



Curriculum 2024 Guide for Subspecialty Training (SST): Urogynaecology

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1. Urogynaecology SST

Doctors who undertake Urogynaecology SST will receive the highest level of training in caring for women presenting with a wide range of urogynaecological conditions, enabling them to work as part of a team in tertiary referral centres. Learners will develop the skills needed to organise and supervise services at a local and regional level, contribute to academic urogynaecology, lead on the translation of new research findings into clinical practice, be providers of support and guidance to non-subspecialist colleagues, and be active in teaching and quality management.

Through this SST, trainees will learn how to be excellent communicators who can co-operatively reach complex and often difficult decisions with women and their families, and other healthcare providers. To achieve this, they will develop an extensive knowledge base, a logical mind, objectivity, empathy and advanced listening skills. Trainees are expected to be non-judgemental, free from bias, and able to negotiate and compromise. They should be kind, decisive when called upon, reflective and supportive. They will have the opportunity to develop a high level of technical expertise, to safely and effectively perform the procedures required in their subspecialty consultant post.

There are three main components to Urogynaecology SST. The first element is the clinical knowledge and skills required to become a Urogynaecology subspecialist, described by the Urogynaecology Capabilities in Practice (CiPs). The clinical CiPs show the practical procedures a learner will become proficient in by the end of training. The second element is the generic skills required for all consultants, namely those of clinical governance, teaching, research, leadership and management. However, these must be acquired and developed within a working environment that cares for women with urogynaecological problems. These skills run through both the subspecialty CiPs and stage 3 of the Core Curriculum. The third element is the subspecialty research CiP, which builds on the research CiP in the Core Curriculum 2024 and will provide the learner with research skills specific to the urogynaecology field.

As a learner progresses through the subspecialty training, they will learn how to handle a variety of scenarios. Learners will also participate in educational events to further develop their training. Throughout training, learners will need to reflect on whether a project has gone well, learn from positive and negative experiences, and use this to improve their own skills.

Before signing off on this SST, the Subspecialty Training Programme Supervisor (STPS) will decide the level of supervision required for each Urogynaecology CiP. If this and the final subspecialty assessment is satisfactory, subspecialty training accreditation will be awarded. More detail is provided in Section 6 of the [Definitive Document for Urogynaecology SST 2024](#).



2. Design of the SST Programme

2024 Urogynaecology SST is made up of the four CiPs from the Special Interest Training Module (SITM) in Urogynaecology and Vaginal Surgery (UGVS CiPs 1–4), and four corresponding subspecialty-specific CiPs that develop the knowledge and skills from the SITM curriculum to a subspecialty level (SST Urogynaecology CiPs 1–4).

In addition to the clinical CiPs, a new CiP addressing skills in research and innovation has been developed as a generic CiP for all subspecialty trainees (SSTR).

Urogynaecology and Vaginal Surgery (UGVS) (the UGVS SITM)	UGVS CiPs 1–4
SST-specific CiPs	SST Urogynaecology CiPs 1–4
SST Research CiP	SSTR CiP

Trainees need to complete all nine CiPs to achieve subspecialty accreditation. The SST Urogynaecology CiPs can only be completed as part of an accredited subspecialty training programme in Urogynaecology. If a trainee has completed part or all of the UGVS SITM (UGVS CiPs 1–4) before starting Urogynaecology SST, they will not need to repeat it.

Learners with previous research experience, such as the Special Interest Professional Module (SIPM) in Clinical Research, can use this as evidence toward the SSTR CiP.

The ‘indicative’ duration of the Urogynaecology SST is 24 months. If a learner undertakes the programme as a full-time trainee from the beginning of ST5, entering with minimal relevant skills or experience, it is expected to take longer than 24 months. They will still have 36 months left in their training programme. However, this timeframe is guide only, as training is entirely competency based. Evidence of skills and competencies acquired before starting the UG SST can be used, where appropriate, as evidence supporting sign-off within the subspecialty curriculum.

The majority of trainees will be still working toward their ‘Certificate of Completion of Training’ (CCT), although some will have already obtained this. Trainees who are pre-CCT will also need to continue accumulating skills and evidence as described for the Core Curriculum CiPs. Further detail can be found in the [Definitive Document for Core Curriculum 2024](#) and the [Essential Curriculum Guide](#).

Here is the GMC-approved Urogynaecology SST:



3. Capabilities in Practice (CiPs)

3.1 UGVS CiPs 1–4

UGVS CiP 1: The doctor has the knowledge, skills and attitudes required to clinically assess patients who have pelvic floor dysfunction.	
Key skills	Descriptors
Takes and presents a urogynaecological history in patients with urinary, bowel, pelvic organ prolapse and sexual problems	<ul style="list-style-type: none"> • Takes and presents an appropriate history, including the impact on quality of life. • Uses terminology in accordance with the International Continence Society. • Communicates patient’s symptoms effectively and understands their severity and social and psychological impact.
Uses standardised assessment tools when assessing patients	<ul style="list-style-type: none"> • Uses a clinical history and a bladder diary to make an initial diagnosis. • Selects appropriate standardised symptom and quality of life questionnaires.
Performs a general, pelvic floor and neurological examination to clinically assess pelvic floor dysfunction	<ul style="list-style-type: none"> • Performs an appropriate examination, elicits abdominal and pelvic signs, and highlights relevant findings to the team. • Describes the stage of pelvic organ prolapse using a recognised method, like the Pelvic Organ Prolapse Quantification (POP-Q) system, or new assessments as they are introduced into clinical practice. • Performs a neurological examination to assess neurological conditions that may affect the pelvic floor, and for perineal denervation. • Puts clinical findings in the context of the patient’s symptoms.
Communicates and links with members of local and regional multidisciplinary teams	<ul style="list-style-type: none"> • Communicates the significance of clinical findings to the patient and multidisciplinary team. • Recognises indications and refers appropriately to specialist centres (e.g. mesh complications, fistula).
Evidence to inform decision – examples of evidence (not mandatory requirements)	
<ul style="list-style-type: none"> • Reflective practice • TO1/TO2 (including SO) • Attend urogynaecology clinics • Case discussion and observation of senior medical staff 	<ul style="list-style-type: none"> • Tailored clinical experience • Feedback from trainer • CbD • Mini-CEX



<ul style="list-style-type: none"> Personal study 	<ul style="list-style-type: none"> Evidence of attendance at appropriate courses
Mandatory requirements	
No mandatory evidence	
Knowledge criteria	
<ul style="list-style-type: none"> The terminology used for pelvic floor dysfunction The relationship between pelvic floor symptoms and other medical conditions, including neurological conditions and their impact on the pelvic floor An understanding of evidence-based guidance Neurological conditions that affect the lower urinary tract (e.g. multiple sclerosis) Objective methods for assessing pelvic organ prolapse, including the POP-Q system Design and validation of standardised symptom and quality of life questionnaires Examination findings relevant to lower urinary tract disorders and prolapse 	

UGVS CiP 2: The doctor selects and performs tests appropriate for common urogynaecological presentations and interprets the results.

