



British Association
of Dermatologists
healthy skin for all



Royal College
of Physicians

RECOMMENCING DERMATOLOGY SERVICES – GENERAL CONSIDERATIONS

Disease volume

The HES data for 2018-19 show that we saw more outpatients and 2-week wait referrals than any other specialty. We are also responsible for the diagnosis and treatment of skin disease in children. Dermatology services are delivered mainly via specially adapted outpatient settings with surgery suites, phototherapy units, treatment rooms for patch testing and specialty dressings, all requiring adequately trained dermatology nurses to deliver some core aspects of care.¹

We know from work published in 2019¹ that only 30% of dermatology departments were using remote consultations, pre-COVID-19; currently, 100% of departments are providing remote access consultations for diagnosis and follow-up, with variable results. As a specialty, we are carrying out work to determine which of these innovations work best in various patient settings. For example, a videoconference may work for a young child with eczema sitting on the mother's lap, but this but would be inappropriate for a female patient with an anogenital disorder.

Differential impact on service provision

Dermatology would be able to offer diagnostic consultation at a faster rate than could be matched by the indicated, definitive investigations and procedures. This is largely due to the prevalence of skin cancer and the accruing backlog which would occur with any reduction in current service capacity.

Factors which also restrict patient throughput are social distancing, COVID-19 screening for patients and staff, and recommendations for PPE (in line with other surgical specialties with aerosol-generating procedures). The ability to provide these core services also requires adequate clinic space and the re-patriation of all relevant staff.

Detailed documentation for the specific re-introduction of these core services is uploaded and continually updated on the BAD website² and should be read in conjunction with this document, as should the previous document on time-dependent interventions and procedures.³

Impact on training

Dermatology registrars train by delivering an average of seven outpatient clinical sessions per week – a mixture of face-to-face consultations and surgery with relevant supervision. They also provide out-of-hours cover for dermatology services, all of which contribute significantly to clinical services. Dermatology is a craft-based specialty training GPs, registrars, nurses and post-CCT fellows.¹ Therefore, exposure to the whole range of dermatology is required to reach the capabilities defined in the current dermatology curriculum. If services were functioning at 25%, 50% or 75% capacity, then training would be impacted due to an altered case mix and a reduction in experience, likely to translate to a delay in reaching the capabilities expected from a dermatologist on the specialist register.

WHAT CAN DERMATOLOGY ACHIEVE AT 25% CAPACITY (PHASE 2)

As stated above, this will differentially impact conditions requiring therapeutic interventions such as skin cancer surgery, photodynamic therapy, phototherapy and patch testing – compared with those which involve an initial consultation or follow-up for stable disease.

Priority consultations

We will continue to deliver mainly remote consultations and encourage teletriage to theatre lists for suspected cancer, where possible. Currently, image quality is variable, and safety netting will lead to an increase in follow-up consultations and diagnostic biopsy. We would give priority to follow-up patients already treated with immunosuppressive therapies who need careful supervision and ongoing advice about shielding. We would begin to prescribe immunosuppressive therapies which were put on pause during phase 1 of the pandemic. We would defer lower-risk skin cancers and those who are followed up for possible skin cancer metastasis unless they are symptomatic

¹ www.bad.org.uk/ResourceListing.aspx?sitesectionid=1139&itemid=9894

² www.bad.org.uk/healthcare-professionals/covid-19/recommencing-services-during-covid-19

³ <https://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=6713>

We would offer face-to-face consultations to those with severe inflammatory skin disease. We would prioritise face-to-face consultations for patients without access to relevant technology, those with anogenital lesions and some out-of-hours emergency work for all ages. With respect to children, we would extend this to include those with rapidly enlarging congenital haemangiomas, any potential skin malignancy, severe inflammatory skin conditions and scarring acne leading to psychological comorbidity and risk of suicide.

Priority interventions

Surgery

Initially, the focus would be to progress the treatment of skin cancers with metastatic potential, such as melanoma and squamous cell carcinoma, or rarer tumours with metastatic potential in all age groups. At this capacity, we would include wide excision of melanoma and melanoma *in situ* (T0) lesions.

Other interventions

Phototherapy, photodynamic therapy and patch testing can all recommence at greatly reduced throughput due to the reasons outlined above.²

WHAT CAN DERMATOLOGY ACHIEVE AT 50% CAPACITY (PHASE 3)

In this phase, we will continue all the work detailed in phase 2, and on the assumption that some of the social restriction for distancing would have been relaxed, allowing more face-to-face consultations and a higher throughput of skin cancer and other interventions for all age groups.

Priority consultations

Gradually, we will increase the face-to-face consultations deferred for the follow-up for skin cancer with metastatic potential,^{4,5} those with anogenital disease and inflammatory skin disorders not responding to the advice given by remote consultations.

Priority interventions

Surgery

There will be a large backlog of basal cell carcinomas accruing from earlier lockdown phases, disease prevalence and the reduced capacity of surgical throughput. Priority needs to be given to high-risk, infiltrative lesions, such as those on functional sites (i.e. periocular basal cell carcinoma and other tumours at high-risk sites); it is important that Mohs micrographic surgery be reintroduced at this stage for the management of these tumours, whilst continuing to provide all the surgical interventions described in phase 2. This will still leave a large number of patients with basal cell cancers in whom there is treatment delay with previously described sequelae.³

Other interventions

Phototherapy, photodynamic therapy and patch testing can all continue at a reduced rate of throughput. This will mean that patients are sub-optimally controlled, particularly with respect to inflammatory skin disease and some types of skin cancer; this may trigger more face-to-face clinic consultations due to disease flares or the need for more advanced surgical procedures.

WHAT CAN DERMATOLOGY ACHIEVE AT 75% CAPACITY (PHASE 4)

All interventions

We are assuming at this stage that social restrictions would have been largely lifted, and that patient throughput will return towards pre-pandemic levels with more tailored advice for those previously shielded and that all staff are repatriated. During this phase, we would continue to provide services to those patients with conditions described in the earlier phases of the re-setting of dermatology services, but we would anticipate a significant backlog in skin cancers to have accrued for reasons described above and in the document for urgent interventions.³

IN CONCLUSION

We as a specialty are committed to harnessing the innovation made in non-face-to-face consultations to optimise the patient experience without compromising patient care. We feel it is important to flag up anticipated delays in treatment of some skin cancers and, due to an altered case mix and patient throughput and the impact this might have over the next 12 months on specialty training. We understand that NHSE will be considering the impact this has on specialised commissioning in a separate document.

⁴ S. G. Keohane, J. Botting, P. G. Budny, *et al.*, British Association of Dermatologists guidelines for the management of people with cutaneous squamous cell carcinoma 2020, *in preparation*.

⁵ NICE melanoma guideline NG14, 2015, <https://www.nice.org.uk/guidance/ng14/chapter/1-Recommendations#follow-up-after-treatment-for-melanoma-2>