

Dermatology

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1 Description of the specialty

Dermatologists are the only experienced, trained and accredited specialists in the diagnosis and management of diseases of the skin, hair and nails in adults and children. There are no others who can provide care of equal quality to that of dermatologists; however, there are only 650 consultant dermatologists in the UK, many of whom work part time. Over 2,000 skin disorders are recognised, so accurate diagnosis is fundamental to successful management. Each year 54% of the population are affected by skin disease, and 23–33% at any one time have disease that would benefit from medical care.^{1,2} Approximately 4,000 deaths occur in the UK annually due to skin disease, most often from malignant melanoma.¹ Skin diseases represent 34% of disease in children,² with atopic eczema affecting 20% of infants. Dermatologists organise and deliver skin cancer services. Others subspecialise in complex medical dermatology, surgery including Mohs' micrographic surgery, allergy, paediatrics, genital disorders, photodermatology, psychodermatology and dermatopathology.

Skin cancer is the most common cancer and the second most common cancer causing death in young adults. Basal cell carcinoma (BCC) numbers equal all other malignancies combined, and increased by 81% between 1999 and 2010.³ Reported melanoma incidence increased by over 400% over 35 years.⁴ Hand eczema is one of the most common reasons for disablement benefit in the UK. Inflammatory skin diseases are disabling, disfiguring and distressing, and reduce quality of life. Expectations of the public have changed and will continue to change in particular with regard to skin disease appearance which can be of great importance, causing disability and loss of function.¹

The professional society for dermatologists is the British Association of Dermatologists (BAD) (www.bad.org.uk), a charity funded by the activity of British dermatologists. The objects are to further knowledge, practice, teaching and research of

dermatology and to advise other interested parties (including healthcare providers and politicians) in dermatology. Dermatologists not only provide care but are active in improving systems for healthcare.

2 Organisation of the service and patterns of referral

Each year 24% of the population see their GPs for skin disease and 882,000⁵ were referred to dermatologists in England in 2009–10 with 2.74 million⁵ consultations. This reflects an increased prevalence of atopic eczema and skin cancer, availability of more effective treatments and patient demand.

Consultant dermatologists are the most efficient providers of skin care, leading interdisciplinary teams including specialty doctors and associate specialist (SAS) doctors, GPs and nurses working in secondary and integrated intermediate care. Government initiatives have experimented with dermatology service delivery and evidence consistently shows that *care should always be delivered by individuals with the right skills, in the right setting, the first time*. Triage by an expert familiar with the full range of services ensures that patients are directed to high-quality, cost-efficient care from the outset. Misuse of non-accredited doctors as long-term locum dermatologists should be decried.

Primary care services

There are 13 million primary care consultations for skin diseases each year.¹ Outcomes could be enhanced by improving undergraduate dermatology teaching and learning, which averages approximately 6 days only. Most GP training schemes have no dermatology attachment. New Department of Health (DH) guidelines allow limited skin surgery to be undertaken under local enhanced (LES) and direct enhanced (DES) GP services, provided that correct governance arrangements are followed.⁶

Community specialist nurses can provide support for education and self-management of chronic

inflammatory skin diseases such as psoriasis, eczema and acne. They can enhance care but there is no evidence that they reduce secondary care referrals.

Intermediate services

GPs with a special interest (GPwSIs) in dermatology can provide effective intermediate care for individuals with chronic mild/moderate inflammatory diseases, skin infections, sun damage and certain skin cancers *as part of an integrated consultant dermatologist-led team*.⁶ There is no good evidence that these services reduce secondary care referrals or save money; they may 'de-skill' GP colleagues.^{7,8} There are detailed DH safety, governance and training guidelines for the accreditation of GPwSIs, which some primary care trusts (PCTs) ignore, risking patient safety.

