The All Party Parliamentary Group on Skin

51 Niddry Lodge, London W8 7JB

APPG on Skin Event – An audit of dermatology services in 2015 - a workforce crisis revealed?

July 14th 2015

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

Speakers: **George Moncrieff** – Chair of the Dermatology Council for England (GM), **Dr Chris Clough** – Chair of the National Clinical Advisory Team (CC)

Introduction and Presentations

PB welcomed everyone to the event and invited GM to begin the presentations.

Presentation of the Audit Report by Dr George Moncrieff

GM set out some of the most pertinent findings from the recent dermatology service audit of the Dermatology Council for England. These included:

- 66% of Trusts that responded were operating with consultant level vacancies, with some Trusts running with up to 3.7 WTE posts unfilled.
- 48% of these trusts that were employing locums were using consultants who were not reported as being on the specialist register.
- 55% of CCGs that responded reported that they had been informed of workforce capacity issues by their providers.
- Approximately 13% of those CCGs singled out high rates of consultant vacancies as the main cause of the workforce capacity issues.

GM highlighted the fact that almost half the trusts were failing to meet 2 week wait referral targets for cancer and suggested this to be extremely worrying as these targets

were their top priority. GM voiced concern as to the impact overwhelming numbers of skin cancer patients were having on the NHS' ability to provide other dermatology services.

GM suggested that general practice is not in a good position to take on the extra capacity due to years of inadequate training in dermatology. Moreover, as the audit demonstrated, CCGs were failing to properly monitor GPs who had been contracted to deliver dermatology services, to ensure that they are adequately credentialed.

The audit also revealed that trusts were responding to the high demand by filling consultant level vacancies long-term with locums. In addition 48% of trusts using locums were employing consultants who were not on the specialist registrar.

GM suggested the report showed a breakdown in communication between the CCGs and providers, with CCGs unaware about trusts' reliance on locums or the state of their GPwSI services.

GM commented that he has never seen general practice in such a state of demoralisation for a variety of reasons including the inability to recruit and retain enough doctors within general practice and to provide adequate training for them. GM felt that whilst this painted a concerning picture, the audit provided sufficient information to highlight the problem and direct action.

Presentation of the Independent Review of Nottingham Dermatology Services by Dr Chris Clough

CC surmised that the overall findings of the review were that there was a total collapse of acute and paediatric dermatology services within Nottingham. He then outlined the timeline for this:

- For many years dermatology services at specialist level had been provided by Nottingham University Hospitals Trust (NUH). The department had developed into a centre of excellence with nationally regarded experts in a number of sub-specialties of dermatology. It was also renowned for its academic research.
- With the advent of the Nottingham Treatment Centre (NTC) run by a private organisation, Circle, outpatient services were transferred to the NTC in July 2008. These included all general dermatology services, dermatology surgery, dermatology oncology with supportive nursing services and treatments. NUH consultants continued to provide much of the outpatient service through a staff supply agreement between NUH and Circle
- In 2012 the CCG commenced a procurement process based on its own specification. This procurement was for a number of services, including dermatology. Bids in response to the tender were received from four different organisations including NUH and Circle. Circle were successful in the bidding process; as part of their bid it was expected that all staff from NUH involved in providing the dermatology outpatient service would TUPE (Transfer of Undertakings under Present Employment) to Circle employment

- Out of 11 consultants only 3 initially accepted TUPE, of whom 2 subsequently left. The decision of most NUH consultants not to TUPE to Circle (and to ultimately seek employment elsewhere) led to a shortfall in the consultant workforce required to deliver the workload.
- He explained that Circle currently had 4 directly employed consultants (3.8 Whole Time Equivalent) and 6 long-term locums in place. The cost of employing locum consultants was nearly £300,000 per annum per post, greatly in excess of that of a standard NHS consultant salary, and had led to financial pressures on the Circle service.
- As a result teaching and training on the NUH/Circle sites had greatly diminished with withdrawal of trainees in keeping with the number of consultants available to teach. In January 2015 it became clear that an acute dermatology service providing specialist in- patient care for dermatological emergencies was no longer possible.

Ultimately CC concluded that:

- There should be a re-examination as to how EU clinicians feed into the UK system, relating specifically to accreditation and training.
- There should be a push for dermatology to be considered a top priority in terms of recruitment problems within the NHS.
- This would then help to turn the NHS from a buyers market into a sellers market

Open Debate

Sir Paul then invited the attendees to discuss the two presentations.

Dr Ruth Murphy (RM) – Academic Vice President of the BAD suggested that although applications via the CESR route enabled those doctors that have not followed approved training programmes to get onto the specialist register, it was an extremely complex process and would not solve the current problem. She argued that with approximately 1 application per month, more needs to be done. RM felt that the problem was not necessarily having enough specialists, but in fact enough GPs with enough general medical experience.

Clive Johnstone (CJ) – Medical Management Services. CJ explained that he runs workshops to help clinicians engage with the commissioning process, and suggested that clinicians themselves are relatively bad at engaging with the commissioning process. CJ suggested that training should be given to help them engage in the process, possibly in the form of workshops such as his.

