



# Phototherapy Service Guidance

**Issue Date:** October 2016

**Review Date:** March 2017

# 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.

## Phototherapy Service Guidance

In May 2013 the BAD invited a range of medical professionals and patient representatives to revisit its published Phototherapy Service Guidance developed in 2011.

The remit of this new Working Party Group (WPG) was to undertake an evidence based review following our NICE Service Guidance accreditation process (see Appendix 1: BAD Developing Dermatology Service Guidance). WPG members were chosen for their specialist experience of phototherapy practice in a variety of delivery settings which includes services provided in densely populated urban areas to sparsely populated rural areas. A broad range of stakeholder representatives are included in the WPG: Dermatologists, Phototherapy Nurses, Phototherapy Physiotherapists, Medical Physicists, and patients.

As part of the evidence review for producing the Phototherapy Service Standards the WPG has also taken into account established managed clinical networks and service frameworks already in place in Scotland and the South East of England. Some of these core principles are formalised in the following set of Service Standards (recommendations) contained within this guidance.

### Statement of Our Service Intentions:

1. Service guidance and core standards covering patient referral, information, consent, treatment and discharge with outcome criteria that will be routinely audited.
2. All staff involved with phototherapy will have undergone requisite training, and will maintain an up-to-date portfolio of continuing professional development and revalidation.

3. Regularly monitor and update treatment protocols to ensure Phototherapy services conform to best clinical practice.
4. Phototherapy ultraviolet (UV) sources and associated equipment will be well maintained and correctly calibrated, routinely checked for reliability and accuracy of UV dose administration, safety and compliance with regulatory standards.
5. The phototherapy unit will be a safe patient-centred environment, meeting regulatory standards.

In order to achieve these aims, each Phototherapy Service Standard defined with the guidance provides a rationale and criteria which should be demonstrated by departments. Each standard contains a list of evidence and audit criteria which departments should assess themselves against. This self-assessment process is supported by a self-audit questionnaire to help departments improve their services and flag up areas of clinical concern within existing Trust governance and risk management protocols.

The self-assessment and audit processes have been subject to pilot tests within a number of National Health Service (NHS) Trust sites. An extensive public consultation with all professional groups involved in the provision of NHS phototherapy 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 phototherapy service guidance are:

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

## Purpose

BAD Service guidelines for phototherapy 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 Phototherapy services and has identified the standards and minimum requirements for the care of patients receiving Phototherapy and/or PUVA treatment. All areas are supported by acute clinical governance frameworks for outpatient services provided by hospital trusts and within the terms of the NHS service Contract.

## Scope

It is important for phototherapy service guidance and accompanying standards to reflect the issues which make a difference to the experience of the patient using the service. For this reason, this guidance follows the patient care pathway for phototherapy. As far as possible, standards are written from the service user perspective and reflect the service infrastructure required to reduce risk and harm.

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 NHS 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 in place;
- Care Quality Commission (CQC) Regulations;
- Health Safety Executive and COSHH Risk Assessments;
- Department of Health Building Notes for facilities;
- NHS Standards Contract terms and conditions;
- GMC Good Medical Practice and Ethical Guidelines.

# 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 safe, effective and high quality Phototherapy Services, which providers operating outside of the NHS will also find useful.

Clinicians who deliver phototherapy services 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 multidisciplinary group set up by the BAD to carry out this work.

In this document standards are expressed as something which Phototherapy services should meet as an overriding duty of principle in order to provide a quality service. They provide the basis for evaluating the quality of services and identify areas for improvement to provide safe and equitable care for patients wherever they are treated.

### *Evidence/Minimum requirements*

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

### *Examples of suitable evidence*

Examples of suitable evidence are the records that applicants 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 against a standard. This is not intended to be either prescriptive or exhaustive (recommendation only). Service providers may provide what they consider to be the most convincing evidence available for their achievement of each standard, whether or not it appears among the listed evidence (see Appendix 2 – Core List of Evidence).

## *Self-Assessment and Audit*

Self-Assessment against the Phototherapy Service Standards will be a voluntary and cyclical process. This process provides independent 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 NHS clinical governance and risk reporting frameworks.

## **Who is this guidance for?**

The service guidance and standards are integral to quality assuring safe and effective care for phototherapy patients. They help to:

- Ensure that new services are set up in a way that will ensure patient safety and optimised treatment;
- Ensure that existing service infrastructure (facilities, equipment and staffing etc.) contributes to the safe and effective delivery of care to patients;
- Clarify service expectations for patients, clinicians, management, commissioners and NHS employees;
- Drive service improvement and development of phototherapy services to meet local need;
- 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 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 and accredited providers.

## **What approach have we taken to develop this guidance?**

This guidance was developed in accordance with the core principles and methods set out by NICE for the developing service guidance. The methodology for developing Service Standards is underpinned and informed by an evidence review and existing national policies. The WPG has also taken into consideration established managed clinical networks for phototherapy operating



in the UK (Scotland and the South East of England). In achieving nationally aligned Service Standards for phototherapy this is an important and critical factor to consider.

Each service standard is supported by the available national evidence and expert clinical judgment of the WPG. Phototherapy Service Standards have been piloted on a number of hospital sites using our self-assessment and audit process with evidence submitted for review by the WPG. This allows accurate feedback to be obtained on the operational process and updates to be made to the Service Standards by the WPG. The finalised phototherapy service guidance and standards have been scrutinised and approved by the BAD Officers prior to consultation with our stakeholders.

A formal consultation period (normally one month) also took place to allow for stakeholder registration and feedback on the Phototherapy 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

Ultraviolet phototherapy and photochemotherapy are used to treat a variety of skin disorders, including psoriasis, eczema, mycosis fungoides, pruritus, vitiligo and many other skin conditions. They are also used prophylactically to “desensitise” the skin in some photosensitivity disorders such as polymorphic light eruption (PLE), solar urticaria and erythropoietic protoporphyria.

We recognise that people working in both phototherapy services and the academic field have the best understanding of the issues and challenges faced in providing high quality care for phototherapy patients.

A comprehensive and long established set of phototherapy standards active in the UK are those defined in the *Managed Clinical Network for Phototherapy services in Scotland HDL (2007) 21*. These include the following Service Standards headings:

- Patient and Parent/Carer Information and Education;
- Multi-disciplinary Working;
- Staff Education and Training;
- Audit, Monitoring and Research;
- Clinical Management Systems, Audit & Monitoring;
- The Patient’s Journey (care pathways).

These standards underpin the core set of values which have been developed by our expert advisory group, and will be further refined through our formal consultation with stakeholders. Our standards are covered by the following topic headings:

**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

**STANDARD 8:** Skin Cancer Surveillance

## 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. As a minimum, 20 cases should be selected for this purpose along with the collation of core evidence for each standard. Some of the activities to undertaken by departments will include:

- Activity data review on referral to treatment start times for phototherapy (6-12 months);
- Staff and patient/carer and unit/ manager questionnaires;
- A service user feedback;
- A review of case notes;
- An audit of treatment, with relevant documentation of equipment and facilities.

### Self-Audit and Reporting

The data and evidence collected during self-assessment against the Phototherapy Service Standards should be used to complete the Phototherapy Service 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.

For Example:

	Essential Criteria	Comments	Status
1B.	90% of all referrals will start treatment within six weeks of referral from dermatology outpatients	79% of patients started treatment within six weeks of referral	<b>Red Flag</b>

**Red Flag [Action Absolutely Required]:** a Red Flag Service Standard is one which any Service has to meet. Failure to meet a Red Flag Service Standard places undue clinical risk on patients, breaches their rights or dignity and mandatorily requires action to correct this failure.

**Yellow Flag [Action Recommended]:** a Yellow Flag Service Standard 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.

In the medium term, our aim is to focus on recording the necessary clinical outcomes data which currently makes up the self-assessment audit. The end result is to eventually have a centralised Phototherapy Patient Information System in place, which can collect key clinical outcome data from each unit, as already occurs in Scotland. Once this is in place, national clinical outcomes reporting will focus on:

- The proportion of patients being treated for diseases other than psoriasis (i.e. eczema, vitiligo etc.) who achieve remission or partial remission of their disease should be in line with the published literature where the data exist.
- Clearance/near-clearance (minimal residual activity) of whole body psoriasis in >70% of completed courses. In psoriasis, PASI or other outcome measure must be used to estimate disease activity.
- Median UVB treatments per successful whole-body treatment course for psoriasis <30.
- For each grade of symptomatic erythema, number of episodes/patient treatments/year, compared to published standards (published rates vary but include: <0.8% of all treatments result in an acute adverse event (0.6% for NB-UVB [0.5% excluding E1], 1.3% for systemic PUVA, and 0.8% for local PUVA). For severe adverse events: 0.05% for NB-UVB and 0.3% for systemic PUVA).
- All patients who have received >200 whole-body PUVA treatments and/or >500 whole-body UVB treatments are invited for annual skin cancer screening review, using clinical observations and, where appropriate (needs to be captured in discharge letter), digital photography. (These thresholds are arbitrary and will be lower in patients with other risk factors for skin cancer).

Given the variation to current service provision providers implementing these new phototherapy Service Standards have a grace period (12 months) to identify shortfalls in their service provision. This enables the multi-disciplinary team to review their local procedures and practices against the accredited phototherapy 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 – Referral

Patients are referred by a general practitioner (GP) or accredited community practitioner to secondary care consultant led 18 week services for phototherapy. Consultant-to-consultant referral to specialised centres is necessary for patients who require complex photo investigations for the management of rare and severe skin diseases (see Evidence Review: Prevalence and Incidence). Phototherapy will be prescribed by a Consultant Dermatologist or another accredited practitioner working under the supervision of a Consultant Dermatologist. The Consultant Dermatologist has, at all times, the overall responsibility for the assessment and care of the patient.

#### Rationale

A Dermatologist should prescribe Phototherapy to patients who have diseases for which this is, at the time of presentation, a potentially effective and safe treatment option.

