**Brent, Ealing and Harrow Community Dermatology Service Specification**

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| 1. Population Needs |
| **National/local context and evidence base**  **National context:** Dermatology is defined as the branch of medicine dealing with the skin and skin diseases.Skin disease affects one third of the population at any one time and it accounts for 15% of all consultations in General Practice[[1]](#footnote-1). The commonest skin diseases continue to increase in frequency and there are more referrals to secondary care Dermatology by GPs than to all of the other medical specialities combined. This is despite the fact that the majority of patients have mild problems that can be easily self-managed.Unlike most medical specialities, which usually cite around 50 diseases, dermatology recognises more than 1,000 conditions affecting skin, hair and/or nails. Accurate diagnosis is fundamental to successful management. Chronic skin disease may have a substantial impact on work, social interaction and healthy living; skin disease is one of the commonest reasons for injury and disablement benefit and spells of certified incapacity to work in the UK. There is also a subset of skin cancers where mortality can be high and early diagnosis is vital[[2]](#footnote-2).Inpatient treatment of skin disease has reduced dramatically with only a small number of the most severe conditions now requiring hospital admission in addition to disorders such as psoriasis and eczema, which has failed to respond to day care /outpatient treatment.The long term nature of many skin diseases means that a significant number of patients will have engagement with the dermatology service for many years, possibly even lifelong. Developments in technologies such as phototherapy have resulted in people requiring frequent visits over prolonged periods of time. This means that care needs to be easily accessible to patients. The Department of Health, the British Association of Dermatologists and the National Collaborating Centre for Cancer have recognised that too many patients are attending hospital based services, for the provision of care that could be managed in a community setting. Initiatives elsewhere in the country demonstrate improved convenience and satisfaction for patients as well as reductions in DNA rates. Studies from some centres suggest up to 50% of patients referred to Dermatology departments could in fact been seen and treated by a GPwSI[[3]](#footnote-3). The key drivers for the development of this service are to provide a local, more accessible and cost effective service for patients, as set out in documents such as:  * ‘Our Health, Our Care, Our Say; A New Direction for Community Services’[[4]](#footnote-4) * ‘Improving Outcomes for People with Skin Tumours including Melanoma’[[5]](#footnote-5) * ‘Model of Integrated Service Delivery in Dermatology’[[6]](#footnote-6)   **Local context:**  The CCGs involved in this procurement are responsible for the health of all people registered with Brent, Harrow and Ealing general practices, even if they live outside of the borders of these boroughs.  This service redesign fits with the Out of Hospital strategy and Shaping a Healthier Future agenda.  **Brent**   * Total GP registered population (2015/16): 369,074 * Population of children under 18 (2015/16): 22.9% * Number of GP practices: 61 * Practices are organised into three localities   **Harrow**   * Total GP registered population (2015/16): 260,000 * Population of children under 18 (2015/16): 22% * Number of GP practices: 33   **Ealing**   * Total GP registered population (2015/16): xxxxxxxx * Population of children under 18 (2015/16): xxxxxx * Number of GP practices: xx * Disease prevalence: There is no North West London or borough specific prevalence data for skin conditions, but in general the ten commonest diagnostic groups of patients are identified who require more than one follow up are: Eczema, Psoriasis, Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma (SCC), Acne, Solar Keratosis, Naevi, Melanoma, Leg ulcers and Lichen Sclerosis.   2015/16 activity for the CCGs in both acute and community is as follows:    The Community Dermatology Service will form part of an integrated Dermatology Service across primary and secondary care. This will entail working closely with GPs, GPwSIs undertaking minor surgery, Acute Specialist Service Departments (Level 4) and Specialist Skin Cancer services. In addition, the service will need to develop links with the local skin multidisciplinary team and cancer network’s skin cancer tumour working groups. The Service will also need to develop links with other secondary care specialities such as Plastic Surgery. |
| 2. Scope |
| **2.1 Aims and objectives of service** The successful provider/providers will be responsible for a multidisciplinary community based service and will manage all the cases which do not require a hospital facility to manage them. The proposed community dermatology service is expected to deal with Tier 3 cases, as shown in the diagram below:cid:image001.jpg@01D3D340.3B1C3B70 The scope of the service will be as follows:   1. The service will provide a one stop consultant-led community dermatology service where patients are seen either by a consultant, dermatology registrar, GPwSIs or specialist nurses and where possible, assessed and treated in one appointment. Consultant-led for this service means that a consultant is available to provide advice, guidance, and professional support in a timely fashion to all staff as needed, although this may not always be face to face. In addition the consultant will have to be present at clinics and complex case discussions as appropriate. 2. The service will treat all ages but for children under the age of 16 any surgical procedures must be referred to secondary care 3. Assessment, investigation and treatment of cancer patients within National and NWL cancer network guidance. 4. Will undertake minor surgery and skin biopsy in the community. The service must integrate with primary care minor surgery DES and refer to this where it is available. 5. All the referrals into the community service will be received from the local Referral Optimisation or Management Services. These services will only administratively triage referrals to the community dermatology service. The service will then be expected to provide a secondary clinical triage to assess the referral and how best to treat the patient. This triage should use the existing referall service infrastructure and mechanisms where appropriate. This triage may be carried out by the GPwSIs in the service, but with access to timely input from the consultant as required. Standardised referral forms will be used, which may be changed during the contract to facilitate greater alignment across the sector. 6. The service must have, or be willing to develop, the capacity to attach photographs to referrals and use these as part of the triage service. In addition, we expect technology to be used to facilitate communication within the service, so photographs may be a key element in GPwSIs accessing specialist advice from the service consultant to support their treatment of a patient. 7. Over time, the service should consider developing the teledermatology capability both within the service and the wider GP community. This will include supporting training for GPs. 8. The service will manage all tier 3 (intermediate community care) cases and adhere to the local referral pathway. This is included later in the service specification for clarity. 9. Assessment, investigation and treatment of all patients with skin diseases, referred from ROS, except patch testing, phototherapy, anti TNF therapy and complex cases. All the patch test, phototherapy, Anti TNF and complex cases will be referred to secondary care 10. The service will be expected to manage and influence those referrals that should be seen in tier 2 (General Dermatological Care). This will include education of practices through providing both materials to support GPs and regular education sessions. There will also be a secondary triage system as described above which will include returning referrals to practice without seeing the patients, along with appropriate advice on how to manage the patient in Tier 2. 