



WORKING PARTY REPORT ON MINIMUM STANDARDS FOR PAEDIATRIC SERVICES 2012

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The remit of this working party was to produce a consensus statement for the British Association of Dermatologists (BAD) on minimum standards for paediatric dermatology provision in the UK. The members were chosen to represent multidisciplinary specialists from a variety of delivery settings who care for children with skin disease.

The objective for a consensus statement is borne out of a need to ensure paediatric dermatology services are provided to a consistent standard across all services settings.

This report captures published recommendations and expert consensus opinion, in order to recommend minimum standards required to care for a child with skin disease in these diverse settings.

Further service provision information and resource tools to support BAD members in providing paediatric dermatology services, accompanies this report and are available on the [BAD website](#).

Introduction

Skin problems are the most common ailments seen in children¹ and are cared for in a number of clinical settings by a variety of health care professionals. The emphasis should be on establishing a holistic approach to the care of children and young people with *their* needs being the most important outcome measure.^{2,3} Specialist care for children with skin disease has traditionally been provided by dermatologists; close collaboration between specialties and multidisciplinary teams has always been an

important part of the management of children with skin disease. As the National Health Service (NHS) changes and develops the traditional boundaries of professional groups and models of service delivery⁴ are challenged, but the fundamental premise of caring for children and young people with skin disease remains the same.

We aspire to ensure that the best care is delivered in a suitable environment by appropriately trained health care specialists. This document should be used to guide departments to review and maintain high quality services for infants (< 1 year), children (<13 years) and young people (13- 16 years) with skin disease and to adopt a flexible approach in those up to the age of 19 years.

Models of care

The Department of Health (DH) published their white paper 'Care Closer to Home' in 2007 which defined the levels of clinical settings:⁵

Level 2 service - Primary care

The initial assessment and management of mild to moderate skin conditions are undertaken in primary care. A majority of children with skin disease are treated in primary care by General Practitioners (GP), practice nurses or community children's nurses. This provides a single local point of contact for the patient and their carer with a satisfactory outcome.

Level 3 service - Community care or intermediate care

This level of service provides assessment and management of moderate skin conditions. Intermediate care is most often provided at a community healthcare facility, but can also be delivered as community clinics in acute hospitals, if this is more convenient for the patient. A number of children are treated by dermatology doctors, GP with Specialist Interests (GPwSIs) and dermatology specialist nurses. Health visitors and community children's nurse assistants can also provide additional support by educating children's parents and carers in the application of topical treatments, bandaging and managing their child's skin condition etc.

Level 3 service - Acute or secondary care

Acute or secondary care services provide assessment and management of severe or complex skin conditions for children or conditions not responding to treatment at level 3. A number of children may need treatment as a day case or inpatients and/or require multidisciplinary input into their care. Larger community hospitals may also provide outreach clinics to give patients in geographically remote areas of the UK access to specialist expertise and acute care treatments. The types of treatments provided in this setting must be based on the staffing expertise and facilities available. These differ from the intermediate levels of treatment defined above. Secondary care is provided by consultant dermatologists, specialist registrars, staff grade and associate specialist doctors and dermatology specialist nurses. This level of service is essential for children whose skin disease cannot be satisfactorily managed by primary or intermediate care services.

Level 4 service - Supra-specialist or tertiary and regional care

Tertiary care provides assessment, investigation and management of complex skin disease and comorbidities for children which cannot be satisfactorily managed by an acute specialist secondary care service. These services are provided by consultant dermatologists (who have a specialist interest in

paediatric dermatology), specialist registrars, specialty and associate specialist doctors and paediatric dermatology specialist nurses.

