SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	Acute Dermatology Service
Commissioner Lead	Scheduled Care Team – East Lancashire CCG
Provider Lead	East Lancashire CCG
Period	2017/18 & 2018/19
Date of Review	Year 1 quarterly review / Year 2 - 6 month review

1. Population Needs

1.1 National/local context and evidence base

Dermatological conditions place a significant burden on the Health Service with studies suggesting that 22.5-33% of the national population suffer from some form of skin disorder at any one time. Most self-care (69%) and 14% seek further medical advice. Skin conditions are the most frequent reason for people to consult their GP with a new problem. Of the approximately 13 million presenting with these skin conditions, around 6% are referred for specialist advice in secondary care with 92% of referrals seeing NHS specialists on a predominantly outpatient-basis.

Referrals into secondary care have increased by an average of 5% per annum for the past 10 years and whilst many patients referred require the expertise and treatment facilities that are only available in secondary care, a significant proportion do not. This combined with varying levels of service provision across England has led to increased waiting times for patient appointments and without a change to service provision, this will continue to create an increasing burden on NHS resources.

There were around 2,500 malignant melanoma deaths in the UK in 2014, that's around 7 deaths every day. Malignant melanoma is the 18th most common cause of cancer death in the UK (2014). Malignant melanoma accounts for 2% of all cancer deaths in the UK (2014). In males in the UK, malignant melanoma is the 16th most common cause of cancer death, with around 1,400 deaths in 2014. In females in the UK, malignant melanoma is the 16th most common cause of cancer death, with around 1,000 deaths in 2014. There were around 780 non-melanoma skin cancer deaths in the UK in 2014, that's around 2 deaths every day. Non-melanoma skin cancer accounts for less than 1% of all

cancer deaths in the UK (2014). In males in the UK, there were around 490 non-melanoma skin cancer deaths in 2014. In females in the UK, there were around 290 non-melanoma skin cancer deaths in 2014. More than half (54%) of malignant melanoma deaths in the UK each year are in people aged 70 and over (2012-2014). Mortality rates for malignant melanoma in the UK are highest in people aged 90+ (2012-2014). In Europe, around 22,200 people were estimated to have died from malignant melanoma in 2012. The UK mortality rate is 19th highest in Europe for males and 17th highest for females. Skin cancer deaths are less common in people living in the most deprived areas. Worldwide, around 55,500 people were estimated to have died from malignant melanoma in 2012, with mortality rates varying across the world.

In 2006, the DH White Paper, *'Our health, our care, our say' a new direction for community based outpatient care,* suggested that patients with long term skin conditions could be managed more effectively in a community setting, with access to specialist services if required.

This model of care outlines the acute specialist Dermatology service and how it dovetails with the wider integrated access to community care, primary care and will aim to enhance patient experience with clear identified pathways.

The acute Dermatology service will offer advice and support to the GPwSI community care provision. They will also support the need for self-management advice and programmes for those patients with long-term Dermatology conditions, thereby; it will support the management of increasing demand for speciality skin services working within the 18 week referral to treatment (RTT) and ensure effective use of NHS resources.

The purpose of this service specification is to outline the commissioning intentions of the CCG and to provide an acute specialist service to manage a specified range of referrals for people with dermatological conditions in line with best clinical practice.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	√
Domain 2	**Enhancing quality of life for people with long-term conditions**	√
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	√
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	√

2.2 Local defined outcomes

The acute based skin service, and the community based services will work as an integrated skin team.

The Acute Dermatology service will be delivered to a high standard, by a range of skilled and competent practitioners including: Consultant Dermatologists, Dermatology medical

team, Advanced Nurse Practitioners, support staff, with overall Clinical leadership from ELHT Consultant Dermatologists, working within a robust governance framework to ensure that the service is:

- **Safe:** patient safety is enhanced by the use of health care processes, working practices and systemic activities that prevent or reduce the risk of harm to patients
- **Effective:** focused on delivering evidenced based practice, with shared decision making; achieving the best outcomes for patients
- **Standardised:** all services are provided to a consistent standard and format so patients can expect the same quality of care and access to care wherever they are treated
- **Fair:** available to all, taking account of the health needs and culturally diverse population of East Lancashire and Blackburn with Darwen
- **Personal:** treating all patients with respect and dignity; tailoring care to individual need
- **Efficient:** operating within a culture of continuous quality improvement and delivering value for money
- **Accessible:** waiting times, smooth integrated pathways with choice of appointment at ELHT hospitals or where appropriate at community services, within each of the boroughs of East Lancashire and Blackburn with Darwen

The service will demonstrate compliance with Care Quality Commission (CQC) Essential Standards of Quality and Safety 2010 Outcomes and equivalent Dermatology professional standards.

All digital imagery and patient information will be linked appropriately through IM&T governance to the Picture Archive Communication Systems (PACS) and NHS information systems throughout all tiers of the service.

The acute service will interpret and implement standards in ways which challenge discrimination, promote equity of access & quality of services, reduce inequalities in health and which respect and protect human rights.

As part of the overall Dermatology model the community based integrated services will be provided by General Practitioners with a Special Interest (GPwSI) and specialist Dermatology nurses; all with appropriate qualifications, skills and competencies and post registration experience; ensuring that all staff have the necessary qualifications, training and experience, have safe-guarding training and are appropriately checked through the Disclosure & Barring Service

Consultant Dermatologists, ANP's, medical staff. GPwSI's and specialist Dermatology nurses will contribute to the integrated skin service meetings and clinical discussions, delivering team training and education, based on best practice relevant to their role.

