Clinical Senate
Yorkshire and the Humber

"An independent source of strategic clinical advice for Yorkshire and the Humber"

Clinical Senate Review

for

North Lincolnshire

Clinical Commissioning

Group on Dermatology

Model of Care

Version 1.0
July 2015

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Yorkshire and the Humber Clinical Senate
Joanne.poole1@nhs.net

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Version Control

Document Version	Date	Comments	Drafted by
Version 0.1	8th June 2015	Based on working group discussion	Joanne Poole
Version 0.2	9th June 2015	Comments from the Chair	Joanne Poole
Version 0.3	12th June 2015	Comments from the working group	Joanne Poole
Version 0.4	21st July 2015	Paragraph re-phrased following commissioner comment. Report ratified by Senate Council at 21st July meeting.	Joanne Poole
Version 1.0	22nd July 2015	Final Version	Joanne Poole

1. Chair's Foreword

1.1 The Senate welcomes the opportunity to work with North Lincolnshire Clinical Commissioning Group (CCG) on reviewing the model of care. The Senate is aware of the sensitivities surrounding this particular service and we hope that commissioners find this a balanced and fair report which will assist in their local discussions.

2. Summary Recommendations

2.1 The Senate has been asked to review whether the service detailed within the specification will provide a clinically safe model of care particularly considering the skin cancer pathway and how the Multi-Disciplinary Team (MDT) meeting is delivered. The Senate takes the view that with a clear and well defined service specification, a safe clinical model of care can be provided. The specification as currently written, however, does not contain sufficient detail on the intended pathways, MDT arrangements, audit, peer review and governance of the community service. The specification needs to be significantly improved in order to ensure that the procurement results in the delivery of a safe and quality clinical service.

3. Background

3.1 Clinical Area and Current Arrangements

3.1.1 North Lincolnshire Primary Care Trust originally commissioned a community based dermatology service in 2011 through an open procurement process. The aim was to deliver a full dermatology service within the community rather than hospital setting, recognising that there is a small cohort of patients who would need treatment within a secondary care setting such as patients requiring complex surgery or general anaesthetic. The specification for the 2011 service included management of 2 week wait referrals for suspected cancer, supported by a skin cancer MDT. At that time, the Yorkshire and Humber Coast Cancer Network signed off the pathways as compliant with Improving Outcomes Guidance[1].

3.1.2 North Lincolnshire Clinical Commissioning Group (CCG) is now reviewing the service specification and is seeking external clinical advice from the Senate that the model is still clinically appropriate.

3.1.3 The CCG have acknowledged that there are challenges in the current interface of services between the community provider and the secondary care provider. There are a number of elements of service that both providers are currently doing and both providers and the CCG have agreed to work together to review the service specification, with the expectation that each provider then delivers their element of the service specification. At present, a number of patients are referred from one provider to the other and this is considered unnecessary. The Senate is aware that there are contrasting opinions from the CCG, the secondary care clinicians and the British Association of Dermatologists (BAD) on the community service, its impact on

[1] National Collaborating Centre for Cancer (2010). NICE Guidance on Cancer Services. Improving Outcomes for People with Skin Tumours including Melanoma (update): The Management of Low-risk Basal Cell Carcinomas in the Community.

the sustainability of the secondary care service, the Multi-Disciplinary Team (MDT) arrangements and whether the service is compliant with the Cancer Improving Outcomes Guidance[1].

3.2 Role of the Senate

3.2.1 The Senate has been asked to assist North Lincolnshire CCG on the appropriateness of the dermatology model of care, which provides the majority of care within a community setting.

3.2.2. The Senate has been asked to focus on "whether the service detailed within the specification will provide a clinically safe model of care particularly considering the skin cancer pathway and how the MDT is delivered."

3.2.3 The Senate advice will inform the commissioning intentions and the revision of the service specification along with production of a service specification in relation to the services remaining to be provided by the Acute Trust in a hospital setting.