#### Standards

	Essential Criteria	Status
1A.1	Prescription of phototherapy and pre-assessment or request letter to the phototherapist, and all decisions regarding the type of phototherapy must be made following a face-to-face consultation with an accredited Consultant Dermatologist or other appropriately trained Clinician working under the direct supervision of a Consultant Dermatologist in the clinic.	RED FLAG
1A.2	The Dermatologist must provide the following information with the patient prescription for Phototherapy in the pre-assessment or request letter to the phototherapist: <ul style="list-style-type: none"> <li>• Details about absence or presence of any contraindications or risk factors to Phototherapy;</li> <li>• Details of which type of Phototherapy is being requested and which disease is being treated.</li> </ul>	YELLOW FLAG
1A.3	Patients must start treatment within six weeks of pre-assessment or request letter to the phototherapist. If treatment is delayed, the reason(s) should be documented in the phototherapy notes.	YELLOW FLAG
1A.4	The patient treatment record, i.e. the ongoing record of treatments as they are carried out, should be up to date at all times in the phototherapy	RED FLAG

	notes.	
<b>1A.5</b>	A summary sheet, including cumulative UVB and PUVA exposures, should be updated following each phototherapy course and an easily accessible record be kept for each patient.	<b>YELLOW FLAG</b>
<b>Audit Outcomes - what will be audited for each Standard</b>		
<b>1A.1</b>	Dermatologist pre-assessment or request letter in the medical notes indicates that the prescribing for phototherapy, sent to the Phototherapist, has been made after a face-to-face consultation with an accredited Consultant Dermatologist or other appropriately trained Clinician, working under the direct supervision of a Consultant Dermatologist in the clinic. Dermatologist pre-assessment or request letter in medical notes indicating this is present in >90% of phototherapy notes by four weeks after completion of treatment.	
<b>1A.2</b>	A Dermatologist pre-assessment or request letter is present in 100% of phototherapy notes for patients by four weeks after completion of their treatment.	
<b>1A.3</b>	The time from date of Dermatologist pre-assessment or request letter, to date of first phototherapy treatment, as determined from patient records, is <6 weeks in 100% of patients.	
<b>1A.4</b>	Up to date ongoing treatment record is present in 100% of phototherapy notes examined during or after completion of treatment course.	
<b>1A.5</b>	Up to date summary of cumulative dosage and course is present in 100% of medical notes by four weeks after completion of treatment.	

### Standard Statement 1B – Urgent referrals

Patients referred urgently for phototherapy by a Dermatologist will start treatment within three weeks of being assessed.

#### Rationale

If the patient is considered to require treatment urgently, then treatment should be started as soon as possible to reduce patient discomfort, and avoid the need for hospital admission.

#### Standard

	Essential Criteria	Status
1B.1	Patients referred urgently for phototherapy should start treatment within maximum three weeks of referral.	YELLOW FLAG

#### Audit Outcomes - what will be audited for each Standard

1B.1	Time from date of Dermatologist referral to date of first phototherapy treatment, for all referrals marked 'urgent', as determined from patient record, is <3 weeks in 100% of patient.s	
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## Standard Statement 1C – Patient Assessment

### Rationale

An accurate diagnosis and assessment of risk factors for complications of phototherapy, and alternative therapies, is required before the decision to prescribe phototherapy can be made. Patients with special needs e.g. children, learning difficulties, language barriers, will have phototherapy treatment suitably adapted to ensure safety of the patient at all times. In order to assess whether or not a further course of phototherapy is indicated, it is essential to have information on previous UVB and PUVA treatment.

### Standards

	Essential Criteria	Status
1C.1	<p>A formal nurse/physiotherapist phototherapy assessment is undertaken before phototherapy treatment starts. This must be recorded in the case notes and should include the following information:</p> <ul style="list-style-type: none"> <li>• Cumulative doses of phototherapy;</li> <li>• Blood results (if required);</li> <li>• Allergies;</li> <li>• Current medication;</li> <li>• Special needs assessment.</li> </ul>	RED FLAG
1C.2	Undertake MPDs for whole body PUVA.	YELLOW FLAG
1C.3	Undertake MEDs for UVB phototherapy or a test dose (on a limited area of skin) where unable to do an MED.	YELLOW FLAG
1C.4	The dermatology life quality index (DLQI) is a validated tool/outcome measure that can be used to assess the physical, psychological and social wellbeing of patients being treated in the phototherapy unit.	YELLOW FLAG

### Audit Outcomes - what will be audited for each Standard

1C.1	A Phototherapist pre-phototherapy assessment record is present in >90% of phototherapy notes by four weeks after completion of treatment.	
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1C.2	MPD technique should be described fully, including the site(s) of test(s), the criteria used to assess erythema, the methodology of masking and exposing test sites, including any devices used for this, the dose and route of psoralens, the sequence of doses used (or the ratio between adjacent exposures).	
1C.3	MED or test dose technique should be described fully, including the site(s) of test(s), the criteria used to assess erythema, the methodology of masking and exposing test sites, including any devices used for this, and the sequence of doses used (or the ratio between adjacent exposures).	
1C.4	Evidence that the DLQI has been offered to 90% of phototherapy patients attending treatments. Its usage should be recorded at key stages of treatment by the patient.	

## STANDARD 2: Patient Information and Consent

Standards		
	Essential Criteria	Status
2A.1	All patients/carers will have received a Patient Information Leaflet (PIL) prior to commencing treatment that covers the specific phototherapy treatment they are due to have, along with any additional information relevant to their treatment sessions. Patients will have acknowledged they have received and understood the leaflet.	YELLOW FLAG
2A.2	All patients should have equal access to NHS services and materials to inform on their care. To help ensure equality of access, departments may need to adjust their messages, modify their tone and present information in alternative formats (see NHS Brand Guidelines for communicating with patients).	YELLOW FLAG
2A.3	Patient leaflets produced by phototherapy units must be kept up to date and reviewed at least every two years.	YELLOW FLAG
2A.4	Patient information leaflets should be provided in plain English and presented in accordance with NHS brand Guidance (see 2A.2). Phototherapy PILS should be available in a variety of formats and languages as appropriate for those patients accessing the service.	YELLOW FLAG
Audit Outcomes - what will be audited for each Standard		
2A.1	Review of notes indicates that >90% of patients have received a PIL prior to commencing treatment.	
2A.2	Dermatology departments should have clear information about their services on the Trust website.	
2A.3	Date of writing indicated on 100% of PILS is within the past two years.	
2A.4	Evidence that PILs are available in languages suitable for the phototherapy unit's demographic population.	

## Standard Statement 2B – Consent

All patients treated with UVB or PUVA to give written informed consent relating to each treatment course, after receiving appropriate information (see Standard 2A).

For those patients who cannot give written informed consent, local Trust guidelines on consent in this situation will be followed.

### Rationale

Patients have a right to know why UVB or PUVA treatment has been recommended, about possible alternative therapies, and about possible adverse effects of the treatment.

The need for informed consent exists for all therapies, but because of the common misconception that UV is “artificial sunlight”, and that “nature” = “safe”, it is prudent to obtain written consent to help ensure that all patients are appropriately informed.

### Standards

	Essential Criteria	Status
2B.1	There must be a record of formal written informed patient consent in the patient’s medical notes. Consent should be obtained as a two stage process, to give the patient the time to change their mind. The Dermatologist should cover overall issues, including long term adverse effects, and discuss alternative treatment options. This should be followed by information from the Phototherapist on the practicalities and details of treatment, including the patient’s responsibilities and rules and regulations, and short term adverse effects.	RED FLAG

### Audit Outcomes - what will be audited for each Standard

2B.1	Evidence of formal written consent prior to phototherapy present in 100% of patient’s notes within four weeks of completion of course. The record of consent must indicate two-stage consent with the first stage including mention of long term adverse effects and alternative treatment options.	
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## Standard Statement 2C

Compliance with requirements regarding Patient Public Involvement (PPI) in developing health and community care services.

### Rationale

Each phototherapy 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 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. 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.

There are also patient and public involvement (PPI) activities in regards to improving clinical audit and governance and in training and education (see Standard 4).

### Standards

	Essential Criteria	Status
2C.1	The Unit possesses a Patient Satisfaction Questionnaire, to offer to patients/parents/carers. It must be available in an appropriate format and language, to take away or access electronically, which includes a question on the information provided and its usefulness and quality. The Unit must, at the very least, carry out a patient satisfaction survey every six months, but ideally provide it for each patient treated.	YELLOW FLAG
2C.2	Staff are given the opportunity to review and respond to patients' queries and complaints.	YELLOW FLAG

### Audit Outcomes - what will be audited for each Standard

2C.1	Evidence in patient notes of >90% of patients being offered a Patient Satisfaction Questionnaire	
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2C.2	Review of all documentation from all patient complaints over previous six months to assess whether staff involved have had the opportunity to review and respond to the complaint. Evidence of such staff involvement to be present in 100% of complaint responses.	
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## STANDARD 3: Staff, Training and Education

### Standard Statement 3A – Staffing Arrangements

The phototherapy unit must ensure it has appropriately qualified and experienced medical and other clinical and non-clinical staff, so that services are provided in all respects, and at all times, in accordance with the NHS Service Contract and Regulations 18 and 19 of the Health and Social Care Act 2008.

#### Rationale

Services must ensure that there are sufficient, appropriately registered, qualified and experienced medical, nursing and other clinical and non-clinical staff, to enable phototherapy services to be provided in all respects and at all times.

#### Standards

	Essential Criteria	Status
3A.1	The phototherapy unit will keep an up to date record of the personnel providing phototherapy service for each of its clinical sites. The training and qualification requirements for Phototherapy staff are detailed in Section 3B.1. Where staff are registered with the relevant professional body, where required, they must have completed the revalidations required by that body.	YELLOW FLAG
3A.2	The unit has its own dedicated lead Consultant who will provide clinical expertise and input into key matters of the phototherapy service, staff support and supervision, and overall service co-ordination. Specialist clinics are set aside in the Consultant's job plan to ensure sufficient time (up to two Programmed Activities (Whole Time Equivalent)) is available for their consistent and regular input to the team and related forums. The Lead Consultant must be an Accredited Consultant Dermatologist.	YELLOW FLAG
3A.3	The phototherapy unit will undertake a detailed review of staffing requirements every six months, to ensure that the provider remains able to meet the requirements.	YELLOW FLAG
3A.4	Phototherapists must carry and display valid and appropriate identification in accordance with Good Health and Social Care practice.	RED FLAG

**Audit Outcomes - what will be audited for each Standard**

<b>3A.1</b>	Presence of an up to date list of phototherapy Unit staff including all members of this multidisciplinary and monitoring team.	
<b>3A.2</b>	Name of Phototherapy Lead Consultant Dermatologist to be provided by the Unit.	
<b>3A.3</b>	Evidence of implementation of 'lessons learned' from all reviews and evaluations is demonstrated at review meetings, along with the extent to which improvements to each affected service have been made as a result.	

