2017 Training Data Analysis

Topic: ATSM/APM training 2017

Background
In the last two years of the training programme, trainees undertake Advanced Training Skills Modules (ATSMs) to develop the high-level skills they will need for a consultant post in their specialist area of interest. Trainees are advised that the majority of consultant jobs in the future will be in obstetrics and it is therefore recommended that they have a minimal level of competence on labour ward. They are currently therefore encouraged to choose at least the advanced labour ward practice ATSM to demonstrate this.

ATSMs are meant to be delivered within the normal working week during normal service hour commitments and only rarely should time be ring fenced for completion of the modules. ATSMs should be undertaken as part of the normal working week and senior trainees should have time prioritised in their personal work schedules to ensure they complete their training requirements. However training can be undertaken outside of core hours if supervised appropriately.

ATSM Educational Supervisors undertake the day-to-day, hands-on training of trainees in any aspect of the curriculum and should have the relevant clinical skills and knowledge in the area being taught.

ATSM Preceptors are responsible for the deanery-wide provision and quality control of their ATSM. They ensure that appropriate educational support is provided and assessments are performed. Where the ATSM requires course attendance, the ATSM Preceptor decides which courses are suitable, with reference to the relevant course syllabus.

ATSM Directors are responsible for all ATSMs within their deanery, including the standard and delivery of training. The ATSM Director coordinates trainee attachments to ensure all trainees can fulfill their ATSM requirements. The ATSM Director acts as the link between the deanery and the RCOG and must sign all ATSM registration and completion forms. Non trainees who are eligible can also register for ATSMs with the support of local trainers and departments.

Training Issues/ Questions
This analysis explored whether trainees were given protected time to complete their ATSMs and whether there was significant variation depending on particular ATSMs. Trainees confidence in achieving independent competence was reviewed as was their supervision.
The relative popularity of the ATSM undertaken by trainees was reviewed in the context of the data provided by the RCOG census which details the specialist interest of consultants and thus the future workforce requirements.

Do trainees have two protected weekly sessions for completion of their ATSM?

Do trainees feel they will achieve level 3 competences?

Do trainees feel supported by their supervisors?
Analysis

There are 1858 trainees in total in the UK with 527 registered for two or more ATSMs. At the time of the survey there were 246 trainees at ST6 and 198 at ST7. There were 1457 respondents to the TEF 2017 survey and a total of 624 respondents to the ATSM questions. This would indicate that there are 97 extra respondents than there are trainees registered for ATSMs.

Nonetheless, a good response to the TEF questions was received ranging from 45-100%.

<table>
<thead>
<tr>
<th>ATSM</th>
<th>Total Registered</th>
<th>Total Trainees (NTN Holders) Registered</th>
<th>TEF responses and % response rate of trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion care</td>
<td>14</td>
<td>9</td>
<td>4 (45%)</td>
</tr>
<tr>
<td>Acute Gynaecology and Early Pregnancy</td>
<td>172</td>
<td>73</td>
<td>47 (64%)</td>
</tr>
<tr>
<td>Advanced Antenatal Practice</td>
<td>73</td>
<td>41</td>
<td>31 (76%)</td>
</tr>
<tr>
<td>Advanced Labour Ward Practice</td>
<td>672</td>
<td>425</td>
<td>255 (60%)</td>
</tr>
<tr>
<td>Advanced Laparoscopic Surgery</td>
<td>10</td>
<td>10</td>
<td>10 (100%)</td>
</tr>
<tr>
<td>Benign Abdominal Surgery: Open and Laparoscopic</td>
<td>187</td>
<td>100</td>
<td>58 (58%)</td>
</tr>
<tr>
<td>Benign Gynaecological Surgery: Hysteroscopy</td>
<td>201</td>
<td>55</td>
<td>27 (49%)</td>
</tr>
<tr>
<td>Benign Vaginal Surgery</td>
<td>9</td>
<td>0</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Colposcopy</td>
<td>24</td>
<td>4</td>
<td>5 (100%)</td>
</tr>
<tr>
<td>Fetal Medicine</td>
<td>49</td>
<td>23</td>
<td>18 (83%)</td>
</tr>
<tr>
<td>Forensic Gynaecology</td>
<td>0</td>
<td>0</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Labour Ward Lead</td>
<td>73</td>
<td>23</td>
<td>13 (56%)</td>
</tr>
<tr>
<td>Maternal Medicine</td>
<td>89</td>
<td>50</td>
<td>37 (74%)</td>
</tr>
<tr>
<td>Medical Education</td>
<td>70</td>
<td>19</td>
<td>12 (63%)</td>
</tr>
<tr>
<td>Menopause</td>
<td>10</td>
<td>5</td>
<td>5 (100%)</td>
</tr>
<tr>
<td>Oncology</td>
<td>56</td>
<td>34</td>
<td>35(100%)</td>
</tr>
<tr>
<td>Paediatric and Adolescent Gynaecology</td>
<td>7</td>
<td>1</td>
<td>? Is this 0 why the (?</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>7</td>
<td>6</td>
<td>3 (50%)</td>
</tr>
<tr>
<td>Subfertility and Reproductive Health</td>
<td>72</td>
<td>31</td>
<td>28 (94%)</td>
</tr>
<tr>
<td>Urogynaecology and Vaginal Surgery</td>
<td>87</td>
<td>49</td>
<td>31 (63%)</td>
</tr>
<tr>
<td>Vulval Disease</td>
<td>25</td>
<td>5</td>
<td>5 (100%)</td>
</tr>
</tbody>
</table>
Of the 527 trainees registered for ATSMs, the most popular ATSM is advanced labour ward practice (425 trainees – 81%) followed by benign abdominal surgery (open and laparoscopic) with 100 trainees (19%), acute gynaecology and early pregnancy (14%) and then about 9-10% trainees registered for either urogynaecology, hysteroscopy, maternal medicine and advanced antenatal practice. Fetal medicine, oncology, subfertility each have about 5% of trainees registered which may reflect the fact that trainees prefer to undertake subspecialist training in these fields instead of undertaking ATSM modules. A small percentage undertake medical education and labour ward lead (about 4-5%) and a handful of trainees (less than 1%) are registered for colposcopy, vulval disease, menopause, sexual health, abortion care and paediatric and adolescent gynaecology.

