Royal College of Obstetricians & Gynaecologists

Curriculum 2024

Subspecialty Training Maternal & Fetal Medicine

Definitive Document

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Royal College of Obstetricians and Gynaecologists, 10-18 Union Street, London SE1 1SZ
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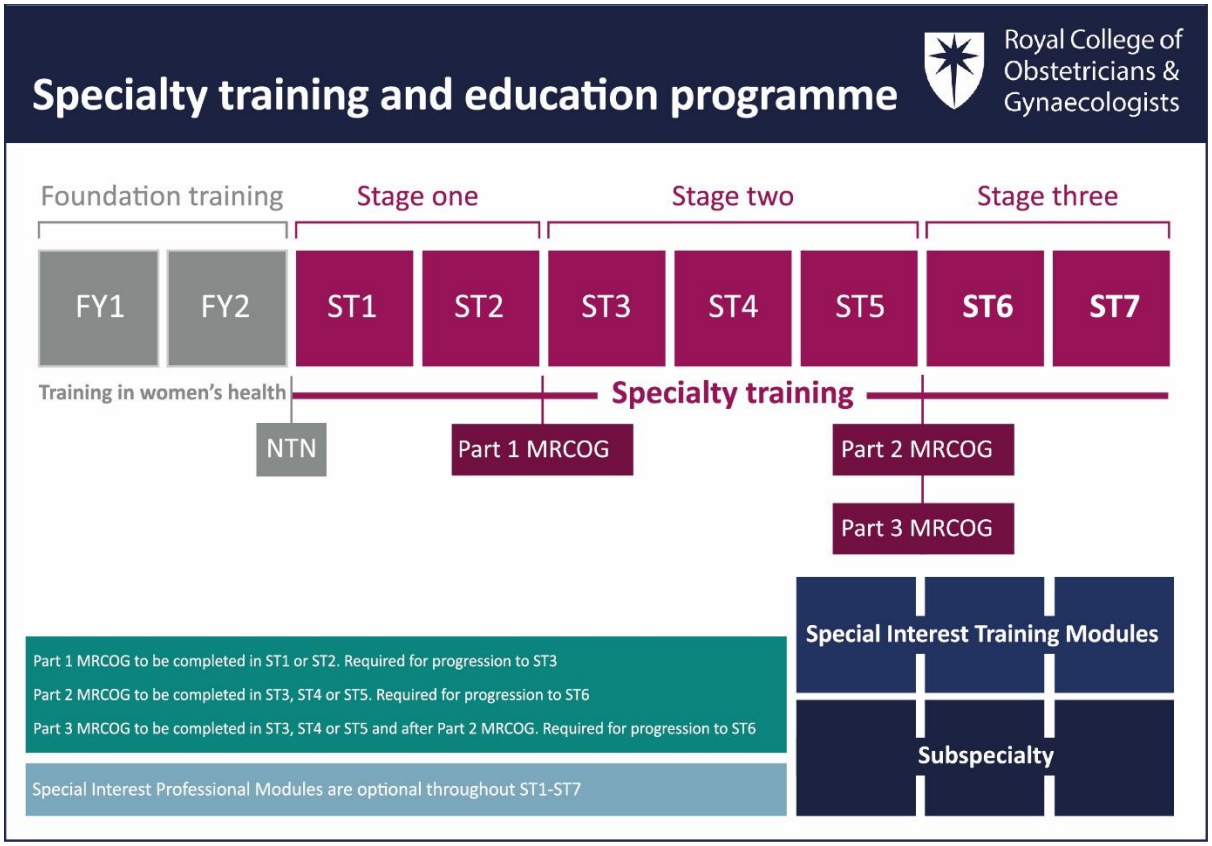
1 Introduction

This Definitive Document relates to the subspecialty of Maternal & Fetal Medicine (MFM) and addresses the purpose, learning outcomes, content of learning, process of training and the programme of assessment for MFM, 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 O&G curriculum. 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.



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2 Purpose of the Maternal Fetal Medicine 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 MFM subspecialty curriculum is to produce doctors with the generic professional and subspecialty-specific capabilities needed to advise and treat people presenting with a wide range of maternal and fetal conditions in tertiary referral centres. MFM 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 MFM 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. 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.*

2.2 General description of the MFM curriculum

MFM 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

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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 Core curriculum 2024, and the sub-speciality specific clinical and research CiPs detailed in this document.

The revised MFM curriculum consists of 16 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 MFM curriculum builds on the modular approach detailed in the RCOG submission for the obstetric SITMs. Four of these obstetric SITMs (Pregnancy Care (PC), Fetal Care (FC), Maternal Medicine (MM) and Prenatal Diagnosis (PD)) act as a foundation and must be completed during MFM 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 twelve SITMs, subspecialty trainees in MFM will also need to complete three 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 MFM

Developing the Obstetrician & Gynaecologist: SST-MFM	
PROFESSIONAL IDENTITY: CLINICAL EXPERT	
PC CiP 1	**The doctor demonstrates the skill and can apply knowledge in the management of the woman whose antenatal care is complicated by commonly encountered medical problems.**

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PC CiP 2	**The doctor demonstrates the skill and can apply knowledge in the management of the woman whose care is complicated by infections commonly encountered in pregnancy.**
PC CiP 3	**The doctor demonstrates the skill and can apply knowledge in the management of the woman whose postnatal care is complicated by commonly encountered medical problems.**
PC CiP 4	**The doctor demonstrates holistic care.**
MM CiP 1	**The doctor is able to work with others to provide high quality care to the woman with medical conditions in pregnancy or planning a pregnancy.**
MM CiP 2	**The doctor has a high level of understanding of the impact that medical conditions have on pregnancy and is able to optimise care for the affected woman.**
FC CiP 1	**Uses ultrasound skills to recognise, monitor and manage compromise to fetal well-being.**
FC CiP 2	**The doctor demonstrates the skills and attributes required assess the fetus at risk of red cell alloimmunisation.**
FC CiP 3	**The doctor demonstrates the skills and attributes required to assess complications of twin pregnancies.**
PD CiP 1	**The doctor can use ultrasound to recognise where fetal anatomy is not normal.**
PD CiP 2	**The doctor can assess and investigate a pregnancy where there are concerns regarding the fetus.**
PD CiP 3	**The doctor demonstrates the skills and attributes required to provide ongoing support and care to parents for whom a problem with their pregnancy has been identified.**
SST MFM CiP1	**The doctor is able to lead in providing care to women with pregnancies complicated by the full range of fetal concerns.**
SST MFM CiP 2	**The doctor can independently manage, in conjunction with specialists from other disciplines, pregnancies complicated by the widest range and most**

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	complex of maternal medical conditions, and contributes to the design and leadership of a Maternal Medicine Network.
SST MFM CiP3	**The doctor can apply knowledge of clinical and molecular genetics to the management of complex pregnancy.**
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.

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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 and 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 MFM CiPs. The combination of the MFM 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 also 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 MFM clinical skills and knowledge, reflecting the broad nature of this specialty in practice. Subspecialists in MFM attaining CCT will also be skilled in managing the labour ward independently, managing acute gynaecological emergencies, as well as caring for people requiring high level subspecialist skills in maternal and fetal medicine. 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 the 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 MFM curriculum will also need to demonstrate that they have achieved a thorough understanding of anatomical knowledge and skills appropriate for a subspecialist MFM consultant, and that they have the knowledge and skills to manage the full range of conditions affecting maternal and fetal health.

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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.

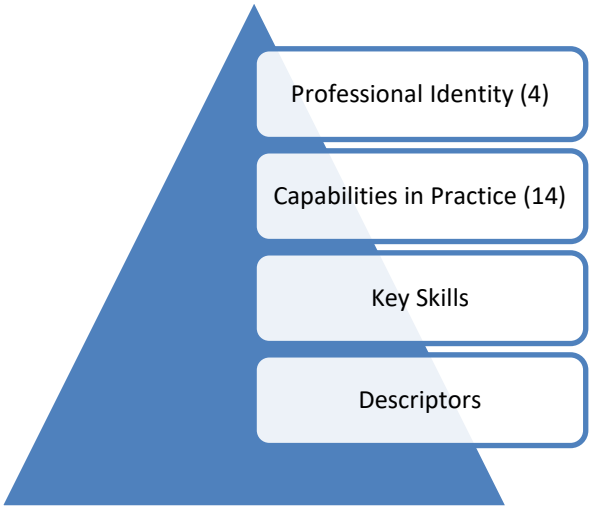
All CCT holders will:

- 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 MFM 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 Curriculum 2024 that incorporate all of these elements, as demonstrated in Figure 1 below.

Figure 1 – Curriculum 2024 design structure



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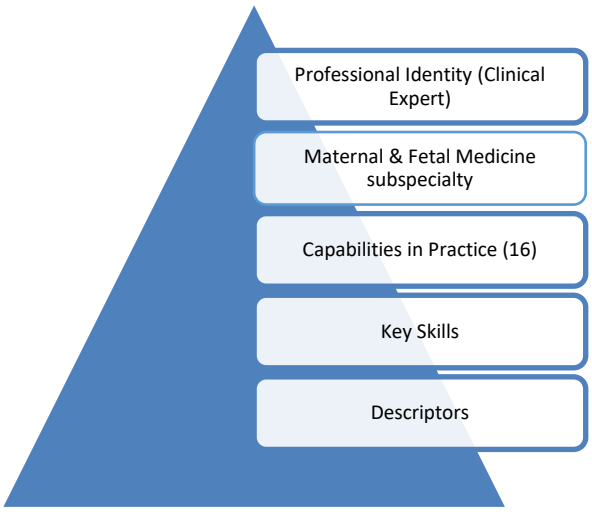
All the CiPs in the MFM curriculum are in the Clinical Expert Professional Identities. This is because the trainee is also completing the Curriculum 2024 that contains all the necessary generic professional skills a CCT-holder will need.

Figure 2 – MFM curriculum design structure



3.1 Curriculum framework features

The curriculum content is structured as follows:

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 MFM 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 MFM 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.

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Section 2 Procedures

All the procedures that are expected to be experienced during the MFM 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 MFM 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 MFM 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 Curriculum 2024. This does not mean that all procedural competencies need to be acquired to level 5 (as described above).

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3.2 Maternal & Fetal Medicine subspecialty curriculum

What follows is the curriculum framework, which articulates the detail for each of the Maternal and Fetal Medicine CiPs, including the mapping to the GPCs.

Subspecialty curriculum framework in Maternal and Fetal Medicine consists of:

- **Pregnancy Care SITM (PC CiPs 1, 2, 3 and 4)**
- **Maternal Medicine SITM (MM CiPs 1 and 2)**
- **Fetal Care SITM (FC CiPs 1, 2 and 3)**
- **Prenatal Diagnosis SITM (PD CiPs 1, 2 and 3)**
- **Three subspecialty specific CiPs (SST MFM CiP 1, 2 and 3)**
- **One subspecialty specific research CiP (SSTR CiP)**

These 16 CiPs are outlined below.

