REPORT ON THE ENQUIRY INTO PRIMARY CARE DERMATOLOGY SERVICES

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A REPORT OF THE ASSOCIATE PARLIAMENTARY GROUP ON SKIN

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1.0 Background

1.1 In July 2000, the Government published the NHS Modernisation Plan for investment in and reform of the NHS. It noted that the development of primary care services was key to the modernisation of the NHS, and several Government initiatives focused on primary care have since been established.

1.2 Although many skin diseases are managed mainly in primary care, dermatology is one area where secondary care waiting times remain long. In recognition of this, the Government noted that changes in primary care would help ease the pressure on hospitals so that they could concentrate on providing appropriate specialist care.

1.3 The Action on Dermatology programme implemented in August 2000 as part of the NHS Modernisation Plan, was established to cut waiting times, streamline care and improve dermatology services. This programme has been welcomed enthusiastically throughout all sections of the dermatology community.

1.4 In response to these initiatives, the Associate Parliamentary Group on Skin decided to consider further the services available in primary care for dermatology patients and the problems that need to be considered and resolved.

1.5 A specialist advisory committee was established to guide the Associate Parliamentary Group in its enquiry. Members of this committee are listed in Appendix Two.

1.6 The Associate Parliamentary Group on Skin accumulated a considerable amount of evidence (listed in Appendix Three) from GPs, nurses, pharmacists, other health professionals, pharmaceutical companies and patient groups.

1.7 The Group also took oral evidence from a series of witnesses in July and October 2001. A list of these witnesses is set out in Appendix One.

2.0 Summary

2.1 It is estimated that a third of the population suffer from skin conditions at any one time in the UK, and skin diseases account for around 15% of a GP's workload.

2.2 Virtually all of these conditions are managed in primary care. Yet dermatology remains an area in which there are high levels of referral to specialist services, and this demand for services outweighs capacity.

2.3 The evidence received maintained that skin diseases could be better managed in primary care, but better management was hindered by the continued lack of appropriate training in the primary care setting. Diagnosis is key to managing skin conditions and although these are seen first in a primary care setting, primary care health practitioners are under no obligation to have training in dermatology.

2.4 Although the Government has noted the use of specialist GPs to take referrals for specialities such as dermatology, as well as nurse-led clinics, concerns have been raised that this should not diminish the need for all primary healthcare practitioners to be required to have training in dermatology. In addition, the dermatology community, particularly patients, requires assurance that those nurses who are able to prescribe dermatological treatments have received dermatology training as part of their course.

3.0 Definition of Primary Care and Primary Care Practitioners

3.1 Definitions of primary care varied throughout the evidence received. Many suggested that primary care represented all healthcare professionals who were outside the hospital arena; others suggested that primary care was simply patients' first port of call for any condition. Primary care practitioners were described as pharmacists, GPs and nurses, as well as family, carers and oneself.

3.2 For the purposes of this enquiry, the definition of primary care from the WHO declaration of Alma-Ata Teamwork in primary healthcare, was used: 'Primary care is the first level of contact of individuals, the family and community with the national health system bringing healthcare as close as possible to where people live and work, and constitutes the first element of a continuing healthcare process.'

3.3 There was some discussion about whether services such as NHS Direct and NHS Direct Online should be considered primary care services. Although these health initiatives do not offer continuing healthcare, in many cases people do use them for information and in some cases advice. However, there is an awareness that proper diagnosis using these routes is difficult.

3.4 The report focuses on primary care practitioners based in the NHS and there is a heavy emphasis on GPs, primary care nurses and pharmacists, which reflects the nature of the evidence received for this enquiry.

4.0 The Scale of the Problem

4.1 Skin disease accounts for around 15% of a GP's workload and 6% of GP prescriptions relates to skin disease.

4.2 Skin disease affects around 33% of the population at any one time; therefore GP consultations reflect a fraction of the problem. The first ports of call for many people seeking help with skin diseases are often their pharmacist, NHS Direct or the internet. Of 66% of calls to NHS Direct that are triaged by nurses, almost 8% relate to skin problems, a higher proportion being for children than for adults.

