

National Dermatology Implementation Plan

1.	Summary	2
2.	Background	3
2.1	National Planned Care Programme	3
2.2	How change will be achieved	3
2.3	Changes in dermatology services	5
3.	The National Dermatology Implementation Plan	11
3.1	Measuring patient experience	11
3.2	Achieving a “sustainable” service	12
3.3	Clinical value prioritisation	13
3.3.1	Do Not Do	13
3.3.2	Thresholds	13
3.3.3	Urgent and priority groups	14
3.3.4	Holistic approach	15
3.4	Integrated care	16
3.4.1	Care collaborative groups	16
3.4.2	Patient empowerment	16
3.5	Best in class	17
4.	Reporting and collaboration	18
4.1	The Welsh Dermatology Board	18
4.2	The transition process	18
Appendix A	List of actions	19

Summary

The purpose of the National Dermatology Implementation Plan is to improve patient experience and deliver sustainable services. The plan builds on a series of developments in Wales to provide a balanced service change for implementation by health boards across Wales.

The plan requires health boards to understand and measure demand, capacity and activity in Dermatology and establish a patient experience measure for dermatology services in Wales.

The three primary drivers for service change will be:

- Clinical Value Prioritisation - making sure that only the right patients are managed in secondary care.
- Integrated Care - establishing collaborative care groups (between hospital, community and primary care) and empowering patients to manage their health.
- Best in Class - measuring value for money and benchmarking against top performing organisations.

A number of speciality implementation plans have been developed by the National Planned Care Programme Board after stakeholder consultation with advice and recommendations from the planned care reference groups that involves patients and the third sector. The National Dermatology Implementation Plan follows the same principles and contains 13 key actions for health boards to implement.

The plan is issued as a Welsh Health Circular (WHC/2017/040). Health boards' delivery against the plan will be reviewed at each meeting of the Welsh Dermatology Board.

A guidance framework for reporting against the National Dermatology Implementation Plan will be developed.

2.0 Background

2.1 National Planned Care Programme

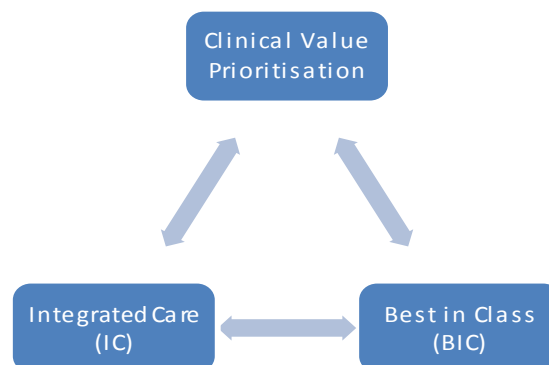
The purpose of the National Planned Care Programme is to:

- 1) Provide “sustainable” planned care services
- 2) Optimise the patient experience of using planned care services.

2.2 How will change be achieved?

The programme requires measurement and management of demand, capacity and activity in each of the outpatient scheduling streams (subspecialties).

To achieve a match between demand, capacity and activity (sustainability) the programme will employ a balanced service change approach based on three primary drivers: Clinical Value Prioritisation, Integrated Care and Best in Class.



Clinical Value Prioritisation (CVP) will include

- Identification and eradication of NICE “do not do” and “interventions not normally undertaken”
- Evidencing agreed pathways of care to ensure correct thresholds of care and management of variation
- Agreeing urgent and priority patient groups
- Taking a holistic approach to patient care including life style modification

Integrated Care (IC) will include:

- Establishing structures in health boards “collaborative groups” (CG) which bring together primary and secondary care clinicians with management support and patient input with agreed terms of reference to ensure that the “right patient is in the right place at the right time”.
- Providing patient empowered entry into the planned care system incorporating education, decision-making aids and a supportive environment for decision-making and a range of treatment options.

Best in Class (BIC) will include

- Establishing outcome measures for each planned care service
- Measuring the cost of providing services using pathway specific tools

The National Planned Care Programme will be delivered according to “managing successful programmes” protocol and will be monitored by a national programme board.

