

Rough Guide to Genitourinary Medicine Guidance for training programme directors, supervisors and residents

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ROYAL COLLEGE
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of EDINBURGH



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Contents

Introduction.....	3
What is different about the 2022 Genitourinary Medicine curriculum?	3
The Genitourinary Medicine curriculum	3
Capabilities in Practice (CiPs)	4
Assessment: What is required from residents and trainers?	8
Types of evidence	13
Induction Meeting with ES: Planning the training year	16
Induction Meeting with Clinical Supervisor (CS).....	17
Transition arrangements for residents already in programme	18
Annual Review of Competence Progression (ARCP)	24
Genitourinary Medicine 2022 ARCP Decision Aid.....	24
The Training Programme.....	30
Training requirements for GUM and HIV	30
Allied specialty training requirements.....	35
Training and IMS2 resources	41
Glossary of abbreviations.....	42
Appendix: Experience Log	44

Introduction

This guide for Genitourinary Medicine (GUM) is to help training programme directors (TPDs), supervisors, residents and others with the practicalities of implementing the new curriculum. It is intended to supplement rather than replace the curriculum document itself. The curriculum, ARCP decision aid and this guide are available on the JRCPTB website.

The Rough Guide has been put together by members of the GUM Specialist Advisory Committee with additional help from many external stakeholders especially residents. It is intended to be a 'living document' and we value feedback via curriculum@jrcptb.org.uk.

What is different about the 2022 Genitourinary Medicine 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) which are based on the concept of entrustable professional activities (EPAs). 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](#).

Duration of training

GUM higher specialty training will usually be completed in four years of full-time training. There will be options for those residents who demonstrate exceptionally rapid development and acquisition of capabilities to complete training sooner than the indicative time. There may also be residents 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](#)).

The Genitourinary Medicine curriculum

The purpose of [the curriculum](#) is to produce doctors with the generic professional and specialty specific capabilities required to lead IM, GUM and HIV services. Upon successful completion of this training or recognition of equivalent training/experience they will be able to provide the highest standards of medical care for patients with STIs and related conditions including: meeting their immediate contraceptive needs, sexual assault, genital dermatoses, sexual dysfunction and the medical care of HIV positive individuals. These doctors will have well developed communication skills and the ability to lead multi-professional teams and work collaboratively with other healthcare professionals within and beyond medicine to provide the holistic health care that patients with, or at risk from sexual ill-health require.

Equally important is the prevention of STIs, HIV and unplanned pregnancy and these doctors will be able to provide and train others in appropriate interventions to promote sexual health. Doctors will also be able to diagnose, treat and manage a wide range of general medical conditions and be able to care for these patients in acute, on call or out-patient settings. Upon completion of this curriculum doctors will be eligible for a CCT which facilitates dual entry onto the GMC specialist register in GUM and IM; an assurance that this doctor is at this point able to undertake high level independent practice as a consultant in GUM and IM in the NHS/HSC in the four nations.

In order to work effectively within integrated sexual health services delivering optimal care, GUM doctors need to be able to safely and effectively assess patients' contraceptive needs, meeting those initially wherever possible and referring into specialist services where indicated.

Concurrently, residents will build on their IM training and attain the experience required to demonstrate competence to deliver general medical care for acute and internal medical patients as inpatients and outpatients. This is required as our patients have increasingly complex co-morbidities and multi-system presentations and their care will be enhanced by broad-based generalist training. Residents will develop the experience and expertise required for attaining the full range of GPCs.

Doctors in training will 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 resident will receive a dual CCT in Genitourinary Medicine and Internal Medicine.

Capabilities in Practice (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 **clinical CiPs** describe the capabilities required for Internal Medicine. The **specialty CiPs** describe the professional tasks or work within the scope of Genitourinary Medicine.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help residents and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated for an entrustment decision to be made.

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

Internal Medicine Clinical CiPs

1. Managing an acute unselected take
2. Managing the acute care of patients within a medical specialty service
3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment
4. Managing patients in an outpatient clinic, ambulatory or community setting, including management of long-term conditions
5. Managing medical problems inpatients in other specialties and special cases
6. Managing a multi-disciplinary team including effective discharge planning
7. Delivering effective resuscitation and managing the acutely deteriorating patient
8. Managing end of life and applying palliative care skills

Specialty CiPs (Genitourinary Medicine)

1. Managing patients with non-complex GUM presentations in out-patient or community settings
2. Managing patients with complex GUM presentations in a specialist out-patient or community setting
3. Providing specialist care for individuals living with HIV in an out-patient or community setting
4. Providing specialist care for individuals with diagnosed HIV/AIDS in a hospital inpatient setting
5. Delivering interventions to prevent transmission of HIV, other blood borne viruses and STIs
6. Supporting early detection of STIs and HIV in all settings
7. Safeguarding of public health and delivering GUM/HIV services and information for specific populations in a range of settings
8. Ability to successfully lead, manage and work with specialist service commissioning in acute and community settings.

Please see the [GUM 2022 curriculum](#) for full details.

Evidence of capability

The curriculum describes the evidence that can be used by the educational supervisor to make a judgement of the resident's capability (see the CiPs tables and the assessment blueprint). The educational supervisor will make a holistic judgement based on the evidence provided, particularly the feedback from clinical supervisors and the multi-disciplinary team. The list of evidence for each CiP is not exhaustive and other evidence may be equally valid.

Presentations and Conditions

The curriculum provides guidance on the presentations and conditions which form the clinical context in which the capabilities are demonstrated. The presentation and conditions listed are either common or serious and residents will be expected to know about these but they will not need to be signed off for individual items.

Practical Procedures

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

Once a resident is competent to perform a procedure unsupervised (as evidenced by summative DOPS) there is no requirement for further assessment. It is a matter of professional insight and probity that a resident should maintain their competency by carrying out the procedure when the opportunity arises. If a resident 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 residents about procedural competence and this should be documented.

For some procedures there is only a requirement to have awareness of the procedure and its complications or to observe a colleague undertaking the procedure, rather than being competent to perform the procedure unsupervised. Each procedure and the minimal level of competency required is clearly set out in the practical procedures table:

MANDATORY PRACTICAL PROCEDURES				
Practical procedure	ST4	ST5	ST6	ST7
Female genital examination including bimanual examination, and speculum insertion		Competent to perform unsupervised	Maintain	Maintain
Male examination with proctoscopy and sample collection		Competent to perform unsupervised	Maintain	Maintain

Anogenital cryotherapy		Competent to perform unsupervised	Maintain	Maintain
Point of care testing for HIV infection		Competent to perform unsupervised	Maintain	Maintain
Female cervical cytology sampling		Satisfactory supervised practice	Competent to perform unsupervised	Maintain
Light microscopy of gram stained slides for detection of STIs		Satisfactory supervised practice	Competent to perform unsupervised	Maintain
Dark ground microscopy (of wet mounted vaginal smear / chancre smear)		Satisfactory supervised practice	Competent to perform unsupervised	Maintain
Preparation and administration of intramuscular vaccination	Satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain
Preparation and administration of intramuscular antibiotics	Satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain
Medical TOP		Awareness of procedure & complications	Awareness of procedure & complications	Awareness of procedure & complications
Surgical TOP		Awareness of procedure & complications	Awareness of procedure & complications	Awareness of procedure & complications
Colposcopy		Awareness of procedure & complications	Awareness of procedure & complications	Observe colleague
RECOMMENDED PRACTICAL PROCEDURES				
Practical procedure	ST4	ST5	ST6	ST7
Genital skin or punch biopsy		Observe colleague	Satisfactory supervised practice	Competent to perform unsupervised
Insertion and Removal of sub-dermal contraceptive implant		Observe colleague	Observe colleague or satisfactory supervised practice	Competent to perform unsupervised

Insertion and Removal of intrauterine device and system		Observe colleague	Observe colleague satisfactory supervised practice	or	Competent to perform unsupervised
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Assessment: What is required from residents and trainers?

Introduction

Decisions about a resident'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 level expected for the current year of training. For the IM clinical and specialty CiPs there will be a judgement made at what level of supervision they require (i.e. unsupervised or with direct or indirect supervision). For each of these CiP 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 [specialty](#) and [IMS2](#) ARCP decision aids.

What the resident needs to do

The main change is the move to dual accreditation with Internal Medicine. Residents need to become proficient in the management of patients being admitted on the medical take and their ongoing care. They also need to attend outpatient clinics in other specialties. Residents should record how many clinics they have attended and how many patients they have been involved with on the Acute Unselected Take (if applicable) in the IMT summary of clinical activity and teaching form on the ePortfolio. See the [IMS2 Rough Guide](#) for detailed information.

