Minimum Requirements Service Specification

Service	Skin Conditions
Period	Design phase and pilot phase plus three years with a further two years' option

1. Population Needs

Skin disease is common and distressing. It is estimated that of the nearly 13 million people presenting to General Practitioners with a skin problem each year in England and Wales, around 6.1% (0.8 million) are referred for specialist advice. While there are well over 1000 dermatological diseases, 10 of them (eczema, psoriasis, acne, urticaria, rosacea, infections/infestations, leg ulcers and stasis eczema, lichen planus and drug rashes) account for 80% of consultations for skin disease in General Practice.

Specially collected data from four specialist Dermatology departments in England show that specialists most commonly see people with skin lesions (35-45%), eczema, psoriasis and acne. There were nearly 4,000 deaths due to skin disease in 2005, of which 1,817 were due to malignant melanoma.

Although it is the case that the commonest disorders are not life threatening, if not treated appropriately patients can suffer harm and longer term health problems. Many of the rarer and some of the severe common skin conditions have an associated morbidity and mortality thus early and accurate diagnosis is critical to suitable management. For those disorders that are not life threatening, the psychological impact on everyday life, work, social interaction and healthy living are substantial.

NHS West Lancashire CCG has a population of 113,000 patients with 19 GP practices providing primary care and Southport and Ormskirk Hospital NHS Trust being the main provider of secondary health care.

These patients are having to visit hospital for treatment as there is currently no community based for West Lancashire CCG patients.

Local clinicians are reporting poor patient experience with secondary care services because of a lack of a resilient workforce and very traditional ways of working

For West Lancashire CCG the total spend on dermatology secondary care services in 2017/18 was £950,579 and prescribing costs for dermatology conditions in 2017/18 was £479,708

The CCG ultimately wishes to commission a community based dermatology service service to help contribute to the triple aim of improved population health, high quality holistic care for patients and reduced cost. It is expected that the service will triage **all?** referrals for dermatology be at the leading edge of technology and maximise the use of dermatology and minor surgery skills within primary care

2. Outcomes

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2.1 Locally defined attributes and outcomes

NHS West Lancashire CCG has an overarching clinical strategy entitled "***Building for the Future"*** which sets out our vision for joined up care over the next 5 years. This procurement is set in the context of this Vision. As such any service should be developed giving due consideration to the four pillars of this Strategy as set out below:

- Collective accountability.
- Care co-ordination.
- Population management.
- Progressive IT infrastructure.

Also considering working closely with health and social care linking with other services in the health economy as necessary to ensure cohesion and integration for the benefit of patients.

The Vision also describes how it will be essential to demonstrate how services will be provided sensitive to local health and service need, addressing health inequalities, wrapped around the patient and focussed on our neighbourhoods; whilst also contributing to time savings in Primary Care and a reduction in attendance at A&E for chronic pain.

The "***Building for the Future"*** strategy document is available at: http://www.westlancashireccg.nhs.uk/wp-content/uploads/Building-for-the-Future-Sept-2015.pdf.

The Supplier should share the Commissioner's vision for change and be willing to work with the Commissioner to drive the transformational change, understanding the need for whole system transformation including:

- Changing cultural beliefs and behaviours across organisational boundaries and throughout the healthcare system.
- Providing modern and innovative IT enabled healthcare services which supports patients at all levels of complexity to remain at the highest level of independence that they can achieve.
- Integrating a range of health, social care and third sector services.
- Influencing supply chain organisations to deliver better outcomes for patients.

Work with the Commissioner and service users and carers with personal experience of the main types of skin conditions specifically to co-design the final version of the outcome based specification to realise improved outcomes for patients in relation to their health and wellbeing and service user experience whilst driving efficiencies and delivering innovation across the system.

Work with the Commissioner and the population of West Lancashire to communicate the right place to access the right care at the right time – demonstrating cohesion across the different parts of the service model and service providers.

Deliver financial requirements within the financial envelope and work with us to develop the financial model.

Actively engage with a wide range of people, their carers, the local community and other stakeholders on an on-going basis across the life of the contract to ensure that changing technology, patient needs, outcomes and preferences are met. This

will include demonstrating an understanding of and appropriately acting upon the needs of patients with skin conditions across West Lancashire.

The Supplier service will be expected to deliver the following:

West Lancashire CCG wishes to work with innovative partner(S) to design a state of the art, safe and effective dermatology service. The work to be commissioned wished to test the application of precision medicine for melanoma , detection and treatment of rashes, utilising the novel technologies of genome sequencing combined with well-known phenotypic characteristics, 3D teledermatology and mobile teledermoscopy assisted by artificial intelligence will allow us to develop protocol-driven support systems."

The work should be based upon the work of Professor Soyer and QUT's Professor Monika Janda published in the Medical Journal of Australia that applying high technology solutions to the difficult task of selecting and monitoring moles was improving survival.

"Adopting military surveillance and warfare technology, there are computer algorithms that search for changes in moles' appearance over time. Deep convolutional neural networks analysis can group them into benign or malignant lesions with high accuracy,"

Following appropriate training, accreditation and monitoring, Smartphones using high resolution and 3D dermatascopes attachments in Primary care practitioners or central clinic photography dependent upon practice preference

Resilient workforce with worldwide expertise from Consultant dermatologists using technology for remote diagnostics and same day reporting and who are available to support primary care clinicians as required.

