



FINAL REPORT
INDEPENDENT REVIEW OF
NOTTINGHAM DERMATOLOGY
SERVICES
4 JUNE 2015

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Commissioning Organisation	NHS Rushcliffe Clinical Commissioning Group
Document Purpose	Independent Review
Document Name	Independent Review of Dermatology Services, Nottingham
Author	Dr Chris Clough
Publication Date	4 June 2015
Target Audience	NHS commissioners, NHS providers, Joint Overview and Scrutiny Committee, Patients and Public groups
Additional Circulation List	NHS England Midlands and East, North Midlands sub-region
Superseded Docs	None
Action Required	See recommendations
Timing/Deadlines	See recommendations
Contact Details for further information	Vicky Bailey, Chief Operating Officer, NHS Rushcliffe CCG vicky.bailey@rushcliffeccg.nhs.uk
Document Status	
Final	

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1 Executive summary

Date of visit: 22 April 2015
Venue: NHS Rushcliffe CCG
Easthorpe House
165 Loughborough Road
Ruddington,
Nottingham NG11 6LQ

Panel Members

Dr Chris Clough Chair of the panel, former Chair National Clinical Advisory Team
Dr Ian Bowns Independent Public Health Consultant
Dr David Colin Thome former National Clinical Director for Primary Care
Dr Stephen Jones former President – British Association of Dermatologists

1.1 Summary of findings

The near collapse of acute and paediatric dermatology services in Nottingham was triggered by the incomplete transfer of consultant dermatologists from Nottingham University Hospital NHS Trust to Circle Nottingham employment, following Circle winning the bid to run the Nottingham Treatment Centre which includes dermatology services. This led to a cascade of problems, mostly concerning recruitment and retention of consultant dermatologists.

Whilst this could not have been predicted at the time of the procurement and contract award, and was an unintended consequence of the procurement, the slow response of commissioners and the main providers to acknowledge the problem and start to work together to solve it has aggravated matters. We believe that there is now a willingness and consensus to move forward and start to rebuild the service on the basis of collaboration between the main stakeholders and to build trust between these organisations.

We have suggested immediate actions that must take place to address urgent problems, and a more long term strategic review of dermatology services to develop the service in the long term for the benefit of all the citizens of Nottingham

2 Introduction

This independent service review of dermatology was initiated by NHS Rushcliffe Clinical Commissioning Group, which is the co-ordinating commissioner for Circle Nottingham services on behalf of the four Nottinghamshire CCGs. Dr Chris Clough was approached by Vicky Bailey, Chief Officer and Senior Responsible Officer, Rushcliffe CCG and asked to chair the review. The panel was selected to ensure independent representation from Primary Care, the British Association of Dermatologists and Public Health (see **appendix 1** for brief biographies of panel members). Dr Jonathan Corne from Health Education England East Midlands was also invited to be an observer and provide an educational perspective. Information was collected from multiple sources including key stakeholders, the CCG and the British Association of Dermatologists, and analysed prior to the visit. The visit was planned via teleconference in the weeks preceding the visit; terms of reference were agreed (**Appendix 2**); the project manager was Tracy Madge. **Appendix 3** is the programme for the day and list of attendees. **Appendix 4** lists the information received.

3 Background to the review

In 2007 the National Independent Sector Treatment Centre (ISTC) programme instigated the building of the Nottingham Treatment Centre (NTC). Nations, subsequently Circle Nottingham, were to provide services under a 5 year contract and they commenced service delivery in a phased manner from 28 July 2008. With the NHS reorganisation and the creation of Clinical Commissioning Groups in 2011, co-ordination of the procurement of services for the NTC was handed over from the PCT to the CCG with Rushcliffe CCG taking the lead on behalf of the Nottinghamshire CCGs, commissioning services for a population base of about 750,000.

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. The various components of its service included general dermatology services (predominantly outpatient based), paediatric dermatology, dermatological surgery, dermatologic oncology (including multidisciplinary team and connections to plastic surgery and other cognate disciplines), an inpatient service and an acute dermatology service providing opinions for other specialties and ward referrals, available 24/7. It was also one of the main centres in the East Midlands for training of dermatology specialty training registrars and an academic centre for clinically based research.

With the advent of the 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, eg phototherapy. NUH consultants continued to provide much of the outpatient service through a staff supply agreement between NUH and Circle in addition to consultants directly employed by Circle and other clinicians (nurses, therapists).

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, to enable them to continue the service. Following the award of the contract, the consultant dermatologists wrote to the CCG explaining that they wished to remain employed by the NHS, and outlining the likely consequences of TUPE enforcement. In the event, out of the 11 consultants, only 3 initially accepted TUPE, of whom 2 have now left. Four more that were eligible, declined TUPE and were unable to stay at NUH on NHS contracts so have chosen to take NHS contracts elsewhere. One has retired and has come back to work part time for Circle. For the remaining 4, TUPE did not apply due to commitments in paediatric dermatology and/or other trusts. One has left to return overseas, and another is leaving for another NHS trust. TUPE did not apply to two paediatric dermatologists because paediatric dermatology services fell outside the CCG procurement. 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.

Dermatology consultant posts nationwide are currently difficult to fill with an estimated shortfall of approximately 200 posts in the UK vacant or occupied by locums (approximately 1 in 5 posts) [British Association of Dermatology figures].

In order to try to sustain the workforce at NUH, in 2014 the Trust set up a separate "repatriation service", provided from City Hospital. This was subject to a legal challenge and eventually, in view of this, was compelled to be withdrawn. Two years on, contractual and service issues have meant that many of the consultants who did not transfer to Circle have opted to leave for posts elsewhere.

Circle now have 4 directly employed consultants (3.8 Whole Time Equivalent) and have 6 long-term locums in place. A number of the locums are European graduates and so do not have automatic entry to the General Medical Council Specialist Register for dermatology to enable them to apply for substantive posts in the UK. Despite that, they are able to work at the level of a consultant. The cost of employing locum consultants is nearly £300,000 per annum per post, greatly in excess of that of a standard NHS consultant salary, and has led to financial pressures on the Circle service.

As a result teaching and training on the NUH/Circle sites has greatly diminished with withdrawal of trainees in keeping with the number of consultants available to teach. Medical students have been transferred to the Royal Derby Hospital.

In January 2015 it became clear that an acute dermatology service providing specialist in-patient care for dermatological emergencies was no longer possible and this is now being provided from the Leicester Royal Infirmary site. The imminent departure of another NUH consultant will leave only 2 full time consultants engaged in paediatric dermatology and ward referral services to support the acute service at NUH will be no longer viable from 18 May 2015. There is now a serious possibility that the two remaining consultants at NUH providing

the specialist paediatric services will leave by the end of the year with the likelihood of a failure to recruit to their posts to replace them.

Hence in spring 2015 the dermatology services in Nottingham are in crisis due to the inability to recruit to substantive posts and the on-going reliance on locum posts at Circle. There is very limited postgraduate training (because this is restricted to clinical supervisors who are on the specialist register), and clinical research has greatly contracted. The emergency dermatological inpatient service has had to be transferred with the imminent demise of any service to provide on call dermatological advice for emergency admissions or acute dermatological problems in patients in any of the other tertiary services (eg acute oncology or haematology). Paediatric dermatology services (for which Nottingham is one of the few tertiary centres) are also under immediate threat.

