Dear Colleague

**Achieving the 18 Week Referral to Treatment Standard in Dermatology Services**

**Summary**

This letter is to provide Boards with the Dermatology Task and Finish Group Output Report and to commend action in the key areas detailed below.

**Background**

A Dermatology Task and Finish Group was sponsored by the Scottish Government's 18 Week RTT Operational Delivery Team on the basis of identified risk against achieving the 18 Weeks RTT Standard. The group is one of eight task and Finish groups, each group consisting of a small number of clinical and managerial specialists in the relevant field.

**Dermatology Task and Finish Group output Report**

The contents of the output report is commended to you to underpin further assessment of your service and intensive action where required. A primary aim of the report is to support opportunities for streamlined service management and ongoing improvement which is patient focussed. We recognise that achieving the 18 Weeks RTT Standard will require whole systems ownership and strong organisational leadership from clinicians and managers to embed and operationalise change on a sustainable basis. Each Boards’ progress in achieving 18 Weeks RTT for Dermatology will be linked to the Scottish Government’s support and escalation process and may be reviewed at the Chief Executives’ Meeting and individual mid-year reviews.

**Key Areas Commended for Action**

The key areas commended to Health Communities and NHS Boards for strategic action are:

- Drive uniform implementation of the Dermatology Referral and Management Pathways and the General Practitioner Referral Guidance to ensure that these are embedded right across the health community on a sustainable basis.

- Utilise the ‘Who is Doing What’ Matrix and Patient Flow Schematic with good practice examples to facilitate focused service redesign and pathway...
work, ensuring patients are on pathways that are appropriate to their condition.

- Proactively pursue detailed capacity planning in order to match capacity with demand, paying particular attention to understanding and then managing seasonal variations in demand.

Actions to Promote Success

- Maintain links with multi-disciplinary colleagues within primary and secondary care to ensure adherence of protocols and equity of access for patients.
- Continue to pursue service re-design opportunities e.g. see and treat services, nurse-led practice.
- Liaise with, and seek support from colleagues from the Improvement and Support 18 Weeks’ teams and with the 18 Weeks’ local teams within Boards.
- Continue to share good practice

Should 18 Weeks RTT performance in this specialty prove unsatisfactory, the escalation process could include further action planning with the Access Support Team, more detailed support intervention as needed and submission of detailed recovery plans.

I look forward to hearing of your success in implementing improvements in Dermatology Services.

Yours sincerely

Mike Lyon
Deputy Director, Health Delivery Directorate
Dermatology Task and Finish Group Output Report

18 Weeks Referral to Treatment Standard

March 2011
Introduction

Foreword and Commendations

The work of the Dermatology Task and Finish Group is sponsored by the Scottish Government’s 18 Weeks Referral to Treatment Operational Delivery Team, and ultimately by the Scottish Government’s Health Delivery Directorate. The Task and Finish Group, has, from a national perspective, considered how to manage identified risks to delivery in this specialty, and this report details outputs of this work.

The core elements of this report are commended to you by the Operational Delivery Team for action. Every Board is expected to ensure that each aspect is fully explored, progressed and embedded appropriately across their Health Community to support timely and high quality patient care. It is essential that all opportunities for streamlined service management and ongoing improvement and transformation are optimised, with the patient’s interest right at the centre. Delivery and improvement require whole systems ownership and strong organisational leadership – both clinical and managerial – in order to embed and operationalise change on a sustainable basis.

The core elements commended to Health Communities and NHS Boards for early action are:

1. Drive uniform implementation of the Dermatology Referral and Management Pathways and the General Practitioner Referral Guidance to ensure that these are embedded right across the health community on a sustainable basis. Engagement should therefore be initiated with stakeholders across the whole care system to promote adherence to the pathways: [http://www.18weeks.scot.nhs.uk/how-to-achieve-and-maintain-18-weeks/patient- pathways/dermatology/](http://www.18weeks.scot.nhs.uk/how-to-achieve-and-maintain-18-weeks/patient-pathways/dermatology/)

2. Utilise the ‘Who is Doing What’ Matrix and Patient Flow Schematic with good practice examples to facilitate focused service redesign and
pathway work, ensuring that patients are on pathways that are appropriate to their condition.

3. Proactively promote detailed capacity planning in order to match capacity with demand, paying particular attention to understanding and then managing seasonal variations in demand.

Should performance within Dermatology prove unsatisfactory, the escalation process triggered by the Scottish Government could include further action planning with the Access Support Team, more detailed tailored support, intervention as needed and submission of detailed recovery plans.

Robert Calderwood
Chair of the 18 Weeks Operational Delivery Team

Chair’s Reflections

I am very pleased to be able to share with you the output report from the Dermatology Task and Finish Group for review and implementation within your Board area. The outputs include a fully updated set of 16 Dermatology pathways which should be useful not only for informing referral and ensuring best treatment but also as a really valuable teaching tool. The national referral letter that the group has produced provides renewed clarity for General Practitioners and secondary care clinicians on appropriate patient management. The report also contains analysis of demand and capacity for dermatology services and information on a range of good practice initiatives across NHS Scotland. In producing this report the group has linked closely with a range of key stakeholders; in particular The Scottish Dermatology Society has been very supportive of this work. I would like to thank all members of the group for their assistance in completing the work.

Heather Knox
Chair of the Dermatology Task and Finish Group
Context

The 18 Weeks Referral to Treatment Target

The Cabinet Secretary for Health and Wellbeing has pledged

“a whole journey waiting time target of 18 Weeks from referral to treatment by December 2011.”

18 Weeks will therefore be the maximum wait from receipt of referral into secondary care to first definitive treatment, for non-emergency conditions.

The 18 Weeks National Delivery Structure

In order to ensure a cohesive approach between the Scottish Government and Health Boards in the delivery of this target, while ensuring maintenance of high quality patient focussed care, a national delivery approach was established. The 18 Weeks’ Programme Board oversees the work of four Delivery Teams – focussing on Information, Emergency Access, Operational Issues, and Diagnostics – which in turn brings a wealth of knowledge, expertise and experience to each specialist area.

Task and Finish Groups

As a consequence of analyses undertaken through the Operational Delivery Team (ODT), a number of Task and Finish Groups were formed. The rationale for forming these short life working groups was to focus on those specialties, on an operational level, identified as posing the greatest risks to the delivery and maintenance of the 18 Weeks Referral to Treatment (RTT) Standard.

Each group consists of a small number of clinicians, service managers, GPs and additional professionals involved in the specialty; the groups are also supported by members from the Scottish Government’s Health Delivery Directorate. The first five ‘at risk’ specialties to have Task and Finish Groups were: Audiology, Dental Specialties, Neurological Services, Orthopaedics and Plastic Surgery. More recently, Task and Finish Groups have been established in Dermatology,
Diagnostics and Demand and Capacity Management. All groups focus on a series of common work strands, namely:

- Measurement and Definitions
- Demand/Capacity/Activity /Queue Analysis
- Demand Side Solutions
- Performance Management
- Service Redesign and Transformation
- Culture/Change
- Workforce
- Communication
Dermatology Task and Finish Group

The Dermatology Task and Finish Group had its first meeting in July 2009. Membership consisted of clinical and managerial expertise, ensuring a systematic and pragmatic approach could be adopted and enabling any work completed within the group to be in keeping with patient focused holistic care. Membership is listed at Appendix One.

The rationale for forming the Dermatology Task and Finish Group, was, due to the high volume of referrals to the service (which appear to have increased on average by 9% per annum between the years 2006-2009) it posed a risk to the delivery and maintenance of the 18 Week Referral to Treatment Target. It was also recognised that approximately 10% of activity occurring within dermatology departments was a consequence of secondary care clinician-to-clinician referrals which were not previously measured against waiting times’ targets (Waiting Times, Data Warehouse, ISD, Scotland). Since March 2010 all source referrals form part of the 18 Weeks RTT Target, therefore it was anticipated that the increase in activity to the service as a consequence of capturing and measuring all source referrals was a further risk to the delivery for dermatology services within NHSScotland.

Figure One shows the percentage increase in referrals to Dermatology outpatient services by NHS Board between 2006 and 2009, captured retrospectively. Given the historic frequent utilisation of short-term measures to reduce waiting times, including waiting list initiatives, we wished to promote the adoption of sustainable solutions to achieve and maintain 18 Weeks RTT across all centres in Scotland, providing an equitable service, while delivering appropriate patient care.
Change in demand - Dermatology - 3yr

Source: SMR00, data from July 2006 - June 2009

Figure One: Change in Number of Referrals to Dermatology Outpatients

Total referrals per year from New Ways for Dermatology - Split by NHS Board

Source: New Ways for most recently published 2 years of data.

Figure Two: Total Dermatology Referrals by NHS Board
Figure Two shows New Ways activity by Board for Dermatology referrals that have been appointed from June 2009 until June 2010 and should be a prospective reflection of out-patient demand.

