DERMATOLOGY SERVICE AND ORGANISATIONAL DEVELOPMENT REVIEW

REPORT

May 2021

Sponsored by

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1. INTRODUCTION

This report has been commissioned as part of the organisation's and Care Group's commitment to promoting the delivery of high quality patient services and the provision of first class leadership and teamwork. This report has been sponsored by Dr in her capacity as the Associate Medical Director for Medical Services. The focus of the report is on the Dermatology Department and combines an evaluation of current service capacity and provision with a recommended approach to improving performance. The report is divided into two main sections: one which sets out a service review; and one which addresses the opportunities for organisational development.

2. PROJECT PURPOSE

The aims of this project are to:

A. Improve the working relationship between medical and nursing staff in the department.

B. Create a positive working environment of enhanced quality of care delivery and individual growth.

C. Improve process to efficiently utilise the human and other resources unique to this department.

D. Improve the relationship of the department with related departments and primary care.

E. Improve patient experience (reduce complaints and maintain the reduction of the waiting list recently achieved).

F. Retain staff and expertise and attract more resources to the island.

3. REVIEW APPROACH

The production of this report has been based on a review of the Dermatology Department through: an evaluation of relevant documentation; interviews with key members of staff; outputs from the Department's teambuilding programme; and knowledge of best practice elsewhere in the health care industry. This approach has drawn on available information and data about current service performance.

The following members of staff have contributed to the review:

- – Acting Dermatology Nursing Manager
- – Senior Staff Nurse
- Dr - GP
- Dr - Locum Consultant
- – ENT/plastics Consultant
- – Lead Nurse for the Care Group
- – Health Care Assistant
- – Department Secretary
- - Appointments Clerk

- Dr - Locum Consultant
- Dr – Clinical Lead for the Care Group
- Mr – Consultant ENT/Head and Neck
- - Staff Nurse
- – Interim Clinical Nurse Specialist

4. CARE GROUP CONTEXT

The Dermatology Department is part of the Medical Services Care Group. The Care Group is planning to undertake a series of service reviews in order to make sure that there is sufficient capacity and capability to meet future demands and that quality and access standards are delivered.

The Medical Services Care Group has set the following priorities for 2021:

A. The Medical Model (Q1):
A change to the medical model providing consultant led care across all elements of the patient pathway in medicine, this will provide high quality integrated care for our patients. The model will provide increased medical support to patients admitted to the surgical bed base as well as the intensive care unit. To unify medicine and improve accessibility to physical health weekly medical consultant input will be provide to the following units St Saviours & Sandybrook Care Home this closely aligns to the Jersey Care Model of providing an integrated service across all domains of the patient pathway from community to primary care and secondary care.

B. Acute Assessment Unit (Q2):
Aligned to one of the Jersey Care Model's objectives to improve the patient pathway for emergency care the formation of the acute assessment unit will provide integration between medicine & surgery. The Acute Assessment Unit will be the route of unscheduled admissions to the hospital for both specialities staffed appropriately to ensure timely patient care is delivered to patients in the acute phase of their pathway. The unit will be medically staffed by the acute physicians and an emergency surgeon. The unit will operate the Enhanced Care Area whereby patients requiring level 1+ care can be safely managed in a non-intensive care setting. A training needs analysis is underway and relevant study days to support this.

C. Outpatient Project (Q2):
Currently across medical services the six outpatient departments are managed within the care group independently, the out-patients project seems the centralisation of outpatients through single line management, this improvement will ensure consistency from both a patient & staff perspective in how outpatient services are operated within the care group.

D. Hospital Wide Clinical Handover (Q3):
To improve patient outcomes and the quality of care which is delivered a hospital wide clinical handover meeting will be introduced by the Medical Care Group. The meeting will be chaired by the Clinical Coordinator and will support the timely escalation of deteriorating patients across the hospital at shift changeover times.

E. Specialist Nurse Review (Q4):

The specialist nurse review will analyse the activities currently undertaken by this workforce within the medical service care group to review opportunities to further utilise specialist nurses across the care group, this is aligned to the nursing workforce strategy in particular the implementation of Advanced Care Practitioners.

