THE COLLEGE OF OPTOMETRISTS

Clinical Learning in Practice (CLiP)
Student handbook

January 2026

Contents

Using this handbook

This handbook provides guidance for students who are starting or in progress on the Clinical Learning in Practice programme. This is when you work for a period of at least 44 weeks in practice and are assessed over four assessment visits.

The guidance included here takes you through the basics of what to expect from CLiP, including the days and hours you should be working, how you should log your experience and what the assessments involve. We also let you know what you should do if things go wrong or you're not getting the experience you think you should.

The first half of the handbook is intended for you to read when you are starting your placement and then go back to as a resource throughout. The final section is guidance for our CLiP Portal logbook, which you may want to use as a reference when you need it, as you start logging your experience and preparing for assessments.

The handbook links to other guidance documents you should check, including the Student guidance for each assessment visit, the guidance for the Service Evaluation Project and the full CLiP Assessment Handbook.

We wish you well on your journey through CLiP, and ask you to contact us at clip@college-optometrists.org if you have any questions which aren't addressed in our guidance.

Clinical Learning in Practice (CLiP) overview

CLiP is a period of 11-12 months in which you work as a student optometrist in practice, under supervision, and are assessed at set points during the year.

You will have an employment contract with your employer, and they are responsible for paying you, providing you with holiday days and ensuring that your supervision arrangements are in place. The College sets out expectations for the number of hours and days you should work and for your support and guidance. The employer needs to follow these expectations and provide you with the right CLiP experience.

Over the course of CLiP, you are going to accrue at least 44 weeks of working in practice as a pre-registration optometrist under supervision. You will be assessed and signed off on most of the learning outcomes included in the General Optical Council (GOC) Requirements, at the highest level, ‘Does’.

When most students complete CLiP, the taught and work experience elements of your degree are completed, and you will need to take final assessments before you can graduate and register as an optometrist with the GOC.

CLiP contract and expectations

Summary

Contract	Support
Employment contract	Access to testing room/equipment
28-31 hours, spread equally over 4 days	Supervision
4 days working as a student optometrist – can include weekend days	
Learning day (Mon-Fri)	
20 hours consulting time	

Contract

The employer you are working with has selected you for the role and has agreed to provide you with work in line with the expectations for CLiP. It is important that you know it is their decision to provide you with this role and they are not under any obligation to continue if something changes and it is no longer possible.

We expect the vast majority of CLiP contracts to continue to the end of your CLiP modules successfully, but it can happen that circumstances change for an employer. The College would work with you and our partner employers support you if something like this were to happen.

The employer you are working with has 'CLiP employer' status, and has agreed to provide you with work following expectations for a certain pattern of working hours and support. This is set out in this section, so that you know what you should expect.

Working days and hours

There are some expectations for your working days and hours which your employer is expected to follow:

- You will work as a pre-registration optometrist between 28 and 31 hours per week.
- These hours will be spread, roughly equally, over four working days per week.
- The four days can include working days at the weekend, but the employer should not arrange for you to work on both Saturday and Sunday on a regular basis.

Additional days and hours

If you and your employer agree that you want to work additional hours, this is allowed, but you cannot work more than 31 hours per week as a pre-registration optometrist. The employer could offer you additional hours working, for example, as an Optical Assistant.

As a student on CLiP, you should not feel pressured into taking on any additional hours. Also, you should seriously consider the effect it may have on your studies, particularly as your 28 to 31 hours will probably not include the time to complete your CLiP Portal logbook – you will need to do this in your own study time outside of those working hours.

Consulting time and room

In every working week, you should spend around 20 hours in the consulting room working with patients.

To be clear, you should not be working on patient consultations as a student optometrist for significantly more or less than 20 hours per week. If you worked less than 20 hours on consultations, you would not accrue enough logged experience to pass CLiP assessments. If you worked more, the burden of logging entries could become too onerous. Also, you would miss out on important professional experience of other areas of the business which you are meant to get as part of CLiP, such as practising dispensing.

There are a few items which you should possess and use as your own equipment in your consulting time:

- Indirect lens (e.g. 'Volk lens')
- Pen torch
- Retinoscope

All other equipment you need should be in the consulting room provided by your employer (see list below).

Learning day

Your employer must allow you one day, on a weekday (Monday to Friday), when you are not required in the practice and can work on tasks assigned by your University, or on other tasks such as completing your logbook or preparing for assessment.

The exact day on which you have your learning day is at the discretion of your employer and it may not be the same day every week.

Patient numbers

In your 20 hours per week of consulting time, it is expected that you will start seeing relatively low numbers of patients. The number of patient consultations you are able to complete in this time will increase over the course of the year.

As such, we give employers guide numbers for how many patients you should be seeing at the different stages of the placement. You should not be significantly above these numbers:

Timeframe	Number
Up to CLiP Part 1 Remote visit (around 9 weeks in)	No more than 4-5 patients per day
Up to CLiP Part 1 Face-to-face visit (around 18 weeks in)	No more than 6-8 patients per day
Up to CLiP Part 2 Remote visit (around 5 weeks into Part 2)	No more than 8-10 patients per day
Up to CLiP Part 2 Face-to-face visit and beyond (around 13 weeks into Part 2)	No more than 12 patients per day

Supervisors

You need to be supervised by employees in your practice who are registered with the College as your supervisors. While you are working with patients, at least one of your supervisors must be in the practice and able to intervene if needed.

There are two types of supervisor in the CLiP arrangements:

- Practice Educational Lead (or 'Practice Lead') – you must have a Practice Lead, who will be a fully qualified Optometrist who is responsible for your general professional development and progress on CLiP.
- Task Supervisor – this is an optional role, a Task Supervisor could be a member of another healthcare profession, or another optometrist. They are able to supervise you on tasks you undertake which are within their own scope of practice – for example, you could do dispensing with a Dispensing Optician who is appointed as your Task Supervisor.

Your Practice Lead will be expected to arrange meetings to discuss progress with you and will need to work with you on your logbook and in preparation for assessment. Task Supervisors can also have access to your logbook and may be working with you on patient consultations and day-to-day questions and advice.

Expectations for supervision

Your supervisors will also be employees in your practice and will have their own work to do. They will also, like you, have scheduled time with patients during which they are not available. So, it is best to keep realistic expectations of what kind of support will be made available and how much time your supervisor should be spending with you:

- You'll be observed closely in the initial weeks of your placement, with supervisors sitting in on patient consultations with you.
- This close support will probably be reduced after a few weeks and the practice will want you to work independently with patients.
- Practice Lead Supervisors should be arranging weekly check-ins with you to discuss your progress.
- On a daily basis, opportunities for communication might be constrained – you can expect that supervisors will say "Let's discuss that later" if they're busy – but they should remember to get back to you.
- Your logbook should be checked and entries 'confirmed' regularly, preferably weekly.
- You should start talking about assessment visits around 4-5 weeks before each visit date – you and a supervisor should check your Risk dashboard and logbook requirements and should arrange for you to be observed.
- Finally, remember that you are an employee at your practice and your employer is supposed to give you a range of tasks to do – so supervisors may ask you to do some tasks which are administrative or customer-facing.

Equipment list

Equipment to be provided by the employer

Amsler charts manual

Colour tests – two versions to screen for all possible defects

Direct ophthalmoscope

Distance and near oculomotor balance tests

Distance and near tests suitable for:

- adults
- young children

Focimeter

Keratometer

Measuring device for accommodation – RAF rule

Personal Protective Equipment (PPE)

Slit-lamp biomicroscope

Test for stereopsis

Threshold controlled visual field equipment

Tonometer – both contact applanation and non-contact applanation (and calibration equipment

Trial lenses, trial frame and accessories including pinhole

Equipment you are expected to own

Indirect lens (e.g. ‘Volk lens’)

Pen torch

Retinoscope

Patient consultations

Procedure with patients

You need to follow some procedures during consultation with every patient, so that the patient understands that their record may be used for assessment purposes.

This will ensure that your logbook entry about the patient, together with their record, is valid for use in your assessments. As such, you must let each patient know that:

- You are a ‘pre-registration optometrist’.
- The notes you make during and after the consultation may be seen by other people involved in your assessment.

Check the patient is OK with this, and record ‘Verbal consent given for assessment’ (or ‘VCG’) on the in-practice patient record.

You don’t need to write ‘VCG’ in the CLiP Portal logbook entry.

Records and logbook entries

You will create the in-practice patient record for the consultation and a supervisor needs to sign this, in line with the procedures at your practice. You also need to create a CLiP Portal logbook entry for each patient you see (details in next section).

You will need to create these logbook entries on a regular basis and may need access to patient records to complete this work. If you need to arrange time to be in the practice and have access to in-practice patient records, in order to complete your logbook, you should discuss this with a supervisor.

What you can log

You can only create a logbook entry for the patients you see in consulting time as a pre-registration optometrist. That is:

- You can log patient interactions for patients you see during your 28 – 31 hours of CLiP work.
- If you work any additional hours in another role, you can’t log any work that you do in this capacity.
- Any patient interactions you log must be real patients – you can’t log experience with a stand-in patient such as a colleague or another student.

Using the logbook

Creating logbook entries

Your logbook is available on the main menu of your CLiP Portal account. This allows you to create logbook entries and to store and search entries you've already made. Supervisors, assessors and others who are assigned to view your account will be able to read your logbook entries. Supervisors also have some editing rights, including the functionality to sign off or 'confirm' entries.

You are expected to create a CLiP Portal logbook entry for **every patient** you see while working on CLiP and you should always think about how these could be used later as assessment evidence.

Types of logbook entry

You can create three different entry types in a logbook entry: an 'interaction', a 'reflection' or a 'note'.

- Interaction – this has set fields which allow you to log clinical interactions you have carried out. Most data you include in an interaction is selected from drop-down options.
- Reflection – this has fields which allow you to reflect on a specific interaction or note. For example, you could say what you learnt from a patient interaction or whether anything could have been done differently. The reflection entry also has an open field which allows you to log stand-alone reflections. Reflection fields are all free-text.
- Note – this is an open text box which can be used to log anything, with no specific fields required. For example, you could use it like a professional diary or journal or you could create notes to record meetings with your supervisors.

A logbook entry can include all three types or any combination.

What types of entry are expected?

To be clear, we don't expect you to create a reflection and a note every time. You will create interactions to record patient consultations and these will be the main types of entry which you need to present in assessment visits. As such, most of your entries are going to have an **interaction** only.

We suggest that it's good practice for you to create a reflection at least once a week, recording your progress on CLiP and key learning points. This can be used in check-in sessions with your supervisors and as a reference to prepare for assessment visits.

Notes are optional and you can use them for whatever you like. When a supervisor confirms your entry, it locks the Interaction so you can't edit it anymore. You might want to create a note as an easy way to add extra information to a confirmed entry.

What you should record in your logbook entries

When you create a logbook entry to record a patient consultation, it needs to have:

- Patient ID in the ‘Reference’ field. Use the same anonymous Patient ID which is used in the in-practice patient record so you can cross-reference easily.
- A completed interaction.
- ‘Student role’ field in the interaction set to ‘Consulting’.
- ‘Patient type’ field in the interaction set to ‘Patient’.
- Details of any conditions the patient has and the tasks you undertook, which you complete using drop-down options in the interaction fields.

And, throughout CLiP Part 1:

- A learning outcome assigned in ‘Clinical core learning outcomes’ field of the entry.
- A short written explanation of why the interaction shows you’ve achieved the learning outcome, in the ‘Consultation notes’ field of the interaction.

You may log some entries for which there is one defining feature you want to come back to, or note for assessment. It will be helpful to add one or two words about this after the Patient ID in the **Reference** field.

You may also want to make a brief note of anything that made the consultation memorable or why it could be included as an entry you’re going to select for an assessment visit in **Consultation notes**.

You don’t need to include detailed information about each patient and the full consultation in the CLiP Portal logbook entry, provided the patient record contains this. We don’t want you to make the record twice – the in-practice patient record can contain the full details.

