Curriculum Guide for Gynaecological Oncology (GO) Subspecialty Training (SST)

1 What is GO subspecialty training about?

Subspecialty training in Gynaecological Oncology (GO) will produce a gynaecological surgeon who is able to provide the highest level of care for women with suspected or proven gynaecological cancer. They will lead and co-ordinate care for these women in association with a wide range of many other women's' health providers including general obstetricians & gynaecologists, sonographers, clinical geneticists, colposcopists and the NHS cervical screening service, medical and clinical oncologists and other surgical oncologists in allied surgical disciplines such as colo-rectal, urological or plastic surgery. They will be leaders for these services at local, regional and even national level, with key roles in education, training, innovation, quality management and improvement, research and governance, pertinent to gynaecological cancer services.

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

GO subspecialty trainees should be exposed to and participate in a wide variety of allied specialties pertinent to gynaecological oncology clinical practice including medical and clinical oncology, diagnostic and interventional radiology, specialist palliative care medicine, urology, colo-rectal and upper abdominal intestinal and hepatobiliary surgery as defined in the Capabilities in Practice (CiPs).

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

There are two main components to GO subspecialty training. Firstly, is the clinical knowledge and skills required for GO subspecialist, described by the Gynaecological Oncology Capabilities in Practice (CiPs). The practical procedures with which a subspecialty trainee needs to become proficient lie within these clinical CiPs. The second element comprises generic, non-technical skills, in the areas relevant to GO subspecialty training: 'Clinical

governance', 'Teaching experience', 'Research', 'Leadership and management experience' and 'Presentations and publications'.

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

2 Design of GO subspecialty training

Gynaecological Oncology (GO) subspecialty training (SST) is a three-year programme (two years if the trainee applies successfully for research exemption), made up of 17 clinical capabilities in practice (CiPs). These are listed in Table 1, and the details of each GO CiP can be found here.

Table 1 –Capabilities in Practice (CiPs) for GO

DEVELOPING THE OBSTETRICIAN & GYNAECOLOGIST – SST-GO	
PROFESSIONAL IDENTITY: CLINICAL EXPERT	
GO CiP1	The doctor assesses and manages patients with suspected and confirmed gynaecological cancers and those without cancer who are concerned they may develop it.
GO CiP2	The doctor plans surgical care and manages problems safely along the entire surgical pathway.
GO 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.
GO CiP4	The doctor assesses ovarian cancer and initiates appropriate interventions for all stages and contexts of disease.
GO CiP5	The doctor assesses uterine cancer and initiates appropriate interventions for all stages and contexts of disease.
GO CiP6	The doctor assesses cervical cancer and initiates appropriate interventions for all stages and contexts of disease.
GO CiP7	The doctor recognises, assesses and manages patients with suspected vulval cancer.

GO 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.
GO 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.
GO 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.
GO CiP11	The doctor requests and interprets the most appropriate radiological investigations and interventions for gynaecological oncology patients.
GO CiP12	The doctor assesses and manages the holistic needs of patients with terminal gynaecological malignant disease alongside specialist palliative care services.
GO CiP13	The doctor understands the impact of gynaecological cancers on the urinary tract and is able to identify, investigate and manage urological complications.
GO CiP14	The doctor assesses and performs appropriate surgery on the gastrointestinal (GI) tract and manage cases perioperatively.
GO 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.
GO CiP16	The doctor is competent in the assessment and initial management of a patient with suspected and confirmed gestational trophoblastic disease.
GO CiP17	The doctor diagnoses, investigates and manages patients with a possible genetic predisposition to gynaecological cancer and their families, alongside specialist genetics services.

No new curriculum items or competencies have been added between the previous GO subspecialty curriculum and this 2019 version. A few competencies have been removed which are no longer applicable to GO subspecialty practice in 2019. The previous 17 GO modules map exactly to the 17 2019 CiPs. Table 2 shows how the modules from the previous GO subspecialty curriculum map to these GO CiPs. The competency level required for GO subspecialty skills has not changed between the old and the reformatted 2019 curriculum.

