GUIDANCE FOR COMMISSIONING

SERVICE GUIDANCE

DERMATOLOGY SERVICES

Produced by: Clinical Services Unit
British Association of Dermatologists
Updated: June 2014

Table of Contents

Preface

Managers and clinicians must work together with patients across traditional organisational boundaries to ensure that patients have access to National Health Service (NHS) Dermatology services that meet their needs. Quality of care and patient safety are central to the successful implementation of Dermatology services. Consultant Dermatologists, who have completed accredited training and are on the Specialist Register of the General Medical Council (GMC), should provide leadership and training for the teams responsible for the delivery of care, while Commissioners should ensure that services are governed appropriately and meet accreditation standards.

This guidance should underpin the commissioning of integrated Dermatology services across primary and secondary care and is informed by the following publications:

- *'Implementing care closer to home – convenient quality care for patients Parts 1-3* (DH 2007).[1]
- *Revised guidance and competences for the provision of services using GPs with Special Interests (GPwSIs) – Dermatology and Skin Surgery(DH 2011)* [2]
- NICE *'Improving Outcomes for People with Skin Tumours including Melanoma' (February 2006)* [3]
- NICE *'Improving outcomes for people with skin tumours including melanoma (update) - The management of low-risk basal cell carcinomas in the community' (May 2010)* [4]
- *National Cancer Peer Review Programme. Manual for Cancer Services: Skin Measures. National Cancer Action Team (2011)* [5]
- *The Action on Dermatology: Good Practice Guide (NHS Modernisation Agency, 2003)*[6]
- *Practice based commissioning: practical implementation (DH 2006)*[7]
- *Procurement Guide for Commissioners of NHS funded services (DH 2010)*[8]
- *Principles and rules for cooperation and competition (DH 2010)*[9]
- *Model of Integrated Service Delivery in Dermatology Skin Care campaign (2007).*[10]
- *Staffing and Facilities for Dermatological Units (BAD 2012)*[11]
- *Staffing and Facilities for Skin Surgery Units (BAD 2012)*[12]
- *Quality Standards for Dermatology: Providing the right care for people with skin conditions. (Primary Care Contract, 2011)*[13]
- *Consultant Physicians Working with Patients revised 5th edition (Royal College of Physicians, 2013)*[14]
- *NHS Standard Contract for 2012/13*[15]

Introduction

Unlike most other medical specialties which usually cite around 50 diseases, Dermatology recognises more than 1000 conditions affecting skin, hair and/or nails. High disease prevalence and low mortality, results in a large burden of skin disease. Approximately 4,000 deaths occur in the UK annually due to skin disease, with 1,800 due to malignant melanoma.[16]

Skin cancer is the commonest form of cancer in the UK and the second most common cancer causing death in young adults. Basal cell carcinoma (BCC) numbers equal all other malignancies combined, and increased by 133% between 1980 and 2000.[17] Reported melanoma incidences increased by 50% over 13 years.[18]

Accurate diagnosis and direct access to care is fundamental to successful management of skin disease. Chronic skin diseases have a substantial impact on work, social interaction and healthy living: skin disease is one of the commonest reasons for injury and disablement benefit and spells of certified incapacity to work in the UK.[19]

Burden of skin disease – at a glance

- 24% of the population consults their General Practitioner (GP) each year because of a skin complaint.[20]
- GPs refer approximately 6.1 % of the dermatological cases they see to secondary care.[21]
- In 2010/11, 873,000 such referrals were made in England, with 2.79m total outpatient appointments for skin diseases.[22]
- Of referrals 50% are cancer-related (skin lesions for diagnosis and/or skin cancer for management).[23]
- Approximately one-third of the dermatological workload in secondary care is surgical.[24]

Referrals to Dermatology services have risen as a consequence of increasing population numbers and frequency of diseases such as skin cancer, leg ulcers and atopic eczema, improved treatments and changing attitudes to skin conditions. This is despite the increased numbers of community based services in-line with recommendations in the previous White Paper *'Our health, our care, our say: a new direction for community services'*.[25]

1. Commissioning Principles Underlying Service Design

Care should be delivered by individuals with the right skills, in the right setting, the first time. The way in which services are provided will depend upon factors including local individual needs, the demography of the area, facilities available and the availability of staff with the required knowledge and skills.
Furthermore the following principles are also relevant in the design of services:

1. Appropriate levels of care should be commissioned to provide integrated community and acute levels of service.
2. The delivery of care requires a multidisciplinary team involving trained Dermatology clinicians, trained nurses and informed pharmacists.
3. Care should take into account the impact of skin diseases on the quality of people's lives (as identified through a skin needs assessment).
4. New service models should be sustainable, meet accreditation standards and be evaluated.
5. Service plans should support the functions of secondary care including the provision of services for acute medical Dermatology, skin cancer surgery, phototherapy, patch (allergy) testing, day cases and inpatients.
6. Service models should provide continuity and be flexible enough to provide patients with rapid access to secondary care if their condition deteriorates. Quality of care requires the accurate diagnosis and management of patients.
7. Identifying the level of unmet need in an area, and have contingencies in place to deal with increased patient numbers to both secondary and community care services.
8. Primary care should take responsibility for the more straightforward parts of the management of long term skin diseases and facilitate self-management through the education of patients.
9. Service models must support the teaching of medical and nursing students, postgraduate training and clinical research.

2. Secondary Care

Hospital-based Dermatology services receive approximately 873,000 referrals each year. A survey in 2006 showed that the referral rate varies between 10 and 21.8 per 1000 population. Up to 50% of these referrals relate to skin cancer[26] and around 20% are for the 3 major inflammatory diseases: eczema (*syn* dermatitis), psoriasis and acne.

Centralised hospital-based services will continue to be the most cost-effective and safe means by providing direct access to care for patients who are acutely unwell and have complex care needs.

They provide:

1. Rapid-access skin cancer screening / treatment clinics – Dermatologists screen around 90% of those suspected of having cancers of the skin and treat approximately three

quarters of all skin cancers. The NICE IOG for skin cancers recommends that high risk BCCs, which represents the majority of BCCs, are treated in the secondary sector.

2. Facilities for dermatological surgery, meetings of multidisciplinary teams to review dermatopathology and management, data collection and data analysis in order that skin cancer management adheres to National Institute of Health and Clinical Excellence (NICE) IOG guidance.[3,4]
3. Care of medical Dermatology patients with complex skin problems, sometimes require multidisciplinary clinics e.g. with Geneticists, Rheumatologists or Gynaecologists.
4. Care of sick patients with severe skin diseases or skin failure, a few of whom will require access to intensive care facilities.
5. *Phototherapy*[27], iontophoresis, wound care and other day treatments.
6. Day case units for infusion of disease-modifying drugs and treatment of complex patients with co-morbidities.
7. *Paediatric Dermatology services*[28] including laser surgery for children with facial vascular birthmarks.
8. Investigation of *cutaneous allergy.*[29] Guidelines suggest that the safe rate of referral for investigation (to avoid missing important allergy, but not to over-investigate) is around 100 patients per 70,000 population per year.[30]
9. Advice on the management of skin problems in patients admitted with other illnesses / disease.
10. Skin cancer screening clinics for patients with organ transplants.
11. Teaching, training and assessment of medical students, doctors and other healthcare professionals.
12. Collection and analysis of clinical data, clinical audit and compliance with requirements of clinical governance.
13. Clinical research including therapeutic trials.

Hospital-based services require at least one whole-time equivalent (WTE) Consultant Dermatologist per 62,500 population.[14] Speciality and Associate speciality doctors play an important role in the provision of the above services in many departments. In addition, departments require the support of trained specialist nurses, who understand the needs of Dermatology patients, and Pharmacists.

3. Teledermatology

Within any model of care, and wherever services are being linked by the use of teledermatology, there should be a clearly identified clinical governance framework, and lines of clinical accountability. The role of teledermatology should be clearly identified for all those involved, i.e. patients, service providers and Commissioners. When developing a model of care that incorporates teledermatology, it is important to identify the resources required to deliver the service (including primary care costs).[31]

Evidence of the effect of telehealth on service use, costs, or cost effectiveness remains scarce. Whether telehealth is considered to be cost effective will depend on the willingness to pay for the outcomes generated, and does not seem to be a cost effective addition to standard support and treatment.[32]

4. Intermediate Care

Some patients may be seen in "intermediate-care" clinics staffed by healthcare professionals working in community settings. Such clinics may be staffed by Consultant Dermatologists, Speciality and Associate Speciality Doctors, General Practitioners with Special Interests (GPwSIs) or specialist Dermatology nurses, but new services should be developed in partnership with secondary care and the sustainability of any new service should be considered. The location, service model and range of facilities will depend on local needs within a managed clinical network.

New services should be implemented with the aim of improving patient care and reducing unnecessary hospital referrals, but convenience for the patient should not be at the expense of quality or safety. The cost effectiveness of such services should be evaluated. Clinics provided by GPwSIs can be more expensive than secondary care services. [33]

Commissioners are required to demonstrate that such services are underpinned by sound clinical governance and that there is a consistent approach to the way in which new roles are developed and supported.