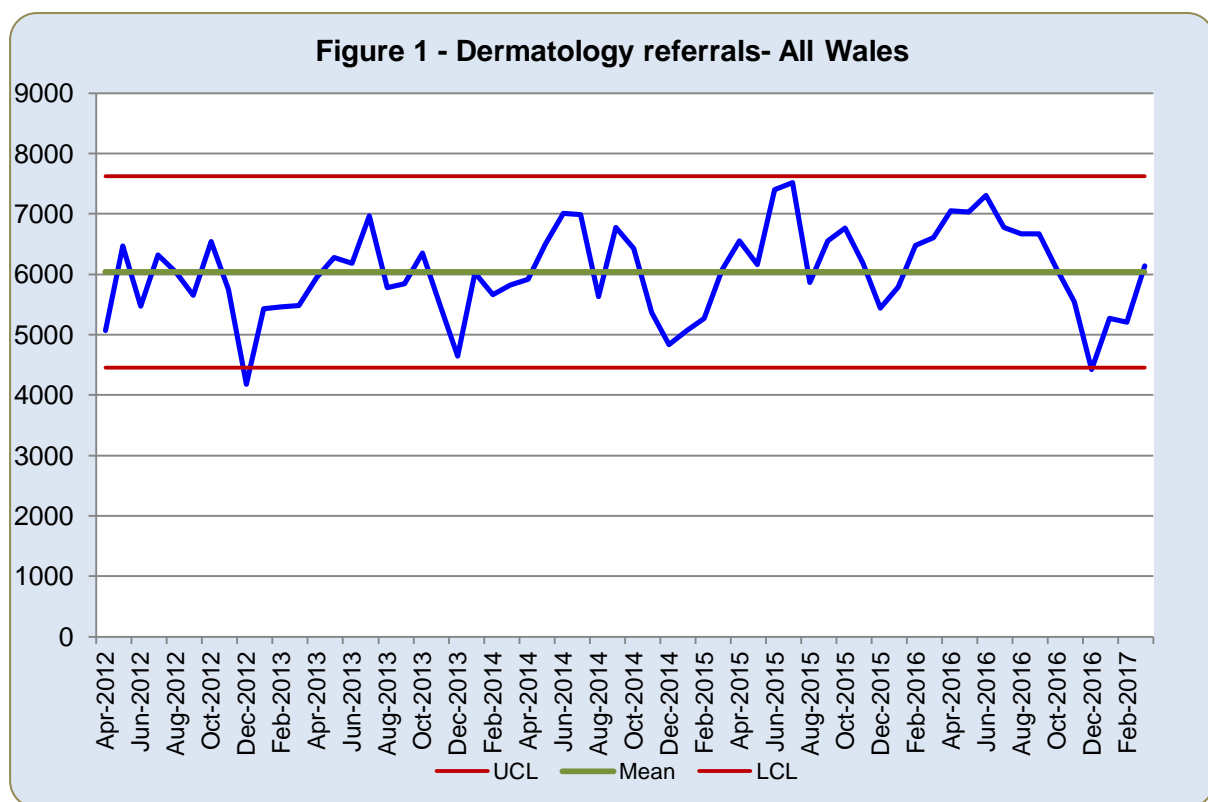
Each national service implementation plan will be delivered by individual health boards and reported through Welsh specialty boards. The programme will be supported by patient involvement and contribution from third sector organisations.

2.4 Changes in dermatology services

Our planned care system is facing challenges and there is a need for significant and urgent change¹.

Across Wales in the last financial year (April 2016 to March 2017) there were 74,208 new outpatient referrals in dermatology², less than ophthalmology and ENT³.

Figure 1² shows the monthly new outpatient referral rate for dermatology across Wales has remained constant³.

