



All Party Parliamentary Group on Skin



**AN INVESTIGATION INTO THE
ADEQUACY OF SERVICE PROVISION
AND TREATMENTS FOR PATIENTS
WITH SKIN DISEASES IN THE UK**

A Report of the
All Party Parliamentary Group on Skin

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GLOSSARY OF TERMS

All Party Group on Skin	An All Party Group specialising in skin which was established in 1993 to raise awareness of skin disease in Parliament.
BAD	British Association of Dermatologists. Professional body for dermatologists.
DEBRA	Dystrophic Epidermolysis Bullosa Research Association
"M25 situation"	Service which becomes completely overwhelmed as soon as it is provided.
"Multi-disciplinary teams"	Teams in a hospital unit which comprise or have easy access to various different, but relevant, skills.
NES	National Eczema Society
"Open access clinics"	Clinics where certain patients with chronic disorders can attend when in need without making an appointment.
"Orphan Drug"	Drug used to treat a disorder which has such a small incidence that it is not commercially viable to develop it.
PA	Psoriasis Association
PGEA	Post Graduate Education Accreditation
PUVA	Psoralens Ultra Violet A treatment
Skin Care Campaign	Umbrella group comprising various skin charities whose aim is to raise awareness of skin disease. Its membership at foundation included the Acne Support Group, DEBRA, the NES, Psoriatic Arthropathy Alliance and Vitiligo Society. Other Groups have since joined.
"Teach and Treat"	Means by which a consultant dermatologist provides treatment in the community at the sametime as teaching those in primary care.

SUMMARY OF RECOMMENDATIONS

- Give GPs incentives to attend dermatology courses [3.10].
- Consider weighting PGEA points systems to reward GPs for attending courses in priority areas [3.10].
- Give dermatology priority status in GP post-graduate training [3.10].
- Actively consider compulsory core curriculum of GP and nurse education and training in dermatology [3.15].
- Devote one month of undergraduate training and one month of GP hospital training to dermatology, rotating with other disciplines - cover as a minimum the common diseases [3.16].
- Reduce time devoted to obstetrics (currently six months) to enable this dermatology training [3.16].
- Require GPs to understand the basics of skin disease before being certificated [3.16].
- Stress dermatology more in practice medicine, eg, by sessional attendance at an outpatient clinic [3.16].
- Government to intervene if Royal Colleges unable to ensure GPs properly trained [3.17].
- Increase consultant numbers - less than half an extra consultant per health authority [3.23].
- Allocate extra consultants to clinics where need is greatest [3.23].
- Encourage specialist expertise of one partner in group general practices [3.31].
- Ensure range of sub-specialisms available within large GP practices [3.31].
- Provide financial incentives to help achieve such specialism [3.31].
- Allow GPs to "advertise" areas of accredited expertise [3.33].
- Alternatively, have locally-held list of approved GP specialisms [3.34].
- Health authority to circulate approved GP specialisms list to all GP surgeries [3.34].
- Pricing and contract structures to reflect the differences in skills and training between the GP and the specialist in this area [3.35].

- Reverse downward trend in number of nurse specialists [3.39].
- Make more use of nurse specialists in the provision of skin services [3.40].
- Specialist nurses to liaise between hospital dermatology departments and the community [3.41].
- Examine efficiency of local service provision and see how it could be improved through better team work [3.45].
- Development and greater use of open access clinics, enabling patient to attend when they need, rather than on a rigid appointment-based system [3.47].
- Assessment of whether highly-specialist dermatology should be handled in tertiary units [3.56].
- Establish register of available high-tech treatments as a priority. Treatments to be administered regionally by the NHSE [3.57].
- Government to support the Orphan Drugs regulation, as proposed by the EC [3.58].
- Government to ensure appropriate tax-breaks provided for above regulation [3.58].
- Educate patients in the responsible use of primary care resources, eg complying with treatments and learning that several treatments may be needed before success [4.4].
- Dermatology units to allocate resource to ensure sufficient nurse specialists available to talk to patients about practicalities of treatment [4.13].
- Guidance with respect to above to be issued by NHSE [4.13].
- GPs to be advised to be more aware, and make more use, of information leaflets provided by patient groups [4.14].
- GP training to include teaching on the availability and use of patient group information leaflets [4.14].
- Ensure patients aware that literature about skin disease is available from the surgery, clinic or community pharmacist - improve public education [4.19].
- Government to continue prioritising of skin cancer under the Health of the Nation [4.23].
- Government to continue to support public education programmes in respect of skin cancer [4.23].
- Joint programmes to provide information to enable the public to recognise danger signs associated with malignant melanomas and other skin cancers [4.24].

- Raise profile of skin disease, possibly through a joint DoH and patient's awareness campaign [4.24].
- Examine need for tighter regulation of "high street" skin clinics [4.26].
- Make three and four-layer bandaging systems available where needed [4.33].
- Provide clear agreements to ensure the provision of commonly needed dressing materials etc [4.33].
- Ensure that all doctors employed by Employment Medical Advisory Service have dermatology training [5.2].
- Abandon the selected list for most dermatology treatments [7.4].

SUMMARY OF DISCUSSION

1.0 BACKGROUND

Of all the body's organs, the skin is the largest. The All Party Parliamentary Group on Skin felt it timely to conduct an investigation because patient groups (the Skin Care Campaign and others), professionals and other members of the Group are concerned about skin disease treatment provision in the UK.

2.0 SKIN DISEASE - THE FACTS

Skin diseases affect 20-33% of the population at any one time, seriously interfering with activities in 10%. Typically, GPs spend at least 10% of their working time dealing with skin diseases. In 1992, skin disease was the sixth most common reason for issuing prescriptions. The main reason for the large burden of skin disease is its high prevalence; small changes in health policy can therefore have big health and financial implications.

3.0 PROVISION OF SERVICES

Recent GMC recommendations on undergraduate training exclude dermatology from the core curriculum in many medical schools, so that even fewer GPs will be adequately trained in dermatology. Skin diseases are so common that it is essential for dermatology to be included in the core curriculum. There is evidence of endemic mis-referral and also that some GPs may trivialise skin conditions or fail to give proper advice. Nurses and pharmacists, though better trained in general than in the past, usually lack specific dermatological training.

Whilst today's patients desire, and are entitled to, a full discussion, many do not get the clear and consistent advice which is vital if treatments are to be effective. Furthermore there is too much buck-passing as to where responsibility for the training actually lies.

Access to urgent referral to hospital out-patient departments or specialist dermatologists is usually timely and appropriate, but patients are often admitted to wards whose staff have no specialist knowledge of dermatology. Non-urgent referral is patchy and variable. There is evidence that the root of the problem is the lack of consultants which is low relative to the rest of Europe. The BAD recommends a population of 150,000 per consultant dermatologist, which suggests that an extra 50 (16%) consultants are needed.

Much dermatological need could be met in primary care but locally available services cannot be advertised and local patients therefore often know little about them.

Nurses are an essential resource for dermatology at every level, from specialist units to the community; basic continuity of care would be significantly enhanced if general practices and social services made better use of them. Regrettably, since 1988, 35% of dermatology consultants have lost the services of dermatology nurses. Patients could make more effective use of primary care if nurses and health visitors could prescribe or advise on the same terms as GPs in some circumstances. Ideally there should be a partnership between the service providers and healthcare managers to ensure that services are provided efficiently, sympathetically and that all parts of the team know what other team members are doing.

