# Middlesbrough Primary Care Skin Service

## I) Background

Middlesbrough is a town situated in the North East of England. It has higher than average levels of unemployment and deprivation.

Middlesbrough Primary Care Trust serves a population of 190,000 although recent reconfiguration has meant that this figure will fall to around 145,000.

The town is served by the James Cook University Hospital, a teaching hospital, which has both departments of dermatology and plastic surgery. The department of dermatology has 4 full time consultants who serve the local population and in addition provide outpatient work in four surrounding district general hospitals.

Middlesbrough had suffered over recent years from high waiting lists in both dermatology and plastic surgery, partly as a result of higher than the national average levels of referrals and under-resourced secondary care departments.

Patients with cases of basal cell carcinoma had waiting times of up to 14 months from referral to time of treatment by the department of plastic surgery, and patient with cases of squamous cell carcinoma of the skin had waiting times of up to 3 months.

Cost implications had also been of concern and a review in 2003 of relatively minor skin surgery performed under local anaesthetic in the departments of plastic surgery and less so general surgery, revealed costs of almost one million pounds.

The Middlesbrough Primary Care Skin Service (MPCSS) was developed in 2003 to help secondary care reduce waiting times, improves access and patient care.

## II) Middlesbrough Primary Care Skin Service - The team

The following individuals support the service:

Dr Tim Cunliffe, GPwSI in Dermatology – 3 sessions a week
Dr M. Shafique, GPwSI in Minor Surgery – 4 sessions a week
Both the GPwSI had appropriate training as recommended by national guidelines. Formal accreditation processes were followed and the accrediting panels included a consultant, GP, trust member and patient representative.

Nursing - Sue Waterfield (full time), Sandra Bailey (part-time) and Pat Evans (Health care assistant). The nursing team are actively involved in clinics, provide cryotherapy and photodynamic therapy.

Admin / secretarial – A generic team that works for several GPwSI services

Management – Part time support to the skin service

## III) Services provided

- The diagnoses and treatment of a wide range of skin disorders
- The management of milder skin cancers using a range of techniques including surgery, Photodynamic therapy and topical treatments
- The surgical removal of lumps and bumps

See section 'VI' for a more detailed list of conditions managed in the Middlesbrough Primary Care Skin Service.

## IV) Premises

The service is paper free with a fully computerised appointment system and patient records. The tools used The service is based in a purpose built treatment centre in the community. The premises close to Middlesbrough Town Centre, is very accessible and has good parking facilities, which are free. Facilities include a high standard of consulting rooms, treatment rooms and minor surgery theatres. enable easy data collection for use in audit and other clinical governance.

## V) Integration with secondary care

- The patient attends the GP

- If the patient needs to be referred for any skin problem (dermatology / plastic surgery) that needs a 'specialist opinion' they are referred electronically to the MPCSS. (Exceptions to this rule are as in table one, below)

- The clinicians of the MPCSS assess the referrals. There are 3 possible outcomes based on the clinical remit (as defined in table one):

  - If the condition is suitable for secondary care only the patient is offered a choice of local secondary care departments.

  - If the condition is suitable for treatment in the community by a GPwSI in dermatology / minor surgery, the patient is offered an appointment at the MPCSS. If they do not wish to go down this route they can still be offered an appointment in secondary care.

  - If the condition is deemed to lie outside of NHS-work (Low-priority framework conditions), the referral is returned to the GP with an explanatory / educational comment.

It is our experience thus far that nearly all patients offered an appointment in the MPCSS accept this. With regards those patients needing to be seen in secondary care almost all patients choose to be seen at the local hospital.

The service has been developed along with supportive consultant colleagues.

Dr Cunliffe:

- Works one session a week working as a clinical assistant in the department of dermatology.
- Attends the monthly departmental teaching session
- Assists with the teaching of medical students

- Specialist registrars spend a limited number of sessions along side Dr Cunliffe in the community dermatology clinic.

Dr Shafique is supported by a consultant plastic surgeon who comes out to the community clinics twice a month.

Both doctors abide by the NICE guidelines on 'Melanoma and other tumours of the skin', and to this end do not manage suspected cases of melanoma or SCC in the community.

**Both the clinical remits & care pathways (underneath) were developed and agreed along with the consultants.**

The Middlesbrough Primary Care Skin Service (MPCSS) meet twice a year with relevant individuals from secondary care to review the work carried out in the community.

Education – See later.

## VI) Clinical remit and care pathways

The pathways cover generic skin disease i.e. not only dermatology but also lumps & bumps, which previously were managed predominantly in the departments of plastic surgery and general surgery.

Considerable time was given to deciding how best to manage referrals. Prior to the development of the MPCSS, there was little in the way of governance with regards to referrals and this had created many problems:

- A significant number of patients did not see the most appropriate professional at the first point of call, so subsequently tertiary referrals were needed.

- Significant amounts of money were being spent in secondary care on the surgical treatment of relatively minor skin lesions – thus taking money away from helping manage more troublesome skin disease.

