



**Rough Guide to Implementation
Dermatology Curriculum
Guidance for training programme directors,
supervisors and trainees
August 2021**

Contents

Introduction.....	3
What is different about the 2021 Dermatology curriculum?	3
The Dermatology curriculum	5
Capabilities in Practice (CiPs)	5
Evidence of capability.....	6
Presentations and Conditions	7
Practical Procedures.....	7
Assessment: What is required from trainees and trainers?	8
Types of Evidence	12
Induction Meeting with ES: Planning the training year	14
Induction Meeting with Clinical Supervisor (CS).....	15
Educational Meetings with Clinical and Educational Supervisors	15
Transition arrangements for trainees already in programme	16
Trainees who have come from alternative entry pathways.....	16
Annual Review of Competence Progression (ARCP).....	16
ARCP Decision Aid for Dermatology 2021.....	20
Training programme.....	27
Training resources links.....	30
Glossary of abbreviations.....	30

Introduction

This guide for Dermatology is to help training programme directors (TPDs), supervisors, trainees and others with the practicalities of implementing the new curriculum. It is intended to supplement rather than replace the curriculum document itself and should be read in conjunction with the curriculum and syllabus guidance (see presentations and conditions below). The curriculum, syllabus guidance, ARCP decision aid and this guide are available on the JRCPTB website. The syllabus guidance is also available on the British Association of Dermatologists website.

The rough guide has been put together by members of the Dermatology SAC with additional help from external stakeholders. Most of the content of page 7-18 are provided by the JRCPTB. The guide is intended to be a 'living document' and we value feedback via curriculum@jrcptb.org.uk.

What is different about the 2021 Dermatology curriculum?

Background

There have been two major drives to the need for change. Firstly, the move away from the 'tick-box' approach associated with the current competency-based curricula to the holistic assessment of high-level learning outcomes. The new curriculum has a relatively small number of 'capabilities in practice' (CIPs) to assess training outcome, which are based on the concept of entrustable professional activities. Secondly, the GMC has mandated that all postgraduate curricula must incorporate the essential generic capabilities required by all doctors as defined in the [Generic Professional Capabilities \(GPC\) framework](#).

Entry criteria

Medical specialty trainees are now divided into groups 1 and 2; trainees in group 1 dual accredit in internal medicine and their chosen specialty, but trainees in group 2 single accredit in their specialty only. Dermatology is a group 2 specialty and will not dual accredit. Trainees will enter higher specialty training following two years of stage 1 internal medicine training or three years of acute care common stem- acute medicine. Full MRCP(UK) is required.

Previous entry criteria allowed an additional pathway for paediatric trainees with full MRCPCH. The new curriculum allows a third route of entry from surgical training with MRCS, in line with the flexibility in training agenda. For further details, see section on alternative training pathways.

Duration of training

Dermatology higher specialty training will usually be completed in four years of full-time training. This is unchanged. There will be options for those trainees who demonstrate

exceptionally rapid development and acquisition of capabilities to complete training sooner than the indicative time. There may also be trainees who develop more slowly and will require an extension of training as indicated in the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide).

Summary of changes

Changes in the new curriculum are summarised here.

Section of curriculum	Change
Entry into training	Now a group 2 specialty, thus will accredit in dermatology only. MRCS has been added as a route of entry.
Syllabus	Replaced by list of presentations and now supplemented by syllabus guidance on JRCPTB website .
Competencies	Replaced by generic and specialty capabilities in practice (CiPs). Specialty CiPs emphasise managing medical complexity within descriptors and detail new areas such as biologics and tele dermatology.
Assessment	ESR and MCR will now assess generic and specialty CiPs.
Evidence	Optional ACAT added. MSFs annually instead of every 2 years. Non-surgical DOPs: 5 now graded as essential and new procedures added such as dermoscopy/taking tele dermatology images. Surgical DOPs: now essential to perform one flap repair to level of supervised practice.
Training programme	Acute dermatology: out of hours commitment no longer required. Patient numbers to be seen by end of training: has changed in accordance with BAD guidance to 13-16 patients in a general out-patient clinic with new to follow-up ratio of 1:1.6 eg 5 new and 8 review patients.
ARCP	New, more detailed ARCP decision aid available on JRCPTB website and in this guide.

The Dermatology curriculum

The purpose of the dermatology curriculum is to produce dermatologists with the generic professional and specialty specific capabilities to safely recognise, diagnose and manage the full range of skin conditions commonly presenting to a general consultant dermatologist in a secondary care setting.

As in the previous curriculum, trainees should be able to manage skin conditions in both adults and children, diagnose and manage skin cancers and benign lesions and perform procedures, including skin surgery. However, the new curriculum attempts to emphasise that this must be achieved in the context of medical complexity, which requires that trainees learn to lead and manage multidisciplinary teams in order to deliver dermatology services effectively and support the wider health-care service. It has also been updated to include biologics, dermoscopy and teledermatology within the capabilities in practice descriptors.

Doctors in training will continue to learn in a variety of settings using a range of methods, including workplace-based experiential learning, formal postgraduate teaching and simulation-based education.

