



SERVICE GUIDANCE AND STANDARDS FOR THE USE OF PHOTOTHERAPY

ISSUE DATE: ____ NEXT REVIEW DATE: ____



NICE has accredited the process used by the British Association of Dermatologists to produce Service Guidance and Standards. Accreditation is valid for 5 years from 7 March 2017.

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Acknowledgements

In May 2013 the British Association of Dermatologists (BAD) invited a range of medical professionals and patient representatives to revisit published minimum service standards developed in 2011. This resulted in the publication of the Service Guidance and Standards for Phototherapy (SGSP) in 2017 and online self-assessment audit for phototherapy units. The results from the SGSP self-assessment audit undertaken during the course of 2017-18 identified some necessary changes. These changes have resulted in the incorporation of the self-assessment audit questions into the SGSP sections and content changes by the PWPG.

Our BAD Officers would like to express their gratitude to the Phototherapy WPG (PWPG) for updating the Service Guidance and Standards for the use of Phototherapy (SGSP) 2021.

These guidelines continue to provide an invaluable resource for Clinical Commissioning Groups (CCGs), Health Boards and dermatology service providers. Our BAD guidelines are produced independently of any funding body and through the time given freely by PWPG members.

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The following people have provided continued advice and support in compiling and editing these standards.

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Pilot Test Sites

We would like to thank the following NHS Hospital Trust departments for agreeing to pilot the Standards and Guidance for the use of phototherapy. Their invaluable feedback from their review and audit of the SGSP has contributed to the development of our standards.

- East Kent NHS Foundation Trust
- Hywel Dda University Health Board
- University Hospitals Bristol and Weston NHS Foundation Trust
- The Royal Devon and Exeter NHS Foundation Trust

Declarations of interest

All PWPG members and Pilot sites were asked to declare any pecuniary or non-pecuniary conflict of interest, in line with the BAD conflict of interests policy as described in the Service Guidance and Standards (SGS) Development Process Document (see Appendix 1 Service Standards Process).

There were no declarations made from our PWPG or our Pilot sites.

Medicolegal implications of SGS

SGS are not intended to be construed or to serve as a standard of clinical care. It is advised, however, that significant departures from the SGS should be fully documented by departments and raised on the risk register with their clinical governance team and board. All self - assessment audit reports should be made available to Clinical Commissioning Groups, Healthwatch, Local Health Overview Scrutiny Boards and the CQC for quality reporting purposes.

CONTENTS

Aims, Purpose and Scope	1
Introduction	3
Standard 1: Referral and Patient Assessment	7
Standard 2: Patient Information and Consent	13
Standard 3: Staff, Training and Education	19
Standard 4: Clinical Management and Monitoring	22
Standard 5: Equipment and Facilities	26
Standard 6: Clinical Governance and Audit	29
Standard 7: Discharge Protocol	33
Standard 8: Skin Cancer Surveillance	35
References and Evidence	37
Prevalence and Incidence	40
Glossary of Abbreviations and Terms	51
Phototherapy Services Standards Consultation Form	63
Appendix 1: Specialty Training Curriculum for Dermatology	64
Appendix 2: Post CCT Training Curriculum	65
Appendix 3: NICE recommendations for Phototherapy for psoriasis	66
Appendix 4: Department of Health: Health Building Notes: Clinical and Support Spaces	68

Aims

Service guidance and standards (SGS) are developed primarily for commissioners of NHS services, service providers (NHS and private practice) and those regulatory bodies involved in the scrutiny of care.

The SGS aims:

- To recommend acceptable NICE Accredited Service Standards for the provision of phototherapy services in the United Kingdom;
- To ensure commissioners of NHS services procure services from appropriately qualified and accredited providers;
- To improve direct access to care for patients requiring treatments and vice versa, reducing unnecessary consultations and improving the overall cost of care;
- To quality assure phototherapy clinical education and training standards within services;
- To quality assure patient outcomes by improving the clinical recording of decisions and audit reporting for phototherapy services.

Purpose

BAD Service Guidance and Standards for Phototherapy are designed to provide a set of required Service Standards which underpin NICE clinical guidelines and inform NICE quality standards (outcome indicators). This document forms the basis of a quality assurance programme for all phototherapy services nationally. It sets out those standards identified as essential to the safe provision of care for all patients being treated in a phototherapy Service, supported by NHS clinical governance frameworks for the relevant service delivery settings and within the terms of the NHS service Contract.

Scope

It is important for the phototherapy service guidance and accompanying standards to reflect both the issues and innovation which can make a difference to the experience of the patient using the service. For this reason, this guidance follows the patient phototherapy care pathway from referral to discharge. As far as possible, standards are written from the service user perspective and reflect the service infrastructure required to reduce risk and harm.

We recognise that services are under increased pressure to demonstrate that they comply with national policies and guidelines. For this reason, our guidance incorporates existing requirements and standards (recommendations) set out nationally for commissioned NHS services and are aligned with:

- Department of Health Policy Implementation Guides;
- NICE guidance;
- NHS England Patient Safety Domain criteria;
- International and UK health services with accreditation frameworks in place;
- Care Quality Commission (CQC) Regulations;
- Health Safety Executive and COSHH Risk Assessments;
- Department of Health Building Notes for facilities;
- NHS Standards Contract terms and conditions;
- GMC Good Medical Practice and Ethical Guidelines.

Introduction

BAD guidance and service standards for the use of phototherapy have been produced in accordance with the core principles and methods set out by NICE for the developing service guidance. This methodology is underpinned and informed by an evidence review of existing published service guidance, national policies and the expertise of our selected PWPG.

In this document standards are expressed as something which phototherapy services should meet as an overriding duty to provide quality care (NHS and private healthcare). They provide the basis for evaluating the quality of a service and areas for improvement.

They also help to:

- Ensure that new services are set up in a way that will ensure patient safety and optimised treatment;
- Ensure that existing service infrastructure (facilities, equipment and staffing etc.) contributes to the safe and effective delivery of care to patients;
- Clarify service expectations for patients, clinicians, management, commissioners and NHS employees;
- Drive service improvement and development of phototherapy services to meet local need;
- Contribute to improved clinical monitoring and recording of quality, results-based outcomes.

All decisions in the development of this guidance have been made by the WPG through a process of informal-consensus and agreement. The finalised phototherapy service guidance and standards have been scrutinised and approved by the BAD Officers prior to consultation with our stakeholders.

A formal consultation period (normally one month) also took place to allow for stakeholder registration and feedback on the phototherapy service guidance and standards. Comments received have been collected using a standard proforma recognised by NICE. Stakeholder feedback has been responded to by the WPG and any necessary changes to guidance actioned prior to its publication.

Service Standards Framework

Ultraviolet phototherapy and photochemotherapy are used to treat a variety of skin disorders, including psoriasis, eczema, mycosis fungoides, pruritus, vitiligo and many other skin conditions. They are also used prophylactically to “desensitize” the skin in some photosensitivity disorders such as polymorphic light eruption, solar urticaria and erythropoietic protoporphyria.

As far as possible, standards are written from the service user perspective and reflect the service infrastructure required to reduce risk and harm. For this reason, this guidance follows the patient care pathway specific for the use of phototherapy resources from referral to discharge.

Our standards are covered by the following topic headings:

STANDARD 1: Referral and Patient Assessment

STANDARD 2: Patient Information and Consent

STANDARD 3: Staff, Training and Education

STANDARD 4: Clinical Management & Monitoring

STANDARD 5: Equipment and Facilities

STANDARD 6: Clinical Governance and Audit

STANDARD 7: Discharge Protocol

STANDARD 8: Skin Cancer Surveillance

Evidence/Minimum requirements

Each service standard has its own 'rationale' and 'essential criteria' section, which must be demonstrated with supporting documentary evidence. The evidence requirements are intended to be well-defined and easy to understand. They must be used to meet the standards specified within the guidance and used in the self-assessment audit. Some of the evidence requirements relate to existing national policy and guidelines, which underpin all services. All standards require a set number of anonymised patient cases to be used as core evidence.

Self-Assessment Audit

Each service standard has a series of audit questions used to demonstrate how essential criteria are being met by a department. The following flag status system is used to identify each essential criteria areas of risk and will be applied to the self-audit reported outcomes.

For Example:

	Essential Criteria	Comments	Status
100%	90% of all referrals will start treatment within six weeks of referral from dermatology outpatients	79% of patients started treatment within six weeks of referral	>100% Green Flag 70-100% Yellow Flag <70% Red Flag

- **Red Flag** [Action Required]: failure to meet these standards places undue clinical risk on patients, breaches their rights or dignity and/or may result in remedial action;
- **Yellow Flag** [Monitoring Required]: service standards that a service would be expected to meet;
- **Green Flag** [No Action Required]: meets service standard essential criteria

Please note where the 'Essential Criteria' outcome dictates clear boundaries for % 100 Green without any moderation, then the Status should be changed to indicate only **Yes = Green** and **No = Red**. The yellow flag is deleted.

Secondary care providers implementing the SGSP have a grace period (12 months) to identify shortfalls in their service provision. This enables the multi-disciplinary team to review their local procedures and practices against the standards and, if necessary, implement the changes required. A summary of the results from the self-assessment audit should form the basis of a Gap analysis and business case for any identified areas of service improvement.

Participation in the self-assessment audit provides valuable assurance about dermatology services and provides important evidence about the safety, effectiveness and responsiveness of services.

It is recommended that you divide the SGSP into sections, assigning each section to a particular individual or the phototherapy team to complete. This is in order to increase buy-in, and also to ensure that any actions that are planned and changes that are made are sustainable (i.e. are not dependent upon a single individual). It is particularly recommended that you involve your trainee cohorts. Many of the standards require audit evidence to demonstrate compliance and these can form the basis of quality improvement projects.

Registration

The [registration form is available on the BAD website](#). It requires each department to provide contact details for the person responsible for co-ordinating the department's participation in the SGSP audit. This should be the 'SGSP lead' or Phototherapy Clinical Nurse Specialist, and they will be the person responsible for liaising with the BAD's Clinical Services Unit (CSU). Note that there can be more than one lead.

For departments in England, the CQC regards the BAD SGS as an approved source of information on the quality of dermatology secondary care services and the standards are mapped to their KLOEs.

Service Guidance and Standards

STANDARD 1: Referral and Patient Assessment

Standard Statement 1A – Referral

Rationale

Patients are referred by a general practitioner (GP) or accredited consultant-led community service provider (e.g. ICATs) or by another consultant to a dermatology secondary or tertiary (18-week wait) service. Paediatric patients with severe inflammatory skin conditions should be referred to a paediatric dermatologist.

Consultant-to-consultant referrals directly to [specialised centres](#) are necessary for patients who require complex interventions to improve the management of unresponsive and severe skin diseases, (see Evidence of Prevalence and Incidence).

All referrals should be appropriately triaged. Phototherapy must be prescribed by a consultant dermatologist (or another accredited practitioner working under their supervision). following a face-to-face consultation with the patient. An accurate diagnosis and assessment of risk factors for complications of phototherapy, and alternative therapies, is required before any decisions to prescribe phototherapy takes place.

Essential Criteria

1A.1	The Dermatologist must have provided the following referral information to determine the patient's suitability for phototherapy treatment. This information must also be included with the patient's prescription for phototherapy in their pre-assessment notes for the Phototherapist (nurse/physiotherapist): • Details of which type of phototherapy is being requested, frequency of treatment, and which disease is being treated. • Assessment of severity of skin disease and body areas for treatment including the exclusion of pre-cancerous and cancerous lesions. • The patient's medical history and diagnoses, including previous cumulative dosage of phototherapy; • Details about absence or presence of any contraindications or risk factors to phototherapy;
1A.2	All referrals must be made following a face-to-face consultation with an accredited Consultant Dermatologist or clinical nurse specialist/specialty grade doctor/ trainee working under the direct supervision of a Consultant Dermatologist in the clinic. This includes in all circumstances where services continue to be provided during emergency measures e.g. COVID.

1A.3	Patients referred routinely should start treatment within 6 weeks of their pre-assessment to phototherapy, subject to service fluctuations. Patients on phototherapy waiting lists exceeding 10 weeks should be reviewed regularly and contacted to ensure they still require treatment.
1A.4	If the patient is considered to require treatment urgently, then treatment should be started as soon as possible (within 3 weeks of referral,) to reduce patient discomfort and avoid the need for hospital admission and/or commencement of systemic therapy.
1A.5	Referral information for the phototherapy service is clearly advertised on the department's website. In England, some GPs can refer directly into phototherapy consultant-led clinics when set up locally. Alternatively, referrals can be made to consultant general inflammatory skin clinics. Minimum clinical criteria for referring to the phototherapy service should be included on e-RS in England and information on the phototherapy service should be advertised on the department's website. All referrals should be triaged for their suitability in both services. Please note GPs <u>cannot</u> directly refer patients to the Phototherapist (nurse or physiotherapist) for phototherapy treatment.
1A.6	A referral and access policy for the unit is locally agreed with the dermatology department and clearly sets out how patients are directed to the service by GPs and other national referral sources (includes consultant-to-consultant referrals).

Examples of Suitable Evidence

A referral form and/or letter is in each patient's notes.
A copy of the current agreed referral and access policy with timescales for review.
A link to the department's website which includes phototherapy service and referral information.
Case mix list of patients referred into the service over 12-24-month period with waiting times.

Audit Outcomes - of 50 Patient Cases		Status
>95%	1A1. The prescription for phototherapy and all the relevant clinical information has been provided by the clinician in the patient's notes	>90% Green 70-90% Yellow <70% Red

100%	1A.2. The prescription and pre-assessment of the patient's suitability for phototherapy, and all decisions regarding the type of phototherapy, is recorded in the case notes following a face-to-face consultation with an accredited Consultant Dermatologist or clinical nurse specialist/ specialty grade doctor/ trainee doctor working under their direct supervision.	>95% Green 85-95% Yellow <85% Red	
>90%	1A3. Patients referred routinely should start treatment within 6 weeks of referral to phototherapy, subject to service fluctuations.	>90% Green 70-90% Yellow <70% Red	
>95%	1A4. Patients warranting an urgent appointment should be seen and start treatment within three weeks of their referral.	>90% Green 70-90% Yellow <70% Red	
100%	1A5. Referral information for the phototherapy clinic (where offered) are clearly advertised on the dermatology department's website.	Yes Green No Red	
100%	1A6. A referral and access policy for the phototherapy clinic is locally agreed with the dermatology department and clearly sets out how patients are directed to the service by GPs and other national referral sources.	Yes Green No Red	
Audit Questionnaire -		No. of cases	%
		/50	
Q1.	1A1. How many patient notes contain the following specific referral information described in 1.A.1 used to inform the patient's pre-assessment for phototherapy? • Details of which type of phototherapy is being requested, frequency of treatment, and which disease is being treated. • Assessment of severity of skin disease and body areas for treatment including the exclusion of pre-cancerous and cancerous lesions. • The patient's medical history and diagnoses including previous cumulative dosage of phototherapy; • Details about absence or presence of any contraindications or risk factors to phototherapy;		
Q2.	1A2. How many phototherapy patients have had a pre-assessment and have been prescribed phototherapy by a Consultant Dermatologist or clinical nurse specialist/ specialty grade doctor/ trainee under their supervision in a face-to-face appointment?		

Q3.	1A3. How many patients requiring non-urgent phototherapy are offered an appointment within six weeks, subject to service fluctuations?		
Q4.	1A4. How many patients requiring urgent phototherapy are offered an appointment within three weeks, subject to service fluctuations?		
Q5.	1A5. Does the phototherapy clinic (where offered) clearly advertise its referral information on its website?	YES	NO
Q6.	1A6. Does the phototherapy clinic have an up-to-date referral and access policy?	YES	NO

Standard Statement 1B – Patient Assessment and Management

Rationale

All decisions must be made following a face-to-face consultation with an accredited Consultant Dermatologist or other appropriately trained clinical nurse specialist/ specialty grade doctor/ trainee working under their supervision. The Consultant Dermatologist has, at all times, the overall responsibility for the assessment and care of the patient. The patient's referral information (see 1A.1) and pre-assessment notes along with prescription for phototherapy must be included in the patient's notes for the Phototherapist (nurse/physiotherapist).

