A12/S/a

2013/14 NHS STANDARD CONTRACT
FOR SPECIALISED DERMATOLOGY SERVICES (ALL AGES)

PARTICULARS, SCHEDULE 2- THE SERVICES, A- SERVICE SPECIFICATIONS

Service Specification No.	A12/S/a
Service	Specialised Dermatology Services (All Ages)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Specialised adult and paediatric dermatology services are defined as dermatology services for patients that require complex investigation, diagnosis, management of rare and severe diseases that are not suitable for or not responding to conventional treatment. These cases usually require multi-disciplinary input with access to specialised dermatology facilities.

National Context: 0.8 million people per year are referred to secondary care dermatologists (4.57% of all hospital outpatient activity in 2006/7) (see ref below) and a proportion (probably 10%) of these require specialised dermatology services. A particular challenge in dermatology is the multiplicity of diagnoses. Delivery of specialised dermatology services requires dedicated multidisciplinary and multi-professional teams with great experience in diagnosing and managing patients with very rare and multisystem, complex needs who often require specialist laboratory-based testing, imaging, medical and surgical management.

Incidence rates per year per 100,000 population of the various disease groups listed in The NHS Commissioning Board (NHS CB) Manual of Specialised Services have been estimated by expert dermatologists in the absence of published data and are given below in Table 1. These figures reflect numbers of new referrals; these conditions are mostly chronic so patients require multiple episodes of care.

Table 1 : Conditions/ Diseases covered in this specification

Paragraph in SSNDS24	Specialised dermatology subspecialty	Incidence /10^5	Short title
1.0 4.14	Specialised paediatric dermatology including neonatal	50	Paed Derm
4.1	Severe or complex psoriasis	40	Psoriasis
4.1	Severe or complex eczema	40	Eczema
4.1	Severe or complex connective tissue disease	1	CTD
4.1	Severe or complex immunobullous disease	1	Immunobullous
4.1	Severe or complex autoimmune skin disease including urticarias/ mastocytosis	6	Autoimmune
4.2	Toxic Epidermal Necrolysis	0.1	TEN
4.2	Life threatening cutaneous vasculitis	0.4	Vasculitis
4.2	Severe pyoderma gangrenosum	0.6	PG
4.2	Severe Graft Versus Host Disease	0.3	GVHD
4.2	Severe Langerhans cell histiocytosis	0.1	LCH
4.4	Difficult genital dermatology: male (excluding cancer)	2	Male genital
4.4	Difficult genital dermatology: female (excluding cancer)	1.0	Female genital
4.6	Non-malignant lymphoedema	0.1	Lymphoedema
4.7	Hair disease that is difficult to diagnose or manage	10	Hair
4.7	Nail disease that is difficult to diagnose or manage	1	Nail
4.8	Rare or complex inherited skin disease (0.1)	0.1	RGSD
4.10	Photo-investigation and specialised photo-dermatology including porphyria	2.2	Photo
4.10	Complex occupational dermatoses and contact dermatoses	6	Contact dermatology
4.10	Psychodermatological disorder that is difficult to diagnose or manage	1	Psychoderm
4.10	Hidradenitis suppurative that is difficult to diagnose or manage	2	Hidradenitis
4.10	Stoma dermatoses that are difficult to diagnose or manage	1	Stoma dermatology
4.12	Laser treatment for birthmarks in children and for patients with rare or complex abnormalities	1.0	Laser

4.12	Complex vascular anomalies involving skin		Vascular anomalies
4.13	Specialised dermatopathology	1.0	Dermpath
4.15	Complex Ehlers Danlos (diagnostics only) currently highly specialised service	0.1	EDS
4.15	Epidermolysis bullosa currently highly specialised service	0.2	EB
4.15	Xeroderma pigmentosum service currently highly specialised service	0.1	XP

Total estimated new cases per year of specialised dermatology = 167/100,000 (total = approx 84,500)

This represents approximately 10% of all dermatology referrals.
In addition a significant proportion of dermatology inpatient activity is likely to be specialised: In 2006/7 there were 369,000 Finished Consultant Episodes (FCEs)relating to dermatology (ref below).

Evidence base

Skin conditions in the UK: a healthcare needs assessment. Schofield K, Grindley D & Williams H 2009 published by Centre of Evidence Based Dermatology, University of Nottingham, UK:
http://www.nottingham.ac.uk/scs/documents/documentsdivisions/documentsdermatology/ hcnaskinconditionsuk2009.pdf

2. Scope

2.1 Aims and objectives of service

The aim of the service is to reduce morbidity, mortality and reduce the consequences of rare and complex skin disorders by providing clear and efficient service pathways enabling patients to access appropriate expert, patient-centred diagnosis and management.

Objectives and Expected Outcomes

- To offer accurate and timely diagnosis: >90% of patients and referrers will have a correct diagnosis within 3 months of referral.
- To provide, where possible, accurate prognostic information to the referrer, patient and family: information will be given to patients within 3 months of first episode predicting likely course of disease over the first year in >90% of cases.
- To provide high quality and proactive treatment and care: specialised dermatology services will share expertise through regular case discussions between experts including overseas colleagues when appropriate.
- To provide symptomatic advice e.g. pain control: >90% of patients with inflammatory

dermatoses should achieve >10% improvement in dermatology disease-related quality of life score within 3 months of referral

- To monitor for and, where possible, to prevent complications of the disease, in particular, in cancer-prone conditions, minimising the interval between onset of symptoms and referral to cancer multidisciplinary team (MDT).
- To provide support, advice and guidance to the wider NHS to manage patients with conditions/ diseases listed in Table 1 including links to appropriate electronic information.
- To provide high quality information for patients, families and carers in appropriate and accessible formats including copies of clinic letters and/or access to a patient-held record.
- To develop the experience, knowledge and skills of the MDT to ensure high quality sustainable provision of the service: continuing professional development will be included in job-planning, and specific training posts developed.
- To provide support and guidance for local teams to manage the patients in their locality, with information being shared within 2 weeks of episode of specialised dermatology activity.

In addition to these generic standards there will be specific quality standards relating to individual subspecialty areas.

2.2 Service description/care pathway

General Principles

Specialised dermatology services include the diagnosis and treatment of rare diseases and the management of severe diseases not suitable for, or not responding to, conventional treatment available in local dermatology departments.

Specialised Services National Definition Set 24 defined numerous different subspecialty areas of specialised dermatology, listed in Table 1, each with their own set of dermatological conditions. Each subspecialty defined in Table 1, will have a network of expert providers based in designated centres. Centres may host more than one subspecialty. In order to be designated for a particular subspecialty, Centres must have a record of receiving tertiary referrals and must have provision for the delivery of and interdependencies required for that subspecialty. Each subspecialty network will share the organisation of high cost interventions, drug monitoring, audit, clinical trials, research, teaching and training. Further details of the care pathways for the individual subspecialties are given in the attached appendices.

The NHS England Manual of Specialised services also includes, under specialised dermatology, cancer and Infections (including HIV). These are not specifically covered in this specification. However, there must be close links with these areas reflecting the importance of clinical collaboration across specialties in managing patients with cancer or infections such as HIV involving the skin.

The Specialised Dermatology multidisciplinary teams will be the leaders in the NHS for

patient care in this area. They will provide a direct source of advice and support when other clinicians refer patients into the specialised service. This support will continue until the patient no longer suffers from one of the agreed list of rare dermatology diseases/conditions.

The Specialised Dermatology multidisciplinary teams will also provide education within the NHS to raise and maintain awareness of dermatology disease and their management.

The Specialised Dermatology multidisciplinary teams will form a relationship with local health and social care providers to help optimise any care for dermatology disease provided locally for the patient. This may include liaison with consultants, GPs, community nurses, social workers etc.

Paediatric considerations

Children with a dermatological condition covered by table 1, should be referred initially to a regional specialised paediatric dermatology service. If necessary the paediatric dermatologist will then consult a dermatology specialist with expertise in the relevant dermatological subspecialty. Some dermatologists with expertise in a particular dermatological subspecialty manage adults and children, the latter in an appropriate specialised paediatric setting. The generic Specialised Paediatrics service specification will apply to patients up to the age of 19 years referred to the specialised dermatology service. Thus, subspecialists dealing with children should have paediatric dermatology skills and access to age-appropriate MDT members and infrastructure. Otherwise they will share management with their nearest specialised paediatric dermatologist. Specialised paediatric dermatology services will also receive referrals of any child whom a general dermatologist or paediatrician has been unable to diagnose or manage because the condition is atypical, severe, or complicated by other paediatric, medical or social factors.

Transition from paediatric to adult services will be managed in accordance with the National Service Framework for Children (ref below). Transition in dermatology is often facilitated by the fact that many dermatologists manage both paediatric and adult patients.

