# Curriculum Guide for Reproductive Medicine (RM) Subspecialty Training (SST)

## 1 What is RM subspecialty training about?

Subspecialty training in Reproductive Medicine will produce a doctor who has had advanced training in medical and surgical management of reproductive endocrinology and infertility, including a range of assisted reproductive techniques and is capable of providing the highest level of care for couples and individuals with fertility problems including those wishing to undertake fertility preservation. They will be leaders for these services at local, regional and potentially even national level, with key roles in education, training, innovation, quality management and improvement, research and governance, pertinent to fertility services.

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

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

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

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

# 2 Design of RM subspecialty training

Reproductive Medicine (RM) subspecialty training (SST) is a three-year programme (two years if the trainee has research exemption), made up of 5 clinical capabilities in practice (CiPs). These are listed in Table 1, and the details of each RM CiP can be found here.

**Table 1 – Capabilities in Practice (CiPs) for RM**

| **DEVELOPING THE OBSTETRICIAN & GYNAECOLOGIST: SST-RM** | |
|---|---|
| *PROFESSIONAL IDENTITY: CLINICAL EXPERT* | |
| RM CiP1 | The doctor is competent in recognising, assessing and managing endocrinological disorders |
| RM CiP2 | The doctor is competent in providing specialist care for women with endometriosis. |
| RM CiP3 | The doctor has the surgical skills appropriate for a subspecialist in reproductive surgery. |
| RM CiP4 | The doctor is competent in recognising, assessing and managing fertility problems and assisted conception. |
| RM CiP5 | The doctor is competent in recognising, assessing and managing complex early pregnancy problems |

No new curriculum items have been added between the previous RM subspecialty curriculum and this 2019 version. A few competencies have been removed which are no longer applicable to RM subspecialty practice in 2019 and these are achieved in the core training i.e. Contraception and Termination of pregnancy have been omitted from the RM CiPs as they are covered in the core curriculum. Guidance on ultrasound training is available here. Table 2 shows how the modules from the previous RM subspecialty curriculum map to these CiPs. The competency level required for RM subspecialty skills has not changed between the old and the reformatted 2019 curriculum.

**Table 2 - Mapping of current Reproductive Medicine (RM) subspecialty curriculum to new RM subspecialty Curriculum 2019**

| **RM Subspecialty Curriculum 2015 Modules** | **New RM SST curriculum capabilities in practice (CiP)** |
|---|---|
| **Module 1a: Female endocrinology** | **RM CiP1: The doctor is competent in recognising, assessing and managing endocrinological disorders** |

| | |
|---|---|
| **Module 1b: The ovary and polycystic ovarian syndrome** | **RM CiP1: The doctor is competent in recognising, assessing and managing endocrinological disorders** |
| **Module 1c: Paediatric and adolescent gynaecology** | **RM CiP1: The doctor is competent in recognising, assessing and managing endocrinological disorders** |
| **Module 1d: Contraception and termination** | **Removed** |
| **Module 1e: Menopause and premature menopause** | **RM CiP1: The doctor is competent in recognising, assessing and managing endocrinological disorders** |
| **Module 2: Endometriosis** | **RM CiP2: The doctor is competent in providing specialist care for women with endometriosis.**<br><br>**CiP3: The doctor has the surgical skills appropriate for a subspecialist in reproductive surgery** |
| **Module 3: Reproductive surgery** | **RM CiP3: The doctor has the surgical skills appropriate for a subspecialist in reproductive surgery** |
| **Module 4a: General subfertility** | **RM CiP4: The doctor is competent in recognising, assessing and managing fertility problems and assisted conception.** |
| **Module 4b: IVF and assisted conception** | **RM CiP4: The doctor is competent in recognising, assessing and managing fertility problems and assisted conception.** |
| **Module 5: Andrology** | **RM CiP4: The doctor is competent in recognising, assessing and managing fertility problems and assisted conception.** |
| **Module 6: Early pregnancy problems** | **RM CiP5: The doctor is competent in recognising, assessing and managing complex early pregnancy problems.** |

## 3 The Capabilities in Practice explained

Each RM CiP is made up of the following components;

a) A headline statement of expectation (high level learning outcome) describing in a generic way what a doctor can do once they have successfully achieved the RM CiP.

b) Key skills and descriptors which give further detail to this statement and give guidance on how the trainee can be judged against the expectations of the RM CiP.

c) Procedures which need to be learned and mastered as part of the RM CiP.

d) Knowledge criteria needed by the trainee to provide a foundation for the skills and practices covered by the RM CiP.