**TEF analysis of ATSMs**

**Abortion care (n=4 respondents)**
These trainees are mostly satisfied with their induction arrangements, supervision, caseload and opportunity to obtain the required level of competence.

**Acute gynaecology and early pregnancy (n=47 respondents)**
The majority of respondents had an induction meeting where their competence and skills were assessed. They were mostly satisfied with the level of training they were receiving but only a minority were regularly receiving two protected sessions of ATSM training. They were able to attend clinic frequently, had the opportunity to operate and felt they had good supervision but an equal amount agreed and disagreed that they had achieved level 3 independent practice. The majority would recommend their unit for training for ATSM.

**Advanced antenatal practice (n=31 respondents)**
Trainees undertaking this ATSM module would recommend their unit for training, feel adequately supported by their supervisors and most of them had induction meetings which assessed their clinical skills. They have the opportunity to achieve level 3 independent practice by attending clinic regularly, have the opportunity to operate but having two protected sessions per week is variably enforced.

**Advanced Labour Ward Practice (n=255 respondents)**
Almost all trainees have had an induction meeting with their ATSM supervisor where their clinical skills and competence were assessed. Trainees feel satisfied that they will achieve level 3 independent practice and in this, more than any other module they regularly have 2 sessions per week, they are exposed to adequate operating and other clinical sessions and would recommend their unit for completion of this ATSM.

**Advanced laparoscopic surgery for excision of benign disease (n=10 respondents)**
There was a 100% response rate of trainees for this ATSM module. They are overwhelmingly positive about their experience either strongly agreeing or agreeing that they will achieve level 3 competence for the module, they have sufficient
clinical exposure and supervision and have weekly sessions protected with good clinic and operative experience.

**Benign abdominal surgery - open and laparoscopic (n=58 respondents)**
The majority of these trainees either strongly agree or agree they have been adequately supported with induction meetings where their skills have been assessed, they attend clinic frequently and have sufficient supervision for operating. There is a variable spread amongst trainees whether their two sessions per week are protected and some concern that despite the support they may not achieve level 3 competence but most would recommend their unit for training.

**Benign gynaecological surgery –hysteroscopy (n=27 respondents)**
Trainees agreed that their induction meeting took place with assessment of their skills and competence. There was adequate supervision and sufficient caseload, however the majority disagreed that their two sessions per week were protected for training, there was variable opportunity to attend clinic, operate and uncertainty whether they would achieve level 3 competence.

**Colposcopy (n=5 respondents)**
Trainees feel well supported by their supervisors and have had induction meetings which assess their clinical competence. They feel satisfied they will achieve level 3 competence and have enough exposure to clinic and operating. Their two sessions per week are variably protected.

**Fetal medicine (n=18 respondents)**
Trainees would recommend their unit of training, feel very satisfied with the level of support, opportunity to achieve their competencies and ability to attend clinic. They do feel they will achieve level 3 competence but their two sessions are not well protected and exposure to practical sessions/procedures is variable although they believe the caseload to achieve competency is available at their units.

