



Curriculum 2024

Subspecialty Training Urogynaecology

Definitive Document

March 2024 – V3.0

Implementation Date: 7 August 2024



Version control		
Version	Modifications	Date
1.0	Final – GMC Submission	18 September 2023
2.0	Final – GMC Approved	17 January 2024
3.0	Final – GMC Final Approval 21 February 2024	March 2024



Contents

1	Introduction.....	5
2	Purpose of the Urogynaecology subspecialty training programme	6
2.1	Background	6
2.2	General description of the UG curriculum	6
2.3	The Advanced Training Review process.....	8
2.4	Flexibility and the transferability of learning	9
3	The organisation and content of the UG curriculum.....	10
3.1	Curriculum framework features.....	12
3.2	Urogynaecology subspecialty curriculum	13
4	The research component of subspecialty training	40
5	Learning and teaching	40
5.1	Stages 1-3 training programme	40
5.2	The general training environment	41
5.3	The subspecialty training environment	43
6	Programme of assessment	43
6.1	Purpose of assessment	43
6.2	Programme of assessment.....	44
6.3	Assessment of CiPs.....	45
6.4	The global judgement process	45
6.5	Assessment of progression	48
6.6	Evidence of progress	49
7	Supervision and feedback	53
7.1	Subspecialty training.....	53
7.2	Generic supervision.....	54
7.3	Appraisal	55
8	Quality management	56
8.1	Monitoring UG subspecialty.....	57
9	Intended use of the UG subspecialty curriculum by trainers and trainees.....	58



9.1	Recording progress in the ePortfolio	58
10	Equality and diversity.....	59
10.1	RCOG's current work on race equality in the specialty	60

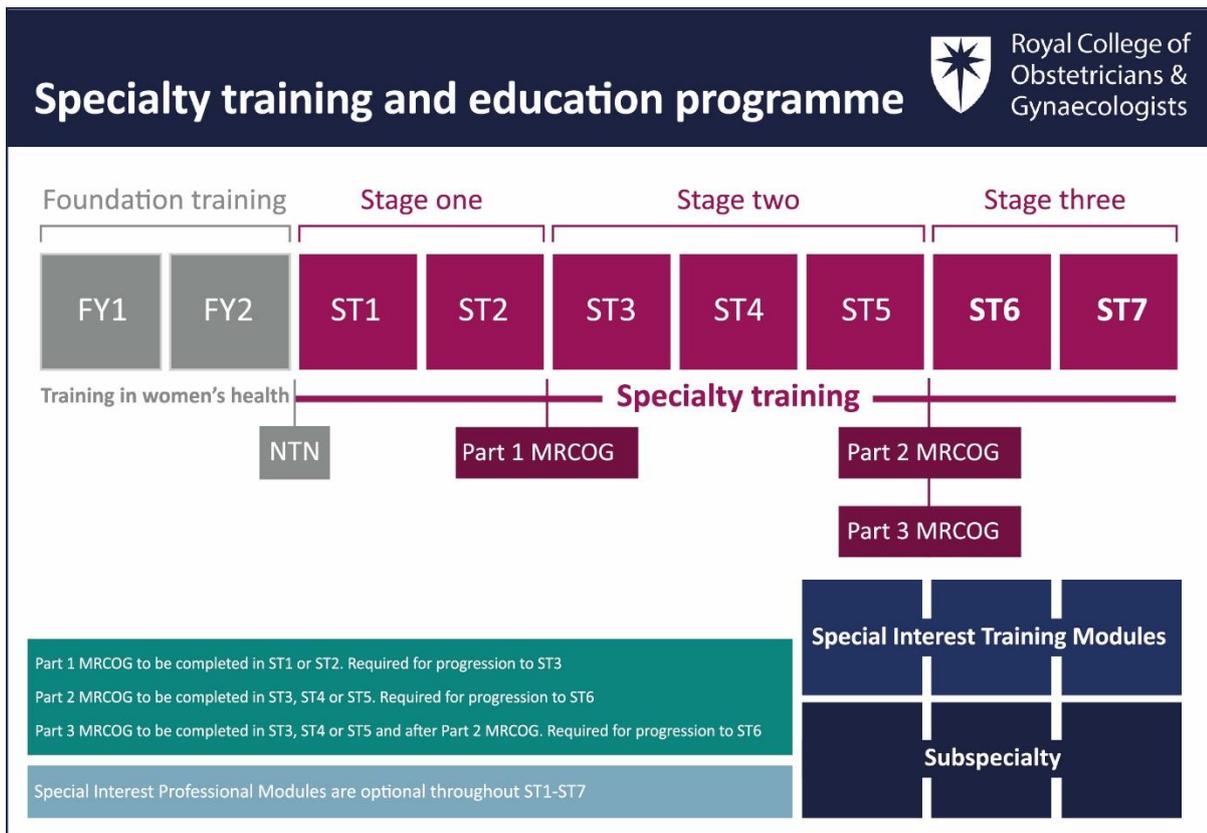


1 Introduction

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 Curriculum 2024 requirements for CCT. The Curriculum 2024 covers three stages of training from ST1-7 as detailed in the Curriculum 2024 Definitive Document.

All of these documents are available on the RCOG website.

O&G is a run-through training programme with an indicative time of seven years. The fundamental training structure and waypoints remain the same in the Curriculum 2024. In the final three years of training, trainee doctors have to complete two Special Interest Training Modules (SITM) OR one of the four subspecialty programmes Urogynaecology (UG), Gynaecological Oncology (GO), Maternal and Fetal Medicine (MFM) and Reproductive Medicine (RM) to be eligible for CCT. The curriculum acknowledges that the specialist will manage female, transgender and non-binary individuals of all age groups and ethnicities, including young people, and vulnerable adults.





2 Purpose of the Urogynaecology subspecialty training programme

2.1 Background

Over recent years, the RCOG has published a number of strategic reports highlighting the training needs and challenges that surround the O&G workforce. The most recent report, the [O&G Workforce Report \(2022\)](#), highlights the complexity of workforce planning in ensuring the training of the right people with the right skills in the right place at the right time, to provide person-centred care. Population demographics and requirements differ across the UK, and so there is regional variation in the services required to ensure equity of care. For workforce planning to be successful, training opportunities and the skillset of the workforce must be driven by current and predicted patient needs. The Advanced Training Review of 2023 builds on the curriculum reviews in 2013 and 2019 to design and deliver a revised curriculum, fit for our future workforce and able to meet the needs of clinical services across the UK.

In 2015, the RCOG Curriculum Review Group was set up to take forward the recommendations made in the RCOG document '*Becoming Tomorrow's Specialist*'. This Working Party report identified the deficiencies in the curriculum in place at that time, with its undue emphasis on technical skills and lack of focus on the non-technical and professional skills required by a modern consultant. Most importantly, and for the first time, the Review Group developed a definition of the required characteristics of an O&G consultant and, providing the basis for future work.

The aim 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 pelvic floor dysfunction conditions in tertiary referral centres. UG subspecialists should have the skills to organise and supervise services at a local and regional level, contribute to relevant research and academia, 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 subspecialist level. It also encourages the pursuit of excellence in all aspects of clinical and professional practice, and expects the trainee to take responsibility for their own learning, as they will need to do as a consultant.

