JRCPTB

Joint Royal Colleges of Physicians Training Board

Dermatology Training Curriculum

Implementation August 2021

ROYAL COLLEGE
of PHYSICIANS
of EDINBURGH

ROYAL COLLEGE OF
PHYSICIANS AND
SURGEONS OF GLASGOW

Royal College
of Physicians

Contents

1. Introduction

This curriculum defines the purpose, content of learning, process of training, programme of assessment and quality management for dermatology higher specialist training leading to the award of completion of training (CCT).

The dermatology curriculum has been developed with the input of consultants actively involved in delivering teaching and training across the UK, trainees, service representatives and lay persons. This has been through the work of the JRCPTB and the Dermatology Specialist Advisory Committee (SAC). The curriculum subcommittee of the SAC report to the SAC and are responsible for updating the curriculum content and assessment methods as necessary. This is an on-going process of review and refinement, with continuous consultation and feedback from the representatives listed above.

2. Purpose

2.1 Purpose of the curriculum

The purpose of the dermatology curriculum is to produce general dermatologists with the generic professional and specialty specific capabilities to safely recognise, diagnose and manage the full range of common skin conditions presenting to a general consultant dermatologist, including hair, nail and mucosal conditions. They should develop awareness and some management expertise of the rarer conditions. They should be able to manage skin conditions in both adults and children in the context of multiple medical problems, diagnose and manage skin cancers and benign lesions and perform skin surgery. They should be able to manage skin eruptions to a high-level including the use of complex new drugs such as biologics, where they should be able to recognise and deal with potentially serious side effects. They should be capable of leading a multidisciplinary team which could consist of specialist nurses, trainees, physician's associates, General Practitioners with a Special Interest or an Extended role (GPwERs) and non-consultant career grade doctors.

Satisfactory completion of training would result in a Certificate of Completion of Training (CCT), enabling recommendation to the GMC for inclusion on the Specialist Register. The trainee who completes this curriculum satisfactorily will be capable of independent unsupervised practice and will be able to perform to a consistent standard as an NHS general dermatology consultant, whether employed in a District General Hospital or a large Specialist Tertiary centre.

The Shape of Training (SoT) review was a catalyst for reform of postgraduate training of all doctors to ensure it is more patient focused, more general (especially in the early years) and with more flexibility of career structure. For physician training, the views and recommendations of SoT were similar to those of the Future Hospital Commission and the Francis report.

A further driver for change was the GMC review of the curricula and assessment standards and introduction of the GPC framework. From May 2017, all postgraduate curricula should be based on higher level learning outcomes and must incorporate the generic professional

capabilities. A fundamental component of the GPCs is ensuring that the patient is at the centre of any consultation and decision making.

JRCPTB, on behalf of the Federation of Royal Colleges of Physicians of the UK, developed a training model whereby dermatology sits within Group 2 specialties who will complete 2 years of stage 1 Internal Medicine Training (IMT). There will be competitive entry to dermatology higher specialist training following completion of the two years. The MRCP(UK) Diploma will be the normal requirement for entry into dermatology training. Circumstances in which acquisition of MRCPCH and MRCS would allow alternative entry into training are detailed.

Changing population needs/ service requirements. Medicine in the UK overall, is faced with an ageing population that has more complex medical needs, associated co-morbidities, and challenging social care issues. Polypharmacy is a particular concern in an ageing population, and differing pharmacokinetics and pharmacodynamics in the elderly pose distinct problems. It is therefore imperative that dermatologists are aware of drug interactions and adverse reactions. Furthermore, they need to have an understanding of why patients have been started on their medical therapies so that they can evaluate the risk/benefit ratio of stopping them. For all these reasons, from a dermatology point of view, there is even further need to ensure that we continue to train doctors with the medical background to understand this and be able to manage patients' dermatological conditions safely within the context of medical complexity. Dermatologists should also be able to continue to support acute care by managing their own acute dermatological emergencies to avoid increasing the burden on the acute unselected medical take.

Dermatologists are the primary point of contact in secondary care for diagnosing skin cancer which is the commonest of all cancers. The burden of skin cancer is rising, partly due to the ageing population. Skin cancer rates are predicted to have risen from 250,000 cases in the UK/ year, to 400,000 by 2025.[1] Melanoma rates have increased by 128% since the early 1990s, peak incidence being in 85-89 yr-olds.[2] Non-melanoma skin cancer rates have increased by 148% since the early 1990s and also rise with age[3]. A BAD audit in 2016 showed that 15% of dermatology outpatient visits were 2 week wait GP referrals for skin cancer, but only 30% of these were malignant. This is an important part of the curriculum as there is a need to maintain and improve on skills for diagnosing skin cancer to cope with the increased demand, particularly with regard to avoiding unnecessary surgery and treatment for patients, whilst improving efficiency.

Burden of skin disease and workforce issues/ service delivery. From the patient point of view, the burden of skin disease is high. In the public health document 'Health Profile for

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[1] *Goon 2017- Bri Jour Dermatol 176(5) · October 2016*
[2] https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/melanoma-skin-cancer/incidence
[3] https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/non-melanoma-skin-cancer/incidence#heading-Two

England 2017'[4], skin disease was the second highest causes of morbidity between 1990 and 2013, preceded only by back and neck pain.

The annual prevalence of skin disease in patients presenting to primary care health professionals in England and Wales in 2006 was around 24%. Of these, 6.1% are referred on for specialist advice, which equated to 0.75 million in 2007.[5] It is therefore important to maintain and improve on the efficiency of dermatology services. However, as a workforce, there are increasingly unfilled dermatology consultant posts across the country, especially within District General Hospitals. There are 578 consultant dermatologists[6] and approximately 200 locum-filled or unfilled consultant dermatologist posts across the UK. Most consultants under the age of 50 years old are less than full-time (LTFT) females and 75% of current trainees are female.[7] In the face of these workforce challenges and the burden of skin disease, dermatologists need to be capable of planning and providing services via different models of care in the future. If necessary, they need to be capable of leading a multidisciplinary team to deliver a general dermatology service for the whole of the local population they are responsible for, rather than delivering one-to-one care. This team could consist of specialist nurses, trainees, physician's associates, GPwERs and non-consultant career grade doctors. It is also important that we produce dermatology trainees with the breadth of general dermatology training to allow them to work in any area of the country to ensure service needs are met for the local populations.

Professional Advances in Dermatology. Since the 2010 curriculum was agreed, there has been an expansion in the specialty with nine new biologic systemic treatments approved by NICE for use in dermatology. These have serious, potentially life-threatening side effects and trainees will need to be able to safely prescribe and manage these within a normal dermatology service. There have also been advances in knowledge as to how inflammatory skin diseases affect patients systemically eg severe psoriasis is associated with cardiovascular, endocrine, neurological and gastrointestinal disease. The curriculum will be updated to include this. Similarly, countrywide, the process of assessment via teledermatology to manage referral numbers has advanced considerably and will now be required within the new curriculum for dermatology.

This purpose statement has been endorsed by the GMC's Curriculum Oversight Group and confirmed as meeting the needs of the health service of the countries of the UK.

The objectives of this curriculum are:
- To set out a range of specific professional capabilities that encompass all knowledge, skills and behaviour required to practice as a general consultant dermatologist on the GMC Specialist Register.
- To set expected standards of knowledge and performance of various professional skills and activities at each stage.

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[4] https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/non-melanoma-skin-cancer/incidence#heading-Two

[5] https://www.nottingham.ac.uk/research/groups/cebd/documents/hcnaskinconditionsuk2009.pdf

[6] April 2018, https://www.statista.com/statistics/594431/dermatologists-in-the-united-kingdom-uk-by-staff-grade/

[7] RCP census data 2015-16

- To suggest indicative training times and experiences needed to achieve the required standards.

  This curriculum will ensure that the trainee develops the full range of generic professional capabilities and specialty specific capabilities to practice as a general consultant dermatologist in the NHS. The required high-level outcomes or capabilities in practice are detailed below.

2.2 High-level learning outcomes – Capabilities in Practice (CiPs)

Learning outcomes – Capabilities in Practice (CiPs)
Generic CiPs
1. Able to successfully function within NHS organisational and management systems
2. Able to deal with ethical and legal issues related to clinical practice
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement
4. Is focused on patient safety and delivers effective quality improvement in patient care
5. Carrying out research and managing data appropriately
6. Acting as a clinical teacher and clinical supervisor
Specialty CiPs
1. **Outpatient dermatology**: managing dermatology patients in the outpatient setting
2. **Acute and emergency dermatology**: managing dermatological emergencies in all environments and managing an acute dermatology service including on-call
3. **Liaison and community dermatology**: working in partnership with primary care and promoting skin health
4. **Skin tumours and skin cancer**: managing a comprehensive skin cancer and benign skin lesion service
5. **Procedural dermatology**: performing skin surgery and other dermatological procedures
6. **Paediatric dermatology**: managing paediatric dermatology patients in all settings
7. **Other specialist aspects of a comprehensive dermatological service** including: 7A) cutaneous allergy 7B) photobiology and phototherapy 7C) genital and mucosal disease 7D) hair and nail disease

2.3 Training pathway

Dermatology is a group 2 specialty and trainees will enter higher specialty training following two years of stage 1 internal medicine training (IMT) or three years of ACCS-IM and completion of the MRCP(UK) diploma.
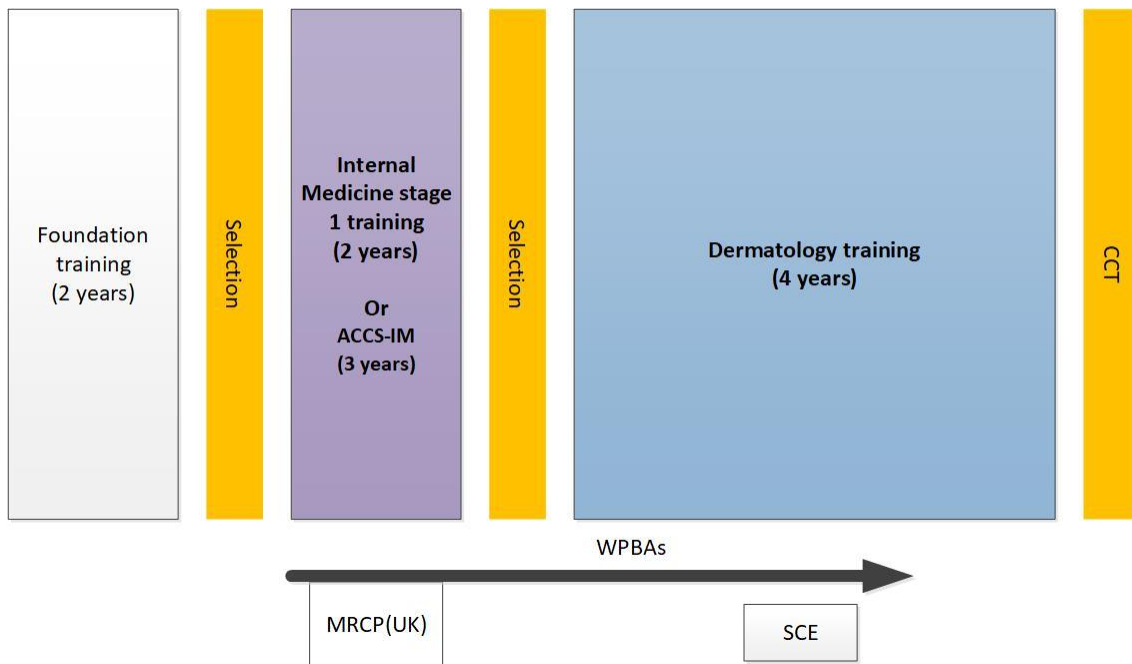
Trainees who have completed two years of core surgical training (CST) or three years of level 1 paediatric training will have transferable capabilities but will require adult general medical capabilities in in order to be able to manage general medical problems in adult patients in isolated units, within the context of dermatological disease and without immediate recourse to other specialists.