11. Only tier 4 cases requiring a hospital facility will be referred to hospitals. All the onward referrals from the community service to hospitals will be via ROS only 12. All patients will be seen in the community service within 4 weeks of receipt of the referral 13. The community service will be provided from at least two locations across the borough, maximising patient choice and the numbers of patients who can be treated close to their home. These are expected to be Wembley Centre for Health and Willesden Medical Centre 14. Improving knowledge of the CCGs’ health professionals around the management of skin diseases through the development and implementation of education programmes for GPs, GPwSIs and other practitioners on the agreed clinical pathway such that Tier 1 and Tier 2 cases are not referred to community or secondary care service 15. Supporting patients around management of skin disease through the provision of information resources, support and guidance. Support for self-care and self-management should include sharing information resources with local GPs. 16. Provide information and support about self-care, prevention of skin disease and on-going management of long term skin conditions to healthcare professionals and patients. 17. GP practices in Brent and Harrow use EMIS, while those in Ealing use System One. Ensuring maximum integration and shared functionality across both systems will be important, and managing any process differences that are needed to ensure equity of treatment and outcome across all three commissioning CCGs. The use of ERS to accept and manage referrals is a requirement of this service. All clinics available on ERS must be clearly labelled and this must meet CCG requirements which may be updated during the contract to provide greater consistency between providers. 18. Robust clinical safety, quality measures and robust governance arrangements 19. Provide value for money, ensuring that patients are treated in an environment most appropriate to their needs at the right cost.   **2.2** **Service description/care pathway** It is expected that the provider will only treat conditions that could not be managed in primary care. In the initial years of contract it may need extensive GP education to support this. The following list is indicative of some conditions that may need to be managed in the consultant led community dermatology service:  * Extensive acne not responding to primary care treatment (the service will include treatment with Roaccutane in the community ) * Extensive psoriasis not responding to primary care treatment * Extensive eczema not responding to primary care treatment * Children with severe eczema requiring specialist nurse support * Skin lesion /rashes requiring diagnosis, * Some cases of severe alopecia,  This service will not cover the Tier 4 (cases requiring hospital facility for managing them)  * Management of complex cases e.g. Cases requiring admission, general anaesthesia, plastic surgery, joint clinic etc. * Patch Tests * PUVA therapy * Anti TNF therapy   These lists are not exhaustive. A fuller list of conditions and treatments and the appropriate care setting, including what is and is not expected to be seen in the community can be found in the Appendix. The community service will provide the following elements:  * Full diagnostic service including phlebotomy, biopsy and swab taking and reporting of results. * Patient advice and education. * Initial treatment if required. * Patients should be referred back to their GPs for medication except for treatment that needs to commence within 7 to 10 working days. * The medication prescribed should be in line with the agreed formulary * Follow up management. * Assessment, investigation and treatment of cancer patients. All cancer cases will be managed by following the North West London Cancer Network pathway * Typed letter after each episode of care containing treatment plan/discharge summary for the patient’s GP within 2 working days with copy sent to patient. * An education programme for primary care staff * Maintenance of a full clinical register and record of all patients treated. * Collection of data for borough wide audit and conduct local audits as appropriate   The provider will ensure that systems are in place for the transport and analysis of diagnostic tests. The provider will ensure that any biopsy results are received and acted upon within 1 working day of receipt of result for the appropriate intervention or follow up. The Providers will report results back to the referring GP for their records only.  The provider will need to demonstrate a system of highlighting identified cancers to the MDT in order to ensure rapid patient pathways.  The providers will need to be able to access the following basic and essential diagnostic tests. These should be available when the patient attends the first appointment or further referral needs to be made and include:   * Baseline pathology * Bloods * Mycology * Dermatoscopy * Microbiology * Urinalysis * Virology   These diagnostics need to be included within the payment arrangements outlined in the relevant section. Cancer pathwayThe community service will be responsible for assessment, investigation and treatment of cancer patients within National and NWL cancer network guidance. The service will manage cancer patients who don’t require hospital facilities to treat them.If cancer is suspected the service will be expected to refer the patient immediately to the acute service via the two week wait pathway.The Pathology service used by the Community Dermatology Service must be accredited to the same standard as NHS pathology labs that handle skin cancer specimens, with an equivalent turn round time of specimen reports. The number of such specimens must be audited and a robust mechanism in place for alerting clinicians in place in a timely fashion. The laboratory must take part in audits and nationally recognised pathology accreditation activity. The patients must be referred to the appropriate MDT, GP informed and clarity sought around who informs the patient. This may be the clinician who performed the biopsy or the GP, but in either case this must be done in a timely manner and onward referral arranged or follow up determined.Medicine ManagementThe provider will have a named clinical governance lead who will ensure that all prescribing is within national and local (NWL) agreed guidelines and treatment pathways. In particular the provider will ensure any NICE guidance issued in relation to Dermatology is implemented within the appropriate timeframe.Prescribing decisions and recommendations will only be made by suitably qualified medical and non-medical independent prescribers.Prescribers will follow the NWL formulary agreed formulary for prescribing or making recommendations to GPs for prescribing. Prescribers will follow local procedures in the introduction of new and/or specialist therapies or high cost drugs, specials and transfers of prescribing responsibilities.Where possible, patients should be referred back to their GPs for medication except for treatment that must start immediately i.e. within 10 to 14 working days or where prescribing responsibility needs to be retained by the specialist e.g. isotretinoin.  In line with the NWL sector Prescribing Policy (available from Medicines Management Team) GPs should not be asked to prescribe medicines included in the ‘red’ list and unlicensed medicines. GPs should not be asked to prescribe unlicensed ‘specials’ when an alternative, more cost effective licensed product is available.Requests to GPs for taking on prescribing of medicines listed within the shared care list of the NHS NWL Prescribing Policy should be sent with an agreed shared care document.The provider will have the required clinical expertise to maintain relevant stock medicines from the NWL formulary in their clinics. A list of the medicines should be submitted with each provider’s application.All medicines (diagnostic, analgesics, anaesthesia, and discharge medicines) and devices will be procured by the treating service provider and should be inclusive of the agreed tariff.The CCG will not be invoiced by the Provider separately for medicines which have been provided, whether through the clinic or by out-patient prescribing. All tariffs are therefore ‘drug inclusive’ and are inclusive of initial supply of medicines. This requires the service providers to have procurement process for medicines and devices in place, with associated governance, i.e. storage and handling and appropriate policies e.g. clinics own medicines policy. The provider should have a mechanism to prescribe medication using an FP10/PGD if medication is immediately necessary.The providers will monitor their prescribing as good practice and provide a report to the CCGs every six months on request.The patient pathway should include community pharmacies to address medication adherence, information on prescriptions, counselling on first supply, any other queries.The providers will meet safe and secure handling of medicines standards (C4d) as required by CQC annual health check, and be able to provide evidence of compliance (i.e. procedures and policies).The providers will demonstrate compliance of any relevant Safety Alert Broadcast systems, NPSA and MHRA safety alerts and notices.The providers will have a formal process of sharing incidents with HCCG including documentation with planned action.The providers will have a process in place to report Adverse Drug Reactions via Yellow card reporting system (i.e. local procedures and policies).Training and Support to ReferrersThe service providers will provide on-going support and education for referring GPs in order to ensure that best management practice is shared. This will include, but not be limited to, the following elements.  * Open meetings for all GPs, nurses and other community staff to attend will be organised including seminars, lectures and case studies. The required number of these events will be 3 per year, held across the commissioning CCGs. The organiser of the event must liaise with other CCG events and training departments in order not to duplicate training or run on the same day as another event. Sessions should be delivered by consultants or other experts in disease areas. * Attend each of the locality meetings or equivalent at least once a year to discuss the service provision with GPs and address their concerns, and to raise awareness of the service and engagement with it and the clinicians. * Offer open access in the clinics for GPs’ and nurses’ training * Open meetings and in-clinic training should be provided to practice nurses and include diagnosis and treatment of most common conditions such as acne, eczema and psoriasis as a minimum. Practice nurses’ sessions should be designed around knowledge of treatments (creams etc.) and their application to enable them to offer face to face advice for patients as well as other appropriate areas. * The service will also support improving knowledge of other NHS health professionals by enabling further teaching of medical students, GP trainees, nursing students, pharmacy students and the community staff  GovernanceGovernance is a mechanism to provide accountability for the way in which an organisation manages itself. Integrated Governance is a collation of systems, processes and behaviours by which healthcare organisations lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations. The Provider is required to have, or adopt, a system of Integrated Governance that incorporates key elements of Clinical Governance and organisational learning to ensure that there is the safe delivery of the Services to Patients.Clinical Governance is a system through which healthcare organisations are made accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish. Clinical Governance should be integrated into the organisation’s whole governance arrangements. The Provider shall comply with their duties under Law to improve the quality of the Services for Patients through the Integrated Governance arrangements set out in the National Standards and having regard to the DH guidance on Clinical Governance  * + 1. **Best Practices**   The providers will carry out the service in accordance with best practice in health care and shall comply with the standards and recommendations contained in, issued or referenced as follows:   * Issued by the Health Care including Standards for Better Health * Staffing and Facilities for Dermatological Units (BAD, Nov 2006) * The Health Act (2006) Part 2 (Prevention and Control of Healthcare Associated Infections) * The National Institute for Health and Clinical Excellence * All Party Group on Skin Reports (2003, 2004, 2006) * Dermatological Care Working Group Report (2001) * Audit Commission “Quicker Treatment Closer to Home” (2004) * Modernisation Agency “Action on Dermatology” (2003) * Skin Care Campaign “Making Psoriasis a Priority” (2005) * Any relevant National Service Frameworks * Issued by any relevant professional body * Data Protection Act 1998 * Comply with Bribery Act (2011)   The Care Quality Commission (CQC) sets out the level of quality that all organisations providing NHS care in England are expected to meet. The Provider is required to achieve registration with CQC and it is their responsibility to perform an analysis of the CQC registration and compliance requirements.  The CQC provide a common set of requirements applying across all healthcare organisations to ensure that health services that are provided are both safe and of an acceptable quality. The Provider must meet all essential standards set out in the ‘Care Quality Commission Guidance and Compliance Essential standards for quality and safety’, published in December 2009.  The Provider is required to declare and provide details of any CQC investigations, claims, suspended doctors, nurses or other healthcare professional registered with a professional body   * + 1. **Health and Safety**   The Providers will be expected to demonstrate compliance with all applicable Health and Safety legislation.  Medical devices and equipment safety policies need to be in place, and the service needs to be compliant with appropriate MHRA directives.  The service will be compliant with national standards for skin surgery, including safe procedures for handling of tissues, consent, record keeping and other processes.   * + 1. **Public and patient involvement**   This will include providing information to patients. A set of high quality comprehensive information leaflets on the main dermatological conditions will be developed and agreed with the CCGs. This will be shared with GP practices and other appropriate locations to facilitate access by patients. In addition the content will be expected to be shared online.  Providers will be expected to co-operate and collaborate with GPs, minor surgery and Acute Specialist Service providers to ensure that patients entering and exiting the service are managed appropriately.   * + 1. **Internal Governance arrangement**   The provider will identify a clinical lead for clinical governance. Their role will be to ensure clinical standards are being adhered to and to liaise on an on-going basis with GPs, the Sub Cluster Governance Lead and Secondary care providers to ensure appropriate clinical governance arrangements are in place. Good clinical leadership is key to promoting Patient safety and to improving quality of care. The Provider must demonstrate in their structure clinical leadership by nominating an Organisational Medical Director whose identified responsibility is to put quality of care at the heart of the Provider’s aims, and to provide a framework for Clinical Governance and support for those delivering the Services. Organisational Medical Director carries corporate/organisational responsibility for the organisation’s activities  The providers will ensure that robust clinical governance processes/policies/protocols are in place, including:   * A clinical lead * Incident reporting * Health and Safety (including needle stick injury and sharps) * Compliance with national and local standards, including NICE, HCC, and NSFs * Infection control * Managing alerts including NPSH * Significant event analysis * Information   + 1. **Patient consent**   The Providers will be required to have processes in place to evidence that valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments/procedures. This will also include evidencing that where a patient lacks the mental capacity to give consent, the principles of the Mental Capacity Act 2005 Code of Practice have been adhered to   * + 1. **Complaints**   The providers will have a complaints policy. All complaints must be recorded and responded to within appropriate timescales. Complaints data should be analysed at regular intervals to identify trends and these must be reported back to the CCGs. An action plan will be produced for all complaints.   * + 1. **Patient safety/Serious unexpected untoward incident (SUI)**   The providers will have a process in place for reporting SUIs. The providers will provide the CCGs with copies of any notifications made where these directly or indirectly concern any patient. The providers will agree with the CCGs arrangements for the notification and investigation of any SUIs and will provide investigation reports and action plans. The Provider should be committed to learning from Adverse Incidents, SUI’s and other Patient Safety incidents to improve the quality of care for Patients Safeguarding adults / Protection of vulnerable adults and childrenThe providers will have a process in place to manage cases for adult protection, when identified Safeguarding children and young people is one of the highest priorities for all CCGs. We are therefore committed to ensuring that ALL our provider organisations and services have safeguarding arrangements in place that minimises the risk of physical, sexual or emotional harm and neglect to all children or vulnerable adults (that is, adults who are at risk of or suffering from domestic abuse, mental health problems, drug or alcohol misuse, mental or physical disability).  