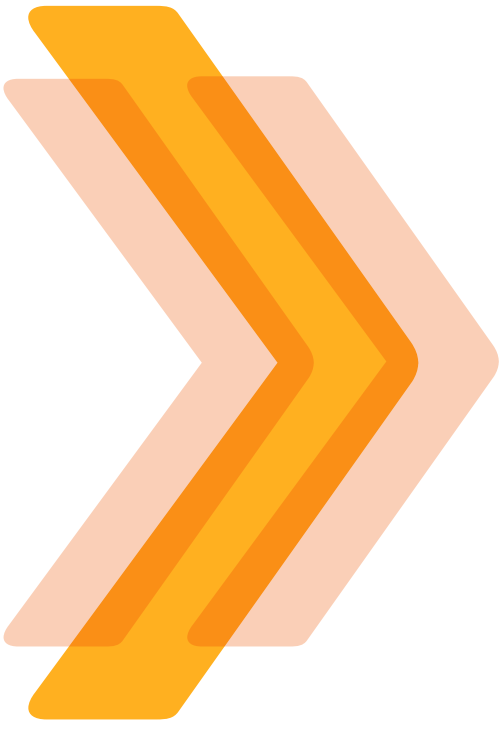
The King's Fund

Ideas that change health care

CASE STUDY

Sunderland dermatology and minor surgery service



October 2014

Specialists in out-of-hospital settings

As part of the drive to keep patients out of hospital and better integrate services across settings, consultants are starting to develop new models of care that link secondary, primary, community and social care professionals.

This case study is one of six, which form part of a project undertaken by The King's Fund to investigate the different ways in which consultants are working beyond their traditional boundaries. The King's Fund's staff reviewed relevant documentation and interviewed staff to help identify the key characteristics of this new way of working, explore the challenges in establishing services of this type and understand what benefit they could bring for patients and the NHS.

The other five case studies are:

- Portsmouth and South East Hampshire diabetes service
- Leeds interface geriatrician service
- Imperial child health general practice hubs
- Haywood rhematology centre
- Whittington respiratory service.

Further details on the other study sites can be found at: **www.kingsfund.org.uk/specialistscasestudies**

For an overview of the project, including key strategies for out-of-hospital working, the challenges to developing these services and the benefits for patients and the NHS please go to: **www.kingsfund.org.uk/specialists**

Background

It is estimated that 54 per cent of the UK population is affected by a skin condition in any given year (Schofield *et al* 2009). Although the majority will self-care, skin conditions are the most common reason for GP consultations for a new problem. Specialists most commonly see patients for skin lesions, eczema, psoriasis and acne (Hospenthal 2013).

Dermatology has a relatively high rate of referrals to specialist care, with 5.5 per cent of the 13 million primary care dermatology consultations in England and Wales referred for specialist advice (Schofield *et al* 2009; The King's Fund analysis of GP-referred outpatient appointments 2012/13). This rate is rising; over the five years from 2007/08, there was a 15.5 per cent increase in GP referrals for dermatology (The King's Fund analysis of NHS comparators data). Analysis produced in 2013 indicates that skin cancer is growing at a rate of 7 per cent each year, and is now almost as common as all other cancers combined (Levell *et al* 2013).

Recent research by The King's Fund (2014) identifies various challenges facing dermatology services at a national level including:

- growing demand and patient expectations, and rising costs of new treatments
- uneven distribution of specialist staff, and a shortage of senior medical and nursing staff
- variations in the quality of diagnosis and treatment as most doctors only receive two weeks' training in dermatology
- concerns about the quality of commissioning for dermatology, and a lack of specialist knowledge among commissioners
- poor mental health provision for people with skin conditions.

Overview

The Sunderland dermatology and minor surgery service is an intermediate service that diagnoses and manages patients with a range of skin conditions whose treatment does not require a hospital setting. The service is run by South Tyneside NHS Foundation Trust and is delivered in a purpose-built primary care centre co-owned by Sunderland CCG and Sunderland City Council.

