



British Association  
of Dermatologists  
*healthy skin for all*

# Service Guidance and Standards For Cutaneous Allergy Investigations

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NICE has accredited the process used by the British Association of Dermatologists to produce Service Guidance and Standards. Accreditation is valid for 5 years from 7 March 2017.

For full details on our accreditation, visit: [www.nice.org.uk/accreditation](http://www.nice.org.uk/accreditation)

## Preface

The British Association of Dermatologists (BAD) is responsible for developing guidance that is solely or mostly focused on the organisation and delivery of dermatology healthcare services (service guidance). These differ from clinical guidelines which mainly deal with the process of care and consider how interventions should be delivered and by whom. Service guidance attempts to link these issues with the broader remit of the health service - in particular the interaction between structures and processes. For example, to deliver effective care it is necessary to ensure there are appropriate facilities, sufficient equipment and staff to deliver the required service or clinical intervention safely to service users etc.

Our approach to the development of current and pending service guidance is based on the core principles and methods guide set out by the National Institute for Health and Care Excellence (NICE) for developing service guidance to meet its accreditation requirements.

Cutaneous allergy services involve the diagnosis and management of allergic contact dermatitis (eczema) and contact urticaria including occupational skin disease. The investigation of patch testing may also be of value in the investigation of some systemic drug reactions and reactions to implantable medical devices (e.g. hip replacements).

Patch testing is a specialist procedure carried out in dermatology departments in the investigation of allergic contact dermatitis (eczema). This test has a sensitivity and specificity of between 70% and 80%.

Cutaneous Allergy Investigation involves the application of allergens as patch tests to identify relevant reactions to substances affecting the patient's skin condition and show whether they are allergic to a particular antigen(s).

In 2012 the BAD invited a range of professionals and patient representatives to form a multidisciplinary Working Party Group (WPG). The British Society for Cutaneous Allergy (BSCA) President was nominated as Chair of the WPG.

The remit of this new WPG is to provide a consensus for measurable standards for cutaneous allergy service provision in the UK. The members from around the UK were chosen for their specialist expertise in patch testing as well as from a range of specialties that are important in supporting a cutaneous allergy service, together with relevant patient involvement.

## Statement of Intentions:

1. Service guidance and core standards covering patient referral, assessment, consent, investigation and discharge, with outcome criteria that will be routinely audited.
2. All staff involved with cutaneous allergy investigations will have the requisite specialist training and will maintain an up-to-date portfolio of continuing professional development for revalidation.
3. Regularly monitor and update investigation protocols to ensure services conform nationally to best practice.
4. Ensure patch testing facilities and equipment is routinely checked for reliability, safety and compliance with Health and Safety Executive (HSE) and regulatory standards.
5. Ensure investigation of cutaneous allergy occurs in a safe patient-centered environment.

In order to achieve these aims, each aspect of the service has standards set which will be routinely assessed and audited. Within this document you will find our Cutaneous Allergy Service Standards, with clear criteria and proposal for documentary evidence with outcome targets for self- assessment and audit.

The self-assessment and audit processes have been subject to pilot tests within a number of NHS trust sites. An extensive public consultation with all professional groups involved in the provision of NHS services has been undertaken in order to ensure appropriate feedback has been disseminated and actioned by the WPG, prior to the publication of this guidance.

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## Aims

The core aims of our national Cutaneous Allergy Service Guidance are:

- To recommend acceptable NICE Accredited Service Standards for patch and photo patch testing units in the United Kingdom;
- To improve direct access to cutaneous allergy services for patients, reducing unnecessary consultations and improving the overall cost of care;
- To quality assure patch test education and training standards for nurses within services;
- To quality assure patient outcomes and improve patient education and clinical recording of cutaneous allergy services.

## Purpose

BAD Service Guidelines for cutaneous allergy are designed to provide a set of required service standards which underpin NICE clinical guidelines and inform NICE quality standards (outcome indicators).

This document forms the basis of a quality assurance programme for cutaneous allergy services and has identified standards of care for patients receiving patch testing.

All service areas are underpinned by acute clinical governance and organisational frameworks within hospital trusts and within the terms of the NHS Service Contract.

## Scope

We believe it is important for Cutaneous Allergy Service Guidance and Standards to reflect the concerns of the person using the service. For this reason, the standards will follow the patient pathway through care, and capture how the service interfaces with other services. As far as possible, standards are written from the service user's perspective and reflect the service infrastructure required to reduce risk and harm.

It is also important to note that the standards aim to explain what is required for effective cutaneous allergy investigation and will not cover peer review measures or outcomes.

We recognise that services are under increased pressure to demonstrate that they comply with national policies and guidelines.

For this reason, our guidance incorporates existing requirements and standards (recommendations) set out nationally for services and are aligned with:

- Department of Health Policy Implementation Guides;

- NICE guidance;
- Recommendations by NHS Estates and the BAD Staffing and Facilities guidance;
- Patient Safety Domain of NHS England;
- Existing UK services which have accreditation frameworks and or Managed Clinical Networks (MCN) in place;
- Care Quality Commission (CQC) Regulations;
- HSE and COSHH Risk Assessments;
- Department of Health Building Notes for facilities;
- GMC Good Medical Practice and Ethical Guidelines;
- NHS Standards Contract terms and conditions.

## Introduction

The following standards contained within this service guidance include the rationale and demonstrable essential criteria which are drawn from existing national policies and guidelines for NHS service delivery.

They clearly define the expectations for achieving a safe, effective and high-quality cutaneous allergy service, therefore services not participating in accreditation may also find them useful.

Clinicians who carry out patch testing are also bound by the standards set by their respective professional bodies in relation to their clinical practice.

## Definitions

### Standard

A standard is something considered by an authority or by general consensus as a basis of comparison in measuring or judging adequacy or quality. These standards have been developed by a multi-disciplinary group set up by the BAD to carry out this work.

In this document standards are expressed as something which services must do as an overriding duty of principle in order to meet the requirements for accreditation. They provide the basis for evaluating quality of service and will evolve over time.

### Evidence/Minimum requirements

The evidence requirements are intended to be well-defined and easy to understand. They must be met to satisfy the standards. Many of the evidence requirements relate to national policy and guidelines.

### Examples of suitable evidence

Examples of suitable evidence are the records that departments can use to demonstrate that they meet the standards, such as anonymised patient case examples. The defined evidence in the next section illustrates the types of information required to demonstrate compliance with a standard. This is not intended to be either prescriptive or exhaustive (recommendation only). Service providers may provide what they consider the most convincing evidence available for their achievement of each standard, whether or not it appears among the examples (see Appendix 2 – Core List of Evidence).

### Self-Assessment and Audit

Self-Assessment against the Cutaneous Allergy Service Standards will be a voluntary and cyclical process. This provides self-validation that a service has demonstrated competence measured against the standards and is considered to be fit for purpose. It drives continuous

improvement by allowing services to identify areas for improvement and take the necessary remedial action(s) within recognised clinical governance and risk reporting frameworks.

## Who is this guidance for?

These Service Guidance and Standards are integral to quality assuring safe and effective care for patients, measuring quality outcomes and effectively managing clinical performance and governance. They help to:

- Ensure that new and existing services are set up in a way that will ensure patient safety and optimal investigation;
- Ensure that existing service infrastructure (facilities, equipment and staffing etc.) contributes to the safe and effective delivery of care to patients;
- Clarify expectations for patients, clinicians, management, commissioners and NHS employees;
- Drive service improvement and development of cutaneous allergy services to meet local needs;
- Contribute to improved clinical monitoring and recording of quality, results-based outcomes.

Service guidance and standards are developed primarily for commissioners of NHS services, service providers (NHS and private practice) and those regulatory bodies involved in the scrutiny of care.

They also aim to reinforce governance and accountability by making service provision transparent and increase patient confidence by demonstrating commitment to service excellence. This will also ensure commissioners of NHS services procure services from appropriately qualified providers. These standards and required suitable evidence are intended to apply to all cutaneous allergy services provided in the UK in support of their accreditation as an NHS provider.

The standards are to be reviewed on an annual basis and applied by departments through a self and peer-review process by individual trust providers.

## What approach have we taken to develop this guidance?<sup>1</sup>

This guidance was developed in accordance with the core principles and methods set out by NICE for developing its service guidance. The methodology for developing service standards is underpinned and informed by an evidence review and existing national policies.

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<sup>1</sup> British Association of Dermatologists: Developing Dermatology Service Guidance and Standards 2017 - <http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=4147>

Each service standard is supported by the available national evidence, expert clinical judgment and patient input from the Cutaneous Allergy WPG. The Cutaneous Allergy Service Standards have been piloted in nominated hospital departments (see Acknowledgements), using our self-assessment and audit process, with evidence submitted for review by the WPG. This allowed accurate feedback to be obtained on the operational process and further updates to be made to the service standards. All decisions in the development of this guidance have been made by the WPG through a process of informal consensus and agreement. The finalised service standards have been scrutinised and approved by the BAD Officers prior to consultation with our stakeholders.

A formal consultation period (normally one month) then took place to allow for stakeholder registration and feedback on the Cutaneous Allergy Service Guidance and Standards. Comments received have been collected using a standard proforma recognised by NICE. Stakeholder feedback has been responded to by the WPG and any necessary changes to guidance actioned prior to its publication.

# The Standards Framework

Patch and photo patch tests are specialist diagnostic procedures used to determine a patient's contact sensitivities. There are approximately 40 substances which are most frequently in contact with the skin that may trigger or aggravate a skin condition.

We recognise that clinicians working in Cutaneous Allergy services have the best understanding of the issues and challenges faced in providing high quality care for patients. The BAD service standards framework is underpinned by a core set of values and principles which support best practice. These are as follows:

- STANDARD 1:** Referral and Patient Assessment
- STANDARD 2:** Patient Information and Consent
- STANDARD 3:** Staff Training and Education
- STANDARD 4:** Clinical Management & Monitoring
- STANDARD 5:** Equipment and Facilities
- STANDARD 6:** Clinical Governance and Audit
- STANDARD 7:** Discharge Protocol

Each service standard sets out the rationale, criteria and audit outcomes specific to the service frameworks for providing a Cutaneous Allergy Services. These standards have been developed by our expert advisory group on Cutaneous Allergy and have been refined in consultation with front-line staff, patients, carers and other interested groups.

## The Self – Assessment Process

There are examples of good practice already in services in many areas of the country; but delivering all ‘essential criteria’ defined under each service standard requires a long-term programme of change. Service providers will require additional support and tools for evaluating their performance and areas for improvement.

Therefore, each service standard’s ‘essential criteria’ is supported by a range of documentary evidence and auditable outcomes. The main source of evidence for auditing essential criteria is obtained from patient case notes. Fifty (50) cases should be selected for this purpose along with the collation of core evidence for each standard. Some of the activities to be undertaken by departments will include a review of:

- Activity data to identify Cutaneous Allergy referral to treatment times, demographics profiles of service users etc.;
- Clinical codes used by the department;
- Staff and service user feedback;
- Storage and treatment facilities.

### Self-Audit and Reporting

The data and evidence collected during the self-assessment phase should be used to complete the Cutaneous Allergy Service Standards Self-Audit Form. The audit outcomes are contained within each standard and outline the level required to meet essential criteria. The following flag status system is used to identify each essential criteria and areas of most risk and should be applied to the self- audit outcomes. The self-audit outcomes are based on a review of the specified number of consecutive patient cases contained under each standard.

For Example:

	Essential Criteria	Audit Outcome	Status
2A.1	All patients must be offered a Patient Information Leaflet (PIL) prior to commencing the diagnostic test that covers the specific battery range of tests they are due to have.	100% of patients are given a PIL prior to their patch testing investigation and made aware of the potential side effects.	>99% <b>Green</b> 70-98% <b>Yellow</b> <70% <b>Red</b>

**Red Flag [Action Required]:** failure to meet these standards places undue clinical risk on patients, breaches their rights or dignity and/or may result in litigation;

**Yellow Flag [Monitoring Required]:** is one which a good Service would be expected to meet. Failure to meet a Yellow Flag Service Standard does not imply the level of clinical risk of a Red Flag, but it is recommended that action is taken to meet the Standard.

**Green Flag [No Action Required]:** meets service standard essential criteria.

Given the variation in current service provision providers implementing these new Cutaneous Allergy Service Standards will have a grace period (12 months) to identify shortfalls in their service provision. This will enable the multi-disciplinary team to review their local procedures and practices against the accredited Cutaneous Allergy Service Standards and, if necessary, implement the changes required. A summary of the results from the self-assessment and audit would form the basis of a business case for any identified areas of service improvement.