## a) High-level learning outcome

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

The 5 mandatory RM CiPs making up the RM SST are listed below. When considering whether progress is being made in each RM CiP it is both the trainee's wider skills as a medical professional and those relating to knowledge and processes of leadership and teamwork which need to be assessed in the round, as well as clinical competence.

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

**Table 3 - Statements of Expectations for RM subspecialty training**

| | **Statement of Expectations for RM subspecialty training** |
|---|---|
| **Meeting expectation RM CiP1** | A trainee meeting expectations will be able to independently perform an assessment of women with female endocrinological disorders affecting fertility and paediatric and adolescent gynaecology conditions. They will be able to formulate a differential diagnosis. They will be using the information acquired to plan further investigations. They will begin to create appropriate individualised management plans to manage fertility aspects of these conditions. They will use drug therapy appropriately. They will liaise with colleagues in other specialties for managing non-fertility aspects of these conditions. |
| **Meeting expectation RM CiP2** | A trainee meeting expectations will be able to independently perform an assessment of women with endometriosis. Using the information acquired, they plan appropriate radiological investigations and will be able to formulate a differential diagnosis. They will be able to discuss the impact of endometriosis on fertility and infertility treatment. They will be able to formulate appropriate individualised management plan and |

| | |
|---|---|
| | involve the multi-disciplinary team, when appropriate. They will use drug therapy appropriately. |
| **Meeting expectations RM CiP3** | A trainee meeting expectations will be able to appropriately select patients for reproductive surgery including surgical sperm retrievals for male factor infertility. They will use evidence based approach to undertake the surgery in a safe manner paying due regard to NICE guidance and appropriate consent. They will be able to manage intra and post-operative complications. |
| **Meeting expectations RM CiP4** | A trainee meeting expectations will be able to independently perform an assessment of individuals and couples with fertility problems. They will be able to undertake a non-judgemental and empathetic discussion around management of infertility including range of assisted reproductive techniques (ART). They will be able to independently undertake trans-vaginal/trans-abdominal ultrasound scan of the pelvis. They will be able to confidently advise individuals and couples of the success rates and risks of ART and recognise and appropriately manage complications of ART. They will be able to independently assess, advice and manage individuals and couples who require extensions of ART such as treatment using donor gamete/embryo, surrogacy, pre-implantation genetic testing and fertility preservation. They will have read and understood the HFEA Code of Practice. They will have a good understanding of ART laboratory techniques. |
| **Meeting expectations RM CiP5** | A trainee meeting expectations will be able to independently perform an assessment of couples following recurrent miscarriage. They will be able to discuss the possible reasons for recurrent miscarriage and use the information acquired to plan further investigations. They will be able to advise individualised management plans and provide support for a successful outcome in future pregnancies. |

**Table 4 - Levels of supervision**

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

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

## b) Key skills and their descriptors

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

## c) Practical procedures

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

- Diagnostic hysteroscopy
- Diagnostic laparoscopy
- Hysteroscopic surgery
- Laparoscopic adhesiolysis
- Laparoscopic treatment of endometriosis
- Laparoscopic ovarian cystectomy
- Laparoscopic salpingectomy
- Laparoscopic salpingostomy
- Myomectomy

However, it is recommended that the other procedural skills listed here which also require level 5 sign off should also be evidenced by at least three competent OSATs where possible before sign-off. This is an extensive list, and it is clear that some ‘procedures’ will be very difficult to evidence with OSATs. Because of this, only the procedures listed above require

three competent summative OSATs for satisfaction of the matrix at the time of the final subspecialty centralised assessment. However, collection of OSATs in a wider range of procedures assists in evidencing the final 'global judgement' of the trainee. Used properly, OSATs are assessing more than pure isolated technical skills; they assess general surgical and ultrasound skills, communication within teams, communication with patients, and the ability of a doctor to reflect on the care they are providing. It is clear, therefore, that a trainee who has demonstrated technical skills in a competent way across a wide range of procedures should be more readily signed off as reaching level 5 in the various RM CiPs which contain 'procedures'.