Maximise the safe and effective use of minor surgery skills within primary care considering the use of technologies such as virtual or augmented reality to impart the necessary training, knowledge and skills

Provide regular support and education to primary care clinicians in the management of patients with dermatological conditions.

Easy tracked pathway to secondary/tertiary care where clinically necessary

Contribute to cancer registry/Network etc

Organise a safe, regulation compliant, training accreditation and monitoring programme for safe initiation and prescribing and monitoring of Isotretinoin to all appropriate patients within the age range specified in these minimum requirements in a primary care setting without the need for a secondary care referral

Research trial with University active in AI in healthcare to contribute to the development of Artificial Intelligence in Dermatology for the diagnosis of mole and rashes with the intention to use this as a diagnostic tool in clinical practice when/if this technology be licensed for diagnostic purposes in the U.K.

- Improved health and health outcomes for the population of West Lancashire that suffer with skin conditions
    - Maximise the potential of primary care in the role of providing dermatology care and shared care and minor surgery skills for removing moles that exist within the primary care community (following the relevant guidance, national and international best practice.) Provide and promote effective e-learning training packages and resources for the most commonly seen skin problems as well as helping to distinguish between potentially malignant and non-malignant disease
    - developing 'GP champions' – where a GP from each practice is identified as the main point of contact for the practice providing education, feedback and key messages from the wider dermatology service. The supplier must build these requirements into its tender cost.
- Reduced net cost after the cost of the new service (delivering savings to the Commissioner) of a minimum of **£300K per financial year** of the new contracted service across hospital and prescribing compared to the 2017/18 cost of skin condition management services for West Lancashire residents. For avoidance of doubt this net saving must be after the increased cost of additional activity in primary or community services.
- A single point of access for all skin condition referrals for triage (including 2 week rule referrals) and to ensure that only appropriate referrals are forwarded to secondary care and most patients are managed and cared for within the community setting.
- Provide individuals with up-to -date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing.
- Maximise and enable empowerment and self-care through education, self-management plans and current and emerging technology where appropriate.
- Patients should be offered online access to their health records.
- Appropriate pathways should be designed for the main groups of patients, i.e. with newly diagnosed moles or rashes
- Innovative use of current and emerging technology to drive the service in the way patients are managed, and to support patients to self-manage and take control of their care and health.
- Patients must be informed about the benefits and risks of conservative treatment measures, medication and surgery.

- Reduction in hospital referrals for patients with skin conditions
- Reduction in outpatient appointments for people with skin conditions.
- Where patients are required to attend face to face appointments the service must:
    - Be provided in locations easily accessible by public transport and by car within the boundaries of West Lancashire.
    - Include co location with appropriate diagnostic services in line and provide services on a one stop shop basis whenever possible and safe to do so
    - Be available in community locations commensurate with population need and patient choice.
    - Informed by equality impact assessment (EIA).
- Patients with skin conditions should be less dependent on health services and encouraged to self-manage their condition where possible.
- Seamless access to appropriate service/s including physical, emotional, social, economic, spiritual and technological interventions.
- Use of a coaching approach, for example 'Better conversation' tools for action.
- Solution focused shared decision making (SFSDM).
- Evidence based interventions following national guidelines such as NICE
- Asset based approach with appropriate governance focusing on outcomes and cost effectiveness.
- The commissioner should be assured that WLCCG patients are achieving the best possible clinical outcomes by receiving the right treatment at the right time.
- Open and transparent performance monitoring shared with commissioners.
- A culture of continuing quality improvement informed by a comprehensive audit programme.

3. Scope

3.1 Aims and objectives of service

3.1.1 Clinical Outcomes

Prescribing

The Provider is responsible for drug costs for acute conditions for the initial prescription.

The Provider is responsible for all drug costs for patients at the first outpatient appointment, and shall continue to dispense the necessary medicines for the first

14 days or a full course or pack of medication for short treatment courses until the patient is referred back to the GP for ongoing management and treatment. For clarity, the Provider shall retain responsibility for any patient who fails to tolerate the initial drug or has treatment failure and requires a change in therapy; whereby the Provider shall bear the costs of any further treatment and drug costs.

The provider will adhere to Pan Mersey formulary and will be responsible for any prescriptions including prescribing any 'Red Drugs'. It may be appropriate for the service user to obtain some medications from their local pharmacy on advice from the Supplier. The Supplier would benefit from a good understanding of local Pharmacies in order to signpost suitable patients for a new medicine service (NMS) / medicines use review (MUR) as appropriate.

Where possible patients who can manage with over the counter medication or from interventions should be encouraged to do so.

The supplier should promote a switch to the most cost effective medication in line with local guidance which will include the titration of medication if applicable.

The pharmacist(s) (or other suitably qualified clinicians) in the service will take a governance role and overview for reviewing the cost effective prescribing of medicines for skin conditions in line with local guidance.

