

Delivering care and training a sustainable multi-specialty and multi-professional workforce

An audit of UK dermatology outpatient departments against the 16 principles of the Royal College of Physicians' report

Outpatients: The future - adding value through sustainability

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Contents

Executive summary	3
Introduction	6
Delivery of care	9
a. Organisation and structure	9
b. Alternative consultation methods	13
c. Treating patients as partners	14
Training	18
Allied working	19
Staff and patient wellbeing	20
Conclusions	22
Summary table of key findings from the audit	24
References	29
Appendix 1: Audit proforma	31
Appendix 2: Bar chart	39

Executive Summary

The burden of skin disease is significant, representing 23% of the presentations to primary care. The referrals to secondary care services continue to grow in number and complexity, year-on-year. This is due to patient demographics and the increasing use of systemic therapies which require careful monitoring.

Over the years, workforce shortages coupled with an increasing burden of skin cancer have forced dermatology departments to evolve into multi-specialty and multi-professional teams. The British Association of Dermatologists (BAD) therefore welcomed the opportunity to benchmark current dermatology outpatient practice against the Royal College of Physicians' (RCP) report *Outpatients: The future - adding value through sustainability* - which outlines 16 principles of good outpatient care - to inform how we, as a specialty, could improve to meet the challenges described in the *NHS Long Term Plan*.

This is important because of the sheer burden of disease assessed and treated in secondary care dermatology services. We are all aware that with predicted year-on-year demands in healthcare, and the rising incidence of skin cancers, the NHS needs to maintain patient-centred services which are also value for money. This audit and the accompanying case-studies document show how dermatology services are currently just able to meet many of these challenges. They achieve this by working with allied healthcare professionals and harnessing technology to make services more efficient. The main findings from this audit are summarised below:

1. Skin cancer is the commonest of all cancer in the UK and referrals for suspected skin cancer have doubled over the last five years. Almost all of these patients are seen by dermatology outpatient services.
2. 2018-19 HES statistics report 3.3 million outpatient attendances for dermatology compared with 1.8 million for rheumatology, a specialty with a similar use of standard systemic and biological agents and approximately the same number of specialists on the GMC register.
3. Skin cancer referrals are prioritised over patients with often debilitating inflammatory skin disease. Only 15% of departments report equity of access for patients with any skin condition. Not all departments offer urgent access to dermatology services seven-days-a-week.
4. Priority is given to new patients, rather than follow-ups. Follow-up patients often require attendance for the monitoring of systemic agents or skin cancer recurrence.
5. Whilst some departments offer out-of-hours services, many are unable to, due to a lack of support services such as phlebotomy, pharmacy, medical photography and nursing support.
6. Half of departments offer patients a one-stop see-and-treat clinic for skin cancer to avoid repeat visits and to initiate treatment pathways as soon as possible.
7. Most departments routinely adopt practices to minimise the number of follow-up visits required, such as informing the patient of their histology results by letter, if appropriate, or implementing telephone monitoring clinics for patients on systemic therapies with stable disease.
8. A third of sites harness teledermatology to avoid unnecessary consultations in secondary care. Teledermatology is also used to train registrars in diagnosis

and teletriage techniques, ensuring a well-trained sustainable workforce for the future NHS.

9. 95% of Dermatology Consultants lead, and are accountable for, multi-professional and multi-specialty teams. These consultants supervise other healthcare professionals and trainees as well as delivering their own busy outpatient clinics.
10. The current specialty training models provide a significant level of service. A typical dermatology registrar working full-time will deliver 7.5 to 8.5 four-hour dermatology clinics or surgery lists per week, in preparation for the consultant role.
11. There also exist, in approximately 15 departments across the UK, Trust-funded post-CCT fellowships, delivering training and service at tertiary level, essential for high quality patient care. These fellows also contribute to secondary care services and support and train other clinic staff.
12. 86% of Dermatology Consultants supervise and train nurses.
13. In order to maximise the workforce, most departments rely on specialised nurses for efficient service delivery. 89% report nurse-led clinics supported by a Dermatology Consultant for the assessment of new or follow-up referrals. Some of these consultations are face-to-face, others are by telephone.
14. 75% of dermatology outpatient departments report that nurses, under consultant supervision, monitor high-cost drugs such as biological therapies for eczema and psoriasis.
15. 66% of dermatology outpatient departments report nurses carrying out skin surgery and isotretinoin monitoring in acne clinics.
16. In an attempt to upskill other specialties, as well as further enhance supervised secondary care provision, 50% of departments train General Practitioners and 40% work with allied specialists. This encourages professional development and leads to integrated pathways of patient care aligned with the *NHS Long Term Plan*.
17. There are more than 4,000 diagnoses in dermatology, some conditions are very rare. Relevant patient information is therefore a key part of care: 97% of departments routinely give, or signpost patients to, relevant material about their skin condition.
18. 90% of departments routinely engage patients in decision-making about ongoing care. This is important, particularly in the context of skin cancer treatment as well as the initiation of systemic therapies, which can have serious adverse effects.
19. 53% of sites report regular overbooking of patient numbers during clinic, with subsequent extended delays for patients on the day. Reasons given for late-running clinics are: failure of IT systems (48%), delays in histopathology reporting (36%) and relative lack of follow-up clinic slots.

This audit report provides a useful tool against which to benchmark dermatology practices and to explore areas for future service improvement.

Key recommendations for improvement:

1. To acknowledge that a critical mass of Dermatology Consultants is required to adequately train and safely supervise complex healthcare teams for service delivery and patient care. Adequate support is required for not only retention, but due to the increasing burden of skin disease, expansion of this cohort of senior clinicians.
2. To provide equity of access for all patients with skin disease, not just those with suspected skin cancer.
3. To ensure equity of access for follow-up as well as new patients.
4. To commission 7-day dermatology services and specialised services.
5. To support all departments to develop technological innovation to improve triage of referrals to secondary care and direct capacity to those patients who need it most.
6. To improve dermatology diagnostic skills in primary care.
7. To conduct focus-group work to determine what dermatology patients want from their consultation and whether these needs vary with disease type and patient age.

Introduction

Skin disease affects people of all ages, it may be acute or chronic, and can have a significant impact on quality of life. Previous publications have stated that 54% of the population is affected by skin disease, and at any point in time 23 to 33% of the population report skin disease which would benefit from medical care.¹ Dermatologists are the specialists who care for adults and children with skin disease and, as a specialty, dermatology is predominantly outpatient based, with necessary access to the wards and the emergency department.

Hospital Episode Statistics (HES) 2018-19 for England alone record 3.3 million outpatient dermatology attendances compared with 1.8 million for rheumatology and 1.8 million for gastroenterology, specialties with similar use of standard systemic therapies and biological agents.² HES for England for the same time period also show dermatology as the specialty with the sixth highest number of outpatient appointments out of over 80 specialties and the highest of the physician specialties.² There are over 30 systemic drugs that are largely specific to dermatology.³

Skin cancers are the UK's most common cancer. Data from 2018-19 show that dermatology delivers more two-week-wait (2ww) cancer referrals than any other specialty.⁴ Suspected skin cancer referrals account for 21% of all 2ww suspected cancer referrals. Dermatology delivers almost all of these consultations, with plastic surgeons seeing the rest.⁴

Year	2WW	Total Breach Days	31 Days	Total Breach Days	62 Days	Total Breach Days
2012-13	210618	10263	35011	561	18290	481
2013-14	245947	12605	37302	670	20423	676
2014-15	290156	20026	40289	979	22720	1035
2015-16	329376	19999	43847	1092	25438	1225
2016-17	371805	24059	46733	1209	27839	1216
2017-18	392912	26897	48366	1224	29192	1270
2018-19	469575	34913	53304	1486	32913	1558
Grand Total	2310389	148762	304852	7221	176815	7461

NHS England, Cancer Waiting Times Statistics, 2012-2019.⁵

The table above demonstrates that 2ww referrals for skin cancer have more than doubled from 2012-2019. Referrals for suspected skin cancer dominate dermatology outpatient services. However, the diagnostic breadth for the specialty is vast, reflecting the fact that the skin is the largest organ in the body, with over 4,000 described diagnoses. Diagnostic uncertainty drives anxiety, and symptoms such as pain and itching are poorly tolerated by patients.

Healthcare in general is faced with an increasingly older population with accruing comorbidities. The *NHS Long Term Plan* acknowledges this and suggests outpatient reform, working with allied healthcare professionals and technology to optimise patient care.⁶

Dermatology services and the NHS Long Term Plan

The RCP report *Focus on Physicians 2018-19* paints a bleak picture of a national shortage of consultants across all specialties. The report shows that dermatology, like other specialties, is unable to fill a particularly high proportion of advertised consultant posts across England and Wales.⁷ This is reflected again in the data obtained in 2019 by the All Party Parliamentary Group on Skin via Freedom of Information requests to NHS Trusts in England⁸, showing a dearth of Dermatology Consultants over large geographic areas. Even Trusts in major cities, including London, are unable to fully recruit Consultant Dermatologists.

The introduction by the Department of Health in 2000 of the rapid access scheme initiating two-week wait (2ww) referrals for suspected cancers has disproportionately affected dermatology services due to the high prevalence of skin lesions. These national standards mandate that 93% of patients with suspected melanoma and squamous cell carcinoma must be seen face-to-face by the secondary care dermatology team within two weeks of referral and 85% must receive definitive treatment within 62 days. In addition to the potential negative impact on patient care, Trusts receive financial penalties if these targets are not consistently met and as such this is an important performance indicator receiving high levels of scrutiny at executive level. This, together with a diminished medical workforce and increased patient complexity has, in the last 19 years, forced the evolution of services in advance of the *NHS Long Term Plan*.⁶

This audit shows that dermatology departments have already developed into multi-professional and multi-specialty units, trained and supported by Dermatology Consultants. Reaching the correct diagnosis as soon as possible underpins the best and most cost-effective treatment for patients. This allows the avoidance of unnecessary diagnostic biopsies which only put histopathology services, already stretched and facing workforce issues, under increased pressure. Dermatology outpatient services also provide teaching and training from undergraduate level upwards and to a range of healthcare professionals including doctors, nurses and physician associates. This requires a critical mass of high performing Consultant Dermatologists to orchestrate its delivery and to sustain a multi-professional and multi-specialty workforce.

The British Association of Dermatologists (BAD) is a registered charity whose objectives are to promote dermatology practice, training and research. Its Education Board, in conjunction with other agencies, develops and supports dermatology training for medical undergraduates, allied healthcare professionals (HCPs), primary care physicians and interface specialties, e.g. paediatrics, gynaecology and plastic surgery, in order to upskill the workforce and to help meet the burden of skin disease.

Aware of both the growing pressures on a critical mass of Dermatology Consultants as well as the negative impact of skin disease on patients' quality of life, the BAD has galvanised its focus to safeguard the mental health and wellbeing of both staff and dermatology patients. Working closely with patient groups, the BAD has developed user-friendly online resources to support patients and encourage self-help for the public. In 2019, support programmes were developed and delivered to help retain the current workforce and support less experienced dermatologists. This is now one of the key objectives for the BAD.

Why was this audit completed and how did we do it?

The recent publication of three documents, the Royal College of Physicians' (RCP) report *Outpatients: The future - adding value through sustainability*⁹, the *NHS Long Term Plan*⁶ and the *Interim NHS People Plan*¹⁰, prompted the BAD to form an outpatient services think-tank to consider how findings reported across outpatient services in other medical specialties were applicable to dermatology. The meeting was attended by members of the Clinical Services Committee of the BAD, its officers and leading representatives from Getting It Right First Time (GIRFT), NHS England, the Royal College of Physicians, the Royal College of General Practitioners, the Chair of the Specialty Advisory Committee to the Royal College of Physicians, the British Dermatology Nursing Group, and Undergraduate Teaching dermatology leads. Its purpose was to discuss the key challenges faced by dermatology outpatient departments with respect both to service delivery and training.

Following consultation with relevant stakeholders, a specialty-specific audit was developed (Appendix 1). This was distributed in autumn 2019 to 209 dermatology departments across the four UK nations for completion by their clinical leads or nominated deputy. The audit questions asked departments to benchmark their current dermatology outpatient service and training against the 16 principles of good outpatient care detailed in the RCP document.⁹ It also provided an opportunity to highlight the barriers dermatology departments face when trying to meet them. Additionally, we asked departments to describe initiatives and innovations they had made to improve patient care, and some of these are reflected in the accompanying case studies document.¹¹

The findings presented are from 111 dermatology departments across the UK: England, 89/118 (75%); Scotland, 8/12 (67%); Wales 5/7 (71%); Northern Ireland, 2/6 (33%) and an additional response from Eire (1), and five where neither the country nor the department were recorded. This report summarises their responses with data for individual audit points presented as a bar chart (Appendix 2).