Specialised dermatology services for children will comply with Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services: Core Standards*. London: The Stationery Office. Gateway reference 3799
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089099

General Paediatric care

When treating children, the Service will additionally follow the standards and criteria outlined in the Specification for Children's Services (attached as Annex 1 to this Specification)

Care pathway

Referral pathway

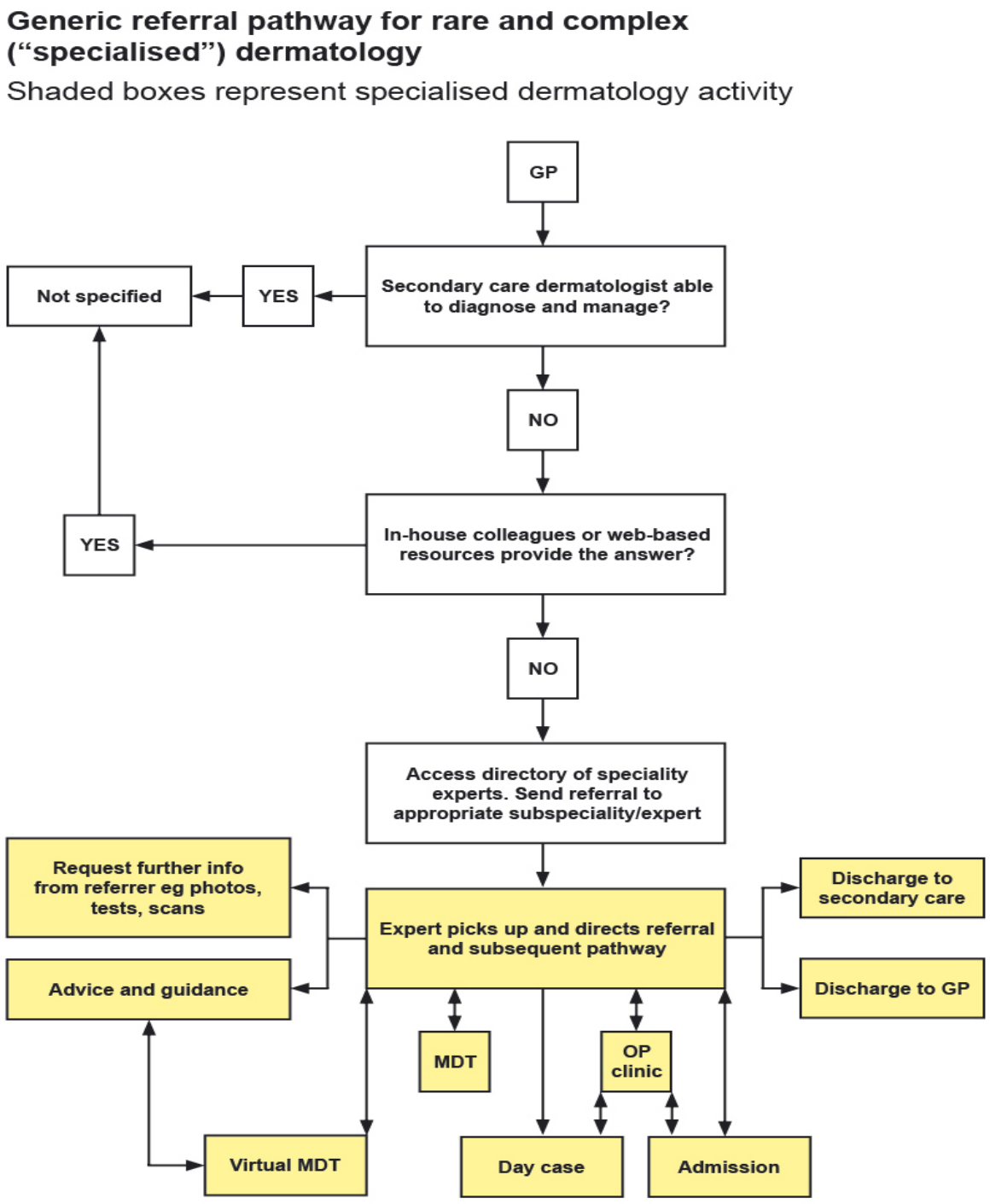

Figure 1.

Generic Referral Pathway for Specialised Dermatology Services (all ages)
Shaded boxes indicate specialised activity

A directory of specialised dermatology services will be available for referrers with links to information including patient support groups. Referrers will select a geographically appropriate disease expert, and in the case of children may alternatively select a geographically appropriate specialised paediatric dermatologist who will liaise with the relevant disease-specific expert. Tele-dermatology referral may avert the need for a face to face consultation.

Patients will be referred to the specialised dermatology service only by secondary care consultants, usually dermatologists, for children, consultant paediatrician referrals will be accepted. For each area of specialised dermatology there are specific referral criteria but the general overarching referral criterion is: *diagnostic uncertainty or management difficulty remaining after consulting colleagues within the same trust.*

Discharge criteria

Patients will be discharged back to the secondary care dermatologist or GP if one or more of the following pertains:

- A definitive diagnosis has been made and a care plan established that can be delivered in secondary or primary care. In these circumstances the service will liaise with local services to provide advice on management and transfer of clinical information
- Patient requests transfer to another care provider.
- Competent adult patient chooses to disengage with the service
- Repeated non-attendance at more than two consecutive clinic appointments. NB For repeated non attendance by paediatric patients, providers will instigate the local safeguarding policy to ensure patients are receiving support and care as appropriate. Clinical teams will work with the GP and/or health visitor to ascertain whether non-attendance is indicative of a child protection issue such as non-compliance by a parent/guardian. Paediatric patients will only be discharged when there is a clear indication that care is no longer required, or is being given elsewhere and discussions have been completed with parents/ legal guardians and the patient's GP

Before discharge, pathways for re-access will be communicated clearly to the patient and local care providers (see below).

Re-referral pathway

Rare and complex dermatological conditions are often chronic and may remit and relapse. For some conditions complications arise at a later stage. Once a management plan has been established, relapses and late complications can often be dealt with in primary or secondary care. If re-referral to the specialised dermatology service is required it should normally follow the same route, and meet the same criteria as the original referral.

However, patient groups remind us of their need to be able to access care promptly when a condition recurs which they know from experience cannot be dealt with adequately in primary or secondary care. Therefore the possibility should exist for the patient to contact directly a member of the MDT, who, depending on urgency, will either advise the patient to seek re-referral from the GP, or will inform the GP and arrange an appropriate appointment with the specialised service.

Diagnosis and Management

See Appendix 2 Specialised dermatology: Subspecialty summary details

The service is commissioned to provide:

- Assessment, diagnosis and management of children, adolescent and adults with all forms of dermatology disorders in Table 1
- Emergency and elective care
- Close working relationship with paediatric services
- Close working relationship with designated site specific cancer services
- Close working relationship with level 3 dermatology services to ensure as much care as possible is delivered closer to home
- Provision of dedicated adolescent transfer service to adult care
- Longer term joint follow up and liaison with local services for life-long dermatological conditions

The generic care pathway for patients meeting the referral criteria for any individual subspecialty area of specialised dermatology involves some or all of the following steps, with both patient and referrer receiving a written summary with relevant diagnosis, prognosis and management advice at each stage:

- Initial (virtual) assessment by expert dermatologist of history and previous investigations/clinical photographs if available
- Virtual MDT if necessary to plan further actions
- Outpatient, inpatient, day case or tele-dermatological assessment by relevant members of the specialised MDT
- Further investigations as required, carried out in patient's own locality if appropriate
- Review (can be virtual) of clinical findings and investigations, and formulation of a management plan
- Case review with expert peers
- Discussion of plan with referrer/patient, face to face or by telephone
- Further outpatient, inpatient or tele-dermatological activity as required for longer term specialised management and monitoring
- Discharge back to secondary care or GP when a definitive diagnosis has been made and/or a management plan agreed that can be delivered in secondary or primary care
- Re-referral to the specialised service if necessary

The main diagnostic and monitoring methods include

- clinical examination by an expert experienced in the particular rare dermatological disease
- clinical photography for tele-dermatological consultation and MDT discussion

- skin biopsy and histological examination

Additional diagnostic and monitoring methods include

- biochemical testing including e.g. drug levels
- microbiological sampling and culture
- haematological examination e.g. for drug toxicity
- genetic testing of blood and skin cells
- Radiological imaging for associated abnormalities in syndromes presenting dermatologically
- Other investigations specific to subspecialty areas e.g. photo-testing, immune-histochemistry

Treatments offered to patients of all ages may include

- topical therapy
- systemic medicine
- phototherapy
- surgical excision/grafting
- laser treatment
- cryotherapy
- interventional radiology
- Photodynamic therapy

Specialised teams will provide specific and general advice including education about the condition and any associated conditions. Patients will be sign-posted appropriately to other resources in particular patient support groups and social care resources.

