

Providing care for patients with skin conditions: guidance and resources for commissioners





Foreword

The White paper published in 2006 *Our Health, Our care, Our Say - a new direction for community services* set out the vision for the future of care outside hospitals. The document included a commitment from the Department of Health (DH) to work with speciality associations 'to define clinically safe pathways that provide the right care in the right setting, with the right equipment, performed by the appropriately skilled person'. Dermatology was identified in the White Paper as one of the six specialities that the DH particularly wanted to work with. A broad stakeholder group, including patient groups and representatives of all those working with people with skin conditions, therefore completed a piece of work reviewing, piloting and recommending models of care that could be used nationwide to facilitate the delivery of the 'Care Closer to Home' agenda. The DH published their recommendations in October 2007 in *Shifting Care Closer to Home Demonstration Sites - report of the speciality subgroup*. One of the recommendations in this document stated:

At national level, greater clinical input from speciality teams would help inform the commissioning cycle and ensure that local commissioners have the information they need to develop integrated services.

In the light of this, the Department of Health agreed to support the production of this guidance and resource pack for commissioners. It has been developed by a similar stakeholder group, supported by a project team which has included PCT commissioners. We would particularly like to thank all those involved in its development.

The guide uses as its underpinning framework, the commissioning cycle as advocated in *World Class Commissioning (DH 2007)*. The aim has been to provide a succinct practical guide which also includes links to important relevant documents. We are not seeking to be prescriptive about the details of care models, as these will need to take account of local circumstances and embrace modern ways of thinking such as 'teams without walls'. However, there is a particular emphasis on involving the public and patients in the commissioning of services consistent with *High quality care for all: NHS Next Stage Review final report* – (Lord Darzai DH 2008).

We hope that it will be useful to commissioners but, much more importantly, we hope that it will really facilitate the provision of high quality, accessible care for skin conditions so that they really ARE provided by 'the right person in the right place, first time'.

Dr. Robin Graham-Brown, Chair, Dermatology Care Closer to Home Group



Mr. Andrew Langford,
Chief Executive, SCC



Ms. Polly Buchanan, Chair, BDNG



Dr. Stephen Kownacki, Chair, PCDS



Dr. Maureen Baker, President, RCGP



Dr. Mark Goodfield, President, BAD



Ms. Helen Northall, Director, PCC

Primary Care Contracting

INTRODUCTION

In October 2007 the DH published *Shifting Care Closer to Home demonstration sites - report of the speciality subgroups* (DH 2007). The dermatology specific recommendations included the following statement:

At national level, greater clinical input from speciality teams would help inform the commissioning cycle and ensure that local commissioners have the information they need to develop integrated services, able to deliver care for the people with skin disease in their local health community. National specialist stakeholder groups should be invited to do this, supported by appropriate resources and systems.

This document has been developed in response to this recommendation.

AIM

To provide guidance and information for commissioners to consider and use when commissioning services for people with skin conditions for a local health community. The guidance seeks to facilitate a whole systems approach to deliver integrated services ensuring timely access, high quality care (close to home where appropriate) and value for money. The care provided will make best use of the knowledge and skills of health professionals at all levels.

PRINCIPLES

This guidance:

- Considers skin health and disease services rather than dermatology services so that care pathways that include other specialities are developed to provide joined up services wherever possible.
- Incorporates the recommendations from. '*Shifting Care Closer to Home-demonstration sites reports of the speciality subgroups*' published in October 2007.
- Uses the commissioning cycle (Figure 1, page 7) as its framework with the commissioning body leading the process and ensuring widespread stakeholder engagement in the context of strong governance frameworks.
- Is comprehensive and consider all areas of skin health and disease: self-care, generalist (where 95% of skin conditions are currently managed) and specialist services (where 5% of skin conditions are currently managed).
- Is explicit in separating levels of care (specialist/generalist) from location of care (primary/secondary care, acute/community).
- Uses available evidence wherever possible in relation to models of care, value for money and outcome measures.
- Links to national guidance documents as appropriate.
- Considers training and supervision needs.
- Takes account of 'future-proofing' and the longer-term view of sustainability of services.
- Works to national targets for access to care.

- Uses levels of care as follows:
 - Level 1 - Self Care, Pharmacy
 - Level 2 - Generalist
 - Level 3 - Specialist (Consultants/Consultant led)
 - Level 4 - Supra-specialist (consultants) e.g. regional services for skin lymphoma, rare inherited skin diseases, lymphovascular services
- and links these levels of care to locally agreed referral thresholds and outputs.

FINANCIAL FLOWS AND COMMISSIONING MODELS OF CARE

The *Shifting Care Closer to Home* recommendations state:

'In order to create an environment where good practice can continue to develop and flourish, it is important that the reform agenda, and in particular the change in financial flows, does not hamper the integration of services. It may be necessary to explore new models that facilitate vertical integration and break down the barriers that Payment by Results, Tariff and Choose and Book can create'.

Commissioners should give careful consideration to the above and be mindful of the need to consider all levels of care as part of the commissioning process. The lack of specificity of the national tariff to date means that so called 'creaming' or 'cherry picking' of the simpler caseload to alternative providers may risk the financial stability and therefore the future of the local specialist service and the provision of care for those requiring specialist dermatology services such as day treatment, phototherapy, systemic treatments, isotretinoin etc.

The removal of dermatology from the national tariff arrangements provides an opportunity to consider these issues and develop different financial models that include incentivising providers to deliver quality, value and patient centred services across the pathway. Examples include the following (Appendix 1 shows this diagrammatically):

Cost per case

This requires the development of negotiated local tariffs that relate more closely to the cost required to deliver the care for both the simpler and more complex cases. Examples of areas where such tariffs need to be developed are as follows:

- New and follow up activity
- Skin surgery (including skin cancer surgery)
- Patch testing
- Course of day treatment
- Course of phototherapy
- One stop rapid access skin lesion assessment
- Course of isotretinoin for acne

Cost for the service

This offers the opportunity for providers to bid to deliver the whole range of services for those with skin conditions across generalist and specialist care and including health promotion within a negotiated financial envelope. Potentially this would facilitate integrated service provision and is particularly attractive as a model to facilitate rapid re-access to appropriate care for those with long-term skin conditions such as psoriasis and eczema. Evidence suggests that the current cost per case payment by results tariff arrangements do not enable this to occur. The advantage of a cost for service model is that it favours integrated care. There is also the potential to develop standards of care across the whole range of skin conditions and to develop health promotion services.

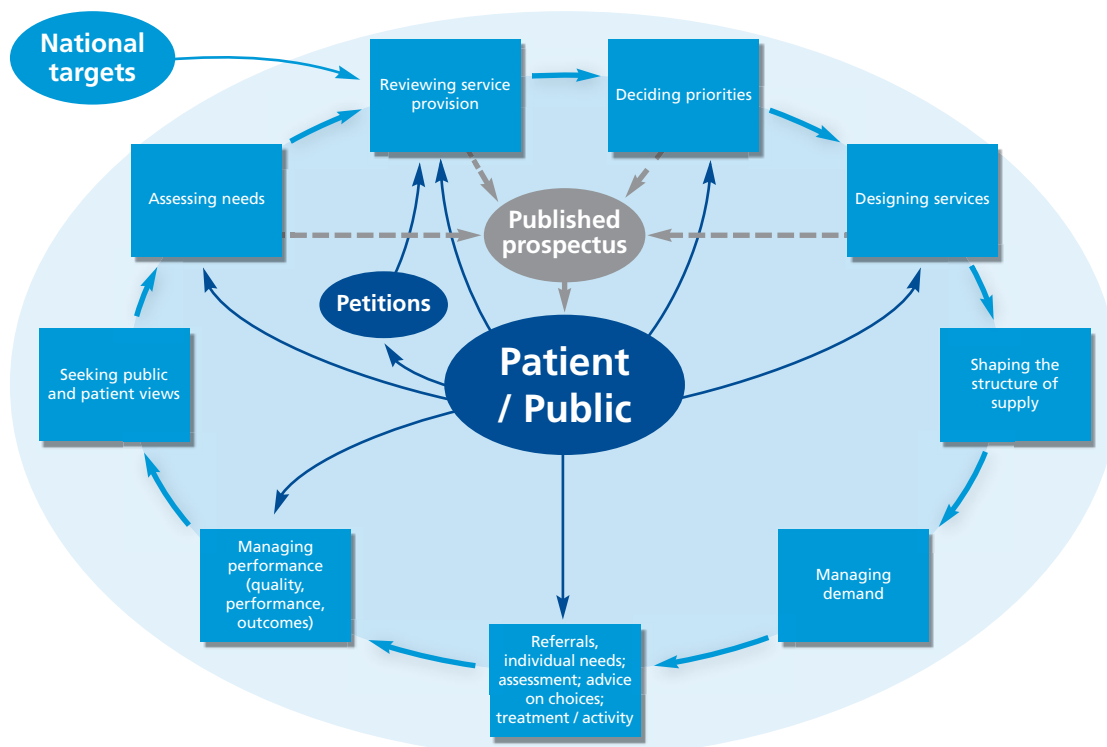
Combination of the above

A compromise model might be to have a mixture of both the above.