The specialty examinations are the Diplomas in [GUM](#) and [HIV](#) and also recommended but not mandated are the assessments in Community Sexual & Reproductive Health; [the DFSRH](#), and [letter of competence for subdermal](#) & [intra-uterine contraception](#). Competence in genital biopsy is no longer mandatory but recommended. As safeguarding is an important part of our clinical practice we have specifically added recognition of modern-day slavery and Female Genital Mutilation. In addition, as many of our services have moved in part to virtual delivery we have included proficiency with virtual working, learning platforms and telemedicine.

Residents need engage with mechanisms to evidence their training and performance by doing 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 resident 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 resident as learning opportunities for a resident to have one to one teaching and receive helpful and supportive feedback from an experienced senior doctor. Residents should therefore be seeking to have SLEs performed as

often as practical. The number of SLEs listed is pro rata to the time spent in GUM vs IM so as to be able to fulfil the requirements of both decision aids. They also 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.

There is an expectation that regular ST training will be hosted by Deaneries and that attendance at such events is >75%. Events can include relevant Regional and Nationally organised GUM training and will be pro rata for LTFT residents. A table such as the example below should be included in the portfolio to allow for assessment at ARCP.

	Indicative number
National Training Days	3
Regional Training Days	≥ 2
Attendance	≥ 75%

Each resident must ensure that they have acquired multi-source feedback (MSF) each year (including at least 3 consultants of minimum 12 raters who are a mix of clinical and non-clinical staff). This feedback should be discussed with their Educational Supervisor (ES) and prompted appropriate reflection. They also need to ensure that they have received a minimum of two reports from consultants who are familiar with their work (ideally not their ES) and who will contribute to the Multiple Consultant Report (MCR). Each consultant contributing to the MCR will give an advisory statement about the level at which they assess the resident to be functioning for each clinical CiP.

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

Interaction between trainer and resident

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

It is recommended that the resident should have two educational supervisors -- one for IMT and one for GUM. If no IM ES is available locally, the same ES can be assigned for both GUM and IM -- if the ES is not IM trained then the IM CS must be closely involved in recording the residents progress in IM on their educational report.

At the beginning of the academic year there should be a meeting with the ES (ideally within 4 weeks) 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 sitting the Diplomas of GUM & HIV
- a discussion about what resources 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

There should be a clinical supervisor (CS) for every placement. The resident should also meet with the clinical supervisor to discuss the opportunities in the current placement including:

- development of a PDP for the placement using SMART objectives
- access to GUM, HIV and Contraception clinics and how to meet the learning objectives
- medical on call; see [IMS2 ARCP decision aid](#) for more detail. It is recommended that the acute medical take be a part of the resident's routine workload throughout the training programme however this is not mandated. Ward-rounds with a senior consultant to review admitted patients and also necessary ward work will need to be built into the rota.
- specialty on call: the resident may also be required to take part in GUM or HIV specialty on call during the day and/or overnight, but this is not mandated and can flexibly take place at any time during the 4-year training programme.
- undertaking an indicative 20 outpatient clinics in medical specialties other than GUM; these could be completed during one year of training or spread more evenly over the 4 years of training
- HIV inpatient experience and joint management of patients on HDU and ICU
- experience in Dermatology
- experience in Obstetrics and Gynaecology
- understanding of management and interpretation of pathology requests and results related to STIs, HIV and BBVs, in addition to knowledge of specimen collection and an ability to develop working relationships with laboratory staff.
- experience in managing end-of-life care
- also mention research opportunities and teaching opportunities

Depending on local arrangements there should be regular meetings (we 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 resident's development as a physician and career goals
- discussing things that went well or things that went not so well

Self-assessment

Residents 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 resident's ePortfolio account.

The purpose of asking residents to undertake this activity is:

- To guide residents 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 resident's ES reviews how the resident 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 resident 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 resident's portfolio. This will help the ARCP panel make a more informed judgement as to the resident'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 resident 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 resident has attained the required standard as set out in the [ARCP 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 resident 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 resident 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 8 **IM clinical** and 8 **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 resident 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 resident 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.

Outline grid of levels expected to be achieved by the end of each training year for Genitourinary medicine specialty capabilities in practice (CiPs)

	GUM Specialty + IM Stage 2					CCT
Specialty CiPs	ST4	ST5	ST6	CRITICAL PROGRESSION POINT	ST7	CRITICAL PROGRESSION POINT
1. Managing patients with non-complex GUM presentations in outpatient or community settings	2	3	3		4	
2. Managing patients with complex GUM presentations in a specialist outpatient or community setting		2	3		4	
3. Providing specialist care for individuals living with HIV in an outpatient or community setting	2	3	3		4	
4. Providing specialist care for individuals with diagnosed HIV/AIDS in a hospital inpatient setting		2	3		4	

5. Delivering interventions to prevent transmission of HIV, other blood borne viruses and STIs	2	3	3		4	
6. Supporting early detection of STIs and HIV in all settings	2	3	3		4	
7. Safeguarding of public health and delivering sexual health/HIV services and information for specific populations in a range of settings		2	3		4	
8. Ability to successfully lead, manage and work with specialist service commissioning in acute and community settings		2	3		4	

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 resident before the ARCP
- Give specific examples and directive narration for each entrustment decision

Types of Evidence

Local Faculty Groups (LFG)

This type of group has been recommended in training previously but is not universally implemented. If available this should be a group of senior clinicians (medical and non-medical) who get together to discuss residents' progress. The purpose is not only to assess a resident but to determine and plan on-going training. It is recommended again as an optimal way of providing information about residents' progress.

The LFG set-up will depend on the circumstances of the organisation. In smaller units the LFG make include all the physicians; while in larger units there may be several LFGs, each in a different department. In all circumstances, as a minimum, an LFG must be able to consider, direct and report on the performance of residents in the acute medicine/on-call setting.

The LFG should meet regularly to consider the progress of each resident and identify training needs, putting in place direction as to how these needs are to be met. This should be documented and communicated to resident's Educational Supervisor and hence to the resident. A mechanism for this to happen should be established.

Multi-Source Feedback (MSF)

The MSF provides feedback on the resident and is a method of assessing generic skills such as communication, leadership, team working and reliability. It closely aligns to the Generic CiPs. A minimum of 12 assessments should be submitted, and 'raters' should include at least 3 consultants and a range of senior trainees and experienced nursing and allied health professional colleagues. One MSF must be completed each training year to cover the generic and clinical capabilities required for both HST and IM. Feedback should then be discussed between supervisor and resident during an appraisal meeting.

Multiple Consultant Report (MCR)

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

Feedback from at least 2 consultants is necessary, one of which must be the clinical supervisor (but ideally not the educational supervisor. The *minimum* number of MCRs considered necessary is one per year i.e. 4 over the period of specialty training.

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

Case based Discussion (CbD)

This tool is designed to provide feedback on discussions around elements of the care of a particular patient. This can include elements of the particular case and the general management of the condition. It is a good vehicle to discuss management decisions.

Mini-Clinical Evaluation (mini-CEX)

This tool is designed to allow feedback on the directly observed management of a patient and can focus on the whole case or particular aspects.

Outpatient Care Assessment Tool (OPCAT)

The OPCAT is designed to be used in a single clinic whether that is face to face or virtual and may be used during a direct observation if the trainer is present or as an assessment at the end of a clinic. This is currently an optional tool which is subject to GMC approval and is available on the e-portfolio. Educational supervisors will need to make an entrustment decision on outpatient capability and completed OPCATs will be useful evidence.

Workplace-Based Assessments

Direct Observation of Procedural Skill (DOPS)

This tool is designed to give feedback and assessment for residents on how they have undertaken a procedural skill. This may be in a simulated or real environment. Formative DOPS may be undertaken as many times as the resident and supervisor feel are necessary. A resident can be signed off as able to perform a procedure unsupervised using the summative DOPS. Observers can be anyone with expertise in the procedure, including experienced nurses and allied health professionals as appropriate.

Teaching Observation (TO)

The TO form is designed to provide structured, formative feedback to residents on their competences at teaching. The TO form can be based on any instance of formalised teaching by the resident which has been observed by the assessor. The process should be resident-led (identifying appropriate teaching sessions and assessors).

Quality Improvement Project Assessment Tool (QIPAT)

The QIPAT is designed to assess a resident's competence in completing a quality improvement project. The QIPAT can be based on a review of quality improvement documentation or on a presentation of the quality improvement project at a meeting. If possible, the resident should be assessed on the quality improvement project by more than one assessor.

Guidance on how to assess QI skills and behaviours has been developed by the Academy of Medical Royal Colleges and is available via [this link](#).