Most patients will be diagnosed and assessed in an outpatient setting and where appropriate in an inpatient (ward or day unit based), with carefully monitored shared care arrangements in place with referring clinicians. Inpatient stay may be the most appropriate setting for emergency assessment and initiation of treatment /infusions in some patients with severe inflammatory/CTD/ immunobullous disorders and in patients with Toxic Epidermal Necrolysis (TEN). Dermatologists may use telemedicine, e.g. to examine clinical or histological photographs or radiological images in order to make a diagnosis, to advise referring doctors on management and to discuss cases with peers.

Specialist MDTs

Membership of the Dermatology Specialised Service MDT will vary according to the particular condition and will be flexible depending on the needs of the individual patient. All MDT members will have experience in managing patients with dermatology conditions or complex diseases. There will be both adult and paediatric MDTs, with some members (including the dermatologist) common to both. Meetings of MDTs may be face-to-face or virtual, with the patient or with other team members.

See Appendix 1A: Specialised Dermatology Service Specialist Multidisciplinary Team members

2.3 Population covered

The service outlined in this specification is for patients with conditions included in table 1, ordinarily resident in England*; or otherwise the commissioning responsibility of the NHS in England (as defined in *Who Pays?: Establishing the responsible commissioner* and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

- Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

2.4 Any acceptance and exclusion criteria

Acceptance Criteria

The over-arching generic referral criterion, covering both adult and paediatric specialised dermatology services is as follows.

- The condition is covered by the list in Table 1
- The referral is from a secondary care consultant, usually a dermatologists
- There remains diagnostic uncertainty or management difficulty even after consulting colleagues within the same trust.

In addition, for each area of specialised dermatology there are specific referral criteria. See Appendix 2 Specialised dermatology: Subspecialty summary details.

The service will be accessible to all patients with a suspected specialised dermatology condition regardless of age, race, or gender**.** Providers will require staff to attend mandatory training on equality and diversity and the facilities provided will offer appropriate disabled access for patients, family and carers. When required the providers will use translators and printed information available in other languages.

The provider will co-operate with the commissioner in undertaking Equality Impact Assessments as a requirement of race, gender, sexual orientation, and religion and disability equality legislation.

To ensure equity of access, wherever possible, access to the service will be according to common routes, policies and criteria that do not disadvantage any relevant patient group. The means by which this is achieved will be made clear e.g.: common admission policy, etc.

Exclusion Criteria

Referrals of patients without a diagnosis of one of the conditions listed or who can be managed in the local setting will be returned to the referrer. Patients cannot be referred to the specialised dermatology service until the referrer can demonstrate that the diagnosis remains unclear and/or all appropriate management options have been exhausted.

Infections including HIV, cancer services and palliative care are not included in this specification, because they are specified elsewhere. However, specialists in these areas are included in MDTs (see Appendix 1) reflecting the considerable overlap between these specialties and specialised dermatology. Patients of the specialised dermatology service who require these services will be referred accordingly. Also, patients with infections cancer or receiving palliative care can be referred to the specialised dermatology service if they otherwise fulfil the referral criteria.

2.5 Interdependencies with other services

Interdependencies and co-located services differ for the different subspecialties.

Core inter-dependencies including infrastructure needs that are required for every disease / condition are included in Appendix 1A and 1B: Specialised Dermatology Service Specialist Multidisciplinary Team members and infrastructure

3. Applicable Service Standards

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

The specialised dermatology (level 4) services will comply with the 8 standards defined in Quality standards for Dermatology, British Association of Dermatologists, 2011 (see link in Appendix 3). In particular:

Standard 1: Principles of dermatology care:

- specialised dermatology services will provide consistent, nationwide high-quality care that meets independent quality standards, such as those developed by NICE: (see outcome measures for individual subspecialties, section 2.2)
- Specialised dermatology services should have access to a range of supportive services that can help meet the holistic needs of people with skin conditions - these could include psychological support, access to medical social workers, camouflage services and occupational therapy.

Standard 2: Patient and public involvement:

- Evidence from providers of services managing skin conditions that they have developed and implemented an annual patient and public involvement plan, which includes use of patient recorded experience measures (PREMs) and patient recorded

outcome measures (PROMs), an effective patient panel, evidence of patient feedback and the provider's response to this.
- Evidence of public and patient involvement when changes to services are proposed.

Standard 3: Appropriately trained staff:

- Competence to deliver services: percentage of staff delivering dermatological services who have successfully completed competence-based training, according to their job role and scope of practice, and fulfilled relevant update requirements. (Standard 100%)

Standard 4: Clinical assessment and management:

- Adherence to current national and local guidelines.
- Patients will have access, appropriate to their needs, to all treatments approved by national agencies, e.g. NICE, carried out in a safe, competent and timely manner according to national and local standards.

Standard 5: Models of care and links to other services:

- Compliance with NICE guidance and, in its absence, with acknowledged best practice and/or local guidance.
- Evidence that a range of integrated services has been developed using consensus guidance.
- Adherence to the NHS Act 2006 and the NHS Constitution.

Standard 6 Diagnostic investigations

- Percentage of preliminary reports that are received by clinicians within seven working days of a specimen being taken (Standard 100%)

Standard 7 Clinical governance

- Audit all providers to undertake audit to review practice and inform the development of guidelines etc.
- Providers of services for people with skin conditions should be able to demonstrate:
    - a named identified clinical governance lead
    - Evidence of annual participation in local, regional and national audit programmes and completion of an annual audit plan with guidelines and protocols as appropriate.
    - evidence that healthcare professionals meet all the statutory requirements to practise, including any in respect of continuing professional development (for more detail see Standard 3)
    - documented evidence that facilities meet agreed national standards
    - Patient-recorded experience measures (PREMs), as described in Standard 2. (Standard: over 90% positive patient experience)

Standard 8 Information governance

- Service providers are registered with the Information Commissioner for data processing. (Standard: 100%)
- Service providers have an information governance policy in place to ensure legal and national guidelines are followed. (Standard 100%)

A comprehensive list of NICE and other guidelines and service standards for dermatological conditions is attached as Appendix 4 Specialised Dermatology Services Applicable Service Standards

4. Key Service Outcomes

The purposes and goals of the service are to offer comprehensive diagnostic investigations, monitoring and expert clinical opinion for the specialised dermatology conditions/ diseases listed in Table 1.

The desired high level outcomes of the service are: accurate, definitive diagnosis access to and therapy with the most effective treatments; avoidance of inappropriate therapies and reduction in treatment related morbidity and mortality; improved quality of life; improved survival.

All services will use the DLQI – Dermatology Quality of Life Index or the CDLQI – Children's Dermatology Quality of Life Index tool to capture outcome data at agreed points in the patient's pathway.

Additionally condition/disease specific outcomes will also be captured and reported.

5. Location of Provider Premises

The CRG has undertaken work to identify where in the country current specialised dermatology activity is being undertaken. However this is currently in draft form and has not been validated or tested against any commissioning criteria.

ANNEX 1 TO SERVICE SPECIFICATION:

PROVISION OF SERVICES TO CHILDREN

Aims and objectives of service

This specification annex applies to all children's services and outlines generic standards and outcomes that would fundamental to all services.

The generic aspects of care:

The Care of Children in Hospital (Health Service Circular (HSC) 1998/238) requires that:

- Children are admitted to hospital only if the care they require cannot be as well provided at home, in a day clinic or on a day basis in hospital.
- Children requiring admission to hospital are provided with a high standard of medical, nursing and therapeutic care to facilitate speedy recovery and minimize complications and mortality.
- Families with children have easy access to hospital facilities for children without needing to travel significantly further than to other similar amenities.
- Children are discharged from hospital as soon as socially and clinically appropriate and full support provided for subsequent home or day care.
- Good child health care is shared with parents/carers and they are closely involved in the care of their children at all times unless, exceptionally, this is not in the best interest of the child. Accommodation is provided for them to remain with their children overnight if they so wish.

Service description/care pathway

All paediatric specialised services have a component of primary, secondary, tertiary and even quaternary elements.

The efficient and effective delivery of services requires children to receive their care as close to home as possible dependent on the phase of their disease.