You are allowed to record entries in which your ‘Student role’ is e.g. Observing rather than Consulting or in which the ‘Patient type’ is e.g. Peer rather than Patient, but these will not count in your Risk dashboard and cannot be used for assessment purposes.

How entries are used

As you create entries with interactions, the Portal counts the information you select from drop-down menus. It will count any entries with interactions in which your role is ‘Student’, the patient type is ‘Patient’ and which a supervisor confirms. It won’t count any entries where the roles are different e.g. you observed a consultation, or the patient was a surrogate.

One way in which the system uses these counted interactions is to form ratings in your risk profile. For example, one of the fields you will need to complete when logging an interaction is the patient’s age profile. These are logged in age ranges e.g. ‘Child 5-6’, ‘Youth 12-16’, ‘Adult 17-45’ and so on. The system will count the number of each type logged and this will contribute to your risk profile on the Risk dashboard area of the Portal (see ‘Student risk profile’ section for more detail).

We also need you to complete certain numbers of different types of interaction as prerequisites for the assessment visits. As you link interactions to certain GOC outcomes, and the Supervisor confirms them, the system will count these interactions as prerequisites for the visit and this will register on the Assessment summary dashboard for the next visit.

Prior to the assessment visit, you and your supervisors will need to review the dashboards and select entries which are suitable for the Assessor to review and discuss at the assessment visit.

Interaction fields

The main categories you can complete when you log an interaction are:

- Patient age group
- Vulnerable?
- Accompanied by
- Other characteristics
- Conditions
- Visual needs
- Tasks undertaken

Most of these areas have sub-categories and a number of items you can select to complete the information. The full list of interaction categories and the items you can select from are set out in the ‘Student risk profile and dashboard’ section below.

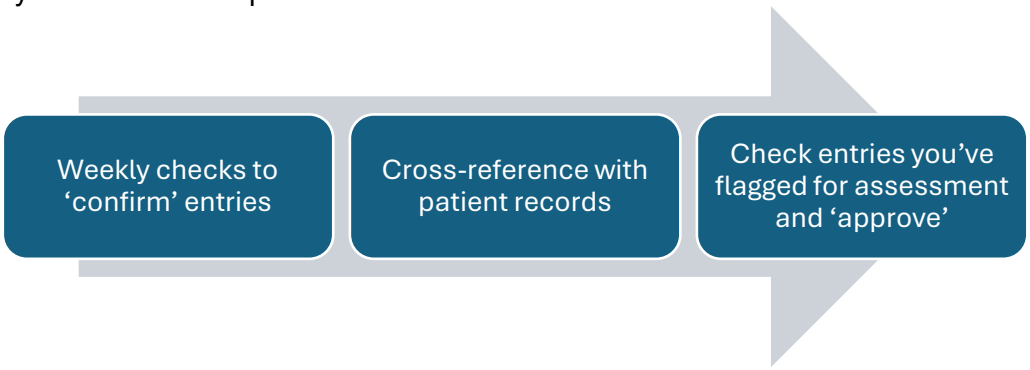
When you select an item to add to an interaction, make sure that it refers directly to your patient. For example, if you select ‘Conditions – Glaucoma’ it would need to be either a patient with glaucoma or one for whom you carried out additional investigations due to suspected glaucoma.

Reviewing logbook entries

The Supervisor's role

Your Practice Lead, and Task Supervisors, will be able to sign off (or 'confirm') interactions in your logbook and will be responsible for confirming the interactions they supervised. After a supervisor has confirmed an interaction, you will not be able to amend or add any more details to the interaction. Your Practice Lead should undertake regular review of your logbook to confirm that the experiences you've logged are genuine and complete.

Supervisors will also need to work with you to help select the learning outcomes which an interaction or reflection can be linked to and to identify learning outcomes which you still need to meet. The dashboards on the CLiP Portal will help supervisors to identify areas where you need more experience.



Checklist for logbook entries

In the early stages of CLiP, and at regular periods throughout, supervisors should check that you are doing the following in your logbook entries:

- Creating a new logbook entry for every patient seen.
- Recording Patient ID in the 'Reference' field so this is visible in the logbook grid.
- Using the same anonymous Patient ID as used in your in-practice patient records, for ease of reference.
- Obtaining verbal consent from each patient for their records to be used in assessment (recorded on the in-practice patient record, not logbook)

And, throughout CLiP Part 1:

- Selecting one or two learning outcomes in the 'Clinical core outcomes' field of the entry.
- Writing a brief explanation in the 'Consultation notes' field of the interaction to explain why this consultation shows you have achieved the learning outcome(s).

Confirming logbook entries

Supervisors will need to 'confirm' each of your logbook entries in the CLiP Portal for the system to count and include the entries on dashboards, and for the entry to be valid for Assessors to review.

Within the CLiP Portal, supervisors are able to view your logbook entries and can confirm and approve them. All your entries need to be confirmed, but only entries which you select for review at an assessment visit need to be approved.

We suggest that supervisors:

- Review and confirm entries on a regular basis, at least weekly.
- Agree procedure for who confirms entries, if there is more than one supervisor.
- Establish an agreed system to review and spot-check entries if they are being bulk-confirmed.

Reviewing the logbook to prepare for assessment

Students and supervisors should arrange to meet well in advance of assessment visits to review logbook entries, discuss readiness for assessment and identify any areas you still need to work on. For example, the assessment visit requirements include types of patient, condition and task and if you are missing any required experience, your supervisor should help you try to fill these gaps.

When the student and supervisors agree that entries will be included for the Assessor to review at the visit, the Practice Lead will ‘approve’ those entries. The Practice Lead, as part of the approval process, needs to check that you have anonymised the corresponding in-practice patient records correctly.

Student risk profile and dashboard

Reasons for the risk profile

The CLiP Portal has a ‘Risk dashboard’ which provides a snapshot of your experience and risk profile based on what you have logged.

The risk dashboard shows your progress using Red-Amber-Green ratings against all the items you can select in your logbook. Some advantages of this overview include:

- The Practice Lead and other Supervisors can make judgements about your progress and the level of independence you can be given in practice.
- Supervisors who are new to you or less familiar with your progress will be able to gain an immediate overview.
- The colour coding against logbook items such as patient type and tasks undertaken highlights where you still need to gain more experience in specific areas.

Drag a column header and drop it here to group by that column — Show/hide columns — Grid configuration — Export

Measure	Category	Sub category	Count of logbook entries	Has interaction	Has reflection	Has notes (Y/N)	Student role	Risk level	RAG status
Conditions	Anterior Segment	Cataract*	1	✓	✗	✗	Consulting	Medium	Red
Conditions	Posterior Segment	Dry AMD	1	✓	✗	✗	Consulting	High	Red
Conditions	Posterior Segment	Other macular disorders*	1	✓	✗	✗	Consulting	High	Red
Patient age group		Infant 0-2 (LV)	1	✓	✗	✗	Consulting	High	Red
Patient age group		Middle-aged 46-60	2	✓	✗	✗	Consulting	Medium	Red
Patient age group		Young adult 17-45	2	✓	✗	✗	Consulting	Low	Amber
Tasks undertaken	Drugs	Mydriatics (HLV)	1	✓	✗	✗	Consulting	HLV	Red
Tasks undertaken	Ocular Motor Balance*	Symptomatic (HLV)	1	✓	✗	✗	Consulting	HLV	Red
Tasks undertaken	Referral	Consult with Supervisor	1	✓	✗	✗	Consulting	High	Red

Page 1 of 1 — 20 items per page — 1 - 11 of 11 items

The risk framework

- When you log interactions, you select from drop-down menus to identify features such as the characteristics of the patient, their visual needs, their conditions and any tasks you undertook.
- Each item which can be selected when logging a patient interaction has a risk rating of low, medium or high (see the full table below).
- The higher the risk, the more times a task must be logged (and signed off as safely completed by the Supervisor) before the rating changes from red to amber or from amber to green.
- There are also guidelines for how many of each item you should have logged and signed off before each assessment visit.
- You and your supervisors will be able to use the risk dashboard to assess whether you are in line with these expectations.
- This analysis can help determine your general progress as a clinician and how much independence you can be given. For example, whether you are able to see certain types of patient without direct observation.

This table summarises how many logged and signed off interactions are needed for items to show as red, amber or green on the risk dashboard:

	Number of interactions signed off		
Risk Level	**Red**	**Amber**	**Green**
Low	0-1	2-4	5+
Medium	0-4	5-9	10+
High	0-9	10-29	30+
High low volume [HLV]	0-2	3-5	6+

As an example of how this can be used, by the time of your first CLiP assessment (CLiP 1R) all low and medium risk categories should be showing on the dashboard as amber.

- For any 'Low' risk items, that means you are expected to have 2 or more entries at this stage in your placement.
- For any 'Medium' risk items, you are expected to have 5 or more entries at this stage.
- 'Accompanied by…' is an example of a medium risk category.
- As such, by the time of the first CLiP assessment (CLiP 1R), at around 9 weeks in, you are expected to have seen 5 or more patients who have been 'Accompanied by' a parent, carer or other role.

Progression monitoring

Here is the guidance of where you should be by the time of each assessment visit – this is also shown in the detailed risk framework table below:

CLiP 1R: All low and medium interaction items (except visual needs) should be amber by the time of this assessment visit. High risk items and the medium risk 'Visual needs' items can be red. If there are some red items at the time of the visit, this should be included in the 'Quality assurance of setting and supervision' discussion with the Assessor.

CLiP 1F: All low and medium interaction items (except visual needs) need to be green by the time of this assessment visit. All other interaction items are expected to be amber or green. If any High risk or visual needs items are red, this does not prevent the visit from going ahead, but you discuss any red items as part of the 'Quality assurance of setting and supervision' discussion with the Assessor.

CLiP 2R: All interaction items should be green, possibly with some amber in high-risk categories. You **must** be green on low vision, paediatric, vulnerable, non-tolerance and use of drugs by the time of the 2R visit.

CLiP 2F: All items are expected to be green before the assessment visit takes place. This will ensure that you have enough evidence for the Assessor to use in Task 3. There is a risk that Task 3 cannot be completed if the logbook entries are not all green. In this scenario, you and the Assessor would need to discuss, as part of the visit, how you are going to complete the logbook expectations by the end of CLiP.

Understanding the risk dashboard

The table below shows all the items you are able to log, the risk rating applied to them and the number of interactions you are expected to have in the logbook at the time of the assessment visit.

The **Field** column represents most of the different fields you need to complete in a logbook interaction.

Category and **Sub-category** are mainly the items you can select in the drop-down options to complete the interaction.

An **asterisk** after a sub-category item (e.g. Cataract*) indicates that you should add consultation notes (free text field in the interaction) to provide more detail.

LV after a sub-category item means 'low volume', items you may see quite rarely.

The main **Risk** categories are: L = Low, M = Medium and H = High.

The category **HLV** is 'High risk - low volume', indicating items, including drugs and emergency referral, for which you are unlikely to reach the normal high risk targets. Expected numbers are set lower for these items, but supervisors should note that they are still high risk. As such, '[HLV]' is used after the sub-category as a reminder. In line with other high risk activity, you are considered to need more practice and should try to exceed the minimum requirement if possible.

Where **cells are merged**, so that there are two or more 'Sub-category' items in the same cell with the same risk rating, this means that any combination of items in that cell will be counted. For example:

- The items in the 'Accompanied by' sub-category (Parent, Friend etc) are in a merged cell with a Medium risk rating.

Parent Carer Family member Friend Interpreter	M	A: 5 - 9

- By the time of the first CLiP assessment (CLiP 1R) you should have seen 5 or more patients who have been 'Accompanied by' a parent, carer or other role.
- You will meet the expectation for CLiP 1R if you have logged one each of Parent, Carer, Family member, Friend and Interpreter (five entries total).
- You could also meet this requirement if you logged five 'Parent' entries and did not have any of the other examples.
- However, in Patient age group, 'Youth 12-16' is a sub-category on its own and is also Medium, so you would need to have five entries for 'Youth 12-16' to reach amber.