Children and adults with special educational needs and/or disabilities (SEND) the neuro-diverse and those with language difficulties, will have phototherapy treatment suitably adapted to ensure safety of the patient at all times. The Consultant Dermatologist must develop an understanding of the patient as an individual, including how the condition (or conditions) affects the person, and how the person's circumstances and experiences affect their condition (or conditions and treatment. See also [NICE's guideline on multimorbidity](#).

In order to assess whether or not a further course of phototherapy is indicated, it is essential to have information on previous UVB and PUVA treatment. The Phototherapist (nurse/physiotherapist)'s phototherapy assessment must also be recorded in the case notes and should include the following information: MED and MPD tests (as appropriate), cumulative dosage of phototherapy, blood results (if required), allergies and current medication and special needs assessment and risk factors for phototherapy.

Essential Criteria

1B.1	A formal Phototherapist (nurse/physiotherapist) phototherapy assessment is undertaken ahead of MPD/MED testing. This should include obtaining the following information which is recorded in the phototherapy treatment chart or notes: • Cumulative number of treatments of phototherapy; • Blood results are normal (if required); • Allergies; • Current medication; • Special needs assessment. • Genital and eye protection has been discussed. •
1B.2	A Phototherapist (nurse/physiotherapist) undertakes MPDs for whole body PUVA or a test dose (on a limited area of skin) where unable to do an MPD.
1B.3	A Phototherapist (nurse/physiotherapist) undertakes MEDs for whole body UVB phototherapy or a test dose (on a limited area of skin) where unable to do an MED.

1B.4	The dermatology life quality index (DLQI) or CDLQI for children is a validated tool/outcome measure that should be used to assess the physical, psychological and social wellbeing of patients (all ages) being treated in the phototherapy unit.
1B.5	For psoriasis patients the use of a validated tool to assess severity of psoriasis, for example the Psoriasis Area and Severity Index (PASI) .is required.
1B.6	For eczema patients the use of a validated tool to assess severity of eczema, for example the Eczema and Severity Index (EASI) or Patient Oriented Eczema Measure (POEM) is required.
1B.7	Children and adults with special educational needs and/or disabilities (SEND) the neuro-diverse, and those with language difficulties have their phototherapy treatment suitably adapted to ensure the dignity and safety of the patient at all times.

Examples of Suitable Evidence

Waiting times to start treatment for routine and urgent patients prescribed phototherapy.
Summary sheet including cumulative UVB and PUVA exposures should be updated following each phototherapy course and an easily accessible record be kept for each patient.
Evidence of Psoriasis Area and Severity Index (PASI) for adult patients or Eczema and Severity Index (EASI)/ Patient Oriented Eczema Measure (POEM) for eczema patients
Evidence of DLQI forms for phototherapy adult patients or Children's Dermatology Life Quality Index (CDLQI) [16] for children and young people.
Case mix list of all phototherapy patients seen in the department during a 12-24-month period.

Audit Outcomes - Review of 50 Patient Cases		Status
85%	1B1.A The patient referral information (see 1A.1) and pre-assessment notes along with prescription for phototherapy must be included in the patients notes for the Phototherapist (nurse/physiotherapist)	>80% Green 70-80% Yellow <70% Red
>90%	1B1.B A phototherapy assessment record, by the Phototherapist (nurse/physiotherapist) is present in the patient's phototherapy notes before their treatment starts.	>85% Green 70-85% Yellow <70% Red
>90%	1B2. MPD technique should be described fully, including the site(s) of test(s), the criteria used to assess erythema, the methodology of masking and exposing test sites (including any devices used for this), the dose and route of psoralens and the sequence of doses used (or the ratio between adjacent exposures).	>85% Green 70-85% Yellow <70% Red

>90%	1B3. MED or test dose technique should be described fully, including the site(s) of test(s), the criteria used to assess erythema, the methodology of masking and exposing test sites (including any devices used for this) and the sequence of doses used (or the ratio between adjacent exposures).	>85% Green 70-85% Yellow <70% Red	
90%	1B4. Evidence that the DLQI / CDLQI has been offered to phototherapy patients attending treatments. Its usage should be recorded at key stages of treatment by the Phototherapist (nurse/ physiotherapist).	>85% Green 70-85% Yellow <70% Red	
>90%	1B5. For psoriasis patients the use of a validated tool to assess severity of psoriasis, for example the Psoriasis Area and Severity Index (PASI), is used.	>85% Green 70-85% Yellow <70% Red	
>90%	1B6. For eczema patients the use of a validated tool to assess severity of eczema, for example the EASI or POEM is used.	>85% Green 70-85% Yellow <70% Red	
100%	1B7. Children and adults with special educational needs and/or disabilities (SEND), the neuro-diverse and those with language difficulties, will have phototherapy treatment suitably adapted to ensure the dignity and safety of the patient at all times.	>95% Green 70-95% Yellow <70% Red	
Audit Questionnaire		No. of case /50	%
Q1.	1B1.A How many case notes include patient referral information, pre-assessment notes and prescription for phototherapy (see 1.A.1)?		
Q2.	1B1.B How many case notes have a record of a Phototherapist (nurse/ physiotherapist) assessment for phototherapy?		
Q3.	1B2. How many patients who have been treated with whole body PUVA have had an MPD or test dose undertaken?		
Q4.	1B3. How many patients who have been treated with whole body nbUVB have had an MED or test dose undertaken?		

Q5.	1B4. How many patients have been assessed using the DLQI / CDLQI respectively?		
Q6.	1B5. How many psoriasis patients have been assessed using the Psoriasis Area and Severity Index (PASI)?		
Q7.	1B6. How many eczema patients have been assessed using the EASI or POEM?		
Q8.	1B7. How many children and adults with special educational needs and/or disabilities (SEND), the neuro-diverse and those with language difficulties, have had their phototherapy treatment suitably adapted to ensure safety of the patient at all times?		

DRAFT

STANDARD 2: Patient Information and Consent

Standard Statement 2A: Provision of Written Patient Information

Rationale

Patients should be given written information specific for their skin disease and treatment regime for phototherapy at their appointment. This should include information as to what their treatment will involve, why they have been recommended for phototherapy and what the possible adverse effects associated with their treatment are.

All patient information should be provided in an accessible variety of formats and languages as appropriate for the patients using the service, including those with Special Educational Needs and Disabilities (SEND) and/or those with language difficulties. This should be available on the department's webpage along with contact details for the phototherapy service.

Additional information on alternative treatments discussed by the consultant with the patient should also be provided.

Essential Criteria

2A.1	All patients/carers must be offered Patient Information Leaflets (PILs) that covers their specific phototherapy treatment and skin disease, prior to commencing treatment.
2A.2	There is a description of the phototherapy service and contact details on the department's webpage for referrers, patients and their carers.
2A.3	All patient information including PILs must be kept up-to-date and reviewed on a yearly basis or when contact details change.

Examples of Suitable Evidence

- Published leaflets and website information
- Patient notes to show that relevant patient information resources have been provided.
- A copy of the PIL or the website address of the phototherapy service describing the service.
- An up-to-date (in year) copy of the service description either as an approved operational policy or other documented approved service document.

Audit Outcomes - Review of 50 Patient Cases

Status

>90%	2A1. Review of notes indicates that all patients have received a PIL prior to commencing treatment.	>90% Green 70-90% Yellow <70% Red	
100%	2A2. Dermatology departments should have clear information about their services on their department's webpage or Trust/Health Board website.	>95% Green 70-95% Yellow <70% Red	
100%	2A3. Date of writing indicated on all phototherapy PILS is within the past two years.	>95% Green 70-95% Yellow <70% Red	
Audit Questionnaire		No. of cases	%
		/50	
Q1.	2A1. How many patients were sent a patient information leaflet on their skin condition and phototherapy treatment at their consultation?		
Q2.	2A2. Is there information available on the trust's/hospital's website regarding the phototherapy service for patients?	YES	NO
Q3.	2A3. Are PILs and websites kept up-to-date and reviewed on a yearly basis or when contact details change?	YES	NO

Standard Statement 2B –Obtaining Validated Consent

Rationale

Patients (adults and children) should be informed of the benefits and risks of phototherapy and why it has been recommended as part of obtaining their consent. The Dermatologist should cover overall issues, including long-term adverse effects, and discuss alternative treatment options. The Phototherapist (nurse or physiotherapist) should also cover the practicalities and details of treatment, patient care, and short-term adverse effects including relapse after treatment.

The need for verbal/written informed consent exists for all clinical interventions, to help ensure that all patients are appropriately informed. For those patients who cannot give written informed consent, local Trust guidelines on consent in this situation will be followed.

Essential Criteria

2B.1	The consultant has discussed the process for their treatment including any long-term adverse effects and alternative treatment options, after care requirements, and short-term adverse effects of treatment.
2B.2	There must be a record of formal written informed patient consent in the patient's medical notes prior to treatment. Consent should be obtained as a two-stage process, (stage 1: Dermatologist; stage 2: phototherapy Nurse or Physiotherapist), to give the patient the time to change their mind.
2B.3	Patients (adults and children) should be offered a chaperone at each visit to the phototherapy service.

Examples of Suitable Evidence

- Confirmation that patient has been sent an appropriate leaflet/PIL prior to the appointment, and understood the phototherapy process, after care requirements, symptoms and adverse effects of the treatment.
- Confirmation of consent prior to the phototherapy pre assessment and during treatment.

Audit Outcomes - Review of 50 Patient Cases

Status

100%	2B1. The consultant has discussed the process for their treatment including any long-term adverse effects and alternative treatment options (first stage of consent).	>95% Green 70-95% Yellow <70% Red
100%	2B2.A There is a signed and dated confirmation of consent, or confirmation of verbal consent obtained by the consultant in the	>95% Green

	patient notes for all phototherapy prescribed. The record of consent must indicate two-stage consent with the first stage taking place at the time phototherapy was prescribed. This should include the information covered in the discussion with the patient covered by 2B1.	70-95% Yellow <70% Red	
100%	2B2.B The Phototherapist (nurse/ physiotherapist) should also reconfirm the patient understands their phototherapy treatment and gives their consent prior to undertaking any MED/MPD testing (second stage of consent). This should also be recorded in the patient notes.	>95% Green 70-95% Yellow <70% Red	
100%	2B3. All patients (adults and children) are offered a chaperone.	>95% Green 70-95% Yellow <70% Red	
Audit Questionnaire		No. of cases /50	%
Q1.	2B1. How many patients had their long-term treatment plan discussed with their prescribing consultant dermatologist or clinical nurse specialist/ specialty grade doctor/ trainee under their supervision?		
Q2.	2B2. How many patients have a record of two-stage informed consent in their notes?		
Q3.	2B3. Does the phototherapy service offer chaperones for patients?	YES	NO

Standard Statement 2C - Patient Public Involvement (PPI)

Rationale

Each phototherapy service has a statutory duty to engage and involve the public/patients/carers in the planning of its service under the NHS constitution for England. These core principles are shared across all health care services provided in Wales, Scotland and Northern Ireland.

There are a variety of ways in which dermatology departments can proactively involve and engage with their patients. This ranges from relatively simple and commonly used methods, such as administering patient experience surveys and reviewing and responding to patient queries and complaints.

There should be defined systems in place to obtain and manage feedback from patients and any queries or concerns raised by the patient should be addressed accordingly, in a timely manner. Patient and public involvement (PPI) activities within a department should include clinical audit and governance and in training and education (see Standard 4).

Essential Criteria

2C.1	To satisfy current revalidation guidelines, sufficient numbers of patients/parents/carers are offered a Patient Satisfaction Questionnaire. These should be available in an appropriate format and language, to take away or access electronically; and include a question on the information provided and its usefulness and quality.
2C.2	Phototherapy staff are given the opportunity to review and respond to patient queries and complaints.
2C.3	Patient feedback (e.g. through dermatology patient panels) may be provided for clinical audit and governance discussions for the service.

Examples of Suitable Evidence

- Reported outcomes from patient complaints, with lessons learned.
- Patient Satisfaction Questionnaire.
- Website link to patient skin disease support groups including the BAD Patient hub.

Audit Outcomes - Review of 50 Patient Cases

Status

90%	2C1. Evidence in patient notes of patients being offered a Patient Satisfaction Questionnaire	>90% Green 70-90% Yellow <70% Red
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100%	2C2. Review of all documentation from all patient complaints over previous six months to assess whether staff involved have had the opportunity to review and respond to the complaint. Evidence of such staff involvement to be present in all complaint responses.	>95% Green 70-95% Yellow <70% Red	
90%	2C3. Informed patient feedback is provided in the department.	>90% Green 70-90% Yellow <70% Red	
Audit Questionnaire		No.	% of cases /50
Q1.	2C1. How many patients were given a Patient Satisfaction Questionnaire by the phototherapy service at least once a year?		
Q2.	2C2. Do all Phototherapists (nurses and physiotherapists) have input into responding to phototherapy complaints from their own patients?	YES	NO
Q3.	2C3. Do patients have an opportunity for feedback to the department?	YES	NO

STANDARD 3: Staff, Training and Education

Standard Statement 3A – Qualified Professional Staff

Rationale

The [Phototherapy modules](#) undertaken during Dermatology specialist training require acquisition of all competencies necessary for consultant practice. Any clinical nurse specialist/ specialty grade doctor/ trainees working under the supervision of a consultant should also meet these requirements in addition to the diagnostic elements of the curriculum. The maintenance of these competencies is applicable to any clinician wanting to continue practice in this specialist area.

Phototherapists (nurse/ physiotherapist) require experience in a dermatology unit and additional training. They must be able to meet the competences set out in the [Phototherapy modules](#).

Both the Nursing and Midwifery Council and General Medical Council produce practice standards for nurse and doctors respectively and require regular educational activities that maintain and develop the individual's competence and performance.

Essential Criteria

3A.1	A Phototherapist must be a physiotherapist registered with the HCPC or a registered Nurse (with at least two years of experience in dermatology). All phototherapy staff must undertake a period of supervised practice with a qualified Phototherapist and be signed off as 'competent'. During this period, clinical notes of patients treated by the trainee should be countersigned by a 'competent' Phototherapist. If a Phototherapist is not either a chartered physiotherapist or first level registered Nurse, they must demonstrate that: 1. They have been working as a Phototherapist in the UK in a recognised phototherapy Unit for a minimum of five years prior to 1st January 2015; 2. They can show that they have been signed off by the Phototherapist* in all relevant competencies. (*a Chartered Physiotherapist or a registered Nurse who has undertaken a period of supervised practice with a qualified Phototherapist and been signed off as 'Competent').
3A.2	The unit has its own dedicated Phototherapy Lead Consultant, or Lead of equivalent standing such as a senior specialty grade doctor, who will provide clinical expertise and input into key matters of the phototherapy service, staff support and supervision, and overall service co-ordination. Specialist clinics are set aside in the Consultant's job plan to ensure that sufficient time (up to two Programmed Activities (Whole Time

	Equivalent)) is available for their consistent and regular input to the team and related forums.
3A.3	The phototherapy unit should undertake a detailed review of staffing requirements every 12 months or six months prior to any long-term scheduled leave to avoid disruption to services.
3A.4	All phototherapy clinicians should undergo some form of educational activity in phototherapy at least once a year, including attending a recognised update or other phototherapy course at least once every three years.
3A.5	All phototherapy clinicians must have an annual appraisal to include a personal development plan for their continuing professional development (CPD), which supports their on-going practice in this area.
3A.6	Senior specialty grade doctors working as leads for phototherapy units are required to have 4 years' experience in dermatology in addition to a minimum of six months training (or accrued experience) at a phototherapy unit to meet the competencies defined within the Dermatology curriculum (see Appendix 1).
3A.7	All staff on the unit should hold up-to-date hospital life support (and paediatric hospital life support if involved with caring for children) mandatory training.
3A.8	All staff should have appropriate training in safeguarding children and adults
3A.9	The Medical Physics Department, or the employer of the designated person in 5A.1, provides training for its staff in phototherapy-related medical physics.

