



Royal College of
Obstetricians &
Gynaecologists

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Subspecialty Training

Urogynaecology

Definitive Document 2019

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Table of Contents

Contents

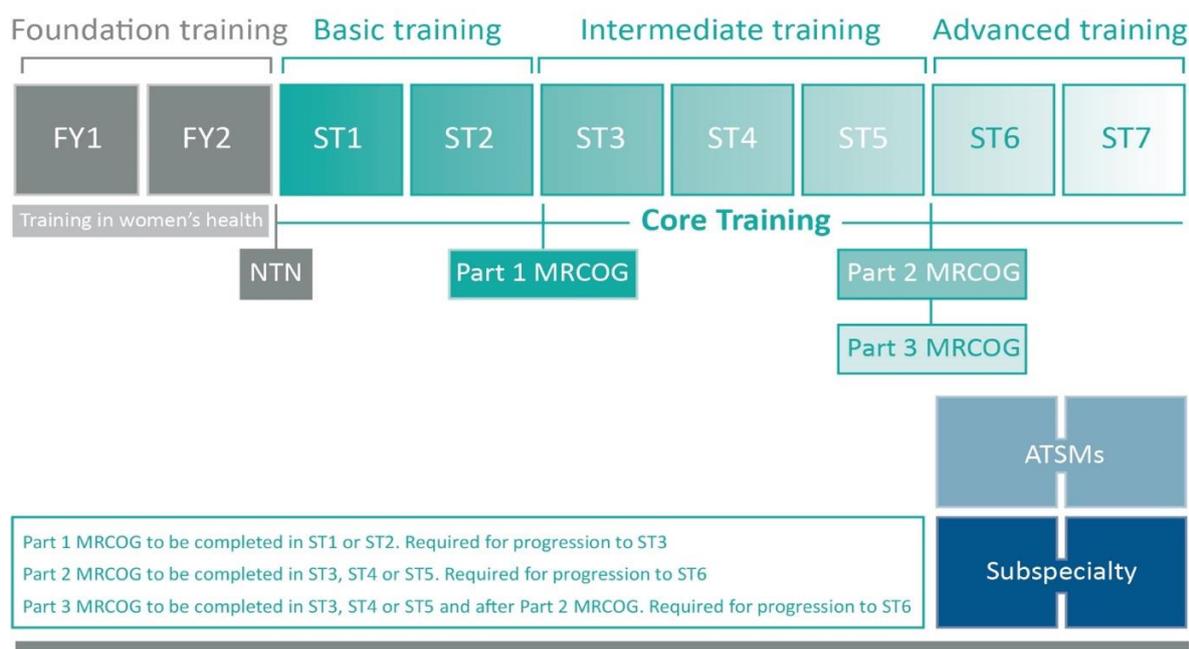
1	Introduction	3
2	Purpose of the Urogynaecology subspecialty training programme	3
2.1	Background	3
2.2	General description of the revised UG curriculum	4
2.3	Interdependencies between the UG subspecialty curriculum and other training programmes, professions or areas of practice	6
2.4	Flexibility and the transferability of learning.....	7
3	The organisation and content of the UG curriculum	8
3.1	Curriculum framework features.....	9
3.2	The Urogynaecology subspecialty curriculum	10
4	The research component of subspecialty training	27
4.1	Research exemption.....	28
4.2	Advanced Professional Module Clinical Research	29
4.3	Non-completion of research component	29
5	Learning and Teaching	29
5.1	The core training programme	29
5.2	The general training environment	30
5.3	The subspecialty training environment	31
6	Programme of Assessment	33
6.1	Purpose of assessment	33
6.2	Programme of assessment	34
6.3	Assessment of CiPs.....	35
6.4	The global judgement process	35
6.5	Assessment of progression	38
6.6	Evidence of progress	39
6.7	Annual Review of Progression (ARCP)	42
7	Supervision and feedback	44
7.1	Subspecialty training	45
7.2	Generic supervision.....	45
7.3	Appraisal.....	47
8	Quality Management	47
9	Intended use of the UG subspecialty curricula by trainers and trainees	49
9.1	Recording progress in the ePortfolio	49
10	Equality and diversity	49

1 Introduction

This Definitive Document relates to the subspecialty of Urogynaecology (UG) and addresses the purpose, learning outcomes, content of learning, process of training and the programme of assessment for UG, which is in addition to the core curriculum requirements for CCT. The Core Curriculum covers ST1-7 as detailed in the Core Curriculum Definitive Document.

O&G is a run-through training programme lasting seven years. The fundamental training structure and waypoints remain the same in the new curriculum. In the final two years of training, trainee doctors have to complete two ATSMs OR one subspecialty programme to be eligible for CCT.

Specialty training and education programme



2 Purpose of the Urogynaecology subspecialty training programme

2.1 Background

Over recent years the RCOG has published three important strategic reports: [Becoming Tomorrow's Specialist](#), [Tomorrow's Specialist](#) and [High Quality Women's Healthcare](#). Although there was an extensive review of the O&G core curriculum during 2012 and 2013, our research made it clear that the emphasis and design of the revised curriculum did not adequately address some of the key professional elements of being a consultant, nor was it flexible enough to be easily modified to fit future working practice. A new more adaptable curriculum was therefore required that will produce specialists who have the skills, knowledge and attributes needed in the 21st century.

The RCOG Curriculum Review Group was set up to take forward the RCOG's *Becoming Tomorrow's Specialist* recommendations relating to pre-CCT training. Its 2015 working party

report identified the deficiencies in the current core curriculum with its emphasis on technical skills, and the lack of focus on non-technical and professional skills required by a modern consultant. Most importantly, the Review Group developed a definition of the required characteristics of an O&G consultant for the first time – and this has provided the basis for the work since carried out. The definition is as follows:

A highly skilled Obstetrician and Gynaecologist with the appropriate knowledge and attitudes to lead and deliver safe, high quality care taking account of individual needs and advocating for women's healthcare. This will involve a questioning approach to research and quality improvement. Working well in multiprofessional teams is essential for safe, effective patient care; Obstetricians and Gynaecologists must be good communicators, supportive of staff and happy to share their expertise and experience, as well as being open to the views of others. On completing training, the individual will be prepared for lifelong learning, which will allow them to be adaptable and flexible for a modern NHS.

At the same time, the publication of the GMC's Generic Professional Capabilities (GPCs) and the requirement to move to outcomes-based curricula combined with the development of a new ePortfolio necessitated a complete review of all the O&G advanced curricula to ensure that they too reflect the aspirations of the Review Group and the definition of the O&G consultant.

2.2 General description of the revised UG curriculum

The RCOG is committed to developing specialists with generic skills and our new curricula framework aims to do just that. Key to this is to define what a modern consultant in the NHS needs to be and to tailor the output of specialty training towards this. The RCOG has also supported the Shape of Training agenda, ensuring the O&G training programme produces generalists with skills to manage emergency care while working collaboratively with other specialties to deliver individualised patient care. All O&G curricula, whether core or advanced, acknowledge that the specialist will manage female, transgender and non-binary individuals of all age groups and ethnicities, including young people, and vulnerable individuals.

In the final 2 years of the training programme, trainees will be expected to develop professional interests which corresponds with their skills and interests and future needs of the health service. They can either choose to do two Advanced Training Skills Modules (ATSMs) or one of four subspecialties. The subspecialties are Urogynaecology (UG), Gynaecological Oncology (GO), Maternal and Fetal Medicine (MFM) and Reproductive Medicine (RM).

The purpose of the UG subspecialty curriculum is to produce doctors with the generic professional and subspecialty-specific capabilities needed to advise and treat people presenting with a wide range of urogynaecological conditions in tertiary referral centres. UG subspecialists should have the skills to organise and supervise services at a local and regional level, contribute to academic urogynaecology, lead on the translation of new research findings into clinical practice, be providers of support and guidance to non-subspecialist colleagues, and be active in teaching and quality management. The UG curriculum recognises these clinical and non-clinical skills and provides a framework for

training by defining the standards required to work at consultant level. It also encourages the pursuit of excellence in all aspects of clinical and professional practice, and for the trainee to take responsibility for their own learning, as they would as a consultant.

UG subspecialty training consists of two years of clinical training plus 12 months of research training. Trainees may opt to be research exempt from the research training if they have already completed the Advanced Professional Module (APM) Clinical Research, or if they have a higher degree (MD(Res) or PhD) relevant to Urogynaecology, or two or more first author UG subspecialty specific publications in citable, refereed MEDLINE journals. A trainee who is not research exempt would be expected to produce a minimum of two first author UG subspecialty specific publications in citable, refereed MEDLINE journals, or complete the APM Clinical Research to complete the research component of subspecialty training. The research element varies from a full year of dedicated research, to research sessions or blocks of research, depending on the organisation of the GMC/RCOG approved subspecialty programme. Subspecialty training can be commenced at ST6 at the earliest, and after successful competitive appointment to a subspecialty training post. Entry to subspecialty training is subject to the trainee having completed all clinical CiPs that lie outside the chosen subspecialty. Normally the trainee should have completed all core clinical O&G CiPs prior to starting but this may not be practically possible.

A trainee is eligible to register for subspecialty training on satisfactory completion of the Annual Review of Competence Progression (ARCP) (i.e. outcome 1) at the end of ST5 which includes attainment of the MRCOG and following successful competitive interview. To be awarded CCT all trainees must complete the generic and specialty specific CiPs. For the CCT to recognise UG subspecialty accreditation they must also complete all of the UG subspecialty specific CiPs.

No change is being proposed to accessing subspecialty training in UG. However, both the ATSM Urogynaecology & Vaginal Surgery and the UG subspecialty curriculum were changed in October 2018 due to the national pause in mesh procedures. For the subspecialty curriculum it was also necessary to remove surgical procedures which are no longer undertaken in clinical practice meaning that trainees would be unable to complete their training.

The revised UG curriculum consists of Capabilities in Practice (CiPs) (high-level statements outlining the expectations of a doctor at the end of training). These all fall into the Clinical Expert Professional Identity (PI). The PIs, which are a fundamental concept of the core curriculum, are divided into generic (Developing the doctor) and specialty-specific (Developing the obstetrician & gynaecologist). The new CiPs require judgment based on the trainee's overall capability at the end of training. They support a move away from a 'disease-based' structure to encourage a more person-centred approach that prioritises the needs and complexities of each individual.

Table 1 – Professional Identity and Capabilities in Practice for UG

DEVELOPING THE OBSTETRICIAN & GYNAECOLOGIST - SST-UG	
<i>PROFESSIONAL IDENTITY: CLINICAL EXPERT</i>	
CiP1	The doctor has the knowledge, skills and attitudes required for clinical assessment of pelvic floor dysfunction
CiP2	The doctor selects and performs appropriate tests and interprets the results
CiP3	The doctor is competent in non-surgical management of pelvic floor dysfunction
CiP4	The doctor is competent to undertake surgical treatment of pelvic floor disorders

In parallel with the introduction of the core curriculum we have reviewed our ‘assessment at work’ methods. We have piloted and collated evidence for modified versions of our existing workplace-based assessment tools, the modification being the addition of a reflective element for each tool. The new tools reflect both the new GPCs mandated by the GMC as well as our own aspirations for developing a lifelong reflective practitioner. These new tools will be used by all trainees.

Our programme of assessment (PoA) will include a broad range of evidence drawn from different formats and environments to ascertain minimal standards and competencies, regarding both expectations and attainments, at critical progression points and on completion of training. The PoA will be based on robust and fair assessment principles and processes.

2.3 Interdependencies between the UG subspecialty curriculum and other training programmes, professions or areas of practice

The overall 7-year training programme aims to develop Obstetricians & Gynaecologists who work in and lead multidisciplinary teams, and who can work with colleagues from a range of professional groups in a variety of hospital and community settings. This emphasis can be seen in the UG CiPs. The combination of the UG subspecialty CiPs with the other core specialty and generic CiPs in the seven year programme will provide a more integrated approach to service and care, to fully meet the needs of the people using our clinical services.

