



**CONSULTATION DOCUMENT**

**Acute Hospital Services**

**Proposals for the Future Organisation and Location of Dermatology  
Services in Greater Glasgow**

**14<sup>th</sup> May 2002**

# NHS Greater Glasgow

## Proposals for the Future Organisation and Location of Dermatology Services in Greater Glasgow

### 1 Introduction

The purpose of this paper is to set out, for consultation, proposals for unifying dermatology services in GGHB. The objective is to ensure that services are provided in the optimum way to maximise efficiency and ensure the highest standards of quality of patient care are delivered. The paper describes the reasons for reviewing the current service and proposes redesigning the service. The proposals have 3 key components

- Providing a unified specialist focal point for the service.
- Rationalising in-patient services and reinvesting resources to improve access.
- Maintaining and developing locally-based out-patient and treatment services.

Discussions between the Health Board, North Glasgow University Hospitals NHS Trust (NGT), South Glasgow University NHS Trust (SGT) and Royal Hospital for Sick Children NHS Trust (Yorkhill) began in the summer of 2000. Following the production of a paper by the Consultant Dermatologists in Glasgow advocating the need to redesign the way in which dermatological services are provided, a working group was established early in 2001. This group has met at regular intervals throughout the year to develop thinking around how the future dermatology services should be delivered. In addition, discussions have also been on going between the NGT and Greater Glasgow Primary Care NHS Trust (PCT) to develop and adopt protocols for referral, which will help to ensure optimum use of services. The expertise of those already providing unified dermatology services in the NHS has also been sought in shaping Glasgow's future service.

### 2 The Proposed Service

This section briefly describes the components of the proposed service and the key features:

**A core dermatology centre** which would:

- be sited within an acute hospital
- contain an in-patient unit with 24 beds.
- be staffed by all Glasgow consultant dermatologists and dedicated dermatology nurses
- provide general dermatology out-patient services for the local population
- provide tertiary services for the city and beyond such as:
  - regional occupational and contact dermatitis investigation unit
  - cutaneous oncology including pigmented lesion clinic
  - dermatological surgery including micrographic and laser surgery
  - specialised phototherapy and photodermatology
- provide a teledermatology hub
- be the clinical academic department for dermatology
- be a major UK department for specialist registrar training
- be the principal site of postgraduate education in dermatology
- house a clinical investigation unit for dermatology
- provide the major administrative base for the service

**3 or 4 ambulatory dermatology centres (ADCs)** which would provide local consultation, minor procedure and treatment services in a distribution similar to that provided by existing departments in the city. Teams of 2-3 consultants from the core unit would staff these. ADCs would have dedicated dermatology nurses who would make important contributions to service delivery. ADCs would also maintain and develop links with local primary care groups and contribute to undergraduate and postgraduate education.

**Paediatric dermatology service** could be similarly organised in a hub and spoke model. The hub would be in the Royal Hospital for Sick Children at Yorkhill. In order to maintain local access, paediatric dermatology services would be provided at all satellite units where appropriate facilities can be made available.

The Royal Hospital for Sick Children would provide tertiary care for Greater Glasgow and secondary care for the local population. This would require the development of referral guidelines between the satellite units and the hub. The standard of care for all children would be guaranteed by the use of clinical guidelines and managed clinical networks for the major paediatric dermatology conditions. Appropriate continuing medical education would be provided for all staff involved in paediatric dermatology. Inclusion in the hub and spoke service would ensure flexibility of medical staffing depending upon local requirements. It is hoped that regional consultants in dermatology would share in this delivery.

A summary of the key features of the new service follows – more details are provided in later sections:

- **An acute hospital site for the core unit.** This is necessary, as the casemix of patients will require access to multidisciplinary care for safe and efficient management. Conversely, dermatologists can contribute to effectiveness of the acute medical service.
- **Cost savings in in-patient care without loss of clinical effectiveness** in providing specialist nursing arise from the provision of a single dedicated unit
- **Revenue savings** will also arise from amalgamation of infrastructure and simplification of on-call arrangements. Medical and nursing staffing will need to be reviewed and adjusted to provide adequate and equitable cover. A need for additional clinical assistant sessions may be balanced by a rationalisation of training posts.
- **Centralisation of medical and nursing expertise and tertiary services** will mean more efficient out-patient management.
- **An enhanced role for dermatology nursing staff** at the main centre and the ambulatory dermatology units will contribute to service delivery. Development of the specialist nursing role at all centres will be essential to the success of these proposals. The liaison nursing service will be developed providing improved links to other services
- **Training for Specialist Registrars** will no longer require complex rotations to gain sub-specialist experience, resolving SAC criticism of the West of Scotland SpR training scheme. The critical mass will facilitate meetings, teaching and research.
- **Clinical effectiveness** will be facilitated by a nodal point for managed clinical networks and care protocols throughout the city.