Youth 12-16	M	A: 5 - 9

Field	Category	Sub-category	Risk	Expected number of logbook entries			
				CLiP 1R	CLiP 1F	CLiP 2R	CLiP 2F
Patient age group		Infant 0-2 (LV) Pre-school child 3-4 Child 5-6 Child 7-11	H	-	A: 10 – 29 or G: 30+	**Must** be G: 30+	G: 30+
		Youth 12-16	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
		Young adult 17-45	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Middle-aged 46-60	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
		Older Adult 61-74 Senior 75+	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
Vulnerable?		[Tick-box]	M	A: 5 - 9	**Must** be G: 10+	**Must** be G: 10+	G: 10+
Accompanied by		Parent Carer Family member Friend Interpreter	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
Other characteristics	Significant family history		M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Communications challenges	Cultural barriers Language barriers Needs help to communicate Hard of hearing	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Comprehension challenges	Neurodiversity (LV) Dementia Learning difficulties	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Visual challenges	Visually impaired	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+

Field	Category	Sub-category	Risk	Expected number of logbook entries			
				CLiP 1R	CLiP 1F	CLiP 2R	CLiP 2F
	Physical Challenges	Physical disabilities	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
Conditions	Anterior Segment	Red Eye	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
		Cataract*	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
		Other*	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Posterior Segment	Glaucoma	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
		Retinal detachment risk Other retinal disorders*	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
		Dry AMD Wet AMD Other macular disorders*	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Refractive errors	Myopia Hyperopia Astigmatism Presbyopia Anisometropia	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Binocular vision anomalies	Heterophoria Heterotropia Incomitance Amblyopia Other*	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Systemic disorders affecting the eye	Diabetes Hypertension Other*	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Neurological	Specify in notes	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Ocular adverse reactions	Specify in notes	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+

Field	Category	Sub-category	Risk	Expected number of logbook entries			
				CLiP 1R	CLiP 1F	CLiP 2R	CLiP 2F
	Non-tolerance	Specify in notes	M	A: 5 - 9	**Must** be G: 10+	**Must** be G: 10+	G: 10+
	No conditions found		L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
Visual Needs	Low Vision	Simple aids Complex aids (LV)	M	-	A: 5 – 9 or G: 10+	**Must** be G: 10+	G: 10+
	Occupational	Vocational Sport Protective	M	-	A: 5 – 9 or G: 10+	Should be G: 10+	G: 10+
		High refractive correction	M	-	A: 5 – 9 or G: 10+	Should be G: 10+	G: 10+
		Single vision	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Progressive	M	-	A: 5 – 9 or G: 10+	Should be G: 10+	G: 10+
	Contact Lens	Rigid Toric Multifocal Myopia management Bandage Cosmetic Scleral orthoK Other soft lenses	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
Tasks undertaken	History and symptoms		L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Pupils		L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Anterior Segment		L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Posterior Segment		L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+

Field	Category	Sub-category	Risk	Expected number of logbook entries			
				CLiP 1R	CLiP 1F	CLiP 2R	CLiP 2F
	Refraction	Objective	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
		Subjective	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		High refractive	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Ocular Motor Balance*	Asymptomatic	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
		Symptomatic [HLV]	HLV	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Intraocular pressures	Contact tonometry [HLV]	HLV	-	A: 3 - 5 or G: 6+	**Must** be G: 6+	G: 6+
		Non-contact tonometry	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Visual fields*		M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Additional tests	Keratometry	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Colour vision Contrast sensitivity	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Other supplementary tests, e.g. Amsler, OCT *	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Drugs	Stain	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Mydriatics [HLV]	HLV	-	A: 3 – 5 or G: 6+	**Must** be G: 6+	G: 6+
		Cycloplegia [HLV]	HLV	-	A: 3 – 5 or G: 6+	**Must** be G: 6+	G: 6+
		Anaesthetic [HLV]	HLV	-	A: 3 – 5 or G: 6+	**Must** be G: 6+	G: 6+
	Management and advice		M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Verification		L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+

Field	Category	Sub-category	Risk	Expected number of logbook entries			
				CLiP 1R	CLiP 1F	CLiP 2R	CLiP 2F
	Dispense		M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Contact Lens	Fit	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
		Aftercare	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Teach	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Referral	Non-emergency [HLV] Emergency [HLV]	HLV	-	A: 3 – 5 or G: 6+	Should be G: 6+	G: 6+
		Consult with colleague Consult with supervisor Recall	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Teamwork	Handover*	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Delegation*	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+

Definitions of items in the risk framework and logbook

1. Note on Other characteristics – Visual challenges - Visually impaired

   Definition of **Visually impaired** is that the patient's eyesight requires visual correction. It can be applied to any patient for whom a prescription would be appropriate and where this has been determined during the student's consultation.

2. Note on Conditions – Neurological

   Neurological conditions relate to the brain, spinal cord and nerves. Logbook entries can record conditions where a neurological problem affects a patient's vision.

3. Note on Conditions – Ocular adverse reactions

   This will usually mean that the patient has had an **adverse reaction** to a drug or other mode of treatment.

4. Note on Visual needs – Low vision – Simple/Complex aids

   Definition of **Low vision** – A person with low vision is one who has an impairment of visual function for whom full remediation is not possible by conventional spectacles, contact lenses or medical intervention and which causes restriction in that person's everyday life. *Low Vision Services Consensus Group. A framework for low vision services in the United Kingdom*. London: Royal National Institute for the Blind, 1999. Both eyes 6/12 or worse (binocular) and/or N6 (with +4 dioptre reading addition) or severely restricted fields (that are consequence of clinical condition). WGOS

5. Note on Tasks undertaken – Intraocular pressures – Contact tonometry

   Contact tonometry is defined here as applanation by using either Perkins, Goldmann or equivalent.

6. Note on Tasks undertaken - Verification

   Verification is the measurement of any type of spectacle lens.

7. Note on Tasks undertaken – Dispense

   A **Dispense** is always face-to-face, and is:

   - dispensing single or multiple low vision aids to one patient,

     OR

   - dispensing a single pair or multiple pairs of single vision or multifocal spectacles to one patient.

   Re-glazing a patient's frame can only be counted as a dispense if measurements are required, the prescription has changed and a dispensing discussion has taken place

8. Note on Tasks undertaken – Contact lens – Fit

   To log a **contact lens fit**, you need to demonstrate that you have:

   - taken all relevant preliminary measurements
   - decided on an appropriate lens specification
   - ordered or selected the fitting lenses
   - checked the ordered/ selected lenses on the eye
   - instructed the patient to wear the lenses

9. Note on Tasks undertaken – Contact lens – Aftercare

   Contact lens aftercare refers to consultation and advice with a patient sometime after the initial fit, usually where a patient is following up with an issue they have had after wearing lenses for some time.

10. Note on Tasks undertaken – Referral

    Referral – Non-emergency would be a referral you make in writing to another healthcare professional outside of your practice, such as a written letter of referral to a hospital. It could also mean that you have used one of your practice routes for referring specific conditions or patient types, such as using a button, form or electronic system your practice has set up.

    Referral – Emergency would be a situation in which you send a patient to A&E or to an acute referral ophthalmic area for urgent treatment on the same day.

    Referral – Consult with colleague may be a less formal interaction than what you would usually consider a 'referral'. This can be about any matter regarding a patient which you need to pass to a colleague other than your supervisor e.g. delegation to OA or dispensing optician.

    Referral – Consult with supervisor should be a matter regarding a patient for which you needed to ask the supervisor's advice, ask the supervisor to sit on the consultation or you asked the supervisor to take over from you.

GOC learning outcomes

What are learning outcomes?

Learning outcomes are statements of what a learner will know or be able to do by the end of a learning experience. On your degree, the University tutors and College Assessors use learning outcomes as a measure of whether you have attained the required standard when they assess you.

The GOC has set learning outcomes for qualification providers to measure what students need to know and be able to do in order to register as an Optometrist. Your degree has been designed around these learning outcomes and so is CLiP.

Areas covered by the GOC learning outcomes

There are seven sections for learning outcomes in the GOC Requirements:

1. Person centred care
2. Communication
3. Clinical practice
4. Ethics and standards
5. Risk
6. Leadership and management
7. Lifelong learning

Learning outcome levels

As well as setting the learning outcomes, the GOC has ascribed levels to each outcome to show the level that the student must attain. There are four levels: ‘Know’, ‘Knows how’, ‘Shows how’ and ‘Does’.

What you need to know, at this stage, is that most CLiP outcomes are set at the level ‘Does’. This means that you need to demonstrate that you are meeting the learning outcomes independently and consistently, on a regular basis, in your daily practice.

This is what College Assessors will try to determine on the assessment visits, and it is why we are assessing you by reviewing and discussing your logbook entries. It gives us an insight into what you have been doing in your daily practice and allows us to check whether you are meeting the required standards.

Clinical Core Outcomes

The Clinical core outcomes listed below are mostly what you are being assessed on in the CLiP Part 1 assessment visits, CLiP 1R and CLiP 1F.

However, these are considered so crucial to clinical practice that if you failed to perform in one of these areas at any point, it could lead to failure of the task being assessed. As such, Assessors will be attentive to these outcomes during all four assessment visits, but they are explicitly testing them in CLiP 1F.

As mentioned elsewhere in this guidance, we advise you to pick at least one core outcome to assign to every entry you log and use the ‘Consultation notes’ or ‘Notes’ fields in the logbook to describe how you met the outcome.

Demonstrating how you met a learning outcome

When you select a clinical core learning outcome for a new logbook entry, you also need to tell us how you met the learning outcome by writing a short explanation in the 'Consultation notes' section of the interaction.

We suggest that you start referring to the 'Student guidance for CLiP 1R' to help guide you in thinking about how you have met learning outcomes. The guidance provides example scenarios in which you might be able to demonstrate how you met each outcome.

For example, one of the outcomes tested in CLiP 1R is:

> *1.3 Protects patients' rights; respects the choices they make and their right to dignity and privacy.*

What could you do which would show you have met this outcome? The Student guidance gives a few examples, including making adjustments for someone with face or head coverings so that you can use a trial frame with them, allowing someone to bring a chaperone into the consultation or using a particular name or form of address they have asked you to use.

We ask that you write a brief summary, one or two sentences, to show how you met the outcome. Using scenarios similar those above, examples of appropriate explanations could be:

> *"Px asked me to call her by a name in English as her real name is hard to pronounce – I used her preferred name throughout the consultation."*
>
> OR
>
> *"I'd arranged for a practice colleague to observe me at this time but when I asked Px if this was OK they seemed unsure, so I said it was no problem and I'd arrange for my colleague to come back later."*

As shown in the examples above, the way you achieve the learning outcome does not have to signal anything unusual or special – you can give ordinary day-to-day examples. Also, you don't need to write a lot – one or two sentences is enough.

Remember that we are assessing 'Does' level – that you are performing to the right standard regularly and consistently in your day-to-day practice – so we don't expect every example to be detailed or extraordinary.

Learning-related core outcomes

Learning-related core outcomes (7.1 and 7.4) are also integrated into every assessment visit, as part of the discussions you have with Assessors toward the end of each visit. These tasks are to monitor your progress and establish that you are developing in your learning over the course of CLiP.