Audit findings

In this document we have synthesised relevant data and present the findings as four key domains, mapped to the RCP's 16 Principles of Care. These are:

- 1. Delivery of care: How are dermatology outpatients services configured to accommodate the needs of patients?**
- 2. Allied working: Do current dermatology outpatients services utilise a multi-professional and multi-specialty workforce to optimise the delivery of patient care?**
- 3. Training: Does dermatology as a specialty effectively optimise its outpatient services to deliver training relevant to patient care at all levels?**
- 4. Staff and patient wellbeing: Do outpatient team members support one another in an environment of sustained pressure? Is there recognition of the importance of treating the mind and skin holistically?**

a. **Organisation and structure**

Five of the principles in the RCP Outpatients report focus on the organisation and structure of referrals and outpatient clinic templates to improve patient satisfaction, quality of care, clinical workload (productivity and efficiency) and value provided.

Principle 1: *“Demand for an outpatient service should be met by available capacity. Capacity should take into consideration fluctuations in demand and staff availability throughout the year.”*

Principle 3: *“Generic referrals should be pooled to minimise waiting times for appointments. Local consultants should review an agreed mix of generic and sub-specialty referrals according to demand.”*

Principle 5: *“Clinic templates should allow for timing flexibility depending on case complexity and the needs of the patient. They should allow a realistic timeframe to conclude business and avoid frequent unsatisfactory visits.”*

Principle 7: *“All clinical information should be available to both the clinician and patient prior to consultation. That includes notes, test results and decision aids.”*

Principle 12: *“Access to follow-up appointments should be flexible. Patient-initiated appointments should be offered, replacing the need for routine ‘check-in’ appointments.”*

Table 1: NHS England: Main specialty by attendance type

(Main specialty denotes the specialty under which the consultant is contracted.)²

	Dermatology
All Attendances	3,310,268
Attended first appointment	1,074,384
Attended first tele consultation	10,725
Attended subsequent appointment	2,193,917
Attended subsequent tele consultation	25,398
Attended but first / subsequent / tele unknown	5,844
Percentage of all attendances	3.4%
Follow-up attendances for each first attendance	2.0

Clinic appointments

In dermatology outpatient departments, appointments are segregated into new and follow-up slots. Appointments are further divided into: general dermatology, two week waits (2ww), and more specialised (tertiary level) services, delivery of which may require post-CCT specialty training. Follow-up appointments may include necessary investigations and treatments such as skin biopsy, contact dermatitis investigation and phototherapy. Day-case and Mohs micrographic surgery are coded separately.

Restrictions on waiting times for new patient appointments are influenced by government targets for general dermatology referrals and 2ww pathways, which compete for available resource. Many skin diseases are associated with widespread inflammation and associated morbidity. This means a patient may need urgent access to secondary care dermatology services at any time from hospital-based or community settings.

In response to this, the survey demonstrates that 41% of sites offer a same day face-to-face consultation for urgent cases from Monday to Friday but only 15% offer this seven days a week. Patients can develop urgent skin disease at any time and may present on the wards and to the emergency department as well as via primary care. Some sites use teledermatology for remote support of patients on the wards.¹¹

Clinic slots and equity of access according to diagnosis

Most departments (85%) report a fixed template for both new patient and follow-up visits. The greatest flexibility is prompted by demand for 2ww wait slots for suspected skin cancer. Respondents feel that this flexibility was driven by government 2ww targets and their attendant breach penalties. More than half (53%) of departments report that additional 2ww slots or clinics are made available whenever demand increases. Two thirds (66%) of respondents feel that Trusts prioritise 2ww wait referrals, sometimes to the detriment of follow-ups and patients with inflammatory skin disease. Only 15% of sites feel that patients have equity of access regardless of diagnosis, the priority otherwise given to 2ww over general referrals and new patients over follow-ups.

Considerations for 2ww referral data

The two-week wait conversion rate (TWWCR) is the percentage of urgent suspected skin cancer referrals that are confirmed as cancer. A study of data from across England from 2009-10 found that the TWWCR for skin cancer ranged from 4.6% to 13.2%, meaning that between 88% and 95% of referrals for suspected skin cancer are found not to be cancerous.¹² Many inflammatory conditions and benign lesions can mimic skin cancers which means that even specialists may be required to monitor or biopsy up to 40% of these referrals. In response to this need, nurses perform biopsy lists for lesions in 66% of departments.

The TWWCR is compounded further by the lack of dermatology training in undergraduate and general practitioner (GP) training. When compared with the conversion rates for other specialties with high referral rates for 2ww referrals in 2010-11, bowel cancer is 5.8% and breast cancer is 9.3%.¹³ In comparison, the TWWCR for lung cancer is 25.5%, which may be more accurate due to changes on chest x-rays.¹³ Targets for 2ww referrals are not in place in Scotland, but referral for suspected skin cancer still dominates the case mix. The Scottish

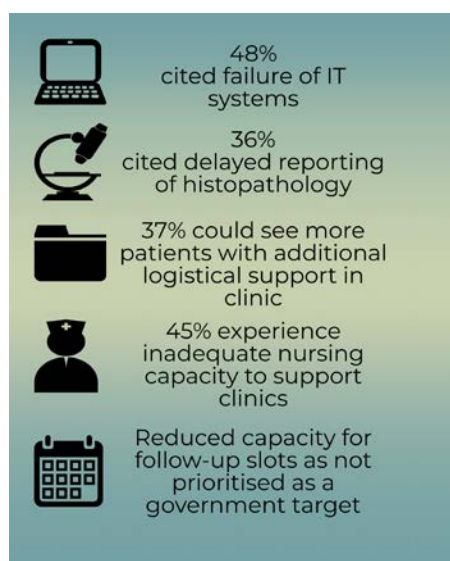
Access Collaborative, a government initiative, is focussed on improving waiting times for patients with skin lesions.¹⁴

Maximising resources to allow rapid access and treatment

In order to ensure that patients are seen as soon as possible by a relevant healthcare professional, 83% of departments pool general referrals. Some departments (53%) have separate waiting lists for more specialised services and investigations, ensuring that the patient is seen first time by the most appropriate person to help them. For example, phototherapy is a treatment largely delivered by nursing staff, and Mohs surgery is a post-CCT competency, so it is essential that patients are triaged to appropriate waiting lists in order to deliver care efficiently. Doctors and nurses are able in departments to flip between secondary and tertiary care services according to demand.

Only 24% of sites report being able to adjust time slots according to complexity, limited largely by the capacity issues, with a general tendency to overbook rather than alter clinic slots which would affect the availability of 2ww slots. Aware that patients require more urgent access for disease flares, 61% of sites report offering open appointments to facilitate this. However, 39% of sites feel that the volume of patients is too high to offer open appointments, as clinics are already largely overbooked and run late. In acknowledgement of patient need, 46% of sites specifically hold a list of patients' contact details so that they can be offered an earlier appointment if one becomes available.

Access to referral documentation is good, with 90% of sites reporting that a referral letter is generally available for each patient and 68% of respondents reporting access to a full set of notes, either paper or electronic.



Overbooked clinics which run late are increasingly the norm, affecting 53% of reporting sites, in contrast to 57% reported by the RCP document of medical specialties across the board.⁹


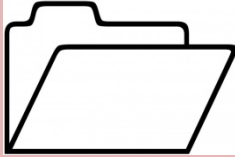

A number of factors are cited as contributing to clinic delays. 48% state that IT systems frequently cause problems and 37% say they would be able to see more patients if more clinic staff were available to support with logistical issues. Incomplete investigations such as delayed histopathology reports (36%) and lack of ancillary staff and follow-up slots also cause inefficiencies and overbooking.

Steps to minimise clinic visits

The RCP document states that across all medical specialties, 20% of pensioners feel worse after they have visited an outpatient department due to the stress of the journey.⁹ 28% of doctors across all medical specialties feel that an alternative to a face-to-face consultation might be appropriate.⁹ We were unable to ascertain from this audit whether this was relevant for dermatology patients and as such it is a qualitative piece of work the BAD intends to do in the future.

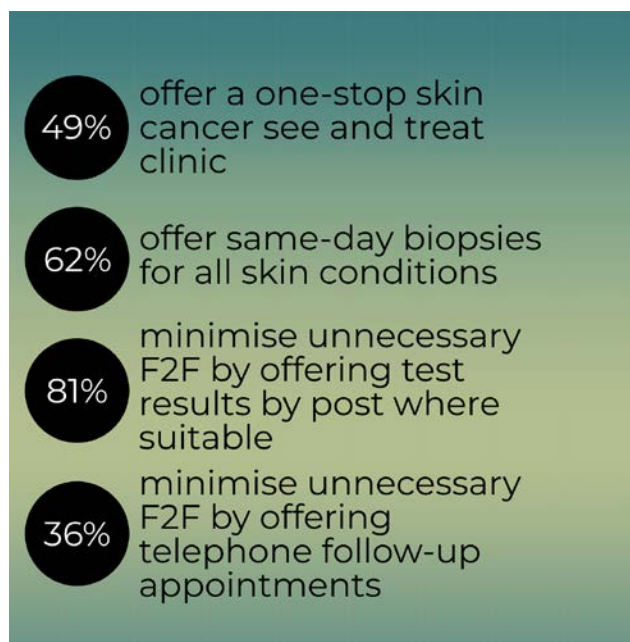
Whilst most initial referrals to dermatology still occur as face-to-face consultations, steps have been taken to minimise both referral to secondary care and subsequent follow-up visits.

The RCP document divides consultations into an initial visit, first follow-up and routine follow-up, as shown below:⁹

		
New patient appointment	Initial follow-up	Routine follow-up
1. Specialist opinion	1. Discuss investigation results	1. Monitor treatment
2. Diagnosis	2. Perform a procedure	2. Detect deterioration
3. Examination	3. Promote healthier lifestyle	3. Prevent admission
4. Initiate investigations	4. Safety net to ensure results reviewed	4. Meet patient expectations
5. Review following discharge or prevent admission		5. Maintain patient access to secondary services

The audit shows that many dermatology departments are already combining the new and initial follow-up consultations. This is achieved in several ways: redirecting the routine follow-up to primary care or remote services using telephone consultation, writing to the patients with results or implementing teledermatology.

Nearly half (49%) of sites offer a one-stop skin cancer see-and-treat clinic.



These measures reduce patient stress by commencing skin cancer management as soon as possible. 62% offer same-day biopsies for all skin conditions.

Test results such as histology are, where possible, routinely sent to the patients to minimise unnecessary face-to-face-consultation in 81% of responding sites. 36% of sites offer telephone follow-up appointments from a doctor or nurse, instead of a routine face-to-face consultation; these types of appointment are particularly useful for patients stable on

standard systemic and biological therapies where there are no shared-care arrangements in place with primary care.

Helplines

Dermatology outpatient services deliver a wide range of specialised investigation and surgical procedures. The relative lack of expertise outside the specialty means that in order to support patients in the community many departments give patients telephone contact information for phone lines, generally staffed by dermatology nurses. The audit demonstrates that 78% of sites provide patients with details of telephone helplines and in half there is a reported explanation about the expected response time. 16% of sites report having insufficient staff to support a helpline at all.

Secretaries cannot discuss medical information; only specialist nurses... Despite having a phone line and CNS nurses, the staff is too small to deal with the volume of requests.

b. **Alternative consultation methods**

Principle 2: “Interventions to reduce new patient demand should be targeted at all referral sources. They must not deter necessary referrals or damage professional working relationships.”

Principle 9: “Alternatives to face-to-face consultations should be made available to patients and included in reporting of clinical activity.”

As reported by RCP, the charity Age UK found that a fifth of pensioners who attended an outpatient appointment (across any medical specialty) in the past year reported feeling worse afterwards because of the stress involved in the journey alone.^{9, 15}

Dermatology has already developed several ways of helping patients without having to bring them to clinic:

- Teledermatology for both new and follow-up patients of all types and ages
- Advice and Guidance via e-referral and telephone helplines
- Writing to patients with results of tissue biopsies and blood tests
- Telephone follow-up clinics for those patients on standard systemic agents with stable disease

A growing number of sites (12%) offer teledermatology to triage to an appropriate service and 33% of sites report offering a teledermatology opinion for general dermatology consultation advice in lieu of an initial face-to-face consultation. Almost one in five (18%) offer teledermatology for paediatric services, and a similar number (16%) offer teledermatology for acute patients and ward referrals. In some instances, this means that advice and guidance can be given, avoiding an outpatient consultation. In others, referrals can be triaged more effectively, for example straight to phototherapy or biopsy services. The system of teletriage is emphasised in the *NHS Long Term Plan*.⁶

Whilst teledermatology services are expanding, they are not universally available. Barriers documented in the audit include:

- Primary care needs to take adequate images for the service and they often are not resourced to do so
- Teledermatology, teletriage and virtual clinics need to be included as part of the general consultant job plan and this is currently not routine practice
- Hospital IT systems are frequently cited as limiting effective teletriage

Virtual clinical activity occurs when a face-to-face consultation is replaced with communication via letter or telephone, for example, to give results, diagnosis, medication changes, or answer patient queries. It is important that all non-face-to-face patient care is included under virtual clinical activity in job plans, rather than under administrative time. Currently only 9% of sites capture this clinical activity in this way. Non-face-to-face clinical activity also includes telemedicine clinics, telemedicine triage and electronic Advice and Guidance.

