



Curriculum Guide for Urogynaecology (UG) Subspecialty Training (SST)

1 What is UG subspecialty training about?

Subspecialty training in Urogynaecology will produce a doctor who has received the highest level of training in caring for women presenting with a wide range of urogynaecological conditions, enabling them to work as part of a team in tertiary referral centres. They will 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.

Subspecialists should be excellent communicators who can co-operatively reach complex and often difficult decisions with women and their families, and other healthcare providers. For this, they need an extensive knowledge base, a logical mind, objectivity, empathy and advanced listening skills. They need to be non-judgemental, free from bias, and be able to negotiate and compromise. They should be kind, but decisive when called upon, reflective and supportive. They need to have a high level of technical expertise to safely and effectively perform procedures required of them in their subspecialty consultant post.

During training doctors should be exposed to and participate in a wide variety of scenarios as well as attending educational events to support their learning in this area. The ability to reflect on and learn when projects have gone well or indeed if they have failed are all skills that should be developed and consolidated as training progresses.

There are two main components to subspecialty training. Firstly, is the clinical knowledge and skills required for a UG subspecialist, described by the UG Capabilities in Practice (CiPs). The practical procedures with which a subspecialty trainee needs to become proficient lie within these clinical UG CiPs. The second element comprises generic, non-technical skills, in the areas relevant to RM subspecialty training: 'Clinical governance', 'Teaching experience', 'Research', 'Leadership and management experience' and 'Presentations and publications'.

Satisfactory sign off to complete UG subspecialty training will require the Subspecialty Training Programme Supervisor (STPS) to make decisions on the level of supervision required for each UG CiP and if this and the final subspecialty assessment is satisfactory, subspecialty training accreditation will be awarded. More detail is provided in the programme of assessment section of the curriculum and in the online Curriculum training resource here.



2 Design of UG subspecialty training

Urogynaecology (UG) subspecialty training (SST) is a three-year programme (two years if the trainee has research exemption), made up of 4 clinical capabilities in practice (CiPs). These are listed in Table 1, and the details of each UG CiP can be found [here](#).

Table 1 – Capabilities in Practice (CiPs) for UG

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

No new curriculum items or competencies have been added between the previous UG subspecialty curriculum and this 2019 version. A few competencies have been removed which are no longer applicable to UG subspecialty practice in 2019. Table 2 shows how the modules from the previous UG subspecialty curriculum map to these UG CiPs. The competency level required for UG subspecialty skills has not changed between the old and the reformatted 2019 curriculum.

Table 2 - Mapping of current Urogynaecology (UG) subspecialty curriculum to new UG subspecialty Curriculum 2019

UG Subspecialty Curriculum 2018 Modules	New UG SST curriculum capabilities in practice (CiP)
Module 1: General Urogynaecology Assessment	UG CiP 1: The doctor has the knowledge, skills and attitudes required for clinical assessment of pelvic floor dysfunction. Cip 2: The doctor selects and performs appropriate tests and interprets the results.
Module 2: Conservative Management of	UG CiP 2: The doctor selects and performs appropriate tests and interprets the results.



Urogynaecological Conditions	CiP3: The doctor is competent in non-surgical management of pelvic floor dysfunction.
Module 3: Surgical Treatments	UG CiP 4: The doctor is competent to undertake surgical treatment of pelvic floor disorders.
Module 4: Urology	The skills and competencies covered by this module have been distributed across UG CiPs 1-4
Module 5: Colorectal	The skills and competencies covered by this module have been distributed across UG CiPs 1-4
Module 6: Neurology	The skills and competencies covered by this module have been distributed across UG CiPs 1-4
Module 7: Laparoscopic Urogynaecology	UG CiP 4: The doctor is competent to undertake surgical treatment of pelvic floor disorders.

