

**REPORT TO THE PRACTICE BASED COMMISSIONING
GOVERNANCE COMMITTEE
TO BE HELD ON: 12th May 2010**

Enclosure:	11				
Subject:	East Staffordshire Community Dermatology Service				
Lead Director:	Sue Price				
Lead Officer:	Rebecca Woods				
Recommendation:	For Approval	x	For Discussion	For Information	

PURPOSE OF THE REPORT:

This report provides a business case to transfer acute based dermatology activity into a community setting, though an Any Willing Provider model.

KEY POINTS:

A Community Based Dermatology Service is proposed to be developed through an Any Willing Provider model.

This service will provide high quality care through appropriately trained and qualified clinicians, including Consultant dermatologists, Dermatology Associate Specialists and GPWSIs.

Patients across all age groups will be able to access this service, but within the first year only patients across the 19 practices in East Staffordshire PBC can be referred. This is to ensure that the service provides high quality care which is sustainable and which can then be expanded to take patients from other areas.

The service will see referrals where there is diagnostic uncertainty or where patients have not responded to treatment offered by their GP across a wide range of dermatological conditions, with the exception of suspected cancer which will be referred directly into acute care.

There will be regular audit the referrals received which will be used to develop education packages for GPs and nurses.

The service will support the appropriate management of patients within a primary care setting through audit, education, tele-dermatology and advice and guidance and will cost less than our acute trust providers.

The Community Based Service will provide a 'see and treat' model of care, improving the patients' experience and delivering a more economic service.

In year one this service will deliver 500 New outpatient appointments, 200 Follow up appointments, 175 minor procedures. Activity will be delivered at 75% of the BHFT tariff for dermatology.

It is anticipated that this will reduce secondary care activity by 500 New appointments

and 1,000 follow ups resulting in a year one saving of £24, 949.

Due to the equipment set up costs and the investment in GPwSI training, year one costs will be higher than in subsequent years and are therefore at 75% of tariff. This percentage will reduce to 70% in year 2.

CORPORATE OBJECTIVES:

The Community Dermatology Service supports the PCT priorities of: QIPP, Care Closer to home, more cost effective models of service delivery, improved utilisation of PCT estate, public and patient engagement in service redesign, using technology to support clinical practice and patient self care.

RESPONSIBLE COMMITTEE:

NAME:

APPROVED at cmte: YES/NO

Date of Cmte:

IMPLICATIONS:

Legal and/or Risk	Any Willing Provider is covered by the standard national acute trust contract.
WCC	Needs assessment Stimulation of the market Public and patient engagement Engagement with clinicians and service redesign Promote continuous improvement through innovation
Patient Safety	Covered under the national standard acute contract and key information requested as part of the service specification.
Patient Engagement	This proposal has the support of the East Staffordshire Patient Participation Group
Financial	This service offers improved value for money, reduces financial impact on acute contracts in terms of new and follow up outpatient activity.
Sustainability	The service is being developed with a vision for expanding the community based service, when the service is providing high quality care and has the capacity to offer services to a wider group of patients.
PBC	PBC have been involved with this proposal.
Workforce / Training	GP development to undertake the Cardiff course has been identified and included within the year one costs of the service, to build local capacity and capability. Further workforce / training requirements will emerge following the referrals audits. Training will be required to support the development of tele-

	dermatology.
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RECOMMENDATIONS / ACTION REQUIRED:

The PBC Governance committee is asked to support this development.

Service Provision Business Case Template

This template has been designed to assist in submitting an outline business case proposal for local service provision. This template should be used for proposals to be submitted under contracting schemes such as a Local Enhanced Service (LES), PMS, SPMS and APMS etc.

The PCT can provide assistance in completing this template. Please provide as much information as possible to enable the PCT to make a provisional informed decision in principle. The PCT will be looking for the proposal to meet local needs as well as falling within the scope of the PCT strategic commissioning framework and priority areas as listed in Section 1 of this template. The PCT will also be looking for evidence that this proposal has been developed in line with local public and front-line staff opinion and that local public health issues have been addressed.

TITLE OF PROPOSAL	Community Dermatology Service (CDS)
ORGANISATION/ COMMISSIONING BODY	South Staffordshire PCT
LEAD NAME FOR PROPOSAL	Rebecca Woods / Dr Devikanand
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Document Control

Document Version	Date of Revision	Summary of Revision
1.0	07/04/10	Initial document
1.1	04/05/10	Updated on data available

Section 1: Compliance with the PCT Commissioning Framework

This business case complies with the following priority areas as outlined in the PCT Commissioning Framework:

PCT Commissioning Framework Priority Areas: <i>PCT to complete PCT Commissioning Framework priorities as outlined in the PCT LDP and ISIP.</i> <i>Full details of each of these areas are available from your PCT</i>	This business case relates to the following <i>(Proposer to tick as appropriate):</i>
<i>PCTS have specific targets on all of the following areas in line with national directives regarding achievement thereof, and practice are expected to work within these priorities as practice based commissioners. With regard to your specific service proposal, please tick all appropriate boxes served by your scheme.</i>	
1. National priorities	✓
1.1 Improving health of the population	✓
1.2 Supporting people with long term conditions	
1.3 Access to services	✓
1.4 Patient/user experience	✓
1.5 Achieving financial balance	✓
1.6 Implementing reform	✓
1.7 6 key service priorities:	
- health inequalities	
- cancer 31 and 62 day waits	
- 18 week wait	✓
- MRSA	
- Patient Choose & Book	
- Sexual health & access to GU medicine	
1.8 Links with Integrated Service Improvement Plan	
(ISIP) & Benefits Realisation Plan (BRP)? / QIPP	✓
2. Local priorities	✓
(for completion locally)	

Section 2: Outline of the Proposed Service Provision

<p>Introduction <i>Give a brief out line of the background (i.e. current service provision and demonstration of need for improvement. Include Health Needs Assessment)</i></p>	<p>Approximately 29% of the national population suffer from some form of skin disorder at any one time and within General Practice, the demand for a specialist service has never been greater. Historically the lack of training in dermatology for GPs and nurses has meant a high acute care referral rate for patients requiring a specialist opinion. Referrals into secondary care have increased by an average of 5% per annum for the past 10 years and will continue to pressurise on current service provision.</p> <p>Nationally demand for dermatology specialist opinion is increasing, in part due to the package holiday and sunbed generations. Recruitment to consultant posts across the country is becoming increasingly difficult and is having an impact upon the ability of acute providers to respond to these increases in demand. Alternative models of service delivery are therefore required to ensure a more sustainable service model for the future.</p> <p>According to Dr Foster analysis, East Staffordshire PBC has a high Standardised Access Ratio (SAR) i.e. 138 as at January 2010, the most recent available data. This trend of new outpatient activity in excess of anticipated levels given the PBC patient population, is supported by anecdotal evidence from the lead consultant at Burton Hospital Foundation Trust (BHFT), who has indicated that c. 20% of acute care activity does not need to be managed by an acute provider.</p> <p>Due to lack of outpatient level clinical coding, it is difficult to obtain accurate data on the levels of activity which could be managed effectively in primary care. However, the percentage of new appointments discharged following a first attendance can be used as a proxy and for ES PBC this is 57%.</p> <p>The high SAR value, the lead Consultant's opinion, the high percentage of patients discharged following their first consultation indicates that a transfer of activity into a community setting would be appropriate.</p> <p>Nationally over 30% of all dermatology services are already being provided within a community setting, and there is a wide range of evidence to support that this is both an effective form of patient care and has improved patient satisfaction. This percentage could however be significantly increased. In January 2006, the Department of Health White Paper 'Our Health, Our Care, Our Say: a new direction for community based outpatient care. The Paper suggested that patients with long term skin conditions could be managed more effectively in community settings, with access to specialist services if required.</p> <p>Many other PCTs have developed community based models of</p>
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	<p>care extremely effectively e.g. Nottingham, Leeds, Warrington, Worcestershire, North Staffordshire which in general can deal with a wide range of dermatological conditions and vary between being consultant led or GPWSI led.</p> <p>The high referral rate and discharge rate following first outpatient attendance, suggests that it would be beneficial to have clearer referral guidelines, which include recommendations on management of patients within primary care. It would also be beneficial to regularly audit referrals to support the delivery of GP and nurse education sessions. This has all been attempted with the existing acute provider, but with very limited success.</p> <p>Discussions regarding piloting new service developments such as tele-dermatology have also not been supported in particular by the BHFT department.</p> <p>In order to develop dermatology services for patients within East Staffordshire it is useful to have a new provider to facilitate the changes in service we have been trying to achieve over the last two years at least.</p> <p>The above analysis demonstrates that there is significant potential to move activity from secondary to primary care, but that this needs to be supported through a number of actions including more effective referral guidelines, audit of referrals and education for GPs and nurses.</p> <p>The clinical lead for the community dermatology service (CDS) is very supportive of the approach outlined above and strongly advocates managing patients in primary care where this is appropriate, providing the necessary education packages to support this, whilst developing a dermatology service in a community as opposed to acute setting. The clinical lead for the service also already provides tele-dermatology sessions at HEFT.</p> <p>The above areas have been written into the service specification.</p> <p>This service is seen to be one which facilitates the longer term aim of transferring activity from acute into primary care, but provides the appropriate support to GPs to deliver this.</p> <p>QIPP has identified that there are significant savings from reducing the new : follow up ratios for dermatology. This has been included within the BHFT contract and the CDS model of 'see and treat' and transferring care back to GPs with a clear care plan will help achieve this lower ratio.</p>
<p>Outline of Proposal <i>How does this link to PCT & Local priorities?</i></p>	<p>To develop a community based dermatology service though an 'Any Willing Provider' contract.</p> <p>This service will have clinical sessions provided by</p>