Tertiary referrals are defined in the DH dermatology specialized services definitions set and include:

- complex cases of common paediatric dermatoses
- rare paediatric dermatoses and genetic skin diseases
- children with skin disease requiring diagnosis
- children with vascular anomalies/complicated haemangiomas and complex birthmarks
- congenital melanocytic naevi
- other types of congenital and acquired naevi
- skin cancers

Care Pathways

Most children access specialist dermatology services via their GP, but also via other specialists (neonatologist, paediatricians, geneticists, plastic surgery etc) and Accident and Emergency (A&E) departments. Care pathways and networks for children with skin disease must be implemented locally by a multidisciplinary team (MDT) to provide integrated services, with well established **links** between generalist (Level 2) services and the local specialist services (Level 3)⁶, incorporating social care and education where appropriate.

For specific common skin conditions such as atopic eczema, integrated **models of care** across primary and secondary care should be promoted.⁷ Primary care healthcare workers need to be able to **access information** quickly on the recognition and management of all common skin diseases. They also need to have rapid access to secondary care clinicians in the form of advice and clinics, when the interventions fail to achieve a satisfactory outcome. This form of advice is likely to be **electronic and web-based**, it will need to be locally customized and regularly updated by responsible named personnel. Whenever possible, secondary services should be undertaken close to home.⁸ **Rapid access pathways** to local consultant dermatologist led paediatric clinics for urgent cases should be readily accessible.

The local specialist service (Level 3) should have established links with regional and nationally commissioned supra-specialist services (Level 4), to facilitate referrals for children with rare and difficult to treat skin conditions.

The following are mandatory requirements in the management of any child or young person with skin disease. They should be established and maintained by the local specialist team.

Established links:

- Electronic advice on diagnoses, management and urgent referral.
- Referral pathways from primary to secondary care.

- In addition to dermatologists the secondary care team should have available specialist nurses, paediatricians, dieticians, play therapists and access to genetic advice and Child and Adolescent Mental Health Services (CAMHS). Liaison access to other specialist paediatric services such as paediatric allergy/immunology, rheumatology, and infectious diseases should also be available in regional centers.
- Clear pathways known by all members of the department for rapid access to child protection teams for children and young people.⁹
- There must be defined methods of communication between primary and secondary care when patients do not attend scheduled appointments, with clear recommendations on further follow-up.
- Defined inpatient arrangements (*see administration section*).
- 24 hour dermatology on-call arrangements and a telephone advice service.
- Transitional care arrangements for children moving into services for young people particularly in an outpatient setting. The management of young children is different from that of adolescents.
- Tertiary services (level 4) should be accessible directly by specialist secondary care dermatologists either by letter, telephone, electronically, or face to face.
- Links with other specialized services needed from Level 4 tertiary care are listed in Appendix 1.
- In April 2010 the NHS standard service contract required acute hospitals to send a discharge summary to their patients GP within 24 hours of discharge (outpatient and inpatient). This should include information on any medication prescribed at the time of discharge, along with any immediate post discharge requirements from primary care.

Referral management

Referral pathways and guidelines for paediatric skin conditions should be drawn up for each service level setting. Each skin condition pathway will need to reflect recognized guidelines from the DH, Royal College of Physicians (RCP), Royal College of Paediatrics and Child Health (RCPCH), British Association of Dermatologists (BAD), Primary Care Dermatology Society (PCDS) and existing National Institute of Health and Clinical Excellence (NICE) recommendations for e.g. atopic eczema for children.¹⁰ These should be discussed and agreed locally with GPs and commissioners along with the referral information which will be required for each patient, such as personal and family history, general health and development, drug treatment and allergies, and social history.

It is important to note that GPs retain the right to refer to a secondary care service (level 3) if they feel it is in the best interest of the child or if the parent/carer requests this option. All service setting options must be discussed with the parent/carer and child (of comprehensive age), to ensure they are able to make an informed choice of where they receive their care.

Triage

Triage of referrals, either by letter or electronically, must be performed by adequately trained experienced clinicians on a regular basis, to ensure that children are seen at an appropriate time and location by the most appropriate healthcare professional(s) to manage their condition.

