Royal College of General Practitioners

Guidance and competences to support the accreditation of GPs with Extended Roles (GPwERs) in Dermatology (including Skin Surgery)

Royal College of General Practitioners 2019

The Royal College of General Practitioners was founded in 1952 with this object:

'To encourage, foster and maintain the highest possible standards in general practice and for that purpose to take or join with others in taking steps consistent with the charitable nature of that object which may assist towards the same.'

Among its responsibilities under its Royal Charter the College is entitled to:

'Diffuse information on all matters affecting general practice and issue such publications as may assist the object of the College.'

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Foreword

In 2000, the NHS plan[1] proposed a new role: the GP with a Special Interest (GPwSI). It was expected that the GPwSI would work as part of locally integrated services providing intermediate care and relieve the pressure on consultants. Dermatology has been at the forefront of the development and implementation of GPwSI services.

Since 2000, dermatologists, GPwSIs in dermatology, GPs and patient groups have worked together on several iterations of accreditation guidance to ensure that patients seen by GPwSIs receive high-quality care. Accreditation processes have usually been delivered locally and the previous guidance was published in 2011.[2]

In 2015, the Royal College of General Practitioners (RCGP) agreed that the term GPwSI should be replaced by the term GP with Extended Role (GPwER) and, following a pilot and a period of collaborative working between members of the RCGP, British Association of Dermatologists (BAD) and Primary Care Dermatology Society (PCDS), accreditation will now be underpinned by a national process delivered by the RCGP, to be delivered on a 12-month trial basis initially.

These guidelines are an update of the 2011 dermatology guidelines[2] and should be read in conjunction with the generic *RCGP framework to support the governance of General Practitioners with Extended Roles*.[3] This document provides information about the training, accreditation and assessment processes that support the accreditation of GPwERs in Dermatology and Skin Surgery. This document also describes the governance arrangements for the maintenance of clinical competence post accreditation using the 5-year revalidation cycle.

This guidance has been revised and updated by representatives of BAD, PCDS and the RCGP and, importantly, with input from the Psoriasis Association, representing the patient voice. We would like to thank all of those involved in the process.

High-quality care and improved patient outcomes can be delivered only by ensuring a highly skilled, appropriately trained workforce. Although the structures and processes within the NHS may change and evolve, the principles in this document are likely to remain valid. Clarity about training, accreditation and maintenance of clinical competence is essential and the implementation of this new process is very welcome.

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1. Introduction

It is expected that general practitioners (GPs) with Extended Role (GPwERs) in dermatology and skin surgery will complete the process of RCGP accreditation before taking up the role.

These guidelines have been updated in the context of the implementation of the new accreditation process, which is delivered by the Royal College of General Practitioners (RCGP) with the support of dermatology specialist organisations including the British Association of Dermatologists (BAD) and the Primary Care Dermatology Society (PCDS), and reflect up-to-date national guidance. The use of the term re-accreditation has been removed and the guidance updated to take into account the principles of the whole scope of practice appraisal and revalidation.

Unlike the 2011 guidance,[2] this document relates only to the accreditation of the individual and not to the premises in which he or she works, which is covered by regulation from the Care Quality Commission and other UK regulators. The 2011 guidance also provided recommendations relating to GPs who provide skin surgery services within their practices under a Directed Enhanced Service (DES) or Local Enhanced Service (LES) but who are not dermatology GPwSIs. This document no longer includes these recommendations although it does differentiate between a GPwER and a GP working within a DES/LES arrangement (refer to page 19).

Although the curriculum and assessment tools remain largely unchanged compared with the 2011 framework,[2] the curriculum will be subject to review in due course, particularly the section relating to the management of low-risk basal cell carcinoma (BCC) in the community. As part of the ongoing review, the framework will also consider further alignment with General Medical Council (GMC) terminology, particularly with regard to capabilities in practice (CiPs).

This guidance is being published during a period of change in the NHS: there is increasing demand for dermatology specialist services as a consequence of the increasing prevalence of skin cancer and an emphasis on the delivery of close-to-home community services.

The principles in this document are intended to ensure the commissioning and provision of high-quality dermatology services. The guidance provides detailed information to ensure that GPs working towards accreditation know the kind of evidence and competences that are expected to be seen and tested during the RCGP accreditation process. Specific information on the training and accreditation of GPwERs working in dermatology and skin surgery is designed to help GPwERs and those developing or commissioning GPwER services to understand the extended knowledge, competences and skills required to provide services beyond the scope of a generalist role. The guidance also makes clear the requirements for ongoing maintenance of clinical competence in the context of the full scope of practice appraisal and revalidation.

In addition to describing a curriculum and assessment tools to support the accreditation of the GPwER, this document describes the expected role of the GPwER within the local dermatology service and the support and facilities that the GPwER should expect in order to deliver a high-quality service. GPwER services are expected to be part of a series of integrated options within a negotiated local framework taking account of the needs of the local health community. It is very important that patients and all service providers are involved at all stages of service development. It is particularly important that the role of GPwERs with particular expertise in skin lesion management does not reduce access to care for people with inflammatory skin disorders. Commissioners also need to be mindful of local tariffs and reflect on the fact that those providing only a skin lesion service

are likely to generate a higher income and have a reduced follow-up rate than those providing a service for inflammatory skin conditions or both services together. Figure 1.1 shows how the role of GPwER services might sit within an integrated dermatology service.

Commissioners need to be reminded that the training and personal development of GPwERs will require initial and ongoing support from dermatology specialists (refer to **Annex A** for a definition of specialist). Any commissioning framework needs to take account of these requirements.

