Skin Care Campaign

BRIEFING PAPER

REFERRAL MANAGEMENT SCHEMES (TIER 2 CLINICAL ASSESSMENT AND TREATMENT SERVICES): IMPLICATIONS FOR DERMATOLOGY SERVICES

Introduction

The Skin Care Campaign is concerned by the increasingly widespread use of referral management systems by Primary Care Trusts (PCTs) and by the implications of such systems for dermatology service provision. The referrals management schemes (RMS) take various forms, from paper-based non clinically led schemes to 'Tier 2 Clinical Assessment and Treatment Services (CATS)'.

This paper explains the background to the issue, how the systems work and the reasons for concern with regard to patients' access to good quality dermatology services. Interwoven with this is the lack of any coverage for dermatology in the Quality and Outcomes Framework in the General Medical Services contract and the variability in the expertise of GPs with Special Interests in dermatology, so brief explanations of those issues are included.

Key Points

- Skin diseases account for some 600,000 referrals into secondary care each year, chiefly because dermatology is a complex specialty and dermatology training for primary care clinicians is minimal.
- Properly resourced secondary care services are essential to the prompt and accurate diagnosis of skin disease, and to the treatment and management of complex or difficult cases. Patients with life-long skin diseases should be able to re-access specialist secondary care services rapidly when necessary.
- Once diagnosed, most inflammatory skin disease can be self-managed by patients with the support of clinics in primary care staffed by suitably trained nurses.
- At present, there are no QOF points for dermatology in the GMS contract and there is therefore no financial incentive for GP practices to improve their dermatology services.
- PCTs are increasingly introducing referral management systems (RMS/CATS) for a range of disease areas, including dermatology, to reduce the numbers of referrals into secondary care. Most if not all of them are setting stringent targets for the systems, and many are offering financial incentives to encourage GPs to use them.
- The effects of RMS/CATS schemes are to:
  - create an additional step in the patient journey, increasing waiting times and reducing patient choice;

  - reduce the likelihood of accurate diagnoses, not least in respect of the rapid diagnosis and treatment of skin cancer;
  - undermine the financial viability of secondary care dermatology departments, making some unsustainable;
  - undermine the role of Primary Care Physicians and remove any incentive for them to expand their knowledge of dermatology
- In most cases, RMS/CATS are centred around GPwSIs in dermatology. There is as yet no accreditation system for GPwSIs and their expertise and experience vary widely. The Department of Health is addressing this issue. Until they have done so, PCTs will continue to introduce RMS/CATS which will significantly damage skin patients' interests.

Background

Some 15-20% of GP consultations have a dermatological component and skin diseases accounted for some 600,000 referrals into secondary care in 2004/05 – more than all other specialties combined. However, chiefly because most treatments for skin diseases are relatively inexpensive, dermatology represented only 2% of total PCT spend.

In simple terms, the reason for the very high number of referrals to secondary care is two-fold. Firstly, with over four thousand skin diseases, dermatology is a very complex specialty in which diagnosis frequently requires considerable expertise and experience. Secondly, since GPs receive very little training in dermatology (typically less than ten days) and practice nurses receive none, primary care is generally ill-equipped to provide high quality dermatology services. Properly resourced secondary care services are therefore essential to the prompt and accurate diagnosis of skin disease, and to the treatment and management of complex or difficult cases.

The SCC supports the Government's view that more dermatology could and should be done in the community. In particular, we support the recommendations made by the NHS Modernisation Agency's Action on Dermatology programme and the revised patient journey in dermatology developed from them by the Department of Health's Dermatology Workforce Group. A description of that journey may be found under Future Service Models (para 8) in the *Report on the All-Party Parliamentary Group on Skin's Enquiry into The Adequacy and Equity of Dermatology Services in the United Kingdom*, published in March 2006.

The SCC recognises the need for systems to manage the numbers of referrals, not least to ensure that those patients who need to be seen in secondary care are seen in a timely fashion. Such systems should not, however, be at the expense of the provision of good quality care for patients.

Quality and Outcomes Frameworks (QOF) and the General Medical Services (GMS) Contract

Despite the high incidence of skin disease, there are no QOF points for dermatology in the GMS contract and there is therefore no financial incentive for GP practices to improve their dermatology services.

Proposals for the inclusion of dermatology in the QOF have been put to the QOF review team but it is not yet known whether they will be included in the contract. Even if they are, they will not come into effect perhaps until April 2008.