Table 2 - Mapping of current Gynaecological Oncology (GO) subspecialty curriculum to new GO subspecialty curriculum 2019

GO SST curriculum 2013 modules	New GO SST capabilities in practice (CiP)
Module 1: General Assessment of a Gynaecological Oncology Patient	GO 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.
Module 2: Pre-, Peri- and Postoperative Care Objectives	GO CiP 2: The doctor plans surgical care and manages problems safely along the entire surgical pathway.
Module 3: Generic Surgical Skills in Gynaecological Oncology	GO 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.
Module 4: Ovarian Cancer	GO CiP 4: The doctor assesses ovarian cancer and initiates appropriate interventions for all stages and contexts of disease.
Module 5: Cancer of the Uterus	GO CiP 5: The doctor assesses uterine cancer and initiates appropriate interventions for all stages and contexts of disease.
Module 6: Cancer of the Cervix	GO CiP 6: The doctor assesses cervical cancer and initiates appropriate interventions for all stages and contexts of disease.
Module 7: Cancer of the Vulva	GO CiP 7: The doctor recognises, assesses and manages patients with suspected vulval cancer.
Module 8: Vaginal Cancer	GO 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.
Module 9: Medical Oncology	GO 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.
Module 10: Clinical Oncology	GO 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.

Module 11: Zadiology	GO CiP 11: The doctor requests and interprets the most appropriate radiological investigations and interventions for gynaecological oncology patients.
Module 12: Palliative Care	GO CiP 12: The doctor assesses and manages the holistic needs of patients with terminal gynaecological malignant disease alongside specialist palliative care services.
Module 13: Urology	GO CiP 13: The doctor understands the impact of gynaecological cancers on the urinary tract and is able to identify, investigate and manage urological complications.
Module 14: Colorectal Surgery	GO CiP 14: The doctor assesses and performs appropriate surgery on the gastrointestinal (GI) tract and manage cases perioperatively.
Module 15: Plastic Surgery and Wound Care	GO 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.
Module 16: Gestational Trophoblastic Disease	GO CiP 16: The doctor is competent in the assessment and initial management of a patient with suspected and confirmed gestational trophoblastic disease.
Module 17: Genetic Predisposition to Gynaecological Cancer	GO CiP 17: The doctor diagnoses, investigates and manages patients with a possible genetic predisposition to gynaecological cancer and their families, alongside specialist genetics services.

3 The Capabilities in Practice explained

Each GO CiP is made up of the following components;

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

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

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

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

a) High-level learning outcome

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

The 17 mandatory GO CiPs making up the GO SST are listed below. When considering whether progress is being made in each CiP it is both the trainee's wider skills as a medical professional and those relating to knowledge and processes of leadership and teamwork which need to be assessed in the round, as well as clinical competence.

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

Table 3 – Statements of Expectations for GO subspecialty training

	Statement of Expectations for GO subspecialty training
Meeting expectations GO CiP1	The doctor must be able to assess and manage patients with suspected gynaecological cancers and those without cancer who are concerned they may develop it e.g. those with genetic or environmental risk factors or pre-disposition; must be able to perform or organize the initial diagnostic or screening investigations; interpret results and counsel patients accordingly; recommend appropriate interventions where appropriate based on such investigations, anticipate possible results, be inclusive of other allied health professionals who may be of benefit to the patient, and plan definitive care.
Meeting expectations GO CiP2	The doctor must be able to plan definitive surgical care, assess and prepare patients for surgery, taking necessary steps including thromboprophylaxis to minimize risks, recognize and manage peri-operative complications, interpret laboratory and radiological results, recognize fluid balance and nutritional supportive requirements, in order to deliver high quality medical care throughout for the surgical patient.
Meeting expectations GO CiP3	The doctor must be able to judge that the patient undergoes a procedure of adequate radicality for gynaecological malignancy safely, depending on the given diagnosis and the patient's particular circumstances, and is able to perform the range of surgical procures necessary for different

