Nottingham and Nottinghamshire ICS

Skin Health

Clinical and Community Services Strategy

FINAL V3.1 October 2020

This information has been placed in the public domain in order to benefit patients across the country as we believe the experience and approach may be useful for others, however we request that acknowledgement to the work in Nottinghamshire is made and referenced in all materials. This helps us to understand the wider impact benefits of our programme. Please cite 'this work has been informed by the Nottingham and Nottinghamshire ICS' when referencing.

Contents

1. Executive Summary

The Integrated Care System (ICS) ambition across Nottinghamshire is to both increase the duration of people's lives and to improve the quality of those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The aim of the Clinical and Community Services Strategy (CCSS) is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention, delivered in people's homes or in community locations where this is appropriate with a long term view of beyond 5 years.

Each year in England, 54% of the population are affected by skin disease, although almost 69% of people tend to self-care. It has been suggested that at any one time, 23%–33% of those affected by skin disease would benefit from medical care. Skin disease is a common and distressing condition, costing the NHS in England and Wales around £1,820 million a year – which is lower than other chronic diseases, however, skin conditions are among the most common diseases encountered by health professionals. There are 13 million primary care consultations for skin conditions each year in England and Wales. The consultation rate is two for each episode, and the average GP has 630 consultations per year for skin conditions, which is likely to be an underestimate due to coding issues. While there are well over 1,000 dermatological diseases, just 10 of them account for 80% of GP consultations for skin conditions.

For a an area of health care that impacts so many people, the education and awareness for healthcare professionals (HCP) is in contrast quite poor. Education and awareness for most GPs and pharmacists is lacking so whilst there are many over-the-counter (OTC) drugs bought and used by people that have developed a skin condition, this presents an opportunity, if appropriately trained for the pharmacist to provide the most appropriate advice and make every contact count (MECC). In 2007, the OTC treatments and drugs bought for skin conditions was estimated at £413.9M or 18.9% of OTC sales, Yet, the training for pharmacists in the management of skin conditions is limited and evidence suggests the advice given may not be appropriate.

This skin health service review has been undertaken as part of the ICS CCSS work stream. It has been supported by clinical experts and stakeholders in the development of place based service models for the future, to support the long term needs of our existing citizens. The review also focuses on embedding prevention in our population over the next 5-10 years, by shifting our culture from one of illness to one of healthier lifestyles and self-care.

The strategy identifies major stages in the skin health patient's journey and stresses a need to reorganise the way in which these services are delivered, from prevention through to longer term support, particularly for those living with long term skin conditions. A whole pathway approach in the provision of skin health services is crucial in order to maximise the clinical outcome for patients, their quality of life and experience of skin health services.

Key themes have been identified along with key transformational opportunities and potential impacts have been developed which include: prevention strategies to promote healthy living and independence through improved self-management; improved access & shared communication about patients' past medical history from acute care settings to community specialists, such as the GP with an extended role (GPwER) in skin health; appropriate levels of workforce skill mix across the ICS; standardise access to services and support such as equitable access to a GPwER or appropriate mental health access.

A transformational 'Bridge to the Future' highlights current service offers across the ICS and identifies some potential long term next steps that can be taken to achieve the identified opportunities with proposed timelines and the expected outcome for our citizens of Nottinghamshire.

The recommended next steps are vital in keeping the momentum of change in the future offer of improved prevention and better health for our citizens; providing the right tools for our population to support their wellbeing; providing strong communication links for our staff is vital to enable them to provide the best care for our citizens; the most appropriate models of care in acute settings, neighbourhood and home need to be provided equitably across the ICS and be provided using best evidence, flexibly and in a patient centred way for them to fulfil their maximum potential throughout their lifetime.

2. Introduction

Background and Purpose	In Nottinghamshire we have made great progress in improving people's health and wellbeing. Today, we can treat diseases and conditions we once thought untreatable. However, our health and care system faces change and this will impact on our services, for example, the growing prevalence of long-term health conditions places new strains on our system. There is inequality evident in both the location of service and in access to services. In some areas, it is easier to access a GP than in others, or to find things to do to enable citizens to stay active and fit. The ICS ambition across Nottinghamshire is to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The requirement for a CCSS came from the recognition that to achieve this ambition the system has to change as a whole, rather than just in its individual acute, primary care, community and social care elements. It is recognised that only by working together to describe changes in how care is provided across the system, rather than through individual organisations, can the scale of change required be delivered.
The ICS Clinical and Community Services Strategy	The aim of the CCSS is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention. This should be delivered closer to people's homes or in community locations where this enables better prevention, more supported self-care and earlier intervention to support citizens. The Strategy recognises that achieving this change is a long term programme that will be delivered over the next 5 years and beyond. This is also to enable a necessary long term investment in the health and care buildings and infrastructure in the system. An overall CCSS whole life model framework has been developed to focus on the need to support people through their lives from living healthy, supporting people with illness and urgent and emergency care through to end of life care. Citizens can experience different parts of the system at different stages in their lives. With the development of the overall Strategy framework the next phase of work is to review the 20 areas of service across the ICS that collectively form approximately 80% of the volume of clinical work in the ICS. This will ensure that overall the Strategy is described as a coherent whole and generates a programme of change for the whole ICS. This review of Skin Health Services is one such review and is part of the second phase of work.
NHS Long Term Plan	The NHS LTP is clear that to meet the challenges that face the NHS it will increasingly need to be more joined up and coordinated in its care; More proactive in the services it provides; More differentiated in its support offer to its individuals. The ICS has focused on describing 5 areas of focus for the delivery of the NHS LTP. These requirements are reflected in each of the service reviews that collectively will describe the CCSS **1. Prevention and the wider determinants of health -** More action on and improvements in the upstream prevention of avoidable illness and its exacerbations **2. Proactive care, self management and personalisation -** Improve support to people at risk of and living with single and multiple long term conditions and disabilities through greater proactive care, self-management and personalisation **3. Urgent and emergency care -** Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting **4. Mental health** - Re-shape and transform services and other interventions so they better respond to the mental health and care needs of our population **5. Value, resilience and sustainability -** Deliver increased value, resilience and sustainability across the system (including estates)

3. Approach and Scope

Approach	This strategy has been developed through an open and inclusive process which weaves together the expertise of clinicians and care experts with commissioners and citizens in determining the future shape of services across the system. There have been a variety of stakeholder and service user events to develop a clinical and community services model. An extensive system wide piece of work is taking place across a minimum of 20 services. The CCSS Programme Board have reviewed these services against a range of quantitative and qualitative criteria and agreed the second phase of six service reviews. These include; Diabetes; Eye Health; Skin Health; Women's Health; Heart Health and Urgent Care. Due to lockdown following the outbreak of the pandemic, Corona Virus Disease 2019 (COVID19), it was decided to stall Heart Health and Urgent Care, which will be resumed in-line with clinical commitments in response to the pandemic. This document discusses the approach, scope, the key issues and potential transformational opportunities within Skin Health services across the ICS. Health, social care, public health and the voluntary sectors have all been considered through reviewing the current service offer across the ICS. The service review was taken over approximately 20 weeks, unfortunately holding a workshop with stakeholders across the ICS was not possible due to the lockdown. An evidence review pack was developed which considered national and local best practice to inform the development of potential themes and new models of care where transformational change may take place across the ICS in the future.
Scope	**In scope:** Skin health as a service includes a wide range of conditions, which can present a challenge in itself to review such a diverse set – there are 1,000+ dermatological diseases, but just 10 of them account for 80% of GPs consultations. However, it was agreed by the steering group to include the main conditions that contribute to the majority of the workload for the service, including paediatrics. The skin conditions this includes are: • Eczema • Psoriasis • Acne • Rosacea • Seborhoeic dermatitis • Pruritis • Prurigo • Skin lesions • BCC • Melanoma Skin cancers can be preventable, in fact in more than 4 out of 5 cases skin cancer can be prevented. **Not in scope:** Skin sarcomas, pressure sores.
Engagement	The Skin Health service review has been supported by a Skin Health Steering Group including stakeholders and clinical experts from across the ICS. They have provided expert advice, guided, confirmed and challenged assumptions throughout the period of review and connected to other workstreams. This group has formed part of the governance process along with the CCSS Programme Board. For the skin health review, it was not possible to hold a workshop or patient focus groups due to the COVID19 lockdown. Previously, this has been held enabling a wide breadth of stakeholders (Patients, Clinicians, Allied Health Professional (AHP), Nurses, Charities, Heads of Service, Commissioners and others) to be proactively involved in re-evaluating current service offers across the ICS, in developing potential themes and agreeing transformational change for the future Clinical and Community Services Strategy. Although engagement was restricted to the steering group, this included members from organisations and roles across the system, including those above, except patients and charities The intention is to still consider patient interaction, perhaps remotely via video conferencing, which will enabled them to confirm and challenge assumptions and play an active part in shaping of the enclosed proposals for any future service changes across the ICS.