- Urgent referrals and patients with skin cancer are funded on a cost per case basis.
- The cost per case for this case mix is determined by the cost of delivering the care and requires the development of appropriate tariffs for different conditions and treatment. Work has already been done to develop such tariffs.
- A capitation based approach for patients with long-term conditions that require support from different services at different times.
- Routine or more straightforward activity funded within a carefully costed sessionally funded model rather than cost per case.
- It is important to consider all aspects of care within such a model, up to and including the expensive 'top end' treatments covered by NICE guidance (NICE 2006).

COMMISSIONING SERVICES FOR PATIENTS WITH SKIN DISEASE USING THE COMMISSIONING CYCLE

Figure 1: The Commissioning Cycle



From: Health reform in England: update and commissioning framework annex DH 2006

1. SEEKING PATIENT AND PUBLIC VIEWS

Establish a local stakeholder group to consider what the needs of the local health community are.

The *Shifting Care Closer to Home* recommendations state:

The local commissioning process outlined in detail in *Part 2 of the guidance on Implementing Care Closer to Home: Convenient Quality Care for Patients* (DH 2007) should be followed in order to ensure full and effective commissioning of dermatology services in a process that involves patients as well as primary and secondary care clinicians working as a multidisciplinary team.

The stakeholder group will be facilitated by the commissioners, who should include representation from the following groups (see Appendix 2 for more detail on how to go about this):

- Patients and the public: required by S242 of the consolidated NHS Act 2006. See '*Strengthening Accountability - Involving Patients and the Public, Practice Guidance*' (DH 2003)
- Local General Practitioners (Level 2 care)
- Pharmacy and Primary Care nursing input (Level 2 nursing care)

- Local Dermatological Specialist (Level 3 care) with representation from other overlap specialities such as plastic surgery and vascular surgery
- Specialist dermatology nursing (providing Level 3 nursing care)
- Representation from Intermediate Dermatology services where applicable
- Public health input
- PCT input (+/- SHA)
- Data/information analyst
- Practice Based Commissioning Group input
- Medical School representation when a teaching department is involved

Model Terms of Reference for the group and timescales are also shown in Appendix 2

There is a statutory requirement for formal consultation where significant changes to the delivery of services are proposed. Appendix 3 gives guidance about the consultation process, with a suggested questionnaire for public and patients.

2. ASSESS NEEDS:

WHAT ARE THE NEEDS OF THE LOCAL HEALTH COMMUNITY IN RELATION TO SKIN CONDITIONS?

This includes consideration of the following:

(a) Local and national incidence and prevalence data.

Obtain information about incidence and prevalence of skin disorders locally and nationally. Possible sources include:

- Dermatology in *Health Care Needs Assessment: The Epidemiologically Based Needs Assessment Reviews, Second Series* 1997. (currently being updated by Schofield Williams and Grindlay to be available late 2008)
- National Library for Skin Disorders and links to other information sources in relation to incidence and prevalence (<http://www.library.nhs.uk/skin/>)
- National cancer registries provide information about skin cancer prevalence and incidence but non-melanoma skin cancer data are not all captured (<http://info.cancerresearchuk.org/cancerstats/types/skin/incidence/>)

As a minimum, commissioners should obtain information about the prevalence and incidence of the top 9 skin disorders (Appendix 4). Work should take account of local factors that influence the prevalence of certain skin conditions that are related to ethnicity and socio-economic factors. Examples include skin cancer in different parts of the country, scalp ringworm in Afro-Caribbean populations and atopic eczema in different health communities, particularly those from the Asian sub-continent.

Remember also to take account of the particular needs of children and the elderly.

(b) Meeting nationally agreed standards / guidance for certain disease areas that relate to skin conditions

Any NICE guidance that must be met. For example:

- Skin cancer Improving Outcomes Guidance (IOG) for patients with skin cancer, including malignant melanomas (NICE 2006)
- Atopic eczema (NICE 2007)
- Biological therapies for psoriasis (NICE 2006)

(c) Current activity levels

These will give some idea of what skin conditions are currently receiving care in both generalist and specialist settings BUT they need to be treated with caution as in areas where there is poor service provision activity levels for specialist services will be historically low.

Benchmarking may be necessary to similar health communities and useful data to benchmark against will include:

Primary care consultations for skin conditions

Referral rates for specialist assessment

Routine/urgent case mix.

Suspected skin cancer referrals

What are the reasons for referral?

Outcome of referral to specialist services

A lot of information is available from HES

(<http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937>), the Office of Health Economics <http://www.ohe.org/page/index.cfm>, the Department of Health and Birmingham RCGP Research Unit http://www.rcgp.org.uk/continuing_the_gp_journey/bru.aspx. The information should be used carefully as there are significant limitations in respect of coding (see Appendix 5).

Remember that these data are being used to try to establish need across the health community and may provide only a 'best guess' approach.

The stakeholder group should consider completing simple scoping exercises to have a greater understanding of needs of the health community for both generalist and specialist services.

Information from patient groups about needs for patients with chronic inflammatory skin disease should be requested locally and nationally through patient groups, with reference to good practice guidance (e.g. the *Action on Dermatology Good Practice Guidance NHS Modernisation Agency 2003*, National Eczema Society <http://www.eczema.org/>, The Psoriasis Association, <http://www.psoriasis-association.org.uk/> The Skin Care Campaign <http://www.skincarecampaign.org/>

(d) Training and education needs

Consider the needs of the local health community in respect of this across the whole range of those involved in care. Include self-care, expert patient programmes and Level 1, 2 and 3 needs for all health care professionals.

Be sure to do this in the context of national guidance

(Nurses <http://www.nmc-uk.org/>, GPwSI

http://www.primarycarecontracting.nhs.uk/uploads/pwsi/gpwsis_dermatology.pdf).

Be sure to ask the following questions:

- What teaching and training is currently provided and by whom?
- How does this sit with the requirements within national guidance?

Remember Part 3 of the DH guidance for the accreditation of GPwSIs is mandatory.

http://www.primarycarecontracting.nhs.uk/uploads/pwsi/impicare_p3_accreditation.pdf

3. REVIEW CURRENT SERVICE PROVISION

- Process map care pathway, as a minimum, for patients with the nine most common skin problems (Appendix 4), but remember that some communities have specific problems outside these conditions, for example Epidermolysis Bullosa and Ichthyoses in immigrant populations with high rates of inter-marriage.
- Such process mapping should cross inter-professional and inter-disciplinary boundaries wherever necessary - particularly relevant for skin lesions and leg ulcers.
- Look at the availability of self-care, expert patient/patient support groups available to local people
- Identify local resources and skills currently delivering care. Review the accreditation of those involved. Do all clinicians meet required standards of accreditation and fit into robust clinical governance frameworks?
- What works well and what could work better?
- What quality measures and quality improvement systems are in place and do they work?
- How much psychosocial support is currently provided and is the care holistic?
- Is there 'seamless timely access to specialist diagnostic skills as and when needed'? (p124 *Shifting Care Closer to Home*)
- Review capacity and demand of current services (both generalist and specialist)
- Review historical activity data: referral rates, new patient and follow up activity. Ideally look at case mix of referrals: routines/urgents/2 week wait referrals for suspected skin cancer
- Consider a scoping activity to look at the reasons for referral (see Appendix 6 for suggested questions).

