ENQUIRY INTO THE TRAINING OF Healthcare Professionals WHO COME INTO CONTACT WITH SKIN DISEASES

Contents

Glossary

CEPs - Continuing Education Points
DGH - District General Hospital
ENT - Ear, Nose and Throat
FOM - Faculty of Occupational Medicine
GMC - General Medical Council
GPs - General Practitioners
MCQ - Multiple Choice Question
NES - National Eczema Society
NHDs - Notional Half Days
PGEA - Post Graduate Education Accreditation
RCGP - Royal College of General Practitioners
RCN - Royal College of Nursing
RCP - Royal College of Physicians
RIDDOR -
RPSGB - Royal Pharmaceutical Society of Great Britain
UKCC - United Kingdom Central Council for Nursing, Midwifery and Health Visiting
WTE - Whole Time Equivalents

1. Summary of Recommendations

2. Background to Report

2.1 In March 1997, the All Party Parliamentary Group on Skin (APPG) published a report entitled “An Investigation into the Adequacy of Service Provision and Treatment for Patients with Skin Diseases in the UK”. The Report looked at all aspects of skin disease and attempted to provide an overview of the way in which the diseases are dealt with in the UK. It contained 42 recommendations.

2.2 Following publication of the Report, the APPG took careful note of the many comments it received. It consulted the various interest groups involved in skin to see which of the areas the Report covered were felt to be the most important for a follow-up inquiry. There was an overwhelming majority of opinion in favour of an enquiry looking specifically at the training aspect of the original Report.

2.3 In the evidence received by the Group both in connection with this and the previous enquiry, there was a considerable number of complaints about shortcomings in the treatment patients receive, especially when dealing with GPs, who sometimes appeared not to know even basic facts about skin disease. The APPG is therefore concerned about the degree to which GPs are properly trained to deal with the skin complaints with which they are presented.

2.4 In all, five relevant groups of health professionals were noted:

- general practitioners
- dermatologists
- nurses (both specialists and generalists)
- occupational physicians and nurses
- pharmacists

2.5 For each of these groups the APPG examined:

- their general role in the health care setting;
- the general training requirement;
- what actual training is given;
- what monitoring systems are in place to ensure that the training is provided and
  undertaken.

2.6 The APPG also asked for written evidence from interested parties and received some xxx written submissions in response. These were carefully considered and comprised part of the basis of oral questioning. The APPG is grateful to all those who took the trouble to make a written submission and to those who gave oral evidence. A list of written submissions and of those who were questioned orally is contained in appendix one at the end of the Report.

3. Overview of the Current Situation in the UK

3.1 Inadequate training of medical professionals leads to two main problems when dealing with dermatology complaints from patients:

- failure by general practitioners to recognise and diagnose even the major and common skin complaints, or sometimes to take them seriously. This may result in considerable time being wasted and/or an excess of unnecessary referral to specialist centres;

- failure of the practitioner and his/her team to provide appropriate treatments which may result in frustration, disillusionment and unwise attempts to self-treat.

3.2 A failure to learn at undergraduate level becomes reinforced through later stages of learning and results in the current situation of poor knowledge and avoidance of what is seen as an esoteric subject. Testing of dermatology in final examinations is minimal.

3.3 Dermatology forms up to 15 percent of the GP's workload and 50 percent of doctors become GPs. The undergraduate and early postgraduate years within hospital are dominated by acute in-patient specialties. Thus dermatology loses out in the hospital

hierarchy and the training given to GPs fails to reflect their future workload.

3.4 One possible opportunity for improving GP dermatological training is during the year spent in general practice, when attachment to dermatological out-patients to cover a basic curriculum can be helpful. Indeed once a junior doctor has sampled general practice, he or she is rapidly made aware of the need for dermatological skills.

3.5 Dermatological training which is available to, and taken up by, professionals such as nurses, pharmacists and those dealing with occupational disorders is generally inadequate. Even where professionals wish to pursue more training, financial and other blocks provide a strong disincentive to do so.

3.6 The Group further believes that the development of teams within the primary care setting to deal with skin problems is hampered by the general lack of training.

3.7 The APPG accepts that shortage of time is a significant factor in training and that dermatology is often overlooked in the hospital setting because of this. It is recognised that there is insufficient time to cover everything in much depth.

3.8 Dermatology requires highly skilled practitioners but generally employs inexpensive equipment. Furthermore, it is predominantly an out-patient specialty and, at least in the context of the hospital, is somewhat stand-alone by nature. The relationship between GPs and dermatologists is likely to be much closer than that between dermatologists and other specialists or physicians in the hospital. These factors tend to diminish dermatology's position in the pecking order of hospital politics.

3.9 Dermatology is sometimes dismissed as unimportant perhaps because it is wrongly perceived to deal with non-life threatening disorders. It is also seen by some as connected

with quality of life rather than clinical need. Dermatology has a lower profile at the cutting
edge of technological advance than some other areas of medicine and is sometimes perceived as being less glamorous.

