BACKGROUND

Between January and March 2019, the APPG on Skin (APPGS) sent and received Freedom of Information (FOI) requests from NHS Foundation Trusts in England, whilst the Dermatology Council of England sent the same FOIs to Scottish Regional NHS Boards, Welsh Health Boards and Northern Irish Health and Social Care Trusts.

The FOIs sought dermatology information from each NHS provider on substantive Consultant Dermatologists, locum Dermatology Consultants, emergency room dermatology provision, and Dermatology Consultant work, substantive or locum, taking place in the community. The FOIs targeted secondary care provision and did not cover all dermatology expertise, such as Advanced Nurse Practitioners and GPs with an extended role in dermatology.

The results provide a national picture of each nation’s provision of secondary care dermatology, as well as revealing individual providers and areas that are particularly challenged to provide adequate Dermatology cover.

Incomplete data was dealt with as follows:

- 4 English NHS Trusts did not submit a response. However, the information on the number of Consultant Dermatologists - but not the number of locums, emergency provision and community work - could be reasonably deduced from the Trusts’ websites. All Trusts with other missing data were removed from the national calculations for the respective questions.
- In a small number of cases, English Trusts only provided a range of answers for confidentiality purposes (e.g. 1 - 5 Consultant Dermatologists). For the purpose of national aggregation the mean number from the range was used.
- WTE and doctor numbers: If only one, and not the other figure, was given, then a ratio of 0.8 Consultant Dermatologists : 1 WTE was used to estimate the missing figure, as it is close to the UK average of 0.79.

The analysis uses **62,500 population per Consultant Dermatologist as a baseline target ratio** since the Royal College of Physicians (RCP) recommends one full-time equivalent (FTE) Consultant Dermatologist per 62,500 population.¹ This figure is endorsed by the British Association of Dermatologists (BAD). It is with note that this figure does not allow for time spent on specialist clinics, teaching students, supervising or training any grade of staff, ward referrals, inpatient care, on-call work, travel, or multidisciplinary teams. The figure is conservative and less than the figure used in the Government’s latest publicly available dermatology workforce planning, which was 55,000 population per Consultant Dermatologist, and was used by the Centre for Workforce Intelligence (2011).²

¹ https://www.rcplondon.ac.uk/file/1578/download?token=TH8kJb7v
² Centre for Workforce Intelligence (August 2011) Dermatology.
### RAW RESULTS

*Devolved population figures from FOI responses, England figures from ONS (November 2018)*  
**Welsh population area of Powys Teaching H has been removed due to outsourced care to England**

<table>
<thead>
<tr>
<th></th>
<th>N. Ireland</th>
<th>Wales</th>
<th>Scotland</th>
<th>England</th>
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<tbody>
<tr>
<td>Consultants</td>
<td>23</td>
<td>38</td>
<td>71</td>
<td>699</td>
<td>831</td>
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<tr>
<td>WTE Consultants</td>
<td>18.4</td>
<td>30.4</td>
<td>54.8</td>
<td>549</td>
<td>652.6</td>
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<tr>
<td>Locum Consultants</td>
<td>2</td>
<td>8</td>
<td>15</td>
<td>184</td>
<td>209</td>
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<tr>
<td>WTE Locums</td>
<td>1.6</td>
<td>6.4</td>
<td>11.1</td>
<td>146</td>
<td>165.1</td>
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<tr>
<td>Total Doctors</td>
<td>25</td>
<td>46</td>
<td>86</td>
<td>883</td>
<td>1040</td>
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<tr>
<td>Total WTE Doctors</td>
<td>20</td>
<td>36.8</td>
<td>65.9</td>
<td>695</td>
<td>817.7</td>
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<tbody>
<tr>
<td>Population per Substantive Consultant</td>
<td>78,000</td>
<td>78,800</td>
<td>76,500</td>
<td>79,500</td>
<td>79,200</td>
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<tr>
<td>Population per Dermatology Consultant (incl. Locums)</td>
<td>71,700</td>
<td>65,100</td>
<td>63,200</td>
<td>63,000</td>
<td>63,300</td>
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<tr>
<td>Population per WTE Consultant</td>
<td>97,400</td>
<td>98,400</td>
<td>99,200</td>
<td>101,300</td>
<td>100,900</td>
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<tr>
<td>Population per WTE Dermatology Consultant (incl. Locums)</td>
<td>89,700</td>
<td>81,300</td>
<td>82,500</td>
<td>80,000</td>
<td>80,500</td>
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<tr>
<td>Population per WTE doctor as % of target (62,500)</td>
<td>144</td>
<td>130</td>
<td>132</td>
<td>128</td>
<td>129</td>
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<th>England</th>
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<tbody>
<tr>
<td>Locum Dermatology Consultants who are not on the specialist register</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>102</td>
<td>106</td>
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<tr>
<td>Locum Dermatology Consultants who are not on the specialist register and are working in isolation</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>25</td>
<td>26</td>
</tr>
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</table>

