



Right person, right place, first time

Transforming elective care services **dermatology**



Learning from the Elective Care Development Collaborative

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Introduction

This handbook describes what local health and care systems can do to transform dermatology elective care services at pace, why this is necessary and how the impact of this transformation can be measured. Practical guidance for implementing and adopting a range of interventions locally is included to help ensure patients see the **right person, in the right place, first time**.

Interventions and case studies are grouped by theme within this handbook. 'How-to' guides and suggested metrics are included.

The list of interventions is not exhaustive and reflects those tested in the second wave of the Elective Care Development Collaborative, along with further relevant information.

The success of interventions designed to transform local elective care services should be measured by changes in local activity following implementation of the intervention and performance against the Referral to Treatment (RTT) standard. Patient and professional outcome and satisfaction should also be measured ([NHS Improvement, 2018](#)).

The second wave of the Elective Care Development Collaborative included rapid testing in dermatology, diabetes and ophthalmology. This handbook is just one of the resources to be produced following this wave. Further handbooks, case studies, resources and discussion can also be found on the [Elective Care Community of Practice pages](#).

You can learn about the interventions tested in previous waves (**MSK** and **gastroenterology**) and find all the handbooks and case studies on [our webpages](#).




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1. The national context and challenges facing elective care services in England

The NHS is experiencing significant pressure and unprecedented levels of demand for elective care.

Around 1.7 million patients are referred for elective consultant-led treatment each month. Between 2011/12 and 2016/17, referrals rose annually by an average of 3.7% per year and since 2005/06, total outpatient appointments have nearly doubled from 60.6 million to 118.6 million.

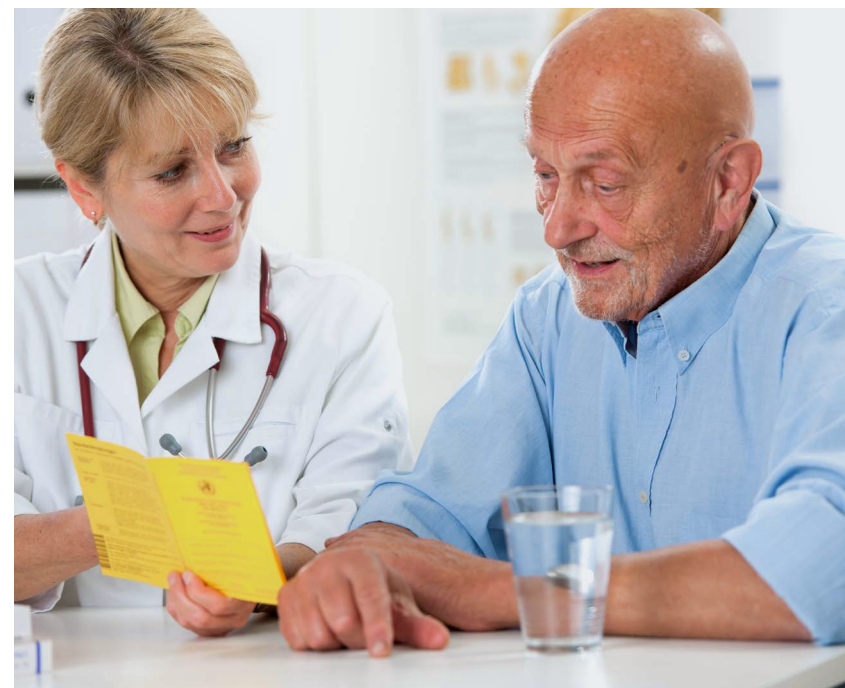
At the end of October 2018 only 87.1% of patients were waiting less than 18 weeks to start treatment (thus not meeting the 92% Constitutional Standard for referral to treatment). 4.2 million patients were waiting to start treatment and of those, 2816 patients were waiting more than 52 weeks.

Timely access to high quality elective care is a key priority under the NHS Constitution.

Two key documents: [Next Steps on the Five Year Forward View](#) and the [NHS Operational Planning and Contracting Guidance 2017-19](#), make the redesign of elective care services a must-do for every local system. They call for better demand management that improves patient care while improving efficiency.

The [NHS Long Term Plan](#) clarifies the direction for health and care over the next ten years, including the importance of transforming outpatient services.

The friends and family test results for October 2018 show that overall satisfaction with outpatient services is high, with 94% of 1,401,736 respondents saying that they would recommend the service to a friend or family member; 3% said they would not recommend the service, with the remaining 3% saying 'neither' or 'don't know'. It is important to take steps to ensure that patient satisfaction remains high.



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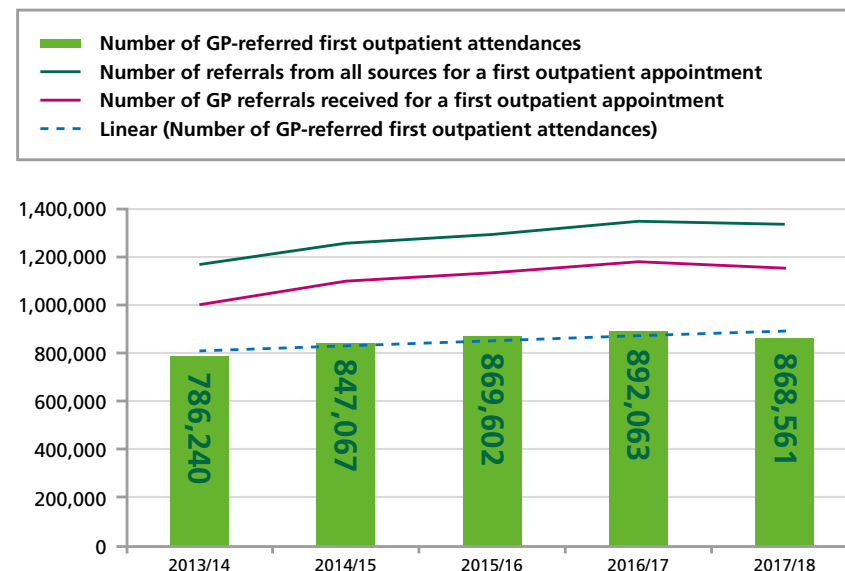
2. The national dermatology challenge

Skin disorders are extremely common. More than half the population are affected annually, leading to 13 million consultations in primary care and 880,000 referrals to specialists. Between 2013/14 and 2017/18 GP referrals for dermatology increased by 15% to 1.16 million per year. Causes of this rise in demand are thought to include the increasingly ageing population, rising expectations of skin appearance, improved treatments and the growing number of people living with conditions such as skin cancer, leg ulcers and atopic eczema.

Current challenges include: a shortage of consultant dermatologists and an ageing workforce ([King's Fund, 2015](#)); variation in diagnosis and management in primary care due to the lack of training for GPs ([British Association of Dermatologists, 2014](#)); limited and fragmented use of available technology ([ABPI, 2018](#)); inadequate triage in both primary and secondary care; limited and inconsistent coding of outpatient activity ([King's Fund, 2015](#)), in particular coding for follow-up appointments and treatment ([Levell et al, 2013](#)).

Opportunities to improve dermatology services include: developing clear multidisciplinary pathways and care models that address patients' physical and psychological needs ([British Association of Dermatologists, 2014](#)); enabling well supported self-management ([Association of the British Pharmaceutical Industry, 2018](#)); better use of teledermatology ([British Association of Dermatologists, 2014](#)); a clear model for community dermatology ([British Association of Dermatologists, 2013](#)) including how best to use nurses,

Dermatology (national data):



Source: [National Commissioning Data Repository](#)

pharmacists and GPs with extended roles to ensure that patients receive the right treatment and care in the most appropriate setting ([Royal College of General Practitioners, 2018](#)); and specialised education for both patients and GPs.

Not all of the above challenges and opportunities could be tackled by teams during their 100 Day Challenge. However, input from key stakeholders shaped both the challenge framework for Wave 2 and the ideas the teams have tested.


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3. The Elective Care Development Collaborative

NHS England's Elective Care Transformation Programme supports local health and care systems to work together to:

- Better manage rising demand for elective care services.
- Improve patient experience and access to care.
- Provide more integrated, person-centred care.