3.10 Although primarily an out-patient specialty, the maintenance of in-patient facilities is crucial for the management of some life-threatening disorders and severe chronic disorders. Examples of dermatology beds and even units being threatened or cut are well documented - there have been examples of bed cuts or threatened or actual ward closures recently in Newcastle, Cardiff, Leeds, Liverpool and St John's in London, to name but a few.

3.11 Dermatology also appears to have missed out on funding of chronic disease management clinics in primary care in contrast to asthma and diabetes. It is likely that these last benefitted by being mentioned in Health of the Nation.

3.12 Furthermore, we note that a supplement is paid for obstetric and gynaecology (o&g) work, so there is an incentive to take on partners who have undertaken their six months in o&g. The Group has been given the example of a practice with 5.5 WTEs all trained in o&g attracting payments of £19,500 per annum. This is considerably higher than the equivalent payment for GPs who are not on the o&g list and who would receive only 58 percent of this amount for undertaking the same work. This type of situation provides a strong disincentive throughout the system to move away from o&g domination of primary care training.

3.13 Recommendation: The APPG believes that there should be a review of "item of service" payments and training credit payments. We shall touch below on aspects relating to the amounts of money practices receive for particular services.

4. Primary Care

A. Primary Care Dermatology Workload

4.1 According to a recent survey, at least 15 percent of consultations in general practice are made up of "disorders of the skin and subcutaneous tissues" (Savin, 1998). This figure probably substantially under estimates the actual number because the latter definition does not include scabies, warts and fungal infections, or tumours, infectious or parasitic disease of the skin.

4.2 There are over 145 cases per 1,000 persons per year for skin disease and some 25 percent of the population has a skin problem at any one time (Williams, 1996).

B. Overview of Undergraduate and GP Training

i. Undergraduate Training

4.3 At undergraduate level there is the potential for at least a minimum level of formal training in dermatology. However, this training is highly variable both in duration and in terms of the likelihood of every undergraduate having completed all aspects of the courses which are available.

4.4 Provision is made in the GMC's recommendations for training in medical schools through modules which address a variety of different disease areas. These can allow up to two weeks of training in dermatology. Many schools are modifying their courses to come into line with these recommendations. However, according to a recent survey, university infrastructure within which the teaching of dermatology to undergraduates should best take place, is almost absent in most medical schools. Clinical experience of patients with skin disease was limited to a few days.

4.5 The same survey showed that, while a few medical schools provided 8-14 days of undergraduate training in dermatology, the majority provided less than six training days. Significantly, a significant number of courses did not involve dermatologists in the pre-clinical training.

4.6 Teaching of basic science pertaining to dermatology is minimal, even though there is general acceptance that this is best taught at the pre-clinical stage.

4.7 The Group is concerned about this latter point. No medical student will fail an exam because of a lack of knowledge about dermatology. Whilst this is perhaps understandable because it clearly would not be practical to fail a student on dermatology alone it does, of course, reinforce the problem. If students, already facing a demanding curriculum, know they can pass by leaving out some areas of the course, such as dermatology, then they will give it much less weight.

4.8 Recommendation: The APPG believes that steps should be taken to strengthen the pre-clinical and clinical content of the undergraduate training course in respect of dermatology. This should be backed by a proper examination of dermatology knowledge.

ii. Postgraduate Training

4.9 Immediately on qualifying, all doctors spend one year in a pre-registration post. This is mainly ward-based, involving two six month rotations usually covering general medical and general surgical areas. It rarely (though understandably), includes dermatology. There is, however, a move towards adding time spent in general practice to this pre-registration period which we would welcome.

4.10 After the pre-registration year, the junior doctor will decide whether to pursue a career in general practice or to stay within the hospital setting. Assuming the former, the doctor then undertakes a general practice training course. This lasts for three years and, in theory, should revolve around all the specialities of importance in the general practice setting. This is not, by any means, always the case. The course usually consists of two years of hospital posts, of which 6 months is almost invariably spent in o&g, and a year as a GP registrar in an approved training practice. Some flexibility exists and several courses now limit the hospital-based teaching to 18 months. This frees up 6 months of extra time for attachment to a GP with opportunities to spend time in other specialties such as dermatology, ENT and ophthalmology,

4.11 Relatively few GP posts in hospital contain an element of dermatology. Dermatological experience when based in the GP practice will usually be heavily contingent on the interest or otherwise of the training GP.

4.12 It is clear that many GPs feel under-equipped to deal with an area which will constitute a large part of their work load. A recent study showed that 97 percent of GPs polled felt that basic training in dermatology was essential and that more time should be allocated to the subject. 98 percent of GPs stated that dermatology should be part of the core curriculum.

