NHS

GIRFT
GETTING IT RIGHT FIRST TIME

Dermatology

GIRFT Programme National Specialty Report

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Foreword from Professor Tim Briggs GIRFT Programme Chair

I am delighted to recommend this Getting It Right First Time review of dermatology by Professor Nick Levell.

This report comes at a time when the NHS has undergone profound changes in response to the COVID-19 pandemic. The unprecedented events of 2020 - and the extraordinary response from everyone working in the NHS – add greater significance to GIRFT's recommendations, giving many of them a new sense of urgency.

Actions in this report, such as the use of virtual advice and guidance to support GPs in managing patients at home, can help the NHS as it faces the substantial challenge of recovering services while remaining ready for any future surges, by operating more effectively and safely than ever before.

Nick's report brings the GIRFT approach to dermatology, a specialty which covers a wide range of conditions, including some of the most common reasons people seek help from the NHS. Often these conditions reduce quality of life and cause distress, and in some severe cases they can be profoundly life changing or even life threatening.

This report, based on Nick's insights from deep dive visits to 80 units and data from 123 dermatology departments, identifies areas of wide variation in dermatology and sets out recommendations that will deliver huge improvements in patient care and outcomes, as well as saving the NHS millions of pounds.

The report highlights some major problems faced by the specialty, such as continued workforce shortages and rising demand, but also shines a light on innovative work Nick has seen in dermatology departments as well as the potential offered by new technologies being developed.

It has been heartening to hear about the support and engagement Nick has had in carrying out his review. That support is crucial, as GIRFT cannot succeed without the backing of clinicians, managers, and all of us involved in delivering care.

With the recommendations made in this report, I hope that GIRFT will provide further impetus for all those involved in the delivery of dermatology to work together, shoulder to shoulder, to create solutions and improvements that have appeared out of reach for too long.

Professor Tim Briggs *CBE*

GIRFT Programme Chair and National Director of Clinical Improvement for the NHS.

Professor Tim Briggs is Consultant Orthopaedic Surgeon at the Royal National Orthopaedic Hospital NHS Trust, where he is also Director of Strategy and External Affairs. He led the first review of orthopaedic surgery that became the pilot for the GIRFT programme, which he now Chairs.

Professor Briggs is also National Director of Clinical Improvement for the NHS.

Introduction

This report and its recommendations aim to increase early access to accurate diagnoses and best treatment for those suffering a skin, hair or nail disorder, no matter what their age – from new born babies to the elderly in residential care.

We have looked at current variation in practice, how departments are addressing shortages in the workforce, and how new digital technologies can help provide patients with effective care and reduce hospital attendance.

Together, these measures offer the potential to provide more people in England with the dermatology expertise they need.

Increasing demand for dermatology services

Dermatology deals with diseases of the skin, hair and nails. There are more than 4,000 dermatological conditions and around half of people at any time consider they have a problem.

Many disorders, such as psoriasis, eczema and acne, interfere with daily life, sleep and the ability to work. Skin cancer is the commonest UK cancer and is doubling every 14 to 15 years, meaning many people seek reassurance about changing moles.

Skin infections, including scabies, MRSA, head lice and ringworm, cause outbreaks in hospitals, nursing homes and schools. Dermatology disorders can cause distress due to altered appearance, such as skin colour changes, scarring, altered facial appearance or hair loss, which can all have a profound effect on mental health and quality of life. Serious diseases usually managed by other specialties often first appear in the skin and so may present to dermatologists. The most severe skin disorders are life threatening.

Access to dermatology

With early, accurate diagnosis and interventions, dermatologists can help almost all patients; providing a cure for many and relieving symptoms for most. This is a huge benefit to those affected, enabling most to get on with their lives. Simple precautions can help prevent many skin cancers.[1]

These are all good reasons why dermatology is the most popular specialty for junior doctors. Yet despite its popularity, there is a severe workforce shortage caused by a long-term restriction on the number of new dermatology training posts. At the time of writing, we found just 508 Whole Time Equivalent (WTE) trained NHS dermatologists in England with 159 WTE vacant posts and 143 WTE posts filled by locums. Many locum consultants are employed through high-cost locum agencies, costing these trusts large sums of money that could be better spent on training more staff. At least ten trusts have no dermatologists at all, while around a third have very severe shortages.

The impact of workforce shortages (see page 9) is felt in all aspects of access to and quality of dermatology care, resulting in the picture of wide variation in care we found. Among the locums, there are some skilled and experienced dermatology consultants. However, there are many who lack full training and this, along with the amount of unfilled posts, inevitably reduces the quality of care that many trusts are able to provide. Most people do not have direct access to an NHS dermatologist so first seek advice from pharmacists, practice nurses and GPs. Yet dermatology teaching in these professions has been considered a low priority for too long, meaning many clinicians have received little or no training from dermatologists.

This shortage of skilled clinicians means that people with skin diseases may not see someone in the NHS who can diagnose and treat their condition first time. Instead, they will need to be seen again and again until, eventually, they meet someone who can diagnose them, treat them and discharge them. For people with disabling skin conditions, this often means repeatedly missing work or school and the trouble of attending several appointments. For those with early skin cancers, it means delays to their diagnosis and treatment. It also leads to the NHS funding unnecessary follow-ups and missed appointments as patients become frustrated with wasted visits.

Solving workforce shortages

It is important to emphasise that the shortage in the dermatology workforce is a problem that does have solutions. There are many able doctors out there who wish to train to become dermatologists (see page 41), and many experienced and skilled clinicians who are keen to train them. There are also many expert dermatology nurses (see page 44) wanting to extend their roles to do surgery and treat patients.

[1] *NICE (2016) Sunlight exposure: risks and benefits (NG34), https://www.nice.org.uk/guidance/ng34*

Despite the prevalence of skin diseases among the population, most medical students get very little training in dermatology. Focused training in primary care (see page 48) is another area that could improve care for millions with skin disorders.

The large sums currently spent on locums and missed or unnecessary outpatient appointments could be diverted to fund all this training.

Digital technology, machine learning and artificial intelligence

While the huge impact of workforce shortages on efficiency, quality of care and safety means we have made that a key focus of our report, we have also looked at issues in access to treatment, innovation and efficient use of NHS resources.

Digital technology offers great potential to help deliver effective dermatology services by reducing the number of people needing to attend hospital. Artificial intelligence and machine learning (see page 107) will soon integrate with many aspects of care delivery and transform all areas of medicine, including clinical diagnosis, investigation choice, treatment monitoring, follow-up and discharge, education and research. Like all system changes this offers both opportunities and challenges.

Professor Nick Levell *MD FRCP MBA*

GIRFT clinical lead for dermatology
Consultant dermatologist at Norfolk and Norwich University Hospital
Chair of the Therapy and Guideline Committee and past president of the British Association of Dermatologists
National speciality lead (dermatology) for the National Institute of Health Research

Statement of support

British Association of Dermatologists (BAD)

The British Association of Dermatologists welcomes the publication of this report. It reflects the huge commitment the GIRFT team, led by Professor Nick Levell, has made to providing an accurate representation and analysis of the dermatology services currently provided across England. The findings correlate well with the four nation data that the British Association of Dermatologists published across 111 hospital trusts in December 2019.

Dermatology is a multifaceted specialty caring for all ages, from skin cancer to complex inflammatory dermatoses and rare genodermatoses. Dermatologists are also responsible for education and training of undergraduates, specialist registrars and allied health professionals. We see more two week wait referrals for suspected skin cancer than any other specialty. Skin cancer is the commonest cancer and nearly all of this is diagnosed and treated by dermatologists. The need to identify patients who required shielding due to the COVID-19 pandemic highlighted the medical complexity of the dermatology casemix. The majority of this work, including skin surgery, is delivered in an outpatient setting working with multi-professional and multi-specialty teams.

The COVID-19 pandemic has driven rapid innovation with the challenge of meeting all the necessary facets of the specialty, where practicable, in a remote setting. This has helped crystallise further the priority recommendations from the GIRFT team for dermatology. There is a need to maximise the workforce to deliver specialist care in both secondary and tertiary settings, while using appropriate technology to do so. It is important that these innovations are applied in effective ways to minimise double handling and maximise efficiency, such as teletriage to direct patients to appropriate lists for surgery. There is a national drive to make up to 70% of follow-up visits virtual. There are groups of patients for whom teledermatology, telephone and video consultations will be used in the longer term but for skin disease, where visual examination and touch are so important, a face-to-face consultation will remain the gold standard.

There is a need to increase the IT literacy of the dermatology workforce and their hosting trusts and for a coordinated national approach to the commissioning of connected pathways of dermatology care from primary to tertiary level, seven days per week. We advocate that the NICE-accredited service standards and clinical guidelines, published by the British Association of Dermatologists, provide an evidence-base for the commissioning of future pathways of care at all levels. We also advocate for an agreed standard of dermatology training at all levels, from undergraduate to tertiary care, as endorsed by the GMC.

We look forward to seeing how the recommendations in this report are implemented and audited, and thank the GIRFT team for all their hard work.

Ruth Murphy
President of the British Association of Dermatologists
(July 2018-2020)

Tanya Bleiker
President of the British Association of Dermatologists
(July 2020-2022)

Executive summary

Dermatology today

Skin, nail and hair disease are among the most common reasons for seeking NHS help. In 2018/19, there were over 3.5m dermatology outpatient and day surgery attendances.[2]

Dermatological conditions range in severity from mild to severe. Disorders can cause much distress and anguish, often causing or contributing to poor mental health.

Skin cancer forms an increasing proportion of the dermatological caseload and now accounts for approximately half of all cancers in the UK.

Dermatological conditions can be caused by inherited, environmental or occupational factors, or a combination of all three. Patients come from all age groups.

Skin problems are the commonest reasons for children and young people to seek medical care.

Some elderly people report that those caring for them consider their skin conditions to be less important than other conditions they may have, even though their skin conditions cause significant discomfort and concern.

Ethnicity has a considerable effect on the incidence and impact of skin disease.

A number of life-threatening conditions may first present with cutaneous (skin) changes. Educating all clinicians in these may improve early disease detection.

Care setting and workforce

Most people with a dermatological concern will first go to their GP or a pharmacist for their diagnosis and treatment. Unfortunately, GP training includes little or no formal training from dermatologists.

If a GP is unable to treat or diagnose a dermatology patient, they will generally refer them to a consultant. Referrals may also come from other allied healthcare practitioners, such as nurses.

Consultant dermatologists will often see patients in an outpatient setting.

Children with skin diseases are looked after by dermatologists, sometimes working in collaboration with paediatricians.

Some skin conditions require inpatient treatment. However, this requirement is falling greatly due to the development of new biological drugs that do not need to be administered in an inpatient setting.

Emergency skin problems are quite common and usually require assessment within 24 to 48 hours. Many can be dealt with by telephone advice (see page 109) from a dermatology doctor or specialist nurse. Out-of-hours on-call emergency cover is needed for a few, rare, life-threatening conditions in adults and children.

Current service organisation

Most acute general trusts provide outpatient dermatology services.

Dermatology requires an effective interface between primary, secondary and tertiary care.

Some people who call themselves dermatologists are not accredited on the General Medical Council (GMC) specialist register. They are to be found working in both NHS and private health care settings.

Specialised dermatology services are commissioned by the internal medicine National Programme of Care (NPoC).

[2] *Hospital Episode Statistics (HES) outpatient and day case figures.*

About our analysis

Our review followed the standard GIRFT process to ensure that we were able to offer evidence-based findings and recommendations.

All 123 dermatology departments of a significant size (including some that have since closed or merged) returned our questionnaire. By February 2020, we had made deep dive visits to 80 of these trusts before GIRFT paused all deep dive visits in March due to the emerging threat of COVID-19.

Our review covers care for all skin, hair and nail conditions.

We have considered skin cancer where it relates to the other themes in our review. GIRFT is currently considering a separate skin cancer workstream to review skin cancer services in more detail.

Although primary care services were not specifically reviewed as part of this programme, there were GPs present at almost all of our deep dive visits.

Data

We used a wide variety of sources for the data on which our report is based, including Hospital Episode Statistics (HES), hospital accounts, reference costs, and staff surveys.

We also used the data collected in our GIRFT questionnaires.

Unlike many other specialties, dermatology has no specialty-level safety or outcome data.

We worked with external parties including NICE, representatives of the ABPI and pharmaceutical industry, other GIRFT workstreams, the NHS England Evidence-Based Interventions Programme, NHS England, NHS Improvement, and the British Association of Dermatologists (BAD), to review specific topics.

Findings

We found wide unwarranted variation in provision of dermatology services across the UK. The experience of people with skin disease varies greatly as a consequence.

We focused our review and recommendations on the areas of dermatology provision that offer the most significant clinical and operational opportunities for improvement.

Workforce

Consultant dermatologists

Shortages in the dermatology medical workforce are having a serious impact on the efficient functioning of nearly all units. These shortages dominated discussions in all but a tiny handful of visits.

Workforce shortages are responsible for:

- the increasing use of high-cost locums and other short-term initiatives;
- long waits for people with non-cancerous but distressing and disabling skin diseases, because the NHS prioritises resources to meet cancer targets;
- considerable variation in provision of the gold standard Mohs skin cancer surgery.

Workforce shortages are also a key factor in variation in access to key services, such as:

- phototherapy for psoriasis and eczema;
- allergy patch testing;
- biological therapy for severe psoriasis;
- emergency care for dermatology;
- care for sick children, for example Birmingham Children's Hospital is now closed for routine secondary care dermatology referrals for children with skin disorders;
- care for genital skin disorders;
- psychodermatology for mental health problems relating to skin.

There is a national shortage of consultant dermatologists with just 659 consultant dermatologists working in the NHS in England. At the same time, there are 159 WTE vacancies. At least ten trusts have no substantive dermatology consultants at all.

Addressing the shortfall

One reason for the shortage of dermatologists is the imbalance between the number of vacancies and the number of training posts available. Yet, there is no shortage of interest from quality candidates for trainee positions. Each year, over 150 well-qualified candidates apply for the 34 available posts.

Health Education England (HEE) has indicated that the number of dermatology consultant training posts is held at the current number for two key reasons:

- because there is a finite funding resource for training;
- because there is a finite number of doctors, so there is a need to balance the requirements of all specialties.

Although increasing the number of training posts would help to ease the shortfall, it's clear that more innovative solutions are needed.

Certificate for Eligibility for the Specialist Register (CESR)

The British Association of Dermatologists (BAD) College of Dermatology has developed an educational pathway that leads to the Certificate for Eligibility for the Specialist Register (CESR). Doctors with the CESR qualification join the GMC specialist register, meaning their status is the same as a consultant who has trained via the standard pathway.

At the time of publication there are 82 (80 WTE) doctors training to do CESR, with wide variation in their regional location.

We encourage trusts facing shortages to train their own dermatologists by following the CESR programme.

Recommendation

We are recommending increasing the number of people training in dermatology.

Networks and hub and spoke services

Several trusts and commissioners are developing networks, partnerships and hub and spoke services as a way of increasing support for smaller dermatology units. The general approach is to enable clinicians working in a small unit to spend one or more days per week in a larger unit.

Current models over-rely on the efforts of one or two individual consultants who are aiming to deliver effective services in the face of numerous pressures.

Shortfalls in the consultant dermatology workforce also mean that some consultants find themselves working single-handed. It is generally poor practice for consultants to work in isolation from other consultants; it means there is no opportunity to discuss new practice or to review each other's practice, which are both essential to protecting patients.

Recommendation

We are recommending that trusts develop regional or sub-regional strategic plans for sustainable partnerships to support smaller units and eliminate single-handed working.

The wider dermatology multidisciplinary team

Specialist nurses

British dermatology leads the world in dermatology nursing. Nurses now do surgery and many other roles previously reserved for doctors, while bringing nursing skills to these roles. Most dermatology units have specialist dermatology nurses working as part of their multidisciplinary teams. This is helping to improve dermatology capacity in those trusts.

All available data and reports from our deep dive visits suggest that specialist nurses deliver good and effective care provided that this is part of a consultant-led dermatology team.

General Practitioners

GPs are the first person most patients see with their skin problems. Around 75% of all NHS consultations for skin problems take place in GP surgeries.

Yet many GPs receive little formal dermatology training beyond one to two weeks as part of their five-year medical school course. Some medical schools have even removed dermatology from their curriculum altogether.

It is essential that all GPs are provided with sufficient basic training to diagnose and provide evidence-based treatments for the common skin diseases.

Pharmacists

Community pharmacists are often the first port of call for people with common dermatological conditions, such as acne or eczema.

Developing the dermatology expertise of pharmacists, potentially to consultant pharmacists, offers another way to meet the increasing dermatology workload.

Physician associates (PAs)

There is great potential for physician associates (PAs) to deliver care to people with dermatological diseases.

We found only one report of a PA in dermatology and they had since left their post.

We believe there needs to be a career structure for PAs to encourage highly educated and able individuals to have a long-term NHS career.

Superclinics

Superclinics are a proven model and are used widely overseas. They maximise the expertise of the most experienced team members for the benefit of the maximum number of patients.

Superclinics offer a solution to meeting additional training needs given that dermatology consultants in short-staffed departments are too busy to provide additional training.

Recommendation

We are recommending optimising the training and function of the whole dermatology multidisciplinary team to deliver better care across settings and reduce locum costs.

Efficient use of NHS resources

Surgery in inappropriately complex settings

We found wide variation in the number of day cases and outpatient procedures between trusts.

At least some of this variation can be explained by the difference between the day case and outpatient procedure tariffs to do the same operation. The current classification leads to a perverse financial incentive to carry out surgery as a day case in inappropriately complex settings in both dermatology and other specialties. There is no evidence that outcomes are improved by carrying out procedures in the more complex settings.

Recommendation

We are recommending there is clear and consistent delineation between day case and outpatient skin cancer activity taking place in dermatology and in other specialties. Funding arrangements should reflect this to support surgery in the most appropriate and efficient setting.

Follow-up rates

We found wide variation in follow-up rates between units.

We found that units with high follow-up rates were often those that find themselves having to employ a series of locum doctors, some of whom may be inexperienced and not on the GMC specialist register.

We found that several trusts carry out an above average number of follow-up appointments in the six months after skin cancer surgery. This may be partly due to variation in local skin cancer pathways. However, this does not fully explain the variation seen.

Outpatient did not attend (DNA) rates

There is considerable variation in did not attend rates between units.

Most trusts have introduced text reminders to help reduce DNAs and this has resulted in some improvement.

Improving how hospitals communicate with their local populations, such as making hospital letters and texts more accessible, could help trusts achieve higher attendance rates.

Recommendation

We are recommending a series of actions to address unwarranted variation in follow up rates, reduce unnecessary follow ups, reduce DNAs and ensure that patients see an appropriately trained person in the right setting to receive the right diagnosis and treatment first time

Shared care between primary and secondary care

Shared care between primary and secondary care services can be an effective way to deliver dermatology services. For example, GPs could carry out appropriate blood tests to avoid long journeys to hospitals.

We found that successful provision of shared care in dermatology between primary and secondary care is patchy. Some GPs are resistant to carrying out testing for a number of reasons including their workload and lack of knowledge and training.

MDT reviews of private patients with cancer

We found that private patients with cancer were reviewed in 63% of NHS MDTs. However, only 9% of trusts reported they were paid for this work. This raises the issues of lost income and, more importantly, governance.

Recommendation

We are recommending a series of actions to improve care continuity and governance for NHS and non-NHS patients.

Equity of care and access to treatments

Mohs surgery

Mohs surgery is the gold standard treatment for certain skin cancers, especially for ill-defined cancers on the face. Although the cost of Mohs surgery is higher than conventional surgery, Mohs is considered to be cost-effective if used in appropriate patient groups as it reduces cancer recurrence rates.

There is wide variation in access to Mohs surgery between CCGs. Some areas are well-served: for example, patients living in Salford are over ten times more likely to get Mohs surgery than those living in some other areas of England who have very poor access to Mohs surgery.

The primary reason for poor access in some areas is the lack of surgeons with training in Mohs.

Recommendation

We are recommending improving equitable access to high-quality Mohs surgery. As this may incur costs in the short-term, with potential longer-term savings, we are also suggesting that a financial impact assessment is produced locally.

Skin melanoma mortality rates

There is variation in rates of skin melanoma mortality between CCGs.

We are currently working with units to identify reasons for the variation. Early indications are that most of the variation is due to ethnicity as melanoma is much more common in people with northern European ancestry.

Skin biopsy rates

Dermatologists are able to identify most skin cancers from their appearance and will usually opt to cut out (excise), the cancerous area without the need for an initial biopsy.

There is wide variation in biopsy rates between trusts, and alsp biopsy rates prior to areas of skin being cut out.

Some units with high rates of biopsies explained that this was because they were unable to employ experienced consultants due to the workforce shortage; inexperienced or unqualified locum doctors carried out relatively high levels of biopsies to reduce their risk of litigation from wrong diagnoses, or because they had little idea what was wrong with the patient.

Clinical nurse specialist contact for people diagnosed with melanoma skin cancer

Clinical nurse specialists (CNS) can provide information, guidance and assistance with managing the diagnosis of cancer, and expert psychological support at times of great distress, such as the diagnosis of a potentially fatal disease.

There is variation between trusts in the reported rates of patients who see a clinical nurse specialist (CNS). Most of this variation is down to reporting errors, but there are shortages of CNSs in some hospitals.

Infection rates

Although dermatology carries out over 200,000 surgical operations for suspected skin cancer each year, the NHS does not have a system for identifying variation in infection rates for this surgery.

Local audit evidence suggests that serious infection is rare after dermatology surgery. Occasional local wound infections require courses of antibiotics from GPs.

Medical photography

Medical photography is essential for identifying lesions for removal if there is a possibility that a surgeon may not otherwise be able to correctly identify the lesion for removal. Failure to identify the area or lesion regarded as abnormal at a previous appointment is a known cause of wrong site cancer surgery, the commonest cause of dermatology never events.

Medical photography also enables cancer MDT meetings to discuss patients (see page 74) without the patient having to be present.

We found that not all units had access to a medical photography service.

Recommendation

We are recommending a series of actions to reduce the likelihood of wrong-site skin cancer surgical never events.

Benign and cosmetic conditions management

It can sometimes be necessary to remove benign lesions with borderline appearance to be sure of not missing skin cancer or other serious conditions.

Some people believe they are entitled to NHS treatment of benign lesions and other conditions of a cosmetic nature. These patients may threaten clinical staff with complaints or litigation if the clinicians do not provide treatment.

Almost a quarter (24%) of dermatology departments did not feel there were effective local protocols to prevent NHS referral of cosmetic disorders.

Recommendation

We are recommending that Clinical Threshold Policies are developed for benign and cosmetic conditions management.

Skin cancer MDTs

We found that the most effective MDTs use technology, such as video conferencing, to enable teams to meet virtually.

Histopathology

Dermatology services rely on histopathology for important tissue diagnoses that are needed to help manage patient care.

Rapidly increasing rates of skin cancer are adding greatly to the histopathology workload. In some histopathology departments, almost half of the cancer workload relates to skin cancers.

Many trusts told us that this increasing workload comes at a time when they are finding it increasingly difficult to recruit histopathology consultants. This is reflected in the wide variation we found in the speed of histopathology reporting.

Some dermatologists specialise in histopathology, reading their own slides and those of colleagues.

It also seems likely that AI will play an increasing role in future histopathology. AI will also be used to enhance expert decision-making by clinicians to ensure that the right lesions are removed for histopathology.

Recommendation

We are recommending a series of actions to improve access to dermatopathology.

Allergy patch testing

Patch testing is most commonly used to identify possible causes of localised, disabling allergic eczema; often on the hands, feet, face, genitals or multiple sites.

Patch testing rates vary significantly by CCG. Some trusts provide no patch testing due to workforce shortages. Other areas run centralised patch testing. This has the advantage of quality of care, but the disadvantage of decreased access for those who must travel greater distances.

The NICE-accredited service standards describe how appropriately trained nurses can do allergy patch testing, bringing additional skills to the team, working alongside and under the supervision of a consultant.

We also found that coding issues mean most trusts are charging a tariff that is artificially low and are under-recording attendances for this investigation on HES.

Recommendation

We are recommending a series of actions to improve access to, and quality of, allergy patch testing services.

Emergency dermatology care

Emergency skin problems are relatively common and require assessment within 24-48 hours. Many can be dealt with by telephone advice from the dermatology team, including specialist nurses.

Life-threatening skin conditions that require out-of-hours on-call emergency cover are rare. When out-of-hours services are available, there is a tendency for doctors working overnight to use them as a general advice service.

Out-of-hours services are expensive to staff; further research is needed to identify the actual requirement for them.

Current consultant contract arrangements mean that little or no allowance is made for the fact that a doctor may have provided out-of-hours service ahead of their regular day working in clinic or doing an operating list.

Recommendation

We are recommending a series of actions to improve access to, and quality of, emergency dermatology care.

Biological medicines (biologics) for psoriasis, eczema and other conditions

In the past, it was normal for dermatology departments to have wards full of people having treatment for psoriasis, eczema and other conditions.

Thanks to biologics, those numbers have greatly reduced over the last 15 years.

Despite NICE and BAD guidance, there is wide variation in the uptake of biologics for psoriasis. There are a number of causes of this:

- variation in how CCGs are interpreting NICE guidance;
- variation in clinicians' readiness to use newer drugs;
- influence of marketing by the pharmaceutical industry;
- variation in patients' readiness to use newer drugs;
- wide range of choices creates confusion;
- administrative burden strengthens inertia;
- anticipating future cost reductions;
- variation in CCG understanding of special interest consultant roles

Recommendation

We are recommending a series of actions to consistently implement NICE guidance to address variation in uptake and use of biological medicines and ensure patients have equitable access to appropriate therapies.

Phototherapy

Phototherapy is the second of four stages in the treatment of psoriasis and eczema and there is evidence that this is a highly cost-effective therapy.

There is wide variation in the level of phototherapy use between trusts, including variation in clinical practice, variation in the availability of trained specialist nurses, variation in opening hours, and distance and time to attend appointments.

Increasing access to phototherapy should reduce the number of people progressing to more complex treatments such as biologics.

Recommendation

We are recommending improving access to and quality of phototherapy services.

Before increasing phototherapy services, trusts should produce a financial impact assessment taking into account the long-term savings and the relationship between use of phototherapy and biologics.

Medical dermatology

For many people their dermatological condition is part of a complex disease affecting other parts of the body.

The most effective care for patients with the most severe and complex diseases comes from specialists from different specialties working together, sharing their expertise as a team. Larger teaching hospitals, which act as tertiary referral centres for complex cases (and some smaller units) run combined clinics to facilitate this kind of shared expertise.

There are currently no consistent specialised commissioning arrangements for these combined clinics. The Dermatology Specialised Service Clinical Reference Group (CRG) is currently developing MDT networks. The CRG advised us that it is also exploring what would be the best arrangements for on-call cover for specialised centres and for certain complex skin diseases in adults and children.

Recommendation

We are recommending that networks are established to encourage shared care and expertise across specialties for complex medical dermatology.

Genital skin disease

Genital skin diseases are often painful, may develop into cancer and have serious effects on sexual function and, as a consequence, on self-image, mental health, fertility and relationships.

We found wide variation in access to vulval clinics and male genital clinics.

Hair and nail disease

Hair loss can be devastating to adults and to children.

Melanoma skin cancer can present under nails, requiring surgery under the nail to diagnose and treat this life-threatening condition.

There is very wide variation in access to specialist hair clinics with just 18 trusts running hair clinics.

Psychodermatology

Psychodermatology deals with mental health issues related to dermatology.

The nature of dermatology means there are many such issues. For example, skin and hair conditions often trigger depression, anxiety, suicidal thoughts and low self-esteem.

Psychodermatology also involves seeing people with psychiatric disorders who present to dermatologists. For example, skin may be self-damaged as a cry for help from children and adults being abused or by those with depression or anxiety.

There is wide variation in access to psychodermatology; there are currently just 11 dermatologists running psychodermatology clinics in nine trusts.

Recommendation

We are recommending improving access to dermatology specialties, including hair and nail disease, female and male genital skin disease, and psychodermatology.

Paediatric dermatology

There are many dermatological conditions that are common in children and young adults, such as eczema and acne.

There are also hundreds of less common skin conditions, some of which are life threatening.

We found that the shortfall in the number of dermatology consultants with a special interest in paediatric skin disease is having a negative impact on the management of paediatric patients in secondary care.

We also heard how issues related to tariffs make it challenging for some trusts to develop paediatric dermatology services in secondary care.

Recommendation

We are recommending improving access to, and quality of, paediatric dermatology services.

Isotretinoin prescribing

Isotretinoin is a highly effective treatment for severe acne and can prevent lifelong scarring. It requires careful monitoring as it is harmful in pregnancy and there are also uncertain associations with suicide, depression and effects on libido.

We found variation in interpretation of the MHRA guidance on isotretinoin prescribing.

Recommendation

We are recommending that prescribing and dispensing practice for isotretinoin is reviewed.

Innovation, research and safety

Teledermatology: advice and guidance, and teletriage

The use of images is integral to teledermatology. High-definition medical photography with appropriate clinical history is used to help clinicians carry out remote diagnosis and management of dermatological conditions, and to support the triage of referred patients to the correct clinical setting.

There is wide variation in access to teledermatology.

Digital technology used to triage referrals shows promise in reducing face-to-face consultations and improving patient pathways. In the future, if developed wisely, this will be used to underpin networks between primary, secondary and tertiary care.

Recommendation

We are recommending that teledermatology services are reviewed to inform trust-level investment and resourcing decisions.

Telephone and video outpatient consultations

Telephone outpatient consultations are popular with many patients and offer the potential to reduce follow-ups, save clinic space, and ease car parking and local road traffic pressures.

The COVID-19 pandemic saw an increase in the use of video consultations. Some departments found them a useful way to see patients who were unable to attend hospital, but others found them impractical.

Recommendation

We are recommending increasing the use of telephone outpatient consultations and exploring further the new video consultation systems which clinicians report to be effective.

Nurses as principal investigators for research

There is growing recognition that nurses working in research can support NIHR clinical studies.

We support the dermatology NIHR programme's aim to develop nurse principal investigators (PIs) in every region to improve recruitment and research participation for patients.

BADBIR (British Association of Dermatologists' Biologics and Immunomodulator Register)

BADBIR (British Association of Dermatologists' Biologics and Immunomodulator Register) is a study consisting of a national registry to assess the safety and efficacy of new psoriasis biologics drugs (see page 84) in comparison to conventional treatments. This should lead to treatment that is more personalised, safer and more effective.

Patients and departments doing clinical research have better clinical outcomes. We support the development of high-quality clinical research such as BADBIR.

Medication safety hazards

We have been working with representatives of NHS England and NHS Improvement and the BAD to find solutions to the following known safety hazards:

- deaths and serious harm following ingestion of potassium permanganate;
- emollient fire hazard.

Recommendation

We are recommending a series of actions to ensure the public, patients and clinicians have access to the latest research studies, information and support to implement national safety recommendations.

Procurement

GIRFT has established a programme to identify and analyse unwarranted variation in procurement in the NHS.

Recommendation

We are recommending a series of actions that will enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.

Litigation

The average total cost of clinical negligence claims in dermatology was estimated to be £5.2m per year from 2013-18.

There is noticeable variation in litigation costs between providers. Nearly half of all providers faced no litigation over the five-year period we looked at, while the provider with the highest costs generates an average £11 of litigation costs per activity.

This variation is primarily due to a small number of high cost claims, particularly when these have occurred in small departments.

Recommendation

We are recommending that trusts implement the GIRFT 5-point plan for reducing litigation costs.

Recommendations

Recommendation	Actions	Owners	Timescale
1. Increase the number of people training in dermatology	**a** Review options to increase funded training posts in regions with greatest shortages of consultants.	HEE; Statutory educational bodies; DHSC	6 months
	b Standardise and formalise CESR training to increase non-locum medical staffing with the aim of allowing trusts to develop sufficient future consultant staff to meet their local needs.	GMC with BAD	Ongoing work in many areas – up to two years
	c Contribute findings to the national programme board being established to address geographic and specialty shortages in doctors	GIRFT	12 months
2. Develop regional or sub-regional strategic plans for sustainable partnerships between local trusts to eliminate single-handed working and support smaller units.	**a** Work collaboratively, for example by identifying non-conventional job planning solutions, and by establishing service-level agreements/joint-working arrangements to develop network models that will provide support to consultants working in smaller units.	Trusts	12 months
3. Optimise the training and function of the whole dermatology multidisciplinary team to deliver better care across settings and reduce locum costs. Develop a clinic structure to support this.	**a** Train dermatology nurses as specialist nurses and as nurse consultants to expand the workforce in a safe, efficient and cost-effective way to meet the challenges of increasing skin cancer and the needs of people with skin disorders.	Trusts (with support from BDNG and BAD)	18 months
	b Adopt the framework for nurse banding and training developed by the BAD and BDNG to standardise roles and education across the NHS for dermatology nurses.	Trusts	12 months
	c Include dermatology in training schemes for GPs and other primary care staff to improve evidence-based patient care and reduce unnecessary referrals.	RCGP; RCN; RPS; BDNG; BAD	18 months
	d Include dermatology training that meets the BAD curriculum in all medical school courses so that all GPs have basic dermatology skills.	Medical schools	For substantial progress within two years of report publication
	e Improve undergraduate dermatology training for pharmacists, so that community pharmacists are able to manage common skin conditions such as eczema, acne, fungal infections and warts in line with current evidence-based dermatology national guidelines.	Pharmacy schools	For substantial progress within two years of report publication
	f Explore the potential for hospital pharmacists to help with the management of patients on systemic medications, including biologics.	Trusts	12 months
	g Develop the use of superclinics as a model to allow safe supervision of a multidisciplinary workforce.	Trusts	12 months

Recommendation	Actions	Owners	Timescale
4. Ensure there is a clear and consistent delineation between day case and outpatient skin cancer surgery activity taking place dermatology. This should apply to other specialties treating skin cancer. Funding arrangements should reflect this to support surgery in the most appropriate and efficient setting.	**a** Develop simpler standardised rules defining outpatient procedures versus day case surgery.	Trusts, commissioners, possible GIRFT skin cancer workstream	12 months
	b Review funding arrangements to standardise funding and practice, ensuring trusts are incentivised to carry out surgery in the most appropriate setting, avoiding unnecessary use of operating theatres.	Trusts; commissioners; possible GIRFT skin cancer workstream	18 months
5. Address unwarranted variation in follow-up rates, reduce unnecessary follow-ups, reduce DNAs and ensure that patients see an appropriately trained person in the right setting to receive the right diagnosis and treatment first time.	**a** Benchmark follow-up rates, both including procedures and excluding procedures, and proportion of new patients discharged. Trusts should identify a target rate based on their circumstances to enable them to assess their performance	GIRFT; trusts	6 months
	b Explore rates for individual clinicians to identify if there are particular case-mix reasons for this.	Trusts	6 months
	c Inform patients of their diagnosis by letter after excision of low risk skin cancers unless there are particular reasons for seeing them again in secondary care.	Trusts	3 months
	d Use the languages widely spoken by the local community in outpatient communications to support patient understanding. Ensure that communications by letter and text use simple language.	Trusts	6 months
6. Improve care continuity and governance for NHS and non-NHS patients.	**a** Establish clear and suitably funded shared care protocols between primary and secondary care providers for dermatology services	GIRFT; trusts; CCGs; GPs; NOTP	18 months
	b Establish clear arrangements between NHS and independent providers to ensure continuity of care for non-NHS patients discussed during dermatology MDT meetings	Trusts	12 months
	c Inform and support the work of NHS England and the Independent Healthcare Providers Network (IHPN) to implement new medical governance framework	GIRFT	12 months
7. Improve equitable access to high-quality Mohs surgery that meets national standards for patients with complex skin cancers.	**a** Continue to review how access to high-quality Mohs surgery that meets national standards can be improved in remote areas.	NHS England (CRG); BAD; BSDS	12 months
	b Commission health economic research to provide evidence to establish a standard rate/population, which will depend on demographics, for Mohs surgery to enable effective planning and equal access to this service.	NIHR	2 years

Recommendation	Actions	Owners	Timescale
8. Reduce the likelihood of wrong-site skin cancer surgical never events.	**a** Consider establishing or improving access to efficient and secure technology as provided by medical illustration services to record the position of lesions booked for surgery.	Trusts	12 months
	b Develop a standard operating procedure, incorporating the WHO checklist, to reduce the risk of wrong site surgery. Audit against this for compliance.	Trusts	For immediate action
9. Develop Clinical Threshold Policies for benign and cosmetic conditions management.	**a** CCGs should work with local GPs and consultants to develop and implement Clinical Threshold Policies, learning from existing best practice and in line with the Evidence-Based Intervention Programme.	CCGs; trusts; NHS England's Evidence-Based Intervention programme	12 months
10. Improve access to dermatopathology.	**a** Develop dermatopathology training (requires implementation of other recommendations to address workforce shortfalls).	HEE; RCPath; BAD	For substantial progress within two years of report publication
	b Promote the development of AI and digitisation of slides to support the work of clinicians in dermatology histopathology reporting.	NHSX	12 months
11. Improve access to, and quality of, allergy patch testing services.	**a** Make access to patch testing more widespread by introducing high quality clinics which meet service standards in areas where provision is low.	Trusts	12 months
	b Develop a national patch testing database to ensure standardisation of testing and facilitate national outcome measures.	BAD; BSCA	For substantial progress within two years of report publication
	c Consistently code patch testing. GIRFT considers that all three visits should be coded as a patch test	Trusts	6 months
	d Produce a local financial impact assessment of improving access to provide equity of care.	Trusts	12 months
12. Improve access to, and quality of, emergency dermatology care.	**a** Establish the workforce to supply office hours dermatology emergency care to support GPs and all acute hospitals with inpatients.	BAD; CCGs, trusts	12 months
	b Conduct research to establish the requirement for out-of-hours dermatology care for life threatening conditions.	CCGs; trusts; dermatology CRG	2 years
	c Reimburse doctors for working on call overnight and allow adequate rest time to avoid safety issues with next-day working after out-of-hours provision.	CCGs and trusts	For immediate action
13. Consistently implement NICE guidance to address variation in uptake and use of biological medicines and ensure patients have equitable access to appropriate therapies.	**a** GIRFT to work with NICE to ensure guidance aimed at CCGs relating to use of biologics can be consistently applied.	GIRFT	12 months
	b Trusts to submit data on biologics use to Rx-Info Define© (the NHS drugs database) and any subsequent NHS drugs databases in order to enable regional benchmarking of biologics use and identification of unwarranted regional variation in prescribing.	Trusts	6 months
	c NIHR to fund research into the influence of pharmaceutical companies on prescribing behaviour in England for high-cost medicines such as biologics.	NIHR	2 years

Recommendation	Actions	Owners	Timescale
14. Improve quality of, and access to, phototherapy for all appropriate patients.	**a** Support NHS Digital's development of a national database for phototherapy	GIRFT	2 years
	b Provide access to phototherapy services at suitable times and venues for people in work.	Trusts	12 months
15. Establish networks to encourage shared care and expertise across specialties for complex medical dermatology.	**a** Support the work of NHS England's Dermatology Specialised Service Clinical Reference Group (CRG) to develop MDT networks for complex medical dermatology	GIRFT/CRG	12 months
16. Improve access to dermatology specialties, including hair and nail disease, female and male genital skin disease, and psychodermatology.	**a** Establish clinics to ensure more locations have access to these services to provide equity of care.	CCGs; trusts	For substantial progress within two years of report publication
17. Improve access to, and quality of, paediatric dermatology services.	**a** Encourage further uptake of the dermatology SPIN module among paediatricians to work alongside paediatric dermatologists to improve access to specialist support for children with skin conditions.	BSPD; RCPCH; RCP	18 months
	b Support further analysis of the potential for NTN Grid training for paediatricians in dermatology to work alongside paediatric dermatologists to improve patient access.	BSPD; RCPCH; RCP	24 months
18. Review prescribing and dispensing practice for isotretinoin.	**a** Review whether isotretinoin prescribing should be extended to fully trained GPwERs.	MHRA; RCGP; BAD; RPS	For immediate discussion
	b Consider how to safely allow certain community pharmacists to dispense isotretinoin to increase access for those people attending community dermatology clinics and with difficulty accessing hospital pharmacies.	MHRA; RCGP; BAD; RPS	For immediate consideration
19. Review teledermatology services to inform trust-level investment and resourcing decisions.	**a** NIHR to fund studies evaluating the efficacy, safety and efficiency of teledermatology with full health economic assessment.	NIHR	2 years
	b Assess teledermatology services based on the points described in our report when considering whether to invest.	Trusts; CCGs	6 months
	c Trusts/CCGs to publish research and learning from teledermatology services so that others can learn lessons and share best practice. The FutureNHS Collaboration Platform is set up for this.	Trusts; CCGs	12 months
	d Offer patients the electronic referral system (e-RS) Advice and Guidance Service.	Trusts	For immediate action
	e Include time spent providing Advice & Guidance and teletriage in the job plans for dermatologists.	Trusts	6 months
	f Support services keen to innovate in this area, in line with the recommendations in actions 19b and 19c.	GIRFT; trusts; CCGs; NOTP	Immediate
	g Prepare teledermatology services and other clinical services for the introduction of AI and machine learning.	Trusts	18 months

Recommendation	Actions	Owners	Timescale
20. Increase use of telephone outpatient consultations.	**a** Introduce telephone consultations for appropriate dermatology patients.	Trusts	For immediate action
	b Include telephone outpatient clinics in job plans.	Trusts	For immediate action
	c Provide guidance and protocols for effective use of telephone and video consultations in dermatology	NOTP	For immediate action
21. Ensure the public, patients and clinicians have access to the latest research studies, information and support to implement national safety recommendations.	**a** Improve awareness and support implementation of national actions related to: • risks of fire associated with use of skin creams and cosmetics containing any oil • risks of accidental ingestion of potassium permanganate antiseptic tablets and solutions • future safety issues when they arise.	GIRFT, BAD, MHRA NHS England and NHS Improvement national patient safety team	For immediate action
	b Encourage all trusts to increase recruitment to clinical research to improve patient outcomes	NIHR, other dermatology research organisations, Trusts, CCGs	18 months
	c Continue to share learning about patient safety issues with the whole multidisciplinary team.	Trusts	Ongoing
	d Report adverse incidents through appropriate channels.	Trusts	For immediate action
	e Continue to work with NHS England and NHS Improvement and the MHRA to review skin product formulation and packaging to reduce the risk of avoidable patient harm.	GIRFT, BAD	Ongoing
22. Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.	**a** Use sources of procurement data, such as the NHS Spend Comparison Service and relevant clinical data, to identify optimum value for money procurement choices, considering both outcomes and cost/price.	Trusts	6 months
	b Identify opportunities for improved value for money, including the development of benchmarks and specifications. Locate sources of best practice and procurement excellence, identifying factors that lead to the most favourable procurement outcomes.	Trusts	12 months
	c Use Category Towers to benchmark and evaluate products and seek to rationalise and aggregate demand with other trusts to secure lower prices and supply chain costs.	Trusts	12 months

Recommendation	Actions	Owners	
23. Implement the GIRFT 5-point plan for reducing litigation costs.	**a** Clinicians and trust management to assess their benchmarked position compared to the national average when reviewing the estimated litigation cost per unit of activity.	Trusts	For immediate action
	b Clinicians and trust management to discuss with the legal department or claims handler the claims submitted to NHS Resolution included in the data set to confirm correct coding to that department. Inform NHS Resolution of any claims that are not coded correctly to the appropriate specialty via CNST.Helpline@resolution.nhs.uk	Trusts	On completion of A
	c Once claims have been verified, clinicians and trust management to further review claims in detail, including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If the legal department or claims handler needs additional assistance with this, each trust's panel firm should be able to provide support	Trusts	On completion of B
	d Claims should be triangulated with learning themes from complaints, inquests and serious incidents (SI). Where a claim has not already been reviewed as SI, we recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared with all front-line clinical staff in a structured format at departmental/ directorate meetings (including multidisciplinary team meetings, and morbidity and mortality meetings where appropriate).	Trusts	On completion of C
	e Where trusts are outside the top quartile of trusts for litigation costs per activity, GIRFT will be asking national clinical leads and regional hubs to follow up and support trusts in the steps taken to learn from claims. Clinical leads and regional hub directors will also be able to share examples of good practice with trusts.	GIRFT hubs	For continual action throughout GIRFT programme

Dermatology today

What it is and who it affects

The specialty of dermatology is concerned with diagnosing and treating diseases and conditions of the skin, nails and hair. Given there are an estimated 4,000 plus possible dermatological diagnoses, it's not surprising that over half the population have a dermatological concern of some form.[3]

Skin, nail and hair disease are among the most common reasons for seeking NHS help, with around one in four people in England and Wales (13.2m) seeing their GP about a dermatological condition every year.[4] In 2018/19, there were over 3.5m dermatology outpatient and day surgery attendances.[5] Dermatological conditions are among the most common reasons for visiting a GP.

Conditions and their effects

Dermatological conditions range in severity from mild cases of eczema, psoriasis, skin infections, acne and mild drug reactions through to severe forms of these and other conditions that have a significant impact on a patient's quality of life.

Disorders may come on suddenly and result in complete hair loss, facial rashes or disfigurement. These problems and their impact on appearance can cause much distress and anguish, often causing or contributing to poor mental health. For example, severe acne can cause depression and social isolation. Other disorders affecting the feet, hands and genitals, such as eczema, psoriasis and lichen sclerosus, can make everyday activities difficult or impossible. Some disorders can be fatal, such as severe skin reactions to medications, squamous cell carcinoma[6] and melanoma.

A number of environmental factors affect dermatological conditions. For example, increasing sun exposure has made skin cancer the commonest UK cancer. Close living and working conditions, such as in schools and nursing homes, can contribute to outbreaks of infectious skin diseases, such as impetigo, fungal infections and scabies. Similarly, increasing levels of global travel mean we see more cases of infections in the UK that affect the skin, such as leprosy and leishmaniasis. Epidemic infections, such as COVID-19, may present with a rash.[7]

Increasing incidence of skin cancer

In recent decades, skin cancer has become more common,[8] with cases in England and Wales increasing by around 8% per year – equivalent to doubling at least every 14 to 15 years. It now accounts for approximately half of all cancers in the UK and forms an increasing proportion of the dermatological caseload. NHS dermatology units now carry out over 200,000 surgical excisions, often for skin cancer, every year.[9, 10, 11]

Skin cancer work is done in collaboration with other specialties, including plastic surgery, maxillofacial, ENT, ophthalmology, oncology, radiotherapy and pathology.

NICE has developed guideline NG12: Suspected cancer: recognition and referral,[12] including a weighted seven-point checklist diagnostic aid (alongside taking a clinical history and naked eye examination).

