



Making real our shared vision for the NHS: optimising the treatment and care of people with long-term skin conditions in England

A report developed by an independent expert working group, supported by the ABPI Dermatology Initiative



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The views expressed in this report are those of the independent Expert Working Group (EWG) members, with report drafting overseen by the members of the Association of the British Pharmaceutical Industry Dermatology Initiative (ABPI DI). This report does not reflect the views of any individual ABPI DI member company.

This report and the service evaluation within it have been commissioned and fully funded by the members of the ABPI DI. The ABPI DI was convened in 2014 – 2017 and has included the following member companies: AbbVie, Almirall, Celgene, Eli Lilly and Company, LEO Pharma UK, Novartis and Sanofi. Please see Appendix 1 for further information about the Expert Working Group members and Appendix 2 for further information about the ABPI Dermatology Initiative.

The report contents have been developed through a series of meetings with an EWG, conducted alongside an independent service evaluation, conducted by a third party with analysis carried out by Dr Julia Schofield MBE. The ABPI DI determined the scope of this review and membership of the EWG was voluntary.

The intended audiences for this report are policy-makers, officials within NHS England and the Department of Health, and healthcare professionals.

Glossary of terms

Topic	Definition
Clinical Commissioning Group (CCG)	Groups of general practices brought together to commission the best services for their patients and population
Dermatology	The following conditions will be used as proxy for dermatology more widely: eczema (including severe eczema and atopic dermatitis), psoriasis, acne urticaria, rosacea, infections/infestations, leg ulcers and stasis eczema, lichen planus and drug rashes. These 10 conditions account for 80% of skin consultations in General Practice. ¹
Diagnostic bottleneck	Diagnostic difficulty in primary care, leading to a large number of secondary care referrals
Generalist	General practitioner or nurse practitioner
GPwSI	GP with special interest or extended role in a specialist area outside the scope of the GP curriculum
GPwER	GP with extended roles. This term has been agreed by the Royal College of General Practitioners and includes those previously referred to as GPs with Special Interests (GPwSI). The term incorporates: ‘an activity beyond the scope of GP training and the MRCGP and that a GP cannot carry out without further training’ or ‘an activity undertaken within a contract or setting that distinguishes it from general practice’ or ‘an activity offered for a fee outside of care to the registered practice population’. ²
Health Care Professional (HCP)	Practitioners that patients with skin conditions may come into contact with including pharmacists, nurses, generalists and specialists
NHS provider	Providers of acute, ambulatory, community or mental health care
Specialist	Those who have advanced training in dermatology, including specialist nurses, GPwSI/GPwER and consultant dermatologists
Supra-specialist	May also be known as tertiary care. Care carried out in an acute care setting for patients with rare or complicated skin disease by either consultant dermatologists or HCPs with specialist skills in the management of complex/rare skin conditions
Sustainability and Transformation Partnerships	Shared proposals developed by the NHS and Local Authorities to improve health and care in England. There are 44 Sustainability and Transformation Partnership footprints in England.
Teledermatology	The use of telecommunication technologies to exchange medical information either by phone or through referring to an image

Forewords



Rt Hon Professor Paul Burstow FRSA
Chair, Dermatology Expert Working Group

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Many of us will experience a skin condition at some point in our life – a health economist need not spell out the impact this has on patients and on our hard-pressed NHS.

Resources are limited and priorities will always have to be set. However, opportunities to make better use of resources should not be overlooked.

Common, long-term skin conditions account for a significant proportion of general practice time, yet dermatology remains a missed opportunity to realise productivity gains and better results for patients.

Over the last year, an independent Expert Working Group (EWG) has drawn on its members' knowledge to develop a shared vision for optimising the care of people with long-term skin conditions in England.

Taking as our starting point the NHS Five Year Forward View (FYFV), the Group has critically examined the state of dermatology and considered how all patients can get the right diagnosis, advice, care and treatment at the right place and time.

In this report we set out our practical recommendations for improving dermatology care and how this can realise NHS England's wider vision for change. We look forward to sharing and developing our ideas further with patient organisations and front-line colleagues.



Funmi Oluwa

Chair, ABPI Dermatology Initiative (ABPI DI)

The NHS is changing and our approach to providing dermatology care must too.

For too long, the complexity and the sheer number of skin conditions have made it difficult for the system to adequately manage them.

However, the vision for NHS England outlined in the FYFV offers a new way to approach caring for people with such conditions across a number of themes including prevention, public health and breaking down care barriers.

It is clear from the work of the EWG that dermatology is ideally placed to benefit from a ‘FYFV approach’, enabling people to have greater control of their own care, and allowing greater local flexibility and the integration of new models of care.

In this report, the EWG has outlined practical solutions that could positively impact the patient experience and relieve the burden on the NHS. We look forward to working in partnership with the NHS in implementing these recommendations to optimise the treatment and holistic care of people with long-term skin conditions in England.

About this report

The NHS is working hard to improve skin cancer diagnosis and treatment and much has been written about how to achieve this. This report is very different. It seeks to address the imbalance in care that has resulted for people with inflammatory skin conditions and particularly long-term skin conditions such as psoriasis, atopic eczema, urticaria, rosacea and acne, as a result of the recent heavy emphasis on skin cancer. It reflects the discussions held during Expert Working Group (EWG) meetings, and the findings of updated data about the amount of skin disease seen in primary care.

There is already a large body of research which explores the burden of skin disease, the patient pathway, the 'diagnostic bottleneck' and the management of skin conditions. Many reports, such as the 2014 King's Fund report³ and the 2013 British Association of Dermatologists (BAD) report,¹ articulate how to best provide services for people living with skin conditions, but none have concentrated specifically on those with *long-term* skin conditions.

This report seeks to fill this gap and position the current understanding of care of people with long-term skin conditions within the national policy context; and recommend achievable and pragmatic next steps for better-coordinated patient pathways, access and care for this group of patients.

In a context of ongoing NHS policy change and a drive for efficiency savings, decisions are being made over what should be prioritised by the NHS. *The Next steps on the NHS Five Year Forward View* document⁴ sets out a trade-off between different areas of healthcare. Therefore, identifying next steps for the diagnosis, treatment and management of patients with long-term skin conditions, many of whom are seen within non-urgent care pathways, within existing resources is timely and must be addressed as a matter of urgency.

About the Expert Working Group

In 2014 the ABPI Dermatology Initiative (ABPI DI) convened an independent EWG to assess the most urgent issues in the care of people with long-term skin conditions; identify priority areas for improvement in line with national policy objectives; and put forward recommendations to improve care and outcomes; and alleviate the burden on the healthcare system.

The EWG is chaired by Professor Paul Burstow and its membership is drawn from dermatology consultants, GPs with Special Interest/Extended Roles (GPwSI/GPwER), specialist nurses, pharmacists and patient advocates (full membership details can be found in Appendix 1).

The EWG used a number of themes to guide their initial conversations:

- Dermatology and the Five Year Forward View – how the new models of care might impact dermatology provision
- The role of healthcare professionals in delivering care for people with long-term skin conditions
- The role of national and local leadership, and accountability within care of long-term skin conditions

About the service evaluation study

As part of gaining an updated understanding of the burden of skin conditions in primary care, the ABPI DI commissioned an update of the evidence published in the 2009 document entitled *Skin conditions in the UK: a health care needs assessment*.⁵

This service evaluation will be published shortly, to provide evidence for the analysis and the next steps provided in this report.

This report has been supported and endorsed by the following contributing organisations:

“

The Primary Care Dermatology Society (PCDS) supports this document and the suggestions made to improve the care of patients with skin disease. We encourage those with the opportunity to put into practice the recommendations of the working group to consider how they might best improve care in their localities.”

The Primary Care Dermatology Society (PCDS)

“

Patients with skin diseases are often ignored or receive poor quality advice and treatment. This group met over the course of a year with the aim of raising the profile of Dermatology in the ‘corridors of power’ in our health service and considered the areas where we felt we could make realistic recommendations to improve the patient experience.

We were mindful of the stresses facing the NHS and the importance of considering resources such as community pharmacists, that have hitherto been under-utilised.

Throughout our discussions, the interests of our patients were paramount.”

The Dermatology Council for England

“

This report reviews current national practice and provides a template for tackling the challenges facing Dermatology into the future.

A key component of all the New Care Models Vanguards is the ability to share and spread the learning so other areas can accelerate and replicate good practice.

Our innovative community dermatology service is one such Vanguard exemplar which has already been shared in other areas.”

Modality Partnership

“

The BDNG are proud to be part of the working group to help in improving patient pathways and to provide better care for people with skin conditions using a variety of self-management tools and technology; maximising available resources and skills so people access the right person at the right time.”

The British Dermatological Nursing Group

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There is no doubting the major achievements of healthcare professionals across the NHS in recent years, in establishing effective and accessible care for patients with potential skin cancers, but as this report points out, the price that has been paid for this improvement has been unacceptably extended waiting times for access to diagnosis and treatment for those with long-term skin conditions such as psoriasis. Nonetheless, although the picture painted of current services in many areas of England and Wales is a bleak one, the report identifies scope for improvement and practical steps that can be taken, using existing resources more effectively for the benefit of the many people whose day-to-day lives involve managing a long-term skin condition. Implementing the report's recommendations will benefit both these individuals, their families and carers, as well as supporting the NHS in its delivery of the FYFV vision.”