**Identified Issues and Risks**

In order to mitigate the risks to delivery of the 18 Weeks RTT Standard within Dermatology services, the group recognised the need to:

- Ensure adequacy and appropriate detail of information to drill into performance management and explore areas for improvement to manage risk.
- Acknowledge the impact of cancer pathways on the delivery of 18 Weeks RTT Standard in this specialty.
- Examine variance between pathways and referral practices across Health Boards.
- Identify and embed new ways of working, to balance capacity with changes in demand.

**Priority Actions and Workstreams**

In order to focus on the factors identified in this initial analysis, the group agreed to:

- Review the content and format of the 16 Centre for Change and Innovation’s (CCI) Dermatology Pathways (2005) and assess their use as an educational referral tool within primary care.

- Consider rolling out a national guidance letter in relation to referrals received by secondary care which can be appropriately treated in the primary care setting or do not require treatment according to national guidance. This guidance will assist General Practitioners (GPs) to make the best use of secondary care expertise for skin conditions, minimising variations in referral thresholds and promoting equity of access to patients referred to these services.
- Complete a patient flow schematic for non-admitted and admitted patients with improvement actions and examples of good practice that can be shared nationally.

- Engage with NHS Education Scotland (NES) to assess training and development opportunities for staff within dermatology departments, in order to maximise skill mix, competencies and use all levels of staff.

- Engage with the Dermatology community, key stakeholders and GPs via a National Event and ensure continual communication with the Scottish Dermatology Society.
Measurement Considerations

Measurement and Definitions

Consistent application of waiting times guidance is fundamental to the accurate measurement of waiting times within Dermatology i.e. the correct application of waiting time clock starts and stops and accurately recording patient unavailability. The waiting times guidance is currently being updated however it will be available online via the 18 Weeks RTT Standard website: www.18weeks.scot.nhs.uk. Contact Joyce Wardrope at joyce.wardrope@nhs.net for further information on this document.

Action Planning

In order to clarify clock starts/stops within Dermatology, a few scenarios have been compiled and can be found at Appendix Two.

Clinical Outcome Recording

Within the specialty, much of the ‘treatment’ provided does not involve admission to hospital. Increasingly, work is undertaken in the outpatient setting, either as part of a ‘see and treat’ or as a return outpatient appointment. This is to be encouraged, but historically, reporting systems did not enable these treatments to be recorded as part of the activity, and similarly, did not ‘stop a clock’ as part of the 18 week pathway.

An important methodology that may be used for capturing all dermatology treatments and clock stops is the uniform application of clinical outcome reporting. Work continues via the Improvement and Support Team and local 18 Weeks’ Teams to ensure that clinical outcome sheets are completed within health boards, for all specialties.

Action Planning: Clinical Outcome Codes

Ensure capture of your outcome codes for all stages of the patient journey, including return outpatient appointments (for treatment or review), as well as first assessment in outpatients.
18 Weeks RTT Measurement

As part of the 18 Weeks RTT Standard, to be achieved by December 2011, whole journey measurement for dermatology is being developed in line with all other services. The national targets for non-admitted and admitted data completeness and performance apply, and ongoing improvement in, and reliance on, these whole journey measures continues to receive high priority nationally.

Demand, Capacity, Activity, Queue Analysis (DCAQ)

Glenday Sieve

Using this approach groups the highest volume procedures across a specialty in order to identify those few procedures which make up the greatest volume of activity. Typically, approximately 6% of total procedures account for 50% of the volume of activity. This offers a practical starting point for improving patient flow and helping to prioritise efforts to reduce referral to treatment times through specific improvement and management strategies. Further information regarding this methodology can be found at:

http://www.nodelaysscotland.scot.nhs.uk/ServiceImprovement/Tools/Pages/IT045_Glenday_Sieve_Runners_Repeaters_Strangers.aspx

Understanding and then managing the balance of demand and capacity in order to quantify and then manage any capacity gap, is fundamental to every health system’s ability to deliver 18 Weeks RTT. We suggest that Boards utilise tools developed by the Improvement and Support Team.

- Waiting List and booking Process Demonstrator.
- Capacity and Queue Calculator.

http://www.nodelaysscotland.scot.nhs.uk/Resources/ResourceGuidelItems/Pages/CapacityandQueueCalculator.aspx

QueSsTCap Data

The following charts provide an assessment of the risk as of September 2010 and highlight some of the variations in supply and demand to be overcome. These are sourced from ISD’s QueSsTCap information, which analyses queue shape, size, trend and capacity using available New Ways of Measuring and Defining Waiting Times data. This information offers an important insight into the balance of capacity and demand for secondary care dermatology services, and an indication of how sustainable the current lengths of wait are likely to be. This understanding may then inform decisions on management of the service and drill down into specific areas for capacity gains.

![Figure Three: New Outpatients on the Waiting List](image)

Figure Three shows the total number of patients on Dermatology waiting lists for a first appointment during 2008, 2009 until September 2010. It shows a significant seasonal trend and a reduction in the numbers on waiting lists in 2009 compared with the previous year. From March 2010 all source referrals are captured and measured against waiting times targets (previously only referrals from general practitioners were...
measured); these include referrals received from an individual, team, service or organisation on behalf of a patient/client or a patient/client may refer him/herself.

![Graph: Distribution of ongoing waits at Sep 2010](image)

**2. Distribution of ongoing waits at Sep 2010**

**New Outpatients - NHS Scotland - Dermatology**

*All Referral Sources*

Please note, patients waiting over 18 weeks are likely to be on waiting list in error.

![Graph](image)

*Source: New Ways data, as at 30 Sep 2010*

**Figure Four: Distribution of Waits**

The graph in Figure Four identifies that Boards were delivering the stage-of-treatment target of no more than a 12 week wait for first outpatient appointment for all-source referrals in September 2010. The shape of this distribution from a national perspective suggests that the list is well managed, with patients mostly being treated in turn. Further drill down into individual Board’s lists is needed to understand and act upon local influences and waiting list management processes.
Figure Five: Additions and Removals

Figure Five shows seasonal variation in additions and removals from the waiting list. It highlights months where removals did not balance with additions and waiting lists increased. Equally, there are months where there were more removals than additions. It is paramount that Health Boards understand their own variation and plan suitable capacity accordingly, in order to proactively manage the presenting cases and thereby to address these peaks and troughs in demand. This may result in a change of workforce solutions e.g. annualisation of consultants’ work plans.
Figure Six: Weeks to Clear

Figure Six calculates the indicative number of weeks required to clear the dermatology new outpatient waiting list for NHSScotland based on activity from October 2009 until September 2010.

This is a representation of all core activity including waiting list initiatives and measures the stage of treatment target. If the indicative number of weeks to clear the list is greater than the stage of treatment target (i.e. 12 weeks) this indicates risk; if the indicative number of weeks required to clear is less than the stage of treatment target, this does not guarantee there is no risk – for example, activity could be being increased by unsustainable waiting list initiatives. It is important for Boards to understand the level of activity required for ‘business as usual’, i.e. to meet
appropriate demand as opposed to the one off activity required for ‘back-log clearance.’

It is paramount that emphasis is placed on sustainability and the focus of attention should be on how to deliver and embed a robust and timely service for patients; not one based on short term solutions or ongoing waiting list initiatives. The Task and Finish Group has identified a range of areas where the uniform application of good practice will offer activity gains and as a result of working smarter, not harder, an increased level of activity may be achieved.

**Action Planning: Capacity Planning**

NHS Boards should develop a capacity plan, including scheduling, managing variation, improving use of available capacity and where appropriate, one off backlog removal. Please see NHS Ayrshire and Arran’s Good Practice Example which can be found at Appendix Three.
Managing Patient Flows

Referral Management

Part of the philosophy of NHSScotland is ensuring that each patient is seen by the right professional, in the right care setting, at the right time, first time. This may be supported to a great extent with the utilisation of Dermatology Referral and Management Pathways which will influence the referral process into secondary care, with the patient right at the heart of this.

It is therefore important to understand who is coming into secondary care, why are they coming in, is this best place for the patient to be, and what are the influencing factors for each referral? It should also be acknowledged that secondary care practitioners are under no obligation to see and assess all patients referred. When appropriate, a clinician may refer a patient directly back to General Practice with advice for further care within the primary care setting, if the patient is not ready for treatment or if the referral threshold applied is not appropriate for secondary care.

This has become standard practice and can be supported by Dermatology Referral and Management Pathways for specific skin conditions and the General Practitioner Referral Guidance Letter. To see all comers for assessment can create a ‘revolving-door syndrome,’ confuse patient expectations, undermine the quality of the patient experience and swamp available capacity, and have a knock on effect on other users of the service.

