Curriculum Guide for Subfertility and Reproductive Health ATSM

1 What is this ATSM about?

This ATSM is designed to ensure that trainees/doctors completing this training are able to competently assess and investigate individuals with difficulty conceiving and to provide appropriate treatment at secondary care level. It is expected that a consultant obstetrician and gynaecologist with an interest in subfertility and reproductive health will be able to provide a comprehensive service encompassing the care of individuals with fertility problems and to recognise when tertiary care is appropriate.

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. Their 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.

Satisfactory sign off to complete the ATSM will require the ATSM Educational Supervisors to make decisions on the level of supervision required for each Subfertility and Reproductive Health Capability in Practice (SRH CiP) and if this is satisfactory, the ATSM 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 the ATSM

The 2019 SRh ATSM is made up of component modules which are now called Subfertility and Reproductive Health Capabilities in Practice (SRH CiP). The SRH ATSM has 4 SRH CiPs.

It is anticipated that for a full-time trainee/doctor who is accessing one or two ATSM training sessions each week 18-24 months of training will be required to complete this ATSM. As was the case with the previous SRH ATSM, a trainee/doctor should complete the gynaecology ultrasound training (previously known as the intermediate ultrasound in gynaecology module) or equivalent prior to, or in parallel with this ATSM. Ultrasound Guidance is currently in development and will be published once finalised.

This ATSM has a work intensity score of 2.0. Trainees/doctors can register for more than two ATSMs concurrently providing the work intensity score is no greater than 3.0.

Here are the GMC-approved key skills and descriptors:

| SRH CiP 1: The doctor recognises, assesses and manages subfertility with reference to female factor infertility. |
|---|---|
| **Key Skills** | **Descriptors** |
| Assesses and investigates women with ovulatory dysfunction | • Takes a detailed history, recording menarche, cycle regularity, hirsutism, acne, alopecia, BMI, galactorrhoea, secondary sex characteristics, previous surgery/chemotherapy/pelvic radiotherapy.  
  • Performs appropriate physical examination including visual fields, and with particular emphasis to secondary sex characteristics.  
  • Arranges appropriate endocrine investigations, including a baseline hormone profile of early follicular phase FSH, LH, Oestradiol, prolactin, TFTs, androgens (testosterone, SHBG, FAI, DHEAS, androstenedione) and 17αhydroxyprogesterone and is able to interpret results appropriately. |
- Is able to carry out ultrasound scans of the pelvis.
- Appropriately organises and reviews the results of CT/MRI scan.
- Screens for associated conditions, e.g. autoimmune factors, genetic causes, diabetes mellitus, late onset congenital adrenal hyperplasia.
- Arranges follow-up investigations.
- Discusses the possible cause for ovulatory dysfunction and its impact on fertility with the patient.

**Communicates and constructs an appropriate management plan for ovulatory dysfunction**

- Formulates an appropriate individualised management plan taking into account patient preferences.
- Discusses potential consequences of expectant management.
- Clearly explains treatment regimes of ovulation induction, success rates (pregnancy rate and live birth rate), potential side effects of drugs and complications, including the risk of multiple pregnancy and ovarian hyperstimulation syndrome (OHSS) and the link with ovarian cancer.
- Provides appropriate treatment monitoring to assess effectiveness of the treatment and minimise the risk of multiple pregnancy.
- Provides appropriate advice for the management of conditions such as the risk of developing gestational diabetes in patients with polycystic ovary syndrome or the effects of medications in pregnancy.

**Prescribes safely**

- Appropriately prescribes ovulation induction agents and progestogens for withdrawal bleed.
- Provides appropriate treatment monitoring to assess effectiveness and minimise the risk of multiple pregnancy.

