



Royal College of
Obstetricians &
Gynaecologists

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Subspecialty Training Gynaecological Oncology

Definitive Document 2019

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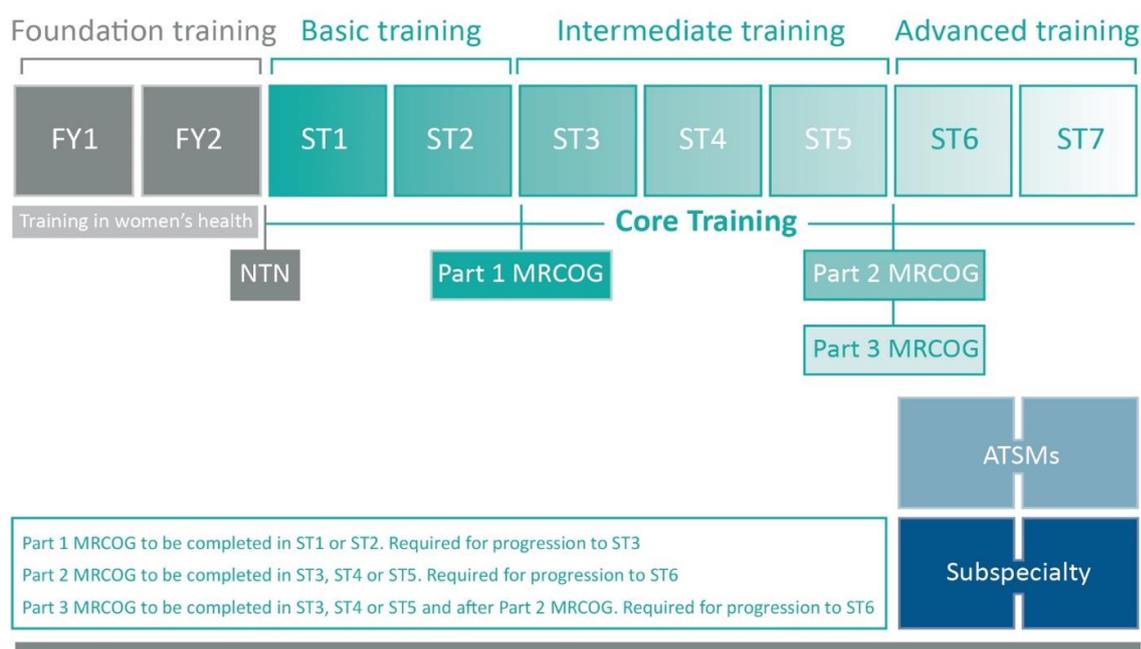
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1 Introduction

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

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

Specialty training and education programme



2 Purpose of the Gynaecological Oncology subspecialty training programme

2.1 Background

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

The RCOG Curriculum Review Group was set up to take forward the RCOG's *Becoming Tomorrow's Specialist* recommendations relating to pre-CCT training. Its 2015 working party report identified the deficiencies in the current core curriculum with its emphasis on technical skills, and the lack of focus on non-technical and professional skills required by a modern consultant. Most importantly, the Review Group developed a definition of the required characteristics of an O&G consultant for the first time – and this has provided the basis for the work since carried out. The definition is as follows:

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

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

2.2 General description of the revised GO curriculum

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

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

The purpose of the GO 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 gynaecological oncology conditions in tertiary referral centres. GO subspecialists should have the skills to organise and supervise services at a local and regional level, contribute to academic gynaecological oncology, 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 GO 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 for the trainee to take responsibility for their own learning, as they would as a consultant.

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

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

No change is being proposed to accessing subspecialty training in GO at this point in time.

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

Table 1 – Professional Identity and Capabilities in Practice for GO

DEVELOPING THE OBSTETRICIAN & GYNAECOLOGIST – SST-GO	
<i>PROFESSIONAL IDENTITY: CLINICAL EXPERT</i>	
CiP1	The doctor assesses and manages patients with suspected and confirmed gynaecological cancers and those without cancer who are concerned they may develop it.
CiP2	The doctor plans surgical care and manages problems safely along the entire surgical pathway.
CiP3	The doctor ensures the patient undergoes a procedure of appropriate radicality for gynaecological malignancy safely, performing it independently or as the leader of a wider surgical effort.
CiP4	The doctor assesses ovarian cancer and initiates appropriate interventions for all stages and contexts of disease.
CiP5	The doctor assesses uterine cancer and initiates appropriate interventions for all stages and contexts of disease.
CiP6	The doctor assesses cervical cancer and initiates appropriate interventions for all stages and contexts of disease.
CiP7	The doctor recognises, assesses and manages patients with suspected vulval cancer.
CiP8	The doctor is competent in the assessment of vaginal cancer, performs the practical aspects of its management and assists in the delivery of non-surgical elements of care.
CiP9	The doctor effectively discusses the role of chemotherapy in the management of gynaecological cancers, both at presentation and in recurrent disease, within the wider multidisciplinary team.
CiP10	The doctor works within the multidisciplinary team to assess the need for radiotherapy in all gynaecological cancers, initiates appropriate interventions and manages side effects.
CiP11	The doctor requests and interprets the most appropriate radiological investigations and interventions for gynaecological oncology patients.

CiP12	The doctor assesses and manages the holistic needs of patients with terminal gynaecological malignant disease alongside specialist palliative care services.
CiP13	The doctor understands the impact of gynaecological cancers on the urinary tract and is able to identify, investigate and manage urological complications.
CiP14	The doctor assesses and performs appropriate surgery on the gastrointestinal (GI) tract and manage cases perioperatively.
CiP15	The doctor understands the principles and practice of plastic surgery techniques and wound care as applied to gynaecological oncology and uses these at an appropriate level.
CiP16	The doctor is competent in the assessment and initial management of a patient with suspected and confirmed gestational trophoblastic disease.
CiP17	The doctor diagnoses, investigates and manages patients with a possible genetic predisposition to gynaecological cancer and their families, alongside specialist genetics services.

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

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

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

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

During its development the core O&G curriculum underwent extensive consultation with stakeholders including trainees, trainers and Heads of Schools, as well as external

stakeholders including other related specialties (Royal College of General Practitioners, Faculty of Sexual and Reproductive Health and Royal College of Midwives), and patient groups to gain their insight into what they require from a high quality O&G consultant. Full details are given in the core O&G curriculum submission.

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

2.4 Flexibility and the transferability of learning

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

As subspecialty trainees are also still following the core O&G curriculum at the same time as their subspecialty training, they are required to display a wide range of behaviours and attributes, in addition to their specialist GO clinical skills and knowledge, reflecting the broad nature of this specialty in practice. Trainees at the time of attaining CCT will be skilled in managing the labour ward independently and managing the acute gynaecological on call service, as well as caring for people with gynaecological cancers. They will have expertise in practical procedures related to the clinical care of women and will be expert communicators with strong interpersonal skills, strong emotional awareness and adept at the management of emotionally complex situations. These core areas ensure that doctors in training and beyond CCT can provide safe care whilst working on a range of challenging and diverse rotas, balancing acute and non-emergency service provision, and encouraging trainees to experience a wide range of hospital and other healthcare environments. Trainees following the GO curriculum will also need to demonstrate that they have achieved thorough anatomical knowledge and surgical skills appropriate for a subspecialist gynaecological oncology surgeon, and that they have the knowledge, skills and attitudes to manage the full range of gynaecological cancers of their patients.

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

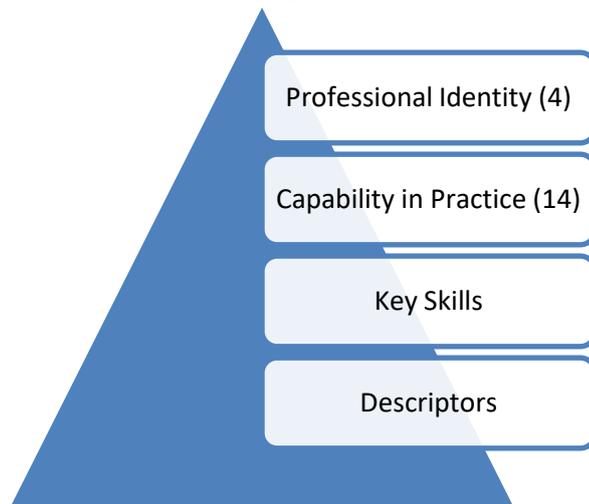
These core areas ensure that doctors in training and beyond CCT can provide safe care whilst working in a range of challenging and diverse work environments, balancing acute and non-emergency service provision. They also encourage trainees to experience a wide range of hospital and other healthcare environments.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

- Be able to develop and apply innovative approaches to teaching in women’s health and research.
- Place the principle of informed decision making with women and their families at the heart of their practice.
- Be advocates for women’s health.
- Be up to date in their practice and promote and implement evidence-based medicine.
- Be a role model for the highest standards of care and professional behaviours within the specialty and across the medical profession as a whole.

3 The organisation and content of the GO curriculum

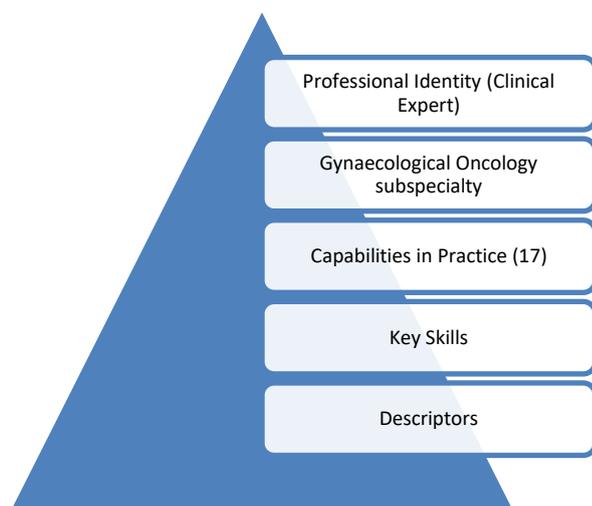
The practice of O&G requires the generic and specialty knowledge, skills and attitudes to advise and treat people presenting with a wide range of gynaecological and obstetric conditions and symptoms. It involves particular emphasis on woman-centred care, diagnostic reasoning, managing uncertainty, dealing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

Figure 1 – Core Curriculum design structure



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

Figure 2 – GO curriculum design structure



3.1 Curriculum framework features

The curriculum content is structured as follows:

Section 1 Capabilities in Practice

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

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

Each CiP lists the knowledge criteria relevant to that CiP.