4. Contents

Strategy Development	This Strategy Document consists of five key elements. These have been developed through a process of design and iteration at the steering groups. The strategy has been developed with reference to the Evidence Review document and alignment to the NHS LTP linked to skin health specifically, but also in some of the generic principles.
Priorities for Change	The work of the Steering Group identified four key areas of focus that need to change in the ICS for Skin Health care. These were based on a review of the current issues facing the ICS and the views of the Steering Group members.
Proposed Future Care System	Following the evidence review at subsequent steering group meetings, attendees started to develop the future care system for Skin Health to address the Priorities for Change. The future care system is described against two dimensions • **Location** split between - Home (usual place of residence) – Acute Hospital with 24/7 medical presence – Neighbourhood representing all community/primary care and ambulatory care settings • **Urgency** split between - **Emergency/Crisis** requiring a service provided 24/7 to avoid crisis or risk to life – **Urgent** requiring a service 7/7 but not 24/7 to meet urgent care needs – **Scheduled/ planned care** reflecting any arrangement where an appointment is agreed between a professional and a citizen The intention of the system model is to focus future care delivery closer to home and also with greater levels of scheduled care to best use the available resources and reduce demand on urgent and emergency care services. The new system to address the Priorities for Change is presented for each location and then summarised overall for the ICS.
Transformation Proposal	The Transformation proposal described the key initiatives or programmes that are required to deliver this new model. Namely, • **Priority** – What is the priority of the initiative in the view of the steering group and workshop attendees? • **Alignment** – At what level of the system should we aim to deliver each initiative? In most instances this is ICS level but there are some instances where the recommendation is for delivery to be at Integrated Care Provider (ICP) level where the greater value is perceived to be in an overall consistent approach. Alternatively, it is at Primary Care Network (PCN) level where differential delivery would benefit the needs of very local populations • **Enabling Requirements** – What is required to enable each Programme to deliver? This includes workforce, technology, estate or service configuration. There are also requirements of culture or finance and commissioning to allow the system to work together differently • **Benefits and Costs** – Where available, the key benefits of the initiative at system level are summarised
Bridge to the Future	The ‘Bridge to the Future’ or future vision of the service was generated at a further virtual steering group meeting. It summarises the current challenges and status of the skin health system in the ICS now (Priorities for Change), where we would like to be and how we plan to get there. Progress with the ‘Bridge to the Future’ and the partnering vision can be returned to with stakeholders as the work develops to ensure the work remains on track.

Skin Health Key Themes and Areas of Priority

Prevention & Self-Care

- Education and Awareness
- Self-help resources
- Early intervention

Dermatology in Primary Care

- Community Hubs
- Triage, Referrals, Tele-dermatology
- Training and Education for GPs, GPSIs

Hospital Care

- Demand and Capacity
- Staff skillmix and upskilling
- Face to face (F2F) inpatient consultation

Condition Management

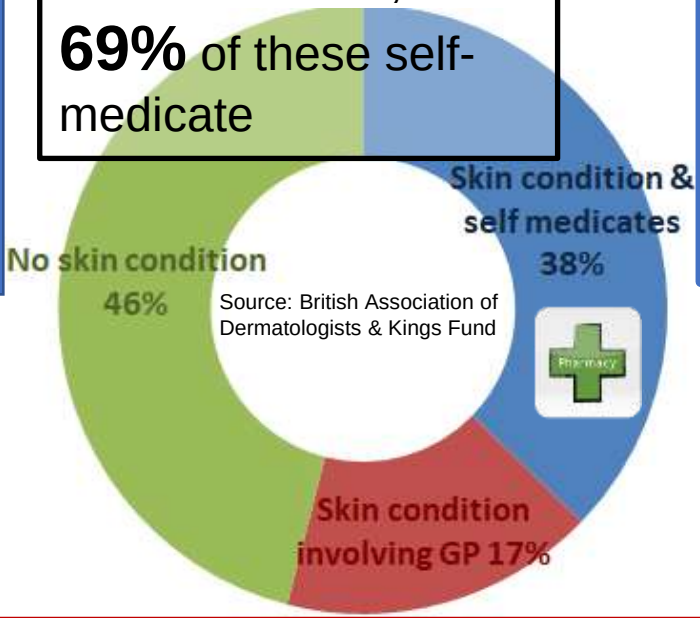
- Ongoing Care and Management
- Living with a skin condition (third sector support)
- Mental and Social Health Support

Access

More than **4** in **5** cases of skin cancer is preventable

British Association of Dermatologists

54% of people have a skin condition, but **69%** of these self-medicate



Source: British Association of Dermatologists & Kings Fund

18% of UK over the counter sales are for skin conditions. £413.9M in 2007.

Skin Conditions in the UK: A health Needs Assessment 2009.

Better skin care in the sun could prevent **90%** of melanomas

Cancer Research UK

In our ICS **0.5M** people buy over the counter skin products yet **pharmacists** have no skin health training

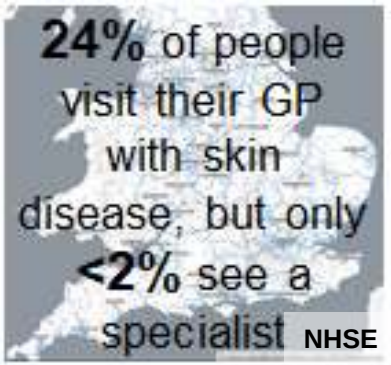
Skin Conditions in the UK: A health Needs Assessment 2009.

Skin disorders are commonest reason to visit GP with a new problem **BUT GP training & knowledge in dermatology is limited**

80% of skin consultations with GPs are for just **10** common skin conditions

British Association of Dermatologists & Kings Fund

65% of NUH telederm requests result in patients discharged to GP with advice and guidance. Aug 19-Jan 20 NUH



Priorities for Change - Infographics

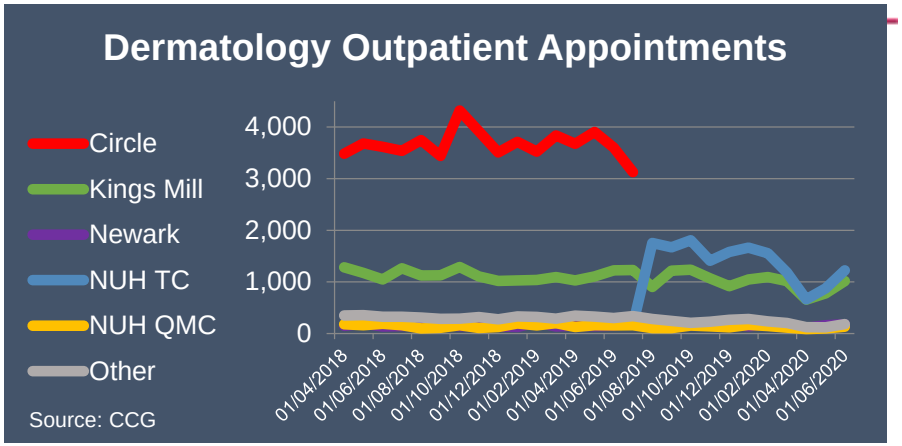
Integrated Care System
Nottingham & Nottinghamshire

www.healthandcarenotts.co.uk @NHSNottingham

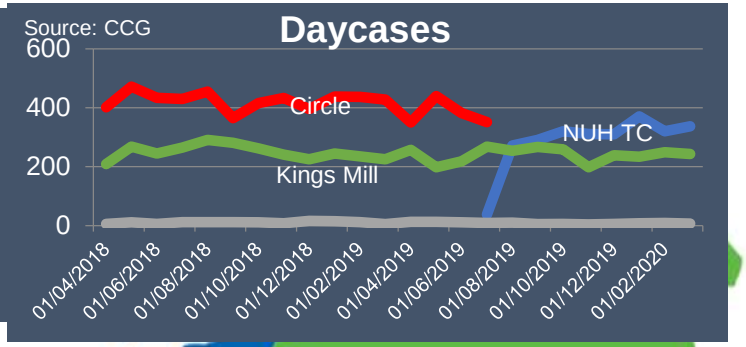
		17/18	18/19	19/20
Circle	elective	98	9	7
NUH	elective	0	0	6
	emergency	6	0	2
SFHFT	elective	31	1	2
	emergency	14	17	5
Other	elective	2	0	2
	emergency	2	0	1

Source: CCG

10M people in the UK with a skin condition say it has affected their **mental health**.
survey E45



OPAs are lower since NUH took over the Treatment Centre



Mid-Notts
Referrals Triaged by GPwER:
63% referrals not seen in acute setting
(1,210 referrals avoided in 2019/20)

Referrals are NOT triaged in these CCGs

e-Referrals:

Source: eHealthScope

	2017/18	2018/19	2019/20
Mid-Notts	4,940	5,069	4,453
Nottingham City	4,176	4,479	4,746
Rushcliffe	1,582	1,941	2,098
South Notts (excl Rushcliffe)	3,621	4,742	4,963
Total ICS	14,319	16,231	16,260

Opportunity to reduce referral levels by effective development of GPwER across the ICS

Rushcliffe
Referrals Triaged by GPwER:
63% referrals avoided acute setting.
(Data from 8 week trial)

Basal Cell Carcinoma (BCC) Referrals are NOT triaged in these CCGs

Rushcliffe
BCC trial: 48% referrals to acute settings prevented

Treatment Centre **BCC** referrals **3.58%** are **cancerous** (Sept-Nov 2019)

5. Priorities for Change

The review identified 4 key areas of focus highlighting potential areas of change which include:

- Prevention & Self-Care (with emphasis on education, awareness and optimising prevention strategies whilst improving early detection and intervention in the neighbourhood setting);
- Dermatology in Primary Care (reviewing the role of the GPs and other HCPs improving education and training to develop GPwERs across the ICS. GPwERs triaging all referrals, increased use of advice and guidance/ Teledermatology);
- Hospital Care (ensuring the right treatment is available in the right place in a timely manner, effectively reducing avoidable hospital visits through effective triage and referral from the community to help with the challenges faced with hospital demand and capacity);
- Condition management (providing improved education of patients to help them come to terms with and understand their condition to improve self-management, but also helping to ensure patients' have access when required to social care along with appropriate mental health support where the need for this has been identified as early as possible and raising patients' awareness of the available charitable and third sector support for specific conditions).