**Table 5 – Outline grid of supervision level expected for procedures**

| *Procedures* | *Level by end of training ** | *RM CIP 1* | *RM CIP 2* | *RM CIP 3* | *RM CIP 4* | *RM CIP 5* |
|---|---|---|---|---|---|---|
| Laparoscopic destruction of superficial endometriosis | 5 | | | X | | |
| Laparoscopic excision of deep endometriosis | 3 | | | X | | |
| Laparoscopic excision/ablation of ovarian endometriomas | 4 | | | X | | |
| Laparoscopic surgery – treatment of ovarian dermoid | 5 | | | X | | |
| Laparoscopic surgery – division of adhesions | 5 | | | X | | |
| Laparoscopic surgery – salpingectomy for hydrosalpinx | 5 | | | X | | |
| Laparoscopic surgery – salpingostomy | 5 | | | X | | |
| Laparoscopic surgery – myomectomy | 2 | | | X | | |
| Hysteroscopic surgery – resection of fibroid | 5 | | | X | | |
| Hysteroscopic surgery – resection of polyp | 5 | | | X | | |
| Hysteroscopic surgery - division of septum | 2 | | | X | | |
| Hysteroscopic surgery - division of adhesions | 5 | | | X | | |
| Hysteroscopic proximal tubal catheterisation | 5 | | | X | | |
| Excision of vaginal septum | 3 | | | X | | |

| *Procedures* | *Level by end of training ** | *RM CIP 1* | *RM CIP 2* | *RM CIP 3* | *RM CIP 4* | *RM CIP 5* |
|---|---|---|---|---|---|---|
| Imperforate hymen | 3 | | | X | | |
| Male surgery – percutaneous epididymal sperm aspiration | 2 | | | X | | |
| Male surgery – testicular sperm aspiration | 2 | | | X | | |
| Male surgery – open testicular biopsy | 2 | | | X | | |
| Male surgery - Microscopic epididymal sperm aspiration | 1 | | | X | | |
| Male surgery - Micro – TESE | 1 | | | X | | |
| Hysterosalpingography (HSG) | 2 | | | | X | |
| Hysterosalpingo contrast sonography (HyCoSy) | 5 | | | | X | |
| Saline sonohysterography | 5 | | | | X | |
| Blue dye test at laparoscopy | 5 | | | X | X | |
| Intrauterine insemination | 5 | | | | X | |
| Embryo transfer | 5 | | | | X | |
| Transvaginal ultrasound egg collection | 5 | | | | X | |
| Trans-abdominal ultrasound egg collection | 2 | | | | X | |
| Embryo transfer procedure | 5 | | | | X | |
| Excision of ovarian cystectomy | 5 | | | X | | |
| Laparoscopic salpingostomy for distal tubal blockages (cuff salpingostomy) | 5 | | | X | | |
| Laparoscopic ovarian diathermy for anovulatory polycystic ovary syndrome | 5 | X | | X | | |
| Proficiency in: Veress needle entry, Hasson & Parmer's point entry techiques | 5 | | | X | | |
| Safe tissue handling with laparascopic instruments, sharp and blunt dissection | 5 | | | X | | |
| Haemostatic techniques at laparoscopic and open surgery | 5 | | | X | | |
| Open myomectomy | 5 | | | X | | |

