

NHS Future Forum

Feedback form

YOUR DETAILS	
Name	Dr Nick Levell MD, Honorary Secretary
Organisation	British Association of Dermatologists
Organisation type: e.g. individual, service user organisation, commissioner, provider, academic institution etc	Charity and specialist medical association for dermatology
Email	admin@bad.org.uk
Telephone	0207 383 0266
In which region are you based? (North West, North East, Yorks & Humber, West Midlands, East Midlands, South West, South East, South West, East of England, London)	Headquarters in Central London representing dermatologists and their patients in England, Wales, Scotland, Northern Ireland and Eire.

A. EDUCATION AND TRAINING

Building on the earlier work of the Future Forum on education and training, and the Department's recent consultation, the Forum have now been asked to help to work through the detail, including how the changes are implemented. Specifically:

How can we make sure that we have the right incentives and accountabilities for developing the healthcare workforce to enable the delivery of world class, patient-centred healthcare?

<p>A1. How can we ensure that education and training in the new system are flexible and fit-for-purpose for the new way that care is delivered and enable training beyond the job, for example stimulating a culture of continuing professional development or academic and research development?</p>	<p>(a) Ensure all providers provide education, training and research (measured using objective professionally agreed outcome standards eg educational supervisor reports, annual reviews of trainees, numbers of accredited trainees produced and for research, peer reviewed papers). Those which do not should pay a penalty or those which do receive a bonus.</p> <p>(b) Continue to develop the NIHR clinical research network, in England and the devolved nations, which delivers in dermatology high quality studies often linked to industry, driving national economic growth.</p> <p>(c) Advertise to the public the benefits of seeing professionals engaged in training (who are likely to have better knowledge, be more up to date, and be better communicators). Promote the better outcomes of those patients involved in research studies so that the public seeks out relevant units.</p> <p>(d) Provide details to patients of education and summary CPD records to show quality of specialist training of healthcare providers to enable informed choice.</p> <p>(e) Oblige all providers of specialist services to undergo annual CPD and revalidation to the relevant royal college standards in the specialist area in which they provide services.</p>
<p>A2. How can we ensure the right balance of responsibilities and accountability and line of sight throughout the new system (e.g. Health Education England and the provider-led networks, employers / professions / education sector, whole workforce) including for research training?</p>	<p>(a) The deaneries have improved educational standards by monitoring medical training; however the system concentrates power in unelected, unaccountable lead Deans. The specialist societies and Royal Colleges should have more influence in the selection and retention of lead Deans.</p> <p>(b) Deaneries should be accountable to Royal Colleges/specialist societies and their training boards to whom they should report measured standards of education and research attainment by trainees.</p> <p>(c) Research outcomes should be considered a valued component of NHS professional work which contributes to better healthcare outcomes and the general economy - and not just an unpaid 'hobby' for enthusiasts, as considered still by some managers. There should be a cultural change in NHS local management by rewarding organizations with good quality research outcomes and output.</p> <p>(d) Research outcome measures could include peer reviewed</p>

	<p>papers, participation with industry in research, participation in NIHR CRN research and additionally (especially but not just) for University Hospitals, research grants won, PhD and MD theses supervised.</p> <p>(e) As doctors move between the devolved nations, there should be liaison between the devolved nations about training and workforce numbers avoid decisions in one country resulting in unforeseen problems elsewhere.</p>
<p>A3. How do we best ensure an effective partnership with health, education and research at a local level?</p>	<p>(a) Reward trusts that deliver research outcomes and educational outcomes as above.</p> <p>(b) Develop the work and maintain funding of the local NIHR clinical research networks which are developing independent and industry clinical research. Continue to use and improve performance management measures as at present to encourage effective outcomes and productive units.</p>
<p>A4. How can we ensure appropriate and effective patient and public engagement in the new system?</p>	<p>(a) Encourage patient/public participation in NIHR national and local research meetings and in medical educational committees such as the SACs.</p> <p>(b) Encourage patient/public participation (via patient support groups) in professional organizations supervision of the work of deaneries.</p> <p>How can we improve information on the quality of education and training?</p> <p>Deaneries outcomes measures should be publically reported and monitored by professional organizations to whom they should be accountable. These could include:</p> <ol style="list-style-type: none"> 1. the number of accredited trainees produced per training post per year 2. the proportion of trainees who drop out of training 3. the proportion of trainees who undertake higher degrees 4. the number of peer reviewed papers and national/international research presentations per trainee/year 5. the number of trainees gaining MDs and PhDs. 6. the proportion of trainees who are in substantive consultant posts one year after the accreditation date.
<p>A5. How to improve information on the quality of education and training, and what should be the roles and accountabilities of the key players in this?</p>	<p>The Centre for Workforce Intelligence must remain resourced to control workforce training numbers by obtaining accurate information, enabling trainee numbers to be predicted, in liaison with specialist societies, including retirement, part-time work and emigration plans. Allowing individual hospitals to determine training numbers, based on short term, local, economic demands will result in workforce chaos. Destabilising training programs will destabilise research and tertiary services and make healthcare unsustainable in the long term.</p>
<p>A6. How can we ensure the new education and training system becomes an effective transmission vehicle for NHS</p>	<p>Similar question to above.</p>

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B. INFORMATION

How can information be made to improve health, care and wellbeing?