As part of this programme, the Elective Care Development Collaborative has been established to support rapid change led by frontline teams. In Wave 2 of the Elective Care Development Collaborative, local health and care systems in Dorset, Stockport, Norfolk and Lincolnshire formed teams to develop, test and spread innovation in delivering elective care services in just 100 days (the 100 Day Challenge). You can find more about the methodology used [here](#).

The teams used an intervention framework to structure their ideas around three strategic themes:

Rethinking referrals



Rethinking referral processes to ensure they are as efficient and effective as possible means that from the first time a patient presents in primary care, patients should always receive the assessment, treatment and care they need from the right person, in the right place, first time.

Shared decision making and self-management support



An all age, whole population approach to personalised care means that:

- People are supported to stay well and are enabled to make informed decisions and choices when their health changes.
- People with long term physical and mental health conditions are supported to build knowledge, skills and confidence to live well.
- People with complex needs are empowered to manage their own condition and the services they use.

This should be considered at every stage of the patient pathway and can be achieved through shared decision making, personalised care and support planning, social prescribing, patient choice, patient activation and personal health budgets.

Transforming outpatients



Transforming outpatients means considering how patient pathways and clinic arrangements (including processes) ensure that patients always receive assessment, treatment and care from the right person, in the right place, first time. This may not be in secondary care. Virtual clinics, technological solutions and treatment closer to home are all possibilities.


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Theme	Intervention	The opportunity
 Rethinking Referrals	Shared learning opportunities and establishing GP champions	If learning and knowledge around the appropriate treatment of dermatological conditions is shared between practitioners, then patients should receive effective treatment and advice earlier. Primary care practitioners should build their knowledge, confidence and expertise reducing the number of referrals into secondary care and improving the quality of referrals made.
	Advice and guidance (via teledermatology and e-Referral Service)	If access to specialist advice and guidance is available via e-Referral Service or teledermatology, more patients should receive effective treatment and advice in primary care. Primary care practitioners should have improved and more responsive access to specialist support. This should reduce the number of referrals into secondary care and improve the quality of referrals made.
	Triage in the community (spot clinics)	If triage in the community that is integrated with secondary care services is implemented, patients should be seen by an appropriate practitioner and spend less time waiting to see them. Practitioners should see the right patients at the right time, reducing the number of referrals into secondary care and waiting times associated with these appointments.
 Shared Decision Making	Self-management resources	If self-management resources for GPs and patients are available within primary care then patients should feel more confident to manage their conditions and be more likely to improve their health outcomes. Practitioners' confidence to manage patients with dermatological conditions in the community should also improve. This should reduce the number of referrals into primary and secondary care and increase the quality of referrals made.
 Transforming Outpatients	One stop clinic	If a one stop clinic is introduced where assessment, diagnosis, and treatment take place on the same day, then patient satisfaction should increase, waiting times for patients referred to secondary care should decrease and the number of outpatient attendances should be reduced.


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5. Opportunities for improvement: rethinking referrals

a. Shared learning opportunities and establishing GP champions



What is this idea?

Shared learning sessions and information packs on key local topics are designed and delivered for primary care clinicians to build their knowledge, skills and confidence. Topics may include common dermatological conditions such as actinic keratosis or new technology such as teledermatology. These sessions and information packs can be delivered by GPs with an extended role (GPwER) ([Royal College of General Practitioners, 2018](#)) or specialists from secondary care.

GP champions are GPs with an interest in dermatology (who may be GPwERs) and who are supported to develop their knowledge and skills to act as a local lead in dermatology ([King's Fund, 2015](#)).

GPwERs are expected to provide support and training to other GPs and members of the primary healthcare team. This process should be supported by commissioning pathways ([RCGP, 2018](#)).

We know it works:

Since the start of the one hundred days in Norfolk:

- 42 practitioners attended a continuing professional development (CPD) shared learning event for dermatology where an information pack and treatment algorithm were launched and discussed. 100% of attendees said that this will change the way they treat patients.
- Attendees rated the event 8.4 out of 10 for content and for how helpful it would be in their day-to-day practice.
- Estimated net annual cost saving for clinical commissioning groups (CCGs): £38,200 (at a cost of £18,500 for two face-to-face events and two webinars per year). This is a gross saving of £56,700 if each 'event attendance' saves one referral.


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Why implement this idea?

GPs receive very little undergraduate training in dermatology and this training is not compulsory. This means that most GPs are not confident in diagnosing or treating many dermatological conditions ([The King's Fund, 2014](#)).

If learning and knowledge around the appropriate treatment of dermatological conditions is shared between practitioners (including GPs, consultants, nurses and pharmacists) and GPwERs are utilised to their full advantage, then:

- **Patients** should be able to access the care they need earlier and have a better experience of support to manage their condition within a primary and community care setting.
- **Primary care clinicians** should build their knowledge, confidence and expertise in dermatology, meaning referrals are made into secondary care only when necessary. Improved communication builds trust between practitioners and improves patient management across care settings. Secondary care specialists should spend more time seeing those patients who need their expertise.
- As clinicians in primary care become more confident and proficient at dealing with dermatological conditions and pathways include GPwER services, the number of unnecessary referrals to secondary care should decrease and variation in the quality of referrals and prescribing should improve.




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How to achieve success: implementing shared learning sessions

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Get the right focus

- Identifying a specific focus for the CPD event can be a useful first step towards engaging the right people and recruiting GP champions.
- Through engaging with people from across the system, you may be able to start having different conversations.
- Share learning and improve the care being delivered.

Involve people with lived experience

- Hearing from people with lived experience is a powerful way to influence change. It also means that the patient perspective is embedded into the new ways of working being developed from supporting information.
- Use the [Primary Care Dermatology Society](#) website and resources to help develop your local education offer.

Schedule and cost events in a way that meets participants' needs

- Consider holding CPD/shared learning events on Saturday mornings. Undertake a quick local survey to see whether more people may be able to attend outside of normal working hours.
- Keep costs low or free for attendees wherever possible.
- Engage and connect people from across your local system even before developing formal learning opportunities. This enables different conversations and shared learning to develop and take place organically.

Film events and gather information to share more widely

- If speakers are happy to be filmed and participants are willing to share feedback, their experiences and perspectives can be shared online, which may reach a wider audience and reduce future costs.

People you may wish to involve from the start:

- | | | |
|------------------------------------|--------------------------------|--------------------|
| • consultant dermatologist | • GPs | • nurse consultant |
| • GP with an extended role (GPwER) | • people with lived experience | • practice nurses |


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Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative

- Number of GPs who have attended/accessed GP shared learning events.
- Advice and guidance requests for dermatology.
- Cost savings: event cost vs. cost per referral.
- Number of referrals made into secondary care (two-week wait, and standard pathway), referrals saved, and associated change in waiting times.
- Number of GPs recruited as champions.
- Percentage of patients self-managing.

Qualitative

- GP impact survey assessing knowledge and confidence levels.
- GP feedback on the value of shared learning events and information resources.
- Feedback from secondary care clinicians about the quality of referrals being made.
- Feedback from primary and secondary care clinicians about their experience of working together throughout the referral process.
- Patient feedback on outcomes and experience.

The following standards and guidance may be useful:

[British Association of Dermatologists e-learning](#)

[Guidance and competences to support the accreditation of GPs with Extended Roles \(GPwER\): Dermatology and Skin Surgery \(Royal College of General Practitioners, 2018\)](#)

[Primary Care Dermatology Society: GPwER webpages](#)

Resources required:

- A venue to hold education sessions.
- Information resources, including patient testimony.
- Administrative support to promote and coordinate the event and pull together the necessary resources.

If planning to develop a case study video or other video resource:

- Filming equipment and editing support.
- People with lived experience who are willing to share their experience.

Intended benefits:

- Improved access to care in primary care for patients.
- Improved knowledge, confidence and expertise for primary care clinicians.
- Improvement in the quality of referrals made into secondary care.


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a. Shared learning opportunities and establishing GP champions: Norfolk case study

The challenge – why here and why now?

In Norfolk, actinic keratosis is the largest source of non-cancer referrals to secondary care (aside from the general category of 'rash'). In north Norfolk, 8% of dermatology referrals were for actinic keratosis (approximately 800 per year). If actinic keratosis is not treated appropriately it can result in cancer but overall it is a relatively low-risk condition, with up-to-date guidance available to follow lending itself to self-care ([British Association of Dermatologists, 2007](#)). The relatively simple advice for treatment of actinic keratosis led the team to believe that they would be able to create significant impact on this issue over the course of 100 days.