By the end of their final year of training, the trainee will receive a CCT in Dermatology.

Capabilities in Practice (CiPs)

CiPs replace competencies in the previous curriculum. They are divided into generic and specialty CiPs.

The **generic CiPs** cover the universal requirements of all specialties as described in the GPC framework. The generic CiPs are common across all physician specialties. Assessment of the generic CiPs will be underpinned by the GPC descriptors. Satisfactory sign off will indicate that there are no concerns.

The **specialty CiPs** describe the professional tasks or work within the scope of Dermatology. They encompass the basic requirements of a consultant dermatologist. Each of the CiPs is described in the curriculum and has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated for an entrustment decision to be made. The syllabus guidance has further information to help inform decisions on CiP attainment.

By the completion of training and award of CCT, the doctor must demonstrate that they are capable of unsupervised practice (level 4) in all specialty CiPs.

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 focussed 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 to be assessed by DOPS

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

Evidence of capability

The curriculum describes the evidence that can be used by the educational supervisor to make a judgement of the trainee's capability (please see the CiPs tables and the assessment blueprint in the curriculum). The educational supervisor will now make a holistic judgement based on the evidence provided, particularly the feedback from clinical supervisors and the multidisciplinary team. The list of evidence for each CiP is a guide and is not exhaustive. Other evidence may be equally valid and not all the types of evidence listed will need to be provided. Further information to facilitate decisions in CiP attainment can be found in the syllabus guidance.

Presentations and Conditions

The syllabus has been removed from the curriculum for 2021. It has been replaced by a section on presentations and conditions. However, there will now be a separate document, the **syllabus guidance**, managed by the Dermatology SAC for the JRCPTB, available on the JRCPTB and British Association of Dermatologists websites. It will be the syllabus aligned with the Dermatology SCE. It will be co-badged with the JRCPTB and the British Association of Dermatologists (BAD) and will enable the SAC to edit the syllabus (with BAD education subcommittee input) in line with new developments in the specialty.

The presentations and conditions form the clinical context in which the capabilities are demonstrated. It should be stressed again, that the conditions listed are by no means exhaustive and the list should be considered as a guide. Trainees will be expected to know about the presentations listed but they will not need to be signed off for individual items. Trainees and trainers should refer to the syllabus guidance for support.

Practical Procedures

The curriculum and ARCP decision aid list the practical procedures required and the minimum level of competency.

Surgical procedures

The addition of a compulsory supervised flap procedure by the end of the final year, will require intense supervision for a short period of training.

Otherwise, surgical procedures are now presented as a table (shown in the ARCP guide within this document), showing the point in training at which those procedures should be obtained. When a trainee has been signed off as being able to perform the simpler year 1 and 2 surgical procedures independently (evidenced by summative DOPS), they are not required to have further assessment (DOPS) of that procedure unless they or their educational supervisor feel it is required.

However, **excisions** will require multiple assessments to encompass a variety of areas on the head, neck, body and extremities, due to variability of underlying anatomical structures. Therefore, assessments on excisions should be continued throughout training.

If a trainee has not performed a particular procedure for some time and no longer feels confident or competent to carry it out, then they should seek further training with appropriate supervision. Trainers should have ongoing conversation with trainees about procedural competence and this should be documented.

Non-surgical procedures

Five non-surgical procedures are now designated as essential for dermatology training in the new curriculum (none were specifically identified as compulsory in the 2010 curriculum,

although a minimum number was required). Some non-surgical procedures are often carried out by other healthcare professionals but since it is helpful for trainees to know about these, the relevant DOPs can be used as a learning tool.

Eczema Area Severity Index scores, dermoscopy and obtaining a teledermatology image have been added to the non-surgical procedures in the new curriculum. As with excisions, dermoscopy is likely to require more than one assessment to encompass the variety of pigmented and non-pigmented lesions that a dermatologist would assess.

Assessment: What is required from trainees and trainers?

Introduction

Decisions about a trainee's competence progression will be based on an assessment of how they are achieving their CiPs. For the generic CiPs it will be a straightforward statement as to whether they are operating at, above, or below the level expected for the current year of training. For the specialty CiPs there will be a judgement made as to what level of supervision they require (ie unsupervised or with direct or indirect supervision). For each of these CiPs there is a level that is to be achieved at the end of each year in order for a standard outcome to be achieved at the Annual Review of Competence Progression (ARCP). The levels expected are given in the grid below and in the ARCP decision aid.

What the trainee needs to do

Trainees still need to do an appropriate number of supervised learning events (SLEs) and workplace based assessments (WPBAs). The requirements are documented in the ARCP decision aid (see ARCP section below) but it should be appreciated by trainer and trainee that the decision aid sets out the absolute minimums. SLEs and formative DOPS are not pass/fail summative assessments but should be seen by both trainer and trainee as learning opportunities for a trainee to have one to one teaching and receive helpful and supportive feedback from an experienced senior doctor. Trainees should therefore be seeking to have SLEs performed as often as practical. In addition, they must continue to attend and document their teaching sessions and must continue to reflect (and record that reflection) on teaching sessions, clinical incidents and any other situations that would aid their professional development.