4.13 Recommendation: The APPG believes that an urgent re-examination should be undertaken of the balance of the GP training course removing the need for six months of o&g training. Since this training is not the only means by which a GP can be placed on the o&g list it should not be allowed to stand in the way of improved GP training in other areas.

4.14 Our understanding is that the RCOG is the Group standing in the way of this happening.

4.15 Recommendation: GPs should cover the core curriculum in dermatology recently approved by the RCGP. Trainee GPs should be provided with a copy of this curriculum and expected to implement it through discussion with their trainer.

iii. Postgraduate Qualification

4.16 GPs are independent contractors working within the NHS and providing general medical services to all registered patients. By definition these services cover the full range of medical conditions and GPs must be able to make a rational decision about the management of any problem presented by a patient. Dermatology represents about 15 percent of GP consultations, so it follows that GPs should be confident in dealing with skin disease. Some 70 percent of these GP consultations relate to a limited number of conditions. These are as follows:

- eczema, psoriasis, acne, benign and malignant growths in the skin, infections of the skin (viral, bacterial, fungal and parasitic) and leg ulcers.

4.17 Undergraduate and postgraduate education for GPs should, therefore, equip them with the ability to recognise these conditions, plan appropriate management and make an appropriate referral to a hospital dermatologist when necessary.

4.18 GPs also work in “primary health care teams” with, for example, practice and community nurses and need to use their skills appropriately. With sufficient training and expertise, many skin disorders could be effectively managed in primary care, freeing up dermatologists’ time to deal with the most difficult, complicated or rare cases.

4.19 In reality, the situation is different, as GPs can be licensed to practice independently without any formal dermatology training. What knowledge they acquire is either from experience or from choosing to attend postgraduate education courses. The latter can be

quite varied in content and no monitoring exists to ensure that GPs cover the full range of conditions outlined above.

4.20 Some GPs do become very proficient at managing skin disease, often after completing prolonged training courses such as the Diploma in Practical Dermatology from Cardiff and or by working as clinical assistants in a hospital dermatology department. Apart from personal satisfaction, there is no incentive for GPs to achieve a higher level of expertise because no enhanced fee is payable for a higher level of care for patients with skin disease in the way that there is for obstetric patients or indeed for diabetics and asthmatics.

C. Comment

4.21 The APPG is conscious that there is a need to be sensitive to the enormous workload with which GPs have to contend and the very wide range of medical areas which require to be covered during training. We accept also the obvious and often made point that general practitioners will be, by definition, generalists and cannot be expected to have detailed knowledge about everything. There is also an argument that the system should address training needs related to some diseases once the trainee GP has had a taste of general practice because they will then have a better understanding of what they need to know and what is less important.

4.22 It is a fact that some GPs lack even basic knowledge about skin disease and will have received minimal, if any, exposure to the subject during training. We have already quoted above the evidence that many GPs themselves feel in need of more training in dermatology.

4.23 GPs undertake 30 hours of continuing medical education per year for which they are paid approximately £2,000. This must contain a reasonable mix over 5 years including health promotion, service provision & admin and disease management. GPs submit their points tally to the Health Authority at the end of the period.

4.24 The post-graduate training system fails to provide incentives for GPs to train in areas of greatest need. Dermatology has suffered from a poor image amongst GPs who, in many cases, are not interested enough to pursue extra training of their own accord.

4.25 We would also question the adequacy of evaluation processes used to assess the quality of post graduate education. Some courses still lack all but the most minimal educational content. The Group welcomes the current discussion about changing post graduate education for GPs. One interesting idea is portfolio learning which would look at the needs of the whole practice and allow training to include all members of the primary care team. This is in line with the current, more inclusive, approach to healthcare provision.

4.26 The APPG believes that it ought to be possible for the majority of mild or common skin diseases to be handled by the GP in the practice if he/she was equipped with a basic level of skill. This would mean that the patient would get speedy and, in many cases, effective treatment close to home, pressure would be removed from the hospital-based skin clinics and scarce resources would be better used. Such a process would free up the clinics to handle the more difficult or rarer diseases with shorter waiting times.

4.27 Above all, the key consideration should be to ensure that the fully-trained GP is capable of establishing which of the disorders that present can be treated at primary level and which need to be referred on. Only by this means will NHS resources be efficiently spent and, most important of all, patients receive the best possible treatment.

4.28 Recommendation: GPs already in practice should be encouraged to read the RCGP's core curriculum in dermatology and plan their post-graduate education accordingly.

4.29 Recommendation: We support calls for the PGEA to be abolished. However, whilst it still exists we strongly feel that it should be re-structured to provide incentives to GPs to fill gaps in their knowledge and to reflect their workload.

4.30 Recommendation: Chronic skin diseases should be added to asthma and diabetes as an area which should attract an additional payment for chronic disease clinics in primary care.

5. Specialist TRaining for dermatologists

A. Workload

5.1 The average dermatologist's workload varies considerably from area to area depending on local needs and available skills and interests. Whilst the formal workload does not include research, committee work or teaching, this is likely to take up considerable time for some dermatologists.