What was the idea?

To improve primary care practitioners' knowledge of treating actinic keratosis through a shared learning event.

The intervention – what did they do and how did they do it?

The idea was led by a consultant and a nurse consultant. They undertook the following:

- **Identified speakers** (including consultants and specialist nurse), venue, audience and date.

- **Prepared talks and teaching materials in advance** including certificates of attendance and participation questionnaire.
- **Identified patients to share their experiences** as part of the event, including case study examples from real patients, either in person or using a video that patients consented to share.
- **Publicised the event** through CCG networks.
- **Invited stakeholders** including GPs, GP vocational trainees, primary care nurses and pharmacists.

What did people say?

"[I feel] more confident in treating actinic keratosis for longer periods and providing reassurance to patients on treatment reactions."

GP, Norfolk.

"Gives me more confidence to recognise actinic keratosis and begin treatment knowing I am not losing time and can still refer later."

GP participant.

"Excellent day. I will definitely make changes to practice."

Advanced nurse practitioner.


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The intervention – what did they do and how did they do it? (continued)

- Delivered the event on a Saturday to maximise attendance. It was free to attend and counted as two and a half hours towards continuing professional development (CPD).
- Gathered feedback from participants through a questionnaire.

Lessons learned

- Demand for this type of event is high, which led the team to wonder whether it could be replicated across the country as a 'GP academy'. There is potential to deliver some elements of the education session via a webinar, which could help with scale and spread, although feedback on the day was that participants would prefer to attend face-to-face sessions.
- Holding shared learning sessions on a Saturday can increase attendance.
- Considering payment structures for the sessions is important when thinking about scale and sustainability.

Headline achievements in 100 days:

Event turnout was 90% (42 attendees of 47 registered).

Excellent participant feedback:

- 100% of respondents said the event will change the way they treat their patients.
- Attendees rated the event 8.4 out of 10 for content and for how helpful it would be in their day-to-day practice.

Estimated net cost saving for CCG: £38,200 per annum, if an annual programme of events is rolled out. This assumes that each 'event attendance' saves one referral. This assumes a tariff of £135 per referral, and 420 annual event attendances (150 at each of two face-to-face events, and 60 at each of two webinars) leading to a gross saving of £56,700 per annum, with a cost of £18,500 for the four events.

Knowledge quiz pre-event score was 2768.39 points (n=23) for speed and correct answers and the post-score was 5537.95 (n=20). The post-event quiz demonstrated correct answers in 97% of cases.

You can find further information about this work, as well as other case studies on the [Elective Care Community of Practice pages](#). For more information, please email: england.electivecare@nhs.net


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b. Advice and guidance: e-Referral Service and teledermatology



What is advice and guidance?

An advice and guidance service enables one clinician to seek advice from another, usually a specialist. For example: this could be about a patient's diagnosis, treatment plan and ongoing management; or it could be for clarification of test results and referral pathways.

There are several methods of obtaining advice and guidance. For example, the [NHS e-Referral Service](#) enables GPs to actively request advice from identified specialists. GPwERs are expected to provide advice and support to other local practitioners to help manage conditions within their expertise ([RCGP, 2018](#)). Teledermatology enables GPs to share an image of the affected skin area securely with a specialist clinician (such as a GPwER or dermatology consultant) for advice and review.



We know it works:

- Utilisation of the NHS e-Referral Service has steadily increased across England from 55% in January 2017 to 73% in May 2018.
- Patient satisfaction with the e-Referral Service was 80% overall ([NHS Digital 2018](#)).
- 66% of calls regarding high-volume elective specialties resulted in an unnecessary hospital visit being avoided ([Consultant Connect, 2018](#)).
- Only 29% of requests through Telederm resulted in a referral to a secondary care specialist ([Telederm, 2017](#)).

Since the start of the one hundred days in Stockport:

- Of the 68 advice and guidance requests made via teledermatology, 99% were responded to the same day (compared to a three or four month waiting list for a face-to-face outpatient appointment).
- Only 18% of the 68 requests resulted in a referral to secondary care.
- 12% of the requests had to be repeated due to inadequate images.

Since the start of the one hundred days in Norfolk:

- The number of advice and guidance requests increased steadily throughout the one hundred days (from 15 per month beforehand to 20 per month at day 100).
- Throughout the one hundred days, 80% of referrals were responded to within 48 hours, meaning their target was met.
- Only 3% of requests resulted in a referral to secondary care.
- 78% of respondents had a high level of satisfaction with the service.


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Why implement this idea?

If quicker and increased access to specialist advice and guidance is introduced:

Patients should be able to have their condition diagnosed and treated in primary care whenever possible and should be supported to manage their condition. They should receive quicker and more convenient access to specialist advice and care when necessary.

Primary care clinicians should be able to manage patients more effectively and avoid unnecessary referrals into secondary care. Where a referral does need to be made, advice and guidance can improve the quality of information that accompanies the referral. This means that specialist expertise can be directed to those patients who need it most. Advice and guidance is a great opportunity for shared learning. As practitioners' confidence and proficiency increases, the overall number of referrals made may reduce, along with waiting times for specialist input.



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How to achieve success: implementing advice and guidance services

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Involve people from across the system

- It is important to achieve buy-in across primary and secondary care before launching the advice and guidance service. Without successful buy-in across the local system, the service is unlikely to be widely used.

Engage with consultants and invite them to join the advice and guidance rota

- Explain the opportunity and potential benefit of joining the rota.
- Inviting consultants to take part in a trial may be more successful initially.

Provide training in relevant equipment (e.g. teledermatology app/e-Referral Service/dermatoscope)

- Develop a quick reference guide for consultants and GPs to refer to as they implement the service.

Agree a way of tracking the use and impact of the advice and guidance/teledermatology service

- Agree activity and impact metrics to demonstrate the success of the advice and guidance service against local priorities, even in the earliest trial stages, to ensure that evidence is there to prove the case for sustainability.
- Ascertain the current baseline and ensure there are processes in place to capture any necessary data as the service develops.

- Install and test the chosen advice and guidance system. Ensure there are opportunities for continual feedback and refinement from users at all stages of implementation.

Promote the service to GPs and practice managers

If choosing to develop an information video to promote and explain the service:

- Liaise with your local leads to offer support and advice on filming and editing.
- Invite clinicians and patients to take part in the film and share their positive experiences of the system.
- Engage the local lead to introduce and explain the intervention.
- Agree an approach to sharing the film and make sure that all relevant agreements and consents are in place.

People you may wish to involve from the start:

- consultants
- GPs
- administrative support
- IT support
- app developer/teledermatology service provider


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Start small before scaling

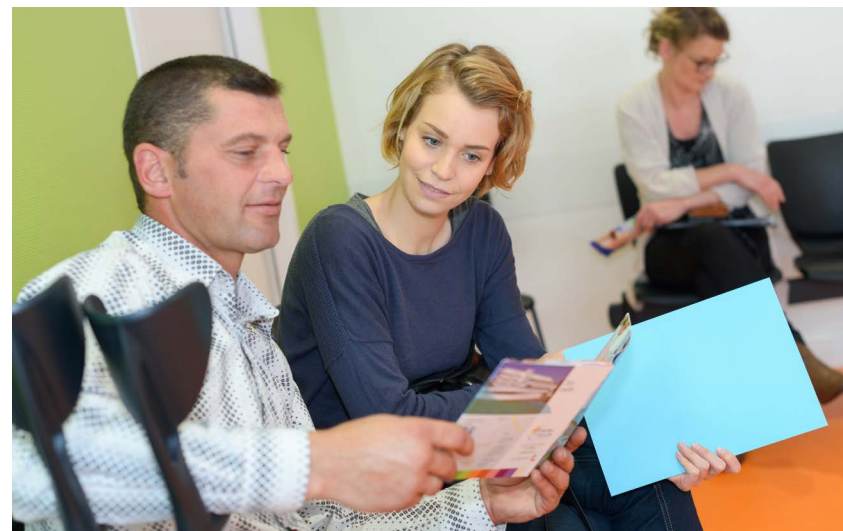
- Start small and scale up only when users are comfortable with the system and technical glitches have been addressed.