Secondary care services

Secondary care dermatology services receive 882,000 referrals each year in England (approximately 16 per 1,000 population).⁹ Up to 50% of referrals relate to skin cancer. Specialist services include:

- skin cancer clinics – dermatologists screen over 90% of skin cancer referrals, treat approximately 75% and reassure the remainder; the National Institute for Health and Care Excellence (NICE) recommends that high-risk BCCs (the majority of cases) are treated in secondary care
- facilities for dermatological surgery, cancer multidisciplinary teams (MDTs) and data collection compliant with NICE guidance
- medical dermatology for complex problems, often in MDT clinics with other specialties such as rheumatology
- inpatient care of sick patients with severe skin diseases or skin failure, sometimes requiring intensive care
- phototherapy (see BAD and British Photodermatology Group working party report),¹⁰ iontophoresis, wound care and other day treatments
- day-case units for infusion of disease-modifying drugs
- paediatric dermatology services including laser surgery (see BAD and British Society for Paediatric Dermatology working party report)¹¹
- investigation of cutaneous allergy and occupational skin disease by patch and prick testing (see BAD and British Society for Cutaneous Allergy working party report)¹²
- investigation of photodermatoses, which affect 18% of the population reducing quality of life, psychological welfare and employability
- management of skin problems in hospital patients with other illnesses, thereby reducing length of stay (LOS)
- skin cancer screening for organ transplant recipients
- genital skin diseases
- management of genodermatoses
- cutaneous infections, tropical diseases and HIV skin diseases
- cellulitis day-case services producing substantial NHS savings
- teaching, training and assessment of medical students, GPs, trainee dermatologists and other healthcare professionals
- collection and analysis of clinical data, clinical audit and compliance with clinical governance requirements
- clinical research including therapeutic trials
- contributions to the wider NHS including NICE, Care Quality Commission, the RCP and BAD (producing guidelines, patient information and outcome measures).

Hospital-based services require at least one whole-time equivalent consultant dermatologist per 62,500 population (see section 8). SAS doctors form an integral part of the hospital team. Departments require the support of pharmacists and trained specialist dermatology nurses who meet competency standards set by their professional body, the British Dermatology Nursing Group (www.bdng.org.uk). Trained dermatology nurses can:

- treat patients in day-care units and on wards, provide and supervise phototherapy, assist with patch testing under consultant supervision, perform surgical procedures, and care for wounds and ulcers
- provide patient information, demonstrate and apply treatments, dress wounds, remove sutures and review follow-ups
- assist in operating theatres and advise patients undergoing surgery
- advise and train professional colleagues caring for patients with skin diseases in the hospital/ community
- with paediatric training, run hospital/outreach services for children with chronic skin disease. Establish and run community clinics

- run monitoring clinics for isotretinoin and biologic/systemic treatments for inflammatory skin diseases.

Tertiary care services

The UK has many national and international experts in dermatology who provide services for complex cases.

As of January 2011, national commissioned group services in England exist for: xeroderma pigmentosum, epidermolysis bullosa, Ehlers–Danlos syndrome, neurofibromatosis types 1 and 2, Fabry disease and cryopyrin diseases. The National Commissioning Board Dermatology Clinical Reference Group is developing, in 2013, nationally commissioned networks of specialised services in over 20 areas of dermatology, which may be commissioned from April 2013 onwards. Proposals for this service include virtual MDTs with referrals delivered through a portal hosted by the BAD.

Psychological services

People with skin disorders often benefit from psychological intervention, but services are often limited by NHS financial restraints. The NICE guidelines for skin cancer care require psychological services to be available for those with skin cancer.

Community care

Community pharmacists can reinforce self-care/self-help messages at the point of dispensing for patients. People spent £413 million (18% of over-the-counter (OTC) sales) on skin treatments in the UK in 2007.¹

Camouflage services may be an integral part of care.

Complementary services

Alternative therapies lack evidence of efficacy and safety and some (eg eastern herbal treatments) may contain potent corticosteroids or liver toxins.

3 Working with patients: patient-centred care

Ensuring that the patient is at the centre of care

Patient involvement and choice

Involving patients in choice and decision-making about their care has been improved by increasing consultation times with doctors and nurses and by providing quality information such as BAD patient information leaflets (PILS) (available at www.bad.org.uk).

Patient choice would be enhanced were information for patients available, at the point of choice, about the qualifications, experience and accreditation of doctors providing services.

Patient support groups and access to information

The BAD recognises and supports 55 patient support groups (PSGs), providing links to their websites from www.bad.org.uk, where over 130 PILS on over 120 conditions are available.

Education and promoting self-care for acute and chronic skin diseases

Information provided by PSGs is invaluable. The BAD provides ongoing support, including financial grants, to the PSGs.

