



Dermatology: Response to and Lessons Learnt during the COVID-19 Pandemic

1. Introduction

The COVID-19 pandemic brought with it many changes. The pace at which digital transformation took place was phenomenal; innovation occurred with relaxation of layers of bureaucracy. With such a rapid change it is important for us to evaluate the impact on quality of care and to avoid locking in practices that are not useful. There have been frustrations over poor resolution of pictures and problems with time lag on video consultations. It is vital that any long-term changes to the way we work are advantageous to ourselves, our wider teams and our patients.

The BAD Lessons Learnt questionnaire was therefore devised and sent out to all Dermatology Clinical Leads in the UK in June 2020 at the start of the recovery phase following the first peak of the pandemic. The aim was to help the BAD identify non-face to face resources used in response to COVID 19 and the impact of the pandemic on our departments and patient care.

Results

Clinical Leads from 80 Hospitals across the UK (70 out of a possible 120 organisations currently using e-RS to advertise a range of dermatology non-face to face and clinical services) completed the survey (See Appendix 2). Across all four nations there was a rapid adoption of non-face-to -face and virtual ways of triaging and reviewing patients during the first phase of the pandemic. Although we have been able to report common themes in service delivery the data was insufficient to allow a detailed analysis of what worked and didn't work well (See Appendix 1 Survey Responses).

1.1 Advice and Guidance

Of the 80 UK trusts that responded to the survey 79 trusts had set up one or more forms of Advice and Guidance using a range of electronic mediums with and without images to respond to GPs within 48 hours of their query. 24 Trusts had an overall increase of 10-50% in A&G referrals during COVID compared with the same period in the previous year. 13 Trusts indicated a 50-100%, 9 Trusts a 100-200% increase and 6 Trust a substantial increase of 200-300%.

1.2 NHS electronic Referral System (eRS)

Secondary care departments can list their referral services on the eRS directory as either 'Directly Bookable' or a 'Referral Assessment Service' (RAS).

During the pandemic 41 Trusts (England) responded that they had set up one or more RAS pathway. The majority used their RAS to triage benign lesions and inflammatory skin conditions with a diagnostic outcome /decision provided within 48 hours.

1.3 Suspected cancer referrals

More than half of Trust responders indicated they had not changed the way they see their 2 week wait patients, continuing with face-to-face clinics. The remaining Trust responders screened their 2 week wait patients using telephone or video conferences with images, triage straight to surgical lists and requests for patient images via email.

This was in line with the temporary COVID 19 measures for 'seeing' 2 week wait referrals in England.

1.4 Follow up appointments

The most common form of triage review for follow appointments by all responders was the review of case notes. A decision was then made to see the patient in clinic, to discharge, to defer their appointment (via telephone or letter) or request patient images via NHS.net email.

For 'rashes of unknown diagnosis' more than half of the responders indicated that they had seen the patient in a face-to-face appointment (new and follow up appointments) and would not be continuing with a non-face to face consultation with this group of patients. The reasons given where the non-face to face appointment took too long to see patients and delayed patient care.

1.5. In -patient referrals

The system(s) used by 23 responding Trust departments to provide non F2F consultations for inpatient referrals showed the largest activity was through NHS.net (8) using photo images to diagnose. The time taken to review inpatient cases amounted to the same taken as a face-to-face review.

Common themes

There were common issues highlighted by responding trusts across all survey questions.

The main issues around tele-triage were poor quality of the referral information and images submitted by GPs, poor quality images submitted by patients, poor IT infrastructure and a lack of management and/or local support. Teledermatology reviews also can take longer than a face-to-face appointment.

Video consultations have not been well received by clinicians and patient's due diagnostic quality and efficiency issues.

Recommendations

The biggest impact on dermatology services during the COVID-19 pandemic was on the rapid implementation of teledermatology pathways and remote consultations in those units not already delivering them.

The benefit of Advice and Guidance has been to support primary care in the prompt management of patients and avoid referral where possible. The risk has been increasing referrals and workload on secondary care. Consultant job plans must recognise this additional workload.

The main long-term benefit of teledermatology triage is to ensure patients receive timely care in the most appropriate setting, increasing capacity in secondary care for patients who need face-to-face referrals. Rapid implementation of teledermatology does not necessarily mean these gains will be realised, as poorly designed workflows and a lack of supporting infrastructure can mean that teledermatology reviews take

longer than a face-to-face appointment. There is a need to review Teledermatology services set up during the pandemic to ensure that there is appropriate software, information governance, suitable training for clinical and administrative staff, supporting infrastructure and well-designed workflows. Pathways need to be streamlined, sustainable and integrated within services. Consultant job plans need to allow for this workload. Time for training StRs should also be accounted for.

During the recovery period it is important to look at remote consultations and in which groups it is useful. In many situations a remote consultation simply deferred a face-to-face consultation rather than replaced, which was of benefit during the pandemic but not a practice to take forwards. Video consultations were generally of limited benefit.

Work with the NHSE/I National Outpatient Transformation Team in Dermatology will be addressing most of these issues.