Section 2 Procedures

All the procedures that are expected to be experienced during the GO 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 GO subspecialty in which a trainee must become proficient to the level expected by the end of training. Trainees must be able to outline the indications for these procedures and recognise the importance of valid informed consent, and of requesting for help when appropriate. For all practical procedures the trainee must be able to recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary. Trainees will be able to record their procedures in the new ePortfolio.

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

Section 3 GMC Generic Professional Capabilities

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

Section 4 Mapping of assessments to CiPs

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

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

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

3.2 The Gynaecological Oncology subspecialty curriculum

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

SST – GYNAECOLOGICAL ONCOLOGY (GO)

SECTION 1: CAPABILITIES IN PRACTICE

CiP 1: The doctor assesses and manages patients with suspected and confirmed gynaecological cancers and those without cancer who are concerned they may develop it.	
Key Skills	Descriptors
Counsels on and directs appropriate screening tests for gynaecological premalignancy and malignancy	<ul style="list-style-type: none"> • Differentiates between the general and high-risk populations. • Counsels patients appropriately regarding screening of the female reproductive tract. • Arranges appropriate screening tests, interprets the results and counsels patients accordingly. • Recommends appropriate action independently or as part of a multidisciplinary team.
Performs the initial assessment of a patient with suspected or confirmed gynaecological cancer	<ul style="list-style-type: none"> • Assesses and manages patients referred through suspected gynaecological cancer pathways. • Takes an appropriate history including symptoms, comorbidities and relevant family history. • Performs an examination adequate for the diagnosis and clinical assessment of gynaecological cancers. • Is confident to exclude the clinical appearances of malignancy on examination. • Arranges appropriate radiological and non-radiological staging investigations.
Anticipates results of investigations, acts on results and plans definitive care	<ul style="list-style-type: none"> • Anticipates likely results and begins planning care involving the multidisciplinary team where indicated. • Communicates the results of investigations to patients and counsels on treatment options and prognosis. • Recognises when to involve other colleagues including clinical nurse specialists, clinical and medical oncologists and palliative care. • Liaises effectively with multidisciplinary team colleagues. • Assesses fitness for surgery and arranges preoperative investigations, anaesthetic assessment and intensive care input.
Evidence to inform decision	
<ul style="list-style-type: none"> • CbD • Mini-CEX • Evidence of attendance • BSCCP accreditation • TO2 (including SO) • Reflective practice 	<ul style="list-style-type: none"> • BGCS webinars • Attendance at 'Connected' advanced communication skills training (ACST) • Attendance at BGCS theoretical course • RCOG eLearning • Structured colposcopy training • Attendance at tutorials and lectures

	<ul style="list-style-type: none"> • Attendance at anaesthetic led pre-assessment clinic
Knowledge criteria	
<ul style="list-style-type: none"> • The indications, processes and limitations of screening for cervical premalignancy in the general population, ovarian cancer in the general and high-risk populations and endometrial cancer in the high-risk population • National cancer screening programmes and the cervical screening programme • When to involve a multidisciplinary team • The patterns of presentation of gynaecological malignancies • The investigations required to accurately confirm or exclude a diagnosis of gynaecological malignancy • Their role in the investigation and initial management of suspected gynaecological cancer, as directed by current national cancer strategy and guidance • Assessment of patient referred by 2-week wait (rapid referral). Knowledge of care pathways for suspected gynaecological cancer • Preoperative investigation of patients, including radiology, assessment of fitness for surgery • What constitutes a high-risk surgical patient • The appropriate treatments for gynaecological cancers including adverse effects, complications and toxicities 	

CiP 2: The doctor plans surgical care and manages problems safely along the entire surgical pathway.	
Key Skills	Descriptors
Prepares patients for surgery	<ul style="list-style-type: none"> • Selects and performs appropriate surgical management of gynaecological cancer according to patients' needs. • Calculates surgical risks. • Counsels patients on surgical treatment options and the risks involved. • Interprets preoperative investigations and liaises with anaesthetic department. • Takes consent for the entire span of procedures relevant to gynaecological oncology. • Selects and prescribes appropriate bowel preparation. • Arranges perioperative ICU/HDU support as appropriate.
Manages surgical problems	<ul style="list-style-type: none"> • Takes steps to minimise the risks of complications. • Manages intraoperative haemorrhage. • Manages unexpected findings, inoperability, unexpected bowel resection and injury, urinary tract injury, vascular injury and other intraoperative complications. • Recognises and manages postoperative complications including but not limited to thrombosis, infection and bowel obstruction. • Seeks help when required from colleagues and other specialties.

	<ul style="list-style-type: none"> Communicates intraoperative details and results to patients and their families appropriately and arranges input from the multidisciplinary team and palliative care if indicated.
Delivers perioperative supportive care	<ul style="list-style-type: none"> Interprets haematology, biochemistry and microbiology results and takes appropriate actions. Interprets fluid balance charts, calculates fluid balance and determines and prescribes replacement requirements safely. Prescribes chemical thromboprophylaxis safely. Recognises when enteral or parental feeding is required and liaises appropriately with nutritional support and GI teams.
Evidence to inform decision	
<ul style="list-style-type: none"> Mini-CEX Evidence of attendance CbD NOTSS Reflective practice TO2 (including SO) Personal mortality and morbidity data 	<ul style="list-style-type: none"> Lectures, tutorials, webinars Attendance at MDT Attendance at Royal College of Surgeons' CCrISP course Critical care attachment including ward rounds, outreach team, ICU, HDU and anaesthetic preassessment clinics Direct supervision in operating theatre Direct supervision from senior colleagues in and out of theatre Attendance at dietician ward rounds as per CiP 14
Knowledge criteria	
<ul style="list-style-type: none"> The type of surgery appropriate for each gynaecological cancer The principles of fluid balance Enteral and parenteral nutrition and indications for each gynaecological cancer 	

CiP 3: The doctor ensures the patient undergoes a procedure of appropriate radicality for gynaecological malignancy safely, performing it independently or as the leader of a wider surgical effort.

Key Skills	Descriptors
Prepares for and manages surgical cases	<ul style="list-style-type: none"> Initiates discussion of management with multidisciplinary team. Organises appropriate surgical team to effect anterior, posterior, total supra- and trans-levator pelvic exenteration in pre- and post-radiation cases. Performs appropriate surgery. Seeks help from more experienced colleagues and other surgical specialties when required. Uses NOTSS tools.
Evidence to inform decision	

<ul style="list-style-type: none"> • NOTSS • CbD • Certificates of attendance • Surgical logbook confirming exposure to procedures expected at level 1 • Reflective practice • Personal mortality and morbidity audit • OSATS: <ul style="list-style-type: none"> ○ Total laparoscopic hysterectomy ○ Total abdominal hysterectomy ○ Total laparoscopic radical hysterectomy ○ Open radical hysterectomy ○ Iliofemoral sub-fascial groin node dissection ○ Laparoscopic pelvic lymph node dissection ○ Open pelvic lymph node dissection ○ Open para-aortic lymph node dissection ○ Total omenectomy ○ Peritoneal stripping ○ Appendicectomy • Formative OSATS confirming involvement for procedures indicated at level 3 	<ul style="list-style-type: none"> • Observation, assistance, direct and indirect supervision to appropriate competency by clinical supervisors • Specific task training and supervision • Attendance at appropriate postgraduate anatomy / surgical courses • TO2 (including SO)
Knowledge criteria	
<ul style="list-style-type: none"> • Anatomy of the female abdomen and pelvis, including blood supply, lymphatic drainage, nervous system and course of the ureter 	

CiP 4: The doctor assesses ovarian cancer and initiates appropriate interventions for all stages and contexts of disease.	
Key Skills	Descriptors
Assesses ovarian cancer	<ul style="list-style-type: none"> • Stages ovarian cancer correctly. • Counsels patients on diagnosis, surgical options, medical options, adverse effects of treatment and prognostic factors. • Maintains good communication with referring units and primary care.
Performs correct surgery for ovarian cancer	<ul style="list-style-type: none"> • Assesses cases laparoscopically and safely retrieves biopsy material.

	<ul style="list-style-type: none"> • Selects cases for maximal cytoreductive effort with the aim of achieving no macroscopic residual disease in primary, interval and secondary debulking contexts. • Identifies patients unsuitable for surgery and those suitable for fertility sparing procedures. • Prepares patients appropriately for surgery. • Performs extended procedures with assistance as appropriate. • Escalates to other colleagues and other specialties. • Formulates a plan and modifies if necessary, including when to perform extended procedures and when to stop operating if surgery is futile. • Determines when palliative surgical effort is appropriate. • Discusses the results of surgery with the patient and their relatives.
Manages non-surgical aspects of care	<ul style="list-style-type: none"> • Communicates discharge information accurately to non-cancer centre based teams. • Formulates appropriate follow-up schedules. • Assesses and arranges management of physical and holistic side effects of treatment. • Is able to effect the medical management of ascites, pleural effusions and bowel obstruction. • Considers all management options and determines where palliative or best supportive care options are appropriate.

