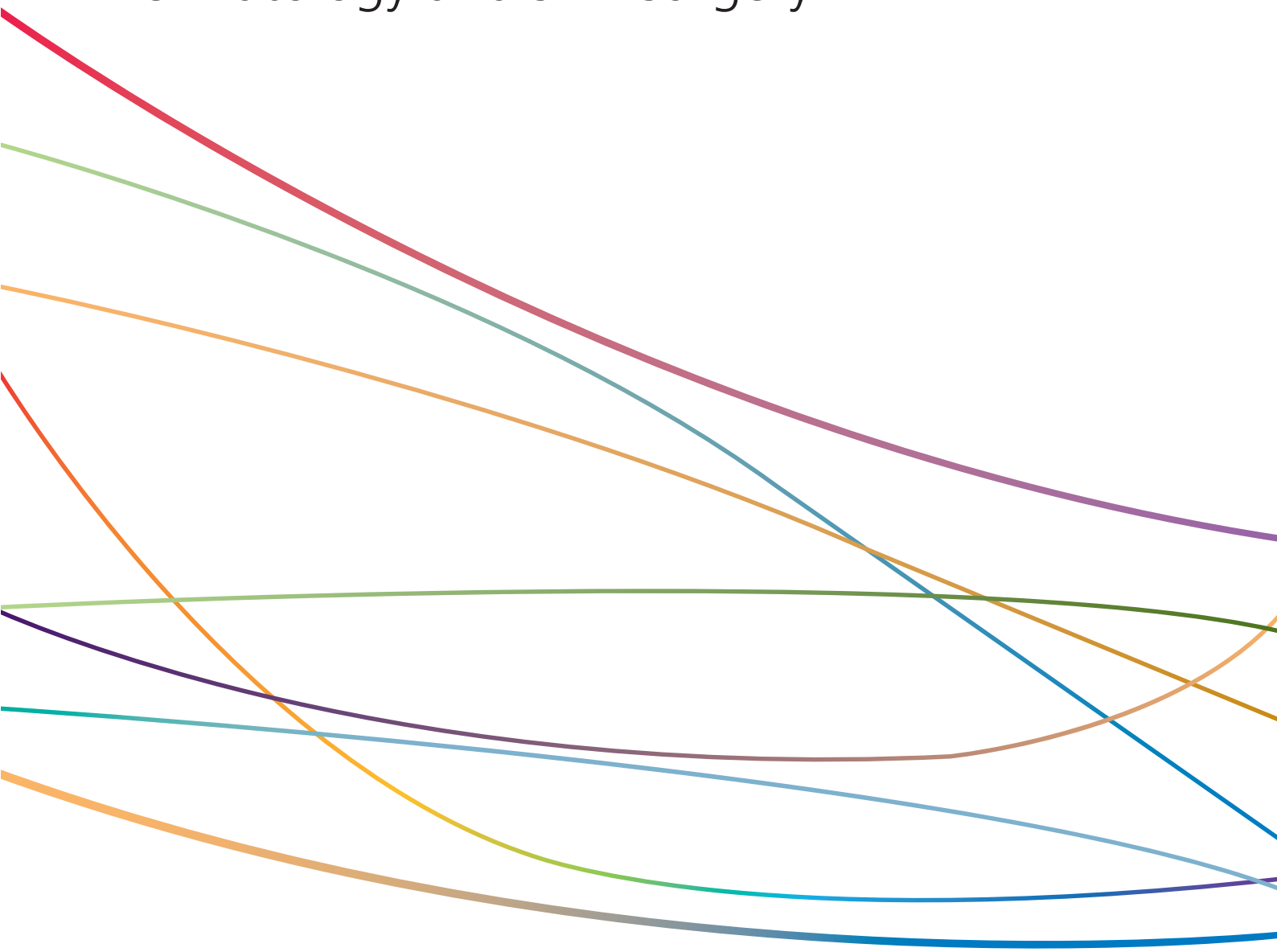
Revised guidance and competences for the provision of services using GPs with Special Interests (GPwSIs)

Dermatology and skin surgery



This guidance should be read (where appropriate) in conjunction with:

Implementing care closer to home: Convenient quality care for patients Part 3: The accreditation of GPs and Pharmacists with Special Interests Supporting Q&A (2007) and *Providing care for people with skin conditions: guidance and resources for commissioners (NHS Primary Care Commissioning 2008)*

Contents

Foreword

In 2007, a guidance document was published to support the provision of dermatology and skin surgery services by General Practitioners with a Special Interest (GPwSI)[1]. This document, to be read in conjunction with Implementing care closer to home: Convenient quality care for patients[2], described different models of dermatology services and provided information about the training, accreditation and assessment processes to support the accreditation of dermatology GPwSIs. It also provided guidance for commissioners in respect of the development of community cancer clinicians and skin surgery services.

The 2007 guidance is now out of date since the publication of the National Institute for Health and Clinical Excellence's (NICE) update of its skin cancer guidance *Improving outcomes for people with skin tumours including melanoma (update) - The management of low-risk basal cell carcinomas in the community (May 2010)*[3]. This update made a specific recommendation that a new GPwSI role should be developed with responsibility for skin lesions, skin surgery and community cancer services.

Additionally, publication of the new 2010 NICE guidance made it necessary to provide recommendations relating to GPs who provide skin surgery services within their practices under the Directed Enhanced Service or under a Local Enhanced Service (DES/LES), but who are not dermatology GPwSIs. This document sets out these recommendations.

Whilst it was important that the 2007 guidance be revised in light of the NICE update, the changes set out in the 2010 White Paper *Equity and Excellence: Liberating the NHS*[4] will, as they are implemented, have an impact on the way in which GPwSI services are commissioned and accredited in the future. The high quality care and improved patient outcomes emphasised in the White Paper can only be delivered by ensuring a highly skilled, appropriately trained workforce. Therefore, the principles in this document are likely to remain valid, although some of the details of the process will be subject to change.

This guidance has been revised and updated by representatives of the British Association of Dermatologists, the Primary Care Dermatology Society, the Royal College of General Practitioners and, importantly, the Skin Care Campaign (the umbrella organisation representing patient charities and groups). We would like to thank all of those involved in the process.

Dr Stephen Jones, President in The Chair, British Association of Dermatologists

Dr Stephen Kownacki, Executive Chairman, Primary Care Dermatology Society

Andrew Langford, Chief Executive, Skin Care Campaign

Dr Clare Gerada, Chair of Council, Royal College of General Practitioners

PART 1: The Dermatology GPwSI Framework

1. Introduction

A GPwSI framework for dermatology was developed by a multidisciplinary working group with broad representation from general practitioners, secondary care specialists and patient groups in 2007. This document is an update of that framework. It has been updated by a similar group to meet the recommendations in the NICE Skin Cancer Guidance update *Improving outcomes for people with skin tumours including melanoma (update) - The management of low-risk basal cell carcinomas in the community (May 2010)*. The NICE update specifically recommended a new GPwSI role with responsibility for skin lesions, skin surgery and community cancer services.

The principles in the document are intended to ensure the commissioning and provision of high quality dermatology services. This guidance provides detailed information to ensure that accreditors know the kind of evidence and competences that may be expected to be seen and tested during the accreditation process set out in *Implementing care closer to home: Convenient quality care for patients, Part 3: The accreditation of GPs and Pharmacists with Special Interests.*

This revised guidance is being published at a time of change in the NHS. Some adjustments to the accreditation process may therefore need to be made in the future, in particular in the light of medical revalidation and of the changes set out in *Equity and Excellence: Liberating the NHS,* especially the development of GP commissioning consortia and that most health services should be subject to 'any qualified provider' by 2013/14. The introduction of choice of 'any qualified provider' for some community services is being introduced from 2011. However, the principles set out in this document are likely to remain valid even if the details of the process are subject to change.