It is the expectation that ALL provider contractors meet the standards set out by the CCGs through the following:-   * Compliance with Working Together to Safeguard Children document March 2010 * Compliance with London Safeguarding Children’s Board Child Protection Procedures 2007 * Compliance with Care Quality Commission Regulations on Cooperating with other providers: Outcome 6 (CQC Quality and Safety Standards 2010) * Compliance with Care Quality Commission Regulations on Safeguarding and Safety: Outcome 7(CQC Quality and Safety Standards 2010) * Compliance with Section 11 Children’s Act 2004 * Any service development should take into account the need to safeguard and promote the welfare of children and young people and should consider where appropriate the views of children and families. * Training all staff to levels 1, 2 or 3 according to the level of contact they have with children and in line with Working Together to Safeguard Children document March 2010. * Keeping a robust, updated database system for staff attendance to safeguarding and child protection training at each level and to share when required to NHS Hounslow. * Ensuring that all staff in contact or working with children have been CRB (Criminal Records Bureau) checked and registered with the Independent Safeguarding Authority (ISA for Vetting and Barring). * Ensuring all staff are clear of their responsibilities within safeguarding * Ensuring staff who have regular contact with children and families receive appropriate safeguarding supervision and that the organisation has an updated Supervision Policy that is reviewed regularly. * Ensuring the organisation cooperates and works with the Safeguarding Team when any audits are being undertaken. * That the organisation complies with any investigations undertaken, e.g.; Sudden Unexplained Incident (SUI), Serious Case Review (SCR) * Ensuring that each provider and independent contractor has a named individual who takes the responsibility for safeguarding and that there is a clear line of accountability within their organisation.   Please note that this is not intended to be a definitive list of everything NHS Hounslow requires from provider services to ensure the safety of children and young people.   * + 1. **Information Governance**   The provider will ensure that information relating to patients is safeguarded and will take account of:   * Confidentiality * The CCGs’ Caldecott Guardians * The CCGs’ information sharing protocols * Informed consent * Records keeping protocols   + 1. **Risk Management**   It is imperative that the service operates a rigorous and comprehensive approach to corporate and clinical risk; this would involve implementing systems and processes that enable the senior team to understand and respond to key clinical and corporate risks to service delivery and patient safety. The Bidders must outline the key areas of risk as they see them in regard to this service and the provision of your model(s) in particular  The Providers will have a comprehensive risk management policy, and systems for incident reporting and safety alert broadcasting must be in place. SUIs (serious unexpected incidents including medication related) will be reported to the commissioners. Regular (initially monthly) reports of incidents and complaints will be made to the commissioners.   * + 1. **Insurance**   The providers will have medical negligence indemnity insurance and all cases will be reported to the CCGs.   * + 1. **Business continuity**   The providers will have a robust Business Continuity plan, which will include:   * Disruption to information systems * Disruption to premises * Flu pandemic/other disease outbreak causing significant staff shortages  Staffing Staff providing the services are likely to fall into one of the five categories below or be any combination of the five, as long as at least one consultant is part of the team.   * Dermatology medical consultant (current or previous NHS consultant contract) * Specialist registrar in Dermatology * GP with specialist interest in dermatology or skin surgery with necessary experience and training and formally accredited as such * Associate Specialist or Hospital Clinical Assistant * Dermatology Nurse Specialist   All personnel providing the service through the contract must have appropriate indemnity cover to meet in full, claims made against them as individuals. Proof of cover must be submitted to the CCGs upon request; Providers will be responsible for ensuring this is in place.  Clinicians should be registered with the appropriate clinical governing body and have evidence of continued professional development. Practitioners will be accredited as competent in the relevant diagnostics and equipment required within their remit, and will have access to annual peer review  Any clinician providing the service must demonstrate a continuing sustained level of activity, be appraised on the delivery of the service and demonstrate evidence of Continuing Professional Development (where their skills are regularly updated)  All staff should have sufficient competency in English to undertake the role, with relevant suitable medical vocabulary and terminology. Where required, they will have passed a suitable examination in medical English vocabulary.  Each Provider will be required to demonstrate they have safe recruitment procedures in place e.g. CRB checks and will be able to meet the requirements of the Vetting and Barring Scheme which comes into effect from October 2009. Where posts remain vacant for longer than 8 months the CCGs may impose penalties.  The providers will institute management and administrative arrangements with clear lines of accountability and an identified lead clinician/manager with overall responsibility for the service. Each Provider will also be required to identify an individual as the point of contact for the CCGs.  The service will maintain professional links with local clinicians and local acute specialist providers and the direction and development of the service will be steered in collaboration with both groups as far as possible  **Staff development and staff competency**  Examples of different evidence of competencies for the service:   * Demonstration of skills under direct observation by a Consultant * Demonstration of knowledge by personal study supported by assessment * Evidence of gained knowledge via attendance at relevant courses or conferences * Demonstration of ability to work in teams by evidence of taking part in multidisciplinary teamwork to plan and deliver service provision and individual patient care. * Evidence of Continuing Professional Development, appraisal and audit. * Delivering multi and uni-professional training. * All staff should be trained in resuscitation to Basic/Advanced Life Support standard.  All staff should attend annual updates in Fire and Health and Safety training **Human resource management**   * The providers are responsible for all recruitment, training, supervision, discipline and development of staff. * Each Provider will be required to provide its proposals for the recruitment and retention of an appropriately skilled workforce as detailed in core services. Providers are required to develop a workforce plan to ensure continuity in the event of staff sickness, retirement etc. * The providers are required to actively support all employees to promote openness, honesty, probity, accountability and the economic, efficient and effective use of resources  IM&T The Provider must ensure that appropriate “IM&T Systems” are in place to support the Service.  “IM&T Systems” means all computer hardware, software, networking, training, support and maintenance necessary to support and ensure effective delivery of the Service, management of patient care, contract management and of the treatment processes.    The Provider shall have details of their ODS code with named contacts who is solely responsible for the directory of services.  For those non nhs organisations notification of their NHS sponsor must be noted. Choose and Book Process maps should be readily available to evidence how the patient will be managed, covering all elements for example slots issue, with timescales.  The provider shall comply with relevant NHS information and data standards, including reporting requirements of SUS and UNIFY and those set out in dataset change notices (DSCNs). The Provider shall notify commissioners promptly where standards are not followed.  