Evidence to inform decision

<ul style="list-style-type: none"> • Mini-CEX • CbD • NOTSS • Surgical log book • Evidence of attendance • Direct observation of trainers • GCP certificate • OSATS: <ul style="list-style-type: none"> ○ Laparoscopic assessment of ovarian cancer ○ Laparotomy for stage 3/4 ovarian cancer 	<ul style="list-style-type: none"> • Theatre attendance • Observation of, assisting and discussion with trainers • MDT meeting attendance • Personal study • BGCS webinars • Appropriate post graduate surgical courses • GCP training and certificate • Interaction with national pseudomyxoma team • TO2 (including SO) • Reflective practice
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Knowledge criteria

<ul style="list-style-type: none"> • The aetiology and presentation patterns of ovarian cancer • The pathology of ovarian cancer • How ovarian cancer is categorised histopathologically including epithelial, germ cell, sex cord stromal and borderline ovarian tumour types • The diagnostic and management pathway for pseudomyxoma peritonei • How to interpret extended tumour panels and immunophenotyping and their use and limitations in assigning or not assigning final cancer site • How to interpret imaging and when a radiological biopsy is indicated and possible

- When laparoscopic assessment is preferable to radiological biopsy
- How to lead multidisciplinary team discussions in planning care for ovarian cancer cases
- Indications, techniques, limitations and complications of surgical treatment of ovarian cancer
- Surgical case selection and when primary, interval or secondary debulking surgery is most appropriate, and when fertility conservation should be considered
- The medical and surgical pathways for the management of ovarian cancer
- Medical management of ascites, pleural effusions and bowel obstruction
- How to determine if disease has recurred and which patients are unsuitable for secondary debulking surgery
- The physical and holistic impact of ovarian cancer treatment

CiP 5: The doctor assesses uterine cancer and initiates appropriate interventions for all stages and contexts of disease.

Key Skills	Descriptors
Assesses uterine cancer	<ul style="list-style-type: none"> • Stages uterine cancer correctly. • Counsels patients on diagnosis, surgical options, non-surgical options, adverse effects of treatment and prognostic factors. • Maintains good working relationships with referring units and primary care.
Performs correct surgery for uterine cancer	<ul style="list-style-type: none"> • Provides appropriate surgical management and staging for uterine cancer and provides minimal access surgery where indicated. • Determines when palliative surgery is appropriate. • Identifies patients unsuitable for surgery. • Identifies patients suitable for fertility sparing procedures. • Recognises and manages intraoperative complications. • Escalates to other colleagues and specialties (e.g. plastic surgery, colorectal).
Manages non-surgical aspects of care	<ul style="list-style-type: none"> • Communicates effectively with clinical oncology colleagues and counsels patients on the role of radiotherapy in the management of uterine cancer. • Counsels on clinical trial entry. • Communicates discharge information accurately to non-cancer centre based teams. • Formulates appropriate follow-up schedules. • Assesses and arranges management of physical and holistic side effects of treatment. • Considers all management options and determine where palliative or best supportive care options are appropriate.
Evidence to inform decision	
<ul style="list-style-type: none"> • Mini-CEX 	<ul style="list-style-type: none"> • Theatre attendance

<ul style="list-style-type: none"> • CbD • Surgical log book • Evidence of attendance • GCP training and certificate • OSATS: <ul style="list-style-type: none"> ○ Open/laparoscopic hysterectomy ○ Open/laparoscopic pelvic lymph node dissection ○ Open para-aortic lymph node dissection 	<ul style="list-style-type: none"> • Observation of, assisting and discussion with trainers • MDT meeting attendance • Personal study • BGCS webinars • Appropriate post graduate surgical courses • GCP training • Direct observation of trainers • NOTSS • Reflective practice • TO2 (including SO)
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Knowledge criteria

<ul style="list-style-type: none"> • The aetiology and presentation patterns of uterine cancer • The histological types of uterine cancer including endometrial and sarcoma subtypes and the implications this has on prognosis • Aetiological factors leading to endometrial cancer, including obesity, estrogens, genetic predisposition • Histological types of endometrial cancer and prognostic implication • Which imaging to request and how to interpret it • How to plan safe care for patients with morbid and super morbid obesity • How to lead multidisciplinary team discussions in planning care for uterine cancer cases • Preoperative investigation of patients, including radiology, assessment of fitness for surgery • Risk of major surgery (surgical and anaesthetic) • Preoperative care of patient undergoing major surgery for gynaecological cancer • Type of surgery appropriate for endometrial cancer • The role of chemotherapy and radiotherapy in the treatment of uterine cancers • The risk factors, how to determine if disease has recurred and explain to patients the management options • Inpatient clinical trials • Recruitment into clinical trials • Rare uterine tumours, e.g. sarcomas • The physical and holistic impact of uterine cancer treatment

CiP 6: The doctor assesses cervical cancer and initiates appropriate interventions for all stages and contexts of disease.

Key Skills	Descriptors
Manages cervical dysplasia	<ul style="list-style-type: none"> • Performs relevant procedures as listed in the procedure table.
Uses diagnostic investigations and	<ul style="list-style-type: none"> • Stages cervical cancer, both radiologically and clinically.

assessments in cervical cancer	<ul style="list-style-type: none"> • Interprets imaging appropriate to cervical cancer – pelvic MRI, CT, PET CT, CXR. • Communicates the results of investigations. • Counsels patients on diagnosis, surgical options, non-surgical options, adverse effects of treatment and prognostic factors, including fertility sparing techniques and role of palliative care when appropriate.
Performs surgery for cervical cancer	<ul style="list-style-type: none"> • Identifies patients unsuitable for fertility sparing, radical and exenterative surgery. • Is able to observe, assist or perform relevant surgery for cervical cancer as listed in the procedure table.
Manages non-surgical aspects of care	<ul style="list-style-type: none"> • Counsels on clinical trial entry. • Communicates effectively with clinical oncology colleagues and counsels patients on the role of radiotherapy in the management of cervical cancer. • Is able to insert brachytherapy applicators. • Is able to assist in the delivery of external beam radiotherapy and chemotherapy. • Communicates discharge information accurately to non-cancer centre based teams. • Formulates appropriate follow-up schedules. • Assesses and arranges management of physical and holistic side effects of treatment including lymphoedema and psychosexual morbidity. • Diagnoses, investigate and manage recurrent cervical cancer. • Considers all management options and determines where palliative or best supportive care options are appropriate.

Evidence to inform decision

<ul style="list-style-type: none"> • BSCCP accreditation certificate • Mini-CEX • CbD • Reflective practice • Surgical log book • Evidence of attendance • OSATS <ul style="list-style-type: none"> ○ Total laparoscopic hysterectomy ○ Total abdominal hysterectomy ○ Total laparoscopic radical hysterectomy ○ Open radical hysterectomy ○ Laparoscopic pelvic lymph node dissection ○ Open pelvic lymph node dissection 	<ul style="list-style-type: none"> • Theatre attendance • Observation of, assisting and discussion with trainers • MDT meeting attendance • Personal study • HDR applicator insertion lists • BGCS webinars • NOTSS • TO2 (including SO)
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<ul style="list-style-type: none"> ○ Open para-aortic lymph node dissection 	
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Knowledge criteria
<ul style="list-style-type: none"> ● The anatomy of the female pelvis, including blood supply, nervous system and lymphatic drainage of the region ● The pathophysiology of cervical intraepithelial neoplasm (CIN) ● The role of human papillomavirus (HPV) in the aetiology and development of CIN and cervical cancer ● The aetiology and presentation patterns of cervical cancer ● The histological types of cervical cancer and the implications this has on prognosis ● The pathology, presentation and diagnosis of cervical cancer ● How cervical cancer is staged ● How to assess fitness for surgery and liaise with anaesthetic colleagues to plan safe care ● How to manage all stages of cervical cancer, including surgery and chemoradiation ● How to lead multidisciplinary team discussions in planning care for cervical cancer cases ● How to investigate and assess surgical and non-surgical options for recurrent cervical cancer ● The course of the ureter throughout the pelvis ● The principles of radical trachelectomy ● The principals of radiotherapy treatment as applied to cervical cancer ● The principles of radiotherapy planning ● The appropriate chemotherapy for cervical cancer ● The short- and long- term complications and side effects of cervical cancer treatments ● Patterns of disease recurrence, how to determine if disease has recurred and how to explain to patients the management options ● The physical and psychosexual morbidity of cancer diagnosis and treatment

CiP 7: The doctor recognises, assesses and manages patients with suspected vulval cancer.	
Key Skills	Descriptors
Assesses and investigates patients with suspected vulval cancer	<ul style="list-style-type: none"> ● Stages vulval cancer accurately. ● Orders appropriate radiological investigations and interprets results. ● Demonstrates awareness of treatment options for vulval cancer and when to involve other specialties including clinical oncology and plastic surgery.
Performs appropriate surgery for vulval cancer and manages follow up	<ul style="list-style-type: none"> ● Performs appropriate surgery. ● Liaises with clinical oncology regarding adjuvant and neo-adjuvant radiotherapy. ● Detects and manages the physical and psychosexual impact of treatment and organise appropriate intervention by other teams. ● Manages long-term complications of treatment of vulval cancer including lymphocyst formation and lymphoedema. ● Detects and manages recurrence of vulval cancer.

Evidence to inform decision	
<ul style="list-style-type: none"> • Reflective practice • Mini-CEX • CbD • Surgical log book • Evidence of attendance • OSATS: <ul style="list-style-type: none"> ○ Iliofemoral groin node dissection ○ Radical vulvectomy 	<ul style="list-style-type: none"> • Observation of, assisting and discussion with trainers • Observation and assisting with sentinel node technique for vulval cancer • Theatre attendance • 5 relevant plastic surgery lists • MDT meeting attendance • Personal study • BGCS webinars • Appropriate post graduate surgical courses • NOTSS • TO2 (including SO)
Knowledge criteria	
<ul style="list-style-type: none"> • The anatomy of the vulva, femoral triangle, vaginal region and lower abdominal wall, including blood supply, nerve distribution and lymph drainage of the region • The epidemiology and aetiology of vulval cancer • The histopathology of vulval cancer (including melanoma) and associated premalignant conditions including VIN • The pattern of spread of vulval cancer • Staging of vulval cancer • Diagnosis and investigations for vulval cancer • Principles of treatment of all stages of vulval cancer • Complications of treatment and appropriate management of all stages of vulval cancer • Pattern of recurrence of vulval cancer • Recognition and management of recurrent cancer of the vulva • Long-term complications of treatment of vulval cancer: <ul style="list-style-type: none"> ○ Lymphocysts ○ Lymphoedema ○ Neuralgia • How to lead multidisciplinary team discussions in planning care • The technique of sentinel lymph node biopsy • The psychosexual morbidity of cancer diagnosis and treatment 	

CiP 8: The doctor is competent in the assessment of vaginal cancer, performs the practical aspects of its management and assists in the delivery of non-surgical elements of care.	
Key Skills	Descriptors
Evaluates vagina cancer, makes and helps deliver a management plan	<ul style="list-style-type: none"> • Arranges staging and imaging investigations. • Performs surgery as appropriate.