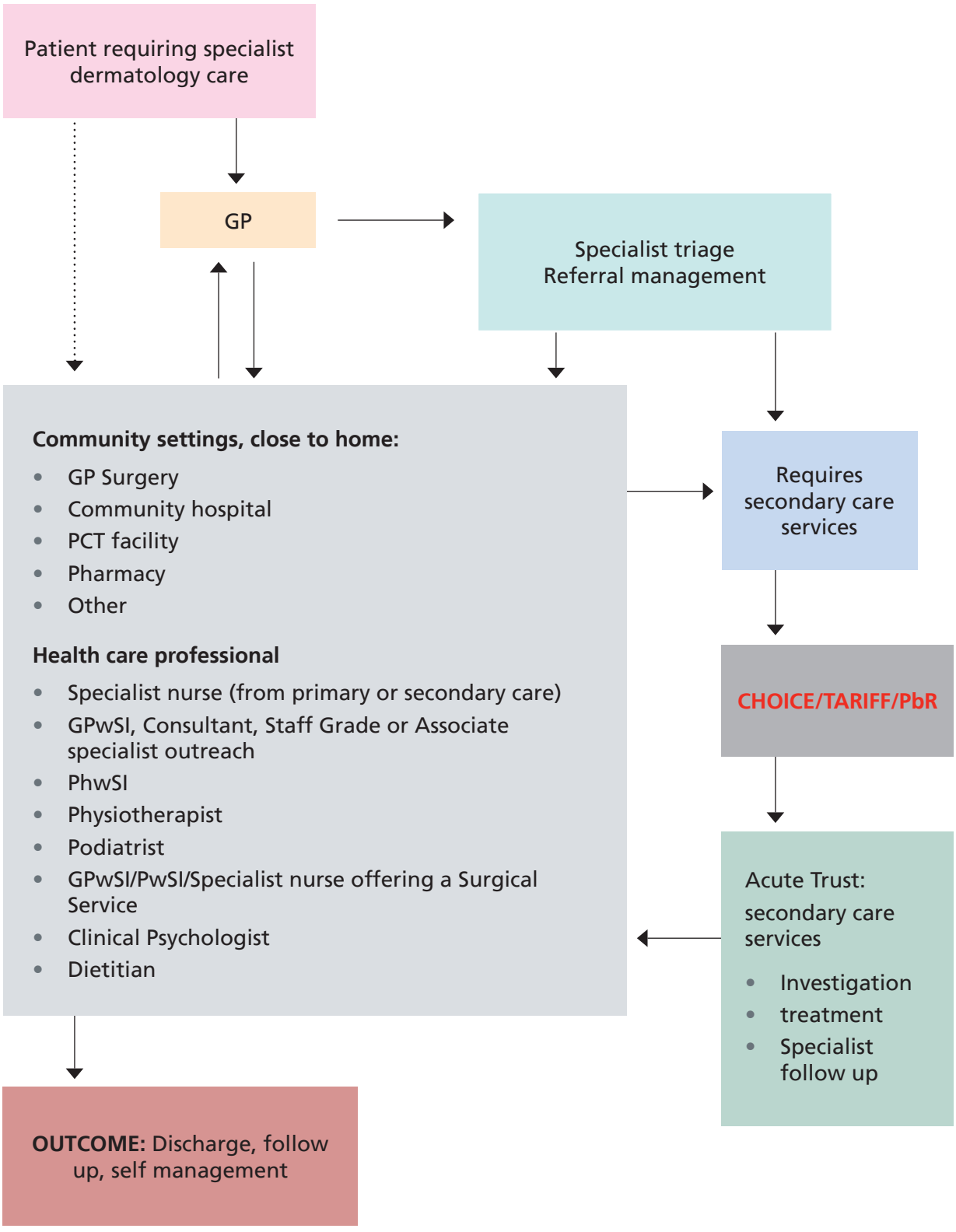
Most of this document describes the framework relating to the specific training and accreditation needs of GPwSIs working in dermatology, skin surgery and the provision of community skin cancer services.

It is designed to help dermatology GPwSIs, and those developing or commissioning GPwSI services, understand and develop the extended knowledge, competences and skills they require to provide services beyond the scope of their generalist roles. GPwSI services are expected to be part of a series of integrated options within a negotiated local framework taking account of the needs of the local health community. As outlined in other guidance for commissioners, it is very important that patients and all service providers are involved at all stages of service development. It is particularly important that the new role of GPwSI with particular expertise in skin lesion management does not reduce the access to care for people with inflammatory skin disorders.

The breadth of diagnostic skills required to ensure the provision of quality dermatology services is currently unlikely to be acquired by non-medically qualified healthcare professionals. However, the importance of other healthcare professionals in the delivery of dermatology services is well accepted and any models of care should take account of this (see Figure 1 for examples of this).

Commissioners need to be reminded that the training and personal development of GPwSIs will require initial and ongoing support from dermatology specialists. Any commissioning framework needs to take account of these requirements.

Figure 1: models of service delivery



2. The service to be provided

Potential activities of a GPwSI service in dermatology

The core activities of a dermatology GPwSI service will vary, dependent upon local needs and resources, and the skills of the clinician. The proposed dermatology service is likely to be accredited first, and the dermatology GPwSI will then be accredited in the context of the service to be provided and the competences required to provide it. Possible models of service include:

- dermatology GPwSI: diagnosis and management of skin disease (Group 1)
- dermatology & skin surgery: diagnosis and management of skin disease and benign skin surgery (Group 2)
- dermatology, skin surgery & community skin cancer: diagnosis and management of skin disease, skin surgery including skin cancer community services (Group 3)
- skin lesions GPwSI: skin lesions and skin surgery including skin cancer community services.

Figure 2 provides an overview of the services that a GPwSI might provide and the guidance that relates to the accreditation of each service.

Models of service delivery are expected to reflect the important principles outlined in the NHS Primary Care Commissioning document, *Providing care for patients with skin conditions: guidance and resources for commissioners*[5]. In addition:

- the service model should take account of relevant national guidance, eg the national institute for Health and Clinical Excellence (NICE) skin cancer guidance[6]
- the model should incorporate examples of nationally agreed good practice (see Skin Conditions in the UK: a Health Care Needs Assessment, Schofield JK, Grindlay D, Williams HC 2009 Chapter 5[7] for a review of models of care).

See Annex A for points to consider when developing a service model.

It is expected that an accredited GPwSI service would include aspects of the following:

Clinical

- Assessment, investigation and treatment of patients referred to the service
- Provision of a range of clinical interventions as appropriate to the accredited service, eg skin surgery, liquid nitrogen cryotherapy, management of leg ulcers and the use of oral and topical treatments as indicated
- Links with other services in order that the full holistic needs of the patient will be met (for example psychological support, podiatry, cosmetic camouflage services)
- The knowledge to signpost patients to other support services including local and national patient support groups.