4 Comments made by stakeholders on the day of the visit

4.1 NUH consultants

- We were a very successful dermatology service at NUH before the attempt to TUPE consultants out to Circle.
- We were not aware of the possibility of TUPE and had not been involved greatly with the bidding process for outpatient services. It was a great shock when we found we may be required to work for Circle, and that the NUH bid had been unsuccessful
- We were a very close department. When we heard we were going to be removed from the NHS and transferred to the private sector we felt we had been sold down the river.
- We were the only service that was affected. At one point transfer of the rheumatology service was a consideration.
- After the contract was awarded to Circle we informed the commissioners and Trust that we would refuse to be TUPEd. We were told by Circle management if we did not come over we would be replaced.
- We did our best to try and protect training and were keen that the Trust set up a repatriation service to enable all services at NUH to continue.
- When we told the commissioners of our concerns, one of them told us they were not there to pander to the emotional needs of consultant dermatologists.
- Our colleagues who have left to go to Bath and Liverpool were involved in this repatriation service, but when it fell through they opted to move to hospitals where they feel able to provide a more clinically appropriate service.
- We are concerned that some of the consultants at Circle are not on the specialist register and cannot train dermatology StRs, and that those who are on the register have declined to organise a training programme for the SHOs.
- We felt we were being very cooperative and worked at the Circle site until last November (one consultant).
- Patients presenting to NUH A&E requiring acute dermatological admission since February 2015 are now transferred to Leicester.

4.2 NUH Management

- As an NHS Trust we feel that our number one priority is to maintain paediatric dermatology, which will be extremely difficult in the future.
- We were unable to provide an adult repatriation service following the legal challenge by the CCGs, mainly because we had not achieved a contract with another commissioner which would have allowed us do this under the Choose and Book system
- CCG and Circle need to agree to a shared model

4.3 Clinical Commissioning Groups and Lead GPs

- When we went to procurement of this service we did not think there was an alternative, or even considered one, to the single provider as the service had worked for the previous five years. Perhaps in retrospect that was a mistake.
- We felt that these consultants, by refusing to TUPE, were being selfish and that largely this was a bereavement response.
- We do not recognise there are necessarily any problems in the service provided by Circle and that they do appear to be committed to research and training.
- Patient experience at the NTC is good.
- At this point, following all the difficulties, we feel there are three options:
 - Firstly, no change but this is not acceptable
 - Secondly, move to an Any Qualified Provider, multiple provider provision
 - Lastly, and our preferred option, is a collaborative one.
- As commissioners, we are happy to make any solution that is feasible happen, but we think the health of the citizens of Nottingham has been improved by the provision of the Circle services.

4.4 Circle Management

- At Circle we rely on a number of fixed long term locums (6) and 4 directly employed consultants, one of whom was previously TUPEd. We do have a UK graduate working as a locum, but she is very worried how she is perceived by the profession, in particular by the British Association of Dermatologists.
- We have suggested that our European graduates, who are working as locums, go through the CESR process to enter directly on the Specialist Register.
- When we lost the trainees at Circle this did mean we lost 25% of the activity they provided but we are very keen that Circle is recognised as a provider of good training.
- Under the present arrangements with the cost of locums it is likely that our service is not financially sustainable.
- We are keen to develop the service in many other ways, for instance using telecommunications and advanced nurse practitioners.
- Generally our service is getting busier; we now operate a telephone hot-line for emergency referrals in hours. Out of hours the calls are left on the answer phone and picked up the following day.
- We are tired of being seen as the bad guys in all this as we feel we deliver a good service and would like to provide training and research.

- We would accept consultants being appointed to NUH and have a staff supply contract as previously
- Our recent CQC visit said our services as a whole were outstanding, and patients have said they are delighted with our service

4.5 Circle Consultants

- When I heard we might be TUPEd to Circle I had a similar emotional response to my colleagues. However I realised that there were excellent facilities where I could deliver my services at Circle. In actual fact, being TUPEd made no difference to patient care. The most difficult thing for me is that I have lost my colleagues and previous friends, and it can be very lonely. I have had to take on more responsibility now they are no longer there to do some of the administrative tasks.
- We could do more research and training, as we did in the previous 5 years, and have only lost this capability because people have left.
- For us to work together, a lot of the negativity that exists about Circle needs to go.
- At Circle I feel I have more freedom to change things and there have been enhancements in services, for instance the skin cancer team which now has a consultant nurse and an advanced nurse practitioner.
- We meet regularly with the Circle managers, 2-3 times per week, and I can't remember this ever happening when I was employed at NUH.
- We do have very good locums and I would be very happy to work alongside consultant colleagues who are employed by any other employer.
- I wish all this negativity would evaporate and that all would be allowed to provide services.
- We would be happy to take part in supporting an acute rota.

4.6 British Association of Dermatologists (BAD)

- The BAD is very concerned about the decline of services in Nottingham from a centre of excellence to somewhere now unable to offer expert dermatology, dermatological care for patients with acute dermatological problems and now its failure to deliver teaching to trainees and medical students.
- The BAD is dismayed that this has been allowed to happen despite the issues being highlighted on many occasions
- The BAD has concerns about governance arrangements.
- The BAD can contribute to the solutions. We have published documents on support for commissioning of dermatology services and a Clinical Services Unit, which specialises in supporting commissioners in developing quality/sustainable services.
- The BAD has a raft of information to aid commissioners to procure a quality/sustainable service and a 'Lessons Learnt' document outlining some of the pitfalls experienced in commissioning around the UK to help prevent the reinvention of 'broken wheels'.

4.7 Managers and lead clinicians of other local providers of Dermatology services

(University of Hospitals of Leicester NHS Trust, Derby Teaching Hospitals NHS Foundation Trust and Sherwood Forest Hospitals NHS Foundation Trust)

- We now need to acknowledge that mistakes have been made at Nottingham.
- Formerly across East Midlands we worked well together.
- Presently Leicester doesn't have the bodies to provide services at Nottingham, but we are very happy to support services in other ways. We wondered whether an in-reach service at Queen's Medical Centre could be provided by a clinical nurse specialist.
- We greatly valued a number of the specialty services that Nottingham offered and are fearful we will lose paediatric dermatology services, which are not presently provided anywhere else in the region.
- At Derby we offer acute dermatology services, we do not offer on call out of hours (17:00 – 09:00 service). If patients require admission with dermatology problems we co-care with acute medicine, providing an opinion to the medicine team on a daily basis.
- We are greatly concerned about the number of ward referrals at a specialist centre like Nottingham, which must be upwards of 6-8 per day, and these will need to be catered for in the very near future.
- Leicester could envisage working in partnership with Nottingham to provide services at Leicester and Nottingham

4.8 Healthwatch and patient involvement manager

- We have not heard a lot of noise about dermatology services but now as part of this review we have specifically asked patients we have managed to get opinions from about 20 who have been treated at the TC. This isn't a large response but there appears to be some consistency in this. It breaks down into those with acute problems and those with long term conditions. Whilst there is little problem for the former, the latter noticed that things now appear rushed and that since the services changed over to Circle there has been a loss of continuity as new doctors will often start from scratch when they meet for the first time (a major issue for someone with a severe chronic disease who has had much input into their care over time). Patients are very anxious about when other people retire (dermatologists).
- We have had one complaint about staff attitude but otherwise staff behaviours have been good.
- Some patients were worried it takes weeks to get a diagnosis
- Some doctors are difficult to understand because English isn't their first language.
- Appointments now appear more rigid, only lasting 10 minutes, and this has meant that sometimes whole body checks for skin lesions have not been performed.

