

# Greater Manchester, Lancashire & South Cumbria Clinical Senate

## Independent Clinical Review of a Community Dermatology Model and Triage Service

A decorative graphic in the bottom left corner consisting of several overlapping, curved bands in shades of purple and teal, creating a sense of movement and depth.

Date: August 2015

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## **Greater Manchester, Lancashire & South Cumbria Clinical Senate**

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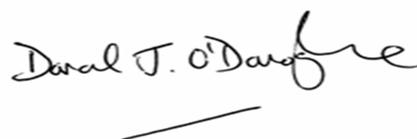
## Chair's foreword

The Clinical Senate was pleased to receive a commission from Fylde and Wyre Clinical Commissioning Group in May 2015 to review a proposed community dermatology service model and triage service. Following receipt of information provided by commissioners the Clinical Senate convened an independent clinical review team (Appendix I). The team is made up of clinical experts who reviewed the information provided and have been able to provide clinical advice and made a number of recommendations in relation to the proposed clinical model.

It was apparent to the review team that Fylde and Wyre CCG's is fully committed to supporting an approach to the development of evidence based and effective working model for community dermatology services that fulfils their obligations as commissioners to the people they serve. The clinically driven, collaborative and needs based approach that they have taken thus far is testament to their commitment to an inclusive process, and is to be commended.

I would like to thank Dr Martin Hogg for chairing this process and the consultants, patient representative and managers who have contributed to this review. The contributors to this process provide their commitment, time and advice freely and without this we would be unable to provide such a comprehensive report. I am forever grateful to the review team and members of the Clinical Senate for their ongoing support and commitment to the provision of robust clinical advice.

The clinical advice within this report is given in good faith and with the intention of supporting commissioners in further development of the model. This report sets out the methodology and findings of the review, and is presented to Fylde and Wyre CCG with the offer of continued support should it be needed.

A handwritten signature in black ink that reads "Donal J. O'Donoghue". Below the signature is a horizontal line.

**Professor Donal O'Donoghue**  
**Senate Chair**  
**Greater Manchester, Lancashire & South Cumbria Senate**

## 1. Executive Summary

1.1 The Greater Manchester Clinical Senate received a request from Fylde and Wyre CCG commissioners to undertake an independent clinical review of proposed plans for a community dermatology service and referral management system.

1.2 An independent clinical review team of clinical experts (Appendix I) was formed to review the information provided by commissioners. The team set out to review the information provided in order to offer independent clinical advice that could be used by commissioners to optimise the proposed clinical model, to provide assurance that the model is clinically effective and safe and to minimise any unintended consequences.

1.3 The review team were quick to recognise that the commissioners must strike a balance between the responsibilities of providing a dermatology service to the population they serve whilst acknowledging the challenges faced in relation to the geography and attracting the skilled workforce and talent to the area. In other words, expecting the same service provision as a busy urban teaching hospital with a large dermatology department would be an unfair comparable.

1.4 The independent clinical review team found that the model was in principle sound and offered a number of recommendations for commissioners to consider. These were in relation to clinical issues that emerged as a result of the review and included: cancer two week rules and management of emergencies, process for feedback of histology results, management of skin cancers that fall out with the two week pathway, triage and referral management, telemedicine/Tele – dermatology, education and training of workforce, clinical standards and quality metrics, patient, carer and public views, on-going role of the clinical network, safety and sustainability.

1.5 The Clinical Senate offers this advice in good faith and extends support to commissioners should they need it in the future.

## 2. Summary of key recommendations

No	Ref.	Summary
1)	7.1.1	Direct referral for cancer 2 week rule and management of dermatological emergencies should be made clear within the pathway algorithm.
2)	8.1.1	A process for action post histology feedback and direct referral to secondary care should be made clear within the algorithm.
3)	8.1.3	A specified pathway for management of high volume patients on the commonly prescribed medication of isotretinoin would improve efficiency and prevent unnecessary referral to secondary care.
4)	9.1.1, 9.1.2	It should be made clear how basal cell carcinomas are to be managed.
5)	10.1.1, 10.1.2	An experienced clinician should manage triage referrals; for best practice standard this should be a substantive hospital consultant or an established GP with a specialist interest in dermatology and/or skin cancer. Triage referrals should be audited bi-monthly to ensure that they are being managed effectively.
6)	11.1.1, 11.1.2	Tele-dermatology can offer care closer to home if delivered in conjunction with focussed training and rigorous protocols. It is not without limitations and should not be used in whole as a substitute for face to face clinical consultations or referral to surgery.
7)	12.1.1	The process for the collection and delivery (type/frequency/process) for clinical outcomes should be fleshed out and detailed within the service specification so that providers, commissioners, patients and carers are clear about what is expected.
8)	7.8.1	It would be useful to know how many false positives and negatives are being referred to specialist dermatology.
9)	13.1.1	It would be helpful to describe more fully in the service specification the expectation of the successful provider in relation to provision of GP education through audit and reflective learning.
10)	14.1.1	The views of patients and carers are not represented within the design of the service specification and this would enhance the pathway further.
11)	14.1.2	The provision of information for patients, including self care, and the points at which this is given, should be described within the service specification.
12)	14.1.4	Access and travel for patients should be considered within the specification.
13)	15.1.1	The Clinical Network objectives should be refreshed and provide information in relation to an on-going role in providing clinical advice for commissioners and to facilitate collaboration between providers.
14)	16.1.1	Collaborative and productive relationships between providers will enable a successful service and ongoing attention should be given to this to avoid any destructive competition.
15)	16.1.2	Consideration should be given on the impact any changes on other services currently provided to the CCG by the secondary care trust.