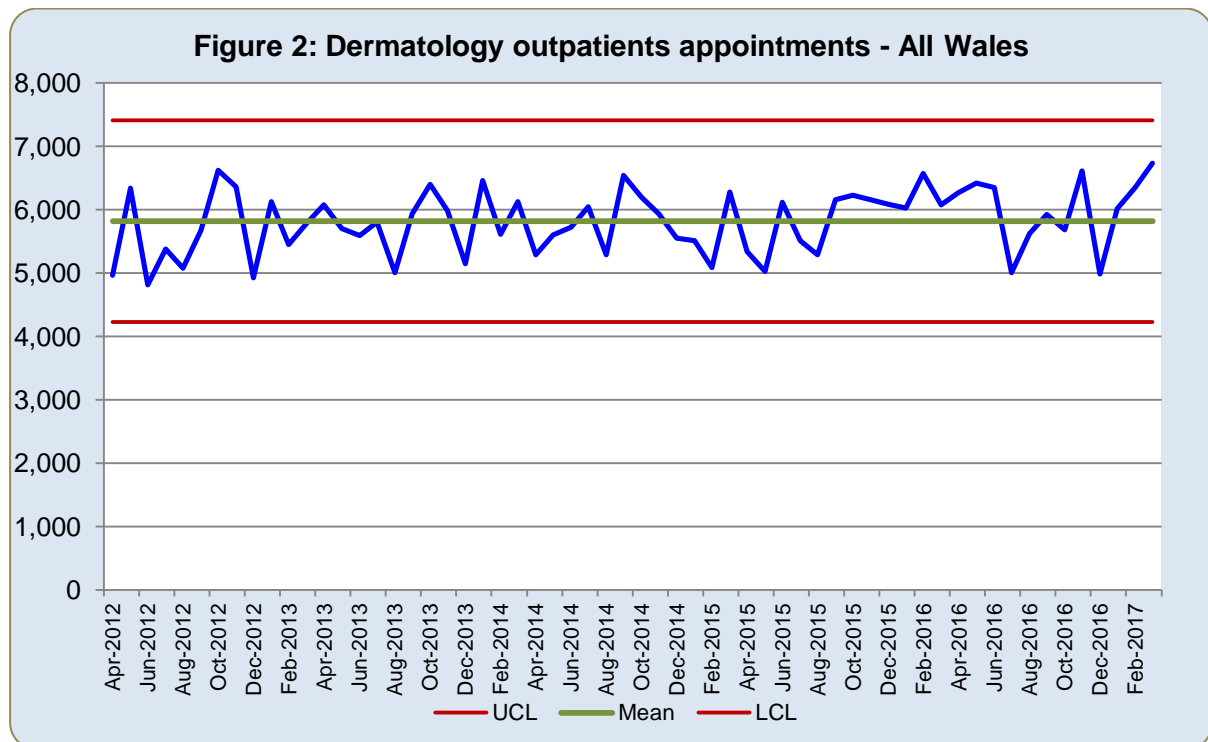


¹ <http://gov.wales/about/cabinet/cabinetstatements/2013/plannedcare/?lang=en>

² NHS Wales Informatics Service Information Services

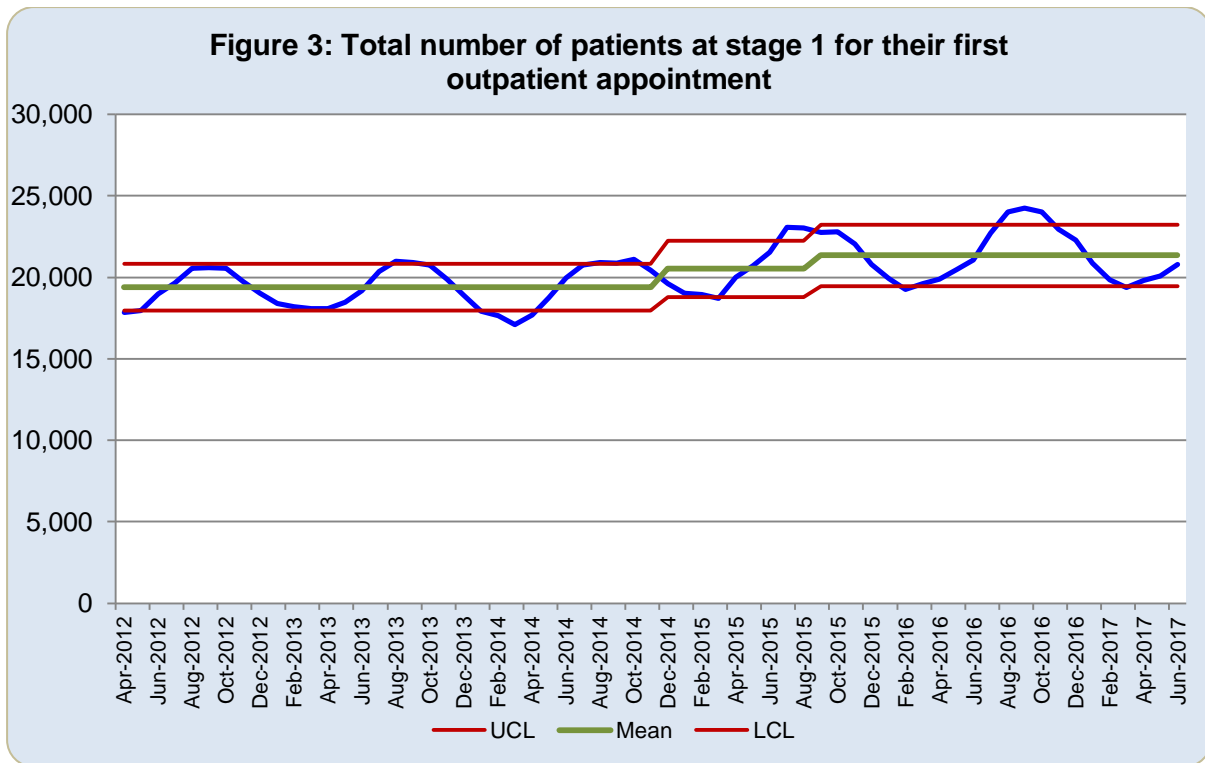
³ Betsi Cadwaladr Health Board has been unable to submit data for part of the health board for November 2016 - May 2017 due to moving to the national Welsh Patient Administration System (WPAS)

During the same period of time, the corresponding new outpatient activity has also remained constant (Figure 2²).