F. Sandybrook Feasibility Assessment (Q4):

Following the closure of Samares interim rehabilitation ward during the COVID-19 pandemic a temporary rehabilitation ward has been established on Plemont Ward at Jersey General Hospital. The Care Group will undertake a feasibility assessment of Sandybrook as to whether a rehabilitation unit could operate from this location. The outcome of the feasibility assessment will determine next steps for this project.

The following Care Group priorities have direct implications for the Dermatology service:

- Outpatient Project (C)
- Specialist Nurse Review (E)

5. DERMATOLOGY SERVICE DESCRIPTION

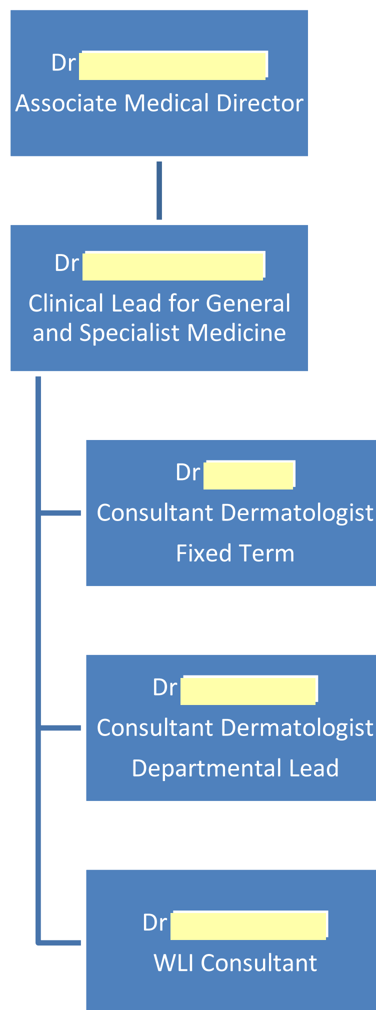
Department Service Outline

The Dermatology Department provides the full range of clinical services associated with a standard acute district general hospital, and is principally an outpatient-based service. Tertiary care is referred to Southampton General Hospital. The Department employs the following members of staff:

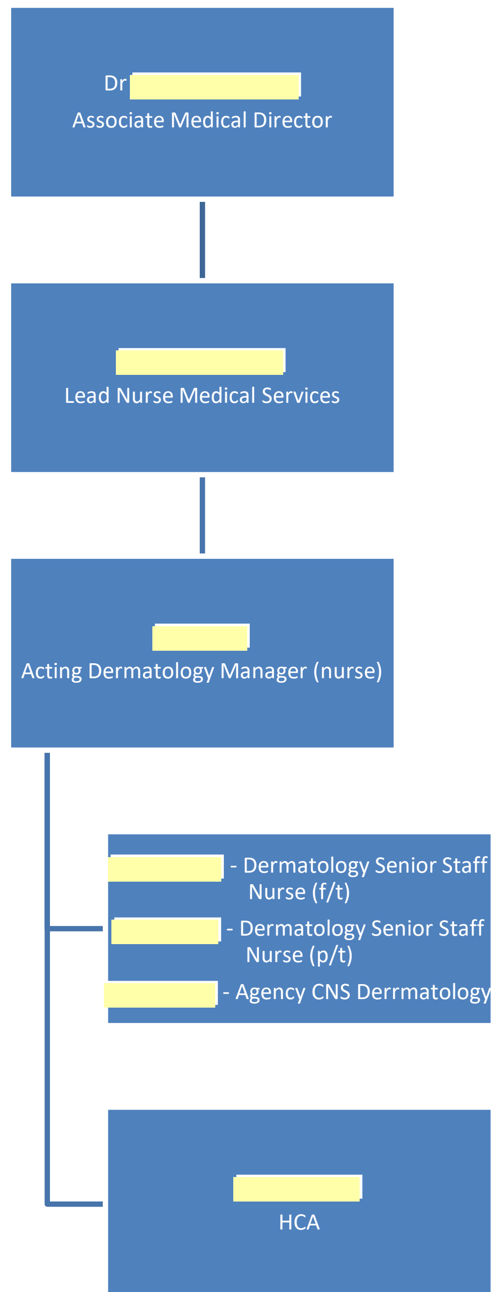
- 1 wte substantive consultant
- 1 fixed term contract for 1 year – funding for substantive available and out to advert
- 1 locum consultant for 6 months
- 3.5 wte nurses
- Administrative staff