2.2 General description of the UG curriculum

UG subspecialty training consists of three years of clinical training, which includes clinical and non-clinical sub-speciality skills, such as leadership and research. It can be commenced from the start of ST5, or any point of training thereafter. This curriculum is designed so that skills and



competencies already achieved during training in the SITMs, which may precede commencement of subspecialty training, will be recognised and need not be repeated, in turn meaning that this indicative training time of three years may be reduced. The trainees must be at ST5 of their training to be eligible to commence SST and will be appointed following a competitive interview process.

To be awarded CCT all subspecialty trainees must complete the generic and specialty-specific CiPs detailed in the curriculum 2024, and the subspecialty specific clinical and research CiPs detailed in this document.

The revised UG curriculum consists of 9 Capabilities in Practice (CiPs) (high-level statements outlining the expectations of a doctor at the end of training), all of which fall into the Clinical Expert Professional Identity (PI). The Professional Identities are a fundamental concept of the Curriculum 2024, divided into generic (developing the doctor) and specialty-specific (developing the obstetrician & gynaecologist). The CiPs require a judgement to be made by both trainee and trainer, of 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.

The revised UG curriculum builds on the modular approach detailed in the RCOG submission for the gynaecology SITMs. The gynaecology SITM Urogynaecology and Vaginal Surgery (UGVS) acts as a foundation and must be completed before or during, UG subspecialty training. It is expected that most trainees entering subspecialty training during the later years of training will have completed some or all of these CiPs, meaning their subspecialty training time will be shortened. In addition to the four SITM CiPs, subspecialty trainees in UG will also need to complete four further subspecialty-specific clinical CiPs that take these skills and competencies to the highest level, and one further CiP which addresses the high-level research skills and understanding expected of a subspecialist managing patients within the NHS.

Table 1 – Professional Identity and CiPs for UG

Developing the Obstetrician & Gynaecologist: SST-UG	
<i>PROFESSIONAL IDENTITY: CLINICAL EXPERT</i>	
UGVS CiP 1	The doctor has the knowledge, skills and attitudes required to clinically assess women with pelvic floor dysfunction.
UGVS CiP 2	The doctor selects and performs tests appropriate for common urogynaecological presentations and interprets the results.



UGVS CiP 3	The doctor manages pelvic floor dysfunction using non-surgical methods.
UGVS CiP 4	The doctor provides high quality surgery for primary incontinence and prolapse.
SST UG CiP 1	The doctor has the knowledge, skills and attitudes required for clinical assessment of complex pelvic floor dysfunction.
SST UG CiP 2	The doctor selects and performs tests appropriate for complex pelvic floor dysfunction and interprets the results.
SST UG CiP 3	The doctor is competent in non-surgical management of complex pelvic floor dysfunction.
SST UG CiP 4	The doctor provides high quality surgical treatment for recurrent, less common, or more complex pelvic floor disorders.
SSTR CiP	The doctor is able to engage with research and promote innovation within their subspecialty.

Our programme of assessment 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 programme of assessment will be based on robust and fair assessment principles and processes.

2.3 The Advanced Training Review process

High-quality women's healthcare relies on an integrated approach to service and care, to fully meet the needs of women. Therefore, a fundamental aim of this curriculum is to develop consultants who work on and lead multidisciplinary teams, from a range of professional groups in a variety of hospital and community settings. RCOG commissioned the Advanced Training Review in 2020 in direct response to feedback from the General Medical Council (GMC) on the 2019 curricula submission and approvals process.

Following this feedback, we have substantially reviewed and updated the ATSMs/APMs training component and aligned the Stages of Training for the structured training programme.

The review of the 2019 advanced training component was conducted by an Advanced Training Steering Group, under the governance of the RCOG Education Board. This group determined the direction of travel and comprised Chairs of the relevant RCOG curriculum committees (Curriculum Committee, Advanced Training Committee, Subspecialty Committee, Specialty Education Advisory



Committee (SEAC), Trainees' representatives and Vice Presidents for Education and Professionalism & Workforce).

O&G subgroups and subgroups for each subspecialty, bringing together relevant clinicians, trainees and lay representatives, undertook the development of the SITM curricula and revision of the subspecialty curricula. Particular effort was made to engage consultants working in both smaller district general hospitals and larger tertiary hospitals, in both special interest and subspecialty posts. The subgroups met on a monthly basis until the revised modules had been finalised.

The development of the revised curricula and recommended training pathway changes have been produced collaboratively with educationalists, trainees, Heads of School and specialist societies.

The Steering Group reported to the Advanced Training Project Board. The outputs from the project have been reported to the Curriculum Committees, SEAC and RCOG Council via the Education Board.

We enabled RCOG Fellows, Members, Associates, Trainees, Specialist Societies, Service Users, other Royal Colleges and Faculties, related charities and employers to feedback views during the consultation period from March to April 2023. The consultation process has resulted in invaluable feedback has helped to further shape the curriculum.

The 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 specialty and generic CiPs in the training programme will provide a more integrated approach to service and care, to fully meet the needs of the people using our clinical services.

2.4 Flexibility and the transferability of learning

Embedding generic CiPs that are high-level statements setting out the general professional skills that all doctors should have at the end of training. Embedding them within the curriculum enables easier transfer between specialties, as the CiPs have also been mapped to the GMC's Generic Professional Capabilities (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.

Pre-CCT subspecialty trainees will be following and completing the Curriculum 2024 at the same time as their subspecialty training, and 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. Subspecialists in UG attaining CCT will also be skilled in managing both the labour ward and acute gynaecological emergencies, as well as caring for people requiring high level subspecialist skills in pelvic floor dysfunction. 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 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 anatomical knowledge, 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.

O&G doctors achieving the CCT regardless of their SITMs 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.

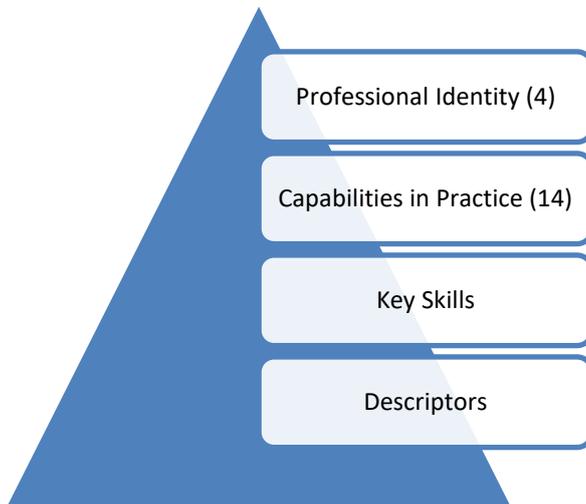
All CCT holders will:

- 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

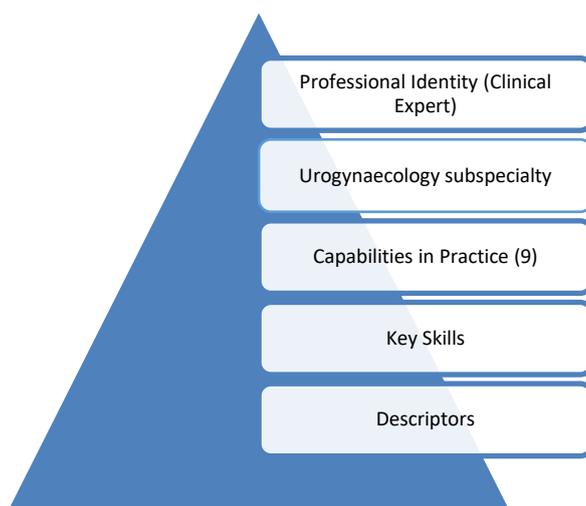
The practice of O&G requires the generic and specialty knowledge, skills and attitudes to advise and treat people presenting with a wide range of gynaecological and obstetric conditions and symptoms. It involves particular emphasis on woman-centred care, diagnostic reasoning, managing uncertainty, dealing with comorbidities, and recognising when specialty opinion or care is required. The modern consultant is defined by four Professional Identities in the O&G Curriculum 2024 that incorporate all of these elements, as demonstrated in Figure 1 below.

