GO, RM and UG Subspecialty Training

Guidance for Subspecialty Training Programme Supervisors and pre-CCT Subspecialty Trainees on the 2019 core curriculum on cross-specialty working

It is a GMC requirement that, in order to achieve a CCT in Obstetrics and Gynaecology, training must be undertaken in both aspects of the specialty. SSTs who are following the 2019 core curriculum are required to evidence the following Capabilities in Practice (CiPs);

i) The advanced CiPs which constitute the subspecialty training programme

ii) The ten non-clinical generic core CiPs. During ST6 and 7, it is expected that all the key skills in these non-clinical CiPs will be evidenced to a level commensurate with an advanced trainee, using evidence obtained following the completion of ST5. The statements of expectation in the core curriculum CiP Guides provide guidance on what is expected and it is recognised that evidence collected during general or subspecialty clinical work and training will be used to evidence these core generic key skills.

iii) The four clinical core CiPs at ST6/7 level. It is not possible to achieve entrustability level 5 for the four clinical CiPs by the end of ST5, and it is a requirement for CCT that trainees demonstrate that they are still developing professionally in ST6/7 across both aspects of the specialty. Over the course of ST6 and 7, it is expected that all the key skills of these clinical core CiPs will be evidenced by at least one piece of quality evidence, obtained and linked since completion of ST5, and that by the end of the training the educational supervisor is confident in signing the trainee off at entrustability level 5. The procedures which need to be evidenced with three summative OSATS for ST6/7 in the core curriculum are:

- Caesarean section (complex)
- Laparoscopic management of ectopic pregnancy
- Ovarian cystectomy
- Surgical management of PPH

There is no requirement to collect 'ongoing competency' OSATS for core procedures that the SST has already demonstrated competency in (with three competent summative OSATs).

Therefore, in addition to providing evidence for the core clinical CiPs 9 and 11, GO, RM and UG pre-CCT subspecialty trainees need also to provide evidence for the obstetric core CiPs 10 and 12. These CiPs relate to emergency and non-emergency obstetrics (see below). This guidance suggests examples of appropriate experience, how this experience can be obtained,

and what the possible evidence might be to allow educational supervisors to sign off progress in these core CiPs for the ARCP. This guidance is not meant to be prescriptive and it is the responsibility of each unit to develop a plan on how this can be achieved during the SST programme.

The key is that the evidence needs to illustrate the advanced maturity of the trainee in dealing with these issues. The CBDs/Mini-CEX do not need to cover the entire obstetric syllabus; they need to demonstrate that the trainee knows how to approach a problem which is new to them; where to look, who to ask, how to communicate with the wider multi-disciplinary team and how to work with the patient, inform and communicate, and facilitate her choices where possible. Reflections demonstrating decision making skills, prioritisation, compromise and resolution of conflict, in the context of emergency and non-emergency obstetrics are to be encouraged.

A gynaecology based SST should be allotted an obstetric supervisor to work with and receive guidance from. This individual needs to be measured and understand what is expected of this trainee who will not be aiming to become an obstetric consultant in the long run. Their evidence should not be compared against the top performing would be obstetricians. They must meet the criteria as specified in the curriculum. They do not need to exceed this.

Pre-CCT trainees who enter subspecialty training later during ST6 or ST7 will be expected to have many of these core key skills evidenced already during advanced training, meaning they will have less to achieve in the cross specialty during SST.

It is therefore recommended that an educational plan is developed at the first educational supervisor meeting when commencing SST and this should include a School Board representative/College Tutor to ensure from the beginning what the requirements are and what the SST needs to work towards to during the programme to achieve CCT with subspecialty accreditation.

Statement of Expectations for CiP 10 : The doctor is competent in recognising, assessing and managing emergencies in obstetrics (Guidance for CiP 10)

ST6 – 7 Meeting expectations	A trainee who is meeting expectations will continue to make progress in the areas covered in their earlier training programme. A trainee who is meeting expectations will be able to lead the multi-professional team and communicate effectively with the wider team, labouring women and their birthing partners and escalate appropriately in a timely manner. They will be able to manage the uncommon obstetric emergency presentations seeking input from other specialties where appropriate. They will be able to formulate an appropriate and individualised management plan taking into account patient preferences and the urgency required. They will be able to manage

	the more complex emergency birth and immediate postpartum problems recognising when support is required from other staff and will be able to communicate concerns effectively and sensitively with colleagues, women and birthing partners. They will have the technical skills required on labour ward for an ST7 and will have the skills necessary to manage labour ward demonstrating leadership skills where appropriate as an ST7 within the multidisciplinary team, ensuring continuity of care, effective handover and appropriate discharge plans are in place.