- For some reason the pharmacy service seems to continue to be provided at NUH and patients do wait a long time there.
- Circle's complaints procedures are not very visible and easy to access
- Patients generally think that, out of all this, lessons need to be learned so that it doesn't happen again, and that it will be crucial in any subsequent planning of services that there is substantial patient and public involvement.
- **Appendix 6** shows collated responses and feedback

4.9 Clinical Senate

- The role of the Clinical Senate is to try and act as an independent honest broker. When approached about the dermatology services we were interested to hear whether there is a plan for future services. As there was nothing at that stage, there was nothing we could review. However we are very happy to look at any emerging proposals.

4.10 Joint Overview and Scrutiny Committee

- It is important that we learn lessons about the tendering processes and fragility of services.
- It strikes us that everybody had their head in the sand about what happened to dermatology services.
- We are worried that what has happened to dermatology may affect other services provided by Circle
- We hear that other clinical staff are leaving, not just doctors.
- We would be very keen for the locum doctors to become substantive, and don't know why this doesn't happen.

5 Discussion and Opinion

Skin disorders are extremely common. As indicated by the BAD documents up to 50% of the population have a problem with their skin each year. Many of these are dealt with by patients themselves, often with over the counter remedies and advice of pharmacists. However about 24% of the general population do present every year to their general practitioner with skin problems. General practitioners and their teams manage the majority of these but 5% do need specialist opinion, often for diagnostic purposes but also when common problems such as eczema, psoriasis and acne become difficult to treat, for severe inflammatory skin disease requiring specialist treatment and for cancer. Overall these referrals form 4.6% of hospital outpatient activity. Skin disorders are important having a major impact on quality of life. In addition, they can have serious consequences as regards morbidity and mortality relating to cancers such as malignant melanoma and other severe dermatological conditions such as toxic epidermal necrolysis (which can be fatal) and immunobullous diseases such as pemphigus which cause a blistering condition requiring sophisticated medical and dermatological support.

When looking at the provision of dermatology services it is important to consider many different levels from prevention of skin conditions (protection from UV radiation, smoking cessation) patient self-care and ensuring effective general practice primary care services as

this is where approximately 90% of skin disease is managed. Whilst we heard that GPs in the Nottingham region were strongly committed to the provision of primary care services for dermatology, we did not hear that there were many GPs with a special interest (GPwSI) in dermatology or other specialist clinicians at primary care level.

The BAD strategic documents describe a useful model of dermatology which is essentially a pyramid, recognising the importance of self-diagnosis, Primary Care management, Intermediate Care provided by GPwSIs or hospital outreach services, Secondary Care based services for specialist diagnosis and treatment (provided in most DGH hospitals) and lastly Specialist Dermatology services for small groups of patients which have existed within regional centres and teaching hospitals.

Historically Nottingham, through NUH, provided the full range of dermatology services at secondary care level in addition to many of the more specialist dermatology services such as paediatric dermatology. They also had a national and indeed international reputation for provision of training of consultant dermatologists, and of clinically based research. We heard from the consultants themselves that they regarded themselves as a finely honed machine providing a cost efficient service.

Into this mix came a national initiative to set up independent sector treatment centres, provided by private, non-NHS organisations. The Nottingham Treatment Centre was built in the grounds of the then Queens Medical Centre campus, since 2006 part of the Nottingham University Hospitals NHS Trust, which was fortunate and enabled it to more easily access NUH staff. In the usual way of things it provided a mixture of different services and an important component, around a fifth, was the dermatology services. The preferred provider, Circle, regarded dermatology as an important service which made a substantial financial contribution to the running of the NTC.

The service was set up in 2008 and ran successfully, initially on a staff support contract with those consultants who previously provided the outpatient service at NUH now providing the same service within the new facilities of the NTC. For five years everybody was happy with this arrangement. Income flowed to Circle for the provision of the service and there was reimbursement to NUH for the staff support from their consultants. Because of the close proximity of the unit, the dermatology team was able to maintain its closeness and working relationships, hence continued to provide other services within NUH such as the ward referral service and the acute service. There was also a separately commissioned paediatric dermatology service.

With the demise of the Primary Care Trust, in 2012 the task of the re-procurement of the services provided by the NTC (several specialties including dermatology) was passed over to the newly created Clinical Commissioning Group. It is clear that this procurement process was entirely above board, and was performed fairly and by independent observers according to standard assessments. . The Circle bid was successful probably partly because of its emphasis on provision of community services, which the CCG wished to see and because of the apparent successful delivery of services in the previous 5 years. The bid from NUH was the reserve bid.

Once Circle had been awarded the contract it became evident that a significant proportion of the NUH consultant workforce, previously seconded to Circle, were not minded to TUPE to Circle's employment. There was no evidence that the CCG were told prior to procurement that dermatology consultants might leave if the contract was awarded to Circle. The consultants told us they were not aware TUPE could be enforced. When this became apparent all the consultants immediately wrote a letter to the commissioners (March 2013, widely circulated) explaining the risks; for example consultants employed by NUH might seek employment elsewhere. It would be relatively easy to find alternative posts due to the national shortage of consultant dermatologists

It is at this stage that the problems really start to emerge for the overall dermatology services. The NUH consultants told us of their upset in their comments to us; the feeling of rejection after years of being an NHS employee and despatched to a private provider; and a provider who had been in the press for their difficulties over provision of services elsewhere. They had a lot of concerns about transfer of their contracts over to an uncertain model at Circle, when Circle had no involvement in the highly specialist aspect of their work or in providing emergency dermatology care. They felt that this would inevitably lead to a downscaling of their ability to deliver effective training and research. They also thought that the commercial approach of Circle inevitably would lead to a poorer service, even though effectively the service was going to stay the same as had pertained in the previous 5 years. There was obviously a break down in trust. Despite this, some consultants did agree to TUPE, albeit with reservations. However one who has continued to be employed by Circle has no regrets, regarding them as a good employer.

From the point of view of Circle, and the CCG, this response was totally unexpected. We did not detect any Machiavellian attempt here to shed these consultants or change the service. Indeed all concerned would have been delighted for the consultants to TUPE. They had not envisaged that it would cause this upset or be a problem.

We feel that the analysis by the CCG, that the issue was one of employment, not service change, is entirely the correct one. Subsequent events have borne this out, as there was no attempt to change the service design at the point of re procurement, or downplay the commitment to research and training. However whilst it might be viewed that the consultants response to being TUPEd was largely an emotional one, the panel feel that this was a valid concern which would be felt by many consultants finding themselves in this position. The strength of feeling was perhaps not fully recognised and accepted by Circle in particular, who thought that, even if a problem, the consultants could easily be replaced; not true, as they have subsequently discovered, or a bereavement response which in some way might settle as some within the CCG thought. People join the NHS for a number of reasons, and for some it is the commitment to public service which attracts them, and why they are willing to go the extra mile by working long hours, with a strong commitment to patient care. Transferring these clinicians (and other workers) to a private organisation with possibly a different value system (perhaps the profit motive) can be very difficult for them. They presumably had dedicated their lives to patient care and may not be able to understand how a private company is motivated to do this as well. This aspect of why people work for an organisation needs to be handled sensitively in any transfer of workforce

The lack of response at this time to the consultants concerns has led to the ongoing problems and difficulties that Circle has had in recruitment, and their reliance now on locums, and the situation whereby Nottingham is now faced with a service on a knife edge, with the imminent loss of a further consultant rendering the acute rota unworkable and the possibility that, if any of the remaining consultants leave, the demise of the tertiary paediatric subspecialty service which is not provided elsewhere in the region. It has been an unmitigated disaster.