**Demonstrates understanding of association of other medical conditions with ovulatory dysfunction and multidisciplinary team approach**

- Liaises with appropriate specialists for further management of associated medical conditions, such as diabetes with polycystic ovary syndrome, pituitary tumours with hypogonadotrophic hypogonadism.
- Advises the patient on lifestyle factors, being sympathetic to the difficulties overcoming lifestyle issues such as obesity.
- Is able to discuss long term effects and management of conditions such as PCOS and premature ovarian failure and arranges appropriate referral for a multidisciplinary approach to their management.

**Assesses and investigates women with uterine and tubal factor infertility**

- Takes a detailed history and performs appropriate physical examination.
- Undertakes screening for chlamydia and gonorrhoea.
- Demonstrates understanding of possible feelings of guilt in patients with previous sexually transmitted infection or pelvic inflammatory disease.

**Decides which diagnostic technique to use and communicates effectively with the patient**

- Discusses diagnostic techniques available for assessing tubal and uterine disease, and any associated risks and complications.
- Arranges and carries out appropriate procedures such as trans-abdominal and trans-vaginal ultrasound scans, HSG, HyCoSy and saline-infusion sonohysterography.
- Knows when to request a CT/MRI scans of abdomen and pelvis and is able to interpret the results.
- Communicates results effectively.
- Records results appropriately, including the need for referral and/or additional imaging.

**Manages women with tubal or uterine factor infertility**

- Formulates an appropriate individualised management plan taking into account patient preferences.
- Discusses the impact of hydrosalpinx on natural fertility and assisted conception, including the role of salpingectomy.
- Discusses with the patient the place of reversal of sterilisation.
- Discusses management of proximal and distal tubal obstruction.
- Is able to decide when and on whom to operate for diagnosis or surgical management.
- Performs effective and safe surgery where appropriate.
- Keeps accurate notes of operative procedures.
- Recognises the limitations of their operative (laparoscopic, open and hysteroscopic surgery) skills and, when appropriate, refers on to colleagues who have advanced laparoscopic/hysteroscopic skills.

**Professional skills and attitudes**

- Sympathises to the psychological impact of infertility.
- Directs patient to information sites and patient support groups.
- Explains the need for diagnostic tests.
- Discusses therapeutic options.
- Breaks bad news.
- Explains the risks and benefits of treatment.

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**SRH CiP 2: The doctor recognises, assesses and manages subfertility with reference to endometriosis.**

<table>
<thead>
<tr>
<th>Key Skills</th>
<th>Descriptors</th>
</tr>
</thead>
</table>
| Assesses women with symptoms suggestive of endometriosis and explains results | - Performs relevant physical examination, including vagino-rectal assessment.  
- Is able to diagnose an endometrioma on pelvic ultrasound scan.  
- Arranges appropriate investigations to establish the diagnosis and its severity, and is able to interpret results.  
- Provides accurate information without judgement on the effects of endometriosis and its treatment on fertility and assisted conception. |
| Performs effective and safe surgery where appropriate | - Is able to decide when and on whom to operate for diagnosis or surgical management.  
- Keeps accurate notes of operative procedures.  
- Refers on to colleagues who have advanced laparoscopic skills, when appropriate.  
- Arranges referral to other specialists when appropriate (e.g. pain clinic, surgeons). |
| Recognises and manages surgical complications | - Recognises and manages intraoperative complications, including when to convert to an open procedure.  
- Recognises and manages immediate (acute haemorrhage, injury to viscera or blood vessels) and late-onset (infection, hernia, thrombosis) postoperative complications. |

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**SRH CiP 3: The doctor recognises, assesses and manages subfertility with reference to male fertility.**

