JRCPTB

Joint Royal Colleges of Physicians Training Board

Rough Guide to Implementation Medical Ophthalmology Curriculum

Guidance for training programme directors, supervisors and trainees

August 2021 – updated April 2022

ROYAL COLLEGE of PHYSICIANS of EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians

Contents

Introduction

This guide for Medical Ophthalmology is to help training programme directors (TPDs), supervisors, trainees and others with the practicalities of implementing the new curriculum. It is intended to supplement rather than replace the curriculum document itself. The curriculum, ARCP decision aid and this guide are available on the JRCPTB website.

The Rough Guide has been put together by members of the Medical Ophthalmology SAC with additional help from many external stakeholders especially trainees. It is intended to be a 'living document' and we value feedback via curriculum@jrcptb.org.uk.

What is different about the 2021 Medical Ophthalmology curriculum?

Background

There have been two major drives to the need for change. Firstly the move away from the 'tick-box' approach associated with the current competency-based curricula to the holistic assessment of high level learning outcomes. The new curriculum has a relatively small number of 'capabilities in practice' (CIPs) which are based on the concept of entrustable professional activities (EPAs). Secondly, the GMC has mandated that all postgraduate curricula must incorporate the essential generic capabilities required by all doctors as defined in the Generic Professional Capabilities (GPC) framework..

Duration of training

Medical Ophthalmology higher specialty training will usually be completed in five years of full-time training. There will be options for those trainees who demonstrate exceptionally rapid development and acquisition of capabilities to complete training sooner than the indicative time. There may also be trainees who develop more slowly and will require an extension of training as indicated in the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide).

The Medical Ophthalmology curriculum

The purpose of the curriculum is to produce doctors with the generic professional and specialty specific capabilities required to practice in Medical Ophthalmology. Medical ophthalmologists, or ophthalmic physicians manage patients presenting with a wide range of medical conditions affecting the eyes, orbits and visual pathways. They will be entrusted to undertake the role of the medical ophthalmology registrar with a view to taking on the role of a consultant Ophthalmic Physician. Consultant ophthalmic physicians usually work in one or more of the following subspecialty areas: ocular inflammation (including uveitis), medical retina, neuro-ophthalmology, diabetes retinal screening, emergency eye care, research.

Doctors in training will learn in a variety of settings using a range of methods, including workplace-based experiential learning, formal postgraduate teaching and simulation-based education.

By the end of their final year of training, the trainee will receive a CCT in Medical Ophthalmology.

Capabilities in Practice (CiPs)

The **generic CiPs** cover the universal requirements of all specialties as described in the GPC framework. The generic CiPs are common across all physician specialties. Assessment of the generic CiPs will be underpinned by the GPC descriptors. Satisfactory sign off will indicate that there are no concerns.

The **specialty CiPs** describe the professional tasks or work within the scope of Medical Ophthalmology.

Trainees entering Medical Ophthalmology from ophthalmic specialty training should also refer to the Rough Guide to Internal Medicine Training.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated for an entrustment decision to be made.

By the completion of training and award of CCT, the doctor must demonstrate that they are capable of unsupervised practice (level 4) in all specialty CiPs.

Capabilities in practice (CiPs)

Generic CiPs

1. Able to successfully function within NHS organisational and management systems
2. Able to deal with ethical and legal issues related to clinical practice
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement
4. Is focussed on patient safety and delivers effective quality improvement in patient care
5. Carrying out research and managing data appropriately
6. Acting as a clinical teacher and clinical supervisor to be assessed by DOPS

Specialty CiPs

1. Managing and leading a multidisciplinary medical ophthalmology team, including management of an outpatient clinic and injection list
2. Diagnosis and management of acute medical ophthalmology emergencies

3. Diagnosis and management of patients with medical ophthalmic conditions, including those with complex conditions, long term conditions and those on immunosuppressants
4. Managing perioperative care of medical ophthalmological patients
5. Competent in all procedural skills for medical ophthalmology as defined by the curriculum
6. Managing medical, ethical and social issues of visual impairment

Specialty CiPs guidance

1. **Managing and leading a multidisciplinary medical ophthalmology team, including management of an outpatient clinic and injection list**: This is looking at the trainees ability to run an outpatient clinic and injection clinic, including supervision and training of trainees an allied health professionals.

2. **Diagnosis and management of acute medical ophthalmology emergencies**: This is looking at the trainees ability to triage, prioritise and manage emergency medical ophthalmic conditions. A trainee should be able to run an Eye Casualty/ urgent referral clinic and liaise with other medical and surgical colleagues.

3. **Diagnosis and management of patients with medical ophthalmic conditions, including those with complex conditions, long term conditions and those on immunosuppressants:** This is looking at the trainees ability to run clinics in medical retina, neuro-ophthalmology and ocular inflammation (uveitis, corneal inflammation, orbital inflammation) including supervision of trainees and allied health professional and liaison with other health professionals. Trainees should be able to prescribe and manage immunosuppression and liaise with other medical teams where appropriate. Trainees should have a good understanding of systemic diseases associated with medical ophthalmology and have placements in dermatology, diabetes and endocrinology, infectious diseases, medical genetics, neurology, renal medicine , transplant medicine, systemic vasculitis, and rheumatology. Trainees should also have an understanding of diabetes retinal screening programmes in the UK and be able to grade retinopathy and refer appropriately.