	<p>appropriately trained and qualified clinicians, including Consultant dermatologists, Dermatology Associate Specialists and GPWSIs.</p> <p>Referrals are expected to be significant in volume, but low in complexity, with all suspected cancer referrals being directly referred to acute care. Patients suitable for the CDs are identified in the section on 'scope' below.</p> <p>The service will support the use of Map of Medicine in the management of referrals and will support the education and training of GPs, as identified following referral and outcome audits. It is anticipated that this service will help support the management of dermatological conditions within GP practices in a way which has not been possible to date.</p> <p>The philosophy of the service will be to provide a 'see and treat' model of care where at all possible to ensure that patients' receive an excellent quality service, minimising the delays between diagnosis and treatment and reducing new to follow up ratios.</p> <p>The service is being developed under an Any Willing Provider model and will initially be delivered from Hill Street, thereby providing care closer to home in an easily accessible community based setting and improving utilisation of PCT estate. It is anticipated that once this service is delivering a high quality service from this venue, a small number of additional venues will be sought in locations to ensure equity of access across the PBC and the potential to offer this service across the East Locality and into Derbyshire.</p> <p>The service will reduce acute care new, follow up and minor procedure activity and associated costs, in line with the QIPP agenda and will provide a more patient focussed, cost effective service closer to patients' homes.</p> <p>The development of this service also offers the potential to test tele-dermatology. Taking a digital image of a patient's condition in a GP practice and e-mailing through to a secure nhs.net account for a specialist opinion. The patient may never physically see a specialist but could still receive a specialist opinion at a lower cost. To date BHFT consultants have not been supportive of such a model of care, however the clinical lead for the CDS already provides this service at HEFT.</p> <p>As a longer term aim, there is the potential for patients to more actively self manage their own condition, by taking digital images of their own skin condition and to monitor changes.</p> <p>In summary this service links to the PCT priorities of:</p> <ul style="list-style-type: none"> • QIPP agenda of reducing demand on secondary care
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	<ul style="list-style-type: none"> • QIPP agenda of reducing new : follow up ratios • Developing more cost effective models of care with the same clinical outcomes • Greater utilisation of PCT estate • Care closer to Home • Public and patient engagement in service redesign • Developing modern service models of care through the use of technology to support tele-dermatology • Patient self management
<p>Aims & Objectives <i>(Please expand on the brief outline that you gave in the Commissioning Proposal)</i></p>	<p>The key aims of the CDS are to:</p> <ul style="list-style-type: none"> • Deliver a high quality dermatology service in a community setting • Improve patient choice • Enhance patient experience • Reduce inappropriate referrals into acute care • Improve access to dermatology care and treatment • Reduce first and follow up outpatient attendances in acute care • Ensure that 18 week referral to treatment • Improve education and training for GPs and nurses • Improve the patient self management of long term skin disease • Promote the development of specialism in primary care • Develop a service which is integrated with acute care and supports the management of patients within primary care. <p>The main aim of this service is to transfer appropriate dermatology activity into a community setting, which offers better value for money. In addition, this also offers the potential to develop more modern models of service delivery as outlined above.</p> <p>The sustainability of a community based service is critical to providing a quality dermatology service. In order to ensure sustainability of service, there are an agreed number of clinical sessions which will be provided on a monthly basis with individual specialists, but there are also an additional number of clinical staff, who are able to provide adhoc sessions as required.</p> <p>As part of this CDS, there is a desire to support the training of GPs within the PBC on the Cardiff course, thereby creating our</p>

	own workforce capacity and capability.
<p>Management of the Service <i>(Explain how the service will be managed i.e. receiving referrals, appointments, outcomes and waiting list requirements)</i></p>	<p>In the first year, this service will receive referrals from GPs across the East Staffs Consortia as an Any Willing Provider.</p> <p>Initially referrals will be sent to Hill Street CDS. Winshill practice staff will collect post on daily basis and will contact patients to offer a choice of appointment dates and times.</p> <p>The CDS will provide monthly information on:</p> <ul style="list-style-type: none"> • Total number of patients seen in the clinic • Total number of patients seen as a first outpatient appointment • Total number of patients seen as a follow-up appointment • The percentage of minor procedures • The number of patients who develop an infection post excision • Total number of DNAs • Total number of rebooked appointments for DNAs • Total number of patients seen by ethnic origin • Total number of patients seen by condition • Total number of patients referred onto secondary care for consultation • Total number of patients referred for surgery • Total number of adverse events associated with treatment • Total number of patients referred into service per practice and/or consortium • Maximum number of weeks wait for first outpatient appointment • Percentage of patients receiving first definitive treatment within 18 weeks • Total number of patients on waiting list • Maximum number of weeks from receipt of referral to onward referral to acute care if required. • Maximum number of weeks wait for follow-up appointment • Total number of Patient Satisfaction Surveys completed • % Referrals reviewed within 2 operational days of receipt • % patients contacted within 3 operational days to agree a mutually acceptable date • % clinic letter issued within 7 days and the Practice to receive them within 14 days. • Number of GP education sessions delivered and topics covered
<p>Scope of the Proposed Service <i>(i.e. which patients will be using the service, Target Localities/patient profile)</i></p>	<p>Within the first year of operation, this service will only be accessible to patients within the East Staffs PBC. However there is potential to expand the service to the South East Staffs PBC and to Derbyshire.</p> <p>The service will see patients in all age groups and will see</p>