<table>
<thead>
<tr>
<th>Key Skills</th>
<th>Descriptors</th>
</tr>
</thead>
</table>
| Takes relevant history and arranges relevant initial investigations to diagnose male factor infertility | - Arranges semen analysis and interprets results.  
- Understands the reasons for and timing of a repeat semen analysis and arranges appropriately.  
- Takes urethral swabs and interprets the results  
- Arranges for appropriate management of any abnormality with swabs, including referral to GUM clinics. |
| Performs physical examination to assess male reproductive system | • Uses an orchidometer to assess testicular volume.  
• Assesses epididymis to detect any abnormalities.  
• Recognises varicocele, testicular tumours, undescended testicles, hypospadias, absence of vasa deferens, inguinal hernia. |
|---|---|
| Arranges further investigations to identify the cause of severe male factor infertility (azoospermia or severe oligospermia with a sperm density of < 5 million/ml) | • Arranges relevant further investigations, as appropriate: repeat semen analyses, urine for retrograde ejaculation, endocrine, microbiological and genetic (karyotype, CF screening). Ultrasound testicular biopsy.  
• Reviews investigations and is able to differentiate pre-testicular, testicular and post-testicular causes of severe sperm abnormality. |
| Communicates and formulates an appropriate management plan, taking into account patient preferences | • Explains the possible causes, treatment options, risks and benefits and the need for onward referral.  
• Arranges appropriate referrals: urologist, endocrinologist, clinical geneticist, psychosexual counsellor, assisted conception.  
• Is able to discuss the role of ART. |
SRH CiP 4: The doctor manages unexplained infertility and has a thorough knowledge of treatment options of infertility including assisted reproduction techniques (ART).

<table>
<thead>
<tr>
<th>Key Skills</th>
<th>Descriptors</th>
</tr>
</thead>
</table>
| Assesses couples to reach a diagnosis of unexplained infertility (diagnosis of exclusion) | • Takes a detailed history.  
• Is able to identify the cause of infertility (as discussed in detail in earlier CiPs):  
  o female factor infertility (ovulatory, uterine and tubal)  
  o male factor infertility  
  o endometriosis  
• Demonstrates understanding of the psychological impact of not identifying a specific cause for the infertility.  
• Arranges appropriate investigations to diagnose the cause of infertility (as described in the earlier CiPs). |
| Demonstrates understanding of psychological aspects of male and female factor subfertility and ART | • Recognises psychological factors in female (e.g. amenorrhoea) and male infertility (e.g. erectile dysfunction).  
• Demonstrates understanding of stress related to infertility, marital disharmony, and difficulties in having intercourse.  
• Discusses the effects of infertility upon the family.  
• Explains about the stress associated with ART.  
• Arranges appropriate referral to: counsellors, psychosexual medicine  
• Discusses the role and value of counselling in the management of the infertile couple. |
| Discusses pros and cons of different therapeutic options | • Clearly explains results of investigations.  
• Informs the couple of the chances of natural conception and success with different treatment options explaining the risks, benefits and alternatives.  
• Devises a care plan taking individual’s/couple’s wishes into consideration. |
| Decides when to proceed with therapeutic options | • Provides support for the couple if expectant treatment is the appropriate way forward.  
• Advises on suitable therapeutic option, taking individual’s/couples’ wishes into consideration. |
| Preparation of patients for ART | • Ensures appropriate assessments are undertaken to confirm suitability for ART.  
• Demonstrates ability to appropriately select patients for ART.  
• Where necessary, arranges relevant further investigations in preparation for ART and interprets the results:  
  o Endocrine including ovarian reserve tests  
  o Pelvic ultrasound scan  
  o Virology screening to include HIV, Hep B and Hep C,  
  o Microbiological screening: chlamydia and gonorrhoea,  
  o Genetic screening (karyotype, CF)  
• Assesses welfare of the child issues. |
| Decides and communicates the timing of assisted conception and formulates an appropriate assisted reproductive technology (ART) procedure | • Explains the role of ART and what an ART programme entails.  
• Discusses suitable ART options.  
• Discusses and recommends the most appropriate ART treatment according to cause of infertility, the results of the investigations and prognostic factors.  
• Explains the need for onward referral to an ART centre.  
• Discusses the benefits, risks, success and limitations of ART.  
• Is able to discuss the potential complications of ART, including OHSS, poor response, failed fertilisation, multiple pregnancy, ectopic pregnancy, risk of infection and bleeding with oocyte retrieval procedure and the risk of genetic disorders after IVF/ICSI.  
• Explains the benefits of hydrosalpinx, fibroid, ovarian cysts (if any) treatment prior to assisted conception and associated risks.  
• Liaises with tertiary centres to arrange appropriate referrals for ART.  
• Undertakes trans-vaginal ultrasound scan for monitoring ovarian stimulation.  
• Discusses the place of pre-implantation genetic testing.  
• Is able to discuss fertility preservation for individuals undergoing medical/surgical treatment affecting fertility and arranges appropriate referrals. |
|---|---|
| Diagnoses and manages ovarian hyperstimulation syndrome (OHSS) | • Discusses the risk factors for developing OHSS and strategies to minimise the risk of OHSS in an ART cycle.  
• Assesses the patient presenting with symptoms of OHSS, classifying according to severity.  
• Formulates management plan for OHSS (outpatient and inpatient).  
• Understands the complications of severe OHSS and the importance of multidisciplinary team management.  
• Advises on management in pregnancy for women who have had severe OHSS. |
| Directs patients to information sites and patient support groups | • Discusses the role and value of self-help groups and community networks of support and arrange appropriate referrals.  
• Arranges appropriate referral to social services for adoption/fostering, local independent adoption societies. |
| HFEA Code of Practice | • Has read the recent HFEA Code of Practice |