The Psoriasis Association

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The Royal Pharmaceutical Society supports the aims of this Dermatology Expert Working Group report in improving the self-management of skin conditions, encouraging the greater use of technology and innovation, and in making the best use of the available dermatology skills and expertise of healthcare professionals.

Although the recent emphasis on the diagnosis and treatment of skin cancers has resulted in a reduction in the dermatology resource available to diagnose and manage long-term skin conditions, community pharmacy provides an easily accessible route to a healthcare professional that can be further utilised.

Pharmacists, and in particular community pharmacists, already support the public and patients in the self-management of simple skin conditions as well as patients with long-term skin conditions. Through developing specific dermatology skills and knowledge, pharmacists have the potential to contribute to an even greater extent to the management of patients with long-term skin conditions and to streamlining the patient pathway.”

The Royal Pharmaceutical Society

Executive summary

Dermatology services are under immense pressure because of the huge emphasis on the diagnosis and management of skin cancer. Although this is appropriate in some cases, an unintended consequence is a dramatic reduction in clinical time available for people with long-term inflammatory skin conditions, such as psoriasis, rosacea, urticaria, eczema, atopic dermatitis and acne. In some cases, waiting lists for routine referrals to specialist dermatology services have been closed.

This report seeks to address this imbalance in care, providing recommendations for changes in patient pathways to improve the treatment and management of patients with long-term skin conditions. Critically this report sets out to highlight small changes that have the potential to deliver big improvements in dermatology services and care, across the patient pathway.

This analysis is positioned within the national health policy context, taking into consideration the often competing priorities of health care systems, but also the need for urgent action for people with long-term inflammatory skin conditions. Our recommendations have been suggested in three areas:

Optimising self-management

The system should empower and equip people to take a more active role in the coordination and management of their treatment. Self-management should be supported by a variety of high-quality materials and frameworks to facilitate patient education, together with effective and timely access to appropriate expertise, advice and treatment services.

Using technology and innovation to streamline the patient pathway

There is a diagnostic bottleneck in dermatology. Too many referrals are being made to a small number of specialists. Streamlining the patient pathway, and ensuring the right care is delivered to people in the right setting, could be achieved via the uptake of appropriate innovation and technology.

Maximising use of available resource, skill and experience

The delivery of care for people with long-term skin conditions is the responsibility of a large group of primary care clinicians providing generalist care and a small group of intermediate care specialists and consultant dermatologists. There is an urgent need to identify, train and accredit HCPs working in intermediate dermatology services, particularly GPs with Extended Roles (GPwER), and develop the skills of other HCPs. This needs to be facilitated by the development of local champions for dermatology.

We believe our recommendations to be pragmatic, achievable and, perhaps most importantly, to make best use of the resources available to the NHS today.

These recommendations fall in line with national policy priorities, supporting the local integration of care, harnessing technology and innovation, and supporting system transformation. This report outlines how the care of people with long-term inflammatory skin conditions can be improved for the large group of people affected. Through this action, dermatology can provide an example of tangible and realistic action for improvement to the wider health system.

Recommendations

Optimising self-management

Assessment of current materials:

That NHS England promote and recommend that HCPs involved in the care of patients with long-term skin conditions signpost patients to a full range of resources that adhere to the Information Standard.

Information across the patient pathway:

That HCPs are able to access the best available Information Standard certified digital and paper resources across the patient pathway to support patients with long-term skin conditions.

Patient empowerment, support and education:

That NHS England promote and support successful self-management by the use of patient education programmes for specific long-term skin conditions, led by suitably trained HCPs based on existing successful programmes, such as those for eczema. This will provide information for patients in a group setting and enable peer-to-peer support. Such programmes could be face-to-face or 'virtual' using innovative approaches to technology.

Using technology and innovation to streamline the patient pathway

Commissioning new referral pathways:

That NHS England put in place suitable incentives to encourage commissioners to implement teledermatology pathways to, wherever possible, triage patients with skin lesions appropriately and free up face-to-face time for clinicians to see patients with inflammatory skin conditions.

Supporting technology across the pathway:

That NHS England promote and incentivise the adoption of technology such as email guidance and smartphone apps across the patient pathway to support the management of people with long-term skin conditions, particularly in relation to timely and appropriate access to care.

Maximising use of available resource, skill and experience

Upskilling GPs wishing to undertake extended roles in dermatology:

That NHS England take steps to ensure that accreditation processes for GPs with Extended Roles (GPwER) are implemented to support the development and expansion of intermediate dermatology services.

Champions:

That NHS England encourage local commissioners to nominate and empower anyone involved and interested in the care of skin conditions to become local dermatology champions to provide leadership and drive integration for improving the experience of patients living with long-term skin conditions.

Right Care, Right Place, First Time:

That NHS England and NHS Improvement make dermatology a subject for joint work by the NHS Right Care and 'Getting it Right First Time' (GIRFT) programmes to provide analysis and insight across the whole pathway and support Sustainability and Transformation Partnerships (STPs) in delivering optimal diagnosis, treatment and self-management.

Introduction

Government is driving efficiencies in the system to achieve essential cost containment. The Department of Health aims to save £22bn by 2020/2021.⁶ While the NHS is under pressure to cut costs, it must also become more clinically efficient and improve outcomes and quality.

In response, the NHS has ambitions to achieve more collaborative and flexible ways of working, giving patients greater control of their care and breaking down barriers in holistic care provision.⁷

Ambitions of the Five Year Forward View:

Giving patients control

Breaking down care barriers

Supporting innovation

Strong foundations of primary care

New models of care

Strong leadership with local flexibility

These principles are highlighted in the FYFV which recognises the need for different approaches to care delivery. It therefore proposes seven new models of care, some of which consider the integration of specialist and generalist care, and the prioritisation of community care.⁷ Rethinking care delivery requires optimising available technology and the existing workforce.

To deliver this vision of more integrated care, local health leaders have been brought together to create 44 STP footprints across England. The plans, running from 2016 to 2021, are being developed to meet local population needs.⁸ Although dermatology is not considered a priority in the existing STP plans, a review has highlighted that over half of the 44 plans do make reference to it.⁹ Reducing acute activity is central to most plans, moving care closer to home whilst achieving considerable savings. This is likely to impact people living with long-term conditions, changing where they receive their care, and who delivers it.

These emerging national policy frameworks do not explicitly address the care of people living with long-term skin conditions. This is a missed opportunity, and risks exacerbating an already troubling imbalance in dermatological care. Since the introduction of the NHS Cancer Plan (2000) and the 14, 31, 62 day cancer treatment targets, dermatology services have been inundated with skin lesions for diagnosis and management. There is mounting evidence that large numbers of patients referred urgently with suspected skin cancer have benign skin lesions and the pick-up of malignant lesions from urgent two-week skin cancer referrals is as low as 12%.¹⁰ In one Trust in England, 45% of new patient activity over one year was related to skin lesions.⁵ This increase in workload for specialist services is not just about rising referrals caused by greater awareness, it is also due to an underlying rise in the incidence of skin cancer.¹¹ A recent survey from the All Party Parliamentary Group on Skin (APPGS) found that at least 10 per cent of responding Trusts were unable to offer an urgent appointment for a non-skin cancer referral in under 10 weeks.¹² Furthermore, there is concern that this situation will worsen as the NHS England *Next steps on the NHS Five Year Forward View* document places less emphasis on waiting time targets for elective/routine activity.⁴

Supporting improvements to care

We must be realistic about who can help achieve this change. Time and capacity are in chronic short supply across the NHS. Dermatology is no different. Despite the prevalence of skin conditions and the significant impact that they can have on patients, the economy, society and the NHS, there is no dedicated national leadership, and local leadership is ad hoc and stretched. The national picture is unlikely to change, with NHS England seeking to streamline its National Clinical Director (NCD) line-up, and, where there is a lack of strong local leadership, there are few system incentives to drive change on the ground and encourage practical

solutions to provide timely access to care for people with skin conditions despite a range of NICE guidelines and quality standards. Skin conditions are outside any quality and outcomes frameworks and the only current incentives for commissioners and providers of dermatology services are aligned firmly with the national skin cancer treatment targets.

In this context, this report considers how people living with the most common, yet often under-prioritised, long-term inflammatory skin conditions – in particular eczema, psoriasis, rosacea, urticaria and acne – can see improvements in their care. We provide an assessment of where and how time and resources might be redirected to ensure these patients are receiving the right care, the first time. The first step to achieving this is to try, wherever possible, to safely free up specialist clinician time from the huge amount of benign skin lesion diagnostic activity and redress the balance in care for people with non-cancer skin conditions by optimising care pathways and the appropriate use of available resources.

