

British Association of Dermatologists: session summary

September 2010

Attendees

Officers

Dr Stephen Jones	President	Wirral
Dr Jane Sterling	Academic VP	Cambridge
Dr Catriona Irvine	Clinical VP	Canterbury
Dr Mark Goodfield	Past President	Leeds
Dr David Eedy	Treasurer	N Ireland
Dr Nick Levell	Hon Sec	Norwich
Dr Tanya Bleiker	Editor	Derby

Clinical Services Committee

Dr Sheru George	Amersham
Dr Karen Gibbon	London
Dr Robert Burd	Leicester

Other members

Dr Ed Seaton	London
Dr Graham Sharpe	Liverpool
Dr Robert Chalmers	Manchester

Observers

Marilyn Benham	BAD CEO
Tania Von Hospenthal	BAD Clinical Services Manager

Facilitators

Hugo Mascie-Taylor	Medical Director	NHS Confederation
Jonty Roland	Senior Policy Researcher	NHS Confederation

Comments Received From

Dr D Mallett	Peterborough
Dr J Schofield	Lincoln and West Hertfordshire

Themes

- *Commissioning services for people with skin conditions*
- *Demand management: reducing referrals, low priority frameworks*
- *Technology to triage referrals*
- *Reducing non-attenders*
- *Telephone consultations, non-face to face consultations*
- *Generic substitution for prescribing*
- *Reducing unnecessary consultations eg different models for pregnancy prevention programme, wigs*
- *Other varied initiatives*
- *System wide issues*

Summary

COMMISSIONING SERVICES FOR PEOPLE WITH SKIN CONDITIONS

- Evidence to date from CC2H (Appdx 1) and world class commissioning (1) suggests that quality services should be integrated. To obtain best use of resources all stakeholder groups (commissioners, dermatologists, GPs and patient groups) should be involved in service design to minimise 'blind alleys' and maximise efficient pathways. Consultants are the greatest expert resource in the NHS and processes excluding them will inevitably be flawed, particularly as undergraduate and GP registrar training contain minimal dermatology.
- For the 6% of skin disease which requires specialist assessment, evidence suggests that these are most efficiently and effectively delivered by a multi-disciplinary team led by consultant dermatologists who can best provide an accurate diagnosis, best manage skin cancer etc cost effectively.
- Patients should see the right person, right place first time to obtain a definitive diagnosis and ensure that they are subsequently seen by the most cost effective member of the team in primary or secondary care appropriate to their diagnosis. This is most efficiently achieved by consultant triage of referral letters. Outwith the most common diagnoses, this will usually mean the patient initially seeing a consultant dermatologist or by a service which has timely access to a consultant if needed (i.e. an integrated service).
- To support the transition from PCT to GP commissioning the B.A.D. will facilitate the production of evidence-based guidelines for commissioners on measurement of quality and outcome for skin disease interventions indicative of a high quality service. This will involve a multi-stakeholder group including patients, nurses, GPs, dermatologists and other healthcare professionals involved in the care of skin disease.
- A working group is already in the process of developing these minimum dataset (MDS) standards now, both across dermatology and by sub-specialty.
- The Association considers that these MDS standards will be particularly useful in an environment of 'any willing provider', by helping commissioners find the right balance between cost and quality of services and ensuring patients get the same quality of care wherever and by whoever it is provided.
- The system of any willing provider does not result in cost effective healthcare. Profit making providers can cherry pick those aspects of care which are profitable but rarely take on the more challenging ones and expensive ones. This leaves NHS organisations with the more expensive areas, for which they still require most of the cost base they did before. Commissioning should consider the entire dermatology service based on robust needs assessments and include all relevant stakeholders.

DEMAND MANAGEMENT

1) Follow up protocols

- There is a great deal of variation in follow up practices, with many patients attending for follow up appointments long after these add value to the patient.
- Patients should be followed up if there is a clear indication such as; structured follow up for skin cancer, those part of shared care protocols, those immunosuppressed patients being monitored for cancer, patients with unstable dermatoses requiring modification of treatment and those with unstable solar damage that require ongoing treatment. For others, if no change in management is recommended, they should be discharged with an appropriate management plan which is agreed by the doctor and patient. This process would be facilitated for patients with chronic diseases if they felt reassured that they would be referred back quickly and easily if their situation changed, something which is becoming more difficult in the current economic climate
- Patients should have rapid access to appropriate diagnostic skills as and when needed. If this process was easier then it may facilitate the delegation of more follow up to members of the dermatology team
- It should be appreciated, however, that follow up of the patient to see if a treatment plan has worked or reviewing a surgical patient to gain feedback on the surgical outcome are learning events that will improve future care. The loss of these encounters, whilst possibly reducing cost in the short term, reduce the learning aspects of patient care.