Examples of Suitable Evidence

- Up-to-date staff training records of those involved with the service.
- Hospital Life Support (and paediatric hospital life support if involved with caring for children) Certificate.
- Review of 50 patient cases to demonstrate case mix outcomes for each phototherapy practitioner.
- Phototherapy and skin disease related CPD for all phototherapy clinical staff.
- Case list of all phototherapy patients seen in the department over a 12-month period

Audit Outcomes - Review of 50 Patient Cases

Status

100%	3A1. All Phototherapists (nurses or physiotherapists) meet the required training standards to practice	Yes Green No Red	
100%	3A2. Name of phototherapy Lead Consultant Dermatologist to be provided by the Unit.	Yes Green No Red	
100%	3A3. Staffing requirements are reviewed every 12 months or 6 months prior to any long term leave	Yes Green No Red	
100%	3A4. All phototherapy clinicians undergo some form of educational activity in phototherapy at least once a year.	Yes Green No Red	
100%	3A5. Compliance with CPD specific to providing the phototherapy service for each practitioner. Full and detailed appraisal in terms of performance and on-going education and training and professional leadership, appropriate to the service.	Yes Green No Red	
100%	3A6. Senior specialty grade doctors working as leads for phototherapy units are required to have 4 years' experience in dermatology in addition to a minimum of six months training at a phototherapy unit	Yes Green No Red	
100%	3A7. All staff on the unit hold up-to-date hospital life support (and paediatric hospital life support if involved with caring for children) mandatory training.	Yes Green No Red	
100%	3A8. All staff have appropriate training in safeguarding children and adults	Yes Green No Red	
100%	3A9. The Medical Physics Department, or the employer of the designated person in 5A.1, provides training for phototherapy staff in phototherapy-related medical physics.	Yes Green No Red	
100%	All phototherapy clinical staff training and updates during the year are held on a register within the department.	Yes Green No Red	
Audit Questionnaire			
Q1.	3A1. Are all phototherapy clinical staff (i.e. Nurses and Physiotherapists) meeting the training standards required for this specialist area of practice, as defined in standard 3A.1	YES	NO

Q2.	3A2. Is there a named phototherapy Consultant lead for the phototherapy service?	YES	NO
Q3.	3A3. Does the phototherapy unit undertake a detailed review of staffing requirements every 12 or 6 months, to ensure that your department remains able to meet the requirements?	YES	NO
Q4.	3A4. Have all phototherapy clinicians undergone some form of educational activity in phototherapy at least once in the past year, including attending a recognised update or other phototherapy course at least in the past three years?	YES	NO
Q5.	3A5. Have all phototherapy staff had an annual appraisal and a personal development plan for their continuing professional development (CPD)?	YES	NO
Q6.	3A6. If a senior specialty grade doctor is working as phototherapy Lead, does she/he have 4 years' experience in dermatology in addition to a minimum of six months training (or accrued experience) at a phototherapy unit to meet the competencies defined within the Dermatology curriculum (see Appendix 1)?	YES	NO
Q7.	3A7. Do all clinical staff hold up-to-date hospital life support and paediatric life support mandatory training?	YES	NO
Q8.	3A8. Do all staff have appropriate training in safeguarding children and adults?	YES	NO
Q9.	3A9. Does the Medical Physics department, or equivalent, provide training for phototherapy staff in phototherapy-related medical physics?	YES	NO

STANDARD 4: Clinical Management & Monitoring

Standard Statement 4A: Clinical Management

Rationale

All patients treated with UVB or PUVA are treated according to optimally effective, and safe, regimens based on the best available study evidence, adapted as necessary to be appropriate for each individual patient, and to local phototherapy unit circumstances

Treatment regimen variables (including starting dose, incremental dosage regimen, treatment frequency, treatment time, concomitant therapies, and decision to stop a course of treatment) influence the efficacy of treatment and the risk of acute side effects. The phototherapy unit should undertake regular reviews of its patients to avoid unsatisfactory responses to treatment.

Essential Criteria

4A.1	Patient records should be available at the start of each clinic for review by the nurse/consultant.
4A.2	Patients should be offered alternative second- or third-line treatment, where a safe or effective alternative exists, when: • narrowband UVB phototherapy results in an unsatisfactory response or is poorly tolerated or • there is a rapid relapse following completion of treatment (rapid relapse is defined as greater than 50% of baseline disease severity within 3 months)
4A.3	The proportion of patients being treated for diseases other than psoriasis (i.e. eczema, vitiligo etc) who achieve remission or partial remission of their disease should be in line with the published literature where the data exist.
4A.4	The proportion of patients being treated for psoriasis with whole body UVB who achieve complete or near complete remission (e.g. at least "Minimal Residual Activity" or fall in PASI by at least 90%, or however outcomes are recorded locally) by the end of the phototherapy is at least 70% and the median number of exposures per successful course is less than 30.
4A.5	Written evidence-based protocols for all relevant forms of phototherapy are available, and used, including discharge protocols and incident reporting protocols.

Examples of Suitable Evidence

- Presence or absence of up-to-date written protocols.

Annual review of the MED/MPD technique.			
The percentages of patients treated with whole-body UVB and whole-body PUVA who were documented to be clear or near-clear/at minimal residual activity at end of course.			
Numbers of treatments per successful (defined as achieving clearance/near clearance/minimal residual activity) whole body UVB course for psoriasis.			
Audit Outcomes - Review of 50 Patient Cases			Status
100%	4A1. Clear record of each dose and summed cumulative dose at the end of each patient treatment course. Patient records are available (paper or electronic) in all cases.	>90% Green 70-90% Yellow <70% Red	
100%	4A2. Patients should be offered alternative second- or third-line treatment, where a safe or effective alternative exists.	>90% Green 70-90% Yellow <70% Red	
>70%	4A3. The proportion of patients being treated for diseases other than psoriasis (i.e. eczema, vitiligo etc) who achieve remission or partial remission of their disease.	>65% Green 50-65% Yellow <50% Red	
>70%	4A4. Clearance/near-clearance (minimal residual activity) of whole-body psoriasis in complete courses.	>65% Green 50-65% Yellow <50% Red	
100%	MED/MPD techniques should be described fully, including the site(s) of test(s), and the sequence of doses used (or the ratio between adjacent exposures).	>90% Green 70-90% Yellow <70% Red	
100%	4A5. Written up to date evidence-based protocols for all relevant forms of phototherapy are used and include patient discharge and incident reporting protocols.	>90% Green 70-90% Yellow <70% Red	
100%	Phototherapy (narrowband UVB, broadband UVB or PUVA) is not being routinely used as maintenance therapy.	>90% Green 70-90% Yellow <70% Red	
Audit Questionnaire			No. of cases /50 %
Q1.	4A2. How many patients are offered second- or third-line treatment when UVB has been unsatisfactory or there is a rapid relapse?		

Q2.	4A3. For non-psoriasis patients, how many had complete clearance or minimal residual activity by the end of the phototherapy treatment course?		
Q3.	4A4. For psoriasis patients, how many had complete clearance or minimal residual activity by the end of the phototherapy treatment course?		
Q4.	4A.5 Are written evidence-based protocols for all relevant forms of phototherapy available, and used, including discharge protocols and incident reporting protocols?	YES	NO

Standard Statement 4B: Monitoring

Rationale

Safe and efficient patient care relies on high quality data. By taking responsibility for their clinical data, clinicians can improve its quality and help drive up standards of care. Accurate recording of clinical investigations /procedures is required for service planning and investment. Suboptimal recording of phototherapy treatments leads to income losses which impact on the maintenance and development of services, staff, equipment and viability of the department.

Essential Criteria

4B.1

The following clinical activities must be recorded for all patients undergoing phototherapy treatments in England. The pathway for recording this activity in the devolved nations should include the OPCS codes used as these are international classifications:

New Consultation with Phototherapy Consultant (pre assessment and prescribing of phototherapy regime)

- WF01B First Attendance - Single Professional

Treatment function codes 330 for adult dermatology or 257 for paediatric dermatology should be allocated against all phototherapy patient activity.

First Follow up appointment – (MED/MPD assessment test with the phototherapy nurse).

- WFO1A Follow-Up Attendance – Single Professional plus one of the following phototherapy outpatient procedure codes:
 - S121: Ultraviolet A light therapy to skin
 - S122: Ultraviolet B light therapy to skin
 - S124: Combined photochemotherapy and ultraviolet B light therapy to skin
 - S128: Other specified phototherapy to skin
 - S129: Unspecified phototherapy to skin

Second and additional phototherapy follow up appointments should be recorded as above.

4B.2	Agreed protocols in place for recording phototherapy treatments and adjunct treatments by all clinical staff.
4B.3	Phototherapy coding forms should be used by practitioners to accurately record activity in the patients notes. Electronic system for recording clinical activity must contain a list of all the recognized phototherapy codes and allow multiple recording of treatments for each patient.
4B.4	Clinical and financial arrangements for the phototherapy service should be reviewed by the clinical lead and any anomalies reported.

Examples of Suitable Evidence

- Phototherapy outpatient income forms or electronic record of phototherapy and adjunct treatment codes used by the department.
- Case mix report of all phototherapy activity for the department over a 12 -24-month period
- Yearly clinical and financial reports for the phototherapy service

Audit Outcomes - Review of 50 Patient Cases		Status
100%	4B1. Audit review of 50 consecutive cases undertaken by the phototherapy service over a 12-month period of activity recorded	Yes Green No Red
100%	4B2. Agreed protocols in place for recording phototherapy treatments and adjunct treatments by all clinical staff.	Yes Green No Red
100%	4B3. Electronic system for recording clinical activity must contain a list of all the recognized phototherapy codes and allow multiple recording of treatments for each patient.	Yes Green No Red
100%	4B4. Clinical and financial arrangements for the phototherapy service should be reviewed by the clinical lead and any anomalies reported.	Yes Green No Red

Audit Questionnaire

Q1.	4B1. Has the department undertaken an audit of its phototherapy service over the last 12 months?	YES	NO
Q2.	4B2. Has the department reviewed its protocols for the recording of phototherapy procedures in the last 12 months?	YES	NO
Q3.	4B3. Does the electronic system for recording clinical activity contain all phototherapy codes?	YES	NO

Q4.	4B4. Are clinical and financial arrangements for the phototherapy service reviewed and anomalies reported?	YES	NO
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STANDARD 5: Equipment and Facilities

Standard Statement 5A - Safety and Compliance

Rationale

All services require adequate facilities, which are compliant with DH building notes (see Appendix 4: NHS Facilities for Clinical Spaces). Consultation rooms are essential for examination of patients.

Spacing should take into account the amount of, and ease of access to phototherapy facilities to facilitate the activity of both the phototherapy staff and patient. The privacy, dignity and respect of healthcare users should be maintained at all times, through the effective use of private rooms, curtains, screens, blankets and appropriate clothing.

The phototherapy unit will have robust and accurate systems in place for ultraviolet dosimetry (i.e. the measurement ultraviolet radiation and estimation of irradiation delivered). All equipment will be regularly calibrated and checked for electrical safety. All calibrations will be traceable to national standards. Staff exposure to ultraviolet radiation will be regularly checked to ensure it is within recommended limits.

Facilities should have appropriate ventilation and cooling to maintain a comfortable environment for staff and patient and to ensure satisfactory operation of phototherapy equipment.

Essential Criteria

5A.1	A designated medical physicist or staff member trained and authorised by a medical physicist expert in UV protection is responsible for UV measurements in all phototherapy Units. Irradiance measurements of phototherapy equipment must be made and recorded regularly at least twice a year. The measurement interval must be adequate to ensure changes in irradiance of more than 10-15% do not go unmonitored.
5A.2	Written dosimetry protocols should be in place, which take account of currently available guidelines and local factors (e.g. BPG Guidelines on UVB (2004) and PUVA (2016); Scottish UV Dosimetry Guidelines, 2008; IPEM Report 101, 2010).
5A.3	Annual inspections of each piece of equipment should include a risk assessment, or a review of any existing risk assessment, and a record of calibration and dosimetry carried out within the last 12 months. This includes handheld meters, which should be available in every unit and used by Phototherapists (nurse/ physiotherapist) for UV irradiance measurements in the Unit with calibrations traced to national standards.
5A.4	Phototherapy units must implement and monitor systems to ensure the general health of service users, staff and others. Staff exposure to ultraviolet radiation must be checked

	annually to ensure it is within recommended limits i.e. does not exceed the limits specified in The Artificial Optical Radiation Regulations
5A.5	Phototherapy units must ensure that their facilities are suitable with respect to design, layout and service users' rights to privacy and dignity. This includes appropriate space for patients to store personal belongings, dress and undress in privacy, with assistance when required.
5A.6	The limits for room temperature set-point are generally between 16°C and 25°C depending on the treatment. This is adjustable within a predetermined range by the user. For single room airflow change rate, the treatment temperature should not exceed 25°C with six air flow changes per hour (this may increase where multi units are provided in one room for treatments).
5A.7	Irradiances should be measured with a meter calibrated in UKAS accredited laboratory (with expanded uncertainty less than 15%), and only by staff trained by Medical Physicists experts in UV protection.
Examples of Suitable Evidence	
Documented Risk Assessment identifying risks, hazards and control measures.	
Documented plan to deal with any emergency.	
Local policy on the changing of privacy curtains, both for routine changing and for when the curtains become soiled. This should be reflected in the department infection control policy.	
Records of inspections show that consulting/treatment rooms provide privacy etc.	
- Availability of dosimetry protocols showing traceability and transparency of calibration. - The name of the medical physicist with overall responsibility for UV dosimetry clearly identified - Medical physics annual report including checklist of above items - Log with dates for replacement of items e.g. bulbs, equipment etc. so can plan in advance e.g. capital bids	
COSHH risk assessment report.	
Audit Outcomes - Review of 50 Patient Cases	
Status	
100%	5A1. Irradiance measurements of phototherapy equipment must be made and recorded regularly at least twice a year. The measurement interval must be adequate to ensure changes in irradiance of more than 10-15% do not go unmonitored.
	Yes Green No Red

100%	5A2. Written dosimetry protocols should be in place, which take account of currently available guidelines and local factors	Yes Green No Red
100%	5A3. Compliant COSHH RISK assessment report including evidence that ventilation requirements are met.	Yes Green No Red
100%	5A4. Staff exposure to ultraviolet radiation must be checked annually to ensure it is within recommended limits	Yes Green No Red
100%	5A5. Evidence that phototherapy facilities are suitable with respect to design, layout and service users' rights to privacy and dignity, as specified in the Department of Health's Health Building Notes 00-02; 00-03 and 12, respectively.	Yes Green No Red
100%	5A6. Evidence that ventilation requirements are met - implicit under the Health and Safety at Work Act 1974 and COSHH, have been made explicit by the Management of Health and Safety at Work Regulations 1999, the Workplace (Health, Safety and Welfare) Regulations 1992 and the Provision and Use of Work Equipment Regulations 1998, all issued as a result of European Directives.	Yes Green No Red
100%	5A7. Irradiance measured with a UKAS calibrated meter within calibration by staff trained by Medical Physics expert in UV.	Yes Green No Red
100%	Number of adverse incidents relating to equipment malfunction or calibration to be analysed during the period they occur.	Yes Green No Red

Audit Questionnaire

Q1.	5A1. Are irradiance measurements taken of phototherapy equipment at least twice a year?	YES	NO
Q2.	5A2. Does the phototherapy unit have up to date written dosimetry protocols and safety standards in place for staff and patients?	YES	NO
Q3.	5A3. Does the phototherapy unit have an up-to-date COSHH risk assessment report?	YES	NO
Q4.	5A4. Does the phototherapy unit measure staff occupational exposure to ultraviolet radiation and ensure they are kept below recommended limits?	YES	NO

Q5	5A5. Are the facilities of the phototherapy unit suitably designed, including for service users' privacy and dignity?	YES	NO
Q6.	5A6. Does the phototherapy unit meet ventilation and temperature control?	YES	NO
Q7.	5A7. Does the department have a medical physicist responsible for the routine calibration and service checks of its phototherapy machines?	YES	NO

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STANDARD 6: Clinical Governance and Audit

Standard Statement 6A - Clinical governance process

Rationale

Phototherapy services should operate within the departmental clinical governance process and recognised policy frameworks. It is recommended as a minimum that a clinical governance framework for a phototherapy service should include a named phototherapy lead clinician. The role of the lead clinician is to take clinical responsibility for ensuring that the service is safe, effective and complies with:

- National service delivery standards;
- Treatment-specific guidelines;
- Disease specific guidelines.