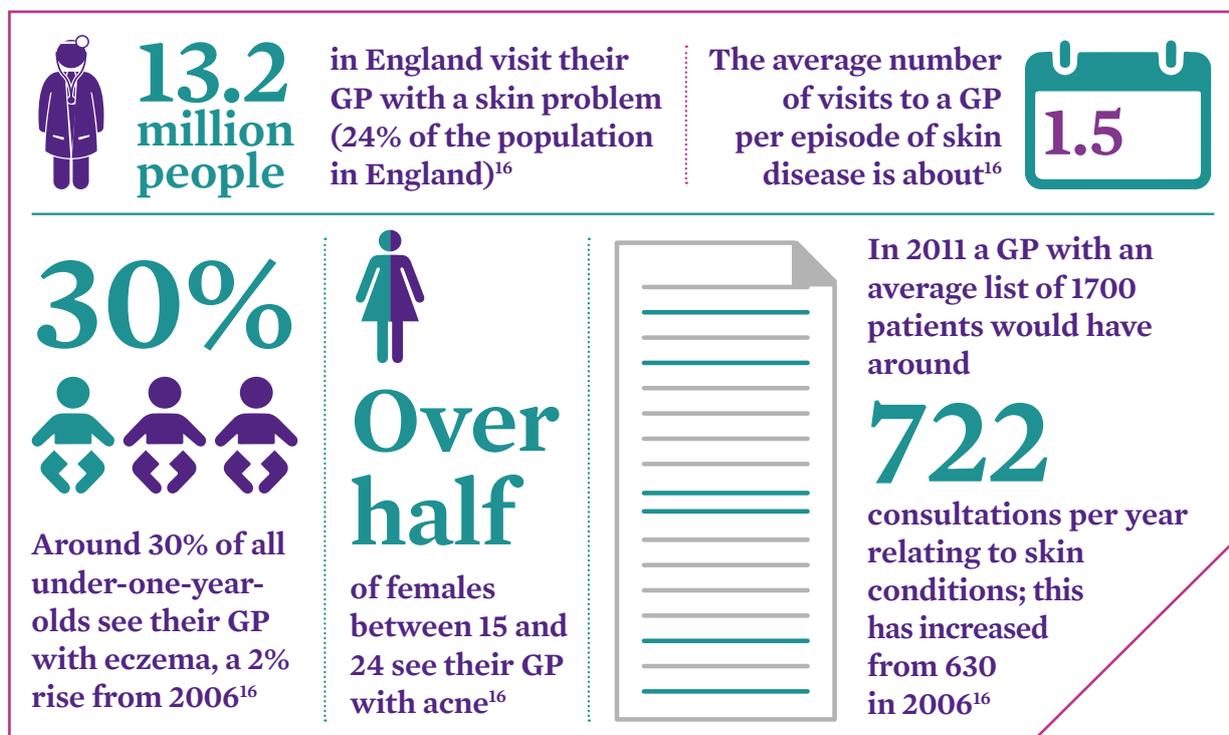
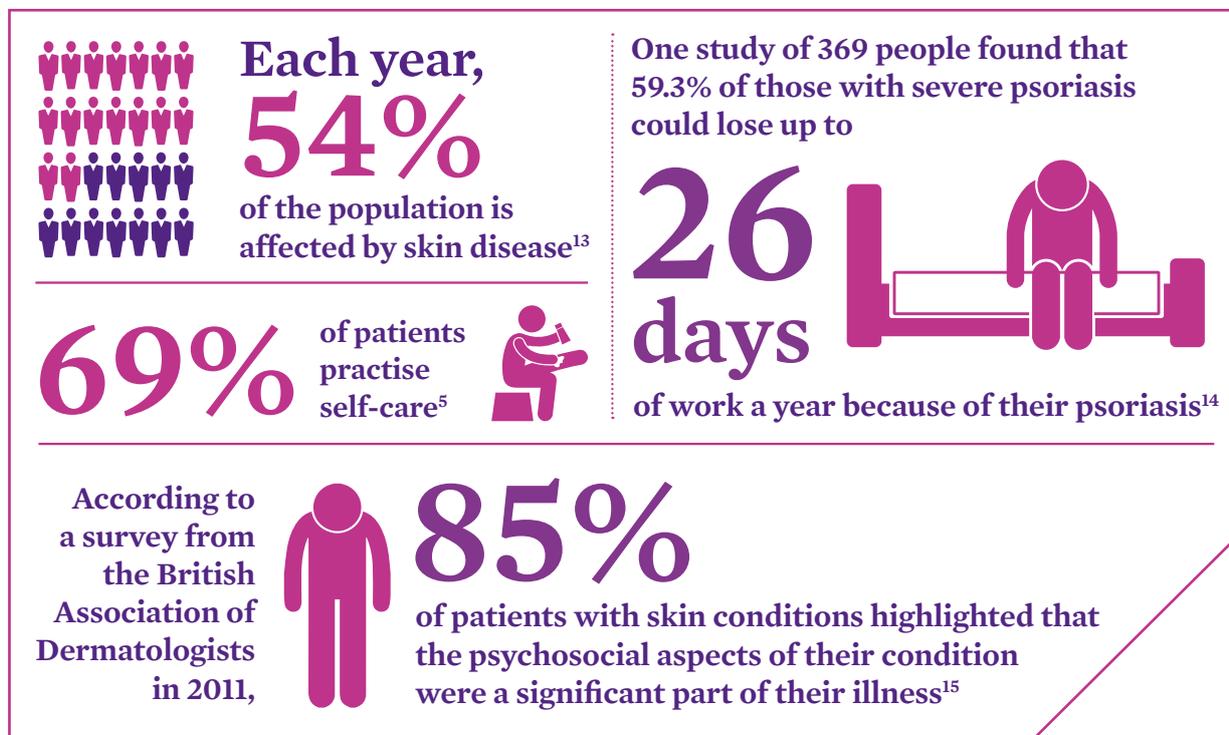
We seek to build on existing research and the work ongoing across the country, where modernisation and innovation are being used to improve care. For example, the extension of the NHS Improvement GIRFT programme to dermatology offers a real opportunity to address countrywide variation in the delivery of services, and the lack of system incentives to implement good practice.

Within this context the EWG identified three priority areas where urgent action is required to free up resource in the system to improve care: optimising self-management, using technology to streamline the patient pathway and maximising use of available resource, skill and experience. In each of these areas we identify practical opportunities for significant and immediate improvement.



The burden of skin conditions in England

This infographic brings together existing and new data on the burden of skin conditions to highlight their impact on patients and the wider health system.



5 Schofield, J., Grindlay, D., Williams, H. (2009). *Skin conditions in the UK: a health needs assessment*. Centre of Evidence Based Dermatology, University of Nottingham.

13 Eedy, D. (2015). *The Crisis in Dermatology*. BMJ Careers.

14 All Party Parliamentary Group on Skin (2013). *The Psychological and Social Impact of Skin Diseases on People's Lives*.

15 British Association of Dermatologists and Psychodermatology UK (2012). *Working Party Report on Minimum Standards for Psychodermatology Services*.

16 LEO Pharma. Schofield, J. (2017). *Overview of headline data for England since 2006*. LEO data on file – DERM-011 2017.

There were 3.26 million outpatient dermatology consultations in England in the 12 month period to the end of March 2016



Of these, **69%** were review appointments¹⁶



£723 million

in 2016 spent on primary care consultations on skin conditions¹⁶

There has been a **35%** rise in new patient outpatient activity in a ten-year period from 2006¹⁶



A GP with a list size of 1700 in 2016 will spend approximately 6657 minutes or

111 hours

per year (or over two hours per week) seeing patients with skin conditions¹⁶



3,086,256 hours

185,175,365 minutes or 3,086,256 hours were spent on skin conditions in primary care in 2016¹⁶



About **7.8%** of all patients with a skin problem are seen by specialists¹⁶



Dermatology outpatient activity accounts for 3.6% of all outpatient activity and is the **5th commonest reason**

that patients are seen in outpatient after trauma and orthopaedics, ophthalmology, general surgery and gynaecology.¹⁶

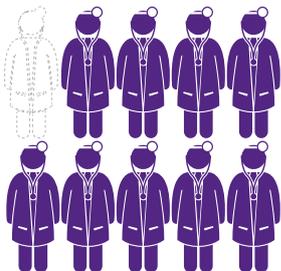
70% of the health and social care budget is spent on long-term conditions¹⁷



In 2012/13 2% of the NHS budget was spent on treating skin conditions¹⁸



1 in 10 consultant dermatologist posts are vacant³



There are between **500 and 600** dermatology consultants;¹⁹ the number of dermatology consultants reduced significantly between 2012 and 2013¹³

There are approximately

1500

members of the British Dermatology Nursing Group²⁰ working in a range of settings with some nurses providing specialist dermatology services



17 UK Government (updated 2015). 2010 to 2015 government policy: long-term health conditions. <https://www.gov.uk/government/publications/2010-to-2015-government-policy-long-term-health-conditions/2010-to-2015-government-policy-long-term-health-conditions> (Accessed May 2017).

18 Millett, D. (2016). GP dermatology training needs overhaul to tackle £2.1bn cost of skin conditions GP Online. <http://www.gponline.com/gp-dermatology-training-needs-overhaul-tackle-21bn-cost-skin-conditions/dermatology/psoriasis/article/1383696> (Accessed June 2017).

3 Edwards, N., Imison, C. (2014). How can dermatology services meet current and future patient needs, while ensuring quality of care is not compromised and access is equitable across the UK? The King's Fund.

