

## **Submission by the British Association of Dermatologists to the Commons Health Select Committee enquiry regarding Long Term Conditions.**

The British Association of Dermatologists is a charity whose objects are the practice, teaching, training and research of Dermatology. It is funded by the activities of its Members. 'Healthy Skin for All' is its motto.

### **1. Dermatology – Long Term Conditions (LTCs)**

**Many skin diseases themselves represent LTCs.**

**People with LTCs in other organs or systems commonly get skin disease.**

**Some skin LTCs are associated with increased physical and psychological disease.**

**The available dermatological resource is already seriously overstretched.**

- **Many skin diseases themselves are LTCs. Examples include psoriasis, eczema, acne, vitiligo, leg ulcers and chronic sun damage resulting in multiple skin cancers.**
  - Chronic skin conditions affect both the young and old and may persist over the course of a lifetime.
  - The burden of chronic skin diseases such as leg ulcers and repeated episodes of skin cancer is increasing as the population ages.
  - Skin disorders are amongst the most common long-term conditions in the UK: there are more than 2,000 different diseases.
  - There is a large number of genetic skin diseases; each one may only affect a small number of people, but taken together they form part of the long term skin disease burden in the UK.<sup>1</sup> For sufferers they are a life sentence of misery, physical and cosmetic disability and psychological challenges.
  - Skin diseases represent 34% of disease in children;<sup>2</sup> 20% of children in the UK have eczema,<sup>3</sup> children with serious skin conditions have their quality of life impaired to the same extent as those with chronic illnesses such as epilepsy, renal disease and diabetes.<sup>4</sup>
  - Acne is an extremely common skin disease - often trivialised as a 'passing phase' of adolescence - yet it commonly persists into the 20s and even 30s and 40s in many people (up to 5% of all women). Acne scarring is permanent. Acne results in long term disabilities including difficulties in relationships and employment prospects.

---

<sup>1</sup> [http://www.oncologypractice.com/fileadmin/content\\_pdf/san/scms\\_pdf/SCMS\\_Vol31\\_No4\\_Molecular\\_Diagnostics.pdf](http://www.oncologypractice.com/fileadmin/content_pdf/san/scms_pdf/SCMS_Vol31_No4_Molecular_Diagnostics.pdf)

<sup>2</sup> ..Consultant physicians working with patients, Royal College of Physicians 2011:

[http://www.rcplondon.ac.uk/sites/default/files/dermatology\\_1.pdf](http://www.rcplondon.ac.uk/sites/default/files/dermatology_1.pdf)

<sup>3</sup> .Odhiambo J, Williams H, Clayton T, Robertson C, Asher MI, the ISAAC Phase Three Study group Global variations in prevalence of eczema symptoms in children from ISAAC Phase Three. *J Allergy Clin Immunol.* 2009;124:1251–8. doi: 10.1016/j.jaci.2009.10.009. AND Shaw TE, Currie GP, Koudelka CW, Simpson EL. Eczema prevalence in the United States: data from the 2003 National Survey of Children's Health. *J Invest Dermatol.* 2011;131:67–73. doi: 10.1038/jid.2010.251

<sup>4</sup> BJD, Beattie\*, P.E. and Lewis-Jones, M.S. (2006), A comparative study of impairment of quality of life in children with skin disease and children with other chronic childhood diseases. *British Journal of Dermatology*, 155: 145–151. doi: 10.1111/j.1365-2133.2006.07185.x

- Hand eczema is one of the most common reasons for disablement benefit in the UK<sup>5</sup>
  - 3% of the population has psoriasis (with a third suffering since childhood). 30% of psoriasis patients needing systemic treatments have been attending Dermatology clinics for over 10 years.
  - Some lifelong diseases such as vitiligo, which results in the loss of normal skin colour, can have a devastating effect on self-esteem for people from black and ethnic minorities.
  - It is estimated that several million people in the UK have significant chronic sun damage resulting in ~13,000 melanomas and ~800,000 basal cell and squamous cell skin cancers a year.
  - People with chronic sun damage suffer increasing numbers of skin cancers as they age - the ageing population will have a bigger incidence of this disease.<sup>6</sup>
  - Chronic skin disease can influence 'major life changing decisions', which then impact on the rest of a person's life.<sup>7</sup>
  - In the UK, data from the WHO Global Burden of Diseases study shows that DALYs (Disability Life-Adjusted Years) for skin conditions are as high as those for diabetes, chronic renal disease, gastrointestinal disorders or neonatal abnormalities. The reason is largely because skin disease is so common.<sup>8</sup>
- **People with LTCs in other organs or systems (eg diabetes, HIV, transplants, cancer) commonly get skin disease;**
    - Patients with chronic disease can be affected by skin disease directly due to the effects of those diseases (eg diabetes and HIV).
    - People with other LTCs also get skin problems due to their treatments. This is especially common when treatment includes drugs such as anti-epileptics, cancer therapies and radiotherapy, or transplants - due to the drugs given to prevent transplant rejection.
    - Increasingly in an ageing population people are on multiple medications: dermatological side-effects are extremely common, ranging from chronic itching and rashes, to life threatening conditions warranting hospitalisation.
  - **Some skin LTCs (e.g. psoriasis) are associated with increased physical and psychological disease.**
    - Patients with chronic psoriasis have increased obesity, hypertension, hypercholestaemia, diabetes, heart disease (the metabolic syndrome) and