Don't get held up by technical concerns

- Starting off with a low tech advice and guidance offer such as an email or phone solution can be an easy way of generating interest and buy-in. This also provides an opportunity to better understand what people actually need.

Make use of available resources

- Consider a trial using existing resources (e.g. email or telephone). This can help achieve buy-in to the system while any IT issues are overcome.



Resources required:

- Email address or phone number for each referrer.
- Agreed advice and guidance provider.
- Teledermatology app and training from the provider.
- Dermatoscope (not necessarily vital at first). If this is being used as part of teledermatology, clinicians would need to be formally trained to use this equipment before the intervention is implemented.

The following standards and guidance may be useful:

[NHS e-Referral Service: guidance for managing referrals](#)

[Offering Advice and Guidance: Supplementary Guidance for CQUIN Indicator](#)

Key performance indicators are included here: [British Association of Dermatologists Quality Standards for Teledermatology](#)

[UK guidance on the use of mobile photographic devices in dermatology \(British Teledermatology Society, 2017\)](#)


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Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative

- Number of advice and guidance queries.
- Time for response to advice and guidance queries.
- Number of teledermatology referrals rejected or percentage of cases where photos sent through teledermatology were of adequate quality.
- Outcomes of patients referred via advice and guidance (referral or no referral).
- Number of GPs using teledermatology.
- Number of referrals to secondary care avoided.
- Number of additional referrals to secondary care (local definition required, but could use number of rejected referrals as a proxy).
- Number of referrals to secondary care (two week wait and standard pathway).
- Waiting time on standard pathway.
- GP confidence to manage patients via advice and guidance time spent on advice and guidance activity (primary and secondary care).

Qualitative

- Feedback from GPs and secondary care clinicians on quality of care through surveys.
- Feedback from patients on experience of advice and guidance.
- Patient case studies capturing outcomes and satisfaction.

Intended benefits:

- Earlier access to specialist advice and reduced patient waiting times.
- Increase in quality of referrals to secondary care.
- Reduction in unnecessary referrals to secondary care.


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The challenge – why here and why now?

Under the wider 'Stockport Together' programme there is an ambition to reduce outpatient attendances by 55% to 65% over the next three years. As part of the dermatology team's work towards this, they aimed to redesign the traditional dermatology GP to hospital pathway of care, where patients can wait 16 weeks to be seen at the hospital. With five GP practices already using teledermatology, it was felt that the 100 Day Challenge was an ideal opportunity to roll out this platform further.

What was the idea?

To expand the use of a teledermatology app from five to ten GP practices in Stockport. The platform enables photos to be added to referrals easily and securely. These referrals are then emailed to a consultant for a clinical decision, either:

- Onward referral into secondary care.
- Advice and guidance.
- Request for more information or an additional image.

What did people say?

"Just brilliant. Quick advice back. Have managed to defer four referrals so far from my GP practice by managing in primary care, advice given via teledermatology".
GP, Stockport.

"It's working really well. There are situations where I'm not sure what the diagnosis is or others where I've tried a few treatments and it's not working – in my experience, it has stopped referrals going to outpatient departments, which is great for me and my patients. They don't have to wait several months for an appointment and the hassle of going to hospital."
GP, Stockport.

"The teledermatology system has proved very easy to use and we have been able to give GPs advice, often avoiding hospital appointments."
Dermatologist, Stockport.

"Our GPs say that the system has altered their referral behaviour to secondary care services, as they are using more in-house skills and then using this as a secondary care opinion. It's also excellent in cases where the patient is really suffering (with an uncomfortable rash, etc.) You can get advice within hours rather than the patient waiting for weeks."
Commissioner, Stockport.


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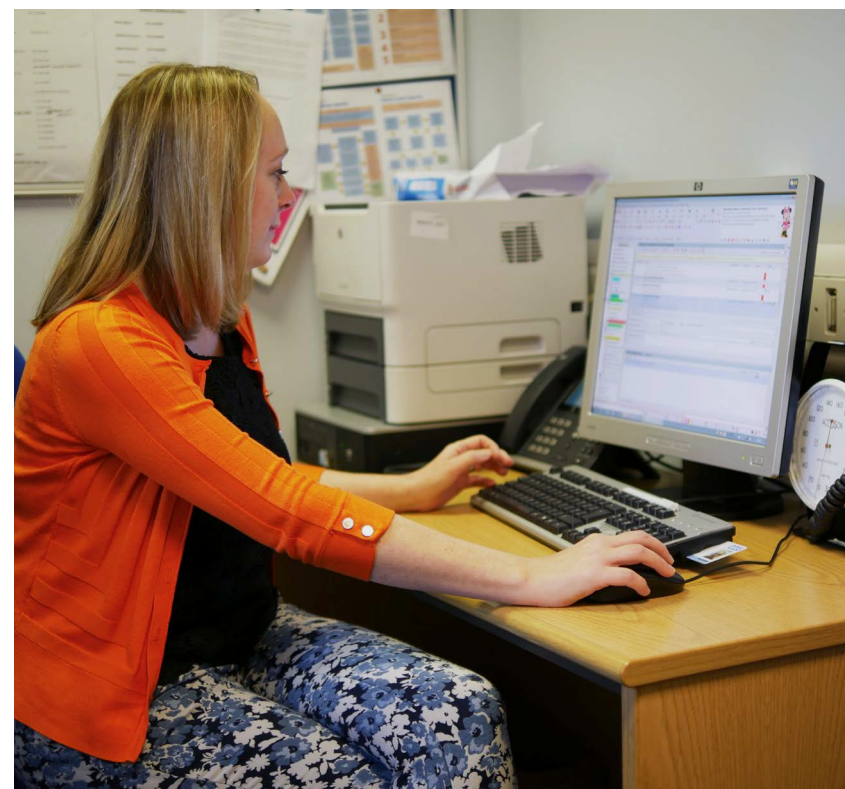


The intervention – what did they do and how did they do it?

The team took a whole system approach and involved the CCG head of service reform, GP leads, service managers and dermatologists from Salford Royal NHS Foundation Trust and a technology provider. They undertook the following:

- **Ensured that the software used was clinically driven**, secure and directly integrated with NHS IT systems already in place.
- **Built relationship with the technology provider team** who answered any queries relating to system issues like log-ins, data information, etc.
- **Gave demonstrations at GP practices** of the teledermatology platform and ran a short group training session for GPs.
- **Met with three dermatologists** and a technology provider to demonstrate teledermatology and secure their agreement to expand the use of the platform.
- **Communicated updates** with the team including when GP practices had 'gone live' with teledermatology. This ensured that dermatologists knew to expect additional referrals.
- **Filmed and shared an information video for local practitioners** explaining teledermatology through working with the CCG communication lead, including filming a person with lived experience who had experienced the service.

- **Tested and adapted the referral process** in response to feedback from clinicians (e.g. reassessed how much detail they needed to give so advice and guidance was useful for GPs).




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Lessons learned

- Starting small and upscaling in stages helps to make sure that users are comfortable with the system and technical glitches can be addressed before rolling out more widely.
- Using teledermatology can encourage shared learning of specialist knowledge between GPs. When consultants reply to GPs with their responses, GPs can share advice and guidance with colleagues, who can then apply it to other patients.
- GPs need proper training in dermoscopy. Implementing dermatoscopes alongside teledermatology can have an even greater impact. In Stockport, a GP picked up three suspicious lesions early through using dermatoscopes and getting an initial assessment via teledermatology.
- Using teledermatology can improve relationships and communication between primary and secondary care colleagues.
- Meeting regularly as a cross-system team helps to support successful implementation of ideas.

Headline achievements in 100 days:

- Expanded teledermatology to five new GP practices.
- 68 referrals made in four month period.
- 18% of referrals required an outpatient appointment.
- 99% of referrals were responded to in the same day (compared to a three or four month waiting list for a face-to-face outpatient appointment).
- Good quality images provided by GPs. Only 12% of referrals were rejected due to inadequate images. Three skin cancer patients were identified via teledermatology, who were then referred and treated urgently.