The subspecialty trainee will need to complete all 16 CiPs to achieve subspecialty accreditation. The subspecialty specific CiPs can only be completed as part of an accredited subspecialty training programme in Maternal and Fetal Medicine. A doctor who has completed part or all of the SITMs (PC CiPs 1-4, MM CiPs 1-2, FC CiPs 1-3 and PD CiPs 1-3) prior to commencing subspecialty training in MFM 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.

MFM Subspecialty Programme Summary

SITMs Pregnancy Care – x4 CiPs Maternal Medicine - x2 CiPs Fetal Care - x3 CiPs Prenatal Diagnosis - x3 CiPs	**12**
Subspecialty training CiPs x3	**3**
Subspecialty specific Research CiP	**1**

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SITM: Pregnancy Care (PC)

SECTION 1: CAPABILITIES IN PRACTICE (CiP)

PC CiP 1: The doctor demonstrates the skills needed, and can apply their knowledge, to manage antenatal care for a pregnant person with common medical problems.	
Key skills	**Descriptors**
Able to take a thorough medical history from the pregnant person	• Demonstrates the ability to take a thorough medical history and considers how pregnancy may affect the medical problem presentation and how the condition may affect the pregnancy. • Demonstrates the ability to record significant family history, drug history (including interactions and pregnancy safety), past medical history and systemic enquiry, including red flags.
Risk assesses the pregnant woman with co-existing medical conditions and plans for her pregnancy, in conjunction with specialist services	• Is able to risk assess women with medical problems and stratify them into low, medium or high-risk groups: those who can be managed using local expertise (category A); those who need clinical review and ongoing advice and guidance from the Maternal Medicine Centre (category B); and those whose care in pregnancy is best led by the Maternal Medicine Centre (category C). • Knows the limits of their knowledge and can communicate effectively with other specialities locally, and with the Maternal Medicine Network, to best manage the care of a pregnant person. Working within guidance and thresholds determined by the local Maternal Medicine Network, is able to: ○ assess a woman with a pre-existing medical condition preparing for pregnancy, and work with her to put together an appropriate plan. ○ evaluate and advise on drug therapy for medical conditions and tailor treatment when this would have a detrimental effect on pregnancy. ○ assess conditions that will have a significant impact on the outcome of pregnancy for a mother and her baby. ○ assess conditions where pregnancy may significantly deteriorate the health of a woman with a pre-existing medical condition and the surveillance required to limit risk. ○ access additional information needed to best manage complex medical conditions. ○ put together a delivery plan that minimises risk to a mother and her baby.

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	○ work in partnership with the woman to plan her care and delivery. • Refers to other medical and maternal medicine specialists, in line with local guidance.
Diagnoses and provides initial management for common acute medical presentations in pregnancy	• Understand what investigations are needed to explore common medical presentations, including shortness of breath, chest pain, headache, collapse, abdominal pain and fever/sepsis. • Constructs a differential diagnosis and requests appropriate investigations. • Initiate appropriate emergency management and liaise with allied specialities for an ongoing plan of care. • Understands the impact of, and interplay between, mental health conditions and maternal medicine conditions, and addresses this in management plans.
Diagnoses and manages hypertensive disorders in pregnancy	• Is able to assess and counsel women with hypertensive disorders, or at risk of a pregnancy-induced hypertensive disorders, pre-conceptually. • Understands and recognises the diverse aetiology of hypertension in pregnancy, whether pre-existing or arising in pregnancy. • Understands the risks that hypertensive disorders pose to pregnant people and can plan safe surveillance and management in the antenatal period. • Understands the risks that hypertensive disorders pose to a baby and can plan safe surveillance in the antenatal period. • Safely manages the hypertensive disorders in a woman in labour. • Understands and can create a safe management plan for a woman with severe pre-eclampsia and the complications of this condition. • Liaises with the multidisciplinary team (MDT), including the tertiary centre, where appropriate, to optimise the care of a woman with hypertensive disorders. • Works in partnership with the woman with a hypertensive disorder to plan her care and delivery. • Understands the long term implications of hypertensive disorders of pregnancy on the health and wellbeing of mother and baby. • Plans appropriate follow-up for a woman with a hypertensive disorder during pregnancy.

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Diagnoses and manages disorders of glucose metabolism in pregnancy	• Assesses and agrees a plan for the woman who has pre-existing diabetes to prepare for pregnancy. Demonstrates knowledge of the risk that pre-existing diabetes has on a mother and her baby. • Works effectively in the MDT to provide the best possible care for a pregnant woman with pre-existing diabetes during pregnancy and in labour. • Refers to the tertiary centre in more complex cases to access specialist care for a pregnant person with diabetes during pregnancy • Diagnoses and can counsel a woman who develops diabetes during pregnancy. • Devises a safe plan for maternal and fetal surveillance during pregnancy. • Can recognise and manage the acute complications of diabetes in pregnancy e.g. diabetic ketoacidosis. • Plans for a woman with diabetes to safely give and is able to adapt the plan to changing circumstances. • Safely manages the delivery of a woman with diabetes. • Works in partnership with a woman to plan her care and delivery. • Understands the long term implications of disorders of glucose metabolism in pregnancy on the health and wellbeing of the mother and her baby • Plans appropriate follow-up care for a pregnant person with diabetes
Diagnoses and manages common endocrine disorders in pregnancy	• Assesses and agrees a plan for the woman with hypothyroidism. • Assesses and agrees a plan for the woman with hyperthyroidism. • Manages the woman with micro- and macroprolactinoma safely through pregnancy.
Supports the health and wellbeing of a morbidly obese pregnant woman	• Is able to risk assess and plan for pregnancy and delivery, including women who have undergone bariatric surgery. • Is able to work with the woman to manage weight gain and create a suitable plan that encourages healthy nutrition. • Discusses and negotiates the most appropriate mode of delivery, taking into account patient choice and the safest delivery option. • Advises on modifications to birth that can enhance safety and the experience of the woman with morbid obesity. • Liaises with midwifery and anaesthetic colleagues to provide the best possible care.
Supports a pregnant woman with an eating disorder	• Is able to risk assess the pregnant person with an eating disorder and make plans for her pregnancy.

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	• Can safeguard the wellbeing of both the mother with an eating disorder and her baby.

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

• Reflective practice • NOTSS • TO2 • CbD • Mini-CEX	• RCOG Learning • Local and deanery teaching • Attendance at appropriate courses and conferences • Attendance at specialist diabetes antenatal clinics • Attendance at maternal medicine clinics • Log of cases and outcomes

Mandatory requirements

No mandatory evidence

Knowledge criteria

- Awareness and understanding of local maternal medicine networks and when to make referrals and involve the MDT
- The pathophysiology, definition, diagnosis, associated acute and long-term maternal and fetal complications, and best practice for managing pre-eclampsia and its variants
- The pathogenesis and classification, prevalence and complications of pre-existing diabetes (e.g. metabolic, retinopathy, nephropathy, neuropathy and vascular disease)
- Monitoring and optimisation of glucose control during labour
- Management of hypoglycaemia and ketoacidosis in pregnancy and labour
- The pathophysiology, presentation and implications for maternal and/or fetal health of common maternal conditions present at booking or that occur during pregnancy
- The aetiology, incidence, diagnosis, management; obstetric, medical and neonatal complications, and recurrence chance of each condition
- The interpretation of electrocardiograms (ECG), chest x-rays and blood gases analysis and how they are influenced by pregnancy
- How pregnancy alters physiology and what impact this has on medical conditions that are present, and how results of investigations should be interpreted during pregnancy
- The impact of drug treatment on the health of the mother and her babe
- The incidence, associated obstetric, medical and neonatal complications of the pregnant obese woman
- The endocrinology of obesity
- Weight reduction strategies and appropriate nutrition in managing the pregnant obese woman
- The risks associated with increased body mass index (BMI) in pregnancy and postpartum, and how these may be minimised
- The steps that can be taken before pregnancy to reduce the risks of morbid obesity during pregnancy

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PC CiP 2: The doctor demonstrates the skills needed, and can apply their knowledge, to manage the care of a pregnant woman whose pregnancy is complicated by infection which may affect the health of her baby.	
Key skills	**Descriptors**
Manages the care of a pregnant woman with infections that can affect their health and that of their baby	• Demonstrates a knowledge of the implications for pregnancy of variety of infections: HIV, syphilis, cytomegalovirus (CMV), toxoplasmosis, hepatitis B and C, herpes simplex virus (HSV), parvovirus and chicken pox (varicella). • Is able to interpret laboratory results for each infection by working closely with virology. • Explains the potential effects of infections on the baby, newborn and long-term effects of fetal infections. • Recognises when to refer a pregnant person with an infection and understands how best to share care and monitor them. • Works with the tertiary centre and MDT. • Works with the MDT to create a plan for medications for the mother during the birth and for the baby postnatally. • Gives appropriate advice to minimise the risk of vertical transmission.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
• Reflective practice • NOTSS • TO2 • CbD • Mini-CEX	• RCOG Learning • Local and deanery teaching • Attendance at appropriate courses and conferences • Log of cases and outcomes
Mandatory requirements	
No mandatory evidence	
Knowledge criteria	
• The clinical features, prevention, vertical transmission risk and ultrasound features of CMV, toxoplasmosis, parvovirus and varicella. Understands the short- and longer-term implications for the baby and newborn of contracting these infections, as well as the laboratory investigation that are needed and how to manage them during pregnancy • The role of the clinical virologist and the limitations of any antenatal treatment options	

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PC CiP 3: The doctor demonstrates the skills needed, and can apply their knowledge, to manage the postnatal care of a pregnant person with common medical problems.	
Key skills	**Descriptors**
Manages the care of a woman with medical conditions in the postnatal period – evidence for a variety of conditions but most include diabetes	• Discusses plans for contraception, tailored to the woman's needs. • Makes sure that the woman receives follow-up care in an appropriate setting. • Can discuss the long-term implications of medical conditions on the woman's health and wellbeing. • Supports the woman to limit the effect of her medical conditions on future pregnancies.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
• Reflective practice • NOTSS • TO2 • CbD • Mini-CEX	• RCOG Learning • Local and deanery teaching • Attendance at specialist diabetes antenatal clinics • Attendance at maternal medicine clinics • Log of cases and outcomes
Mandatory requirements	
No mandatory evidence.	
Knowledge criteria	
• Contraception in the postnatal period • Provision of long-acting contraceptives • Implications of medical conditions on the wellbeing of mother and baby, and understands the impact on further pregnancies	

PC CiP 4: The doctor provides holistic care to a pregnant person.	
Key skills	**Descriptors**
Is able to apply legal and ethical principles in pregnancy care, where this is needed	• Is able to screen for and organise safeguarding of a woman at risk of domestic violence. • Can screen for and organise safeguarding of the neonate at risk of harm. • Is able to counsel and complete an advance directive (recording decisions on healthcare in preparation for a future event) for the woman who declines blood products.