Role of the expert patient

The Dermatology Councils for England, Scotland and Wales represent multiple stakeholders including the PSGs. Patient and public involvement groups (PPIs) are active in many dermatology departments.

4 Interspecialty and interdisciplinary liaison

Dermatology care is carried out most efficiently in the UK using a hospital-based team led by a consultant dermatologist, with SAS doctors, GPs and nurses in secondary and integrated intermediate care.

Multidisciplinary teams in skin cancer clinics involve dermatologists, surgeons, histopathologists, oncologists, radiotherapists, nurses, and psychiatrists and psychologists (see BAD and Psychodermatology UK working party report on psycho-dermatology).¹³

Combined clinics between dermatologists and hospital specialists exist for complex problems, eg involving rheumatology, plastic surgery, HIV, genital/oral diseases, psychiatry, paediatrics, genetics, stomas, eyes, vascular surgery and allergy.

5 Delivering a high-quality dermatology service

What is a high-quality service?

A dermatology service should provide patient-centred care focusing on outcomes that meet national standards. To achieve this, all staff must be correctly trained and accredited and the local service structure should provide

facilities that enable safe and effective investigation and treatment. A multi-stakeholder document, the production of which was supported by the DH *Quality standards for dermatology*, provides commissioners with guidance in commissioning high-quality dermatology services.¹⁴ A high-quality service should follow and audit compliance with national guidelines provided by NICE and the BAD, and should participate in BAD-facilitated and -hosted national audits.

Staffing

Consultant dermatologists should be on the specialist register of the General Medical Council (GMC). They should not work alone and must have appropriate support staff including specialist dermatology nurses and trained secretarial staff.

Local facilities needed for dermatology patients¹⁵

The following local facilities are needed:

- dedicated outpatient units with rooms for patient education, breaking bad news and counselling
- areas for contact allergy testing with storage areas for allergens meeting national published standards
- surgical facilities meeting national standards for space, cleanliness and equipment, with storage for liquid nitrogen
- laser-safe areas where required
- facilities for Mohs' micrographic surgery where required, meeting national standards
- day-care centres staffed by dedicated dermatology nurses
- phototherapy units for adults and children staffed by trained dermatology nurses who can also provide skin care (unlike physiotherapists), meeting national standards for equipment and safety. Medical physicists should monitor ultraviolet (UV) output. A named consultant dermatologist should be responsible for the service
- *hospital beds* staffed by trained specialist dermatology nurses with 24-hour medical care. Dermatology patients require a specialised dermatology nurse to apply treatments and provide education, with adequate bathing and treatment rooms. Inpatients should be geographically close to outpatient units for maximal efficiency
- laboratory support including chemical pathology, haematology, radiology, microbiology, mycology, histopathology and immunopathology
- information technology (IT) hardware and software that is robust, modern, reliable, fast, in the right place and immediately available

- medical photography services (eg for mole mapping and monitoring)
- comprehensive pharmacy services
- appropriate accommodation for paediatric dermatology clinics and inpatient care.

Maintaining and improving quality of care

Dermatologists lead the team delivering clinical services, driving service developments/innovations to improve patient outcomes.

Education and training

Education and training of medical students, specialty registrars (StRs), GPs and nurses improve care for patients with skin disease. Twenty per cent of GP consultations relate to skin disease but only 20% of GP training schemes include dermatology. Medical students, on average, receive approximately 6 days only of dermatology education. The BAD campaigns for more and better undergraduate and GP training in dermatology. Consultants conduct assessments (such as mini-clinical evaluation exercise (mini-CEX), direct observation of procedural skills (DOPs)) for trainee dermatologists, SAS, and foundation year 1 and 2 (FY1 and FY2) doctors and medical students. Entry to dermatology training requires proficiency in core internal medical training, including passing the MRCP qualification. Trainee dermatologists follow a 4-year curriculum, overseen by the specialist advisory committee (SAC), encompassing all aspects of dermatology.

Mentoring and appraisal of medical and other professional staff

The UK leads the world in development of specialist dermatology nurses.

Continuing professional development

Dermatologists spend more than 50 hours per year on continuing professional development (CPD).

Clinical governance

Clinical governance meetings discussing outcomes and reviewing departmental data, audit, complaints, new guidelines, etc should be included in the work programme. Protected time should be allowed for local, regional and national audit.