4. **Managing perioperative care of medical ophthalmological patients:** This is looking at the trainees ability to manage patients undergoing ophthalmic surgery. They should be able to determine when surgery is appropriate, communicate risks and benefits with patients, risk stratify and prioritise patients appropriately and manage patients pre and post-operatively. An understanding of the surgical procedures is important.

5. **Competent in all procedural skills for medical ophthalmology as defined by the curriculum**: This is looking at the trainees ability to perform procedures required for patients attending with emergency eye conditions, and those in medical retina, neuro-ophthalmology and ocular inflammation clinics.

6. **Managing medical, ethical and social issues of visual impairment**: This is looking at the trainees ability to identity patients with visual impairment and to support them

appropriately, including referral to low vision services and offering certification of visual impairment. Trainees should follow and advise patients on DVLA guidelines for driving.

Evidence of capability

The curriculum describes the evidence that can be used by the educational supervisor to make a judgement of the trainee's capability (please see the CiPs tables and the assessment blueprint). The educational supervisor will make a holistic judgement based on the evidence provided, particularly the feedback from clinical supervisors and the multi disciplinary team. The list of evidence for each CiP is not exhaustive and other evidence may be equally valid.

Presentations and Conditions

The curriculum provides guidance on the presentations and conditions which form the clinical context in which the capabilities are demonstrated. The presentation and conditions listed are either common or serious and trainees will be expected to know about these but they will not need to be signed off for individual items.

Practical Procedures

The curriculum and ARCP decision aid list the practical procedures required and the minimum level of competency. Trainees should be supported to attend supervised laser and injection clinics, and to have simulated training where available.

Once a trainee is competent to perform a procedure unsupervised (as evidenced by summative DOPS) there is no requirement for further assessment. It is a matter of professional insight and probity that a trainee should maintain their competency by carrying out the procedure when the opportunity arises. If a trainee has not performed a particular procedure for some time and no longer feels confident or competent to carry it out, then they should seek further training with appropriate supervision. Trainers should have ongoing conversation with trainees about procedural competence and this should be documented.

By the end of training a trainee should be able to supervise procedures and to oversee laser and injection clinics.

Assessment: What is required from trainees and trainers?

Introduction

Decisions about a trainee's competence progression will be based on an assessment of how they are achieving their CiPs. For the generic CiPs it will be a straightforward statement as to whether they are operating at, above, or below level expected for the current year of training. For the specialty CiPs there will be a judgement made at what level of supervision they require (i.e. unsupervised or with direct or indirect supervision). For each of these CiP there is a level that is to be achieved at the end of each year in order for a standard outcome to be achieved at the Annual Review of Competence Progression (ARCP). The levels expected are given in the grid below and in the ARCP decision aid.

What the trainee needs to do

Trainees entering Medical Ophthalmology from Internal medicine need to complete FRCOphth part 1 by the end of ST4. Trainees entering training from Ophthalmic Specialty training need to complete the MRCP (UK) by the end of ST4. The refraction certificate has been removed but trainees still need to complete the clinical rating scale for refraction.

Trainees need to do an appropriate number of supervised learning events (SLEs) and workplace based assessments (WPBAs). The requirements are documented in the ARCP decision aid (see ARCP section below) but it should be appreciated by trainer and trainee that the decision aid sets out the absolute minimums. SLEs and formative DOPS are not pass/fail summative assessments but should be seen by both trainer and trainee as learning opportunities for a trainee to have one to one teaching and receive helpful and supportive feedback from an experienced senior doctor. Trainees should therefore be seeking to have SLEs performed as often as practical. They also must continue to attend and document their teaching sessions and must continue to reflect (and record that reflection) on teaching sessions, clinical incidents and any other situations that would aid their professional development. They should record how many clinics they have attended in the summary of clinical activity form.

Each trainee must ensure that they have acquired multi-source feedback (MSF) on their performance each year and that this feedback has been discussed with their Educational Supervisor (ES) and prompted appropriate reflection. They also need to ensure that they have received a minimum of 4 reports from consultants who are familiar with their work and who will contribute to the Multiple Consultant Report (MCR). Each consultant contributing to the MCR will give an advisory statement about the level at which they assess the trainee to be functioning for each clinical CiP.

As the ARCP approaches, trainees need to arrange to see their ES to facilitate preparation of the ES report (ESR). They will have to self-assess the level at which they feel they are operating at for each CiP. In an analogous fashion to the MSF, this self- assessment allows the ES to see if the trainee's views are in accord with those of the trainers and will give an idea of the trainee's level of insight.

Interaction between trainer and trainee

Regular interaction between trainees and their trainers is critical to the trainee's development and progress through the programme. Trainees will need to engage with their clinical and educational supervisors.

At the beginning of the academic year there should be a meeting with the ES to map out a training plan for the year. This should include;

- how to meet the training requirements of the programme, addressing each CiP separately
- a plan for taking the FRCOphth part 1 or MRCP (UK)
- a discussion about what resources are available to help with the programme
- develop a set of SMART Personal Development Plans (PDPs) for the training year
- a plan for using study leave
- use of the various assessment/development tools

The trainee should also meet with the clinical supervisor (CS) to discuss the opportunities in the current placement including;

- developing a PDP including SMART objectives for the placement
- access to clinics and how to meet the learning objectives
- expectations for on-call
- expectations for the management of inpatients

Depending on local arrangements there should be regular meetings (we recommend approximately one hour most weeks) for personalised, professional development discussions which will include;

- writing and updating the PDP
- reviewing reflections and SLEs
- reviewing MCR and other feedback
- discussing leadership development
- discussing the trainee's development as a physician and career goals
- discussing things that went well or things that went not so well

Self-assessment

Trainees are required to undertake a self-assessment of their engagement with the curriculum and in particular the CiPs. This is not a 'one-off' event but should be a continuous process from induction to the completion of the programme and is particularly important to have been updated ahead of the writing of the ES report and subsequent ARCP. Self-assessment for each of the CiPs should be recorded against the curriculum on the trainee's ePortfolio account.