Prevention and Self-Care	In a survey conducted by the British Skin Foundation, they reported 60% of British people currently suffer from or have suffered form a skin disease at some point during their lifetime, including conditions such as eczema, skin cancer and acne. Despite this high figure, and the fact that skin disorders being the commonest reason that people visit their GP with a new problem, the level of training and knowledge of primary care health professionals in dermatology is limited. In addition to GPs, there is an opportunity through the role of HCPs in primary care, to significantly contribute to prevention and self-care and also to early intervention to prevent deterioration of skin conditions. Many resources are available, but these are currently span across many websites or other media links, some perhaps using advertising tactics to boost sales of skincare products. Many of the available resources offer very good advice on the impact of factors such as stress, diet, climate, environment skin products and sun exposure. Leaflets are provided for patient information, available from pharmacies, GP surgeries giving advice on correct application of Perhaps by grouping the accurate and up-to-date information on developed platforms on trusted sites, such as the NHS App focused on Patient Knows Best (PKB) it can lead to needed improvements in sharing self-care resources. Through improved education and raising awareness of the general population, such improvements can help to reduce poor self-management and therefore deterioration of some skin health conditions, but also enable people to recognise more serious conditions sooner and seek the appropriate expert advice and care. Education and awareness needs to be embedded across the ICS to enable improved understanding and access to advice and guidance (A&G) for all GPs. Skin cancers need to be detected early to help reduce a patients risk of disfigurement or in serious cases, of death. Skin cancers found and removed early are almost always curable. The most common type is basal cell carcinoma, (BCC), which grows slowly over time and may damage nearby tissue and organs if left untreated. Squamous cell carcinoma (SCC) is less common but grow faster, with risk of spreading to other body parts and can be fatal if left untreated. Actinic keratosis (AK)) is also known as solar keratosis caused by UV radiation, is the most common pre-cancer which can advance to SCC, or other types of skin cancer. With all these and other skin cancers early detection is again vital and so being able to have these properly assessed and detected or confirmed is paramount and having this access locally in the community is key to improving triage and outcomes. There are GPwER for skin cancers in some parts of the ICS region but this does not provide the equity of access required for all the population to provide. This is a particular area of focus required to improve skin health services across the region.

Dermatology in Primary Care	Locally across the Nottingham and Nottinghamshire ICS, some referrals are made directly to secondary care and some are triaged, with only the appropriate cases going to secondary care for review by a dermatologist. Triaging in community reduces referrals to secondary care and it is evident from local data that this approach is cost effective. In most areas across the region, however, this is not happening so patients are often inappropriately referred perhaps unnecessarily taking the dermatologists time. From 13 million GP appointments annually, only 5.5% are referred onto specialist dermatology services. 80% of these GP appointments are made up of 10 most common skin conditions. Between a third and a half of patients referred by general practitioners to specialists are referred for advice about diagnosis, with the remainder being referred for advice about treatment. The use of digital images and Teledermatology is increasing in skin health, more so than many other specialties. It is important this is does not replace F2F appointments with specialists when needed, with this being the gold standard. Improving triage through use of digital images, allows patients to be better directed to the appropriate specialist in a timely fashion - only 29% of requests through Telederm resulted in a referral to a secondary care specialist. Skin health is a large part of a GPs work but not reflected in the amount of training they receive. There is no compulsory requirement for dermatology training in undergraduate or postgraduate medical programmes of study. There are a large number of independent and supplementary prescribers working in primary care who are able to prescribe for people with skin disease, yet they may receive little or no training in dermatology. Accreditation requires GPwERs to remain as GPs, so the Community clinics have always been an 'add-on' rather than a job in themselves. The model developed locally in Rushcliffe is of one (or more) accredited GPwERs working alongside one (or more) GPs working towards accreditation. This has been quite effective. However, capacity is always going to remain limited in comparison to doctors who only do Dermatology. Mid-Notts also has a GPwER model, providing effective care for its patients and consequently the patients from these two areas have a very different dermatology pathway to the rest of the ICS. They have access to GPwERs which are not available for the rest of the ICS. Rushcliffe citizens are also triaged for BCC via the GPwERs which is unavailable in the rest of the ICS.
Hospital Care	Locally, skin referrals have been rising and referrals to treatment (RTT) targets are not being met. Locally, there is also a shortage of dermatologists, particularly in the Treatment Centre (TC), NUH, with 2 unfilled posts. Where 24% of the population of England and Wales see their GP with a skin condition, only 1.5% are referred onto a specialist. Since 2005 the total outpatient appointments for skin health nationally have nearly doubled to around 118million annually. Causes of this rise in demand are thought to include the increasingly ageing population, rising expectations of skin appearance, improved treatments and the growing number of people living with conditions such as skin cancer, leg ulcers and atopic eczema. Patients also have rising expectations regarding skin, hair and nails. With capacity being an issue in the ICS (more so in the TC), new ways of working need to be considered to prevent increased RTTs. A one stop clinic is an outpatient clinic held either within secondary care or the community where patients are assessed, diagnosed and treated on the same day. Patients receive ongoing treatment advice and guidance if appropriate before being discharged back to the care of their GP. These clinics are typically consultant led and specifically for non-complex cases where patients are unlikely to require ongoing support or input from secondary care. Patients are sent information in advance of the clinic so that they can make an informed decision about their treatment options before they are seen. As described above, improvements across the region in triage of patients may also help to reduce the referrals to hospital specialists. By further developing partnership working with GPwER and GPs improvements can be met. Many units no longer provide 24 hour on-call for dermatology emergencies, but arrangements should be in place to ensure that patients with urgent dermatological problems are seen by a dermatologist within 24 hours of admission and that specialist registrars are trained in emergency dermatology. The demand for out-of-hours dermatology across the East Midlands is low, but access to timely dermatology advice is essential in some situations. Commissioning of a regional dermatology out-of-hours service incorporating digital technology may help to improve the equity of access for all patients across the region.

Condition Management	Once a skin health condition has been identified and diagnosed, there may be curable treatment in some cases or requirements for long-term management of the condition in other cases. It is imperative that the appropriate emphasis and support is made at this stage of the patient journey to reduce lasting impact and ensure the patient is able to manage to live with the condition. Certain skin conditions have significant impact on everyday life - be it physically (hands, legs) or mentally (anxiety over appearance with exposed skin health conditions). There are many charities and voluntary services available to help people manage and live confidentially and independently with skin health conditions. Ongoing care and effective management of long-term skin conditions requires the support and input from the appropriate healthcare professionals, which can enable optimised self-care, thus making more efficient use of available resources. Self-management allows patients to manage their own condition on a long-term basis sometimes with medical input. For skin health, empowering people and communities is a core tenet of the five year forward view and the new models of care, emphasising the role of the individual in maintaining their independence and wellbeing (NHS England, 2017). In December 2015, The Health Foundation released a guide to self-management support, which prescribes a process to help HCPs provide practical advice to patient to enable development of self-management knowledge and skills. This approach enables a holistic approach to patient centred support and can be applied to a variety of services including skin health National initiatives recognise the need to educate patients and promote self-management, however, albeit under expert guidance. Third sector services outline benefits when patients receive the care and support early in the their patient journey. Increasingly better holistic care is recognised as providing patients with an improved quality of life when living with skin health conditions. It is important for HCPs to know which services are available in order to signpost patients appropriately. More evidence is emerging around the importance of addressing psycho-dermatology in patients with skin conditions. Using the principles of MECC, through education of HCPs can provide improved outcomes as early interventions and signposting for support can minimise the deterioration of mental health of patients.