- Look at settings in which care is currently delivered (acute/community, specialist/generalist) and how (face to face/telephone).
- Link this to national targets that have to be met and whether they are being met. These will include 2-week wait, 31/62 day cancer diagnosis and treatment targets and 18-week referral to definitive treatment target.
- Be sure that the use of national targets does not disadvantage other patient groups who are not benefiting from a 'target' relevant to their particular skin condition. If this is the case it may be that additional capacity in other areas is needed.
- Does current service meet the 'Right person, Right place, First time' approach to care?
- What arrangements are currently in place to teach, train and provide on-going professional development for those delivering the service and other health care professionals in the community?

Appendix 7 shows examples of information that might be useful to aid the process.

4. DECIDE PRIORITIES

- Any agreed priorities need to link in to the strategic direction both from the DH, SHA and in the PCT prospectus.
- 'One pot spent well' approach.
- Confirm 'must-do' priorities as per NICE guidance.
- Consider Public Health priorities (for example skin cancer primary and secondary prevention).
- Operating Framework priorities= shifting care closer to home but not at expense of quality.

Shifting care dermatology recommendation (p124) states:

While local commissioning is bound to make best use of the skills and resources available, national standards should be set as to what is and what is not eligible for NHS treatment as a safeguard against the 'post code lottery' effect.

Currently there is variation around the country in relation to the availability of skin surgery for non-cancerous skin lesions unless accompanied by functional impairment. There are no explicit nationally agreed frameworks that address this issue so decisions will need to be taken locally within the stakeholder group in an explicit and open way.

The stakeholder group need to complete a Health Inequalities Impact Assessment process to determine how a change in local strategy, plans or programmes in skin care may have an effect on the health of a population.

This will enable the stakeholder group to review the impact of providing or not providing certain services to help influence decisions about relative priorities. For further guidance visit:

http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Healthassessment/DH_4093617

5. DESIGN SERVICES

Review national guidance about models of care (Appendix 8)

- Care Closer To Home model of care (Appendix 8 Figure 1)
- Dermatology Workforce group
[http://www.skincarecampaign.org/pages/documents/Service%20Models%20Final%20\(February%202007\).pdf](http://www.skincarecampaign.org/pages/documents/Service%20Models%20Final%20(February%202007).pdf)
- Action on Dermatology Good Practice Guidance (Appendix 8 Figure 2)
http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&products_id=218
- NICE skin cancer IOG model, with particular reference to community cancer clinicians and care close to home skin cancer services (Appendix 8 Figure 3)
- Action on Plastic Surgery Good Practice Guidance 2007
http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&products_id=223&Joomcartid=rli61621hfpm62h3b03593c4v6

Other factors to consider:

- Ensuring timely access to diagnosis
- Right place, right person, first time
- Consider local resources: people, facilities
- Type of consultation: face-to-face, telephone
- Location of services
- Local specialist services (allergy, vulva, transplant clinic); and links to regional and national specialist services (level 4 care). (BAD 2006
http://www.bad.org.uk/healthcare/service/Staffing_and_Facilities_for_Dermatological_Units_June_2004.doc.pdf)
- New to follow up ratios

Be mindful of the following *Shifting Care Closer to Home* recommendation, which states:

There is a need to ensure that targets for follow up activity are flexible enough to reflect both the needs of the patient and the increased complexity of specialist caseload that has already occurred in some areas as a result of the shift of less complex cases to generalists and extended role practitioners. Rigidly enforced national rates are already working to the detriment of certain patient groups.

- Services for sick patients in hospital
- Day treatment, OP phototherapy services
- Referral management (see later in demand management)
- DH targets including cancer treatment targets, 18 week referral to definitive treatment (see skin lesion pathway commissioning model.
<http://www.18weeks.nhs.uk/Content.aspx?path=/achieve-and-sustain/Specialty-focussed-areas/Dermatology>)
- Teaching and training

- Digital imaging/tele dermatology:

The *Shifting Care Closer to Home* recommendations state:

The routine use of digital imaging is not recommended as an alternative to the delivery of face-to-face dermatology services. However in areas where the population is sparse or widely dispersed, or where there are enthusiastic clinicians, this type of service may be helpful. Where this type of service is developed a tariff needs to be agreed nationally.

Remember the following:

- Estates (facilities)
- Parking, transport
- Information technology, record keeping.

In relation to childrens' services the document recommends the following:

When setting up closer to home services for children and young people it is important to ensure close collaboration between the patient and their family, the community paediatric nursing team, GPs and dermatologists in line with the NSF for Children Young People and Maternity Services (DH 2004)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4094444).

6. SHAPE THE STRUCTURE OF SUPPLY

The important principles around who should deliver the care and their level of knowledge and skills should include:

- Joined up services: integrated models with shared appropriate teaching and learning
- An awareness of the need to recognise that patients relatives and pharmacists are part of the 'supply'
- Use of local resources (people and facilities) to develop local solutions but using national guidance from professional organisations around training, assessment of competency, accreditation and on-going continuing professional development (eg via the Knowledge and Skills Framework, British Association of Dermatologists <http://www.bad.org.uk/about/>, British Dermatology Nursing Group <http://www.bdng.org.uk/>, Primary Care Dermatology Society <http://www.pcds.org.uk/>)
- Ensuring that quality standards are the same wherever and whoever provides the service (DH 2006) by the use of robust standards of accreditation for the service and the facilities (includes record keeping data collection etc) and those delivering the service
- Demonstration of competency based on formal assessment and supervised practice for extended role practitioners, along with GPwSIs (<http://www.primarycarecontracting.nhs.uk/173.php>, http://www.primarycarecontracting.nhs.uk/uploads/pwsis/gpwsis_dermatology.pdf) Part 3 of the generic (GPwSI) guidance is mandatory.

It is the responsibility of **commissioners** to ensure that wherever the service

is delivered and whoever delivers it, it is appropriately accredited and sits within recognised clinical governance frameworks.

The *Shifting Care Closer to Home* recommendations state:

- The guidelines set out in the BAD (2006) publication *Staffing and Facilities for Dermatological Units* and in the recent speciality specific Guidance and Competencies document for GPwSI (2007) should be followed at all times to ensure that there is no variation in quality of care or facilities whatever the setting. It should also be borne in mind that the facilities needed for day treatment (baths and showers) and phototherapy are usually best provided in hospital settings (acute or community).
- it is essential that *Implementing Care Closer to Home: Convenient Quality for Patients Parts 1-3* (DH2007) and the new speciality specific guidance for dermatology GPwSI, *Guidance and Competencies for the Provision of Services Using GPs with Special Interests (GPwSI): Dermatology and Skin Surgery* (DH2007) are implemented to ensure high-quality dermatology services. In addition the NICE improving outcomes guidance for skin cancer (*Improving Outcomes for people with Skin Tumours, including melanoma NICE 2006*) should be fully implemented.