The GMC now require annual multi-source feedback (MSF) to inform the generic CiPs. This is more than the previous requirement for alternate year MSFs in dermatology. Trainees should make sure that that this feedback has been discussed with their educational supervisor (ES) and prompted appropriate reflection. They also need to ensure that they have received a minimum of 4 Multiple Consultant Reports (MCR) from consultants who are familiar with their work. This is unchanged to requirements of the previous curriculum. The MCRs will be amalgamated and will contribute to the ES report. Each consultant contributing to the MCR will give an advisory statement about the level at which they assess the trainee to be functioning for each clinical CiP.

As the ARCP approaches, trainees need to arrange to see their ES to facilitate preparation of the ES report. They will have to self-assess the level at which they feel they are operating at for each CiP, roughly a month before the ARCP. In an analogous fashion to the MSF, this self-assessment allows the ES to see if the trainee's views are in accord with those of the trainers and will give an idea of the trainee's level of insight.

The following points are relevant to linking evidence to capabilities in the ePortfolio:

- the assessment of entrustment is based on evidence. The ES, ARCP panel, and the penultimate year assessment assessor will all depend on the evidence linked to each capability
- it is important not to link any one piece of evidence to more than three or four capabilities
- it is important to ensure that every capability has sufficient evidence linked to it to allow assessment of progress during training and entrustment at the end of training
- An excess of evidence is unhelpful, and the evidence provided should cover different aspects of the linked capability
- the links between evidence and capabilities should be kept up to date. Links should be made when the evidence is added
- intermittent review with the ES is advisable to ensure links are suitable

Interaction between trainer and trainee

Regular interaction between trainees and their trainers is critical to the trainee's development and progress through the programme. Trainees will need to engage with their clinical and educational supervisors.

At the beginning of the academic year there should be a meeting with the ES to map out a training plan for the year. This should include:

- how to meet the training requirements of the programme, addressing each CiP separately
- a plan for taking the SCE in Dermatology
- a discussion about what resources there are available to help with the programme
- develop a set of SMART Personal Development Plans (PDPs) for the training year
- a plan for using study leave
- use of the various assessment/development tools

The trainee should also meet with the clinical supervisor (CS) to discuss the opportunities in the current placement including:

- how to meet the learning objectives
- expectations for level of capability in clinics and level of supervision required
- discuss procedural skill consolidation and supervision required

Depending on local arrangements there should be regular meetings (JRCPTB recommend approximately one hour most weeks) for personalised, professional development discussions which will include:

- writing and updating the PDP
- reviewing reflections and SLEs
- reviewing MCR and other feedback
- discussing leadership development
- discussing the trainee's development as a dermatologist and career goals
- discussing things that went well or not so well

Self-assessment

Trainees are required to undertake a self-assessment of their engagement with the curriculum and in particular the CiPs. This is not a 'one-off' event but should be a continuous process from induction to the completion of the programme and is particularly important to have been updated ahead of the writing of the ES report and subsequent ARCP. Self-assessment for each of the CiPs should be recorded against the curriculum on the trainee's ePortfolio account.

The purpose of asking trainees to undertake this activity is:

- To guide trainees in completing what is required of them by the curriculum and helping to maintain focus of their own development. To initiate the process, it is important that the induction meeting with a trainee's ES reviews how the trainee will use the opportunities of the coming academic year to best advantage in meeting the needs of the programme. It will allow them to reflect on how to tailor development to their own needs, over-and-above the strict requirements laid out in the curriculum.
- To guide the ES and the ARCP panel as to how the trainee considers they have demonstrated the requirements of the curriculum as set out in the decision aid and where this evidence may be found in the trainee's portfolio. This will help the ARCP panel make a more informed judgement as to the trainee's progress and reduce the issuing of outcome 5s as a result of evidence not being available or found by the panel.

What the Educational Supervisor (ES) needs to do

The educational supervisor and trainee should meet beforehand to plan what evidence will need to be obtained. This can be used by the ES to write an important and substantial ES report (ESR).

The ESR will be the central piece of evidence considered by the ARCP Panel when assessing whether the trainee has attained the required standard as set out in the decision aid. As such, both time and planning will need to be given to writing it; this process will need to start at the beginning of the training year.

Educational Supervisor Report (ESR)

The ESR should be written ahead of the ARCP and discussed between the supervisor and the trainee before the ARCP, with any aspects likely to result in a non-standard outcome at ARCP made clear. This conversation should be documented. The report documents the entrustment decisions made by the supervisor for all the CiPs set out in the curriculum. The decisions should be based on evidence gathered across the training year as planned at the induction meeting with the trainee and modified through subsequent, regular, professional development meetings. The evidence should be gathered from several sources as appropriate for the particular CiP.

In completing the ESR, assessments are made for each **generic CiP** using the following 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

Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include:

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

For the **specialty CiPs**, the ES makes a judgement using the levels of entrustment in the table below.