Action Planning

Remember that any secondary care practitioner has the right to refer a patient back to the referrer e.g. if the procedure would be more appropriately carried out within the primary or community care setting, or alternative care pathways may be initiated.
Triage

It is now common practice for GPs to send electronic referrals to secondary care services, thereby reducing the burden of unnecessary paperwork and expediting the referral process. There is considerable scope to build on current systems to improve patient information flows and perhaps reduce face-to-face consulting time.

The Dermatology department within NHS Tayside delivers an electronic triage service with the option of attaching digital images. This system allows rapid screening of patients who are subsequently directed to the most appropriate pathway. Electronic triage is also an effective tool for providing a management plan for the treatment of some skin conditions in remote and rural settings where access to secondary care services may prove geographically challenging.

One Stop Clinics

These clinics are already commonly used by Dermatology services across NHSScotland. One stop clinics allow patients to be reviewed, and (the majority) receive definitive treatment at their first outpatient appointment. These clinics can also be supported by nurse specialists, freeing up considerable consultant time for patient diagnoses and prescribing appropriate treatment plans. One stop clinics also reduce the number of steps within the patient journey, therefore can improve the RTT waiting time and enhance the patient’s experience.

Advice Only Service

On occasion, primary care practitioners make referrals into secondary care in order to obtain advice or preliminary guidance, which may then be carried out in primary care. Some Boards provide the facility to request ‘advice-only’, which does not necessitate the patient presenting for assessment in secondary care and ‘using up’ a clinic slot and does not start the 18 Week RTT ‘clock’ e.g. Lothian’s e-mail advice service.

Waiting List Management

It is very important to ensure that all lists are proactively managed, including validation of patients waiting and each patient’s actual need to be on a list. It is
suggested that waiting lists can be managed more effectively by ensuring:

- Effective booking systems are utilised
- Treating patients in turn
- Pooling lists
- Managing DNA rates
- Not listing patients until they are ready for treatment
- Referring for advice only
- Managing return appointments differently to reduce high new: return ratios

Pathway Approach Philosophy

Equity of access for all patients should be a fundamental consideration, and there remains further scope for changes in the way which patient journeys are managed and the care setting in which they are delivered. Using a pathway approach with a common schematic to standardise or streamline the patient journey whenever appropriate can help minimise bottlenecks and smooth out handoffs.

Dermatology Referral and Management Pathways

It is widely acknowledged that the pathways are an invaluable educational tool especially for GPs and GP Registrars in the primary care setting and junior doctors in the secondary care setting, given the relative lack of undergraduate dermatology teaching and post graduate experience for most junior doctors in both settings.

The Centre for Change and Innovation’s (CCI) published 16 Dermatology pathways and The Dermatology Task and Finish Group has undertaken to update these.

Dermatology Referral and Management Pathways

- Acne
- Alopecia
- Atopic Eczema
- Benign Lesions
- Eczema
- Molluscum Contagiosum
- Nail Dystrophy
- Non-Melanoma Skin Cancers
- Pruritus: General and Localised
- Psoriasis
- Rosacea
- Scabies
- Solar (Actinic) Keratoses and Bowen’s Disease
- Suspicious Pigmented Lesions and Changing Melanocytic Naevi
- Urticaria
- Viral Warts

The Dermatology Referral and Management Pathways can be accessed at:


The Dermatology Referral and Management pathways comprise of a combination of photographs to assist clinicians in the diagnosis of specific skin conditions, together with advice and treatment algorithms which are intended to promote best practice in the management of these common skin conditions. This ensures access for all patients is maximised, as that only patients who need to access secondary care do so.

As noted above, it is acknowledged that, due to the restructuring of medical training over the years, both in the undergraduate and post graduate GP training, exposure to dermatological conditions has been reduced. It is also recognised that there is currently relatively low awareness, and / or adherence to the dermatology patient pathways and considerable variation in referral practice by GPs and junior doctors.

One of the objectives of the Task and Finish Group was to ensure that the up-dated Dermatology Management Pathways were disseminated and then used across primary care. This will increase best practice in dermatology management and treatment in primary care, and ultimately improve equity of care for patients requiring secondary care expertise.
**Action Planning**

The Dermatology pathways have been up-dated by clinical stakeholders and are commended for use in all localities. Implementation and embedding these pathways into everyday use must now be the focus and detailed plans for their roll out are needed. There may be further scope for education and training. Targeted continuing professional development may assist some GPs to more appropriately manage some dermatological conditions in primary care.

**General Practitioner Referral Guidance Letter**

The General Practitioner Referral Guidance letter, shown in Appendix Four, provides a list of specific skin conditions and advice on the most appropriate management of these in Primary Care. The guidance is procedure, not specialty specific, and should be adhered to by all clinicians not only those working within Dermatology departments. This will allow a consistent approach to be maintained in the treatment of these skin conditions, and helps to ensure the delivery of an equitable service. For example, the guidance in the letter states that treatment is not required for benign skin lesions, unless in exceptional circumstances. This approach to benign skin lesions has also been endorsed by the Plastic Surgery Task and Finish Group within the *Exceptional Aesthetic Referral Protocol* which can be accessed via:


The Exceptional Aesthetic Referral Protocol is currently under review and will be updated following input from additional clinical stakeholders, including Dermatologists, Plastic Surgeons, Ear, Nose and Throat Surgeons and Oral and Maxillo-Facial Surgeons.

The Dermatology Task and Finish Group commends adherence of the fundamental principles of the GP Referral Guidance letter and advises that it should be tailored to accommodate local variations in dermatology services.
Patient Flow Schematic

In order to continue to share good practice, a one page patient flow schematic was devised; this details good practice examples in Health Boards, primarily for non-admitted patients, but also covers the inpatient setting. The one page schematic is detailed in Appendix Five and should be used as a device in planning service changes or identifying areas for further improvement work.

Good Practice in Referral Management

The Dermatology Task and Finish Group recognises that there is good practice in referral management taking place across the country. A number of examples are given in the ‘Who is Doing What’ matrix in Appendix Six including this example from NHS Lothian.

Since 2004, a Dermatology e-mail advice service has been running from the Dermatology department of Edinburgh’s Royal Infirmary. On average this receives 60 queries per month. Although not actively encouraged, GPs, on occasion, send clinical photographs as attachments. The service was principally set up to give advice, but approximately one third of queries request a diagnosis. To date, there have been three audits of the service. Responses reveal high GP and patient satisfaction and, it is of particular value as an educational tool. An independent management audit also suggested that the service reduces referrals in over 40% of the GP queries, thereby preventing over 300 new patient referrals per annum. GPs who utilise this service believe it is highly valuable. It is also important to recognise that to operate this advice service efficiently, clinical administration time is required. At present two hours are allocated per week.

The Dermatology Task and Finish group has also recommended the following good practice in Cryotherapy and in the treatment of leg ulcers.
Community Based Cryotherapy

It is widely acknowledged that viral warts either resolve spontaneously or respond well to over-the-counter preparations; therefore many Dermatology departments do not operate a wart clinic. However, the Task and Finish Group recommends the use of community based Cryotherapy to resistant hand warts and community based podiatrists for recalcitrant plantar warts.

Community Based Clinics for the Treatment of Leg Ulcers

As these clinics treat a significant number of patients with leg ulcers, staff are able to provide continuity of care and are highly skilled in the treatment of this condition. Community based clinics enable many patients to be treated closer to their home, thereby embedding the principle of Shifting the Balance of Care.

Action Planning: Sharing Good Practice

A detailed ‘Who is Doing What’ Matrix was compiled and shared at the National Dermatology Event in February 2010 and is attached at Appendix Six.

Teledermatology

Teledermatology (TD) has been reported in the literature as offering potential in assisting with the triage of certain dermatology referrals and also in facilitating care to patients in remote locations. At a time of increased demand for the timely assessment of skin lesions, the provision of high quality images to aid specialist triage of referrals can assist in efficient service delivery, improving speed of access for patients with suspected skin cancer.

Teledermatology in NHS Scotland

The Dermatology Task and Finish Group recognises that there is good practice in Teledermatology taking place across the country. A number of examples have been given as part of the ‘Who is Doing What’ matrix in Appendix Six. Further detail of this work has been provided here.
NHS Forth Valley

A service has been initiated utilising the expertise of a medical photographer moving between community locations in the area. This provides high quality digital images to accompany SCI referrals of patients with suspected skin cancer to permit their efficient direction within the specialist service. This community photo-triage service has allowed for 72% of referrals to be directed away from a consultant-led clinic to directly booked surgery or other therapy clinics, nurse-led clinics or direct onward referral to another specialty, simplifying the patient journey within secondary care.