4.3 Virtually all skin diseases are seen and managed initially in primary care. However, 76% of dermatology consultations in primary care arise from a small number of conditions: eczema, psoriasis, acne and leg ulcers. The prevalence of atopic eczema in children is around 15–20% and is increasing. Psoriasis affects 2% of the population and

for the majority of those it is a chronic disease. Acne requiring a GP consultation and prescription-only medication is present in 14% of those in the 15–24 age group.

4.4 Also commonly seen are infections (e.g. impetigo and dermatophyte infections), infestations (e.g. head lice and scabies), urticaria, rosacea, herpes simplex, shingles, vascular lesions, benign skin tumours (e.g. warts, skin tags, seborrhoeic warts, benign moles), pre-malignant conditions (e.g. solar keratosis and Bowen's disease), non-melanoma skin cancer and malignant melanoma.

4.5 Although some skin diseases are not perceived to be serious in clinical terms, the stigma they impose can cause anxiety out of all proportion to their severity. It is not just in the more serious cases and potentially fatal conditions such as skin cancer and Epidermolysis Bullosa that skin diseases can be physically disabling, disfiguring, painful, intensely irritating and distracting. The quality-of-life issues associated with them can be very damaging, including significant sleep loss; severe disruption of family life; discrimination, teasing and bullying in schools; difficulty in obtaining employment; prejudice at work; and severe problems in forming social relationships. There is research evidence to show significant increases in behavioural problems in children with some skin diseases and similarly significantly increased suicide rates in adults.

4.6 With adequate training and resources, most skin disease can be treated in primary care. Those needing referral to secondary care include most skin cancers; severe cases of eczema, psoriasis and acne requiring potentially toxic medication such as methotrexate, oral isotretinoin or cyclosporin; life-threatening rashes such as erythroderma, pemphigus and pemphigoid; and difficult rashes posing diagnostic problems beyond the skill of an adequately trained GP. These probably account for less than 10% of all skin disease.

4.7 The proportion of patients referred to secondary care varies considerably, depending on the skills and confidence of the GP. Overall, around 5% of all skin patients seen by GPs are referred. The initial findings of the National Institute for Clinical Excellence's pilots of its referral guidance for acne, childhood atopic eczema and psoriasis are likely to indicate that more appropriate referral would increase this percentage.

4.8 Protracted waiting times are frustrating and distressing for dermatology patients. Although the conditions are rarely life threatening, skin diseases have a huge negative impact on the quality of all aspects of patients' lives, including employment.

4.9 Excessive waiting times appear to be caused chiefly by two factors – inadequate GP training in dermatology and a serious shortage of consultant dermatologists.

4.10 Over the past three years, NHS trusts have been set increasingly stringent annual targets for the reduction in size and length of outpatient waiting lists. Although most trusts have met them through the development of additional short-term capacity and through administrative efficiencies, the improvements are generally not sustainable. Waiting times tend to increase when the temporary capacity is removed from the system. Staff have expressed concerns that the focus on long-wait patients can distort clinical

priorities and that waiting times for minor surgery or light treatment have risen as a consequence of the increased throughput.

4.11 Concern has been expressed that the requirement for suspected cases of skin cancer to be seen in secondary care within two weeks may be extending waiting times for people with inflammatory skin diseases. Evidence of this has been difficult to obtain because the picture has been distorted by the short-term initiatives described above.

4.12 The NHS Modernisation Plan sets targets for a reduction of the maximum wait for an outpatient appointment in any speciality to three months by the end of 2005. In the financial year 2001–02, interim targets include reducing the number of patients waiting over 13 weeks to below the March 2001 target levels set for each NHS trust, and the achievement of a maximum waiting time of 26 weeks by March 2002.

4.13 Overall, figures for England suggest that there is a downward trend in the numbers of patients experiencing long waits. The number of dermatology patients experiencing a wait of over 13 weeks was at its lowest level for several years at the end of March 2001 when, in England, 19,274 patients were waiting for up to 13 weeks to be seen and 14,529 were waiting for between 13 and 25 weeks. Predictably, this latter figure rose again in the first quarter of the financial year 2001–02 as short-term capacity was wound down.

4.14 The position in respect of patient numbers waiting over 26 weeks is slightly different and shows a steady reduction from a peak of over 15,000 in March 1999 to 4,718 in March 2001. Despite this general improvement, dermatology remains one of the four specialities with the highest number of long waits, the other three being ophthalmology, ENT and orthopaedics. Between them, these specialities account for nearly half the overall number of such patients.