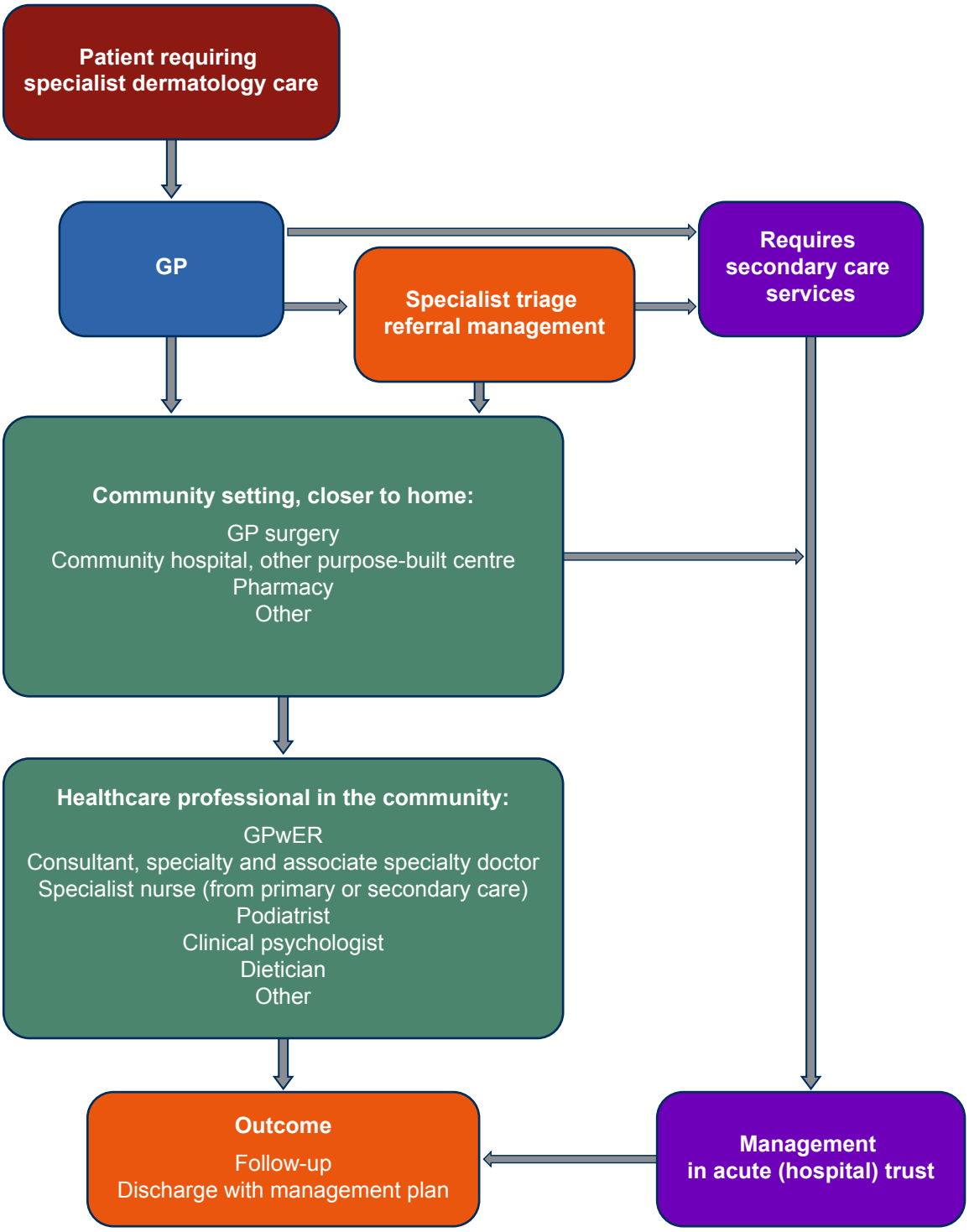


Figure 1.1 Models of service delivery.

2. The GP with Extended Role accreditation process

The process of GPwER accreditation is mapped out in **Annex B** and detailed in the generic RCGP framework.[3] It is important for candidates to ascertain that they are working with a senior clinical supervisor (**Annex A**) with the necessary experience to sign off the clinical supervisor's report. If this is not the case refer to the GPwER section of the RCGP website (www.rcgp.org.uk/gpwer-dermatology) for further information.

3. The roles and services to be provided by the dermatology GP with Extended Role

The core activities of the dermatology GPwER will vary depending on local needs and resources and the skills of the clinician. There are three dermatology GPwER roles (Figure 3.1):

- **Group 1 – GPwER in Medical Dermatology**: the diagnosis and management of inflammatory skin disease, and the diagnosis and non-surgical management of skin lesions
- **Group 2 – GPwER in Skin Lesion Management**: the diagnosis and management of skin lesions, usually including low-risk BCC, using both surgical and non-surgical methods
- **Group 3 – GPwER in Medical Dermatology and Skin Lesion Management**: combines groups 1 and 2.

Notes on the above groups:

- Skin lesions usually excluded from GPwER work include suspected cases of melanoma, squamous cell carcinoma, high-risk BCC and other high-risk skin cancers
- GPwER in groups 2 or 3 who treat low-risk BCC (refer to **Annex C** for the definition of low-risk BCC as managed by GPwERs) need to comply with the NICE guidance referred to in this framework, or other relevant guidance if working in a devolved nation

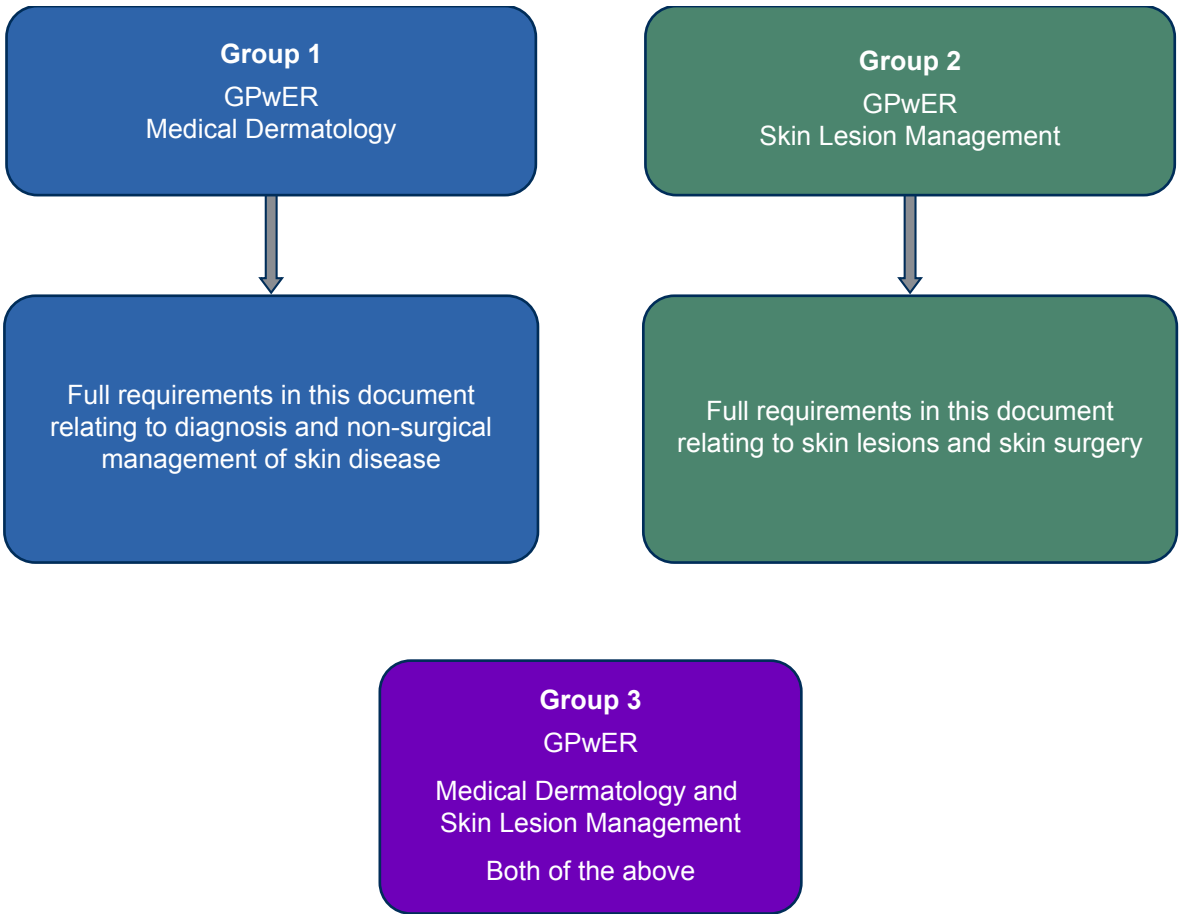


Figure 3.1 Overview of GPwER models.

