

# Quality in the dermatological contract

## A REPORT FROM THE WORKSHOP ON QUALITY ISSUES IN DERMATOLOGICAL CONTRACTING OF THE BRITISH ASSOCIATION OF DERMATOLOGISTS

**ABSTRACT**—This document is a summary of the most important points from a meeting convened by the audit sub-committee of the British Association of Dermatologists (BAD) and the research unit of the Royal College of Physicians on 16 May 1994. Participants represented the views of district general and teaching hospital dermatologists, a fundholding general practitioner, a health commissioning agent and patient support groups. The meeting was preceded by a workshop on 6 April 1994, involving 16 patient support groups chaired by Consumers Association from which a discussion paper was presented by two representatives. This report is intended for dermatologists, contract managers and purchasers.

The need for specialist dermatological services has never been greater and is steadily expanding. The number of new patient consultations in 1992 in England was 529,556 (10.9 per 1,000 population) and in the same year follow-up appointments totalled 1,098,355 (22.7 per 1,000) [1]. If access to dermatologists becomes easier these numbers are likely to increase [2].

Most British dermatologists are already fully stretched and the demands made of them exceed their capacity to respond. Nevertheless, dermatology in the UK is highly regarded throughout the world. This status has been hard won and its continuation should not be taken for granted. Thirty years ago many dermatologists were peripatetic but between 1960 and 1980 there was a steady improvement in working conditions. Centres of excellence were established in the teaching hospitals and in large non-teaching centres, due largely to the hard work of those appointed to these posts.

Dermatologists offer expertise on common as well as uncommon skin diseases, some of which, such as pemphigus and lupus erythematosus, are painful and life-threatening. Many other skin diseases, including eczema and the more fulminant forms of acne, are dis-

figuring, distressing and leave permanent scars. Other conditions, such as psoriasis, are often mild, but may become severe and disabling.

Special centres have been established to offer skilled management of certain rarer skin diseases and these must be protected in any contractual arrangements. For example, industrial skin diseases are the commonest form of occupational health problem and cause much unemployment. Centres have been set up for the investigation of such diseases, particularly by patch testing, and great strides have been made in eliminating the chemicals most likely to cause problems. Skin malignancies have become an increasingly important part of a dermatologist's work, as normal sun exposure has been augmented by package holidays in sunny climates.

Dermatologists welcome health service research to identify the differential health gain from dermatological consultant advice. There are few research data at present but as information becomes available it will clearly be one factor to influence purchasers' decisions concerning dermatological services.

Those contracting for dermatological services must accept that the maintenance of the current high standards is a dynamic process which requires recognition in the agreed levels of funding.

### Prevalence of skin disease

Two London prevalence studies hint that only a fraction of skin morbidity reaches the medical profession [2]. In one, 73% of those with skin disease had not sought medical advice. In the other, about one-fifth of adults in Lambeth were found to have a skin condition worthy of medical attention, although only one-fifth of them had been to a doctor in the preceding six months. Paradoxically, it appears that easier access to dermatology services, for example through outreach clinics, could lead to more referrals rather than to shorter hospital waiting lists.

General practitioners (GPs) find that between 5% and 10% of their work has to do with skin disorders but dermatology is still not formally included in many training schemes. In one area, only 11% of vocationally trained GPs had worked in dermatology, although 21% of those who had not done so wished that they had. Three months of such dermatology training experience might have made one-quarter of referrals to one dermatology department unnecessary. Training

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can improve the sometimes poor recognition of common skin disorders but it is naive to assume that it reduces the overall rate of referrals. Indeed, GPs with particular areas of expertise tend to have high, but appropriate, referral rates in those same specialties.

Some GPs consistently refer more skin problems to hospital than others, ranging in one study from 3.1% to 12.2% of all those seen. The severity of the skin condition is not in itself an overriding factor. In the morbidity statistics from general practice, 8.1% of serious conditions and 6.5% of trivial ones were sent on to hospital. Conversely, many patients whose GPs have no intention of sending them to hospital can be helped by suggestions made by dermatologists [3]. The rate of referral correlates most strongly with the supply of dermatologists.

### Quality issues in the dermatology contract

The concept of a quality driven service, with standards of care clearly defined in contracts, provides a framework in which the quality of dermatology care for a community can be improved. Standards need to be set at each stage in the process: in the referral system; in relation to outpatient clinics; dermatological surgery; outpatient/daypatient treatment service; inpatient care; and discharge from the dermatology process. The contracting process could include the use of treatment guidelines when constructing local arrangements for referral, for shared-care, and for the clinical audit criteria which are necessary for quality control. Other outcome measures that might be used include quality of life assessments and patient satisfaction questionnaires.

