# The All Party Parliamentary Group on Skin

58-60 Kensington Church Street, London W8 4DB

## APPG on Skin Event – A Crisis in Dermatological Education and Workforce

*Minutes*

December 2nd 2014

**Chair:** Sir Paul Beresford (PB) - MP Mole Valley (PB)

**Speakers:** David Eedy – President of the British Association of Dermatologists (DE), Stephen Kownacki – Executive Chair of the Primary Care Dermatology Society (SK), Ben Riley – Medical Director at the Royal College of GPs (BR), John Howard – Head of Education and Quality for Primary and Community Care at Health Education, East of England (JH), and Jacky Hayden – Dean of Postgraduate Medical Studies at Health Education England (JHY)

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### Introduction and Presentations

PB welcomed everyone to the event, and invited DE to begin the presentations.

### Presentation by David Eedy

DE set out several of the national problems facing the consultant dermatologist workforce. These included that:

- There were not sufficient numbers of dermatologists. France had 1 dermatologist per 120 000 people. England had 1 dermatologist per 200 000 people.
- 20% of consultant dermatologist posts were currently unfilled.
- There were 684 FTE dermatologists in the UK, but at least 1000 were needed.

- Locums were increasingly being used, however whilst they should only be in place for 6 months across the country 17 locums had been in post between 2 and 20 years. These locums may not have sufficient training.

DE also noted problems with the GP workforce. He suggested that the Care Closer to Home Initiative had caused problems by moving consultants out of trusts, and increasing the focus on primary care. However, he believed GPs were not best placed to handle this demand, and lacked the skills to deal with chronic problems. DE further suggested the use of GPSIs was taking resources away from dermatologists, but not necessarily reducing demand on the strained workforce. He also said that dermatology consultations lasted only 8 minutes, which was not sufficient time to diagnose a problem.

DE pointed out that with many consultants taking early retirement, and with the workforce gravitating towards larger dermatology centres (such as London, Bristol and Manchester), many areas were understaffed. However he said that there was interest in dermatology and for every trainee post DE said that they had 7 applicants. DE thought that the problem might be a lack of money within HEE. Specific resultant problems he identified were:

- North Cumbria had no substantive consultant.
- One of the largest dermatology centres in the past in the UK, Nottingham Hospitals University Trust is loosing most of its dermatologists, and its ability to provide adult on call dermatology services, Nottingham was losing its status as a training centre.
- Cancer referral targets are being missed in many centres across England.

### Presentation by Stephen Kownacki

SK explained his involvement with the APPGS and the Primary Care Dermatology Society (PCDS). He noted that the PCDS had been engaged with the RCGP to discuss the problems at a primary care level with dermatology, but that so far there were '*no answers*'. He stated that the PCDS had been involved with running over 25 one day and two day conferences across the country to train GPs.

SK agreed that more consultant dermatologists were needed, and felt that a problem was that NHS incentivised senior consultants to leave the NHS for private practice. However SK urged the dermatologist workforce to stay open to collaborative working with other parts of the NHS, as there would probably never be enough dermatologists. SK suggested that taking the case study of Cumbria, there were people in that region trying to provide a dermatology service.

SK said that there was '*more than one way to provide a good dermatology service'* and that - taking into account the Five Year Forward View - the system needed to look at ways to work together, as the situation depended upon the workforce available and the geography.

However, SK advocated increasing dermatology provision at all levels. He said that the Deans of Medical Schools should be responsible for increasing dermatology education. He called for significant and mandatory increases in vocational training in dermatology. SK suggested that a dermatology element must be in the exams or the student and doctors would avoid learning the topic. He concluded by arguing for the responsible organisations to work together, instead of competing for scarce resources.

## Presentation by Ben Riley

BR opened his presentation by pointing out that despite being under great pressure, General Practice still had the highest satisfaction rating of all NHS services in recent surveys. He also stated that to become a GP required around 10 years of training, with the RCGP only responsible for setting the curriculum studied during the final three-year specialty training period. He noted that while the college plays an important role setting the academic practice it does not deliver the training, which occurs through Health Education England.

BR pointed out that the RCGP had already published a detailed statement on the care of people with skin problems. He also felt that GPs had to demonstrate a significant competency in dermatology to complete training. He referred to the final part of the GP training programme, where GPs have to demonstrate they have met competencies relevant to the care of people with skin problems and said that trainees must successfully complete all of the MRCGP exams and assessments to practise independently.

He stated that the RCGP agreed that skin conditions were poorly represented in medical training pathways. However BR argued that GP training was the shortest of all medical specialities, despite incorporating the broadest subject matter, making it difficult for specialty training to make up for earlier deficits in a doctor's training experience. BR said that in 2012 the RCGP won support to increase GP training to 4 years, which would include scope for more dermatology elements, but he said that NHS funding bodies had not implemented this yet.

## Presentation by John Howard

JH set out that the HEE agreed in principle that dermatology training was insufficient, but pointed out that it was also insufficient in paediatrics and mental health. He stated that HEE believe it was necessary to extend GP training to 4 years.

JH took the position that GPs were not specialists, he felt that they needed to have a basic understanding of subject matter, but importantly to know when it would be appropriate to refer on.

JH said that each trainee in the hospital phase of their training had an educational supervisor, who would discuss the learning needs of the individual student with them. This educational supervisor would cover every area including dermatology. JH said that competencies were not assessed through time based periods, and this made it difficult for the HEE to quantify the amount of time spent in dermatology training but that did not mean that they are not receiving such training. JH also pointed out that following GP training, the GP would gain experience and knowledge during their time in practice.