3 The Capabilities in Practice explained

Each UG CiP is made up of the following components:

- A headline statement of expectation (high level learning outcome) describing in a generic way what a doctor can do once they have successfully achieved the UG CiP.
- Key skills and descriptors which give further detail to this statement and give guidance on how the trainee can be judged against the expectations of the UG CiP.
- Procedures which need to be learned and mastered as part of the UG CiP.
- Knowledge criteria needed by the trainee to provide a foundation for the skills and practices covered by the UG CiP.

a) High-level learning outcome

The high-level learning outcome of the UG CiP describes in a generic way what a doctor can do once they have successfully completed the UG CiP. A competency level must be proposed by a trainee for each of these high-level learning outcomes using the entrustability scale listed in Table 4 at Subspecialty Training Programme Supervisor educational meetings, and prior to the subspecialty assessment. The Subspecialty Training Programme Supervisor (STPS) will make their own judgement based primarily on the evidence presented by the trainee, and this may be aligned with the trainee opinion, or may differ.

The 4 mandatory UG CiPs making up the UG SST are listed below. When considering whether progress is being made in each UG CiP it is both the trainee's wider skills as a medical



professional and those relating to knowledge and processes of leadership and teamwork which need to be assessed in the round, as well as clinical competence.

To help trainees and trainers assess progress in subspecialty training, there is a Statement of Expectations for trainees for each UG CiP (Table 3). It offers guidance as to what constitutes acceptable progress in that UG CiP.

Table 3 – Statements of Expectations for UG subspecialty training

	Statement of Expectations for UG subspecialty training
Meeting expectation UG CiP1	<p>A trainee meeting expectations will be able to:</p> <ul style="list-style-type: none">• independently perform a history including impact of condition on quality of life, in patients with urinary, bowel, pelvic organ prolapse and sexual problems using accepted scoring systems.• a general, pelvic floor and neurological examination to clinically assess pelvic floor dysfunction .• assess women presenting with urethral diverticulae, mesh complications, urinary tract or enteric fistulae and neurological conditions affecting the bladder.• determine when liaison or referral to other specialists is required to formulate a differential diagnosis.• use the information acquired to plan further investigations and begin to create appropriate individualised management plans.
Meeting expectation UG CiP2	<p>A trainee meeting expectations will be able to</p> <ul style="list-style-type: none">• Perform & Interpret complex urodynamic Investigations. They will be able to interpret the results of complex urodynamic assessment including videourodynamics, urethral function tests and ambulatory urodynamics.• recognise when further investigations are required and make appropriate referrals with interpretation of these results, including appropriate imaging of the urinary and gastrointestinal tract, and neurophysiological investigation.• explain these investigations to the patient conveying what this means for their treatment.• work within multidisciplinary team services, including Urology and Coloproctology, in regional referral pathways and in the management of complex cases.



Meeting expectations UG CiP3	<p>A trainee meeting expectations will be able to:</p> <ul style="list-style-type: none">• conservatively manage patients with urinary incontinence and pelvic organ prolapse within a multidisciplinary team.• explain the importance of urinary containment and support groups to patients.• use drug therapy appropriately as well as vaginal pessaries and urinary catheters.• appropriately counsel patients with faecal incontinence and obstructive defaecation and initiate investigation and conservative treatment.
Meeting expectations UG CiP4	<p>A trainee meeting expectations will be able to :</p> <ul style="list-style-type: none">• appropriately select patients for incontinence and prolapse surgery including those with recurrent incontinence and/ or prolapse and those who may have concurrent colorectal problems requiring surgery.• appropriately select patients for vaginal, abdominal or laparoscopic prolapse procedures and/or continence surgery and to counsel patients on the risks and benefits of mesh in accordance with national guidelines. <p>undertake surgical procedures in a safe manner paying due regard to NICE guidance, and take appropriate consent after detailed counselling</p> <ul style="list-style-type: none">• engage in surgical audit, using appropriate national databases.• diagnose and manage intraoperative haemorrhage, bladder & Bowel injury liaising with other specialties as clinically appropriate.• investigate, diagnose and initiate management of intraoperative and post-operative complications including post operative voiding dysfunction and to liaise with other specialties appropriately.