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</thead>
<tbody>
<tr>
<td>Dermatology Consultants (incl. Locums) who undertake community clinics</td>
<td>5</td>
<td>7</td>
<td>4</td>
<td>103</td>
<td>119</td>
</tr>
</tbody>
</table>
⇒ No Consultant Dermatologist is employed to work wholly in the community in Northern Ireland, Wales, Scotland and England.

⇒ The majority of health providers in the UK provide dermatology services available for ward patients and emergency room (ER) on a daily basis during weekdays.
  - Northern Ireland – 100% Trusts.
  - Wales – All except one Board.
  - Scotland – All except three Boards.
  - England – 10 Trusts do not provide any dermatology services for ward patients and ER, whilst a further 7 Trusts only provide this care on an ad hoc basis or on only a few weekdays. In total, 85% of Trusts, that responded and have secondary care dermatology departments, have dermatology services available for ward patients and emergency room on a daily basis during weekdays.

**DISCUSSION**

**ENGLAND**

In England, there is a range of NHS Trusts and NHS Foundation Trusts. Some focus solely on mental health, community services or a specialist service. These providers were discounted from the analysis.

Overall the FOI revealed there to be 699 Consultant Dermatologists in England, representing 549 WTE Consultants, and 184 Dermatology locums, representing 146 WTE locums.

In total there are 695 WTE Consultants and locums in England for a population of approximately 55.6 million. This represents **1 WTE per 80,000 of the population – 17,500 above the RCGP and BAD’s recommended target.** Going by this target, to reach the 889.6 WTE level for England’s population area, **194.6 WTE dermatologists would need to be trained and employed.** This represents a **28% increase in current staffing levels.**

21% of the WTE Consultant workforce in Dermatology is operating as a locum. This is not substantially above the UK average (20.2%). However, at a numerical figure of 146 WTE doctors, this is deeply concerning since many of these locums are not on the specialist register and with current training numbers it would take years to redress this balance.

Recruitment is not an issue in England as nationally and locally there has been a 100% fill rate in dermatology training for the past four years. However, there are insufficient numbers of Dermatologists being trained to fill the locum and vacant posts. Yet, the number of trainee doctors that can specialise in dermatology is fixed. In 2018, there were 206 doctors in dermatology specialty training.

102 Dermatology Consultants are acting as locums working in a Trust and not on the specialist register, and of these, **25 are working in isolation** (i.e. single-handed). Therefore, the FOI uncovered concerning practices where units are providing dermatology care by individuals working single-handedly and sometimes not on the specialist register, which might be at significant clinical risk.

On an individual basis, some Trusts have good dermatology coverage, whilst others are inadequate. Overall, the FOI reveals that large geographical areas have too few Dermatologists. Even Trusts in major cities, including London, are unable fully to recruit Consultants in their departments. **4 Trusts even have no permanent Consultants and rely solely on locums covering the service.**

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3 https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2019-02-06/217639/
The use of Consultant time for community clinics is more widespread in England than Northern Ireland, Wales and Scotland. There are 103 Consultants who engage in some community work in England, which represents 11.5% of Consultant Dermatologists (incl. locums). Although, no Consultant Dermatologist is employed to work wholly in the community in England or in Northern Ireland, Wales and Scotland.

