All Party Parliamentary Group on Skin
Parliamentary Meeting

Monday 11th March 2013
House of Commons, Committee Room 14

Speakers:

Prof. Christopher Bunker, President of the British Association of Dermatologists (BAD) - CB

Parliamentary Members Present:

Sir Paul Beresford MP (Chair)
Baroness Masham of Ilton (Vice-Chair)
Baroness Gardner of Parkes
Rt Hon Cheryl Gillan MP

Minutes

The Chair welcomed everyone to the meeting and introduced the speakers.

1. Introduction

CB began by setting out the main topics of his presentation:
Crisis in Dermatology and for People with Skin Disease

- Demographics and Demand
- Workforce
- Configuration
- Research
- Influence

2. Demographics and Demand

CB set out the three main challenges of demographics and demand. An ageing population was one. As people were living longer, demand on dermatology services was steadily rising. The increased rate of skin cancers diagnosed in the UK combined with the complications of long-term chronic diseases and their treatments, meant that demand on healthcare was rising at an alarming rate.

CB reminded the audience of the work of a skin specialist. This included managing up to 2000 different diseases of the skin, hair and nails in adults and children. Each year 54% of the population was affected by skin

disease, and 23–33% at any one time had a disease that would benefit from medical care. Approximately 4,000 deaths occured in the UK on an annual basis due to skin disease, most often from malignant melanoma. Skin diseases represented 34% of all diseases in children (atopic eczema affected 20% of infants). Skin cancer was the most common cancer and the second most common cancer causing death in young adults. Basal cell carcinoma (BCC) numbers equaled all other cancers combined, and increased by 133% between 1980 and 2000.

Dermatologists also manage the psychological burden carried by patients with a skin disease, which could be very severe.

3. Workforce

CB said that there were approximately 830 posts available in the NHS for Consultant Dermatologists but with the actual number of dermatologists in the UK around 650, this left a deficit of almost 200 vacancies.

Despite the demand for Dermatology services, Dermatology is unevenly and inadequately taught at Medical School and rarely if ever considered a core module.

This walked hand-in-hand with poor training and uneven training for GPs, who often referred patients unnecessarily to secondary care for a second opinion. Were GP education better, patient management in the primary care setting would be improved and the number of unnecessary referrals could be significantly reduced, as could the potential for litigation on the other end of the scale. 9 out of 10 claims over delayed diagnosis of melanoma involved GPs.

More generally the morale of medical and nursing staff was waning considerably and the relative unimportance attached to Dermatology by policy makers was not helping.

4. Configuration

Dermatology services had traditionally revolved around the secondary care hospital base because that has been perceived to be the most efficient way to deliver care i.e. by a team of specialists pooled together in one integrated setting. The shift away from this to the community, despite superficial benefits, fragments integrated services (and teaching, training and research synergies) built up over decades and leaves the hospital itself devoid of readily accessible Dermatological input and nowhere to look after the sick Dermatological patient. These things are further jeopardised by the Any Qualified Provider scheme - disintegration of services and the redistribution of profit away from the NHS and into private pockets.

There is also much unneeded bureaucracy in the system that could be reduced. For example Multi-Disciplinary Team working for the treatment of skin cancer patients was not necessary for the majority of cases: most patients with skin cancer could be dealt with rapidly, effectively and safely by an accredited Dermatologist without the need for additional input. Unnecessary referrals from GPs under the two week wait rule were also wasting resources that could be better spent assessing and treating those who actually need the skin cancer service.

Isotretinoin for the treatment of severe acne was another example of over zealous micromanagement. The drug was unnecessarily difficult to prescribe and females were needlessly being subjected to recall to clinic monthly for a pregnancy test and repeat prescription.

The hospital setting would always be needed for Dermatology, yet this was slowly being eroded through the loss of beds, on call expertise and the outsourcing of outpatient activity – away from the geographic location of the hospital. Links with other disciplines such as paediatrics and the essential provision of services such as phototherapy and patch testing were also being affected

In Nottingham, Consultants have little choice now but to become actual employees of Circle, an independent provider that has recently won the tender for a Treatment Centre that includes the Dermatology service, removed from the NHS hospital base. The problem is that many of these Dermatologists also work in other areas such as paediatrics and as a result will elect to retain their NHS employment at the hospital and so will not be available for general Dermatology duties at the Treatment Centre, a significant schism geographically and professionally, deleterious to integrated patient care. This is just one example of the disintegration that is happening up and down the country.

CB explained that Dermatology had been placed in Domain 2 (Long term Conditions) under the NHS Commissioning Board. This concerns him greatly as Dermatology fails to fit into any of the areas covered by the Clinical Directorships being appointed in Domain 2 (listed below). This leaves the 13 million patients with skin disease, that present annually to their GPs, without anyone specifically coordinating commissioning policy for them.

Domain 2: Long Term Conditions
- Dementia
- Integration and Frail Elderly
- End of Life Care
- Mental Health
- Chronic Disability and Neurological Conditions
- Musculoskeletal Disorders
- Spinal Disorders
- Renal Disease

The expansion of so-called 'alternative providers' is a cause for concern as there is no real alternative to the experienced, trained and accredited dermatological staff and services already in place. Community clinics have some superficial attractions and properly configured could complement other services, but require intelligent integration to provide continuity of care. However, commissioners and independent providers may be too readily influenced by cost rather than quality issues. Revisions to the recent secondary legislation on competition suggest that policy makers are being forced to act by expediency. More ad hoc secondary legislation is likely. Furthermore, few of the decisions being made around service redesign seem to take into account the unheard of voice of patients.