These key skills also map to a variety of generic professional capabilities. Evidence supporting progress in this ATSM should link to generic capabilities such as dealing with complexity, teamwork and leadership and knowledge of patient safety issues.

When considering whether progress is being made in the ATSM it is both the trainee’s/doctor’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/doctors and trainers assess progress in this ATSM, there is a Statement of Expectations for trainees for each SRH CiP. It offers guidance as to what constitutes acceptable progress in the ATSM.

<table>
<thead>
<tr>
<th>Meeting expectation SRH CiP1</th>
<th>Statement of Expectations for the ATSM in SRH</th>
</tr>
</thead>
<tbody>
<tr>
<td>A trainee/doctor meeting expectations will be able to independently perform an assessment of women with female factor infertility. They will be able to formulate a differential diagnosis. They will be using the information acquired to plan further</td>
<td></td>
</tr>
</tbody>
</table>
investigations and are able to undertake trans-vaginal ultrasound scan of the pelvis. They will begin to create appropriate individualised management plans to manage ovulatory dysfunction and uterine or tubal factor infertility. They will use drug therapy appropriately. They will be able to recognise the need for referral to colleagues with advanced surgical skills.

Meeting expectation SRH CiP2

A trainee/doctor meeting expectations will be able to independently perform a history and examination of women presenting with endometriosis. They will be able to perform investigations to diagnose endometriosis. They will be able to appropriately select patients for surgery and to undertake the surgery in a safe manner paying due regard to NICE guidance and appropriate consent. They will be able to manage post-operative complications and to recognise when a patient should be referred for subspecialist management.

Meeting expectations SRH CiP3

A trainee/doctor meeting expectations will be able to independently perform an assessment of men with male factor infertility. They will be able to formulate a differential diagnosis. They will be using the information acquired to plan further investigations and will begin to create appropriate individualised management plans. They will arrange appropriate referrals to other specialists including referrals to a tertiary unit for assisted conception.

Meeting expectations SRH CiP4

A trainee/doctor meeting expectations will be able to assess and discuss the diagnosis of unexplained infertility. They will be able to address the psychological aspects of infertility and fertility treatment. They will be able to appropriately select patients for assisted conception treatment and ensure appropriate assessments are undertaken to confirm their suitability. They will be able to discuss and recommend the most appropriate ART treatment and the benefits, risks, success and limitations of ART for individual circumstances. They will be able to assess and manage women with ovarian hyperstimulation syndrome.