	gynaecological malignancies, either performing it independently or as the leader of a wider surgical effort.
Meeting expectations GO CiP4	The doctor must be able to assess and perform surgery for suspected or proven ovarian cancer in both the primary and neo-adjuvant settings, including the principles of surgical staging and surgical resection or cytoreductive surgery; the doctor must be able to manage the non-surgical aspects of care also such as medical management of advanced or recurrent malignancy, including palliative and supportive care measures.
Meeting expectations GO CiP5	The doctor must be able to assess, investigate and perform appropriate surgery for uterine cancer independently, and offer counselling regarding the use of adjuvant treatments with multidisciplinary involvement; offer appropriate follow-up arrangements after treatment; recognize and manage recurrent disease, and offer alternative treatment strategies in the palliative setting.
Meeting expectations GO CiP6	The doctor must be able to diagnose, and arrange appropriate investigations to stage, both clinically and radiologically cervical cancer. The doctor must be able to perform surgery up to the level of radical hysterectomy for cervical cancer but also recognise the indications for fertility-sparing options for early-stage disease, and exenterative surgery for locally advanced or centrally recurrent pelvic disease. The doctor must know the indications for non-surgical treatment and counsel patients regarding use of radiotherapy and chemoradiation treatments, be able to insert brachytherapy applicators, assist in the delivery of such treatments, and be competent in the follow-up of treated patients and the management of any resulting complications following surgery or radiotherapy based treatments. The doctor must be aware of the physical and psychosexual impact of such treatments and the resources available for women during and after treatment.
Meeting expectations GO CiP7	The doctor must be able to recognise, diagnose and treat vulval cancer, including use of appropriate investigations and their interpretation; be able to undertake radical surgery independently, but understand and recognize when involvement of other specialties such as plastic surgery or clinical oncology in the management of such cases may be necessary. The doctor must be aware of the physical and psychosexual impact of such treatments and the resources available for women during and after treatment.
Meeting expectations GO CiP8	The doctor must be able to recognize and arrange appropriate investigations for suspected or proved vaginal cancer. The doctor must be able to perform the surgery, and liaise with clinical oncology and in

	the delivery of radiotherapy and chemotherapy. The doctor must be aware of the physical and psychosexual impact of such treatments and the resources available for women during and after treatment.
Meeting expectations GO CiP9	The doctor must be able to counsel patients regarding the role of chemotherapy for gynaecological cancers both in the primary and in the recurrent cancer setting and take take a full role in the MDT discussion of appropriateness or otherwise of patients for chemotherapy. The doctor must be aware of the resources available, possible enrolment into appropriate clinical trials, and the principle side-effects or toxicity that may arise during or after treatment. The doctor should be able to manage the complications of treatment and also should recognise the indications when treatment should be stopped.
Meeting expectations GO CiP10	The doctor must be able to assess the needs for radiotherapy, assist in its delivery, be familiar with able to manage the common treatment-related toxities, and investigate and manage long-term complications of side-effects.
Meeting expectations GO CiP11	The doctor must be able to request and interpret the most appropriate radiological imaging pertinent to GO working within an MDT setting.
Meeting expectations GO CiP12	The doctor must understand and be familiar with the concept and delivery of palliative care to women with terminal gynaecological malignant disease: the decision for palliative care, use of a holistic approach addressing physical, psychological, spiritual, social and psychosexual needs to relieve symptoms and anxieties. The doctor must be knowledgeable of specialist palliative care medicine, psychosexual and other specialist services within a MDT setting. Participation in an advanced communications course for cancer clinicians.
Meeting expectations GO CiP13	The doctor must be able to recognise and investigate urological complications of gynaecological malignancy due to advanced stage, progressive or recurrent disease, or complications due to treatment, and counsel patients appropriately. Competence in simple urological procedures is expected and close liaison with colleagues in urological surgery.
Meeting expectations GO CiP14	The doctor must be able to assess the need and preparation for, and perform gastrointestinal surgery necessary for the treatment of gynaecological malignancy, the management of fistulae, and recognise the nutritional requirements patients, either independently or in

	conjunction with specialist gastrointestinal surgeons and nutrition specialist services; be able to investigate and manage gastrointestinal complications following surgery or other treatments, know when to involve other specialists in their management, and counsel patients accordingly. Attendance at a CRISP course.
Meeting expectations GO CiP15	The doctor must understand the process of wound healing and be competent in the management of associated wound problems including infections and incisional herniae; understand the role and applications of plastic surgical techniques in GO, particularly in the management of vulval and vaginal malignancy and surgery for recurrent disease, and be able to counsel patients accordingly.
Meeting expectations GO CiP16	The doctor must be competent in the initial diagnosis, assessment and surgical treatment of suspected gestational trophoblastic disease; staging and management of confirmed disease in close liaison with supraregional GTD centres. Attendance at a national one day meeting on GTD.
Meeting expectations GO CiP17	The doctor must be able to identify and counsel those women potentially at high risk of gynaecological malignancy, take a detailed family history, liaise with specialist clinical genetics services, arrange appropriate investigations, perform risk-reducing surgery, and counsel regarding subsequent hormone replacement therapy.