You can find further information about this work, as well as other case studies on the [Elective Care Community of Practice](#) pages. For more information, please email: england.electivecare@nhs.net


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c. Triage in the community (spot clinics)



What is triage in the community?

Spot clinics are held in the community to enable patients to be triaged into the correct pathways. Triage is undertaken by a specialist, who may be a consultant or a GP with an Extended Role (GPwER). Any patient may be referred into the spot clinic if there is a query about whether they should be placed upon the two week wait pathway. At the spot clinic, the specialist is able to review a higher number of patients than they can at a typical outpatient clinic, as they are assessing specifically for triage rather than treatment.

Why implement triage in the community?

Patients are often referred to the two week wait pathway 'just in case' if the referral route for their symptoms is unclear. This leads to a high number of unnecessary referrals into that pathway and significant delays.

If specialist triage in the community is implemented (e.g. through a spot clinic):

- **Patients** should spend less time on the waiting list and be triaged more quickly into the appropriate pathway. Patient experience should improve because those that need to see a specialist are able to do so quickly in a clinic that is closer to home. Patients who do not need significant specialist support should be discharged more quickly.

- **Primary care clinicians** should increase their confidence and expertise within primary care as a result of the shared learning opportunity. Consultants should be able to see more patients at each spot clinic than in standard outpatient clinics, reducing patient waiting time. Consultants should be able to spend less time on additional appointments (e.g. appointments resulting in no further treatment) and more time seeing the right people, in the right place, first time.
- There should be a reduction in the waiting time for referrals on both the two week wait and standard pathways. The number of additional referrals to secondary care (e.g. referrals resulting in no further treatment) should reduce.

We know it works:

Since the start of the one hundred days in Lincolnshire:

- 43% of the 73 patients seen during four spot clinics were diverted away from secondary care (either requiring no further treatment or treatment from the GP only).
- A further 9% of patients received treatment in the community.
- Only 7 of the 73 patients were referred to the two week wait pathway. Previously, all 73 patients would have been.
- Cost savings of £4,688 were recorded across the four clinics (held over a four week period). This was calculated by subtracting the cost of the clinics from the money saved through avoided referrals.


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How to achieve success: implementing triage in the community

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Set up the clinics

- Develop a patient pathway for referral to the spot clinics. Ensure all staff are aware of this and GPs know how to refer. Engaging practices and GPs right from the beginning to ensure buy-in is crucial.
- Develop a specific referral form. This means that GPs can refer directly to the clinic meaning the relevant information will be available and patient outcomes can be tracked appropriately.
- Organise the space and staffing for the clinics. Consider how this will be incorporated into job planning, including administration. Administrative support will be crucial, so this also needs to be considered.
- Promote the service to GPs and to patients. Develop suitable materials and ensure that there is a comprehensive communications plan in place well before the launch of the clinic to ensure the promotional materials reach the right people.

Ensure clinical accountability

- Holding spot clinics within a community setting may raise some questions about clinical accountability that should be resolved before starting the clinics. For example:
 - Is the hosting GP or the lead clinician clinically accountable for the patients seen within the clinic?

- If it is a triaging clinic, it may involve patients being seen by different professionals and the lead clinician not seeing all of the patients. In this case, there needs to be a process in place to ensure consistent clinical accountability in the event of any queries.

Invest time in developing the right IT support

- Set up IT so that direct referrals from GPs to spot clinics are possible. Investing time in developing the right booking system helps to ensure that clinics are booked to full capacity and so are cost effective.

People you may wish to involve from the start:

- | | | |
|----------------------------------|------------------|--------------------|
| • consultant | • GP | support |
| • nurse specialist/ practitioner | • practice nurse | • IT support |
| | • administration | • practice manager |

Resources required:

- Space in a community setting, e.g., a GP practice to host the specialist triage clinic.
- dermatoscope


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Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative:

- Number of spot clinics held.
- Number of patients seen in spot clinics.
- Time spent running spot clinics (consultant).
- Number of patients seen in spot clinics referred to two week wait pathway.
- Number of patients seen in spot clinics referred to standard pathway.
- Number of patients seen in spot clinic not referred to secondary care (therefore percentage of patients diverted from secondary care).
- Number of patients seen in standard outpatient clinics.
- Time spent running standard outpatient clinics (consultant).
- Number of referrals to two week wait pathway.
- Number of referrals to standard pathway.

- Number of additional referrals to secondary care (local definition required, but could use referrals resulting in no further treatment as a proxy).
- Waiting time (standard pathway and two week wait pathway).

Qualitative:

- Patient feedback on referral satisfaction through survey, including convenience of appointments, waiting time and discharge time.
- Practitioner feedback through survey. GP and GP specialist feedback on confidence to manage conditions within primary care. Secondary care clinicians feedback on quality of referrals.

Intended benefits:

- Reduced number of appointments per patient procedure.
- Reduction in unnecessary referrals.
- Increase in efficiency.

The following standards and guidance may be useful:

[Guidelines for the Care of Patients with Actinic Keratosis \(British Association of Dermatologists, 2017\)](#)


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c. Consultant led triage in the community (spot clinics): Lincolnshire case study



The challenge – why here and why now?

Since 2005/06, outpatient appointments in Lincolnshire have doubled. Two week wait referrals have increased by 57% in the last five years and now account for a third of referral activity. This leads to significant delays in the standard pathway. A significant part of the workload in dermatology includes skin tumours (benign, precancerous and malignant lesions) many of which can be addressed in a spot clinic. Lincolnshire is a rural county with a limited road network and poor public transport services. It often takes patients more than an hour to get from home to a hospital appointment. There is a desire to deliver services closer to patients' homes. The team would like to use the spot clinic model as a basis to develop a one stop clinic and a self-referral clinic. Triage is consultant led in the spot clinic. It is hoped that as the clinics develop, GPs will be able to join the consultations for education and continuing professional development (CPD).

What was the idea?

To trial consultant led triage (spot clinics) in the community that GPs can refer to directly. The clinic is designed for patients where the GP believes the issue is not cancerous, but is unsure of the diagnosis.

The weekly clinics involve short consultations, enabling consultants to see and triage around 24 patients in two hours.

The intervention – what did they do and how did they do it?

The idea was led by GPs, practice nurses and a consultant, with administration support. They undertook the following:

- **Developed patient pathway for spot clinics**, trained staff in the process for this pathway and ensured that everyone involved had sight of the pathway.
- **Worked with the local 'Choose and Book' team** to agree a process for referrals to be made directly into the spot clinics by GPs.
- **Communicated the concept to GPs via email**, including screenshots of the new process and asking for questions and feedback. Ensured any queries or concerns were followed up in person or over the phone where possible.
- **Developed a questionnaire for attendees at the spot clinic** to gain feedback on their experience.
- **Organised the estates and staffing** (including a GP clinic with appropriate treatment rooms, and administration staff).


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The intervention – what did they do and how did they do it? (continued)

- **Ensured consultant buy-in** by approaching a consultant in person to run the clinic and by discussing the plan at a meeting with other consultants to ensure that they were happy with the approach.
- **Ran clinics on a weekly basis** with a consultant seeing 24 patients in two hours. Nurses prepared three patients at a time for consultation. The consultant saw each patient individually in separate rooms. As soon as the consultant had seen the first patient and ensured that they were clear on their next step, the nurse in that room would bring the next patient in and prepare them while the consultant moved to the next room. This way, the consultant was able to triage prepared patients continuously for two hours.
- **Ensured that patients were clear on the next steps.** For example, whether an onward referral was required or if no further appointments were necessary.

What did people say?

"Fast time from referral, staff very good, good clinic venue."
Patient, Lincolnshire.


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Lessons learned

- Spending time at the beginning setting up the IT booking system is important as not having it up and running can have a negative impact on the number of attendees.
- Developing a comprehensive communications plan for GPs well in advance of the clinic is essential. It took the team longer than expected to work through all the aspects of this plan, which led to an intensive piece of work communicating the launch of the clinics and the new processes.
- Ensuring that everyone has a clear understanding of accountability at each stage of a spot clinic can overcome anxiety about risks in relation to clinical accountability.