Performs non-surgical aspects of care for vaginal cancer	<ul style="list-style-type: none"> • Arranges and aids in the delivery of radiotherapy, chemotherapy and chemoradiotherapy. • Detects and manages physical and psychosexual morbidity (e.g. referral to lymphoedema specialist nurse, psychotherapist or counsellor).
Evidence to inform decision	
<ul style="list-style-type: none"> • Mini-CEX • Cbd • Surgical log book • Evidence of accreditation • Evidence of attendance • NOTSS 	<ul style="list-style-type: none"> • Observation and discussion with senior staff • BGCS webinars • BSCCP accreditation • MDT attendance • TO2 (including SO) • Reflective practice
Knowledge criteria	
<ul style="list-style-type: none"> • The aetiology of vaginal cancer, including sarcoma botryoides, melanoma and metastatic lesions • Benign conditions which may co-exist or mimic vaginal cancer • The pathophysiology of vaginal intraepithelial neoplasia • Multifocal lower genital tract malignancy • The clinical presentation, investigation and FIGO staging • In-detail management strategies for vaginal cancer • The physical and psychosexual morbidity of vaginal cancer diagnosis and treatment 	

CiP 9: The doctor effectively discusses the role of chemotherapy in the management of gynaecological cancers, both at presentation and in recurrent disease, within the wider multidisciplinary team.	
Key Skills	Descriptors
Discusses management of all gynaecological cancers including most appropriate chemotherapy regimen, according to patient's disease and medical status	<ul style="list-style-type: none"> • Is able to lead multidisciplinary team discussions in planning care for women with ovarian cancer, including advice about neoadjuvant or adjuvant chemotherapy.
Assesses patients having chemotherapy	<ul style="list-style-type: none"> • Counsels patients on the basics of chemotherapy including adverse effects and complications of chemotherapy. • Counsels on enrolling in clinical trials. • Assesses response to chemotherapy.
Recognises, investigates and manages chemotherapy toxicity	<ul style="list-style-type: none"> • Recognises, investigates and manages toxicity. • Involves relevant teams in the management of patients.

	<ul style="list-style-type: none"> Recognises when chemotherapy should be stopped.
Evidence to inform decision	
<ul style="list-style-type: none"> Reflective practice CbD Mini-CEX Evidence of attendance Direct observation of trainer TO2 (including SO) 	<ul style="list-style-type: none"> Lectures, tutorials, BGCS webinars Attendance at MDT Medical oncology attachment Attendance at medical oncology ward rounds (it is suggested that this should be approximate 4 medical oncology ward rounds) Attendance at medical oncology clinics (it is suggested that this should be approximate 4 oncology clinics) Attendance at chemotherapy administration sessions (it is suggested that this should be approximate 4 sessions) Good clinical practice course Attendance at medical oncology outpatient clinics, ward rounds and chemotherapy
Knowledge criteria	
<ul style="list-style-type: none"> Relevant cell biology including cell-cycle kinetics, log kill hypothesis, cycle and phase specificity Classes of chemotherapeutic agents and their mechanisms of action The indications for chemotherapy The benefits and limitations of single agent and combination chemotherapy The pharmacology of the main chemotherapy agents used in gynaecological cancers The role of hormonal and other agents Non-surgical therapeutic options for recurrent disease Chemotherapeutic management of gestational trophoblastic disease The principles of chemotherapy dose calculation and scheduling Seminal chemotherapeutic trials in gynaecological cancers The concept of adjuvant and neoadjuvant therapy Guidelines and definitions for evaluation of response The principles of phase I, II, and III clinical trials Short- and long-term toxicity, both general and drug-specific The limitations of chemotherapy 	

CiP 10: The doctor works within the multidisciplinary team to assess the need for radiotherapy in all gynaecological cancers, initiates appropriate interventions and manages side effects.

Key Skills	Descriptors
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Assesses need for radiotherapy	<ul style="list-style-type: none"> • Selects patients for radiotherapy according to disease, tumour type and stage.
Assists in delivering the radiotherapy pathway and management of common toxicities	<ul style="list-style-type: none"> • Assists in preparing patients for radiotherapy. • Counsels patients on how radiotherapy works, how it will affect them and potential complications. • Recognises and manages adverse effects of radiotherapy on tissues including but not limited to skin, urinary tract, gastrointestinal tract, and vagina (hormone replacement therapy, dilators, psychosexual aspects). • Recognises and investigates tumour recurrence following primary radiotherapy and chemoradiation.
Manages major side effects of radiotherapy with reference to other colleagues	<ul style="list-style-type: none"> • Manages long-term effects of radiotherapy such as vaginal stenosis, ovarian failure, oedema, osteopenia, fistula recognition.
Evidence to inform decision	
<ul style="list-style-type: none"> • Mini-CEX • CbD • Evidence of attendance • Reflective practice • Observation, assisting and discussions with trainers and members of MDT • TO2 (including SO) 	<ul style="list-style-type: none"> • Direct observation of trainers • Attendance at radiotherapy theatre lists (it is suggested that this should be approximate 4 sessions) • Attendance at radiotherapy planning sessions (it is suggested that this should be approximate 4 sessions) • Attendance at combined oncology clinics • BGCS webinars
Knowledge criteria	
<ul style="list-style-type: none"> • Cell-cycle kinetics, recovery and repair of tissues • The different types of radiation • Inverse square law, time–dose relationships, half-life isotopes • Ionisation and modifying factors, radiation units, iso-dose curves • The principles of fractionation, orthovoltage and supra-voltage • CT planning and dosimetry, types of fields, sources and methods • The principles of radiotherapy, effects on organs and radio sensitivity of different cancers • The difference between curative and palliative treatment • The usages of chemotherapy as an adjuvant • Radiation effects, potentiation of effects and protection from effects • The sensitivity of different organs • Complications in: <ul style="list-style-type: none"> ○ Gastrointestinal tract ○ Urinary tract ○ Skin ○ Bone marrow 	

- Kidney
- Ureter
- Central nervous system
- Genital tract

CiP 11: The doctor requests and interprets the most appropriate radiological investigations and interventions for gynaecological oncology patients.

Key Skills	Descriptors
Requests appropriate radiological investigation(s) and interprets the results	<ul style="list-style-type: none"> ● Requests plain X-rays, ultrasound scans, cross-sectional imaging and nuclear medicine techniques appropriately. ● Takes informed consent for radiological tests. ● Liaises with radiology colleagues regarding clinical scenarios to ensure the most appropriate radiological investigations are safely performed (e.g. non-contrast CT if renal failure). ● Seeks advice as required. ● Communicates results to patients and their families appropriately and arranges input from the multidisciplinary team if indicated.
Assesses the need for radiological interventions	<ul style="list-style-type: none"> ● Takes informed consent for interventional radiological procedures. ● Manages peri-procedural medical considerations (e.g. anticoagulation). ● Recognises and manages complications relating to interventional radiological procedures.

Evidence to inform decision

<ul style="list-style-type: none"> ● CbD ● Mini-CEX ● Evidence of attendance ● TO2 (including SO) ● Reflective practice 	<ul style="list-style-type: none"> ● MDT meeting attendance ● Attendance at radiology reporting sessions (it is suggested that this should be approximate 4 sessions) ● Attendance at interventional radiology sessions ● Attendance at PET CT reporting session ● Relevant postgraduate courses and lectures ● Online learning, e.g. RCOG eLearning module on 'Diagnostic imaging in gynaecological oncology' ● BGCS webinars
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Knowledge criteria

<ul style="list-style-type: none"> ● The limitations and side effects relating to the use plain X rays, ultrasound scans, cross-sectional imaging and nuclear medicine techniques ● Main imaging modalities in gynaecological oncology: ● Physics ● Indications

- Limitations
- How to interpret imaging in a systematic manner
- How to identify sentinel nodes using imaging and nuclear medicine techniques
- The indications and limitations of interventional radiological procedures, including:
 - Guided biopsies
 - Stenting
 - Caval filters
 - Embolisation
 - Nuclear medicine

CiP 12: The doctor assesses and manages the holistic needs of patients with terminal gynaecological malignant disease alongside specialist palliative care services.