- **National priorities** including skin cancer services will be addressed
- **Post-graduate training** for SHOs and general practitioners will be improved by an emphasis on education as a key role for consultant dermatologists. Links with general practice will be encouraged.
- **Continuing professional development** will be enhanced and hence the reconfigured service will help to facilitate **revalidation** of consultants.
- **Team organisation** providing continuity of care in in-patient and out-patient services, and the most efficient use of staff resources.
- **Attractive consultant posts** which can be filled when qualified applicants are few.
- **Opportunities for income generation** will arise from provision of core services to surrounding health boards, from clinical trials, from sub-specialist services such as a regional (or national) occupational and contact dermatitis service, dermatological surgery including micrographic surgery and dermatological laser treatment, and from provision of treatment services such as phototherapy to the private sector.

### 3 Existing Provision in Dermatology

In Glasgow, dermatology services are currently provided on 6 main sites by 11 consultant dermatologists and training staff. One is a full-time paediatric dermatologist, and one has a major commitment to contact dermatitis. One post is vacant and one is frozen. About 23,000 new patients (over a quarter of the Scottish total) are seen annually, with total attendances of 115,000.

#### Western Infirmary

Three NHS consultants are based here, of whom two also undertake clinics at Yorkhill. There are two specialist registrars, a clinical lecturer and 3 Senior House Officers (SHOs). In addition, the University Professor (post vacant) and Senior Lecturer both hold honorary consultant contracts. Four sessions previously undertaken by a consultant shared with Argyll and Clyde NHS Board are currently unfilled.

There are 20 dedicated in-patient beds and an out-patient treatment centre staffed by dermatology nurses, a minor surgery theatre and a multifunctional phototherapy suite. Out-patient clinics including specialist pigmented lesion clinic and patch testing clinic are held in the general out-patient department. The University department provides library and seminar facilities.

#### Stobhill Hospital

Until 1999 there were 2 consultant dermatologist posts. One shared with the Royal. There are 3 SHO posts but no other junior staff.

There is a dedicated dermatology out-patient unit, with treatment and phototherapy facilities staffed by dermatology nurses.

## **Glasgow Royal Infirmary**

2 consultants are based at GRI, and sessions from one of the Stobhill posts. There is an associate specialist, 1 specialist registrar, 3 SHOs and 4 clinical assistant sessions.

There is a dedicated dermatology out-patient unit, with treatment and phototherapy facilities staffed by dermatology nurses, and a library. The regional Contact Dermatitis Investigation Unit (to which Dr. Forsyth has a major sessional commitment) is sited at the Royal Infirmary.

## **Southern General Hospital**

3 consultants, 2 SHOs and a specialist registrar are shared with the Victoria, and there are 5 clinical assistant/hospital practitioner sessions.

16 in-patient beds at the Southern General Hospital, with an integrated out-patient clinic, procedure room, out patient treatment centre, multifunction phototherapy suite, and private laser suite (Lasercare) with some NHS access. There is a departmental library/seminar room.

## **Victoria Infirmary**

In addition to medical staff based at SGH, there are 11 clinical assistant/hospital practitioner sessions. Out-patient clinics, minor surgery, simple (UVB) phototherapy and treatment services, and contact dermatitis clinics are provided in a dedicated out-patient unit.

## **Yorkhill**

One consultant dermatologist is full time at Yorkhill but two others based at the Western Infirmary provide another WTE. There are 2 clinical assistant sessions. There is no dedicated treatment service. Individual departments elsewhere in the city also deal with paediatric cases and provide local out-patient treatment services for children, although with increased consultant provision Yorkhill can accommodate more new referrals.