The purpose of asking trainees to undertake this activity is:

- To guide trainees in completing what is required of them by the curriculum and helping to maintain focus of their own development. To initiate the process it is important that

the induction meeting with a trainee's ES reviews how the trainee will use the opportunities of the coming academic year to best advantage in meeting the needs of the programme. It will allow them to reflect on how to tailor development to their own needs, over-and-above the strict requirements laid out in the curriculum

- To guide the ES and the ARCP panel as to how the trainee considers they have demonstrated the requirements of the curriculum as set out in the Decision Aid and where this evidence may be found in the trainee's portfolio. This will help the ARCP panel make a more informed judgement as to the trainee's progress and reduce the issuing of outcome 5s as a result of evidence not being available or found by the panel

What the Educational Supervisor (ES) needs to do

The educational supervisor and trainee should meet beforehand to plan what evidence will need to be obtained. This can be used by the ES to write an important and substantial ES report (ESR).

The ESR will be the central piece of evidence considered by the ARCP Panel when assessing whether the trainee has attained the required standard as set out in the Decision Aid. As such, both time and planning will need to be given to writing it; this process will need to start at the beginning of the training year.

Educational Supervisor Report (ESR)

The ESR should be written ahead of the ARCP and discussed between the supervisor and the trainee before the ARCP, with any aspects likely to result in a non-standard outcome at ARCP made clear. This conversation should be documented. The report documents the entrustment decisions made by the supervisor for all the CiPs set out in the curriculum. The decisions should be based on evidence gathered across the training year as planned at the Induction Meeting with the trainee and modified through subsequent, regular, professional development meetings. The evidence should be gathered from several sources as appropriate for the particular CiP.

In completing the ESR, assessments are made for each **generic CiP** using the following anchor statements:

Below expectations for this year of training; may not meet the requirements for critical progression point
Meeting expectations for this year of training; expected to progress to next stage of training
Above expectations for this year of training; expected to progress to next stage of training

Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include;

- Source of the evidence and its context, outlining contradicting evidence if appropriate

- Examples (of statements)
- Direction for future development/improvement

For the **specialty CiPs**, the ES makes a judgement using the levels of entrustment in the table below.

Level 1: Entrusted to observe only – no provision of clinical care
Level 2: Entrusted to act with direct supervision: The trainee may provide clinical care, but the supervising physician is physically within the hospital or other site of patient care and is immediately available if required to provide direct bedside supervision
Level 3: Entrusted to act with indirect supervision: The trainee may provide clinical care when the supervising physician is not physically present within the hospital or other site of patient care, but is available by means of telephone and/or electronic media to provide advice, and can attend at the bedside if required to provide direct supervision
Level 4: Entrusted to act unsupervised

Only the ES makes entrustment decisions. Detailed comments must be given to support entrustment decisions that are below the level expected. As above, it is good practice to provide a narrative for all ratings given.

Important Points

- Plan the evidence strategy from the beginning of the training year
- Write the report in good time ahead of the ARCP
- Discuss the ESR with the trainee before the ARCP
- Give specific, examples and directive narration for each entrustment decision

Types of Evidence

Multi-Source Feedback (MSF)

The MSF provides feedback on the trainee that covers areas such as communication and team working. It closely aligns to the Generic CiPs. Feedback should be discussed with the trainee. If a repeat MSF is required it should be undertaken in the subsequent placement.

Multiple Consultant Report (MCR)

The MCR captures the views of consultant (and other senior staff) based on observation of a trainee's performance in practice. The MCR feedback gives valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required.

The ***minimum*** number of MCRs considered necessary is 4 per year.

Consultant supervisors completing the MCR will use the global anchor statements [meets, below or above expectations] to give feedback on areas of clinical practice. If it is not possible for an individual to give a rating for one or more area they should record 'not observed'. Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include:

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

Supervised Learning Events

Case based Discussion (CbD)

This tool is designed to provide feedback on discussions around elements of the care of a particular patient. This can include elements of the particular case and the general management of the condition. It is a good vehicle to discuss management decisions.

Mini-Clinical Evaluation (mini-CEX)

This tool is designed to allow feedback on the directly observed management of a patient and can focus on the whole case or particular aspects.

Clinical rating scale

This is a modified mini-CEX from ophthalmic specialty training.

Workplace-Based Assessments

Direct Observation of Procedural Skill (DOPS)

This tool is designed to give feedback and assessment for trainees on how they have undertaken a procedural skill. This may be in a simulated or real environment. Formative DOPS may be undertaken as many times as the trainee and supervisor feel is necessary. A trainee can be signed off as able to perform a procedure unsupervised using the summative DOPS.

Teaching Observation (TO)

The TO form is designed to provide structured, formative feedback to trainees on their competences at teaching. The TO form can be based on any instance of formalised teaching by the trainee which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors).

Quality Improvement Project Assessment Tool (QIPAT)

The QIPAT is designed to assess a trainee's competence in completing a quality improvement project. The QIPAT can be based on a review of quality improvement documentation or on a presentation of the quality improvement project at a meeting. If possible, the trainee should be assessed on the quality improvement project by more than one assessor.