Trainees from these backgrounds will be able to enter higher specialist dermatology training via one of the following alternative pathways. This is in line with guidance issued via the Academy of Medical Royal Colleges for flexibility in postgraduate training and changing specialties.

- Satisfactory completion of three years of level 1 paediatric training programme with full MRCPCH (UK) or two years of Core Surgical Training (CST) with full MRCS plus achievement of IMY2 capabilities.
- Satisfactory completion of three years of level 1 paediatric training programme with full MRCPCH (UK) or two years of Core Surgical Training (CST) with full MRCS plus 12 months' experience in medical specialties in a range of acute hospital medical specialties that admit acutely unwell medical patients and manage their immediate follow up.

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2.4 Duration of training

Dermatology higher specialist training will normally be an indicative four year programme that will begin following completion of two years of the internal medicine stage 1 curriculum (or alternatives as above).

There will be options for those trainees who demonstrate exceptional development and acquisition of capabilities to complete training more rapidly than the current indicative time although it is recognised that clinical experience is a fundamental aspect of development as a good dermatologist on the GMC Specialist Register (guidance on completing training early will be available on the JRCPTB website). There may also be a small number of trainees who develop more slowly and will require an extension of training in line the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide).

Trainees are required to register for specialist training with JRCPTB at the start of their training programmes.

2.5 Flexibility and accreditation of transferable capabilities

The curriculum incorporates and emphasises the importance of the generic professional capabilities (GPCs). GPCs will promote flexibility in postgraduate training as these common capabilities can be transferred from specialty to specialty. In addition, supporting flexibility for trainees to move between these specialties without needing to repeat aspects of training. The curriculum supports the accreditation of transferrable competencies (using the Academy framework).

2.6 Less than full time training

Trainees are entitled to opt for less than full time training programmes. Less than full time trainees should undertake a pro rata share of the out-of-hours duties (including on-call and other out-of-hours commitments) required of their full-time colleagues in the same programme and at the equivalent stage.

Less than full time trainees should assume that their clinical training will be of a duration pro-rata with the time indicated/recommended, but this should be reviewed in accordance with the Gold Guide.

2.7 Generic Professional Capabilities and Good Medical Practice

The GMC has developed the generic professional capabilities (GPC) framework[8] with the Academy of Medical Royal Colleges (AoMRC) to describe the fundamental, career-long, generic capabilities required of every doctor. The framework describes the requirement to develop and maintain key professional values and behaviours, knowledge, and skills, using a

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[8] Generic professional capabilities framework

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common language. GPCs also represent a system-wide regulatory response to the most common contemporary concerns about patient safety and fitness to practise within the medical profession. The framework will be relevant at all stages of medical education, training and practice.

The nine domains of the GMC's Generic Professional Capabilities

Professional knowledge

Professional skills

Health promotion and illness prevention

Research and scholarship

Professional values and behaviours

Leadership and team

Education and training

Patient safety and quality improvement

Safeguarding vulnerable groups

Good medical practice (GMP)[9] is embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors the GPC framework articulates GMP as a series of achievable educational outcomes to enable curriculum design and assessment.

The GPC framework describes nine domains with associated descriptor outlining the 'minimum common regulatory requirement' of performance and professional behaviour for those completing a CCT or its equivalent. These attributes are common, minimum and generic standards expected of all medical practitioners achieving a CCT or its equivalent.

The nine domains and subsections of the GPC framework are directly identifiable in the curriculum. They are mapped to each of the generic and specialty CiPs, which are in turn mapped to the assessment blueprints. This is to emphasise core professional capabilities that are essential to safe clinical practice and that they must be demonstrated at every stage of training as part of the holistic development of responsible professionals.

This approach will allow early detection of issues most likely to be associated with fitness to practise and to minimise the possibility that any deficit is identified during the final phases of training.

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[9] Good Medical Practice

3. Content of Learning

The practice of dermatology at consultant level requires proficiency in generic and specialty capabilities to effectively and efficiently diagnose and manage patients presenting with a wide range of dermatological conditions, including complex and rare disease. Working accurately at a brisk pace is critical due to the high throughput of patients and heavy burden of disease. It is essential that a dermatologist practise in partnership with allied professionals to lead and deliver a comprehensive dermatology service as a team. Delivery of care can be appropriately delegated to meet demand, and awareness of clinical and educational governance is paramount. Specialty capabilities include secondary care outpatient dermatology, acute and emergency dermatology, liaison and community dermatology, skin tumours and skin cancer, procedural dermatology including skin surgery, paediatric dermatology and other specialty capabilities. Underpinning all of these are high-level skills in: advanced dermatological therapeutics, dermatopathology and professional behaviour and communication skills.

The curriculum is spiral; topics and themes will be revisited to expand understanding and expertise. The level of entrustment for capabilities in practice (CiPs) will increase as the individual progresses from requiring direct supervision to working in an unsupervised capacity.

3.1 Capabilities in practice

CiPs are based on the concept of entrustable professional activities[10] which use the professional judgement of appropriately trained, expert assessors as a defensible way of forming global judgements on professional performance.

They are units of professional practice to which a learner is entrusted, to execute without supervision once the learner has demonstrated the knowledge, skills and behaviour to do so. The expert assessor must feel confident the trainee is actually *able* to perform essential tasks in professional practice, rather than merely knowing or showing *how* to do them. In this curriculum, they are divided into generic and specialty CiPs, which describe the professional tasks or work within the scope of dermatology.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the knowledge, skills and attitudes which should be demonstrated. Doctors in training may use these capabilities to provide evidence of how their performance meets or exceeds the minimum expected level of performance for their year of training. The descriptors are not a comprehensive list and there are many more examples that would provide equally valid evidence of performance.

Many of the CiP descriptors refer to patient-centred care and shared decision-making. This emphasises the importance of patients at the centre of decisions about their own

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[10] Nuts and bolts of entrustable professional activities

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treatment and care, including exploration of treatment options, risks and benefits, and choices available.

Additionally, the CiPs repeatedly refer to the need to demonstrate professional behaviour with regards to patients, carers, colleagues and others. Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment which will support them to live as well as possible, whatever their illness or disability. Appropriate professional behaviour should reflect the principles of GMP and the GPC framework.

In order to complete training and be recommended to the GMC for the award of CCT and entry to the Specialist Register, the doctor must demonstrate that they are capable of unsupervised practice in all generic and specialty CiPs. Once a trainee has achieved level 4 sign off for a CiP it will not be necessary to repeat assessment of that CiP if capability is maintained (in line with standard professional conduct).

This section of the curriculum details the six generic CiPs and seven specialty CiPs for dermatology. The dermatology specialty capabilities in practice (CiPs) describe the professional tasks or work within the scope of Dermatology. The expected levels of performance, mapping to relevant GPCs and the evidence that may be used to make an entrustment decision are outlined for each CiP. The list of evidence for each CiP is not prescriptive and other types of evidence may be equally valid for that CiP.

3.2 Generic capabilities in practice

The six generic CiPs cover the universal requirements of all specialties as described in GMP and the GPC framework. Assessment of the generic CiPs will be underpinned by the descriptors for the nine GPC domains and evidenced against the performance and behaviour expected at that stage of training. Satisfactory sign off will indicate that there are no concerns. It will not be necessary to assign a level of supervision for these non-clinical CiPs.

In order to ensure consistency and transferability, the generic CiPs have been grouped under the GMP-aligned categories used in the Foundation Programme curriculum plus an additional category for wider professional practice:

- Professional behaviour and trust
- Communication, team-working and leadership
- Safety and quality
- Wider professional practice

For each generic CiP there is a set of descriptors of the observable skills and behaviours which would demonstrate that a trainee has met the minimum level expected. The descriptors are not a comprehensive list and there may be more examples that would provide equally valid evidence of performance.

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KEY

CbD	Case-based discussion	DOPS	Direct observation of procedural skills
GCP	Good Clinical Practice		
Mini-CEX	Mini-clinical evaluation exercise	MCR	Multiple consultant report
MSF	Multi source feedback	PS	Patient survey
QIPAT	Quality improvement project assessment tool	TO	Teaching observation

Generic capabilities in practice (CiPs)
Category 1: Professional behaviour and trust
1. Able to function successfully within NHS organisational and management systems

Descriptors	• Aware of and adheres to the GMC professional requirements • Aware of public health issues including population health, social detriments of health and global health perspectives • Demonstrates effective clinical leadership • Demonstrates promotion of an open and transparent culture • Keeps practice up to date through learning and teaching • Demonstrates engagement in career planning • Demonstrates capabilities in dealing with complexity and uncertainty • Aware of the role of and processes for commissioning • Aware of the need to use resources wisely • Demonstrates management of a change project or Quality improvement activity
GPCs	Domain 1: Professional values and behaviours Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF Active role in governance structures eg leading a governance or audit meeting Management course End of placement reports Evidence of adoption of leadership roles eg audit lead, rota organiser, trainee representative, organising academic meetings
2. Able to deal with ethical and legal issues related to clinical practice	
Descriptors	• Aware of national legislation and legal responsibilities, including safeguarding vulnerable groups • Behaves in accordance with ethical and legal requirements • Demonstrates ability to offer apology or explanation when appropriate • Demonstrates ability to lead the clinical team in ensuring that medical legal factors are considered openly and consistently
GPCs	Domain 3: Professional knowledge • professional requirements

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	• national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF CbD DOPS Mini-CEX SCE End of placement reports

Category 2: Communication, teamworking and leadership

3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement	
Descriptors	• Communicates clearly with patients and carers in a variety of settings • Communicates effectively with clinical and other professional colleagues • Identifies and manages barriers to communication (eg cognitive impairment, speech and hearing problems, capacity issues) • Demonstrates effective consultation skills including effective verbal and nonverbal interpersonal skills • Shares decision making by informing the patient, prioritising the patient's wishes, and respecting the patient's beliefs, concerns and expectations • Shares decision making with children and young people • Applies management and team working skills appropriately, including influencing, negotiating, re-assessing priorities and effectively managing complex, dynamic situations
GPCs	Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	MCR MSF PS End of placement reports ES report