Both parties acknowledge that it is essential to provide timely and accurate monitoring information to fulfil l their aims and statutory responsibilities.  The parties will review the requirements for locally agreed data flows on an annual basis to ensure continuing relevance. Changes to existing requirements, as well as any new requirements, will be subject to agreement between the Parties and shall be agreed as a variation to the agreement. Wherever possible centrally submitted data will be used to reduce duplication of effort  The Provider must put in place appropriate governance and security for the IM&T System to safeguard patient information  The Provider must ensure that the IM&T Systems and processes comply with statutory obligations for the management and operation of IM&T within the NHS, including, but not exclusively:   * Common law duty of confidence; * Data Protection Act 1998; * Access to Health Records Act 1990; * Freedom of Information Act 2000; * Computer Misuse Act 1990; and * Health and Social Care Act 2001.   There is a statutory obligation to protect patient identifiable data against potential breach of confidence when sharing with other countries.  The Provider must meet prevailing national standards and follow appropriate NHS good practice guidelines for information governance and security, including, but not exclusively:  NHS Confidentiality Code of Practice;  Registration under ISO/IEC 16799-2005 and ISO 27001-2005 or other appropriate information security standards;  Use of the Caldicott principles and guidelines;  Appointment of a Caldicott Guardian;  Policies on security and confidentiality of patient information;  Clinical and information governance in line with the NHS Information Governance Toolkit; and  Risk and incident management system  Pseudonymisation of data  No failure of CfH, NPfIT, NHS Brent, NHS Ealing, NHS Harrow or any other subcontractor supplying IM&T services or infrastructure will relieve the Provider of their responsibility for delivering dermatology services. **Therefore, the Provider must have an IM&T Systems disaster recovery plan to ensure service continuity and prompt restoration of all IM&T Systems in the event of major systems disruption or disaster** Equipment The provider will be responsible for the purchase and maintenance of all equipment inclusive of the agreed tariff  The Premises may contain equipment, furniture, furnishings and consumables used in the delivery of the Services (e.g. reception and office desks, consulting room furniture, fridges used for storing drugs, syringes, sample collection materials, bandages, etc.). Collectively these will be known as the “Equipment”. The Equipment may include permanently installed Equipment as well as Equipment used in the maintenance and upkeep of the Premises  The provider will ensure that all medical equipment is regularly calibrated or serviced in line with the manufacturer’s guidelines  **Standards**  Where the Provider purchases equipment for use within the CCGs’ premises The Provider must ensure that Equipment complies with statutory requirements and the latest relevant British Standard or European equivalent specification where such exist and the Provider shall furnish the NHS Hounslow Contract Manager with proof of the same if requested.  The Provider must provide, install, operate and maintain all Equipment in accordance with all applicable laws and manufacturers' instructions.  The Provider must ensure that Equipment used to deliver the Services would not cause interference with or damage to equipment used by others.  The Provider must ensure that Equipment is fit for purpose and purchased with compatibility in mind.  **Due Diligence**  Bidders must have carried out all appropriate investigations with regard to equipment and have taken into consideration the results of all such investigations prior to submitting their Bid  **Contracting arrangement**  The CCG Equipment is made available to the Provider and the Provider shall comply with the terms of Schedule 6 of the Contract.  The Provider shall provide any other Equipment, whether fixed or mobile, necessary for the delivery of the Services and operation of the Premises (the “Provider Equipment”).  **Consumables**  Providers must ensure that consumables are stored safely, appropriately and in accordance with all applicable laws, good practice guidelines and suppliers' instructions  **Costs**  Cost of equipments including maintenance and any licensing will be included in the agreed price    **Management of equipment**  The proper and adequate control of Equipment is an important aspect in the safe and effective delivery of the Services  **Post contract responsibility**  The Provider will be responsible for the Equipment, excluding any CCG owned Equipment, beyond the term of the Contract  **Acceptance of Provider Equipment by NHS Brent**  The choice of Provider Equipment and consumables will be subject to approval by the CCGs   * 1. **Population covered (accessibility)**   The service will be available for patients who are registered with a General Practitioner (GP) in Brent, Ealing or Harrow who have been assessed by their GP as suitable to attend.  General rules of accessibility for whole service:   * The service must be able to meet the needs of those who do not have English as a first language. Patients will be asked by the Providers as to their need for an interpreter for the clinic. It will be the responsibility of Providers to arrange it inclusive of tariff where language support needs are identified. * The service must recognise cultural diversity and meet the needs of the population it services * The service must be located in an accessible area, with good access to transport links * The service must have access to parking for patients * The service must provide transport for patients who are assessed as having sufficient impairment to make public transport impossible and no other means of travelling to the service * The service must be provided from at least 3 sites positioned to meet the needs of the local population   The service should develop an accessibility and non-attendance policy to be approved by the commissioning organisation prior to mobilisation and go-live. This will include telephone contact with patients who do not attend their first appointment, and discharge if a second appointment is not attended  **Waiting times**  The maximum waiting time from receipt of referral to first appointment should be 4 weeks. Providers must ensure that they adhere to all cancer waiting times targets (2 weeks) and 18 weeks pathway.  Clinical assessment, diagnostics and commencement of treatment is to occur within as short a timeframe as possible and practicable.  First line diagnostics to occur on the day of clinical assessment wherever possible  The service must adhere to the 18 week Referral to Treatment target for those referrals into secondary care.  **Appointment making**  The provider will be responsible for ensuring an appropriate appointment booking system is in place. Patient should be able to have a confirmed appointment booked within 2 days of receipt of referral **Effective Communication** Providers will offer a range of leaflets, covering the core conditions to support patient understanding and where appropriate self-care. These core leaflets should be available in multiple languages, relevant to local area.  Providers must provide clear, comprehensive, written feedback to referrers if inappropriate referrals are made to the service. This written feedback should be provided at the time the referral is returned and should include references to the agreed pathways, as well as guidance to how to manage the condition in primary care, with links to further information or other resources as appropriate. These resources should be shared with GPs, ideally through local systems where available.  Providers to ensure that information on patients is fed back to the referrer (and GP where different from the referrer) on completion of the course. This should include any clinical management advice/plan and outcomes   * 1. **Any acceptance and exclusion criteria**   **Acceptance criteria:**   * Referral to secondary care should be made via ERS. The patient choice discussion should occur between referring clinician and patient at the time when referral is made. * The service should have access to and arrange interpreting services when required. * Staff will behave in accordance with trust policies and code of professional conduct. * The service must offer transport in line with guidance set out in the White Paper, ‘Our health, our care, our say: a new direction for community services’ (2006). If a patient’s GP feels that transport is necessary to enable them to attend, this must be agreed with the providers who will arrange this.   