The present combination of limited resources and still unmet needs means that dermatology services must be monitored regularly and carefully to ensure that the use of precious staff time and specialist resources is as efficient as possible.

Other areas where standards must be set and included in contracts are: the training of medical and nursing staff; the availability of appropriate facilities and equipment; administration; information for, and education of, patients; and the storage and handling of medical records.

### Whose view of quality matters?

#### *The patient's view*

The patient's view is of central importance and dermatology contracts should enshrine the idea that patients' needs must come first. The dermatology case-mix includes patients with tumours and acute dermatoses who make fewer than three visits to a department and others with chronic skin disease who may attend intermittently over many years; and these groups will have different expectations and views of the service. All patients require good communication;

speed of care; accuracy of diagnosis; correct investigation; most effective treatment; properly trained staff; reduction of handicap caused by disease; understanding of the stigma of having a skin disease; and support, understanding and encouragement when disillusioned or depressed. In addition, there should be a complaint system used constructively by the provider.

Open appointment systems and the opportunity for a prolonged consultation when necessary are considered more valuable by patient support groups than rigid adherence to waiting time criteria. Also important to those groups are: the treatment of patients as individuals; an identifiable point of contact (usually a named, dermatologically trained nurse working as part of a multidisciplinary team) within both hospital and community dermatology services; access to social and clinical psychological support services; provision of high quality educational literature; and clinical audit to monitor the effectiveness of treatment.

#### *The general practitioner's view*

The GPs' view of the quality of the dermatology service is of great importance and often focuses on the ease with which advice is obtained as much as on the care provided when the patient is finally seen. Other issues of importance include: the availability of dermatologists for telephone advice; reasonable waiting times for clinics; a mechanism for having patients seen rapidly; and evidence that hospital staff set quality standards and evaluate the validity of their procedures.

#### *Other views of importance*

Consultants in other specialties who seek dermatology advice generally require the rapid availability of a dermatologist to visit patients on other wards and to see referrals quickly.

Other views of importance include those of dermatology administrative staff whose concerns are principally with the handling of referrals, and of dermatology nursing staff for whom a wide range of quality issues relates to the nursing standards applied to dermatology.

Purchasing authorities consider the wider needs of the community. They are in a position to specify priorities—for example the diagnosis and treatment of skin cancer—but require professional advice to ensure that, for example, carcinoma-in-situ is not given priority over scarring cystic acne or a flare-up of atopic eczema. Purchasing authorities should know that encouraging GPs to perform more minor surgery will cut the demand for dermatology surgery [4] though it may compromise standards [5]. They should also note that improved training of GPs in dermatology, while important and a high priority for patients [6] and GP trainees [7], does not reduce referrals to dermatology departments, though it may change their pattern [8].



The definition of quality must include the views of patients, dermatologists and purchasers. However, the dermatologist has special knowledge within the provider unit to identify those quality issues which are of fundamental clinical importance to the patient. Dermatologists have the responsibility of defining clinical quality standards within the specialty and ensuring that the agreed clinical standards are available to their patients. Dermatologists' priorities include recognition of the importance of teaching, training and research by the insertion into contracts of clauses designed to support these activities and to give adequate time in which to carry them out.

## Defining quality in the dermatology referral and encounter

### 1. Entry (referral)

Key quality points concerning the referral process include;

- a *Availability*: of 24 hour cover and advice from a dermatologist. Ready availability of telephone advice to general practitioners either constantly during the day or with dedicated times for telephone consultation.
- b *Review of referral letters by the dermatologist*: to be performed on a regular basis to assess the degree of urgency.
- c *Dedicated support staff*: a dedicated dermatology secretary or a dermatology outpatient booking clerk is necessary to provide continuity and an understanding of the process which ensures that patients' referrals are handled appropriately and also that telephone calls from patients about their referral are dealt with knowledgeably. A quality dermatology service cannot function without these staff members because of the large numbers of new patients with skin disease, and their subsequent requirements for treatment, surgery, education etc.
- d *Waiting list time*: explicit standards concerning reasonable time from referral to first appointment for urgent or non-urgent patients. The national standards given in the Patient's Charter should be regarded as minimal requirements.