19 NHS Improvement (2016). NHS Hospital and Community Health Service monthly workforce statistics. <http://content.digital.nhs.uk/catalogue/PUB22340/nhs-work-stat-aug-2016-doc-spec-lev1.xlsx> (Accessed April 2017).

20 Number supplied by the British Dermatological Nursing Group (as of April 2017).



Optimising self-management

The system should empower and equip people to take a more active role in the coordination and management of their treatment. Self-management should be supported by a variety of high-quality materials and frameworks to facilitate patient education, together with effective and timely access to appropriate expertise, advice and treatment services.

What is self-management?

- Self-management is defined as a situation where ‘the individual manages their problem themselves with the support of those around them and sometimes with medical input’.⁵
- Self-management is widely acknowledged to have the potential to improve health outcomes²¹ and, in some cases, to improve patient experience by increasing confidence.²²
- Empowering people and communities is a core tenet of the FYFV and the new models of care, emphasising the role of the individual in maintaining their independence and wellbeing.⁷
- Patient-centred, community-driven care encourages the patient to take the lead role in the management of their condition – minimising reliance on generalist and specialist care.

Barriers to self-management

- The Proprietary Association of Great Britain (PAGB) 2016 *Self-Care Nation* report highlighted a disconnect between people’s willingness to self-manage and their actions, with over one third of patients having visited their GP with a self-treatable condition in the last year.²³
- Access to diagnosis is a significant barrier. Many individuals are willing to pursue self-management but an authoritative initial diagnosis is a prerequisite.
- The lack of signposting to authoritative, high-quality patient information has been identified as a major barrier to effective self-management.²³
- Many patients are seeking medical information online, with over a quarter reportedly using online information and forums to self-diagnose.²³
- Clarity for HCPs on the most appropriate resources is necessary as, increasingly, information provided is easily accessible to both patients and HCPs on the internet.²⁴
- Another barrier for patients is identifying which HCPs they should consult with regarding their condition. Although pharmacists are often well-placed to support self-management, almost half of the respondents in a 2016 survey indicated that they would not visit their local pharmacist as a primary contact for advice about a self-treatable condition,²³ despite 99% of those surveyed reportedly living within 20 minutes of a community pharmacy.²³

Moving forward

To improve and encourage self-management, patients must have access to both diagnosis and high-quality resources and information. All HCPs across the care pathway must take responsibility for the information they provide to their patients. This information must be of a minimum standard, but HCPs should have the freedom to tailor information to the clinical context, and the needs of each patient. Materials recommended by HCPs should adhere to NHS England’s Information Standard principles, demonstrating appropriate processes of production, evidence, user understanding and involvement, appropriate end product, and feedback and review processes.²⁵

Patients interact with different HCPs at different stages of their care pathway – be it self-care and management, generalist, specialist or supra-specialist support – each interaction requires different information or resources.

Healthcare professional	Source
Generalist	e.g. GP packages, the Psoriasis Association, National Eczema Society, Primary Care Dermatology Society, British Dermatological Nursing Group, RCGP dermatology modules
Specialist	e.g. BAD, online resources
Supra-specialist	e.g. BAD, Allergy UK, British Skin Foundation, online resources
Practice-based pharmacist	e.g. Royal Pharmaceutical Society
Community pharmacist	e.g. NHS Choices, Royal Pharmaceutical Society, patient support groups including the Psoriasis Association, National Eczema Society
Self-care	e.g. the Psoriasis Association, National Eczema Society, online self-management apps, NHS Choices, the British Skin Foundation

Signposting patients to the right resources is also critical. This is the duty of all healthcare professionals, whether in consultation with a patient or when developing online materials. All materials should be kept up to date by the organisation that hosts the information.

There is evidence that information can also be successfully delivered via set-piece educational programmes and initiatives. These programmes, which have been developed for patients and their families with eczema and acne, can be delivered by a range of HCPs and can be virtual or face to face, offering patients the opportunity to ask questions and learn the basic information about their conditions from professionals and peers. Review of group learning for eczema has been shown to be successful and is likely to reduce multiple GP consultations and potentially reduce the need for specialist referrals.²⁶

Recommendations

Assessment of current materials:

That NHS England promote and recommend that HCPs involved in the care of patients with long-term skin conditions signpost patients to a full range of resources that adhere to the Information Standard.

Information across the patient pathway:

That HCPs are able to access the best available Information Standard certified digital and paper resources across the patient pathway to support patients with long-term skin conditions.

Patient empowerment, support and education:

That NHS England promote and support successful self-management by the use of patient education programmes for specific long-term skin conditions, led by suitably trained HCPs based on existing successful programmes, such as those for eczema. This will provide information for patients in a group setting and enable peer-to-peer support. Such programmes could be face to face or ‘virtual’ using innovative approaches to technology.

Observation of best practice: Eczema education programme^{26,27}

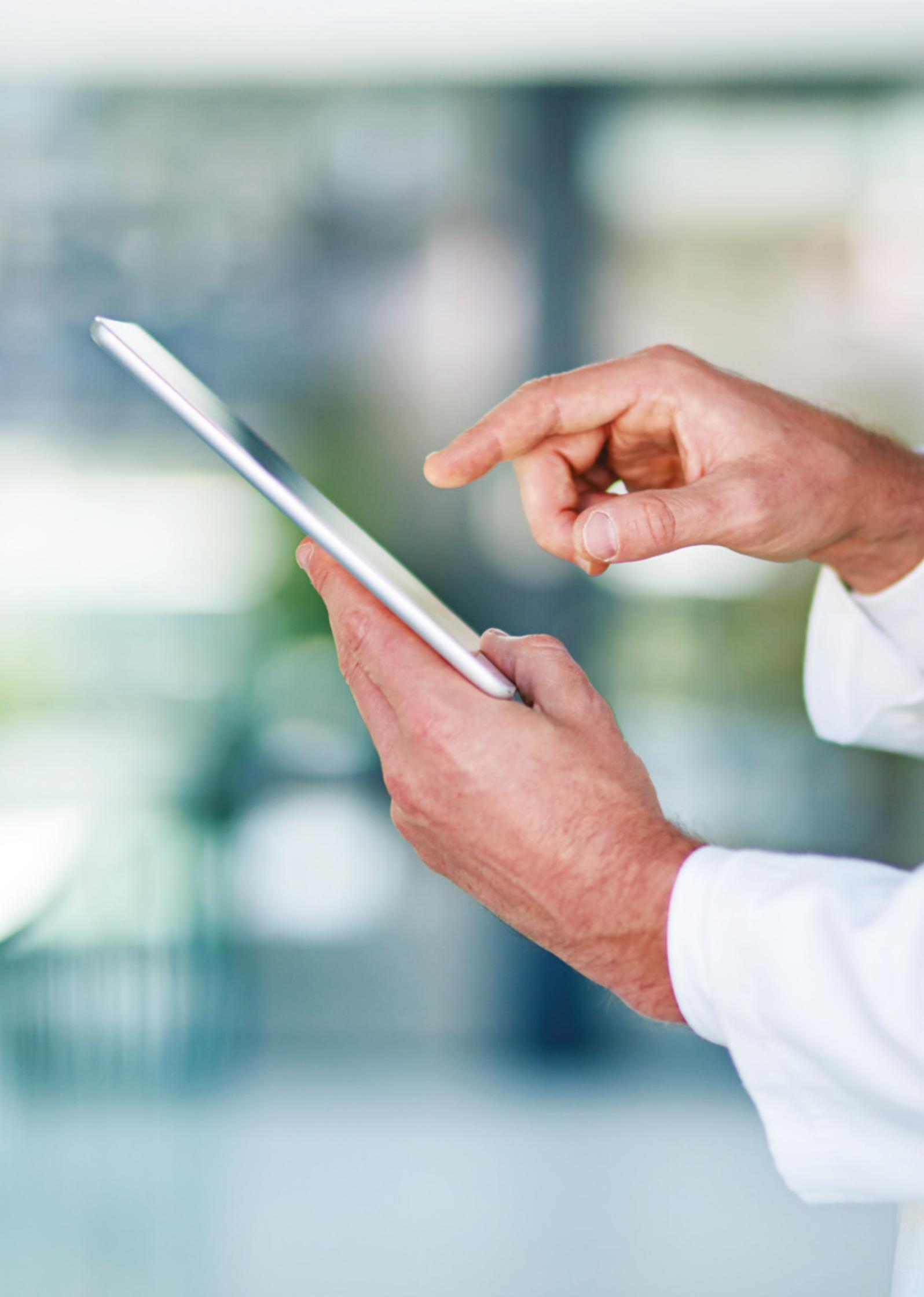
The dermatology nursing team at Guy's and St Thomas' NHS Trust have developed an educational programme for patients and carers of children with atopic eczema with a bespoke version for older children and teenagers.