Education and liaison

- Provision of advice and support to local practitioners through non-face-to-face contact (eg telephone, internet or other means) in the management of those dermatological conditions within the expertise of the GPwSI

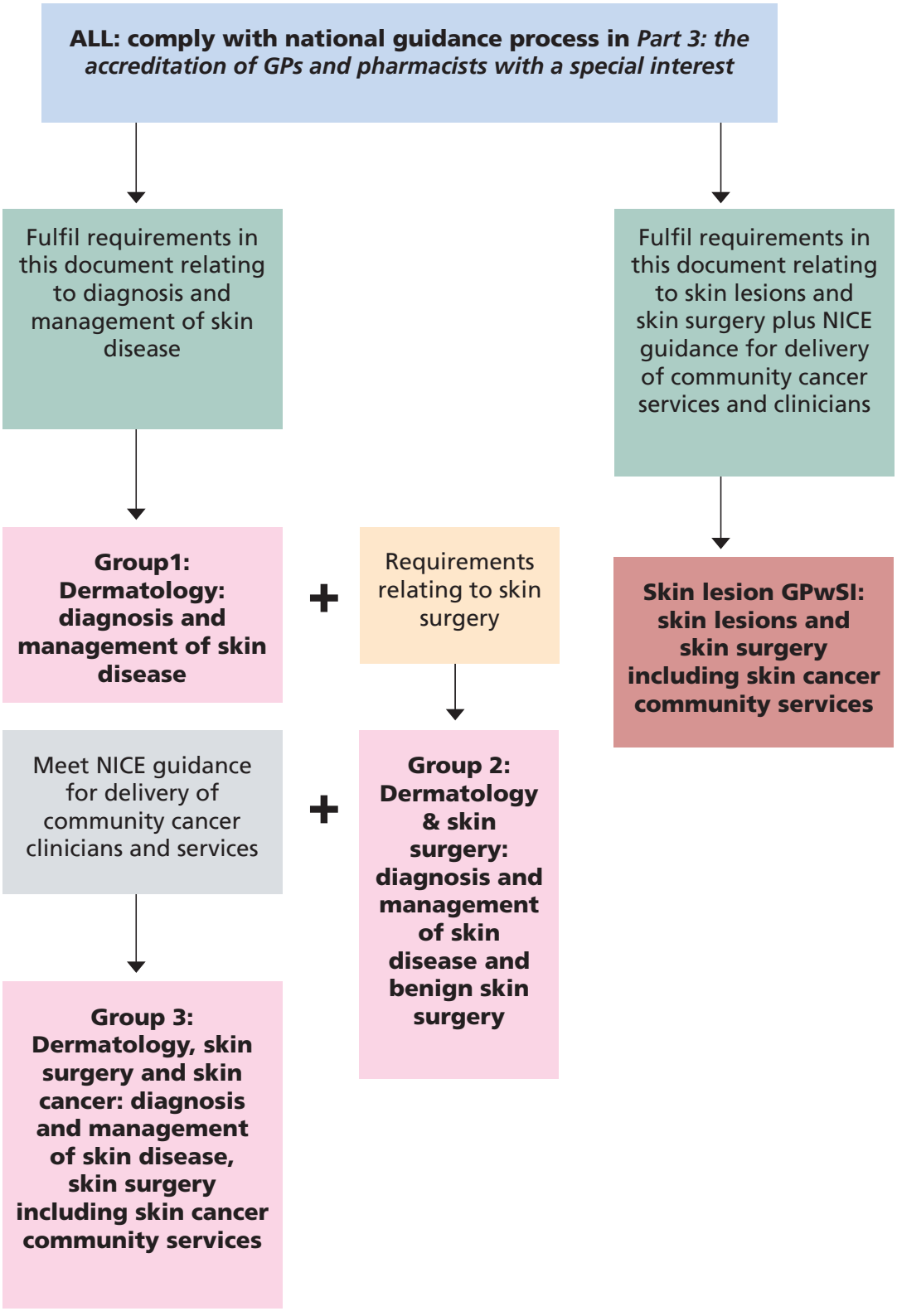
- Provide support and training to GPs and members of the primary healthcare team in the management of common skin conditions to enable other clinicians to develop, maintain and improve their level of competency in the management of skin conditions
- Liaise with and provide support for other dermatology GPwSIs in the area.

Service development/leadership

- Work with the local secondary care specialists to develop an integrated dermatology service model with care pathways that meet the requirements for the accreditation of the service by the accreditation panel, linked to the health care needs of the local community
- In collaboration with other members of the local health community, develop and implement management guidance for primary care practitioners in the care of common dermatological conditions
- Develop links with other professional groups, pharmacists, health visitors, school nurses, podiatrists and primary care nurses, for the effective shared care for patients with chronic skin conditions
- Support and develop the role of dermatology specialist nurses working in outreach/close to home settings
- Become involved in integrated training programmes across primary and secondary care for medical and nursing staff
- Work with patients, the public and service providers to support an integrated, patient centred approach to commissioning services.

The location of the service will also vary depending on the needs of the local community.

Figure 2: Overview of GPwSI in dermatology services and accreditation requirements



3. The support and facilities required

Nationally agreed standards for facilities exist. In addition, there are specific requirements for providing dermatology services which are best considered when accrediting the service. Useful advice can be found on the British Association of Dermatologists' website[8]. Though the facilities and support will vary according to the service being provided, the basic requirements for GPwSIs managing a clinical caseload would include some of the following:

- access to suitably trained dermatology specialist nurse support, ideally, acting as a liaison between primary and secondary care (for example, by the provision of an outreach dermatology specialist nursing service). This can then facilitate seamless care. However, development of specialist dermatology skills in a designated in-house community or practice nurse might also be considered
- for surgical procedures: access to suitable assistance and appropriate resuscitation equipment
- a well-lit consultation room with adequate facilities for diagnosis and treatment procedures and operative equipment that meets the requirements necessary for skin surgery
- access to liquid nitrogen if cryotherapy is to be performed, with attention to Health and Safety guidance in relation to its storage and use
- administrative support and appropriate staff to ensure the clinic runs efficiently
- an adequate means of record keeping including a failsafe record to ensure that all results are actioned appropriately and reported to the patient in a timely fashion (particularly important for histopathology reports)
- where skin surgery sessions are performed, close links with local dermatology and histopathology departments. Documentation of lesions, including photographic records as appropriate, are recommended (taken and recorded following national guidelines[9]).
- GPwSIs are expected to keep their facilities up to date, in keeping with national guidance, and ensure that their patients have access to any innovations in dermatology treatment suited to the primary care setting
- the facilities are to be accredited and should take account of the Government's Standards for Better Health[10]; this is particularly important in the context of providing skin surgery services where specific national standards need to be met
- dermatology services are expected to be provided in well-equipped community hospitals and primary care settings[11].

4. The curriculum and core competences required

The general practitioner is expected to demonstrate that he/she is a competent and experienced generalist, as well as having the specific competences and experience for the dermatology special interest area. Generalist skills can be assessed in a number of ways but are readily demonstrated by GPs who have passed the membership examination of the Royal College of General Practitioners (RCGP) and who are current members of the College. It is expected that the GP will have an ongoing significant commitment to general practice, as outlined in the generic guidance, in order to retain excellent generalist skills.

The competences required to deliver a GPwSI service are seen as a development of generalist skills as outlined by the RCGP and the British Association of Dermatologists (BAD) in Dermatology for General Practice Trainees[12] (1998). In addition to good communication skills, experience in teaching and training healthcare professionals in dermatology and a commitment to cascading knowledge and skills are important. It is expected that, to optimise quality of care, dermatology GPwSIs will be familiar with new and existing NICE guidance and quality standards relevant to their clinical area.