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Provides the best possible outcomes for a pregnant person who is socially vulnerable	• Is aware of the effect of social deprivation on pregnancy outcomes. • Understands the prevalence of domestic violence, the need to screen all women for this and agree a plan to safeguard the pregnant person and their children.

Evidence to inform decision – examples of evidence (not mandatory requirements)	
• Reflective practice • NOTSS • TO2 • CbD • Mini-CEX	• Attendance at pre-birth planning meetings with the safeguarding team

Mandatory requirements
No mandatory evidence

Knowledge criteria
• How social disadvantage can cause medical and neonatal complications, and legal consequences of social disadvantage with respect to: domestic violence, teenage pregnancy and asylum seekers • The influence of ethnic and religious background on obstetric expectations and outcome • The law in relation to seeking asylum • When and how to use different agencies involved in processing claims for asylum seekers and meeting their practical needs • The role of different agencies (social services, police and voluntary groups) in investigating suspected domestic violence and protecting vulnerable women and children • The law in relation to physical and sexual assault, bodily harm and rape • Female genital mutilation (FGM) procedures and their consequences, including for pregnancy and birth • Child protection issues associated with FGM • Religious beliefs and customs that may affect healthcare or consent for medical interventions

SECTION 2: PROCEDURES

There are no procedures in this SITM.

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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 PC CiPs

PC CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: The doctor demonstrates the skills needed, and can apply their knowledge, to manage antenatal care for a pregnant person with common medical problems		X	X	X	X	X
2: The doctor demonstrates the		X	X	X	X	X

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PC CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
skills needed, and can apply their knowledge, to manage the care of a pregnant person with common infections						
3: The doctor demonstrates the skills needed, and can apply their knowledge, to manage the postnatal care of a pregnant person who has common medical problems		X	X	X	X	X
4: The doctor provides holistic care to a pregnant person		X	X	X	X	X

SITM: Maternal Medicine (MM)

SECTION 1: CAPABILITIES IN PRACTICE

MM CiP 1: The doctor is able to work with others to provide high quality care to the woman with medical conditions in pregnancy or planning a pregnancy.	
Key skills	**Descriptors**

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Effectively communicates with the team providing care	• Builds on the key skills of the Pregnancy Care SITM and uses them when working on the full range of medical problems which may complicate pregnancy. • Works collaboratively across specialties and, where relevant, manages clinical networks through MDT meetings to construct pre-pregnancy, antepartum, intrapartum and postpartum management plans to ensure that high quality care is available locally to women with complex medical problems. • Plans care for women with complex medical problems in collaboration with other specialties. Makes appropriate referral to a regional maternal medicine clinic, where relevant. (In England this will be through the Maternal Medicine Networks either through MDTs for category B medical problems or referral for ongoing care to a Maternal Medicine Centre for category C medical problems). • Is aware of a possible genetic diagnosis that may not have been diagnosed to date. Refers to clinical genetics as appropriate.
Provides tailored pre-pregnancy counselling	• Can advise the person with complex medical conditions of the impact of pregnancy on their condition. • Is able to advise the person with complex medical conditions on the impact of the condition on their pregnancy. • Is able to advise on modifications that will optimise her health before embarking on pregnancy. • Is able to adjust medication to the safest regime for pregnancy. • Is able to put together a plan so the person knows what to expect once they become pregnant. • Is able to advise on the timing of pregnancy. • Is able to advise someone against conception in circumstances where the risk of pregnancy is too great.
Is able to consider the anaesthetic implications of maternal conditions, liaise with anaesthetic colleagues and plan according to someone's needs	• Is familiar with the anaesthetic considerations for the person with a variety of medical conditions. • Is able to work with anaesthetic colleagues to assess pregnant persons with complicated medical conditions and put together a plan to keep the person and the baby safe during pregnancy, delivery and the postnatal period. • Demonstrates familiarity with the effect of different intrapartum analgesia to make sure persons with complex medical conditions are safe in labour. • Participates in obstetric anaesthesia clinics.
Can perform a risk benefit analysis of investigations and	• Knows which investigations and medications are appropriate and can discuss the safety of these for the mother and fetus.

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treatments that could be used during pregnancy	• Is able to interpret tests e.g. chest x-ray, artificial blood gas (ABG) and electrocardiogram (ECG), lung function tests and echocardiogram. • Demonstrates understanding of the effects of drugs used for maternal indications on the fetus. • Understands and accommodates the physiological effects of pregnancy on interpreting laboratory results and the pharmacokinetics of any drugs used.

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

• Reflective Practice • NOTSS • TO2 • CbD • Mini-CEX	• RCOG Learning • Local and deanery teaching • Attendance at obstetric anaesthesia clinics • Attendance at maternal medicine network meetings

Mandatory requirements

No mandatory evidence

Knowledge criteria

- Local team structures, networks and guidelines for the management of medical conditions in pregnancy and outside of pregnancy.
- Awareness and understanding of local Maternal Medicine Networks and regional thresholds when to make referrals and include the MDT. Knows when it is appropriate to manage locally, or to manage locally with input from the regional maternal medicine clinic/the Maternal Medicine Centre and when referral to regional clinics/centres is advised.
- Criteria for referral to Maternal Medicine Centres/regional clinics.
- Structure of the Maternal Medicine Networks/regional clinics.
- In England categories for level of care within the Maternal Medicine Networks i.e. category A, B and C.
- When to seek specialist input.
- The structure and organisation of high dependency, intensive care and outreach teams.
- Indications for high dependency and intensive care.
- Methods of invasive monitoring for oxygenation, acid base balance, intra-arterial pressure, cardiac output, preload and contractility.
- The principles and practice of palliative care.

MM CiP 2: The doctor has a high level of understanding of the impact that medical conditions have on pregnancy and is able to optimise care for the affected woman.

Key skills	Descriptors

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Is able to manage care for the pregnant person who has renal problems in pregnancy	• Can construct an appropriate plan for pregnancy, delivery and the postnatal period to minimise the risks the woman's medical condition. • Can construct a plan for pregnancy, delivery and the neonatal period to minimise the risk to the fetus/baby. • Is able to recognise the presentation of renal disorders in pregnancy, can construct a differential diagnosis and work with the MDT to put together a suitable management plan for pre-existing or new onset conditions. • Understands which tests are appropriate in pregnancy for diagnosis and monitoring, and which are not valid or have different reference ranges in a pregnant woman. • Understands when tests pose an additional risk to the mother or fetus, and is able to discuss the relative risk and benefits of this. Can support a woman who deems the risk too high. • Has a good working knowledge of medical treatments for renal conditions that are safe in pregnancy, and can modify treatments when they are not safe. Knows how to access advice on safety.
Is able to manage care for someone who has haematological problems in pregnancy	• Can construct an appropriate plan for pregnancy, delivery and the postnatal period to reduce the risks associated with the woman's medical condition. • Can construct a plan for pregnancy, delivery and the neonatal period to reduce the risk to the fetus/baby. • Is able to recognise the presentation of haematological disorders in pregnancy, can construct a differential diagnosis and work with the MDT to put together a suitable management plan for pre-existing or new onset conditions. • Understands which tests are appropriate in pregnancy for diagnosis and monitoring of haematological disorders, and which are not valid or have different reference ranges in a pregnant woman. • Understands when tests pose an additional risk to the mother or fetus, and is able to discuss the relative risk and benefits of this. Can support a woman who deems the risk too high. • Has a good working knowledge of medical treatments for haematological conditions that are safe in pregnancy, and can modify treatment when they are not safe. Knows how to access advice on safety.
Is able to manage care for someone who congenital and acquired cardiac conditions in pregnancy	• Can construct an appropriate plan for pregnancy, delivery and the postnatal period to reduce the risks associated with the woman's medical condition.

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	• Can construct a plan for pregnancy, delivery and the neonatal period to minimise the risk to the fetus/baby. • Is able to recognise the presentation of cardiac disorders in pregnancy, can construct a differential diagnosis and work with the MDT to put together a suitable management plan for pre-existing or new onset conditions. • Understands which tests are appropriate in pregnancy for diagnosis and monitoring of cardiac disorders, and which are not valid or have different reference ranges in the pregnant woman. • Understands when tests pose an additional risk to the mother or fetus and is able to discuss the relative risk and benefits of this. Can support a woman who deems the risk too high. • Has a good working knowledge of medical treatments for cardiac conditions that are safe in pregnancy and is able to modify treatment when they are not safe and knows how to access advice on safety.
Is able to care for someone who has inflammatory conditions (connective tissue disorders, inflammatory bowel disease and dermatological problems) in pregnancy	• Can construct an appropriate plan for pregnancy, delivery and the postnatal period to reduce the risks associated with the woman's medical condition. • Can construct a plan for pregnancy, delivery and the neonatal period to minimise the risk to the fetus/baby. • Is able to recognise the presentation of inflammatory or dermatological conditions in pregnancy, can construct a differential diagnosis and work with the MDT to put together a suitable management plan for pre-existing or new onset conditions. • Understands which tests are appropriate in pregnancy for diagnosis and monitoring of inflammatory disorders, and which are not valid or have different reference ranges in a pregnant woman. • Understands when tests pose an additional risk to the mother or fetus and is able to discuss the relative risk and benefits of this. Can support a woman who deems the risk too high. • Has a good working knowledge of medical treatments for inflammatory disorders that are safe in pregnancy, including biologics. Is able to modify treatment when they are not safe and knows how to access advice on safety.
Is able to manage care for someone who has epilepsy and other common neurological problems in pregnancy	• Can construct an appropriate plan for pregnancy, delivery and the postnatal period for women with epilepsy, multiple sclerosis, idiopathic intracranial hypertension and chronic headache. • Can put together a plan for pregnancy, delivery and the neonatal period to minimise the risk to the fetus/baby.