Key skills	Descriptors
Performs, understands, and interprets appropriate investigation for assessment of pelvic floor and functional bladder symptoms	<ul style="list-style-type: none"> Requests and interprets results of urinalysis and formal urine culture and cytology. Assesses urinary residual by bladder scan. Undertakes urodynamics according to the standards set down in the common curriculum for multidisciplinary training in urodynamics (www.ukcs.uk.net). Undertakes urodynamic investigation according to national standards. Demonstrates an understanding of fluid dynamics, bladder, and urethral function. Understands the basic principles of urodynamic testing. Demonstrates an ability to set up, use and maintain the equipment. Takes the measures necessary to achieve quality control of the equipment. Explains the relevance of the test findings. Is able to understand the impact of results on clinical management.
Refers for further investigation and management when appropriate	<ul style="list-style-type: none"> Recognises indications for more advanced urodynamic assessment (i.e. video urodynamics, ambulatory urodynamics and urethral function studies) and refers appropriately. Identifies available modalities and indications for imaging the urinary tract and makes appropriate requests.



	<ul style="list-style-type: none"> Identifies available modalities and indications for investigating bowel symptoms and makes appropriate requests.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
<ul style="list-style-type: none"> Reflective practice Direct observation of senior colleagues Attendance at local, deanery and national teaching and meetings: <ul style="list-style-type: none"> attendance at a national urodynamics course attendance at a national or regional anatomy teaching course 	<ul style="list-style-type: none"> Confirmed participation in multidisciplinary team meetings and clinics Leads critical incident review CbD Mini-CEX TO1/TO2 (including SO)
Mandatory requirements	
<ul style="list-style-type: none"> OSATS: <ul style="list-style-type: none"> standard urodynamics (cystometry) 	
Knowledge criteria	
<ul style="list-style-type: none"> Relevant anatomy and physiology, and pathophysiology of pelvic floor conditions Indications for and methods of urodynamic testing, including: <ul style="list-style-type: none"> Urinalysis Urine culture and cytology Pad tests Assessment of urinary residual and bladder scan Uroflowmetry Subtracted dual channel cystometry Modalities for imaging the urinary tract Regional referral pathways and the role of regional subspecialist in the management of complex cases Modalities for investigating bowel symptoms 	

UGVS CiP 3: The doctor manages pelvic floor dysfunction using non-surgical methods.	
Key skills	Descriptors
Demonstrates conservative management of pelvic floor dysfunction	<ul style="list-style-type: none"> Recognises the importance of non-surgical management in the treatment pathway and explains this to patients. Manages patients using agreed clinical pathways and evidence-based guidelines. Is aware of referral of patients to physiotherapists and nurse specialists at an early stage in the treatment pathway.



	<ul style="list-style-type: none"> • Works in a multidisciplinary team and liaises appropriately with community continence services. • Counsels patients on containment measures and support groups.
Demonstrates conservative management of overactive bladder syndrome	<ul style="list-style-type: none"> • Analyses charts (frequency, frequency/volume, input/output) and counsels the patient accordingly. • Recognises the role of drug therapy for patients with overactive bladder symptoms, including pharmacological action, interactions and adverse effects. • Implements drug therapy appropriately and counsels patients on its success and adverse effects. • Manages patients with mixed urinary incontinence as part of a multidisciplinary team.
Demonstrates conservative management of stress urinary incontinence (SUI)	<ul style="list-style-type: none"> • Assesses pelvic floor strength. • Instructs patients on the role of pelvic floor muscle assessment and training, and other physical therapies, and refers on to colleagues, as appropriate.
Demonstrates non-surgical management of pelvic organ prolapse	<ul style="list-style-type: none"> • Assesses and manages complications of vaginal pessaries as part of a multidisciplinary team, referring on to other specialities as appropriate.
Recognises indications for anorectal investigation and treatment	<ul style="list-style-type: none"> • Counsels patients on simple treatments for faecal incontinence and obstructive defaecation and refers appropriately.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
<ul style="list-style-type: none"> • Reflective practice • Attend a physiotherapy clinic and observe management given by pelvic floor physiotherapist • Attend a continence clinic and observe continence nurse • Confirmed participation in multidisciplinary team clinics and meeting 	<ul style="list-style-type: none"> • Demonstrates adequate exposure to managing pelvic floor dysfunction using non-surgical methods during training • CbD • Mini-CEX • Feedback with trainer • TO1/TO2 (including SO) • Attendance at local/deanery teaching or training days/courses
Mandatory requirements	
No mandatory evidence	
Knowledge criteria	
<ul style="list-style-type: none"> • The role of pharmacology in pelvic floor dysfunction, including mechanism of action, adverse effects, and interaction, for treatment of: <ul style="list-style-type: none"> ○ overactive bladder syndrome ○ nocturnal frequency and nocturia ○ stress urinary incontinence 	



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

UGVS CiP 4: The doctor provides high-quality surgery for primary incontinence and prolapse.