## **4 The Case for Change – The Need for a Unified Service**

A number of issues contribute to the case for change:

- As with many other specialties, the trend in dermatology has been towards increasing sub-specialisation. It is no longer expected that every consultant dermatologist in a major centre can provide all aspects of dermatological care to the highest standards. Almost all have a special interest.
- Major sub-specialties include cutaneous oncology, dermatological surgery, laser surgery, occupational and contact dermatitis, paediatric dermatology and genetic disease, vulval disease, photobiology and phototherapy. Third-line management of severe blistering or inflammatory skin disorders is also important. The pathology of the skin is a sub-specialist interest for pathologists (and some dermatologists), but requires a critical mass of material to maintain expertise. These sub-specialist interests are all represented in Glasgow, but are dispersed around the city.

- A unified service with more effective use of consultant time and enhanced nursing roles will reduce waiting times in a specialty where there are major problems.
- Given that the existing departments have a tradition of collaboration, with referrals between departments, specialist registrar training and CME activity as examples, it is a small step to consider that these should be united into a single dermatology service for the city. However there will be a continuing need to provide care for the whole city using staff and facilities in ambulatory centres elsewhere in the city.
- There is a significant opportunity to develop nursing services by re-shaping the current arrangements.
- The need for a unified service is, however, more than convenience and opportunity. The expectations of clinical governance and the need to demonstrate clinical effectiveness, combined with the continuing training of both nursing and medical staff, including revalidation, drives the proposal of a single unit as a means of guaranteeing efficiency and the highest standards of quality in the dermatology service for Glasgow and adjacent areas.
- Detailed proposals have been developed to increase nursing efficiency role enhancement, as a key part of these proposals.
  - Other benefits of a unified dermatology service include the integration of postgraduate and specialist registrar training, and a single interface with services such as oncology plastic and vascular surgery, which would form managed care networks with dermatology.
- A single dermatology service based in one unit will provide efficient use of both junior and senior staff for emergency rotas.
- As clinical treatments have changed dermatology in patient bed numbers in Glasgow have fallen from 138 twelve years ago to the current 36. This reduction has been made possible by an increased emphasis on out-patient ambulatory care provision. However, as the number of patients treated in this way has increased, so the case-mix of in-patients has changed to include a higher proportion of those with associated problems, which make them unsuitable for ambulatory care., e.g. the elderly and/or those who have additional medical problems (mainly arthritis, cardiac disease, psychiatric disorder or alcoholism). Efficient and high quality in-patient service provision is not possible with the current disposal of beds across Glasgow.

There is, therefore, a continuing need for high quality dedicated in-patient care for dermatology patients. The number of GGHB patients admitted to the existing wards has averaged 553 over the last 4 years (Appendix I). In addition, 12% of new out-patients seen in Glasgow hospitals are from adjacent health boards, and can be expected to be admitted in proportion (total = 619). Assuming an improved average length of stay of 12 days (Scottish average 13.0) and 85% occupancy, this would require 24 beds. Moreover, the British Association of Dermatologists recommends a minimum of 2 beds per 100,000 population, but indicates that local circumstances may increase this need. Inflating the GGHB population of about 911,000 by 12% to account for cross-boundary flow gives a figure of 1.02 million.

Deprivation, heart disease, and alcoholism are all major public health problems for Glasgow which impact on the need for in-patient management. Thus allowing for medical and social factors, both the British Association of Dermatologists guidelines and experience suggest 24 beds (2.4 per 100,000) is an appropriate figure for Glasgow.

The in-patient unit would provide special facilities for management of dermatological problems. These include ward treatment rooms, special bathing and extra showering facilities, and side rooms with provision for isolation, and UV screening for photosensitive patients.

Centralised and reduced in-patient provision would need to be balanced by high quality ambulatory care services in other sites.

In addition to this section, potential benefits of change are also described in Section 2 – outlining the key features of the model

## 5 What Would the New Service Look Like?

This section describes in more detail the components of the service outlined in Section 2.