The acute service will operate within robust Governance arrangements; being actively engaged in clinical governance to ensure probity around clinical leadership, clinical and cost effectiveness, health and safety, risk analysis and mitigation of risk, corporate governance, and evidence based practice; underpinned by clinical and performance standards.

The acute service will adhere to NICE guidance, where applicable. And to Professional standards and clinical priorities.

Clinical and professional leadership will be assured by the service; ensuring consistent delivery of a quality service with particular attention to: appointment of high calibre staff,

effective team work, training and development, appraisal, assurance of professional standards, appropriate attitudes and behaviour, engaged workforce and review of individual professional practice & competence, within the acute skin service.

The service will work within a culture of continuous improvement; all staff will identify improvement in practice, along with removal of non-value adding activity, supporting the introduction of new systems/procedures/policies/protocols that will benefit patients' experience & outcomes, reduce the risk of harm and increase efficiency.

These standards will be reviewed as part of the existing governance processes, or as directed by NHS regulation to ensure the delivery of safe personal effective care; a quality report (schedule 2G) will be provided, by the acute service, through joint clinical leadership with the clinical lead and thereon, as agreed within the contract and performance monitoring process, to the CCG.

3. Scope

3.1 Aims and objectives of service

Aims

The overall aim of the integrated Dermatology service is to deliver high quality patient-centred care, which is well co-ordinated between both acute and community tiered services. The acute service will provide highly specialist skin care for 2wR complex long term conditions and relapse response, through the framework to facilitate step up and step down process and will be responsive to individual need.

The community based service will provide specialist skin care for less complex / routine conditions and will only onward / step up refer patients to the hospital based element of the service should they require, by protocol, highly specialised secondary care intervention. Both services will be tailored to individual need; being locally accessible, equitable and efficient providing value for money services within the health economy.

The acute skin service will ensure that people with skin conditions have access to high quality effective and timely advice, assessment, diagnosis and treatment, appropriate to their condition. The approach is based on shared decision making & care and structured around a smooth patient journey & seamless care pathways.

Through increased integration of services and timeliness of treatment, the integrated service aims to reduce the need for hospital based intervention and provide specialist care based on needs to patients and carers alike, in the community where possible and appropriate.

The model of service will focus on the holistic needs of the service user, through a collective partnership and pro-active team approach, to develop an informed empowered patient, with greater autonomy and independence to manage their longer term skin condition and well-being but with the ability to recognise symptoms, which may require further specialist advice and to access appropriate advice and care directly

The integrated skin service will support primary care practitioners and other clinicians in driving up skills and knowledge, as part of the enhancement plan

Objectives

The acute based skin service, and the community based services will work as an integrated skin team to:

Provide a point of access, through agreed referral pathways and work towards a single point of access, for people with a skin condition, requiring specialist skill and knowledge.

Provide specialist assessment, treatment & clinical management, with optimal outcomes and support patients with self-management strategies and lifestyle change, to aid and encourage people living with long-term skin conditions to make daily decisions that improve health-related behaviours and clinical outcomes

Improve access and deliver an equitable service, that is culturally sensitive and meets the diverse population health needs of East Lancashire and Blackburn with Darwen

Provide timely access to a range of tests, to determine diagnosis, facilitate shared decision making with each individual patient, initiate timely appropriate treatment, monitor chronic skin conditions effectively

Provide holistic care and agreed clinical management plans, delivered within the community where clinically possible and appropriate, designed around a coordinated team approach that meets the individual's physical, psychological, emotional and social needs by offering appropriate assessment, tests and treatment and/or signposting to appropriate services, delivering this with excellent patient reported experience and optimal patient reported outcomes.

Deliver triage and agreed packages of care that moves the patient swiftly along an agreed seamless pathway and to ensure each patient is seen by the right person, first time.

Provide early access to individualised care, which support a faster return to work for those patients requiring time off sick, which promote effective clinical management, for those in discomfort, which manage skin disease for those with long-term conditions and which maximises well-being, thereby improving the quality of life for each patient

Support patients with self-management strategies and lifestyle changes, with a focus on the needs of the individual, providing timely specialist intervention where and when appropriate but facilitating independence and autonomy, promoting the self-management of a person's skin condition and well-being in a care closer to home or home environment.

Build upon partnerships and collaborative working and support primary care practitioners & other clinicians, in the identification of patients with more acute urgent / 2wR skin conditions and in the continuing care of people with less complex / long-term skin conditions or during times of stability, through education, effective working relationships. The e-referral Advice and Guidance functionality will provide a secure IT platform to manage patients effectively between each tier of the integrated model.

Provide expertise, by the Consultant Dermatologists, to out-patients at Royal Blackburn Hospital and Burnley General Hospital, as required, giving direct care to patients and supporting other clinical colleagues, with clinical management plans that optimise workforce and facilitate a successful planned discharge, working within agreed protocols to return care to primary care, where clinically appropriate

Demonstrate via the contracting and performance framework a movement in the clinical threshold for accessing specialist skin care, from hospital based care to community GPwSI or primary care provision, where clinically appropriate, thereby reducing demand for hospital based care & releasing scarce resource; ensuring that, in any necessary onward

referrals to the hospital based element of the service, the patient has an identified clinical need and clinical information is communicated in a timely and efficient manner.