See the full list of Clinical core outcomes and Learning-related core outcomes below:

Clinical core outcomes

Outcome / Level	Example failing performance
1.1 Actively listens to patients and their carers to ensure patients are involved in and are at the heart of decisions made about patient's care.	Demonstrates a rude, poor or patronising questioning technique Fails to note critical information provided by patient
1.2 Manages desired health outcomes of patients, taking into consideration any relevant medical, family and social history of the patient, which may include personal beliefs or cultural factors.	Provides advice that directly conflicts with patient's desired outcomes Acts in a way that clearly makes the patient uncomfortable Does not meet legal requirements in relation to data management. Does not meet legal requirements in relation to equality.
1.3 Protects patients' rights; respects the choices they make and their right to dignity and privacy.	
1.5 Commits to care that is not compromised because of own personal conscious and unconscious values and beliefs.	
4.9 Complies with equality and human rights' legislation, demonstrates inclusion and respects diversity.	
4.12 Complies with legal, professional and ethical requirements for the management of information in all forms including the accuracy and appropriateness of patient records and respecting patient confidentiality.	
1.6 Obtains and verifies continuation of valid consent from adults, children, young and vulnerable people and their carers and records as appropriate.	Repeatedly fails to establish consent (or meet legal requirements re consent).
4.4 Applies the relevant national law and takes appropriate actions i) to gain consent and ii) if consent cannot be obtained or is withdrawn.	
2.1 Conducts communications in a sensitive and supportive manner adapting their communication approach and style to meet the needs of patients, carers, health and care colleagues and the public.	Communicates in an unprofessional or misleading manner
3.1 Undertakes safe and appropriate ocular examinations using appropriate techniques and procedures to inform clinical decision-making within individual scope of practice.	Safety of patient compromised requiring assessor intervention

4.8 Complies with health and safety legislation.	Compromised safety of patient or self, without making attempt to correct.
5.5 Applies infection prevention control measures commensurate with the risks identified.	Poor hygiene or infection control potentially impacting patient safety Unsafe disposal of clinical waste
5.7 Able to risk assess i) patient's clinical condition and ii) a situation in clinical practice and make appropriate clinical decisions.	Safety of patient compromised requiring assessor intervention

Learning-related core outcomes

GOC Outcome	SPOKE indicative guidance
7.1 Evaluates, identifies, and meets own learning and development needs. (DOES)	Analyses and responds to own learning and development needs. Prepares and follows a personal development plan, utilising appropriate learning opportunities.
7.4 Engages in critical reflection on their own development, with a focus on learning from experience, using data from a range of information sources (such as clinical audits, patient feedback, peer review and significant event analysis) and identifying and addressing their new learning needs to improve the quality and outcomes of patient care. (DOES)	Assesses own learning needs and engages in self-directed learning to maximise potential and improve outcomes. Critically reflects on own practice, and participates in multi-disciplinary service and team evaluation formulating and implementing strategies to act on learning and make improvements. Actively engages in peer review to inform own practice, formulating and implementing strategies to act on learning and make improvements. Demonstrates how audit can contribute to improvement in the quality and/or efficiency of patient care.

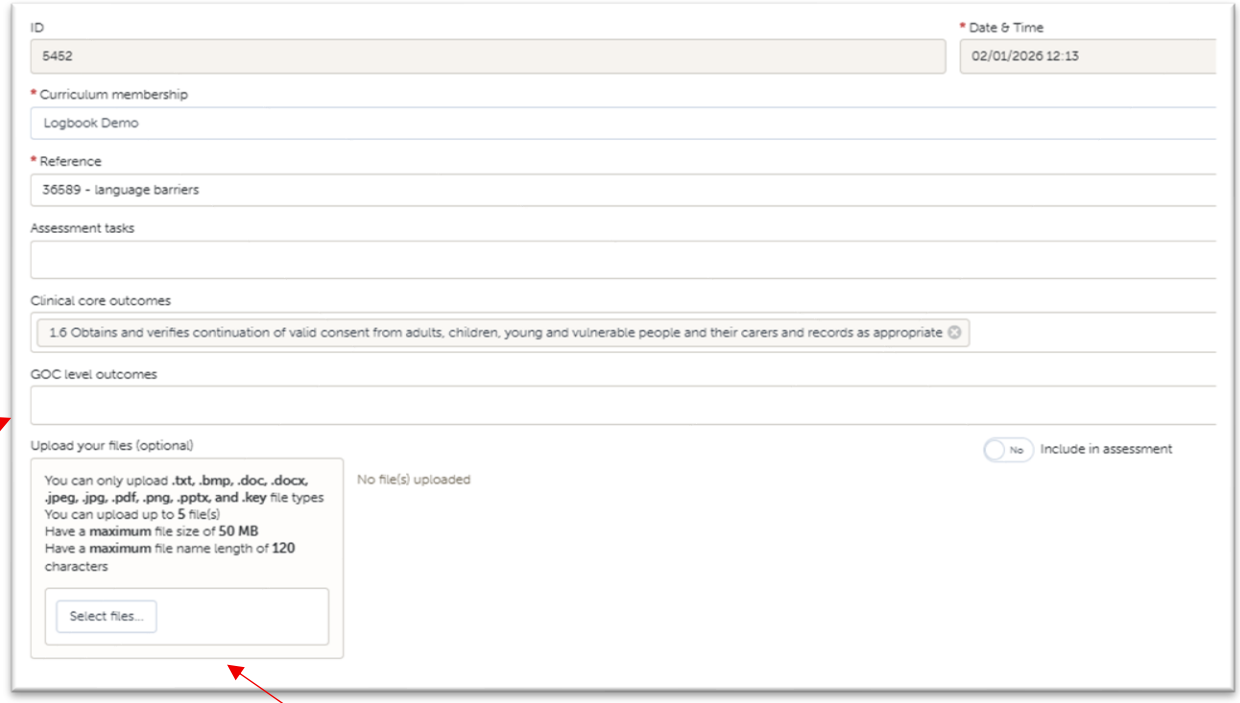
Example logbook entries

Standard logbook entry fields

Reference field just has the **patient ID** and some **key information** about the patient interaction.

While you're on CLiP Part 1, try to select one or two **Clinical core outcomes** for each entry you log.

Leave **GOC level outcomes** blank.

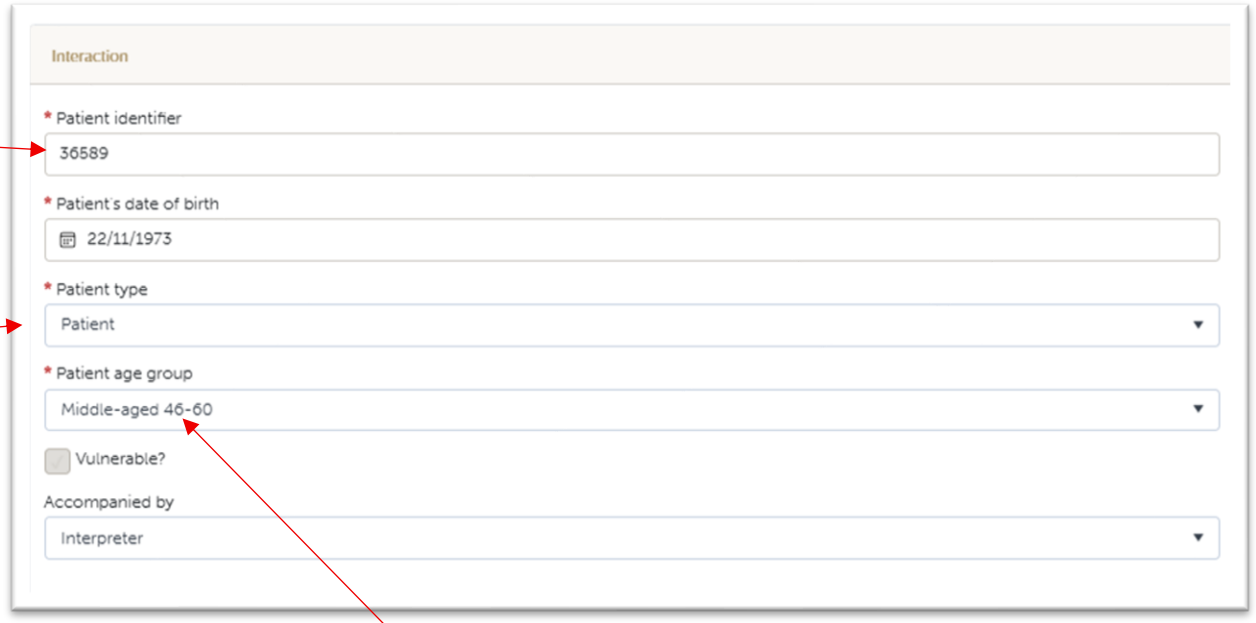


Please **don't** upload any patient-related **scans** or **records** to a logbook entry.

Interaction fields for patient profile

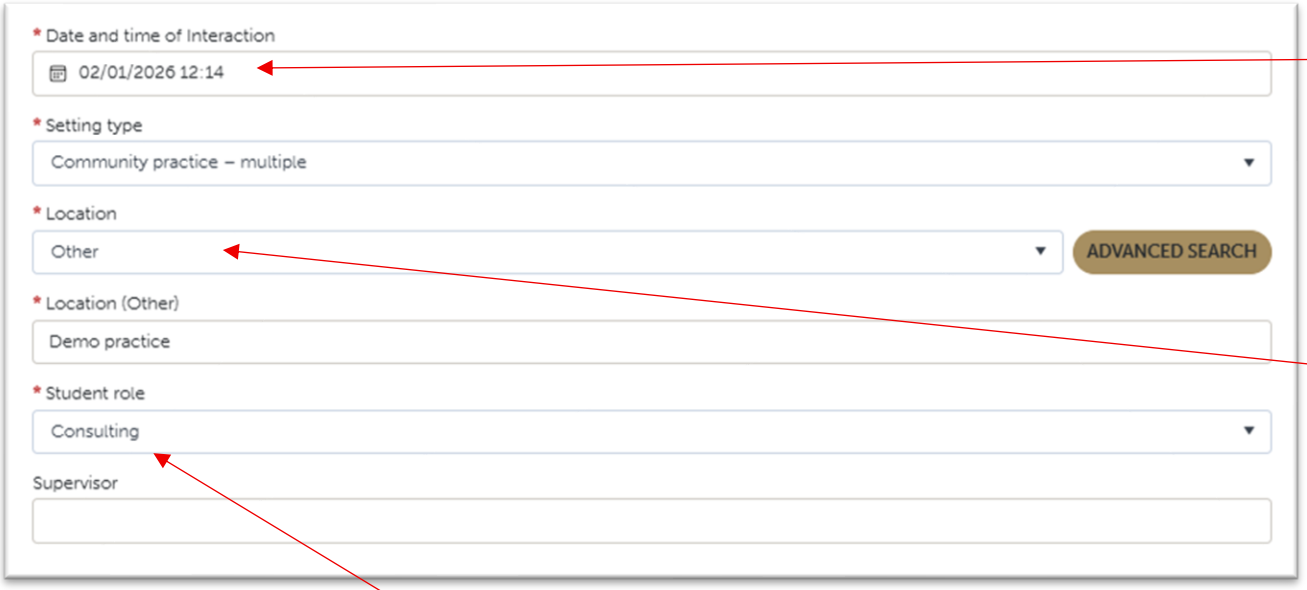
Patient ID here should be the same as in the 'Reference' field above

Patient type needs to be set to **Patient** for it to count in your Risk dashboard



Any fields marked with a **red asterisk** are required, and you won't be able to save if it's blank

Interaction fields for practice information



This date will be set to the time of writing but you can change it – you can type in the date rather than selecting

You can start typing your **practice name** and it should appear for you to select