Guidance on how to assess QI skills and behaviours has been developed by the Academy of Medical Royal Colleges and is available via this link.

Examination

Trainees entering Medical Ophthalmology from Internal medicine should pass the FRCOphth part 1 by the end of ST4. Trainees entering from Ophthalmic Specialty training should pass the MRCP (UK) by the end of ST4.

Other assessments

Knowledge based assessment (KBA)

This is a formative assessment taken by trainees annually from ST5-7. It is designed to sample areas of the curriculum, identify knowledge gaps and focus learning. Trainees will normally sit the paper in the autumn, on the same day, at the same time, in their own unit.

The papers are marked independently and the trainee's mark, range of marks and a summary of the topics are fed back to the trainee and supervisor. If questions are answered poorly or incorrectly to the extent that concerns are raised pertaining to patient safety, these will also be reported.

It is important that trainees meet with their educational supervisor to review the KBA outcome and that a plan to address any deficiencies is documented on the e-portfolio. If there are any areas of concern or if the trainee has not performed as expected there should be evidence on the eportfolio to show learning and progression.

Reflection

Undertaking regular reflection is an important part of trainee development towards becoming a self-directed professional learner. Through reflection a trainee should develop SMART learning objectives related to the situation discussed. These should be subsequently incorporated into their PDP. Reflections are also useful to develop 'self-knowledge' to help trainees deal with challenging situations.

It is important to reflect on situations that went well in addition to those that went not so well. Trainees should be encouraged to reflect on their learning opportunities and not just clinical events

Suggested evidence for each CiP

The suggested evidence to inform entrustment decisions is listed for each CiP in the curriculum and ePortfolio. However, it is critical that trainers appreciate that trainees do not need to present every piece of evidence listed and the list is not exhaustive and other evidence may be equally valid.

Induction Meeting with ES: Planning the training year

Writing the ESR essentially starts with the induction meeting with the trainee at which the training year should be planned. The induction meeting between the ES and the trainee is pivotal to the success of the training year. It is the beginning of the training relationship between the two and needs both preparation and time. The induction meeting should be recorded formally in the trainee's ePortfolio. The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the training year. This is also a time for ES and trainee to start to get to know each other.

Ahead of the meeting review:

- Review Transfers of Information on the trainee
- Review previous ES, ARCP etc. reports if available
- Agree with the placement CSs how other support meetings will be arranged. Including;
    - Arrangements for LFGs if applicable
    - Arrangements for professional development meetings

At the meeting the following need to be considered:

- Review the placements for the year
- Review the training year elements of the generic educational work schedule or its equivalent
- Construct the personalised educational work schedule for the year or its equivalent
- Construct the annual PDP and relevant training courses
- Discuss the trainee's career plans and help facilitate these
- Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs
- Discuss the teaching programme
- Discuss procedural simulation
- Discuss procedural skill consolidation
- Discuss arrangements for LTFT training if appropriate
- Plan additional meetings including the professional development meetings and the interaction with the placement CSs
- Planning of SLEs and WPBA
- Arrangements for MSF
- Review the ARCP decision aid
- Arrangements for Interim Review of Competence Progression (IRCP)
- Arrangements for ARCP and the writing and discussion of the ESR
- Pastoral support
- Arrangements for reporting of concerns
- Plan study leave

At the end of the meeting the trainee should have a clear plan for providing the evidence needed by the ES to make the required entrustment decisions.

Important Points

- Prepare for the meeting
- Make sure that knowledge of the curriculum is up-to-date
- Set up a plan for the training year

Induction Meeting with Clinical Supervisor (CS)

The trainee should also have an induction meeting with their placement CS (who may also be their ES). The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the placement. This is also a time for CS and trainee to start to get to know each other.

Ahead of the meeting review the following should be considered;

- Review Transfers of Information on the trainee
- Review previous ES, ARCP etc. reports if available
- Arrangements for LFGs or equivalent

The following areas will need to be discussed, some of which will reinforce areas already covered by the ES but in the setting of the particular placement:

- Review the training placement elements of the generic educational work schedule or its equivalent
- Construct the personalized educational work schedule for the placement or its equivalent
- Construct the set of placement-level SMART objectives in the PDP
- Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs
- Discuss procedural skill consolidation
- Discuss arrangements for LTFT training if appropriate
- Plan additional meetings including professional development meetings and the interaction with the placement CSs (depending on whether the ES or CS will be undertaking these)
- Arrangements for MSF
- Review the ARCP decision aid
- Pastoral support
- Arrangements for reporting of concerns
- Plan study leave

Professional Development Meetings

Trainers and trainees need to meet regularly across the training year. The GMC recommend an hour per week is made available for this activity. While it is not expected or possible for it to be an hour every week, the time not used for these meetings can be used to participate in LFG and ARCPs etc.

These meetings are important and should cover the following areas. This list is not exhaustive. Meet away from the clinical area regularly to:

- Discuss cases
- Provide feedback
- Monitor progress of learning objectives
- Discuss reflections
- Provide careers advice
- Monitor and update the trainee's PDP

- Record meeting key discussion points and outcomes using the Educational Meeting form on the ePortfolio
- Record progress against the CiPs by updating the comments in the CiP section of the portfolio (this will make writing the ESR at the end of the year much easier)
- Provide support around other issues that the trainee may be encountering

Transition arrangements for trainees already in programme

The GMC requires all trainees to transition to a new curriculum. The only exception is trainees in their final year when a curriculum is introduced. This ensures that trainees are trained and assessed against the most recent standards for the specialty.