The cost of transport will be covered by the agreed tariff  **Exclusion criteria**  Patients not registered with Brent, Ealing or Harrow GPs   * 1. **Interdependencies with other services and notification as appropriate** * GPs * Carers * Acute Specialists * Cancer network * British Associations of Dermatology (BAD) * Care for elderly * Social care   **2.13 Communication with GPs/referrers**  Patients GPs are often the central point of access for patients with the health care system- therefore regular and clear communication between the provider and General Practice is essential.  All letters to patients and GPs will be clearly legible; will be posted and/or sent via electronic transmission within 2 days of the appointment and will contain as a minimum:   * Patient’s name, date of birth and NHS number * Named clinician in charge. * Primary and where appropriate, secondary diagnosis and/ or procedure. * Referral to other services * Diagnostic tests and results * Full management plan and follow up arrangements and suggestions for further treatments, which could if necessary be added by the GP should the patient fail to respond to initial therapy. * This should include a clearly marked section for **GP Action:** * A medication update for the patient stating dose, frequency and duration of course of newly prescribed drugs and notification if any medications are stopped. * Skin specialist contact number for ease of communication and query. * Where possible copies of clinical protocols/guidelines. * Information regarding patient DNA and Discharge   Use of electronic communication tools is required to support and automate this process. 2.14 Discharge criteria and Planning The providers will inform the patient’s GP by letter every time a patient is seen and if the patient is discharged from the service or is referred on to another service, within 2 days of consultation.  The discharge letter should contain:   * Patient’s name, date of birth and NHS number * Named clinician in charge. * Primary and where appropriate, secondary diagnosis and/ or procedure. * Reason for discharge * Referral to other service * Diagnostic tests * Full management plan and follow up arrangements and suggestions for further treatments, which could if necessary be added by the GP should the patient fail to respond to initial therapy. * A medication update for the patient stating dose, frequency and duration of course of newly prescribed drugs and notification if any medications are stopped. * Skin specialist contact number for ease of communication and query. * Where possible copies of clinical protocols/guidelines   If the CCGs introduce a standard discharge letter, the service will be expected to adopt this.  **Cancellation Policy**  If a patient cancels their appointment with more than 24 hours’ notice they will be offered another appointment.  If a patient cancels twice on consecutive appointments they are liable to be discharged except in exceptional circumstances. A warning will be given after the first cancellation.  If a patient cannot book a further appointment for valid reasons, the appointment may be left open for a maximum of one month.    **Did Not Attend (DNA)**  If a patient did not attend their appointment either new or follow up they will be contacted via telephone and letter to book a new appointment in 2 weeks. If a new appointment is not taken they will be discharged except in exceptional circumstances.  Once discharged if a patient telephones the department they will be advised to go back to their doctor for another referral if they still require treatment.  In exceptional circumstances a patient may be offered another appointment once discharged. Prevention, self–care and Patient and Carer Information Advice on self-management and patient education leaflets to be made available by the service. This should be shared with the CCGs for their online resources, as well as with GP practices, pharmacies and other relevant organisations.  Providers will offer a comprehensive range of patient information and will direct patients to other resources such as support groups in order to educate support and empower them to live with their skin problems. Information will be formatted according to the CCGs’ guidelines, and agreed by the relevant Communications Department(s) and should be made available in different languages as required, as referenced previously.  **2.16 Referral**  All the referrals into the service will be via the CCGs’ referral management services. A guideline for the flow of referrals is shown below. Elements that need to be managed by the community service are shown in red. |
| 3. Applicable Service Standards |
| **3.1 Applicable national standards e.g. NICE, Royal College**  The commissioned service should comply with all national best practice standards and guideline for dermatology including:   * Issued by the Health Care including Standards for Better Health * Staffing and Facilities for Dermatological Units (BAD, Nov 2006) * The Health Act (2006) Part 2 (Prevention and Control of Healthcare Associated Infections) * The National Institute for Health and Clinical Excellence * All Party Group on Skin Reports (2003, 2004, 2006) * Dermatological Care Working Group Report (2001) * Audit Commission “Quicker Treatment Closer to Home” (2004) * Modernisation Agency “Action on Dermatology” (2003) * Skin Care Campaign “Making Psoriasis a Priority” (2005) * Any relevant National Service Frameworks * Issued by any relevant professional body * Data Protection Act 1998 * Comply with Bribery Act (2011) |
| 4. Key Service Outcomes |
| * 1. **Service Outcomes**   The expected outcomes that relate to access and performance are:   * More equitable access and treatment of dermatology patients within different levels of deprivation * A reduction in referrals to secondary care services and a reduction in the number of follow ups across all levels of care * Increased patients satisfaction with Dermatology services * Services closer to patients’ homes * Improved communication between specialist clinicians and GP’s * Improved knowledge in primary care staff members about skin conditions and better management of Tier 2 cases.   1. **Patient Outcomes**   The expected outcomes that relate to the quality of patient care are:   * Improved quality of care within primary and community settings * Reduce the waiting time * Services closer to patients’ homes * Improved access to advice and information and increased knowledge and awareness of the management of Dermatology within primary care and patients * Increased patients’ satisfaction with Dermatology services   It is important to demonstrate the impact on patients’ quality of life and experience within the new service. Provider will carry out quality of life measurement questionnaires before and after treatment, and will collate feedback forms to demonstrate continuity of high standard service and provision for improvement depending on patients’ responses.   * 1. **Clinical Outcomes**   The expected clinical outcomes that relate to the quality of patient care are:   * Assessment and management of each patient within the appropriate level by the most appropriate clinician in an appropriate timescale * A reduction in referrals to this services over 3 years and reduction in the number of follow ups across all levels of care * Improved communication between specialist clinicians and GPs by using email, telephone and including a detailed care plan in all outpatient letters * Increased development and education of GPs and nurses in dermatology |
| 5. Location of Provider Premises |
| **5.1 Locations of Service**    It will be for providers to set out their proposal as to where services will be delivered - Providers will have an option to use premises already identified by the CCGs or to utilise alternative premises where they believe it to be the optimal solution.  It is important that there is equitable and easy access for patients across all three boroughs and the premises solution identified must ensure this.     * 1. **Days/Hours of Operation**   The Provider will ensure that the service open for patient consultations 52 weeks per year as a minimum between Mondays-Friday between the hours of 9-5. Weekend clinics can be provided where there is patient demand and clinical capacity.  The service provider should give relevant information to patients as to what services to access should a treatment complication arise outside these normal hours. |