3.3 Process of Review

3.3.1 The Senate received the service specification on 22nd April 2015 and agreed the Terms of Reference for the review at the end of April. The Senate Working Group was appointed on 5th May 2015. The Senate Working Group held two teleconferences to aid their discussions. The Council was informed of the working group discussions at its May meeting and members also had opportunity to comment on the draft service specification. In response to the additional questions raised by the Working Group, the commissioners provided additional information on 18th May and 21st May including information on audit, governance, peer review and specific pathways. The Working Group held a teleconference with commissioners and clinical representatives on 8th June 2015 to clarify outstanding questions. The Working Group agreed its draft report and submitted this to the CCG on the 17th June. The CCG have opportunity to comment on the report prior to its final ratification by the Council.

4. Recommendations

4.1 General Recommendations

4.1.1. The Senate agrees in principle with the concept of a community dermatology service, including a service that includes the management of skin cancers. This is reflected in:

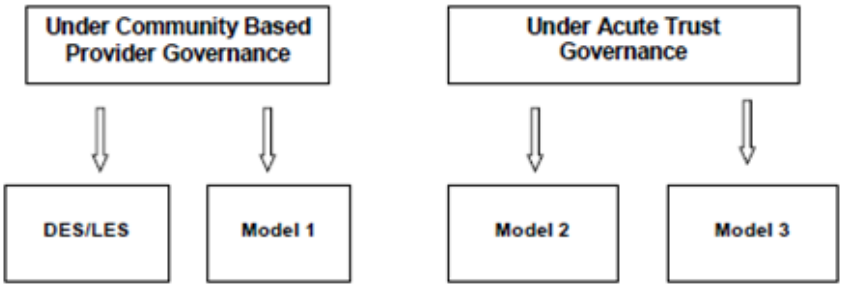
- NICE. Improving outcomes for people with skin tumours including melanoma (update)[2].

- The management of low-risk basal cell carcinomas in the community (May 2010)[3] which recommends three models of care for the management of Basal Cell Carcinoma in the community. The pathways for low-risk Basal Cell Carcinomas (BCC) management are now integral to the new NHS England minor surgery Direct Enhanced Service Contract for GPs.

- 'Manual for cancer services 2008: skin measures'[4] which define Model Two Practitioners in outreach community skin cancer services provided by acute trusts or Local Health Boards linked to the Local Hospital Skin Multi-Disciplinary Team (LSMDT).

4.1.2 The Senate is aware of other examples where under secondary care governance there are clinicians excising Melanomas, Squamous Cell Carcinomas and Basal Cell Carcinomas in the community. Commissioners need to be aware, however, that the model proposed in the service specification goes beyond the management of BCCs and therefore the remit of the community service will be beyond the recommendations of the above Guidance. The Manual for Cancer Services, July 2014[5], also continues to confine community based skin cancer surgery as follows:

Acceptable Models for the Management of Skin Cancer in the Community by Surgical Excision or Curettage



4.1.3 The Manual specifies that the service provided under the Direct Enhanced Service (DES)/Local Enhanced Service (LES) contracting system and the Model 1 service are to allow doctors in the community to diagnose and surgically treat low risk BCCs at 2 levels of risk under 2 different levels

[2] NICE. Improving outcomes for people with skin tumours including melanoma: Evidence Update October 2011.
[3] NICE Guidance on Cancer Services (May 2010). Improving Outcomes for People with Skin Tumours including Melanoma (update): The Management of Low-risk Basal Cell Carcinomas in the Community.
[4] NHS National Cancer Action Team. National Cancer Peer Review Programme. Manual for Cancer Services 2008: Skin Measures.
[5] The National Peer Review Programme. The Manual for Cancer Services, Skin Measures, Version 1.2 July 2014, page 15

of training/ other requirements. Service Model 2 is to allow trained medical or nurse practitioners to offer a technical surgical service in the community, for skin cancers, diagnosed and given a treatment plan by other legitimate referrers. Service Model 3 is to allow for hospital specialists from MDTs practicing in the community. Therefore, the accepted models of care according to the Guidance fall in either Community Based Provider Governance or Acute Trust Governance and the service specification provided to the Senate proposes a merging of these 2 models.