Audit Assessment (AA)

The Audit Assessment tool may be used to assess a resident's competence in completing an audit. The Audit Assessment can be based on review of audit documentation or on a presentation of the audit at a meeting. If possible, the resident should be assessed on the same audit by more than one assessor.

Examination

The Worshipful Society of the Apothecaries has developed the [Dip GUM](#) and the [Dip HIV](#), which are blueprinted to the [GUM curriculum](#). A detailed syllabus has been produced to provide clarity on Diploma content and can be found on the JRCPTB website [here](#). The convenors and external assessors of both exams are co-opted members to the GUM SAC, which meets 3 times a year. During the course of training, residents are required to complete the Dip GUM and Dip HIV.

It is envisaged that by the end of ST6, all residents will have had adequate opportunities to be proficient in the management of the range of common GUM presentations, and have had appropriate exposure to allied disciplines and to specialist training opportunities so as to develop the knowledge, skills and attitudes required of specialists in most aspects of STI and sexual health care. For most residents, HIV training continues throughout the training programme and that appropriate levels of expertise may only be developed later in the training programme. In accordance with the schedule stipulated in the ARCP decision aid. It is therefore anticipated that residents will pass Dip GUM by the end of year 3 (ST6) of GUM

training and Dip HIV by completion of training (ST7). **Both these Diplomas therefore represent critical progression points in the GUM training programme.**

Reflection

Undertaking regular reflection is an important part of resident development towards becoming a self-directed professional learner. Through reflection a resident 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 residents deal with challenging situations.

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

Suggested evidence for each CiP

The suggested evidence to inform entrustment decisions is listed for each CiP in the curriculum and ePortfolio. However, it is critical that trainers appreciate that residents do not need to present every piece of evidence listed and the list is not exhaustive and other evidence may be equally valid.

Induction Meeting with ES: Planning the training year

Writing the ESR essentially starts with the induction meeting with the resident at which the training year should be planned. The induction meeting between the ES and the resident is pivotal to the success of the training year. It is the beginning of the training relationship between the two and needs both preparation and time. The induction meeting should be recorded formally in the resident's ePortfolio. The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the training year. This is also a time for ES and resident to start to get to know each other.

Ahead of the meeting review:

- Review Transfers of Information on the resident
- Review previous ES, ARCP etc. reports if available
- Agree with the placement CSs how other support meetings will be arranged. Including;
 - Arrangements for LFGs or equivalent
 - Arrangements for professional development meetings

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 personalised educational work schedule for the year or its equivalent
- Construct the annual PDP and relevant training courses

- Discuss the resident's career plans and help facilitate these
- Discuss the use of reflection and assess how the resident uses reflection and dynamic PDPs
- Discuss the teaching programme
- Discuss procedural skill consolidation
- Discuss arrangements for LTFT training if appropriate
- Plan additional meetings including the professional development meetings and the 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 resident 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 resident should also have an induction meeting with their placement CS (who may also be their ES). The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the placement. This is also a time for CS and resident to start to get to know each other.

Ahead of the meeting review the following should be considered;

- Review Transfers of Information on the resident
- Review previous ES, ARCP etc. reports if available
- Arrangements for LFGs or equivalent

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:

- Review the training placement elements of the generic educational work schedule or its equivalent
- Construct the personalized educational work schedule for the placement or its equivalent
- Construct the set of placement-level SMART objectives in the PDP

- Discuss the use of reflection and assess how the resident uses reflection and dynamic PDPs
- Discuss procedural skill consolidation
- Discuss arrangements for LTFT training if appropriate
- Plan additional meetings including professional development meetings and the interaction with the placement CSs (depending on whether the ES or CS will be undertaking these)
- Arrangements for MSF
- Review the ARCP decision aid
- Pastoral support
- Arrangements for reporting of concerns
- Plan study leave

Professional Development Meetings

Trainers and residents need to meet regularly across the training year. 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 LFG and ARCPs etc.

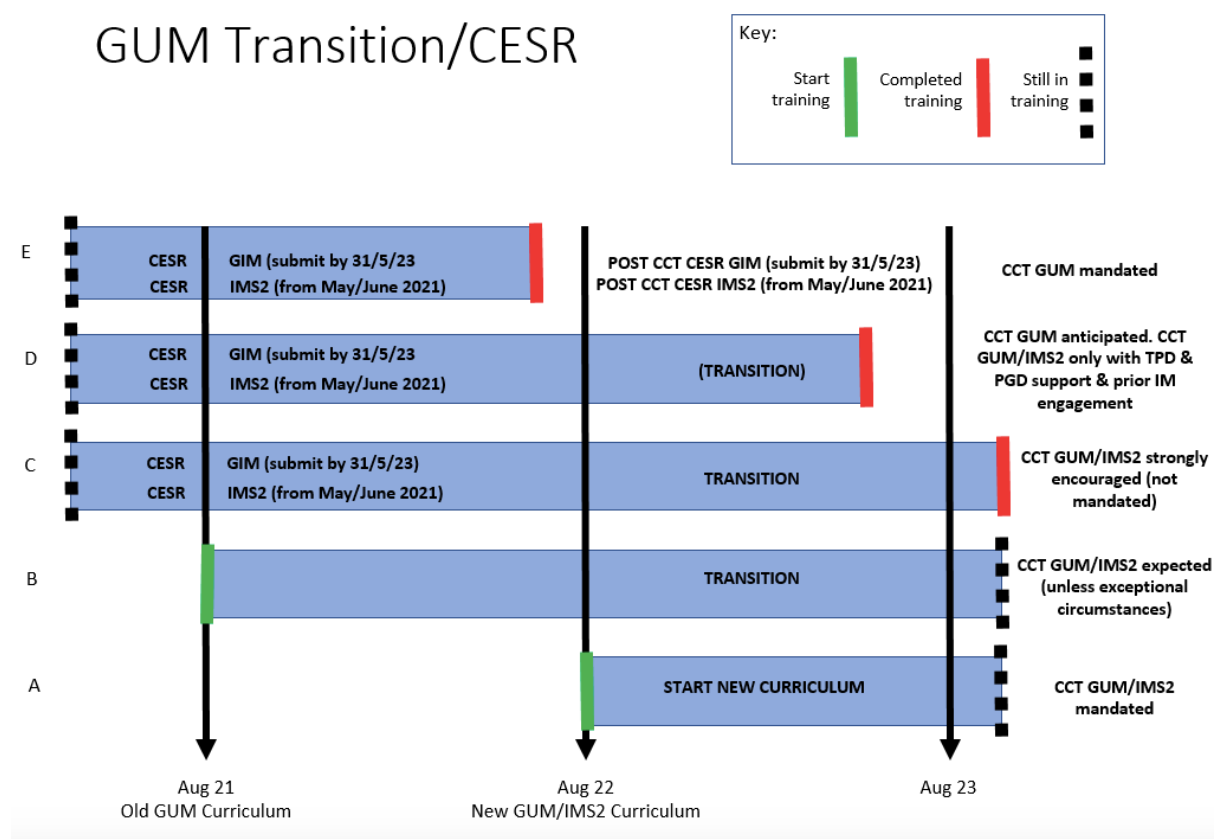
These meetings are important and should cover the following areas. This list is not exhaustive. Meet away from the clinical area regularly to:

- Discuss cases
- Provide feedback
- Monitor progress of learning objectives
- Discuss reflections
- Provide careers advice
- Monitor and update the resident'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 resident may be encountering

Transition arrangements for residents already in programme

The JRCPTB has published [transition guidance](#) for residents already in programme who wish to transfer to the Genitourinary Medicine (GUM) 2022 curriculum including new dual accreditation with Internal Medicine stage 2 (IMS2). The majority of residents starting on or after 1 August 2021 will be expected to transfer to the new curriculum. Entrants from 1 August 2022 will be automatically enrolled to the 2022 dual GUM/[IMS2 curriculum](#). The document includes details about transition arrangements for those already in programme prior to August 2021 (see figure below). It is recommended that a gap analysis is carried out

for doctors in training who will transfer from the 2016 curriculum to the new curricula and dual train with internal medicine from August 2022. The [gap analysis guidance](#) and [form](#) should be used for this process. The SAC has also prepared [guidance](#) to support residents who wish to apply for specialist accreditation in General Internal Medicine (GIM) and Internal Medicine via the [Portfolio pathway](#) (formerly known as CESR).



Annual Review of Competence Progression (ARCP)

Introduction

The [ARCP](#) is a procedure for assessing competence annually in all medical residents 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 residents 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 residents are anxious about such an outcome and everything possible should be done to ensure that no resident inappropriately receives a non-standard outcome.