Whilst numerous meetings have been held, we think there has been a lack of acceptance of the consultants' fears, which are seen in several quarters as irrational. Nevertheless they do exist, and the panel does have some sympathy with them. Whilst this decision by the consultants was not inevitable, it might have been anticipated as a risk and managed accordingly. There has been a lack of flexibility about how this service could be provided, and how TUPE was used. Whilst it is easy to say this in retrospect, there are lessons to be learnt here about how further service changes/procurements may occur, particularly those requiring TUPE arrangements. All in all this has led to an adversarial situation between providers and the CCG. Unfortunately things have been said, leading to a breakdown in relationships with the NUH consultants.

There was further loss of Trust between NUH and the CCGs and Circle when NUH set up a short-lived separate dermatology service, incorrectly judging that its on-going specialist contact with NHS England permitted it to do so.

Despite all this, Circle has managed to provide a good elective adult dermatology service, which is exactly what they were required to do. Patient feedback is excellent, local general practitioners are very pleased with the services, and the recent CQC report on services as a whole is also very encouraging. Healthwatch Nottinghamshire's assessment from the patients who attended the pre-review discussion would be that the service is highly valued by patients but that some people have poor recent experience, particularly patients with long term conditions. **Appendix 6** shows the collated responses from the Healthwatch Nottinghamshire sources. The consultants and nurse who we have heard from were also very content with their move to Circle. They feel they have been managed appropriately, and that far from being a bad employer, they value their relationship with Circle management. They have been able to achieve a lot of new things with the support of Circle. They would encourage their NUH colleagues to change their minds about Circle

Our overall conclusion is that no one person or organisation is to blame for what happened to Nottingham dermatology. This is a service that fell to pieces when the majority of relevant NUH consultants declined to TUPE, and over time resigned from NUH.

It could be said that that CCG should have predicted, and taken more account of, the possible responses to TUPE of the NUH consultants; this should at least have been part of their risk assessment. It could be said that Circle had their head in the sand about what might happen when the consultants failed to TUPE, and that they failed to heed the consultants' warnings.

NUH should have informed the CCGs more effectively of their proposal to set up a limited outpatient dermatology service (in addition to their informing NHS England).

Professional bodies such as BAD were put in a difficult situation when they saw what was happening to their members, both in NUH and those that had transferred to Circle. They were extremely concerned that a previously excellent, nationally renowned service was crumbling and the impact it was going to have on the provision of dermatology services for the people of Nottingham. As a result, when they saw that nothing was being done at a local level to resolve the situation they felt impelled to publicise things for the sake of Nottingham residents. Whilst some feel that some of their actions (eg briefing the OSC without prior sharing the document with the CCG and others) were unacceptable, the OSC felt that their briefing paper was the most helpful document they received. We hope that the spirit of collaboration that is emerging in Nottingham will enable the BAD to make a healthy contribution to the emerging service and begin to support the new beginning we envisage now happening in Nottingham.

6 Lessons to be learnt

- 1 Service providers, when entering bids for contested contracts, need to take the process seriously, understand what the commissioners are expecting and should involve their clinicians
- 2 Transfers of service involving TUPE should be considered carefully and the consequences fully understood as to what would ensue if staff does not wish to transfer and how that might impact on the continuity of service provision. This should be part of the risk assessment process.
- 3 Providers who are putting in bids dependent on TUPE for additional or existing staff also need to be aware of the potential pitfalls and carry out appropriate risk assessment. Where there is a healthy market for provision of consultant services the situation is much easier but where, as in this case, consultant services are much in demand, they need to be aware of the potential for consultants to move elsewhere rather than be TUPEd to their services
- 4 Staff need to be appropriately informed if commissioning changes are likely to result in a requirement for TUPE. They need to be counselled through the process so they fully understand that TUPE may not require them to change their jobs in any significant way, but it can be enforced. Clarity and transparency is required throughout the process
- 5 It is likely that, with the future direction of health service provision in England, there will be many opportunities for private companies to bid for established NHS services. Staff and medical staff in particular, need to be aware of this emerging world and the changes it may require in their attitude to risk, but also the opportunities it can create for them.

7 Next steps and Action Plan

Primarily, we have been charged to provide action steps which may lead to a resolution of some of the problems that Nottingham is now facing, firstly in the immediate/short term and secondly in the moderate to long term. Certainly, as can be seen from above, there are problems that need addressing immediately if paediatric dermatology in particular is to survive at Nottingham and if patients with acute dermatological problems are going to receive appropriate care.

Secondly we recognise that there is an opportunity with the procurement round occurring 3 years hence to spend some time developing plans which will affect the changes required, to create a high quality service in Nottingham.

Lastly, all we spoke to, and we are of a like mind, support the fact that a high quality and comprehensive dermatology service is required in Nottingham. It is not acceptable to consider provision from elsewhere; whilst this might happen by default, all providers and commissioners working together should do their best to prevent this from happening. This is not just an issue of access for patients in Nottingham, but also the support of established centres of excellence, of which Nottingham Dermatology services need to play their part.

Whilst carrying out this visit, we made it clear to all those we interviewed that our prime concern was not to dwell on the past but to move on to ensure a safe service can be secured as soon as possible. Everybody we spoke to was in agreement with this aim. Whilst difficult to achieve, there are a number of options. We believe that a collaborative approach would be the best way forward.

- 1 To do nothing at this stage is not an acceptable option. To allow the service to collapse and for other providers to emerge presents a huge risk in terms of safety, quality of the service and eventually cost of the service.
- 2 The second option we considered was whether permitting other providers, in particular NUH, to set up a service on Choose and Book would enable this service to develop. This might risk an unstructured and uncoordinated service with a risk of over provision and the likelihood of increased costs for the CCG. It does not address the immediate issues of lack of trust in Nottingham providers, leading to the recruitment and retention problems of consultant staff we have witnessed.
- 3 A collaborative approach (accepting there are continued market forces at play) is most likely to result in a solution which is acceptable not only to all providers but which remains affordable for the CCG and is most likely to fulfil the needs of the patients – the population of Nottingham – providing a high quality service with all elements of specialist and generalist dermatology. We have encouraged all we spoke to, to consider this as the best possible way forward

Thus the following steps should be considered as part of immediate plans to save what remains of the dermatology service at NUH, and start to turn around the outside view, particularly amongst professionals, that the service providers and commissioners in Nottingham are “toxic” and unlikely to be good employers. It is most important that Nottingham is seen as a good place to work and train if they are to recruit dermatologists in a highly competitive market.

We believe that, as a matter of some urgency, all the main stakeholders need to sign up to this approach so it is clear that they have shared objectives; that is the creation and preservation of high quality dermatology services. This is the minimum prerequisite for trust to be engendered with the dermatology staff. There is a need to focus on the present workforce, to prevent them from leaving. Managerial support is important, but bringing consultants and other clinical staff across providers together, so that they can talk, and begin to work out how they can ensure continuity of the service from here on is paramount.