- It has been well documented that support for parents of children with eczema is crucial in ensuring effective self-management²⁶ and that this can positively impact disease severity of children with eczema.
- The aim of the education programme is to equip people with the skills to manage their (or their child's) eczema, using the provision of structured and evidence-based information to parents and carers of children with eczema²⁶ to enable them to manage their child's condition. The programme is delivered over three consecutive weekly sessions and weekend sessions are also available for wider accessibility.²⁶
- A similar programme is tailored to teenagers. The Teenager Eczema Education Programme is a bespoke one-day course for children aged between 12 and 18 with atopic eczema.²⁷ It aims to ensure that teenagers engage with caring for their skin and feel empowered to speak confidently and assertively to the many adults who oversee their care. Parents have a parallel session for the afternoon.
- The interventions are delivered by a nurse trainer and evidence from the teenage programme suggests that the course helps empower teenagers to manage their eczema.²⁷

Observation of best practice: Arthritis Ireland 'Living Well with Arthritis'²⁸

Arthritis Ireland has been running the Stanford University developed Arthritis Self-Management Programme – known as Living Well with Arthritis in Ireland – since 2006. More than 5,000 people have now successfully completed the course. This programme could be replicated for people with long-term skin conditions.

- By complementing clinical treatment with education and training in problem solving and action planning, it enables and empowers patients to live happier, healthier lives.
- In a three-year evaluation – comprising 3,500 participants put through 200 courses – the results show a significant improvement in ability to cope with pain, fatigue and general ability to live with the condition. Furthermore, there is conclusive evidence to demonstrate that this programme reduces healthcare utilisation, with patients reporting a 25% reduction in visits to GPs, fewer emergency department visits, fewer visits to the hospital clinic and fewer overnight hospital stays.
- Living Well with Arthritis is delivered over a six-week period in weekly 2.5 hour sessions. Each group usually has 18 people and is led by two trained leaders. Most of the leaders have conditions themselves or are HCPs.
- Living Well with Arthritis Online is a free online course with video lessons and downloadable materials that improves patients' understanding of arthritis, the various medications available and introduces key tools to help people manage their condition.



Using technology and innovation to streamline the patient pathway

There is a diagnostic bottleneck in dermatology. Too many referrals are being made to a small number of specialists. Streamlining the patient pathway, and ensuring the right care is delivered to people in the right setting, could be improved by increasing the use of and uptake of appropriate innovation and technology.

Moving along the patient pathway

- A patient or care pathway can be defined as ‘a way of setting out a process of best practice to be followed in the treatment of a patient or client with a particular condition or with particular needs. They are a distillation of the best available expert opinion on the care process and should be evidence based.’²⁹
- A defined pathway serves to clarify clinical roles and responsibilities and signpost the route for patients.
- The large number and varying nature of skin conditions necessitate nuances in the pathway for different conditions. This added complexity is compounded by variations in the functioning of trusts, surgeries and individual clinicians’ practices across the NHS.
- Given the high prevalence of skin conditions, and the associated burden on the healthcare system, it is crucial to consider how an overarching patient pathway can best serve this disease area.⁵
- Recent analyses estimate that 7.8% of all patients presenting to the GP with a skin problem are referred to be seen by specialists.¹⁶ It is estimated that 40–50% of dermatology specialist activity is related to skin lesions.³ This figure is much higher in some parts of the country and the number of patients referred is rising, with an increase in new patient outpatient activity of 35% since 2006.¹⁶
- Dermatology outpatient activity accounts for 3.6% of all outpatient activity and is the fifth most common reason that patients are seen in outpatients after trauma and orthopaedics, ophthalmology, general surgery and gynaecology.¹⁶
- For people with skin problems there is a recognised ‘diagnostic bottleneck’, with many patients waiting to be seen for many months for a diagnosis. There is good evidence that clinically led referral management/triage can help with this problem.³⁰
- Current care pathways generally do not permit patients with long-term conditions to re-access specialist services when their skin condition flares. They experience long delays when they are re-referred as new patients.
- Waiting times for patients with long-term inflammatory skin conditions vary but are likely to be greater than 18 weeks. More complete information on waiting times was published by the APPGS.¹²
- The current tariff system which determines the price of services and aims to improve financial balance across the health service has created perverse incentives, with private providers able to cherry-pick easy cases and complex cases remaining under the care of specialist services for the same tariff.
- Encouraging and incentivising commissioners to use imaginative tariffs, such as for non-face-to-face interactions, clinically led referral management and teledermatology for skin lesion referrals, would be a positive step towards recognising that patients do not always need to be seen face to face. Capitation-based tariffs for patients with long-term care needs would reduce bureaucracy and remove access obstacles.

Waiting times¹²

10% of trusts: unable to offer a patient a routine appointment within 18 weeks

2.5% of trusts: waiting times over 30 weeks for a routine patient appointment

At least 10% of trusts: unable to offer a patient an urgent referral appointment in less than 10 weeks

6% of trusts: do not offer urgent appointments except for suspected skin cancer referrals

Moving forward

Using technology to improve connectivity and communication

- Optimising and incentivising the use of existing technology and NHS e-referral systems have the potential to support the implementation of new service models, particularly referral management and triage, and also provide opportunities for education to support and develop diagnostic skills in generalist care. There are many areas in which technology can improve access to information, support continuing professional development and communication between HCPs.
- There are around 40,000 GPs on the GP register,³¹ between 500 and 600 dermatology consultants¹⁹ and 1,500 members of the British Dermatology Nursing Group.²⁰ The difference between these workforce numbers highlights the difficulty of providing specialist dermatology support to a large group of non-specialist HCPs. Technology could improve knowledge sharing between these clinicians, to optimise appropriateness of referrals and delays in access to care for patients.
- Technology can also help people self-manage, and access the service they need at the right time. For example, mobile devices can support remote consultations or facilitate advice over email.
- The value of technology can only be realised once there is clarity about the referral pathway and the roles and responsibilities of all HCPs operating across the pathway.

Teledermatology to support triage and referral management

- Teledermatology, the use of telecommunication technologies to exchange medical information either by phone or through referring to an image, can assist already diagnosed patients to access further or specialist support.
- In 2013 the Department of Health asked a stakeholder group to develop Quality Standards for Teledermatology. This gives clear guidance about the use of different models of teledermatology services and in particular its use as a triage tool – better serving the needs of the patient and making efficient use of limited resources.³²
- The use of mobile devices in dermatology has the potential to improve referral management and triage in a clinical setting. Issues around information governance are addressed by the publication of *UK Guidance on the Use of Mobile Photographic Devices in Dermatology*.³³ This guidance aligns to advice from the General Medical Council and the Information Commissioner's Office on confidentiality and data sharing.
- All teledermatology tools must be linked to services that can provide face-to-face support to patients.
- There is particular potential for teledermatology to triage skin lesions, thereby releasing time for face-to-face consultations for patients with inflammatory dermatoses and long-term skin conditions.
- However, the number of tele-consultations remain low. Of 3.26 million outpatient dermatology consultations in the 12-month period to the end of March 2016, there were 4,696 tele-consultations.¹⁶

Referral process

Improving care will require greater uptake of innovation and technology across the patient pathway. In order to improve the system, models of care need to be implemented that optimise the existing workforce, but better utilise innovative technology and processes. To reduce unnecessary referrals, clear protocols and pathways for further treatment are required.

There are multiple points at which technology and teledermatology could play a significant role in the streamlining of the patient pathway. The use of technology has many potential benefits, including the following:³²

- The use of teledermatology for skin lesion triage may reduce the need for face-to-face visits, saving time and resources.
- Lower costs are incurred for patients, including no car parking charges and minimal absence from work.
- It enables work across large geographical areas.
- Multi-professional and multi-disciplinary working is enabled through image sharing and discussion.
- Opportunities arise for further education and information-sharing between HCPs.

Recommendations

Commissioning new referral pathways:

That NHS England put in place suitable incentives to encourage commissioners to implement teledermatology pathways to, wherever possible, triage patients with skin lesions appropriately and free up face-to-face time for clinicians to see patients with inflammatory skin conditions.

Supporting technology across the pathway:

That NHS England promote and incentivise the adoption of technology such as email advice and guidance and smartphone apps across the patient pathway to support the management of people with long-term skin conditions, particularly in relation to timely and appropriate access to care.



Observation of best practice: West Lincolnshire teledermatology³⁰

In 2014 West Lincolnshire CCG approached United Lincolnshire Hospitals NHS Trust to discuss strategies to reduce referrals to specialist services. The following initiatives were implemented:

- All routine referrals to dermatology were reviewed by either a dermatology GPwSI/GPwER or a consultant dermatologist.
- Referrals were triaged appropriately and redirected to other specialities if appropriate.
- Any referrals that met the criteria for 'low priority treatments' were sent back to the GP.
- A Choose and Book advice and guidance teledermatology service was implemented for skin lesions.
- Using the 2013 teledermatology standards a referral pathway was developed. GP surgeries were provided with cameras and dermatoscopes and images sent with skin lesion referrals.

Prior to these initiatives referral rates were steadily rising year on year; with the introduction of this approach, referrals were stable and did not increase.

The leadership for this project and its successful implementation was due to an enthusiastic manager working for the CCG.

Observation of best practice: Teledermatology to support diagnosis and management in Devon³⁴

The Royal Devon and Exeter Hospital have been running a teledermatology service for five years. The purpose of this service is to provide patients and GPs with direct access to advice from a consultant dermatologist to support diagnosis and management, with a turnaround time for referrals of three days.