Models of service delivery are expected to reflect local needs and be developed in the context of relevant national guidance, for example the National Institute for Health and Care Excellence (NICE) skin cancer guidance,[4,5] and to meet any relevant quality standards, for example those set by the Care Quality Commission and other relevant organisations. Although there will be differences in the devolved nations, the principles will be much the same. It is expected that the dermatology GPwER service will include aspects of the following:

Clinical

- Assessment, investigation and treatment of patients referred to the service.
- Provision of a range of clinical interventions as appropriate to the accredited service (e.g. the use of oral and topical treatments, liquid nitrogen, skin surgery).
- Links with other services to ensure that the full holistic needs of the patient are met (e.g. psychological support, podiatry, cosmetic camouflage services).
- The knowledge to signpost patients to other support services, including local and national patient support groups.

Education and liaison

- Provision of advice and support to local practitioners through non-face-to-face contact (e.g. telephone, internet) in the management of those dermatological conditions within the expertise of the GPwER.
- Provision of support and training to GPs and members of the primary healthcare team in the management of common skin conditions to enable other clinicians to develop, maintain and improve their level of clinical competence in the management of skin conditions. The process of education should be supported through commissioning pathways.
- Liaise with and provide support for other dermatology GPwERs in the area.

Service development/leadership

- Work with local secondary care specialists and other groups managing skin conditions (e.g. tissue viability teams, podiatry) to develop an integrated dermatology service model that facilitates streamlined care pathways linked to the healthcare needs of the local community.
- Support and develop the role of dermatology specialist nurses working in outreach/close-to-home settings.
- In collaboration with other members of the local health community (e.g. GPs, practice nurses, pharmacists, health visitors, school nurses), develop and implement management guidance in the care of common dermatological conditions.
- Become involved in integrated training programmes across primary and secondary care for medical and nursing staff.
- Work with patients, the public and service providers to support an integrated, patient-centred approach to commissioning services.

The location of the service will also vary depending on the needs of the local community. See **Annex D** for points to consider when developing a service model.

4. The support and facilities the GP with Extended Role will require

Nationally agreed standards for facilities exist, including those specifically relating to the provision of dermatology care. Useful advice can be found in peer-reviewed journals (e.g. see Humphreys[6]) and obtained from BAD.[7] Although the facilities and support will vary according to the service being provided, the basic requirements for GPwERs managing a clinical caseload include some of the following:

- Access to suitably trained dermatology specialist nurse support, ideally acting as a liaison between primary and secondary care (e.g. by the provision of outreach dermatology specialist nursing support). This can then facilitate seamless care. However, development of specialist dermatology skills in a designated in-house community or practice nurse should also be considered.
- For surgical procedures, access to suitable assistance and appropriate resuscitation equipment.
- A well-lit consultation room with adequate facilities for diagnosis and treatment procedures and operative equipment that meets the requirements necessary for skin surgery.
- Access to liquid nitrogen if cryosurgery is to be performed, with attention to health and safety guidance in relation to its storage and use.
- Administrative support and appropriate staff to ensure that the clinic runs efficiently.
- An adequate means of record keeping including a failsafe record to ensure that all results are actioned appropriately and reported to the patient in a timely fashion (particularly important for histopathology reports).
- If skin surgery sessions are to be performed, close links with local dermatology and histopathology departments. Documentation of lesions, including photographic records as appropriate, is recommended (taken and recorded following national guidelines[8]).
- GPwERs are expected to keep their facilities up-to-date, in keeping with national guidance, and ensure that their patients have access to any innovations in dermatology treatment suited to the primary care setting.
- Facilities should take into account the standards set by the relevant regulator (e.g. Care Quality Commission in England); this is particularly important in the context of providing skin surgery services when specific national standards need to be met.
- Dermatology services are expected to be provided in well-equipped community hospitals and primary care settings.[9]
- As part of a well-integrated service, GPwERs should have good access to and support from secondary care specialist services (e.g. dermatology, plastic surgery) when possible.

5. The curriculum and core competences (capabilities in practice) required

The GP is expected to demonstrate that he or she is a competent and experienced generalist as well as having the specific competences and experience for the dermatology special interest area. Generalist skills can be assessed in several ways but are readily demonstrated by GPs who have passed the membership examination of the RCGP or have demonstrated eligibility for the GP register through other routes.. It is expected that the GP will have an ongoing, significant commitment to general practice, as outlined in the generic guidance,[3] to retain excellent generalist skills.

The competences required to deliver a GPwER service are seen as a development of generalist skills as outlined by the BAD in the *Undergraduate Dermatology Curriculum*.[10] In addition to good communication skills, experience in teaching and training healthcare professionals in dermatology and a commitment to cascading knowledge and skills are important. It is expected that, to optimise quality of care, dermatology GPwERs will be familiar with guidelines and quality standards relevant to their clinical area.

CiPs focus on what happens in clinical practice, requiring demonstration of multiple competences simultaneously and specific knowledge, skills, attitudes and behaviours. This framework refers to two CiPs:

1. Capable of working autonomously and providing high-quality care for general dermatology conditions in a community setting – in this framework, this definition refers to group 1 GPwERs (Medical Dermatology).
2. Capable of working autonomously and providing high-quality care in a community skin lesion clinic – in this framework, this definition refers to the group 2 GPwERs (Skin Lesion Management).

In terms of demonstrating CiPs, the mini-clinical evaluation exercise (mini-CEX) and direct observation of practical skills (DOPS) are still a requirement in the assessment of clinical competences. However, additional supporting evidence, including reflection on learning activities, audits, senior clinical supervisor reports (SCSRs) and patient surveys, is required to provide a more holistic assessment of the candidate. **Annex F** provides an overview of the dermatology CiPs used in this guidance.

The following describes the aims of the dermatology GPwER curriculum, its content and methods of learning and assessment. It is expected that all dermatology GPwERs involved in the care of patients with inflammatory skin disease and skin lesions should be able to demonstrate that they meet the core competences set out in this document as part of the accreditation process.

5.1 Curriculum: principles

Competent practitioners can demonstrate:

- effective communication skills during interaction with patients and colleagues, including the ability to explore people's understanding, reactions and opinions and practise with a holistic approach

- an ability to explain the risks and benefits of treatment options and involve patients in decisions about their management
- sufficient knowledge and skill in diagnosis to ensure the safe and effective practice of dermatology
- competence in establishing a differential diagnosis by the appropriate use of history, clinical examination and investigations
- an ability to carry out minor practical procedures
- knowledge of NICE guidelines and other guidance relevant to skin disease
- recognition of their limitations in expertise and knowledge of mechanisms of referral.

Specific knowledge, attitude and skills

A curriculum for the GPwER follows, which includes syllabus content, teaching and learning and assessment. This is considered to be the minimum standard that must be met by any generalist wishing to offer a dermatology GPwER diagnosis and management service.

5.2 Curriculum: syllabus content

Specific content for training – all dermatology GPwERs (groups 1, 2 and 3) should have a good understanding of:

- the importance of skin type
- the recognition and management of common non-malignant, premalignant and malignant lesions, using history, clinical examination and dermoscopy, including:
  - benign melanocytic naevi
  - seborrhoeic keratoses (basal cell papilloma)
  - dermatofibroma
  - haemangioma
  - epidermoid and pilar cysts
  - lipoma
  - pyogenic granuloma and blood vessel-derived tumours
  - hypertrophic and keloid scars
  - actinic keratosis
  - Bowen's disease
  - keratoacanthoma
  - squamous cell carcinoma
  - BCC
  - lentigo maligna
  - melanoma
- the recognition and management of rarer solitary lesions such as Spitz naevi, sebaceous tumours and relevant adnexal tumours (e.g. pilomatrixoma, syringomas, cylindromas)
- the link between skin lesions and other systemic conditions (e.g. family cancer syndromes, cutaneous metastases, long-term immunosuppression)

- current NICE guidelines and other relevant guidance on managing low-risk BCC, either surgically or non-surgically
- local referral pathways and working as part of a multidisciplinary team.