Specialised services in community settings can be delivered by a range of clinicians:

Diagrammatic representation of ways in which commissioners can 'shape the supply' to deliver care in community settings

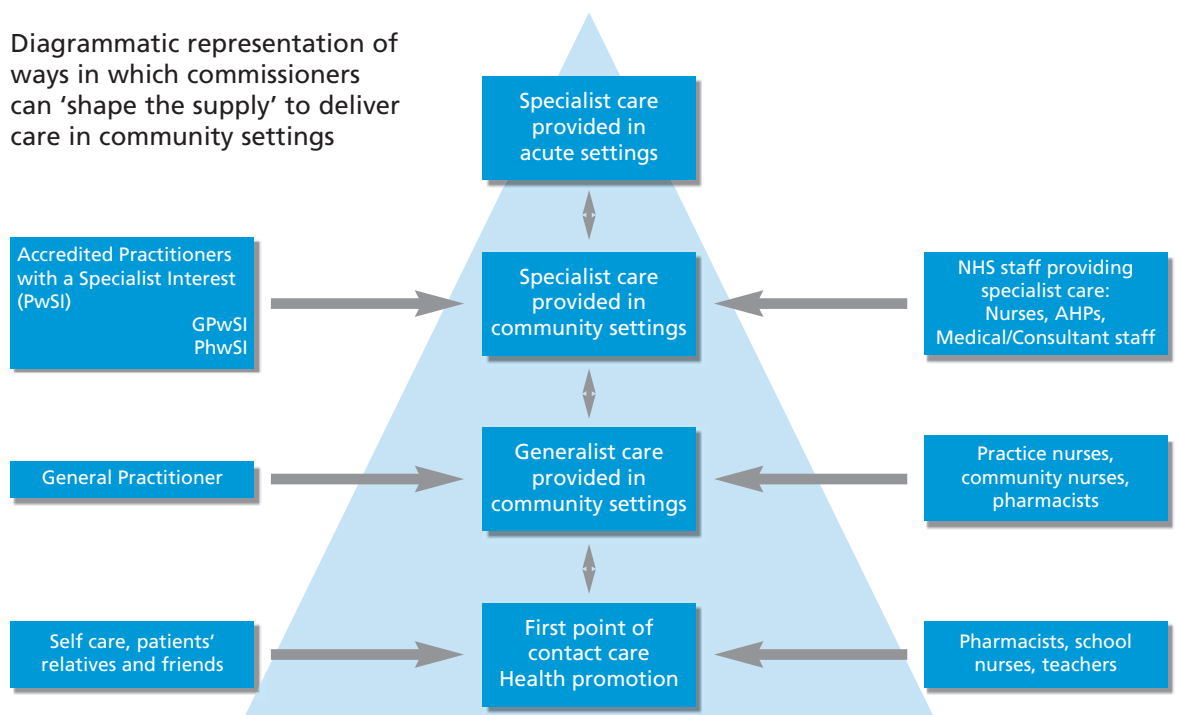


Diagram modified from Department of Health (2007) *Implementing Care Closer to Home: convenient quality care for patients* <http://www.primarycarecontracting.nhs.uk/173.php>

7. ENSURE APPROPRIATE ACCESS TO CARE

The development of the service specification using the commissioning cycle, with the engagement of the public, patients and health care professionals, **must** ensure that there is consensus about what services are and are not being commissioned and therefore available to the local health community. The whole health community then has ownership of the patient pathway and a requirement to ensure that access to care is appropriate and timely. This will need to take account of the following specific issues:

- Local decisions in respect of relative priorities for care
- Specific local issues in relation to case mix complexity, not forgetting minority and ethnic groups
- A clear process to ensure that decisions taken are implemented effectively
- A framework for regular review so that decisions can be modified in a timely fashion if it becomes clear that appropriate access to care is not occurring.

Referral management systems (RMS) and Clinical Assessment and Treatment Services (CATS)

Patient groups are concerned that RMS and CATS create an additional step in the patient journey, reduce access to specialist services and are being implemented as a cost-saving exercise to provide services pre-choice pre-tariff.

<http://www.skincarecampaign.org/pages/documents/REFERRAL%20MANAGEMENT%20SCHEMES.pdf>

If these services are to be developed then these views must be considered.

Early evidence (JK Schofield personal results) suggests that close to home intermediate care dermatology services can be delivered for patients with **non-urgent** skin disease in the context of CATS but the following three factors are likely to determine their success:

- Very experienced clinicians performing the triage process (ideally the consultant or a very experienced GPwSI working in conjunction with the specialist team) to ensure right person right place first time.
- A mix of experienced clinicians delivering the care to include specialist nurses, experienced GPwSI services and consultant outreach. The latter is often valuable to support the team in their clinical practice.
- An integrated model of care where all clinicians working within the service are part of the specialist dermatology service clinical governance framework.

8. CLINICAL/ INFORMED DECISION MAKING

Any model that is commissioned **must** allow patients to have sufficient information to make choices about the following:

- Who delivers their care
- Where that care is delivered
- The care they would like to receive for their condition

Resources should be available to support and enable the decision making processes at all levels.

9. MANAGING PERFORMANCE (quality, performance, outcomes)

Commissioners should manage performance using a matrix of measures of patient experience, relevant clinical outcomes and quality. The measures must be patient focussed:

(a) The overall patient experience: process, timely access to services and facilities:

- Did the full range of care work well for you?
- What else would have made your care better?
- Was your problem better after treatment?
- Were you treated with respect and dignity?
- Practical issues such as parking, transport and facilities
- 18 week referral to definitive treatment time
- 2 week skin cancer wait
- 31/62 day cancer diagnosis and treatment times

(b) Clinical outcome measures:

NICE outcome measures. Quality outcomes that reflect clinical care are included in those clinical areas that relate to NICE guidance and must be measured. For example

- NICE skin cancer guidance (for example discussion of cases at MDT, information provision for patients)
- NICE guidance for children with atopic eczema
- NICE guidance requirements for the prescribing of biological agents for psoriasis

Specific quality of life (QoL) measures are available for a range of inflammatory skin conditions and should be used to measure outcome of care in the common skin diseases as follows:

- Atopic eczema
- Psoriasis
- Acne
- Other types of eczema

The QoL tools can be used in generalist and specialist settings (<http://www.dermatology.org.uk/>)

Other measures to use:

- There is a range of clinically relevant measures that assess severity of disease and improvement following treatment and are already in use in many specialist settings. These include the Leeds acne grading score, the PASI assessment for psoriasis and similar scoring systems for eczema
- Leg ulcer healing rates

- Time to diagnosis of skin cancer (crosses generalist and specialist care)
- Cosmetic outcome, infection and complication rates for skin surgery

(c) Quality measures:

Demonstration of competencies of those delivering the care against nationally agreed standards of accreditation. This will include national guidance for doctors and nurses (see: DH PwSI and Dermatology GPwSI guidance and BDNG/RCN Dermatology competencies Framework <http://www.library.nhs.uk/skin/ViewResource.aspx?resID=82489> and NHS Education Scotland Dermatology Competencies Framework for Primary Care Practitioners)

