OCCG SERVICE SPECIFICATION (2017/18)

Primary Care Service for Skin Cancers: Dermatology Shared Care Monitoring for Melanoma, Lichen Sclerosus and Squamos Cell Carcinoma

1. Background

For patients who have had a diagnosis of Melanoma, Squamous Cell Carcinoma, Vulval Lichen Sclerosus or Vulval Lichen Planus it is important that there is ongoing monitoring to detect any malignant change/recurrence in-line with national guidelines. For some of this activity it is appropriate that the care is undertaken through shared care arrangements. For patients with a diagnosis of vulval lichen sclerosus or vulval lichen planus the guidelines indicate that the majority of this care will be provided through primary care. These patients are discharged from hospital care and will have all their care in primary care. Some patents will be managed by shared care, initiated by the dermatology department, but most will eventually return to primary care. A copy of the shared care protocol (overleaf) will be sent to the practice when a patient is started on shared care.

Since 2009/10 the dermatology department has been reviewing all patients with a diagnosis of Lichen Sclerosus and a large number have been discharged back to primary care in line with national guidelines on LS as they have been assessed as being at very low risk of complications and advised to visit their GP annually for review and to report any skin changes to their GP. These patients are not covered by this service as there are no on-going shared care arrangements.

Some patients with Vulval Lichen Sclerosus and Vulval Lichen Planus will present with symptoms that are difficult to control, have poor response to treatment or with concerns about progressive severe scarring. The management of these patients can be undertaken through shared care arrangements initiated in secondary care. For these patients practices are eligible for one annual payment under service for two reviews per annum. Suitable patients will be identified by the hospital consultant.

Patients diagnosed with Stage IB and IIA **Malignant Melanoma** (Level III, Grade B) can be managed through shared care arrangements following diagnosis. Patients will be seen twice a year in primary care and twice a year in secondary care for the first three years. In the fourth and fifth year the patient will be seen once in primary care and once by a secondary care consultant.

A new low risk group for **Malignant Melanoma** (Stage IA Melanoma) has been identified which will only need following up at 4 monthly intervals for one year, having two visits to the hospital and one to the GP before being discharged from formal follow up.

Shared care arrangements for medium risk **Squamous Cell Carcinomas** are being introduced in line with the national guidelines which specify 6 monthly attendances with the GP over two years. During that time they will also be seen by the hospital 6 monthly.

2. Service Scope

See appendices for guidelines for Lichen Sclerosus, Lichen Planus, Squamous Cell Carcinoma and Melanoma.

3. Patient Re-call

Practices are required to create and maintain a register of patients treated under the shared care protocol and run regular searches identifying patients due for review.

Patients should be invited in writing to attend the practice for their review in line with the shared care protocol. The letter should detail the purpose of the visit and recommend attendance.

4. Coding

Please see Appendix 1 for the codes to be used.

The coding required for payment includes three codes:

1. The shared Care code
2. A diagnosis Code
3. Dermatology examination code

5. Payment

In 2017/18 practices will receive payments as indicated in the table below for reviews undertaken under the shared care arrangements.

Please note that the frequency of the review is dependent upon the diagnosis:

Diagnosis	Frequency of Review	Payment per review
Lichen Sclerosus	Two reviews per annum in primary care	£55
Erosive Lichen Planus	Two reviews per annum in primary care	£55
Malignant Melanoma – Stage IA	One review in primary care Duration 1 year	£55
Malignant Melanoma – Stage IB and IIA	Two reviews in primary care per annum for 3 years / one review in primary care in years 4 and 5	£55
Squamous Cell Carcinoma	Two reviews in primary care per annum. Duration 2 years	£55

Payment will be made quarterly based on actual activity carried out as reflected in quarterly activity monitoring reports to the CCG as per clause 6 below.

6. Monitoring

Practices are asked to submit a quarterly report using QUEST of actual activity to the CCG by the 15th of the month following the end of each quarter during the year.

7. Termination

This service will terminate on 31st March 2019. Any change or early termination of this agreement must be agreed by both Commissioner and Provider.

