INTERIM REPORT

AN AUDIT OF DERMATOLOGICAL COMMISSIONING AND WORKFORCE CAPACITY

JULY 2015

The Dermatology Council for England compiled this report and accompanying data set jointly with Decideum Ltd.

The DCE is an organisation comprised primarily of patient groups working within the field of dermatology but also professional bodies representing clinicians from both primary and secondary care. Its Chair is Dr George Moncrieff, a GPSI in dermatology. For further details please visit the DCE website here.

Decideum is a public affairs agency that also acts as the secretariat to the All Party Parliamentary Group on Skin. Details of the All Party Group and funding sources can be found via the parliamentary register for All Party Groups available here. Decideum's Senior Account Manager, Mark Johnson, was elected by the DCE membership to serve as its Secretary in 2014 and provides advisory and administrative assistance to Council on a regular basis.

Whilst every effort has been made to ensure that the both the data and accompanying analysis are accurate, the authors of this report accept full responsibility for any errors identified post-publication. Should any errors be identified, these shall be corrected on the DCE website.

We are grateful to the Parliamentary Officers of the APPG on Skin for agreeing to promote this report following their annual general meeting on the 11th June.

We would also like to thank NHS staff for working tirelessly to deliver care to patients in spite of the many challenges facing the health service in 2015.

1. Executive Summary & Background

This short report presents the interim findings of the Dermatology Council for England's (DCE) audit of the English dermatology workforce.

The exercise, conducted using freedom of information requests sent to Clinical Commissioning Groups and provider Trusts, was designed not as a rigorous scientific study, but as an experiment to try and source intelligence relating to the status of dermatology services and their capacity to deliver care within an increasingly pressurised environment.

A range of questions were asked with regard to the number of permanent and temporary staff in place, the type of dermatology service commissioned, whether consultation had been carried out with service users and whether either the CCG or Trust in question had concerns with regard to the viability of the service given the current shortage of dermatological expertise.

Whilst the analysis for this report commenced a few weeks ago - prior to the receipt of all FOI responses - the full (anonymised) results of this exercise have been published online and are available via the All Party Parliamentary Group on Skin (APPGS) website and should soon be available to view on the DCE's own website. We would strongly encourage interested parties to view this data, which demonstrates a stretched service, highly dependent on temporary staffing arrangements and subject to wide variations in approach to workforce planning and recruitment.

Whilst the results contained within this report warrant attention, they should be considered alongside the plethora of publications already in the public domain, many of which cover the workforce issue and related concerns regarding the lack of dermatological education for primary care health practitioners. Both the British Association of Dermatologists (BAD) and the APPGS have published widely on the subject of dermatological services – we would advise interested members of the public to visit their respective websites as a first port of call.

To quote the King's Fund May 2015 report on dermatology services:

> *'Dermatology represents an important part of NHS provision. There are approximately 13 million GP consultations for skin conditions a year and 716,830 new referrals and yet this important area is poorly understood and has received comparatively little attention. Commissioning has often been poor. Inadequate planning has left gaps in the workforce. The 40,000 GPs managing this workload have received little training in dermatology and there are only 650 consultants to advise them and provide the more specialist care.'*

The chronic lack of substantive consultant dermatologists working in the NHS is not a new issue. In 2011, the Centre for Workforce Intelligence produced a report forecasting 362 fewer full-time equivalent consultants than the BAD recommended numbers by 2020. It recommended an increase in training numbers and acknowledged the fact that this profession had particularly high rates of consultant vacancies and dependency on locums – a theme that has re-emerged from the DCE's audit.

This same recommendation was repeated in June 2015 when the Independent Review into Nottingham Dermatology Services was published, advocating the following: *'The BAD has supported the increase in number of trainees and we would urge Health Education England to consider this request'.*[1]

Whilst it is the DCE's intention to further analyse the results of this audit and produce a fuller set of concise recommendations to policy makers in the near future, it is clear from our interim results that the BAD's call for investment in consultant trainee numbers is entirely justified. Alongside investment in primary care dermatological education, we would urge the health service to conduct a root and branch analysis of dermatological workforce needs so as to reduce dependence on temporary staff, boost the teaching capacity of Trusts and improve oversight of primary and intermediate care services.