## Standard Statement 3B – Training and Education

All health care professionals providing phototherapy treatment must be specialty-specific trained to be competent in undertaking the duties for which they have been employed. Professional development must be ongoing and include internal and external multidisciplinary education.

### Rationale

Patients are treated by competent and trained Phototherapists. Phototherapists are members of the phototherapy team, and part of a multidisciplinary dermatology team, which includes dermatology consultants, specialty doctors, specialty registrars, medical physicists, registered nurses, chartered physiotherapists and other staff under their supervision.

To ensure optimal effectiveness and safety, phototherapy must be administered by phototherapists with an adequate knowledge both of the treatments, and of the conditions being treated. Many Phototherapy Units also act as chronic skin disease (predominantly psoriasis, atopic dermatitis and vitiligo) treatment units, with patients given advice on necessary concomitant treatments (e.g. topical scalp psoriasis therapies and topical therapies for dermatitis).

### Standards

	Essential Criteria	Status
3B.1	<p>A phototherapist must be a physiotherapist registered with the HCPC or a 1<sup>st</sup> level registered Nurse. All phototherapy staff must undertake a period of supervised practice with a qualified phototherapist and be signed off as 'competent'. During this period, clinical notes of patients treated by the trainee should be countersigned by a 'competent' phototherapist.</p> <p>It is recognised that, prior to the Introduction of these Standards, some Phototherapists working long term do not possess this level of Nursing or Physiotherapy qualification. For this group the following applies - if a phototherapist is not either a chartered physiotherapist or a 1<sup>st</sup> level Registered Nurse, they must demonstrate that:</p> <ol style="list-style-type: none"><li>1. They have been working as a phototherapist in the UK in a recognised phototherapy Unit for a minimum of five years prior to 1<sup>st</sup> January 2015;</li></ol>	RED FLAG



	<p>2. They can show that they have been signed off by a recognised Phototherapist* in all relevant competencies.  (*a Chartered Physiotherapist or a 1<sup>st</sup> level registered Nurse who has undertaken a period of supervised practice with a qualified phototherapist and been signed off as 'Competent').</p>	
<b>3B.2</b>	All phototherapists should undergo some form of educational activity in phototherapy at least once a year, including attending a recognised update or other phototherapy course at least once every three years.	<b>YELLOW FLAG</b>
<b>3B.3</b>	All phototherapy staff must have an annual appraisal and have a personal development plan for their continuing professional development (CPD) which supports their ongoing practice in this area, and is in line with this Standard. Maintenance of a portfolio with evidence of reflective practice in phototherapy.	<b>YELLOW FLAG</b>
<b>3B.4</b>	Providers must have in place systems for seeking and recording specialist professional advice and must ensure every member of staff in the provision of the service receives proper and sufficient continuing professional and personal development, clinical supervision, training and instruction.	<b>YELLOW FLAG</b>

**Audit Outcomes - what will be audited for each Standard**

<b>3B.1</b>	<p>List of Phototherapy Unit staff with their Physiotherapy or Nursing qualifications and confirmation that they have been signed off as 'competent' in phototherapy following a period of supervised practice. For staff who are not a Chartered Physiotherapist or a 1<sup>st</sup> level Registered Nurse, demonstration that:</p> <ol style="list-style-type: none"> <li>1) They have been working as a Phototherapist in the UK in a recognised phototherapy Unit for a minimum of five years prior to 1<sup>st</sup> January 2015</li> <li>2) They can show that they have been signed off by a recognised Phototherapist in all relevant competencies.</li> </ol> <p>100% of Phototherapy staff to have necessary qualifications and signed off as competent following a period of supervised practice.</p>	
<b>3B.2</b>	Evidence for 100% of phototherapist staff of phototherapy educational	

	activity within the last year, including attending a recognised update or other phototherapy course within the past three years.	
<b>3B.3</b>	Evidence of appraisal within the last 12 months for 100% of phototherapy Unit staff.	
<b>3B.4</b>	Full and detailed appraisal in terms of performance and ongoing education and training and professional leadership, appropriate to the service.	

## STANDARD 4: Clinical Management & Monitoring

### Standard Statement 4A

All patients treated with UVB or PUVA are treated according to optimally effective, and safe, regimens based on the best available study evidence, adapted as necessary to be appropriate for each individual patient, and to local Phototherapy Unit circumstances.

#### Rationale

Treatment regimen variables (including starting dose, incremental dosage regimen, treatment frequency, concomitant therapies, and decision to stop a course of treatment) influence the efficacy of treatment, acute side effects, cumulative exposures and ultraviolet doses required (thereby probably affecting risk of skin cancer as a late side effect).

### Standards

	Essential Criteria	Status
4A.1	Patient records should be available at the start of each clinic for review by the nurse/consultant.	RED FLAG
4A.2	Written evidence-based protocols for all relevant forms of phototherapy are available, and used, including discharge protocols and incident reporting protocols.	RED FLAG
4A.3	In psoriasis, psoriasis area and severity index (PASI) or other outcome measure must be used to estimate disease area activity (adult patients only).	YELLOW FLAG

### Audit Outcomes - what will be audited for each Standard

4A.1	Patient records are available (paper or electronic) in 100% of cases.	
4A.2	Unit to provide the written phototherapy protocols used by the Unit, which have to be reasonably up to date and indicate their evidence base, and include all relevant forms of phototherapy, discharge protocols and incident reporting protocols.	
4A.3	Clearance/near-clearance (minimal residual activity) of whole body psoriasis in >70% of complete courses.	

## Standard Statement 4B

All patients receiving phototherapy are placed on a clinical management system with their record of consent. This system holds details of each episode of treatment and allows for ongoing clinical information to be recorded for use in direct patient care and service audit.

### Rationale

Information is at the core of phototherapy care for individuals, for service planning and for assessing patient adherence to the treatment regimen. Data collection and audit facilitate effective healthcare since outcomes can be monitored and lead, where necessary, to improvement in the quality of treatment and care.

All phototherapy units must record the patient treatment pathways as follows:

- New Consultation;
- First follow-up appointments (should record the MED or MPD test using the assessment code X622, along with the relevant treatment code (see below));
- Second and consequent follow-ups should record the treatment using the treatment codes shown below.

NB: for specialised services, a primary diagnosis must be recorded in the patient's medical notes, along with any co-morbidities and procedures. This includes all patients seen in the outpatient unit.

Treatment codes:

JC29Z S121 Ultraviolet A light therapy to skin

JC29Z S122 Ultraviolet B light therapy to skin

JC32Z S123 Combined photochemotherapy and ultraviolet A light therapy to skin

JC32Z S124 Combined photochemotherapy and ultraviolet B light therapy to skin

It is important that the phototherapy unit records all phototherapy treatments carried out at all follow up appointments, in line with the new tariff arrangements for 2017-2019. The recording of phototherapy treatments should not affect departments overall new to follow up ratios with commissioners. On average new to follow up treatment ratios for

phototherapy are 1:18, based on HSCIC published statistics for 2014-2015.

**Standards**

	<b>Essential Criteria</b>	<b>Status</b>
<b>4B.1</b>	An outpatient income form is used (paper or electronic) by the phototherapy nurse to record the patients course of treatment including MPD/MED tests.	<b>YELLOW FLAG</b>
<b>4B.2</b>	The phototherapy team will actively review the activity recorded by the departments on a quarterly basis (as a minimum) to quality assure data being captured by the team.	<b>YELLOW FLAG</b>

**Audit Outcomes - what will be audited for each Standard**

<b>4B.1</b>	>95% of all patient treatments are recorded in the department's activity reports.	
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## STANDARD 5: Equipment and Facilities

### Standard Statement 5A - Equipment

The phototherapy unit will have robust and accurate systems in place for ultraviolet dosimetry (i.e. the measurement and delivery of ultraviolet radiation). All equipment will be regularly calibrated and checked for electrical safety. All calibrations will be traceable to national standards. Staff exposure to ultraviolet radiation will be regularly checked to ensure it is within recommended limits.

#### Rationale

Robust and accurate systems of ultraviolet exposure measurement and delivery are necessary to ensure the rapid clearance of disease with minimum risk of excessive erythema. Accurate exposure measurements also facilitate the introduction of new treatment regimes, allow the comparison of results between phototherapy centres, and assist in the safe transfer between units of patients.

Routine calibration and service checks ensure early detection of equipment problems, minimising risks to patients, and maintain traceable records of safety and quality assurance systems. Regular ultraviolet risk assessments of the phototherapy unit will ensure the safety of patients, staff and visitors. Expertise and equipment to undertake such dosimetry is only available from Medical Physics. Staff occupational exposure to ultraviolet radiation must be assessed and kept below recommended limits.

Full acrylic guards over the lamps in phototherapy cabins are fitted as standard, in line with Medicines and Healthcare products Regulatory Agency (MHRA) requirements since 2003 and the associated Scottish Safety Action Notice (2003) [(SAN(SC)03/14].