The cost-effectiveness of imaging skin lesions at the time of referral was recently assessed in NHS Forth Valley in a study supported by the Scottish Centre for Telehealth. The additional step of photography did not increase costs and yet increased service capacity. The high quality of images taken by a medical photographer requires to be balanced against the inconvenience for patients of the need to attend for the photograph. There remains a risk of reduced picture quality when pictures are taken by referring GPs and encouraging picture attachments in skin lesion referrals is a challenge for already busy Practices. A position statement on TD was published by the Scottish Dermatology Society in 2009 (www.sds.org.uk) which provides a cautious but well-reasoned assessment of the potential place for TD within the dermatology service in NHS Scotland. A study with ISD has been initiated to assess current teledermatology activity in Scotland with a view to deriving specific coding.

NHS Highland

In NHS Highland TD is used to respond to GP enquiries across the Highlands assisting in the provision of tele-opinions and providing rapid advice on diagnosis and management with the potential to initiate investigation. This system is advantageous, especially where patient journey times to specialist units are long.
### NHS Lanarkshire

A photo-triage service for skin cancer referrals has been operational for several years utilising hospital-based medical photographers. This service has reduced waiting times for cancer diagnosis.

### NHS Tayside

All GP practices in Tayside send electronic referrals, affording the opportunity for rapid screening, reduced paperwork, immediate electronic advice, and triage based with or without digital images. On average, 12000 referrals are seen per annum, and in past 12 months 17% of all referrals had a digital image attached. This system has proven to:

- Improve triage
- Reduces number of new appointments by approx 8 per week
- Reduces return by changing patient pathway e.g. one-stop clinic
- Can improve care whilst awaiting appointment
- Be useful in selecting cases for distant disease management, where travel difficult

But there are downsides:

- Significant cost in GP time, IT investment, and screening time.
- Needs experienced consultant Dermatologist
- Only very occasionally obviates need for specialist appointment for skin cancer

NHS Tayside’s system is based on existing infrastructure. The technical quality of images is gradually improving. Part of this is due to the widespread availability of simple, easy to use digital cameras, and part due to training

Within NHSScotland TD has been demonstrated to offer benefits in the efficient triage of certain patients with skin lesions which can help contribute to meeting the goals of the 18 weeks RTT initiative. At present, few photo-triage referrals are passed back to a general practitioner without a face-to-face consultation occurring,
but it is anticipated that such numbers will increase providing safe practice can be demonstrated. It is essential that image assessment is by an experienced skin cancer physician with the opportunity for clinical assessment wherever there is diagnostic doubt.
Dermatology Workforce

Skill Mix

Workforce considerations can inevitably impact on the ability of any service to deliver timely, high quality patient care. This is even more reason to explore and address the skill mix and competency base within the workforce. Dermatology services have increasingly used members of the multi disciplinary team e.g. nurse specialists to review patients at chronic disease clinics and perform minor surgical procedures. The development of enhanced roles can free up considerable amounts of consultant time for direct patient care.

Boards are encouraged to review their workforce capacity and competency profile, with a view to strengthening roles and responsibilities of different contributors, to ensure that each task is undertaken by the most appropriate person. This will help to maximise the use of all aspects of the workforce, ensuring that each professional’s skills are used to the full and that the best use is made of the overall human resource available. It is paramount for Boards to have accurate demand and capacity data to ascertain workforce requirements for each stage in the patient journey.

Given the existing multi-disciplinary workforce and the range of services provided many NHS Boards have identified new ways of working to optimise the use of and the skill-mix of available practitioners. For example many Dermatology services work collaboratively with other specialities, such as Oral and Maxillo-Facial and Plastic Surgery. Joint working is particularly effective in the area of ‘see and treat’ clinics, such as skin lesion clinics as it allows the development of competencies to support care pathways and streamline systems and processes.

However, there is still a need to focus on the initial management of the patient journey and what can be done in Primary Care to prevent the need for onward referral, especially if we are going to embed the principles of Shifting the Balance of Care and delivering care closer to the patient’s home.
Workforce Solutions Workshop

A workshop took place in November 2009 and members of the Dermatology Task and Finish Group facilitated some of the group discussions. A clear message from the day was to ensure that services are designed to meet patients’ needs and workforce planning is required to support this key principle. Principles that can assist with promoting this concept include:

- Designing pathways to support the delivery of optimal care and patient experience, and these should be evidence based.

- The design of a patient pathway should be used to determine the skills, competencies and roles required. The demand and the capacity required, at each stage in the patient pathway needs to be quantified.

- There should be an assessment of who does what at each stage in the pathway. There is evidence that professionals can be operating at the lower end of their competency range, despite training and development. Workload and productivity should be reviewed. This may provide some opportunities within current staffing for increased capacity. Data from clinical outcoming may assist with this process.

- Where new roles are developed there is a need for standardisation of titles, responsibilities, skills and competencies and consideration of national accreditation and validation.

- More attention needs to be focused on administrative and clerical roles to support pathway and patient flow management.

- All these considerations should be used as a basis for informed workforce planning, both nationally and locally to facilitate provision of a workforce fit for the future.
### Action Planning – Skills Mix

Evaluate skill mix and which professionals are best placed to undertake which functions. Where necessary this may be done under protocol.
Communication and Engagement

The Task and Finish Group undertook a range of activities in order to communicate and engage with the Dermatology community.

- Prior to up-dating the CCI Dermatology Pathways and completing the GP advice letter for skin conditions, advice was sought by the Task and Finish Group from the wider Dermatology community via the Scottish Dermatology Society.

- Links were made with the Chief Pharmacist’s Office within the Scottish Government’s Health Directorate.

- GPs within one of the West of Scotland’s Community Health and Care Partnership’s audited knowledge, use and value of dermatology pathways in relation to their last ten Dermatology referrals (approximately 420 referrals in total) and tested out two possible versions of the Dermatology Referral and Management Pathways prior to these being up-dated. This process facilitated information sharing and assisted with informed decision making within the group.

- The Improvement and Support Team hosted a national Dermatology event in February 2010 on behalf of the Task and Finish Group, in order to engage with the dermatology community. Clinicians from the Task and Finish Group participated in key plenary and group sessions; this provided an important forum for considering delivery expectations, sharing best practice and different approaches, and considering how NHSScotland might collectively overcome key bottlenecks e.g. information gathering.

- Links were also made with Information Services Division Scotland, who provided the graphs contained within this report.
Ongoing work within the Task and Finish Group allowed the opportunity to adopt innovative practices which could be tailored to suit each Board’s requirements. It was recognised that local approaches would be required in re-design work within the specialty, e.g. restructuring the urban service is a strategy that is being implemented in large Health Boards.
Conclusion

Members of the Task and Finish Group have focused in on the key issues which they feel may have the maximum impact.

Each Board is now expected to use this to design a critical path for the unequivocal delivery of waiting times' within Dermatology services.

Individual Boards may need to be performance managed through the coming months if delivery proves unsatisfactory.
Summary of Next Steps for Boards

Boards’ Action Planning

Measurement and Definitions

- Ensure that generic 18 Weeks RTT definitions are applied at the highest level.
- Use the bespoke dermatology scenarios to ensure that clock starts and stops are fully understood and universally applied.
- Pursue clinical outcome coding as the norm.
- Continue work to capture all treatment activity undertaken in an outpatient setting – especially in a return outpatient slot (not always traditionally captured).
- Promote the importance of accurate data capture and recording as a basis for service planning, improvement and performance.

Demand, Capacity, Activity and Queue

- Use improved data sets as the basis for detailed capacity demand planning.
- Use DCAQ tools and methodologies to plan and optimise use of available slots.
- Use QueSSTCap to predict and manage capacity gaps.

Primary Care Solutions

- Use professionally-developed and endorsed pathways to manage variations in referrals across practices, and to implement common thresholds for equity of access.
- Drive uniform implementation and embedding of pathways across the whole health community.
- Promote and apply common referral thresholds for skin lesions based on collaboration with clinicians from other specialties via The Exceptional Aesthetic Referral Protocol and the Dermatology GP Skin Referral Form.

Performance Management

- Use data to identify trends and risks and to manage performance.

Service Redesign and Transformation
- Use ‘who is doing what matrix’ to identify examples of good practice that can be transferred to your service.
- Promote, where appropriate collaborative working with clinicians from other specialties e.g. plastic surgery.

**Cultural**

- Assure a high organisational profile for Dermatology.
- Reinforce, culturally, that Dermatology is part of an 18 Weeks RTT including all treatments undertaken in an outpatient setting.

**Workforce**

- Review roles and competencies of multi disciplinary teams across Dermatology.
- Consider increased use of enhanced roles (under protocol where appropriate) to free up consultant slots for assessment and treatment.