### Presentation by Jacky Hayden

JHY introduced herself as the Lead Dean for Dermatology and Psychiatry within HEE. She noted that in the HEE national plan they had identified a gap of around 100 dermatologists. She pointed out that currently there are slightly more than 200 trainees in dermatology and agreed that in a 4 year training programme that would not be enough to meet the gaps in the workforce.

JHY stated that HEE agreed that there is a problem and pointed out that the HEE and the BAD had agreed a full-scale review of the service provision, which would cover primary, secondary, tertiary and quaternary care.

However JHY urged audience members to accept that there were some limits in relation to the medical workforce. This included the participation rate, and the overall funding method. She noted that there was an overall funding envelope and a limited number of doctors completing training. However she pointed out that HEE were hoping to work with the BAD to accurately assess what the workforce and HEE were able to deliver.

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## Open Debate

Sir Paul invited the audience to discuss potential solutions to the problems raised by the panel.

George Moncrieff (GM) - Chair of the Dermatology Council suggested that the dermatology workforce was '*staring in the face of a real disaster*', and pointed out that several medical schools offered no dermatology provision. He stated that GPs were often referring obviously benign cases and overloading the health

system. From personal experience GM suggested that the average GP trainer did not feel competent in dermatology. GM also suggested that he had been told in confidence that the 4th training year was unlikely. GM argued that GPs needed support from HEE, and said that it needed to be mandatory to get at least 2 days of dermatology education. JH disagreed with GM's assessment, and instead suggested that it was merely difficult to gather data on training programmes. GM said that feedback from patient support groups showed that they felt they were not receiving the support they needed from GPs, and again noted problems with over referrals for benign conditions.

DE pointed out that in addition, money was being spent propping up secondary care departments in unsustainable ways such as opening on weekends. DE felt that the money could be better invested by increasing the number of dermatologists. DE said that it could cost about £6000 to bring in dermatologists on waiting list initiatives. DE pointed out that in addition, money was being spent propping up secondary care departments in unsustainable ways such as opening on weekends. DE felt that the money could be better invested by increasing the number of dermatologists. DE said that it could cost about £6000 to bring in dermatologists on waiting list initiatives. This elicited some agreement from SK, and from BR on the point that it was inefficient to fill gaps with long-term locums.

Julia Schofield (JS) – Dermatology Consultant spoke in support of the idea that a GP is not a specialist but a generalist. However she pointed out that the knowledge of GPs was incredibly variable. JS suggested that education should be targeted at one or two specific problem areas of knowledge, such as skin lesions.

Jerry Marsden (JM) - Dermatology Consultant agreed with JS that there was a need to focus on the greatest areas of demand. JM felt specifically that triage was a problem, and a key area for managing risk improvement. JM suggested that the retired consultant dermatologist workforce could be used to teach GPs. He felt that an overarching body composed of the RCGP and the PCD could be created to provide dermatology training.

GM pointed out that there were pockets of excellence, and agreed that national leadership could solve the endemic problems. JH pointed out that solutions could be focused around referral management systems, and through forthcoming structural change elements such as tele-dermatology. However GM felt that these changes would not be enough, and called upon the RCGP to support dermatology as one of the biggest parts of the GP service.

DE suggested that nurses were already doing everything they could to support dermatology services, and argued that studies had not been able to prove any economic benefit from tele-dermatology.

Lord Alderdice (LA) – Liberal Democrat Peer felt that it would be useful to explore using the retiring or retired workforce, and suggested implementing a phased retirement allowing the last few years to be spent providing training. JS supported this idea, but pointed out that pressure on acute finances and the current NHS structures was forcing doctors to leave the NHS totally.

JHY also agreed with this idea, and pointed out that Michael Goldacre was currently reviewing graduates from 1974 to examine the experience of this cohort approaching retirement. JHY said that funding would have to come from existing resources. She suggested that HEE were exploring the possibility of junior consultants having a more gentle 'lead in' by working with senior consultants approaching retirement.

Ray Jobling (RJ) – Chairman of the Psoriasis Association commented that whilst he agreed that GPs could not be expected to function as specialists, he felt that there were problems when patients were seeing newly trained GPs.

BR said that it is not possible to give every trainee GP experience of working in a dermatology post, but felt that the problem was the lack of a national strategy.

DE commented that in Cumbria, and Devon there was nowhere for patients to access emergency acute dermatology services. In Cumbria emergencies and complex dermatology would have to be transferred to Newcastle or Manchester. DE also noted that Manchester, formerly a centre of excellence, is now depending on around 9 locum consultants to run the service.

Anthony Hubbard (AH) – SKCIN suggested that Continuing Professional Development points should be made mandatory for dermatology, to reflect the large percentage of the GP workload.

JH argued that the systems of assessing GP needs was based around annual appraisals, and said that complaints about trainees were low. However, SK pointed out that dermatology is one of the most common areas of recommendation for further training from appraisers that they received.

Julie Van Onselen (JVO)– Dermatology Nurse said that the role of the primary care support team needed to be more fully considered, including nurses and health visitors. She argued that training in nurses is poor too, and suggested that Health Visitors in particular can have an important role, such as spotting babies developing eczema. JVO called for QOFs based around common skin

conditions, and argued that there needed to be joint CPD work between GPs and nurses.

Henrietta Spalding (HS) – Changing Faces suggested a CQUIN would be a useful tool for validating dermatology, as tested in other specialities.

RJ emphasised that the Psoriasis Association was not criticising GPs, but felt that not everyone was practicing the guidelines set by NICE. .

PB thanked everyone for their contributions and brought the roundtable to a close.