Dermatology needs a makeover

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The King’s Fund has recently published a document on what the future of dermatology services might look like. It was an independent report, funded by the British Association of Dermatologists. Evidence was taken from primary, secondary and intermediate care services and looked at various models of service provision. Based on a published assessment of need, there ought to be at least 1600 consultant dermatologist posts in the UK. In fact there are approximately 800, of which some 200 are either unfilled or staffed with locum consultants or doctors who are not on the specialist register. It is also clear that during this time of austerity that there will be no funding for more consultant posts. Currently, dermatology services are under increasing pressure with rising demand from both skin cancer and an ageing population. There is a pressing need to find alternative ways of supplying dermatology services.

Self-management and self-care
The report identifies opportunities for dermatology self-care and self-management with better use of community resources such as pharmacists, as well as use of online resources. This might mean that patients try treatment before consulting their GPs, but also runs the risk of incorrect self-diagnosis and inappropriate treatment. However, so far this does not seem to be a major problem as information has been available on the internet for some years and, while GPs probably still see some patients brandishing print-outs from websites, an incorrect diagnosis rarely causes harm.

Primary care education
The report identifies an urgent need to improve the quality of dermatology knowledge in primary care. Given the high frequency with which dermatology patients are seen in primary care, it makes a lot of sense to improve dermatology knowledge and experience in primary care. There is woefully inadequate teaching of dermatology in medical schools and equally inadequate teaching of dermatology during GP training despite 10–20 per cent of consultations in primary care having a skin-related component. Some solutions suggested by the King’s Fund include having GP “experts” in larger practices, better use of online resources (such as the lesion recognition toolkit on doctors.net) and targeted CPD. All are examples taken from real-life good practice around the country.

Intermediate care services
The King’s Fund took evidence from experienced intermediate care providers (GPwSIs). The report identified the critical importance of strong links between primary and secondary care in making intermediate care work effectively so that patients are directed to the correct service first time and GPs can access advice and appointments in a timely manner whether from intermediate or secondary care services. The intermediate care services that gave evidence were the “successful” ones, but even they struggled with the problem of dermatology services being awarded to cheaper community-based providers. The latter cherry-pick easier cases and have a greater rate of onward referral, which turns out to be more expensive in the long run.

The use of images (including dermoscopic images) and online referrals for teledermatology has been successful in some areas of the country although there is no single model that would apply to all circumstances. At its best it can support primary care with triage of referrals and provide educational input particularly in rural/remote areas. It is not as useful in urban areas where distance to clinics is less of a concern and it also runs the risk of paradoxically increasing demand (supply led demand) and so might not provide long-term cost-savings.

Commissioning of dermatology services
One major concern uncovered by the King’s Fund was the effect of poor commissioning of dermatology services. There was evidence of a failure to understand the needs of dermatology patients and consequently poor commissioning, which led to short-term savings but with longer-term increased costs (e.g. patients being seen in “cheap” community clinics but often needing onward referral with duplication of appointments and hence cost). More worryingly, there was evidence that poor commissioning led to fragmentation of existing services with destabilisation of good secondary services, with the unintended consequences of loss of local expertise, training, research and services.

Where there are existing good dermatology services, it is important to support their continued functioning. It is not necessary to have a new provider if the existing one is doing a good job. CCGs need to support good services and engage with existing providers to provide CPD locally or to signpost online CPD resources.

In a larger group practice there may be some dermatology expertise and the various UK dermatology diplomas can be a good way to consolidate this expertise in a practical way. This can be a cost-effective way to reduce referrals, particularly as 10 conditions make up 80 per cent of dermatology referrals.

These can be an excellent resource if closely linked to secondary care so that patient pathways are efficient. Conversely, they can struggle if isolated and not supported by secondary care. Commissioners of intermediate and secondary care services should specify the co-operation that should be made by these services to avoid duplication and to streamline pathways.

Declaration of interests
None to declare.

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