	<p>referrals where there is diagnostic uncertainty or where patients have not responded to treatment offered by their GP.</p> <p>The service will cover a wide range of dermatological conditions including:</p> <ul style="list-style-type: none">• Acne• Rosacea• Eczema• Psoriasis• Impetigo• Pruritus• Tinea (ringworm)• Urticaria and angiodema• Warts• Scabies• Solar keratoses• Onychodystrophy <p>This service will provide the PBC with the opportunity to clearly define skin conditions which GPs should refrain from referring and if necessary can provide advice and guidance to support GPs with the management of conditions in primary care. This can be provided through telephone discussion, correspondence, tele-dermatology and GP education sessions. Robust data can be collected by this service to identify education requirements.</p> <p>Conditions which should not be referred due to lack of effective treatment options include:</p> <ul style="list-style-type: none">• Pityriasis Versicolor – this can be treated by GPs and onward referral should only be made if the condition is atypical or particularly severe• Early male pattern baldness – no medication is available on the NHS.• Androgenic alopecia in females – referral should only be made if the condition is very severe or there are atypical features such as scarring or occurring in a very young woman.• Physiological hirsutism – unless the condition is particularly severe or physiologically damaging, very little can be achieved by a referral• Melasma / chlosma – refer only if there is diagnostic doubt or the case is very severe.• Cosmetic skin tags <p>Other conditions which should not be referred:</p> <ul style="list-style-type: none">• Suspected skin cancers• Patients requiring phototherapy• Laser service• Contact allergy testing• Dermatology emergencies
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<p>Clinical Effectiveness <i>(What evidence is there of the clinical effectiveness of the proposed service?)</i></p>	<p>There is national evidence that similar models of care operate in Nottingham, Leeds, Warrington, Worcestershire, North Staffordshire, Derby.</p> <p>This service will offer a high quality service, provided by appropriately trained and qualified clinicians, including Consultant dermatologists, Dermatology Associate Specialists and GPWSIs. However with this being in a community setting it offers better value for money at a lower cost.</p> <p>Patients will receive treatment in accordance with NICE guidance and the British Association of Dermatologists.</p> <p>An acute consultant will provide a small number of sessions per annum to assess whether the service delivers to the definition of good clinical practice.</p> <p>The potential of a joint community consultant appointment with BHFT has been investigated but is not currently being pursued due to trust concerns. However, there may be the opportunity to employ such a consultant in partnership with Mid Staffordshire FT.</p>
<p>What will be the benefits to Patients? <i>(e.g. How will this link in to Choice/Choose & Book?)</i></p>	<p>This service will provide clinics within community settings, with no car parking charges.</p> <p>This will be an additional provider in the locality, thereby offering more patient choice.</p> <p>The sessions will run into early evenings, thereby making them more accessible to patients.</p> <p>The service will ultimately be easily accessible to patients through choose and book.</p>
<p>What will be the benefits for Clinicians/Staff?</p>	<p>Deliver care in a more modern environment and more modern clinical models of service delivery.</p> <p>GPs will have more information on their referrals to support education and training to support the management of patients in primary care. Through advice and guidance and tele-dermatology, GPs will be more supported in their clinical management of patients.</p>
<p>What will be the anticipated benefit area for the PCT <i>(i.e. Number of Reduced Admissions / Avoided Out Patient attendances)</i></p>	<p>Reduction of 500 new and 1,000 follow up acute care outpatient appointments in year one of operation.</p> <p>Re-provision in year one of 500 new and 200 follow up appointments in a community setting, but overall demand is anticipated to reduce by implementing more robust clinical referral criteria, by providing a see and treat model of care and by providing advice and guidance to GPs.</p> <p>Anticipate further reduction in acute care activity in year two</p>