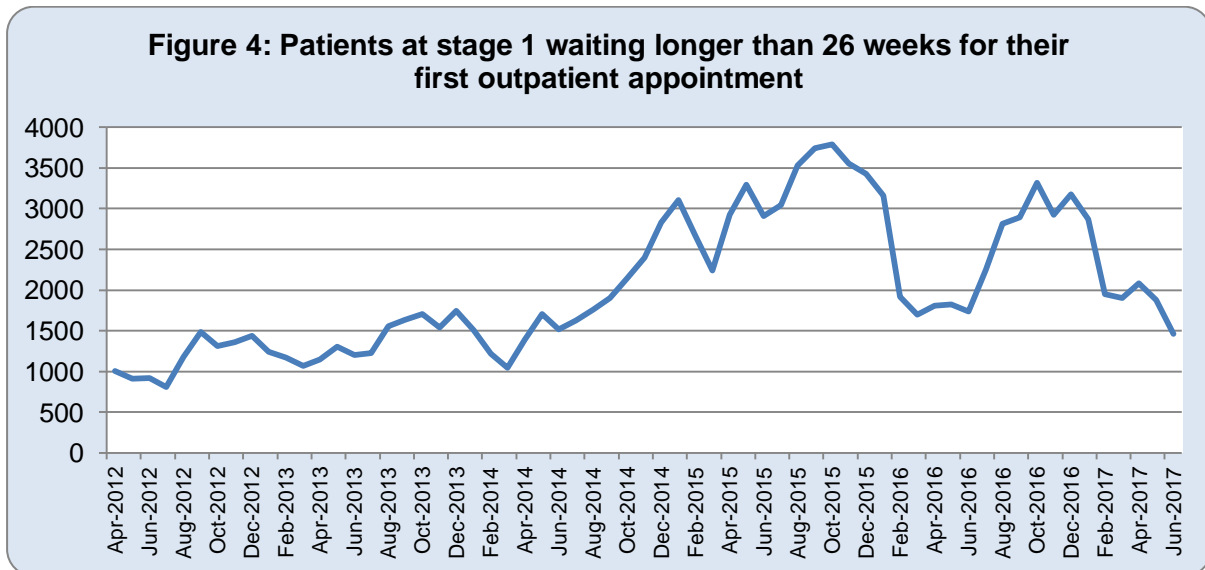


While the median figures for new outpatient demand (6,036 patients per month) and activity (5,817 patients per month) look similar, they conceal a small underlying gap of approximately 200 appointments per month.

Virtual activity such as Teledermatology is not captured in reported activity data. However, despite increasing use of virtual systems of care, the total numbers of patients waiting for a new outpatient appointment has still increased (Figure 3²).



The numbers of patients waiting longer than 26 weeks for their first outpatient appointment (Figure 4²) has increased, suggesting a significant element of treat out of turn⁴.



The impact of additional activity (waiting list initiatives / outsourcing) on the *structural deficit* (gap between demand and activity) is currently unknown but likely to be considerable.

There is no similar national reported data for follow up outpatients; data submitted by health boards is not officially validated by Welsh Government.

⁴ Patients not treated in order of clinical priority/ chronological order – 1000 lives