Skin lesions are included, with the exception of pigmented lesions. The service also facilitates the direct booking of patients with basal cell carcinomas on to skin surgery lists, reducing the number of visits to hospital.

A study undertaken by C. Charman and Y. Al-Nuaimi sought to review referrals made through the service. The study found that the service supplemented the dermatology department and provided GPs with an alternative referral route.

- Teledermatology referrals increased from 136 a year in 2011 to 1086 in 2015.
- Referrals were received from 48 GP surgeries in total.
- Following the teledermatology referral, two thirds of patients were found not to require face-to-face review.
- The service provided rapid access to dermatology care.
- Secure image storage and consent for teaching also allowed the images to be used for teaching in both primary and secondary care settings.

Observation of best practice: Acne – use of a digital skin assessment device in an ‘end-to-end digital research project’³⁵

Harrogate and District NHS Foundation Trust are working with a company who have developed a digital skin assessment device called ScanZ and have secured a substantial European Horizon 2020 grant to develop their device. This technology which allows the user to scan and track acne will serve to support both the patient and the prescriber.

The aim will be to test the use of the device in the community to reduce the long-term use of antibiotics – (average durations are over five years, according to an established acne database of 15 years) by aligning the device to an appropriate evidence-based treatment algorithm. As well as aiming to encourage more judicious use of antibiotics with the implicit aim of reducing potential antimicrobial resistance (AMR) the aim will also be to improve patient outcomes by reducing the likelihood of scarring by aligning patients to better treatment regimes.

Case study: New models of care, technology and referrals³⁶

The Modality Partnership undertook a small in-house project on the use of mobile phones to support referrals. This demonstrated the potential of technology in managing diagnostic doubt and supporting referrals.

Either the referring clinician or patient took a picture of the patient’s skin lesion on the patient’s own smartphone and emailed it to a secure NHS address. Patients were then referred to the dermatology service as normal and the pictures were reviewed by experienced GPwSI/GPwER. Clinical opinion was recorded on the basis of the picture and the advice was then compared to the advice given to the patient by the clinician when they were seen in the clinic.

This method brought mixed success. Where the clinician took the picture, the images were more specific, better focused and more appropriate for assessment. There was a far higher correlation between the teledermatology and face-to-face advice and differential diagnosis given in these cases.

Unforeseen complications that caused issues were:

- Additional inappropriate photos were taken by the patient and sent by email.
- In some cases, patients did not have data capacity to share the picture without access to wi-fi.
- Patients failed to email the picture in a timely way, despite earlier agreement, resulting in mismatched pictures and referrals.
- Poor quality images were taken by the patient.

The results in general were promising. Good-quality clinical images taken by a clinician on a simple smartphone device and emailed in association with written clinical details is a very efficient and rapid way of triaging referrals. This is an excellent way of providing advice and guidance and of reducing appointment duplication by ensuring appropriate investigations, blood tests, etc. are carried out prior to the patient’s appointment.



Maximising use of available resource, skill and experience

The delivery of care for people with long-term skin conditions is the responsibility of a large group of primary care clinicians providing generalist care and a small group of intermediate specialists, consultant dermatologists and specialist nurses. There is an opportunity to support these and other HCPs in the development of further skills, and to encourage those who are interested to become local champions for dermatology.

Primary care clinicians

- GPs and nurses working in primary care usually act as the first point of contact for patients and are expected to diagnose, treat and advise on next steps. Patients may also present at a community pharmacy.
- Skin conditions form a significant proportion of the workload for GPs,³ equating to 13.2 million GP consultations.¹⁶ Despite the regularity with which primary and community practitioners deal with long-term skin conditions, neither GP nor undergraduate pharmacy education place sufficient emphasis on common skin conditions.³ Capacity constraints across the NHS inhibit efficiency and productivity across community, generalist and specialist care.³⁷

GPwSI/GPwER

- GPs with extended roles (GPwER, formerly known as GPwSI) that are outside of the scope of the GP curriculum³⁸ are important in the delivery of intermediate dermatology services and can successfully provide additional capacity to deliver care for less complex cases. There are clear frameworks for accreditation of these roles but these have not been effectively implemented since the end of PCTs and the establishment of CCGs.
- There are a range of roles for GPwER/GPwSI clearly stated in 2011 NHS guidance for the provision of services using GPs with Special Interests. This guidance also established a new GPwSI role with responsibility for skin lesions, skin surgery and community cancer services.³⁹
- GPwER/GPwSI have an increasingly important role to play in the local integration of services and supporting colleagues to develop their knowledge of skin conditions and their optimal management.
- There are frameworks in place for GPs seeking further accreditation to take up post-graduate dermatology study.

Pharmacists

There are potential roles for community pharmacists in the care of patients with long-term skin conditions and a willingness to provide patients with advice about common skin problems. A small preliminary study conducted in community pharmacies highlighted significant variation in the level of knowledge, diagnostic skills and information given by pharmacists. This indicates that investment in additional training and education would be required to develop the pharmacist role.

- Community-based pharmacists could be better utilised as a first point of information for patients with long-term skin conditions. They could theoretically provide an essential bridge between community and generalist care, advising patients on medicines usage and conducting necessary follow-up.
- They can provide valuable support advising on over-the-counter treatments, application of emollients, and the ongoing management of long-term conditions.^{5,40}
- Practice-based pharmacists can provide the Medicines Use Review (MUR) service, reviewing a patient's use of their medication. This allows the pharmacist to identify any problems the patient experiences and ensures that the patient understands how their medicines should be used.⁴¹
- GP practice-based pharmacists have the necessary skills to support patients with long-term conditions and many are already working at advanced practitioner level.⁴²
- By 2020 it is expected there will be a further 1,500 pharmacists in GP practices.⁴³
- Access to patient records would ensure that community pharmacists who are directly involved in patient care are able to provide high-quality, safe and effective care.⁴⁴

Moving forward

Specialist dermatology services should be underpinned by a strong foundation of community-based primary care HCPs, with access to tools for knowledge sharing, and clearer referral protocols. The ultimate goal is to ensure that patients get the appropriate support, when they need it, from the right person with the right skills to manage the problem. Importantly, for generalists to manage the wide range of skin conditions more effectively, they need to be upskilled to better diagnose and manage skin lesions. This in turn will free up capacity in specialist clinics for patients with long-term skin conditions who are in need of urgent specialist support.

There needs to be more recognition and support for HCPs who are interested in dermatology diagnosis and treatment, with opportunities for them to develop this interest. In these roles, HCPs can become more involved in routine diagnosis, treatment and follow-up.³ There is a pressing need for the accreditation processes for GPwSI/GPwER to be implemented to encourage the development of this role in intermediate dermatology services.

Strong local leadership is essential for the delivery of an optimal patient pathway. To date, integration of services at local level has developed organically, often led by an HCP who has taken forward their own vision of an integrated service. These existing ‘dermatology champions’ need to be recognised and supported to develop their role, and allow for duplication across local NHS services. For those commissioning dermatology services – e.g. Clinical Commissioning Groups (CCGs) – there is a real opportunity to shape the patient journey. Commissioners and HCPs must work closely together to ensure that commissioning decisions reflect the needs of the patient population and the resources available locally. This will require more active local leadership or dermatology champions.

NHS England’s Right Care and NHS Improvement’s GIRFT programmes will be working closely together to support STPs and local health economies. The national GIRFT initiative, supported by NHS Improvement is expanding in 2017 to incorporate a work stream on dermatology.⁴⁵ The dermatology clinical lead will oversee the creation of a national data review. The programme seeks to improve clinical outcomes and reduce clinical variation. The recently announced GIRFT Clinical Lead for Dermatology will provide much needed direction at a national level, filling a gap that has been keenly felt by those working in dermatology.

The opportunity should be taken to bring dermatology into the Right Care programme too. With at least 14 out of 44 STPs identifying dermatology in their plans,⁹ this would fit well with NHS England’s emerging new operating model, looking to facilitate and support delivery of the Five Year Forward View and STPs.

There are also opportunities to optimise the way care is delivered, in line with the new models of care in the FYFV, including co-locating specialists alongside GPs. This can not only change how and where care is delivered, but also provide an ongoing tool for Continuing Professional Development (CPD). The ‘multispecialty community providers’ model of care provides a strong framework for dermatology care, emphasising the importance of community care and building stronger connections between all levels of care delivery. Examples of this in practice can be found on pages 29-31.

Recommendations

Upskilling GPs wishing to undertake extended roles in dermatology:

That NHS England take steps to ensure that accreditation processes for GPwER are implemented to support the development and expansion of intermediate dermatology services.

Champions:

That NHS England encourage local commissioners to nominate and empower anyone involved and interested in the care of skin conditions to become local dermatology champions to provide leadership and to drive integration for improving the experience of patients living with long-term skin conditions.

Right Care, Right Place, First Time:

That NHS England and NHS Improvement make dermatology a subject for joint work by the NHS Right Care and GIRFT programmes to provide analysis and insight across the whole pathway and support STPs in delivering optimal diagnosis, treatment and self-management.

Case study:

Harnessing skills of Pharmacists in GP practices⁴⁶

A project funded by LEO Pharma supported pharmacists from Interface Clinical Services (ICS) Ltd (an independent clinical services provider) to work with GP practices to provide an annual review for psoriasis patients.