Category 3: Safety and quality

4. Is focused on patient safety and delivers effective quality improvement in patient care	
Descriptors	• Makes patient safety a priority in clinical practice • Raises and escalates concerns where there is an issue with patient safety or quality of care • Demonstrates commitment to learning from patient safety investigations and complaints • Shares good practice appropriately • Contributes to and delivers quality improvement

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	- Understands basic Human Factors principles and practice at individual, team, organisational and system levels - Understands the importance of non-technical skills and crisis resource management - Recognises and works within limit of personal competence - Avoids organising unnecessary investigations or prescribing poorly evidenced treatments
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills - practical skills - communication and interpersonal skills - dealing with complexity and uncertainty - clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge - professional requirements - national legislative requirements - the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement - patient safety - quality improvement
Evidence to inform decision	MCR MSF QIPAT End of placement reports

Category 4: Wider professional practice
5. Carrying out research and managing data appropriately

Descriptors	- Manages clinical information/data appropriately - Understands principles of research and academic writing - Demonstrates ability to apply for ethical research approval - Demonstrates ability to carry out critical appraisal of the literature - Demonstrates ability to write a clinical or scientific paper - Understands the role of evidence in clinical practice and demonstrates shared decision making with patients - Demonstrates appropriate knowledge of research methods, including qualitative and quantitative approaches in scientific enquiry - Demonstrates appropriate knowledge of research principles and concepts and the translation of research into practice - Follows guidelines on ethical conduct in research and consent for research - Understands public health epidemiology and global health patterns - Recognises potential of applied informatics, genomics, stratified risk and personalised medicine and seeks advice for patient benefit when appropriate
GPCs	Domain 3: Professional knowledge - professional requirements - national legislative requirements - the health service and healthcare systems in the four countries Domain 7: Capabilities in safeguarding vulnerable groups

	Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF SCE GCP certificate (if involved in clinical research) Evidence of literature search and critical appraisal of research Use of clinical guidelines Quality improvement and audit Evidence of research activity End of placement reports
6. Acting as a clinical teacher and clinical supervisor	
Descriptors	• Delivers effective teaching and training to medical students, junior doctors and other health care professionals • Delivers effective feedback with action plan • Able to supervise less experienced trainees in their clinical assessment and management of patients • Able to supervise less experienced trainees in carrying out appropriate practical procedures • Able to act a clinical supervisor to doctors in earlier stages of training
GPCs	Domain 1: Professional values and behaviours Domain 8: Capabilities in education and training
Evidence to inform decision	MCR MSF TO Relevant training course End of placement reports

3.3 Specialty capabilities in practice

The specialty CiPs describe the clinical tasks or activities which are essential to the practice of Dermatology. The CiPs have been mapped to the nine GPC domains to reflect the professional generic capabilities required to undertake the clinical tasks.

Satisfactory sign off will require educational supervisors to make entrustment decisions on the level of supervision required for each CiP and if this is satisfactory for the stage of training, the trainee can progress. More detail is provided in the programme of assessment section of the curriculum.

KEY

CbD	Case-based discussion	DOPS	Direct observation of procedural skills
Mini-CEX	Mini-clinical evaluation exercise	MCR	Multiple consultant report
MSF	Multi source feedback	PS	Patient survey
QIPAT	Quality improvement project assessment tool	SCE	Specialty Certificate Examination
TO	Teaching observation	ACAT	Acute care assessment tool

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Specialty CiPs	
1. Outpatient dermatology: Managing dermatology patients in the outpatient setting	
Descriptors	• Demonstrate professional behaviour with regards to patients, carers, colleagues and others • Demonstrates effective consultation skills • Demonstrates high-level clinical skills and use of appropriate investigational tools to establish dermatological diagnoses in secondary care • Demonstrates appropriate use of assessment tools with regards to disease severity and impact on quality of life (eg PASI, EASI, MASI, PEST, HiSCR, DLQI) • Demonstrates understanding of dematopathology and laboratory techniques, ensuring appropriate investigation and clinicopathological correlation as necessary • Formulates and explains an appropriate management plan, taking into account patient preferences with focus on patient-centred care and shared decision making • Practices holistically in understanding psychosocial impact and mental health issues relating to dermatological disease • Demonstrates appropriate awareness of comorbidities and complex medical disease in relation to patients' dermatology conditions to enable holistic patient management, including how inflammatory skin diseases affect patients systemically eg severe psoriasis associated with cardiovascular disease • Demonstrates understanding of and follows local and national guidelines and clinical trial protocols • Demonstrates safe and effective prescription, management and monitoring of advanced systemic dermatological therapeutics such as immunomodulators, immunosuppressants, biologics, antimalarials, and retinoids, as well as topical therapy • Demonstrates awareness of the role of research (including immunological research) in understanding and management of dermatological disease • Demonstrates efficient time management skills in the general secondary outpatient clinic (indicative numbers 5 new and 8 review patients per clinic at end of training) and ability to discharge appropriately • Liaises with other specialty and primary care services when appropriate • Demonstrates ability to supervise multidisciplinary and multi-professional teams to deliver outpatient dermatology service • Shows awareness of patient journey and appropriate grading of referrals, ensuring patients are seen at the right place and right time • Demonstrates understanding of importance of clinical and educational governance
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty

	• clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF Mini-CEX CbD DOPS ACAT PS SCE Reflection on cases encountered, clinic attachments, independent study and teaching or courses attended if appropriate QIPAT or Audits performed or observed
2. Acute and emergency dermatology: Managing dermatological emergencies in all environments and managing an acute dermatology service including on-call	
Descriptors	• Demonstrates professional behaviour with regards to patients, carers, colleagues and others • Demonstrates prompt assessment and safe management of common and rare dermatological emergencies encountered in all settings • Formulates and explains an appropriate diagnostic and management plan, taking into account level of urgency and clinical risk • Demonstrates appropriate understanding of investigational tools and dematopathology required in the acute setting with recognition of need for clinicopathological correlation as necessary • Demonstrates clinical leadership, complex decision-making and risk management to ensure safe, effective, holistic and timely care for patients • Demonstrates effective telephone and teledermatology assessment and triage of referrals from GP and other specialties • Demonstrates good clinical judgement and appropriate telephone advice to colleagues on management of dermatologic disease • Demonstrates appropriate dermatological management of inpatients under the care of other specialties • Appropriate management of dermatology inpatients with common and rare skin disease, including management of related or unrelated medical comorbidities • Provides clinical leadership and good team working skills with dermatology inpatients, including those with complex medical conditions • Recognises the need to liaise with other specialty services where appropriate • Recognises and manages the deteriorating patient and refers appropriately to intensive care or high dependency unit

	• Demonstrates safe prescription and delivery of specialist dermatological treatments, with recognition and management of complications • Demonstrates understanding of and follows local and national guidelines and clinical trial protocols • Delivers patient-centred care including shared decision making • Ensures continuity of patient care through appropriate transfer of information with safe and effective handover and discharge planning
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	MCR MSF Mini-CEX CbD DOPS ACAT PS SCE Independent study and teaching or courses attended if appropriate QIPAT or Audits performed or observed
3. Liaison and community dermatology: Working in partnership with primary care and promotion of skin health	
Descriptors	• Demonstrates professional behaviour with regards to patients, carers, colleagues and others • Demonstrates ability to deliver holistic dermatology care across the primary-secondary care interface with understanding of leadership and management of teams of allied health professionals • Understands and takes into account psychosocial impact and mental health issues relating to dermatological disease • Able to communicate with primary care teams appropriately with understanding of what primary care can offer • Demonstrates effective telephone and teledermatology assessment with triage of referrals from GPs and multi-professional colleagues • Demonstrates appropriate telephone advice to colleagues for diagnosis and management of dermatologic disease • Demonstrates safe prescribing and monitoring of topical and systemic therapies using shared-care protocols • Recognises need for escalation from primary to secondary care for dermatological conditions

	• Demonstrates engagement with public health issues relating to dermatological disease and promotion of skin health • Understands issues relating to migrant populations and delivery of dermatological care in areas with poor resource
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR MSF Mini-CEX CbD DOPS PS SCE Reflective log of triage and emergencies Reflection on cases encountered, attachments, independent study and teaching or courses attended if appropriate Reflection on attachments in general practice observing GPs, community nurses and the administration processes in primary care
**4. Skin tumours and skin cancer:** Managing a comprehensive skin cancer and benign skin lesion service
Descriptors	• Able to diagnose and manage primary malignant disease of the skin including common and rare tumours, using the dermatoscope as appropriate • Able to diagnose and manage benign tumours of the skin and its appendages including common and rare lesions, using the dermatoscope as appropriate, thus avoiding unnecessary procedures • Able to accurately assess loco-regional and metastatic skin cancer and manage with a multi-professional approach • Able to identify, assess and effectively manage high risk skin cancer patients, eg immunosuppressed patients, dysplastic naevus syndrome, genodermatoses • Demonstrates understanding of skin cancer prevention and screening • Understands advanced topical and systemic medical management of skin cancer, including immunotherapy and signalling pathway inhibitors • Follows local and national guidelines and clinical trial protocols

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	- Safe and effective prescription, management and monitoring of dermatological medical therapeutics relating to skin cancer and pre-cancer - Understands non-surgical methods of skin cancer management eg radiotherapy - Demonstrates appropriate use of diagnostic imaging tools for primary and metastatic skin cancer eg dermoscopy, photography, CT or MRI scans - Demonstrates appropriate understanding of dematopathology and importance of clinicopathological correlation - Demonstrates professional behaviour with regards to patients, carers, colleagues and others - Delivers patient-centred care including shared decision making - Demonstrates effective consultation skills including challenging circumstances and breaking bad news - Ability to lead and work collaboratively within a skin cancer multidisciplinary team containing allied surgical specialties, oncologists, radiologists, histopathologists - Able to effectively manage an outpatient skin cancer 2 week wait clinic, including appropriate triage and discharge (indicative number: 15 new patients per clinic by end of training, when trainee reviewing patients without personally performing surgical procedures) - Demonstrates ability to supervise multidisciplinary and multi-professional teams to deliver outpatient dermatology 2 week wait service
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills - practical skills - communication and interpersonal skills - dealing with complexity and uncertainty - clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge - professional requirements - national legislative requirements - the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	MCR MSF Mini-CEX CbD DOPS PS SCE Reflection on cases encountered, clinic attachments in eg medical and clinical oncology, independent study and teaching or courses attended if appropriate Evidence of attendance and participation in skin cancer MDTs
5. Procedural dermatology: Performing skin surgery and other dermatological procedures	
Descriptors	- Understands clinical differential diagnoses prior to skin surgery to optimise care - Understands indications for full scope of dermatology surgical procedures - Able to appropriately perform surgical diagnostic procedures safely eg punch, shave, simple excision