	as capacity expands and confidence in the service increases.
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Milestones & Timescales	Milestone	Timescale
	Development of business case for PBC / PEC / PBC Governance	April / May 2010
	Development of service specification, including referral criteria, supported by Map of Medicine.	April 2010
	Development of clinical room at Hill Street	May 2010
	'Recruitment' of clinical staff	April 2010
	Clarification of patient information reporting arrangements	May 2010
	Marketing of service to East Staffs PBC	May 2010
	Start receiving referrals and offering appointments for service delivery in May.	End May?
	Service commences	Mid June
	Agreement in principle to a joint consultant post across acute and community care.	TBA
	Support application by GPs to the Cardiff Course	September 2010
	Pilot telemedicine.	August 2010
	Audit effectiveness of service	October 2010.
	Develop GP education sessions based on 6 months of operation and launch of telemedicine	October 2010
	Review costing of service	March 2011

Initial Risks Associated with the Service Provision Proposal and Strategy for managing those risks (Countermeasure)	Risk	Countermeasure
	Clinicians not delivering agreed clinical sessions.	Agreements with additional clinicians to provide adhoc sessions, joint consultant post and development of GPsWSI.
	Demand exceeding capacity	Agreements with additional clinicians to provide adhoc sessions, joint consultant post and development of GPsWSI.
	Cover initial set up costs	Year one costs increased to reflect in particular equipment set up costs.
	Room at Hill Street not complying with clinical standards.	Meetings being held to manage this and service will not commence unless room is compliant.

Section 3: Financial Implications

Annual Expenses (Cost of New Service) <i>List a breakdown of all expenses, remembering to add on-costs to staff costs</i>	Year 1	Notes
Capital Costs		
Staffing Costs, including backfill for clinicians running new service provision		
	£24,345	Consultant sessions
	£16,089	3 GPsWsis
	£13,230	Specialist nurse sessions (44)
	£6,336	Admin
Training and Supervision Costs	£2,000	GPsWSI Cardiff course
Equipment & Materials		
consumables	£2,250	Minor ops packs
	£1,000	Stationary / paper records in advance of clinical system at Hill Street
	£3,854	Equipment and biopsy packs
	£1,000	Set up telephones and stationary
Other Expenses		
Total Cost of New Service	£70,104	
Anticipated Revenue <i>please explain source of revenue</i>	£74,847	
Profit Element for Service Provider	£4,743	

Anticipated Financial Benefit to PBC Budgets	Year 1	Year 2	Year 3
Anticipated freed up resources achieved through avoided secondary care activity. <i>Please specify:</i>			
Less Cost of new Service Provision to users of the service	Cost of activity if remains in acute: £99,796 Cost of activity in CDS: £74,847		
Surplus to PBC Budgets	£24,949 Based on 75% reduction on tariff.	Further savings with agreement reduce to 70% tariff	

How much funding is being requested & identification of purpose	None
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Section 4: Corporate Governance

Please note that some contracting methods will entail certain liabilities, for example a Limited Company option under APMS. It is therefore essential specialist advice is taken to understand clinical/personal liability, medical indemnity etc.

<p>On which contracting basis do you intend this service provision to be based? e.g. LES, PMS, SPMS, APMS, PCT GPSI Commissioned Service, please explain.</p>	<p>Any Willing Provider.</p>
<p>Which National, NSF and PCT Targets will this service provision deliver against?</p>	<p>Waiting time for first and follow up appointments Waiting times to first definitive treatment.</p>
<p>Patient, Public & Front-line Staff Involvement. <i>Please describe how you have involved Patient, Public and front-line staff in this proposed development.</i></p>	<p>Proposal discussed and developed with BHFT consultants and managers. Proposal discussed and developed with members from the East Staffs Consortia District Patient Engagement Group.</p>

Section 5: Quality & Corporate Assurance

Please note there is value in discussing your proposals early on with your PCT Clinical Governance Lead

Clinical Governance Assurances	
Please Specify Audit arrangements i.e., patient satisfaction surveys, reduction of hospital referrals & admissions	Patient satisfaction surveys Reduction of referrals to secondary care Audit of attendance outcomes Audit of referrals Surgical infection rates
What Quality Checks will be in place?	BHFT clinical sessions to oversee service. Joint clinical audits between community based and acute care clinicians.
What information will you supply to the PCT and with what regularity?	Please refer to above section – ‘ Management of the Service ’
Outline Contractual Arrangements (To be detailed in the Service Level Agreement)	
Proposed period of Contract	Any Willing Provider
Proposed Notice Period	Any Willing Provider
What Contract Review arrangements do you envisage?	March 2011
How will Complaints be managed?	In accordance with PCT policy.