APPENDIX 1

Oxfordshire CCG

Data Collection Specification for Primary Care for Skin Cancers: Dermatology Shared Care Monitoring for Melanoma, Lichen Sclerosus and Squamos Cell Carcinoma 2017/18

	Item		**Read Code and Description**
Search Population - Lichen Sclerosis	Any record of Vulval Lichen Sclerosus and of arrangements for shared care with the specialist		M2102 Lichen sclerosus et atrophicus 66S2. Shared care - specialist / GP
For payment	Dermatology exam in the quarter		2F... O/E - dermatology exam.
Search Population – Lichen Planus	Any record of Vulval Lichen Planus and of arrangements for shared care with the specialist		M1702 Lichen planus atrophicus 66S2. Shared care - specialist / GP
For payment	Dermatology exam in the quarter		2F... O/E - dermatology exam.
Search Population – Malignant Melanoma	Malignant Melanoma in the last 5 years with arrangements for shared care with the specialist in the last year		B32% Malignant melanoma of skin 66S2. Shared care - specialist / GP
	Stage IA		B328. Malignant melanoma stage IA
	For payment	Dermatology exam in the quarter	2F... O/E - dermatology exam.
	Stage IB or IIA		B329. Malignant melanoma stage IB B32A. Malignant melanoma stage IIA
	For payment	Dermatology exam in the quarter	2F... O/E - dermatology exam.
Search population - Squamous Cell Carcinoma	Squamous Cell Carcinoma in the last 2 years with arrangements for shared care with the specialist in the last 2 years		B338. Squamous cell carcinoma of skin 66S2. Shared care - specialist / GP
For payment	Dermatology exam in the quarter		2F... O/E - dermatology exam.

Temporary residents will not be included.

APPENDIX 2

VULVAL LICHEN SCLEROSUS: PRIMARY CARE MANAGEMENT

The dermatology dept has been reviewing the follow up of Vulval Lichen Sclerosus patients in view of recent national guidelines in patients diagnosed with Lichen Sclerosus and concluded that many lower risk women would be adequately managed by annual review in primary care.

Patients whose disease is stable and low risk will be discharged from the clinic after seeing the consultant to discuss this. They will be advised to self-examine and visit their GP if they develop persistent ulcers or nodules that don't respond to three weeks twice daily topical treatment with Dermovate.

All patients who have used topical steroid during the previous year are recommended to be reviewed annually and examined in primary care. *Please see below for more detail.*

Patients should be referred back urgently into the specialist service if there are concerns.

Below is information for GPs

αβχ
Department of Dermatology
The Churchill Hospital
Tel: 01865 228266
Fax: 01865 228260

VULVAL LICHEN SCLEROSUS: COMMUNITY CARE

Lichen Sclerosus
Your patient has been attending our clinic with Lichen Sclerosus of the vulva and/or perianal area. This condition is a chronic one and is associated with a 3-5% risk of malignant change which may occur as early as the 30s. We are currently recommending that following treatment, patients are followed up yearly for signs of early malignant change. We are also encouraging women to self examine and report any changes.

Community care is suitable for women with well controlled Lichen Sclerosus (requiring less than 30g Dermovate ointment or equivalent in any 6 month period), those who find travel to a hospital clinic too difficult or for those who express a preference for GP care. We propose that follow-up care should be carried out by the General Practitioner at yearly intervals. In case your experience with this disease is limited we have produced this advice sheet to help you. *Please contact us or refer back if you have any concerns.*

Vulval appearances and symptoms to expect in Lichen Sclerosus:

- The disease can present either as a localised patchy problem, or involvement can be extensive affecting the entire vulva/perineum, typically extending to the perianal area
- Plaques are usually white and generally thin and atrophic (like cigarette paper)
- Purpura and haemorrhage are common features
- Architectural change is common and there may be labial fusion with a contracted introitus, and the clitoris may be buried
- Fissures are common, but must be seen to heal
- Secondary infection with candida (which may be clinically atypical) and bacteria may cause worsening of symptoms. Please do a ***vulval*** swab and treat as appropriate if you suspect this
- Remember that many patients are post-menopausal and may also need local oestrogen

What to look for:

- Erosions which do not respond to topical application of Dermovate Ointment twice daily for three weeks should be referred urgently for review at the vulval clinic.
- Hyperkeratotic areas or fissured areas that do not respond to Dermovate Ointment twice daily for three weeks need an urgent referral
- Nodule formation is a very suspicious sign and needs urgent referral. *If a tumour is strongly suspected urgent referral via the 2 week wait to gynaecology is preferable to avoid delay in treatment.*
- Lichen Sclerosus has a strong clinical association with other autoimmune diseases such as thyroid disease, pernicious anaemia, vitiligo and diabetes. Please remain vigilant that these can arise at any stage and may require treatment and monitoring.