Dermatology patients in particular say that appointments systems are inflexible, meaning that they are seldom seen in hospital when their skin condition suddenly erupts and is at its worst. At a minimum, all clinics should operate a flexible appointment system allowing for cancellations when the condition is calm and urgent self-referral when it suddenly flares up.

Patients with rare or less common skin diseases, which are legion, face special problems - ignorance, neglect, lack of expert knowledge and understanding, absence of NHS and other support are key amongst these. Many dermatologists feel that purpose-designed tertiary units, though costly, are the future for specialist dermatology. Hospital staff often do not know where to get specialist help because there is no central register of units with special skills in rare conditions. Some rare conditions do not yet have a treatment and it is difficult to bring new discoveries into clinical practice because the small numbers of people affected make them an unattractive market both commercially and within the NHS.

4.0 PATIENTS - ROLES AND RESPONSIBILITY

Wide variation in dermatology services means that generalisation is difficult, but the evidence is that dermatology patients are accorded relatively low priority from health professionals except those with a special interest. Resultant, referral rates are significant and have risen in the last ten years because of a societal change in attitudes and expectations with people less likely to tolerate disability.

As with many systemic diseases, the success of a given treatment does depend on patient compliance. Part of the solution to poor compliance would be a programme of public education. Counselling of patients can also help. It is essential that patients take an active part in preparing and agreeing their own treatment plans, and even more vital for parents to do this on behalf of their children. Hospital clinicians do not always appreciate the realities of their suggested treatments. Written information is available and can greatly help towards adequate management in the community.

Despite the quality of much patient information, some would be still better with less use of medical jargon and technical language. There is a need for more specific information on uncommon conditions and individual treatments, and for up-to-date information on research and new treatments. Language and cultural factors may affect the ease with which members of ethnic minorities understand and use information: some districts have acted on this but there are still too few posters, leaflets and booklets for people whose first language is not English.

Despite some six million visits per week to the Nation's 12,000 community pharmacists, their potential and expertise are generally under-estimated and under-exploited, partly because some patients cannot afford over-the-counter remedies.

In line with the modern approach to medicine and disease, the Group is concerned about the prevention of skin disease as much as with its treatment. The Group believes that public information programmes in relation to skin cancer have gained high public recognition and that, as a result of these, increasing numbers of people are now aware of the risks associated with excessive exposure to the ultra-violet rays. The over-riding priority in this area is to raise the profile of skin disease itself.

There is evidence that dermatologists underestimate the psychiatric or psychological problems associated with skin conditions: the need for better liaison between psychologic and dermatological services is internationally recognised but such arrangements are rudimentary in the UK. Note should also be taken of the valuable role played by patient groups in providing support, guidance and understanding to patients and their families of the social and psychological impact on their lives of living with these diseases.

Some patients lack access to the full range of products they need and, as already noted, may be unable to afford over-the-counter preparations, especially as many who do not see their doctors about their skin problems often try several different products. There are particular problems in respect of the treatment of leg ulcers. The scientifically validated four-layer bandage system for chronic venous ulceration is unavailable on GPs prescription although it improves healing, reduces morbidity, saves nurses' time and saves money.

5.0 OCCUPATIONAL DISORDERS

Occupationally caused skin problems are not uncommon and are eminently preventable. However, in the UK (unlike other countries), while there are occupational dermatologists, there is no formal qualification in occupational dermatology and general dermatologists do not always understand working environments.

6.0 IMPACT ON RESEARCH OF THE NHS REFORMS

Most dermatological research is carried out by pharmaceutical companies but economic pressures are forcing them to focus on more lucrative areas. Research into the need for dermatology - why some people seek skin care and others do not - is also important.

Whilst the NHS reforms have improved accountability and costing information, they are regarded by many as having done little to improve and develop services so far as dermatology is concerned. Purchasers and providers give low priority to dermatology and purchasers are often refusing to carry the costs of medicines used in clinical trials.

7.0 THE SELECTED LIST

The selected list limits the products that may be prescribed by GPs under the NHS and have affected dermatological research in a variety of ways. Acceptability is vital for effective treatment so patients' preferences, especially for topical medications, require a wide range of alternatives to be available. Lack of research and the impact of the limited list on product development will stultify treatment in dermatology more than in most other disciplines.

8.0 CONCLUSION

This report is intended as a blue-print to pave the way for improvements in dermatology service provision at all levels of the NHS in the coming years. The report has been examined by representatives of many of these bodies and there is a high degree of agreement amongst them in respect of its recommendations. The report is supported by the Group's officers, representing cross-party agreement. It is the Group's intention to monitor the progress made in implementing these recommendations contained in this report over the next Parliament.

AN INVESTIGATION INTO THE ADEQUACY OF SERVICE PROVISION AND TREATMENTS FOR PATIENTS WITH SKIN DISEASES IN THE UK

A Report of the All Party Parliamentary Group on Skin

1.0 BACKGROUND

1.1 Of all the body's organs, the skin is the largest. It is also the most versatile in function, the most evident reflector of psychological and physical health and often a harbinger of inner illness. Above all, though, the skin is unique in being directly and constantly exposed to external elements. Its colour, tone and texture and its ability to signal emotion and cause sexual attraction make its condition and appearance of key importance to every individual.

1.2 The adequacy of service provision and treatments for people with skin diseases should be of continuous concern. It usually isn't because the skin is perceived to lack the mystery of the hidden organs and its importance is under-appreciated even by many professionals. It has a remarkable capacity to sustain and renew itself, to withstand assault from sun, wind and water and to recover from injury and mistreatment, but is prey to hundreds of diseases, disorders and infections. These can cause chronic physical and mental pain and distress.

1.3 The All Party Parliamentary Group on Skin felt it timely to conduct an investigation because patient groups (the Skin Care Campaign and others), professionals and other members of the Group are concerned about skin disease treatment provision in the UK.

1.4 The Group received 67 written submissions from clinicians and nurses specialising in or having an interest in dermatology, from general practitioners, professional organisations, patient representatives, public health officials, health authorities, pharmaceutical companies, skin disease associations and academic units. In addition, oral evidence was taken from ten witnesses at three sessions. These examined the provision of dermatology treatments at the primary, secondary and tertiary stages in some detail.

2.0 SKIN DISEASE - THE FACTS

2.1 Skin diseases affect 20-33% of the population at any one time, seriously interfering with activities in 10%. Patients need a full range of services, from self-help groups to specialist in-patient care. Epidemiological evidence suggests that many cases of skin disease do not reach the GP or even the local pharmacist¹; nevertheless, each year about 15% of the population consult GPs about skin complaints. 5% of these are referred on for specialist advice. Typically, GPs spend at least 10% of their working time dealing with skin diseases².

2.2 Dermatology accounted for £617 million in direct costs to the NHS in 1994 (2% of the total NHS budget)³. In the 1992 Health Survey of England, skin disease was the sixth most common reason for issuing prescriptions, total costs of which in 1993 were £143.6 million, representing one of the lowest cost per item. Over-the-counter preparations cost £138.8 million (11.8% of total OTC sales)⁴.

