SCHEDULE 2 PART A - SERVICE SPECIFICATION

Mandatory headings 1 – 5. Mandatory but detail for local determination and agreement.
Optional heading 6. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement.

Service Specification No.	**02_GMS_0042**
Service	**Community Dermatology Service Intermediate Care July 2013**
Commissioner Lead	**Clinical Commissioning Programme for General Medical & Surgical**
Provider Lead	
Period	**1st January 2013 to 31st December 2017**
Date of Review	**Review in 2014**

1. Population Needs

1.1 National Context

Skin conditions are the most frequent reason for people to consult their GP with a new problem. Around 24% of the population of England and Wales visited their GP with a skin problem in 2006 with the most common reasons being skin infections and eczema.

Changes in health service provision, predicated by re-organisations and the need to commission high quality cost effective services, has in part driven the move to deliver certain services and specialities more appropriately in the community setting.

Dermatology is a specialty specifically identified by the Department of Health as being suitable for the relocation of a large proportion of work from secondary to primary care under the 'Shifting Care Closer to Home' policy. Care closer to home refers to offering patients more choice of provider and more convenient access to services.

Community based services are also recommended within the following guidance:

- Department of Health (2003) Action on Dermatology. Good Practice Guide. NHS Modernisation Agency;
- Department of Health (2005) Care Closer to Home; Creating a Patient led NHS;
- Department of Health (2006) Our Health, Our Care, Our Say: a new direction of community services
- Department of health (2007) Guidance and Competencies for the Provision of Services using GPs with Special Interests (GPwSI's): Dermatology;
- Models of Integrated Service Delivery in Dermatology, Dermatology Workforce Group (2007)
- Primary Care Contracting (2008) providing care for patients with skin conditions: guidance and resources for commissioners.

1.2 Local context and Evidence Based

Across NHS Dorset and NHS Bournemouth and Poole the provision of community based dermatology services have varied in terms of diagnostic access due to a lack of surgical capability. This has meant patients being referred to secondary care services for diagnostic biopsy and non complex lesion removal.

The aim is to commission a local Primary Care led Community Intermediate Dermatology Service which:

- Delivers high quality dermatology service within a primary care setting;
- Improves patient access to dermatology care, diagnostics and treatment within the community;
- Improves patient choice;

- Reduces waiting times for treatment;
- Reduces inappropriate referrals to secondary care;
- Reduces first and follow up out-patient attendances in secondary care;
- Improves education and training structures for GP's and Nurses in Primary Care;
- Improves the patient management of long term skin disease; and
- Promotes the development of specialisation in primary care.

Dorset, Bournemouth and Poole Primary Care Trust Cluster serve a registered population of approximately 751,000 people set within practice based Localities as set out in Table 1

Table 1: Registered Population by Locality as at June 2011

Locality	Age Band 0-16	Age Band 17+	Total
Christchurch	8,460	45,201	53,661
Compass	27,484	140,138	167,622
East Dorset	10,960	53,361	64,321
North Bournemouth	2,892	12,834	15,726
North Dorset	15,072	62,595	77,667
Parkstone	6,225	25,316	31,541
Poole Bay	4,713	33,356	38,069
Poole Central	11,011	50,016	61,027
Poole North	9,434	42,029	51,463
Purbeck	4,641	25,018	29,659
West Dorset	14,375	71,640	86,015
Weymouth and Portland	13,036	60,945	73,981
TOTAL	**128,303**	**622,449**	**750,752**

The estimated activity suitable for the primary care Community Intermediate Dermatology Service as detailed in this service specification has been identified using 2011/12 Month 8 data and forecasting for the year. The reason for using such recent data is the lack of consistent 2010/11 data across all providers.

The prevalence of skin disease that would benefit from clinical treatment affects 22.5 – 33% of the population at any given time (shifting Care Closer to Home: Dermatology). Given the Cluster population this would equate to 168,919 – 247,748 of the population.

The main providers of Dermatology services currently across Dorset are the three acute Trusts; Dorset County Hospital NHS Foundation Trust, Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. In addition Dorset Healthcare University NHS Foundation Trust delivers community services at various sites across the county and there is some activity undertaken by Salisbury and Yeovil Hospitals.

Table 2 provides the forecast activity for 2011/12 by Locality. It should be noted that the day case and Out Patient Procedure data is based on a subset of the activity that sits within the JC and JD HRG's. Additionally it is felt that the data from community services may be an underestimate of the actual activity currently taking place outside of the acute Trusts.