During its development the core O&G curriculum underwent extensive consultation with stakeholders including trainees, trainers and Heads of Schools, as well as external stakeholders including other related specialties (Royal College of General Practitioners, Faculty of Sexual and Reproductive Health and Royal College of Midwives), and patient groups to gain their insight into what they require from a high quality O&G consultant. Full details are given in the core O&G curriculum submission.

The British Society for Urogynaecology (BSUG) has been consulted and contributed to the revision of the UG subspecialty curriculum into the new outcomes-based format. The content of this curriculum is fundamentally unchanged from the current version in terms of knowledge criteria and clinical content. Where appropriate, generic professional skills have been removed as these are now covered in the core curriculum.

2.4 Flexibility and the transferability of learning

The creation of generic CiPs within the core curriculum design allows ease of transfer between specialties, as these have been mapped to the GMC's GPCs. In addition, all the clinical CiPs, whether in core, ATSMs or subspecialty curricula, have been mapped to the GPCs. Evidence can be acquired by experiences in a wide range of posts and environments, allowing flexibility to meet the needs of the service and the individual trainee.

As subspecialty trainees are also still following the core O&G curriculum at the same time as their subspecialty training, they are required to display a wide range of behaviours and attributes, in addition to their specialist UG clinical skills and knowledge, reflecting the broad nature of this specialty in practice. Trainees attaining CCT will be skilled in managing the labour ward independently and managing the acute gynaecological on call service, as well as caring for people with urogynaecological conditions. They will have expertise in practical procedures related to the clinical care of women and will be expert communicators with strong interpersonal skills, strong emotional awareness and adept at the management of emotionally complex situations. These core areas ensure that doctors in training and beyond CCT can provide safe care whilst working on a range of challenging and diverse rotas, balancing acute and non-emergency service provision, and encouraging trainees to experience a wide range of hospital and other healthcare environments. Trainees following the UG subspecialty curriculum will also need to demonstrate that they have achieved a thorough understanding of the anatomy, physiology and pharmacology of the lower urinary tract and the impact of pregnancy, parturition, menopause and ageing on lower urinary tract function and that they have the knowledge, skills and attributes to manage the full range of urogynaecological conditions of their patients. They must also be aware of the effects of disease, both mental and physical upon the pelvic organs.

All Obstetricians and Gynaecologists achieving CCT regardless of their ATSMs or subspecialty training will therefore have demonstrated achievement of a range of generic and specialty-specific capabilities. Doctors achieving CCT with subspecialist accreditation will also have demonstrated achievement of a set of subspecialist CiPs. These CiPs fully incorporate the GPCs, meeting the requirements set out by the GMC.

These core areas ensure that doctors in training and beyond CCT can provide safe care whilst working in a range of challenging and diverse work environments, balancing acute and non-emergency service provision. They also encourage trainees to experience a wide range of hospital and other healthcare environments. All CCT holders will:

- Be able to develop and apply innovative approaches to teaching in women's health and research.
- Place the principle of informed decision making with women and their families at the heart of their practice.

- Be advocates for women’s health.
- Be up to date in their practice and promote and implement evidence-based medicine.
- Be a role model for the highest standards of care and professional behaviours within the specialty and across the medical profession as a whole.

3 The organisation and content of the UG curriculum

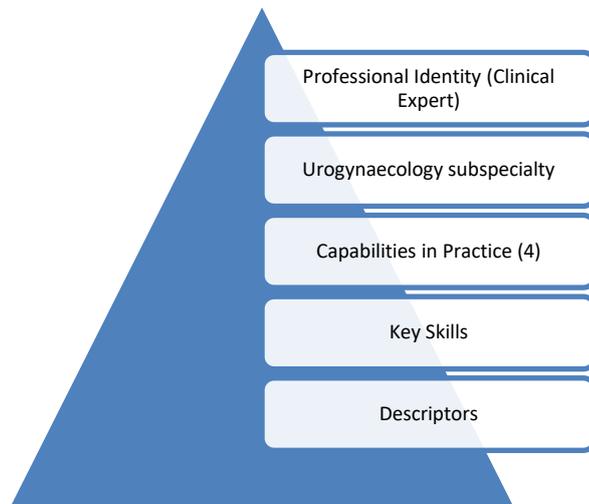
The practice of O&G requires the generic and specialty knowledge, skills and attitudes to advise and treat people presenting with a wide range of gynaecological and obstetric conditions and symptoms. It involves particular emphasis on woman-centred care, diagnostic reasoning, managing uncertainty, dealing with comorbidities, and recognising when specialty opinion or care is required. The modern consultant is defined by four Professional Identities (PIs) in the new O&G Core Curriculum to incorporate all these elements, as demonstrated in Figure 1 below.

Figure 1 – Core Curriculum design structure



All the CiPs in the UG curriculum are in the Clinical Expert Professional Identity. This is because the trainee is also completing the Core Curriculum which contains all the necessary generic professional skills a CCT-holder will need.

Figure 2 – UG curriculum design structure



3.1 Curriculum framework features

The curriculum content is structured as follows:

Section 1 Capabilities in Practice

Each CiP is supported by the key skills expected to be demonstrated by an accredited UG subspecialist. Each key skill has a set of descriptors associated with that activity or task. These are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated by O&G doctors in the UG subspecialty. Descriptors may be used to provide guidance to trainees when they self-assess their performance against the minimum expected standards for their year of training. They are not a comprehensive list and there are many more examples that would provide equally valid evidence of performance. Many of the descriptors refer to person-centred care and informed decision making. This is to emphasise the importance of exploring and discussing care or treatment options, their risks and benefits, with women and their families.

Each CiP gives guidance for the kinds of evidence that will be required to demonstrate progress, including a list of the summative OSATS.

Each CiP lists the knowledge criteria relevant to that CiP.

Section 2 Procedures

All the procedures that are expected to be experienced during the UG subspecialty training programme are listed, with an indication of the final level expected by the end of training, and which CiP they belong to. There are a number of procedural skills in the UG subspecialty in which a trainee must become proficient to the level expected by the end of training. Trainees must be able to outline the indications for these procedures and recognise the

importance of valid informed consent, and of requesting for help when appropriate. For all practical procedures the trainee must be able to recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary. Trainees will be able to record their procedures in the new ePortfolio.

When a trainee has been signed off as being able to perform a procedure independently, they are not required to have any further assessment (OSATS) of that procedure, unless they or their Educational Supervisor think that this is required (in line with standard professional conduct).

Section 3 GMC Generic Professional Capabilities

Appropriate professional behaviour should reflect the principles of the GMC's [Good Medical Practice](#) and the GPCs. Therefore all subspecialty curricula have been mapped to the GMC GPC domains.

Section 4 Mapping of assessments to CiPs

The mapping shows the possible formal methods of assessment for each CiP. Section 6.7 outlines more detail on the mapping.

Assessment of the CiPs will be underpinned by the descriptors and judged against the requirements articulated in the UG Curriculum Guide. The Subspecialty Training Programme Supervisor (STPS) will carry out an annual global judgement, and satisfactory sign off will indicate that there are no concerns before the trainee can progress to the next assessment point.

In order to complete training and be recommended to the GMC for the award of CCT and entry onto the specialist register, the doctor must demonstrate that they are capable of unsupervised practice (level 5) in all CiPs except where otherwise indicated, as well as meet the requirements of the Core Curriculum.

3.2 The Urogynaecology subspecialty curriculum

What follows is the curriculum framework, which articulates the detail for each of the Urogynaecology CiPs, including the mapping to the GPCs.

SST – Urogynaecology (UG)

SECTION 1: CAPABILITIES IN PRACTICE

CiP 1: The doctor has the knowledge, skills and attitudes required for clinical assessment of pelvic floor dysfunction.	
Key Skills	Descriptors
Takes and presents a urogynaecological history, including impact of condition on quality of life, in patients with urinary, bowel, pelvic organ prolapse and sexual problems	<ul style="list-style-type: none"> • Takes and presents an appropriate history and uses terminology in accordance with the International Continence Society. • Communicates patient's symptoms effectively and understands their severity and social and psychological impact.
Uses standardised assessment tools when assessing patients	<ul style="list-style-type: none"> • Uses clinical history and bladder diary to make an initial diagnosis. • Selects, uses and analyses appropriate standardised symptom and quality of life questionnaires.
Performs a general, pelvic floor and neurological examination to clinically assess pelvic floor dysfunction	<ul style="list-style-type: none"> • Performs an appropriate examination, elicits abdominal and pelvic signs, and highlights relevant findings to team. • Describes stage of pelvic organ prolapse using a recognised methods, including usage of Pelvic Organ Prolapse Quantification (POPQ) system or new assessments methods as they are introduced into clinical practice. • Performs neurological examination to assess both neurological conditions that may affect the pelvic floor, and for perineal denervation. • Puts clinical findings in the context of the patient's symptoms. • Communicates significance of clinical findings to the patient and to multidisciplinary team.
Assesses women with potential urethral diverticula	<ul style="list-style-type: none"> • Diagnoses urethral diverticula and investigates appropriately.
Assesses women with potential mesh complications	<ul style="list-style-type: none"> • Assists and has been supervised in the assessment, diagnosis and management of mesh complications and can order appropriate investigations. • Recognises indications for referral to specialist mesh centres.
Assesses women with potential urinary tract and enteric fistulae	<ul style="list-style-type: none"> • Diagnoses fistulae and orders appropriate investigations.

Assesses women with potential neurological conditions affecting the bladder	<ul style="list-style-type: none"> • Carries out appropriate neurological examination and requests appropriate investigations for these conditions.
Links with specialists in other disciplines to assess and manage complex pelvic floor disorders	<ul style="list-style-type: none"> • Determines correct indications for referral to specialist urology for complex urodynamic stress incontinence and detrusor overactivity. • Determines correct indications for referral to specialist colorectal services for rectal prolapse and functional bowel disorders. • Determines correct indications for referral to specialist neurology or neurourology for the management of neurological conditions affecting the bladder.

Evidence to inform decision

<ul style="list-style-type: none"> ○ Reflective practice ○ Multi-source feedback TO1s ○ Attend urogynaecology clinics ○ Case discussion and observation of senior medical staff ○ Personal Study ○ Tailored Clinical Experience 	<ul style="list-style-type: none"> ○ Feedback from trainer ○ CbD ○ Mini-CEX ○ Annual subspecialty assessment ○ Evidence of attendance at appropriate courses
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Knowledge Criteria

<ul style="list-style-type: none"> • The relationship between pelvic floor symptoms and other medical conditions, including neurological conditions and their impact on the pelvic floor • An understanding of evidence-based guidance • How standardised symptom and QoL questionnaires are devised and validated • What examination findings are relevant to lower urinary tract disorders and prolapse • The impact of neurological conditions on lower urinary tract function (e.g. multiple sclerosis), and how to assess and counsel patients and counsel appropriately • The lower urinary tract manifestations of specific neurological conditions and their management: <ul style="list-style-type: none"> Spina bifida Multiple sclerosis Parkinson's disease Spinal cord injury Lower motor neuropathy Stroke • Surgical principles for the treatment of complex urodynamic stress incontinence and detrusor overactivity: <ul style="list-style-type: none"> Artificial urinary sphincters Augmentation cytoplasty Urinary diversion procedures • The investigation and diagnostic criteria for fistulae (vesicovaginal, urterovaginal, urethrovaginal) and the surgical principles for repair and complications that may occur • Urethral diverticula
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- Treatments for ureteric obstruction and ureteric injury, including ureteric stents (double J stents or ureteric catheters)
- Surgical principles of ureteric reanastomosis and reimplantation techniques
- Methods of investigations and principles of treatment of incontinence:
 - Secondary anal sphincter repair
 - Bulking agents
 - Pelvic floor exercises
 - Surgical management of rectal prolapse such as delormes, rectopexy
 - Use of constipating agents
- Methods of investigations and principles of treatment for emptying problems:
 - Use of laxatives / conservative therapies
 - Transanal repair of rectocele
- Methods of investigations and principles of treatment for urgency:
 - Biofeedback
 - Drug treatment
 - Behavioural modification
- Investigations and principles of treatment of enteric fistulae, including those involving bladder, vagina, anus or perineum
- Pelvic floor electromyogram:
 - Use of sacral nerve stimulators
 - Tibial nerve stimulation

CiP 2: The doctor selects and performs appropriate tests and interprets the results.