The ARCP gives the final summative judgement about whether the resident 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 resident experience to ensure that each resident has completed (or is on track to complete over ensuing years) the various learning experiences mandated in the curriculum.

It is envisaged that by the end of ST6, all residents will have had adequate opportunities to be proficient in the management of the range of common GUM presentations, and have had appropriate exposure to allied disciplines and to specialist training opportunities so as to develop the knowledge, skills and attitudes required of specialists in most aspects of STI and sexual health care. For most residents, HIV training continues throughout the training programme and that appropriate levels of expertise may only be developed later in the training programme. In accordance with the schedule stipulated in the ARCP decision aid, it is therefore anticipated that residents will pass Dip GUM by the end of year 3 (ST6) of GUM training and Dip HIV by completion of training (ST7). Both these Diplomas therefore represent critical progression points in the GUM training programme.

Genitourinary Medicine 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 residents are assessed and how they will progress through their ARCPs. It is vital we avoid an increase in residents failing to achieve a standard ARCP outcome by helping residents 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 resident is safe and capable of progressing to the next stage of training?"

Relationship with Educational Supervisor (ES)

It is vital that the resident 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 resident should seek to achieve during that training year. The resident 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 resident as to further evidence that might be required.

It is recommended that the resident should have two educational supervisors -- one for IMT and one for GUM. The resident should be meeting with them regularly to discuss their progress. If no IM ES is available locally, the same ES can be assigned for both GUM and IM -- if the ES is not IM trained then the IM CS must be closely involved in recording the residents progress in IM on their educational report.

Clinical supervisor (CS)

The resident should have a Clinical Supervisor for each attachment and once again the resident should meet up with the CS at the start of the attachment. Similar discussions should be held with the CS as have been held with the ES and once again, a PDP with SMART objectives should be constructed for each attachment. At the end of the attachment, the CS should be well placed to complete a Multiple Consultant Report (MCR). The CS should also document the progress that the resident has made towards completing all the objectives of the PDP.

The resident should provide an 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 an MCR. Throughout the attachment the resident should be having SLEs completed by both consultants and more senior residents. 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 resident is acquiring clinical (and generic) capabilities
- They may give the resident the opportunity to have additional one to one clinical teaching from a senior colleague
- They allow the excuse for residents 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 resident”. It is important that they make meaningful comments about why they have assigned that particular level of performance/behaviour to that particular resident. 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 resident can progress to the next year of training. Constructive comments are also of course valued by the resident. It is very helpful if the resident 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 resident 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 resident reviews their ePortfolio and ensures that all requisite information is available in a logical and accessible format. 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
- Evidence of attendance at >75% of ST training events (pro rata) needs uploading to the resident's ePortfolio and will be reviewed annually at the ARCP
- The indicative minimum number of SLEs (as demanded by the annual decision aid) has been completed and recorded in the ePortfolio
- MSF has been completed and the results released by the ES. 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 resident has had significant clinical/educational interaction
- The resident has self-rated themselves for each CiP on the curriculum page
- The SMART objectives documented in their PDP have either been achieved fully 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 resident 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 ES 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 resident 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.

ARCP panels for GUM and IMT may be held jointly or separately at the discretion of Deaneries. Two separate outcomes must be recorded, with progress noted according to each ARCP decision aid and noting how much training time, and hence training opportunities, have been spent in IMT that calendar year. This is particularly relevant for those who are LTFT or who have been on OOPE. Attainment of SLEs and DOPS in the year being assessed by ARCP should be proportionate to time spent training in GUM and GIM in that year.

The PYR (penultimate year review)

Penultimate Year Reviews (PYRs) have replaced Penultimate Year Assessments (PYAs) as the JRCPTB recognises that it is critically important that resident doctors approaching their final year of training know what they need to do to complete their training by their planned date of CCT. Although the PYR is no longer mandated, the Royal College of Physicians continues to recommend this process as best practice, so the process is laid out here.

The PYR reviews the resident doctor's specialty training undertaken to date and agrees the specialty curricula requirements that remain outstanding to complete training. The outstanding requirements will be listed in the Penultimate Year Review as Mandatory targets and documented on the resident doctor's ePortfolio. Recommended (non-mandatory) targets may also be listed. All mandatory targets must be listed and noted as "ACHIEVED" in the ARCP outcome 6.

The PYR is usually undertaken by an External Advisor and as part of an ARCP panel (usually at the resident doctor's penultimate ARCP) but PYRs can be held separate to ARCP panels. The GUM PYR should take place 12-18 months (NB not pro-rata if the resident is LTFT) before the completion of training.

The GUM SAC recommends that residents prepare the following for their PYR:

- an up-to-date CV (and file this in their ePortfolio Personal Library in a file headed <GUM PYR>)
- a 5-minute presentation that should explain how they have met the requirements of the curriculum (and file this in their ePortfolio Personal Library in a file headed <GUM PYR>)
- a completed 'Penultimate Year Review (PYR) - Genitourinary Medicine' form on their e-portfolio which can be found under the PYA/PYR tab

The above will be reviewed by the External Advisor alongside all other e-portfolio evidence to enable them to complete a second 'Penultimate Year Review (PYR) - Genitourinary Medicine' form on the resident doctor's e-portfolio. All mandatory and any recommended targets will be listed on this form.

Resident doctors dual accrediting in GIM will require a GUM PYR and a GIM PYR – these may be done simultaneously or separately. Please see the JRCPTB GIM [IMS2 Rough Guide](#) and [training page](#) for full information in relation to the GIM PYR process. The [GIM PYR trainee report](#) is currently a word document which should be completed by the resident doctor and uploaded to their e-portfolio.

Genitourinary Medicine 2022 ARCP Decision Aid

This decision aid provides guidance on the requirement to be achieved for a satisfactory ARCP outcome at the end of each training year. The training requirements for Internal Medicine (IMS2) are set out in the IMS2 curriculum and ARCP decision aid available on the JRCPTB website.

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
Educational supervisor (ES) report	An indicative one per year to cover the training year since last ARCP (up to the date of the current ARCP)	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 and assessed using global ratings. Residents should record self-rating to facilitate discussion with ES. ES report will record rating for each generic CiP	ES to confirm resident meets expectations for level of training	ES to confirm resident meets expectations for level of training	ES to confirm resident meets expectations for level of training	ES to confirm resident meets expectations for completion of training
Specialty capabilities in practice (CiPs)	See grid of levels expected for each year of training. Residents must complete self-rating to facilitate discussion with ES. ES report to confirm entrustment level for each CiP	ES to confirm resident is performing at or above the level expected for all CiPs	ES to confirm resident is performing at or above the level expected for all CiPs	ES to confirm resident is performing at or above the level expected for all CiPs	ES to confirm level 4 in all CiPs by end of training
Multiple consultant report (MCR)	An indicative minimum number. Each MCR is completed by a consultant who	2	2	2	2

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
	has supervised the resident's clinical work. The ES should not complete an MCR for their own resident				
Multi-source feedback (MSF)	An indicative minimum of 12 raters including 3 consultants and a mixture of other staff (medical and non-medical). MSF report must be released by the ES and feedback discussed with the resident before the ARCP. If significant concerns are raised then arrangements should be made for a repeat MSF	1	1	1	1
Supervised Learning Events (SLEs): Case-based discussion (CbD) and mini-clinical evaluation exercise (mini-CEX)	An indicative minimum number to be carried out by a range of senior assessors including consultants. Residents are encouraged to undertake more and 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	6 CbD 6 Mini-CEX	6 CbD 6 Mini-CEX	6 CbD 6 Mini-CEX	6 CbD 6 Mini-CEX

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
	resident's personal development and reflected on by the resident				
Direct Observation of Procedural Skills (DOPS)	An indicative minimum number	2	4	4	2
Diplomas: DFRSH Dip GUM Dip HIV	This is the order recommended to complete these knowledge-based assessments. There will be some flexibility at ARCP however critical progression points are passing Dip GUM by end ST6 and Dip HIV by end ST7. DFRSH is recommended but not mandatory		DFSRH passed (Recommended)	Dip GUM passed (Mandatory)	Dip HIV passed (Mandatory)
LoC SDI LoC IUT	Attainment of the LoC SDI and LoC IUT is recommended but not mandatory				Achieved LoC SDI (Recommended) Achieved LoC IUT (Recommended)
Advanced life support (ALS)		Valid	Valid	Valid	Valid
Quality improvement (QI)/ Audit	QI project to be assessed with quality improvement project tool (QIPAT)	Participation in quality improvement project or audit	Participation in quality improvement project or audit	Completion of quality improvement project with satisfactory QIPAT	Portfolio of quality improvement / audit involvement