4.15 Location variations in referral speed between primary and secondary care are widespread. These variations are usually a result of organisational differences rather than system differences.

5.0 Training of Primary Care Practioners

5.1 As has already been noted, dermatology training for primary care health professionals is wholly inadequate. Almost all of the evidence made this clear, especially in respect of GP training. A recent study noted that the most common reason for referral to secondary care was lack of knowledge, followed by lack of facilities and lack of time.

5.2 In July 1998, the All-Party Parliamentary Group on Skin (APPG) published a report on training of health professionals who come into contact with skin diseases. It made a number of recommendations, many of which have not been implemented but remain valid in the view of the expert group.

5.3 Since publication of the 1998 report, there has been very little progress apart from the publication of the core curriculum for GP registrars, produced jointly by the British Association of Dermatologists (BAD) and the Royal College of General Practitioners

(RCGP) in 1998 and issued by the RCGP. A further report, entitled ‘Learning General Practice Dermatology’, considered how this core curriculum might be delivered, and provided best-practice guidelines for teaching.

5.4 Despite these efforts, it remains the case that medical schools and their students fail to recognise the importance of dermatology training for health professionals working in primary care, and thus this training in medical school is still wholly inadequate. There is no formal requirement for primary care health professionals to have been trained in dermatology.

5.5 Two surveys carried out in 2000, one of consultant dermatologists conducted by the BAD and one of medical college deans conducted by the Skin Care Campaign (SCC) and Ash Communications, showed that at the time, the documents had had no effect on GP training.

5.6 The RCGP’s curriculum is suitable but there is no organisational backup to implement it. GP registrars’ training will be altered to move away from the two years in hospital one year in practice split to allow for 18 months in practice, and this extra time could be used to gain experience in dermatology. It would, however, take a change of the regulations to make this compulsory. At present the Department of Health regulates GP registrar training through the Joint Committee on Postgraduate Training in General Practice.

5.7 Nurses and pharmacists can undertake their initial education and training with little reference to skin diseases. Podiatrists deal with the problem of the foot and lower leg and do have mention of relevant diseases in their training but no specific mention of a basic grounding in skin diseases is made.

Resources for Training

5.8 No specific resources are made available to train primary care professionals in dermatology. Much is made of the role of consultant dermatologists but they are too few in number to have the time available, even though the numbers suggest an annual ratio of four GP registrars to one consultant. If more consultant posts were created, this could allow for teaching in outpatient clinics but this would, by nature, be biased towards secondary care.

5.9 GPs with an interest in dermatology receive further training and education as clinical assistants and hospital practitioners in hospital dermatology departments. These GPs have become very experienced health practitioners in dermatology. However, at present, the fee paid for clinical assistants does not cover the cost of locum cover in the GP’s practice. These GPs continue to improve their skills and knowledge at a financial loss to their practice, and despite the fact that there is no formal training or accreditation process. An immediate review of these payments, and adjustment of them to make work as a clinical assistant both realistic and attractive, is highly recommended.

5.10 Once GPs are fully qualified they are expected to develop their own programme to continue professional learning. The emphasis is now moving towards mentoring and personal learning plans that take into account areas of weakness, and away from attending a series of lectures. This should lead to more training being taken up after qualification and groups such as BAD, the Primary Care Dermatology Society (PCDS) and the British Dermatological Nursing Group (BDNG) could provide advice on preparing suitable learning packages. As more GPs become better trained, they should then be able to pass this on to registrars.

5.11 Diploma courses for GPs in dermatology do exist and are successful enterprises. A one-year distance course, including some practical teaching, is run by the University of Wales at Cardiff. In addition, there are proposals for courses at St Bartholomew's and the Royal London School of Medicine. The Royal College of Physicians and the Surgeons of Glasgow also offer a Diploma in Dermatology by examination. If the Government plans to encourage GPs to develop a special interest in dermatology, there is a clear need for more courses like these.