5.2 Guidelines produced by the British Association of Dermatologists in October 1995 suggest that most consultants probably spend 3-5 notional half days (NHDs) a week in the out-patient clinic. They should each see between 15 and 20 patients dependent on the mix of new and follow-up patients - fewer if in a teaching clinic; most clinics are, however, heavily over-booked.

5.3 Part of the clinic time is allocated to dictating letters and checking laboratory reports.

5.4 A consultant is likely also to undertake two ward rounds each week (one NHD) with a further NHD spent providing other specialist clinics. One or more NHDs might well be devoted to time in theatre undertaking surgical work.

5.5 In addition, most consultants undertake management and administration duties, research and teaching (especially of undergraduates), committee work and travelling incurred by on-call commitments. One NHD is spent on medical audit and continuing medical education.

5.6 In practice these figures are optimistic since the pressure on dermatologists' time is enormous and increasing.

B. Training

5.7 Dermatologists can only undertake specialist training in dermatology after they have completed a minimum of two years post registration general medical training in hospital, post registration and passed the membership of the Royal College of Physicians exam.

5.8 The training curriculum for dermatologists is laid out in a document prepared by the Specialist Advisory Committee (SAC) of the Royal College of Physicians (RCP). This includes ten sessions in general practice. There is a defined system of

assessment and monitoring to ensure that all the required elements of training are experienced. The assessment includes completion of entries in a log book, documenting experience, interviews with trainees and assessment by independent assessors. At present, the curriculum has been set to occupy four years, but it is presently under review and an increase to five years is planned in the near future. The possibility of an exit exam is under consideration by the RCP.

5.9 Recommendation: The requirement of ten sessions in general practice should be reinforced by the appropriate training programme directors.

5.10 All specialist registrars are expected to gain experience in teaching others. However, it is the view of the APPG that more emphasis could be placed on doctors being taught how to teach both medical students and colleagues in other parts of the NHS. The ability to pass on knowledge is something which, to some extent, can itself be taught. In the modern NHS, where inter-communication and inter-dependence are key elements, it is important that doctors with specialist skills are able to pass appropriate parts of their knowledge on to others and that they are provided with training in this.

5.11 Recommendation: Given the low numbers of dermatologists, it is especially important that training in teaching techniques is included in the post-graduate syllabus, thus maximising the effectiveness of teaching the subject to healthcare professionals.

5.12 The Group has also received representations from a number of different organisations in concerning the poor quality of paediatric training in respect of dermatology. Currently few paediatricians have any training in dermatology and vice versa. With some diseases, e.g, dystrophic epidermolysis bullosa, this might have a profound affect on the standard of treatment that its provided. Dermatology is one of the last specialities which has no paediatric sub specialty, something which we believe needs to be addressed. The APPG would be interested to hear views on how this situation might be addressed in the future.
Possible solutions include funding a limited number of consultant posts in paediatric dermatology. Lectures on paediatric dermatology could also be given to trainee dermatologists.

5.13 Recommendation: The question of paediatric training in dermatology should be re-examined by the executive of the British Association of Dermatologists.

6. Basic Nurse Training

6.1 All nurses undergo the same initial training (with regional variations). Once trained, the nurse is responsible for making sure (s)he is up to date. In the UK, post graduate nurses are required to undertake five days of update training over 3 years. This policy is laid down by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). Nurses identify their professional development programme on an individual basis related to their personal situation and local service needs.

6.2 The undergraduate nurse curriculum contains little dermatology, although recently there has been an increase in the issues of skin care related to tissue viability and infection control. There is also an element of dermatology in the Common Foundation Programme which covers the normal functioning of the body, as well as tangentially in some other parts of the course. Practical experience of dermatology nursing depends by chance on clinical placements during the undergraduate programme.

6.3 Recommendation: Basic training in dermatology nursing care in the undergraduate curriculum should be compulsory.

6.4 Once in a formal structure and practising, nurses do undergo personal development but this is usually in areas other than dermatology. Continuing education opportunities for nurses are only funded via the Non-Medical Education and Training (NMET) stream through those contracts negotiated by the Education Consortia with the nurse education providers in the universities. Individual nurses, departments or practices have to find their own funding for ongoing training for nurses which involves attendance at other ad hoc programmes, study days, conferences and secondments or through work experience.

6.5 Recommendation Local Education Consortia should be commissioning, in a formalised manner, appropriate theoretical and clinical programmes to prepare qualified nurses to care for those with skin diseases.

6.6 In addition, they should support attendance and placement at other educational and training activities.

6.7 Formal post-registration educational opportunities in dermatology are available in only four areas in the UK and these are outlined below in the section on dermatology nurses specialists. Clearly this is insufficient and attention should be given to increasing their numbers.