#### Standards

	Essential Criteria	Status
5A.1	A designated medical physicist, or other designated person with suitable expertise in medical physics, is responsible for ensuring that UV measurements are carried out in such a way as to ensure that the patient receives the prescribed dose to an acceptable level of accuracy.	RED FLAG
5A.2	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	RED FLAG

	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.	
5A.3	For each piece of equipment a record of inspection (including risk assessment), calibration and dosimetry in the last 12 months should be provided for the audit by the responsible person identified in 5A.1.	YELLOW FLAG
5A.4	<p>'Expanded uncertainty' of irradiance measurements of large area sources should be &lt;15%.</p> <p>There is an element of doubt associated with every measurement. Uncertainty is a quantification of the doubt. A measurement result is only complete if it is accompanied by a statement of its uncertainty. This should be calculated in accordance with recognised principles (e.g. Measurement Good Practice Guide No. 11: A Beginner's Guide to Uncertainty of Measurement by Stephanie Ball, Issue 2, Published by National Physical Laboratory 2001, ISSN 1368-6550).</p>	YELLOW FLAG
5A.5	Irradiance measurements on phototherapy equipment should be made and recorded at an appropriate interval, as decided by the responsible person identified in 5A.1. The measurement interval must be adequate to ensure changes in irradiance of more than 20% do not go unmonitored. The measurements should be performed by a trained phototherapist or member of the medical physics staff.	YELLOW FLAG
5A.6	Handheld meters should be available on every Unit and used by the Phototherapists for UV irradiance measurements in the Unit. They should be calibrated annually, with calibrations traceable to national standards.	YELLOW FLAG
5A.7	Phototherapy units must implement and monitor systems to ensure the general health of service users, staff and others. Specifically, each treatment centre must be able to demonstrate that systems are in place to ensure that staff exposure to UV does not exceed the limits specified in The Artificial Optical Radiation Regulations.	YELLOW FLAG
5A.8	The Medical Physics Department, or the employer of the designated person in 5A.1, provides training for its staff in phototherapy-related medical physics and keeps documentary evidence of training and continued competence which is available for inspection.	YELLOW FLAG

**Audit Outcomes - what will be audited for each Standard**

<b>5A.1</b>	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.	
<b>5A.2</b>	Dosimetry protocols used by the Unit to be provided on request by the designated medical physicist.	
<b>5A.3</b>	For each piece of equipment in the Unit, a record of inspection (including risk assessment), calibration and dosimetry in the last 12 months should be provided for the audit by the responsible person identified in 5A.1.	
<b>5A.4</b>	Audit of the medical physicist's dosimetry records indicates that the expanded uncertainty of irradiance measurements' has been determined and is less than 15%.	
<b>5A.5</b>	Audit of the measurement records shows that Irradiance measurements on phototherapy equipment have been made and recorded by nursing or physics staff at an appropriate interval, as decided by the responsible person identified in 5A.1.	
<b>5A.6</b>	Record of calibration of handheld meters used by Phototherapists. Such a record must be within the past 12 months, and must include a calibration traceable to a national standard.	
<b>5A.7</b>	Copy of protocol or policy of the Unit which covers how the Unit ensures that staff exposure to UV does not exceed the limits specified in The Artificial Optical Radiation Regulations.	
<b>5A.8</b>	Medical Physics staff training records demonstrate that staff who are involved with the phototherapy unit, are engaging in continuing professional development in phototherapy-related activity and that they have demonstrated competence in performing a set of dosimetry measurements for phototherapy UV sources.	



## Standard Statement 5B - Facilities

### Rationale

Spacing should take into account the amount of, and ease of access to, phototherapy machines to facilitate the activity of both the phototherapy nurse and patient.

Privacy curtains used to separate phototherapy treatments areas should have fittings that make them quick and convenient to replace; such fittings are common in disposable curtains. Reusable curtains should be able to withstand decontamination in healthcare laundering. There should be a local policy on the changing of privacy curtains, both for routine changing and for when the curtains become soiled. This should be reflected in the department infection control policy.

The limits for room temperature set-point are generally between 16°C and 25°C depending on the particular application such as phototherapy but are adjustable within a predetermined range by the user. For single room airflow change rate where a phototherapy treatment temperature should not exceed 25°C with six air flow changes per hour (this may increase where multi units are provided in one room for treatments).

The privacy, dignity and respect of healthcare users should be maintained at all times, through the effective use of private rooms, curtains, screens, blankets and appropriate clothing. Staff should ensure that there is sufficient space within curtained areas for a patient to dress and undress in privacy, with assistance when required.

### Standards

	Essential Criteria	Status
5B.1	Phototherapy 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.	YELLOW FLAG
5B.2	Phototherapy patients should always be adequately dressed or covered prior to leaving the clinical area for any reason, so that their privacy, dignity and respect are maintained.	YELLOW FLAG
5B.3	Facilities should have appropriate ventilation and cooling to maintain a comfortable environment for staff and patient and to ensure satisfactory operation of phototherapy equipment.	YELLOW FLAG

5B.4	PUVA baths are provided in semi-ambulant bathing facilities.	YELLOW FLAG
<b>Audit Outcomes - what will be audited for each Standard</b>		
5B.1	Evidence that phototherapy 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.	
5B.2	Evidence that changing rooms meet the requirements for patients, as specified in the Department of Health's Health Building Notes 00-02: Sanitary Spaces.	
5B.3	Evidence that ventilation requirements are met - implicit under the Health and Safety at Work Act 1974 and COSHH, have been made explicit by the Management of Health and Safety at Work Regulations 1999, the Workplace (Health, Safety and Welfare) Regulations 1992 and the Provision and Use of Work Equipment Regulations 1998, all issued as a result of European Directives.	
5B.4	Evidence that bathing and changing facilities meet the requirements for patients, as specified in the Department of Health's Health Building Notes 00-02: Sanitary Spaces	

## STANDARD 6: Clinical Governance and Audit

### Standard Statement 6A

A good clinical governance process is required to ensure a safe, high quality service that shares good practice, evidences learning and strives for continuous quality improvement. All adverse and serious adverse incidents are recorded and reported within recognised policy frameworks. The phototherapy service will encourage regular meetings between all members of the multidisciplinary phototherapy team to discuss matters pertaining to clinical governance and audit. The service will adopt a “no-blame” culture to encourage the full and detailed reporting of adverse events in phototherapy.

#### Rationale

Providers are responsible for the safety of their patients and must ensure robust systems are in place for recognising, reporting, investigating and responding to Serious Incidents and for arranging and resourcing investigations.

Reports of adverse incidents should be made available, so that any problems with equipment, staff or procedures can be identified before they cause adverse events or interruption to the service. Review of protocols and procedures allows these to be checked against current best practice or national guidelines and updated if necessary.

#### Standards

	Essential Criteria	Status
6A.1	<p>All phototherapists are involved in some form of clinical governance activity at least twice per year, including a governance meeting which covers the topics of:</p> <ul style="list-style-type: none"> <li>• Clinical incidents;</li> <li>• Health and safety;</li> <li>• Audit and guidelines.</li> </ul>	YELLOW FLAG
6A.2	<p>All adverse events should be noted at the clinical governance and audit meetings. Any adverse event more serious than an E2 erythema must be discussed at the meeting, and the outcome recorded on the adverse event form and if appropriate, on all serious incidents reported on the Trust incident form.</p>	YELLOW FLAG

6A.3	There should be a clear system for recording and recalling episodes of symptomatic erythema. Episodes should be graded accordingly.	YELLOW FLAG
6A.4	An audit should be carried at a minimum of every 12 months of all episodes of erythema. This will inform the interpretation of results for the total numbers of treatments and total number of patients seen by the unit for each treatment type.  Published rates vary, but include reported rates of: below 0.8% of all treatments result in an acute adverse event (0.6% for nbUVB [0.5% excluding E1], 1.3% for systemic PUVA, and 0.8% for local PUVA) only 0.05% of treatments result in severe adverse event (0.05 for nbUVB and 0.3 for systemic PUVA).	YELLOW FLAG
<b>Audit Outcomes - what will be audited for each Standard</b>		
6A.1	Record of clinical governance meetings over the previous year – there must be evidence of a Phototherapy Unit Governance meeting (or of another clinical governance activity) at least once every six months.	
6A.2	Evidence from Clinical Governance/Audit meeting minutes that all episodes of burning more serious than E2 erythema have been discussed at the meeting and the outcome recorded on the adverse event form and if appropriate on a Trust Incident Form.	
6A.3	There should evidence provided of a clear system for recording and recalling episodes of symptomatic erythema. Episodes should be graded according to the following scheme: <ul style="list-style-type: none"> <li>• E1 Just perceptible erythema;</li> <li>• E2 Well defined marked erythema which is asymptomatic or causing minimal discomfort;</li> <li>• E3 vivid painful erythema with oedema;</li> <li>• E4 vivid painful erythema with oedema and blistering.</li> </ul>	
6A.4	Results of the audits should be expressed as numbers of symptomatic erythema episodes/patients treatments/year of episodes, expressing results both as totals and subdivided by grade of erythema.	

## STANDARD 7: Discharge Protocol

### Standard Statement 7A

All units should have a clear protocol to guide those administering treatment on when a course should be stopped. Patients should be able to access treatment, if necessary, for any relapse in their presenting condition following phototherapy.

#### Rationale

Patients must be discharged after an appropriate number of treatments for an individual's skin condition. Early discharge leads to inadequate improvement in the condition treated (and may lead to early relapse). Delayed discharge exposes patients to unnecessary risks of adverse effects, and wastes resources. The majority of indications for UVB and PUVA are chronic diseases that can be controlled, but not cured. Most patients will experience recurrence of their condition some time following phototherapy, although this will sometimes be mild and amenable to home management. Patients need to know how to obtain advice if their condition recurs.

#### Standards

	Essential Criteria	Status
7A.1	There is a protocol with guidance on when to stop treatment, and when to seek a Dermatologist's advice on when to stop a course of treatment.	YELLOW FLAG
7A.2	On discharge, patients are given information on how to access services again after discharge, when that should prove to be necessary. This should include information on any follow up assessments for patients where skin cancer risk has become high enough to warrant long term clinical monitoring, a clinical judgement which includes patients passing 'threshold' cumulative doses as detailed in Section 8.	YELLOW FLAG
7A.3	The patient's GP and referring Consultant are notified within 10 working days following completion of a course of phototherapy, and informed of any follow-up arrangement and containing relevant information about the course and cumulative doses. They should also be informed where a patient's skin cancer risk has become high enough to warrant long term clinical monitoring, a clinical judgement which includes patients passing the various 'threshold' cumulative doses as detailed in Section 8.	YELLOW FLAG

**Audit Outcomes - what will be audited for each Standard**

<b>7A.1</b>	Unit to provide the written phototherapy protocols used by the Unit, which must include discharge protocols.	
<b>7A.2</b>	>90% of Phototherapy notes audited contain note that patient has been given information on how to access services again after discharge.	
<b>7A.3</b>	Notes audit indicates that >90% of notes, within four weeks of completion of treatment course, contain a letter/report summarising the course sent to patient's GP and referring Consultant.	

## STANDARD 8: Skin Cancer Surveillance

### Standard Statement 8A

All patients at significantly increased risk of skin cancer as a result of UVB and/or PUVA treatment are made aware of their increased risk, their GP is informed and they are offered annual tumor surveillance skin examination with local centres. This Standard is not implying mandatory ceilings and limits to cumulative doses of UV from phototherapy. It is about monitoring of patients who have had high cumulative UV doses.