Staff and Management Structure

Medical Management and Staffing Structure



Dermatology Department Structure



Department Clinical Services

The Department has established a range of patient pathways, which were approved on 19th March 2021. The set of pathways include the management of the following conditions:

- Acne
- Psoriasis
- Urticaria
- Actinic keratosis
- Atopic eczema in adults
- Atopic eczema in children

- Hand and foot eczema
- Rosacea
- Hidradenitis suppurativa
- Basal cell carcinoma
- Squamous cell carcinoma
- Suspected pigmented lesions
- Benign skin lesions

6. SECTION ONE: DERMATOLOGY DEPARTMENT SERVICE REVIEW

This first section of the report provides a summary, with analysis, of the Dermatology Department's service provision and capacity. This approach enables a baseline to be established so that a view can be taken on whether the capacity and capability of the Department is able to meet future demands on the service. This review establishes a thorough baseline from which future service developments and changes can be introduced and monitored.

The Department has made significant progress in a number of areas, such as:

- **Waiting times:** Reduction from 306 patients waiting more than three months in 2017 to 29 on 2021.
- **Referral guidelines:** Roll-out of referral guidelines.
- **Melanoma detection:** Early detection of melanoma from 15% t0 45%.
- **Clinical audit:** Regular programme of clinical audits.
- **Service volume:** Dermatology accounts for 5% of total OPD activity [source: www.gov.je] – 733 consultations (up from c400 in 2019) and 60 minor ops undertaken each month.
- **Service continuity:** During the pandemic, 66% of all activity was maintained during 2020 compared with 2019.

Service Activity – Appointment Outcomes 2020

Appointment Outcomes	J	F	M	A	M	J	J	A	S	O	N	D	Total	%
Not recorded	<5	5	6	0	<5	<5	<5	5	<5	<5	<5	<5	36	3%
Add to elective list	1	31	21	<5	<5	<5	32	37	11	16	6	23	188	17%
Awaiting report	0	<5	0	0	0	0	0	0	0	0	0	0	<5	0%
Discharge	18	32	33	10	12	31	64	25	19	28	22	50	344	31%
Follow-up appointment given	17	32	43	18	12	38	40	43	22	36	45	43	389	35%
Referred to test/investigation	0	<5	0	0	0	0	0	0	0	0	0	0	<5	0%
Referred to specialist nurse	7	7	<5	0	0	0	6	10	0	<5	<5	0	36	3%

Referred to another consultant	0	0	0	0	0	7	7	0	0	<5	<5	<5	18	2%
Referred to another department	<5	17	<5	0	0	0	8	<5	<5	8	<5	7	60	5%
SOS appointment 6 months	<5	<5	<5	<5	<5	0	6	7	0	<5	<5	5	34	3%
Transferred to private care	0	<5	0	0	0	0	0	0	0	0	0	0	<5	0%
Total	49	129	118	32	30	81	165	131	59	97	86	132	1109	100%

Service Review

Delivering high quality skin cancer prevention with a focus on early detection and treatment fully aligned with evidence-based guidelines is strongly aligned to Health & Community Service commitments to:

- Support individuals to prevent ill health and adopt self-care as part of their commitment to maintaining a healthy lifestyle.
- Ensure services provided by HCS and external partners are high-quality, efficient and effective.