Ten Trusts do not provide any dermatology services for ward patients and ER. Within these Trusts the dermatology services are almost wholly reliant on locum Consultants who are not on the specialist register for Dermatology, suggesting that dermatology services are commissioned as an out-patient service rather than as a model of integrated medical care.

**Scotland**

14 NHS boards deliver healthcare services in Scotland. However, the island providers of NHS Shetland and NHS Orkney rely on a visiting dermatology service from NHS Grampian. NHS Western Isles also relies on one visiting clinician. Therefore, there are 11 main providers of dermatology services.

The audit revealed concerning findings with **understaffed Boards and a number of vacancies**.

This includes NHS Borders having only **1 Consultant in post for a population of over 115,000**, and a dermatology locum Consultant employed on an ad hoc basis, even though they are budgeted for 2.6 WTE Consultants.

Similarly, NHS Grampian, which has a population coverage of 586,400, and covers Shetland (23,100) and Orkney (21,500), only has 3.5 WTE Consultant Dermatologists in post and **vacancies for 3.0 WTE**. It is also concerning that of NHS Grampian’s use of 1.48 WTE locums, it has 0.88 WTE locums working in dermatology who are not on the specialist register and are working in isolation.

At the time of the audit, the figures reveal that Scotland had 54.8 WTE Consultants (71 in total) and 11.1 WTE locums (15 in total). This means there is a coverage of around one dermatologist per 82,500 of the population – **20,000 above the RCP and BAD’s recommended target. 21.1 WTE dermatologists would need to be trained and recruited** to reach this recommended level – a **32% increase in staffing**.

NHS Lanarkshire’s population of 658,100 has only 2.3 WTE Consultants and 1.3 WTE locums. This **represents one WTE dermatologist per 183,000 people**. NHS Grampian and NHS Borders also have under-resourced Boards, with a population per dermatologist of 127,000 and 115,000, respectively.

Three Boards were well staffed - NHS Tayside (1 WTE : 53,300 population), Ayrshire & Arran (1 WTE : 58,300 population), and NHS Fife (1 WTE : 62,500 population).

Only two Boards, NHS Forth Valley and NHS Highlands, revealed that they have any consultants undertaking community clinics, and NHS Forth Valley’s were all in Community Hospital sites, whilst NHS Highlands’ community services are set to end in April 2019.

One FOI response revealed that there were no Consultants undertaking community clinics because “until vacancies have been recruited to, peripheral clinics have been put on hold.” Therefore, staff shortages in secondary care units are preventing the Scottish Government from treating patients in the community and are hindering an integration of health and care in the community.

Three Boards do not have dermatology services available for ward patients and ER on a daily basis during weekdays. One of these Boards provides the service on some days, another has struggled to recruit dermatologists in any capacity and the reason behind the third Board is unclear.
Wales

Seven Local Health Boards (HBs) deliver healthcare services in Wales to population areas that range from 132,500 to 696,300.

The findings present a mixed picture. Bro Morgannwg University HB has 9 substantive and 3 locum Consultant Dermatologists for a population of 531,900, Cwm Taf University has 4 substantive and 1 locum Consultant Dermatologists for a population of 299,100, and Cardiff & Vale University has 9 substantive Consultant Dermatologists for a population area of 493,400. Therefore, these three HBs might provide sufficient dermatology coverage, provided the dermatologists are not substantially working part-time.

Betsi Cadwaladr University HB has 7 substantive and 3 locum Consultant Dermatologists for a population of 696,300, whilst Aneurin Bevan has 9 substantive and 0.2 WTE locum Consultant Dermatologists for a population of 587,700. Therefore, these two HBs have dermatology services that are not substantially above the 62,500 target, and therefore, are not too stretched above their capacity, provided dermatologists are not substantially working part-time.

The smallest HB, Powys Teaching, does not employ any dermatologists as their northern dermatology activity is outsourced to the Shrewsbury and Telford Hospital NHS Trust in England, and for South Powys they have 2 Consultants that provide community hospital dermatology services.

The most concerning findings from the audit was that Hywel Dda HB, which covers a population area of 384,200, has 0 substantive Consultant Dermatologists and only a 0.25 WTE locum. They do have nurse led community dermatology clinics, however, this is deeply problematic given that Consultant Dermatologists are the only health professionals able to appropriately diagnose and treat a number of skin conditions.