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	• Is able to recognise the presentation of neurological disorders in pregnancy, can construct a differential diagnosis and work with the MDT to put together a suitable management plan for pre-existing or new onset conditions. • Can counsel a woman with epilepsy and other neurological problems to safeguard her baby.
Is able to care for someone who has liver disorders in pregnancy	• Can construct an appropriate plan for pregnancy, delivery and the postnatal period to reduce the risks associated with the woman's medical condition. • Can construct a plan for pregnancy, delivery and the neonatal period to minimise the risk to the fetus/baby. • Is able to recognise the presentation of liver disorders in pregnancy, can construct a differential diagnosis and work with the MDT to put together a suitable management plan for pre-existing or new onset conditions. • Understands which tests are appropriate in pregnancy for diagnosis and monitoring of liver disorders, and which are not valid or have different reference ranges in the pregnant woman. • Understands when tests pose an additional risk to the mother or fetus, and is able to discuss the relative risk and benefits of this. Can support a woman who deems the risk too high. • Has a good working knowledge of medical treatments for liver conditions that are safe in pregnancy, and is able to modify treatment when they are not safe. Knows how to access advice on safety.
Is able to manage care for someone who has HIV in pregnancy	• Can construct an appropriate plan for pregnancy, delivery and the postnatal period to reduce the risks associated with the HIV in pregnancy. • Can construct a plan for pregnancy, delivery and the neonatal period to minimise the risk to the fetus/baby. • Understands which tests are appropriate in pregnancy for diagnosis and monitoring, and which are not valid or have different reference ranges in a pregnant woman. • Understands when tests pose an additional risk to the mother or fetus and is able to discuss the relative risk and benefits of this. Can support a woman who deems the risk too high. • Has a good working knowledge of medical treatments for HIV conditions that are safe in pregnancy and is able to modify treatment when they are not. Knows how to access advice on safety and the criteria for commencing treatment during pregnancy.

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Is able to care for someone who has respiratory compromise in pregnancy	• Can construct an appropriate plan for pregnancy, delivery and the postnatal period to reduce the risks associated with the woman's medical condition. • Can put together a plan for pregnancy, delivery and the neonatal period to reduce the risk to the fetus/baby. • Is able to recognise the presentation of respiratory disorders in pregnancy, can construct a differential diagnosis and work with the MDT to put together a suitable management plan for pre-existing or new onset conditions. • Understands which tests are appropriate in pregnancy for diagnosis and monitoring, and which are not valid or have different reference ranges in a pregnant woman. • Understands when tests pose an additional risk to the mother or fetus and is able to discuss the relative risk and benefits of this. Can support a woman who deems the risk too high. • Has a good working knowledge of medical treatments for respiratory conditions that are safe in pregnancy and is able to modify treatment when they are not safe. Knows how to access advice on safety.
Is able to manage care for someone who has current or past malignancy in pregnancy	• When malignancy is diagnosed in pregnancy, is able to support a woman through a tailored plan for treatment during pregnancy and provide them with reassurance of the suitability of this plan during. • Is able to weigh up the timing of delivery around someone's treatment needs. • When malignancy has been treated prior to pregnancy, is aware of the implications for maternal health during pregnancy and is able to mitigate against these. • Is mindful of the fetal considerations when managing malignancy in pregnancy. • Understands which tests are appropriate in pregnancy for diagnosis and monitoring of cancer, and which are not valid or have different reference ranges in a pregnant woman. • Understands when tests pose an additional risk to the mother or fetus and is able to discuss the relative risk and benefits of this. Can support a woman who deems the risk too high.

Evidence to inform decision – examples of evidence (not mandatory requirements)	
• Reflective Practice • NOTSS • TO2 • CbD	• RCOG Learning • Local and deanery teaching • Attendance at appropriate courses and conferences (eg BMFMS, MOMS) • Log of cases with outcomes

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• Mini-CEX	• Attendance at non-obstetric specialist medical clinics • Attendance at maternal medicine MDTs

Mandatory requirements

No mandatory evidence

Knowledge criteria

- The normal functional and anatomical changes of the different body systems during pregnancy (e.g. cardiovascular, respiratory, gastrointestinal, endocrine and haematological)
- The pathological changes in the function of these body systems in pregnancy
- Renal conditions - understands the risk factors, presentation, investigation, differential diagnosis, management and outcomes of renal conditions predating and arising in pregnancy, and the effect of labour and birth on these conditions:
    - acute renal impairment
    - hydronephrosis
    - renal disease and hypertension
    - glomerulonephritis
    - reflux nephromathy
    - renal transplant
- Haematological - understands the risk factors, presentation, investigation, differential diagnosis management and outcomes of renal conditions predating and arising in pregnancy and the effect of labour and birth on these conditions:
    - sickle cell disease and crisis
    - thalassaemia
    - thromboembolic disease
    - bleeding disorders
    - disorders of platelets
- Cardiac - understands the risk factors, presentation, investigation, differential diagnosis management and outcomes of cardiac conditions predating and arising in pregnancy and the effect of labour and birth on these conditions:
    - congenital cardiac disease
    - ischaemic cardiac disease
    - mechanical and tissue valve replacements
    - peripartum cardiomyopathy
- Connective tissue disorders - understands the risk factors, presentation, investigation, differential diagnosis management and outcomes of connective tissue disorders predating and arising in pregnancy and the effect of labour and birth on these conditions:
    - System lupus erythematosus (SLE)
    - rheumatoid arthritis
    - autoimmune lymphoproliferative syndrome (APLS)
- Gastrointestinal - understands the risk factors, presentation, investigation, differential diagnosis, management and outcomes of gastrointestinal conditions predating and arising in pregnancy and the effect of labour and birth on these conditions:
    - acute fatty liver
    - Crohn's disease

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  - ulcerative colitis
  - obstetric cholestasis
  - hyperemesis gravidarum
  - immune and infective hepatitis
  - liver transplant
- Dermatological conditions - understands the risk factors, presentation, investigation, differential diagnosis, management and outcomes of dermatological conditions predating and arising in pregnancy and the effect of labour and birth on these conditions:
  - psoriasis
  - eczema
  - pemphigoid
  - polymorphic eruption of pregnancy
  - prurigo
  - pruritic folliculitis
- Neurology - understand the risk factors, presentation, investigation, differential diagnosis, management and outcomes of neurological conditions predating and arising in pregnancy and the effect of labour and birth on these conditions:
  - multiple sclerosis
  - epilepsy
  - bell's palsy
  - migraine
  - stroke
  - cerebral palsy
- HIV infection - understands the risk factors, presentation, investigation, differential diagnosis, management and outcomes of HIV predating and arising in pregnancy and the effect of labour and birth on these conditions.
- Current pharmacological management of HIV, and drug side effects.
- Respiratory disease - understands the risk factors, presentation, investigation, differential diagnosis, management and outcomes of respiratory conditions predating and arising in pregnancy and the effect of labour and birth on these conditions:
  - asthma
  - cystic fibrosis
- Malignancy - understands the risk factors, presentation, investigation, differential diagnosis, management and outcomes of malignancy predating and arising in pregnancy and the effect of labour and birth on malignancy:
  - breast cancer
  - leukaemia
  - lymphoma
- Genetics and disease inheritance of medical disorders – the risk to the mother and to the fetus and screening options e.g. haemoglobinopathy
- How pregnancy can influence the findings of investigations and may alter treatment effects
- How the medical problem may deteriorate during pregnancy, how this might present, and how it would be managed.
- Paediatric network guidelines for the management of newborn problems, including frameworks around extreme prematurity and antenatal parallel care planning.

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- The pharmacology of drugs used to manage these conditions.
- The pregnancy and breastfeeding safety profile of drugs, chemotherapy and radiotherapy used to manage these medical conditions .
- Recurrence risks for future pregnancies
- The best forms of contraception for women with these specific medical disorders

SECTION 2: PROCEDURES

There are no procedures in this SITM.

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 MM CiPs

MM CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: The doctor is able to work with others to provide high quality care to someone with		X	X	X	X	X

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MM CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
medical conditions in pregnancy or who is planning a pregnancy						
2: The doctor has a high level of understanding of the impact that medical conditions have on pregnancy and can provide the best care for the affected woman		X	X	X	X	X

SITM: Fetal Care (FC)

SECTION 1: CAPABILITIES IN PRACTICE

FC CiP 1: Uses ultrasound skills to recognise, monitor and manage compromise to fetal wellbeing.	
Key skills	**Descriptors**
Uses ultrasound to screen, diagnose and manage fetal compromise	• Understands the principles of transabdominal and transvaginal scanning, using ultrasound safely. • Able to measure fetal biometry to monitor the fetus at risk of growth restriction. • Able to recognise and manage early and late severe fetal growth restriction (FGR), referring cases of early FGR to tertiary services. • Able to recognise disorders of amniotic fluid volume and plan accordingly.

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Uses Doppler studies to screen, diagnose and manage fetal compromise	• Able to perform uterine artery Dopplers to assess the risk of placental dysfunction. • Able to perform umbilical artery Dopplers to assess fetal resilience. • Able to perform middle cerebral artery (MCA) Dopplers to evaluate fetal compromise. • Able to perform ductus venosus Dopplers to evaluate fetal compromise.
Uses ultrasound to assess placental location	• Able to use transvaginal scanning to diagnose and manage low-lying placenta.
Discusses their findings with the pregnant woman	• Demonstrates the ability to communicate their findings and the degree of risk effectively so that the woman can be involved in an informed decision-making process.
Assesses and plans the management and delivery of a fetus with severe growth restriction	• Provides ongoing assessment of fetal biometry over time when severe FGR is identified. • Able to use fetal Dopplers – umbilical, MCA and ductus venosus – to assess fetal wellbeing and plan the timing of delivery. • Able to discuss gestation-related risk of delivery versus continuation of pregnancy with the pregnant woman and facilitate informed decision-making.
Provides support and counselling post birth and for future pregnancies	• Provides follow up after the birth and accesses support services for the parents, where outcomes are complicated or poor. • Explains additional information learned after the birth e.g. placental histology. • Able to make a plan for future pregnancies, outlining recurrence risks and preventive strategies.

