Written evidence submitted by the British Association of Dermatologists (EPW0030)

Policy Area	Government Commitment
Planning for the workforce	1. Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs.
Building a skilled workforce	1. Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead. 2. £1 billion extra of funding every year for more social care staff and better infrastructure, technology and facilities. 3. Supporting moves towards prevention and support, we will go faster for community-based staff. Over the next three years we want all staff working in the community to have access to mobile digital services, including the patient's care record and plan, that will help them to perform their role. This will allow them to increase both the amount of time they can spend with patients and the number of patients they can see. Ambulance services will also have access to the digital tools that they need to reduce avoidable conveyance to A&E.
Wellbeing at work	1. Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services. 2. Reduce bullying rates in the NHS which are far too high. 3. Listen to the views of social care staff to learn how we can better support them – individually and collectively.

Planning for workforce:

In dermatology in the U.K. we are seeing an increasing shortage of full time equivalent consultant dermatologists. This is fueled by the changing working patterns of consultants with increased part time working and a shortage of National Training Numbers. This is on a background of increasing demand for dermatology expertise year on year in the U.K. Dermatology in the NHS deals with diseases that are disfiguring and cause severe psychological impact on the individual. The illnesses can be debilitating, such as hidradenitis suppurativa, and may need prolonged hospital admission, such as is the case with patients who have Toxic Epidermal Necrolysis and severe immunobullous or inflammatory skin diseases. Without consultant dermatologists to advise on these sickest patients, prolonged admissions, increased morbidity and potentially increasing mortality may ensue.

Over the last 2 years, with the COVID-19 pandemic, a number of departments had reduced staff due to illness, had staff redeployed and had to delay treatments. This has had a consequential effect of increasing patient waiting lists. This has compounded the problems caused by the shortage of staff and will need time as well as extra resources to be addressed.

The lack of training opportunities and the lack of WTE consultant dermatologists has been raised in the Get It Right First Time (GIRFT) report on dermatology. Therefore, further strategic planning is needed to address this, to look at the future demand for dermatology expertise and plan appropriate training opportunities. Without addressing this mis-match, the shortage of consultant dermatologists will continue and extrapolating from the last 5-10 years, will continue to worsen, with the loss of dermatology expertise in some hospitals in the U.K. Ultimately, a commitment to increase dermatology trainees is required to help address not just the shortages today but also to prevent them becoming worse in the future.

The Dermatology GIRFT report (published 9th Sept 2021) highlighted the severe workforce shortages in dermatology due to long term restriction on training numbers. Dermatology training is highly competitive with many applicants applying for each training post. The English data from the GIRFT report shows that there were just 508 (WTE) dermatology consultants and 159 (WTE) vacancies. This is reflected in the data collected by the Royal College of Physicians (RCP) on workforce and obtained in 2019 by the All Party Parliamentary Group on Skin via Freedom of Information requests to NHS Trusts in England, showing a dearth of Dermatology Consultants over large geographic areas. Even Trusts in major cities, including London, are unable to fully recruit Consultant Dermatologists. http://www.appgs.co.uk/publication/2019-audit-of-uk-dermatology-coverage/

It is essential that shortages in the dermatology medical workforce are addressed if we are to provide equal access to quality dermatology care.

The GIRFT dermatology national report highlights that,

'....shortages in the dermatology medical workforce are having a serious impact on the efficient functioning of nearly all units. This was the most important problem raised by managers and consultants, meaning discussions about resolving workforce problems dominated all but a handful of visits. Workforce shortages are a key factor in the increasing use of high-cost locums and other short-term initiatives in an attempt to control waiting lists. Around a third of units have very serious staffing shortages, with some closed to routine dermatology referrals and only providing an urgent skin cancer service. In some areas of southern England, where neighbouring units have partially or fully closed, there is very limited access to NHS consultant dermatologists.'

We would like to highlight a few key points:

- Workforce shortages has resulted in inequitable access to good care and delays in diagnosis with significant impact on quality of life for patients with skin disease of all ages. Shortages affect all areas but are particularly severe in district general hospital secondary care sites, which in turn puts increased burden of work on large tertiary centres, who already struggle to meet service and training needs.

- Skin cancers are the UK's most common cancer with around 240 000 cases in England per year, many of whom are now waiting over a year for treatment as a result of the pandemic on top of chronic workforce shortages. Data from 2018-19 show that dermatology delivers more two-week-wait (2ww) suspected cancer referrals than any other specialty. Suspected skin cancer referrals account for 21% of all 2ww suspected cancer referrals. Dermatology delivers almost all of these consultations, with plastic surgeons seeing the rest https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/07/Cancer-Waiting-Times-Annual-Report-201819-Final-1.pdf. 2ww referrals for skin cancer have doubled from 2012 to 2019, https://www.england.nhs.uk/statistics/statistical-work-areas/%20cancer-waiting-times/

- The burden of skin disease is significant, representing 23% of the presentations to primary care. Dermatologists deal with eczema which is the commonest disease affecting the population in infants and acne which is the commonest disease in adolescents.

- The referrals to secondary care services continue to grow in number and complexity, year-on-year. This is due to patient demographics, ageing population, increasing numbers of skin cancer and the increasing use of systemic therapies which require careful monitoring. These increasing referrals results in many UK hospitals now failing to meet targets, or resulting in reallocation of priorities so that people with severe skin disease are commonly (even before Covid) waiting many months to see a dermatologist.