| *Procedures* | *Level by end of training ** | *RM CIP 1* | *RM CIP 2* | *RM CIP 3* | *RM CIP 4* | *RM CIP 5* |
|---|---|---|---|---|---|---|
| Excision of rudimentary horn of uterus (laparoscopic resection) | 1 | | | X | | |
| TAH+/-BSO X | 5 | | | X | | |
| Trans-vaginal ultrasound scan for: | | | | | X | |
| • follicular tracking | 5 | | | | X | |
| • Normal pelvis | 5 | | | | X | X |
| • Antral follicle count | 5 | | | | X | |
| • follicular tracking IVF | 5 | | | | X | |
| • endometrial development | 5 | | | | X | |
| • uterine fibroids | 5 | | | | X | X |
| • uterine cavity abnormalities | 5 | | | | X | |
| • congenital uterine anomaly | 5 | | | | | X |
| • ovarian pathology | 5 | | | | X | |
| • Adnexal pathology | 5 | | | | X | |
| • oocyte retrieval | 5 | | | | X | |
| • embryo replacement | 5 | | | | X | |
| • early pregnancy assessment | 5 | | | | X | X |

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

## d) Knowledge criteria

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

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

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

- OSATS
- CbD
- Mini-CEX
- Discussion of correspondence Mini-CEX
- Reflective practice
- TO2 (including SO)
- NOTSS
- Regional and National teaching and training
- RCOG (and other) eLearning
- Conferences and courses attended
- Procedural log
- Specialist clinics attendance
- Case log
- Case presentations
- Participation in HFEA and UKAS inspection
- Attendance at ART Ethics Committee Meeting
- Quality Improvement activity

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

**Table 6**

| RM CIP | OSATS | Mini-CEX | CbD | NOTSS | TO1/TO2 | Reflective practice |
|---|---|---|---|---|---|---|
| 1: The doctor is competent in recognising, assessing and managing endocrinological disorders | | X | X | X | X | X |
| 2: The doctor is competent in providing specialist care for women with endometriosis. | | X | X | X | X | X |
| 3: The doctor has the surgical skills appropriate for a subspecialist in reproductive surgery. | X | X | X | X | X | X |
| 4: The doctor is competent in recognising, assessing and managing fertility problems and assisted conception. | X | X | X | X | | X |
| 5: The doctor is competent in recognising, assessing and managing complex early pregnancy problems. | X | X | X | X | X | X |

## 5 When can a RM CiP be signed off?

The RM CiP is the fundamental basis of global judgement. Assessment of RM CiPs involves looking across a range of key skills and evidence to make a judgement about a trainee's suitability to take on particular responsibilities or tasks as appropriate to their stage of training. It also involves the trainee providing self-assessment of their performance for that stage of training. Each RM CiP has a lead statement, and the trainee and STPS must make their assessment of the competency level reached, as judged globally against this statement. There is no need to make an assessment of each key skill or descriptor within each RM CiP. The key skills and their descriptors are there to guide training and expectations but do not

need to be assessed individually. However, review of these skills and descriptors will aid in the global assessment of progress with that RM CiP and its lead statement.

Clinical Supervisors and others contributing to assessment will provide formative feedback to the trainee on their performance throughout the training year. Evidence to support the global rating for the RM CiP will be derived from workplace-based assessments and other evidence, e.g. TO2. The progress a trainee is making with the acquisition of technical procedural skills which form part of an RM CiP, should also be considered when giving a global rating (see below).

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

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

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

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

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

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

At certain key time points (usually prior to a subspecialty assessment), but also at any other point suggested by the trainee or their STPS, both the trainee and the STPS will make their own judgements of what competency level has been reached in each RM CiP Most crucially this is a global judgement. There does not have to be evidence linked to every key skill, until the trainee reaches the point of completion of the subspecialty training programme. In addition, evidence for the following generic areas relevant to MFM SST: 'Clinical governance', 'Teaching experience', 'Research', 'Leadership and management experience' and 'Presentations and publications' as outlined in the matrix will be needed at senior trainee

level (see point 6 below). It is the **quality** of the evidence not the quantity which is key. The progress a trainee is making with the acquisition of technical procedural skills which form part of that RM CiP, and their knowledge base, should also be considered when giving a global rating.