Maximise the use of new innovations and technology where appropriate and where there is evidence of efficacy, and support an innovative flexible approach to service delivery; delivering one-stop shop clinics, web based information, telephone follow up consultations, advice line / enquiry email in-box.

Respect patients' rights and diversity, and promote action to reduce inequalities in people's health and experiences of healthcare. (Service condition 13 Equality and Non-discrimination)

3.2 Service description/care pathway

Through better integration of services patients will receive the right care, in the right place, by the right person at the right time. The provider will ensure delivery of a high quality patient-centred service which manages patients with a range of skin conditions deemed as specialist or urgent and for those requiring acute intervention and or surgical procedures. The service should offer efficient service provision to ensure (VfM) to the health economy and demonstrate good evidence based/effective outcomes for patients by working closely with other professionals to ensure that whenever clinically appropriate patients will be stepped down and treated in the community, avoiding the need for repeated visits to hospital outpatient clinics. The provider will be responsible for operational management of the service.

The Integrated skin service pathway is based on the following principle:

Right person, first time.

The broad model of service for integrated skin care, within East Lancashire and Blackburn with Darwen (See appendix 1)
The key elements within the model and care pathway, applicable to the Integrated Skin service, are outlined below:
Advice, guidance & education
Referral through single point of access
Triage
Clinical Assessment
Diagnostics
Treatment
Patient education & support in self-management
Onward referral
Discharge
Patients may move through the pathway in a different order to that outlined above and may not be assessed as appropriate for all elements

Advice, guidance & education

As part of the developing integrated model the provider will detail their own plans in regard to advice and "consultation" with both the community provider and primary care to ensure a seamless provision for patient care. This may include the following elements:

- Telephone advice line, during core working hours, to be developed to facilitate advice and guidance

- Where appropriate we would encourage consultants to provide, specialist advice to assist GPs to manage patients in primary care and achieve optimal outcomes, without the need for referral.
- Email / letter on treatment plans, discharge delivered as part of the referral pathway and triage process

This would be key to an integrated service delivery model and would be part of a developing area of the speciality

Current point of access

Routine referrals will be made into the service by an East Lancashire or BwD GP, Urgent care practitioner, through the current access points, when it is considered that specialist skin care is required and where there is patient agreement.

Referral will be undertaken in accordance with agreed protocols and care pathways, in line with evidence based / best practice.

A locally determined Minimum Data Set for each referral, will ensure the integrated service receives adequate clinical information and undertakes accurate triage

Referrals for routine skin conditions made by GPs will come into the service via the national e-referral system – current practice as per appendix 3 acute delivery, non-appropriate referrals stepped down to community provider

Future access

The acute service will work with the community providers to devise a triage and single point of access (SPoA) pathway across the integrated model, with the outcome of full implementation of appendix 3

- It is anticipated this will then reduce inappropriate referrals to secondary care
- Key area of development required within the first 12 months.

Triage of routine referral

Triage will consist of a brief clinical assessment to determine the appropriateness, timing, sequence and pathway that the referral will take. It is based on a short evaluation of the referral information and will be undertaken by a suitably qualified Dermatology trained practitioner

If the outcome of triage is suitable to be seen within the community skin service this will be communicated to patients; and they will be stepped down to the community service. The community service will contact the patient and offer choice of location and date and time of appointment

Where clinical information is incomplete or where the referral is inappropriate / outside the offer of NHS treatment, the referral will be returned to the referrer with clear guidance and instructions on the next steps. The PLCV for policy for commissioning intervention to remove benign skin lesions is being reviewed and will be distributed once ratified this will be outlined in (schedule 2G)

The acute element of the skin service will aim to make available sufficient appointments, to meet agreed demand thresholds & volume of activity, for referrals triaged to the service.

The service will aim to ensure that no patient will experience an appointment slot issue (ASI) for the service and all patients will be offered a timely initial appointment, appropriate to their clinical need.

2WR referrals

All 2wR suspect malignant melanomas and SCC's referrals will be made on a 2wR profoma into the acute provider via the 2wR pathway (See Appendix 5) All referrals will be appointed and booked within 24 hrs of receipt, patients are then contacted via letter / telephone call and informed of their appointment date and time and venue.

1.7 2WR_2016_Skin Dermatology_Second

1.7 2WR_2016_Skin Dermatology_Interme

Awaiting template update from the Cancer team, following clinical meeting, these will be embedded once received.

BCC and lesions of uncertainty will follow the referral pathway to the intermediate service

Clinical Assessment

Clinical assessment will require a face-to-face consultation between the patient and the appropriate professional, from within the integrated skin service. The initial assessment, of the patient's condition and the impact this has on the individual's health and well-being, will inform the plan of care, tailored to each person's needs.

The Dermatology life quality index will be used, where possible and appropriate, to enable the service to identify the skin health state of each individual at initial assessment, during the episode of care, as required and at completion of treatment.

quality life index 17.11.16.pdf

Patient's will be engaged in the assessment and will be invited to identify both short and longer term personal goals that are relevant & reasonably expected to be attained, following treatment and/or support with self-management / in self-management programmes.