2) Procedures of low clinical priority

- The criteria for low priority procedures are not uniformly applied across the NHS, and there is some unnecessary variation between subspecialties.
- If the NHS were clearer about what it does and does not treat, it could take a different approach to these procedures, by instead of banning them, telling patients that they can pay to have them done. This would create a source of revenue for the health service and, since many cases would involve minor surgical procedures, would provide education for junior doctors and some nurses.
- Skin tags and seborrhoeic keratoses would be possible examples of areas where this could be done

3) Reducing unnecessary procedures in primary care

- Procedures of 'limited clinical effectiveness' (POLCE) which are not to be referred to secondary care, unless there is diagnostic uncertainty, should also not be treated in primary care.
- One quality control which could be applied locally and dermatologists should support and which would be cost effective is that biopsy of undiagnosed rashes and lesions or removal, of lesions should not be done unless until expert opinion has first been given.

- The value of inserting the dermatologist in the patient pathway between the GP and dermatology surgery has also been demonstrated in some areas. “ 2 week cancer clinics reassure and discharge 80% of patients and thereby save surgery costs. 40% of dermatology patients are referred with ‘lesions’ and most of these are reassured and discharged thereby saving surgery costs.

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USE OF TECHNOLOGY

1) 2 week cancer referral triage

- One dermatology unit reported that they had managed to make significant productivity gains from the application of teledermatology to their triage process.
- Another unit uses a pool of trained nurses in community hospitals to make an initial consultation and take patient histories and digital images of the affected areas of skin. These are sent to the dermatologist electronically, for triage. This has resulted in a significant reduction in the number of new patients the dermatologist needs to see face to face and has, therefore, improved departmental efficiency and improved some waiting times. Patients, however, still need to travel to the ‘community hospital’ and it is not clear whether or not the resources needed for the longer nurse consultation and photography, combined with the duplicate consultation and travel for those ultimately seeing a doctor results in a significant saving.

Such models are currently still controversial and there is no agreement in the profession about patient safety. Most units do still see all such patients so triaged

2) Triage of ‘rashes’.

- When used for ‘rashes’ teledematology may help triage but only if high quality images are combined with a good history. This may allow up to 20% of referrals to be redirected to the GP (2) but should only be done as part of an established and integrated service and should be closely audited for cost and safety. The quality and cost effectiveness of out-sourcing either the imaging or triage should be considered highly questionable.
- Used by the worried well to check moles result in large numbers of unnecessary NHS referrals with subsequent anxiety and pressure to perform surgery for medico-legal reasons.

REDUCING NON – ATTENDERS

- Consultations where patients DNA are a clear area of wasted capacity
- Simple automated systems that text and/or email patients with reminders of their appointment significantly improve i.e. reduce DNA rates. In some areas they resulted in DNA rates halving with a saving of resource which can be re-invested. Fewer DNA's will permit a necessary reduction in clinic templates, which currently allow for 'no shows'. The increase in throughput would then be moderate.
- The cost of these systems is now small and there are various other functions they can provide, such as using the patient's first language or reminding them of particular documents they need to bring with them to an appointment.

TELEPHONE CONSULTATIONS, NON FACE TO FACE CONSULTATIONS

- For patient follow up consultations, many of the face to face consultations undertaken by dermatologists could be done as a conversation over the telephone instead, increasing productivity and reducing patient transport costs. In some cases such as chronic disease management, these "follow ups" could be conducted by a nurse instead of the dermatologist.
- Some of the most common conditions could be followed up this way, such as patients with chronic diseases, those on systemic drugs etc. The latter is the subject of a QOF 'shared care' proposal which would reduce secondary care follow up and improve safety for this group of patients who are in danger of being 'lost due to new patient targets.
- Cost savings would accrue to the wider NHS rather than the trust in which the dermatologist works, since the tariff for telephone consultations is considerably less than that of a face to face one

GENERIC SUBSTITUTION FOR PRESCRIBING

- For certain common systemic drugs there is scope to increase the use of generic substitutes without affecting quality eg Isotretinoin and ciclosporin (as long as patients receive the same 'brand' throughout their treatment course as bioavailability may differ between products).
- Electronic prescribing in secondary care (as exists in primary care) has the potential to reduce costs by restricting prescribers to generic agents, reducing the risks of prescribing drugs which interact and limiting prescriptions to agreed duration, all of which improve safety and save money.
- The list of Dermatology Specials [.bad.org.uk/site/1284/default](http://bad.org.uk/site/1284/default), lists approved special formulations which are commonly used by dermatologists in the UK. Arrangements have been made for these to be produced centrally at low cost and high quality. Community pharmacists should be mandated to purchase these products from these centres and not from small volume producers where costs are invariably high.