The requirement for patients on topical treatments to receive an annual review is stated within the NICE Quality Standard for Psoriasis, with those on active topical therapy, phototherapy or systemic therapy being offered an annual assessment for psoriatic arthritis.⁴⁷

Selected patients using active topical psoriasis treatment were invited to clinic where a patient review was completed with each patient by the ICS pharmacist.

The patient's assessment was then reviewed with the GP and any required actions implemented.

The pharmacist's review covered:

- Relevant history
- Psoriatic arthritis check using Psoriasis Epidemiological Screening Tool (PEST)
- Disease impact calculated using the Dermatology Life Quality Index (DLQI)
- Satisfaction with current treatment (informed by DLQI)
- Satisfaction with current treatment outcomes (informed by DLQI)
- Discussion regarding treatment adherence and application
- Difficult-to-treat sites
- Checks for steroid atrophy and other treatment-related side effects
- Need for steroid breaks
- Discussion regarding treatment options available

932 patients were seen in the first clinics, with 323 returning for a follow-up second clinic appointment eight weeks later.

Examples of the actions taken at clinic 1 included:

Action taken	Patient numbers
Corrected frequency of use	861
Corrected application technique	860
Advised on the need for steroid breaks	790
Emollient added	513
Joined online patient support programme	238
Recommend GP to review patient	135
Recommend referral to rheumatology	116
Recommend referral to dermatology	69

Of the 323 patients returning for review after eight weeks:

- 177 patients had a DLQI score indicating psoriasis had a moderate to extremely large effect on their life at the initial clinic, which reduced to 101 patients at the week 8 clinic.
- There was a 43% reduction in the number of patients reporting that their psoriasis had a moderate to extremely large effect on their life.
- Total DLQI scores had reduced by 29% versus baseline clinics.
- Positive feedback was received from patients, most of whom had been overdue a review of their condition.⁴⁶

Observation of best practice: Urinary incontinence and governance structures^{48, 49}

Urinary incontinence is a very common condition affecting millions of men and women worldwide. Between three to six million people in the UK are affected by some degree of urinary incontinence.

There are a number of similarities between urinary incontinence and long-term skin conditions including stigma, high prevalence and lack of understanding about severity and impact. Despite this, urinary incontinence is an area which moved up the political and NHS agenda and saw a change in governance structures as result of widespread campaigns and increased political attention.⁴⁸

Growing visibility of the condition's stigma, its economic impact, high prevalence and lack of understanding about severity and impact have led to the development of a number of policy frameworks. The United Kingdom Continence Society (UKCS) *Excellence in Continence Care* document provides minimum recommendations for training and practice through all levels of care, providing 'modules' in various areas of services and management order to standardise care.⁴⁹

Case study: Modality Community Dermatology Service – Connected Care Partnership Vanguard⁵⁰

Programme overview

The Modality Community Dermatology Service started in 2007 and now operates in 10 locations, offering services to over 300 practices across three CCGs. There are currently eight GPwSI/GPwER, mostly trained in-house, that receive approximately 650–700 referrals per month and complete over 10,000 consultations per year.

- Referrals are accepted for all adult and child dermatological conditions requiring specialist opinion.
- The large clinical team includes GPwSI/GPwER, nurses, nurse surgeons and consultant input.
- The service is delivered from 10 community-based locations, with evening appointments to accommodate patient needs.
- The programme includes specialist treatments such as skin prick-testing for allergy, laser therapy and camouflage.

Reducing waiting times and hospital referrals

- The programme has a hospital referral rate of less than 3%.
- 70% hospital tariff is charged.
- Triage is completed within five days.
- Average waiting time is less than one month and urgent referrals can be seen in between three and five days.
- The service supports education of local GPs, nurses, trainees and other HCPs.
- The service was awarded the GP Practice Dermatology Award at the 2016 General Practice Awards.

Case study:

Bristol Community Health Dermatology Service⁵¹

Programme overview

The Bristol community dermatology service was established in 2001 and covers 48 GP practices seeing a population of approximately 480,000. Clinics are held in four locations within the city, with GPwSI/GPwER holding four sessions a week (with clinical supervision from a secondary care dermatology consultant once a month) and nurse-led clinics five days a week.

- Referrals come from any allied HCPs, practice nurses, community nurses, health visitors and secondary care for review.
- The GPwSI/GPwER see patients who need diagnosis or who have complicated chronic skin disease, and nurses see patients for education and support; additionally they check diagnosis, management planning and treatment regimes.
- Joint home visits take place with community nurses or health visitors and review boards are coordinated if required.
- There are additional eczema education sessions.

Links with secondary care and a wide HCP network

- The programme has good links with secondary care teams, and healthcare professionals within the service can refer onward for further treatment or call/email the secondary care team for advice.
- Nurses have access to paediatric supervision (one clinic a week) within secondary care, with a paediatric dermatology consultant who will triage straight to the team.
- The programme is supported by educational study days for community nurses, health visitors, podiatrists and GPs, held between two and four times a year.
- There is data sharing with other community services within Bristol Community Health as well as GPs, and the programme has computerised prescription, letter templates and treatment care plans.

Case study:

Chronic Spontaneous Urticaria (CSU) – impact of the diagnostic delay on healthcare resources⁵²

A recent audit funded by Novartis and carried out at St James's University Hospital in Leeds for chronic spontaneous urticaria identified significant diagnostic delay and associated impacts. CSU is frequently misdiagnosed, leading to incorrect treatment and delay in referral to specialist care where necessary. The audit sought to determine how effectively health care resources were used in the diagnosis and management of CSU and whether this can be optimised with the application of best practice guidelines. The audit found:

- The mean diagnostic delay was four years with patients averaging 13 GP visits before diagnosis.
- Cases were frequently misdiagnosed as allergy or other skin disorders and 19% of cases had no initial diagnosis.
- 49% of patients had presented as an emergency at least once.
- The mean cost was £1,534 per patient (range £851–£2,213); if guidelines had been followed this figure would have been reduced to £564.
- The mean length of the patient journey would have been reduced by 16.5 months.



Conclusion: A call to action

Dermatology offers a perfect case study in how the vision of the Five Year Forward View can be translated into actions that deliver better outcomes for patients and better use of resources.

With the latest data showing that 24% of the population have a skin disease for which they seek medical advice,¹⁶ there is an urgent need to take practical action to manage the current demand more effectively.

The Expert Working Group who have written this report believe that the Five Year Forward View and the *Next steps* report set an approach that when applied to long-term skin conditions will make a difference to the quality of life of thousands of people whilst also delivering productivity gains.

Integrating care locally can make the best use of clinical skills and ensure that more people get the right care in the right place first time. By spreading best practice and following the evidence, the NHS can empower people with the skills and knowledge they need to better self-manage their long-term skin conditions. By harnessing technology and innovation, such as teledermatology and digital devices, the NHS can speed up diagnosis and treatment and help more people manage their own health.

Although dermatology is not identified as a priority in STP plans, a review of plans has highlighted that over half of the Sustainability and Transformation Partnerships do make reference to it. The EWG believe that this report offers NHS England and NHS Improvement the practical steps they can take to support the ambitions of these STPs.

Our call to action is simple: make dermatology an exemplar for integration, self-care and harnessing technology and innovation.



Appendix 1: Dermatology Expert Working Group Membership



Rt Hon Professor Paul Burstow FRSA

Chair, Dermatology Expert Working Group

Paul Burstow is a social policy entrepreneur and thought leader. He chairs the Tavistock and Portman NHS Foundation Trust, is chair of the Social Care Institute for Excellence and is Professor of Mental Health Policy at the University of Birmingham. Between 1997 and 2015 he was Liberal Democrat MP for Sutton and Cheam. He served as the Minister of State for Care Services between 2010 and 2012. In the latter role he covered a wide range of social policy issues including mental health, adult social care, carers, personal health budgets, safeguarding vulnerable adults, end-of-life care and long-term conditions.



Dr Colin Cable

Assistant Chief Scientist, Royal Pharmaceutical Society (RPS)

Dr Colin Cable is a pharmacist with a PhD in the drug delivery field. On completion of his PhD in 1990, Dr Cable joined the Royal Pharmaceutical Society of Great Britain (RPSGB), becoming Head of the Pharmaceutics Division.

From 2002 to 2008 Dr Cable held a joint appointment with the RPSGB and the Western General Hospital in Edinburgh. Dr Cable had responsibility for providing pharmaceutical care to ear, nose and throat, and to dermatology patients. In addition, Dr Cable collaborated with academic pharmacy colleagues at Strathclyde University. In recognition of this work Dr Cable was appointed an honorary lecturer at Strathclyde University from 2007 to 2011.

In 2009, Dr Cable returned full-time to the Royal Pharmaceutical Society to become part of the Science team. His role as Assistant Chief Scientist involves promoting pharmaceutical science, developing guidelines for pharmacists, promoting the pharmacy evidence base, responding to media enquiries and assisting in the development of RPS policy which is underpinned by pharmaceutical science.

Dr Cable has been involved in the *Handbook of Pharmaceutical Excipients* since 1992, initially as a member of the International Steering Committee and currently as an editor.