The proposed plan of care will be discussed with each patient, outlining any risks and benefits and shared decision making will inform the agreed way forward and provide consent.

Where possible and appropriate, the acute service will deliver a one-stop-shop approach, where tests / assessment / treatment / procedures will be provided at the same appointment.

The outcome of assessment will be recorded within the patient's health record and on the patient information system.

The outcome of clinical assessment may be an identified need for tests and /or delivery of the agreed plan of care by the appropriate member/s of the acute skin team or result in discharge back to the referring clinician.

Diagnostics

Investigative tests, clinically appropriate to the individual need, will be identified at assessment and/or clinical review, during a patient's journey, and undertaken to aid and support the identification and extent of the patient's skin condition.

Where possible and appropriate, tests will be carried out at the initial assessment.

Access to any second line investigative tests will be timely, to ensure the patient receives early treatment and effective care with the optimal clinical outcome.

Where clinically possible and appropriate, skin conditions, appropriate to the person's needs, will be carried out in community services, thereby releasing capacity in the hospital element of the service to support those patients with complex conditions / urgent care needs

Treatment

Treatment will be delivered by appropriate qualified members of the acute skin service working under the leadership and governance of the dermatology clinical director. All treatment will commence as early as possible and, within a maximum 18-weeks from receipt of referral.

All treatments offered and provided, within the acute service, will have an evidence base and will be tailored to individual need.

The service will effectively manage a low rate of DNA's and cancellations (Schedule 2G). All treatment will be arranged via appointment. Some treatments e.g. aggressive skin cancers maybe delivered via one-stop-shop approach where possible.

Patients will only be provided with routine follow-up appointments, where it is agreed it will add value to the person's care and clinical outcome. Follow ups will be in line with national expectation or local agreement and will not exceed:
Routine 1:3 ? (to be negotiated)
PUVA treatment 1:? (to be negotiated)
Phototherapy treatment 1:? (to be negotiated)
(schedule ??)

Any complication, directly linked to an episode of treatment, will be dealt with by the acute skin service, unless it is an emergency.

Patient reported clinical outcome measures will be used to determine the results of treatment and intervention, for each patient, within the service via the Dermatology Life Quality Index + Friends and family test.

The service will regularly review the clinical outcomes and establish standards against which to continuously improve all aspects of practice.

The service will work to the ELHT Access and Booking policy (Schedule 2G) and ensure that, for any patients who do not attend their appointment/s, health records are clinically reviewed and safely managed. If the clinical review indicates a need for follow up within the skin service, the hospital based element or the community service contact will be made with the patient and ensure they are aware of the clinical reason they are required to attend and the importance, therefore, to agree and keep the next appointment. If the

clinical review identifies an indication to discharge, the referrer will be notified without delay and the patient and GP will be copied into correspondence.

Patient education and support

Members of the acute skin team will demonstrate attitudes and behaviours that embrace the stepped care model; assisting in the management of demand for specialist skin care, through the development of an activated and engaged patient and the delivery of supported care within the community and as close to home as possible.
This will be monitored and managed utilising various components including patient feedback: PALS; complaints and incident reporting. Additionally staff supervision, appraisal and continued professional development will monitor communication skills and embedding of organisational values into service delivery.

All patients with a long-term skin condition, seen by the service, will have the opportunity to be actively engaged in self-management, through delivery of programmes where applicable and provision of individual advice and information, adopting shared care decision making principles, to enable each person to recognise and respond quickly to symptoms of an exacerbation and effectively self-manage their condition, where possible.

Integrated pathways

The acute skin service, under clinical director and community services leadership and with interface to primary care, is intended to deliver a comprehensive range of specialist treatments and long-term condition management and effectively manage a patient's skin care within the community, by default.

Hospital based skin care, will be limited to the requirement for highly specialist skills for such as; surgical assessment / skin surgery / the more invasive skin procedures / complex & serious skin disease, where the diagnostic assessment and/or treatment can only be delivered within a hospital environment (See Appendix 3) skin care that can be delivered within a community service will be re-directed following triage.

Patients with on-going needs that, following acute care, can be managed within the community service will also be stepped down (see appendix 3 for guidance).

Any consideration for movement, through seamless pathways, between elements of the integrated service, will be made in line with best practice, college/professional guidelines, locally agreed protocols and NICE guidance.

Discharge

Discharge planning aims to improve the coordination of effective and efficient care within the integrated skin service, support self-management after a patient’s discharge and optimise longer-term clinical outcomes.

Effective discharge planning will require the skin team to anticipate any potential clinical challenges and potential barriers to discharge, through the delivery of a comprehensive assessment and on-going clinical review, working collectively and in close collaboration with the patient.

Discharge planning will commence at the outset of care.
Assessment will outline individual needs, identify treatment goals, agree a plan of care and indicate an expected length of treatment.

Discharge will occur when the member of the acute skin service and the patient agree that treatment has optimised progress towards or has achieved goals and delivered optimal clinical outcomes. A discharge planning tool / matrix is to be developed within the service to support the discharge decision.

An individual letter will be created at the point of discharge back to the patients GP or healthcare professional.

The report will, however, outline any indications for re-referral, should there be a clinical need that would require further specialist skin care.

The discharge report will be dispatched and a copy of the discharge documentation will be sent to the patient and to the patient's GP, should he/she not be the referrer.
(schedule 2J Transfer and Discharge from Care Protocol)

A number of additional supporting documents are available within the directorate, which reflect clinical best practice and RDG guidance.