3 The Capabilities in Practice (CiPs) explained

Each SRH CiP is made up of the following components:

a) A high-level learning outcome describing in a generic way what a doctor will be able to do once they have successfully achieved the CiP.

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

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

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

a) High-level learning outcome

The high-level learning outcome of each SRH CiP describes in a generic way what a doctor can do once they have successfully completed the SRH CiP. A competency level must be proposed by a trainee/doctor for each of these high-level learning outcomes using the entrustability scale listed in Table 1 at ATSM Educational Supervisor meetings, and prior to ARCPs. The trainer will make their own judgement based primarily on the evidence presented by the trainee/doctor, and this may be aligned with the trainee/doctor opinion, or may differ.
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 SRH CiP. These give guidance to the trainer and trainee/doctor as to what is needed to be achieved for completion of the SRH CiP. Competency levels do not need to be ascribed to these individual key skills prior to assessments, however the evidence collected by the trainee/doctor 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 SRH CiP.

c) Practical procedures

The procedures associated with this ATSM are listed in Table 2 and progress will be evidenced with OSATS, reflections and procedure logs. Training courses, simulation training and case based discussions may also help to support procedural competency sign off. The procedures requiring three summative OSATS (competent to level 4) are the same as those in the previous ATSM and are listed in Section 2 of the ATSM. For other procedures in this ATSM where level 5 competency is required it is highly recommended that three summative OSATS assessed as being competent are collected, but it is not currently mandatory.

d) Knowledge criteria

It is recognised that the full spectrum of subfertility and reproductive health problems will not be witnessed by the trainee/doctor whilst they undertake the ATSM, and expecting independent competency in managing the full range of subfertility and reproductive health problems is unachievable. However, a certain level of knowledge is expected as this will facilitate in the evidence-based management of all subfertility and reproductive health problems, common and uncommon. The knowledge criteria for each SRH CiP make clear what level of theoretical understanding and foundation knowledge is expected of an SRH ATSM holder. This will be at a higher level than the knowledge base expected for the MRCOG examinations. Trainees/doctors who do not witness the range of subfertility and reproductive problems covered by this ATSM should, at the very least, have working knowledge of them all.

4 How are the levels of supervision used to assess progress?

Each clinical SRH CiP has to be signed off using the new 5 levels of supervision, as defined in Table 1 below.

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

This method of sign-off moves away from a process of box-ticking and towards a process that says ‘I trust you to do these work activities. If not, I need to identify the underlying competencies that need to be developed so that you can progress to the next level of trust.’
The approach focuses on the outcome of training and defines this outcome in terms of the work that a trainee/doctor is trusted to do. By the end of training, doctors are ‘trusted’ to undertake all work tasks independently and without supervision. An SRH CiP is therefore a critical part of professional work that can be identified as a unit to be entrusted to a trainee/doctor once efficient competence has been reached.

The concept allows each task to be linked explicitly to the most crucial competencies which are then observed during normal clinical practice.

SRH CiPs emphasise the role of observation and judgement, and replicate real-life practice. For example, a consultant must decide what each trainee/doctor can be trusted to do, as well as determine the amount of supervision, direct or indirect, that they need to undertake activities safely. These kinds of judgements are routinely made in the workplace and are based on the experience of the consultant. By the end of training, a doctor must be trusted to undertake all the key critical tasks needed to work as a consultant – and that becomes the outcome and end point of training.

The trainee/doctor will make a self-assessment to consider whether they meet expectations for the time spent undertaking the ATSM, using the five supervision levels listed in Table 1 and highlighting the evidence in the ePortfolio. The ATSM Educational Supervisor will then consider whether the trainee is meeting expectations or not by assigning one of the five supervision levels.

Trainees/doctors will need to meet expectations for the time spent undertaking the ATSM 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 CiPs in this ATSM is level 5.