**Local key performance indicators**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Description of KPI** | **Minimum Performance Standard** | **Method/Timing of Monitoring** | **Breach** | **Consequence of breach** |
|  | Patient Satisfaction with the service [survey questionnaire to be agreed between provider and commissioner] | 90% satisfied with the service  Minimum response 40% of patients who attend CDS | **QUARTERLY**  Establish a regular programme of surveying the CDS patients to elicit views about patient experience, service quality and barriers to attending.  Commissioners required to agree questionnaires and means of administration | Less than 90% satisfied with the service  Less than 40% responses from patients who attend CDS clinic | Remedial plan agreed to address deficiency in process  See consequence of breach section at end of KPI list |
|  | Reporting the number of cancers diagnosed by category (low/high BCC, SCC, MM) | 100% reported | **Monthly** | Less than 100% | See consequence of breach section at end of KPI list |
|  | Waiting Times- Percentage of patients seen and treated within 4 weeks of receipt of the referral | 95% treated within 4 weeks | **Monthly** | Less than 95% | See consequence of breach section at end of KPI list |
|  | Percentage of referrals directed to Level 4 and reason for referral (onward referral) | 100% reported | **Monthly** | Less than 100% | See consequence of breach section at end of KPI list |
|  | Percentage of referrals directed back to primary care | *100% reported* | **Monthly** | Less than 100% | See consequence of breach section at end of KPI list |
|  | Overall reduction in referrals to secondary care within 3 years of contract award but visible and auditable on a quarterly basis | *30% reduction* | **Quarterly**  Monthly SUS/SLAM activity monitored against agreed trajectory | Over performance against agreed baseline | The associated secondary care costs will be passed on to the provider unless it can be proven that the over performance was not a result of a failing within the CDS e.g. Population growth |
|  | Consultant input into at Community service | Lead Consultant to attend clinical sessions (at least 70% attendances) provided as part of contract.  Provider will need to have appropriate cover arrangements in place for absence/sickness etc.  Consultant to provide timely responses to queries from other service clinicians – both triage and clinic queries | **MONTHLY**  Evidence of Consultant attendance at clinics e.g. Notes of MDT meetings, job plan, attendance records  Response times to queries to the dedicated inbox for these | **Below the agreed target** | This will be considered to be a fundamental of contract terms. Two separate episodes (within 8 weeks) will result in performance notice. Persistent failure i.e. defined as more than 4 absences in a 12 week period will lead to a termination of the contract unless Provider can demonstrate exceptional circumstances |
|  | Number of educational sessions done broken down by group sessions, in-clinic training, telephone and email advice broken down by practices | 3 sessions per year, held at different locations across Brent, Ealing and Harrow | Quarterly | NA | Remedial plan agreed to address deficiency in process |
|  | Turnaround time for the sending letters after assessing/treating patient | 95% within 2 working days | Monthly | Less than 90% within 2 working days | See consequence of breach section at end of KPI list |
|  | Breakdown of incidents, SUI, never events and complaints | No occurrence | Monthly | Occurrence of any of these events | Provider to perform root cause analysis and produce remedial action plan to avoid reoccurrence.  See consequence of breach section at end of KPI list |
|  | Infection control standards | 85% compliance with infection control audit standards | Quarterly | If required levels of compliance falls | See consequence of breach section at end of KPI list |
|  | Percentage of DNAs by new and FU (against total period appointments) | 9% | Monthly | 10% | See consequence of breach section at end of KPI list |
|  | Delivery against all agreed adult and child safe guarding protocols and procedures set out in service specification | 100% compliance required | MONTHLY  Monthly update on agreed indicators  Agreed reporting schedule as part of contract review process | Required level of compliance falls below 100%.  Referral to CQG if concerns persist | See consequence of breach section at end of KPI list |
|  | Discharge letters contain management information to support patients/GPs manage the condition without coming back to the service | 100% | Monthly | 95% | See consequence of breach section at end of KPI list |