Skin cancer prevention is of clear importance. NICE guideline NG34 sunlight exposure: risks and benefits advises on safe sun exposure.[13]

[3] *Schofield J, Grindlay D, Williams H (2009) Skin conditions in the UK: a Health Care Needs Assessment. Centre of Evidence Based Dermatology, University of Nottingham. www.nottingham.ac.uk/research/groups/cebd/documents/hcnaskinconditionsuk2009.pdf.*

[4] *Association of the British Pharmaceutical Industry Dermatology Initiative (2018) Making real our shared vision for the NHS: optimising the treatment and care of people with long-term skin conditions in England. www.abpi.org.uk/media/4684/der-0080-0517-dermatology_initiative_report_rev16.pdf*

[5] *Hospital Episode Statistics (HES) outpatient and day case figures.*

[6] *Venables ZC, Autier P, Nijsten T et al.(2019) Nationwide Incidence of Metastatic Cutaneous Squamous Cell Carcinoma in England. JAMA Dermatol. 155(3):298-306.*

[7] *Galván Casas C, Català A, Carretero Hernández G et al (2020) Classification of the cutaneous manifestations of COVID‐19: a rapid prospective nationwide consensus study in Spain with 375 cases. British Journal of Dermatology. https://onlinelibrary.wiley.com/doi/10.1111/bjd.19163*

[8] *Venables ZC, Nijsten T, Wong KF et al.(2019) Epidemiology of basal and cutaneous squamous cell carcinoma in the U.K. 2013-15: a cohort study. Br J Dermatol. 2019. 181(3):474-482.*

[9] *Goon PKC, Greenberg DC, Igali L, Levell NJ (2017) Predicted cases of U.K. skin squamous cell carcinoma and basal cell carcinoma in 2020 and 2025: horizon planning for National Health Service dermatology and dermatopathology. Br J Dermatol. 176(5):1351-1353.*

[10] *Goon PKC, Greenberg DC, Igali L, Levell NJ (2016) Squamous Cell Carcinoma of the Skin has More Than Doubled Over the Last Decade in the UK. Acta Derm Venereol 96(6):820-1.*

[11] *Levell NJ, Igali L, Wright KA, Greenberg DC (2013) Basal cell carcinoma epidemiology in the UK: the elephant in the room. Clin Exp Dermatol. 38(4):367-9.*

[12] *NICE (2015, updated 2017) Suspected cancer: recognition and referral (NG12), https://www.nice.org.uk/guidance/ng12*

[13] *NICE (2016) Sunlight exposure: risks and benefits (NG34), https://www.nice.org.uk/guidance/ng34*

GIRFT skin cancer workstream

Due to the increasing prevalence and impact of skin cancer, GIRFT is currently considering a workstream to review skin cancer services. That workstream would build on this report and reports from other workstreams, including plastic surgery.

It is likely that the skin cancer workstream would focus on:

- incidence of skin cancer and its impact;
- optimal treatment pathways, including links between specialties;
- the most efficient setting for skin cancer work;
- the potential for skin cancer work to be carried out by the wider NHS workforce, building on one the main themes of this dermatology report.

Causes and patient cohort

Dermatological conditions can be caused by inherited, environmental or occupational factors, or a combination of all three.

Patients come from all age groups. However, skin cancer in the ageing population, along with younger people's concerns about skin cancer, increasing public expectations for perfect skin, and the huge opportunities offered by new targeted genetic and biological treatments, are increasing demands for dermatological care.

Ethnicity

Ethnicity has a considerable effect on the incidence and impact of skin disease. For example, skin cancer is much more common in those with North European ancestry, while severe childhood eczema is more common in those with South Asian ancestry. In terms of impact, the depigmented areas of vitiligo will tend to have greater impact on those with darker skin.

Paediatric dermatology

Skin problems are the commonest reasons for children and young people to seek medical care. Eczema is the most common reason for young people below the age of 10 to seek help from the NHS, and acne is the most common reason between the ages of 10 to 20.[14]

Most dermatologists are involved in managing the common skin conditions seen in children. Some clinicians with training in both paediatrics and dermatology specialise in paediatric dermatology (see page 98) dealing with common and rarer conditions in specialist centres.

Skin disease in the elderly

Many elderly people have multiple illnesses, including skin conditions. Some of these patients report that those caring for them consider their skin conditions to be less important than other conditions, even though those skin conditions are a cause of significant discomfort and concern.

Multi-morbidities

Life-threatening conditions, such as contagious diseases caught in the UK and abroad, internal cancers, diabetes, heart, respiratory, gastrointestinal and rheumatological diseases, may all first present with cutaneous (skin) changes.

Educating all clinicians in these cutaneous changes may improve early disease detection, improve the chances of curing patients, provide better care, and reduce onward transmission of contagious disease.

Public expectations of perfection

Media images of 'perfect' skin, nails and hair have changed people's expectations for how they should look. One result of this change is that people now seek and expect NHS treatment for milder conditions that may have been tolerated in the past.

There is also a growing demand for cosmetic anti-ageing treatments, such as fillers or Botox injections, which are outside the scope of NHS services.

[14] *Kuan V, Denaxas S, Gonzalez-Izquierdo A et al. (2019) A chronological map of 308 physical and mental health conditions from 4 million individuals in the English National Health Service. Lancet Digit Health. 1(2):e63-e77. https://www.thelancet.com/journals/landig/article/PIIS2589-7500%2819%2930012-3/fulltext*

Care setting and workforce

Diagnosis

Most people with a dermatological concern will go to their GP or a pharmacist for their first diagnosis. Unfortunately, GP training includes little and sometimes no dermatology. This means many people experience variable expertise when they first contact the NHS.

With the appropriate training, it should be possible for the first clinician a patient sees to make a correct diagnosis for most conditions with minimal investigation, by asking questions and looking at the skin. After discussion with the patient, it should then be possible to agree the most effective treatment first time. This would avoid wasting time for the patient and enable them to improve quicker. For melanoma, a type of skin cancer, early diagnosis also greatly increases survival.

As well as these patient benefits, early diagnosis and treatment also minimises NHS staff, investigation and treatment costs.

Referral and treatment

If a GP is unable to treat or diagnose a dermatology patient, they will generally refer them to a consultant for further advice. Referrals may also come from other allied healthcare practitioners, such as nurses or podiatrists. There is national guidance on referrals, such as Evidence-Based Interventions guidance from NHS England.

Consultant dermatologists have the greatest expertise in dermatology and will often see people in an outpatient setting in a community clinic or in the outpatient department of a hospital.

Consultants lead multidisciplinary teams, which may include experienced SAS doctors (specialty doctors and associate specialists), nurses, doctors in training, or GPs with extended expertise (GPwER – a GP with Extended Roles). This team approach enables larger numbers of people to be seen, with less experienced team members asking advice from the consultant.

Sometimes patients are seen in a single clinic, where every patient has access to a closely supervising expert consultant dermatologist. The consultant does not have their own lists but sees most patients. This model is sometimes called a superclinic (see page 50).

Other members of the dermatology team may see appropriate patients independently in other settings, for example GPwERs in community settings. This can work well provided that:

- triage is effective in selecting the right people for the right clinician;
- patients are quickly referred to the right person if they are initially seen by somebody unable to diagnose or manage their disorder.

With models of this type, it is essential that people are not bounced back and forth between multiple disjointed systems, as sometimes happens.

People who need dermatological services generally receive their care as an outpatient. This may be at a single visit if it's possible to make a diagnosis and then provide or prescribe the correct treatment after a discussion and examination. Alternatively, care will take place later on the same day, or at a later date, in the form of one or a combination of the following:

- investigations, such as allergy patch testing, blood tests or a skin biopsy;
- complex therapies, such as phototherapy or photodynamic therapy;
- advice about dressings or the correct way to apply creams;
- initial investigation and ongoing management of conditions such as severe psoriasis, eczema, hidradenitis or lupus (some treatments include strong and potentially toxic systemic drugs, such as methotrexate or new targeted biological therapies such as adalimumab);
- surgery, such as urgent excision of a life-threatening melanoma or the complex excision of other skin cancers (some surgery may involve other specialties);
- referral to dermatology consultants running more specialist clinics, often involving other specialties, such as: genetic conditions in children; rheumatological conditions such as vasculitis; blood conditions such as skin lymphoma; complex disorders of the genitals in men and women, such as lichen sclerosus; hair disorders, such as scarring alopecia; and psychiatric or psychological disorders affecting the skin (this often works most efficiently for certain disorders when consultants run parallel clinics).

Paediatric care

Children with skin diseases are looked after by dermatologists, sometimes working in collaboration with paediatricians. There are many hundreds of complex genetic and inherited disorders, which require highly specialised dermatology care as part of a multidisciplinary team.

Inpatient care

Some skin conditions require inpatient treatment. However, this requirement is falling greatly due to the development of new biological drugs for the treatment of severe inflammatory skin diseases that can be administered away from an inpatient setting.

Inpatients under other medical teams may require dermatology input. For example, to help with diagnosis in complex cases or to identify if new rashes are due to an allergy to medication or something else. Dermatology nurses may be asked to help support inpatients and nursing colleagues in the correct use of dressings, topical and systemic treatments. This encourages effective self-management post-discharge, reducing readmission.

Some patients are transferred to the dermatology unit for skin biopsies.

On-call emergency cover

Emergency skin problems are quite common and usually require assessment within 24 to 48 hours of seeing a GP or A&E doctor, or when already admitted to hospital.

Many can be dealt with by telephone advice (see page 109) from a dermatology doctor or specialist nurse, but some require face-to-face assessment. A few, rare, life-threatening skin conditions require out-of-hours on-call emergency cover. These include rare skin diseases in neonates and severe reactions to medication.

External provision

Some NHS dermatology care is provided by external private healthcare providers, often where there are shortages or as a result of competitive tendering for services.

GIRFT is currently considering a separate workstream to review the use of independent provision in the NHS.

Current service organisation

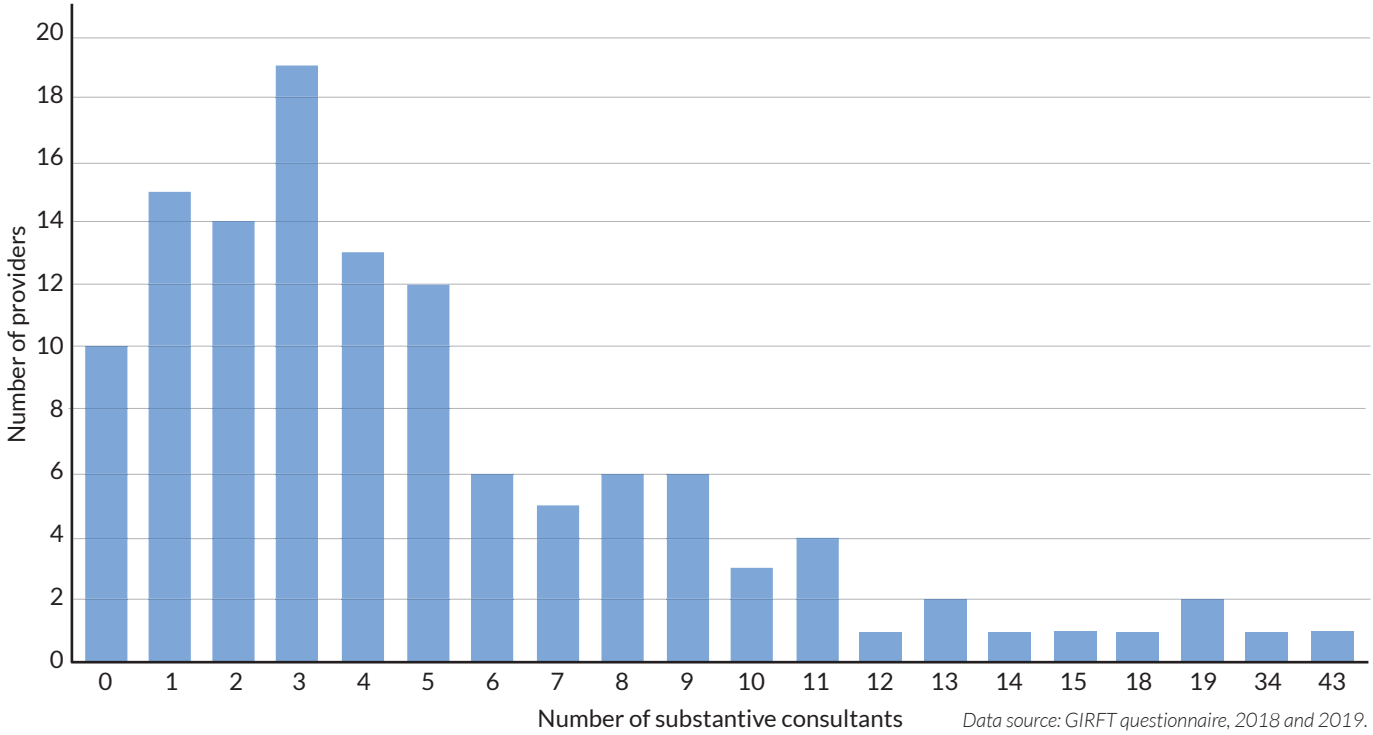
Outpatient services

Most acute general trusts provide outpatient dermatology services. These tend to be provided as a combination of hospital-site clinics and community-based clinics.

We identified 123 trusts with significant dermatology activity in 2019. There is considerable variation in the number of dermatology consultants working in trusts, with the six largest trusts (by number of consultants) combined having nearly as many consultants as the smallest 70 trusts combined, as shown in Figure 1. The largest has as many as the smallest 39 combined. Many smaller trusts, often in remote areas but also some in London, find it difficult to attract and retain staff due to the workforce shortage. This means they have to rely on high-cost consultant locums, often employed through locum agencies. Many of these expensive locums are not on the specialist register. Our report looks at the opportunities for savings and quality improvements this offers.

Dermatology nurses (see page 44) are an important part of the dermatology team and are increasingly taking on new roles, including seeing patients who would have previously be seen by doctors. The nurses take part in skin cancer surgery, manage childhood skin conditions, long-term systemic treatment, help with patch testing (see page 79) and phototherapy services (see page 87), and many other roles. In this way, English dermatology nursing is world-leading in the adoption of these advanced nurse roles.

Figure 1: Number of substantive dermatology consultants (not WTE) employed by NHS trusts



Data source: GIRFT questionnaire, 2018 and 2019.

Interface between services

More than most other specialties, dermatology requires an effective interface between primary, secondary and tertiary care. This demands effective patient pathways and guidelines for each aspect of the service, from timely referral, to management to discharge.

These factors continue to pose significant challenges for service organisation and reconfiguration.

Non-registered providers

Some people who call themselves dermatologists are not accredited on the General Medical Council (GMC) specialist register. They are to be found working in both NHS and private health care settings and some regularly write misleading media articles promoting expensive products and treatments.

As with other medical specialisms, there is no legal protection of the terms 'dermatologist' or 'consultant', so whilst some non-registered providers using these terms to describe themselves have some experience, others have little or no dermatology training. This can be confusing for people who think they have seen a trained dermatologist, but then do not improve with treatment, or for those who develop unexpected complications or side effects.

The GMC register is available for anyone to search at *www.gmc-uk.org/registration-and-licensing/the-medical-register.*

Specialised commissioning

National Programmes of Care (NPoC) and Clinical Reference Groups (CRG)

Specialised services commissioned by NHS England are grouped into six National Programmes of Care (NPoC). These coordinate and prioritise work across the services they cover.

Specialised dermatology services fall under the internal medicine NPoC. These services cover both adult and paediatric dermatology and skin cancer services.

Each NPoC has several Clinical Reference Groups (CRGs). The CRGs provide clinical advice and leadership. They also involve patients and the public in any changes to the commissioning of specialised services.

The Dermatology Specialised Service CRG leads on the development of clinical commissioning policies, service specifications and quality standards in dermatology. It advises on innovation, horizon scanning, and service reviews, and also guides work to reduce variation and deliver increased value.

About our analysis

Our review followed the standard GIRFT process to ensure that we're able to offer evidence-based findings and recommendations. These are based on clinical data, deep dive visits, current best practice and clinical experience of providing dermatology services in the NHS and other settings.

We identified 132 trusts that carry out significant dermatology activity and asked them to take part in our review. Of these, 123 trusts have provided us with data, which we analysed and used to inform our deep dive visits. By February 2020, we had made deep dive visits to 80 of these trusts before GIRFT paused face-to-face visits in March due to the emerging threat of COVID-19.

At each visit, we spent around two hours discussing the trust's data with its clinicians, managers, CCG representatives, trust executives and other staff. We then agreed five key actions and made further recommendations.

Participating units

In May 2018, we sent questionnaires to 132 trusts with dermatology departments carrying out significant activity according to HES data. We received 117 responses.

In July 2019, we again sent the questionnaires to give trusts the opportunity to update their responses. We received 47 updates and six new responses, while 70 trusts did not update their response.

The nine trusts that did not respond to either survey had either closed to dermatology activity, had seen most local provision switch to independent or private providers, or had been taken over by neighbouring departments in different trusts.

By 2019, all units of a significant size and some closed departments had returned a questionnaire, totalling 123 responses.

Since May 2018, over 32 trusts have merged, reducing the number of deep dive visits we will make to 110-115.

Scope

Our review covers care for all skin, hair and nail conditions.

Skin cancer

We have considered skin cancer where it relates to the other themes in our review and as it relates to around 50% of dermatology activity. However, because of increasing prevalence and impact of skin cancer, GIRFT is currently considering a separate skin cancer workstream to review skin cancer services in more detail. That review would consider the issues raised in our report and expand these to a multidisciplinary approach.

Independent providers

GIRFT is currently considering a separate workstream in 2020 to review independent provision of NHS care in England. That review would consider quality and health economic issues, including those related to dermatology.

Care in devolved nations

There are currently no plans to expand the dermatology GIRFT programme to the devolved nations. The Welsh Government's Department of Health and Social Services is carrying out a similar programme based on the GIRFT dermatology workstream.

The GIRFT team met with clinicians from the devolved nations to identify areas of good practice, such as in phototherapy.

Primary care

Although primary care services were not specifically reviewed as part of this programme, there were GPs present at almost all of our deep dive visits. These were usually either GPs with Extended Roles (GPwERs) or GPs involved in commissioning, who were able to provide detailed knowledge and experiences of dermatology in primary and intermediate care.

Around 75% of patient visits for NHS skin care take place in primary care, yet many GPs have received little dermatology

training. Improving primary care provision of dermatology is essential and would help to ensure people get the right diagnosis first time.

Any such review must consider the opportunities to improve dermatology knowledge and education among primary care providers. The Primary Care Dermatology Society provides an excellent education programme for qualified GPs, and the British Association of Dermatologists has an educational workstream with the Royal College of General Practitioners for GPs with Extended Roles (GPwERs). However, these programmes mostly reach GPs who already have some interest and expertise in dermatology.

As most GP training rotations do not include dermatology, undergraduate education should include sufficient dermatology training to provide future GPs with the basic skills they need. However, despite comment and work done in this area by the All Party Parliamentary Group on Skin and the British Association of Dermatologists (BAD) since 1998,[15] most medical schools in England provide only a few days training in skin diseases.

Data

We used a wide variety of sources for the data on which our report is based, including Hospital Episode Statistics (HES), hospital accounts, reference costs, and staff surveys.

We also used the data collected in our GIRFT questionnaires. We developed these questionnaires following a specialty-wide consultation exercise in December 2017 in which we asked all dermatology consultants for examples of good practice and areas where they wished to improve.

Safety and outcome data

Unlike many other specialties, dermatology has no specialty-level safety or outcome data. However, the BAD produces specialty-led guidelines for treatment using the gold standard GRADE (Grading of Recommendations, Assessment, Development and Evaluations) evidence-based methodology.

There are also service standards, produced using NICE-accredited processes, for dermatology specialist areas, such as patch testing, phototherapy, photodynamic therapy, psychodermatology and Mohs surgery.

External parties

We have worked with a number of external parties to review specific topics, including:

- NICE to understand variation in biologics prescribing;
- representatives of the ABPI and pharmaceutical industry to understand commercial concerns;
- other GIRFT workstreams, including rheumatology, to look at biosimilar adoption;
- the NHS England Evidence-Based Interventions Programme to provide guidance on benign skin lesions and indications for appropriate removal;
- NHS England and NHS Improvement, and the BAD to look at medicine safety issues.

[15] *All Party Parliamentary Group on the Skin (1998) Enquiry into the training of healthcare professionals who come into contact with skin diseases. www.appgs.co.uk/publication/%e2%80%a2-enquiry-into-the-training-of-healthcare-professionals-who-come-into-contact-with-skin-diseases-1998/.*

Findings and recommendations

We have used the weight of evidence to focus our efforts on the areas of current dermatology provision that offer the most significant clinical and operational opportunities for improvement.

Our recommendations are grouped into the following areas:

- workforce, including consultants and specialist nurses;
- efficient use of NHS resources;
- equity of care and access to treatments, including Mohs skin cancer surgery, access to biologics for severe psoriasis and eczema, allergy patch testing, paediatric dermatology, phototherapy and psychodermatology;
- innovation and research, including teledermatology and AI;
- procurement;
- litigation.

Workforce

During our visits it became very clear that shortages in the dermatology medical workforce are having a serious impact on the efficient functioning of nearly all units. This was the most important problem raised by managers and consultants, meaning discussions about resolving workforce problems dominated all but a handful of visits.

Workforce shortages are a key factor in the increasing use of high-cost locums and other short-term initiatives in an attempt to control waiting lists. Around a third of units have very serious staffing shortages, with some closed to routine dermatology referrals and only providing an urgent skin cancer service. In some areas of southern England, where neighbouring units have partially or fully closed, there is very limited access to NHS consultant dermatologists.

Workforce shortages have had the greatest impact on people with distressing and disabling skin disorders that are non-cancerous. This is because the NHS prioritises resources to meet cancer targets, including skin cancers. Hospitals are asked to make sure that staff focus on seeing people with skin cancers soon which, if there are shortages of staff, means longer waits for people with non-cancerous but serious skin diseases.

It is essential that shortages in the dermatology medical workforce are addressed if we are to provide equal access to quality dermatology care. We have looked in detail at the issues affecting each of the key workforce groups and have recommended a set of solutions to tackle shortages.

Consultant dermatologists

Dermatology is one of the most popular specialties for young doctors. Each year, over 150 junior doctors apply for around 34 vacant training posts, with unsuccessful applicants often reapplying in subsequent years.

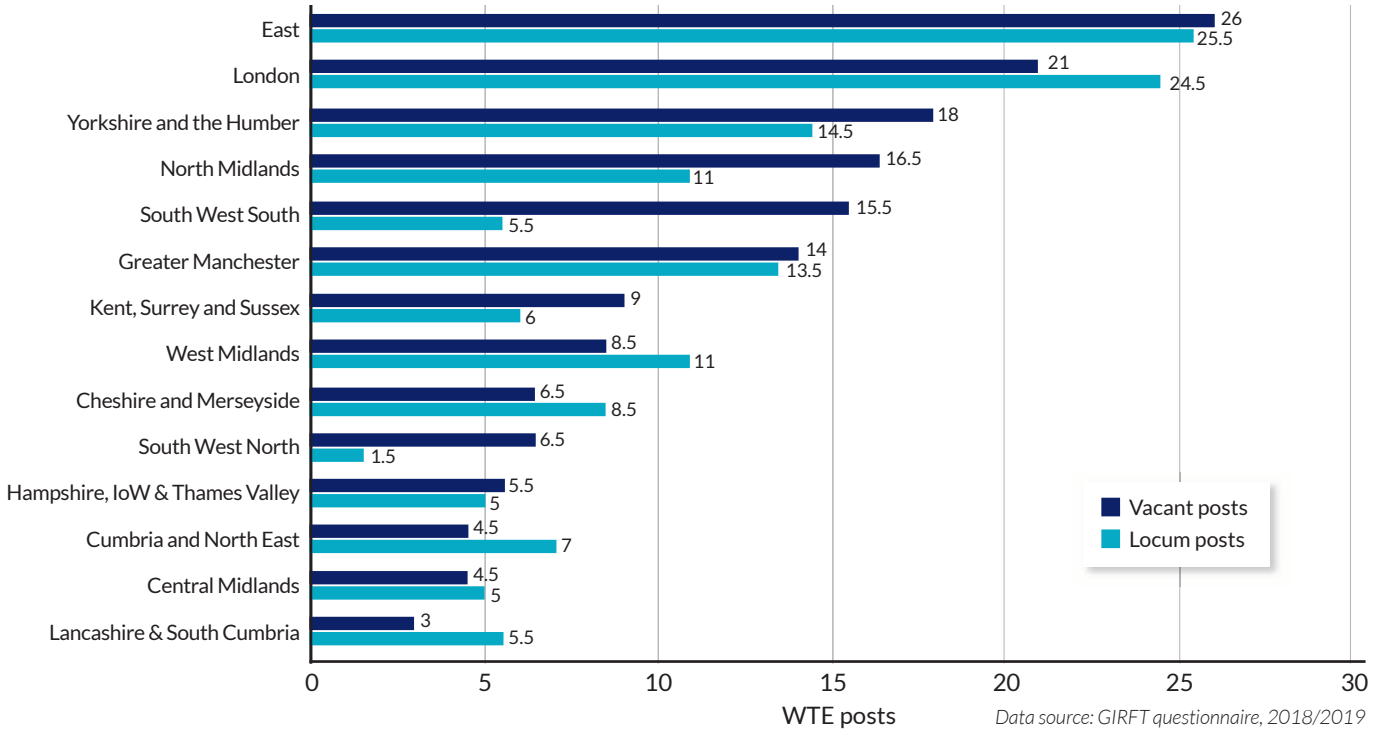
Dermatology also has one of the highest levels of satisfaction of any specialty. In one (unpublished) survey of 300 consultant dermatologists, over 98% confirmed they would still choose dermatology if they had the chance to train in any specialty.

Despite this, there is a national shortage of consultant dermatologists and there are just 659 consultant dermatologists working in the NHS in England (508 whole time equivalent (WTE) consultants). At the same time, there are 159 WTE vacancies and at least 10 trusts have no substantive dermatology consultants at all, as shown in figure 1 and in Appendix 1: Dermatology workforce data.

Regional variation in vacancies and locum numbers

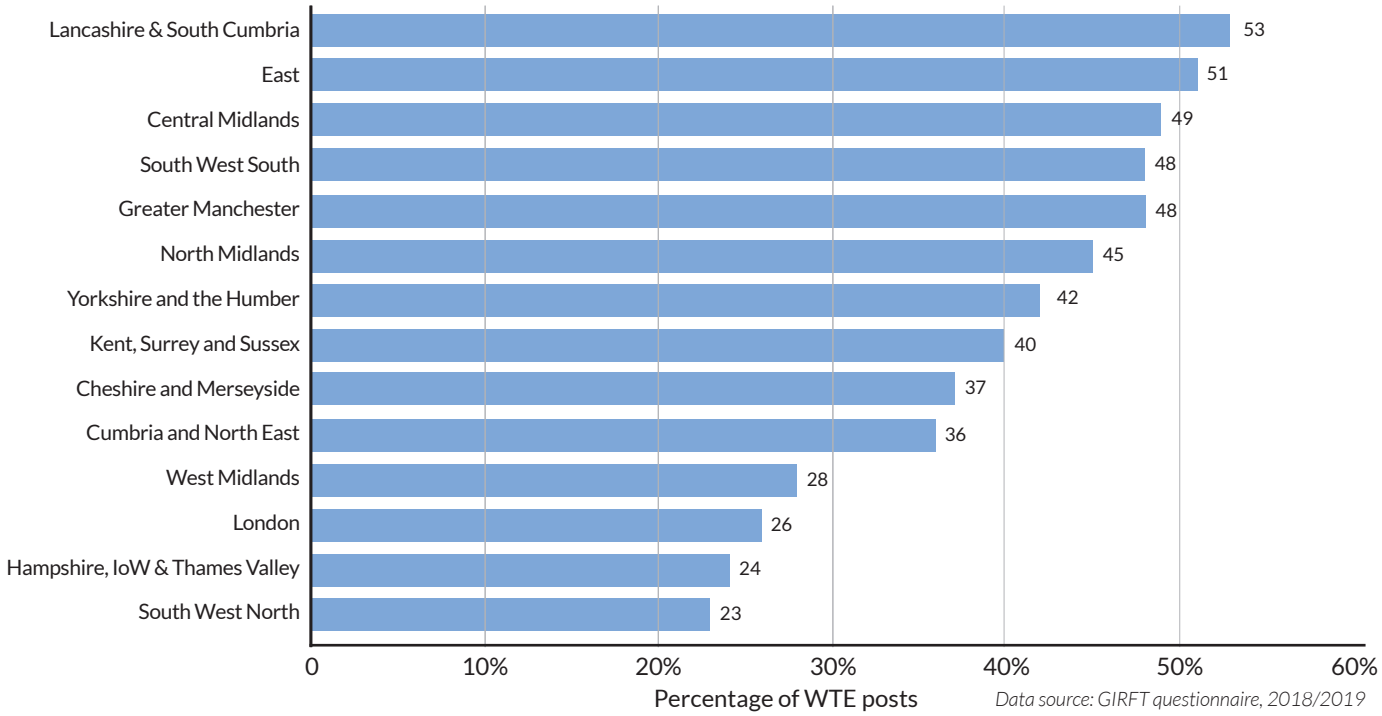
There is variation in the numbers of vacant and locum consultant post numbers in different NHS regions, as shown in Figures 2, 3 and 4.

Figure 2: Number of vacant and locum consultant posts by NHS region



Data source: GIRFT questionnaire, 2018/2019

Figure 3: Number of vacant and locum dermatology whole time equivalent (WTE) consultant posts as a percentage of total demand

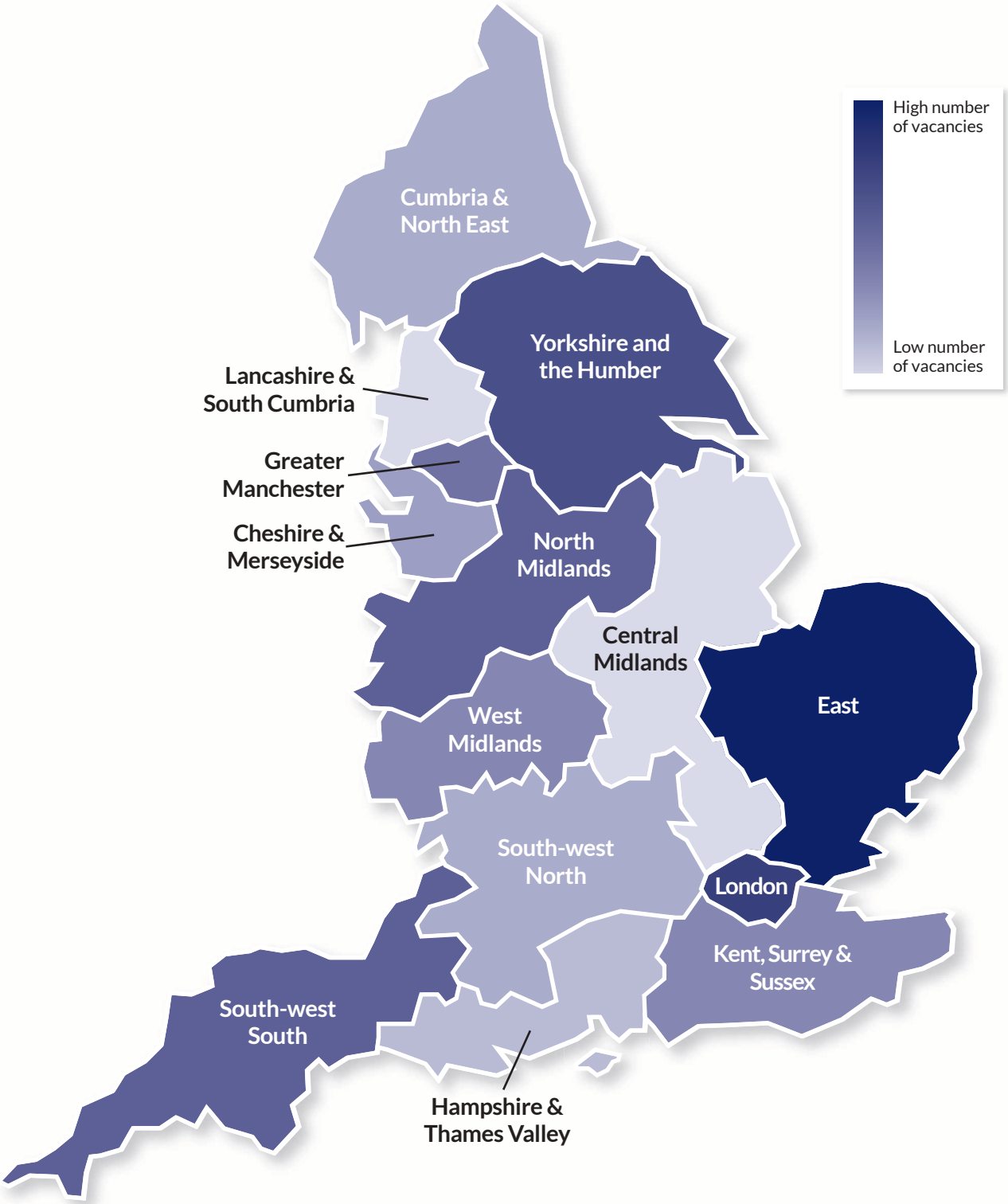


Data source: GIRFT questionnaire, 2018/2019

Note on vacancy data

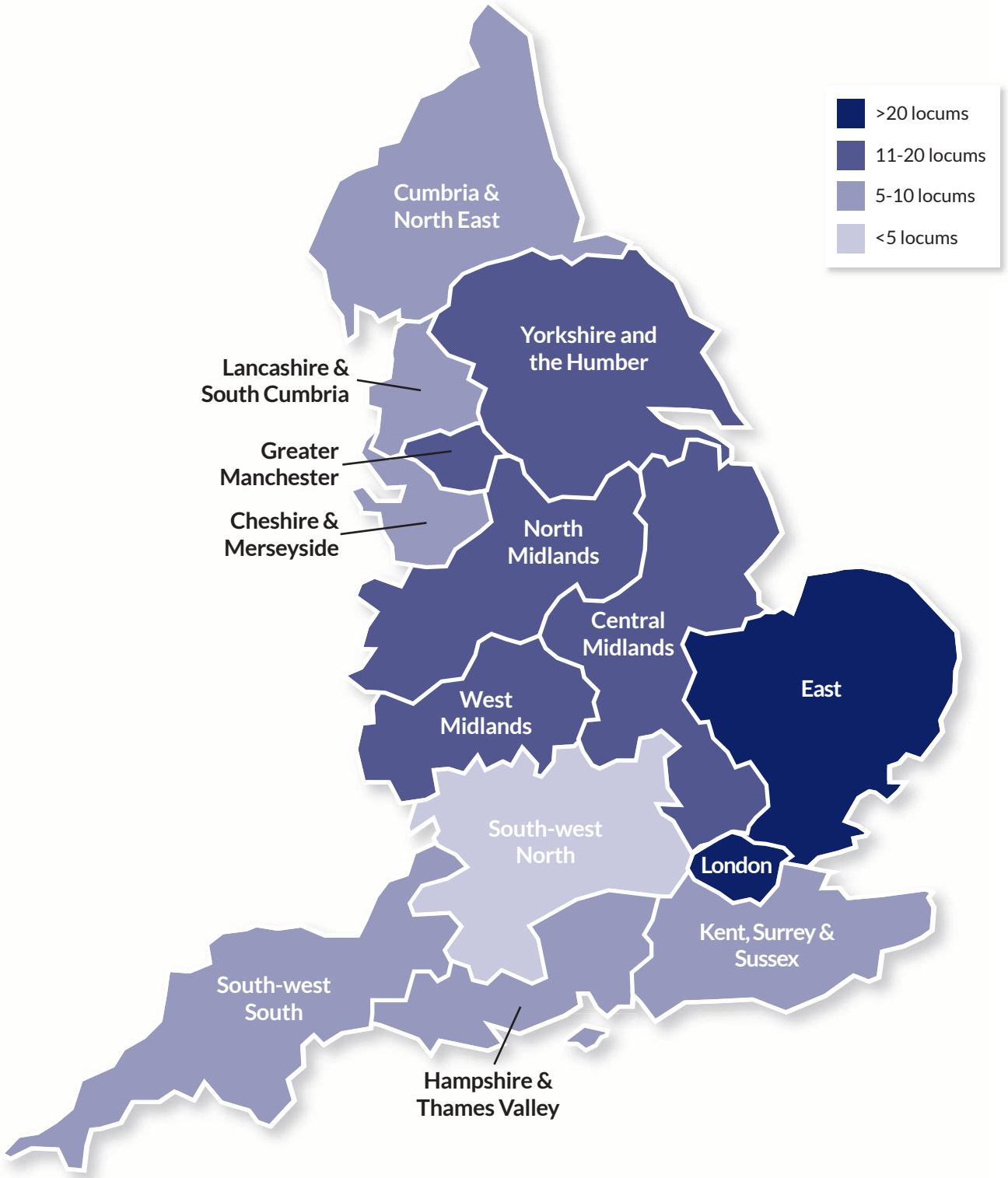
When we discussed vacancies during deep dive visits, we found that a few trusts had reported posts as vacant although those posts were filled by locums. However, we found that most departments reported accurately and had not double-counted vacant and locum posts. Others had under-estimated vacancies by not reporting vacant posts that they then told us about at the deep dives. Overall we believe the values in Figure 3 are a fair reflection of the true picture.

Figure 4a: Workforce heatmaps
Vacant WTE consultant posts (to nearest 0.5 WTE) as a rate per 100,000 population



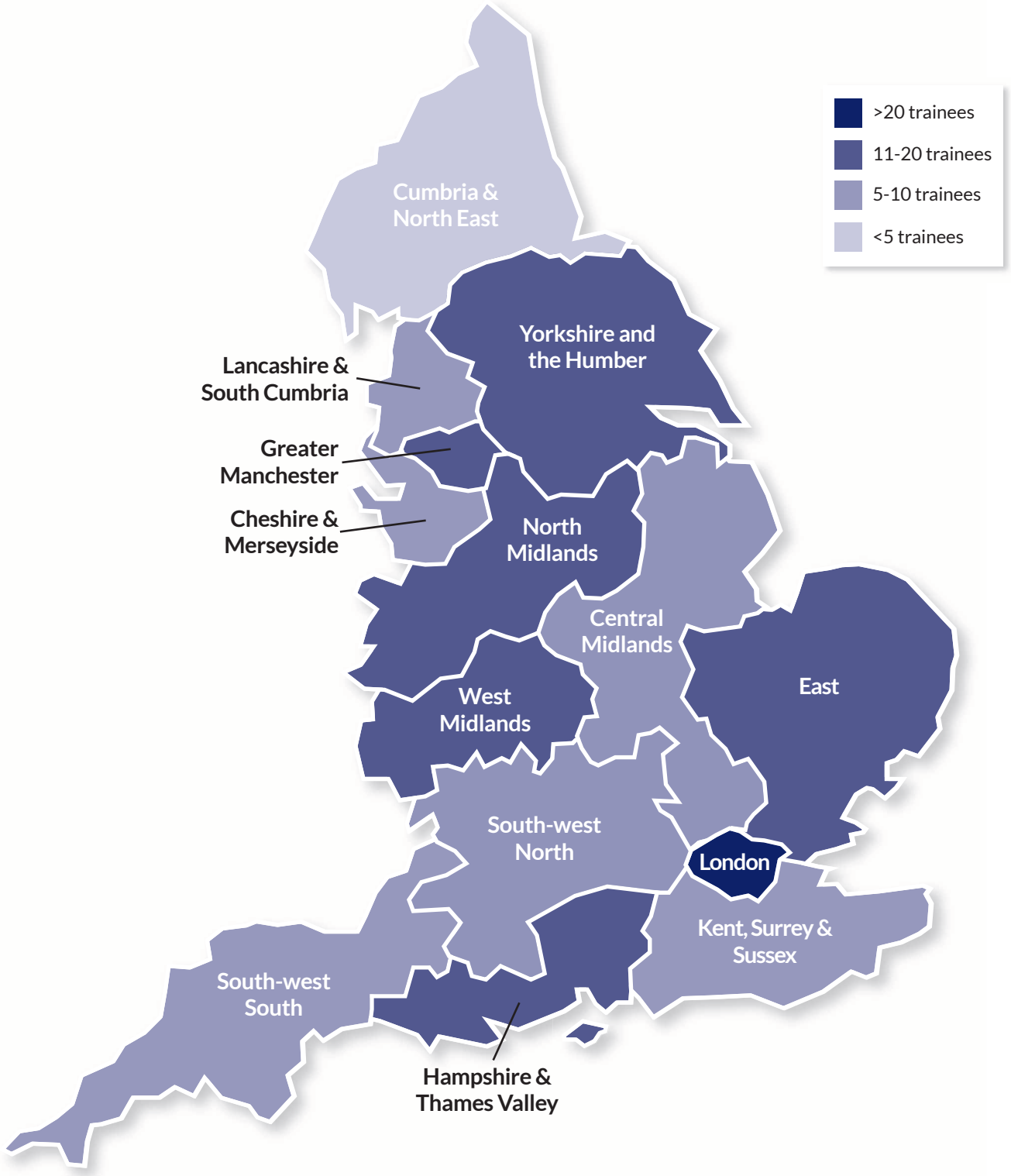
Data source: GIRFT questionnaire, 2018 and 2019.

Figure 4b: Workforce heatmaps
Number of locum consultant dermatologists by region



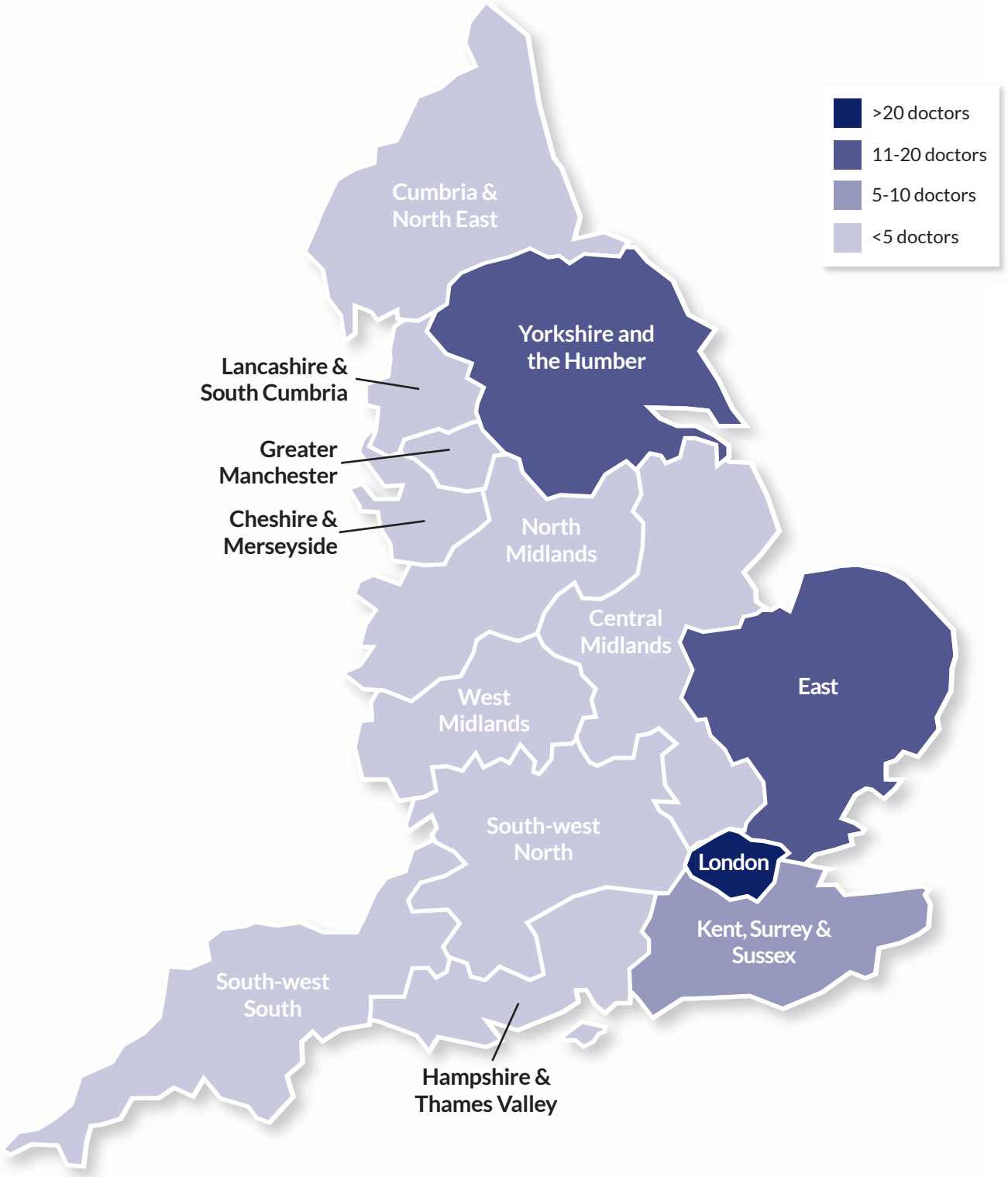
Data source: GIRFT questionnaire, 2018 and 2019.

Figure 4c: Workforce heatmaps
Number of trainee dermatologists by region



Data source: GIRFT questionnaire, 2018 and 2019.

Figure 4d: Workforce heatmaps
Number of doctors training to become dermatology consultants via CESR by region



Data source: GIRFT questionnaire, 2018 and 2019.

Effect on workload

In our deep dive visits, we found that most units adjacent to under-staffed units were receiving large numbers of referrals from the catchment areas of struggling units. This shows how the shortage of consultants both limits patient access to services and increases the dermatology workload at neighbouring trusts.

Increasing locum provision

The shortage of consultant dermatologists has created a demand for locum dermatologists. Locums are often employed through high-cost locum agencies, which significantly add to NHS costs. There are currently 190 locums filling 144 WTE consultant posts, as shown in Appendix 1: Dermatology workforce data.

The distribution of locums is similar to that of the vacant consultant posts, as shown in Figure 4b.

Although most stay, some consultants choose to leave NHS employment to work for locum agencies who contract them back to work in the NHS, sometimes in the same department. We were told by some dermatologists that several factors are making locum positions more attractive than a permanent NHS position. Pay is only one factor, but clearly plays a key role.

Many doctors told us that they have considered the impact of the changes to the NHS pension scheme when weighing up whether to remain in the NHS or work as a self-employed locum.

Aside from salary and pension, some doctors choose locum work as it offers more flexible working hours, including school holidays for those with young families, with no out-of-hours responsibilities. Others found the NHS environment difficult or preferred the independence of self-employment.

Most dermatologists do still choose to remain in the NHS. These clinicians told us they valued being able to deliver the highest possible standards of medical care while working in large specialist teams and engaging in research and education to improve standards of care.