The table below summarises the key features of the Dermatology service:

Features	Key Indicators	Observations	Actions
Activity	○ 626 patients seen in February 2021 ○ Based on the above month = 7,500 patients per year ○ Average time per patient = 10.6 minutes	Check whether February activity is representative of the full year	Produce a capacity model which meets forecasted demand and implement a staffing service which can deliver the required capacity Implement changes to clinic timetable to align to correct clinic sessions Utilisation of nurse led clinics to increase clinic activity Commissioning of community provider to undertake suture/dressings Begin the confocal service one stop clinic for PLC

Current capacity	○ Mean total capacity = 31 per week ○ Net weekly PTL size change needed to meet = +13 per week ○ Extra slots needed per week : • To sustain level at 65th percentile = +18 • To sustain level comfortably at 85th percentile = +25	Check how required maximum waiting time can be met through increased capacity, greater efficiency and service changes Check what capacity needed to sustain service levels at 65th and 85th percentile levels	Produce a demand model which takes into account: likely demand; changes through demand management initiatives; access targets; and staff productivity Nurse led clinics Review private patient activity taking place in clinic to ensure it is during non-contracted hours Submit proposal for charitable funding for clinical fellow post in dermatology and confocal Implement job planning
Clinics	○ Proposal to introduce a new clinic to see excema, undertake cryotherapy, and provide gateway triage for GPs ○ Short-notice cancellations of clinics and slot reduction	Check whether this can be provided within existing capacity and evaluate the financial obstacles to community-based treatment Check extent of clinic cancellations and slot allocations	Review as part of business case and clinic services evaluation
Demand	○ Mean referrals received = 42 per week: • Urgent = 9 • Routine paper = 33 ○ Estimated maximum PT size = 333-369	Check what future demand could be to model required capacity	Benchmark with other dermatology services what forecasted demand is likely to be and what is best practice Following the implementation of e-referral ensure referrals are rejected

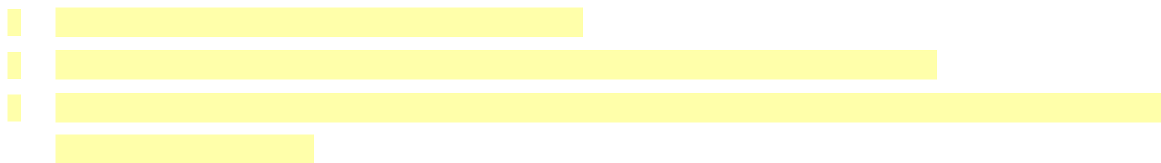
			with advice if the primary referral guidelines have not been followed
Non attendance	○ DNAs = 2.4 per week: • Rearranged = 1.8 • Discharged = 0.6 ○ Mean rearranged slots = 21.3 per week	Check how DNA levels can be reduced	Review DNAs for a period to determine how best to reduce non-attendance and provide appropriate clinical interventions
Financials	○ 2021 budget = £664k ○ 2021 forecast spend = £952k ○ Forecast 2021 pay overspend: £93.5k ○ Forecast 2021 non-pay overspend = £219.5k ○ Pay overspend due to medical agency with underspends in SHOs	Check how income (£38k) can be achieved Check how pay spend can brought into balance Check how drugs spend can be brought into balance	Review draft business case in light of demand model and what it is intended to achieve, and include additional investment (e.g. telemedicine) to increase productivity and quality of care Implement medicine CIP for inflammatory patients Implement charging model for confocal to generate income
Nursing roles	○ Roles which are not fulfilled due to insufficient capacity: • Patient paperwork post-clinic • Patient assessment and education • Audit data collection and analysis • Staff education and mandatory study • Responses to patient queries • Dermatology development • Untimely minor ops bookings • Wigs processing	Check to what extent each of these roles are not fulfilled and how they could be undertaken in a timely manner through increased staff capacity and/or skill mix changes	Undertake skill mix review