Services should therefore be organised and delivered through "integrated pathways of care" (*National Service Framework for children, young people and maternity services* (Department of Health & Department for Education and Skills, London 2004)

Interdependencies with other services

All services will comply with *Commissioning Safe and Sustainable Specialised Paediatric Services: A Framework of Critical Inter-Dependencies* – Department of Health (DH)

Imaging

All services will be supported by a 3 tier imaging network ('*Delivering quality imaging services for children*' DH 13732 March 2010). Within the network:

- It will be clearly defined which imaging test or interventional procedure can be performed and reported at each site
- Robust procedures will be in place for image transfer for review by a specialist radiologist, these will be supported by appropriate contractual
- and information governance arrangements
- Robust arrangements will be in place for patient transfer if more complex imaging or intervention is required
- Common standards, protocols and governance procedures will exist throughout the network.
- All radiologists, and radiographers will have appropriate training, supervision and access to continuing professional development (CPD)
- All equipment will be optimised for paediatric use and use specific paediatric software

Specialist Paediatric Anaesthesia

Wherever and whenever children undergo anaesthesia and surgery, their particular needs must be recognised and they should be managed in separate facilities, and looked after by staff with appropriate experience and training.[1] All UK anaesthetists undergo training which provides them with the competencies to care for older babies and children with relatively straightforward surgical conditions and without major co-morbidity. However those working in specialist centres must have undergone additional (specialist) training[2] and should maintain the competencies so acquired[3] *. These competencies include the care of very young/premature babies, the care of babies and children undergoing complex surgery and/or those with major/complex co-morbidity (including those already requiring intensive care support).

As well as providing an essential co-dependent service for surgery, specialist anaesthesia and sedation services may be required to facilitate radiological procedures and interventions (for example MRI scans and percutaneous nephrostomy) and medical interventions (for example joint injection and intrathecal chemotherapy), and for assistance with vascular access in babies and children with complex needs such as intravenous feeding.

Specialist acute pain services for babies and children are organised within existing departments of paediatric anaesthesia and include the provision of agreed (hospital wide) guidance for acute pain, the safe administration of complex analgesia regimes including epidural analgesia, and the daily input of specialist anaesthetists and acute pain nurses with expertise in paediatrics.

*The Safe and Sustainable reviews of paediatric cardiac and neuro-sciences in England have noted the need for additional training and maintenance of competencies

by specialist anaesthetists in both fields of practice.

References

1. Guidelines on the Provision of Anaesthetic Services (GPAS) Paediatric anaesthetic services. Royal College of Anaesthetists (RCoA) 2010 www.rcoa.ac.uk
2. Certificate of Completion of Training (CCT) in Anaesthesia 2010
3. CPD matrix level 3

Specialised Child and Adolescent Mental Health Services (CAMHS)
The age profile of children and young people admitted to specialised CAMHS day/in-patient settings is different to the age profile for paediatric units in that it is predominantly adolescents who are admitted to specialised CAMHS in-patient settings, including over-16s. The average length of stay is longer for admissions to mental health units. Children and young people in specialised CAMHS day/in-patient settings generally participate in a structured programme of education and therapeutic activities during their admission.

Taking account of the differences in patient profiles the principles and standards set out in this specification apply with modifications to the recommendations regarding the following

- Facilities and environment – essential Quality Network for In-patient CAMHS (QNIC) standards should apply (http://www.rcpsych.ac.uk/quality/quality,accreditationaudit/qnic1.aspx)
- Staffing profiles and training - essential QNIC standards should apply.
- The child/ young person's family are allowed to visit at any time of day taking account of the child / young persons need to participate in therapeutic activities and education as well as any safeguarding concerns.
- Children and young people are offered appropriate education from the point of admission.
- Parents/carers are involved in the child/young persons care except where this is not in the best interests of the child / young person and in the case of young people who have the capacity to make their own decisions is subject to their consent.
- Parents/carers who wish to stay overnight are provided with accessible accommodation unless there are safeguarding concerns or this is not in the best interests of the child/ young person.

Applicable national standards e.g. NICE, Royal College

Children and young people must receive care, treatment and support by staff registered by the Nursing and Midwifery Council on the parts of their register that permit a nurse to work with children (Outcome 14h *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010)

- There must be at least two Registered Children's Nurses (RCNs) on duty 24 hours a day in all hospital children's departments and wards.

- There must be an Registered Children's Nurse available 24 hours a day to advise on the nursing of children in other departments (this post is included in the staff establishment of 2RCNs in total).

Accommodation, facilities and staffing must be appropriate to the needs of children and separate from those provided for adults. All facilities for children and young people must comply with the Hospital Build Notes *HBN 23 Hospital Accommodation for Children and Young People* NHS Estates, The Stationary Office 2004.

All staff who work with children and young people must be appropriately trained to provide care, treatment and support for children, including Children's Workforce Development Council Induction standards (Outcome 14b *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010).

Each hospital who admits inpatients must have appropriate medical cover at all times taking account of guidance from relevant expert or professional bodies (National Minimum Standards for Providers of Independent Healthcare, Department of Health, London 2002)."Facing the Future" Standards, Royal College of Paediatrics and Child Health.

Staff must carry out sufficient levels of activity to maintain their competence in caring for children and young people, including in relation to specific anaesthetic and surgical procedures for children, taking account of guidance from relevant expert or professional bodies (Outcome 14g *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010).

Providers must have systems in place to gain and review consent from people who use services, and act on them (Outcome 2a *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010). These must include specific arrangements for seeking valid consent from children while respecting their human rights and confidentiality and ensure that where the person using the service lacks capacity, best interest meetings are held with people who know and understand the person using the service. Staff should be able to show that they know how to take appropriate consent from children, young people and those with learning disabilities (Outcome 2b) (*Seeking Consent: working with children* Department of Health, London 2001).

Children and young people must only receive a service from a provider who takes steps to prevent abuse and does not tolerate any abusive practice should it occur (Outcome 7 *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010 defines the standards and evidence required from providers in this regard). Providers minimise the risk and likelihood of abuse occurring by:

- Ensuring that staff and people who use services understand the aspects of the safeguarding processes that are relevant to them.
- Ensuring that staff understand the signs of abuse and raise this with the right person when those signs are noticed.
- Ensuring that people who use services are aware of how to raise concerns of abuse.

- Having effective means to monitor and review incidents, concerns and complaints that have the potential to become an abuse or safeguarding concern.
- Having effective means of receiving and acting upon feedback from people who use services and any other person.
- Taking action immediately to ensure that any abuse identified is stopped and suspected abuse is addressed by:
    - having clear procedures followed in practice, monitored and reviewed that take account of relevant legislation and guidance for the management of alleged abuse
    - separating the alleged abuser from the person who uses services and others who may be at risk or managing the risk by removing the opportunity for abuse to occur, where this is within the control of the provider
    - reporting the alleged abuse to the appropriate authority
    - reviewing the person's plan of care to ensure that they are properly supported following the alleged abuse incident.
- Using information from safeguarding concerns to identify non-compliance, or any risk of non-compliance, with the regulations and to decide what will be done to return to compliance.
- Working collaboratively with other services, teams, individuals and agencies in relation to all safeguarding matters and has safeguarding policies that link with local authority policies.
- Participates in local safeguarding children boards where required and understand their responsibilities and the responsibilities of others in line with the Children Act 2004.
- Having clear procedures followed in practice, monitored and reviewed in place about the use of restraint and safeguarding.
- Taking into account relevant guidance set out in the Care Quality Commission's Schedule of Applicable Publications
- Ensuring that those working with children must wait for a full CRB disclosure before starting work.
- Training and supervising staff in safeguarding to ensure they can demonstrate the competences listed in Outcome 7E of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010

All children and young people who use services must be

- Fully informed of their care, treatment and support.
- Able to take part in decision making to the fullest extent that is possible.
- Asked if they agree for their parents or guardians to be involved in decisions they need to make.

(Outcome 4I *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010)

Key Service Outcomes

Evidence is increasing that implementation of the national *Quality Criteria for Young People Friendly Services* (Department of Health, London 2011) have the potential to greatly improve patient experience, leading to better health outcomes for young people

and increasing socially responsible life-long use of the NHS. Implementation is also expected to contribute to improvements in health inequalities and public health outcomes e.g. reduced teenage pregnancy and STIs, and increased smoking cessation. All providers delivering services to young people should be implementing the good practice guidance which delivers compliance with the quality criteria

Poorly planned transition from young people's to adult-oriented health services can be associated with increased risk of non adherence to treatment and loss to follow-up, which can have serious consequences. There are measurable adverse consequences in terms of morbidity and mortality as well as in social and educational outcomes. When children and young people who use paediatric services are moving to access adult services (for example, during transition for those with long term conditions), these should be organised so that:

- All those involved in the care, treatment and support cooperate with the planning and provision to ensure that the services provided continue to be appropriate to the age and needs of the person who uses services.

The *National Minimum Standards for Providers of Independent Healthcare*, (Department of Health, London 2002) require the following standards:

- **A16.1** Children are seen in a separate out-patient area, or where the hospital does not have a separate outpatient area for children, they are seen promptly.
- **A16.3** Toys and/or books suitable to the child's age are provided.
- **A16.8** There are segregated areas for the reception of children and adolescents into theatre and for recovery, to screen the children and adolescents from adult Patients; the segregated areas contain all necessary equipment for the care of children.
- **A16.9** A parent is to be actively encouraged to stay at all times, with accommodation made available for the adult in the child's room or close by.
- **A16.10** The child's family is allowed to visit him/her at any time of the day, except where safeguarding procedures do not allow this
- **A16.13** When a child is in hospital for more than five days, play is managed and supervised by a qualified Hospital Play Specialist.
- **A16.14** Children are required to receive education when in hospital for more than five days; the Local Education Authority has an obligation to meet this need and are contacted if necessary.
- **A18.10** There are written procedures for the assessment of pain in children and the provision of appropriate control.