Note on locum data

During our deep dive visits, we found that a few of the locums in our data are now working in the vacant NHS posts though most trusts said they had counted the locums and vacant posts separately.

Escalating locum costs

On our deep dive visits, we heard from many trust management teams that employment costs are continuing to escalate due to trusts having to pay high rates to locum agencies. This is despite national efforts to reduce reliance on medical locums. While trusts are understandably reluctant to release details of locum costs as this can lead to further wage inflation, we know from our conversations with consultants that it's not unusual for locum agencies to offer salaries that more than double the amount a consultant might expect to earn as an employee of an NHS trust.

In addition to the pay costs, it would not be unusual for trusts to have to pay additional agency fees. Many trusts told us that their dermatology locum costs are substantial and that it would be a more efficient use of resources to expand training in dermatology across the NHS.

These figures show that resolving the dermatology workforce problem represents a huge notional financial opportunity for the NHS.

Locum quality and performance

Employing substantive consultants rather than some of the non-consultant grade locums available offers the opportunity to provide better care. While some trusts told us that they had some excellent locum dermatologists, others expressed their concerns about the quality of locum they are able to recruit. They pointed to their poor performance figures or relatively high litigation rates as evidence of issues with previously employed locums who had lacked experience, ability or commitment.

Difficulty in recruiting consultants to smaller units

Nearly all smaller units in particular told us how they struggled to recruit consultants to substantive posts and, in some cases, locums. From our discussions at deep dives, there appear to be a number of reasons for these difficulties related to the role and experiences of consultants in smaller units. We have outlined these in Table 1.

The specialty must not seek to step back to previous ways of working. However, it is important to understand what it is about practising dermatology (and other specialties) in a smaller unit that might be less attractive to consultants so that we can plan future services in a sensible way.

These factors suggest a minimum number of consultants are required to achieve a sustainable dermatology department that is able to attract and retain consultants in the face of increasingly complex medical work. From conversations during our deep dive visits, we estimate that minimum number is approximately four WTE consultants. Some medical directors told us this number was their experience in other specialties too.

Some departments have been merged for many years, following trust mergers. Where two teams have been relocated to one site and work together, they generally function as one team. Where the two teams have remained on separate sites, the teams tend to work separately for many of their functions. Despite evident efforts from all concerned, travel time between sites appears to be a barrier to joint working. However, relocation to one site may reduce access for some patients and will usually involve work to ensure facilities are fit for purpose.

Table 1: How the changing role of doctors and greater complexity and specialisation is affecting recruitment in smaller units

1990	2020
Fewer complex drugs and treatments, so medicine required less knowledge.	Many complex drugs, treatments and investigations. More knowledge and continued professional development (CPD) required.
One person could do every subspecialty (paediatrics, surgery, allergy etc.). New consultants were usually confident of their ability to work in all subspecialty areas.	Difficult to remain competent across all of the specialty. New consultants may lack confidence to work without support from a team of colleagues covering different subspecialties.
Patients did not have access to the internet to check facts were correct. Gaps in knowledge were less evident.	Patients are more informed and empowered to challenge a doctor's knowledge, diagnosis or advice.
Patients and the legal process often did not identify and forgave doctors who made mistakes due to gaps in knowledge.	Greater likelihood of litigation, complaints, and custodial sentences for doctors who make mistakes.
There was no clinical governance, appraisal, emails, mandatory training. Less administrative burden.	Sanctions for not keeping up to date with multiple administrative tasks. Less time for patient care.
Work culture of 80-100-hour weeks was considered normal.	Recognition of the importance of work/life balance for clinicians and their patients.
Private practice led to good incomes for those consultants working in a single-handed post in small market towns who wished to do this.	There is less incentive to do private practice as NHS locum work can offer financial rewards with less ongoing responsibilities.
Doctors could prioritise and use own judgement to build small departments as they considered best.	Clinical priorities are set by others so doctors may feel disempowered in making changes to their units and may seek strength in numbers.

SAS doctors (specialty doctors and associate specialists)

Some doctors choose not to become consultants and work long-term as SAS doctors (specialty doctors and associate specialists), employed by NHS hospitals. There are 194 dermatology SAS doctors and they provide a significant contribution to hospital patient care (see appendix 1).

SAS doctors face many of the same issues as consultants relating to retention. Some also told us that they feel their role goes unacknowledged. It is important to retain these doctors and they should be given opportunities for training and career development.

Proximity to family and friends

When choosing a future consultant post, the most important factor given by trainees is working near to family and friends.

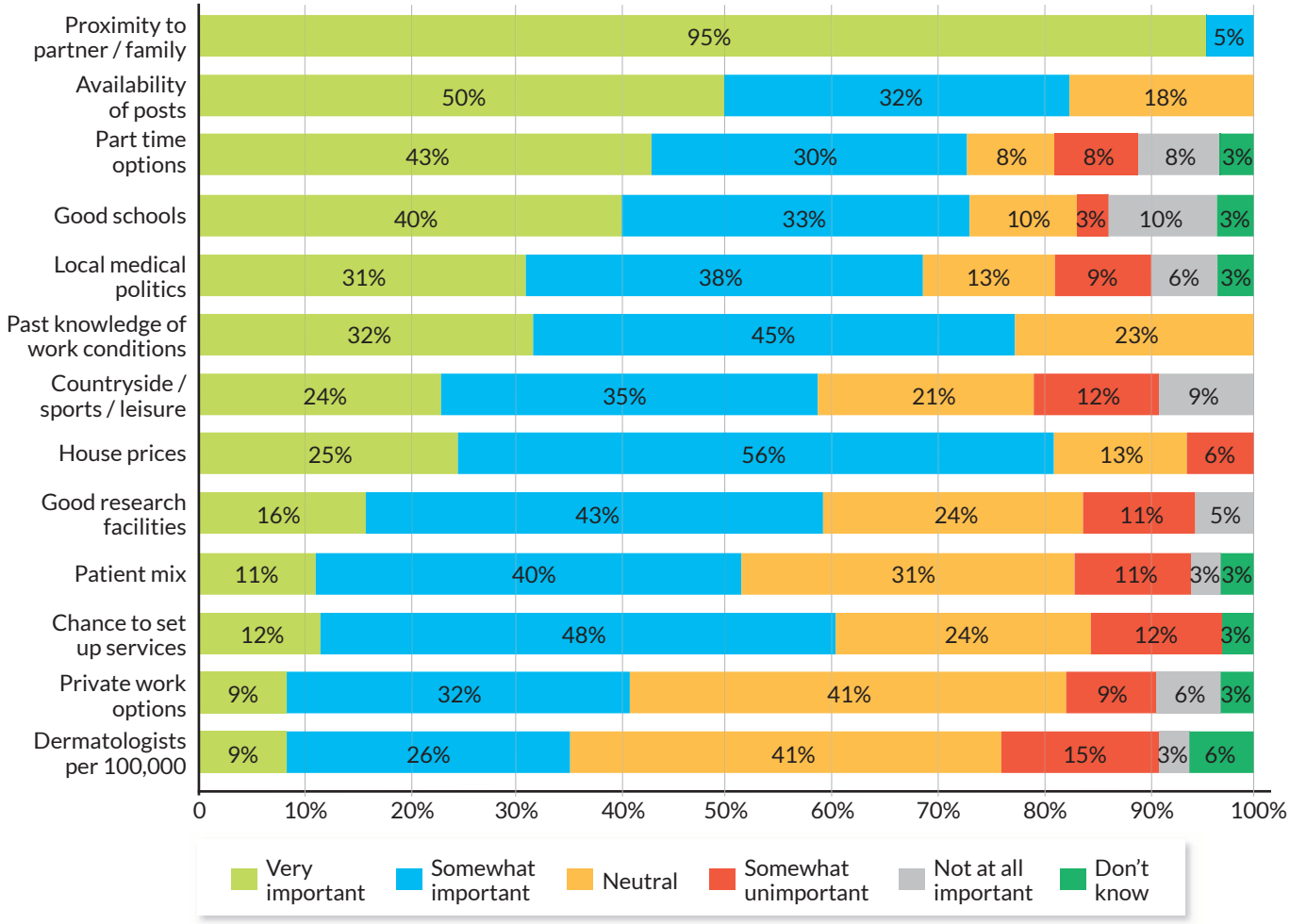
Research carried out by the BAD in 2018 found that 87.5% of trainees are only prepared to take a consultant post in the region where they trained or an adjacent region. This is understandable as many trainees have children in local schools and partners working locally. In the BAD survey, 95% of trainees said working near to where they trained was very important. See Figure 5.

Tackling this issue requires a review of the current training model. At the moment, NHS workforce planning mainly happens at a national level with training centred on large training centres. This means that many trainees are used to working in large centres and some told us they feel unprepared for work as a consultant in a small unit. There is also wide regional variation in the number of trainees. Most trainees are not located in the areas with the greatest deficit in consultant numbers as shown in Figure 4c.

Future dermatology training must be reconfigured to match the employment needs of the local health service.

Figure 5: Most important factors in trainee dermatologists' choice of where to work

In answer to question: When deciding which region you would to work in, upon completion of specialist training, what factors will be important?



Data source: Goad N, Levell NJ, UK Dermatology specialist trainee career intentions, Clin Exp Dermatol. 2018 Mar;43(2):200-201.

Addressing the shortfall

Addressing the shortfall in order to fill the 159 WTE vacant posts would require a 31% increase in the current workforce of 509 WTE consultants.

If the fully trained consultants currently working as locums do not return to NHS employment, then an increase in the current workforce of up to 28% would be required to replace the 144 (WTE) currently working as locums. Some of these locums may return to NHS consultant posts, although many are not currently qualified to do so.

These figures all assume that demand does not increase. However, we know that skin cancer, which accounts for around half of NHS dermatology work, is increasing by around 8% per year and demand is likely to increase.

Shortfall in number of trainee consultant dermatologists

One reason for the shortage of dermatologists is the imbalance between the number of vacancies and the number of training posts available.

Our questionnaire found just 206 (175.5 WTE) English dermatology training posts. Since these 206 trainees are always at different stages in their training programme, which lasts six years on average allowing for career breaks for parenting and research, this produces an average of 34 (29 WTE) new dermatologists per year.

Assuming that all consultants choose to work in the NHS for an average consultant career of 25 years, this would expand the number of NHS dermatologists by nine WTE per year. At this rate, it would take over 17 years to fill the 156 WTE vacant posts. This also assumes there is no increase in demand and dermatology continues to rely on locums.

However, we know that skin cancer is increasing by 8% per year and represents at least half of all NHS dermatology work. Even a 4% increase in demand would require an increase in at least 20 new WTE posts per year over the current 509 WTE posts. Based on these calculations, if we rely just on the training posts, the number of vacant consultant posts will probably increase by at least 10 WTE per year.

Since each training post generates one doctor every six years, even increasing the number of training posts by 25% would only mean around eight extra consultants per year. At that rate, it would take over 10 years to eliminate the current shortfall, assuming no change in the level of demand and assuming we continue to rely on locums. Yet we know that demand is likely to increase, some choose not to work in the NHS and that some in the current workforce have been considering their positions in view of changes to tax and pension arrangements.

Training posts

There is no shortage of quality candidates for trainee positions. Each year, over 150 well-qualified candidates apply for the 34 available posts.

Health Education England (HEE) is the organisation responsible for ensuring the future NHS workforce is available in the right numbers with the necessary skills, values and behaviours. It has indicated that the number is currently held at 206 posts for two key reasons:

- because there is a finite funding resource for training;
- because there is a finite number of doctors, so there is a need to balance the requirements of all specialties.

Although increasing the number of training posts would help to ease the shortfall, it's clear that more innovative solutions are needed.

Tackling the shortage: CESR programme

In an effort to tackle the shortfall in numbers of consultant dermatologists, the British Association of Dermatologists (BAD) and GIRFT are encouraging trusts facing shortages to train their own dermatologists.

The BAD College of Dermatology has been developing an educational structure to support an alternative training pathway to becoming a consultant. The pathway leads to a qualification called the Certificate for Eligibility for the Specialist Register (CESR). Doctors with the CESR qualification join the GMC specialist register, meaning their status is the same as a consultant who has trained via the standard pathway.

At the time of publication there are 82 (80 WTE) doctors training to do CESR. There is currently wide variation in their location, as shown in Figure 4d.

Finding suitable doctors to train to CESR

Increasing the number of doctors to train to CESR will mean recruiting suitable people. There are several potential sources for these 'home-grown' dermatologists, including:

- around 120 skilled trainees with Membership of the Royal Colleges of Physicians (MRCP) are turned down by HEE for dermatology training every year;
- clinicians from other specialties, for example GPs looking to retrain in dermatology;
- long-standing SAS doctors (specialty doctors and associate specialists) who are not consultants but are experienced dermatology hospital doctors and make a significant contribution to dermatology provision (many SAS doctors are happy with their role while others aspire to be consultants);
- overseas doctors trained in dermatology who are interested in working in England;
- doctors who, for family or personal reasons, are looking for more flexibility in their training than that offered by the standard HEE pathway;
- doctors who have previously unsuccessfully applied for dermatology training and who are currently working in a different specialty (departments training for CESR told us that the CESR route has attracted doctors in this situation who would have otherwise left the NHS to work in the independent sector or abroad).

Using the term 'trainee'

There has been some resistance to using the term trainee for those on the CESR pathway, from those who believe only those on a HEE training pathway should be described as trainees. Since these doctors have committed to training, we consider they should be defined as trainees.

Networks and hub and spoke services

We found several examples of trusts and commissioners developing networks, partnerships and hub and spoke services as a way of increasing support for smaller dermatology units. There are several variations, but the general approach is to enable clinicians working in a small unit to spend one or more days per week in a larger unit. Conversely, those in a larger unit may spend one or two days per week in a smaller unit or community service. These approaches offer several benefits:

- increased support for consultants so that they do not have to work in isolation;
- increased patient quality of care and safety by avoiding single-handed practitioners;
- maintains services in smaller trusts, which would otherwise fall below a critical mass, so that provision of local care is sustainable.

Building an effective network

The most effective form of network will depend on many factors including local geography, population density and population demographics. Age and ethnicity will affect the prevalence of certain common dermatological conditions, such as skin cancer. The shape of dermatology services is likely to change greatly in coming years due to increases in skin cancer, global travel, technology and artificial intelligence. All of these reasons mean we have chosen not to recommend the exact form of network model that should be used.

Appropriate networks and hub and spoke services could support the development of integrated care systems (ICS), with specialists in a tertiary centre providing advice and support to colleagues in secondary, primary and community care. However, workforce issues would need to be addressed to ensure feasibility of any new models of working.

We have described two examples of effective current practice in the case studies below. We are not suggesting that these are necessarily models that other units should attempt to replicate as each area must consider the specific requirements of the patient population it serves.

Over-reliance on the efforts of individual consultants

The position with current hub and spoke models is fluid and unstable. Generally, current models rely on the efforts of individual consultants who are aiming to deliver effective services in the face of numerous pressures. Typically, this means those services over-rely on the efforts of one or two individual consultants, or other specialist doctors, along with unit staff. As there are few, if any, larger units that are not facing capacity issues due to high demand, very few departments told us that they are able to free up consultants to support nearby units.

Consultants find themselves working single-handed

Shortfalls in the consultant dermatology workforce also mean that some consultants find themselves working single-handed; without another consultant working alongside them. It is generally poor practice for consultants to work in isolation from other consultants; it means there is no opportunity to discuss new practice or to review each other's practice, which are both essential to protecting patients.

CASE STUDY

Network support to ensure that essential dermatology services can be delivered

Taunton and Somerset NHS Foundation Trust and University Hospitals Bristol NHS Foundation Trust

After the dermatology service at Taunton collapsed over the course of 18 months following the retirement or departure of all consultants, Dr David De Berker, consultant dermatologist at Bristol, coordinated a response to ensure that some key services can still be provided.

Taunton's service now includes a nurse-led skin cancer follow up service, a phototherapy service, and some local secondary care service services provided by a collaboration of consultants from neighbouring trusts. Dr De Berker travels to Taunton once a week to support the service, and also provides phone and internal telemedicine support.

The service has managed to retain follow-up for existing patients and receives patients with diagnoses and management plans from other trusts. Although the service remains closed to referrals from local GPs, over 1,500 patients have been able to carry on their complex medical management and skin cancer follow-up.

As well as enabling patients to continue their treatment, the aim was to ensure that nursing staff were able to remain in post, delivering services. The trust has been able to increase the number of senior nurses and has established a five-year development plan that envisages a largely nurse-led dermatology follow-up service.

CASE STUDY

Secondary care dermatology clinic in a primary care setting

North Devon District Hospital / Litchdon Medical Centre

North Devon District Hospital's secondary care dermatology service is run single-handedly by dermatology consultant Dr Karen Davies from a local GP surgery, Litchdon Medical Centre in Barnstaple. The service provides a full range of secondary care services, with some clinics at the hospital. Patients must be referred by their GP.

Dr Davies is supported by a team of GPs with an extended role (GPwER) in dermatology, providing those doctors with further training and experience. The department also provides dermatology training to medical students as well as postgraduate training to specialty registrars.

Dermatology consultants from Exeter visit to support the service.

Although this service is very dependent on a single consultant and will require recruitment to be sustainable in the longer term, it shows how a good service can be provided to a rural population in the face of shortages in the consultant workforce.

Recommendations

Recommendation	Actions	Owners	Timescale
1. Increase the number of people training in dermatology	**a** Review options to increase funded training posts in regions with greatest shortages of consultants.	HEE; Statutory educational bodies; DHSC	6 months
	b Standardise and formalise CESR training to increase non-locum medical staffing with the aim of allowing trusts to develop sufficient future consultant staff to meet their local needs.	GMC with BAD	Ongoing work in many areas – up to two years
	c Contribute findings to the national programme board being established to address geographic and specialty shortages in doctors.	GIRFT	12 months
2. Develop regional or sub-regional strategic plans for sustainable partnerships between local trusts to eliminate single-handed working and support smaller units.	**a** Work collaboratively, for example by identifying non-conventional job planning solutions, and by establishing service-level agreements/joint-working arrangements to develop network models that will provide support to consultants working in smaller units.	Trusts	12 months

Specialist nurses

British dermatology leads the world in dermatology nursing and specialist nurses offer a safe and effective way to meet the increasing dermatology workload as part of a consultant-led clinical team.

Current roles carried out by specialist nurses include:

- skin cancer clinics where they see new patients, operate on patients, attend multidisciplinary team (MDT) meetings and carry out follow-up;
- biological drug and systemic drug follow-up nurse clinics;
- paediatric eczema clinics;
- lymphoedema and cellulitis services;
- telephone consultations;
- research nurses.

The British Dermatological Nursing Group (BDNG), the specialty organisation for UK dermatology nurses, runs an extensive programme of educational courses for specialist dermatology nurses.

Current provision

Most dermatology units already have specialist dermatology nurses working as part of their multidisciplinary teams. This is helping to improve dermatology capacity in those trusts.

Trusts reported a total of just over 1,000 qualified nurses working entirely in dermatology, many as specialist nurses (see Appendix 1: Dermatology workforce data). However, we believe this underestimates the actual number.

Variation in roles of specialist nurses

There is wide variation in the way units currently utilise the skills of their specialist nurses, as shown in Appendix 3: Specialist nurse roles. Together, these offer many opportunities to expand the dermatology workforce.

The BAD and BDNG developed a framework in 2020 that defined the role of specialist dermatology nurses at different bandings called Role Descriptors for Clinical Dermatology Nurses[16] The framework goes up to the level of consultant nurses and details the training and education needs at each band.

Due to constraints on space, it is important that nurses carrying out clinic roles previously done by doctors achieve the same throughput of patients per hour as medical doctors so as to achieve service efficiencies. Some specialist clinics, run by clinicians from any profession, require longer consultations, particularly when addressing complex medical, diagnostic or psychological issues.

Standards of care

At deep-dive visits questions were sometimes raised regarding the safety of practitioners taking on advanced roles. We looked at two indicators to assess this: litigation and patient satisfaction.

There is no evidence of any increase in litigation costs for activities carried out by specialist nurses. Data on patient satisfaction levels from nurse-led services strongly suggests high levels of satisfaction. All available data and reports from our deep dive visits suggest that specialist nurses deliver good and effective care provided that this is part of a consultant-led dermatology team.

Consultant nurses

Consultant nurses are a type of specialist nurse that support dermatology services. They have additional training and expertise so they are able to take on responsibility for the overall care of patients under the clinical governance of the service director. They also have leadership, education and research roles.

The trusts with consultant nurses told us they found the nurses to be a cost-effective and safe way to improve access for patients.

Just 12 trusts told us they currently have consultant nurses working in dermatology. Figure 6 shows the uneven geographic coverage of consultant nurses across England.

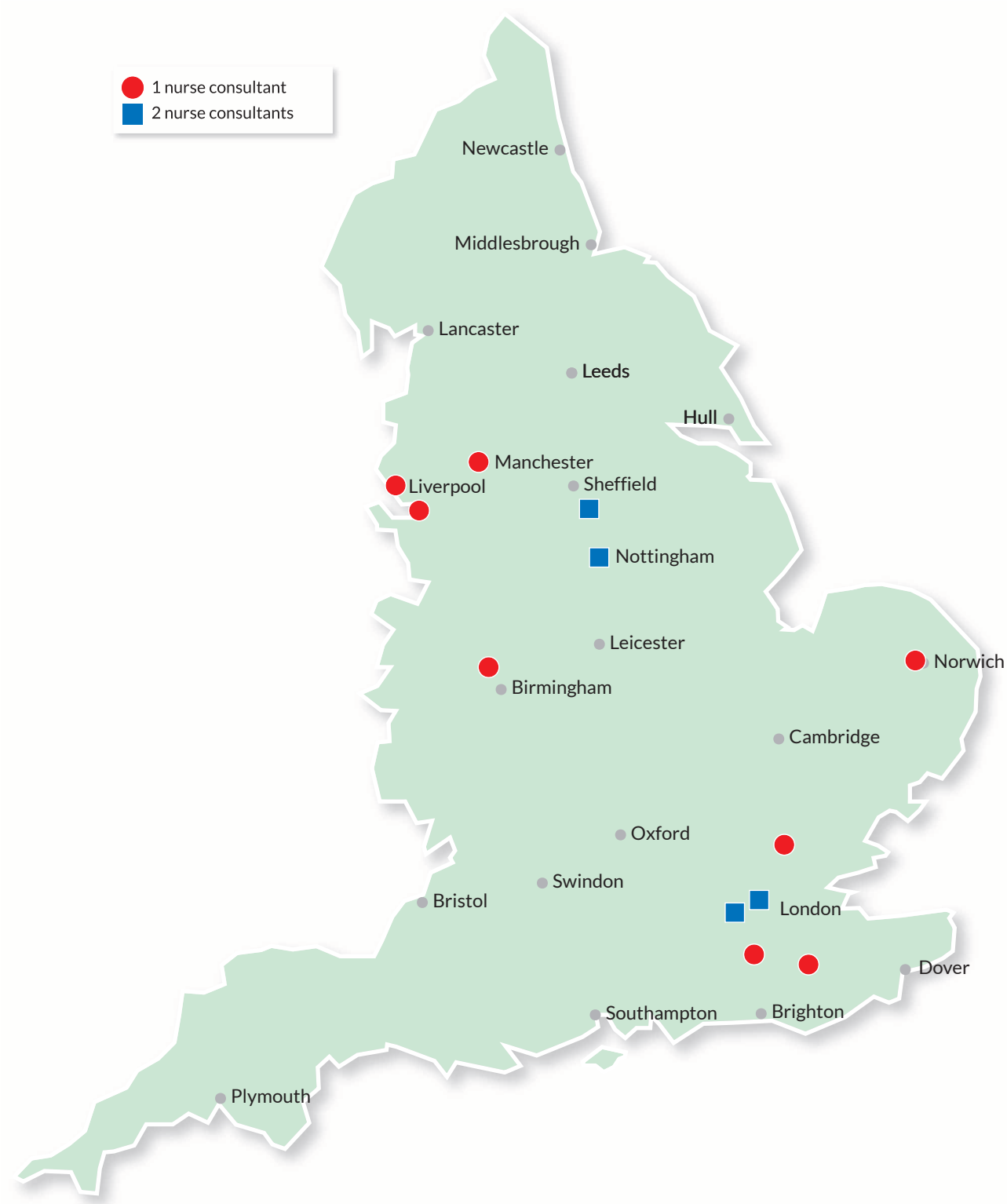
As with all training, developing consultant nurses requires the nurse and their supervising consultant and hospital to take on additional training, supervision and governance responsibilities to achieve long-term benefits.

Healthcare Assistants

There are also many healthcare assistants (HCAs) and assistant practitioners working wholly in dermatology who are members of the BDNG. Although they are not registered nurses, many of these professionals have decades of dermatology experience and are an essential part of overall dermatology capacity. They should be provided with support and encouragement to stay in the NHS workforce by enabling and encouraging them to develop their roles and jobs when they are enthusiastic to do so.

[16] *British Dermatological Nursing Group, Role descriptors for clinical dermatology nurses https://www.bad.org.uk/healthcare-professionals/clinical-services/bdng*

Figure 6: Location of trusts with consultant nurses working in dermatology



Data source: GIRFT questionnaire, 2018 and 2019

Supporting nurse retention

Some nurses we spoke to talked about reaching a ceiling in their clinical career, with no opportunities for career development other than to go into non-clinical management or community roles. Developing clinical roles for senior clinical nurses, such as specialist nurses and consultant nurses, provides an incentive for nurses to stay in hospital NHS posts.

CASE STUDY

Nurse-led eczema education

Guy's and St Thomas' NHS Foundation Trust

Kira Jackson, a nurse consultant, is the clinical lead for GSTT's Eczema Education Programme (EEP), which provides nurse-led education on managing eczema effectively for parents and carers of children with eczema. Parental satisfaction with the programme is very high and it has achieved statistically significant improvement in both quality of life and patient/parent-reported eczema severity.[17]

Ann Gray, a clinical nurse specialist and the EEP coordinator, delivers the course in a group session to an agreed session plan that features a presentation, practical treatment demonstrations and parent pictorial workbook. It can be delivered as a single 3.5-hour session or split into two shorter sessions over different days, which can be useful for parents and carers who are short of time. It's also suitable for use in different settings, such as community or secondary care.

The group session format offers parents and teenagers the chance to meet and share experiences with others. It also provides an efficient use of resource, which means parents and carers get a longer and more detailed structured session than might be possible in a one-to-one setting.

GSTT have also developed a version of the programme tailored specifically for teenagers: the Teenager Eczema Education Programme (TEEP). This single session focuses on activities around self-esteem, managing their concerns, working towards autonomy and self-management of eczema in adulthood. TEEP won the British Journal of Nursing Dermatology Award in 2017.

The programme began in 2009 and is now embedded in the paediatric eczema care pathway at GSTT. It is adapted to suit an NHS setting from the German 'eczema schools' model.

CASE STUDY

Establishing a dermatology service led by nurse consultants

The Rotherham NHS Foundation Trust

Faced with significant challenges in recruiting medical dermatology consultants, Rotherham decided to focus on developing and appointing nurse consultants to provide dermatology care.

Two nurse consultants, Sandra Lawton and Tara Lees, now work autonomously within the dermatology team, leading specific services that include: paediatric eczema, community care, vulval skin conditions, adult laser therapy, and adult chronic inflammatory skin disease. The nurses are both non-medical prescribers, manage their specific caseloads, and also coordinate systemic and biologic therapy pathways.

Together, the nurses have adult and paediatric qualifications and a combined 55 years of dermatology experience. This means they are able to provide leadership, education and support to patient groups, clinicians within the department, other hospital services, and to the wider community. Research is another important aspect of their work.

The nurse consultants triage referrals to ensure patients are seen by the appropriate clinicians and follow appropriate pathways. Complex medical cases are triaged directly to appropriate clinicians, utilising the skills of the whole team appropriately and reducing waiting times for patients.

The nurse consultants note the need to be flexible to meet the challenges of such a varied role, and that it also provides a clear career structure and job satisfaction.

[17] *Ersser SJ, Farasat H, Jackson K, Dennis H, Sheppard ZA, More A. A service evaluation of the Eczema Education Programme: an analysis of child, parent and service impact outcomes. British Journal of Dermatology 2013, 169(3) pp. 629–36.*

CASE STUDY

Developing a dermatology nurse registrar programme

Norfolk and Norwich University Hospitals NHS Foundation Trust

Nurse consultant Carrie Wingfield at Norwich's dermatology unit identified that consultant nurses with the appropriate expertise and training would be able to support its skin cancer service and run its cellulitis/lymphoedema service.

As there is no consistent pathway for consultant nurses, the unit set about developing a pilot formal training programme, now called the nurse registrar programme. The programme provides a pathway for highly experienced dermatology nurses to progress their career, therefore helping to retain valued nurses with high levels of expertise and experience. From day one, the trainee nurse registrars, Mel Sutherland and Kate Davies, were able to able to provide patient care by delivering templated and supervised clinics, which helps the unit to meet the high demand for dermatology services.

After identifying the necessary skills and competencies needed in candidates, the unit advertised two positions. Two successful candidates were appointed and are now training to consultant nurse grade. Subsequently, each nurse registrar has chosen to focus on different areas, further broadening the expertise in the department:

- Kate has a focus on skin cancer diagnosis and management and has advanced surgical skills;
- Mel has a medical focus on inflammatory dermatoses, cellulitis and lymphoedema.

The programme delivers a structured clinical portfolio, including the four pillars of advance nursing practice: research, leadership, strategic planning, teaching and education, and service development.

The programme is currently being evaluated and results are due at the end of 2020.

An audit of patient experience found 100% satisfaction.

General Practitioners

GPs play a key role in dermatology provision as they are the first healthcare professional most patients see with their skin problems. Around 75% of all NHS consultations for skin problems take place in GP surgeries. This forms a significant part of the GP caseload, for example acne is the most common reason for teenagers to consult their GP.[18]

Dermatology training deficit

Despite such a significant demand for dermatology consultations, many GPs receive little formal dermatology training beyond one to two weeks as part of their five-year medical school course. At times, some medical schools have even removed dermatology from their curriculum altogether; despite having no good reason for doing so. We also heard from University Hospital Birmingham dermatologists that they were advised that undergraduate dermatology teaching might be ceased at the university.

Only a small proportion of the three-year specialist GP training programmes offer dermatology as a three-month training option. Our questionnaire identified just 80 trainee GPs (38 WTE) in dermatology units. Given there are around 3,500 GP training posts, this suggests that less than 10% of GP trainee posts involve secondary care dermatology.

As dermatological conditions are so common, all GPs should receive adequate training at undergraduate and postgraduate level so that they are able to recognise and manage common skin diseases. This would help to prevent unnecessary referrals of patients to secondary care, which currently lengthens patient pathways and increases costs.

Recent years have seen a substantial increase in the number of suspected cancer referrals to dermatology services. Many trusts told us that the substantial increase in unnecessary skin cancer referrals was increasing waits for people with other urgent conditions. While we wish to encourage people with skin cancer to present early to hospital, large numbers of unnecessary referrals reduce access for people with other urgent skin conditions.

Improving education in skin cancer for practice nurses and providing GPs with training so that they all have the expertise to be able to recognise common, benign skin growths would help to reduce unnecessary skin cancer referrals. This would help to improve quality of care and use NHS resources appropriately. NICE has produced a quality standard for the diagnosis and treatment of skin cancer.[19]

[18] *Kuan V, Denaxas S, Gonzalez-Izquierdo A (2019) A chronological map of 308 physical and mental health conditions from 4 million individuals in the English National Health Service. Lancet Digit Health. 1(2):e63-e77.*

[19] *NICE (2016) Skin cancer quality standard (QS130), https://www.nice.org.uk/guidance/qs130*

Teaching within dermatology units

Most dermatology units (75%) told us they are involved in teaching dermatology to medical students. However, 23% of these units said they receive no funding for teaching.

Tackling the deficit

It is essential that all GPs are provided with sufficient basic training to diagnose and provide evidence-based treatments for the common skin diseases. To this end, the BAD undergraduate training team has produced a recommended curriculum for medical students, and the All-Party Parliamentary Group on the Skin has also made recommendations in this area.[20] However, despite repeated recommendations over the past 20 years, it remains the case that people with skin disease who visit their GP may still be seen by a doctor with little formal dermatology training.

It stands to reason that those GPs who have received limited education in evidence-based dermatology will not have the level of expertise to be able to offer evidence-based treatments. This is wasting resources and making treatment less efficient and effective.

Several initiatives are already seeking to address the current deficit. For example:

- We found some examples of initiatives to improve postgraduate training around the country, including dermatologists delivering evening lectures and other forms of training to GPs.
- Some GPs wish to develop a special interest in dermatology and many of these join the Primary Care Dermatology Society. The society offers specialist training in the form of courses and meetings to support GPs who wish to develop their skills in primary dermatology care.
- A number of GPs who want to provide dermatology clinics are working as part of a team with their local consultant dermatologists.
- The BAD and Royal College of General Practitioners (RCGP) have an initiative to develop a formal training programme for GPs with extended roles (GPwERs – formerly GPwSI).

CASE STUDY

GPwERs working with secondary care

Dr Tim Cunliffe, GP with extended roles (GPwER)
Middlesbrough Specialist Skin Service (MISSS)

Dr Tim Cunliffe is the lead GPwER (GP with extended roles – formerly GPwSI) working in the Middlesbrough Specialist Skin Service (MISSS), an established community dermatology team. The MISSS is based in a purpose-built centre in the community with modern consulting and operating facilities. The team is well integrated with secondary care dermatology and plastic surgery services, and sits in the same directorate as dermatology at South Tees Hospitals NHS Foundation Trust.

As a GPwER with considerable expertise and experience in dermatology, Dr Cunliffe is able to work closely with colleagues in dermatology and plastic surgery secondary care, bringing appropriate patients into the department for investigation and treatment.

This joined-up approach helps to provide a seamless pathway for patients and avoids unnecessary appointments. It also benefits from the checks and balances, and shared knowledge of up-to-date practice that comes from both parties working closely together. These are essential in helping clinicians remain safe and competent, and in ensuring that primary and secondary care providers work together effectively.

Dr Cunliffe has trained another GPwER, and is the process of training three more, which will help to ensure the sustainability of the service.

[20] *All Party Parliamentary Group on the Skin (1998) Enquiry into the training of healthcare professionals who come into contact with skin diseases. www.appgs.co.uk/publication/%e2%80%a2-enquiry-into-the-training-of-healthcare-professionals-who-come-into-contact-with-skin-diseases-1998/.*

Pharmacists

Community pharmacy services

Around 54% of the population experience a skin problem every year. Of these people, around 69% opt for some form of self-care.[21]

Community pharmacists are often the first port of call for people with common dermatological conditions, such as acne or eczema. This means pharmacists' knowledge and understanding of common dermatology conditions is vitally important.

Secondary care pharmacists

Pharmacists' expertise in medication not only makes them ideally suited for initiating treatment, but also for monitoring people who are on long-term complex medications. In particular, they can offer insight into side effects, pregnancy risks and interactions with other medications

Developing the dermatology expertise of pharmacists, potentially to consultant pharmacists, offers another way to meet the increasing dermatology workload.

The BAD has a pharmacist education workstream that is currently looking at ways to improve dermatological expertise among pharmacists.

Physician associates (PAs)

Physician associates (PAs) are a relatively new group of healthcare professionals with the skills and knowledge to deliver care and treatment under defined levels of supervision. There is great potential for PAs to deliver care to people with dermatological diseases, which would be another step in easing the current workforce shortages.

We found only one report of a PA in dermatology and they had since left their post, although we were told they had been inspired by their experience as a PA to go to medical school to train with the aim of becoming a consultant dermatologist.

We believe there needs to be a career structure for PAs to encourage highly educated and able individuals to have a long-term NHS career.

The BAD is currently exploring how PAs might be best employed in dermatology.

Superclinics

This report makes several recommendations to address the current dermatology consultant workforce shortage and to manage the rapidly growing demand for dermatology relating to increases in the incidence of skin cancer. Several of these recommendations require training for a wider community of clinicians, such as nurses and physician associates. Superclinics offer a solution to meeting additional training needs given that dermatology consultants in short-staffed departments told us they that were often too busy to provide additional training.

Superclinics are a proven model and are used widely overseas, such as at the Charite Hospital, Berlin, which has been running a dermatology superclinic for over 10 years. The concept of a superclinic is to maximise the expertise of the most experienced team members for the benefit of the maximum number of patients. The consultant leading the clinic has very few, or no, patients on their own clinic list, but instead sees most of their subordinates' patients. Team members may include junior doctors or nurses.

The consultant's role is to:

- ensure all new patients have either the correct diagnosis, with a management plan, or are placed on the optimal management pathway;
- ensure there is no unnecessary or wasteful prescribing or investigation;
- ensure that no patients are followed up by supporting team members unnecessarily and to discharge all possible patients with a management plan;
- supervise at least three doctors, nurses or other clinicians;
- ensure all team members arrive on time and stay until all patients have been seen;

[21] *Schofield J, Grindlay D, Williams H (2009) Skin conditions in the UK: a Health Care Needs Assessment. Centre of Evidence Based Dermatology, University of Nottingham. www.nottingham.ac.uk/research/groups/cebd/documents/hcnaskinconditionsuk2009.pdf.*

- check that all team members work through the clinic (except for any agreed breaks) and don't take breaks between patients to do emails and make phone calls etc;
- ensure a fast flow of patients by supporting any team members taking too long with a consultation;
- train team members, including work-based assessments;
- ensure appropriate patients are involved in research, audit and system improvement projects.

This approach ensures maximum efficiency of the clinic. The loss in consultant list activity is more than compensated by the efficiencies gained.

CASE STUDY

Superclinic with advanced nurse practitioners

Leeds Teaching Hospitals NHS Trust

Leeds' superclinic and advanced nurse practitioners (ANPs) are key to ensuring the trust sees dermatology patients in an effective, timely, safe and patient-centred manner.

Each Wednesday, Dr Walayat Hussain, consultant dermatologist, and colleagues run the superclinic, bringing together the expertise and skills of allied health professionals. Dr Hussain takes a supervisory role, working with consultant colleagues from plastic surgery, dermatology registrars, nursing staff and physician associates. Working with these health professionals, in particular those from plastic surgery, means patients can be managed appropriately in a single clinic appointment, without the need for a further hospital visit.

Advanced nurse practitioners in the clinic have the training and expertise to both clinically assess patients and perform skin surgery, while bringing nursing skills and competencies to the team.

The superclinic model increases the efficiency of the skin cancer pathway, as fewer unnecessary diagnostic procedures are requested by junior staff members. In addition, far fewer patients are bought back for follow-up. There is a further benefit in staff retention; nurse practitioners and physician associates trained to work in the superclinic have very high levels of job satisfaction.

Leeds reports that the superclinic approach has seen a marked improvement in patient flow, with selected patients receiving treatment on their first appointment as a one-stop service. Analysis by the trust's performance team, based on validated metrics, show that the clinic is 30% more efficient than traditional models.

Recommendations

Recommendation	Actions	Owners	Timescale
3. Optimise the training and function of the whole dermatology multidisciplinary team to deliver better care across settings and reduce locum costs. Develop a clinic structure to support this.	**a** Train dermatology nurses as specialist nurses and as nurse consultants to expand the workforce in a safe, efficient and cost-effective way to meet the challenges of increasing skin cancer and the needs of people with skin disorders.	Trusts (with support from BDNG and BAD)	18 months
	b Adopt the framework for nurse banding and training developed by the BAD and BDNG to standardise roles and education across the NHS for dermatology nurses.	Trusts	12 months
	c Include dermatology in training schemes for GPs and other primary care staff to improve evidence-based patient care and reduce unnecessary referrals.	RCGP; RCN; RPS; BDNG; BAD	18 months
	d Include dermatology training that meets the BAD curriculum in all medical school courses so that all GPs have basic dermatology skills.	Medical schools	For substantial progress within two years of report publication
	e Improve undergraduate dermatology training for pharmacists, so that community pharmacists are able to manage common skin conditions such as eczema, acne, fungal infections and warts in line with current evidence-based dermatology national guidelines.	Pharmacy schools	For substantial progress within two years of report publication
	f Explore the potential for hospital pharmacists to help with the management of patients on systemic medications, including biologics.	Trusts	12 months
	g Develop the use of superclinics as a model to allow safe supervision of a multidisciplinary workforce.	Trusts	12 months

Efficient use of NHS resources

We looked at areas where more efficient use of NHS resources could be achieved.

Surgery in inappropriately complex settings

Where appropriate, carrying out day surgery in procedure rooms or smaller operating theatres would help to improve NHS efficiency.

We found wide variation in the number of day cases and outpatient procedures between trusts, as shown in Figure 7.

At least some of this variation can be explained by having two different scales of tariffs for the same operations. A trust can be paid around five times as much for an operation carried out as a day case as for the same operation carried out as an outpatient procedure. The current classification leads to a perverse financial incentive to carry out surgery as a day case in inappropriately complex settings, such as in a general anaesthetic-equipped operating theatre rather than as an outpatient procedure in a smaller operating theatre or procedure room, in order to claim the higher tariff. There is no evidence that outcomes are improved by carrying out procedures in the more complex settings.

Doing operations as day cases earns greater income for the trust. A further benefit to the trust is that doing simple procedures as day cases reduces the average cost to the trust of its day case surgery. This produces lower overall reference costs for the trust, meaning that it appears to have better financial performance.

This imbalance between the two tariffs must be addressed in order to remove the incentive to carry out procedures in a more complex setting. The funding mechanisms should not reward those doing procedures in inappropriately complex settings. Incentivising trusts to move appropriate surgical cases into fully equipped procedure rooms, where operations can safely take place, would free up larger operating theatres for those requiring these facilities and would reduce system costs.

Other specialties face the same issue, for example plastic surgery.

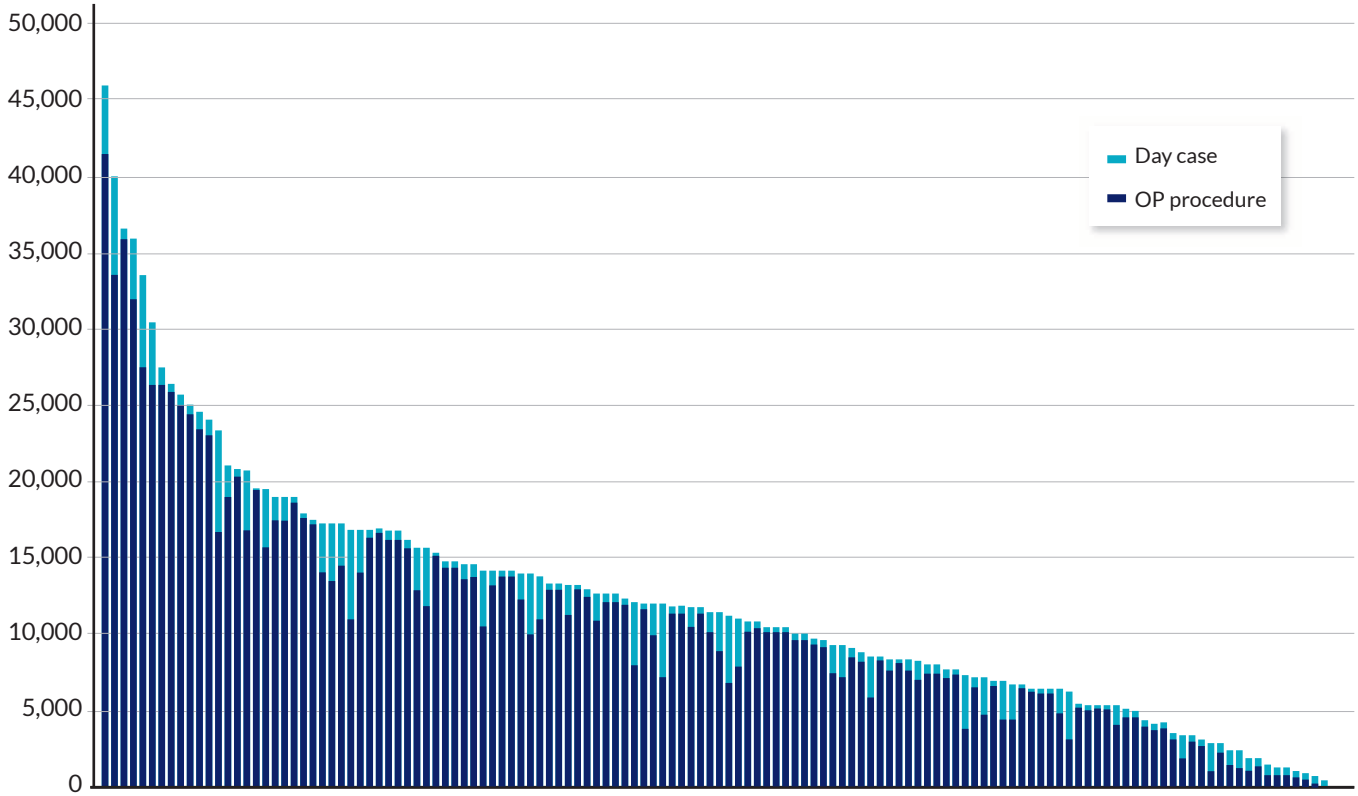
Block contracts

The difference between tariffs will become less of an issue if services move to block contracts rather than tariff-based contracts in the future.

Block contracts between CCGs and trusts establish a fixed sum for all activity. This reduces the impact of tariff differentials since the price is agreed. The increased use of block contracts by CCGs may help to eliminate the element of variation in practice that is caused by tariff differences. However, if the block contract payment is based on activity from previous classifications, this will reward the units that have had a history of classifying more surgery as day cases.

GIRFT is currently considering a skin cancer workstream that would review the classification, tariff and coding of skin cancer further. We would anticipate further recommendations related to the topic of tariffs from that workstream.

Figure 7: Outpatient and day-case procedure by provider



Data source: HES, April 2018 to March 2019

Recommendations

Recommendation	Actions	Owners	Timescale
4. Ensure there is a clear and consistent delineation between day case and outpatient skin cancer surgery activity taking place dermatology. This should apply to other specialties treating skin cancer. Funding arrangements should reflect this to support surgery in the most appropriate and efficient setting	**a** Develop simpler standardised rules defining dermatology outpatient procedures versus day case surgery.	Trusts, commissioners, possible GIRFT skin cancer workstream	12 months
	b Review funding arrangements to standardise funding and practice, ensuring trusts are incentivised to carry out surgery in the most appropriate setting, avoiding unnecessary use of operating theatres.	Trusts, commissioners, possible GIRFT skin cancer workstream	18 months

High follow-up rates

Providing patients with the right diagnosis and treatment first time delivers a better experience for patients, reduces costs, increases space for new patients and shortens waiting lists.

Follow-up rates provide a measure of the number of follow-up visits made by patients to a unit. Having a relatively high follow-up rate means patients at that unit are having relatively more follow-ups than at other units.