**A Core Dermatology Centre** would:

- be sited within an acute hospital
- contain an in-patient unit with 24 beds
- be staffed by all Glasgow consultant dermatologists
- and dedicated dermatology nurses
- provide general dermatology out-patient services for the local population
- provide tertiary services for the city and beyond such as:
  - regional occupational and contact dermatitis investigation unit
  - cutaneous oncology including pigmented lesion clinic
  - dermatological surgery including micrographic and laser surgery
- specialised phototherapy and photodermatology
- provide a teledermatology hub
- be the clinical academic department for dermatology
- be a major UK department for specialist registrar training
- be the principal site of postgraduate education in dermatology
- house a clinical investigation unit for dermatology

The main dermatology department would contain a 24 bed in-patient unit, located on an acute hospital site, because the case-mix will include both acutely ill dermatology patients, and a high proportion of patients with other medical problems as previously stated.

The acute hospital setting would also ensure links with other units and specialties in service delivery, and improve opportunities for development, multidisciplinary training, and collaborative clinical research.

The core unit would also provide out-patient services for the local area as for ambulatory centres. The key role, however, will be in provision of tertiary services and would require provision of modern clinic space.

Tertiary services would include:

- the regional occupational and contact dermatitis investigation unit;
- cutaneous oncology including a tertiary pigmented lesion clinic,
- tertiary care of severe chronic inflammatory skin disorders,
- genetic skin diseases,
- dermatological surgery.

The latter would require state-of-the-art facilities, a minimum of two theatre rooms, a preparation room for micrographic (Mohs) surgery and changing rooms for the patients. A dermatological laser suite would allow laser treatment. Tertiary forms of phototherapy such as PUVA and photodynamic therapy, and facilities for investigation and management of photosensitivity disorders (with liaison to the national Photobiology Unit in Dundee), will require space and equipment.

The core unit would be the most likely point of liaison for clinical networks with oncology, plastic and vascular surgery, and gynaecology (vulval disease).

A teledermatology and communication hub would provide links with ambulatory units and more remote departments or even general practices.

The central site would concentrate specialist training in dermatology and allow Glasgow to enhance its reputation as one of the major UK centres and, in the longer term, ensure the provision of high quality dermatologists. To foster strong academic research and teaching, the core unit would be close to the University Department of Dermatology. If not on the same site, the centre would need to be the clinical academic department, and have appropriate library and postgraduate teaching facilities. In addition, the existence of a united service creates opportunities for clinical research, which would require provision of facilities. A clinical investigation centre would enable the new department to be at the cutting edge of new dermatological treatments, as well as the opportunity to attract funds to enhance the service.

The pooling of nursing expertise would ensure that the unit would lead nurse training and sub-specialisation in dermatology. The unit would be the centre for postgraduate training of community nurses and general practitioners, with the ambulatory dermatology centres and liaison nurses participating in the delivery of practical instruction.

The core unit would be staffed by all existing Glasgow based NHS consultants (except the Yorkhill one), clinical sessions of academic staff, specialist registrars, non-training grades (Associate Specialists, Staff Grades, Hospital Practitioners & Clinical Assistants), SHOs (medical, general practitioner, or other trainees), dermatology specialist nurses (including liaison nurses), and dedicated administrative and support staff. Each consultant would provide services, including tertiary services, at the core unit and as part of a team including juniors at one ambulatory centre.

**It is proposed that the core unit is situated on the Southern General site for the following reasons:**

- there is space available which would enable early consolidation of in-patient services with the first increment of other facilities.
- The site provides reasonable access for Greater Glasgow and the West of Scotland
- The site is the GGNHSB preferred option for all acute in-patient services for South Glasgow.

### **Ambulatory Dermatology Centres (ADCs)**

- Dermatology is a high throughput out-patient orientated service. The existence of a high quality central facility does not remove the need for provision of high quality local services in other sites. Consultant staff provide part of the service, but continuity and the provision of additional services such as minor surgery or one-stop clinics requires reliable and suitably trained medical and nursing support. Dedicated out-patient units with treatment and simpler phototherapy facilities are needed, and, as mentioned above, the secure provision of trained and resourced nursing staff is critical to the ability to provide such care. In addition, some local provision could be made for initial management of patient treatment, but referral for tertiary services such as sophisticated surgery, contact dermatitis testing, or laser services, would be provided as part of a managed clinical network.
- **Services would continue to be provided from all of the existing locations in Greater Glasgow.** This will mean 3/4 ADCs in addition to the main dermatology centre and provision at the Royal Hospital for Sick Children. Two of these could be part of Ambulatory Care Hospital (or ACAD) developments at Stobhill and the Victoria Infirmary. Depending on the siting of the main unit, modern facilities would need to be identified during reconfiguration of services in West Glasgow, the Glasgow Royal Infirmary, and the Southern General.
- Each ADC would deal with the majority of out-patient referrals for the local population. They would be staffed on a sessional basis in proportion to the level of demand by a team of 2 or more Consultant Dermatologists, additional medical staff including specialist registrar, SHOs and clinical assistants and dedicated dermatology nursing staff with training and experience in the specialty. Staffing complements at all levels would be calculated on the basis of equity based on population and need across the city, and to optimise the use of the facilities. For optimal use of resources, dedicated facilities in each ADC would be used on a full-time basis, although a smaller centre such as Stobhill, lower levels of demand might justify sharing facilities with other out-patient services.
- Each ADC would provide :-
  - consultation and examination rooms;
  - an appropriately equipped minor surgical procedure/theatre room;
  - treatment rooms for dressings including leg ulcers (minimum of 2), with an electrically operated leg ulcer chair;