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President BAD

Appendix 1. Survey Responses

Question 1: Does your department provide any form of Advice and Guidance (A&G)?

Of the 80 UK Hospital Trust survey responders 79 answered this question. 70 indicated Yes and 9 said No to providing a form of Advice and Guidance service.

Question 2: What type of Advice and Guidance services does your department provide?

There are 8 Trusts providing 4 options for their A&G services, another 13 Trusts provide 3 options, and 20 Trusts provide 2 options. 25 Trusts provide one type of A&G service using a range of platforms via e-RS, NHS email and provider apps. The majority of trust responders indicated A&G services included referrals with or without images as their main option.

Wales - departments rely on images being sent in with the referral via the Welsh clinical gateway. Consultants respond by letter. Repeated requests to switch on the ability to respond electronically have been unproductive.

Scotland - referrals come from GP on SCI gateway and are managed through Trackcare. Department provides a generic email address for GPs to use with option for photos. These are upload to Medical Image Manager, part of the electronic patient record, but separate from the SCI store where clinical letters are stored.

Question 3: Which skin conditions does your department include via A&G?

Question 4: Which age groups does your department offer this service to?

29 Trusts responded to this question with the majority indicating they use A&G review Benign skin lesions & inflammatory skin conditions for all ages.

Question 5: What proportion of your department A&G requests normally result in a referral weekly?

A&G weekly requests resulting in a referral showed a conversation range of 10 to 50% across responder Trusts. The average range showed between 20-30% and 40-50%. This is directly related to the quality of the referral information. 24 Trusts indicated an 10-50% increase in A&G weekly referrals during COVID, 9 Trusts 100-200% and 16 Trusts experienced an 200-300% increase.

Question 6: What percentage increase has your department seen during COVID for A&G requests compared with the same period last year?

24 Trusts had an overall increase of 10-50% in A&G referrals during COVID compared with the same period last year. 13 Trusts indicated a 50-100%, 9 Trusts a 100-200% increase and 6 Trust a substantial increase of 200-300%.

Question 7: Does your department provide any form Referral Assessment Service (RAS)?

Of the 80 UK Hospital Trust survey responders 76 answered this question. 41 indicated Yes and 35 said No to providing a form of Referral Assessment Service.

Question 8: What type(s) of Referral Assessment Service (RAS) does your department provide?

Of the 41 trusts providing a Referral Assessment Service 31 Trusts indicated which form of RAS they provide to review their referrals. 24 Trusts are providing a single RAS triage service without images with the balance providing RAS Triage with images (including/excluding dermoscopy).

Question 9. How does your department review patients with booked new appointments?

All 80 UK Hospital Trust survey responders answered this question. 68 indicated Yes and 12 said No to providing a form of triage review for new patient appointments. 21 Trusts using Electronic triage of referral letter without images with another 30 Trusts triaging referral letters without images. These services are existing and will continue long term. Common issues highlighted with the ability to carry out effective triage review included, poor quality images and or GP information provided with the referral letter, poor IT infrastructure and lack of management support.

Question 10. How does your department manage its Follow Up Appointments?

Of the 80 UK Hospital Trust survey responders 77 indicated Yes and 3 said No to providing a form of triage review of their follow up appointments. The most common forms of management by all trusts is a review of case notes to see the patient in clinic, to discharge, to defer their appointment or request patient images via NHS.net email. 30 trusts are using video conferencing with patient requested images. 19 Trusts undertake video conferencing without images. 18 of these trusts also provide telephone conferencing with and without patients requested images alongside their video conferencing. Only 7 trusts indicated used a form of app to review their follow up appointments.

Question 11: How does your department see its 2 Week Wait patients currently?

All 80 UK Hospital Trust survey responders 41 indicated they had not changed the way they see their 2 week wait patients, continuing with face-to-face clinics. The other 35 Trusts screen their 2 week wait patients using telephone or video conferences with images, triage straight to surgical lists, requests for patient images via email. 26 Trusts have indicated they will continue with their non-face to face triage arrangements after COVID. The majority of these trust were able to discharge from 20-30% (6), 30-40% (5), 40-50% (3), 50-60% (4).

Question 12: What non F2F resources are working well for your department?

Of the 80 UK Hospital Trust survey responders 72 completed some sections of the survey. The main resources used to review patients with specific skin conditions for new and follow up appointments were telephone with images (highest number), video with images and non-face-to-face only.

In general, the most common outcome of non-face to face patient activity was for their discharge and or management plans.

For 'rashes of unknown diagnosis' more than half of the trusts responded to indicate they had seen the patient in a face-to-face appointment and would not be continuing with a non-face to face consultations with this group of patients. The reasons given where the non-face to face appointment took too long to see patients and delayed patient care.

For pigmented lesions and 'non pigmented lesions' the majority of trusts indicated they were able to triage to defer the patient appointment, directly book to surgery or discharge (non-pigmented lesions) with a management plan. Again, common problems included poor quality images and or lack of GP information provided with the referral letter. They also found the non- face to face appointment either took the same amount of time or longer to review the patient. The majority of trusts indicated they would continue to keep the non- face to face review for some patients.