Research – clinical studies and basic science

Clinical and basic science research is essential to drive innovation and improve outcomes. The UK

Dermatology Clinical Trials Network has over 600 members. Academic dermatologists contribute to NHS work by setting up tertiary services, and leading UK dermatology education and research. The second largest charity for dermatology research, the British Skin Foundation, is funded and supported by the BAD, which has also set up, in 2012, a network for translational dermatology research. The NIHR Dermatology Specialty Group is being reorganised in 2013 and supports delivery of clinical dermatology research studies on the NICE research portfolio.

Local management roles

Dermatologists have multiple roles, leading clinical areas such as paediatric dermatology or patch testing and being responsible for registrar training or undergraduate teaching, audit and clinical governance. They also may be MDT chair or clinical service lead.

Regional and national work

Medical representation is essential on local, regional and national committees, and for national, professional or governmental bodies such as the DH, GMC, SAC, the RCP and the British Medical Association (BMA). The BAD has elected officers and committees that contribute substantially to national policy. Appropriate time should be allocated in the work programme for these important roles if the NHS is to function efficiently.

The *British Journal of Dermatology* and *Clinical and Experimental Dermatology*, essential for service development and CPD, are run by the BAD, with editorial work and paper reviews undertaken by UK dermatologists.

National guidelines

National guidelines are produced by dermatologists and listed on www.bad.org.uk, badged by NHS Evidence. Dermatologists contribute to NICE appraisals and guidelines and NHS 'Clinical knowledge summaries'.

Audits, quality tools and frameworks

All dermatologists participate in local, regional and national audit programmes, and many help develop quality tools and service frameworks.

6 Clinical work of consultants in dermatology

Inpatient work

In many hospitals, dermatology care is moving from a fixed ward base to multidisciplinary involvement with

dermatology patients on multiple wards. This must be reflected in job plans, with inpatients also receiving expert, dedicated dermatological nursing care.

- *Ward rounds*, leading and training a team including registrars, specialist nurses and students, usually occur for dermatology inpatients twice weekly.
- *Referral work*. Urgent requests for dermatological opinions on acute admissions require review on ward rounds. These frequently reduce length of stay in hospital.

Outpatient and day-case work

Outpatient and day-case work is the core work of most dermatologists. The nature of these clinics and specialist procedures varies considerably.

- *General dermatology clinics*: the ratio of new to follow-up patients and time allocated vary depending on the type/complexity of the cases seen. On average 12–16 patients may be seen in a clinic. In clinics teaching undergraduates, training registrars, or supervising doctors and nurses, numbers must be reduced accordingly.
- *Skin cancer/'see-and-treat' clinics*: various models are used. In screening clinics dermatologists see larger numbers of patients. See-and-treat clinics provide surgery on the first visit, reducing the numbers seen.
- *Specialised clinics within dermatology* include paediatrics, skin allergy, photodermatology and genital clinics.
- *Complex case clinics*: regions and large departments hold multidisciplinary clinics weekly or monthly for complex cases.
- *Surgery lists* may include biopsies (often done by nurses), day-case skin surgery lists including Mohs' micrographic surgery and laser lists (requiring a laser-safe area and general anaesthetic facilities for children). Skin surgery will usually take 20 minutes for a skin biopsy, 30 minutes for a simple excision and 60–90 minutes for more complex flaps and graft repairs. Micrographic surgery can take 90 minutes to several hours. These times do not include 'turnaround' time between cases, which depends on trained nursing support and efficiency.

Specialist on call

Dermatology trainees require training in acute 'on-call' dermatology. Patients with severe skin disease or skin failure should have access to expert dermatology advice.

Other specialist activities

Other specialist activities include weekly 1–2 hour MDT cancer meetings reviewing cancer cases according to the NICE guidelines, cancer networks, case conferences and nationally commissioned specialist services.

Clinically related administration

Clinically related administration includes screening and prioritising referral letters, reviewing and acting upon laboratory results and communicating with and about patients with colleagues in writing, by telephone or email. The time ratio between direct patient contact and clinical administration for dermatologists is 1:0.4.