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
	Audit to be assessed with Audit Assessment (AA)			and/or involvement in national audit with satisfactory AA	
Teaching attendance	Evidence to be kept in ePortfolio and assessed at ARCP	Attendance at >75% organised training days			
Teaching	To be assessed by teaching observation (TO)	Evidence of participation in teaching of medical students, junior doctors and other health care professionals	Evidence of participation in teaching of medical students, junior doctors and other health care professionals	Evaluated participation in teaching confirmed by satisfactory TO	Evidence of participation in evaluated teaching with delegate evaluation of that teaching
Dermatology capabilities	See syllabus and specialty CiP 2: Managing patients with complex GUM presentations in a specialist outpatient or community setting				Achieved by CCT
Gynaecology capabilities	See syllabus and specialty CiP 2: Managing patients with complex GUM presentations in a specialist outpatient or community setting		Recommended that achieved by end ST5		
Laboratory & Pathology capabilities	See syllabus and specialty CiP 6: Supporting early detection of STIs and HIV in all settings			Recommended that achieved by end ST6	

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
Contraception capabilities	See syllabus and specialty CiP 1: Managing patients with non-complex GUM presentations in outpatient or community settings		Passed DFSRH (recommended)	Dip GUM passed (mandatory)	Achieved by CCT Achieved LOC SDI (recommended) Achieved LOC IUT (recommended)
Patient Survey			1		1
Management	See syllabus and specialty CiP 8: Ability to successfully lead, manage and work with specialist service commissioning in acute and community settings	Generic management and leadership capabilities e.g. ability to prioritise personal and team work, working effectively with colleagues and to meet scheduled commitments Knowledge of local governance and complaints procedures	Participation in and some awareness of some aspect of management. e.g. responsibility for organising rotas, teaching sessions or journal clubs	Awareness of managerial structures and functions within the NHS. Develops and works as part of a wider professional network in sexual health and HIV care. e.g. attendance at relevant training modules, knowledge of diagnostic coding and data analysis, and participation in	Understanding of managerial structures and recognises differing tendering/commissioning processes in the four Nations and across NHS and non-NHS providers. e.g. reflective e-portfolio entries around relevant NHS management activities, budget and cost savings, quality improvement projects, service innovation Achieved by CCT

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
				local management meetings	
Research	See Syllabus and specialty CiP 7: Safeguarding of public health and delivering sexual health/HIV services and information for specific populations in a range of settings	Evidence of critical thinking around relevant clinical questions	Evidence of developing research awareness (e.g. participation in research studies, critical reviews, presenting at relevant research meetings/courses)	Evidence of developing research capability (e.g. participation in research studies, critical reviews, presenting at relevant research meetings/courses)	Evidence of research capability – this may include a completed study with a peer reviewed publication or abstract. Achieved by CCT

The Training Programme

This section provides guidance on how the training programme should be delivered, based on section 4.1.1 of the curriculum. The first section here describes the main body of training and required elements, which will take place in an outpatient or community setting. Further mandatory training requirements are described subsequently.

Training requirements for GUM and HIV

Aims of outpatient GUM and HIV training

To acquire the knowledge and skills described in the specialist curriculum (CiPs 1-8).

Duration and organisation of training

For the following statements a 'clinic' or session is expected to be of 3.5-4 hrs duration including time for patient-related administrative tasks such as letters and management of results. All numbers are indicative as guidance:

- At least 1 general HIV clinic per week throughout specialist GUM training
- 5 to 6 clinics a week comprising general GUM and/or specialist GUM and/or specialist HIV clinics or equivalent ward time managing HIV inpatients. One of these sessions per week may be allocated for attending specialist non-GUM training e.g. dermatology, gynaecology, public health and laboratory attachment
- 1 session per week for Continuing Medical Education (CME)
- 1 session per week comprising clinical or departmental administration and/or management and/or departmental research
- 1 session per week for self-development time (SDT) to include involvement in Quality Improvement projects, small group/informal simulation, meeting with supervisors, working on the e-Portfolio, reflecting on clinical practice, preparing/delivering teaching, exploration and development of sub-specialist interests

Throughout training, residents should be encouraged to attend their local or regional ART multi-professional meeting where treatment decisions are discussed and finalised. Specialist HIV on call is encouraged during training but is not mandated.

Learning outcomes for ST4 and/or ST5

The aim of these two years is to lay the groundwork of knowledge and skills for the following specialist curriculum and GPC syllabus requirements:

- Sexual and medical history taking
- Genital Examination
- STI/BBV sample taking and interpretation of results, including microscopy
- HIV and hepatitis testing, diagnosis and onward referral
- Epidemiology, pathology, diagnosis and clinical management of common genitourinary infections (also see pathology lab block below)

- Strategies used in STI, HIV and Hepatitis prevention, health promotion, partner notification and role of third sector/voluntary groups
- PEP and PrEP provision, vaccination
- Legal and ethical considerations in STI and HIV care
- Identification and assessment of those with safeguarding needs including <18s; level 3 safeguarding
- Understands the needs of those who may have difficulty accessing services (due to hearing/visual impairment, physical disability, language barrier)
- Remote management of sexual health including telephone clinics, postal testing, digital partner notification
- Function of the intact immune system
- Epidemiology, natural history and pathophysiology of HIV; general management of HIV 1 & HIV 2 infection
- Assessment of the newly diagnosed PLWH and monitoring of asymptomatic PLWH
- Antiretroviral prescribing:
 - Instituting first-line ART
 - Monitoring of stable patients established on treatment
- Undertakes HIV outpatient lists under direct consultant supervision

The following aspects of the curriculum should begin to be addressed:

- HIV inpatient management (or can complete later)
- Research methods, including statistics, with a view to initiating a research project
- Audit and/or quality improvement project/s
- Public health training (see specialty CiP 8)
- Teaching/training

Depending on individual needs, parts of this programme can be deferred to ST6 or 7.

Learning outcomes for ST6 and/or ST7

In these years the basic capabilities in knowledge and skills will be consolidated in:

- Epidemiology, diagnosis, and clinical management of genitourinary infections and their complications
- The running of integrated or specialist outpatient clinic in a variety of settings
- Epidemiology, diagnosis, initial management of patients with viral hepatitis
- Identification, initial assessment, management and appropriate referral of psychosexual dysfunction and genital pain syndromes
- Management of STIs in pregnancy
- Investigation and management of genital infections in the new-born, infants and children
- Clinical management of the sexual & reproductive health of those with safeguarding needs including <18s
- Management of those who have experienced sexual assault, sexual exploitation, sexual abuse gender-based violence, victims of modern slavery, female genital mutilation (FGM) or who are engaging in chemsex

- Legal and ethical considerations in STI and HIV care including valid consent, Fraser competency assessment and the Sexual Offences Act
- Assessment of individuals with previously undiagnosed HIV infection in all settings
- Understanding and management of all HIV related disease including AIDS and non-AIDS defining malignancies
- Prevention of late diagnosis
- Provision of tailored advice regarding the risk of onward transmission of HIV
- Knowledge of the data supporting the prescribing of antiviral medications
- Antiretroviral prescribing/management of patients in the outpatient setting
- HIV in specialist groups
- Knowledge and experience of assessing the psychosocial needs of PLWH
- Management of the sexual and reproductive health needs of PLWH

In addition, the following should be completed/consolidated:

- HIV inpatient management (or can complete earlier in ST4 or ST5)
- Gynaecology experience
- Dermatology experience
- Laboratory and Pathology training
- Audit including completing at least one audit cycle or a quality improvement project
- Leadership and management training and experience (see specialty CiP 8) to include:
- Public health training
- Teaching/training

The remainder of the time may be divided into:

- Developing special interests (e.g. vulval, adolescent, HIV specialist clinics, HIV/STI prison healthcare, service development, teaching) and/or
- Carrying out research and managing data effectively
- Overseas experience can be incorporated in this period but is not mandatory

All out of programme experience must be prospectively approved by the Local rotation TPDs and HEE, NES, HEIW or NIMDTA respectively. Please see the JRCPTB website) and section 4.4 of the curriculum for details.

Inpatient HIV training

Aims of HIV inpatient training

To gain knowledge and skills in the investigation, diagnosis, and management (including appropriate referral) of patients with complex HIV/AIDS-related presentations, residents will need time attached to an HIV in-patient service. Such experiential learning should be supplemented by directed self-learning, supported with more formal teaching.

Duration and organisation of training

Attachments should in most instances be for a minimum of 3 months and can be at any time during GUM training. This also represents a period when residents might usefully experience other important facets of their training for example complex ART prescribing, treatment of different patient groups e.g. injecting drug users, adolescents, pregnant women, TB coinfecting patients and experience of patients with HBV/HCV co-infection.