The following describes the aims of the dermatology GPwSI curriculum, its content, methods of learning and assessment. Although the competences required will depend on the service being delivered, it is expected that all dermatology GPwSIs involved in the care of people with skin disease and skin lesions should be able to demonstrate that they meet the core competences set out in this document as part of the accreditation process. The competences will vary dependent upon the service that the GPwSI is delivering, with additional specific requirements for each of the different GPwSI groups.

4.1 Curriculum: Principles

Competent practitioners are able to demonstrate:

- effective communication skills during interaction with patients and colleagues, including the ability to explore people's understanding, reactions and opinions and practise with a holistic approach
- an ability to explain the risks and benefits of treatment options and involve patients in decisions about their management
- sufficient knowledge and skill in diagnosis to ensure the safe and effective practice of dermatology
- competence in establishing a differential diagnosis by the appropriate use of history, clinical examination and investigations
- an ability to carry out minor practical procedures
- knowledge of NICE guidance relevant to skin disease
- recognition of their limitations in expertise and knowledge of mechanisms of referral.

Specific knowledge, attitudes and skills

There follows a curriculum for training. Dermatology GPwSIs are expected to have a good knowledge of these curriculum areas. This is considered to be the minimum core curriculum for any generalist wishing to offer more specialist dermatology diagnosis and management services.

4.2 Curriculum: Content

Specific content for training for ALL dermatology GPwSI Groups 1, 2, 3 and skin lesions GPwSI

- Recognition and management of common non-malignant, pre-malignant and malignant lesions, including:
    - Benign melanocytic naevi
    - Dermatofibroma
    - Haemangioma
    - Epidermoid/pilar cysts
    - Seborrhoeic keratoses (basal cell papilloma)
    - Pyogenic granuloma and blood vessel derived tumours
    - Hypertrophic scars
    - Actinic keratosis
    - Bowen's disease
    - Keratoacanthoma
    - Basal cell carcinoma
    - Lentigo maligna
    - Melanoma
    - Squamous cell carcinoma.
- Rarer solitary skin lesions, for example: sebaceous naevi, calcified pilomatrixoma, glomus tumour and the commoner adnexal tumours (e.g syringomas, cylindromas).
- The link between skin lesions and other systemic conditions (e.g. family cancer syndromes, skin secondaries, long term immune-suppression).
- The importance of skin type.
- An understanding of the psychosocial issues that affect many patients with skin conditions and their management, including referral pathways.

Additional content for GPwSI Groups 1, 2 and 3

- Recognition and holistic management of common dermatoses and their symptoms, including:
    - Eczema
    - Psoriasis
    - Acne
    - Urticaria/angio-oedema
    - Rosacea
    - Pruritus
    - Granuloma annulare
    - Infections and infestations
    - Leg ulcers and gravitational disease
    - Drug rashes
    - Lichen planus
    - Pigmentary disorders including vitiligo

    - Hyperhidrosis
    - Hirsutism
    - Hair, nail and scalp disorders.
- Skin manifestations of systemic diseases.
- An understanding of photodermatoses.

Understanding the appropriate use of different diagnostic and investigatory tools

All GPwSIs

- Dermoscopy
- Histology and the use of different stain techniques including the importance of immunofluoresence studies

GPwSI Groups 1,2,3

- Serology
- Bacteriology, mycology and virology
- Patch testing

Skin surgery curriculum - GPwSI Groups 2, 3 and skin lesions GPwSI

All GPwSIs performing skin surgery should be familiar with the following:

- Issues relating to skin surgery facilities, obtaining informed consent, documentation, specimen transportation, infection control, audit and administration
- The importance of co-morbidities and relevant drug history
- Anatomical hazards
- Aseptic technique
- Local and topical anaesthesia
- Handling of surgical instruments
- Suture techniques
- NICE guidelines in relation to providing services for people with skin cancer
- Peri-operative complications
- Immediate and post-operative wound care
- Management of post-operative complications such as haemorrhage, wound dehiscence and infection
- Management of hypertrophic/keloid scars

The curriculum relating to procedures will vary depending on the range and complexity of the surgery that the GPwSI is providing in his/her clinical practice and skills may evolve over time. The accreditation of the clinician will reflect the competences that have been demonstrated against any or all of the following procedures:

- Curettage and cautery
- Shave biopsy/excision
- Incisional biopsy including punch biopsy
- Ellipse excision
- Suturing:

    - Surface interrupted sutures
    - The use of deep sutures as required
    - Other suture techniques such as subcuticular, mattress sutures, purse string, pulley etc
- Dog ear: prevention and repair
- Flaps and grafts
- The use of steri-strips and surgical glue
- Healing by secondary intention
- Use of diathermy and other methods of achieving haemostasis

(NB: Group 1 GPwSIs may need to be familiar with the relevant sections of this curriculum, and complete the appropriate assessments, if they plan to perform incisional/ punch biopsies or inject triamcinolone as part of service provision).

Knowledge of the appropriate use of topical agents/treatments

All GPwSIs

- Liquid nitrogen cryotherapy
- 5 Fluorouracil
- Diclofenac
- Imiquimod
- Photodynamic therapy

Group 1,2 and 3 GPwSIs

- Emollients
- Vitamin D derivatives
- Topical steroids
- Topical antibiotics
- Topical antivirals and antifungals
- Topical retinoids
- Topical immunosuppressants, eg tacrolimus/pimecrolimus
- Wet wraps/emollient wraps
- Leg ulcer dressings
- Keratolytic agents

Appropriate use and monitoring of systemic therapy

- Antihistamines
- Antibiotics/antivirals/antifungals
- Anti-malarials
- Oral steroids
- Oral retinoids
- Narrow-band UVB and PUVA

Appropriate use and monitoring of cytotoxics/immunosuppressants

- Hydroxycarbamide
- Azathioprine
- Methotrexate
- Ciclosporin

And any other medication as appropriate to the GPwSIs expertise and practice.

Oral retinoid prescribing

Isotretinoin

The current Medicines and Healthcare products Regulatory Agency (MHRA) view on isotretinoin prescribing is as follows (March 2007):

The Summary of Product Characteristics in the licence for isotretinoin states that it can be prescribed by or under supervision of physicians with expertise in the use of systemic retinoids for the treatment of acne and a full understanding of the risks of isotretinoin and monitoring requirements. This wording is chosen for compliance with other European states but in theUnited Kingdom refers to consultant dermatologists[13].

The MHRA position therefore makes it inappropriate for this guidance document to provide a national framework to accredit GPwSIs in the prescribing of isotretinoin. Consultant dermatologists and experienced GPwSIs working within an integrated service may wish to develop a locally agreed care pathway and accreditation process to facilitate the prescribing of isotretinoin. However, they need to be mindful that this is an 'off-licence' indication and be cognisant of the MHRA view. They may also wish to seek the advice of their professional indemnity organisation.

Alitretinoin

The Summary of Product Characteristics states:

Alitretinoin should only be prescribed by dermatologists, or physicians with experience in the use of systemic retinoids who have full understanding of the risks of systemic retinoid therapy and monitoring requirements.

The MHRA has indicated that alitretinoin should be prescribed within the same context as for isotretinoin. Additionally clinicians prescribing alitretinoin should do so with reference to NICE guidance.

4.3 Curriculum: Teaching and learning

Theoretical training

Practitioners are expected to demonstrate that they have completed recognised training, which may include acknowledgement of prior learning and experience. This can be acquired in different ways:

- Relevant, current or recent experience (within the last five years) in a specialist dermatology department
- successful completion of an appropriate postgraduate qualification in dermatology and/or dermatological surgery (e.g.diploma) – this is recommended as a good way of obtaining and demonstrating structured learning
- self-directed learning via the internet with evidence of the completion of individual tasks

- attendance at recognised meetings/lectures/tutorials on specific relevant dermatological topics.