Key Skills	Descriptors
Performs, understands and interprets appropriate investigation for assessment of pelvic floor and functional bladder symptoms	<ul style="list-style-type: none"> • Requests and interprets results of urinalysis and formal urine culture and cytology. • Assesses urinary residual by bladder scan. • Undertakes urodynamic investigation according to the standards set down in the A1 module of the common curriculum for multidisciplinary training in urodynamics (www.ukcs.uk.net). <ul style="list-style-type: none"> ○ Undertakes urodynamic investigation according to national standards. ○ Demonstrates an understanding of fluid dynamics, bladder and urethral function. ○ Understands the basic principles of urodynamic testing. ○ Demonstrates and ability to set up, use and maintain the equipment and the measures necessary to achieve quality control. • Interprets results of more complex urodynamic assessment including: <ul style="list-style-type: none"> • Videocystourethrography • ambulatory urodynamics • urethral function studies

Refers for further investigation and management when appropriate	<ul style="list-style-type: none"> • Identifies available modalities and indications for imaging the urinary tract, makes appropriate requests and interprets results. • Interprets results appropriately for urinary tract investigations, including: <ul style="list-style-type: none"> Renal ultrasound Abdominal X-ray CT/ MRI Intravenous urogram /CT Urogram / MRI Urogram Micturating Cystogram Isotope renography (e.g. Mag 3) • Identifies available modalities and indications for investigating the gastrointestinal tract, makes appropriate requests and interprets results. • Interprets results appropriately for gastrointestinal tract investigations, including: <ul style="list-style-type: none"> ○ Anorectal function studies ○ Endoanal ultrasound ○ Defaecating proctogram / MRI ○ Barium enema ○ Contrast CT colon / Colonoscopy • Interprets pelvic floor electromyogram results. • Describes tests to patient and refers to relevant specialists. • Works within multidisciplinary team services, including Urology and Coloproctology, in regional referral pathways and in the management of complex cases.
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Evidence to inform decision

<ul style="list-style-type: none"> • Reflective practice • Direct observation of senior colleagues • Attendance at Local, Deanery and National Teaching & meetings <ul style="list-style-type: none"> ○ Attendance at a national urodynamics course ○ Attendance at a national or regional anatomy teaching/course • Works with clinicians in other disciplines and spends time in their service coloproctologists, radiologists, physiotherapists, specialist nurses Urologists and radiologists neurology, regional Neuromodulation services • Attendance at perineal & anorectal physiology investigation clinics 	<ul style="list-style-type: none"> • Confirmed participation in multidisciplinary team meetings and specialist clinics • Leads critical incident review • OSATS <ul style="list-style-type: none"> ○ Urodynamic assessment ○ Cystourethroscopy with both rigid & flexible cystoscopes ○ Bladder biopsy ○ Bladder scan • CbD • Mini-CEX • TO2 (including SO) • NOTSS • Annual subspecialty assessment
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Knowledge Criteria

- Relevant anatomy, physiology and pathophysiology of pelvic floor conditions
- Which investigations are appropriate based on clinical assessment
- Investigations of lower urinary tract:
 - Urinalysis
 - Urine culture and cytology
 - Frequency/volume charts
 - Pad test
 - Bladder scan
 - Uroflowmetry
 - Cystometry
 - Videocystourethrography
 - Ambulatory urodynamics
 - Urethral function studies
 - Cystourethroscopy: rigid/flexible
 - Bladder Biopsy
- Investigations of upper urinary tract:
 - Renal ultrasound
 - Abdominal X-ray
 - Intravenous urogram / CT Urogram / MRI Urogram
 - Micturating Cystogram
 - Isotope renography (e.g. Mag 3)
- Neurourology:
 - Pelvic floor electromyography (use of sacral nerve stimulators, tibial nerve stimulation)
- Pelvic floor investigation:
 - Magnetic resonance imaging
 - Ultrasound of pelvic floor
- Colorectal investigations:
 - Anorectal function studies
 - Barium enema
 - Contrast CT colon / Colonoscopy
 - Defaecating proctogram
- The impact of results on clinical management
- The role of more complex urodynamic assessment techniques and when to perform them
- Effects of abnormal anatomy, physiological events and systemic disease; the related symptoms and clinical findings
- Principles of pharmacology and mode of action of substances acting on pelvic organs and lower urinary tract
- Indications for different types of catheters, insertion of catheters and intermittent self-catheterisation
- Indications for and fitting of ring, shelf and other pessaries
- Use of different charts to assess intake and/or output and to assess and treat women with excessive voiding patterns
- Pharmacology, including mechanism of action, adverse effects and interaction, for treatment of:

Overactive bladder syndrome

Nocturnal frequency and nocturia

Stress urinary incontinence

Painful bladder syndrome

Use of hormone replacement therapy

- Effects of drugs used in other conditions on the lower urinary tract system
- Principles of different modalities of pelvic floor exercises:
 - Cones
 - Electrical therapy
 - Magnetic stimulator
 - Biofeedback
- Principles of and possible indications for treatment overactive bladder syndrome:
 - Biofeedback
 - Acupuncture
 - Hypnotherapy
 - Psychotherapy
- Surgical principles for the treatment of complex urodynamic stress incontinence and detrusor overactivity:
 - Artificial urinary sphincters
 - Augmentation cytoplasty
 - Urinary diversion procedures
- The investigation and diagnostic criteria for fistulae (vesicovaginal, urterovaginal, urethrovaginal) and the surgical principles for repair and complications that may occur
- Urethral diverticula
- Treatments for ureteric obstruction and ureteric injury, including ureteric stents (double J stents or ureteric catheters)
- Surgical principles of ureteric reanastomosis and reimplantation techniques
- Methods of investigations and principles of treatment of incontinence:
 - Secondary anal sphincter repair
 - Bulking agents
 - Pelvic floor exercises
 - Surgical management of rectal prolapse such as delormes, rectopexy
 - Use of constipating agents
- Methods of investigations and principles of treatment for emptying problems:
 - Use of laxatives / conservative therapies
 - Transanal repair of rectocele
- Methods of investigations and principles of treatment for urgency:
 - Biofeedback
 - Drug treatment
 - Behavioural modification
- Investigations and principles of treatment of enteric fistulae, including those involving bladder, vagina, anus or perineum
- Effects of neurological conditions on lower urinary tract function
- Lower urinary tract manifestations of:
 - Spina bifida
 - Multiple sclerosis

- Parkinson's disease
- Spinal cord injury
- Lower motor neuropathy
- Stroke

CiP 3: The doctor is competent in non-surgical management of pelvic floor dysfunction.

Key Skills	Descriptors
Demonstrates conservative management of pelvic floor dysfunction	<ul style="list-style-type: none"> ● Recognises the importance of non-surgical management in the treatment pathway and explains this to patients. ● Manages patients with agreed clinical pathways and evidence-based guidelines. ● Is aware of referral of patients to physiotherapists and nurse specialists at an early stage of the treatment pathway. ● Works in a multidisciplinary team and liaises appropriately with community continence services. ● Counsels patients on containment measures and support groups.
Demonstrates conservative management of overactive bladder syndrome	<ul style="list-style-type: none"> ● Analyses charts (frequency, frequency/volume, input/output) and counsels accordingly. ● Implements drug therapy appropriately and counsels on success and adverse effects. ● Manages patients with mixed urinary incontinence as part of a multidisciplinary team. ● Counsels on the role of neuromodulation in management of pelvic floor disorders, including potential complications and refers appropriately.
Demonstrates conservative management of stress urinary incontinence	<ul style="list-style-type: none"> ● Assesses pelvic floor strength. ● Instructs patients on the role of pelvic floor muscle assessment and training, and other physical therapies, and refers onto colleagues as appropriate.
Demonstrates non-surgical management of pelvic organ prolapse	<ul style="list-style-type: none"> ● Assesses and manages complications of vaginal pessaries as part of a multidisciplinary team, referring on to other specialties when appropriate.
Manages indications and use of the different types of urinary catheters	<ul style="list-style-type: none"> ● Demonstrates understanding of the indications, usage and potential complications for the different types of catheters. ● Manages complications of catheters appropriately. ● Counsels on and teaches intermittent self-catheterisation and manages complications appropriately.
Initiates management of faecal incontinence	<ul style="list-style-type: none"> ● Requests appropriate investigations and interprets results. ● Formulates a management plan and modifies it if necessary. ● Initiates conservative management for faecal urgency and incontinence, including behavioral therapy.
Initiates management of obstructive defaecation	<ul style="list-style-type: none"> ● Requests appropriate investigations and interprets results independently.

	<ul style="list-style-type: none"> • Formulates a management plan and modifies it independently if necessary. • Initiates conservative management independently, including behavioral therapy.
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Evidence to inform decision

<ul style="list-style-type: none"> • Reflective practice • Attend a physiotherapy clinic and observe management given by pelvic floor physiotherapist • Attend a continence clinic and observe continence nurse • Confirmed participation in specialist clinics and multidisciplinary team meetings • Works with clinicians in other disciplines and spends time in their service coloproctologists, radiologists, physiotherapists, specialist nurses Urologists and radiologists neurology, regional Neuromodulation services • Attendance at perineal & anorectal physiology investigation clinics • Observation of, assisting and discussion with senior medical staff • Personal study 	<ul style="list-style-type: none"> • Demonstrates adequate exposure during training • CbD • Mini-CEX • OSATS: <ul style="list-style-type: none"> ○ Inserts and changes suprapubic catheters • Feedback with trainer • TO2 (including SO) • Attendance at local/deanery teaching or training days/courses • Annual subspecialty assessment
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Knowledge criteria

<ul style="list-style-type: none"> • Relevant anatomy, physiology and function to the clinical situation • The role of pharmacology in pelvic floor dysfunction, including mechanism of action, adverse effects and interaction, for treatment of: <ul style="list-style-type: none"> ○ Overactive bladder syndrome ○ Nocturnal frequency and nocturia ○ Stress urinary incontinence ○ Painful bladder syndrome ○ Use of hormone replacement therapy • The role of pharmacology, including mechanism of action, adverse effects and interaction of hormone replacement therapy • The effects of drugs used in other conditions on the lower urinary tract system • The principles of bladder retraining and how to instruct patients on this treatment • The role of neuromodulation in the treatment of OAB, including tibial nerve stimulation, and how to counsel on success and adverse effects • The role of pelvic floor re-education in female urinary incontinence and other available physical therapies • The principles of different modalities of pelvic floor exercises: <ul style="list-style-type: none"> ○ Cones ○ Electrical therapy ○ Magnetic stimulator

- Biofeedback

- The indications for and fitting of ring, shelf and other pessaries
- The principles of management of faecal urgency & incontinence
- The conservative management for faecal urgency & incontinence, including behavioral therapy
- The role of pelvic floor exercises and biofeedback
- Understands the role of sacral neuromodulation for faecal incontinence and has observed the procedure
- The principles of management of obstructive defaecation
- The pharmacology, role and complications of laxatives and other drug therapies for these conditions
 - The role of the multidisciplinary team in patient management and how to refer on as appropriate
- Effects of abnormal anatomy, physiological events and systemic disease, related symptoms and clinical findings
- Indications for different types of catheters, insertion of catheters and intermittent self-catheterisation
- Use of different charts to assess intake and/or output and to assess and treat women with excessive voiding patterns
- Principles of and possible indications for treatment of overactive bladder syndrome:
 - Biofeedback
 - Acupuncture
 - Hypnotherapy
 - Psychotherapy
- Surgical principles for the treatment of complex urodynamic stress incontinence and detrusor overactivity:
 - Artificial urinary sphincters
 - Augmentation cytoplasty
 - Urinary diversion procedures
- The investigation and diagnostic criteria for fistulae (vesicovaginal, urterovaginal, urethrovaginal) and the surgical principles for repair and complications that may occur
- Urethral diverticula
- Treatments for ureteric obstruction and ureteric injury, including ureteric stents (double J stents or ureteric catheters)
- Surgical principles of ureteric reanastomosis and reimplantation techniques
- Methods of investigations and principles of treatment of incontinence:
 - Secondary anal sphincter repair
 - Bulking agents
 - Pelvic floor exercises
 - Surgical management of rectal prolapse such as delormes, rectopexy
 - Use of constipating agents
- Methods of investigations and principles of treatment for emptying problems:
 - Use of laxatives / conservative therapies
 - Transanal repair of rectocele
- Methods of investigations and principles of treatment for urgency:
 - Biofeedback

- Drug treatment
- Behavioural modification
- Investigations and principles of treatment of enteric fistulae, including those involving bladder, vagina, anus or perineum
- Effects of neurological conditions on lower urinary tract function
- Lower urinary tract manifestations of:
 - Spina bifida
 - Multiple sclerosis
 - Parkinson's disease
 - Spinal cord injury
 - Lower motor neuropathy
 - Stroke
- Pelvic floor electromyogram:
 - Use of sacral nerve stimulators
 - Tibial nerve stimulation

CiP 4: The doctor is competent to undertake surgical treatment of pelvic floor disorders.