All hospital settings should meet the *Standards for the Care of Critically Ill Children* (Paediatric Intensive Care Society, London 2010).

There should be age specific arrangements for meeting Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These require:

- A choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs;
- Food and hydration that meet any reasonable requirements arising from a service user's religious or cultural background

- Support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.
- For the purposes of this regulation, “food and hydration” includes, where applicable, parenteral nutrition and the administration of dietary supplements where prescribed.
- Providers must have access to facilities for infant feeding, including facilities to support breastfeeding (Outcome 5E, of the Essential Standards of Quality and Safety, Care Quality Commission, London 2010).

All paediatric patients should have access to appropriately trained paediatric trained dieticians, physiotherapists, occupational therapists, speech and language therapy, psychology, social work and CAMHS services within nationally defined access standards.

All children and young people should have access to a professional who can undertake an assessment using the Common Assessment Framework and access support from social care, housing, education and other agencies as appropriate

All registered providers must ensure safe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines (Outcome 9 *Essential Standards of Quality and Safety*, Care Quality Commission, London 2010). For children, these should include specific arrangements that:

- Ensures the medicines given are appropriate and person-centred by taking account of their age, weight and any learning disability
- ensuring that staff handling medicines have the competency and skills needed for children and young people’s medicines management
- Ensures that wherever possible, age specific information is available for people about the medicines they are taking, including the risks, including information about the use of unlicensed medicine in paediatrics.

Many children with long term illnesses have a learning or physical disability. Providers should ensure that:

- They are supported to have a health action plan
- Facilities meet the appropriate requirements of the Disability Discrimination Act 1995
- They meet the standards set out in Transition: getting it right for young people.Improving the transition of young people with long-term conditions from children's to adult health services. Department of Health, 2006, London

Appendices

Appendix 1a: Specialised Dermatology Service Specialist Multidisciplinary Team Members

Appendix 1b: Specialised Dermatology Service Specialist Infrastructure

Appendix 2: Specialised Dermatology: Subspecialty Summary Details

Appendix 3:
http://www.bad.org.uk/Portals/_Bad/Quality%20Standards/Dermatology%20standards%20FINAL%20-%20July%2011.pdf

Appendix 4: Specialised Dermatology Services Applicable Service Standards

Appendix 1A

Specialised dermatology services: co-dependencies and MDT members (See table 1 for abbreviations)

X (bold) indicates disciplines required to deliver core elements of the service; X indicates extended MDT members.

*Service highly specialised

Not necessarily co-located

For patients under 19 years, health professionals should have appropriate paediatric expertise (see Annex 1 Generic Service Specification for children)

The following co-dependent services are assumed: general medicine/paediatrics, general surgery, junior medical staff, radiology, routine labs (chemistry, haematology, histopathology), pharmacy, social work

	* Adult EB	* Paed EB	* XP	*EDS	Paediatric dermatol	Psoriasis	Eczema	Connective Tissue Dis	Autoimmune	Immunobullous	TEN	Vasculitis	PG	GvHD	LCH	Female genital	male genital	Lymphoedema	hair	nail	RGSD	photoderm	Laser	vascular anomalies	Dermpath	Contact derm	Psychoderm	Hidradenitis	Stoma derm
Allergy					X		**X**		**X**		**X**					X						X				X			X
BMT specialist					X									**X**															
Burns specialist					X						**X**																		
Cancer services	**X**	X	**X**		X										X	X	X				X	X							
Cardiology	X	X		X	X																X			X					
Clinical genetics#	**X**	**X**	X	**X**	X		X											X	X	X	**X**	**X**		X					
Clinical immunology					X		**X**	**X**	**X**	X		X									X	X				X			
Dental/Oral medicine	**X**	**X**			X			X		**X**	**X**					X					X								
Dermatological surgeon	X	X	**X**		X															**X**									
Dermatologist	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Dermatology CNS	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**		**X**	**X**	**X**	**X**

Dermatopathologist#	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X			**X**				**X**
Dietician	**X**	**X**			**X**		**X**		X	X	**X**										X							X	X
Drug monitoring #					X	X	X	X	**X**	X	X	X	X	X	**X**							**X**							**X**	**X**
Endocrinology	X	X	X		X										X	X					X								
ENT	X	X	X		X		X			X	X	X	**X**					X			X		X	X					
Gastroenterology	**X**	**X**		X	X		**X**	X			**X**	**X**	**X**	X			X	X			X			X				**X**	X
Genetic testing #	**X**	**X**	**X**	**X**	X													**X**	X	X	**X**	X		**X**					
GUM																**X**	**X**												
Gynaecology	**X**				X					X	X				**X**														
Haematology	X	X			X			X	X			X	**X**	**X**	X									X					
HIV services					X						X					X	X												
ICU		X			X						**X**	X																	
Infectious diseases					X				X			**X**																**X**	
Labs, specialised #	**X**	**X**	**X**	**X**	X					**X**															X				
Medical photography	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X
Medical physics			**X**			X							**X**									**X**	**X**	X					
Nephrology	X	X			X	**X**		**X**			**X**																		
Neurology/neurophysiology			**X**		X			X						X							**X**								
Occupational therapy/orthotics	X	X	X	X	X												X				X			X					
Occupational physician																										**X**			
Ophthalmology	**X**	**X**	**X**	**X**	X	X	**X**		**X**	**X**			X		X						**X**	**X**		X					
Pain team	**X**	**X**			X		X		X	**X**	X	**X**	X		**X**	X					X			X				X	
Physiotherapy	**X**	**X**		**X**	X			X						**X**		X		**X**			**X**			**X**					
Specialised plastic surgeon	**X**	**X**	**X**		X											X	X	**X**		**X**				**X**				**X**	
Play worker for children		**X**	X		**X**	X	X	X		X	X	X		X					X	X	X	X	X	X					
Psychiatry																											**X**		
Psychology	**X**	**X**	**X**	X	X	**X**	**X**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	**X**	X	X

Psycho-sexual specialist																**X**	**X**											**X**	X
Radiology specialised	X	X			X			X										**X**			**X**			**X**				**X**	
Respiratory					X		**X**	**X**			X	X																	
Rheumatologist					X	**X**		**X**				**X**	X	X														**X**	
SALT	X	X			X					X	X																		
Stoma nurse specialist																													**X**
Surgery, colorectal																												**X**	X
Urology	X	X			X					X	X					X	X	X										X	
Vascular surgery				X	X													X						**X**					

Appendix 1B: Specialised Dermatology Service: Infrastructure required (See table 1 for abbreviations)

*Service currently highly specialised

For patients under 19 years, infrastructure should be appropriate for children (see Annex 1 Generic Service Specification for children)

	* Adult EB	* Paed EB	* XP	*EDS	Paediatric	Psoraiais	Ezczema	CTD	Autoimmune	Immunobullous	TEN	Vasculitis	PG	GvHD	LCH	Female genital	male genital	Lymphoedema	hair	nail	RGSD	photoderm	Laser	vascular anomalies	Dermpath	Contact derm	Psycho derm	Hidradenitis	Stoma derm
Accomodation*																													
Dermatology Inpatient beds	√	√			√	√	√	√		√	√	√	√	√								√						√	
Day treatment facility	√	√	√	√	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√	√	√	√	√		√**	√	√	√
Infusion suite						√	√	√	√	√		√	√	√								√						√	
Dermatology surgical theatres	√	√	√	√	√	√	√	√	√	√		√	√	√	√	√	√		√	√	√	√	√	√				√	√
Fluorescent lamps																						√							
Phototherapy																													
Phototherapy machines /						√	√															√				√			√
Phototesting																													
Monochromator																						√							
Solar simulator																						√							
Lasers																													
Pulse dye laser					√																		√	√					
CO2 laser																							√	√					
NDYAG - LP																							√	√					

IPL																							√	√					
Smoke evacuator/ozone extractor																						√	√	√					
QSWITCH NDYAG																							√						
Alexandrite																							√						
Other																													
Surgical appliances dept	√	√																	√										√
Cold immersion facilities									√																				
Bicycle ergometer									√																				
Fibroscanner						√																							
IMF laboratory	√	√						√		√		√													√				
Electron microscope	√	√		√																√									
Specialised patch testing**							√														√				√**			√
Genetic testing	√	√	√	√															√		√								

*Facilities must be available for resuscitation in the event of an anaphylactic reaction and staff suitably trained to manage any event.