3.3 Population covered

Patients registered with an East Lancashire or Blackburn with Darwen GP. The acute provider will also be accessible to patients that reside outside of Pennine Lancashire, via the national choice menu on e-Referral

There may be a need to provide some appointments outside of normal working hours i.e. some weekend appointments. Providers may propose such opening times as they are confident they will be able to accommodate their indicative activity levels and the maximum waiting times, as well as supporting accessibility requirements.

3.4 Any acceptance and exclusion criteria and thresholds

See appendix 3 – referral criteria listing conditions for Secondary Care, Intermediate Care and Primary Care.

The service will include clinical triage for routine through single point of access, with pathways and process in place for both 2wR and routine skin need, for all patients with a specialist skin condition, registered with an East Lancashire or Blackburn with Darwen GP.

Triage outcome for those with skin conditions, that are considered appropriate for the integrated skin service, will result in a specialist skin assessment with the appropriate practitioner, at the appropriate location and appropriate time.
Inappropriate referrals will either be re-directed to the Intermediate service or returned to the referrer, with a clinical explanation

- The provider will manage any referrals from triage that relate to Cancer referrals and dermatological emergencies direct to the most appropriate clinical pathway.
- The provider will step down any referral within tolerance threshold that meets the agreed community service criteria, to the relevant process pathway, first time and each time (appendix 3 criteria)
- The provider will return and advise the referring GP any referrals at triage which relate to conditions that should be treated under a standard GMS or PMS contract; or managed within the local DES or LIS provision. Including those that meet the PLCV policy (schedule 2G)

The Provider shall ensure that the service offered is respectful and must not discriminate on grounds of age, gender, sexuality, ethnicity or religion. The service should be sensitive to the needs of patients whose first language is not English and those with hearing, visual or learning disabilities. (Service condition 13 Equality and Non-discrimination)

Exclusion Criteria

Referral criteria listing conditions for Secondary Care, Intermediate Care and Primary Care and PLCV policy (See appendix 3)

It is anticipated that by using the fully integrated service model, only identified referrals that meet the community service or primary care criteria will be redirected as per appendix 2. The provider is not expected to duplicate specialist services already provided by the community service or primary care and will not be funded for any procedures listed within the PLCV policy. (Schedule 2G)

The Commissioner will monitor monthly redirected referrals to community service care, as set out (5. Applicable Quality requirements)

The following conditions are classed as 'cosmetic procedures' and should not be treated or stepped down to either community service or primary care:-

Asymptomatic definite benign moles
Basal cell papilloma/sebhorroeric warts
Dermatofibromas
Dermal nerofibromas
Epidermoid cysts
Haemangioma in adults less than 1cm
Lipomata
Milia
Mollusca contagiosa lesions
Naevi
Pilar cysts
Scars, keloid scars
Sebaceous cysts
Skin tags
Stretch marks
Symptomatic seborrhoeic keratosis
Tattoo removal
Vascular naevi (haemangioma, port wine stains, spider naevus, telangiectasia)
Viral warts and verruca's (excluding genital)
Xanthelasma

**PLCV Policy for commissioning interventions to remove Benign Skin Lesions is being reviewed and will be distributed once ratified.

3.5 Interdependence with other services/providers

East Lancashire and Blackburn with Darwen CCG's will actively encourage partnership working and collaborative working and will expect the provider to foster good working relationships with all interdependence services to support integration and seamless patient pathways

See Appendix 4

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The service provider will provide treatment in line with agreed clinical protocols and will adhere to the following guidelines (as amended) in delivery of this integrated service:

- NICE guidelines including *Improving Outcomes Guidance* (skin tumours including melanoma Feb 2010) https://www.nice.org.uk/guidance/csg8
- British Association of Dermatologists, Clinical Guidelines www.bad.org.uk
- Guidance and competencies for the provision of services using GPs with Special Interests (GPwSI) (DH Apr 2007) https://www.pcc-cic.org.uk/sites/default/files/articles/attachments/revised_guidance_and_competences_for_the_provision_of_services_using_gps_with_special_interests_0.pdf

The above is not an exhaustive list; the provider will be responsible for ensuring it meets any amendments or new guidelines / policies as they are published, during the lifetime of the contract.

The provider will provide treatment in line with agreed clinical protocols and will adhere to the following guidelines (as amended) in delivery of this integrated service:

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

To be reported as local information requirements

Quality Requirement	Threshold	Method of Measure	Consequence of Breach	Timing of application of consequence	Applicable Service Specification
Activity Report to be submitted to CCG Commissioners		A monthly report to be submitted providing the following information: ➢ Total number of patients referred into Acute Dermatology service	Service Condition 28 – Information Requirements	Monthly	Acute Dermatology Service

		➢ Total number of patients triaged - Number/% accepted within 3 days - Number/% stepped down or returned to referred - Number/% to other services i.e. Gynae, max fax, H&N, Ophthalmology ➢ Number of new and follow up patients seen by each specialist in the service, e.g. Consultant, ANP ➢ Number of referrals to intermediate care following assessment/treatment ➢ Number of referrals referred back into the service within 6 months			