We also had concerns with regards creating too much patient choice, as studies have indicated in the past that this is likely to lower a GPs threshold to refer, which may in the long-term affect patient care adversely.

The MPCSS therefore opted to develop a referral management service that offers 'appropriate' choice, defines what is safe to be managed in the community, and helps manage demand by also reducing inappropriate referrals.

The system developed is termed the Middlesbrough PCT Access & Referral Service (MARS), which is fully electronic and works as follows:

- The patient attends the GP

- If the patient needs to be referred for any skin problem (dermatology / plastic surgery) that needs a 'specialist opinion' they are referred electronically to the MPCSS. (Exceptions to this rule are as in table one, below)

- The clinicians of the MPCSS assess the referrals. There are 3 possible outcomes based on the clinical remit (as defined in table one):

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**We cannot stress too strongly that this system has been developed in co-operation with our secondary care colleagues and the triage is run by a group of skilled professionals. We have also taken into account that the development of any such triage system must not affect the financial viability of our vital secondary care departments – to this end the MARS service allows us to provide secondary care with enough patients to avoid any such difficulties.**

The MARS system also enables us to direct patients through to secondary care for more specialist clinics such as contact dermatitis clinics and also for the purposes of teaching.

Table one, which is shown on the next 2 pages, defines which conditions are suitable for management in:

- Secondary care only
- GPwSI in dermatology
- General Practice
- Non-NHS work (as defined by the ‘Low Priority Framework’ guidance)

This document was produced with the local consultants and then forwarded to all GPs in the area.

(Please see next two pages re table one)

*Table one*

| |
|---|
| **Group A (URGENT) - Direct referral to secondary care**<br><br>**Suspicion of melanoma or SCC**: Refer as 2-week rule (if proven histology refer to plastic surgery).<br><br>**Other urgent disorders:** Erythroderma (>90% skin involvement), widespread blistering disorder, or patients with a rash AND who are systemically unwell: Fax letter / Speak directly to consultant dermatologist. |
| **Group B (Other skin conditions needing specialist opinion)**<br>**- Refer electronically to Clinical Assessment Service (CAS) for triage and booking** |

## Secondary Care Only

High-risk BCC (Large BCC, H-zone of the face, ears, morphoeic)

Troublesome acne that may need oral isotretinoin or other specialist treatment

Moderate/severe psoriasis that may need light or systemic therapy

Severe eczema that may need systemic or light therapy

Allergic contact dermatitis

Alopecia that is any of:
- Diffuse
- Has significant scarring
- Alopecia Areata

Nail disorders where there is marked destruction of the nails or a pigmented streak possibly suggestive of melanoma

Photodermatoses

Venous leg ulcers not responding to community treatment

Dermatological conditions of the genitalia

Hyperhidrosis not responding to topical or other appropriate therapy

Suspected connective tissue disorders

Cutaneous vasculitis

## Intermediate conditions

### - Suitable for treatment in Middlesbrough Primary care skin service

Actinic keratoses

Bowen's disease

Low-risk BCC

Moderate to severe eczema

Other moderate inflammatory dermatoses that are poorly controlled despite treatment from the GP

The troublesome 'red face'

Rashes of diagnostic uncertainty in patients without associated systemic upset

Pyogenic granuloma (Beware differential diagnoses of amelanotic melanoma)

Other nail disorders (Please exclude a fungal infection prior to referral)

Other scalp disorders

Keloid scars

Seborrhoeic keratoses or other benign skin lesions that cause **significant facial disfigurement**

Lumps and bumps (i.e. epidermoid cysts, pilar cysts of the scalp, lipoma) that are big enough to cause significant discomfort for the patient AND where the GP feels unhappy about removing the lesion.

**PS GPs must state size & position of lesion on referral because very large lesions will be passed directly to plastic surgery**

## Conditions suitable for NHS treatment in the laser department

Facial / neck port wine stains:
**Refer for assessment as soon as possible after birth**.

The following strawberry naevi:
- Affecting aesthetically important areas such as the face
- Anywhere on the body if complicated by bleeding, ulceration or causing functional impairment

**Again refer early, especially if risk of amblyopia** that can occur within 10 days if interfering with vision

Significant facial telangiectasia resistant to medical therapies & IN ADDITION as a result of rosacea or a connective tissue disorder.