From our discussions with managers at NUH, Circle and elsewhere it seems that all are prepared to make concessions and go the extra mile to make things work collaboratively going forward and it may be, therefore, that as a first step a meeting of the relevant clinicians (perhaps first in Nottingham and then possibly involving those elsewhere) with a view to discussing clinically appropriate solutions which managers might then support is facilitated. Additionally it is vitally important that patients and the public, who are now very concerned about the service, are brought in at an early stage to any discussions about the plans for dermatology. We could imagine that, in due course, an event is organised including all stakeholders; that is providers, patients and the public, specialist societies and commissioners, facilitated by an external professional around common themes such as what needs to happen now for dermatology services, and what needs to happen in the future.

The pressing problem of ward referrals at NUH cannot be ignored. NUH is a significant provider of specialist services for a large population and requires support from dermatology. Whilst acute dermatological admissions can be managed at Leicester at present, there are the needs of those presenting with acute dermatology problems in other specialities. The substantive Circle consultants expressed a willingness to become involved with this and discussions should ensue with a matter of urgency; an in reach service is possible. In the longer term other options may need to be considered, bringing in nearby providers to see in what way they can help. Whilst presently they feel they have little capacity, perhaps if they saw themselves as part of the solution their opinions may change and a larger workforce, all considered together, may find there are ways of cross cover across sites that may be helpful to all. Presently these other providers did not feel they were part of the solution. Indeed our meeting with them was the first time they had been able to contribute. All seemed very enthusiastic that they would support the Nottingham services, and some were beginning to think of ways how they could collaborate much more effectively. For instance, Leicester expressed interest in exploring a wider solution that brings together their services with Nottingham, providing a genuine two-city service this across both sites.

7.1 Medium and longer term solutions

It is not acceptable in the medium and longer term for acutely ill dermatology patients to be transferred immediately to Leicester for acute care. Whilst the numbers are small, the present arrangement should be seen as temporary. The main requirement for care of these patients is acute medical and intensive care, utilising high dependency units or occasionally intensive care units with the direction of dermatology consultants providing assessment and advice. This is the model that that works well at Derby and could be replicated at NUH if

appropriate dermatology opinion was available through an on-call system (this could be phone advice out of hours supplemented by same day or next day consultant review).

Medium and long term solutions give an opportunity to think about new ways of working and service provision. There is an opportunity with the contract up for renewal in 3 years' time to take a more considered approach. Certainly an event staged as above might produce a number of themes. Overall we think it important that this is not just a focus on present secondary providers, but the overall service from self-care and prevention through to what happens in primary care on to more specialist services and highly specialised services. Such an approach should lead to a more complete development of primary care services so that much more is done within GP practices, and other clinicians are brought in to assist with the service, for instance pharmacists and nurses. Please see **Appendix 5** for analysis of service models and benchmarking.

We would like to see much more shared working between primary and secondary care providers, ie in the main between GPs and specialists. Fully understanding patient pathways may lead to a more effective way of attributing work, ensuring appropriate referrals through to specialist services, and producing better outcomes for patients. We support a population model, with specialist leaders who advise on patient pathways and can support those in primary care with diagnosis and provide advice, and ensure appropriate triage of referrals throughout the system. Designing services around single common diseases or problems can be very helpful in promoting this approach; for instance, services for people with eczema, psoriasis, acne and pigmented lesions. Often this can lead to new and novel ways of service provision with the involvement of other trained clinicians such as clinical nurse specialists, GPwSIs and pharmacists. Single disease services are notable for promoting an all-inclusive population approach with ease of access. BAD (see <http://www.bad.org.uk/healthcare-professionals/clinical-services>), and others, offer substantial guidance on the establishment of such services, and we understand the Kings Fund are about to publish further relevant work. Appropriate governance systems and data collection, including patient related and clinical outcomes, should be put in place to better inform commissioning.

Additionally for super-specialist services, wider geographical areas may well need to be considered. All commissioners within the East Midlands should get together to consider whether a strategic clinical network in dermatology is justified (it could be time limited). It would have the benefits in identifying and concentrating services on fewer sites of super-specialist services. The advantage of that is that these services could be of higher quality, with a more sustainable workforce, working more efficiently. Units such as this, driving through higher activity, often have better outcomes because clinicians are more used to dealing with these complex cases. This applies in particular to paediatric dermatology, but also to acute inpatient dermatology where presently there are variable services throughout the region. Whilst there is a limited evidence base to support any one particular model, one would expect a model which has specialist support from all clinicians, would produce better outcomes not only in terms of clinical outcome but service related outcomes such as length of stay, cost per episode etc. Certainly this is seen in other specialties. For instance there may only need to be one or two units across a larger region that provide acute inpatient dermatology, numbers of admissions are small, and the resource required would need to be well used. The BAD has the expertise and knowledge to inform the debate about the planning of an appropriate, comprehensive dermatology service and has produced guidance

on the requirements for effective commissioning of high quality/sustainable services. It can also advise on the size of population needed to sustain high quality super-specialist services. The BAD Clinical Services Unit should be involved in these discussions. A clinical network would ensure that access was equitable for all within the network, and that there were appropriate referral routes. Appropriate protocols would need to be in place to ensure the right patient is seen by the right person in the right service at the right time.

Much of what happened in Nottingham was compounded by the fact that currently there is a significant shortfall in the number of consultant dermatologists in the UK and the lack of training opportunities for potential dermatologists in the UK has led to this problem. Workforce planning for a small specialty such as dermatology is fraught with difficulty, with the risk of under and over provision in the marketplace. We note that the BAD has been alerting NHS Education England (and its predecessors) to its concerns about the mismatch between trainee numbers and numbers of consultant posts for several years. The problem is compounded by the differences in recognition of training between the UK and Europe. Trainees in Europe embark on training in Dermatology and Venereology and do not train in general medicine; hence their European training certification is not recognised by the GMC for direct entry onto the dermatology specialist register. This means that European graduates can only be appointed to locum posts and only apply for substantive consultant posts once they have demonstrated to the GMC that they have achieved all the competencies required for equivalence via the CESR route. As it is unlikely that the GMC will change the rules to enable more European graduates to be directly appointed, we think the best way to create more available doctors able to be consultants in the UK is to expand the trainee numbers. Although scarcity is often the mother of invention, in this case the opposite is true. Whilst there continues to be a demand for dermatologists it will prove difficult for commissioners and providers to change the way dermatology services are provided. The BAD has supported the increase in number of trainees and we would urge Health Education England to consider this request.

In future technology will be increasingly useful. Simple computer based technologies such as having available patient pathways (the BAD Clinical Services unit can supply examples) could be developed for all primary care providers to enable them to route patients through the system and find the appropriate referral route if needed, or management plan. Telemedicine has a potential role in the provision of a comprehensive dermatology service but is most effectively used as one aspect of an integrated service. Telemedicine may not be a cheaper option, but does enhance patient quality by ensuring that patients stay within the GP practice, or indeed their homes.

8 Recommendations

All stakeholders should consider this report and take action in line with its conclusions and recommendations.