High follow-up rates can provide a useful indicator of whether diagnosis and treatment is right first time. There is an opportunity to improve quality of care in trusts with high follow-up rates.

National Outpatient Transformation Programme (NOTP)

The NHS England and NHS Improvement National Outpatient Transformation Programme (NOTP) will support the redesign of clinical pathways in high volume specialties, including dermatology. The aim of the redesigned pathways is to ensure that patients get the advice and care they need in the right place the first time, with shorter waits and fewer trips to hospital.

The NOTP will also develop consistent and effective ongoing personalised care through increased use of patient-initiated follow-ups.

The NOTP launched in April 2020.

Our review

We looked at follow-up rates for hospital attendances including procedures and the rate for hospital attendances excluding procedures. We looked at both rates because there is considerable variation in how trusts classify dermatology outpatient appointments and procedures. By considering the two rates together (and by knowing how many procedures were done) we were able to make valid comparisons between units and draw our conclusions. Overall, we found that the figure including procedures allowed more valid benchmarking, unless the department does unusually high or low numbers of phototherapy procedures.

Wide variation and causes of high follow-up rates

We found wide variation in follow-up rates between units, as shown in Figure 8.

Unwarranted high follow-up rates are often caused by:

- inexperienced clinicians bringing people back unnecessarily because they are uncertain of their diagnosis or treatment;
- inexperienced clinicians not accurately diagnosing and treating patients first time.

We found that units with high follow-up rates were often those that find themselves having to employ a series of locum doctors, some of whom may be inexperienced and not on the GMC specialist register. These doctors may follow-up a greater number of patients because they are less sure of diagnosing conditions correctly and prescribing treatment.

Within any department, there may be some clinicians who see more people with complex conditions. This means any comparison of individual ratios must always consider the complexity of cases seen by the doctor.

Benchmarking follow up rates

Average follow-up rates are:

- 1:2.4 for outpatients and procedures;
- 1:1.9 for outpatients only.

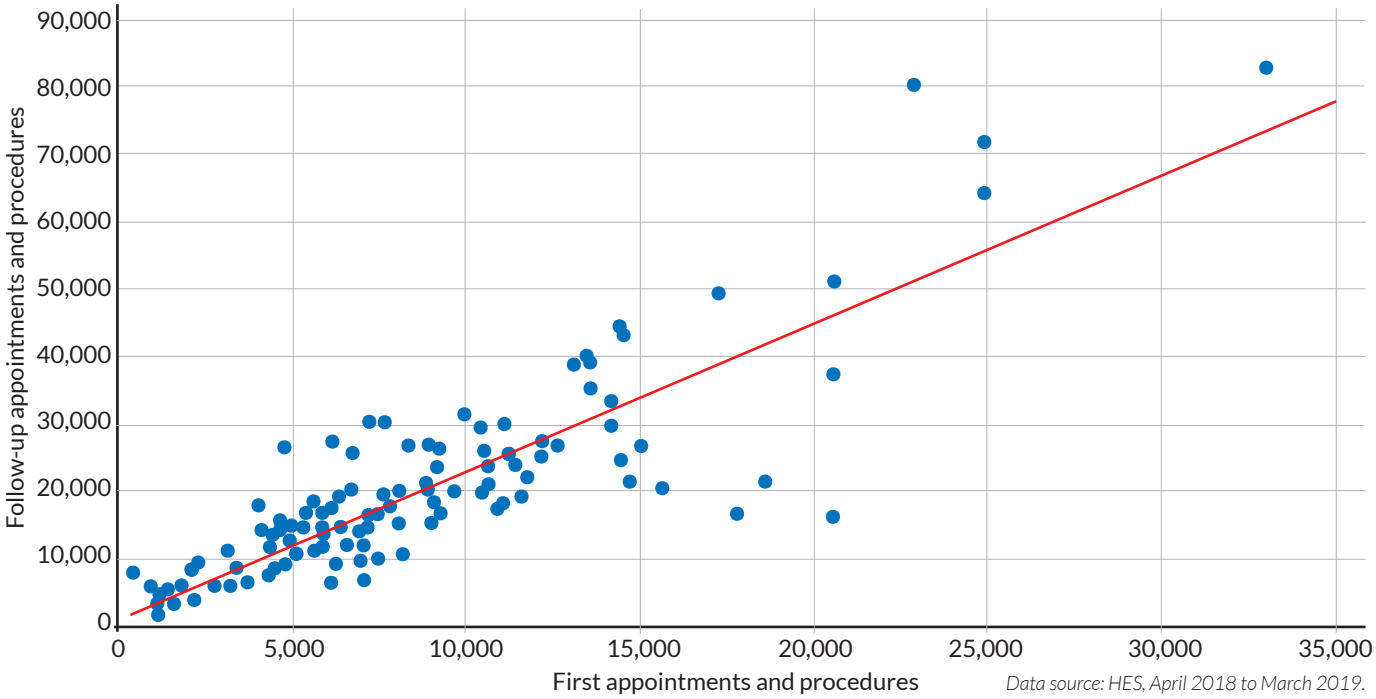
On average, this means:

- a department with 10,000 new outpatients and procedures in a year would also see 24,000 patients for follow-up appointments or procedures;
- a department with 10,000 new outpatients in a year would also see 19,000 patients for follow-up appointments.

Trusts typically discharge around a third of new patients following a new patient appointment without any follow-up appointment.

The two follow-up rates and the proportion of new patients discharged offer reasonable benchmarks. These benchmarks should be adjusted to allow for warranted variation, as described below.

Figure 8: New and follow-up appointments including procedures



Data source: HES, April 2018 to March 2019.

Warranted variation in follow-up rates in certain units

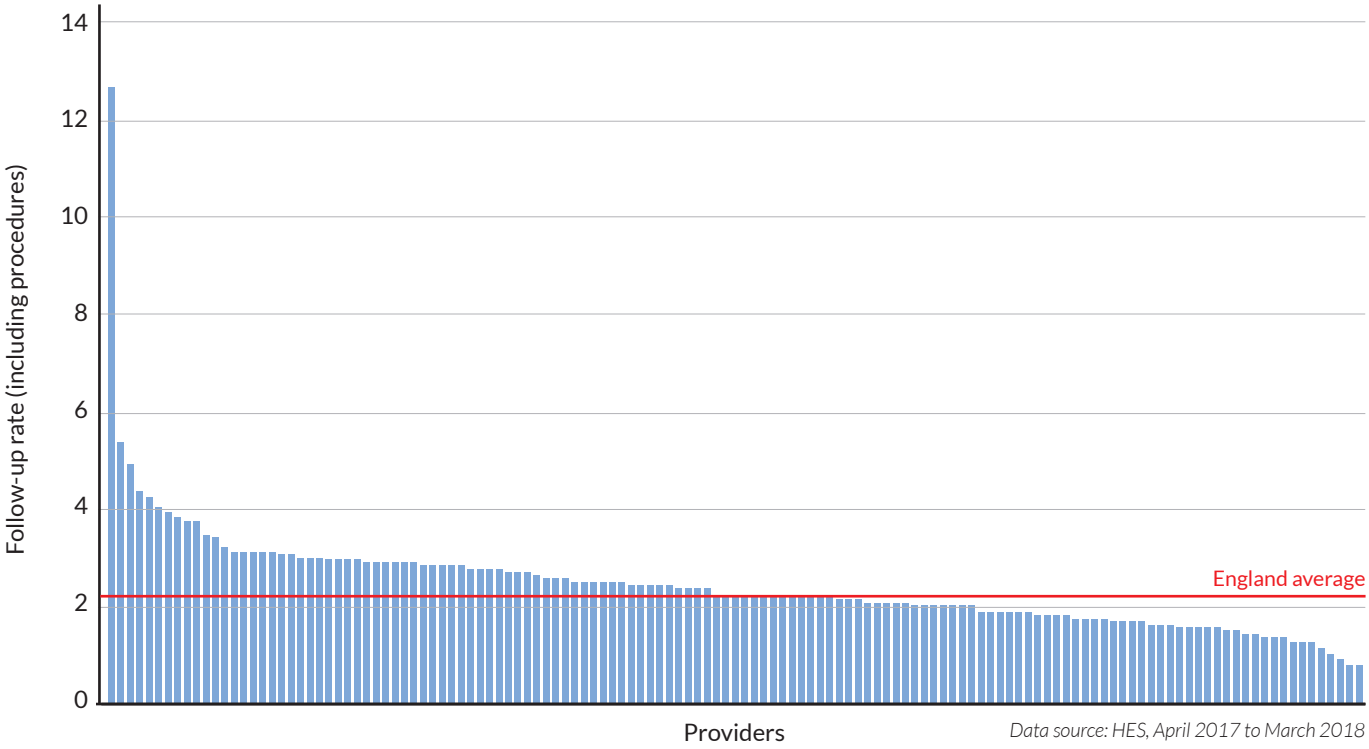
Some of the variation between units is explained by casemix. Complex cases will generally have higher follow-up rates than less complex cases. Therefore, it would be reasonable to see higher follow-up rates and lower discharge rates in those units that are seeing a relatively high number of more complex cases.

- Some very large units may be acting as tertiary referral centres. This means they see a relatively high number of more complex patients who will require a higher rate of follow-up appointments.
- Some units are in areas where local commissioners are commissioning independent providers or consultant-led, community-based services to take 'straightforward' cases. This means a greater proportion of the cases the trust sees are complex cases.
- A unit may be receiving a high proportion of complex referrals from a neighbouring area where dermatology services have reduced their activity or closed their doors to new referrals due to staffing shortages. People with complex problems are more likely to travel greater distances to be treated, so when one trust closes to referrals, its patients with more complex needs transfer to neighbouring trusts.

Tackling variation in follow-up rates

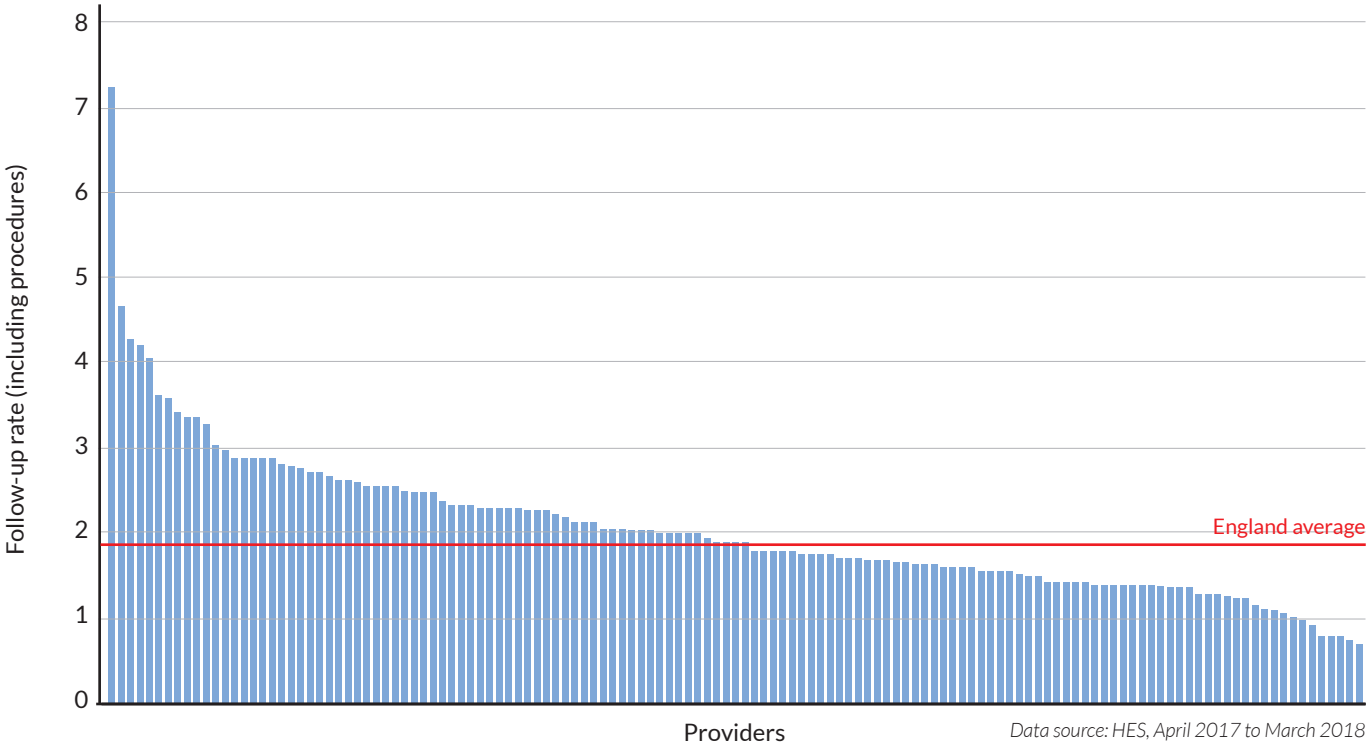
There is considerable unwarranted variation in follow-up rates between trusts as shown in Figures 9, 10 and 11. If all trusts could match the performance of the trusts with lower rates, taking into account the reasons for warranted variation mentioned above, this would offer a significant opportunity to free up resources to treat more new patients.

Figure 9: Outpatient follow-up rates, including procedures, by provider



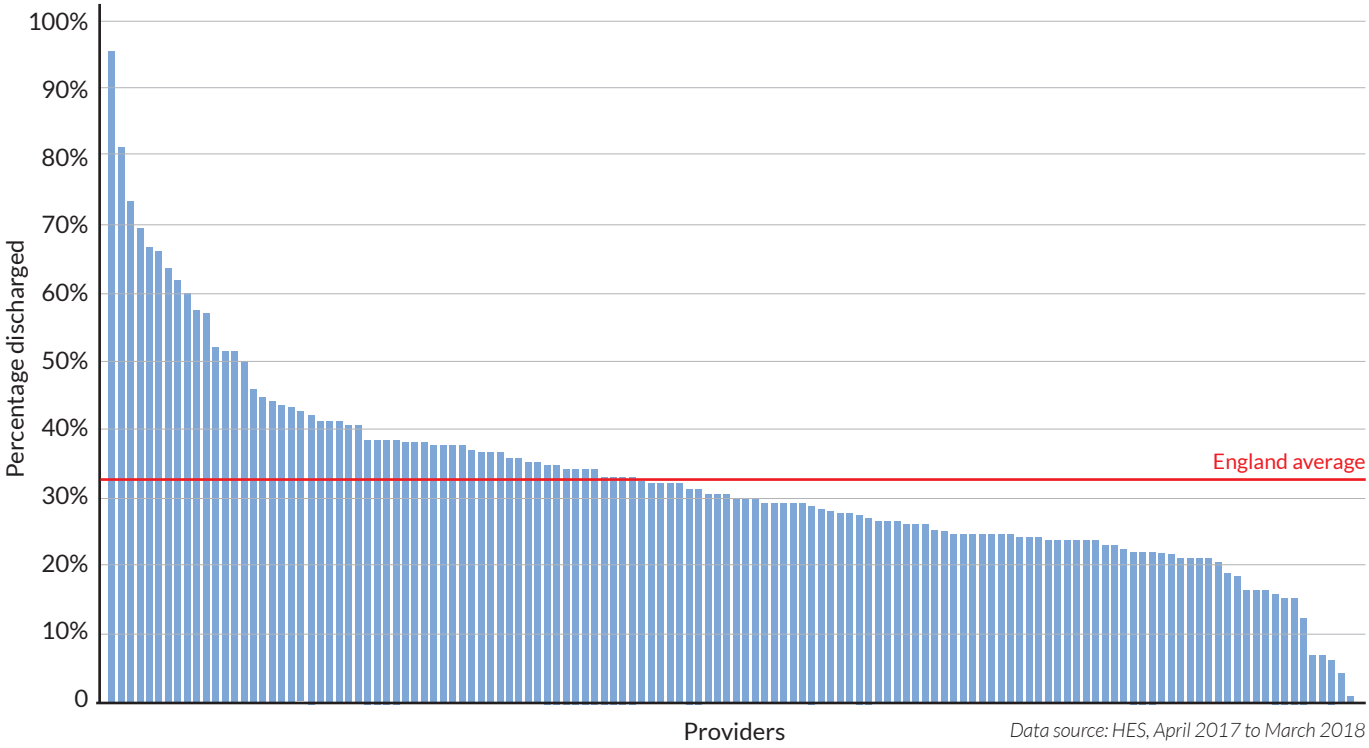
Data source: HES, April 2017 to March 2018

Figure 10: Outpatient follow-up rates, for attendances only, by provider



Data source: HES, April 2017 to March 2018

Figure 11: Percentage of first outpatient attendances where patient is discharged and not followed up, by provider



Data source: HES, April 2017 to March 2018

Exceptionally low follow-up rates

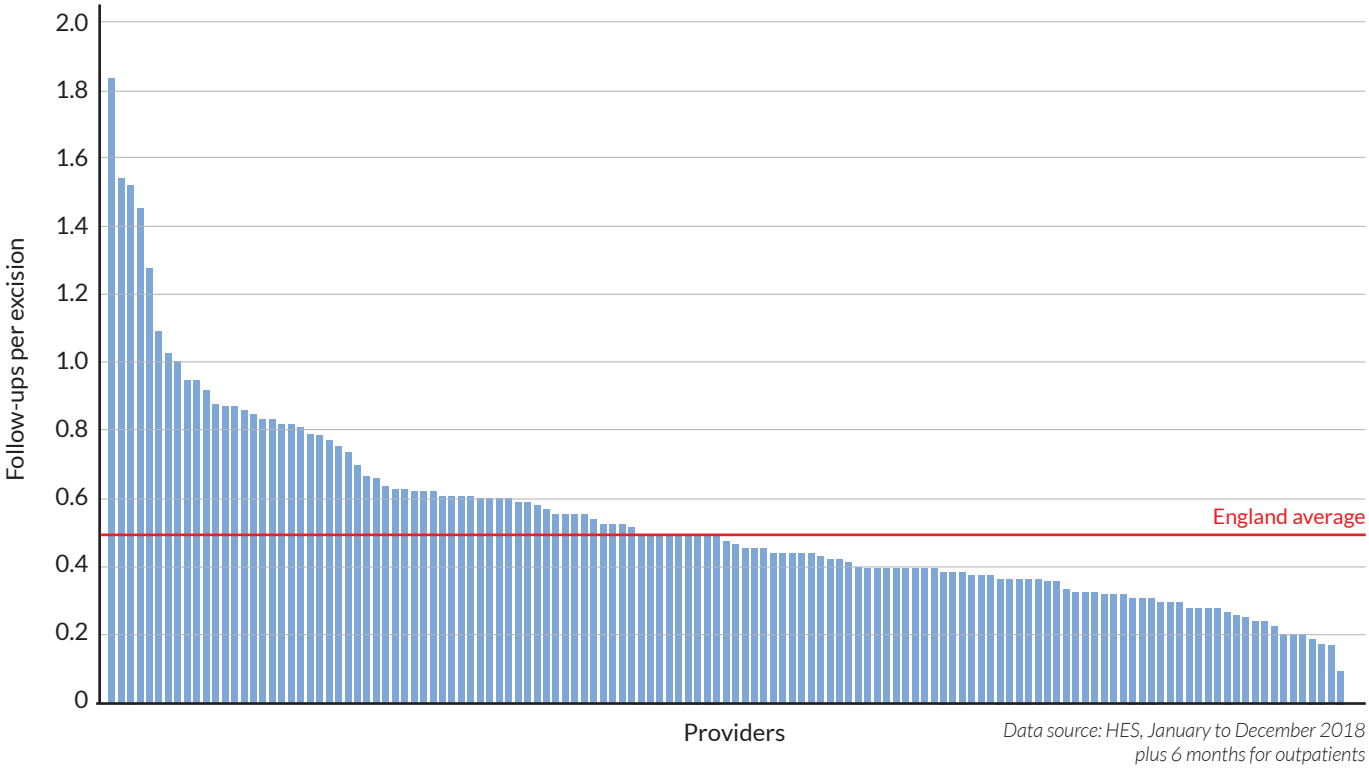
Very low follow-up rates or very high discharge rates from first outpatient attendances in units are sometimes an indicator of severe staffing shortages that mean the unit is not able to schedule follow-up appointments even when they are appropriate, for example monitoring safe use of systemic medication or cancer follow-up. This has the potential to become a patient safety issue.

Follow-up rates after skin cancer surgery

We found that several trusts carry out an above average number of follow-up appointments in the six months after excision surgery, as shown in Figure 12. This may be partly due to excision of more high-risk tumours, which require more follow-up, or due to variation in local skin cancer pathways. However, this does not fully explain the variation seen.

In most trusts, people with low risk basal cell carcinomas (BCCs) are informed of their diagnosis by letter, which allows more new patients to be seen earlier.

Figure 12: Average number of outpatient follow-ups within six months of each excision by provider



Data source: HES, January to December 2018 plus 6 months for outpatients

Outpatient did not attend (DNA) rates

There is a cost whenever a patient does not attend their outpatient appointment. Not only is there a risk that the patient's condition will worsen, the valuable appointment slot is lost to other patients, and the scheduled consultant, nurse and treatment facility resources are potentially left without any activity.

Improving DNA rates offers a considerable opportunity to save NHS resources.

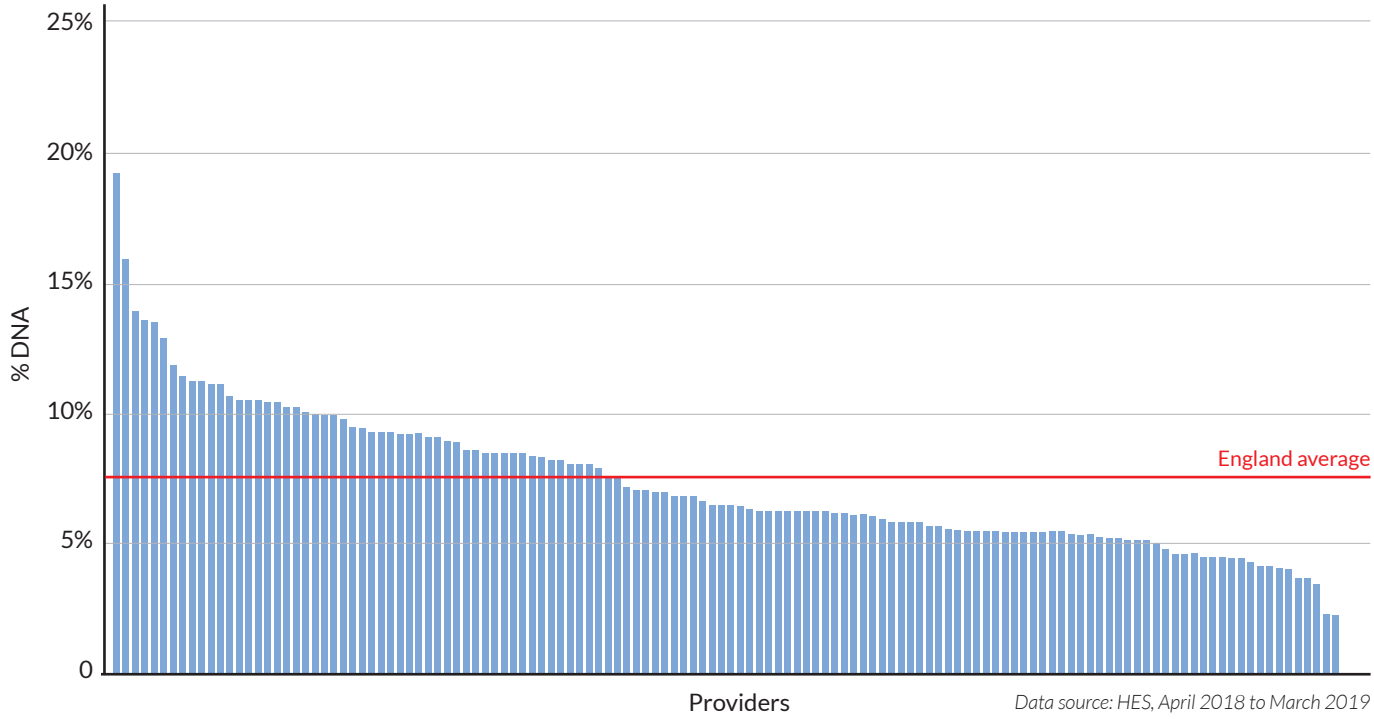
High DNA rates in outpatient appointments

High numbers of people do not attend their outpatient appointments in all specialties, including dermatology.

In dermatology, there is also considerable variation between units. Those with the highest DNA rates are 2-3 times greater than the lowest, as shown in Figures 13 and 14.

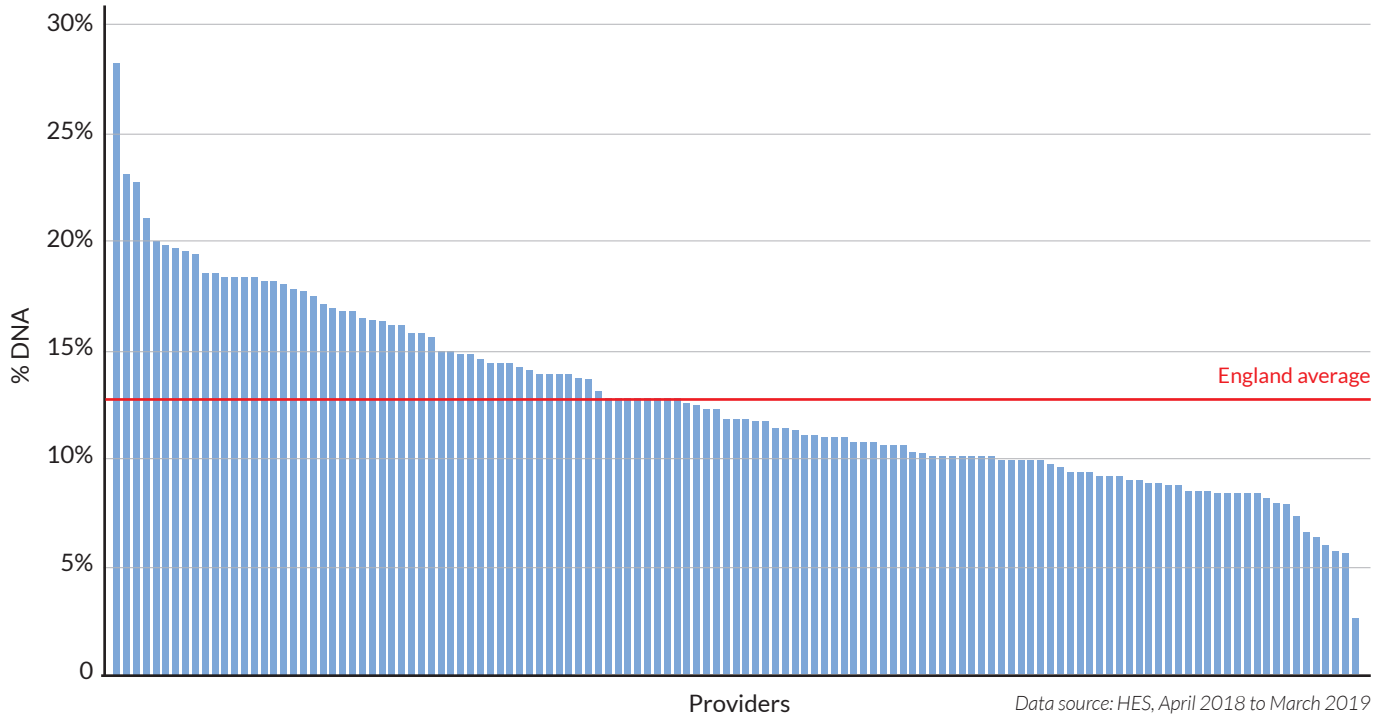
Most trusts have introduced text reminders to help reduce DNAs and this has resulted in some improvement.

Figure 13: Adult dermatology did not attend rates by provider



Data source: HES, April 2018 to March 2019

Figure 14: Paediatric dermatology did not attend rates by provider



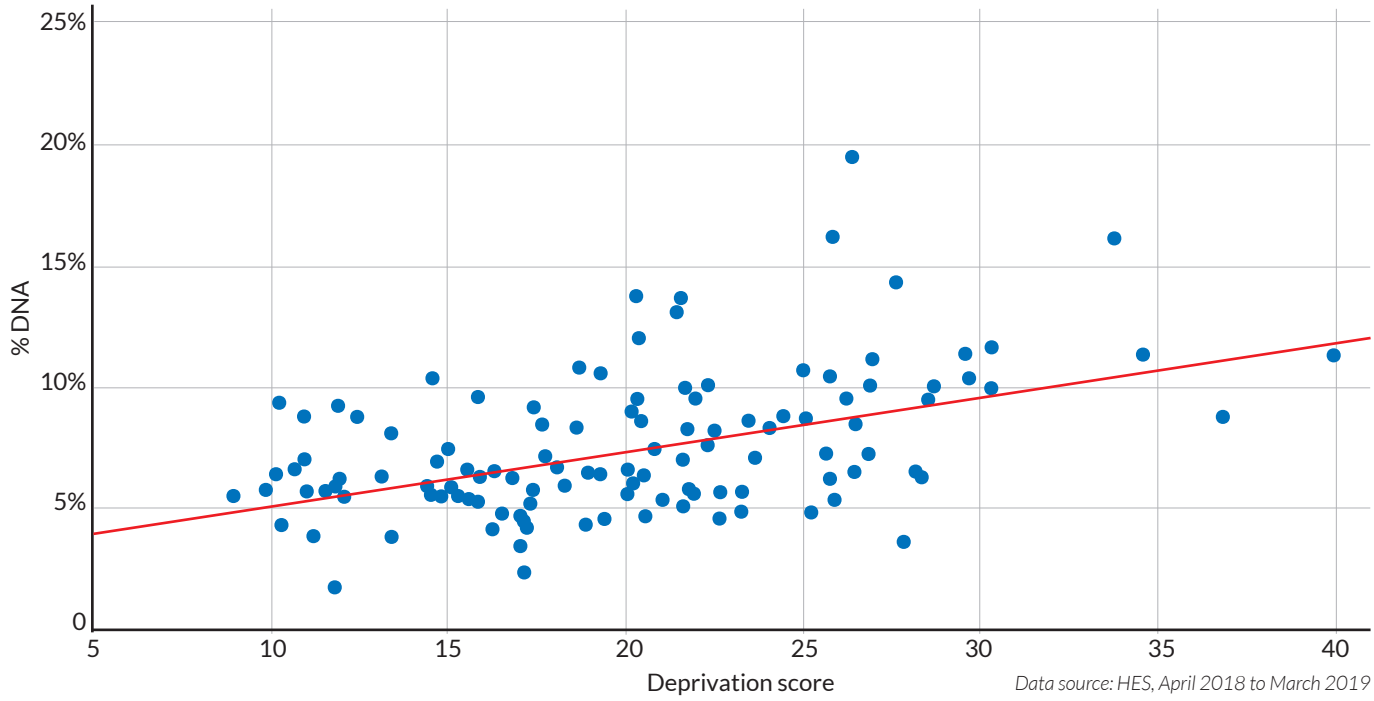
Data source: HES, April 2018 to March 2019

Language and deprivation

DNA rates are often high in trusts in areas of higher deprivation, as shown in Figure 15 and Figure 16. Populations with higher levels of deprivation may have more difficulties with travel costs and problems with understanding hospital communications due to literacy issues and understanding of written English.

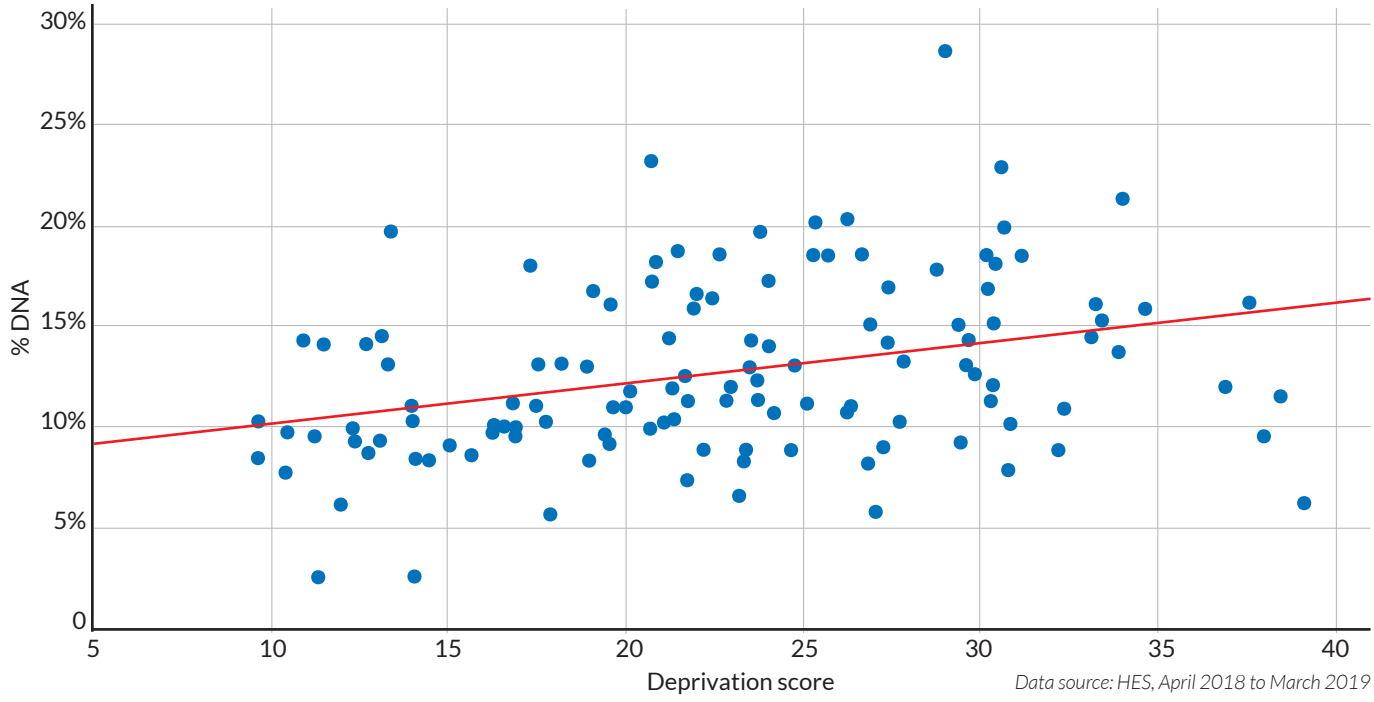
Improving how hospitals communicate with these populations, such as making hospital letters and texts more accessible, could help trusts achieve higher attendance rates.

Figure 15: Adult dermatology did not attend rates versus deprivation score, by provider



Data source: HES, April 2018 to March 2019

Figure 16: Paediatric dermatology did not attend rates versus deprivation score, by provider



Data source: HES, April 2018 to March 2019

CASE STUDY

Using an application to support management of patient pathways

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Wrightington, Wigan and Leigh has developed an application to help its performance team identify and manage patients who are potentially on an 18-week plus pathway. This has proved to be the most effective way for them to manage patient pathways.

Each day, the application reviews all patients to identify errors that may be contributing to any delays in their pathway, such as incorrect coding.

Any issues are flagged and the team can then take action, such as:

- checking clinic letters to identify if patients are waiting for test results;
- checking if test results are available;
- asking clinicians to review or contact the diagnostic area to chase up results or speed up appointments;
- asking clinicians to act on results;
- if appropriate, stopping the clock.

They can then liaise with medical secretaries to make sure all actions have been carried out and the patient pathway is revised.

CASE STUDY

Using multilingual texts and appointment letters

Tameside Hospital NHS Foundation Trust

Attending a hospital appointment can be a daunting experience for many patients; as can navigating a hospital site.

Since introducing text messages and appointment letters written in patients' preferred language, Tameside has found that patients are more likely to attend their appointment at the correct place and time, and to bring relevant information and medications with them. Staff in the bookings team have noted a reduction in the number of calls about appointment details, while patient experience has also improved.

The text messages and appointment letters were professionally translated into five languages commonly spoken among the local community. Patients can choose to specify which language they would prefer for their correspondence, and this is noted in their patient file and electronic record. They then receive all messages and letters in their preferred language.

Recommendations

Recommendation	Actions	Owners	Timescale
5. Address unwarranted variation in follow-up rates, reduce unnecessary follow-ups, reduce DNAs and ensure that patients see an appropriately trained person in the right setting to receive the right diagnosis and treatment first time.	**a** Benchmark follow-up rates, both including procedures and excluding procedures, and proportion of new patients discharged. Trusts should identify a target rate based on their circumstances to enable them to assess their performance.	GIRFT; trusts	6 months
	b Explore rates for individual clinicians to identify if there are particular case-mix reasons for this.	Trusts	6 months
	c Inform patients of their diagnosis by letter after excision of low risk skin cancers unless there are particular reasons for seeing them again in secondary care.	Trusts	3 months
	d Use the languages widely spoken by the local community in outpatient communications to support patient understanding. Ensure that communications by letter and text use simple language.	Trusts	6 months

Shared care between primary and secondary care

Shared care between primary and secondary care services can be an effective way to deliver services. For example, having GPs carry out appropriate blood tests can enable patients to avoid long journeys to hospital. There are examples of shared care working well in other specialties, such as gastroenterology and rheumatology where there are clear protocols between GPs and secondary care.

We found that successful provision of shared care in dermatology between primary and secondary care is patchy, as shown in Table 2. Only 43% of units have shared care protocols for all appropriate drugs, while just under 32% of units have no shared care protocols at all in place.

Table 2: Trusts with shared care protocols with primary care in place for appropriate long-term systemic drugs

Shared care protocols	Source and year	% Yes	% Some drugs	% No	Responses
Are effective shared care protocols (with primary care) in place for appropriate long term sytemic drugs?	GIRFT questionnaires 2018	35.0%	32.5%	32.5%	117 repsonses
	GIRFT questionnaires 2019	43.1%	25.2%	31.7%	123 repsonses
	Change in % response from 2018-19: (15.4%)	8.1%	-7.3%	-0.8%	19 responses updated

Data source: GIRFT questionnaire, 2019.

Some GPs are resistant to carrying out testing. We heard that there are a number of reasons for this, including:

- their workload means they are too busy to take on further activities;
- they may be unsure which tests to carry out due to a lack of knowledge and training;
- they may be frustrated that tests for the same drug vary from one specialty to the next, for example the differences in requirements for liver screening and chest x-rays that exist between dermatology and rheumatology for methotrexate treatment;
- they may be cautious of the risk of using a drug outside its licence;
- GPs sometimes consider that they are not reimbursed to do this work.

We did find some examples of good practice. For example, some trusts have developed protocols for GPs and all relevant specialties for shared care for certain medications, such as methotrexate.

National Outpatient Transformation Programme (NOTP)

The National Outpatient Transformation Programme (NOTP) will review the end-to-end outpatient pathways for dermatology across primary and community settings.

This work commenced in April 2020.

CASE STUDY

Self-imposing a maximum appointment waiting time for new patients suspected of having a basal cell carcinoma

Harrogate and District NHS Foundation Trust

Harrogate and District has established a maximum waiting time of six weeks for appointments for new patients suspected of having a basal cell carcinoma (BCC). This has resulted in the trust vastly reducing the number of BCC patients on the two-week pathway, making that pathway work more effectively for the patients who need to be seen most urgently.

The new approach was developed as the trust identified that many GPs were not happy for their patients to wait four months for a BCC appointment, irrespective of the level of risk (although it is safe to wait up to four months for a BCC referral, there is always the risk of diagnostic inaccuracy at the initial GP consultation: the risk that a GP may mistake an aggressive skin tumour for a BCC).

Knowing this, GPs were opting to list a high number of suspected BCC patients on the two-week pathway. This was swamping the two-week wait pathway, making the target difficult to achieve for patients, including those it was designed to protect from delays.

Making GPs aware of the new approach has been key to its success. Admin staff and managers must also understand that the self-imposed six-week target is as important as the national two-week target.

MDT reviews of private patients with cancer

Multidisciplinary team (MDT) reviews provide a forum for a wide range of clinicians, including senior consultants, junior doctors and nurses, to discuss each case. They are a fundamental pillar of NHS skin cancer services.

We found that private patients with cancer were reviewed in 63% of NHS MDTs. However, only 9% of trusts reported they were paid for this work. This raises the issues of lost income and, more importantly, governance. The 'Report of the Independent Inquiry into the Issues raised by Paterson'[22] makes detailed recommendations regarding governance of private patients discussed in MDTs.

Lost income

It would be reasonable to believe that the NHS should charge for the care it provides to patients on behalf of private providers. However, two trusts told us that the cost of recovering this income would probably outweigh any potential income. Some NHS trusts have agreements in place with local private hospitals.

Governance

When an MDT reviews an NHS patient, there are processes and procedures in place to ensure that:

- all appropriate patients are reviewed;
- appropriate action is taken following the review, such as the patient receiving the treatment recommended by the MDT.

[22] *Paterson Inquiry (2020) Report of the Independent Inquiry into the Issues raised by Paterson. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863211/issues-raised-by-paterson-independent-inquiry-report-web-accessible.pdf*

There is currently no governance of this process for private patients reviewed in most NHS MDTs. This means there is a risk that follow-up actions are not carried out and the patient does not get the care they need.

There is a clear need to establish standard protocols around the sharing of patient information, before and after treatment, to ensure continuity of care and avoid duplication of effort. If information sharing is not well coordinated, this can result in disjointed follow-up of patients following treatment or surgery, as well as duplication of work and investigations when patients are referred on to NHS services.

Some important action on information sharing is already underway, including the development of a Consultant Oversight Framework, led by Sir Bruce Keogh. This will establish an approach for overseeing consultant practice in the independent sector.

Recommendations

Recommendation	Actions	Owners	Timescale
6. Improve care continuity and governance for NHS and non-NHS patients.	**a** Establish clear and suitably funded shared care protocols between primary and secondary care providers for dermatology services.	GIRFT; trusts; CCGs; GPs; NOTP	18 months
	b Establish clear arrangements between NHS and independent providers to ensure continuity of care for non-NHS patients discussed during dermatology MDT meetings.	Trusts	12 months
	c Inform and support the work of NHS England and the Independent Healthcare Providers Network (IHPN) to implement new medical governance framework.	GIRFT	12 months

Equity of care and access to treatments

Mohs surgery

Mohs micrographic surgery (Mohs surgery) is a specialised form of surgery to remove certain skin cancers.

In Mohs surgery, the visible portion of a tumour is first removed. Then further tissue that may contain cancer cells is removed one layer at a time and examined under a microscope at each stage. The process is repeated until all cancer cells have been removed.

Gold standard treatment

Mohs surgery is the gold standard treatment for certain skin cancers, especially for ill-defined cancers on the face. Although the cost of Mohs surgery is higher than conventional surgery, Mohs is considered to be cost-effective if used in appropriate patient groups. Benefits of Mohs include:

- 99% plus cure rate compared to 95% from simply cutting out the cancer, getting the treatment right first time;
- removes only cancerous cells, rather than needing to remove a safety margin of normal skin as is the case with conventional surgery, sparing unnecessary removal of tissue from the nose, lips or eyelids;
- reduces the risk of complicated cancer recurrences involving the face or eye;
- reduces the need for follow-up;
- reduces disfiguring scarring.

Need for health economic analyses

Good quality health economic analyses are required to support development of Mohs in the UK. Key considerations include the following:

- Surgeons must be trained in the technique. Although Mohs surgeons will repair most cases themselves, they must be able to collaborate with other reconstructive surgeons on complex cases.
- Specialist skin cancer MDTs (SSMDTs) should select patients suitable for Mohs to ensure that those likely to benefit most receive treatment.
- Mohs requires access to a pathology laboratory and pathology technician to help prepare the removed tissue which is analysed at the time by the Mohs surgeon.

Standards and training

In 2020, the BAD published service guidance and standards for Mohs surgery.[23] The standards were developed within a NICE-accredited service standards framework and were approved and co-badged by the Royal College of Pathologists (RCP), British Association of Oral and Maxillofacial Surgeons (BAOMS), ENT UK, the British Society for Dermatological Surgery (BSDS), the British Society for Dermatopathology (BSD), the British Oculoplastic Surgery Society (BOPSS), and the BAD. These service standards should help to resolve unwarranted variation in the way that Mohs surgery is carried out.

The BSDS organises education in dermatology surgery, including Mohs Surgery and runs the post-CCT Mohs fellowships, which are approved by the General Medical Council (GMC).

The British Association of Plastics and Reconstructive and Aesthetic Surgeons (BAPRAS) and BOPSS have produced 'Mohs Micrographic Surgery (MMS) UK surgical standards & service guidance'. [24]

The BSDS intend to launch two important initiatives in 2020 with the aim of improving standards:

- an anonymised national database based on the minimum dataset in the NICE-accredited Mohs service standards produced by the BAD;
- an external quality assurance scheme for Mohs pathology, to be administered by the RCPath Dermatopathology EQA centre at the University of Leicester.

[23] *BAD et al. (2020) Service Guidance and Standards for Mohs Micrographic Surgery (MMS). https://www.bad.org.uk/healthcare-professionals/clinical-services/service-guidance/mohs*

[24] *BAPRAS and BOPSS (2019). Mohs Micrographic Surgery (MMS) UK surgical standards & service guidance. https://www.bopss.co.uk/bopss/mohs-micrographic-surgery-mms/*

Variation in access to Mohs surgery

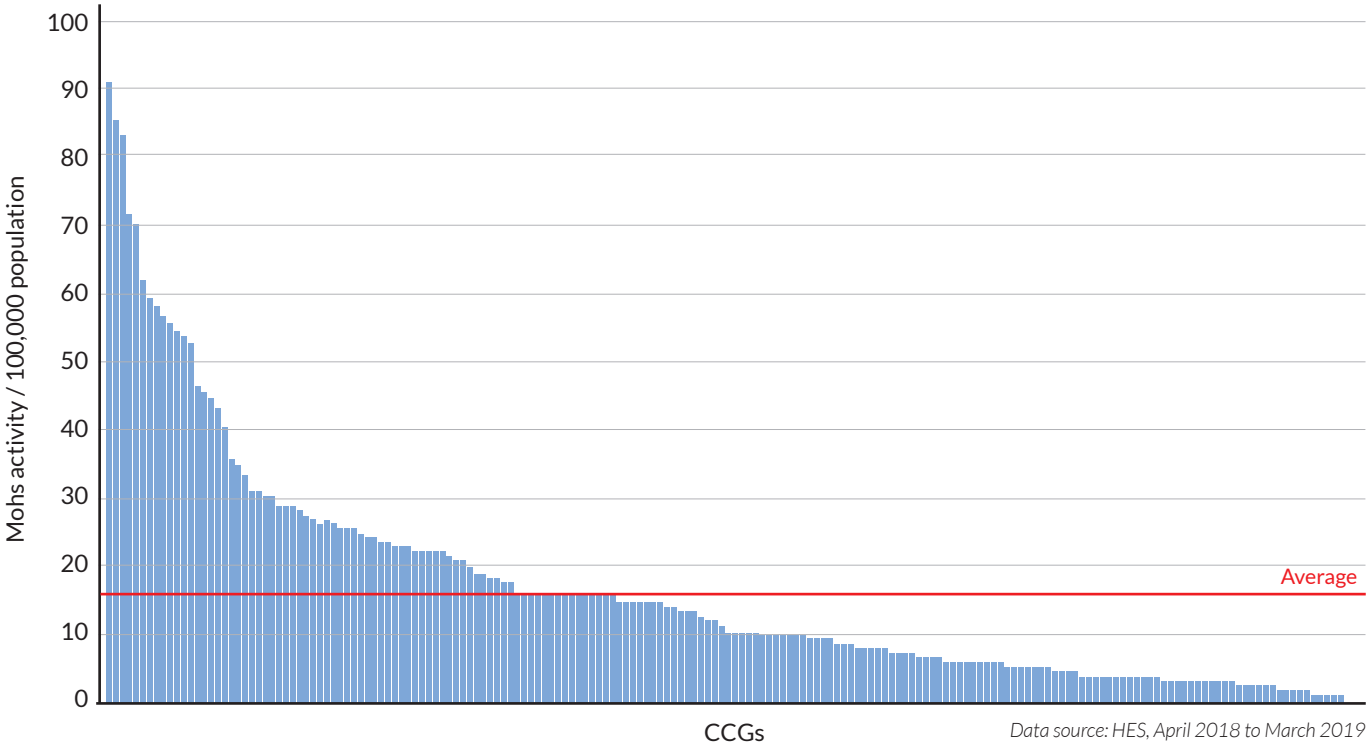
There is wide variation in access to Mohs surgery between CCGs, as shown in Figure 17. Some areas are well-served: for example, patients living in Salford are over ten times more likely to get Mohs surgery than those living in some other areas of England who have very poor access to Mohs surgery.