The phototherapy service is delivered by a multi-professional team. Members of the team and their roles in contributing to the service should be recorded. Team members would typically include the following: dermatology consultants, specialty grade doctors, phototherapy nurses/physiotherapists and trainee grade doctors, medical physicists.

Providers are responsible for the safety of their patients and must ensure robust systems are in place for recognising, reporting, investigating and responding to 'Serious Incidents' and for arranging and resourcing investigations.

Reports of adverse incidents should be made available, so that any problems with equipment, staff or procedures can be identified before they cause adverse events or interruption to the service. Review of protocols and procedures allows these to be checked against current best practice or national guidelines and updated if necessary.

Essential Criteria

6A.1	An audit should be carried at a minimum of every 12 months of all episodes of symptomatic erythema. The interpretation of results will be informed by the total numbers of treatments and total number of patients seen by the unit for each treatment type. Published rates of symptomatic erythema vary and erythema standards have not been established for the different forms of phototherapy however, yearly regional audits carried out by the Yorkshire phototherapy network have documented E2 erythema ranging from 0.8% to 2% of all exposures in patients with psoriasis treated with whole
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	body nb-UVB across different units. No episodes of E3 or E4 erythema were documented and these should only occur very rarely.
6A.2	There should be regular meetings (at least four a year) between all members of the multidisciplinary phototherapy team. The agenda for these regular clinical governance meetings should include the following elements: • Review of phototherapy activity since the previous meeting (summary of treatment numbers for each clinician). • Review of phototherapy waiting list data (if a waiting list exists) to assess demands on the service and issues for service delivery. • Review of adverse events. All adverse events should be discussed by the team. Where patient safety is an issue, the team need to consider the cause of the adverse event, and measures to be taken if necessary, to avoid a repeat in the future. • Discussion of difficult or instructive cases. As with any clinical therapy service, there may be some cases that are atypical or unusual. Discussion of these cases is often instructive for team members and may improve patient outcomes.
6A3.	All team members should attend clinical governance meetings
6A.4	There should be standardised methods for recording incidents on DATIX or equivalent incident reporting systems to review episodes of symptomatic erythema. Episodes should be graded using the following definitions: • E1 Just perceptible erythema • E2 Well defined marked erythema causing minimal discomfort • E3 vivid painful erythema • E4 vivid painful erythema with oedema and/or blistering.
6A.5	Any adverse event more serious than an E2 erythema shall be discussed at the clinical governance meeting, and the outcome should be recorded on the trust's 'Serious Incidents' form (or adverse events form for devolved nations).
6A.6	A record should be kept of the performance outcomes of the key safety checks undertaken by the phototherapy team.
Examples of Suitable Evidence	
• Waiting list data and prioritisation of high-risk cases.	
• Record of DATIX or other Incident reporting system data for serious incidents.	
• Case-based discussions of challenging phototherapy patients and outcomes.	

Minutes of clinical governance meetings discussing clinical incidents, health and safety review, adverse events and lessons learned.			
Written evidence-based protocols for reporting incidents.			
Audit Outcomes - what will be audited for each Standard			Status
100%	6A1. All adverse events should be appropriately documented and investigated, with remedial measures instituted	Yes Green No Red	
100%	6A2. There should be at least four full team phototherapy meetings a year.	Yes Green No Red	
100%	6A4. There should be standardised methods for recording incidents on DATIX, or equivalent incident reporting systems, for recording and recalling episodes of E3 or E4 .	Yes Green No Red	
100%	6A5. Evidence from Clinical Governance/Audit meeting minutes that all adverse events have been discussed at the meeting and the outcome recorded on the trust's 'Serious Incidents' form (or adverse events form for devolved nations).	Yes Green No Red	
100%	6A6. A record should be kept of the performance outcomes of the key safety checks undertaken by the phototherapy team, or individual on the team's behalf.	Yes Green No Red	
100%	An audit has been undertaken every 12 months all episodes of E2, E3 or E4, interpreting the result of total numbers of patients and total numbers of treatments. Results of the audits should be expressed as numbers of symptomatic erythema episodes/patients treatments/year, expressing results both as totals and subdivided by grade of erythema.	Yes Green No Red	
100%	Lessons learned are in a written report. Any system changes implemented are recorded as outcomes.	Yes Green No Red	
Self-Assessment and Audit Questionnaire - Review of 50 Patient Cases			
Q1.	6A1. Does the phototherapy unit audit its acute adverse event rates including rates of symptomatic erythema every 12 months? See 6A1.	YES	NO
Q2.	6A2. Does phototherapy unit have quarterly team meetings to discuss and review the service?	YES	NO
Q3.	6A3. Do all team members attend clinical governance meetings?	YES	NO

Q4.	6A4. Is there a DATIX/incident reporting system for E3 or E4?	YES	NO
Q5.	6A5. Are any adverse events more serious than E2 discussed and the outcome recorded?	YES	NO
Q6.	6A6. Does the phototherapy unit have records of performance for key safety checks?	YES	NO

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STANDARD 7: Discharge Protocol

Standard Statement 7A Discharging Patients from care

Rationale

All units should have a clear protocol to guide those administering treatment on when a course should be stopped.

Most patients will experience recurrence of their condition some time following phototherapy, although this will sometimes be mild and amenable to home management. Patients need to know how to obtain advice if their condition recurs and how to re-access the service. Some of these patients may be suitable for Patient-Initiated Follow up appointment to see a consultant dermatologist.

Early discharge leads to inadequate improvement in the condition treated (and may lead to early relapse). Delayed discharge exposes patients to unnecessary risks of adverse effects and wastes resources.

Essential Criteria

7A.1	There is a protocol with guidance on when to stop treatment, and when to seek a Dermatologist's advice on when to stop a course of treatment.
7A.2	On discharge, patients must be given information on how to re-access the service should this be necessary. The patient should also be given information on the management of their skin condition, and management of flares, with instruction to their GP to provide ongoing treatment.
7A.3	Consider offering suitable patients who experience regular flares of their skin condition following phototherapy, and who are able to self-manage, a Patient-Initiated Follow Up appointment.
7A.4	The patient's GP and referring Consultant are notified within 10 working days following completion of a course of phototherapy and informed of any follow-up arrangements and given relevant information about the course and cumulative doses.

Examples of Suitable Evidence

- Protocol with guidelines for stopping treatment.
- GP letter in patient notes.
- Hospitals must publish local access policies and demonstrate evidence of having taken account of GP feedback when considering service development and redesign.
- Hospitals to communicate clearly and promptly with GPs following outpatient clinic attendance, where there is information which the GP needs quickly in order to manage patient's care (certainly no later than 14 days after the appointment)

Audit Outcomes - Review of 50 Patient Cases		Status	
100%	7A1. Unit to provide the written phototherapy protocols used by the Unit, which must include discharge protocols.	>90% Green 70-90% Yellow <70% Red	
>90%	7A2. Phototherapy notes show the patient has been given information on how to access services again after discharge.	>80% Green 65-80% Yellow <60% Red	
>95%	7A4. An audit of patient case notes shows the completion of the treatment course and a letter/report summarising the course was sent to patient’s GP and referring Consultant.	>90% Green 70-90% Yellow <70% Red	
Audit Questionnaire			
Q1.	7A1. Is there a phototherapy protocol with guidance for staff on when to stop treatment?	YES	NO
		No. of cases /50	%
Q2.	7A2. How many patients have been given information on how to access services again after they have been discharged, including follow up appointments?		
Q3.	7A3. How many patients (where suitable) have been put on a Patient Initiated Follow Up programme?		
Q4.	7A4. How many patients’ GP/Consultant have been sent notes detailing the completion of their treatment course?		

STANDARD 8: Skin Cancer Surveillance

Standard Statement 8A: Monitoring for Skin Lesions

Rationale

PUVA treatment causes an increased risk of skin cancer. Narrowband UVB has yet to be demonstrated to be a skin cancer risk. However, there may be a risk related to the overall numbers of treatments and ultraviolet doses administered, and also to pre-existing risk factors for skin cancer in some patients i.e patients of lower skin types, fair complexion, red hair and who have a large number of naevi.

This Standard does not imply mandatory ceilings and limits to cumulative doses of UV from phototherapy. It is about monitoring of patients who have had high cumulative UV doses. There are no limits to the numbers of treatments patients may have.

There are no limits to the numbers of treatments patients may have. However, the figures of >200 PUVA and >500 UVB treatments are thresholds to trigger a skin cancer screening review in all phototherapy patients. Decisions about whether or not to continue to treat past these arbitrary threshold numbers are the responsibility of the Dermatology Consultant. The Dermatology Consultant has to assess the relative risks and benefits of the various treatment options available for each patient. In some patients, the correct decision is to continue beyond these arbitrary threshold figures. Patients must be made aware of their increased risk and should be offered annual tumour surveillance skin examination with local centres.

Essential Criteria

8A.1	It must be documented that patient has reached >200 whole-body PUVA treatments and/or >500 whole-body UVB treatments in main hospital case notes and in letters to GPs.
8A.2	Dermatology consultant assesses the risk for continued treatment for the patient past arbitrary threshold numbers. Alternative therapy options should also be discussed with the patient.
8A.3	All phototherapy departments should have a skin cancer surveillance appointment letter template to use to send out to patients with cumulative dosages >200 whole-body PUVA treatments and/or >500 whole-body UVB treatments.

Examples of Suitable Evidence

- Survey of skin cancers detected each year at annual reviews for any new or suspected lesions.
- List of patients with cumulative dosages of >200 PUVA and/or >500 UVB treatments

GP patients' letters indicating high dosage of PUVA or UVB			
Patient letters for skin cancer surveillance appointment			
Audit Outcomes - Review of 50 Patient Cases			Status
>90%	8A1. All clinic letters indicate the high cumulative dose in clinic and GP letters where patients have had >200 whole-body PUVA treatments and/or >500 whole-body UVB treatments.	>80% Green 65-80% Yellow <60% Red	
>90%	8A3. All patients with >200 whole-body PUVA treatments and/or >500 whole-body UVB treatments should be offered a skin cancer surveillance appointment annually.	>80% Green 65-80% Yellow <60% Red	
Audit Questionnaire			No. of % cases /50
Q1.	8A1. How many patient notes indicate where high cumulative UV doses have been received, if applicable?		
Q2.	8A3. How many patients with >200 PUVA and/or >500 UVB treatments have been sent a letter offering them a skin cancer surveillance appointment?		

References and Evidence

Evidence searches were made using the following electronic databases from May 2013 until February 2015: Cochrane Library; PubMed; British Medical Journal (BMJ); British Journal of Dermatology (BJD); Royal Society of Medicine (RSM) Library.

Our selection criteria included the headings from our Service Guidance and Standard's core principles, on a generalist and clinical intervention level (e.g. general facilities versus clinical intervention-specific facilities). This provided us with a wider scope, due to the limited availability of service-based evidence.

Evidence Search: May 2013 – February 2015 (Update carried out October 2020- December 2021).

	Standard								Last Reviewed
	1	2	3	4	5	6	7	8	
Core Evidence									
Care Quality Commission. The Fundamental Standards.	X	X	X	X	X	X	X	X	2020
Confidentiality: Good Practice in Handling Patient Information. General Medical Council. Updated 2018.	X	X	X	X	X	X	X	X	2020
Confidentiality. NHS Code of Practice. 2003.	X	X	X	X	X	X	X	X	2020
Accreditation of Qualifying Programmes in Physiotherapy. Chartered Society of Physiotherapy. 2020.			X						2019
Data Protection Act 2018.	X	X	X	X	X	X	X	X	2020
Department of Health. Health Building Note 00-02: Sanitary Spaces.					X				2020
Department of Health. Health Building Note 00-03: Clinical and Clinical Support Spaces.					X				2020
Department of Health. Health Building Note 12: Out-patients Department.					X				2020
Department of Health. The NHS Constitution for England (last updated 2015).	X	X	X	X	X	X	X	X	2020
Equality Act 2010.	X	X	X	X	X	X	X	X	2020
Essential Standards of Quality and Safety. Care Quality Commission. 2010.	X	X	X	X	X	X	X	X	2020
Fitness to Practice Rules: Nursing and Midwifery Council. 2004.			X	X					2020
General Medical Council. Ethical Guidance, Decision Making and Consent. 2020	X	X	X	X	X	X	X	X	2020
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9: Person-Centred Care.	X	X	X	X	X	X	X	X	2020

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10: Dignity and Respect.				X	X	X			2020
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11: Need for Consent.		X							2020
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15: Premises and Equipment.					X				2020
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good Governance.	X	X	X	X	X	X	X	X	2020
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18: Staffing.			X	X					2020
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19: Fit and Proper Persons Employed.			X	X					2019
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Duty of Candour.	X	X	X	X	X	X			2020
How to Write in Plain English. The Plain English Campaign.	X	X	X	X	X	X	X	X	2020
National Health Service England. 2019/20 National Tariff Payment System.				X					2020
National Health Service Standards Contract 2020/21.	X	X	X	X	X	X	X	X	2020
National Institute for Health and Care Excellence. Health and Social Care Directorate Quality Standards Process Guide. 2016	X	X	X	X	X	X	X	X	2020
NICE guidelines on behaviour change: individual approaches and behaviour change: general approaches.		x							2020
NICE guidelines on medicines adherence and medicines optimisation.		x							2020
NICE guideline on transition from children's to adults' services for young people using health or social care services		x							2020
NICE guideline on patient experience in adult NHS services		x							2020
Nursing and Midwifery Council Registration.			X						2020
Principles for best practice in clinical audit. NICE. 2008.					X	X			2020
Patient's Global Assessment (classified as clear, nearly clear, mild, moderate, severe or very severe)	x	x							2020
The Professional Record Standards Body (PRSB) - PRSB Standards for the Structure and Content of Health and Care Records 2018	x		x				x		2020

NHSX, The Records Management Code of Practice for Health and Social Care. 2021		X		X		X			2020
Specialty Training Curriculum for Dermatology. 2010. Joint Royal Colleges of Physicians Training Board.			X						2020
Professional Guidance on the Safe and Secure Handling of Medicines. 2018. Royal Pharmaceutical Society.					X				2020
NHS Discharge Protocol							X		2020
General Medical Council. Good practice in prescribing and managing medicines and devices	X								2020
Specialist Evidence									
A randomized comparison of methods of selecting narrow-band UV-B starting dose to treat chronic psoriasis. Dawe RS, Cameron H, Yule S, et al. Arch Dermatol. 2011;147(2):168-174. 2010.	X							X	2020
A randomized, observer-masked, trial of 2x vs 3x weekly narrow-band ultraviolet B phototherapy for chronic plaque psoriasis. Cameron H, Dawe RS, Yule S, et al. Br J Dermatol; 147: 973-978. 2002	X		X	X				X	2020
British Photodermatology Group Guidelines, 2002; Scottish UV Dosimetry Guidelines, 2001; IPEM Report 76, 1997					X				2020
British Association of Dermatologists and British Photodermatology Group Guidelines for the Safe and Effective Use of Psoralen-Ultraviolet A Therapy. 2015. Ling TC, Clayton TH, Crawley J et al. Br J Dermatol. 2016;174(1):24-55.	X	X			X	X			2020
National Health Service, Privacy and Dignity, The elimination of mixed sex accommodation, 2007.					X				2020
Health and Social Care Information Centre. Checklist Guidance for Reporting, Managing and Investigation Information Governance Serious Incidents Requiring Investigation. 2013.						X			2020
House of Commons Public Administration Select Committee. Investigation Clinical Incidents in the NHS. 2015.						X			2020
General management of Psoriasis –Recommendations. The British Association of Dermatologists. 2006	X						X	X	2020
Guidelines on the Measurement of Ultraviolet Radiation Levels in Ultraviolet Phototherapy: Report Issued by the British Association of Dermatologists and British Photodermatology Group 2015. Moseley H, Allan D, Amatiello H et al. Br J Dermatol. 2015 Aug;173(2):333-50.			X			X			2020