Dr George Moncrieff FRCP, FRCGP

Chair of the Dermatology Council for England

2. The Trust Audit

2.1 The Dermatology Council for England audited a selection of trusts, chosen at random from each of the regions covered by NHS England's former area teams. As it stands 38 out of the 54 trusts selected have replied to the FOI requests.

2.2 The audit revealed a chronic lack of consultant dermatologists in England and a resultant impact on the ability of secondary care providers to meet referral targets.

2.3 The audit found that **66%** of respondents were operating with **consultant level vacancies** with some trusts running with up to **3.7 WTE posts unfilled**.

Number of Consultant Level Vacancies (total posts)	Number of Trusts	Percentage share of those with Vacancies (%)
0	11	31
1	10	28
2	11	31
3	2	6
4	2	6

Though providers were making efforts to fill the resultant service gaps, **45% (of those that provided an answer) reported that they did not have a fully staffed specialist secondary care service**.

2.4 The audit also demonstrated a high rate of long-term dependency on locums within the dermatology services likely as a result of the consultant level vacancies.

2.5 **71% of respondents were employing locum consultants** and for 23% of these trusts the locum consultants made up the majority of their workforce (meaning that for **13% of all respondents the locums were the core workforce**).

2.6 Though providers are to be commended for their efforts to fill the gaps in the consultant workforce, **48%** of trusts employing locums were using consultants who **were not reported as being on the specialist register**.

2.7 It was also clear that the reliance on locums was not a short-term issue. Of those employing locums **52% had been in post for between 1 and 4 years**. The audit did not quantify the length of employment past the 4 year point so it is likely that some had been in post for even longer than this period.

2.8 Breaking down this figure of those trusts using locums:

a) 30% employed at least one locum who had been in post for more than 1 year but less than 2 years
b) 22% employed at least one locum who had been in post for more than 2 years but less than 3 years
c) 11% employed at least one locum who had been in post for more than 3 years but less than 4 years
d) 19% employed at least one locum who had been in post for 4 or more years.

In total this figure equated to 32 locums across 26 trusts who had been in post for between 1 and 4 years. Although the use of consultant locums is not intrinsically bad, as they can assist in service delivery during times of change or fluctuations in demand, the apparent shortfall of consultants qualified to teach or train the influx of new doctors will, we anticipate, have a detrimental impact in the near future.

2.9 As the answers provided from the trusts concerning two week wait targets for cancer referrals are extremely varied, it was not possible to comprehensively compare the results across the whole dataset. For those trusts that replied in percentage terms, only 50% complied with the NHS guideline that 93% of all referrals had to be within two weeks. For those trusts that recorded the number of months that the 93% target was breached, all six had breaches within the last 5 years; one provider had in fact breached the target 8 months out of 12 for the year 2014/15. Out of the 38 trusts it was possible to categorically determine compliance statistics for only 17 of them, out of these few, 65% breached the national guidelines in one or more of the last 5 years

2.10 The trusts with consultant level vacancies also reported high average waiting times for urgent non-cancer referral at an average of 7 to 7.6 weeks.[1] For two providers this meant an 18 and 19 week wait for urgent referrals. Even discounting these outliers the average wait was between 5.8 and 6 weeks.

3. The CCG Audit

3.1 The Dermatology Council for England (DCE) audited all 209 CCGs in England, of which 204 replied. Unfortunately one CCG had to be excluded from the audit due to the fact that it split provision for dermatology services across three localities, necessitating three different responses (which may have skewed the results).

3.2 The audit revealed that to some degree commissioners are aware of the increasing pressure that dermatology services are coming under. This was most clearly seen through the lens of workforce capacity issues. However, the audit raised concerns that commissioners may be transferring dermatological care down to the community setting without the appropriate arrangements being put into place.

3.3 It is clear that commissioners are knowledgeable of the difficulties facing their providers, with **55% of respondents reporting that they had been informed of workforce capacity issues**. Of these CCGs some 24%, approximately 13% of all CCGs included in this audit, singled out that these issues were related to the high rates of consultant vacancies. A small, but significant, proportion (5% of CCGs reporting workforce capacity issues) also singled out problems relating to the inability of community or primary care services to provide the necessary dermatology services.