Table 4 – 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

Trainees will need to meet expectations for the time spent undertaking subspecialty training as a minimum to be judged satisfactory to progress. The expectations for the level of supervision expected by the end of training for all the UG CiPs in UG subspecialty training is level 5.

b) Key skills and their descriptors

Beneath each high-level learning outcome are a series of key skills which provide further detail and substance to what the purpose and aims are of the UG CiP. These give guidance to the trainer and trainee as to what is needed to be achieved for completion of the UG CiP. Competency levels do not need to be ascribed to these individual key skills prior to assessments however the evidence collected by the trainee should be supporting progress in the acquisition of these skills over the course of training. Review of these key skills, and progress with them, forms an essential part of the global assessment of progress with the UG CiP. It is expected, by the time of completion of subspecialty training, that all the key skills in the UG CiPs will be evidenced.

c) Practical procedures

The procedures which feature in the UG SST, and the competency level required by the end of training, are listed in Table 5. Evidence supporting the acquisition of these procedural skills will take the form of OSATs, reflections and procedure logs. Training courses, simulation training and case-based discussions may also help to support procedural competency sign off. In line with the previous curriculum, the following procedures each require three OSATs evidencing competent independent practice;

- Vaginal hysterectomy
- Anterior repair
- Posterior repair
- Sacrospinous fixation
- Sacrocolpopexy
- Laparoscopic Sacrocolpopexy
- 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
- Cystoscopy
- BNI
- Intravesical BOTOX
- Urodynamics

However, it is recommended that the other procedural skills listed here which also require level 5 sign off should also be evidenced by at least three competent OSATs where possible before sign-off. This is an extensive list, and it is clear that some ‘procedures’ will be very difficult to evidence with OSATs. Because of this, only the procedures listed above require three competent summative OSATs for satisfaction of the matrix at the time of the final subspecialty centralised assessment. However, collection of OSATs in a wider range of procedures assists in evidencing the final ‘global judgement’ of the trainee. Used properly, OSATs are assessing more than pure isolated technical skills; they assess general surgical and ultrasound skills, communication within teams, communication with patients, and the ability of a doctor to reflect on the care they are providing. It is clear, therefore, that a trainee who has demonstrated technical skills in a competent way across a wide range of procedures should be more readily signed off as reaching level 5 in the various UG CiPs which contain ‘procedures’.

Table 5 – Outline grid of supervision level expected for procedures

<i>Procedures</i>	<i>Level by the end of training*</i>	<i>CIP 2</i>	<i>CIP 3</i>	<i>CIP 4</i>
Urodynamic assessment	5	X		
Urethral function studies	2	X		
Videourodynamic function studies	2	X		
Cystourethroscopy with both rigid & flexible cystoscopies	2	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>				
<ul style="list-style-type: none"> Laparoscopic and open sacrocolpopexy 	5			X
<i>Advanced laparoscopic surgery</i>				
<ul style="list-style-type: none"> Close port sites safely with all entry types 	5			X
<ul style="list-style-type: none"> Suture using laparoscopic needle holders 	5			X
<ul style="list-style-type: none"> 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>				
<ul style="list-style-type: none"> Colposuspension (open or laparoscopic) 	5			X
<ul style="list-style-type: none"> 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>				
<ul style="list-style-type: none"> Colpocleisis 	1			X
<ul style="list-style-type: none"> 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

*corresponds to 5 levels of supervision used to assess UG CiPs

d) Knowledge criteria

It is recognised that the full spectrum of urogynaecological conditions will not be witnessed by the trainee whilst they undertake UG subspecialty training, and expecting independent competency in managing the full range of urogynaecological problems is unachievable. However, a broad and detailed knowledge base is expected as this will facilitate in the evidence-based management of all urogynaecological problems, common and uncommon. The [knowledge criteria](#) for each UG CiP make clear what level of theoretical understanding and foundation knowledge is expected. This will be greater than the knowledge base expected for the MRCOG examinations.

4 What kind of evidence might be relevant to UG subspecialty training?

As a trainee progresses through their subspecialty training they will be expected to collect evidence which demonstrates their development and acquisition of key skills, procedures and knowledge acquisition. Examples of types of evidence are given below, but this list is not exhaustive. Trainees and trainers can discuss and agree other sources of relevant evidence. The emphasis should be on the **quality** of evidence, not the quantity. This evidence will be reviewed by the STPS when they are making a global assessment of the progress against the high-level outcome of each of the UG CiPs.