8-MOP PUVA for psoriasis: a comparison of a minimal phototoxic dose-based regimen with a skin-type approach. Collins P, Wainwright NJ, Amorim I et al. 8-. Br J Dermatol 135:248-54 .1996	X							X	2020
Narrow-band (TL-01) ultraviolet B phototherapy for chronic plaque psoriasis: three times or five times weekly treatment? Dawe RS, Wainwright NJ, Cameron H, Ferguson J. Br J Dermatol; 138: 833-39. 1998.	X							X	2020
Narrow-band ultraviolet B (TL-01) phototherapy for psoriasis: which incremental regimen? Wainwright NJ, Dawe RS, Ferguson J. Br J Dermatol; 139: 410-14. 1998.	X			X					2020
NCCG Psoriasis. Assessment and management of psoriasis. Clinical Guideline Methods, evidence and recommendations. NICE. 2012. NICE Quality Standard 40 – Psoriasis (QS40). August 2013.	X	X		X	X			X	2020
NHS Scotland. Safety action notice. Full-body phototherapy cabinets: risk of laceration from un-guarded UV tubes (SAN(SC)03/14).					X				2020
NICE Clinical Guideline 181 – Cardiovascular disease: risk assessment and reduction, including lipid modification (CG181). July 2014.	X	X		X					2020
NICE Quality Standard 15 – Patient Experience in Adult NHS Services (QS15). February 2012.	X	X		X					2020
Phototherapy Guidelines - Dowling Day Treatment Unit St John's Institute of Dermatology St Thomas' Hospital London Guidelines originally written by Dr. R. Palmer, Sister T. Garibaldinos, Prof. J. Hawk in January 2005 : Guidelines updated by: Dr. R. Sarkany in July 2009.	X							X	2020
Rate of acute adverse events for narrow band UVB and psoralen UVA phototherapy. Photodermatology photoimmunology & photomedicine. 2007;23:68-72Martin JA, Laube S, Edwards C, Gambles B, Anstey AV.				X					2020
Royal College of Nursing. Defending Dignity: Challenges and Opportunities for Nursing. 2008.				X					2020
Standards for Photonet National Managed Clinical Network. Photonet National MCN. 2018.	X			X		X			2020
The Control of Artificial Optical Radiation at Work Regulations 2010. The Health and Safety Executive.				X	X				2020
European Commission, MEDICAL DEVICES: Guidance Document – Classification of medical devices, 2010					X				2020
Department of Health, Estates and Facilities Alert, EFA/2012/002, Equipment using ultraviolet (UV) tubes. 2012.					X				2020

Randomized Double-blind Trial of the Treatment of Chronic Plaque Psoriasis: Efficacy of Psoralen-UV-A Therapy vs Narrowband UV-B Therapy”, Sami S. Yones, MSc, FCD; Roy A. Palmer, MA, MRCP; Trish T. Garibaldinos, RN; et al. Arch Dermatol. 2006;142(7):836-842.				X					2020
A regional audit of symptomatic erythema rates in psoriasis patients treated with whole-body narrowband ultraviolet type B: a basis for setting an erythema standard - Whitehouse - 2020 - Clinical and Experimental Dermatology - Wiley Online Library					X				2021

DRAFT

Evidence Review: Prevalence and Incidence

Evidence searches were made using the following electronic databases from May 2013 until February 2015: Cochrane Library; PubMed; British Medical Journal (BMJ); British Journal of Dermatology (BJD); Royal Society of Medicine (RSM) Library. Where NICE Guidance exists for the clinical indication or skin disease area, the citations contained within inform on the prevalence and incidence evidence and services, where relevant.

Ultraviolet phototherapy and photochemotherapy are used to treat a variety of skin disorders, including psoriasis, eczema, mycosis fungoides, pruritus, vitiligo and many other skin conditions. They are also used to desensitise the skin in some photosensitivity disorders such as polymorphic light eruption, solar urticaria and erythropoietic protoporphyria.

Relevant disease summaries with prevalence statistics and co-morbidity information are provided below for many of the diseases which are the commonest indications for phototherapy. By its nature, this list is necessarily not comprehensive:

1. Psoriasis

Prevalence: The prevalence of psoriasis is estimated to be around 1.3–2.2% in the UK. Psoriasis can occur at any age, although is uncommon in children (0.71%) and the majority of cases occur before 35 years. A bimodal age of onset has been recognised in several large studies. The mean age of onset for the first presentation of psoriasis can range from 15 to 20 years of age, with a second peak occurring at 55–60 years¹.

Risk factors and Co-Morbidities

- Psoriatic arthritis (PsA) affects up to 40% patients with skin or nail psoriasis. Annual assessment for psoriatic arthritis is required for psoriasis patients within the first 10 years of onset. (See NICE clinical guidance 153).
- Increased risk of *cardiovascular diseases requiring assessment every five years*. See (NICE clinical guideline 67) and (NICE public health guidance 25).
- Increased risk of lymphoma and non-melanoma skin cancer.
- Increased risk factor for Venous Thromboembolism in adults. See NICE clinical guideline 92.
- Profound functional, *psychological*, and social morbidity with predisposed depression in patients. See (NICE clinical guideline 91) and (NICE clinical guideline 28).

Phototherapy for the treatment of psoriasis:

For most people, psoriasis is managed in primary care. The most common therapies used are creams, gels and ointments as topical applications; these include mild to potent steroids, vitamin D analogues, dithranol and emollients. Specialist referral is needed at some point for up to 60% of people. For those whose psoriasis cannot be controlled alone with topical treatments, phototherapy therapy is the most commonly used second

¹ NCCG Psoriasis. Assessment and Management of Psoriasis: Clinical Guideline Methods, Evidence and Recommendations. NICE. 2012.

line therapy². Narrowband UVB phototherapy is very commonly used in severe flares of psoriasis and chronic psoriasis unresponsive to topical therapy. PUVA is also a valuable second line therapy in psoriasis. Psoriasis is the most common reason of all for a Dermatology patient to be referred for phototherapy.

2. Sclerosing Skin Diseases

2.1 Morphoea

Prevalence: The incidence of morphoea has been estimated as approximately 2.7 per 100,000 people per year. This is a disorder characterised by the overproduction and deposition of collagen leading to thickening of the dermis, subcutaneous tissues, or both. Morphoea is classified into circumscribed, generalised, linear (Coup de sabre, progressive hemifacial atrophy) and pansclerotic subtypes according to the clinical presentation and depth of tissue involvement.

Aetiology: An autoimmune aetiology is supported by the frequent presence of autoantibodies in affected individuals, as well as the association of morphea with other autoimmune diseases, including systemic lupus erythematosus, vitiligo, type 1 diabetes mellitus and autoimmune thyroiditis.

Comorbidities and risk factors: Linear and deep morphea subtypes can cause considerable morbidity, including joint contractures, limb-length discrepancy and hemifacial atrophy with potential neurologic and ophthalmologic complications.

Therapy: Few controlled trials have been performed and there is a wide variation in the approach to treatment. Limited disease can be managed with topical treatment including superpotent topical steroid, tacrolimus, calcipotriene and combination of calcipotriol with betamethasone dipropionate. Patients with generalised, linear, or deep morphoea typically require more aggressive therapy. These include systemic corticosteroids, methotrexate (MTX) and Mycophenolate mofetil. A few reports describe responses of severe morphoea to cyclosporine. Phototherapy may be beneficial as an additional second-line therapy for refractory or severe disease, or as a first-line therapy for patients with generalised morphea given its low side effect profile compared to immunosuppressive agents. Broadband UVA, UVA1 (340-400 nm) and psoralen plus UVA (PUVA) photochemotherapy has been reported to result clinical improvement of morphoea lesions in multiple case series and a randomised controlled trial.

2.2 Systemic sclerosis

Prevalence: The incidence of systemic sclerosis is estimated at 0.2 -1.9 per 100,000 population per year. It is a multisystem disease characterised by fibrosis and vascular abnormalities in association with autoimmune inflammation. These lead to fibrosis of skin, subcutaneous tissue, muscles and joints, and internal organ involvement of the gastrointestinal tract, heart, lungs and kidneys. There are two main forms of systemic sclerosis, diffuse and limited type, which have different patterns of clinical involvement, complications and autoantibody abnormality.

Comorbidities and risk factors: Skin sclerosis, sclerodactyly, Raynaud's phenomenon, ulceration, calcinosis and telangiectasia are prominent cutaneous features. Synovitis with joint contractures occurs. Systemic complications include renal failure, lung fibrosis, pulmonary hypertension as well as cardiovascular and

² <http://pathways.nice.org.uk/pathways/psoriasis/phototherapy-for-psoriasis>

gastrointestinal disease.

Therapy: The therapeutic approach depends on the presentation of the disease and complexity of symptoms. PUVA and UVA-1 phototherapy have in role in the treatment of skin sclerosis. Calcium-channel blockers and iloprost can be required for Raynaud's phenomenon. Therapies targeted at the systemic involvement and severe cutaneous disease include oral and intravenous corticosteroids, penicillamine and immunomodulatory agents such as Methotrexate, Chlorambucil, Mycophenolate mofetil, Cyclosporine, Tacrolimus, Thalidomide and Cyclophosphamide

2.3 Lichen sclerosis

Prevalence: The incidence of lichen sclerosis is unknown. This is a chronic inflammatory dermatosis that results in white plaques characterised by epidermal atrophy and scarring. The aetiology and pathogenesis are unknown but may include genetic, infectious, environmental and hormonal factors.

Comorbidities and risk factors Lichen sclerosis has both genital and extragenital presentations and there is an increased risk of squamous cell carcinoma in chronic genital disease. Genital disease, both vulval and penile, outnumbers extragenital reports by more than 5:1. Extragenital lesions may occur anywhere on the body, although the back and shoulders are reported most commonly. Systemic disease or involvement of other organ is not described. Recalcitrant cases, especially those associated with erosion or progressive scarring may result dyspareunia, dysuria, phimosis and urinary obstruction.

Therapy: Genital lichen sclerosis may respond to potent topical corticosteroids and calcineurin inhibitors have been found to help some patients. Circumcision may benefit male patients with lichen sclerosis. Asymptomatic extragenital lichen sclerosis often requires no treatment. Narrow-band UVB, PUVA and UVA1 are reported to be beneficial in small case series of mainly extragenital disease. Systemic retinoids have been useful in limited studies. Methotrexate and other immune suppressing medications have been used, alone and in combination with topical and systemic corticosteroids for intractable cases.

2.4 Scleredema

Prevalence: Scleredema is an uncommon fibromucinous connective-tissue disease. It is characterised clinically by woody induration and hardening of the skin as the result of excessive mucin deposition between thickened collagen bundles in the dermis. Precise prevalence figures are not available. There are three clinical forms of scleredema which have a different history, course and prognosis and are classified by their associated condition - post infection, blood dyscrasia (monoclonal gammopathy and myeloma) and diabetes mellitus.

Comorbidities and risk factors: Although the disorder is usually restricted to the skin, the tongue, pharynx, esophagus, skeletal muscle, and cardiac muscle may rarely be affected. Reported associations include the following: Hyperparathyroidism-, Rheumatoid arthritis and Sjögren syndrome, HIV disease, Malignant insulinoma and Carcinoid tumour

Therapy: Postinfectious scleredema may spontaneously resolve. Scleredema associated with a monoclonal gammopathy or diabetes typically does not regress spontaneously, and no therapy is consistently effective. Most therapeutic reports are limited to single case reports or small case series. Systemic steroids, cyclosporine, methotrexate, penicillamine have all been tried with limited success. Case reports also describe the use of phototherapy mainly PUVA and UVA1. Reports have described efficacy with intravenous

immunoglobulin therapy.

3. Mycosis Fungoides

Prevalence: This disease makes up around 72% of cutaneous T-cell lymphomas (CTCL)³. The incidence is approximately 0.36 cases per 100,000 population per year⁴. It most often presents in those aged 45 to 60 years but has been diagnosed in children and adolescents. It is 50% more common in black than in white patients and twice as frequent in men as in women. Some occupational factors may be associated – e.g., Glass formers, pottery and ceramics workers. There is some clustering in families⁵.

Therapy: The mainstay of therapy for patch stage disease is narrowband UVB phototherapy. PUVA remains a major therapeutic modality in the treatment of cutaneous T cell lymphoma, especially in the treatment of plaque stage disease. PUVA phototoxicity has been shown to selectively target neoplastic T lymphocytes in the skin. PUVA remains the major therapy for plaque stage disease in Mycosis Fungoides. Maintenance therapy should be considered to prevent relapse in quickly recurrent disease. PUVA is also used in the tumour phase, combined with systemic therapies – e.g. PUVA plus interferon. See BAD Guidelines for the Management of Primary Cutaneous T-Cell Lymphomas⁶.

4. Vitiligo

Prevalence: Vitiligo is the 'most common' chronic depigmentation disorder of the skin and affects all age groups and all ethnic groups. A recent review of worldwide studies on the prevalence of vitiligo placed the figure at 0.5 to 2% of adult population (Christian Kruger PhD, and Karin Uta Schallreuter, MD; *International Journal of Dermatology* 2012).

Description: It is characterised by well demarcated areas of depigmentation. In many patients, it is a long-term disorder which may remit and relapse. Vitiligo appears to be an organ-specific autoimmune disorder. Vitiligo affects at least one person in every hundred throughout the world, including in the UK. Anyone can develop the condition, whatever their skin colour or ethnic origin and 50% of cases develop before the age of 20 years. The disease affects the skin, through destruction of functional epidermal melanocytes, and in many cases the hair as well, through hair follicle melanocytes.

Risk factors and Co-Morbidities: There are associations with diabetes mellitus, hypothyroidism, Addison's disease, alopecia areata. See (NICE Public Health Guidance 35). The vitiligo patient's change in appearance

³ Mycosis fungoides and Sezary syndrome. Lancet. Morales-Suarez-Varela MM, Olsen J, Johansen P, et al. 2008 Mar 15;371(9616):945-57

⁴ Occupational risk factors for mycosis fungoides: a European multicenter case-control study. Morales-Suarez-Varela MM, Olsen J, Johansen P, et al. J Occup Environ Med. 2004 Mar;46(3):205-11.

⁵ Familial mycosis fungoides: report of 6 kindreds and a study of the HLA system. Hodak E, Klein T, Gabay B, et al; J Am Acad Dermatol. 2005 Mar;52(3 Pt 1):393-402.

⁶ British Association of Dermatologists. Guidelines for the Management of Primary Cutaneous T-Cell Lymphomas. Whittaker SJ et al. Br J Dermatol. 2003; 149: 1095-1107.

can have an overwhelming impact on their self-esteem and feeling of wellbeing, and on the patient's ability to maintain healthy and intimate relationships with others.

Therapy⁷: A number of treatments can be temporarily effective to slow the progress of Vitiligo. However, the chances of its recurrence are high. Treatment options include topical steroids (potent or very potent); topical calcineurin inhibitors (which do not cause the atrophy caused by potent topical steroids but frequently cause irritant effects); depigmentation (for smaller, visible areas) and surgery. Phototherapy is a widely used and valuable mainstay second line therapeutic modality in vitiligo where disease is severe and unresponsive to topical therapies. Prolonged courses of narrow band ultraviolet B lead to complete remission in around 35% of patients, though relapse rates within the subsequent four years are high as with all therapies in vitiligo. PUVA is of similar efficacy to UVB.

5. Eczema and Nodular Prurigo

Prevalence: Eczema is an increasingly common condition affecting 1 in 9 people in England. It is estimated that 15-20% of school children and 2-10% of adults are affected^{8,9} The age-sex standardised incidence of eczema was 9.58 per 1000 person-years in 2001 and increased to 13.58 per 1000 patients in 2005 ($p < 0.001$). By 2005, eczema affected an estimated 5,773,700 (95% confidence intervals [CI] 5,754,100–5,793,400) individuals in England, who, on average, consulted a general practitioner 4.02 (95% CI 4.01–4.03) times a year. In the period 2001-2005, the number of eczema related prescriptions increased by 56.6% (95% CI 56.6–56.7), so by 2005 an estimated 13,690,300 (95% CI 13,643,200–13,737,600) prescriptions were issued¹⁰. An estimated 1.7 million children in the UK have eczema, and the numbers appear to be rising¹¹. The large majority (about 80%) of cases present before the age of five years. There is an increased prevalence in those with an affected parent.

General description: Atopic eczema/dermatitis is defined as a chronic, relapsing, itchy, inflammatory skin condition associated with epidermal barrier dysfunction, which is in many cases believed to result from an underlying filaggrin gene defect. Eczema can also be caused or exacerbated by irritants, contact allergy, food/drug allergy and infections. Eczema can affect any part of the skin and can also be confined to localised areas such as the hands and feet (palmoplantar eczema).