Table 2: Full Year Effect Forecast Activity for 2011/12 (based on Month 8 Activity)

Locality	New	FU	Out Patient Procedure	Day Case
Christchurch	1,383	2,556	356	548
Compass	2,043	4,473	482	665
East Dorset	1,175	2,240	563	383
North Bournemouth	159	440	26	57
North Dorset	1,118	2,012	902	87
Parkstone	333	749	125	119
Poole Bay	603	1,151	258	188
Poole Central	792	1,995	348	252
Poole North	615	1,262	273	189
Purbeck	366	654	212	131
West Dorset	1,056	1,209	752	153
Weymouth and Portland	1,107	1,097	726	84
Other	99	141	32	51
TOTAL	**10,848**	**19,976**	**5,051**	**2,904**

The forecasted activity is based on New and Follow up out-patients (current activity), Out Patient Procedures (sub set of JC10Z, JC14Z, JC15Z and JC18Z activity) and Day Case (Sub Set of JC14Z and JC15Z activity).

Due to a lack of robust data across the whole of the county for 2010/11 it is not possible to determine the true growth in activity year on year, so the cluster is modelling on a 5% growth in activity as identified by a number of PCT's 2011/12 will be used as a baseline to support future modelling.

Based on forecast activity for 2011/12 the activity deemed as suitable for the Community Intermediate Dermatology Service (including current Community activity) is:

New Attendance 4,951
Follow Up 8,475 (aim is to reduce follow up activity over the long term)
Out Patient Procedure 3,453

The number of cancer registrations for Dorset County (3 main acute trusts) for 2005-2009 is 11,601 with Basal Cell Carcinomas accounting for 8,039 of the total (it is not possible to define by 'high' and 'low' risk). In 2009 the cancer registrations were 2,279 with Basal Cell Carcinomas accounting for 1,525 registrations[1].

1. *South West Public Health Observatory Report (February 2012)*

2. Scope

2.1 Aims and objectives of service

The commissioner requires a responsive community based intermediate service model with the overall aim to provide routine, clinically appropriate diagnosis and treatment of acute dermatological conditions and support for primary care clinicians in the management of patient with long term conditions.

2.1.1 Aims of Service

The aim of the service is to aid early diagnosis and management of patients with a dermatological condition and avoid unnecessary referral to secondary care, while providing robust services more locally for patients.

Additional aims of the service include:

- To operate to evidence based pathways covering the defined presentations and conditions within this specification
- To ensure that referrals can be made through choose and book using agreed local templates;
- To offer the patient choice of location as close to their home as possible;
- To work with commissioners and other providers to ensure an integrated network of services;
- To collect and publish audit data on a variety of performance, service user and quality criteria and work collectively with the commissioners to implement service development as a consequence of the feedback;
- To work collaboratively with other providers to ensure that transfer of care protocols are developed and followed which ensure that service users have a seamless pathway.

2.1.2 Objectives

The objectives of the service are:

- A clinician led service providing uniformity of care across localities.
- To provide safe, high quality, cost effective and evidence based care for patients in the community with defined dermatological conditions
- Management and reduction of inappropriate referrals through education and support to primary care;
- To promote patient independence through programmes promoting ongoing health education including keeping individuals independent;
- To develop and inform local care pathways and protocols supporting an integrated approach to dermatological issues
- To provide a responsive service achieving national and local waiting time targets;
- The safe, appropriate and timely referral on to secondary care when needed;
- Specialist triage of dermatology referrals to ensure patients are seen in the right place, by the right person at the right time.

2.2 Service description/care pathway

The provider is responsible for the costs associated with delivering the service except where stated within this specification.

2.2.1 Clinical Responsibility

For the avoidance of doubt the Patient's GP will remain the most responsible person within the overall care pathway. Once a referral has been accepted medical responsibility for the Patient's care during the procedure will transfer to the Clinician employed by the provider, whether directly or through sub contractual agreement.

This specification is for a Community Dermatology Service (Level 3) led by Primary Care as shown in Figure 1