Key skills	Descriptors
Counsels patients appropriately on surgical management of pelvic floor disorders	<ul style="list-style-type: none"> ● Formulates a management plan and modifies it, if necessary. ● Counsels on the different surgical options for prolapse and incontinence, including non-surgical alternatives, complications, and outcomes. ● Demonstrates ability to take informed consent for surgery accordingly.
Demonstrates safe surgical practice	<ul style="list-style-type: none"> ● Recognises the indications and complications of surgical procedures in the management of pelvic floor dysfunction. ● Selects patients appropriately for vaginal prolapse and/or continence surgery. ● Performs surgery for primary incontinence and prolapse in a fluent and safe manner. ● Recognises the clinical findings which need onward management from a multidisciplinary team, including urology and sub-specialist urogynaecologists. ● Counsels on remaining NICE-approved primary procedures for stress urinary incontinence.
Manages postoperative complications, including voiding difficulty	<ul style="list-style-type: none"> ● Advises nursing staff on catheter management following continence surgery. ● Supervises a patient undergoing a programme of intermittent self-catheterisation. ● Recognises the role of other specialists in the management of surgical complications.



Recognises indications for referral to sub-specialist teams	<ul style="list-style-type: none"> Demonstrates an understanding of the different available surgical procedures for apical prolapse, including their indication and how to refer on for them, if required.
Actively participates in clinical audit	<ul style="list-style-type: none"> Commits to audit of procedures, according to guidelines. Uses nationally recommended databases, such as the BSUG Audit Database. Engages in local audits and leads a minimum of one audit a year, which must include one surgical audit.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
<ul style="list-style-type: none"> Reflective practice Non-Technical Skills for Surgeons NOTSS Attendance at postoperative ward rounds Attendance at risk management meetings Direct observation/consultant supervision within the module Attendance at multidisciplinary team (MDT) meetings Participation and completion of audit 	<ul style="list-style-type: none"> Tailored clinical experience under supervision: <ul style="list-style-type: none"> personal study appropriate postgraduate education courses and reading recording outcomes on national databases (e.g. BSUG Audit Database) CbD Feedback from trainer TO1/TO2 (including SO) Mini-CEX
Mandatory requirements	
<ul style="list-style-type: none"> OSATS: <ul style="list-style-type: none"> rigid cystourethroscopy anterior vaginal wall repair (colporrhaphy) posterior vaginal wall repair ± perineorrhaphy vaginal hysterectomy sacrospinous fixation colposuspension (open, laparoscopic or robotic) autologous fascial sling 	
Knowledge criteria	
<ul style="list-style-type: none"> The necessary equipment, diathermy instrumentation and theatre set-up Potential surgical complications, assessment, investigation (including imaging) and management How to manage major haemorrhage The indications and complications of the following procedures, including principles of surgery: <ul style="list-style-type: none"> cystoscopy anterior and posterior vaginal wall repair +- perineorrhaphy vaginal hysterectomy for prolapse, including uterosacral plication or McCall culdoplasty 	



- continence procedures in line with NICE guidance and as relevant to local services
- bladder neck injections
- sacrospinous fixation
- Surgical management of detrusor overactivity
- Treatment options for recurrent SUI and pelvic organ prolapse (POP) and ability to refer appropriately
- Surgical management of faecal incontinence and appropriate referral
- The surgical procedures for vault and apical prolapse, including potential benefits and risks
- The role of the local and regional MDT in primary and complex pelvic floor surgery
- How to audit surgical outcomes
- Preoperative and postoperative care

3.2 SST Urogynaecology CiPs 1–4

SST Urogynaecology CiP 1: The doctor has the knowledge, skills and aptitude required for clinical assessment of complex pelvic floor dysfunction.

Key skills	Descriptors
Assesses women with potential urethral diverticula (UD)	<ul style="list-style-type: none"> ● Diagnoses UD and investigates the condition appropriately.
Assesses women with potential mesh complications	<ul style="list-style-type: none"> ● Assists and has been supervised in the assessment, diagnosis and management of mesh complications and can request appropriate investigations. ● Recognises indications for referral to specialist mesh centres.
Assesses women with potential urinary tract and enteric fistulae	<ul style="list-style-type: none"> ● Diagnoses fistulae and orders appropriate investigations.
Assesses women with potential neurological conditions that affect the bladder	<ul style="list-style-type: none"> ● Carries out appropriate neurological examination and requests appropriate investigations for these conditions.
Links with specialists in other disciplines to assess and manage complex pelvic floor disorders	<ul style="list-style-type: none"> ● Determines correct indications for referral to specialist urology for complex urodynamic stress incontinence (USI) and detrusor overactivity. ● Determines correct indications for referral to specialist colorectal services for rectal prolapse and functional bowel disorders. ● Determines correct indications for referral to specialist



	neurology or neurourology for the management of neurological conditions that affect the bladder.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
<ul style="list-style-type: none"> • Reflective practice • Attend urogynaecology clinics • Case discussion and observation of senior medical staff • Personal study • Tailored clinical experience • Works with clinicians in other disciplines and spends time in their service: <ul style="list-style-type: none"> ○ coloproctologists, radiologists, physiotherapists, specialist nurses ○ urologists and radiologists ○ neurology and regional neuromodulation services 	<ul style="list-style-type: none"> • Feedback from trainer • CbD • Mini-CEX • Evidence of attendance at appropriate courses • TO1/TO2 (including SO)
Mandatory requirements	
No mandatory evidence	
Knowledge criteria	
<ul style="list-style-type: none"> • The impact of neurological conditions on lower urinary tract function (e.g. multiple sclerosis), and how to assess and counsel patients appropriately • The lower urinary tract manifestations of specific neurological conditions and their management: <ul style="list-style-type: none"> ○ spina bifida ○ multiple sclerosis ○ Parkinson’s disease ○ spinal cord injury ○ lower motor neuropathy ○ stroke • Surgical principles for the treatment of complex urodynamic stress incontinence and detrusor overactivity: <ul style="list-style-type: none"> ○ artificial urinary sphincters ○ augmentation cystoplasty ○ urinary diversion procedures • The investigation and diagnostic criteria for fistulae (vesicovaginal, uterovaginal and urethrovaginal) and the surgical principles for repair and complications that may occur • Urethral diverticula • Treatments for ureteric obstruction and injury, including ureteric stents (double-J stents or ureteric catheters) • Surgical principles of ureteric reanastomosis and reimplantation techniques 	



- Methods of investigations and principles of treatment of faecal incontinence:
 - secondary anal sphincter repair
 - bulking agents
 - pelvic floor exercises
 - surgical management of rectal prolapse such as Delorme’s procedure and rectopexy
 - use of constipating agents
- Methods of investigations and principles of treatment for bowel emptying problems:
 - use of laxatives/conservative therapies
 - trans-anal rectocele repair
- Methods of investigations and principles of treatment for bowel urgency:
 - biofeedback
 - drug treatment
 - behavioural modification
- Investigations and principles of treatment of enteric fistulae, including those involving bladder, vagina, anus, or the perineum
- Pelvic floor electromyogram: use of sacral nerve stimulator
- Tibial nerve stimulation
- Range of mesh complications, methods of investigation and principles of treatment
- Context of mesh complications and specialist mesh centres in the United Kingdom

SST Urogynaecology CiP 2: The doctor selects and performs tests that are appropriate for complex pelvic floor dysfunction and interprets the results.