Dr Susan Cooper **Sister Susan Booker**
Consultant Dermatologist **Nurse Practitioner**

SMC March 2011

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VULVAL LICHEN SCLEROSUS: SHARED CARE

Below is the information for GPs:

αβχ
Department of Dermatology
The Churchill Hospital
Tel: 01865 228266
Fax: 01865 228260

VULVAL LICHEN SCLEROSUS: SHARED CARE

Lichen Sclerosus
Your patient has been attending our clinic with Lichen Sclerosus of the vulva and/or perianal area. This condition is a chronic one and is associated with a 3-5% risk of malignant change which may occur as early as the 30s.

We propose that shared follow-up care should be carried out between the hospital and the General Practitioner and should be on the basis of hospital review every eighteen months with the rest of the six monthly reviews be carried out in the community. When the disease is in clinical remission (symptoms well controlled and requiring less than 30g Dermovate ointment in any 6 month period) we will recommend that all reviews are done in the community. Community care may also be more suitable for those who find travel to hospital difficult or express a preference for community care. Patients can be referred back urgently if there are any concerns.
In case your experience with this disease is limited we have produced this advice sheet to help you.

Vulval appearances and symptoms to expect in Lichen Sclerosus:

- The disease can present either as a localised patchy problem, or involvement can be extensive affecting the entire vulva/perineum, typically extending to the perianal area
- Plaques are usually white and generally thin and atrophic (like cigarette paper)
- Purpura and haemorrhage are common features
- Architectural change is common and there may be labial fusion with a contracted introitus, and the clitoris may be buried
- Fissures are common, but must be seen to heal
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- Secondary infection with candida (which may be clinically atypical) and bacteria may cause worsening of symptoms. Please do a ***vulval*** swab and treat as appropriate if you suspect this
- Remember that many patients are post-menopausal and may also need local Oestrogen

What to look for:

- Erosions which do not respond to topical application of Dermovate Ointment twice daily for three weeks should be referred urgently for review at the vulval clinic.
- Hyperkeratotic areas or fissured areas that do not respond to Dermovate Ointment twice daily for three weeks need an urgent referral
- Nodule formation is a very suspicious sign and needs urgent referral. If a tumour is strongly suspected referral via the 2 week wait to gynaecology is more appropriate to avoid delays in treatment.
- Lichen Sclerosus has a strong clinical association with other autoimmune diseases such as thyroid disease, pernicious anaemia, vitiligo and diabetes. Please remain vigilant that these can arise at any stage and may require treatment and monitoring.

Dr Susan Cooper **Sister Susan Booker**
Consultant Dermatologist **Nurse Practitioner**

SMC March 2011

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APPENDIX 3 VULVAL LICHEN PLANUS – SHARED CARE

Some **erosive Lichen Planus** may be suitable for shared care, being seen at 6 monthly intervals with every second or third visit to a consultant.

αβχ
Department of Dermatology
The Churchill Hospital
Tel: 01865 228266
Fax: 01865 228260

VULVAL LICHEN PLANUS: SHARED CARE

Lichen Planus
Your patient has been attending our clinic with Lichen Planus of the vulva and/or perianal area. She is currently in clinical remission; however this condition is a chronic one and is associated with a 3-5% lifetime risk of malignant change which may occur as early as the 30s.

We propose that shared follow-up care should be carried out between the hospital and the General Practitioner and should be on the basis of hospital review every eighteen months with the rest of the six monthly reviews be carried out in the community. When your patient is in clinical remission requiring minimal treatment **we will recommend that all follow up takes place in the primary care**. In case your experience with this disease is limited we have produced this advice sheet to help you. *Please contact us or refer back if you have any concerns.*

Vulval appearances and symptoms to expect in Lichen Planus:

- The disease usually presents with erosions at the vaginal introitus that are typically edged by a lacy-white border. These erosions often persist.
- In some cases (hypertrophic disease) thickened white plaques may develop
- Architectural change is common and there may be labial fusion with a contracted introitus, and the clitoris may be buried.
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- Secondary infection with candida (which may be clinically atypical) and bacteria may cause worsening of symptoms. Please do a ***vulval*** swab and treat as appropriate if you suspect this.
- Remember that many patients are post-menopausal and may also need local Oestrogen