#### Rationale

PUVA treatment causes an increased risk of skin cancer. Although follow-up of patients treated with narrowband UVB has not as yet detected a skin cancer risk, it is possible that with long enough follow up of those who have had many exposures, a risk will be identified. The increased risk is related to overall numbers of treatments and ultraviolet doses administered, and also to pre-existing risk factors for skin cancer in patients. It is the responsibility of those prescribing these treatments to alert patients to the risks, and to minimise these in various ways, including follow-up assessments to identify any skin cancers or pre-cancers at early, treatable stage. This is necessary for patients who have had high cumulative doses of phototherapy.

There are no limits to the numbers of treatments patients may have. However, the figures of >200 PUVA and >500 UV treatments are thresholds to trigger skin cancer screening review. There will be patients in whom it is clinically appropriate to continue to treat beyond these numbers. Decisions about whether or not to continue to treat past these arbitrary threshold numbers are the responsibility of the Dermatology Consultant. The Dermatology Consultant has to assess the relative risks and benefits of the various treatment options available for each patient. In some patients the correct decision is to continue beyond these arbitrary threshold figures.

### Standards

	Essential Criteria	Status
8A.1	It must be documented that patient has reached >200 whole-body PUVA treatments and/or >500 whole-body UVB treatments in main hospital case notes and in letters to GPs.	YELLOW FLAG

Audit Outcomes - what will be audited for each Standard

<b>8A.1</b>	Random note audit of clinic letters indicates that the high cumulative dose is mentioned in clinic and GP letters in >90% of patients where they have had >200 whole-body PUVA treatments and/or >500 whole-body UVB treatments.	
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## References and Evidence

	Standard							
	1	2	3	4	5	6	7	8
<b>Core Evidence</b>								
Care Quality Commission. The Fundamental Standards.	X	X	X	X	X	X	X	X
Confidentiality. General Medical Council. 2009.	X	X	X	X	X	X	X	X
Confidentiality. NHS Code of Practice. 2003.	X	X	X	X	X	X	X	X
Curriculum Framework for Qualifying Programmes in Physiotherapy. Chartered Society of Physiotherapy. 2002.			X					
Data Protection Act 1998.	X	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	X
Disability Discrimination Act 1995 and 2005.	X	X	X	X	X	X	X	X
Essential Standards of Quality and Safety. Care Quality Commission. 2010.	X	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	X
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9: Person-Centred Care.	X	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	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		
How to Write in Plain English. The Plain English Campaign.	X	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	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	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. Joint Royal Colleges of Physicians Training Board.			X					
Standards for medicines management. Nursing and Midwifery Council. 2008.					X			
<b>Specialist Evidence</b>								
A randomized comparison of methods of selecting narrow-band UV-B starting dose to treat chronic psoriasis. Dawe RS, Cameron H, Yule S, et al. Arch Dermatol 2010.			X				X	X
A randomized, observer-masked, trial of 2x vs 3x weekly narrow-band ultraviolet B phototherapy for chronic plaque psoriasis. Cameron H, Dawe RS, Yule S, et al. Br J Dermatol; 147: 973-978. 2002.			X	X				X
British Photodermatology Group Guidelines, 2002; Scottish UV Dosimetry Guidelines, 2001; IPEM Report 76, 1997.					X			
British Association of Dermatologists and British Photodermatology Group Guidelines for the Safe and Effective Use of Psoralen-Ultraviolet A Therapy. 2015. Ling TC, Clayton TH, Crawley J et al. Br J Dermatol. 2016;174(1):24-55.	X	X			X	X		
Department of Health (2006), Dignity in Care Chief Nursing Officer (2007), Mixed Sex Accommodation in Hospitals Healthcare Commission (2007), Caring for Dignity.					X			
Health and Social Care Information Centre. Checklist Guidance for Reporting, Managing and Investigation Information Governance Serious Incidents Requiring Investigation.						X		

2013.								
House of Commons Public Administration Select Committee. Investigation Clinical Incidents in the NHS. 2015.						X		
General management of Psoriasis –Recommendations. The British Association of Dermatologists. 2006	X						X	X
Guidelines for topical PUVA: a report of a workshop of the British Photodermatology S. Halpern, A. Anstey, R. Dawe, B. Diffey, P. Farr, J. Ferguson, J.M. Hawk, S. Ibbotson, J.M. McGregor, G.M. Murphy, S.E. Thomas, L. Rhodes. Br J Dermatol; 142: 22: 31. 2000	X					X		
Guidelines on the Measurement of Ultraviolet Radiation Levels in Ultraviolet Phototherapy: Report Issued by the British Association of Dermatologists and British Photodermatology Group 2015. Moseley H, Allan D, Amatiello H et al. Br J Dermatol. 2015 Aug;173(2):333-50.				X	X			
Medical Devices Agency. <i>Medical Device Alert. Reference: MDA/2003/006 Ultraviolet (UV) Phototherapy Cabinets.</i> London: Medical Devices Agency, 2003.					X			
Mid-Staffordshire NHS Foundation Trust Public Inquiry. Robert Francis QC. 2013.						X		
MOP PUVA for psoriasis: a comparison of a minimal phototoxic dose-based regimen with a skin-type approach. Collins P, Wainwright NJ, Amorim I et al. 8-. Br J Dermatol 135:248-54 .1996	X							X
Narrow-band (TL-01) ultraviolet B phototherapy for chronic plaque psoriasis: three times or five times weekly treatment? Dawe RS, Wainwright NJ, Cameron H, Ferguson J. Br J Dermatol; 138: 833-39. 1998.	X						X	
Narrow-band ultraviolet B (TL-01) phototherapy for psoriasis: which incremental regimen? Wainwright NJ, Dawe RS, Ferguson J. Br J Dermatol; 139: 410-14. 1998.	X			X				
NCCG Psoriasis. Assessment and management of psoriasis. Clinical Guideline Methods, evidence and recommendations. NICE. 2012.	X	X		X			X	
NHS Scotland. Safety action notice. Full-body phototherapy cabinets: risk of laceration from un-guarded UV tubes (SAN(SC)03/14). Available at: <a href="http://www.hfs.scot.nhs.uk/services/incidentreporting-and-investigation-centre-iric/safety-action-notices/safetyaction-notices-issued-in-2003/">http://www.hfs.scot.nhs.uk/services/incidentreporting-and-investigation-centre-iric/safety-action-notices/safetyaction-notices-issued-in-2003/</a> (last accessed 1 July 2015).					X			
NICE Clinical Guideline 43 – Obesity Prevention (CG43). December 2006.	X	X		X				
NICE Clinical Guideline 67 – Lipid Modification: Cardiovascular Risk Assessment and the Modification of Blood Lipids for the Primary and Secondary Prevention of Cardiovascular Disease (CG67). May 2008.	X	X		X				
NICE Quality Standard 15 – Patient Experience in Adult NHS Services (QS15). February	X	X		X				

2012.								
NICE Quality Standard 40 – Psoriasis (QS40). August 2013.	X	X		X	X			
Measurement Good Practice Guide No. 11: A Beginner’s Guide to Uncertainty of Measurement by Stephanie Ball, Issue 2, Published by National Physical Laboratory 2001, ISSN 1368-6550.					X			
Phototherapy Guidelines - Dowling Day Treatment Unit St John’s Institute of Dermatology St Thomas’ Hospital London Guidelines originally written by Dr. R. Palmer, Sister T. Garibaldinos, Prof. J. Hawk in January 2005 : Guidelines updated by: Dr. R. Sarkany in July 2009.	X						X	
Rate of acute adverse events for narrow band UVB and psoralen UVA phototherapy. Photodermatology photoimmunology & photomedicine. 2007;23:68-72Martin JA, Laube S, Edwards C, Gambles B, Anstey AV.				X				
Royal College of Nursing. Defending Dignity: Challenges and Opportunities for Nursing. 2008.					X			
Standards for Photonet National Managed Clinical Network. Photonet National MCN. 2013.			X	X		X		
The assessment and management of psoriasis. NICE Psoriasis. October 2012.	X						X	X
The Control of Artificial Optical Radiation at Work Regulations 2010. The Health and Safety Executive.				X	X			

# Evidence Review: Prevalence and Incidence

Ultraviolet phototherapy and photochemotherapy are used to treat a variety of skin disorders, including psoriasis, eczema, mycosis fungoides, pruritus, vitiligo and many other skin conditions. They are also used to desensitise the skin in some photosensitivity disorders such as polymorphic light eruption, solar urticaria and erythropoietic protoporphyria.

Relevant disease summaries with prevalence statistics and co-morbidity information are provided below for many of the diseases which are the commonest indications for phototherapy. By its nature, this list is necessarily not comprehensive:

## 1. Psoriasis

**Prevalence:** The prevalence of psoriasis is estimated to be around 1.3–2.2% in the UK. Psoriasis can occur at any age, although is uncommon in children (0.71%) and the majority of cases occur before 35 years. A bimodal age of onset has been recognised in several large studies. The mean age of onset for the first presentation of psoriasis can range from 15 to 20 years of age, with a second peak occurring at 55–60 years<sup>1</sup>.

### Risk factors and Co-Morbidities

- Psoriatic arthritis (PsA) affects up to 40% patients with skin or nail psoriasis. Annual assessment for psoriatic arthritis is required for psoriasis patients within the first 10 years of onset. (See NICE clinical guidance 153).
- Increased risk of *cardiovascular diseases requiring assessment every five years*. See (NICE clinical guideline 67) and (NICE public health guidance 25).
- Increased risk of lymphoma and non-melanoma skin cancer.
- Increased risk factor for Venous Thromboembolism in adults. See NICE clinical guideline 92.
- Profound functional, *psychological*, and social morbidity with predisposed depression in patients. See (NICE clinical guideline 91) and (NICE clinical guideline 28).

### Phototherapy for the treatment of psoriasis:

For most people, psoriasis is managed in primary care. The most common therapies used are creams, gels and ointments as topical applications; these include mild to potent steroids, vitamin D analogues, dithranol and emollients. Specialist referral is needed at some point for up to 60% of people. For those whose psoriasis cannot be controlled alone with topical treatments, phototherapy therapy is the most commonly used second line therapy<sup>2</sup>. Narrowband UVB phototherapy is very commonly used in severe flares of psoriasis and chronic psoriasis

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<sup>1</sup> NCCG Psoriasis. Assessment and Management of Psoriasis: Clinical Guideline Methods, Evidence and Recommendations. NICE. 2012.