Key skills	Descriptors
Performs, understands and interprets appropriate investigation for assessment of pelvic floor and functional bladder symptoms	<ul style="list-style-type: none"> • Performs and interprets results of more complex urodynamic assessment, including: <ul style="list-style-type: none"> ○ video-cystourethrography ○ ambulatory urodynamics ○ urethral function studies. • Interprets results appropriately for urinary tract investigations, including: <ul style="list-style-type: none"> ○ renal ultrasound ○ abdominal X-ray ○ computerised tomography (CT)/magnetic resonance imaging (MRI) ○ intravenous urogram/CT urogram/MRI urogram ○ micturating cystogram ○ isotope renography (e.g. MAG3 scan). • Interprets results appropriately for gastrointestinal tract investigations, including: <ul style="list-style-type: none"> ○ anorectal function studies



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



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

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

Key skills	Descriptors
Demonstrates conservative management of complex pelvic floor disorders	<ul style="list-style-type: none"> ● Can counsel patients on the role of neuromodulation in managing pelvic floor disorders, including potential complications, and refers appropriately. ● Demonstrates understanding of, and initiates pharmacological measures in, more complex pelvic floor disorders.
Manages indications and use of the different types of urinary catheters	<ul style="list-style-type: none"> ● Demonstrates understanding of the indications, use and potential complications for the different types of catheters. ● Manages complications of catheters appropriately. ● Can counsel patients on, and teaches them about, intermittent self-catheterisation and manages any complications that arise from this appropriately.
Initiates management of faecal incontinence	<ul style="list-style-type: none"> ● Requests appropriate investigations and interprets results. ● Formulates a management plan and modifies it, if necessary. ● Initiates conservative management for faecal urgency and incontinence, including behavioral therapy.



Initiates management of obstructive defecation	<ul style="list-style-type: none"> Requests appropriate investigations and interprets results independently. Formulates a management plan and modifies it independently, if necessary. Initiates conservative management independently for obstructive defecation, including behavioral therapy.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
<ul style="list-style-type: none"> Reflective practice Attend a physiotherapy clinic and observe management given by pelvic floor physiotherapist Attend a continence clinic and observe continence nurse Confirmed participation in specialist clinics and MDT meetings Works with clinicians in other disciplines and spends time in their service: <ul style="list-style-type: none"> coloproctologists, radiologists, physiotherapists and specialist nurses urologists and radiologists neurology, regional neuromodulation services 	<ul style="list-style-type: none"> Attendance at perineal and anorectal physiology investigation clinics Observation of, assisting and discussion with, senior medical staff Personal study Demonstrates adequate exposure during training CbD Mini-CEX Feedback with trainer TO1/TO2 (including SO) Attendance at local/deanery teaching or training days/courses
Mandatory requirements	
<ul style="list-style-type: none"> OSATS: <ul style="list-style-type: none"> Inserts and changes suprapubic catheters 	
Knowledge criteria	
<ul style="list-style-type: none"> Relevant anatomy, physiology, and abnormal function to the clinical situation The role of pharmacology in pelvic floor dysfunction, including mechanism of action, adverse effects, and interactions The effects of drugs used in other conditions on the lower urinary tract system The role of neuromodulation in the treatment of Overactive Bladder Syndrome (OAB), including tibial nerve stimulation, and how to counsel someone on success and adverse effects The principles of different modalities of pelvic floor exercises: <ul style="list-style-type: none"> cones electrical therapy magnetic stimulator biofeedback The principles of management of faecal urgency and incontinence 	



- The conservative management for faecal urgency and incontinence, including behavioral therapy
- Understands the role of sacral neuromodulation for faecal incontinence and has observed the procedure
- The principles of managing obstructive defecation
- The pharmacology, role and complications of laxatives and other drug therapies for these conditions
- The role of the MDT in managing patients and how to refer on, as appropriate
- Indications for different types of catheters, insertion of catheters and intermittent self-catheterisation
- Principles of, and possible indications for, treating overactive bladder syndrome:
 - biofeedback
 - acupuncture
 - hypnotherapy
 - psychotherapy

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

Key skills	Descriptors
Can counsel patients appropriately on surgical management of pelvic floor disorders	<ul style="list-style-type: none"> • Can counsel patients in situations of surgical complexity, including failed previous surgery.
Demonstrates safe surgical practice	<ul style="list-style-type: none"> • Selects patients appropriately for vaginal, abdominal, or laparoscopic prolapse procedures and/or continence surgery. • Performs surgery for primary and recurrent, prolapse and stress urinary incontinence independently, in a fluent and safe manner.
Diagnoses and manages intra- and postoperative complications	<ul style="list-style-type: none"> • Inspects bladder, ureter, and the small and large bowel for perforation or damage, and undertakes appropriate special tests such as air insufflation and using dyes to aid recognition of injury. • Recognises and repairs bladder injuries and institutes appropriate postoperative bladder drainage. • Recognises and observes management of other intraoperative visceral injury, including bowel, urethra and ureters. • Recognises and controls haemorrhage until appropriate help, if required, is available.