Figure 1 – Curriculum 2024 design structure



All the CiPs in the UG curriculum are in the Clinical Expert Professional Identities. This is because the trainee is also completing the Curriculum 2024 that 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

CiPs are the high-level learning outcomes within each of the Professional Identities. 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 that should be demonstrated by O&G doctors in the UG subspecialty. Descriptors can 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, including their risks and benefits, with women and their families.

Each CiP gives guidance for the variety 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, and there are a variety of ways in which the acquisition of these procedural skills can be evidenced. A number of these procedural skills that must be achieved to level 5 competency must be evidenced by three summative competent OSATs (Objective Structured Assessments of Training) and these are clearly marked in the procedure table. 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, and where three summative OSATs are mandated for competency sign-off, 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 3.2 outlines more detail on the mapping.

Assessment of the CiPs are underpinned by the descriptors and judged against the requirements articulated in the UG Curriculum Guide(s). 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.

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 O&G Curriculum. This does not mean that all procedural competencies need to be acquired to level 5 (as described above).

3.2 Urogynaecology subspecialty curriculum

Subspecialty curriculum framework in Urogynaecology consists of:

- **Urogynaecology and Vaginal Surgery SITM (UGVS CiPs 1, 2, 3 and 4)**
- **Four subspecialty specific CiPs (SST UG CiPs 1, 2, 3 and 4)**
- **One subspecialty specific research CiP (SSTR CiP)**

These 9 CiPs are outlined below.

The subspecialty trainee will need to complete all 9 CiPs to achieve subspecialty accreditation. The subspecialty-specific CiPs can only be completed as part of an accredited subspecialty training programme in Urogynaecology. A doctor who has completed part or all of the SITM (UGVS CiPs 1-4) prior to commencing subspecialty training in UG does not need to repeat any part of the SITM CiPs already completed.

Trainees with previous research experience, such as SIPM Clinical Research, can be used as evidence for the Research (SSTR) CiP and does not need to be repeated.



UG Subspecialty Programme Summary

SITM Urogynaecology & Vaginal Surgery (UGVS) – x4 CiPs	4
Subspecialty training – x4 CiPs	4
Subspecialty specific Research CiP	1

SITM: Urogynaecology and Vaginal Surgery (UGVS)

SECTION 1: CAPABILITIES IN PRACTICE (CiP)

UGVS CiP 1: The doctor has the knowledge, skills and attitudes required to clinically assess patients who have pelvic floor dysfunction.	
Key skills	Descriptors
Takes and presents a urogynaecological history in patients with urinary, bowel, pelvic organ prolapse and sexual problems	<ul style="list-style-type: none"> • Takes and presents an appropriate history, including the impact on quality of life. • 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 a clinical history and a bladder diary to make an initial diagnosis. • Selects 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 the team. • Describes the stage of pelvic organ prolapse using a recognised method, like the Pelvic Organ Prolapse



	<p>Quantification (POP-Q) system, or new assessments as they are introduced into clinical practice.</p> <ul style="list-style-type: none"> • Performs a neurological examination to assess neurological conditions that may affect the pelvic floor, and for perineal denervation. • Puts clinical findings in the context of the patient's symptoms.
Communicates and links with members of local and regional multidisciplinary teams	<ul style="list-style-type: none"> • Communicates the significance of clinical findings to the patient and multidisciplinary team. • Recognises indications and refers appropriately to specialist centres (eg mesh complications, fistula).
Evidence to inform decision – examples of evidence (not mandatory requirements)	
<ul style="list-style-type: none"> • Reflective practice • TO1/TO2 (including SO) • Attend urogynaecology clinics • Case discussion and observation of senior medical staff • Personal study 	<ul style="list-style-type: none"> • Tailored clinical experience • Feedback from trainer • CbD • Mini-CEX • Evidence of attendance at appropriate courses
Mandatory requirements	
No mandatory evidence	
Knowledge criteria	
<ul style="list-style-type: none"> • The terminology used for pelvic floor dysfunction • 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 • Neurological conditions that affect the lower urinary tract (e.g. multiple sclerosis) • Objective methods for assessing pelvic organ prolapse, including the POP-Q system • Design and validation of standardised symptom and quality of life questionnaires • Examination findings relevant to lower urinary tract disorders and prolapse 	



UGVS CIP 2: The doctor selects and performs tests appropriate for common urogynaecological presentations 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 urodynamics according to the standards set down in the common curriculum for multidisciplinary training in urodynamics (www.ukcs.uk.net). • 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 an ability to set up, use and maintain the equipment. Takes the measures necessary to achieve quality control of the equipment. • Explains the relevance of the test findings. • Is able to understand the impact of results on clinical management.
Refers for further investigation and management when appropriate	<ul style="list-style-type: none"> • Recognises indications for more advanced urodynamic assessment (ie video urodynamics, ambulatory urodynamics and urethral function studies) and refers appropriately. • Identifies available modalities and indications for imaging the urinary tract and makes appropriate requests. • Identifies available modalities and indications for investigating bowel symptoms and makes appropriate requests.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
<ul style="list-style-type: none"> • Reflective practice • Direct observation of senior colleagues • Attendance at local, deanery and national teaching and meetings: <ul style="list-style-type: none"> ○ attendance at a national urodynamics course ○ attendance at a national or regional anatomy teaching course 	<ul style="list-style-type: none"> • Leads critical incident review • CbD • Mini-CEX • TO1/TO2 (including SO) • Confirmed participation in multidisciplinary team meetings and clinics
Mandatory requirements	
<ul style="list-style-type: none"> • OSATS: <ul style="list-style-type: none"> ○ standard urodynamics (cystometry) 	



Knowledge criteria

- Relevant anatomy and physiology, and pathophysiology of pelvic floor conditions
- Indications for and methods of urodynamic testing, including:
 - Urinalysis
 - Urine culture and cytology
 - Pad tests
 - Assessment of urinary residual and bladder scan
 - Uroflowmetry
 - Subtracted dual channel cystometry
- Modalities for imaging the urinary tract
- Regional referral pathways and the role of regional subspecialist in the management of complex cases
- Modalities for investigating bowel symptoms

UGVS CiP 3: The doctor manages pelvic floor dysfunction using non-surgical methods.