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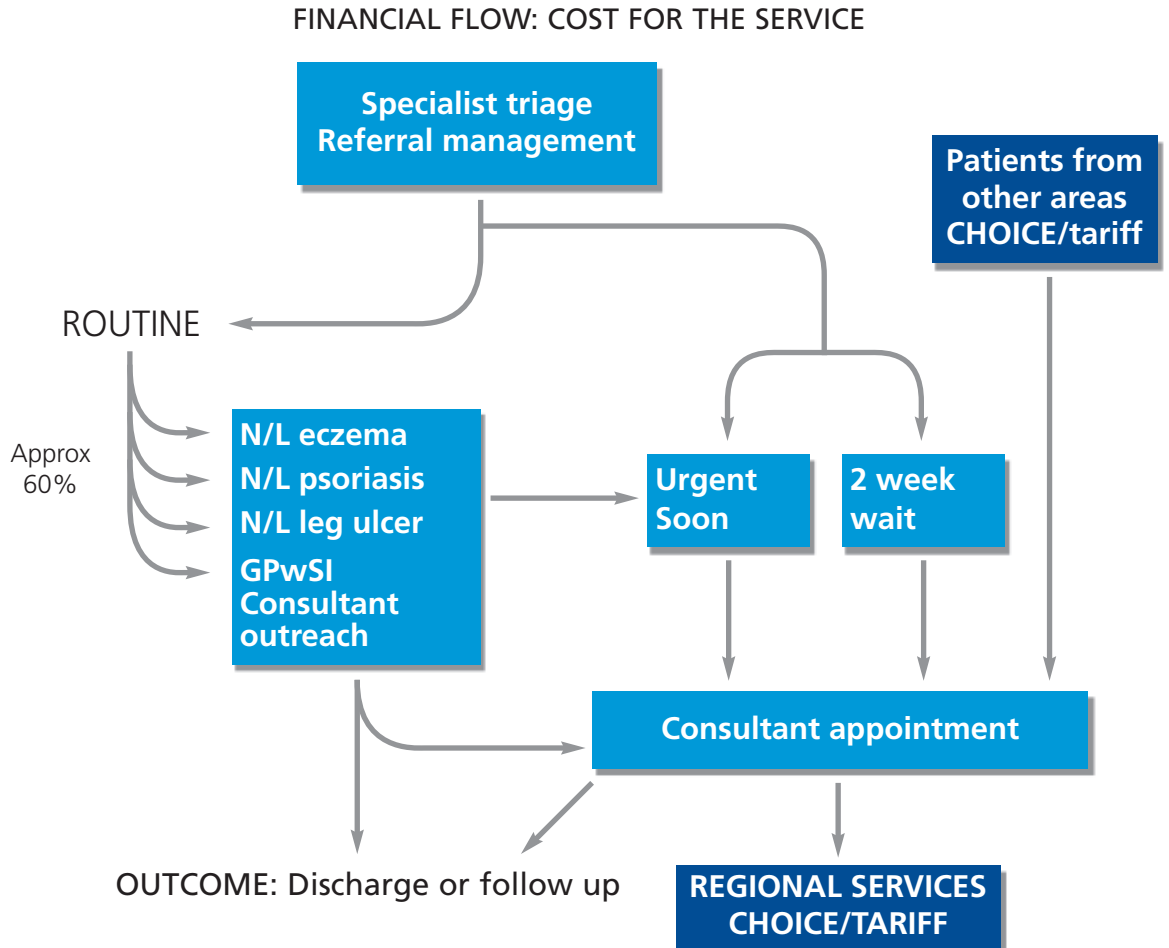
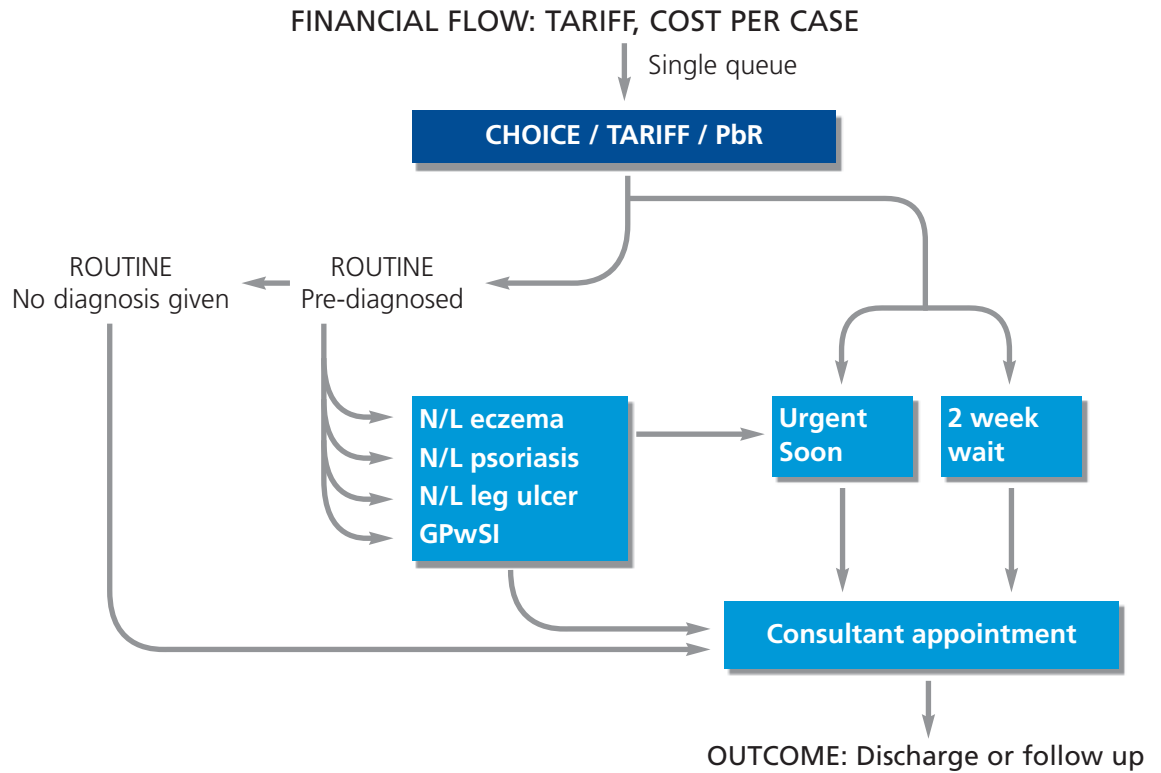
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Appendix 1:



Appendix 2:

TERMS OF REFERENCE FOR A PCT STAKEHOLDER COMMISSIONING GROUP

This framework is designed to be used by PCTs when establishing a stakeholder group that will influence how the PCT commissions services for patients with skin conditions. The basic outline and objectives should be the same for all PCTs but amendments may need to be made for specific areas. It is important to note that representation or issues that are not possible within a PCT should be looked at as development issues for the group.

STAKEHOLDER GROUP FOR THE COMMISSIONING OF DERMATOLOGY / SKIN CARE SERVICES IN _____ PCT.

For this type of commissioning group to work effectively the PCT will have to give the group autonomy for making commissioning decisions.

OBJECTIVES

The stakeholder group will use accurate, up to date national and local current dermatology needs assessment data to ensure the best possible provision of services for patients with skin conditions for the local population. The group should also monitor and act on issues of unacceptable quality or inadequacy in service provision. Decisions for development should be an integral part of the PCT's Local Development Plan.

MEMBERSHIP

The group should have representation from:

- Patients and the public (with LINKs support)
- PCT commissioning directorate (a commissioner with the autonomy to make decisions)
- Primary care - with a generalist's view on dermatology services (Level 2 care)
- Primary care - with a particular interest in dermatology services and/or Intermediate dermatology services where applicable
- Secondary care/Specialist care - specialist clinical representation from the local acute hospital dermatology service (Level 3 care)
- Public Health input supported by information analysts from the PCT and the acute sector
- Nursing input: ideally representing Primary, Specialist dermatology services and the Tissue viability/community nursing team
- A pharmacist - preferably with a specialist interest in dermatology

All members should have equal representation with a democratic vote for all decisions.

OUTLINE WORK PLAN

The stakeholder group will use the commissioning cycle, all appropriate national guidance and the document entitled *Providing care for patients with skin conditions: guidance and resources for commissioners (PCC 2008)* to:

- Deliberate on all relating to service issues for patients with the whole range of skin conditions for the PCT population
- Commission a needs assessment for people requiring dermatology / skin care services
- Develop a prioritised development plan that meets as many of the needs as possible
- Ensure services are audited and monitored effectively
- Develop redesign plans where problems exist
- Ensure that each person accessing any dermatology service gets the “right person, in the right place, the first time”
- Where necessary take decisions in respect of so called ‘ low-priority’ treatments

CRITERIA FOR SUCCESS

To ensure the group works effectively, the following should be monitored to prove success and validate continuation of this type of commissioning:

- Commission at least 2 yearly satisfaction surveys
- Build in monitoring criteria to all service delivery contracts
- Develop tight 3-6 monthly targets for failing services
- Ensure inclusion in the local development plan
- Monitor all complaints made about services, act where persistent trends exist and ensure resources are properly financed
- Where services do not exist or money is not available, the group will need to monitor ‘gaps’ and re-prioritise if necessary

Appendix 3: Guidance about the consultation process

Principles

- The commissioners of the service (PCT) must follow the intent of legislation which is to involve patients and public in the planning and development of services (see Appendix 2 for how to do this)
- Proposals need good clinical support across a broad spectrum of clinicians involved in their design during the consultation period
- The process must be transparent and well publicised
- There needs to be a clear understanding of the implications of changes in care pathways on patients and on personnel providing the care for individual patients
- The information presented to the Overview and Scrutiny Committee after completion of the consultation process must be accurate and reliable