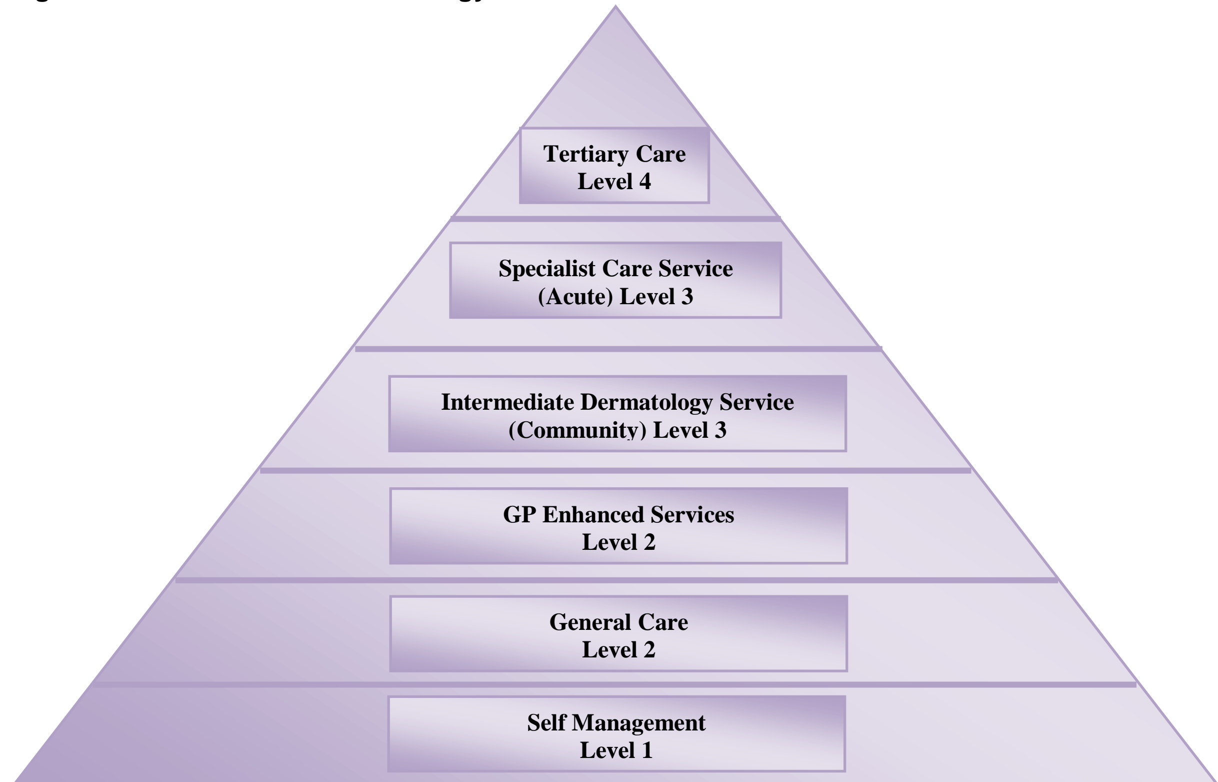
2.2.2 Service Description

The Community Dermatology Service is a Level 3 Intermediate care service which is delivered by primary care with formal Consultant Dermatologist supervision for the GPwSI's delivering the service to maintain practitioner competence and support provider integration.

GPs will refer to community services (except where they suspect cancer) where patients will be triaged by the provider(s). It will be the provider's responsibility to deal with appropriate referrals, sending the remaining referrals to secondary care for treatment as set out in section 2.2.2.

The commissioner expects the provider to accept referrals of patients of all ages, however they will ensure that children under the age of 16 years requiring surgical procedures are referred to secondary care.

Figure 1: Levels of Dermatology Services Across Dorset



Level 4 Tertiary Care provides specialist care for rarer cancers and complex surgery.

Level 3 Specialist Care Service provides specialist dermatology services including cancer within the community or a secondary care setting. This service is Consultant led.

Level 3 Community Intermediate Care Services provides GP led intermediate care for patients with dermatology conditions and skin lesions. This service is a GP led community service with strong links into secondary care and consultant Dermatologist support/supervision.

Level 2 Enhanced Services provides GPs with additional dermatological support either within their own practice or for the patients within their locality

Level 2 General Care is provided by GP's, Pharmacists and support groups

Level 1 Self Management is as stated where the patient is supported to self care

Referrals are accepted for patients registered with a GP in either Dorset PCT or Bournemouth and Poole PCT that meet the criteria set out within this specification

General Eligibility criteria include:

- Adults and children (not surgery for under 16 years)
- Assessed as appropriate for community dermatology service
- Low risk Basal Cell Carcinoma's
- Cancer is **NOT** thought to be the most likely diagnosis (patients with suspected cancers, with the exception of low risk BCC's must follow the 2 week cancer pathway).