The primary reason that there is such poor access in some areas is the lack of surgeons with training in Mohs. We found just 79 dermatology doctors carrying out Mohs surgery in England, as shown in Figure 18. Mohs activity is concentrated in fewer than 30 specialist centres, as shown in Figure 19.

NHS England defines Mohs as a specialist service. This means it should be provided by departments that are designated as offering specialist skin cancer services. The Dermatology Clinical Reference Group (CRG) currently designates 56 English trusts as specialist skin cancer centres, otherwise known as SSMDTs (or level 5). We were told by some departments with these SSMDTs that they were keen to set up Mohs surgery and that this was supported by neighbouring SSMDTs that were struggling to deal with the workload.

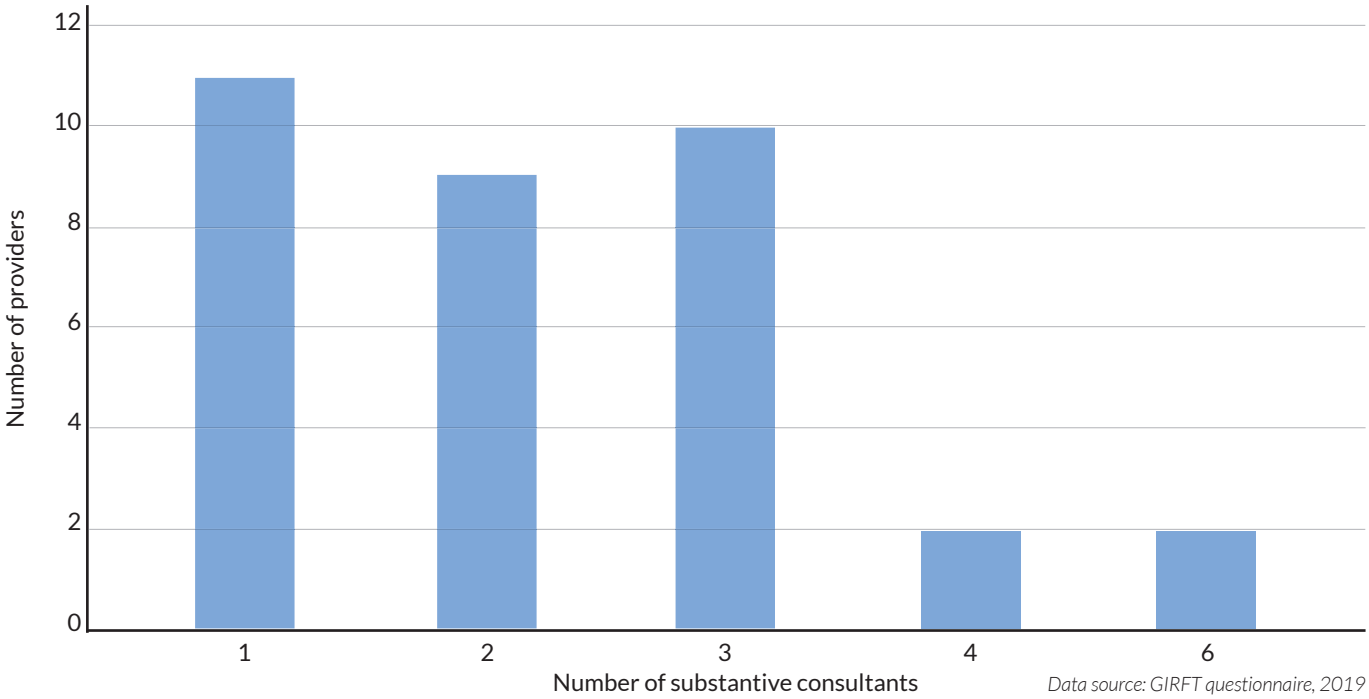
The BSDS told us that there is now fellowship training in Mohs for around ten surgeons per year. They advised us that this means there should be around 50 extra Mohs surgeons in the next five years, which is far greater than projected retirements.

Figure 17: Mohs activity per 100,000 population by CCG



Data source: HES, April 2018 to March 2019

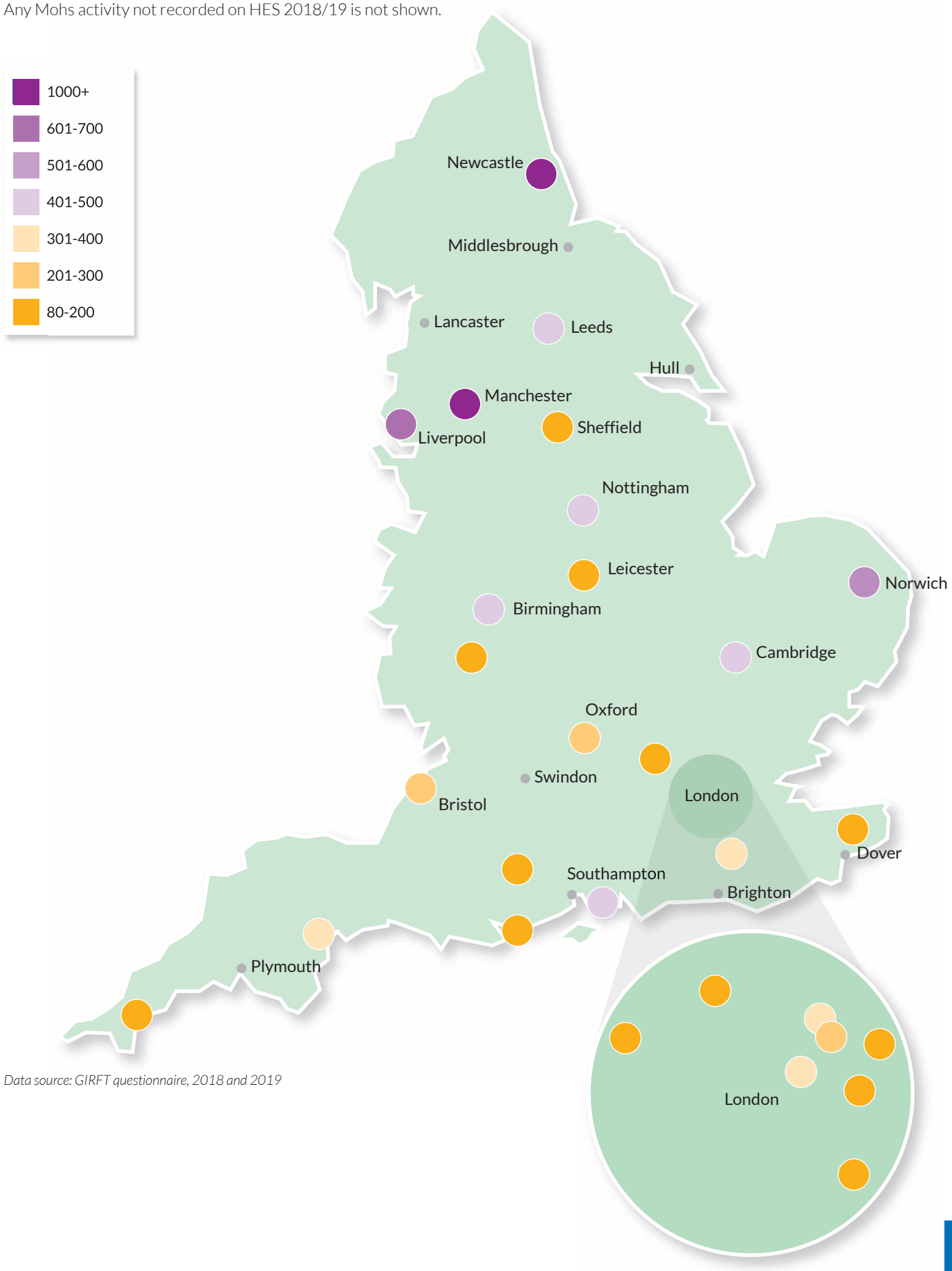
Figure 18: Number of trusts with consultants carrying out Mohs surgery



Data source: GIRFT questionnaire, 2019

Figure 19: Heatmap showing the location of the Mohs surgery departments with HES recorded activity in 2018/19 of at least 80 procedures per year

Any Mohs activity not recorded on HES 2018/19 is not shown.



Data source: GIRFT questionnaire, 2018 and 2019

Establishing an appropriate level of Mohs surgery

When we asked dermatologists, they found it difficult to advocate anything other than Mohs as the best treatment for certain complex skin cancers.

We estimate that increased demand for Mohs, coupled with continued increases in rates of skin cancer, will triple the requirement for Mohs over the next ten years. The increased numbers of Mohs surgeons being trained will help to deal with this projected demand.

It has been suggested to us that capacity in Mohs could be increased by utilising the skills of registered nurses or physician associates trained to support elements of Mohs surgery, working under the close guidance and supervision of fully trained Mohs surgeons. However, the BSDS has advised us that they consider that this will not be necessary in view of the increased training of dermatologists through Mohs fellowships. They also expressed some concerns to us this could lower standards.

Assessing the financial impact of improved access to Mohs

We are recommending improving equitable access to high-quality Mohs surgery. As this may incur costs in the short-term, with potential longer-term savings, we are also suggesting that a financial impact assessment is produced locally.

Other work on access to Mohs surgery

GIRFT is currently considering a skin cancer workstream. One of the themes that workstream would be likely to review is ways to improve access to high-quality Mohs surgery that meets national standard. Stakeholders would be invited to collaborate.

We understand that the dermatology specialised CRG is also looking at the issue.

CASE STUDY

Purpose-built Mohs unit

Salford Royal NHS Foundation Trust

Salford's purpose-built Mohs Micrographic Surgery Unit sees around 1,200 patients per year, making it one of the busiest such units in the UK.

Established in 1994, the unit was redeveloped and expanded in 2013/14. This resulted in a marked increase in the unit's capacity and means a much greater number of patients across Greater Manchester can now access the benefits of Mohs surgery.

The unit's expansion saw the number of Mohs surgeons increased from two to four, and the number of dedicated Mohs nurses from two to six. It now has six procedure rooms, each with electronically controlled operating chairs that can be precisely positioned to provide excellent access to the head and neck.

Lab facilities were also greatly expanded. A pool of four dedicated Mohs biomedical scientists now rotate between the unit and the main pathology lab, providing high-quality pathology slides. This enables the unit to meet the national Mohs standards for histopathology.

There is also a large waiting room to accommodate patients' relatives, and free patient tea and coffee facilities.

While any specialty can refer appropriate skin cancer patients to the Unit, around 75% come from dermatologists. A further 20% of cases are referred by oculoplastic/ophthalmology clinicians. These cases are generally complex, requiring specialised reconstruction, meaning the Mohs surgery cure rate is particularly valuable. The remainder of cases tend to be from ENT, plastic surgery and maxillofacial. Most reconstructions are done by the Mohs surgeons, with approximately 20% of cases jointly managed with the referring specialties.

Recommendations

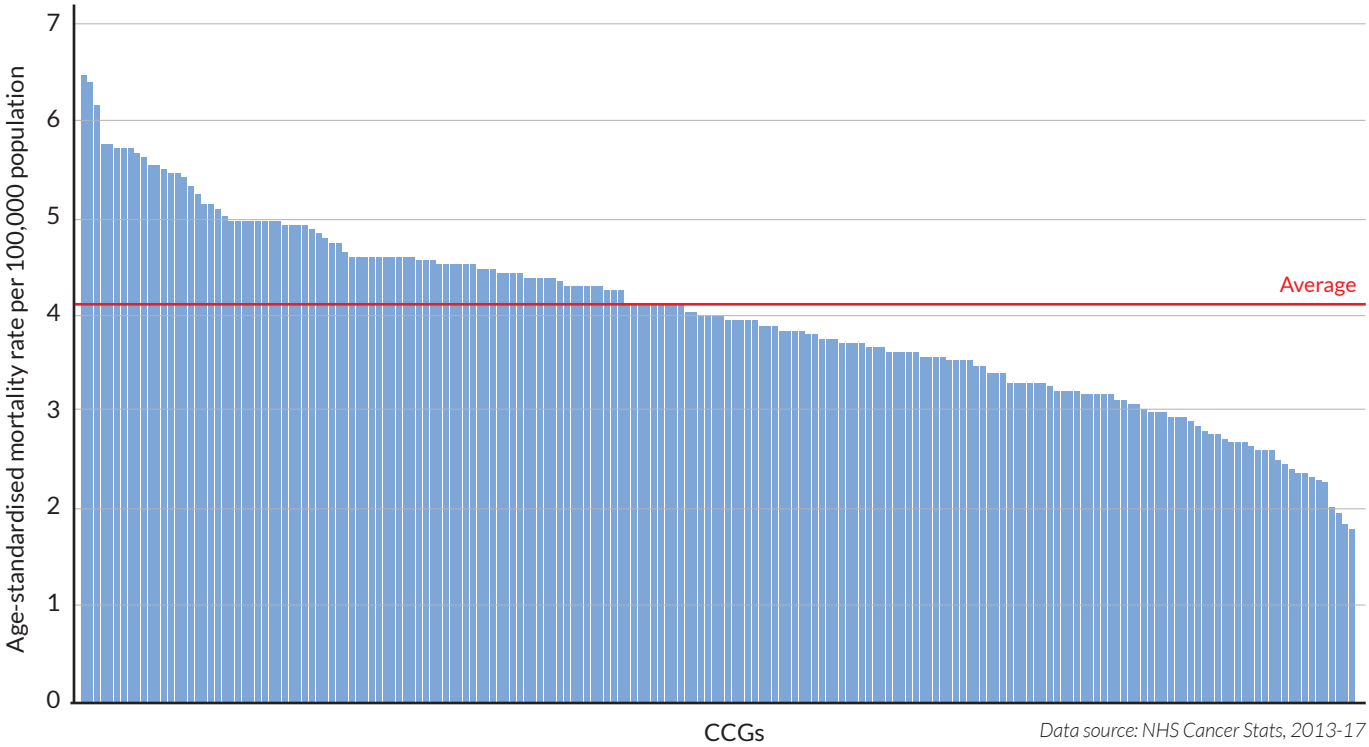
Recommendation	Actions	Owners	Timescale
7. Improve equitable access to high-quality Mohs surgery that meets national standards for patients with complex skin cancers.	**a** Continue to review how access to high-quality Mohs surgery that meets national standards can be improved in remote areas.	NHSE England (CRG); BAD; BSDS	12 months
	b Commission health economic research to provide evidence to establish a standard rate/population, which will depend on demographics, for Mohs surgery to enable effective planning and equal access to this service.	NIHR	2 years

Skin melanoma mortality rates

There is variation in rates of skin melanoma mortality between CCGs, as shown in **Figure 20**.

We are currently working with units that cover CCGs with substantially different rates of skin melanoma mortality to identify reasons for the variation. Early indications are that most of the variation is due to ethnicity as melanoma is much more common in people with northern European ancestry. We are exploring whether some of the variation is due to early or late presentation, which may relate to access to healthcare.

Figure 20: Age-standardised mortality for malignant melanoma by CCG



Data source: NHS Cancer Stats, 2013-17

Skin biopsy rates

Dermatologists take small 3-5 mm biopsies of skin when they want to get further information. This is done if the diagnosis of a rash or a possible skin cancer is not clear to the clinician, or if a lesion is particularly large and in an area that is problematic for scars.

However, dermatologists are able to identify most skin cancers from their appearance and will usually opt to cut out (excise), the cancerous area without the need for an initial biopsy. This saves patients the discomfort and inconvenience of unnecessary surgery, shortens the time to curative surgery which improves outcomes, shortens waiting lists, and saves dermatology and histopathology resources.

Results of doing unnecessary biopsies

Some biopsies are essential, but if an inexperienced doctor is not confident about diagnoses they will do more biopsies, creating a longer waiting list for this investigation. A patient with a suspected skin cancer on the face may find themselves having to wait four months for a biopsy, a month for a histopathology result and then a further four months for excision. Over those nine months, the cancer may have doubled in size,[25] meaning the patient now needs surgery that will leave a facial scar twice as long. If the trust has long waits for histopathology, the delay could be even longer.

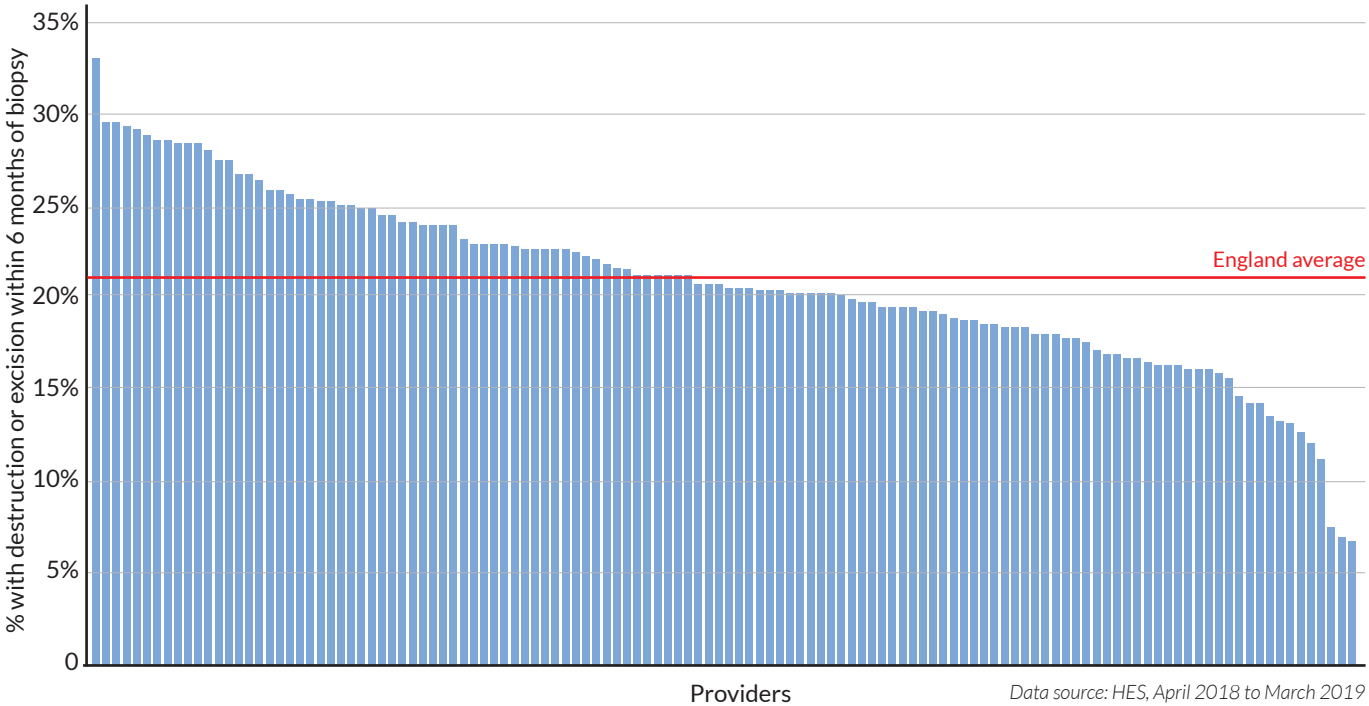
Current variation

There is wide variation in biopsy rates and also biopsy rates prior to areas of skin being cut out between trusts. Some skin cancers require biopsies before being cut out, for example those which require Mohs surgery or those with atypical appearances, but most do not need two procedures. Figure 21 shows the variation in the proportion of people who go on to have an area cut out after a biopsy. Figure 22 shows how the proportion of all patients seen in the department who have a biopsy varies greatly between trusts.

Some units with high rates of biopsies explained this was because they were unable to employ experienced consultants due to the workforce shortage. They had noticed certain inexperienced or unqualified locum doctors carried out relatively high levels of biopsies to reduce their risk of litigation from wrong diagnoses, or because they had little idea what was wrong with the patient. This delayed diagnoses, wasted resources and led to unsatisfactory patient experiences.

The current levels of variation in biopsy rates and biopsy prior to excision offer further safety, quality, and economic evidence that current workforce shortages must be addressed.

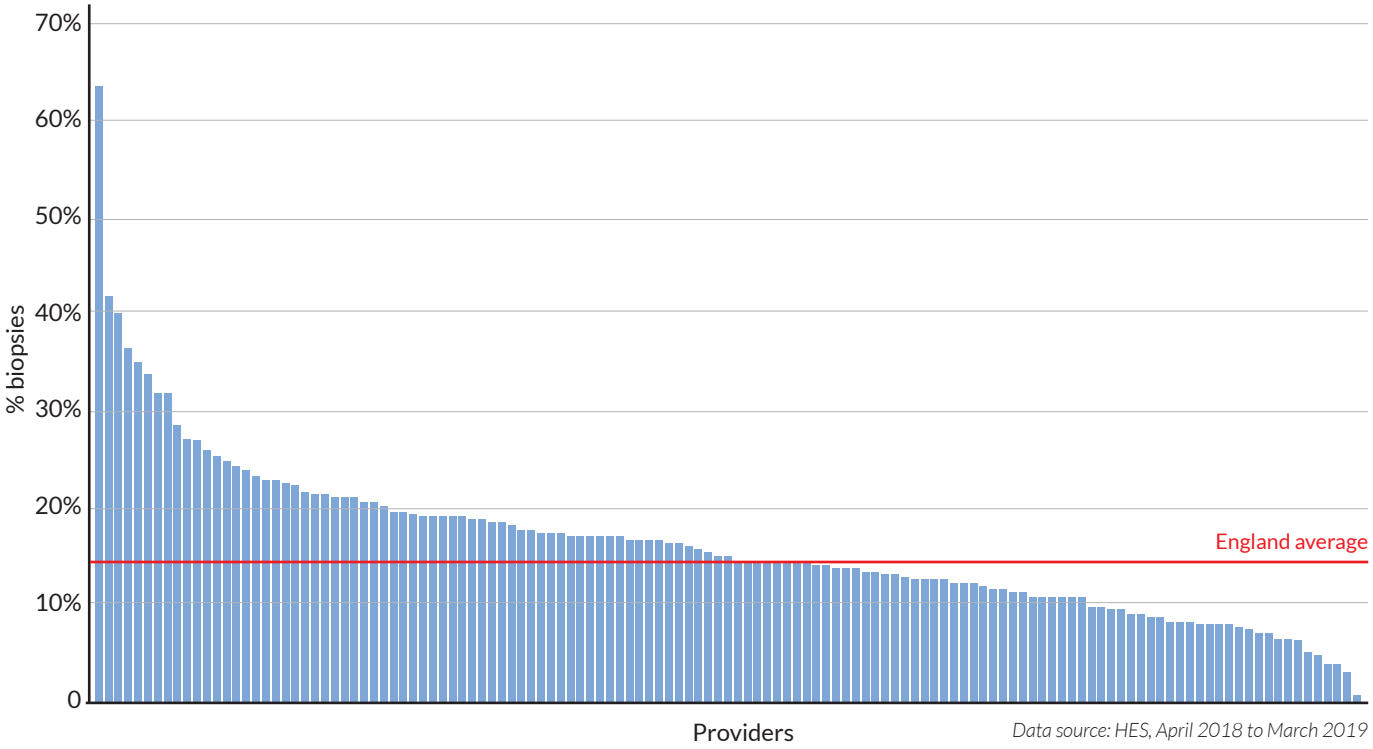
Figure 21: Percentage of patients having a destruction or excision within 6 months of biopsy, by provider



Data source: HES, April 2018 to March 2019

[25] *Khoo ABS, Goon PKY, Sudhoff H, Goon PKC (2019) Comparative Analyses of Tumour Volume Doubling Times for Periocular and Non-periocular Head and Neck Basal Cell Carcinomas. Acta Derm Venereol. www.medicaljournals.se/acta/content_files/files/pdf/99/13/5591.pdf.*

Figure 22: Percentage of outpatient appointment, outpatient procedures and day case activity that have a biopsy, by provider



Data source: HES, April 2018 to March 2019

Clinical nurse specialist contact for people diagnosed with melanoma skin cancer

Clinical nurse specialists (CNS) are registered nurses educated and trained to do advanced practice in a particular specialist area. In the case of cancer, they are commonly known as cancer nurses or cancer nurse specialists.

CNSs can provide expert psychological support at times of great distress, such as the diagnosis of a potentially fatal disease.

Current variation

There is variation between trusts in the reported rates of patients with melanoma who see a clinical nurse specialist (CNS).

We identified that most of this variation is down to reporting errors, but there are shortages of CNSs in some hospitals.

Departments were advised to report this accurately, so that those trusts with genuine problems can be identified in future.

Infection rates

Although dermatology carries out over 200,000 surgical operations for suspected skin cancer each year, the NHS does not have a system for identifying variation in infection rates for this surgery.

This is because current systems focus on infection rates following surgery in operating theatres, whereas most dermatology day-surgery takes place in procedure rooms. Procedure rooms are the appropriate and cost-effective settings for most dermatology surgery.

Local audit evidence suggests that serious infection is rare after dermatology surgery. Occasional local wound infections require courses of antibiotics from GPs.

Medical photography

Key uses of medical photography in dermatology include:

- to aid safe identification of lesions to prevent never events;
- in teledermatology;
- in multidisciplinary team meetings (MDTs).

Safe identification of lesions

Medical photography is essential for identifying lesions for removal if there is a possibility that a surgeon may not otherwise be able to correctly identify the lesion for removal.

For example, if a patient has 20 irregular moles on their back and a consultant in clinic considers that one particular mole should be removed to exclude melanoma skin cancer, the suspicious lesion is marked with an arrow by the clinician and then photographed, ideally by a trained medical photographer. The photograph is stored on a confidential hospital medical illustration system for reference at the time of surgery.

Failure to identify the area or lesion identified as abnormal at a previous appointment is a known cause of wrong site cancer surgery, the commonest cause of dermatology never events.

Medical photography is not necessary for all surgery, such as when there is no chance of a lesion being identified incorrectly.

Teledermatology

Medical photography is often used in internal teledermatology (see page 102) so that clinicians can quickly provide opinions on ward referrals.

This is particularly efficient for hospitals when dermatology clinicians are based at other sites and an opinion is needed quickly before discharging an inpatient.

Some hospitals use a trained nurse to give opinions and take images using a tablet device for consultant opinions.

CASE STUDY

Providing same-day opinions using high-quality images

Lancashire Teaching Hospitals NHS Foundation Trust

Dr Chris Dobson is a consultant dermatologist based at Chorley and South Ribble Hospital. He provides same-day opinions to staff at Royal Preston Hospital using the high-quality images taken by a medical photographer at the Preston site.

The images, along with information from clinicians at Preston, enable Dr Dobson to advise on the management of patients and identify those that require a face-to-face consultation. Those patients are then put on the most appropriate pathway, having been effectively triaged through the review of high-quality images.

This approach facilitates faster turnover and discharge of inpatients. It also enables the trust to share expertise, while saving consultant time and costs in travelling between the two hospitals.

CASE STUDY

Using a teledermatology service to facilitate a successful off-site dermatology department

Luton and Dunstable University Hospital, NHS Foundation Trust (Now Bedfordshire Hospitals NHS Foundation Trust)

Luton has used teledermatology to help establish their community dermatology service based in Luton town centre, several miles from the main hospital site.

Digital platform

A digital platform facilitates innovative workflow patterns, including inpatient and outpatient teledermatology, skin procedure, admission and ward round planning, handover, and education of users and referrers (GPs) via digitised feedback. The system runs on readily available hardware, such as tablet devices with dermoscopic attachments, making initial outlays low. The platform adheres to UK teledermatology standards published by the BAD and with all GDPR requirements.

Dermatology nurse specialists

The service employs three dermatology nurse specialists, Jennylyn Ros, Charu Chauhan and Dale Montesclaros. The experienced dermatology nurses travel to the main site daily to improve patient management and provide support, such as guidance on applying creams and dressings. They can enter clinical information and take photographs using a tablet device – a form of internal teledermatology. Dermatologists in the dermatology unit review the information and images, to provide advice. This guidance helps early discharge of patients.

Consultant dermatologists only need to travel to the hospital to see more complex cases; typically once a week. This maximises their clinic time.

Key benefits

The benefits include:

- an improved and increased service that went from a locum running three out of six two-week wait clinics (all face-to-face) to substantive dermatology consultants running three face-to-face clinics and five via teledermatology;
- improved outcomes, including no skin cancer breaches and reassurance and discharge back to GP for patients with benign lesions;
- cost savings, including no longer needing to employ a locum doctor;
- new purpose-designed environment that is better for patients to attend and for staff to work in, helping with staff recruitment and retention.

Multidisciplinary team meetings (MDTs)

Medical photography enables cancer MDT meetings to discuss patients (see page 77) without the patient having to be present. Mohs guidance (see page 66) recommends that photographs of lesions should be recorded for each patient, partially to facilitate MDT discussion.

Typical MDTs may make treatment recommendations on over 50 patients in 90 minutes, this would be impossible if patients had to be present in person.

Current variation in access to medical photography

We found that not all units had access to a medical photography service.

We support the use of medical photography, alongside the use of the World Health Organisation (WHO) Surgical Safety Checklist, to improve patient safety and reduce unnecessary harm.

We encourage providers to produce their own financial impact assessment when considering medical photography.

Recommendations

Recommendation	Actions	Owners	Timescale
8. Reduce the likelihood of wrong-site skin cancer surgical never events.	**a** Consider establishing or improving access to efficient and secure technology as provided by medical illustration services to record the position of lesions booked for surgery.	Trusts	12 months
	b Develop a standard operating procedure, incorporating the WHO checklist, to reduce the risk of wrong site surgery. Audit against this for compliance.	Trusts	For immediate action

Benign and cosmetic conditions management

It can sometimes be necessary to remove benign lesions with borderline appearance in order to be sure of not missing skin cancer or other serious conditions. As skin cancer rates increase, it is inevitable that more benign lesions will be removed. Other benign conditions should be treated or removed by the NHS only if they are causing severe symptoms, such as regular bleeding or repeated infections requiring antibiotics, or resulting in severe disfigurement or bullying in children. Some benign lesions are removed because they have a risk of developing into cancer or to establish a diagnosis of syndromes with skin manifestations. Some benign lesions, such as infantile haemangiomas, are treated early as they have a significant risk of developing serious or life-threatening complications.

This is a complex and grey area that can cause problems for clinicians because some people believe they are entitled to NHS treatment of benign lesions and other conditions of a cosmetic nature. These patients may threaten clinical staff with complaints or litigation if the clinicians do not provide treatment. The patients know that complaints have consequences for clinical staff, who may then comply in an attempt to avoid the administrative work and reputational damage generated by complaints.

A number of procedures and the treatment of conditions of a benign or cosmetic nature are subject to specific commissioning guidance and policies at either a national or local level. Where national guidance exists, such as that developed by NHS England's Evidence-Based Interventions Programme, it should be followed.

As almost everyone has some aspect of their appearance they are not happy with, rules are required to set the boundaries for who is eligible for treatment on the NHS. These rules are called Clinical Threshold Policies (CTPs), see Appendix 2: Example of a clinical threshold policy.

CTPs work best when they are drawn up by CCGs in collaboration with local GPs and specialists as this maximises local engagement. However, CTPs should also take account of national guidance to minimise local variation in access to treatment.

We found almost a quarter (24%) of dermatology departments did not feel there were effective local protocols to prevent NHS referral of cosmetic disorders. The resulting treatment of cosmetic conditions on the NHS in some areas adds to waiting lists for those waiting with serious disorders and worsens staffing shortages. Reducing rates of NHS surgery of a more cosmetic nature is an opportunity for increased NHS efficiency. The GIRFT dermatology programme has been working with NHS England and NHS Improvement in this area.

Recommendation

Recommendation	Actions	Owners	Timescale
9. Develop Clinical Threshold Policies for benign and cosmetic conditions management.	**a** CCGs should work with local GPs and consultants to develop and implement Clinical Threshold Policies, learning from existing best practice and in line with the Evidence-Based Intervention Programme.	CCGs; trusts; NHS England's Evidence-Based Intervention programme	12 months

Skin cancer MDTs

Certain cases of skin cancer are reviewed in a multidisciplinary team meeting held each week. MDTs work best when those who diagnose and treat cancers are all able to participate, but this can be difficult given travel and time pressures.

The most effective MDTs use technology, such as video conferencing, to enable teams to meet virtually. This gives patients on remote sites full access to the best expert cancer advice.

CASE STUDY

Use of video technology in a skin cancer MDT

Norfolk and Norwich University Hospitals NHS Foundation Trust

Norfolk and Norwich's skin cancer MDT, led by oncologist Dr Jenny Nobes, uses video technology to enable team members based in several different locations to join.

The MDT meets for an hour and a half at 8am every Monday, and can discuss anywhere up to 60 cases in this time.

The meeting is hosted in Norwich, with staff based up to 90 minutes drive away in Great Yarmouth, Kings Lynn, Cambridge and Ipswich joining via video conference (see page 102) at set points. Colleagues based on-site in Norwich also frequently opt to attend via video link.

Patients are assessed using medical photography (see page 74) images from the medical photography department. The team review pathology slides read by histopathologists based in Norwich and Cambridge, who also join the meeting.

Histopathology

Dermatology services rely on histopathology for important tissue diagnoses that are needed to help manage patient care.

Increasing workload

Rapidly increasing rates of skin cancer are adding greatly to the histopathology workload. In some histopathology departments, almost half of the cancer workload relates to skin cancers. Even though melanoma deaths may not be increasing greatly[26] overall rates of melanoma are increasing. Therefore, clinicians usually opt to remove borderline lesions to reduce the risk of missing a skin cancer. This is understandable when early diagnosis of a melanoma means being able to treat the patient, whereas missing it could result in their death. Consequently, patients, GPs and specialists should err on the side of caution, which increases referrals to hospital and the removal suspicious lesions for histopathology examination. This leads to substantial increases in histopathology workload.

Many trusts told us that this increasing workload comes at a time when they were finding it increasingly difficult to recruit histopathology consultants.

There is variation in access to and use of histopathologists trained in skin cancer:

- 75% of trusts said skin cancer trained histopathologists report on skin cancers;
- 11% of trusts said skin cancers were reported by histopathologists not trained in skin cancer;
- 14% of trusts were unsure.

Variation in speed of histopathology reporting

There is wide variation between trusts in the speed of histopathology reporting. Average waits were 3.7 weeks for a result, but units said that they could typically wait up to 14 weeks, as shown in Table 3. Some departments wait up to 28 weeks for a routine report, while others reported their longest wait as just one week, as shown in Table 4.

Many trusts told us they have dermatology and pathology workforce shortages. These shortages should be addressed in order to minimise delays in histopathology reporting.

[26] *Herbert A, Koo MM, Barclay ME, et al. (2018) Stage-specific incidence trends of melanoma in an English region, 1996-2015: longitudinal analyses of population-based data. Melanoma Res. https://journals.lww.com/melanomaresearch/Abstract/publishahead/Stage_specific_incidence_trends_of_melanoma_in_an.99263.aspx.*

We understand that an NHS England and NHS Improvement diagnostics team will be addressing the time taken to issue histopathology reports. The team intends to identify and share good practice with a view to streamlining histopathology pathways.

Table 3: Histopathology: average waiting times

Histopathology waiting times	Source and year	Mean	Median	England range	Responses
How many weeks on average do you currently wait for routine histopathology from your department?	GIRFT questionnaires 2018	3.5	3.0	0 to 14	117 repsonses
	GIRFT questionnaires 2019	3.7	3.0	0 to 14	123 repsonses
	Change in % response between 2018-20: (17.1%)	0.2	0.0	-	21 responses updated

Data source: GIRFT questionnaire, 2019.

Table 4: Histopathology: longest waits

Histopathology waiting times	Source and year	Mean	Median	England range	Responses
How many weeks are the longest waits for routine histopathology from your department (not counting samples sent for tertiary opinions)	GIRFT questionnaires 2018	5.7	4.0	1 to 28	117 repsonses
	GIRFT questionnaires 2019	5.8	4.0	1 to 28	123 repsonses
	Change in % response between 2018-19: (18.7%)	0.2	0.0	-	23 responses updated

Data source: GIRFT questionnaire, 2019.

Dermatopathology

Some dermatologists specialise in histopathology, reading their own slides and those of colleagues. This group, together with histopathologists who specialise in the skin, belong to the British Society for Dermatopathology (BSD). The society promotes the knowledge and teaching of dermatopathology and organises educational events.

AI in histopathology and skin cancer diagnosis

A number of applications of AI (artificial intelligence) (see page 107) are being developed in histopathology, including using AI to look at margins and count stained cells. Applications such as these offer the potential to improve and speed up histopathology reporting in dermatology. It seems likely that AI will play an increasing role in the future of histopathology.

AI applications are also being developed to help with diagnosis of melanoma from digital images.[27] If used unwisely, such applications could result in increases in histopathology workload with little benefit. The challenge will be to utilise new technologies in a way that enhances expert decision-making to ensure the right lesions are removed.

[27] *Esteva, A., Kupel, B. et al. (2017) Dermatologist-level Classification of Skin Cancer With Deep Neural Networks Nature (2017). Feb 2;542(7639):115-118 https://pubmed.ncbi.nlm.nih.gov/28117445/*

CASE STUDY

Dermatologists providing histopathology reports to local departments

Dorset County Hospital NHS Foundation Trust

Dr Saleem Taibjee is one of a small number of dermatologists to have passed the Diploma in Dermatopathology, and is one of a handful of UK dermatologists to regularly report dermatopathology cases as part of their routine clinical work.

With this expertise, Dorset is able to provide dedicated services on site to examine and assess patient samples. Dr Taibjee also supports the Dorset Specialist Skin Cancer Multidisciplinary Team, and provides second opinions on difficult cases. These cases are referred by local histopathologists and dermatologists, with samples sent using existing trust pathology courier services. Dermatologists with both clinical and histopathology expertise are able to provide clinically relevant reports on complex cases, including inflammatory conditions.

Results are reported internally through the existing pathology systems, integrated with the trust electronic health records. Results for external trusts are sent securely by NHS email.

Many of the consultants that receive reports commented on the excellence, accuracy, and helpful diagnoses provided by this service.

Recommendations

Recommendation	Actions	Owners	Timescale
10. Improve access to dermatopathology.	**a** Develop dermatopathology training (requires implementation of other recommendations to address workforce shortfalls).	HEE; RCPath; BAD	For substantial progress within two years of report publication
	b Promote the development of AI and digitisation of slides to support the work of clinicians in dermatology histopathology reporting.	NHSX	12 months

Allergy patch testing

Allergic eczema often gets worse if not diagnosed, leading to lifelong prescriptions and visits to healthcare professionals. Treatment may involve continued blood test monitoring and the use of systemic drugs, which may have serious side-effects.

Identifying an allergy with an allergy patch test can prevent all of this. It may be that a patient can cure their eczema with something as simple as changing their shampoo or their sofa. This also makes patch testing cost-effective.

Patch testing is most commonly used to identify possible causes of localised, disabling allergic eczema; usually on the hands, feet, face, genitals or across multiple sites.

Patch testing standards

Patch testing requires a patient to attend three times in a week; usually on a Monday, Wednesday and Friday. At their final visit, patients are given details of the patch test results along with a plan to manage any allergies identified.

There are NICE-accredited service standards for patch testing to ensure that patients get tested for the right items, that the results of the tests are accurate, and that patients get the correct advice.

Variation in current access

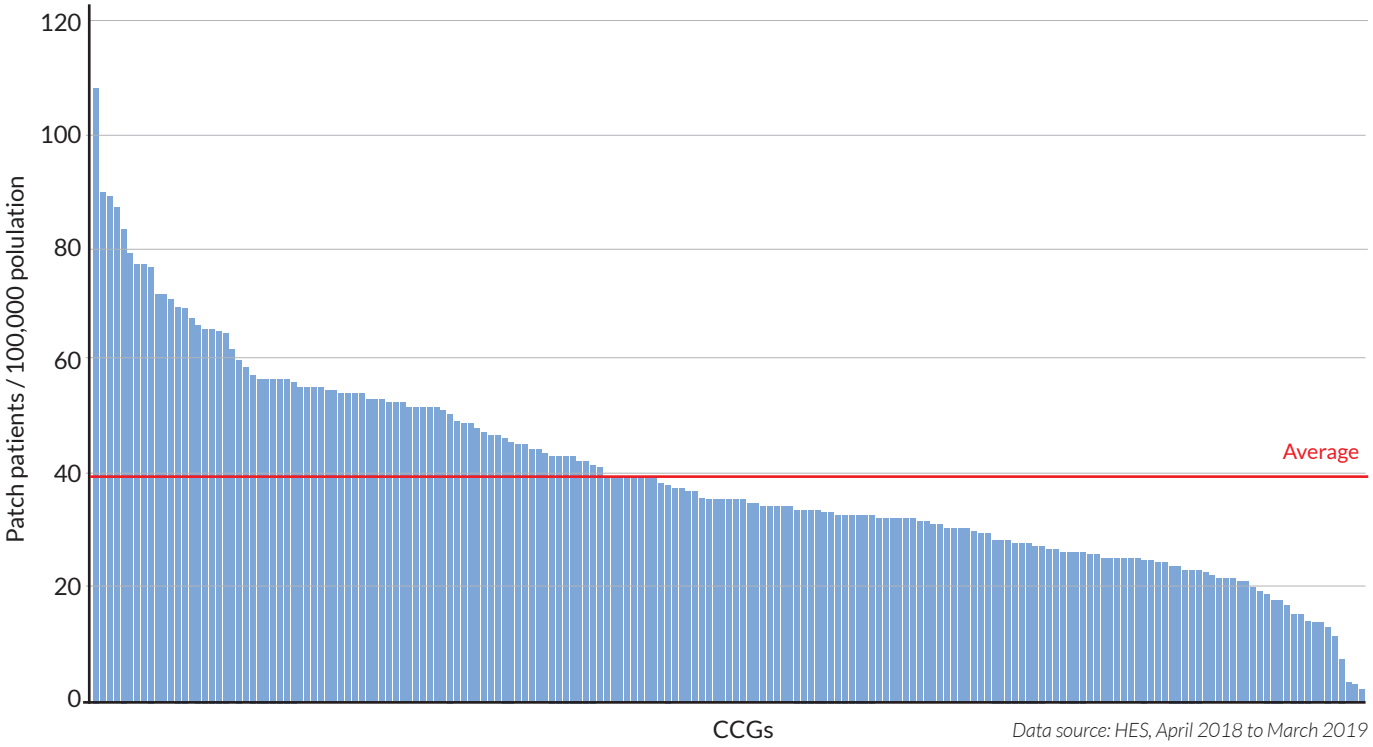
We found 95 consultants in 68 trusts run patch testing clinics. Patch testing rates vary significantly by CCG, as shown in

Figure 23. Some of this variation is due to lower uptake of patch testing where people face having to make a long journey three times in one week in order to have their test.

Some trusts provide no patch testing due to workforce shortages. Other areas run centralised patch testing at a tertiary centre. This has the advantage of a higher quality of care for those who attend, but the disadvantage of decreased access for those who must travel greater distances. These factors need to be balanced to provide high-quality care, accessible to all.

We have made a recommendation to improve access to and quality of allergy patch testing services. This includes introducing high-quality clinics in areas where provision is currently low. Doing this may incur short term costs, but deliver longer term savings by providing the right diagnosis first time and reduce ineffective follow-up appointments and prescribing. Therefore, we urge trusts to develop a financial impact assessment on establishing clinics in their region.

Figure 23: Variation in patch testing for cutaneous allergy by CCG



Data source: HES, April 2018 to March 2019

Service standards and specialist nurses

The NICE-accredited service standards for allergy patch testing describe how appropriately trained nurses can "undertake the prescription, reading and interpretation of the patch tests and subsequently give advice". These nurses work alongside and under the supervision of a consultant.

Developing specialist nurses in this role helps to improve access to patch testing and releases consultant time for other activity.

Absence of patch test database

Until 2012, the UK had a national patch test database. This was developed and maintained for the British Society for Cutaneous Allergy (BSCA) by the late dermatologist Dr Barry Statham. However, following Dr Statham's death, the database is no longer maintained.

A new national database would allow collection and comparison of data to improve quality of care. Funding from the BAD has been in place since 2017 and NHS Digital and the BSCA are now working together on an initiative to set up a new database.