All BAD service guidance will be produced within recognised NICE accreditation standards (kite marked). As such all our guidance (clinical and services related) are required to inform all service specifications for Dermatology within the NHS Standard Service contract. The self-audit reporting tool can be used by providers and commissioners to inform on key contractual performance and quality outcomes for dermatology services.

# STANDARD 1: Referral and Patient Assessment

## Standard Statement 1A: Referrals

### Rationale

Patients are referred by a general practitioner (GP) or accredited community practitioner to secondary care<sup>2</sup> consultant-led 18-week services for cutaneous allergy investigation. Occupational health professionals will also refer in patients requiring investigation and/or workplace assessment of occupational skin disease (these should be offered by more specialised centres). Appropriately trained nurses may also refer. Other specialties may also refer patients for investigation prior to the implantation of a medical device or to investigate potential adverse reactions to drugs or medical devices. All referrals should be appropriately triaged.

GPs or accredited community practitioners should directly refer all paediatric patients with suspected allergic contact dermatitis for assessment by the dermatologist/paediatric dermatologist first. Referrals should then be appropriately triaged on receipt.

Patch tests will be prescribed by a consultant dermatologist or another accredited practitioner working under the supervision of a consultant dermatologist. In larger teaching hospitals, a consultant lead may receive internal referrals from their consultant dermatology colleagues. The consultant dermatologist undertaking the patch test investigations has overall responsibility for the assessment and management of the patient.

Consultant-to-consultant referrals directly to specialised centres are necessary for patients who require complex patch and photo patch tests to improve the management of unresponsive and severe skin diseases, including occupational dermatitis (see Evidence Review: Prevalence and Incidence).

### Essential Criteria

1A.1	The referral letter must include information about the: <ul style="list-style-type: none"><li>• Clinical indicators for requesting patch tests;</li><li>• Details about absence or presence of any contraindications or risk factors;</li><li>• Details about the occupational influences and exposure causing skin allergy (if applicable).</li></ul>
1A.2	Referral criteria for the patch test service are clearly advertised on the department's website. E-referral should ideally be used to advertise the patch test service to allow GPs to refer to a patch test consultation clinic and the patient to book appointments from available clinic slots with the patch test consultant.

<sup>2</sup> "secondary care services" means services provided as part of the health service in a hospital setting, or by those working in or based in a hospital setting, other than emergency services, primary care services or the services specified in Schedule 4 (Specialised Services)

1A.3	Patients should be given an urgent appointment (within four weeks) when there is significant impact on quality of life; impact on occupation (off work); or surgery is dependent on the result.		
1A.4	A referral and access policy for the unit is locally agreed and clearly sets out how patients are directed to the service from GPs and other national referral sources (includes consultant-to-consultant referrals).		
<b>Examples of Suitable Evidence</b>			
<ul style="list-style-type: none"> <li>• A referral form and/or letter is in each patient's notes.</li> </ul>			
<ul style="list-style-type: none"> <li>• A copy of the current agreed referral and access policy with timescales for review.</li> </ul>			
<ul style="list-style-type: none"> <li>• A link to the department's website which includes patch test service and referral information.</li> </ul>			
<ul style="list-style-type: none"> <li>• Case mix list of patients referred into the service over 12-24-month period.</li> </ul>			
<b>Audit Outcomes</b>			<b>Status</b>
>95%	Patient referral letters meet referral criteria.		>90% <b>Green</b> 70-90% <b>Yellow</b> <70% <b>Red</b>
100%	Patch test service and referral information is advertised on the department's website and appointments are electronically referred on e-referral.		>90% <b>Green</b> 70-90% <b>Yellow</b> <70% <b>Red</b>
>90%	Patients referred (non-urgent) for patch testing should be seen within 12 weeks of referral, subject to service fluctuations.		>90% <b>Green</b> 70-90% <b>Yellow</b> <70% <b>Red</b>
>95%	Patients warranting an urgent appointment should be seen within four weeks.		>90% <b>Green</b> 70-90% <b>Yellow</b> <70% <b>Red</b>
<b>Self-Assessment and Audit Questionnaire – Review of 50 Patient Cases</b>			<b>YES</b> <b>NO</b>
Q1.	Is there an accurate record of the patient's referral letter with clinical indicators in the patients notes?		
Q2.	Are patients referred for urgent patch testing offered an appointment within four weeks?		

Q3.	Are patients referred for non- urgent patch testing offered an appointment within 12 weeks?		
Q4.	Does the patch testing unit have an up-to-date referral access policy?		
Q5.	Does the patch test unit have up-to-date information about the service advertised on the department's website?		

## Standard Statement 1B: Patient Assessment and Management

### Rationale

The patient's history is crucial for understanding the causes of their cutaneous allergy and the subsequent investigations and prescribing of the patient's allergens. All decisions must be made following a face-to-face consultation with an accredited consultant dermatologist or other appropriately trained clinician working under their supervision.

Patch, photo patch, prick and contact urticaria testing should always be prescribed by a consultant dermatologist or other appropriately trained clinician working under their supervision who is qualified to prescribe the UK baseline series of allergens (together with relevant additional series, and appropriately diluted patient samples, following review of safety data sheets, ingredient lists and other relevant information/data).

Registered specialist nurses require expertise in patch testing and an understanding of the various exposures that may result in an allergic reaction and the hazards associated with the application of allergens when dealing with the patient.

### Essential Criteria

1B.1	Perform a thorough history in patients with suspected contact dermatitis to distinguish clinical patterns of dermatitis likely to be associated with the skin allergy.
1B.2	Identify occupational triggers and lifestyle influences causing the skin allergy.
1B.3	Prescribe baseline series and additional series relevant to identifying the underlying cause of the patient's cutaneous allergy. See audit outcomes below.
1B.4	Prick testing is also undertaken where appropriate or onward referrals are made to an allergy department.

### Examples of Suitable Evidence

- Reports from workplace visits to assess occupational dermatoses (where applicable to the service).
- 50 patch test patient case notes to review clinical investigation, pre-patch test diagnosis and allergens prescribed.
- Case mix list of types of allergens prescribed to each patient seen in the department during a 12-24-month period.

Audit Outcomes – 50 patient cases

Status

100%	All patients are prescribed the baseline and additional patch test series (see Appendix 5).	>90% <b>Green</b> 70-90% <b>Yellow</b> <70% <b>Red</b>	
100%	Prick testing is undertaken where appropriate or that onward referrals to an allergy department have been made.	>90% <b>Green</b> 70-90% <b>Yellow</b> <70% <b>Red</b>	
90%	Patients with hand eczema are tested to a recommended rubber series, as appropriate.	>90% <b>Green</b> 70-90% <b>Yellow</b> <70% <b>Red</b>	
100%	All hairdressers with hand dermatitis are tested to a recommended hairdressing series.	100% <b>Green</b> 70-99% <b>Yellow</b> <70% <b>Red</b>	
100%	All patients with facial eczema are tested to a cosmetic series.	>95% <b>Green</b> 70-94% <b>Yellow</b> <70% <b>Red</b>	
100%	All patients with atopic eczema are tested to a medicament series.	100% <b>Green</b> 70-99% <b>Yellow</b> <70% <b>Red</b>	
100%	All photo patch tested patients are tested to a recommended photo allergy series in tertiary care.	100% <b>Green</b> 70-99% <b>Yellow</b> <70% <b>Red</b>	
<b>Self-Assessment and Audit Questionnaire – Review of 50 Patient Cases</b>		<b>YES</b> <b>NO</b>	
Q1.	Are all patients referred for patch testing assessed by a consultant dermatologist or other appropriately trained clinician working under their supervision?		
Q2.	Are all patch, photo patch, prick and contact urticaria tests prescribed by a consultant dermatologist or other appropriately trained clinician working under their supervision?		
Q3.	Are all patients prescribed the baseline and relevant extended series at their assessment?		

## STANDARD 2: Patient Information and Consent

### Standard Statement 2A - Provision of Written Patient Information

#### Rationale

Patients should be given written information, which should be specific for their situation, including the name(s) of the allergens chosen for testing. In case of cosmetics allergens, International Nomenclature of Cosmetic Ingredients (INCI) names must be provided; in other cases, International Nonproprietary Names (INN) are helpful. Chemical Abstract Service (CAS) numbers and common names are helpful in other fields. Information should be repeated during follow-up visits at day 2/3 and 4-7.

Prior to any diagnostic tests, patients must always be fully informed as to what their investigations involve, why they have been recommended for patch testing and what the possible adverse effects associated with the application of patch tests are. All information and engagement should be accessible to patients and provided in a variety of formats and languages as appropriate for those patients accessing the service.

Alternative treatments may also be discussed by the consultant with the patient. Any patient not deemed clinically suitable for patch testing must be given a comprehensive explanation.

#### Essential Criteria

2A.1	All patients must be offered a <a href="#">Patient Information Leaflet (PIL)</a> prior to commencing the diagnostic test.
2A.2	PILs and websites must be kept up-to-date and reviewed on a regular basis (i.e. every 3 years).
2A.3	There is a description of the patch test service for referrers, patients and their carers on the trust's/hospital's website.

#### Examples of Suitable Evidence

- Review of published leaflets and website information, including checks that the information is regularly updated. See BAD/BSCA website for updates.
- Review of patient notes to show that relevant patient information resources have been provided.
- A copy of the PIL or the URL of the patch test service describing the service.

- An up-to-date (in year) copy of the service description either as an approved operational policy or other documented approved service document.

Audit Outcomes		Status	
100%	Patients are given a PIL prior to their patch testing investigation and made aware of the potential side effects.	>99% <b>Green</b> 70-98% <b>Yellow</b> <70% <b>Red</b>	
Self-Assessment and Audit Questionnaire - Review of 50 Patient Cases		YES	NO
Q1.	Are all patients offered a patient information leaflet on their skin condition and patch testing process for their investigations?		
Q2.	Is there information available on the trust's/hospital's website the patch test service for patients?		

## Standard Statement 2B – Obtaining Validated Consent

### Rationale

Patients should be informed about the purpose and benefits of patch testing, how patch testing is undertaken, and symptoms that may occur. It is necessary to give information about avoidance of showers, wetting the test sites, UV irradiation and excessive exercise, and loosening of patches, and about symptoms such as itching, severe or late reactions, and potential adverse effects from patch testing.

The need for verbal/written informed consent exists for all investigations, to help ensure that all patients are appropriately informed.

### Essential Criteria

2B.1	Patients (adults and children) must provide their informed consent, before any investigation or additional investigations can occur; in line with hospital policy.
2B.2	Patients (adults and children) should be informed of the benefits and risks of patch testing and why it has been recommended as part of obtaining their consent. This includes explaining the range of battery tests which will be used and responding to patient concerns.
2B.3	Patients (adults and children) should be offered a chaperone at each visit to the patch test service.

### Examples of Suitable Evidence

- Confirmation that patient has been sent an appropriate leaflet/PIL prior to the appointment, and understood the investigations process, after care requirements, symptoms and adverse effects for patch testing.
- Confirmation of consent prior to the investigation and application of patch tests.
- Proof that patch test clinicians are up-to-date with mandatory training.

### Audit Outcomes

### Status

100%	Signed and dated confirmation of consent, or confirmation of verbal consent and full patient understanding is present in of patient notes for all patch test prescribed.	>98% <b>Green</b> 90-97% <b>Yellow</b> <90% <b>Red</b>
100%	PILs have a version number, review date and are up-to-date.	>99% <b>Green</b> 70-98% <b>Yellow</b> <70% <b>Red</b>

Self-Assessment and Audit Questionnaire – 50 patient cases		YES	NO
Q1.	Are all patients offered a patient information leaflet on their skin condition and patch testing batteries to be applied for their investigations?		
Q2.	Is full and accurate information on the patch test service available on the trust's/hospital's website for patients?		
Q3.	Are all patch test clinicians trained and up-to-date with mandatory training?		
Q4.	Does the patch test service offer chaperones for patients?		

## Standard Statement 2C - Involving Patients

### Rationale

There are a variety of ways in which dermatology departments can proactively involve and engage with their patients. This ranges from relatively simple and commonly used methods, such as administering patient experience surveys and reviewing and responding to patient queries and complaints, to the more complex such as asking patients to keep a diary, conducting discovery interviews or establishing a patient panel, to influence service delivery and commissioning challenges.