6. Proposed future care system

Home

Planned/Scheduled	Urgent – 24 hours	Emergency/Crisis – 4 hours
Prevention & Self-Care – Education & awareness, self-help resources • Using NHS App/ patient knows best (PKB) – to help manage and interact better with patients remotely. • Education and advice on 'slip, slap, slop' for skin care, appropriate use of medicines and creams, either OTC, or prescribed. • 3rd sector helping to allay common ailments to support – signposting or advertising to raise awareness of what charitable support is available. • Education and awareness for HCPs to advise general communications – good health, but main point is being able to signpost to expert areas for skin conditions. • Use of Apps, on governance trusted sites (e.g. NHS App), directing people to the right place to seek advice and support. Can the governance be made more accurate and trustworthy through a single route – right information and signposting to the right source at point of diagnosis – consistent message across ICS (F12/ NHS App/ PKB, etc.)? This can be used for prevention and self-care improvements – defined responsibility to keep information current. • Being aware of action triggers to proceed to next stage of what treatment you may need, algorithms to help progress to levels of care needed. • Mental health/ social care support at home to support independent living Sustainable by: • Improved support and understanding of risks allows early prevention • Promotes awareness to support self-care • Improved outcomes - reduced rate of disease progression and improved management by lowering prevalence and improving awareness		
Dermatology in Primary Care – Community Hubs, triage/ referrals/ Tele-Dermatology, Training and Education for GPs/ GPwERs • Virtual appointment via smart devices between GPwER and patient home – including appropriate photos. • Patient triage prior to tele/ virtual appointment with GP (to gain background to issue) - provides GP with more detail to be able to signpost/ respond quicker and more appropriately – reduces defensive medicine by allowing GPs to control triage of referrals better. • Tele-derm to allow photos to be sent in if appropriate – also would allow better auditing. • Being armed with the background to enable an informed decision allows more accurate and effective treatment. Sustainable by: • Encourages early detection and therefore early intervention	Dermatology in Primary Care • Some of the planned/ scheduled algorithm moves into the urgent box depending on the route of the investigation. 111 service access more likely OOH. • May need on-call for advice from a GPwER – virtually – low frequency of OOH requirement so perhaps link to an East Midlands model. Sustainable by: • Provides quick response enables earlier intervention • Reduces hospital visits	Dermatology in Primary Care • Some of the planned/ scheduled algorithm moves into the emergency box depending on the route of the investigation – may need 999 response. Sustainable by: • May prevent acute admission
Hospital Care – Capacity and demand, staff skillmix & upskilling, F2F In-patient consultation • Recognition of right trigger to require more urgent response • Understanding the benefits and disadvantages of face to face (F2F) consultations before going virtual. • Dermoscopy/ Telederm to aid decision whether virtual or F2F appointment is required – triaged via GPwER Sustainable by: • Prevents avoidable admissions and GP/ GPwER visits through improved triage		
Condition Management – Ongoing care and management, living with a long-term skin condition, mental & social health support • Understanding how we support those with additional needs – so also making the accessible information and advice available for those more vulnerable, also for carers • Need a consistent method of sharing information and records appropriately across the system and all HCPs – would prevent duplication of tests etc. The design of this system would provide improved equity of access, whatever is deployed would need to be replicable with local access – some things will need more expert response and so more centrally located, e.g. photographs at local pharmacies to send to GPwER enabling more timely advice and guidance. Sustainable by: • Provides home support and promotes self-care and awareness for prevention but also enables people to live more independently, reduces care packages and avoidable appointments		

Colour KEY to information source: Steering Group Evidence Document/ Guideline

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

6. Proposed future care system

Neighbourhood

Planned/Scheduled

Prevention & Self-Care – Education & awareness, self-help resources

- Community pharmacy – education, support patients from first point of call. Formularies that could be used to get education and awareness to patients – what they can buy over the counter.
- Link to the hospital guidelines. Dermnet other providers with great resources BAD.
- Patient.info only aware once GP tells them.
- Work with other professions, beauty therapists to recognise conditions.

Sustainable by:

- Improved support and understanding of risks allows prevention and early detection
- Promotes awareness to support self-care and independence – reduced episodes

Dermatology in Primary Care – Community Hubs, triage/ referrals/ Tele-Dermatology, Training and Education for GPs/ GPwERs

- Integrated service and intermediate care. Need to look at model and evidence what is effectively managed in integrated care – not everything. Cancer and general dermatology. Severe psoriasis and severe drug rashes. Severe life threatening dermatosis likely to require immunosuppressant treatment. Diagnostic uncertainty.
- Rushcliffe – BCC – F2F – 23% to secondary care. General derm 25%. Good model to triage all referrals. Prescribing funding has increased due to all GPs involved in the service.
- GPwER – should be allowed to prescribe red drugs, amber and green drugs only secondary care can prescribe. Ensure adherence to APC guidelines
- Guidelines on managing skin cancers in the community – more GPwER for cancers
- Improved triage to deal with more cases in community (Mid Notts all non- 2WW get triaged)
- Photograph accompanying referral, apps allow patient to take their own photos (aligns to LTP)
- Telederm – nationally choice F2F or advice and guidance referral. Guidance Telederm by consultant dermatologist not GPwER – in national framework, by electronic referral system. Photograph to support enables triage. Best of both worlds. Is it cost effective for all referrals. What infrastructure. 2. Central deposit where secured and PC and secondary care can access. Quality varied. Needs calibrating.
- Patient knows best software. Cusp of starting. Patient can upload photo to GP.
- Training and educating for GPs. Use GPwER, GP registrar – little training currently. Train pharmacist to recognise minor conditions, under-treatment. Consistent advice to patients.

Sustainable by:

- Reduce demand on acute hospitals supporting reduced waiting times and access locally improves satisfaction

Hospital Care – Capacity and demand, staff skillmix & upskilling, F2F In-patient consultation

- Route into secondary care for those that have been seen in community GPwER different to those that haven't seen. Integrated model

Sustainable by:

- Care closer to home, whilst reducing demand on 2° care, partnership working
- Provides much needed social care input early to better support and manage MH

Condition Management – Ongoing care and management, living with a long-term skin condition, mental & social health support

- Better dedicated psychological pathway for those with skin disease. Self-help to dedicated psychologist.
- No community access to trained dermatology nurses. Vital role to this.
- QIPP - practice nurses annual reviews for eczema patients, all domain of dermatology nurse. Practice nurses trained up for asthma, diabetes etc. but not in skin. Need appropriate expertise but not necessarily secondary care. Skill mix practice AHP. Pharmacy.
- Shared care protocol for immunosuppressant – a few GP practices that – extended list of meds in Nottingham, but out of area some improvement can be made. Chronic eczema, doses stable then annual review can be carried out in primary care. Treatment decisions made by specialist care (secondary care) and monitoring in primary care. More drugs to consider adding to this list.
- Vastly improved signposting to skin care charitable organisations able to support patients

Sustainable by:

- Supports independence with more local care – less burden on healthcare

Urgent – 24 hours

Prevention

- Acutely infected eczema useful, impetigo, cellulitis, self-help – guidance when to call doctor and who to call.
- Community pharmacist and patients require more education of what is or not appropriate and need to recognise red flags – review Pharmacist with Extended Role (PwER) perhaps aligned to PCN pharmacies or larger GP pharmacies – LPC to be involved in how this would work.

Sustainable by:

- Provides quick response enables earlier intervention and support to avoid crisis services

Dermatology in Primary Care

- Mental health support for those patients with long term skin health conditions suffering depression

Sustainable by:

- Provides quick response enables earlier intervention and support to avoid crisis services

Hospital Care

- More integration to give opportunity to phone / email consultant, based on system processes.

Sustainable by:

- Develop efficiencies. - shared care and reduces avoidable referrals

Emergency/Crisis – 4 hours

Colour KEY to information source: Steering Group Evidence Document/ Guideline

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6. Proposed future care system

