide further information, or for the panel to set targets for training, should there have been any concerns or development needs identified, and a further review is set.

23.3 As detailed in the Gold Guide, the ARCP panel must choose from 8 outcomes: Satisfactory progress demonstrated. May proceed to the next stage of training. Development of specific competences required. Needs targeted training in some areas but does not require additional time in training. May proceed to the next stage of training but should demonstrate that the specific issues have been addressed and competence achieved.

Inadequate progress. Additional training time is required, the panel will make specific recommendations about this including the length of the additional training

and will plan an interim ARCP. Only one additional year of training is allowed, without special review by the Postgraduate Dean, therefore this may be for a shorter time frame in the first instance.

Released from training. Insufficient and sustained lack of progress, despite additional training time may result in this outcome.

Incomplete documentation presented. Trainees must complete the documentation and provide a written explanation of why it was missing within 5 days.

Completed all required competences and may be recommended to GMC for CCT.

Fixed term posts (e.g. LATs) receive 7.1, 7.2 or 7.3 as appropriate. 7.4 is awarded for incomplete evidence.

Out of Programme form where OOPE/OOPR/OOPC is not recognised for training.

Outcomes 2 and 3 are there to ensure that all trainees are given the opportunity to acquire the necessary competencies. Specific plans are put in place to help the trainee to acquire these skills and obtain their CCT. To prevent outcome 5, trainees should get in touch with their Educational Supervisor at an early stage and ask for advice.

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

Evidence	Guidance
Educational Supervisor Reports (ESR)	Two signed ESRs should be completed within the e-Portfolio, one for each 6-month attachment. Ensure that all the boxes have been completed, and that the ES has included free-text comments.
Clinical Supervisor Reports (CSR)	Four signed CSRs should be completed within the e-Portfolio as a minimum. There must be 2 for each 6-month attachment. However, if a trainee spends clinical time regularly with additional supervisors, they should also complete a report. There should be free-text comments included rather than just tick boxes.
PDP/Appraisals	The embedded PDP should be populated and assigned to the appropriate ARCP. Any targets set at the previous ARCP will pre-populate the PDP. Further goals are discussed with the ES, and SMART objectives completed. Trainees should have uploaded evidence that they have completed the previous year's PDP goals or include comments on progress towards completing them.
Eye Logbook	The Eye Logbook summary must be uploaded onto the e-Portfolio, including the cataract surgery complication rate (which should also be documented in the ESR). OST6-7 trainees should have evidence of supervising juniors (they need approximately 20 SJ before end of training) and managing the complications of cataract surgery such as vitreous loss. OST6-7 trainees should also have completed an audit of 50 consecutive cataract operations

	<p>with refractive outcomes.</p> <p>There should be a continuous audit of cataract surgery complications throughout training with the outcomes.</p> <p>Evidence of surgical simulation should be documented, e.g.: the Excel spreadsheet from the EyeSI simulator.</p>
Research/Audit/Quality Improvement/ Publications /Teaching	<p>Quality improvement projects or audit; publications and presentations should be uploaded with evidence of the trainee's involvement. These should be embedded in the ESR and populate the 'Summary of Training Evidence' section of the ARCP. There should be a personal audit of 50 consecutive cataract surgery cases (to include refractive data where possible) before the end of OST7. Some Schools use a scoring system to rate productivity in RSTA sessions. If used, this should be included in the ESR.</p> <p>Attendance record at postgraduate teaching should be uploaded.</p> <p>Teaching and Training should be uploaded, including feedback.</p>
WpBAs ("traffic-light" grid)	<p>All WpBAs included in the e-Portfolio for the trainee's 'Stage of Training' should be completed and will show as Green. For OST4-7 there must be a proportionate completion of the cumulative requirements. Trainees can complete competences ahead, completing the WpBA for a later Stage of Training. These are viewed in the e-Portfolio of that year demonstrating the trainee is ahead and will pre-populate the requirements at the more senior stage as that is reached.</p> <p>The free-text boxes must be completed for the WpBA to be valid. The 'Suggestions for Development' box show in a table and trainees should have reviewed these and included evidence of how these are addressed or discussed with their ES throughout the year. There must be a majority of consultant assessors for the WpBAs. If another trainee is used as an assessor, then the assessor must be a minimum of 2 years senior to the trainee.</p> <p>There should be no clustering of WpBAs, which indicates lack of engagement in the educational process. Trainees should complete WpBAs throughout the year, preferably about one per fortnight.</p>
MSF	<p>There should be at least one MSF per year. The MSF takes time to organise and get signed off, so the trainee should initiate this at least three months before the ARCP.</p>
CPD diary	<p>This should be populated and up to date, with evidence of appropriate reflection on learning events. It is not enough for the trainee to state that they attended a conference. The diary should indicate what was learned, and how it will affect their practice.</p>
Exams	<p>The results from RCOphth download directly. For unsuccessful attempts, the College feedback should be uploaded as a resource.</p>
Significant events/ complaints	<p>These should be summarised in the ESR, but there should be appropriate reflective evidence with lessons learnt, uploaded as a resource on the e-Portfolio, or in the CPD diary. This may be in the form of a 'Case Review', 'Significant Events' or 'Complaints'</p>