The service will offer clinical triage, assessment, diagnostic biopsy, and treatment for the following conditions:

- rashes of diagnostic uncertainty (where no concerns of malignancy exist);
- Inflammatory disorders not responding to GP treatment, e.g. lichen planus;
- Follow up for Isotretinoin following work up from consultants (shared care arrangements should be established at the discretion of the secondary care clinicians);

- Moderate acne;
- Moderate psoriasis for treatment principally with topical therapies;
- Moderate eczema for treatment principally with topical therapies and supervision by nurses/health visitors;
- Other moderate inflammatory dermatoses that are poorly controlled despite treatment from the GP
- Non Scarring localised alopecia;
- Keloid scars
- Urticaria
- Solar Lentigo
- Benign Naevi (for diagnosis as removal non commissioned for cosmetic purposes)
- Non Scarring Nail dystrophy
- Bowens Disease (for diagnostic purposes as should be managed by GP)
- Benign lesions:
  - Symptomatic lesions such as;
    - Pyogenic granulomata
    - Dermatofibromata
- Patients referred from secondary care for follow up

The service will provide the following diagnostic services and interventions;
- Punch biopsy;
- Shave biopsy;
- Skin surgery
- Cryotherapy
- Oral and topical treatments.

The service should have access to the following;
- Histopathology
- Blood sampling
- Phototherapy treatment services

In addition the service may offer a range of specialist nurse led care including;
- Camouflage;
- Dithranol treatments;
- A range of dressings to support the treatment and management of appropriate skin conditions

Further detail of where patients should be referred can be seen in Appendix A.

2.2.3 Exclusion Criteria

Specific exclusion criteria include;
- Referrals from practices outside of NHS Dorset and NHS Bournemouth and Poole;
- High Risk Basal Cell Carcinoma referred into secondary care as routine referral not 2 week wait;
- Urgent suspected skin cancers, (melanoma, SCC) referred as 2 week waits;
- Indication for the systemic therapy in the treatment of psoriasis/eczema based on past or current diagnosis/treatment;
- Complex paediatric dermatology
- Rash with systemic upset
- Clear indication that the GP wishes the patient to be considered for isotretinoin;
- Any treatment which does not meet the policies within the PCT's Understanding Local Treatment Policies. These local policies can be found at http://www.bournemouthandpoole.nhs.uk/WS-Pan-Dorset/Downloads/NHS-BP/Policies/Clinical/Benign%20Skin%20Lesion%20Policy.pdf
- Clinically benign skin lesions requiring removal on purely cosmetic grounds. The commissioners will not pay for removal of lesions on purely cosmetic grounds;
- The administration of Botox will not be funded.

Where complex non-urgent assessment or treatment is required, the patient will be referred back to the GP for onward referral with a choice of provider.

2.2.4 Referral

Referral will be via the Choose and Book system. Providers would be expected be connected to the Choose and Book system (directly bookable service) at the earliest opportunity.

It is anticipated that the majority of referrals will be generated/referred by and then returned to the care of their General Practitioners; however provider activity will be driven by patient choice.

Only referrals made using the mandated referral form will be accepted by the provider. Incomplete referrals or those made without the mandated form will be rejected and returned to the referring GP.

Referrals will be triaged for appropriateness within [48] hours of receipt of referral by one of the clinical team (example GPwSI's) delivering the service and the outcome will be either:

- **Not Seen** – returned to GP with treatment/management advice;
- **Accepted and Seen in Clinic** – assessed and treated; or
- **Referred on** – rejected and referred on to a specialist service (for example, Podiatry or secondary care.

Some referrals may be received from secondary care for continuing care following specific agreement with local commissioners and development of shared care protocols.

Providers must provide literature for General Practitioners and referrers to assist them in the decision making processes associated with identifying the most appropriate provider and the information needed to ensure that the patient will achieve the best and quickest diagnostic/treatment outcome.

The provider will not discriminate between or against patients or carers on the grounds of gender, age, ethnicity, disability, religion, sexual orientation or any other non-medical characteristic.

The provider will provide appropriate assistance and make reasonable adjustments for patients and carers who do not speak, read or write English or who have communication difficulties, in order to:

- minimise clinical risk arising from inaccurate communication;
- support equitable access to healthcare for people for whom English is not a first language; and
- support effectiveness of service in reducing health inequalities.

Providers will provide to Commissioners detailed referral statistical information to allow refinement of the clinical pathway, data will include:

- Name and role of referrer;
- Referring organisations
- DNA's;

DNA's

- Patients who refuse three reasonable appointment offers should be discharged back to their GP.
- If a patient DNA's (does not attend their appointment without previously notifying the provider) the provider should not offer an alternative appointment without first receiving a re-referral from their GP. The provider will not be paid for appointments where the patient has failed to attend a booked appointment.
- The commissioner does NOT pay for patients who DNA their appointment.