	• PDT clinics, Effudix and liquid nitrogen follow-ups • No scope to staff phototherapy • SOS wounds and urgent/SOS telephone consultations		
Private practice	○ 15 private patients seen at start of public clinics. ○ Majority are scheduled 30 minutes before the clinic commences ○ There is a list of 23 interventions and procedures with specific charges	Check how non-medical staff are deployed and time allocated to private practice	Review current private practice workload and make sure that income at least matches cost and introduce transparent scheduling which works for both private and public care provision Implement charging model for confocal to generate income
Technology	○ No use made of telemedicine	Opportunity to use telemedicine to improve access and make better use of resources in line with best practice elsewhere	See section below which sets out action plan for the introduction of telemedicine
Waiting times	○ Mean waiting time = 14 weeks ○ Median waiting time = 12 weeks ○ After planned mid-point (week 10) = 52.2% ○ In planned final week (week 15) = 4.1%		Include consideration of backlog and necessary run rate to meet access targets in service planning Review IMAS modelling based on the above action

Service Capacity

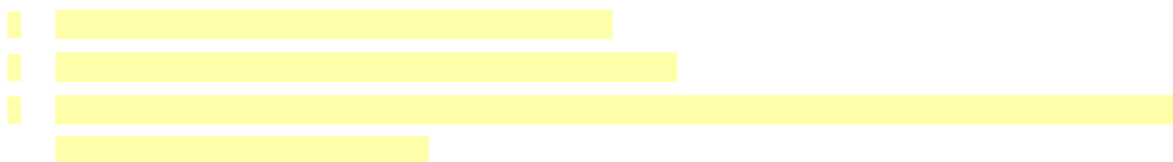
The amount of consultant service capacity can be calculated from the available job plan and clinic schedules.

Consultant (1 wte) with a job plan- capacity:



Consultants (2 wte) without job plans, assessed using weekly timetable – capacity:

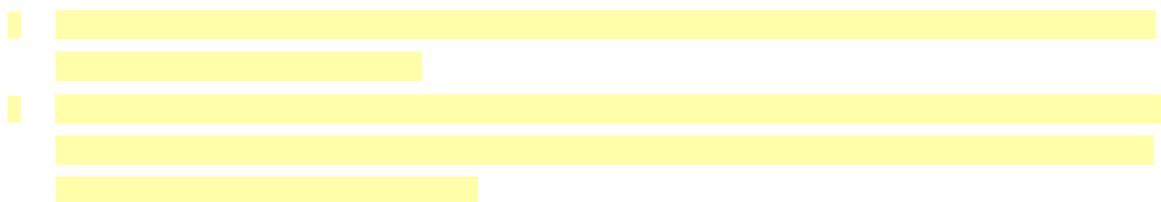
Consultant OPD capacity:



Medical staff deployment – issues to review:

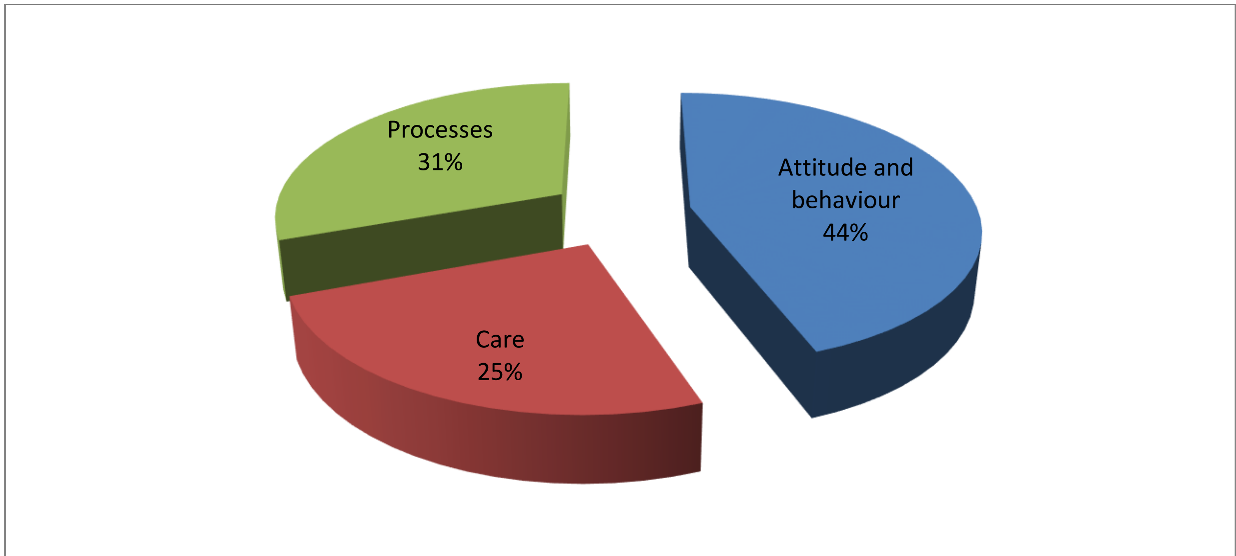
- Numbers of patients booked per clinic and by doctor
- Amount of admin time per clinic by doctor

