SCHEDULE 2 – THE SERVICES

A. Service Specifications

<table>
<thead>
<tr>
<th>Service Specification No.</th>
<th>001</th>
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<tbody>
<tr>
<td>Service</td>
<td>Teledermoscopy Service</td>
</tr>
<tr>
<td>Commissioner Lead</td>
<td>Dr Nicholas Rayner and Dr Andrew Yager</td>
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<tr>
<td>Contracting Lead</td>
<td>Helen Abel, Lead for Service Delivery &amp; Contract Management</td>
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<td>Provider Lead</td>
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<tr>
<td>Period</td>
<td>1 year from commencement of contract</td>
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<tr>
<td>Date of Review</td>
<td>January 2015</td>
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1. Population Needs

1.1 Purpose
This document sets out the Service Specification for a Tele-health Dermatology Service for the West Suffolk Clinical Commissioning Group (WSCCG).

Teledermatology is emerging as a popular solution to the problem of diagnostic uncertainty of many skin lesions presenting in primary care.

This service will enable the referring clinician to send a message and images (photographs) to the Provider and receive a timely diagnosis and management plan for patients with a skin lesion of diagnostic uncertainty. This is also referred to as store & forward technology.

The use of store and forward technology allows GPs rapid access to a specialist opinion on diagnosis and management, thereby reducing unnecessary referrals to secondary care.

Using smartphone technology, this service will provide referring clinicians with rapid access to dermoscopic assessment of skin lesions by dermatologist specialists as an alternative to routine referral to secondary care.

Store and forward teledermatology gives GPs the opportunity to seek expert help to assist diagnosis of skin lesions. If diagnostic uncertainty exists, GPs capture a high resolution image of the lesion using a dermascope. These images and supporting information are then sent to the dermatology specialist via a secure network for review. This will result in timely provision of a diagnosis and management plan (Report) supplied to the referring clinician to identify if care should be provided in either a secondary or primary care setting.
The introduction of a teledermatology service will reduce unnecessary referrals to secondary care dermatology services, thereby increasing efficiency. It also provides a learning opportunity for GPs as they receive feedback on the diagnoses of lesions they have seen.

There have been a range of recent publications supporting the shift of dermatology care closer to home and delivering integrated pathways of care that ultimately produce better value and improved outcomes for patients. These include:

- Providing care for patients with skin conditions: guidance and resources for commissioners, Primary Care Contracting 2008
- Models of Integrated Service Delivery in Dermatology, Dermatology Workforce Group, January 2007
- Shifting Care Closer to Home: Dermatology, Department of Health, 2007
- Quality Standards for Dermatology, July 2011
- NICE guidance on Cancer Services Improving Outcomes for People with Skin tumors including Melanoma (update).
- Health and Social Care Act 2012

National Publications:

- Department of Health (2008) High Quality Care for All: NHS Next Stage Review Final Report states “improving access is a priority articulated in every vision, across every pathway of care”¹
- The NHS Constitution (2009) NHS Pledge to provide convenient and easy to access services²
- “Our Health, Our Care, Our Say” (2006)³
- Quality Standards for Teledermatology: Using Store and Forward Images ⁴
- Providing the Right Care for Patients with Skin Conditions (2011)⁵

Local Publications:

- East of England SHA Towards the Best Together aims to deliver more care closer to home, away from acute hospital settings ⁶

Almost 25% of the population seeks GP advice on a dermatological problem each year and over 20% of GP appointments involve dermatological issues (Schofield et al 2009). Increased exposure to sun and an ageing population have led to an increase in skin lesion numbers. In the UK, four million dermatology referrals a year are made to secondary care (Schofield et al 2009).

¹ Department of Health (2008) High Quality Care for All NHS Next Stage Review Final Report, Department of Health: London
³ Department of Health (2006) “Our Health, Our Care, Our Say” Department of Health: London
⁵ Primary Care Commissioning
2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators
The implementation of the service described in this specification is anticipated to contribute towards improvement in the following indicators from the NHS Outcomes Framework:

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Preventing people from dying prematurely</th>
<th>x</th>
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<tbody>
<tr>
<td>Domain 2</td>
<td>Enhancing quality of life for people with long-term conditions</td>
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<tr>
<td>Domain 3</td>
<td>Helping people to recover from episodes of ill-health or following injury</td>
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<tr>
<td>Domain 4</td>
<td>Ensuring people have a positive experience of care</td>
<td>x</td>
</tr>
<tr>
<td>Domain 5</td>
<td>Treating and caring for people in safe environment and protecting them from avoidable harm</td>
<td>x</td>
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</table>

2.2 Local defined outcomes
The Provider will deliver and evidence the following key outcomes:

- 75% of patients, whose lesions are assessed and determined as benign, by the Provider led teledermatology service, will be managed in primary care. These patients, previously managed in secondary care, will have a care plan provided to enable the referring clinician to manage in a primary care setting.
- A 75% reduction in the number of patients referred to hospital for first outpatient appointment for suspect lesions.
- Provision of an evidence based (NICE and Quality Standards for Teledermatology) high quality service that triages (outside of the two week wait pathway) for patients with suspicious skin lesions to the most appropriate skin service. This will be within primary care management or referral to secondary care services. The service will provide clinically effective diagnostic management and treatment to patients who have an unknown skin lesion.