**Communication**

- Sharing good practice e.g. via the Scottish Dermatology Society.
- Consider adopting practices from the ‘who is doing what’ matrix and liaising with Boards to ascertain best practices and how to avoid pitfalls.
### Appendix One: Membership of the Dermatology Task and Finish Group

<table>
<thead>
<tr>
<th>Member</th>
<th>Board and Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heather Knox (chair)</td>
<td>Director of Regional Planning, West of Scotland</td>
</tr>
<tr>
<td>David Bilsland</td>
<td>Consultant Dermatologist, Clinical Lead, NHS Greater Glasgow &amp; Clyde</td>
</tr>
<tr>
<td>Gillian Christie</td>
<td>Scottish Government, Health Directorate, Programme Director</td>
</tr>
<tr>
<td>Jacqui Dougall</td>
<td>Scottish Government, Health Directorate, Project Manager</td>
</tr>
<tr>
<td>Colin Fleming</td>
<td>Consultant Dermatologist, NHS Tayside</td>
</tr>
<tr>
<td>Danny Kemmett</td>
<td>Consultant Dermatologist, NHS Lothian</td>
</tr>
<tr>
<td>Colin Morton</td>
<td>Consultant Dermatologist, NHS Forth Valley</td>
</tr>
<tr>
<td>Michelle McNulty</td>
<td>Scottish Government, Health Directorate, West of Scotland, Service Improvement Manager</td>
</tr>
<tr>
<td>John Nugent</td>
<td>GP adviser to The Improvement and Support Team</td>
</tr>
<tr>
<td>Karen Stephen</td>
<td>Dermatology Nurse Specialist, NHS Tayside</td>
</tr>
<tr>
<td>Kate Thomas</td>
<td>Deputy Director, Future Services, NHS Ayrshire &amp; Arran</td>
</tr>
</tbody>
</table>
Appendix Two: Dermatology Task and Finish Group Scenarios

A patient is referred to a secondary care Dermatology service for assessment of a single skin lesion.

- The patient’s waiting time clock starts on the date of receipt of the referral to Secondary Care.
- The patient then attends for a new outpatient appointment in Dermatology.
- The clinician finds that the lesion requires treatment.
  - If this treatment takes place in that clinic, the patient’s waiting time clock will stop on the day that the treatment is carried out.
  - If the treatment cannot be carried out in that new outpatient appointment slot, the patient will require a further appointment as a return outpatient.
  - The patient’s waiting time clock will continue tick until that appointment and the required treatment is carried out. Only once the treatment is carried out will the waiting time clock will stop.

- If the Dermatology Consultant discovers that the patient has another skin lesion, which has not been the reason for the original referral, the treatment of the second lesion would be treated as ‘new’. In this situation a new waiting times clock would require to be started.

- After each appointment, whether new, return or see and treat, the Consultant selects the appropriate clinic outcome code for the patient. This identifies where the patient is on their pathway and confirms the patient’s outcome e.g. still waiting to be treated, removal from waiting list and discharged back to primary care or watchful waiting. Local health records staff will be able to advise on correct clinic outcomes codes for your area.

A patient is referred to secondary care Dermatology service with suspected atopic eczema.
- The patient’s waiting time clock starts to tick the date of receipt of the referral to secondary care.

- The patient then attends for a new outpatient appointment in the Dermatology department.

- The clinician reviews the patient, makes a diagnosis of probable allergic contact dermatitis, recommends treatment and refers for patch testing.
  - The clock will continue to tick until the patch testing is completed.

However:

- If the clinician reviews the patient and makes a diagnosis of probable atopic dermatitis, recommends treatment and refers for patch testing.

- The clock will stop. First definitive treatment has been instituted for the primary problem – not allergic contact dermatitis in this case and patch testing is an adjunct to this treatment.

- The appropriate clinic outcome code should be selected by the consultant. Local health records staff will be able to advise on correct clinic outcomes codes for your area.
Appendix Three: Good Practice Example

DCAQ Analysis in NHS Ayrshire and Arran

In Ayrshire and Arran we had a need to understand the variation within our waiting lists, whether that be demand, capacity or activity and the resulting impact on our queue. We decided to review all aspects of our waiting list in a series of graphics that were fairly dynamic and displayed all aspects of DCAQ in ‘real time’. This would allow us to view the lists from a basic top level and then drill down into the detail behind anomalies and special cause variation.

We managed to convert our waiting list detail into a graphic that included the demand (patients added to the waiting list weekly), activity (patients being removed from the list weekly) and the impact on the patients waiting (queue remaining).

The graphic below shows an example of the Dermatology outpatient waiting list. The x-axis represents weeks waited with the key indicated number of patient referrals added, the current number waiting and appointments being seen in the next week.

This simple graphic allowed us to analyse the waiting lists considerably. Our first observation was the distribution of the waiting list and variation of the appointed patients.
We could assess peaks in the demand as well as troughs and inconsistencies within the waiting list. This allowed us to make basic capacity calculations and plan ahead.
Inconsistencies in the demand, analyse possible carve out or drop in demand – ability to plan

The graphic allowed us to assess the level of variation in appointments. It was extensive and we clearly had issue with our ability to see patients in the order of their referral as well as understanding the processing of the urgent demand.

Assess evidence of book in turn activity and urgent demand
Most importantly, assess variation week on week – see carve out & the impact

The graphic was created with live waiting list data and this allowed us to drill down behind the variation to assess the causes. We could quickly see where we had spurious variation in booking and where but, also where we potentially had sub-specialty issues or other forms of carve out.
Not all carve out is unnecessary, but most often ask questions of the list construction e.g. all of these patients have waited 5 weeks.

Orthopaedic example shows difference in wait for Hand specialty v's general orthopaedics.
The key to this was our ‘What if?’ analysis using the same ‘real time’ data. If we took the variation and modelled booking in turn we could assess where we could reduce waits by reducing variation. The model below show that by keeping our waiting list in order and modelling it forward how we would quickly reduce the waits.

Model best practice & assess impact on the longest wait - 9 weeks in this instance

One week on we can potentially reduce the maximum wait to 7 weeks.
If we are to achieve 18 Weeks RTT Standard we will need to reduce the maximum wait of key stages in the patient journey. This can only be achieved by understanding the construction of the waiting lists and the variation within them. Once the causes are identified we have the opportunity to put systematic corrective actions in place and optimise our processes.

We will be unable to state with any certainty that we have a capacity and demand problem without understanding the key processes in detail.
Dear Doctor

Patient Name:     Patient CRN:

Thank you for your recent referral for the patient which has been considered by our consultants in line with the NHSScotland Dermatology Referral and Management Pathways and the Exceptional Aesthetic Referral Protocol. As a result we are unable to send an appointment to your patient for the reason indicated below:

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benign lesions, including moles</strong></td>
</tr>
<tr>
<td>We are unable to remove benign lesions for cosmetic reasons, unless in exceptional circumstances which are outlined in the 'Exceptional Aesthetic Referral Protocol'.</td>
</tr>
<tr>
<td><strong>Hypersensitivity testing</strong></td>
</tr>
<tr>
<td>We are not equipped to undertake immediate hypersensitivity testing for extracutaneous symptoms such as suspected food allergy. Cases of severe or recurrent immediate hypersensitivity reactions should normally be referred to a Clinical Immunology specialist prior to referral for investigation. Patch testing is subject to local arrangements and useful for contact dermatitis only.</td>
</tr>
<tr>
<td><strong>Seborrhoeic keratoses</strong></td>
</tr>
<tr>
<td>These do not usually require treatment. Cryotherapy or curettage in Primary Care is advised but only for symptomatic lesions. Where there is diagnostic doubt, secondary care advice can be made available but patients should be advised such appointments are for diagnosis only.</td>
</tr>
<tr>
<td><strong>Skin tags, cysts, lipomas or other benign lesions</strong></td>
</tr>
<tr>
<td>We are unable to remove skin tags, cysts, lipomas or other benign lesions.</td>
</tr>
<tr>
<td><strong>Spider haemangiomas / Telangiectasias</strong></td>
</tr>
<tr>
<td>No treatment is recommended as they can resolve spontaneously, especially in children. Please also see the 'Exceptional Aesthetic Referral Protocol'.</td>
</tr>
<tr>
<td><strong>Viral warts (hand wart, verrucae and mollusca)</strong></td>
</tr>
<tr>
<td>Typically have an excellent prognosis. As cryotherapy is often poorly tolerated and there is no evidence that it offers better outcomes than over-the-counter preparations, we no longer operate a wart clinic. Referral to a podiatrist can be considered for recalcitrant plantar warts.</td>
</tr>
<tr>
<td><strong>Xanthelasma</strong></td>
</tr>
<tr>
<td>Patients should be reassured that no treatment is required. A request for camouflage can be made to a Camouflage Clinic.</td>
</tr>
</tbody>
</table>
NHSScotland Dermatology Referral and Management Pathways and the Exceptional Aesthetic Referral Protocol have been developed by clinical staff to ensure there is capacity to treat patients who have severe dermatoses or suspected skin cancer as quickly as possible.

NHSScotland Dermatology Referral and Management Pathways:

Exceptional Aesthetic Referral Protocol:
http://www.18weeks.scot.nhs.uk/how-to-achieve-and-maintain-18-weeks/task-and-finish-groups/dermatology/

Patient Information Sheets can be found at: http://bad.org.uk/site/792/default.aspx

We remain pleased to receive referrals where diagnostic doubt exists, but patients should be advised that this appointment will be to assess the lesion(s) and that surgical removal or therapy may not be offered for the reasons given above.