Referral Management Systems

Rapidly increasing numbers of PCTs are introducing referral management systems (RMS/CATS) for a range of disease areas, including dermatology. Their purpose is to reduce the numbers of referrals into secondary care. Most, if not all, are setting targets for the systems – typically, that 80% of GPs' referral letters should be reviewed, often by a GP with a Special Interest in Dermatology (GPwSI), and that 60% of cases should be retained within the PCT, rather than being referred to secondary care. In at least one case, the PCT is withdrawing Clinical Assistants from their hospital sessions, requiring them to review GP referrals instead. Some PCTs are limiting the number of follow-up appointments a patient may have in secondary care.

Publicly, the PCTs say the RMS/CATS are a response to the 'care closer to home' messages contained in the Government's White Paper, *Our health, our care, our say*, published in January 2006. Privately, they acknowledge that the schemes, facilitated by the opportunities for cost containment presented by Practice-Based Commissioning and Payment by Results, are being introduced solely for financial reasons, to reduce their spend in secondary care.

The effect on patients' interests

Although RMS/CATS are being introduced for a wide variety of specialties, the SCC can only comment on their implications for people with skin diseases.

Their immediate effect is to introduce an additional step into the patient journey, increasing the time taken to obtain an opinion and reducing the likelihood of accurate diagnoses for many patients who would otherwise have been seen by a specialist in secondary care.

They also completely remove patient choice, a central plank of the government's health policy.

Secondary care dermatology departments need a critical mass of patients in order to remain viable. In the slightly longer term, it seems certain that RMS will make some non-viable, causing the closure of dermatology departments and a loss of access to specialist dermatology services. This, in a specialty that is already under-resourced and in which coverage of the country is patchy.

Some 'modern' high quality community-based secondary care services, which currently meet all Department of Health targets and the aspirations set out in the recent White Paper, *Our health, our care, our say*, are likely to be dismantled and financially destabilised by RMS/CATS.

GPwSIs

RMS/CATS tend to be heavily based on the use of GPwSIs for the provision of dermatology services in primary care.

The concept of GPwSIs was introduced in the early 2000s in order to help reduce waiting times for first out-patient appointments in secondary care. GPwSIs work best when they are fully integrated with local specialist dermatology services. The financial destabilisation of secondary care dermatology services by RMS/CATS will remove any incentive for secondary care specialists to support or develop the GPwSI role.

There is as yet no formal accreditation system for GPwSIs and the quality of GPwSI services is very variable. Some who have close working relationships with local secondary care dermatology departments, and who work or have worked as clinical assistants in secondary care, are knowledgeable and experienced. However, only 30% of GPwSIs in dermatology have been appointed in accordance with DH guidance. While most of the remaining 70% may have diplomas in primary care dermatology from the University Hospital of Wales in Cardiff or from the University of Glasgow, few have substantial experience in the specialty, many have only informal and occasional relationships with their colleagues in secondary care and some have no such relationships at all.

We understand that the DH Practitioner with Special Interests working party is addressing these issues, that PCTs may shortly be informed that primary care dermatology services must be accredited in accordance with DH guidance and that such accreditation will be inspected by the Healthcare Commission. Until that happens, PCTs may be expected to continue to develop and implement RMS/CATS which may be found to be unsustainable when the guidance comes into effect but which will, in the meantime, have done significant damage to skin patients' interests.

The way ahead

The objective of RMS/CATS should be to provide quality care closer to home. The SCC believes strongly that, rather than impose solely financially driven and primary care-based RMS/CATS on local health communities:

In our view, PCTs' objectives for dermatology should be to provide quality care closer to home. The SCC believes strongly that, rather than impose solely financially driven and community-based schemes on local health communities:

- PCTs should work with local hospital-based dermatology departments to develop coherent, integrated services which recognise both the essential nature of specialist services and the need for far more skin disease to be managed in the community;
- At least one GP in every GP practice should take an active interest in skin diseases and dermatology, the training for which could be provided by attachments to specialist, hospital-based dermatology services;
- PCTs should work with their GPs and secondary care providers to develop agreed referral guidelines and protocols for managing common skin disorders;
- referral letters should go directly to consultant dermatologists;
- inappropriate referrals, which do not meet the agreed guidelines, should be returned to the GP with advice on how the problem should be managed or an explanation as to why the referral cannot be seen;
- it should be for secondary care clinicians to decide whether a patient needs follow-up appointments in secondary care or whether the patient's disorder can be treated and managed safely and effectively in the community; and
- clinics run by suitably trained and experienced nurses should be established in the community to enable most people with inflammatory skin diseases to self-manage their disorders.

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