<sup>2</sup> <http://pathways.nice.org.uk/pathways/psoriasis/phototherapy-for-psoriasis>

unresponsive to topical therapy. PUVA is also a valuable second line therapy in psoriasis. Psoriasis is the most common reason of all for a Dermatology patient to be referred for Phototherapy.

## 2. Sclerosing Skin Diseases

### 2.1 Morphoea

**Prevalence:** The incidence of morphoea has been estimated as approximately 2.7 per 100,000 people per year. This is a disorder characterised by the overproduction and deposition of collagen leading to thickening of the dermis, subcutaneous tissues, or both. Morphea is classified into circumscribed, generalised, linear (Coup de sabre, progressive hemifacial atrophy) and pansclerotic subtypes according to the clinical presentation and depth of tissue involvement.

**Aetiology:** An autoimmune aetiology is supported by the frequent presence of autoantibodies in affected individuals, as well as the association of morphea with other autoimmune diseases, including systemic lupus erythematosus, vitiligo, type 1 diabetes mellitus and autoimmune thyroiditis.

**Comorbidities and risk factors:** Linear and deep morphea subtypes can cause considerable morbidity, including joint contractures, limb-length discrepancy and hemifacial atrophy with potential neurologic and ophthalmologic complications.

**Therapy:** Few controlled trials have been performed and there is a wide variation in the approach to treatment. Limited disease can be managed with topical treatment including superpotent topical steroid, tacrolimus, calcipotriene and combination of calcipotriol with betamethasone dipropionate. Patients with generalised, linear, or deep morphoea typically require more aggressive therapy. These include systemic corticosteroids, methotrexate (MTX) and Mycophenolate mofetil. A few reports describe responses of severe morphoea to cyclosporine. Phototherapy may be beneficial as an additional second-line therapy for refractory or severe disease, or as a first-line therapy for patients with generalised morphea given its low side effect profile compared to immunosuppressive agents. Broadband UVA, UVA1 (340-400 nm) and psoralen plus UVA (PUVA) photochemotherapy has been reported to result clinical improvement of morphoea lesions in multiple case series and a randomised controlled trial.

### 2.2 Systemic sclerosis

**Prevalence:** The incidence of systemic sclerosis is estimated at 0.2 -1.9 per 100,000 population per year. It is a multisystem disease characterised by fibrosis and vascular abnormalities in association with autoimmune inflammation. These lead to fibrosis of skin, subcutaneous tissue, muscles and joints, and internal organ involvement of the gastrointestinal tract, heart, lungs and kidneys. There are two main forms of systemic sclerosis, diffuse and limited type, which have different patterns of clinical involvement, complications and autoantibody abnormality.

**Comorbidities and risk factors:** Skin sclerosis, sclerodactyly, Raynaud's phenomenon, ulceration,

calcinosis and telangiectasia are prominent cutaneous features. Synovitis with joint contractures occurs. Systemic complications include renal failure, lung fibrosis, pulmonary hypertension as well as cardiovascular and gastrointestinal disease.

**Therapy:** The therapeutic approach depends on the presentation of the disease and complexity of symptoms. PUVA and UVA-1 phototherapy have in role in the treatment of skin sclerosis. Calcium-channel blockers and iloprost can be required for Raynaud's phenomenon. Therapies targeted at the systemic involvement and severe cutaneous disease include oral and intravenous corticosteroids, penicillamine and immunomodulatory agents such as Methotrexate, Chlorambucil, Mycophenolate mofetil, Cyclosporine, Tacrolimus, Thalidomide and Cyclophosphamide

### 2.3 Lichen sclerosus

**Prevalence:** The incidence of lichen sclerosus is unknown. This is a chronic inflammatory dermatosis that results in white plaques characterised by epidermal atrophy and scarring. The aetiology and pathogenesis are unknown but may include genetic, infectious, environmental and hormonal factors.

**Comorbidities and risk factors** Lichen sclerosus has both genital and extragenital presentations and there is an increased risk of squamous cell carcinoma in chronic genital disease. Genital disease, both vulval and penile, outnumbers extragenital reports by more than 5:1. Extragenital lesions may occur anywhere on the body, although the back and shoulders are reported most commonly. Systemic disease or involvement of other organ is not described. Recalcitrant cases, especially those associated with erosion or progressive scarring may result dyspareunia, dysuria, phimosis and urinary obstruction.

**Therapy:** Genital lichen sclerosus may respond to potent topical corticosteroids and calcineurin inhibitors have been found to help some patients. Circumcision may benefit male patients with lichen sclerosus. Asymptomatic extragenital lichen sclerosus often requires no treatment. Narrow-band UVB, PUVA and UVA1 are reported to be beneficial in small case series of mainly extragenital disease. Systemic retinoids have been useful in limited studies. Methotrexate and other immune suppressing medications have been used, alone and in combination with topical and systemic corticosteroids for intractable cases.

### 2.4 Scleredema

**Prevalence:** Scleredema is an uncommon fibromucinous connective-tissue disease. It is characterised clinically by woody induration and hardening of the skin as the result of excessive mucin deposition between thickened collagen bundles in the dermis. Precise prevalence figures are not available. There are three clinical forms of scleredema which have a different history, course and prognosis and are classified by their associated condition - post infection, blood dyscrasia (monoclonal gammopathy and myeloma) and diabetes mellitus.

**Comorbidities and risk factors:** Although the disorder is usually restricted to the skin, the tongue,

pharynx, esophagus, skeletal muscle, and cardiac muscle may rarely be affected. Reported associations include the following: Hyperparathyroidism, Rheumatoid arthritis and Sjögren syndrome, HIV disease, Malignant insulinoma and Carcinoid tumour

**Therapy:** Postinfectious scleredema may spontaneously resolve. Scleredema associated with a monoclonal gammopathy or diabetes typically does not regress spontaneously and no therapy is consistently effective. Most therapeutic reports are limited to single case reports or small case series. Systemic steroids, cyclosporine, methotrexate, penicillamine have all been tried with limited success. Case reports also describe the use of phototherapy mainly PUVA and UVA1. Reports have described efficacy with intravenous immunoglobulin therapy.

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### 3. Mycosis Fungoides

**Prevalence:** This disease makes up around 72% of cutaneous T-cell lymphomas (CTCL)<sup>3</sup>. The incidence is approximately 0.36 cases per 100,000 population per year<sup>4</sup>. It most often presents in those aged 45 to 60 years, but has been diagnosed in children and adolescents. It is 50% more common in black than in white patients and twice as frequent in men as in women. Some occupational factors may be associated – e.g., Glass formers, pottery and ceramics workers. There is some clustering in families<sup>5</sup>.

**Therapy:** The mainstay of therapy for patch stage disease is narrowband UVB phototherapy. PUVA remains a major therapeutic modality in the treatment of cutaneous T cell lymphoma, especially in the treatment of plaque stage disease. PUVA phototoxicity has been shown to selectively target neoplastic T lymphocytes in the skin. PUVA remains the major therapy for plaque stage disease in Mycosis Fungoides. Maintenance therapy should be considered to prevent relapse in quickly recurrent disease. PUVA is also used in the tumour phase, combined with systemic therapies – e.g. PUVA plus interferon. See BAD Guidelines for the Management of Primary Cutaneous T-Cell Lymphomas<sup>6</sup>.

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<sup>3</sup> Mycosis fungoides and Sezary syndrome. Lancet. Morales-Suarez-Varela MM, Olsen J, Johansen P, et al. 2008 Mar 15;371(9616):945-57

<sup>4</sup> Occupational risk factors for mycosis fungoides: a European multicenter case-control study. Morales-Suarez-Varela MM, Olsen J, Johansen P, et al. J Occup Environ Med. 2004 Mar;46(3):205-11.

<sup>5</sup> Familial mycosis fungoides: report of 6 kindreds and a study of the HLA system. Hodak E, Klein T, Gabay B, et al; J Am Acad Dermatol. 2005 Mar;52(3 Pt 1):393-402.

<sup>6</sup> British Association of Dermatologists. Guidelines for the Management of Primary Cutaneous T-Cell Lymphomas. Whittaker SJ et al. Br J Dermatol. 2003; 149: 1095-1107.



## 4. Vitiligo

**Prevalence:** Vitiligo is the ‘most common’ chronic depigmentation disorder of the skin, and affects all age groups and all ethnic groups. A recent review of worldwide studies on the prevalence of vitiligo placed the figure at 0.5 to 2% of adult population (Christian Kruger PhD, and Karin Uta Schallreuter, MD; *International Journal of Dermatology* 2012).

**Description:** It is characterised by well demarcated areas of depigmentation. In many patients it is a long term disorder which may remit and relapse. Vitiligo appears to be an organ-specific autoimmune disorder. Vitiligo affects at least one person in every hundred throughout the world, including in the UK. Anyone can develop the condition, whatever their skin colour or ethnic origin and 50% of cases develop before the age of 20 years. The disease affects the skin, through destruction of functional epidermal melanocytes, and in many cases the hair as well, through hair follicle melanocytes.

**Risk factors and Co-Morbidities:** There are associations with diabetes mellitus, hypothyroidism, Addison’s disease, alopecia areata. See (NICE Public Health Guidance 35). The vitiligo patient’s change in appearance can have an overwhelming impact on their self-esteem and feeling of wellbeing, and on the patient’s ability to maintain healthy and intimate relationships with others.

**Therapy<sup>7</sup>:** A number of treatments can be temporarily effective to slow the progress of Vitiligo. However, the chances of its recurrence are high. Treatment options include topical steroids (potent or very potent); topical calcineurin inhibitors (which do not cause the atrophy caused by potent topical steroids but frequently cause irritant effects); depigmentation (for smaller, visible areas) and surgery. Phototherapy is a widely used and valuable mainstay second line therapeutic modality in vitiligo where disease is severe and unresponsive to topical therapies. Prolonged courses of narrow band ultraviolet B lead to complete remission in around 35% of patients, though relapse rates within the subsequent four years are high as with all therapies in vitiligo. PUVA is of similar efficacy to UVB.