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

Only the ES makes entrustment decisions. Detailed comments must be given to support entrustment decisions that are below the level expected. As above, it is good practice to provide a narrative for all ratings given.

Important Points

- Plan the evidence strategy from the beginning of the training year
- Write the report in good time ahead of the ARCP
- Discuss the ESR with the trainee before the ARCP
- Give specific, examples and directive narration for each entrustment decision

Types of Evidence

Multi-Source Feedback (MSF)

The MSF provides feedback on the trainee that covers areas such as communication and team working. It closely aligns to the generic CiPs. Feedback should be discussed with the trainee. If a repeat MSF is required, it should be undertaken in the subsequent placement.

Multiple Consultant Report (MCR)

The MCR captures the views of consultant (and other senior staff) based on observation of a trainee's performance in practice. The MCR feedback gives valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required.

The *minimum* number of MCRs considered necessary is 4 per ARCP, but more may be requested if deemed necessary by trainers. The ES may ask the trainee to arrange MCRs from specific clinical supervisors.

Consultant supervisors completing the MCR will use the global anchor statements [meets, below or above expectations] to give feedback on areas of clinical practice. If it is not possible for an individual to give a rating for one or more area they should record 'not observed'. Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include:

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

Supervised Learning Events

The Acute Care Assessment Tool (**ACAT**) has been added to the dermatology curriculum for 2021 as an *optional* assessment. It was designed for the acute medical take to assess and facilitate feedback on a doctor's performance but can now be adapted to a wider remit for dermatology trainees. Its purpose is to capture complex decision-making skills beyond a single clinical episode and enables global feedback on planning/ leading clinics or triage and prioritising patients.

Since the curriculum was accepted by the GMC, an outpatient assessment tool (OPCAT) has become available on ePortfolio for all medical specialties. It is not possible to add OPCAT to the curriculum at this stage, but we suggest that OPCAT could also be used as an optional assessment.

In dermatology, the ACAT & OPCAT could be used by the clinical supervisor when assessing multi-professional working and/or situations where a trainee is interacting with a number of different patients. The available OPCAT form assesses patient centred care and communication but the dermatology curriculum also requires ability to plan and run clinics. Thus, the supervisor could add comments in the free text boxes to allow OPCAT to be used in an outpatient setting to enable feedback on the broader skill set of how to plan and run the clinic efficiently, including multi-disciplinary working. After an on-call session, the ACAT could allow feedback on ability to triage/ prioritise patients and liaise appropriately with multi-professional colleagues.

ACAT and OPCAT should **not** be used to produce a “multiple Case based Discussion”. Each ACAT/ OPCAT should cover the care of a minimum of five patients. Ultimately, it is hoped that specific dermatology assessment tools will be developed to assess clinic and on call work.

Details on all other SLEs and WPBAs can be found in the curriculum and are essentially unchanged, excepting the increased frequency of MSFs, which must now be performed annually.

Examination

The Specialty Certificate Examination in Dermatology (SCE) is mandatory for attainment of the CCT. Trainees must pass the SCE by the end of their training. Information about the SCE in dermatology, including guidance for candidates, is available on the MRCP (UK) website www.mrcpuk.org.

The syllabus can be viewed on the JRCPTB website [here](#).

Reflection

Undertaking regular reflection is an important part of trainee development towards becoming a self-directed professional learner. Through reflection a trainee should develop SMART learning objectives related to the situation discussed. These should be subsequently incorporated into their PDP. Reflections are also useful to develop ‘self-knowledge’ to help trainees deal with challenging situations.

It is important to reflect on situations that went well in addition to those that went not so well. Trainees should be encouraged to reflect on their learning opportunities and not just clinical events.

Induction Meeting with ES: Planning the training year

The induction meeting between the trainee and their ES, at which the training year should be planned, is pivotal to the success of the training year. It is the beginning of the training relationship between the two and both preparation and time are required. The induction meeting should be recorded formally in the trainee's ePortfolio and provide a starting point for input of information for the ESR. The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the training year.

Ahead of the meeting review:

- review any Transfers of Information on the trainee
- review previous ES, ARCP etc. reports if available
- agree with the placement CSs how other support meetings will be arranged.

At the meeting the following need to be considered:

- review the placements for the year
- review the training year elements of the generic educational work schedule or its equivalent
- construct the annual PDP and relevant training courses planned
- discuss the trainee's career plans and help facilitate these
- discuss the use of reflection and make an assessment of how the trainee uses reflection
- discuss the teaching programme
- discuss procedural skill consolidation
- discuss arrangements for LTFT training if appropriate
- plan interaction with the placement CSs
- planning of SLEs and WPBA
- arrangements for MSF
- review the ARCP decision aid
- arrangements for ARCP and the writing and discussion of the ESR
- pastoral support
- arrangements for reporting of concerns
- plan study leave

At the end of the meeting the trainee should have a clear plan for providing the evidence needed by the ES to make the required entrustment decisions.