	<ul style="list-style-type: none"> • Recognises delayed onset complications, such as peritonitis, ileus, faecal contamination, or urinary leakage. • Recognises postoperative ureteric injury or obstruction and initiates investigations and management of them with the urology team. • Uses upper renal tract investigations appropriately. • Recognises the role of other specialists in managing surgical complications.
Selects appropriate mesh and can counsel patients about the benefits and risks of using mesh	<ul style="list-style-type: none"> • Applies up to date knowledge and guidelines to selecting and using mesh. • Can counsel patients independently regarding mesh complications, including: infection, erosion, extrusion, and chronic pain.
Performs incontinence and prolapse surgery and manages complications	<ul style="list-style-type: none"> • Demonstrates understanding of what clinical findings require referral for assessment or further management by Urology. • Is able to perform the procedures listed below. • Recognises when it is unsafe to continue with a procedure laparoscopically and the need to convert to a laparotomy, call for support, or when the procedure should be abandoned altogether.
Manages postoperative voiding difficulty	<ul style="list-style-type: none"> • Can counsel patients on the different types of catheters (intermittent, urethral and suprapubic), explaining how to use them, their advantages, appropriateness and risks.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
<ul style="list-style-type: none"> • Reflective practice • NOTSS • Attendance at theatre lists • Attendance at postoperative ward rounds • Attendance at risk management meetings • Leads critical incident review • Direct observation/consultant supervision within the module • Tailored clinical experience, under supervision, of: <ul style="list-style-type: none"> ○ personal study ○ appropriate postgraduate education courses and reading ○ recorded outcome on national databases (e.g. BSUG) 	<ul style="list-style-type: none"> • Cbd • Mini-CEX • Feedback from trainer • TO1/TO2 (including SO) • Attendance at MDT meetings • Attendance at regional mesh complications MDT • Participation and completion of audit
Mandatory requirements	



- OSATS:
 - intravesical administration of botulinum toxin (through both rigid and flexible cystoscopes)
 - sacrocolpopexy (open, laparoscopic or robotic)
 - colposuspension (open, laparoscopic or robotic)
 - autologous fascial sling
 - at least two first-line stress urinary incontinence procedures, in line with NICE guidance, and as relevant to local services, e.g. colposuspension (open, laparoscopic or robotic), autologous fascial sling
 - bladder neck injections

Knowledge criteria

- Knowledge of appropriate preoperative investigations
- The equipment for vaginal, open, and laparoscopic procedures and theatre set-up
- Diathermy instrumentation:
 - how to use laparoscopic bipolar energy effectively and at least one energy source for cutting, i.e. monopolar or ultrasound
 - the principles underlying other types of energy sources
 - the safety checks required before activating the energy source
- Potential surgical complications and how to avoid them
- Relevant anatomy, including anatomy of sacral promontory
- Safe laparoscopic entry and choosing correct entry for each patient, including: use of Veress needle, open entry, direct vision entry and Palmer's point entry
- The principles of surgical site closure, including port site closure in laparoscopic surgery, and the need to avoid surgical site hernia or damage underlying structures
- The principles of more complex repairs, such as segmental bowel resection and ureteric anastomosis and reimplantation
- The principles underlying the repair of major vessels
- The role of synthetic mesh, in line with national guidelines, including the potential risks, as well as benefits, of mesh procedures
- The indications, and potential complications of urethral dilatation
- The variations of apical procedures, such as sacrohysteropexy
- The various types of mesh that are available and their suitability for sacrocolpopexy and sacrohysteropexy
- The methods of mesh fixation to the sacral promontory, including safe use of stapling devices
- The use of imaging in assessing and managing postoperative complications
- The role of investigations and diagnostic criteria for fistulae (vesicovaginal, ureterovaginal and urethrovaginal)
- The role of the MDT in managing these patients and how to refer on, as appropriate
- The surgical principles of fistula repair and complications that may occur



- The role of investigations and diagnostic criteria for urethral diverticula
- The surgical principles of diverticulum surgery and complications that may occur
- Potential complications following mesh procedures for incontinence and/or prolapse
- Understands the surgical principles for the treatment of complex urodynamic stress incontinence and detrusor overactivity, including the following procedures:
 - artificial urinary sphincters
 - augmentation cystoplasty
 - urinary diversion procedures
 - sacral nerve stimulation
 - bladder-neck injections
 - botulinum toxin injections
 - sacral nerve stimulation
- The principles for treating voiding difficulties, including urethral dilatation, postoperative problems, and the advantages/disadvantages of different techniques
- The principles for treating complex pelvic organ prolapse, including paravaginal repair
- The principles for treating vault prolapse, including:
 - sacrospinous fixation
 - sacrocolpopexy (open, laparoscopic or robotic)
- The principles of subsequent management
- Surgical principles for the treatment of complex urodynamic stress incontinence and detrusor overactivity:
 - artificial urinary sphincters
 - augmentation cystoplasty
 - urinary diversion procedures
- The investigation and diagnostic criteria for fistulae (vesicovaginal, uterovaginal and urethrovaginal) and the surgical principles for repair and complications that may occur
- Urethral diverticula
- Treatments for ureteric obstruction and ureteric injury, including ureteric stents (double-J stents or ureteric catheters)
- Surgical principles of ureteric re-anastomosis and reimplantation techniques
- Secondary anal sphincter repair
- Surgical management of rectal prolapse, such as Delorme's procedure and rectopexy

3.3 The SSTR CiP

The previous requirement for 'research accreditation' (evidenced by a higher degree, the Research Advanced Professional Module or two relevant first author papers) has been removed from the 2024 SST curriculum. In recognition of the important contribution made by, and expected of, most subspecialists, this requirement has been replaced with a subspecialty-specific research CiP. Trainees who have already been involved in research are likely to be able to use evidence of these research skills to support sign-off of this CiP.