The recommended characteristics of an in-patient unit are:

- An average of 10 in-patients per month. If fewer in-patients are anticipated a longer period of attachment is acceptable if the case-mix enables the resident to see the wide range of opportunistic infections (OIs) and malignancies in the curriculum.
- On-site access to intensive care
- Multi-professional management of complex ART prescribing
- Management of patients with HBV/HCV co-infection
- Management of pregnant women living with HIV
- Well-defined specialist cancer referral protocols

Residents should document their experience of in-patients and complex ART management using appropriate workplace-based assessments on the e-portfolio.

During the period of attachment residents should, under supervision, be responsible for the initial assessment of HIV positive individuals presenting acutely unwell. This does not have to be out of hours. Ideally, involvement in the care of patients requiring in-patient care should occur throughout the period of training and not be solely restricted to the period of attachment to an in-patient unit.

In view of the decrease in clinical exposure within smaller HIV outpatient units due to the decreased incidence of OIs/cancers and the rationalisation of in-patient services to HIV centres, the TPD must ensure that if the training is not available within the host training centre, that the training programme includes secondment to an in-patient unit at another HIV centre. An audit undertaken by the British HIV Association (BHIVA) found that that secondment of residents, where necessary within current network arrangements, will mostly be achievable within the same clinical network. If not, the Deanery will be accountable for alternative arrangement with another network. A secondment must be of sufficient duration to meet the training objectives; three months is an indicative period. The Diploma in HIV must be obtained by the end of training in order to achieve CCT.

Learning outcomes for HIV Inpatient training

These map to mainly to specialty CiP 4 in the curriculum, but elements of other parts of the curriculum may be delivered during this aspect of training. Residents should gain experience and knowledge of:

- Managing unwell patients with HIV and/or co-morbidities and/or co-infections as part of the MDT
- Complex prescribing and drug interactions, toxicities in patients on ART
- Leading decision-making for PLWH requiring complex care, including elderly patients with frailty

- The legal and ethical aspects relating to HIV care including capacity, confidentiality, DNAR orders, end of life care
- The management of the full range of opportunistic infections in PLWH; understanding of the epidemiology, clinical presentation, and investigation of these conditions
- The use of primary and secondary chemo-prophylaxis against opportunistic infections
- The epidemiology, diagnosis, investigation and management of immune reconstitution inflammatory syndrome (IRIS)

Contraception training

Aims of contraception training

To ensure residents have the knowledge, skills and attitudes to assess patients' contraception needs, meeting those initially wherever possible and referring into specialist services where indicated

Duration and organisation of training

Before entering GUM specialty training

Although some residents may have had prior experience in contraception in previous posts e.g. in General Practice, gynaecology, emergency department, the expectation is that they will continue to build on this during their GUM training.

During GUM specialty training

Most training in contraception now takes place within integrated sexual and reproductive health services. This should commence in the first year of training, initially by observing in clinic, ultimately leading to independent practice. By the end of training some residents may choose to acquire the LoC SDI and LoC IUT to be able to independently fit these LARC methods, although this is not mandatory. By the end of training it is also recommended that residents complete the theoretical and practical training needed to obtain [the DFSRH](#), however this is also not a mandatory requirement.

Learning outcomes for contraception training

Residents will be expected to assess suitability for and initiate contraception such as:

- combined hormonal contraception (COCP, patch, vaginal ring)
- fertility based awareness methods
- progesterone only pill
- barrier methods (condoms male and female, diaphragm/cap)
- oral emergency contraception
- injectable contraception

Residents should also be able to assess patients regarding suitability for and refer into specialist services where needed:

- sub dermal implants and
- intrauterine devices/systems

Obstetrics and Gynaecology Training

Aims of obstetrics and gynaecology training

To ensure residents have the knowledge, skills and attitudes required to identify and appropriately manage common gynaecological and obstetric conditions presenting to GUM/HIV departments. Certain obstetric and gynaecological conditions may present to GU services and the resident should be familiar with such aspects as aetiology, epidemiology, clinical features, investigation, management and prognosis. These conditions are listed in the [curriculum section 3.5](#).

Duration and organisation of training

Residents must observe gynaecological and obstetric practice, enabling them to have a broad understanding of this speciality and its application in GUM clinical practice. This can be obtained as follows:

Before entering GUM specialty training

Residents who have completed a minimum of three months in a Foundation Year 1 or 2, ST1 or ST2 post in gynaecology or obstetrics and gynaecology, before embarking on GUM specialty training, can use this experience to meet the training objectives.

During that time residents should have monitored their knowledge and competence using their portfolio and have had this countersigned by their ES at that time.

At the start of GUM specialty training, residents will meet with their ES to review capabilities to date against objectives in the curriculum and identify how best to complete any additional training identified.

During GUM specialty training

Residents without sufficient previous experience in gynaecology and obstetrics to meet the training objectives should undertake a programme of gynaecological training, preferably during the first two years of specialist training in GUM. This will be attained through half or full day release or through single or multiple attachments.

In order to meet the syllabus objectives training will include attendance at a wide range of obstetrics and gynaecology clinics and services. The minimum number of clinics/sessions that residents are expected to attend is not stipulated but must be sufficient to complete all the capabilities. Emergency presentations must be observed by shadowing the on-call gynaecology team during daytime working hours (out of hours attachments are not compulsory). Where units do not divide clinics into these specialist services, the resident must ensure that the wide range of experience is achieved thorough general clinics and ward/emergency care attachments. An indicative programme would be the following clinics/sessions:

- 4 general gynaecology
- 4 antenatal
- 3 colposcopy
- 2 endocrine
- 1/2 uro-gynaecology
- 2 infertility

- 2 endometriosis
- 2 gynaecology oncology
- 4 vulval
- 2 termination of pregnancy
- 2 menopause
- FGM clinic if available
- 3 Emergency Pregnancy Unit (EPU) sessions
- 2 days shadowing emergency on call/observing a wide range of in-patient attendances

It is not expected that a single named consultant supervises across the range of general and specialised clinics. However, residents are encouraged to make arrangements with one or two consultants that have the broadest supervision roles to obtain evidence and feedback on their learning experience including WBAs. An experience log is attached (appendix A) to this guide and is suggested for recording evidence of experience gained in obstetrics and gynaecology. This could be uploaded to the personal library on the e-portfolio and linked to the relevant competencies in the curriculum.

Learning outcomes of obstetrics and gynaecology training

- Residents will demonstrate assessment and referral of pregnancy, gynaecological and obstetric problems

Laboratory Pathology Training including Microscopy

Aims of laboratory pathology training

To ensure that residents have the knowledge, skills and attitudes required to manage pathology requests and interpretation of results related to STIs, HIV and BBVs, in addition to knowledge of specimen collection and an ability to develop working relationships with laboratory staff.

Duration and organisation of training

Some pathology training is available in the GUM clinic. Self-directed learning and attendance at courses/lectures may be required to gain factual knowledge. In addition time spent attending the local or regional microbiology and virology laboratories will be required. An indicative week-long attachment (or equivalent as a session/week) would usually suffice to meet required lab-based competencies. There may need to be a flexible/opportunistic approach to the lab attachment if training is taking place in a community-based Trust without its own lab, although all services will have a lab to which they send samples where experience may be sought. This will be initiated during ST4/5. Completion of these competencies is recommended by the end of ST6 and is mandatory by end of ST7/CCT. An experience log is attached (appendix B) to this guide and is suggested for recording evidence of experience gained.

Microscopy training maybe delivered in a variety of ways, either within the lab block, or in clinic depending on local arrangements. All residents should complete the [BASHH BSIG Micro](#) online training, and it is strongly recommended that HSTs complete the

log book and competency assessment found therein. These should be uploaded to the personal library on the e-portfolio and linked to relevant sections of the curriculum. Locally available tools may be used as long as they demonstrate equivalence. Note that light and dark microscopy are mandated practical procedures in the curriculum.