Planned/Scheduled	Urgent – 24 hours	Acute Hospital Emergency/Crisis – 4 hours
Prevention & Self-Care – Education & awareness, self-help resources • Prevention is less of a theme for skin care in hospital • Self-care can be promoted – cream continuation – restricted prescribing – emollient prescribing needs to be more consistent – consistent advice • Emollient prescribing – chronic skin condition repeats – training on formulary – teaching locally in primary care and advice via acute – network role • Responsibility with patient Sustainable by: • Promotes awareness to support self-care and independence – reduced hospital visits • More appropriate appointments in acute hospitals – better patient experience		
Dermatology in Primary Care – Community Hubs, triage/ referrals/ Tele-Dermatology, Training and Education for GPs/ GPwERs • Monitoring of Methotrexate • Monitoring safety – blood tests, compliance • Monitoring skin as well – quick contact point with secondary care • Similar with rheumatology and gastroenterology • Stable patients only • Triage hub in each ICP – to feed in • Pando app – saved referrals into secondary care local advice, GP education – text systems via SystmOne for patients • Telederm is in place and advice and guidance (A&G) is in place – needs engaging • First process has to be Telederm referral – mandatory • IPad models don't work – technology considerations Sustainable by: • Reduce demand on acute hospital capacity including reduced waiting times • Access locally improves patients satisfaction • Improved triage reduced avoidable appointments	Dermatology in Primary Care • Training up of network of GPwERs – 4 sessions covers Rushcliffe – replicate in other areas – getting experience is a challenge Sustainable by: • Strongly supports pathway transformation, with improved triaging, appropriate referrals	
Hospital Care – Capacity and demand, staff skillmix & upskilling, F2F In-patient consultation • Supporting shared care in the primary care setting • Systemic and biologics and skin cancer • Optimisation of topical treatment • Initiate treatment and only once a year – advise via records – advice and guidance • Biologics – 3 monthly monitoring, secondary care via healthcare at home • Oral retinoids – • Safety/unstable/single specialty medication • If every location in Nottinghamshire had a triage system – filter • Can write back and advise based on referral – move into Teledermatology Sustainable by: • Improve efficiency of care in acute setting – right care, right place, right time • Promotes true partnership working to simplify triaging and referrals	Hospital Care • Access to secondary care advice for urgent care – on call dermatologist – phone needs to be held by juniors mobile phone – ring back – urgent cases/GP concern make – more juniors – given workforce in consultant body • Reassurance and advice for primary care – severe skin disease – urgent appointment or admission decision – • Working hours service – 5 days – up until 5pm – frequency of need is not common – awareness of service • If stable remain at home with urgent appointments Sustainable by: • Develop efficiencies. In urgent case triaging	Hospital Treatments • Out of hours – A&E admission – rare emergencies • If severe flare up – stabilisation via medicine Sustainable by: • Negates need for OOH resident consultant
Condition Management – Ongoing care and management, living with a long-term skin condition, mental & social health support • Universal access to ECLO in acute trusts • To stay in hospital: specialist paeds, new macular detachment, surgery, active diabetic retinopathy, neuro ophthalmology – virtual clinics for curable conditions Sustainable by: • Appropriate support and specialist treatment and care	Condition Management • Telephone consultation for advice – Dr Doctor – Acne – for regular consultation Sustainable by: • Reduced attendance for urgent cases, promote self-care	

Colour KEY to information source: Steering Group Evidence Document/ Guideline

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Future Care System – Summary

Integrated Care System
Nottingham & Nottinghamshire

www.healthandcarenotts.co.uk @NHSNottingham

Availability	Acute/ MH Hospital	Neighbourhood	Home
Emergency 4 hours or less – 24/7	• Out of hours A+E admission – rare emergencies, but some provision required • 24/7 regional service required covering all age groups, but not specific to Notts. ICS as would rarely be used – check with specialised commissioning - review against GIRFT report • If severe flare up – stabilisation via medicine		• Some of planned/ scheduled algorithm moves into the emergency box depending on the route of investigation – may need 999 response although very rare – need for 24/7 regional cover (see Acute/ Emergency) - The exact cover is to be determined - use of technology to get dermatology specialist advice. • With depression becoming a bigger issue in those with major skin conditions, immediate access to mental health support to avoid crisis management
Urgent Care/ within 24 hours – 7 days	• Training up of network GPwERs to improve integrated working across ICS • Access to secondary care advice for urgent care – on call dermatologist/ juniors mobile phone with ring back for urgent cases/GP concern • If stable remain at home with urgent appointments	• Acutely infected eczema, impetigo, cellulitis, self-help – guidance when to call doctor and who to call needs clarification • Regional-wide audit regarding on-call use to be reviewed • Community pharmacist and patients require more education of what is or not appropriate and need to recognise red flags – review role of PwER perhaps aligned to PCN pharmacies or larger GP pharmacies – LPC to be involved in how this would work • Opportunity for GPs to contact GPwER and GPwER to contact consultant • Urgent access to mental health services to avoid crisis management for those with long term ski conditions	• Some of the planned/ scheduled algorithm moves into the urgent box depending on the route of the investigation • 111 service access more likely OOH • Access to regional on-call for urgent cases, e.g. for antibiotics
Scheduled – Appt based	• Improved promotion of self-care • Prescribing continuation plan (Acute or primary care) in line with APC guidelines • Teaching and advice via acute locally in primary care – Telederm and advice & guidance is in place – needs engaging • Commissioning of prescribing funds need to recognise the patient care irrespective of primary or secondary – needs to be considered as part of the change model – funding to follow place of prescribing • Monitoring of stable patients – acute service to work with community • Capacity and demand – GPwER to be supported by access to specialist in hospital • Agreement required on which range of drugs can be prescribed by GPwERs – prevents appointments purely for a prescription • Consistent triage and referral system in every ICS location • Template results – based on protocol without seeing patients – telephone appointments for results with specialty nurses – expand range of conditions, using telephone consultation more	•Education for pharmacists and other HCPs, including beauty therapists, to allow them to raise awareness, but also be able to recognise skin conditions early and signpost •Establish GPwERs across the ICS as a priority and then provide training for GPs, AGPs in larger practices, also consideration for Pharmacists with Extended Roles •Existing peer support network has various levels of skin health expertise allowing training to be shared – this needs to be formalised providing a route for the ICS to introduce and train GPwER services across all locations •Need to review required sessions per week across the ICS to provide a GPwER service •Digital Images accompanying referral, Apps allow patients to take own photos – enables better triage •Robust triaging all referrals through GPwER – with access to consultant advice/ expedited appointment if needed •Guidelines on managing skin cancers in community – needs consistent and well covered triage – e.g. BCC, SCC but complex cancers to stay in acute •Route into hospital needs to be standardised - all patients should have quick access to acute if needed •Dedicated access to psychological pathway for those with skin conditions •Need role of a dermatology nurse in community •Treat eczema like asthma – annual reviews, as for asthma – GP/ Practice nurse led •Improve signposting to charitable organisations able to support patients	• Trusted education and advice on prevention and care, appropriate use of medicines and creams, OTC or prescription • Utilisation of digital technology in the form of Apps to allow improved working – to help manage and interact better with patients remotely • Virtual appointments between GPwER and patient at home following triage to collect history, promoting use of photos – history allows more accurate and informed decisions • GPwER to use digital images to aid triage in making decision whether consultant appointment can be virtual or should be face to face and to consider which hospital clinic is appropriate • Support those with additional needs – so making accessible information and advice available for those more vulnerable, also for carers – in understandable format • Mental health/ social care support at home to support independent living

Level of Care

7. Transformation Proposal

Whole system skin health Prevention Strategies and a 3 tier Education Programme cutting across the ICS for:: • ICS Population • Health Care Professionals/ support services • Patients **Medium Priority**	Far more needs to be done to raise awareness of the prevention agenda and ensure the areas of highest risk to skin health are targeted with prevention strategies and structured education. Education for the ICS population on general skin health awareness and information needs to be made readily available from trusted sources both printed and online (e.g. NHS App). Including information to advise early intervention for lesions. Areas of health inequalities, such as socio-economically deprived, ethnic minority areas need to be targeted as these populations are often slow to seek advice and diagnosis. Providing access to trusted resources for the ICS population and enabling easy access (e.g. NHS App/ PKB) with structured encouragement and education from an early age is evident in preventing conditions from developing, but also in seeking accurate and up-to-date self-help treatments or advice and guidance. Involving consultant dermatologists in the education of GPs and other community HCPs to create a stronger link between the community and the hospital and sharing of knowledge to be able to advise and signpost accordingly. Training to improve the access to GPwER in skin health and improved guidance for Pharmacists to gain an equal level of understanding to enable enhanced appropriate care and advice for patients in communities seeking OTC or prescribed remedies. There is also a need to raise awareness for improved and early support from social care/ mental health services for depression linked to skin conditions. Education should also reach other HCPs including dentists, optometrists and AHPs, beauty therapists, to help in signposting if identifying more severe conditions that are untreated or undiagnosed. Through improved communication with patients they can also be better educated on self-management and signposted to local support including 3rd sector and charities able to provide support for their condition. Consultants making patients fully aware of their journey, with information provided in various formats to suit. **Impact & Benefit** • Better knowledge for prevention, early detection of skin health conditions reducing costs to healthcare economy • More effective use of medications and reduced prescription costs – system –wide approach can make prescribing more efficient (reduces issues around steroid side-effects and allows better monitoring of patients) • Earlier intervention reduces treatment burden **Alignment –** For prevention and education it is key that a universal approach is taken and alignment across the ICS to ensure consistency. This approach needs to delivered through a structured education programme to reach all HCPs, enabling improved detection and signposting.
Improve local access through development of the GPwER service and shared learning between practitioners across all parts of the ICS to make referrals and triaging more efficient through increased use of technology (tele-dermatology and digital images) **High Priority**	If prevention and early detection approaches are to help transform services, then on top of education and awareness reaching across the system, the local offer of primary care needs to be consistent across all areas. This means developing and expanding models of care currently working very well in some areas such as mid-Notts and Rushcliffe. Currently some referrals are made directly to secondary care and some are better triaged, with only the appropriate cases going to secondary care for review by a dermatologist. GPs working alongside accredited or experienced GPwER in skin health, has shown to be very effective locally. With the expansion of these teams the aspiration to fill the gaps in the ICS can be delivered. Instead of a binary model of care, with a relatively low number of highly trained dermatologists working in hospitals, and a large number of health care professionals in the community with little or no training in dermatology, a more triangulated service that encompasses several layers of different professionals with varying degrees of knowledge and skills would match population needs more appropriately. Through partnership working making optimal use of digital images and Teledermatology, but also applying lessons from COVID19 in using opportunities to work virtually where possible. **Impact & Benefit** • Reduced referrals to hospital – releasing consultant time to see patients with severe conditions • Equity of access to GPwER across ICS – aspiration for 100% coverage – improved patient care and satisfaction • Reduction in waiting times **Alignment –** Improved local access and triaging should be aligned at ICP level with the same approaches applied across the ICS