5 How are the procedures associated with the clinical SRH CiPs assessed?

The procedures associated with this ATSM are listed in Table 2 and progress will be evidenced with OSATS. Each procedure requires three summative OSATS assessed as being competent prior to be able to performing the practical procedure independently with support (level 4).

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Level by end of training*</th>
<th>CIP 1</th>
<th>CIP 2</th>
<th>CIP 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound assessment of:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>o Normal pelvis</td>
<td>5</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>o Ovarian lesions</td>
<td>5</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>o Uterine fibroids</td>
<td>5</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>o Endometrial abnormality</td>
<td>5</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>o Monitoring ovarian stimulation</td>
<td>5</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>o Tubal pathology</td>
<td>5</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Diagnostic laparoscopy and Dye test</td>
<td>5</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Laparoscopic treatment of early-stage endometriosis</td>
<td>5</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Treatment of ovarian endometrioma by laparoscopy or laparotomy</td>
<td>5</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Operative laparoscopy for ovarian Cystectomy</td>
<td>5</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Procedures</td>
<td>Level by end of training*</td>
<td>CIP 1</td>
<td>CIP 2</td>
<td>CIP 4</td>
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<tr>
<td>Oophorectomy - by laparoscopy or laparotomy</td>
<td>5</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Proficiency in:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Hasson, direct and Palmer’s point Veress needle entry techniques</td>
<td>5</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>o safe entry into the abdominal cavity and closure</td>
<td></td>
<td></td>
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<tr>
<td>o choice of position and safe insertion of secondary ports</td>
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<td></td>
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<tr>
<td>o safe tissue handling with laparoscopic instruments, sharp and blunt dissection</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>o haemostatic techniques</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hysterosalpingography (HSG)</td>
<td>2</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HyCoSy</td>
<td>5</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Saline infusion sono-hysteroscopy</td>
<td>5</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operative laparoscopy for salpingectomy</td>
<td>5</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operative laparoscopy for adhesiolysis</td>
<td>5</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Operative hysteroscopy for polypectomy</td>
<td>5</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hysteroscopic proximal tubal catheterisation</td>
<td>3</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Operative hysteroscopy for intra-uterine adhesiolysis</td>
<td>3</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Operative hysteroscopy for uterine septum resection</td>
<td>3</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Operative hysteroscopy for resection of submucous fibroids</td>
<td>3</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Operative laparoscopy for salpingostomy</td>
<td>3</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Operative laparoscopy for ovarian diathermy</td>
<td>5</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open myomectomy</td>
<td>5</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Surgical sperm retrieval</td>
<td>1</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

*Corresponds to 5 levels of supervision used to assess SHR CiPs.

6 What kind of evidence might be relevant to this ATSM?
As a trainee/doctor progresses through their ATSM training they will be expected to collect evidence which demonstrates their development and acquisition of the key skills, procedures and knowledge. Examples of types of evidence are given below, but please note that this is an indicative, not a prescriptive, list. Other sources of evidence may be used by agreement except for the workplace-based assessments – i.e. if they are listed, then at least one must be presented as evidence. The emphasis should be firmly on the quality of evidence, not the quantity. This evidence will be reviewed by the ATSM Educational Supervisor when they are making a global assessment of the progress against the high-level learning outcome of each CiP.
- OSATS
- CbD
- Mini-CEX
- Discussion of correspondence Mini-CEX
- Reflective practice
- TO2 (including SO)
- NOTSS
- Confirmed attendance at specialist clinics
- Local, Deanery and National Teaching
- RCOG (and other) eLearning
- Conferences and courses attended
  - RCOG/BFS ATSM course on Subfertility and Assisted Conception
- Procedural log
- Case log
- Case presentations
- Quality Improvement activity

The mapping of workplace-based assessments to CiPs is shown in Table 3 below:

