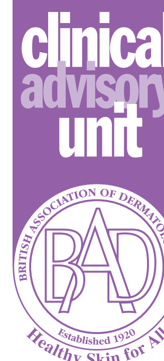
Guidance for Commissioning Dermatology Services



INTRODUCTION

Skin disease which might benefit from medical care is very common. About 15% of the population consults their GP each year because of a skin complaint and about 5% of those who seek help from their GP are referred for further specialist advice.

- GPs refer approximately 5% of the dermatological cases they see to secondary care (Williams 1997)
- in 2001/02, 600,000 such referrals were made, with 2m total outpatient appointments for skin diseases (NHS Modernisation Agency 2005) in 2005/06 GP referrals generated 671,283 first outpatient attendances for dermatology (NHS Information Centre statistic)
- Of referrals 50% are cancer-related (skin lesions for diagnosis and/or skin cancer for management) (West Herts. NHS Trust 2004)
- Approximately one-third of the dermatological workload in secondary care is surgical (Williams 1997).

Referrals to dermatology services have risen as a consequence of the increased frequency of diseases such as skin cancer (the commonest cancer), leg ulcers and atopic eczema, improved treatments and changing attitudes to skin conditions.

Chronic care is being moved from acute hospitals into the community and many dermatology services have already been reconfigured in line with recommendations in the White Paper *'Our health, our care, our say: a new direction for community services'* (DH 2006) A survey performed in 2006 revealed that 72% of 57 secondary care departments were offering services in community settings and that in many units clinical nurse specialists, general practitioners with special interests (GPwSIs) staff grade doctors and associate specialists already work closely with consultant dermatologists to enhance the care of patients *(Schofield et al 2007)*

The guidance in this document was informed by the following publications, all of which are referenced in the appendix:

1. *'Implementing care closer to home – convenient quality care for patients Parts 1-3* (DH 2007). This Department of Health publication provides the generic framework for accrediting services, facilities and the individuals delivering care. Another document provides specific guidance on the training and assessment required to support the accreditation of Dermatology GPwSIs *Guidance and Competencies for the Provision of Services Using GPs with Special Interests (GPwSI) in Community Settings: Dermatology and Skin Surgery.*

2. NICE Improving Outcome guidance for People with Skin Tumours including melanoma (2006) set out the systems necessary for the diagnosis and management of skin cancer

3. *The Action on Dermatology: Good Practice Guide* describes the lessons learnt from 15 pilot sites of new models of care.

4. The Dermatology Subgroup of the Long-Term Conditions Care Group Workforce team have recommended service models for dermatology *Model of Integrated Service Delivery in Dermatology Skin Care campaign (2007).*

5. *Staffing and Facilities for Dermatological Units BAD (2006). http://www.bad.org.uk/healthcare/service/Staffing_and_Facilities_for_Dermatological_Units_Nov_2006.pdf.* These guidelines advise on the staffing and facilities necessary to run an effective and integrated dermatology service.

Managers and clinicians must work together with patients across traditional organisational boundaries to ensure that patients have access to NHS dermatology services that meet their needs. The guidance should underpin the commissioning of networks of dermatology services that are integrated across primary and secondary care. Quality of care and patient safety are central to the successful implementation of services. Consultant dermatologists, who have completed accredited training and are on the Specialist Register of the GMC, should provide leadership and training for the teams responsible for the delivery of care while commissioners should ensure that services are governed appropriately and meet accreditation standards.

BACKGROUND INFORMATION

Unlike most other medical specialties which usually cite around 50 diseases, dermatology recognises more than 1000 conditions affecting skin, hair and/or nails. Accurate diagnosis is fundamental to successful management. High disease prevalence and low mortality results in a large burden of skin disease. Skin cancer is the commonest cancer. Numbers of basal cell carcinomas (BCC) are equivalent to the total of all other malignancies combined. The epidemic of skin cancer continues, with the incidence of basal cell carcinomas increasing by 235% between 1980 and 1990, and melanoma doubling in frequency every 10 years. *(Williams 1997).* Chronic skin diseases may have a substantial impact on work, social interaction and healthy living: skin disease is one of the commonest reasons for injury and disablement benefit and spells of certified incapacity to work in the UK *(Williams 1997)*

THE PRINCIPLES UNDERLYING SERVICE PLANNING

Care should be delivered by individuals with the right skills, in the right setting, the first time. The way in which services are provided will depend upon factors that include local needs, the geography of the area, the facilities available and the availability of staff with the required knowledge and skills. *April 2008*