<p>B1. How can cultural and behavioural change be fostered to stimulate collection and use of data amongst all professionals?</p>	<p>Resistance to cultural and behavioural change relating to data collection could be reduced by:</p> <p>(a) Minimising data collection to that essential to improve health, research and education outcomes.</p> <p>(b) Increasing (not reducing) management SPA time for hospital consultants. This has been eroded over the last few years by up to 40% in some hospitals. Thus consultants have less time for data collection.</p> <p>(c) Producing functional, quick and robust IT systems and computer hardware and software to reduce wasted time for professionals. Current NHS computers may take ten minutes to switch on and may have a printer several minutes away. Some consultants have to take work home in order to print.</p> <p>(d) Avoiding future piecemeal aggregation of additional data collection by non-joined-up initiatives adding incrementally to professional workload eg duplication of patient data collection.</p>
<p>B2. How can we ensure information is available that enables people to take more control of their own care and enable shared decision-making?</p>	<p>(a) Encouraging professional associations to produce high quality patient information in conjunction with patients.</p> <p>(b) Encouraging professional organizations and hospitals to work closely with high quality patient support groups.</p> <p>(c) Give IT support grants to patient support groups to develop websites provided that they meet certain criteria including integrative working with professional groups.</p>
<p>B3. How can we ensure that information supports improved care and better integration of services (for example commissioning, research, clinical audit, public health) whilst protecting patient confidentiality?</p>	<p>(a) Obliging free and open transfer of electronic information between all NHS health care providers via secure internet systems, using national standards for file compatibility (eg MS 97 word/PDF/JPG compatible files).</p> <p>(b) Balancing the needs and benefits of free information transfer with the recognition that an absolute guarantee of complete confidentiality has never been possible. Paper notes were and are sometimes lost.</p>
<p>B4. How can we open up access to information and support people to use it?</p>	<p>(a) Provide grants to organizations who provide and disseminate high quality information, in electronic, written, audio, Braille and multilingual formats, used by substantial numbers of people.</p> <p>(b) Encourage standards for information quality with benchmarking awards.</p>

C. INTEGRATED SERVICES	
<i>How can we take advantage of the health and social care modernisation programme to ensure services are better integrated around people's needs?</i>	
C1. What does good look like?	<p>(1) Good services are designed by local consultants, GPs and patients to reflect local needs based on national evidence based quality standards set by NICE and specialist societies e.g. the British Association of Dermatologists.</p> <p>(2) People accessing good services are able to make an informed decision based on knowledge of the training, experience and competency of the providers.</p> <p>(3) Good services are sustainable, so provide education for health care professionals.</p> <p>(4) Good services will improve with time and encourage innovation and research.</p> <p>(5) Good services will integrate all aspects of care in a given disease area resulting in seamless care.</p>
C2. Where should services be better integrated around patients, service users and carers . both within the NHS, and between the NHS and local government services, in particular social care (for example, better management of long term conditions, better care of older people, more effective handover of a person's care from one part of the system to another, etc)?	<p>(1) Communication can be improved relating to people's medication, allergies, previous illnesses and current problems when transferring between agencies.</p> <p>(2) People with chronic illness (eg psoriasis and eczema) are given lower priority in society so may not be able to access specialist services which could improve function and quality of life.</p> <p>(3) People with disability, learning difficulties and the very elderly may be less assertive and therefore have problems accessing specialist services (being referred instead to intermediate services).</p>
C3. How can integrated services achieve better health, better care, and better value for money?	<p>(1) Allowing equal access to expert secondary care to all, irrespective of age, disability, race and gender and recognizing institutional barriers to secondary care referral.</p> <p>(2) Prevent private providers from ring-fencing areas of health care and creating communication barriers to protect their commercial interests in these areas.</p> <p>(3) Integrated services should guide patients to the care they need and not just the care a provider of the service supplies (e.g. when a certain number of arthroscopies had been purchased and so were done, regardless of actual need)</p>
C4. What, if any, barriers to integration should be removed, and how can we incentivise better integration of services at all levels	<p>(1) A barrier to integration is some distrust between primary and secondary care relating to healthcare initiatives over the last two decades. These have shifted power to primary care and introduced a perception in secondary care that some in primary care have conflicted interests.</p> <p>(2) Avoid commercial competition between primary and secondary care.</p> <p>(3) Performance targets, although beneficial to individual groups, may result in other groups losing out unless</p>