	• Demonstrates knowledge of dermatopathological issues underpinning diagnostic biopsy to maximise outcome • Able to perform appropriate surgical procedures for skin cancer management eg wide excision. • Demonstrates compliance with national guidelines on excision margins • Understands indications for advanced surgical procedures eg Mohs micrographic surgery, flaps and graft repairs • Able to obtain valid consent, including understanding of capacity • Able to manage post-operative care, wound healing and complications • Able to perform cryotherapy for benign and precancerous or malignant lesions appropriately • Demonstrates ability to lead team delivering a surgical dermatology service • Understands use of laser therapy in dermatological disease and refers appropriately • Understands cosmetic dermatological procedures and can provide evidence-based counselling • Can diagnose complications from nonsurgical cosmetic procedures and counsel appropriately
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 6: Capabilities in patient safety and quality improvement
Evidence to inform decision	MCR MSF Mini-CEX CbD DOPS PS SCE Reflection on cases encountered, attachments/observation in eg laser therapy, independent study and teaching or courses attended if appropriate
6.Paediatric dermatology: Managing paediatric dermatology patients in all settings	
Descriptors	• Demonstrates professional behaviour in relation to paediatric patients and their carers • Demonstrates ability to take relevant paediatric history from patients and their carers • Able to diagnose and manage the same range of common and rare dermatologic disease in children as are found in adults, with the exception of occupational dermatoses

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	• Able to diagnose and manage common and rare conditions unique to neonatal, infant and paediatric population such as genodermatoses, congenital lesions, infectious disease • Able to triage and prioritise urgency of skin disease in paediatric population, escalate care when required and discharge appropriately • Formulates and explains an appropriate management plan, taking into account patient and family preferences with focus on patient-centred care and shared decision making • Able to triage and prioritise urgency of skin disease in paediatric population, escalate care when required and discharge appropriately • Shows safe and effective prescription, management and monitoring of topical and advanced systemic dermatological therapeutics in children with understanding of evidence for off-license use • Demonstrates understanding of and follows local and national guidelines and clinical trial protocols • Demonstrates appropriate understanding of dematopathology and laboratory techniques with clinicopathological correlation as necessary • Demonstrates appropriate use of assessment tools with regards to normal development, disease severity and impact on quality of life • Understands and takes into account psychosocial impact and mental health issues relating to dermatological disease in paediatric patient • Demonstrates ability to identify vulnerable children and engage in appropriate safeguarding • Demonstrates appropriate liaison with primary care and paediatric services • Demonstrates appropriate communication skills, sensitivity and professional behaviour towards paediatric patients, carers and multidisciplinary team
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR MSF Mini-CEX CbD DOPS PS

	SCE
	Reflection on cases encountered, clinic attachments, independent study and teaching or courses attended if appropriate

7. **Other specialist aspects of a comprehensive dermatological outpatient service** including:
7A) cutaneous allergy
7B) photobiology and phototherapy
7C) genital and mucosal disease
7D) hair and nail disease

Descriptors	**7A**
	• Ability to select patients appropriately for cutaneous allergy investigation
	• Ability to perform standard contact dermatitis investigations appropriately including allergen selection, test interpretation and communication of avoidance advice
	• Ability to diagnose and manage all forms of urticaria including use of advanced therapeutics eg biologics
	• Ability to refer patients with cutaneous allergy appropriately for tertiary care
	7B
	• Ability to counsel and select patients appropriately for phototherapy and photochemotherapy
	• Ability to supervise safe and appropriate delivery of phototherapy and photochemotherapy by allied health professionals
	• Ability to counsel and select patients appropriately for photodynamic therapy
	• Ability to supervise safe and appropriate delivery of photodynamic therapy by allied health professionals
	• Ability to diagnoses and manage photosensitive dermatological disease
	• Ability to refer photosensitive disease appropriately for tertiary care
	7C
	• Ability to diagnose and manage common and rare genital or oral dermatological disease, including premalignancy and malignancy
	• Recognises normal and anatomical variants relating to genitalia and oral cavity
	• Ability to diagnose and manage cutaneous disease with oral and mucosal manifestations
	• Demonstrates understanding of patient confidentiality issues and psychosocial impact of genital and mucosal dermatological disease
	• Ability to refer genital and mucosal dermatological disease appropriately for tertiary care
	• Ability to liaise with multidisciplinary specialists appropriately
	• Understanding of dermatopathology and clinicopathological correlation
	7D
	• Ability to diagnose and manage common and rare diseases of the hair and nails
	• Ability to diagnose and manage cutaneous disease with skin and hair manifestations
	• Understanding of dermatopathology and clinicopathological correlation
	• Ability to refer appropriately for tertiary care
GPCs	Domain 1: Professional values and behaviours
	Domain 2: Professional skills
	• practical skills
	• communication and interpersonal skills
	• dealing with complexity and uncertainty

	• clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries
Evidence to inform decision	MCR MSF Mini-CEX CbD DOPS PS SCE Reflection on cutaneous allergy attachment, cases encountered, other clinic attachments/ observation eg units that specialise in evaluation of photosensitive patients, GUM, Oral Medicine where possible, independent study and teaching or courses attended if appropriate Supervised workplace visit for occupational dermatoses

3.4 Presentations and conditions

The table below details the key presentations and conditions of Dermatology. Each of these should be regarded as a clinical context in which trainees should be able to demonstrate CiPs and GPCs. In this spiral curriculum, trainees will expand and develop the knowledge, skills and attitudes around managing patients with these conditions and presentations. The patient should always be at the centre of knowledge, learning and care.

Trainees must demonstrate core bedside skills, including information gathering through history and physical examination and information sharing with patients, families and colleagues.

Treatment care and strategy covers how a doctor selects drug treatments or interventions for a patient. It includes discussions and decisions as to whether care is focused mainly on curative intent or on symptomatic relief and management of chronic disease. It also covers broader aspects of care, including involvement of other professionals or services.

Particular presentations, conditions and issues are listed either because they are common or serious (having high morbidity, mortality and/or serious implications for treatment or public health).

For each condition/presentation, trainees will need to be familiar with such aspects as aetiology, epidemiology, clinical features, investigation, management and prognosis. Since there are more than 4,000 possible diagnoses relevant to the skin, our approach is to provide general guidance.

Curriculum area	Presentations	Conditions/Issues
Inflammatory dermatoses and erythroderma	Psoriasis, eczema, acneiform dermatoses, neutrophilic dermatoses, lichenoid dermatoses, pityriasis, granulomatous disease, leg ulcers	Aetiology and natural history Cutaneous and non-cutaneous presentations Assessment and diagnostic tools Dermatopathological correlation Dermatological therapeutics Psychosocial impact Associated co-morbidities Triage and prioritisation Cutaneous and non-cutaneous presentations Need for multi-specialty/multi-professional liaison
Connective tissue disease	Lupus eythematosus, dermatomyositis, mixed connective tissue disease, vasculitis, panniculitis, morphoea	Aetiology and natural history Cutaneous and non-cutaneous presentations Assessment and diagnostic tools Dermatopathological correlation Dermatological therapeutics Psychosocial impact Associated co-morbidities Triage and prioritisation Need for multi-specialty/multi-professional liaison
Cutaneous allergy and urticaria	Acute and life-threatening drug eruptions, contact and occupational dermatitis, urticaria, angioedema	Aetiology and natural history Cutaneous and non-cutaneous presentations Assessment and diagnostic tools Dermatopathological correlation Dermatological therapeutics Psychosocial impact Associated co-morbidities Triage and prioritisation Need for multi-specialty/multi-professional liaison
Immunobullous disease	Bullous pemphigoid, pemphigus vulgaris, other bullous dermatoses	Aetiology and natural history Cutaneous and non-cutaneous presentations Assessment and diagnostic tools Dermatopathological correlation Dermatological therapeutics Psychosocial impact Associated co-morbidities Triage and prioritisation Need for multi-specialty/multi-professional liaison

Curriculum area	Presentations	Conditions/Issues
Cutaneous infection and infestation	Bacterial, fungal, parasitic and viral disease affecting skin, hair and nails	Aetiology and natural history Cutaneous and non-cutaneous presentations Assessment and diagnostic tools Dermatopathological correlation Dermatological therapeutics Psychosocial impact Associated co-morbidities Triage and prioritisation Need for multi-specialty/multi-professional liaison Public health issues and education
Skin cancer and benign tumours	Melanoma, keratinocyte carcinomas (basal and squamous cell carcinoma), adnexal and other tumours, cutaneous lymphomas, benign skin lesions	Aetiology and natural history Cutaneous and non-cutaneous presentations Assessment and diagnostic tools Dermatopathological correlation Dermatological therapeutics Psychosocial impact and breaking bad news Associated co-morbidities Triage and prioritisation Need for multi-specialty/multi-professional liaison Public health issues and education Consent and competence Skin surgery and procedural issues
Paediatric dermatology	The full range of adult dermatoses excluding occupational dermatoses. Genodermatoses, congenital lesions, neonatal disease	Aetiology and natural history Cutaneous and non-cutaneous presentations Assessment and diagnostic tools Dermatopathological correlation Dermatological therapeutics in paediatric population Psychosocial impact and developmental issues Associated co-morbidities Triage and prioritisation Need for multi-specialty/multi-professional liaison Consent and child safe-guarding issues Genetic screening
Photodermatology	Primary and exogenous photodermatoses, photo-exacerbated dermatoses, metabolic and genetic photodermatoses	Aetiology and natural history Cutaneous and non-cutaneous presentations Assessment and diagnostic tools including photo-investigation and photo-diagnosis Dermatopathological correlation

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Curriculum area	Presentations	Conditions/Issues
		Dermatological therapeutics including photo-(chemo) therapy Psychosocial impact Associated co-morbidities Triage and prioritisation Need for multi-specialty/multi-professional liaison
Mucosal, hair and nail disease	Inflammatory and infectious disease, auto-immune disease, cancers, genodermatoses	Aetiology and natural history Cutaneous and non-cutaneous presentations Assessment and diagnostic tools Dermatopathological correlation Dermatological therapeutics Psychosocial and psychosexual impact Associated co-morbidities Triage and prioritisation Need for multi-specialty/multi-professional liaison Patient confidentiality Public health issues
Skin disease in pregnancy	Pregnancy-specific skin disease, hormone-related skin disease and pre-existing skin disease	Aetiology and natural history Cutaneous and non-cutaneous presentations Assessment and diagnostic tools Dermatopathological correlation Dermatological therapeutics and impact on embryo/foetus Psychosocial impact Associated co-morbidities Triage and prioritisation Need for multi-specialty/multi-professional liaison
Psychocutaneous medicine	Primary psychological or psychiatric conditions presenting as a skin condition Primary skin conditions exacerbated by/ presenting with psychological disease	Aetiology and natural history Cutaneous and non-cutaneous presentations Assessment and diagnostic tools Dermatological therapeutics Associated co-morbidities Need for multi-specialty/multi-professional liaison Patient confidentiality

3.5 Practical procedures

There are a number of procedural skills in which a trainee must become proficient. Trainees must be able to outline the indications for these procedures and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthetics, minimisation of patient discomfort, and requesting help when appropriate. For all practical

procedures the trainee must be able to recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary.