Medical photography is a key part of patient care for both skin lesions and rashes

Access to good quality medical photography is needed to provide safe and effective dermatology care. The NICE guidance for skin cancer¹⁶ advises the use of photography to monitor a borderline lesion rather than removing it. Medical photography is mandatory for many departments adopting a wrong site surgery protocol to avoid never events.

Ideally, clinical photographs should be taken by experienced medical photographers in medical illustration departments.¹⁷ Only half of departments report the availability of medical photography on site and even fewer when the clinics are in the evenings or at weekends. Many clinics report initiating their own processes, such as using mobile phones to take photos or requesting patients photograph themselves and uploading these images onto the patients' electronic records. These systems need standardisation to ensure systems are encrypted and comply with data storage guidelines, and to promote a sufficient standard of image quality. To this effect, in 2017 the BAD published UK guidance on the use of mobile photographic devices in dermatology which provides healthcare professionals with a clear understanding of their responsibilities when capturing and transferring such images.¹⁷

c. Treating patients as partners

Principle 4: “All outpatient care pathways should aim to minimise disruption to patients’ and carers’ lives.”

Principle 6: “Patients should be directly involved in selecting a date and a time for an appointment. That can happen either in person, via telephone or electronically.”

Principle 8: “Patients should be fully informed of what to expect from the service prior to appointments. That includes the aim of the appointment and expected waiting times.”

Principle 10: *“Patients should be supported and encouraged to be co-owners of their health and care decisions with self-management and shared decision-making.”*

Principle 11: *“Patients and community staff should be able to communicate with secondary care providers in a variety of ways, and know how long a response will take. This aids self-management, and provides a point of contact for clarification or advice regarding minor ailments.”*

Principle 14: *“Letters summarising a clinical encounter should be primarily addressed to the patient, with the community healthcare team receiving a copy”*

“All outpatient care pathways should aim to minimise disruption to patients’ and carers’ lives” is the most all-encompassing of the principles contained within the *Outpatients: The future - adding value through sustainability* report.

Integral to meeting this objective is involving patients in their care. National surveys tell us that over 40% of people want to be more involved in decisions about their care.^{18,19} At its foundation is patient empowerment to choose a clinic time which is convenient and accommodates other commitments, such as work and family. This principle is a paramount first step in personalising care to the needs of the patient. Allowing patients to select the date and time of their appointment not only minimises disruption to that individual, but also to the healthcare provider, through reduction of cancelled or missed appointments and rescheduling.

While this is not yet universal across the UK, in part due to the absence of Choose and Book systems in Wales, with the implementation of e-RS in 2015 it is encouraging that two-thirds of respondents (66%) give patients a choice of an appointment, rather than allocating the patient a designated appointment time. This is variable between hospitals but is mainstream practice for most dermatology departments. Despite the mandate that e-RS must be utilised for all new GP to consultant referrals from October 2018, alternative bookings systems remain in place largely due to functional limitations in IT.

Half of sites (52%) report that patients can book their appointment via an e-referral system, although this system is currently only available for new appointments.

40% of respondents report that patients can experience problems accessing booking services by phone, which reflects staffing issues. 15% report problems accessing IT.

Out-of-hours clinics

Research showing the clinical benefits and service quality improvements from providing NHS services on a seven-day-a-week basis²⁰ predominantly relates to acute and emergency care. However, the four main drivers for seven-day services (reducing mortality, increasing hospital efficiency, providing easier access to NHS services, and ensuring patients receive the same standard of care regardless of the day of the week) are applicable more broadly. Due to a

lack of dermatology training amongst the general healthcare workforce, the provision of urgent dermatology care lies with acute secondary care Trusts.

Many patients, due to work or personal commitments, prefer to be seen out-of-hours for routine referrals. Several sites (14%) report offering evening and weekend clinics. The types of patients seen in these settings are driven by limited access to necessary ancillary services, such as phlebotomy and pharmacy.

- Many respondents stated that phlebotomy (44%) and pharmacy (40%) are not available in the evening, restricting the types of patients that can be seen out-of-hours
- 48% of sites report that out-of-hours clinic provision is limited by a lack of nursing, admin or photography services

Patient information prior to the appointment

83% of clinics report that patients receive written information prior to their appointment, and half provide patients with specific information tailored to their clinic type. 25% of sites report that the information sent out to the patient was often incorrect due to administrative failure to understand the diverse nature of dermatology services. However, audits of documentation given to patients prior to their appointment only occur in 10% of clinics. This is a gap which could potentially be filled by the BAD Clinical Services Unit.



97% routinely source information leaflets for patients



88% signpost patients to web based resources



90% make every attempt to engage patients in decision making and record this in the notes



83% send written information to patients prior to their appointments

Patient experience, as advocated by the *Institute of Medicine and the NHS Outcomes Framework*, should be one of the pillars of quality in healthcare alongside patient safety and clinical effectiveness. There is strong evidence linking the patient experience and adherence to the recommended medical treatment,²⁰ with positive associations between the quality of clinician-patient communication and compliance with the management plan. In one

meta-analysis, in 125 of 127 studies analysed, the odds of patient adherence were 1.62 times higher where physicians had communication training.^{21,22}

97% of clinics report compliance with this standard, as patients are routinely given information leaflets about their condition and treatment, and 88% receive signposting to relevant web-based resources where additional patient information can be obtained. 91% of sites report that every attempt is made to involve patients in decision-making about disease management and that this is recorded in the patient's notes.

We audit our work to check compliance with published standards pertaining to patient engagement.

LAUNCHED IN 2019.

THE BAD'S NEW PATIENT HUB

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Dermatology is fortunate to have access to a range of peer-reviewed, clinically accurate patient information resources. Those created by the BAD are devised with public / patient involvement and span a variety of formats including printed materials, video guides and websites. The emphasis is to empower patients with knowledge of the causes of their disease, as well as available treatment options and preventative measures. These tools are regularly used as an aid to support shared decision-making in clinic, and as an additional reputable and reliable resource for the patient. Information can be found via the hub www.skinhealthinfo.org.uk, which houses an A-Z of patient information leaflets, video guides on how to apply a range of topical treatments, links to plain

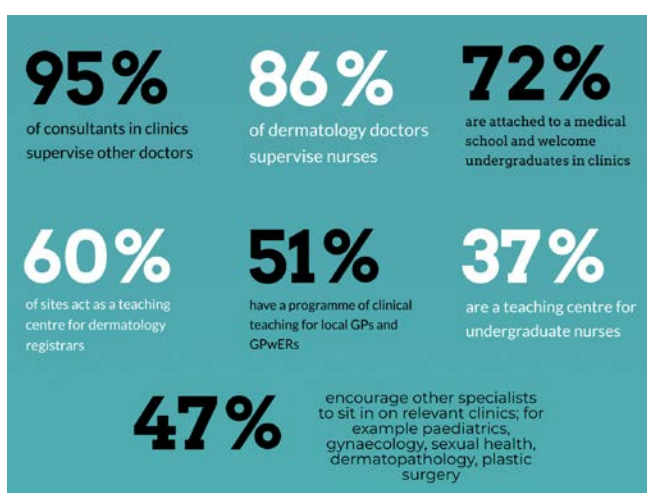
language summaries of research, links to other websites such as www.acnesupport.org.uk, a jargon buster and much more.

Principle 14 states that letters summarising a clinical encounter should be primarily addressed to the patient, with the community healthcare team receiving a copy. Whilst written communication was deemed to be important, respondents felt that correspondence following initial consultations should be primarily addressed to the referring healthcare professional, in dermatology almost always the GP, with a copy to the patient, rather than vice versa as the audit suggests. However, the respondents felt that the reverse should be true when patients were being informed about their test results and cancer treatment.

Principle 15: “All outpatient services should offer a supportive environment for training.”

Nearly one-quarter (23%) of consultations in primary care are skin related.²³ This does not yet translate to delivery of dermatology training at undergraduate level, for foundation doctors or for GPs. In one in ten medical schools, it may be possible to complete undergraduate education without ever receiving any formal dermatology-focused education.²⁴ As a result, referral rates to secondary care have remained high, due to lack of confidence around the diagnosis and driven by a fear of missing skin cancer.

Outpatient services are led by Dermatology Consultants with support from their registrars and a multi-professional workforce. 95% of sites report that Dermatology Consultants supervise other healthcare professionals. Dermatology specialty training is delivered almost exclusively via outpatient clinics resulting in specialty registrars making a significant contribution to service delivery in preparation for the consultant role. A typical dermatology whole-time-equivalent registrar will deliver 7.5 to 8.5 four-hour (3.5h in Wales) clinical / surgical sessions per week.²⁵ 60% of responding sites in this audit train registrars.



In a typical outpatient clinic, Dermatology Consultants will oversee the training of specialty registrars, GPs, nurse specialists and practitioners, foundation and IMT doctors, medical students and, more recently, physician associates. The time to meet service demands competes with capacity for teaching. Dermatology departments attempt to accommodate both, but this remains a constant challenge.

71% of respondents cite a lack of clinic space and clinical time as a barrier to delivering more teaching in the clinics. In part response, some departments such as Bristol have developed methods for teaching and delivering teletriage.¹¹

72% of departments train medical students, 37% are training centres for undergraduate nurses and 8% offer training for physician associates. 47% encourage doctors from other specialties such as paediatrics and sexual health to sit in on clinics. Just over half of departments (51%) have a programme of clinical teaching for local GPs and GPwERs.

Our hospital is half the size it needs to be and we do not have enough clinic rooms / consultants to allow people to sit in as much as we would like.

Principle 13: “All care pathways should optimise their staff skill-mix. Allied medical professionals and specialist nurses should be an integral part of service design.”



The delivery of dermatology outpatient care alongside other specialties is also growing.

One in four respondents (24%) work alongside other specialists such as rheumatology, paediatrics or plastic surgery, so that joint consultations can take place. This provides an opportunity for mutual learning with the benefit to the patient of a single outpatient consultation.

Dermatology nurses have always been an integral part of dermatology service design and delivery. In line with the *NHS*

Long Term Plan, most outpatient departments train and supervise the nursing staff to deliver core services such as phototherapy and deliver outpatient clinics supervised by a Dermatology Consultant. Year-on-year, dermatology departments prescribe an increasing number of high cost drugs or those which the MHRA advise be monitored in secondary care, such as isotretinoin. Once patients are stable, these can be safely monitored by nurses in clinics with consultant support. This is now routine practice in 75% of the responding departments.

21% of departments report that clinics are delivered by other healthcare professionals additional to nursing staff, Dermatology Consultants and doctors. Most respondents cite a lack of trained specialised nurses as the main barrier to fully optimising a multi-professional workforce. As many clinics are severely overstretched, finding time to devise and implement new systems involving other specialities within the hospital is reported as challenging.

Principle 16: “All outpatient-related services should promote wellbeing for staff and patients.”

Dermatologists have always been aware of the impact that skin disease has on the wellbeing of their patients. There is a significantly higher prevalence of clinical depression (10.1% vs. 4.3%), anxiety disorder (17.2% vs. 11.1%), and suicidal ideation (12.7% vs. 8.3%) among patients with common skin diseases compared with controls.²⁶

17.3% of psoriasis patients have experienced suicidal ideation; 67.6% of these patients experience suicidal ideation due to their skin condition. Such results identify a major additional burden on those suffering with skin disease and have important clinical implications.²⁶

Formal psychology support for patients is very difficult to source, with few Psychologists, and all having long waiting times. The ideal standard would be a Psychologist attached to the Dermatology department for the large burden of Psychological disorders experienced by patients.

A survey of Consultant Dermatologists revealed that 17% of dermatology patients need psychological support to help with psychological distress secondary to a skin condition. 14% of dermatology patients have a psychological condition exacerbating their skin disease and 85% of patients have indicated that the psychosocial aspects of their skin disease are a major component of their illness.²⁷

I am actively involved in training opportunities around motivational interviewing to trigger change in behaviour for patients with skin disease (holistic patient care).

It is probably not surprising, therefore, that awareness of the importance of emotional support for patients amongst consultants is high. 89% of consultants signpost their patients to support sites for the psychological burden of skin disease, including free online resources developed by the BAD such as Skin Support (www.skinsupport.org.uk). However, 71% of our respondents report a lack of psychology support available for their services.