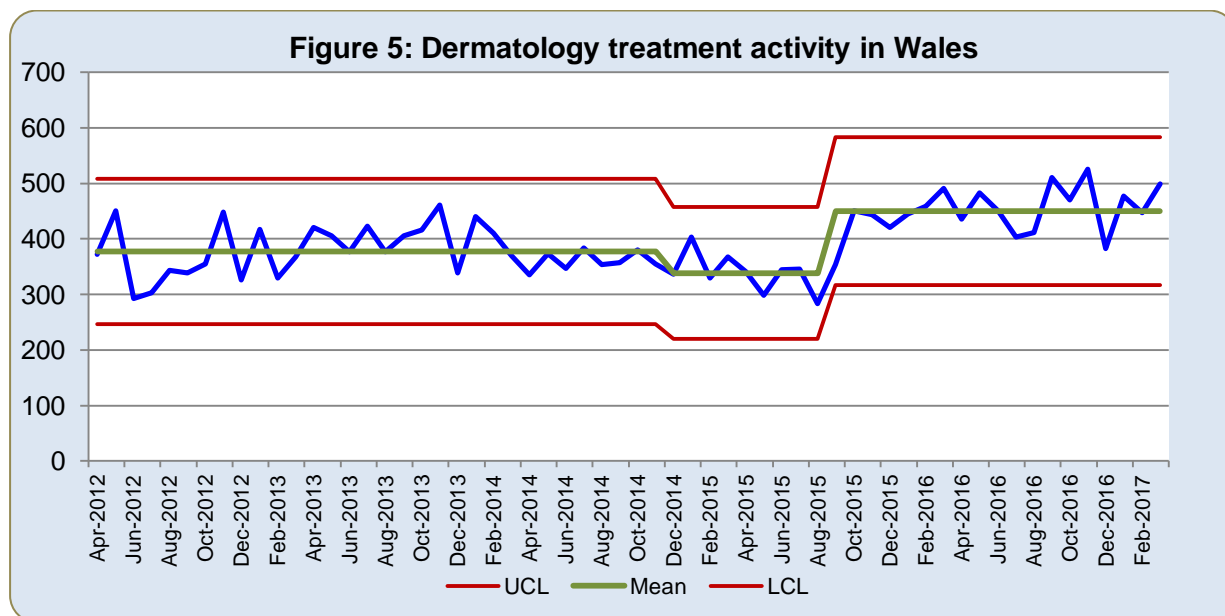
Table 1⁵ shows the average monthly volumes of patients waiting for a follow up outpatient appointment (April 2016 to March 2017) for each health board in Wales. These figures include booked and non booked patients as well as patients with no follow up date. The data confirms that the numbers of patient waiting for follow up appointments in dermatology is far greater than for new outpatients.

In addition there are significant differences in the number of patients waiting for follow up appointments between the different health boards. The follow up phase of the patient pathway will therefore be an important part of service redesign.

Table 1⁵: Monthly average numbers of patients on the follow up waiting list by health board (April 2016 to March 2017)

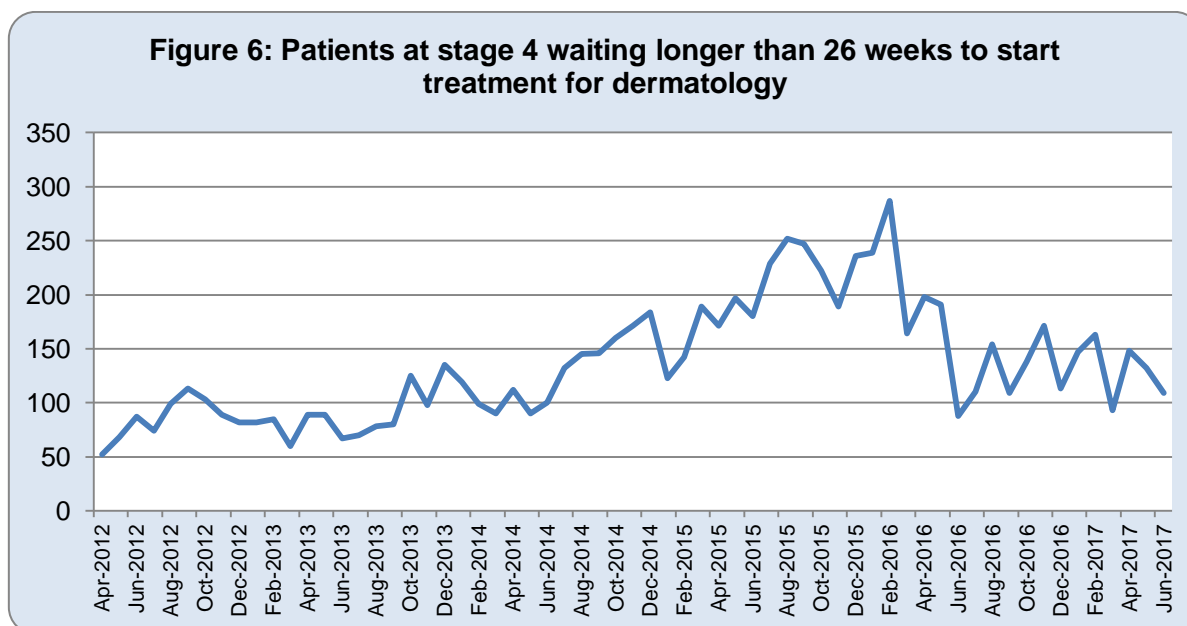
	ABUHB	ABMUHB	BCUHB	CVUHB	CTUHB	HDUHB	All Wales
Follow up waiting list	5,716	7,202	8,715 ³	10,907	2,249	1,796	33,873
New OPD waiting (total)	112	56	38	89	83	71	532

Figure 5² shows the all Wales Dermatology ‘surgical’ treatment activity.