Trainees should receive training in procedural skills in a clinical skills lab if required. Assessment of procedural skills will be made using the direct observation of procedural skills (DOPS) tool. The table below sets out the minimum competency level expected for each of the practical procedures. The procedures must be achieved by the end of the indicated year of training but can be achieved in earlier years if the opportunity arises.

When a trainee has been signed off as being able to perform a procedure independently, they are not required to have any further assessment (DOPS) of that procedure, unless they or their educational supervisor think that this is required (in line with standard professional conduct), or additional skill sets are demonstrable, for example performing the same surgical procedure but at different anatomical sites, or using the dermatoscope on different lesions, eg benign, malignant and inflammatory skin disease.

Surgical procedures

Procedures to achieve by end of training year indicated	ST3	ST4	ST5	ST6
Curette and cautery	Competent to perform the procedure unsupervised	Maintain	Maintain	Maintain
Cryotherapy of benign or premalignant lesions	Competent to perform the procedure unsupervised	Maintain	Maintain	Maintain
Cryotherapy of superficial basal cell cancer		Competent to perform the procedure unsupervised	Maintain	Maintain
Dog ear repair				Competent to perform the procedure unsupervised
Excision of lesion on trunk or limbs with direct closure using deep (subcuticular) & surface (percutaneous) sutures		Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised	Maintain
Excision of lesion on head and neck with direct closure using deep (subcuticular) & surface			Able to perform the procedure under direct supervision	Competent to perform the procedure unsupervised

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Procedures to achieve by end of training year indicated	ST3	ST4	ST5	ST6
(percutaneous) sutures				
Incisional skin biopsy	Competent to perform the procedure unsupervised	Maintain	Maintain	Maintain
Punch biopsy	Competent to perform the procedure unsupervised	Maintain	Maintain	Maintain
Shave excision		Competent to perform the procedure unsupervised	Maintain	Maintain
Small flap repair				Able to perform the procedure under direct supervision
Genital/ mucosal biopsy				Competent to perform the procedure unsupervised

Non-surgical procedures

The following procedures must be achieved to a level of unsupervised practice by end of ST6

Procedure
Dermoscopy
Dermatology Life Quality Index and other assessment tools eg Psoriasis Area Severity Index, Eczema Area Severity Index
Triamcinolone injection
Take skin scrapings and nail clippings for mycology
Wood's light examination

The following procedures should be used to demonstrate learning but are not essential for a trainee to be able to perform themselves

Procedure
ABPI (ankle brachial pressure index) measurement
Allergen prick testing
Botulinum toxin injections for treatment of hyperhidrosis
Diphencyprone sensitisation
Iontophoresis
Minimal Erythema Dose or Minimal Phototoxic Dose (MED or MPD)
Microscopy of hair shaft
Microscopy of skin scrapings for fungi

Procedure
Microscopy for identification of scabies mite
Monochromator testing
Patch test application
Photopatch testing
Photoprovocation testing
Photodynamic therapy
Take a high-quality teledermatology medical localizing and close-up image using a mobile device

4 Learning and Teaching

4.1 The training programme

The organisation and delivery of postgraduate training is the responsibility of the Health Education England (HEE), NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical and Dental Training Agency (NIMDTA) – referred to from this point as 'deaneries.' A training programme director (TPD) will be responsible for coordinating the specialty training programme. In England, the local organisation and delivery of training is overseen by a School of Medicine.

Each training programme will have individual differences but should be structured to ensure comprehensive cover of the entire curriculum. The sequence of training should allow appropriate progression in experience and responsibility. Ideally, it should be flexible enough to enable the trainee to develop a special interest. The experience provided at each training site should ensure that all curriculum requirements are met whilst unnecessary duplication and educationally unrewarding experiences are avoided.

Some elements of the curriculum may require attachments to specialist clinics or units. For example, during the second or third year of training a trainee may undertake work in a specialist phototherapy clinic once a week for several months. The length of time required for each specialist attachment is flexible and will depend on the intensity of training experience and capabilities to be acquired, balanced with the wider training programme structure and service needs. This will vary from one training programme to another, and with the experience and ambitions of the trainee. Thus, the attachments will be agreed by the educational supervisor, training programme director and trainee.

Trainee weekly timetables will vary from one programme to another, and within each programme. In general, the average weekly timetable should include between 6 and 7 half day sessions of direct clinical experience. This should include one surgery session for most of the training programme. The remaining 3 to 4 sessions should be used for administrative work, personal study and research. In addition, the trainee should usually gain experience from out-of-hours on-call work during most of the training programme.

Progression through the programme will be determined by the Annual Review of Competency Progression (ARCP) process and the training requirements for each indicative

year of training are summarised in the ARCP decision aid (available on the JRCPTB website). Trainees will have an appropriate clinical supervisor and a named educational supervisor. The clinical supervisor and educational supervisor may be the same person.

The following provides a guide on how training programmes should be focused to enable trainees to gain the experience and develop the capabilities to the level required.

Dermatology clinics including specialty clinics: dermatology is primarily an outpatient based specialty and as such, clinics should compose a large proportion of training.

General dermatology outpatient: general clinics should comprise a significant part of the first year. It should also form a significant part of at least two more years of training. Trainees should see both new and review patients. The number of patients seen in clinic will vary with the complexity and year of training. As a rough guide for a programme director or supervisor, a trainee should be given approximately 10 patients to see within a general dermatology clinic by the end of ST3, eg 4 new and 6 review patients. By completion of training, they should be given 13-16 patients in a general dermatology outpatient clinic with a ratio of 1 new: 1.6 follow up, eg 5 new and 8 review patients.[11] Sufficient time must be made available for the clinical supervisor to teach and advise the trainee during these clinics.
Specialty outpatient clinics: sufficient time should be spent as attachments to specialised clinics (eg contact dermatitis, advanced and Mohs surgery, biologics, photobiology) to achieve the relevant specialty capabilities. Teaching in these clinics will be delivered by health practitioners with the relevant experience in the specialist area.

Acute dermatology-related take: the trainee must have a regular commitment to an acute dermatology-related take to allow sufficient experience of emergency dermatological presentations and become capable of managing acute serious skin disease in all environments. The trainee should be responsible for taking calls from community and hospital colleagues, and learn how to triage and prioritise appropriately, including need for urgent care. This on-call experience should cover the care of dermatology inpatients, urgent community referrals, referrals regarding inpatients on general wards (adult and paediatric), the intensive care unit and the emergency department.
Many hospitals no longer provide a 24-hour dermatology out-of-hours service. Although preferred, it is not always necessary to have an acute dermatology out-of-hours on-call service and training programmes will vary from region to region with respect to how the acute dermatology experience is provided. If out-of-hours cover is provided, then this is typically done as cover from home, and may be achieved by working an extended day or providing overnight and weekend cover. The time taken to achieve the necessary capabilities will vary from region to region. Any differences or changes in working patterns must not result in an overall loss of training experience. While providing out-of-hours cover, the trainee should be supported at all times by an on-call consultant.

Surgical lists: trainees should gain experience of dermatological surgery by performing a surgical list under supervision regularly, with increasing independence throughout training.

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[11] https://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=6127

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There should be sufficient exposure to gain the capabilities listed. Skills in advanced skin surgery may be acquired within a dedicated skin surgery list, supervised by a healthcare professional with expertise in this area.

Management and leadership: trainees should gain experience and confidence in leading clinical teams eg supervising other doctors and allied professionals, in order to run an outpatient clinic or community service. Trainees should be allowed to attend and contribute to departmental management meetings, especially in the final year of training, to acquire understanding and experience of NHS management. They should also be allowed to take an active role in governance structures, eg leading a governance or audit meeting, and adoption of leadership roles, eg audit lead, rota organiser, trainee representative, organising academic meetings.

Dermatopathology: dermatopathologists are not available in all hospitals and the subject is complex. The trainee should be given the opportunity to evaluate histological skin slides. Ideally, they should be able to discuss appropriate clinical diagnoses with the histopathology team, ensuring they are able to correlate pathology findings with clinical features.

Teledermatology: trainees should be given sufficient exposure to teledermatology consultations with primary, intermediate or secondary care, to enable proficiency in running a service themselves. They should be supervised by a healthcare professional with expertise in this area with increasing independence throughout training.

4.2 Teaching and learning methods

The curriculum will be delivered through a variety of learning experiences and will achieve the capabilities through a variety of learning methods. There will be a balance of different modes of learning from formal teaching programmes to experiential learning 'on the job'. The proportion of time allocated to different learning methods may vary depending on the nature of the attachment within a rotation.

Where it is clear from trainees' experience that parts of the curriculum are not being delivered within their workplace, appropriate off-the-job education or rotations to other workplaces can be arranged. In addition, British Association of Dermatologists' co-badged courses can supplement training where exposure on-site may be lacking. Regular meetings with the educational supervisor will monitor the trainee's on-going progress to determine whether parts of the curriculum are not being delivered within their present workplace.

This section identifies the types of situations in which a trainee will learn.

Work-based experiential learning
Most of the dermatology curriculum is suited to delivery by work-based experiential learning and on-the-job supervision. The content of work-based experiential learning is decided by the local faculty for education but includes active participation.

The educational objectives of attending clinics are:

- To understand how to plan and run an outpatient clinic, managing large numbers of new and review patients, whilst supervising juniors and affiliated staff.
- To understand the management of chronic skin diseases.
- To understand the assessment and management of skin cancer and benign tumours.
- Be able to assess and manage a patient in a defined timeframe.
- To interpret and act on the referral letter to clinic.
- To propose an investigation and management plan in a setting different from the acute medical situation.
- To review and amend existing investigation plans.
- To write an acceptable letter back to the referrer and patient.
- To communicate with the patient and where necessary relatives and other health care professionals.

These objectives can be achieved in a variety of settings including hospitals, day care facilities and the community. The clinic might be run primarily by a specialist nurse (or other qualified health care professionals) rather than a consultant.

After initial induction, trainees will review patients in clinic settings, under direct supervision. The degree of responsibility taken by the trainee will increase as competency increases. Trainees should see a range of new and follow-up patients and present their findings to their clinical supervisor. Clinic letters written by the trainee should also be reviewed and feedback given.

Clinic experience should be used as an opportunity to undertake supervised learning events and reflection.

Acute dermatology-related take and reviewing patients with consultants
It is important that trainees have an opportunity to present at least a proportion of the patients whom they have seen on-call to their consultant for senior review in order to obtain immediate feedback into their performance (that may be supplemented by an appropriate WBA or SLE such as a mini-CEX, CBD or ACAT). This may be accomplished when working on call alongside a consultant, or on a post-take ward round with a consultant.

Supervisors should expect to discuss the diagnosis and management of all on-call or ward referrals with trainees during their first year, and to accompany them to review many of the cases thereafter. Trainees should be given increasing responsibility for carrying out consultations independently, but consultant advice should be readily available at all times.