- The starting point for quality of care, wherever it is based and however organised, is an accurate diagnosis.
- Care should be delivered as close to the patient's community as is consistent with safety and cost effectiveness.
- The delivery of care requires a multidisciplinary team involving trained clinicians, trained nurses, informed pharmacists and educated patients.
- Care should take account of the impact of skin diseases on the quality of people's lives.
- Primary care should take responsibility for the more straightforward parts of the management of long term skin diseases and facilitate self-management.
- Service plans should support the functions of secondary care including the provision of services for acute medical dermatology, skin cancer surgery, phototherapy and patch (allergy) testing.
- Service models should provide continuity and be flexible enough to provide patients with rapid access to secondary care if their condition deteriorates.
- Service models must support the teaching of medical and nursing students, postgraduate training and clinical research.
- New service models should be sustainable, meet accreditation standards and be evaluated.

SECONDARY CARE

Hospital-based dermatology services receive approximately 700,000 referrals each year. A survey in 2006 showed that the referral rate varies between 10 and 21.8 per 1000 population. Up to fifty percent of these referrals relate to skin cancer *(Schofield 2004, Action on Plastic Surgery scoping work)* and around 20% are for the 3 major inflammatory diseases: eczema (*syn* dermatitis), psoriasis and acne.

Centralised hospital-based services will continue to be the most cost-effective and safe means of providing these elements of the dermatology service unless there is substantial investment on facilities in the community:

1) Rapid-access skin cancer screening / treatment clinics- Dermatologists' screen around 90% of those suspected of having cancers of the skin and treat approximately three-quarters of all skin cancers. The NICE IOG for skin cancers recommends that high risk BCCs, which represents the majority of BCCs, are treated in the secondary sector
2) Facilities for dermatological surgery, meetings of multidisciplinary teams to review dermatopathology and management, data collection and data analysis in order that skin cancer management adheres to NICE IOG guidance
3) The care of medical dermatology out-patients with complex problems, sometimes in multidisciplinary clinics e.g. with geneticists, rheumatologists or gynaecologists
4) The care of sick patients with severe skin diseases or skin failure, a few of whom will require access to intensive care facilities
5) Phototherapy, iontophoresis, wound care and other day treatments
6) Day case units for infusion of disease-modifying drugs
7) Paediatric dermatology services including laser surgery for children with facial vascular birthmarks
8) Investigation of cutaneous allergy. Guidelines suggest that the safe rate of referral for investigation (to avoid missing important allergy, but not to over-investigate) is around 100 patients per 70,000 population per year. *(Allergy -2007 p102)*
9) Advice on the management of skin problems in patients admitted with other illnesses
10) Skin cancer screening clinics for patients with organ transplants
11) Teaching, training and assessment of medical students, doctors and other healthcare professionals
12) Collection and analysis of clinical data, clinical audit and compliance with requirements of clinical governance
13) Clinical research including therapeutic trials

Hospital-based services require around one consultant dermatologist and two dedicated dermatology beds per 100,000 population. *(British Association of Dermatologists (2006) Staffing and Facilities for Dermatological Units)*. Associate Specialist and Staff Grade doctors play an important role in the provision of the above services in many departments. In addition, departments require the support of trained specialist nurses, who understand the needs of dermatology patients, and pharmacists.

Telemedicine has not yet proved to be a cost-effective alternative to direct contact with patients (English JSC and Eedy DJ (2007))

The CCH report states:

"The routine use of digital imaging is not recommended as an alternative to the delivery of face-to-face dermatology services. However, in areas where the population is sparse and widely dispersed, or where there are enthusiastic clinicians, this type of service may be helpful. Where this type of service is offered a tariff needs to be agreed nationally"

PRIMARY CARE

Most skin disease is managed within primary care. The quality is variable because of limited exposure to the specialty during medical training. Opportunities for postgraduate dermatology training for GPs are limited. Only a minority of GPs have significant knowledge or skills in dermatology. *(Burge SM (2002))*

The role of primary care can be summarised as follows:

1) All patients should have rapid access to a healthcare professional with the skills to diagnose their skin disease.
2) GPs should be able to diagnose and manage the common skin disorders in their characteristic forms.
3) Patients with the common inflammatory skin disorders should receive education and care from a trained professional, often a nurse, in a community setting.
4) After diagnosis, all patients with disease requiring on-going management should be cared for within local protocols for Chronic Disease Management.
5) Referral protocols should be agreed between primary and secondary care.