The Skin Support site acts as a hub for psychological assistance specifically catering to people with skin disease. It brings together a vast range of materials in a centralised, easily accessible location, and the BAD creates bespoke materials to address gaps in information provision. The self-help materials are a combination of leaflets, audio files and links, addressing an array of issues including anxiety, depression, social isolation and reduced self-esteem. The site also features in-depth information on over 100 skin disorders, including prevention and treatment advice, to educate patients on their disorder and to encourage compliance with recommended treatment options. Additionally, it provides links to resources specifically created for carers and young people, to help families and friends better understand the difficulties associated with living with a skin condition.

Much focus has been directed in recent months on the importance of maintaining the wellbeing of healthcare staff, in a rising culture of burnout and 'moral injury'. Burnout is a constellation of symptoms which include exhaustion, cynicism, and decreased productivity, while moral injury describes the challenge of simultaneously knowing what care patients need but being unable to provide it due to constraints that are beyond our control.²⁸

Encouragingly, 83% of departments actively try to provide a supportive team culture, and 57% provide mentoring to trainees and new consultants. There is a lack of comparators published in the current literature for other specialties. 61% of departments report that staff make a concerted effort to support each other and routinely meet socially.

Throughout the audit several factors have emerged which might conceivably contribute to stress and anxiety for both patients and doctors:

- Late running of clinics due to overbooking of patients
- Clinic templates not allowing sufficient flexibility for patient complexity
- Staff shortages in dermatology and dermatopathology
- Inefficient IT and booking systems for patient appointments
- Inadequate staffing to support phone lines for bookings, advice and clinic changes
- Priority for 2ww patients compared to those with chronic skin disease
- Lack of resources including space, workforce, and out-of-hours pharmacy and phlebotomy

Secondary care dermatology departments currently deliver the highest number of outpatient consultations of all the physician specialties. In addition, skin cancer is the commonest of all cancer in the UK, with a doubling of referrals for suspected cancer in the last five years. Almost all of these are assessed and treated in dermatology. In the last 15 years, advances in the treatment of severe inflammatory disease also means that there is a year-on-year increase in the use of high-cost systemic therapies, all of which require dermatology expertise in their prescription and monitoring.

This audit has demonstrated a number of innovations implemented by dermatology departments across the UK in an attempt to meet the inexorable rise of service demands. Examples of good practice include expansion of the role of allied healthcare professionals, particularly nurses, collaborative working with primary care, and harnessing technology. Dermatology as a specialty has evolved into a dedicated multi-professional and multi-specialty workforce well on track to meet the objectives detailed in the *NHS Long Term Plan*. It is also clear that dermatology departments continue to make a significant investment in teaching and training to promote an effective and sustainable multidisciplinary workforce.

The RCP outpatient document⁹ considers the concept of value in the workplace. It states that:

“Within the NHS, value refers to the allocation of resources to the most effective care which is free at the point of delivery. Using value as an organising principle for commissioning services increases the efficiency of resource allocation – as delivering high-quality but low-value services consumes more resource than moderate quality but high-value services. Value-based decisions take into account not only what activity can be minimised but also what can be avoided. This prevents unnecessary waste for the patient and provider, such as patient travel and multiple attendances.”

This audit shows that many dermatology outpatient services provide a high throughput of often complex patients, using effective triage techniques and a multi-professional workforce. **95% of consultants supervise, teach and train on a daily basis, providing leadership, and educational and clinical governance in order to support and develop heterogenous service teams.** These practices are in line with NHS future plans to maximise the skill set of the entire healthcare workforce to deliver patient care.

This audit has shown that despite all these efforts, departments describe clinics as routinely overbooked and running late. **Priority is given to new patients and 2ww wait referrals, leading to an inequity of access** for follow-up patients, or those with severe inflammatory skin conditions requiring an opinion from a dermatologist.

Many of the drivers for enhanced efficiency fall largely beyond specialty control.

These include **inadequate hospital infrastructure such as clinic room space and support services**, which significantly impacts on efficiency, both in- and out-of-hours. Clinic delays are the norm, for reasons that include de-prioritisation at a national level of follow-up patients and those with general dermatology conditions, and inadequate hospital IT systems.

Nonetheless, dermatology departments are embracing technology to minimise face-to-face consultations and to support the holistic needs of its patients. The supporting case study document¹¹ demonstrates effectiveness

in reducing the need to attend secondary care for suspected skin cancer, and for general dermatology in adults and children. Pathways are also in place to teach and train in this technology for the future workforce. However, **this model is reliant on a critical mass of consultants to continue to meet these demands and deliver high-value services** in their current form. This audit highlights areas where improvements are still needed.

The general lack of competency in dermatology outside the specialty makes an argument for an expert dermatology opinion for all new patients. This minimises the need for unnecessary diagnostic testing and treatment, in line with the ethos of Getting It Right First Time, and is particularly relevant given the lack of histopathology resources.

Dermatology services are good value, functioning as a pyramidal structure with a number of variable components and delegations strategies, with the consultant accountable for patient care and educational governance. The current service model will continue to maximise training opportunities for undergraduates, junior doctors and specialty doctors, as well as several allied specialties and healthcare professionals alike. **The creation of 15 Trust-funded post-CCT fellowship programmes to train in key tertiary areas** also provides further support to secondary care services, whilst developing tertiary level expertise. **Training capacity at all levels, as with service capacity, however, is restricted by two key factors: clinic space and specialist time.**

This is the first specialty to audit against the RCP report *Outpatients: The future - adding value through sustainability*. It represents a significant percentage of dermatology departments in England, Scotland and Wales, but less so in Northern Ireland.

Overall, the audit has provided a useful tool against which to benchmark current dermatology practices and explore areas for future service improvement.

Summary of key audit findings

Audit point	Compliance	Comment
<p>1. Demand for an outpatient service should be met by the available capacity. Capacity should take into consideration fluctuations in demand and staff availability throughout the year.</p>	<ul style="list-style-type: none"> • Priority is given to 2ww referrals at 66% of sites • 15% of sites have equity of access for all patient types • 41% of sites offer urgent face-to-face consultation, Monday to Friday, and 15% at weekend • 29% of sites have dermatology appointments which can be adjusted according to complexity • At 53% of sites slots are made available for 2ww when demand increased 	<ol style="list-style-type: none"> 1. Equity of access required for general dermatology and follow-up patients required 2. Equity of access required for urgent skin conditions 7-days-a-week 3. Increased flexibility in clinic slots desirable to reflect patient complexity 4. Technology can be used to triage more effectively and increase capacity for all patient types
<p>2. Interventions to reduce new patient demand should be targeted at all referral sources. They must not deter necessary referrals or damage professional working relationships.</p>	<ul style="list-style-type: none"> • 12% of dermatology services report teletriage 	<ol style="list-style-type: none"> 5. Due to year-on-year rising referrals for 2ww and low conversion rates to cancer (in line with breast and colorectal cancer), effective triage via teledermatology could reduce the burden on secondary care 6. Increased support for teledermatology service from primary care are required 7. Better IT systems in hospitals are needed 8. Reflection of teletriage as part of the consultant job plan is required
<p>3. Generic referrals should be pooled to minimise waiting times for appointments. Local consultants should review an agreed mix of generic and sub-specialty referrals according to demand.</p>	<ul style="list-style-type: none"> • 83% of departments meet this standard for pooling general referrals • 50% report pooling of specialised referrals between colleagues with appropriate training 	<ol style="list-style-type: none"> 9. Generally good compliance with pooling of referrals where appropriate
<p>4. All outpatient care pathways should aim to minimise disruption to patients' and carers' lives.</p>	<ul style="list-style-type: none"> • 66% report offering a choice of new patient slots during working hours • 14% offer slots in the evenings and 14% offer slots at weekends • 40-44% report that a lack of pharmacy and phlebotomy are limiting factors after hours • 48% report out-of-hours clinic provision limited by a lack of nursing, admin or photography services 	<ol style="list-style-type: none"> 10. Patient choice and flexibility is largely restricted to new patients rather than follow up patients 11. Clinic choice, particularly after hours, is limited by availability of ancillary services 12. Follow-up patients are often ill requiring access for disease flares, drug complications or cancer 13. Accessing these pathways needs improvement

<p>5. Clinic templates should allow for timing flexibility depending on case complexity and the needs of the patient. They should allow a realistic timeframe to conclude business and avoid frequent unsatisfactory visits.</p>	<ul style="list-style-type: none"> • Flexibility around the clinic template is limited. 85% have fixed slots for new patient and follow-up patients • Most slots are only flipped to accommodate 2ww referrals • 52% the clinics are routinely overbooked and run late 	<p>14. Clinics run late. Factors relating to this are overbooking, particularly follow-up slots, failing IT, lack of nursing and admin support and delayed histology reporting</p> <p>15. Maximising opportunities to follow-up patients remotely may reduce clinic overbooking and reduce visits to hospital where possible</p>
<p>6. Patients should be directly involved in selecting a date and time for an appointment. That can happen either in person, via telephone or electronically.</p>	<ul style="list-style-type: none"> • 52% of sites offer patients direct e-RS booking • 14% for surgery slots • 40% report patients as have difficulty accessing services • 75% of sites send patients reminder texts about appointments 	<p>16. Clear priority given to new patients rather than follow-up patients in most Trusts when booking appointments</p> <p>17. Patients often agree to follow-up during their consultation but the available clinic times cannot accommodate the request</p> <p>18. Hospital support systems, both administrative and IT, are unable to provide adequate support in many sites to facilitate patient access for appointments</p> <p>19. e-RS is currently only available in primary care and we suggest ways of optimising these services for patient booking</p>
<p>7. All clinical information should be available to both the clinician and patient prior to consultation. That includes notes, test results and decision aids.</p>	<ul style="list-style-type: none"> • 90% of sites receive referral documentation • 48% report failing IT systems for clinic delays • 36% report delayed histopathology for delays in patient care 	<p>20. Most sites have referral letter documentation for new patients</p> <p>21. Results, particularly histopathology results are often delayed. Any steps to minimise pressure on histopathology services should be encouraged. i.e. triage for expert opinion where possible to minimise the need for biopsy</p>
<p>8. Patients should be fully informed of what to expect from the service prior to appointments. That includes the aim of the appointment and expected waiting times.</p>	<ul style="list-style-type: none"> • 83% of sites provide information about their clinic appointment • 50% supply information about specialist appointments (such as patch testing, surgery) • 10% audited receipt of this information • 41% of departments have a directory of services accessible to the public • 25% sites state that incorrect clinic information is often sent out to patients by administrative staff 	<p>22. More sites might wish to develop a directory of service and audit its utility to the patient</p> <p>23. Sites should routinely audit against receipt and utility of preclinic specialist information e.g. patch testing, Mohs surgery, minor procedures, skin cancer two week wait appointments</p>

<p>9. Alternatives to face-to-face consultations should be made available to patients and included in reporting of clinical activity.</p>	<ul style="list-style-type: none"> • 81% of departments write to patients with histology or lab results, where appropriate, rather than arranging an initial follow-up consultation • 36% offer telephone follow-up • 26% offer teledermatology appointments • 9% have relabelled their clinics as virtual • 49% sites offer a one stop see-and-treat service for skin cancer 	<p>24. Significant steps already to minimise face-to-face consultations</p> <p>25. Further development of telephone and teledermatology follow-up consultations is needed</p> <p>26. Triage may allow new patients to be directed more effectively and provide more capacity in secondary care for urgent patients and same-day cancer treatments</p>
<p>10. Patients should be supported and encouraged to be co-owners of their health and care decisions with self-management and shared decision-making.</p>	<ul style="list-style-type: none"> • 97% of sites give patients leaflets about their disorder and treatment options • 88% of sites signpost patients to web-based resources • 91% engage patients in decision-making 	<p>27. Good engagement with this principle</p>
<p>11. Patients and community staff should be able to communicate with secondary care providers in a variety of ways, they should know how long a response will take. This aids self-management and provides a point of contact for clarification or advice regarding minor ailments.</p>	<ul style="list-style-type: none"> • 78% sites provide helplines to patients • 50% sites provide information about how the helpline response should take • 61% of sites offer patients open appointment 	<p>28. Helpline services are well established but their access is limited by appropriately trained nursing staff to support the lines and give appropriate information to patients</p>
<p>12. Access to follow-up appointments should be flexible. Patient-initiated appointments should be offered, replacing the need for routine 'check in' appointments.</p>	<ul style="list-style-type: none"> • 61% of sites offer patients open appointment • Routine appointments for stable disease minimised • 81% patients receive clinic results by letter rather than returning to clinic 	<p>29. Follow-up appointments were not as flexible, or as accessible, as new patient appointments</p> <p>30. Routine check in appointments were minimised using telephone follow-up clinics and writing with results</p> <p>31. Open appointments were offered in some sites</p> <p>32. Telephone helplines were also useful in this context but limited by available resources</p>