5. Research

Moving on to research CB said that the NHS often has trouble translating what was already known from recent clinical research. For example there is no evidence that sentinel node biopsy for melanoma improves survival yet it is widely practiced. It is very expensive to the NHS and there are side effects. It is not advocated by any Guidelines or NICE. Securing funding for dermatological research is immensely challenging as is recruiting, training and retaining the research workforce (considerably threatened by changes in medical training and recruitment). Funding is badly needed for research into the most urgent areas of dermatological need.

6. Influence.

CB bewailed the lack of influence that skin medicine commanded, pointing to the unheard voice of patients, the unheard voices of specialist doctors in primary and secondary care and nurses. 'People do not understand what we do' he said. There is a poor comprehension of Dermatology.

7. Solutions

The BAD is a charity whose objects are to promote for the public good the teaching, training, research and practice of Dermatology. Its income comes from member subscriptions, journals and conferences and surplus is spent on the above or on research through the British Skin Foundation. These things legitimise the airing of

the above concerns and its active engagement in proposing and promulgating solutions.

Demographics and Demand

In the absence of any significant NHS initiatives to date, the BAD is developing registries and audits to quantify some important areas where data are scarce eg non melanoma skin cancer (estimated at over 120,000 case pa) and especially to provide qualitative statistics about performance and outcomes. Patients deserve these and Commissioners need them to make the right decisions about where and by whom such work should be done. Specifically the BAD is funding the development of Patient Reported Outcomes Measures (PROMs).

Workforce

The BAD is deliberating with the RCGP, RCPCH, RCP, PCDS, BDNG, RCS and BAAPS to campaign at Heath Education England, the DH and through the GMC and Shape of Training to improve the teaching of Dermatology to Medical Students and Nurses, to bolster the training of GPs, and to regulate the accreditation of GPwSIs and the practice of cosmetic procedures, in order to protect and enhance the training and accreditation of Dermatologists.

Configuration

Already the BAD has issued or contributed to important documents that help define dermatological health needs, explain and assist in the commissioning process and delineate quality standards (Teledermatology and Psychodermatology). This multidisciplinary work continues. The BAD has been vociferous in the ongoing Future Hospital Commission undertaken by the RCP arguing for the hospital base for Dermatology and the dermatological needs of sick inpatients. The BAD actively challenges egregious commissioning and outcomes. CB emphasised the fact that a number of problems had arisen in the last two years due to the reconfiguration of services, unacceptable commissioning practice and outcomes. There are vital lessons to be learned. The BAD and the RCP are working on a 'Lessons to be Learnt' document to be published later in the Spring, from which all would benefit, not just patients with skin disease. The BAD has earmarked a significant sum for researching alternative models of service delivery given the constraints detailed above and hopes to announce a partnership with the Kings Fund to take this forward in the very near future. The best interests of patients and taxpayers are served by continuity of care and integration. Academic Health Science Centres and Networks provide the best vehicle for these aspirations in Dermatology. The DH is keen on Strategic Clinical Networks and the BAD will argue that this is a suitable approach for skin disease.

A key issue is that the perceived profitability of Dermatology should be 'repatriated' for service (and teaching training and research) and that public money derived from the tax take for health should not disappear into either excessive unnecessary management costs in the NHS or the pockets of private investors, but be repatriated for the good of patients and the specialty.

Research

See above. Disintegration threatens research. British Dermatology punches above its weight in the research arena but the future needs securing, especially concerning the recruitment and training of the research leaders of tomorrow. The BAD spends directly on research and facilitates other activities. British Dermatology has been a lauded player in the NIHR Clinical Research Network environment and we have our own highly successful Dermatology Clinical Trials Network. The national biologics registry (BADBIR) is envied around the world and the data for research (about efficacy and safety) that it is capable of generating is just beginning to be tapped. The BAD will similarly facilitate other multipartite Registry projects (eg around skin cancer especially non-melanoma skin cancer and genetic skin disease). UKTREND will bring together leading researchers, funding bodies and industry to integrate research activity: it has been funded and will be hosted by the BAD. Charitable activity directly and indirectly can be bolstered. The BSF has reviewed its strategy both

around increased fundraising and the type of research it supports. Following CBs approaches Skin Disease has been offered a meeting to set out its stall in a meeting with Dame Sally Davies the Chief Medical Officer and Chief Scientific Adviser to the DH in July, an opportunity so far accorded only to HIV, Obesity, Physical Activity and Alcohol-a real coup and a real opportunity. As above, a fundamental principal must be that any inherent 'profitability' in Dermatology should be shared with the patients from whom it is derived in research (and teaching and training and service improvement as above).

Influence

CB is committed with the BAD in trying to get heard, for the benefit of the nations dermatologically sick and disadvantaged. We have the legitimacy and credibility of our charitable objects and our professional positions. 'We are the trained, experienced, accredited vocationalists'. The APPGs should be pivotal in influence at Westminster and all BAD Members will be Advisory Members in the near future. Patients Support Groups and the Dermatology Councils of England, Wales and Scotland are becoming more vocal and persuasive. The BAD has a practised communications team, the better to engage with the media. But the key thing is to meld coalitions of multipartite (eg BAD, PCDS, BDNG, RCP, RCPCH, RCGP, BAAPS) to try to shape the future to provide a better deal for patients with skin disease - remember ~13 million a year consulting a doctor.