** to include storage space (including fridges and freezer) for allergens and access to a suitably equipped pharmacy (with fume cupboard) to prepare and dilute drugs and extemporaneous allergens from the work place

Appendix 2: **Service specification for specialised dermatology: Subspecialty summary details**

Subspecialty	Referral criteria	Investigations and management provided	Types of episode (all can involve MDT) • teledermatology • OP • day case • inpatient stay
All/Joint (minimum)	1. The condition is covered by The Manual of Specialised Services. 2. The referral is from a secondary care consultant, usually a dermatologists 3. There remains diagnostic uncertainty and/or management difficulty even after consulting colleagues within the same trust, recognizing additional needs in children (Annex 1).	1. Expert assessment by specialised dermatologist (virtual or Face to Face). 2. Provision of management plan 3. Liaison with secondary care dermatology Also, establishment/ Maintenance of • provider directory • patient register • virtual discussion network	Assessment of electronic referral by specialised dermatologist.
Paediatric dermatology	Children with skin conditions 1. needing MDT input 2. meeting the referral criteria for any other specialized dermatology subspecialty 3. requiring systemic therapy	Paediatric MDT input Tests and interventions determined by subspecialty expert teams.	Mostly outpatient visits Day case and Inpatient admissions for MDT assessment and management planning

Severe psoriasis	Patients with psoriasis which 1. has not responded to licensed oral therapies or NICE approved biological therapy including: • Severe or very severe* plaque psoriasis • Localised forms of psoriasis (eg: palmoplantar pustulosis, acrodermatitis of hallopeau; nail disease) associated with significant functional impairment and/or major impact on patients well being (i.e. DLQI>10) 2. Is life-threatening (generalised pustular psoriasis; erythroderma; unstable psoriasis) 3. requires MDT input including • Psoriasis with psoriatic arthritis where no local combined rheumatology/dermatology clinic is available • Psoriasis with multimorbidity (ies) that complicate choice and / or use of second or third line therapy (for example, active infection, recent or current history of cancer, liver disease, renal disease, cardiovascular disease) • Psoriasis in people whose skin disease is associated with	Complex topical therapies including phototherapy Combination and high dose immunosuppressive therapy (oral/iv) Biologic therapy (intravenous infusion) MDT assessments and investigations (particularly rheumatology for associated arthritis)	Virtual MDT discussion of complex cases Mostly outpatient and daycase activity Inpatient/HDU/ITU care needed for unstable or life-threatening psoriasis

	psychological or psychiatric morbidity • Psoriasis in people whose past or current psoriasis treatments impact on management (for example, multiple skin cancers following psoralen and ultraviolet A (PUVA), irreversible ciclosporin- induced nephrotoxicity, hepatic fibrosis) *NICE criteria (PASI >10, DLQI>10 and PASI>20, DLQI >18 respectively) References: NICE commissioning algorithm		
Severe eczema	Patients with eczema which 1. Is SEVERE as indicated by: • Treatment resistant eczema *despite standard topical treatment*: severity scores such as oSCORAD >15 or POEM >10) or quality of life scores (such as DLQI >10) • Long-term treatment or unsatisfactory clinical response despite with prednisolone or azathioprine or cicosporin or methotrexate or mycophenolate mofetil. • Consideration of systemic treatment <16 yrs	Complex topical therapies including phototherapy Combination and high dose immunosuppressive therapy (oral/iv) Biologic therapy (immunomodulatory) MDT assessments and investigations (allergy, immunology/atopic disease affects skin, lungs, GI tract, nose, eyes) Immunological investigations Specialist patch/photo testing (will be undertaken if local testing is not available, or the appropriate panels of allergens are not available locally, or if specialist interpretation is required)	Mostly Virtual MDT assessment Outpatient visits Day case Patch/photo testing Brief admissions for disease assessment and management planning

	2. Needs expert dermatological advice because • Diagnosis uncertain • Abnormal results of screening investigations • Suspicion of allergic contact dermatitis (ACD) / difficult managing ACD • Growth affected by disease/treatments • Photosensitivity (suspected or proven) unresponsive to sun protection • Rare eczematous dermatological disease: Netherton's syndrome, Hyper IgE syndrome, Hypereosinophilic syndrome 3. Needs Specialist MDT: • Atopic disease specialists: multi-organ atopy (airway / nose / eye / GI) unresponsive to standard therapy; severe/complex IgE allergy (multiple sensitizations, desensitization planned) • Associated psychological disease • Suspicion/presence of immunological disease		

	(recurrent /severe infections, infections with unusual organisms, family history, HIV) • Other co-existent severe medical disease		
Connective Tissue Disease	Connective tissue disease involving the skin where 1. Diagnosis is known but significance of associated features uncertain. 2. Management is in place but needs realignment. 3. It is refractory to, or developing complications on, conventional therapies. 4. may rapidly cause permanent disability e.g. linear morphoea, which can produce severe joint contractures and hemifacial atrophy.	Skin biopsy Combination and high dose immunosuppressive therapy (oral/iv) Biologic therapy (intravenous infusion) MDT assessments and investigations (particularly rheumatology, immunology)	Mostly Virtual MDT assessment OP visits Day case Brief admissions for disease assessment and management planning [inpatients would normally be under care of rheumatologists]
Immuno-bullous disease	Patients with immunobullous disorders including 1. Pemphigus, pemphigoid or IgA disorder not responding adequately to immunosuppression as described in BAD guidelines 2. Chronic disease requiring > 10mg prednisolone daily together with adjuvant immunosuppression 3. Uncontrolled flares of disease that fails to respond to maximisation of therapy	Skin biopsy Central lab providing highly specialized histopathology (immuno-histochemistry and immune-electronmicroscopy) MDT assessments and investigations (particularly relating to mucosal involvement ie oral medicine, and genital dermatology) Combination and high dose immunosuppressive therapy (oral/iv) Biologic therapy (intravenous infusion) Extracorporeal	Most cases dealt with remotely (referring dermatologist sends clinical history, blood and skin biopsy for specialised immuno-histochemistry and clinicopathological correlation) Mostly Virtual MDT (Clinical assessment

		plasmapheresis (ECP)	Outpatient (OP) visits Day case Brief admissions for disease assessment and management planning
Autoimmune skin disease	Patients with 1. Urticaria unresponsive to conventional second-line agents 2. Severe and hereditary angio-oedema (HAE) 3. Severe mastocytosis with skin lesions 4. Vitiligo unresponsive to conventional second-line agents	Combination and high dose immunosuppressive therapy (oral/iv) Biologic therapy (iv infusion) C1Esterase inhibitor for HAE MDT assessments and investigations	Mostly OP
Toxic Epridermal Necrolysis (TEN)	All cases of suspectedToxic Epidermal Necrolysis characterized by Cutaneous pain, Purpuric macules/ atypical target lesions, Nikolsky sign positive, Blisters/incipient/actual epidermal detachment, Multisite mucositis	Intensive supportive therapy. Close liaison with plastics/burns/ ophthalmology /other. MDT members Investigation for underlying cause (drug, infection)	Initial (urgent) telederm assessment; Emergency transfer (usually helicopter) to regional centre All inpatient, usually requiring high-dependency or intensive care unit or Burns unit
Vasculitis	Cutaneous Vasculitis with serious complications of disease (haemorrhage, sepsis, necrosis) or therapy. [Vasculitis with significant involvement of other organs would be primarily under the	Combination and high dose, immunosuppressive therapy (oral/iv) Biologic therapy (intravenous infusion)	Mostly Virtual MDT assessment and advice OP visits Day case Brief admissions for

	care of the relevant organ specialty]	MDT assessments and investigations (especially rheumatology, immunology)	disease assessment and management planning
Pyoderma Gangrenosum	Pyoderma gangrenosum with 1. Uncertainty about underlying disease 2. significant life quality impairment (DLQI score Greater then 10) 3. lesions causing severe pain 4. large lesions (e.g. measurement>5cm). 5. failure to respond to potent topical steroids, prednisolone and cyclosporine.	Skin biopsy Combination and high dose immunosuppressive therapy (oral/iv) Biologic therapy (intravenous infusion) MDT assessments and investigations (for underlying cause, and management)	Mostly Virtual MDT assessment and advice OP visits Day case Brief admissions for disease assessment and management planning
Graft versus Host Disease (GvHD)	Cutaneous Graft versus Host Disease that is 1. Moderate or severe (1C) 2. Failing to respond to 1st line therapy 3. Requiring assessment for ECP (second line treatment for skin, oral or liver cGvHD (1B) 4. Requiring ECP [GvHD with significant involvement of other organs would be primarily under the care of the relevant Transplant team]	Skin biopsy Assessment for and delivery of Extracorporeal photopheresis (ECP) UVA1 Phototherapy	Mostly Virtual MDT assessment and advice OP visits Day case Brief admissions for disease assessment and management planning (usually under Transplant team)
Langerhans Cell Histiocytosis (LCH)	LCH involving the skin [LCH with significant involvement of other organs would be primarily under the care of an oncologist]	Skin biopsy Investigations for systemic involvement MDT assessment [chemotherapy usually delivered by oncology team)	Mostly Virtual MDT assessment and advice OP visits Day case Brief admissions for disease assessment and management planning (usually under