Statement of Expectations for CiP 12 : The doctor is competent in recognising, assessing and managing non-emergency obstetrics (Guidance for CiP 12)

ST6 – 7 Meeting expectations	A trainee who is meeting expectations will be able to demonstrate that they are comfortable meeting with mothers and their families across a range of clinical settings, including pre-conceptual and postnatal care. They will be able to conduct a relevant and constructive meeting with mothers and their families in most clinical settings.

1. What would be appropriate experience taking account of the subspecialism for GO, RM and UG subspecialty trainees for core CiPs 10 and 12? Give examples

CiP 10:

The trainees should be covering ST3-5s when on call and overseeing the management of labour ward. These sessions should be planned to have obstetric consultant educational supervision cover to ensure that the CiP can be achieved. In addition, a comprehensive package that includes for example skills drills, simulation training, updates on the latest evidence based obstetric practice and research, role-play and eLearning could complement the fulfilment of this CiP.

CiP 12:

Many key skills of this CiP could be achieved through ongoing on call emergency obstetrics, but any case based discussions would need to cover the antenatal care for that patient, as well as the emergency admission or the intrapartum period. However, a supervised postnatal follow up/debrief would be also required to adequately cover this CiP at ST6-7 level. Attendance at a variety of antenatal clinics would be beneficial e.g. FM clinic, maternal medicine clinic, general clinic, lifestyles clinic.

Examples could include:

- RM attendance at maternal medicine / pre-conception advice / lifestyle clinic
- UG involvement in postnatal debriefing after childbirth injury
- GO experience and clinics can be used to demonstrate 'that they are comfortable meeting with mothers and their families across a range of clinical settings, including pre-conceptual and postnatal care'. Fertility related discussion in gynae-cancer clinic

In addition, a comprehensive package, including simulation training, updates on the latest evidence based obstetric practice and research, role play and eLearning could complement the fulfilment of this CiP.

2. Suggestions how GO, RM and UG subspecialty trainees could obtain the appropriate experience

The trainee should have an allotted obstetric supervisor who understands the specific obstetric requirements of a gynaecological subspecialist trainee

CiP 10:

- Dedicated educational programme
- Continuing obstetric emergency on calls (with resident or non-resident consultant)
- Elective caesarean section list e.g. one per year
- Attendance at 'skills and drills'

CiP 12:

- Dedicated educational programme
- A mixture of one-off individual antenatal clinics, specialist and general, organised at the convenience of the trainee e.g. four per yea
- Fertility related discussion in gynae-cancer clinic
- RM clinic for the women with gynaecological cancer prior to commencing cancer treatment

3. What would be possible evidence to achieve Level 5 entrustability?

Could be evidenced by examples of:

- CbD
- Mini-CEX
- OSATS - Three 'competent' OSATs for complex CS and surgical management of PPH, only if not already achieved

- NOTSS
- Reflective practice
- Multisource feedback
- TO2
- RCOG eLearning
- Leading a critical incident review
- Simulation training

Appendix 1

Key skills for CiPs 10 and 12

Key skills for CiP 10	**Key skills for CiP 12**
Manages pain and bleeding in the obstetric person	Manages pre-existing medical conditions in the pregnant woman
Manages concerns about fetal wellbeing prior to labour	Manages medical conditions arising in pregnancy
Manages suspected pre-term labour/ruptured membranes	Manages fetal concerns
Manages labour	Manages mental health conditions in pregnancy and the postnatal period
Manages intrapartum fetal surveillance	Manages complications in pregnancy affected by lifestyle
Manages induction and augmentation of labour	Supports antenatal decision making
Manages emergency birth and immediate postpartum problems	Manages the postnatal period
Manages maternal collapse and people who are acutely unwell in pregnancy	
Manages labour ward	