Diagnostics

- It is expected that many diagnostics such as images of moles and rashes etc and laboratory tests will have been initiated and the results collated in primary care prior to referral, the results being available to the service for patients referred to the Supplier. The Supplier should ensure they can access the results of diagnostic investigations that have been requested by primary care to avoid any duplication.
- The service should offer a full range of diagnostic services in line with NICE guidance for skin conditions where required while avoiding any duplication where investigations have already been carried out in Primary Care.

This will include as a minimum:

• Punch biopsy
• Excision biopsy
• Incision biopsy
• Skin scraping
• Blood tests
• Swabs
• Dermatoscopy
• Urinalysis
• Microbiology
• Virology

- Diagnostics should provide 24-hour turnaround of electronic reporting with results embedded into images.
- The Supplier should utilise electronic requesting and reporting for all diagnostic tests.
- The Supplier should have access to Picture Archiving and Communication Systems (PACS) to access any diagnostic imaging already completed.

3.1.2 Patient Experience, service outcomes and performance

The service should deliver the best possible patient experience by providing:

- A convenient local service commensurate with population need, patient choice and informed by equality impact assessment.
- Patients managed in the community as far as possible.
- Single point of access.
- A seamless holistic service meeting patient's needs.
- Timely follow ups meeting patient's needs.
- Patients to be able to self-refer up to one year after discharge.
- Patient education and solution focused shared decision making so that everyone feels fully informed about their condition and treatment options.
- Patients always know they have the option to cease treatment should they wish.
- A positive patient experience in a welcoming and friendly environment.
- High levels of patient satisfaction with >80% people recommending the service to family and friends.
- Levels of service ensuring low drop-out and DNA rates and increased patient compliance.

Referral rates for benign conditions/head of population/ GP Ratio of malignant conditions referred/ all conditions referred

/ GP Every false-negative diagnosis should be openly reported and shared so that every stakeholder learns and addresses the everyday process errors that underlie a service failure
Average and range of the time between flare-ups for individual patients within a population
Time for new referral to being seen and a clinical diagnosis made (sub measure for suspected cancers)
Productivity of the community dermatology service Income and activity of the service Number of new patients waiting for new appointments
Number of patients in the follow-up pool
Number of patients with a pending follow-up appointment

Number of patients with dermatology conditions discharged/per annum/£ spend
Average and range of the intervals for referral and presentation

3.1.3 Value for Money

Excellent value for money through:

- Reduction in GP referrals to secondary care
- Reduction in Hospital outpatient attendances for skin conditions
- Cost reductions in medication for skin conditions.

The overall principle will be to work in collaboration with successful Supplier(s) to ensure they design and then pilot the revised way of achieving the outcomes described, prior to entering into a 3 year contract (with an option for 2 further years).

The project will be split into the following 3 phases.

- Design phase (phase1) lasting 3 months from procurement. The design phase will follow Pre Qualification Questions (PQQ) that will include questions on Supplier's technical and professional ability. There will be up to 2 providers in the design phase. Following the design phase one design will be selected to be used for the pilot phase.
- The chosen design and the preferred bidder will progress to the pilot phase (phase 2) which will last for 2 years from the end of the design phase and will consist of one provider.
- Delivery phase (phase 3) is to last up to 5 years following on from the pilot phase.

During phases 1 and 2 the CCG will aim to protect the preferred Supplier(s) from financial risk. From phase 3, it is expected that further risk may be transferred to the preferred Supplier at the Commissioner's reasonable discretion in agreement with the Supplier.

Estimated contract value/ budget available

Costings expressed at 2016/17 price base but with an adjustment to reflect the reduction in 2017/18 NHS national tariff price for skin conditions. Given that the service is new, these costings have been based on various assumptions which will crystallise somewhat during phase 1 and further during phase 2, the negotiation phases. They are currently therefore our best estimates based on information available and should be used to support the design of the service

Anticipated Savings

There is an expectation that there will be total minimum recurrent savings per annum of **£300K per year** with effect from the pilot delivery stage of phase 2 (i.e. allowing a lower level of savings during the phase 2 mobilisation period). Savings of below this annual level may be deemed indicative of a failure in the design of

the system.

In terms of savings, as a minimum the Commissioner requires the aggregate cost of the new service to be less than the cost of treating those patients under the traditional model. Even that does not take account of the management resource which has been expended in procuring the new service, for which some return should be expected. The minimum level of savings identified of **£300K per year** would be expected to achieve this requirement.

However depending upon the situation pertaining during the design and pilot phases, there may be an inherited non recurrent backlog of patients to be initially assessed and treated which may impact on delivery of the first year savings target.

Provision of Care

The Commissioner expects bidders to clarify what elements (and respective cost / activity levels) of provision will be delivered by the bidder and what elements of provision the bidder expects will be delivered by 3rd party organisations such as primary care providers.

During phase 2, 3rd party provision of care will be funded directly by the Commissioner to help mitigate risk to bidders. It is expected that the successful bidder would reimburse 3rd party organisations for any care provided (including diagnostics) and recover these costs from the Commissioner as a pass-through payment.

For phase 3, the Commissioner will explore devolving 3rd party care budgets (including any diagnostics) to the successful bidder. It is anticipated there will be more certainty pertaining to 3rd party activity levels at this point and therefore less risk to the 3rd party care budget holder.