Each Cutaneous Allergy service has a statutory duty to engage and involve the public/patients/carers in the planning of its service under the NHS constitution for England. These core principles are shared across all health care services provided in Wales, Scotland and Northern Ireland.

There must also be defined systems in place to obtain and manage feedback from patients and any queries or concerns raised by the patient should be addressed accordingly, in a timely manner. Patient and public involvement (PPI) activities within a department should include clinical audit and governance and in training and education (see Standard 4).

### Essential Criteria

2C.1	To satisfy current revalidation guidelines, sufficient patients/parents/carers are offered a Patient Satisfaction Questionnaire. These should be available in an appropriate format and language, to take away or access electronically; and include a question on the information provided and its usefulness and quality.
2C.2	Patch testing staff are given the opportunity to review and respond to patient queries and complaints.
2C.3	Patient feedback (e.g. through dermatology patient panels) may be given for clinical audit and governance discussions for the service.
2C.4	Patient feedback must be used to guide the ongoing training and education of patch testing staff.

### Examples of Suitable Evidence

- Reported outcomes from patient complaints, with lessons learned.
- Patient satisfaction questionnaire.
- Advertisement link to patient skin disease support groups.

Audit Outcomes		Status	
100%	Patient Satisfaction Questionnaires should be offered to patients yearly, as a minimum.	100% <b>Green</b> 70-99% <b>Yellow</b> <70% <b>Red</b>	
100%	Informed patient feedback is provided in the department.	100% <b>Green</b> 70-99% <b>Yellow</b> <70% <b>Red</b>	
Self-Assessment and Audit Questionnaire – Review of 50 Patient Cases		YES	NO
Q1.	Do all patch test clinicians have input into responding to patch test complaints from their own patients?		
Q2.	Does the patch test service undertake patient satisfaction questionnaires every year?		
Q3.	Do patients have an opportunity for feedback to the department?		

## STANDARD 3: Staff Training and Education

### Standard Statement 3A - Qualified Professional Staff

#### Rationale

The Cutaneous Allergy, Contact Dermatitis and Occupational Dermatoses module undertaken during Dermatology specialist training requires acquisition of all competencies to be gained by consultants. Any accredited practitioner working under a consultant should also meet these requirements in addition to the requisite progressive elements of the curriculum. The maintenance of these competencies is applicable to any consultants wanting to continue practice in this specialist area whether at a District General Hospital or Tertiary Centre.

For those consultants working in a Tertiary Centre additional post CCT experience equivalent to that in the post CCT training fellowship is required for specialised practice in areas of photo patch testing and occupational dermatoses.

Registered specialist nurses require experience in a dermatology unit and additional training following the British Dermatological Nursing Group (BDNG) "A Framework of Competence for the Specialist Interest Modules in: Patch and Photo Patch Testing".

Both the Nursing and Midwifery Council and General Medical Council produce practice standards for nurse and doctors respectively and require regular educational activities that maintain and develop the individual's competence and performance.

#### Essential Criteria

3A.1	Senior specialty grade doctors working as leads for patch tests units are required to have 4 years' experience in dermatology in addition to a minimum of six months training (or accrued experience) at a contact dermatitis investigation unit to meet the competencies defined within the Dermatology curriculum (see Appendix A).
3A.2	The named, lead senior dermatologist(s) should be capable of undertaking occupational workplace visits to identify unrecognised allergens and establishing relevance when appropriate.
3A.3	The named lead senior dermatologist(s) should be available on site when clinics are being provided by patch test practitioners under their supervision.
3A.4	Registered specialist dermatology nurses (with at least two years of experience in dermatology) should undertake further training in patch testing equivalent to

	that of a medical dermatology trainee in cutaneous allergy (six months) to enable them to read and interpret tests.
3A.5	Nurses who undertake the prescription, reading and interpretation of the patch tests and subsequently give advice must hold a prescribing qualification and be assessed as being an “expert nurse” using a patch testing competency framework (Level 3) <sup>3</sup> . All nurse prescribing is under the remit of the consultant lead.
3A.6	All staff on the unit should be suitably trained in managing an anaphylactic event and hold up-to-date hospital life support (and paediatric hospital life support if involved with caring for children) mandatory training.
3A.7	All staff should maintain an up-to-date development portfolio and be supported in this regard via training courses and updates every year.
3A.8	All staff should have appropriate training in safeguarding children.

#### Examples of Suitable Evidence

- Up-to-date staff training records of those involved with the service.
- Hospital Life Support (and paediatric hospital life support if involved with caring for children) Certificate.
- Review of 50 patient cases to demonstrate case mix outcomes for each patch test practitioner.
- Patch test and skin allergy related CPD for all patch test clinical staff.
- Case list of all patch test patients seen in the department over a 12-month period.

Audit Outcomes		Status
100%	All patch test clinical staff training and updates during the year are held on a register within the department.	Yes <b>Green</b> No <b>Red</b>
100%	Compliance with CPD specific to providing the patch test service for each practitioner.	Yes <b>Green</b> No <b>Red</b>
100%	All consultants, or dermatologists working under their supervision to deliver the patch test service, have seen the	100% <b>Green</b> 70-99% <b>Yellow</b> <70% <b>Red</b>

<sup>3</sup> Patch Testing: A Best Practice Guide, British Dermatological Nursing Group (BDNG), 2016

	required number of patients to maintain their practice (100 patients <sup>4</sup> per annum).		
100%	A minimum of 150 patch tests are performed per annum by the dermatology unit. For specialist centres this should be a minimum of 300 cases per annum.	Yes <b>Green</b> No <b>Red</b>	
<b>Self-Assessment and Audit Questionnaire – Review of 50 Patient Cases</b>		<b>YES</b>	<b>NO</b>
Q1.	Are all patch test clinical staff meeting the training standards required for their specialist area of practice?		
Q2.	Are all clinical staff trained in managing anaphylactic shock?		
Q3.	Do all clinical staff hold up-to-date hospital life support and paediatric life support mandatory training?		
Q4.	Are all consultants (or dermatologists delivering the patch tests under the supervision of the consultant) meeting the minimum number of patch tests for their practice?		
Q5.	Does the patch test unit meet the minimum standards for total number of patch tests to be performed?		

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<sup>4</sup> This figure aims to support departments in developing their services. A red flag on numbers seen should not mean closure but is a sign that urgent consideration and attention is needed. The authors appreciate that this may be a challenge in some remote services with a low population density where provision of services should remain a priority.

## STANDARD 4: Clinical Management & Monitoring

### Standard Statement 4A: Clinical Management

#### Rationale

An experienced dermatologist will be able to correctly predict the clinically relevant contact allergens in some patients, on the basis of the history and the clinical appearance of the dermatitis. However, the failure to correctly predict those less common allergens is the reason why a 'baseline series' of test allergens should be applied in the evaluation of all patients suspected of having contact dermatitis.

Additional series of tests should be used in addition to the baseline series as standard practice to provide a broader range of investigations for patients. The application of the tests should be applied at Day 0, removed at Day 2/3 and final readings undertaken at Day 4-7.

Where pre-prepared tests (TRUE Test®) are used they will need to be supplemented to meet the UK baseline standards series, in addition to other tests series required (see Appendix 5). It has been estimated that by using pre-prepared tests alone between 60% and 70% of relevant allergic reactions may be missed<sup>5,6</sup>.

#### Essential Criteria

4A.1	On Day 0, a full diagnostic assessment must be completed by a dermatology consultant or suitably trained doctor under their supervision. The BSCA's recommended baseline series will be prescribed and used alongside other series and patient's own samples (if needed), including those from the workplace (if relevant).
4A.2	A patch test specialist nurse may prepare the battery series and apply the tests after the Day 0 consultation, or the patient may choose another day to start the patch test investigation. A chaperone may be present for the application.
4A.3	On Day 2/3, one suitably trained dermatologist/specialist nurse must be present to read, interpret the tests and prescribe additional allergens as required. Suitably trained staff should also be present to apply additional tests.
4A.4	On Days 4-7, one suitably trained dermatologist/specialist nurse must be present to read, interpret the tests and give appropriate advice on management.

<sup>5</sup>TRUE Test, A Reliable Method for Patch Testing in the Community? Foulds I. Br J Dermatol, 2007; 157 suppl 1: 85.

<sup>6</sup>The Detection of Clinically Relevant Contact Allergens with a Standard Screening Tray of 28 Allergens. Patel D, Belsito DV. Contact Dermatitis, 2012; 66: 154-8.

4A.5	Patients should ideally be seen by the same practitioner at each visit, for continuity of care.	
4.A6	Occupational workplace visits to identify unrecognised contact allergens and to establish the relevance of confirmed allergens may be required.	
4.A7	Prick testing is appropriate in up to 33% of patients so facilities should be available to maximise diagnostic accuracy, or patients referred on to an allergy clinic.	
4A.8	Appropriate follow-up is arranged.	
<b>Examples of Suitable Evidence</b>		
	<ul style="list-style-type: none"> <li>Review of 50 patients case notes on series tested, prescription of further allergens during the tests to clarify doubtful reactions and follow up outcomes.</li> </ul>	
	<ul style="list-style-type: none"> <li>Case List of patients seen in the department for patch test and prick testing over 12-24-month period.</li> </ul>	
	<ul style="list-style-type: none"> <li>Clinical results should be entered in a database and critically compared with national pooled results.</li> </ul>	
	<ul style="list-style-type: none"> <li>A list of other series is available and the frequency with which they are used is documented.</li> </ul>	
<b>Audit Outcomes</b>		<b>Status</b>
100%	All baseline series include the allergens at the correct concentration and vehicle as in the BSCA baseline series.	100% <b>Green</b> 90-99% <b>Yellow</b> <90% <b>Red</b>
95%	Patch test reactions are interpreted correctly and recorded by a trained dermatologist or (Level 3) patch test nurse specialist (combined reactions to nickel, cobalt and chromate in a patient with atopic eczema are likely to be irritant). It is recommended results should be entered in a database and critically compared with national pooled results.	>95% <b>Green</b> 70-94% <b>Yellow</b> <70% <b>Red</b>
100%	Prick testing using the relevant tests or onward referral to an allergy clinic is offered to appropriate patients.	Yes <b>Green</b> No <b>Red</b>
<b>Self-Assessment and Audit Questionnaire – Review of 50 Patient Cases</b>		<b>YES</b> <b>NO</b>
Q1.	Are all patients assessed by a consultant dermatologist or suitably trained doctor under their supervision for patch tests	<input type="checkbox"/>

Q2.	Does the consultant dermatologist or suitably trained doctor under their supervision prescribe the required patch tests?		
Q3.	Are patients seen on Day 2/3 for the reading of their tests by a trained dermatologist/specialist nurse?		
Q4.	Are patients seen on Days 4-7 for the reading of their tests by a trained dermatologist/specialist nurse?		
Q5.	Is the patient seen by the same practitioner at each patch test appointment?		

#### Standard Statement 4B: Recording Patch Test Service Activity

##### Rationale

Safe and efficient patient care relies on high quality data. By taking responsibility for their clinical data, clinicians can improve its quality and help drive up standards of care. Accurate recording of clinical investigations /procedures is required for service planning and investment. Suboptimal recording of patch test investigations leads to income losses which impact on the maintenance and development of services, staff, equipment and viability of the department.

For specialised services undertaking complex investigations and photo testing all patients seen in the department as day cases and must have a diagnosis recorded, evidence of an MDT discussion and the specialised procedures code(s) recorded for payment by NHS England.

##### Essential Criteria

4B.1	<p>The following clinical activities must be recorded for all patients undergoing patch testing.</p> <p><b>New consultation clinic with patch test consultant:</b> to investigate patient history and prescribe range of tests. This consultation may take place on <b>Day 0</b> of the patient pathway.</p> <ul style="list-style-type: none"> <li>WF01B First Attendance - Single Professional or WFO2B First Attendance – Multi Professional (under treatment function codes 330 for adult dermatology or 257 for paediatric dermatology).</li> </ul> <p><b>Day 0:</b> First follow up appointment.</p>
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- WFO1A Follow-Up Attendance – Single Professional or WFO2A Follow-Up Multi Professional (under treatment function codes 330 for adult dermatology or 257 for paediatric dermatology);
- Plus, the application of tests (select codes as appropriate for the range of tests being applied):
  - Secondary Care Services
    - U271 – Patch Test – BSCA Baseline
    - U272 - Patch Test – Other Series Tested
    - U273 - Patch Test – Closed Routine
    - U275 - Patch Test - Open
    - U276 - Patch Test – Own Products
    - U278 – Other Specified
    - U279 - Unspecified
    - U288 – Prick Test
  - Specialised Services (Tertiary Care)
    - U274 – Patch Test – Closed Special
    - U277 – Photo Patch Testing

For specialised services, a primary diagnosis must be recorded in the patient's notes, along with the patient's co-morbidities and procedures at each stage of the patient pathway.