Remember that in addition to presenting the outcome of the consultation process to the OSC you will need to provide the following information:

- Accurate information on likely impact on referrals and wait times based on good validated information
- Where statements such as 'improved quality of life for patients with chronic skin disease' are made they should be supported by outcome measures and quality standards
- The stakeholder group involved in developing the model of care should be detailed against the recommended list of those that should be involved (Appendix: 2).
- Definitions of primary and secondary vs. specialist and generalist care need to be made clear
- The commissioners (PCT) must have clear service specifications with quality standards incorporated and a policy for procurement which is legal and fair

Consultation process

The Health and Social care Act 2001 (now S242 of the consolidated NHS Act 2006) places a duty on NHS Trusts, Primary Care Trusts and SHAs to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for change. This duty is supported by the document '*Strengthening Accountability - Involving Patients and the Public, Practice Guidance*'

Statutory consultation is necessary for any major change to existing service provision; i.e. relocation from a hospital setting of a significant proportion of non-acute general dermatology outpatient activity into a community based service.

This level of consultation should include:

- Written consultation document explaining proposed changes
- 12 week minimum consultation process
- Full stakeholder involvement
- Overview and Scrutiny Committee informed
- LINKS participation
- Discussion with existing users and providers
- Public and/or stakeholder events as appropriate
- Comments reviewed at end of consultation process prior to decision
- Agreed plan and feedback made public

Examples of the above mechanisms should include:

- Locality based meetings
- Consultation questionnaires to users, local people and providers of the service
- Public meetings
- Comments from Patient Support Groups (local and national)
- Information on the local PCT website
- Parliamentary constituency office engagement
- Overview and Scrutiny Committee
- Skin Cancer Network involvement

The consultation process must be detailed and specific about any proposed service change.

If you are relocating services from acute to community settings, you should make clear where the new location will be. The location of any new service will have an impact on the outcome of any consultation process and as such specific locations, the type of services available and their frequency must be specified.

Any questionnaire should be specific rather than general in nature.

Examples of questions that could be used are as follows:

We are planning to offer new clinics at The Perfect Surgery in Closetohome Land. These will be held once weekly and a specialist from the hospital will come to see the patients. Do you think this is a good idea?

(Rather than: Do you agree or disagree with the proposal to develop community-based clinics for outpatient skin care services?)

We think you will find The Perfect Surgery in ClosetoHome Land very convenient for your care. However we are a bit worried that there is not a lot of parking at the surgery. Please can you let us know which is the

most important to you when considering the location of your care by putting these four items in order of importance (where 1 is the most important and 4 the least important)

- *closeness to home*
- *car parking*
- *public transport access*
- *closeness to other services (shops, pharmacy, GP)*

The clinics at the Perfect Surgery in Closetohome Land will only be held on Tuesdays whereas the clinics at the hospital are every day. We would be grateful if you could again rank what is most important to you about your care

- *choice of the day of the week,*
- *opening times,*
- *choice of appointment date and time,*
- *choice of clinician,*
- *other (please give details)*

Appendix 4: the Top nine skin conditions

Atopic eczema

Psoriasis

Leg ulcers

Skin cancer

Acne

Viral warts

Other infective skin disorders

Benign tumours and vascular lesions

Contact dermatitis and other eczemas

Appendix 5: Coding and activity data

Primary care activity:

Activity data from the Birmingham Royal College of General Practitioners Unit http://www.rcgp.org.uk/continuing_the_gp_journey/bru.aspx about Primary Care prevalence and incidence of skin disease is helpful. Coding is using ICD 9. Chapter XII relates to skin conditions but commissioners should be aware that this does not include the following:

- All skin tumours, benign and malignant
- Viral and fungal skin infections
- Viral warts

- Symptoms and signs related to the skin

So the prevalence and weekly incidence is very significantly under-represented in data that consider only the Chapter XII activity.

Specialist/secondary care activity:

This is captured using ICD 10 codes Chapter XII (L00-99) and the conditions listed above are once again not included in the Chapter data that is most commonly used for reporting. Thus Hospital Episode Statistics and the data from the Office of Health Economics fail to include mortality from malignant melanomas within the statistics relating to skin disease mortality rates.

Procedural activity:

Skin surgery: There are variations about the capture of activity data in relation to skin surgery procedures. In some settings these are classified as day cases and attract a tariff accordingly. In other centres the activity is charged as a follow up Out-patient consultation. When considering skin surgery activity it is therefore important to establish the amount of surgery performed as accurately as possible but this may not be possible by analysis of the data that the commissioners have access to.

Other activity specific to dermatology services: Phototherapy, day treatment, photodynamic therapy need to be quantified accurately and methods of data capture in relation to these are poorly developed at present. Whilst sophisticated data capture and coding tools now exist for In-patient activity, systems for Out-patient activity are much less well developed. Commissioners need to be aware of this and seek advice about these services.

Appendix 6

Why are you referring your patient for a specialist opinion?

For diagnosis and/or further investigation

Advice only

Treatment/management

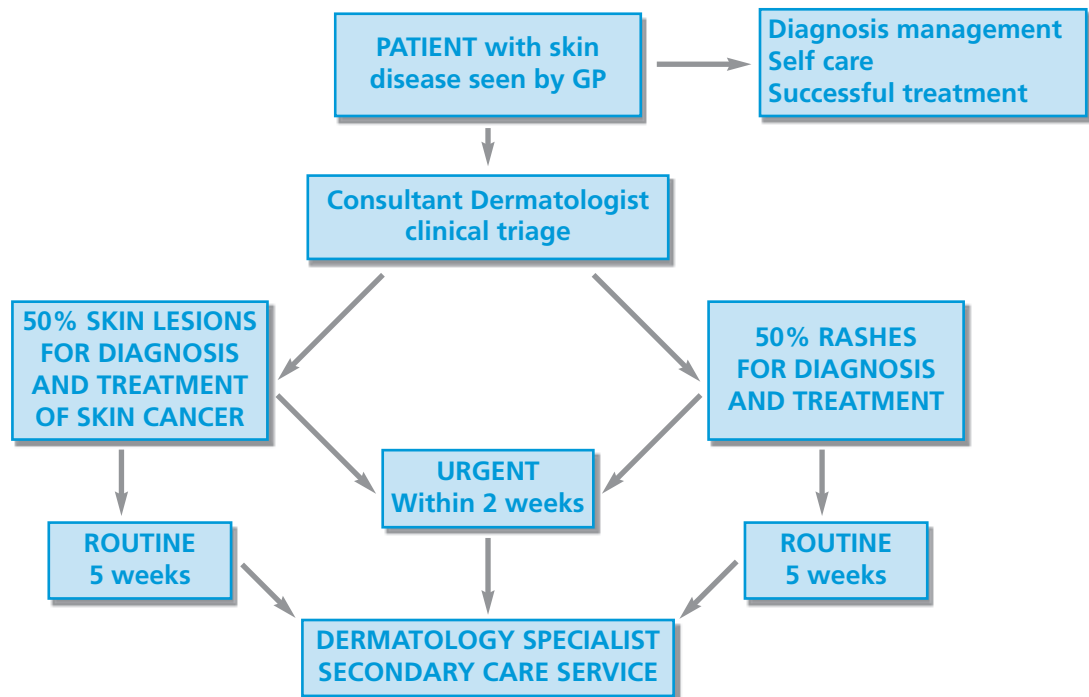
Patient request for second opinion

Reassurance

Other

Appendix 7: Factors to consider when reviewing current service provision with examples

1. Define current pathways: example of a care pathway



2. Financial flows: example of care pathway linked to financial flows

3. Process map patient journey

Identify bottlenecks

Scoping exercises where data is missing

Data and knowledge must influence service provision

What works well and what works badly?