The service, the facilities and those delivering the service must meet national guidance for accreditation. *(Department of Health (2011) Revised Guidance and Competencies for the Provision of Services Using GPs with Special Interests (GPwSI) in Community Settings: Dermatology and Skin Surgery London*[2] *and NHS Contract for 2012 - 2013*.[15]

5. Intermediate Care Provided by GPWSIS

The service will depend on the training and competencies of the GPwSI, but should be overseen by a Consultant Dermatologist. The service should be appropriately accredited according to their accreditation group level of practice. The GPwSI group levels are defined on pages 11 – 18 of the GPwSI curriculum[2] and remain in place to date since the inception of CCGs.

The service may include:

- Diagnosis and management of moderate skin conditions.
- Follow-up of patients with moderate skin conditions.
- Skin surgery (in line with local priorities and NICE IOG for skin cancer).
- Telephone advice for local GPs.
- Support for Dermatology specialist nurses working in the community.

GPwSIs are expected to maintain their professional development by attending regular sessions in a local Dermatology department in secondary care and by holding a joint clinic with the Consultant Dermatologist at least once a month for the discussion of difficult cases.

6. Intermediate Care Provided by Specialist Nurses

A trained specialist nurse could provide treatment and support the self-management of moderate inflammatory skin diseases such as eczema and psoriasis in an intermediate-care clinic (see below). The nurse should have support on at least a monthly basis from a medical specialist who is a GPwSI with defined competencies in skin disease along with supervision and clinical governance from a Consultant Dermatologist.

7. Primary Care

Most mild skin disease is managed within primary care with only a minority of GPs having significant knowledge and skills in Dermatology.[34] The quality of diagnosis and management is variable due to the GPs limited exposure to Dermatology during undergraduate and postgraduate training. However GPs can obtain the skills and knowledge of a generalist by following the Royal College of General Practitioners (RCGP) curriculum of skin conditions post Certificate of Completion of Training (CCT).[35] Arrangements with local Dermatology departments should be made to facilitate training.

The role of primary care can be summarised as follows:

1. All patients should have rapid access to a healthcare professional with the skills to diagnose their skin disease.
2. GPs should be able to diagnose and manage the common skin disorders in their characteristic forms.
3. Patients with the common inflammatory skin disorders should receive education and care from a trained professional, often a nurse, in a community setting.
4. After diagnosis, all patients with disease requiring on-going management should be cared for within local protocols for Chronic Disease Management.
5. Referral protocols should be agreed between primary and secondary care.

8. Community Specialist Nurses

The support for self-management of chronic inflammatory skin diseases should be provided in a community clinic staffed by a trained specialist nurse. Nurses may be based in primary or intermediate care clinics (see below). Given the frequencies of the common skin disorders, as well as the need for repeat consultations, a practice of 5000 patients will need at least 0.5 WTE of practice nurse time to provide support, education and active management of patients with psoriasis, eczema (mainly children) and acne.[10] The nurse should work under the supervision of a named doctor and have links with Dermatology nurses in secondary care. The nurse might provide:

1. Disease information including access to patient support group(s).
2. Treatment according to protocols and education in their use.
3. Easy access to further appointments or telephone advice.

4. Rapid access to a GP or Consultant Dermatologist in the event of treatment failure or if the condition deteriorates rapidly.

9. Community Pharmacists

Community Pharmacists should be included in the primary care team so that they can reinforce care and self help messages at the point of dispensing. The skills of the practice pharmacist should be utilised in the development of care plans – both generic and patient specific. They should work under the supervision of a named doctor to contribute pharmaceutical expertise to the care of people with skin disorders. Such models already exist in the primary care management of other conditions such as hypertension, heart failure and diabetes. The Department of Health document, *Guidance and competencies for the provision of services using Pharmacists with Special Interests (PhwSIs)*[36] describes different models of care and provides information about the competences, training, accreditation and assessment processes to support the accreditation of PhwSIs in Dermatology.

10. Clinical Assessment and Treatment Centres (CATS)

CATs or Independent Clinical Assessment and Treatment Centres (ICATS), are used in some areas to triage and/or review GP referrals to reduce the number of patients seen in secondary care. Referral protocols should be agreed between primary and secondary care, but guidelines or protocols cannot replace clinical acumen and "reading between the lines". Those triaging Dermatology referrals must have the skills to recognise the urgency of the problem and the management required or patient safety will be compromised. Where services have been commissioned under the Any Qualified Provider (AQP) model, triaging is normally undertaken by each provider; the patient is either treated in the community or referred back to the GP with a management plan, or onto secondary care.