Practical training

This should be tailored and appropriate to the service requirements of the GPwSI but will include attachment to a secondary care dermatology unit under the supervision of a consultant dermatologist. For skin surgeons this may also include an attachment to a plastic surgeon or maxillo-facial surgeon. It may be helpful to include some sessions with an accredited GPwSI as part of the programme. The GPwSI will need to attend sufficient clinics to be able to obtain training and experience in the areas listed below relevant to the specified area of clinical practice and be able to demonstrate the competences required to meet the assessment requirements for accreditation:

All GPwSIs

- Indications for and use of liquid nitrogen cryotherapy;
- Use of a dermatoscope and its role in supporting the diagnosis of skin lesions
- Medical management of non-melanoma skin cancer and pre-cancer
- Basic skin surgery (Group 1 GPwSIs should be familiar with this, even if they are not regularly performing skin surgery)
- Knowledge of different staining techniques for histological specimens and an understanding of when the different stain techniques are indicated (such as immunofluorescence) and requirements for preparation and fixation of samples if needed
- Taking of samples for bacteriology, mycology and virology investigation.

Groups 1,2 and 3 GPwSIs

- Diagnosis, assessment and management of patients with common skin diseases to the standard accepted for accreditation
- Use and application of day treatment and phototherapy
- Management of leg ulcers including Doppler ABPI assessment
- Use and application of patch testing.

Ways in which this practical training can be achieved include:

- as a clinical assistant or other non specialist training post under the supervision of a consultant dermatologist (and plastic surgeon for skin surgery skills) in the secondary care dermatology service
- as a GP Speciality Trainee undertaking a six-month GP Speciality Training (ST) attachment
- as part of a GP Speciality Training (ST) programme
- during the Foundation Year 2 post
- as a clinical placement agreed locally.

The most suitable teaching/learning and assessment methods will vary according to individual circumstances and it is recommended that this be agreed between trainee and trainer in advance.

Teaching/learning methods

A number of different teaching and learning methods can be utilised including:

- acquiring many of the required competences during the attachment to a dermatology unit under the supervision of a consultant dermatologist (or plastic surgeon for surgical skills); the latter can sign off each skill as it is acquired in the log-book detailing the required competences for accreditation
- a periodic case note review by the supervising consultant
- attendance at a structured course of lectures/tutorials designed to cover basic dermatology
- a combination of clinical assessments and direct observation of practical skills (DOPS), depending on the type of service they offer (see Annex B).

Mix of theoretical training, supervised practice and competency-based assessment

The use of supervised practice and formal competency-based assessment is now widely accepted in under-graduate and post-graduate medical training and is considered key to ensuring clinical competency and patient safety. The assessment tools in this document reflect this emphasis. Some universities have developed training modules that include theoretical training followed by supervised practice and formal competency-based assessments. Such courses use many of the assessment tools described in this framework. While these courses are no substitute for clinical experience, this type of training module would be useful in supporting the training and accreditation process for GPwSIs.

4.4 Curriculum: Assessment - evidence of acquisition of competences

This includes the evidence required to demonstrate competency and criteria for maintenance of competency as defined within this framework. These have been agreed nationally by appropriate stakeholders.

The final accreditation sign-off process is outlined in *Implementing care closer to home: Convenient quality care for patients, Part 3: The accreditation of GPs and Pharmacists with Special Interests*, and includes provision of evidence of the acquisition of appropriate competences in dermatology.

The assessment of individual competences will be undertaken by a combination of some (but not all) of the following:

- observed practice using modified mini clinical examination (mini-CEX; see Annex B)
- case note review
- reports from senior professionals in the multidisciplinary team (using 360-degree appraisal tools)
- demonstration of skills under direct observation by a specialist clinician DOPS (see Annex B)
- simulated role play objective structured clinical examination (OSCE);
- reflective practice
- relevant postgraduate qualification in dermatology (strongly recommended);
- logbook/portfolio of achievement
- observed communication skills, attitudes and professional conduct

- demonstration of knowledge by personal study supported by appraisal (+/- knowledge-based assessment)
- evidence of gained knowledge via attendance at accredited courses or conferences.

While it is envisaged that competency will be assessed across many of the clinical domains set out in Annex B, it is expected that the assessment process will be tailored towards the service that the GPwSI will deliver. This will be agreed between the trainer and trainee at the start of the training. Annex C summarises the assessment requirements for each of the GPwSI roles.

5. Maintaining good medical practice

5.1 All GPwSIs

Monitoring and clinical governance

Mechanisms of clinical governance need to be agreed as part of the service accreditation to ensure maintenance of local and nationally agreed standards in respect of patient care, as part of the locally agreed integrated dermatology service.

Maintenance of competences

Practical arrangements for this should be agreed by all key stakeholders (commissioners, primary and secondary care providers) as part of the service accreditation.

All GPwSIs are expected to maintain a personal development portfolio to identify their education requirements matched against the competences required for the dermatology service and evidence of how these have been met and maintained. This portfolio can act as an ongoing training record and logbook and be countersigned as appropriate by an educational supervisor, the local consultant dermatologist, to confirm the satisfactory fulfilment of the required training experience and the maintenance of the competences enumerated in this document and by the accreditors. The portfolio should also include evidence of audit and continuing professional development (CPD) and would be expected to form part of the GPwSI's annual appraisal and revalidation evidence. An example of a log diary is included at Annex D.

To develop and maintain skills in dermatology regular exposure to patients with skin disease in the appropriate clinical area is important and the following is required to ensure good clinical practice:

- at least one session a week in the specialist area in order to obtain adequate exposure to a varied casemix to support CPD
- a monthly joint clinic with the consultant dermatologist. This is expected to be a clinic where the GPwSI and the consultant are working alongside each other providing the opportunity for the discussion of difficult cases and as an opportunity for CPD.

Arrangements for this should be agreed at the end of the training programme.

It is also expected that practitioners will:

- be actively involved in the local dermatology service
- maintain their competences through continuing education (15 hours a year minimum dermatology CPD)
- contribute to local clinical audits at least once a year
- meet with their supervising consultant annually to complete an appraisal interview and appraisal summary related to the GPwSI activity for review as part of the GP's appraisal process.

GPwSIs are expected to monitor service delivery, which incorporates the following:

- clinical outcomes and quality of care
- follow-up rates
- referral rates of patients to specialists by the GPwSI
- access times to the GPwSI service
- patient experience questionnaires.

Active membership of a primary care dermatology organisation (such as the Primary Care Dermatology Society, www.pcds.org.uk) and/or associate membership of the British Association of Dermatologists (www.bad.org.uk) would provide GPwSIs with opportunities to develop their knowledge and skills, as would the Association for Surgeons in Primary Care (ASPC) for skin lesion GPwSIs (www.aspc-uk.net). (The ASPC, like the PCDS is part of the RCGP Alliance of Primary Care Societies).

5.2 Specific requirements for GPwSIs performing surgery (Groups 2, 3 and skin lesions)

A record demonstrating regular skin surgery sessions (minimum of 20 surgical lists per year, with an average of 5 per list, predominantly ellipse excisions).

Annual audit data including the following:

- recording clinical vs. histological diagnosis
- patient experience and some evidence of cosmetic outcomes (for example, using before and after clinical photography)
- complication rates to include infection, dehiscence and incomplete excision rates
- competency assessment tools (such as DOPS) for newly acquired skills.

