Notes for the All Party Parliamentary Group on Skin – December 2014

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Summary

HEE agrees that the initial training of GPs in dermatology is inadequate. This is fundamentally due to the restrictions of the statutorily based 3 year training programme introduced in the 1970s. The case to extend the duration of GP training has been widely accepted. Currently trainees learn dermatological practice through a variety of resources and learning opportunities which vary across the country depending upon local resources. The evidence is that GPs on completion of training are competent practitioners trained to manage dermatological problems in general practice, to recognise the limits of their personal competence and to continue to develop their skills and learning throughout their careers. We recognise that the scope of dermatological practice is different in general and hospital practice.

We believe that there should be more education for GPs throughout their careers and that the sharing of advances and new techniques between hospital and primary care can improve quality and service efficiency. The changes outline in the NHS Forward View represent an opportunity to alter the nature of current services in to a more integrated service using appropriate clinicians to provide the wide scope of dermatology services needed by the population of the UK.

Introduction

The notes below are intended to supplement the oral presentation provided at the roundtable debate.

- GP training – HEE/Deaneries manage training – 3 year programme with 18 months in hospital posts and 18 months in practice.
- We agree training in dermatology insufficient – as is for paediatrics, mental health etc. What do we leave out from the current inadequate 3 year scheme to accommodate more training?
- We need a 4 year curriculum as accepted by HEE, DH, Medical Programme Board

Pre CCT training

- Numbers – currently 5214 trainees across England who are in hospital posts; c600 dermatology consultants in England. In the East of England for example there are 438 trainees in hospitals, with 18 acute Trusts. Therefore, assuming 2 dermatology jobs per Trust the maximum number of 3 months posts that are available would be 216, i.e. scope for 50% of trainees to have in patient experience.
- By contrast there are 9 dermatology training programmes across three training programmes. Some of the available posts are likely to be too specialised and not to have adequate general experience. Therefore there are simply not adequate post to allow each trainee to work in a dermatology unit. We need to explore other solutions
- GP trainees learn about dermatology in a number of ways which is why it is difficult to capture the exact input trainees receive. We do not work on the principle of a time-based

course but rather monitor their development of competence. This is done by training our hospital clinical supervisors on the GP curriculum and ensuring trainees see an educational supervisor – an experienced GP trainer – once every 6 months to review their development and learning needs.

- GP trainees have a half day release programme every week in academic term times throughout their three year programme. They learn about dermatology through on line or physical courses, attending out patients, dedicated training sessions in their half day release courses and problem case discussions. During their 18 months in general practice they have their consultations reviewed in daily de-briefs, have 2 hours of tutorial time with an experienced trainer a week and attend practice clinical meetings. Their knowledge and competence in dermatology is assessed through the RCGP's two specific exams – the Applied Knowledge Test and Clinical Skills Assessment - and work place based assessment which continues throughout their 3 year programme. They have to be signed off as being competent practitioners in all these areas to achieve MRCGP and be admitted to the GP Register.
- The GP training programme is not designed to make GPs experts, but generalists. Their job is to manage uncertainty and reduce risk by appropriate treatment or referral. They are not there to make a formal histological diagnosis but to choose the correct management. For example, it can be difficult to tell the difference between some chronic eczemas and contact dermatitis; the GP's job is to recognise the need for referral, to provide initial therapy and implement maintenance therapy.
- We train to ensure new GPs are safe and competent by recognising their own boundaries as generalists. With a curriculum covering all specialties and a half-life of medical knowledge of just over 5 years, they need to be life-long learners to stay safe in practice. We recognise we have to teach them how to be a GP, in addition to giving trainees basic knowledge.
- Trainees are required to provide service as well as learn in hospital. In general practice they have intensive education through an apprentice model; this is the only practical way of ensuring that they learn using the material they are seeing in the short time of the course, and can develop the ability to recognise their own limits and learning needs.
- GPs need to learn dermatology relevant to their patient's needs as the Schofield paper says. Much of that will be in practice, seeing the population they will be working with, apart from publications, dermatology posts, OPD attendance, half day release and tutorials.
- In fact 91% of melanomas are referred by a GP with 82% of those referred in the first or second visits – this is a high rate of cancer identification compared to other cancers
- Because of the apprenticeship model and the half day release course throughout the three years there is appropriate variation in the way that teaching and learning occur. We measure progress through trainee reflection and demonstration of competence rather than time or topic based courses or posts. This is why it is difficult for each LETB/Deanery to describe all the interventions made to teach dermatology.

Dermatology in practice

- Populations and diagnosis – a diagnosis of skin disease is present in about 37% of consultations, or 630 per year per practitioner, with 245 of the population presenting a skin disease problem to GPs. The vast majority of these are infections, viral infections and

eczema. The range of un-selected skin problems presented will be different to that seen in the referred population in secondary care. Often they are earlier in the disease progression. This difference in the nature of GP dermatology and hospital practice means it is not appropriate to judge the performance of GPs using the standards for hospital practitioners. This is why only 6.1% are referred; the rest are "GP problems" managed appropriately. It also explains why all GPs will say they need more education in skin diseases and why their diagnostic accuracy in GP dermatology – acne, warts, alopecia is nearing 100% but 47% in malignant and pre-malignant lesions (Schofield p54).

- GPs are life-long learners; we should not consider most of the education of GPs occurs during their 3 years of training when they have up to 10 times that period in practice where they continue to learn and develop their skills and experience.
- To refine the performance of GPs, Dermatology specialists should continue the education of colleagues; audits of results of feedback on referrals, education on new techniques and therapies and telephone or tele-dermatology support would all help.
- There are new innovations which should be spread to all doctors, whether in primary care or not. Dermoscopy is one; another is the use of weighted checklists such as the 7 point check list. These need to be spread and communicated to all GPs.

Other educational opportunities:

1 4 year training pilots including dermatology and potentially accreditation as having a special interest
2 Post CCT fellowships as two year salaried GP posts including dermatology and minor surgery – again GPwSI
3 Referral management services in CCGs with an educational component
4 Joint training for GP trainees with dermatology trainees
5 The impact of new service structures with community outreach as detailed in the "NHS Forward Vision" document