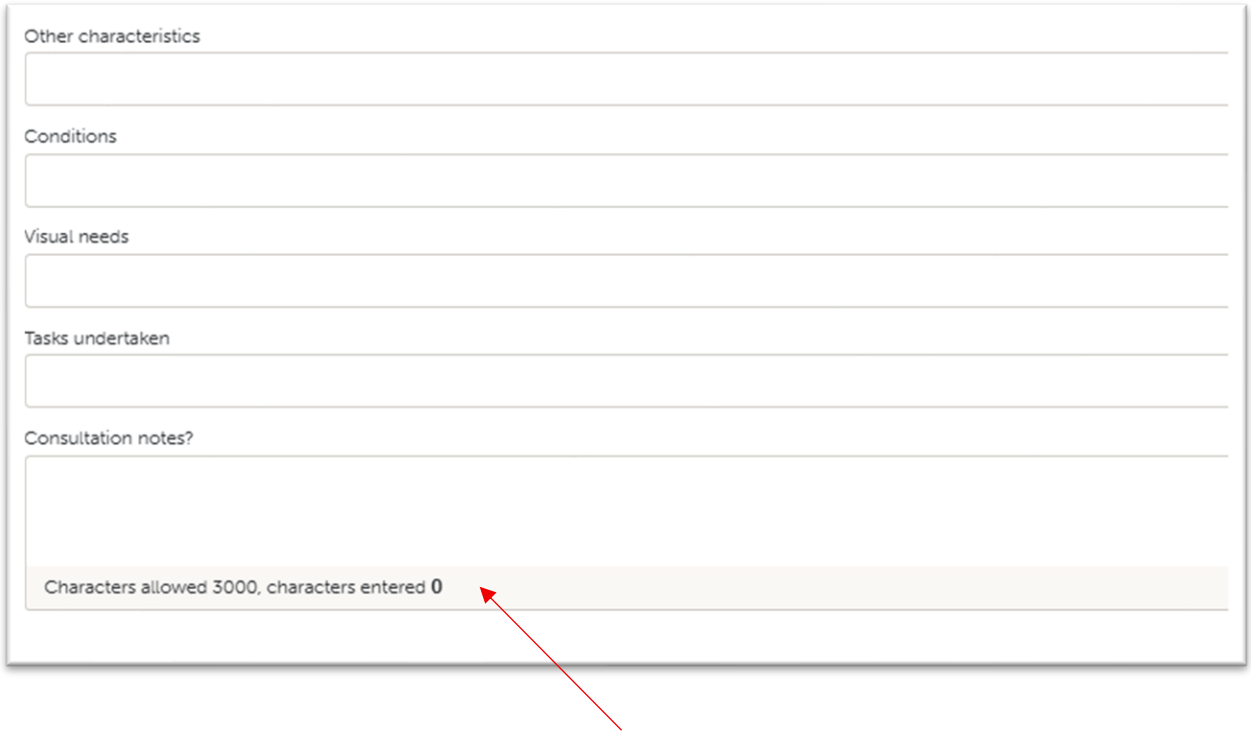
Student role needs to be set to **Consulting** for it to count in your Risk dashboard

Interaction fields for consultation

You can click in these fields and select items from the **drop-down**

OR

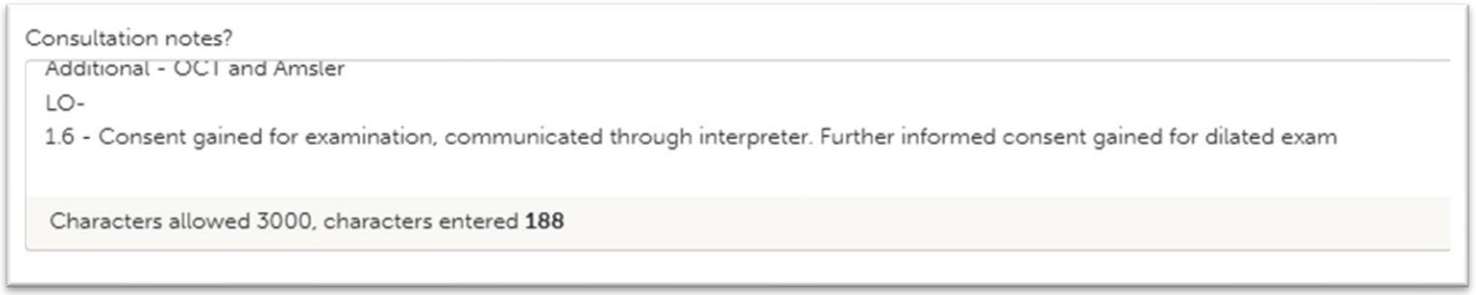
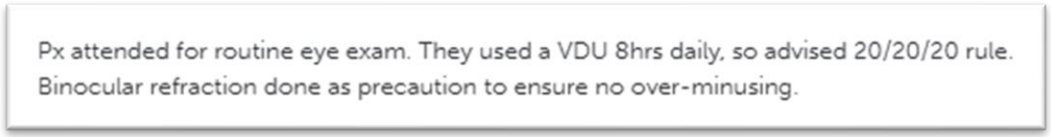
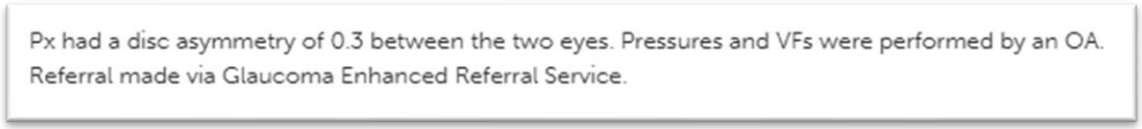
start typing the item you need and it will pop up.



The consultation notes field is free-text – write brief notes on what was special about this interaction and/or how you met the learning outcome you've selected (see below).

Logbook consultation notes – good examples

We want the detail of your patient consultations to be in your in-practice patient record, so don't write more than you need to in your logbook consultation notes. Here are some examples of brief information you should include:

When you select a logbook item with an asterisk ('*') such as 'Visual fields' or 'Additional tests / Other supplementary tests', the asterisk means you need to provide some more details.	
During CLiP Part 1, try and select at least one Clinical core outcome and use 'Consultation notes' to explain how you demonstrated the outcome.	
If you are including a logbook entry for **assessment**, it can be useful to provide a brief outline of what happened	 

Logbook consultation notes – things to avoid

These are examples of ways in which you could end up doing more work than you need when you write consultation notes. Remember that the Assessor just needs to get a sense of what type of patient interaction this was – they will then ask you to show them the patient record if they want to use the entry for the assessment.

This entry contains great detail but it's more than we need for your logbook. Writing this much for a lot of logbook entries is likely to take up too much of your time.	The patient had not worn contact lenses for a while and had since become presbyopic. I completed a task analysis and recognised that the patient needed to be able to look at close work and distance objects, so I ascertained whether one of their eyes was more dominant than the other. I checked the best vision sphere and provided as much plus as possible in the eye used for distance vision, and used the least amount of add in the non-dominant eye.I did an anterior eye check under white light and blue light (after instilling NaFL), and then inserted the lenses and evaluated the fit. I checked the vision and that the patient was happy with what they were seeing. I then performed a teach to go over insertion and removal to remind the patient how to do it (since it had been a while). The patient spoke English as a second language and so I ensured I demonstrated everything really clearly.
In CLiP Part 1 you should link to **one** or **two** learning outcomes only and explain in your consultation notes how you met them. These notes about the learning outcomes are good, but the entry has too many learning outcomes (**three**).	1.6 – Verbal consent obtained from the patient to be seen by me. Patient attended with a carer as they were living with dementia; implied consent was obtained throughout the examination. 4.4 – Since the patient had disclosed that they were living with dementia, I assumed capacity for consent. However, I also involved the carer in all the consultation. 4.8 – The patient touched a lot of surfaces in the test room to help with their stability. I ensured the room was cleaned appropriately after the patient left.

Assessment visit overview

Clinical Learning in Practice (CLiP) assessment is divided into two halves, CLiP 1 and CLiP 2. The College delivers assessment visits, for both parts, twice a year. This means that if any student needs to re-take CLiP, they can re-take the half/part they failed and don't have to start all over again. They can also re-take the CLiP part without waiting a full year.

Each CLiP part has one remote and one face-to-face assessment visit. Each assessment visit is divided into tasks (and sometimes sub-tasks), each of which are associated with one or more GOC learning outcomes at a specified level. Again, this allows for any resits of failed elements to be re-taken efficiently – a student would only need to resit the task they've failed, rather than the full assessment visit.

The complexity of assessment tasks increases over the duration of CLiP. By the time you complete the CLiP 2 face-to-face visit, you should be fully developed in your practice and ready to become a full registrant with the GOC.

In addition, CLiP 1 has a written piece of work, the Service Evaluation Project, which is grounded in your own practice.

The assessment strategy for CLiP is to observe you in practice and to verify your logged experience. Assessors will engage in professional discussion with you about your logbook entries. They will check that you understand what you have logged and recorded, and that you can reflect on that experience. They will ask follow-up questions when they review logbook entries and pose alternative scenarios to check whether you can apply what you've learnt to other situations.

Assessors will also test your ability to make, and rationalise, appropriate clinical decisions on the basis of objective data, in line with GOC standards and other relevant clinical frameworks.

Assessment visits

How assessment visits are organised

Assessment visits are organised roughly every 9-12 weeks while you are working in practice in CLiP. You will usually have an assessment visit within a set time window and you will need to be ready in terms of all the visit prerequisites and training.

There will be one remote and one face-to-face visit in each of the two CLiP parts, so four assessment visits in total:

CLiP 1R – CLiP Part 1 remote visit

CLiP 1F – CLiP Part 1 face-to-face visit

CLiP 2R – CLiP Part 2 remote visit

CLiP 2F – CLiP Part 2 face-to-face visit

A different Assessor will be assigned to each visit.

General visit requirements

The general requirements for all visits are that you:

- Are ready to start on time.
- Have your photo ID ready to show at the start.
- Are ready to share in-practice patient records.

For remote visits, you will need to have in-practice patient records corresponding to your logbook entries which are both:

- fully anonymised and;
- open and ready to share on your computer.

For remote visits, you can be at home or in the workplace but must have a reliable internet connection and be in a room where you are alone and will not be interrupted.

For face-to-face visits, your Practice Lead supervisor must be available during the visit. The Assessor will need to be able to access the CLiP Portal during the visit so you must have WiFi details ready to share.

Preparing for assessment visits

You need to have all your logbook requirements for the visit prepared and approved a week in advance of each visit. If there are any gaps in the requirements, the Assessor will have to award a fail result for the relevant task and you will need to re-take it. As such, it is very important that you and your supervisors check your logbook regularly as each visit approaches to ensure that you are ready for the visit in time.

The dashboards in the CLiP Portal and the visit guidance with logbook checklists can be used to carry out checks. Student guidance has been prepared for each visit and is available on the Assessment visits area of the College website. We advise Supervisors and students to start preparing with this separate guidance. These include preparation checklists for each visit and we recommend starting checks 4-5 weeks ahead of the visit at the latest.

Quality assurance tasks

Most tasks within each visit are assessed, but each visit ends with a 'Quality assurance of setting and supervision' task to make sure you are being properly supported in your workplace. The Assessor can also discuss your progress on the placement, focussing on areas of the risk profile where you not at the expected level, for example.

Preparing in-practice patient records

For some assessment tasks, there are requirements to select an in-practice patient record for the Assessor to review. Patient records used for the assessment visit must:

- be original;
- be contemporaneous (completed at the time of the patient consultation);
- comprise the written record only – fields and scans are not required;
- include a note that the patient gave consent for them to be used for assessment purposes (e.g. VCG / verbal consent given); and
- not be altered in any way, other than being anonymised.

On a face-to-face visit, it is expected that students will be able to show the original records to the Assessor on a practice computer. On a remote visit, they will probably be using their own computer at home to share records. For data protection purposes, the student will therefore need to anonymise and copy all records before they transfer them.

The process for anonymising records for use on remote visits is:

- Supervisor approves the record as one the student can use in assessment.
- Student duplicates the record, in the practice.
- Student anonymises the duplicated record, in the practice, using electronic editing tools or black marker for a paper record.
- Student edits to remove view of patient name, address, date of birth, GP details, telephone number and any other information which could be used to identify the patient.
- Student does not make any further changes to the record: all details of the patient consultation must remain unchanged.
- Supervisor checks the record.
- Student copies record to their computer.
- Student uses the Patient ID as filename for the record, for easy cross-reference with the CLiP Portal logbook entry.
- When supervisor approves the logbook entry, this confirms they have checked and approved any accompanying anonymised record.