- OSATS
- CbD
- Mini-CEX
- Discussion of correspondence Mini-CEX
- Reflective practice
- TO2 (including SO)



- NOTSS
- Regional and National teaching and training
- RCOG (and other) eLearning
- Conferences and courses attended
- Procedural log
- Case log
- Case presentations
- Attendance at a national urodynamics course
- Attendance at a regional / national anatomy course
- Attendance at clinics in other disciplines, including anorectal physiology investigations
- Attendance at regional MDT
- Quality Improvement and Audit activity
- Leading a critical incident review

Table 6 gives guidance regarding which work placed based assessments should be used to evidence of key skills for each UG CiP in UG subspecialty training.

Table 6

UG 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



5 When can a UG CiP be signed off?

The UG CiP is the fundamental basis of global judgement. Assessment of UG 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. Each UG CiP has a lead statement, and the trainee and STPS must make their assessment of the competency level reached, as judged globally against this statement. There is no need to make an assessment of each key skill or descriptor within each UG CiP. The key skills and their descriptors are there to guide training and expectations but do not need to be assessed individually. However, review of these skills and descriptors will aid in the global assessment of progress with that UG CiP and its lead statement.

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 UG CiP will be derived from workplace-based assessments and other evidence, e.g. TO2. The progress a trainee is making with the acquisition of technical procedural skills which form part of an UG CiP, should also be considered when giving a global rating (see below).

A trainee can make a self-assessment of their progress in an UG CiP at any point in the training year. The first question for a trainee to ask themselves is

- Do I think I meet the expectations for this year of training?

If the answer is yes then the next questions to ask are:

- Have I produced evidence and linked that evidence to support my self-assessment?
- Is this the best evidence to support this? Have I got some evidence about the key skills?
- Is this evidence at the right level?
- Do I understand the knowledge requirements of this UG CiP? If not do I need to look at the [knowledge syllabus](#)?

Once the trainee has completed the self-assessment and has been encouraged to provide a short summary to the rationale for their self-assessment, the STPS needs to review the evidence and ask the same questions.

- Do I agree with with the trainee for the self-assessment for this UG CiP? Is this sufficient evidence to sign off the UG CiP as level 5?
- Is this the best evidence? Would some of this evidence be more appropriate in other UG CiPs as evidence? For example, would the CbD about a change of practice be better linked to a clinical CiP?
- Is there other evidence that has been missed?
- Is the level right for this trainee? Are they meeting the standards of expectations?



At certain key time points (usually prior to a subspecialty assessment), but also at any other point suggested by the trainee or their STPS, both the trainee and the STPS will make their own judgements of what competency level has been reached in each UG CiP. Most crucially this is a global judgement. There does not have to be evidence linked to every key skill, until the trainee reaches the point of completion of the subspecialty training programme. In addition, evidence for the following generic areas relevant to UG SST: 'Clinical governance', 'Teaching experience', 'Research', 'Leadership and management experience' and 'Presentations and publications' as outlined in the matrix will be needed at senior trainee level (see point 6 below). It is the **quality** of the evidence not the quantity which is key. The progress a trainee is making with the acquisition of technical procedural skills which form part of that UG CiP, and their knowledge base, should also be considered when giving a global rating.

Each clinical UG CiP in this curriculum has to be signed off using the new 5 levels of supervision, as defined in table 4 (above), and the generic areas relevant to UG SST (see point 6 below) will need to be evidenced as outlined in the matrix. Each UG CiP must eventually be signed off to level 5.

Trainees will need to meet expectations for the year of training as a minimum to be judged satisfactory to progress. The expectations for the level of supervision expected for each year of subspecialty training for all the UG CiPs are in table 7 below. Progress with the generic areas relevant to UG SST must be kept under constant review by the trainee and STPS, and both the STPS educational supervisors report, and the centralised assessment process will document how these are being achieved and evidenced.