Teledermatology

Teledermatology may be a useful triage tool for geographically remote areas *only* as part of an integrated consultant-led team subject to full clinical governance; there is no evidence that it can safely reduce referrals outside this setting.¹¹ Quality standards for teledermatology have been produced in 2012–13 by a multistakeholder group, supported by the DH, to guide commissioners. These standards should be available on the Primary Care Commissioning website and on www.bad.org.uk in 2013 (personal communication, Jan McLelland, honorary secretary, BAD).

7 Opportunities for integrated care and continuity

Consultant dermatologists are the most efficient providers of skin care. Due to consultant shortages in the UK, dermatology services work most efficiently as interdisciplinary, consultant dermatologist-led teams including SAS doctors, GPs and nurses (in secondary and intermediate care). GPwSIs must comply with DH rules on training and governance.¹⁶

8 Workforce requirements for the specialty

Based on government statistics for new patient referrals in 2009–10, a population of 250,000 generates 4,000 new patients.⁵ With a ratio of 1 new to 1.6 follow-up patients achievable for general dermatology clinics (not counting patients attending for patch testing, phototherapy, surgery and other specialist treatments that should be separated and removed from this statistic),¹⁷ 6,400 follow-up patients would give 10,400 patients per year in total.

The recorded new to follow-up ratio in 2009–10 for dermatology in England was 1:2.1.⁵ Commissioners using current recording methods should expect these figures.

Activities related to direct clinical care generate approximately 0.4 PA (programmed activity) for each clinic (Table 1). A 10-PA consultant should work 5 PAs in the clinic, operating theatre, seeing ward patients, etc, with 2 PAs of patient administration and 0.5 PA for MDT. A newly appointed consultant on 8.5 DCC and 1.5 SPA (ie with no teaching, research and trainee supervision or department management) may do an extra 0.7 PA in clinic or operating (with an extra 0.3 patient admin) initially pending job planning review.

A consultant with no travel to other centres, no inpatients, ward rounds or on call, no specialist clinics, no clinic teaching and no junior supervisory role should undertake 2 new, 2 follow-up (or equivalent mixed clinics) and 1 skin surgery clinic per 10-PA week. With 12 new patients (20 minutes per consultation), 16 follow-up cases (15 minutes per consultation) or up to 7 surgical cases per clinic, 24 new patients, 32 follow-up patients and 7 surgical procedures are seen per week. These are maximum numbers; actual numbers and new:follow-up ratios vary according to case type/complexity, with a ratio of 1:1.6 reported for psoriasis.¹⁸ People attending phototherapy, day care, treatment visits, surgery or investigations should not count or be coded as follow-up cases. Intermediate services take simple cases, resulting in more complex cases in secondary care adversely affecting new to follow-up ratios.

In an average 42-week year, a consultant will see 1,008 new and 1,344 follow-up patients and perform 280 operations. A population of 250,000, therefore, requires 4 whole-time equivalent (WTE) consultants (ie one consultant per 62,500 based on DH 2009–10 figures). This does not allow for specialist clinics, teaching students, supervising or training any grade of staff, ward referrals, inpatient care, on-call work, travel or MDTs.

There were 655 (557 WTE) consultant dermatologists, 213 WTE specialty registrars (equivalent to 44 WTE consultants) and 157.3 WTE SAS doctors (equivalent to 125 WTE consultants) in the 2012 UK BAD workforce survey, totalling approximately 726 WTE consultants. For the population of 61,800,000⁶ the UK workforce requirement for a consultant-led service is a minimum

Table 1 Example of job plan (England)

Activity	Workload	Programmed activities (PAs)
Direct clinical care		
Ward rounds, day-care supervision, nurse clinic supervision, ward referrals in hospitals with contractual agreements	Referrals from hospital colleagues; inpatient bed numbers vary	0.5–1.5
General outpatient clinics	12 for new clinic (20 min/consultation) or 16 follow-ups (15 min) or combination	3–4
Skin surgery	7 cases of average complexity	0–1
Skin cancer multidisciplinary team	Weekly or alternate weeks	0.5–1
Dermatopathology	Variable	0–0.5
On-call duties	Variable	0–1
Administration and management	‘Choose and book’, direct patient care, review of results, communication with other, healthcare professionals (0.4 per clinic or surgical list)	2–2.5
Specialist clinics	eg paediatric, patch testing, phototherapy, psoriasis, skin cancer	0–2
Travel	Variable	0–1
Total number of direct clinical care PAs		7.5 on average
Supporting professional activities (SPAs)		
Work to maintain and improve the quality of healthcare	Revalidation, undergraduate education, nurse, GP and hospital doctor training and supervision, appraisal educational supervisor or programme director for specialty registrars; departmental management and service development audit and clinical governance CPD and revalidation, research, etc	2.5 on average (1.5 minimum for revalidation if no teaching/research/trainee supervision/department management)
Other NHS hospital responsibilities	Medical director/clinical director/lead consultant in specialty/clinical tutor	Local agreement with trust
External duties	Work for deaneries/royal colleges/specialist societies/DH or other government bodies	Time for this has been agreed by NHS leaders

