Community Based Dermatology Service
Commissioning Specification

Version 8 – February 2009
1. Introduction

1.1 Bath and North East Somerset Primary Care Trust (BANES PCT) Practice Based Commissioning (PBC) Executive Group has identified dermatology as a key priority during 2008/09. The purpose of this service specification is to outline the commissioning intentions of BANES PCT to procure a service in the community to manage a specified range of referrals for people with dermatological conditions in line with recognised best clinical practice in dermatology.

2. Background and Drivers for Change

2.1 BANES PCT was established on 1 April 2001 and covers a population of around 172,000. The PCT commissions primary care services from 27 GP practices and one nurse led homeless PMS practice. The total GP registered population in BANES PCT is approximately 194,000.

2.2 The White Paper: Our Health, Our Care, Our Say (June 2005) identified four key priorities: better prevention services with earlier intervention; giving people more choice and a louder voice; tackling inequalities and improving access to community services and more support for people with long term conditions.

2.3 Surrounding areas, including Wiltshire, Somerset, Gloucester and Bristol have set up community based dermatology services with varying degrees of success. Common attributes of successful schemes include working in close collaboration with both Primary and Secondary care clinicians to ensure an effective service. This proposed model is based on current services in South Gloucester which have shown that it is possible to set up an clinically and cost effective community based service with high patient satisfaction, and improved access for patients.

2.4 GP referrals to Dermatology at the RUH rose by 5% in 2003-04, by 4% in 2005-06 and by 12.5% in 2006-07. There was a slight decrease of .8% in 2007-08. From April – July 2008, there have been 1237 GP referrals. If this rate continues throughout the year, it will mean that there will be a 23% rise in referrals in 2008-09.

2.5 Weighted dermatology referral rates into secondary care in BANES are the highest in the Avon, Gloucester and Wiltshire area, and are higher than average for England overall. This figure probably reflects the limited primary care specialist dermatology services available in BANES compared to other areas.

3. Any Willing Provider

3.1 This service will be procured on the basis of the Any Willing Provider model. Within this any willing provider model there are no guarantees of volume or payment in any contract given. BANES PCT will only award contracts to providers who can demonstrate that they meet national minimum quality criteria (as set out by the Healthcare Commission) and local quality standards.
4. **Expected Outcomes**

The PCT is working towards developing more outcome focused services. The table below sets out the outcomes for the Community Dermatology Service with a range of measures to monitor the delivery of the service.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Outcomes</th>
<th>Measures</th>
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</table>
| Improved access for patients                         | Provision of alternative locations and, initially, reduced waiting times | Number of sessions provided per month in each location  
Patients to be seen within 4 weeks |
| Care closer to home                                  | Patients treated in the community                                         | Episodes completed in the community without referral to secondary care compared to 08-09 baseline |
| Improved patient experience                         | Reduced waiting times  
Community locations                                                               | Patient feedback via questionnaire and telephone feedback interviews  
Quarterly reporting of number of, and summary, of complaints, and actions taken  
Quarterly reporting of number of, and summary of, adverse events/untoward incidents and actions taken |
| Efficient and effective service including robust assessment, diagnosis and treatment | Successful treatment of dermatological conditions in the community         | Evidence of adherence to operational pathways which are supported by written and regularly updates protocols and procedures for diagnosis, treatment and referral |
| Improved GP education                               | Support and education given to primary care clinicians in their management of patients with dermatological conditions | Partnership working with acute providers in relation to education and support |
| More cost effective service releasing funding for reinvestment in other areas of patient care | Control demand, intervention and onward referral rates                     | • Total number of referrals received and triaged shown by GP practice.  
• New to follow up ratio  
• (“new” is defined as a patient who has not attended for over six months, DoH PbR Guidance, version 1, Dec 06, page 8).  
• Number of referrals passed onto secondary care after triage  
• Number of referrals passed onto secondary care after assessment.  
• Number of referrals to other specialist services. |
| Reduced inequalities                                 | Case mix represents local community                                        | Numbers of people from minority ethnic groups, women, people on low incomes, the elderly & people with physical disability are measured & reflect local population |
5. **Service Outline**

5.1 The service provider may choose a service focused on a professionally supported GP with Special Interest (GPwSI), a mixed GPwSI/consultant model or a purely consultant based service.

5.2 The service will be available to adults (18 and over) registered with a GP within BANES PCT.

5.3 Anticipated levels of activity may be found in Appendix 2.

5.4 The service providers will triage all dermatology referrals that are received by the service on a daily basis (Monday to Friday). Referrals will be assessed for either treatment within the community dermatology service or onward referral to secondary care or return to the Primary Care Clinician with appropriate advice and support.