Flexing of budgets to reflect activity

If, as is expected, a higher rate of savings in skin conditions is achieved, this would mean greater savings accruing to the Commissioner. The Commissioner would not wish to constrain the successful Supplier from making savings, consistent with clinical appropriateness, and so will increase the above budgets should actual levels of savings be higher than the minimum assumed.

Payments

Phase 1

For the preferred bidders:

- 50% of the Phase 1 tendered value will be guaranteed and paid upon

submission of the interim written report in line with the design stage outputs described below.

- The remaining 50% of the Phase 1 tendered value will only be due if the final design phase outputs are assessed by the Commissioner as meeting all Phase 1 minimum requirements.

Note that at interim stage, the Commissioner will provide feedback to preferred bidders to support them in achieving all minimum requirements. However, preferred bidders should note that if they still fail to meet all minimum requirements the second 50% of tendered value will not be due to them.

Phase 2

From phase 2 onwards payments will be made on the first working day of each month in accordance with an agreed payment schedule. During phase 2 the monthly payments to the successful bidder will cover the successful bidder's cost of running the service and directly providing care.

It is expected that the successful bidder would reimburse 3rd party organisations for any care provided at the request of the Service (including diagnostics) and recover these costs from the Commissioner as a pass-through payment. The successful bidder will be able to recover these costs from the Commissioner each month through submitting an invoice to the Commissioner.

Phase 3

For phase 3, the CCG will explore devolving 3rd party care budgets (including any diagnostics) to the successful bidder. It is anticipated there will be more certainty pertaining to 3rd party activity levels at this point and therefore less risk to the 3rd party care budget holder.

Payments will either continue as in Phase 2 or be adapted to reflect any devolved budgets.

3.1.4 Technology (patient facing)

- Innovative use of appropriate technology for self-help and management.
- Innovative use of appropriate technology for recording and monitoring.

Investigate the use of current and emerging technology to support patients, which may include but not be limited to

Testing the application of precision medicine for melanoma within community and primary care settings under the care of a suitably qualified and experienced consultant dermatologists , detection and treatment of rashes, utilising the novel technologies of genome sequencing combined with well-known phenotypic characteristics, 3D teledermatology and mobile teledermoscopy assisted by artificial intelligence will allow us to develop protocol-driven support systems."

Research trial with University active in AI in healthcare to contribute to the development of Artificial Intelligence in Dermatology for the diagnosis of mole and rashes with the intention to use this as a diagnostic tool in clinical practice when/if this technology be licensed for diagnostic purposes in the U.K.

Independent and impartial reviews of health and care related apps should be done by organisations such as Orcha that work in collaboration with the NHS (see https://www.orcha.co.uk/ for further information.

The use of current and emerging technology should be maximised to support patients for example, to enable self-help, and to provide information to patients. The implementation of any new technology where evidence of its use is not currently substantiated in skin condition management should be investigated in partnership with a suitable academic institution.

The Commissioner expects a service that not only achieves the above outcomes but also routinely and reliably demonstrates that they are being achieved.

3.1.5 Education

Clinicians

Provide and promote effective eLearning packages
Training and accreditation of GPsWSI
Further training, accreditation of GPs in minor surgery to allow them to undertake mole removal to the required standard.
Development of GP champions
Training of GPs in the safe initiation and prescribing and monitoring of Isotretinoin to all appropriate patients within the age range specified in these minimum requirements in a primary care setting without the need for a secondary care referral

Asset Based Approach

- Maximise the potential of Ass
-
- Feedback on referrals.
- Ongoing knowl

Stress hormones are incredibly important in dermatology, especially when looking at the role of stress in triggering or exacerbating common skin conditions such as eczema, psoriasis and acne.

Stress hormones such as Corticotropin-releasing factor (CRF) or CRH are a crucial part of the central stress response system. When people become emotional or stressed, CRF can be released from sensory nerves and immune cells, which in turn can lead to skin and systemic diseases. The Supplier should therefore design an asset based approach to health for patients whose condition is being aggravated by stress and/or anxiety that fits with the local social prescribing approach with full integration and possible subcontracting with appropriate services.

Patients should be supported to access appropriate services during their care with the Supplier as well as after being discharged for those patients who would benefit from lifestyle advice, for example

- Diet advice
- Advice on managing specific conditions and information on local groups.
- Relaxation technique
- Signposting to community activities - art, music, drama, volunteering.
- Counselling, anger management.
- Information on alternative therapies.
- Discussion groups/expert patient sessions.
- Peer support.
- Breathing.
- Mindfulness.

3.2 Service description/care pathway

Care pathways should consider:

- Existing follow up patients already under the care of a dermatology service
- New patients requiring dermatological advice or treatment
- A maintenance pathway for discharged patients

The service must be developed to simultaneously pursue the three dimensions of the Institute of Healthcare improvement's "Triple Aim" approach, i.e.:

- Improving the patient experience of care (including quality and satisfaction).
- Improving the health of the population.
- Reducing the per capita cost of health care.

3.3 Population covered

The service will be provided for residents aged **9 years** and above that are registered with a GP practice within the geographical footprint of West Lancashire CCG.