**Day 2/3:** Second follow up appointment - removal of patch tests and review of test sites for allergic reactions.

- WFO1A Follow-Up Attendance – Single Professional or WFO2A Follow-Up Multi Professional (under treatment function codes 330 for adult dermatology or 257 for paediatric dermatology);
- Any additional tests added at this appointment should be recorded using the Day 0 codes above.

**Day 4-7:** Third follow up appointment - final reading.

- WFO1A Follow-Up Attendance – Single Professional or WFO2A Follow-Up Multi Professional (under treatment function codes 330 for adult dermatology or 257 for paediatric dermatology);
- Any additional tests added at this appointment should be recorded using the Day 0 codes above.

**Day 7:** Fourth follow up appointment: optional for complex patients etc.

	<ul style="list-style-type: none"> <li>WFO1A Follow-Up Attendance – Single Professional or WFO2A Follow-Up Multi Professional (under treatment function codes 330 for adult dermatology or 257 for paediatric dermatology);</li> </ul> <p>NB: As a minimum, all patients should be offered the extended series of patch tests, and local tariffs should be agreed for patients requiring additional tests.</p>	
4B.2	Agreed protocols in place for recording patch, photo patch and prick test investigations for all clinical staff.	
4B.3	Patch test coding forms should be used by practitioners to accurately record activity in the patients notes. Electronic system for recording clinical activity must contain a list of all the recognised patch tests codes and allow multiple recording of these series by patient.	
4B.4	Clinical and financial arrangements for the patch test service should be reviewed by the clinical lead and any anomalies reported.	
<b>Examples of Suitable Evidence</b>		
	<ul style="list-style-type: none"> <li>Patch test outpatient income forms or electronic record of patch test codes used by the department.</li> </ul>	
	<ul style="list-style-type: none"> <li>Case mix report of patch test activity for the department over 12-24-month period.</li> </ul>	
	<ul style="list-style-type: none"> <li>Yearly clinical and financial reports for the patch test service.</li> </ul>	
<b>Audit Outcomes</b>		<b>Status</b>
100%	Audit review of 50 consecutive cases undertaken by the patch test services over a 12-month period.	100% <b>Green</b> 70-99% <b>Yellow</b> <70% <b>Red</b>
90%	Patch test patients are seen on Days 0, 2 and 4.	>95% <b>Green</b> 70-94% <b>Yellow</b> <70% <b>Red</b>
100%	Protocols have been followed for recording of patch test investigations and all patch test results are documented correctly.	100% <b>Green</b> 70-99% <b>Yellow</b> <70% <b>Red</b>
<b>Self-Assessment and Audit Questionnaire – Review of 50 Patient Cases</b>		<b>YES</b> <b>NO</b>

Q1.	Does the patch test service provide appointments for patients on Days 0, 2 and 4?		
Q2.	Has the department undertaken an audit of its patch test service in the past 24 months?		
Q3.	Has the department reviewed its protocols for the recording of patch test results in the last 24 months?		

## STANDARD 5: Equipment and Facilities

### Standard Statement 5A: Safety and Compliance

#### Rationale

All Cutaneous Allergy services require adequate space for medicine storage and preparation room compliant with DH building notes (see Appendix 4): NHS Facilities for outpatient services). Consultation rooms are essential for examination of the patient's skin and extent of their contact dermatitis/ eczema etc. During the course of the patch test investigations patient require adequate space for ambulant dressing and undressing.

It is essential for patch test services to have a standalone refrigerator and freezer for the safe storage of allergens at the required temperatures. Where drugs and other chemicals are used, these must have a Control of Substances Hazardous to Health (COSHH) assessment and be stored securely both in a lockable unit and room.

The preparation and dosing of allergen should be accurately carried out using the right equipment for the respective test. In cases where photo patch testing is undertaken, the equipment must be regularly calibrated to ensure an accurate dose of UVA is administered.

#### Essential Criteria

5A.1	Lockable standalone refrigerator and freezer for the safe storage of allergens at the required temperatures. Patch test materials should be stored at 4°C and protected from light. For some of the products (or patch test substances), storage at -18°C is recommended, for example isocyanates.
5A.2	Some contact allergens with high vapour pressure, such as some fragrance chemicals, acrylates, and isocyanates, are unstable and require more frequent renewal and strict storage conditions. Acrylates degrade at the tip of the syringe containing the allergen and a small amount should be discarded at the beginning of that day's patch test preparation. Glutaraldehyde in petrolatum and formaldehyde in aqueous solution are also subject to instability and deterioration. It is important to keep a log of and respect expiry dates.
5A.3	The critical factor for sensitisation and elicitation of contact allergy is the 'dose per unit area. It is important for the dose of allergen to be standardised for each type of test chamber. Generally, petrolatum-based patch test substances should be loaded into the test chambers shortly before application of the patches (no longer than a few hours), liquids and some volatile petrolatum-based substances (e.g. acrylates) at the time of application.
5A.4	Resuscitation trolley must be nearby in the event of an anaphylactic reaction.

5A.5	Photo patch testing equipment must be regularly calibrated to ensure an accurate dose of UVA is administered.
5A.6	Disposable containers, syringes, stirrers and spatulas should be used for preparing the test substances. Solid materials in crystal or powder form can be ground with a pestle and mortar.
5A.7.	Units must ensure that their facilities are suitable with respect to design, layout and service users' rights to privacy and dignity. This includes appropriate space for patients to change and store personal belongings. Waiting areas must be suitable for children and be fully accessible.
5A.8	Every patch test service requires a dedicated allergen preparation area, with secure, lockable refrigerators and freezers, for the storage of allergens. Facilities should have appropriate ventilation and cooling to maintain a comfortable environment for staff and patient and to ensure satisfactory operation of equipment.
5A.9	Written Physicist dosimetry protocols should be in place, which take account of currently available guidelines and local factors (e.g. BPG Guidelines, 2002; Scottish UV Dosimetry Guidelines, 2001; IPEM Report 76, 1997). The responsibility for ensuring that these are of a suitable standard lies with the Medical Physicist/other designated person with suitable expertise in Medical Physics.

#### Examples of Suitable Evidence

- COSHH risk assessment report.
- Refrigerator and freezer temperature logbook or record.
- Allergens logbook or record with storage and expiry dates.
- Micropipettes are used to dispense allergens in aqueous solution.
- Evidence that UVA equipment is regularly calibrated for photo patch test services.
- Equipment order.

#### Audit Outcomes

#### Status

100%	Compliant COSHH RISK assessment report including evidence that ventilation requirements are met.	Yes <b>Green</b> No <b>Red</b>
100%	Specialised services should stock extended acrylate, epoxy, formaldehyde resin and plastic series and be fully compliant with UK	Yes <b>Green</b> No <b>Red</b>

	Standards of Care for Occupational Contact Dermatitis and Occupational Urticaria.		
100%	All units must be able to appropriately dilute a patient's own workplace sample.	Yes <b>Green</b> No <b>Red</b>	
100%	Name of medical physicist, or other person with suitable expertise in medical physics, designated as responsible for UV measurements to be provided by phototherapy unit for photo patch testing.	Yes <b>Green</b> No <b>Red</b>	
100%	Evidence that facilities are suitable with respect to design, layout and service users' rights to privacy and dignity, as specified in the Department of Health's Health Building Notes 00-02; 00-03 and 12, respectively.	Yes <b>Green</b> No <b>Red</b>	
100%	All units must have access to secure, lockable refrigerators and freezers, for the storage of allergens	Yes <b>Green</b> No <b>Red</b>	
<b>Self-Assessment and Audit Questionnaire – Review of 50 Patient Cases</b>		<b>YES</b>	<b>NO</b>
Q1.	Does the patch test unit have an up-to-date COSHH risk assessment report?		
Q2.	Are all allergens logged with their expiry date and storage temperatures?		
Q3.	Are all allergens stored within their required temperatures and renewed before their expiry date?		
Q4.	Does the department have a medical physicist responsible for UV measurements for photo patch testing?		
Q5.	Does the department have suitable facilities for allergen preparation and storage?		

## STANDARD 6: Clinical Governance and Audit

### Standard Statement 6A: Clinical Governance and Audit Meetings

#### Rationale

Patch test services should operate within the departmental clinical governance process. It is recommended as a minimum a clinical governance framework for a patch test service should include a named patch test lead clinician. The role of the lead clinician is to take clinical responsibility for ensuring that the service is safe, effective and complies with:

- National service delivery standards;
- Treatment-specific guidelines;
- Disease specific guidelines.

The patch test service is delivered by a multi-professional team. Members of the team and their roles in contributing to the service should be recorded. Team members would typically include the following: dermatology consultants, specialty grade doctors, patch test nurses, medical physicists, trainee grade doctors, pharmacists.

#### Essential Criteria

6A.1	The Patch test team should have regular team meetings. The broad aim of these meetings is to ensure that the service is focused on the need to provide timely, safe and effective Patch test services to local patients.
6A.2	<p>The agenda for these regular clinical governance meetings should include the following elements:</p> <ul style="list-style-type: none"> <li>• Review of patch test activity since the previous meeting (summary of treatment numbers for each clinician).</li> <li>• Review of patch test waiting list data (if a waiting list exists) to assess demands on the service and issues for service delivery.</li> <li>• Review of adverse events. All adverse events should be discussed by the team. Where patient safety is an issue, the team need to consider the cause of the adverse event, and measures to be taken if necessary, to avoid a repeat in the future.</li> <li>• Discussion of difficult or instructive cases. As with any clinical therapy service, there may be some cases that are atypical or unusual. Discussion of these cases is often instructive for team members and may improve patient outcomes.</li> </ul>
6A.3	Standardised methods for recording incidents on DATIX or equivalent incident reporting systems.

6A.4	A record should be kept of the performance of the key safety checks in the patient pathway by the patch test team, or individual on the team's behalf.
6A.5	Unexpected irritant reactions may be seen when non-standard allergens or products are tested, despite appropriate dilution based on the available product information. A patch test reaction may rarely result in localised transient hyperpigmentation or hypopigmentation in some patients. A positive patch test reaction can sometimes persist for up to several weeks for example gold chloride 0.5% aq. is notorious for causing persisting reactions

#### Examples of Suitable Evidence

<ul style="list-style-type: none"> <li>Structured electronic documentation of all investigative information/results, together with basic demographic and clinical information: site of onset of dermatitis (and duration); gender; occupation and leisure activities; patch test results (including type (allergic/irritant) and severity; and final diagnosis.</li> </ul>
<ul style="list-style-type: none"> <li>Minutes of Clinical Governance Meetings discussing outcome reports of adverse events and lessons learned.</li> </ul>
<ul style="list-style-type: none"> <li>Case based discussions of challenging patch test patients and outcomes</li> </ul>
<ul style="list-style-type: none"> <li>Waiting list cases and prioritisation of high-risk cases.</li> </ul>
<ul style="list-style-type: none"> <li>Record of DATIX or other Incident reporting system data for serious incidents.</li> </ul>

Audit Outcomes		Status
100%	There should be at least four full team meetings a year or alternative attendance at neighboring patch test centre meetings where a service has a single-handed consultant.	Yes <b>Green</b> No <b>Red</b>
>80%	Team members must attend full team meetings, with attendance monitored.	Yes <b>Green</b> No <b>Red</b>
100%	All adverse events should be appropriately documented and investigated, with remedial measures instituted.	Yes <b>Green</b> No <b>Red</b>
100%	Lessons learned are in a written report and system changes were implemented are recorded as outcomes.	Yes <b>Green</b> No <b>Red</b>
100%	Yearly review of allergens product list to update series to national series.	>95% <b>Green</b> 70-94% <b>Yellow</b> <70% <b>Red</b>

Self-Assessment and Audit Questionnaire – Review of 50 Patient Cases		YES	NO
Q1.	Does the patch test unit have quarterly team meetings to discuss and review the service?		
Q2.	Does the patch test unit attend regular clinical governance meetings?		
Q3.	Does the patch test unit have records of performance for key safety checks?		
Q4.	Is there a DATIX/incident reporting system for adverse reactions?		
Q5.	Is there a record of positive patch test records for audit purposes?		