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

Key skills	Descriptors
Demonstrates research skills	<ul style="list-style-type: none">• Is able to demonstrate practice in healthcare research and the different methodologies within their subspecialty.• Shows continued engagement in Good Clinical Practice (GCP) and Research and Development (R&D) processes.• Engages in ethics and governance processes within research, demonstrating they are able to follow guidelines on ethical conduct and consent for research.• Demonstrates involvement in informatics, statistical analysis and emerging research areas within their subspecialty.• Shows engagement with national trials within their subspecialty, including patient recruitment, trial monitoring and adverse event reporting.• Shows understanding of the role of public and patient involvement within clinical trials.• Is able to discuss clinical trials with, and facilitate recruitment of, patients within their subspecialty.• Has the ability to translate research into clinical practice within their subspecialty.
Demonstrates critical thinking	<ul style="list-style-type: none">• Is able to develop and critically appraise a research protocol.• Is able to critically evaluate clinical trial data to establish the clinically significant outcomes and relevance for clinical practice within their subspecialty.• Is able to interpret research findings, reflect on the potential impact on their clinical practice and share this with colleagues and patients.• Can develop and critically appraise a patient information leaflet.• Is able to interpret research findings within their subspecialty and discuss these when taking informed consent for treatment.
Innovates	<ul style="list-style-type: none">• Demonstrates how their clinical practice has developed from innovative research within their subspecialty.



	<ul style="list-style-type: none"> Is able to demonstrate engagement with the introduction of any innovations within their subspecialty, including governance and costs.
Evidence to inform decision – examples of evidence (not mandatory requirements)	
<ul style="list-style-type: none"> National teaching and courses Critical appraisal of protocols/papers Subspecialty journal club presentations GCP re-certification Participation, including recruitment for national multicentre trials Preparation of research protocol/grant applications Oral, and/or poster presentations at national/international subspecialty meetings 	<ul style="list-style-type: none"> SIPM in Clinical Research Peer reviewed original research publications relevant to their subspecialty A higher degree such as a PhD or research MD
Mandatory requirements	
No mandatory evidence	

4. GMC Generic Professional Capabilities (GMCs)

The key skills in all nine CiPs also map to a variety of [generic professional capabilities](#) (GPCs). When providing evidence of their progress in this programme, learners should make sure that it also displays progress/capability in the GMC GPCs, such as dealing with complexity, teamwork and leadership, and knowledge of patient safety issues.

Mapping to the GPCs
Domain 1: Professional values and behaviours
Domain 2: Professional skills
Domain 3: Professional knowledge
Domain 4: Capabilities in health promotion and illness prevention
Domain 5: Capabilities in leadership and team-working
Domain 6: Capabilities in patient safety and quality improvement
Domain 7: Capabilities in safeguarding vulnerable groups
Domain 8: Capabilities in education and training



Domain 9: Capabilities in research and scholarship

Learners can expect to be assessed on their wider skills as a medical professional, their skills in leadership and teamwork, and their level of clinical competence. Evidence showing progress in these areas will result in the learner progressing through the programme.

To help learners and Educational Supervisors determine what acceptable progress looks like, there is a Statement of Expectations for each of the nine CiPs.

	Statement of Expectations for the Urogynaecology SST
Meeting expectations for the UGVS CiP1	<p>Learners can independently take and present a urogynaecological history in patients with urinary, bowel, pelvic organ prolapse and sexual problems. Learners are confident using standardised assessment tools when assessing patients.</p> <p>Learners can perform a general, pelvic floor and neurological examination to clinically assess pelvic floor dysfunction, and use clinical assessment to formulate a differential diagnosis. They are able to use the information acquired to plan further investigations and begin to create appropriate individualised management plans.</p> <p>Learners are able to communicate the significance of findings to the patient and multidisciplinary team, and recognise indications for appropriate referral to specialist centres.</p>
Meeting expectations for the UGVS CiP2	<p>Learners can perform, understand and interpret appropriate investigation for assessment of pelvic floor and functional bladder symptoms, undertaking urodynamics according to the standards set down in the common curriculum for multidisciplinary training in urodynamics (www.ukcs.uk.net).</p> <p>Learners are able to explain investigations to the patient, conveying what this means for their treatment, and recognise when further investigations or referral are required.</p>
Meeting expectations for the UGVS CiP3	<p>Learners can demonstrate conservative, non-surgical management of pelvic floor dysfunction, recognise the importance in the treatment pathway, and explain this to patients.</p> <p>Learners are able to work in a multidisciplinary team and liaise appropriately with physiotherapists, nurse specialists and community continence services.</p>



	<p>Learners can implement drug therapy appropriately, and assess and manage complications of vaginal pessaries.</p> <p>Learners are able to counsel patients on simple treatments for faecal incontinence and obstructive defecation, referring for relevant investigations and treatment.</p>
Meeting expectations for the UGVS CiP4	<p>Learners can recognise the indications and complications of surgical procedures used in the management of pelvic floor dysfunction.</p> <p>Learners are able to counsel patients on the different surgical options for prolapse and incontinence, according to NICE guidance, including non-surgical alternatives, complications and outcomes, and can take informed consent.</p> <p>Learners select patients appropriately for vaginal prolapse and continence surgery, perform surgery in a safe and fluent manner, and manage postoperative complications.</p> <p>Learners recognise when a patient should be referred for subspecialist management, and actively participate in clinical audit of procedures, according to guidelines.</p>
Meeting expectations for the SST Urogynaecology CiP1	<p>Learners can comprehensively assess women with less common and the most complex of urogynaecological problems, working through an MDT to refer to allied tertiary level services where appropriate, and devise individualised management plans.</p>
Meeting expectations for the SST Urogynaecology CiP2	<p>Learners are able to perform and interpret more complex urogynaecological investigations, work with the MDT to order tests performed by other specialists, and communicate and manage the results in an individualised way.</p>
Meeting expectations for the SST Urogynaecology CiP3	<p>Learners are able to manage patients with very complex pelvic floor disorders, including faecal incontinence and those needing long-term catheterisation.</p>
Meeting expectations for the SST Urogynaecology CiP4	<p>Learners can work with an MDT to select and counsel patients for surgical options in the setting of recurrent urogynaecological problems and/or concurrent colorectal/anogenital concerns.</p> <p>Learners are able to perform evidence-based vaginal, abdominal or laparoscopic procedures, with appropriate management of complications and postoperative care, for prolapse and/or incontinence in line with national guidance.</p>



Meeting expectations for the SSTR CiP

Learners have knowledge, understanding and practical experience of research skills pertinent to their subspecialty.

Learners can demonstrate ongoing engagement with research in their subspecialty field, are able to critically appraise their own research findings and those of others, and can translate innovation into everyday subspecialty practice.