⁷ [Interventions for vitiligo](#). Whitton ME, Pinart M, Batchelor J, Leonardi-Bee J, González U, Jiyad Z, Eleftheriadou V, Ezzedine K. Cochrane Database Syst Rev. 2015 Feb 24;2:CD003263.

⁸ Trends in the epidemiology and prescribing of medication for eczema in England. Colin R Simpson, John Newton, Julia Hippisley-Cox, Aziz Sheikh. Journal of the Royal Society of Medicine March 1, 2009 vol. 102 no. 3 108-117:

⁹ Atopic eczema in children, NICE Clinical Guideline (December 2007) <http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11901>

¹⁰ Trends in the epidemiology and prescribing of medication for eczema in England. Colin R Simpson, John Newton, Julia Hippisley-Cox, Aziz Sheikh. Journal of the Royal Society of Medicine March 1, 2009 vol. 102 no. 3 108-117:

¹¹ Trends in the prevalence and severity of asthma, rhinitis and atopic eczema in 6- to 7- and 13- to 14-yr-old children from the north-east of England. Shamssain M. Pediatr Allergy Immunol 2007; 18: 149-53.

Nodular prurigo is a chronic and often recalcitrant, itchy skin condition of unknown etiology characterised by the development of firm cutaneous lumps. Up to 80% of patients have a personal or family history of atopic dermatitis, asthma or hay fever (compared to about 25% of the normal population).

Associated diseases and non-cutaneous complications: Atopic rhinitis (hayfever), atopic conjunctivitis, atopic asthma and type I allergies are all more common in patients with atopic eczema. Nodular prurigo can be associated with a range of underlying conditions including infections, malignancy, renal failure, hepatic and haematological abnormalities, metabolic and psychological/psychiatric co-morbidities.

Therapy: There are multiple treatment options that can be considered depending on the location, severity of the disease and impact on quality of life. These include emollients, topical steroids, topical calcineurin inhibitors, bandages and medicated dressings, antihistamines, phototherapy, systemic immunosuppression with ciclosporin, methotrexate, azathioprine and mycophenylate mofetil, systemic retinoids such as Alitretinoin, and perhaps emerging biologic therapies as well.

Where phototherapy fits into the treatment of the disease (how important is it and when is it used?): Phototherapy is a valuable treatment option in the management of severe generalised atopic eczema, and nodular prurigo and can also be considered for localised palmoplantar eczema when other management options have failed, or are inappropriate, and where there is a significant negative impact on quality of life. It is also useful for its steroid sparing effects. nbUVB is generally considered first line for generalised involvement and topical /oral PUVA is considered first line for localised palmoplantar eczema.

6. Urticaria

Definition and prevalence: Chronic Urticaria (CU) can occur in response to drugs, physical stimuli, as part of inflammatory or inherited diseases, or can be idiopathic in nature. Chronic idiopathic urticaria is the most common type of CU, comprising up to 90% of all cases of CU¹². Approximately 15% of people experience urticaria at some time in their lives. Acute urticaria is much more common than CU. (Estimated lifetime incidence is 1 in 6 people compared to 1 in 1,000.) The prevalence rate for CU has been estimated as 1-5 per 1,000. Acute urticaria is most common in children, and is more common in women than in men, particularly in the 30-60 age range. It is more common in individuals who suffer with atopy¹³.

Risk factors and comorbidities: Urgent hospital admission may be indicated if acute urticaria rapidly develops into angioneurotic oedema or anaphylactic shock.

Numerous autoimmune conditions have been associated with chronic idiopathic urticaria, including thyroid disease, celiac disease, diabetes type I, *systemic lupus erythematosus* and rheumatoid arthritis (RA)¹⁴. See (BAD Guidelines -Evaluation and management of urticaria in adults and children (2007)¹⁵.

¹² Urticaria and angio-oedema. A review of 554 patients. Champion RH, Roberts SO, Carpenter RG, et al. Br J Dermatol. 1969 Aug;81(8):588-97.

¹³ Urticaria; NICE CKS, December 2011

¹⁴ Chronic Urticaria and Autoimmunity - Kathleen Fraser BHSc1 and Lynne Robertson MD, FRCPC2 College of Medicine, University of Saskatchewan, Saskatoon, SK, Canada.

¹⁵ Guidelines for evaluation and management of urticaria in adults and children. C.E.H. Grattan and F. Humphreys on behalf of the British Association of Dermatologists Therapy Guidelines and Audit Subcommittee.

Role of phototherapy in management: Phototherapy (PUVA and NB-UVB) is one of the available second line therapies for urticaria unresponsive to first line therapies, and appears to be particularly useful in the treatment of symptomatic dermatographism.

7. The Photodermatoses

Photodermatoses where phototherapy is a commonly used treatment modality:

- *Polymorphic Light Eruption*: a very common itchy inflammatory rash that occurs in response to sunshine generally in the spring and summer.
- *Solar Urticaria*: A rare severe physical urticaria generally characterised by UVA or visible light sensitivity. It is idiopathic. It can occur at any age.
- *Actinic Prurigo*: a rare severe inflammatory condition characterised by prurigo and induced by UV, often UVA.
- *Erythropoietic Protoporphyria*: a hereditary porphyria, a lifelong condition which causes bouts of severe pain on sun exposure.

Prevalence:

- *Polymorphic light eruption*: In a recent population survey in the U.K.¹⁶, Polymorphic Light Eruption was found to affect 15% of healthy people, with a female to male ratio of approximately 2:1¹⁷. A family history of PLE has been reported in almost 50% of cases, suggesting a possible genetic component¹⁸. It is more common in those with fair skin and tends to affect women more often than men. Age of onset is usually 20-40 years.
- *solar urticaria*: unknown but estimated as around 1:100,000 prevalence
- *actinic prurigo*: unknown
- *erythropoietic protoporphyria*: prevalence in the UK 6.3/million¹⁹. An estimated 5,000-10,000 individuals worldwide have EPP. EPP is considered the most common form of porphyria in children.

Risk factors and co-morbidities:

- *Polymorphic light eruption*: risk factor: there is a strong familial component

¹⁶ The Heritability of Polymorphic Light Eruption. Thomas P Millard, Veronique Bataille Harold Snieder, Tim D Spector and Jane M McGregor, *Journal of Investigative Dermatology* (2000) 115, 467–470.

¹⁷ Polymorphic light eruption: prevalence in Australia and England. Pao C, Norris PG, Corbett M & Hawk JL. *Br J Dermatol* (1994) 130: 62–64.

¹⁸ Current aspects of polymorphous light eruptions in Sweden. Ros AM & Wennersten G. *Photodermatology* (1986) 3: 298–302

¹⁹ Erythropoietic protoporphyria in the U.K.: clinical features and effect on quality of life. Holme SA, Anstey AV, Finlay AY, Elder GH, Badminton MN. *Br J Dermatol*. 2006;155:574-81.

- *solar urticaria*: comorbidity: often causes a severe disabling perennial photosensitivity resulting in severe secondary psychological consequences and limitation of employment and other life opportunities
- *actinic prurigo*: risk factor: a family history of PLE and HLA type DR4
- *erythropoietic protoporphyria*: About 20-30% of individuals with EPP have some degree of liver dysfunction. Up to 5% of affected individuals may develop more advanced liver disease, most notably cholestatic liver failure. In most individuals, underlying liver cirrhosis is already present; however, some may present with rapidly progressive cholestatic liver failure. Gallstones are of increased frequency in EPP. Vitamin D deficiency is common in EPP as in other photodermatoses.

Phototherapy for management of the photodermatoses:

PLE: Annual desensitisation therapy with NB-UVB or PUVA is effective in severe PLE with response rates around 80-90%.

Actinic prurigo: when photoprotection and topical steroids fail to control the disease, second line treatment options include immunosuppressant systemic drugs (including thalidomide) and/or PUVA or NB-UVB photodesensitisation therapy.

Solar urticaria: when photoprotection and antihistamine therapy are ineffective, second line therapies include systemic immunosuppressants, biologic drugs and plasmapheresis. 'Rush hardening' photodesensitisation (NB-UVB or UVA) can be used in severe cases though they are initially complex and labour intensive because of the frequency of treatments required and the need to avoid widespread induction of the eruption by the UV. Photodesensitisation in this disease is therefore reserved for severe cases unresponsive to other therapies and is only carried out in phototherapy centres with appropriate highly specialist expertise and experience.

Erythropoietic protoporphyria: PUVA and NB-UVB can both be useful as desensitising therapy before spring begins to harden the skin and reduce the skin's sensitivity to sunlight. Some degree of improvement occurs in some patients, but they still do have significant photosensitivity even after therapy.

8. Other Inflammatory Dermatoses

There are case reports of response of many inflammatory dermatoses to phototherapy or photochemotherapy. There are too many to list individually here, but we have focussed on a number where treatment is worth considering (cutaneous graft versus host disease (cGVHD), lichen planus, granuloma annulare (GA), pityriasis lichenoides chronica (PLC), generalised cutaneous mastocytosis (urticarial pigmentosa).

Prevalence: Chronic cGVHD occurs in 30-50% of allogeneic bone marrow transplant patients; lichen planus <1%; PLC probably <0.1%; GA probably <1%; mastocytosis incidence 1: 150,000 per year;

General description: *Cutaneous GVHD* may be acute or chronic and is a result of reaction of donor immune cells with host skin. Clinical spectrum may resemble eczema, lichen planus, lichen sclerosis or scleroderma and it may vary in severity from mild to life-threateningly severe.

Lichen planus is a disease of unknown aetiology with evidence supporting immunologically mediated pathogenesis. The eruption most frequently affects the volar aspects of the wrists, the lumbar skin and the lower legs, but any skin or mucous membrane surface can be involved. Several morphological variants are described.

PLC is a generalised eruption which is occasionally itchy. It is part of a spectrum of pityriasis lichenoides which varies from acute necrotic lesions to chronic scaly lesions. It may last from six months to years and may be relapsing.

GA is usually symptomless but cosmetically problematic disorder which is commonly localised but may be more widespread or diffuse. It tends to improve spontaneously although some patients may have persistent signs over a period of years.

Mastocytosis is a benign proliferation of functionally normal mast cells within the skin and sometimes other body systems. In childhood 50% of cases clear by adolescence. In adulthood, it is generally indolent although clearance in time has been reported in perhaps 10%. Itching and flushing are the main symptoms.

Associated diseases: GVHD in the skin may be associated with GVHD in other organs including mucous membranes, liver, gut and lung.

There are no proven associations of *lichen planus* but consideration should be given to lichenoid drug reactions in individuals with this condition.

The acute forms of *pityriasis lichenoides* may be associated rarely with lymphoma.

One study showed insulin dependent diabetes is about 17 times more common in *GA* patients than expected, although others have not confirmed this association.

Studies have shown that over half of patients with *cutaneous mastocytosis* have benign bone marrow involvement on biopsy. Progression to malignancy is very rare.

Therapy: Depending on severity *cGVHD* is treated with topical corticosteroids, or systemic immune suppression.

The majority of *lichen planus* patients can be managed with potent topical steroid preparations. Severe generalised lichen planus may warrant limited courses of systemic corticosteroids, especially in acute presentations. Other systemic immunosuppressive agents and acitretin have been used.

PLC may respond to oral tetracyclines or erythromycin. Topical corticosteroids may produce symptomatic relief. Methotrexate is sometimes considered in patients not responding to phototherapy.

GA may not require any treatment other than reassurance. Some reports suggest improvement of localised lesions with intralesional corticosteroid or cryotherapy.

Mastocytosis may be controlled by avoidance of physical triggers of mast cell degranulation, antihistamines and sodium chromoglycate.

Phototherapy: *Cutaneous GVHD* can respond to narrow band UVB, oral and bath PUVA and these therapies are usually used as adjunctive steroid-sparing agents. Success is judged on ability to reduce the dose of systemic immune suppression. Some reduction in dose has been shown in most case series and complete

remission in a few. There is concern regarding development of squamous cell carcinoma with prolonged use of PUVA in this population, and severe lichenoid or sclerodermoid cGVHD may be better treated with extracorporeal photopheresis (ECP).

Generalised *lichen planus* in patients not responding to (or with contraindications to) systemic immunosuppression could be considered. Some evidence supports the use of oral and bath PUVA as well as NB-UVB. Reported responses are 50-90% and overall less than psoriasis and likely to need a more prolonged course. Relapse is common. Post treatment pigmentation can be persistent. There are some reports of exacerbation with PUVA.

PLC is commonly treated with UV therapy. NB-UVB is the first choice with response rates of 48-90%. PUVA is reserved for resistant cases. Relapse is quite likely within six months.

GA may show improvement with oral or bath PUVA. It is reserved for generalised GA in patients with prolonged disease who insist on treatment. About 70% may show clearance or improvement but 60% of these relapse within three years. NB-UVB may show a good response in 50%.

Mastocytosis has been shown to respond to oral or bath PUVA with reduction in symptoms, improved appearance and reduction in mast cell numbers in the skin. However, relapse is early and given the long-term nature of the condition, careful consideration should be given before embarking on treatment.

Glossary of Abbreviations and Terms

BAD	British Association of Dermatologists
BDNG	British Dermatological Nursing Group
BPG	British Photodermatology Group
CCG	Clinical Commissioning Group
cGVHD	Cutaneous Graft Versus Host Disease
COSHH	Control of Substances Hazardous to Health
CPD	Continuing Professional Development
CQC	Care Quality Commission
CTCL	Cutaneous T-cell Lymphoma
CU	Chronic Urticaria
DLQI	Dermatology Life Quality Index
DQIP	Data Quality Improvement Plan
ECP	Extracorporeal Photopheresis
e-RS	E-Referral Service
GA	Granuloma Annulare
GMC	General Medical Council
GP	General Practitioner
HCPC	Health and Care Professions Council
HSE	Health and Safety Executive
MDT	Multi-Disciplinary Team: all health professionals involved in an individual patient's care
MED	Minimal Erythema Dose
MHRA	Medicines and Healthcare Products Regulatory Agency

MPD	Minimal Phototoxic Dose
MTX	Methotrexate
NB-UVB	Narrowband UVB phototherapy
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
PALS	Patient Advice and Liaison Services
PCDS	Primary Care Dermatology Society
Photonet	National Managed Clinical Network for Phototherapy in Scotland
PIL	Patient Information Leaflet
PLC	Pityriasis Lichenoides Chronica
PLE	Polymorphic Light Eruption
PPI	Patient Public Involvement
PsA	Psoriatic Arthritis
PUVA	The combination of a psoralen, applied locally or taken in tablet form, and ultraviolet A: Psoralen Ultraviolet A
RCP	Royal College of Physicians
SDIP	Service Development and Improvement Plan
UV	Ultraviolet
UVA	Ultraviolet radiation in the waveband 315 – 400nm
UVB	Ultraviolet radiation in the waveband 280 315nm
WPG	Working Party Group

Acceptance of Referrals and Non-Contract Activity

The Contract (full-length) includes a specific requirement on providers (SC6.6.2) to accept every referral, regardless of the identity of the Responsible Commissioner, where this is necessary to enable a patient to exercise his/her legal right of choice of provider. This applies whether or not the Responsible Commissioner for the patient affected is a party to a written contract with the provider. As a guideline, NHS England strongly recommends that any Clinical Commissioning Group (CCG) with activity of over £200,000 per annum with an acute provider should put in place a written contract.

Accredited specialist

An accredited specialist in dermatology is a doctor whose specialty is recorded as 'Dermatology' in the General Medical Council's (GMC) list of specialists registered medical practitioners (consultants). He/she is a doctor who has completed either specialist UK training in dermatology approved by the GMC; or has been assessed as having equivalent experience.

Audit

Systematic review of the procedures used for diagnosis, care, treatment and rehabilitation, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient.

Clinic Letters

NHS England has included a new requirement on providers to communicate clearly and promptly with GPs following outpatient clinic attendance, where there is information which the GP needs quickly in order to manage a patient's care. For 2017/18, they intend to strengthen this requirement, requiring electronic transmission of clinic letters to practices as with discharge summaries to a similar timescale.

Clinical audit

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery (National Institute for Health and Clinical Excellence).