2.3 There are more than 1,000 skin diseases but 70% of the dermatological workload in primary and secondary care is taken up by nine categories (skin cancer, acne, atopic eczema, psoriasis, viral warts, other infective skin disorders, benign tumours and vascular lesions, leg ulceration, contact dermatitis and other eczemas). Effective treatments are available at low cost for most.

2.4 Mortality (mostly from skin cancer, the most common form of cancer, but also from herpes and eczema in a few cases) accounts for 0.46% of all deaths. Every year, 40,000 people in the UK contract skin cancer. Although melanoma, the most serious form of skin cancer, is often eminently curable if detected early enough, it is now the second most common cause of death among people aged 24-35, reported new cases having risen by 90% between 1974 and 1989 and the number of deaths by 60% between 1974 and 1994⁵.

2.5 For most patients, skin disease is chronic, with acute exacerbations. After the initial diagnosis, most cope well, but often require help and advice when exacerbations occur. Minor skin complaints can cause greater anguish than more serious conditions.

2.6 The main reason for the large burden that skin disease presents is its high prevalence; small changes in health policy can therefore have big health and financial implications. The increasing prevalence of some skin diseases, notably skin cancer, atopic eczema (especially in children), and venous leg ulcers (due to the ageing population) have caused waiting lists to lengthen. Added to this is the development of better treatments for such conditions as acne and psoriasis, and publicity about moles and other skin growths.

2.7 These factors also seem likely to require more resources as awareness of the need to consult and the demand for treatment continue to grow. Recent trends, however, have been the other way - dermatology has been seen as a 'soft and easy' target for economies.

2.8 Many people with skin diseases can be treated in the community but about 12.5 per 1000 are referred to dermatologists annually; in-patients account for 1.4% of hospital admissions⁶. Low numbers of consultant dermatologists and of junior doctors training to become dermatologists reflect a perception that skin disease is unimportant.

3.0 PROVISION OF SERVICES

Primary Care

3.1 It is a frequent, often unbacked, accusation in any debate about health service provision that much need is unmet, that demand outstrips supply and that shortfalls and inadequacies abound. But the weight of evidence in respect of skin disease suggests that this is not mere 'shroud-waving'.

3.2 Some 15 percent of GP consultations are in respect of skin disease and yet the GP dermatology training programme reflects only a minute fraction of that figure, if there is any training at all.

3.3 Dermatology is not a compulsory part of GPs' training schemes, barely a fifth having a dermatological component. Where training does take place, it typically lasts only three weeks at most. It is therefore hardly surprising that most doctors enter general practice with only a rudimentary grasp of the subject and are correspondingly poor at managing skin problems.

3.4 If the basic training were better, vocational training in general practice could concentrate on expanding skills and experience rather than having to teach fundamentals. Recent General Medical Council recommendations on undergraduate training exclude dermatology from the core curriculum in many medical schools, so that even fewer GPs will be adequately trained in dermatology. Clearly, if it is taught only as a special option, doctors will gain even less training in skin diseases. There is a danger that the big disciplines will get bigger and the small ones disappear. Dermatology is usually in the latter category.

3.5 Skin diseases are so common that it is essential for dermatology to be included in the core curriculum. Undergraduate students ought to receive a minimum of four weeks dermatology teaching. After qualification, vocational training for general practice should include a period of postgraduate training, either as Senior House Officer on a dermatology unit, or on a specific attachment for teaching/training in a dermatology clinic. Generally there are not enough GP-orientated dermatology SHO posts and the system for a "training attachment" does not exist at present.

3.6 Because GPs are under-trained in dermatology - only 1 in 10 has had specialist training - there is a welter of mis- and un-diagnosis and treatment. Some GPs are reluctant to refer when they should, or refer for trivial conditions because of the cap on payments they receive for minor procedures.

3.7 Although some GPs have become more skilled and knowledgeable, patients all too often fail to receive sufficiently quick access to full and accurate diagnosis, explanation and prognosis. There is considerable anecdotal evidence of endemic mis-referral. Women with vulval skin conditions, for instance, are often sent to gynaecologists who are not dermatologically trained. There is evidence that some GPs may trivialise skin conditions (making patients feel guilty about seeking medical help) or fail to give proper advice. Both the NES and PA say that patients, and especially those with eczema or psoriasis, often feel their GPs know little about their complaints, show little interest and tend (as with many other medical conditions) to be dismissive about the 'emotional' aspects.

3.8 There is little, if any, on-the-job training in primary dermatology and not all medical schools are allocating teaching time. GPs can obtain advice regarding continuing education, notably from the Primary Care Dermatology Society, the Royal College of Physicians in some areas, the British Association of Dermatologists, journals, conferences for clinical assistants in dermatology, hospital forums, the medical information services of pharmaceutical companies, postgraduate meetings and study days. Also, patient groups and the Skin Care Campaign provide much help and back-up to health professionals which is welcome and valuable. Examples are the NES's patient-centred primary care training programmes for nurses and pharmacists and pilot projects for GPs.

3.9 In most areas, dermatology departments offer regular meetings with GPs and the latter may attend a limited number of out-patient clinics. "Teach and Treat" initiatives can provide support, information and continuing education but require scarce consultant time and are often poorly attended by GPs. A University of Wales College of Medicine national distance learning programme leading to a Diploma in Practical Dermatology is undertaken by about 65 GPs a year (who pay for this themselves). Advice over the phone would help GPs in difficult cases, while district and practice nurses should be able to liaise with clinic nurses to achieve continuity of care and share new skills and techniques. Treatment and management would be improved if GP trainers, course organisers and the relevant professional bodies worked together. There are also a few locally run postgraduate courses for community pharmacists.

3.10 Recommendation. The Group believes that GPs need to be given incentives to attend some of the wide range of courses available to expand their knowledge of dermatology. We recommend that consideration be given to weighting the PGEA points system to provide extra reward for GPs attending courses in priority areas. Dermatology should be given priority status in terms of GP post-graduate training.

3.11 Nurses and pharmacists, though better trained in general than in the past, usually lack specific dermatological training. Primary care teams often feel unable to find the time for patients that their skin conditions probably warrant, and district nurses cannot always undertake twice-daily visits when these would be desirable.

3.12 Many study days are available but some hospital trusts have cut study leave budgets and are reluctant to give time off. Nurses in particular are finding it ever harder to obtain time and funding for continuing education. Some have even paid for attending conferences in their own time and at their own expense.

3.13 Whilst today's patients desire, and under the Patient's Charter are entitled to, a full discussion, many do not get the clear and consistent advice which is vital if treatments are to be effective. Those from minority ethnic or cultural backgrounds or with pigmented skin have particular problems which are often overlooked not least because some receive advice on only part of their problems⁷. The scarcity of support for those who have to handle the social and psychological impact of living with chronic disorders indefinitely is a major cause of patient dissatisfaction.

3.14 Recommendation. It is clear that a lack of appropriate training is a major problem in the diagnosis, management and treatment of skin disease at the primary level. Whilst the Group accepts that it is not possible for all GPs and the primary care team to be trained to sub-specialist level in dermatology, it is equally not acceptable for the ad hoc nature of GP training in dermatology to continue. Furthermore there is too much buck-passing as to where responsibility for the training actually lies.

3.15 A structured and compulsory core curriculum programme of GP and nurse education and training in dermatology should be actively considered. This would help to raise the quality of referrals by cutting out some of the inappropriate ones, although we accept that it might not reduce the total number. GPs may be unwilling to refer simply because they do not know about the latest treatments; GPs with expertise who do know about them tend to refer more rather than less.