6.8 Many nurses find difficulty in obtaining release for study leave particularly in small units and in primary care. This has been exacerbated by the problems in nurse recruitment and by financial restrictions.

6.9 Recommendation: The APPG believes that a pool of funding should be made available by Government to allow nurses to be released for study leave.

7. Dermatological Nurse Specialists

A. Current Situation

7.1 The main facets of the role of the dermatology nurse in both primary and secondary care are to:

- help patients in maintaining a healthy skin and in controlling their skin condition by carrying out prescribed treatments, as well as encouraging them to manage their own skin care independently;

- provide education for the patient, their families and carers about the skin condition and its treatments. Education of clinical colleagues is important so that skin disease sufferers receive appropriate skin care when being treated for other medical conditions. Nurses can contribute to the education of all people about the need for routine skin care to help them maintain a healthy skin and prevent skin failure. They can help raise awareness of the public generally to reduce the social isolation experienced by many skin disease sufferers;

- co-ordinate the various aspects of care needed by their patients by working with the patients and all the members of the professional team involved in the patient care programme;

- support the patient by giving emotional and psychological help and advising about patient support groups and availability of other self-help opportunities.

B. Specialist Training

7.2 In primary care, community and practice nurses could additionally undertake screening and advisory clinics for common skin conditions. In secondary and tertiary referral units, specialist nurses provide direct, highly-specialised care, they liaise with primary level colleagues to maintain continuity of care and are available as a specialist resource, both as an advisor and consultant to all professionals involved in dermatology patient care.

7.3 There are currently a few pockets of well qualified nurses but, overall, highly qualified dermatology nurses are few in number. There are three main post-graduate courses which are in Sheffield (ENB 393 Dermatology Nursing), Cardiff (ENB N25 Diploma in Practice Dermatology Nursing), Southampton and London (Developments in Dermatology Nursing - both similar courses).

7.4 Other educational opportunities are provided by the British Dermatological Nursing Group in a series of annual one day core educational modules, the Skin Care Campaign through its programme of Skin Information Days, the RCN Special Interest Group national study days, the National Eczema Society's one day Eczema in the Community courses, the Acne Support Group's distance learning package and through some other training events sponsored by industry.

7.5 For most dermatology nurses, training in clinical practice is undertaken "on-the-job". Some of the major dermatology units also run in-house training programmes for hospital

and community nurses and have developed the role of the dermatology community liaison nurse.

7.6 Other than the validated academic courses mentioned above, there is no nationally recognised monitoring system of education

and training programmes, although the RCN awards Continuing Education Points (CEPs) for activity of high quality that has been accredited by the RCN Institute.

7.7 Recommendation: The APPG believes that there is a significant need for nurses with specialist training. This should be addressed by funding for good quality training.

7.8 One way might be to encourage an expansion of distance learning for theoretical areas of knowledge, supplemented by residential courses. These might be comparable with those run by the National Asthma Training Centre in Warwick from which has been developed a nationwide network of 7,000 trained asthma nurses.

7.9 It is unlikely that proper funding in this area would have major budgetary implications but it would make a vast difference to standards of patient care. Recognising the ongoing debate within the nursing profession about nurse specialism, the APPG has decided to await proposals before commenting further. However, we would wish to see the role of nurses specialising in dermatology being substantially extended.

7.10 Recommendation: Government should take responsibility for ensuring that health authorities make the proper provision of dermatology nurse specialists in hospitals in their areas and in the community.

8. Practice and Community Nurses

8.1 There is a need to prepare nurses for expanded roles and additional responsibilities in both primary and secondary care.

8.2 The skills of both practice and community nurses often relate to those of the GPs with whom they mainly deal and interact. Whether the GP has additional training or interest in dermatology is likely to dictate the extent to which nurses have these skills in this setting.

8.3 The Group notes that, with practice nurses, skill levels tend to be higher where they operate from health centres and are employed by the local Trust.

8.4 The APPG believes that there is a much greater role to be played in dermatology by both groups of nurses. This could

partly pick up on the role performed by dermatology nurse specialists in hospitals - that is providing advice, being alert to environmental and domestic factors which might impact on skin disease and helping patients to become proficient in their use of treatments. However, it is unlikely that this would be a practical suggestion without provision of the appropriate training.

8.5 It is also important that the training needs of nurse prescribers are taken into account and that this training is improved accordingly.
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8.6 There is a need for more developed multi-disciplinary programmes so that nurses and other staff do not operate in isolation from their GPs, local pharmacists/etc or specialist departments in DGHs. The development of such services, along with the training inherent in making them work, would undoubtedly improve the quality of treatment provided for patients. It would also involve all levels of professional in mutual training and ideas-exchange, which we consider to be highly desirable, if not essential.