Appointment system

Waiting times should be compliant with the NHS standard contract for 18 week wait and 2 week wait services. Provision for rapid access clinics for the early assessment of children requiring urgent care is also essential. Flexibility should be integral to the appointment system with separate paediatric clinics listed on Choose and Book. Clinics should be age appropriate.⁶ Within the clinic template, priority should be given for some timing flexibility e.g. to spend more time with the family of a patient with atopic eczema, rather than the need to keep strictly to out-patient waiting times guidelines.¹¹ Timing appointments to minimise loss of schooling and family disruption should be the norm.

Referrals to other services

In addition to clinical links within the specialty of dermatology, clear referral pathways between different services (General paediatrics, Plastic and reconstructive surgery, Maxillo-facial surgery, Paediatric rheumatology, Paediatric allergy, Paediatric ophthalmology, CAMHS, Teenage and Young adult cancer services (TYAC)) are needed, irrespective of the provider of care and consistent with national guidance.

Consultant to consultant referrals for patients with the same underlying condition are likely to be follow-on referrals after the first outpatient appointment, and should be included within the 18 week pathway (with the clock starting at the point of the original GP referral).¹²

If a consultant identifies another condition which requires a referral to another consultant for treatment, this will start a new patient pathway under the 18 week timeframe. The original referral pathway also continues with its own 18 week pathway clock. The consultant should copy the details of the referral to primary care for possible veto in exceptional circumstances, which should be specified in local commissioning arrangements. Where no specification has been made in the contracts, secondary care can assume approval by primary care to refer on.

DNA management

The reason for non-attendance must be investigated to ensure that children who do not attend appointments are not being put at risk. Clinics and appointments should be appropriately arranged, reflecting the age of the child, e.g. appointments should be offered outside normal school hours, to accommodate the needs of the parents, where possible. Knowledge of local school holidays dates are also helpful.

Staffing requirements and training

Care must be delivered in an integrated fashion and coordinated around the child or young person's particular needs and the needs of their family. Dermatology clinical staff must have the appropriate level of education, training, knowledge and skills to provide high quality care to children and young people.¹³ Dermatology training is essential to ensure accurate diagnosis, management and care of children and young people with skin disease. In addition secondary care teams must include professionals trained and competent to manage children who are unwell.

Every department should have robust recruitment policies in place for appointing appropriately trained individuals. It is mandatory for employers to ensure up-to-date extended Criminal Records Bureau (CRB) checks/disclosures for any clinician working with children; clear policies should be in place for ensuring practitioners achieve and maintain safeguarding training at level 3.¹⁴

Staff training and development programmes should ensure safe practice and comply with clinical governance and good practice guidelines. For all medical staff, maintaining and appraising competencies on an annual basis by continuing education and training is essential.

Nursing

Nursing staff have a pivotal role in the care of children and young people with skin disease at all levels of clinical settings. In primary care, specific dermatology input should be part of nurses' ongoing professional development. Close liaison is needed with the local dermatology department (see pathways) for continuity of care and continuing advice. Within the specialist service, experienced dermatology nurses caring for skin disease, ensure effective care both in outpatient and inpatient settings. Outpatient dermatology nurses are involved in individual, family or group education sessions and application and demonstration of dressings, often in the environment of day treatment centres. Extended roles include liaison roles, nurse led clinics, specialised care and management of the genodermatoses including blistering disorders.

Dedicated dermatology nurses are therefore essential to any specialist service. The Royal College of Nursing (RCN) has recommendations for dermatological competences (RCN 2009) with a framework built on a generic nursing role (level 5, 6 & 7).¹⁵ In addition, paediatric trained nurses should be available in specialist out-patient services caring for children with skin disease.¹⁶ Staff need to understand and respect the role of parents and carers and should have training in the necessary communication skills to enable them to work effectively with children, young people and their parents and carers.¹³ We recommend **at least two nurses**, specifically trained in the needs of children, should be available in those out-patient departments where children are managed and staffing is predominantly with adult trained dermatology nurses.