5.5 The following exceptions should not be referred to this service but should be referred directly to secondary care.
   
   a) Two week wait skin cancer referrals  
   b) Dermatological emergencies

5.6 Patients who require assessment by the community dermatology service will be booked into clinics within four weeks of triage for a one stop assessment and treatment, where applicable.

5.7 Service providers will be expected to provide advice, support and education to Primary Care practitioners in order to ensure that Primary Care’s expertise and management of dermatological conditions is enhanced by the community dermatology service.

5.8 Service providers will be expected to provide a minimum of one education and feedback workshop for Primary Care practitioners per year, in addition to ongoing case support. Educational sessions are expected to be delivered collaboratively with other providers and will be included in the tariff price (see 5.12 for further details on the tariff).

5.9 The service will provide the following:

   - Full diagnostic service with biopsy and swab taking and reporting results
   - Patient advice and education
   - Initial treatment if required
   - Initial prescribing via FP10 prescription from the BCAP Formulary for 4 weeks only
   - Follow up at a subsequent clinic appointment if necessary
   - Discharge summary to be provided for GP within 7 working days. Summary to include: typed treatment plans, details of medications prescribed, recommendations for ongoing management and contact details to allow GP to discuss any aspects of the case with the community dermatology service.

5.10 The service will not include phototherapy, contact allergy patch testing, surgical procedures that are considered to be plastic surgery or removal of large excisions.

5.11 The number of follow ups will be at the discretion of the service provider in conjunction with the referring GP. The service should aim to keep the ratio of new to follow up appointments at, or below, the national rate of 1:0.9.
5.12 The service will be offered at the following price:

- First contact (outpatient appointment) at 90% (£103.50) of current tariff
- Follow up appointment at 90% (£57) of current tariff

This tariff does not include prescribing costs.

5.13 The service will be delivered within this tariff for the first year of the contract, but with the intention to review ‘shadow year’ data to re-align the tariff for future years.

6. Conditions to be treated

6.1 The following conditions are likely to be treated by the community dermatology service:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Details</th>
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<tbody>
<tr>
<td>Chronic inflammatory dermatoses (eczema, psoriasis etc.) not requiring consideration of phototherapy, day unit treatment or systemic treatment</td>
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<tr>
<td>Undiagnosed rashes in otherwise well patients</td>
<td></td>
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<tr>
<td>Infections and infestations, e.g. tinea, impetigo and scabies</td>
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<tr>
<td>Precancerous skin lesions (actinic keratoses). Organ transplant patients with solar keratoses should be referred to the RUH service</td>
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<tr>
<td>Bowen’s disease</td>
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<tr>
<td>Facial rashes</td>
<td></td>
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<tr>
<td>Cryotherapy</td>
<td></td>
</tr>
<tr>
<td>Undiagnosed skin lesions (except 2 week wait skin cancer)</td>
<td></td>
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<tr>
<td>Urticaria</td>
<td></td>
</tr>
<tr>
<td>Pruritus</td>
<td></td>
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<tr>
<td>Nail, hair and scalp disorders, non scarring alopecias</td>
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<tr>
<td>Low risk BCCs as specified in NICE guidance</td>
<td></td>
</tr>
<tr>
<td>Acne not requiring systemic isotretinoin</td>
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</table>

6.2 The service provider will be required to perform minor surgical procedures such as curettage and diagnostic biopsies.

6.3 There may be patients whose clinical circumstances are sufficient to warrant an assessment against BANES PCT’s Interventions Not Normally Funded (INNF) Policy. Patients who require minor surgery as part of their treatment can be referred to the B&NES Minor Surgery Service. The service specification for minor surgery is available from the PCT if required.

7. Facilities

7.1 The following facilities represent a minimum requirement for the provision of a community dermatology service:

- Consulting rooms with examination area
- Good natural and task lighting
- Dermatoscope
- Digital camera
- Appropriate computer equipment for record keeping
- Cryotherapy
- Reception and waiting area
- Storage for dressings, treatments etc.
8. Location and Operating Times

8.1 The service will be delivered in community locations in BANES (to be agreed with the provider but locations should allow good access for the whole population). The services should be within the BANES PCT geographical area, and preferably located with good car parking and public transport links. The community locations will be DDA (Disability Discrimination Act) compliant.

8.2 The service will be provided within the hours of 8 am to 6 pm, Monday to Friday. The number of sessions will be discussed and agreed with the service provider.