Jennifer Viles (JV) – Special Advisor to APPGS suggested that the reasons consultants left NUH was as a result of changes in the terms and conditions that Circle were trying to impose on them.

CC argued that this was not the case, there are legal requirements to guard against this and there was no suggestion that their terms and conditions would change. He felt there may have been some fears that Circle would want to change the service provided in some way in the future, but CC commented that nobody would expect the service to stay the same forever.

JV replied that she heard that one dermatologist was not allowed to continue the research that he was already undertaking and that is why he left. CC rejected this claim, but did concede that this was illustrative of a wider point; clinical commissioning affects everyone and there is a need for greater engagement by service providers during CCG contractual negotiations.

Irene Leigh (IL) – the BAD commended the work of the Kings Fund in collaborating with the BAD to produce a report on the ways dermatology services can meet current and future needs. IL felt that a further look at this report could provide solutions to the current situation.

Rt Hon Lord Clarke of Windermere (LC) – updated the group on his parliamentary activity in the House of Lords and highlighted his concerns about the difference in provision of routine dermatology services and those services focused on skin cancer in an acute setting.

GM accepted that at times primary and secondary care seem to be at 'logger heads', and suggested that much better integration between the two is crucial. GM stated that NICE guidelines on skin cancer have in fact reinforced divisions, rather than helping primary and secondary care come together. GM also commented that GPs have been excluded from a lot of the skin cancer work because it demands such high standards in that one area that GPs are never able to achieve it. GM noted that with an ageing population and the ever-greater pressure on the NHS it was vital to get primary and secondary care working together.

Professor John Howard (JH) – Health Education England (HEE) conceded that there was inadequate training and that the training length of GPs was not sufficient. However he felt there were indications that some dermatology training was going on after formal education had finished.

JH stated that as far as HEE was concerned, they understand the nature of the dermatology workforce crisis and had established a taskforce to look at all areas of this. He noted that a report would be produced, along the lines of the report produced by the King's Fund, however a definitive timescale was not yet unavailable.

Becky Heath (BH) **–** Dermatology Consultant highlighted the recurring problem of 'short termism' within the NHS, noting that it is extremely difficult for trusts to plan and grow a department if they know their contracts are up in three years. BH felt that alternative models of care, such as a cascade model under which she operates, needed to be considered not just increasing the number of trained clinicians.

GM signalled his support for this, with his vision that consists of a geographically defined group of GPs that are linked to a consultant dermatologist or a team of

consultants. This model would also facilitate a much better two-way education between GPs and consultants within a 'team mentality'.

GM argued that there was not enough GP education in the vocational years, and said that for many years there had been a perception that GPs could learn on the job which he suggested was inaccurate.

Stephen Kownacki (SK) - Executive Chair of the Primary Care Dermatology Society commented that when talking to some of his members he got the impression that there was a lack of confidence. Unlike in other fields of medicine where learning is acquired through experience, dermatology knowledge must be absolute from the very beginning.

SK also commented that politicians could sometimes have a detrimental impact on the attitudes of GPs, especially when clinicians are 'pilloried' for making mistakes. He felt this fuels the culture of referral and creates an ever-greater pressure on consultant dermatologists. SK stated that some 80-90% of 2-week wait referrals were obviously benign.

Marilyn Benham (MB) – Chief Executive of the BAD suggested that telemedicine was one crucial area of healthcare that was not being supported enough. The BAD had piloted a support network for triage cancer clinics provided through telemedicine but MB commented that further investment in this area was needed. MB felt that without any economic studies of telemedicine it was difficult to get governmental support.

SK suggested that sometimes people forget the time and cost involved in telemedicine. Although the examination and diagnosis may be done remotely there is a need to bear in mind the pre-existing workload before attributing further telemedicine type duties on clinicians.

There was however a consensus that telemedicine could be a great tool in coping with the increasing demand on dermatology services. It was felt that a costed pilot was necessary to prove the case for further investment.

Inquiry into New Models of Care

PB then moved the debate onto the discussion for the parameters of the APPGS planned inquiry into new models of care and invited attendees to share their thoughts.

IL suggested a review of the King's Fund report, as it contains some innovative suggestions. She also felt that a comparison between England and the Devolved Nations could be a line of enquiry, as she believed Scotland in particular to be ahead in some areas.

Fummi Oluwa (FO) **–**Leo Pharma suggested looking at specific providers from within England, especially Vitality operating in West Leicester, which had some innovative methods of prioritisation.

JH suggested that these new models should not be restricted to just secondary care, but we should take this opportunity to re-examine how primary care operates.

Gary Jones (GJ) –Abbvie suggested that the present process of devolving power to Manchester would provide an opportunity to explore new options.

All attendees agreed that that a thread of constant change must not undermine the provision of services. Instead new models of care should improve on already present good practice and bring stability.

PB thanked everyone for attending and their contributions. He noted that he would try to get a Minister along to the next APPGS meeting, but suggested that this would be easier if the group were presenting solutions. To this end PB invited everyone to write to the Group with their comments on what had been discussed and with any proposals or suggestions.