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7. Transformation Proposal

Appropriate mental health and social care support for those with a long term skin condition. **Medium Priority**	Although a common theme amongst many services, people suffering with long term skin health conditions are more likely to suffer mental health (MH) issues - in a recent survey it was found that 10 million people in the UK with a skin condition such as eczema, psoriasis, rosacea and acne say it has affected their MH. The steering group recognised the need to ensure education is at the level where the principles of MECC are embedded in a transformed skin health service. The opportunity for HCPs to support and signpost skin health patients that may be suffering from MH issues as a result of living with a skin health condition, therefore needs to be recognised and seen as the responsibility of all HCPs. With 60% of British people having suffered from, or living with a skin condition, there should be some urgency to ensure MH issues are fully supported where prevalent. Basic training is required for all HCPs to appreciate the needs of those patients whose MH is affected by a skin health condition and be able to sign-post to receive appropriate support. Expansion of services offered through Notts Healthcare on *Let's Talk-Wellbeing*, Long Term Conditions Team, Dermatology Pilot to ensure access is available across the ICS. Recognition and appropriate access to psycho-dermatology for those patients that need it – GPwER and consultants to be cognisant of psycho-dermatology. Raising awareness and improved signposting to 3rd sector charitable organisations **Impact & Benefit** • Reduce impact on health and social care economy through improved management of MH issues • Charities able to support patients and provide access to peer support, coping mechanisms, etc. • Reduced deterioration of skin health condition (psycho-dermatology) **Alignment –** Adopting appropriate adjustments and support for skin health patients that have MH issues as a result, should be aligned across the ICS
Develop skin lesion non-2WW BCC pathway to provide equity of access across all settings of the ICS **High Priority**	The steering group recognise there is an opportunity to broaden the offer of care for skin lesions on the non-2ww BCC pathway. At NUH/TC the BCCs referred in to dermatology are seen within 6 weeks as a local standard. With the 2ww referrals increasing, the TC dermatology service are already considering whether BCCs below the neck can be managed via Teledermatology on the 18 week pathways, as doing this would increase the 2ww capacity. TC audited 615 BCC records from Sep/Oct/Nov 2019 , of these 593 had no cancer , 22 had a skin cancer which is 3.58%, of the total BCC referrals received. Currently all Basal Cell Carcinoma (BCC) are seen within 2 weeks by the GPwER in Rushcliffe only. Patients are seen in community clinic or are sent onto secondary care. Those that are seen in clinic are discharged, followed up in community clinic, referred onto secondary care as BCC or 2WW SCC or melanoma. For 8 weeks of data of the 86 BCC referrals triaged at Rushcliffe Community Dermatology 41 (%) avoided a secondary care referral with 65 (76%) seen in the community clinic of which 29 (45% of those seen in community) were discharged, 12 (18% of those seen in community). 24 (37% of those seen in community) were forwarded to secondary care in addition to 21 (24% of all referrals) that were send to secondary care without being seen in the community clinic. This approach is clearly effective and provides optimal management with consultant support and in expanding the GPwER service would be an appropriate model to consider to develop this pathway across the ICS. **Impact & Benefit** • Improve confidence and accuracy of referrals, e.g. BCC vs SCC in 2WW • Patients referral on right pathway at right time first time • To some degree this can also help with the capacity limits with the low number of dermatologists **Alignment –** In order to maintain equitable access and consistent pathways, developing a skin lesion non-2ww BCC pathway should be provided across the ICS. This may require local delivery at PCN level as specialist roles are developed in areas they do not currently exist.

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7. Transformation Proposal

Optimal Hospital Dermatology Services and Resource levels **High/ Medium Priority**	As the skin health transformation proposals evolve over the coming years, this will help resolve some of the hospital capacity and demand issues. It remains important to provide safe and effective care in the hospital setting. There is currently a national shortage of dermatologists and local challenges may be slightly mitigated through optimised triage and referral processes, but a review of dermatologist numbers is still required – GIRFT recommends 12 dermatologists for the population served in Nottingham (cf. 7 substantive posts). There is no quick fix for this as training numbers limit the consultants coming through – CESR training allows some slack but does not solve the problem. Through upskilling of nurse roles to CNS with extended duties allows some tasks to be supported, but acknowledgement of training and capacity is required. Developing a dedicated support structure for community practitioners is also vital to see the success of local care delivery for skin health. This requires training practitioners to attend hospital clinics and have formal affiliation with the dermatology service in the acute setting. A truly integrated service needs to be reflected in the workforce plan. **Impact & Benefit** • Diversify workforce for sustainability • Workforce satisfaction • Improve patient experience **Alignment** – An integrated approach to hospital dermatology services should be aligned to an ICS level.

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Skin Health Transformation Proposal Summary (Updated)

	Priority (High/ Med/ Low)	Alignment (ICS/ ICP/ PCN)	Workforce	Technology	Estate/ Configuration	Culture	Finance/ Commissioning	Benefits (*Less than £20,000 per QALY is cost effective)
Whole system skin health **Prevention Strategies** and a 3 tier **Education Programme** cutting across the ICS for:: • ICS Population • Health Care Professionals/ support services • Patients	Med	ICS	- Development of reference group to continually oversee progress of these – representative from each group - Consultant PA/ session to support training and education - Nurse specialist capacity - Consultant and GP training time and accreditation (18 months) - Pharmacy role/ training	- Further App development, Web, TV, ICS level information sharing/ advertising – use good existing information incl. BAD - NHS App – more sign up needed - Availability and access of a link/ leaflet to guide GPs to use steroids correctly (ensure there is no under-prescribing)	•ICS central hub managed centrally (aggregate with other reviews) •Practices have facilities-clinics	- Connecting several models of working closely for all skin HCPs (1°, community, 2°, social care and MH) - Local HCPs advise for mild symptoms if GP visit avoidable, e.g. pharmacist, online information - Also training pharmacists to notice red flags of more severe conditions to enable them to signpost to GP only when necessary	- Formalise funding for consultant training time - Integral to model and commissioning process - Funding for post graduate learning	- Earlier detection and diagnosis/ treatment of skin health conditions - Reduced costs to healthcare economy
Improve **Local Access** through **development of the GPwER** service and shared learning between practitioners across all parts of the ICS to make referrals and triaging more efficient through increased use of technology (tele-dermatology and digital images)	High	ICS – Local PCN delivery depends on resource and demand	- Accredited training through RCOGP and BAD, supported by dermatologist - Structured education, training and guidance for pharmacists – - Develop required numbers of GPwER, but to have an affiliation with an acute Trust dermatology dept. - OOH work is very rare, e.g. erythmaderma requires stabilisation before dermatology input is required so medic can deal with emergency care element with dermatologist seeing the patient the following day - Appropriate Tele-derm time would be required as PAs	- Technology in place Mid Notts okay interoperability but may need consideration as it extends across ICS - Use of digital images and tele-dermatology in primary care - Use of digital dermoscopy - Secure Apps to allow patients to take own photos if appropriate to help triage	- Clinic rooms in different localities, waiting rooms. - GPwER would need space to take the photographs.	- Breakdown of professional barriers and improves communication and trust between GPs, GPwER and dermatologists - Right person, right place, first time - Use of Telederm has to be made easy to ensure GPs are able to and happy to use it - Medications review is undertaken in hospital annually to ensure the correct prescribing in the right place is or can happen	-Commissioning to develop GPwER in all regions to offer equitable access across ICS - Same principle of integrated model - £25,000 to train GPwER £5 to 10k for course 1 year paid work £15k - Consultant PAs to train them - Prescribing commissioning funds to follow place of prescribing (i.e. 1° or 2° care) - Workload costs for prescribing in different settings - Medication – consideration budget and time – shared care agreements	- Improve triage process with earlier access for patients - Reduced variation in quality of referrals with improved prescribing - Increase number of GPs with advanced knowledge in dermatology - Aspirations – 100% population coverage – sustainable for now but adequate succession planning to achieve the aspiration - Reduction in secondary care attendances, waiting list reductions, acknowledging pressure on consultant workforce - Diversify workforce for sustainability - Workforce satisfaction - Improve patient experience
Appropriate **mental health** and **social care** support for those with a long term skin condition.	Med	ICS	- Appropriate skills and training for HCPs to provide appropriate support or know when to signpost - Access to clinical psychologist – no provision psycho-dermatology and will need additional consultant workforce - General access to counselling skills and workforce impact - Consultant and or GPwER with interest in psychodermatology			- HCPs to use MECC principle work to ensure patients with mental health issues as a result of a skin condition are supported - Attending dermatology or PwER	- Appropriate funding to meet required mental health support services for skin health patients - Workforce requirements described - Specific mental health needs for young people - Funding of dedicated psychologist service	- Reduced deterioration of skin health condition (psychodermatology) -Reduce impact on health and social care economy through better management of MH issues - Charities able to support patients and provide access to peer support, coping mechanisms, etc.
Develop skin lesion non-2WW BCC **pathway** to provide equity of access across all settings of the ICS	High	ICS	- GPwER and GP with an interest in dermatology to be RCOGP and BAD accredited, with affiliation to acute dermatologist - Some regular activity undertaken in hospital	- IT same system or able to read/update the other systems – connecting existing systems successfully	- Skin surgery in the community settings – suites and requirements to deliver this	- Need to drive more interest to develop more of these roles across the ICS - Acceptance of cancer management in the community. MDT model, how to integrate into skin cancer MDT.	- Equipment, remuneration, capital costs	- Improve confidence and accuracy of referrals, e.g. BCC vs SCC in 2WW - Patients referral on right pathway at right time first time - To some degree this can also help with the capacity limits with the low number of dermatologists
Optimal **Hospital Dermatology Services and Resource** levels.	High/ Med	ICS	- Dermatologist numbers to match demand - Develop Specialist Nurse Role - acknowledge capacity and training requirements	- Across primary and secondary care - Better technology video conferencing – images. Hospital computers need videos etc.	- OPA space?- due to increase in referrals over all. Increased capacity to operate – won't be completely offset by community	- Culture underpinning pathway principles right place right time right person - Increase profile of dermatology.	- Workforce funding change of case mix – tariff - Funding of the service - Funding to support increase of training numbers required	- Diversify workforce for sustainability - Workforce satisfaction - Improve patient experience