Additional content for training – Groups 1 and 3 Dermatology GPwERs:

- the recognition and holistic management of common dermatoses and their symptoms, including:
  - eczema
  - psoriasis
  - acne
  - rosacea
  - perioral dermatitis
  - seborrhoeic dermatitis
  - urticaria/angioedema
  - pruritus
  - granuloma annulare
  - infections and infestations
  - leg ulcers and gravitational disease
  - lichen simplex chronicus
  - lichen planus
  - pigmentary disorders including vitiligo
  - hyperhidrosis
  - hirsutism
  - common hair and scalp conditions, and recognising when to refer to a dermatologist (e.g. scarring alopecia)
  - common nail conditions (e.g. psoriasis and fungal infections)
- an understanding and recognition of the groups of conditions listed below, some of which occasionally present to a GPwER clinic, and most of which require treatment by a dermatologist:
  - dematological emergencies (e.g. erythroderma, pustular psoriasis)
  - common and important adverse cutaneous drug eruptions (e.g. exanthematous, toxic epidermal necrolysis)
  - skin manifestations of systemic disorders
  - common and important genital dermatoses (e.g. lichen sclerosus)
  - photodermatoses
  - connective tissue disorders (e.g. lupus, scleroderma, dermatomyositis)
  - bullous disorders (e.g. bullous pemphigoid)
  - dermatitis artefacta
- the psychosocial issues that affect many patients with skin conditions and their management, and the use of the Dermatology Quality Of Life Index (DQLI)[11] and other quality-of-life measures
- the importance of skin type and how it can affect the presentation and management of skin conditions.

It is usually expected that competencies should be assessed when the patient is in clinic. There may be occasions when some of the conditions listed above are seen so infrequently by the candidate that an assessment can only be performed based on images of a patient seen during a previous encounter (with adherence to guidelines on medical photography and data protection), or other images of the condition (for example in books or on the internet).

Understanding the appropriate use of different diagnostic and investigatory tools – dermatology GPwERs should have a good understanding of:

All dermatology GPwERs

- dermoscopy
- histology

Groups 1 and 3 Dermatology GPwERs

- bacteriology, mycology and virology
- serology
- patch testing
- the use of different stain techniques, including the importance of immunofluorescence studies used in bullous and connective tissues disorders.

Skin surgery – Groups 2 and 3 Dermatology GPwERs should have a good understanding of:

- NICE guidelines and other relevant guidance in relation to providing services for and the management of patients with skin cancer
- issues relating to skin surgery facilities, obtaining informed consent, documentation, specimen transportation, infection control, audit and drug administration
- the importance of comorbidities and relevant drug history
- anatomical hazards
- aseptic technique
- local and topical anaesthesia
- the handling of surgical instruments
- suture techniques
- perioperative complications
- postoperative wound care, including the management of postoperative complications, (e.g. haemorrhage, wound dehiscence and infection)
- the management of hypertrophic/keloid scars.

Although the curriculum relating to procedures will vary depending on the range and complexity of the surgery that the GPwER is providing in his or her clinical practice groups 2 and 3 dermatology GPwERs would be expected to be competent in all of the following:

- curettage and cautery

- shave biopsy or excision
- incisional biopsy, including punch biopsy
- elliptical excision
- suturing:
  - surface interrupted sutures
  - deep sutures
  - pulley sutures or horizontal (looped) mattress sutures – it is important to know at least one of these two methods, which are occasionally needed when the skin is under significant tension (e.g. some procedures on the lower legs)
- dog ear prevention and repair
- the use of wound closure strips and surgical glue
- the use of intralesional corticosteroids for the treatment of hypertrophic and keloid scars
- procedures **not essential** for GPwER accreditation include:
  - other suture techniques (e.g. subcuticular, purse string)
  - flaps and grafts.

NB: Group 1 Dermatology GPwERs may need to be familiar with the relevant sections of the skin surgery curriculum and complete the appropriate assessments, for example if they plan to perform punch/incisional biopsies for inflammatory dermatoses, or use intralesional corticosteroids.

Knowledge of the appropriate use of non-surgical treatments used in basal cell carcinoma, pre-cancerous lesions, and occasionally other conditions:

- cryosurgery
- topical agents used in the management of precancerous lesions and some BCCs
- skin radiotherapy
- photodynamic therapy (PDT).

Knowledge of the appropriate use of topical agents/treatments – Groups 1 and 3 Dermatology GPwERs should have a good understanding of:

- emollients
- vitamin D derivatives
- topical steroids
- topical antibiotics, antivirals and antifungals
- topical retinoids
- topical immunomodulators (pimecrolimus and tacrolimus)
- wet wraps and emollient wraps
- leg ulcer dressings
- keratolytic agents.

Appropriate use and monitoring of systemic therapy – Groups 1 and 3 Dermatology GPwERs should have a good understanding of:

- antihistamines
- antibiotics, antivirals and antifungals
- antimalarials
- oral steroids
- oral retinoids
- narrow band ultraviolet B (UVB) and psoralen plus ultraviolet A (PUVA).

Appropriate use and monitoring of cytotoxics and immunosuppressants – Groups 1 and 3 Dermatology GPwERs

The following medications should be instigated by a consultant:

- azathioprine
- methotrexate
- ciclosporin
- biologics and small molecules drugs
- other systemic treatments used to treat moderate to severe inflammatory dermatoses.

However, GPwERs are expected to know when such treatments may be required and how these medications are monitored, as they may be involved in the long-term follow-up of such patients.

Oral retinoid prescribing

Isotretinoin

The current Medicines and Healthcare products Regulatory Agency (MHRA) view on isotretinoin prescribing (August 2007)[12] is as follows.

The summary of product characteristics in the licence for isotretinoin states that it can be prescribed by or under supervision of physicians with expertise in the use of systemic retinoids for the treatment of acne and a full understanding of the risks of isotretinoin and monitoring requirements. This wording is chosen for compliance with other European states but in the UK refers to consultant dermatologists.

The MHRA position therefore makes it inappropriate for this guidance document to provide a national framework to accredit GPwERs in the prescribing of isotretinoin. Consultant dermatologists and experienced GPwERs working within an integrated service may wish to develop a locally agreed care pathway and accreditation process to facilitate the prescribing of isotretinoin by a GPwER. However, they need to be mindful that this is an 'off-licence' indication and cognisant of the MHRA view. They may also wish to seek the advice of their professional indemnity organisation.