Coding issues with patch testing

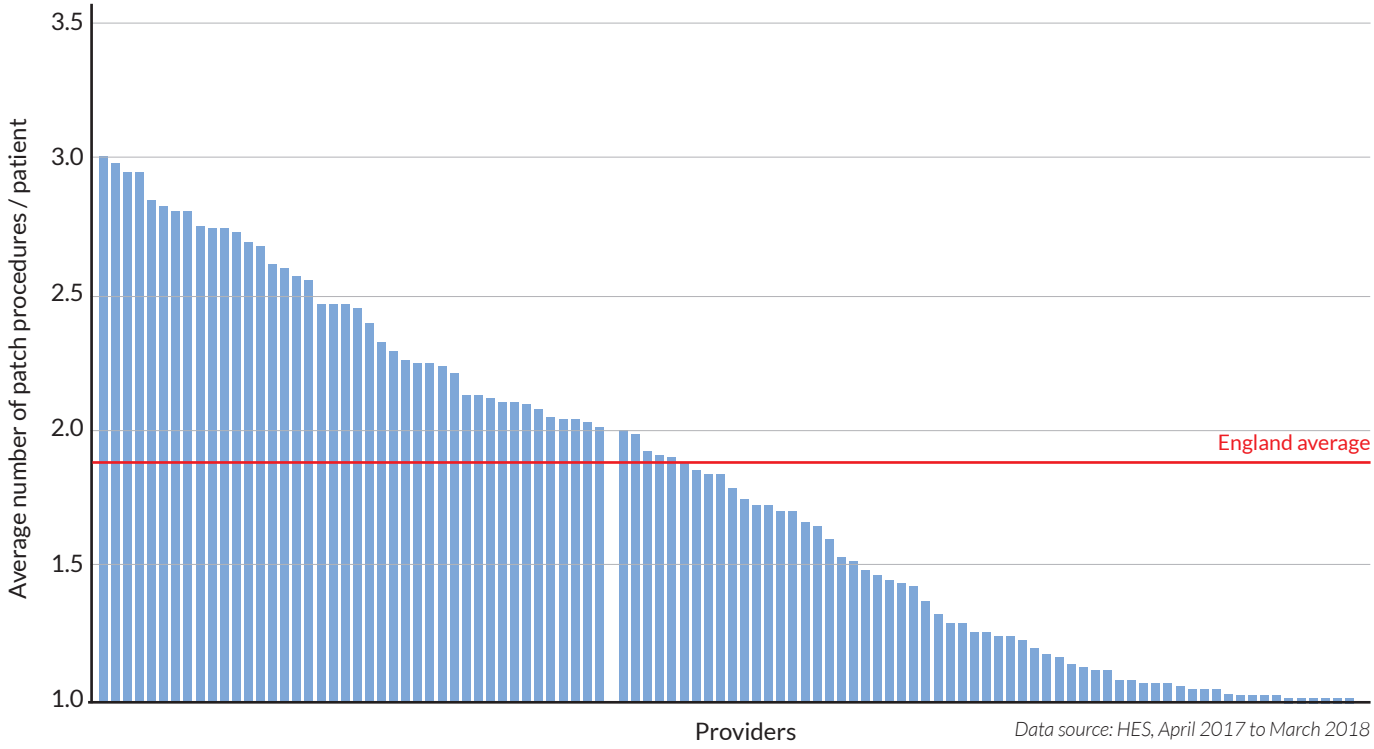
The tariff for patch testing is based on it being charged for all three visits relating to the patch test. This tariff is greater than that for a follow-up appointment.

As Figure 24 shows, there is variation in the way that trusts are coding patch testing:

- some trusts code all three visits as a patch test;
- some trusts only code the first test as a patch test, and code the two subsequent appointments as follow-ups rather than patch tests;
- other trusts code some patients once and some three times.

This means that most trusts are charging a tariff that is artificially low and are under-recording attendances for this investigation on HES.

Figure 24: Average number of patch procedures per patch test patient, by provider



Data source: HES, April 2017 to March 2018

Recommendations

Recommendation	Actions	Owners	Timescale
11. Improve access to, and quality of, allergy patch testing services.	**a** Make access to patch testing more widespread by introducing high-quality clinics which meet service standards in areas where provision is low.	Trusts	12 months
	b Develop a national patch testing database to ensure standardisation of testing and facilitate national outcome measures.	BAD; BSCA	For substantial progress within two years of report publication
	c Consistently code patch testing. GIRFT considers that all three visits should be coded as a patch test.[28]	Trusts	6 months
	d Produce a local financial impact assessment of improving access to provide equity of care.	Trusts	12 months

Emergency dermatology care

Emergency skin problems are relatively common, requiring assessment within 24-48 hours after seeing a GP or A&E doctor, or after developing on a hospital ward. Many can be dealt with by telephone advice from the dermatology team, including specialist nurses.

Out-of-hours services

There are a few, rare, life-threatening skin conditions that require out-of-hours on-call emergency cover. These include rare skin diseases in neonates and severe reactions to medication, for example toxic epidermal necrolysis.

When out-of-hours services are available, there is a tendency for doctors working overnight to use them as a general advice service. This is because it is easier to call the out-of-hours service than to ask a colleague to call for advice during office hours. This adds to the workload of the out-of-hours service, impacting the ability of the department to deliver routine clinic services.

Out-of-hours services are expensive to staff. Further research is needed to identify the actual requirement for out-of-hours services.

Emergency cases in the community

Most patients in the community who have an emergency dermatology problem go to see their GP. The GP may try to call their local dermatology service for advice if needed. These calls usually occur during GP surgery hours.

Only 53% of dermatology units provide a phone advice service to GPs, and most of these services are office hours only. This is a result of consultant workforce shortages in many small dermatology services where doctors are all doing clinics and operating, so cannot take telephone calls. Larger units have trainee doctors who are able to provide an advice rota during the day and sometimes out-of-hours.

In practice, many GPs get to know the dermatology consultants in their local district hospital and use those informal networks to get advice and guidance.

Emergency cases in hospital

Around 500 inpatients per year in an average-sized hospital will be referred for emergency dermatology advice or review. Many of these do not require face-to-face assessment. We found some hospitals triage these referrals with nurses or by using images and digital technology.

80% of trusts provide an emergency dermatology service. In general, trusts that do not provide an emergency service are those with the most severe staffing shortages; those with just one substantive consultant or none at all.

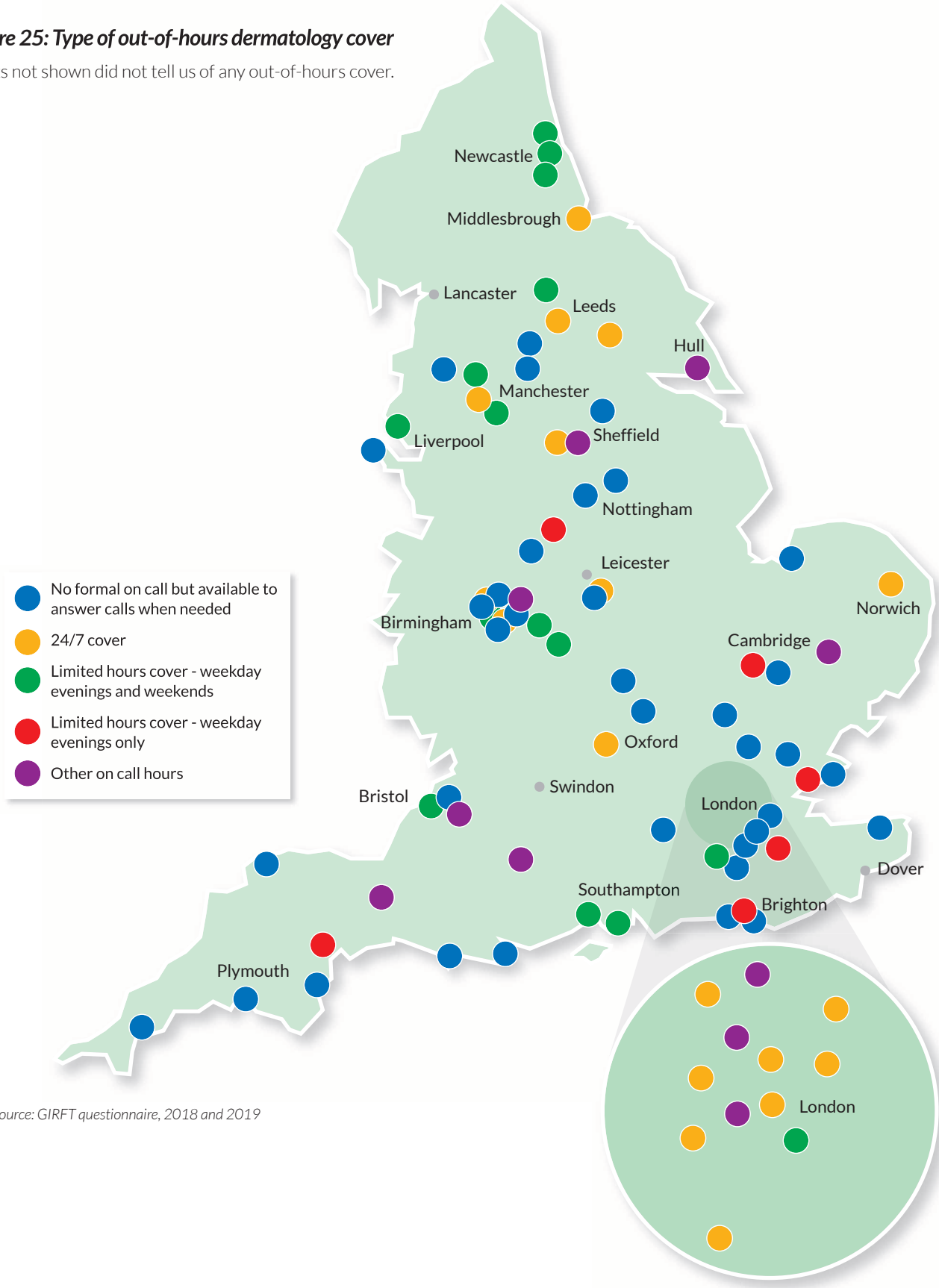
15% of trusts provide 24/7 on-call services. These are usually in large regional centres with sufficient trainees to staff a full rota. A further 17% provide limited out-of-hours, on call services, see Figure 25.

[28] *Trusts seeking to notify commissioners of changes in the way they record activity should note the information included in Appendix 4.*

There are relatively few out-of-hours dermatology emergencies that cannot safely wait 24-48 hours to be seen in clinic. However, depending on the results of research to determine demand, there is probably a need for at least one service in each region.

Figure 25: Type of out-of-hours dermatology cover

Trusts not shown did not tell us of any out-of-hours cover.



Data source: GIRFT questionnaire, 2018 and 2019

Cover type	Number of providers
24/7 cover	18
Limited hours cover – weekdays, evenings and weekends	15
Limited hours cover – weekday evenings only	6
No formal on-call cover, but available to answer calls when needed	37
Other on-call hours	10
Total number of unique providers	**86**

Data source: GIRFT questionnaire, 2018 and 2019

Consultant contracts and payment for out-of-hours work

Current consultant contract arrangements mean that little or no allowance is made for the fact that a doctor may have provided out-of-hours service ahead of their regular day doing outpatient clinics or surgery lists.

There is increasing evidence that people are not able to work to the best of their abilities when tired. This carries patient safety issues.

Recommendations

Recommendation	Actions	Owners	Timescale
12. Improve access to, and quality of, emergency dermatology care.	**a** Establish the workforce to supply office hours dermatology emergency care to support GPs and all acute hospitals with inpatients.	BAD; CCGs; trusts	12 months
	b Conduct research to establish the requirement for out-of-hours dermatology care for life threatening conditions.	CCGs; trusts; dermatology CRG	2 years
	c Reimburse doctors for working on call overnight and allow adequate rest time to avoid safety issues with next-day working after out-of-hours provision.	CCGs and trusts	For immediate action

Biological medicines (biologics) for psoriasis, eczema and other conditions

People with severe skin diseases used to have to spend weeks every year as hospital inpatients receiving their treatment. Once back at home, they had to use creams that were often messy or smelly. Even then, these treatments offered only partial control of diseases that sufferers would find distressing and embarrassing, and that would make living a normal life impossible. This would sometimes lead to mental health problems such as depression, and alcohol abuse.

Biologics, or biological medicines, are a relatively new type of medicine that have improved the lives of tens of thousands of people with severe inflammatory diseases. They are made from proteins and other substances produced by the body and are easily given by injection pen. For example, biologics offer almost complete control of severe psoriasis with a simple injection, usually less than once a fortnight and sometimes just four times a year. In the past, it was normal for hospitals to have wards full of people having dermatology treatments. Thanks to biologics, those numbers have greatly reduced over the last 15 years.

If evidence for biologic safety grows and costs reduce, it is likely that biologics will replace older systemic drugs for most people in the future.

The Dermatology Specialised Service Clinical Reference Group (CRG) advised us that it is currently reviewing biologic therapy with the aim of providing guidelines on use of biologics in specialised services.

Biologics prescribing

The cost of biologics is relatively high at anywhere between approximately £3,000 and £10,000 plus per patient, per year. While this equates to over £90m per year for psoriasis in England, the NICE guidance shows that biologics are cost-effective. They can reduce the need for many hundreds of dermatology inpatient beds and improve the quality of life and economic productivity of many thousands of people. There are now over ten NICE-approved biologics for psoriasis.

New biologics for severe eczema and hidradenitis are now approved by NICE and other skin disorders, such as alopecia areata and vitiligo, are in research. As eczema is a relatively common condition affecting up to 10% of adults and 20% of children, it is important that the NHS ensures that resources are given to those most in need.

Variation in uptake of biologics

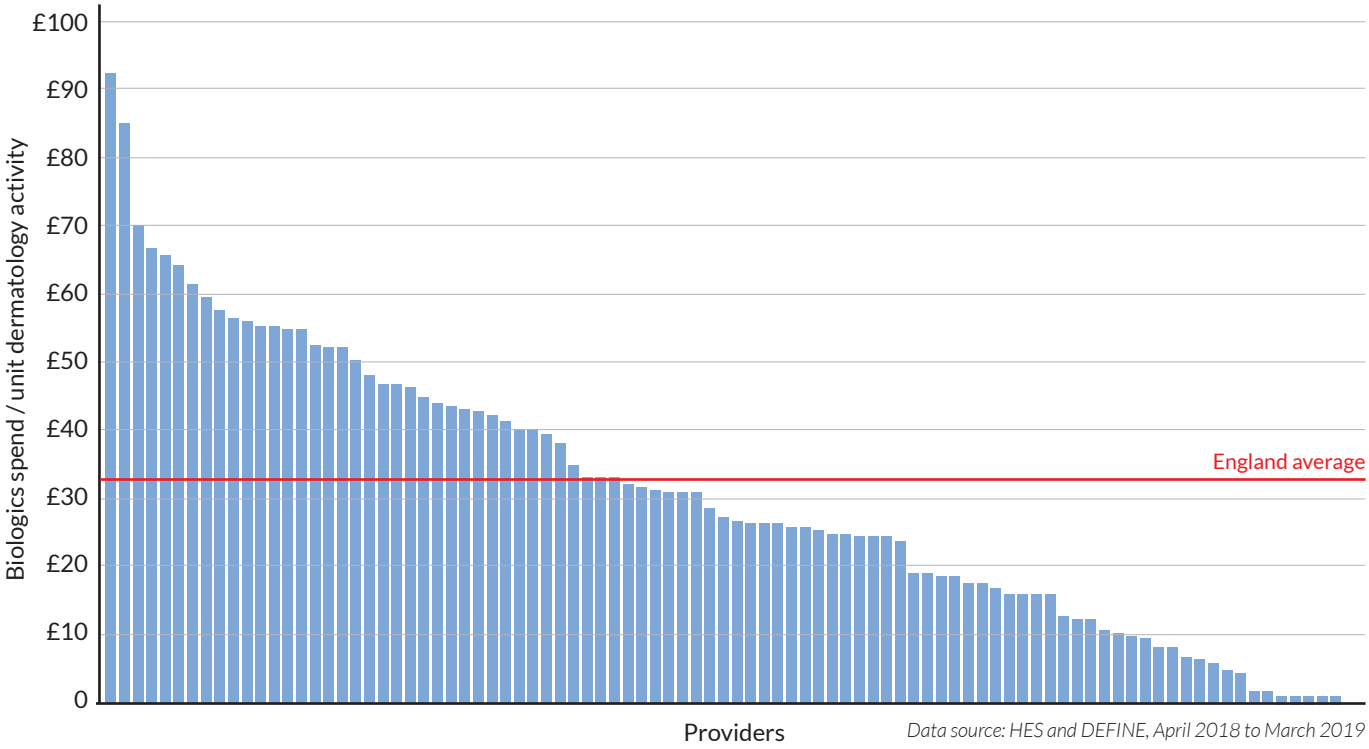
Despite NICE and BAD guidance, there is wide variation in the uptake of biologics for psoriasis between trusts, as shown in Figure 26. We collaborated with NICE to explore the underlying reasons for this variation by asking units about their use of biologics at our deep dive visits.

We found the following factors are affecting compliance with NICE and BAD psoriasis biological guidance:

- **Variation in how CCGs are interpreting NICE guidance**
  56% of trusts said that they have to wait for CCG approval before prescribing NICE-approved drugs.
  12% of trusts said CCGs had told them they could not prescribe certain NICE-approved biologics for psoriasis.
- **Variation in clinicians' readiness to use newer drugs**
  Some clinicians will consider a newer, more expensive drug that is proven to be more effective to be superior to an established drug with strong safety evidence. Other clinicians have different attitude towards risk, preferring the older, safer, cheaper, but less effective drug. This difference in attitude towards risk is influenced by personality and by previous experiences. A clinician who has seen a previous patient come to harm or die from a rare side effect may be more risk averse.
- **Influence of marketing by the pharmaceutical industry**
  During our deep dive visits, many clinicians told us that pharmaceutical company marketing and contact was a factor in their familiarity with different biologics. Pharmaceutical companies fund phase 4 studies, which support clinicians in learning how to use new biologic drugs.
- **Variation in patients' readiness to use newer drugs**
  Patients vary in their attitude towards risk: some are very cautious and insist on having the drug with the best safety record; others are very keen to have the latest product they have seen advertised.

  Some clinicians told us of patients who were interested in finding out about specific biologics having seen advertisements run by companies producing these products.
- **Wide range of choices creates confusion**
  There are now many similar products, so most clinicians stick with the few they are familiar with.
- **Administrative burden strengthens inertia**
  Clinicians may not see the need to spend hours on the paperwork required in some hospitals to add yet another option to a formulary that they perceive to have no advantages over existing products.
- **Anticipating future cost reductions**
  The costs of older biologics drop substantially when they are no longer covered by patent restrictions. When choosing between two apparently similar drugs, some clinicians prioritised those they believed were likely to reduce in cost sooner.
- **Variation in CCG understanding of special interest consultant roles**
  Some CCGs may restrict prescribing beyond a few choices as they are not aware that certain consultants with a specialist interest in psoriasis are eligible to advise on use of biologics.

Figure 26: Biologics spend per unit of dermatology activity, by provider (only those units who reported data on biologics use)



Data source: HES and DEFINE, April 2018 to March 2019

Biologics included: Adalimumab, Brodalumab, Etanercept, Infliximab, Ixekizumab, Secukinumab, Ustekinumab.
Unit of activity: All outpatient appointments, outpatient procedures and day cases (for providers reporting biologics spend).

Recommendations

Recommendation	Actions	Owners	Timescale
13. Consistently implement NICE guidance to address variation in uptake and use of biological medicines and ensure patients have equitable access to appropriate therapies.	**a** GIRFT to work with NICE to ensure guidance aimed at CCGs relating to use of biologics can be consistently applied.	GIRFT	12 months
	b Trusts to submit data on biologics use to Rx-Info Define© (the NHS drugs database) and any subsequent NHS drugs databases in order to enable regional benchmarking of biologics use and identification of unwarranted regional variation in prescribing.	Trusts	6 months
	c NIHR to fund research into the influence of pharmaceutical companies on prescribing behaviour in England for high-cost medicines such as biologics.	NIHR	2 years

Phototherapy

Phototherapy is the second of the following four broad stages in the treatment of the common conditions of psoriasis and eczema:

- creams;
- phototherapy;
- older systemic drugs;
- biologic therapies and new molecules.

It is a cost-effective treatment[29] that can clear psoriasis safely and effectively and is also used in the treatment of many other conditions. Phototherapy machines are used in hospitals and clinics and last for years.

Phototherapy works by exposing the skin to ultraviolet A (UVA) or ultraviolet B (UVB) light. UVA is used in combination with psoralen as an oral or topical medication (psoralen UVA – PUVA), most commonly on the hands and feet. A course of treatment usually involves 15 to 20 visits to hospital, two to three times a week.

The BAD service standards for phototherapy, developed using NICE-accredited processes, establish the equipment, facility, treatment, healthcare competency, and clinical governance required to ensure patient safety and efficiency.

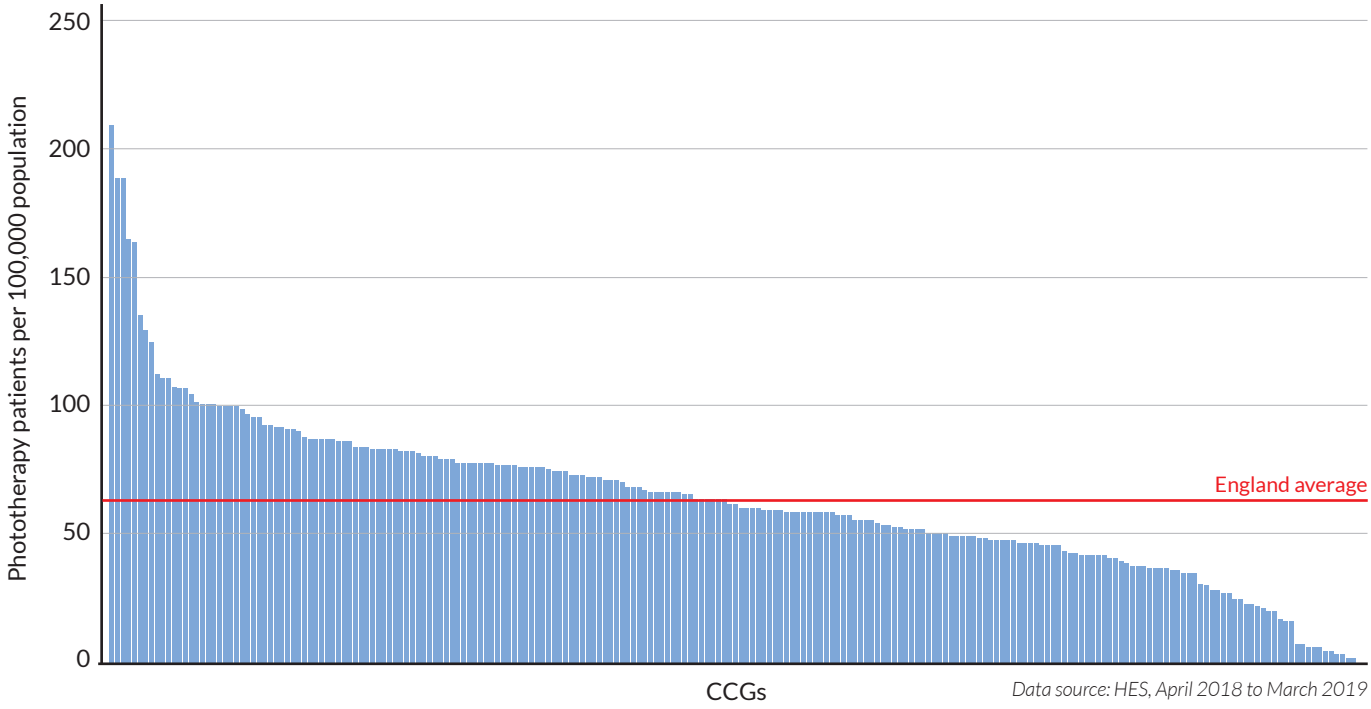
Variation in use of phototherapy

There is wide variation in the level of phototherapy use between trusts, resulting in considerable variation in access between CCGs, as shown in Figure 27. 45 trusts told us they run separate phototherapy clinics.

A combination of reasons were suggested to us for this:

- variation in clinical practice;
- waiting lists due to shortages of specialist dermatology nurses who deliver phototherapy services;
- availability of nursing staff trained in phototherapy;
- some departments are only open for limited hours (many people with severe psoriasis or eczema are at working age, so have to fit treatment around work);
- variation in the distance and time to attend appointments.

Figure 27: Phototherapy patients/year per 100,000 population by CCG



Data source: HES, April 2018 to March 2019

[29] *Boswell K, Cameron H, West J et al. Narrowband ultraviolet B treatment for psoriasis is highly economical and causes significant savings in cost for topical treatments. Br J Dermatol. 2018. 179(5):1148-1156.*

Relationship between phototherapy and biologics use

As phototherapy is significantly less expensive per patient per year than biologics treatment, using the treatments appropriately could release significant funds.

Phototherapy is earlier in the treatment pathways for psoriasis and eczema, so it is reasonable to expect that reduced access to phototherapy is likely to progress some patients to biologics (more expensive) or systemic drugs (less safe). Further to this, home phototherapy can improve patient access for departments now limited by the requirements of social distancing. A home phototherapy service has been piloted in West Yorkshire and an existing service is now being expanded in Dundee, Scotland.

Financial impact assessment

We are recommending improving access to and quality of phototherapy services.

Before increasing phototherapy services, trusts should produce a financial impact assessment taking into account the long-term savings and the relationship between use of phototherapy and biologics.

Initiative to establish a phototherapy network

We welcome the current initiative to set up a network of phototherapy services by the following: Dr Robert Sarkany and working group at Guy's and St Thomas' NHS Foundation Trust, the BAD, the BPG, and NHS Digital.

A similar service in Scotland called Photonet[30] has standardised treatments, offering better safety and more cost-effective treatment.

CASE STUDY

Providing home phototherapy services

Leeds Teaching Hospitals NHS Trust

Dr Victoria Goulden, consultant dermatologist at Leeds Teaching Hospitals, has successfully piloted the use of remote phototherapy services at home.[31] The service is designed to improve access to treatment for patients whose circumstances make regular hospital attendance difficult, such as distance from the hospital, or work and care responsibilities. It is based on a similar service provided by Ninewells Hospital, NHS Tayside.

Leeds' home phototherapy service mainly focuses on treating patients with psoriasis and eczema. It has achieved outcomes similar to those achieved with hospital phototherapy, with similarly low levels of adverse effects including symptomatic erythema. All patients have expressed high levels of satisfaction with the service and would choose home phototherapy again.

The uptake of home phototherapy in England has been low. Dr Goulden highlights the importance of carefully selecting patients who are able to manage this complex treatment. Patients are provided with training and supported by remote but close monitoring from the clinical team following clear local governance arrangements to minimise any potential risks.[32] The home phototherapy team includes a consultant dermatologist, phototherapy nurse practitioner and medical physics practitioner. Dr Goulden noted that development of national clinical guidelines and a governance framework would "encourage the development of home phototherapy in the UK."

Recommendations

Recommendation	Actions	Owners	Timescale
14. Improve quality of, and access to, phototherapy for all appropriate patients.	**a** Support NHS Digital's development of a national database for phototherapy.	GIRFT	2 years
	b Provide access to phototherapy services at suitable times and venues for people in work.	Trusts	12 months

[30] *National Managed Clinical Network for Phototherapy in Scotland (Photonet) www.photonet.scot.nhs.uk/*

[31] *Warburton KL, Ward A, Turner D, Goulden V. Home phototherapy: experience of setting up a new service in the U.K.'s National Health Service. Br J Dermatol. 2020 Jan; 182(1):251-253. doi: 10.1111/bjd.18511*

[32] *Sarkany RP, Anstey A, Diffey BL, et al. Home phototherapy: report on a workshop of the British Photodermatology Group. Br J Dermatol. 1999. 140(2):195-9.*

Medical dermatology

For many people their dermatological condition is part of a complex disease which may affect other parts of the body. For example:

- people with severe inflammatory skin disease often have other conditions in other body systems;
- some severe medical disorders, or their treatments, affect many organs of the body, including the skin;
- serious skin diseases needing treatments that can lead to problems in other organs.

All consultant dermatologists should be skilled in management of these patients. Even though this is the case, the most effective care for patients with the most severe and complex diseases comes from specialists from different specialties working together, sharing their expertise as a team. Larger teaching hospitals, which act as tertiary referral centres for complex cases (and some smaller units), run combined clinics to facilitate this kind of shared expertise. Clinicians should have as much exposure as possible to different patient populations and other clinicians' methodologies in order share and increase their expertise and so achieve the best outcomes for people with complex skin diseases.

There are many types of combined clinics. Examples of well-established clinics include:

- severe rheumatology diseases, such as lupus, vasculitis, systemic sclerosis and dermatomyositis (63 dermatologists do separate rheumatology clinics[33]);
- severe psoriasis complicated by conditions such as arthritis, heart disease and depression;
- severe blistering disorders of the skin, which may involve the genitals, eyes and mouth;
- skin lymphoma which may require input from haematologists and cancer specialists.

There are currently no consistent specialised commissioning arrangements for these combined clinics. The Dermatology Specialised Service Clinical Reference Group (CRG) is currently developing MDT networks. We understand that the CRG is proposing a hub and spoke model centred around specialised centres for specific regions and for specific diseases. The specialised dermatology MDTs would receive referrals and provide advice and guidance to the referring consultants.

The CRG advised us that they are also exploring what would be the best arrangements for on-call cover for specialised centres and certain complex skin diseases in adults and children.

Recommendation

Recommendation	Actions	Owners	Timescale
15. Establish networks to encourage shared care and expertise across specialties for complex medical dermatology.	**a** Support the work of NHS England's Dermatology Specialised Service Clinical Reference Group (CRG) to develop MDT networks for complex medical dermatology.	GIRFT/CRG	12 months

[33] *GIRFT questionnaire responses, 2019.*

CASE STUDY

Psoriasis rapid access clinic

Salford Royal NHS Foundation Trust

Salford's Psoriasis Rapid Access Clinic (P-RAC) delivers coordinated care in an approach that has the potential to revolutionise care for patients with psoriasis.

The community-based clinic was opened in January 2019 as a response to emerging evidence that early treatment for psoriasis increases the chance of remission. Most patients with psoriasis develop the condition before the age of 35 and accumulate physical, psychological and socioeconomic morbidity over time. Recognising this, the clinic provides expert care early in the disease cycle; ideally within one year of diagnosis.

Care includes a full range of consultant-led, multidisciplinary expertise, including screening for comorbidities, such as depression and anxiety, psoriatic arthritis, metabolic disease and risk factors for cardiovascular disease. This avoids the fragmented approach that can otherwise characterise psoriasis care, with patients having to make multiple hospital visits for different aspects of their condition.

A variety of patient and physician reported outcome measures have been improved and the clinic has already been able to demonstrate a positive shift in patients' understanding, sense of control over their health, and readiness to make healthy lifestyle choices. Screening has uncovered considerable comorbidity, and integrated care pathways ensure patients are referred appropriately first time.

A further advantage is that patients who are early in their disease course provide an important opportunity for prospective studies on how the immunology and epigenetics of psoriasis may change with time.

The clinic is a successful collaboration between the Salford CCG Innovation and Research Oversight Group and the University of Manchester under the auspices of the Greater Manchester Health and Social Care Partnership (GMHSCP) and Health Innovation Manchester.

Genital skin disease

Genital skin disorders due to infectious sexually transmitted diseases are looked after by community genitourinary clinics, run by consultant genitourinary physicians. However genital skin is also susceptible to other skin diseases such as eczema, psoriasis, skin cancers and specific diseases such as lichen sclerosus. These conditions often have serious effects on sexual function and, as a consequence, on self-image, mental health, fertility and relationships.

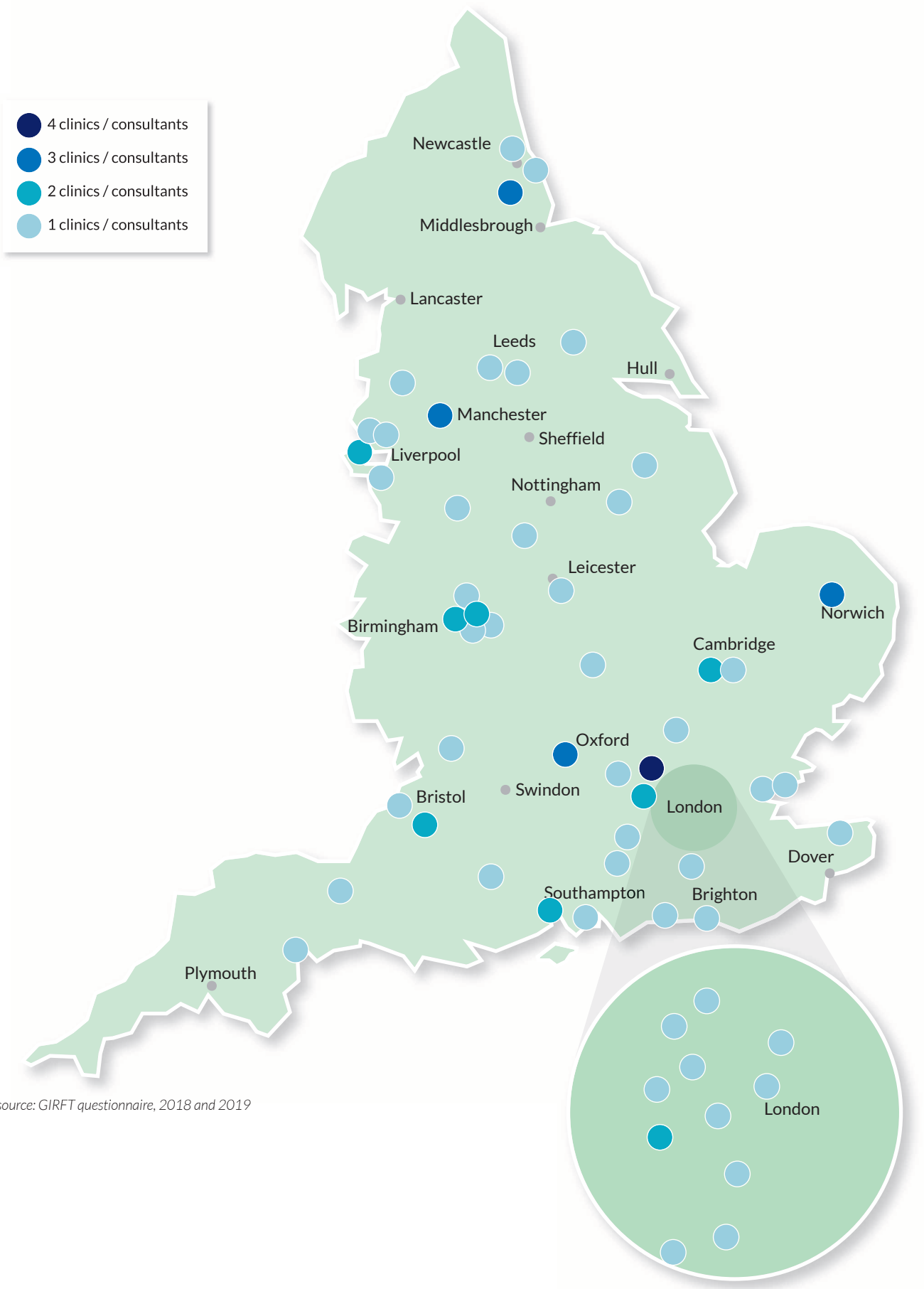
Consultant dermatologists see people with these conditions in hospital clinics and some consultants specialise in this area.

Combined clinics are often carried out with gynaecologists, urologists and genitourinary doctors, with a multidisciplinary team, often including nurse practitioners and psychologists.

We found wide variation in access to vulval clinics and male genital clinics:

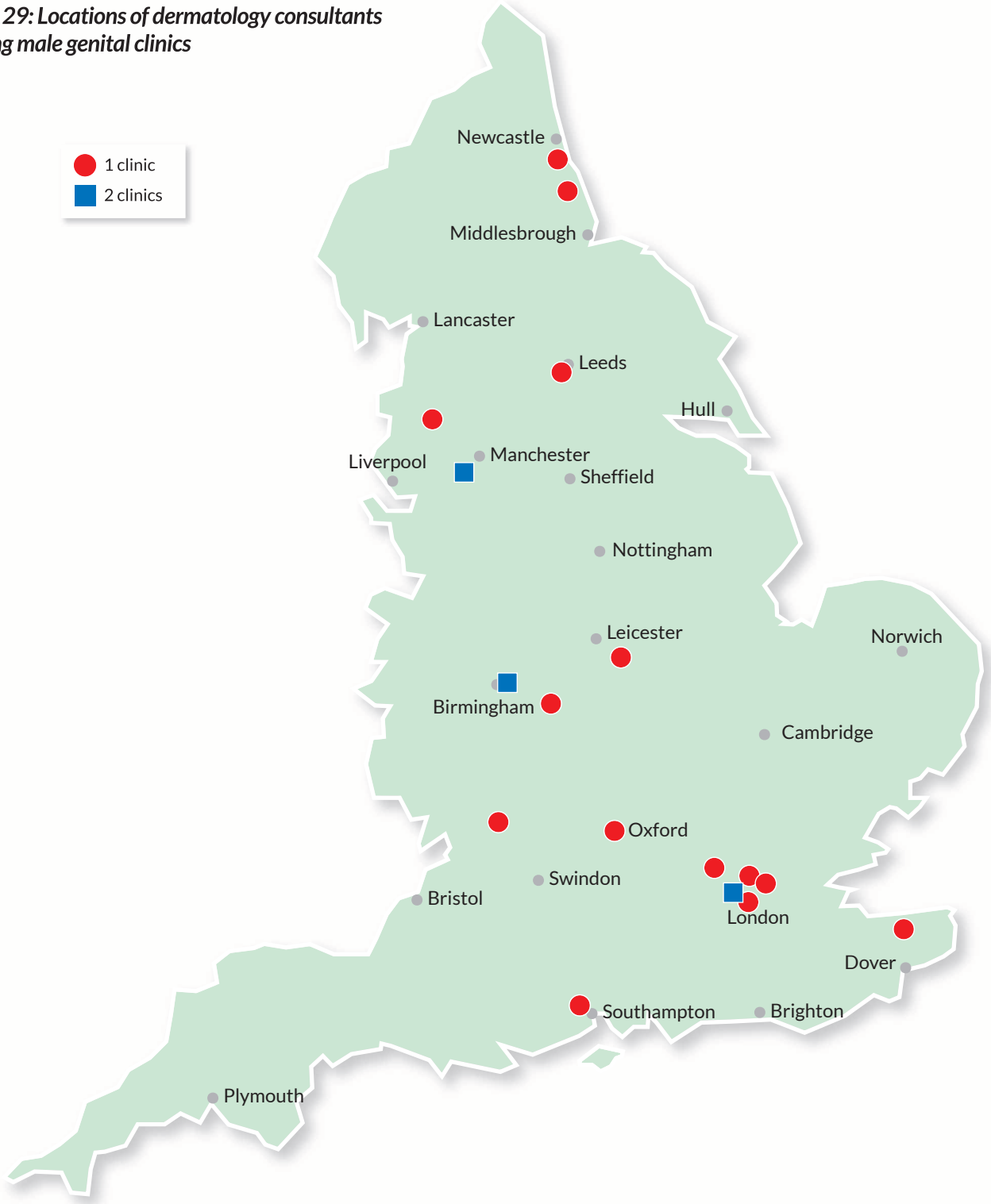
- 76 dermatologists in 58 trusts run separate vulval clinics, see Figure 28;
- 20 dermatologists in 17 trusts run male genital clinics, see Figure 29.

Figure 28: Locations of dermatology consultants running vulval clinics



Data source: GIRFT questionnaire, 2018 and 2019

Figure 29: Locations of dermatology consultants running male genital clinics



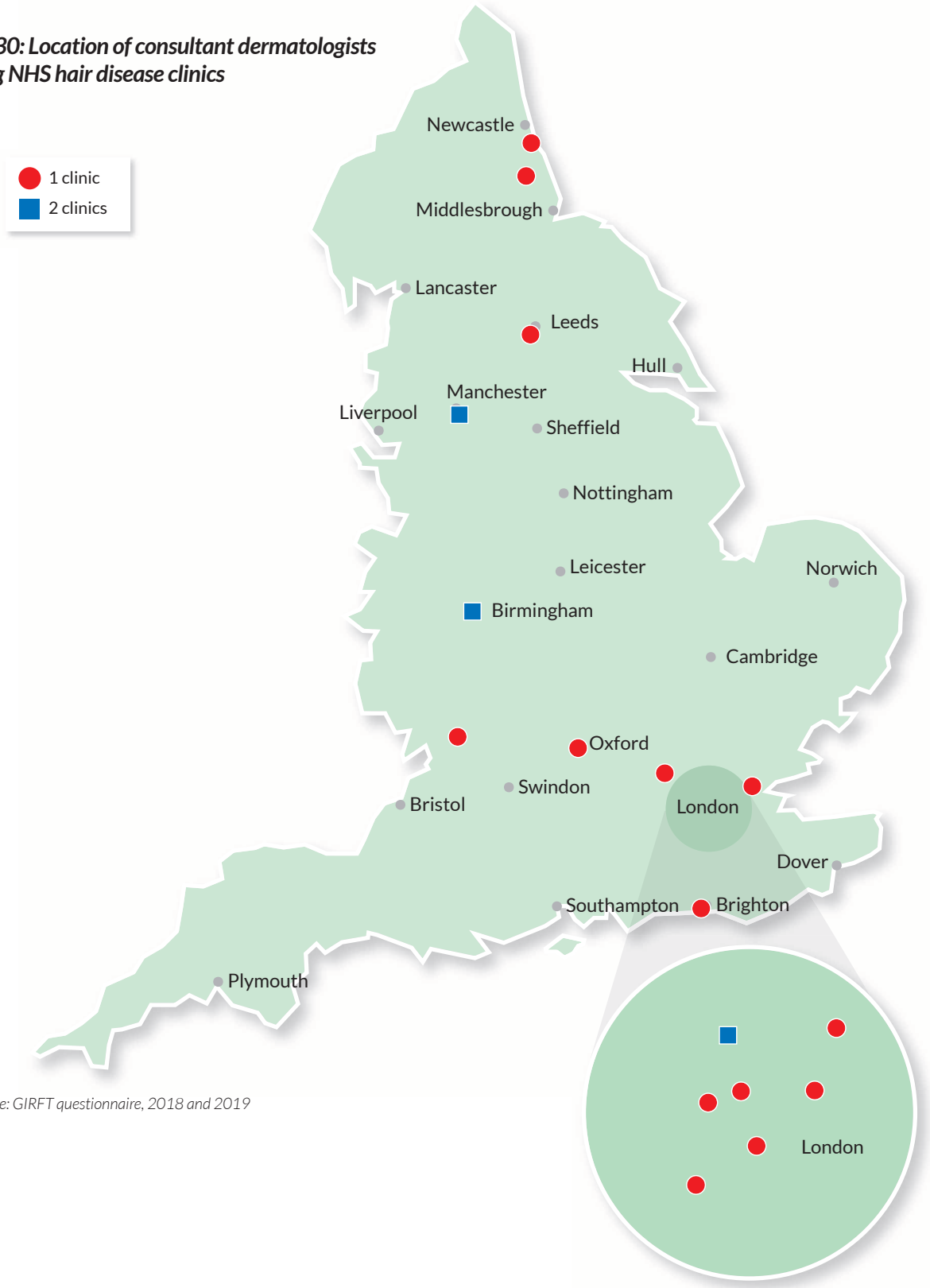
Data source: GIRFT questionnaire, 2018 and 2019

Hair and nail disease

Hair loss can be devastating to adults and children. Male pattern hair loss is not treated by the NHS. In children, fungal infections or alopecia areata are common problems causing widespread hair loss or scalp disease that can affect school attendance, confidence and social functioning. Melanoma skin cancer can present under nails, requiring surgery under the nail to diagnose and treat this life-threatening condition.

Most consultant dermatologists deal with these conditions in general dermatology clinics. As Figure 30 shows, there is very wide variation in access to specialist hair clinics, with just 17 trusts (20 dermatologists) running specialist hair clinics.

Figure 30: Location of consultant dermatologists running NHS hair disease clinics



Data source: GIRFT questionnaire, 2018 and 2019

Psychodermatology

Psychodermatology deals with mental health issues related to dermatology. The nature of dermatology means there are many such issues, for example:

- skin and hair conditions often trigger depression, anxiety, suicidal thoughts and low self-esteem.
- acne is the most common reason for teenagers to seek medical help – it can affect self-confidence and mental health, which may not be recognised by clinicians[34].
- diagnosis of a potentially fatal skin cancer has profound effects on most people.
- eczema is the most common reason for children and parents to seek medical help from GPs; it can impact sleep, school attendance, concentration, self-esteem, and mood (for child and parent).

Psychodermatology also involves seeing people with psychiatric disorders who present to dermatologists, for example:

- Skin may be self-damaged as a cry for help in children and adults being abused or by those with depression or anxiety; the damage can be mistaken for, or disguised as, a skin condition.
- People with delusions of infestation due to mental illness may present to dermatology for treatment of the skin infestation that they believe they have. This condition has usually considerable impact on the ability of the patient and their family to function normally.
- People with body dysmorphic disorder demand unnecessary treatments from the NHS and have a high rate of suicide.

The risks of affected people attending clinics run by doctors without the psychological or psychiatric expertise that is essential to manage the problem include missed diagnosis, harm to patients and increased NHS and litigation costs.

Psychodermatology requires liaison between dermatologists, psychologists and psychiatrists. Treating appropriate patients in a psychodermatology clinic delivers appropriate care. It is also cost-effective as it reduces follow-up appointments, did not attend rates, unnecessary treatment and litigation.

Less severe problems are ideally dealt with by a GP with skills in both dermatology and psychiatry working with other health care professionals.

Current provision

There is wide variation in access to psychodermatology. There are currently just 11 dermatologists running psychodermatology clinics in nine trusts, as shown in Figure 31. Some cover very large geographic areas, while others are unable to take referrals from outside their locality due to their huge workload.

Psychodermatology UK, the specialist society dealing with these conditions told us that only some of these clinics are able to deal with the more serious cases. They also told us there is even less provision for paediatric psychodermatology, with only one clinic nationally. Most children with a psychodermatology condition do not meet the threshold for Child and Adolescent Mental Health Services (CAMHS), leading to long-term mental and physical health impact. These points further highlight the variable access to services.

We asked units whether they had access to psychiatrists. Of the 122 units that responded:

- just 16% said they had access;
- 42% said access was available but not easy to use;
- 42% said they had no access at all.

66% of departments said they were able to offer psychological support to patients with skin cancer.