Case mix information primary care (remember nurse practitioners)

Referral rates for different diagnoses

Specialist services case mix

4. Skin surgery services

Baseline audit of surgery performed in Primary Care

PCT enhanced services records

Diagnoses and indications for surgery

Audit Primary Care cancer excisions

Identify practices performing regular skin surgery

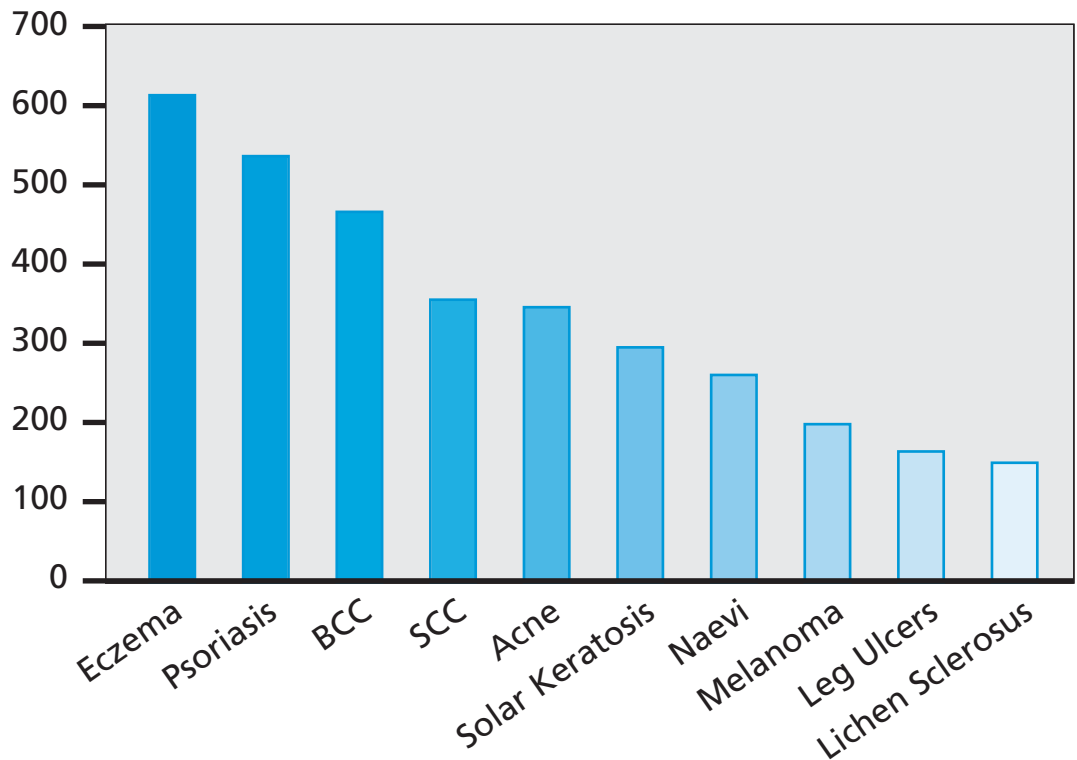
Audit of secondary care skin surgery services - is it all diagnostic and cancer work?

How many skin surgery slots per new patient (usually 1:3)

5. Specialist service new to follow up ratios with diagnostic information

Sample information to collect:

- % of patients with no follow-up appointments (usually approx 35%)
- % of patients having only one follow-up appointment (usually approx 35%)
- The ten commonest diagnostic groups of patients requiring more than one follow-up appointment (see example below from West Herts 2005-2006)



- Reasons for specialist follow up (see example table next page)

Diagnosis	Reasons for follow-up	Comments
Basal cell carcinoma	High recurrence sites. After curettage and cautery. Multiple tumours. To meet national guidance.	Completely excised BCCs all discharged
Eczema	Patients requiring second line treatments such as ciclosporin, azathioprine, oral steroids, phototherapy, day treatment. Avoids hospitalisation	Children followed up and supported in nurse led eczema clinic Dermatology liaison services helpful
Psoriasis	Patients with disease that is difficult to manage requiring complex therapies Avoids hospitalisation	Nurse led psoriasis clinic in place Second line drug Monitoring clinic in place Biologics will increase rather than decrease this
Squamous cell carcinoma	To follow national guidance	Well differentiated completely excised tumours discharged to GP Consider Cancer Specialist Nurse role for screening of high risk groups (renal transplant patients)
Melanocytic naevi	Mostly patients with multiple melanocytic naevi	Expert patient programme being developed Consider Cancer Specialist Nurse role for screening of high risk groups
Acne	Male patients requiring isotretinoin require 2/3 follow up visits, most female patients 5 follow-up visits to meet national requirements	Nurse led clinic in place to take on the pregnancy prevention programme
Actinic keratoses	Often have associated skin cancer	Trying to discharge this cohort, many are subsequently re-referred
Malignant melanoma	National guidelines require 3 monthly review for 3-5 years	Consider Cancer Specialist Nurse role for follow-up programme
Lichen sclerosus	Small cohort with difficult disease	Meeting national guidance
Leg ulcers	Non-healing leg ulcers requiring specialist input	Investment in community leg ulcer services would reduce these follow ups

Appendix 8: Design the service

Figure 1: from care Closer to Home 2007
(modified from Model of Integrated Service Delivery. Skin Care Campaign 2007)

Care Closer to Home 2007 Figure 2: Dermatology patient journey
(source: modified from Model of Integrated Service Delivery. Skin Care Campaign 2007)