Important Points

- prepare for the meeting
- make sure that knowledge of the curriculum is up-to-date
- set up a plan for the training year

Induction Meeting with Clinical Supervisor (CS)

The trainee may also have an induction meeting with their placement CS (who may or may not be their ES). This is especially relevant where the trainee is placed in another department away from the main training centre. The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the placement.

Ahead of the meeting review:

- review any Transfers of Information on the trainee
- review previous ES, ARCP etc. reports if available

The following areas will need to be discussed, some of which will reinforce areas already covered by the ES but in the setting of the particular placement:

- how to meet the learning objectives
- expectations for level of capability in clinics and supervision required
- discuss procedural skill consolidation and supervision required
- arrangements for MSF
- pastoral support
- arrangements for reporting of concerns
- plan study leave

Educational Meetings with Clinical and Educational Supervisors

Trainees need to meet their trainers regularly across the training year to allow the trainee to develop professionally. The GMC recommend an hour per week is made available for this activity. While it is not expected or possible for it to be an hour every week, the time not used for these meetings can be used to participate in ARCPs etc.

These meetings are important and should cover the following areas. This list is not exhaustive. Meet away from the clinical area regularly to:

- Discuss cases, including case based discussions
- Provide feedback
- Monitor progress of learning objectives
- Discuss reflections
- Provide careers advice
- Monitor and update the trainee's PDP
- Record meeting key discussion points and outcomes using the Educational Meeting form on the ePortfolio
- Record progress against the CiPs by updating the comments in the CiP section of the portfolio (this will make writing the ESR at the end of the year much easier)
- Provide support around other issues that the trainee may be encountering

Transition arrangements for trainees already in programme

The GMC require that all trainees transfer to the new curriculum in August 2021, with the exception of those trainees within their final year of training. Less than full time trainees will not need to transfer if they are in their final year of training (pro rata for less than full time trainees).

For trainees transferring to the new curriculum, they must rate themselves on the new CiPs as soon as possible after August 2021. They are NOT expected to relink evidence.

The trainee should then meet with their ES so that the ES can perform an initial assessment of CiPs and produce a gap analysis within the first month or two after transitioning to the new curriculum. This is to agree on what evidence from previous competencies can be applied to the new CiPs and which skills remain outstanding. There should be a form available on ePortfolio to help with this.

Guidance on performing the gap analysis has been produced by the [Academy of Medical Royal Colleges](#) and the transition guide is available on the Dermatology webpage.

Trainees who have come from alternative entry pathways

Trainees from surgical or paediatric 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.

Annual Review of Competence Progression (ARCP)

Introduction

The ARCP is a procedure for assessing competence annually in all medical trainees across the UK. It is owned by the four Statutory Education Bodies (Health Education England, NHS Education for Scotland, Health Education and Improvement Wales and Northern Ireland Medical & Dental Training Agency) and governed by the regulations in the Gold Guide. The JRCPTB can therefore not alter the way in which an ARCP is run but can provide guidance for trainees and trainers in preparing for it and guide panel members on interpretation of both curricular requirements and the decision aid when determining ARCP outcomes. Although

receiving a non-standard ARCP outcome (i.e. anything but an outcome 1 or 6) should not be seen as failure, we know that many trainees are anxious about such an outcome and everything possible should be done to ensure that no trainee inappropriately receives a non-standard outcome.

The ARCP gives the final summative judgement about whether the trainee can progress into the subsequent year of training (or successfully complete training if in the final year). The panel will review the ePortfolio (especially the ES report) in conjunction with the decision aid for the appropriate year. The panel must assure itself that the ES has made the appropriate entrustment decisions for each CiP and that they are evidence based and defensible. The panel must also review the record of trainee experience to ensure that each trainee has completed (or is on track to complete over ensuing years) the various learning experiences mandated in the curriculum.

Dermatology training and the ARCP

The change from the tick-box style competencies to the high-level Capabilities in Practice (CiPs) will have a major impact on how trainees are assessed and how they will progress through their ARCPs. It is vital we avoid an increase in trainees failing to achieve a standard ARCP outcome by helping trainees and trainers to prepare for the ARCPs and by stressing to ARCP panels the basis of their assessment. ARCP panel members must ask the question: “Overall, on reviewing the ePortfolio, including the Educational Supervisor report, the Multiple Consultant Reports, the Multi-Source Feedback and (if necessary) other information such as workplace based assessments, reflection etc, is there evidence to suggest that this trainee is safe and capable of progressing to the next stage of training?”

Relationship with Educational Supervisor (ES)

It is vital that the trainee and the ES develop a close working relationship and meet up as soon as possible after the start of training. At that meeting, the ES should discuss how the various curriculum requirements will be met and how evidence will be recorded to ensure that it can be demonstrated that the Capabilities in Practice have been achieved at the appropriate level. This meeting should also result in the production of a Personal Development Plan (PDP) consisting of a number of SMART objectives that the trainee should seek to achieve during that training year. The trainee should meet up with their ES on a number of other occasions during the training year so that the ES can be reassured that appropriate evidence is being accumulated to facilitate production of a valid ES report towards the end of the year and guide the trainee as to further evidence that might be required.