To be Completed by PCT:

Comments received:	Date
Practice Based Commissioning practice/consortia	
Clinical Governance Lead	
Executive Directors	
Professional Executive Committee	

Outcome of Application	Name	Date
Approved – on the basis of:		
Rejected - Reasons for Rejection:		
Passed for Payment:		

SCHEDULE 2 THE SERVICES

Schedule 2 Part 1: Service Specifications

[Mandatory headings, but detail for local determination and agreement]

Service	Community Dermatology Service
Commissioner Lead	Rebecca Woods
Provider Lead	Dr Devikanand
Period	3 years, with annual review

1. Purpose

1.1 Aims

- Deliver a high quality dermatology service in a community setting
- Improve patient choice
- Enhance patient experience
- Reduce inappropriate referrals into secondary care
- Improve access to dermatology care and treatment across the East Locality
- Reduce first and follow up outpatient attendances in secondary care
- Ensure that 18 week referral to treatment
- Improve education and training for GPs and nurses
- Improve the patient self management of long term skin disease
- Promote the development of specialism in primary care
- Develop a service which is integrated with secondary care and supports the management of patients within primary care.

1.2 Evidence Base

- Action on Dermatology (January 2003)
- British association of Dermatologists guidelines on qualifications for GPwSI (April 2008)
- Nottingham, Leeds, Warrington, Worcestershire, North Staffordshire community based dermatology services.

1.3 General Overview

Approximately 29% of the national population suffer from some form of skin disorder at any one time and within General Practice, the demand for a specialist service has never

been greater. Historically the lack of training in dermatology for GPs and nurses has meant a high acute care referral rate for patients requiring a specialist opinion. Referrals into secondary care have increased by an average of 5% per annum for the past 10 years and will continue to pressurise on current service provision.

Nationally demand for dermatology specialist opinion is increasing, in part due to the package holiday and sunbed generations. Recruitment to consultant posts across the country is becoming increasingly difficult and is having an impact upon the ability of acute providers to respond to these increases in demand. Alternative models of service delivery are therefore required to ensure a more sustainable service model for the future.

According to Dr Foster analysis, East Staffordshire PBC has a high Standardised Access Ratio (SAR) i.e. 138 as at January 2010, the most recent available data. This trend of new outpatient activity in excess of anticipated levels given the PBC patient population, is supported by anecdotal evidence from the lead consultant at Burton Hospital Foundation Trust (BHFT), who has indicated that c. 20% of acute care activity does not need to be managed by an acute provider.

Due to lack of outpatient level clinical coding, it is difficult to obtain accurate data on the levels of activity which could be managed effectively in primary care. However, the percentage of new appointments discharged following a first attendance can be used as a proxy and for ES PBC this is 57%.

1.4 Objectives

- Improve access to dermatologist specialist opinion
- Improve the education within primary care for GPs and nurses
- Increase capability for provision of advice and guidance to GPs
- Improve the quality of life for patients with dermatological conditions
- Deliver value for money community based dermatology service
- Provide a 'see and treat' model of care
- Pilot telemedicine
- Improve self management of patients

1.5 Expected Outcomes

- Reduce first and follow up attendances in acute care
- Reduce new to follow up ratio of acute providers
- Reduce costs associated with dermatological activity
- Increased number of patients being referred into community based dermatology service
- Increased number of community based clinics
- Education for GPs and nurses to support management of patients in primary care
- Improve patient experience through short wait times and 'see and treat' model

2. Service Scope

2.1 Service Description

The service aims to provide a high quality service, providing consultation, diagnosis and treatment for patients with dermatological conditions which are not considered to be potential cancer.

2.2 Accessibility/acceptability

Within the first year of operation, this service will only be accessible to patients within East

Staffs PBC. However there is potential to expand the service to the South East Staffs PBC and to Derbyshire.

The service will see patients in all age groups and will see referrals where there is diagnostic uncertainty or where patients have not responded to treatment offered by their GP.

GPs can also request advice and guidance from the service and there will be a pilot of telemedicine.

The service will cover a wide range of dermatological conditions including:

- Acne
- Rosacea
- Eczema
- Psoriasis
- Impetigo
- Pruritus
- Tinea (ringworm)
- Urticaria and angiodema
- Warts
- Scabies
- Solar keratoses
- Onychodystrophy

Patients will receive treatment in accordance with NICE guidance and the British Association of Dermatologists.

This service will provide the PBC with the opportunity to clearly define skin conditions which GPs should refrain from referring and if necessary can provide advice and guidance to support GPs with the management of conditions in primary care. This can be provided through telephone discussion, correspondence, tele-dermatology and GP education sessions. Robust data can be collected by this service to identify education requirements.