A separate exercise has been undertaken to evaluate Dr job plan scheduled and indicative activity, which shows:



Service Performance

A formal review of complaints about the service over the past four years (2016-21) shows what has caused the concerns about service practice. The Datix summary is not quite the same as the other source as it is not aligned to Care Groups. The graph below sets out the distribution of complaints by type of concern.



7. SECTION TWO: ORGANISATIONAL DEVELOPMENT REVIEW

The Dermatology Department undertook a teambuilding session in February 2021, in order to support its organisational development programme. This work included the production of a SWOT analysis, and the results are summarised below.

Strengths

- Small Site
- Continuity of Care
- Equipment / Technology
- Knowledge/ Skills of MDT
- Management Support
- Patient Trust
- Team
- Variety
- Intensity of Support
- Commitment
- Environment
- Patient Centred
- Influence in Decisions
- Engagement
- Happy Patients

Weaknesses

- Friction
- Approachable
- Communication/ Handover
- Sharing of Daily Plan (Safety Huddles?)
- Skin Cancer CNS Lack of
- Derm MDT Co-Ordinator Lack of
- Oncology Support / Surgical Support @ MDT
- Case Discussion Sessions needed
- Phototherapy Service Suspension
- Servicing of equipment
- Vacancy – Nursing
- Secretary Support ↑↑
- Engagement – Recep, Secretary, HCAs
- Inclusion

Opportunities

- Cancer Services
- Confocal
- Nurse – Led Support
- Care Group Support
- JCM
- Staff Development

Improvements Done

- Clinic Slots 20 min
- CPD
- Education
- Psychological Impact
- Continuity of Staff
- 2nd Consultant
- WLI 3rd Consultant
- Quality of Care
- Receptionist
- Secretary Space
- Confocol
- Openness / Candor
- E-Refer
- Waiting List
- GP @ MDT

Service Improvement Options

The organisation and performance of the service could be more efficient and effective by implementing the following initiatives as part of the Department Action Plan. This will require the production of a comprehensive project plan which covers: timescales; milestones; leads; mitigation; measures; monitoring; and resources.

Initiative	Details	Impact
Access triage	Limit current open access (virtual and in person) by patients to nursing staff	Increase service capacity
Capacity increase	Model how OPD capacity (core and ad-hoc) can be increased and demand managed so that extra capacity can meet up to 25 slots per week	Meet and sustain required waiting time levels Utilise confocal to implement one stop PLC clinics
Clinic times	Afternoon clinics to start earlier with reorganisation of nursing support	Increase service capacity
Complaints management	Tendency for any complaint to be routed via the formal complaints process which misses the opportunity for real-time resolution	Introduce an initial step when there is negative feedback to seek resolution at the time before going through a formal route
Department action plan	Review and implement project plan for Department agreed actions	Increase operational efficiency and service quality
E-referrals	Fully implement e-referrals system after partial introduction	Increase appropriate access to services and improve record-keeping Enable rejection of referral if protocol not followed Agree timetable to stop accepting referral letters
MDT working	Given the expansion of the clinical team, there is limited capacity to undertake coordination of MDT working	Introduce a MDT Coordinator to fulfil this function
Place of care	Support primary care to provide level of care	Increase service capacity
Recruitment	Complete recruitment to additional nursing capacity (RN and	Increase service capacity

	nurse specialist) so that there are no vacancies	
Secretarial support	Expand the level of administrative support to free up clinical capacity and given the increase in substantive consultant staff, and introduce G2 dictation for pool working	Increase service capacity. Consider increasing main OP admin to full-time to support both departments. Increase flexibility and continuous cover
Scheduling phasing	Review how long it takes to schedule appointments from receipt of referral and bring phasing forward	Meet required minimum waiting times
Team integration	Bring administrative staff into a single line of management	Improve teamwork and staff effectiveness