Trainees in medical ophthalmology training who are working to the 2015 curriculum will transfer to the 2021 curriculum in August 2021, apart from trainees in their final year of training who may continue on the 2015 curriculum.

Trainees transferring to the 2021 curriculum should have a meeting with their ES to review their progress against the new curriculum and make plans to address any gaps in training. Trainees are not expected to transfer evidence from previous years to the new curriculum.

Trainees who have come from alternative entry pathways

Trainees entering from Ophthalmic Specialty Training should follow the internal medicine training stage 1 curriculum for ST3 and 4.

Annual Review of Competence Progression (ARCP)

Introduction

The ARCP is a procedure for assessing competence annually in all medical trainees across the UK. It is owned by the four Statutory Education Bodies (Health Education England, NHS Education for Scotland, Health Education and Improvement Wales and Northern Ireland Medical & Dental Training Agency) and governed by the regulations in the Gold Guide. The

JRCPTB can therefore not alter the way in which an ARCP is run but can provide guidance for trainees and trainers in preparing for it and guide panel members on interpretation of both curricular requirements and the decision aid when determining ARCP outcomes. Although receiving a non-standard ARCP outcome (i.e. anything but an outcome 1 or 6) should not be seen as failure, we know that many trainees are anxious about such an outcome and everything possible should be done to ensure that no trainee inappropriately receives a non-standard outcome.

The ARCP gives the final summative judgement about whether the trainee can progress into the subsequent year of training (or successfully complete training if in the final year). The panel will review the ePortfolio (especially the ES report) in conjunction with the decision aid for the appropriate year. The panel must assure itself that the ES has made the appropriate entrustment decisions for each CiP and that they are evidence based and defensible. The panel must also review the record of trainee experience to ensure that each trainee has completed (or is on track to complete over ensuing years) the various learning experiences mandated in the curriculum.

The critical progression points in the Medical ophthalmology training are the end of ST4, where trainees need to have completed both MRCP(UK) and FRCOphth part 1 to continue to ST5, and completion of training at the end of ST7.

Medical Ophthalmology training and the ARCP

The change from the tick-box style competencies to the high-level Capabilities in Practice (CiPs) will have a major impact on how trainees are assessed and how they will progress through their ARCPs. It is vital we avoid an increase in trainees failing to achieve a standard ARCP outcome by helping trainees and trainers to prepare for the ARCPs and by stressing to ARCP panels the basis of their assessment. ARCP panel members must ask the question: "Overall, on reviewing the ePortfolio, including the Educational Supervisor report, the Multiple Consultant Reports, the Multi-Source Feedback and (if necessary) other information such as workplace based assessments, reflection etc, is there evidence to suggest that this trainee is safe and capable of progressing to the next stage of training?"

Relationship with Educational Supervisor (ES)

It is vital that the trainee and the ES develop a close working relationship and meet up as soon as possible after the start of training. At that meeting, the ES should discuss how the various curriculum requirements will be met and how evidence will be recorded to ensure that it can be demonstrated that the Capabilities in Practice have been achieved at the appropriate level. This meeting should also result in the production of a Personal Development Plan (PDP) consisting of a number of SMART objectives that the trainee should seek to achieve during that training year. The trainee should meet up with their ES on a number of other occasions during the training year so that the ES can be reassured that appropriate evidence is being accumulated to facilitate production of a valid ES report towards the end of the year and guide the trainee as to further evidence that might be required.

Clinical supervisor (CS)

The trainee should have a Clinical Supervisor for each attachment and once again the trainee should meet up with the CS at the start of the attachment. Similar discussions should be held with the CS as have been held with the ES and once again, a PDP with SMART objectives should be constructed for each attachment. At the end of the attachment, the CS should be well placed to complete a Multiple Consultant Report (MCR). The CS should also document the progress that the trainee has made towards completing all the objectives of the PDP.

The trainee should provide a MCR from each designated CS as they are best placed to provide such a report but in addition should approach other consultants with whom they have had a significant clinical interaction and ask them also to provide a MCR. Throughout the attachment the trainee should be having SLEs completed by both consultants and more senior trainees. The number of SLEs demanded by the decision aid should be regarded as an absolute minimum and additional ones should be sought because

- Although they are formative, not summative assessments, they do provide additional evidence to show that a trainee is acquiring clinical (and generic) capabilities
- They may give the trainee the opportunity to have additional one to one clinical teaching from a senior colleague
- They allow the excuse for trainees to receive targeted and constructive feedback from a senior colleague.

Completing reports

When completing reports, all consultants should do more than just tick a box and make some generic comment such as “good trainee”. It is important that they make meaningful comments about why they have assigned that particular level of performance/behaviour to that particular trainee. In doing this, the descriptors assigned to each CiP should be especially useful as an *aide-memoire*. They should specifically not be used as a tick list that requires a comment for each descriptor but should just allow the senior doctor completing the report to reflect on what comments would be helpful to the ES for completion of their report and to the ARCP panel in determining whether the trainee can progress to the next year of training. Constructive comments are also of course valued by the trainee. It is very helpful if the trainee can have constructive comments if they are progressing along the “normal” trajectory and especially if they are exceeding expectations either globally or in certain areas. If a trainee is performing below expectations then it is absolutely mandatory that meaningful, insightful and precise comments are provided.