Yours faithfully
Appendix Five: Patient Schematic
## Appendix Six: Who is Doing What Matrix

<table>
<thead>
<tr>
<th>Improvement Areas</th>
<th>Q1 – Improvements Implemented?</th>
<th>Q2 – Improvements Planned?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Understanding DCAQ for the service</td>
<td>DCAQ training was provided as part of the DCC collaborative exercise and was implemented in the department at that time.</td>
<td>The number of new patients allocated in each out-patient clinic to consultants has been increased together with a range of changes in the staff supporting the service and the DCAQ is being updated to reflect that.</td>
</tr>
<tr>
<td>2) Triage</td>
<td>95% of all referrals are sent electronically through the SCI systems.</td>
<td>Currently investigating processes to allow onwards consultant to consultant referrals to Plastic Surgery.</td>
</tr>
<tr>
<td></td>
<td>Consultants undertake electronic vetting of referrals on a daily basis.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rosters are now in place with arrangements made to provide cover across periods of consultant annual leave and other absences.</td>
<td></td>
</tr>
<tr>
<td>3) Extended Roles</td>
<td>Four GPwSI provide a clinical assistant service in out-patient clinic areas to support consultant staff. Two of the GPwSI also undertake a lesion biopsy service within their GP premises.</td>
<td>A 12 month pilot will start in November 2009 providing a nurse outreach service in 7 locations throughout A&amp;A to which patients with mild to moderate conditions will be directed following vetting by consultants. An option as that pilot progresses is to take direct GP referrals and also to undertake training and awareness sessions with the GPs within the clinic areas to improve GP management of Dermatology including more accurate referral information.</td>
</tr>
<tr>
<td></td>
<td>A number of nursing staff undertake biopsies, minor surgery and routine follow up which are held parallel to out-patient clinic sessions. The lead nurse undertakes her own clinic sessions for Psoriasis, Eczema and Acne patients. A liaison dermatology nurse is linked to 3 GP surgeries and offers guidance on chronic conditions.</td>
<td></td>
</tr>
<tr>
<td>4) Primary Care interface</td>
<td>Referral templates are currently available for pigmented lesion and acne patients.</td>
<td>Developed and implemented local referrals exclusion for Dermatology based on national Task and Finish group output. his will also incorporate revised CCI pathways for Dermatology due for publication Dec 2010. Develop processes and protocols for referral for advice only via SCI. Clinical Director and consultants currently engaged in designing one stop lesions' service. Need to establish referral criteria, frequency of clinics and resources required.</td>
</tr>
<tr>
<td></td>
<td>A pathway group has been established locally to identify system wide issues for Dermatology</td>
<td></td>
</tr>
<tr>
<td>5) Teledermatology</td>
<td>Currently piloting in 5 practices across A&amp;A in order to establish processes, systems and technologies required to evaluate use of photo triage systems.</td>
<td>Develop use of SCI for embedding photographs within electronic referrals.</td>
</tr>
<tr>
<td>6) Phototherapy</td>
<td>The two major service delivery sites both have an adequate photo therapy service and the service has recently purchased a mobile unit</td>
<td>Develop best practice / guidelines for use of photo-triage technologies.</td>
</tr>
<tr>
<td>Improvement Areas</td>
<td>Q1 – Improvements Implemented?</td>
<td>Q2 – Improvements Planned?</td>
</tr>
<tr>
<td>--------------------------------</td>
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</tr>
<tr>
<td>7) Managing DNAs</td>
<td>A&amp;A has a clear policy regarding the management of DNAs and this has been applied to the Dermatology Service.</td>
<td>A&amp;A currently running a trial of telephone bases appointment confirmation service to assess the benefits in reducing DNAs.</td>
</tr>
<tr>
<td>8) Interface with other specialties</td>
<td>Dermatology has a well structured arrangement with Plastics and General Surgery in terms of the identification of patient groups which should be managed by respective services and also in relation to the support required particularly for extensive surgery or surgery of a cosmetic nature which cannot be achieved within the Dermatology service.</td>
<td>A joint Dermatology and Plastic surgery outpatient service has been established at the Royal Alexandra Hospital in Paisley and the outcome of that will be monitored to see if there would be any potential in establishing a similar service in A&amp;A.</td>
</tr>
<tr>
<td>9) Clinic outcomes – non-admitted pathways</td>
<td>Clinic outcome recording now established in all out-patient clinics.</td>
<td>Focus on value added data available from clinical outcome recording to inform future improvement projects.</td>
</tr>
<tr>
<td>10) New to return ratio and practice protocols</td>
<td>As part of the out-patient templates agreed for consultant staff indicative new to return ratios have been established to reflect any subsequent specialty interest.</td>
<td>Continue to evaluate the level of review appointments, reduce them where appropriate and identify alternatives to consultant appointments.</td>
</tr>
</tbody>
</table>
Following recent discussions with the Dermatology team and the ongoing 18 weeks service redesign work progressing within NHS Dumfries and Galloway, the team have been comfortably meeting their waiting time targets. However, after several recent meetings we have identified some high impact changes that have supported the team in meeting the challenges of achieving the waiting time targets.

The majority of referrals are received electronically via the SCI portal. New patients are triaged frequently by the consultant and given a priority of urgent, soon or routine, then booked into an appropriate clinic. In a typical week clinics are undertaken by the Consultant, GPwSI (three sessions) and the Nurse Specialist (DNS). There are two new nurse led patient clinics undertaking minor surgical procedures, such as the treatment of moles, warts and a variety of other skin lesions. There is also a clinic for the treatment of acne.

Timings for doctor led clinics range from 5 – 15 minutes. In addition, some Doctor led clinics are also held in the evening. The clinics are supported by the nurse who provides assistance with clinical procedures. This process helps clinical staff manage the flow of patients more effectively and separate rooms are made available for both the doctor and nurse, which helps to manage the timings of these clinics. Having an experienced nurse present in the clinic allows the clinical staff to undertake the majority of procedures rather than bringing patients back to a separate operating session. This works effectively as a one stop clinic. On average 18 – 22 patients are seen in a medical led session and between 4 – 6 patients are seen in the nurse led clinics.

The nursing staff are involved in providing several return clinics for patients. These clinics include UVL, leg ulcers, minor surgery, acne and follow up treatment for patients requiring systemic therapy. The DNS is a nurse prescriber enabling her to provide a more holistic approach to the care and treatments of patients with dermatological conditions.

One of the measurable outcomes highlights that even with the challenge of increasing referrals to just under 3000 per annum, the average waiting time for patients to see a clinician is currently between 5-7 weeks. However, waiting times can vary over the holiday period. The numbers of DNA’s for new and return patients are relatively low, and, in addition, return patients are being seen within their appropriate timeframe.