Key Skills	Descriptors
Counsels patients wishing surgical management of pelvic floor disorders	<ul style="list-style-type: none"> ● Formulates a management plan and modifies if necessary. ● Counsels on the different surgical options for prolapse and incontinence including non-surgical alternatives, other surgical options, complications and outcomes and takes consent for surgery accordingly. ● Counsels patients with failed previous surgery.
Performs safe surgical practice	<ul style="list-style-type: none"> ● Selects patients appropriately for vaginal, abdominal or laparoscopic prolapse procedures and/or continence surgery. ● Performs surgery for primary, and recurrent, prolapse and stress urinary incontinence independently in a fluent and safe manner.
Diagnoses and manages intra- and postoperative complications	<ul style="list-style-type: none"> ● Inspects bladder, ureter, small and large bowel for perforation or damage, and undertakes appropriate special tests such as air insufflation and use of dyes to aid recognition of injury. ● Recognises and repairs bladder injuries and institutes appropriate postoperative bladder drainage. ● Recognises and observes management of other intraoperative visceral injury including bowel, urethra and ureters. ● Recognises and controls haemorrhage until appropriate help, if required, is available. ● Recognises delayed onset complications such as peritonitis, ileus, faecal contamination or urinary leakage. ● Recognises postoperative ureteric injury or obstruction and initiates investigations and management with urology team. ● Uses upper renal tract investigations appropriately.

	<ul style="list-style-type: none"> Recognises role of other specialists in the management of surgical complications.
Selects appropriate mesh and counsels patient regarding benefits and risks of mesh use	<ul style="list-style-type: none"> Applies up to date knowledge and guidelines to mesh selection and use. Counsels patients independently regarding mesh complications including infection, erosion, extrusion and chronic pain.
Actively participates in clinical audit	<ul style="list-style-type: none"> Commits to audit of procedures according to guidelines. Uses nationally recommended databases, such as BSUG audit database. Engages in local audits and leads a minimum of one audit per year which must include one surgical audit.
Performs incontinence and prolapse surgery and manages complications	<ul style="list-style-type: none"> Demonstrates understanding of what clinical findings require referral for assessment or further management by Urology. Is able to perform procedures listed below. Recognises when it is unsafe to continue with a procedure laparoscopically and the need to convert to a laparotomy, call for support, or when the procedure should be abandoned altogether.
Manages postoperative voiding difficulty	<ul style="list-style-type: none"> Instructs nursing staff on catheter management following continence surgery. Counsels patients on the different types of catheters (intermittent, urethral, suprapubic), explaining potential use, advantages, appropriateness and risks. Supervises a patient undergoing a programme of intermittent self-catheterisation.

Evidence to inform decision

<ul style="list-style-type: none"> Reflective practice NOTSS Attendance at theatre lists Attendance at Post-operative Ward Rounds Attendance at Risk Management meetings Leads critical incident review Direct observation / consultant supervision within the module Tailored clinical experience under supervision <ul style="list-style-type: none"> Personal study Appropriate postgraduate education courses and reading Recorded outcome on national databases (e.g. BSUG) CbD Feedback from trainer 	<ul style="list-style-type: none"> OSATS <ul style="list-style-type: none"> Administration of Botulinum Toxin for the management of Refractory OAB, through both rigid and flexible cystoscopes Non-mesh Anterior repair (colporrhaphy) Non-mesh Posterior repair (colporrhaphy) Vaginal hysterectomy for prolapse Uterosacral plication or McCall's culdoplasty for vault support at vaginal hysterectomy Sacrospinous fixation Laparoscopic and open Sacrocolpexy Close port sites safely with all entry techniques
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<ul style="list-style-type: none"> • TO2 (including SO) • Annual subspecialty assessment • Attendance at multi-professional team meetings • Attendance at regional mesh complications MDT • Participation and completion of audit 	<ul style="list-style-type: none"> ○ Suture using laparoscopic needle holders ○ Undertake intra-corporeal and extracorporeal knot tying ○ At least 2 first-line Stress urinary Incontinence Procedures in line with NICE guidance and as relevant to local services, e.g. colposuspension (open or laparoscopic), Autologous Fascial Sling ○ Bladder neck injections ○ Management of intraoperative bladder injury ○ Insertion of uretric stent/catheters
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Knowledge Criteria

- The indications and complications of surgical procedures in management of pelvic floor dysfunction
- The ASA score of fitness for surgery, and implications of co-morbidities, such as previous surgery and Body Mass Index, of procedure choice, success rates and potential complications
- Knowledge of appropriate preoperative investigations
- The equipment for vaginal, open and laparoscopic procedures and theatre set-up
- Diathermy instrumentation:
 - How to use laparoscopic bipolar energy effectively and at least one energy source for cutting, i.e. monopolar or ultrasound
 - The principles underlying other types of energy sources
 - The safety checks required before activating the energy source
- Potential surgical complications and how to avoid them
- Relevant anatomy including anatomy of sacral promontory
- Safe laparoscopic entry and choosing correct entry for each patient, including use of veress needle, open entry, direct vision entry, palmer's point entry
- The principles of surgical site closure, including port site closure in laparoscopic surgery, and the need to avoid surgical site hernia or damage underlying structures
- The principles of more complex repairs such as segmental bowel resection and ureteric anastomosis and reimplantation
- The principles underlying the repair of major vessels
- The role of synthetic mesh in line with national guidelines, including the potential risks as well as benefits of mesh procedures
- The indications, and potential complications of urethral dilatation
- The variations of apical procedures, such as sacrohysteropexy
- The various types of mesh available and their suitability for sacrocolpopexy and sacrohysteropexy
- The need for preparation of the patient with oestrogen cream where there is atrophy
- The methods of mesh fixation to the sacral promontory, including safe use of stapling devices
- The use of imaging in assessment and management of postoperative complications
- The role of investigations and diagnostic criteria for fistulae (vesicovaginal, ureterovaginal, urethrovaginal)

- The role of the multidisciplinary team in management of these patients and how to refer on as appropriate
- The surgical principles of fistula repair and complications that may occur
- The role of investigations and diagnostic criteria for urethral diverticula
- The surgical principles of diverticulum surgery and complications that may occur
- Potential complications following mesh procedures for incontinence and/or prolapse
- Understands the surgical principles for the treatment of complex urodynamic stress incontinence and detrusor overactivity, including the following procedures:
 - Artificial urinary sphincters
 - Augmentation cytoplasty
 - Urinary diversion procedures
 - Sacral Nerve Stimulation
 - Bladder-neck injections
 - Botulinum toxin injections
 - Sacral nerve stimulation
- The principles for treating voiding difficulties, including urethral dilatation, postoperative problems, and the advantages/disadvantages of different techniques
- The principles for treating pelvic organ prolapse, including:
 - Anterior and posterior repairs
 - Paravaginal repair
 - Vaginal hysterectomy
 - Uterosacral plication or McCal culdoplasty for vault support at hysterectomy
- The principles for treating vault prolapse, including:
 - Sacrospinous fixation
 - Sacrocolpopexy (open and laparoscopic)
- How to audit surgical outcomes
- The principles of subsequent management
- What preoperative and postoperative care the patient needs
- Surgical principles for the treatment of complex urodynamic stress incontinence and detrusor overactivity:
 - Artificial urinary sphincters
 - Augmentation cytoplasty
 - Urinary diversion procedures
- The investigation and diagnostic criteria for fistulae (vesicovaginal, uterovaginal, urethrovaginal) and the surgical principles for repair and complications that may occur
- Urethral diverticula
- Treatments for ureteric obstruction and ureteric injury, including ureteric stents (double J stents or ureteric catheters)
- Surgical principles of ureteric reanastomosis and reimplantation techniques
- Methods of investigations and principles of treatment of incontinence:
 - Secondary anal sphincter repair
 - Bulking agents
 - Pelvic floor exercises
 - Surgical management of rectal prolapse such as delormes, rectopexy
 - Use of constipating agents

- Methods of investigations and principles of treatment for emptying problems:
 - Use of laxatives / conservative therapies
 - Transanal repair of rectocele
- Methods of investigations and principles of treatment for urgency:
 - Biofeedback
 - Drug treatment
 - Behavioural modification
- Investigations and principles of treatment of enteric fistulae, including those involving bladder, vagina, anus or perineum
- Effects of neurological conditions on lower urinary tract function
- Lower urinary tract manifestations of:
 - Spina bifida
 - Multiple sclerosis
 - Parkinson's disease
 - Spinal cord injury
 - Lower motor neuropathy
 - Stroke
- Pelvic floor electromyogram:
 - Use of sacral nerve stimulators
 - Tibial nerve stimulation

SECTION 2: PROCEDURES

Procedures	Level by end of training	CIP 2	CIP 3	CIP 4
Urodynamic assessment	5	X		
Urethral function studies	2	X		
Videourodynamic function studies	2	X		
Ambulatory urodynamic studies	2	X		
Cystourethroscopy with both rigid & flexible cystoscopes	5	X		
Bladder biopsy	5	X		
Bladder scan	5	X		
Pelvic floor EMG	1	X		
Renal ultrasound	1	X		
Intravenous urogram / CT urogram / MRI urogram	1	X		
Micturating cystogram	1	X		
Isotope renography	1	X		
Ultrasound of the pelvic floor	1	X		
MRI scan of the pelvic floor	1	X		
Barium enema	1	X		
Contrast CT / Colonoscopy	1	X		
Anorectal function studies	1	x		
Defaecating proctogram	1	X		
Endoanal ultrasound	1	X		
Sacral nerve stimulation	1		X	
Posterior tibial nerve stimulation	1		X	
Teaches CISC	3		X	
Inserts and changes pessaries	5		X	
Administration of Botulinum Toxins for the management of Refractory OAB, through both rigid and flexible cystoscopes	5			X
<i>Vaginal surgery for primary and recurrent pelvic organ prolapse</i>				
• Non-mesh anterior repair (colporrhaphy)	5			X
• Non-mesh posterior repair (colporrhaphy)	5			X
• Vaginal hysterectomy for prolapse	5			X
• Uterosacral plication or McCall's culdoplasty for vault support at vaginal hysterectomy	5			X
• Sacrospinous fixation	5			X
<i>Abdominal and laparoscopic surgery for pelvic organ prolapse</i>				
• Laparoscopic and open sacrocolpopexy	5			X
<i>Advanced laparoscopic surgery</i>				
• Close port sites safely with all entry types	5			X
• Suture using laparoscopic needle holders	5			X
• Undertake intra-corporeal and extracorporeal knot tying	5			X
<i>At least 2 first-line stress urinary incontinence procedures in line with NICE guidance and as relevant to local services, e.g.</i>				