<p>13. All care pathways should optimise their staff skill mix. Allied medical professionals and specialist nurses should be an integral part of service design.</p>	<ul style="list-style-type: none"> • 95% consultants supervise others during their outpatient clinic • 86% of responding sites report Dermatology Nurses delivering services under supervision and then specifically: <ul style="list-style-type: none"> • 77% of sites have nurses provide biological therapy clinics • 67% of sites report nurses perform surgery lists • 66% of sites have nurses deliver acne clinics • 57% sites report nurses routinely delivering general clinics • 44% sites deliver paediatric dermatology nursing lists • <1% of sites report not having dermatology nurses delivering care 	<p>33. Allied healthcare professionals, particularly specialised nurses underpin dermatology outpatient services</p> <p>34. Nurses deliver follow-up clinical activity face-to-face and by telephone</p> <p>35. Nurses provide skin surgery service</p> <p>36. They rely on the support of a critical mass of consultant colleagues to train and support them</p>
<p>14. Letters summarising a clinical encounter should be primarily addressed to the patient, with the community healthcare team receiving a copy.</p>	<ul style="list-style-type: none"> • 72% of sites write to the GP and referring doctors, or healthcare professionals, and copy to the patient as routine • 43% of sites give patients a summary of their cancer treatment • Letters detailing results were addressed to the patient with a copy to the GP 	<p>37. Most sites send the initial consultation letter to the referring clinician with the patient copied-in</p> <p>38. Results were sent to the patients with the referring healthcare professional copied-in</p> <p>39. No sites write directly to the patient, after their first consultation, with the healthcare professional copied-in</p>
<p>15. All outpatient services should offer a supportive environment for training.</p>	<ul style="list-style-type: none"> • 95% of sites have consultants supervise and train whilst in clinic • 60% of sites train specialty registrars • 51% sites train GPs and GPwERs • 72% sites train medical students • 37% sites train nursing students • 47% train other allied specialties such as histopathology, rheumatology, paediatrics and plastic surgery • 8% train Physicians Associates 	<p>40. Dermatology is exemplary in the use of outpatients for training at all levels</p> <p>41. Limitations to this are lack of workforce and space</p> <p>42. The senior doctors are providing the service, training and supervision and are a limited resource</p>

<p>16. All outpatient-related services should promote wellbeing for staff and patients</p>	<ul style="list-style-type: none"> • 76% of sites direct patients to websites which provide psychological support for skin disease • 72% report no formal psychology services • 58% provide formal mentorship for new consultants • 84% sites try to positively create a supportive culture 	<p>43. Good compliance with this standard 44. The development of psychological services for people with skin disease would be beneficial</p>
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Dermatology Outpatient Services

RCP Principles for good outpatient care

Following are the 16 principles with criteria set against them. Please tick all that apply to your service. You may then use the free text box to give details of any comments or barriers that you face in meeting these principles. Finally at the end of the survey we would like to hear examples of good practice or improvements which have been helpful in your practice.

1. Principle 1

Demand for an out-patient service should be met by available capacity. Capacity should take into consideration fluctuations in demand and staff availability throughout the year.

As a general principle clinic slot availability is flexible within our department and can be flipped on demand to accommodate clinical need e.g. double slots for complex patients

Demand is only flexible around 2wws - not for other skin disease referrals

2ww slots/clinics are made available whenever demand increases

Clinic slots are not made available for inflammatory skin disease whenever demand increases
We feel there is equal access for all patients in our department throughout the year

The Trust priority is 2wws and in a setting of insufficient capacity, these trump everything else to the detriment of follow up and patients with inflammatory skin disease

Barriers to delivery

2. Principle 2

Interventions to reduce new patient demand should be targeted at all referral sources. They must not deter necessary referrals or damage professional working relationships.

We offer a same day f2f consultation for urgent cases Mon to Fri

We offer a same day f2f consultation for urgent cases 7 days a week

We offer a same day teledermatology consultation for urgent cases Mon to Fri

We offer a same day teledermatology consultation for urgent cases 7 days a week

We offer teledermatology for paediatric services

We offer teledermatology for acute patients and ward referrals

We use teledermatology for 2wws

We use teledermatology for general dermatology

Our local community services (separate to those run by hospital team) triage their referrals

Community triage slows up pathways

We use teledermatology for triage

Our IT systems are not fit for purpose, regularly resulting in clinic delays

Barriers to delivery

3. Principle 3

Generic referrals should be pooled to minimise waiting times for appointments. Local consultants should review an agreed mix of generic and sub-specialty referrals according to demand.

Our department pools referrals (except for tertiary referrals)

Our department does not pool referrals

Sometimes it can be difficult for a tertiary patient to be seen

We have separate sub-specialty waiting lists, e.g. patch testing/mohs surgery

Barriers to delivery

4. Principle 4

All outpatient care pathways should aim to minimise disruption to patients' and carers' lives.

Our department gives patients a choice of appointments during the normal working day

Our department offers appointments in the evening

Our department offers appointments at weekends

Our department cannot get the support needed, nursing, admin, photography to offer out of hours clinics

Our department only offers evening appointments for 2ww referrals

Phlebotomy is not available in the evenings after 5.30 and this restricts the type of patients we can see out of hours

Pharmacy is not available in the evenings after 5.30 and this restricts the type of patients we can see out of hours

We have electronic prescribing

Barriers to delivery

5. Principle 5

Clinic templates should allow for timing flexibility depending on case complexity and the needs of the patient. They should allow a realistic timeframe to conclude business and avoid frequent unsatisfactory visits.

We have a fixed time slot for a new patient

We have a fixed time slot for a follow up patient

Time slots can vary according to complexity

Time slots can vary according to the health care provider

Nurse led clinic slots are longer than doctor led clinic slots

We do not have any nurse led clinics

We have one stop skin cancer see and treat clinics

We can perform same day biopsies and excisions

We have limited surgery capacity and this is prioritised for 2wws

We have parallel clinics for walk arounds and multidisciplinary discussion/instant referral: Plastic Surgery, Rheumatology, etc.

Medical photography is available on site during clinics

If medical photography is not available on site during clinic we use other systems (please describe in the box below)

Medical photography is often closed at lunchtime or closes early. It is never open at weekends

Clinics are overbooked and often run late

Barriers to delivery

6. Principle 6

Patients should be directly involved in selecting a date and a time for an appointment. That can happen either in person, via telephone or electronically.

Patients are offered direct booking via e-RS

For new patient slot

For follow-up slot

For surgery slot

Patients do not have access via e-RS

The department has a clear directory of services on its website

Patients frequently tell us that they have problems booking appointments due to IT access

Patients frequently tell us that they have problems booking appointments due to phone access or similar

Patients get reminder texts for appointments

Don't know

Barriers to delivery

7. Principle 7

All clinical information should be available to both the clinician and patient prior to consultation. That includes notes, test results and decision aids.

Paper based clinical records are available

Online clinical records are available

Investigation results are available online

There is admin support for each clinic

There is nursing support for each clinic

Nurse support is variable, we usually do not have enough nurses to support a clinic

We have a healthcare assistant looking after many clinics and assisting in theatres

Access to a full set of notes, either paper or electronic, is generally available
A referral letter is generally available for each patient
Clinic delays occur routinely due to lack of relevant information such as referral letters, test results etc
IT systems frequently cause clinic delays
I would be able to see more patients in clinic if support staff were available to help with logistical issues
Long waits for histology reporting can delay patient care

Barriers to delivery

8. Principle 8

Patients should be fully informed of what to expect from the service prior to appointments. That includes the aim of the appointment and expected waiting times.

All patients are sent information about their appointment prior to attending
Patients are provided with specific information tailored to their clinic type, i.e. 2ww, patch testing etc
Admin struggle with the complexity of our service so patients do get the wrong letter or clinic location
The documentation given prior to the appointment is recorded on the patients notes and routinely audited

Barriers to delivery

9. Principle 9

Alternatives to face-to-face consultations should be made available to patients and included in reporting of clinical activity.

We offer teledermatology appointments to patients
Telephone follow up appointments are offered from doctor or nurse in lieu of a face-to-face consultation
We have insufficient staff to offer telederm or telephone follow up
Test results such as histology are where possible routinely sent to the patients to avoid face to face consultation
We have virtual clinics for providing test results

Barriers to delivery

10. Principle 10

Patients should be supported and encouraged to be co-owners of their health and care decisions with self- management and shared decision-making.

Patients are routinely given information leaflets about their condition and treatment
Patients are signposted to use web based resources, such as BAD.org.uk, dermnetnz.org, NICE etc.
Every attempt is made to engage the patient in decision making and this is recorded in the notes

Barriers to delivery

11. Principle 11

Patients and community staff should be able to communicate with secondary care providers in a variety of ways, and know how long a response will take. This aids self-management, and provides a point of contact for clarification or advice regarding minor ailments.

Written information is routinely given to patients to phone up help lines; email nurse specialists, secretaries etc., if there are concerns about their treatment

Patients are informed about how long a response from the hospital should take

We do not have the clinical nurse specialists or secretaries necessary to provide such support

Barriers to delivery

12. Principle 12

Access to follow-up appointments should be flexible. Patient-initiated appointments should be offered, replacing the need for routine 'check-in' appointments.

Patients are offered open appointments

Patients contact details are recorded to enable an earlier appointment if available

The volume of patients is too great to offer open appointments

Patients routinely inform us that they cannot get through to admin staff to book an appointment

Barriers to delivery

13. Principle 13

All care pathways should optimise their staff skill-mix. Allied medical professionals and specialist nurses should be an integral part of service design.

Consultant Dermatologists work in clinic and supervise other dermatology doctors

Dermatology doctors work in clinic and supervise general practitioners

Dermatology doctors work in clinic and supervise dermatology nurses

Dermatology registrars routinely deliver clinics

Nurses deliver Leg Ulcer clinics

Nurses deliver skin cancer surgical lists

Nurses deliver postoperative care

Nurses deliver biologic therapy clinics

Nurses deliver phototherapy clinics

Nurses deliver patch test clinics

Nurses deliver acne clinics

Nurses deliver paediatric clinics

Nurses deliver other clinics

Other allied health care professionals deliver clinics

We do not have trained dermatology nurses

We do not have sufficient allied health care professionals

Barriers to delivery

14. Principle 14

Letters summarising a clinical encounter should be primarily addressed to the patient, with the community healthcare team receiving a copy.

It is routine practice for patients to be offered a copy of their clinic letter with GP/district nurse copied in

All cancer patients are sent a cancer treatment summary

We write to the referrer GP and copy the patient when the GP is being asked to initiate an ongoing plan of care

Barriers to delivery

15. Principle 15

All outpatient services should offer a supportive environment for training.

We are a teaching centre for dermatology registrars

We have a programme of clinical teaching for local GPs and GPwERs

We are attached to a medical school and welcome undergraduate in our clinics

We have a PA rotation scheme

We offer taster weeks for FYs

We offer electives to overseas students

We encourage other specialists to sit in on relevant clinics, i.e. paed, plastics, gynae, sexual health, dermatopathology

Consultants are over-stretched with service delivery and cannot always accommodate other specialists or students Lack of clinic space and time constraints are a barrier to delivering teaching in the clinic

We are a teaching centre for undergraduate nurses

Barriers to delivery

16. Principle 16

All outpatient-related services should promote wellbeing for staff and patients.

We are aware of the psychological impact of skin disease on our patients and where possible signpost to support

There is a lack of psychology support available for our services

We encourage a supportive team culture amongst our staff

We provide mentoring to our trainees and new consultants

The department routinely meets socially

Barriers to delivery

Dermatology Outpatient Services

RCP Principles for good outpatient care

Name of person completing this survey

Name of Hospital

Number of dermatology 2 Week Waits seen annually

How many 2 Week Waits are seen annually by your Trust for all specialties?

Which specialty in your Trust sees the highest number of 2 Week Waits

Dermatology Outpatient Services

RCP Principles for good outpatient care

We would now like to hear about the improvements you have made to your services. Please use the free text box below and send any supporting documents to [email]

Please also indicate if you would be happy for your department to be included as a case study of good practice with respect to a service and/or training improvement.