Conditions which should not be referred due to lack of effective treatment options include:

- Pityriasis Versicolor – this can be treated by GPs and onward referral should only be made if the condition is atypical or particularly severe
- Early male pattern baldness – no medication is available on the NHS.
- Androgenic alopecia in females – referral should only be made if the condition is very severe or there are atypical features such as scarring or occurring in a very young woman.
- Physiological hirsutism – unless the condition is particularly severe or physiologically damaging, very little can be achieved by a referral
- Melasma / chlosma – refer only if there is diagnostic doubt or the case is very severe.
- Cosmetic skin tags

Other conditions which should not be referred:

- Suspected skin cancers
- Patients requiring phototherapy
- Laser service
- Contact allergy testing
- Dermatology emergencies

It is the aim of the service to start small and ensure that a high quality service is provided and then to expand on a gradual basis. The next phase could be to include referrals from the South East Staffs consortium and to provide services from a location within that consortium area.

2.3 Whole System Relationships

The community dermatology service will closely analyse referrals and will use this information to design generic and specific education sessions for GPs and nurses.

The service will also work closely primarily with BHFT dermatology service to ensure:

- a) the development and adherence to clear guidance for onward referral, and
- b) that patients currently under acute care are managed in the community where appropriate.

An acute consultant will provide a small number of sessions per annum to assess whether the service delivers to the definition of good clinical practice.

2.4 Interdependencies

As above.

The community service will require support from the acute care pathology department.

2.5 Relevant networks and screening programmes

None.

2.6 Contractual Arrangements

Covered by the national standard acute trust contract.

3. Service Delivery

3.1 Service model

The service will be delivered by:

- **Appropriately trained and qualified clinicians. The provider must demonstrate to the satisfaction of the Commissioner that they are able to diagnose, assess and treat patients with both common and acute skin diseases to a high standard of care.**

To maintain clinical competency within this field, the provider must ensure that every clinical member of the team registered with the GMS, or other professional body, reviews a minimum of 30 patients and five different dermatological conditions per year. If an individual practitioner falls below this threshold in two consecutive years, they will cease to be accredited by the Commissioner to carry out this service.

The provider will evidence:

- a) an enhanced level of knowledge and skills to those acquired by non-specialist colleagues
 - b) good communication skills
 - c) competence in teaching and training health care professionals
 - d) commitment to cascade knowledge and skills.
- **Secretarial staff who are adequately trained in dermatological terms and must be**

provided with appropriate word processing and data collection facilities to allow for robust clinical audit.

- The provider must ensure that there is sufficient secretarial and administrative support for all the activity generated within the Community Dermatology Service.

3.2 Care Pathways

To be provided.

3.3 The provider will receive an indicative price up to a maximum of:

- Outpatient First Attendance – £90.75
- Outpatient Follow up Attendance – £48.00
- Minor procedure - £103.50

It is anticipated that due to the set up costs of equipment and investment in GPwSI training, year one costs are slightly inflated.

3.4 Equipment and other resources

Provision of equipment is included within the national standard acute trust contract.

The production of patient information leaflets and all promotional literature will be the responsibility of the provider. The information should be appropriate for the requirements of a patient's age, sex, ethnic origin, religion or disability. The service shall make available any literature produced by patient support groups and display addresses and points of contact.

3.5 Information governance and support infrastructure

The provider shall at all times ensure:

- Clinic reception, procedure and office areas have access to IT points and access to appropriate Patient Administration Systems.
- Generation of both appointment letters and clinic letters
- Capture and analysis of data from within the clinical sessions to support the development of education sessions.

The provider is to ensure that:

- patient's registered practice is issued with a clinic letter within seven days and is received by the GP practice within 14 days.
- the patient's GP is informed when a patient does not attend their appointment within five days of the occurrence.

A monthly data set will be required and as should as a minimum include:

- Patient name
- Patient NHS number

- Patient date of birth
- Patient ethnicity
- Patient practice
- Name and designation of person providing care
- Reason for consultation
- Patient outcome

3.6 Key information deliverables:

The monthly information recorded will include:

- Total number of patients seen in the clinic
- Total number of patients seen as a first outpatient appointment
- Total number of patients seen as a follow-up appointment
- The percentage of minor procedures
- The number of patients who develop an infection post excision
- Total number of DNAs
- Total number of rebooked appointments for DNAs
- Total number of patients seen by ethnic origin
- Total number of patients seen by condition
- Total number of patients referred onto secondary care for consultation
- Total number of patients referred for surgery
- Total number of adverse events associated with treatment
- Total number of patients referred into service per practice and/or consortium
- Maximum number of weeks wait for first outpatient appointment
- Percentage of patients receiving first definitive treatment within 18 weeks
- Total number of patients on waiting list
- Maximum number of weeks from receipt of referral to onward referral to acute care if required.
- Maximum number of weeks wait for follow-up appointment
- Total number of Patient Satisfaction Surveys completed
- % Referrals reviewed within 2 operational days of receipt
- % patients contacted within 3 operational days to agree a mutually acceptable date
- % clinic letter issued within 7 days and the Practice to receive them within 14 days.
- Number of GP education sessions delivered and topics covered

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

Within the first year of operation, this service will only be accessible to patients within East Staffs PBC. However there is potential to expand the service to the South East Staffs PBC and to Derbyshire.