• Colposuspension (open or laparoscopic)	5			X
• Autologous fascial sling	5			X
Bladder neck injections	5			X
Management of intraoperative bladder injury	5			X
Insertion of ureteric stent / catheters	5			X
<i>Other prolapse procedures e.g.</i>				
• Colpocleisis	1			X
• Manchester repair	1			X
Repair of enteric fistulae	1			X
Transanal repair of rectocele	1			X
Delormes procedure	1			X
Rectopexy	1			X
Secondary anal sphincter repair	1			X
Artificial urinary sphincter	1			X
Augmentation cytoplasty	1			X
Vesico vaginal Fistula repair	1			X
Urethrovaginal fistula repair	1			X
Nephrostomy	1			X
Urinary diversion procedures	1			X
Uretric reanastomosis and reimplantation	1			X
Urethral diverticulectomy	2			X
Urethral dilatation	1			X
Surgical management of mesh complications	2			X

SECTION 3: GMC GENERIC PROFESSIONAL CAPABILITIES

Mapping to GPCs

Domain 1: Professional values and behaviours

Domain 2: Professional skills

- Practical skills
- Communication and interpersonal skills
- Dealing with complexity and uncertainty

Domain 3: Professional knowledge

- Professional requirements
- National legislative structure
- The health service and healthcare system in the four countries

Domain 5: Capabilities in leadership and team working

Domain 6: Capabilities in patient safety and quality improvement

Domain 8: Capabilities in education and training

Domain 9: Capabilities in research and scholarship

SECTION 4: MAPPING OF ASSESSMENTS TO CiPs

CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: The doctor has the knowledge, skills and attitudes required for clinical assessment of pelvic floor dysfunction.		X	X		X	X
2: The doctor selects and performs appropriate tests and interprets the results.	X	X	X	X	X	X
3: The doctor is competent in non-surgical management of pelvic floor dysfunction.	X	X	X		X	X
4: The doctor is competent to undertake surgical treatment of pelvic floor disorders.	X		X	X	X	X

4 The research component of subspecialty training

The aim of the research component of the subspecialty training programme is to ensure that subspecialty-accredited doctors are competent in the design and execution of a research study of sufficient quality to meet internationally recognised standards of research excellence, such as those published in the Medical Research Council's [Good research practice: principles and guidelines](#). Trainees will need to demonstrate expertise in clinical and/or laboratory research methodology including the ability to:

- critically assess research papers
- design and run a research project
- understand statistical methods
- be aware of the ethical issues involved in research

Trainees also need to either:

- complete the research component of the subspecialty training programme **or**
- obtain research exemption through published output.

4.1 Research exemption

All applications for exemption are reviewed by the RCOG's [Subspecialty Committee](#). Trainees will still be expected to undertake research during subspecialty training, even if they have fulfilled the research criteria before entering the programme. Approval of research exemption before starting subspecialty training requires:

- Completion of a research or academic programme that has led to the award of an MD (Res) or PhD thesis, **OR**
- Publication of two first-author papers of original research in citable, refereed [MEDLINE](#) journals relevant to the subspecialty, **OR**
- Satisfactory completion of the [Clinical Research Advanced Professional Module \(APM\)](#)

If research exemption is granted at commencement of training the trainee will undergo a two-year subspecialty training programme subject to achieving the clinical competences within two years. If the trainee has completed a period of research before starting subspecialty training but has not yet fulfilled the published output criteria they will be registered for a three-year programme. The trainee should apply for research exemption once the published output criteria have been fulfilled. The overall progress of clinical progression will be assessed at the next SST assessment to establish the remaining training time.

Completion of the research criteria at the end of a three-year subspecialty training programme requires:

- Completion of a research or academic programme that has led to the award of an MD (Res) or PhD thesis, **OR**
- Publication of two first-author papers of original research in citable, refereed [MEDLINE](#) journals relevant to the subspecialty, preferably (but not necessarily) arising from a dedicated period of research lasting at least one year **OR**
- Satisfactory completion of the [Clinical Research Advanced Professional Module \(APM\)](#)

As the subspecialty training programme is a capability based programme it is therefore expected that if the trainee does not fulfil the research exemption requirement before commencing the programme, they will require three years to achieve both research and clinical capabilities stipulated in the subspecialty programme.

MD/PhD

- The MD (Res)/PhD **must** be relevant to the chosen subspecialty. An MD (Res) awarded from a university outside Great Britain or Ireland would not be considered equivalent to a UK MD (Res)
- An international PhD may be considered equivalent to a UK PhD if the trainee can provide supporting evidence that a period of supervised research led to the award of

the PhD; the Subspecialty Committee requires supporting evidence before they can grant equivalence

Published papers

- First-author papers must be relevant to the chosen subspecialty
- Review articles (other than high-quality systematic reviews, preferably [Cochrane Reviews](#)) and case reports are excluded
- 'Exceptional' requests (i.e. a non-first author paper that the trainee wishes to be accepted as one paper towards research exemption) will be considered only if a minimum research period of two years has been undertaken, a fellowship whose primary purpose was to coordinate a trial has been completed, or there is supporting evidence of active involvement in all aspects of delivery of the study and authorship of an article published in a high-impact journals such as the [New England Journal of Medicine](#), [The Lancet](#), [BMJ](#) or [Nature](#).

4.2 Advanced Professional Module Clinical Research

UG trainees can choose to take the APM Clinical Research as a way of completing the research component if they are not research-exempt. The APM is the first in a new suite of modules that are designed to enhance the acquisition of generic professional skills.

The aim is to define the skills that a consultant Obstetrician/Gynaecologist requires in order to support clinical research service as an active participant (Principal Investigator, co-applicant/collaborator, recruiter) in a primary, secondary or tertiary care setting. The APM can be completed as an optional module for O&G trainees who have an interest in academic training any time during their specialty training, generally from ST3. It is also intended to be available to NHS O&G consultants to develop their skills and knowledge.

4.3 Non-completion of research component

If the trainee reaches the end of subspecialty training without satisfying the research criteria, they will be offered a maximum 6-month extension to complete the research element, at the discretion of the Postgraduate Dean.

If the trainee reaches the end of the 6-month extension without completing the research component, the RCOG's [Subspecialty Committee](#) will not award subspecialty accreditation unless there are extenuating circumstances. Award of the [CCT](#) will be at the discretion of the Local Education Training Board / Deanery, although this might involve a further period of general training.

5 Learning and Teaching

5.1 The core training programme

The organisation and delivery of postgraduate training is the responsibility of the Health Education England (HEE) and Local Education Offices (LETBs), NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical and Dental Training Agency (NIMDTA). A Training Programme Director will be responsible

for coordinating the O&G training programme in each deanery. The local organisation and delivery of training is overseen by a school of O&G.

Progression through the programme will be determined by the annual review of curriculum progression (ARCP) process and the training requirements for each indicative year of training are summarised in the O&G ARCP decision aid. The successful completion of each stage of training will be dependent on achieving the expected level in all CiPs and procedural skills. The programme of assessment will be used to monitor and determine progress through the programme. Training will normally take place in a range of settings, e.g. community, District General Hospitals and Teaching Hospitals.

The sequence of training should ensure appropriate progression in experience and responsibility. The training to be provided at each training site is defined to ensure that, during the programme, the entire syllabus is covered and also that unnecessary duplication and educationally unrewarding experiences are avoided. The sequence of training should ideally be flexible enough to allow the trainee to develop a special interest which can be taken forward during the advanced training period.

5.2 The general training environment

In order to fulfil the UG curriculum requirements, trainees need to train and work in high quality training environments. The GMC has clear standards in its [Promoting excellence document](#) which specify that employers must provide trainers with the support and resources they need to meet their education and training responsibilities. Employers should also protect time for training and produce rotas that help deliver that goal. Where the GMC survey shows this is not happening, they expect employers to take action to ensure their training environments meet their standards.

The RCOG annual trainee evaluation form (TEF) and subsequent analyses also provides longitudinal data for schools and units to use to drive improvements in the education they provide. The TEF data is specialty specific so can provide detailed feedback on specific areas of training and education that support curriculum delivery.

The RCOG has produced new quality criteria, based on GMC and RCOG standards and good practice noted through the TEF exercise, which will enable individual training placements to benchmark the education and training they provide and further develop high quality placements. These will detail how we can enable trainees to:

- Provide safe and effective care.
- Have a supportive working environment.
- Enjoy a better educational experience.

The quality criteria provide guidance regarding the range and access to informal, formal and experience-based learning that will be required to fulfil the curriculum requirements. The curriculum will provide a balance of different learning methods for trainees to progress through, from formal teaching programmes to learning 'on the job'. The proportion of time allocated to each method may vary depending on the nature of the attachment within a rotation. Rotations should be constructed to enable the trainee to experience the full range of educational and training opportunities.

Informal learning methods will include:

- **Learning with peers** - There are many opportunities for trainees to learn with their peers. Local postgraduate teaching opportunities allow trainees of varied levels of experience to come together for small group sessions. Examination preparation encourages the formation of self-help groups and learning sets.
- **Work-based experiential learning** - The content of work-based experiential learning is decided by the local faculty for education within a unit.

Formal postgraduate teaching sessions

The content of other formal postgraduate teaching sessions and access to other more formal learning opportunities are determined by the local faculty of O&G education. UG trainees will attend those that are of interest or relevance to them. There are many opportunities throughout the year for formal teaching locally and at regional, national and international meetings. Many of these are organised by the RCOG.

Independent self-directed learning

Trainees will use this time in a variety of ways depending upon their stage of learning.

Suggested activities include:

- Reading, including journals and web-based material such as e-Learning for Healthcare (e-LfH) and RCOG eLearning.
- Maintenance of personal portfolio (self-assessment, reflective learning, personal development plan).
- Audit, quality improvement and research projects.
- Achieving personal learning goals beyond the curriculum.

5.3 The subspecialty training environment

Subspecialty training can only be followed in a centre that has been accredited by the RCOG Subspecialty Committee. The generic criteria for accreditation are as follows:

- A centre should have sufficient caseload to support the trainee in completing the approved subspecialty curriculum within the required time frame.
- The numbers specified within the workload domain of the approval criteria would usually support one trainee, provided there is evidence of clinical supervision and timetabling for all elements of the curriculum within that centre.
- Recognition may be granted for 2 trainees per centre where there is supporting evidence from the deanery/LETB and where the centre can still deliver the breadth and depth of training.
- Mitigating factors in relation to the caseload required for recognition of a centre for subspecialty training include the track record of the training centre, working within a training network, highly specialised or supra-regional areas of clinical practice provided within that centre, and workforce requirements within a geographical area. Recognition would be unlikely where an individual centre within a network could not deliver the majority of the elements of the curriculum, or where the approval criteria are fulfilled through a rotation involving more than 2 centres.

- Recognition could be achieved where centres work together across commissioning regions or geographies to fulfil the approval criteria and reflect the need for regionalisation of training in developing the future workforce within a large region or country.
- There should be a minimum of 2 full-time consultants working as subspecialists in any centre approved for subspecialist training. Each centre should name the clinical supervisor who will deputise when the Subspecialty Training Programme Supervisor (STPS) is on leave. The Subspecialty Committee would review ongoing recognition of a centre during long-term absence of an STPS.
- Each centre should inform their deanery/LETB of the theatre lists that have been identified to prioritise training of their subspecialty trainee, and lists where training will be shared with an ATSM or other trainee.
- A trainee should complete all aspects of the curriculum and be given the opportunity to visit other centres to gain level 1 experience of highly specialised techniques relevant to the curriculum, and experience of less common conditions occurring within a population.