ARCP preparation

As the ARCP approaches, it is essential that the trainee reviews their ePortfolio and ensures that all requisite information is available in a logical and accessible format. In particular they should ensure that:

- All appropriate certificates have been uploaded to the personal library and are clearly signposted
- An appropriate amount of reflection has been documented
- As a bare minimum (see comments above), the requisite number of SLEs (as demanded by the annual decision aid) has been completed and recorded in the ePortfolio
- The logbook has been uploaded to the library
- MSF has been completed and the results released by the ES. It is critical that appropriate discussion/reflection has occurred and been recorded in response to the MSF
- MCR has been completed by each CS and additional ones have been completed by any supervisor with whom the trainee has had significant clinical/educational interaction
- The trainee has self-rated themselves for each CiP on the curriculum page
- The SMART objectives documented in their PDP have either been achieved fully and the evidence for that achievement has been clearly documented. If any objectives of the PDP have not been fully achieved, then the reasons for that have been clearly documented and evidenced.
- An appointment has been made with their ES to discuss the annual ES report that will inform the ARCP panel

The ES should review the portfolio to ensure that all the above requirements have been met and record a final rating for each CiP on the curriculum page. The ES should meet up with the trainee to discuss the ESR so that there are no surprises.

The ARCP

At the ARCP, the panel should review the ePortfolio and in particular it should focus on the ESR report but also review the MCRs, the MSF, the PDPs and reflection. It should also reassure itself that all the mandatory courses and exams have been attended/passed. If members of the panel have any concerns that the trainee under review is not eligible for a standard outcome (outcome 1 or outcome 6) then they should examine more detail in the ePortfolio and review more of the SLEs and other subsidiary information.

ARCP Decision Aid for Medical Ophthalmology – updated April 2022

This decision aid provides guidance on the requirement to be achieved for a satisfactory ARCP outcome at the end of each training year. This document is available on the JRCPTB webpage for Medical Ophthalmology. *Trainees in ST3-4 who have entered medical ophthalmology from ophthalmic specialty training should follow the internal medicine ARCP decision aid.*

Evidence / requirement	**Notes**	**Year 1 (ST3) IM entry**	**Year 2 (ST4) IM entry**	**Year 3 (ST5)**	**Year 4 (ST6)**	**Year 5 (ST7)**
Educational supervisor (ES) report	An indicative one per year to cover the training year since last ARCP (up to the date of the current ARCP)	Confirms meeting or exceeding expectations and no concerns	Confirms meeting or exceeding expectations and no concerns	Confirms meeting or exceeding expectations and no concerns	Confirms meeting or exceeding expectations and no concerns	Confirms will meet all requirements needed to complete training
Generic capabilities in practice (CiPs)	Mapped to Generic Professional Capabilities (GPC) framework and assessed using global ratings. Trainees should record self-rating to facilitate discussion with ES. ES report will record rating for each generic CiP	ES to confirm trainee meets expectations for level of training	ES to confirm trainee meets expectations for level of training	ES to confirm trainee meets expectations for level of training	ES to confirm trainee meets expectations for level of training	ES to confirm trainee meets expectations for level of training
Specialty capabilities in practice (CiPs)	See grid below of levels expected for each year of training. Trainees	ES to confirm trainee is performing at or	ES to confirm trainee is performing at	ES to confirm trainee is performing at or	ES to confirm trainee is performing at	ES to confirm level 4 in all CiPs by end of training

Evidence / requirement	Notes	Year 1 (ST3) IM entry	Year 2 (ST4) IM entry	Year 3 (ST5)	Year 4 (ST6)	Year 5 (ST7)
	must complete self-rating to facilitate discussion with ES. ES report will confirm entrustment level for each CiP	above the level expected for all CiPs	or above the level expected for all CiPs	above the level expected for all CiPs	or above the level expected for all CiPs	
Multiple consultant report (MCR)	An indicative minimum number. Each MCR is completed by a consultant who has supervised the trainee's clinical work. The ES should not complete an MCR for their own trainee	4	4	4	4	4
Multi-source feedback (MSF)	An indicative minimum of 12 raters including 3 consultants and a mixture of other staff (medical and non-medical). MSF report must be released by the ES and feedback discussed with the trainee before the ARCP. If significant concerns are raised then arrangements	1	1	1	1	1

Evidence / requirement	Notes	Year 1 (ST3) IM entry	Year 2 (ST4) IM entry	Year 3 (ST5)	Year 4 (ST6)	Year 5 (ST7)
	should be made for a repeat MSF					
Supervised Learning Events (SLEs): Case-based discussion (CbD) and/or mini-clinical evaluation exercise (mini-CEX)	An indicative minimum number to be carried out by consultants. CRS should be repeated twice by different assessors. Trainees are encouraged to undertake more and supervisors may require additional SLEs if concerns are identified. SLEs should be undertaken throughout the training year by a range of assessors. Structured feedback should be given to aid the trainee's personal development and reflected on by the trainee	6 CBD 2 mini CEX CRS each repeated twice Assess vision (CA2) Visual fields by confrontation (CA3) Eye examination (CA5) Pupil examination (CA6) Ocular motility (CA7) Intraocular pressure (CA8) Slit lamp (CA9)	6 CBD 4 mini CEX CRS repeated twice Examine the fundus (CA10)	6 CBD 4 mini CEX CRS repeated twice Retinoscopy	6 CBD 4 mini CEX	6 CBD 4 mini CEX
FRCOphth part 1 (IM entry)			Attempted	Passed		

