

**REPORT TO THE PBC GOVERNANCE BOARD
TO BE HELD ON: 13.10.10**

Enclosure:	6				
Subject:	Dermatology Triage Pilot				
Lead Director:	Geraint Griffiths				
Lead Officer:	Jane Chapman				
Recommendation:	For Approval	√	For Discussion		For Information

PURPOSE OF THE REPORT:

To present the Dermatology Triage Service business case to the Board and seek approval to commission the service

KEY POINTS:

Stafford and Cannock PbC Consortia have been working with MSFT for some time to develop alternative services to reduce the pressure on acute colleagues. Consultant Dermatologists have identified that a significant proportion of their referrals do not need a consultant led service but the confidence in Primary Care to deal with dermatology conditions varies.

Stafford and Surrounds PBC Consortium has developed a business case to pilot the introduction of a Triage Service.

The Triage Service will reduce

- Reduce referrals to secondary care allowing them to focus on the most complex conditions
- Provide patients with appropriate care in the community
- Provide data on referral patterns which can be used to support future training
- Reduce costs

CORPORATE OBJECTIVES:

Care Closer to Home
Financial Balance & QIPP

RESPONSIBLE COMMITTEE:

NAME: PBC GOVERNANCE BOARD

APPROVED at cmte: YES/NO

Date of Cmte:

IMPLICATIONS:

Legal and/or Risk	
WCC	High quality services delivered to patient in a local setting
Patient Safety	The lead GP has a recognised qualification to enable her to undertake work which has been confirmed by PCT Governance Team
Patient Engagement	Discussed development of services in the community with PPG at April meeting who supported the approach.
Financial	The calculations estimate a minimal saving of £40k
Sustainability	The pilot is being linked to the surgical dermatology service to provide some support. Greater sustainability will be built into any future commissioned service.
PBC	The project has been developed by PBC
Workforce / Training	The lead GP has completed the Cardiff Diploma course. There are no further training implications.

RECOMMENDATIONS / ACTION REQUIRED:

The PBC Governance Board are/is asked to: approve the commissioning of the pilot.

Business Case Template for Inflammatory Skin Disorders in Primary Care

Clinical Lead: Dr Lindsey Harris

Summary

Levels of knowledge in dermatology vary greatly amongst primary care physicians. Waiting lists exceed the 18 week stated maximum by the DoH locally in Stafford and Cannock, due to large numbers of referrals.

It is difficult to get data regarding diagnostic read codes and management from secondary care out patients.

Following an audit of SaS PBC GP referrals for the month of January 2010, presented in appendix, it is apparent that many of the referrals that wait a long time to be seen could be seen by a GP with further training and a special interest in dermatology

DOH definition of GPwSI:

“A GPwSI may be defined as a practicing GP who, in addition to their generalist role, provide specialist services to meet the needs of patients in primary and secondary care organisations.”

Current Service

Patients are referred via choose and book by their GP.

There are currently a shortage of dermatology consultants and a difficulty to fill the posts locally. There are some specialist trained nurses and 2 health visitors with an interest in eczema and common paediatric dermatology disorders.

Unfortunately due to dermatology being one of the highest areas of referral for many GP`s waiting times to be seen often exceed 18 weeks.

Drivers for change

DoH have stated that the waiting time to be seen for an initial consultation with a specialist should be 18weeks.

It has long been acceptable to use the specialist knowledge of our colleagues “in-house” if we know a fellow GP has further knowledge in a clinical area.

Patient choice.

Patients at Stafford district PPG Forum have expressed a preference to have more local services available rather than always needing to attend a hospital clinic. This has also been demonstrated in patient satisfaction scores for other services that have been moved to the community.

Proposal

Dr Harris, has completed her Diploma in Practical Dermatology (Cardiff) and is waiting to do a year of supervised work, 1 clinic a week in dermatology out patients, this will encourage continued governance and hopefully develop and maintain relationships with secondary care.

Dr Harris will review all referrals and offer an appointment to patients who meet the clinical criteria for the service (see attached referral protocol). Patients not meeting the criteria will not be offered an appointment and re-directed to secondary care. Dr Harris does not plan to be the default route for dermatology referrals as GP's may prefer to refer directly to a consultant if they feel that a secondary care led service such as light therapy or initiation of a DMARD is necessary. However, if the consortium felt it would be beneficial to triage all referrals she would be prepared to do this.

Benefits

The service can be delivered at Stafford Greyfriars or Brewood, which offers a greater geographical choice for patients in the SAS consortium, and can be more easily accessed via public transport. Patients will be assessed and investigated on the same day, including blood tests and punch biopsies if necessary and appropriate at the time for the patient. Waiting times will aim to be less than 6 weeks. Hopefully this will shorten dermatology waiting times to within the acceptable time frame. Financial savings of at least 30% - see attached audit

Financial

The costs of this service could be done at 70% of secondary care tariff. This rate has been seen as reasonable by SaS Consortium for the existing ENT service and Dermatology Minor Surgery service. Similar services nationally usually range between 50 and 80% of tariff.

Costings

Activity data from secondary care has not been easy to obtain.

All of the practices in SaS Consortium agreed to an audit of their dermatology referrals in January 2010.

The results (see appendix) show that the average cost of a new appointment was 129.52

The average cost of a follow up was 68.68

The average cost of a procedure (excision biopsy) was 543.00

Proposal from Brewood.