3.4 Any acceptance and exclusion criteria and thresholds

All of the following criteria must be met:

- Referral from Primary Care Clinicians including GPs and practice nurses

The service will provide the following:

- full diagnostic service with near patient testing, biopsy and swab taking and reporting results
- patient advice and education
- initial treatment if required
- The Provider will initiate the first prescription and will pick up costs associated with the prescribing and be responsible for registering all prescribers with the NHS BSA and ordering their own prescription pads
- follow up at a subsequent clinic appointment if necessary
- Discharge summary to be provided to patients GP within 1 working day.
- The discharge 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.

Conditions to be treated:

- Chronic inflammatory dermatoses including local access to phototherapy
- Undiagnosed rashes in otherwise well patients • Infections and infestations • Lesions (all lesions should be accurately measured by the referrer and documented).
- Referrer must also include past history to any services for the same condition.
- Precancerous skin lesions (actinic keratoses).
- Bowen's disease
- Facial rashes
- Cystic Acne
- Psoriasis
- Undiagnosed skin lesions
- Urticaria
- Pruritis
- Nail, hair and scalp disorders, non-scarring alopecias
- Low risk BCCs as specified in NICE guidance
- Moderate conditions were diagnosis in doubt
- Pigmentary Disorders
- Pigmented lesions where 2 week fast track referral not indicated (Organ transplant patients with solar keratoses should be referred to secondary care)
- Contact allergy patch testing
- Patients requiring simple Laser treatment in suitable facilities
- Photo-investigation and specialised photo-dermatology
- Occupational dermatoses and contact dermatoses

- Genetic dermatology

Choice

The community locations must all be DDA (Disability Discrimination Act) compliant.

The provider will ensure the service user has access to a list of secondary care clinically appropriate provider choices.

The referrer should initiate the choice offer and discuss the relevant clinical aspects of choice with the service user. The provider should work with the CCGs to support service users in discussing other aspects of choice.

The provider will ensure the service user has access to meaningful information to support their choice decision in circumstances where onward referral to a hospital is required.

Exclusion Criteria

Exclusion Criteria
The service will not, surgical procedures that are considered to require plastic surgery or removal of large excisions.
It is anticipated that by using the fully integrated service model, only appropriate onward referrals will be made to secondary care.
The Commissioner will agree an appropriate threshold (or percentage) for onward referrals to Hospital, based on benchmarking and best practice. Any referrals which are made to the Hospital service above the agreed threshold will not be funded.
The Commissioner will also agree an appropriate threshold (or percentage) for re-referrals to the Community service within 3 months following discharge. Any re-referrals which are made to the community service within the specified time period will not be funded.
The above requirements will be detailed in the full suite of key performance indicators to be agreed following contract award.
• Lesions with significant risk of SCC or melanoma or other high risk malignancy
• Likely BCC if above clavicle
• Any lesions in patients who are immunocompromised
• Any lesions in patients with a previous history of SCC or malignant melanoma
• Any facial lesion above 1.5 cm (or any criteria determined by audit or previous triage) similarly, any lesion on the lower leg above e.g. 1.5 cm
• Patients who seem significantly likely to require secondary care admission/day care
• Severe inflammatory skin disease requiring non-conventional therapy
• Specialised skin surgery
• Life threatening skin disease
• Specialised skin cancer
• Genital dermatology
• Non-malignant lymphoedema
• HIV and infectious disease of the skin

• Leprosy
• Specialised dermapathology
• Benign lesions referred for cosmetic or 'patient preference' reasons only
• Warts and Verrucae (unless an exceptional case can be made)
• Molluscum contagiosum (unless an exceptional case can be made

3.5 Interdependence with other services/providers

The Supplier should aim to offer an integrated model of service delivery and should utilise the skills of other external providers. Any contractual relationships established will be the responsibility of the Supplier. Below is a table highlighting some of the key relationships and how these could be utilised.

The Supplier should ensure it has an effective understanding of all the providers working within the chronic pain pathways and be able to establish operational links with each service to ensure smooth transfers of patients between services.

Supplier/Key Relationship	**How Utilised**
Primary Care	Working with Primary Care to ensure knowledge and understanding of the referral process from all clinical staff working in practices, good quality of referrals, a good understanding of the service and how Primary Care can actively manage patients once discharged from the service. Provide appropriate levels of access to training and education including e-modules to referring clinicians. Provide regular updates to the CCG's GP membership (every 3 months). Work with Primary Care to establish support programmes within GP practice where it is safe to do so.
Pharmacy	Pharmaceutical support should be available to the dermatology team. Clinical pharmacy services should be available in clinics to augment the specialist nursing service and to oversee and provide medicines advice for patients who require complex drug regimes' for co-existing conditions. Pharmacy services should: Formulary adherence of Pan Mersey formulary Emollient sample kits Patient education, advice and support and point of dispensing and or prescribing Liaison with community pharmacists and GP practice pharmacists Providers would be responsible for: Providing all drugs on discharge and at out-patient appointment, which are required as a result of presenting complaint or intervention, up to a minimum of 14 days or a complete course or pack

	Repeat supply of all drugs which are classified as RED by West Lancashire CCG/Pan Mersey, which are required as a result of presenting complaint or intervention Initiating, adhering to and providing GPs with appropriate shared care guidelines for all drugs designated as AMBER by West Lancashire CCG/Pan Mersey which are required as a result of the presenting complaint