Evidence / requirement	Notes	Year 1 (ST3) IM entry	Year 2 (ST4) IM entry	Year 3 (ST5)	Year 4 (ST6)	Year 5 (ST7)
Knowledge based assessment				Completed with no concerns	Completed with no concerns	Completed with no concerns
Advanced life support (ALS)		Valid	Valid	Valid	Valid	Valid
Teaching observation (TO)		1	1	1	1	1
Patient survey (PS)	An indicative minimum of 20 responses	1		1		1
Quality improvement (QI) project	Project to be assessed with quality improvement project tool (QIPAT)	QIPAT project ongoing	QIPAT completed	QIPAT ongoing	QIPAT completed	
Reflection		Evidence of engagement	Evidence of engagement	Evidence of engagement	Evidence of engagement	Evidence of engagement
Teaching attendance	An indicative minimum hours per training year. To be specified at induction	Minimum 50 hours	Minimum 50 hours	Minimum 50 hours	Minimum 50 hours	Minimum 50 hours
Logbook		1	1	1	1	Minimum indicative 50 retinal laser and 50 intravitreal injections

Evidence / requirement	Notes	Year 1 (ST3) IM entry	Year 2 (ST4) IM entry	Year 3 (ST5)	Year 4 (ST6)	Year 5 (ST7)
Medical placements	Trainees should complete placements in the following: Dermatology, Diabetes & Endocrinology, Diabetic Retinopathy screening, Infectious Diseases, Medical Genetics, Neurology, Renal Medicine/transplant medicine/systemic vasculitis and Rheumatology			At least 25% of placements should have been undertaken	At least 50% of placements should have been undertaken	All placements completed by end of training

Practical procedural skills

Trainees must be able to outline the indications for the procedures listed in the table below and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthesia, minimisation of patient discomfort, and requesting for help when appropriate. For all practical procedures the trainee must be able to appreciate and recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary. Please see table below for minimum levels of competence expected in each training year. When a trainee has been signed off as being able to perform a procedure independently they are not required to have any further assessment (DOPS) of that procedure unless they or their educational supervisor think that this is required (in line with standard professional conduct).

Laser and injection procedures should be recorded in an anonymised logbook.

Procedure	**ST3 (entry from IM)**	**ST4 (entry from IM)**	**ST5**	**ST6**	**ST7**
Minimum level required					
Remove corneal foreign body	Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised	Maintain	Maintain	Maintain
Punctal plugs		Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised	Maintain	Maintain
Remove sutures from eye and adnexae	Able to perform the procedure under direct supervision	Competent to perform the	Maintain	Maintain	Maintain

Procedure	ST3 (entry from IM)	ST4 (entry from IM)	ST5	ST6	ST7
		procedure unsupervised			
Fit a bandage contact lens	Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised	Maintain	Maintain	Maintain
Irrigation and debridement of ocular contaminants	Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised	Maintain	Maintain	Maintain
Corneal scrape	Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised	Maintain	Maintain	Maintain
Botox periocular injection		Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised	Maintain	Maintain
Yag laser capsulotomy		Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised	Maintain	Maintain
Peripheral laser iridotomy		Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised	Maintain	Maintain

Procedure	ST3 (entry from IM)	ST4 (entry from IM)	ST5	ST6	ST7
Intravitreal injection			Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised	Maintain
Intravitreal implant				Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised
Periocular steroid injection			Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised	Maintain
Macular laser			Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised	Maintain
Panretinal photocoagulation			Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised	Maintain

Levels to be achieved by the end of each training year for specialty CiPs

Level descriptors

Level 1: Entrusted to observe only – no clinical care; Level 2: Entrusted to act with direct supervision; Level 3: Entrusted to act with indirect supervision; Level 4: Entrusted to act unsupervised

Specialty CiP	ST3 (IM entry)	ST4 (IM entry)	ST5	ST6	ST7	CRITICAL PROGRESSION POINT
1. Managing and leading a multidisciplinary medical ophthalmology team, including management of an outpatient clinic and injection list	1	2	2	3	4	
2. Diagnosis and management of acute medical ophthalmology emergencies	2	2	3	3	4	
3. Diagnosis and management of patients with medical ophthalmic conditions, including those with complex conditions, long term conditions and those on immunosuppressants	2	2	2	3	4	
4. Managing perioperative care of medical ophthalmological patients	2	2	3	3	4	
5. Competent in all procedural skills for medical ophthalmology as defined by the curriculum	2	2	2	3	4	
6. Managing medical, ethical and social issues of visual impairment	2	2	3	3	4	

Training programme - Mandatory training requirements

Core ophthalmic practice

Purpose
An ophthalmic physician should have a broad understanding of ophthalmology and be able to manage patients presenting with emergency medical ophthalmic conditions as well as identify patients requiring ophthalmic surgery.

Learning Outcomes
Specialty CiP 2. Diagnosis and management of medical ophthalmic emergencies
Specialty CiP 4. Managing peri-operative care of medical ophthalmological patients
Specialty CiP 4. Competent in all procedural skills as defined by the curriculum (remove corneal foreign body, punctal plugs, remove sutures from eye and adnexae, fit a bandage contact lens, irrigation and debridement of ocular contaminants, corneal scrape, botox periocular injection, yag laser capsulotomy, peripheral iridotomy)

Duration and attachments
2 years (ST3 and 4) for entrants from IMT.
Trainees should rotate around subspecialties in attachments of an indicative 4-6 months. Clinics should include emergency eye care, cornea, oculoplastics, glaucoma, medical and surgical retina, neuro-ophthalmology, uveitis, cataract and paediatrics. Trainees should be given the opportunity to train with orthoptists and optometrists. Simulation training in laser is recommended. Training should be offered on a supervised anterior segment laser list. Trainees should observe common ophthalmic surgical procedures including cataract and retinal detachment surgery. A timetable (full time) will normally consist of one research session, one session for administration and one session for post-graduate teaching. There should normally be an indicative minimum of one session of emergency eye care or on-call for ophthalmology. Trainees should take part in the routine management of ward admissions.