8.7 The APPG believes that, with a small amount of planning and foresight (both of which ingredients are currently missing amongst health authorities in this area of medicine), this multi-disciplinary approach to improving dermatology services could be secured for very little, if any, extra funding. For example, diabetic and asthma clinics attract a payment of £400 per GP per year. This appears to have provided enough incentive for considerable numbers of these clinics to be established around the country.

9. Occupational Health Nurses

9.1 Those nurses wishing to pursue occupational health studies can undertake a part time degree in Health Studies (Occupational Health pathway) over 2-3 years. A diploma is also available, although most nurses take the degree.

9.2 A number of strands relating to dermatology are integrated into the degree and these include studying skin problems in relation to work-place hazards.

9.3 Emphasis is placed on identifying potential sources of problems and then studying preventative measures and the value

and uses of educational programmes. Reference is made to specialists at this point of the course.

9.4 A joint Department of Health/English Nursing Board document on occupational nursing has recently been produced called Occupational Health Nursing - Contributing to Healthier Workplaces. We welcome its publication.

10. occupational health physicians

10.1 It is clear from evidence received by the APPG that insufficient general attention has been paid until recently to the question of occupational skin disorders. Some employers, for example, did not take the issue seriously, although we are told that this situation has begun to change. Many more employers are now becoming more aware of the importance that they should attach to ensuring that employees are not exposed to substances or situations which could cause temporary or long term damage to the skin.

10.2 RIDDOR regulations place a statutory obligation on employers to report certain occupational diseases. Most reputable companies, for whom skin disease is an issue, will have long since put appropriate preventative, educational and treatment processes in place. The problem here is mainly in respect of smaller less reputable organisations, perhaps including those with peripatetic work-forces, where controls are likely to be slacker, if they exist at all.

10.3 The situation has been improved by the emergence of a number of companies specialising in occupational health services. These companies are particularly useful in the area of education and fault-finding in organisations' processes.

10.4 There are some remaining training concerns though. Whilst occupational health physicians and nurses are increasingly professional, many general dermatologists have only a small amount of experience in dealing with occupational skin disorders. The APPG has been told that only a small number of consultant dermatologists have sufficient experience to deal with complex cases.

10.5 One suggestion has been made that specialist registrars in dermatology should be compelled to undergo an attachment to

departments of dermatology which have particular experience in occupational aspects of skin disease. This may not be totally practical given that insufficient numbers of such departments exist. However, the APPG does believe that a start needs to be made in this area. The funding of a few registrarships in particular units would help to increase numbers of appropriately trained dermatologists in this area.

10.6 Occupational physicians who undertake courses overseen by the Faculty of Occupational Medicine (FOM) and emerge as Associates or Members of the Faculty will have undertaken a rigorous course and examination, several aspects of which will include dermatology. The Faculty states that skin disease plays a major role amongst the skills and competencies required of occupational physicians. Whilst it is not absolutely impossible to pass the Associateship of the FOM without thorough knowledge of dermatology, it is highly unlikely that a candidate would. There is therefore a strong incentive to undertake the dermatology aspects of the course.

10.7 Occupational physicians employed by the NHS are Associates of the FOM - they are required to be so by the European Specialist Qualifications Order 1995, under which they must be placed on the Specialist Register of the GMC. Difficulties do arise, however, with those medical practitioners who regard themselves as specialists in occupational disease without having passed either the Diploma of the FOM or the Associate examination. These individuals do advise companies and may not be well equipped to do so.

10.8 Recommendation: This practice should be examined and regulated.

10.9 It is the APPG's intention to produce a report on occupational skin disease in due course and the issues raised above will be considered in more detail at that point. We would welcome suggestions on the comments above.

11. Pharmacists

A. Current Situation

11.1 Pharmacists are experts in medicines and their use. Dispensing is a key role in the community and in hospitals. Pharmacists ensure that patients have the right medicine in the

right dose, in line with their doctor's instructions. They check prescriptions for safety and
ensure the proper information on use is provided. Many pharmacists keep patient

medication records - a useful safety precaution for those taking a number of medicines. The modern practice of pharmacy makes wide-ranging demands of the pharmacist. One important factor is the motivation of the patient to use the medication appropriately.

11.2 Pharmacists also advise on common ailments, for which there is a growing number of effective medicines available from pharmacies without prescription. Where symptoms suggest a more serious condition pharmacists will advise patients to see their doctor. They
also offer other health-related services such as pregnancy testing and lifestyle advice related to diet, blood pressure and cholesterol.

11.3 A growing part of the pharmacist's role is advice to other professionals on all aspects of medicine use including working with doctors on prescribing and formulary development.

B. Registration as a Pharmacist

11.4 There are approximately 35,000 pharmacists in Great Britain all of whom must be registered with the Royal Pharmaceutical Society (RPSGB). Some 20,000 members work in community (retail) pharmacy; approximately 5,000 in hospital pharmacy; and about 1,500 in industry. Other pharmacists work in academic research and teaching.