### 3. Introduction

3.1 The Clinical Senate were pleased to receive a request in April 2015 from Fylde and Wyre CCG commissioners to undertake a review of their plans for a new community dermatology service and referral management system. The Clinical Senate accepted this commission in May 2015 and this report outlines the background to the review, the methodology used and findings of the independent clinical review team.

### 4. Background

4.1 Fylde and Wyre CCG performed a review of Dermatology Services in April 2014 to understand the current service provision and to establish if there were opportunities to improve by redesign the service. All dermatology referrals are currently made to the local acute Trust who has one Consultant Dermatologist who is nearing retirement.

4.2 Recommendations of the review included the establishment of a local Clinical Network to facilitate commissioner and provider collaboration on improvement efforts and to provide system leadership, and to perform a clinical audit of existing pathways (PLVC benign skin lesions and high volume pathways) in order to make recommendations regarding the future configuration of services on the Fylde Coast.

4.3 Following this review the Clinical Network recommended procurement of a community dermatology service and referral management/triage system and produced a service specification designed to improve access to dermatology services for the population of Fylde and Wyre CCG.

4.4 The commissioners described the purpose of establishing a community service to reduce pressure on secondary care as current levels of demand are unsustainable, to improve accessibility to services and provide appropriate care closer to home. The target population is the entire population of Fylde & Wyre CCG and there were no exclusions in terms of population groups.

### 5. Methodology

5.1 An independent clinical team was convened to perform a desktop review of proposed service plans, details of the review team can be found in *Appendix 1*. The question for the review was agreed with commissioners as:

‘Can the Clinical Senate provide clinical advice following a review of the proposed service model that could be used to 1) assure commissioners that the scope and content of the service model is clinically effective and safe and 2) optimise the service specification and quality measures to ensure delivery of best practice clinical outcomes and minimise any unintended consequences’

5.2 Information for review was provided by the sponsoring commissioner, this included:

- A Draft Service Specification
- Independent Review Slides
- Membership of the Dermatology Clinical Network
- Objectives of the Clinical Network
- An Audit Report of current service provision

5.3 Members of the team reviewed the information provided and two WeBex meetings were held to discuss initial findings and to clarify information. The report was compiled during an iterative process of drafting and comments between the review team members. The report was then taken to the Senate Council for discussion on the 16<sup>th</sup> July 2015 and ratified via email two weeks later.

## **6. Findings and recommendations of the review**

### **6.1 Clinical Review of proposed pathway**

6.1.1 The team reviewed the proposed pathway and found that in principle this was sound, however there were a number of points for commissioners to consider that are detailed within this report.

### **7.1 Cancer 2 week rules and emergencies**

7.1.1 As it stands there is no direct referral for possible skin cancers under 2-week rule and dermatology emergencies appear to have been excluded from this specification. It would be important to describe this in the pathway to provide as much information as possible for GP referrers in order to guide practice.

### **8.1 Process for feedback of histology results and other communications**

8.1.1 The feedback process post histology and possible requirement for referral to or back into secondary care is not included within the pathway. This would be important to avoid incidents of patients inadvertently coming off the pathway when an efficient process for further clinical assessment is required. In other words, there needs to be an effective pathway straight into secondary care when histology finds a malignant result and should be represented in the pathway algorithm.

8.1.2 Clear, plain English letter writing with letters copied to patients in almost all instances as well as a manageable process for results (especially unexplained cancers) is critical and requires as few steps in the pathway as possible. To minimise risk, it is preferable that a named person receipt and feedback communication rather than just a 'fax number'.

8.1.3 Controlled drugs, including the very commonly prescribed acne medication of isotretinoin, needs a special mention because of the very large number of patients who will be taking this medication. Either a specified pathway within community dermatology is required, alternatively all patients would need to be referred to secondary care (this would be inefficient and an additional burden).