In-practice patient records are not uploaded to the CLiP Portal. You need to have the anonymised records open and ready to share, on your device, before the visit starts.

Assessment visit schedule

See below.

Month	Week	CLiP Model A (January start)	CLiP Model B (July start)
Jan	1	Earliest placement start date	CLiP Part 2 start
	2		
	3		
	4		
Feb	1	Latest placement start date	CLiP 2R: Part 2 remote visits
	2		
	3		
	4		
March	1		
	2		
	3		
	4	CLiP 1R: Part 1 remote visits	
	5		CLiP 2F: face-to-face visits
April	1		
	2		
	3		
	4		
May	1		
	2		
	3	CLiP 1F: face-to-face visits (and submission of Service Evaluation Project)	
	4		
	5		End of placement
June	1		
	2		
	3		
	4	End of CLiP Part 1	
July	1		Earliest placement start date
	2		
	3		
	4		
August	1	CLiP Part 2 start	Latest placement start date
	2		
	3		
	4		
	5	CLiP 2R: Part 2 remote visits	
Sept	1		
	2		
	3		CLiP 1R: Part 1 remote visits
	4		
Oct	1		
	2		
	3		
	4	CLiP 2F: face-to-face visits	
	5		
Nov	1		
	2		CLiP 1F: 1 face-to-face visits (and submission of Service Evaluation Project)
	3		
	4		
Dec	1		
	2		
	3		
	4	End of placement	End of CLiP Part 1

Assessment visit administration

- You will receive an email in the first few weeks of CLiP to tell you when your CLiP 1R assessment visit will be. We will not be able to change assessment dates.
- You should refer to the Student guidance for each visit for advice on how to prepare and what you need to have ready.
- Before the visit, you will need to complete the student survey on the CLiP Portal – see logbook checklist in the Student guidance or the CLiP Portal guidance at the end of this document for instructions.
- For face-to-face visits, your Practice Lead Supervisor will need to be in the practice for the duration of the visit.
- After the visit, we will confirm your result as soon as possible. You can view your result in the CLiP Portal by going to 'Assessment'. When your result is final it is marked as 'Confirmed'.
- You can see your results for each task and Assessor comments by going to the completed assessment form – select 'Go to assessment form'.

Assessment visit requirements and special circumstances

Visit prerequisites

It is the student's responsibility to ensure that you have logged all the prerequisite evidence and arranged for your Practice Lead to approve it prior to the assessment visit deadline, which will normally be one week in advance.

Any task that does not have the full complement of prerequisite evidence logged by the deadline will be treated as failed, unless there are approved exceptional circumstances.

Visit attendance

Students who present themselves for assessment at the visit will be treated as declaring themselves fit-to-sit the assessment. Only in exceptional cases will circumstances declared after the assessment visit has taken place be considered for mitigation. For example, the student was hospitalised and unable to notify us of absence on the day of the visit.

If students or the practice are not ready to start the assessment visit on time, visits can be started late, provided at least one hour of the allotted time remains. However, only the tasks that can be completed in full, in the remaining allowed time, will be assessed.

Students who do not present themselves for the assessment visit will be considered to have failed unless there are documented and approved exceptional circumstances relating to lateness or absence.

Students who have a valid reason for absence must provide this, together with appropriate evidence, by email to education.admin@college-optometrtsists.org. Notification of absence must take place as soon as possible, ideally before the visit is due to start. If evidence is provided after the visit, the reason for delay must also be evidenced.

Failing and re-sitting

At the assessment visit, the Assessor will log a Pass or Fail result for each task.

Where a task consists of a number of sub-tasks, the student will need to pass all the sub-tasks to pass that task. In the event that they fail any sub-task, they would need to take and pass the entire task again.

If a student passes a number of tasks in the visit but fails others, they will only need to take and pass the tasks which they failed again.

Whether the result for each task is Pass or Fail, the Assessor will be able to write comments to give the student feedback.

The Assessor's judgement is final and the College will not accept challenges made on the basis that the student does not agree with the assessment decision.

If the result for any task is a Fail, the Assessor will identify the GOC outcome, bullet-point indicator or SPOKE indicative guidance point which the student did not meet. Free-text commentary will also be recorded.

Students will be given two attempts at completing each task. Where a student fails a task, the College will usually arrange a separate assessment visit within the following weeks for the student to attempt it again. The only exception to this in CLiP 1R, in which some

outcomes are assessed again at the CLiP 1F visit. As such, if a student fails any part of CLiP 1R Task 3, they do not need to re-take these elements as the outcomes are tested again at CLIP 1F.

If any task has not been successfully completed by the end of CLiP 1 or CLiP 2, then that part of CLiP must be repeated in full, to ensure time and experience to consolidate and improve the relevant clinical skills.

The student will be allowed one more attempt to complete the CLiP Part in full. If they fail any tasks on this second attempt at the whole part, they will be given the opportunity to attempt each task again a second time if required.

As a result, the maximum number of times any task can be attempted is four, provided no exceptional circumstances are taken into account.

Preparing to resit tasks

Students who need to resit elements of an assessment will have a new visit date arranged and will need to re-sit the failed task(s) only.

Provided the Assessor did not give specific feedback on the logbook entry used for the task, the same logbook entry or entries can be used for the resit. If a student uses the same logbook entry, the corresponding patient records **must not** be amended or changed.

If feedback was given to change or replace a logbook interaction, the student can do this and a supervisor will need to confirm and approve prior to the resit.

Exceptional circumstances

Where a task, visit or missed submission deadline is subject to approved exceptional circumstances, that element will be postponed and rescheduled, without penalty, to a date set by the College in the light of the circumstances.

Should the circumstances prevent progress or attendance over a prolonged period, such that the student will be unable to:

a) accrue 22 weeks patient-facing activity before the start of CLiP Part 2; or

b) accrue 44 weeks of patient-facing activity before the end of CLiP Part 2; or

c) be unable to complete CLiP Part 1 assessment within the 22 weeks; or

d) be unable to complete CLiP Part 2 assessment before the end of their placement;

…then they may be required to restart the relevant section of CLiP (1 or 2) at the next start point. Typically, this would apply for circumstances that last more than three weeks total, depending on other leave taken.

No additional fees will be charged for this, and the College will support students to find an alternative placement if their employer is unable to extend the placement period.

Applications for exceptional circumstances

Exceptional circumstances postponements will only be awarded in response to an application made to the College, with supporting evidence, sent to education.admin@college-optometrtsists.org. Where supporting evidence will be available at a later date, this must be indicated. Prolonged or complex exceptional circumstances will

require more substantial evidence of impact and may also require University approval and trigger other support processes.

The following table shows a non-exhaustive list of potential exceptional circumstances and forms of evidence that might be provided, alongside some examples of circumstances that would not qualify as exceptional:

Circumstance	Examples that would normally be approved	Evidence	Examples that would not normally be approved
Ill health, including mental health	Illness that would warrant not attending work	Formal letter or document from a health professional	Claims for illness after the visit has taken place
Bereavement	Loss of close family member	Death certificate or funeral arrangements Employer-approved compassionate leave	Loss of a distant relative, unless evidence is provided of impact such as caring responsibilities for of from the student
Caring responsibilities	Serious injury or illness in a close family member such as parent, spouse, partner, sibling or child	Medical records	Expected childcare responsibilities such as school holidays. Caring for family members with minor illness such as coughs and colds
Pregnancy and maternity	Serious complications in pregnancy or maternity	Medical records	Being pregnant with no complications (although students may apply for reasonable adjustments)
Job loss / Placement disruption	Redundancy, or long-term /permanent closure of practice Loss of access to practice records	Employment termination records Employer-provided evidence	Misconduct or other termination reasons.
Leave	Maternity, paternity, adoption or compassionate leave	Employer records of maternity, adoption or compassionate leave	Holidays
Assessment disrupted	Fire alarm, mystery patient sickness, assessor prevented from attending, unavoidable practice closure	Assessor report	Minor interruptions of less than five minutes

Reasonable adjustments

Reasonable adjustments approved by the student's University will be applied to CLiP assessments as follows:

Approved Adjustment	Assessment	Application to CLiP
Extra time	Visit	Visit will be extended by percentage required. However, clinical tasks which are conducted so slowly, in the view of the assessor, as to cause the patient risk or discomfort will be failed, even if completed within the extended time period.
Extra time	Service evaluation project submission dates	These must be completed by the visit date. The visit will be scheduled for the last week of the allotted (three-week) window.
Breaks	Visit	Rest breaks as specified will be provided.
Use of one eye for retinoscopy (e.g. for Amblyopia)	Visit – Direct observation tasks	Will be permitted but must use recognised technique (e.g. Barrett) to good effect.

All other adjustments will be implemented in the light of discussions between the College and the University Link Tutor.

Where workplace adjustments have been provided by the employer for students with disabilities, or with relevant temporary conditions, these will normally be permitted during the face-to-face assessment. These must be notified at the start of CLiP, or as soon as requested by the student, to the College. Where there is any question that such adjustments would impact the validity of outcome or conduct of assessments, the student's University will determine what is acceptable for use in CLiP.

Where concerns remain on either side that performance standards may be impacted through implementation of any specific adjustment, or equality legislation may be breached if not enacted, the GOC will be approached for final decision.

Appeals

Students who believe that an administrative mistake has been made by the College should contact clip@college-optometrists.org as soon as possible to ask for it to be rectified. Students must follow the appeals process of their own University in relation to any other concerns about the outcome of CLiP assessments.

Misconduct during assessment

Where professional or academic misconduct is suspected or identified during assessment, the Assessor will report, including available evidence, to the College. The College will notify the University, and the Lead Assessor will instigate further investigation and provide the outcome to the University for decision.

Fitness to train

On receipt of evidence that indicates that the student's fitness-to-train may be impaired, the College will inform the University for action. Where the impairment may present an

immediate concern for the welfare of the student, patients, colleagues or others the College will take such action as is deemed appropriate to protect those involved.

Service Evaluation Project (SEP)

SEP Summary

A service evaluation looks at how well a service is meeting its goals and aims to improve the experience for people using that health service. For this project, you need to carry out an enquiry-based audit that checks how the current service compares to the standards in your practice. For example, you could review how quickly patients are seen after referral or whether staff are following safety guidelines. In your written project, you should also suggest ways to make the service better, such as improving appointment scheduling or adding extra support for patients.

Each student will need to decide on their own focus for the project: it will help to identify a sub-set of patients, clinical activities, or conditions to study retrospectively. You should think about what interests you in clinical practice, and what standards are associated with that area. This could be (for example) in one of the following areas:

- Referrals
- Dispensing
- Record-keeping
- Additional tests
- Recalls

The project will seek to find out if the practice is providing the appropriate service delivery that meets the standards associated with that service, and if that service can be improved in any way.

Preparing and submitting the project

You are provided with a Service Evaluation Project Instructions and Templates document (including guiding questions and timelines) to guide you in developing an enquiry-led project. This leads you through the required areas you should cover, with a section of the workbook provided to write about each, including:

- evaluation of the current state of play (audit)
- opportunities for and risks of change
- proposals for value maximisation and risk mitigation

The Project will also include consideration of ways of improving patient experience and patient outcomes through:

1. Personal and team behaviours
2. New technology and services
3. Practice environment review and change
4. Referrals and navigation of commissioning frameworks (external environment)

You will also consider what adaptations would be required for the proposed improvements to be applied in other environments.

In the CLiP 1F assessment visit, the Assessor will ask verification questions to ensure that the output is genuinely grounded in your practice and owned by you. The final submission

date for the written project will be the submission date for CLiP 1F (one week in advance of the visit).

Following the visit, the work will be assessed by an assigned College marker and feedback will be provided. Work that does not meet the standard may be revised and re-submitted once only.

You will need to go to the Assessment visits area of the College website to find full information about SEP and download the template document.

Speaking up

In this handbook and our other presentations to you about CLiP, we have tried to be clear about what the expectations are for your CLiP job and your general experience in the workplace.