Clinical governance

Clinical governance provides a quality framework through which healthcare organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.

Clinical Networks

Groups of commissioners and providers of health or social care, concerned with the planning and/or delivery of integrated health or social care across organisational boundaries, whether on a national, regional or local basis.

Clinical practice guidelines

Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances. They aim to provide evidence-based interventions to improve patient outcomes.

Clinical supervision

Clinical supervision is a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence. Clinical Supervision is central to the process of learning and to the scope of the expansion of practice and should be seen as a means of encouraging self-assessment analytical and reflective skills.

Clinician

A clinician is a professionally qualified person providing clinical care to patients.

Commissioning for Quality and Innovation (CQUIN)

CQUIN is the national quality incentive scheme. Guidance on CQUIN will be available at: <https://www.england.nhs.uk/nhs-standard-contract/cquin/>

Competent

Competent means that the individual can perform the task with ability.

Consent

The intention of this regulation is to make sure that all people using the service, and those lawfully acting on their behalf, have given consent before any care or treatment is provided. Providers must make sure that they obtain the consent lawfully and that the person who obtains the consent has the necessary knowledge and understanding of the care and/or treatment that they are asking consent for. Providers must make sure that they take into account people's capacity and ability to consent, and that either they, or a person lawfully acting on their behalf, must be involved in the planning, management and review of their care and treatment.

Consultant

A person employed or engaged by the provider of equivalent standing and skill as a person appointed by an NHS Body in accordance with the Law governing the appointment of consultants.

Consultant Led Service

A service for which a consultant retains overall clinical responsibility (without necessarily being present at each service-user appointment), and in respect of which referrals of service-users are made directly to a named consultant.

Counting and Coding Practice

Changes in counting and coding practice by providers are set out in the contract under section SC28. This requires that each party (provider and commissioner) gives the other at least six months' notice of proposed counting and coding changes, with the change normally taking effect from the start of the following Contract Year. The underlying requirement in SC28.7 is that activity should be recorded correctly in relation to national guidance (the NHS Data Dictionary, for instance). However, there will be instances where systematic incorrect

recording is identified which is common for dermatology services and in such cases the process for notifying, agreeing and implementing changes to recording practice (to bring recording into line with national rules and guidance) set out in SC28.8 onwards must be followed.

The contractual provisions relating to the financial impact of any agreed counting and coding changes provide protection against this for both parties. SC28.11 sets out that the parties must make financial adjustments so that the overall financial impact of agreed changes is neutral.

It is important that data quality and accuracy continue to improve, and NHS England recognise that it can be difficult to distinguish between gradual improvements in the accuracy of recording, based on better coding at individual patient level, and more systematic changes.

Data

Data refers to all records and correspondence.

The Data Protection Act

The [Data Protection Act](#) controls how your personal information is used by organisations, businesses or the government. Everyone responsible for using data has to follow strict rules called 'data protection principles'.

Data Quality Improvement Plans (DQIP)

Data Quality Improvement Plans (DQIPs) allow the commissioner and the provider to agree a local plan to improve the capture, quality and flow of data to support both the commissioning and contract management processes. DQIPs should provide quantified assurance that action is being taken to improve capture where a data set exists and is relevant for the service and conforms to recognised national standards. Codes must map to national values etc. GC21.6 requires each provider to undertake audits of its performance against the Information Governance Toolkit, and these audits will be a valuable source of information about where data quality needs to be improved, including clinical information assurance and aspects of patient safety-related data quality.

Department of Health

The Department of Health in England of HM Government or other relevant body, or such other body superseding or replacing it from time to time and/or the Secretary of State.

Dermatology Life Quality Index (DLQI)

A quality of life questionnaire for adult dermatology patients. When using DLQI, healthcare professionals should take into account any physical, sensory or learning disabilities, or other communication difficulties that could affect the responses to the DLQI. In such cases, healthcare professionals should ensure that the DLQI continues to be a sufficiently accurate measure.

Dignity and Respect

The intention of this regulation is to make sure that people using the service are treated with respect and dignity at all times while they are receiving care and treatment. To meet this regulation, providers must make sure that they provide care and treatment in a way that ensures people's dignity and treats them with respect at all times. This includes making sure that people have privacy when they need and want it, treating them as equals and providing any support they might need to be autonomous, independent and involved in their local

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community. Providers must have due regard to the protected characteristics as defined in the Equality Act 2010.

Directly Bookable

In relation to any Service, the Provider's patient administration system being compliant with and able to communicate with the NHS e-Referral Service enabling available appointment slots to show on the NHS e-Referral Service, thereby enabling a Referrer or Service User to book a Service User appointment directly onto the Provider's patient administration system.

Duty of Candour

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Equality

This means recognising that while people are different and need to be treated as individuals, everyone is the same in terms of having equal value, equal rights as human beings and a need to be treated with dignity and respect.

E-Referral Guidance

The guidance in relation to e-referrals is available at: <https://digital.nhs.uk/services/e-referral-service>.

Fit and Proper Staff

The intention of this regulation is to make sure that providers only employ 'fit and proper' staff who are able to provide care and treatment appropriate to their role and to enable them to provide the regulated activity. To meet this regulation, providers must operate robust recruitment procedures, including undertaking any relevant checks. They must have a procedure for ongoing monitoring of staff to make sure they remain able to meet the requirements, and they must have appropriate arrangements in place to deal with staff who are no longer fit to carry out the duties required of them.

Fit to practise

The health professional possesses the appropriate knowledge, skills and experience to practise safely and effectively.

Formulary

A list of medications that are approved by the Provider on the basis of their proven efficacy, safety and cost-effectiveness to be prescribed for Service Users by the Provider's clinical Staff.

Good Clinical Practice

Using standards, practices, methods and procedures conforming to the Law and reflecting up-to-date published evidence and using that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced clinical services provider and a person providing services the same as or similar to the Services at the time the Services are provided,

including (where appropriate) assigning a Consultant to each Service User who will be clinically responsible for that Service User at all times during the Service User's care by the Provider.

Good Governance

The intention of this regulation is to make sure that providers have systems and processes that ensure that they are able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A). To meet this regulation; providers must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes must also assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others. Providers must continually evaluate and seek to improve their governance and auditing practice. In addition, providers must securely maintain accurate, complete and detailed records in respect of each person using the service and records relating to the employment of staff and the overall management of the regulated activity.

Health Building Notes

Health Building Notes give "best practice" guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities. They provide information to support the briefing and design processes for individual projects in the NHS building programme

Health Care

Health care refers to services provided for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.

Health Technical Memoranda

Health Technical Memoranda give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare (for example medical gas pipeline systems, and ventilation systems).

Multidisciplinary

A multidisciplinary team is a group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The composition of multidisciplinary teams will vary according to many factors. These include: the specific condition, the scale of the service being provided, and geographical/socio-economic factors in the local area.

National Price

The national price for a health care service specified by the National Tariff, as may be adjusted by applicable national variation specified in the National Tariff under section 116(4)(a) of the 2012 Act.

National Quality Requirements

The requirements set out in Schedule 4B (*National Quality Requirements*).

National Tariff

The national tariff, as published by Monitor under section 116 of the 2012 Act (including any rules included under section 116(4)(b) of the 2012 Act), as applicable at the time at which the relevant Service is provided.

Never Events, Serious Incidents and Patient Safety Incidents

Never Events are a particular type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Each Never Event has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event, particularly if there is evidence that the category of Never Event has occurred in the past, for example through reports to the National Reporting and Learning System (NRLS), and a risk of recurrence remains.

The current framework, including the detailed list of Never Events, is available at <https://www.england.nhs.uk/patient-safety/>.

NHS England expects to publish an updated Never Events Policy Framework shortly, including a revised list of the events themselves. The sanction associated with Never Events is now set out in SC36.38 of the Contract. Schedule 6C (Incidents Requiring Reporting Procedure), requires the provider to report any Serious Incidents (SIs) via the Strategic Executive Information System (STEIS) in line with the timeframes set out in the NHS Serious Incident Framework and ensure such incidents are also reported to the National Reporting and Learning System.

NHS Constitution for England

The Constitution sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of the Constitution in their decisions and actions.

NHS Service Contract

The NHS Standard Contract must be used by CCGs and by NHS England where they wish to contract for NHS-funded healthcare services (including acute and community-based services). The elements of the Contract for local agreement fall within the section 'Particulars'. The 'Service Conditions' outlined may be varied only by selection of applicability criteria, determining which clauses do and do not apply to the particular contract. The content of any applicable Service Condition may not be varied. The 'General Conditions' contained must not be varied at all. The contract creates legally binding agreements between NHS commissioners and Foundation Trusts, independent sector, voluntary sector and social enterprise providers. Agreements between commissioners and NHS Trusts are 'NHS contracts' as defined in Section 9 of the National Health Service Act 2006. NHS Trusts will use exactly the same contract documentation, and their contracts should be treated by NHS commissioners with the same degree of rigour and seriousness as if they were legally binding.

The National Institute for Health and Care Excellence

Special health authority responsible for the provision of national guidance on: the promotion of good health; and the prevention/treatment of ill health.

NICE Safe Staffing Guidelines

The National Quality Board has set out the immediate expectation of NHS providers in providing safe staffing levels. This guidance is a comprehensive review of the evidence in this area and produce definitive guidelines on safe staffing to support local decisions at ward and organisational level.

Peer review

Peer review is a structured, consistent and objective evaluation of an organisation or its services or processes reflecting accepted standards. It should be performed by true peers i.e. similar professionals.

Person-Centred Care

The intention of this regulation is to make sure that people using a service have care or treatment that is personalised specifically for them. This regulation describes the action that providers must take to make sure that each person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences. Providers must work in partnership with the person, make any reasonable adjustments and provide support to help them understand and make informed decisions about their care and treatment options, including the extent to which they may wish to manage these options themselves. Providers must make sure that they take into account people's capacity and ability to consent, and that either they, or a person lawfully acting on their behalf, must be involved in the planning, management and review of their care and treatment.

Premises and Equipment

Are defined in regulations with the intention to make sure that the premises where care and treatment are delivered are clean, suitable for the intended purpose, maintained and where required, appropriately located, and that the equipment that is used to deliver care and treatment is clean, suitable for the intended purpose, maintained, stored securely and used properly. Providers retain legal responsibility under these regulations when they delegate responsibility through contracts or legal agreements to a third party, independent suppliers, professionals, supply chains or contractors. They must therefore make sure that they meet the regulation, as responsibility for any shortfall rests with the provider.

Quality

Quality is used in this document to denote a degree of excellence.

Quality of Care

The Health and Social Care Act 2012 defines quality as encompassing three dimensions: clinical effectiveness, patient safety and patient experience.

- The Contract requires providers to run services in line with recognised good clinical or healthcare practice, and providers must comply with national standards on quality of care – the NHS Constitution, for instance, and the Fundamental Standards of Care regulations (SC1).
- The Contract sets clear requirements in respect of clinical staffing levels (GC5). Providers must continually evaluate individual services by monitoring actual numbers and skill mix of clinical staff on duty against planned numbers and skill mix, on a shift-by-shift basis; they must carry out and publish detailed reviews of staffing levels, and their impact on quality of care, at least every six months.
- The Contract requires providers to adhere to national guidance on specific service areas, such as duty of candour (SC35).

- The Contract requires the provider to put in place policies and procedures which will support high-quality care. Among these are the provisions on clinical audit (GC15 and SC26), consent (SC9), patient, carer and staff involvement and surveys (SC10, SC12), complaints (SC16) and incidents and Never Events (SC33).
- The Contract requires the provider to demonstrate that it is continually reviewing and evaluating the services it provides, taking into account patient feedback, complaints and surveys, Patient Safety Incidents and Never Events, learning lessons and implementing improvements (SC3).

These are set out in Schedules 4A and 4B. Both are sets of nationally-mandated standards, with the Operational Standards derived specifically from the **NHS Constitution**. All providers are expected to achieve all of the Operational Standards and National Quality Requirements which relate to the commissioned services.

Quality assurance

Quality assurance refers to the planned and systematic activities in a quality system that gives confidence or make certain that quality requirements for a product or service will be fulfilled.

Research

Research is the gathering of data, information and facts and aims to derive generalisable new knowledge.

Scope of practice

Scope of practice refers to the areas of a health professional's occupation where they have the knowledge, skills and experience to practise safely and effectively.

Secondary Care

Services provided as part of the health service in a hospital setting, or by those working in or based in a hospital setting, other than emergency services, primary care services etc.

Service Development and Improvement Plans (SDIP)

Unless specifically mandated in the contract, SDIPs are for local agreement between the NHS Providers and commissioners. SDIPs may for instance include productivity and efficiency plans agreed as part of the provider's contribution to local commissioner QIPP plans; or any agreed service redesign programmes; or any priority areas for quality improvement such as those defined in NICE GUIDANCE or national Service Standards.

Service level agreement

A service level agreement or customer service agreement is a document which specifies the services that will be delivered and the way in which they will be delivered to ensure uniform understanding.

Service Specification

The service specifications are one of the most important parts of the NHS contract, as they describe the services being commissioned and can, therefore, be used to hold the provider to account for the delivery of the services, as specified. Service specifications should be recorded in Schedule 2A of the Particulars and should set out in a brief summary any relevant context /scope of the service either at a national or local level; applicable measures relating to these should be set out in Schedule 4 (Quality Requirements) and Service Standards which the service should adhere to e.g. NICE standards, and nationally agreed standards.

Staff

The entire group of people who work at an organisation including those who are:

- Employed / agency / bank / voluntary;
- Clinical e.g. nurses, doctors and occupational health technicians;
- Non-clinical e.g. administrative staff.

Staffing

The intention of this regulation is to make sure that providers deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements described in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. To meet the regulation, providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times and the other regulatory requirements set out in this part of the above regulations. Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. They should be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show that they meet the professional standards needed to continue to practise.

Treatment

In Regulation 2(2) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, treatment includes: a diagnostic or screening procedure carried out for medical purposes, the ongoing assessment of a person's mental or physical state, Nursing, personal and palliative care, and giving vaccinations and immunisations. This regulation excludes the regulated activity of assessment or medical treatment for persons detained under the 1983 Act.

Phototherapy Standards Feedback Form

We hope that you have found the Phototherapy Service Guidance useful and would very much appreciate your feedback.

Your comments will be acknowledged by the CSU and any necessary changes to guidance incorporated into our next review of this publication.

1. Have you found these standards useful? Yes/No

Comments: *Type here*

2. Do you have suggestions for new sections or topic areas you would like to see included in future versions?

Type here

3. Do you have suggestions for new standards you would like to see included in future versions?

Type here

4. Do you have any general suggestions about this document that would improve its usefulness?

Type here

5. What is your profession?

Type here

Thank you for taking the time to complete this form. Please return to the attention of Natalie Keeling at servicestandards@bad.org.uk or posted to The British Association of Dermatologists, Clinical Services Unit, Willan House, 4 Fitzroy Square, London, W1T 5HQ.

Appendix 1: Specialty Training Curriculum for Dermatology

Section B - Modular Elements

These elements will be undertaken as a module during specialist training. The timing of the module will depend on the individual training programme. There is no final column indicating 'year' for acquisition of competence as all competencies are expected to be gained at completion of the module.