## STANDARD 7 – Discharging Patients

### Standard Statement 7A – Patient Education and Management

#### Rationale

Allergic contact dermatitis may completely resolve following successful education of the patient on allergen avoidance, with workplace conditions being addressed as required, provided that exposure can be sufficiently reduced.

Sufficient time should be allowed to discuss the allergies in detail with the patient, explaining potential sources of exposure and to advise on how to avoid future skin contact with the allergen. Ingredient label reading of any personal products intended for use on their skin is recommended, so that the patient can identify whether the product is free of the allergen.

#### Essential Criteria

7A.1	All patients should be given a clear plan for managing their dermatitis following the results of their patch tests, with all findings documented in the GP letter and their hospital record.
7A.2	Patients should also be offered a copy of the discharge letter for their records; with a list of the allergens they should avoid and look for in products which they use daily.
7A.3	Systematic evaluation of patients with occupational dermatitis needs to address diagnoses, the affected site, the offending work material and the causative allergen or irritant for optimal patient counselling and exposure reduction.

#### Examples of Suitable Evidence

- Copy of the discharge letter and relevant patient information in the patient notes.
- Discharge letters from 50 patient's cases over a 6-month period.
- Occupational health assessment report to employer on patch test outcomes.

#### Audit Outcomes

100%	Patients are offered a discharge letter containing advice relevant to the allergic reactions seen and allergen specific management information.	100% <b>Green</b> 70-99% <b>Yellow</b> <70% <b>Red</b>
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>90%	Discharge letters are sent to the GP (referred)/Occupational Health Assessor and patient (where applicable) within seven working days of the patient being seen.	>90% <b>Green</b> 70-90% <b>Yellow</b> <70% <b>Red</b>	
<b>Self-Assessment and Audit Questionnaire – Review of 50 Patient Cases</b>		<b>YES</b>	<b>NO</b>
Q1.	Are discharge letters sent to the patient’s GP/occupational health assessor (and the patient if requested)?		
Q2.	Are all patients given appropriate care and management advice for their skin disease within seven working days of discharge?		
Q3.	Are patients given a copy of their occupational health report (if relevant) after discharge?		

## References

Evidence searches were made using the following electronic databases in July 2014: Cochrane Library; PubMed; British Medical Journal (BMJ); British Journal of Dermatology (BJD); Royal Society of Medicine (RSM) Library.

Our selection criteria included the headings from our Service Guidance and Standard's core principles, on a generalist and clinical intervention level (e.g. general facilities versus clinical intervention-specific facilities). This provided us with a wider scope, due to the limited availability of service-based evidence.

Evidence Search: July 2014 (Updated 2017)

	Standard						
	1	2	3	4	5	6	7
<b>Core Evidence</b>							
Confidentiality. General Medical Council. 2009.	X	X	X	X	X	X	X
Confidentiality. NHS Code of Practice. 2003.	X	X	X	X	X	X	X
COSSH Risk Assessments							
Curriculum Framework for Qualifying Programmes in Physiotherapy. Chartered Society of Physiotherapy. 2002.			X				
Data Protection Act 1998.	X	X	X	X	X	X	X
Department of Health. Health Building Note 00-02: Sanitary Spaces.					X		
Department of Health. Health Building Note 00-03: Clinical and Clinical Support Spaces.					X		
Department of Health. Health Building Note 12: Out-patients Department.					X		
Department of Health. The NHS Constitution for England (last updated 2015).	X	X	X	X	X	X	X
Disability Discrimination Act 1995 and 2005.	X	X	X	X	X	X	X
Essential Standards of Quality and Safety. Care Quality Commission. 2010.	X	X	X	X	X	X	X
Fitness to Practice Rules: Nursing and Midwifery Council. 2004.			X	X			
Good Medical Practice. Standards and Ethics Guidance for Doctors. 2013.	X	X	X	X	X	X	X
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9: Person-Centred Care.	X	X	X	X	X	X	X

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10: Dignity and Respect.				X	X	X	
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11: Need for Consent.		X					
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15: Premises and Equipment.					X		
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good Governance.	X	X	X	X	X	X	X
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18: Staffing.			X	X			
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19: Fit and Proper Persons Employed.			X	X			
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Duty of Candour.	X	X	X	X	X	X	
Health and Safety Executive (HSE) Guidance							
How to Write in Plain English. The Plain English Campaign.	X	X	X	X	X	X	X
National Health Service England. 2016/17 National Tariff Payment System.				X			
National Health Service Standard Contract 2016/17.	X	X	X	X	X	X	X
National Institute for Health and Care Excellence. Health and Social Care Directorate Quality Standards Process Guide. 2014.	X	X	X	X	X	X	X
NHS Service Contract for Acute and secondary care	x	x	x	x	x	x	x
Nursing and Midwifery Council Registration.			X				
Principles for best practice in clinical audit. NICE. 2008.					X	X	
Records Management. NHS Code of Practice. 2006.		X		X		X	
Specialty Training Curriculum for Dermatology. 2010 (amended 2012). Joint Royal Colleges of Physicians Training Board.			X				
Standards for medicines management. Nursing and Midwifery Council. 2008.					X		
Standards for competence for registered nurses: Nursing and Midwifery Council			x	x			
The Fundamental Standards. Care Quality Commission.	X	X	X	X	X	X	X
<b>Specialist Evidence</b>							

BAD and BSCA working party report on setting standards for Cutaneous Allergy services.	X	X	X	X	X	X	X
British Association of Dermatologists' Guidelines for the Management of Contact Dermatitis 2017. GA Johnston, LS Exton, MF Mohd Mustapa, JA Slack, IH Coulson, JSC English, JF Bourke. British Journal of Dermatology 2017 (in press)	X	X	X	X	X	X	X
British Occupational Health Research Fund systematic review of contact dermatoses <a href="http://www.bohrf.org.uk/projects/dermatitis.html">http://www.bohrf.org.uk/projects/dermatitis.html</a>							
Cutaneous Allergy Business Case Template. British Association of Dermatologists. June 2013.	X	X	X	X	X	X	X
De Groot AC. Patch testing, 3rd Edition: Update 2008 – 2015. Wapserveen, The Netherlands: acdegroot publishing, 2015 ISBN/EAN: 978-90-813233-2-1					X		
European Society of Contact Dermatitis guideline for diagnostic patch testing – recommendations on best practice. Contact Dermatitis, 73, 195–221.	X	X	X	X	X	X	X
Patch testing with hair cosmetic series in Europe: a critical review and recommendation. Uter W, Bensefa-Colas L, Frosch P, Giménez-Arnau A, John SM, Lepoittevin JP, Lidén C, White IR, Duus Johansen J. Contact Dermatitis. 2015;73:69-81.				X			
Patch testing with rubber series in Europe: a critical review and recommendation. Warburton KL, Uter W, Geier J, Spiewak R, Mahler V, Crépy MN, Schuttelaar ML, Bauer A, Wilkinson M. Contact Dermatitis. 2017; 76: 195-203.				X			
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Prevalence of contact allergy in the general population in different European regions. Diepgen TL, Ofenloch RF, Bruze M, Bertuccio P, Cazzaniga S, Coenraads PJ, Elsner P, Goncalo M, Svensson Å, Naldi L. Br J Dermatol. 2016 Feb;174(2):319-29. doi: 10.1111/bjd.14167.	X	X	X	X	X	X	X
Prevalence of Contact Allergy to p-Phenylenediamine in the European General Population. Diepgen TL, Naldi L, Bruze M, Cazzaniga S, Schuttelaar ML, Elsner P, Goncalo M, Ofenloch R, Svensson Å. J Invest Dermatol. 2016 Feb;136(2):409-15.	X	X	X	X	X	X	X
Prevalence of fragrance contact allergy in the general population of five European countries: a cross-sectional study. Diepgen TL, Ofenloch R, Bruze M, Cazzaniga S, Coenraads PJ, Elsner P, Goncalo M, Svensson Å, Naldi L. Br J Dermatol. 2015 Dec;173(6):1411-9.	X	X	X	X	X	X	X

The Detection of Clinical Relevant Contact Allergens with a Standard Screening Tray of 28 Allergens. Patel D, Belsito DV. Contact Dermatitis, 2012; 66: 154-8.				X			
TRUE Test, A Reliable Method for Patch Testing in the Community? Foulds I. Br J Dermatol, 2007; 157 suppl 1: 85.				X			
UK Standards of Care for Occupational Contact Dermatitis and Occupational Urticaria. Adishes A, Robinson E, Nicholson P, Sen D, Wilkinson SM. Br J Dermatol 2013; 168: 1167-1175					X		

## Prevalence and Incidence

Evidence searches were made using the following electronic databases in July 2014: Cochrane Library; PubMed; British Medical Journal (BMJ); British Journal of Dermatology (BJD); Royal Society of Medicine (RSM) Library. Where NICE Guidance exists for the clinical indication or skin disease area, the citations contained within inform on the prevalence and incidence evidence and services, where relevant.

Search strategy: Contact dermatitis textbooks and a literature search in July 2014 using combinations of the search terms 'patch testing, contact dermatitis, contact allergy and technique' revealed numerous publications. A large number of those dealing with technical aspects (test systems, test materials, allergens, vehicles, concentration, and stability) were reviewed, and recent references were selected. The number of up-to-date controlled clinical experiments is limited, and many of the current standards in clinical use are based on old studies, which do not provide a high level of evidence.

Contact dermatitis (eczema) accounts for 4.7% of dermatological consultations. By adolescence, 15% of children have become sensitised to a contact allergen, and 7% give a history of reacting following exposure<sup>7</sup>; this allergy usually lasts for life. By adulthood, 27%<sup>8</sup> of the population has developed cutaneous sensitisation to at least one allergen in the EU baseline series. It has been estimated that 14.5% of the general population is allergic to nickel<sup>4</sup> and the conservatively estimated prevalence of fragrance contact allergy is 1.9%<sup>9</sup>, with contact allergy to p-Phenylenediamine was 0.8%<sup>10</sup>.

Skin disease is the second commonest physical occupational disease in the European Union, after musculoskeletal disorders. Contact dermatitis accounts for 70-90% of all occupational skin disease, while contact urticaria accounts for less than 10%. Up to half of workers with

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<sup>7</sup> Prevalence of atopic dermatitis, asthma, allergic rhinitis, and hand and contact dermatitis in adolescents. The Odense Adolescence Cohort Study on Atopic Diseases and Dermatitis. C.G.Mortz, J.M.Lauritsen, C.Bindslev-Jensen, K.E.Andersen. *Br J Dermatol* 2001; 144: 523-32.

<sup>8</sup>Prevalence of contact allergy in the general population in different European regions. Diepgen TL, Ofenloch RF, Bruze M, Bertuccio P, Cazzaniga S, Coenraads PJ, Elsner P, Goncalo M, Svensson Å, Naldi L. *Br J Dermatol*. 2016 Feb;174(2):319-29. doi: 10.1111/bjd.14167.

<sup>9</sup> Prevalence of fragrance contact allergy in the general population of five European countries: a cross-sectional study. Diepgen TL, Ofenloch R, Bruze M, Cazzaniga S, Coenraads PJ, Elsner P, Goncalo M, Svensson Å, Naldi L. *Br J Dermatol*. 2015 Dec;173(6):1411-9.

<sup>10</sup> Prevalence of Contact Allergy to p-Phenylenediamine in the European General Population. Diepgen TL, Naldi L, Bruze M, Cazzaniga S, Schuttelaar ML, Elsner P, Goncalo M, Ofenloch R, Svensson Å. *J Invest Dermatol*. 2016 Feb;136(2):409-15.

occupational contact dermatitis experience adverse effects on quality of life, daily function and relationships at home.<sup>11</sup>

Allergic contact dermatitis in children does occur but has been under-recognised and only recently more extensively studied. Many physicians consider atopic dermatitis as the only diagnosis when children of all ages suffer from eczema. In reality, all children, whether atopic or not, may become sensitised to environmental chemicals such as topical pharmaceuticals and cosmetic products, to topical products used by their caregivers (dermatitis by proxy), or to any other material that comes into prolonged contact with the skin.

The spectrum of contact allergens of adolescents is more similar to that of adults, including contact with occupational sensitisers. Patch testing in children is considered to be safe and is recommended when allergic contact dermatitis is suspected or needs to be excluded, as in adults.