2.2.5 Assessment and Treatment

The first Dermatology appointment should be undertaken within [10] working days of acceptance of referral and at an absolute maximum of [20] working days ([4] weeks).

Written consent must be obtained for all patients having a surgical procedure in compliance with General Medical Council standards.

The service provider should ensure that all patients are assessed on arrival by a competent and suitably trained clinician.

The assessment for procedures should be conducted with the patient and recorded and include as a minimum:

- Patient demographics
- Appropriate medical history
- The patient understanding of their condition and any procedure/treatment to be carried out
- Medical condition on arrival
- Mental capacity
- Moving and handling risk assessment

Patients must be offered the option of a chaperone for any examination. The definition of intimate or invasive may differ between individual patients for ethnic, religious or cultural reasons.

The provider should be aware of the weight limit for examination couches and trolleys and ensure that the appropriate equipment is available or make suitable alternative arrangements when necessary.

The commissioner is looking for a 'one stop' approach for the majority of attendances with diagnostics taking place on the same day.

The Provider must ensure flexible capacity to cope with seasonal and unexpected changes in demand to ensure the waiting times are met.

2.2.6 Discharge Planning

The majority of patients will be seen in the community dermatology service and discharge back to their GP with a report and or treatment plan after the first visit.

Typed treatment plans and discharge summaries will be sent to the patients GP and/or referring clinician within [2] working days.

If the patient has sutures for removal the details regarding the time scale for removal will be included in the discharge summary and the referring practice will provide this service for the patient.
If the practice has concerns about the wound, for example the wound is not healing; the patient will be reviewed promptly by the clinician who carried out the procedure.

It is not envisaged that all patients will require a follow up, however this is at the discretion of the responsible clinician. If follow up occurs a clinical record will be made of the consultation and the referring GP will be notified of the reason for the follow up and the outcome.

For the small number of patients requiring admission to secondary care the service provider should ensure that the patient is transferred to the appropriate speciality and that transfer documentation, including test results are complete so as to prevent unnecessary duplication or delays in the overall pathway of care.

2.2.7 Referral to other Services

The Provider will be expected to work and liaise with secondary care providers for referral into their services where required. However, the Provider will avoid referring to another provider any non-urgent or routine treatment without first referring the matter to the Patient's GP.

2.2.8 Transfer of Care

The Service Provider must ensure robust processes are in place for the rapid transfer to specialties within Secondary Care where the patient's condition warrants this transfer. Protocol's must be agreed between the service provider and the secondary care provider and attached to the contract.

The Service Provider must ensure the unit and all clinical staff are trained and competent to manage patients in the event of cardiac arrest, respiratory arrest, or anaphylaxis.

2.2.9 Patients with suspected Cancer

Following the procedure patients with suspected cancer or unexpected cancer on histology must be referred to the cancer Multidisciplinary team immediately.

The provider must ensure robust pathways are in place between themselves, the GP's and Secondary care to facilitate this.

The expected pathways are set out in appendix A1-3

2.2.10 Pathology

The commissioner expects all lesions removed to be sent for histological reporting.

The service provider must contract with an accredited histopathology service and ensure appropriate sample turnaround times with reports coming back to the provider for monitoring and action.

Expected turnaround of diagnostic tests are:
- Histology 15 working days
- Bloods 48 hours

A written protocol will be produced to include details of how all specimens are tracked, results reported and the next steps actioned.

Negative test results may be given to patients in writing. Positive results will be given in face to face appointments with the appropriate healthcare professional. Patients should be advised of their results at the earliest opportunity.

If unexpected serious pathology is suspected on examination of the patient, the provider will:
- Discuss the findings with the patient and the need for further investigation within the secondary care setting;
- Complete an initial report detailing the suspicions and the subsequent discussions with the patient. Send this to the referring GP either electronically or via safe haven fax on the day of attendance;
- Using an agreed referral pathway with the Local Skin Multi-Disciplinary Team, (on the day the patient is seen) contact the relevant clinician for immediate entry onto the cancer pathway, it is expected that this will be a Consultant within the Multi-disciplinary team;
- Send a copy of the initial report, including any photographic images to the Local Skin Cancer MDT coordinator at the relevant acute Trust;
- Inform the appropriate nurse specialist;
- Ensure that the clinician who examined the patient is available to discuss the case either in person or by telephone at the relevant MDT meeting;
- Providers will be expected to devise and demonstrate a clear pathway for suspected cancer referrals to local acute Trusts.