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 using agreed clinical pathways and evidence-based guidelines. • Is aware of referral of patients to physiotherapists and nurse specialists at an early stage in 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 the patient accordingly. • Recognises the role of drug therapy for patients with overactive bladder symptoms, including pharmacological action, interactions and adverse effects. • Implements drug therapy appropriately and counsels patients on its success and adverse effects. • Manages patients with mixed urinary incontinence as part of a multidisciplinary team.
Demonstrates conservative management of stress urinary incontinence (SUI)	<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 on to 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 specialities as appropriate.
Recognises indications for anorectal investigation and treatment	<ul style="list-style-type: none"> Counsels patients on simple treatments for faecal incontinence and obstructive defaecation and refers appropriately.

Evidence to inform decision – examples of evidence (not mandatory requirements)

<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 multidisciplinary team clinics and meeting 	<ul style="list-style-type: none"> Demonstrates adequate exposure to managing pelvic floor dysfunction using non-surgical methods during training CbD Mini-CEX Feedback with trainer TO1/TO2 (including SO) Attendance at local/deanery teaching or training days/courses
---	---

Mandatory requirements

No mandatory evidence

Knowledge criteria

- The role of pharmacology in pelvic floor dysfunction, 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, including vaginal oestrogen
- Use of different charts to assess intake and/or output of urine and to assess and treat patients with excessive voiding patterns
- Principles of pelvic floor muscle training and role of different physical therapies
- Principles of bladder retraining and how to instruct patients on this treatment
- Non-surgical management of pelvic organ prolapse
- The indications for and fitting of ring, shelf, and other pessaries
- Basic understanding of anorectal dysfunction, faecal urgency, and incontinence



UGVS CIP 4: The doctor provides high-quality surgery for primary incontinence and prolapse.	
Key skills	Descriptors
Counsels patients appropriately on surgical management of pelvic floor disorders	<ul style="list-style-type: none"> Formulates a management plan and modifies it, if necessary. Counsels on the different surgical options for prolapse and incontinence, including non-surgical alternatives, complications, and outcomes. Demonstrates ability to take informed consent for surgery accordingly.
Demonstrates safe surgical practice	<ul style="list-style-type: none"> Recognises the indications and complications of surgical procedures in the management of pelvic floor dysfunction. Selects patients appropriately for vaginal prolapse and/or continence surgery. Performs surgery for primary incontinence and prolapse in a fluent and safe manner. Recognises the clinical findings which need onward management from a multidisciplinary team, including urology and sub-specialist urogynaecologists. Counsels on remaining NICE-approved primary procedures for stress urinary incontinence.
Manages postoperative complications, including voiding difficulty	<ul style="list-style-type: none"> Advise nursing staff on catheter management following continence surgery. Supervises a patient undergoing a programme of intermittent self-catheterisation. Recognises the role of other specialists in the management of surgical complications.
Recognises indications for referral to sub-specialist teams	<ul style="list-style-type: none"> Demonstrates an understanding of the different available surgical procedures for apical prolapse, including their indication and how to refer on for them, if required.
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 the BSUG Audit Database. Engages in local audits and leads a minimum of one audit a year, which must include one surgical audit.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
<ul style="list-style-type: none"> Reflective practice Non-Technical Skills for Surgeons NOTSS 	<ul style="list-style-type: none"> CbD Feedback from trainer



<ul style="list-style-type: none">• Attendance at postoperative ward rounds• Attendance at risk management meetings• Direct observation/consultant supervision within the module• Attendance at multidisciplinary team (MDT) meetings• Participation and completion of audit• Tailored clinical experience under supervision:<ul style="list-style-type: none">○ personal study○ appropriate postgraduate education courses and reading○ recording outcomes on national databases (e.g. BSUG Audit Database)	<ul style="list-style-type: none">• TO1/TO2 (including SO)• Mini-CEX
---	---

Mandatory requirements

- OSATS:
 - rigid cystourethroscopy
 - anterior vaginal wall repair (colporrhaphy)
 - posterior vaginal wall repair (colporrhaphy)
 - vaginal hysterectomy
 - sacrospinous fixation
 - colposuspension (open, laparoscopic or robotic)
 - autologous fascial sling

Knowledge criteria

- The necessary equipment, diathermy instrumentation and theatre set-up
- Potential surgical complications, assessment, investigation (including imaging) and management
- How to manage major haemorrhage
- The indications and complications of the following procedures, including principles of surgery:
 - cystoscopy
 - anterior and posterior vaginal wall repair +/- perineorrhaphy
 - vaginal hysterectomy for prolapse, including uterosacral plication or McCall culdoplasty
 - continence procedures in line with NICE guidance and as relevant to local services
 - bladder neck injections
 - sacrospinous fixation
- Surgical management of detrusor over-activity
- Treatment options for recurrent SUI and pelvic organ prolapse (POP) and ability to refer appropriately
- Surgical management of faecal incontinence and appropriate referral



- The surgical procedures for vault and apical prolapse, including potential benefits and risks
- The role of the local and regional MDT in primary and complex pelvic floor surgery
- How to audit surgical outcomes
- Preoperative and postoperative care

SECTION 2: PROCEDURES

Procedures marked with * require 3 summative OSATS

Procedures	Level by end of training	CIP 2	CIP 3	CIP 4
Standard urodynamics (cystometry)*	5	X		
Bladder scan	5	X		
Inserts and changes pessaries	5		X	
Rigid cystourethroscopy*	5			X
<i>Vaginal surgery for primary pelvic organ prolapse</i>				
○ anterior vaginal wall repair (colporrhaphy)*	5			X
○ posterior vaginal wall repair (colporrhaphy)*	5			X
○ vaginal hysterectomy*	5			X
○ uterosacral plication or McCall culdoplasty for vault support at vaginal hysterectomy	5			X
○ sacrospinous fixation*	5			X
<i>One first line procedure for primary stress urinary incontinence in line with NICE guidance and as relevant to local services, eg</i>				
○ colposuspension (open, laparoscopic or robotic)*	5			X
○ autologous fascial sling*	5			X

Subspecialty trainees in Urogynaecology will be expected to acquire the procedural skills listed in this table and those listed in the UG SST-specific procedures table.



SECTION 3: GMC GENERIC PROFESSIONAL CAPABILITIES (GPCs)

Mapping to GPCs

Domain 1: Professional values and behaviours

Domain 2: Professional skills

Domain 3: Professional knowledge

Domain 4: Capabilities in health promotion and illness prevention

Domain 5: Capabilities in leadership and team-working

Domain 6: Capabilities in patient safety and quality improvement

Domain 7: Capabilities in safeguarding vulnerable groups

Domain 8: Capabilities in education and training

Domain 9: Capabilities in research and scholarship

SECTION 4: MAPPING OF ASSESSMENTS TO UGVS CiPs

UGVS CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: The doctor has the knowledge, skills and attitudes required to clinically assess patients with pelvic floor dysfunction		X	X		X	X
2: The doctor selects and performs tests appropriate for common	X	X	X		X	X



UGVS CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
urogynaecological presentations, and interprets the results						
3: The doctor manages pelvic floor dysfunction using non-surgical methods		X	X		X	X
4: The doctor provides high-quality surgery for primary incontinence and prolapse	X	X	X	X	X	X



UG SST specific CiPs

SECTION 1: CAPABILITIES IN PRACTICE (CiP)

SST UG CiP 1: The doctor has the knowledge, skills and aptitude required for clinical assessment of complex pelvic floor dysfunction.	
Key skills	Descriptors
Assesses women with potential urethral diverticula (UD)	<ul style="list-style-type: none">• Diagnoses UD and investigates the condition 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 request 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 that affect 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 (USI) and detrusor over-activity.• 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 that affect the bladder.