8.1 To be done urgently

- 1 Rushcliffe CCG to initiate meetings with other key stakeholders to formulate a memorandum of understanding. This should be at a high level between chief executives of the organisations involved. We would suggest at a minimum that this involves Rushcliffe CCG, Circle and NUH. With a fair wind this could be achieved within weeks.
- 2 Agreement of common objectives, the core of which is the preservation of dermatology services within Nottingham and a commitment to develop those services. This would enable all the organisations involved to organise an event involving all providers, stakeholders and patients and the public. This should be independently facilitated and should be charged with the task of trying to answer key questions regarding the immediate sustainability of the services, what is required, and the long term vision for the dermatology service.
- 3 Investment should be made in supporting and developing consultants and other clinical staff, bringing together key players within the organisation to foster relationships. The consultants should work as a single body/team across both provider organisations. We believe that there are the beginnings of an understanding of how commissioners and the providers can build a relationship of trust and sustain the service. In particular it may be easier to appoint new consultants to NUH contracts who subsequently do a large part of their work within the Circle service. Appropriate job plans would need to be developed, with attention to training and research opportunities. Circle and NUH should continue to recruit, and do this together coordinating the job plans to maximise the chance of recruiting the best possible candidate and ensuring that workload and workforce are matched across the wider service.
- 4 The commissioners should invite BAD representatives to planned events and for Circle to show them the good work done within the NTC. The situation has led to unfavourable news coverage and the bringing together and closer cooperation between the parties involved will allow for a much more favourable and positive reporting of the situation in Nottingham in the dermatological and medical media, and a greater chance of future recruitment of dermatologists to the area.

8.2 Medium to long term

- 1 Rushcliffe CCG should take the initiative to invite other CCGs to consider the requirements for a strategic clinical network, with the aim of looking at the larger geographical provision of specialist services and how they could be more efficiently provided.
- 2 Bring together a dermatology action group with representation from local CCGs, present providers and patients and the public to consider the longer term strategy for dermatology
- 3 NHS Education England to urgently consider the need for expansion of dermatology training numbers.

9 Appendices

9.1 Appendix 1 – Panel Biographies

Dr Chris Clough is a consultant neurologist at King's College Hospital, London. He led the amalgamation of three services to form the Regional Neurosciences Centre, based at King's College Hospital, becoming the first regional Director of Neurosciences in August 1995. In 1998 Chris became Medical Director at King's College Hospital where he was joint lead for clinical governance and research and development director. Chris has held the posts of Chief Medical Advisor to the South East London SHA, Medical Director for the Joint Committee on Higher Medical Training, Federation of Royal Colleges and Clinical Advisor to the NHS Institute. Chris has led numerous independent reviews of NHS services across the country as Chair of the National Clinical Advisory Team for the Department of Health.

Dr Stephen Jones is a Consultant Dermatologist, from Wirral University Teaching Hospital, NHS Foundation Trust and honorary member and Past President of the British Association of Dermatologists, Fellow Royal Colleges of Physicians London & Edinburgh.

Dr Ian Bowns is a medically-qualified Public Health Consultant with over 20 years' experience in the NHS, academia and Public Sector Consultancy.

Dr David Colin-Thomé is the former national director for primary care at the Department of Health, with 36 years of experience as a GP. Before being appointed as national clinical director, David was director of primary care at the Department of Health's London regional office, senior medical officer at the Scottish Office and director of primary care North West region NHS Management Executive. He was also formerly a member of Halton Health Authority, Cheshire Family Health Services Authority and a local councillor. David is an honorary visiting professor at Manchester Business School, Manchester University and of the School of Health, University of Durham. He was awarded the OBE in 1997.

Dr Jonathan Corne will be observing the panel. Jonathan undertook pre-clinical training at Cambridge followed by clinical training at Kings College Hospital and undertook house officer and senior house officer posts at Kings College Hospital and Guys Hospital, London. Jonathan is currently Head of the East Midlands (North) Postgraduate Specialty School of Medicine.

9.2 Appendix 2 – Terms of Reference

Terms of Reference

Review of Dermatology Services in Nottinghamshire

April 2015

1. Purpose

To undertake an independent clinical review of adult and children's dermatology services in Nottinghamshire. To propose short, medium and long term solutions to the problems of consultant recruitment and retention over the past 2 years, taking account of surrounding health systems, and looking to the future requirement of dermatology services and the workforce required to deliver these.

2. Goals

To propose a sustainable dermatology service relevant to the population health needs of Nottinghamshire.

To assess the availability of the resources needed to deliver this in light of the national consultant shortage. (Comparison with similar health systems may provide alternate solutions)

To propose short, medium and long terms solutions to CCG and NHS England commissioners.

To suggest a service specification which will follow the proposed service model and should enable the CCG and NHS England to jointly commission the required service.

Scope of the review

- Staffing
 - Workforce planning
 - Access to education and training needs for all clinical staff (medical, nursing and AHPs)
 - Recruitment and retention of clinical staff
- Comparison of dermatology services with other similar providers/CCGs
 - Clinical outcomes
 - Patients experience
 - GP referral rates, , New: FU ratio, Standardised Admissions Rates (SARs)
- Pathways
 - Current treatments delivered within the service and their outcomes
 - Future research and development
 - Specialised and non-specialised commissioning responsibilities
 - Current services in line with national guidance
 - Comparison of services delivered by other health communities similar to Nottingham i.e. links to plastics, cancer services

- The evidence base for the services that need to be commissioned relevant to the population
- Models of delivery
 - Use of technology, e.g. telemedicine
 - Different contracting models
 - Other models of delivery in other health care systems

3. Tasks

- Produce a report to advise CCGs and NHS England.
- Update stakeholders on the progress and outcome of the review
- Involve significant stakeholders in the review

4. Authority

The project will be accountable to the CCGs with NHS Rushcliffe CCG acting as the coordinating commissioner for the review overall and for adult services and NHS England for children's services.

5. Reporting

A project manager accountable to NHS Rushcliffe CCG will oversee and support the independent review team, and ensure the report is available to all the organisations involved with the dermatological review. The draft report will be delivered to the CCG by mid May 2015, and to all stakeholders for identification of any errors of fact. The final report will be delivered by 31 May 2015. The action points to be considered by the CCG at the first available executive meeting and a response delivered by the end of June 2015 to all stakeholders, with the report and response in the public domain as soon as possible.

9.3 Appendix 3 - Interview Timetable and Attendees

Nottingham Dermatology Service: Independent Panel Review 22nd April 2015

Venue:

Easthorpe House, NHS Rushcliffe Clinical Commissioning Group

Interview Timetable and Attendees

Time	Organisation	
08:30	Panel pre-meet	Dr Chis Clough, Chair, Consultant Neurologist, Kings College Hospital, London Dr David Colin-Thome, Independent Healthcare Consultant GP Dr Stephen Jones, Consultant Dermatologist, Wirral University Teaching Hospital, NHS Foundation Trust I(NHS FT) Dr Ian Bowns, Public Health Consultant Dr Jonathan Corne, Panel Observer, Health Education East Midlands (HEEM)
09:00	Nottingham University Hospitals NHS Trust, Clinicians	Dr Jane Ravenscroft and Dr Ruth Murphy, Consultant Dermatologists
09:30	Nottingham University Hospitals NHS Trust, Managers	Stephen Fowle, Medical Director Rachel Eddie, Deputy Director of Operations Carol Greenfield, Deputy General Manager Keith Oliver, General Manager
10:00	Clinical Commissioning Groups GP leads and Chief Officers NHS England commissioners	Dr Hugh Porter, Clinical Lead, Nottingham City Dr Paul Oliver, Clinical Lead, Nottingham North and East Dr Guy Mansford, Clinical Lead, Nottingham West Kate Hunter, Head of Acute and Community Contracting, Mansfield and Ashfield and Newark and Sherwood Dr Stephen Shortt, Clinical Lead, Rushcliffe Vicky Bailey, Chief Officer, Rushcliffe Jon Gulliver, Specialised Commissioning, NHS England
10:45	Break	
11:00	Nottingham NHS Treatment Centre, Circle Nottingham, Managers	Helen Tait, General Manager Andy Addison, Operations Manager Paul Dawson, Patient and Public Engagement Representative
11:30	Nottingham NHS Treatment Centre, Circle Nottingham Circle Clinicians	Dr Anand Patel and Dr Sandeep Varma, Consultant Dermatologist Kate Blake, Lead Nurse
12:30	Lunch	
13:00	British Association of Dermatologists	Dr David Eedy, President, British Dermatology Society