			oncologists)
Male genital skin disease	Severe male genital disease with persisting 1. concern about possible sexually transmitted disease 2. impaired sexual function 3. urological morbidity 4. risk of cancer	Skin biopsy Investigations for associated problems Treatment with topical/systemic agents or dermatological / urological surgery Occasional admission for IV antibiotics and surgery	Mostly OP, usually MDT Occasional IP admission
Female genital skin disease	Severe female genital disease including 1. Lichen planus • with multi-site involvement • erosive • vulvo-vagino-gingival syndrome 2. Lichen sclerosus with • resistance to conventional treatment • severe scarring complications • concern about vulval intra-epithelial neoplasia (VIN) 3. Pre-malignant disease including • Multifocal VIN, recurrent or in immunosuppressed • Extra-mammary Paget's disease 4. Vulvodynia unresponsive to conventional treatment 5. Vulval involvement with another SSNDS24 condition	Skin biopsy Investigations for associated problems Treatment with topical/systemic agents or surgery Combination and high dose immunosuppressive therapy (oral/iv) Biologic therapy (intravenous infusion)	virtual MDT assessment Mostly OP visits

Lymphoedema	Non-malignant, non-infective lymphoedema due to 1. genetic disorder 2. lymphatic malformation 3. other lymphatic disorder.	Lymphoscintigraphy MR lymphoscintigraphy Genetic testing Decongestive Lymphatic Therapy MDT discussion	Some virtual MDT assessment and advice Mostly OP and Day case
Hair disorder	Hair disease that is difficult to diagnose or manage including 1. cicatricial alopecias unresponsive to topical/intralesional steroid 2. genetic and acquired disorders of hair growth 3. extensive (multiple patches, totalis, universalis) alopecia areata suitable for contact immunotherapy {British Association of Dermatology guidelines} if not available within local dermatology services 4. progressive diffuse hair loss 5. associated with severe psychological morbidity	Hair microscopy and specialised scalp Histopathology Hair amino acid analysis Contact immunotherapy Biologic therapy	Most cases dealt with remotely (referring dermatologist sends clinical history and hair sample) Virtual MDT assessment and advice OP visits
Nail disorder	Nail disease impacting on Quality of Life and requiring 1. Biopsy (requires special techniques) 2. Surgical correction	Nail biopsy Histopathology Specialised surgery Biologic therapy	Mostly Virtual MDT assessment and advice OP visits
RGSD	Patients with 1. a clinical diagnosis of RGSD, who have no special needs at present, but who might benefit from future research and developments and from being included	MDT assessment Genetic testing Co-ordination of long-term multidisciplinary care	Mostly Virtual MDT assessment and advice Outreach nurse visits especially for neonates OP visits

	on a national diagnostic register. 2. with a clinical diagnosis of RGSD who require genetic testing 3. with a troublesome RGSD requiring specialist dermatological advice 4. with a complex RGSD requiring multidisciplinary management 5. with an unusual skin condition or birthmark thought to be genetic in origin but not yet diagnosed	Dermatological nursing management of severe conditions including ichthyoses Life-long access to information and support	Day case Brief admissions for disease assessment and management planning
Photo-dermatology	Patients with 1. suspected photosensitive dermatoses where the diagnosis is uncertain. 2. photosensitivity where management is failing, 3. photosensitivity where phototesting is required to establish a clear diagnosis, determine the severity, define the causative wavelengths of UV and visible radiation 4. photosensitive porphyrias	Complex phototesting Porphyrin testing (existing national service) Thalidomide, Immunosuppressive drugs, Biologics, Ivlg, α-MSH analogue/melanotropic peptide, Photodesensitisation Long term multidisciplinary management of cutaneous porphyria patients Bone-marrow transplantation for CEP would be under BMT service	Mostly Virtual MDT assessment and advice OP visits Day case Inpatient care needed for unstable disease
Laser	Children with any skin condition requiring laser including 1. port wine stain 2. other vascular and lymphatic malformations	MRI /MR angiography Laser treatment (range of different lasers needed) GA facilities for children and some adults	OP visits Day case

	3. other naevoid disorders e.g. epidermal and melanocytic naevi, 4. multiple skin tumours e.g. neurofibromata, trichoepitheliomata and angiofibromata. Adults requiring laser for a skin condition 1. requiring general anaesthesia 2. which is rare or complex and laser treatment is not available in local services including • multiple skin tumours such as neurofibromata, trichoepitheliomata and angiofibromata • some vascular/lymphatic malformations/ectasias • other disfiguring disorders eg rhinophyma and difficult keloid scars.		
Vascular anomalies	Vascular anomaly which 1. Is symptomatic, causing • Pain • Abnormal growth • Functional disability 2. Might be associated with additional abnormalities requiring further investigation	MDT assessment of scans and photographs Radiological intervention Plastic/vascular surgery MDT assessment	Mostly Virtual MDT assessment and advice OP visits Day case Short inpatient stays
Dermato-pathology	Any skin histopathological case in which a consensus diagnosis cannot be reached by the histopathologists at the lreferring hospital	Histopathology and expert MDT	Laboratory samples only Actual and virtual Clinico-pathological conference

			(CPCs)
EDS	Established Highly specialised service		
EB	Established Highly specialised service		
XP	Established Highly specialised service		
Contact dermatoses	Complex cutaneous allergy: 1. where the referring centre either • has tested but suspects a missed allergen • does not have relevant allergens available 2. occupational skin disease where there is exposure to allergenic industrial chemicals 3. systemic drug reactions potentially occurring through a type IV hypersensitivity mechanism	Prick and patch testing to relevant allergens	Mainly OP visits Occasional factory & site visits to investigate occupational dermatoses
Psychoderm	Patients with primary psychiatric disease (eg dermatitis artefacta, delusional infestation, and body dysmorphic disease) presenting to dermatologists; or patient s with primary dermatological disease in which there are serious psychosocial co-morbidities (such as patients with acne who are significantly depressed, anxious or considering suicide)	MDT assessment (dermatology, psychiatry, CAMHs, psychology, specialist nurse), and then treatment designed according to patient needs.	Mostly OPD treatment with appropriate management of the skin and the psychiatric disease. Referral to child protection or vulnerable adult services.
Hidradenitis	Patients with 1. Very severe hidradenitis suppurativa (Hurley Stage 3 disease) 2. Severe hidradenitis Suppurativa (Hurley Stage 2 disease) or complex acneiform eruptions with significant	Skin biopsy Complex wound care input Combination systemic and immunosuppressive therapy (oral) Biologic therapy (intravenous infusion)	Virtual MDT discussion of complex cases Mostly OP visit Day case IP admission for disease flare, assessment and

	impact on quality of life (e.g. DLQI>10) or failure to respond to standard therapies. 3. Need for specialised MDT input due to: • Complications (e.g. fistulating disease, severe genital lymphoedema requiring specialised radiology, colorectal surgery, urology) • Disease associations (e.g. Inflammatory arthropathy, inflammatory bowel disease requiring rheumatology, gastroenterology) • Complex disease requiring joint management (plastic surgery, microbiology) • Associated psychological disease	MDT assessment and investigations (especially rheumatology, specialised radiology, colorectal surgery, plastic surgery).	management planning+/- surgical intervention (latter under relevant surgical team)
Stoma derm	Intractable problems with skin around stoma including 1. Appliance failures; ↓DLQI 2. Allergy suspected to appliance etc 3. Irritant reactions 4. Other dermatoses 5. Related to underlying disease Crohn's including extraintestinal especially genitocrural & oral Vascular changes	Specialized patch testing Skin or bowel (stoma) Biopsy Surgical management (local skin) MDT review (stoma services, surgery, gastro) Investigations associated pathologies Treatment regimens Topical Systemic Phototherapy Biologics	Mostly outpatient Email/ teledermatology Day surgery visit Some elective infusions (biologics)

Appendix 3: Link to Quality standards for dermatology: providing the right care for people with skin conditions, British Association of Dermatologists, July 2011
http://www.bad.org.uk/Portals/_Bad/Quality%20Standards/Dermatology%20Standards%20FINAL%20-%20July%202011.pdf

Appendix 4 :Specialised Dermatology Services Applicable Service Standards

The following guidelines are applicable to one or more subspecialty areas of specialised dermatology

- The National Service Framework for long term conditions
- National service framework for older people: modern standards and service models
- National Service Framework for Children, Young People and Maternity Services: Maternity services