Acitretin and alitretinoin

The summary of product characteristics state that acitretin and alitretinoin should be prescribed only by dermatologists or physicians with experience in the use of systemic retinoids who have a full understanding of the risks of systemic retinoid therapy and monitoring requirements. The MHRA has indicated that acitretin and alitretinoin should be prescribed within the same context as isotretinoin. Additionally, clinicians prescribing alitretinoin should do so with reference to NICE guidelines.[13]

5.3 Curriculum: teaching and learning

Theoretical training

Practitioners are expected to demonstrate that they have completed recognised training, which may include acknowledgement of prior learning and experience. This can be acquired in different ways, many of which are complementary and should not be considered to be mutually exclusive:

- relevant, current or recent experience (within the last 5 years) in a specialised dermatology setting (e.g. dermatology outpatient department, a community GPwER clinic)
- successful completion of an appropriate postgraduate qualification in dermatology or dermatological surgery (e.g. certificate, diploma, masters) – this is recommended as a good way of obtaining and demonstrating structured learning
- self-directed learning via the internet with evidence of the completion of individual tasks
- attendance at recognised meetings, lectures or tutorials on specific relevant dermatological topics.

Clinical training

This should be tailored and appropriate to the training needs of the GPwER but will include attachment to a relevant specialist(s) (refer to Annex A for definition of a specialist). The GPwER will need to attend sufficient clinics to be able to obtain training and experience relevant to the specified area of clinical practice and be able to demonstrate the competences required to meet the assessment requirements for accreditation. Training and experience are required in the following areas:

All dermatology GPwERs (groups 1, 2 and 3)

- use of a dermatoscope and its role in supporting the diagnosis of skin lesions
- indications for and use of cryosurgery
- medical management of premalignant skin lesions (e.g. actinic keratoses, Bowen's disease) and basal cell carcinomas
- indications for using skin radiotherapy
- basic histology.

Groups 1 and 3 Dermatology GPwERs

- taking of samples for bacteriology, mycology and virology investigations
- diagnosis, assessment and management of patients with common skin diseases to the standard accepted for accreditation
- knowledge of different staining techniques for histological specimens and an understanding of when the different stain techniques are indicated (such as immunofluorescence) and requirements for preparation and fixation of samples if needed
- use and application of day treatment and phototherapy
- management of leg ulcers including Doppler ankle brachial pressure index (ABPI) assessment
- use and application of patch testing.

Skin surgery

- Group 1 Dermatology GPwERs will need to undertake training in the procedures necessary to take diagnostic biopsies of inflammatory dermatoses if they choose to take on a surgical role for this group of patients
- Groups 2 and 3 Dermatology GPwERs will need to undertake training in those procedures needed for skin lesion management, e.g. shave excision, curettage and cautery, incisional biopsy and elliptical excision

Ways in which this clinical training can be achieved include:

- during the foundation year 2 (F2) post
- as a GP specialty trainee undertaking a 6-month GP Specialty Training (ST1) attachment
- as part of a ST1 programme
- as a hospital practitioner or specialty doctor under the supervision of a consultant dermatologist (and plastic surgeon for skin surgery skills) in a secondary care dermatology service
- working with an experienced GPwER in the community
- working with another relevant specialist (refer to **Annex A** for definition of a specialist) as a clinical placement agreed locally.

The most suitable teaching and learning and assessment methods will vary according to individual circumstances and it is recommended that this is agreed between the GP and the clinical supervisor in advance (refer to **Annex A** for definition of a clinical supervisor).

Teaching/learning methods

A number of different teaching and learning methods can be utilised, including:

- acquiring many of the required competences during the attachment to a relevant specialist(s) (refer to **Annex A** for definition of a specialist) who can sign off each skill as it is acquired
- case-based discussion (CBD), including a periodic review of notes by the clinical supervisor
- attendance at a structured course of lectures or tutorials designed to cover basic dermatology a combination of clinical assessments and DOPS, depending on the type of service offered

A mix of theoretical training, supervised practice and competency-based assessment

In addition to the assessment tools used in this document, some universities have developed training modules that include theoretical training followed by supervised practice and formal clinical competence-based assessments. Such courses use many of the assessment tools described in this framework. Although these courses are no substitute for clinical experience (which is the most effective way of gaining knowledge and demonstrating clinical competence), this type of training module can be useful in supporting the training and accreditation process for GPwERs.

5.4 Curriculum: assessment

This includes the evidence required to assess competences and provide sufficient evidence to demonstrate that a candidate can work autonomously and provide high-quality care in general dermatology and skin lesion management. The required evidence has been agreed nationally by appropriate stakeholders.

Methods of demonstrating competency include:

- relevant postgraduate qualification in dermatology (strongly recommended). Group 2 Dermatology GPwERs may consider alternatives such as dermoscopy and surgical modules/ qualifications
- observed practice using the modified mini-CEX
- observed practice by DOPS
- reflection on learning activities, which should include:
  - CBD, including a review of clinical notes
  - independent study, teaching or courses attended
  - evidence of participation in skin cancer multidisciplinary teams (MDTs) when appropriate
- audit
- observed communication skills, attitudes and professional conduct – these can be assessed through the use of patient surveys, multi-source feedback (MSF) and SCSRs
- senior clinical supervisor's report (SCSR)
- any other learning points – clinical or non-clinical.

It is preferable to have more than one clinical supervisor (**Annex A**) involved in the assessment of competencies. It is expected that the SCSR would be completed by the senior clinical supervisor (**Annex A**).

Refer to **Annex E** for further information on the assessment of competencies.

5.5 Curriculum: evidence required

Generalist skills, which are an important aspect of the care delivered by a GPwER, are demonstrated through successful completion of the Royal College of General Practitioners (MRCGP) assessment

or equivalent routes to the generalist register. The specific evidence required for dermatology is as follows.

All dermatology GPwERs (groups 1, 2 and 3)

A relevant postgraduate qualification in dermatology/skin surgery is strongly recommended. If the candidate does not have such a qualification, he or she will need to provide adequate evidence in other areas to demonstrate competency, for example through other training modules that facilitate structured learning of relevant topics, longer clinical attachments and greater reflection on learning.

The requirements should be agreed by the clinical supervisor and GPwER at the start of the training and continually reviewed throughout the training.

Group 1 Dermatology GPwERs: Medical Dermatology

- Mini-CEX for skin lesions (Form 1) and inflammatory dermatoses (Form 2).
- DOPS1 (Form 3a) for those performing skin biopsies of inflammatory dermatoses.
- Reflection on learning activities – CBD, MDT, courses attended, independent learning (Form 4).
- Reflection on a patient survey (Forms 5a and 5b).
- SCSR (Form 7a).
- Any other information relevant to the training.

Group 2 Dermatology GPwERs: Skin Lesion Management

- Mini-CEX for skin lesions (Form 1).
- DOPS2 (Form 3b).
- Reflection on learning activities – CBD, MDT, courses attended, independent learning (Form 4).
- Audit – complete excision rates of BCC with reflection, or an alternative, such as clinical diagnosis versus histology if not managing BCC (refer to Form 6 for guidance).
- Reflection on a patient survey (Forms 5a and 5b).
- SCSR (Form 7a).
- Any other information relevant to the training.

Group 3 Dermatology GPwERs: Medical Dermatology and Skin Lesion Management

- Mini-CEX for skin lesions (Form 1).
- Mini-CEX for inflammatory dermatoses (Form 2).
- DOPS1 (Form 3a)
- DOPS2 (Form 3b)
- Reflection on learning activities – CBD, MDT, courses attended, independent learning (Form 4).
- Audit – complete excision rates of BCC with reflection, or an alternative, such as clinical diagnosis versus histology if not managing BCC (refer to Form 6 for guidance).