In enhanced nursing roles within the dermatology clinic such as dressings, education and nurse-led clinics there is a need for both dermatology and paediatric competencies. Competencies for paediatric dermatology nursing have recently been defined by the RCN⁴ and nurses with these competencies should be available. Adult-trained dermatology nurses with one year's outpatient experience and no formal paediatric training can obtain specific skills required for working with children with skin conditions in non-acute settings (primary and or secondary care) at a 4 day course organised by the School of Postgraduate Medicine at the University of Hertfordshire.¹⁷

In tertiary (Level 4) settings, staffing should be with trained paediatric dermatology nurses.

General Practitioner (GP)

Most skin disease is managed in primary care. Anyone experiencing a skin problem is seen initially by their GP or practice nurse (level 2); in some cases they may be seen by a community dermatology nurse or a pharmacist with special training in skin problems. Sufficient education and training in general practice is therefore essential to guarantee patients are managed effectively and safely. Primary care physicians should have the appropriate level of competence in managing skin conditions, such as those defined in the Royal College of General Practitioners (RCGP) curriculum, section 15.10 skin conditions.¹⁸ There is also an undergraduate dermatology curriculum which can be used for basic dermatology training in skin conditions. However, the current exposure to the teaching of dermatology at both an undergraduate and postgraduate level is virtually nonexistent, unless this is a specialist area the GP wants to practice in. This does not equip the GP with the knowledge and skills to deal with the large number of patients who will present in their practice with a skin condition. As a minimum, regular Clinical Professional Development (CPD) session attendance for dermatology is recommended with

further educational support provided by their local dermatology department. However, to rectify this problem, we recommend that dermatology training should have considerably more emphasis in GPs vocational training schemes.

GPwSI

The core activities of a dermatology GPwSI service will vary, dependent upon local needs and resources, and the skills of the clinician. Both the GPwSI and the level of service they provide should be reaccruited annually. GPwSI should work with the **local** secondary care specialists to develop an integrated dermatology service model with care pathways that meet the requirements for the accreditation of the service. They also develop links with other professional groups, including pharmacists, health visitors, school nurses, and primary care nurses, to ensure effective shared care for patients with chronic skin condition.

Dermatology doctors

Specialist care is delivered by consultant dermatologists, non-consultant career grade (NCCG) doctors, nurse consultants, specialist registrars, specialty doctors, accredited or training GPwSIs. All patients in specialist care will attend a hospital based dermatology service or a community health facility suitable for specialist care. Children and young people with skin disease should be managed in secondary care by doctors who have undergone dermatology training in the diagnosis, investigation and treatment of skin disease in this age group. At the time of writing, these competencies are defined in the 2010 dermatology curriculum.¹⁹ In secondary care, a paediatric dermatology service **must** include a named clinician trained in the care of children. Other specialists such as general paediatricians, respiratory paediatricians, allergy specialists and immunologists seeing children with skin disease, should have competencies in dermatology or liaise closely with the dermatology service. For inpatient care, children should be admitted to a paediatric ward under a named paediatrician, with access to a dermatology consultant opinion and shared care between the specialties (*see administration section*).¹⁴

Level 4 care should be undertaken by a lead dermatologist with special skills in the management of complex and/or rare skin disorders in children, in close liaison with a range of healthcare professionals.

Liaison: In each specialist centre there should be a lead dermatology consultant in close collaboration with a named consultant trained in the care of children who act as 'liaison' officers to other paediatric specialties e.g. geneticists, ophthalmologists, ENT, plastic surgery.

Multi Disciplinary Team (MDT)

Many different healthcare professionals are involved in the delivery of paediatric health services. Integration of these teams is essential for the best management of dermatological problems.⁸

Children's community services

There should be clear links to children's community services:

- 1) Health visitors for under five year olds.
- 2) Community children's nurses.