5.3 Specific requirements (in addition to 5.2 above) for Group 3 and skin lesion community cancer clinicians

The additional specific requirements for community cancer clinicians require the GPwSI to:

- be linked to a named local skin cancer MDT and attend 4 local skin cancer MDT meetings per year (one of which should discuss audit)
- attend an annual joint clinical session with a consultant dermatologist or SAS (Speciality Associate Specialist) doctor that is a core member of the skin cancer MDT
- undertake 15 hours (2 days) of CPD relating to skin cancer. Attendance at MDTs is included in these 15 hours
- provide evidence of an annual review of clinical compared with histological accuracy in the diagnosis of the low-risk BCCs they have managed
- present specific information about the location, histological type and management plan for this group of patients and completeness of excision in relation to low risk BCCs treated by ellipse excision.

In addition, at least one of the community cancer clinician GPwSIs in a network will be expected to attend network site specific group meetings.

There are specific important statements in two documents published by NICE relating to community cancer clinicians. The 2006 document *Improving Outcomes for People with Skin Tumours including Melanoma states:*

'All doctors and specialist nurses working in the community who knowingly treat skin cancer patients should be approved by, and be accountable to, the local LSMDT/SSMDT skin cancer lead clinician. They should work closely together to agreed local clinical protocols for referral, treatment and follow-up. These should be coherent with network-wide clinical protocols and signed off by the network site-specific lead for skin cancer.'

'They should also work at least one session per week as a clinical assistant, hospital practitioner, associate specialist or staff-grade doctor in the local hospital department. This should be in a parallel clinic with an appropriate hospital specialist, normally a dermatologist, who is a member of the LSMDT/SSMDT'.

In addition the NICE document Improving Outcomes for people with skin tumours including melanoma (update) - The management of low-risk basal cell carcinomas (May 2010) specifies the following:

The Group 3 and skin lesion community cancer clinicians should attend, at least annually, an educational meeting (organised by the skin cancer network site specific group), which should:

- present the 6 monthly BCC network audit results, including a breakdown of individual performance
- the audit to be completed against the standards in the NICE guidance document relating to type, size and location of lesion
- include one CPD session (a total of 4 hours) on skin lesion recognition and the diagnosis and management of low risk BCCs.

Note: Attendance at four MDTs per year plus the annual educational meeting arranged by the network plus the joint clinical session with the core member of the MDT is likely to fulfil the 15 hours skin cancer CPD requirements for this group of clinicians.

5.4 Re-accreditation

The recommendations for re-accreditation are set out in *Implementing care closer to home Convenient quality care for patients, Part 3: The accreditation of GPs and Pharmacists with Special Interests.*

PART 2: General Practitioners Performing Skin Surgery

As outlined earlier in this document, skin surgery services can be delivered by dermatology and skin lesions GPwSIs, and the framework in Part 1 sets out clearly the requirements for training and accreditation. Additionally, there are many GPs, who do not consider themselves dermatology or skin lesions GPwSIs, who would like to provide (or are already providing) skin surgery services within their practices.

The professional and patient representative groups that contributed to this guidance were concerned to ensure that people had equity in access to high quality care. This section, therefore, provides recommendations from these groups in respect of GPs (and other primary care health care professionals) that provide skin surgery services as part of primary medical care contracts using the Directed Enhanced Service or under a Local Enhanced Service (DES/LES). Responsibility for primary medical care, which currently sits with PCTs, will move to the NHS Commissioning Board when it becomes formally established, and the process for how this will be managed will be considered as part of the wider healthcare reforms.

Skin surgery services provided using the Directed Enhanced Service or under a Local Enhanced Service (DES/LES) under General or Personal Medical Services

GPs and other primary care health care professionals performing skin surgery within the framework of the DES under General or Personal Medical Services have contractual requirements in relation to the service they provide (if it is agreed locally, these may also be incorporated into a LES). These requirements (shown in green below), are set out in The Primary Medical Services (Directed Enhanced Services) (England) Directions 2010[14].

The professional and patient representative groups who contributed to this guidance have identified measures of competency and activity against these requirements, which commissioners and deliverers of minor surgery under a DES or LES will wish to consider to ensure care is appropriate and of high quality.

'a requirement that the contractor ensures that any health care professional who is involved in performing in any surgical procedures has:

i. any necessary experience, skills and training with regard to that procedure

ii. resuscitation skills'

To assess whether this requirement has been met, it is recommended that consideration be given to the following:

- has a new skin surgery practitioner demonstrated competency to a suitably qualified external body using objective evidence and competency based assessment tool? The assessment tools in this document are appropriate (Direct Observation of Procedural Skills, known as DOPS)
- has an existing practitioner demonstrated competency to perform the designated procedure(s) to a suitably qualified external body using objective evidence and competency based assessment tools within the preceding three years? DOPS assessment, as above, is appropriate
- does the practitioner continue to perform skin surgery with a regular, sustained level of activity and follow a program of revalidation? 100 skin surgery procedures

per year that leave a scar (excluding cryosurgery) is recommended. If less than 100 procedures per year are performed, it is suggested that the practitioner demonstrate ongoing competency to perform the designated procedure(s) by completion of further DOPS assessments at three yearly intervals, unless the activity increases to the recommended amount

- has the practitioner demonstrated training and ongoing medical education in the recognition and management of skin lesions appropriate to their role (for example, a practice nurse performing skin surgery on pre-diagnosed skin lesions will have different skin lesion diagnostic skill requirements to a GP diagnosing and excising lesions)?
- does the practitioner have evidence of annual training in resuscitation?

'a requirement that the contractor:

i. obtains written consent for the surgical procedure before it is carried out (where a person consents on a patient's behalf, that person's relationship to the patient must be recorded on the consent form), and

ii. takes all reasonable steps to ensure that the consent form is included in the lifelong medical records held by the patient's general practitioner'

To assess whether this requirement has been met, it is recommended that consideration be given to the following:

- is the practitioner familiar with Department of Health and General Medical Council guidance on informed consent, particularly in relation to the Mental Capacity Act and obtaining consent from minors, and has best practice as detailed in these guidance documents been adopted?

'a requirement that the contractor ensures that all tissue removed by surgical procedures is sent for histological examination, unless there are acceptable reasons for not doing so'

To assess whether this requirement has been met, it is recommended that consideration be given to the following:

- does the practitioner send all skin specimens removed to histology for analysis and provide information about the site of excision and provisional diagnosis on the histology request form?
- does the practitioner maintain a 'fail-safe' log of all procedures performed with histological outcome to ensure that patients are informed of the final diagnosis, and whether any further treatment or follow-up is required? Is this undertaken in a timely fashion?

'a requirement that the contractor ensures that it has appropriate arrangements for infection control and decontamination in premises where surgical procedures are undertaken'

To assess whether this requirement has been met, it is recommended that the following be considered:

- is the practitioner aware of, and following, all relevant national guidance in relation to policies and procedures (for example premises, facilities, infection control, needlestick injuries etc)?

'a requirement that the contractor ensures that all records relating to all surgical procedures are maintained in such a way:

i. that aggregated data and details of individual patients are readily accessible for lawful purposes, and

ii. as to facilitate regular audit and peer review by the contractor of the performance of surgical procedures under the plan'

To assess whether this requirement has been met, it is recommended that the following be considered:

- does the practitioner provide evidence of an annual review of clinical compared with histological accuracy in diagnosis to demonstrate diagnostic competency?
- has a wound infection and patient experience study been completed?
- when low risk BCCs are excised, does the practitioner demonstrate that the requirements in *Improving Outcomes for people with skin tumours including melanoma (update) - The management of low-risk basal cell carcinomas (May 2010)* are met (see Annex E)?
- is the above considered as part of the annual appraisal process?