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

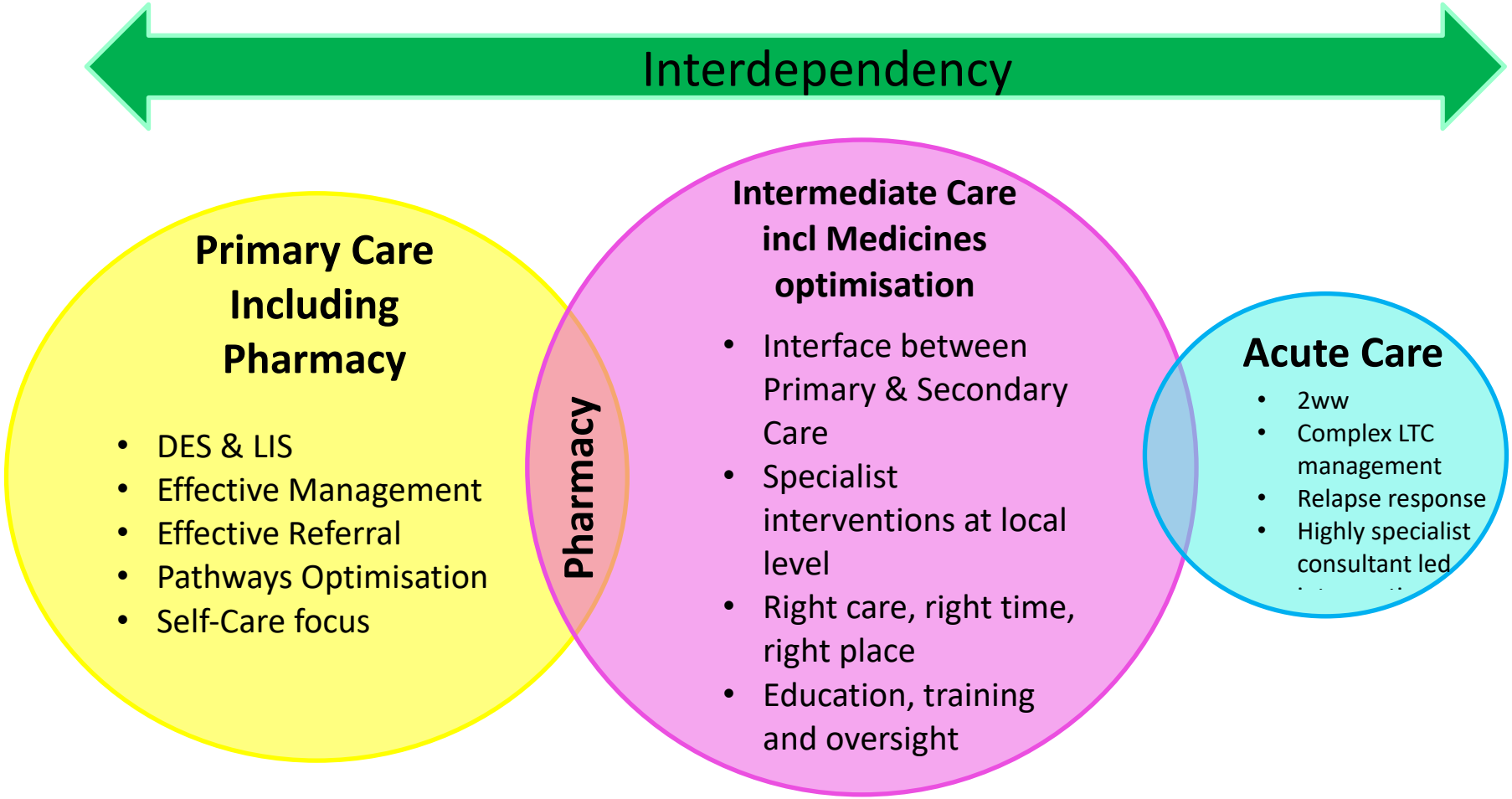
6. Location of Provider Premises

The Secondary Care Provider's Premises are located at:

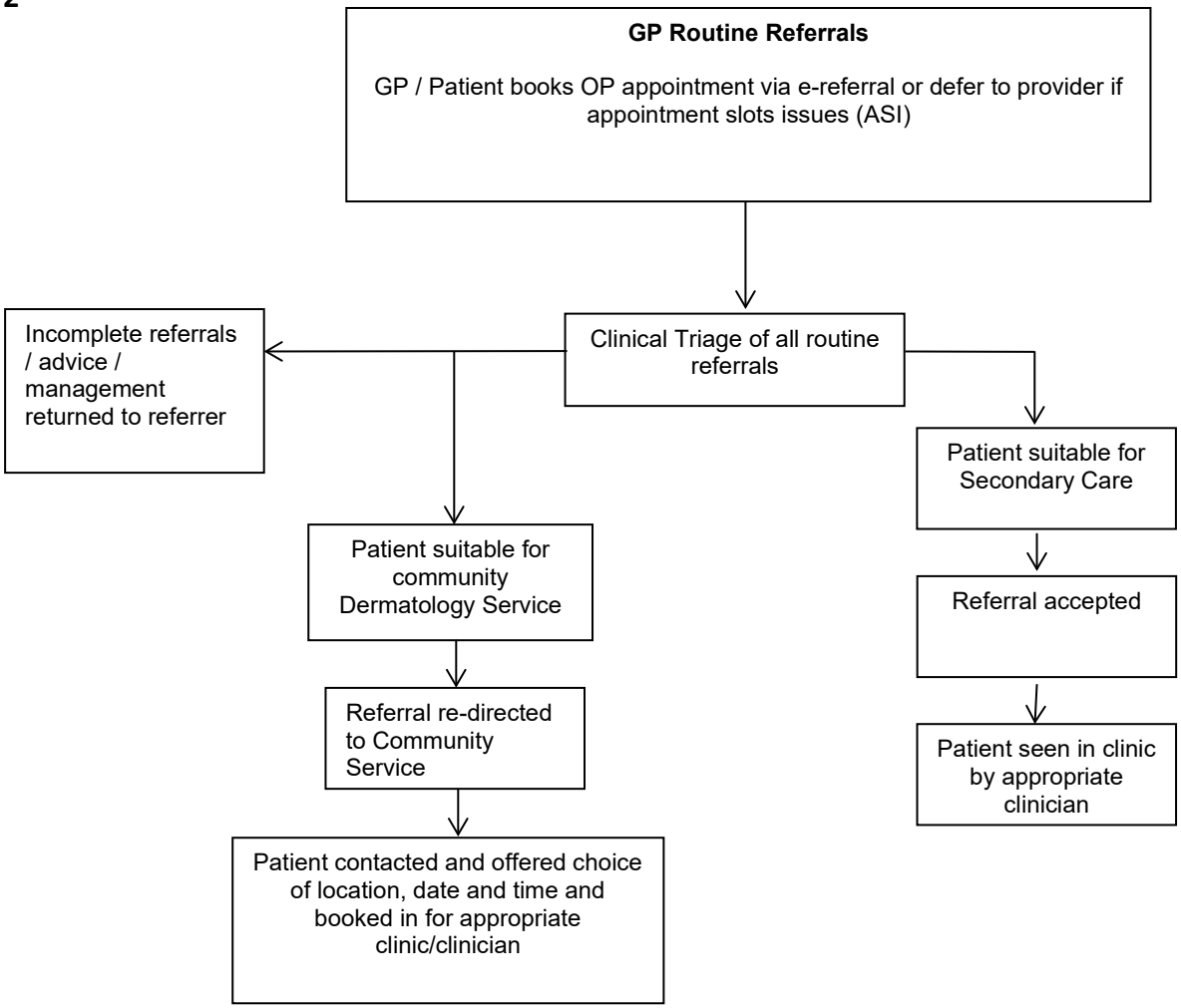
Royal Blackburn Hospital
Burnley General Hospital
Rossendale Health Centre

7. Individual Service User Placement

Appendix 1


Interdependency
Primary Care Including Pharmacy
• DES & LIS
• Effective Management
• Effective Referral
• Pathways Optimisation
• Self-Care focus
Pharmacy
Intermediate Care incl Medicines optimisation
• Interface between Primary & Secondary Care
• Specialist interventions at local level
• Right care, right time, right place
• Education, training and oversight
Acute Care
• 2ww
• Complex LTC management
• Relapse response
• Highly specialist consultant led

Appendix 2

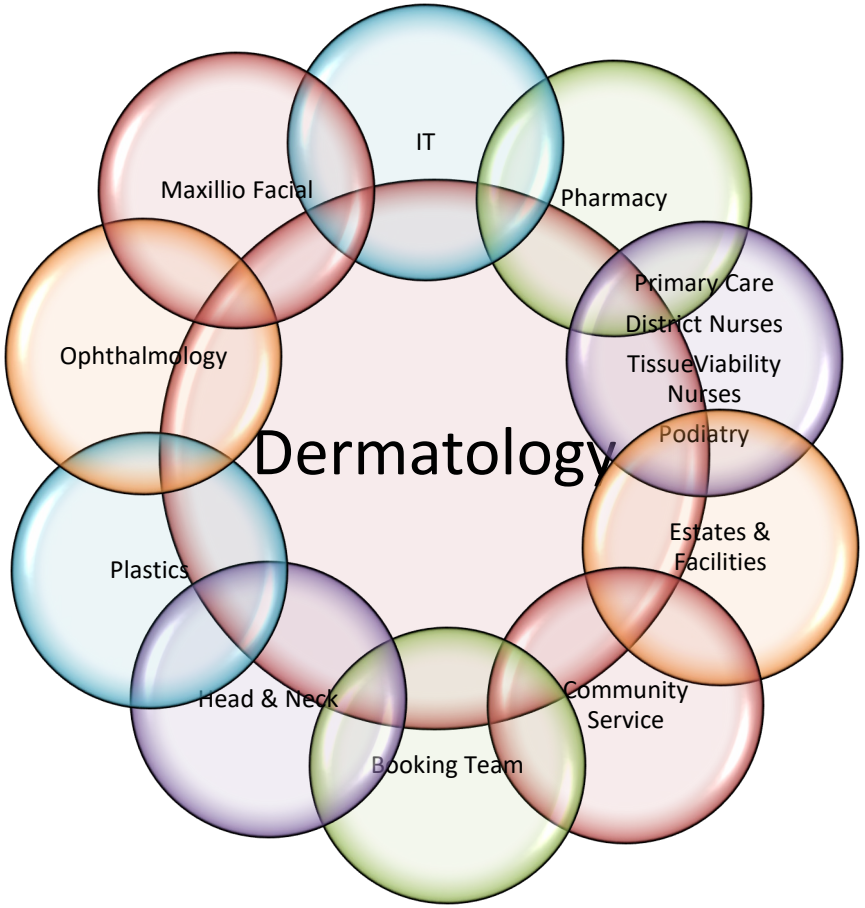

GP Routine Referrals
GP / Patient books OP appointment via e-referral or defer to provider if appointment slots issues (ASI)
Clinical Triage of all routine referrals
Incomplete referrals / advice / management returned to referrer
Patient suitable for community Dermatology Service
Referral re-directed to Community Service
Patient contacted and offered choice of location, date and time and booked in for appropriate clinic/clinician
Patient suitable for Secondary Care
Referral accepted
Patient seen in clinic by appropriate clinician