Personal ward rounds and provision of ongoing clinical care for dermatology inpatients
Although dermatology is primarily an outpatient-based specialty where ongoing clinical care is managed in patients with chronic skin disease, every patient seen on the ward also provides a learning opportunity. This includes dermatology inpatients and inpatient referrals. Learning will be enhanced by following the patient through the course of their dermatological illness. The experience of the evolution of patients' problems over time is a

critical part both of the diagnostic process as well as management. Patients seen should provide the basis for critical reading and reflection on clinical problems.

Trainees have supervised responsibility for the care of inpatients. This includes day-to-day review of clinical conditions, note keeping, and the initial management of the acutely ill patient with referral to and liaison with clinical colleagues as necessary. The degree of responsibility taken by the trainee will increase as competency increases. There should be appropriate levels of clinical supervision throughout training, with increasing clinical independence and responsibility. Every time a trainee observes another doctor seeing a patient or their relatives there is an opportunity for learning. Ward rounds should be led by a more senior doctor and include feedback on clinical and decision-making skills.

Multidisciplinary team meetings
There are many situations where clinical problems are discussed with clinicians in other disciplines. These provide excellent opportunities for observation of clinical reasoning. For example, skills in assessing and managing skin cancer will be gained via attendance at multidisciplinary skin cancer meetings or clinics, which includes clinicopathological correlation.

Formal postgraduate teaching
The content of these sessions is determined by the local faculty of medical education and will be based on the curriculum. There are many opportunities throughout the year for formal teaching in the local postgraduate teaching sessions and at regional, national and international meetings.

Suggested activities include:
- a programme of formal bleep-free regular teaching sessions
- case presentations
- research, audit and quality improvement projects
- lectures and small group teaching
- Grand Rounds
- clinical skills demonstrations and teaching
- critical appraisal and evidence-based medicine and journal clubs
- joint specialty meetings
- attendance at training programmes organised on a deanery or regional basis, which are designed to cover aspects of the training programme outlined in this curriculum.

Learning with peers
There are many opportunities for trainees to learn with or from their peers. Local postgraduate teaching opportunities allow trainees of varied levels of experience to come together for small group sessions.

Independent self-directed learning
Trainees will use this time in a variety of ways depending upon their stage of learning. Suggested activities include:
- reading, including web-based material such as e-Learning for Healthcare (e-LfH)
- maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)
- audit, quality improvement and research projects
- reading journals
- achieving personal learning goals beyond the essential, core curriculum.

Formal study courses
Time to be made available for formal courses is encouraged, subject to local conditions of service. Examples include management and leadership courses and communication courses, which are particularly relevant to patient safety and experience.

No single course is considered compulsory. The choice of which course to attend should be considered and decided upon by the educational supervisor and trainee, taking in to account training opportunities within the local training programme.
In additional the trainee should be able to attend national training opportunities for delivery of external teaching. A full list of national available courses and meetings in dermatology in the UK is available on the British Association of Dermatologists website (www.BAD.org.uk). The trainee does not need to attend all of these but should discuss with their Educational Supervisor which are likely to be of most use to them as an individual. This will depend on the local strengths of the training department, and on the trainee's particular interests.

4.3 Academic training

The four nations have different arrangements for academic training and doctors in training should consult the local deanery for further guidance.

Trainees may train in academic medicine as an academic clinical fellow (ACF), academic clinical lecturer (ACL) or equivalent.

Some trainees may opt to do research leading to a higher degree without being appointed to a formal academic programme. This new curriculum should not impact in any way on the ability to take time out of programme for research (OOPR) but such time requires agreement between the trainee, the TPD and the Deanery with guidance from the appropriate SAC.

4.4 Taking time out of programme

There are a number of circumstances when a trainee may seek to spend some time out of specialty training, such as undertaking a period of research or taking up a fellowship post. All such requests must be agreed by the postgraduate dean in advance and trainees are advised to discuss their proposals as early as possible. Full guidance on taking time out of programme can be found in the Gold Guide.

4.5 Acting up as a consultant

A trainee coming towards the end of their training may spend up to three months "acting-up" as a consultant, provided that a consultant supervisor is identified for the post and satisfactory progress is made. As long as the trainee remains within an approved training programme, the GMC does not need to approve this period of "acting up" and their original CCT date will not be affected. More information on acting up as a consultant can be found in the Gold Guide.

5 Programme of Assessment

5.1 Purpose of assessment

The purpose of the programme of assessment is to:
- assess trainees' actual performance in the workplace
- enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, understand their own performance and identify areas for development
- drive learning and enhance the training process by clarifying what is required and motivating the trainee to ensure they receive suitable training and experience
- demonstrate trainees have acquired the GPCs and meet the requirements of GMP
- ensure that trainees possess the essential underlying knowledge required for their specialty
- provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme
- inform the ARCP, identify any requirements for targeted or additional training and facilitate decisions regarding progression through the training programme
- identify trainees who should be advised to consider changes of career direction.

5.2 Programme of Assessment

Our programme of assessment refers to the integrated framework of exams, assessments in the workplace and judgements made about a learner during their approved programme of training. The purpose of the programme of assessment is to robustly evidence, ensure and clearly communicate the expected levels of performance at critical progression points and to demonstrate satisfactory completion of training as required by the curriculum.

The programme of assessment is comprised of several different types of assessment. A range of assessments is needed to generate the necessary evidence required to form global judgements about satisfactory performance, progression, and completion of training. All assessments, including those conducted in the workplace, are linked to the relevant curricular learning outcomes (eg through the blueprinting of assessment system to the stated curricular outcomes).

The programme of assessment emphasises the importance and centrality of professional judgement in making sure learners have met the outcomes and expected levels of performance set out in the approved curricula. Assessors will make accountable

professional judgements. The programme of assessment includes how professional judgements are used and collated to support decisions on progression and satisfactory completion of training.

The assessments will be supported by structured feedback for trainees. Assessment tools will be both formative and summative and have been selected on the basis of their fitness for purpose.

Assessment will take place throughout the training programme to allow trainees to continually gather evidence of learning and to provide formative feedback. Formative assessment tools will contribute to summative judgements about a trainee's progress as part of the programme of assessment. The number and range of these will ensure a reliable assessment of the training relevant to their stage of training and achieve coverage of the curriculum.

Reflection and feedback should be an integral component to all SLEs and WBPAs. In order for trainees to maximise benefit, reflection and feedback should take place as soon as possible after an event. Every clinical encounter can provide a unique opportunity for reflection and feedback and this process should occur frequently. Feedback should be of high quality and should include an action plan for future development for the trainee. Both trainees and trainers should recognise and respect cultural differences when giving and receiving feedback.

5.3 Assessment of CiPs

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks.

Clinical supervisors and others contributing to assessment will provide formative feedback to the trainee on their performance throughout the training year. This feedback will include a global rating in order to indicate to the trainee and the educational supervisor how they are progressing at that stage of training. To support this, workplace based assessments and multiple consultant reports will include global assessment anchor statements.

Global assessment anchor statements

➤ Below expectations for this year of training; may not meet the requirements for critical progression point
➤ Meeting expectations for this year of training; expected to progress to next stage of training
➤ Above expectations for this year of training; expected to progress to next stage of training

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Towards the end of the training year, trainees will make a self-assessment of their progression for each CiP and record this in the eportfolio with signposting to the evidence to support their rating.

The educational supervisor (ES) will review the evidence in the eportfolio including workplace based assessments, feedback received from clinical supervisors (via the Multiple

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Consultant Report) and the trainee's self-assessment and record their judgement on the trainee's performance in the ES report, with commentary.

For **generic CiPs**, the ES will indicate whether or not the trainee is meeting expectations using the global anchor statements above. Trainees will need to meet or exceed expectations for the stage of training in order to progress to the next training year.

For **specialty CiPs**, the ES will make an entrustment decision for each CiP and record the indicative level of supervision required with detailed comments to justify their entrustment decision. The ES will also indicate the most appropriate global anchor statement (see above) for overall performance.

Level descriptors for specialty CiPs

Level	Descriptor
Level 1	**Entrusted to observe only** – no provision of clinical care
Level 2	**Entrusted to act with direct supervision**: The trainee may provide clinical care, but the supervising physician is physically within the hospital or other site of patient care and is immediately available if required to provide direct bedside supervision
Level 3	**Entrusted to act with indirect supervision**: The trainee may provide clinical care when the supervising physician is not physically present within the hospital or other site of patient care, but is available by means of telephone and/or electronic media to provide advice, and can attend at the bedside if required to provide direct supervision
Level 4	**Entrusted to act unsupervised**

The ARCP will be informed by the ES report and the evidence presented in the e-Portfolio. The ARCP panel will make the final summative judgement on whether the trainee has achieved the generic outcomes and the appropriate level of supervision for each CiP. The ARCP panel will determine whether the trainee can progress to the next year/level of training in accordance with the Gold Guide. ARCPs will be held for each training year. The final ARCP will ensure trainees have achieved level 4 in all CiPs for the critical progression point at completion of training.

5.4 Critical progression points

There will be a key progression point on completion of specialty training. Trainees will be required to be entrusted at level 4 in all CiPs by the end of training in order to achieve an ARCP outcome 6 and be recommended for a CCT.

The educational supervisor report will make a recommendation to the ARCP panel as to whether the trainee has met the defined levels for the CiPs and acquired the procedural competence required for each year of training. The ARCP panel will make the final decision on whether the trainee can be signed off and progress to the next year/level of training [see section 5.6].

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In Table 1 an outline grid sets out the expected level of supervision and entrustment for the specialty CiPs and includes the critical progression points across the whole training programme.

Table 1: Outline grid of levels expected for Dermatology specialty CiPs

Level descriptors
Level 1: Entrusted to observe only – no clinical care
Level 2: Entrusted to act with direct supervision
Level 3: Entrusted to act with indirect supervision
Level 4: Entrusted to act unsupervised

Specialty CiP	Specialty training				CCT
	ST3	ST4	ST5	ST6	
1. **Outpatient dermatology**: managing dermatology patients in the outpatient setting	2	3	3	4	CRITICAL PROGRESSION POINT
2. **Acute and emergency dermatology**: managing dermatological emergencies in all environments and managing an acute dermatology service including on-call	2	3	3	4	
3.**Liaison and community dermatology**: working in partnership with primary care and promoting skin health	2	3	3	4	
4.**Skin tumours and skin cancer**: managing a comprehensive skin cancer and benign skin lesion service	2	3	3	4	
5.**Procedural dermatology**: performing skin surgery and other dermatological procedures	2	3 (with suitable case selection)	3 (with suitable case selection)	4	
6.**Paediatric dermatology**: managing paediatric dermatology patients in all settings	2	2	3	4	
7.**Other specialist aspects of a comprehensive dermatological service** including: 7A) cutaneous allergy 7B) photobiology and phototherapy 7C) genital and mucosal disease 7D) hair and nail disease	2	2	3	4	

5.5 Evidence of progress

The following methods of assessment will provide evidence of progress in the integrated programme of assessment. The requirements for each training year/level are stipulated in the ARCP decision aid (www.jrcptb.org.uk).