9. Booking of Patients

9.1 Those patients who need to be assessed by the service will be seen within four weeks of receipt of the referral for an assessment and treatment in line with RTT (Referral to Treatment) targets.

9.2 The service provider should be able to demonstrate the delivery of patient choice and ensure that all patients requiring onward referral are offered choice as per DH guidelines. Referrals to the Service will be via the appropriate Choose and Book pathway.

9.3 The service provider will undertake all clinic bookings, manage the waiting list within the agreed waiting times, deal with patients’ queries, reception, preparing reports and discharge letters.

9.4 Non-emergency patient transport will be arranged by the service provider in accordance with the criteria laid down in BANES PCT’s Non Emergency Patient Transport Policy.

10. Clinical Guidelines

10.1 Providers will be required to adhere to the following guidelines in the delivery of this service –

- NICE guidelines including *Improving Outcomes Guidance* (skin tumours including melanoma Feb 2006)
- British Association of Dermatologists Clinical Guidelines
- Guidance and competencies for the provision of services using GPs with Special Interests (GPwSIs) (DH April 2007)
- Implementing care closer to home: Convenient quality care for patients, Part 3: the accreditation of Gps and Pharmacists with Special Interest (DH April 2007)
- Action on Dermatology – Good Practice Guidance (NHS Modernisation Agency 2003)

10.2 It is also expected that clinicians will:

- Be actively involved in the local dermatology service
- Maintain their competencies and that they are able to demonstrate a minimum of 15 hours a year of dermatology continuous professional development (CPD)
- Contribute to a local clinical audit at least once a year
- Maintain a professional portfolio which provides evidence of audits and educational training

10.3 Where a provider chooses to provide the service with GPwSI, the provider must assure the PCT that the GPwSI has undertaken sufficient dermatology training through previous experience or through a Post Graduate Qualification in dermatology.
11. Monitoring Arrangements

11.1 The contract will be monitored by the PCT and the PbC Consortium Executive. The Assistant Director of Commissioning will be the operational lead and deal with any day to day queries or issues.

11.2 Prior to commencement of the contract, the service providers will be required to attend a pre-contract meeting with the PCT and PbC Consortium Executive to agree all matters related to the contract. Solutions to problems raised at the pre-contract meeting will be mutually agreed prior to the contract commencing and the PCT will provide a minute of any agreements. These minutes will form part of the contract.

11.3 Thereafter, activity levels and outcomes for the service will be monitored via monthly reports on key performance indicators (KPIs) as detailed in section 12 and quarterly review meetings.

11.4 In addition, the service provider will provide an annual report in a format agreed with the PCT which will include analysis of the contract and the annual activity under the contract. The report should also outline any key issues for the service, e.g. staff turnover, sickness, complaints received, adverse incidences and expenditure in the previous 12 months and priorities and recommendations for the forthcoming year.

11.5 All monitoring and associated meetings will be undertaken at the service provider’s expense.

12. Key Performance Indicators

12.1 Every month the service provider will supply, in a format to be determined and supplied by the PCT, key statistical information on the service and patients. This information must be provided to the PCT’s authorised representative within ten working days of the end of the month.

12.2 This information is vital to the successful implementation of this contract and failure to provide the information will be deemed as a default by the service providers.

12.3 The KPIs for the service are:

- Number of referrals received and triaged, identified by GP practice and broken down by race, gender, sexual orientation, religion, age, disability
- Number of new and follow up patients seen (“new” being defined as a patient who has not attended for over six months, DoH PbR Guidance, version 1, Dec 06, page 8)
- Number of patients seen by each specialist in the service, e.g. nurse, doctor
- Number of referrals passed onto secondary care after triage
- Number of referrals passed onto secondary care after assessment
- Number of referrals returned to primary care after triage
- Number of referrals returned to primary care after assessment
- Number of referrals to other specialist services
- Number of patients who did not attend for their assessment
- Number of patients waiting to be seen and for how long
- Number of referrals deemed “inappropriate” and returned to the practice
- New to follow up ratio
• Number of contacts made by GPs for advice and support in the management of their patients including telephone, letter, email
• Percentage of clinic letters sent to referrer within 7 days of patient attendance
• Number of, and summary of, complaints and actions taken
• Number of, and summary of, adverse events/untoward incidents and actions taken
• Patient satisfaction surveys to be carried out randomly and reported on annually
• GP satisfaction surveys to be carried out at six monthly intervals

12.4 All information relating to the delivery and performance of the service must be inputted into a suitable data handling system set up to provide the PCT with the required monitoring and evaluation information.