Table 4 – Levels of supervision

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

Trainees will need to meet expectations for the time spent undertaking subspecialty training as a minimum to be judged satisfactory to progress. The expectations for the level of

supervision expected by the end of training for all the GO CiPs in GO subspecialty training is level 5.

b) Key skills and their descriptors

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

c) Practical procedures

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

- Laparoscopic hysterectomy (TLH)
- Groin lymphadenectomy
- Pelvic lymphadenectomy (open and lap)
- Open para-aortic lymphadenectomy
- Vulvectomy
- Rad Hysterectomy (open and Lap)
- Omentectomy
- Small bowel resection +/- anastomosis
- Large bowel resection
- Diaphragm/peritoneal resection/stripping

However, it is recommended that the other specific procedural skills listed here which also require level 5 sign off should also ideally be evidenced by at least three competent OSATs where possible before sign-off. This is an extensive list, and it is clear that some ‘procedures’

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

Table 5 – Outline gird of supervision level expected for procedures

Procedures	*Level by end of training **	*GO CIP 2*	*GO CIP 3*	*GO CIP 4*	*GO CIP 5*	*GO CIP 6*	*GO CIP 7*	*GO CIP 13*	*GO CIP 14*	*GO 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			
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				

Procedures	*Level by end of training **	*GO CIP 2*	*GO CIP 3*	*GO CIP 4*	*GO CIP 5*	*GO CIP 6*	*GO CIP 7*	*GO CIP 13*	*GO CIP 14*	*GO CIP 15*
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/ stoma 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		

Procedures	*Level by end of training **	*GO CIP 2*	*GO CIP 3*	*GO CIP 4*	*GO CIP 5*	*GO CIP 6*	*GO CIP 7*	*GO CIP 13*	*GO CIP 14*	*GO CIP 15*
Ureteric reimplantation	1							X		
Ureteroscopy	1							X		
Primary ureteric anastomosis	1							X		
Cystectomy	1							X		
Illeal conduit formation	1							X		
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

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

● with assistance of surgical colleagues where necessary

d) Knowledge criteria

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

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

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

- OSATS
- CbD
- Mini-CEX
- Discussion of correspondence Mini-CEX
- Reflective practice
- TO1/2 (including SO)
- NOTSS
- Regional and National teaching and training
- RCOG, BGCS Webinars and other eLearning
- GO Conferences and courses attended
- Procedural log
- Case presentations
- Attendance on a CRISP course
- Attendance on a GTD course
- Attendance on an advanced communications course for cancer clinicians
- Attendance at clinics in other allied disciplines, including medical and clinical oncology, colo-rectal and urological surgery
- Participation in MDT meetings
- Quality Improvement and Audit activity

- Evidence of colposcopy training and BSCCP accreditation

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

Table 6

GO 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 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 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

GO CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
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 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 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 specialist palliative care services.		X	X		X	X

GO CIP	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice
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 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

5 When can a GO CiP be signed off?

The GO CiP is the fundamental basis of global judgement. Assessment of GO CiPs involves looking across a range of key skills and evidence to make a judgement about a trainee's suitability to take on particular responsibilities or tasks as appropriate to their stage of training. It also involves the trainee providing self-assessment of their performance for that stage of training. Each GO CiP has a lead statement, and the trainee and STPS must make their

assessment of the competency level reached, as judged globally against this statement. There is no need to make an assessment of each key skill or descriptor within each GO CiP. The key skills and their descriptors are there to guide training and expectations but do not need to be assessed individually. However, review of these skills and descriptors will aid in the global assessment of progress with that GO CiP and its lead statement.

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

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

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

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

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

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

- Do I agree with the trainee for the self-assessment for this GO CiP? Is this sufficient evidence to sign off the GO CiP as level 5?

- Is this the best evidence? Would some of this evidence be more appropriate in other GO CiPs as evidence? For example, would the CbD about a change of practice be better linked to a clinical CIP?

- Is there other evidence that has been missed?

- Is the level right for this trainee? Are they meeting the standards of expectations?

At certain key time points (usually prior to a subspecialty assessment), but also at any other point suggested by the trainee or their STPS, both the trainee and the STPS will make their own judgements of what competency level has been reached in each GO CiP Most crucially this is a global judgement. There does not have to be evidence linked to every key skill, until the trainee reaches the point of completion of the subspecialty training programme. In

addition, evidence for the following generic areas relevant to GO SST: 'Clinical governance', 'Teaching experience', 'Research', 'Leadership and management experience' and 'Presentations and publications' as outlined in the matrix will be needed at senior trainee level (see point 6 below). It is the **quality** of the evidence not the quantity which is key. The progress a trainee is making with the acquisition of technical procedural skills which form part of that GO CiP, and their knowledge base, should also be considered when giving a global rating.