**Labour ward lead (n=13 respondents)**
The majority of respondents are satisfied with their training in this module – respondents agree they have good supervision, access to clinical and operating sessions, enough opportunities to achieve level 3 competencies and almost all of them are able to protect their two weekly sessions for ATSM purposes and would recommend their unit for training.

**Maternal medicine (n=37 respondents)**
Training in this ATSM is variable. The majority of respondents have had an induction meeting with assessment of their skills and competencies, their two weekly sessions are protected and they have regular meetings with their ATSM supervisor. They have good access to clinic and feel they will achieve their level 3 competencies as they have opportunities to access training, however, their access to practical training is variable with as many trainees agreeing and disagreeing they have good access and a majority of trainees felt they did not have adequate supervision to achieve their competencies.
Medical education (n=12 respondents)
Trainees report good induction meetings where their competencies and skills are assessed and have regular meetings with their ATSM supervisor. However, they are generally negative about the level of supervision they receive, and their two sessions for ATSM are not well protected. They do feel they have adequate opportunities but there is variable response whether they have achieved level 3 competencies.

Menopause (n=5 respondents)
Trainees are generally well satisfied with this ATSM being able to achieve level 3 competencies with good supervision and access to training opportunities. The only complaint was a lack of protection for two weekly ATSM sessions.

Oncology (n=35 respondents)
Trainees are satisfied with their experience in this ATSM. They have sufficient access to clinic and surgical training; they are well supervised and have enough opportunities to achieve competence. They have regular meetings with their ATSM supervisors and have induction meetings where their skills and competencies are evaluated. This is the one ATSM where two weekly sessions do seem to be well protected however there is variability in trainees feeling they have achieved level 3 competencies.

Sexual health (n=3 respondents)
Trainees are generally ambivalent about their training in the sexual health ATSM.

Subfertility and reproductive health (n=28 respondents)
Trainees have a variable experience in this ATSM. They are adequately supervised, with access to clinic and surgical training. They have regular meetings with their ATSM supervisors and induction meetings occur with evaluation of their skills and competencies. Opportunities to achieve level 3 competencies are variable yet the majority of respondents would recommend their unit.

Urogynaecology and vaginal surgery (n=31 respondents)
Trainees report sufficient caseload for their training with good supervision and access to clinic and surgical training. They meet with their ATSM supervisor regularly and induction meetings are held with assessment of past competence and skills. Their two sessions per week seem to be well protected yet there is variability whether the trainees have achieved level 3 competencies.

Vulval disease (n=5 respondents)
Trainees are ambivalent about their experience in this module.

Conclusions
It is apparent that there are three popular ATSMs – advanced labour ward practice is seen almost as a pre-requisite for all trainees which begs the question why it is considered an ATSM when so many trainees undertake it. It would seem that some trainees (15-20% are keen to ensure they have either benign gynaecological operating skills or skills to manage acute gynaecology and early pregnancy complications. There is a third group of ATSMs which 5% of trainees are undertaking in order to gain subspecialist skills in a variety of avenues perhaps setting themselves up to undertake subspecialist training. There are very few trainees undertaking ATSM training in colposcopy (this may reflect that many trainees undertake this training outside ATSM training with BSCCP), vulval disease (1%), menopause (1%) and sexual health (<1%) indicating that the majority of new CCT holders will not have specialist knowledge of these areas resulting in a potential gap in not only knowledge but also future service provision. These numbers do not match the numbers of consultants with interests in these areas as revealed in the RCOG census (6.2%, 5.9% & 1.7% respectively)

Induction meetings happen with sufficient assessment of skills and knowledge at these meetings. The majority of trainees do not have their two sessions per week well protected in any ATSM module other than in advanced labour ward ATSM. If, however, the competencies are being acquired it is necessary to ask if all ATSMs require the 2 sessions a week as they all have differing workload intensity scores and the sessions may be split between the 2 modules being undertaken.

**Recommendations**

The continuation of Advanced Labour Ward practice as a standalone ATSM needs to be reviewed. As so many trainees undertake this module should it be incorporated into the core curriculum and if so, can we ensure that sub-specialty trainees will acquire the skills required to allow them to reach CCT level?

There needs to be consideration of promoting and improving the take up of the less popular modules so we have a workforce that has the expertise required to meet the current and future service requirements. This is an issue for Heads of School and School Boards led by the RCOG. There are some units that get negative feedback across the board for all ATSMs and this should be highlighted to the Heads of School so that the provision in each HEE area can be reviewed. Given the small numbers of respondents, longitudinal data on this negative feedback may be helpful rather than relying on one year’s data. Similarly high achieveing units should be encouraged to share good practice.
Authors

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