If the routine pathology report reveals unexpected serious pathology the provider will;
- Arrange for the patient to have a face to face appointment with the appropriate health care professional to discuss the findings and the need for further investigation within the secondary care setting;
- Send the pathology report and planned referral pathway to the referring GP either electronically or via safe haven fax on the day the report is received;
- Using an agreed referral pathway with the Local Skin Multi-Disciplinary Team, (on the day the patient is seen) contact the relevant clinician for immediate entry onto the cancer pathway, it is expected that this will be a Consultant within the Multi-disciplinary team;
- Send a copy of the initial report, including any photographic images to the Local Skin Cancer MDT coordinator at the relevant acute Trust;
- Inform the appropriate nurse specialist;
- Ensure that the clinician who carried out the procedure is available to discuss the case either in person or by telephone at the relevant MDT meeting;
- Providers will be expected to devise and demonstrate a clear pathway for suspected cancer

referrals to local acute Trusts.

Where the histology is not being sourced from a local secondary care provider the Commissioned service must make arrangements with their chosen pathology provider to:

- Make a histopathologist available to discuss suspicious reports at the local MDTs;
- Make available to the local MDT the removed skin material so it can be reviewed at the MDT meeting.

2.2.11 Prescribing

The Provider has full responsibility for the cost of any drugs prescribed within the service.

Prescribing of any medication will be required for 28 days (or such shorter period for a full course of medication as appropriate) post discharge and will be provided as part of the service and will be included in the price.

All prescribers must adhere to both legal and good practice guidance on prescribing and medicines management in line with the Medicines Act 1968, associated legislation and regulations.

The Commissioner will issue a code to the provider for FP10 prescriptions for drugs prescribed within the service.

All prescribers must engage in quality and cost effective prescribing in the context of overall use of NHS resources.

2.2.12 Report

A written clinical report should be sent to the referrer (and GP if this is not the same individual) within [2] working days following the procedure with the maximum being [5] working days. The information should be communicated electronically by a secure network

The provider will ensure that the report is produced and as a minimum it will provide the referrer with:

- An initial diagnosis;
- Information about any biopsies taken and details of when results can be expected;
- Details of any medication changes advised
- Details of any suggested changes to treatment plan
- Details of any onward referrals, including referral to secondary care if appropriate

The report must be documented in the patients records, communicated to the patient, the GP and to relatives/carers as appropriate, and should form part of any onward referral to secondary care.

A final report should be sent following any biopsy results as set out in Appendix B1.

2.2.13 Locations and Facilities

It is the Provider's responsibility to source the premises in which to deliver the service in accordance with the population needs.

The following list describes the resource requirements that would be expected of a community based dermatology service as a minimum. This list is not exhaustive and should be used as a guide:

- Complete access to diagnosis and treatment in convenient geographical locations;
- Access to consultation rooms and appropriate facilities for diagnosis and treatment procedures;
- Administrative support to ensure that clinics are organised and reported. This will include support to books clinics, manage and report waiting lists, manage and store patient records and provide the necessary statistical returns;
- The service provider will have a commitment to moving towards an integrated health record for all patients into the service.
- Information technology and arrangements for IT support and information Governance.

The Provider will ensure the service has sufficient onsite parking to accommodate patients and is accessible by public transport.

The Provider will be responsible for ensuring they are registered with the Care Quality Commission to provide the service from their chosen location(s).

2.2.14 Days/Hours of Operation

The provider will ensure the service will be available, between Mondays – Fridays during daytime hours (up to 8pm) with sufficient clinics to meet waiting time criteria. Opening times and days maybe flexed to meet demand.

Flexible opening will also be considered such as evenings and weekends.

2.2.15 Workforce/Training and Education/Research

It is the responsibility of the provider to recruit/provide suitable personnel and as such all staff will be appropriately trained, qualified and registered to undertake their roles and responsibilities.

Qualification and on-going CPD will be in line with the Department of Health (2007) publication Guidance and Competencies for the provision of services using GPwSI's: Dermatology and Skin Surgery. Qualifications include:

- Diploma in dermatology or equivalent;
- Assessed as competent in skin surgery;
- Consultant dermatologist accreditation as competent to undertake independent dermatology clinics;
- Inclusion on a Primary Care Trust Performers List;
- Ongoing mentorship arrangements with Consultant Dermatologist.