The criteria for UG accreditation, which are approved by the British Society for Urogynaecology, are as follows:

- Minimum number of theatre lists undertaken by designated consultant urogynaecologists = 3 per week
- Minimum number of urogynaecology outpatient clinics = 2 per week
- Minimum number of urodynamics clinics = 4 per week (mix of consultant- and nurse-led clinics)
- Minimum number of new urodynamic referrals >400 per annum
- Minimum number of new urogynaecology referrals >750 per annum
- Referrals should come from at least 3 other units (demonstration of tertiary practice)
- Surgical procedures on site or easily accessed within same service organization:
 - >40 primary procedures for SUI (excluding Urethral Bulkers), which could be a combination of the following: mid-urethral tapes/colposuspension (open or lap)/autologous fascial slings for primary stress urinary incontinence
 - >20 cases of intra detrusor botulinum toxin A injections
 - >20 cases urethral bulking agents
 - >100 cases undergoing 1 or more vaginal operations for pelvic organ prolapse
 - >30 procedures for vault prolapse/year (mix of sacrocolpopexy and sacrospinous fixation)
 - >10 procedures for recurrent/failed prolapse surgery
 - >10 procedures for recurrent/failed SUI surgery
 - >50 diagnostic cystoscopies including flexible and rigid cystoscopy (non SUI procedure cystoscopies)
 - >20 Laparoscopic apical procedures (i.e. sacrocolpopexy +/- or sacrohysteropexy/cervicopexy)
- Unit should perform, or have arrangements in place for trainee to access, laparoscopic hysterectomies.

- Conservative therapies on-site or easily accessed within the same service organisation:
 - Nurse-led urodynamics clinics = at least 2 per week
 - Women's health physiotherapist with range of physical therapies for pelvic floor dysfunction
 - Bladder training clinic = 1 per week
 - Nurse-led ISC available for outpatients
- Other clinics:
 - Perineal clinic/management of third-degree tears at specific clinic (1 per month)
 - Availability to perform video urodynamics
 - Availability for ambulatory urodynamics
- The centre must have a minimum of 2 accredited urogynaecology subspecialist consultants within unit (minimum 2 consultants or FTE with at least 6 urogynaecology clinical sessions/week **each**)
- The centre must have regular multidisciplinary team meetings
- The centre must have monthly audit meetings and/or risk management meetings
- Easy access to (<30 minutes) within the same service organisation for **ALL** of the following:
 - Urology
 - Coloproctology
 - Medical physics
 - Care of the elderly
 - Physiotherapy
 - Anorectal physiology including anorectal ultrasound
 - Neurology including MS clinics and neurophysiology
- The centre must ensure that on-call arrangements do not interfere with elective urogynaecology activities

6 Programme of Assessment

6.1 Purpose of assessment

The purpose of the programme of assessment is to:

- Assess trainees' actual performance in the workplace.
- Encourage the development of the trainee as an adult responsible for their own learning.
- Enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, understand their own performance and identify areas for development.
- Drive learning and enhance the training process by making it clear what is required of trainees and motivating them to ensure they receive suitable training and experience.
- Demonstrate trainees have acquired the GPCs and meet the requirements of good medical practice.

- Ensure that trainees possess the essential underlying knowledge required for their specialty.
- Provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme.
- Inform the ARCP, identifying any requirements for targeted or additional training where necessary and facilitating decisions regarding progression through the training programme.
- Identify trainees who should be advised to consider changes of career direction.

6.2 Programme of assessment

Our overall programme of assessment as outlined in the Core Curriculum Definitive Document refers to the integrated framework of exams, assessments in the workplace and judgements made about a learner during their approved programme of training. The purpose of the programme of assessment is to clearly communicate the expected levels of performance and ensure these are met on an annual basis and at other critical progression points, and to demonstrate satisfactory completion of training as required by the curriculum.

The programme of assessment for the UG subspecialty curriculum comprises the use of a number of individual assessment tools which are the same as those for the core curriculum, apart from the MRCOG which must have already been achieved. These include summative and formative workplace-based assessments. A range of assessments is needed to generate the necessary evidence required for global judgements to be made about satisfactory performance, progression in, and completion of, training. All assessments are linked to the relevant learning outcomes stated in the curriculum.

The programme of assessment emphasises the importance of professional judgment in making sure learners have met the learning outcomes and expected levels of performance set out in the approved curriculum. It also focuses on the learner as a reflective practitioner. Assessors will make accountable, professional judgements on whether progress has been made according to a learner's self-assessment. The programme of assessment explains how professional judgements are used and collated to support decisions on progression and satisfactory completion of training.

Assessments will be supported by structured feedback for trainees. Assessment tools, which are well established in O&G training, will be both formative and summative and have been selected on the basis of their fitness for purpose and their familiarity to trainees and trainers.

Trainees will be assessed throughout the training programme, allowing them to continually gather evidence of learning and to provide formative feedback. Those assessment tools which are not identified individually as summative will contribute to global judgements about a trainee's progress as part of the programme of assessment. The number and range of these will ensure a reliable assessment of the training relevant to their stage of training and achieve coverage of the curriculum.

Reflection and feedback should be an integral component to all workplace-based assessments. Every clinical encounter can provide a unique opportunity for reflection and feedback and this process should occur frequently – and as soon as possible after any event to maximise benefit for the trainee. Feedback should be of high quality and should include an action plan for future development for the trainee. Both trainees and trainers should recognise and respect cultural differences when giving and receiving feedback. Our assessment tools have been revised to include reflection and have been piloted during 2018.

6.3 Assessment of CiPs

The CiP is the fundamental basis of global judgement. Assessment of CiPs involves looking across a range of key skills and evidence to make a judgement about a trainee's suitability to take on particular responsibilities or tasks as appropriate to their stage of training. It also involves the trainee providing self-assessment of their performance for that stage of training.

Clinical Supervisors and others contributing to assessment will provide formative feedback to the trainee on their performance throughout the training year. Evidence to support the global rating for the CiP will be derived from workplace-based assessments and other evidence, e.g. TO2.

6.4 The global judgement process

Towards the end of the training year, trainees will assess their own progression for each CiP (Figure 3a) and record this in the ePortfolio, signposting to the evidence that supports their rating. The Subspecialty Training Programme Supervisor (STPS) will review the evidence in the ePortfolio including workplace-based assessments, the TO2 and the trainee's self-assessment and record their global judgement of the trainee's performance in the Subspecialty Educational Supervisor Report (SST ESR), with commentary. Figure 3b shows how the trainee's self-assessment and the evidence feed into the global judgement by the STPS.

Figure 3a – Trainee self-assessment of a CiP

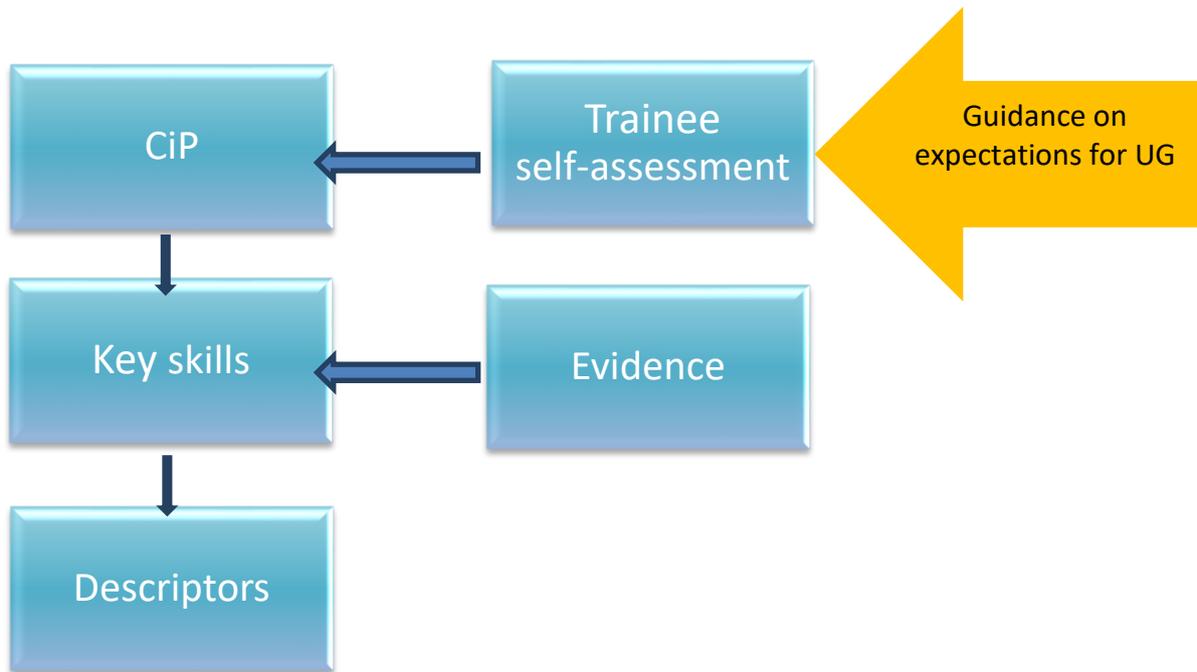
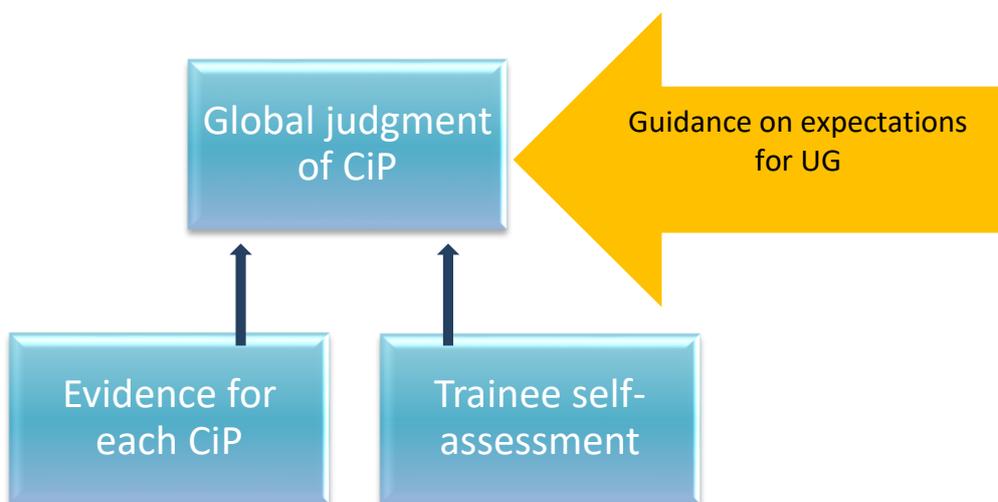


Figure 3b – STPS assessment of all CiPs



The trainee will make a self-assessment to consider whether they meet expectations for the UG subspecialty as a whole, using the five supervision levels listed in Table 3 and highlighting the evidence in the ePortfolio. The STPS will indicate whether the trainee is meeting expectations or not by assigning one of the five supervision levels, as in the template below.

Table 3 shows the five supervision levels that are based on an entrustability scale which is a behaviourally anchored ordinal scale based on progression to competence and reflects judgments that have clinical meaning for assessors¹.

Table 2 – Levels of supervision

Level	Descriptor
Level 1	Entrusted to observe
Level 2	Entrusted to act under direct supervision: (within sight of the supervisor).
Level 3	Entrusted to act under indirect supervision: (supervisor immediately available on site if needed to provide direct supervision)
Level 4	Entrusted to act independently with support (supervisor not required to be immediately available on site, but there is provision for advice or to attend if required)
Level 5	Entrusted to act independently

Global judgement to be used for each CiP

Trainee self-assessment

FOR EACH CiP

Statement of what level of supervision is required.

Link to evidence on the ePortfolio.

STPS Educational Supervisors assessment

I agree with the trainee’s self-assessment and have added my comments to each CiP.

I do not agree with the trainee’s self-assessment for the following reasons:

STPS Educational Supervisors global judgement of the CiPs

I consider that the trainee’s performance overall meets the clinical entrustability scale of 1-5 (specify) and that the trainee is:

- Not meeting expectations for the subspecialty training in UG; may not meet the requirements for critical progression point

¹ [Entrustability Scales: Outlining Their Usefulness for Competency-Based Clinical Assessment](#)

- Meeting expectations for the subspecialty training in UG; expected to progress to next stage of training

The generic skills for subspecialty training, i.e. communication, team working, leadership, good medical practice and maintaining trust, teaching, research, governance and risk management, administrative skills and service management, information use and management will be evidenced and assessed through the generic CiPs in the core curriculum. The evidence will need to be at an appropriate level for a subspecialist. The expectations for the UG curriculum as a whole for generic CiPs will be specified in the UG curriculum guidance. Those subspecialty trainees who are undertaking subspecialty training post-CCT will be signposted to the relevant generic CiPs and advised in the guidance that they will need to include evidence within their ePortfolio for these.