3.16 We recommend at least one month of undergraduate training and one month of the GP hospital training period should be devoted to dermatology, rotating with other disciplines, and covering as a minimum the common diseases. This time could be found by reducing, for example, the obstetrics part of the curriculum which, at six months, is generally regarded as an over-generous training period. Once the trainee-GP has moved into practice medicine, more stress should be placed on dermatology and there should be a requirement that GPs understand at least the basics of skin disease before being certificated and gain a reasonable amount of practical experience. Attendance at an outpatients clinic is vital and could be achieved on a sessional basis integrated with other disciplines or whilst training in a GP practice.

3.17 There is a duty on the Royal Colleges, born of the need for more effective health care provision, to ensure that GPs are properly trained to handle the major parts of their workload. However, Government as the provider of primary care and therefore, in effect, the "employer" of the GP, has a key responsibility to ensure that its contractors are properly trained. If the Royal Colleges do not respond to this obvious need on GP training, we believe that Government should intervene.

Access

3.18 Although access to urgent referrals to hospital out-patient departments or specialist dermatologists is usually timely and appropriate, patients are often admitted to wards whose staff have no specialist knowledge of dermatology⁸.

3.19 Non-urgent referral is patchy and variable, with persistent and unacceptably long waiting times in many places - 36-42 weeks is common and up to two years has been cited⁹. Questions are raised as to whether resource allocation is adequate - that is are there enough dermatology specialists in hospitals to deal with both out- and in-patient needs?

3.20 Furthermore the amount of time given to patients in dermatology clinics is, in some cases, even shorter than the time they spend with the GP. Where appropriate, it would be a useful improvement for the dermatologist to be given scope to spend 10-15 minutes with some patients rather than 4 or 5 rushed minutes. The Group has heard evidence of some dermatology centres being run like cattle markets¹⁰. This an undesirable state of affairs.

3.21 There is some evidence that the root of the problem is the lack of consultants which is low relative to the rest of Europe. There are 320 dermatologists in the UK, which is proportionately a tenth of the number in France and the lowest ratio to population in the EU by a factor of three¹¹. This is not as woeful a situation as it might appear since much dermatology in France by-passes the primary sector altogether. Furthermore, the number of UK consultants is not strictly comparable to the numbers in some other EU countries where senior registrars are classified in the consultant numbers.

3.22 The Government has a good record in terms of the increase in dermatology secondary care staff and there has been a significant increase in consultants in the last five years up from 228 to 252 in the five years to 1993¹². However, more needs to be done. The British Association of Dermatologists recommends a population of 150,000 per consultant dermatologist, which suggests that an extra 50 (16%) consultants are needed¹³.

3.23 Recommendation. The Group supports the BAD's view that a limited number of extra consultants is needed. We accept the evidence that dermatology departments are, in many cases over-stretched, and that this is having an adverse effect on the treatment which patients receive and the time they are required to wait. We therefore recommend that the Government gives spur to the progress it has already made in increasing consultant numbers in recent years. To meet the BAD's requirement would involve the provision of less than half an extra consultant per health authority. Consultants should obviously be allocated to those clinics where need is greatest.

3.24 The combination of better GP training and a relatively modest increase in the number of consultants should ensure not only an improvement in skin services but also that an "M25

situation" does not arise. Very often, the provision of extra resources simply encourages even more people to use the service so that it reverts rapidly back to the same situation. Better GP training will lead to a reduction in inappropriate referrals thus ensuring that extra demand is efficiently handled by all parts of the system.

3.25 The Group accepts that there is a practical problem in this recommendation in that there is already difficulty in filling the existing consultant vacancies. Attention does need to be paid to this latter problem but it does not deny the fact that too few consultants are trying to treat too many patients.

3.26 Much dermatological need could be met in primary care but locally available services cannot be advertised and local patients therefore often know little about them. GPs now provide a much wider range of services than previously, notably for viral warts, and community and practice nurses are more often treating leg ulcers, but the fact remains that primary care teams are, rightly, not specialists.

3.27 Group general practices could have special expertise if one partner developed an interest, and patient support groups could also give primary care teams independent advice and the benefit of their experience.

3.28 GP specialist expertise could be obtained by spending a period as a clinical assistant, with the GP spending one session a week working in a dermatology clinic alongside a specialist. There are already some 370 such assistants in the UK but they are only likely to make a significant impact on the management of skin disease at primary care level if:

- there are many more of them (they currently total less than one percent of GPs). It may mean that clinical assistants need to be given financial incentives to pick up specialist skills;
- they are able to market their skills more widely and provide the service of a "super-GP" within the limit of their own practice.

3.29 Recommendation. There are a number of problems associated with the latter suggestion, not least the logistics of making specialist skills widely known. However we believe that this approach might hold many of the answers to improving skin care services at primary level. Even if specialist GPs were modestly remunerated for their efforts, this might well be a highly cost-effective way of addressing the problems which currently exist. **We believe that consideration should be given by Government to the ideas outlined above.**

3.30 We also support the generally held view that patients should both have access to the best treatment and that, if this can be provided close to home, that is even more desirable.

3.31 Recommendation. The Group feels that it is therefore important to work towards a solution which provides better training of GPs within their own practices. Great advances could be made if thought was given to a way of ensuring a range of sub-specialisms was available within large GP practices. Financial incentives towards building up such specialism might one way of achieving this.

3.32 We reject the idea of moving towards a system of super-GP specialists because there is a fear that isolation from the dermatology department would lead to inadequate supervision. Combined with insufficient training and continuing medical education, a sub-optimal specialist service is likely to result whilst too much time away from other GP activities will decrease the practitioner's other skills and undermine the holistic approach to patients.

3.33 Recommendation. The Group however believes that consideration should be given to allowing GPs to "advertise" areas of accredited expertise. We acknowledge that such a development would require careful handling and probably need to be hedged with restrictions. Indeed it may be that some form of certification is required.

3.34 An alternative suggestion would be to have an approved list of GP specialisms held locally for which patients could apply. This could also be circulated around all GP surgeries by the health authority with a mandate that it should be displayed prominently in the practice.

3.35 The Group recognises that there is a danger that purchasers may feel they can buy dermatology services from a local GP who happens to have this as an interest. This could threaten the position and even survival of the relevant hospital-based dermatology unit without necessarily delivering a better service to the patient. **It is important therefore that the pricing and contract structures reflect the differences in skills and training between the GP and specialist in this area.**

Nurse Specialists

3.36 Nurses are an essential resource for dermatology at every level, from specialist units to the community; basic continuity of care would be significantly enhanced if general practices and social services made better use of them. By educating and informing patients, not least about support groups (some names of which can be found in the glossary), they are the key to patients' adherence to treatment regimens. Community nurses who spend time in the homes of newly-diagnosed patients, showing them how to manage their disease, can reduce the number of in-patient visits needed, especially in respect of children.

3.37 Nurses also play a vital role in the use of dressings and the application of emollients, although many need training in the treatment and management of common skin diseases like eczema and psoriasis. They could also, given the opportunity, do more to help patients plan a routine for maintaining skin health.