3. Scope

3.1 Aims
The aims of the service are:

- Using smartphone technology, the service shall provide GPs with rapid access to dermoscopic assessment of skin lesions by dermatologist specialists as an alternative to routine referrals to secondary care;
- Reduce secondary care referrals / activity;
- Provide advice and guidance to the referring clinician. provide care closer to home without the need for onward referral
3.2 Objectives of service
The objectives of the service are:

- To provide specialist interpretation of the photographs, accompanied by the referring clinicians completed referral form to support and advise diagnosis by the Provider.
- To offer services in appropriate settings to patients who are clinically suitable
- To improve clinical outcomes by early detection and intervention of previously undetected cancerous lesions
- To improve the patient experience and deliver a high quality service
- To reduce health inequalities through triage to enable more patients to be treated with primary care within West Suffolk CCG.
- To improve the GP knowledge of skin lesions through education and feedback

3.3 Service description/care pathway
Using a smartphone and smartphone compatible dermatoscope, patients are selected for referral on the following criteria:

- A lesion of less than 20 cm in size and / or, less than 5% of the total body surface area
- The patient has three cases or fewer of melanoma in their family history
- The lesion is likely to be benign
- The lesion is not obviously a Malignant Melanoma, Squamous Cell Carcinoma or Basal Cell Carcinoma. All obvious Malignant Melanoma, Squamous Cell Carcinoma or Basel Cell Carcinoma should be sent to the secondary care provider via the cancer two week wait pathway.

With informed consent, the referring clinician will provide a minimum of two images: one image taken using the phone and APP only, and the second with a dermatoscope.

- The referring clinician will submit all images onto a standardised referral form providing clinical details, history and reason for referral to the Provider. The design / required content fields of the referral form is the responsibility of the Provider and shall be compliant with the National Guidance of Telehealth quality requirements and should contain as a minimum images, primary diagnosis and differential diagnosis and responses to free field questions submitted with referral. The Provider is required to amend the form from time to time to reflect any changes in best practice.

- Submitted images and the referral form shall be submitted to a secure website that meets all applicable NHS Standards and Guidance, including Caldicott and governance requirements via an application (APP) on a smartphone. Duplicate referrals/ submissions or reporting errors will not be funded.

- A suitably qualified reporting clinician (see 3.15 Professional Qualifications) shall review the information and images and provide a Report to the referring clinician within a maximum of three Operational Days. For the avoidance of doubt, an Operational Day shall be Monday-Friday : 09.00-17.00 hrs, excluding Bank Holidays
• The GP Practice shall receive the report either by secure mail (NHS.net to NHS.net) or an email with hyperlink notifying of the Report. As part of the installation process the Provider shall ascertain email addresses and practice preferred options.

• The Practice will be able to retrieve the report that is in a secure format than can be printed or downloaded into a clinical system, and as a minimum, as a pdf.

• The Provider shall notify all participating GP practices of any technical difficulties with the website, portal of software within 60 minutes of occurrence.

3.4 Population covered
Patients registered with a GP Practice within the West Suffolk CCG which comprises of 25 GP practices. There will be a phased roll-out plan for all GP practices starting with an initial cohort of 5 in the first month. The final implementation plan will be agreed between the Provider and the West Suffolk CCG.

3.5 Any acceptance and exclusion criteria and thresholds
The service will operate for any patient registered with a West Suffolk CCG GP practice.

3.6 Interdependence with other services/providers:
• General Practitioners and associated staff
• Consultants within Secondary Care
• Providers of Community health services
• West Suffolk CCG
• Patient Advice and Liaison Service (PALS)

3.7 Location(s) of service delivery
The service shall be provided remotely within the UK and the servers will be situated within the UK.

3.8 Days and hours of operation
As a remote service, access shall be 24/7 if needed and support should be available from 09.00 – 17.00 hrs, Monday to Friday (Operational Day), excluding Bank Holidays, as a minimum.

3.9 Referral route
The referral route will be referring clinicians from GP Practices; this could include GPs, GP registrars, nurse practitioners or practice nurses.

The Provider is required to work with representatives from West Suffolk CCG to further develop the operational pathways, referral criteria and guidelines to ensure that referrals are appropriate and managed in a timely manner in accordance with national and local maximum waiting time targets.

3.10 Equipment
The Provider will supply, install and upgrade appropriate software and applications used by the service, including any upgrades or future innovations connected with the service. This will be in accordance with all relevant NHS Guidance, including e-health guidelines.