Clinical supervisor (CS)

The trainee should have a Clinical Supervisor for each attachment and once again the trainee should meet up with the CS at the start of the attachment. At the end of the attachment, the CS should be well placed to complete a Multiple Consultant Report (MCR).

The trainee should provide a MCR from each designated CS as they are best placed to provide such a report but in addition should approach other consultants with whom they have had a significant clinical interaction and ask them also to provide a MCR. Throughout the attachment the trainee should be having SLEs completed by both consultants and more senior trainees. The number of SLEs demanded by the decision aid should be regarded as an absolute minimum and additional ones should be sought because:

- Although they are formative, not summative assessments, they do provide additional evidence to show that a trainee is acquiring clinical (and generic) capabilities
- They may give the trainee the opportunity to have additional one to one clinical teaching from a senior colleague
- They allow trainees to receive targeted and constructive feedback from a senior colleague.

Completing reports

When completing reports, all consultants should do more than just tick a box and make some generic comment such as “good trainee”. It is important that they make meaningful comments about why they have assigned that particular level of performance/behaviour to that particular trainee. In doing this, the descriptors assigned to each CiP should be especially useful as an *aide-memoire*. They should specifically not be used as a tick list that requires a comment for each descriptor but should just allow the senior doctor completing the report to reflect on what comments would be helpful to the ES for completion of their report and to the ARCP panel in determining whether the trainee can progress to the next year of training. Constructive comments are also of course valued by the trainee. It is very helpful if the trainee can have constructive comments if they are progressing along the “normal” trajectory and especially if they are exceeding expectations either globally or in certain areas. If a trainee is performing below expectations then it is absolutely mandatory that meaningful, insightful and precise comments are provided.

ARCP preparation

As the ARCP approaches, it is essential that the trainee reviews their ePortfolio and ensures that all requisite information is available in a logical and accessible format by 2 weeks prior to the ARCP. In particular they should ensure that:

- All appropriate certificates have been uploaded to the personal library and are clearly signposted
- An appropriate amount of reflection has been documented
- As a bare minimum, the requisite number of SLEs (as demanded by the annual decision aid) has been completed and recorded in the ePortfolio
- MSF has been completed so that the ES can discuss the results and release them. It is critical that appropriate discussion/reflection has occurred and been recorded in response to the MSF

- MCR has been completed by each CS and additional ones have been completed by any supervisor with whom the trainee has had significant clinical/educational interaction
- The trainee has self-rated themselves for each CiP on the curriculum page
- The SMART objectives documented in their PDP have been achieved and the evidence for that achievement has been clearly documented. If any objectives of the PDP have not been fully achieved, then the reasons for that have been clearly documented and evidenced.
- An appointment has been made with their ES to discuss the annual ES report that will inform the ARCP panel

The ES should review the portfolio to ensure that all the above requirements have been met and record a final rating for each CiP on the curriculum page. The ES should meet up with the trainee to discuss the ESR so that there are no surprises.

The ARCP

At the ARCP, the panel should review the ePortfolio and in particular it should focus on the ESR report but also review the MCRs, the MSF, the PDPs and reflection. It should also reassure itself that all the mandatory courses and exams have been attended/passed. If members of the panel have any concerns that the trainee under review is not eligible for a standard outcome (outcome 1 or outcome 6) then they should examine more detail in the ePortfolio and review more of the SLEs and other subsidiary information.

At the penultimate ARCP panel, an external assessor from an outside deanery will also assess the trainee. The external assessor will review the trainee's e-portfolio and conduct a private 1:1 discussion with the trainee. In this discussion, the external advisor will give feedback to the trainee and determine remaining training requirements. The external assessor will suggest both mandatory and recommended targets for the trainee to complete by the final ARCP meeting.

The external assessor undertaking the Penultimate Year Assessment review has a further role in monitoring the performance of the training programme. They will ask the trainee(s) for their comments on the strengths and weaknesses of the programme and will record how well the ARCP process is undertaken. Trainees should give honest factual feedback. All the external reports are collated and presented to the Specialist Advisory Committee to inform training decisions.

ARCP Decision Aid for Dermatology 2021

This decision aid provides guidance on the requirements to be achieved for a satisfactory ARCP outcome at the end of each training year. This document is available on the JRCPTB website <https://www.jrcptb.org.uk/training-certification/arcp-decision-aids>