COMMUNITY SPECIALIST NURSES

The support for self-management of chronic inflammatory skin diseases should be provided in a community clinic staffed by a

trained specialist nurse. Nurses may be based in primary or intermediate care clinics (see below). Given the frequencies of the common skin disorders, as well as the need for repeat consultations, a practice of 5000 patients will need at least 0.5wte of practice nurse time to provide support, education and active management of patients with psoriasis, eczema (mainly children) and acne. The nurse should work under the supervision of a named doctor and have links with dermatology nurses in secondary care. The nurse might provide:

1) Disease information including access to patient support group(s)
2) Treatment according to protocols and education in their use
3) Easy access to further appointments or telephone advice
4) Rapid access to a GP or consultant dermatologist in the event of treatment failure or if the condition deteriorates rapidly

COMMUNITY PHARMACISTS

Community pharmacists should be included in the primary care team so that they can reinforce care and self help messages at the point of dispensing. The skills of the practice pharmacist should be utilised in the development of care plans – both generic and patient specific. They should work under the supervision of a named doctor to contribute pharmaceutical expertise to the care of people with skin disorders. Such models already exist in the primary care management of other conditions such as hypertension, heart failure and diabetes.

INTERMEDIATE CARE

Some patients may be seen in "intermediate-care" clinics staffed by healthcare professionals working in community settings. Such clinics may be staffed by consultant dermatologists, Associate Specialist or Staff Grade doctors, GPwSIs or specialist dermatology nurses, but new services should be developed in partnership with secondary care and the sustainability of any new service should be considered. The location, service model and range of facilities will depend on local needs within a managed clinical network.

New services should be implemented with the aim of improving patient care and may reduce the need for hospital visits, but convenience for the patient should not be at the expense of quality or safety. The cost effectiveness of such services should be evaluated. Clinics provided by GPwSIs can be more expensive than secondary care services. *(Jackson S (2007) Dermatology GPwSI: terms and conditions e-mail survey (unpublished data)*

Commissioners are required to demonstrate that such services are underpinned by sound clinical governance and that there is a consistent approach to the way in which new roles are developed and supported. The service, the facilities and those delivering the service must meet national guidance for accreditation. *(Department of Health (2007a) Guidance and Competencies for the Provision of Services Using GPs with Special Interests (GPwSI) in Community* Settings: *Dermatology and Skin Surgery London)* Training recommendations and systems of accreditation must be defined and enforced in the interest of quality of patient care and patient safety.

INTERMEDIATE-CARE PROVIDED BY GPWSIS

The service will depend on the training and competencies of the GPwSI, but should be overseen by a consultant dermatologist. The service may include:

- Diagnosis and management
- Follow-up of patients with chronic skin conditions
- Skin surgery (in line with local priorities and NICE IOG for skin cancer)
- Telephone advice for local GPs
- Support for dermatology specialist nurses working in the community

GPwSIs are expected to maintain their professional development by attending regular sessions in a local dermatology department in secondary care and by holding a joint clinic with the consultant dermatologist at least once a month for the discussion of difficult cases.

INTERMEDIATE-CARE PROVIDED BY SPECIALIST NURSES

A trained specialist nurse might support the self-management of chronic inflammatory skin diseases such as eczema and psoriasis in a clinic in intermediate-care or in primary care (see above). The nurse should have support on at least a monthly basis from a medical specialist who may be a GPwSI with defined competencies or a consultant dermatologist.

CLINICAL ASSESSMENT AND TREATMENT CENTRES

CATs (syn:RMS –Referral Management Centres, ICATS – Independent Clinical assessment and treatment centres), which may be run by private companies or the NHS, are being introduced with the aim of triaging and/or intercepting GP referrals to reduce the number that reach secondary care. Referral protocols should be agreed between primary and secondary care, but guidelines or protocols cannot replace clinical acumen and "reading between the lines". Those triaging dermatology referrals must have the skills to recognise the urgency of the problem and the management required or patient safety will be compromised.

The BAD recommends that GP referrals are always triaged by consultant dermatologists.

Referral management services should only be set up after consultation with all stakeholders, including those in secondary care and the public. Without engagement at all levels, Referral management services may merely introduce an additional tier of care, reduce patient choice and quality of care and destabilise local NHS hospitals.

EDUCATION

Skin disease affects between one quarter and one third of the population at any one time. It accounts for up to a fifth of all GP consultations, and in 2001/02 generated over 600,000 GP referrals to secondary care. Yet GPs receive an average of no more than six days training in dermatology during the whole of their time as undergraduate and postgraduate medical students and only around one in five GP training schemes offer a dermatology element in their training programmes. *(Burge SM 2002)*. It is inevitable that many doctors will enter general practice with limited knowledge and understanding of common skin diseases which can present significant clinical diagnostic problems.