---

<sup>5</sup> Williams H, Dellavalle RP, Garner S, *Acne Vulgaris*, The Lancet, Volume 379, Issue 9813, Pages 361 - 372, 28 January

<sup>6</sup> Sinclair, R. (2013), *Nonmelanoma skin cancer in Australia*. *British Journal of Dermatology*, 168: 1–2. doi: 10.1111/bjd.12167

<sup>7</sup> Z U Bhatti, A Y Finlay, C E Bolton, L George, J P Halcox, S M Jones, R I Ketchell, R H Moore, M S Salek. *Chronic disease influences over 40 Major Life Changing Decisions (MLCDs): a qualitative study in dermatology and general medicine*. (Submitted to JEADV)

<sup>8</sup> *United Kingdom Performance on Health: Implications from the Global Burden of Disease Study 2010* The Lancet, Volume 381, Issue 9871, Pages 997 - 1020, 23 March 2013 doi:10.1016/S0140-6736(13)60355-4

mortality. 20% of patients with psoriasis develop chronic arthritis.

- In the United Kingdom, in excess of 10,400 diagnoses of depression, 7,100 diagnoses of anxiety, and 350 diagnoses of suicidality are attributable to psoriasis annually<sup>9</sup>
- **The available dermatological resource is already seriously overstretched**
  - 24% of the population consults a GP each year because of a skin complaint. Skin disease is one of the most common reasons for a new consultation with GPs.
  - GPs refer approximately 6.1% of these cases to secondary care and in 2010/11 873,000 such referrals were made in England with 2.9m total outpatient appointments for skin diseases.
  - There is a 20% under-provision of Dermatology services in the UK: with only 650 Consultants in the country.
  - Despite the above statistics, GPs receive on average no more than six days training in Dermatology during the whole of their time as undergraduate and post-graduate medical students, and only around one in five GP training schemes offer a Dermatology element<sup>10</sup>. It is therefore inevitable that many doctors will enter General Practice with limited knowledge and understanding of common skin diseases that can often present significant clinical diagnostic and management problems.
  - Referrals to Dermatology services have risen as a consequence of increasing population numbers, frequency of skin diseases, improved treatments and changing attitudes to skin conditions. This is despite the increased number of community based services following the recommendations of the White Paper 'Our health, our care, our say: a new direction for community services' (2006).

## 2. Varying the current mix of service

- 2.1 In the BAD's document 'Guidance for Commissioning Dermatology Services' we set out the range and scope of services which would best serve Dermatology patients at different levels, including Community Pharmacists and Specialist Nurse-led clinics supporting patients with self-management, and covering primary and intermediate care to secondary and tertiary services. The BAD supports the provision of a comprehensive mix of services but not the promotion of one type of service over another – there will always be a need for centralised hospital-based services. These continue to be the most cost-effective and safe means of providing direct access to care for patients who are acutely unwell and have complex care needs. Increased Consultant-led community services and education of primary care doctors and nurses will all help to improve integrated care of patients through a pyramid of appropriate expertise, so that patients see the right person at the right time.

## 3. The readiness of local NHS services to treat patients with LTCs (including multiple conditions) within the community

---

<sup>9</sup> *The Risk of Depression, Anxiety, and Suicidality in Patients With Psoriasis A Population-Based Cohort Study* CHOSIDOW OLIVIER, MD, PhD; P. DELLAVALLE ROBERT, MD, PhD, MSPH; DO DAIHUNG, MD; GONZÁLEZ URBÀ, MD, PhD; M. POPESCU CATALIN, MD, PhD; WILLIAMS HYWEL, MSc, PhD, FRCP; Shanu Kohli Kurd, MD, MSCE, MHS; Andrea B. Troxel, ScD; Paul Crits-Christoph, PhD; Joel M. Gelfand, MD, MSCE Arch Dermatol. 2010;146(8):891-895. doi:10.1001/archdermatol.2010.186.