<table>
<thead>
<tr>
<th>SRH CIP</th>
<th>OSATS</th>
<th>Mini-CEX</th>
<th>CbD</th>
<th>NOTSS</th>
<th>TO1/TO2</th>
<th>Reflective practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: The doctor recognises, assesses and manages subfertility with reference to female factor infertility.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2: The doctor recognises, assesses and manages subfertility with reference to endometriosis.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3: The doctor recognises, assesses and manages subfertility with reference to male fertility.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4: The doctor manages unexplained</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>SRH CIP</td>
<td>OSATS</td>
<td>Mini-CEX</td>
<td>CbD</td>
<td>NOTSS</td>
<td>TO1/TO2</td>
<td>Reflective practice</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>infertility and has a thorough knowledge of treatment options of infertility including assisted reproduction techniques (ART).</td>
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</tbody>
</table>

7 Generic Capabilities in Practice

The non-clinical skills previously referred to in the ATSM curriculum have now been removed because they are covered by the 10 Core CiPs 1-8, 13 and 14. Trainees/doctors undertaking the ATSM at ST6 and ST7 will be assessed against the expectations for a senior trainee/doctor laid out in the explanatory documents for these core CiPs, which can be found with the details of the core curriculum (Core CiP Guides). However, the evidence collected for the sign-off of these core CiPs at senior level is expected to reflect the ATSM undertaken by the trainee/doctor. At least one quality improvement project therefore should pertain to subfertility and reproductive health, and teaching sessions and evidence of advanced communication skills using CbDs should, for example, be obtained through subfertility and reproductive health working. Post-CCT trainees/doctors who will have these generic CiPs signed off already should, nevertheless, provide evidence which proves they have these non-clinical skills as required by someone who has a special interest in fetal medicine.

8 When can a SRH CiP be assessed?

A trainee/doctor can make a self-assessment of their progress in a SRH 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 CiP? If not do I need to look at the knowledge syllabus as outlined in the full curriculum?

Once the trainee has completed the self-assessment the educational supervisor (ES) needs to review the evidence and ask the same questions.

- Do I agree with the trainee/doctor for the self-assessment for this SRH CiP? Is this sufficient evidence to support sign off of the SRH CiP at level 5?
- Is this the best evidence? Would some of this evidence be more appropriate in other 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?

When the ATSM Educational Supervisor judges that the trainee/doctor has met the expectations for that year they can sign off the SRH CiP. Most crucially this is a global judgement. There does not have to be evidence linked to every key skill. One piece of well presented evidence with some reflection may be enough to sign off the SRH CiP. It is the quality of the evidence not the quantity which is key. The progress a trainee/doctor is making with the acquisition of technical procedural skills which form part of that SRH CiP, and their knowledge base, should also be considered when giving a global rating.

Each clinical SRH CiP in this module has to be signed off using the new 5 levels of supervision, as defined in Table 1 (above), and the generic capabilities will need to be signed off with reference to the statements of expectations described in the core curriculum for an advanced trainee/doctor. Each SRH CiP must eventually be signed off to level 5.

Progress with the aspects of the generic CiPs relevant to the SRH ATSM must be kept under constant review by the trainee/doctor and ATSM Educational Supervisor. The educational supervisor’s report prepared for the ARCP will document how these are being achieved and evidenced.

Once the ATSM Educational Supervisor has assigned an entrustability level for each SRH CiP, based on the global assessment methodology, the trainee/doctor has an opportunity to document why they disagree with their ATSM Educational Supervisor, if disagreement exists over any one particular SRH CiP.

The ATSM Educational Supervisor will be expected to make an overall assessment of progress with the ATSM, as detailed below in Table 4. The ATSM assessment will then feed into the educational supervisor’s report for the ARCP.