- Reflection on a patient survey (Forms 5a and 5b).
- SCSR (Form 7a).
- Any other information relevant to the training.

As part of the verification process the RCGP will contact a random selection of senior clinical supervisors.

All relevant documentation required for the collection and submission of evidence can be found on the RCGP website (www.rcgp.org.uk/GPwER-dermatology).

There are significant differences between a GP providing a commissioned skin surgery/minor surgery service (such as under a DES or LES contract) and a GPwER:

- **GPs providing surgical services** - manage benign skin lesions and small low-risk BCC beneath the clavicle. They are **first and foremost surgical services**. GPs would be expected to have an understanding of lesion recognition appropriate to their surgical remit but they have **not** undertaken specialist training and competency based assessment in skin lesion recognition and management. In essence, skin surgery services such as DES or LES only cover clinical remits that are within the normal scope of General Practice; as such the RCGP **does not** consider that such roles warrant extended role accreditation. It remains good practice to make certain that the premises used are fit for purpose, and that the GP has their surgical competencies assessed (for example using a Direct Observation of Practical Procedure assessment tool) and periodically reviews their quality of their care.
- **GPwERs** – work as an integrated team with commissioned secondary care services. GPwERs have undertaken formal specialist training and assessment in the diagnosis (clinical and dermoscopic) of skin lesions, enabling the GPwER to be commissioned to provide **skin lesion clinics** (excluding 2-week waits). Groups 2 and 3 GPwER also provide **surgical services** with a wider remit, which may include certain BCC on the head and neck (refer to Annex C). The remit described is broad and so formal accreditation is required.

6. Existing GPs with a Special Interest: transition to GP with Extended Role status

It is recognised that alternative arrangements are required for those GPwSIs who have been previously accredited in line with the 2007[14] or 2011[2] Department of Health guidelines for GPwSI in dermatology, skin surgery or community skin cancer services. Although such individuals are required to go through the same accreditation process, including completion of the Portfolio of Evidence document, less evidence is required.

The requirements for this group are as follows:

- evidence of former successful accreditation through an appropriate body (for example a Deanery, Clinical Commissioning Group, Primary Care Trust)*
- SCSR – it is expected that this would be completed by a relevant consultant (in most cases a dermatologist); in exceptional circumstances (e.g. if there is no local consultant), refer to the RCGP website (www.rcgp.org.uk) for advice
- reflection on a patient survey
- an audit (Groups 2 and 3 GPwERs only) of complete excision rates of BCC with reflection, or an alternative, such as clinical diagnosis versus histology if not managing BCC (refer to Form 6 for guidance).
- specialty-specific personal development plans.

*It is normally expected that a GPwSI going through transition will provide evidence of previous accreditation. In exceptional circumstances (for example if the initial accreditation process was undertaken many years ago and the sign-off documents have not been retained) the superior clinical supervisors report (Form 7b) contains a declaration that the consultant can sign if they are able to acknowledge previous accreditation.

As part of the verification process the RCGP will contact a random selection of senior clinical supervisors, to confirm the report submitted was completed and signed off by themselves

7. Maintaining good medical practice

Monitoring and clinical governance

Mechanisms of clinical governance for the dermatology GPwER and the service provided should meet nationally agreed standards of care. Principles for this are included in the RCGP generic guidance for GPwERs.[3]

7.1 Maintenance of competences

The dermatology GPwER should identify a clinical guide (refer to **Annex** A for definition of a clinical guide), which in some cases will be the same individual who acted as the clinical supervisor during the accreditation process, to undertake an annual performance review of the specialist GPwER role. Once completed and signed off, the document can be attached to the whole scope of practice appraisal document used by the GP appraiser. Successful annual appraisal over a 5-year cycle will enable revalidation. For further information refer to the RCGP framework[3] to support the governance of GPwER.

To develop and maintain skills in dermatology, regular exposure to patients with skin disease in the appropriate clinical area is important and the following is normally required to ensure good clinical practice:

- **Group 1 Dermatology GPwERs (Medical Dermatology)** – at least one clinical session per week in the specialist area to obtain adequate exposure to a varied case mix.
- **Group 2 Dermatolgy GPwERs (Skin Lesion Management)** – a minimum of 20 surgical lists per year, with an average of five per list; predominantly ellipse excisions are recommended. An annual audit should also be undertaken (if managing BCC refer to section 7.3, otherwise consider an alternate audit, e.g. clinical diagnosis versus histological diagnosis).
- **Group 3 Dermatology GPwERs – a combination of groups 1 and 2**.

If a dermatology GPwER has not had the levels of exposure to patients with skin disease as referred to above, they must reflect on the reasons why, with their clinical guide, as part of their specialist annual performance review, and come to an appropriate professional judgement about the implications for continuing in the role and to support the development of appropriate personal development plan (PDP) goals to ensure that patient safety can be maintained. There will always be exceptional cases where the requirements of the role are outside the normal range and it is important that there are structures in place for dermatology GPwERs working in such a way to demonstrate to their responsible officer that they have maintained their skills in the extended role.

It is considered best practice to work alongside a clinical guide (for definition of clinical guide refer to Annex A) on a regular basis, ideally at least monthly, to provide opportunities for continuing professional development (CPD) through the discussion of difficult cases. There are many other ways in which CPD can be gained, including through active membership of relevant dermatology organisations.

Dermatology GPwERs are also expected to demonstrate evidence of quality improvement activity (QIA) in their specialist role. Examples of QIA include learning from cases, data and events, for example:

- Reflection on CBDs.
- Reflection and review of a set of clinic notes, alone or with a clinical guide.
- Reflection on the outcomes of clinical audit – this can be non-surgical, surgical or both depending on the GPwER role. Surgical audit may include clinical versus histological diagnosis accuracy, complete excision rates of BCC, complication rates and cosmetic outcomes using serial photography.
- Learning and changes made from any learning events (positive and negative) or GMC-level significant events.
- Reflection on feedback from patients and colleagues, both solicited (at least once in the revalidation cycle) and unsolicited (in the form of complaints and compliments and other ad hoc feedback).
- Reflection on service redesign and management activity.
- Reflection on any teaching or training undertaken in the role.

For all of the above, the GMC emphasises the importance of lessons learned and changes made as a result.

It should also be the role of the service in which the GPwER works to monitor standards, which may include:

- clinical outcomes and quality of care
- access times to the service
- new to follow-up ratios
- onward referral rates to other specialists.

7.2 Specific requirements for those Groups 2 and 3 Dermatology GPwERs managing basal cell carcinomas

England and Wales

There are two NICE documents that relate to the management of low-risk BCC in the community: *Improving outcomes for people with skin tumours including melanoma (update)*[4] and *Improving outcomes for people with skin tumours including melanoma*.[5]

The recommendations in this document reflect the NICE guidance above, which is as follows:

- GPwERs working in the community who knowingly treat skin cancer patients should be approved by, and be accountable to, the local hospital skin cancer MDT (LSMDT) or specialist skin cancer MDT (SSMDT) lead clinician.
- They should work closely together to agreed local clinical protocols for referral, treatment and follow-up. GPwERs should attend at least four LSMDT meetings per year, one of which should be the MDT audit meeting during which the GPwER's annual BCC data should be presented.

Figures should be compared with national standards as well as those of colleagues working in the local skin cancer network.