The service provides:

- diagnosis for a range of skin conditions through general dermatology clinics run by a consultant dermatologist and a GP with a special interest (GPwSI)
- nurse-led clinics that monitor prescribed management plans and deliver a range of treatments such as steroid injections
- health care assistant-run clinics that provide patient education
- advice, education and support for patients with chronic conditions, who can access a telephone advice line or a rapid access clinic when experiencing a flare-up
- a dedicated nurse-led clinic for people with severe acne
- minor skin surgery – generally performed by the nurse surgeon or by one of two GPs who run minor surgery sessions in the centre. Patients can be assessed, treated and discharged on the same day
- telephone advice on diagnosis and treatment for GPs, practice nurses and other health care professionals (such as school nurses, district nurses, staff from minor injury units and chiropodists) provided by the consultant dermatologist, GPwSI and senior nursing staff

- education sessions for GPs and primary care practice teams delivered on a quarterly basis by the consultant dermatologist with input from the rest of the team.

All of the services provided in the intermediate service are also delivered at the local hospital, run by a different acute trust. This means patients have a choice about where they are treated. Prior to the development of the intermediate service, all patients requiring specialist dermatology care would have been treated in the hospital, and some of those requiring minor surgery would have been treated in general practice.

The service is part of South Tyneside NHS Foundation Trust, an integrated acute and community trust. It is funded through their block contract with South Tyneside CCG. Sunderland CCG, for whom the service is provided, is a co-signatory of this contract.

The service has grown and developed over the past 12 years. In 2002, a nurse and a health care assistant were recruited to support GPs in managing patients with chronic conditions and carrying out minor surgery in primary care. In 2005 it moved to a new primary care centre built locally with £1 million of Department of Health funding. A consultant dermatologist was appointed on a half-time basis to provide leadership on clinical governance and training, and to enable delivery of treatments only available under specialist supervision. In 2010, an advanced nurse practitioner was appointed to provide full-time senior clinical management and leadership.

There are ambitions to expand the service into patch-testing, the treatment of hand eczema and potentially phototherapy – services that are currently only provided in hospital. This would require additional staffing, training and specialist equipment. Extending the service's geographical scope to other CCG populations and trialling the use of tele-dermatology consultations are also being considered.

