Practical Advice on Setting up a New Service
- GPwSI in Dermatology and Skin Surgery

Is there a need for a new service?

It is important to perform a health needs assessment of the local population. As part of this process there needs to be a review of all existing services providing care for patients with skin conditions, for example:

- Dermatology
- Plastic surgery
- General surgery – lumps & bumps
- Community leg ulcer clinics
- Podiatrists – skin care of the feet, fungal infections and warts

Once a health needs assessment has taken place, any gaps in health care can be identified and used to help with service development.

Planning

Once a local need has been demonstrated any planning needs to be discussed with all relevant individuals, including local consultants. There may be occasions in which integration, either way, may be difficult. Please refer to 'Managing local difficulties' at the end of this document for more advice on such matters.

Training and accreditation of GPwSI

The full guidelines for the accreditation of GPwSI can be found on this section of the website. While the concept of a GPwSI in Dermatology is well established, that of a GPwSI in Skin Surgery is more recent. There are three key elements to successful accreditation in **skin surgery**:

i) Skin surgery – good standards needed to ensure high levels of complete excision rates for basal cell carcinoma and good cosmetic results for surgical procedures in general

- The number of surgical DOPs (Direct Observation of Practical procedures) required will, in part, depend on the skills of the individual; clearly those already highly skilled will require fewer assessments than those with less experience. The documentation required for the DOPs is found in the full GPwSI guidelines
- Surgical aspects of training and assessment can be carried out by a range of individuals such as a dermatologist, plastic surgeon or other clinician routinely performing skin surgery and who is a member of the local LSMDT for skin cancer

ii) Good diagnostic skills, including the use of dermoscopy, and the knowledge of appropriate non-surgical treatments

- This is an equally important aspect of training. Good diagnostic skills are required so that on one hand important diagnoses are not missed, and on the other hand benign lesions are not removed which do not need to be. GPwSI in Skin Surgery also need to have the skills to

manage pre-cancerous lesions such as actinic keraotses and Bowen's disease using non-surgical treatments
- Dermatological training is needed for this component of the training – plastic surgeons and other surgeons do not have training in skin lesion diagnosis and non-surgical treatments
- If you are currently working as a GPwSI in Dermatology and your previous accreditation included skin lesions it will not be necessary to repeat this element of assessment

iii) Membership of the local LSMDT team is needed for all GPwSI managing skin cancer

- Membership involves attendance at relevant MDT meetings for case discussion. In addition, attendance is required for at least one audit meeting per year, where the clinician will be expected to present his/her results in terms of complete excision rates for BCC, complication rates and patient satisfaction surveys

Mentorship

Mentorship for the training and ongoing support of GPwSI needs to be via a consultant. Most of the time this will be a dermatologist, however, there may be occasions where GPwSI in Skin Surgery are mentored by a plastic surgeon.

Demand management

In order to manage demand effectively any new service needs to work closely with secondary care and other primary care colleagues, and consider the following:

- Education of GPs and other primary care health professionals – up to 30% of GP consultations have some element of dermatology in them. With limited training available for GPs (the average medical undergraduate curriculum contains six days of dermatology and most GPs learn their Dermatology by exposure to skin problems in their daily practice) current referral rates to secondary care for skin disorders are high. Education should be based on those conditions associated with high referral rates such as skin lesions, acne and eczema

- 'Low priority framework' conditions ie principally cosmetic – a significant number of such conditions still end up being funded in General Practice or in secondary care (plastic surgery, general surgery and dermatology). Local governance and care pathways can help manage these matters

- Referral management schemes – see below

Referral management schemes

This topic often provokes much debate. In the right hands it can bring significant benefit to a local community, but in the wrong hands it can create considerable difficulties and may even threaten the financial stability of secondary care.

A good referral management scheme can aid the patient pathway by making sure that the patient is seen by the most appropriate individual at the first point of call, hence, reducing tertiary referrals. It is also more likely to prevent 'low-priority' conditions from being referred. Such schemes are likely to be most effective if they cover all skin referrals ie inclusive of dermatology, relevant plastic surgery and general surgery (lumps and bumps etc).

Of course, before such a scheme is set up it must fulfil guidance laid out by the DH, which essentially means that:

- One size does not fit all
- It must have been developed with the agreement of local specialists
- The process of triage can only be done by a consultant, or GPwSI accredited in line with the most recent DH guidelines
- Choice must be input into the pathway

Teledermatology

The role of teledermatology is currently under review

Sustainability and long-term planning

- GPwSI services need to be sustainable and, to this end, it is always sensible to train up at least two GPwSI in order to provide cross cover
- Long-term planning – the incidence of skin conditions is increasing significantly and so commissioners need to take a long-term view of service development

General tips

- Be strict with DNAs and use early discharge where appropriate
- Develop standard template letters for secretaries where possible, this is particularly useful for skin surgery
- Open appointments can be used for patients whose symptoms have settled by the time they are seen, or who are likely to flare up in between appointments
- When patients are discharged, those with inflammatory skin conditions should receive patient management sheets, which instruct the patient and GP how to manage the condition in the long term
- There is not a great deal of evidence to support the treatment of warts. However, this cannot be generalised to all patients and some may gain benefit from treatment. Young children are unlikely to tolerate cryotherapy, and for such referrals a standard letter can be sent to the parents explaining the treatment and asking them to contact your service if they still wish to be seen

Managing local difficulties

If a clear need exists to develop a new service but secondary care do not wish to engage there are a number of things to consider:

- Try to understand the reasons why – sometimes these may be easily overcome
- Discuss clinical remits and boundaries ie balance what conditions you plan to manage in the community with what the consultants feels should be managed in secondary care
- Discuss how your role could help secondary care:
    - The need to see less of the ‘routine’ work
    - Offer assistance in the education of GPs, GP registrars and junior doctors by teaching, and helping develop local guidelines
    - Health promotion
    - By acting as a link between secondary and primary care

If all the above fails and you have been through all the right loops, there are some alternative options to consider. The generic and overarching guidelines for PwSI (Practitioners with a Special Interest) state that although a **local consultant** is the most suitable person to act as a supervisor for training, other individuals could be considered. For example, if 50 clinical sessions are required for the purpose of training and accreditation these could be spread across dermatologists from other localities, accredited GPwSI services or plastic surgical lists. Indeed, if the main service to be provided is skin surgery then the local plastic surgeon should be involved in training – however, even with such a scenario an appropriate level of dermatological input is still needed with regards lesion diagnosis, dermoscopy and non-surgical treatment options.

The final option is to contact the PCDS. The PCDS and BAD are currently looking into the possibility of developing an independent accrediting panel but this is unlikely to be in the immediate future.

This document was updated on the 1st September 2012