Commissioning skin surgery services

Commissioners are reminded that anyone having a surgical procedure performed ought to be confident that:

- the procedure was necessary
- it was appropriate to have the procedure performed (in relation to agreed local and national low priorities frameworks)
- the appropriate procedure was performed (this requires access to diagnostic skills)
- the clinician performing it was suitably trained
- the facilities were to the appropriate standard.

To reduce unnecessary and inappropriate skin surgery, good diagnostic skills are essential. All clinicians performing skin surgery should be strongly encouraged to improve their diagnostic skills.

Commissioners may wish to develop service delivery models that separate diagnosis and management as proposed in the NHS Modernisation Agency's Action On Plastic Surgery (AOPS) guidance[15]. These proposals suggested rapid access to specialist diagnostic services supported by suitably trained and accredited skin surgery services delivered as an integrated model across health communities.

Annex A: Points to consider when developing a service model for GPwSI services

General

- The types of patients with skin disease suitable for the service should be considered, including age range, symptoms, severity of symptoms, minimum and maximum caseload/frequency and reason for referral.
- It is important that the workload is such that GPwSIs are able to exercise their generalist as well as special interest skills.
- The numbers seen should be sufficient to maintain and develop expertise to justify the need for the services and should be broadly in line with those seen in a comparable hospital-based dermatology clinic.
- Patients referred to the service are unlikely to have acute or emergency skin disease or skin cancer (unless a specific skin cancer service is being developed). Nevertheless, it is expected that the GPwSI will have in place appropriate care pathways to manage such patients if they present unexpectedly to the service.

Where skin surgery services are being provided across a health community, commissioners are reminded that patients should be reassured about the following:

- that the procedures being performed are necessary
- that it is appropriate to have the procedure performed (in relation to agreed local and national low priorities frameworks)
- that the appropriate procedure is performed (this requires access to diagnostic skills)
- that the clinician performing it is suitably trained
- that the facilities are to the appropriate standard.

We recommend that commissioners commission skin surgery services as part of an integrated model of dermatology services.

Local guidelines for the use of the service

- Details will be determined at local level following negotiations between key stakeholders within the local community, including patient groups wherever possible. The service needs to reflect the requirements of the local community.
- Local guidelines for the service should reflect and incorporate nationally agreed guidelines and as such the GPwSI will demonstrate awareness of national relevant advice issued by organisations such as the BAD, NICE, Department of Health, and the NHS Modernisation Agency. This will include the Action On Dermatology good practice guide[16] and the baseline standards for all dermatology departments.

These guidelines should include the following information for referring clinicians:

- types of patients to be referred to service, including inclusion and exclusion criteria
- referral pathways
- response time
- communication pathways.

Annex B: Assessment tools

It is expected that, as part of the accreditation process, the assessment of individual competences will include observation of clinical practice using approved work place based assessment tools. The recommended clinical assessment tools include the modified mini-CEX (mini clinical examination), DOPS (direct observation of procedural skills) and case based discussions linked to a log diary/portfolio of cases. The assessments should cover the range of knowledge and skills required for the clinical service to be provided.

The following notes are intended to support the effective use of these assessment tools.

- The assessments will be performed by suitably trained assessors, having experience of the use of the appropriate assessment tool. This will usually be a consultant dermatologist on the specialist register or dermatology associate specialist.
- The assessor should be regularly undertaking the activity/skill being assessed and be appropriate to the assessment. For example for advanced skin surgery procedures this may be a suitably trained surgeon.
- Wherever possible more than one assessor should be involved in the assessment process and this is particularly important where the mentor is one of the assessors
- It is strongly recommended that a series of appropriate clinical assessments including a modified mini-CEX take place at three monthly intervals until competency has been demonstrated during the training period prior to accreditation.
- Each clinical assessment is expected to take the equivalent of one session and should be performed by a consultant dermatologist, ideally an alternative to the training consultant.
- The assessor is expected to be present throughout the session and to make assessments, covering different clinical domains, from a number of patient interactions.
- Several modified mini-CEXs covering different areas are expected to be performed during each of the clinical assessment sessions.
- The subject/areas covered will depend on the type of service the dermatology GPwSI is going to offer. This will be agreed at the start of the training.
- The assessment outcome will be 'satisfactory' or 'unsatisfactory'. Time will be allocated for feedback.
- It is expected that one of the assessments should include a review of case notes and, for those offering a surgical service, a review of histology reports (to consider appropriateness of procedure, completeness of excision etc).
- It is expected that GPwSIs will need training in the recognition and management of conditions normally seen/managed in secondary care and that this knowledge will be acquired via continuing medical education.
- Logbooks – there will be other competences that are not included but desirable; these will be documented in the GPwSI logbook and signed off by the trainer. This will probably differ for the individual GPwSIs and the detail will need to be agreed with the trainer at the beginning of training.
- As a post evolves and develops into new clinical areas following accreditation for a particular role, further assessments may be required to demonstrate new competences appropriate to a changing role

- Studying for a diploma in dermatology provides a good opportunity for structured learning.
- Clinicians will be expected to demonstrate evidence of 360-degree review using approved tools, for example those available from http://www.jrcptb.org.uk/assessment/Pages/Workplace-Based-Assessment.aspx
- The DOPS tool will be appropriate for the assessment of practical skills during the DOPS assessment sessions.
- Helpful general and specialty-specific guidance for the use of DOPS and mini-CEX can be found at the websites of the British Association of Dermatologists (www.bad.org.uk), the Royal College of General Practitioners (www.rcgp.org.uk), and the Joint Royal Colleges Postgraduate Training Board (www.jrcptb.org.uk).

Table 1a: Clinical assessment using a modified mini-cex for all GPwSIs Recognition and management of common non-malignant, pre-malignant and malignant lesions.

Subject	Satisfactory	Unsatisfactory	Assessor's comment and signature	Date
Benign melanocytic naevi				
Basal cell papilloma/ seborrhoeic keratosis				
Dermatofibroma				
Haemangioma				
Epidermoid/pilar cyst				
Pyogenic granuloma and blood vessel derived tumours				
Hypertrophic scars				
Actinic keratoses				
Bowen's disease				
Keratoacanthoma				
Squamous cell carcinoma				
Basal cell carcinoma				
Lentigo maligna				
Malignant melanoma				
Differential diagnoses of skin lesions (e.g. discoid eczema, tinea, plaque psoriasis)				
The role of dermoscopy				
Familiarity with and knowledge of NICE skin cancer guidance				

Table 1b: Clinical assessment using a modified mini-cex for Groups 1, 2 and 3 GPwSIs, inflammatory skin disorders

Subject	Satisfactory	Unsatisfactory	Assessor's comment and signature	Date
Eczema				
• Atopic				
• Seborrhoeic				
• Varicose				
• Allergic contact				
• Irritant contact				
Psoriasis				
• Plaque				
• Guttate				
• Palmar-plantar				
• Pustular				
• Erythrodermic				
Acne				
Urticaria/angio-oedema				
Rosacea				
Infections				
Infestations				
Leg ulcers				
Gravitational disease				
Diseases of hair nails and mucosa				
Drug rashes				
Pigmentary disorders including vitiligo				
Hyperhidrosis				
Hirsutism				
Lichen planus				
Skin manifestations of systemic diseases				
An understanding of photodermatoses				

Table 2: Clinical assessment using Direct Observation of Procedural Skills (DOPS)

These apply to Groups 2, 3 and skin lesion GPwSIs and the DOPS assessed will vary with the clinical service provided. The skills marked * are appropriate, as a minimum, for Group 1 GPwSIs. Where a Group 1 GPwSI wishes to offer a skin biopsy diagnostic service as part of the management of inflammatory skin disorders then the appropriate DOPS assessments for skin biopsy will need to be undertaken.