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<sup>11</sup>British Occupational Health Research Fund systematic review of contact dermatoses <http://www.bohrf.org.uk/projects/dermatitis.html>

## Glossary of Abbreviations and Terms

<b>BAD</b>	British Association of Dermatologists
<b>BSCA</b>	British Society for Cutaneous Allergy
<b>CCG</b>	Clinical Commissioning Group
<b>CCT</b>	Certificate of Completion of Training
<b>COSHH</b>	Control of Substances Hazardous to Health
<b>CPD</b>	Continued Professional Development
<b>CQC</b>	Care Quality Commission
<b>CQUIN</b>	Commissioning for Quality and Innovation
<b>DLQI</b>	Dermatology Life Quality Index
<b>DQIP</b>	Data Quality Improvement Plans
<b>GP</b>	General Practitioner
<b>HSE</b>	Health and Safety Executive
<b>INCI</b>	International Nomenclature of Cosmetic Ingredients
<b>INN</b>	International Nonproprietary Names
<b>MCN</b>	Managed Clinical Network
<b>MDT</b>	Multi-Disciplinary Team: all health professionals involved in patient care
<b>NHS</b>	National Health Service
<b>NICE</b>	National Institute for Health and Clinical Excellence
<b>NMC</b>	Nursing and Midwifery Council
<b>NRSL</b>	National Reporting and Learning System
<b>PIL</b>	Patient Information Leaflet
<b>PMETB</b>	Postgraduate Medical Education and Training Board
<b>PPI</b>	Patient and Public Involvement
<b>RCP</b>	Royal College of Physicians

<b>SAS</b>	Staff and Associate Specialist
<b>SDIP</b>	Service Development and Improvement Plan
<b>SI</b>	Serious Incident
<b>STA</b>	Specialist Training Authority
<b>STEIS</b>	Strategic Executive Information System
<b>WPG</b>	Working Party Group

### **Acceptance of Referrals and Non-Contract Activity**

The Contract (full-length) includes a specific requirement on providers (SC6.6.2) to accept every referral, regardless of the identity of the Responsible Commissioner, where this is necessary to enable a patient to exercise his/her legal right of choice of provider. This applies whether or not the Responsible Commissioner for the patient affected is a party to a written contract with the provider. As a guideline, NHS England strongly recommends that any Clinical Commissioning Group (CCG) with activity of over £200,000 per annum with an acute provider should put in place a written contract.

### **Contact dermatitis**

An inflammatory skin reaction caused by direct contact with noxious agents in the environment. The pathomechanism may involve immunological hypersensitivity (allergy) or not (irritant contact dermatitis), or may be mixed.

### **Contact allergy**

Is an altered immune status of an individual induced by a particular sensitising substance, a contact allergen. This involves a clinically unapparent sensitisation phase, also called the induction phase, resulting in the expansion of a clone of allergen-specific T cells. At this point, an individual is immunologically sensitised

### **Cross-sensitivity**

Occurs when a person sensitised to a particular allergen also reacts to another, structurally related allergen to which he or she has not been previously sensitised. The allergens involved are usually chemically similar, sometimes after oxidation or metabolic transformation in the skin.

### **Accredited specialist**

An accredited specialist is a doctor whose specialty is recorded in the General Medical Council's list of registered medical practitioners. He/she is a doctor who has completed specialist training

in their specialty approved by the Postgraduate Medical Education and Training Board (PMETB) or its predecessor the Specialist Training Authority (STA) or an appropriate competent authority in other Member States of the European Economic Area. Others will have been found eligible by the PMETB or the STA following an assessment of the specialist training undertaken and/or the specialist qualifications awarded elsewhere.

### **Audit**

Systematic review of the procedures used for diagnosis, care, investigation and rehabilitation, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient.

### **Clinic Letters**

NHS England has included a new requirement on providers to communicate clearly and promptly with GPs following outpatient clinic attendance, where there is information which the GP needs quickly in order to manage a patient's care. For 2017/18, they intend to strengthen this requirement, requiring electronic transmission of clinic letters to practices as with discharge summaries to a similar timescale.

### **Clinical audit**

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery (NICE).

### **Clinical governance**

Clinical governance provides a quality framework through which healthcare organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.

### **Clinical Networks**

Groups of commissioners and providers of health or social care, concerned with the planning and/or delivery of integrated health or social care across organisational boundaries, whether on a national, regional or local basis.

### **Clinical practice guidelines**

Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances. They aim to provide evidence-based interventions to improve patient outcomes.

## **Clinical supervision**

Clinical supervision is a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence. Clinical Supervision is central to the process of learning and to the scope of the expansion of practice and should be seen as a means of encouraging self-assessment analytical and reflective skills.

## **Clinician**

A clinician is a professionally qualified person providing clinical care to patients.

## **Commissioning for Quality and Innovation (CQUIN)**

CQUIN is the national quality incentive scheme. Guidance on CQUIN will be available at: <https://www.england.nhs.uk/nhs-standard-contract/16-17/>.

## **Competent**

Competent means that the individual can perform the task with ability.

## **Consent**

The intention of this regulation is to make sure that all people using the service, and those lawfully acting on their behalf, have given consent before any care or treatment is provided. Providers must make sure that they obtain the consent lawfully and that the person who obtains the consent has the necessary knowledge and understanding of the care and/or treatment that they are asking consent for. Providers must make sure that they take into account people's capacity and ability to consent, and that either they, or a person lawfully acting on their behalf, must be involved in the planning, management and review of their care and treatment.

## **Consultant**

A person employed or engaged by the provider of equivalent standing and skill as a person appointed by an NHS Body in accordance with the Law governing the appointment of consultants.

## **Consultant Led Service**

A service for which a consultant retains overall clinical responsibility (without necessarily being present at each service-user appointment), and in respect of which referrals of service-users are made directly to a named consultant.

## **Contract reviews**

Contract reviews are periodic evaluations performed by the service provider and the customer to ensure that the agreement specifies all of the customer's requirements and that all of those requirements are being satisfied.

## Counting and Coding Practice

Changes in counting and coding practice by providers are set out in the contract under section SC28. This requires that each party (provider and commissioner) gives the other at least six months' notice of proposed counting and coding changes, with the change normally taking effect from the start of the following Contract Year. The underlying requirement in SC28.7 is that activity should be recorded correctly in relation to national guidance (the NHS Data Dictionary, for instance). However, there will be instances where systematic incorrect recording is identified which is common for dermatology services and in such cases the process for notifying, agreeing and implementing changes to recording practice (to bring recording into line with national rules and guidance) set out in SC28.8 onwards must be followed.

The contractual provisions relating to the financial impact of any agreed counting and coding changes provide protection against this for both parties. SC28.11 sets out that the parties must make financial adjustments so that the overall financial impact of agreed changes is neutral. It is important that data quality and accuracy continue to improve, and NHS England recognise that it can be difficult to distinguish between gradual improvements in the accuracy of recording, based on better coding at individual patient level, and more systematic changes.

## Data

Data refers to all records and correspondence.

### The Data Protection Act

The [Data Protection Act](#) controls how your personal information is used by organisations, businesses or the government. Everyone responsible for using data has to follow strict rules called 'data protection principles'.

### Data Quality Improvement Plans (DQIP)

Data Quality Improvement Plans (DQIPs) allow the commissioner and the provider to agree a local plan to improve the capture, quality and flow of data to support both the commissioning and contract management processes. DQIPs should provide quantified assurance that action is being taken to improve capture where a data set exists and is relevant for the service and conforms to recognised national standards. Codes must map to national values etc. GC21.6 requires each provider to undertake audits of its performance against the Information Governance Toolkit, and these audits will be a valuable source of information about where data quality needs to be improved, including clinical information assurance and aspects of patient safety-related data quality.

### Department of Health

The Department of Health in England of HM Government or other relevant body, or such other body superseding or replacing it from time to time and/or the Secretary of State.

### Dermatology Life Quality Index (DLQI)

A quality of life questionnaire for adult dermatology patients. When using DLQI, healthcare professionals should take into account any physical, sensory or learning disabilities, or other

communication difficulties that could affect the responses to the DLQI. In such cases, healthcare professionals should ensure that the DLQI continues to be a sufficiently accurate measure.

### **Dignity and Respect**

The intention of this regulation is to make sure that people using the service are treated with respect and dignity at all times while they are receiving care and treatment. To meet this regulation, providers must make sure that they provide care and treatment in a way that ensures people's dignity and treats them with respect at all times. This includes making sure that people have privacy when they need and want it, treating them as equals and providing any support they might need to be autonomous, independent and involved in their local community. Providers must have due regard to the protected characteristics as defined in the Equality Act 2010.

### **Directly Bookable**

In relation to any Service, the Provider's patient administration system being compliant with and able to communicate with the NHS e-referral Service enabling available appointment slots to show on the NHS e-Referral Service, thereby enabling a Referrer or Service User to book a Service User appointment directly onto the Provider's patient administration system.

### **Duty of Candour**

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

### **Equality**

This means recognising that while people are different and need to be treated as individuals, everyone is the same in terms of having equal value, equal rights as human beings and a need to be treated with dignity and respect.

### **E-Referral Guidance**

The guidance in relation to e-referrals is available at: [www.chooseandbook.nhs.uk/staff/overview/guidance](http://www.chooseandbook.nhs.uk/staff/overview/guidance).

### **Expanded Uncertainty**

Expanded uncertainty is a standardised, internationally recognised method of expressing the margin of doubt for irradiance measurements.

### **Fit and Proper Staff**

The intention of this regulation is to make sure that providers only employ 'fit and proper' staff who are able to provide care and treatment appropriate to their role and to enable them to provide the regulated activity. To meet this regulation, providers must operate robust

recruitment procedures, including undertaking any relevant checks. They must have a procedure for ongoing monitoring of staff to make sure they remain able to meet the requirements, and they must have appropriate arrangements in place to deal with staff who are no longer fit to carry out the duties required of them.

### **Fit to practise**

The health professional possesses the appropriate knowledge, skills and experience to practise safely and effectively.

### **Formulary**

A list of medications that are approved by the Provider on the basis of their proven efficacy, safety and cost-effectiveness to be prescribed for Service Users by the Provider's clinical Staff.

### **Good Clinical Practice**

Using standards, practices, methods and procedures conforming to the Law and reflecting up-to-date published evidence and using that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced clinical services provider and a person providing services the same as or similar to the Services at the time the Services are provided, including (where appropriate) assigning a consultant to each service user who will be clinically responsible for that Service User at all times during the Service User's care by the Provider.

### **Good Governance**

The intention of this regulation is to make sure that providers have systems and processes that ensure that they are able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A). To meet this regulation; providers must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others. Providers must continually evaluate and seek to improve their governance and auditing practice. In addition, providers must securely maintain accurate, complete and detailed records in respect of each person using the service and records relating the employment of staff and the overall management of the regulated activity.

### **Health Building Notes**

Health Building Notes give "best practice" guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities. They provide information to support the briefing and design processes for individual projects in the NHS building programme

## **Health care**

Health care refers to services provided for or in connection with the prevention, diagnosis or investigation of illness, and the promotion and protection of public health.

## **Health Technical Memoranda**

Health Technical Memoranda give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare (for example medical gas pipeline systems, and ventilation systems).

## **Multidisciplinary**

A multidisciplinary team is a group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The composition of multidisciplinary teams will vary according to many factors. These include: the specific condition, the scale of the service being provided, and geographical/socio-economic factors in the local area.

## **National Price**

The national price for a health care service specified by the National Tariff, as may be adjusted by applicable national variation specified in the National Tariff under section 116(4)(a) of the 2012 Act.

## **National Quality Requirements**

The requirements set out in Schedule 4B (*National Quality Requirements*).

## **National Tariff**

The national tariff, as published by Monitor under section 116 of the 2012 Act (including any rules included under section 116(4)(b) of the 2012 Act), as applicable at the time at which the relevant Service is provided.

## **Never Events, Serious Incidents and Patient Safety Incidents**

Never Events are a particular type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event, particularly if there is evidence that the category of Never Event has occurred in the past, for example through reports to the National Reporting and Learning System (NRLS), and a risk of recurrence remains.

The current framework, including the detailed list of Never Events, is available at <http://www.england.nhs.uk/ourwork/patientsafety/>.

NHS England expects to publish an updated Never Events Policy Framework shortly, including a revised list of the events themselves. The sanction associated with Never Events is now set

out in SC36.38 of the Contract. Schedule 6C (Incidents Requiring Reporting Procedure), requires the provider to report any Serious Incidents (SIs) via the Strategic Executive Information System (STEIS) in line with the timeframes set out in the NHS Serious Incident Framework and ensure such incidents are also reported to the National Reporting and Learning System.