Education and training of local healthcare professionals (especially nurses and GPs) should be enhanced. Larger group practices might consider developing in-house dermatology expertise by offering training opportunities for interested partners and nursing staff.

CONCLUSIONS

All patients should receive the right care, delivered in the right place, by the right person, the first time. This document summarises the service models favoured by the British Association of Dermatologists. More detailed information is available on the website of the British Association of Dermatologists (www.BAD.org.uk) and in the documents to which the text refers (see appendix).

APPENDIX

References

All Party Parliamentary Group on Skin Disease (1998) *Enquiry into the Training of Health Professionals Who Come into Contact with Skin Diseases.* APPGS

All Party Parliamentary Group on Skin Disease (2004) *Report on Dermatological Training for Health Professional.* APPGS

All Party Parliamentary Group on Skin Disease (2006) *Report on the Adequacy and Equity of Dermatology Services in the United Kingdom.* APPGS

Bleiker TO, Shahidullah H, Dutton, E and Graham-Brown RAC (2000) *The Prevalence and Incidence of Atopic Dermatitis in a Birth Cohort: The Importance of a Family History of Atopy*. Arch Dermatol 136: 274.

British Association of Dermatologists (2006) *Staffing and Facilities for Dermatological Units* (www.bad.org.uk/healthcare/service/Staffing _and_Facilities_for_Dermatological_Units_Nov_2006.pdf)

Burge SM (2002) *Undergraduate Education*. Br J Dermatol Feb. 146(2): 295-303

Carr A et al. (2007) *A Pilot Study of a Community Pharmacist Intervention to Promote the Effective Use of Emollients in Childhood Eczema.* Pharmaceutical Journal 278: 319-322

Courtenay M and Carey N (2006) *Nurse-led Care in Dermatology: A Review of the Literature.* Brit J Dermatol 154: 1-6

Davies, E (2007) personal communication to Robin Graham-Brown, 31 May 2007

Department of Health (1999) *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare.* London: DH

Department of Health (2001) *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century.* London: DH

Department of Health (2004a) *Agenda for Change: Final Agreement.* London: DH

Department of Health (2004b) *The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process.* London: DH

Department of Health (2006a) *Our Health, Our Care, Our Say: A New Direction for Community Services,* London: HMSO.

Department of Health (2006b) *Your Health, Your Care, Your Say: Research Report.* London: DH

Department of Health (2007a) *Guidance and Competencies for the Provision of Services Using GPs with Special Interests (GPwSI) in Community Settings: Dermatology and Skin Surgery London:* DH (www.pcc.nhs.uk/uploads/pwsis/GPwSI_dermatology.pdf).

Department of Health (2007b) *Implementing Care Closer to Home: Convenient Quality Care for Patients (in three parts with 'Supporting Q&A' supplement).* London: DH (downloadable from www.pcc.nhs.uk/173.php)

Department of Health and Department for Education and Skills (2004) *National Service Framework for Children, Young People and Maternity Services.* London: DH

Downing A, Newton Bishop JA and Forman D (2006) *Recent Trends in Cutaneous Malignant Melanoma in Yorkshire Region of England: Incidence, Mortality and Survival in Relation to the Stage of Disease,1993—2003.* Br J Cancer, July, 3, 95 (1): 91-95

El-Dars LD, Davies G and Roberts DL (2005) *Management of Nonmelanoma Skin Cancer by 'Expert GPs'.* Brit J Dermatol 151 (Suppl. 68): 21-62

English JSC and Eedy DJ (2007) *Has Teledermatology in the UK Finally Failed?* Brit J Dermatol 156(3): 411

Finch TL, Mair FS and May CR (2007) *Teledermatology in the UK: Lessons in Service Innovation.* Brit J Dermatol 156: 521-527

Fraser-Andrews EA and Shuttleworth (2002) *Digital Photography is not a Substitute for Clinical Examination in the Management of Suspected Cutaneous Malignancy.* Brit J Dermatol 147 (Suppl. 62): 7-8.