Subject	Satisfactory	Unsatisfactory	Assessor's comment and signature	Date
Obtaining informed consent				
Technique for* cryotherapy				
Technique for administration of intralesional triamcinolone*				
Practice of aseptic technique				
Safe use of local anaesthesia				
Technique for curettage and cautery				
Technique for performing punch biopsy				
Technique for performing an incisional biopsy				
Technique for performing shave biopsy/excision				
Simple suture technique				
Anatomy relevant to area of surgery				
Technique for performing an ellipse excision				
Haemostatic techniques				

Full excision with appropriate closure including deep sutures as required and interrupted sutures: trunk and limbs				
Full excision with appropriate closure including deep sutures as required and interrupted sutures: face				
Subcuticular suturing				
Other suture techniques (specify)				
Dog ear: prevention and management				
Wound care including application of steristrips and other types of wound closure				
Post-operative advice and wound care management				
Post-operative complications				
Specimen preservation and transportation, histology stains				
Documentation				

Table 3: Case Based Discussion: suggested framework and sample headings

Introduction Presenting Complaint Background History & Examination
Differential Diagnosis
Management
Follow-Up
Assessment of management
Challenges
Specialist Opinion
Lessons Learnt
References

Annex C: Assessment requirements

Services provided	Assessment required
Group 1 Dermatology: diagnosis and management of skin disease	Mini-CEX at three monthly intervals until competency is demonstrated Table 1a (recognition and management of common non-malignant, pre-malignant and malignant lesions) and Table 1b (inflamatory skin disorders). Limited procedural DOPS assessments (Table 2) dependent upon services provided (minimum cryotherapy).
Group 2 Dermatology & skin surgery: diagnosis and management of skin disease and benign skin surgery	Mini-CEX at three monthly intervals until competency is demonstrated Table 1a (recognition and management of common non-malignant, pre-malignant and malignant lesions and Table 1b (inflammatory skin disorders) DOPS assessments (Table 2) dependent upon skin surgery services to be provided
Group 3 Dermatology, skin surgery & community skin cancer: diagnosis and management of skin disease, skin surgery including community skin cancer services	Mini-CEX at three monthly intervals until competency is demonstrated Table 1a (recognition and management of common non-malignant, pre-malignant and malignant lesions) and Table 1b (inflammatory skin disorders). Meet requirements in the updated NICE IOG 2010. DOPS assessments (Table 2) dependent upon skin surgery services to be provided
Skin lesions GPwSI: skin lesions and skin surgery including community skin cancer services	Mini-CEX at three monthly intervals until competency is demonstrated, Table 1a (recognition and management of common non-malignant, pre-malignant and malignant lesions). Meet requirements in the updated NICE IOG 2010. DOPS assessments (Table 2) dependent upon skin surgery services to be provided

Annex D: Log diary (sample page)

Date	Location/ setting	Patient initials, gender and age	Clinical diagnosis	Learning/ action points	Action taken
21/08/2010	GPwSI clinic, St Elsewheres community hospital	JKS aged 25, female	Acne with severe psychological impact and body dysmorphic disorder	Find out more about this problem and management. Would be great to offer more support for this patient, look at available training courses in this area (mind and skin)	Booked to attend 'Mind and Skin' module at local university
21/08/2010	GP surgery	MB 35yrs, female	Nail dystrophy related to use of false nails	Find out more about problems of contact dermatitis and nail products, identify appropriate texts	Purchases 'Nails: appearance ad therapy' by de Berker

Annex E: Extract from NICE skin tumour guidance (update)

Excision of low risk basal cell carcinoma performed by general practitioners (DES/LES), from National Institute for Health and Clinical Excellence (2010)
Improving outcomes for people with skin tumours including melanoma (update) - The management low-risk basal cell carcinomas in the community

Low-risk Basal Cell Carcinomas (BCCs) for DES/LES

GPs performing skin surgery within the framework of the DES and LES under General or Personal Medical Services

Only those low-risk BCCs in anatomical sites where excision is easy and in patients who do not have other associated risk factors should be managed by GPs with no special interest or training in skin cancer. The types of low-risk BCC that these GPs can excise and the requirements for their accreditation by the PCT or LHB are outlined below:

Box 1 Low-risk BCCs for DES/LES

Services for the removal of low-risk nodular BCCs that can be commissioned from GPs within the framework of the DES and LES under General or Personal Medical Services

Services should be commissioned from these GPs where there is no diagnostic uncertainty that the lesion is a primary nodular low-risk BCC and it meets the following criteria:

- The patient is not:
  - aged 24 years or younger (that is, a child or young adult)
  - immunosuppressed or has Gorlin's syndrome
- The lesion:
  - is located below the clavicle (that is, not on the head or neck)
  - is less than 1 cm in diameter with clearly defined margins
  - is not a recurrent BCC following incomplete excision
  - is not a persistent BCC that has been incompletely excised according to histology
  - is not morphoeic, infiltrative or basosquamous in appearance
  - is not located:
    - over important underlying anatomical structures (for example, major vessels or nerves)
    - in an area where primary surgical closure may be difficult (for example, digits or front of shin)
    - in an area where difficult excision may lead to a poor cosmetic result
    - at another highly visible anatomical site (for example, anterior chest or shoulders) where a good cosmetic result is important to the patient.

If the BCC does not meet the above criteria, or there is any diagnostic doubt, following discussion with the patient they should be referred to a member of the LSMDT.

If the lesion is thought to be a superficial BCC the GP should ensure that the patient is offered the full range of medical treatments (including, for example, photodynamic therapy) and this may require referral to a member of the LSMDT.

Incompletely excised BCCs should be discussed with a member of the LSMDT.

Criteria for accreditation of GPs within the framework of the DES and LES under General or Personal Medical Services

GPs performing skin surgery on low-risk BCCs within the framework of the DES and LES
under General or Personal Medical Services should:

- demonstrate competency in performing local anaesthesia, punch biopsy, shave excision, curettage and elliptical excision using the direct observation of procedural skills (DOPS) assessment tool in the Department Health Guidance for GPwSIs in dermatology and skin surgery
- have specialist training in the recognition and diagnosis of skin lesions appropriate to their role and then follow a program of revalidation
- send all skin specimens removed to histology for analysis
- provide information about the site of excision and provisional diagnosis on the histology request form
- maintain a 'fail-safe' log of all their procedures with histological outcome to ensure that patients are informed of the final diagnosis, and whether any further treatment or follow-up is required
- provide quarterly feedback to their PCT or LHB on the histology reported as required by the national skin cancer minimum dataset, including details of all proven BCCs
- provide details to their PCT or LHB of all types of skin cancer removed in their practice as described in the 2006 NICE guidance on skin cancer services and should not knowingly remove skin cancers other than low-risk BCCs
- provide evidence of an annual review of clinical compared with histological accuracy in diagnosis for the low-risk BCCs they have managed
- attend, at least annually, an educational meeting (organised by the Skin Cancer Network Site Specific Group), which should:
    - present the 6-monthly BCC network audit results, including a breakdown of individual practitioner performance
    - include one CPD session (a total of 4 hours) on skin lesion recognition and the diagnosis and management of low-risk BCCs
    - be run at least twice a year.

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