Key Skills	Descriptors
Communicates effectively with patients with terminal gynaecological malignant disease and their relatives	<ul style="list-style-type: none"> • Counsels patients and relatives and communicates information about disease process and prognosis. • Uses a holistic approach (physical/ psychological/ social/ spiritual) in the assessment of symptoms and anxieties of the patient and their relatives.
Manages patients alongside specialist palliative care and community services	<ul style="list-style-type: none"> • Involves members of specialist palliative care team in the multidisciplinary management of patients. • Works with the specialist palliative care team in hospital, hospice and community settings.
Manages symptoms associated with terminal malignancy	<ul style="list-style-type: none"> • Implements and manages appropriate pain relief therapies. • Involves specialist pain services appropriately. • Inserts and manages an ascitic drain. • Implements and manages therapies for the relief of nausea and vomiting. • Implements therapies for the relief of oedema. • Manages nutrition in patients with terminal gynaecological malignant disease. • Recognises and manages ascites, bowel obstruction and urinary obstruction in patients with terminal gynaecological malignant disease.
Manages patients that may require the involvement of other specialists	<ul style="list-style-type: none"> • Recognises and manages anxiety and depression in patients with gynaecological malignant disease and seeks specialist input where necessary. • Recognises psychosexual problems in patients with gynaecological malignant disease and seeks specialist input where necessary.
Evidence to inform decision	
<ul style="list-style-type: none"> • Reflective practice • Mini-CEX 	<ul style="list-style-type: none"> • Working in supervised environment with senior team

<ul style="list-style-type: none"> • Cbd • Records of attendance • TO2 (including SO) 	<ul style="list-style-type: none"> • Working within multidisciplinary team • Palliative care MDT meetings • BGCS webinars • Advanced communication skills training (Connected) • Palliative care attachment (it is suggested that this should be approximately 3 weeks) and should include attending palliative care clinics (including a pain-based session) • Communicating with patients and managing their care on a day-to-day basis • Attendance with specialist oedema physiotherapist
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Knowledge criteria

<ul style="list-style-type: none"> • When palliative care input is required • The role of specialist palliative care team in hospital, hospice and community settings • The role of specialist palliative care within the gynaecological multidisciplinary team • The role of the general practitioner, district nurse, cancer specialist nurse, family, religion, cancer support groups/ Macmillan and social services in the support of patients • How to break bad news to a patient • Symptoms associated with terminal malignancy • The causes of and patterns of pain • Choice of appropriate analgesic • Pain services available • Therapies for pain relief and how they work • The pathophysiology of nausea and vomiting • The pathophysiology of oedema and therapies for relief • Anxiety and depression

CiP 13: The doctor understands the impact of gynaecological cancers on the urinary tract and is able to identify, investigate and manage urological complications.

Key Skills	Descriptors
Investigates and diagnoses disorders of the urinary tract in a gynaecological cancer setting	<ul style="list-style-type: none"> • Orders appropriate investigations, interprets them and liaises with the urology team as appropriate.
Performs relevant procedures to facilitate the investigation and management of urological complications	<ul style="list-style-type: none"> • Selects appropriate patients for surgical intervention involving the urinary tract, e.g. ureteric stenting, fistula repair, exenterative surgery.

	<ul style="list-style-type: none"> • Counsels patients and family about the effects of gynaecological malignancy and its treatment on the urinary system. • Recognises and manages injury to the urinary tract. • Is able to insert suprapubic catheter. • Manages the pre- and postoperative care of patients undergoing urology procedures.
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Evidence to inform decision

<ul style="list-style-type: none"> • Mini-CEX • CbD • Reflective practice • Surgical log book • Evidence of attendance • NOTSS • TO2 (including SO) • OSATS: <ul style="list-style-type: none"> ○ Cystoscopy ○ Repair of injury to the bladder ○ Ureterolysis ○ Repair of minor ureteric damage 	<ul style="list-style-type: none"> • Attendance at urology theatre lists (it is suggested that this should be approximate 4 lists) • Attendance at urodynamic session • Attendance at urology ward rounds • Attendance at urology MDT • Attendance at urology clinic • Attendance at urology sessions (it is suggested that this should be approximate 10 sessions) • Attendance at joint oncology clinics • Observation of, assisting and discussion with urology and gynaecological oncology trainers • Personal study • BGCS webinars
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Knowledge criteria

<ul style="list-style-type: none"> • The anatomy and physiology of the kidney, ureters and urethra • The effects of gynaecological malignancy on the urinary tract • The effects of treatment such as radical surgery or radiotherapy on the urinary tract • How to explain the effects of gynaecological malignancy and treatments on urinary system, e.g. fistula, obstruction, bladder disorders • How to appropriately investigate suspected urinary tract disorders in the context of gynaecological malignancy • How to interpret the results of investigations • How to select patients who would benefit from intervention surgery involving the urinary tract, e.g. Urethral stenting, fistula repair, exenterative surgery • How to recognise and manage injury to urinary tract • The principles of repair of injury to the urinary tract including bladder, ureter and urethra • Pre- and postoperative care of patients undergoing urology procedure

CiP 14: The doctor assesses and performs appropriate surgery on the gastrointestinal (GI) tract and manage cases perioperatively.

Key Skills	Descriptors
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Prepares patients for gastrointestinal (GI) surgery and manages the unanticipated need for GI surgery	<ul style="list-style-type: none"> • Orders and interprets appropriate preoperative investigations including radiological evaluation of the GI tract. • Identifies patients pre- and intraoperatively who will benefit from bowel surgery. • Counsels patients pre- and postoperatively regarding bowel surgery, stoma management and the risks and benefits of GI surgery. • Orders bowel preparation appropriately. • Selects and marks stoma sites.
Manages postoperative scenarios following GI surgery	<ul style="list-style-type: none"> • Manages serosal and full thickness small and large bowel injuries. • Plans and prescribes TPN with assistance from specialist TPN pharmacist. • Manages enteric fistulas conservatively. • Manages enteric fistulas surgically with the input of other teams. • Manages the postoperative care of patients who have undergone bowel surgery. • Manages the critically ill surgical patient.

Evidence to inform decision

<ul style="list-style-type: none"> • Reflective practice • CbD • Mini-CEX • NOTSS • Evidence of attendance • Surgical log book • OSATS: <ul style="list-style-type: none"> ○ Small bowel resection and anastomosis ○ Stoma formation • Formative OSATS: <ul style="list-style-type: none"> ○ Large bowel resection ○ Large bowel anastomosis ○ AP resection (as part of pelvic exenteration for example) 	<ul style="list-style-type: none"> • Attendance at CCrISP course • Attachment to colorectal surgical team (it is expected that it would take a trainee at least 4 weeks to achieve the surgical competencies) • Attendance at colorectal outpatient clinics • Attendance at ITU ward rounds • Attendance at dietician ward rounds • Attendance at surgical anastomosis course • Attendance with stoma therapist • Senior staff supervision • Observation / assisting senior staff • TO2 (including SO)
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Knowledge criteria

<ul style="list-style-type: none"> • The anatomy and physiology of the gastrointestinal tract • The pathophysiology of the intestinal function • The principals of GI surgery including exposure handling and injury to tissues • The indications for bowel surgery in the gynaecological oncology setting • The principles of resection and repair of intestinal tissues, including primary repair, secondary repair, ileostomy and colostomy formation • Care of critically ill patient • Use of radiology in investigation and management of GI tract disorders • Appropriate selection of patients who will benefit from bowel surgery

- Preoperative preparation required for a patient who may or will have bowel surgery

CiP 15: The doctor understands the principles and practice of plastic surgery techniques and wound care as applied to gynaecological oncology and uses these at an appropriate level.

Key Skills	Descriptors
Selects and applies appropriate plastic surgical techniques for primary closure	<ul style="list-style-type: none"> • Performs appropriate repair and closure of surgical wound with correct suture material.
Manages wound complications	<ul style="list-style-type: none"> • Diagnoses wound infections and selects appropriate antibiotics. • Recognises wound dehiscence. • Diagnoses and manages incisional hernias. • Is able to identify and manage surgical I+D independently and with appropriate colleagues. • Surgically manages wound dehiscence and effects repair alongside appropriate colleagues when appropriate.
Effects vulval and vaginal wound closure and reconstruction	<ul style="list-style-type: none"> • Is able to use different surgical techniques to close a surgical site after radical vulval surgery. • Selects patients for appropriate surgical interventions, including split-thickness skin graft, rotational flaps, advancement grafts and myocutaneous flaps.

Evidence to inform decision

<ul style="list-style-type: none"> • Mini-CEX • CbD • Reflective practice • Surgical log book • NOTSS • Direct Observation by Senior Staff 	<ul style="list-style-type: none"> • Attachment to plastic surgery team (it is expected that it would take a trainee at least 4 weeks to achieve the surgical competencies) • Attendance with Tissue Viability Team • TO2 (including SO)
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Knowledge criteria

<ul style="list-style-type: none"> • Vulval, perineal and groin anatomy • The physiology of wound healing and factors influencing healing • How and when to use rotational flaps, advancement grafts and myocutaneous flaps in the primary closure of vulval surgical sites • Surgical site infection • Recognising, managing and the various strategies available to repair a dehisced wound • The medical and surgical strategies appropriate to incisional hernia repair • Techniques of vulval repair and reconstruction • The different mesh repair options available for surgical closure • The indications for and how to organise and administer the surgical techniques of split thickness grafting, rotational flaps, advancement grafts and myo-cutaneous flaps in gynaecological oncology surgery

- Vaginal reconstruction
- Which patients benefit from which plastic surgical techniques used to reconstruct the vagina after exenterative pelvic surgery

CiP 16: The doctor is competent in the assessment and initial management of a patient with suspected and confirmed gestational trophoblastic disease.

Key Skills	Descriptors
Counsels patients on the diagnosis, investigation and management of gestational trophoblastic disease	<ul style="list-style-type: none"> • Counsels patients on suitable contraceptive options following a molar pregnancy. • Counsels patients about the diagnosis of gestational trophoblastic disease and its management.
Performs the initial assessment and investigations in the diagnosis of gestational trophoblastic disease and assist in its management	<ul style="list-style-type: none"> • Liaises with supra-regional centre to register the patient for follow up, and for advice on management if required. • Recognises the complications of treatment and management of gestational trophoblastic disease. • Is able to safely perform a suction evacuation, including preoperative, intraoperative and postoperative management.
Assesses patients with gestational trophoblastic neoplasia	<ul style="list-style-type: none"> • Counsels patients on the diagnosis of gestational trophoblastic neoplasia and disease. • Liaises with supra-regional centre for advice on management if required. • Recognises complications of treatment and management of gestational trophoblastic neoplasia and disease. • Carries out appropriate investigations for staging of gestational trophoblastic neoplasia and is able to classify patients into low or high-risk groups.