⁵ Welsh Government reported data

Figure 6² shows the number of patients waiting beyond 26 weeks to start treatment for Dermatology.



A high proportion of Dermatology treatment is performed in an outpatient setting and is not captured in the officially reported treatment activity levels. Therefore the true treatment activity and waiting time performance cannot be derived from the graphs above. It is important that this anomaly is remedied in the work of the Welsh Dermatology Board. Only then will it be possible to accurately assess the true balance between demand and activity for surgical treatment in dermatology as well as changes in treatment demand over time.

Prudent health care policy⁶ is addressed by a strategic approach to changes in planned care services across Wales, which embrace the following;

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
- Care for those with the greatest health need first, making the most effective use of all skills and resources;
- Do only what is needed, no more, no less; and do no harm;
- Reduce inappropriate variation using evidence-based practices consistently and transparently.

There is a need for conditions such as psoriasis to be considered as a “teachable moment” in order to focus attempts to modify lifestyle factors that adversely affect outcomes after treatment.

⁶ www.1000livesplus.wales.nhs.uk/prudent-healthcare

Integrated care is based on the principle of achieving health and wellbeing with the patient and public as equal partners through co-production. The National Planned Care Programme aims to remodel the relationship between user and provider by empowering patients to become more knowledgeable and confident in making the correct treatment decision using a variety of related approaches including patient activation, decision support tools and peer support in a suitable supportive environment.

Finally, measurement of service quality and cost ensures the concept of value for money is real and transparent thus enabling health boards to develop actions to match top performing services and organisations.

The Dermatology Implementation Plan is a service change initiative that builds on new approaches to develop sustainable services with optimal patient experience.

3. The National Dermatology Implementation Plan

Dermatology encompasses a range of diseases such as skin cancers, psoriasis and inflammatory skin conditions and a wide variety of treatments including surgery and biological agents. Services are provided for large numbers of children as well as adults.

In addition to technological advances in treatment, major changes in the way that dermatology services are provided are evolving with increased use of new technologies to enable virtual assessment of patients, avoiding face to face consultations in selected cases.

The National Dermatology Implementation Plan, through consultation has agreed that its focus will be upon addressing the key areas that will support the development of a sustainable service in Wales. It therefore focuses upon those areas where changes can be made in the most efficient and effective manner.

3.1 Measuring patient experience

The National Dermatology Implementation Plan aims to optimise patient experience by taking actions to improve patient experience using the principle of “you said we did”. The outcome of the questionnaire used to obtain the Patient Reported Experience Measure (PREM) is not intended to rank health boards according to patient’s responses, but to understanding current problems in care delivery, inform continuous improvement and redesign of services and also help professionals reflect on their own and their team’s practice based on the feedback from patients experience.

In order to demonstrate progress and success in measuring patient experience, it will be necessary for each health board to adopt a standard questionnaire (enabling patients to comment and reflect on their experiences across the pathway).

Action 1 Health boards will collect and report on patient reported experience measures (PREMs).

3.2 Achieving a sustainable service

The purpose of the plan is also to achieve a sustainable service by matching demand and activity for each of the following patient streams:

- Urgent suspected cancer
- Other paediatrics
- Other adults

All pathways with the exception of the suspected cancer pathways may also have a prioritisation by the degree of urgency (“urgent” and “routine”).

Health boards will adopt systems to measure demand, capacity and activity in each of the above patient streams at the high-level pathway points:

- New outpatient
- Follow up outpatient
- Treatment

Action 2 Health boards will put in place systems to measure and report demand, capacity and activity according to an agreed set of national (all Wales) parameters for each of the pathways above.

3.3 Clinical Value Prioritisation

3.3.1 Do not do

Prudent healthcare principles encourage clinicians to “*do no harm*”. The list of procedures that clinicians should avoid includes NICE “Do not Dos” (DND), “Interventions not Normally Undertaken” (INNU) and health board decisions on procedures that should not be undertaken.

In dermatology, the DND focus will be on excision of benign skin lesions and whether or not these are performed in primary or secondary care setting.