Referral pathway

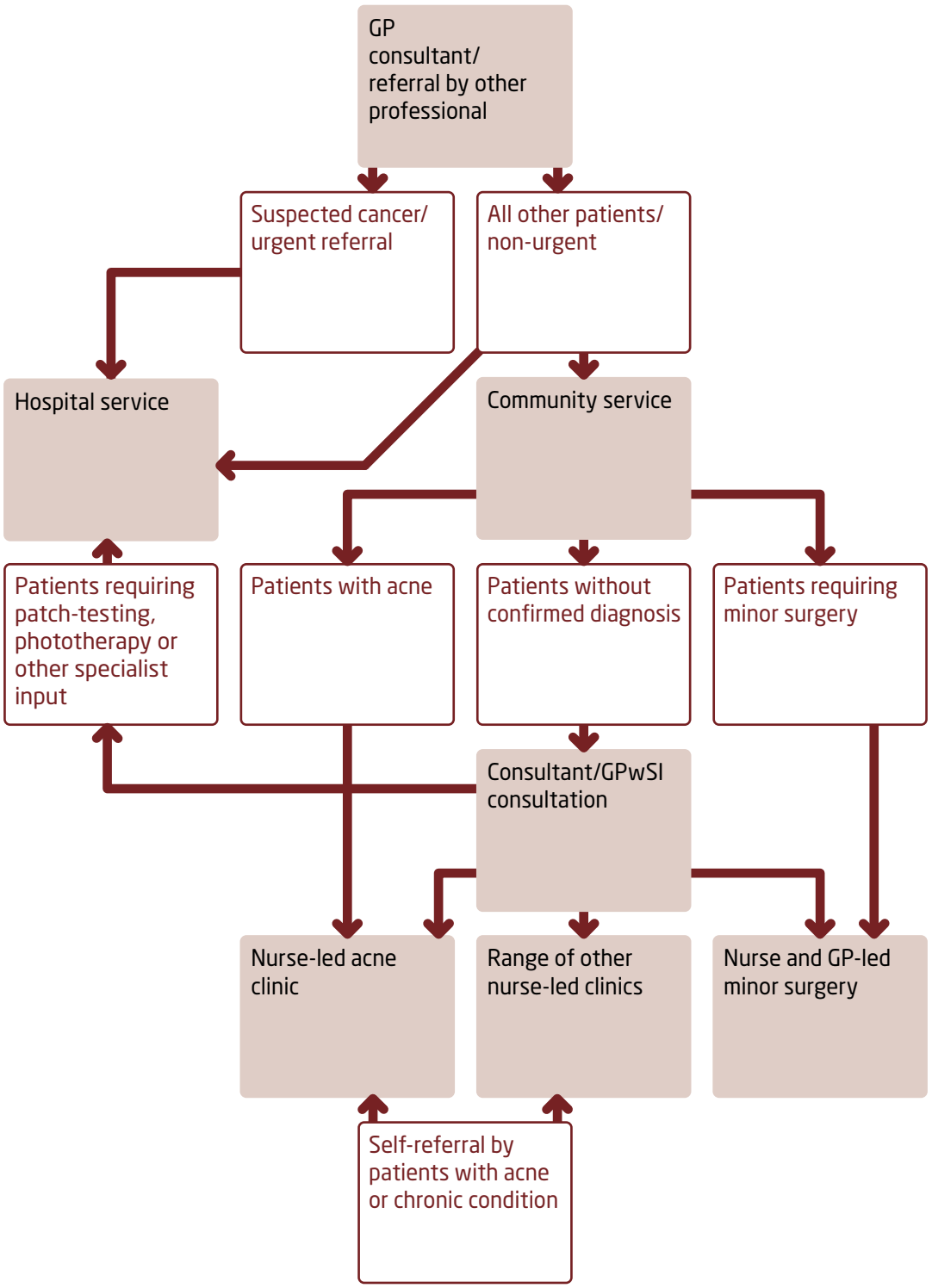
The service receives referrals from GPs and other health professionals, including school nurses, health visitors, district nurses, podiatry and the minor injuries unit. All referrers follow standard exclusion criteria outlining available NHS treatments and non-NHS alternatives. A small number of hospital consultants refer to the service for follow-up appointments after hospital treatment and can also refer patients for education and self-management advice.

Administrative staff sort referrals into the appropriate clinic for an initial consultation and these are then checked by the nurse practitioner or consultant dermatologist. Patients with acne who experience a flare-up can self-refer back to the service within a year of their initial appointment, and patients with chronic conditions can self-refer within six months without contacting their GP.

The consultant dermatologist and GPwSI only provide ongoing management for patients with complex needs. Patients with a confirmed diagnosis by their GP may be referred directly to the nurse-led acne clinic and to the minor surgery service. Patients without a confirmed diagnosis have an initial consultation with the consultant dermatologist or part-time GPwSI, and are then referred on to nurse-led clinics for follow-up appointments and treatment.

The service does not treat patients for suspected cancer or those requiring urgent treatment; they are referred directly by the GP to the hospital. Patients found to require patch-testing and phototherapy are referred from the community service to the hospital.

Sunderland dermatology and minor surgery service referral pathway



Innovative features

- The service provides **timely access for patients with chronic conditions** through their rapid access clinics and enables patients known to the service to self-refer within a specific time frame without needing to be re-referred by their GP.

- Professionals within the service are supported by the consultant dermatologist and nurse practitioner to work to **the limits of their training and skills**. Nursing staff reported that they were given opportunities for training and development, and were empowered to take on roles and responsibilities not offered elsewhere. Examples include the nurse-led acne clinic and nurse-led surgery, with patients not needing to see a consultant dermatologist at any stage in their patient journey, and the range of other clinics for follow-up appointments run by nurses and health care assistants.

Impact

The service has gathered some evidence on its impact, although they emphasised the need for investment and capacity to enable robust evaluation.

- **Patient experience** surveys (covering two quarters in 2013, and a total of 42 patients) found 100 per cent of patients would recommend the service to others. Patients were said to prefer being treated in a community setting due to the convenience of the location; the setting being less intimidating than a hospital; and staff having more time to spend with patients, partly due to the use of extended nurse roles enabling longer appointment times.