Nick Evans

Chairman, Psoriasis Association

Nick Evans worked as an NHS manager for over 38 years in both hospitals and health authorities, and was an executive director of various NHS organisations for over 20 years until his retirement in 2011. Nick's interest in dermatology services began in 2001 when he was seconded to the NHS Modernisation Agency, and set up and led the national Action On Dermatology programme.

Since leaving the NHS, Nick has maintained his links with dermatology, chairing the advisory committee to the All-Party Parliamentary Group on Skin, and as a Trustee of the Psoriasis Association.

The Psoriasis Association is the leading national charity and membership organisation for people affected by psoriasis – patients, families, carers and health professionals in the UK.



Dr Stephen Kownacki

Executive Chairman, Primary Care Dermatology Society (PCDS)

Dr Stephen Kownacki developed his interest in dermatology on the Northampton Vocational Training Scheme under the guidance of Dr Dick Coles, founder of the Psoriasis Association. He worked as a hospital practitioner at Northampton General Hospital for almost 30 years.

He retired in July 2011 from being senior partner in a large Wellingborough practice where he developed a nurse-led advisory service for the Primary Care Trust which was open for patient self-referrals.

He remains active in the education of registrars locally and enjoys giving talks and writing, particularly about the dissemination of knowledge and the development of learning practices.

He is keen to break down the barriers between the professions and to develop a more cohesive approach to the care of patients with skin problems. As chair of the PCDS he meets regularly with the President of the British Association of Dermatologists to discuss items of mutual interest. He represents the society on a number of stakeholder groups including the Dermatology Council for England and the All Party Parliamentary Group on Skin.

Dr Alison Layton MB, ChB, FRCP

Consultant Dermatologist at Harrogate and District NHS Foundation Trust

Dr Alison Layton was appointed as Consultant Dermatologist at Harrogate and District NHS Foundation Trust in 1994 and was appointed as Honorary Clinical Senior Lecturer at Hull York Medical School in 2012. She is also Co-Clinical Director of the National Institute for Health Research (NIHR) Yorkshire and Humber Clinical Research Network and Associate Medical Director for research at Harrogate and District NHS Foundation Trust.

She has a particular interest in androgen mediated disorders including acne and polycystic ovary syndrome (PCOS). Dr Layton has acted as Chief Investigator and Principal Investigator for many clinical trials examining medications for inflammatory dermatoses, and conducts basic science research as an affiliate for the Centre for Immunology and Infection at the School of Biology, York University.

Dr Layton is one of the reviewers for national guidelines for rosacea and acne as well as for a number of NICE guidelines relating to dermatological conditions. Dr Layton has reviewed and developed Cochrane reviews relating to acne and is often invited to peer-review original research papers for journals.

She is regularly invited to lecture and chair sessions at international symposia and has written many chapters and review articles specifically relating to her areas of expertise.



Dr George Moncrieff FRCP, FRCGP

Chair of the DCE (Dermatology Council for England) and PCDS committee member

Dr George Moncrieff graduated from St Thomas' Hospital, London in 1979 and was awarded the Grainger prize in Dermatology in his final year. After a few years in hospital medicine he decided General Practice would be more fulfilling and joined the Banbury Vocational Training Scheme. In 1984, he acquired Membership of the Royal College of Physicians (RCP).

He has been a full-time partner in Bicester since 1985. He was a trainer from 1989 to 2007 and an undergraduate medical tutor in Oxford from 1999 until 2012. From 2000 until 2010 he was an examiner for the Diploma of Child Health (DCH).

He is Chair of the DCE and has been a member of the PCDS since 1997 and a committee member since 2000. He obtained the Diploma in Practical Dermatology from Cardiff in 1998 and was an external examiner for this diploma from 1998 until 2005.

Since 2000 he has run an 'interface dermatology clinic' for patients in north-east Oxfordshire. Currently, practices looking after a population of over 80,000 send most of their Dermatology patients to this clinic (excluding obvious two-week bureau referrals).

From 2010 until 2014 he was the Royal College of General Practitioners Curriculum Guardian for Dermatology. In 2014 he was elected Chair of the Dermatology Council for England, a body that aims to represent the issues facing dermatology, including patient support groups, HCPs and the pharmaceutical industry. He had Fellowships from the RCGP in 2013 and the RCP in 2015.



Dr Tracey O'Shea

Community Dermatology Clinic Lead at Modality Partnership, and practising GP

Dr Tracey O'Shea graduated from Newcastle University in 1999. After qualifying as a GP in 2004 and obtaining the Cardiff Diploma in 2005, she began undertaking dermatology clinics. In 2007, she was instrumental in starting the Modality Community Dermatology Clinic. This is now one of the largest community clinics in the country taking referrals from three Clinical Commissioning Groups covering a population of over 1,000,000 people. The service runs clinics at nine locations across Birmingham five days a week and currently employs eight dermatology GPwSI and three specialist nurses. The service currently offers over 10,000 patient consultations per year.

Dr O'Shea works as a GP in inner-city Birmingham for two sessions a week and as a dermatology GPwSI for seven sessions a week.



Dr Julia Schofield

Consultant Dermatologist, United Lincolnshire Hospitals NHS Trust and Principal Lecturer, University of Hertfordshire

Dr Julia Schofield trained initially in general practice in Manchester and Salford and then chose to pursue a career in dermatology. She was a consultant dermatologist at St Albans and Hemel Hempstead Hospitals from 1995 to 2008. She now works in Lincolnshire, having chosen to move her NHS practice there to support her family. She has a strong interest in teaching and education, particularly GPs and nurses and in 2006 developed an MSc in dermatology skills and treatment at the University of Hertfordshire. She currently oversees the programme's delivery and development and delivers much of the teaching for this successful Master's programme.

In 2008, Dr Julia Schofield was awarded the British Association of Dermatologists sabbatical fellowship and as a special lecturer at the University of Nottingham completed a large piece of research looking at the health care needs of people with skin disease. Her book *Skin Conditions in the UK: A Healthcare Needs Assessment* was published in 2009. This considered the burden of skin disease and made recommendations around improving patient care. The work is widely quoted and used to influence service delivery for people

with skin conditions. She has worked closely with stakeholders and the Department of Health over her career, developing a range of national guidance documents particularly related to GPwSI services. She has been a member of two NICE guideline development groups, most recently the melanoma guideline group (2015) and is currently a specialist advisor to the group developing quality standards for skin cancer.

She works closely with patient groups and is a trustee of the Psoriasis Association.

Dr Schofield was awarded an MBE for her contribution to dermatology services in the Queen's 2012 Birthday Honours List.



Lynne Skrine

President, British Dermatological Nursing Group (BDNG)

Lynne Skrine was appointed as President-Elect of the British Dermatological Nursing Group (BDNG) in 2015. She is the Dermatology Team Leader for Bristol Community Health and was Nurse Manager for Bristol Dermatology Centre until 2013. Alongside her position at the BDNG, Lynne is a member of the Royal College of Nursing, Nursing and Midwifery Council and the British Association of Skin Camouflage.

The BDNG is an independent speciality group for nurses and healthcare professionals with an interest in dermatology. The aims of the group are to: promote the development of the highest standard of care for the patient receiving dermatological care; promote the development and recognition of the nurse's role in dermatology; promote and support education of nurses for their role in dermatology; promote and support research into all aspects of dermatology nursing and dermatological nursing care; and provide a source of expertise for nurses facing clinical and managerial challenges in the field of nursing.



Funmi Oluwa

Market Access Director UK/IE at LEO Pharma and Chair, ABPI Dermatology Initiative

Funmi Oluwa is the Chair of the ABPI Dermatology Initiative. Funmi works as Head of Market Access for LEO Pharma UK and Ireland. LEO is a pharmaceutical company whose mission is to help people achieve healthy skin.

Amanda Simonds

Senior Corporate Affairs & Patient Advocacy Manager, Immunology and Inflammation at Celgene Ltd and Vice-Chair, ABPI Dermatology Initiative

Amanda Simonds is the Vice Chair of the ABPI Dermatology Initiative. Amanda is responsible for Corporate Affairs and Patient Advocacy for Celgene in the UK and Ireland. Celgene is a US-based pharmaceutical company, committed to improving the lives of people with immune and inflammatory diseases.

Appendix 2: About the ABPI Dermatology Initiative

The ABPI DI was convened in 2014 – 2017 and has included the following member companies: AbbVie, Almirall, Celgene, Eli Lilly and Company, LEO Pharma UK, Novartis and Sanofi.

The ABPI DI seeks to collaborate with people and organisations from across the field of dermatology to improve care for people with skin conditions and support the medicines optimisation agenda.



As a group, the ABPI DI is proud of the contribution our treatments can make to improving patients' lives. The effective use of treatments is essential to high-quality care. The pharmaceutical industry will continue working in partnership with the NHS to ensure people receive the care they need and deserve.

We are also proud that we have been able to work with the members of the Expert Working Group to produce this report. We would like to thank Professor Paul Burstow and the members of the EWG for their time and their commitment to providing better care for people with skin conditions.”

Comment from Funmi Oluwa, Chair of the ABPI Dermatology Initiative



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