NICE clinical guidelines

- Self-harm (CG16)
- Pressure ulcer management (CG29)
- Acutely ill patients in hospital (CG50)
- Atopic eczema in children (CG57)
- Surgical site infection (CG74)
- Medicines adherence (CG76)
- Critical illness rehabilitation (CG83)
- When to suspect child maltreatment (CG89)
- Sedation in children and young people (CG112)
- Food allergy in children and young people (CG116)
- Patient experience in adult NHS services (CG138)

NICE public health guidance

- Behaviour change (PH6)
- Looked-after children and young people (PH28)
- Skin cancer prevention: information, resources and environmental changes (PH32)
- Prevention and control of healthcare-associated infections (PH36)

NICE technology appraisals

- TA024 Wound care - debriding agents (TA24) (replaced by CG74)
- TA081 Frequency of application of topical corticosteriods for eczema

- TA082 Pimecrolimus and tacrolimus for atopic dermatitis (eczema)

- TA103: Etanercept and efalizumab for the treatment of adults with psoriasis
- TA134: Infliximab for the treatment of adults with psoriasis
- TA146: Adalimumab for the treatment of adults with psoriasis
- TA177 Alitretinoin for the treatment of severe chronic hand eczema
- TA180: Ustekinumab for the treatment of adults with moderate to severe psoriasis

NICE interventional procedures guidance

- Photodynamic therapy for non-melanoma skin tumours (including premalignant and primary non-metastatic skin lesions) (IPG155)
- Liposuction for chronic lymphoedema (!PG251)

NICE quality standards

- Patient experience in adult NHS services

NICE commissioning algorithm

- Plaque psoriasis commissioning algorithm

British Association of Dermatologists clinical guidelines

The entire list of guidelines is available at http://www.bad.org.uk//site/622/default.aspx and relevant guidelines are pasted below:

ACITRETIN	British Association of Dermatologists' guidelines on the efficacy and use of acitretin in dermatology AD Ormerod, E Campalani and MJD Goodfield, BJD, Vol. 162, No.5, May 2010 (p952-963)
ACTINIC KERATOSES	Guidelines for the management of actinic keratoses D de Berker, JM McGregor and BR Hughes, BJD, Vol. 156, No. 2, February 2007 (p222-230)
ALOPECIA AREATA	British Association of Dermatologists' guidelines for the management of alopecia areata 2012 AG Messenger, J McKillop, P Farrant, AJ McDonagh and M Sladden, BJD, Vol. 166, No. 5, May 2012 (p916-926)
AZATHIOPRINE	British Association of Dermatologists' guidelines for the safe and effective prescribing of azathioprine

	2011 SJ Meggitt, AV Anstey, MF Mohd Mustapa, NJ Reynolds and S Wakelin, BJD Vol. 165, No. 4, October 2011 (p711-734)
BIOLOGIC INTERVENTIONS (PSORIASIS)	British Association of Dermatologists' guidelines for biologic interventions for psoriasis 2009 CH Smith, AV Anstey, JNWN Barker, AD Burden, RJG Chalmers, DA Chandler, AY Finlay, CEM Griffiths, K Jackson, NJ McHugh, KE McKenna, NJ Reynolds, AD Ormerod, BJD, Vol. 161, No. 5, November 2009 (p987-1019)
BOWEN'S DISEASE	Guidelines for management of Bowen's disease: update 2006 NH Cox, DJ Eedy, CA Morton, BJD, Vol. 151, No. 1, January 2007 (p11-21)
BULLOUS PEMPHIGOID	Guidelines for the management of bullous pemphigoid F Wojnarowska, G Kirtschig, AS Highet, VA Vening, NP Khumalo, BJD, Vol. 147, No. 2, August 2002 (p214-221)
CONTACT DERMATITIS	Guidelines for care of contact dermatitis J Bourke, I Coulson, J English, BJD, Vol. 160, No. 5, May 2009 (p946-954)
ISOTRETINOIN (ACNE)	Advice on the safe introduction and continued use of isotretinoin in acne in the UK 2010 MJD Goodfield, NH Cox, A Bowser, JC McMillan, LG Millard, NB Simpson, AD Ormerod, BJD, Vol. 162, No. 5, June 2010 (p1172-1179)
LICHEN SCLEROSUS	British Association of Dermatologists' guidelines for the management of lichen sclerosus 2010 SM Neill, FM Lewis, FM Tatnall, NH Cox, BJD, Vol. 163, No. 4, October 2010 (p672-682) Bunker CB. Comments on the British Association of Dermatologists guidelines for the management of lichen sclerosus. Br J Dermatol. 2011;164:892-4.
PEMPHIGUS VULGARIS	Guidelines for the management of pemphigus vulgaris KE Harman, S Albert and MM Black, BJD Vol. 149, No. 5, November 2003 (p926)
PHOTODYNAMIC THERAPY	Guidelines for topical photodynamic therapy: update CA Morton, KE McKenna, LE Rhodes, BJD, Vol. 159, No. 6, December 2008 (p1245-1266)
PHOTOTHERAPY	Guidelines for dosimetry and calibration in ultraviolet radiation therapy: a report of a British Photodermatology Group workshop DK Taylor, AV Anstey, AJ Coleman, BL Diffey, PM Farr, J Ferguson, S Ibbotson, K Langmack, JJ Lloyd, P McCann, CJ Martin, H du P Menage, H Moseley, G

	Murphy, SD Pye, LE Rhodes, S Rogers, BJD, Vol. 146, No. 5, May 2002 (p755-763)
PRIMARY CUTANEOUS T-CELL LYMPHOMAS	Guidelines for the management of primary cutaneous T-cell lymphomas SJ Whittaker, JR Marsden, M Spittle and R Russell Jones,) BJD, Vol. 149, July 2003 (p1095)
PSYCHODERMATOLOGY	British Association of Dermatologists' working party report on minimum standards for psychodermatology services 2012 http://www.bad.org.uk/Portals/_Bad/Clinical%20Services/Psychoderm%20Working%20Party%20Doc%20Final%20Dec%202012.pdf
TOPICAL PUVA	Guidelines for topical PUVA: a report of a workshop of the British Photodermatology Group SM Halpern, AV Anstey, RS Dawe, BL Diffey, PM Farr, J Ferguson, JLM Hawk, S Ibbotson, JM McGregor, GM Murphy, SE Thomas, LE Rhodes, BJD, Vol. 142, 2000 (p22-31)
URTICARIA (AND ANGIOEDEMA)	Guidelines for evaluation and management of urticaria in adults and children CEH Grattan and FY Humphreys, BJD, Vol. 157, December 2007 (p1116-1123)
VITILIGO	Guidelines for the management and diagnosis of vitiligo DJ Gawkrodger, AD Ormerod, L Shaw, I Mauri-Sole, ME Whitton, MJ Watts, AV Anstey, J Ingham and K Young, BJD, Vol. 159, No. 5, November 2008 (p1051-1076) Additional tables
OCCUPATIONAL CONTACT DERMATITIS	Diagnosis, management and prevention of occupational contact dermatitis: concise guidelines Royal College of Physicians, British Association of Dermatologists, British Occupational Health Research Foundation of Occupational Medicine, Health and Work Development Unit and NHS Plus. Concise guidance to good practice series, No 13. London RCP, April 2011
1.1 Primary Care Dermatological Society & British Association of Dermatologists – “Guidelines”	
ATOPIC ECZEMA	Guidelines for the management of topic eczema Summarised by Medendium PublishingGroup’s “Guidelines” (BAD and PCDS)
PSORIASIS	Recommendations for the initial management of psoriasis Summarised by Medendium Publishing Group's "Guidelines" (BAD and PCDS

1.2 British Society of Rheumatology & British Health Professionals in Rheumatolog	
DMARD	BSR & BHPR guideline for disease-modifying anti-rheumatic drug therapy (DMARD) in consultation with the British Association of Dermatologists
1.3 Royal College of Ophthamologists & British Association of Dermatologists	
HYDROXYCHLOROQUINE	Hydroxychloroquine and Ocular Toxicity Recommendations on Screening 2009
1.4 British Photodermatology Group	
PUVA	Eye protection for PUVA patients (1999)
ORAL LICHEN PLANUS	Guidelines for the management of oral lichen planus in secondary care (2010)
1.5 Clinical Knowledge Summaries - Topic Review	
VENOUS LEG ULCER	Venous leg ulcer - topic review
1.6 Royal College of Nursing - Clinical Guidelines	
VENOUS LEG ULCER	Venous leg ulcer: clinical guidelines
1.7 BNF-sponsored Summary Guidelines	
Alopecia Areata	Bullous Pemphigoid
Biological Interventions	Contact Dermatitis
Bowens Disease	Lymphoma
1.8 British Society for the Study of Vulval Disease	
VULVAL DISEASE	Standards of care for women with vulval conditions