Learning outcomes for Laboratory Pathology training

The resident will be able to:

- explain the fundamental characteristics of test performance, including sensitivity and specificity; positive predictive value and negative predictive value and is able to make simple calculations of these from data
- explain the advantages and disadvantages of introducing a screening test to contrasting populations, including the merits of register based vs. opportunistic screening, evaluation of screening, using actual or proposed examples in sexual health
- explain antigen and antibody tests, DNA amplification techniques and their advantages and limitations. Correctly interpret NAATs and serological tests, including equivocal tests and explain results to patients and junior colleagues
- explain the range of laboratory tests for gonorrhoea, chlamydia, LGV, mycoplasma, syphilis, trichomonas, chancroid, donovanosis, candida, bacterial vaginosis, HIV, HSV, HPV, and Hepatitis A/B/C. To include microscopy, point of care tests, culture, NAATs, serology
- understand need for confirmation by same or different tests and timescale for results
- explain which sites to sample, storage of specimens and transfer time to lab. Describe time frame to positive result from infection and to negative result post treatment
- perform Gram-stains and wet-mount microscopy and interpret the findings, perform direct inoculation of clinical material on transport and culture media.
- use the microscope, including bright and dark field microscopy, setting up, adjusting and maintenance

Dermatology Training

Aims of dermatology training

To ensure that residents have the knowledge, skills and attitudes required to identify and appropriately manage common dermatological conditions seen in patients presenting to GUM and HIV departments ([see curriculum Section 3.5](#)).

Duration and organisation of training

Residents' specific training requirements should be identified in partnership with their ES to determine the best way to meet the dermatology learning objectives. These can be obtained as follows:

Before entering GUM specialty training

Residents who have completed a minimum of a three-month post in dermatology during Foundation Years or CMT/IMS1, before embarking on GUM specialty training,

can use this experience to meet the learning objectives. During that time residents should have monitored their knowledge and competence using their portfolio and have had this signed off by a designated dermatology supervisor. At the start of GUM specialty training, residents will meet with their ES to review capabilities to date against objectives in the curriculum and identify how best to complete any additional training identified.

During GUM specialty training

Residents without sufficient previous experience in dermatology to meet the training objectives should undertake a programme of dermatology training, preferably during the latter two years of specialist training in GUM. This will be attained through half or full day release or through single or multiple attachments. In order to meet the dermatology learning objectives, residents will attend a variety of related outpatient clinics and attend dermatology ward rounds and dermatology histopathology meetings. Outpatient clinics could include general dermatology as well as more specialist genital dermatology clinics, which may be run by dermatologists, GU physicians or gynaecologists depending on local services. Experience of genital malignancies may require residents to attend gynaecology oncology, urology and plastic surgery clinics. A minimum number of clinics/sessions that residents are expected to attend is not stipulated although an indicative number of 10 is suggested. An experience log is attached (appendix C) to this guide and is suggested as a way of recording evidence of experience gained in dermatology. This could be uploaded to the personal library on the e-portfolio and linked to the relevant competencies in the curriculum.

Learning outcomes for Dermatology Training

- Clinical management of patients with genital dermatological conditions and awareness of when to refer to specialist services
- It is recommended that residents are proficient at performing genital biopsies although this requirement is no longer mandatory

Palliative and end of life care training

Palliative and end of life care is a core component of the IM curriculum and residents will continue to develop their knowledge and skills throughout specialty training. Palliative and end of life care is one of the eight clinical CiPs, with specialist palliative care experience recommended. There is sometimes the opportunity to experience this during ward attachments to an HIV in-patient unit. If not, experience of end of life care can be achieved during attachments to other medical teams (e.g. geriatric medicine, oncology, respiratory medicine) and ICU but residents may have the opportunity to undertake a palliative medicine attachment to a specialist palliative care setting (or range of settings). During a palliative medicine placement, residents will have a CS and will be encouraged to undertake relevant WBAs to evidence entrustment decisions for IM Clinical CiP 8. Depending on the setting in which they are based, residents will have the opportunity to provide direct care to hospice/specialist

palliative care unit inpatients, work in day hospice and outpatient settings, undertake domiciliary visits and work with hospital and community palliative care teams. During an attachment, residents are likely to participate in the specialty palliative care on call.

Research Training

Aims of research training

To ensure residents develop and can implement an evidence-based approach to patient care, quality improvement and service and specialty development through engagement with the research process. To develop the capabilities required to contribute to wider scientific enquiry in a safe and ethical manner.

Duration and structure of research training

Before entering GUM specialty training

Many residents will have acquired many of the generic capabilities already during foundations and IMS1 and 2. Residents who have undertaken additional academic posts or higher degrees will have substantial skills and knowledge which they will continue to develop. At the start of GUM specialty training, residents will meet with their ES to review capabilities to date against objectives in the curriculum and identify how best to complete any additional training identified.

During GUM specialty training

Awareness will be developed from the start of training and continue throughout. Initially, critical thinking around relevant clinical questions should be developed by attendance at a specialty journal club, specialist conferences/meetings, training days or e-learning etc; then as training progresses, other activities can be undertaken to acquire the necessary capabilities, including, but not exclusively the following activities:

- Critical appraisal course
- Writing a critical review
- Reviewing literature for guideline
- Presenting at research meetings/courses
- GCP certification
- Research methods course
- Attendance at an ethics meeting
- Initiation of a research project, ethics submission, grant application, writing patient information leaflet, database set up and/or analysis
- Participation in clinical trials, via referral, recruitment, consenting patients, being on delegation log
- Applied informatics/genomics training
- Completion of a study with a peer reviewed publication or abstract

Learning outcomes for research training

See generic CiP 5 and specialty CiP 8:

- Manages clinical information/data appropriately

- Understands principles of research and academic writing
- Demonstrates ability to carry out critical appraisal of the literature
- Understands the role of evidence in clinical practice and demonstrates shared decision making with patients
- Demonstrates appropriate knowledge of research methods, including qualitative and quantitative approaches in scientific enquiry
- Demonstrates appropriate knowledge of research principles and concepts and the translation of research into practice
- Follows guidelines on ethical conduct in research and consent for research
- Recognises potential of applied informatics, genomics, stratified risk and personalised medicine and seeks advice for patient benefit when appropriate

Training in clinical leadership and management

Aims of leadership and management training

To give residents the capabilities to lead the multi-professional effort to deliver and progress effective evidence-based services that meet the needs of the population in conjunction with commissioning bodies in a cost-sensitive environment.

Duration of leadership and management training

These skills will have been substantially developed already in residents through management of the acute take in IMY3 (e.g. ability to prioritise, work effectively with team members), whilst other generic capabilities will have been acquired during foundation and IMS1 and 2 training. These will continue to be developed through specialty training with focus on the areas required for management and leadership of specialist sexual health services, which has unique features due to a strong emphasis on multi-professional working and current commissioning arrangements. Certain elements can be developed out of experience or activities that can be sought out locally, for example:

- Attendance at service development meeting, governance meetings, commissioning meetings
- Rota or teaching schedule management
- Responding to complaints or incidents
- Sitting on interview panels, shortlisting
- Supervision of junior colleagues
- Running quality improvement projects e.g. patient satisfaction surveys

It is suggested that residents should have monitored their knowledge and competence of managements capabilities using their e-portfolio with specific WBA or reflective entries around relevant management activities.

Other capabilities will be acquired through specific training days/meetings or e-learning, which should cover the following areas:

- Writing a business/service plan
- Writing a job description including person specification and short-listing criteria

- Managing complaints
- Managing conflict
- Local and national processes for investigation of complaints, significant events, serious untoward incidents and near misses
- The commissioning and tendering processes
- Financial budgeting and budget setting
- Service Development and design - preparing and submitting development bid
- Understanding the political, organisational and professional organisation of the NHS across the four home nations of the UK and the impact of devolution
- Explain local and regional organisational frameworks
- Managing poor performance/delivering negative feedback
- How to be a supervisor
- Quality improvement
- Co-production/patient participation
- Consultant CPD/appraisal/revalidation
- Psychometric profiling
- Creating research proposals and projects
- Never events and near misses

Learning outcomes for leadership and management training

These map to generic CiP 1 and specialty CiP 8:

- Aware of and adheres to the GMC professional requirements, the role of and processes for operational structures within the NHS, the need to use resources wisely
- Demonstrates effective clinical leadership, promotion of an open and transparent culture, engagement in career planning, capabilities in dealing with complexity and uncertainty
- Understands working with bodies responsible for the organisation and commissioning of services to deliver cost-sensitive specialist services that meet local population demographics
- Recognises the tendering/commissioning process is different in the four Nations and across NHS/HSC and non-NHS providers. Demonstrate contribution/participation within local process.
- Demonstrates evidence-based approach and participates/leads in research, audit and quality improvement projects to guide service innovation
- Develops and works as part of wider multi-professional network in sexual health and HIV care

Training resources

The [HEE study leave list](#) provides a list of generic (see 'all specialties') and specialty specific courses. Both **mandatory** and **optional** courses can be funded through study leave budget. To find the list go to → Study Leave Specialty list → Medicine.