Question 13. During the COVID 19 pandemic did your Trust continue the following treatment services?

Of the 80 UK Hospital Trust survey responders 76 completed this section of the survey. 20 Trusts said No, 31 indicated Yes for male and female patients, 7 for male patients only and 8 Yes for severe patients only.

Question 14. How does your department provide Acute or Emergency Services (on call, rapid access services, ED, Wards, Admissions)?

Of the 80 Trusts completing the survey 67 responded to this question. The three core services provided are GP emergency referrals (Rapid Access Service), Adult on call referrals from within the hospital (Emergency depts/Wards/Admissions unit etc.) and Paediatric on call referrals from within the hospital (Emergency dept/Wards/Admissions unit etc.)

Question 15. How does your department review these patients?

Of the 80 Trusts completing the survey 27 responded to this question. 22 Trusts indicated 7 of these services were set up during COVID with the remaining 15 already existing. A mixture of both the new and existing services would continue for the long term (15). 6 Trusts indicated they had problems with the quality of referral information.

The system(s) used by 23 responding Trust departments to provide non F2F consultations for inpatient referrals showed the largest activity was through NHS.net (8) using photo images to diagnose. A further 6 Trusts indicated they had no on face-to-face consultations.

On average the 23 responding trusts took between 10-15 minutes to 25-30 minutes to review a patient. The source of the referral and review methodology did not alter the average time taken to diagnose and manage the patient. More than half of the 23 responding trusts receive between 10 to 20 referrals per week.

Appendix 2: Trust Hospital Survey Responders (England, Scotland, Wales, Northern Ireland)

Addenbrooke's Hospital (Cambridge University Hospitals NHS Foundation Trust)
Aneurin Bevan University Hospital, Wales
Ashford & St Peter's Hospitals NHS Trust
Barts Health Royal London Hospital
Belfast Trust, Northern Ireland
Brighton & Sussex University Hospitals NHS Trust
Buckinghamshire Healthcare NHS Trust
Cardiff and Vale University Hospital Board, Wales
Chelsea and Westminster Hospitals NHS Foundation Trust
Chesterfield Royal hospital
County Durham and Darlington NHS Foundation trust
Croydon University Hospital
Cwm Taf Morgannwg University Health Board, Wales
Dorset County Hospital
East Kent University Hospital NHS Foundation trust
Epsom and St Heliers
Frimley Park Hospital
Glan Clwyd Hospital, Betsi Cadwaladr University Health Board
Gloucestershire Hospitals NHS foundation trust
Great Ormond Street Hospital
Great Western Hospital NHS Foundation Trust
Hampshire Hospitals NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Homerton University Hospital
Imperial College Healthcare Foundation trust
James Paget University Hospital
Kettering Hospital
King's College Hospital NHS Foundation Trust (South sites)
Leeds Teaching Hospitals NHS Trust
Lewisham NHS Trust
Liverpool University Hospitals NHS Foundation Trust
London North West University Hospitals NHS Trust
Luton and Dunstable university Hospital
Manchester Foundation Trust
Mid and South Essex Hospitals trust, Broomfield Hospital
Mid Yorkshire Hospitals NHS Trust
NHS FORTH VALLEY, Scotland
NHS Highland, Scotland
NHS Lanarkshire, Scotland
NHS Lothian, Scotland
NHS Tayside, Scotland
Norfolk and Norwich University Hospital NHS Foundation Trust
North Bristol NHS Trust
North Lincolnshire & Goole NHS Foundation Trust

Northampton General Hospital
Nottingham University Hospitals NHS Trust
Peterborough City Hospital
Portsmouth Hospitals NHS Trust
Queen Elizabeth NHS Foundation Trust, King's Lynn
Rotherham NHS Foundation Trust
Royal Berkshire Hospitals NHS Foundation Trust
Royal Bolton Hospital
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
Royal Cornwall Hospitals NHS Trust
Royal Devon & Exeter Hospitals
Royal Marsden Hospital
Royal United Hospital NHS Trust
Sheffield Teaching Hospitals NHS Trust
South Tees Hospital Foundation Trust
South Warwickshire NHS Foundation trust
Southport and Ormskirk General Hospital
St Georges University Hospitals NHS Foundation Trust
St Helens and Knowsley Hospitals NHS Trust
Tameside and Glossop Integrated Care NHS Trust
Torbay and South Devon NHS Foundation Trust
United Birmingham Hospitals
United Lincolnshire Hospitals Trust
University Hospital Plymouth
University Hospital Southampton NHS Foundation Trust
University Hospitals of Derby and Burton NHS Trust
University Hospitals Coventry and Warwickshire NHS Trust
Verona Health
Virgin Care Dermatology North and East Lincolnshire
Walsall Healthcare NHS Trust
Whipps Cross Hospital
Whittington Health NHS Trust
Wye Valley NHS Trust
Yeovil Teaching Hospitals
York Teaching Hospitals NHS Trust