### 2. Outpatient clinics

Criteria required for a quality outpatient clinic service include:

- a *A dedicated outpatient area*: the gold standard would be a suite of rooms dedicated solely to the purpose of dermatology. The minimum standard should define a set of rooms where the dermatology clinic is always held. Only in this way can an appropriate environment be

provided for the placing of educational material and treatment facilities (see also 2e).

- b *Flexible appointment system*: this should include the allocation of sufficient time for patients and their families to consult the dermatologist. For example, the need for the flexibility to spend an extended time with the family of a child with atopic eczema should have a greater priority than the need to keep strictly to outpatient waiting time guidelines.
  - c *Number of patients at each clinic*: the British Association of Dermatologists (BAD) guidelines for a clinic with appropriate support services suggest a maximum of 12 new patients or 24 return patients or a *pro rata* mix in a single consultant session. This number of consultations could not be delivered in the absence of full support services as detailed in this document. Teaching commitments and/or the need to perform procedures during the session must be accompanied by a reduction in the number of appointments in order to maintain the quality standard.
  - d *Experienced dermatology nurses*: the important role of the dermatological specialist nurse should be recognised and expanded to include liaison with community services, teaching community nurses and both teaching and counselling of patients who suffer from chronic disease.
  - e *Rooms*: provided for dressings, dermatological surgery, cryosurgery, treatment and patient education. These should offer privacy for the patient and staff.
  - f *Supply of dressings, creams, wigs, etc*: the quality contract will ensure that access to medications, treatments, cosmetic camouflage, cover creams, wigs, bandages and all the other aids essential to managing skin diseases are available according to need. Clear information on safe use and side effects, as well as a realistic expectation of benefits, should be given. This should be communicated to patients in a variety of ways including oral demonstrations, leaflets, and video.
  - g *A pharmacy service*: able to meet needs identified in the clinic.
  - h *Dermatology secretarial staff*: necessary to provide rapid letters and feedback to GPs. Secretarial staff should be adequately trained in dermatological terms and policies and provided with appropriate word-processing and data collection facilities to allow proper clinical audit.
- Specification of minimum times for letters back from dermatology clinics to GPs would be reasonable in a contract.
- Contracts might specify the availability of specialised outpatient clinical services including, for example, paediatric dermatology



clinics in an appropriate children's environment or necessary facilities to carry out full contact dermatitis investigations. Pigmented lesions clinics and other specialist clinics could be tailored to meet the needs of the local community.

3. *Outpatient treatment service*

An outpatient treatment service for the day care of patients with psoriasis or eczema for topical dressings, and for PUVA and UVB therapy, provides a better service to those patients who have severe skin disease while allowing them to work and carry on normal family life.

All PUVA units should be supervised by a named consultant, thus ensuring accuracy of dosimetry, record keeping and the training and monitoring of the staff who administered treatment.

After-hours and weekend access to these services is popular with patients but the benefit for an individual centre may have to be set against the cost of employing extra staff.

These provisions may reduce the number of dermatology beds needed to serve a community.

4. *Dermatological surgery*

Thirty five to 40% of dermatology referrals have a surgical aspect. A quality service should include:

- a *A specified dermatology operating theatre:* equipped with appropriate instruments and facilities.
- b *Trained nursing staff:* accustomed to assisting with dermatological procedures or trained to carry out some procedures themselves.
- c *A defined case load:* there should be an agreed definition of a day case and recognition of the time required to perform the various surgical procedures.

5. *Inpatient care*

- a *High quality bed provision:* more effective outpatient treatments and improved social conditions and housing have reduced the number of general dermatology beds required but there remains a need for a smaller number of high quality inpatient beds (some with facilities for reverse barrier nursing) for patients with severe and life-threatening skin conditions. Examples of these include pustular psoriasis, blistering diseases and severe drug reactions.
- b *Experienced dermatology nurses:* a quality contract should include the provision of beds, staffed by experienced dermatology nurses. Each patient must be allocated a specific named nurse on admission to hospital.

6. *Laboratory support services*

Dermatology requires support in common with many other general medical specialties—for example chemical pathology, haematology, X-ray etc, but particularly requires immunology, immunopathology and histopathology.

7. *Support of other hospital specialties*

Dermatology patients require easy access to other hospital specialists—for example plastic surgery, radiotherapy, oral surgery and psychiatry.

8. *Training of dermatologists*

The training of dermatologists is defined by a national curriculum and the quality is monitored by the Specialist Advisory Committee for Dermatology of the Joint Committee for Higher Medical Training.

A quality contract recognises the needs of trainees in dermatology and provides facilities whether in a base hospital or an outreach clinic for regular teaching and assessment. It also acknowledges that trainees have to be released from their regular duties to attend training sessions in subjects such as photobiology or mycology.