Evidence	Notes	Year 1 (ST3) requirement	Year 2 (ST4) requirement	Year 3 (ST5) requirement	Year 4 (ST6) requirement
Educational supervisor (ES) report	Indicative one per year but must cover the training year since last ARCP (up to the date of the current ARCP) or from start of training if ST3. Will include ratings on CiPs plus feedback on MCRs & assessments below	Confirms meeting or exceeding expectations and no concerns	Confirms meeting or exceeding expectations and no concerns	Confirms meeting or exceeding expectations and no concerns	Confirms will meet all requirements needed to complete training
Generic capabilities in practice (CiPs)	Mapped to Generic Professional Capabilities (GPC) framework & assessed using global ratings. Trainees should record self-rating to facilitate discussion with ES. ES report will record rating for each generic CiP	ES to confirm trainee meets expectations for level of training	ES to confirm trainee meets expectations for level of training	ES to confirm trainee meets expectations for level of training	ES to confirm trainee meets expectations for completion of training
Specialty capabilities in practice (CiPs)	Trainees must complete self-rating to facilitate discussion with ES. ES report will confirm entrustment level for each CiP as per Table 1	ES to confirm minimum level s expected	ES to confirm minimum level s expected	ES to confirm minimum level s expected	ES to confirm level 4 in all specialty CiPs by end of training
Multiple consultant report (MCR)	Indicative minimum number is shown. Each MCR is completed by a clinical supervisor (CS). The ES should not complete an MCR for their own trainee.	4	4	4	4

Evidence	Notes	Year 1 (ST3) requirement	Year 2 (ST4) requirement	Year 3 (ST5) requirement	Year 4 (ST6) requirement
Multi-source feedback (MSF)	Indicative minimum 12 raters including 3 consultants & mixture of other staff (medical & non-medical). MSF report must be released by ES & feedback discussed with trainee before ARCP. If significant concerns raised, additional MSFs may be required.	1	1	1	1
Patient survey	Minimum of 20 patients. ES will feed results back to trainee and complete patient survey form	1	1	1	1
Supervised learning events (SLEs): Acute care assessment tool (ACAT)	In dermatology, CS could use ACAT to assess situations where trainee is interacting with several patients on call. Enables global feedback on triage & prioritising patients. Each ACAT must include minimum of 5 cases. This tool is not for assessment of management of individual cases	optional	optional	optional	optional
Outpatient care assessment tool (OPCAT)	In dermatology, CS could use OPCAT to assess situations where trainee is interacting with several patients in clinic. Enables global feedback on planning/ leading clinics. Each OPCAT must include minimum of 5 cases. This tool is not for assessment of management of individual cases	optional	optional	optional	optional
Case-based discussion (CbD)	Indicative minimum number to be carried out. Trainees are encouraged to				

Evidence	Notes	Year 1 (ST3) requirement	Year 2 (ST4) requirement	Year 3 (ST5) requirement	Year 4 (ST6) requirement
and mini-clinical evaluation exercise (mini-CEX)	undertake more & supervisors may require additional SLEs if concerns are identified. SLEs should be undertaken throughout the training year by a range of assessors. Structured feedback should be given to aid the trainee's personal development	8 CbD 4 mini-CEX	8 CbD 4 mini-CEX	8 CbD 4 mini-CEX	8 CbD 4 mini-CEX
Practical procedures: surgical & non-surgical Direct Observation of Procedural Skills (DOPS)	Indicative minimum numbers. Surgical procedures should achieve level indicated in Table 2 Non-surgical procedures are listed in Table 3	4 surgical 2 non-surgical	4 surgical 2 non-surgical	4 surgical 2 non-surgical	4 surgical 2 non-surgical
Quality improvement (QI) project	Project to be assessed with quality improvement project tool (QIPAT)	1	1	1	1
Teaching observation (TO)	Can be based on any instance of formalised teaching by the trainee which is observed by the assessor	1	1	1	1
Research supervisor report (RSR)	To cover training year since last ARCP. ES to do RSR if trainee not actively engaged in research yet.	1	1	1	1
Dermatology SCE		Not required	Not required	Attempt/pass	Pass

Table 1: Outline grid of minimum levels expected for Dermatology specialty CiPs by end of each training year

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	

Table 2: Practical procedural skills -surgical

Trainees must be able to outline the indications for the procedures listed in the table below and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthesia, minimisation of patient discomfort, and requesting help when appropriate. For all practical procedures the trainee must be able to appreciate and recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary. Please see further information below.

Surgical Procedures	Year 1 (ST3)	Year 2 (ST4)	Year 3 (ST5)	Year 4 (ST6)
Curette and cautery	can perform unsupervised			
Cryotherapy of benign or premalignant lesions	can perform unsupervised			
Cryotherapy of superficial basal cell cancer		can perform unsupervised		
Dog ear repair				can perform unsupervised
Excision of lesion on trunk or limbs with direct closure using deep (sub-cuticular) & surface (percutaneous) sutures		satisfactory supervised practice	can perform unsupervised	
Excision of lesion on head and neck with direct closure using deep (sub-cuticular) & surface (percutaneous) sutures			satisfactory supervised practice	can perform unsupervised
Incisional skin biopsy	can perform unsupervised			
Punch biopsy	can perform unsupervised			
Shave excision		can perform unsupervised		
Small flap repair				satisfactory supervised practice

Surgical Procedures	Year 1 (ST3)	Year 2 (ST4)	Year 3 (ST5)	Year 4 (ST6)
Genital/ mucosal biopsy				can perform unsupervised

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 year 1 and 2 procedures 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). However, excisions will require more than one assessment on different areas of the head and neck or body due to variability of underlying anatomical structures.