Service Development Business Case

The Department has produced a business case, which is yet to be approved. The business case recommends a series of steps to address major nursing staffing gaps, to improve quality of care for skin cancer patients in Jersey and to further contribute to the overall quality of service provision and reduction of waiting lists. The critical element of the strategy is a replacement of nurse manager/ nurse prescriber and the recruitment of Skin Cancer Specialty Nurse as per NICE recommendations.

The planned outcomes from the implementation of the business case include:

- Increase the rates of early skin cancer detections in primary care
- Further reduction of invasive skin cancer incidence
- Continue meeting skin cancer treatment targets
- Fully implement NICE skin cancer recommendations
- Raise the standard of service provision – offer full range of treatments
- Reduce risk exposure for the hospital
- Reduce patient wait lists
- Reduce overall costs for the healthcare system

Whilst the business case addresses the need to increase funding for medical staff, this does not increase capacity, as it simply covers the existing overspend. Excluding the impact of new ways of working and greater demand management, the business case does not mean that increased service volumes (clinic appointments) will be delivered so that the minimum waiting times can be achieved. Based on the estimated additional extra 25 clinic slots required per week to meet this requirement, without efficiency improvements, this means that there will need to be an extra 3.2 clinics per week (calculated by using 30 minutes per new patient and clinics running for 4 hours). The final business case needs to take account of the need for more secretarial staffing support.

Implementing Best Practice

The Department would benefit from considering best practice which is already in place elsewhere in healthcare, and to take account of the plans which other health organisations have with regard to service improvement. The introduction of telemedicine is probably the best example of how innovation could improve the efficiency and quality of the Department's services. Imperial College has produced a plan for implementing telemedicine in dermatology, entitled: "A Teledermatology Roadmap for 2020-21 v1.0" [reference: file:///C:/Users/David/Downloads/NOTP%20Teledermatology%20Roadmap%2020202021%20v10%20FINAL.pdf]

This roadmap describes the opportunity which telemedicine presents given the volume of services which dermatology services need to provide. In 2019-20, there were 3m dermatology outpatient appointments in England, making it the sixth highest treatment function in terms of volume. Most dermatology departments struggle to meet the growing new patient demand – and need for ongoing regular reviews – due to the limited consultant workforce. Existing models of teledermatology triage services suggest a significant opportunity for managing demand for diagnosis, and in doing so releasing capacity for better quality and more timely treatment for those who need it. Pilots in Leeds and York receiving referrals with high quality dermoscopic images from GPs suggest approximately 10-30% of cases can be managed without a face-to-face consultation.

This roadmap sets out what all systems can do now to optimise teledermatology triage and advice and guidance to help them safely manage new patient demand while restoring their dermatology services. The roadmap includes information and research produced by the British Association of Dermatology to support the introduction of telemedicine. The roadmap includes five steps to deliver teledermatology triage now:

a) Include images with dermatology referrals and Advice and Guidance requests to enable consultant triage, ensuring face to face attendances only when necessary.
b) Triage both suspected cancer and routine referrals using teledermatology
c) Include clinical review of teledermatology advice and guidance requests and referrals in consultant job plans as part of their direct clinical care.
d) Record teledermatology activity accurately to reflect the type of clinical contact taking place, demonstrate the benefits and support sustainable funding models.
e) Maintain teledermatology pathways through continuous training across professional groups and care settings.

Existing models of teledermatology triage services suggest a significant opportunity for managing demand for dermatology diagnosis, and in doing so releasing capacity for better quality and more timely treatment for those who need it. A fourteen-year review of a UK teledermatology service found that 50% of cases were discharged to the GP with advice and 34% booked directly for surgery. Given the pandemic, teledermatology triage provides the alternative for dermatology outpatient services and by taking advantage of available technologies can also improve productivity while providing the same level of access to high quality care, diagnostics and treatments.