The following will apply to all staff groups including temporary staff, e.g. NHS bank and agency:

- Staff will be qualified and registered (where appropriate) in accordance with their anticipated scope of professional responsibility;
- Professional accountability must be formulated within an agreed governance structure;
- Staff will have a commitment to continuing professional development through the pursuit of relevant professional and academic study;
- Staff will participate in regular personal performance reviews including the development of a personal development plan;
- Appropriate supervision arrangements for all levels of staff will be in place, including induction and clinical supervision;
- All staff will be required to attend relevant mandatory training;
- All staff will be required to satisfy appropriate CRB checks;
- All staff will be appropriately trained/qualified and registered to undertake their roles and responsibilities.

As set out by the Care Quality Commission, registration documentation will be held on record by the provider for all medical staff and will be available for inspection. A certificate of registration will be prominently displayed by the provider in all sites that the service is provided from.

Policies and protocols will be available with a system in place to ensure staff compliance.

An appropriately qualified and experienced medical lead for the service will be required with responsibility for overseeing the clinical governance framework and processes.

2.2.16 General Practitioner with a Special Interest

The service provider will be responsible for ensuring that GPwSI's have been assessed as competent, hold current professional registration and indemnity insurance and who also meet the following criteria;

- Annually undertake an observed 'appraisal list' with an approved assessor;
- Undertake annual peer supervision;

- Maintain a professional development logbook, recording, practical supervision received, courses attended and other related further education;
- Audit all clinical lesions removed
- Be in receipt of feedback on performance

Maintain competency as set out within the Guidance and Competencies for the provision of services using GPs with Special Interests (GPwSIs): *Dermatology and skin surgery.*

2.3 Population covered

Patient using the service will be registered with a GP practice within either NHS Dorset or NHS Bournemouth and Poole.

Suspected malignancy will not be included in the service but it is recognised that some malignancies may be identified or suspected once assessment and/or treatment has taken place.

2.4 Interdependencies with other services

The majority of patients will be referred by and then returned to the care of their usual GP.
A small number of patients may have serious pathology identified and they will require onward referral to secondary care.

It is expected that GPwSI's will be part of or have links into Local Skin Multi-disciplinary Teams.

Key interdependencies include;
- GPs
- Secondary care
- Dermatology units
- Histopathology Services
- Pain services
- Patient Contact Centre
- Community Hospitals

It is expected that there will be robust relationships with the acute consultants to support integration and streamline the pathway.

2.5 Other

2.5.1 Management and Leadership

There is a contractual requirement for the provider to satisfy the commissioner that they have an organisational structure that clearly identifies responsibilities and accountabilities in the following areas:
- Managerial leadership
- Professional leadership
- Clinical leadership
- Clinical governance
- Corporate governance

The service should be provided in line with the patient and public rights and the values set out within the NHS Constitution.

2.5.2 Quality and Safety

The provider will have a framework that assures patient and staff safety and is supported by a range of policies and strategies including as a minimum:
- Incident and serious incident reporting
- Risk management
- Clinical governance strategy
- Health and safety policy

- Chaperone policy
- Policy for the protection of vulnerable adults and children
- Infection prevention and control policy, including decontamination
- Complaints policy
- Patient information and patient experience policy
- Single sex accommodation policy
- Management of medicines policy
- Emergency and contingency procedures

2.5.3 Governance

The Provider will have an established Clinical Governance programme which as a minimum covers the following:

- Patient, public and carer involvement;
- Risk management, including incidents and complaints;
- Staff management and performance, including recruitment, workforce planning and appraisals;
- Education, training and continuous professional development;
- Clinical effectiveness and audit;
- Information governance;
- Communication both internal and external; and
- Leadership at all levels of the organisation.

The provider will share key clinical governance information with commissioners and through them the local acute Trust.

The provider will act on any recommendation in any Care Quality Commission report that the Independent Regulator requires to be implemented or is otherwise agreed by the parties to be implemented. Results and recommendations from annual Care Quality Commission audits will be built into a programme of continual improvement.

2.5.4 Information Governance

The Provider will identify an Information governance lead.

The Provider will have in place a completed NHS Information Governance Statement of Compliance (IGSoC) process, comprising:

- IGSoC signed by the most senior executive in the organisation, and sent from that individuals mailbox (usually the CEO) to igsoc@nhs.net;
- Logical Connection Architecture – a description of the applying organisations network infrastructure;
- Sponsorship letter from the NHS organisation to whom you provide services.

All IGSoC processes will have to be approved via Connecting for Health IGSoC Team. http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/igsoc

The provider must complete and provide evidence that they have achieved minimum of level 2 scores for their organisations Information Governance Toolkit http;/www.igt.connectingforhealth.nhs.uk/

The Provider will comply with all relevant national information governance and best practice standards including:

- NHS Security Management – NHS Code of Practice;
- NHS Confidentiality – NHS Code of Practice;

The Provider will participate in additional Information Governance audits agreed with the Commissioner.