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

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

The expected progression described in Table 7 is modelled against full time clinical training. Many trainees work less than full time, and other trainees spend only a proportion of their working week in clinical subspecialty training if this is combined with an academic lecturer post. For those trainees on a three-year programme, the proportion of time spent on their research, and when this is done over the course of the three years, will vary, although the total whole-time equivalent (WTE) *clinical* training should be two years, with 12 months for the research component. It is not possible to write an outline grid of progress expected for RM CiPs which covers all these variations in the pattern of subspecialty training. At each subspecialty assessment, the panel will judge the evidence against how much whole-time equivalent *clinical* training time has occurred, not the number of calendar months since training began, or since the last assessment. It is expected that the STPS, through their reports, will make clear to the assessment panel how much WTE clinical training is being assessed.

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

through clinical training, the centralised assessment panel will expect the scores of the entrustability levels to have reached 14 (entrustability level 5 x 5 RM CiPs = 25). This will be calculated in a pro rata way for trainees who have completed only part of a full year of clinical training. This is a guide only, but serves to assess progress across a wide variety of different programme formats.

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

| | RM SST | | Subspecialty Accreditation |
|---|---|---|---|
| **Capabilities in practice** | **Progress expected by completion of 12 months WTE of clinical training** | **Progress expected by completion of 24 months WTE of clinical training** | |
| 1: The doctor is competent in recognising, assessing and managing endocrinological disorders. | **3** | **5** | **CRITICAL PROGRESSION POINT** |
| 2: The doctor is competent in providing specialist care for women with endometriosis. | **3** | **5** | |
| 3: The doctor has the surgical skills appropriate for a subspecialist in reproductive surgery. | **2** | **5** | |
| 4: The doctor is competent in recognising, assessing and managing fertility problems and assisted conception. | **3** | **5** | |
| 5: The doctor is competent in recognising, assessing and managing complex early pregnancy problems. | **4** | **5** | |

# 6 Generic capabilities

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

- Clinical Governance

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

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

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

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

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

## 7 The subsequent ARCP

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

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

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

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

## 8 Example case study

Dr Adeyemi has completed ten months of training as an ST6, and has commenced the Subfertility and Reproductive Health (SRH) ATSM. **He is using the 2019 core curriculum**. Prior to this, he had spent two years in a clinical research post which gave him excellent work experience in an IVF unit and has submitted an MD which will be examined very soon. Two first author papers have been generated and submitted. He applies for a subspecialty training post in RM, and is successful. He is granted a two-year programme in anticipation of research exemption.

Before commencing subspecialty training, he has a meeting with the ATSM educational supervisor. He judges his own progress in SRH ATSM CiPs 1, 2, 3 and 4 and is pleased that his supervisors agree with him. The agreed levels of competency across the SRH ATSM CiPs are 3, 1, 3 and 3 (for SRH ATSM CiPs 1, 2, 3 and 4 respectively). He is also making progress with having the generic core competencies signed off at ST6/7 level.

On commencing subspecialty training his new supervisor reviews his ePortfolio and has no disagreement with regards to his progress with these SRH ATSM CiPs. Together, they firstly review the RM SST CiPs which will need to be completed to level 5 competency over the next two years. The subspecialty training programme in this unit employs a modular approach. Dr Adeyemi will focus his first six months on scanning, attending fertility and endometriosis clinics, learning reproductive surgery and ART. Next six months he will be targeting andrology

clinics and continue his training with reproductive surgery and ART. Year 2 is when he will be spending some of his time in endocrinology and paediatric and adolescent gynaecology clinics, but will continue his training in reproductive surgery and ART.

Secondly, they review his progress with the core generic competencies, and clarify what will be needed as evidence for his centralised assessment and if anything more will be needed to sign off all the generic and non-clinical specialty core CiPs to ST6/7 level for his final ARCP.

Finally, they review his progress with the clinical core CiPs (9 to 12) and how these might be evidenced and signed off to entrustability level 5 by the time he completes training. They review guidance from the RCOG which gives examples of how the obstetric core CiPs (10 and 12) can be adequately evidenced for an RM trainee.