**Provider is expected to achieve the performance threshold for each KPI as stated in the table above.**

**\*Consequence of breaches:**

Where a Provider is performing below the performance threshold for:

**A)** **3 or more KPIs in one month**

**B)** **One of the KPIs for three consecutive months**

**Phase1**

KPI underperformance is reported that meets either criteria A or B above. Following the monthly performance meeting, the commissioner will either write to the provider stating that:

* they are satisfied with explanation for underperformance and confirm that no element of payment will be withdrawn
* the breach consequences will apply, but will be suspended for one month to allow for the provider to put in corrective actions to meet required performance levels

**Phase 2**

1) Breach of any of the two criteria above will result in 10% withholding of payment on the following month’s invoice. i.e. if provider failed to perform in month 3, when month 4 invoice is raised- 10% of that invoice amount will be withheld.

2) If Provider meets the KPI in following month, the withheld amount will be refundable. If Provider continues to breach the KPI, withheld amount will not be refunded. i.e. if the provider fails to perform on month 3, month 4 invoice payment will be withheld by 10% but if Provider performs to target in month 4, on month 5 invoice, the 10% withheld amount will be refunded.

3) If provider fails to perform in subsequent months (i.e. month4) – 10% withholding of payment becomes nonrefundable and a further 10% of payment will be withheld on to month 5 invoice.

**Appendix 1 – Conditions to be managed by the Community Dermatology Service**

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Primary Care** | **Community Dermatology Service** | **Secondary Care** |
| Eczema (atopic) | Mild to moderate | Extensive and /or unresponsive to treatment  Sleep problems  Psychosocial upset  Secondary infection  Possible contact allergy | If >90% coverage  Systemically unwell  Eczema herpeticum |
| Eczema (atopic), paediatric | Mild to moderate | Eczema not controlled (2+ flares per month)  Severe psychosocial/social difficulties  History of GI symptoms  History suggestive of dietary allergy | Children requiring nurse support |
| Eczema (hand and foot) | Mild to moderate | Poor response to topical steroids  Recurrent secondary infection  History of occupational exacerbations  Suspicion of contact allergy |  |
| Psoriasis | Mild to moderate | Unresponsive to treatment (3 months)  Involvement of sites which are difficult to treat et face, palms, genitalia | Emergency referral for erythrodermic or pustular psoriasis  Refer to rheumatology is any possibility of psoriatic arthropathy  Requiring phototherapy or systemic therapy |
| Lichen Planus |  | Mild to moderate |  |
| Urticaria & allergies | Mild to moderate | Persistent & unresponsive to 3 different anti-histamines each for 4-6 weeks | Urticarial vasculitis with associated joint pains, persistent wheals (more than 24 hours) and bruising |
| Fungal infections | Mild to moderate | Unresponsive to treatment  Suspicion of subungual tumour | Refer to podiatrist if toe nail dystrophy secondary to trauma or painful psoriatic toe nails |
| Acne vulgaris | Mild to moderate | Severe nodular/cystic acne  Extensive and /or unresponsive to treatment (for eg  Isotretinoin prescriptions and  Roaccutane prescriptions) | Severe psychological upset |
| Phototherapy |  |  | All phototherapy to be in secondary care |
| Pigmented skin lesions |  | Investigation & treatment if required | Use 2ww pathway if suspected malignant melanoma  Treatment if required |
| Premalignant skin lesions eg Bowen’s disease/solar keratoses | Mild | Investigation & treatment if required  Unresponsive to treatment  Painful, rapidly growing lesion  Cryotherapy | Use 2ww pathway if suspected SCC  Treatment if required  Immunosuppressed patients |
| Skin lesions/ rashes requiring diagnosis |  | Diagnosis & treatment if possible | Diagnosis & treatment if not in community |
| Patch testing |  |  | All patch testing to be in secondary care |
| Low risk BCCs on trunks and limbs |  | Investigation & treatment if required | Treatment if required |
| Alopecia | Mild to moderate | Extensive and /or unresponsive to treatment  Inflammatory scarring alopecia |  |
| Minor surgery on suitable conditions |  | Excision of BCC/ solar keratoses  Patch testing  Punch biopsies | PUVA  All remaining |
| Warts, verrucae and other non herpetic viral infections | Mild to moderate | Extensive and /or unresponsive to treatment (2 years)  Cosmetic removal NOT included  Cryotherapy | Multiple recalcitrant warts in the immunosuppressed |
| Rosacea | Mild to moderate | Severe or unresponsive to treatment | Consider referral to plastic surgery for rhinophyma or severe telangiectasia |
| Methotrexate |  |  | Only in secondary care |
| Cryotherapy |  | For any condition |  |
| Mild/ moderate/ non-worrying dermatoses and skin lesions in children |  | Diagnosis, investigation or management | If diagnostic doubt |
| Other chronic rashes in adult |  | Diagnosis, investigation or management | If diagnostic doubt |
| Dermatitis (including seborrhoeic) | Mild to moderate | Unresponsive to treatment (4-6 weeks) |  |
| Lichen simplex |  | Mild to moderate |  |
| Folliculitis |  | Mild to moderate |  |
| Vitiligo |  | Mild to moderate |  |
| Pityriasis versicolor |  | Mild to moderate |  |
| pityriasis rosea chloasma |  | Mild to moderate |  |
| molluscum contagiousum | Mild | Mild to moderate | Immunosuppressed patients  Consider referral to GUM for infection screening if widespread or anogenital |
| Granuloma annulare |  | Mild to moderate |  |
| Common cutaneous infections |  |  |  |
| Pruritus | Mild to moderate | Unresponsive to management |  |
| Scabies | Mild to moderate (unless crusted) | Crusted scabies  All when unresponsive to treatment |  |
| Specialised skin surgery |  |  | All |
| Life threatening skin disease |  |  | All |
| Photo investigation and specialised photodermatology |  |  | All |
| Skin cancer |  |  | 2ww pathway where there is a suspected cancer |
| HIV and infectious disease of the skin |  |  | All |
| Leprosy |  |  | All |
| Occupational dermatoses and contact |  | Initial investigation and treatment |  |

1. Royal College of GPs, morbidity statistics. From General Practice: Fourth National study 1991-92,London, HMSO,(1995) [↑](#footnote-ref-1)
2. Guidance for Commissioning Dermatology Services. www.bad.org.uk [↑](#footnote-ref-2)
3. British Medical Journal, Evaluation of General Practitioner with Special interest in Dermatology: randomised controlled trial BMJ, 2005, 331:1441-1446, 17thDecember. [↑](#footnote-ref-3)
4. Our Health, Our Care, Our Say; A New Direction for Community Services, DH (2006) [↑](#footnote-ref-4)
5. Improving Outcomes for People with Skin Tumours including Melanoma, The Manual, NICE (2006) [↑](#footnote-ref-5)
6. Model of Integrated Service Delivery in Dermatology, Skin Care Campaign (2007) [↑](#footnote-ref-6)