The roadmap sets out a set of actions for each step, which secondary care clinicians can implement:

Steps	Actions
Include images with dermatology referrals and Advice and Guidance requests to enable consultant triage, ensuring face to face attendances only when necessary.	• Consider using eRS RAS pathways for dermatology referral triage • Provide a clear directory of services including consistent naming conventions with inclusion and exclusion criteria. Include clear instructions for the images required, e.g. one positioning and one or two close-up or dermoscopic images for lesions where possible • Provide a teledermatology Advice & Guidance service in addition to a referral triage pathway to provide rapid advice to primary care and avoid unnecessary referrals
Triage both suspected cancer and routine referrals using teledermatology	• Ensure triage of suspected cancers is carried out by consultant dermatologists, ideally members of the LSMDT or SSMDT • Record the correct cancer wait times data for the two-week wait and faster diagnosis standard. Further guidance will be developed on applying cancer wait times guidance to support services introducing skin cancer teledermatology
Include clinical review of teledermatology advice and guidance requests and referrals in consultant job plans as part of their direct clinical care	• Review job plans with dermatology specialists and include direct clinical time for delivery of different types of teledermatology care - triage, virtual attendance and Advice & Guidance • Establish consistent coding and classification practices so that teledermatology care is counted as activity and encourage clinical teams to perform regular audit and service evaluation of case numbers and outcomes
Record teledermatology activity accurately to reflect the type of clinical contact taking place, demonstrate the benefits and support sustainable funding models	• Record teledermatology attendances as not face-to-face activity in the activity dataset • Record teledermatology Advice & Guidance requests and triage outcomes to monitor avoided face to face appointments • Perform regular service evaluation of your teledermatology service, including clinician time, digital resources, equipment and outcomes
Maintain teledermatology pathways through continuous training across	• Provide regular and updated training on use of teledermatology processes for the different care pathways

professional groups and care settings.	• Ensure that software updates or new system integrations are implemented alongside training for all staff

The Welsh National Dermatology Implementation Plan contains useful guidance on what can be achieved through innovation and service development. The Plan set out three primary drivers for service change:

- 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.

Reference: https://gov.wales/sites/default/files/publications/2019-02/national-dermatology-implementation-plan.pdf

8. FUTURE SERVICE PROVISION

Service Provision Options

This report has identified a range of initiatives and activities which need to be implemented in order to develop the dermatology service so that it can meet the growing demand. The Department has the opportunity to increase capacity by investment in additional staffing and the introduction of new ways of working. The new ways of working are intended to increase efficiency and manage demand, so that more patients can be diagnosed and treated within the existing capacity. The proposed new ways of working include: telemedicine; GP referral protocol; extending clinic times; reduction in routine reviews; and skill mix changes, such as extending the role of the specialist nurse and reallocating administrative duties.

There could be obstacles outside the control of the Dermatology Department which might inhibit the a new approach to demand management, such as increasing the role of primary care as patients are required to pay for services which are otherwise free when provided by the hospital. In addition, the Dermatology Department needs to secure investment as well as be committed to introducing new ways of working, such as the use of telemedicine.

The organisation needs to undertake contingency planning should the extra investment not be available and/or the pace of change with regard to new ways of working is insufficient. This contingency plan needs to include more options for alternate methods for the provision of dermatology services. In this respect, plans to appoint a Clinical Nurse Specialist (CNS) and request to The Deanery to appoint a medic al trainee post could be developed.

9. PRINCIPAL ACTIONS

I. **Deliver required capacity** – introduce best performance practice and additional capacity so that required quality and access targets can be achieved.

II. **Organisational development programme delivery** – finalise design of OD programme based on the diagnosis and implement.

III. **Contribute to delivery of Care Group priorities** – design programme to support delivery of Care Group priorities.

IV. **Future service provision** – produce a contingency plan for implementing an alternative method for the provision of the service.

3rd May 2021/kh