6.5 Assessment of progression

Subspecialty trainees will be formally assessed on an annual basis prior to their ARCP by a subspecialty assessment panel as to whether the trainee is making sufficient progress to complete the UG curriculum and acquired the procedural competence required. The recommended outcome of the SST assessment will feed into the Educational Supervisor Report (ESR). The ESR will make a recommendation to the ARCP panel on progress to complete the UG curriculum. The ARCP panel will make the final decision on whether the trainee can be signed off and progress to the next year.

The UG curriculum contains an outline grid of progress in procedures expected for each CiP.

Table 3 outlines the defined levels of achievement for the CiPs required for each year of UG training.

Table 3 – Outline grid of progress expected for UG CiPs

Level descriptors for clinical CiPs

Level 1 - Entrusted to observe

Level 2 - Entrusted to act under direct supervision

Level 3 - Entrusted to act under indirect supervision

Level 4 - Entrusted to act independently with support

Level 5 - Entrusted to act independently

Capabilities in practice	UG SST		Subspecialty Accreditation
	Progress expected by completion of 12 months WTE of clinical training	Progress expected by completion of 24 months WTE of clinical training	CRITICAL PROGRESSION POINT
1: The doctor has the knowledge, skills and attitudes required for clinical assessment of pelvic floor dysfunction.	3	5	

2: The doctor selects and performs appropriate tests and interprets the results.	3	5	
3: The doctor is competent in non-surgical management of pelvic floor dysfunction.	3	5	
4: The doctor is competent to undertake surgical treatment of pelvic floor disorders	2	5	

6.6 Evidence of progress

Many trainees work less than full time, and other trainees spend only a proportion of their working week in clinical subspecialty training if this is combined with an academic lecturer post. For those trainees on a three year programme, the proportion of time spent undertaking the research component and clinical training will vary over the three years although the total whole time equivalent clinical training will be two years, and one year for the research requirements. It is therefore not possible to write a matrix which takes accounts of all these variations in the pattern of subspecialty training. At each subspecialty assessment, the panel will judge the evidence provided against the period of whole time equivalent CLINICAL training time and not the number of calendar months since training began or since the last assessment. It is expected that the subspecialty educational supervisors, through their reports, will make it clear to the assessment panel how much WTE clinical training is being assessed.

Some subspecialty trainees will accrue skills and competencies steadily across all the capabilities in practice, throughout their subspecialty training, and the matrix gives guidance as to what is deemed adequate progress by the end of the first 12 months WTE of clinical training. However, other trainees follow a modular approach during subspecialty training, and the progression through the CiPs will be quite different for them and their progress may not be so readily compared to the matrix. For these trainees, assessors will be expecting completion of some CiPs ahead of time, whilst others may not have been commenced by the end of the first 12 WTE months of clinical training. It is not possible to create a didactic matrix which covers all training programmes, and common sense and professional judgement will be required, in the same way as it was in the previous curriculum, with respect to competency accrual and sign off of CiPs.

The following methods of assessment will provide evidence of progress. The requirements for each training year/level are stipulated in the Matrix of Progression. Evidence is a crucial concept in the new curriculum, and as well as the methods listed below, can include other sources, such as the Personal Development Plan or quality improvement project or procedure log. The trainee will collect evidence to support their self-assessment, and the STPS will use it to reach a global judgement. These methods are described briefly below. More information and guidance for trainees and assessors are available in the ePortfolio and on the RCOG website (www.rcog.org.uk).

Summative assessment

- Objective Structured Assessment of Technical Skills (OSATS) - summative

Formative assessment

- Case-Based Discussions (CbD)
- Mini-Clinical Evaluation Exercise (mini-CEX)
- OSATS - formative
- Team Observation (TO1), TO2 and Self-observation (SO)
- Non-Technical Skills for Surgeons (NOTSS)

Supervisor report

- Educational Supervisor Report (ESR)
- Subspecialty Educational Supervisor Report (SST ESR)

Objective Structured Assessment of Technical Skills (OSATS)

There are a number of fundamental procedures in each ATSM that require an objective assessment tool to aid the review process. OSATS are validated assessment tools that assess technical competency in a particular technique. OSATS will be completed throughout training until the trainee is competent to practise independently. OSATS can be undertaken as many times as the trainee and their supervisor feel is necessary (formative). A trainee can be regarded as competent to perform a procedure independently after they have completed 3 summative OSATs by more than one appropriate assessor.

Case-based Discussion (CbD)

The CbD assesses the performance of a trainee in their management of a patient to provide an indication of competence in areas such as clinical reasoning, decision making and application of medical knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by trainees. The CbD should focus on a written record (such as written case notes, out-patient letter, discharge summary). A typical encounter might be when presenting newly referred patients in the outpatient department.

Mini-Clinical Evaluation Exercise (mini-CEX)

This tool evaluates a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as history taking, examination and clinical reasoning. The trainee receives immediate feedback to aid learning. The mini-CEX can be used at any time and in any setting when there is a trainee and patient interaction and an assessor is available.

Multi-source feedback

The TO1 form is a multi-source feedback tool based on the principles of [good medical practice](#), as defined by the [General Medical Council \(GMC\)](#). TO1 forms are used to obtain feedback from a range of healthcare professionals and forms part of a trainee's assessment. The TO1 is a snapshot feedback tool to be used by individuals at a fixed point in time.

Individual team members completing a TO1 form should do so based on their experience of working with the trainee. The trainee will also be able to self-assess using a modified TO1 form (SO) which has been piloted along with the modified WBA tools. The TO1 forms are summarised in a TO2 form which informs the ARCP.

Non-Technical Skills for Surgeons (NOTSS) - new

The NOTSS system provides a framework and common terminology for rating and giving feedback on non-technical skills. Used in conjunction with medical knowledge and clinical skills, NOTSS is a tool to observe and rate behaviour in theatre in a structured manner. This enables clear and transparent assessment of training needs. NOTSS describes the main observable non-technical skills associated with good surgical practice, under the following headings:

- Situation awareness
- Decision making
- Communication and teamwork
- Leadership.

The RCOG has piloted the NOTSS system for use on the labour ward and in the gynaecological operating room. We have removed the rating system to focus on providing constructive and timely feedback. The system includes only those behaviours that are directly observable or that can be inferred through communication. NOTSS covers a wide range of non-technical skills in as few categories as possible.

Training evaluation form (TEF)

Trainees are required to complete a TEF on annual basis. The data from the TEF enables a proactive approach to the monitoring of quality of training by triangulating with other available data eg. GMC National Training Survey. This data is shared with deaneries and published on the RCOG website. In recognition of the importance that the RCOG places on trainee feedback, completion of the TEF is a requirement in the training matrix of progression.

Subspecialty Educational Supervisor report (SST ESR)

The STPS will annually record a longitudinal, global report of a trainee's progress over the full range of UG CiPs on a range of assessments and observations in practice or reflection on behaviour by those who have appropriate expertise and experience. The SST ESR can incorporate commentary or reports from observations, such as from supervisors, or formative assessments demonstrating progress over time. The STPS will offer a global judgement as to whether the trainee should progress to the next year of training.

Annual subspecialty assessment

Subspecialty trainees in UG are reviewed annually where the trainee's progress towards the required subspecialty CiPs will be formally assessed. The SST assessment follows the same principles as the ARCP but needs to be undertaken by subspecialists.

The subspecialty assessment is undertaken prior to the trainee's ARCP as the recommended outcome needs to feed into the ARCP process. The completed SST ESR is considered by a panel of subspecialty assessors, and an outcome recommended as to whether the trainee is meeting their subspecialty requirements. This decision is recorded in an outcome form, and in the ESR. Decisions on progression fundamentally rely on the professional judgement of the STPS based on the global judgement produced for each CiP and the outcome of the subspecialty assessment. The RCOG has produced the UG Matrix of Progression for UG, which is shown in Table 4. It is essentially a subspecialty assessment decision aid which sets out the requirements for a satisfactory subspecialty assessment outcome at the end of each training year and critical progression point. As a precursor to the subspecialty assessment, the RCOG strongly recommends that trainees have an informal ePortfolio review with their STPS/SST Educational Supervisor. This provides opportunities for early detection of trainees who are failing to gather the required evidence for the subspecialty assessment.

6.7 Annual Review of Progression (ARCP)

The decisions made at critical progression points and upon completion of training should be clear and defensible. They must be fair and robust and make use of evidence from a range of assessments, potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise or experience. They can also incorporate commentary or reports from longitudinal observations, such as from supervisors, or formative assessments demonstrating progress over time.

Decisions on progression fundamentally rely on the professional judgement of the STPS based on the global judgement produced for each CiP and the outcome of the annual subspecialty assessment.

Periodic (at least annual) reviews should be used to collate and systematically examine evidence about a doctor's performance and progress in a holistic way and make decisions about their progression in training. The ARCP process supports the collation and integration of evidence to make decisions about the achievement of expected outcomes. The ARCP process is described in the Gold Guide. LETBs/deaneries are responsible for organising and conducting ARCPs. The evidence to be reviewed by ARCP panels should be collected in the trainee's ePortfolio. As a precursor to ARCPs, the RCOG strongly recommends that trainees have an informal ePortfolio review either with their Educational Supervisor (STPS/SST ES) or arranged by the local school of O&G. These provide opportunities for early detection of trainees who are failing to gather the required evidence for ARCP.

Table 4 – Matrix of Progression

*Each procedural skill requires 3 OSATS assessed as being competent prior to being able to

Matrix for Subspecialty Training in Urogynaecology		
	Progress expected by completion of 12 months WTE of clinical training	Progress expected by completion of 24 months WTE of clinical training
Formative workplace-based assessments		
These are encouraged as a method to provide evidence for CiPs. The aim is for quality over quantity. Useful WBAs will challenge, act as a stimulus and mechanism for reflection, uncover learning needs and provide an opportunity for developmental feedback		
Mini-CEX	✓	✓
CBD	✓	✓
NOTSS	✓	✓
Reflective practice	✓	✓
Formative OSATS	Optional but encouraged	
Summative workplace-based assessments		
Competent Summative OSATS*	✓	✓
TO2	2	2
Other evidence required for SST assessment (to be specified in UG curriculum guidance)		
Research **	✓	✓
Educational Supervisor's Report		
Supervisor's report	1	1
Trainee feedback		
Training evaluation form (TEF)	✓	✓

perform the practical procedure independently with support

**If not research exempt, evidence of research activity and have a plan for satisfying research component as per RCOG research criteria

Table 5 shows the possible formal methods of assessment for each CiP. It is not expected that every method will be used for each CiP and additional evidence will be suggested as indicated in the Matrix of Progression and in the individual CiP.

Table 5 - Assessments mapped to CiPs

CiP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: The doctor has the knowledge, skills and attitudes required for clinical assessment of pelvic floor dysfunction.		X	X		X	X
2: The doctor selects and performs appropriate tests and interprets the results.	X	X	X	X	X	X
3: The doctor is competent in non-surgical management of pelvic floor dysfunction.	X	X	X		X	X
4: The doctor is competent to undertake surgical treatment of pelvic floor disorders.	X		X	X	X	X

7 Supervision and feedback

This section of the curriculum describes how trainees will be supervised, and how they will receive feedback on performance. For further information please refer to the AoMRC guidance on Improving feedback and reflection to improve learning².

² [Improving feedback and reflection to improve learning. A practical guide for trainees and trainers](#)

Access to high quality, supportive and constructive feedback is essential for the professional development of the trainee. Trainee reflection is an important part of the feedback process and exploration of that reflection with the trainer should ideally be a two-way dialogue. Effective feedback is known to enhance learning and combining self-reflection with feedback promotes deeper learning.