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

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

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

Some subspecialty trainees will accrue skills and competencies steadily across all the capabilities in practice, throughout their subspecialty training, and the outline grid of progress expected for GO CiPs gives guidance as to what is deemed adequate progress by the end of the first 12 months WTE of clinical training. However, other trainees follow a modular approach during subspecialty training, and the progression through the GO CiPs will be quite different for them and their progress may not be so readily compared to this outline grid. For these trainees, assessors will be expecting completion of some GO CiPs ahead of time, whilst other GO CiPs may not have been commenced by the end of the first 12 WTE months of

clinical training. It is not possible to create a didactic outline grid which covers all training programmes, and common sense and judgement will be required, in the same way as it was in the previous curriculum, with respect to competency accrual and module sign off. However, as a rough guide, after one year WTE clinical subspecialty training, i.e. half way through clinical training, the centralised assessment panel will expect the scores of the entrustability levels to have reached 43 (entrustability level 5 x 17 GO CiPs = 85). This will be calculated in a pro rata way for trainees who have completed only part of a full year of clinical training. This is a guide only, but serves to assess progress across a wide variety of different programme formats.

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

	GO SST		Subspecialty Accreditation
Capabilities in practice	**Progress expected by completion of 12 months WTE of clinical training**	**Progress expected by completion of 24 months WTE of clinical training**	
1: The doctor 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.	**3**	**4**	
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.	**3**	**4**	
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	**4**	**5**	

predisposition to gynaecological cancer and their families, alongside specialist genetics services.			

6 Generic capabilities

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

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

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

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

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

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

7 The subsequent ARCP

Pre-CCT subspecialty trainees should ideally have an ARCP scheduled within a couple of months of their centralised SST assessment. ARCPs are clearly not needed for overseas SSTs, or those who have their CCT already. The narrative outcome awarded by the centralised

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

For **pre-CCT SSTs using the 2019 core curriculum**, the key additional areas to focus on are the evidencing of all the core generic and non-clinical specialty CiPs to ST6/7 level, and the sign-off of the core clinical CiPs (9-12) to entrustability level 5 by the completion of training and the final ARCP. All subspecialty trainees using the 2019 core curriculum do need to collect evidence to satisfy all four core clinical CiPs to entrustability level 5, but DO NOT need to collect 'ongoing competency' OSATs for core procedures that they have already demonstrated competency in (with three competent summative OSATs), in line with the new 2019 core matrix.

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

8 Example case study

STPS focus

You are a STPS having a meeting with a trainee who has completed 6 months of their first year of SST in GO. He is enthusiastic in theatre and has research exemption following three first author publications in the field, but despite your encouragement to do so in the first year of training, you suspect that he has not concentrated adequate attention or time to the non-

surgical GO CiPs in the curriculum, in particular oncology and palliative care medicine of which he has no prior experience. His communication skills require improvement and his medical management of an acute admission with bowel obstruction due to recurrent ovarian cancer concerned you due to his lack of knowledge. His TO1s did not include medical or clinical oncologists, nor members of the palliative care team who regularly attend the MDT meetings, and only one CNS. The trainee is keen to complete all GO CiPs on ovarian (GO CiP 4), endometrial (GO CiP 5) and cervical cancers (GO CiP 6).

This trainee is an ST6 on the 2019 core curriculum, and in view of this the STPS emphasises that the trainee needs to collect evidence supporting the sign-off of the non-clinical generic core CiPs to meet ST6/7 expectations. They also need to complete the clinical core CiPs (9-12) to entrustability level 5 by the time they are completing subspecialty training. As yet, the trainee has not done anything to satisfy the generic skills requirements of subspecialty training and they have attached no new evidence to any of the core curriculum clinical and non-clinical CiPs.

Following your meeting with the trainee you recommend targeted training to include completion of an advanced communication skills course, and completion of the palliative care GO CiP 12 and oncology GO CiPs 9 and 10 before the end of Year 1 and request a further set of TO1s be sent out before 12 months to include a wider range of MDT members to reflect this. Only then may GO CiPs 4, 5 and 6 be signed off.

The trainee is participating on an on-call obstetrics rota out-of-hours and you strongly recommend that they collect some evidence of their ongoing involvement in obstetrics training at advanced level. You suggest exploring in detail the effect of cervical treatments for CIN and early stage cervical cancer on subsequent pregnancy outcomes, and to use a recent case of a radical trachelectomy in a young woman to illustrate this in a case based discussion.