Please provide details below

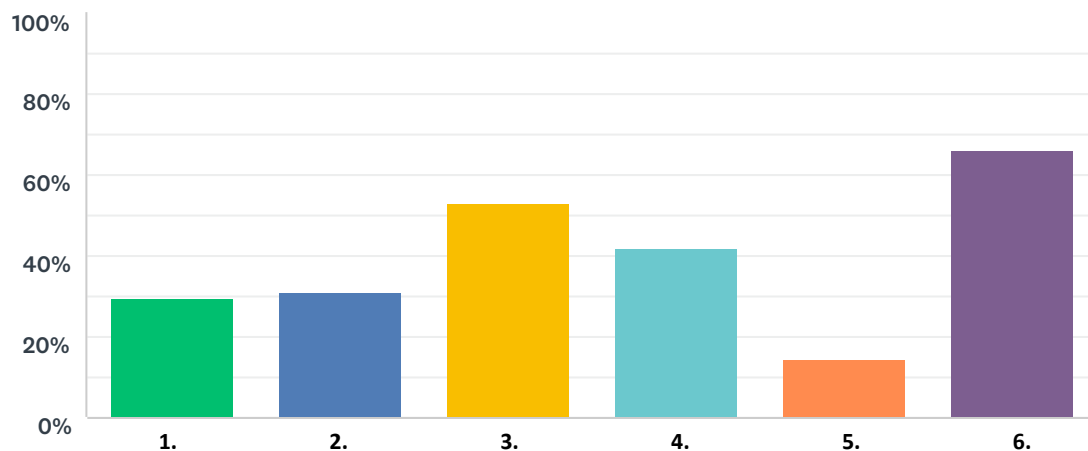
Dermatology Outpatient Services

Thank you

Appendix 2

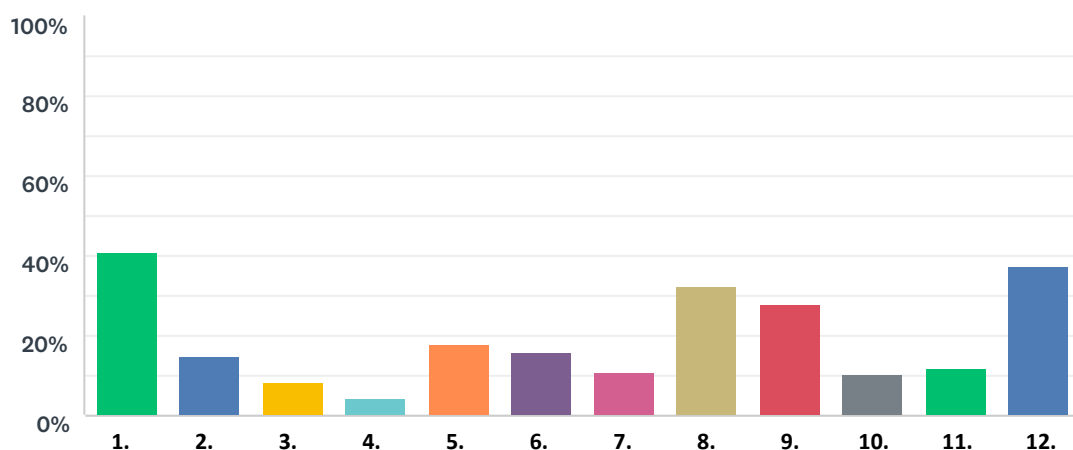
Summary of responses

Principle 1 “Demand for an out-patient service should be met by available capacity. Capacity should take into consideration fluctuations in demand and staff availability throughout the year.”



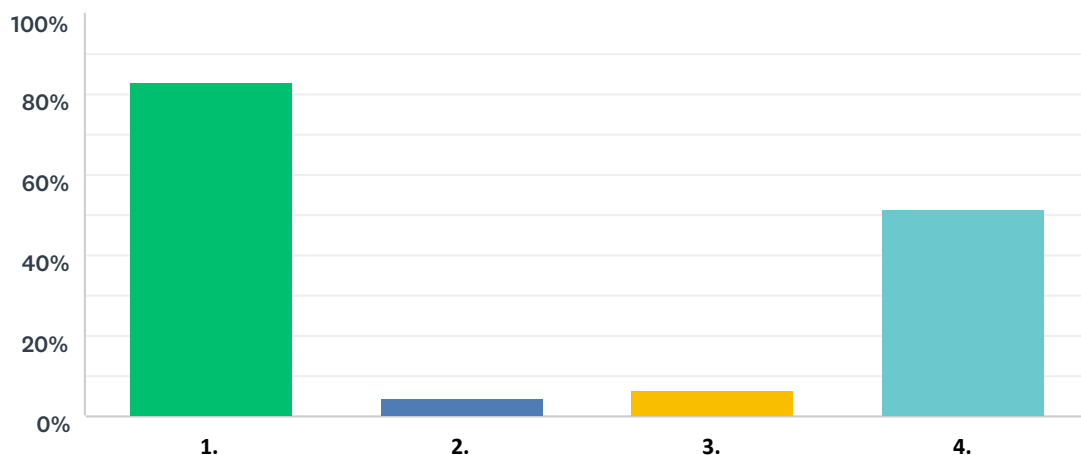
ANSWER CHOICES		RESPONSES	
1.	As a general principle clinic slot availability is flexible within our department and can be flipped on demand to accommodate clinical need e.g double slots for complex patients	29.36%	32
2.	Demand is only flexible around 2wws - not for other skin disease referrals	31.19%	34
3.	2ww slots/clinics are made available whenever demand increases	53.21%	58
4.	Clinic slots are not made available for inflammatory skin disease whenever demand increases	42.20%	46
5.	We feel there is equal access for all patients in our department throughout the year	14.68%	16
6.	The Trust priority is 2wws and in a setting of insufficient capacity these trump everything else to the detriment of follow up and patients with inflammatory skin disease	66.06%	72
Total Respondents: 109			

Principle 2 “Interventions to reduce new patient demand should be targeted at all referral sources. They must not deter necessary referrals or damage professional working relationships.”



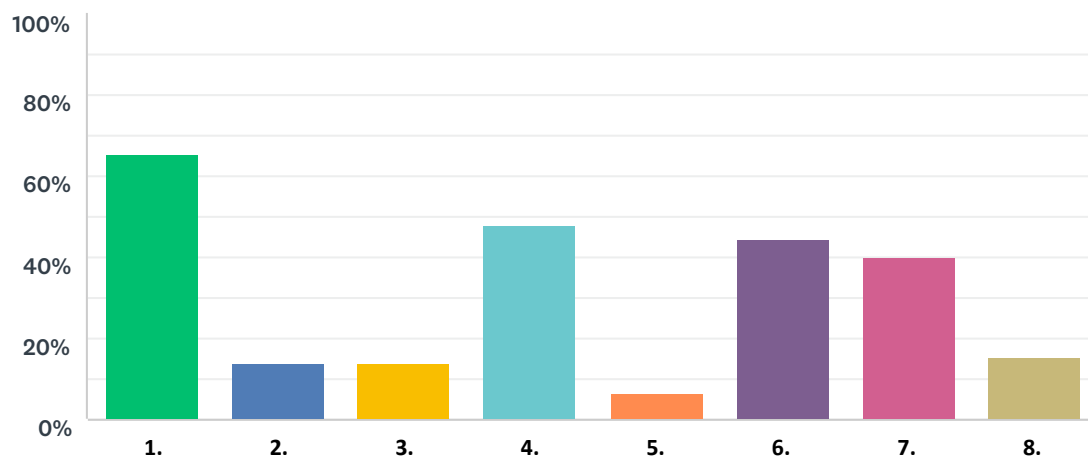
ANSWER CHOICES	RESPONSES	
1. We offer a same day f2f consultation for urgent cases Mon to Fri	41.12%	44
2. We offer a same day f2f consultation for urgent cases 7 days a week	14.95%	16
3. We offer a same day teledermatology consultation for urgent cases Mon to Fri	8.41%	9
4. We offer a same day teledermatology consultation for urgent cases 7 days a week	4.67%	5
5. We offer teledermatology for paediatric services	17.76%	19
6. We offer teledermatology for acute patients and ward referrals	15.89%	17
7. We use teledermatology for 2wvs	11.21%	12
8. We use teledermatology for general dermatology	32.71%	35
9. Our local community services (separate to those run by hospital team) triage their referrals	28.04%	30
10. Community triage slows up pathways	10.28%	11
11. We use teledermatology for triage	12.15%	13
12. Our IT systems are not fit for purpose, regularly resulting in clinic delays	37.38%	40
Total Respondents: 107		

Principle 3 “Generic referrals should be pooled to minimise waiting times for appointments. Local consultants should review an agreed mix of generic and sub-specialty referrals according to demand.”



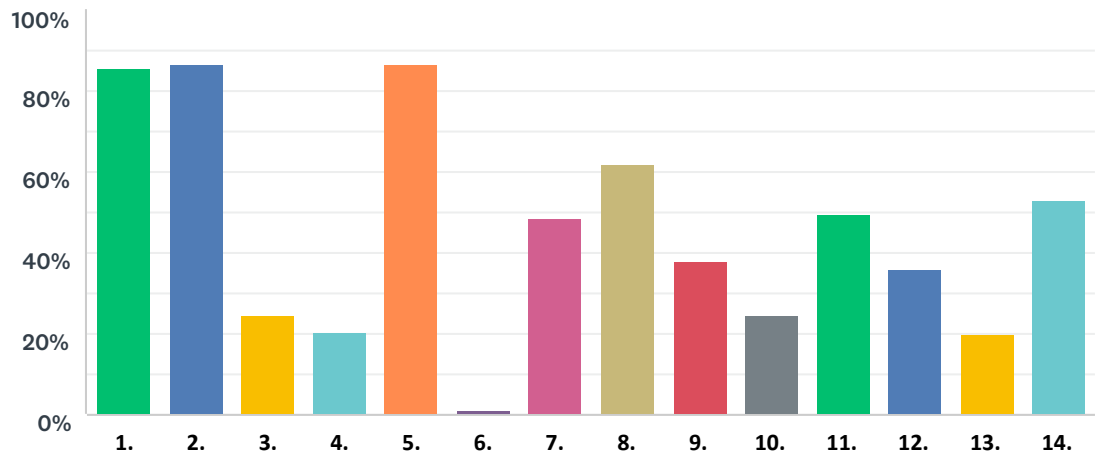
ANSWER CHOICES	RESPONSES
1. Our department pools referrals (except for tertiary referrals)	82.88% 92
2. Our department does not pool referrals	4.50% 5
3. Sometimes it can be difficult for a tertiary patient to be seen	6.31% 7
4. We have separate sub-specialty waiting lists, e.g. patch testing/mohs surgery	51.35% 57
Total Respondents: 111	

Principle 4 “All outpatient care pathways should aim to minimise disruption to patients’ and carers’ lives.”



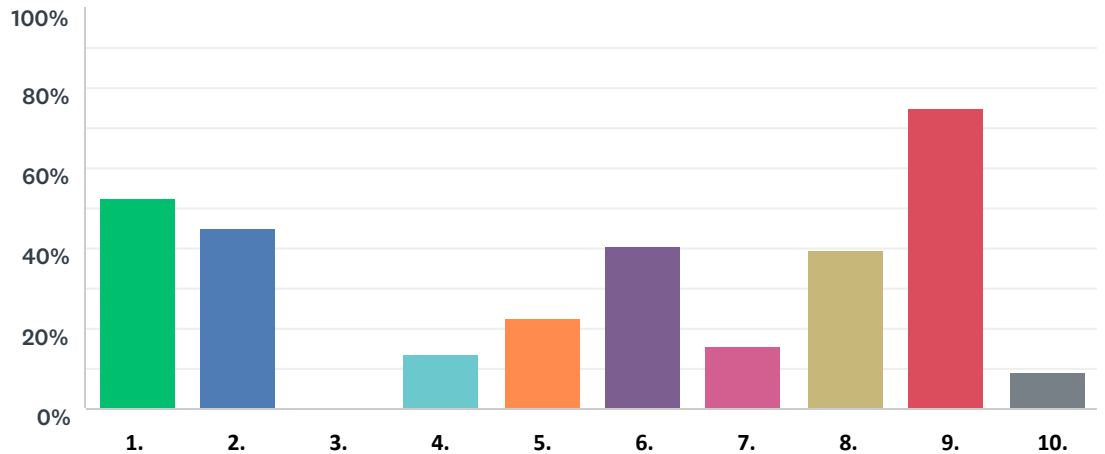
ANSWER CHOICES	RESPONSES
1. Our department gives patients a choice of appointments during the normal working day	65.74% 71
2. Our department offers appointments in the evening	13.89% 15
3. Our department offers appointments at weekends	13.89% 15
4. Our department cannot get the support needed, nursing, admin, photography to offer out of hours clinics	48.15% 52
5. Our department only offers evening appointments for 2ww referrals	6.48% 7
6. Phlebotomy is not available in the evenings after 5.30 and this restricts the type of patients we can see out of hours	44.44% 48
7. Pharmacy is not available in the evenings after 5.30 and this restricts the type of patients we can see out of hours	39.81% 43
8. We have electronic prescribing	15.74% 17
Total Respondents: 108	

Principle 5 “Clinic templates should allow for timing flexibility depending on case complexity and the needs of the patient. They should allow a realistic timeframe to conclude business and avoid frequent unsatisfactory visits.”