11.5 RPSGB is the professional organisation for pharmacy and works to promote the development of high standards of practice and to safeguard public health. It has statutory responsibility for the registration of pharmacists and pharmacy premises and enforces the law on retail sale and supply of human and animal medicines. It also has responsibility for setting and monitoring professional standards and for the disciplinary process.

C. Education and Training

11.6 In order to register as a pharmacist, a candidate must have completed a recognised degree in pharmacy and have undergone a year's training in practice and passed a registration examination. The RPSGB supervises the educational content of degree courses and sets a national programme of on-the-job pre-registration training and the national registration examination. It also promotes programmes of continuing education. A new system of Continuing Professional Development will be piloted commencing autumn 1998. At present the Code of Ethics recommends that pharmacists undertake 30 hours of continuing education a year including at least one direct learning event.

11.7 Pharmacy degree courses are of four years duration, offered at 16 universities throughout the United Kingdom and are accredited by the Royal Pharmaceutical Society.

11.8 Degree courses covers four broad subject areas which are set out in Appendix Four. A number of these areas includes skin disease and this is also covered as part of a number of the main teaching areas. These include behavioural and social science relevant to health care, bio-pharmaceutics (including absorption, distribution, metabolism and elimination processes) and pharmacology which covers all bodily systems including the skin.

11.9 The APPG feels that too few pharmacists specialise in dermatology. Where they do, the dermatology training should include teaching from dermatologists at the appropriate part of the course.

11.10 There is concern about the lack of funding for the clinical teaching of pharmacy undergraduates although one school of pharmacy has secured a funding contribution from the NHS Non-Medical Education and Training budget (administered by local NHS education and training consortia) towards the clinical teaching of pharmacy undergraduates.

11.11 Recommendation: We believe that this funding should be expanded to cover all schools of pharmacy and that the clinical teaching should include aspects of dermatology.

D. Pharmacy Postgraduate Education

11.12 Central arrangements are made for provision of community pharmacists. There are four centres (England, Scotland, Wales and Northern Ireland) each providing a comprehensive range of direct and distance learning programmes. Most of the direct learning courses are held out of working hours because of the difficulties obtaining cover during the day. This also makes it difficult for them to attend multi-disciplinary programmes.

11.13 With the exception of England, the centres also provide programmes for hospital pharmacists. In England the provision for hospital pharmacists is variable. In some NHS Regions the hospital trusts support a very comprehensive programme provided by a dedicated team of staff whereas in others it is very much dependent on local initiative. Many hospital pharmacists find difficulty in obtaining release for study leave and this has been made more difficult by recent manpower difficulties. Well over 30% of hospital pharmacists hold or are studying for postgraduate degrees or diplomas mainly in clinical pharmacy.

11.14 Recommendation: The APPG believes that funding should be made available to enable hospital pharmacists to gain training in dermatology by attendance at release courses, if they wish this.

11.15 Hospital pharmacists have a role in advice on wound management and as members of tissue viability groups. Some have special expertise in dermatology treatment but there is a demand for more pharmacists to specialise in this area.

11.16 Community pharmacists frequently deal with minor skin conditions and are often asked for advice and recommendations. In addition they dispense prescriptions following consultation with doctors for more serious complaints and provide advice and counselling on use of products. There are programmes for pharmacists to support this role. These are validated and participants who complete an MCQ Assessment receive a confirmation of completion.

11.17 Funding for one day post-graduate courses for pharmacists in some skin diseases has been removed, having until recently been provided by the NHS. The National Eczema

Society has stated that it regards these courses as a force for good in improving community pharmacy in relation to skin disease and would like to see the funding of them reinstated.

11.18 Recommendation: We would support this suggestion.

12. Multi-Disciplinary TEAMs

12.1 Multi-disciplinary teams contain a mix of professionals including nurses, GPs and specialists, where possible pharmacists and sometimes dietitians, chiropodists, etc. They are able to provide a rounded view of a particular problem and play an important role in system and service management and with case conferences relating to particular patients.

12.2 The degree to which multi-disciplinary teams in general practice exist or are encouraged to deepen their knowledge of skin disease seems partly to depend on whether the practice contains a GP who has a particular enthusiasm for the subject. This will, to an extent, be dependent on whether (s)he has received much by way of formal training in the area. The GP is pivotal in encouraging the development of multi-disciplinary teams in the primary care setting. Unless the GP and the practice nurse have a grounding in dermatology, skin problems will continue to be marginalised.

12.3 For uncertain reasons chronic dermatological disorders such as eczema and psoriasis have failed to attract funding for chronic disease management clinics within general practice. Nurse-led diabetic and asthmatic clinics have special funding (as noted above) and this has greatly helped to improve their management by encouraging a more holistic approach to the disease. The same is required for dermatology which surely comprises a large enough percentage of the GP's workload to merit this type of approach. As demonstrated above, the necessary funding need not be exorbitant. The issue should be addressed as part of a general review of payments suggested above.