Evidence to inform decision

<ul style="list-style-type: none"> • Reflective practice • Mini-CEX • Cbd • Logbook of experience • Evidence supporting competency in the assessment and initial management of partial mole, complete mole and choriocarcinoma • Evidence of attendance 	<ul style="list-style-type: none"> • BGCS webinars • Attendance at the national one-day meeting • Case discussion with senior medical staff • Personal study • Attendance at MDT • Medical oncology attachment • TO2 (including SO)
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Knowledge criteria

<ul style="list-style-type: none"> • The definition and classification of gestational trophoblastic disease • The histopathology of gestational trophoblastic disease • The epidemiology and aetiology of gestational trophoblastic disease

- Clinical features and behaviour of different entities of gestational trophoblastic disease
- The principles of investigation, treatment and follow up of patients with gestational trophoblastic disease.
- Histopathological features of gestational disease
- The principles and pitfalls in the measurement of human chorionic gonadotrophin
- The role of surgery and radiotherapy in the management of gestational trophoblastic neoplasia
- The management of chemo-resistant and relapsed gestational trophoblastic disease
- The genetic and molecular markers and their potential clinical applications

CiP 17: The doctor diagnoses, investigates and manages patients with a possible genetic predisposition to gynaecological cancer and their families, alongside specialist genetics services.

Key Skills	Descriptors
Identifies and counsels patients at high risk of a genetic predisposition to gynaecological cancer	<ul style="list-style-type: none"> • Identifies and counsels patients and families with a family history suggesting a genetic predisposition to gynaecological cancer.
Assesses and manages patients at high risk of a genetic predisposition to gynaecological cancer	<ul style="list-style-type: none"> • Takes a genetic history, formulates a family tree and performs appropriate physical examination. • Orders appropriate investigations. • Liaises with specialist genetics services to assess the risk of developing cancer.
Counsels and manages well patients with a genetic predisposition to gynaecological cancer	<ul style="list-style-type: none"> • Counsels patients on subsequent management of a genetic predisposition to gynaecological cancer, including risk of cancer, cancer screening, prophylactic surgery and hormone replacement therapy use. • Counsels on and manages the implications on family members of a genetic predisposition to gynaecological cancer. • Works with other services to ensure appropriate management. • Organises appropriate investigations for screening if required. • Recognises the requirement for a failsafe for conservative management. • Counsels patients on hormonal and other medication in relation to outcomes after screening or treatment.
Manages patients who may benefit from prophylactic surgery	<ul style="list-style-type: none"> • Performs prophylactic surgery where appropriate involving laparoscopic techniques as required and counsels patients on the possible adverse effects of surgery.
Evidence to inform decision	
<ul style="list-style-type: none"> • Reflective practice • Mini-CEX • CbD 	<ul style="list-style-type: none"> • BGCS webinars • Advanced communication skills training (Connected)

<ul style="list-style-type: none"> • Evidence of attendance • Log of experience • TO2 (including SO) 	<ul style="list-style-type: none"> • Working in supervised environment with senior team • Working within a multidisciplinary team • Attachment to cancer genetics unit • Attendance at cancer genetics clinics (it is suggested that this should be approximate 4 clinics) • Communicating with patients and managing their care on a day-to-day basis
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Knowledge criteria

<ul style="list-style-type: none"> • The epidemiology, aetiology, clinical features and behaviour of familial ovarian cancer syndromes, BRCA and hereditary non-polyposis colorectal cancer • The principles and pitfalls in the assessment of the molecular diagnostic techniques presently available • The molecular biology and histopathology associated with genetic predispositions to gynaecological cancer • Clinical features and behaviour of different genetic predispositions • The principles of management of different entities leading to a genetic predisposition to gynaecological cancer • Complexity of counselling and complications of subsequent management of patients with a genetic predisposition to gynaecological cancer • The role of prophylactic surgery in the management of patients with a genetic predisposition to gynaecological cancer and the specific problems for follow up in relation to hormonal, psychological and reproductive sequelae

SECTION 2: PROCEDURES

Procedures	Level by end of training	CIP 2	CIP 3	CIP 4	CIP 5	CIP 6	CIP 7	CIP 13	CIP 14	CIP 15
Total laparoscopic hysterectomy	5		X		X	X	X			
Total abdominal hysterectomy	5		X		X	X	X			
Total laparoscopic radical hysterectomy	5		X		X	X	X			
Open radical hysterectomy	5		X		X	X	X			
Iliofemoral sub-fascial groin node dissection	5		X				X			
Laparoscopic pelvic lymph node dissection	5		X		X	X	X			

Procedures	Level by end of training	CIP 2	CIP 3	CIP 4	CIP 5	CIP 6	CIP 7	CIP 13	CIP 14	CIP 15
Open pelvic lymph node dissection	5		X		X	X	X			
Laparoscopic lymph node dissection	5				X					
Open para-aortic lymph node dissection	5		X		X	X	X			
Total omentectomy	5		X				X			
Peritoneal stripping	5		X				X			
Appendicectomy	5		X				X		X	
Radical vulvectomy	5						X			
Liver mobilisation	3		X							
Diaphragmatic resection	3		X							
Gynaecological element of pelvic exenteration	3		X			X	X			
Laparoscopic para-aortic lymph node dissection	2		X			X				
Splenectomy	2		X	X						
Colorectal contribution to radical oophorectomy / pelvic exenteration	2		X							
Radical trachelectomy	1		X			X				
Sentinel lymph node biopsy	1		X							
Post radiation exenteration	1		X			X				
Urological contribution to pelvic exenteration	1		X			X				
Bowel resection	4			X						
Anastomosis/ ostomy formation	4			X						
Diaphragmatic surgery	4			X						
Removal of disease about the hepatobiliary structures	4			X						
Laparoscopic assessment of ovarian cancer	5			X						
Laparotomy for stage 3/4 ovarian cancer	5			X						
Colposcopy	5					X				
Cervical biopsy including punch biopsy	5					X				
Large-loop excision of the transformation zone (LLETZ)	5					X				
Ablation therapy	5					X				
Vulvoscopy	5						X			
Major skin flaps with plastic surgeon	5						X			
Cystoscopy	5							X		
Repair of injury to the bladder	5							X		
Repair of minor ureteric damage	5							X		
Ureteric stenting	1							X		
Ureteric reimplantation	1							X		
Ureteroscopy	1							X		
Primary ureteric anastomosis	1							X		
Cystectomy	1							X		
Illeal conduit formation	1							X		

Procedures	Level by end of training	CIP 2	CIP 3	CIP 4	CIP 5	CIP 6	CIP 7	CIP 13	CIP 14	CIP 15
Continent urinary diversion	1							X		
Rigid sigmoidoscopy	5								X	
Systematic exploratory laparotomy and identify abnormalities correctly	5								X	
Appendicectomy	5								X	
Small bowel resection and anastomosis *	4								X	
Form end/ loop ileostomy *	4								X	
Form colostomy *	4								X	
Stoma formation *	4								X	
Large bowel resection with formation of colostomy	4								X	
Large bowel anastomosis	2								X	
Abdominoperineal (AP) resection	2								X	
Repair of incisional hernia without mesh	2									X
Rhomboid flap	2									X
Lotus petal flap	2									X
Simple flap for vulval closure	3									X
Split thickness skin graft	1									x
Myocutaneous flaps	1									x
Full thickness skin grafts	1									x

*with assistance of surgical colleagues where necessary

SECTION 3: GMC GENERIC PROFESSIONAL CAPABILITIES

Mapping to GPCs

Domain 1: Professional values and behaviours

Domain 2: Professional skills

- Practical skills
- Communication and interpersonal skills
- Dealing with complexity and uncertainty
- Clinical skills (*history taking, diagnosis and management, consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable diseases*)

Domain 3: Professional knowledge

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

Domain 4: Capabilities in health promotion and illness prevention

Domain 5: Capabilities in leadership and teamworking

Domain 6: Capabilities in patient safety and quality improvement

- Patient safety
- Quality improvement

Domain 7: Capabilities in safeguarding vulnerable groups

SECTION 4: MAPPING OF ASSESSMENTS TO CiPs

CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: The doctor assesses and manages patients with suspected and confirmed gynaecological cancers and those without cancer who are concerned they may develop it.		X	X		X	X
2: The doctor plans surgical care and manages problems safely along the entire surgical pathway.		X	X		X	X
3: The doctor ensures the	X		X	X	X	X

CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
patient undergoes a procedure of appropriate radicality for gynaecological malignancy safely, performing it independently or as the leader of a wider surgical effort.						
4: The doctor assesses ovarian cancer and initiates appropriate interventions for all stages and contexts of disease.	X	X	X	X	X	X
5: The doctor assesses uterine cancer and initiates appropriate interventions for all stages and contexts of disease.	X	X	X	X	X	X
6: The doctor assesses cervical cancer and initiates appropriate interventions for all stages and contexts of disease.	X	X	X	X	X	X
7: The doctor recognises, assesses and manages	X	X	X	X	X	X

CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
patients with suspected vulval cancer.						
8: The doctor is competent in the assessment of vaginal cancer, performs the practical aspects of its management and assists in the delivery of non-surgical elements of care.		X	X	X	X	X
9: The doctor effectively discusses the role of chemotherapy in the management of gynaecological cancers, both at presentation and in recurrent disease, within the wider multidisciplinary team.		X	X		X	X
10: The doctor works within the multidisciplinary team to assess the need for radiotherapy in all gynaecological cancers, initiates appropriate interventions and manages side effects.		X	X		X	X
11: The doctor requests and		X	X		X	X

CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
interprets the most appropriate radiological investigations and interventions for gynaecological oncology patients.						
12: The doctor assesses and manages the holistic needs of patients with terminal gynaecological malignant disease alongside specialist palliative care services.		X	X		X	X
13: The doctor understands the impact of gynaecological cancers on the urinary tract and is able to identify, investigate and manage urological complications.	X	X	X	X	X	X
14: The doctor assesses and performs appropriate surgery on the gastrointestinal (GI) tract and manage cases perioperatively.	X	X	X	X	X	X
15: The doctor understands the		X	X	X	X	X

CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
principles and practice of plastic surgery techniques and wound care as applied to gynaecological oncology and uses these at an appropriate level.						
16: The doctor is competent in the assessment and initial management of a patient with suspected and confirmed gestational trophoblastic disease.		X	X		X	X
17: The doctor diagnoses, investigates and manages patients with a possible genetic predisposition to gynaecological cancer and their families, alongside specialist genetics services.		X	X		X	X

4 The research component of subspecialty training

The aim of the research component of the subspecialty training programme is to ensure that subspecialty-accredited doctors are competent in the design and execution of a research study of sufficient quality to meet internationally recognised standards of research

excellence, such as those published in the Medical Research Council's [Good research practice: principles and guidelines](#). Trainees will need to demonstrate expertise in clinical and/or laboratory research methodology including the ability to:

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

Trainees also need to either:

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

4.1 Research exemption

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

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

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

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

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

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

MD/PhD

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

Published papers

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

4.2 Advanced Professional Module Clinical Research

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

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

4.3 Non-completion of research component

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

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

5 Learning and Teaching

5.1 The core training programme

The organisation and delivery of postgraduate training is the responsibility of the Health Education England (HEE) and Local Education Offices (LETBs), NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical and Dental Training Agency (NIMDTA). A Training Programme Director will be responsible for coordinating the O&G training programme in each deanery. The local organisation and delivery of training is overseen by a school of O&G.