The Provider will specify the details of the dermatoscope, smartphone and any other essential equipment to be used by referring clinicians that is compatible with the service. This equipment will be purchased by the Commissioner.
It is the responsibility of the Commissioner to ensure network availability and up-grades, as required.

3.11 Training
GP's and all other referring clinicians will be trained to use the service by the Provider in line with the final implementation plan, enabling clinicians to;

- Correctly use the Smartphone and dermatoscope for good quality images
- Correctly use the application and system, including obtaining and recording patient consent, sending the details and uploading of photos
- Support appropriate selection of patients
- Interpret the reports and act on feedback

3.13 Reporting
Reports will contain the original images, additional information provided by the referring clinician, the diagnosis and differential diagnosis. The reports shall be in a format that can be uploaded into clinical systems. The reporting clinician will be suitably qualified with training and accreditation in assessment of dermoscopy images and treatment of suspected cancerous lesions of the skin.

3.14 Audit
The Provider shall complete regular, but no less than bi-annual, audits to assess the clinical effectiveness, diagnostic accuracy and quality of reporting. Audits shall result in action plans and evidence of learning and completed one month post audit. The reports shall be available to the Commissioner on request.

The Provider shall participate in governance meetings on all elements of the patient pathway with GPs and secondary care providers.

The Provider shall send any audits and reports that either the organisation or clinician is required to send to any professional body or undertake as part of the professional registration.

3.15 Professional Qualifications and Governance
The Provider shall meet all necessary information and clinical governance standards, in particular NICE guidelines, NHS standards and the British Association of Dermatologists.

- All reporting clinicians shall have current professional clinical registration including;
- Full GMC registration including dermatology specialist register and not be subject to any investigation or proceedings by the GMS.
- Be a member of the British Association of Dermatologists.
- Meet the continuing Medical Education requirements for revalidation by the GMS along with any college(s)/association/society to which they belong.
- Be able to demonstrate an appropriate level of clinical education and specialisation in dermatoscope and dermatology.
- Carry adequate professional indemnity
4. Applicable Service Standards

4.1 Activity
Activity for the year is estimated to be a total of 1,630 referrals. This will be following full roll out to all 25 practices. It is anticipated that within the first year of service activity will be as below as full roll out will not be achieved:

4.2 Payment

Year 1 Indicative Referral Activity: 1,179

Price per referral to include all components of reporting and service provision as set out in the Service Specification. Finance scoring will be done on the Price per Referral.

5. Applicable quality requirements
<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Threshold</th>
<th>Method of Measurement</th>
<th>Consequence of breach</th>
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<tbody>
<tr>
<td>Diagnosis and management plan (Report) provided to the GP practice with 3 Operational Days from submission of Referral</td>
<td>100%</td>
<td>Monthly report from provider</td>
<td>Non-payment for each report Provided to Referrer &gt; 3 Operational Days Breach report and Root Cause Analysis undertaken for any report &gt; 3 Operational Days</td>
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</tbody>
</table>
| Reduction in the number of patients requiring onward referral onto secondary care by GPs for 1st outpatient appointment within dermatology for suspect lesions | a) <75% reduction  
b) 65-75% reduction  
c) >65% reduction  
Baseline tbd in Q1 | Monthly report from provider              | a) No consequences  
b) Trigger for review  
c) GC9  
Exemption in Q1 during practice roll out/ whilst baseline determined                                                                                                                     |
| Upload availability:  
Fully operational service 24 hours a day/ 7 days a week for website, portal and software APP | 100%      | Monthly report from provider              | a) Operational Day-(Mon-Fri 0900-1700)-review  
b) Outside Operational Day-GC9                                                                                                                                                                                                    |
| Referring clinician Experience:  
Referring clinician reporting a positive experience with the service | 95% (of a sample size which must be 30% of all referral activity) | Quarterly provider survey               | GC9                                                                                                                                                                                                                   |
| Patient Experience:  
patients reporting a positive experience with the service | 75% (of a sample size which must be 30% of all referral activity) | Quarterly provider survey               | GC9                                                                                                                                                                                                                   |
TELEDERMOSCOPY – MODEL OF CARE

Q. 1

Is the lesion >20cm or covering 5% of body?

- Yes → Refer to secondary care
- No → Are there 3 or more cases of melanoma in FHx?

- Yes → Refer to secondary care
- No → Proceed to Q2

Q. 2

Is the lesion obviously benign?

- Yes → Refer to secondary care
- No → Is the lesion obviously MM or SCC?

- Yes → Refer to secondary care
- No → Is the lesion obviously a BCC?

- Yes → Refer to secondary care
- No → Refer to Teledermoscopy

Acronyms
Fx – Family history
2 WW – 2 week wait
MM-Malignant Melanoma
SCC –Squamous Cell Carcinoma