Dr Adeyemi's next ARCP happens to be 10 months after he starts subspecialty training. This means that his first subspecialty assessment is nine months following his start date. Three weeks before his centralised subspecialty assessment, Dr Adeyemi meets with his supervisor to review his progress and complete the supervisors form. Dr Adeyemi feels that he has now completed to level 5 RM SST CiP 2 and level 4 in RM SST CiP 4. He feels he has reached level 2 in RM SST CiPs 3 and 5 and level 1 in CiP 1.

His supervisor reviews his evidence and agrees with this assessment, except for RM SST CiP 5 (complex early pregnancy problems). Dr Adeyemi previously worked with an internationally renowned expert in recurrent miscarriage and has a very good understanding of assessment and management of couples with recurrent miscarriage. His supervisor reviews his OSATs, CbDs, mini-CEXs, procedure log and relevant reflections and feels he can be signed off at level 4 in RM SST CiP4.

Together, they then review the generic areas relevant to RM SST. Dr Adeyemi has almost completed an audit of the management of couples with recurrent implantation failure, and has helped to write a regional guideline on this topic. Together with his supervisor, he has worked to show that the live birth rate following single embryo transfer is similar to double embryo transfer, but significantly reduces the risk of multiple pregnancy for couples with recurrent implantation failure. His multi-source feedback is mostly very good, and he has a number of mini-CEX, reflections and NOTTS work place based assessments that he has linked to these core generic competencies, which support his very good communication skills. His NOTTS from labour ward suggest that he is a rather laid back individual who has a tendency to be rather passive during very busy times. They agree that he is making mostly good progress with these aspects of the curriculum but that he needs to focus on his prioritisation and leadership skills They discuss strategies for addressing these issues.

Dr Adeyemi has been awarded his MD, and both papers have been accepted for publication. He is research exempt, but needs to maintain some research activity over the remainder of his subspecialty training.

In summary, nine months into his subspecialty training, Dr Adeyemi is well ahead in some of the RM SST CiPs (because of aptitude and also because of the time spent before subspecialty training on the ATSM) but is further behind in one (likely as a result of the modular programme which need to be targeted in the coming months). Overall, however, the supervisor feels that progress is where it should be for this point in his training. Indeed, the sum of the entrustability levels across these five RM CiPs is 16, which is well over half what it will be at completion of SST (25; 5x5) He is awarded a satisfactory narrative outcome at his centralised assessment, and soon after meets with his ES once again to complete the ESR for his ARCP.

This is then an opportunity to focus on the progress Dr Adeyemi is making with his core generic and non-clinical specialty CiP completion and his core clinical CiP completion. It becomes clear that although Dr Adeyemi has a wealth of evidence supporting a wide range of generic skills and competencies, which was more than sufficient to satisfy the centralised assessors, he has not attached this evidence to the key skills of the core generic and non-clinical specialty CiPs in any comprehensive way. Following advice from his ES, he does this, along with some additional evidence he has collected, and then sends CiP assessment requests to his ES who is then happy to sign them off indicating that the trainee is meeting expectations for an ST6/7 trainee across all these generic and non-clinical specialty CiPs. Greater concerns are raised by reviewing CiPs 10 and 12 however, which have no evidence attached since the trainee commenced ST6. The ES reminds the pre-CCT RM trainee that he will be eventually awarded a CCT in both obstetrics and gynaecology, and that he needs to evidence his ST6/7 level competencies in obstetrics as well as gynaecology. They review RCOG advice covering this issue, and the trainee agrees to complete work place based assessments whilst covering obstetric emergencies on call, attends a fetal medicine where invasive prenatal testing is occurring, a maternal medicine clinic to observe how women with complex medical problems are cared for, and a couple of general antenatal clinics so that he remains up to date with more standard consultant based antenatal care. Because the trainee cannot evidence his progress in these obstetric capabilities in practice in time for his ARCP, he is awarded an outcome 2 by the ARCP panel (i.e. progress has been acceptable overall but there are some competences that have not been fully achieved and need to be further developed: additional training time not required). He already has a plan for how these issues will be addressed going forwards.

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