Mark Sindall
18 Weeks RTT Project Officer
Direct: 01387 241988 (Ext: 33988)
<table>
<thead>
<tr>
<th>Improvement Areas</th>
<th>Q1 – Improvements Implemented?</th>
<th>Q2 – Improvements Planned?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Understanding DCAQ for the service</td>
<td>Review of Nursing Services across NHS Fife to identify potential capacity has been completed and community clinics have been established within 3 sites, with further clinic locations being identified to ensure equity of access.</td>
<td></td>
</tr>
<tr>
<td>2) Triage</td>
<td>Daily triage at Queen Margaret Hospital, but only three times per week at Victoria Hospital due to lack of clinical staff.</td>
<td>Improve daily triage through the implementation of Referral Management System. This will be implemented by December 2010.</td>
</tr>
<tr>
<td>3) Extended Roles</td>
<td>Nursing Review completed and improved utilization of nursing staff, including specialist nursing within the community.</td>
<td></td>
</tr>
<tr>
<td>4) Primary Care interface</td>
<td>Use when up-dated Dermatology Treatment and Management Pathways are approved</td>
<td>Additional GPwSI identified within the Kirkcaldy and Levenmouth CHP. Accommodation is now being sought.</td>
</tr>
<tr>
<td>5) Teledermatology</td>
<td>Awaiting review of COPD pilot.</td>
<td>GPs supplied with cameras in connection with COPD and possibility of pursuing it within Dermatology conditions.</td>
</tr>
<tr>
<td>6) Phototherapy</td>
<td>Provided at both sites.</td>
<td></td>
</tr>
<tr>
<td>7) Managing DNAs</td>
<td>Pilot of text reminder service has been undertaken and a reminder service is now under procurement.</td>
<td></td>
</tr>
<tr>
<td>8) Interface with other specialties</td>
<td>Improved communication with medical secretaries for Plastic Surgery and Dermatology (now in same room).</td>
<td></td>
</tr>
<tr>
<td>9) Clinic outcomes – non-admitted pathways</td>
<td>Fully electronic recording of clinical outcomes are now being recorded with compliance level within Dermatology between 85-91%</td>
<td>Clinic outcomes will help to identify those patients who return for treatment rather than ‘follow-up’ to give better information on new to review ratio. This will also be work that will be driven by the out-patient group.</td>
</tr>
<tr>
<td>10) New to return ratio and practice protocols</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement Areas</td>
<td>Q1 – Improvements Implemented?</td>
<td>Q2 – Improvements Planned?</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1) Understanding DCAQ</td>
<td>Dr Morton – Consultant has attended DCAQ training</td>
<td>½ day session to look at various aspects of the service including demand and capacity.</td>
</tr>
<tr>
<td>for the service</td>
<td></td>
<td>0.5 WTE consultant post advertised Dec '09, post not filled and now post frozen as part of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Board’s savings plan.</td>
</tr>
<tr>
<td>2) Triage</td>
<td>Referrals via SCI through Dermatology box or cancer pathway box.</td>
<td>Recurring funding for photo triage</td>
</tr>
<tr>
<td></td>
<td>Photo triage in place as a pilot, awaiting recurring funding, for suspicious lesions only.</td>
<td>Expand service to non suspicious lesions with three Consultants within NHS FV – OMFS and</td>
</tr>
<tr>
<td></td>
<td>Final business case for photo-triage to be signed off by the Board, however, indications</td>
<td>ENT</td>
</tr>
<tr>
<td></td>
<td>are, monies have been secured to continue the photo-triage service.</td>
<td>Criteria needed for non urgent lesions – cosmetic work – Awaiting launch of GP referral</td>
</tr>
<tr>
<td></td>
<td>General Triage – all referrals vetted by one Consultant as other</td>
<td>letter within Dermatology Output Report with CEL (December 2010).</td>
</tr>
<tr>
<td></td>
<td>Consultant locum and other posts are vacant.</td>
<td></td>
</tr>
<tr>
<td>3) Extended Roles</td>
<td>Nurse led clinics in community and in acute setting</td>
<td>Endeavour to deliver an efficient service as possible, making best use of extended roles</td>
</tr>
<tr>
<td></td>
<td>Nurses do majority of follow up as well as cryotherapy but also do see</td>
<td>and community triage.</td>
</tr>
<tr>
<td></td>
<td>some new patients following triage by Consultant</td>
<td>However, referral numbers continue to climb.</td>
</tr>
<tr>
<td>4) Primary Care interface</td>
<td>Cancer lead GP – Paul Baughan involved in the photo triage</td>
<td>Education of GP around care in primary care, what should be sent to acute etc.</td>
</tr>
<tr>
<td></td>
<td>Three GPwSI who do two sessions a week</td>
<td>Agree patient pathways for GPs to follow</td>
</tr>
<tr>
<td>5) Teledermatology</td>
<td>Photo - triage</td>
<td>Workshop at the ½ day session to look at dermatology services</td>
</tr>
<tr>
<td>6) Phototherapy</td>
<td>Compliant with MCN</td>
<td></td>
</tr>
<tr>
<td>7) Managing DNAs</td>
<td>Complying with new ways.</td>
<td></td>
</tr>
<tr>
<td>specialties</td>
<td>Dermatology consultant does do substantial amount of surgery as well.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No joint clinics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did have an MDT for skin cancer which has fallen away</td>
<td></td>
</tr>
<tr>
<td>9) Clinic outcomes – non-</td>
<td>Took part in RTT status code pilot and record outcomes for each patient</td>
<td></td>
</tr>
<tr>
<td>admitted pathways</td>
<td>at end of clinics. Reprinting clinic outcomes for both new and return</td>
<td></td>
</tr>
<tr>
<td></td>
<td>patients.</td>
<td></td>
</tr>
<tr>
<td>10) New to return ratio</td>
<td>Part of KPIs for 18 week team review of service. Concerted action within</td>
<td>Discuss at away day</td>
</tr>
<tr>
<td>and practice protocols</td>
<td>the team to ensure appropriateness of referrals and efforts made to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>triage to appropriate clinic/follow up.</td>
<td></td>
</tr>
<tr>
<td>Improvement Areas</td>
<td>Q1 – Improvements Implemented?</td>
<td>Q2 – Improvements Planned?</td>
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</tr>
<tr>
<td>1) Understanding DCAQ for the service</td>
<td>Initial DCAQ work carried out</td>
<td>Further DCAQ work underway to look at Queue and backlog management.</td>
</tr>
<tr>
<td>2) Triage</td>
<td>Pooled referrals and e-triege being rolled out – Stobhill initially</td>
<td>Roll out in the North planned by August 09</td>
</tr>
<tr>
<td>3) Extended Roles</td>
<td>Clinic co-ordinators at Stobhill and GRI. Nurse led clinics delivered by Nurse practitioners</td>
<td>Potential to look at one referral point for Dermatology services</td>
</tr>
<tr>
<td>4) Primary Care interface</td>
<td>All referrals to Secondary care</td>
<td>Potential review of A&amp;C rolls to see if roll out of clinic coordinators is feasible.</td>
</tr>
<tr>
<td>5) Teledermatology</td>
<td>Currently deliver an outreach service to Argyll.</td>
<td>Visit to Lochgiliphead with Plastics planned to review their practice.</td>
</tr>
<tr>
<td>6) Phototherapy</td>
<td>Every site</td>
<td></td>
</tr>
<tr>
<td>7) Managing DNAs</td>
<td>Varies across sites</td>
<td></td>
</tr>
<tr>
<td>8) Interface with other specialties</td>
<td>Closely work with Plastics – pathways in place for Melanoma and Lesions</td>
<td></td>
</tr>
<tr>
<td>9) Clinic outcomes – non-admitted pathways</td>
<td>Roll out in the Western initially</td>
<td>Roll out across all sites</td>
</tr>
<tr>
<td>10) New to return ratio and practice protocols</td>
<td>Needs reviewing – regular reports produced</td>
<td></td>
</tr>
</tbody>
</table>
**Improvement Areas** | **Q1 – Improvements Implemented?** | **Q2 – Improvements Planned?**
--- | --- | ---
1) Understanding DCAQ for the service | Following OP Demand analysis it was identified that the biopsy pathway had areas which should be improved i.e. the biopsy letter. | Pilot of immediate biopsy booking immediately after the patient's first attendance. The patient will select the suitable time for the appointment. This will cut out 2 weeks from the pathway as a letter is not processed to initiate the biopsy appointment. A trial of this process has been carried out which has identified some changes required. These are under discussion.

2) Triage | For the last 18 months all non urgent vetting has been centralised as a team vet carried out once per week. This has ensured consistency of vetting and streamlining to the correct sub-specialty. As a spin off we now have a much more accurate quantification of the sub-specialty workload split. | A pilot for e-vetting for skin cancer referrals linked with photo-triage has been agreed and has commenced.

3) Extended Roles | 3 nurses have been trained in carrying out biopsies and simple excision biopsies and since May 2009 have been providing a weekly clinic each. | Discussion is underway around the development of a nurse camouflage clinic.

4) Primary Care interface | For 18 months GP have been carrying out simple lesion clinics on a routine basis on all 3 main hospital sites. | The national Dermatology Patient pathways are being discussed with Primary care with a view to implementing Lanarkshire versions. Dr Thomson (Lead GP) is in on-going discussion with GP Localities regarding increasing the level of electronic referral.

5) Teledermatology | No existing plans. There are currently non-electronic links to Plastic Surgeons through the MDT. | Planned re-launch of Skin Cancer photo-triage to increase uptake of the facility across Lanarkshire. Currently 30% use. This will link to e-Vetting and assists in delivery of the 31/62 day Cancer target.

6) Phototherapy | No current plans in place. | No current plans in place.

7) Managing DNAs | | Current DNA rate is 12% and it is expected that the lesion assessment clinics with links to one-stop clinics will reduce DNA rates.

8) Interface with other specialties | | Plastic surgery via MDT. Specific issues regards 31/62 day Cancer pathway and 18 Weeks RTT are under discussion.

9) Clinic outcomes – non-admitted pathways | | Currently the clinicians are not completing forms. The issue has been raised at recent CSIG meeting and is under discussion.