- phototherapy room, with whole body cubicle for narrow-band UVB phototherapy;
  - shower, bath, and changing facilities adjacent to treatment & phototherapy rooms;
  - teledermatology link to main Dermatology centre;
  - IT links for phototherapy management and other audit applications,
  - secretarial and administrative support
- Each centre would provide a mixture of consultant clinics, nurse led clinics, minor procedure clinics and treatment services. Experience in South Glasgow has emphasised the need for non-training grade medical staff such as clinical assistants to enable consultant led clinics to meet demand, to provide one-stop consultations where possible, and to undertake minor surgery. These staff are usually local general practitioners with an interest in dermatology, enhancing links with primary care. There will be an increasing role for dedicated dermatology nursing staff in all centres.
  - A senior dermatology nurse would be responsible for running the service at each site. Many nurses are acquiring new skills such as minor procedures and simple patch testing, and conducting nurse led clinics. Nursing staff will take increasing responsibility for the management of chronic relapsing skin disorders and leg ulcers.

### Paediatric Dermatology

- Paediatric dermatology service could be similarly organised in a hub and spoke model. The hub would be in the Royal Hospital for Sick Children. In order to maintain local access, paediatric dermatology services would be provided at all satellite units where appropriate facilities can be made available. The Royal Hospital for Sick Children would provide tertiary care for Greater Glasgow and secondary care for the local population. This would require the development of referral guidelines between the satellite units and the hub. The standard of care for all children would be guaranteed by the use of clinical guidelines and managed clinical networks for the major paediatric dermatology conditions. Appropriate continuing medical education would be provided for all staff involved in paediatric dermatology. Inclusion in the hub and spoke service would ensure flexibility of medical staffing depending upon local requirements. It is hoped that regional consultants in dermatology would share in this delivery.

These proposals change only in-patient activity from 700 cases provided between the Western and Southern General to a 100% service on a single site at the Southern. Out-patient and day cases would be provided on the current pattern.

## 6 Improving Services for Patients

The enhanced dermatology service would produce better service in all areas. Examples of how the unified service will do this in relation to priority areas are given below.

### Skin Cancer

- The NHS aims to halt the year on year increase of skin cancer cases by 2020. One of the essential goals of the new service would be to **promote skin health** to the Glasgow community. This educational role could be extended to other aspects of dermatological education and dermatology nurses would play a leading role here.

- Melanoma is the least common but most serious of the major skin cancers. **Fast tracking of suspected melanoma** would be incorporated into the service at all sites and a specialist pigmented lesion clinic as operated at the Western Infirmary for many years will continue. A managed clinical network will integrate care provision with our colleagues in plastic surgery and oncology.
- The majority of skin malignancies are non-melanoma skin cancers (basal cell and squamous cell carcinomas) and the first line management of these tumours is surgical excision. One of the aims of the new service would be to offer **one-stop clinics** for non-melanoma skin cancer. The investment in staffing and facilities described above will be particularly critical in allowing us to meet the targets set by DOH guidelines in skin cancer.

The core unit will enable expertise to be concentrated in the management of rare forms of cutaneous neoplasia such as cutaneous T cell lymphoma.

### **Inflammatory Skin Disease**

- Eczema and psoriasis are common and often disabling conditions. A major focus of the service would be the provision of high quality, locally accessible care for patients with severe chronic inflammatory skin disease. Many of these patients have additional medical or social problems and require dermatological support in the community, as well as day care and in-patient hospital treatment.