The CiP knowledge criteria show the processes/frameworks a learner should understand and the clinical knowledge they must have if they want to become a subspecialist in urogynaecology. This is more in-depth than the knowledge base expected for the MRCOG. The key skills and descriptors outline the expected learning outcomes for the Urogynaecology SST. However, learners will not experience the entire range of possible scenarios during their training; therefore, after completing the programme they should continue their learning and skill development through their independent practice as a urogynaecologist and at MDT meetings.

5. Procedures associated with the clinical Urogynaecology CiPs

The procedures required to complete this SST are listed below. A learner can show progress in these procedures through OSATS, procedure logs, attendance at courses and other forms of evidence.

Each procedure is assigned a supervision, or entrustability, level (defined in Section 6.4 of the [Definitive Document for Urogynaecology SST 2024](#)) recognising that acquisition of safe independent practice in some of the more complex and uncommon procedures may only be achieved as a consultant, working with more experienced colleagues. Level 5 indicates that a learner should be able to perform the procedure independently.

Procedures marked with * must be evidenced with three competent summative OSATS. The others can be evidenced using summative OSATS and other means (e.g. CBD, Mini-CEX, formative OSATS, reflections). For procedures that can be performed open, laparoscopic or via robotics, candidates need three summative OSATS with the procedure done via the same approach, e.g. three laparoscopic SCP or three robotic SCP.

Some of these procedures also feature in a similar table in the UVGS SITM curriculum guide, but the same supervision level is not necessarily required for completion of the SITM.



Procedures	Level by end of training	UGVS CiP2	UGVS CiP3	UGVS CiP4	SST CiP2	SST CiP3	SST CiP4
Standard urodynamics (cystometry)*	5	X					
Urethral function studies	2				X		
Video-urodynamic function studies	2				X		
Ambulatory urodynamic studies	2				X		
Cystourethroscopy							
o flexible cystourethroscopy*	5				X		
o rigid cystourethroscopy*	5			X	X		
o operative cystourethroscopy +/- bladder biopsy*	5	X			X		
Bladder scan	5	X					
Pelvic floor electromyography (EMG)	1				X		
Renal ultrasound	1				X		
Intravenous urogram/CT urogram/MRI urogram	1				X		
Micturating cystogram	1				X		
Isotope renography	1				X		
Ultrasound of the pelvic floor	1				X		
MRI scan of the pelvic floor	1				X		
Barium enema	1				X		
Contrast CT/colonoscopy	1				X		
Anorectal function studies	1				X		
Defecating proctogram	1				X		
Endoanal ultrasound	1				X		
Sacral nerve stimulation	1					X	
Posterior tibial nerve stimulation	1					X	
Teaches clean intermittent self-catheterisation (CISC)	3					X	
Inserts and changes suprapubic catheters	5					X	
Inserts and changes pessaries	5		X				



Procedures	Level by end of training	UGVS CiP2	UGVS CiP3	UGVS CiP4	SST CiP2	SST CiP3	SST CiP4
Intravesical administration of botulinum toxin, through both rigid and flexible cystoscopes*	5			X			X
Vaginal surgery for primary and recurrent pelvic organ prolapse:							
○ non-mesh anterior repair (colporrhaphy)*	5			X			X
○ non-mesh posterior repair (colporrhaphy)*	5			X			X
○ sacrospinous fixation*	5			X			X
○ vaginal hysterectomy*	5			X			
○ uterosacral plication or McCall culdoplasty for vault support at vaginal hysterectomy	5			X			
Advanced laparoscopic surgery:							
○ close port sites safely with all entry types	5						X
○ suture using laparoscopic needle holders	5						X
○ undertake intracorporeal and extracorporeal knot tying	5						X
Abdominal surgery for pelvic organ prolapse:							
○ sacrocolpopexy (open, laparoscopic or robotic)**	5						X
At least two first-line stress urinary incontinence procedures, in line with NICE guidance, and as relevant to local services, e.g.							
○ colposuspension (open, laparoscopic or robotic)*	5			X			
○ autologous fascial sling*	5			X			
Bladder neck injections*	5						X
Management of intraoperative bladder injury	5						X



Procedures	Level by end of training	UGVS CiP2	UGVS CiP3	UGVS CiP4	SST CiP2	SST CiP3	SST CiP4
Insertion of ureteric catheters	5						X
Other prolapse procedures, e.g.							
o colpocleisis	1						X
o Manchester repair	1						X
Repair of enteric fistulae	1						X
Trans-anal repair of rectocele	1						X
Delorme's procedure	1						X
Rectopexy	1						X
Secondary anal sphincter repair	1						X
Artificial urinary sphincter	1						X
Augmentation cystoplasty	1						X
Vesicovaginal fistula repair	1						X
Urethrovaginal fistula repair	1						X
Nephrostomy	1						X
Urinary diversion procedures	1						X
Ureteric re-anastomosis and reimplantation	1						
Urethral diverticulectomy	2						X
Urethral dilatation	1						X
Surgical management of mesh complications	2						X

* For sacrocolpopexy, one of the three summative OSATS can be a sacrohysteropexy, but the approach must remain the same.

OSATS are not assigned a level of entrustability, rather they are assessed as being *competent* or *working toward competence*. The entrustability levels here are given to guide the assessor in judging whether the learner has reached the required degree of independence at the end of training.

6. Evidence required

Discussion and detail on how trainees can evidence the acquisition of key skills and competencies during subspecialty training can be found in Section 4 of the [Essential Curriculum Guide](#).