## 9.1 Skin cancers that fall out with the two week pathway

9.1.1 There is an enormous burden of work for surgery for BCC because of the high-volume. Many BCCs are on the face and a community service, if "Consultant Led" and correctly supervised, does not need to be restricted by NICE dermatology guidance because this guidance is now very dated and was designed to limit individual GPs or GPSIs performing inappropriate surgery in an unsupervised manner through a community clinic. Most modern Community dermatology clinics include BCC surgery delivered by appropriate healthcare professionals under strict consultant supervision and audit.

9.1.2 Within the service specification it is important to be very clear what the agreement is between commissioner and provider with regard to management of BCCs. Surgical procedures benefit from remaining within a group of surgical practitioners who are performing these procedures on a regular basis so are competent and current at doing it. Moreover, it must be clear that the successful provider for this service will take responsibility for good clinical outcomes and appropriate training of staff.

9.1.3 There are a number of skin cancers that are not referred under the two week pathway. As the pathway stands, it is unclear whether there is capacity within the non-two week pathway part of the algorithm for such cases. For these skin cancers, a number of them still have to go to acute trust but they don't fall under the criteria of lower risk. It is useful to note that the criteria for lower risk depend on whether or not it is picked up by a Local Enhanced Service (LES).

9.1.4 For Basal Cell Carcinoma (BCC) the guidance from NICE (2010)<sup>1</sup> guidance for model 1 GPwSI does include lesions above the clavicle as long as the patient has been discussed by an MDT.

9.1.5 In the exclusion criteria of the service specification, where it reads ‘Lesions with significant risk of SCC or melanoma or other high risk malignancy’ it should read ‘Possible diagnosis of SCC or malignant melanoma, or other rare skin cancer .....’ on the basis that the guidelines should provide as much assistance to GPs as possible.

## 10.1 Triage and Referral Management

10.1.1 Within the draft specification, patients are referred to dermatology service within 72 hours. It is advised that triage of referrals are made by very experienced clinicians. Triage that is consultant led is desirable and offers the advantage of the ability to triage the most rare and possibly malignant skin lesions, thus reducing unnecessary steps within the pathway downstream.

10.1.2 Best practice triage is that which is performed by a substantive hospital consultant or an established GP with a specialist interest in dermatology and/or skin cancer. It has been delivered safely by other clinical professionals provided they have appropriate training and are under consultant supervision.

10.1.3 Since triage can be managed via electronic transfer of documents it is possible to commission this aspect of the service to a separate provider that has the capacity and capabilities to manage referrals within a 24 hour turnaround time.

10.1.4 It is important to build in a quality measurement system that shows how referrals are being managed. For example, a bi-monthly audit of 20 referrals would provide information that would demonstrate where referrals are being triaged to and the outcomes of the treatment that will give assurance to commissioners.

## 11.1 Telemedicine and tele-dermatology

11.1.1 Tele-dermatology is a useful tool if delivered correctly, for example from a spread of GP surgery locations and can provide a service closer to home for many patients. Up to 75% of dermatology referrals can be managed like this, many with a GP management plan and some with

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<sup>1</sup> NICE (2010) Improving Outcomes for People with Skin Tumours including melanoma (update)  
<http://www.nice.org.uk/guidance/csgstim/evidence/improving-outcomes-for-people-with-skin-tumours-including-melanoma-update-the-management-of-lowrisk-basal-cell-carcinomas-in-the-community-2010-partial-guidance-update2>

an onward referral to surgery or face to face requirement.

11.1.2 The use of telemedicine in dermatology, for example photographs and video-enabled conferencing, can add to the overall referral information given. However, caution is advised as it is not completely reliable and there are clinical incidents associated with it. Adequate training provision is important and it should not be used in whole for substitute access to face to face clinical consultations and for referral for surgery. In offering a tele-dermatology service protocols for correct photo assessment must be rigorous.

## 12.1 Clinical Standards and Quality Metrics

12.1.1 It is important that quality metrics and process for clinical audit are well described within the service specification as this will guide the service and provide clarity to providers, commissioners, patients and carers with regard to expectations. Such a description would capture the type and frequency of quality measures and quality returns directly related to clinical outcomes and patient experience that are expected of the provider.

12.1.2 There are a number of clinical guidelines relating to the dermatology service specification that offers a guide and direction to commissioners. It would be important to include within the reference list of the service specification the NICE guidelines (2006) 'Improving outcomes for patients with skin tumours, including melanoma' and the update for the same group NICE guidelines (2010).

12.1.3 In addition, measures within the Cancer Peer Review for skin cancer offer quality measures for those patients who have malignant skin tumours that can be used<sup>2</sup>. Finally, as a framework for the GPwSI service, the 'revised guidance and competencies for the provision of services using GPs with Special Interest (GPwSI)'<sup>3</sup> offers a guide for the GPwSI framework.