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

• NOTSS • TO2 • CbD • Mini-CEX	• Reflective practice • Attendance at appropriate courses e.g. ultrasound theory/practice • Log of cases with outcomes

Mandatory requirements

- OSATS
  - fetal biometry and liquor volume
  - transvaginal placental localisation
  - umbilical artery Doppler
  - middle cerebral artery Doppler

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○ ductus venosus Doppler ○ uterine artery Doppler
Knowledge criteria
• The risks associated with the different ultrasound modalities and how to limit them – mechanical index (MI) and thermal index (TI) • How to use machine controls to optimise the image, including: power, gain, focal length, magnification, sector width, frame rate, pulse repetition frequency, colour and power Doppler modes. • The difference between small for gestational age (SGA) and fetal growth restriction (FGR) • The differential diagnosis for fetal growth restriction • How Doppler assessments are used to monitor growth restriction, timing of birth and detect fetal anaemia • National guidance on monitoring for FGR, the timing of birth and signs that a referral need to be made to a subspecialist when managing FGR • How fetal anomalies may influence the Doppler waveforms (e.g. cardiac arrhythmias, fetal anaemia, hydrops and twin-to-twin transfusion syndrome (TTTS)) • Definition of low-lying placenta and how to make the diagnosis using ultrasound • Management of placenta praevia • The risk factors for abnormal placental invasion (AIP) and vasa praevia and how to diagnose them using ultrasound, and/or when to refer to a regional AIP service • Definition of oligohydramnios and polyhydramnios and the differential diagnosis, investigation and management

FC CiP 2: The doctor demonstrates the skills and attributes required to assess the fetus at risk of red cell alloimmunisation.	
Key skills	**Descriptors**
Safely manages the pregnancy where there is a risk of red cell immunisation	• Provides appropriate antenatal care to the woman with a pregnancy at risk. • Recognises when there is a risk of fetal anaemia. • Explains the potential fetal and maternal risks of red cell antibodies. • Liaises with blood transfusion and neonatal services. • Classifies the risks for any pregnancy complicated by red cell antibodies. • Performs and interprets the findings of a MCA Doppler. • Monitors the pregnancy at risk and understands the thresholds for referral to tertiary units with transfusion services.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
• NOTSS • TO2 • CbD	• Reflective practice • Evidence of MDT working • RCOG Learning:

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• Mini-CEX	○ observation of fetal blood transfusion
Mandatory requirements	
• OSATS ○ middle cerebral artery Doppler	
Knowledge criteria	
• Differential diagnosis for fetal anaemia • Ultrasound and cardiotocography (CTG) changes secondary to severe fetal anaemia • Which red cell antibodies may cause haemolytic disease of the fetus and newborn, and threshold antibody levels that carry significant risk • When and how surveillance for fetal anaemia should be instituted • How MCA velocities are used to monitor signs of anaemia • Triggers for referral to a tertiary level unit capable of performing intrauterine transfusion • Treatment of fetal anaemia • The role of intravenous immunoglobulin (IVIgG) in haemolytic disease of the fetus and newborn • Management of the newborn risk of kernicterus	

FC CiP 3: The doctor demonstrates the skills and attributes required to assess complications of twin pregnancies.	
Key skills	**Descriptors**
Uses ultrasound to monitor twin pregnancies	• Able to determine the chorionicity of a twin pregnancy when scanning in first trimester. • Able to assess and monitor a twin pregnancy using biometry and Doppler scanning techniques.
Manages complicated twin pregnancies	• Able to diagnose and make an initial assessment of growth discordancy in twin pregnancies. • Able to discuss effectively the timing of delivery with parents and facilitate informed decision-making, considering the risk to both twins of delivery or continuing the pregnancy when there is growth discordancy. • Refers to tertiary services when early and severe growth discordancy occurs. • Able to assess and monitor the monochorionic twin pregnancy for presence and evolution of TTTS. • Refers to tertiary services when there is evidence of TTTS or selective FGR in monochorionic twins. • Assists with follow up after treatments for TTTS. • Recognises the possibility of other complications of monozygotic twinning, including selective FGR, discordant anomalies, twin reversed arterial perfusion sequence (TRAP) and single

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	intrauterine death, and refers appropriately to fetal medicine tertiary services. • Is aware of the principles of management of higher multiples.

Evidence to inform decision – examples of evidence (not mandatory requirements)	
• NOTSS • TO2 • CbD • Mini-CEX	• Reflective practice • Attendance at specialist twin clinics • Log of cases with outcomes • Observation of advanced procedures in the management of complicated twin pregnancies e.g. fetal reduction and laser ablation

Mandatory requirements

- OSATS
  - multiple gestation chorionicity
  - twin pregnancy assessment

Knowledge criteria

- Definition of significant growth discordance in twin gestations and the importance of chorionicity
- Management of growth discordancy in twin pregnancies
- The clinical and ultrasound features of TTTS, and referral triggers for fetal medicine subspecialty input
- Short and long-term outcomes from TTTS
- The management of TTTS and follow up regimes, following treatment
- The ultrasound features of TRAP and conjoined twins
- Ongoing management of a pregnancy complicated by co-twin death
- Other complications of multiple gestations that necessitate discussion with, or referral to, a tertiary fetal medicine service, e.g. discordant anomaly

SECTION 2: PROCEDURES

Procedures marked with * require three summative competent OSATS.

Procedures	*Level by end of training*	*CiP 1*	*CiP 2*	*CiP 3*
Fetal biometry and liquor volume*	5	X		
Transvaginal placental localisation*	5	X		
Umbilical artery Doppler*	5	X		
Middle cerebral artery Doppler*	5	X	X	
Ductus venosus Doppler*	5	X		
Uterine artery Doppler*	5	X		
Multiple gestation chorionicity*	5			X
Twin pregnancy assessment*	5			X

Subspecialty trainees in Maternal and Fetal Medicine will be expected to acquire the procedural skills listed in this table as well as the subspecialty-specific procedures listed in the MFM subspecialty-specific procedure table.

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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 FC CiPs

FC CiP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: Uses ultrasound skills to recognise, monitor and manage compromise to fetal wellbeing		X	X	X	X	X
2: The doctor demonstrates the skills and attributes required to assess the fetus at risk of red cell alloimmunisation	X	X	X	X	X	X

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FC CiP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
3: The doctor demonstrates the skills and attributes required to assess complications of twin pregnancies	X	X	X	X	X	X

SITM: Prenatal Diagnosis (PD)

SECTION 1: CAPABILITIES IN PRACTICE (CiP)

PD CiP 1: The doctor can use ultrasound to recognise where fetal anatomy is not normal.	
Key skills	**Descriptors**
Demonstrates normal structural findings in all trimesters and recognises iwhen they cannot be demonstrated	• Performs and records a detailed, systematic ultrasound of the fetus in line with NHS Fetal Anomaly Screening Programme (FASP) guidance. • Understands the strengths and limitations of ultrasound for each organ system within each trimester. • Explains normal anatomical views to the pregnant person. • Documents and records normal anatomical views. • Recognises when image quality is technically poor. • Can explain next steps to the pregnant person if normal views cannot be obtained.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
• Reflective practice • NOTSS • TO2 • CbD • Mini-CEX	• RCOG Learning • FASP online training • Local and deanery teaching • Attendance at relevant courses and conferences • Log of cases and outcomes • Attendance at fetal medicine clinics • Attendance at multidisciplinary team (MDT) meetings • Attendance at specialist neonatal and paediatric clinics • Examples of anonymised birth plans

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Mandatory requirements	

• OSATS
  ○ fetal anomaly scan
  ○ fetal echo	

Knowledge criteria	
• The normal appearance on ultrasound scans, in all trimesters, of the fetal central nervous system (CNS), face and neck, thorax, cardiovascular system, abdominal wall and gastrointestinal tract, urogenital system, and the fetal skeleton and extremities • Local protocols for follow up, if any, after an incomplete anatomy scan • Normal embryology of all body systems, and the common fetal anomalies that can happen when they do not develop in the way they should, as identified by FASP. • Normal fetal behaviour and activity, and abnormalities of this • Fetal circulation, and how it adapts at birth • Diagnostic features of each condition targeted by FASP, their differential diagnosis and chance of structural, chromosomal and syndromic associations. These conditions are Trisomy 21, 18 and 13, anencephaly, spina bifida, congenital diaphragmatic hernia, gastroschisis, exomphalos, renal agenesis, facial cleft, hypoplastic right or left heart and lethal skeletal dysplasia • The thresholds for diagnosing mild, moderate and severe ventriculomegaly measurements, and the potential implications of the different severities of ventriculomegaly • The role of magnetic resonance imaging (MRI) for CNS lesions • The difference between Dandy-Walker malformation, Dandy-Walker Variant and mega cisterna magna, the implications of each and the pitfalls in prenatal diagnosis • The common fetal tachycardia and bradycardia arrhythmias and the role of the paediatric cardiologist in their management • The different types of ventricular septal defect (VSD) and their association with cardiac, extracardiac and chromosomal anomalies. Understand the role of the paediatric cardiologist in their management • The ultrasound features of transposition of the great arteries, atresia of either outflow tract, stenosis of either outflow tract, double outlet right ventricle or a common outflow tract (truncus arteriosus) • The association of these conditions with further cardiac, extracardiac and chromosomal anomalies • The role of the paediatric cardiologist in the management of fetal cardiac problems • The ultrasound features of gastrointestinal (GI) atresia, associations and surgical options following birth • The spectrum of ultrasound findings of echogenic bowel and its association with chromosomal anomalies, cystic fibrosis, growth restriction and viral infections • Urinary tract obstruction and multi cystic dysplastic kidney (MCDK): aetiology, spectrum of severity, postnatal investigation and the likely short- and long-term impact of these conditions • The local pathway for postnatal referral for talipes and the Ponseti approach to treatment • Limb reduction defects: associations and aetiology • Findings suggestive of lethal skeletal dysplasia and the features of the more common non-lethal dysplasias, particularly certain types of osteogenesis imperfecta and achondroplasia	

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• A differential diagnosis for non-immune hydrops, the need for tertiary referral and the range of investigations likely to be offered

PD CiP 2: The doctor can assess and investigate a pregnancy where there are concerns about the fetus.	
Key skills	**Descriptors**
Can provide genetic counselling in common prenatal situations	• Takes medical history and constructs, where appropriate, a family tree for people who are pregnant, or have a chance of, genetic conditions. • Explains common modes of Mendelian and multifactorial inheritance, and recurrence risks. • Counsels for previous trisomy and monosomy X. • Counsels for previous neural tube defect.
Provides initial counselling for common fetal structural anomalies and manages people in partnership with tertiary fetal medicine services	• Is experienced in carrying out ultrasound diagnosis and managing pregnancies complicated by fetal anomalies that are covered by the FASP. • Discusses other potential prenatal tests such as fetal karyotyping.. • Recognises when to refer the person who is pregnant to a tertiary centre and how best to share care and monitoring. • Liaises with the tertiary centre and the MDT to manage pregnant people with fetal anomalies. • Formulates, implements and, where appropriate, modifies management plan, in collaboration with subspecialists. • Counsels pregnant people and their partners about the fetal risks, implications for the pregnancy and the long-term outcome. • Signposts pregnant people to external sources of information and support. • Constructs a follow-up plan for the pregnancy to support the pregnant person and plan next steps. • Plans birth and appropriate neonatal support with a fetal medicine specialist.
Counsels and manages pregnancies at risk of fetal infection	• Investigates common fetal infections. • Works with virology to interpret laboratory results for each infection. • Explains the potential long-term effects of fetal infections on fetuses and newborns. • Recognises when to involve other specialists in the care of a pregnant person with a suspected or confirmed fetal infection and plans for the sharing of care and monitoring.