12.4 The Group feels that a suitable vehicle for post-graduate multi-disciplinary training would be to hold a number of days training which involved all of the different professional groups, such as nurses, pharmacists, chiropodists as well as GPs and a specialist in order to consolidate the team approach idea. With an eye to the structure of the new NHS, these should be GP-led.

12.5 In order to provide an incentive to attend those courses which reflect the GP's work load, we would suggest that one way

might be to ensure that such courses received extra weighting in the PGEA system, assuming that the Government decides to retain this system.

12.6 The lack of a systematic approach towards setting up multi-disciplinary teams means that there is often no structured way for other team members to pick up skills either. Nurses, for example, both in the primary and secondary setting, are frequently neither given sufficient time to pursue extra training in areas such as dermatology and nor are they funded for doing so, often even having to pay transport costs out of their own pockets.

12.7 With the development of primary care groups, it is hoped that multi-disciplinary teams with dermatology expertise can be established to improve needs assessment, investigation and management of skin disease and liaison with the local dermatology department.

12.8 Recommendation: Funding should be made available to allow the skill of pharmacists to be utilised by multi-disciplinary teams.

12.9 Recommendation: The APPG believes health authorities and/or primary care groups should be required to put into place planning for the establishment of multi-disciplinary teams in dermatology. These teams should be linked to the local dermatology unit.

13. Summary

13.1 The APPG on Skin has drawn a number of conclusions from the evidence collected by its enquiry. These are set out below.

i) Dermatologists are the only group of skin care professionals for whom overall training is adequate and effective to deal with the dermatology case-load they face.

ii) Dermatology forms up to 15 percent of the work-load of general practitioners. Yet many GPs practice with little undergraduate and no postgraduate training in the subject. Undergraduate courses contain an average of 5-6 days of dermatology which should be increased. It is necessary to

introduce an incentive system to encourage better postgraduate training.

iii) Nurses generally receive very little training about skin problems, although individuals may acquire expertise in particular areas, such as wound care. Practice and community nurses are unlikely to receive further training unless there is active promotion of dermatological care by the GP(s) leading the practice. Measures must be instituted to facilitate the release of nurses from their normal duties to attend postgraduate training courses. This is all the more important in view of the trend towards nurse prescribing.

iv) Pharmacists receive very little training in clinical dermatology. There is a clear need for them to know more about the skin and its diseases, particularly in view of the advisory role of the pharmacist in relation to patients who self-medicate.

v) There is a need for widespread creation of effective primary care teams involving healthcare professionals from different disciplines (GPs, nurses, pharmacists, etc) with clear links to the local dermatology department. These would create the conditions for greatly enhanced continuing education of professionals in dermatology.

13.2 The APPG's overall feeling is that there needs to be much more routine consideration of the role of the different medical professionals. This should be matched by a more strategic approach to training requirements. Health bodies should be undertaking assessments of the various needs and roles which local health needs imply and the ensuring that these are addressed in training.

14. References

Quoting digested statistics from McCormick A, Fleming D, Charlton J. Morbidity Statistics from General Practice: 4th National Study 1991-1992. London: HMSO, 1995.

Hay R. Undergraduate Teaching in Dermatology and General Practice. British Journal of Dermatology 1993; 129:356

15. Appendices

Appendix One - List of Written Evidence Submissions

Appendix Two - List of those Giving Oral Evidence with Date of Evidence

Appendix Three - Advisory Committee

Professor Peter Friedmann - Chairman.

Peter Lapsley

Ann Lewis

Dr Tim Mitchell

Dr Meg Price

Lyn Stone

Appendix Four - The Four Broad Areas of the Pharmacy Degree Course

- The origin and chemistry of drugs (pharmaceutical chemistry). Emphasis is placed on the study of synthetic (man-made) drugs, although drugs from natural sources, usually plants, are also studied.

- The preparation of medicines (pharmaceutics). This unique part of the pharmacy degree course is concerned with the study of the formulation of drugs into a variety of dosage forms, along with the quality assurance aspects of industrial scale production and quality control of medicines. More traditional skills of small-scale medicine preparation are taught in this part of the course, as well as the role of dressings and appliances.

- The action and uses of drugs and medicines (pharmacology). The application of pharmacology

requires the study of disease, disease therapy and the side effects of drugs. Knowledge of pharmacology combined with pharmaceutics enables the pharmacist to optimise the drug therapy and dosage form for the most beneficial effect in the patient. Drug treatment of skin conditions, the importance of formulation, the effects of both active drug and vehicle in skin preparations.

- Pharmacy Practice. This includes the dispensing and counselling skills required of the pharmacist, as well as legal knowledge. Pharmacists are prepared for their growing role in responding to the symptoms of illness; health promotion; advising doctors, nurses, other carers and patients on all aspects of drug therapy.

All Party Parliamentary Group on Skin
5th July 1998