<sup>10</sup> Chiang Y et al Burge SM 2008 BJD 159 Suppl 1p 1.

- 3.1 The lack of dermatological training at undergraduate and postgraduate level for GPs has the knock-on effect that provision in primary care is limited. Although a number of intermediate services have been set up in the community and are staffed by a range of healthcare professionals such as GPwSIs, these should be developed in partnership with secondary care. The location, service model and range of facilities dependant on local needs should be assessed prior to implementing service redesign. The cost effectiveness and quality outcomes of such services should also be evaluated. For example, clinics provided by GPwSIs can be more expensive than secondary care services.<sup>11</sup>
- 3.2 Clinical Assessment and Treatment Centres are also used in some areas to triage and/or review GP referrals to reduce the number of patients referred to secondary care. The BAD recommends that GP referrals are always triaged by a Consultant Dermatologist with GPwSI and Dermatology nurse support, and that referral management services should only be set up after consultation with all stakeholders, including the public and those in secondary care. Without engagement at all levels, referral management services may introduce an additional tier to accessing care, reduce patient choice and quality of care, and worse still, destabilise local NHS hospital services.
- 3.3 Providing *Care Closer to Home* often involves decommissioning parts of Dermatology Outpatients services in order to provide intermediate levels of care in the community. However, the objective of such decommissioning – to bring about improvements in service provision - has not been realised. Instead, there are *increased* referrals to both community and hospital services, rather than reduced referrals to the hospital setting. Under the existing *Any Qualified Provider* model, and with the use of private providers, recognised care pathways across different levels of care can become fragmented. This happens even when these services are provided by local clinicians under a *Limited Liability Partnership*. In the majority of cases where this has happened the cost of care remains the same per head of patients as the hospital service. This cost does not, though, factor in the additional costs for patient care for those ‘lost’ on the referral pathway between their GP and the community, before getting to secondary care.
- 3.4 Although moving care closer to home has been a policy ambition for some time, referral rates to both community and secondary care services have continued to rise since its inception, and there are worrying signs that primary care is buckling under the current pressures of demand.<sup>12</sup>

#### **4. Practical assistance offered to Commissioners**

- 4.1 The BAD has produced the document ‘*Guidance for Commissioning Dermatology Services*’ (2012) which can be downloaded from the BAD website ([bad.org.uk](http://bad.org.uk)), and the Clinical Services Unit provides individual support to Commissioners, stakeholders and Dermatology Departments on commissioning issues. From this service and the case studies received, the unit has now produced a document called ‘*Commissioning a Dermatology Service: Lessons for the NHS*’ which draws together learning from case studies, and provides reflections and recommendations that will be of practical use to Commissioners.

---

<sup>11</sup> .Jackson S (2007) *Dermatology GPwSI: terms and conditions email survey (unpublished data) AND Economic evaluation of a general practitioner with special interests led dermatology service in primary care.* Coast, J et al. *BMJ* 2005; 331 doi: <http://dx.doi.org/10.1136/bmj.38676.446910.7C> (15 /12/ 2005)

<sup>12</sup> . Kings Fund “*Shifting care closer to home: slogan or solution?*”

*Quality Standards for Dermatology; providing the right care for people with skin conditions* is a multi-stakeholder (including the BAD) publication and is available on the PCC website and has implications for commissioning.

## **5. The ability of NHS to treat multi-morbidities and the patient as a person**

- 5.1 Patients with skin disease often require treatment for existing co-morbidities (for example psoriasis and the metabolic syndrome) by their GP and Dermatology and other specialists; these patients need to be identified because they impact on services across the levels of care and across specialties. A *Needs Assessment* is therefore a crucial step in drawing up service specifications.
- 5.2 Dermatologists are frequently required to review patients under other specialist departments where treatments, both pharmacological and otherwise, can cause side-effects presenting as skin problems – often causing extra distress, physical morbidity and risk to an already sick individual. Drug reactions in skin are a common reason for admission to hospital and sometimes can be life-threatening. Immunosuppression (for example in HIV, AIDS or following organ transplants) as well as treatments for other cancers and diseases have all led to an increase in the number of people developing skin complications, including secondary skin cancers.
- 5.3 Identifying these dermatological co-morbidities (and their treatment) from coded information is particularly problematic as the patient under care will be logged under another specialty or consultant. The majority of Trusts have divisional budgets, (entitled, for example, General Medicine, Medical Specialties, or hosted by another specialist department e.g. Plastic Surgery), this fails to recognise the work of the Dermatology Department because it does not allow a) the identification of multidisciplinary care pathways or b) accurate planning of services by the Trust and Commissioners.
- 5.4 Recognition of multi-disciplinary care pathways should be highlighted to Commissioners considering services with a high level of multiple morbidities in certain patient groups. Within the NHS flexibility and integration have evolved around on-call services and in-patient consultations – if these services are contracted to private providers then the additional costs associated with these *ad-hoc* consultations would need to be factored in.