Generic courses/events:

- Exam preparation course relevant to level of training
- Developing skills for educational supervision
- National Conference or course attendance relevant to curricular progression
- National Courses and Events for Critical Appraisal Training
- National Courses and Events relating to Human Factors Training
- National Statistical analysis courses
- Courses to prepare for consultant interview (last two years of training)
- National courses in relation to research methodology
- Teaching course
- Courses relevant to clinical leadership and management

Specialty specific courses/events:

- [DFSRH information](#)
- Practical training for DFSRH
- Assessment half day for DFSRH
- Practical training for the insertion of contraceptive implants [\(info\)](#)
- Practical training for the insertion of intrauterine devices and systems [\(info\)](#)
- British Association for Sexual Health and HIV (BASHH) [Masterclass in HIV](#)
- [HIV resident association](#) meetings
- [ABC of sexual dysfunction course](#)
- BHIVA - General Medicine for HIV Physicians [course](#)
- Adult Sexual Assault Examination and Aftercare (2 days)
- [BHIVA Conference](#)
- BASHH [Spring Meeting](#)
- BASHH [Doctors-in-training](#) day
- BASHH [Scientific Meetings](#)
- BASHH [STIs and HIV Course](#)
- BASHH [BSIG Microsite](#)
- Revision course for [Dip GUM OSCE](#) (1 day)
- Revision course for [Dip HIV](#) (1 day)
- BASHH [Genital Dermatology course](#) (1 day)
- DFSRH sexual and reproductive health [meetings/updates](#)
- FSRH Annual [Scientific Meeting](#)

Other resources:

- [Internal Medicine Stage 2 Curriculum](#)
- [Internal Medicine Stage 2 ARCP Decision Aid](#) (August 2022)
- JRCPTB guidance re [self-development time](#) for physicians in higher specialty training

Glossary of abbreviations

AA	Audit Assessment
AIDS	Acquired Immunodeficiency Syndrome
ALS	Advanced Life Support

ARCP	Annual Review of Competence Progression
ART	Antiretroviral Therapy
BASHH	British Association for Sexual Health and HIV
BBVs	Blood Borne Viruses
BHIVA	British HIV Association
CESR	Certificate of Eligibility for Specialist Registration
CiPs	Capabilities in Practice
CbD	Case-based Discussion
CCT	Certificate of Completion of Training
CME	Continuing Medical Education
CMT	Core Medical Training
CS	Clinical Supervisor
DFSRH	Diploma of the Faculty of Sexual and Reproductive Health
Dip GUM	Diploma in Genitourinary Medicine
Dip HIV	Diploma in HIV Medicine
DNAR	Do Not Attempt Resuscitation
DOPS	Direct Observation of Procedural Skills
EPA	Entrustable Professional Activity
ES	Educational Supervisor
ESR	Educational Supervisor Report
GCP	Good Clinical Practice
GIM	General Internal Medicine
GMC	General Medical Council
GPC	Generic Professional Capabilities
GUM	Genitourinary Medicine
JRCPTB	Joint Royal Colleges of Physicians Training Board
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HDU	High Dependency Unit
HEE	Health Education England
HEIW	Health Education and Improvement Wales
HIV	Human Immunodeficiency Virus
HSC	Health and Social Care
IM	Internal Medicine
IMS 1/2	Internal Medicine Stage 1/2
IMT	Internal Medicine Training
IMY3	Internal Medicine Training Year 3
IRCP	Interim Review of Competence Progression
LARC	Long Acting Reversible Contraception
LoC IUT	Letter of Competence in Intra-Uterine Techniques
LoC SDI	Letter of Competence in Subdermal Implants
LFG	Local Faculty Group
LTFT	Less Than Full Time
MDT	Multidisciplinary Team
MCR	Multiple Consultant Report
Mini-CEX	Mini Clinical Evaluation Exercise
MSF	Multi-Source Feedback
NES	NHS Education for Scotland
NHS	National Health Service
NIMDTA	Northern Ireland Medical & Dental Training Agency

NTN	National Training Number
OGM	Ordinary General Meeting
OI	Opportunistic Infection
OOPE	Out of Programme Experience
OPCAT	Outpatient Care Assessment Tool
OSCE	Objective Structured Clinical Examination
PDP	Professional Development Plan
PEP	Post Exposure Prophylaxis
PLWH	Person Living with HIV
PREP	Pre-Exposure Prophylaxis
PGD	Postgraduate Dean
PYR	Penultimate Year Review
QIPAT	Quality Improvement Assessment Tool
SLE	Supervised Learning Event
ST	Specialist Resident/Training
SAC	Specialist Advisory Committee
SDT	Self-Development Time
SMART	Specific, Measurable, Achievable, Realistic and anchored within a Time Frame
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TO	Teaching Observation
TOP	Termination of Pregnancy
TPD	Training Programme Director
WBA	Workplace Based Assessment

Appendix: Experience Logs

Experience Log A: Obstetrics and Gynaecology p45

Experience Log B: Laboratory Pathology block p48

Experience Log C: Dermatology p51

Obstetrics and Gynae Experience Log for GU Medicine HSTs

*See Rough Guide page 34 and Section 3.5 of the Curriculum for suggested numbers of sessions

Clinical Experience*	<u>Site</u>	Date	Supervisor Signature/Grade	Notes
General Gynae				
General Gynae				
General Gynae				
General Gynae				
Antenatal				
Antenatal				
Colposcopy				

Colposcopy				
Colposcopy				
Colposcopy				
Endocrine				
Clinical Experience*	<u>Site</u>	Date	Supervisor Signature	Notes
Endocrine				
Uro-gynae				
Uro-gynae				
Infertility				
Infertility				
Endometriosis				

Endometriosis				
Gynae Oncology				
Gynae Oncology				
Vulval				
Clinical Experience*	<u>Site</u>	Date	Supervisor Signature	Notes
Vulval				
Vulval				
Vulval				
Termination of Pregnancy				
Termination of Pregnancy				
Menopause				

Menopause				
FGM				
Emergency Pregnancy Unit				
Emergency Pregnancy Unit				
Emergency Pregnancy Unit				
Clinical Experience*	<u>Site</u>	Date	Supervisor Signature	<u>Notes</u>
Shadowing on-call				
Shadowing on-call				
In-patient care				
Other				
Other				

Other				
Other				
Other				

Lab/pathology Experience Log for GU Medicine HSTs

*See Rough Guide page 36-37; an indicative week-long attachment (or equivalent) would usually suffice to meet required lab-based competencies

Day/ session	Site	Date	Supervisor Signature/Grade	Notes*
1	RD+E	25.10.2009	x	Eg Observation of molecular lab, culture bench, observation and discussion around storage and transport of specimens, lab SOPs
2				
3				
4				

Day/ session	Site	Date	Supervisor Signature/Grade	Notes*
5				

Day/ session	Site	Date	Supervisor Signature/Grade	Notes*

Day/ session	Site	Date	Supervisor Signature/Grade	Notes*

Learning outcomes for Laboratory Pathology training

The resident will be able to:

- explain the fundamental characteristics of test performance, including sensitivity and specificity; positive predictive value and negative predictive value and is able to make simple calculations of these from data
- explain the advantages and disadvantages of introducing a screening test to contrasting populations, including the merits of register based vs. opportunistic screening, evaluation of screening, using actual or proposed examples in sexual health
- explain antigen and antibody tests, DNA amplification techniques and their advantages and limitations. Correctly interpret NAATs and serological tests, including equivocal tests and explain results to patients and junior colleagues
- explain the range of laboratory tests for gonorrhoea, chlamydia, LGV, mycoplasma, syphilis, trichomonas, chancroid, donovanosis, candida, bacterial vaginosis, HIV, HSV, HPV, and Hepatitis A/B/C. To include microscopy, point of care tests, culture, NAATs, serology
- understand need for confirmation by same or different tests and timescale for results
- explain which sites to sample, storage of specimens and transfer time to lab. Describe time frame to positive result from infection and to negative result post treatment

Dermatology Experience Log for GU Medicine HSTs

*See Rough Guide page 37 and Curriculum Section 3.5: Outpatient clinics could include general dermatology as well specialist genital dermatology clinics. Experience of genital malignancies may require residents to attend gynaecology oncology, urology and plastic surgery clinics. An indicative number of 10 clinics is suggested.

Clinical Experience*	Site	Date	Supervisor Signature/Grade	Notes
<i>eg General Derm Outpatients</i>		<i>25.10.2009</i>	<i>x</i>	<i>Psoriasis, eczema</i>
<i>eg Genital Derm Clinic</i>				<i>Lichen Scerosus, vulval eczema</i>
<i>eg Derm Histopath MDT</i>				<i>Discussed melanoma, BCC etc</i>

Clinical Experience*	Site	Date	Supervisor Signature/Grade	Notes

Clinical Experience*	Site	Date	Supervisor Signature/Grade	Notes