Contracts must accommodate the need of existing consultants for continuing medical education and include time to attend clinical and audit meetings. Future contracts will have to take into account the consequences of the proposed shortening of higher specialist training (Calman report). These changes are likely to decrease the proportion of clinical service currently delivered by registrars and senior registrars and increase the time spent by consultants in supervising and teaching trainees.

9. *Trainee general practitioners*

The teaching of dermatological clinical skills to trainee GPs and the continuing education of GPs are important roles of a dermatological service. These must be respected in a quality contract.

10. *Teaching undergraduates*

Teaching hospitals have a duty to teach dermatology to medical students. This will undoubtedly reduce the number of patients who can be seen in a clinic.

A quality contract should encourage patients to take part in teaching, ensuring that they are informed of the presence of students and respecting their right to refuse to be seen by them.



11. *Research*

British dermatology is still an international leader in clinical research. Most major advances in clinical research have come from the close collaboration between clinical and laboratory scientists and the patients who attend the clinic.

A quality contract should foster these links and may include elements of clinical research when that is likely to increase understanding of disease of clinical processes.

12. *Clinical audit*

Clinical audit is essential to ensure the maintenance of high clinical standards. Audit criteria may be defined according to local circumstances. Audit of service performance will be carried out and results communicated to purchasers on a regular basis with full preservation of confidentiality. Patients should be involved in surveys of quality of service delivery.

13. *Patient support groups*

The quality contract should recognise that the patient groups provide an important source of support for patients with specific skin diseases. Departments should make available to patients literature produced by the patient support groups and display addresses and points of contact.

14. *Exit (discharge)*

*Discharge letter and future management plans:* at the time of discharge from either inpatient or outpatient care the general practitioner should be informed of the patient's status and a plan for further management should be suggested. A quality contract should include a time limit for this activity.

**Outreach clinics**

The provision of specialist medical services at a location convenient to the patient must surely be an aim of any purchaser but there is a risk that too narrow a view might be taken, with an undue emphasis on convenience of care for a few, with resulting damage to the overall service. There may be good geographical reasons for holding outreach clinics in country areas where there are widely spaced communities with poor transport. Such clinics are best served by consultants employed by the NHS who are fully accredited and are maintaining their skills by continuing medical education and contact with colleagues in a multidisciplinary hospital. Clinics should offer equal access to all patients regardless of purchasing status and should be

free from diagnostic constraints. A recent BAD survey [9] has indicated that dermatologists performing outreach clinics see, on average, only 10 patients per session against the BAD recommended figure of 12 to 24 (see 2c). In addition, a number of surveys [9-11] indicate that one third of patients seen in outreach clinics need further procedures which require a visit to hospital.

Purchasers therefore have to accept that a consultant session in an outreach clinic is less cost effective than one in a hospital.

Occasionally, there may be a teaching element in outreach clinics but this is likely to be small [12] and the consultant's time could be used more effectively teaching and supervising trainees at the home base.

**Future quality development**

Several practical developments in the organisation and provision of dermatology services may improve quality.

In some large centres it is possible to organise *disease specific clinics* for first time referrals. These have the potential benefit of providing a focus point for gathering together specialist health workers and providing disease specific teaching and advice. Pilot projects should be established to measure the added benefit through careful audit involving health workers and patients.

In some centres, *specialist dermatology nurses* have been appointed to liaise between hospital and community, or have specific disease responsibilities such as atopic eczema or chronic leg ulceration. The treatment, patient teaching, counselling and communication roles of these nurse specialists may add to the quality of the dermatology service but their work should be audited to ensure that their skills are being used effectively.

The use of *patient held dermatology records* [13] in parallel with department held records may add to the quality of care by ensuring good communication between all involved. However, the possible benefits of this concept would need to be tested and audited before widespread introduction can be considered.

**Conclusions**

The emphasis on quality in dermatology contracts should be welcomed as an opportunity to improve patient care.

Dermatologists are in a pivotal position to define clinical quality standards and to influence objectives and priorities. In turn, they are responsible for ensuring that those clinical standards are met on behalf of their patients.

Dermatologists must agree the workload in any contract for dermatological services.

In planning dermatological services, where there are limited resources and a large amount of unmet need, the provision of services must be monitored to



ensure the most efficient use of staff time and resources.

Well structured and validated arguments are needed to ensure that each patient receives high quality clinical care rather than simply a high quality handling process.

#### Contributors to the workshop

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