4.2 Location(s) of Service Delivery

The service will be delivered through community clinics in East Staffordshire including initially Hill Street Health and Wellbeing Centre, with other potential locations being developed later.

All locations must offer appropriate capacity and setting to allow for communication, consultation and booking in / reception and treatment areas.

Sites should have adequate patient parking and access be compliant with the Disability and Discrimination Act (2005).

Clinic locations should demonstrate their accessibility to main road networks and public transport for those patients where private transport is not an option.

4.3 Days/Hours of operation

The service will provide a minimum of four sessions a month operating Monday to Saturday. The hours of service will vary, but the provider will need to offer appointments into the early evenings, to enable patients to have greater flexibility of appointment times than those provided by acute providers.

4.4 Referral criteria & sources

Referrals will be from GPs

Inclusion Criteria:

The service will see patients in all age groups and will see referrals where there is diagnostic uncertainty or where patients have not responded to treatment offered by their GP.

GPs can also request advice and guidance from the service and there will be a pilot of telemedicine.

The service will cover a wide range of dermatological conditions as referred to in 2.2 above.

4.5 Referral route

All patients that meet the inclusion criteria can be referred to this service by their GP. Initially referrals can be made via referral letter or e-mail. Once the service has expanded to the East Locality, it will be made available through choose and book.

Process and timescales:

- a) Referrals will be reviewed within 2 operational days of receipt
- b) Administration staff will contact the patient within 3 operational days to agree a mutually acceptable date
- c) All patients will be offered a choice of appointments within a maximum 8 week period.
- d) All patients will be seen and treated within a maximum of 8 weeks, thereby providing sufficient time, if required, to onward refer to secondary care and still be able to deliver an 18 week referral to treatment waiting time.

4.6 Exclusion criteria

Suspected cancer patients will not be suitable for this service. Any referrals received which following triage are considered to be potential cancer will be forwarded on to any acute provider of the patient's choice within 2 operational days.

5. Transfer of and Discharge from Care Obligations

Patients will be discharged back to their GP once treatment has been undertaken or a treatment plan identified, following a definitive diagnosis.

The provider will issue a clinic letter to the referrer within five operational days from the time that the consultation / treatment took place, with a copy to the patient if clinically appropriate to do so. The provider should make correspondence available in different languages, Braille, large print, if requested.

6. Self-Care and Patient and Carer Information

Dermatology Society patient information leaflets will be made available for patients to support self management and care.

7. Quality Requirements

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>
<u>Quality</u>				
A programme of audits to be available to the PCT	Audit programme	Annual	Audit programme	
Reporting of Serious Untoward Incidents will follow PCT procedure.		None	Provider to report	Clause 32
The Contractor must establish and operate a robust complaints procedure in line with NHS guidelines. All complaints should be monitored, audited and action taken as necessary.	Complaints report	All complaints handled in accordance with the PCTs complaints policy	Review quarterly	
The service must undertake patient satisfaction surveys	Survey	Annual survey		
<u>Performance & Productivity</u>				
Review by acute consultant to assess whether the service delivers to the		Twice a year minimum.		Clause 32

definition of good clinical practice.				
Review by PBC to assess outcomes of service.		Annual review		
Minimum of 85% of minor procedures to be undertaken as part of first appointment.		Biannual review		
New:follow ratio is not to exceed 1:0.5 unless this has been previously agreed with the Commissioner.		Quarterly review		None payment of activity

The provider must identify a clinical lead for the service and must comply with National DH Clinical Governance requirements as a minimum meet the standards included in the National Quality Standards and Standards for Better Health. These will be monitored on an annual basis, via inspection.

8. Activity

8.1

<i>Activity Performance Indicators</i>	<i>Threshold</i>	<i>Method of measurement</i>	<i>Consequence of breach</i>	
New outpatients	500	Monthly activity reports		
Follow ups	200	Monthly activity reports		
Minor procedures	175	Monthly activity reports		

8.2 Activity Plan

Year one:

500 New

200 Follow Ups

175 Minor procedures

Year two:

To be reviewed but potential to expand to 20% of BHFT contract.

8.3 Capacity Review

If demand increases by more than 10%, this will trigger a capacity review.

9. Prices & Costs

9.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
National Tariff plus Market Forces Factor				
Non-Tariff Price (cost per case/cost and volume/block/other)*	New outpatient	£90.75		£74,847
	Follow up outpatient	£48		
	Minor ops	£103.50		
Total		£		£74,847

**delete as appropriate*

9.2 Cost of Service by commissioner

Total Cost of Service	Co-ordinating PCT Total	Associate PCT Total	Associate PCT Total	Associate PCT Total	Total Annual Expected Cost
£	£	£	£	£	£