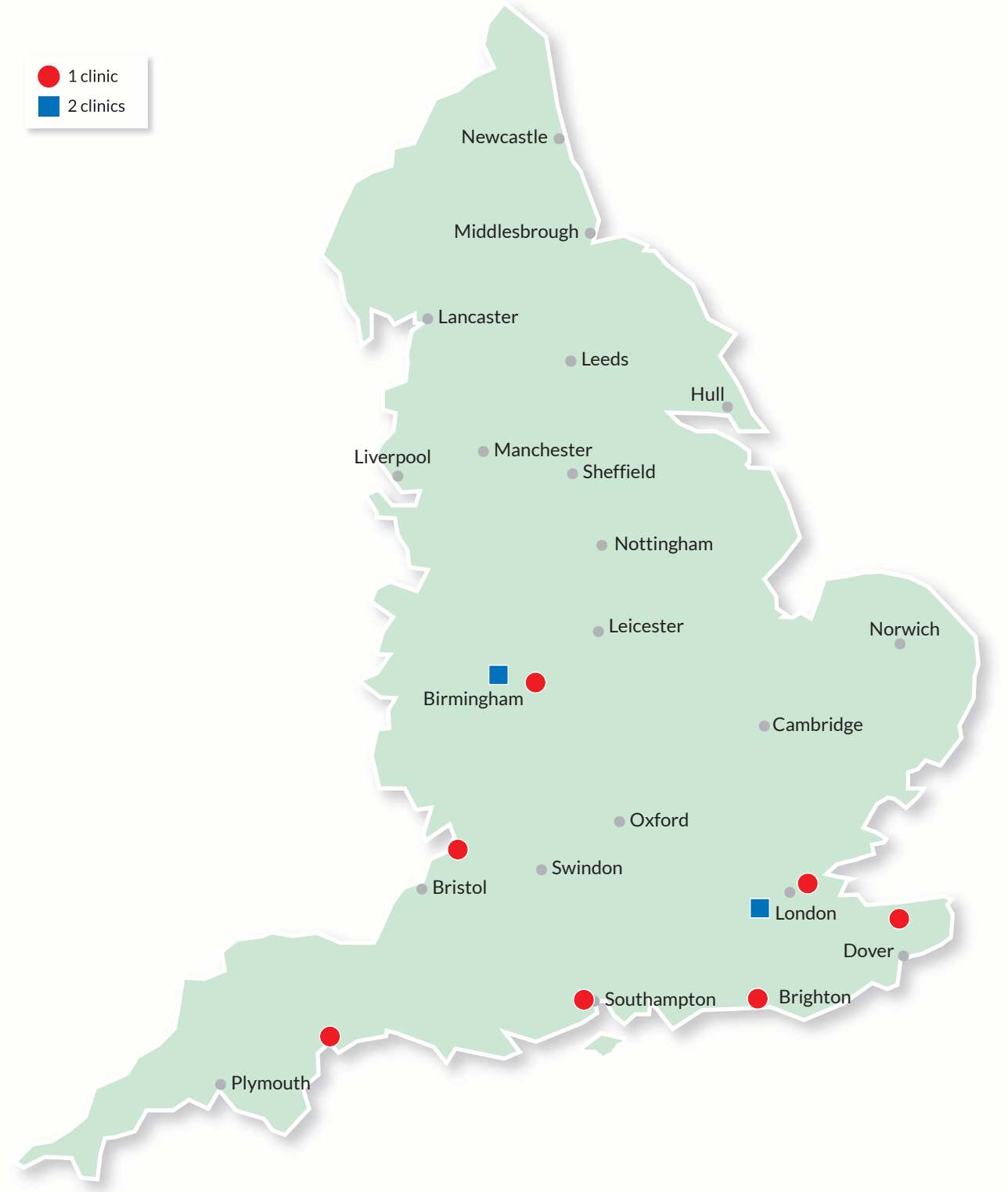
Northern regions have very few psychodermatologists. We heard how this leads to patients from north Lancashire being referred to Birmingham.

Dermatologists in Lancashire, Yorkshire and Northumberland all expressed enthusiasm to set up regional services to improve access and equality of care in their regions (see page 97).

Specialist dermatologist nurses (see page 44) also have an important role in providing specialist care to children with psychological issues relating to skin diseases.

[34] *Cowdell F, Eady EA, Layton AM et al.(2016) Ineffective consultations for acne: what is important to patients? Br J Dermatol. 175(4):826-8.*

Figure 31: Location of consultant dermatologists running psychodermatology clinics



Data source: GIRFT questionnaire, 2018 and 2019

CASE STUDY

Psychodermatology service

Guy's and St Thomas' NHS Foundation Trust

Guy's and St Thomas' psychodermatology service has grown from a two-session per week secondment in 2013 to three full-time psychologists.

Psychologists are assigned to a number of secondary and tertiary clinics. In most clinics the psychologists are available to see patients on the same day as their visit to see other dermatology staff. They are also available to see patients for psychological therapy in their own clinics.

The psychology service has clear referral criteria that distinguish it from primary care psychology and community mental health teams. Dermatology staff follow the referral pathway for liaison psychiatry for diagnostic assessment of mental health, medication reviews and recommendations, and if there is elevated patient risk related to mental health. The pathway provides for same-day assessment where risk is deemed particularly high and for less urgent assessment for low risk referrals. Treatment sessions are limited to 12 plus a one-month follow-up to keep the service viable.

Embedding psychologists in multidisciplinary teams provides the wider team with access to expertise on mental health and the emotional aspects of living with a skin condition. It also supports access to psychology for those patients who may not realise or believe their problem is primarily psychological rather than dermatological.

The service applies a stepped-care approach in line with NICE guidance for the management of depression in people with long-term physical health problems and the BAD's minimum standards for psychodermatology services.

Routine screening by the service has identified a high percentage of previously unrecognised psychological morbidity.

GSTT's psoriasis and eczema service was awarded the British Medical Journal Dermatology Team of the Year (2016) for its entry Holistic Care for Skin Disease, which featured data from their psychodermatology service.

CASE STUDY

Providing a psychodermatology service

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

In October 2019, Dr Stephanie Ball and Dr Soraia Sousa established a new psychodermatology service in Newcastle, serving the north-east of England and Cumbria. Previously, there was no psychodermatology service in the region. This meant patients with complex psychological needs were seen in a general dermatology clinic where appointment times are not sufficient to deal with psychological issues.

The Newcastle service is based on a similar service set up in Lothian, Scotland by psychiatry trainee Dr Catriona Howes, supervised by Dr Wotjek Wojcik, with Dr Ball.

Clinical governance

The service is led jointly by a senior trainee doctor in dermatology and a senior trainee doctor in psychiatry.

The trainees see patients together, while supervision is provided by a consultant dermatologist and a consultant liaison psychiatrist who can be called upon for advice. The consultant liaison psychiatrist also provides formal supervision sessions for both trainees to mitigate any clinical governance issues.

Using a trainee-led model capitalises on the greater flexibility of trainee timetables versus the fixed job plans of the consultant body. It also provides valuable training opportunities for the trainees involved.

Promising early results

Early results show few cancellations and no non-attendances. Anecdotal evidence shows that patients have been very grateful for the time spent listening to their histories, and for the thorough follow-up letters they receive. These letters include a personal formulation of the patient's problems, set out a plan of action, and often signpost further useful apps and workshops. Patients also appreciate having two perspectives and a joint formulation from the two clinicians present.

New patients have one-hour appointment slots, while follow-up appointments are 30 minutes. As the service is new, referrals currently come from other dermatologists in the region rather than directly from primary care. Conditions seen include delusional infestation, dermatitis artefacta and body dysmorphic disorder, along with skin picking disorder, trichotillomania and mood and anxiety disorders secondary to a chronic dermatological diagnosis, such as eczema and hidradenitis suppurativa.

The service has required very little initial investment other than a large room for the clinic and some administrative support.

Recommendation

Recommendation	Actions	Owners	Timescale
16. Improve access to dermatology specialties, including hair and nail disease, female and male genital skin disease, and psychodermatology.	**a** Establish clinics to ensure more locations have access to these services to provide equity of care.	CCGs; trusts	For substantial progress within two years of report publication

Paediatric dermatology

There are many dermatological conditions that are common in children and young adults. For example, eczema is the most common reason for young people to seek help from the NHS below the age of 10, and acne is the most common reason between the ages of 10 and 20.[35] This means it is essential that GPs and dermatologists are good at managing these conditions.

There are also hundreds of less common, often genetic, childhood skin conditions, some of which are life threatening. Children with these conditions require specialist dermatology diagnosis and support with treatment

We looked at the provision of services at both ends of this spectrum.

Acne services

Research in acne has identified that some patients would like primary care services to have increased knowledge of the available treatments and would like hospital services to ask more about the impact of acne on their lives and emotions.[36]This can be addressed by increasing psychodermatology services and training for consultants as well as increasing dermatology training for GPs.

Current provision for paediatric patients in secondary care

We found that the shortfall in the number of dermatology consultants with a special interest in paediatric skin disease is having a negative impact on the management of paediatric patients in secondary care.

Clinical care is usually provided by dermatologists, who all train in paediatric dermatology. They work closely with general paediatricians, often in shared outpatient areas and wards. Specialised paediatric nurses (see page 44) also have an important role in providing specialist care to children with skin diseases.

In smaller trusts, most general dermatologists see both adults and children. Services for children with skin diseases have been closed in some hospitals, such as in Kings Lynn in Norfolk, due to the shortages of dermatologists. This means some children now have to travel large distances for secondary care, leading to inequity of access. Overall, 116 out of 123 trusts have dermatologists who see children in clinics. We found that 237 dermatologists in 93 trusts run specialised paediatric clinics, showing the high level of demand for paediatric dermatology specialist care.

In larger dermatology units that receive tertiary referrals, sub-specialisation usually occurs with only some dermatologists doing paediatric clinics. These services see a mixture of secondary care and tertiary conditions.

Some specialist paediatric dermatology units also provide regional and supraregional services for very rare diseases. These are usually based at specialist children's hospitals, such as Great Ormond Street Hospital, Guy's and St Thomas' NHS Foundation Trust (includes Evelina London Children's Hospital on site), Birmingham Women's and Children's NHS Foundation Trust, Nottingham Children's Hospital, Sheffield Children's Hospital, Newcastle Children's Hospital and Alder Hey Children's Hospital. We were told by consultants in Birmingham that inability to recruit consultants led to closure in 2019 of the Birmingham Children's Hospital to routine secondary-care dermatology referrals.

We understand from our deep dive visits that issues related to tariffs make it challenging for some trusts to develop services for paediatric patients in secondary care.

Increasing dermatology expertise in general paediatricians

Training in paediatric dermatology for general dermatologists and paediatric dermatologists is supported by the British Society for Paediatric Dermatology. There are two approved post-CCT Fellowships in Paediatric Dermatology for dermatologists who wish to develop a special interest in paediatric dermatology. One is based at Guy's & St Thomas' NHS Foundation Trust and the other at Birmingham Children's Hospital.

In 2015, the Royal College of Paediatrics and Child Health (RCPCH) established a special interest (SPIN) module qualification in dermatology to help improve access to paediatric dermatology for paediatricians. We support expansion of this initiative, which has helped improve access to paediatric dermatology services in the face of dermatology workforce shortages.

At Level 3 of training (ST6-8), paediatric trainees may sub-specialise in a specific area of paediatrics. Those who complete an approved programme of sub-specialist training are eligible to enter on the GMC Specialist Register as a Paediatrician

[35] *Kuan V, Denaxas S, Gonzalez-Izquierdo A et al. (2019) A chronological map of 308 physical and mental health conditions from 4 million individuals in the English National Health Service. Lancet Digit Health. 1(2):e63-e77. https://www.thelancet.com/journals/landig/article/PIIS2589-7500%2819%2930012-3/fulltext*

[36] *Cowdell F, Eady EA, Layton AM et al.(2016) Ineffective consultations for acne: what is important to patients? Br J Dermatol. 175(4):826-8.*

with a sub-specialty. This process is also known as the NTN Grid recruitment.[37] We understand that the RCPCH has considered an NTN Grid dermatology programme for paediatricians. We support further discussions between the BSPD and RCPCH to identify if this would help improve access to paediatric dermatology for patients.

CASE STUDY

Using the SPIN dermatology module to build a stronger paediatric dermatology service

Nottingham University Hospitals NHS Trust

Faced with a shortage in paediatric dermatology staff prompted by the privatisation of adult dermatology services, Dr Jane Ravenscroft, service lead for paediatric dermatology at Nottingham, worked with colleagues in paediatrics to create posts for three paediatricians to train in dermatology.

One paediatrician opted to train in all aspects of dermatology using the SPIN module. The other two learnt generic dermatology skills, then focused on those specific areas that complemented their existing specialisms.

This new way of training has fostered a seamless integration between dermatology and paediatrics. It has also promoted a wider dissemination of dermatology expertise and training among other staff in the children's hospital.

The generic paediatric skills of the paediatricians has helped to develop a better service for children. For example, one paediatrician with an interest in allergy has introduced new skills in managing eczema to provide comprehensive care to severely atopic children. In the same way, a paediatrician with adolescent health skills helps children and young people with acne.

The approach has both improved care for children with acute skin problems and reduced demand for referrals to paediatric dermatology.

Having a stronger, invigorated paediatric dermatology department has enabled Nottingham to recruit a third paediatric dermatologist, further strengthening the team and creating a sustainable service.

Recommendations

Recommendation	Actions	Owners	Timescale
17. Improve access to, and quality of, paediatric dermatology services.	**a** Encourage further uptake of the dermatology SPIN module among paediatricians to work alongside paediatric dermatologists to improve access to specialist support for children with skin conditions.	BSPD; RCPCH; RCP	18 months
	b Support further analysis of the potential for NTN Grid training for paediatricians in dermatology to work alongside paediatric dermatologists to improve patient access.	BSPD; RCPCH; RCP	24 months

[37] *Royal College of Paediatrics and Child Health (RCPCH) (2019) Sub-specialty training (NTN grid) application guidance www.rcpch.ac.uk/resources/sub-specialty-training-ntn-grid-application-guidance*

Isotretinoin prescribing

Acne is the commonest reason for teenagers seeking medical advice. If not correctly treated, it can have devastating effects on mental health, social development, relationships and future employability.

Isotretinoin is a highly effective treatment for severe acne and can prevent lifelong scarring. It requires careful monitoring as it produces abnormalities in babies if given to pregnant mothers. There are also uncertain associations with suicide, depression and effects on libido.

Current guidance

The Medicines & Healthcare products Regulatory Agency (MHRA) has produced guidelines on safe use of isotretinoin. Among other points, the guidelines:

- restrict prescribing to consultant dermatologist-led teams;
- restrict dispensing to hospital pharmacies, although this is not being followed in some CCGs, as shown in Figure 32;
- set out rules on the use of contraception prior, during and after treatment, to prevent pregnancy..

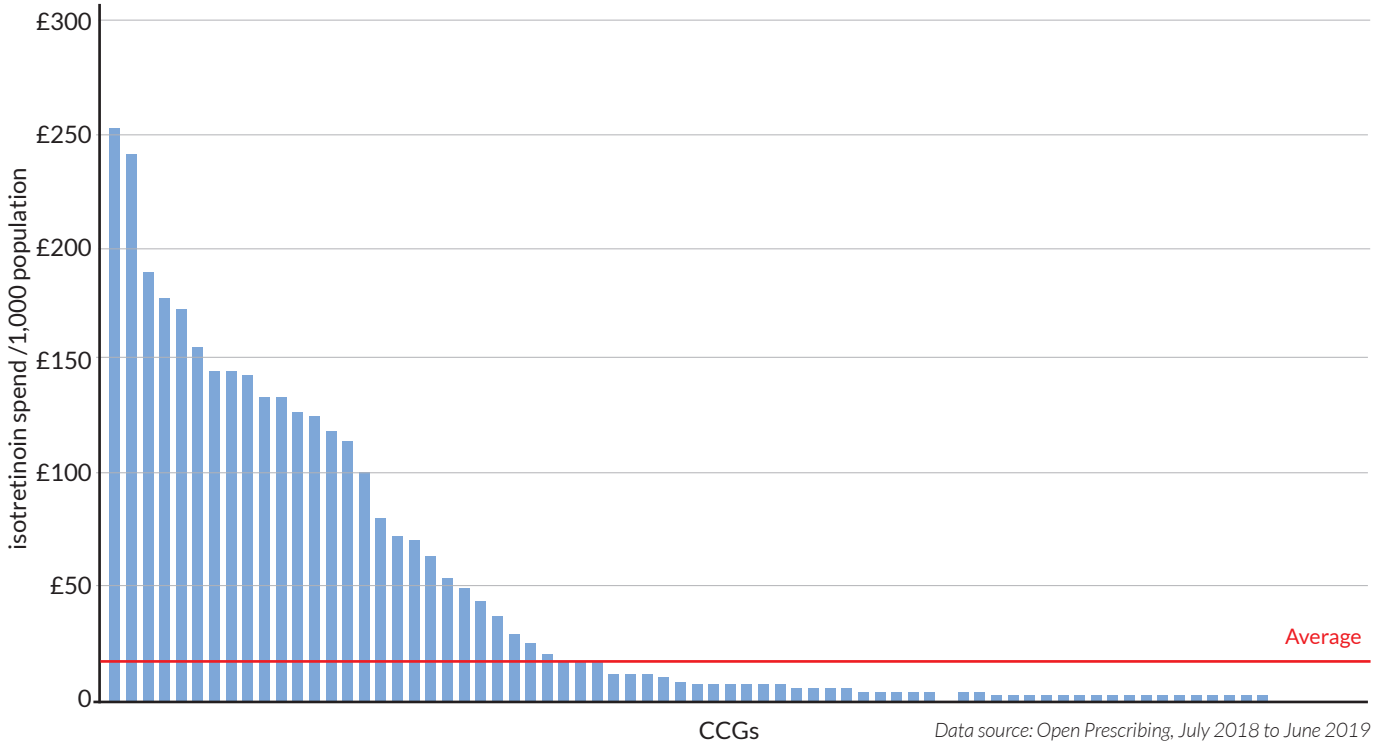
These rules can prove challenging given the current shortfalls in the dermatology workforce, and especially for dermatology teams working in community settings. Furthermore, we heard that some women can consider it unreasonable to have to take contraception. This includes women who advise the NHS that they are not at risk of pregnancy due to their religious views or because of their sexuality.

Current prescribing practice

We found that consultant teams vary in their interpretation of the MHRA guidance. The data suggest that some isotretinoin prescribing is taking place in the community, probably outwith MHRA guidance. See Figure 32.

We also heard a widely expressed view that fully accredited GPwERs should be able to prescribe isotretinoin; GPs are trained in assessing mental health issues, and in assessing and prescribing contraception.

Figure 32: Annual spend on NHS oral isotretinoin dispensed in community pharmacies per 1,000 population by CCG



Data source: Open Prescribing, July 2018 to June 2019

National Outpatient Transformation Programme

The National Outpatient Transformation Programme's dermatology redesign workstream will explore solutions to providing care closer to home and avoiding unnecessary trips to hospital. This will include a review of care that can be provided safely and sustainably in the community, and the commissioning models that will be required to support it.

Reviewing current guidelines

The BAD formed a multidisciplinary working group under Professor Alison Layton to help identify solutions in areas of controversy related to current guidance in late 2019.

The MHRA formed a working group to look at similar issues in 2020, so the BAD working group has decided to wait for the MHRA findings before issuing any guidance.

Recommendations

Recommendation	Actions	Owners	Timescale
18. Review prescribing and dispensing practice for isotretinoin.	**a** Review whether isotretinoin prescribing should be extended to fully trained GPwERs.	MHRA; RCGP; BAD; RPS	For immediate discussion
	b Consider how to safely allow certain community pharmacists to dispense isotretinoin to increase access for those people attending community dermatology clinics and with difficulty accessing hospital pharmacies.	MHRA; RCGP; BAD; RPS	For immediate consideration

Innovation, research and safety

Teledermatology: Advice and Guidance, and teletriage

Many specialties use telemedicine at different stages of the patient pathway. For example, GPs may use telemedicine (sometimes attaching images to their request) to get advice and guidance before referring a patient. While it may also be used with referred patients, when it is usually referred to as teletriage.

Telemedicine in dermatology is generally called teledermatology.

The use of images is integral to teledermatology. High-definition medical photography with appropriate clinical history is used to help clinicians carry out remote diagnosis and management of dermatological conditions, and to support the triage of referred patients to the correct clinical setting.

Teledermatology may be used to provide support that is either:

- internal within a hospital, such as to support referrals between clinicians on different sites; or
- external, such as for GPs to get guidance from consultants, or for consultants to get support from a tertiary centre.

The teledermatology solution may be either:

- integrated to support standard referral pathways between GPs, specialists and tertiary centres, supporting the development of integrated care systems (ICS);
- stand-alone, where an independent provider (often private) may offer GPs advice as a separate pathway.

Table 5: Effects of good and poor teledermatology

Good teledermatology	Poor teledermatology
Helps to educate GPs	De-skills GPs
Does not increase referrals	Increases overall referrals
Uses high-quality images	Uses poor-quality images
Provides patients with a more rapid accurate diagnosis and effective treatment and is an effective use of resources	Is inaccurate, leading to wrong diagnosis and treatment, longer referral pathways, delays in effective treatment and wasted NHS resources
Early diagnosis reduces cancer mortality	Missed diagnosis increases cancer mortality

Current access to teledermatology

There is wide variation in access to teledermatology:

- 30% of trusts told us their local teledermatology services are adequately and safely integrated with their services;
- 52% of trusts said their local teledermatology services are not adequately and safely integrated with their services;
- 18% of the 117 departments who responded to the GIRFT questionnaire had no local teledermatology service at all.

Current evidence

There is conflicting evidence on the benefits of teledermatology in terms of improved outcomes, cost savings or reduced referrals. Those that advocate teledermatology told us it can help manage the increasing number of referrals, enabling faster and more efficient treatment of patients in the community, without the need for a hospital visit.

Those with concerns about the technology argue that:

- papers advocating teledermatology often use poor quality health economic analyses;
- companies selling their teledermatology services are compromised by their financial conflicts of interest and make exaggerated marketing claims to CCGs and clinicians;
- teledermatology stimulates demand, so impressive results in numbers of patients returned to GPs can reflect an increase in GP referral rate of simple problems.

Initial pilot studies show some impressive results from the use of teledermatology to screen or triage skin cancer referrals.[38, 39] However, there have also been concerns regarding the safety of teledermatology relating to its use for possible melanoma skin cancer assessment, both for the risks of not removing the referred index lesion(s), but also for non-index lesions which may be missed. Long-term follow-up for several years is required for those who are advised that they do not need surgery. This will identify if the error rate of missed cancer[40] is any higher than that seen with conventional treatment.

The learning curve for clinicians using teledermatology means training and assessment is necessary. As with all medicine, working in isolation is not advised: some of the clinicians we spoke to felt that doing teledermatology as a team offered the benefits of being able to ask each other for advice and share learning.

Despite these concerns, our view is that teledermatology at its best can be of great value to patients as part of an integrated service. It would support the development of integrated care systems (ICS) and a network approach to dermatology services with specialists in a tertiary centre providing advice and support to colleagues in secondary, primary and community care. There is also no doubt that developments in AI and photography will augment future teledermatology services.

Ongoing analyses of potential benefits or otherwise is required. We consider it is essential that services accurately measure and evaluate the short and long term impact on GP referral rates, patient safety and potential health economic benefits. This will help to ensure that teledermatology is carried out effectively and safely, shortens patient pathways, and delivers a good use of resources.

Advice and Guidance services (A&G)

Advice and Guidance (A&G) services allow GPs to request diagnosis and management advice from specialists before or instead of referring patients to hospital. Digital A&G services, usually operating with a 48-hour turnaround, are increasingly being used across many hospital specialties to reduce the need for face-to-face referral. This is a key part of the NHS Long Term Plan. GPs can attach patient images to the A&G request. These platforms have largely replaced email.

A&G can be provided through the standard NHS referral platform or through independently developed platforms. The NHS e-Referral System (e-RS) is the most widely used platform for digital A&G. NHS England and NHS Digital have produced a national e-RS A&G toolkit[41] to guide commissioners, clinicians and managers. Other web-based independent A&G platforms can be used instead of e-RS or to supplement e-RS A&G.

Some clinicians told us they consider that the e-RS A&G system offers the following key benefits:

- full integration with the standard e-Referral System means minimal duplication of work for GPs;
- provides a way to keep records for future audit;
- no added up-front costs for the health system (in contrast to independently developed systems that may have one-off, maintenance or per-patient costs).

However, other clinicians told us they consider e-RS A&G to be slow and inconvenient in comparison to the independently developed systems; they argued that such inefficiencies outweigh any benefits. The interoperability of e-RS and independently developed platforms continues to develop.

We consider the pros and cons of A&G and independently developed platforms in Appendix 4.

What to look for when considering teledermatology

Trusts considering investing in a teledermatology system should make a detailed assessment of the merits of each system against their requirements.

The Elective Care Transformation Programme (ECTP) has developed the Elective Care Community of Practice online platform for commissioners, clinicians and providers to share knowledge and materials, and collaborate more effectively.[42] The platform connects teams, organisations and other stakeholders across the healthcare system and aims to improve communication and knowledge sharing among NHS and other healthcare professionals. The ECTP is collecting data on teledermatology and A&G and provides examples of best practice on the Future NHS Collaboration Platform.

[38] *Edwards C and Macedo C. (2017) A pilot study to investigate the potential for teledermatology triage of 2-week-wait new skin cancer referrals at Chelsea and Westminster Hospital. Br J Dermatol 177 (Suppl. 1), pp 185–189.*

[39] *Thomas L, King A, Fuller C and Macedo C (2018) The facts, figures and tribulations of a new teledermatology service: an update on the pilot study presented at the 97th British Association of Dermatologists annual meeting. Br J Dermatol 179 (Suppl. 1), pp183–186.*

[40] *Ng J, Florence L and Fearfield L (2019) Teledermatology follow-up for lesion monitoring: an audit regarding suitability and application in the clinic setting. Br J Dermatol 181 (Suppl. S1), pp168–176.*

[41] *Advice and guidance toolkit for the NHS e-Referral Service (e-RS), https://digital.nhs.uk/services/e-referral-service/document-library/advice-and-guidance-toolkit*

[42] *Elective Care Transformation Programme, Community of Practice, https://www.england.nhs.uk/elective-care-transformation/community-of-practice/*

The BAD's teledermatology subcommittee can advise clinicians, managers and commissioners on their options.[43] Two national guidelines giving advice on the governance, safety and IT issues around teledermatology have been produced with BAD involvement:

- UK guidance on the use of mobile photographic devices in dermatology;[44]
- Quality standards for teledermatology.[45]

We strongly recommend visiting other units to see different systems in use. As with all similar investments and procurements, it is essential not to buy on the basis of salesperson or brochure promises alone. From our deep dive visits to date and other conversations, the following trusts are amongst those that have reported being satisfied with their teledermatology systems:

- University Hospitals Bristol NHS Foundation Trust (Dr David De Berker)
- Leeds Teaching Hospitals NHS Trust (Dr Wal Hussein – who is piloting use in pigmented lesions)
- Brighton and Sussex University Hospitals NHS Trust (Dr Paul Farrant)
- East Kent Hospitals University NHS Foundation Trust (Dr Saul Halpern)
- Luton and Dunstable University Hospital NHS Foundation Trust (Dr Berni De Silva)
- Royal Devon and Exeter NHS Foundation Trust (Dr Carolyn Charman)
- East Sussex Healthcare NHS Trust (Dr Jan von der Worth)
- Chelsea and Westminster Hospital NHS Foundation Trust (Dr Lucy Thomas)
- Gloucestershire Hospitals NHS Foundation Trust (Dr James Milne and Dr Alan Gwynn)

Teledermatology pilots

We encourage trusts that choose to pilot teledermatology systems for NHS patients to collect and publish their pilot data. Teledermatology pilots should evaluate:

- effect on referral rate
- safety
- impact on patient pathway
- timeliness of correct diagnosis
- effectiveness of treatment
- overall health economic impact (assessed by professional health economists)
- patient feedback confirming that service is patient-centred
- service is equitable, serving all relevant communities

Job plans and teledermatology

Job plans provide a strict timetable for NHS doctors, including hospital consultants. They detail exactly what doctors should be working on – and where – on an hour-by-hour basis during the working week, including on-call and out-of-hours work.[46]

We asked trusts whether time spent doing teledermatology and providing advice and guidance to GPs is included in doctors' job plans (see Table 6):

- 24% said this was job-planned
- 17% said it was partially job-planned
- 46% said it was not job-planned
- the remaining 13% said that this was not applicable.

Effectively this means that doctors in 46% of trusts are carrying out NHS teledermatology in their own time.

[43] *For further information https://www.bad.org.uk/healthcare-professionals/teledermatology*

[44] *Primary Care Commissioning (2017), UK guidance on the use of mobile photographic devices in dermatology, http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=5818*

[45] *Primary Care Commissioning (2017), Quality standards for teledermatology, http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=794*

[46] *Job Planning for Dermatologists, BAD http://www.bad.org.uk/healthcare-professionals/clinical-services/employment-guidance-for-dermatologists*

Table 6: Teledermatology in doctors' job plans

Based on responses from 123 trusts.

Time spent on teledermatology	Source and year	% Yes	% Partial	% No	% Not applicable	Responses
Is time spent on teledermatology and/or advice and guidance to GPs included in doctors' job plans in your department?	GIRFT questionnaires 2018	18.8%	17.1%	45.3%	18.8%	117 repsonses
	GIRFT questionnaires 2019	24.4%	17.1%	45.5%	13.0%	123 repsonses
	Change in % between 2018-2019: (15.4%)	5.7%	0.0%	0.1%	-5.8%	19 responses updated

Data source: GIRFT questionnaire, 2019.

Rates of teledermatology activity

It is encouraging that 87% of departments are now providing teledermatology through A&G or teletriage. However, it is disappointing that by not including this work in job plans nearly half of trusts are not encouraging the staff who are doing this innovative activity. The reason for this may be that some trusts do not think they are receiving payment from CCGs. As Table 7 shows, 33% of trusts said they were not receiving payment for A&G, though the number that consider they are being paid increased from 32% in 2018 to 41% in 2019.

Table 7: Use of electronic advice and guidance

GP electronic advice and guidance	Source and year	% Yes unfunded	% Yes, funded with a local tariff	% No	% Don't know	Responses
Does your department provice electronic advice and guidance (responding to letters from GPs with an email reply)?	GIRFT questionnaires 2018	35.9%	31.6%	29.9%	2.6%	117 repsonses
	GIRFT questionnaires 2019	33.3%	40.7%	23.6%	2.4%	123 repsonses
	Change in % between 2018-2019: (15.4%)	-2.6%	9.1%	-6.3%	-0.2%	24 responses updated

Data source: GIRFT questionnaire, 2019.

National Outpatient Transformation Programme

Launched in April 2020, the National Outpatient Transformation Programme will be working to enable transformation of outpatient services in three priority areas: optimising referrals, modernising care delivery, and personalising ongoing care.

The dermatology redesign workstream will explore how teledermatology can be used to support these priorities. The workstream will do this by collaborating with frontline staff and communities to understand current barriers and develop solutions for effective and sustainable models of care.

CASE STUDY

Teledermatology service to support management of two-week wait patients

Chelsea and Westminster Hospital NHS Foundation Trust

After a successful pilot study, consultant dermatologist Dr Lucy Thomas at the Chelsea and Westminster established a a teledermatology service in 2017 that has now successfully processed over 3,000 patients.

Since introducing the service, the trust has achieved an increased squamous cell carcinoma pick-up rate and a 15% reduction in the number or biopsies requested (overall 25% have a biopsy procedure). (NHS England data July 2019)

It is also in the top 10 performing NHS trusts, seeing 99.5% of patients within the two-week wait target (NHS England data, July 2019).

The service uses medical photographers based in the hospital to manage most two-week wait skin cancer referrals. The quality of information and images is good in over 98% of cases. Consultants can process cases in around 10 minutes and around a third of patients can be discharged immediately, without a face-to-face clinician appointment.

There have been no adverse events detected to date.

In April 2019, the trust expanded the service to include follow-up appointments to allow monitoring of pigmented lesions. An audit of face-to-face follow-up appointments for this purpose showed that up to 468 outpatient appointments could be released by re-directing them via the teledermatology service.

CASE STUDY

Teledermatology: increasing the use of Advice and Guidance in primary care

Gloucestershire Hospitals NHS Foundation Trust

Commissioner and GP, Dr Alan Gwynn, and consultant dermatologist, Dr James Milne, have led a project in Gloucester to provide GPs with training in skin lesion recognition and the use of Advice and Guidance.

The project resulted in increased use of Advice and Guidance by the GPs who took part, and slowed the rate of increase in their referrals for skin cancer in comparison to a control group who received no training.

A sub-group of GPs who took part were also provided with dermatoscopes (magnifying devices using polarised light) and training in how to use them. This group showed a more pronounced reduction in the rate of increase in referrals for skin cancer.

The success of the project suggests a potential way to use technology and training to help deal with the increase in skin cancer referrals, which is a problem for many trusts dealing with staffing shortages.

The team summarised their approach by saying that: "to do teledermatology, you need equipment, aptitude and attitude."

The GIRFT team was impressed by their enthusiasm and innovation. We would add that the expertise (training) of the integrated team was also key to their success.

CASE STUDY

Teledermatology to assess patients for two-week wait referrals

Leeds Teaching Hospitals NHS Trust

Consultant dermatologists at Leeds use teledermatology to review appropriate two-week wait referrals for suspected skin cancer. By screening high quality images for patients with a good history, Leeds is able to return around 30% of cases to GPs without the need for face-to-face consultations.

Leeds provides local GPs with training and equipment to enable them to take and submit three high quality images (locator, macroscopic and dermatoscopic) for suspected skin cancer. GPs submit these images via using Digitally Assembled Referral Toolkit (DART) referral forms on e-RS (e-Referral System).

Consultant dermatologist Dr Walayat Hussain and consultant colleagues then review the referrals daily. GPs and patients are informed of their diagnosis within 48 hours, and told whether the patient requires a hospital clinic appointment.

The team has also developed patient information leaflets. These are integrated into the teledermatology system so that patients and GPs are provided with information at the time it is needed.

Since the service was launched, Leeds calculates that 3,500 unnecessary hospital appointments have been saved. Approximately 120 clinic slots per month are freed for assessing skin cancer patients who do require a hospital appointment.

Similarly, 23.4 hours of consultant time holding consultations per month is saved. This outweighs the amount of time taken to assess images, releasing a net figure of almost 14 hours of consultant time per month to deal with other dermatology patients.

Data so far show no evidence of a higher rate of missed cancers in patients reviewed by the teledermatology service than for patients seen by conventional services.

AI and machine learning in diagnosis, screening and management

Many clinicians in the UK and abroad are working alongside technologists to develop dermatology tools that use AI (artificial intelligence) and ML (machine learning). In the near future, it is likely that AI and ML will integrate with all aspects of medicine, including referral management, triage, teledermatology, secondary care consultations, results interpretation and management of the long-term needs of patients.

There has been research showing that ML can successfully analyse high-quality images to differentiate melanomas (see page 78). The race is now on to introduce efficient systems into clinical care that could help doctors decide whether or not a possible cancer needs surgical removal.

Key targets for development

The e-Referral System (e-RS) Advice and Guidance (A&G) would be an ideal target for those developing AI and ML given its NHS-wide use and integration with existing systems.

Designing effective studies

Comparison studies will be required to evaluate the use of AI and ML systems as diagnostic aids versus face-to-face dermoscopy. These studies must use participant populations that represent those who will be cared for using the systems in practice.

NHS Digital has comprehensive information available for developers who are looking to produce health apps or digital tools. Developers are required to answer a range of questions ensuring safety, clinical effectiveness, data protection and whether or not the product falls under the category of a medical device. It is important that any technology developer works closely with clinicians and the NHS to ensure products are safe and fit for purpose.

Population level screening

A number of tech organisations are developing smart device apps that will offer people the chance to screen their own skin. Such technology offers great opportunities in skin disease and other areas. However, it is important that these apps have a robust evidence base. This will help to ensure that AI and ML improve quality of care and enhance the patient experience without compromising safety.

Accuracy and quality will also be essential to avoid overwhelming NHS services. There are over 50 million people in England, each with an average of over 20 pigmented areas on their skin: that's over 1 billion pigmented lesions in England. About 16,000 melanomas per year are detected in the UK, meaning the risk of any one pigmented lesion being a melanoma is less than 1 in 62,000.

In order to avoid missing melanomas, any app would have to be calibrated to identify some benign lesions as being cancer: this would be a false positive. Even if this was only 1 in 100 benign lesions, then the NHS could find itself with up to 10 million worried members of the public seeking a primary or secondary care appointment for reassurance and requesting surgery.

There are ways to mitigate these risks and it is essential these measures are put into place so that the public and health providers get maximum benefit from the technology.

Recommendations

Recommendation	Actions	Owners	Timescale
19. Review teledermatology services to inform trust-level investment and resourcing decisions.	**a** NIHR to fund studies evaluating the efficacy, safety and efficiency of teledermatology with full health economic assessment.	NIHR	2 years
	b Assess teledermatology services based on the points described in our report when considering whether to invest.	Trusts; CCGs	6 months
	c Trusts/CCGs to publish research and learning from teledermatology services so that others can learn lessons and share best practice. The FutureNHS Collaboration Platform is set up for this.	Trusts; CCGs	12 months
	d Offer patients the electronic referral system (e-RS) Advice and Guidance Service.	Trusts	For immediate action
	e Include time spent providing Advice & Guidance and teletriage in the job plans for dermatologists.	Trusts	6 months
	f Support services keen to innovate in this area, in line with the recommendations in actions 19b and 19c.	GIRFT; trusts; CCGs; NOTP	Immediate
	g Prepare teledermatology services and other clinical services for the introduction of AI and machine learning.	Trusts	18 months

Telephone and video outpatient consultations

Telephone outpatient consultations are popular with many patients and offer the potential to reduce follow-ups, save clinic space, and ease car parking and local road traffic pressures. They can be particularly useful for disease monitoring clinics and may be an area where specialist nurses can contribute skills.

There was a big increase in the use of telephone consultations between 2018 and 2019, with 51% of trusts now using them, as shown in Table 8. Telephone consultations backed up with photography further increased in all departments during the COVID-19 pandemic. It seems likely that most departments will increasingly adopt telephone consultations for suitable patients. It is important that guidance and protocols are established to support the safe uptake of this useful technology.

The COVID-19 pandemic saw an increase in the use of video consultations. Some departments found them a useful way to see patients who were unable to attend hospital, but others found them impractical. Early reports suggest these consultations were often slower than face-to-face consultations. There were some difficulties in seeing certain body areas, such as genitals and scalp, and in being able to get close-up views of lesions. There were also child protection concerns in relation to genital examinations, consent, and recording and storing videos.

Job planning

Telephone and video outpatient consultations are equivalent to clinic activity and generate administrative work, so should be job planned.

Table 8: Telephone outpatient consultations

Telephone outpatient consultations	Source and year	% Yes	% No	Responses
Does your department provide telephone outpatient consultations?	GIRFT questionnaires 2018	35.0%	65.0%	117 repsonses
	GIRFT questionnaires 2019	51.2%	48.8%	123 repsonses
	Change in % response between 2018-19: (20.3%)	16.2%	-16.2%	24 responses updated

Data source: GIRFT questionnaire, 2019.

National Outpatient Transformation Programme

Modernising care delivery by making greater use of telephone and video consultations will be a key priority of the National Outpatient Transformation Programme.

The programme's aim with this initiative will be to deliver efficient care that makes best use of clinical and patient time, streamlines patient interactions between teams, and ensures the best decisions are made.

Recommendations

Recommendation	Actions	Owners	Timescale
20. Increase use of telephone outpatient consultations.	**a** Introduce telephone consultations for appropriate dermatology patients.	Trusts	For immediate action
	b Include telephone outpatient clinics in job plans.	Trusts	For immediate action
	c Provide guidance and protocols for effective use of telephone and video consultations in dermatology.	NOTP	For immediate action

Nurses as principal investigators for research

The National Institute of Health Research (NIHR) Clinical Research Network is the government funded body that supports high-quality clinical research in healthcare, including in the NHS. It is not unusual for the NIHR to be supporting over 50 studies of new dermatology treatments across 230-plus departments and clinics at any one time. There is good evidence that centres that do more research have better clinical outcomes, so research initiatives should be encouraged.

There is growing recognition that nurses working in research can contribute clinical, managerial and leadership skills to support NIHR clinical studies. This offers the potential to facilitate research programmes in trusts. For example, a nurse could take on the responsibility for local recruitment and delivery of multicentre studies as a principal investigator (PI).

We support the dermatology NIHR programme's aim to develop nurse PIs in every region to improve recruitment and research participation for patients. This initiative will:

- free-up consultant time;
- increase dermatology nurses' motivation to increase their specialist interest in an area of research;
- increasing nurses' dermatology skills and knowledge;
- support nurse retention in the NHS;
- offer more patients an opportunity to participate in research – with the aim of improving their outcomes.

CASE STUDY

Establishing a clinical research unit

Harrogate and District NHS Foundation Trust

Professor Alison Layton in Harrogate has developed a successful clinical research unit in a district general hospital setting. The unit specialises in androgen-related skin disorders, particularly acne and associated endocrinopathies, and has attracted research funding, employed research nurses and enabled many patients to benefit from being involved in clinical research. An ongoing research programme in the dermatology department involves all the team in identifying patients who might wish to take part in research.

The unit has engaged with the Yorkshire and Humber Clinical Research Network, and delivers non-commercial and commercial NIHR clinical trials. It has also developed a supra-regional dedicated acne service.

Over the last 15 years, the unit has built a large dataset as part of an ethically approved acne registry. This has enabled research aimed at understanding epidemiology and improving outcomes for acne. The results of this research have been adopted across the care pathway for acne patients in national and international guidelines.

As well as supporting the dermatology research programme, Harrogate's development of research nurses and support in them working towards principal investigator roles has further motivated and encouraged those nurses to stay in the unit. This means their key expertise and knowledge is retained.

BADBIR (British Association of Dermatologists' Biologics and Immunomodulator Register)

BADBIR (British Association of Dermatologists' Biologics and Immunomodulator Register) is a study consisting of a national registry to assess the safety and efficacy of new psoriasis biologics drugs (see page 84) in comparison to conventional treatments. NICE encouraged the establishment of this registry, recommends that patients should be given the opportunity to participate in it, and is monitoring the results of the research.

Most, but not all, trusts recruit patients to BADBIR, as shown on Figure 33. We encourage all trusts to support the recruitment of patients to BADBIR and to the forthcoming similar registry study for eczema biologics called A*STAR.

B-STOP and PSORT

Two associated studies are also currently considering genomics and other genetic factors of psoriasis. These studies (see page 90) are the Biomarkers of Systemic Treatment Outcomes in Psoriasis study (B-STOP) and Psoriasis Stratification to Optimise Relevant Therapy (PSORT). Data from these studies should enable future generations to benefit from medical treatment that is safer, more effective and more personalised.

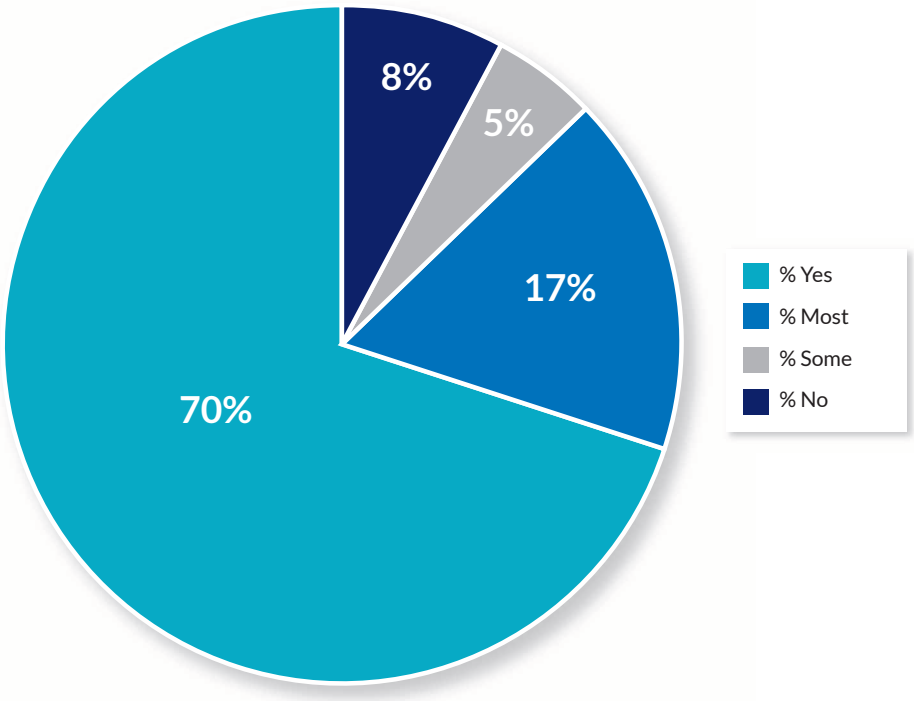
Dermatology research

Patients and departments involved in clinical research have better clinical outcomes. We support the development of high-quality clinical research such as BADBIR. Many high-quality clinical studies like BADBIR are running across the country, which are listed on the NIHR dermatology portfolio. We support the development of high-quality clinical research.

- The British Skin Foundation charity raises funds for research into skin disease.
- UK Trend, run by the BAD, translates ideas from basic laboratory research into clinical research studies.
- The UK Dermatology Clinical Trials Network is a charity with over 800 doctors, nurses, patients and researchers. It produces and runs evidence-based clinical research, often in overlooked common diseases and treatments.
- The National Institute of Health Research (NIHR) is a government funded body supporting high-quality clinical research with over 50 dermatology studies running in over 230 sites at any one time.

Figure 33: Trusts that are asking patients on biologics for consent to be entered on BADBIR

Are consenting psoriasis patients on biologicals entered on BADBIR?



Data source: GIRFT questionnaire, 2018

Medication safety hazards

We have been working with representatives of NHS England, NHS Improvement and the BAD to find solutions to some safety hazards.

Deaths and serious harm following ingestion of potassium permanganate

Potassium permanganate is an antiseptic often used in the treatment of elderly people suffering from leg ulcers or swollen legs due to lymphoedema and eczema. It is available in tablets and crystal form to be diluted in water. When diluted, it creates a red/purple solution that looks like fruit juice or wine.

There have been a number of cases of elderly people mistaking the solution for a drink and drinking it. As potassium permanganate is corrosive, this has led to several deaths and many serious incidents in hospitals, nursing homes and at patients' homes.

There have also been cases of people being given the tablets in error by nurses who have mistaken them for a potassium supplement.

Emollient fire hazard

Any sort of cream or hair product leaves an oily residue. This includes over-the-counter creams, most cosmetics and medication creams. Over time, this residue accumulates on bedding and clothes, despite washing, as well as on skin and hair. If the clothing or bedding then comes into contact with a flame it can catch fire.