3.38 Regrettably, since 1988, 35% of dermatology consultants have lost the services of dermatology nurses¹⁴. Their numbers nationally have fallen by more than a third in the past four years and by up to two thirds in some areas, notably London. Furthermore, the drive for economies has also led to the replacement of some trained nurses by auxiliaries.

3.39 Recommendation. The Group believes that significantly more use could be made of nurses in the provision of skin services. It is concerned by the recorded fall in the number of dermatology nurses. We believe that consideration should be given to how this trend can swiftly be reversed.

3.40 Nurses have a vital role to play in dermatology and are often extremely willing to learn and apply new skills. More use should be made of this excellent resource.

3.41 Patients would benefit if there were specialist nurses who liaised between hospital dermatology departments and the community: liaison or multi-disciplinary clinics embracing all relevant specialties have proved successful in several places.

3.42 Patients could make more effective use of primary care if nurses and health visitors could prescribe or advise on the same terms as GPs in some circumstances. Such an approach might well require more trained nurses than are currently available. Although this might have some resource implications, active consideration should be given to it.

Co-ordination and Communication Within the Team

3.43 The maintenance or repair of skin integrity requires the co-operative expertise of several professions to a greater degree than most other treatments but is not easy or frequently achieved. The concept of multi-disciplinary teams, although commonplace in other fields, is seldom applied, for instance, for chronic wounds in hospital.

3.44 Many hospital trusts lack sufficient support staff and facilities. Even when adequate, poor co-operation and communication amongst staff sometimes creates difficulties. This is one key area where the problem is often not a lack of resource. Failure to communicate between different aspects of the multi-disciplinary team both within the hospital and outside should not be tolerated. Ideally there should be a partnership between the service providers and healthcare managers to ensure that services are provided efficiently, sympathetically and that all parts of the team know what other team members are doing.

3.45 Recommendation. The Group believes that the starting point in assessing the adequacy of service provision locally should be to examine how efficiently the service is being provided and how it could be improved through better team work. This has the advantage for the team that a cohesive unit is much more likely to succeed in requests for increased resources than a fragmented one.

Open access clinics

3.46 Apart from patients' complaints, common to all medical areas, that they see a different doctor each time they visit hospital, are kept waiting around too long and are then given no more than a few minutes of the doctor's time, dermatology patients in particular say that appointments systems are inflexible, which means they are seldom seen in hospital when their skin condition suddenly erupts and is at its worst¹⁵.

3.47 Recommendation. The Group believes that this last problem might be eased through the greater use of open-access clinics which allow patients to attend, within "opening hours", the hospital when they need to and not on the basis of a rigid appointment which may not coincide with a particular need for a consultation.

3.48 Brighton General Hospital, for example, runs a self-referral clinic for patients with long-term conditions which allows them to ring up and ask for an appointment at short notice. There is evidence that this system has not been abused and it gives the dermatologist the advantage of seeing the condition at its worst and not up to twelve weeks later when it may have calmed down. There are other examples of this approach working well although it requires careful management and may not be suitable for all areas. At a minimum, it should be possible for all clinics to operate a flexible appointment system allowing for cancellations when the condition is calm and urgent self-referral when it suddenly flares up.

3.49 There is the general question of access especially in rural areas. This is a particular problem in the area of skin disease because many GPs don't recognise the conditions with which the patient presents and need therefore to refer on.

3.50 The advantages of outreach clinics are often advanced but are disliked by clinicians nor attended by GPs. Nearly half the patients seen in such clinics have to be seen again in the central skin department - this hardly seems cost-effective, especially in the absence so far of any wide scale audit of outcomes. Furthermore, outreach clinics cannot provide the full range of hospital facilities, lack experienced nurses, seldom participate in medical education and could weaken the hospital service.

3.51 Recommendation. Multi-disciplinary liaison clinics, that is those with a full range of expertise such as a consultant, nurse specialist, dietician etc, have proved helpful to

patients in some areas. Open access clinics offer particular hope as a good use of resources and, being accessed by patients at the precise point of need, more responsive. We would recommend their development.

Specialist Services and Treatments

3.52 Patients with rare or less common skin diseases, which are legion, face special problems - ignorance, neglect, lack of expert knowledge and understanding, absence of NHS and other support are key amongst these. Also a problem is the paucity of information and inadequate, ineffective or even non-existent treatments. This points to the need for a few centres of specialist excellence, something which has barely been addressed by NHS planners.

3.53 There are, for instance, few dedicated laser centres treating disfigurement such as port wine stains, yet this affliction can, in some cases, be cleared completely by lazer treatment. Purchasers often deny appropriate funding because they see these as merely a cosmetic problem.

3.54 Few hospitals offer ultra violet and treatments such as PUVA which, because they are seen to be expensive, may not be recommended; indeed, patients may not even be told about them. It is worth noting that PUVA can cost less than many of the anti-biotics used in most District General Hospitals. However, it is possible that new beds will be needed with the development of such treatments. Many dermatologists feel that purpose-designed tertiary units, though costly, are the future for specialist dermatology. Recent experience has been one of falls, sometimes considerable, in specialist unit bed numbers¹⁶.

3.55 Hospital staff often do not know where to get specialist help because there is no central register of units with special skills in rare conditions. Such a register would make it much easier for people to be referred appropriately and would maximise their chances of getting good available treatment. Some rare conditions do not yet have a treatment and it is difficult to bring new discoveries into clinical practice because the small numbers of people affected make them an unattractive market both commercially and within the NHS. The EU's proposal for an Orphan Drugs law to match that in the United States could be very important in speeding the discovery of new treatments and hastening them to market.

3.56 Recommendation. The Department of Health should assess whether highly-specialist dermatology should be routinely handled in purpose-designed tertiary units. These units would contain state-of-the-art equipment and might be organised on a regional basis.

3.57 A register of available high-tech treatments should be established as a matter of priority and administered regionally via the NHSE.

3.58 The UK Government should support the proposal for an Orphan Drugs regulation which has been proposed by the European Commission and ensure that appropriate tax breaks are provided to under-pin it.

Summary

3.59 It is easy to demand more money, resources, facilities and personnel, but such demands, though valid, often miss the point. Provision is usually more complicated than a simple resource question; other approaches therefore deserve consideration. The suggestions above are an attempt to bring forward imaginative solutions to the present problems from which a mix of policies can be developed.

3.60 Keys to improving the quality and accessibility of dermatological services include education of the public on such risks as excessive exposure to sunshine and the significance of pigmented lesions (where much work is already being done). We would argue that the widespread introduction of screening for skin cancer would not be a cost-effective use of resources. Furthermore it is important to maintain a balance between skin cancer (even though it is potentially fatal) and other skin diseases. The effect of anxiety about skin cancer has been argued to have had a major impact on the worsening of provision for patients with other types of skin disease.

3.61 Better education of GPs, for whom there is no requirement to have had specialist training and a better primary-secondary interface would greatly help. We also recommend that active consideration should be given to the merits of making more use of agreed protocols between primary and secondary services to ensure that patients do not receive conflicting advice.

3.62 Patient groups argue that some doctors and nurses are averse to accepting information from patients and the fact is that no one - not even the specialist - knows more about the reality of living with a particular skin problem than the patients themselves. It is essential that they are actively and continually involved in preparing and agreeing their treatment plans. It is also important that guidance is issued to medical staff to this effect and that the attitude gradually becomes imbued amongst carers. Patient group training programmes similar to those mentioned above, are a big step in the right direction.