5.12 Nurses have less opportunity than GPs for continued professional development. Primary care nurses can be divided into those who are employed directly by GPs and those who are employed by a local trust and attached to particular practices or geographical areas. At present, the trusts are largely hospital-based, but the move towards primary care trusts and bodies should take nursing management and administration out into the community where the nurses actually work.

5.13 Primary care nurses may have difficulty, especially given the time involved, in continuing professional development after qualification, although courses in dermatology for nurses do exist. A proper structure for funding study-leave needs to be established and offered to both GPs and nurses in order for them to take advantage of these initiatives. In addition, due to the difficulty in accessing professional development outside the workplace, more imaginative ways of tackling it should be considered, including distance learning, CD ROMs, videos, mentor support and internet courses.

5.14 Pharmacists and podiatrists may also be employed by trusts and the same study entitlements should apply. Pharmacists working for large-chain pharmacies often have a requirement to undertake continuing professional development as a condition of their employment; this should include dermatology. Self-employed pharmacists and other single-handed pharmacist managers find it much more difficult to take time off during the working day; funding should be provided to cover locum requirements and to enable them to study without jeopardising the financial viability of the pharmacy. The amounts involved are very small and the potential gains large.

6.0 Improving Dermatology Services in Primary Care

Standards of Services

6.1 Dermatology services should provide seamless care. Patients should recieve continuing care in the community with appropriate and speedy access to secondary care when necessary. Such services should be jointly planned between primary and secondary

care, taking into account the needs of the local population. Liaison nurses and outreach clinics may provide opportunities for improving communication and a sense of shared care.

6.2 Standards of dermatology services in primary care vary throughout the country, as do referral systems between primary and secondary care. National Service Frameworks (NSFs) have promised to improve the quality and consistency of services for other conditions such as cancer, paediatric intensive care, mental health and coronary heart disease. It is most unlikely that the proposed development of an NSF for long-term medical conditions, focused on neurological conditions, would be of significant benefit to people with skin diseases, especially as its remit remains unclear and confusing. Patients would, however, benefit greatly from the development of an NSF for diseases of the skin.

6.3 The Action on Dermatology Programme, operating under the auspices of the National Patients Access Team, is improving dermatology services substantially. The appointment of a senior director to manage it has greatly improved relationships and co-operation between skin patients and health professionals concerned with dermatology on the one hand and the Government on the other.

Recommendations

- Consideration should be given to setting national standards through a National Service Framework for diseases of the skin.
- A permanent post should be established within the Department of Health to ensure that the work being done by the Action on Dermatology Programme continues, and to provide a point of continuing contact between the department and its stakeholders within dermatology.

Training

6.4 Training for all healthcare professionals at pre- and post-registration stage, and at basic and specialist level, is required. The recommendations from the All-Party Parliamentary Group report into the adequacy of training of healthcare professionals (1998) should be implemented. This will help to improve care offered to dermatology patients in the community.

6.5 Following the publication of the 1998 report, a core curriculum was developed identifying the dermatology training that should be included in pre-registration medical student training. To date, medical schools have not incorporated this advice into their curriculums. Unless this is addressed, primary care dermatology services will not be improved.

6.6 Adequate resources need to be made available for continued development for all healthcare professionals. Further training involves time, equipment and extra manpower. In particular, educational funds should be made available and further consideration should be given to the remuneration of hospital practitioners and clinical assistants who have developed their skills in dermatology. At present, the remuneration received for this

work does not cover their GP locum fees. In addition, we recommend that paid study-leave be provided for nurses.

6.7 Some initiatives to encourage GP training are being developed. In particular, a small working group led by Dr Margaret Price has been put together to work on GP training and encourage one consultant dermatologist and one Primary Care Dermatology Society member in each of BAD's regions to become GP training leads. The objective is to ensure that every GP registrar on a vocational training scheme is aware of the core curriculum in dermatology and has access to both a basic course in dermatology and a clinical attachment in dermatology. If GPs become specifically interested in dermatology, they are more likely to be encouraged to move from basic training to training as a GP with a special interest.