Rhinophyma

Iatrogenic facial tattoos

Facial pigmentation resulting from drugs such as minocycline

Facial hirsuites causing significant psychological upset and not responding to Vaniqa cream (The best laser results are seen in patients with coarse hair & light skin)

Large xanthalasmata causing visual disturbance may be treated with laser therapy or chemical peels

Acne scarring is controversial. There is currently is no convincing evidence to support laser therapy or dermabrasion for acne scarring – See local guidelines

## Group C – Conditions suitable for management in a GP setting (GP or nurse)

- Mild to moderate inflammatory skin disorders
- Cryotherapy for 'troublesome' warts in patients who have not responded to appropriate topical treatments for periods of at least 3 months – Children under the age of 10 rarely tolerate liquid nitrogen.
  (NB genital warts that should be referred directly to GUM department)
- Molluscum contagiosum – Reassure / 1% Hydrogen peroxide cream may be beneficial / Cryotherapy should again be avoided in children under the age of 10.
- Benign lesions that catch on clothes or bleed (always send for histology)
- Other benign lumps and bumps that cause the patient discomfort
- Haemangioma that bleed recurrently
- Some 'intermediate' disorders managed in Group B by the Primary Care Skin Service - Where level of experience appropriate

## Group D – Non-NHS conditions ('Low priority framework')

The following conditions should not be referred for treatment on the NHS:

**Skin tags –** Most can be snipped off without LA using sterile scissors

**Other lesions known to be benign** e.g. aysmptomatic melanocytic naevi, dermatofibroma

Most cases of **seborrhoeic keratoses**, which can be left alone or managed with cryotherapy during GP consultation

**Small + asymptomatic lipoma or epidermoid cysts of the trunk & limbs**

**Vascular & other disorders that do not fall into group B laser therapy e.g.** Most facial spider naevi, venous lakes of the lips, limited facial hirsuites, other disorders of the trunk and limbs that are vascular & asymptomatic, freckles & lentigo, tattoos (unless facial & iatrogenic) and leg thread veins.

## VII) Outcomes

The improvement in patient care that has been delivered since the Middlesbrough Primary Care Skin Service was introduced can be demonstrated as follows:

**For the patients seen in the MPCSS (GPwSI) clinics:**

Patient experience questionnaires – Overall 'average' experience scored as excellent
Complete excision rate for 26 Basal Cell Carcinoma excised in the last 12 months = 100%
Current waiting times 31 days for GPwSI in Dermatology
Current waiting time 29 days for GPwSI in Minor Surgery

**For the outpatients departments at James Cook University Hospital (From 2002/2003 – 2005/2006):**

**Dermatology –** Waiting lists reduced down by 44.3% (from 149 days to 83 days), and adjusted referrals reduced by 43% (Adjusted to take into account a national rise in dermatology referrals of 5% per annum over this period i.e. was 2695 in 2002/3 which would have equated now to 3099. Actual referrals for 2005/2006 were 1931).

**Plastic surgery (minor surgery only as opposed to reconstructive work) –** Waiting lists reduced from 260 days to 41 days.

These figures are based on the GPwSI in dermatology providing 3 clinics a week, the GPwSI in minor surgery providing 4 clinics a week, and no change in staffing levels in the relevant departments at the James Cook University Hospital.

The effects of reducing waiting lists in secondary care have meant that those patients with the most troublesome skin disorders are getting seen with less delay.

**Additional outcomes:**

- Increased levels of education (see below)

## VIII) Education

The MPCSS believe that one of the key roles of the team in helping manage long-term demand is education and to this end it is developing joint educational initiatives with local consultants. Some of the educational plans have already been rolled out and some are in the pipeline. Education is delivered in a number of ways:

- Electronic guidelines have been distributed to all local GP surgeries.
- Time out sessions for local GPs and other primary care health professionals - Protected afternoons for local surgeries enable high-level attendance at time out sessions during which time GPwSI and local consultants present on the management of common dermatological disorders.
- In house minor surgery training
- Innovative training posts for GP registrars who will spend part of their time in the MPCSS and part of their time in the department of dermatology at the local hospital.

Our education is focusing on key high-referral areas such as eczema, actinic keratoses and pigmented lesions. We believe that increasing the use of dermoscopy in general practice will help to reduce the number of benign lesions referred for diagnoses.

## IX) Cost

The cost of delivering the skin service for 05/06 – over which period there were 1458 patient contacts – was £232K. This includes staffing costs and consumables. The team is now in the process of comparing the total service cost including all overheads against the tariff cost of sending patients into secondary care under Payment By Results. This will indicate the potential cost saving to the local health economy. Although work on cost benefits is ongoing, early indications are that the saving could be as much as 25 %.

## X) Future developments

The service continues to develop as follows:

**Sustainability** - A third GPwSI is being trained to help make the service sustainable and to provide cover when needed.

**Nurse development –** We are training our nurses to take on some of the minor surgery work such as punch biopsy, curettage and shave excision.

**Links to other service in the community –** We work closely with a tissue viability nurse and are linking up with podiatry who will take over the care of most patients referred to our service with verrucae.

**Working with schools –** We are planning a 'sun-safety' programme for our local schools next spring. We also aim to work more closely with school nurses with regards the management of acne and eczema in schools.

**Patients:**

- We are in the process of developing a website to aid patients in self-management.
- We plan to increase our level of patient involvement and also offer our services for any part of the community who may wish to organise a lecture on any aspect of skin disease.

Middlesbrough Primary Care Service gladly will gladly welcome any enquires about our service or any individuals wishing to visit us. We can be contacted at:

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