6a. Photosensitivity and Photodiagnosis

To be able to diagnose and manage patients with a photosensitive disease		
To be able to appropriately refer patients for monochromator light testing and photoprovocation testing		
Knowledge	Assessment Methods	GMP
Define electromagnetic spectrum, including UVB, UVA, visible light	SCE, CbD	1
Define the term "photosensitivity"	SCE, CbD	1
Describe classification of photosensitivity disorders	SCE, CbD	1
Explain the mechanisms underlying photosensitivity disorders	SCE, CbD	1
State clinical features of the photosensitive disorders	SCE, CbD	1
State common exogenous photosensitisers – topical, drug and dietary	SCE, CbD	1
Describe indications for phototesting and photopatch testing	SCE, CbD	1, 2
Describe appropriate range of investigations for photosensitive patient	SCE, CbD	1, 2
Describe procedures for phototesting and photopatch testing	SCE, CbD	1, 2
Describe light sources for MED, provocation and photopatch testing	SCE, CbD	1
Define safety procedures for use of ultraviolet radiation sources	SCE, CbD	2
Describe pathology tests that assist photodiagnosis, i.e. on blood, urine, stool and skin samples, including porphyrin and autoantibody tests, and their roles	SCE, CbD	1
Describe management of photosensitivity disorders, including photoprotective measures and topical and systemic medications	SCE, CbD	1
Skills		
Detect patient with photosensitivity disorder	mini-CEX, CbD	1
Perform appropriate history and examination of photosensitive patient	mini-CEX, CbD	1
Recognise patterns of clinical features occurring in different photosensitivity conditions and how they assist diagnosis	mini-CEX, CbD	1
Describe administration of phototesting and photopatch testing	mini-CEX, CbD	1
Interpret results of monochromator testing, provocation testing and photopatch testing	mini-CEX, CbD	1
Interpret results of pathology tests utilised in photodiagnosis		1
Communicate test results and diagnosis of photosensitivity disorders to patient and other health professionals	mini-CEX, CbD	1, 3
Select appropriate patients for phototesting and recognise importance of results.	mini-CEX, CbD, PS	1, 3
Communicate management of photosensitivity disorders, including appropriate photoprotective measures, local and systemic treatments, to patient and other health professionals	MSF, CbD	1, 2
	mini-CEX, CbD, PS	1, 3
Behaviours		
Recognise possibility of cutaneous photosensitivity in appropriate patients	CbD, mini-CEX	1
Contribute to multidisciplinary photodiagnostic team	MSF	3
Teaching and Learning Methods		

Independent study
 Postgraduate course
 Observation and performance within specialist outpatient unit dedicated to evaluation of photosensitive patients
 Journal club
 Methods agreed by Educational Supervisor and Trainee

6b. Phototherapy and Photochemotherapy

To be able to select appropriate patients for phototherapy and photochemotherapy To be able to deliver and supervise phototherapy and photochemotherapy services		
Knowledge	Assessment Methods	GMP
Describe the mechanisms underlying beneficial and hazardous effects of phototherapy and photochemotherapy on tissue	SCE, CbD	1
State indications and contraindications for phototherapy and photochemotherapy	SCE, CbD	1, 2
Define which form of therapy should be used and its delivery (eg topical, local, systemic, broadband UVB, Narrow band UVB, PUVA)	SCE, CbD	1
Explain ultraviolet dosimetry and treatment regimens	SCE, CbD	1, 2
State what topical or systemic therapies may be used in addition to the course of phototherapy to optimise the response	SCE, CbD	1, 2
State adverse effects of different forms of therapy	SCE, CbD	1
Define management of patients who have had large numbers of UV treatments.	SCE, CbD	1, 2
Describe phototherapy equipment, MED/MPD test devices and UV protective eyewear	SCE, CbD	1, 2
Describe safety and quality control of UV equipment, including role of medical physics department	SCE, CbD	1, 2, 3
Explain how to set up a new service	SCE, CbD	1, 2
Discuss new developments in phototherapy	SCE, CbD	1
Describe UVA1 as a phototherapy treatment modality.	SCE, CbD	1
Describe how clinical governance systems can be used to improve the safety and effectiveness of ultraviolet phototherapy	SCE, CbD	1, 2
Skills		
Communicate the risk-benefit ratio for UVB and for PUVA to patients. Counsel patients about phototherapy and PUVA and obtain their informed consent for these treatments.	mini-CEX, CbD, PS	1, 3
Select appropriate treatment regimens	mini-CEX, CbD	1, 2
Identify patients failing to respond to treatment, reasons for this and management options	mini-CEX, CbD	1, 2
Evaluate the efficacy of UV therapies and be able to apply suitable discharge criteria	mini-CEX, CbD	1
Diagnose and manage adverse events precipitated by phototherapies.	mini-CEX, CbD	1
Behaviours		
Contributes to multidisciplinary team including phototherapy nurses, medical physics and doctors	CbD, MSF	3
Recognise importance of NICE, BAD and BPG guidelines for phototherapies	CbD	1, 2
Recognises limits of different forms of therapy	CbD	1
Teaching and Learning Methods		

Independent study

Observation and supervised performance in consultant led dedicated phototherapy outpatient clinic, ideally in both specialist centres and local units, for long enough to gain experience in all common and the majority of rare disorders treated with different therapies

Supervised performance in outpatient treatment centre, both regular planned sessions and ad hoc reviews of patients in difficulty

Observation and work with nursing and phototherapy staff in delivery of phototherapy and photochemotherapy

Suitable external course

Methods agreed by Educational Supervisor and Trainee

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Appendix 2: Post-CCT Training Curriculum

The British Association of Dermatologists has produced a Speciality Training Curriculum for Post-CCT Fellowship in Photodermatology, developed in conjunction with the British Photodermatology Group (BPG) (2020) which can be accessed here:

<https://cdn.bad.org.uk/uploads/2021/12/29200138/Post-CCT-Photodermatology-Fellowship-2020.pdf>

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Appendix 3: NICE recommendations for Phototherapy treatment for psoriasis

1.4 [Phototherapy \(broad- or narrow-band UVB light and \(PUVA\)](#)

1.4.1.1 Offer narrowband ultraviolet B (UVB) phototherapy to people with plaque or guttate-pattern psoriasis that cannot be controlled with topical treatments alone. Treatment with narrowband UVB phototherapy can be given 3 or 2 times a week depending on patient preference. Tell people receiving narrowband UVB that a response may be achieved more quickly with treatment 3 times a week.

1.4.1.2 Offer alternative second- or third-line treatment when:

narrowband UVB phototherapy results in an unsatisfactory response or is poorly tolerated or

there is a rapid relapse following completion of treatment (rapid relapse is defined as greater than 50% of baseline disease severity within 3 months) or

accessing treatment is difficult for logistical reasons (for example, travel, distance, time off work or immobility) or

the person is at especially high risk of skin cancer.

1.4.1.3 Consider psoralen[31] (oral or topical) with local ultraviolet A (PUVA) irradiation to treat palmoplantar pustulosis.

1.4.1.4 When considering PUVA for psoriasis (plaque type or localised palmoplantar pustulosis) discuss with the person: other treatment options

that any exposure is associated with an increased risk of skin cancer (squamous cell carcinoma)

that subsequent use of ciclosporin may increase the risk of skin cancer, particularly if they have already received more than 150 PUVA treatments

that risk of skin cancer is related to the number of PUVA treatments.

1.4.1.5 Do not routinely offer co-therapy with acitretin[32] when administering PUVA.

1.4.1.6 Consider topical adjunctive therapy in people receiving phototherapy with broadband or narrowband UVB who:

have plaques at sites that are resistant or show an inadequate response (for example, the lower leg) to phototherapy alone, or at difficult-to-treat or high-need, covered sites (for example, flexures and the scalp), and/or

do not wish to take systemic drugs or in whom systemic drugs are contraindicated.

1.4.1.7 Do not routinely use phototherapy (narrowband UVB, broadband UVB or PUVA) as maintenance therapy.

1.4.1.8 Ensure that all phototherapy equipment is safety-checked and maintained in line with local and national policy[33].

1.4.1.9 Healthcare professionals who are giving phototherapy should be trained and competent in its use and should ensure an appropriate clinical governance framework is in place to promote adherence to the indications for and contraindications to treatment, dosimetry and national policy on safety standards for phototherapy[33].

1.4.2 Risk of skin cancer and how to minimise risk

1.4.2.1 Do not use PUVA in people with psoriasis of any type and a genetic predisposition to skin cancer for example, xeroderma pigmentosum or familial melanoma.

1.4.2.2 Do not use PUVA when other appropriate treatments are available in:

people with a personal history of skin cancer or

people who have already received 150 PUVA treatments or

children.

1.4.2.3 Use PUVA with caution or consider other treatment options in:

people at risk of skin cancer (melanoma and non-melanoma type) (see 'Improving outcomes for people with skin tumours including melanoma' [NICE cancer service guidance])

people with lighter skin types, such as skin types I or II on the Fitzpatrick scale[12]

people who are likely to require ciclosporin or long-term methotrexate

young people.

1.4.2.4 Offer lifetime skin cancer surveillance to people treated with PUVA who have:

had more than 150 PUVA treatments or

developed skin cancer.

1.4.2.5 Ensure that a permanent record of the person's cumulative number of UV treatments is kept (for example, in a national record).

Appendix 4: Department of Health: Health Building Notes: Clinical and Support Spaces

The Department of Health's Health Building Notes give 'best practice' guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities.

Health Technical Memoranda give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare (for example medical gas pipeline systems, and ventilation systems).

They are applicable to new and existing sites, and are for use at various stages during the inception, design, construction, refurbishment and maintenance of a building.

The following diagrams demonstrate core requirement for a safe and compliant phototherapy service.

Figure 1 Consulting room

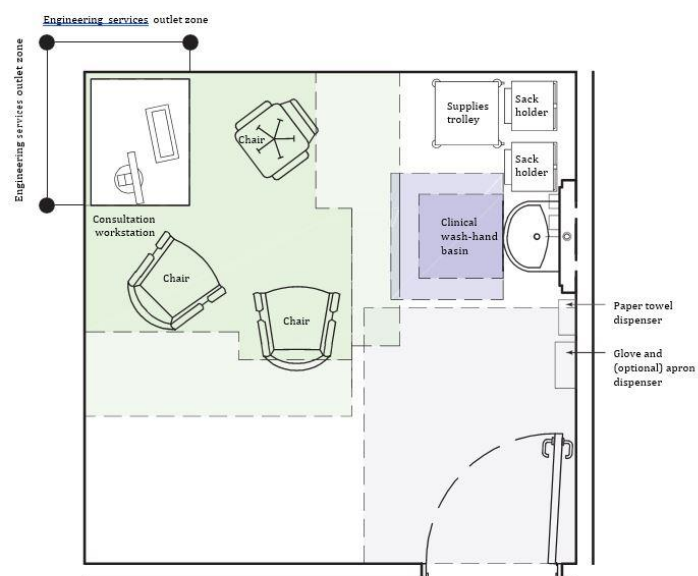


Figure 2 Combined versus separate consulting and examination rooms

Example 1: 4 Consulting/examination rooms (@ 16 m²)

Range of uses:

1-4 doctors

1-4 clinic sessions

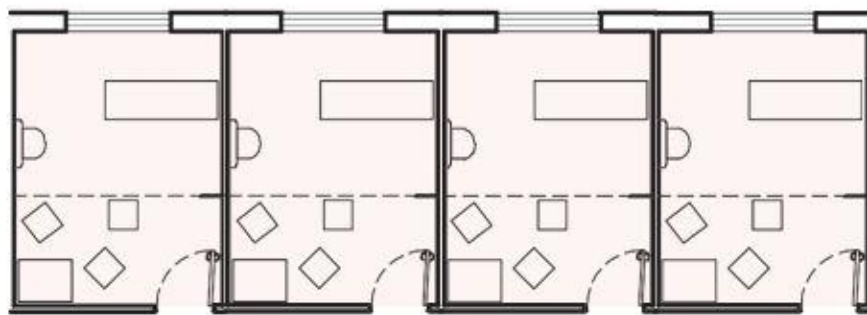


Figure 2.1: 2 Consulting and 4 examination rooms (@ 12 m²)

Range of uses:

1-2 doctors

1-2 clinic sessions

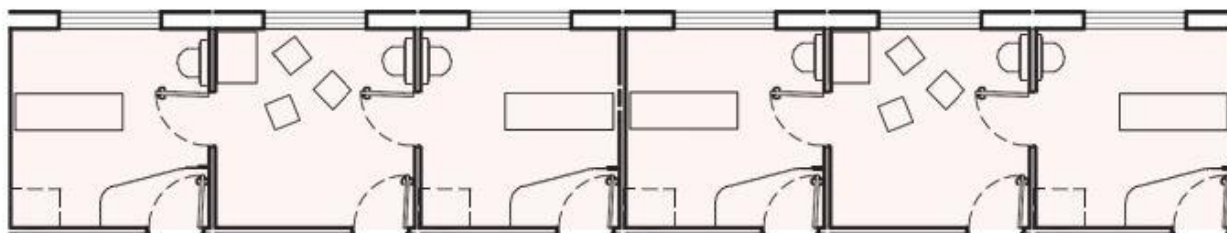


Figure 10 Treatment room: all-round couch access

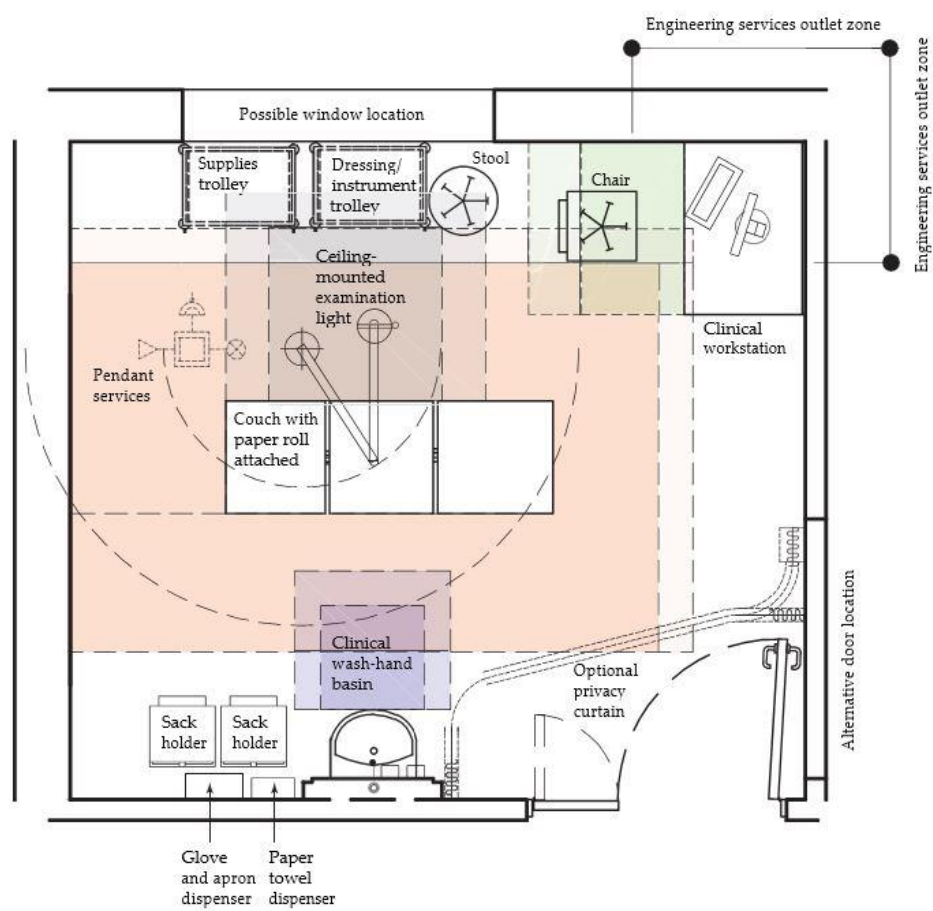


Figure 7 Space requirements for ambulant dressing and undressing

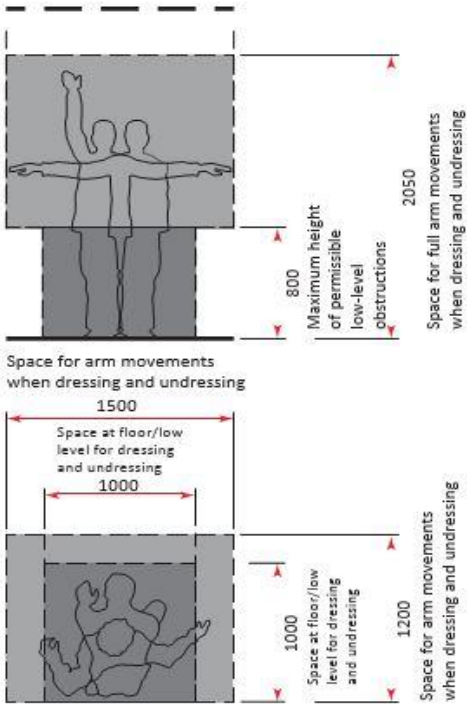


Figure 14 Space requirements for accessing modular base and upper cabinets. Please see figure 11, 12 and 13 for further storage requirements