Evidence to inform decision – examples of evidence (not mandatory requirements)

- | | |
|--|---|
| <ul style="list-style-type: none">• Reflective practice• Attend urogynaecology clinics• Case discussion and observation of senior medical staff• Personal study• Tailored clinical experience• Works with clinicians in other disciplines and spends time in their service:<ul style="list-style-type: none">○ coloproctologists, radiologists, physiotherapists, specialist nurses○ urologists and radiologists○ neurology and regional neuromodulation services | <ul style="list-style-type: none">• Feedback from trainer• CbD• Mini-CEX• Evidence of attendance at appropriate courses• TO1/TO2 (including SO) |
|--|---|

Mandatory requirements

No mandatory evidence

Knowledge criteria

- The impact of neurological conditions on lower urinary tract function (e.g. multiple sclerosis), and how to assess and counsel patients appropriately
- The lower urinary tract manifestations of specific neurological conditions and their management:
 - 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:
 - artificial urinary sphincters
 - augmentation cystoplasty
 - urinary diversion procedures
- The investigation and diagnostic criteria for fistulae (vesicovaginal, uterovaginal and urethrovaginal) and the surgical principles for repair and complications that may occur
- Urethral diverticula
- Treatments for ureteric obstruction and 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 faecal incontinence:
 - secondary anal sphincter repair
 - bulking agents
 - pelvic floor exercises
 - surgical management of rectal prolapse such as Delorme’s procedure and rectopexy
 - use of constipating agents
- Methods of investigations and principles of treatment for bowel emptying problems:
 - use of laxatives/conservative therapies
 - trans-anal rectocele repair
- Methods of investigations and principles of treatment for bowel urgency:
 - biofeedback
 - drug treatment
 - behavioural modification
- Investigations and principles of treatment of enteric fistulae, including those involving bladder, vagina, anus, or the perineum
- Pelvic floor electromyogram: use of sacral nerve stimulator
- Tibial nerve stimulation
- Range of mesh complications, methods of investigation and principles of treatment
- Context of mesh complications and specialist mesh centres in the United Kingdom

SST UG CiP 2: The doctor selects and performs tests that are appropriate for complex pelvic floor dysfunction 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"> • Performs and interprets results of more complex urodynamic assessment, including: <ul style="list-style-type: none"> ○ video-cystourethrography ○ ambulatory urodynamics ○ urethral function studies • Interprets results appropriately for urinary tract investigations, including: <ul style="list-style-type: none"> ○ renal ultrasound ○ abdominal X-ray ○ computerised tomography (CT)/magnetic resonance imaging (MRI) ○ intravenous urogram/CT urogram/MRI urogram ○ Micturating Cystogram ○ isotope renography (e.g. MAG3 scan)



	<ul style="list-style-type: none"> • Interprets results appropriately for gastrointestinal tract investigations, including: <ul style="list-style-type: none"> ○ anorectal function studies ○ endoanal ultrasound ○ Defecating proctogram/MRI ○ barium enema ○ contrast CT colon/Colonoscopy • Interprets pelvic floor electromyogram results
<p>Refers for further investigation and management, when appropriate</p>	<ul style="list-style-type: none"> • Describes the test procedure and results to patient and refers to relevant specialists. • Works within MDT services, including Urology and Coloproctology, in regional referral pathways and in managing complex cases.
<p>Evidence to inform decision – examples of evidence (not mandatory requirements)</p>	
<ul style="list-style-type: none"> • Reflective practice • Direct observation of senior colleagues • Attendance at local, deanery and national teaching and 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, including: <ul style="list-style-type: none"> ○ coloproctologists, radiologists, physiotherapists, specialist nurses ○ urologists and radiologists ○ neurology, regional neuromodulation services • Attendance at perineal and anorectal physiology investigation clinics 	<ul style="list-style-type: none"> • Confirmed participation in MDT meetings and specialist clinics • Leads critical incident review • CbD • Mini-CEX • TO1/TO2 (including SO) • NOTSS
<p>Mandatory requirements</p>	
<ul style="list-style-type: none"> • OSATS: <ul style="list-style-type: none"> ○ flexible cystourethroscopy ○ rigid cystourethroscopy ○ operative cystourethroscopy +/- bladder biopsy 	
<p>Knowledge criteria</p>	
<ul style="list-style-type: none"> • The role of more complex methods of investigation of lower urinary tract disorders: <ul style="list-style-type: none"> ○ video-cystourethrography 	

- ambulatory urodynamics
- urethral function studies
- cystourethroscopy: rigid/flexible
- bladder biopsy
- Investigations of the upper urinary tract:
 - renal ultrasound
 - abdominal X-ray
 - intravenous urogram/CT urogram/MRI urogram
 - micturating cystogram
 - isotope renography (e.g. MAG3 scan)
- Neurourology:
 - pelvic floor electromyography (use of sacral nerve stimulators and tibial nerve stimulation)
- Pelvic floor investigation:
 - magnetic resonance imaging
 - ultrasound of pelvic floor
- Colorectal investigations:
 - anorectal function studies
 - barium enema
 - contrast CT colon/Colonoscopy
 - defecating proctogram
- The impact of results on clinical management
- Effects of abnormal anatomy, physiology, and systemic disease. Also, the related symptoms and clinical findings
- Use of different charts to assess intake and/or output and to assess and treat women with excessive voiding patterns

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

Key skills	Descriptors
Demonstrates conservative management of complex pelvic floor disorders	<ul style="list-style-type: none"> ● Can counsel patients on the role of neuromodulation in managing pelvic floor disorders, including potential complications, and refers appropriately. ● Demonstrates understanding of, and initiates pharmacological measures in, more complex pelvic floor disorders.



<p>Manages indications and use of the different types of urinary catheters</p>	<ul style="list-style-type: none"> • Demonstrates understanding of the indications, use and potential complications for the different types of catheters. • Manages complications of catheters appropriately. • Can counsel patients on, and teaches them about, intermittent self-catheterisation and manages any complications that arise from this appropriately.
<p>Initiates management of faecal incontinence</p>	<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.
<p>Initiates management of obstructive defecation</p>	<ul style="list-style-type: none"> • Requests appropriate investigations and interprets results independently. • Formulates a management plan and modifies it independently, if necessary. • Initiates conservative management independently for obstructive defecation, including behavioral therapy.