	structured reflective template. <a href="http://www.aomrc.org.uk/statements/interim-guidance-on-reflective-practice/">http://www.aomrc.org.uk/statements/interim-guidance-on-reflective-practice/</a>
e-Portfolio	The e-Portfolio should be to date and resources should be labelled clearly and correctly.

## **24. Preparing for CCT**

24.1 A CCT is awarded by the GMC and confirms that a doctor has completed an approved training programme and is eligible for entry onto the specialist register.

The Royal College of Ophthalmologists will recommend doctors in training to the GMC for awarding a CCT on successful completion of Ophthalmic Specialist Training and receipt of a completed application from the trainee.

24.2 Trainees are required to apply to both the Royal College of Ophthalmologists and the GMC for a CCT. Where a portion of training has occurred outwith a UK training programme not covered by an ARCP outcome, e.g. entering training at OST3 with non-UK experience, then the candidate will apply to the Royal College and GMC in the same way but be awarded a CESR (CP).

24.3 Trainees should prepare well in advance for their final ARCP, ensuring their whole portfolio is up to date with no outstanding requirements from previous years.

24.4 Prior to their final ARCP, additional documentation for consideration of CCT is required to be completed and uploaded into their portfolio. Namely:

[CCT application form](#) (please note that this form needs to be signed by the Postgraduate Dean)

Logbook

[Cumulative Data Sheet](#) (signed by the TPD)

50 consecutive case cataract audit presented as an audit paper (with comparison to national standards) and supported by raw data. The College website contains further guidance and an example model

Continuous cataract complications audit

Report on TSC (if applicable)

24.5 Trainees are required to email the College as instructed for their application to be considered once this information is uploaded.

24.6 Trainees will be contacted directly by the GMC to complete a separate online application through GMC Connect.

---

24.7 When the GMC has received a recommendation from the College and the online application process (including payment of the fee) is completed, the GMC will issue the CCT.

24.8 Detailed information and requirements for CCT are found on the College and GMC websites.

<https://www.rcophth.ac.uk/training/certification-of-training-and-specialist-training/award-of-the-cct/>

<https://www.gmc-uk.org/registration-and-licensing/join-the-register/registration-applications/specialist-application-guides/guide-to-a-certificate-of-completion-of-training>

## **25. Acceleration of Training**

Trainees who have acquired all the necessary competencies early and demonstrated maturity in developing the necessary generic professional capabilities may, rarely, be considered for acceleration of training. Further guidance may be found in the Education and Training section of the College website.

<https://www.rcophth.ac.uk/training/certification-of-training-and-specialist-training/award-of-the-cct/>

## **26. Effects on training of 2016 Junior Doctors Contract**

For those trainees employed on the 2016 Junior Doctors Contract, work schedules and on-call rotas must be compliant with the requirements of the contract.

<http://www.nhsemployers.org/news/2016/03/2016-doctors-in-training-contract>

At the start of each placement trainees will agree a personalised work schedule with their Educational Supervisor, reflecting their hours of work and on-call and educational requirements, and this will be communicated to medical staffing/HR. They will have access to the Exception Reporting process to highlight issues over workload, excess hours worked or missed breaks or educational opportunities, and these will be dealt with by the Educational Supervisor.

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