12.5 There will be occasions when service providers are requested to provide specific information regarding the service by the PCT and PbC Consortium Executive. Such information will be provided within the scope and context of the contract.

13. Confidentiality & Record Keeping

13.1 The service provider must advise all staff on the importance of maintaining confidentiality and implement procedures which ensure that patients' affairs are only discussed with relevant people and agencies.

13.2 The service provider must not destroy any records relating to the provision of the service without the express written consent of the PCT. Where the PCT give such consent a register must be kept of which records have been destroyed and on what date.

14. Workforce

14.1 Operational management

14.1.1 There will be a dedicated operational lead within the service provider's organisation to manage the contract and have financial and operational responsibility

14.2 Medical staff

14.2.1 The service will be provided by medical staff with appropriate experience and qualifications. This could be either Consultant Dermatologists or GPs with special interest in dermatology.

14.2.2 All staff able to demonstrate proof of registration with GMC. In addition, GPs must demonstrate compliance with Department of Health accreditation guidelines. Consultant Dermatologists need to be in a substantive post elsewhere, and a member of the British Association of Dermatologists.

14.2.3 If the service is provided with a GPwSI they must be able to demonstrate their continuing professional development and a system for mentoring. A minimum of one session per month should be within a secondary care setting, and one clinic a month should be held jointly with a consultant Dermatologist in the community setting.
14.3 Nursing staff

14.3.1 It is anticipated that a high quality service community dermatology service will require nursing staff with considerable dermatology expertise and experience, who are able to manage their own caseload of patients. Specialist nurses should be able to demonstrate competencies in clinical, educational and managerial skills, including nurse prescribing.

14.3.2 Nursing staff must also be able to demonstrate their continuing professional development and a system for mentoring, e.g. specialist dermatology nursing staff will be required to attend a weekly liaison session with a secondary care nursing team for educational and clinical developments and continuity of patient care. The specialist nurse must have access to a medical staff for advice.

14.4 Administrative staff

14.4.1 The providers will undertake all clinic bookings, dealing with patients queries, reception, preparing reports and discharge letters. Administrative staff should have appropriate experience in a clinical environment to undertake these tasks effectively and efficiently.

14.5 Training and Competencies

14.5.1 The service provider will:

- Maintain a record of the dates and types of training given to all staff performing the service. Written evidence of training and development plans and arrangements for staff support are required throughout the duration of the contract. All such records should be immediately available to the commissioner on request for inspection purposes.
- Ensure all staff have the knowledge, skills, competence and understanding to operate efficiently and effectively in their respective roles.
- Ensure all staff have on-going mentorship.
- Ensure all staff have as a minimum basic life support training annually and attend other relevant mandatory training such as manual handling and lifting.
- Ensure all staff can produce evidence of registration with relevant bodies, ie GMC, NMC.

14.6 Staff Conduct

14.6.1 The service provider will have procedures in place governing the relationship between staff providing the service and those accessing it. The aim of these procedures will be to prevent potentially abusive relationships developing and provide staff with guidelines covering their conduct towards those using the service.

14.7 Criminal Records Bureau (CRB) Checks

14.7.1. It is the service provider’s responsibility to ensure that all staff have had a CRB check and that they have complied fully with the CRB Code of Practice. Should any offences be recorded on the CRB disclosure then the service providers shall not allow that person to work on this contract without first obtaining written approval from the PCT.
14.8 Changes in Staff

14.8.1 The service provider shall provide the PCT with a staffing structure of its organisation and shall indicate the managerial responsibility for the provision of the service, prior to commencement of the contract. The service provider shall inform the PCT of any new appointments or proposed changes to the existing organisational structure, in writing and in advance of the proposed changes becoming effective.

14.9 Identification Cards

14.9.1 The service provider’s staff shall carry and display identification cards at all times. The identification card must contain as a minimum the service providers’ name, the staff member’s name and a colour photograph.

15. Partnerships

15.1 The PCT actively encourages partnership working and expects service providers to form effective partnerships with existing providers where their services are complementary to the dermatology service.

16. Clinical Governance / Quality Assurance

16.1 Service providers will be required to provide the service within the key principles of the NHS and will be expected to comply with Standards for Better Health, the National Service Frameworks relevant NICE guidelines and technical appraisals.

16.2 Service providers will be required to have a quality assurance system and mechanisms to monitor and quality assure the service.

16.3 Service providers will adhere to the minimum standards set out within “Your Guide to the NHS.”

17. Risk Management

17.1 The service provider should be able to demonstrate an appropriate system and policy for recording, monitoring and reporting of risk issues.