The BAD recommends that GP referrals are always triaged by Consultant Dermatologists with GPwSI and Dermatology nurse support. Sufficient audit of referrals must be undertaken on a regular basis. The BMA's guidance *"Referral management schemes: guiding principles for the establishment, objectives and continuing progress of referral management schemes"* [37] aims to set out the key guiding principles of referral management schemes.

Referral management services should only be set up after consultation with all stakeholders, including those in secondary care and the public. Without engagement at all levels, referral management services may merely introduce an additional tier of care, reduce patient choice and quality of care and destabilise local NHS hospitals.

11. Education

Skin disease affects between one quarter and one third of the population at any one time. It accounts for up to a fifth of all GP consultations, and in 2010/11 generated over 873,000 GP referrals to secondary care.[38] Yet GPs receive an average of no more than six days training in Dermatology during the whole of their time as undergraduate and postgraduate medical students and only around one in five GP training schemes offer a Dermatology element in their training programmes[34] It is inevitable that many doctors will enter general practice with limited knowledge and understanding of common skin diseases which can present significant clinical diagnostic problems.

Education and training of local healthcare professionals (especially nurses and GPs) should be enhanced and undertaken as part of any existing community service contract, following the Dermatology undergraduate curriculum[39] and the RCGP Curriculum (15.10).[35] Larger group practices might consider developing in-house Dermatology expertise by offering training opportunities for interested partners and nursing staff.

12. Conclusions

All patients should receive the right care, delivered in the right place, by the right person, the first time. This document summarises the service levels of care covered by existing Department of Health (DH) government frameworks. It also reflects the requirements for commissioning, tendering and procuring of Dermatology services to ensure fair and equitable services for patients and providers. More detailed information is available on the website of the British Association of Dermatologists (www.BAD.org.uk).

References

1. Department of Health (2007b) Implementing Care Closer to Home: Convenient Quality Care for Patients (in three parts with 'Supporting Q&A' supplement). London. http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH_074419
2. Department of Health (2011) Revised guidance and Competences for the Provision of Services Using GPs with Special Interests (GPwSI) in Community Settings: Dermatology and Skin Surgery. London. http://www.pcc-cic.org.uk/sites/default/files/articles/attachments/revised_guidance_and_competences_for_the_provision_of_services_using_gps_with_special_interests_0.pdf
3. NICE (2006) Improving outcomes for people with skin tumours including melanoma–The Manual. London. http://www.nice.org.uk/nicemedia/pdf/CSG_Skin_Manual.pdf
4. NICE (2010) Improving outcomes for people with skin tumours including melanoma (update) – The management of low-risk basal cell carcinomas in the community. London. (http://www.nice.org.uk/nicemedia/live/10901/48878/48878.pdf)
5. National Cancer Action Team (2011) National Cancer Peer Review Programme, Manual for Cancer Services: Skin Measures. http://www.cquins.nhs.uk/download.php?d=resources/measures/Skin_Measures_April2011.pdf
6. NHS Modernisation Agency (2003a) Action on Dermatology: Good Practice Guide. http://www.institute.nhs.uk/index.php?option=com_joomcart&main_page=document_product_info&products_id=218&cPath=67)
7. Department of Health (2006) Practice based commissioning: practical implementation. London. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@pub/@ppg/documents/digitalasset/dh_062706.pdf
8. Department of Health (2010) Procurement Guide for Commissioners of NHS funded services. London. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152018/dh_118219.pdf.pdf
9. Department of Health (2010) Principles and rules for cooperation and competition, London. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152017/dh_118220.pdf.pdf
10. Skin Care Campaign (2007) Model of Integrated Service Delivery in Dermatology. London. http://www.ichthyosis.org.uk/wp-content/uploads/2011/02/Service-Models-Final-February-2007.pdf
11. British Association of Dermatologists (2012) Staffing and Facilities for Dermatological Units. http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=1005
12. British Association of Dermatologists (2012) Staffing and Facilities for Skin Surgery Units. http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=1007