Evidence to inform decision – examples of evidence (not mandatory requirements)

<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 MDT meetings • Works with clinicians in other disciplines and spends time in their service: <ul style="list-style-type: none"> ○ coloproctologists, radiologists, physiotherapists and specialist nurses ○ urologists and radiologists ○ neurology, regional neuromodulation services 	<ul style="list-style-type: none"> • Personal study • Demonstrates adequate exposure during training • CbD • Mini-CEX • Feedback with trainer • TO1/TO2 (including SO) • Attendance at local/deanery teaching or training days/courses
--	---



<ul style="list-style-type: none">• Attendance at perineal and anorectal physiology investigation clinics• Observation of, assisting and discussion with, senior medical staff	
Mandatory requirements	
No mandatory evidence	
Knowledge criteria	
<ul style="list-style-type: none">• Relevant anatomy, physiology, and abnormal function to the clinical situation• The role of pharmacology in pelvic floor dysfunction, including mechanism of action, adverse effects, and interactions• The effects of drugs used in other conditions on the lower urinary tract system• The role of neuromodulation in the treatment of Overactive Bladder Syndrome (OAB), including tibial nerve stimulation, and how to counsel someone on success and adverse effects• The principles of different modalities of pelvic floor exercises:<ul style="list-style-type: none">○ cones○ electrical therapy○ magnetic stimulator○ biofeedback• The principles of management of faecal urgency and incontinence• The conservative management for faecal urgency and incontinence, including behavioral therapy• Understands the role of sacral neuromodulation for faecal incontinence and has observed the procedure• The principles of managing obstructive defecation• The pharmacology, role and complications of laxatives and other drug therapies for these conditions• The role of the MDT in managing patients and how to refer on, as appropriate• Indications for different types of catheters, insertion of catheters and intermittent self-catheterisation• Principles of, and possible indications for, treating overactive bladder syndrome:<ul style="list-style-type: none">○ biofeedback○ acupuncture○ hypnotherapy○ psychotherapy	



SST UG CiP 4: The doctor provides high-quality surgical treatment for recurrent, less common, or more complex pelvic floor disorders.

Key skills	Descriptors
Can counsel patients appropriately on surgical management of pelvic floor disorders	<ul style="list-style-type: none">• Can counsel patients in situations of surgical complexity, including failed previous surgery.
Demonstrates 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, and the small and large bowel for perforation or damage, and undertakes appropriate special tests such as air insufflation and using 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 of them with the urology team.• Uses upper renal tract investigations appropriately.• Recognises the role of other specialists in managing surgical complications.
Selects appropriate mesh and can counsel patients about the benefits and risks of using mesh	<ul style="list-style-type: none">• Applies up to date knowledge and guidelines to selecting and using mesh.• Can counsel patients independently regarding mesh complications, including: infection, erosion, extrusion, and chronic pain.



<p>Performs incontinence and prolapse surgery and manages complications</p>	<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 the 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.
<p>Manages postoperative voiding difficulty</p>	<ul style="list-style-type: none"> • Can counsel patients on the different types of catheters (intermittent, urethral and suprapubic), explaining how to use them, their advantages, appropriateness and risks.
<p>Evidence to inform decision – examples of evidence (not mandatory requirements)</p>	
<ul style="list-style-type: none"> • Reflective practice • NOTSS • Attendance at theatre lists • Attendance at postoperative ward rounds • Attendance at risk management meetings • Leads critical incident review • Direct observation/consultant supervision within the module • Tailored clinical experience, under supervision, of: <ul style="list-style-type: none"> ○ personal study ○ appropriate postgraduate education courses and reading ○ recorded outcome on national databases (e.g. BSUG) 	<ul style="list-style-type: none"> • CbD • Mini-CEX • Feedback from trainer • TO1/TO2 (including SO) • Attendance at MDT meetings • Attendance at regional mesh complications MDT • Participation and completion of audit
<p>Mandatory requirements</p>	
<ul style="list-style-type: none"> • OSATS: <ul style="list-style-type: none"> ○ intravesical administration of botulinum toxin (through both rigid and flexible cystoscopes) ○ non-mesh anterior repair (colporrhaphy) ○ non-mesh posterior repair (colporrhaphy) ○ sacrospinous fixation ○ Sacrocolpopexy (open, laparoscopic or robotic)*colposuspension (open, laparoscopic or robotic) ○ autologous fascial sling 	



Knowledge criteria

- 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 and 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 that are available and their suitability for sacrocolpopexy and sacrohysteropexy
- The methods of mesh fixation to the sacral promontory, including safe use of stapling devices
- The use of imaging in assessing and managing postoperative complications
- The role of investigations and diagnostic criteria for fistulae (vesicovaginal, ureterovaginal and urethrovaginal)
- The role of the MDT in managing 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 cystoplasty
 - 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 complex pelvic organ prolapse, including paravaginal repair
- The principles for treating vault prolapse, including:
 - sacrospinous fixation
 - sacrocolpopexy (open and laparoscopic)
- The principles of subsequent management
- Surgical principles for the treatment of complex urodynamic stress incontinence and detrusor overactivity:
 - artificial urinary sphincters
 - augmentation cystoplasty
 - urinary diversion procedures
- The investigation and diagnostic criteria for fistulae (vesicovaginal, uterovaginal and 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 re-anastomosis and reimplantation techniques
- Secondary anal sphincter repair
- Surgical management of rectal prolapse, such as Delorme’s procedure and rectopexy

SECTION 2: PROCEDURES

Procedures marked with * require three summative competent OSATS.

<i>Procedures</i>	<i>Level by end of training</i>	<i>CIP 2</i>	<i>CIP 3</i>	<i>CIP 4</i>
Urethral function studies	2	X		
Video-urodynamic function studies	2	X		
Ambulatory urodynamic studies	2	X		
Cystourethroscopy				
○ flexible cystourethroscopy*	5	X		
○ rigid cystourethroscopy*	5	X		
○ operative cystourethroscopy +/- bladder biopsy*	5	X		
Pelvic floor electromyography (EMG)	1	X		
Renal ultrasound	1	X		



Procedures	Level by end of training	CIP 2	CIP 3	CIP 4
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		
Defecating proctogram	1	X		
Endoanal ultrasound	1	X		
Sacral nerve stimulation	1		X	
Posterior tibial nerve stimulation	1		X	
Teaches clean intermittent self-catheterisation (CISC)	3		X	
Inserts and changes suprapubic catheters	5		X	
Intravesical administration of botulinum toxin, through both rigid and flexible cystoscopes*	5			X
<i>Vaginal surgery for recurrent pelvic organ prolapse:</i>				
○ non-mesh anterior repair (colporrhaphy)*	5			X
○ non-mesh posterior repair (colporrhaphy) *	5			X
○ sacrospinous fixation*	5			X
<i>Abdominal and laparoscopic surgery for pelvic organ prolapse:</i>				
○ Laparoscopic sacrocolpopexy*	5			X
○ Open sacrocolpopexy	1			X
<i>Advanced laparoscopic surgery:</i>				
○ close port sites safely with all entry types	5			X
○ suture using laparoscopic needle holders	5			X
○ undertake intracorporeal and extracorporeal knot tying	5			X
<i>At least two first-line stress urinary incontinence procedures, in line with NICE guidance, and as relevant to local services, e.g.</i>				
○ colposuspension (open, laparoscopic or robotic)*	5			X
○ autologous fascial sling *	5			X
Bladder neck injections	5			X
Management of intraoperative bladder injury	5			X



<i>Procedures</i>	<i>Level by end of training</i>	<i>CIP 2</i>	<i>CIP 3</i>	<i>CIP 4</i>
Insertion of ureteric catheters	5			X
<i>Other prolapse procedures e.g.</i>				
o colpocleisis	1			X
o manchester repair	1			X
Repair of enteric fistulae	1			X
Trans-anal repair of rectocele	1			X
Delorme's procedure	1			X
Rectopexy	1			X
Secondary anal sphincter repair	1			X
Artificial urinary sphincter	1			X
Augmentation cystoplasty	1			X
Vesicovaginal fistula repair	1			X
Urethrovaginal fistula repair	1			X
Nephrostomy	1			X
Urinary diversion procedures	1			X
Ureteric re-anastomosis and reimplantation	1			X
Urethral diverticulectomy	2			X
Urethral dilatation	1			X
Surgical management of mesh complications	2			X

Subspecialty trainees in Urogynaecology will be expected to acquire the procedural skills listed in this table and those listed in the Urogynaecology and Vaginal Surgery SITM procedures table.