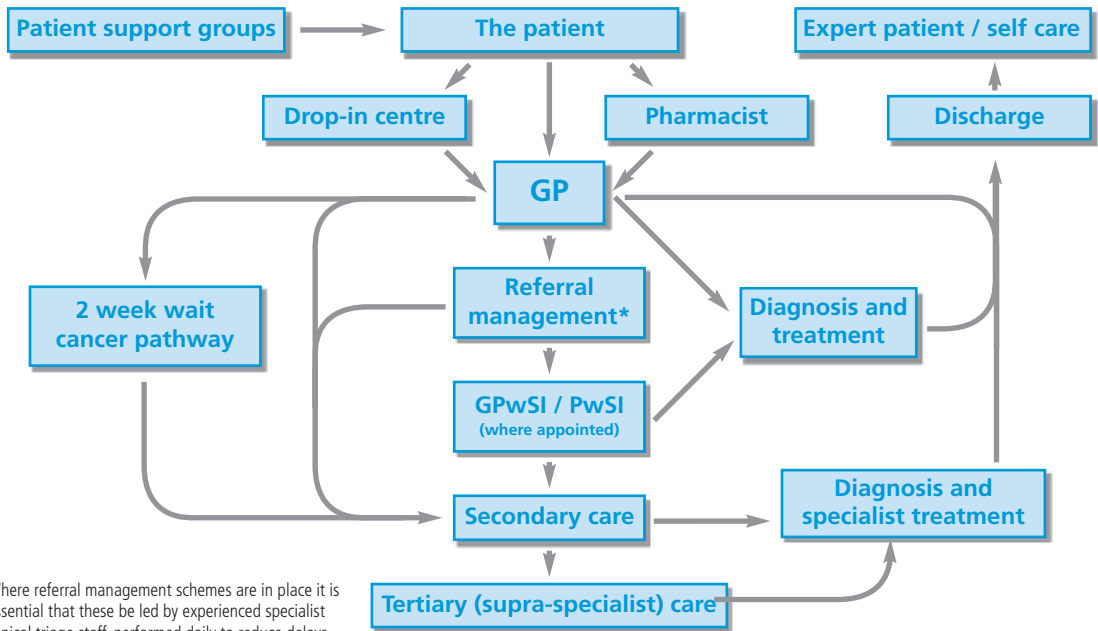


Figure 2: from Action on Dermatology Good Practice Guidance 2003

Box 1 - designing services around the patient's changing needs

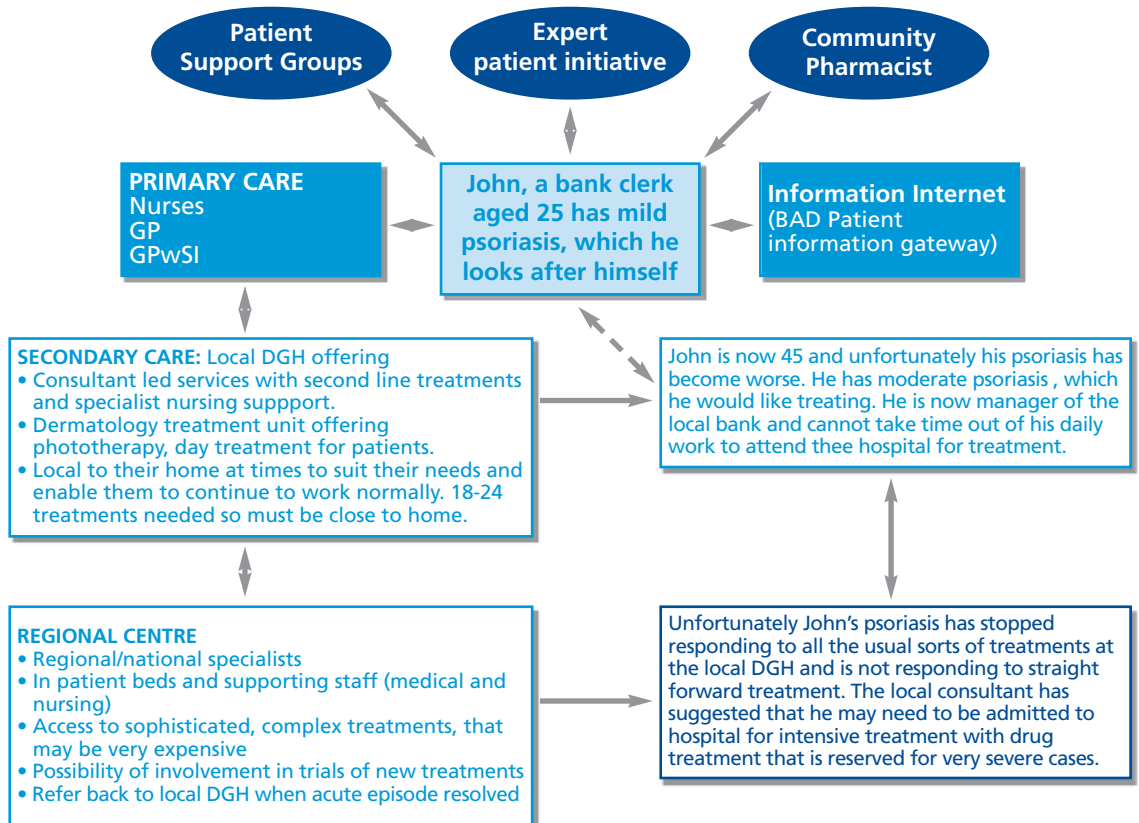
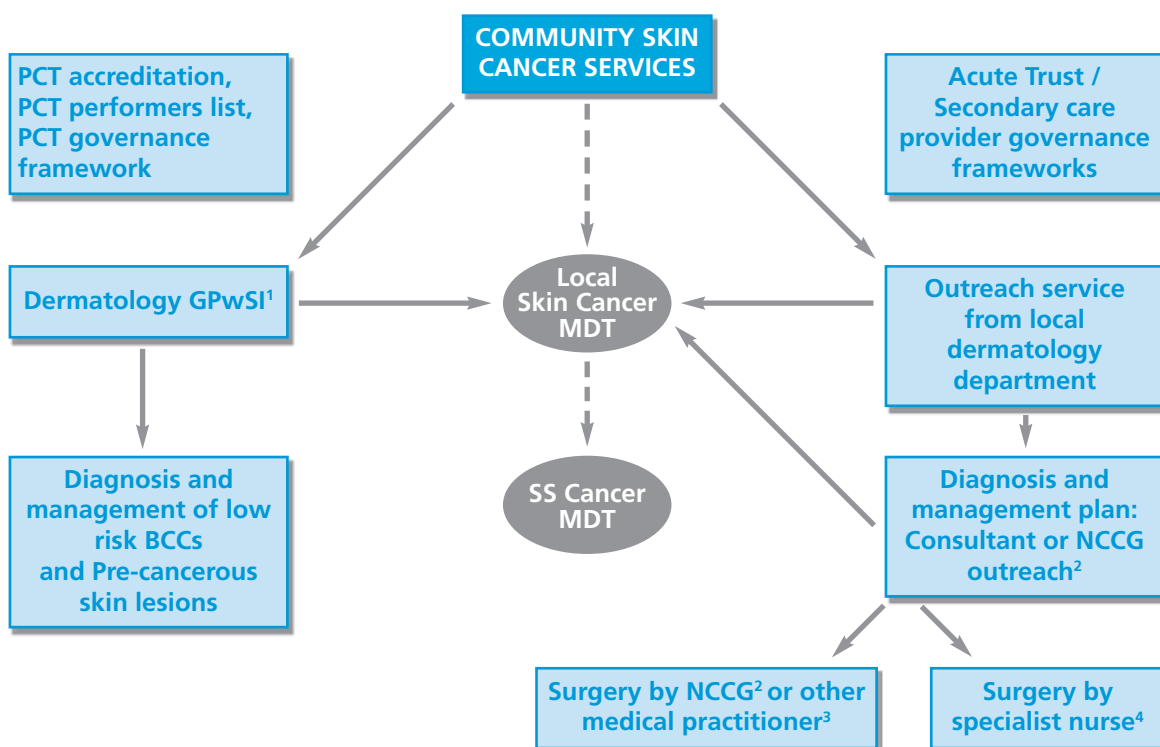


Figure 3: Possible model of community cancer services



1. Dermatology GPwSI

2. Consultant or NCCG outreach for diagnosis and management (with or without surgery).

3. Surgery only provided by medical practitioners who have demonstrated appropriate levels of skill and knowledge using the competency based assessment and frameworks outlined in http://www.primarycarecontracting.nhs.uk/uploads/pwsis/gpwsis_dermatology.pdf pages 24-26.

4. Surgery only provided by specialist nurses who have demonstrated appropriate levels of skill and knowledge. The competency based assessment and frameworks outlined in http://www.primarycarecontracting.nhs.uk/uploads/pwsis/gpwsis_dermatology.pdf, pages 24-26 can be used.

Appendix 9

Membership of Steering Group

Dr Robin Graham-Brown (Chair)	Consultant Dermatologist
Dr Pauline Brimblecombe	Royal College of General Practitioners
Ms Polly Buchanan	British Dermatology Nursing Group
Dr Tim Cunliffe	Primary Care Dermatology Society
Mr Nick Evans	Director for Partnerships West Hertfordshire Hospitals NHS Trust
Dr Sheru George	British Association of Dermatologists
Dr Mark Goodfield	British Association of Dermatologists
Dr Stephen Kownacki	Primary care Dermatology Society
Mr Andrew Langford	Skin Care Campaign
Dr David Shuttleworth	British Association of Dermatologists
Mr Rod Tucker	Community Pharmacist
Ms Sheela Upadhyaya	Clinical Advisory Unit , British Association of Dermatologists

Project group

Dr Julia Schofield, Consultant Dermatologist West Hertfordshire Hospitals NHS Trust (Project Group Lead)
Mr Nigel Gray, Director of Development & Commissioning (Adult Services) Leeds PCT
Dr Martin McShane, Director of Strategic Planning and Health Outcomes Lincolnshire PCT
Mr Andrew Langford, Chief Executive, Skin Care Campaign
Dr Tim Cunliffe GPwSI in dermatology and skin surgery, Middlesbrough PCT, Primary Care Dermatology Society
Dr Stephen Kownacki, General Practitioner, Primary Care Dermatology Society
Ms Sheela Upadhyaya, Clinical Advisory Unit , British Association of Dermatologists
Ms Rhona Woosey, Locality Commissioning Manager, Selly Oak Locality, Directorate of Service Modernisation & Primary Care