4.0 PATIENTS - ROLES AND RESPONSIBILITY

4.1 Wide variation in dermatology services means that generalisation is difficult, but the broad thrust of evidence is that dermatology patients are accorded relatively low priority from health professionals except those with a special interest.

4.2 As a result, referral rates are significant. They vary widely even at district level due to population differences. But overall, of the 15% of the population who consult their GP each year because of a skin complaint, 1 in 5 - approximately 500,000 people - are referred for specialist advice. More significantly it is estimated that some 80 percent with a skin problem does not seek medical help either because the problem is mild and controllable, because patients are unaware of service on offer, or because previous experience has led them to believe that it is a waste of time¹⁷.

4.3 Referral rates have risen in the last ten years. This is because of a societal change in attitudes and expectations with people less likely to tolerate disability. Patients are also more assertive in pressing for treatment, second opinions and referrals than in the past. Some are less willing to wait for the GP's treatment to run its course and others make too many appointments for minor and self-limiting ailments. There is anecdotal evidence that some GPs succeed in reducing their referral rates only to see them rise again. This is because satisfied patients often don't hesitate to return to a service they know and trust when further problems arise.

4.4 The Group has made a number of suggestions above as to ways in which primary and secondary care services could be improved. However there is a role for patients to play too. We believe that too little has been done to educate patients in the responsible use of primary care resources not least in complying with treatments and learning that several different treatments may need to be tried before a successful one is found.

Compliance

4.5 The way in which services and treatments are used is, of course, often as important as their availability. As with many systemic diseases, the success of a given treatment does depend on patient compliance. Skin disease is no different, and poor adherence to the prescribed or recommended treatment is likely to lead to its failure.

4.6 A problem here is that some patients have an attitude that they deserve an instant cure which does not require any effort on their part and also that clinicians are there for the patient's convenience. For treatments to have the best chance of success we believe that there must be a proper partnership between clinician and patient. This involves clinicians doing all in their power to identify the cause of the disorder, working with the patient to identify a treatment path and demonstrating sympathy and understanding throughout the process. In turn, and crucially, it is up to patients to work with clinicians by providing background information, listening to and taking advice and ensuring that they comply with jointly agreed treatments.

4.7 Part of the solution to poor compliance would be a programme of public education. There may also be a case for integrated skin units based in hospitals to use specialist nurses to work

with medical staff to demonstrate prescribed treatments. On the other hand, problems could be overcome if there were more community-based specialist skin care nurses to advise patients on the complex regimens that skin diseases require and identify underlying environmental causal elements which can cause allergic reactions. Counselling of patients can also help.

Counselling, Information and Discussion of Treatment

4.8 As every patient is an individual with his or her particular problems, there is no substitute for one-to-one discussion with a professional. It is essential that patients take an active part in preparing and agreeing their own treatment plans, and even more vital for parents to do this on behalf of their children.

4.9 Many skin conditions are chronic and time-consuming to treat, and may well mean applying creams, ointments or emollients which are socially or cosmetically unacceptable or inconvenient to use. Emollients in particular need to be used several times a day. They are often inadequately rather than inappropriately prescribed and therefore only small cost benefit results. Also, patients' behaviour, lifestyle and use of everyday products will have a profound influence on the efficacy of medical interventions. Thus it is clear that the involvement by such patients in deciding on their treatment is paramount in gaining full treatment co-operation. They are not always helped by the instructions on medicine containers - how much exactly is 'use sparingly'?

4.10 Skin diseases such as eczema, do not behave consistently and environmental factors often play a major part, so patients often have a lot to learn about managing their condition and preventing recurrences. Helping them to help themselves by carrying out the treatment most suited to them, helping them to manage their disease in the long term, generally takes a few meetings at the dermatological department, where staff should ensure that they understand the principles and practice of their treatment. This is difficult with patients who attend hospital only once and, of course, neither the small number of dermatological nurses nor district nurses are likely to have the time to provide thorough guidance. Hospital clinicians do not always appreciate the realities of their suggested treatments - for instance, after a patient with psoriasis leaves hospital, it will probably no longer be practicable to use tar-based treatments because sheets can no longer be laundered daily.

4.11 Written information is available and can greatly help towards adequate management in the community. It is important because most patients forget most of what they are told, seldom absorbing more than two pieces of information per interview. They need clear information to make informed decisions. When treatment is offered, the patient should be succinctly told, at that point, what commitment is required and warned, if appropriate, that the outcome may not be entirely successful. There should be follow-up sessions so that any problems can be discussed.

4.12 Informative leaflets, pamphlets and other literature from professional organisations and patient support groups should be much more readily available than they usually are - notoriously, some GPs are poor at distributing information. Although prescriptions are not always accompanied by written instructions, many pharmaceutical companies provide useful and instructive material, largely without the commercial bias of which they are widely suspected. Community pharmacists can also be a useful source of general information, while videos in clinics and waiting rooms and telephone help lines could be helpful too if more widely available.

4.13 Recommendation. The Group believes that the only way in which patients can be encouraged to play more of a part in their own treatments, thereby improving compliance and efficacy, is through an inclusive process involving discussion and sometimes counselling. There are no accurate estimates of wastage from treatments which don't work because of improper use or never really being used by the patient at all. However, anecdotal evidence suggests that this figure is high. We believe that it would be much more cost-effective for dermatology units to allocate resource to ensure that they have sufficient nurse specialists available to talk to patients about the practicalities of treatment. Guidance to this effect should be issued by the NHSE. The outlay involved would be relatively small for the huge benefit it would bring.

4.14 The Group is aware that insufficient use is made by GPs of the information and support provided by patient groups. The Group is aware of the very high quality information which is provided by all of the patients organisations amongst our membership together with the Skin Care Campaign. GPs should be much more aware of their services than they often are, and we recommend that this should, in future, be instilled during training. Skin charities, together with the British Association of Dermatologists, are efficient at distributing literature to GP practices. We would like to see more of it reaching patients and less disappearing into filing cabinets.

4.15 Recommendation. The suggestion has been made that membership of patient groups should be available on prescription. Whilst the Group accepts that this is an imaginative and innovative idea, we believe that the practicalities of its operation work against it. We are also unconvinced that patients would make sufficient use of it to justify the expense. However, we would be happy to consider any evidence to the contrary.

4.16 Despite the quality of much patient information, some would be still better with less use of medical jargon and technical language. In dermatology, medical terms are less descriptive than in other areas and it is harder for GPs, much less patients, to categorise diseases. An audit in one region found that GPs were unable to make the right diagnosis in 45% of cases¹⁸. There is a need for more specific information on uncommon conditions and individual treatments, and for up-to-date information on research and new treatments.

4.17 Language and cultural factors may affect the ease with which members of ethnic minorities understand and use information: some districts have acted on this but there are still too few posters, leaflets and booklets for people whose first language is not English.

The Role of Pharmacies

4.18 Despite some six million visits per week to the Nation's 12,000 community pharmacists¹⁹, their potential and expertise are generally under-estimated and under-exploited, partly because some patients cannot afford over-the-counter remedies. But pharmacies are not only good sources of information for recurrent and minor to moderate conditions, but in many cases can also give people immediate access to a healthcare professional without having to battle through an appointments system. However it should be noted that access to confidential advice in pharmacies is not always readily available or on view. Furthermore some clinicians are doubtful about their value in dermatological diagnosis and management.

