Dermatology PhwSI guidance – The British Association of Dermatologist response.

- The prevalence of skin disease in general practice is around 25% of all disease groups

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Principles of service provision

Here you need to link to the Shifting care recommendations which post date the case studies to which you refer.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079728

The recommendations evaluated the pilots in the context of all the evidence and made recommendations about models of care. It is then important to reference our new document 'People with skin conditions: guidance and resources for commissioners' which PCC are publishing on 7th July. I think you should make reference to the fact the PhwSI will be considered as part of the 'shape the supply' part of the commissioning cycle.

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This is where it gets more difficult! I think we need to be clear whether some of the proposed areas are realistic.

- Liquid nitrogen cryotherapy: I am not sure in what context a PhwSI would use this. We no longer use it for treating viral warts (poor evidence base) and so it is largely used for actinic keratoses (debate though about whether these all need treating) and some skin cancers and pre-malignant problems (Superficial BCCs and Bowens disease). I am not sure that there would be enough activity of this type to warrant the development of a PhwSI liquid nitrogen service and it would require extensive training in the diagnosis and management of skin cancers.
- Leg ulcers: are you really suggesting that pharmacists would get involved in the assessment of patients with leg ulcers? This would involve a major undertaking in terms of facilities and time. There would need to be a treatment room with appropriate facilities. Leg ulcer assessments take about 1 hour and include Doppler ABPI assessment. Bandaging techniques require specialist skills. Local health communities would not be wise to invest in community pharmacists to develop the service
- Pre-malignant, malignant and non-malignant lesions. The NICE IOG is very proscriptive about the role of health care professionals in the diagnosis and management of malignant and pre-malignant skin lesions and I am not aware that there is any provision within the document to facilitate the development of PhwSIs in this role. The guidance for dermatology GPwSI community cancer clinicians, which enables the management of low risk BCCs only, was agreed within the NICE guidance but I cannot envisage the cancer leads agreeing to a PhwSI role in the diagnosis and management of skin cancer in the context o such rigid criteria for GPwSIs, NICE guidance and the national standards which have just been agreed. I do not think that this will be supported by other stakeholders.
- Hair and nail disorders and bacterial fungal and viral skin infections are moving into the remit of diagnostic skills, which may be possible but may be met with reservations by other

stakeholders. What is interesting is that this group probably presents most commonly to pharmacists and actually would be better dealt with by an overall improvement in the level of training and knowledge of pharmacists rather the development of the PhwSI role.

My personal view is that the PhwSI role sits best with pre-diagnosed chronic skin disease and I would have preferred an emphasis on this rather than so much that requires diagnostic skills which are much more difficult to learn.

Page 8: SLA

This need to make clear that the service sits as part of the overall integrated service that commissioners have commissioned based on the commissioning cycle ref. It should also state absolutely clearly that the SLA must incorporate reference to how the service is linked to other parts of the pan health community service for people with skin problems.

Support and facilities

Not happy about liquid nitrogen!

Record keeping surely needs to be joined up to the local primary care IT system if at all possible on order that everyone can see what management the patient is receiving.

Page 9: Clinical governance and standards

These need to match those in the new commissioning guidance which includes assessment of quality of life impact.

Page 10: The competences required

The BAD is firmly of the view that the diagnosis and treatment of serious malignant disease must remain beyond the expectations of such a scheme. It takes a very long time to accurately make such diagnoses and should be taught as knowledge to support diagnosed patients only.

The BAD is of the opinion that there is too much emphasis on a diagnostic role for pharmacists, which is the most challenging area of Dermatology and would require them to have training similar to that of an SpR. Pharmacists should build on skills they already have which means concentrating on management of already diagnosed conditions.

The BAD is firmly of the view that cryotherapy, minor surgery, leg ulcers, phototherapy or skin cancer are likely to remain in the domain of medically trained personnel. To apply cryotherapy adequately requires significant experience. More importantly the lesion needs to be diagnosed first and this is the major issue surrounding the use of cryotherapy: one cannot apply cryotherapy to something which has not been diagnosed with certainty.

It is difficult to conceive of how pharmacies are to be re-configured to treat leg ulcers. This will almost certainly require dermatological nursing skills in the pharmacy.

Phototherapy requires expensive equipment and requires the regular monitoring of such equipment by a medical physicist as laid down by national guidelines. Patients must be screened for pre-malignant / malignant conditions first and other autoimmune conditions such as lupus erythematosis excluded. This is not within the realms of a pharmacist. The highest reason for litigation in dermatology is in the area of phototherapy: if this proposal were to go ahead, then patients will suffer harm and will, almost certainly, resort to litigation.

Skin cancer is an extremely difficult are for most medical practitioners: it has been regularly shown that GPs do not do skin surgery to the same competency as hospital doctors. To achieve the technical skills required for skin surgery for pharmacists will be totally unachievable.

The treatment of skin cancer requires years of learning as to what is benign and what is malignant. GPs perform poorly at this. To fulfil the current skin cancer NICE IOGs, pharmacists will require training in skin surgery, attendance at multidisciplinary team meetings on a regular basis, a log of procedures done, audit of outcomes and methods of follow-up. Please consider in detail the NICE IOG guidance at:

NICE Improving outcomes for people with skin tumours, including melanoma. February 2006. http://www.nice.org.uk/nicemedia/pdf/CSG_Skin_Manual.pdf

The BAD believes that pharmacists are poorly equipped in their training to interpret histology reports (which is too specialised and builds on initial training acquired during a medical degree). To do so would need considerable training and regular attendance at joint pathology / dermatology discussion fora, usually held in hospitals weekly or alternate weeks, where cases are discussed in relation of clinicopathological correlation.

In this document there is no acknowledgement of the considerable time involved for the trainers and assessors, i.e. mostly Consultant Dermatologists. While in theory services such as these might reduce our workload, in practice this rarely seems to be the case and more often they seem to address unmet need. Hospital trusts would have to free up Consultant time (to facilitate a service, which could be seen as a direct competitor) and this would not be provided for free!

Page 13: Maintenance of competencies

I think this needs to be more proscriptive. I think we said 15 hours in the GPwSI guidance and this needs to match that document I would have thought.

Final paragraph first bullet point: Be an active member of the local dermatology specialist service. A GPwSI will usually be expected to attend the clinical governance meeting of the local dermatology specialist team so this needs to be standardised for the PhwSI.

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CHS113 is not appropriate as the PhwSI will not be offering phototherapy

CHS 114, The BAD cannot conceive of the position of pharmacists doing skin surgery. The diagnosis will need to be secured first and where are these skin surgery skills going to be acquired or practiced. Are pharmacies going to have theatres?

CHS116 see previous comments in respect of leg ulcers

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Again I worry about the drift into the diagnostic here and the huge range of conditions listed.

The BAD don't think skin biopsy is appropriate at all. Where you have expert diagnosticians then skin biopsy procedures are less likely to be necessary

Dermoscopy takes ages to learn properly and needs to be learnt in addition to diagnostic skills for skin lesions. I think it is totally inappropriate for PhwSIs

What diagnostic tests are being referred to? Need to state clearly what is meant (? Mycology or microbiology)

Page 17

Isotretinoin: the MHRA has made a clear statement about this included in the dermatology guidance. There may be some room for this but (i.e. the ongoing monitoring of isotretinoin) but the present MHRA position precludes this.

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Appendix 2

Just important that this matches what we have said for the GPwSI as an absolute minimum because the pharmacist is starting from a lower baseline in terms of dermatology knowledge and training other than in the therapeutics of skin disease.