Time	Organisation	
13:30	Clinical Directors/Leads, Derby, Leicester and Sherwood Forest hospitals (teleconference facilities will be available)	Duncan Bedford Divisional Director and Dr Tanya Bleiker, Consultant Dermatologist, Derby Teaching Hospitals, NHS FT Theresa Joseph, Consultant Dermatologist, Sherwood Forest Hospitals, NHS FT Jane Edyvean, Head of Operations, Acute Medicine, University Hospitals of Leicester NHS Trust
14:00	Healthwatch Nottinghamshire and public/patients	Claire Grainger, Chief Executive Healthwatch Nottinghamshire, Nottinghamshire County Jane Kingswood, Community and Partnership Worker, Healthwatch Nottinghamshire, Nottinghamshire County
15:00	Break	
15:15	East Midlands Clinical Senate	Dr David J Rowbotham Co-Chair, East Midlands Clinical Senate
16:00	Overview and Scrutiny Committee	County Councillor Parry Tsimbiridis, Chairman City Councillor Ginny Klein, Vice-Chair Jacky Williams (Chair of the Quality Account Study Groups for NUH and the Treatment Centre. Martin Gately, Lead Officer for Health Scrutiny at the County Council
16:45	Post panel meeting	Chis Clough Dr David Colin-Thome Dr Stephen Jones Dr Ian Bowns Dr Jonathan Corne
17:30	Panel debrief to Clinical Commissioning Groups and NHS England	Chis Clough Dr David Colin-Thome Dr Stephen Jones Dr Ian Bowns Dr Jonathan Corne Vicky Bailey Dr Guy Mansford Jon Gulliver
18:15	Close	

9.4 Appendix 4 – Information Pack Contents

Nottingham Dermatology service review April 2015 INFORMATION PACK CONTENTS

Enclosure Number	Title
Enclosure 1	Dermatology review - final draft TORs - 13.3.2013
Enclosure 1a.	Timetable.
Enclosure 2	OSC Overview.
Enclosure 2a	MD and CEO NUH position statement25-02-15.
Enclosure 2b	Circle paper to OSC Feb 2015
Enclosure 2c	OSC Notes March 15
Enclosure 2d	BAD response to OSC Mar 15.
Enclosure 3	Specification General Dermatology.doc
Enclosure 4	Specialised Spec all ages 2013.
Enclosure 5	Spec for cancer-skin-adult.
Enclosure 6	. 01-05-14 Circle Benchmarking Report V1.1
Enclosure 7	17-02-15 SARS Report.
Enclosure 8	Circle CQC report.
Enclosure 8a	National Peer Review of Circle 2014
Enclosure 8b	2015 HEEM Workforce paper
Enclosure 8c	HEEM 2015 quality free text comments
Enclosure 9	11-03-13 Cons Dermatology Letter to CCG.
Enclosure 10	11-02-13 announcing preferred bidder
Enclosure 11	12-3-13 DH request post BAD and contract award.
Enclosure 12.	20-03-13 CCG Response letter to BAD
Enclosure 13	20-3-13 Letter to Consultants from CCG
Enclosure 14	22-03-13 BAD Letter to Nottingham CCG
Enclosure 15	03-04-14 Email trail re NUH offer on C&B
Enclosure 16	12-05-14 non-payment to NUH
Enclosure 16a	17-07-14 Legal letter to NUH re activity and non-payment.
Enclosure 17	11-08-14 CCG to NUH re non contract activity.doc
Enclosure 18	24-11-14 email NUH to CCG re review and urgency.
Enclosure 19	05-01-15. constituent letter to MP
Enclosure 19a	15-01-15 CCG response to MP letter
Enclosure 20	02-02-15 Email context for new service
Enclosure 20a	02-02-15 new service Arrangements
Enclosure 21	23-01-15 email for transfer of patients to Derby.
Enclosure 22	13-03-15 email from Circle giving up exclusivity
Enclosure 23	Summary Dermatology - FOI and PQs
Enclosure 24	2009 HNA on Skin
Enclosure 24a	Dermatology services transformation.

Enclosure Number	Title
Enclosure 25	PCC skin care guidance
Enclosure 26	BAD Comm Guide
Enclosure 26a	BAD Quality Standards
Enclosure 27	Dermatology Activity April 2013 to Feb 2015 South Notts CCGs
	Circle dermatology information
On day	NUH Evidence to the CCG April 2015
	Collated comments from users of the service – Dermatology review 22-4-15 collected by Nottingham Healthwatch Nottinghamshire
	Care Quality Commission Report on Circle Nottingham NHS Treatment date of inspection 28-1-15 (to be published May 2015)

9.5 Appendix 5 – Service Models and Benchmarking

Service models

One of the commissioners' expressed intentions was to move appropriate dermatology services into community settings. There are already moves underway, but there is scope for greater use of more innovative service models. Most involve use of different staff (e.g. primary care staff) or expanding the roles of existing staff groups, particularly specialist nurses. Other innovations reaching the mainstream involve greater use of technology, particularly telemedicine. The various options are summarised in documents such as Skin Conditions in the UK: a Health Care Needs Assessment (particularly Chapters 4 and 5) document available at

<http://www.nottingham.ac.uk/research/groups/cebd/documents/hcnaskinconditionsuk2009.pdf>).

The Kings Fund/BAD Report entitled "How can dermatology services meet current and future patient needs while ensuring that quality of care is not compromised and that access is equitable across the UK?" (<http://www.bad.org.uk/shared/get-file.ashx?id=2347&itemtype=document>) gives additional and updated illustrations of service models and their potential impact. It is unlikely that it is sensible to commission every particular service described in these documents, but local commissioners need to consult with patients, public and professionals and then specify the most appropriate service "mix" for the wider Nottingham health economy.

Benchmarking

The considerable limitations on the data available regarding specialist treatment undertaken in English hospitals have been noted by others (e.g. the 2009 HCNA). This reflects the importance given historically to any specialty that is predominantly out-patient based. There is, for example, no routine diagnostic data for first or follow-up out-patient attendances.