Hafejee A and Coulson IH. (2006) letter in Br J Dermatol 155: 1297

HSJ (2007) *PCTs Grapple with Grey Areas of GP-led Commissioning,* 24 May

HOUSE OF LORDS Technology Committee Report of Session 2006–07 – Allergy

Jackson S (2007) *Dermatology GPwSI: terms and conditions e-mail survey (unpublished data)*

Johnston GA, Bilbao RM and Graham-Brown RAC (2003) *The Use of Complementary Medicine in Children with Atopic Dermatitis in Secondary Care in Leicester.* Brit J Dermatol 149: 566-571

Johnston GA, Bilbao RM and Graham-Brown RAC (2004) *The Use of Dietary Manipulation by Parents of Children with Atopic Dermatitis.* Brit J Dermatol 150(6):1186-1189

Kumar P et al. (2000) *Incidence of Incomplete Excision in Surgically Treated Basal Cell Carcinoma: A Retrospective Clinical Audit.* Br J Plast Surg 53: 563-566

NHS Improvement Agency (2000) *The NHS Plan: a Plan for Investment, a Plan for Reform.* London: HMSO

NHS Modernisation Agency (2003a) *Action on Dermatology: Good Practice Guide* (www.archive.modern.nhs.uk/serviceimprovement/1339/1988/7626/9650/ Derm%20GPG%20vFinal%20for%20web.pdf)

NHS Modernisation Agency (2003b) *Guidelines for the Appointment of General Practitioners with Special Interest in the Delivery of Clinical Services, Dermatology,* HMSO: London.

NHS Modernisation Agency (2005) *Action on Plastic Surgery: Good Practice Guide* (www.wise.nhs.uk/NR/rdonlyres/BBA564B6-2690-49F9-90A1-E4E2E3A9ACAB/1315/doc2_plastic.pdf).

NHS Primary Care Contracting (Jan. 2007) *Primary Care Service Framework: Support for Self Care in Primary Care* (www.primarycarecontracting.nhs.uk/ uploads/medical/pcsf/primary_care_service_framework_self_care_v7_final.pdf)

NICE (2006) *Improving Outcomes for People with Skin Tumours, including Melanoma.* NICE: London

Platts A (2004) presentation on 'Lessons from Action on Dermatology', Royal College of Physicians, April.

Royal College of Nursing (2005) *Competencies: An Integrated Career and Competency Framework for Dermatology Nursing* (www.rcn.org.uk/publications/pdf/DermatologyCompetencies.pdf)

Rosen R, Jones R, Tomlin Z and Cavanagh M (2005) *Evaluation of General Practitioners with Special Interests: Access, Cost, Evaluation and Satisfaction with Services.* London: NHS Delivery and Organisation R&D Programme

Salisbury C and Noble A et al. (2005) Evaluation of a General Practitioner with a Special Interest Service for Dermatology: Randomised Controlled Trial. BMJ 33: 1441-1446

Schofield JK, Adlard TP and Gunn S (2007) *Dermatology Follow-up Caseload: National Recommendations, Local Problems* (in press).

Schofield JK, Irvine A, Jackson S, Adlard TP, Gunn S and Evans N (2005) *General Practitioners with a Special Interest (GPwSI) in Dermatology: Results of an Audit against Department of Health (DH) Guidance.* Br J Dermatol 153(Suppl. 1): 0-1

Schofield JK, Shuttleworth D, George S and Graham-Brown R (2007) *Care Closer to Home and Dermatology Services: How Are We Doing?* Br J Dermatol (in press)

Schreuder F and Powell BW (1999) Incomplete Excision of Basal Cell Carcinomas: An Audit. Clin Perform Qual Health Care 7:119-120

Sibbald, B, McDonald R and Roland M (2007) *Shifting Care from Hospitals to the Community: A Review of the Evidence on Quality and Efficiency.* J Health Serv Res Policy 12(2): 110-117

Skin Care Campaign (2006) *Referral Management Schemes (Tier 2 Clinical Assessment and Treatment Services): Implications for Dermatology Services.* Briefing Paper, June (downloadable from www.skincarecampaign.org/pages/home.htm)

Skin Care Campaign (2007) *Model of Integrated Service Delivery in Dermatology* (downloadable from www.skincarecampaign.org/pages/home.htm)

Smethurst DP and Williams HC (2002) *Self-regulation in Hospital Waiting Lists.* J R Soc Med 95: 287-289

Tucker R. (2004) *Exploring Prisoners' Views of a Pharmacist-led Dermatology Clinic.* Pharmacy in Practice 14(4): 113-114.

Tucker R. (2005) *Exploring the Views of Prisoners Attending a Pharmacist-run Dermatology Clinic.* Pharmaceutical Journal 274: 232--233

West Herts NHS Trust (2004) unpublished scoping work for Action on Plastic Surgery project (see NHS Modernisation Agency 2005)

Williams HC (1997) 'Dermatology' in Stevens A and Raftery J (eds) *Health Care Needs Assessment Series 2.* Oxford: Radcliffe Medical Press