10) New to return ratio and practice protocols | | Outpatients - Return to New (HEAT E4) 0.7 0.7 0.8

Figures above show Q2, Q3 and Q4 for 2008/09 Return to New Ratio.
<table>
<thead>
<tr>
<th>Improvement Areas</th>
<th>Q1 – Improvements Implemented?</th>
<th>Q2 – Improvements Planned?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Understanding DCAQ for the service</td>
<td>DCAQ work completed in Dermatology. Service now has an understanding of capacity versus demand. New SCI gateway referral pro formas for Cancer referrals Letter send to GPs advising on referrals protocols and strict adherence to them when referring patients.</td>
<td>Job Planning, increasing DCC time from SPA time to increase capacity. Clinic Templates ensuring full 4 hour session in clinics Strict monitoring of Consultant Leave Delivery of a 42 week working year</td>
</tr>
<tr>
<td>2) Triage</td>
<td>Triage now undertaken daily on each site. No delays in triaging. Centralisation of referrals at St John’s has now been completed, with Lauriston processing all referrals</td>
<td>Centralisation of referrals from Roodlands make triage system much better and timely</td>
</tr>
<tr>
<td>3) Extended Roles</td>
<td>Clinical Nurse Specialists x 2 now undertaking return clinics enabling Consultants within the Tumour group to see more new patients. New CNS role in cryotherapy has increased capacity by 420 slots per year</td>
<td>Increased NP activity Look to expand the Tumour CNS role to 3 Look to develop the role of Physician Assistant to take role of Hospital Practitioner for biopsy work Skill more nursing staff in biopsy work – 1 more CNS training Sept 09</td>
</tr>
<tr>
<td>4) Primary Care interface</td>
<td>A Dermatology e-mail advice service has been running from the Dermatology department of Edinburgh’s Royal Infirmary. e-referrals and e-triage pilot planned in next few months.</td>
<td></td>
</tr>
<tr>
<td>5) Teledermatology</td>
<td>Not undertaken.</td>
<td></td>
</tr>
<tr>
<td>6) Phototherapy</td>
<td>Increased availability of Phototherapy slots now additional 126 slots per week Direct referrals to treatment now (previously referred as NP from general clinics and clock re-started)</td>
<td>Increasing capacity Equity of access around Lothian Funding issues around these developments</td>
</tr>
<tr>
<td>7) Managing DNAs</td>
<td>Consultants review DNAs at the end of each clinic and make decision regarding re-appointing patients. One strike and back to GP policy stricter implementation.</td>
<td>Implementation of Telephonetics in the near future (end of Sept). This should reduce the number of DNAs within clinics as patients will be reminded of their appointment and given the option to cancel and re-book if required.</td>
</tr>
<tr>
<td>8) Interface with other specialties</td>
<td>Joint clinic with Plastics ensuring patients treatment is undertaken on the same day,</td>
<td>Evaluate pilot and look to expand service if successful. Joint Business case between Plastics and Dermatology would be required.</td>
</tr>
<tr>
<td>9) Clinic outcomes – non-admitted pathways</td>
<td>Outcoming now undertaken by all Dermatologists and support staff</td>
<td>Make changes to standard outcoming templates to ensure 18 week RTT pathway is able to be monitored effectively</td>
</tr>
<tr>
<td>10) New to return ratio and practice protocols</td>
<td>Tumour Consultant has driven down some review numbers now NP activity</td>
<td>A lot more work needs done around review numbers – need to progress with this Audit planned on snapshot to get a feel for reviews Challenge in job planning – changing clinic templates reviews to NP</td>
</tr>
<tr>
<td>Improvement Areas</td>
<td>Q1 – Improvements Implemented?</td>
<td>Q2 – Improvements Planned?</td>
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</tr>
<tr>
<td>1) Understanding DCAQ for the service</td>
<td>Training provided. Monitoring of demand on-going. Review of demand and capacity performed previously with re-design of services to meet needs at that time.</td>
<td>Presently undertaking review of demand, queuing and capacity with support from regional and national teams</td>
</tr>
<tr>
<td>2) Triage</td>
<td>Single Consultant triage of referrals within each locality to ensure consistency. Feedback given to GPs with reference to Patient Pathways.</td>
<td></td>
</tr>
<tr>
<td>3) Extended Roles</td>
<td>All patients referred with Leg Ulceration assessed and treated by Leg Ulcer Specialist Nurse. Nurse-led clinics held for; Psoriasis, Mohs surgery review, General Dermatology, Systemic Therapy Monitoring, Cryotherapy, Skin Surgery, Botox, Hyfrecation, Intra-lesional injection, Iontophoresis, Paediatrics, Technician clinics: hair removal laser, PDT, Grentz ray Two Independent Nurse Prescribers</td>
<td>New roles will be explored when results of DCAQ results received</td>
</tr>
<tr>
<td>4) Primary Care interface</td>
<td>Two GPwSI performing clinics in secondary care setting On-going educational events provided for primary care staff</td>
<td>Further two GPs identified to perform clinics within secondary care</td>
</tr>
<tr>
<td>5) Teledermatology</td>
<td>Most referrals received and screened electronically with images where appropriate to aid triage. Feedback provided electronically to GP’s regarding appropriateness of referral and advice regarding treatments.</td>
<td>Plan for all referrals to be received electronically</td>
</tr>
<tr>
<td>6) Phototherapy</td>
<td>Nurse-led Phototherapy provided at three sites within Tayside and 1 in NE Fife. Services offered include: Grentz Ray UVA, UVA1, PUVA, UVB, Home phototherapy service provided for those patients who are unable to attend for treatment and are suitable for self administration.</td>
<td>Expansion of home phototherapy</td>
</tr>
<tr>
<td>7) Managing DNAs</td>
<td>DNAs not routinely re-appointed, GPs informed.</td>
<td>Audit presently being undertaken to look at reasons for DNA and diagnosis</td>
</tr>
<tr>
<td>8) Interface with other specialties</td>
<td>Shared triage and treatment of Skin Cancer referrals between Plastic Surgery, Dermatology and Maxillo-facial surgery. Close working with other specialties for Mohs surgery reconstruction</td>
<td>On-going development of close working partnerships</td>
</tr>
<tr>
<td>9) Clinic outcomes – non-admitted pathways</td>
<td>Outcomes presently recorded from clinics only, limited procedures gathered</td>
<td>Presently reviewing and up-dating outcome sheets to capture procedures and more detailed clinic data</td>
</tr>
<tr>
<td>10) New to return ratio and practice protocols</td>
<td>Variable</td>
<td>This will be addressed following DCAQ results</td>
</tr>
</tbody>
</table>
### Q1 – Improvements Implemented?

<table>
<thead>
<tr>
<th>Improvement Areas</th>
<th>Q1 – Improvements Implemented?</th>
<th>Q2 – Improvements Planned?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Understanding DCAQ for the service</td>
<td>Photo-dermatology implemented in Shetland</td>
<td>Patients journey and pathways plotted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E-mailing referrals to Grampian</td>
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<tr>
<td></td>
<td></td>
<td>Frequency of visits and Consultant / GPwSI mix under review</td>
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<td></td>
<td></td>
<td>New to review ratio being reduced by clinicians</td>
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<tr>
<td></td>
<td></td>
<td>‘Review’ backlog to be seen in WLI clinics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A system to monitor and record all requests for advice to run alongside the normal referral requests has been requested to help reduce demand upon appointments.</td>
</tr>
<tr>
<td>2) Triage</td>
<td>Pre-vetting of all referrals (any referrals which could be taken by local surgical team for a surgical pathway are pre-vetted by Mr Mikolajczk) prior to hitting Dermatology.</td>
<td>E-mailing referrals to Grampian</td>
</tr>
<tr>
<td>3) Extended Roles</td>
<td>Photo-dermatology implemented in Shetland</td>
<td>GPwSI to cover Shetland clinics alone with an increased frequency of clinics – under review</td>
</tr>
<tr>
<td>4) Primary Care interface</td>
<td></td>
<td>Cryotherapy – wart clinics to be held in Primary Care.</td>
</tr>
<tr>
<td>5) Teledermatology</td>
<td></td>
<td>Teledermatology clinics could be implemented in future</td>
</tr>
<tr>
<td>6) Phototherapy</td>
<td>Photodermatology implemented and first batch of patients seen in OPD</td>
<td>Continuity of service in Shetland</td>
</tr>
<tr>
<td>7) Managing DNAs</td>
<td>Review patients phoned to remind them of their appointments by medical records staff.</td>
<td></td>
</tr>
<tr>
<td>8) Interface with other specialties</td>
<td>Pre-vetting of all referrals (any referrals which could be taken by local surgical team for a surgical pathway are pre-vetted by Mr Mikolajczk) prior to hitting Dermatology. Once patients have been seen by Dermatology and they require surgery, they are passed to the local Surgical team for treatment in Shetland</td>
<td></td>
</tr>
<tr>
<td>9) Clinic outcomes – non-admitted pathways</td>
<td>Review appointments reduced, so patients to be followed up in Primary Care.</td>
<td>A system to monitor and record all requests for advice to run alongside the normal referral requests has been requested to help reduce demand upon appointments and for review patients to come back into the system when advice for GP would suffice</td>
</tr>
<tr>
<td>10) New to return ratio and practice protocols</td>
<td>From the last clinic, of 13 patients – nine were discharged and four required review</td>
<td></td>
</tr>
</tbody>
</table>