18. Complaints

18.1 The service provider shall have a documented complaints procedure which is known to patients, carers and the service provider’s staff and shall ensure that the complaints procedure is available on request. The procedure shall be agreed with the commissioner prior to commencing the contract.

18.2 Every patient shall also have the right to access B&NES PCT’s complaints procedure.

18.3 The service provider shall attempt to resolve complaints by informal discussions with the patient and/or carer. If discussion fails to provide a solution that is satisfactory to both service provider and patient, a full written report shall be submitted to the commissioner, who will undertake to investigate the complaint.

18.4 The service provider shall notify the PCT of all complaints made in the provision of the service and how each case was resolved.
19. **Clinical Audit**

19.1 The service provider will be required to undertake and report on at least one clinical audit per year, and make a copy of the report available to the commissioner.

20. **Policies & Procedures**

20.1 The service provider must have in place, and adhere to, the following policies:

- Equality and diversity
- Recruitment
- Health & safety
- Lone working
- Record keeping
- Confidentiality/data protection/Caldicott
- Complaints

Copies of these policies shall be made available to the commissioner on request.

21. **Publicity / Promotion**

21.1 The service provider will be required to promote and publicise the service across the practices in B&NES.

22. **Funding**

22.1 The PCT will pay the service provider on a cost per case basis at an agreed local tariff for first and follow-up appointments.

22.2 Service providers will be expected to work closely with the PCT and PbC Consortium Executive in the overall management of the total dermatology resource available for BANES.

23. **Notice Period**

23.1 Service providers and the PCT will give six months’ notice of termination of the contract.

24. **References**

- NICE guidelines including *Improving Outcomes Guidance* (skin tumours including melanoma Feb 2006)
- British Association of Dermatologists Clinical Guidelines
- Guidance and competencies for the provision of services using GPs with Special Interests (GPwSIs) (DH April 2007)
- Implementing care closer to home: Convenient quality care for patients, Part 3: the accreditation of GPs and Pharmacists with Special Interest (DH April 2007)
- Action on Dermatology – Good Practice Guidance (NHS Modernisation Agency 2003)

February 2009
Primary Care
Management of patients with Dermatological conditions

Secondary Care Provider
Includes complex cases, cancer, urgent referrals

Community Dermatology Service(s)
Education and support to Primary Care
See and treat Dermatological conditions that can be managed in Primary Care but beyond the referrer’s current ability.
Referral onwards of conditions more appropriate for secondary care management

Education and support for primary care

Conditions more appropriately managed by secondary care

Conditions more appropriately managed by secondary care

Conditions more appropriately managed by secondary care
Appendix 2

Anticipated Level of Activity

The total dermatology resource available for BANES will determine the number of new appointments, follow ups and onward referrals available, whilst maintaining a maximum six week waiting time.

93% of BANES dermatology referrals are currently seen at the RUH, with the remaining 7% at UBHT and North Bristol Trust. There are approximately 2800 GP referrals to the RUH per year.

GP referrals convert to 2050 1<sup>st</sup> outpatient attendances. There are an additional 100 1<sup>st</sup> outpatient attendances from other sources of referral (e.g. consultant referrals) and 3000 follow-ups per year.

The above totals represent the dermatology commissioning resource for BANES. The community dermatology service will assess and treat a proportion of patients who would otherwise have been referred to secondary care, whilst continuing to refer on all suitable patients.

This service will support the strategic objectives of ensuring that up to 50% of the delivery of the service is based in a community setting. For information only, the levels of referral activity for 2007-08 and projected levels for 2008-09 are shown below:

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<thead>
<tr>
<th></th>
<th>2007/08</th>
<th>2008/09</th>
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</thead>
<tbody>
<tr>
<td>GP Referrals</td>
<td>2825</td>
<td>2923</td>
</tr>
<tr>
<td>Other Referrals</td>
<td>134</td>
<td>139</td>
</tr>
<tr>
<td>OP First Attendances – consultant &amp; non consultant led</td>
<td>2939</td>
<td>3041</td>
</tr>
<tr>
<td>OP Follow Up Attendances – consultant &amp; non consultant led</td>
<td>5761</td>
<td>6221</td>
</tr>
</tbody>
</table>

The service providers will work closely with the Practice Based Commissioning Consortium Executive and the PCT to ensure an appropriate balance between referral thresholds, patients seen by the community dermatology service and onward referrals. Performance will be reviewed on a regular basis by the PBC Executive and/or the PCT.

Please note that the referral figures are an indication of patient numbers and are not a guarantee of numbers expected to be seen by a willing provider.