The expected progression described in Table 7 is modelled against full time clinical training. 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 on their research, and when this is done over the course of the three years, will vary, although the total whole-time equivalent (WTE) *clinical* training should be two years, with 12 months for the research component. It is not possible to write an outline grid of progress expected for UG CiPs which covers all these variations in the pattern of subspecialty training. At each subspecialty assessment, the panel will judge the evidence against how much whole-time equivalent *clinical* training time has occurred, not the number of calendar months since training began, or since the last assessment. It is expected that the STPS, through their reports, will make 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 outline grid of progress expected for UG CiPs 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 UG CiPs will be quite different for them and their progress may not be so readily compared to this outline grid. For these trainees, assessors will be expecting completion of some UG CiPs ahead of time, whilst other UG CiPs 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 outline grid which covers all training programmes, and common sense and judgement will be required, in the same way as it was in the previous curriculum, with respect to competency accrual and module sign off. However, as a rough guide, after one year WTE clinical subspecialty training, i.e. half way through clinical training, the centralised assessment panel will expect the scores of the entrustability levels to have reached 10 (entrustability level 5 x 4 UG CiPs = 20). This will be calculated in a pro rata way for trainees who have completed only part of a full year of clinical training. This is a guide only, but serves to assess progress across a wide variety of different programme formats.

Table 7 – Outline grid of progression for the UG CiPs in UG subspecialty training

	UG SST		Subspecialty Accreditation
Capabilities in practice	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 Generic capabilities

Subspecialty training has always had a generic curriculum, and trainees have always been expected to present evidence supporting competency in the generic areas relevant to UG SST. All subspecialty trainees will need to provide evidence collected during subspecialty training for the following areas at the centralised assessments:

- Clinical Governance
- Teaching Experience



- Research and Innovation
- Leadership and Management
- Presentations and Publications

This evidence should be uploaded into the 'Other evidence' section of the ePortfolio.

Pre-CCT subspecialty trainees on the 2019 core curriculum will be expected by subsequent **ARCP** panels to meet the expectations of the core generic and non-clinical specialty CiPs at ST6/7 level, using their exposures and experiences in subspecialty training to evidence these generic capabilities and skills. The evidence of generic skills that they accumulate for their subspecialty training, in line with the above list, should be linked to the appropriate core generic and non-clinical specialty CiPs and may need to be supplemented to satisfy their educational supervisors and ARCP panels that the full range of core generic and non-clinical specialty CiP key skills requirements are being met at ST6/7 level.

For each of these core generic and non-clinical specialty CiPs, there is a CiP guide [here](#) outlining what the level of expectation is for senior trainees in ST6 and 7.

Pre-CCT on the 2013 core curriculum, CCT holders and overseas doctors undertaking subspecialty training do not need to complete the core generic and non-clinical specialty CiPs, although may choose to link the evidence of their generic skills, collected according to the above list, into the core generic or non-clinical specialty CiPs on the ePortfolio after uploading this evidence into the 'other evidence' section of the eportfolio.

7 The subsequent ARCP

Pre-CCT subspecialty trainees should ideally have an ARCP scheduled within a couple of months of their centralised SST assessment. ARCPs are clearly not needed for overseas SSTs, or those who have their CCT already. The narrative outcome awarded by the centralised assessment will be used as a significant contributor to the ARCP assessment, but trainees do need to appreciate that satisfactory progression through subspecialty training does not *necessarily* guarantee a satisfactory outcome (outcome 1) at the subsequent ARCP. For this reason, they will need to complete an ESR for their ARCP with their educational supervisor, separate and in addition to the SST ESR they created for their subspecialty assessment. The two different forms of ESRs are clearly marked and easily accessible from the front page of the trainee or supervisor log-in for that trainee. Trainees need to ensure that they are also achieving any matrix requirements for the core curriculum which are additional to those on the subspecialty matrix.