The benchmarking data available within the timescale of the review compared rates first attendances referred by GPs across the County, finding quite limited variation across the CCGs in the south of the County. The great majority of patients referred are seen within the relevant (18 week) target. The lead commissioner (Rushcliffe CCG) examined routinely available benchmarking data on the range of services provided by the Nottingham Circle Treatment Centre from sources such as the national PbR Benchmarking tool and Dr Foster. Based upon activity data for 2013, this suggested that attendance rates for Psoriasis (without any procedure being recorded) and surgery for known or suspected skin cancer are particularly high. Rates seem particularly high for the catchment area of the Circle service and for cases where no procedure has been recorded. These appear to be recorded as day cases, which carry a significantly higher tariff cost to the commissioner than the same cases treated in an out-patient or community setting. Consequently, these are areas for particular attention when considering alternative service models that might be more cost-effective and capable of delivery nearer to patients' homes. There are already examples of services that undertake some of these activities in community settings (e.g. Sunderland's Dermatology and Minor Surgery Service, see <http://www.kingsfund.org.uk/publications/specialists-out->

[hospital-settings/case-studies](#)). National comparisons have also suggested scope some reductions in follow-up appointment rates in a number of specialties, including dermatology. The latest available rates indicate that up to month 11 of 2014/15, Circle saw 7,811 new Outpatient (OP) first attendances and 17,629 follow-ups (FU). This would give a ratio of 2.25 FUs for every new patient seen. Although there are considerable difficulties in making simple comparisons, particularly for a combined secondary and tertiary service such as Nottingham, this is higher than many units have been achieving, suggesting scope for improvement. This would have the additional advantage of reducing pressure on the service.

9.6 Appendix 6 - Healthwatch Nottinghamshire Collated Responses

Healthwatch Nottinghamshire

Evidence for Independent Review Panel of Dermatology Service in Nottingham

22nd April 2015

In summary

Some good care, but enough evidence to be concerned. Due to the short time scale of this process, we did not have time to do a large amount of engagement activity. Therefore we have collated as much evidence as possible from a public event, and other sources.

What will happen next?

- The report will be published? Patients were keen to see it.
- What follow up will happen?
- Seems to be a need for a PPI group of some kind to be established?
- We would like a response from the Panel which we can share with the patients.

Key Themes from patient feedback:

Several patients gave positive, or neutral feedback, a number have made negative comments, in some cases several comments by a single individual. With skin conditions, as a long term condition, often means very regular visits to the department. Therefore, even a seemingly minor issue, can become significant if repeated over time. Also with the potential seriousness of conditions, we are particularly concerned that regular checks for early intervention may have been lost.

<i>Theme</i>	<i>Examples</i>	<i>Quotes</i>
Staff Turnover, particularly Retirement of Staff	Lack of continuity. Mentioned by lots of patients, but particularly those with long term conditions.	“I think the constant turnover of doctors and the lack of any consultant lead is concerning both for local patients and for the future of the service.” “For Long Term Conditions continuity of treatment is really important. Seeing a new clinician each time is unhelpful.” [You have to explain your

<i>Theme</i>	<i>Examples</i>	<i>Quotes</i>
		<p>condition, and many years of history each time] [in comparison, LTC treatment in other departments is by the same Dr throughout]</p> <p>“...the consultant I was now seeing was a locum... it was clear he had not read my notes prior to my appointment. I had to go through all the same questions again and he could not locate the photos that had been taken by the hospital (I had to show the ones I had taken on my phone) which was very frustrating.”</p>
Staff Attitude	Helpful but busy. Rudeness.	<p>“saw a very rude and unhelpful doctor who I refused to see again”</p> <p>“saw a senior consultant in the department and was extremely impressed with the help she was able to give”</p>
Communication	Concerns about poor communication	<p>“A nice lady but couldn’t clearly understand her diction. Confusion between BCC and BBC”</p> <p>“just told "its skin cancer" bluntly”</p> <p>“Waiting for 6 weeks to receive a biopsy result, and due to this wait I went to the appointment assuming that it was all clear and I was completely unprepared for the news that I had cancer”</p> <p>“Recently had a Saturday appointment, so didn’t have to take time off work, then could not do blood test, or collect for pharmacy as they were both shut.”</p>
Quality of Care	Concern about mistakes, complaints made. Checks not done, which used to be.	<p>“Unclear complaints procedure and delayed response / there is not a complaints procedure listed on the Circle website”</p> <p>“...has not been fully checked over all skin since the switch. This used to happen at every appointment. With all over eczema it is important to check this regularly.” [PUVA treatment makes this more important.]</p>

<i>Theme</i>	<i>Examples</i>	<i>Quotes</i>
		<p>Concern that some clinicians don't have specific knowledge needed. When mentioned a treatment, the doctor went to look it up. This worried the patient that they didn't know what was needed.</p> <p>"Poor aftercare - I had severe nerve damage after surgery ... and this severely impacted upon my quality for life for nearly a year. I repeatedly told Circle staff at my appointments, but I was told these problems would settle down by themselves after 6 months it still had not, when I asked if I could be referred for physiotherapy I was told that this would not help me"</p>
Process - appointments and admin	Difficulty making appointment. Confusion about the system. Inability to book ahead.	<p>"lack of coherence of the system and the apparent randomness of receiving an appointment"</p> <p>"should get a phone call, but doesn't, so has to call to chase it"</p> <p>"no follow up, should have been phoned but wasn't, called to chase and was told the consultant "Mr is a very busy man"</p> <p>Appointment times "...used to be variable - from 5 to 40 minutes depending how long you needed this was really good for LTC management as needs vary"</p>
Pharmacy delays	Delays	<p>"The pharmacy is a joke that you have to wait 40 minutes"</p> <p>"separate section of pharmacy for Treatment Centre patients, which is always slow and seems disorganised"</p> <p>"You can wait here for about an hour to get your medicine which is too long"</p>

<i>Theme</i>	<i>Examples</i>	<i>Quotes</i>
Workload	Staff good but too busy	<p>“the nursing staff were really good but very, very busy.”</p> <p>“by the time it was due almost all the doctors in the clinic would be new so she didn’t know any of them....every time I go to the reception desk to make my next appointment it’s always extremely difficult for the staff to find an appointment slot as the clinic is so over subscribed for the medical staff and appointments available.”</p> <p>“ I used to have a nurse present at each consultation, who could translate the doctor’s language for patient, also would advocate for patient when needed”</p>

Questions raised by Patients and the Public:

1. Concerned what will happen when my doctor retires?
2. Can I be reassured at least that the contract still requires the Dermatology team to fully participate in the training of new doctors and nurses?
3. I think the constant turnover of doctors and the lack of any consultant lead is concerning both for local patients and for the future of the service.
4. Are appointments now, ten minutes only, one size fits all? Seems like would make more sense to have short ones for a quick, one off check. And optional longer ones for people managing a long term condition.
5. Are locums not registered?
6. How do I make a complaint?
7. Will loss of local services mean patient have to travel out of area?
Parent concern at having to take unwell children to Leicester.
8. Will lessons learnt be included in report?
9. Can the good reputation as a world renowned Dermatology Centre ever be re-established?
10. Lack of consultation in initial contract process.
11. Technology needs sorting out.
12. Pharmacy needs sorting out.
13. Staff time should be improved.
14. Care – can you bring back personalised care?
15. How would patients find out about new research and treatment? If it did develop?
16. ‘What on earth were those responsible for service contracts thinking of when letting Circle management change doctors and surgeons’

Sources of Opinions:

1. Previously collected stories from Healthwatch Nottinghamshire (County residents).
2. Previously collected stories from Healthwatch Nottingham (City residents) at visit to Circle Treatment Centre
3. Opinions collected at Public Drop in event 16th April 2015
4. Comments submitted by those who could not attend the drop in event.