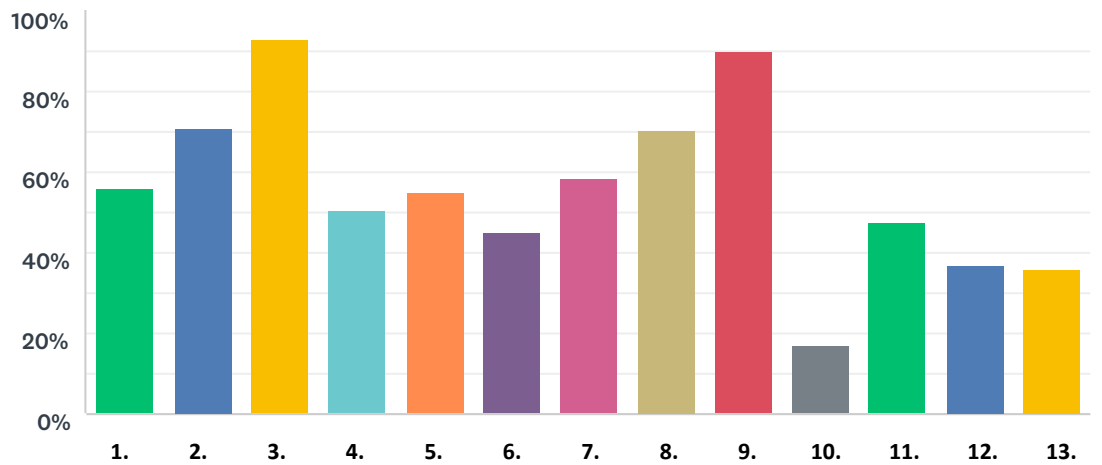
ANSWER CHOICES	RESPONSES
1. We have a fixed time slot for a new patient	85.59% 95
2. We have a fixed time slot for a follow up patient	86.49% 96
3. Time slots can vary according to complexity	24.32% 27
4. Time slots can vary according to the health care provider	20.72% 23
5. Nurse led clinic slots are longer than doctor led clinic slots	86.49% 96
6. We do not have any nurse led clinics	0.90% 1
7. We have one stop skin cancer see and treat clinics	48.65% 54
8. We can perform same day biopsies and excisions	62.16% 69
9. We have limited surgery capacity and this is prioritised for 2wvs	37.84% 42
10. We have parallel clinics for walk arounds and multidisciplinary discussion/instant referral: Plastic Surgery, Rheumatology etc	24.32% 27
11. Medical photography is available on site during clinics	49.55% 55
12. If medical photography is not available on site during clinic we use other systems (please describe in the box below)	36.04% 40
13. Medical photography is often closed at lunchtime or closes early. It is never open at weekends	19.82% 22
14. Clinics are overbooked and often run late	53.15% 59
Total Respondents: 111	

Principle 6 “Patients should be directly involved in selecting a date and a time for an appointment. That can happen either in person, via telephone or electronically.”



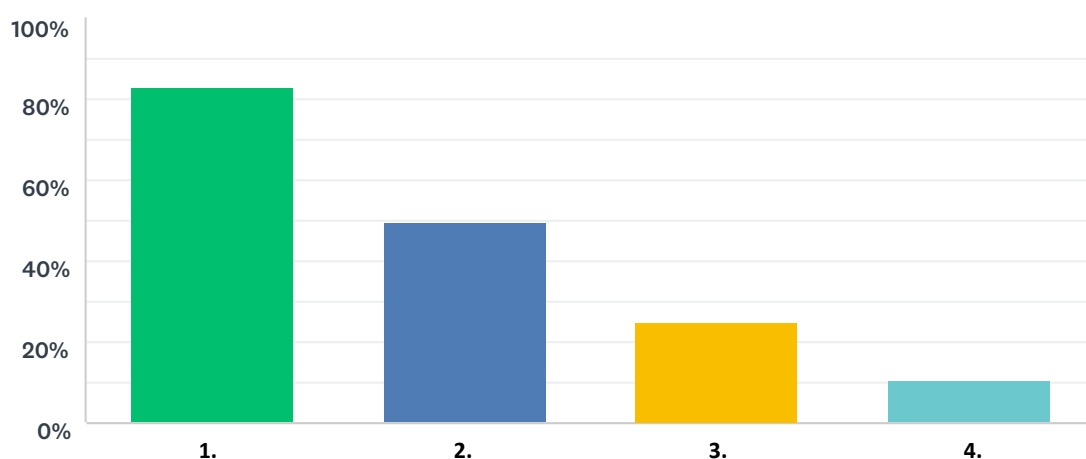
ANSWER CHOICES	RESPONSES	
1. Patients are offered direct booking via e-RS	52.25%	58
2. For new patient slot	45.05%	50
3. For follow up slot	0.00%	0
4. For surgery slot	13.51%	15
5. Patients do not have access via e-RS	22.52%	25
6. The department has a clear directory of services on its website	40.54%	45
7. Patients frequently tell us that they have problems booking appointments due to IT access	15.32%	17
8. Patients frequently tell us that they have problems booking appointments due to phone access or similar	39.64%	44
9. Patients get reminder texts for appointments	74.77%	83
10. Don't know	9.01%	10
Total Respondents: 111		

Principle 7 “All clinical information should be available to both the clinician and patient prior to consultation. That includes notes, test results and decision aids.”



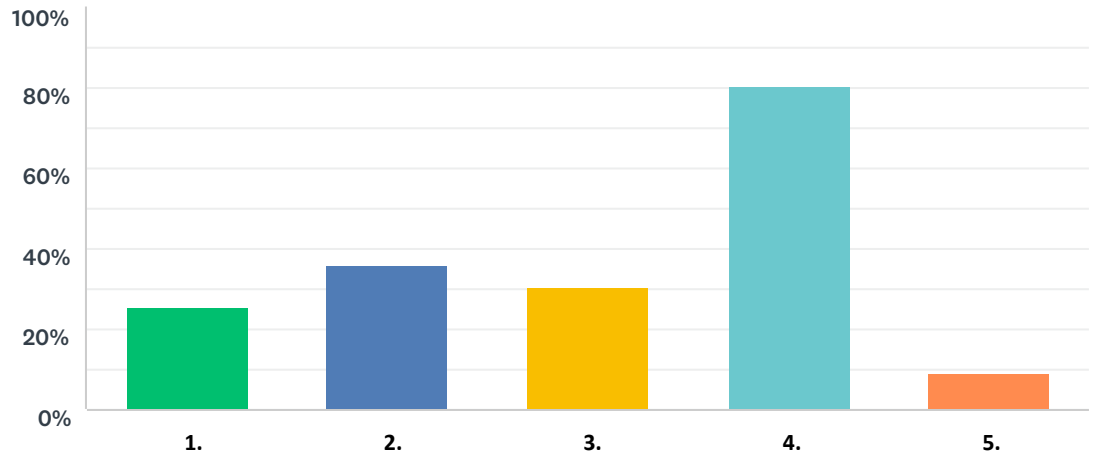
ANSWER CHOICES	RESPONSES	
1. Paper based clinical records are available	55.86%	62
2. Online clinical records are available	71.17%	79
3. Investigation results are available on line	92.79%	103
4. There is admin support for each clinic	50.45%	56
5. There is nursing support for each clinic	54.95%	61
6. Nurse support is variable, we usually do not have enough nurses to support a clinic	45.05%	50
7. We have a healthcare assistant looking after many clinics and assisting in theatres	58.56%	65
8. Access to a full set of notes, either paper or electronic, is generally available	70.27%	78
9. A referral letter is generally available for each patient	90.09%	100
10. Clinic delays occur routinely due to lack of relevant information such as referral letters, test results etc	17.12%	19
11. IT systems frequently cause clinic delays	47.75%	53
12. I would be able to see more patients in clinic if support staff were available to help with logistical issues	36.94%	41
13. Long waits for histology reporting can delay patient care	36.04%	40
Total Respondents: 111		

Principle 8 “Patients should be fully informed of what to expect from the service prior to appointments. That includes the aim of the appointment and expected waiting times.”



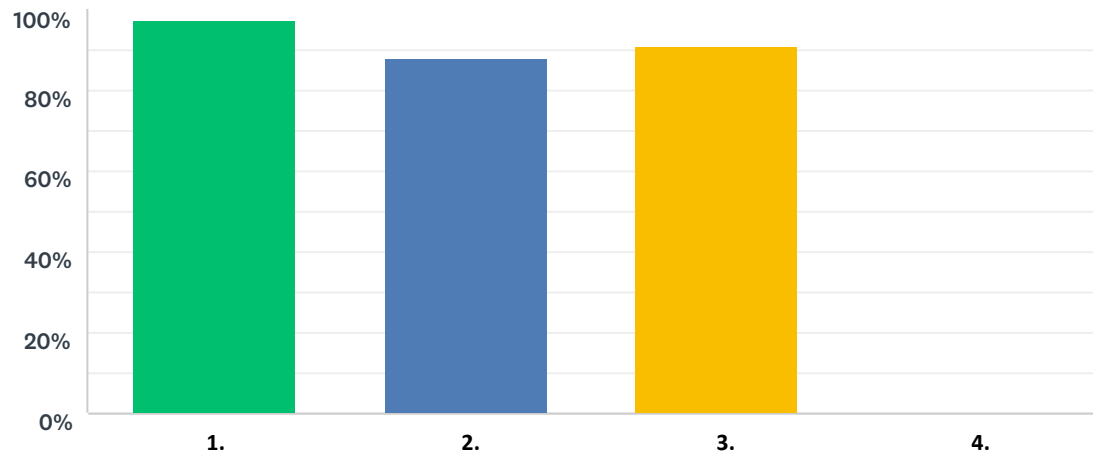
ANSWER CHOICES	RESPONSES	
1. All patients are sent information about their appointment prior to attending	82.86%	87
2. Patients are provided with specific information tailored to their clinic type ie 2ww, patch testing etc	49.52%	52
3. Admin struggle with the complexity of our service so patients do get the wrong letter or clinic location	24.76%	26
4. The documentation given prior to the appointment is recorded on the patients notes and routinely audited	10.48%	11
Total Respondents: 105		

Principle 9 “Alternatives to face-to-face consultations should be made available to patients and included in reporting of clinical activity.”



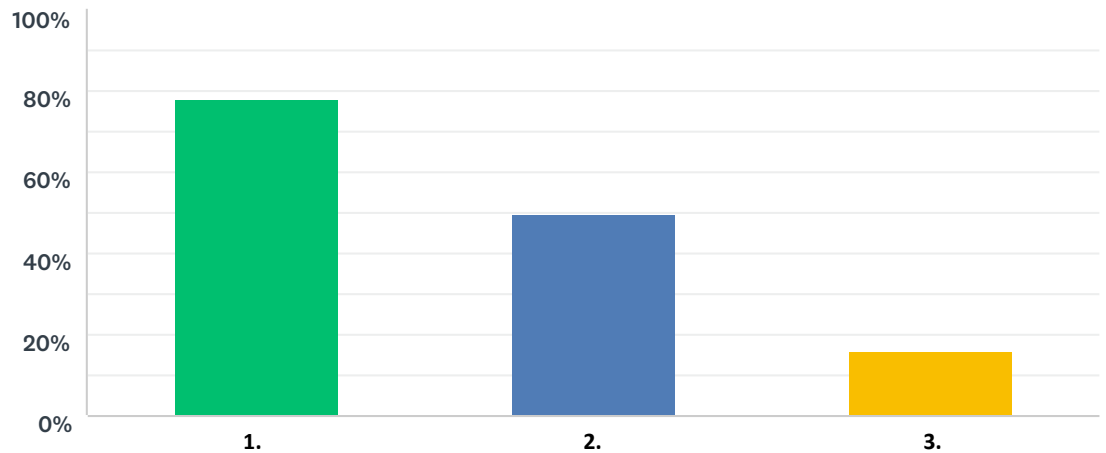
ANSWER CHOICES	RESPONSES
1. We offer teledermatology appointments to patients	25.69% 28
2. Telephone follow up appointments are offered from doctor or nurse in lieu of a face-to-face consultation	35.78% 39
3. We have insufficient staff to offer telederm or telephone follow up	30.28% 33
4. Test results such as histology are where possible routinely sent to the patients to avoid face to face consultation	80.73% 88
5. We have virtual clinics for providing test results	9.17% 10
Total Respondents: 109	

Principle 10 “Patients should be supported and encouraged to be co-owners of their health and care decisions with self-management and shared decision-making.”