There may also be patients on waiting lists that, for administrative or good clinical reasons who do not need to be seen. A process of validation can remove such waiting list entries by either administrative (clerical validation) or clinical staff (clinical validation).

Action 3 Health boards will report the number of patients with benign skin lesions seen by secondary care clinicians (new outpatient activity) and the number of benign skin lesions excised in both primary and secondary care (treatment activity).

Action 4 Health boards will undertake waiting list “validation” to remove patients who don’t require a new or follow-up outpatient appointment.

3.3.2 Thresholds

The prudent health care principle of caring for those with the greatest needs first, involves carrying out the minimum appropriate interventions while focusing upon a smaller number of areas with greater impact and outcomes.

Health boards should establish processes to prevent referral into secondary care of patients who will gain little benefit from the referral. In dermatology this involves the routine adoption of “telemedicine” using principles established by the Welsh Dermatology Board.

In order to make most appropriate use of secondary care capacity (and at the same time optimise patient experience) health boards should maximise the use of one stop clinics (see and treat) for patients with skin lesions.

Any health boards which is deemed to be an “outlier” by the Welsh Dermatology Board will be required to develop a “recovery plan” and participate in a “peer review process” to improve their position

Action 5 Health boards will report on new dermatology referrals / 100,000 population / month. Any health board(s) judged to be an outlier by the Welsh Dermatology Board will need to develop a recovery plan and participate in a peer review process to improve their position

Action 6 Health boards will report the number of new out patient referrals who have a virtual telemedicine assessment and the number of such patients whose face to face consultation is subsequently deemed unnecessary

Action 7 Health boards will report the number and proportion of patients with skin lesions who were treated on a one stop basis.

3.3.3 Urgent and priority groups

Across Wales approximately 1,100 new referrals per month to dermatology services are urgent suspected cancer (USC); which is approximately 17% of all new dermatology referrals⁷. Health boards are monitored against national cancer standards and will continue to report compliance with the 31 day and 62 day standards.

In order to improve cancer referral to treatment performance and in keeping with the planned care programme purpose of sustainability, health boards should aim to ensure that where appropriate that all urgent suspected cancer referrals have their first outpatient appointment within two weeks of receipt of the referral.

All patients who are not suspected as having cancer will be designated “routine”. When there is a compelling clinical reason for a patient to be seen within a shorter time frame, the patient may be designated as “urgent”.

Action 8 Health boards will report time to first outpatient appointment for urgent suspected cancer. Health boards failing to meet the 31 or 62 day standards will be required to provide the Welsh Dermatology Board with a recovery plan focusing on how they will improve their dermatology cancer performance.

⁷ 62 day cancer standard targets (Welsh Government) 2012 - 2016

3.3.4 Holistic approach

Psoriasis is a common skin condition affecting up to 3% of the UK population⁸. Many studies have reported a higher incidence of smoking and alcohol consumption in psoriatic patients.⁹ Both smoking and alcohol consumption have been associated with lower response rates to treatment in patients with psoriasis. In addition, there is higher mortality rate in patients with severe psoriasis and this may at least in part be related to higher levels of co-morbidity associated with life style factors.¹⁰

Patients with psoriasis who smoke or admit to alcohol consumption above the recommended limit (14 units a week¹¹) will be referred to the appropriate local services as part of their active treatment.

In order to enable this holistic approach to patients with psoriasis, health boards should through their public health teams, ensure that there are suitable antismoking and alcohol dependency support services available to local communities and that appropriate referral mechanisms exist.

Action 9 Health Boards will report on local Public Health policies for patients with psoriasis who require access to an antismoking or alcohol dependency programme.

⁸ psoriasis-association.org.uk

⁹ [Gerdes S, Zahl V, Weichenthal M, Mrowietz U. A Dermatology. 2010;220\(1\):38-43. doi: 10.1159/000265557. Epub 2009 Dec](#)

¹⁰ [Pukkala E. Excess mortality related to alcohol and smoking among hospital-treated patients with psoriasis 1999 Dec;135\(12\):1490-3](#)

¹¹ UK alcohol unit guidance (Jan 2016)

3.4 Integrated care

3.4.1 Interface collaboration

New structures called Collaborative Care Groups will be established in each health board to manage the flow of patients between primary and secondary care, similar structures already exist with most health boards having an established eye care group.

It will be the responsibility of each health board to establish their own collaborative based on national terms of reference. The collaboratives will have the following principles:

- Include local professionals (GP and consultant), service managers and patients with health board executive leadership
- Oversee patient streams from primary to secondary care
- Monitor local progress against the National Dermatology Implementation Plan

Action 10 Each health board will establish a Dermatology Collaborative Care Group with a view to monitor patient flow and facilitate delivery of the National Dermatology Implementation Plan.