12.1.5 It is important to note that the 'revised guidance and competencies for the provision of services using GPs with Special Interest' are a guide by one group of health professionals for

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<sup>2</sup> NHS England (2014) Manual for Cancer Services: Skin Measures <http://www.cquins.nhs.uk/?menu=resources>

<sup>3</sup> [https://www.pcc-cic.org.uk/sites/default/files/articles/attachments/revised\\_guidance\\_and\\_competences\\_for\\_the\\_provision\\_of\\_services\\_using\\_gps\\_with\\_special\\_interests\\_0.pdf](https://www.pcc-cic.org.uk/sites/default/files/articles/attachments/revised_guidance_and_competences_for_the_provision_of_services_using_gps_with_special_interests_0.pdf)

another and do not need to be strictly adhered to if the service spec is clear and the commissioners and new provider both understand what they are signing up to.

### 13.1 Education and Training of Workforce

13.1.1 The independent review slides provided in the information for the review describe spend on service but fails to describe what it is being spent on. It would be useful to understand the type of referrals being made and the number of false positives and negatives to specialist dermatology.

13.1.2 There is evidence in other parts of the country of an apparent erosion of skills in primary care resulting in referrals of 'query cancer' with the vast majority not being cancer (circa 90%). This puts unnecessary pressure on dermatology services.

13.1.3 Therefore, it would be beneficial to describe within the service specification the requirement for the intermediary service to support GP education through audit and reflective learning. This is so that GP colleagues continue to gain skills in these common conditions, and subsequently reduce the number of false positive referrals to dermatology. This would also support a requirement for knowledge transfer into primary care to support self-care.

### 14.1 Patient, carer and public views

14.1.1 Within the information provided, the consultation or involvement of patients in the design of the pathway and plans is not described. Including the views of patients and carers would enhance the pathway further. For patients, it is very important to feel that clinicians that are looking after them are appropriately trained and this should be clear in the service specification.

14.1.2 What is also important to patients is the provision of information at an early point in the pathway, there is no mention of information provision for patients in the service specification and it is a concern that patients may struggle to get the information correctly.

14.1.3 This in turn would support self-care elements of the pathway for patients. There is no overt mention of the requirement to have shared decision making; it would be encouraging to see this in the flow diagram that is presented within the specification.

14.1.4 There is no information provided regarding the issue of travel and access for patients and an

assessment of the proposals on this in order to mitigate the impact of this for patients and carers. It would provide reassurance to patients that consideration had been given to this aspect of changes to the pathway.

### 15.1 Clinical Network

15.1.1 It would be beneficial to review the objectives of the Clinical Network. This is because as it stands the network appears to only be set up to make recommendations for the new pathway. Moving forward, there is a role for the Network providing clinical advice and facilitating of collaboration on service design between primary, intermediate and secondary care, clinical advice for the education and training aspects of the pathway, review of clinical outcomes, facilitation of reflective practice and on-going quality improvement. The development of formal terms of reference for the network would provide clarity of aims and objectives moving forward.

### 16.1.1 Safety and Sustainability

16.1.1 Productive relationships between the chosen provider, secondary care and intermediate care will be key to a successful service for patients and it is important that some attention is given to actively developing those relationships to avoid destructive competition.

16.1.2 Consideration should be given on the impact any changes on other services currently provided to the CCG by the secondary care trust. This is to ensure that there is no adverse effect on whole pathway service provision and in particular the specialist element of the pathway.

### 17. 1 Summary and Conclusion

17.1.1 The independent clinical review team set out to provide clinical advice that could be used to provide assurance to commissioners that the scope and content of the service model is clinically effective and safe, and to optimise the service specification and quality measures to ensure delivery of good clinical outcomes whilst minimising any unintended consequences.

17.1.2 The review team were able to meet the objectives of the review and present the findings of the independent clinical review team within the body of this report. The report outlines fifteen recommendations and highlights a number of areas where further consideration should be given in the development of the dermatology pathway and service specification. The review team acknowledge the

specific challenges with regard to attracting workforce to the area and understand the need to design a service that meets the needs of the population in the most effective way possible.

17.1.2 The review team ask that the commissioners focus on the recommendations made and to prioritise the development of a quality metric system that will provide on-going quality measures that can be used for assurance, and to drive improvement of the service.

17.1.3 The advice within this report is given in good faith and is correct at the time of writing. Moving forward the Clinical Senate extends the offer of further support should commissioners request it.

## **Appendix 1.**

### **Contributors**

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## Glossary

GPwSI = General Practitioner with Special Interest (in dermatology)

BCC = Basal Cell Carcinoma

LES = Local Enhanced Service

MDT = Multi-Disciplinary Team

SCC = Squamous Cell Carcinoma