4.1.4 The Senate takes the view that under an appropriate structure of governance and peer review it is possible to commission a clinically safe service where the full range of skin cancer services are provided by a suitably accredited independent provider. The Senate however feels that the specification in its current form does not contain sufficient detail to clearly define the service and to enable us to agree that it will result in a clinically safe model of service. This report details the areas where the specification needs to have greater clarity, particularly with regard to audit, governance and peer review. Commissioners are asked to note that the Senate can only provide support to this model if the community provider service and MDT is peer reviewed separately to the Acute Trust service. The Senate recommends that the internal validation of the peer review measures should occur within the first 12 months of operation and the external peer review should be invited in in the second year of operation.

4.1.5 The Senate is concerned that there is not a consensus view between the current providers regarding the service model. The Senate is also concerned that patients may be referred between providers unnecessarily. The Senate discussed this with commissioners and understands that the commissioners are intending to revise the model of care within this procurement to address this fundamental issue. However, the Senate highlights that regardless of the documented service specification, the success of the service will be as dependent on robust and professional working relationships between the two providers and the commissioner as it is on the documented pathways. Commissioners need to be aware of this as their procurement progresses to ensure that patients do not receive a fragmented service.

4.2 Areas of Improvement to the specification

4.2.1 The Range of the Skin Cancer Service

4.2.1.1 From the information originally provided the Senate found it difficult to understand how patients would flow through the service. The specification states that the Community Dermatology Service aims to offer provision of:

- A full range of dermatology assessments, diagnosis and treatments in community settings

- Diagnosis and management of common dermatological conditions for adults and children
- Minor skin surgery including lumps and bumps and diagnosis and management of skin cancers but excluding activity that is undertaken through the Direct Enhanced Service for minor surgery

4.2.1.2 We understand from discussion with commissioners that the intention is to provide a full skin cancer service through the community contract. The Senate understanding is that patients would be transferred to secondary care for surgery where this requires a general anaesthetic or is more complex, but is below the threshold of requiring plastic surgery. Patients requiring plastic surgery would be referred to Hull. We recommend that the specification clarifies this matter. The Senate felt that Appendix 1 was particularly lacking in clarity. All providers of the service and those professionals referring patients into the service need absolute certainty on where the thresholds of referral are and what referrals, by exception, go straight into secondary care. We recommend that the required pathways for the range of skin cancers are included within the specification.

4.2.1.3 The Senate has received assurance from commissioners that secondary care have developed a capacity plan that will enable it to provide a secondary care dermatology service for North East Lincolnshire on a community basis using a new build primary care centre within Grimsby. In order for the community service to deliver a clinically safe model of service there needs to be a viable and sustainable Acute Trust service for referral of complex excisions.

4.2.1.4 The Senate did have some concerns with the detail of the pathways provided and do not consider it necessary to biopsy all suspicious lesions before onward referral as stated in the Squamous Cell Carcinoma (SCC) pathway. The criteria in the SCC pathway for "referral out of our service" does not seem to be specified. There is also inadequate reference to non-benign lesions in the pathways

4.2.2. MDT arrangements and attendance

4.2.2.1 The specification currently does not detail the MDT requirements in sufficient detail. From correspondence with commissioners the Senate understands that the requirement is for the community service to run the MDT and have full responsibility for those meetings. The specification needs to clearly define the management, administration and governance of the MDT as this is of crucial importance to patients with skin cancer. It is also recommended that the attendance requirements are updated to reflect the Skin Measures Jan 2014[6] which states that Local Specialist MDT core member attendance should be 2/3rds.

[6] The National Peer Review Programme. The Manual for Cancer Services, Skin Measures, Version 1.2 July 2014, page 51, point 14-2J-104

4.2.3 Staff Supervision, Training and Experience

4.2.3.1 There is currently a lack of detail within the specification on staffing requirements for the service. The service needs to be clinically led by an accredited Consultant Dermatologist. If commissioners expect there to be a Consultant available on the site that care is provided then this should be explicit within the specification. The standards and tools to support the accreditation process for GPwSIs are contained within national guidance documents[7] and the recommendations within the NICE 2010 guidance[8]: The specification needs to detail commissioner requirements on the supervision, training and experience of the community service staff to ensure that this community service model is provided by suitably qualified and experienced staff. There needs to be a mechanism for commissioners reviewing the staffing of the service.