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<sup>7</sup> Interventions for vitiligo. Whitton ME, Pinart M, Batchelor J, Leonardi-Bee J, González U, Jiyad Z, Eleftheriadou V, Ezzedine K. Cochrane Database Syst Rev. 2015 Feb 24;2:CD003263.

## 5. Eczema and Nodular Prurigo

**Prevalence:** Eczema is an increasingly common condition affecting 1 in 9 people in England. It is estimated that 15-20% of school children and 2-10% of adults are affected<sup>8,9</sup> The age–sex standardised incidence of eczema was 9.58 per 1000 person-years in 2001 and increased to 13.58 per 1000 patients in 2005 ( $p < 0.001$ ). By 2005, eczema affected an estimated 5,773,700 (95% confidence intervals [CI] 5,754,100–5,793,400) individuals in England, who, on average, consulted a general practitioner 4.02 (95% CI 4.01–4.03) times a year. In the period 2001-2005, the number of eczema related prescriptions increased by 56.6% (95% CI 56.6–56.7), so by 2005 an estimated 13,690,300 (95% CI 13,643,200–13,737,600) prescriptions were issued<sup>10</sup>. An estimated 1.7 million children in the UK have eczema, and the numbers appear to be rising<sup>11</sup>. The large majority (about 80%) of cases present before the age of five years. There is an increased prevalence in those with an affected parent.

**General description:** Atopic eczema/dermatitis is defined as a chronic, relapsing, itchy, inflammatory skin condition associated with epidermal barrier dysfunction, which is in many cases believed to result from an underlying filaggrin gene defect. Eczema can also be caused or exacerbated by irritants, contact allergy, food/drug allergy and infections. Eczema can affect any part of the skin and can also be confined to localised areas such as the hands and feet (palmoplantar eczema).

Nodular prurigo is a chronic and often recalcitrant, itchy skin condition of unknown etiology characterised by the development of firm cutaneous lumps. Up to 80% of patients have a personal or family history of atopic dermatitis, asthma or hay fever (compared to about 25% of the normal population).

**Associated diseases and non-cutaneous complications:** Atopic rhinitis (hayfever), atopic conjunctivitis, atopic asthma and type I allergies are all more common in patients with atopic eczema. Nodular prurigo can be associated with a range of underlying conditions including infections, malignancy, renal failure, hepatic and haematological abnormalities, metabolic and psychological/psychiatric co-morbidities.

**Therapy:** There are multiple treatment options that can be considered depending on the location, severity of the disease and impact on quality of life. These include emollients, topical steroids, topical calcineurin inhibitors, bandages and medicated dressings, antihistamines, phototherapy, systemic immunosuppression with ciclosporin, methotrexate, azathioprine and

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<sup>8</sup> Trends in the epidemiology and prescribing of medication for eczema in England. Colin R Simpson, John Newton, Julia Hippisley-Cox, Aziz Sheikh. Journal of the Royal Society of Medicine March 1, 2009 vol. 102 no. 3 108-117:

<sup>9</sup> Atopic eczema in children, NICE Clinical Guideline (December 2007) <http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11901>

<sup>10</sup> Trends in the epidemiology and prescribing of medication for eczema in England. Colin R Simpson, John Newton, Julia Hippisley-Cox, Aziz Sheikh. Journal of the Royal Society of Medicine March 1, 2009 vol. 102 no. 3 108-117:

<sup>11</sup> Trends in the prevalence and severity of asthma, rhinitis and atopic eczema in 6- to 7- and 13- to 14-yr-old children from the north-east of England. Shamssain M. Pediatr Allergy Immunol 2007; 18: 149-53.

mycophenylate mofetil, systemic retinoids such as Alitretinoin, and perhaps emerging biologic therapies as well.

**Where phototherapy fits into the treatment of the disease (how important is it and when is it used?):** Phototherapy is a valuable treatment option in the management of severe generalised atopic eczema, and nodular prurigo and can also be considered for localised palmoplantar eczema when other management options have failed, or are inappropriate, and where there is a significant negative impact on quality of life. It is also useful for its steroid sparing effects. NB-UVB is generally considered first line for generalised involvement and topical /oral PUVA is considered first line for localised palmoplantar eczema.

## 6. Urticaria

**Definition and prevalence:** Chronic Urticaria (CU) can occur in response to drugs, physical stimuli, as part of inflammatory or inherited diseases, or can be idiopathic in nature. Chronic idiopathic urticaria is the most common type of CU, comprising up to 90% of all cases of CU<sup>12</sup>. Approximately 15% of people experience urticaria at some time in their lives. Acute urticaria is much more common than CU. (Estimated lifetime incidence is 1 in 6 people compared to 1 in 1,000.) The prevalence rate for CU has been estimated as 1-5 per 1,000. Acute urticaria is most common in children, and is more common in women than in men, particularly in the 30-60 age range. It is more common in individuals who suffer with atopy<sup>13</sup>.

**Risk factors and comorbidities:** Urgent hospital admission may be indicated if acute urticaria rapidly develops into angioneurotic oedema or anaphylactic shock.

Numerous autoimmune conditions have been associated with chronic idiopathic urticaria, including thyroid disease, celiac disease, diabetes type I, *systemic lupus erythematosus* and rheumatoid arthritis (RA)<sup>14</sup>. See (BAD Guidelines -Evaluation and management of urticaria in adults and children (2007)<sup>15</sup>.

**Role of phototherapy in management:** Phototherapy (PUVA and NB-UVB) is one of the available second line therapies for urticaria unresponsive to first line therapies, and appears to be particularly useful in the treatment of symptomatic dermatographism.

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<sup>12</sup> Urticaria and angio-oedema. A review of 554 patients. Champion RH, Roberts SO, Carpenter RG, et al. Br J Dermatol. 1969 Aug;81(8):588-97.

<sup>13</sup> Urticaria; NICE CKS, December 2011

<sup>14</sup> Chronic Urticaria and Autoimmunity - Kathleen Fraser BHSc1 and Lynne Robertson MD, FRCPC2 College of Medicine, University of Saskatchewan, Saskatoon, SK, Canada.

<sup>15</sup> Guidelines for evaluation and management of urticaria in adults and children. C.E.H. Grattan and F. Humphreys on behalf of the British Association of Dermatologists Therapy Guidelines and Audit Subcommittee.

## 7. The Photodermatoses

Photodermatoses where Phototherapy is a commonly used treatment modality:

- *Polymorphic Light Eruption*: a very common itchy inflammatory rash that occurs in response to sunshine generally in the spring and summer.
- *Solar Urticaria*: A rare severe physical urticaria generally characterised by UVA or visible light sensitivity. It is idiopathic. It can occur at any age.
- *Actinic Prurigo*: a rare severe inflammatory condition characterised by prurigo and induced by UV, often UVA.
- *Erythropoietic Protoporphyrria*: a hereditary porphyria, a lifelong condition which causes bouts of severe pain on sun exposure.

Prevalence:

- *Polymorphic light eruption*: In a recent population survey in the U.K.<sup>16</sup>, Polymorphic Light Eruption was found to affect 15% of healthy people, with a female to male ratio of approximately 2:1<sup>17</sup>. A family history of PLE has been reported in almost 50% of cases, suggesting a possible genetic component<sup>18</sup>. It is more common in those with fair skin and tends to affect women more often than men. Age of onset is usually 20-40 years.
- *solar urticaria*: unknown but estimated as around 1:100,000 prevalence
- *actinic prurigo*: unknown
- *erythropoietic protoporphyria*: prevalence in the UK 6.3/million<sup>19</sup>. An estimated 5,000-10,000 individuals worldwide have EPP. EPP is considered the most common form of porphyria in children.

Risk factors and co-morbidities:

- *Polymorphic light eruption*: risk factor: there is a strong familial component
- *solar urticaria*: comorbidity: often causes a severe disabling perennial photosensitivity resulting in severe secondary psychological consequences and limitation of employment and other life opportunities
- *actinic prurigo*: risk factor: a family history of PLE and HLA type DR4

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<sup>16</sup> The Heritability of Polymorphic Light Eruption. Thomas P Millard, Veronique Bataille Harold Snieder, Tim D Spector and Jane M McGregor, *Journal of Investigative Dermatology* (2000) 115, 467–470.

<sup>17</sup> Polymorphic light eruption: prevalence in Australia and England. Pao C, Norris PG, Corbett M & Hawk JL. *Br J Dermatol* (1994) 130: 62–64.

<sup>18</sup> Current aspects of polymorphous light eruptions in Sweden. Ros AM & Wennersten G. *Photodermatology* (1986) 3: 298–302

<sup>19</sup> Erythropoietic protoporphyria in the U.K.: clinical features and effect on quality of life. Holme SA, Anstey AV, Finlay AY, Elder GH, Badminton MN. *Br J Dermatol*. 2006;155:574-81.

- *erythropoietic protoporphyria*: About 20-30% of individuals with EPP have some degree of liver dysfunction. Up to 5% of affected individuals may develop more advanced liver disease, most notably cholestatic liver failure. In most individuals, underlying liver cirrhosis is already present; however, some may present with rapidly progressive cholestatic liver failure. Gallstones are of increased frequency in EPP. Vitamin D deficiency is common in EPP as in other photodermatoses.

### Phototherapy for management of the photodermatoses:

*PLE*: Annual desensitisation therapy with NB-UVB or PUVA is effective in severe PLE with response rates around 80-90%.

*Actinic prurigo*: when photoprotection and topical steroids fail to control the disease, second line treatment options include immunosuppressant systemic drugs (including thalidomide) and/or PUVA or NB-UVB photodesensitisation therapy.

*Solar urticaria*: when photoprotection and antihistamine therapy are ineffective, second line therapies include systemic immunosuppressants, biologic drugs and plasmapheresis. 'Rush hardening' photodesensitisation (NB-UVB or UVA) can be used in severe cases though they are initially complex and labour intensive because of the frequency of treatments required and the need to avoid widespread induction of the eruption by the UV. Photodesensitisation in this disease is therefore reserved for severe cases unresponsive to other therapies, and is only carried out in phototherapy centres with appropriate highly specialist expertise and experience.

*Erythropoietic protoporphyria*: PUVA and NB-UVB can both be useful as desensitising therapy before spring begins to harden the skin and reduce the skin's sensitivity to sunlight. Some degree of improvement occurs in some patients but they still do have significant photosensitivity even after therapy.