Referral to other services:
It is recognised that due to the complexity of patients within an acute specialist level 4 service, that referral to other services may be required, this may include:

- Plastic surgery
- Clinical oncology
- Rheumatology
- Immunology
- Paediatrics
- Mental Health

Whole System Relationships (in addition to those in the table above)

- District Nurses / treatment rooms
- Health visitors
- Tissue Viability/ Leg Ulcer service
- Acute trust Dermatology
- Public health
- Paediatric departments
- Acute Paediatric trust/ services
- Medicines Management teams
- Voluntary/ third Sector

Interdependencies
- Acute trusts

The above list is neither prescriptive nor exhaustive.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The following national standards have been used in the design of this document and must be complied with by the Supplier:

(Add here)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

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

• NICE guidelines including Improving Outcomes Guidance (skin tumours including melanoma Feb 2010)
• British Association of Dermatologists, Clinical Guidelines
• Guidance and competencies for the provision of services using GPs with Special Interests(GPwSI)(DHApr2007)
• Implementing care closer to home: Convenient quality care for patients, Part 3: the accreditation of GPs and Pharmacists with Special Interest (DH Apr 2007).

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

The Provider will nominate a dedicated operational lead within their organisation to manage the contract and have financial and operational responsibility.
Medical Staff: The service will be overseen by accessible Consultant Dermatologists and supported by medical staff with appropriate experience and qualifications i.e. GPwSI in dermatology.

The Provider will be expected to undertake a full Equality Impact Assessment within 12 months of the service becoming operational.

The Provider will undertake all clinic bookings, dealing with patient queries, reception, preparing reports and discharge letters.

The Provider will demonstrate the appropriate system and policy for recording, mitigating, monitoring and reporting of risk issues.

4.3 Applicable local standards

- The service should be CQC registered with no conditions.
- The service will share information with commissioners to support quality improvements (subject to IG rules).
- The service will actively collect analyse and act on feedback from patients and carers.
- The service will participate in clinical audit cycles and external peer review.
- The service will signpost patients to local services which could help them.
- Information and services will be available for individuals who are able to self-manage their conditions or who need care plan support.
- The Supplier should actively work with other providers to increase the efficacy of the new service (e.g. third sector, schools, libraries, religious organisations, social services).
- The Supplier should demonstrate that they have identified any potentially hard to reach groups (as defined by the Joint Strategic Needs Assessment (JSNA)) that exist within their target population, and have taken appropriate action to improve access to the service for these groups.

- The Supplier should offer robust evidence based procedural interventions

4.4 Qualifications and Mandatory Training

The Service must adhere to the Terms and Conditions and the General Conditions of the NHS Standard Contract.

All staff must be appointed in line with professional qualifications / standards as appropriate and continue to update skills in line with professional codes of conduct. The Supplier must maintain a record of the dates and training given to all clinicians and staff working within the service. All such records should be immediately available to the Commissioner for audit purposes on request. The Supplier must ensure that training requirements and competencies are monitored through regular assessment and staff appraisal and that staff are enabled to progress through supported learning.

No healthcare professional shall perform any clinical service unless he / she have such clinical experience and training as are necessary to enable him / her properly to perform such services. The Supplier shall be responsible for ensuring that their staff:

- Have relevant professional registration and enhanced checks undertaken prior to seeing patients alone.
- Have, prior to starting in post, provided two references (clinical if applicable), relating to two recent posts (which may include any current post) as a health care professional which lasted for three months without a significant break, or where this is not possible a full explanation and alternative referees.
- All access robust induction training applicable to their individual role.
- Have access to and evidence of safeguarding training and development in line with their professional bodies recommendations.
- Undertake annual audit to ensure compliance with the above.

4.5 Workforce requirements

The Supplier must have in place a comprehensive, coherent, robust plan for recruitment, management and development of staff with the principle objectives to:

- Meet the essential day to day staff leadership, management and supervisory needs to the contract during its lifetime, including during mobilisation and, if appropriate, contract termination.
- Adhere to TUPE legislation (as applicable).
- Support the provision of safe, high quality clinical services.
- Ensure through appropriate audit, training and continuous professional development that all staff involved in treating NHS patients are and remain qualified and competent to do so.
- Support the implementation of all relevant statutory and non-statutory NHS standards, regulations, guidelines and codes of practice.
- Maintain an effective working partnership with local NHS employers to continuously develop and maintain best people management practices and ways of working.

- Reduce dependency on agency or locum staff to deliver services, such use not to exceed 10% unless in extreme circumstances.

The Supplier must have in place a recruitment and retention strategy. This must:

- Can attract and retaining high quality job applicants.
- Optimise individual skill levels and potential.
- Fully harness available skills and commitment.
- Encourage and engender support for new ways of working.