We want you to know what you should expect, so that you can say something if that is not what happens in your case.

If anything seems wrong with the CLiP work and the experience you are getting:

- Say something as soon as you're able – if you leave things too late, it could affect your overall experience on CLiP.
- Discuss it with your supervisors and employers, as the first step.
- Refer them to the CLiP 'Employer Handbook' and 'Assessment Handbook' if they seem unsure of the rules and expectations.
- If things don't improve, let the College know at: clip@college-optometrists.org
- You can also talk to your Assessor during the 'QA setting and supervision' task discussion at Assessment visits – but please consider whether this would be leaving it too late and say something sooner if you need to...

More guidance

We have produced Student guidance for each assessment visit, complete with a logbook checklist which shows exactly what you need to record in your logbook to meet the prerequisites. You can find these, together with the documents for the Service Evaluation Project, on the Assessment visits area of the College website.

If you want to see more details about the assessment, including the marking criteria which Assessors are using, you can view the full CLiP Assessment Handbook.

If you want to see all the detail we provide employers about your CLiP job and experience, you can see the CLiP Employer Handbook.

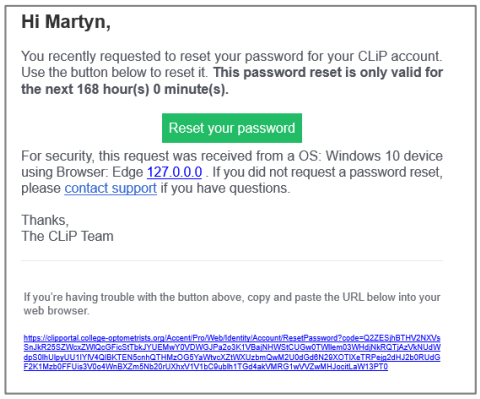
You can find guidance on using the CLiP Portal for Logbook and Assessment purposes below.

CLiP Portal guidance

Getting started

When the College activates your CLiP Portal account, you will receive an email from the system inviting you to set up a password. This will be straightforward if you click on it and do the set-up as soon as you receive the email.

The email is from sender ‘Accent’ and address no-reply@hicom.co.uk



Hi Martyn,

You recently requested to reset your password for your CLiP account. Use the button below to reset it. **This password reset is only valid for the next 168 hour(s) 0 minute(s).**

Reset your password

For security, this request was received from a OS: Windows 10 device using Browser: Edge 127.0.0.0 . If you did not request a password reset, please contact support if you have questions.

Thanks,
The CLiP Team

If you're having trouble with the button above, copy and paste the URL below into your web browser.

https://clipportal.college-optometrists.org/Accent/Pro/Web/Identity/Account/ResetPassword?code=Q2ZESjhBTHVZNXVsSnJkR2I5ZWoxZWQcGFkSlTbkJYUEMwY0VOWGJPa2s3K1VBaNhIWSlCUGwGTWllem03WHdNNlRQTVAzVkNUdWdp50lhUlpyUU1IYN4QIBKTEN5cnhQTHMzOG5YaWtycXZtWXUzbmQwM2U0d3d6N2tXOTlXeTRPeja2dHJ2b0RUdGF2K1Mzb0FFUis3V0o4WnBXZm5Nb20rUXhvV1V1bC9ubih1TGd4aKVMRG1wVVZwMHJoctLaW13PT0

There is a time limit on these emails but if it has expired when you come to use it, you can follow these steps:

- After you click the link in the email it may take you to a notice saying that it’s expired.
- Click ‘Login’ in top right anyway.
- It takes you through to a normal username/password login window.
- Click ‘Forgot password’
- It will send you a new email and you can use that.

Link to the CLiP Portal

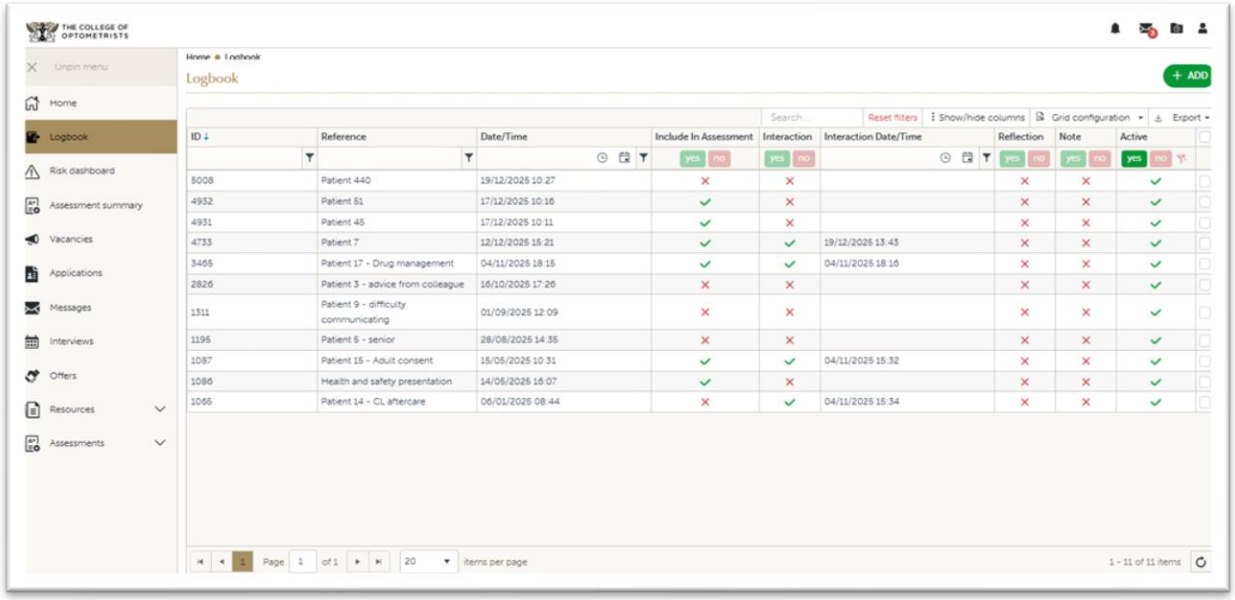
You should be able to access the Portal on computer, phone or tablet. However, many of the logbook grids will be better viewed on a larger screen.

Navigation and functions

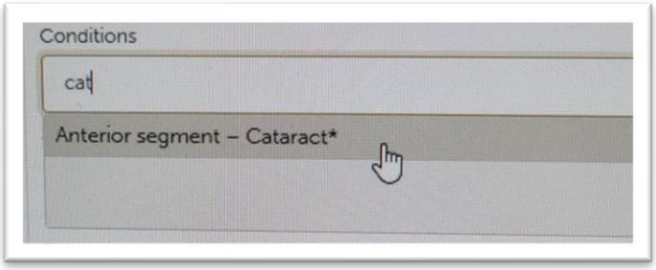
- You will find the main menu on the left side of the screen.
- You can Pin the menu so that it stays in place.
- When you navigate to different pages, you can move back by selecting again from the main menu or by clicking on the breadcrumb trail at the top of the page.
- Menu options and most other functions on the Portal are single-click, but you will need to double-click if you’re opening a row in a grid.
- The grids in the Portal have usual Microsoft Dynamics functionality – you can use filters and you can change the order of columns by clicking on the column title.
- Grids show 20 items by default but you can always increase this using the filter at the bottom of the grid.
- You can also add or remove columns and save any new configurations so that the grid looks the same the next time you log in.

Creating a logbook entry

Go to ‘Logbook’ in the main menu to see the logbook grid in which you can search and access all your entries.



- Use the ‘+ADD’ button to create a new logbook entry.
- Complete the ‘Reference’ field in the main entry and you will be able to save it (remember to use the in-practice patient ID in the Reference field).
- After you save, you get the option to add ‘Interaction’, ‘Reflection’ or ‘Note’ at the top of the entry.
- If you are recording a patient consultation, add an interaction.
- You’ll need to complete all fields in the interaction with an asterisk (*) and you can’t save it until these are completed.
- Most of the fields in the interaction are completed from drop-down menus and some of these (e.g. Conditions, Tasks undertaken) are multi-select, so you can include more than one item.
- **Tip**: instead of scrolling down the drop-down menus, try typing in the item you are looking for. The drop-down menu should then offer you a shorter selection – as shown below when we start typing ‘cataract’.



You can also type in a date for patient Date of birth instead of using the date picker.

- Try to identify a Clinical core learning outcome which you can link to the entry. You are allowed to enter one or two learning outcomes, no more, in the ‘Clinical core outcomes’ field of the main entry.
- After you link an entry to a Clinical core outcome, write a short note to explain what you did which demonstrates that you met the outcome. You can write this in ‘Consultation notes’ in the Interaction or you can add it in a ‘Note’.
- After you complete the required interaction fields, the ‘SAVE’ button will turn green and you can save your entry.
- **Tip**: Include **only** one or two learning outcomes in the ‘Clinical core outcomes’ field and leave ‘GOC level outcomes’ blank. You don’t need to enter more than two outcomes.

Amending logbook entries

After you save a logbook entry, you can initially go back and change any details there. However, after a supervisor confirms the entry, the fields in ‘Interaction’ will be locked.

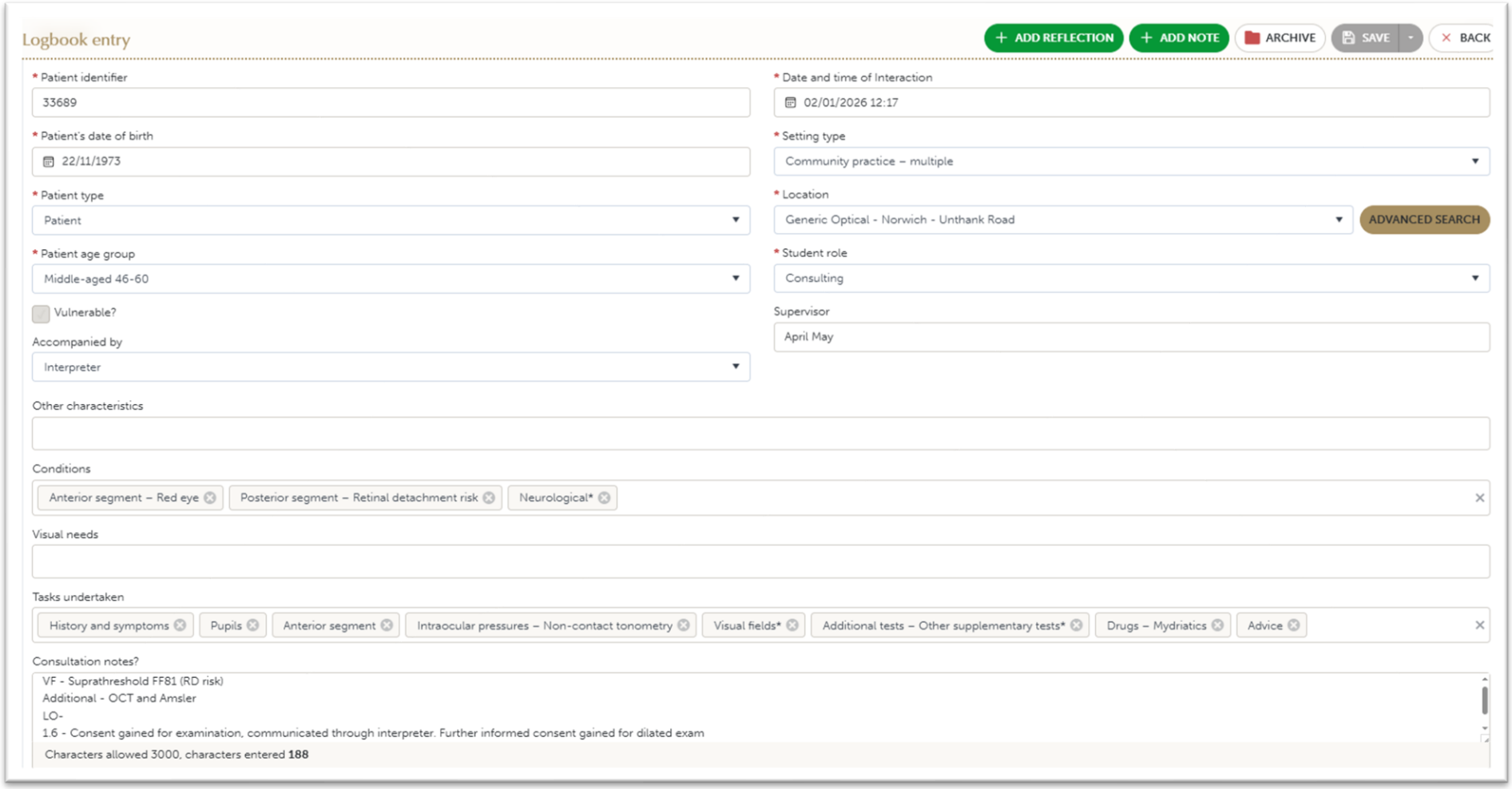
You can still:

- Add a reflection.
- Add information to the main entry fields – for example, you can still add a learning outcome or change ‘Include in assessment’.
- Add a note – if you add a learning outcome, you can then add ‘Note’ to explain how the entry meets the learning outcome.

