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Editorial for BJD May issue

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Authors: Alex Anstey and Andrew Finlay

Dermatology outpatient care in the UK: modernising services requires patients as our partners

Anstey AV^{1,2}, Finlay AY¹

Cardiff University¹, School of Medicine, Heath Park, Cardiff CF14 4XN

Betsi Cadwaladr University Health Board², Ysbyty Gwynedd, Bangor, Gwynedd LL57 2PW

“The time has come to re-evaluate the purpose of outpatient care and align those objectives with modern-day living and expectations” RCP London 2018

“Evening dermatology clinics were introduced in our hospital by necessity as there was no room for more daytime clinics. No one asked the patients for their views”. This dermatologist was struck by the change in atmosphere between evening clinics and daytime clinics. It was the same patients and the same staff in the same clinic rooms, but at a different time; so why the change in atmosphere? The answer was obvious: parking, work and a calm atmosphere. The hospital car parks empty rapidly after five; evening appointments seldom require time off work; there were no competing clinics, so the outpatient department was quiet. Why does this matter? Because having unstressed patients attending at a time that suits them usually results in improved interactions with the clinic staff. Doctoring becomes more enjoyable if the patients are relaxed and have had a chance to prepare themselves mentally for the forthcoming interaction. If patients ask the right questions and are listened to, they have reached first base, improving the chance of creating a shared agenda with their dermatologist. This in turn improves the chance of better patient outcomes and better patient adherence; everyone is a winner. This is just one example, and highlights an imperative: as clinicians we have a duty to bring our outpatient interactions with patients into the 21st century.¹

Outpatient hospital clinics are dynamic systems. For a system to be viable, it must be able to cope with the complexity of its environment.² What has this to do with hospital outpatient clinics? According to the Royal College of Physicians (RCP) report on outpatient services, outpatient clinics have not changed in decades and are no longer fit for purpose.³ In plain language, the complexity of patients' lives and of medical care means that hospital outpatient clinics are doomed to fail unless they can create a variety of options for outpatient care; thus, only complexity absorbs complexity. Imagine the difficulty a dermatologist has in trying to manage an elderly patient with mucous membrane pemphigoid, ensuring understanding and treatment compliance, interacting with ophthalmology and oral medicine specialists, whilst trying to boost morale of the patient and her relatives. A conventional outpatient clinic slot is clearly not the ideal environment for reconciling the competing demands of such a complex clinical situation. With this in mind, the scale of the failure of current outpatient clinics in the UK might not be a surprise: nearly eight million DNAs (Did Not Attend) and a further eight million cancelled appointments in 2016/2017.⁴ Innovation is now needed, recognising that attending hospital is inconvenient, time consuming and costly for most of our patients.⁵

What changes does the RCP report recommend? In essence, major reform of outpatient services underpinned by better use of the technology that is already available. The report includes sixteen principles for good outpatient care (Fig 1). Additionally, the RCP report includes seven exemplar

projects from around the UK, although none relate to dermatology. How have other disciplines responded to the need to deliver excellent services, with limited resources, in a fiscally challenging environment? In short, they have responded with imagination, creativity and innovation. Incremental innovation with tiny improvements to the existing system occurring year-on-year has been the norm in the NHS in recent decades. However, the RCP report acknowledges that healthcare in the UK has now reached the stage where this is no longer sufficient; something more radical is needed. Common themes are apparent from these seven projects: additional funding was relatively small or was not required; a greater focus on improving the patient experience; technology was often used to underpin the changes; collaboration and integration of services between primary and secondary care.³

Most NHS dermatology services in the UK will already have adopted some of these RCP principles; few if any will have embraced all 16. There are multiple examples from dermatology in offering alternatives to face-to-face consultations, thereby increasing capacity, and freeing up outpatient clinic slots for those patients needing clinic interaction⁶. These alternatives include teledermatology clinics^{7,8}, triage of e-referrals to ensure the correct option for each patient^{9,10}, virtual clinics utilising e-mail or telephone¹¹, nurse-led Skype clinics¹², and even patient-initiated consultations¹³. Additionally, there is now growing insight into the nuances of clinician and patient perspectives on outpatient discharge decisions¹⁴. While some dermatologists are restrained by their antiquated NHS clinic appointment systems, many are not and can already offer patients choice for date and timing of appointments. Furthermore, increasing numbers of NHS Trusts and Health Boards have fully electronic patient records, thereby removing the chance of notes failing to appear in clinic, and facilitating access to key data from those records¹⁵. However, some of these 16 principles will be aspirational for UK dermatologists. For example, demand for services being met by supply; care pathways whose aim is to minimise disruption to patient or carer's lives.

Embracing all 16 of these principles will be difficult. Nevertheless, the status quo is not an option, as made clear by the RCP report. Flexibility in how dermatologists work will be important if outpatient clinics are to be more responsive to patient needs. For example, the dermatologist who opened this editorial has two mid-week evening clinics per week and has Fridays off in lieu. Transformative change on the scale recommended by this RCP report is unlikely to occur without help from key players: our patients. There is already a growing literature on patient needs and preferences concerning their care by dermatologists.^{12-14, 16-18} Any changes to the way we run NHS outpatient dermatology services should take stock of this literature. Just as important will be listening to our patient's experiences of outpatient services as we seek to engage our teams in the change process that is now needed.