### **NHS Constitution for England**

The Constitution sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of the Constitution in their decisions and actions.

### **NHS Service Contract**

The NHS Standard Contract must be used by CCGs and by NHS England where they wish to contract for NHS-funded healthcare services (including acute and community-based services). The elements of the Contract for local agreement fall within the section 'Particulars'. The 'Service Conditions' outlined may be varied only by selection of applicability criteria, determining which clauses do and do not apply to the particular contract. The content of any applicable Service Condition may not be varied. The 'General Conditions' contained must not be varied at all. The contract creates legally binding agreements between NHS commissioners and foundation trusts, independent sector, voluntary sector and social enterprise providers. Agreements between commissioners and NHS trusts are 'NHS contracts' as defined in Section 9 of the National Health Service Act 2006. NHS trusts will use exactly the same contract documentation, and their contracts should be treated by NHS commissioners with the same degree of rigour and seriousness as if they were legally binding.

### **The National Institute for Health and Care Excellence**

Special health authority responsible for the provision of national guidance on the promotion of good health; and the prevention/treatment of ill health.

### **NICE Safe Staffing Guidelines**

The National Quality Board has set out the immediate expectation of NHS providers in providing safe staffing levels. This guidance is a comprehensive review of the evidence in this area and produce definitive guidelines on safe staffing to support local decisions at ward and organisational level.

### **Open test**

In the open test, a product, 'as is' or dissolved in water or some organic solvent (e.g. ethanol or acetone), is dripped onto the skin and allowed to dry. No occlusion is used. The usual test site is the volar forearm, but it is less reactive than the upper back or the upper arm. An open test is recommended as the first step for testing poorly defined sub-stances or products such as those brought by the patient (see section 'patch testing of patients' own materials').

Readings are made at regular intervals during the first 30–60 min after application, in order to detect immediate reactions, including urticaria. A second reading should be performed at D3–D4. A negative open test result can be explained by insufficient penetration but indicates that one may proceed with an occlusive patch test.

### **Patch testing with patients' own products**

Approximately 4000 contact allergens are known, but only several hundred commercially available allergen preparations exist. Testing with patients own products is the only way of finding new allergens in the clinic. Previously known allergens can be found in new types of product; that is, testing with patients' own materials may reveal previously unknown sources of sensitisation. In addition, patch testing with patients' own materials often helps in the assessment of the clinical relevance of an allergic reaction to standard allergens.

### **Peer review**

Peer review is a structured, consistent and objective evaluation of an organisation or its services or processes reflecting accepted standards. It should be performed by true peers i.e. similar professionals.

### **Person-Centred Care**

The intention of this regulation is to make sure that people using a service have care or treatment that is personalised specifically for them. This regulation describes the action that providers must take to make sure that each person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences. Providers must work in partnership with the person, make any reasonable adjustments and provide support to help them understand and make informed decisions about their care and treatment options, including the extent to which they may wish to manage these options themselves. Providers must make sure that they take into account people's capacity and ability to consent, and that either they, or a person lawfully acting on their behalf, must be involved in the planning, management and review of their care and treatment.

### **Photo patch testing**

Photo patch testing is mainly indicated in the study of photo-allergic contact dermatitis, where UV exposure is necessary to induce the hypersensitivity reaction. It can also be helpful in the study of any dermatitis on photo-exposed areas or photosensitivity resulting from the use of systemic drugs.

### **Premises and Equipment**

Are defined in regulations with the intention to make sure that the premises where care and treatment are delivered are clean, suitable for the intended purpose, maintained and where required, appropriately located, and that the equipment that is used to deliver care and treatment is clean, suitable for the intended purpose, maintained, stored securely and used properly. Providers retain legal responsibility under these regulations when they delegate responsibility through contracts or legal agreements to a third party, independent suppliers,

professionals, supply chains or contractors. They must therefore make sure that they meet the regulation, as responsibility for any shortfall rests with the provider.

## Quality

Quality is used in this document to denote a degree of excellence.

## Quality of Care

The Health and Social Care Act 2012 defines quality as encompassing three dimensions: clinical effectiveness, patient safety and patient experience.

- The Contract requires providers to run services in line with recognised good clinical or healthcare practice, and providers must comply with national standards on quality of care – the NHS Constitution, for instance, and the Fundamental Standards of Care regulations (SC1).
- The Contract sets clear requirements in respect of clinical staffing levels (GC5). Providers must continually evaluate individual services by monitoring actual numbers and skill mix of clinical staff on duty against planned numbers and skill mix, on a shift-by-shift basis; they must carry out and publish detailed reviews of staffing levels, and their impact on quality of care, at least every six months.
- The Contract requires providers to adhere to national guidance on specific service areas, such as duty of candour (SC35).
- The Contract requires the provider to put in place policies and procedures which will support high-quality care. Among these are the provisions on clinical audit (GC15 and SC26), consent (SC9), patient, carer and staff involvement and surveys (SC10, SC12), complaints (SC16) and incidents and Never Events (SC33).
- The Contract requires the provider to demonstrate that it is continually reviewing and evaluating the services it provides, taking into account patient feedback, complaints and surveys, Patient Safety Incidents and Never Events, learning lessons and implementing improvements (SC3).

These are set out in Schedules 4A and 4B. Both are sets of nationally mandated standards, with the Operational Standards derived specifically from the **NHS Constitution**. All providers are expected to achieve all of the Operational Standards and National Quality Requirements which relate to the commissioned services.

## Quality assurance

Quality assurance refers to the planned and systematic activities in a quality system that gives confidence or make certain that quality requirements for a product or service will be fulfilled.

## Repeated open application test

The ROAT is a standardised exposure test which aims to elicit allergic contact dermatitis in the test area. Test solutions, either commercial products or special test substances, are applied twice daily for up to 2 weeks (but sometimes for up to 4 weeks) on the exural (volar) aspect of

the forearm near the antecubital fossa. The size of the test area is usually 3 × 3 to 5 × 5 cm, and the amount of test substance should be sufficient to cover the test area. The applications continue until a reaction develops or until the end of the selected exposure period. The ROAT is used to clarify the relevance of selected positive and doubtful patch test reactions by testing (leave-on) cosmetics, topical drugs, and other suitable formulations.

## **Research**

Research is the gathering of data, information and facts and aims to derive generalisable new knowledge.

## **Scope of practice**

Scope of practice refers to the areas of a health professional's occupation where they have the knowledge, skills and experience to practise safely and effectively.

## **Secondary Care**

Services provided as part of the health service in a hospital setting, or by those working in or based in a hospital setting, other than emergency services, primary care services etc.

## **Semi-open test**

A semi-open test mainly for testing patient-supplied products with suspected irritant properties, for example shampoos, detergents, paints, varnishes, cooling fluids, pharmaceuticals and some cosmetics. A small amount of the product is applied with a cotton swab on an area (1 cm<sup>2</sup>) of the skin, allowed to dry completely, checked for signs of contact urticaria, and then covered with permeable tape. Readings are performed in the same way as for patch testing. Immediate reactions may appear after 20–30 min as a sign of contact urticaria, and dermatitis reactions may develop at D2–D4. This is a diagnostic tool that requires some experience for interpretation.

## **Service Development and Improvement Plans (SDIP)**

Unless specifically mandated in the contract, SDIPs are for local agreement between the NHS Providers and commissioners. SDIPs may for instance include productivity and efficiency plans agreed as part of the provider's contribution to local commissioner QIPP plans; or any agreed service redesign programmes; or any priority areas for quality improvement such as those defined in NICE GUIDANCE or national Service Standards.

## **Service level agreement or customer service agreement**

A service level agreement or customer service agreement is a document which specifies the services that will be delivered and the way in which they will be delivered to ensure uniform understanding.

## **Service Specification**

The service specifications are one of the most important parts of the NHS contract, as they describe the services being commissioned and can, therefore, be used to hold the provider to account for the delivery of the services, as specified. Service specifications should be recorded in Schedule 2A of the Particulars and should set out in a brief summary any relevant context /scope of the service either at a national or local level; applicable measures relating to these should be set out in Schedule 4 (Quality Requirements) and Service Standards which the service should adhere to e.g. NICE standards, and nationally agreed standards.

## **Staff**

The entire group of people who work at an organisation including those who are:

- Employed / agency / bank / voluntary.
- Clinical e.g. nurses, doctors and occupational health technicians.
- Non-clinical e.g. administrative staff.

## **Staffing**

The intention of this regulation is to make sure that providers deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements described in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. To meet the regulation, providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times and the other regulatory requirements set out in this part of the above regulations. Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. They should be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show that they meet the professional standards needed to continue to practice.

## **Treatment**

In Regulation 2(2) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, treatment includes: a diagnostic or screening procedure carried out for medical purposes, the ongoing assessment of a person's mental or physical state, Nursing, personal and palliative care, and giving vaccinations and immunisations. This regulation excludes the regulated activity of assessment or medical treatment for persons detained under the 1983 Act.

## Acknowledgements

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No conflicts of interest were recorded in the development of these Service Standards.

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## Pilot Sites

We would like to thank the following NHS departments for agreeing to pilot these standards and for their valuable feedback.

- Royal Devon and Exeter NHS Foundation Trust
- Leeds Teaching Hospitals NHS Foundation Trust
- Luton and Dunstable University Hospital NHS Foundation Trust
- South Eastern Health and Social Care Trust
- Portsmouth Hospitals NHS Trust

## Cutaneous Allergy Services Standards Consultation Form

We hope that you have found the Cutaneous Allergy Service Standards useful and would very much appreciate your feedback.

Your comments will be acknowledged by the CSU and any necessary changes to guidance incorporated into our next review of this publication.

1. Have you found these standards useful? Yes/No  Comments: <i>Type here</i>
2. Do you have suggestions for new sections or topic areas you would like to see included in future versions?  <i>Type here</i>
3. Do you have suggestions for new standards you would like to see included in future versions?  <i>Type here</i>
4. Do you have any general suggestions about this document that would improve its usefulness?  <i>Type here</i>
5. What is your profession?  <i>Type here</i>

Thank you for taking the time to complete this form. Please return to the attention of Paul Callaghan at [servicestandards@bad.org.uk](mailto:servicestandards@bad.org.uk) or posted to The British Association of Dermatologists, Clinical Services Unit, Willan House, 4 Fitzroy Square, London, W1T 5HQ.

# Appendix 1: Specialty Training Curriculum for Dermatology

## Section B

### Modular Elements

These elements will be undertaken as a module during specialist training. The timing of the module will depend on the individual training programme. There is no final column indicating 'year' for acquisition of competence as all competencies are expected to be gained at completion of the module.

