Dermatological conditions suitable for primary, community and secondary care

Primary Care / Local Enhanced Service (GP services)	GP to seek advice from Community Dermatology (Step Up)	Community Dermatology Service (Intermediate Care)	Community to seek Advice from Secondary Care (Step Up)	Secondary Care (Hospital)
• Mild acne and rosacea • Mild to moderate dermatitis or eczema • Small benign lesions and lumps, including skin tags in line with PLCV • Mild to moderate psoriasis • Basal cell papilloma/sebhorroeric warts in line with PLCV • Mollusca contagiosa in line with PLCV • Actinic /solar keratoses • Mild/moderate infections and infestations (e.g. tinea, impetigo, scabies) • Symptomatic seborrhoeic keratosis • Viral warts and verruca's (excluding genital) in line with PLCV • Uncertain mollusca contagiosa ➢ Minor surgical procedures – curettage/diagnostic biopsies ➢ Haemangioma in adults less than 1cm ➢ Sebaceous cysts ➢ Dermatofibromas	• Moderate infections and infestations (e.g. tinea, impetigo, scabies) where topical treatment is unsuccessful • Haemangioma in adults more than 1cm • Minor surgical procedures – curettage/diagnostic biopsies	• Chronic inflammatory dermatoses after trial of suitable treatment in primary care eg topical steroids /emollients (eczema/psoriasis etc.) NOT requiring phototherapy/day unit treatment/systemic treatment • Psoriasis after trial of treatment in primary care (involving more than 20% of body surface area) • Eczema; seborrhoeic, atopic (but not suspected allergic contact dermatitis) neurodermatitis • Undiagnosed rashes in otherwise well patients • Bowen's disease • Undiagnosed skin lesions where concern or uncertainty and not 2 week wait indicated • Chronic/debiting urticaria mild/moderate with failed primary care treatment • Chronic/debiting Pruritus not responding to primary care treatment • Nail disorders • Hair, scalp disorders, non-scarring alopecias • Female genital dermatology including vulval lichen sclerosus	• Female genital dermatology including vulval lichen sclerosus if intermediate treatment unresponsive • Male genital dermatology, including genital rash unresponsive to topical treatment • Occupational dermatoses and contact dermatoses where patch testing required • Hyperhidrosis only if iontophoresis required • Nail disorders - Consider advice from Secondary care or Podiatry prior to making a referral • Psoriasis possibility requiring phototherapy	• 2 week wait cancer referrals • High risk basal cell carcinoma (dermatology, maxillofacial) • Dermatological emergencies • Severe inflammatory skin disease requiring phototherapy,or systemic therapy (eg eczema, psoriasis, lichen planus, urticaria) • Life threatening skin disease • Severe paediatric skin disease • Photo-investigation and specialised photo-dermatology for photosensitive conditions • Specialised skin cancer eg CTCL/ rare tumours • Skin disease related to connective tissue disease • Cutaneous vasculitis • HIV related skin disease • Pathology requiring MDT discussion/management • Complex mycoses • Severe hair and nail disease – with scarring or significant psychological impact

		• Male genital rash (likely to respond to topical treatment) • Low risk BCCs as specified in NICE guidance (up to 10mm in diameter, below the clavicle) • Moderate acne not requiring systemic isotretinoin • Vitiligo • Moderate infections and infestations (e.g. tinea, impetigo, scabies) requiring systemic management • hyperhidrosis – only consider referral if iontophoresis required • Inflammatory skin conditions e.g. Lichen planus, granuloma annulare • Benign moles and Pigmented lesions where 2 week wait is not indicated and where there is concern or uncertainty • Morphoea (localised) • Moderate to severe Folliculitis and not responding to primary care treatment • Keloid scarring • Dysmorphophobia • Patients stepped down from secondary care • Shared drug monitoring where appropriate **For note**: In delivering clinical management to all the above skin conditions, the community service will provide medical student teaching		• Specialist intervention for patients having undergone organ transplant • Suspected allergic contact dermatitis • Severe axillary hyperhidrosis requiring botulinum toxin injections • Photodynamic therapy for patients requiring secondary care e.g. transplant recipients • Severe / scarring acne – Isotretinoin treatment • Severe rosacea, refractory to 1st line treatment • Severe hidradenitis suppurativa • Immune-suppressed patients with possible skin cancer • Auto-immune blistering disorders e.g. pemphigoid • Severe drug reactions e.g. Stevens-Johnson syndrome • Systemic illnesses related to skin disorders e.g. Lupus • Any patient requiring step-up from intermediate service.