School nurses and teachers

School nurses provide an invaluable link to the school environment where children spend much of their time. They are able to liaise with teachers and first aiders within the school environment, and input management advice to the school tailored to the child's individual needs. This allows children to

continue to access their education. School teachers within the inpatient setting also contribute to the ongoing provision of education for children and young people. They are able to liaise with schools, acquiring and setting work in a way that takes account of the patient's medical condition, as well as providing feedback to schools about strategies that can be used in a school environment to ensure optimal achievement in spite of the medical condition.

Dieticians

Assessment of nutrition and ensuring adequate growth is an essential part of any paediatric condition, particularly the chronic conditions such as eczema and psoriasis. Involvement of dieticians in the management of these patients is often necessary. Good links with the paediatric dietetic services should be established.

Child and Adolescent Mental Health Service (CAMHS)

A number of skin conditions are associated with significant psychological co-morbidity in the child or the family or can occur as a result of psychological issues affecting the skin. Access to the Primary Child and Adolescent Mental Health Service (PCAMHS) input should be part of any paediatric dermatology services.

Play therapists

Play specialists should be available for children undergoing procedures such as phlebotomy, skin biopsy and also during inpatient care.

Ethnic considerations

Lists of named interpreters trained to work with children and their parents/carers should be available in outpatient clinics. This can be supported by patient information leaflets translated into appropriate languages which should be available from all health care settings.

Social service

In the hospital setting, clear access to social service should be available for families.

Facilities

Paediatric Dermatology services should be delivered in well designed, appropriately equipped, child friendly environments. Ideally, dedicated paediatric facilities should be used but when this is not possible, a suitably adapted and separate area within an adult or general healthcare setting may be used. The safeguarding of children and young people both physically and psychologically should underpin any service providing paediatric healthcare.¹⁴

When planning facilities for delivering paediatric dermatology services, the following should be taken into consideration:

Safety

All furnishings and equipment designed with child safety in mind (no low level shelving or sharp edges, tamper proof couch mechanisms, cool water taps and protected power sockets). It is sensible to have a no hot drink policy for both parents and staff, or if they are being consumed they should be in lidded cups.

Environment

Child friendly decor and furnishings appropriate for children, young people and adults (parents). There should be adequate space within waiting areas, clinic rooms and inpatient facilities to accommodate buggies and other family members. A Separate waiting areas for young people with age appropriate information and activities.

Toileting

Child friendly toileting facilities should be available in all areas where children are being seen. Baby changing facilities are essential and may usefully be combined with measuring facilities (see below).

Measuring growth

Measurement of weight and linear growth is an essential part of paediatric healthcare and a designated and private area should be part of any facility where children are being assessed. Equipment should include baby scales, standard scales (sitting and standing), infant length and child height stadiometers. All equipment should be calibrated regularly.

Play

Children have a basic need for play and recreation and therefore all children and young people should have access to play and hobby materials within any healthcare setting. The availability of age appropriate, wipe-clean and preferably quiet toys, books, games and art materials will ensure a more relaxed patient and parent experience. Television and DVDs within waiting areas and procedure rooms provide good distraction.

Education

Children, young people and parents should have access to age appropriate educational material in the form of healthcare advice leaflets, access to helpful websites and information about patient support groups. Within an inpatient setting, children and young people should be able to continue with their school activities and education if they are able to. Provision of a school room to allow this to occur away from the bedside is important.

Investigations and procedures

Venepuncture, skin prick and patch testing, dressing changes, therapeutic baths, phototherapy and biopsies may all be required in the management of children with dermatological conditions and where these should take place must be planned. Informed consent for procedures should be explicit and age appropriate.¹² Where these procedures cannot be undertaken in a dedicated paediatric setting e.g. phototherapy or patch testing, children should be seen at a separate time to adult patients and consideration made about how best to facilitate a child focused experience. DVD's and music can be useful distractions during painful procedures and the involvement of play therapists and children's nurses will also improve the experience for children and their parents. Children should not be sedated for painful procedures without appropriately skilled staff (able to manage paediatric airways) immediately available.