3.4.2 Patient empowerment

Co-production Wales is clear about enabling citizens and professionals to share power and work together in equal partnerships.

There is evidence that patient activation improves patient outcomes¹². Decision support tools may also enhance patient experience and patients often benefit from a “supportive environment” when they are asked on to make important decisions about their health and well-being¹³.

Health boards will establish and provide decision support mechanisms as part of the collaborative.

Action 11 Health boards will establish patient empowerment measures in the community, and report on the impact on patient flow and outcomes.

¹² Supporting people to manage their health (Judith Hibbard, Helen Gilbert) Kings Fund 2104

¹³ Making shared decision a reality. No decision about me without me (Angela Coulter, Alf Collins) Kings Fund 2011

3.5 Best in class

It is self evident that in order to demonstrate that they are making most effective use of resources, individual services should be able to measure 'value for money' in a way that allows comparison with recognised high performing services or 'best In class'.

In keeping with other specialties in the Planned Care Programme, value for money in dermatology will be based on a single indicator pathway and expressed in measures of quality and cost, in a way which enables value comparisons between the different health boards in Wales.

The indicator pathway will be psoriasis and quality of the service provided will be measured by Psoriasis Area Severity Index (PASI) and the Dermatology Life Quality Index (DLQI). The relative costs of the psoriasis will be based on the biologic spend adjusted for variables such as number of patients and disease severity.

Each health board will have responsibility for managing their own position with regard to outliers. The Welsh Dermatology Board will support actions to improve collective outcomes in individual health boards.

Action 12 Health boards will put in place systems to record, report and manage quality and cost of their psoriasis service according to a standard methodology.

4. Reporting and collaboration

4.1 The Welsh Dermatology Board

Health board's performance against the National Dermatology Implementation Plan will be reported to the Welsh Dermatology Board.

4.2 The transition process

Health boards will be expected to develop and implement a plan to achieve a sustainable service (transition plan) developed as part of the "Integrated Medium Term Planning" (IMTP) process.

The transition plan will be based on the following:

Service changes: numerical impact of actions included in the National Dermatology Implementation Plan

Productivity / efficiency assumptions: numerical impact of any efficiency and productivity gains a health board feels are locally applicable.

Capacity changes: increase in the level of human resource to meet any residual sustainability gap

The transition plan will be presented as a list of products, each with a numerical impact and time line. The expectation is that each product will be managed in health boards as a "project" using Gantt charts (or similar methodology).

Action 13 Health boards will develop and implement a dermatology transition plan to be included as part of their annual integrated plan.

Appendix A: List of Actions

- Action 1** Health boards will collect and report on patient reported experience measures (PREMs).
- Action 2** Health boards will put in place systems to measure and report demand, capacity and activity according to an agreed set of national (all Wales) parameters for each of the pathways above.
- Action 3** Health boards will report the number of benign skin lesions seen by secondary care clinicians (new outpatient activity) and the number of benign skin lesions (treatment activity).
- Action 4** Health boards will undertake waiting list “validation” to remove patients who don’t require a new or follow-up outpatient appointment.
- Action 5** Health boards will report on new dermatology referrals / 100,000 population / month. Any health board(s) judged to be an outlier by the Welsh Dermatology Board will need to collaborate in a peer review process to develop a recovery plan.
- Action 6** Health boards will report the number of new out patient referrals who have a virtual telemedicine assessment and the number of such patients whose face to face consultation is subsequently deemed unnecessary.
- Action 7** Health boards will report the number and proportion of patients with skin lesions who were treated on a one stop basis.
- Action 8** Health boards will report time to first outpatient appointment for urgent suspected cancer. Health Boards failing to meet the 31 or 62 day standards will be required to provide the Welsh Dermatology Board with a recovery plan focusing on how they will improve their dermatology cancer performance.
- Action 9** Health Boards will report on local Public Health policies for patients with psoriasis who require access to an antismoking or alcohol dependency programme.
- Action 10** Each health board will establish a dermatology Collaborative Care Group (CCG) with a view to monitoring patient flow and to facilitate delivery of the National Dermatology Implementation Plan.
- Action 11** Health boards will establish patient empowerment measures in the community, and report on the impact on patient flow and outcomes.

Action 12 Health boards will put in place systems to record, report and manage quality and cost of their psoriasis service according to a standard methodology.

Action 13 Health boards will develop and implement a dermatology transition plan to be included as part of their annual integrated plan.