3.4 The audit also revealed a rise in demand for dermatology services, with 16% of CCGs highlighting increasing referrals, particularly for 2-week cancer referrals.

3.5 These had resulted in practical problems not picked up by the audit of trusts. One CCG reported a provider that had closed its doors to routine referrals for 5 months. Another CCG described a provider that had to restrict referrals for associated commissioners for 6 months, though they continued to offer services to their main commissioner.

3.6 The audit also revealed several issues related to the transfer of dermatology care into the community setting. Several CCGs explicitly noted that they were attempting to meet capacity issues by contracting with community providers, however several had experienced difficulties finding the appropriate trained staff. One CCG specifically noted a "*lack of trained nurse specialists, GPwSI and consultant dermatologists in London*".

3.7 Respondents appeared to be sometimes commissioning GPwSI led services without the sufficient accredited staff numbers or accreditation processes in place. The guidance for the provision of services using GPs with Special Interests clearly states that to "ensure good clinical practice" and therefore "maintain key competences," all GPs must "attend a monthly joint clinic with a consultant dermatologist."[2] **However 29% of the 104 CCGs that commission this service, had one or more providers not meeting this requirement.** One reason given seemed to suggest that due to the lack of consultant dermatologists they did not physically have the capacity to accredit their GPs. With 18 CCGs not answering or giving only partial information, the figure of unaccredited GPs contracted to run community dermatology clinics might be higher.

3.8 A further **26% of CCGs contracting GPwSI services either did not answer the question or were unaware of the processes in place locally to ensure on-going accreditation**. Though the latter reason was frequently down to the sub-contractual nature of the service provision, it highlights a worrying lack of oversight given that there is no compulsory dermatological element to GP training.

3.9 Additionally, a small number of commissioners highlighted that capacity issues had arisen due to the poor integration between community and secondary care services.

3.10 Worryingly, whilst the audit revealed that there was some degree of oversight and awareness from the CCGs **only 37% had actively reviewed their service provision since the formation of the CCG.** Many of these reviews amounted to basic routine contractual activities, and this suggests a serious disconnect compared to the 55% of CCGs that claimed to have been alerted of capacity issues.

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[1] Discounting providers who did not answer

[2] Guidance for GPwSI service provision

3.11 However, there were also some excellent examples of informed service commissioning, including CCGs who had reviewed service provision in conjunction with community providers and the British Association of Dermatologists, CCGs who had set up bi-monthly training sessions for their GPwSIs and CCGs who had held region wide reviews of the patient pathway.

The DCE has provided in this report, a very short and by no means complete analysis of the data collected via our freedom of information exercise. Acknowledging our limited capacity and resources we would encourage all interested organisations or members of the public to access the full data set provided online. It is our hope that this data will assist organisations working in the field of dermatology to communicate the need for improvement whether this be locally, with providers and CCGs, or nationally in engagements with policy-makers.

4. Further Resources

The Kings Fund, *How can dermatology services meet current and future patient needs, while ensuring quality of care is not compromised and access is equitable across the UK?* (2015)

http://www.bad.org.uk/shared/get-file.ashx?id=2348&itemtype=document

Clough. C, *Final Report, Independent Review of Nottingham Dermatology Services* (4th June 2015)

http://www.healthwatchnottinghamshire.co.uk/wp-content/uploads/2015/06/Final-Report-from-the-Independent-Review-Nottingham-Dermatology-Service.-4-June-2015.pdf

British Association of Dermatologists, *'Lessons for the NHS – Commissioning a Dermatology Service'* (2013)

http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=1009

APPG on Skin, Minutes of December 2014 event on Dermatological Workforce

http://www.appgs.co.uk/wp-content/uploads/2015/01/APPGS_Minutes2ndDec14final.pdf

APPG on Skin 2013 report: *The Psychological and Social Impact of Skin Diseases on Peoples' Lives*

http://www.appgs.co.uk/publication/the-psychological-and-social-impact-of-skin-diseases-on-peoples-lives-final-report-2013/