For **pre-CCT SSTs using the 2019 core curriculum**, the key additional areas to focus on are the evidencing of all the core generic and non-clinical specialty CiPs to ST6/7 level, and the sign-off of the core clinical CiPs (9-12) to entrustability level 5 by the completion of training and the final ARCP. All subspecialty trainees using the 2019 core curriculum do need to collect



evidence to satisfy all four core clinical CiPs to entrustability level 5, but DO NOT need to collect 'ongoing competency' OSATs for core procedures that they have already demonstrated competency in (with three competent summative OSATs), in line with the new 2019 core matrix.

Pre-CCT SSTs using the 2013 core curriculum will still be assessed at their ARCP using the 'old' core matrix. This does mandate a specific number of work place based assessments that the matrices for the 2019 core curriculum do not. However, it has been decided that subspecialty trainees using the 2013 core curriculum DO NOT need to collect OSATs showing ongoing competency for core procedures such as laparoscopy, caesarean section or instrumental birth (which are listed as mandatory on the old core matrix at ST6/7 level. This, for example, means that an UG SST who has previously been signed off as competent at performing caesarean section or instrumental birth (which you must before progressing into ST6 and/or subspecialty training) need not collect further caesarean section or instrumental birth OSATs showing ongoing competency. This advice supersedes any previous information found in older versions of this document or guidance available elsewhere. Trainees will still need to ensure that all advanced competences in the 2013 core curriculum (i.e. dark pink boxes in old logbook) are completed by the end of SST training with appropriate documentation on ePortfolio for their ARCP.

8 Example case study

Example 1 - STPS focus

You are a STPS having a meeting with a trainee, who asks for assessment of UG CiP 1 after considering the questions regarding the evidence. They feel that they meet the statement of expectations and feel they can be signed off as entrustability level 5 for this UG CiP. They have submitted the following evidence and linked it to the UG CiP 1:

- WPBAs
- Reflection on a patient with prolapse and incontinence
- Evidence of involvement in a QI project relevant to urogynaecology.
- eLearning module
- TO1s from urogynaecology nurse, physiotherapist and 2 urogynaecology consultants
- Evidence of attendance at spinal injuries course
- Log of specialty clinics attended including colorectal, urology, MS clinics , nurse clinics and physiotherapy

You agree that the trainee has high level skills in assessing a patient with pelvic floor dysfunction and you are confident that they can do this independently across a wide range of scenarios, both common and uncommon. You were impressed by the QI project which had



been undertaken regarding classification of POP and you discussed with the trainee how this project could be extended for use in the department. You feel the quality and breadth of the evidence which is linked to UG CiP 1 is good, so you can feel confident in signing off UG CiP 1 to level 5 entrustability.

Example 2 – UG SST (trainee focus)

You are an UG SST trainee considering sign-off for UG CiP 3. You are 5 months into UG SST and have submitted the following evidence linked to UG CiP 3:

- WPBAs
- Log of attendance at a physiotherapy clinic and a continence nurse clinic
- OSATS for suprapubic catheter change
- TO2s
- Attendance at BSUG annual meeting

You feel this evidence matches the Statement of Expectations for UG SST because it shows evidence of the cases you have seen and feedback from your TO2.

You discuss this UG CiP and your request to be signed off to level 5 with your STPS at your next meeting.

The STPS considers the key questions:

- **Is this sufficient evidence to support sign off of this UG CiP to level 5? Am I happy there is evidence to support the acquisition of key skills?** The evidence consists of WPBAs regarding assessment and management of overactive bladder syndrome and stress urinary incontinence
- **Is this the best evidence? Would some of this evidence be more appropriate in other CiPs as evidence?** Some of the evidence linked to this UG CiP would be more appropriate for UG CiP 2. While the evidence covers some of the knowledge aspects of this UG CiP, the trainee has not demonstrated the breadth and depth of knowledge required as the cases detailed in the WPBAs are predominantly for primary prolapse and incontinence e.g. there should be evidence for management of complex pelvic floor dysfunction including faecal incontinence and neurological dysfunction. In addition they have not shown evidence of all of the key skills required and the TO2 did not have any physiotherapist or nurse contribution.
- **Is the level right for this trainee?** You conclude that this trainee has not yet demonstrated the skills to the level of a urogynaecological subspecialist and they have shown little insight into their own clinical performance, as evidenced by the lack of reflection and the belief that level 5 entrustability could be achieved and evidenced



within 5 months of commencing the programme. Based on the evidence given so far, you would be prepared to sign this trainee off at level 2 entrustability at the present time.