In addition, to improve risk management, specialised clinics will be held at the core unit to deal with patients requiring higher risk third line treatments.

### **Leg Ulcer Assessment and Resource Service**

- Leg ulcers are a major cause of chronic disability and important consumers of use health care resources. Although community leg ulcer clinics have greatly enhanced the standard of care, there is a continuing need for a central resource for assessment and access to tertiary resources, including contact dermatitis testing, specialised and emerging wound management techniques, and liaison with vascular services through a managed network.

## **7 Impact on Resources**

This proposal integrates existing staff and patterns of service delivery. Nonetheless, implementing the modern, high quality dermatology services envisaged for Glasgow will require investment in facilities and staff. Some up-to-date facilities will be provided in the new ambulatory care centres, but support for adequate staffing for the new service may have to come from savings made by closing existing in-patient units and reorganisation of on-call arrangements. This section focuses on staffing issues – work on modelling the costs of current services and their transferability, is in hand.

## **Staffing Implications - Medical Staff**

### Consultants

The reconfiguration of existing consultant job plans to incorporate the team approach would depend on which hospital site was chosen for the single department, and would be the subject of further discussion. However, each ambulatory dermatology centre would have between 4 and 8 consultant sessions (maximum 3 per consultant), with the remaining daily cover for ambulatory care being maintained by non-training grade medical staff (e.g. clinical assistant minor surgery sessions) and dedicated dermatology nurse specialists.

### Specialist Registrars

At present there are 5 specialist registrars in the West of Scotland, rotating through 4 centres (including Monklands Hospital). Under the proposed arrangement the registrars will be based in the main department for most of their time, as it will no longer be necessary for them to rotate within Glasgow to receive experience in special interest areas. They will however gain general experience by accompanying specific consultant teams into one of the other sites, and by rotating to general hospitals such as Monklands.

### SHOs

Senior House officers are important members of the department but their relative lack of experience means that their service role in out-patient dermatology is limited. Enhanced formal training for SHOs will be improved by a centralised service. The on call rota for junior medical staff will be much simplified.

### Non-training grade staff

Non-training grade staff will mainly be clinical assistants. It is usual for these positions to be filled by local general practitioners with an interest in dermatology, often with previous dermatology experience. The advantages of such posts are that once trained by a consultant the clinical assistant greatly enhances the running of clinics by giving continuity of care. The presence of a clinical assistant ensures that greater efficiency in consultant clinics and provides minor surgical support services. In addition such posts help to strengthen the community link with local primary care groups.

Use of this grade will be expanded so that the minimum staffing for each routine consultant clinic at the main centre and in the ambulatory care centres will be a consultant, a trainee (SHO or SpR) and a clinical assistant or other non-training grade.

## **Staffing Implications - Nursing Staff**

The Group has initiated a detailed review of dermatology nursing led by senior nursing staff in both Trusts to develop proposals to shift the balance of nursing from in-patient services to specialist out-patient care.

### Academic Perspective on Proposed Re-provision of Dermatology Services

The academic status of dermatology in Glasgow will be enhanced by the creation of a hub and spoke service. There will be a single point of contact between clinical dermatologists and the University Department of Dermatology and other collaborators. A centre of clinical excellence will promote the development of sub-specialist expertise, a key component of which is participation in academic research. The large catchment area will facilitate epidemiological investigation and the recruitment of patients for study. These advantages will be enhanced by regional roles in some specialist areas. There will be a co-ordinated approach to undergraduate and postgraduate education and training, and continuing medical education, across the city. Trainees based at a single site rather than rotating to different hospitals will find it easier to undertake extended clinical or non-clinical research projects.

To achieve these aspirations the new service should be configured to build on Glasgow's research strengths and, in particular, to maintain strong links with university departments in both clinical and life sciences spheres. Ideally, clinical and academic dermatology units should be co-located, but the established interests of the University Department of Dermatology are best served in its present location. Accordingly, wherever the clinical hub is sited, regular and systematic links must be maintained for NHS as well as clinical academic staff. These will include a joint programme of meetings and research seminars, and opportunities for trainees to take part in laboratory projects. Research strategy will be co-ordinated to take advantage of expertise and opportunities in the city. There is already substantial common interest in epidermal proliferation and differentiation, especially as regards skin cancer and its pathogenesis, but also in psoriasis and genetic disorders of keratinisation. The epidemiology, diagnosis, and management of skin cancer will remain an important shared research theme. Both service and research links with pathology are critical. The existence of a specialist centre with clinical research facilities within an acute hospital site will provide new opportunities for translational research in dermatology.