Trainers should be supported to deliver valuable and high quality feedback, including through face to face training. Trainees would also benefit from such training as they frequently act as assessors to junior doctors. All involved could also be shown how best to carry out and record reflection.

7.1 Subspecialty training

The Subspecialty Training Programme Supervisor (STPS) is responsible for the day-to-day, hands-on training of the subspecialty trainee and in the organisation and delivery of all aspects of the [subspecialty curriculum](#) at trust level. This will also include workplace-based assessments and providing feedback to the trainee.

Any newly appointed STPS must be subspecialty accredited. The STPS should obtain feedback from other subspecialty-trained colleagues for the annual assessment of a trainee's progress. Unless there are exceptional local circumstances, each subspecialty training centre (irrespective of the number of programmes offered) should have only one STPS per subspecialty, which should not be a job share. The STPS responsibilities include:

- Take responsibility for maximising the educational opportunities provided in the accredited subspecialty training centre to meet the training needs of the subspecialty trainee.
- Ensure all components of the curriculum are included in the subspecialty training programme.
- Ensure that the trainee's mandatory logbook is accurate and up to date. The STPS should check that the trainee has sufficient evidence to allow the assessment panel to judge the trainee's progress at the annual assessment.
- Take responsibility for the completion and submission of the application for recognition as a subspecialty training centre.
- Take responsibility for ensuring that the subspecialty training programme is advertised nationally and appointed in open competition.
- Take responsibility for completion and submission of trainee registration documentation (within 6 months of the trainee starting subspecialty training).

7.2 Generic supervision

All elements of work in training posts must be supervised, with the level of supervision dependent on the experience of the trainee, their clinical exposure and case mix undertaken. Outpatient and referral supervision must routinely include the opportunity to personally discuss all cases if required. As training progresses the trainee should have the opportunity for increased autonomy, consistent with safe and effective care for the patient.

Organisations must make sure that each doctor in training has access to a named Clinical Supervisor and the STPS. Depending on local arrangements these roles may be combined into a single role of Educational Supervisor/STPS. However, it is preferred that a trainee has

a single named Educational Supervisor for (at least) a full training year, in which case the Clinical Supervisor is likely to be a different consultant during some placements.

The role and responsibilities of supervisors have been defined by the GMC in their standards for medical education and training³.

Clinical Supervisor

The Clinical Supervisor oversees the doctor's clinical work throughout a placement. They lead on reviewing the doctor's clinical or medical practice throughout a placement and contribute to the STPS report on whether the doctor should progress to the next stage of their training.

The STPS, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. The STPS should be part of the clinical specialty team. If the clinical directorate (clinical director) has any concerns about the performance of the trainee, or there have been issues of doctor or patient safety, these would be discussed with the STPS. These processes, which are integral to trainee development, must not detract from the statutory duty of the trust to deliver effective clinical governance through their management systems.

Educational and clinical supervisors need to be formally recognised by the GMC to carry out their roles⁴. All Educational Supervisors are recognised by RCOG as Tier 2 educators in the Faculty Development Framework. It is essential that training in assessment is provided for trainers and trainees in order to ensure that there is complete understanding of the assessment system, assessment methods, their purposes and use. Training will ensure a shared understanding and a consistency in the use of the workplace-based assessments and the application of standards.

Opportunities for feedback to trainees about their performance will arise through the use of the workplace-based assessments, regular appraisal meetings with supervisors, other meetings and discussions with supervisors and colleagues, and feedback from the subspecialty assessment and ARCP.

Trainees

Trainees should make the safety of patients their first priority. Furthermore, trainees should not be practising in clinical scenarios which are beyond their experiences and competences without supervision.

Trainees should actively devise individual learning goals in discussion with their trainers and should subsequently identify the appropriate opportunities to achieve said learning goals. Trainees would need to plan their workplace-based assessments accordingly so that they collectively provide a picture of their development during a training period. Trainees should actively seek guidance from their trainers in order to identify the appropriate learning opportunities and plan the appropriate frequencies and types of assessment according to

³ [Promoting excellence: standards for medical education and training](#)

⁴ [Recognition and approval of trainers](#)

their individual learning needs. It is the responsibility of trainees to seek feedback. Trainees should self-reflect and self-evaluate regularly with the aid of feedback. Furthermore, trainees should formulate action plans with further learning goals in discussion with their trainers.

7.3 Appraisal

A formal process of appraisals and reviews underpins training. This process ensures adequate supervision during training, provides continuity between posts and different supervisors and is one of the main ways of providing feedback to trainees. All appraisals should be recorded in the ePortfolio.

Induction appraisal

The trainee and STPS/SST Educational Supervisor should have an appraisal meeting at the beginning of the SST post to review the trainee's progress so far, agree learning objectives for the SST post ahead and identify the learning opportunities presented by the SST post. Reviewing progress through the curriculum will help trainees to compile an effective Personal Development Plan (PDP) of objectives for the SST post. This PDP should be agreed during the Induction Appraisal. The trainee and supervisor should also both sign the educational agreement in the ePortfolio at this time, recording their commitment to the training process.

Monthly meetings

Monthly meetings between trainee and STPS/Educational Supervisor are not mandatory but are encouraged. These are particularly important if either the trainee or educational or clinical supervisor has training concerns, or the trainee has been set specific targeted training objectives at their subspecialty assessment and ARCP. At these meetings trainees should review their PDP with their supervisor using evidence from the ePortfolio. Workplace-based assessments and progress through the curriculum can be reviewed to ensure trainees are progressing satisfactorily, and attendance at educational events should also be reviewed.

End of attachment appraisal

Trainees should review the PDP and curriculum progress with their STPS/Educational Supervisor using evidence from the ePortfolio. Specific concerns may be highlighted from this appraisal. The end of attachment appraisal form should record the areas where further work is required to overcome any shortcomings. Further evidence of competence in certain areas may be needed, such as planned workplace-based assessments, and this should be recorded. If there are significant concerns following the end of attachment appraisal, then the Training Programme Director should be informed.

8 Quality Management

The organisation of training programmes for O&G is the responsibility of HEE LETBs/local teams and the devolved nations' deaneries. The HEE Offices/deaneries will oversee programmes for postgraduate medical training in their regions. A Training Programme Director will be responsible for coordinating the O&G training programme in each trust. The

Schools of O&G in England, Wales and Northern Ireland and NHS Education Scotland will undertake the following roles:

- Oversee recruitment and induction of trainees from Foundation to ST1 O&G.
- Allocate trainees into particular rotations for ST1 O&G appropriate to their training needs.
- Oversee the quality of training posts provided locally.
- Interface with other specialty training faculties (General Practice, Anaesthesia etc.) and other healthcare professionals (midwives, specialist nurses).
- Ensure adequate provision of appropriate educational events.
- Ensure curricula implementation across training programmes.
- Oversee the workplace-based assessment process within programmes.
- Coordinate the ARCP process for trainees.
- Provide adequate and appropriate career advice.
- Provide systems to identify and assist doctors with training difficulties.
- Provide flexible training.
- Recognise the potential of specific trainees to progress into an academic career.

Educational programmes to train Educational Supervisors and assessors in workplace-based assessment may be delivered by HEE Offices/deaneries or by RCOG or both.

Development, implementation, monitoring and review of the UG subspecialty are the responsibility of the RCOG via the Speciality Education Advisory Committee (SEAC) and Subspecialty Committee. SEAC is formally constituted with representatives from each health region in England, from the devolved nations and with trainee and lay representation. It is the responsibility of the RCOG to ensure that curriculum developments are communicated to Heads of Schools, regional specialty training committees, TPD, STPSs and ATSM Directors.

The RCOG serves its role in quality management by monitoring and driving improvement in the standard of all O&G training. SEAC includes all Heads of UK O&G schools as members and is actively involved in assisting and supporting LETBs/deaneries to manage and improve the quality of education within each of their approved training locations. It is tasked with activities central to assuring the quality of medical education such as writing the curriculum and assessment systems, reviewing applications for new posts and programmes, provision of external advisors to deaneries and recommending trainees eligible for CCT or Certificate of Eligibility for Specialist Registration (CESR).

The RCOG uses data from five quality datasets across the O&G specialty and four subspecialties to provide meaningful quality management. The datasets include the GMC National Training Survey (NTS) data, Training Evaluation Form (TEF) data, ARCP outcomes, MRCOG exam outcomes and External Advisor reports. These datasets form the basis of the annual report to the GMC on the quality of O&G training nationally.

Quality criteria have been developed to drive up the quality of training environments and ultimately improve patient safety and experience. These are monitored and reviewed by RCOG to improve the provision of training and ensure enhanced educational experiences.

The principles of the quality criteria for O&G will be transferred to the new curriculum to ensure this continues.

9 Intended use of the UG subspecialty curricula by trainers and trainees

The UG subspecialty curriculum, Matrix of Progression and subspecialty assessment decision aid will be available from the RCOG via the website www.rcog.org.uk and ePortfolio.

Clinical supervisors and STPS should use the curriculum and decision aid as the basis of their discussion with trainees, particularly as part of preparing for the annual subspecialty assessment and the ARCP process. Both trainers and trainees are expected to have a good knowledge of the curriculum and should use it as a guide for their training programme. Each trainee will engage with the curriculum by maintaining an ePortfolio. The trainee will use the curriculum to develop learning objectives and reflect on learning experiences.

9.1 Recording progress in the ePortfolio

The ePortfolio allows evidence to be built up to inform decisions on a trainee's progress and provides tools to support their education and development. The RCOG is investing in a new ePortfolio platform which will be designed to support the process of learning and recording of evidence with improved functionality. It will also include a procedures log.

The trainee's main responsibilities are to ensure the ePortfolio is kept up to date, arrange assessments and ensure they are recorded, prepare drafts of appraisal forms, maintain their PDP, record their reflections on learning and record their progress through the curriculum.

The supervisor's main responsibilities are to use ePortfolio evidence such as outcomes of assessments, reflections and PDPs to inform appraisal meetings. They are also expected to update the trainee's record of progress through the curriculum, write end-of-attachment appraisals and supervisor's reports.

HEE Offices, Training Programme Directors, College Tutors and ARCP panels will use the ePortfolio to monitor the progress of trainees for whom they are responsible.

The RCOG will use summarised, anonymous ePortfolio data to support its work in quality assurance.

10 Equality and diversity

The RCOG will comply, and ensure compliance, with the requirements of equality and diversity legislation set out in the Equality Act 2010.

The RCOG believes that equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the Colleges, either as members of staff and Officers; as advisers from the medical profession; as members of the Colleges' professional bodies or as doctors in training and examination candidates.

HEE Local Offices/deaneries will quality assure each training programme so that it complies with the equality and diversity standards in postgraduate medical training as set by GMC. They should provide access to a professional support unit or equivalent for trainees requiring additional support.

Compliance with anti-discriminatory practice will be assured through:

- Monitoring of recruitment processes.
- Ensuring all College representatives and Programme Directors have attended appropriate training sessions prior to appointment or within 12 months of taking up post.
- HEE Offices/deaneries ensuring that Educational Supervisors have had equality and diversity training (for example, an e-learning module) every 3 years.
- HEE Offices/deaneries ensuring that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training (at least as an e-module) every 3 years.
- Ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature. HEE Offices/deaneries and Programme Directors must ensure that on appointment trainees are made aware of the route in which inappropriate or discriminatory behaviour can be reported and supplied with contact names and numbers. HEE Offices/deaneries must also ensure contingency mechanisms are in place if trainees feel unhappy with the response or uncomfortable with the contact individual.
- Providing resources to trainees needing support (for example, through the provision of a professional support unit or equivalent).
- Monitoring of College Examinations.
- Ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly advantage or disadvantage a trainee with any of the Equality Act 2010 protected characteristics. All efforts shall be made to ensure the participation of people with a disability in training through reasonable adjustments and recognising that not all disabilities are visible.