Recommendations

- The Government should place more pressure on the General Medical Council, which defines the core curriculum for undergraduate degrees, to ensure that medical schools and universities include dermatology at the undergraduate and postgraduate level.
- The Group welcomes the development of a Medical Education Standards Board, as set out in the NHS Modernisation Plan, to ensure that interests of patients and the service needs of the NHS are fully aligned with the development of the curriculum and approval of training programmes. When the new board is established, the dermatology needs of patients should be considered as a priority, and a patient representative should be included on the board.
- The provision of resources for professional development and locum fees for hospital practitioners and clinical assistants should be reviewed. Any specialised community clinic providing an intermediate level of care for skin diseases should have funding to allow for training of other primary care staff.
- Paid study-leave should be provided for nurses. Further consideration should be given to locum cover or fees for self-employed pharmacists to continue their training.
- The recommendations from the APPG report on the training of health professionals who come into contact with skin disease should be implemented.

Primary Care Models

6.8 The Dermatology Care Working Group, chaired by the Skin Care Campaign, has published a report entitled 'Assessment of Best Practice for Dermatology Services in Primary Care'. It includes 25 examples of ways in which dermatology services may be provided in primary care that the Group applauds.

6.9 No one model for primary care dermatology services can suit all areas. It is desirable, however, that these services should work to objectives similar to those set out in this section. As the roles of primary care professionals develop and change, so will the configuration of these services. The devolving of prescribing rights to nurses and some pharmacists is imminent. This, along with other changes, emphasises the need for flexibility, adaptability and a willingness to modify models and practices as local services evolve.

6.10 This report does not aim to recommend specific models, but acknowledges that there is likely to be development at different levels. Some community services will develop specialist knowledge and specialist services.

Recommendation

- Primary care models should be adaptable to local needs and, despite local differences, efforts should continue to spread best practice. The 'Assessment of Best Practice for Dermatology Services in Primary Care' provides models that can be adapted to local circumstances and needs, and should be available for consideration by all Primary Care Organisations (PCOs).

Dermatology Specialists

6.11 The NHS Modernisation Plan noted that up to 1,000 specialist GPs would be taking referrals from fellow GPs for conditions in specialities such as dermatology. It is essential that the creation of specialist GPs and nurses in the community should not detract from the need for all primary care staff to improve their dermatology knowledge and skills.

6.12 The development of GPs with a special interest would benefit dermatology. This role will cover many different specialities, and projects have already been set up to provide an intermediate level between primary and secondary care. GPs in these posts often have a postgraduate qualification in dermatology and experience working in the hospital setting as clinical assistants. They work in conjunction with specialist dermatology nurses and should improve the care of patients with chronic skin diseases. Primary care staff should be able to spend time in these clinics, learning more about managing patients with skin diseases and taking the knowledge and experience gained back to their individual practices.

6.13 Nurses who develop a special interest and ability in dermatology will greatly increase the potential for community services to meet the needs of their patients. The provision of specialist nurses should be encouraged, and appropriate training and support be made available.

6.14 Provision of specialist GPs and nurses should take account of local needs and practices and should not be nationally standardised.

Recommendations

- Specialist dermatology community provision should be encouraged and developed. However, for this to happen, training needs to be available and this will often come from expertise in secondary care. There must be continued investment in secondary care expertise, i.e. consultant dermatologists and specialist and consultant dermatology nurses.
- Where specialist services are not developed, training is still required to ensure that healthcare professionals can manage the majority of common chronic diseases seen in their practices.

Prescribing

6.15 Pharmacists are frequently the first ports of call for people with skin diseases. Many people with skin diseases benefit from informal access to the healthcare system, for example when seeking advice from pharmacists on self-treatment. Pharmacists' ability to assist self-treatment has expanded with the increasing range of topical pharmacy-only products available for recommendation; and, of course, pharmacists fill all prescriptions for skin treatments.

6.16 Pharmacist prescribing is currently the subject of a formal consultation being undertaken by the Department of Health. The aim is to maximise benefit to patients and the NHS through increased flexibility in use of workforce skills. This applies equally to nurses and pharmacists. It is envisaged that supplementary prescribing by pharmacists should follow initial diagnosis by a doctor and could involve adjustment and amendment of initial prescriptions. This, in effect, would be a voluntary prescribing partnership between an independent prescriber and a supplementary prescriber to implement an agreed treatment plan for an individual patient, usually in relation to a long-term condition. The Group welcomes these initiatives, which will benefit sufferers from chronic skin conditions.