- Undertaking a minimum of 4 hours of CPD on skin cancer annually. This could be achieved by attending an educational meeting organised by the local skin cancer network site-specific group. Relevant dermatology organisations also provide opportunities for skin cancer CPD.

Devolved nations

- Refer to appropriate local and national guidelines.

Additional audit opportunities for any Group 2 or 3 Dermatology GPwERs (England, Wales and the devolved nations)

Other audits are not mandatory, but depending on PDPs as discussed with the clinical guide, may include:

- patient experience with evidence of cosmetic outcomes (e.g. using before and after clinical photography)
- complication rates to include infection, dehiscence and incomplete excision rates.

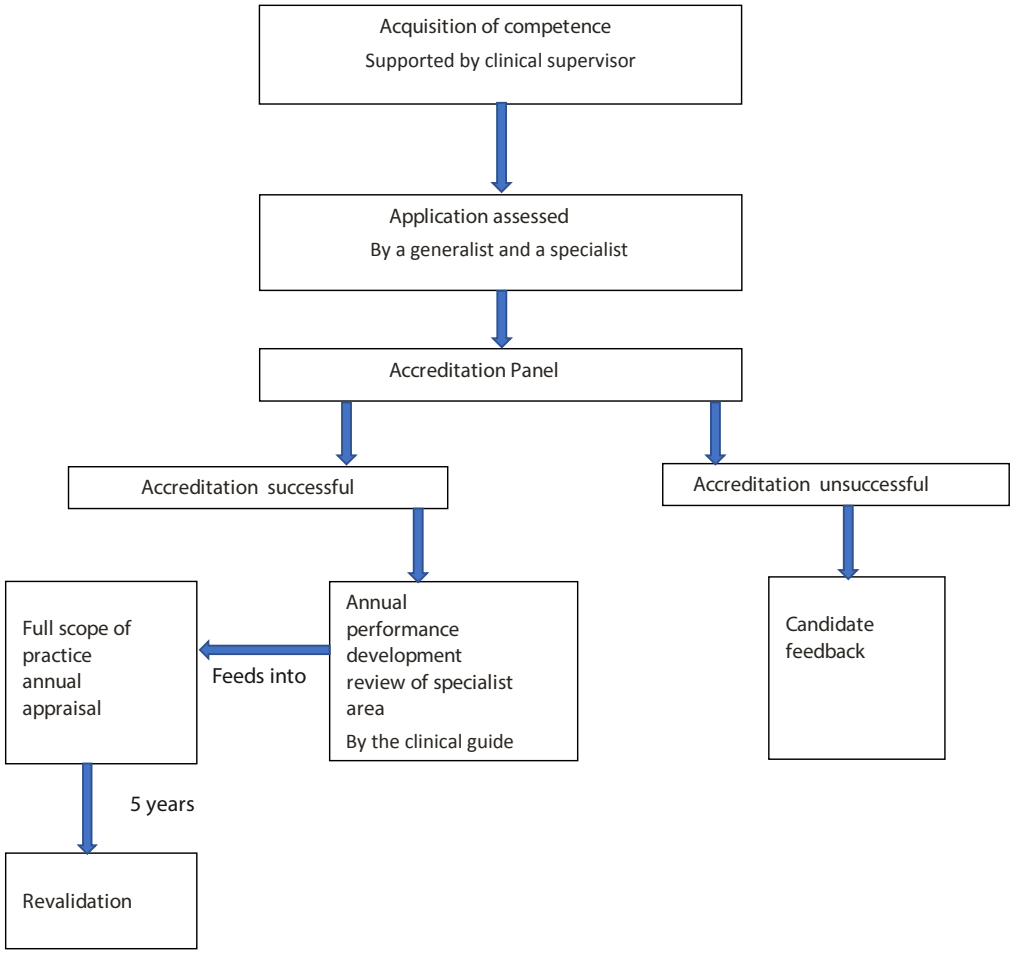
7.3 Extension of roles

- Individual competences – if you seek to extend your remit in dermatology or skin surgery, you will need to demonstrate attainment of relevant competencies, which would need to be signed off by your Clinical Guide, and a copy kept for your records.
- Groups – moving up from one group to another is a broad change in practice and requires further accreditation. Please refer to the post-accreditation page on the GPwER section of the RCGP website.

Annex A: Glossary of terminology

Clinical supervisor	Pre-accreditation supervising peer – may be a specialist in the relevant extended role or another health professional supervising within their sphere of competence in relation to what is being assessed. A GP may have more than one clinical supervisor, each supervising a different area of competence.
Senior clinical supervisor	The clinical supervisor who has regular clinical interaction with the candidate and is required to complete the senior clinical supervisor's report. The senior clinical supervisor is usually expected to be a consultant, associate specialist or RCGP accredited GPwER working as part of an integrated model with secondary care colleagues.
Clinical guide	Post-accreditation peer – usually the specialist who undertakes the annual performance development review as additional evidence for the whole scope of practice appraisal.
GPwER	General Practitioner with Extended Role A GP undertaking an area of work that is beyond core general practice and the MRCGP and requires additional training. Although not mandatory, the RCGP considers accreditation in an extended role to be best practice.

Annex B: The GP with Extended Role accreditation process flowchart



Annex C: Definition of low-risk basal cell carcinoma (BCC) for GPs with Extended Role

The following NICE definition is used **ONLY** in the context of GPwERs. The definition for GPs managing BCC under DES/LES and other recognised arrangements differs. Like all guidance, this list is a guide – the spectrum of BCCs managed by an individual GPwER will be determined partly by the competences that have been signed off and partly by arrangements agreed with local consultants working within the skin cancer MDT.

The definition of a low-risk BCC is made after **EXCLUDING** the following.

Patients who are:

- aged 24 years or younger
- immunosuppressed or have Gorlin's syndrome.

Lesions that:

- are on the nose and lips (including nasofacial sulci and nasolabial folds) or around the eyes (periorbital) or ears
- are greater than 2cm in diameter below the clavicle or greater than 1cm in diameter above the clavicle, unless they are superficial BCCs that can be managed non-surgically
- are morphoeic, infiltrative or basosquamous in appearance
- have poorly defined margins.

A review of the NICE guidelines on low-risk BCC is expected in due course.

Annex D: Points to consider when developing a service model for GP with Extended Role services

General

- The types of patients with skin disease suitable for the service should be considered, including age range, symptoms, severity of symptoms, minimum and maximum caseload/frequency and reason for referral.
- It is important that the workload is such that the GPwER is able to exercise his or her generalist as well as special interest skills.
- The numbers seen should be sufficient to maintain and develop expertise to justify the need for the services and should be broadly in line with those seen in a comparable hospital-based dermatology clinic.
- Patients referred to the service are unlikely to have acute or emergency skin disease or skin cancer (unless a specific skin cancer service is being developed). Nevertheless, it is expected that the GPwER will have in place appropriate care pathways to manage such patients if they present unexpectedly to the service.

Where skin surgery services are being provided across a health community, commissioners are reminded that patients should be reassured about the following:

- that the procedures being performed are necessary
- that it is appropriate to have the procedure performed (in relation to agreed local and national low priorities frameworks)
- that the appropriate procedure is performed (this requires access to diagnostic skills)
- that the clinician performing it is suitably trained
- that the facilities are to the appropriate standard.

We recommend that commissioners commission skin surgery services as part of an integrated model of dermatology services.