of 989 (WTE) dermatologists, indicating a shortfall of over 250 WTE dermatology consultants.

Reductions in clinic numbers are required for consultants supervising and training other doctors and medical students. The impact varies (typically one patient slot/individual) but may mean up to a 30% reduction in patient numbers.

9 Consultant work programme/specimen job plan

The work programme/specimen job plan discussed here is for a consultant dermatologist working in a district general hospital. The standard contract for a full-time NHS consultant is 10 PAs per week, typically divided into 7.5 PAs for direct patient care including ward work

and 2.5 PAs for supporting activities (SPAs) (7:3 ratio in Wales).

The balance of formal clinics, surgery, specialist clinics, ward work and supervisory activity will vary. Direct patient contact time must be accompanied by appropriate clinical administration time (1 clinical PA requires 0.4 PA administration time).

Numbers in clinics should be adjusted to ensure completion within 4 hours (3.75 in Wales), including clinic teaching and immediate clinical administration.

The BMA and the RCP give 2.5 SPAs (3 in Wales) as the 'typical' requirement, with 1.5 typically needed for the purposes of revalidation. Additional time is required for training, the lead dean stating that StR supervision requires 0.5 SPA and FY1/FY2 supervision 0.25 SPA weekly. New jobs should detail the proposed SPAs and existing consultants may need to justify SPAs at the job plan review.

Work for national bodies should be acknowledged and programmed and may require a negotiated reduction in the clinical elements of the job plan. On-call commitments will vary with local policies and staffing levels. Those working part-time or in academic posts must revalidate. Adequate SPA time must, therefore, be available while maintaining a sensible balance in a part-time contract. Hospital consultants involved in teaching and research need additional time for these activities, which will reduce the clinical elements of the job plan.

10 Key points for commissioners of dermatology services

- 1 Dermatology care should always be delivered by individuals with the right skills, in the right setting, the first time.
- 2 Patients offered choice should receive full information about the qualifications, accreditation and range of services offered by providers.
- 3 Dermatologists manage diseases of the skin, hair and nails in adults and children. As over 2,000 conditions are recognised, accurate diagnosis is fundamental to successful management.
- 4 Each year 54% of the population are affected by skin disease, and 23–33% at any one time have disease that would benefit from medical care.^{1,2}

- 5 Skin cancer is the most common cancer and the second most common cause of death in young adults. Basal cell carcinoma numbers equal all other malignancies combined and increased by 81% between 1999 and 2010.³ Reported melanoma incidence increased by 50% over 13 years.⁴
- 6 Consultant dermatologists see over 1,000 new patients per year and provide expert management, leading and training an MDT of dermatology nurses and GPs working across traditional healthcare boundaries. Efficiency of consultants is maximised by support and teamwork with specialist nurses and secretaries, optimising communication with the public and other practitioners.
- 7 There is no evidence that intermediate care in dermatology saves money or reduces referrals to secondary care, although such services may be popular with patients.^{7,8} There are DH documents on GPwSI training and governance that should be followed for patient safety.¹ DH training and governance guidance (2010–11) for GPwSI surgery for low-risk skin cancers should be followed.
- 8 Teledermatology may be a useful triage tool for geographically remote areas but only as part of an integrated consultant-led team subject to full clinical governance; there is no evidence that it can safely reduce referrals outside this setting.¹⁶
- 9 Dermatology consultants should not work in isolation but with consultant colleagues with a range of subspecialist skills.
- 10 The British Association of Dermatologists clinical services unit (www.bad.org.uk) provides clear, evidence-based guidance¹⁹ and is able to advise commissioners about dermatology services and help resolve issues.

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