	<p>accompanied by sufficient funding. The skin cancer targets resulted in difficulties for some of those with acute flares of chronic severe skin disease to be seen promptly.</p>
<p>C5. Who needs to do what next to enable integration to be progressed in a pragmatic and achievable?</p>	<p>Government should introduce a stable national network of secondary care providers and incentivize leaders in each locality in each specialty to draw up models for primary care/intermediate care/secondary interaction.</p>
<p>C6. How can innovation in integrated care be identified and nurtured?</p>	<p>Competition is the antithesis of integration at the local level. Competition, if essential for ideological purposes, should be at the regional level between local networks of integrated providers.</p> <p>Innovation in health care delivery is stimulated by clinical research so commissioners must have solid short and long term incentives to invest in research.</p> <p>The National Institute for Health Research has resulted in a sustained programme of integrated research between primary and secondary care with good outcomes. Funding for the NIHR should be protected and increased in those areas that deliver to performance targets.</p> <p>Innovation in integrated care can be identified and nurtured by the department of health and national commissioning group engaging and working with the specialist societies, e.g. the British Association of Dermatologists, to find ways of achieving change safely for patients with the support of all stakeholders.</p>

D. THE NHS'S ROLE IN THE PUBLIC'S HEALTH

How can we ensure that the public's health remains at the heart of the NHS?

<p>D1. What role can the NHS and health and care professionals effectively play in systematically delivering improved population health outcomes including tackling inequalities?</p>	<p>(a) Consultants in hospitals are uniquely placed as local experts in disease and health to advise on lifestyle measures that will benefit local populations to increase public health.</p> <p>(b) Skin Cancer is more common than all other cancers put together and outcomes are improved by early detection, achievable through education through the media and schools, which local dermatologists can deliver if resourced.</p>
<p>D2. What are the mechanisms that commissioners, providers and the wider system could use to help support professionals in improving outcomes?</p>	<p>(a) Professional bodies such as the British Association of Dermatologists run successful health promotion campaigns, e.g. The Melanoma Taskforce, with other charities and groups. Commissioners should recognize the contributions of professional organizations and support consultants who work with them to benefit public health locally, regionally and nationally.</p> <p>(b) Consultants should be supported and encouraged to take time to attend local schools, workplaces and to interact with local media to give health promotion.</p>
<p>D3. How can we ensure that the NHS's role in the public's health aligns with the roles of Public Health England and local authorities?</p>	<p>(a) Local authorities are major employers so should have workplace advice on sun protection and early recognition of skin cancer, particularly for outdoor workers.</p> <p>(b) Local authorities should be obliged to consider sun protection in civic events.</p>
<p>D4. How can the NHS contribute to people's health and wellbeing in its role as a large employer?</p>	<p>(a) Hand eczema (dermatitis) worsened by hand washing and urticaria due to latex allergy cause NHS staff illness and absence. Continued investment in dermatology allergy services including patch testing for NHS staff would improve these problems.</p> <p>(b) Stress worsens common skin diseases such as psoriasis. Workplace stress is common in the NHS. Access to psoriasis treatments such as phototherapy is beneficial.</p> <p>(c) Family friendly, part time working schemes for female medical trainees were abolished nine years ago resulting in medical couples with young children living hundreds of miles apart. Schemes to reunite families broken by the NHS would benefit children.</p>

OTHER FEEDBACK

Is there any other feedback you'd like to give us?

Please send your responses or any queries by email, to:

nhsfutureforum@dh.gsi.gov.uk

Alternatively, you can reach us by post, at:

**NHS Future Forum
Room 602A, Skipton House
80 London Road
London
SE1 6LH**

You can provide feedback to any or all of the questions above. The NHS Future Forum is reporting back to the Government later this year, but at different times for different focus areas.

To ensure that the NHS Future Forum can use your views to help shape its advice to the Government, please make sure that we receive your responses on **education and training, information and the NHS's role in the public's health** by **18 October 2011**. Please make sure that we receive your responses on **integrated services** by **18 November 2011**.

Confidentiality of Information:

1. We manage the information you provide in response to these engagement questions in accordance with the Department of Health's Information Charter.
2. Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).
3. If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.
4. The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.