The staffing and facilities of the hub unit must be designed to reflect its role as the leading dermatology department in the West of Scotland. Dedicated clinical research space and equipment will be needed. For both consultants and trainees, timetables will have to be designed to protect academic time, as there is a danger that hub and spoke design will fragment individual job plans. For the same reason, adequate office space and secretarial support are necessary. For undergraduate and postgraduate education, seminar/library, and comprehensive ICT facilities are mandatory. Dermatological care provision, teaching and research have a particular requirement for medical illustration support, which must also be considered in redesigning the service.

Individuals or organisations wishing to comment on the proposals should send their responses to:

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**by no later than Friday, 2<sup>nd</sup> August 2002**

## Activity of Glasgow Dermatology Services

| <b>Adult Inpatients</b> | <b>Year</b> | <b>96/97</b> | <b>97/98</b> | <b>98/99</b> | <b>99/00</b> |
|-------------------------|-------------|--------------|--------------|--------------|--------------|
| <b>GHB</b>              |             |              |              |              |              |
| Western Infirmary       | 309         | 297          | 293          | 276          |              |
| Stobhill Hospital       | 53          | -            | -            | -            |              |
| Southern General        | 220         | 260          | 227          | 277          |              |
| <b>Total GGHB</b>       | <b>582</b>  | <b>557</b>   | <b>520</b>   | <b>553</b>   |              |
| <b>Non-GGHB</b>         |             |              |              |              |              |
| Western Infirmary       | 156         | 194          | 200          | 151          |              |
| Stobhill Hospital       | 28          | -            | -            | -            |              |
| Southern General        | 49          | 53           | 40           | 30           |              |
| <b>Total Non-GGHB</b>   | <b>233</b>  | <b>247</b>   | <b>240</b>   | <b>181</b>   |              |
| <b>Total</b>            | <b>815</b>  | <b>804</b>   | <b>760</b>   | <b>734</b>   |              |

| <b>New Outpatients</b>    | <b>96/97</b> | <b>97/98</b> | <b>98/99</b> | <b>99/00</b> |
|---------------------------|--------------|--------------|--------------|--------------|
| <b>North</b>              |              |              |              |              |
| Western Infirmary         | 5931         | 6132         | 6022         | 6098         |
| Stobhill Hospital         | 2901         | 3208         | 2891         | 1991         |
| Glasgow Royal Infirmary   | 4551         | 4568         | 5768         | 4542         |
| <b>South</b>              |              |              |              |              |
| Southern General          | 2787         | 2974         | 2835         | 2784         |
| Victoria Infirmary        | 4766         | 4574         | 4811         | 4607         |
| <b>Yorkhill</b>           |              |              |              |              |
| RHSC Yorkhill             | 1260         | 1236         | 1588         | n/a          |
| <b>Total New Patients</b> | <b>22213</b> | <b>22692</b> | <b>23724</b> |              |

| <b>Outpatient Activity (1998/99)</b> | <b>New</b>   | <b>Return</b> | <b>Procedures*</b> | <b>Total</b>  |
|--------------------------------------|--------------|---------------|--------------------|---------------|
| <b>North</b>                         |              |               |                    |               |
| Western Infirmary                    | 6022         | 9530          | 13005              | 27547         |
| Stobhill Hospital                    | 2891         | 6500          | 12305              | 21505         |
| Glasgow Royal Infirmary              | 5768         | 9606          | 10701              | 26075         |
| <b>South</b>                         |              |               |                    |               |
| Southern General                     | 2835         | 3399          | 12513              | 18747         |
| Victoria Infirmary                   | 4811         | 5803          | 6526               | 17140         |
| RHSC Yorkhill                        | 1588         | 2744          | -                  | 4332          |
| <b>Total Attendances</b>             | <b>23724</b> | <b>37976</b>  | <b>55050</b>       | <b>115346</b> |

Phototherapy, nurse treatments, biopsies and minor surgery, contact dermatitis.