Appendix 3

Secondary Care	Advice to Intermediate Dermatology /Step Down	Intermediate Dermatology Service	Primary Care / Local Enhanced Service
• 2 week wait cancer referrals • High risk basal cell carcinoma (dermatology, maxillofacial) • Dermatological emergencies • Severe inflammatory skin disease requiring phototherapy,or systemic therapy (eg eczema, psoriasis, lichen planus, urticaria) • Life threatening skin disease • Severe paediatric skin disease • Photo-investigation and specialised photo-dermatology for photosensitive conditions • Specialised skin cancer eg CTCL/ rare tumours • Skin disease related to connective tissue disease • Cutaneous vasculitis • HIV related skin disease • Pathology requiring MDT discussion/management • Complex mycoses • Severe hair and nail disease – with scarring or significant psychological impact • Specialist intervention for patients having undergone organ transplant • Suspected allergic contact dermatitis • Severe axillary hyperhidrosis requiring botulinum toxin injections • Photodynamic therapy for patients requiring secondary care e.g. transplant recipients • Severe / scarring acne – Isotretinoin	Acnes – refer to secondary care if failure of 2 separate antibiotic courses each of at least 3 months duration or scarring present. Endure female patients have appropriate contraception counselling Psoriasis – If PASI > 5 and not responding to maximal topical therapy consider referral to secondary care for phototherapy /systemic therapy Eczema – If EASI score > 5 and not responding to maximal topical therapy consider referral to secondary care for phototherapy/systemic therapy	• Chronic inflammatory dermatoses after trial of suitable treatment in primary care eg topical steroids /emollients (eczema/psoriasis etc.) NOT requiring phototherapy/day unit treatment/systemic treatment • Psoriasis after trial of treatment in primary care (involving more than 20% of body surface area) • Eczema; seborrhoeic, atopic (but not suspected allergic contact dermatitis) neurodermatitis • Undiagnosed rashes in otherwise well patients • Bowen's disease • Undiagnosed skin lesions where concern or uncertainty and not 2 week wait indicated • Chronic/debilitating urticaria mild/moderate with failed primary care treatment • Chronic/debilitating Pruritus not responding to primary care treatment • Nail disorders • Hair, scalp disorders, non-scarring alopecias • BCCs and lesions of uncertainty as specified in the (BCC cancer template) • Moderate acne not requiring systemic isotretinoin • Vitiligo • Moderate infections and infestations (e.g. tinea, impetigo, scabies) requiring systemic	• Mild acne and rosacea • Mild to moderate dermatitis or eczema • Small benign lesions and lumps, including skin tags in line with PLCV • Mild to moderate psoriasis • Basal cell papilloma/sebhorroeric warts in line with PLCV • Mollusca contagiosa in line with PLCV • Actinic /solar keratoses (Clinical decision needed) • Mild/moderate infections and infestations (e.g. tinea, impetigo, scabies) • Symptomatic seborrhoeic keratosis • Viral warts and verruca's (excluding genital) in line with PLCV • Uncertain mollusca contagiosa ➢ Minor surgical procedures – curettage/diagnostic biopsies ➢ Haemangioma in adults less than 1cm ➢ Sebaceous cysts ➢ Dermatofibromas

treatment • Severe rosacea, refractory to 1st line treatment • Severe hidradenitis suppurativa • Immune-suppressed patients with possible skin cancer • Auto-immune blistering disorders e.g. pemphigoid • Severe drug reactions e.g. Stevens-Johnson syndrome • Systemic illnesses related to skin disorders e.g. Lupus • Any patient requiring step-up from intermediate service • Genital Dermatoses • Female genital dermatology including vulval lichen sclerosus • Male genital rash (likely to respond to topical treatment)		management • hyperhidrosis – only consider referral if iontophoresis required • Inflammatory skin conditions e.g. Lichen planus, granuloma annulare • Benign moles and Pigmented lesions where 2 week wait is not indicated and where there is concern or uncertainty • Morphoea (localised) • Moderate to severe Folliculitis and not responding to primary care treatment • Keloid scarring • Dysmorphophobia • Patients stepped down from secondary care • Shared drug monitoring where appropriate For note: In delivering clinical management to all the above skin conditions, the community service will provide medical student teaching	

Appendix 4


IT
Maxillio Facial
Pharmacy
Primary Care
District Nurses
Tissue Viability Nurses
Podiatry
Ophthalmology
Dermatology
Estates & Facilities
Plastics
Head & Neck
Community Service
Booking Team

Appendix 5

2wR Pathway in Relation to Presentation at Dermatology