4.19 The Group believes that it is important that patients are aware that advice is available from their doctors, specialists and nurses and that literature concerning their condition is often easily obtained through the surgery, clinic or community pharmacist. Consideration should be given to ways of improving this process of public education.

Improving Public Awareness

4.20 In line with the modern approach to medicine and disease, the Group is concerned about the prevention of skin disease as much as with its treatment.

4.21 There is a particular need for the public to be told about the dangers of excessive sun exposure and the consequent risk of melanoma, albeit that public awareness programmes are sometimes regarded as costly and of uncertain effectiveness. Although eminently preventable, melanoma is the second most common cause of death amongst people aged 24-35²⁰; mortality has risen by 73% since the mid-70s and incidence has risen steeply, as mentioned above.

4.22 The Group believes that public information programmes in relation to skin cancer have gained high public recognition and that, as a result of these, increasing numbers of people are now aware of the risks associated with excessive exposure to the ultra-violet rays. Public announcements at sports events and on weather forecasts about the sun's strength on a particular day have caught the public imagination and there is some evidence of compliance with the guidance issued.

4.23 Recommendation. The Group is strongly of the opinion that the Government should continue its prioritising of skin cancer under the Health of the Nation. This commitment should continue to be supported by public education programmes. However we are concerned that more impetus should now be given in these programmes to providing information which allows the public to recognise danger signs associated with malignant melanomas and other skin cancers. Many organisations are producing good guidance but we are doubtful that many members of the public know what to look for or have a high awareness of danger signals. This is particularly important since recovery rates are high if treatment is given early.

4.24 The over-riding priority in this area is to raise the profile of skin disease itself. The nature, effects of and non-infective aspects of many skin diseases needs to be brought home to the public. This might remove some of the stigma and eventually eliminate prejudice against those with skin disease. A joint Department of Health and patient's awareness campaign has been suggested. Such campaigns have been mounted in other disease areas and this idea has some merits.

High Street Skin Clinics

4.25 Patients who are desperate to be rid of unsightly or painful skin disorders do sometimes resort to high street skin "clinics". The Group is constantly told by many of its members that the value of the advice provided in many of these "clinics" is often doubtful.

4.26 Recommendation. We believe that there may be a strong case for looking at the services these establishments offer with a view to making tighter regulation. The Group will consider whether it should conduct an investigation later in the year.

Psychological Factors

4.27 A major concern for people is the social and psychological impact of living with a chronic and evident disorder of the skin in a society which lays such importance on looking good. As long as care providers continue to overlook this aspect, as they often do because of time constraints, care will not improve and patients will be left dissatisfied with the results of treatment. In some cases there will be residual scarring causing embarrassment or other psychological consequences.

4.28 There is evidence that dermatologists underestimate the psychiatric or psychological problems associated with skin conditions: the need for better liaison between psychologic and dermatological services is internationally recognised but such arrangements are rudimentary in the UK. The drive towards moving dermatology services further away from hospital-based practice may make future liaison with psychologic services even more difficult than it is already.

4.29 Note should also be taken of the valuable role played by patient groups in providing support, guidance and understanding to patients and their families of the social and psychological impact on their lives of living with these diseases.

Treatment of Leg Ulcers

4.30 Some patients lack access to the full range of products they need and, as already noted, may be unable to afford over-the-counter preparations, especially as many who do not see their doctors about their skin problems often try several different products. Indeed the Group has been informed by patient groups that, even when seeing a GP, it is invariably the case that people will try several products before finding a suitable treatment.

4.31 There are particular problems in respect of the treatment of leg ulcers. The incidence of chronic wounds is higher than generally realised - pressure sores alone cost an estimated £200 million annually and leg ulcers even more²¹. Pressure sores are not a disease in their own right, so there are few comprehensive services for their prevention and treatment. Lack of awareness of chronic wounds may be due to the isolation of individual sufferers.

4.32 The scientifically validated four-layer bandage system for chronic venous ulceration is unavailable on GPs prescription although it improves healing, reduces morbidity, saves nurses' time and saves money. GPs and district nurses can't prescribe or obtain the dressings, elastic stockings and other treatments that are available in hospitals, leaving patients who have found what they need in hospital unable to get it outside. The Group has heard that many nurses prescribe one type of bandage and swap them for three and four-layer ones. This is illegal, but difficult to condemn since it is prompted by inappropriate rules. The supply of new and better dressings is a problem in terms of who in the NHS pays for them.

4.33 Recommendation. The Group believes that the three and four-layer bandage systems and cavity dressings should be made available where needed. There should be clear agreements on the provision of commonly needed dressing materials and on the distribution of these by appropriate professionals through the Community Health Trusts.

5.0 OCCUPATIONAL DISORDERS

5.1 Occupationally caused skin problems are not uncommon and are eminently preventable. However, in the UK (unlike other countries), while there are occupational dermatologists, there is no formal qualification in occupational dermatology and general dermatologists do not always understand working environments. A network of skin clinics where there are dermatologists trained and experienced in occupational skin complaints would be invaluable. Although patch testing can be helpful in pinpointing the source of skin complaints, it is suitable only in a specialist setting and is not often performed. The Employment Medical Advisory Service can offer specialist advice and treatment centrally, but perhaps a local approach would be more logical when patients in the same organisation had similar skin problems.

5.2 Recommendation. We are concerned by evidence that doctors employed by the Employment Medical Advisory Service are not required to have any dermatology training at all and yet skin disorders will be one the main areas which they encounter. This situation needs to be corrected.

5.3 The Group will be looking further at occupational skin disorders in the coming months and will make separate recommendations once it has finished its enquiry.

6.0 IMPACT ON RESEARCH OF THE NHS REFORMS

6.1 To judge by the number of papers in specialist journals, research has certainly not dried up, but dermatology remains as it has always been, something of a research Cinderella. Most dermatological research is carried out by pharmaceutical companies but economic pressures are forcing them to focus on more lucrative areas.

6.2 Research will, however, continue to be needed over the next decade, not only for medical reasons but to help formulate public health policies that respond to increased demand for services. Yet unless there are changes in funding, it seems likely to diminish still further, even though, in dermatology, it requires less capital spending and ongoing resources than many other medical specialities. Research into the need for dermatology - why some people seek skin care and others do not - is also important.

6.3 The Group greatly welcomes the new impetus given to research by the re-launched Skin Disease Research Fund which will now be known as the British Skin Foundation.

6.4 Whilst the NHS reforms have improved accountability and costing information, they are regarded by many as having done little to improve and develop services so far as dermatology is concerned.

6.5 In large departments, there has been a polarisation of the university and NHS sides and some argue that there is less opportunity for academics to undertake clinical work and for NHS consultants to do academic research. Consultant dermatologists in teaching hospital, who would have undertaken research in the past, are now under pressure to work in the community instead, and trainees in dermatology who used to undertake research between their registrar and senior registrar appointments cannot now do so because, since the Calman Report, that gap no longer exists, although there is time before they enter dermatology or after they finish specialist training.