Medical photography

This is an essential part of dermatology assessment in many clinical situations. Provision needs to be made for this to occur within the healthcare setting, in situations where it is inappropriate to send the child to the medical illustration department.

Administration

Children and young people should be seen on separate clinic lists from adults; this needs to be acknowledged within the Choose and Book templates. If separate clinics are not possible then consideration should be given to grouping children at one end of a clinic. **Inpatients** should be admitted to the paediatric wards under a named consultant who will be responsible for the patients care. In line with RCPCH recommendations, patients should be seen within 4 hours by a middle grade paediatrician and 24 hours by a consultant.¹⁴ They should have access to a dermatology consultant opinion and clinical review to ensure that shared care provides the most effective treatment for the patient. Dermatology nurses should be available to attend the paediatric wards, assist with inpatient skin treatments and educate children's nursing staff and parents on dermatological management.

Prescribing

Neonates and children differ in their response to medication compared with adults. Doses need adjustment according to age and size of the child as children have a greater BSA/weight ratio. In addition, with topical prescriptions particular care has to be taken to avoid local and systemic side effects.²⁰ In paediatric dermatology, the majority of prescriptions tend to be **topical preparations**, although **systemic medicines** are also used.

General Requirements

- Prescriptions should be made by appropriately trained health care professionals with up to date competences.¹⁹
- Safe medication practice is enhanced through improved training, continuing professional development, the provision of evidence based information and systems to ensure safety of practice.⁶
- Good communication with child and parent is essential to facilitate informed decisions when discussing any treatment options. This will enhance concordance and should be supported by appropriate patient information leaflets (PILs).
- Facilitate informed decisions about treatment options with careful explanation to enhance concordance. This should be supported by appropriate PILs.
- Always take into account children's needs and preferences when discussing treatment options.¹³
- Informed consent for treatments should be explicit and age appropriate. The healthcare professional may need to assess whether the child is Gillick competent.^{13,21}
- The prescriber must be able to justify and feel competent when using unlicensed medicines or licensed medicines for unlicensed applications ('off-label' use) as is more common in the case of prescribing for children. The use of unlicensed and off-label medicines for children and young people should comply with local standards and arrangements should be in place to oversee this.⁶
- Nurse prescribing in the setting of dressing clinics is to be actively encouraged, to ensure timely administration of appropriate topical medication.

Topical preparations

Adequate training and up to date competencies in dermatological prescribing is mandatory to take into account amounts of treatments used on various sites, bases available, potencies of topical preparations and age of patient.

To enhance compliance and effective treatment, education sessions by appropriately trained individuals should be available for all parents/patients when applying topical preparations particularly dressings.

Adequate amounts of emollients and barrier preparations should be available on repeat prescription with clear prescribing instructions including amounts required between secondary and primary care.

There are a range of diverse clinical situations when Specials may be judged by the prescriber to be in the best interest of the patient on the basis of available evidence.²² In children, Specials may be the only option for the prescriber for some conditions and in some circumstances are routinely prescribed. In dermatology, there are a large number of Specials in use. In 2008, the BAD reviewed the national use of dermatological Specials and subsequently produced a rationalised formulary to improve access to, and appropriate prescribing of Specials.²³

Anti inflammatory preparations are frequently used in dermatology particularly topical steroids and topical calcineurin inhibitors. A clear understanding is needed of appropriate prescribing in various body sites, with extra care in infants, neonate and premature babies.

Prescribers should recognise local and systemic side effects of topical preparations.