Summative assessment

Examinations and certificates
- Specialty Certificate Examination in Dermatology (SCE)

Workplace based assessment (WPBA)
- Surgical Direct Observation of Procedural Skills (DOPS) – summative
- Non-surgical Direct Observation of Procedural Skills (DOPS) – summative

Formative assessment

Supervised Learning Events (SLEs)
- Case-Based Discussions (CbD)
- mini-Clinical Evaluation Exercise (mini-CEX)
- Acute Care Assessment Tool (ACAT)

WPBA
- Surgical Direct Observation of Procedural Skills (surgical DOPS) – formative
- Non-surgical Direct Observation of Procedural Skills (non-surgical DOPS) – formative
- Multi-Source Feedback (MSF)
- Patient Survey (PS)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)

Supervisor reports

- Multiple Consultant Report (MCR)
- Educational Supervisor Report (ESR)
- Research Supervisor Report (RSR)

These methods are described briefly below. More information and guidance for trainees and assessors are available in the e-Portfolio and on the JRCPTB website ([www.jrcptb.org.uk)](www.jrcptb.org.uk).

Assessment should be recorded in the trainee's eportfolio. These methods include feedback opportunities as an integral part of the programme of assessment.

Case-based Discussion (CbD)
The CbD assesses the performance of a trainee in their management a patient to provide an indication of competence in areas such as clinical reasoning, decision-making and application of medical knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by trainees. The CbD should

focus on a written record (such as written case notes, outpatient letter, and discharge summary). A typical encounter might be when presenting newly referred patients in the outpatient department.

Mini-Clinical Evaluation Exercise (mini-CEX)
This tool evaluates a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as history taking, examination and clinical reasoning. The trainee receives immediate feedback to aid learning. The mini-CEX can be used at any time and in any setting when there is a trainee and patient interaction and an assessor is available.

Direct Observation of Procedural Skills (DOPS)
A DOPS is an assessment tool designed to evaluate the performance of a trainee in undertaking a practical procedure, against a structured checklist. In Dermatology, the majority of DOPS relate to skin surgery/ cryotherapy, but nonsurgical DOPS have also been designed for other practical procedures such as obtaining mycology samples and injecting triamcinolone. The trainee receives immediate feedback to identify strengths and areas for development. DOPS can be undertaken as many times as the trainee and their supervisor feel is necessary (formative). A trainee can be regarded as competent to perform a procedure independently after they are signed off as such by an appropriate assessor (summative).

Multi-source feedback (MSF)
This tool is a method of assessing generic skills such as communication, leadership, team working, reliability etc, across the domains of Good Medical Practice. This provides systematic collection and feedback of performance data on a trainee, derived from a number of colleagues. 'Raters' are individuals with whom the trainee works, and includes doctors, administrative staff, and other allied professionals. Raters should be agreed with the educational supervisor at the start of the training year. The trainee will not see the individual responses by raters. Feedback is given to the trainee by the educational supervisor.

Patient Survey (PS)
A trainee's interaction with patients should be continually observed and assessed. The Patient Survey provides a tool to assess a trainee during a consultation period. The Patient Survey assesses the trainee's performance in areas such as interpersonal skills, communication skills and professionalism.

Quality Improvement Project Assessment Tool (QIPAT)
The QIPAT is designed to assess a trainee's competence in completing a quality improvement project. The QIPAT can be based on review of quality improvement project documentation or on a presentation of the quality improvement project at a meeting. If possible, the trainee should be assessed on the same quality improvement project by more than one assessor.

Teaching Observation (TO)
The TO form is designed to provide structured, formative feedback to trainees on their competence at teaching. The TO can be based on any instance of formalised teaching by the

trainee which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors).

Acute care assessment tool (ACAT)
The ACAT was designed to assess and facilitate feedback on a doctor's performance during their practice on the acute medical take. In dermatology, this tool could be used by the clinical supervisor when assessing other situations where a trainee is interacting with a number of different patients eg in an outpatient clinic or after an on-call session. It would enable feedback on how to plan and run an outpatient clinic efficiently. When assessing an on-call session, it would allow feedback on ability to triage and prioritise patients.

Multiple Consultant Report (MCR)
The MCR captures the views of consultant supervisors based on observation on a trainee's performance in practice. The MCR feedback and comments received give valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required. MCR feedback will be available to the trainee and contribute to the educational supervisor's report.

Educational supervisors report (ESR)
The ES will periodically (at least annually) record a longitudinal, global report of a trainee's progress based on a range of assessment, potentially including observations in practice or reflection on behaviour by those who have appropriate expertise and experience. The ESR will include the ES's summative judgement of the trainee's performance and the entrustment decisions given for the learning outcomes (CiPs). The ESR can incorporate commentary or reports from longitudinal observations, such as from supervisors (MCRs) and formative assessments demonstrating progress over time.

Speciality Certificate Examination
The Specialty Certificate Examination has been developed by the Federation of Royal Colleges of Physicians in conjunction with the British Association of Dermatologists. The examination tests the extra knowledge base that trainees have acquired since taking the MRCP(UK) diploma. The knowledge base itself must be associated with adequate use of such knowledge and passing this examination must be combined with satisfactory progress in workplace based assessments for the trainee to successfully reach the end of training and be awarded the CCT in Dermatology. Information is available on the MRCPUK website.

5.6 Decisions on progress (ARCP)

The decisions made at critical progression points and upon completion of training should be clear and defensible. They must be fair and robust and make use of evidence from a range of assessments, potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise or experience. They can also incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

Periodic (at least annual) review should be used to collate and systematically review evidence about a doctor's performance and progress in a holistic way and make decisions about their progression in training. The annual review of progression (ARCP) process

supports the collation and integration of evidence to make decisions about the achievement of expected outcomes.

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks, as do decisions about the satisfactory completion of presentations/conditions and procedural skills set out in this curriculum. The outline grid in section 5.4 sets out the level of supervision expected for each of the clinical and specialty CiPs. The table of practical procedures sets out the minimum level of performance expected at the end of each year or training. The requirements for each year of training are set out in the ARCP decision aid (www.jrcptb.org.uk).

The ARCP process is described in the Gold Guide. Deaneries are responsible for organising and conducting ARCPs. The evidence to be reviewed by ARCP panels should be collected in the trainee's e-Portfolio.

As a precursor to ARCPs, JRCPTB strongly recommends that trainees have an informal e-Portfolio review either with their educational supervisor or arranged by the local school of medicine. These provide opportunities for early detection of trainees who are failing to gather the required evidence for ARCP.

In order to guide trainees, supervisors and the ARCP panel, JRCPTB has produced an ARCP decision aid which sets out the requirements for a satisfactory ARCP outcome at the end of each training year and critical progression point. The ARCP decision aid is available on the JRCPTB website www.jrcptb.org.uk.

The penultimate ARCP prior to the anticipated CCT date will include an external assessor from outside the training programme. This is known as a Penultimate Year Assessment (PYA) and will identify any outstanding targets that the trainee will need to complete to meet all the learning outcomes.

Poor performance should be managed in line with the Gold Guide.

5.7 Assessment blueprint

The table below show the possible methods of assessment for each CiP. It is not expected that every method will be used for each competency and additional evidence may be used to help make a judgement on capability.

KEY -

ACAT	Acute care assessment tool	CbD	Case-based discussion
DOPS	Direct observation of procedural skills	Mini-CEX	Mini-clinical evaluation exercise
MCR	Multiple consultant report	MSF	Multi source feedback
PS	Patient survey	QIPAT	Quality improvement project assessment tool
SCE	Specialty Certificate Examination	TO	Teaching observation

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Blueprint for WPBAs mapped to CiPs

Learning outcomes	CbD	DOPS	MCR	Mini-CEX	MSF	PS	QIPAT	TO	ACAT
Generic CiPs									
Able to function successfully within NHS organisational and management systems			√		√		√	√	
Able to deal with ethical and legal issues related to clinical practice	√	√	√	√	√				
Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement	√	√	√	√	√	√			
Is focused on patient safety and delivers effective quality improvement in patient care	√	√	√	√	√		√	√	
Carrying out research and managing data appropriately			√		√		√	√	
Acting as a clinical teacher and clinical supervisor			√		√			√	
Specialty CiPs									
Outpatient Dermatology: managing dermatology patients in the outpatient setting	√	√	√	√	√	√	√		√
Acute and Emergency Dermatology: managing dermatological emergencies in all environments and managing an acute dermatology service including on-call	√	√	√	√	√	√	√		√
Liaison and Community Dermatology: working in partnership with primary care and promoting skin health	√	√	√	√	√	√	√		
Skin cancer and skin tumours: managing a comprehensive skin cancer and benign skin lesion service	√	√	√	√	√	√	√		
Procedural Dermatology: performing skin surgery and other dermatological procedures	√	√	√	√	√	√	√		
Paediatric Dermatology: managing paediatric dermatology patients in all settings	√	√	√	√	√	√	√		√
Other specialist aspects: of a comprehensive dermatological outpatient service including: 7A) cutaneous allergy 7B) photobiology and phototherapy 7C) genital and mucosal disease 7D) hair and nail disease	√	√	√	√	√	√	√		√

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Blueprint for examination (SCE) mapped to CiPs

Learning outcomes	SCE/ KBA
Specialty CiPs	
Outpatient dermatology: managing dermatology patients in the outpatient setting	√
Acute and emergency dermatology: managing dermatological emergencies in all environments and managing an acute Dermatology service including on-call	√
Liaison and community dermatology: working in partnership with primary care and promoting skin health	√
Skin cancer and skin tumours: managing a comprehensive skin cancer and benign skin lesion service	√
Procedural dermatology: performing skin surgery and other dermatological procedures	√
Paediatric dermatology: managing paediatric dermatology patients in all settings	√
Other specialist aspects: of a comprehensive dermatological outpatient service including: 7A) cutaneous allergy 7B) photobiology and phototherapy 7C) genital and mucosal disease 7D) hair and nail disease	√

6 Supervision and feedback

This section of the curriculum describes how trainees will be supervised, and how they will receive feedback on performance. For further information please refer to the AoMRC guidance on Improving feedback and reflection to improve learning[12].

Access to high quality, supportive and constructive feedback is essential for the professional development of the trainee. Trainee reflection is an important part of the feedback process and exploration of that reflection with the trainer should ideally be a two-way dialogue. Effective feedback is known to enhance learning and combining self-reflection to feedback promotes deeper learning. A Reflective Log on triage and emergency cases should be submitted to support specialty specific CiPs 1, 2 and 3.

Trainers should be supported to deliver valuable and high-quality feedback. This can be by providing face to face training to trainers. Trainees would also benefit from such training as they frequently act as assessors to junior doctors, and all involved could also be shown how best to carry out and record reflection.