	• Liaises appropriately with the tertiary centre and the MDT to manage fetal infection.
Counsels and manages severe early fetal growth restriction (FGR)	• Is able to produce a differential diagnosis for severe early FGR. • Knows when and which further investigations should be offered for severe early FGR. • Liaises with the fetal medicine tertiary referral centre about diagnosis of severe early FGR and to manage it.
Counsels pregnant person about prenatal investigations	• Understands both the non-invasive and invasive options and is able to discuss the risks and benefits, facilitating choice. • Understands the different levels of resolution of genetic testing and can communicate the importance of this to parents. • Explains the risks and benefits of each procedure to the pregnant person and any alternatives. • Communicates the scope and limitations of these tests. • Describes how prenatal samples are processed and when, and how, the results are given. • Offers genetic counselling where appropriate.

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

• Reflective practice • NOTSS • TO2 • CbD • Mini-CEX	• RCOG Learning • Local and deanery teaching • Attendance at relevant courses and conferences • Attendance at clinical genetics clinics • Log of cases and outcomes • Attendance at fetal medicine clinics • Attendance at MDT meetings • Attendance at specialist neonatal and paediatric clinics • Examples of anonymised birth plans

Mandatory requirements

No mandatory evidence

Knowledge criteria

- The genetic basis for trisomy 21, 18 and 13 and the ultrasound features associated with them
- The range of tests available for screening and testing for the common fetal trisomies and the organisation and quality control of the screening service
- Other aneuploidies: the implications of Turner syndrome (45,XO), Klinefelter syndrome (47,XXY) and Triple X syndrome (47,XXX) and appreciate the approach to managing pregnancies complicated by much rarer and unique chromosomal anomalies

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• The underlying genetic inheritance patterns and prenatal testing for cystic fibrosis, muscular dystrophy and Fragile X syndrome, and the need for liaison with clinical genetics • When it is appropriate to offer invasive testing, and when not to • The role of non-invasive testing • The implications for the current pregnancy and the long-term prognosis for each condition, and recurrence risks for future pregnancies • The limitations of ultrasound in detecting and diagnosing congenital anomalies (e.g. cleft palate) or predicting prognosis (e.g. diaphragmatic hernia) • Triggers and diagnoses that need to be referred to tertiary services • Diagnostic features of each condition, their differential diagnosis and the chance of associated structural, chromosomal and syndromic associations • The role of DNA analysis from maternal plasma

PD CiP 3: The doctor demonstrates the skills and attributes required to provide ongoing support and care to people who have had a problem identified with their pregnancy.	
Key skills	**Descriptors**
Counsels on and organises, or refers onwards for, termination of pregnancy for fetal anomaly	• Raises the option of termination of pregnancy for fetal anomaly appropriately and sensitively. • Counsels pregnant person about the different methods of termination, explaining when termination is offered and when feticide is legally mandated. • Organises termination of pregnancy for fetal anomaly (or refers appropriately where there is conscientious objection or the need for tertiary involvement). • Supports the parent journey from diagnosis to follow up with planning for future pregnancies. • Adjusts care around termination of pregnancy in high-risk situations. • Manages complications of termination of pregnancy. • Is aware of and can signpost to appropriate organisations that provide support.
Supports a pregnant person who wants to continue with their pregnancy where the fetus will not survive to birth, or the baby is expected to die in the neonatal period	• Supports and empowers the parent or parents in their decision. • Plans for delivery with the parent or parents and paediatric team to give them the best experience possible in the circumstances, with clarity on intervention and non-intervention in labour. • Plans an appropriate end of life pathway with the family and paediatric team.
Provides follow up and counselling after a pregnancy complicated by fetal anomaly	• Explains the role of the post-mortem and any other relevant post-birth tests (e.g. genetic testing, post-mortem MRI). • Explains the findings and implications of any additional post-birth investigations.

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	• Refers, where appropriate, to the wider MDT, including clinical genetics. • Counsels the parent or parents about the chance of recurrence across the range of conditions targeted by FASP, and arranges genetic counselling where appropriate. • Proposes a plan to manage future pregnancies. • Recognises when tertiary service involvement is appropriate for more complex cases.

Evidence to inform decision – examples of evidence (not mandatory requirements)	
• Reflective practice • NOTSS • TO2 • CbD • Mini-CEX	• RCOG Learning • Local and deanery teaching • Attendance at relevant courses and conferences • Attendance at neonatal unit ward rounds • Log of cases and outcomes • Attendance at fetal medicine clinics • Attendance at MDT meetings • Attendance at specialist neonatal and paediatric clinics • Examples of anonymised birth plans

Mandatory requirements
No mandatory evidence

Knowledge criteria
• The antenatal management, intrapartum care and immediate postnatal management of each condition • The impact of the diagnosis and individual circumstances on the timing, location and mode of birth • The local prenatal, birth and post-birth pathways for care of the fetus and newborn with these conditions • The legal framework under which termination of pregnancy by feticide may be offered • Recognise which conditions are amenable to prenatal treatment (e.g. diaphragmatic hernia and spina bifida) • The recurrence risk and management plan for future pregnancies for each condition

SECTION 2: PROCEDURES

The trainee will provide evidence through OSATS of their competency to perform fetal anomaly scans (i.e. they may choose to have an OSAT demonstrating their assessment of a single fetal system, but they should be able to demonstrate that they have knowledge of all the fetal systems to the standard of FASP). Procedures marked with * require three summative competent OSATS.

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Procedures	*Level by end of training*	*CIP 1*	*CIP 2*	*CIP 3*
Fetal anomaly scan*	4	X		
Fetal echo*	4	X		
Amniocentesis	1		X	
CVS	1		X	
Therapeutic amniodrainage	1		X	
Feticide	1			X

Subspecialty trainees in Maternal and Fetal Medicine will be expected to acquire the procedural skills listed in this table as well as the subspecialty-specific procedures listed in the MFM subspecialty-specific CiPs table.

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Mapping to GPCs
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Domain 8: Capabilities in education and training
Domain 9: Capabilities in research and scholarship

SECTION 4: MAPPING OF ASSESSMENTS TO PD CiPs

PD CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: The doctor can use ultrasound to	X	X	X	X	X	X

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PD CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
recognise where fetal anatomy is not normal						
2: The doctor can assess and investigate a pregnancy where there are concerns about the fetus		X	X	X	X	X
3: The doctor demonstrates the skills and attributes required to provide ongoing support and care to people who have had a problem identified with their pregnancy		X	X	X	X	X

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MFM SST specific CiPs

SECTION 1: CAPABILITIES IN PRACTICE (CiP)

SST MFM CiP1: The doctor is able to lead in providing care to women with pregnancies complicated by the full range of fetal concerns.	
Key skills	**Descriptors**
Manages rare fetal structural anomaly	• Diagnoses, provides a differential diagnosis for, and manages the full range of rare fetal structural anomaly. • Demonstrates how ultrasound findings of rare fetal structural anomalies are researched and managed. • Can counsel women and their partners about fetal risks, implications for the pregnancy and long term outcomes. • Offers other prenatal test as appropriate, and involves Clinical Genetics team. • Liaises appropriately with the referring centre and the multidisciplinary team (MDT). • In collaboration with paediatric specialists, formulates, implements and, where appropriate, modifies a management plan. Specialists include paediatric cardiology, urology, neurology and members of the surgical team. • Signposts to external sources of information and support. • Constructs a follow-up plan for the pregnancy. • Plans birth and appropriate neonatal support for someone who is pregnant and has concerns about their baby. • Formulates a management plan for future pregnancies.
Manages fetal hydrops	• Constructs a differential diagnosis and uses appropriate investigations. • Treats reversible causes. • Manages pregnancies where the cause of the hydrops remains unclear. • Pursues the diagnosis post-birth and provides counselling for future pregnancies.

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Manages rare complications of multiple gestations	• Diagnoses and manages twin-to-twin transfusion syndrome (TTTS) and provides follow-up care. • Manages discordant anomaly, including counselling on the selective termination of pregnancy. • Recognises and manages twin reversed arterial perfusion (TRAP) sequence. • Refers to quaternary services for high level procedures, where indicated. • Manages monoamniotic twin pregnancies. • Manages triplet and higher order multiple gestations, including providing counselling, without judgement, on multifetal pregnancy reduction. • Diagnoses and manages severe early onset selective fetal growth restriction in monochorionic and dichorionic multiple pregnancies.
Manages pregnancies with a high chance of fetal alloimmune disorders	• Explains the potential fetal and maternal risks of red cell antibodies. • Provides surveillance for pregnancies complicated by Parvovirus infections. • Liaises with blood transfusion and neonatal services. • Classifies risks for any pregnancy complicated by red cell antibodies and provides appropriate surveillance for fetal anaemia. • Prepares women and their partners for the neonatal care necessary in cases of **haemolytic** disease of the fetus and newborn (HDFN). • Explains the risks of maternal antiplatelet antibodies and knows when they should be tested for. • Manages a pregnancy complicated by maternal antiplatelet antibodies, including birth and neonatal care, and offers antenatal treatment, where appropriate.
Offers and provides termination of pregnancy at all gestations appropriately	• Raises the option of termination of pregnancy for fetal anomaly appropriately. • Can counsel a pregnant person about the different methods of termination. • Organises termination of pregnancy for fetal anomaly. • Adjusts care around termination of pregnancy in high-risk situations. • Manages complications of termination of pregnancy.

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Manages high level procedural skills	• Can counsel on, and take consent fo,r high-level interventional procedures.
Is able to support non-subspecialist colleagues to manage pregnancies complicated by fetal problems	• Provides subspecialist advice to non-subspecialist colleagues. • Works in partnership with referring clinicians to provide joint care.