4.2.4 Accessibility for patients

4.2.4.1 The Senate understands that the community services are currently provided in purpose built facilities. There is little detail within the specification on the facility requirements and the Senate recommends that further information is provided in the service specification so that the provider fully understands the minimum standards required for their facilities. Commissioners may want to consider a CQC inspection of the facilities.

4.2.4.2 The Senate recommends that commissioners consider how accessible these services are to patients when re-procuring the service. Commissioners need to consider whether centres are delivering care accessible via public transport and whether there is adequate parking at these facilities. Patients needing transport for medical reasons need access to the same support as they would for a clinic at the hospital.

4.2.4.3 The Senate sought information from commissioners concerning the provision of medical photography, photodynamic therapy and histology, (particularly those bullous disorders that need to undergo immuno fluorescence study). It is important that medical photographs are provided seamlessly to the LSMDT and that all suspicious pigmented lesions are photographed according to the guidelines. The Senate also notes that it is good practice for all lesions to be excised to be photographed to allow review of the original lesion in the light of pathology. The arrangements for how this will happen need to be made clear within this specification.

[7] Revised Guidance and Competencies for the Provision of services using GPs with Special Interests (GPwSIs). Dermatology and Skin Surgery, June 2011. NHS.
[8] NICE Guidance on Cancer Services (May 2010). Improving Outcomes for People with Skin Tumours including Melanoma (update): The Management of Low-risk Basal Cell Carcinomas in the Community.

4.2.4.4 The Senate also recommends that the specification explicitly addresses how patients gain access to skin cancer nurse specialists and is more specific on how psychological support from trained practitioners is available within the service. It is also recommended that the specification states that all clinicians involved in the service should have attended the advanced communication skills course to facilitate appropriate breaking of bad news.

4.2.5 Audit and Governance Procedures

4.2.5.1 Currently the specification does not make reference to the audit and governance procedures relating to this contract. The Senate recommends that there is clarity within the specification on those clinical audit, governance and peer review responsibilities. Paragraph 4.1.4 of this report states that the Senate can only provide support to this model if the community provider MDT is separately peer reviewed. The Senate recommends that the internal validation of the peer review should occur within the first 12 months of operation and the external peer review should be invited in in the second year of operation. The requirements for peer review compliance, and the schedule for this assessment, need to be clearly stated within the service specification so that the potential providers have absolute clarity.

4.2.5.2 It is recommended that commissioners ensure that they have the data to know

- How many skin cancers were referred to the community service
- What were the outcomes of the referral?
    - Of the biopsies carried out, how many were benign and how many were malignant (the emphasis on safety may suggest that it does not matter how many false positive cases of skin cancer there were as long as the number of false negatives was low but there is the issue of unnecessary surgery)
    - Of the cases which were proven to be malignant, how many were excised by the community service and how many were transferred to the Acute Trust
    - Of the cases which were excised by the community service, how many were adequately excised?
    - Of the BCCs excised by the community service how many were superficial BCCs which could have been treated medically or with curettage rather than a formal excision?

4.2.5.3 Commissioners need to ensure that they have the mechanisms to monitor whether the community service provides accurate clinical diagnosis and appropriate surgery by practitioner. Compliance with the peer review measures will ensure the appropriate audit and governance framework is provided for this service.

4.2.6 Future Developments

4.2.6.1 The Senate recommends that the specification needs to state that the provider needs to meet all measures for skin cancer as these are updated in the future and the time to comply with any changes should be specified.