SECTION 3: GMC GENERIC PROFESSIONAL CAPABILITIES (GPCs)

Mapping to GPCs

Domain 1: Professional values and behaviours

Domain 2: Professional skills

Domain 3: Professional knowledge

Domain 4: Capabilities in health promotion and illness prevention

Domain 5: Capabilities in leadership and team-working



Domain 6: Capabilities in patient safety and quality improvement

Domain 7: Capabilities in safeguarding vulnerable groups

Domain 8: Capabilities in education and training

Domain 9: Capabilities in research and scholarship

SECTION 4: MAPPING OF ASSESSMENTS TO SST UG CiPs

SST UG CiP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: The doctor has the knowledge, skills and aptitude required for clinical assessment of complex pelvic floor dysfunction		X	X		X	X
2: The doctor selects and performs tests that are appropriate for complex pelvic floor dysfunction and interprets the results	X	X	X	X	X	X
3: The doctor is competent in non-surgical management of complex pelvic floor dysfunction	X	X	X		X	X
4: The doctor provides high-	X	X	X	X	X	X



SST UG CiP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
quality surgical treatment for recurrent, less common, or more complex pelvic floor disorders						

Research – Subspecialty Training

SECTION 1: CAPABILITIES IN PRACTICE (CiP)

SSTR CiP: The doctor is able to engage with research and promote innovation within their subspecialty.

Key skills	Descriptors
Demonstrates research skills	<ul style="list-style-type: none"> • Is able to demonstrate practice in healthcare research and the different methodologies within their subspecialty. • Shows continued engagement in Good Clinical Practice (GCP) and Research and Development (R&D) processes. • Engages in ethics and governance processes within research, demonstrating they are able to follow guidelines on ethical conduct and consent for research. • Demonstrates involvement in informatics, statistical analysis and emerging research areas within their subspecialty. • Shows engagement with national trials within their subspecialty, including patient recruitment, trial monitoring and adverse event reporting. • Shows understanding of the role of public and patient involvement within clinical trials. • Is able to discuss clinical trials with, and facilitate recruitment of, patients within their subspecialty.



	<ul style="list-style-type: none"> • Has the ability to translate research into clinical practice within their subspecialty.
Demonstrates critical thinking	<ul style="list-style-type: none"> • Is able to develop and critically appraise a research protocol. • Is able to critically evaluate clinical trial data to establish the clinically significant outcomes and relevance for clinical practice within their subspecialty. • Is able to interpret research findings, reflect on the potential impact on their clinical practice and share this with colleagues and patients. • Can develop and critically appraise a patient information leaflet. • Is able to interpret research findings within their subspecialty and discuss these when taking informed consent for treatment.
Innovates	<ul style="list-style-type: none"> • Demonstrates how their clinical practice has developed from innovative research within their subspecialty. • Is able to demonstrate engagement with the introduction of any innovations within their subspecialty, including governance and costs.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
<ul style="list-style-type: none"> • National teaching and courses • Critical appraisal of protocols/papers • Subspecialty journal club presentations • GCP re-certification • Participation, including recruitment for national multicentre trials • Preparation of research protocol/grant applications • Oral, and/or poster presentations at national/international subspecialty meetings 	<ul style="list-style-type: none"> • SIPM in Clinical Research • Peer reviewed original research publications relevant to their subspecialty • A higher degree such as a PhD or research MD

SECTION 2: PROCEDURES

There are no procedures in this SST Research CiP.



SECTION 3: GMC GENERIC PROFESSIONAL CAPABILITIES (GPCs)

Mapping to GPCs

Domain 1: Professional values and behaviours

Domain 2: Professional skills

Domain 3: Professional knowledge

Domain 4: Capabilities in health promotion and illness prevention

Domain 5: Capabilities in leadership and team-working

Domain 6: Capabilities in patient safety and quality improvement

Domain 7: Capabilities in safeguarding vulnerable groups

Domain 8: Capabilities in education and training

Domain 9: Capabilities in research and scholarship

4 The research component of subspecialty training

The subspecialty research CiP (SSTR CiP) builds on the Curriculum 2024 research requirements. It trains the sub-specialist to interpret and contribute to clinical research within their subspecialty, and to discuss and introduce new evidence to improve clinical outcomes for patients within their subspecialty.

Trainees who have completed the SIPM in Clinical Research or have had OOP research experience can use this evidence towards this CiP meaning those key skills and descriptors will not be repeated. Leading to the shortening of training time.

5 Learning and teaching

5.1 Stages 1-3 training programme

The organisation and delivery of postgraduate training is the responsibility of the National Health Service England (NHSE), 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 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

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 specifies 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, employers are expected to take action to ensure their training environments meet GMC 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, and so can provide detailed feedback on specific areas of training and education that support curriculum delivery.

The RCOG has produced a 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 the RCOG's Learning platform.
- 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.

A centre should have sufficient caseload to support the trainee in completing the approved subspecialty curriculum within the required timeframe.

Recognition may be granted for more than 1 trainee per centre, where there is supporting evidence that there is sufficient workload within the centre for given number of trainees.

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 in career direction.



6.2 Programme of assessment

Our overall programme of assessment as outlined in the Curriculum 2024 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 2024.

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 Curriculum 2024, 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 judgement 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 provide formative feedback. Those assessment tools that 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 of 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 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.