You recommend that the trainee gets more involved in the managerial aspects of the gynae oncology service, and that they write a guideline and help with a recent risk review of an unexpectedly poor outcome of a recent patient who had life threatening complications following surgery for ovarian cancer. This evidence will be reviewed by the centralised assessment panel in 6 months' time to assess the progress with generic skills, and then soon after by the ARCP panel to ensure that there is satisfactory progress with the non-clinical core CiPs.

GO SST (trainee focus)

You are a GO SST trainee considering sign-off for GO CiP 5. You are 6 months into GO SST and have submitted the following evidence linked to the GO CiP from the evidence boxes.

- WPBAs

- Log of attendance at a CRISP course
- GCP training and certificate
- CbD of 3 high grade endometrial cancer cases
- OSATS for TLH, lap pelvic lymphadenectomy, lap PA node dissection
- TO1s and 2
- Surgical log book

You feel this evidence matches the Statement of Expectations for GO SST because it shows evidence of the cases you have seen and feedback from your TO2.

You discuss this GO CiP and your request to be signed off with your STPS at your next meeting.

The STPS considers the key questions:

- **Is this sufficient evidence to support sign off of the CiP? Am I happy there is evidence to support the acquisition of key skills?** The evidence consisted of WPBAs regarding assessment and management of uterine cancers including two cases of high grade disease
- **Is this the best evidence? Would some of this evidence be more appropriate in other CiPs as evidence?** The evidence is appropriate but there is no evidence of more unusual uterine tumours such as sarcoma, or management of recurrent disease
- **Is the level right for this trainee?** Level 3 is probably most appropriate at this time point until further experience is gained or recorded in the log of experience. Despite two cases being high grade tumours which usually require some adjuvant therapy, no record or comment of this was included in the evidence submitted: no reflective notes or CbDs to support any experience in the use of adjuvant therapy or evidence of the recurrent disease setting.

The STPS discusses with the trainee that while they have a good understanding and have demonstrated competence in the management of uterine cancer at presentation, you do not feel able to sign off this GO CiP 5 to level 5 currently on the evidence provided, as it must include evidence of involvement in the management of all stages of disease and contexts of the disease. While two patients included in the evidence submitted had Grade 3 tumours, no reference was made to the stage of disease after the definitive histology was available, nor the possible role of adjuvant radiotherapy or possible chemotherapy. You discuss and agree level 3 would be most appropriate on the evidence submitted at this time and recommend attention be paid to these areas and submission of more evidence to address these deficiencies prior to completion of GO CiP5 in the near future and agree a date for a next meeting.

You agree that you do need to spend time on developing and evidencing non-clinical skills, and obstetric skills, to satisfy both the SST matrix for the centralised assessment, and the core curriculum matrix for the subsequent ARCP panel.

Five months later

The trainee sends GO CiP assessment requests to the STPS, who reviews them and decides if they agree or disagree with the entrustability levels that the trainee has awarded themselves. The STPS does now agree that further progress has been made with the clinical GO CiPs, both the surgical and non-surgical ones. When the entrustability levels of the 17 GOCiPs are summated, the total reaches 45, and this is deemed to be satisfactory progress for almost a year of clinical subspecialty training time. The trainee and STPS meet to complete the SST ESR and the STPS congratulates the trainee on the progress they have made with the subspecialty training curriculum. They have written a new guideline on the management of women with ovarian cysts and masses, and they have also helped redesign the MDT referral form. They have led a series of tutorials and lectures to the general O&G trainees and have presented at a national meeting the findings from their research. An audit of referrals for postmenopausal bleeding is underway. The STPS agrees that this is good evidence to satisfy progress with the non-clinical generic skills and encourages the trainee to upload this evidence to the 'other evidence' section of the eportfolio and to then link it to appropriate core generic and non-clinical specialty CiPs. The STPS feels confident that the centralised assessment panel will give a satisfactory narrative outcome, but has concerns that the subsequent ARCP panel will comment on the lack of new evidence in the clinical core obstetric CiPs which the trainee has neglected, despite advice.

The trainee is awarded a satisfactory outcome by the centralised assessment panel, but four weeks later, at their ARCP, they are awarded an outcome 2 because the evidence supporting progress in the core CiPs at ST6/7 level is deemed inadequate. No additional training time is required, but a plan with SMART objectives is required, outlining how these areas will be addressed before a further ARCP review in 6 months' time (i.e. progress has been acceptable overall but there are some competences that have not been fully achieved and need to be further developed: additional training time not required).

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