5 Summary and Conclusions

5.1 The Senate agrees in principle with the concept of a community dermatology service including a service that includes the management of skin cancers. Commissioners need to be aware, however, that the model proposed in the service specification goes beyond the management of BCCs and therefore the remit of the community service will be beyond the recommendations of the Improving Outcomes Guidance. The Senate takes the view that under an appropriate structure of governance and peer review it is possible to commission a clinically safe service where the full range of skin cancer services are provided by a suitably accredited independent provider. The Senate however feels that the specification in its current form does not contain sufficient detail to clearly define the service and to enable us to agree that it will result in a clinically safe model of service.

5.2 The Senate recommends that the specification has greater clarity on:

- The skin cancer pathways and range of the skin cancer service
- MDT arrangements and attendance
- Staff supervision, training and experience
- Accessibility for patients (including to the facilities and the services including skin cancer nurse specialists)
- Audit, governance and peer review
- Future developments for the service.

APPENDICES

Appendix 1

LIST OF SENATE WORKING GROUP MEMBERS

The Working Group developed for this review consists of:

Senate Council Members

Professor Chris Welsh
Senate Chair

Christine Beever
Patient representative

Senate Assembly Members

Dr Clare Rogers
Yorkshire and Humber Strategic Clinical Network for Cancer Clinical Lead, Consultant Breast Surgeon, Doncaster and Bassetlaw NHS Hospitals

Mr AJ Stephenson
Consultant Plastic, Reconstructive & Burns Surgeon & Specialist Skin MDT Lead Clinician, Sheffield Teaching Hospitals NHS Foundation Trust

Co-opted Members

Professor Kevin Hardy
Medical Director, St Helens & Knowsley Teaching Hospitals NHS Trust

Mr Nicholas White
Consultant Plastic and Craniofacial Surgeon, Birmingham Children's Hospital and Queen Elizabeth Hospital, Chair of the West Midlands Expert Advisory Group on Skin Cancer.

Dr Soon Lim
Vice President and Education Lead, the Association of Surgeons in Primary Care Director of Minor Surgery, RCGP, Beds and Herts, East Anglia, Thames Valley, Vale of Trent and North East London faculties

Appendix 2

DECLARATION OF INTERESTS

Working Group Members Declaration of Interests

None declared

Senate Council Members Declaration of Interests

Name	Title	Organisation	Date of Declaration	Reason for Declaration	Date of Response	Proposed Way of Managing Conflict
Paul Twomey	Medical Director (Joint)	NHS England - North (Yorkshire and the Humber)	29.4.15	The North Lincolnshire CCG is within the North Yorkshire's Area Team boundaries	29.4.15	Many thanks for your email dated 29th April declaring a conflict of interest in relation to the work referred to us from North Lincolnshire CCG relating to the model of care for their dermatology service. Your conflict arises because you are the NHS England - North Medical Director responsible for assuring this work. To manage this conflict of interest we need to ensure that you do not take part in any Council or sub group discussions as they relate to this matter.

Appendix 3

TERMS OF REFERENCE

Template to request advice from the Yorkshire and the Humber Clinical Senate

Name of the lead (sponsoring) body requesting advice: North Lincolnshire Clinical Commissioning Group

Type of organisation: Commissioning

Name of main contact: Jane Ellerton

Designation: Snr Manager, Commissioning

Email: jane.ellerton@nhs.net **Tel:** 01652 251075 **Date of request: 22/04/15**

Please note other organisations requesting this advice (if more than the lead body noted above):

NL CCG is requesting this advice to inform discussions with current service providers

Is the Senate being consulted for advice or as part of the formal assurance process?

Advice

Please state as clearly as possible what advice you are requesting from the Clinical Senate and what documentation you propose sharing with the Senate.

NL CCG is seeking advice on the appropriateness of a dermatology model of care, which provides the majority of care within a community setting. The majority of dermatology care does not require a hospital setting, however there are elements of care that may require interventions within a hospital setting, such as some surgical procedures.

The Senate are asked to consider whether the service detailed within the specification will provide a clinically safe model of care particularly considering the skin cancer pathway and how the MDT is delivered.

NL PCT originally commissioned a community based dermatology service in 2011 through procurement, which included 2 week wait referrals for suspected cancer. At that time, the Yorkshire and Humber Coast Cancer Network signed off the pathways as compliant with Improving Outcomes Guidance.