There are continual challenges to the UK's viability to opt out of the Working Time Directive on a European basis and therefore to sustain the future viability of this service the Supplier must have in place a working hour's policy which ensures the health and wellbeing of staff and users of the service. This policy must also cover the working hours of clinical staff outside of the service, and in particular, the Supplier must ensure they have a mechanism in place which supports them in reviewing and monitoring the hours worked by clinical staff and assuring themselves that the service they provide is safe. The Supplier must have in place a staffing strategy to meet specified levels of service that identifies the requirements for support ancillary staff services. The strategy should include contingency plans for times of high demand and/or high levels of staff absence. The Supplier must have in place mechanisms for keeping the commissioner informed when staffing capacity is unlikely to meet demand and the actions that will be taken to address this. It is expected that the Supplier will have in place mechanisms to actively review and monitor the working hours of all staff members. The Commissioners reserve the right to carry out unannounced audits to assess compliance.

4.6 Workforce standards

The Supplier must ensure that all proposed workforce strategies, policies, processes and practices comply with all relevant employment legislation applicable in the UK.

In addition, the Supplier is required to comply with the provisions of the following policies and guidance as amended from time to time:

- NHS Employment Check Standards, March 2008 (revised July 2010).
- Registration with Care Quality Commission (http://www.cqc.org.uk/).
- Criminal Records Bureau Code of Practice and Explanatory Guide for Registered Persons and other recipients of Disclosure Information published by the Home Office under the Police Act 1997 (revised April 2009) ("Code of Practice on Disclosure").
- The Department of Health (DH) guidance on the employment or engagement of bank staff, if any.
- Any guidance and/or checks required by the Independent Safeguarding Authority or any other checks which are to be undertaken in accordance with current and future national guidelines and policies.
- All guidance issued by the Care Quality Commission including the guidance entitled "Compliance: Essential Standards of Quality and Safety (March 2010)"

and any other guidance issued by the Care Quality Commission from time to time.

- The Code of Practice for the International Recruitment of Healthcare Professionals (December 2004) www.dh.gov.uk/assetRoot/04/09/77/34/04097734.pdf.
- The Cabinet Office Statement entitled "Principles of Good Employment Practice (December 2010)".
- All relevant employment legislation and codes of practice applicable in the UK.

The Supplier has the following responsibilities in line with the delivery of this service:

- To ensure that all members of the service maintain their knowledge and skills by keeping up to date, attending meetings and participation in in-house academic sessions. This requirement would be assessed during an annual appraisal.
- To provide clinical education to practices within the locality to support further development of their knowledge and skills in the on-going management of patients.
- To ensure that all professional staff are supported to undertake clinical supervision in line with the relevant statutory body requirements.

4.7 Equipment

It is the responsibility of the provider to purchase, maintain to a high standard and replace all relevant equipment required to provide the service. The Commissioner will expect a detailed plan for both the commissioning and maintenance of all equipment and clear accountability for making sure its implementation.

4.8 Information Management & Technology (IM&T)

The Commissioner requires the Supplier to use EMIS Community Web or an equivalent system to deliver the service as utilised across primary/community care in the local health economy. If, however the service provider does not use EMIS Community Web, it is the responsibility of the provider to ensure that their clinical system is fully interoperable with EMIS Community Web and shared patient records should be available between the Supplier and General Practice. Any costs for achieving interoperability should be borne by Supplier.

The Supplier will be responsible for the provision, maintenance and cost of all Information Management & Technology (IM&T) hardware and software, licenses and IT support services required to meet the needs of the service. These will need to meet local and national standards and support the Commissioner's direction of travel regarding interoperability. The Supplier must ensure that appropriate "IM&T Systems" are in place to support the service prior to the go-live date. "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 organisation's business processes, which must include:

- Clinical services including ordering and receipt of pathology, radiology and other diagnostic procedure results and reports.
- Prescribing.
- A single electronic patient health record for every patient, which should include the patient's NHS Number.
- Inter-communication or integration between clinical and administrative systems for use of patient demographics.
- Use of the NHS e-Referral Service (e-RS) (or any future replacement) and systems for referral management and booking for both Primary Care referrals to the Supplier and onward referral from the service to a specialist.

The Supplier must use appropriate technologies for Managing call traffic to the service:

- Main telephone system (PABX).
- Automated call distribution (ACD).
- Interactive voice response (IVR).
- Customer announcements.
- Call recording.
- Dealing with calls.

The Supplier must use appropriate technologies for Managing contact to the service and information within the service:

- Customer contact management.
- Scripting.
- Case-based reasoning.
- Resolving enquiries.
- Applications systems.
- Intranets.
- Workflow.
- Document image processing.
- Geographic information systems.

The Supplier will need to ensure that IM&T Systems are effective for referrals and bookings including appointment booking, scheduling, tracking, management and the onward referral of patients for further specialised care provided by the NHS, independent sector or social care and must be compliant with the NHS e-RS requirements including the use of smart cards. The appropriate security, information management and technology should be in place to support the services.

The following systems should be in place and comply with NHS requirements:

- NHS e- Referral System: use of the Directly Bookable Service (DBS) for all patient referrals into the service.

- N3: use of the national network for all external system connections to enable communication and facilitate the flow of patient information.
- Patient Demographic Service (PDS): use of the PDS to obtain and verify NHS Numbers for patients and ensure their use in all clinical communications.
- NHSMail: use of the NHSMail email service for all email communications concerning patient-identifiable information or the appropriate local solution.
- The Supplier must undertake testing of the IM&T Systems proposed, including those supplied by the Commissioner, by the Supplier, by third party suppliers and also of any interfaces and inter-working arrangements between parties or systems, so as to guarantee compliance with all appropriate standards.