6.1 Supervision

All elements of work in training posts must be supervised with the level of supervision varying depending on the experience of the trainee and the clinical exposure and case mix undertaken. Outpatient and referral supervision must routinely include the opportunity to discuss all cases with a supervisor if appropriate. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

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[12] Improving feedback and reflection to improve learning. A practical guide for trainees and trainers

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Organisations must make sure that each doctor in training has access to a named clinical supervisor and a named educational supervisor. Depending on local arrangements these roles may be combined into a single role of educational supervisor. However, it is preferred that a trainee has a single named educational supervisor for (at least) a full training year, in which case the clinical supervisor is likely to be a different consultant during some placements.

The role and responsibilities of supervisors have been defined by the GMC in their standards for medical education and training[13].

Educational supervisor

The educational supervisor is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements.

Clinical supervisor

Consultants responsible for patients that a trainee looks after provide clinical supervision for that trainee and thereby contribute to their training; they may also contribute to assessment of their performance by completing a 'Multiple Consultant Report (MCR)' and other WPBAs. A trainee may also be allocated (for instance, if they are not working with their educational supervisor in a particular placement) a named clinical supervisor, who is responsible for reviewing the trainee's training and progress during a particular placement. It is expected that a named clinical supervisor will provide a MCR for the trainee to inform the educational supervisor's report.

When meeting the trainee, the educational and relevant clinical supervisors, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. If the service lead (clinical director) has any concerns about the performance of the trainee, or there are issues of doctor or patient safety, these would be discussed with the clinical and educational supervisors as well as the trainee. These processes, which are integral to trainee development, must not detract from the statutory duty of the trust to deliver effective clinical governance through its management systems.

Educational and clinical supervisors need to be formally recognised by the GMC to carry out their roles[14]. It is essential that training in assessment is provided for trainers and trainees in order to ensure that there is complete understanding of the assessment system, assessment methods, their purposes and use. Training will ensure a shared understanding and a consistency in the use of the WPBAs and the application of standards.

Opportunities for feedback to trainees about their performance will arise through the use of the workplace based assessments, regular appraisal meetings with supervisors, other meetings and discussions with supervisors and colleagues, and feedback from ARCP.

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[13] Promoting excellence: standards for medical education and training
[14] Recognition and approval of trainers

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Trainees

Trainees should make the safety of patients their first priority and they should not be practising in clinical scenarios which are beyond their experiences and competencies without supervision. Trainees should actively devise individual learning goals in discussion with their trainers and should subsequently identify the appropriate opportunities to achieve said learning goals. Trainees need to plan their WPBAs accordingly to enable their WPBAs to collectively provide a picture of their development during a training period. Trainees should actively seek guidance from their trainers in order to identify the appropriate learning opportunities and plan the appropriate frequencies and types of WPBAs according to their individual learning needs. It is the responsibility of trainees to seek feedback following learning opportunities and WPBAs. It is the trainee's responsibility to organise these assessments in a timely fashion throughout the training year. Trainees should self-reflect and self-evaluate regularly with the aid of feedback. Furthermore, trainees should formulate action plans with further learning goals in discussion with their trainers.

6.2 Appraisal

A formal process of appraisals and reviews underpins training. This process ensures adequate supervision during training, provides continuity between posts and different supervisors and is one of the main ways of providing feedback to trainees. All appraisals should be recorded in the e-Portfolio

Induction Appraisal

The trainee and educational supervisor should have an appraisal meeting at the beginning of each post to review the trainee's progress so far, agree learning objectives for the post ahead and identify the learning opportunities presented by the post. Reviewing progress through the curriculum will help trainees to compile an effective Personal Development Plan (PDP) of curriculum objectives for the upcoming post. This PDP should be agreed during the Induction Appraisal. The trainee and supervisor should also both sign the educational agreement in the e-portfolio at this time, recording their commitment to the training process.

Mid-point Review

This meeting between trainee and educational supervisor is not mandatory (particularly when an attachment is shorter than 6 months) but is encouraged particularly if either the trainee or educational or clinical supervisor has training concerns or the trainee has been set specific targeted training objectives at their ARCP). At this meeting trainees should review their PDP with their supervisor using evidence from the e-portfolio. Workplace based assessments and progress through the curriculum can be reviewed to ensure trainees are progressing satisfactorily, and attendance at educational events should also be reviewed. The PDP can be amended at this review.

End of Attachment Appraisal

Trainees should review the PDP and curriculum progress with their educational supervisor using evidence from the e-portfolio. Specific concerns may be highlighted from this appraisal. The end of attachment appraisal form should record the areas where further work is required to overcome any shortcomings. Further evidence of competence in certain

areas may be needed, such as planned workplace based assessments, and this should be recorded. If there are significant concerns following the end-of-attachment appraisal then the programme director should be informed. Supervisors should also identify areas where a trainee has performed about the level expected and highlight successes.

7 Quality Management

The organisation of training programs is the responsibility of the deaneries. The deaneries will oversee programmes for postgraduate medical training in their regions. The Schools of Medicine in England, Wales and Northern Ireland and the Medical Specialty Training Board in Scotland will undertake the following roles:

- oversee recruitment and induction of trainees into dermatology
- allocate trainees into particular rotations appropriate to their training needs
- oversee the quality of training posts provided locally
- ensure adequate provision of appropriate educational events
- ensure curricula implementation across training programmes
- oversee the workplace based assessment process within programmes
- coordinate the ARCP process for trainees
- provide adequate and appropriate career advice
- provide systems to identify and assist doctors with training difficulties
- provide flexible training.

Educational programmes to train educational supervisors and assessors in workplace based assessment may be delivered by deaneries, the British Association of Dermatologists and the Royal Colleges.

Development, implementation, monitoring and review of the curriculum are the responsibility of the JRCPTB and the SAC. The committee will be formally constituted with representatives from each health region in England, from the devolved nations and with trainee and lay representation. It will be the responsibility of the JRCPTB to ensure that curriculum developments are communicated to heads of school, regional specialty training committees and TPDs.

The JRCPTB has a role in quality management by monitoring and driving improvement in the standard of all medical specialties on behalf of the three Royal Colleges of Physicians in Edinburgh, Glasgow and London. The SACs are actively involved in assisting and supporting deaneries to manage and improve the quality of education within each of their approved training locations. They are tasked with activities central to assuring the quality of medical education such as writing the curriculum and assessment systems, reviewing applications for new posts and programmes, provision of external advisors to deaneries and recommending trainees eligible for CCT or Certificate of Eligibility for Specialist Registration (CESR).

JRCPTB uses data from six quality datasets across its specialties and subspecialties to provide meaningful quality management. The datasets include the GMC National Training Survey (NTS) data, ARCP outcomes, examination outcomes, new consultant survey,

penultimate year assessments (PYA)/external advisor reports and the monitoring visit reports.

Quality criteria have been developed to drive up the quality of training environments and ultimately improve patient safety and experience. These are monitored and reviewed by JRCPTB to improve the provision of training and ensure enhanced educational experiences.

8 Intended use of curriculum by trainers and trainees

This curriculum and ARCP decision aid are available from the Joint Royal Colleges of Physicians Training Board (JRCPTB) via the website www.jrcptb.org.uk.

Clinical and educational supervisors should use the curriculum and decision aid as the basis of their discussion with trainees, particularly during the appraisal process. Both trainers and trainees are expected to have a good knowledge of the curriculum and should use it as a guide for their training programme.

Each trainee will engage with the curriculum by maintaining an e-Portfolio. The trainee will use the curriculum to develop learning objectives and reflect on learning experiences.

Recording progress in the ePortfolio

Upon enrolling with JRCPTB, trainees will be given access to the ePortfolio. The ePortfolio allows evidence to be built up to inform decisions on a trainee's progress and provides tools to support trainees' education and development.

The trainee's main responsibilities are to ensure the ePortfolio is kept up to date, arrange assessments and ensure they are recorded, prepare drafts of appraisal forms, maintain their personal development plan, record their reflections on learning and record their progress through the curriculum.

The supervisor's main responsibilities are to use ePortfolio evidence such as outcomes of assessments, reflections and personal development plans to inform appraisal meetings. They are also expected to update the trainee's record of progress through the curriculum, write end-of-attachment appraisals and supervisor's reports.

Deaneries, training programme directors, college tutors and ARCP panels may use the e-Portfolio to monitor the progress of trainees for whom they are responsible.

JRCPTB will use summarised, anonymous ePortfolio data to support its work in quality assurance.

All appraisal meetings, personal development plans and workplace based assessments (including MSF) should be recorded in the ePortfolio. Trainees are encouraged to reflect on their learning experiences and to record these in the ePortfolio. Reflections can be kept private or shared with supervisors.

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Reflections, assessments and other ePortfolio content should be used to provide evidence towards acquisition of curriculum capabilities. Trainees should add their own self-assessment ratings to record their view of their progress. The aims of the self-assessment are:

- to provide the means for reflection and evaluation of current practice
- to inform discussions with supervisors to help both gain insight and assists in developing personal development plans.
- to identify shortcomings between experience, competency and areas defined in the curriculum to guide future clinical exposure and learning.

Supervisors can sign-off and comment on curriculum capabilities to build up a picture of progression and to inform ARCP panels.

9   Equality and diversity

The Royal Colleges of Physicians will comply, and ensure compliance, with the requirements of equality and diversity legislation set out in the Equality Act 2010.

The Federation of the Royal Colleges of Physicians believes that equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the Colleges, either as members of staff and Officers; as advisers from the medical profession; as members of the Colleges' professional bodies or as doctors in training and examination candidates.

Deaneries quality assurance will ensure that each training programme complies with the equality and diversity standards in postgraduate medical training as set by GMC. They should provide access to a professional support unit or equivalent for trainees requiring additional support.

Compliance with anti-discriminatory practice will be assured through:
- monitoring of recruitment processes
- ensuring all College representatives and Programme Directors have attended appropriate training sessions prior to appointment or within 12 months of taking up post
- Deaneries ensuring that educational supervisors have had equality and diversity training (for example, an e-Learning module) every three years
- Deaneries ensuring that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training (at least as an e-module) every three years
- ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature. Deaneries and Programme Directors must ensure that on appointment trainees are made aware of the route in which inappropriate or discriminatory behaviour can be reported and supplied with contact names and numbers. Deaneries must also ensure contingency mechanisms are in place if trainees feel unhappy with the response or uncomfortable with the contact individual
- providing resources to trainees needing support (for example, through the provision of a professional support unit or equivalent)

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- monitoring of College Examinations
- ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly advantage or disadvantage a trainee with any of the Equality Act 2010 protected characteristics. All efforts shall be made to ensure the participation of people with a disability in training through reasonable adjustments.

JRCPTB

Joint Royal Colleges of Physicians Training Board

ROYAL COLLEGE
of PHYSICIANS
of EDINBURGH

ROYAL COLLEGE OF
PHYSICIANS AND
SURGEONS OF GLASGOW

Royal College
of Physicians