The CCG is now reviewing the service specification and given that the Y&HCCN no longer exists, is seeking external clinically independent advice from the Senate that the model is still clinically appropriate. Attached is the NL CCG draft revised service specification

Please state your rationale for requesting the advice? (What is the issue, what is its scope, what will it address, how important is it, what is the breadth of interest in it?).

Whilst the Y&HCCN signed off the pathways for 2 week wait referrals through the community dermatology service, this needs review to ensure the revised draft service specification is fit for purpose and compliant with IOG. In addition, there have been some concerns raised by clinicians within the both provider services regarding MDT arrangements. It should be noted that some of these clinicians work in both provider services.

What is the purpose of the advice? (How will the advice be used and by whom, how may it impact on individuals, NHS/other bodies etc.?).

Advice will inform the commissioning intentions and the revision of the service specification, along with production of a service specification in relation to the services remaining to be provided by the acute Trust in a hospital setting.

Please provide a brief explanation of the current position in respect of this issue(s) (include background, key people already involved).

NL PCT originally commissioned a community based dermatology service in 2011. The aim of this specification was to deliver a full dermatology service within the community rather than hospital setting, recognising that there is a small cohort of patients who would need treatment within an acute setting such as patients requiring complex surgery or general anaesthetic. This specification included management of 2 week wait referrals for suspected cancer, supported by a skin cancer MDT. At that time, the Yorkshire and Humber Coast Cancer Network signed off the pathways as compliant with Improving Outcomes Guidance.

The current provider has an interface with the acute Trust, Northern Lincolnshire and Goole NHS Foundation Trust, for those patients requiring surgery in an acute setting. There are a number of elements of service that providers are currently doing and both providers and the CCG have agreed to work together to review the service specification, with the expectation that each provider then delivers their element of the service specification. At present, patients are referred from one provider to another unnecessarily.

The draft service specification is at odds with advice provided to the acute Trust Dermatologists from British Association of Dermatologists in relation to 2 week wait referrals?

When is the advice required by? Please note any critical dates.

Review of service specification and advice regarding community service providing 2 week wait pathway.

Proposed timescale for response- 4 weeks

Has any advice already been given about this issue? If so please state the advice received, from whom, what happened as a consequence and why further advice is being sought?

Y&HCCN originally signed off the 2 week wait pathways in 2012, after which the community provider started to accept 2 week wait referrals, managed in line with IOG guidance including discussion at skin cancer MDT.

This is at odds with advice provided to NLAG Dermatologists. BAD has advised NLaG of its view regarding 2 week waits on the basis that "*delivery of a two week wait pathway, which as a direct pathway of care (no choice to patients) should not be included in community based services. As the Trust is the approved network provider for the LMSDT/SSMDT, all GP referrals must continue to be referred to the locality sites*".

Is the issue on which you are seeking advice subject to any other advisory or scrutiny processes? If yes please outline what this involves and where this request for advice from the Clinical Senate fits into that process (*state N/A if not applicable*)

No.

The Senate report will be shared with CCG as part of the development and approval of the final specification

Please note any other information that you feel would be helpful to the Clinical Senate in considering this request.

Please send the completed template to: joanne.poole1@nhs.net. *For enquiries contact Joanne Poole, Yorkshire and the Humber Clinical Senate Manager at the above email or 01138253397 or 07900715369*

Version 2.0 April 2014

Appendix 4

BACKGROUND INFORMATION

The evidence received for this review is listed below:

- Service Specification Version 6 24/06/14 (2)
- The 2week wait pathway
- Basal Cell Carcinoma pathway
- Melanoma pathway
- Melanoma follow up pathway
- Squamous Cell Carcinoma pathway
- Squamous Cell Carcinoma follow up pathway
- Clinical Audit Strategy C – P5.9 February 2014
- Clinical Audit Policy C-PR-5.8 July 2013
- Clinical staff
- Peer Review of Clinical Practice C-Pr- 5.21 February 2014