The Supplier 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:

- Common law duty of confidence.
- Data Protection Act 1998.
- GDRP (add here)
- Access to Health Records Act 1990.
- Freedom of Information Act 2000.
- Computer Misuse Act 1990.
- Health and Social Care Act 2001.
- UK Medical Devices Regulations 2002 (as amended) unless the potential Supplier can demonstrate an exemption.

The Supplier must be compliant with national standards and follow appropriate NHS good practice guidelines for information governance and security, including, but not exclusively:

- NHS Confidentiality Code of Practice.
- Use of the Caldicott principles and guidelines.
- Appointment of a Caldicott Guardian.
- Policies on security and confidentiality of patient information.
- Clinical governance in line with the NHS Information Governance Toolkit.
- Risk and incident management system.
- Information Governance Statement of Compliance (IGSoC).

4.9 Referral Process

- Referrals into the service will be via patient's GP practice
- Referrals will be received into the service via the NHS e-Referral Service (e-RS).
- All referrals should be triaged daily via the NHS e-RS, referring patients on to other services as appropriate.
- Text reminders to patients about their appointment should be sent to consenting patients that have a mobile phone contact number.
- The Supplier is responsible for the booking of interpreters when this requirement is stated within the referral letter or indicated via the NHS e-RS.
- The Supplier should process Did Not Attend (DNA) events via the NHS e-RS in order that the referrer has access to this information via the e-RS Worklist facility.
- The Supplier should process discharge information back to the practice within two working days of the patient being discharged from the service. The process of forwarding discharge information back to the referring practice should be electronic.
- The Supplier will provide access to Advice and Guidance for referrers via the NHS e-RS with a turnaround of no more than two working days for all Advice and Guidance requests.
- The Supplier must setup their service as an assessment service on the NHS e-RS. There are two types of assessment service available on the e-RS:
    - Clinical Assessment Service (CAS)
    - Telephone Assessment Service (TAS)
- If the CAS setup is used patients must be able to attend the appointment to progress their referral. If the TAS setup is used patients must be able to telephone the service or be telephoned on the date and time of the appointment they are given to progress their referral.
- Referrals must be submitted by General Practices to the Supplier via the NHS e-RS. Any referrals from General Practice that are not submitted via the NHS e-RS should followed up and the referring practice supported to enable future referrals to be submitted by the e-RS. Referrals from Joint Health should be submitted via the NHS e-RS and followed up if not to ensure all future referrals are submitted via the e-RS.
- All referrals should be triaged by appropriately qualified staff to assess appropriateness and decide the onward pathway for each referral. The outcome of the triage should be recorded on the e-RS to allow the referrer to see the outcome. Also, any referrals to first outpatient consultant lead services should be referred on via the e-RS
- Patients should be given a choice of where they would prefer to be seen and an appointment or appointment request should be created with the details given to the patient.
- The referral must undergo the initial triage by the Supplier within two days from receipt of referral.
- The Supplier will provide appropriate clinical and onward referral information adhering to the NHS Choice Framework as appropriate.

4.10 **Discharge Processes**

Patients should be discharged with a clear management plan supported by appropriate use of technology, e.g. a personalised videoes. This management plan should include clear information on how to self-manage their condition, how to contact the patient's General practice and how to gain future access to the service, as appropriate. A key outcome of the service is to reduce reliance on health service resources where appropriate, and empower patients to manage their condition. However, if patients do need access to ongoing advice/treatments from the provider they can do so as part of a maintenance package of care on a self-referral basis for up to one year after discharge. This maintenance package of care should be made up of an indicative number of follow ups. The maintenance package of care should also have a clear exit strategy from the service. Keeping GPs informed about the discharge process and patient management plans is essential. The Supplier should provide clinical information on discharge from the service to the patients GP and Patients will receive an electronic or written copy of their discharge letter from the service. GPs will need to be sent discharge information and key information about their patient's management plan within two working days electronically.

Acceptable discharge criteria are as follows:

- Resolved.
- Optimum outcome following treatment or advice achieved.
- Patient able to self-manage.
- Patient able to manage condition with exercise programme or third sector activity.
- Patient failed to attend for initial appointment or full course of treatment in line with the DNA policy agreed with the commissioner.
- Patient declines to participate in recommended evidence based management.
- Patient requires referral to another discipline or back to original referrer.
- Discharge back to GP for further management with advice.

Information provided to a patient's GP at discharge should include:

- Patient identifiable details (patient NHS number / name).
- Date of attendance and discharge.
- Investigations carried out with the results and appropriate advice.
- Summary of findings (including diagnosis).
- Information provided to the patient.
- Management plan including any requirements for shared care
- Medications initiated or terminated.
- Follow-up arrangements.

4.11 Response Times and Prioritisation

- Patients requiring face to face contact should be seen by the service within two weeks of referral.

- Same day telephone advice should be available for Primary Care Clinicians including out of hours and Extended hours GPs in order to prevent A&E attendance or secondary care admission.
- Patient's referred as urgent or triaged and updated to being urgent by the service should be seen within seven days.