13. Quality Standards for Dermatology: Providing the right care for people with skin conditions. (Primary Care Contract, 2011)
14. Royal College of Physicians (2011) Consultant Physicians Working with Patients 5th edition. http://www.rcplondon.ac.uk/sites/default/files/dermatology.pdf
15. Department of Health(2012) NHS Standard Contract for 2012/13. https://www.gov.uk/government/publications/leave-for-will-pls-nhs-standard-contracts-for-2012-13
16. Schofield J, Grindlay D and Williams H (2009) Skin Conditions in the UK: a Health Care Needs Assessment. Centre of Evidence Based Dermatology, University of Nottingham. http://www.nottingham.ac.uk/scs/documents/documentsdivisions/documentsdermatology/hcnaskinconditionsuk2009.pdf
17. Royal College of Physicians (2011) Consultant Physicians Working with Patients 5th edition. http://www.rcplondon.ac.uk/sites/default/files/dermatology.pdf
18. Levell NJ, Beattie CC, Shuster S, Greenberg DC (2009) Melanoma epidemic: a midsummer night's dream? Br J Dermatol 2009 Sep;161(3):630–4.
19. Williams HC (1997) 'Dermatology' in Stevens A and Raftery J (eds) Health Care Needs Assessment Series 2. Oxford: Radcliffe Medical Press.
20. Royal College of General Practitioners Birmingham Research Unit (2006b) Weekly Returns Service annual report 2006 [online]. Birmingham: Royal College of General Practitioners Birmingham Research Unit. http://www.rcgp.org.uk/pdf/bru_annual%20report%202006%20final.pdf
21. Schofield J, Grindlay D and Williams H (2009) Skin Conditions in the UK: a Health Care Needs Assessment. Centre of Evidence Based Dermatology , University of Nottingham. (http://www.nottingham.ac.uk/scs/documents/documentsdivisions/documentsdermatology/hcnaskinconditionsuk2009.pdf)
22. Hospital Episode Statistics Online. http://www.hscic.gov.uk/hes
23. West Herts NHS Trust (2004) unpublished scoping work for Action on Plastic Surgery project (see NHS Modernisation Agency 2005).
24. Williams HC (1997) 'Dermatology' in Stevens A and Raftery J (eds) Health Care Needs Assessment Series 2. Oxford: Radcliffe Medical Press.
25. Department of Health (2006a) Our Health, Our Care, Our Say: A New Direction for community Services, London: HMSO. http://www.official-documents.gov.uk/document/cm67/6737/6737.pdf
26. NHS Modernisation Agency (2005) Action on General Surgery: Good Practice Guide. http://www.institute.nhs.uk/index.php?option=com_joomcart&main_page=document_product_info&products_id=221&cPath=67
27. British Association of Dermatologists (2011) Working Party Report on Minimum Standards for Phototherapy Services. http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=1621
28. British Association of Dermatologists (2012) Working Party report on minimum standards for paediatric services. (TBC) http://www.bad.org.uk/healthcare-professionals/clinical-services/service-standards/paediatrics

British Association of Dermatologists (2012) Working Party report on minimum standards for cutaneous allergy services. (TBC) http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=1618

29. Bhushan M, Beck MH (1999). An audit to identify the optimum referral rate to a contact dermatitis Investigation unit. Br J Dermatol 1999; 141: 570-2.
30. PCC Quality Standards for Teledermatology: Using 'Store and Forward' images. http://www.pcc-cic.org.uk/sites/default/files/articles/attachments/teledermatology_report_aw_for_web3.pdf
31. Refer cost effectiveness of telehealth for patients with long term conditions (whole systems demonstrator telehealth questionnaire study): nested economic evaluation in a pragmatic, cluster randomised controlled trial, BMJ 2013;346:f1035 http://dx.doi.org/10.1136/bmj.f1035
32. Jackson S (2007) Dermatology GPwSI: terms and conditions e-mail survey (unpublished data.
33. Burge SM (2002) Undergraduate Education. Br J Dermatol Feb. 146(2): 295-303.
34. Royal College of General Practitioners (2007) Skin Problems: Curriculum for Trainees in Dermatology. http://www.rcgp.org.uk/gp-training-and-exams/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-3-21-Skin-Problems.ashx
35. Department of Health (2009) Guidance and competencies for the provision of services using Pharmacists with Special Interests (PHwSIs) – People with Skin Conditions. http://www.pcc.nhs.uk/uploads/pwsis/March%202009/phwsi_skin_care_framework_dh_bt_220509.pdf)
36. British Medical Association (2007) Referral management principles. http://bma.org.uk/-/media/Files/PDFs/Practical%20advice%20at%20work/Contracts/referralmanagementprinciples.pdf
37. HES online http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=892
38. British Association of Dermatologist (2006) Dermatology in the Undergraduate Medical Curriculum http://www.bad.org.uk/healthcare-professionals/education