One HB - Betsi Cadwaladr University - employs a locum doctor working in dermatology who is not on the specialist register.

The overall picture is of understaffed and overstretched dermatology departments. If we remove Powys Teaching HB from the analysis because of its outsourcing of dermatology care to England, then at the time of audit, there were approximately 38 substantive Consultant Dermatologists and 8 locums, which equates to 36.8 WTE doctors in total. This represents 1 WTE per 81,300 of the population – which is 18,800 above the RCP and BAD's recommended target. 11.1 WTE Dermatologists would need to be trained and employed to meet this target – representing a 30% increase.

The use of community dermatology clinics is mixed. Hywel Dda's clinics are nurse led, Betsi Cadwaladr University has 4 Consultants engaging in clinics, Abertawe Bro Morgannwg University has 2, Cardiff & Vale University has 1, whilst Aneurin Bevan, Powys Teaching and Cwm Taf University do not have any Consultant engagement in community dermatology clinics.

Apart from Powys Teaching HB, each HB has dermatology services available for ward patients and ER on a daily basis.

Northern Ireland

In Northern Ireland, 5 Health and Social Care (HSC) Trusts provide integrated health and social care services.
According to the audit, the population coverage of each HSC is roughly the same at approximately 350,000. Only Northern HSC Trust has a significantly different population size at 471,000. Therefore, the audit expected to uncover similar coverage of dermatology expertise.

This was not the case. The average number of Consultant Dermatologists employed by an HSC Trust was 4.6 (3.7 WTE), but this ranged from only 1 Consultant Dermatologist and no locums in Western HSC Trust to 8 Consultant Dermatologists in Belfast HSC Trust.

Of the 5 HSC Trusts, only Belfast has levels of staffing that meet the RCP and BAD’s recommended levels. Therefore, the overall picture is one of too few dermatologists – on average each substantive and locum Consultant Dermatologist is responsible for 71,700 people. This rises to 89,700 people when we calculate for the likely WTE ratio. Therefore, each WTE doctor is covering on average a population area of almost 27,200 above their capacity.

There are currently only 20 WTE doctors and, for a population of 1.793 million, there should be 28.7 WTE to meet the RCP and BAD’s target. This represents a required 8.7 WTE increase in Consultant numbers – or a 44% increase in existing WTE doctor numbers.

Currently, few locums are used to cover any gaps in service provision – at the time of the audit, only 2 two of the Dermatology Consultant locums were on the specialist register.

Each Trust has dermatology services available for ward patients and ER on a daily basis.

The use of Consultants for undertaking community clinics is underutilized within Northern Ireland. In fact, only a single Trust reported that one Consultant undertakes the practice. Given the under resourced dermatology departments, this lack of priority given to community clinics is not untoward.

**CONCLUSION**

It is the responsibility of individual health providers to have staffing arrangements in place that deliver safe and effective care. This report shows that in order to provide Consultant led dermatology services many providers are reliant on locum Consultant Dermatologists, many of whom are not on the specialist register for dermatology and some of whom are working in isolation. England was particularly shown to rely on locums that are perhaps not on the specialist register, and a portion of these work in isolation. This could cause suboptimal care for patients.

This has ramifications on the ability of each nation’s health system to adequately treat all patients with skin conditions within secondary care in a timely and safe manner. Given the population per WTE Consultant Dermatologist of some providers, the FOIs indicate that some departments could be overburdened and stretched beyond their capacity.

If all Consultants and locums were working full-time then the UK coverage would be acceptable at 63,300 people per doctor. However, this is not the case as many work part-time. Each WTE doctor working in dermatology in the UK is responsible for over 80,000 people (80,500).

The audit revealed that no Consultants in England, Wales, Scotland and Northern Ireland work wholly in the community, and few Consultants undertake some community work – apart from in England. This is to be expected given many health providers’ understaffed departments, which rightly take precedence for Consultants.

The audit found that despite the considerable workforce some providers do not have dermatology services for ward patients and ER on a daily basis (Monday to Friday), and that this appears to be a particular risk when providers commission out-patient services only and rely on locums that are not on the specialist register and are working in isolation.