6.6 Purchasers and providers give low priority to dermatology and purchasers are often refusing to carry the costs of medicines used in clinical trials. Dermatology has traditionally had fewer registrars in full time research posts than other disciplines. Changes in organisation and structure affect the conduct of trials and procurement changes influence the kind of drugs being developed. The result of this will be less 'incremental innovation', that is, development of so-called "me-too drugs". Dermatological patients can benefit from these products more than most because marginal differences in products can mean the difference between a successful and an unsuccessful outcome dependent on one patient's susceptibility against another's to minute differences between apparently similar products.

6.7 The Group will also be looking further at research in a future report.

7.0 THE SELECTED LIST

7.1 The selected list, which limits the products that may be prescribed by GPs under the NHS (though not as stringently as initially proposed), have affected dermatological research in a variety of ways.

7.2 A selected list is particularly inappropriate to dermatology. Not only do skin diseases account for only 2% of the total NHS budget²², so any savings are relatively tiny, but in no other field do patients respond more differently to apparently 'identical' products because of different susceptibility to the same compounds in different patients. Acceptability is vital for effective treatment so patients' preferences, especially for topical medications, require a wide range of alternatives to be available. The point has already been made that patients often try a number of different treatments, whether consulting their GP or not, before finding one which satisfies their needs.

7.3 Generic prescribing, a major plank of the NHS reforms, is particularly unsuited to dermatological products because small chemical differences can have large effects on efficacy and side-effects. While it is unlikely that anyone will die because of generic prescribing, thousands of patients and their families are likely to endure a worse quality of life than need be.

7.4 Recommendation. The Group believes that the selected list is an unsuitable concept for most dermatology treatments and should formally be abandoned in respect of this disease area.

7.5 Together with budgeting and marketing considerations, the overall prospects are poor for dermatology, especially as commercial imperatives confine it largely to domestic 'niche' companies rather than major research-based pharmaceutical multi-nationals. Dermatological needs are served by a disproportionately large number of domestic companies. Lack of

research along with the damage inflicted by the limited list on product development will stultify treatment in dermatology more than in most other disciplines.

8.0 CONCLUSION

8.1 This report is intended as a blue-print to pave the way for improvements in dermatology service provision at all levels of the NHS in the coming years. Its preparation has taken nearly eighteen months and input was sought and received from all interested parties in the field from patients to clinicians, nursing organisations to Royal Colleges and from hospital trusts and other purchasers to the pharmaceutical industry.

8.2 The report was examined by representatives of many of these bodies prior to its publication. There is a high degree of agreement amongst them as to the appropriateness of most of the recommendations within it.

8.3 The report also enjoys the support of the officers of the All Party Group on Skin, which commissioned it, representing cross-party agreement. The Group numbers amongst its membership 40 MPs and Peers from all the main political parties. Its non-parliamentary membership includes nearly 100 bodies and individuals covering all the main interest groups associated with health care in the UK.

8.4 It is the Group's intention to monitor the progress made in implementing these recommendations contained in this report over the next Parliament.

Access to all parts of the oral and written evidence is available on request to the Group's Administrative Secretary on 0181 789 2798.

ENDS

Parliamentary All Party Group on Skin,
9th March 1997

Appendix One

References

All references are drawn from oral and written evidence available from the Administrative Secretary on 0181•789 2798

1. Oral evidence - 21.3.96; p.2.. **Williams HC.**
2. Health Care Needs Assessment: Dermatology; p.37 (5.7). **Williams HC. NHS Research and Development Division, 1996.**
3. **Ibid;** p.6.
4. **Ibid;** p.20.
5. Written evidence from **Timmis JB.** Whittington Hospital, London; 25.11.95; p.2.
6. Health Care Needs Assessment: Dermatology; p.34 (5.4). **Williams HC. NHS Research and Development Division, 1996.**
7. Written evidence from **Lawlor F.** Newham General Hospital, London; 13.12.95; P.1.
8. Written evidence from **DEBRA;** 23.11.95; p.1.
9. Oral evidence - **various witnesses.**
10. Oral evidence - **various witnesses.**
11. Health Care Needs Assessment: Dermatology; p. 29 (5.4) and Table 4. **Williams HC. NHS Research and Development Division, 1996.** Also: written evidence from the **British Association of Dermatologists;** 24.1.96; p.1. And: **Catterall. M.** Basildon and Thurrock General Hospitals, Essex. Evidence No.43; 1.12.95; i.
12. **APG on Skin** newsletter - No 4; December 1995; p. 6.
13. Written evidence from **Mendelsohn SS.** Countess of Chester Hospital, Chester; 23.1.96; p.1.
14. Health Care Needs Assessment: Dermatology; p.33. **Williams HC. NHS Research and Development Division, 1996.**
15. **Skin Care Campaign;** 7.12.95; p.3.
16. Written evidence from **Elvy BL.** Oak Street Medical Practice, Norwich; 29.1.96; p.4.
17. Health Care Needs Assessment: Dermatology; pp.13-18. **Williams HC. NHS Research and Development Division, 1996.**
18. **Basarab et al. British Journal of Dermatology 1996;** 135:70-73. Cited in oral evidence - 9.5.96; p.4. **McGibbon D,** St Thomas's Hospital, London.
19. Oral evidence - 7.12.95; p.2. **Stewart B.**
20. Written evidence from **Timmis JB.** Whittington Hospital, London; 25.11.95; p.2.
21. The Hidden Epidemic. Written evidence from the **Tissue Viability Society,** Salisbury; 1996; p.1 (3).
22. Health Care Needs Assessment: Dermatology; p.35. **Williams HC. NHS Research and Development Division, 1996.**

Appendix Two

List of Oral Evidence Witnesses

First Session: 7th December 1995

Ms Tina Funnell, Chief Executive, SCC & NES
Dr Patrick Gray, Dermatology GP of the Year
Mrs Barbara Stewart, Pharmacy Practice Consultant
Ms Lyn Stone, Chairman, RCN's Dermatology Nurses Group

Second Session: 21st March 1996

Dr Tim Mitchell, Secretary, Primary Care Dermatology Society
Dr Hywel Williams, Consultant Senior Lecturer in Dermatology, Queen's Medical Centre, Nottingham
Dr John Williamson, Consultant Dermatologist, Amersham General Hospital

Third Session: 9th May 1996

Dr John Cotterill, Medical Director, Lasercare Clinics
Dr David McGibbon, Clinical Director, St John's Institute, St Thomas's Hospital, London
Dr Simon Stevens, Director of Acute Commissioning, Brighton & Hove FHSA

Appendix Three

List of Written Evidence

Organisation/Individual	Evidence Number
Dr E D Harlow	1
British Association of Dermatologists	2
North West Regional Health Authority	3
Dr S I L Higgs	4
Norfolk & Norwich NHS Trust	5
Southend NHS Trust	6
Queen's Medical Centre, Nottingham	7
Cannock Chase Hospital	8
Northgate Village Surgery	9
Redbridge & Waltham Forest Health Authority	10
Association of Community Health Councils	11
Dr Gerry Nevitt	12
Skin Care Campaign	13
EnviroDerm Services	14
Dr C G Traill	15
Priory Road Surgery	16
Royal College of Nursing	17
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Dr R G Moore	19
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Health Visitors' Association	22
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Royal Pharmaceutical Society of GB	29
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Central Sheffield University Hospitals	31
Psoriatic Arthropathy Alliance	32
Ehlers-Danlos Support Group	33
British Dermatological Nursing Group	34
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