Table 3: Practical procedural skills -non-surgical

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 can be used to demonstrate learning, but are not essential for the 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
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
Take a high-quality teledermatology dermoscopic image using a mobile device

Training programme

As previously, 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.

In general, the average weekly timetable should consist of 6-7 fixed clinical sessions per week with 3 to 4 sessions for administrative work, personal study and research. Some elements of the curriculum may require attachments to specialist clinics or units. 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. However, some guidance is provided here:

Dermatology clinics

Clinics should compose a large proportion of training.

General dermatology outpatients: general clinics should comprise a significant part of the first year. They should also form a significant part of at least 2 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 able to see 13-16 patients independently in a general dermatology outpatient clinic with a ratio of 1 new: 1.6 follow up, eg 5 new and 8 review patients. Sufficient time must be made available for the clinical supervisor to teach and advise the trainee during these clinics, therefore actual numbers seen may be lower. These numbers may need to be reduced when there is a disproportionate amount of remote or virtual working.

Skin cancer clinics: this is a large proportion of a consultant dermatologist's work and trainees should be exposed to skin cancer clinics for an indicative minimum of 18 months of training, with one major skin cancer clinic per week. By completion of training, they should be able to see 15 new skin cancer patients independently. This number is based on the trainee reviewing patients but not personally performing surgical procedures as they go along. These numbers may be reduced if there is a disproportionate amount of virtual or remote consultation.

Contact dermatitis clinics: sufficient time should be spent to achieve the relevant specialty capability. The SAC recommends an indicative time of 4 months.

Paediatric clinics: sufficient time should be spent to achieve the relevant specialty capability. The SAC recommends an indicative period of 6 months, where trainees are committed to at least one or two paediatric clinics per week.

Other specialty clinics: such as hair and nail, oral, vulval, male genital and photobiology, can be attended if available, in order to achieve the relevant specialty capabilities. Teaching in these clinics will be delivered by health practitioners with the relevant experience in the specialist area. All these presentations can also present in general dermatology clinic. Trainees may also attend courses or use e-learning for healthcare modules to gain experience of these specialties.

Acute dermatology-related take

The trainee must have a regular commitment to an acute dermatology-related take for most of their training period 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. The on-call experience should cover the care of dermatology in-patients, urgent community referrals, referrals regarding in-patients 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. There should be sufficient exposure to gain the capabilities listed, which would usually be at least one list per week for most of the training period.

Skills in advanced skin surgery may be acquired within a dedicated skin surgery list, supervised by a healthcare professional with expertise in this area. The addition of a

compulsory supervised flap procedure to this curriculum, will require intense supervision for a short period of training.

Experience in Mohs micrographic surgery units is primarily limited to observation, though contribution to reconstruction closures may be available depending on the programme.

Management and leadership

The new curriculum aims to emphasise these skills which are now a continuous, not modular, element of training progression. Trainees should gain experience and confidence in leading clinical teams eg supervising other doctors and allied professionals, in order to enable them to ultimately run an outpatient clinic or community service effectively and efficiently.

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 and its dynamic nature. 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.

Phototherapy and photodynamic therapy

Trainees should gain enough experience in phototherapy and photodynamic therapy to be able to prescribe and supervise its delivery. This may mean specialist attachments or regular contact and review of these patients within their general dermatology training.

Dermatopathology

Dermatopathologists are not available in all hospitals where a trainee may ultimately become a consultant, 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. Experience can also be gained from e-learning for healthcare or other virtual learning platforms.

Teledermatology

Trainees should be given sufficient exposure to teledermatology consultations within 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. In some cases, this may require gaining experience out of area. Teledermatology courses are also available.

Training resources links

Curriculum, Rough Guide, Syllabus and ARCP decision aid on the JRCPTB

Dermatology webpage - www.jrcptb.org.uk/specialties/dermatology

Dermatology SCE- www.mrcpuk.org

BAD website - www.bad.org.uk

Glossary of abbreviations

ACAT	Acute Care Assessment Tool
ALS	Advanced Life Support
BAD	British Association of Dermatologists
ARCP	Annual Review of Competence Progression
CiP	Capabilities in Practice
CbD	Case-based Discussion
CCT	Certificate of Completion of Training
CS	Clinical Supervisor
CBME	Competency Based Medical Education
DME	Director of Medical Education
DOPS	Direct Observation of Procedural Skills
EPA	Entrustable Professional Activity
ES	Educational Supervisor
GPC	Generic Professional Capabilities
HoS	Head of School
JRCPTB	Joint Royal Colleges of Physicians Training Board
MDT	Multidisciplinary Team
MCR	Multiple Consultant Report
Mini CEX	Mini Clinical Evaluation Exercise
MMC	Modernising Medical Careers ??
MSF	Multi-Source Feedback
NTN	National Training Number
OPCAT	Outpatient assessment tool
PDP	Professional Development Plan
PS	Patient Survey
SLE	Supervised Learning Event
TPD	Training programme director
WPBA	Workplace Based Assessment

JRCPTB

Joint Royal Colleges of Physicians Training Board