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

• Reflective practice • TO2 (includes SO) • Mini-CEX (to include feticide). • Procedural log • CbD	• RCOG and other learning • Attendance at regional national meetings and training courses • Observation of, and reflection on, high-level fetal procedures • Observation of neonatal surgery • Attendance at local and regional MDT meetings • Clinical attachments on tertiary level NNU and/or paediatric ITU • Attendance at paediatric follow up clinics • Relevant audit and quality improvement project

Mandatory requirements

- OSATS:
  - CVS
  - amniocentesis
  - fetal echocardiography (ECHO)
  - anomaly scan
  - cervical length scan
  - therapeutic amniodrainage
  - fetocide

Knowledge criteria

- Embryology of all key fetal anatomical systems
- Pathology and epidemiology of all major anomalies affecting each fetal system in addition to those covered in CiP 2 and 3, including, as a minimum:
  - encephalocele, holoprosencephaly, microcephaly and intracranial mass
  - cardiac tumours
  - renal cystic disease, duplex kidney and bladder/cloacal exstrophy
  - laryngeal/tracheal atresia, pulmonary sequestration and pleural effusion
  - meconium ileus, hepatic calcification/mass, abdominal cyst and ascites
  - cystic hygroma, micrognathia, macroglossia, anophthalmia and neck mass
  - skeletal dysplasias (early or late onset), polydactyly, sirenomelia, sacral agenesis and hemivertebra
  - fetal akinesia/hypokinesia sequence

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    - sacrococcygeal teratoma
- Diagnostic features of each condition, their differential diagnosis and the chance of associated structural, chromosomal and syndromic associations in the fetus
- Outcomes, prognoses and recurrence risks associated with each of these conditions and abnormalities
- Antenatal management, intrapartum care and immediate postnatal management of each condition
- Conditions that are responsive to prenatal therapy (e.g. fetal arrhythmias, spina bifida and congenital diaphragmatic hernia) and how these treatments are administered and the complications of them.
- The additional information which might be gained by use of 3D imaging and/or fetal MRI
- The differential diagnosis for fetal hydrops, and how to address this systematically
- The differential diagnosis for fetal anaemia
- Which red cell antibodies carry the greatest chance of haemolytic disease of the fetus and newborn, what thresholds there are for commencing surveillance for fetal anaemia, when to refer for fetal blood sampling and transfusion, how this is performed, and how the newborn is managed when there is a chance of haemolytic disease
- How platelet antibody-antigen combinations commonly cause neonatal alloimmune thrombocytopenia and what the outcomes can be, and how the chance of harm can be reduced.
- The embryology of normal twinning and the incidence and pathogenesis of abnormal twinning, resulting in TTTS, selective fetal growth restriction (sFGR), TRAP sequence and conjoined twins.
- When treatment is indicated for these conditions, and the pros and cons of treatment options
- A differential diagnosis for s-FGR and the classification of s-FRG in monochorionic gestations, and the impact that chorionicity has on outcomes and interpreting surveillance
- The differential risks associated with co-twin death in monochorionic and dichorionic multifetal gestations
- The outcomes of higher-order pregnancies, and the impact on these of multifetal pregnancy reduction
- The techniques used for selective termination of pregnancy for discordant anomalies in multiple gestations, and the risks involved
- UK law on termination of pregnancy, including justifying criteria, gestational limits and when to perform feticide, and ethical issues around late amniocentesis/late termination of pregnancy
- The significance of signs of life following a termination
- The various methods of termination of pregnancy, and the pros and cons of each method
- The indications, methods, potential benefits and complications of the following high-level fetal medicine procedures: vesicocentesis, pleural and vesical shunt placement, placental laser, radiofrequency ablation, cord occlusion and fetal blood transfusion
- The structure of the local paediatric network, including surgical services
- Paediatric network guidelines for the management of newborn problems, including frameworks around extreme prematurity, and antenatal parallel planning

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SST MFM CiP 2: The doctor can independently manage, in conjunction with specialist from other disciplines complicated by the widest range and most complex of maternal medicine conditions, and contributes to the design and leadership of a Maternal Medicine Network or regional service.	
Key skills	**Descriptors**
Manages the care of the pregnant woman presenting with any co-existing medical problem, including those with rare disorders and severe manifestations or complications of more common problems	• Extends further the key skills described in the Pregnancy Care and Maternal Medicine SITMs to provide pre-pregnancy counselling, antenatal, intrapartum and postnatal care to women with highly complex medical problems (e.g. category C in England). • Can lead on the care provision of a pregnant person who is receiving joint care from a non-subspecialist and tertiary level team. • Provides constructive advice to the non-subspecialist obstetrician and physician.
Lead MDT meetings	• Demonstrates the ability to work with other disciplines to make sure women receive the best possible care for their medical conditions, despite their pregnancy status. • Understands and advises the MDT on the risks and benefits of different methodologies used in imaging and therapeutics. • Understands, advises and signposts the MDT about prescribing in pregnancy.
Provides regional clinical leadership	• Leads on the coproduction of guidelines and standards which aim to best identify, refer and manage pregnant women, or those who wish to become pregnant, with co-existing medical conditions, and those who develop medical illness during their pregnancy. • Designs and contributes to the monitoring of the above standards. • Coordinates and contributes to the education and training of the multi-disciplinary team working within the Maternal Medicine Network/regional service. • Makes sure everyone receives equal access to specialised care. • Recognises the increased vulnerability of women from ethnic minorities and socially deprived groups in the design of systems.

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Engages with other stakeholders	• Works with relevant networks e.g. maternity and perinatal mental health networks, fetal medicine services and neonatal operational delivery networks. • Works with high level management organisations and bodies such as local maternity services, integrated care systems, NHSE/I, NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW), Northern Ireland Medical and Dental Training Agency (NIMDTA) and maternity strategic clinical networks. • Liaises and works in partnership with other contributors to the care pathway e.g. ambulance trusts, GPs and health visitors.

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

• CbD • Mini-CEX • Reflective practice • TO2 (includes SO)	• RCOG Learning • Anonymised examples of pregnancy care plans for women with medical disorders • Attendance at specialist courses and conferences • Attendance at adult medical clinics • Attendance at obstetric anaesthetic clinics • Local and deanery teaching • Attendance and leading of Maternal Medicine MDTs

Mandatory requirements

No mandatory evidence

Knowledge criteria

- Structure of local maternal medicine networks and regional thresholds for referral and MDT involvement
- The pathology, prevalence, presentation and diagnosis of, and risks and best practice management for, women who have significant medical problems (pre-pregnancy, antenatal and postnatal) that predate or arise in pregnancy or in the puerperium. Examples of category C medical problems outlined in the National Maternal Medicine Service Specification include:
  - Heart: pulmonary hypertension, severe left ventricular ejection fraction <45%, complex congenital heart disease (univentricular system, including Fontan, severe aortic and mitral valve stenosis and mechanical valve), aortic dilation, ventricular arrhythmias, new ischaemic heart disease and heart transplant.
  - Lung: sickle chest crisis, restrictive lung disease with forced vital capacity <50%, neuromuscular disorder with respiratory muscle involvement e.g. myasthenia gravis, Guillain-Barre syndrome, lung transplant and pulmonary vasculitis
  - Gastrointestinal and liver: portal hypertension, complex pancreatitis, active malignancy, cirrhosis, decompensated liver disease and liver transplant

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- Endocrine: primary and secondary hyperaldosteronism, phaeochromocytoma, Cushing's syndrome, acromegaly, metabolic disorder (e.g. glycogen storage disorder) and hypo- and hyperparathyroidism
- Kidney: active lupus nephritis, new renal vasculitis, pre-pregnancy chronic kidney disease stage 4 and 5, renal dialysis, simultaneous renal and pancreatic transplant
- Rheumatological: large and medium vasculitis and vascular Ehlers-Danlos syndrome
- Neurological: All epilepsy without local access to a combined clinic, including specialist neurology and obstetrics, symptomatic raised intracranial pressure, unstable congenital vascular malformation (CVM)/arteriovenous malformation/AVM, recent intracerebral haemorrhage(<2 years), acute stroke, new onset Guillain-Barre syndrome, new diagnosis or recent exacerbation of myasthenia gravis, active central nervous system malignancy and myotonic dystrophy
- Haematological: complex thalassaemia, current extensive venous thromboembolism, active haematological malignancy, clotting deficiency (Factor II, X and combined deficiency), Von Willebrand disease type II and III, carriers of haemophilia with male or unknown gender of fetus (including knowledge of when to offer late amniocentesis, and intrapartum management of such cases), transfusion dependent disease, antiphospholipid syndrome with extensive arterial events, antithrombin deficiency and moderate/severe platelet function disorder or with platelet count <100

- Findings of relevant national reports including MBRRACE report and recommendations
- How pregnancy induces significant changes in all aspects of physiology in pregnancy and the postpartum period. Plus the effect that pregnancy has on additional medical conditions
- How the medical problem may deteriorate acutely during pregnancy, how this might present and how it would be managed

SST MFM CiP3: The doctor can apply their knowledge of clinical and molecular genetics to manage complex pregnancy.	
Key skills	**Descriptors**
Manages a pregnancy at elevated chance of, or affected by, aneuploidy	• Takes an appropriate history and arranges appropriate parental investigations. • Communicates effectively with women and their partners/families about risk, screening and testing options. • Manages the care of a woman with a personal or family history of a chromosomal anomaly, including assessment of risk, prenatal diagnostic options, and further management options after testing. • Manages an ongoing aneuploid pregnancy, including plans for birth and a multidisciplinary approach to the care of the newborn. • Recognises when advice from, and referral to, clinical genetics services is needed.

Manages a pregnancy with a chance of a single gene disorder in a structurally normal fetus	• Takes an appropriate history, constructs a family tree and arranges appropriate parental investigations. • Communicates effectively with women and their partners/families about risk, screening and testing options. • Manages the care of a woman with a personal or family history of a single gene disorder, including assessment of risk, prenatal diagnostic options, and further management options, after testing. • Manages an ongoing pregnancy affected by a single gene disorder, including communication and planning with paediatric services. • Recognises when advice from, and referral to, clinical genetics services is needed.
Diagnoses and manages genetic and syndromic disorders in a fetus that has a structural anomaly	• Can appropriately counsel and manage in families with a previous child with multiple anomalies or syndromic disorder. • Accesses online information, of the highest quality, regarding very rare syndromic and genetic problems. • Manages the care of a woman with a personal or family history of a syndromic anomaly, providing information, screening and prenatal testing options. • Uses a dysmorphology database to reach a differential diagnosis. • Recognises when referral is indicated for more specialised counselling and genetic advice. • Provides options to manage an affected pregnancy, including termination of pregnancy, without judgement. • Manages an ongoing pregnancy, including planning for birth and a multidisciplinary approach to the care of the newborn.
Requests and uses a wide range of molecular, cytogenetic and biochemical tests for prenatal diagnosis	• Is able to take non-directive informed consent for performing these tests. • Is able to interpret and communicate the results of these tests and knows when a multidisciplinary approach is required. • Identifies the role of genomic testing in both maternal and fetal medicine, in pregnancy, or ideally in pre-conception counselling ○ Maternal Medicine – Expanding research towards genetic prediction tests of obstetric disease

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	processes, such as pre-eclampsia, gestational diabetes, obstetric cholestasis ○ Role of genomics in preconception care for women with rare genetic disease and pregnancy care for women with rare genetic disease, especially in affected families seeking IVF, planning surrogacy, or carrier screening. ○ Role of whole genome testing vs whole exome sequencing.