Wigs and cosmetic camouflage should be considered as important therapeutic options for certain disfiguring conditions and should be available as recommended by the dermatologist and with advice/information from Changing Faces.²⁴

Systemic therapies

When prescribing syrups, where possible, the sugar-free preparations should be prescribed. Ensure age appropriate use of medications such as antibiotics, retinoids and the oral contraceptive pill. Prescriber should be able to recognize predictable and unpredictable adverse reactions of systemic therapy.

Appropriate monitoring for systemic treatments, particularly immunosuppression, is required with the availability of paediatric phlebotomists as well as play specialists or CAMHS for needle phobia. Access to paediatric day investigation units under the care of a named paediatric dermatologist or paediatrician is essential for delivery of some systemic medication.

Governance requirements

Children's dermatology services should operate in an environment that is committed to the principles of clinical governance, with the primary aim of providing the safest and most effective care. Ideally, to ensure equity of care across the UK, children's services should strive towards the introduction of UK wide national clinical standards for paediatric dermatology care. However it is not sufficient to focus solely on clinical aspects of delivering care as non-clinical support services e.g. administration, estates facilities and human resources all impact on clinical care. Clinical governance should be embedded in the clinical practice of all services in order to standardise and constantly improve clinical effectiveness.

The Chief Executive carries ultimate responsibility for clinical governance. Each department should have a named clinical governance lead (usually a consultant dermatologist) who should be a member of the hospital clinical governance subcommittee. The clinical governance lead for the department is responsible for:

- Identifying capability and capacity of the department.
- Identifying deficits in current services.
- Producing a developmental plan for the department.
- Organising and chairing clinical governance meetings.
- Identifying developmental needs of staff and disseminating information about clinical governance activities within the organisation.

Specialist services for children with skin conditions should provide clinical leadership, including supervision, training, clinical expertise, clinical management and research into skin conditions. There should be clear lines of responsibility and accountability for the overall quality of clinical care. A comprehensive programme of quality improvement activities, clear policies aimed at managing risk and procedures for all professional groups to help them identify and rectify poor performance. Individuals also have responsibility for the service and should ensure that they keep themselves up to date and are practising within their scope and area of responsibility. They should raise and voice their concerns when standards are being compromised and continually strive for quality so as to promote and safeguard the interests and well being of patients.

The seven key components of clinical governance can be broadly categorised into 3 areas: ¹

- **Processes for quality improvement:** Patient and public involvement, risk management, clinical audit, clinical effectiveness programmes, staffing and staff management.
- **Staff Focus:** Education, training and continuing personal and professional development.
- **Information:** Support clinical governance and health care delivery, diagnostic database and clinical information systems, keeping of medical records and documentation, appropriate use and processing of high-quality patient data, maintaining confidentiality.

The paediatric dermatology 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: Lead clinician (usually a dermatologist); named dermatology nurse ideally dual qualified or a paediatric nurse to link with and provide paediatric nursing advice. Other members of the team will include members of the medical/nursing teams with support from professionals involved in the care pathways: paediatricians, dieticians, CAMHS geneticists, play specialists etc.

The paediatric dermatology team should have **regular team meetings, ideally every month but at a minimum 4 times a year**. The broad aim of these meetings is to ensure that the service is focused on the need to provide timely, safe and effective services to local patients. The agenda for these regular paediatric clinical governance meetings should include the following elements:

1. Clinical effectiveness

All services should review their clinical effectiveness including paediatric waiting list data and paediatric activity since the previous meeting.

2. Risk management

All providers of services for children and young people with skin conditions should have procedures in place to minimise risk to both service users and staff. Clear mechanisms should be in place to report, review and respond formally to all clinical incidents and complaints using, for example:

- Incident and near miss recording, with investigation and root cause analysis.
- Audit of current practices, standards and medical records.

3. Audit

All providers of services for children with skin conditions should, as a minimum, audit annually elements of clinical practice against current local and national guidelines, evidence-based pathways and procedures. Audit outcomes should be used to evaluate care pathways, monitor the quality of clinical activity and make changes as necessary to optimise care.