6.17 Nurses have leading roles to play in the treatment and management of skin diseases. Many of the treatments for such diseases can safely be prescribed by appropriately trained nurses. The Group therefore welcomes the Government's plans to enable nurses to issue prescriptions and suggests the nurse-prescribing formulary be reviewed frequently and regularly to ensure that nurse prescribers have access to the widest possible range of treatments for skin diseases.

6.18 Nurses who are given the right to prescribe should have appropriate training in dermatology if they are to prescribe treatments for skin diseases and conditions.

6.19 Further consideration should be given to allowing GPs to prescribe certain secondary-care medications, including more potent treatments such as isotretinoin for acne.

6.20 An MCA reclassification of some licensed medicines, including topical steroids, could facilitate the public's access to more potent treatments for commonly occurring skin conditions. Access to information and advice from pharmacists at the point of purchase will be an important feature of such developments.

Recommendations

- The Group supports the development of nurse and pharmacist prescribing, on the basis that this is supported with appropriate training. It is imperative that nurses who are prescribing treatments for skin disease have sufficient training in dermatology.
- Many treatments for skin diseases such as emollients and mild topical corticosteroids are relatively benign but important treatments, and we would wish to see pharmacists with appropriate training and within certain constraints given the authority to (a) fill repeat prescriptions, (b) vary prescriptions within certain categories of treatment, e.g.

emollients, to enable patients to find those that suit them best and thus to increase compliance, and (c) to prescribe such treatments themselves.

- The nurse-prescribing formulary should be reviewed frequently and regularly, to ensure that nurse prescribers have access to the widest possible range of treatments for skin diseases.

Information and Research

6.21 People with chronic skin diseases benefit greatly from sound information and support. This takes time that primary care health professionals generally lack. Skin patient support groups are well equipped to provide this service.

6.22 There is good evidence to show that lay-led self-management programmes can improve clinical outcomes, patient satisfaction and quality of life, and that they can reduce the health service burden. Chronic skin diseases lend themselves well to such programmes. The Group therefore welcomes the Government's commitment to the Expert Patient programme.

6.23 More funding should be made available for research into primary care dermatology services.

6.24 Research in primary care should be encouraged through formal links with hospital-based research departments.

Recommendations

- Primary healthcare professionals should be encouraged to direct people with chronic skin diseases, or those who care for such people, towards the relevant skin patient support group.
- Skin diseases should be included in the Government's Expert Patient programme from the outset.
- Consultant dermatologists should be encouraged to include primary healthcare professionals and expert patients in research units.
- More funding should be made available for primary care based research because most skin diseases are treated in this setting.

Teledermatology

6.25 There is some agreement in the dermatology community that teledermatology can be useful in certain circumstances, specifically in remote communities. Teledermatology initiatives should proceed with caution. Careful evaluation of services is required to assess whether they do have a positive impact on patient care.

Action on Dermatology

6.26 Concerned by long waiting times to see a consultant dermatologist, and recognising that substantially more could be practised in primary care, the Government's Action on Dermatology programme, begun in August 2000, is working towards changing the pattern

of dermatology services. The programme envisages having GPs with a special interest in dermatology and specialist dermatology nurses, and an improvement in the interface between primary and secondary care.

6.27 In 2001, the programme made significant funding available for dermatology facilities, but not for staff. Similar funding for facilities is being made available in 2002–03. The main thrust of the Action on Dermatology programme is through 15 pilot sites, which are developing and testing different patterns of dermatology service delivery. The success of the pilot sites, and their later rolling out to other services throughout England, depends on the development of GPs and nurses with a special interest in dermatology. These people need to be trained but, realistically, the only group who can train them are consultant dermatologists and specialist dermatology nurses.