6.3 Assessment of CiPs

A global judgement by the educational supervisor is the fundamental basis of assessment of progression through the learning aims and requirements of a Capability in Practice. 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 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

Toward 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

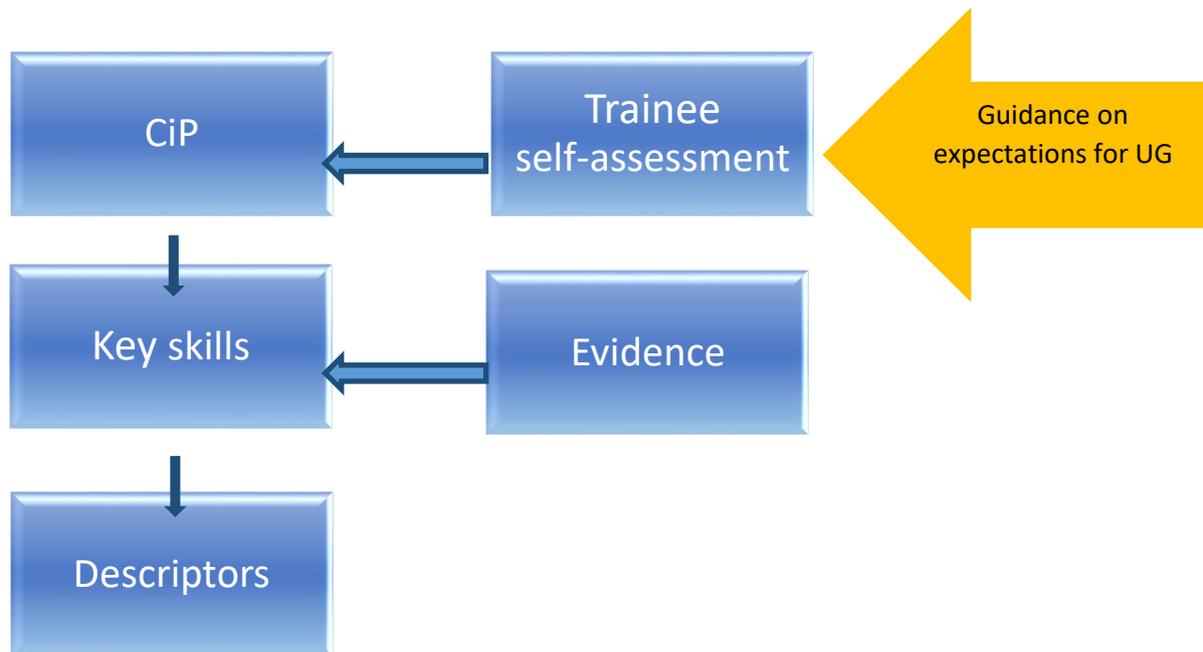
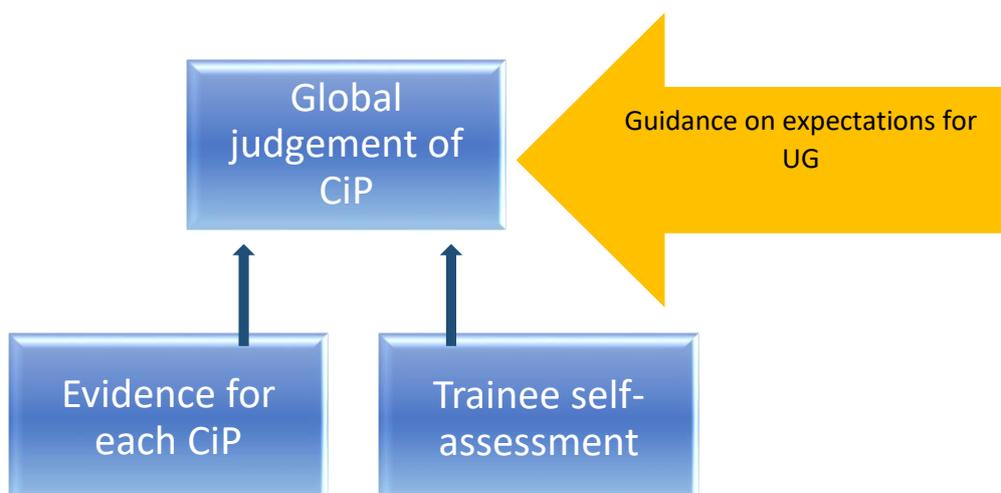


Figure 3b – STPS assessment of all CiPs





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 2 shows the five supervision levels that are based on an entrustability scale that are behaviourally anchored ordinal scale based on progression to competence and reflects judgements 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

¹ [Entrustability Scales: Outlining their usefulness for competency-based clinical 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
- 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 Curriculum 2024. 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.

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. Subspecialty training programmes are constructed in different ways, with some adopting a modular approach and others exposing the trainee to all disciplines throughout the programme. It is therefore not possible to write a matrix that 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.

Common sense and professional judgement will be required when assessing overall progress across the subspecialty curriculum at each yearly assessment, however there will be general guidance for panels to follow.

The following methods of assessment will provide evidence of progress. Evidence is a crucial concept in the 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 the UG subspecialty curriculum that requires 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 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) that has been piloted along with the modified WBA tools. The TO1 forms are summarised in a TO2 form that informs the ARCP.

Non-Technical Skills for Surgeons (NOTSS)

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. For subspecialty training the same principles apply as in the Curriculum 2024 but we expect the trainee to do these for sub-speciality related learning events.

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 e.g. 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 and the trainee's progress towards the required subspecialty CiPs will be formally assessed. The SST assessment follows the same principles as the ARCP, and needs to be undertaken by all subspecialists in training.

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. 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. 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.

7 Supervision and feedback

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

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.

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



- 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

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



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 that 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 to identify the appropriate learning opportunities and plan the appropriate frequencies and types of assessment according to 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.

⁴ [Recognition and approval of trainers](#)



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 the 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 NHSE/local teams and the devolved nations' deaneries. The NHSE 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 NHSE offices/deaneries or by RCOG or both.

8.1 Monitoring UG subspecialty

The development, implementation, monitoring and review of the UG subspecialty are the responsibility of the RCOG via the SEAC and the Subspecialty Committee. The 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, Training Programme Directors, STPSs and SITM 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 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 the CCT or Portfolio Pathway.

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 improve the quality of training environments and ultimately, the patient safety and experience. These are monitored and reviewed by RCOG to improve the provision of training and ensure enhanced educational experiences.

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

The UG subspecialty curriculum 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 developments and changes on the existing ePortfolio platform which will enable the Curriculum 2024 being delivered. The ePortfolio platform is 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, and write end-of-attachment appraisals and supervisor's reports.



NHSE 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.

RCOG has a number of initiatives and working groups to keep exploring and addressing the areas of equality, diversity and inclusion. In partnership with the GMC, RCOG analyses and monitors a range of datasets and has plans to report on this new initiative.

NHSE local offices/deaneries will quality assure each training programme to ensure 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 before appointment or within 12 months of taking up their post.
- NHSE local offices/deaneries ensuring that Educational Supervisors have had equality and diversity training (e.g. an e-learning module) every 3 years.
- NHSE local 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. NHSE local 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. NHSE local 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.

10.1 RCOG's current work on race equality in the specialty

We have committed to an action plan with the GMC demonstrating how we are targeting the attainment gap and working towards achieving fair training cultures. This work is overseen by both the RCOG SEAC and the Exams and Assessment Committee, as well as the College's honorary Differential Attainment Advisor and Educational Supervision Champion. These issues have been explored in past RCOG World Congresses and other quality improvement and development conferences.

Race Equality Taskforce members have published on differential attainment in [Obstetrics, Gynaecology and Reproductive Medicine](#) and [The Obstetrician and Gynaecologist](#), and contributed to the development of BMA guidance on induction for [International Medical Graduates recruited to the NHS](#).

We have also worked hard to listen to lived experiences of these issues, surveying our membership and holding focus groups for over 400 trainees, SAS and LE doctors, consultants, and medical directors working in O&G in deaneries across the UK. [Our annual Training Evaluation Form \(TEF\)](#) now includes questions on racism and cultural bias. The information gained from these will inform future work.

Find out more at
rcog.org.uk



Royal College of
Obstetricians &
Gynaecologists