Dermatology GIRFT Programme

National Specialty Report: Proposed Recommendations

The draft GIRFT report is yet to be published. With permission from the GIRFT team, the 23 proposed recommendations that have arisen from the report were presented by Professor Nick Levell on 15th September 2020 and the recording of this webinar is available to watch on the BAD website (https://www.bad.org.uk/events). These proposed recommendations are further listed here and will be useful reference for departments whilst awaiting the final publication.

Proposed Recommendations

Workforce

1. **Increase the number of people training in dermatology.**

   a. Review options to increase funded training posts in regions with greatest shortages of consultants.
   b Standardise and formalise CESR training to increase non-locum medical staffing with the aim of allowing trusts to develop sufficient future consultant staff to meet their local needs.
   c Contribute findings to the national programme board being established to address geographic and specialty shortages in doctors

2. **Develop regional or sub-regional strategic plans for sustainable partnerships between local trusts to eliminate single-handed working and support smaller units.**

   a. Work collaboratively, for example by identifying nonconventional job planning solutions, and by establishing service-level agreements/joint-working arrangements to develop network models that will provide support to consultants working in smaller units.

3. **Optimise the training and function of the whole dermatology multidisciplinary team to deliver better care across settings and reduce locum costs. Develop a clinic structure to support this.**

   a. Train dermatology nurses as specialist nurses and as nurse consultants to expand the workforce in a safe, efficient and cost-effective way to meet the challenges of increasing skin cancer and the needs of people with skin disorders.

   b Adopt the framework for nurse banding and training developed by the BAD and BDNG to standardise roles and education across the NHS for dermatology nurses.

   c Include dermatology in training schemes for GPs and other primary care staff to improve evidence-based patient care and reduce unnecessary referrals.

   d Include dermatology training that meets the BAD curriculum in all medical school courses so that all GPs have basic dermatology skills.

   e Improve undergraduate dermatology training for pharmacists, so that community pharmacists are able to manage common skin conditions such as eczema, acne, fungal infections and warts in line with current evidence-based dermatology national guidelines.

   f Explore the potential for hospital pharmacists to help with the management of patients on systemic medications, including biologics.

   g Develop the use of superclinics as a model to allow safe supervision of a multidisciplinary workforce.

Efficient use of NHS resources

4. **Ensure there is clear and consistent delineation between day case and outpatient skin cancer activity taking place in dermatology and in other specialties. Funding arrangements should reflect this to support surgery in the most appropriate and efficient setting.**

   a. Develop simpler standardised rules defining outpatient procedures versus day case surgery.

   b Review funding arrangements to standardise funding and practice, ensuring trusts are incentivised to carry out surgery in the most appropriate setting, avoiding unnecessary use of operating theatres.

5. **Address unwarranted variation in follow up rates, reduce unnecessary follow ups, reduce DNAs and ensure that patients see an appropriately trained person in the right setting to receive the right diagnosis and treatment first time.**

   a. Benchmark follow-up rates, both including procedures and excluding procedures, and proportion of new patients discharged. Trusts should identify a target rate based on their circumstances to enable them to assess their performance

   b Explore rates for individual clinicians to identify if there are particular case-mix reasons for this.

   c Inform patients of their diagnosis by letter after excision of low risk skin cancers unless there are particular reasons for seeing them again in secondary care.

   d Use the languages widely spoken by the local community in outpatient communications to support patient understanding. Ensure that communications by letter and text use simple language.

6. **Improve care continuity and governance for NHS and non-NHS patients.**

   a. Establish clear and suitably funded shared care protocols between primary and secondary care providers for dermatology services

   b Establish clear arrangements between NHS and independent providers to ensure continuity of care for non-NHS patients discussed during dermatology MDT meetings

   c Inform and support the work of NHS England and the Independent Healthcare Providers Network (IHPN) to implement new medical governance framework

Equity of care and access to treatments

7. **Improve equitable access to high-quality Mohs surgery that meets national standards for patients with complex skin cancers.**
    a. Continue to review how access to high-quality Mohs surgery that meets national standards can be improved in remote areas.
    b. Commission health economic research to provide evidence to establish a standard rate/population, which will depend on demographics, for Mohs surgery to enable effective planning and equal access to this service.

8. Reduce the likelihood of wrong-site skin cancer surgical never events.
    a. Consider establishing or improving access to efficient and secure technology as provided by medical illustration services to record the position of lesions booked for surgery.
    b. Develop a standard operating procedure, incorporating the WHO checklist, to reduce the risk of wrong site surgery. Audit against this for compliance.

9. **Develop Clinical Threshold Policies for benign and cosmetic conditions management.**

    a. CCGs should work with local GPs and consultants to develop and implement Clinical Threshold Policies, learning from existing best practice and in line with the Evidence-Based Intervention Programme.

10. **Improve access to dermatopathology**

    a. Develop dermatopathology training (requires implementation of other recommendations to address workforce shortfalls).

    b. Promote the development of AI and digitisation of slides to support the work of clinicians in dermatology histopathology reporting.

11. **Improve access to, and quality of, allergy patch testing services.**

    a. Make access to patch testing more widespread by introducing high quality clinics which meet service standards in areas where provision is low.

    b Develop a national patch testing database to ensure standardisation of testing and facilitate national outcome measures.

    c Consistently code patch testing. GIRFT considers that all three visits should be coded as a patch test

d Produce a local financial impact assessment of improving access to provide equity of care.