The table below may be useful for learners to see whether a specific workplace-based assessment can be used as evidence of progress in each CiP:



CiP	OSATS	Mini-CEX	CbD	NOTSS	TO1/TO2	Reflective practice
UGVS CiP1: The doctor has the knowledge, skills and attitudes required to clinically assess patients who have pelvic floor dysfunction.		X	X		X	X
UGVS CiP2: The doctor selects and performs tests appropriate for common urogynaecological presentations and interprets the results.	X	X	X		X	X
UGVS CiP3: The doctor manages pelvic floor dysfunction using non-surgical methods.		X	X		X	X
UGVS CiP4: The doctor provides high-quality surgery for primary incontinence and prolapse.	X	X	X	X	X	X
SST Urogynaecology CiP1: The doctor has the knowledge, skills and aptitude required for clinical assessment of		X	X		X	X



CiP	OSATS	Mini-CEX	CbD	NOTSS	TO1/TO2	Reflective practice
complex pelvic floor dysfunction.						
SST Urogynaecology CiP2: The doctor selects and performs tests that are appropriate for complex pelvic floor dysfunction and interprets the results.	X	X	X	X	X	X
SST Urogynaecology CiP3: The doctor is competent in non-surgical management of complex pelvic floor dysfunction.	X	X	X		X	X
SST Urogynaecology CiP4: The doctor provides high-quality surgical treatment for recurrent, less common, or more complex pelvic floor disorders	X	X	X	X	X	X

6.1 Generic capabilities

All subspecialty doctors will need to provide evidence collected during subspecialty training for the following areas, at the centralised assessments:

- Clinical governance
- Teaching experience
- Research and innovation



- Leadership and management
- Presentations and publications.

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

Pre-CCT subspecialty doctors on the Core Curriculum 2024 will be expected to meet the expectations of the core generic and non-clinical specialty CiPs at ST5/6/7 level. They can use their experiences during subspecialty training and emergency duties to help evidence these generic capabilities and skills. The evidence should be linked to the appropriate core generic and non-clinical specialty CiPs, and may need to be supplemented to satisfy their Educational Supervisors and Annual Review of Progression (ARCP) panels that they meet the full range of requirements at ST5/6/7 level.

For each core generic and non-clinical specialty CiP, there is a CiP guide outlining what the level of expectation is for senior doctors in ST5, ST6 and ST7.

CCT holders and overseas doctors undertaking subspecialty training do not need to complete the core generic and non-clinical specialty CiPs, although they can choose to link evidence of their generic skills into the core generic or non-clinical specialty CiPs on the ePortfolio after uploading this evidence into the 'other evidence' section of the ePortfolio.

7. Assessing progress

A trainee's progress follows the same principles of any other trainee in obstetrics and gynaecology, as detailed in [Essential Curriculum Guide](#). However, the annual subspecialty assessment of progress is performed centrally, coordinated by the RCOG. Before this assessment, the subspecialty trainee and supervisor will need have performed assessments for each of the nine CiPs, look at the evidence collected so far and give a global judgement on the trainee's progress. Together, they will construct the subspecialty-specific Educational Supervisor's Report (SST ESR), and this, alongside the evidence in the trainee's ePortfolio, will be reviewed by a subspecialty assessment panel. The panel will give a narrative outcome, stating if they judge the trainee to have successfully completed subspecialty training, to be making good progress or if they are behind schedule and may need additional focus or training time.

For pre-CCT subspecialty trainees, this narrative outcome is a major part of the trainee's evidence for their subsequent ARCP, which will also assess their progress through the Core Curriculum. Learners do need to appreciate that satisfactory progression through subspecialty training does not guarantee a satisfactory outcome (outcome 1) at the subsequent ARCP. For this reason, they will need to complete an ESR for their ARCP with their Educational Supervisor; this is separate from the SST ESR they created for their subspecialty assessment. The two different forms of ESRs are clearly marked and easily accessible on the front page of the learner or supervisor ePortfolio log-in for that learner.



Learners need to ensure that they are also achieving any [Training Matrix of Progression](#) requirements for the Core Curriculum that are additional to those on the [Urogynaecology subspecialty matrix](#).

For pre-CCT subspecialty trainees on the Core Curriculum 2024, the key additional areas to focus on are evidencing all of the core generic and non-clinical specialty CiPs to ST5/6/7 level, and sign-off of the core clinical CiPs (9–12) to entrustability level 5 by the completion of training and the final ARCP. All subspecialty learners using the Core Curriculum 2024 should collect evidence to satisfy all four core clinical CiPs to entrustability level 5, but DO NOT need to collect ‘ongoing competency’ OSATS for core procedures that they have already demonstrated competency in (with three competent summative OSAST), in line with the 2024 core matrix.

It is a GMC requirement that to achieve a CCT in Obstetrics and Gynaecology, training must be undertaken in both aspects of the specialty. Therefore, in addition to providing evidence for the core clinical CiPs 9 and 11, Urogynaecology pre-CCT subspecialty trainees also need to provide evidence for the obstetrics core CiPs 10 and 12. These CiPs relate to emergency and non-emergency obstetrics. Information on the experience and evidence required for the obstetrics core CiPs 10 and 12 can be found in [‘Guidance for Subspecialty Training Programme Supervisors and pre-CCT urogynaecology subspecialty trainees on Core Curriculum 2024 on cross specialty working’](#).

8. Career guidance

Learners require two SITMs or subspecialty training for CCT. A learner aspiring to become a urogynaecologist should be advised to undertake the Urogynaecology and Vaginal Surgery SITM in order to make themselves more competitive for the subspecialty interview, as the Urogynaecology SST builds on this SITM. However, it is not mandated that the SITM has been started, or completed, for a learner to be eligible for the Urogynaecology SST. Any completed CiPs of the Urogynaecology and Vaginal Surgery SITM or all of the SITM can be used for the Urogynaecology SST. However, learners’ choices will be dependent on training opportunities available for their chosen SITMs.

Advice for learners who aspire to become a urogynaecologist is to start preparing for this direction as early as possible. They should have career conversations early in their training with their Educational Supervisor, find a mentor in the field of urogynaecology, complete the Clinical Research SIPM, achieve publications and start enquiring where posts may come up, as SST posts may be outside their region.

For further careers advice, learners should have a discussion with their Training Programme Director/SITM Director.



9. Further resources

The further resources listed below can be found on the [RCOG Curriculum 2024 webpages](#):

- [Essential Curriculum Guide](#)
- [Definitive Document for Urogynaecology SST 2024](#)
- [Curriculum Guide for Urogynaecology and Vaginal Surgery SITM](#)
- [Curriculum Guide for Clinical Research SIPM](#)
- [Training matrix for SST UG](#)
- [Definitive Document for Core Curriculum 2024](#)
- [Training Matrix of Progression](#)
- [British Society of Urogynaecology \(BSUG\)](#)

Find out more at
rcog.org.uk/curriculum2024



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