You can find further information about this work, as well as other case studies on the [Elective Care Community of Practice](#) pages. For more information, please email: england.electivecare@nhs.net

Headline achievements in 100 days:

- 73 patients were seen at four spot clinics, held over a four week period.
- Initial results showed that 43% of cases were diverted away from secondary care (either requiring no further treatment, or treatment from GP only). A further 9% of people were referred directly for surgery in the community.
- Patient satisfaction scores were very high on every area: 100% of patients rated the clinic as good or excellent; patient satisfaction was above 85% on eight out of nine questions asked (parking was the only area where scores were lower than 85%).
- Cost saving of £4,688 was recorded across the four weeks. This figure was calculated by subtracting the cost of running the clinic from the money saved through avoided referrals.
- Further benefits from the clinic included a significant diversion of non-cancerous patients to more appropriate treatment, with only 10% of spot clinic patients referred to the two week wait pathway. These results would have been different before the trial.


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a. Self-management education and support

What is self-management education and support?

Self-management is one of the core components of person-centred care. Self-management information and education supports and empowers patients with long term conditions to understand and manage their health and wellbeing effectively. It raises awareness of the variety of treatment and management options available and encourages effective shared decision making ([The Health Foundation, 2015](#)). Self-management education can be delivered via various methods including face-to-face meetings, online or by telephone. This information and advice may be generic or specific to dermatology. Patient decision aids such as simple algorithms or flowcharts of the patient pathway can help clarify treatment options and expected effects.

Why implement self-management education and support?

Most people with long term conditions such as dermatology would like to play a more active role in their own care, even if they are already managing their own condition to some extent ([National Voices, 2014](#)). Self-management education is most effective when integrated into routine healthcare. If professionals support and encourage self-management and education resources are available for practitioners and patients in primary care:

- People feel more confident, are more engaged and are more likely to undertake actions to manage their dermatological condition. If they can access resources when they need them this may lead to improved health behaviours ([National Voices, 2014](#)), improved health outcomes ([NESTA, 2016](#)) and increased adherence to treatment recommendations. They should be better able to cope with 'flare-ups' of their condition and know when it is necessary to access the most appropriate treatment options.
- **Clinicians** have increased confidence to have effective shared decision making conversations and can support and empower patients to manage their own conditions in the community.
- There should be an overall reduction in the number of referrals to secondary care and the number of presentations in primary care as patients become more confident and know how to cope with and manage their symptoms.

We know it works:

Since the start of the one hundred days in Norfolk:

- An information pack for patients has been produced and distributed to practitioners who attended the education event to share with other patients they are working with.


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a. Self-management information resources

How to achieve success: implementing self-management education and support

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Plan your self-management education resources

- **Ensure that self-management education and information resources are of high quality and are relevant to the needs of patients within the local area.**

The best resources for self-management education have often been trialled and evidenced. [The Quality Institute for Self Management Education and Training \(QISMET\) Quality Standard: QIS2015](#) may be useful to check for certified resources.

- **Involve members of your target cohort in the design and development of the self-management support offer.** This will enable you to understand what people actually want.
- **Make use of resources that are already available.** Review and map the self-management education and support offer locally and nationally (including patient organisations and local VCS groups). Use this to identify opportunities and local areas of need.
- **Tailor and adapt resources to make them relevant for the local context.** There is often a lot of information available but it is not always easy to access. Consider using a range of approaches to increase access to information for patients, including pulling together disparate resources into one information pack.

- **Develop resources where you identify there is a gap.** Developing resources locally (such as videos or leaflets) can help to ensure that the message being given is right within the local context and that information is accessible in the most useful formats.
- **Integrate education programmes, information resources and patient decision aids into local referral pathways.** These should include content around the need to review self-management if symptoms change and emphasise that people with learning disabilities or who are not fluent in English might need additional support to self-manage. Self-management education can be offered as part of a person-centred care and support plan.
- **Provide a range of options for people to access self-management education and support.** This may include structured education, support groups, emails, text messages or coaching sessions. Information on its own is less effective. Self-management education is most effective when combined with other forms of support, rather than simply giving people leaflets to read.
- **Decide on the format for any structured education sessions.** Reviews suggest that outcomes are better when health professionals are involved, but peer led education is very popular. Peer support following formal or structured education is also very useful.


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a. Self-management information resources

- **Ensure the programme is accessible.** Consider the needs of the patient cohort you are focussing on and remove barriers to attendance wherever possible. For example, people of working age often find it difficult to attend sessions during the working day and those with caring responsibilities themselves may find it difficult to be away for any length of time. If offering face-to-face sessions there should be a variety of times and venues that are convenient. Community venues that have good parking and are easily accessible by public transport may be a useful option.
- **Establish processes to manage referrals and self-referrals.** Identify administrative support to coordinate the service.
- **Think about how to engage with patients in the most effective way to increase attendance and completion rates.** Some people have high motivation and will readily participate in education programmes. However, others may be harder to engage. Patients with low activation and dual diagnosis need much more support than those with high activation. Programmes need to be tailored to meet patients' needs or have a core programme for all. This should then be supported by additional modules for those requiring additional support. Consider using the Patient Activation Measure tool to measure effectiveness.

Promote your self-management education resources

- **Design leaflets and flyers for use locally.** These might signpost to education sessions or online support. They might also be a resource in themselves, containing useful information for patients and carers. Seek the expertise and assistance of your local communications team.
- **Promote resources and education sessions to patients and the public.** Be inventive about where and how you do this. People who may benefit from self-management support may not be aware of it and may not always attend health care settings regularly. Try advertising where people are most likely to be.

People you may wish to involve from the start:

- consultants
- GPs
- practice nurses
- administration support
- IT support
- practice managers
- communications team


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a. Self-management education and support

Implement the self-management support offer

- **Enable health care professionals across both primary and secondary care to tailor the support offer to their patient.** Ensure that all staff are aware of the resources available and the role they have to play in supporting self-management and promoting education sessions and resources.
- **Focus on the outcomes that are important to individuals.** Positive clinical outcomes should enable individual goals to be achieved, possibly with other non-clinical support.
- **Ensure organisational processes support and enable self-management.** For example, IT systems may need to be adapted to enable virtual consultations or people may need to be able to self-refer when appropriate.

Resources required:

- Space to display information packs at GP practices.
- Electronic and paper versions of information resources available to share with patients.
- Access to available information and time to consolidate into a pack.

If planning to develop a case study video or other video resource:

- Filming equipment and editing support.
- People with lived experience who are willing to share their perspective.

The following standards and guidance may be useful:

[Person-Centred Care in 2017 – Evidence from Service Users](#)

[Person-Centred Dermatology Self-Care Index](#)

[Supporting Self-Management: A Summary of the Evidence \(National Voices, 2014\)](#)

[A practical Guide to Self-Management Support – Key Components for Successful Implementation \(The Health Foundation, 2015\)](#)

[Realising the Value: Ten Actions to Put People and Communities at the Heart of Health and Wellbeing \(Nesta, 2016\)](#)


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a. Self-management education and support

Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative

- Number of information packs given out/accessed (downloads of videos).
- Number of patients involved in GP education sessions.
- Number of additional referrals (local definition required, but could use referrals resulting in no further treatment as a proxy).
- Number of patients completing appropriate treatment plans.
- Number of referrals to secondary care.
- Number of attendances in primary care.
- Patient waiting time to see dermatologist.

Qualitative measures to consider

- Patient feedback on the effectiveness of the information pack and impact on confidence to self-manage.
- Practitioner feedback on their confidence in their own ability to help patients self-manage.
- Practitioner feedback on their confidence to manage conditions within primary care.

Intended benefits:

- Increased patient confidence to manage their condition and make informed decisions.
- Improvement in health outcomes for patients.
- Increased knowledge and confidence for clinicians to support self-management and shared decision making.




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a. Self-management education and support: Norfolk – algorithm for actinic keratosis pathway and patient information pack case study

The challenge – why here and why now?

In Norfolk, actinic keratosis is the largest source of non-cancer referrals to secondary care (aside from the general category of 'rash'). In north Norfolk, 8% of dermatology referrals are for actinic keratosis (approximately 800 per year). If actinic keratosis is not treated appropriately it can result in cancer but overall it is a relatively low-risk condition, with up-to-date guidance available to be shared with patients lending itself to self-care. The relatively simple advice for treatment of actinic keratosis led the team to believe that they would be able to create significant impact on this issue over the course of 100 days.