Ocular inflammation

Purpose
An ophthalmic physician should be able to diagnose and manage patients with ocular inflammation, investigate for systemic disease and liaise appropriately with other specialties.

Learning outcomes
Specialty CiP 1. Managing and leading a multidisciplinary medical ophthalmology team, including management of an outpatient clinic and injection list
Specialty CiP 2. Diagnosis and management of acute medical ophthalmology emergencies
Specialty CiP 3. Diagnosis and management of patients with medical ophthalmic conditions, including those with complex conditions, long term conditions and those on immunosuppressants
Specialty CiP 4. Managing perioperative care of medical ophthalmological patients

Specialty CiP 5. Competent in all procedural skills for medical ophthalmology as defined by the curriculum (intravitreal injection, intravitreal implant, periocular steroid injection)
Specialty CiP 6. Managing medical, ethical and social issues of visual impairment

Duration and attachments
Trainees should spend on average 1-2 clinics per week in ocular inflammation from ST5-7. Clinics should include adult and paediatric uveitis, orbit and cornea. Trainees should also have attachments to medical specialties allied to medical ophthalmology for 1-2 clinic sessions per week to include rheumatology, infectious diseases (HIV, tuberculosis, genitourinary medicine), systemic vasculitis/ renal medicine/ transplant medicine and dermatology.

Medical retina

Purpose
An ophthalmic physician should be able to diagnose and manage patients with medical retina disorders, investigate for systemic disease, deliver intravitreal and retinal laser treatments, and liaise appropriately with other specialties

Learning outcomes
Specialty CiP 1. Managing and leading a multidisciplinary medical ophthalmology team, including management of an outpatient clinic and injection list
Specialty CiP 2. Diagnosis and management of acute medical ophthalmology emergencies
Specialty CiP 3. Diagnosis and management of patients with medical ophthalmic conditions, including those with complex conditions, long term conditions and those on immunosuppressants
Specialty CiP 4. Managing perioperative care of medical ophthalmological patients
Specialty CiP 5. Competent in all procedural skills for medical ophthalmology as defined by the curriculum (intravitreal injection, intravitreal implant, macular laser, panretinal photocoagulation)
Specialty CiP 6. Managing medical, ethical and social issues of visual impairment

Duration and attachments
Trainees should spend on average around 2 clinics per week in medical retina from ST5-7, one of which should be a laser or injection clinic. Trainees should also have attachments to medical specialties allied to medical ophthalmology for 1-2 clinic sessions per week to include diabetes, diabetes retinal screening and clinical genetics.

Neuro-ophthalmology

Purpose
An ophthalmic physician should be able to diagnose and manage patients with disorders of ocular motility and the visual pathways, investigate for systemic disease and liaise appropriately with other specialties.

Learning outcomes

Specialty CiP 1. Managing and leading a multidisciplinary medical ophthalmology team, including management of an outpatient clinic and injection list
Specialty CiP 2. Diagnosis and management of acute medical ophthalmology emergencies
Specialty CiP 3. Diagnosis and management of patients with medical ophthalmic conditions, including those with complex conditions, long term conditions and those on immunosuppressants
Specialty CiP 6. Managing medical, ethical and social issues of visual impairment

Duration and attachments
Trainees should spend on average 1-2 clinics per week in neuro-ophthalmology from ST5-7. Trainees should also have attachments to medical specialties allied to medical ophthalmology to include neurology, neuroradiology, endocrinology and clinical genetics.

Clinical research

Purpose
An ophthalmic physician should share evidence based decision making with patients in clinical practice. They should be able to conduct clinical research and write a research paper.

Learning outcomes
Generic CiP 5. Carrying out research and managing data appropriately
Specialty CiP 3. Diagnosis and management of patients with medical ophthalmic conditions, including those with complex conditions, long term conditions and those on immunosuppressants.

Duration and attachments
Trainees should have 1 session a week for research throughout training. There should be opportunities to support clinical trials and to undertake personal research projects under supervision.

Training Resources

JRCPTB Medical Ophthalmology webpage

JRCPTB Physician Trainer Resources

Glossary of abbreviations

ALS	Advanced Life Support
ARCP	Annual Review of Competence Progression
CiP	Capabilities in Practice
CbD	Case-based Discussion
CCT	Certificate of Completion of Training
CRS	Clinical rating scale
CS	Clinical Supervisor
DOPS	Direct Observation of Procedural Skills
DVLA	Driver and vehicle licensing agency
EPA	Entrustable Professional Activity
ES	Educational Supervisor
FRCOphth	Fellow of the Royal College of Ophthalmologists
GPC	Generic Professional Capabilities
GMC	General Medical Council
IMY1-3	Internal Medicine Year 1-3
JRCPTB	Joint Royal Colleges of Physicians Training Board
MCR	Multiple Consultant Report
Mini CEX	Mini Clinical Evaluation Exercise
MSF	Multi-Source Feedback
NTN	National Training Number
PDP	Professional Development Plan
PS	Patient Survey
SLE	Supervised Learning Event
ST	Specialty training year
WPBA	Workplace Based Assessment

JRCPTB

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