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References

1. Richards T. Bring outpatients into 21st century (and give patients a say in the design of new services). *BMJ* 2018; 361: k2472 doi: 10.1136/bmj.k2472 (published 6 June 2018)
2. WR Ashby. An Introduction to Cybernetics. London, Chapman & Hall 1956
3. Royal College of Physicians. Outpatients: The future – adding value through sustainability. London: RCP, 2018. eISBN 978-1-86016-734-8
4. Secondary Care Analysis Team, NHS Digital. Hospital Outpatient Activity 2016-17 (accessed January 2019)
5. Anstey A. Innovation in dermatology. *Br J Dermatol* 2014; 170: 229-230
6. Edwards N, Imison C. How can dermatology services meet current and future needs, while ensuring quality of care is not compromised and access is equitable across the united Kingdom. Kings Fund 2015
7. Finnane A, Siller G, Mujcic R, Soyer P. The growth of skin emergency teledermatology service from 2008 to 2014. *Australasian J Dermatol* 2016; 57: 14-18
8. Chuchu N, Dinnes J, Takwoingi Y et al. Cochrane Skin Cancer Diagnostic Test Accuracy Group. Teledermatology for diagnosing skin cancer in adults. *Cochrane Database Syst Rev* 2018; 12: CD013193
9. Morton CA, Downie F, Auld S et al. Community photo-triage for skin cancer referrals: an aid to service delivery. *Clin Exp Dermatol* 2011; 36: 248-54
10. Deluca J, Goldschmidt A, Eisendle K. Analysis of effectiveness and safety of a three-part triage system for the access to dermatology specialist health care. *JEADV* 2016; 30: 1190-4
11. Alwash N, Patel M, Degiovanni C. The virtual systemic monitoring clinic. *Br J Dermatol* 2018; 179 (Suppl 1): 14-16
12. Oostveen AM, Beulens CA, van de Kerkhof PC et al. The effectiveness and safety of short-contact dithranol therapy in paediatric psoriasis: a prospective comparison of regular day care and day care with telemedicine. *Br J Dermatol* 2014; 170: 454-7
13. Khoury et al. A prospective 52-week randomised controlled trial of patient-initiated care consultations for patients with psoriasis. *Br J Dermatol* 2018; 179: 301-8
14. Harun NA, Finlay AY, Piquet V, Salek S. Understanding clinician influences and patient perspectives on outpatient discharge decisions: a qualitative study. *BMJ Open* 2017; 7: e010807
15. Sheikh A, Cornford T, Barber N et al. Implementation and adoption of nationwide electronic health records in secondary care in England: final qualitative results from prospective national evaluation in “early adopter” hospitals. *BMJ* 2011; 343: d6054
16. Golbari NM, Kimball AB, XXXX et al. Assessment of treatment-seeking behaviour in patients with psoriasis. *Br J Dermatol* 2018; 179: 989-990
17. Atwan A, Piquet V, Finlay AY et al. Dermatology life quality index (DLQI) as a psoriasis triage tool. *Br J Dermatol* 2017; 177: e136-e137
18. Van Egmond S, Wakke M, XXXX. Needs and preferences of patients regarding basal cell carcinoma and cutaneous squamous cell carcinoma care: a qualitative focus group study. *Br J Dermatol* 2019; 180: 122-9

Royal College of Physicians: principles for good outpatient care

1. Demand for an outpatient service should be met by the available capacity. Capacity should take into consideration fluctuations in demand and staff availability throughout the year.
2. Interventions to reduce new patient demand should be targeted at all referral sources. They must not deter necessary referrals or damage professional working relationships.
3. Generic referrals should be pooled to minimise waiting times for appointments. Local consultants should review an agreed mix of generic and sub-specialty referrals according to demand.
4. All outpatient care pathways should aim to minimise disruption to patients' and carers' lives.
5. Clinic templates should allow for timing flexibility depending on case complexity and the needs of the patient. They should allow a realistic timeframe to conclude business and avoid frequent unsatisfactory visits.
6. Patients should be directly involved in selecting a date and time for an appointment. That can happen either in person, via telephone or electronically.
7. All clinical information should be available to both the clinician and patient prior to consultation. That includes notes, test results and decision aids.
8. Patients should be fully informed of what to expect from the service prior to appointments. That includes the aim of the appointment and expected waiting times.
9. Alternatives to face-to-face consultations should be made available to patients and included in reporting of clinical activity.
10. Patients should be supported and encouraged to be co-owners of their health and care decisions with self-management and shared decision-making.
11. Patients and community staff should be able to communicate with secondary care providers in a variety of ways, and know how long a response will take. This aids self-management, and provides a point of contact for clarification or advice regarding minor ailments.
12. Access to follow-up appointments should be flexible. Patient-initiated appointments should be offered, replacing the need for routine 'check in' appointments.
13. All care pathways should optimise their staff skill mix. Allied medical professionals and specialist nurses should be an integral part of service design.
14. Letters summarising a clinical encounter should be primarily addressed to the patient, with the community healthcare team receiving a copy.
15. All outpatient services should offer a supportive environment for training.
16. All outpatient-related services should promote wellbeing for staff and patients.