#### 1a. Cutaneous Allergy, Contact Dermatitis and Occupational Dermatoses

<b>To be able to investigate, diagnose and manage patients with skin allergy, including presentations of contact dermatitis and contact urticaria</b>		
<b>To be able to investigate, diagnose and manage patients with common occupational dermatoses</b>		
<b>Knowledge</b>	<b>Assessment Methods</b>	<b>GMP</b>
Explain mechanisms involved in allergic and irritant contact dermatitis	CbD, SCE	1
Define the investigation of contact dermatitis within an occupational setting	CbD, SCE	1
Explain the indications for patch testing and photo patchtesting	CbD, SCE	1
Identify allergens within the British standard series	CbD, SCE	1
Describe contraindications to patch testing	CbD, SCE	1
State limitations of patch test results	CbD, SCE	1
Explain use of control patients	CbD, SCE	1
<b>Skills</b>		
Perform thorough history taking in patients with suspected contact dermatitis	CbD, mini-CEX	1
Distinguish clinical patterns of dermatitis likely to be associated with skin allergy	CbD, mini-CEX	1
Formulate appropriate pre-patch test diagnosis	CbD, mini-CEX	1
Select appropriate allergens for patch testing and photo patchtesting	CbD, mini-CEX	1
Demonstrate application of patch tests and instructions of patients during the patch test procedure	CbD, DOPS, mini- CEX	1
Interpret patch test results	CbD, mini-CEX	1
Interpret material safety data sheets	CbD, mini-CEX	1
Communicate test results to patients	CbD, mini-CEX	1,3
Discuss preparation of specific products for patch testing, including patient's own products	CbD, mini-CEX	1
Demonstrate use of repeated open application test	CbD, mini-CEX	1

<b>Behaviours</b>		
Recognise use of patch testing in the assessment of suspected contact dermatitis	CbD, mini-CEX	1,2
Contribute to multidisciplinary team including specialist nurses and pharmacy	CbD, mini-CEX, MSF	1,3
Choose appropriate patients for patch testing and recognise importance of results	CbD, mini-CEX	1
<b>Teaching and Learning Methods</b>		
Observation and discussion with senior medical and nursing staff in patch testing department		
Supervised outpatient patch test clinics with specialist consultants with expertise in contact dermatitis		
Independent study		
Attend appropriate course		
Supervised workplace visit to assess occupational dermatoses		
Methods agreed by Educational Supervisor and Trainee		

### 1c. Prick Testing

<b>To be able to evaluate patients for contact urticaria and type I hypersensitivity and perform prick testing safely</b>		
	<b>Assessment Methods</b>	<b>GMP</b>
<b>Knowledge</b>		
Define indications for prick testing	CbD, SCE	1
Explain mandatory precautions, and indications for adrenaline auto-injector	CbD, SCE	1
Outline resuscitation techniques	CbD, SCE	1
Identify precautions necessary for latex allergic patients	CbD, SCE	1
<b>Skills</b>		
Performs procedures for testing for suspected contact urticaria and type I hypersensitivity	DOPS, mini-CEX	1
Demonstrate adrenaline auto-injector use	DOPS, mini-CEX	1
<b>Behaviours</b>		
Recognises dangers of prick testing	CbD, MSF	1
<b>Teaching and Learning Methods</b>		
Observation and performance of testing under supervision in outpatients		
Attendance on cardiopulmonary resuscitation course		
Methods agreed by Educational Supervisor and Trainee e.g. e-learning modules		

# Appendix 2: Post CCT Training Curriculum

<http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=6066>

## Appendix 3: Core List of Auditable Evidence for Services

50 x Patient case notes for cutaneous allergy investigations – anonymised information

Referral forms

Consent forms

Complaint letters - anonymised

Incident reports about the cutaneous allergy service

Activity data for the cutaneous allergy service (last 12 months)

List of unit staff

Evidence of staff appraisal

Up-to-date written patch test protocols

Evidence of clinical governance meetings

Record of risk-assessment inspections for unit equipment

Record of protocol covering staff exposure to UV

Record of calibration inspections for unit equipment

\*Please note that there may be additional evidence to be submitted as part of this process.

# Appendix 4: Specialised Service Specification for Dermatology

<https://www.england.nhs.uk/wp-content/uploads/2013/06/a12-spec-dermatology.pdf>

## Appendix 5: Department of Health: Health Building Notes: Clinical and Support Spaces

The Department of Health's Health Building Notes give 'best practice' guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities.

Health Technical Memoranda give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare (for example medical gas pipeline systems, and ventilation systems).

They are applicable to new and existing sites, and are for use at various stages during the inception, design, construction, refurbishment and maintenance of a building.

The following diagrams demonstrate core requirement for a safe and compliant patch test service.

Figure 1 Consulting room

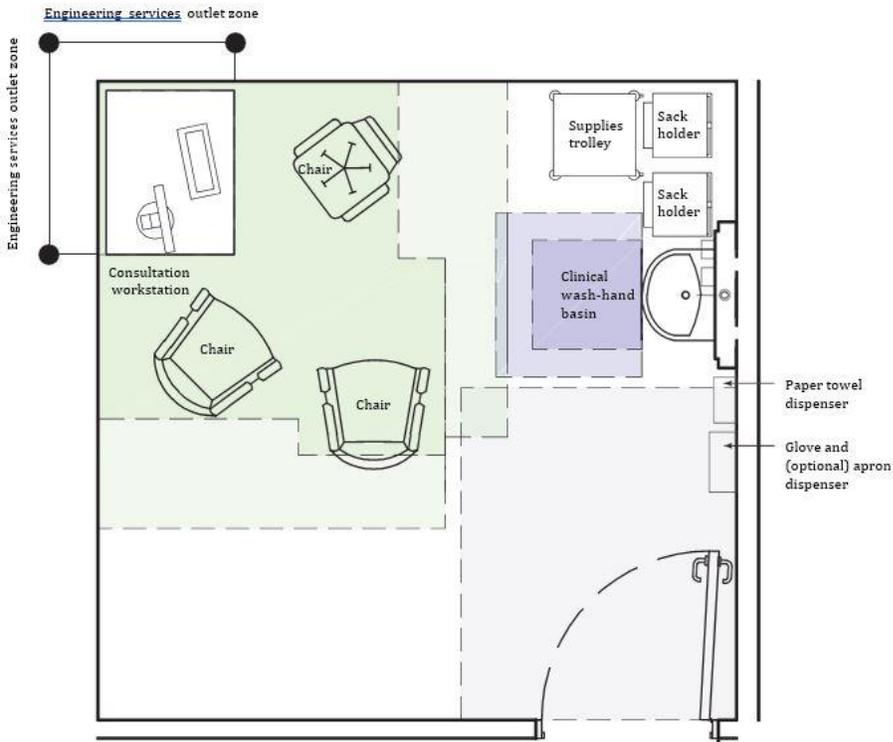


Figure 2 Combined versus separate consulting and examination rooms

Example 1: 4 Consulting/examination rooms (@ 16 m<sup>2</sup>)

Range of uses:

1-4 doctors

1-4 clinic sessions

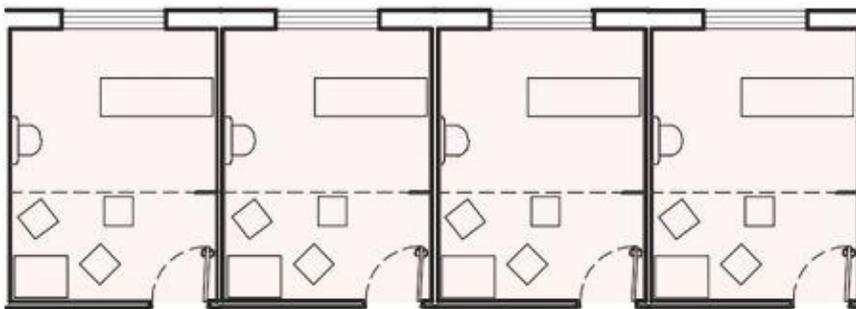


Figure 2.1: 2 Consulting and 4 examination rooms (@ 12 m<sup>2</sup>)

Range of uses:  
 1-2 doctors  
 1-2 clinic sessions

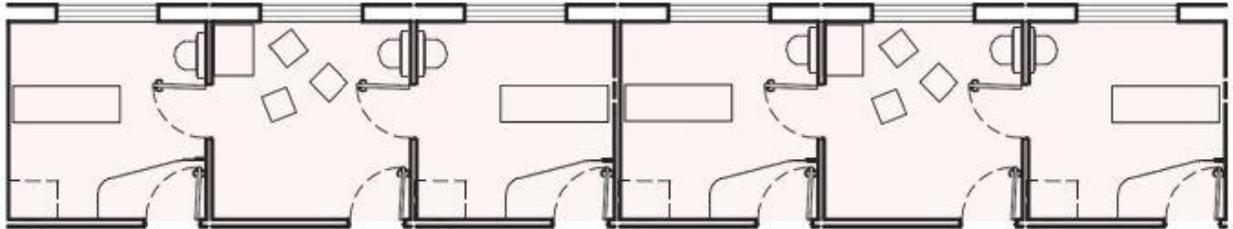


Figure 10 Treatment room: all-round couch access

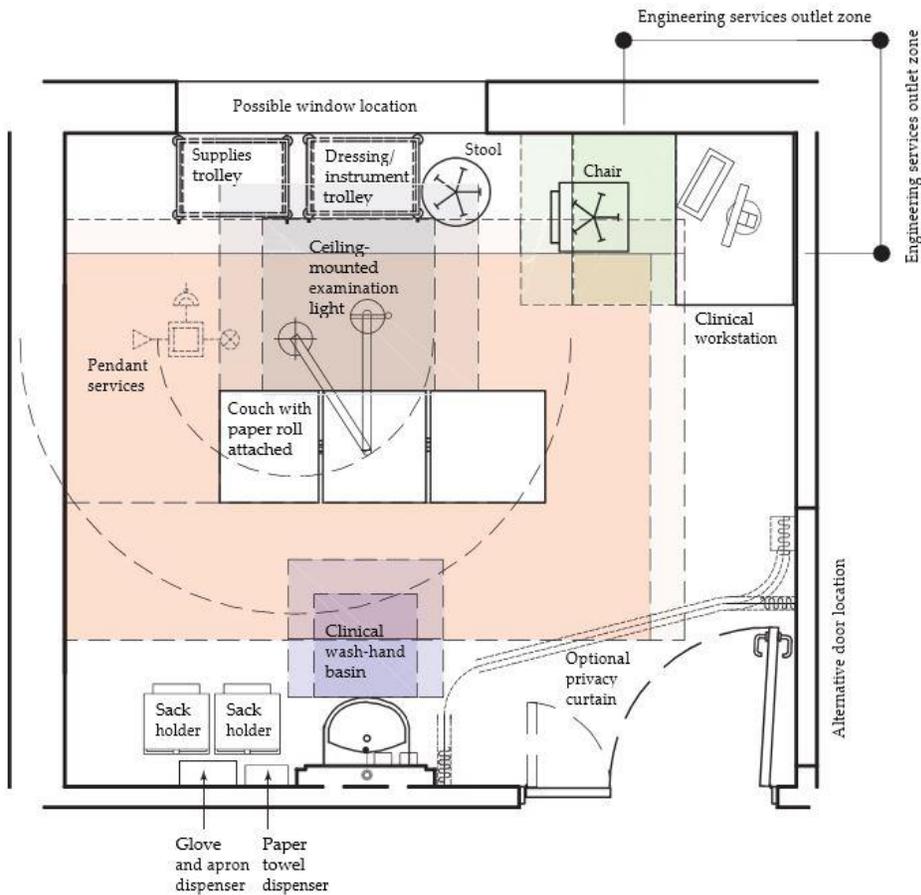


Figure 7 Space requirements for ambulant dressing and undressing

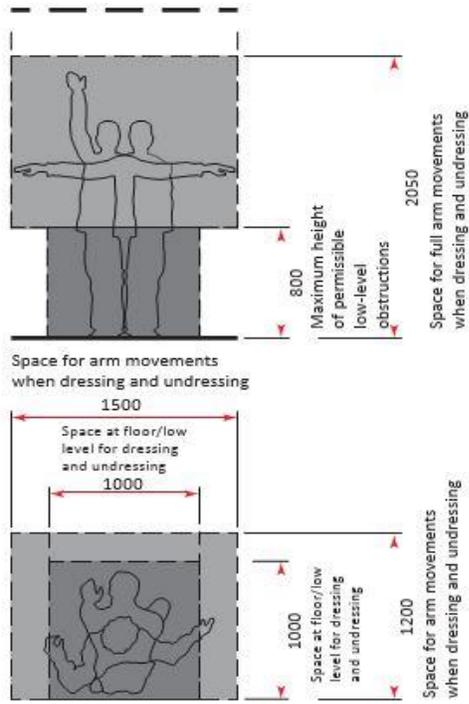
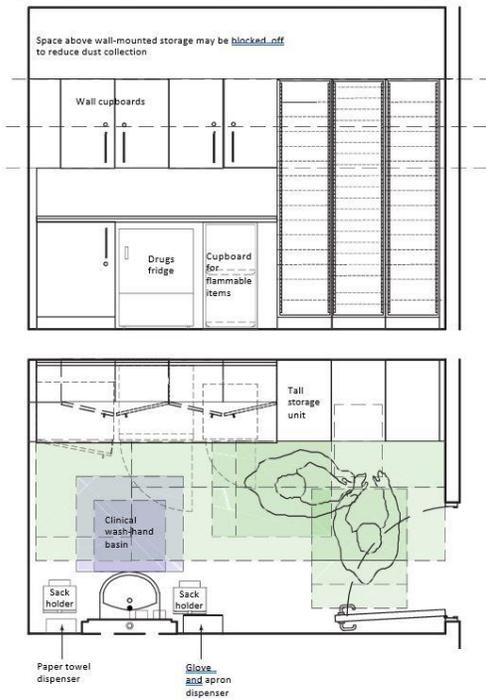


Figure 14 Space requirements for accessing modular base and upper cabinets. Please see figure 11, 12 and 13 for further storage requirements



# Appendix 5: Patch Test Series

<http://cutaneousallergy.org/resources/recommended-series/>