12. **Improve access to, and quality of, emergency dermatology care.**

    a. Establish the workforce to supply office hours dermatology emergency care to support GPs and all acute hospitals with inpatients.

    b Conduct research to establish the requirement for outof-hours dermatology care for life threatening conditions.

    c Reimburse doctors for working on call overnight and allow adequate rest time to avoid safety issues with next-day working after out-of-hours provision.

13. **Consistently implement NICE guidance to address variation in uptake and use of biological medicines and ensure patients have equitable access to appropriate therapies.**

    a. GIRFT to work with NICE to ensure guidance aimed at CCGs relating to use of biologics can be consistently applied.

    b Trusts to submit data on biologics use to Rx-Info Define© (the NHS drugs database) and any subsequent NHS drugs databases in order to enable regional benchmarking of biologics use and identification of unwarranted regional variation in prescribing.

    c NIHR to fund research into the influence of pharmaceutical companies on prescribing behaviour in England for high-cost medicines such as biologics.

14. **Improve quality of, and access to, phototherapy for all appropriate patients.**

    a. Support NHS Digital's development of a national database for phototherapy

    b Provide access to phototherapy services at suitable times and venues for people in work.

15. **Establish networks to encourage shared care and expertise across specialties for complex medical dermatology.**

    a. Support the work of NHS England's Dermatology Specialised Service Clinical Reference Group (CRG) to develop MDT networks for complex medical dermatology

16. **Improve access to dermatology specialties, including hair and nail disease, female and male genital skin disease, and psychodermatology.**

    a. Establish clinics to ensure more locations have access to these services to provide equity of care.

17. **Improve access to, and quality of, paediatric dermatology services.**

    a. Encourage further uptake of the dermatology SPIN module among paediatricians to work alongside paediatric dermatologists to improve access to specialist support for children with skin conditions.

    b Support further analysis of the potential for NTN Grid training for paediatricians in dermatology to work alongside paediatric dermatologists to improve patient access.

18. **Review prescribing and dispensing practice for isotretinoin.**

    a.Review whether isotretinoin prescribing should be extended to fully trained GPwERs.

    b Consider how to safely allow certain community pharmacists to dispense isotretinoin to increase access for those people attending community dermatology clinics and with difficulty accessing hospital pharmacies.

Innovation, research and safety

19. **Review teledermatology services to inform trust-level investment and resourcing decisions.**

    a. NIHR to fund studies evaluating the efficacy, safety and efficiency of teledermatology with full health economic assessment.

    b Assess teledermatology services based on the points described in our report when considering whether to invest.

    c Trusts/CCGs to publish research and learning from teledermatology services so that others can learn lessons and share best practice. The FutureNHS Collaboration Platform is set up for this.

    d Offer patients the electronic referral system (e-RS) Advice and Guidance Service.

    e Include time spent providing Advice & Guidance and teletriage in the job plans for dermatologists.

    f Support services keen to innovate in this area, in line with the recommendations in actions 19b and 19c.

    g Prepare teledermatology services and other clinical services for the introduction of AI and machine learning.

20. **Increase use of telephone outpatient consultations.**

    a. Introduce telephone consultations for appropriate dermatology patients.

    b Include telephone outpatient clinics in job plans.

    c Provide guidance and protocols for effective use of telephone and video consultations in dermatology

21. **Ensure the public, patients and clinicians have access to the latest research studies, information and support to implement national safety recommendations.**

    a. Improve awareness and support implementation of national actions related to:
    • risks of fire associated with use of skin creams and cosmetics containing any oil
    • risks of accidental ingestion of potassium permanganate antiseptic tablets and solutions • future safety issues when they arise.

    b Encourage all trusts to increase recruitment to clinical research to improve patient outcomes

    c Continue to share learning about patient safety issues with the whole multidisciplinary team.

    d Report adverse incidents through appropriate channels.

    e Continue to work with NHS England and NHS Improvement and the MHRA to review skin product formulation and packaging to reduce the risk of avoidable patient harm.

Procurement

22. **Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.**

    a. Use sources of procurement data, such as the NHS Spend Comparison Service and relevant clinical data, to identify optimum value for money procurement choices, considering both outcomes and cost/price.

    b Identify opportunities for improved value for money, including the development of benchmarks and specifications. Locate sources of best practice and procurement excellence, identifying factors that lead to the most favourable procurement outcomes.

    c Use Category Towers to benchmark and evaluate products and seek to rationalise and aggregate demand with other trusts to secure lower prices and supply chain costs.

Litigation

23. Implement the GIRFT 5-point plan for reducing litigation costs.

a. Clinicians and trust management to assess their benchmarked position compared to the national average when reviewing the estimated litigation cost per unit of activity.

b Clinicians and trust management to discuss with the legal department or claims handler the claims submitted to NHS Resolution included in the data set to confirm correct coding to that department. Inform NHS Resolution of any claims that are not coded correctly to the appropriate specialty via CNST.Helpline@resolution.nhs.uk

c Once claims have been verified, clinicians and trust management to further review claims in detail, including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If the legal department or claims handler needs additional assistance with this, each trust's panel firm should be able to provide support

d Claims should be triangulated with learning themes from complaints, inquests and serious incidents (SI). Where a claim has not already been reviewed as SI, we recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared with all front-line clinical staff in a structured format at departmental/ directorate meetings (including multidisciplinary team meetings, and morbidity and mortality meetings where appropriate).

e Where trusts are outside the top quartile of trusts for litigation costs per activity, GIRFT will be asking national clinical leads and regional hubs to follow up and support trusts in the steps taken to learn from claims. Clinical leads and regional hub directors will also be able to share examples of good practice with trusts