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

• Reflective practice • Local and deanery teaching • TO2 (includes SO) • Mini-CEX • CbD	• NOTSS • RCOG Learning

Mandatory requirements

No mandatory evidence

Knowledge criteria

- Normal chromosome structure and function
- Gene structure and function, including gene control, mechanisms and effects of mutation, and genetic heterogeneity
- Patterns of genetic inheritance and susceptibility, gene expression and penetrance, multifactorial and mitochondrial inheritance
- Cell division (meiosis and mitosis), and abnormalities arising from these processes
- Types of aneuploidy, including structural rearrangements, deletions and commonmicrodeletions, trisomies, sex chromosome anomalies (including monosomy X, Klinefelter syndrome and Triple X), extra markers, mosaicism (fetal and placental), uniparental disomy and triploidy
- The underlying genetic aetiology of the single gene disorders mentioned in CiP 2 and 3, and the following conditions:
  - myotonic dystrophy
  - Huntington's disease
  - haemoglobinopathies, haemophilia and other common bleeding disorders
  - inborn errors of metabolism
- Detailed knowledge of the following syndromes and associations:
  - DiGeorge
  - Fryns
  - Beckwith-Wiedemann
  - Meckel-Gruber
  - Smith-Lemli-Opitz
  - VATER/VACTERL association
- The pre- and postnatal phenotypes of these common aneuploidies, single gene disorders and

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syndromes, including prognosis
- Methods of screening for aneuploidy, including ultrasound, biochemical and non-invasive DNA based techniques
- The statistical terms relevant to screening, including sensitivity, specificity, false positive rates, positive predictive rates, and how these are interdependent
- The meaning of likelihood ratios in risk calculations
- Current screening programmes, including national implementation, audit, quality control, the UK National Screening Committee and regional screening coordinators
- How recurrence risks for chromosomal and single gene disorders are derived
- Prenatal testing options, both invasive and non-invasive, including ultrasound, MRI, non-invasive prenatal testing, amniocentesis, CVS and fetal blood sampling.
- Laboratory techniques for analysing parental and fetal samples, including quantitative polymerase chain reaction, fluorescence in situ hybridization, karyotyping, microarray, mutational analysis, sequencing (exome, or whole genome), enzymatic analysis and analyte assessment.

SECTION 2: PROCEDURES

Procedures marked with * require three summative competent OSATS

Procedures	*Level by end of training*	*CiP 1*
CVS*	5	X
Amniocentesis*	5	X
Fetal ECHO*	5	X
Anomaly scan*	5	X
Cervical length scan*	5	X
Therapeutic amniodrainage*	5	X
Fetocide*	5	X
Twin amniocentesis	4	X
Drainage of fetal cystic structure	3	X
MPFR/selective termination in dichorionic twins or higher order pregnancy	3	X
Fetal blood transfusion	1	X
Fetal shunt	1	X
Placental laser	1	X

Subspecialty trainees in Maternal and Fetal Medicine will need to acquire the procedural skills listed in this table as well as the procedures listed in the Fetal Care and Prenatal Diagnosis SITMs procedures table.

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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 MFM CiPs

SST MFM CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: The doctor is able to lead in providing care to women with pregnancies complicated by the full range of fetal concerns	X	X	X		X	X
2: The doctor can independently manage pregnancies complicated by the widest range, and most complex, of maternal medicine		X	X		X	X

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SST MFM CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
conditions, alongside specialists from other disciplines, contributing to the design and leadership of the maternal medicine subspecialty service (in England this will be through the Maternal Medicine Networks either through MDTs for category B medical problems or referral for ongoing care to a Maternal Medicine Centre for category C medical problems).						
3: The doctor can apply their knowledge of clinical and molecular genetics to manage complex pregnancy.		X	X	X	X	X

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Research - Subspecialty Training

SECTION 1: CAPABILITIES IN PRACTICE

SSTR CiP: The doctor is able to engage with research and promote innovation within their subspecialty.	
Key skills	**Descriptors**
Demonstrates research skills	• 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. • Has the ability to translate research into clinical practice within their subspecialty.
Demonstrates critical thinking	• 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.

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Innovates	• 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)	
• 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	• 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

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4 The research component of subspecialty training

The subspecialty research CiP (SSTR CiP) builds on the Curriculum 2024 research requirements. It trains the subspecialist to interpret and contribute to clinical research within their sub-specialty, 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 MFM 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. MFM 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 one 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.

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- 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 MFM 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

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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.

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Figure 3a – Trainee self-assessment of a CiP

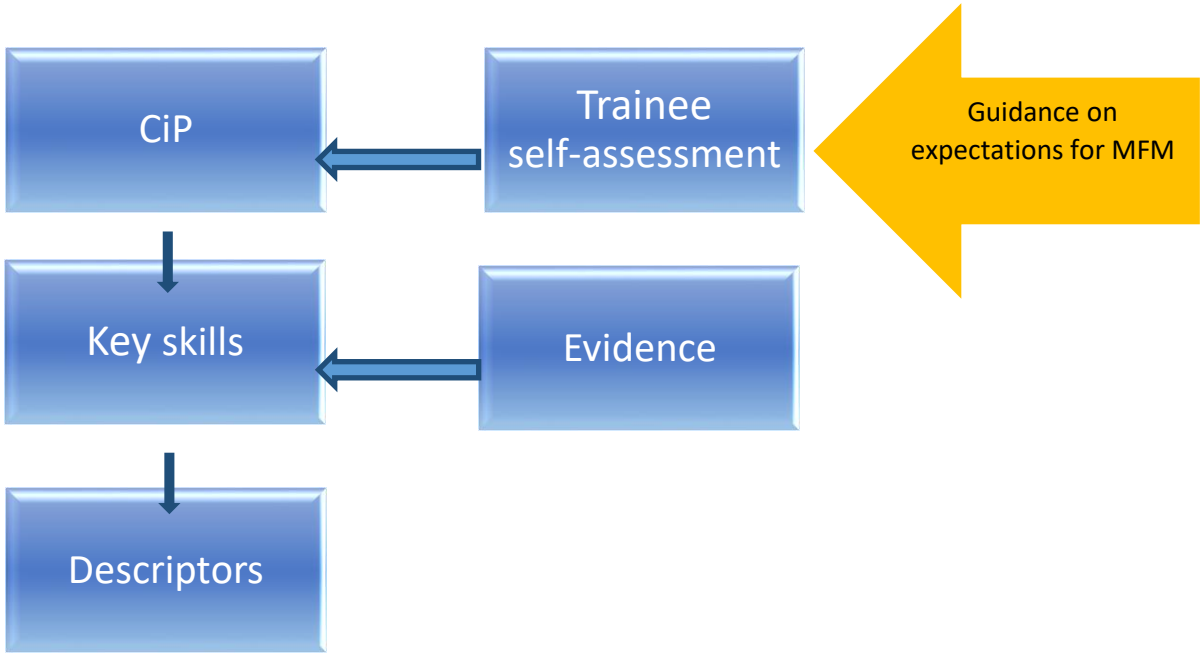
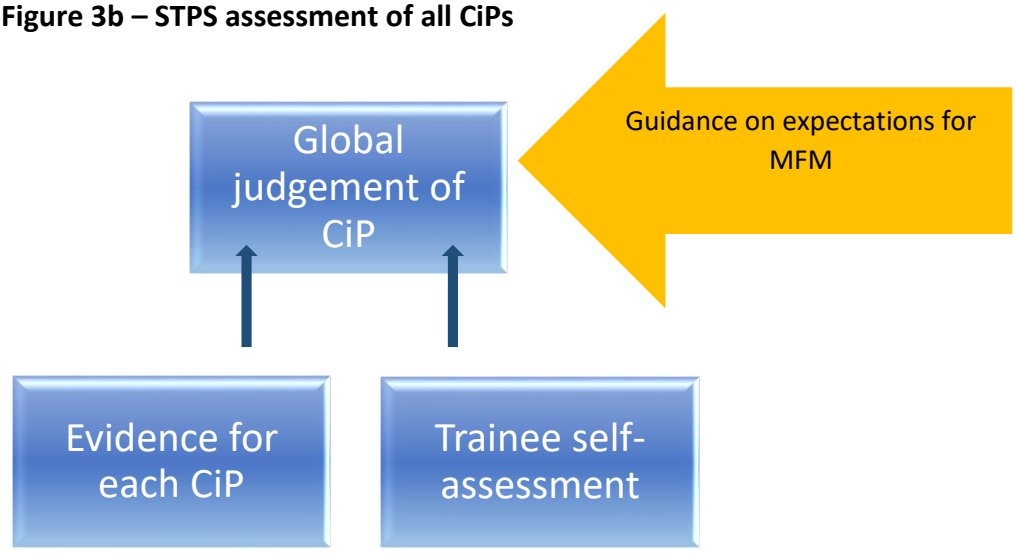


Figure 3b – STPS assessment of all CiPs



The trainee will make a self-assessment to consider whether they meet expectations for the MFM 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.

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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 assessors[1] .

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

[1] Entrustability Sales: Outlining their usefulness for competency-based clinical assessment

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Global judgement to be used for each CiP

Trainee self-assessment

FOR EACH CiP

Statement of what level of supervision is required.

Link to evidence on the ePortfolio.

SST 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:

SST 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 MFM; may not meet the requirements for critical progression point
- Meeting expectations for the subspecialty training in MFM; 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 MFM curriculum as a whole for generic CiPs will be specified in the MFM 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.

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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 MFM 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 MFM 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 new curriculum, and as well as the methods listed below, can include other sources, such as the Personal Development Plan or quality improvement project or procedure log. The trainee will collect evidence to support their self-assessment, and the STPS will use it to reach a global judgement. These methods are described briefly below. More information and guidance for trainees and assessors are available in the ePortfolio and on the RCOG website (www.rcog.org.uk).

Summative assessment

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

Formative assessment

- Case-Based Discussions (CbD)

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

Supervisor report

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

Objective Structured Assessment of Technical Skills (OSATS)

There are a number of fundamental procedures in the MFM 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.

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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 specialty 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.

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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 MFM based 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 MFM 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 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

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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 learning[2].

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 training[3].

Clinical Supervisor

The Clinical Supervisor oversees the doctor's clinical work throughout a placement. They lead on reviewing the doctor's clinical or medical practice throughout a placement and contribute to the STPS report on whether the doctor should progress to the next stage of their training. The STPS, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. The STPS should be part of the clinical specialty team. If the clinical directorate (clinical director) has any concerns about the performance of the trainee, or there have been issues of doctor or patient safety, these would be discussed with the STPS. These processes, which are integral to trainee development, must not detract from the statutory duty of the trust to deliver effective clinical governance through their management systems.

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

Educational and clinical supervisors need to be formally recognised by the GMC to carry out their roles[4]. 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.

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

[4] Recognition and approval of trainers

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.

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- 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 MFM subspecialty

The development, implementation, monitoring and review of the MFM 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 MFM subspecialty curriculum by trainers and trainees

The MFM subspecialty curriculum and subspecialty assessment decision aid will be available from the RCOG via the website www.rcog.org.uk and ePortfolio.

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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.

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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 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.

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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.

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