- **Waiting times** were lower than in the hospital-based dermatology service: median wait for first appointment was 4.8 weeks, compared to 6.7 weeks at the acute trust (NHS England 2014). This was in part attributed to patients not having to wait to see a doctor and in part to the efficiencies of patient segmentation, with patients with more complex conditions requiring extensive follow-up seen in the hospital.

- Although several interviewees referred to the **cost-effectiveness** of the community service, an economic analysis has not been conducted and no evidence was available to support this. In addition, the community service had not led to a reduction in hospital activity or to a reduction in overall dermatology costs for the health economy. Although the service has expanded from providing care for 5,000 to 12,000 patients within the same funding envelope, there has been no reduction in referrals to the hospital-based service. Interviewees attributed this to rising demand for dermatology services and the community service uncovering previously unmet demand.

Barriers and enablers to service development

Local context

- Without the **engagement and drive of a single individual** who created a role split between acute and community provision, the service may have developed differently. This level of consultant input might not be required in other locations, as this level of intermediate care only requires consultant management rather than direct input through clinics. It could be limited to the consultant triaging referrals into designated clinic lists.

- Although much of what had been achieved in the service, particularly around developing extended staff roles, could be achieved in a hospital setting, patients reported preferring the option to be treated in the primary care centre. This service provides an example of a **viable alternative to hospital provision** for part of the specialist dermatology case load.

Service design

- Interviewees noted that **referrer education** was essential when introducing an intermediate service of this type. It ensures that the new service does not cause delays to the patient pathway. This is particularly important for patients with suspected skin cancer, who should be referred to the acute rather than community service. Referrer education is also important to ensure that patients who can be treated in general practice continue to be seen there. An intermediate service can lower the threshold for referral and lead to de-skilling of GPs as it provides capacity for patients to be diagnosed and treated elsewhere. This is particularly an issue in dermatology due to the lack of GP skills and training in the specialty. The service was working to address this by running education sessions to GPs and practice teams, which interviewees reported had resulted in closer relations with GPs and

an improved understanding of referral pathways. Interviewees suggested that upskilling GPs more generally in dermatology diagnosis and treatment, and harnessing GPwSIs more widely, would help to mitigate this risk.

- The development of specialist nursing roles had helped **recruitment** within the service. Nurses reported that they enjoy the challenging roles on offer as well as the opportunity to undertake mentoring courses and use these skills within their practice.

- Nurses within the service took on the new role of referring patients to the acute service when necessary. However, there was **resistance** in the system to this new way of working, with secondary care nurses in the acute service not accepting nurse-written referrals. This highlights the importance of engaging with staff across the system when implementing new nursing roles.

Funding arrangements

- South Tyneside NHS Foundation Trust is a combined community service and acute trust that does not provide any acute dermatology services. Because of this, the consultant who works in their dermatology centre is employed by and also runs clinics at the acute dermatology service at County Durham and Darlington NHS Foundation Trust. South Tyneside reimburses County Durham and Darlington for half his time. Under this arrangement, the contract is held directly with the consultant, meaning there is no requirement to provide cover during periods of absence. Consequently, there is no **robust arrangement to provide cover** if the consultant is on leave or ill. It also means there is a risk around succession planning when the lead consultant retires. The service is investigating tele-dermatology or greater use of GPwSIs as a means of accessing additional specialist input when needed. Contracting consultant input from a team of consultants, rather than an individual, would ensure 52-week specialist cover.

- Because of the structure of dermatology services locally, the service has not generated cost savings in the local health economy; rather it has provided new capacity for **unmet demand** and rising need. An interviewee noted that to achieve a reduction in hospital referrals would require a fundamental change in GP referral practices or the commissioner disinvesting in parts of the hospital-based service. There were concerns about how a change in

referral pathways could be encouraged, and whether commissioners would realistically disinvest in acute services, given that hospital and community services in Sunderland were provided by different trusts. Shifting activity out of hospital has the potential to destabilise the acute service, as it may be left with complex, costly patients. This highlights the importance of achieving buy-in from all local players in the health system to achieve fundamental pathway redesign. If pathway redesign does not occur across the whole system, there is little potential to generate cost savings for the whole system – instead, the introduction of a community service simply provides additional capacity.

References

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The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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