What was the idea?

To prepare a simple algorithm (flowchart) for GPs on how to treat actinic keratosis and manage the side effects of treatments, accompanied by new packages of information (based on existing material) for GPs and patients about self-management of actinic keratosis.

Why this idea?

If an algorithm (flowchart) for GPs on how to treat actinic keratosis and information for patients on self-management of their condition are available within primary care:

- GP, nurse and pharmacist confidence and ability to deal with actinic keratosis in the community should improve.
- Patient confidence and ability to self-manage their condition should improve.
- Additional referrals to secondary care should reduce.




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a. Self-management education and support: Norfolk – algorithm for actinic keratosis pathway and patient information pack case study

The intervention – what did they do and how did they do it?

This intervention was led by consultants and GPs. They undertook the following:

- **Reviewed existing information** available to both patients and GPs on the treatment of actinic keratosis.
- **Identified relevant guidelines** required for the pathway.
- **Designed the actinic keratosis algorithm pathway**, including gathering feedback from consultants and GPs on initial drafts.
- **Distributed the algorithm** at the CPD event (see [CPD case study](#)).
- **Created information packs for patients and GPs** about self-management of actinic keratosis and the use of topical treatments by compiling information that already existed into a single, comprehensive pack.
- **Gathered GP and patient opinion of the information packs** through telephone interviews.
- **Launched the algorithm** at the team's half day CPD event, held as part of the 100 Day Challenge.



What did people say?

Two patients recommended the continued use of the self-care pack:

"It sorted me out largely, so yes, [I'd recommend it]"

"Yes, because it works!"

Patients, Norfolk.


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a. Self-management education and support: Norfolk – algorithm for actinic keratosis pathway and patient information pack case study

Lessons learned

Algorithms and information packs are relatively simple and accessible approaches to increasing GP confidence and knowledge of different pathways and patient self-management. The learning from this idea could be applied to different subspecialties and conditions.

Framing the algorithm and information packs as a guide rather than a mandated process helps to make sure that GPs still feel able to refer to secondary care if they have concerns about the progress of a patient's condition. It also means they feel able to use their own specialist knowledge to make decisions.



Headline achievements:

- The actinic keratosis algorithm was approved by all consultants at Norfolk and Norwich University Hospitals and launched.
- Positive feedback on the packs from the limited feedback received in the 100 days (of three patients who had used the resource, two were happy with the pack, while one had not used it).

You can find further information about this work, as well as other case studies on the [Elective Care Community of Practice](#) pages. For more information, please email: england.electivecare@nhs.net


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What is a one stop clinic?

A one stop clinic is an outpatient clinic held either within secondary care or the community where patients are assessed, diagnosed and treated on the same day. Patients receive ongoing treatment advice and guidance if appropriate before being discharged back to the care of their GP.

These clinics are typically consultant led and specifically for non-complex cases where patients are unlikely to require ongoing support or input from secondary care.

Patients are sent information in advance of the clinic so that they can make an informed decision about their treatment options before they are seen.

Why implement one stop clinics?

If a one stop service allowing assessment, diagnosis and treatment to take place on the same day is introduced within secondary care:

- **Patients** should be able to access appropriate support quickly and be treated in one visit, meaning fewer trips to hospital/community settings for each procedure and less time spent on waiting lists. Patient satisfaction will increase as a result.
- **Practitioners** should be able to contribute their respective expertise and skills to quickly assess, diagnose and treat conditions in one clinic, leading to increased positive feedback from clinicians.

- There should be a reduction in the number of appointments per procedure for each patient and therefore a reduction in waiting times for urgent and routine appointments with secondary care clinicians. The number of outpatient attendances and follow up appointments should reduce, along with the overall cost per patient.

We know it works:

A systematic review of 29 studies identified that one stop clinics are associated with a reduction from 75 to 15 days in the interval from referral to testing. 79% of patients were diagnosed the same day, compared to 25% on traditional pathways (Friedemann et al., 2018).

Since the start of the one hundred days in Stockport:

- A successful trial with 68 patients received positive response from patients, clinicians, nurses, administration and management teams. Nine out of ten one stop patients surveyed said they preferred having the procedure done on the same day compared to coming back another time.
- Average waiting time for two week wait patients fell on average by 13 days from 15 days to two days.

Since the start of the one hundred days in Lincolnshire:

- The team has run a successful trial of their spot clinic (see '[spot clinic](#)' case study) and have a plan to develop this into a one stop clinic.


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How to achieve success: implementing one stop clinics

The sections below include learning from sites in Wave 2 of the Elective Care Development Collaborative:

Coordinate efforts with other relevant bodies

- Consider linking in with external organisations such as the British Association of Dermatologists to make sure the appropriate level of information about one stop clinics is sent to patients in advance of their clinic appointment.

Obtain patient consent

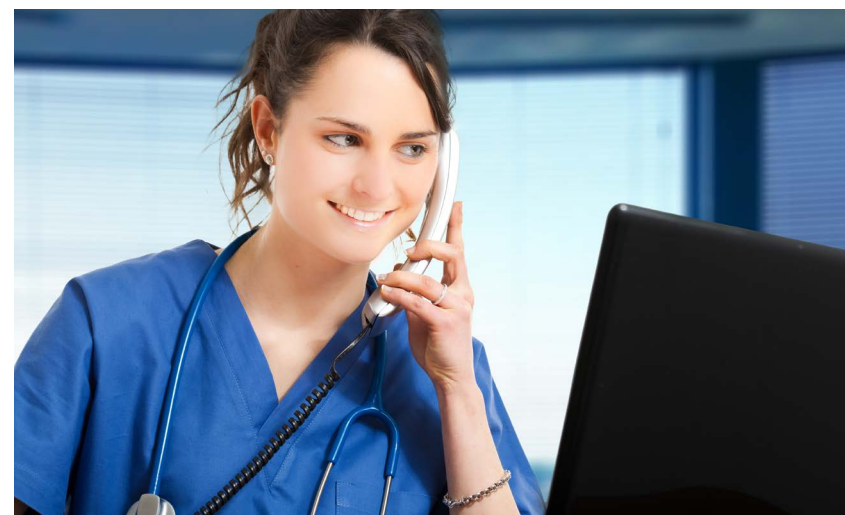
- Identifying opportunities for patients to give and reconfirm their consent to satisfy confidentiality is an important part of the design of one stop clinics. A two stage process, for example, may involve gaining consent via post before the appointment and creating time in the outpatient department on the day of the clinic for the healthcare team to confirm that the patient wants to proceed with their decision.

Enable live feedback

- Capturing live feedback from clinicians and patients after each clinic means that the process can be adapted and improved quickly.

People you may wish to involve from the start:

- consultants
- specialist nurses
- service manager
- commissioners
- administration staff




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Plan the clinic

- Identify the services and space that will be necessary for the clinics. This may include staff and equipment for both diagnostics and treatment.
- Ensure that you have appropriate clinicians, nursing and administrative staff in place to cover the clinics.
- Research the documentation needed for patients prior to an appointment at the clinic and ensure that processes are in place so that this can be completed in advance.
- Consider how processes may be streamlined to reduce costs and administrative time. For example, bookings may be done simultaneously and information can be sent to patients at one time rather than on separate occasions.

Ensure access to diagnostics

- It is essential that all necessary services are easily available for the one stop clinic.
- Engage clinicians from across specialties including diagnostics in the design of the clinic to ensure that the service can run smoothly.

Resources required:

- Theatre space
- Time to carry out post clinic survey or consultation with patients.

The following standards and guidance may be useful:

British Association of Dermatology guidance:

[Outreach Clinic Guidance for Dermatology Services](#)

[Guidance for Commissioning Dermatology Services](#)

[Staffing and Facilities Guidance for Dermatology Services](#)

[Actinic Keratosis Primary Care Treatment Pathway](#)

[Outpatient clinics – A Guide to Good Practice, Royal College of Surgeons 2017](#)


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Metrics to consider for measuring success

Think about how you are going to provide evidence of the impact you are having. This is not an exhaustive list. However, the following metrics could be used to help demonstrate impact.