What to look for:

- New hyperkeratotic areas that do not respond to Dermovate ointment twice daily for three weeks.
- Very persistent, thickened or enlarging erosions.
- Nodule formation is a very suspicious sign and needs urgent referral. *If a tumour is strongly suspected then referral via the 2 week wait to gynaecology is more appropriate to avoid delays in treatment.*
- Rarely the narrowing of the vaginal introitus may be so severe that urinary retention may occur.
- Lichen Planus can occur at other body sites eg the oral mucosa, scalp, extragenital skin and nails.
- Finally Lichen Planus has a strong clinical association with other autoimmune diseases such as thyroid disease, pernicious anaemia, vitiligo and diabetes. Please remain vigilant that these can arise at any stage and may require treatment and monitoring.

Dr Susan Cooper **Sister Susan Booker**
Consultant Dermatologist **Nurse Practitioner**

SMC March 2011

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VULVAL LICHEN PLANUS – PRIMARY CARE MANAGEMENT

αβχ
Department of Dermatology
The Churchill Hospital
Tel: 01865 228266
Fax: 01865 228260

VULVAL LICHEN PLANUS: COMMUNITY CARE

Lichen Planus

Your patient has been attending our clinic with Lichen Planus of the vulva and/or perineum. She is currently in clinical remission, however this condition is a chronic one and is associated with an estimated 3-5% risk of malignant change which may occur as early as the 30s. We are currently recommending that following treatment, patients are followed up at yearly intervals for life for signs of early malignant change.

Community care is suitable for women with well controlled Lichen Planus (typically requiring less than 30g Dermovate ointment or equivalent in any 6 month period), those who find travel to a hospital clinic difficult or for those who express a preference for GP care. We propose that follow-up care should be carried out by the General Practitioner at six monthly intervals. In case your experience with this disease is limited we have produced this advice sheet to help you. *Please contact us or refer back if you have any concerns.*

Vulval appearances and symptoms to expect in Lichen Planus:

- The disease usually presents with erosions at the vaginal introitus that are typically edged by a lacy-white border. These erosions often persist.
- In some cases (hypertrophic disease a) thickened white plaques may develop
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- Architectural change is common and there may be labial fusion with a contracted introitus, and the clitoris may be buried.
- Secondary infection with candida (which may be clinically atypical) and bacteria may cause worsening of symptoms. Please do a ***vulval*** swab and treat as appropriate if you suspect this.
- Remember that many patients are post-menopausal and may also need local Oestrogen

What to look for:

- New hyperkeratotic areas that do not respond to Dermovate ointment twice daily for three weeks.
- Very persistent, thickened or enlarging erosions.
- Nodule formation is a very suspicious sign and needs urgent referral. *If a tumour is strongly suspected urgent referral via the 2 week wait to gynaecology is preferable to avoid delay in treatment.*
- Rarely the narrowing of the vaginal introitus may be so severe that urinary retention may occur.
- Lichen Planus can occur at other body sites eg the oral mucosa, scalp, extragenital skin and nails.
- Lichen Planus has a strong clinical association with other autoimmune diseases such as thyroid disease, pernicious anaemia, vitiligo and diabetes. Please remain vigilant that these can arise at any stage and may require treatment and monitoring.

Dr Susan Cooper
Consultant Dermatologist

March 2011 SMC

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APPENDIX 4

Melanoma Follow Up

Stage IA Melanoma – Low Risk

Under this service practices will undertake one annual review in the 12 months following diagnosis of a low risk Melanoma for those patients that are being treated under a shared care protocol as below:

Melanoma Follow Up

Stage IB and IIA Melanoma

The patient will be seen in the outpatient clinic initially then further appointments will usually alternate between the Specialist and GP according to the stage of disease at diagnosis. The patient should check the original Melanoma site once a week for the first year then once a month after that. The frequency of the hospital and GP visits depends on the thickness of the Melanoma. The scar, surrounding skin, regional draining lymph nodes and general skin should be examined. Details of the likely frequency of visits is detailed below:

	Stage IA Melanoma	Stage IB and IIA Melanoma	Stage IIB, IIC and IIIA Melanoma	Stage IIIB, IIIC and IV Melanoma
	Level III, Grade B	Level III, Grade B	Level III, Grade B	Level III, Grade B
	Shared Care Potential	**Shared Care Potential**	Secondary Care Led	Secondary Care Led
Recommendation Ref: BAD Guidelines for mgt of cutaneous Melanoma 2010, J.R. Marsden et al.	Three visits over 12 months (one in **primary care** and two in secondary care) are suggested to teach self-examination, and then they may be discharged from regular follow up	Patients should learn how to self-examine for locoregional metastasis and new primaries, and understand how to access the follow-up team promptly for suspect	Patients should be taught self-examination and be seen 3 monthly for 3 years, and 6 monthly to 5 years. No routine investigations are required.	Many patients will be eligible for adjuvant trials. Those outside of trials should be seen 3 monthly for 3 years from the date of staging, 6 monthly to 5 years, then annually to 10
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		recurrence, They should be seen every 3 months for 3 years, then 6 monthly to 5 years alternating between primary & secondary care. No routine investigations are required.		years by an SSMDT.

Patients will, as far as possible, be instructed in self-examination and receive written information about Melanoma, the contact details of the skin cancer nurse specialist & clear instructions and actions to take should they suspect new or recurrent disease. All patients are at risk of further skin cancers & pre-cancerous skin disease such as actinic (solar) keratoses & Bowen's disease. They will receive written information on sun avoidance measures.

The original site i.e. scars and surrounding skin as well as the regional draining lymph nodes should be examined. The patient should be asked about and examined for other suspicious skin lesions. All patients suitable for shared care follow-up will be given a patient-held follow-up record documenting their details including diagnosis, specialist contact details, follow-up regimen & chart to record clinical findings. The patient is instructed to bring this to each GP & specialist follow-up appointment.

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Appendix 5

Squamous Cell Carcinoma (SCC)

SCC shared care guidance has recently been agreed nationally, and some patients with SCCs can be seen in primary care under this. This will now be paid for as part of this service in a similar way to the malignant Melanoma payment.

Early detection and treatment improves survival of patients with recurrent disease. Seventy-five percent of local recurrences and metastases are detected in 2 years and 95% are detected within 5 years. The Department of Dermatology or Plastic Surgery will stratify SCC patients into 3 risk categories: low, medium & high based on the anatomical site affected, the size of the tumour, its underlying aetiology, degree of histological differentiation and host immunosuppression. The risk of metastasis is related to its site - in order of increasing metastatic potential:

1. SCC arising at sun-exposed sites excluding lip and ear.
2. SCC of the lip.
3. SCC of the ear.
4. Tumours arising in non-sun-exposed sites (e.g. perineum, sacrum, sole of foot).
5. SCC arising in areas of radiation or thermal injury, chronic draining sinuses, chronic ulcers, chronic inflammation or Bowen's disease.

Patients will, as far as possible, be instructed in self-examination and receive written information about SCC, the contact details of the skin cancer nurse specialist & clear instructions and actions to take should they suspect new or recurrent disease. All patients are at risk of further skin cancers & pre-cancerous skin disease such as actinic (solar) keratoses & Bowen's disease. They will receive written information on sun avoidance measures.

Low risk
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SCCs judged to be of low risk of local recurrence and/or metastasis will be reviewed in secondary care, usually the Department of Dermatology, 3 months after their definitive treatment and then discharged. They do not need regular follow up thereafter.

Low risk SCCs are defined as those arising in patients with no background immune dysfunction on sun-exposed sites, except the lip & ear, measuring less than 20mm in diameter or 4mm in thickness that are well differentiated

Medium risk
Those judged to be of medium risk will be followed up for 2 years at 3 monthly intervals i.e. twice a year by the GP and twice a year by the hospital on an alternating basis. The original site i.e. scars and surrounding skin as well as the regional draining lymph nodes should be examined. The patient should be asked about and examined for other suspicious skin lesions. All patients suitable for shared care follow-up will be given a patient-held follow-up record documenting their details including diagnosis, specialist contact details, follow-up regimen & chart to record clinical findings. The patient is instructed to bring this to each GP & specialist follow-up appointment.

High risk
These patients will be followed up in secondary care only.