Recommendations

The Group welcomes this Government initiative but sees it as important to ensure that:

- in addition to meeting the Government's waiting-time requirements, the programme delivers real, consistent and sustainable improvements in dermatology services
- the programme marks the beginning of continuous Government commitment to the provision of proper dermatology services, rather than being a short-term solution to a politically inconvenient waiting-times problem
- funding should be extended to cover staff because primary care does not have the level of staffing required to maximise the use of new facilities
- GPs with a special interest in dermatology are not regarded, either by Government or by other GPs, as reducing the need for all GPs to receive proper training in dermatology
- growth in the numbers of GPs with a special interest in dermatology is not used to justify any erosion of the number of consultant dermatologists the Government has agreed to be necessary. As has already been noted, there are far too few at present. The Workforce Numbers Group (formerly known as SWAG) has agreed that 835 consultant dermatologists are needed; there are 465 currently practising. In addition to the increased training work that will be required of consultant dermatologists in order to train GPs with a special interest, the whole thrust of the development of higher quality dermatology services is leading to the necessity for development of further sub-speciality dermatology clinics, for example in paediatric dermatology, occupational dermatology, inflammatory disease clinics and pigmented lesion clinics. These demand more consultant dermatologist input, not less.

7.0 Conclusions

7.1 Several key messages emerged from the evidence received by the enquiry. Although there was a general enthusiasm for Government initiatives such as the Action on Dermatology programme, nurse prescribing and GP specialists, this was also linked to some concerns.

7.2 Specifically, issues were raised over the accreditation process for GP specialists, the training and formulary for nurse prescribers and the outcomes of the Action on Dermatology programme. The report makes a number of recommendations, which address these concerns.

7.3 The overwhelming concern in virtually all the evidence received was the continued lack of training that primary care practitioners receive in dermatology. Previous APGS reports have highlighted this problem and improvements in the training of health professionals remains key to improving the management and treatment of skin diseases in primary care.

7.4 In order to tackle the problems in the long-term management of skin conditions and diseases, the Government needs to be more involved in the training requirements for medical students, who will become NHS GPs and nurses, to ensure that the services they provide will coincide with the primary care services required. Ministers should be exerting more pressure on the bodies, such as the General Medical Council, that decide the core curriculums for medical students. This should be linked with innovative schemes and incentives for continued training in dermatology at the postgraduate level and beyond.

7.5 The Government's Action on Dermatology initiative has provided a good initial approach to dealing with some of the problems facing primary care dermatology services specifically, but the programme is finite and has a defined remit. Given the lack of consultant dermatologists in the UK and the high prevalence of skin conditions, it is imperative that the Government's efforts in dermatology maintain momentum in order to produce significant benefit for dermatology services. Further research or focus on training of primary care health practitioners is key and the appointment of a dermatology official or tsar to continue to assess the work of Action on Dermatology, spread best practice in primary care and set national standards, would benefit dermatology and the serious problems the speciality faces.

APPENDIX ONE
WITNESSES PROVIDING ORAL EVIDENCE

July 2001
Dr Thomas F. Poyner – Vice-Chairman, Primary Care Dermatology Society
Dr Mike Sadler – Medical Director to NHS Direct Hampshire & Isle of Wight; Medical Adviser to NHS Direct Online

October 2001
Christine Clark – Pharmaceutical Consultant
Ray Jobling – Chair, Psoriasis Association
Gill Rolfe – Dermatology nurse specialist for the Primary Care Group, Wellingborough

APPENDIX TWO
SPECIAL ADVISERS TO THE ENQUIRY

Dr Tim Mitchell – Group Chairman, Secretary, Primary Care Dermatology Society
Peter Lapsley – Chief Executive, Skin Care Campaign

Rebecca Penzer – International Project Co-ordinator (Skin Care), University of Southampton, School of Nursing and Midwifery; Treasurer, British Dermatological Nursing Group
Barbara Stewart – Pharmacy Practice Consultant; pharmacist member of the Expert Scientific Committee of the National Eczema Society.