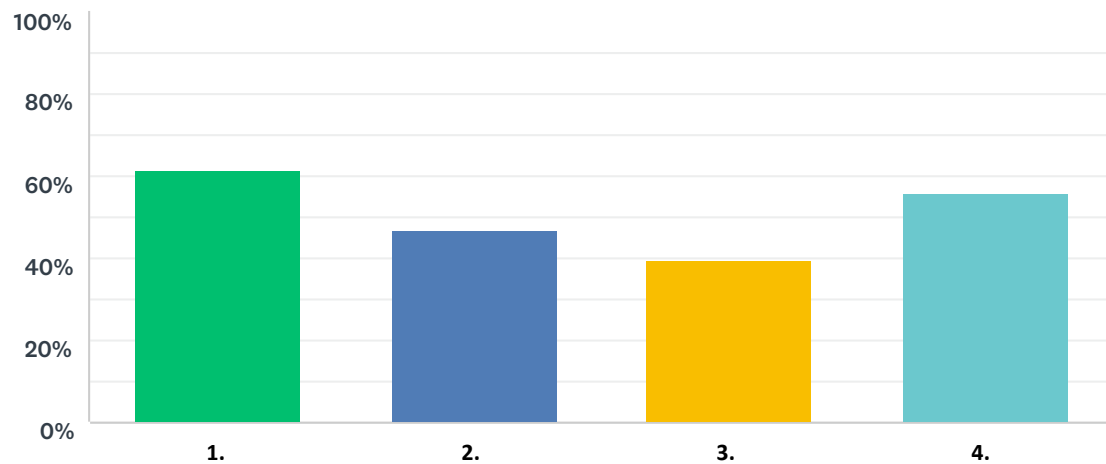
ANSWER CHOICES	RESPONSES
1. Patients are routinely given information leaflets about their condition and treatment	97.27% 107
2. Patients are signposted to use web based resources, such as BAD.org.uk, dermnetnz.org, NICE etc.	88.18% 97
3. Every attempt is made to engage the patient in decision making and this is recorded in the notes	90.91% 100
4. Patients are given the opportunity to attend combined clinics for surgery and other therapy to discuss treatment options	0.00% 0
Total Respondents: 110	

Principle 11 “Patients and community staff should be able to communicate with secondary care providers in a variety of ways, and know how long a response will take. This aids self-management, and provides a point of contact for clarification or advice regarding minor ailments.”



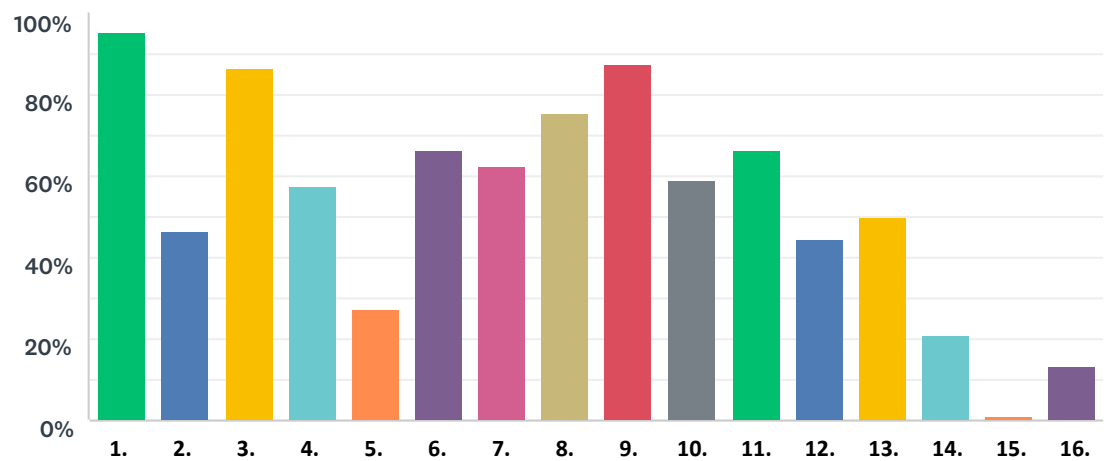
ANSWER CHOICES	RESPONSES
1. Written information is routinely given to patients to phone up help lines; email nurse specialists, secretaries etc if there are concerns about their treatment	78.10% 82
2. Patients are informed about how long a response from the hospital should take	49.52% 52
3. We do not have the clinical nurse specialists or secretaries necessary to provide such support	16.19% 17
Total Respondents: 105	

Principle 12 “Access to follow-up appointments should be flexible. Patient-initiated appointments should be offered, replacing the need for routine ‘check-in’ appointments.”



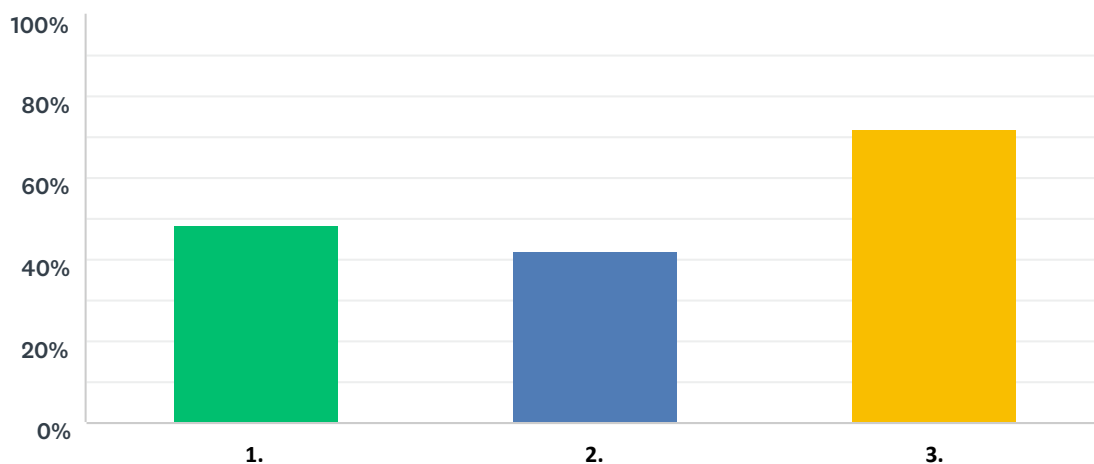
ANSWER CHOICES	RESPONSES
1. Patients are offered open appointments	61.47% 67
2. Patients contact details are recorded to enable an earlier appointment if available	46.79% 51
3. The volume of patients is too great to offer open appointments	39.45% 43
4. Patients routinely inform us that they cannot get through to admin staff to book an appointment	55.96% 61
Total Respondents: 109	

Principle 13 “All care pathways should optimise their staff skillmix. Allied medical professionals and specialist nurses should be an integral part of service design.”



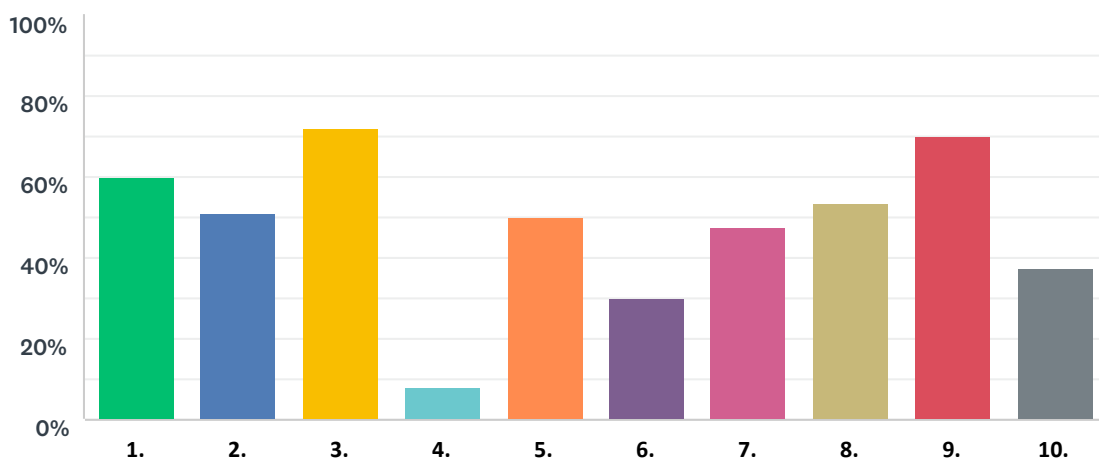
ANSWER CHOICES	RESPONSES
1. Consultant Dermatologists work in clinic and supervise other dermatology doctors	95.45% 105
2. Dermatology doctors work in clinic and supervise general practitioners	46.36% 51
3. Dermatology doctors work in clinic and supervise dermatology nurses	86.36% 95
4. Dermatology registrars routinely deliver clinics	57.27% 63
5. Nurses deliver Leg Ulcer clinics	27.27% 30
6. Nurses deliver skin cancer surgical lists	66.36% 73
7. Nurses deliver post operative care	62.73% 69
8. Nurses deliver biologic therapy clinics	75.45% 83
9. Nurses deliver phototherapy clinics	87.27% 96
10. Nurses deliver patch test clinics	59.09% 65
11. Nurses deliver acne clinics	66.36% 73
12. Nurses deliver paediatric clinics	44.55% 49
13. Nurses deliver other clinics	50.00% 55
14. Other allied health care professionals deliver clinics	20.91% 23
15. We do not have trained dermatology nurses	0.91% 1
16. We do not have sufficient allied health care professionals	13.64% 15
Total Respondents: 110	

Principle 14 “Letters summarising a clinical encounter should be primarily addressed to the patient, with the community healthcare team receiving a copy.”



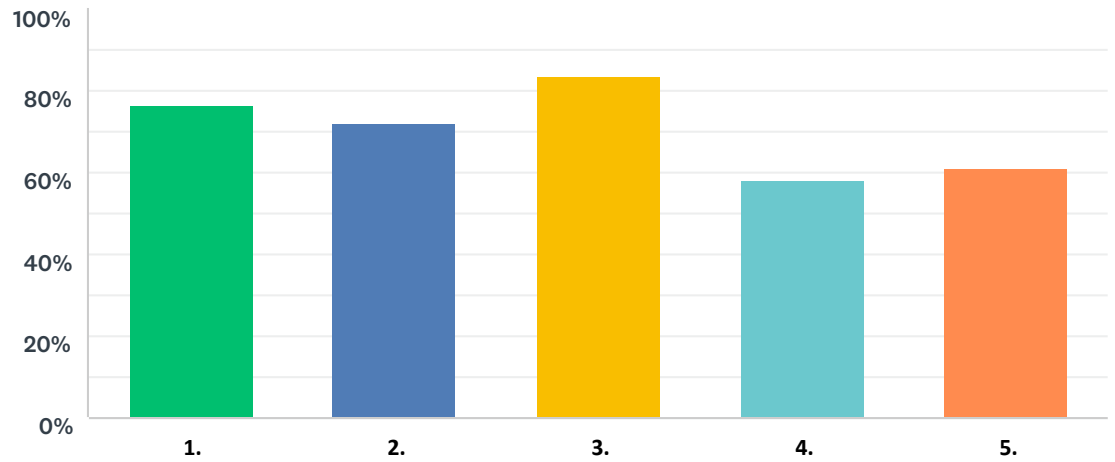
ANSWER CHOICES	RESPONSES
1. It is routine practice for patients to be offered a copy of their clinic letter with GP/district nurse copied in.	48.60% 52
2. All cancer patients are sent a cancer treatment summary	42.06% 45
3. We write to the referrer GP and copy the patient when the GP is being asked to initiate an ongoing plan of care	71.96% 77
Total Respondents: 107	

Principle 15 “All outpatient services should offer a supportive environment for training.”



ANSWER CHOICES	RESPONSES
1. We are a teaching centre for dermatology registrars	60.00% 66
2. We have a programme of clinical teaching for local GPs and GPWERS	50.91% 56
3. We are attached to a medical school and welcome undergraduate in our clinics	71.82% 79
4. We have a PA rotation scheme	8.18% 9
5. We offer taster weeks for FYs	50.00% 55
6. We offer electives to overseas students	30.00% 33
7. We encourage other specialists to sit in on relevant clinics ie paed, plastics, gynae, sexual health, dermatopathology	47.27% 52
8. Consultants are over-stretched with service delivery and cannot always accommodate other specialists or students	53.64% 59
9. Lack of clinic space and time constraints are a barrier to delivering teaching in the clinic	70.00% 77
10. We are a teaching centre for undergraduate nurses	37.27% 41
Total Respondents: 110	

Principle 16 “All outpatient-related services should promote wellbeing for staff and patients.”



ANSWER CHOICES	RESPONSES	
1. We are aware of the psychological impact of skin disease on our patients and where possible signpost to support	76.36%	84
2. There is a lack of psychology support available for our services	71.82%	79
3. We encourage a supportive team culture amongst our staff	83.64%	92
4. We provide mentoring to our trainees and new consultants	58.18%	64
5. The department routinely meets socially	60.91%	67
Total Respondents: 110		