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8. Enabling Requirements

Workforce	Enhancing the future health and social care for skin health services, requires the following main considerations for workforce: • Cross pathway working (primary and secondary and community care) for clinicians and primary care practitioners with specific development and expansion of local successful models delivering care through expertise in GPwER • Recognition that a training/ development period of 18 months is required to gain accreditation working towards GPwERs or skin care specialist in primary care • Widespread training of healthcare professionals (HCPs) to empower them to provide appropriate advice or signposting for prevention of skin health conditions through healthy living, self-help and early detection, perhaps building into mandatory training • Training and education in consideration of providing Pharmacists with Extended Roles (PwER), being local champions to advise and help with self-care or signpost for more serious issues
Technology	The main areas in which technology can effect transformation for skin health care include: • If it is accepted that a single IT system may not be deliverable in the long term then focus should be on connecting existing systems successfully – more to do with access and permissions • App development/ promotion for signposting self-care resources or local services (e.g. PwER, or charities) – bas eon NHS App/ PKB • Waiting rooms in various health and social care settings to use screens with rolling information on health and social care advice/ support services available – promote healthier living • Better use of reliable handheld devices across community and home settings to improve access to eSCR • Increase use of Teledermatology and digital images to improve triage and referral process – also introducing artificial intelligence (AI) – looking to pick up issues through AI – patients using photographs to help virtual triage of minor issues
Estate	• There is an emphasis on making skin health services more accessible locally, although this does not stipulate a hub and spoke type approach needing community hub space, there may be some central space required for training and local education • It is also crucial to ensure better local access is made available in some of the more remote regions and areas of higher deprivation or cultural/ ethnic diversity • Provision of care closer to home, can also help to optimise the space footprint required in acute hospital departments.
Culture	• To drive a culture change we need shared and integrated use of workforce across organisations to enable the sharing of resources as there are limited staff groups and expertise, with the introduction of local training in expanding the GPwER model this should improve education across the workforce. • Organisational trust and changes in how future services are commissioned will provide the greatest influence on the future of integrated service provision and how best evidence can influence the future skin health service offer across the ICS.

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9. Skin Health Services Vision

'Bridge to the Future'

From…		2022/23 Phase 1	2023-2026 Phase 2	2026+ Phase 3	To…
• Not enough prevention strategies in place disseminate information to prevent skin conditions • Inconsistent education/ training across the region • Low awareness and sign-posting to self-help resources from HCPs	Prevention & Self-Care	• PH to provide initial input to develop right platforms to reach audience, e.g. skin health on NHS App • Dermatology organisations, charities, etc. to aid with partnering dissemination of correct and trusted information • Reinstate educational meetings for GPs and extend invite ICS wide • Set a target to review dermatology in the NHS App – link in PKB for local ambition • Develop Tech, e.g. AI for photos and screening	• Embedding education programmes for HCPs, including signposting to reputable sources that are consistent and accessible • Increase uptake of NHS App use and PKB • Set up rolling education programmes e.g. in GP practices/ council buildings • Enhancements to education offer, establish media and formats • Plug any self-help gaps	• Targeted signposting through appropriate media running • Established education programmes – evaluate and improve • Widely used technology for self-care and learning, NHS App/ PKB for dermatology • Brief education built into mandatory training	• Consistent and equitable prevention through wide-spread public awareness and education with sign-posting for early, right intervention • Improved triaging to effectively identify and treat/ cure skin health conditions • Appropriate technology platforms to enable education of population, HCPs and patients
• Inconsistent triaging with poor quality referrals to acute • No structured education for GPs to encourage GPwER take-up • Community access and support needs improving for patients • Inadequate use of technology for complex, uncertain cases	Dermatology in Primary Care	• Plan to develop appropriate triage protocols via GPwER (where they exist), for each ICP • Complete a needs assessment to define GPwER model of care • Plan accreditation and education programme in partnership with acute consultants – needs support to develop leadership capacity to make this happen • Adopt digital image technology for use across the ICS – use F12 key • Better integration of core systems for better partnering, e.g. SystmOne • Funding options for GPwER model	• Expand/ cross-train from established areas to widen offer of GPwERs triaging direct to 2° care clinic – reducing referrals within 2° care dermatology or plastics – feedback for continuous improvement adapting pathway for changing needs and lessons learnt • Nursing and consultant support to community service developed • Consistent use of F12 • Established and robust programmes to encourage take up of GPwER education, use existing success stories for encouragement	• Fully integrated GPwER service affiliated to acute dermatology service • Consistent use of images in pathways • eSCR on integrated platforms • Embedded pathways across the system	• True partnership working across pathway through development of region-wide GPwERs • Improved triaging, improve time to see, in right place, improve quality of care • Appropriate referrals through partnership working between GPs/ GPwERs and consultants, avoiding unnecessary F2F appointments • Consistent use of tele-dermatology and digital images to support early accurate triaging
• Longer waits due to capacity issues and complex referral routes • Inadequate skillmix amongst support HCPs/ nurses • Insufficient resource to meet service needs • Lack of F2F of in-patient consultation at NUH	Hospital Care	• Develop skills of nurse (CNS), e.g. prescribing courses – link to institute of excellence • Adopt COVID effect, e.g. push A&G, Telederm, etc. • Consider specific areas e.g. isotretinoin, where new ways of working could allow GPwERs to manage conditions in the community – integrated working • Consider consultant numbers alongside CESR training • Define OOH pathway requirements (with neighbouring ICSs) • Determine need for F2F in-patient consultation	• Closer working established between cons. dermatologists and community clinics – reducing proportion of patients attending 2° care • CNS to do appropriate role as determined • Increase virtual access to consultant • Further development of HCP roles to deliver capacity • Urgent and emergency OOH support provided through agreed cover (East Midlands wide) to provide for frequency of need	• True partnership working established between GP-GPwER-Consultant in all hospital linked activity • Full use of Teledermatology across system • Consultants partnered with GP/ GPwERs through affiliated to hospital for clinic lists, mentoring, training and A&G • Established CESR training route to allow substantive posts to be filled • In-patient requirement met by consultants	• Appropriate referrals with increased care closer to home • Waiting times consistently meeting targets through capacity release back to community • Appropriate skillmix across acute staff, including education programmes to upskill • Sufficient resources to efficiently meet service needs • Appropriate in-patient provision
• Inconsistent follow up and treatment management • Poor patient education with inadequate self-management • Lack of awareness and signposting to 3rd sector support • No structured MH support	Condition Management	• Pharmacists, GPs, Dermatologists to become familiar with 3rd sector support for each skin condition to enable signposting and support for patients • Assess need of and review current MH provision to define requirements • Information prescription to accompany each outpatient discharge plan • Reinstate and develop education sessions on skin cancers and other skin conditions – prevention and self-care • Scope available technology to monitor own skin condition for self-management • Increase awareness of IAPT	• Improve access to new technology for self-monitoring • Developing and making more use of practice nurse skills to help manage patients with long term skin conditions • Developing support groups within the community to support LTC management • Developing the pathway to incorporate MH support (MECC) to recognise and refer	• Practice nurses undertaking review management for skin LTCs • Ease and early access to MH support for skin health patients • Better understanding and much improved self-management • Peer groups for support developed with 3rd sector organisations locally • Developed and operational technology to help monitor report conditions, making use of AI development	• Regular patient reviews for those with skin health LTCs across the ICS • Raised patient awareness and education for self-management and independent living • Accessible 3rd sector and mental health support early in patient journey, as appropriate