4. Patient experience

Services should, as a minimum, gather patient recorded experience measures (PREMs) annually. The results should be shared and any actions agreed.

5. Service developments

Policies and procedures: New evidence-based practice, research, national standards, guidance and audit results all need to be disseminated to staff to ensure the implementation of procedures which achieve quality outcomes.

6. Update on new clinical guidelines including;

- Treatment specific guidelines
- Disease specific guidelines

7. Staff training

It is essential that all providers of care for children and young people with skin conditions are appropriately trained and competent to deliver care. All providers of services for children with skin conditions should have a clear framework for education, training and CPD that includes mentorship, clinical supervision, case note review (where appropriate) and assessment of development and ongoing competence. Such training and CPD should be discussed and planned to ensure that all team members fulfil professional requirements to be fully up to date with appropriate CPD compliance.

Discussion of difficult or instructive cases: as with any clinical service, there are some cases that respond in an atypical or unusual way. Discussion of these cases is often instructive for team members. Furthermore, such discussion is usually helpful in order to optimize treatment for individual cases and to improve patient outcomes generally.

Coding

Dermatology departments must ensure their paediatric clinics are set up as allocated lists and use the correct treatment function code (257) for this service. Paediatric dermatology services receive a higher tariff for first and follow up appointments along with first multidisciplinary appointments and multidisciplinary follow up appointments. This helps to identify paediatric activity which would otherwise be lost in general dermatology department activity. It is also essential to help identify those paediatric outpatient procedures which have been provided for future service planning.

Where multidisciplinary clinics are provided, it is important that procedures undertaken by the dermatologists are coded to dermatology service budgets. Unfortunately some trusts have divisional budgets which are most unhelpful when trying to identify the income generated by each individual department. Explaining service requirements and capacity needs to commissioners also becomes problematic and lessens the value of the dermatology paediatric service. Dermatology departments should speak to their coding and information departments to discuss how this problem can be corrected.

Summary

This document for the minimum standards of paediatric dermatology services has been written with the intention that the care of neonates, children and young people with skin disease is optimal at all levels of healthcare delivery. We emphasise the importance of providing services for children, young people and their parents in child friendly environments with increased information and choice over the support they receive. We recommend that they have high quality services and access to multidisciplinary teams in providing personalised support. We would emphasise that the service provided should be established around the needs of the child, rather than the child having to fit into existing service structures. We hope these recommendations help departments to maintain and improve their own standards of paediatric dermatology care. In addition, the working party proposes that these standards will help inform commissioners of the requirements and standards needed in the care of this important group of dermatology patients. The recommendations contained within this document are based on available DH sources and recommendations from the Royal Colleges as well as the expert consensus of the working party members.

Dr Olivia Schofield

Chair of the paediatric dermatology working party

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Appendix 1

Types of service/disease group that may be included in Level 4

- Allergy services for complex testing and immunotherapy.
- Genetic dermatology: Rare and severe inherited skin diseases. Diagnostic and genetic counselling service, outreach (to community and district general hospital) nursing service.
- Photodermatology: Skin disorders related to sunlight, including rare conditions such as porphyria and xeroderma pigmentosum. Specialist diagnostic services, including light testing.
- Lymphovascular services Patients with skin disease related to lymphovascular disorders.
- Connective tissue disorders systemic lupus erythematosus and a whole range of other conditions. Multidisciplinary team working particularly with rheumatologists.
- Genital dermatology Genital dermatoses, including patients with complex vulval and penoscrotal disorders.
- Patients with HIV.
- Dermatitis artefacta: Psychiatric and psychological assessment and treatment as appropriate.
- Specialist laboratory services: Immunohistochemistry, mutation analysis, prenatal diagnostic services, molecular diagnostic services using polymerase chain reaction (PCR).
- Research any skin disease requiring evaluation of new treatments or investigation of the basic science underlying the condition. Recruitment of patients into studies of new therapeutic agents.