To maintain clinical governance and maintain performance, it would be necessary to have recognised links with secondary care.

To work 1 clinic a week free of charge in secondary care in own time to develop and maintain clinical knowledge.

Estimated savings for PBC.

The below data is based on the dermatology audit from January 2010 (see appendix)

The audit shows that the month of January 2010 there were 112 total dermatology referrals.

42 were skin lesions/low risk bcc`s that could have been directed to dermatology minor surgery.

6 cancelled or dna`d.

4 letters had too little information to triage effectively.

19 patients needed secondary care specialist input for cancer, complex needs or secondary care led medication such as DMARD`s.

the remaining 42 patients could have been seen appropriately by a GPwSI.

Of these 42:

21 were discharged after 1 appointment.

8 required a practical procedure such as a punch biopsy.

Event	Cost in secondary care	Cost in primary care (70% tariff)
First appt	42x129.52	42x90.66
Follow up appt	21x68.68	21x48.07
Biopsy	8x543.00	8x380.10
Total	11,226.12	7,857.99

Majority of patients discharged after 1 appointment had an inflammatory skin disorder such as psoriasis or eczema and needed review of their emollient and steroid use. These are the patients that do not always need secondary care input. Total cost saving of 3,368.13 for the month of January

**Average 40,417 per year
(plus added benefit of greatly reduced waiting times)**

Recurrent full year costs

All costs associated with the service will be met by Brewood Practice including
 GP Travel
 Clinical Administration
 GP letters
 Pathology reports
 Liason with secondary care if needed
 Hire of facilities at Greyfriars in Stafford.

Histological analysis of punch biopsies is currently on a block charge and not an issue.

Risks

Risks	Mitigating action
1. Changes in diagnostic test resourcing/costing	Audit excision biopsies, and negotiate if threshold changes. Consider an alternative provider if necessary.
2. Illness of GP	Identify a second GP who is willing to train and participate in the service
3. Lack of support from secondary care	This is why weekly clinical placement in secondary care for a minimum of 1 year as dictated by the DoH would be beneficial
4. Secondary care consultant dissatisfaction	To maintain communication with secondary care
5. Patient dissatisfaction	To annually audit patient satisfaction
6. No other GP yet identified to support the triage system	Nicky Brookes from Cannock PCT is trying to set up an alternative pathway for Cannock and identify GP`s with a special interest

Activity

Reported to the PCT quarterly.

Service Level Agreement

Cost per case basis up to agreed capacity of the provider.

3 months notice required on either side.

Provider will use the same premises as Dermatology Minor Surgery for Low risk BCC, ensuring infection control.

The facility will be inspected by the PCT infection control nurse to ensure adequate premises if required.

Measures for Commissioner

Dermatology “non-lesion”, rash/inflammatory skin disorder referrals at out patients– monthly

Costs of above at outpatients.

Complication and infection rate 6 monthly.

Patient satisfaction annually.

Referrer satisfaction annually.

**Referral form for Inflammatory Skin Disorder/Unknown rash
(see attached list for appropriate referrals)**

(Investigations and procedures available with this referral process: bloods, skin scrapings, inspection with woods lamp, microbiology swabs, punch biopsies, cryotherapy, application of skin dressings, demonstration of topical medication correct usage in quantity and dose, Doppler of foot arteries (NOT ABPI))

Name

Age

Address

PMH

DH

Description of skin problem

Areas affected

Treatments already tried

Investigations already done – if any
(scrapings, bloods, biopsies)

DO NOT SEND URGENT REFERRALS:

Suspected scc or melanoma

Erythroderma (inflammation involving more than 90% skin surface area,)

Widespread severe blistering disorder

Patient is systemically unwell with their ras

Referral criteria

(Taken from existing Middlesborough dermatology triage pathway - Dr Tim Cunliffe)

Secondary Care Only

High-risk BCC (Large BCC, H-zone of the face, ears, morphoeic)

Troublesome acne that may need oral isotretinoin or other specialist treatment

Moderate/severe psoriasis that may need light or systemic therapy

Severe eczema that may need systemic or light therapy

Allergic contact dermatitis (may need allergy testing)

Alopecia that is
- Diffuse
- Has significant scarring

Nail disorders where there is marked destruction of the nails or a pigmented streak possibly suggestive of melanoma

Photodermatoses

Venous leg ulcers not responding to community treatment

Hyperhidrosis not responding to topical or other appropriate therapy

Suspected connective tissue disorders

Cutaneous vasculitis

Intermediate conditions

Suitable for treatment in Primary Care

Bowen's disease

Low-risk BCC

Lumps and bumps (i.e. epidermoid cysts, pilar cysts of the scalp, lipoma) that are big enough to cause significant discomfort for the patient AND where the GP feels unhappy about removing the lesion.

Seborrhoeic keratoses or other benign **skin** lesions that cause **significant facial disfigurement**

THE ABOVE SHOULD BE SENT TO DERMATOLOGY MINOR SURGERY

Actinic keratoses

Moderate to severe eczema

Other moderate inflammatory dermatoses that are poorly controlled despite treatment from the GP

The troublesome 'red face'

Rashes of diagnostic uncertainty in patients without associated systemic upset

Pyogenic granuloma (Beware differential diagnoses of amelanotic melanoma)

Other nail disorders

Other scalp disorders