10. Conclusions and Next Steps

Conclusions	The review of Skin Health services as part of the development of a Clinical and Community Services Strategy for Nottingham and Nottinghamshire ICS has been undertaken using a co-design model where patients, carers, key stakeholders and voluntary sector groups such as MySight and SeeAbility, have collaboratively worked together to shape a vision for the future care system. Although work has progressed quite well working remotely and holding video meetings, patient engagement would have been beneficial and will be revisited when the system allows this safely. The four key themes for improvement identified are: • Prevention & Self-Care (with emphasis on education, awareness and optimising prevention strategies whilst improving early detection and intervention in the neighbourhood setting); • Dermatology in Primary Care (reviewing the role of the GPs and other HCPs improving education and training to develop GPwERs across the ICS, with vastly improved triaging working with hospital consultants to expand the use of digital images and Teledermatology); • Hospital Care (ensuring the right treatment is available in the right place in a timely manner, effectively reducing avoidable hospital visits through effective triage and referral from the community to help with the challenges faced with hospital demand and capacity); • Condition management (providing improved education of patients to help them come to terms with and understand their condition to improve self-management, but also helping to ensure patients' have access when required to social care along with appropriate mental health support where the need for this has been identified as early as possible and raising patients' awareness of the available charitable and third sector support for specific conditions). The review describes a future care system in optimal care settings and with care provided at different levels of urgency and envisages 2 high priority, 1 high/ medium and 2 medium priority programmes to transform care: • **Med** – Whole system skin health prevention strategies and awareness through a 3 tier education programme across the ICS • **High** – Enabling local access through development of the GPwER model and true partnership working using Teledermatology and digital images across Nottinghamshire • **Med** – Appropriate support, care and access to mental health services for patients with long term skin health problems • **High** – Develop skin lesion non-2ww BCC pathways to provide equity of access across all settings of the ICS • **High/ Med** – Hospital dermatology services and resources To achieve these there are a range of enabling requirements for the ICS across workforce, estate, technology, culture and financial systems. Collectively these initiatives can transform and provide long term health improvement and sustainability in the area of skin health care in the Nottingham and Nottinghamshire ICS.
Next Steps	This strategy sets the future direction of development for skin health care in the ICS and it is proposed it will shape future work of the ICS in a number of ways: • The identified priorities and programmes should be used to inform commissioning ICS, ICP and PCN activity • The enabling activities require development and inclusion in the relevant ICS workstreams to inform their work programmes • The impact on estate and configuration changes require inclusion in a programme of pre-consultation business case development alongside the service changes recommended from other reviews, although the impact for skin health is less specific in relation to community hub space • The aggregate impact of the collective suite of service reviews should be used to shape focus of future service provision in acute and community settings in the ICS

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

11. List of Abbreviations

1°, 2° Care	Primary, Secondary Care	ELBG	Ear Lobe Blood Gas	NHSE	National Health Service England
A&E	Accident and Emergency	EM ODN	East Midlands Operational Delivery Network	NHSI	National Health Service Improvement
ACE	Adverse Childhood Experience	EMAS	East Midlands Ambulance Service	NICE	National Institute for Health and Care Excellence
ACP	Advanced Care Practitioner	EMRAD	East Midlands Ambulance Radiography	NICU	Neonatal Intensive Care Unit
ADHD	Attention Deficit Hyperactivity Disorder	ENCH	Enhanced Health in Care Homes	NNU	Neonatal Unit
AF	Atrial Fibrilation	EoL	End of Life	Notts.	Nottinghamshire
AI	Artifical Intelligence	eSCR	Electronic Shared Care Record	NRC	National Rehabilitation Centre
AK	Actinic Keratosis	ESD	Early Supportive Discharge	NRCP	National Register of Certified Professionals
AMD	Age-related Macular Degeneration	ESDT	Early Supportive Discharge Teams	NRT	Nicotine Replacement Therapy
ANP	Advanced Nurse Practitioner	F2F	Face to Face	NUH	Nottingham University Hospitals
App	Application	FeNO	Frasntonal Exhaled Nitric Oxide	O_2	Oxygen
APPG	All Party Parliamentary Group	FT	Foundation Trust	OCCCF	Ophthalmic Common Clinical Competency Framework
ARTP	Association for Respiratory Technology and Physiology	FTE	Full Time Equivalent	OCT	Optical Coherence Tomography
ASC	Autism Spectrum Conditions	FU	Follow Up	OOH	Out of Hours
AT	Assisitive Technology	GOC	General Optical Council	OPM	Office of Public Management
ATAIN	Avoiding Term Admission Into Neonatal units	GOS	General Ophthalmic Service	OTC	Over-the-Counter
BAD	British Association of Dermatology	GP	General Practitioner	PCN	Primary Care Network
BAME	Black, Asian and Minority Ethnic	GPRCC	General Practice Repository for Clinical Care	PCP	Personalised Care Plan
BB	Better Births	GPwER	General Practitioner with an Extended Role	PCR	Patient Care Record
BCC	Basal Cell Carcinoma	GRASP-COPD	Guidance on Risk Assessment on Stroke Prevention for COPD	PH	Public Health
BEH	Behavioural and Emotional Health	H&SC	Health and Social Care	PHE	Public Health England
BF	Breast Feeding	HCP	Healthcare Professional	PHM	Population Health Management
BFI	Baby Friendly Initiative	HES	Hospital Episode Statistics	PID	Project Initiation Document
BLF	British Lung Foundation	HES	Hospital Eye Service	PKB	Patient Knows Best
BMI	Body Mass Index	HV	Health Visitor	PN	Practitioner Nurse
BMJ	British Medical Journal	IAPT	Improving Access to Psychological Therapies	PR	Pulmonary Rehabilitation
BP	Blood Pressure	ICP	Integrated Care Partnership	PwER	Pharmacist with Extended Role (in skin health)
BSG	British Society of Geriatrics	ICS	Integrated Care System	QALY	Quality Adjusted Life Years
BTS	British Thoracic Society	ICT	Information and Communication Technology	QIPP	Quality, Innovation, Productivity and Prevention
CBT	Cognitive Behaviour Therapy	IT	Information Technology	QMC	Queen's Medical Centre
CCG	Clinical Commissioning Group	IUT	In-Utero Transfer	RCN	Royal College of Nursing
CCSS	Clinical and Community Services Strategy	KMH	Kings Mill Hospital	RCOG	Royal College of Obstetricians and Gynaecologists
CFS	Clinical Frailty Scale	LD	Learning Disability	RCOphth	Royal College of Ophthalmology
CGA	Clinical Geriatric Assessment	LMNS	Local Maternity and Neonatal System	RNIB	Royal National Institute for the Blind
CoC T&F	Continuity of Care Task and Finish	LNU	Local Neonatal Unit	ROI	Return on Investment
CoO	College of Optometrists	LOC	Local Optical Council	ROVI	Rehabilitation Officer for Visually Impaired
COPD	Chronic Obstructive Pulmonary Disease	LoS	Length of Stay	RTT	Request To Treatement
COVID19	Corona Virus Disease 2019	LTC	Long Term Conditions	SALT	Speech and Language Therapy
CQUIN	Commissioning for Quality and Innovation	LTOT	Long Term Oxygen Therapy	SaToD	Smoking at Time of Delivery
CUES	COVID Urgent Eye-care System	LTP	Long Term Plan	SBLCB	Saving Babies Lives Care Bundle
CVD	Cardio Vascular Disease	LTV	Long Term Ventilation	SC	Social Care
CVI	Certification of Vision Impairment	LV	Low Vision	SCC	Squamous Cell Carcinoma
CYP	Children and Young People	MDT	Multi-Disciplinary Team	SEND	Special Educational Needs and Disabilities
CYPF	Children, Young People and Families	MECC	Make Every Contact Count	SFH	Sherwood Forest Hospitals
DASV	Domestic Abuse and Secual Violence	$MgSO_4$	Magnesium Sulphate	SIGN	Scottish Intercollegiate Guidelines Network
DNA	Did Not Attend	MH	Mental Healthcare	SPA	Single Point of Access
DOS	Directory of Service	Mid Notts.	Mansfield & Ashfield, Newark & Sherwood	STP	Sustainability and Transformation Partnership
ECG	Electrocardiogram	MMR	Measles, Mumps, Rubella	TC	Treatment Centre
ECLO	Eye Clinic Liaison Officer	NCH	Nottingham City Hospital	TIA	Trans-Ischaemic Attack
eCVI	Electronic Certfication of Vision Impairment	NHFT	Nottinghamshire Healthcare Foundation Trust	VI	Visual Impairment
ED	Emergency Department	NHS	National Health Service	WHO	World Health Organisation
EFI	Electronic Frailty Index				

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12. Data Sources

Data Sources	British Association of Dermatology British Skin Foundation The King's Fund Local Data from NUH, SFHFT, Social Care, CCGs, GPRCC National Institute for Health and Care Excellence NHS England NHS Long Term Plan NHS Wales Public Health England

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