Quantitative

- Number of referrals to two week wait pathway.
- Wait list for two week wait referrals.
- Average waiting time (referral to treatment) for two week wait pathway.
- Number of patients seen at one stop clinic.
- Number of patients treated on the same day at the one stop clinic.
- Number of outpatient attendances.
- Breaches in waiting times for surgery.
- Number of referrals to standard pathway.
- Average waiting time (referral to treatment) for standard pathway.
- Standard pathway number of days end to end.
- Two week referral pathway number of days end to end.
- Number of patients seen in average theatre clinic.

Qualitative

- Patient feedback on satisfaction through survey and follow up telephone calls.
- Practitioner feedback on clinic effectiveness.
- Patient and/or clinician video or case studies demonstrating the difference in outcomes. Think about how you are going to provide evidence of the impact you are having.

Intended benefits:

- Reduced number of appointments per patient procedure.
- Reduced cost per procedure.
- Increased patient satisfaction.
- Reduction in time from referral to treatment.


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The challenge – why here and why now?

Under the wider 'Stockport Together' programme, there is an ambition to reduce outpatient attendances by 55% to 65% over the next three years. The dermatology team also wanted to focus on addressing the current long waiting times. Stepping Hill Hospital has high demand for dermatology theatre appointments in the two week wait service (approximately 15 days) and as a result, patients can experience delays in this pathway. By offering two week wait patients a same day procedure, the aim was to reduce their overall pathway length by up to 14 days.

The intervention – what did they do and how did they do it?

The team employed a whole system approach, including input from consultants, nurses, a service manager, commissioners, a representative from the British Association of Dermatology and administrative staff. During the one hundred days, they undertook the following:

- **Researched and designed the patient information that patients needed to receive prior to attending a clinic,** linking in with the British Association of Dermatology for advice and recommendations.
- **Sent letters including this information to patients,** explaining that they may have a procedure done on the same day as their clinic if appropriate.
- **Designed a one stop rota for trial month** and communicated this with the dermatology team (including clinicians, nursing and administration staff). Service managers highlighted theatres that could be used as part of one stop clinics and those assigned to routine work.
- **Encouraged live feedback from clinicians to management team** and made changes for next clinics throughout 100 days.
- **Completed qualitative telephone survey** with ten patients attending a one stop clinic to get their feedback (for illustrative results see 'What did people say?').


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Lessons learned

- Running one stop clinics can enable theatre lists to be fully utilised as there was less chance of patients not attending appointments (DNAs). It also facilitates interaction between listing and operating consultants to ensure that patients receive optimum care.
- Developing a clear plan and agreeing all processes prior to roll out is important. The team delayed going live by one month to ensure that they had the right processes in place.
- Developing clear documentation for patients regarding what to expect and when they formally give their consent for procedures is vital to make sure that patients are able to make informed decisions. Any information developed should be compliant with the British Association of Dermatologists.
- Building good relationships with clinicians and management prior to implementation helped to make sure that feedback was given. The team were responsive to this and comfortable making changes.
- Receiving information about the one stop clinics at the time of referral to secondary care rather than later on can help patients make an informed decision about their treatment options and encourage them to attend the most appropriate secondary care appointment.

Headline achievements in 100 days:

- In a six week time period, of 100 patients listed for a procedure, 68 had their procedure done on the same day as their clinic appointment.
- Average theatre waiting time for two week wait patients fell by 13 days from 15 days to two days (15 patients audited in March 2017 compared to 15 in March 2018).
- Positive response from patients, clinicians, nurses, administration and management teams: 90% of one stop patients surveyed said they preferred having the procedure done on the same day compared to coming back another time.

What did people say?

"I think in terms of cancer tracking targets and potential breaches, this trial has been nothing short of a complete success. I am hardly ever using the theatre delays tracker, and if so, it is never to do with capacity... rather, patient holidays, which is out of our control."
Theatre coordinator, Stockport.

You can find further information about this work, as well as other case studies on the [Elective Care Community of Practice](#) pages. For more information, please email: england.electivecare@nhs.net


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All dermatology teams made significant progress during Wave 2 of the Elective Care Development Collaborative. The case studies in this handbook show what can be achieved locally in just one hundred days. The ideas reached different stages of implementation but the 100 Day Challenge has proved a catalyst for wider collaborative transformation in dermatology across the participating local health and care systems.



There is learning from across the second wave that will be useful for other areas who are transforming dermatology elective care services. Useful considerations include:

1. **Think big, start small:** start in one area before scaling to test your assumptions and learn what does (and doesn't) work.
2. **Involve people from across the system:** working with people from across the system will help you to understand unintended or unexpected impacts of your ideas and help you think differently about what can make the most difference. The teams found it particularly helpful to work alongside people with lived experience as they developed and tested their ideas.
3. **Don't focus too much on high tech solutions:** if access to technology is a barrier, consider low tech alternatives as a starting point to test proof of concept and help make the case for any future investment.
4. **Develop and maintain relationships with system leaders:** engage with senior leadership to open new lines of communication and create an environment in which frontline staff know they have permission to test their ideas. Foster the development of relationships among all members of the team, and be honest about challenges so that system leaders are aware of what is happening and can help to unblock barriers as they arise.


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9. Key resources

- [Guidance and competences for GPs with Extended Roles in dermatology and skin surgery \(Royal College of General Practitioners, 2018\).](#)
- [How can dermatology services meet current and future patient needs while ensuring that quality of care is not compromised and that access is equitable across the UK? \(British Association of Dermatologists 2015\).](#)
- [Quality standards for Dermatology \(Primary care Commissioning, 2011\).](#)
- [Quality Standards for Teledermatology \(Primary care Commissioning, 2013\).](#)
- [RCGP framework to support the governance of GPs with Extended Roles \(Royal College of General Physicians, 2018\).](#)
- [Outreach Clinic Guidance for Dermatology Services \(British Association of Dermatologists, 2013\).](#)
- [The Person-Centered Dermatology Self-Care Index: a tool to measure education and support needs of patients with long-term skin conditions \(Cowdell et al., 2012\).](#)
- [Actinic Keratosis Primary Care Treatment Pathway \(Primary care Dermatology Society, 2007\).](#)
- [Guidelines for the management of actinic keratoses \(British Association of Dermatologists, 2017\).](#)
- [Skin diseases in primary care: what should GPs be doing? \(Stephen Kownacki, 2014\).](#)

Patient organisations

- The British Association of Dermatologists has a comprehensive list of patient organisations on their website: www.bad.org.uk/for-the-public/patient-support-groups

Contact us:

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Some interventions tested within the 100 days can be supported by evidence generated from other initiatives and localities. The table below is a summary of which dermatology interventions, and more specifically their outcomes and impacts, can be supported by this evidence.

Intervention	Impact	Link	Description	Location within source
Advice and guidance – e-Referral Service and teledermatology	Reduction in waiting time to access specialist input.	NHS e-Referral Service: Summary (NHS Digital, 2018)	Summary of NHS e-Referral Service. This review concludes that one of the benefits of the e-Referral Service includes shorter referral to treatment times.	Section: Benefits of the service
Self-management information sources	Improved health behaviours and reduction in secondary care referrals.	Supporting self-management (National Voices, 2014)	Summary of systematic reviews regarding impacts of self-management interventions. The evidence suggests that self-management is improving patient knowledge as well as service usage/costs.	Page: 1, summary table
	Improved health outcomes.	Realising the value (NESTA, 2016)	Final report of the 'realising the value' programme. A key finding of self-management interventions is shown to be the improvement of health outcomes for both mental and physical health.	Page: 18, Mental and physical health and wellbeing


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Intervention	Impact	Link	Description	Location within source
One stop clinic	Reduction in hospital/ community setting trips.	Improving productivity in elective care (Monitor, 2015)	NHS Improvement report around elective care services. One of the good examples shows a clear pathway of a one stop clinic and how various interventions take place in one clinic.	Appendix: C - The Newcastle Upon Tyne Hospitals NHS Foundation Trust 'one stop clinic'
	Reduction in number of follow ups.	Outpatients clinics: A guide to good practice (Royal College of Surgeons, 2017)	A guide to good outpatient clinic practice by The Royal College of Surgeons. The evidence suggests that this will reduce the number of appointments per procedure.	Page: 36