## **6. The implications of an ageing population**

- 6.1 Growth of the ageing population will increase the prevalence of skin LTCs. This is highlighted by the DALY statistic – although this captures disability over the entire population, i.e. young and old, and over time, one of the reasons why diabetes is less disabling is that it has higher mortality, whilst those with skin conditions continue to live with them into old age, increasing the DALY numbers.
- 6.2 The skin cancer epidemic gathers pace. The vast majority of skin cancer is due to chronic photo-damage as a result of increased recreational exposure and this shows no signs of diminishing. Many patients will have several episodes of skin cancer and pre-cancer as they get older. There are about ~13,000 melanomas and ~800,000 other skin cancers a year in the UK.
- 6.3 With increasing population growth and increasing longevity it is important to invest in Dermatology services, and training in Dermatology, so that the burden of chronic skin disease can be better managed with better outcomes for all patients. This includes the elderly and those whose skin disease is due to an associated LTC and/or its treatment.

## 7. The interaction between mental health conditions and LTCs

- 7.1 The BAD recognises the strong inter-relationship of mental health conditions with long-term physical health conditions, and particularly with skin conditions that are often both disabling and disfiguring. It is also important to acknowledge that patients may present with a skin condition which masks an underlying, untreated mental health problem. The recent BAD document *'Working Party Report on Minimum Standards for Psycho-Dermatology Services 2012'* outlines key information on psychosocial support service delivery requirements. The report delineates minimum service standards for psychosocial support.
- 7.2 The BAD has also recently been awarded, a Department of Health *Innovation, Excellence & Strategic Development Fund* grant to create a web-hub to provide psychological support to those suffering with skin conditions.
- 7.3 It should be highlighted that both these pieces of work have been driven by the under-provision of dermatology psychological services.<sup>13</sup> A recent study showed that 17% of patients needed psychological support to help them cope with psychological conditions secondary to their skin condition, 14% of patients had psychological conditions exacerbating their skin condition, 3% of patients presented with primary psychiatric disorders, and 8% had worsening psychiatric problems due to concomitant skin disorders.<sup>14</sup>

## 8. Conclusions.

Skin disease contributes hugely to LTCs in the UK; millions of people have dermatological LTCs such as eczema, psoriasis, acne, vitiligo and occupational skin disease. Additionally, there is a growing sector of the ageing population with chronic sun-damage and the serial skin cancers that ensue. Many other primarily non-dermatological LTCs create significant dermatological needs, due to the disease itself or to its treatment with drugs and their consequences and side effects. Some dermatological LTCs, especially psoriasis, are associated with significant co-morbidity – the metabolic syndrome and arthritis.

Provision of the type of care affected people need is under-resourced, fragmented and of variable quality, in terms of manpower and facilities. This is exacerbated by poor teaching and training of Dermatology in Medical Schools and General Practice, and under-funding of relevant research.

Addressing these issues of resource, training and research should lead to greatly improved care for people with LTCs delivered by Consultant-led, vertically integrated services.

### Notes:

The BAD documents referred to above can be found at: [bad.org.uk](http://bad.org.uk) under the Clinical Services menu.

*Quality Standards for Dermatology; providing the right care for people with skin conditions*

---

<sup>13</sup> (Riaz S, Staughton R, Bridgett C, *Mapping PsychoDermatology in the United Kingdom*, poster presented at the British Association of Dermatologists Annual Meeting 2004 / : "Psychocutaneous medicine and its provision in the UK"; A P Bewley, C Fleming and R Taylor, Barts and the London Trust, London, UK Presented at the British Association of Dermatologists Annual Meeting 2012 )

<sup>14</sup> (Study details: "Psychocutaneous medicine and its provision in the UK"; A P Bewley, C Fleming and R Taylor, Barts and the London Trust, London, UK)

can be found on the PCC website [://www.pcc-cic.org.uk/article/quality-standards-dermatology](http://www.pcc-cic.org.uk/article/quality-standards-dermatology)

**Contact details:**

Deborah Mason – 020 7391 6355

Email: [@bad.org.uk](mailto:@bad.org.uk)

The British Association of Dermatologists

Willan House

4 Fitzroy Square

London W1T 5HQ