The Medicines and Healthcare products Regulatory Agency (MHRA) has heard from the fire services of over 50 fatalities resulting from such incidents. MHRA has issued an advisory notice to extend the risk of severe and fatal burns to all paraffin-based emollients, regardless of paraffin concentration.[47]

Recommendations

Recommendation	Actions	Owners	Timescale
21. Ensure the public, patients and clinicians have access to the latest research studies, information and support to implement national safety recommendations.	**a** Improve awareness and support implementation of national actions related to: • risks of fire associated with use of skin creams and cosmetics containing any oil • risks of accidental ingestion of potassium permanganate antiseptic tablets and solutions • future safety issues when they arise.	GIRFT, BAD, MHRA NHS England and NHS Improvement national patient safety team	For immediate action
	b Encourage all trusts to increase recruitment to clinical research to improve patient outcomes.	NIHR, other dermatology research organisations, Trusts, CCGs	18 months
	c Continue to share learning about patient safety issues with the whole multidisciplinary team.	Trusts	Ongoing
	d Report adverse incidents through appropriate channels.	Trusts	For immediate action
	e Continue to work with NHS England and NHS Improvement and the MHRA to review skin product formulation and packaging to reduce the risk of avoidable patient harm.	GIRFT, BAD	Ongoing

[47] *https://www.gov.uk/drug-safety-update/emollients-new-information-about-risk-of-severe-and-fatal-burns-with-paraffin-containing-and-paraffin-free-emollients*

Procurement

Reducing unwarranted variation in procurement will improve NHS buying power and use resources better. The Department of Health and Social Care is supporting a number of procurement initiatives to help trusts reduce variation in procurement.

Important areas of focus include teledermatology and future artificial intelligence applications. It is important that trusts consider a robust evidence base for these before making what will be major purchasing decisions.

Current variation

In 2016, NHS Improvement mandated that all trusts must submit their monthly purchase order data to a central database, called the Purchase Price Index & Benchmarking data tool (PPIB). This was the first time a single national dataset of NHS procurement information had been collected.

For the last 18 months, the GIRFT programme has been analysing this data to better understand the variation in products and brands used, and prices paid, across NHS trusts. The results of this analysis, highlighting examples of extreme variation in product, brand and price, has been a feature of previous GIRFT reports. Over this time, it has become increasingly clear that variation is often down to clinical choice. There is a growing list of examples where the evidence-base to support product and brand selection has been weak and, in some cases, patient safety has been compromised. These findings have received media attention and have prompted debates in the House of Commons and House of Lords to determine what can be done to improve the situation.

Extreme variation in procurement choices not only compromises patient safety, but it also adds significant costs to the NHS Supply Chain. Every brand used requires inventories and dilutes NHS purchasing power. Addressing this variation improves safety and effectiveness as well as facilitating better value for money.

Eliminating unwarranted variation

GIRFT has established a programme to identify and analyse unwarranted variation in procurement in the NHS. The programme aims to:

- improve the evidence-base to enable better decision-making;
- accelerate adoption of new proven technologies;
- improve overall value for money by reducing supply chain costs.

The GIRFT Clinical Technology Optimisation programme works with GIRFT clinical leads to examine the data and evidence that support products. In some specialties, the programme has established national Clinical Technology Advisory Panels (CTAPs) that include leading clinicians. These CTAPs address product safety, effectiveness, innovation and value with the aim of providing better information to NHS clinicians and procurement professionals.

NHS Spend Comparison Service

NHS England and NHS Improvement recently launched a new NHS Spend Comparison Service to replace the PPIB dataset.[48] The new service allows trusts to compare the products they use and prices they pay with other NHS trusts.

The service is currently targeted at NHS procurement staff, but GIRFT is working to tailor the data for medical directors and NHS clinicians. We will map procurement data to clinical outcome and HES data, so clinicians can better understand the consequences of their procurement decisions.

Category towers

GIRFT has been working with the new NHS operating model for NHS procurement, including the 11 new procurement initiatives, to help trusts and clinicians address variation and improve value for money.

These 11 initiatives are called category towers and will deliver the future operating model for medical, capital and non-medical areas of the procurement spend. Office solutions (category tower 9) will be the first of these to go live.

We encourage trusts to work with the new category towers to support the rationalisation and standardisation of procurement.

[48] *https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/spend-comparison-service*

Developing a greater understanding of variation

The GIRFT programme recognises that there are often sound clinical reasons behind choices of device and treatment methods. Patient outcomes, product evidence and product innovation are key considerations, alongside supply chain efficiency and best value.

The GIRFT procurement team is working with GIRFT clinical leads and trusts to understand more about the variation in procurement costs. As part of this process, the team will provide trusts with data and ask medical and procurement teams to validate and provide evidence for their procurement choices.

Recommendations

Recommendation	Actions	Owners	Timescale
22. Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.	**a** Use sources of procurement data, such as the NHS Spend Comparison Service and relevant clinical data, to identify optimum value for money procurement choices, considering both outcomes and cost/price.	Trusts	6 months
	b Identify opportunities for improved value for money, including the development of benchmarks and specifications. Locate sources of best practice and procurement excellence, identifying factors that lead to the most favourable procurement outcomes.	Trusts	12 months
	c Use Category Towers to benchmark and evaluate products and seek to rationalise and aggregate demand with other trusts to secure lower prices and supply chain costs.	Trusts	12 months

Reducing litigation

As well as addressing variation in clinical practice, each GIRFT review assesses the impact and causes of litigation.

Giving providers and clinical staff the opportunity to learn from best practice, claims, complaints, patient safety incidents (PSIs)/serious incidents (SIs) and inquests will help improve patient care, reduce length of stay and reduce the frequency of incidents. In turn this will lead to reduced costs, both in terms of litigation itself and of managing complications related to incidents.

Our review

We reviewed all claims data relating to dermatology; not just the data relating to the 123 units in our questionnaire sample. This enabled us to look at litigation relating to NHS dermatology services as a whole, including litigation data from some smaller centres and from independent providers of NHS care. This means the total volume and cost of claims presented in this report differs from the data packs we used in our deep dive visits.

Additionally, our analysis in this report estimates the costs of claims at the same point in every year to enable us to make a year-on-year analysis. This contrasts to the provider datapacks, where we estimated costs over a five-year period.

Clinical negligence claims in dermatology

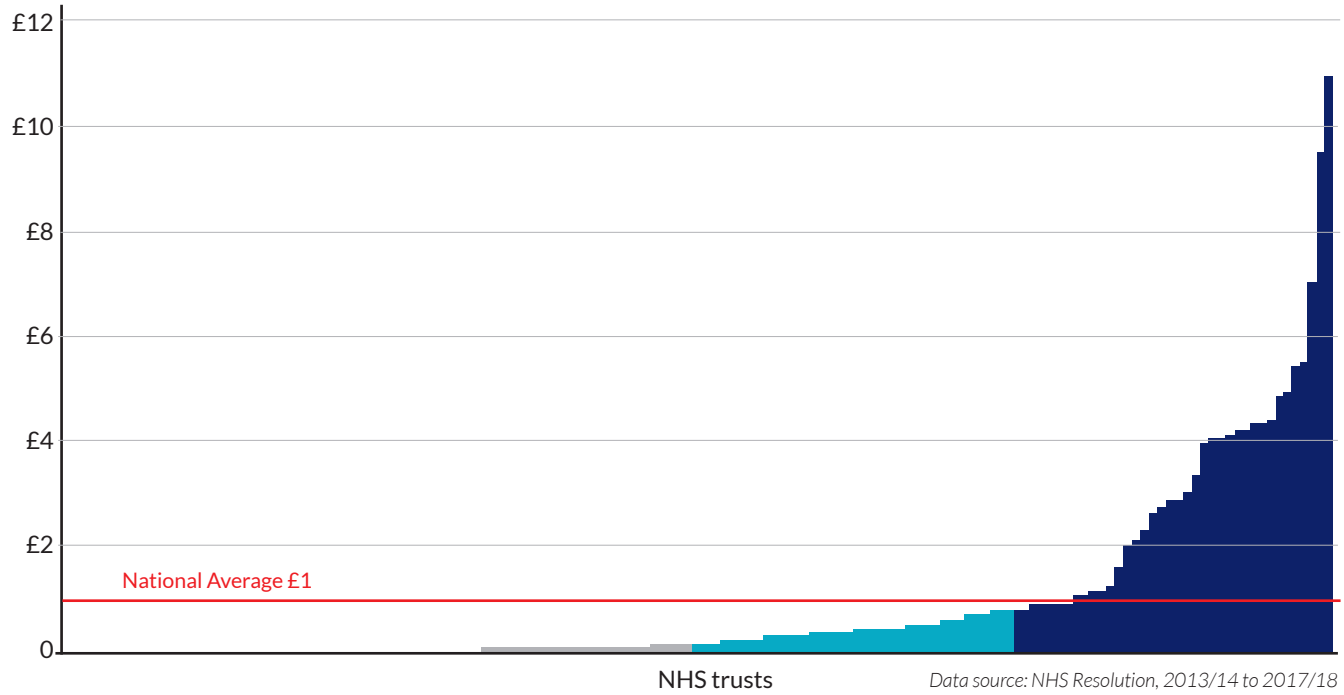
NHS Resolution data shows that the average total cost of clinical negligence claims in dermatology was estimated to be £5.2m per year from 2013-18.

The average cost of a dermatology litigation claim during this period was £76,706, with the average cost per dermatology consultation or operation being £1.

Variation in average litigation costs

There is noticeable variation in litigation costs between providers. Nearly half of all providers faced no litigation over the five-year period we looked at. Therefore, the best performing providers have average litigation costs of £0 per activity, while the provider with the highest costs generates an average £11 of litigation costs per activity. The variation is primarily due to a small number of high cost claims, particularly when these have occurred in small departments.

Figure 34: Estimated litigation costs for dermatology per activity



Data source: NHS Resolution, 2013/14 to 2017/18

The activity denominator includes all day case activities, outpatient procedures and attendances, for patients of all ages.

Claims trends and causes

Trends

There was a steady fall in the estimated costs of claims over the three-year period from 2015/16 to 2017/18, as shown in Table 9. This has been accompanied by a favourable trend in claims volume reported.

As most of the cost is related to a few claims per year, the figures may just reflect a statistical variation rather than a true trend.

Table 9: Volume and cost of medical negligence claims against dermatology notified to NHS Resolution – 2013/14 to 2017/18

Year	Number of claims	Percentage change in number of claims (%)	Total cost (£m)	Percentage change in total costs (%)
2013/14	71	-	£5.71m	-
2014/15	78	10%	£6.19m	8%
2015/16	65	-17%	£5.44m*	-13%
2016/17	61	-6%	£4.44m	-20%
2017/18	62	2%	£4.07m	-8%
Total	337	-	£25.85m	-

Data source: NHS Resolution, 2013/14 to 2017/18

**2015/16 total costs of claim has been reduced by updating the valuation one claim which dropped from £3.3m at its notification year end to £13,666 as at the end of March 2018. It is unusual to have this level of claim in dermatology. The claim was successfully defended, with the NHS paying its own legal costs only.*

Claims are often multifactorial, which can mean that a claim may be attributed to more than one cause. This explains the difference between the total number of claims during the period and the sum of claims for each of the common causes being more than 100%.

The most common causes of claims were the following:

- treatment (166 claims, 42%);
- diagnosis (120 claims, 30%);
- surgery/procedure (79 claims, 20%);
- nursing/assistance care (15 claims, 4 %);
- infection/sepsis (5 Claims, 1%).

Surgery/procedure and infection/sepsis

There were 79 claims related to skin surgery/procedure and five claims related to wound infections or sepsis from other causes.

In 2019, the BAD conducted a baseline audit to measure the quality of the dermatology skin surgery service. It is paramount that dermatology units meet NICE skin cancer standards in order to ensure safe and effective care is provided to all patients.

The BAD has produced a series of service standards using a NICE-approved process. Completion of these has been recommended to all trusts visited by GIRFT to improve patient safety.

Informed consent

23 of the 79 claims that were related to surgery/procedure were due to failure to warn/informed consent.

The Montgomery ruling in 2015 emphasised the importance of clinicians discussing all available treatment options, including conservative treatment, with patients. The discussion must be tailored to the individual patient and clinicians must inform the patient of all material risks associated with the proposed procedure.

The consent process should allow patients, and where possible family and carers, sufficient time to have a detailed conversation with the clinician to reach a supported decision. Clinicians must record key elements of their discussion with the patient in the patient's medical records and written information detailing risks and benefits of their treatment options should be provided to the patient.

There is more information on consent on the BAD and GMC websites.[49]

Wrong site surgery

25 claims (7%) were related to wrong site surgery, which is a never event and should never happen (see NHS Improvement Never Events list).

Never events represent a systematic failure to ensure patient safety and must be eradicated by more diligent organisation and closer adherence to tools including the WHO Surgical Safety Checklist. Implementing the recommendations we make in relation to medical photography (see page 74) will help to reduce dermatology never events.

Psoriasis treatment

13 claims (3%) were related to treatment of psoriasis and two of these led to fatality.

NICE has produced guideline CG153 Psoriasis: assessment and management,[50] and the BAD has produced clinical guidelines for management of psoriasis.[51] When assessing and treating patients with psoriasis, clinicians must ensure they comply with these national standards.

Diagnosis

81 out of the 120 claims related to diagnosis were specifically related to failure/delay in diagnosis, while 26 were directly related to failure to perform tests/interpret results.

It is clear that many of the claims associated with failure or delay in diagnosis are related to experience and decision-making. The workforce shortages in dermatology mean there are some long-term locum dermatologists who are not on the GMC specialist register and who move from trust to trust. We have made recommendations elsewhere in this report to address workforce and training issues. Implementation of those recommendations will help to reduce failures and delays in diagnosis.

Nursing care/assistance

15 claims (4%) were related to inadequate nursing care/assistance.

When reviewing claims trusts should ensure all clinical staff involved in patient care are included in their governance structure to maximise learning from claims and the sharing of this learning.

Sharing information effectively to reduce claims

Despite the relatively low volume and encouraging trend in claims volume and cost, every effort must be made to learn from clinical negligence claims in order to improve future practice. A good example of this working in practice are the lessons that have already been learnt about the benefits of using photography to reduce the chances of wrong site surgery.

A key step for learning and improvement to take place is to ensure that clinicians and managers have a full and shared understanding of their trust's claims history. It was clear from our deep dive visits that many providers have little knowledge of the claims against them.

In some trusts, managers felt that the clinicians had been informed about claims, yet this belief was not shared by clinicians who denied knowledge of these. This suggests that a different approach towards engaging with clinicians is required. The GIRFT 5-point plan, described below, sets out a process for reviewing claims and sharing learning so that both clinicians and managers are aware of relevant claims and that all opportunities for learning are maximised.

On a positive note, clinicians were generally enthusiastic and interested to find out more about their trust's claims history. In all trusts that had experienced claims, the clinicians agreed to review details of those claims in their governance meetings.

[49] *BAD Consent https://www.bad.org.uk/healthcare-professionals/clinical-services/consent#*
GMC Consent: patients and doctors making decisions together https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent

[50] *NICE (2012, updated 2017) Psoriasis: assessment and management (CG153), https://www.nice.org.uk/guidance/cg153*

[51] *BAD Psoriasis guidance, http://www.bad.org.uk/healthcare-professionals/psoriasis*

Sharing details of the existence and cost of litigation claims

Further work is needed at both a local and national level to analyse and share claims data in order to improve patient care. We found that most trusts are already engaged in this process.

Concerns over investment costs

A number of trusts expressed their concern at the potential investment required to eliminate never events. For example, the costs involved in establishing effective photography services.

We urge trusts to continue to discuss the required investment with commissioners and for all parties to work together to ensure that patient safety is prioritised.

Recommendations

Recommendation	Actions	Owners	
23. Implement the GIRFT 5-point plan for reducing litigation costs.	**a** Clinicians and trust management to assess their benchmarked position compared to the national average when reviewing the estimated litigation cost per unit of activity.	Trusts	For immediate action
	b Clinicians and trust management to discuss with the legal department or claims handler the claims submitted to NHS Resolution included in the data set to confirm correct coding to that department. Inform NHS Resolution of any claims that are not coded correctly to the appropriate specialty via CNST.Helpline@resolution.nhs.uk	Trusts	On completion of A
	c Once claims have been verified, clinicians and trust management to further review claims in detail, including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If the legal department or claims handler needs additional assistance with this, each trust's panel firm should be able to provide support	Trusts	On completion of B
	d Claims should be triangulated with learning themes from complaints, inquests and serious incidents (SI). Where a claim has not already been reviewed as SI, we recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared with all front-line clinical staff in a structured format at departmental/ directorate meetings (including multidisciplinary team meetings, and morbidity and mortality meetings where appropriate).	Trusts	On completion of C
	e Where trusts are outside the top quartile of trusts for litigation costs per activity, GIRFT will be asking national clinical leads and regional hubs to follow up and support trusts in the steps taken to learn from claims. Clinical leads and regional hub directors will also be able to share examples of good practice with trusts.	GIRFT hubs	For continual action throughout GIRFT programme

Financial impact statement

Potential benefits

This report sets out a series of ways to improve the delivery of dermatology services.

Improvements to the patient experience would be seen in more equitable access to treatment, fewer admissions, and fewer repeat visits. All of these also benefit providers, reducing the costs of common procedures and pathways and freeing up resource for other purposes. While the impact in some areas is hard to measure, in others there is a clear tangible benefit.

Notional financial opportunity

The notional financial opportunity could be between £20m and £35.5m a year. These figures provide an estimated financial value for a wide range of efficiency opportunities, which may not all be cash releasing.

The figures are based on a selection of metrics (Table 10) and provide an indication of what may be possible. The metrics do not represent a comprehensive set of all opportunities discussed in the report. The gross notional financial opportunities put an estimated value on the resource associated with variation based on all providers achieving at least the average or best quartile performance. The opportunities are not cash-releasing efficiency savings.

In addition to the specific areas outlined in the table, the report has identified a total spend of £26m on litigation over a five-year period. We expect the implementation of the GIRFT Programme's five-point plan should improve patient safety and reduce litigation costs for the specialty.

Further opportunities

The opportunity values shown are for illustration only. Individual providers and clinicians should assess their own services to determine the unwarranted variation that exists and the associated opportunity. Their assessment will help them to prioritise the service changes that they wish to deliver. Individual providers may also have other opportunities that are not included here.

Table 10: Notional financial opportunity

Improvement	Standard			Target		
	Target	Activity opportunity*	Gross notional financial opportunity**	Target	Activity opportunity*	Gross notional financial opportunity**
Reduce outpatient follow-ups *(Recommendation 5)*	*Providers above national average moving 25% closer to national average*			*Providers above national average moving 40% closer to national average*		
Opportunity: Reduce unnecessary outpatient follow-up activity. *Base data: HES April 18 - Mar 19.* *Cost estimated on cost of face-to-face outpatient follow-ups in dermatology specialties.*	2.28 follow-ups per new attendance (national average)	78,000 follow-up attendances	£9.1m	2.28 follow-ups per new attendance (national average)	125,000 follow-up attendances	£14.6m

Table 10: Notional financial opportunity (continued)

Improvement	Standard			Target		
	Target	Activity opportunity*	Gross notional financial opportunity**	Target	Activity opportunity*	Gross notional financial opportunity**
Reduce adult DNA rates *(Recommendation 5)* Opportunity: Reduce adult DNA rates in outpatients. *Base data: HES April 18 - Mar 19.* *Cost estimated on cost of face-to-face outpatient in dermatology specialties, based on 17/18 Reference Costs (inflated to 2020/21).*	*National average* 7.11%	32,200 outpatient attendances	£4m	*Best quartile* 5.16%	73,700 outpatient attendances	£9.1m
Reduce paediatric DNA rates *(Recommendation 5)* Opportunity: Reduce paediatric DNA rates in outpatients. *Base data: HES April 18 - Mar 19.* *Cost estimated on cost of face-to-face outpatient in dermatology specialties..*	*National average* 11.28%	5,800 outpatient attendances	£0.7m	*Best quartile* 8.56%	12,600 outpatient attendances	£1.6m
Reduce unnecessary biopsies Opportunity: Reduce unnecessary biopsy activity. *Base data: HES April 18 - Mar 19.* *Cost estimated on cost of biopsy activity.*	*Providers above national average moving 25% closer to national average* 14.59% (national average)	6,000 procedures	£1.1m	*Providers above national average moving 50% closer to national average* 14.59% (national average)	12,100 procedures	£2.3m
Increase use of telephone consultations for outpatient follow-ups *(Recommendation 20)* Opportunity: Increase use of telephone consultations (rather than face-to-face appointments). *Base data: HES April 18 - Mar 19.* *Cost estimated on cost differential between face-to-face and non-face-to-face outpatient consultations*	*National average* 2.58%	25,700 outpatient attendances	£1.5m	*Best quartile* 5%	54,300 outpatient attendances	£3.2m

Table 10: Notional financial opportunity (continued)

Improvement	Standard			Target		
	Target	Activity opportunity*	Gross notional financial opportunity**	Target	Activity opportunity*	Gross notional financial opportunity**
Reduce locum spend *(Recommendation 3)* Opportunity: reduce additional cost associated with using locums. *Base data from questionnaires.* *Cost estimated at £60k additional cost per locum - based on NHS Improvement agency price cap, which is likely to be an underestimate of actual costs*	*Reduce locums by 15%*	21 locum WTEs	£1.3m	*Reduce locums by 20%*	29 locum WTEs	£1.7m
Reduce inappropriate referrals to dermatology *(Recommendation 9)* Opportunity: reduce inappropriate referrals, avoiding outpatient activity. *Base data HES April 18 - Mar 19 by CCG, compared to CCG populations.* *Cost estimated on cost of first face-to-face outpatient attendance*	*CCGs above national average moving 15% closer to national average* 12.9 per 1,000 population (national average)	16,700 first outpatient attendances	£2.3m	*CCGs above national average moving 20% closer to national average* 12.9 per 1,000 population (national average)	22,300 first outpatient attendances	£3m
Total			**£20m**			**£35.5m**

** Activity opportunities are annual figures.*

***Costing financial opportunity: unless otherwise stated, cost estimates are based on national average of 17/18 reference costs, uplifted to 20/21 pay and prices using tariff inflation.*

About the GIRFT programme

Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS. Funded by the Department of Health and Social Care and jointly overseen by the Royal National Orthopaedic Hospital NHS Trust, NHS England and NHS Improvement, it combines wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience, without the need for radical change or additional investment. While the gains for each patient or procedure may appear marginal they can, when multiplied across an entire trust – and even more so across the NHS as a whole – deliver substantial cumulative benefits.

The programme was first conceived and developed by Professor Tim Briggs to review elective orthopaedic surgery to address a range of observed and undesirable variations in orthopaedics. In the 12 months after the pilot programme, it delivered an estimated £30m-£50m savings in orthopaedic care – predominantly through changes that reduced average length of stay and improved procurement.

The same model is now being applied in over 40 different areas of clinical practice. It consists of four key strands:

- a broad data gathering and analysis exercise, performed by health data analysts, which generates a detailed picture of current national practice, outcomes and other related factors;
- a series of discussions between clinical specialists and individual hospital trusts, which are based on the data – providing an unprecedented opportunity to examine individual trust behaviour and performance in the relevant area of practice, in the context of the national picture. This then enables the trust to understand where it is performing well and what it could do better – drawing on the input of senior clinicians;
- a national report, that draws on both the data analysis and the discussions with the hospital trusts to identify opportunities for NHS-wide improvement;
- an implementation phase where the GIRFT team supports providers to deliver the improvements recommended.

GIRFT and other improvement initiatives

GIRFT is part of an aligned set of workstreams within NHS England and NHS Improvement. It is the delivery vehicle for one of several recommendations made by Lord Carter in his February 2016 review of operational efficiency in acute trusts across England. As well as support from the Department of Health and Social Care and NHS England and NHS Improvement, it has the backing of the Royal Colleges and professional associations.

GIRFT has a significant and growing presence on the Model Hospital portal, with its data-rich approach providing the evidence for hospitals to benchmark against expected standards of service and efficiency. The programme also works with a number of wider NHS programmes and initiatives which are seeking to improve standards while delivering savings and efficiencies, such as NHS RightCare, acute care collaborations (ACCs), sustainability and transformation partnerships (STPs), integrated care systems (ICSs) and the Evidence-Based Interventions programme.

Implementation

GIRFT has developed a comprehensive implementation programme designed to help trusts and their local partners to address the issues raised in trust data packs and the national specialty reports to improve quality. GIRFT regional hubs provide support at a local level with clinical and project delivery leads able to visit trusts and local stakeholders in each region on a regular basis. They advise on how to reflect the national recommendations into local practice and support efforts to deliver any trust specific recommendations emerging from the GIRFT visits. These teams also help to disseminate best practice across the country, matching up trusts who might benefit from collaborating in selected areas of clinical practice.

Through all its efforts, local or national, the GIRFT programme strives to embody the 'shoulder to shoulder' ethos that has become GIRFT's hallmark, supporting clinicians nationwide to deliver continuous quality improvement for the benefit of their patients.

Glossary

Acute care collaborations (ACCs)
A group of NHS trusts working together to improve their clinical and financial viability in delivering acute care, reducing variation in care and efficiency. For example, hospitals working together as groups or chains, specialty franchises and clinical networks. Part of NHS England's new care models programme.

https://www.england.nhs.uk/new-care-models/about/acute-care-collaboration/

Allergy patch testing
A test to investigate eczema that may be caused by an allergen. A small amount of suspected allergens are applied to the skin and then monitored over five days.

Alopecia areata
A common cause of hair loss, often affecting children and young adults.

Basal cell carcinoma (BCC)
A type of non-melanoma skin cancer. BCC accounts for about 75 in every 100 skin cancers and is the commonest cancer in the UK.

BCC and squamous cell carcinoma (SCC) are the two most common types of non-melanoma skin cancer.

Casemix
The type or mix of patients, categorised by a variety of measures, including: demographics, disease type and severity, and the diagnostic or therapeutic procedures performed.

Category towers
The procurement function of the NHS Supply Chain operating model. There are 11 category towers, with each one specialising in a particular area of products or services, for example medical equipment.
www.supplychain.nhs.uk/sccl

Clinical Commissioning Groups (CCGs)
Clinically-led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area. *www.nhscc.org/ccgs/*

Clinical Research Network
Networks that coordinate and support the delivery of clinical research in healthcare. Coordinated by the NIHR.

Commissioning
The various processes that identify the health needs of a population, such as a local area, and purchase services to meet those needs.

Comorbidity
The simultaneous presence of two or more chronic (long-term) diseases or conditions.

Consultant dermatologist
A medical doctor who has completed a training programme placing them on the General Medical Council (GMC) specialist register, available to search on the internet.

Day case
When a patient is admitted electively for care that day, with the use of a hospital bed or recliner chair, but without an overnight stay.

Day of surgery admission
Admission to hospital on the same day that surgery takes place.

Dermatology Clinical Reference Group (CRG)
The Clinical Reference Group for dermatology that commissions some specialised dermatology treatments.

Eczema (also known as dermatitis)
An itchy skin disease affecting 20% of children. It is the commonest reason for children to attend a doctor. It can be inherited and, in adults and children, has many possible causes.

Elective (surgery or care)
Surgery or care that is planned rather than carried out as an emergency (non-elective).

GPwER (GP with Extended Roles)
A GP who has undergone specific training and re-accreditation to carry out work beyond their regular GP training. The extended role is typically carried out under a separate commissioning agreement.

GRADE (Grading of recommendations, assessment, development and evaluations)
A widely-accepted evidence-based methodology for developing and presenting evidence and making recommendations.

Healthcare Resource Group (HRG)
Standard groupings of clinically-similar treatments that use common levels of healthcare resource. HRGs help organisations to understand their activity in terms of the types of patients they care for and the treatments they undertake.

Histopathology
The microscopic examination of tissue samples.

Hospital Episode Statistics (HES)
Data on all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. HES data aim to collect a detailed record for each 'episode' of admitted patient care commissioned by the NHS and delivered in England, by either an NHS hospital or the independent sector. HES data are used in calculating what hospitals are paid for the care they deliver.

Hyperhidrosis
Disabling excessive sweating, often of the hands, which can make using touchscreens or keyboards impossible. Often treated by iontophoresis or injection of botox.

Integrated care systems (ICS)
NHS organisations, in partnership with local councils and others, taking collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.
www.england.nhs.uk/integratedcare/integrated-care-systems

Length of stay
The length of an inpatient episode of care, calculated from the day of admission to day of discharge, and based on the number of nights spent in hospital.

Lichen sclerosus
Lichen sclerosus is a skin condition that causes scarring and increased cancer risk on the genitals. Treatment can relieve the symptoms and reduce cancer risk.

Model Hospital
A free digital tool provided by NHS Improvement to enable trusts to compare their productivity and identify opportunities to improve. The tool is designed to support NHS provider trusts to deliver the best patient care in the most efficient way. https://model.nhs.uk

Mohs micrographic surgery (Mohs)
A specialised form of surgery to remove certain skin cancers, usually BCCs.

MRSA (methicillin-resistant Staphylococcus aureus)
A type of bacteria that's resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections. Sometimes called a 'superbug.

Multidisciplinary team (MDT)
A team of healthcare professionals from different disciplines.

National Clinical Improvement Programme (NCIP)
A programme to provide both team- and clinical-level activity and metrics about the whole of a clinician's practice. It aims to provide a single point of access to existing information from Hospital Episode Statistics(HES), audit and registry, and private sector.
https://gettingitrightfirsttime.co.uk/associated-projects/ncip/

National Institute for Health and Care Excellence (NICE)
Provides evidence-based guidance, advice, quality standards, performance metrics and information services for health, public health and social care. www.nice.org.uk

NHS Resolution (formerly the NHS Litigation Authority)
Provides expertise to the NHS to resolve negligence concerns, share learning for improvement and preserve resources for patient care. NHS Resolution is an arm's length body of the Department of Health and Social Care. This means it is an independent body, but can be subject to ministerial direction.
www.resolution.nhs.uk

NHS RightCare
An NHS England programme that works locally with systems (bodies involved in delivering services) to diagnose issues, develop solutions and deliver improvements.
www.england.nhs.uk/rightcare

National Institute of Health Research (NIHR)
The UK's largest funder of health and care research. Primarily funded by the Department of Health and Social Care.

National Outpatient Transformation Programme (NOTP)
National Outpatient Transformation Programme supports the redesign of clinical pathways in high volume specialties, including dermatology, so that patients can get the advice and care they need in the right place the first time, with shorter waits and fewer trips to hospital.

NHS Supply chain
An organisation that provides healthcare products and supply chain logistics to the NHS, including procurement, logistics, e-commerce, and customer and supplier support.
www.supplychain.nhs.uk

Non-elective (surgery or care)
Surgery or care that is carried out as an emergency rather than being planned (elective).

Patient Level Information and Costing Systems (PLICS)
A system of collecting and deriving costs at the patient level.

Payment by Results (PbR)
The payment system in England used by healthcare commissioners to pay healthcare providers for each patient seen or treated. The system takes account of the complexity of the patient's healthcare needs.

Photodynamic therapy (PDT)
A treatment involving light-sensitising cream and a light source to destroy abnormal cells. Used to treat certain types of skin cancer and pre-cancer.

Phototherapy
A natural or artificial light treatment that works by exposing the skin to ultraviolet A (UVA) or ultraviolet B (UVB) light. Used to treat psoriasis, eczema and vitiligo.

Psychodermatology
Psychodermatology is the branch of dermatology that deals with mental health issues related to dermatology. Conditions such as acne may cause depression or anxiety.

Purchase Price Index and Benchmarking (PPIB)
A system to collect procurement data from NHS trusts that enables trusts to compare and benchmark data.

Reference costs
Reference costs are the average unit cost to the NHS of providing defined services to NHS patients in England in a given financial year. They show how NHS providers spend money to provide healthcare to patients. NHS providers submit reference costs annually.

SAS doctors (specialty doctors and associate specialists)
Hospital medical doctors with at least four years of postgraduate experience, two of which are in their chosen specialty.

Skin melanoma
Melanoma is a type of skin cancer that can spread to other organs in the body. It is one of the commonest causes of cancer death in younger adults.

Special interest (SPIN) module qualification
A form of medical training.

Spell
A period of healthcare, for example a period spent in hospital or admission to hospital.

Squamous cell carcinoma (SCC)
A type of non-melanoma skin cancer. SCC accounts for about 20 in every 100 skin cancers. It can spread to other organs of the body.

Basel cell carcinoma (BCC) and SCC are the two most common types of non-melanoma skin cancer.

Surgical Safety Checklist
The World Health Organisation (WHO) Surgical Safety Checklist is a tool designed to ensure that critical safety measures are performed before, during and after an operation by supporting communication and teamwork between surgeons, anaesthesia providers and nurses.

Sustainability and transformation partnerships (STPs)
Partnerships between NHS providers, CCGs, local authorities and other health and care services to develop proposals for how local areas will work together to improve health and care for their local population. There are 44 STPs.
www.england.nhs.uk/integratedcare/stps

Tinea
A fungal infection affecting the skin, hair, nails and scalp of children and adults causing ringworm. It can allow other serious infections into the body if untreated.

Vitiligo
A condition causing areas of depigmentation. Vitiligo affects around 2% of the population, with the impact usually much greater in those with more pigmented skin. It is sometimes treated with phototherapy.

Acknowledgements

This report is built on the amazing support I have received since I first asked dermatology colleagues for their thoughts on where we should focus our efforts.

Back then, in December 2017, hundreds of dermatology colleagues took the time to respond. The ideas we heard formed the backbone of the questionnaires we sent to every dermatology department in England. As a community, I believe we should be proud that clinical leads at every single one of the 123 departments in England completed the questionnaire, giving us a 100% response.

We received wonderful, friendly hospitality from dermatology clinical and management teams, trust boards, pharmacists, coders, GPs, CCG commissioners at our deep dives. I want to thank all of you for your time and enthusiastic engagement. I hope many of you will recognise your suggestions and observations in this report.

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Emma Jones helped me write all of the 4,000 to 5,000-word local reports with defined actions and recommendations within 48 hours of each hospital deep dive visit.

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GIRFT regional hubs.

Appendix 1: Dermatology workforce data

Region	Substantive medical consultants				Locum medical consultants		Specialist trainees (StRs)		Training towards CESR		Other SAS doctors	GPs	GP trainees	Core medical trainees	Specialist nurses, excluding research nurses
	No.	WTE	No. per million unweighted population	Vacancy WTE	No.	WTE	No.	WTE	No.	WTE	No.	No.	No.	No.	No.
London	198	131	20.1	21	32	24.5	48	44	24	23	17	19	10	5	133
Yorkshire and Humber	52	44.5	9.1	18	20	14.5	23	16.5	8	13	24	27	9	7	158
Cumbria and North East	32	20.5	9.9	4.5	11	7	9	8	2	1.5	4	25	3	1	69
Cheshire and Merseyside	33	26	12.6	6.5	9	8.5	11	10	3	3	4	16	5	2	48
North Midlands	27	33.5	7.1	16.5	14	11	8	7	4	4	8	9	2	0	52
West Midlands	55	50	12.1	8.5	8	11	21	20	2	2.5	12	7	2	2	95
Central Midlands	12	10	4.5	4.5	7	5	8	7.5	2	1.5	6	10	0	2	21
East	63	50.5	9.2	26	32	25.5	19	15	14	12	38	25	9	2	130
Greater Manchester	44	30	14.5	14	22	13.5	17	14.5	0	0	8	18	9	2	48
Lancashire and South Cumbria	8	7.5	4.5	3	6	5.5	2	1.5	5	4.5	5	0	2	0	34
South West South	30	22.5	9.4	15.5	11	5.5	7	6.5	6	3.5	35	26	6	0	79
South West North	32	26.5	12.4	6.5	6	1.5	8	5.5	2	2	8	17	4	0	38
Hampshire, Isle of Wight and Thames Valley	44	32.5	9.8	5.5	4	5	11	11	0	0	17	13	5	2	81
Kent, Surrey and Sussex	29	23	6.1	9	8	6	14	8.5	10	9.5	8	14	14	1	42
NHS England	659	508	11.2	159	190	144	206	175.5	82	80	194	226	80	26	1,028

Data source: GIRFT

Appendix 2: Example of a clinical threshold policy

Produced by Norfolk and Waveney Clinical Policy Development Group

The Clinical Commissioning Groups for Great Yarmouth and Waveney, North Norfolk, South Norfolk, West Norfolk and Norwich.

Benign skin lesions and mild inflammatory skin disorders in adults

Date of version reproduced here: 12 September 2019
Note: This may not be the current version at time of reading.

Status:	Threshold

Norfolk & Waveney CCGs will **not** routinely fund referral to secondary care for treatment of the following lesions and conditions:

- Seborrhoeic keratosis
- Benign naevi
- Epidermoid, pilar or sebaceous cysts
- Skin tags (including anal)
- Milia
- Viral warts (except if immunosuppressed)
- Corns and calluses
- Dermatofibroma
- Telangiectasia, spider naevi and small haemangiomas (Campbell de Morgan spots) unless this is thought to be part of a systemic syndrome (Fabry's etc)
- Comedones
- Lipomata (unless rapidly enlarging and painful, please state size on referral)
- Xanthelasma
- Keloid scarring unless this is post-operative
- Tattoos
- Molluscum contagiosum (except if immunosuppressed)
- Fungal infections of toenails
- Physiological androgenic alopecia (pattern baldness)
- Hirsutism (unless thought to be part of an endocrinological disorder, in which case refer to endocrinology)
- Melasma/Cholasma
- Congenital vascular lesions in adults for cosmetic intervention

Norfolk & Waveney CCGs **WILL** routinely fund referral to secondary care for treatment of the following lesions and conditions under the specific circumstances detailed below. Please note that the clinical thresholds below do **not** apply to children:

- Actinic keratosis, if this has been unresponsive to 4-weeks treatment with once daily Efudix Cream and reviewed 6-8 weeks following completion of therapy
- Eczema, if this has failed to respond to treatment with emollients and appropriate topical steroids
- Mild psoriasis, if this has failed to respond to an appropriate Vitamin D analogue and topical steroid combination
- Seborrhoeic dermatitis, if this failed to respond to topical Ketoconazole administered in a cream, or shampoo or to clotrimazole-hydrocortisone cream.

- Mild to moderate rosacea, if this has not responded to 3-months of standard systemic therapy with systemic Tetracycline or Erythromycin
- Mild to moderate acne vulgaris, if this has not responded to 3-months conventional treatment with systemic Tetracycline or Erythromycin at the correct dose for acne, in combination with a prescribed retinoid or other non-antibiotic topical therapy

Note: Severe, scaring or cystic acne should be referred for consideration of treatment with isotretinoin

Referrals for the above lesions and conditions from **both** the above lists from primary to secondary care **will** be funded if:

- There is diagnostic doubt
- Lesions are a manifestation of an underlying syndrome
- There is a risk of malignancy
- There is documented evidence of significant recurrent infection
- There is documented evidence of significant recurrent bleeding
- There are significant pressure symptoms

Cases for individual consideration

On a case to case basis, patients might be eligible for surgical intervention, in consideration of their exceptionality. The requesting clinician must provide information to support the case for being considered an exception, by submitting an individual funding request.

CCG Variation:	
Clinical Codes for audit/monitoring	

Appendix 3: Specialist nurse roles

117 trusts answered the questionnaire, which asked if these roles were present.

Role	Number of providers	Percentage of providers
Dermatology nurse consultant	13	11%
Skin cancer nurses	104	89%
Skin cancer nurse-led clinic	77	66%
Skin cancer nurse-led clinic where nurse sees new patients	27	23%
Paediatric dermatology nurses	47	40%
Registered children's nurse in dermatology department	20	17%
Paediatric eczema nurse-led clinic	56	48%
Paediatric eczema nurse-led clinic where nurse sees new patients	25	21%
Nurse prescribers	78	67%
Research nurses	50	43%
Biological drug follow-up nurse clinic	84	72%
Systemic drug follow-up nurse clinic	76	65%
Isotretinoin follow-up nurse clinic	88	75%
Leg ulcer nurse clinic	31	26%
Iontophoresis nurse clinic	58	50%
Nurses reading patch tests	54	46%
Nurses seeing new patch test patients	29	25%
Botox for hyperhidrosis nurse clinic	30	26%
Transplant patient skin cancer surveillance nurse clinic	22	19%
Cryotherapy nurse clinic for warts	22	19%
Cryotherapy nurse clinic for pre-malignant lesions	14	12%
Nurses doing punch biopsies	94	80%
Nurses doing elipse excision surgery	68	58%
Nurses doing flaps and grafts	9	8%
Nurses doing Mohs surgery	1	1%
Nurses helping with the management of skin problems for inpatients in your hospital under other specialties	52	44%
Up-to-date written training, supervision and governance protocols for all areas of nurse provision above	83	71%

Date source: GIRFT questionnaire, 2018.

Appendix 4: Comparison of the Advice and Guidance service (A&G) on the e-Referral Service (e-RS) versus independent platforms

Electronic referrals have the potential to support dermatology in several ways, including the potential for increased use of image sharing.

The NHS Advice and Guidance service (A&G) on the e-Referral Service (e-RS) is the NHS platform for electronic referrals. A number of commercial referral platforms are also available. We spoke to some users who prefer e-RS based systems whereas others prefer commercially available independent platforms.

Trusts and CCGs must assess their requirements against the pros and cons of each platform when considering which to use.

Table 11 highlights the key pros and cons of each platform as described to us by trusts during our deep dive visits and by experienced users of these systems.

Table 12 shows the functionality currently available on A&G versus independently developed platforms.

Table 11: Key pros and cons of A&G versus independently developed platforms

PROS

e-RS A&G	Independent platform
Full integration with the standard e-Referral System means minimal duplication of work for GPs.	Many users report greater functionality compared to e-RS A&G (see Table 12).
Existing conformity and standardisation across the NHS.	Some can be used in primary, secondary and tertiary care.
Used in primary, secondary and tertiary care.	Users report systems that are robust and stable.
Robust and stable.	May offer good data tools for waiting times and clinical audit.
Can be integrated into recruitment for research.	Most providers are responsive to needs for modification of format and configuration.
Offers huge volume of data across most trusts, including for research.	
Robust data security.	
Application programming interface (API) workstreams within NHS to continuously refine compatibility with NHS systems.	
Future changes to e-RS will be national and integrated into NHS systems – greater future security of investment.	

CONS

e-RS A&G	Independent platform
Reduced functionality compared to some independently developed platforms.	Additional assurances required for information governance and data security.
Functions important to your department may not be available.	Risk of platform becoming obsolete if no longer supported by provider.
Some users report slow and incomplete responses to user requests for adaption.	Risk of platform being transferred between providers, including the sale of stored patient data.
	Risk of pricing and charging increases.

Table 12: Comparison of the functionality using e-RS A&G and the functionality which may be found on some independently developed or commercial A&G platforms.

Note that all platforms will continue to develop functionality. You should carry out up-to-date research when considering any investment.

GP initiation		
Function	**A&G using e-RS**	**Independent or commercial platforms for A&G (features may vary)**
Requires the referrer to specify the current problem and exact question being asked.	Possible to add a pro forma referral as a document.	Possible to develop pro forma within system.
Allows easy categorisation (rash/lesion/2WW) of any onwards referrals by referrer and responder.	Requires GP to make further referrals.	System may offer increased flexibility for conversion of A&G to referrals if required.
Continuity of image capture and Advice and Guidance process.	Commercial app can be used to attach image to e-RS.	Platform may allow continuity between image capture on mobile device app and A&G process.

Consultant reporting		
Function	**A&G using e-RS**	**Independent or commercial platforms for A&G (features may vary)**
Creation of worklist with added features.	Basic format with no filters.	Additional features available on some systems.
Rapid access to content on opening with effective usability.	Generally good but may be limited by NHS IT systems.	May be quicker, especially for systems developed for mobile device applications.
Use of templates for quicker responses and recording outcomes for audit.	Limited.	May offer improved usability.
Functionality that allows use for teaching, such as flagging suitable cases.	Past cases can be used for education but cases not flagged.	May offer additional functions to improve usability.

Backend		
Function	**A&G using e-RS**	**Independent or commercial platforms for A&G (features may vary)**
Activity and outcome data available for audit and interrogation (including GP, practice, geographic, and consultant data).	Restricted to senior analysts. Previous data can be searched by clinicians.	May be more directly accessible for clinicians

System integration		
Function	**A&G using e-RS**	**Independent or commercial platforms for A&G (features may vary)**
Uploading to trust electronic patient record.	Not automatic but can be accessed from e-RS.	Possible with configuration.

Appendix 5: Changes to coding

NHS Standard Contract, Service Condition 28: Giving commissioners notice of changes in the way you record activity

If you intend to change the way you record activity, for example in order to correct inaccurate specialty attribution, Service Condition 28 of the NHS Standard Contract requires you to:

- give your commissioner notice; and
- neutralise any financial impact of the change in the short term.

You can find the relevant section of the Contract at: *https://www.england.nhs.uk/publication/nhs-standard-contract-2017-18-and-2018-19-service-conditions-full-length-may-2018/*

The Contract provisions are further explained in section 44 of the Contract Technical Guidance at: *https://www.england.nhs.uk/publication/nhs-standard-contract-2017-18-2018-19-technical-guidance-may-2018/*

Appendix 6: Conflicts of interest statement for Professor Nick Levell

10 May 2020

Paid employment

- Employed as a consultant dermatologist at the Norfolk and Norwich University Hospital NHS Trust.
- Employed by GIRFT as National Clinical Lead for the dermatology GIRFT project.
- Employed as dermatology National Speciality Lead by the UK, National Institute of Health Research (NIHR).
- Associate editor for Rook's Textbook of Dermatology (published by Wiley), which gives some royalties.

Pharmaceuticals and private practice

- No funding or support from, and no research for, pharmaceutical companies since October 2015.
- No private medical practice since October 2017
- No healthcare-related investments other than broad-based general ISA and pension funds.

Charity and other roles

- Unpaid charity trustee and executive of the UK Dermatology Clinical Trials network.
- Unpaid immediate past president of the British Association of Dermatologists (BAD), which is a charity. Chair of the Therapy and Guidelines Committee for the BAD, together with various other committee roles for the BAD.
- Unpaid past president of the British Society for Medical Dermatology.
- Unpaid vice-president of the European Society for the History of Dermatovenererology.

Appendix 7: Environmental impact statement

A number of the recommendations in this report offer the benefit of potential reductions in CO_2 emissions by reducing hospital attendances. As well as the carbon cost of travel, hospital attendances often require the use of disposable gloves, aprons, face masks and other plastics.

Examples of ways that the recommendations may reduce emissions include:

- Triaging lesions using teledermatology means some patients can be referred back to their GP without having to attend hospital. Estimates suggest that over 30% of referrals could be returned to GPs. (This assumes that patients do not attend hospital to have a photograph and that increased use of teledermatology does release currently unmet demand.)
- Increasing the use of telephone consultations and home phototherapy offer the potential to reduce the number of people attending hospital.
- Reducing the number of follow-ups means fewer hospital attendances. For example, establishing one stop clinics for skin cancer surgery, or giving results by letter or phone would reduce follow-up attendances.
- Avoiding unnecessary skin biopsies, reduces the use of surgical kits, which contain disposable plastic items.

For more information about GIRFT,
visit our website: www.GettingItRightFirstTime.co.uk
or email us on info@GettingItRightFirstTime.co.uk

You can also follow us on Twitter @NHSGIRFT and
LinkedIn: www.linkedin.com/company/getting-it-right-first-time-girft

The full report and executive summary are also available to download as
PDFs from: www.GettingItRightFirstTime.co.uk

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