Local guidelines for the use of the service

Details will be determined at local level following negotiations between key stakeholders within the local community, including patient groups wherever possible. The service needs to reflect the requirements of the local community.

Local guidelines for the service should reflect and incorporate nationally agreed guidelines and as such the GPwER will demonstrate awareness of national relevant advice issued by organisations such as the BAD, NICE, Department of Health and other relevant organisations. These guidelines should include the following information for referring clinicians:

- types of patients to be referred to the service, including inclusion and exclusion criteria
- referral pathways
- response time
- communication pathways.

Annex E: Assessment tools

It is expected that, as part of the accreditation process, the assessment of competences will include observation of clinical practice using approved work place-based assessment tools. The recommended clinical assessment tools include the modified mini-CEX, DOPS and CBD linked to a learning diary. Additional supporting evidence such as reflection on courses attended, CSR and patient surveys are required to provide a more holistic assessment of the candidate.

The assessments should cover the range of knowledge and skills required for the clinical service to be provided.

The following notes are intended to support the effective use of these assessment tools:

- The assessments will be performed by suitably trained clinical supervisors (refer to **Annex A**) with experience of the use of the appropriate assessment tool.
- The clinical supervisor should be suitable to undertake the assessment. For example, for advanced skin surgery procedures this may be a suitably trained surgeon.
- Whenver possible, more than one clinical supervisor should be involved in the assessment process; this is particularly important in cases in which the mentor is one of the assessors.
- It is strongly recommended that a series of appropriate clinical assessments, including a modified mini-CEX and DOPS (when appropriate), takes place at reasonable time intervals until competency has been demonstrated during the training period prior to accreditation.
- The clinical supervisor is expected to be present throughout the session and to make assessments from several patient interactions covering different clinical domains.
- Several modified mini-CEXs covering different areas are expected to be performed during each of the clinical assessment sessions.
- The subject/areas covered will depend on the type of service that the dermatology GPwER is going to offer. This will be agreed at the start of the training.
- The assessment outcome will be 'satisfactory' or 'unsatisfactory'. Time will be allocated for feedback.
- It is recommended that one of the assessments should include a review of case notes and, for those offering a surgical service, a review of histology reports (e.g. to consider appropriateness of procedure, completeness of excision).
- It is expected that GPwERs will need training in the recognition and management of conditions normally seen/managed in secondary care and that this knowledge will be acquired via continuing medical education.
- Learning diary – an ongoing process that can be used for CBD, reflection from CPD, reflection from MDT meetings and other competences that are not included but desirable.
- As a post evolves and develops into new clinical areas following accreditation for a particular role, further assessments may be required to demonstrate new competences appropriate to a changing role.
- Studying for a diploma in dermatology provides a good opportunity for structured learning.
- Clinicians will be expected to demonstrate evidence of colleague feedback, for example through the SCSR.

Helpful general and specialty-specific guidance for the use of DOPS and the mini-CEX can be found at the websites of the RCGP (www.rcgp.org.uk), BAD (www.bad.org.uk) and Joint Royal Colleges Postgraduate Training Board (www.jrcptb.org.uk).

Annex F: Capabilities in practice – an overview

CiPs focus on what happens in clinical practice, requiring demonstration of multiple competences simultaneously and specific knowledge, skills, attitudes and behaviours. This framework maps to two CiPs, as shown below.

Capable of working autonomously and providing high-quality care for general dermatology conditions in a community setting – this relates to Group 1 Dermatology GPwERs		
DESCRIPTOR (key observable activities, tasks, behaviours)	**EVIDENCE**	**RELEVANT COMPETENCES FROM THE CURRICULUM**
Formulates appropriate diagnostic and management plan for inflammatory skin dermatoses, skin infections, other skin eruptions and skin manifestations of internal disease Demonstrates understanding of dermatopathology reports and the structure and function of normal skin Demonstrates safe prescribing and monitoring of common dermatological topical and systemic therapies Demonstrates ability to work within scope of own practice and refer to secondary care when required	DOPS Mini-CEX CBD MSF CSR Reflection on independent study, teaching and courses attended Evidence of appropriate medical records, correspondence or referrals to multiprofessional colleagues Audit Patient surveys	Recognition and holistic management of common dermatoses and their symptoms, including variants of eczema, psoriasis, acne, urticaria/angioedema, rosacea, infections and infestations, leg ulcers, lichen simplex chronicus, lichen planus, drug eruptions, disorders of the hair and nails, pigmentary (hyper and hypo) disorders, hyperhidrosis, hirsutism, photodermatoses, connective tissue disorders, bullous dermatoses, dermatitis artefacta and skin manifestations of systemic disease Understanding of serology, bacteriology, mycology, virology and contact dermatitis investigations Understanding and use of dermoscopy and histology, including immunofluorescent studies Appropriate use of liquid nitrogen, topical medical oncology treatments and PDT Appropriate use of emollients, vitamin D derivatives, topical steroids, topical antibiotics, antivirals and antifungals, topical immunosuppressants, emollients and wet wraps, leg ulcer dressings and keratolytic agents Appropriate use and monitoring of systemic agents such as antihistamines, antibiotics, antivirals, antifungals, antimalarials, oral steroids and oral retinoids Appropriate use of phototherapy, leg ulcer management and Doppler ABPI assessment Appropriate use and monitoring of cytotoxic and immunomodulating agents aligned with NICE guidelines such as azathioprine, methotrexate, ciclosporin Appropriate use and monitoring of biologics and small-molecule drugs

Capable of working autonomously and providing high-quality care in a community skin lesion clinic – this relates to Group 2 Dermatology GPwERs		
DESCRIPTOR (key observable activities, tasks, behaviours)	**EVIDENCE**	**RELEVANT COMPETENCES FROM THE CURRICULUM**
Formulates an appropriate diagnosis and management plan for benign, premalignant and malignant skin lesions Demonstrates understanding and use of dermoscopy Demonstrates ability to appropriately perform curettage and cautery, punch and incisional biopsy and excision of benign and malignant lesions Demonstrates ability to appropriately use or refer lesions for medical or device-based therapies Demonstrates understanding of dermatopathology reports Demonstrates ability to recognise differential diagnoses of skin lesions (e.g. discoid eczema, plaque psoriasis) Familiarity with and knowledge of NICE guidelines and other relevant skin cancer guidance Demonstrates ability to manage hypertrophic/keloid scars	DOPS Mini-CEX CBD MSF CSR Reflection on independent study, teaching and courses attended Reflection of cases discussed in skin cancer MDTs Evidence of appropriate medical records, correspondence and/or referrals to multiprofessional colleagues Audit Patient surveys	Recognition and management of common non-malignant, premalignant and malignant lesions and rarer solitary skin lesions Recognition of the links between skin lesions and systemic conditions Understanding of the importance of skin type Understanding of diagnostic and investigatory tools, including dermoscopy and histology Understanding of issues relating to skin surgery facilities, informed consent, documentation, specimen transportation, infection control, audit and administration Understanding of comorbidities, relevant drug history, anatomical hazards, aseptic technique and local and topical anesthesia Ability to handle surgical instruments, perform suturing techniques and achieve haemostasis Understanding of NICE guidelines Ability to manage perioperative and postoperative care and complications, including hypertrophic/keloid scars Ability to appropriately use cryosurgery and topical medical oncology treatments and PDT

Annex G: List of contributors

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