You discuss with the trainee that you do not feel able to sign off this UG CiP to level 5 currently. You discuss what would be appropriate types of WPBA for completion of this UG CiP to level 5, including the management of faecal incontinence and urgency. You agree with the trainee that the evidence could be strengthened by including some of the physiotherapists and nurses on the next TO2. You discuss opportunities for the trainee to lead the regional urogynaecology MDT and attend clinics and biofeedback sessions with the colorectal team.

Example 3 (STPS focus and subsequent ARCP)

You are the STPS to a third year subspecialty trainee in urogynaecology who chose to move onto the 2019 core curriculum, following the advice of a college tutor. She has six months left of clinical subspecialty training, having spent her second year in research, from which she produced three first authored papers, wrote a number of reviews, and presented at a number of local, national and international meetings. This year she has established a more effective referral pathway into tertiary services, reinvigorated the regional MDT, and audited referrals from secondary care providers. Surgically she is very talented, and her multisource feedback has always been very good. On review of her UG CiPs you can see that the key skills are well evidenced and she has already accumulated three summative OSATs for almost all the procedures on the 'mandated' list. She needs a couple more competent OSATs for laparoscopic colposuspension, but you have no concerns that this won't be achieved very soon. She has also collected OSATs and other evidence for a wide range of other urogynaecological skills and procedures which demonstrate her overall surgical competence and ability to offer the correct intervention. You feel that she has demonstrated the generic skills more than adequately, with the exception of risk management. You suggest that she helps you with an investigation and response to a formal complaint that has been received, and to follow through the process to its completion. You discuss a few other things she might focus on in her last six months, and which key skills need stronger evidence, but your message is a very reassuring one with respect to her completing her subspecialty training on time.

Because she opted to move onto the 2019 core curriculum, you ask her how she is progressing with the core CiPs. She looks anxiously at the floor, and confesses that she has made little progress with this. You open up the core CiPs to find only scanty evidence attached to very few key skills. You point out to her that if her ePortfolio looks like this, at the time of her 'final' ARCP, she will not be awarded an outcome 6 and CCT, irrespective of completing subspecialty training successfully. She is risking an outcome 3, and additional training time being needed, AFTER subspecialty training, so that she might complete the core curriculum at advanced level to the satisfaction of the ARCP panel. However, you are able to reassure her that many of the core key skills can be evidenced by using the evidence she has accumulated during her subspecialty training. It will be a tedious job to go through this evidence and attach it to core



key skills, but when this is done she is likely to find that much of the core curriculum is well evidenced for ST6/7 level. A plan can then be made to address any gaps over the next six months. She does cover obstetrics whilst on call, and you recommend that she seek out a consultant obstetrician to review work place based assessments she will undertake in the next few months. She agrees she will attend a couple of general antenatal clinics, as well as the specialist clinic for women sustaining severe perineal injury during child birth. Neither of you are terribly familiar with the core non-clinical CiPs, but when you look into each one of these in turn, you realise that many of the cases she has been involved in and reflected on during her subspecialty training do very well evidence skill and competency in a broad range of generic domains. By the time she has completed this exercise she is relieved to find that there is a relatively small number of core non-clinical key skills which she has no evidence for. She can, however, see how she might go about focussing on these areas within her own subspecialty and realises that actually they will further enhance her subspecialty training, rather than distracting her from it.

(For clarity, engagement with the core clinical and non-clinical CiPs is necessary by this trainee because they are using the 2019 core curriculum. Overseas and post-CCT subspecialty trainees do not need to engage with core curriculum CiPs, but do need to collect evidence of generic skills as listed in section 6; this evidence will be assessed by the centralised assessment panel. Pre-CCT trainees on the 2013 core curriculum also need to collect this generic evidence, and ensure that they are reaching the requirements of the 2013 core matrix).