REDUCING UNNECESSARY CONSULTATIONS

1) Modifying the pregnancy prevention plan

- The pregnancy prevention plan states that female patients on certain common drugs prescribed by dermatologists (isotretinoin, and alotretinoin) must be on two forms of contraception and are required to attend the hospital once a month for a pregnancy test.
- Shared care with GPwSIs in the community may be effective as long as they are cognizant of the safety issues and are accredited by the dermatologists under whose name the drug is prescribed as dictated by the MHRA guidance.
- The plan has not reduced the incidence of unplanned pregnancies, however, and it's the rationale for its continuation is questionable.

2) Wigs

- Dermatologists are currently the only health practitioners (other than oncologists) permitted to prescribe wigs. There is no clinical justification for this rule, which creates needless demands on dermatology units and generates unnecessary patient visits for the prescribing and renewal of wigs.
- The ability to prescribe wigs should be widened to GPs and oncologists.

OTHER VARIED INITIATIVES

1) Management of cellulitis

Cellulitis is responsible for over £100 million pounds on in patient care nationally in the NHS. Audit shows approximately 30% of patients diagnosed with cellulitis by GPs and general physicians in fact have other dermatological causes of red legs and do not have cellulitis. Consequently admission of these patients to hospital for one or more weeks for intravenous antibiotics results in wasted bed stays, inappropriate admission, inappropriate IV antibiotics resulting in C Difficile infection and delayed discharge.

Furthermore much cellulitis is due to underlying skin disease and therefore cellulitis is often recurrent if the skin disease remains unrecognized and untreated.

Furthermore lower limb cellulitis can if correctly diagnosed and managed almost always be treated at home.

An innovative, dermatology led lower-limb cellulitis service has in the Norfolk and Norwich University hospital over three years almost eliminated inpatient treatment of lower-limb cellulitis and eradicated inappropriate treatment with IV antibiotics.

Patients are managed at home with hospital visits to monitor clearance and aim to prevent recurrence.

2) Joint working with GPs to reduce demand:

- Many GPs call or write letters to dermatologists asking for advice. This currently isn't recognized as activity and so isn't chargeable. Introducing a tariff for this would remove perverse incentives, improve communication between clinicians and- studies show- reduce referral
- PbR requires there to be a patient encounter for charging to occur, for letter/email or telephone advice to be chargeable, this would have to change, but the Association would support this.

3) Teaching and Training

- Training and education should be an integral part of any proposed service if it is to be of high quality and sustainable.
- GP education should be targeted to the common dermatoses. While there are thousands of skin conditions that dermatologists need to be aware of, 90% of GP referrals relate to less than 20 conditions. Some of these cases do not need referral or can be managed in primary care once the diagnosis is confirmed and a treatment plan agreed. If each health economy targeted the diagnosis and management of skin lesions by funding face to face tuition or via existing on-line education packages, inappropriate demand on specialist resources could be significantly reduced. Dermatologists would support this, but the changes needed to manage and resource this initiative would be require investment.
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SYSTEM WIDE ISSUES

- The commissioning of 'Any Willing Provider' does not result in cost effective healthcare. Profit making providers can cherry pick those aspects of care which are profitable but rarely take on the more challenging ones and expensive ones. This leaves NHS organisations with the more expensive areas, for which they still require most of the cost base they did before. Commissioning should consider the entire dermatology service based on robust needs assessments and include all relevant stakeholders.
- Tariff may sometimes encourage unnecessary attendances by providing an incentive to giving a patient a follow up appointment for a day case procedure rather than operating on a see and treat basis.

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• REFERENCES

- 1) NHS Primary Care Contracting (2008). Providing care for patients with skin conditions: guidance and resources for commissioners. Leeds:NHS Primary Care Contracting

- 2) Schofield JK, Grindlay D, Williams HC. (2009). Skin conditions in the UK: a health care needs assessment. Centre for Evidence Based Dermatology, University of Nottingham UK.
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- APPENDICES
- Appdx 1) Summary of literature relating to DH Long Term Conditions Referral Pathway. BAD 2010
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