## 8. Other Inflammatory Dermatoses

There are case reports of response of many inflammatory dermatoses to phototherapy or photochemotherapy. There are too many to list individually here, but we have focussed on a number where treatment is worth considering (cutaneous graft versus host disease (cGVHD), lichen planus, granuloma annulare (GA), pityriasis lichenoides chronica (PLC), generalised cutaneous mastocytosis (urticarial pigmentosa).

**Prevalence:** Chronic cGVHD occurs in 30-50% of allogeneic bone marrow transplant patients; lichen planus <1%; PLC probably <0.1%; GA probably <1%; mastocytosis incidence 1:150,000 per year;

**General description:** *Cutaneous GVHD* may be acute or chronic and is a result of reaction of donor immune cells with host skin. Clinical spectrum may resemble eczema, lichen planus, lichen sclerosis or scleroderma and it may vary in severity from mild to life-threateningly severe.

*Lichen planus* is a disease of unknown aetiology with evidence supporting immunologically mediated pathogenesis. The eruption most frequently affects the volar aspects of the wrists, the lumbar skin and the lower legs, but any skin or mucous membrane surface can be involved. Several morphological variants are described.

*PLC* is a generalised eruption which is occasionally itchy. It is part of a spectrum of pityriasis lichenoides which varies from acute necrotic lesions to chronic scaly lesions. It may last from six months to years and may be relapsing.

*GA* is usually symptomless but cosmetically problematic disorder which is commonly localised but may be more widespread or diffuse. It tends to improve spontaneously although some patients may have persistent signs over a period of years.

*Mastocytosis* is a benign proliferation of functionally normal mast cells within the skin and sometimes other body systems. In childhood 50% of cases clear by adolescence. In adulthood it is generally indolent although clearance in time has been reported in perhaps 10%. Itching and flushing are the main symptoms.

**Associated diseases:** GVHD in the skin may be associated with GVHD in other organs including mucous membranes, liver, gut and lung.

There are no proven associations of *lichen planus* but consideration should be given to lichenoid drug reactions in individuals with this condition.

The acute forms of *pityriasis lichenoides* may be associated rarely with lymphoma.

One study showed insulin dependent diabetes is about 17 times more common in *GA* patients than expected, although others have not confirmed this association.

Studies have shown that over half of patients with *cutaneous mastocytosis* have benign bone marrow involvement on biopsy. Progression to malignancy is very rare.

**Therapy:** Depending on severity *cGVHD* is treated with topical corticosteroids, or systemic immune suppression.

The majority of *lichen planus* patients can be managed with potent topical steroid preparations. Severe generalised lichen planus may warrant limited courses of systemic corticosteroids, especially in acute presentations. Other systemic immunosuppressive agents and acitretin have been used.

*PLC* may respond to oral tetracyclines or erythromycin. Topical corticosteroids may produce symptomatic relief. Methotrexate is sometimes considered in patients not responding to phototherapy.

*GA* may not require any treatment other than reassurance. Some reports suggest improvement of localised lesions with intralesional corticosteroid or cryotherapy.

*Mastocytosis* may be controlled by avoidance of physical triggers of mast cell degranulation, antihistamines and sodium chromoglycate.

**Phototherapy:** *Cutaneous GVHD* can respond to narrow band UVB, oral and bath PUVA and these therapies are usually used as adjunctive steroid-sparing agents. Success is judged on ability to reduce the dose of systemic immune suppression. Some reduction in dose has been shown in most case series and complete remission in a few. There is concern regarding development of squamous cell carcinoma with prolonged use of PUVA in this population, and severe lichenoid or sclerodermoid cGVHD may be better treated with extracorporeal photopheresis (ECP).

Generalised *lichen planus* in patients not responding to (or with contraindications to) systemic immunosuppression could be considered. Some evidence supports the use of oral and bath PUVA as well as NB-UVB. Reported responses are 50-90% and overall less than psoriasis and likely to need a more prolonged course. Relapse is common. Post treatment pigmentation can be persistent. There are some reports of exacerbation with PUVA.

*PLC* is commonly treated with UV therapy. NB-UVB is the first choice with response rates of 48-90%. PUVA is reserved for resistant cases. Relapse is quite likely within six months.

*GA* may show improvement with oral or bath PUVA. It is reserved for generalised *GA* in patients with prolonged disease who insist on treatment. About 70% may show clearance or improvement but 60% of these relapse within three years. NB-UVB may show a good response in 50%.

*Mastocytosis* has been shown to respond to oral or bath PUVA with reduction in symptoms, improved appearance and reduction in mast cell numbers in the skin. However relapse is early and given the long term nature of the condition, careful consideration should be given before embarking on treatment.

## Glossary of Abbreviations and Terms

<b>BAD</b>	British Association of Dermatologists
<b>BDNG</b>	British Dermatological Nursing Group
<b>BPG</b>	British Photodermatology Group
<b>CCG</b>	Clinical Commissioning Group
<b>cGVHD</b>	Cutaneous Graft Versus Host Disease
<b>COSHH</b>	Control of Substances Hazardous to Health
<b>CPD</b>	Continuing Professional Development
<b>CQC</b>	Care Quality Commission
<b>CTCL</b>	Cutaneous T-cell Lymphoma
<b>CU</b>	Chronic Urticaria
<b>DLQI</b>	Dermatology Life Quality Index
<b>DQIP</b>	Data Quality Improvement Plan
<b>ECP</b>	Extracorporeal Photopheresis
<b>GA</b>	Granuloma Annulare
<b>GMC</b>	General Medical Council
<b>GP</b>	General Practitioner
<b>HCPC</b>	Health and Care Professions Council
<b>HSCIC</b>	Health and Social Care Information Centre
<b>HSE</b>	Health and Safety Executive
<b>MDT</b>	Multi-Disciplinary Team: all health professionals involved in an individual patients care
<b>MED</b>	Minimal Erythema Dose



<b>MHRA</b>	Medicines and Healthcare Products Regulatory Agency
<b>MPD</b>	Minimal Phototoxic Dose
<b>MTX</b>	Methotrexate
<b>NB-UVB</b>	Narrowband UVB phototherapy
<b>NHS</b>	National Health Service
<b>NICE</b>	National Institute for Health and Care Excellence
<b>NMC</b>	Nursing and Midwifery Council
<b>PALS</b>	Patient Advice and Liaison Services
<b>PCDS</b>	Primary Care Dermatology Society
<b>Photonet</b>	National Managed Clinical Network for Phototherapy in Scotland
<b>PIL</b>	Patient Information Leaflet
<b>PLC</b>	Pityriasis Lichenoides Chronica
<b>PLE</b>	Polymorphic Light Eruption
<b>PPI</b>	Patient Public Involvement
<b>PsA</b>	Psoriatic Arthritis
<b>PUVA</b>	The combination of a psoralen, applied locally or taken in tablet form, and ultraviolet A: Psoralen Ultraviolet A
<b>RCP</b>	Royal College of Physicians
<b>SDIP</b>	Service Development and Improvement Plan
<b>UV</b>	Ultraviolet
<b>UVA</b>	Ultraviolet radiation in the waveband 315 – 400nm
<b>UVB</b>	Ultraviolet radiation in the waveband 280 315nm
<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.

### **Accredited specialist**

An accredited specialist in dermatology is a doctor whose specialty is recorded as 'Dermatology' in the General Medical Council's (GMC) list of specialist registered medical practitioners (consultants). He/she is a doctor who has completed either specialist UK training in dermatology approved by the GMC; or has been assessed as having equivalent experience.

### **Audit**

Systematic review of the procedures used for diagnosis, care, treatment 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 (National Institute for Health and Clinical Excellence).

### **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.

**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 treatment 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.

### **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.

## **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.

### **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.

### **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**

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 practise.

### **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

The BAD Officers would like to express their gratitude to the WPG and its stakeholders for producing the Phototherapy Service Guidance and Standards. These guidelines provide an invaluable resource for dermatology departments and their patients. These guidelines were produced by the BAD independently of any funding body and through the time given freely by WPG members.

### Multidisciplinary Working Party Group

The following people have provided continued advice and support in compiling and editing these standards.

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Nichola Mair	Network Coordinator, South-East of England Phototherapy Managed Clinical Network
Emma Rush	Chairman of the Vitiligo Society
David Chandler	Founder of the Psoriasis and Psoriatic Arthritis Alliance (PAPAA)

### **Phototherapy Pilot Sites**

We would like to thank the following NHS Hospital Trust departments for agreeing to pilot the Phototherapy Service Guidance and for their valuable feedback.

- Barts Health NHS Trust
- Central Manchester University Hospitals NHS Foundation Trust
- East Kent Hospitals University NHS Foundation Trust
- Luton and Dunstable University Hospitals NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Portsmouth Hospitals NHS Trust
- Royal Free London NHS Foundation Trust
- Royal Wolverhampton NHS Trust
- South Eastern Health and Social Care Trust
- Southport and Ormskirk Hospitals NHS Trust
- The Royal Devon and Exeter NHS Foundation Trust
- University Hospital of South Manchester NHS Foundation Trust

# Phototherapy Standards Feedback Form

We hope that you have found the Phototherapy Service Guidance 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: *Type here*

2. Do you have suggestions for new sections or topic areas you would like to see included in future versions?

*Type here*

3. Do you have suggestions for new standards you would like to see included in future versions?

*Type here*

4. Do you have any general suggestions about this document that would improve its usefulness?

*Type here*

5. What is your profession?

*Type here*

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: Developing Dermatology Service Guidance 2016

<http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=4147>

## Appendix 2: Core List of Evidence

*20 x Patient case notes for phototherapy – anonymised information*

*Referral forms*

*Consent forms*

*Complaint letters - anonymised*

*Incident reports about the phototherapy service*

*Activity data for the phototherapy service (last 12 months)*

*List of unit staff*

*Evidence of staff appraisal*

*Up-to-date written phototherapy protocols*

*Evidence of clinical governance meetings*

*Evidence of a recording system for symptomatic erythema*

*Dosimetry protocols*

*Dosimetry records*

*Record of risk-assessment inspections for unit equipment*

*Record of protocol covering staff exposure to UV*

*Record of calibration inspections for unit equipment*

*Medical physics staff training records*

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



## Appendix 3: Specialised Service Specification for Dermatology

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