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

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

5.2 The general training environment

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

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

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

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

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

Informal learning methods will include:

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

Formal postgraduate teaching sessions

The content of other formal postgraduate teaching sessions and access to other more formal learning opportunities are determined by the local faculty of O&G education. GO 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 StratOG (the RCOG's eLearning 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.

4.3 The subspecialty training environment

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

- A centre should have sufficient caseload to support the trainee in completing the approved subspecialty curriculum within the required time frame.
- The numbers specified within the workload domain of the approval criteria would usually support one trainee, provided there is evidence of clinical supervision and timetabling for all elements of the curriculum within that centre.
- Recognition may be granted for 2 trainees per centre where there is supporting evidence from the deanery/LETB and where the centre can still deliver the breadth and depth of training.
- Mitigating factors in relation to the caseload required for recognition of a centre for subspecialty training include the track record of the training centre, working within a

training network, highly specialised or supra-regional areas of clinical practice provided within that centre, and workforce requirements within a geographical area. Recognition would be unlikely where an individual centre within a network could not deliver the majority of the elements of the curriculum, or where the approval criteria are fulfilled through a rotation involving more than 2 centres.

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

The criteria for GO centre accreditation, which are approved by the BGCS, are as follows:

Workload (per annum) and scope

- Access to a minimum number of 6 lists per week for major surgical procedures or 10 per week if applying for accreditation for 2 trainees
- Minimum number of new cancers – 300 (500 if applying for accreditation for 2 trainees)
- >50 laparoscopic hysterectomies for endometrial cancer
- >15 laparoscopic pelvic lymphadenectomies
- >15 radical surgical procedures for cervical cancer (>10 laparoscopic)*
Can include laparoscopic abdominal radical trachelectomy
- 10 para-aortic lymphadenectomies
- Evidence of complex surgery for gynaecological cancer including large bowel resection, small bowel resection, diaphragmatic stripping, peritoneal stripping, splenectomy
- >20 radical excision procedures for vulval cancer
- Groin node surgery
 - >6 inguino-femoral groin node dissections
 - >6 groin sentinel nodes
- >5 exenterations for advanced or recurrent gynaecological cancer
- Pre-invasive disease service
 - >250 new referrals for abnormal cervical cytology
 - >15 new referrals for VIN/VaIN

*There are anticipated changes to both practice and disease incidence which may influence the number of cases, so these numbers need to be carefully monitored.

Service organisation

- The centre must have a minimum of 3 subspecialty trained Gynaecological Oncology consultants or 5 consultants if applying for 2 trainees
- The centre must have weekly, fully constituted centre multidisciplinary team meeting
- The centre must have access to and demonstrate working relationships with radiotherapy, chemotherapy, combined/parallel clinics, colorectal surgery, urological oncology, plastic surgery, ITU and pain management
- Data collection: cancer site breakdown, stage, surgical treatment and peri-operative morbidity/mortality
- Intraoperative frozen section facilities
- The centre must ensure that on-call arrangements do not interfere with elective Gynaecological Oncology activities.

6 Programme of Assessment

6.1 Purpose of assessment

The purpose of the programme of assessment is to:

- Assess trainees' actual performance in the workplace.
- Encourage the development of the trainee as an adult responsible for their own learning.
- Enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, understand their own performance and identify areas for development.
- Drive learning and enhance the training process by making it clear what is required of trainees and motivating them to ensure they receive suitable training and experience.
- Demonstrate trainees have acquired the GPCs and meet the requirements of good medical practice.
- Ensure that trainees possess the essential underlying knowledge required for their specialty.
- Provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme.
- Inform the ARCP, identifying any requirements for targeted or additional training where necessary and facilitating decisions regarding progression through the training programme.
- Identify trainees who should be advised to consider changes of career direction.

6.2 Programme of assessment

Our overall programme of assessment as outlined in the Core Curriculum Definitive Document refers to the integrated framework of exams, assessments in the workplace and judgements made about a learner during their approved programme of training. The

purpose of the programme of assessment is to clearly communicate the expected levels of performance and ensure these are met on an annual basis and at other critical progression points, and to demonstrate satisfactory completion of training as required by the curriculum.

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

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

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

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

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

6.3 Assessment of CiPs

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

involves the trainee providing self-assessment of their performance for that stage of training.

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

6.4 The global judgement process

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

Figure 3a – Trainee self-assessment of a CiP

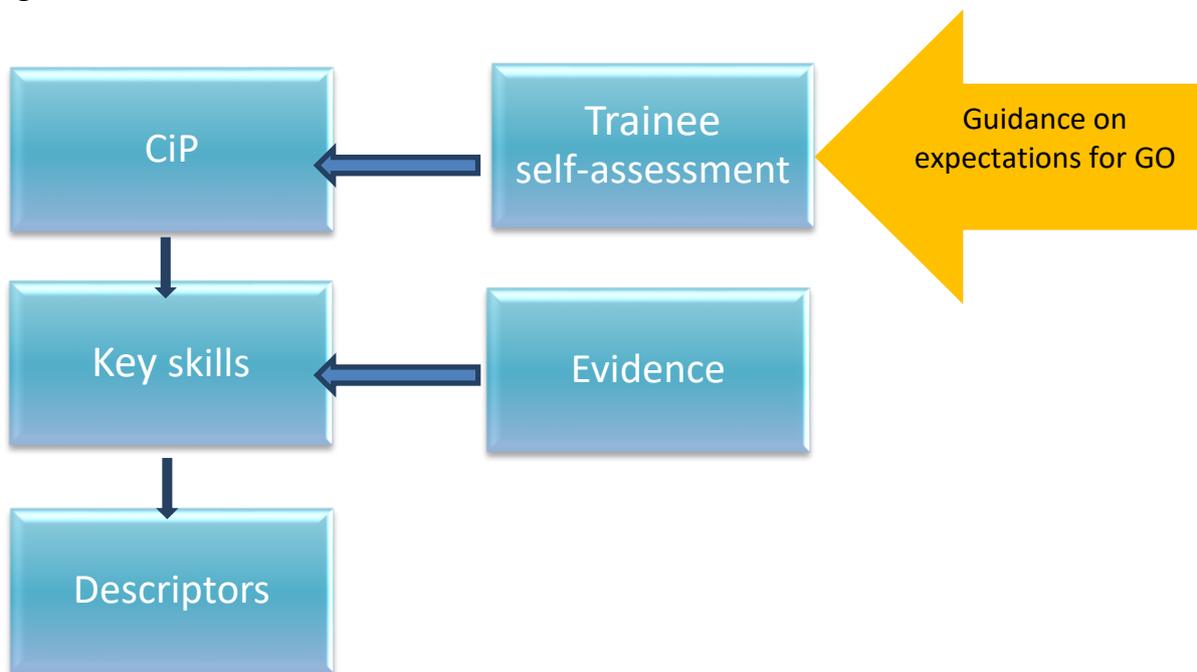
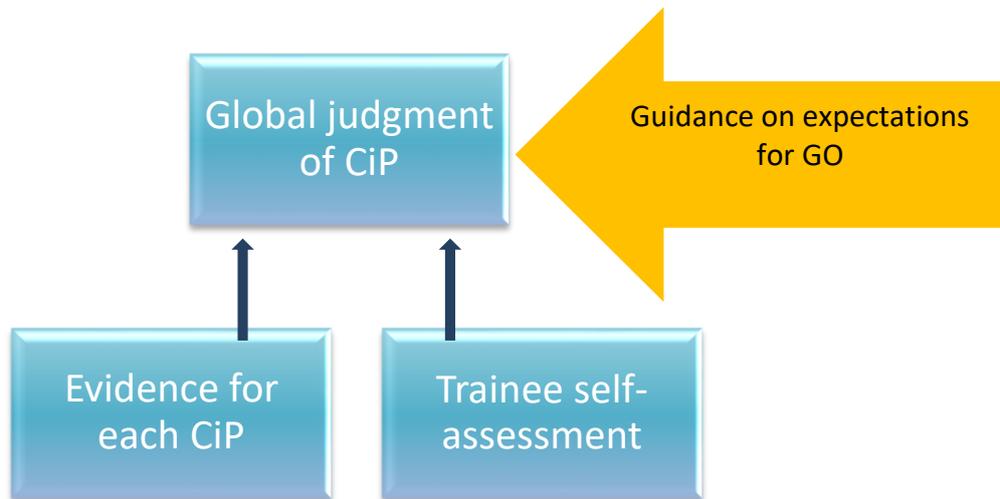


Figure 3b – STPS assessment of all CiPs



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

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

Table 2 – Levels of supervision

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

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

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 GO; may not meet the requirements for critical progression point
- Meeting expectations for the subspecialty training in GO; expected to progress to next stage of training

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

6.5 Assessment of progression

Subspecialty trainees will be formally assessed on an annual basis prior to their ARCP by a subspecialty assessment panel as to whether the trainee is making sufficient progress to complete the GO 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 GO curriculum. The ARCP panel will make the final decision on whether the trainee can be signed off and progress to the next year.