- There is more less than fulltime working (LTFT) and portfolio careers in the workforce which requires more people to be trained to keep the same number of whole time equivalents. The covid-19 pandemic also threatens to increase the number of doctors leaving the profession and retiring early due to burnout, stress and retirement driven by the e.g. pensions legislation/cap.

What are the main steps that must be taken to recruit the extra staff that are needed across the health and social care sectors in the short, medium and long-term?

- Improve medical, nursing and AHP workforce calculations taking into account increased LTFT/ retirement/ population needs.
- Increase medical student numbers to allow for greater health care needs of ageing population.
- Undertake analysis of leaving staff to understand reasons for loss of doctors who are in training and other NHS staff who leave early.
- Improve wellbeing of current NHS staff, so NHS remains a competitive employer
- Understand reasons for loss of senior doctors through early retirement and how to retain in NHS for longer.

What are the principal factors driving staff to leave the health and social care sectors and what could be done to address them?

- Burnout/ stress due to working longer hours than renumerated and required.
- Loss of team working for junior doctors in some roles.
- Changing expectations of work-life balance.
- Wellbeing/ support in junior doctors and senior doctors. There has been a loss of the camaraderie in medicine over the last 20-30 years. There used to be acknowledgement that medicine and nursing was highly stressful involving very long hours. Recreational facilities, staff rooms, sporting facilities, separate eating facilities have all been removed to save money in hospitals over the last 30 years, as the focus has been on process rather than people.
- Early retirement for domestic, financial and lifestyle reasons.
- Removal of financial incentives for very senior doctors to stay in the NHS after the age of around 55 – linked to…..
- Pension issues – the reduction in the benefits of the NHS scheme and the incorrect conviction held that the scheme remains generous to those age 55 and over continues to push senior staff into NHS retirement.

Building a skilled workforce:

There is a lack of skilled consultant dermatologists and this has been increasing over the last few years, with increasing demands for dermatology expertise. This is evidenced by increasing skin cancer numbers, the increasing use of biologic agents to treat skin disease and the increasing result of skin toxicities from systemic agents being used to treat non dermatological conditions.

COVID-19 has also had also had an impact with re-deployment of trainees. In dermatology this has had a significantly greater impact as the work when re-deployed is not directly like any of the requirements for dermatology training as dermatology trainees do not train in general medicine. This has a potential impact on their training, which may need to be prolonged.

The use of new technology requires training of staff, but also limits more traditional teaching methods, e.g. the reduction of face to face appointments. This means that there are less training opportunities and hence it may take longer for trainees to become as skilled in interpreting signs of skin diseases and making accurate diagnoses. It is also important that new technologies have adequate evidence before being used, e.g. the use of Artificial Intelligence (AI) in dermatology practice and that there is funding to allow implementation of new technologies in a consistent manner to prevent a ‘postcode lottery’ approach. This will also require investment in IT for both the physical machines to enable to new technologies to run but also maintenance of these machines, updating as the requirements to run the software increases over time as well as ongoing staff training to make sure they

can be utilised in a safe manner.

The lack of dermatology professionals is not limited to consultants and investment is needed to help train enough dermatology nurses to provide day care facilities for those with severe disease. Without this, there will be limitations on treatments for severe skin disease and potentially a loss of skills to be able to provide these in the future. It is also important to note that there are shortages of traditional medications e.g. Dithranol. This helped prevent patients needing more toxic therapies in the past. The lack of these medications directly affects patient care but also there will be a loss of the skills needed to use these in day treatment centers over time, meaning that these will no longer be viable options for patients in the future without prioritising the supply chain.

An increasing gap for the consultant workload is time to deliver education and training not only for the NTN Specialist Registrars but also for medical students, junior doctors, GPwERS (GP with extended role), GPs, nurses, ACPs, PAs, Pharmacists etc. An audit in 2019 performed by the BAD reported that 95% of consultants supervise, teach and train on a daily basis, providing leadership, and educational and clinical governance in order to support and develop heterogenous service teams. 86% of Dermatology Consultants supervise and train nurses. The need to educate and train is likely to increase and a critical mass of specialists needs to be maintained to deliver service as well as training.

Wellbeing at work:

The Dermatology workforce has been under long-term service pressures which were exacerbated by the COVID19 pandemic. Many staff have worked above and beyond what they are paid to do, based on goodwill. This has led to increased stress in staff and has impacted on their mental and physical health. The stress has not only been related to looking after those patients with COVID19 but with dealing with unfamiliar environments when re-deployed and the backlog in services after returning from re-deployment. Funding will be needed to help provide solutions for the problems assailing staff and to help them deal with the mental health impact of the pandemic.

The impact on mental and physical health is also shared by patients. Longer waits mean a later diagnosis which may mean a more advanced disease or even a disease that is no longer treatable when diagnoses, as well as increased anxiety and stress about their health leading to worsening mental health. Waiting lists have also led to patients becoming dis-satisfied with their care which can lead to bullying and harassment of health care workers. Addressing not just the impact on the health-care workers but also the patients will be something requiring increased investment over several years to help resolve.

May 2022