APPENDIX THREE
LIST OF WRITTEN EVIDENCE

Organisation	Evidence Number
Winifred Farrell RGN, University of Huddersfield	01
Margaret Price MA FRCP, Brighton General Hospital	02
Dr A.L. Wright, St Luke's Hospital, Bradford	03
Mrs Marilyn Sherlock, Institute of Trichologists	04
Dr K.L. Dalziel, BAD	05
Dr U. Kumar, Medina Medical Centre, Luton	06
Dr Stephen Hayes, Botley, Hants	07
Dr David Gawkrodger, Royal Hallamshire Hospital, Sheffield	08
Dr J.C. Young, Norwood Medical Centre, Barrow-in-Furness	09
Dr Dilys Harlow, Southmead Health Centre, Bristol	10
Dr Thomas Poyner, Queens Park Medical Centre, Stockton-on-Tees	11
Professor Yvonne Carter, Barts and the London NHS Trust	12
Dr Peter Slimmings, Stoke Road Surgery, Cheltenham	13
Dr Inma Mauri-Solé, Bath	14
Professor John Hawk, St Thomas' Hospital, London	15
Dr A. Blake, Spa Medical Practice, Droitwich	16
A. Roger Green FRCS, British Association of Plastic Surgeons, London	17
Dr T.S. Ravindran, East Park Medical Centre, Wolverhampton	18
Dr Peter Thornton, Carnoustie Medical Group, Carnoustie	19
Dr W.I. Henderson, Kingsway Medical Practice, Glasgow	20
Dr Rino Cerio, Barts and the London NHS Trust	21
Dr David Paige, Barts and the London NHS Trust	22
Sandra Lawton, Queen's Medical Centre, Nottingham	23
Dr Pamela Cribb, St Woolas Hospital, Gwent	24
Dr Waseem Chaudhry, Ty Bryn Surgery, Gwent	25
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APPENDIX FOUR
SUMMARY OF MAIN RECOMMENDATIONS

STANDARDS OF SERVICE

- Consideration should be given to setting national standards through a National Service Framework for Diseases of the Skin.
- A permanent post should be established within the Department of Health to ensure that the work being done by the Action on Dermatology Programme continues and to provide a point of continuing contact between the department and its stakeholders within dermatology.

TRAINING

- The Government should place more pressure on the General Medical Council, which defines the core curriculum for undergraduate degrees, to ensure that medical schools and universities include dermatology at undergraduate and postgraduate levels.
- The Group welcomes the development of a Medical Education Standards Board. When the new board is established, the dermatology needs of patients should be considered as a priority and a patient representative should be included on the board.
- The provision of resources for professional development and locum fees for hospital practitioners and clinical assistants should be reviewed.
- Paid study-leave should be provided for nurses and further consideration should be given to providing locum cover or fees to assist self-employed pharmacists to continue their training.
- The recommendations from the 1998 APPG Report on the training of health professionals who come into contact with skin disease should be implemented.

PRIMARY CARE MODELS

- The report entitled 'Assessment of Best Practice for Dermatology Services in Primary Care' provides models that can be adapted to local circumstances and needs, and should be available for consideration by all primary care organisations.

DERMATOLOGY SPECIALISTS

- Specialist dermatology community provision should be encouraged and developed. However, for this to happen training must be available and this training will often come from expertise in secondary care. Continued investment in secondary care expertise, i.e. consultant dermatologists and specialist and consultant dermatology nurses, is essential.

• Where specialist services are not developed, training is still required to ensure that healthcare professionals can manage the majority of common chronic diseases seen in their practices.

PRESCRIBING

• It is imperative that nurses who are prescribing treatments for skin disease have sufficient training in dermatology.
• Pharmacists with appropriate training and within certain constraints should be given the authority to (a) fulfil repeat prescriptions (b) vary prescriptions within certain categories of treatment, e.g. emollients, to enable patients to find those that suit them best and thus to increase compliance, and (c) to prescribe such treatments themselves.
• The nurse-prescribing formulary should be reviewed frequently and regularly to ensure that nurse prescribers have access to the widest possible range of treatments for skin diseases.

INFORMATION AND RESEARCH

• Primary healthcare professionals should be encouraged to direct people with chronic skin diseases, or those who care for such people, towards the relevant skin patient support group.
• Skin diseases should be included in the Government's Expert Patient Programme from the outset.
• Consultant dermatologists should be encouraged to include primary healthcare professionals in research units.
• More funding should be made available for primary care based research because most skin diseases are treated in this setting.

ACTION ON DERMATOLOGY

The Group welcomes this Government initiative but regards it as important to ensure the following:
• The programme marks the beginning of continuous governmental commitment to the provision of proper dermatology services.
• Funding is extended to cover staff because primary care does not have the level of staffing required to maximise the use of new facilities.
• Growth in the numbers of GPs with a special interest in dermatology is not used to justify any erosion of the number of consultant dermatologists the Government has agreed to
be necessary.