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

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

**Table 3 – Outline grid of progress expected for GO CiPs
Level descriptors for clinical CiPs**

Level 1 - Entrusted to observe

Level 2 - Entrusted to act under direct supervision

Level 3 - Entrusted to act under indirect supervision

Level 4 - Entrusted to act independently with support

Level 5 - Entrusted to act independently

Capabilities in practice	GO SST		Subspecialty Accreditation
	Progress expected by completion of 12 months WTE of clinical training	Progress expected by completion of 24 months WTE of clinical training	
1: The doctor assesses and manages patients with suspected and confirmed gynaecological cancers and those without cancer who are concerned they may develop it.	3	5	CRITICAL PROGRESSION POINT
2: The doctor plans surgical care and manages problems safely along the entire surgical pathway.	3	5	
3: The doctor ensures the patient undergoes a procedure of appropriate radicality for gynaecological malignancy safely, performing it independently or as the leader of a wider surgical effort.	3	5	
4: The doctor assesses ovarian cancer and initiates appropriate interventions for all stages and contexts of disease.	3	5	
5: The doctor assesses uterine cancer and initiates appropriate interventions for all stages and contexts of disease.	3	5	
6: The doctor assesses cervical cancer and initiates appropriate interventions for all stages and contexts of disease.	3	5	
7: The doctor recognises, assesses and manages patients with suspected vulval cancer.	3	5	

8: The doctor is competent in the assessment of vaginal cancer, performs the practical aspects of its management and assists in the delivery of non-surgical elements of care.	3	5	
9: The doctor effectively discusses the role of chemotherapy in the management of gynaecological cancers, both at presentation and in recurrent disease, within the wider multidisciplinary team.	3	5	
10: The doctor works within the multidisciplinary team to assess the need for radiotherapy in all gynaecological cancers, initiates appropriate interventions and manages side effects.	3	5	
11: The doctor requests and interprets the most appropriate radiological investigations and interventions for gynaecological oncology patients.	4	5	
12: The doctor assesses and manages the holistic needs of patients with terminal gynaecological malignant disease alongside specialist palliative care services.	4	5	
13: The doctor understands the impact of gynaecological cancers on the urinary tract and is able to identify, investigate and manage urological complications.	3	5	
14: The doctor assesses and performs appropriate surgery on the gastrointestinal (GI) tract and manage cases perioperatively.	4	5	
15: The doctor understands the principles and practice of plastic surgery techniques and wound care as applied to	3	5	

gynaecological oncology and uses these at an appropriate level.			
16: The doctor is competent in the assessment and initial management of a patient with suspected and confirmed gestational trophoblastic disease.	3	5	
17: The doctor diagnoses, investigates and manages patients with a possible genetic predisposition to gynaecological cancer and their families, alongside specialist genetics services.	4	5	

6.6 Evidence of progress

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

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

The following methods of assessment will provide evidence of progress. The requirements for each training year/level are stipulated in the Matrix of Progression. Evidence is a crucial concept in the new curriculum, and as well as the methods listed below, can include other sources, such as the Personal Development Plan or quality improvement project or

procedure log. The trainee will collect evidence to support their self-assessment, and the STPS will use it to reach a global judgement. These methods are described briefly below. More information and guidance for trainees and assessors are available in the ePortfolio and on the RCOG website (www.rcog.org.uk).

Summative assessment

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

Formative assessment

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

Supervisor report

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

Objective Structured Assessment of Technical Skills (OSATS)

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

Case-based Discussion (CbD)

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

Mini-Clinical Evaluation Exercise (mini-CEX)

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

Multi-source feedback

The TO1 form is a multi-source feedback tool based on the principles of [good medical practice](#), as defined by the [General Medical Council \(GMC\)](#). TO1 forms are used to obtain feedback from a range of healthcare professionals and forms part of a trainee's assessment. The TO1 is a snapshot feedback tool to be used by individuals at a fixed point in time. Individual team members completing a TO1 form should do so based on their experience of working with the trainee. The trainee will also be able to self-assess using a modified TO1 form (SO) which has been piloted along with the modified WBA tools. The TO1 forms are summarised in a TO2 form which informs the ARCP.

Non-Technical Skills for Surgeons (NOTSS) - new

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

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

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

Training evaluation form (TEF)

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

SST Educational Supervisor report (SST ESR)

The STPS will annually record a longitudinal, global report of a trainee's progress over the full range of GO 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 GO are reviewed annually where the trainee’s progress towards the required subspecialty CiPs will be formally assessed. The SST assessment follows the same principles as the ARCP but needs to be undertaken by subspecialists.

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

6.7 Annual Review of Progression (ARCP)

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

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

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

Table 4 – Matrix of Progression

*Each procedural skill requires 3 OSATS assessed as being competent prior to being able to perform the practical procedure independently with support.

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

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

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

Table 5 - Assessments mapped to CiPs

CiP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
1: The doctor assesses and manages patients with suspected and confirmed gynaecological cancers and those without cancer who are concerned they may develop it.		X	X		X	X
2: The doctor plans surgical care and manages problems safely along the entire surgical pathway.		X	X	X	X	X
3: The doctor ensures the patient undergoes a procedure of appropriate radicality for gynaecological malignancy safely, performing it independently or as the leader of a wider surgical effort.	X		X	X	X	X
4: The doctor assesses ovarian cancer and initiates	X	X	X	X	X	X

CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
appropriate interventions for all stages and contexts of disease.						
5: The doctor assesses uterine cancer and initiates appropriate interventions for all stages and contexts of disease.	X	X	X	X	X	X
6: The doctor assesses cervical cancer and initiates appropriate interventions for all stages and contexts of disease.	X	X	X	X	X	X
7: The doctor recognises, assesses and manages patients with suspected vulval cancer.	X	X	X	X	X	X
8: The doctor is competent in the assessment of vaginal cancer, performs the practical aspects of its management and assists in the delivery of non-surgical elements of care.		X	X	X	X	X
9: The doctor effectively		X	X		X	X

CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
discusses the role of chemotherapy in the management of gynaecological cancers, both at presentation and in recurrent disease, within the wider multidisciplinary team.						
10: The doctor works within the multidisciplinary team to assess the need for radiotherapy in all gynaecological cancers, initiates appropriate interventions and manages side effects.		X	X		X	X
11: The doctor requests and interprets the most appropriate radiological investigations and interventions for gynaecological oncology patients.		X	X		X	X
12: The doctor assesses and manages the holistic needs of patients with terminal gynaecological malignant disease alongside		X	X		X	X

CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
specialist palliative care services.						
13: The doctor understands the impact of gynaecological cancers on the urinary tract and is able to identify, investigate and manage urological complications.	X	X	X	X	X	X
14: The doctor assesses and performs appropriate surgery on the gastrointestinal (GI) tract and manage cases perioperatively.	X	X	X	X	X	X
15: The doctor understands the principles and practice of plastic surgery techniques and wound care as applied to gynaecological oncology and uses these at an appropriate level.		X	X	X	X	X
16: The doctor is competent in the assessment and initial management of a patient with suspected and		X	X		X	X

CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
confirmed gestational trophoblastic disease.						
17: The doctor diagnoses, investigates and manages patients with a possible genetic predisposition to gynaecological cancer and their families, alongside specialist genetics services.		X	X		X	X

7 Supervision and feedback

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

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.

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

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

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

7.2 Generic supervision

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

Organisations must make sure that each doctor in training has access to a named Clinical Supervisor and the STPS. Depending on local arrangements these roles may be combined into a single role of Educational Supervisor/STPS. However, it is preferred that a trainee has a single named Educational Supervisor for (at least) a full training year, in which case the Clinical Supervisor is likely to be a different consultant during some placements.

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

Clinical Supervisor

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

The STPS, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. The STPS should be part of the clinical specialty team. If the clinical directorate (clinical director)

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

has any concerns about the performance of the trainee, or there have been issues of doctor or patient safety, these would be discussed with the STPS. These processes, which are integral to trainee development, must not detract from the statutory duty of the trust to deliver effective clinical governance through their management systems.

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

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

Trainees

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

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

7.2 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

⁴ [Recognition and approval of trainers](#)

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

Monthly meetings

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

End of attachment appraisal

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

8 Quality Management

The organisation of training programmes for O&G is the responsibility of HEE LETBs/local teams and the devolved nations' deaneries. The HEE Offices/deaneries will oversee programmes for postgraduate medical training in their regions. A Training Programme Director will be responsible for coordinating the O&G training programme in each trust. The Schools of O&G in England, Wales and Northern Ireland and NHS Education Scotland will undertake the following roles:

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

- Provide flexible training.
- Recognise the potential of specific trainees to progress into an academic career.

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

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

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

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

Quality criteria have been developed to drive up the quality of training environments and ultimately improve patient safety and experience. These are monitored and reviewed by RCOG to improve the provision of training and ensure enhanced educational experiences. The principles of the quality criteria for O&G will be transferred to the new curriculum to ensure this continues.

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

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

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

9.1 Recording progress in the ePortfolio

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

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

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

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

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

10 Equality and diversity

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

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

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

Compliance with anti-discriminatory practice will be assured through:

- Monitoring of recruitment processes.
- Ensuring all College representatives and Programme Directors have attended appropriate training sessions prior to appointment or within 12 months of taking up post.
- HEE Offices/deaneries ensuring that Educational Supervisors have had equality and diversity training (for example, an e-learning module) every 3 years.
- HEE Offices/deaneries ensuring that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training (at least as an e-module) every 3 years.

- Ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature. HEE Offices/deaneries and Programme Directors must ensure that on appointment trainees are made aware of the route in which inappropriate or discriminatory behaviour can be reported and supplied with contact names and numbers. HEE Offices/deaneries must also ensure contingency mechanisms are in place if trainees feel unhappy with the response or uncomfortable with the contact individual.
- Providing resources to trainees needing support (for example, through the provision of a professional support unit or equivalent).
- Monitoring of College Examinations.
- Ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly advantage or disadvantage a trainee with any of the Equality Act 2010 protected characteristics. All efforts shall be made to ensure the participation of people with a disability in training through reasonable adjustments and recognising that not all disabilities are visible.