If you realise that you have missed something out of an interaction or you have got something wrong, you can ask a supervisor to ‘unconfirm’ the entry so you can go back and work on it. They will then need to confirm it again when you’re ready.

See, below, an example of a completed interaction with clear and concise notes explaining how the student met the learning outcomes.

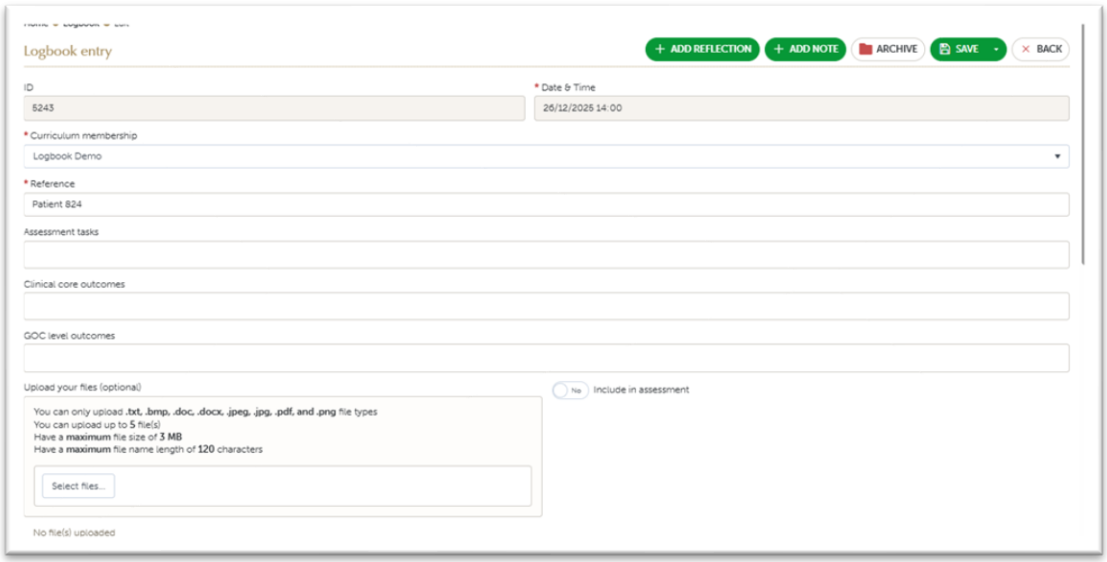
Example of completed interaction with consultation notes



Notes: In 'Tasks undertaken' field, 'Visual fields' and 'Additional tests' both have an asterisk which means you need to give more detail in the notes – there are brief notes on what was done. The entry is linked to Clinical core outcome 1.6 and there is also a brief note to say how this outcome was met.

Preparing entries for assessment

You can use the main fields at the top of your logbook entry to flag entries as ones you may want an Assessor to review at an assessment visit.



There are three fields you can use here to mark up an entry for assessment purposes:

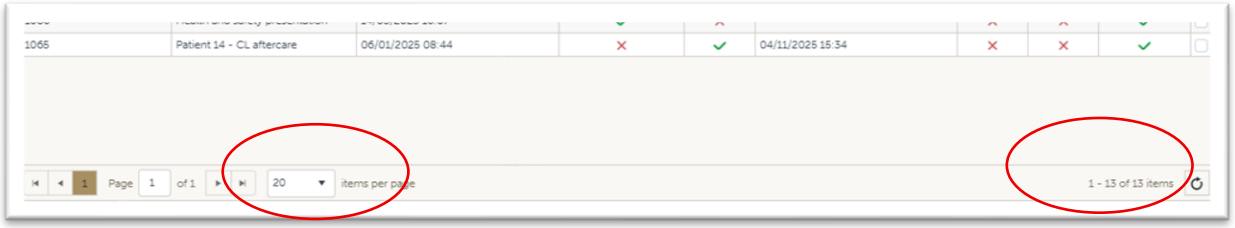
- Assessment tasks – start typing the task you want to assign to and pick from the list.
- Clinical core outcomes – if relevant, select the learning outcome for your task.
- Include in assessment – toggle to ‘Yes’.

Tip: If you create an entry and think it might be useful for a future assessment, but you’re not sure yet, you can just change ‘Include in assessment’ to ‘Yes’. This will help you to search it later (because you can filter by ‘Include in assessment’ – see below) and you can still change the ‘Yes’ back to ‘No’ at any time, even if your supervisor has confirmed the entry.

You should refer to the separate ‘Student guidance’ for each assessment visit to check the requirements for the logbook entries you need to have.

Using the logbook grid to search

In the main Logbook view, you see a grid containing all the entries you’ve created. At the bottom right of the grid, it will tell you how many items you are displaying.

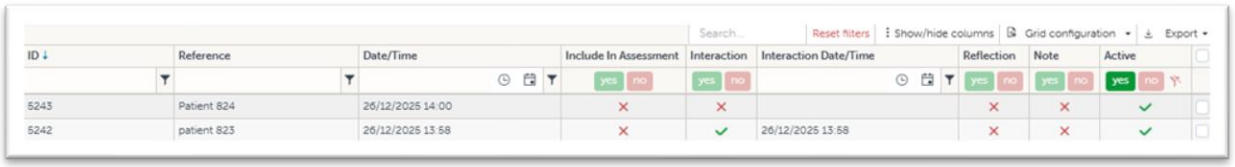


You can use the filter at the bottom of the logbook to change the number of items you see on each page.

You can use the filters at the top of the grid to order and search for items in different ways:

- The ‘Search…’ bar at the top will do a key-word search on any items you have selected in an entry or any text you have written.

- The ‘yes’ and ‘no’ filters will help you select by the different categories. For example, if you want to see only entries for which you have selected ‘Include in assessment’, you can use the ‘yes’ button on that column.
- The blank boxes under each title allow you enter a key word to search for in that category – for example, you can search for a particular Patient ID in ‘Reference’.
- If you click in the grey row next to each column heading it will order the grid by that category – for example, if you click next to where it says ‘Date/Time’ it will order the grid by date and time of the entry.



- After you’ve applied filters, remember you will need to clear them if you want to see all your logbook entries in the grid again – use ‘Reset filters’ at the top of the grid.

Changing the logbook grid view

You can add or remove columns to the grid to get the view you prefer. For example, you can add a 'Task' column to the grid by selecting 'Show/hide columns' at the top of the grid and ticking the box for 'Task'.

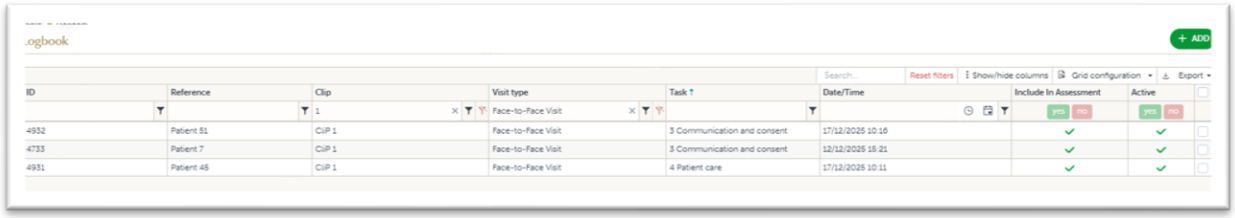
Saving and clearing logbook grid views:

- If you want to save changes to the grid so your selections stay the same for next time you log on, go to 'Grid configuration' next to 'Show/hide columns' and choose 'Save configuration'. Next time you go in, a green symbol appears to show you have a configuration saved.
- 'Grid configuration > Save configuration' will save the selection of columns you have displayed and should also save your filters until the next login.
- If you want to keep the column selection but remove all the filters you've applied, use 'Reset filters'.
- If you want to re-set the column selection, use 'Grid configuration > Reset configuration'.
- This is a useful **troubleshooting** measure. If you expect to see entries in your grid view and you can't see them, then you may have used a filter and forgotten it was selected. Try using 'Reset filters' first and see if that works. If it doesn't, then re-set the Grid configuration as a second step.

Recommended view for assessment preparation

Here's our recommended selection for your grid view if you are preparing for assessment visits:

- In 'Show/hide columns', untick:
  - Interaction
  - Interaction date/time
  - Reflection
  - Note…
- …and then tick:
  - Clip
  - Visit type
  - Task
- In 'Grid configuration > Save configuration'
- Then, for e.g. CLiP 1F visit, filter by:
  - Clip: 1 (type '1' in the blank box at top of column and 'Enter')
  - Visit type: Face-to-face visit (start typing 'face' in blank box and it should come up) and 'Enter'
  - Click top of Task column (next to where it says 'Task') to order the items by Task number



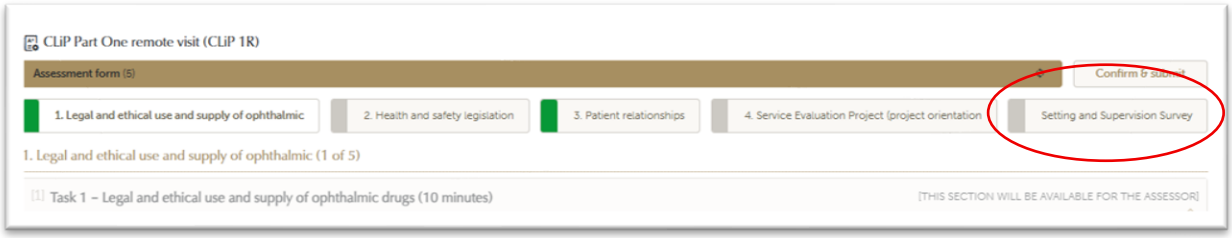
Logbook grid view with 'Clip' filtered to part '1' and 'Visit type' filtered to 'Face-to-Face Visit'.

Assessment visits

In the CLiP Portal, you can access the page for an upcoming assessment visit by going to 'Assessments' in the main menu.

You will need to complete a survey here before each visit. Here's how to access the survey:

- Go to Assessments > Assessments
- Double click on the next visit in the 'Student assessments' grid
- Select 'Go to Assessment Form'
- Most sections of the form should be greyed out – you can't edit them. However, you can select 'Setting and Supervision Survey' – click on the tile at the top of the form.



- Complete the form.
- Click 'Next' at bottom of the form.
- On Assessment submission page, click 'I confirm' and 'Submit' buttons.

After you have completed your visit, you will be able to return to this Assessments page to check whether your Assessor has confirmed your results and to review your completed form.

Document version	Date	Update
1.1	02/01/2026	First version
1.2	28/01/2026	Updated – RF definitions, assessment visits, logbook examples