<table>
<thead>
<tr>
<th>Table 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Global judgement to be used for each SRH CiP</strong></td>
</tr>
<tr>
<td><strong>Trainee/doctor self-assessment</strong></td>
</tr>
<tr>
<td>FOR EACH SRH CiP (1-4)</td>
</tr>
<tr>
<td>Link to evidence on the ePortfolio.</td>
</tr>
<tr>
<td><strong>ATSM Educational Supervisor’s assessment</strong></td>
</tr>
<tr>
<td>I agree with the trainee’s/doctor’s self-assessment and have added my comments to each AOCiP.</td>
</tr>
<tr>
<td>I do not agree with the trainee’s/doctor’s self-assessment for the following reasons:</td>
</tr>
<tr>
<td><strong>ATSM Educational Supervisor’s overall progress with the ATSM</strong></td>
</tr>
<tr>
<td>➢ Not meeting expectations for the SRH ATSM; may not achieve level 5 on the entrustability scale across all SRH CiPs in the appropriate time scale</td>
</tr>
<tr>
<td>➢ Meeting expectations for the SRH ATSM; expected to achieve level 5 on the entrustability scale across all SRH CiPs in the appropriate time scale.</td>
</tr>
</tbody>
</table>
9 Are there any examples or case studies?

Example 1 – ATSM Educational Supervisor focus

You are an ATSM Educational Supervisor having a meeting with a trainee/doctor, who asks for sign off of SRH CiP 1 after considering the questions regarding the evidence. They feel that they meet the statement of expectations. They have submitted the following evidence linked to the SRH CiP 1.

- WPBAs
- Reflection on a patient with polycystic ovary syndrome or hydrosalpinx
- Evidence of involvement in a QI project relevant to reproductive medicine and surgery.
- eLearning module

Therefore, based on your meetings with the trainee/doctor you feel that they have provided evidence which demonstrates progress since commencing the ATSM. You were impressed by the QI project which had been undertaken regarding ultrasound scan training and you discussed with the trainee/doctor how this project could be extended for use across all trainees/doctors in the department. You feel the quality of the evidence which is linked to the SRH CiP 1 is good, so you can feel confident in signing off this SRH CiP 1 as complete.

Example 2 – ST7 trainee (trainee/doctor focus)

You are an ST7 trainee considering sign-off for SRH CiP 4. You are 5 months into ST7 and have submitted the following evidence linked to the SRH CiP.

- WPBAs
- TO2s
- Attendance at specialist clinics in the IVF unit
- Attendance at BFS/RCOG ATSM course

You feel this evidence matches the Statement of Expectations for ST7 because it shows evidence of the cases you have seen and feedback from your TO2.

You discuss this SRH CiP and your request to be signed off with your ATSM Educational Supervisor at your next meeting.

The ATSM Educational Supervisor considers the key questions:

- **Do I agree with the trainee/doctor for the self-assessment for this SRH CiP? Is this sufficient evidence to support sign off of the SRH CiP at level 5?** The evidence consisted of a WPBA regarding appropriate assessments prior to providing assisted reproductive techniques treatment.
- **Is this the best evidence? Would some of this evidence be more appropriate in other CiPs as evidence?** While this evidence covers some of the knowledge aspect of the SRH CiP, they have not demonstrated all of the key skills required e.g. the TO2 did not have any fertility nurses or sonographers involved but comments on team working.
- **Is the level right for this trainee?** I don’t feel this is the right level for ST7 as they have shown little insight into their own clinical performance, as evidenced by the lack of reflection.
You discuss with the trainee/doctor that you do not feel able to sign off this SRH CiP currently. You discuss what would be an appropriate level of WPBA for SRH CiP completion including discussion around risks of assisted reproductive techniques treatment, ultrasound assessment monitoring ovarian stimulation and management of ovarian hyperstimulation syndrome. You agree with the trainee that the evidence could be strengthened by including some of the ultra-sonographers and fertility nurses on the next TO2. You discuss opportunities for the trainee to attend the reproductive medicine MDT.