2.5.5 Patient Satisfaction and Complaints

Patients must at all times be respected and treated in a kind and considerate manner by staff who should at all times demonstrate a professional and patient friendly attitude.

The provider will conduct a six monthly patient satisfaction survey using a questionnaire agreed with the commissioner. The sample should be drawn from patients seen during the six month period and should represent at least 10% of the activity.

The Provider will participate in commissioner led patient satisfaction surveys in addition to the six monthly surveys with prior notice from the commissioner in support of developing care across the whole health community.

The provider will operate a complaints procedure that is in line with existing NHS Complaints standards, and will promote this to patients, providing clear details of who to contact and how to escalate complaints to the commissioner if they do not feel their concerns have been addressed.

In addition to providing the commissioner with a monthly summary of complaints received, the service provider will keep appropriate records of all complaints (verbal and written), which will be available for audit.

The commissioner expects the service provider to comply with national policies and local arrangements for notification and investigation of Serious Untoward Incidents (SUIs) and Never Events as set out in the body of the contract.

2.5.6 Patient Consent

The Provider will ensure that written informed consent is provided for all endoscopic procedures carried out, in compliance with GMC standards.

If English is not the first language, the patient is supported by a translator from a service provider recognised by the Commissioner.

2.5.7 Subcontracting

The service Provider will ensure that no part of the service outlined in this specification may be subcontracted to any other party than the approved provider without prior agreement and approval of the commissioner.

Any sub contracting agreements must meet the requirements of the standard NHS contract as published by the Department of Health.

2.5.7 Protection of Vulnerable Adults

The provider will ensure that concerns are reported to Social Services direct or the relevant local team and the Policy for Vulnerable Adults adhered to. It will then be the responsibility of the social services team to take the matter forward via an investigation or planning process.

The Police shall also be contacted where it is thought a criminal act may have been committed.

2.5.8 Safeguarding Children

The provider shall ensure that concerns are reported to Social Services direct or the relevant local team and the Policy for Vulnerable Children adhered to. It will then be the responsibility of the social services team to take the matter forward via an investigation or planning process.

The Police shall also be contacted where it is thought a criminal act may have been committed.

3. Applicable Service Standards

3.1 Applicable national standards e.g., NICE, Royal College

A number of key clinical guidelines and technology appraisals are also applicable to this specification, including, but not limited to, the following:

- Atopic Eczema: NICE CG57[1]
- Atopic Dermatosis: NICE TA82[2]
- Eczema: NICE TA177[3]
- Psoriasis: NICE TA103[4]/134[5]/146[6]/180[7]
- Psoriatic Arthritis: NICE TA199[8]
- British Association of Dermatology Guidance[9]
- Improving Outcomes Guidance[10]
- Guidance on referral for suspected Cancer CG27[11]
- NHS Outcomes Framework[12]

1. http://www.nice.org.uk/CG57
2. http://www.nice.org.uk/TA82
3. http://www.nice.org.uk/TA177
4. http://www.nice.org.uk/TA103
5. http://www.nice.org.uk/TA134
6. http://www.nice.org.uk/TA146
7. http://www.nice.org.uk/TA180
8. http://www.nice.org.uk/TA199
9. http://www.bad.org.uk/site/622/default.aspx
10. http://www.nice.org.uk
11. http://guidance.nice.org.uk/CG27
12. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

3.2 Applicable local standards

CQUIN will be applicable to the service at 2.5% and details will be set out within Section B Part 9.2 of the 2012/13 NHS Standard Contract. It is likely that CQUIN will focus on the achievement of the outcomes associated with establishing integrated pathways across the health community.

4. Key Service Outcomes

The expected outcomes include, but are not limited to:

- The majority of patient with non complex dermatology needs within Dorset will be managed within the community;
- Increased number of ‘one stop’ community based services;
- improvements in the individuals dermatological condition;
- improved self management by patients particularly those with long term dermatological conditions;
- improved management of patients in general practice through improved referrer knowledge and education;
- reductions referrals to secondary care
- improvements in efficiency and productivity of dermatology services
- improved patient experience through short waiting times and see and treat model (one stop)
- close analysis of referrals will inform the design of generic and specific education sessions for GP’s and nurses.

5. Location of Provider Premises

The Provider's Premises are located at:

[Name and address of the Provider's Premises **OR** details of the Provider's Premises **OR** state "Not Applicable"]

6. Individual Service User Placement

[Insert details including price where appropriate of Individual Service User Placement]