Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	04 December 2018
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Dermatology Service Fragility
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joe Teape, Director of Operations
SWYDDOG ADRODD: **REPORTING OFFICER:**	Karen Barker, Service Delivery Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The fragility of the Dermatology Service in Hywel Dda has previously been highlighted to this Committee, and is currently scored as 20 on the Operational Risk Register.

This paper updates the Quality, Safety & Experience Assurance Committee (QSEAC) on the current issues, mitigation processes and support being provided from Welsh Government and other Health Boards. The Committee is asked to review and support the actions put in place to support the continued delivery of the service.

Cefndir / Background

Across the UK, the medical dermatology workforce has a recognised shortfall in both consultant and middle grade doctors, a shortfall replicated across Wales and the Hywel Dda region. Currently there are 7 consultant vacancies within Wales and a remaining workforce with 45% approaching retirement in the next 10 years. Since 2016, 9 of the 11 Registrars undertaking the Dermatology training scheme have left Wales to take up consultant posts elsewhere, with 8 of them relocating to England. In light of the concern over medical workforce, Skin Care Cymru has commissioned the Medical School from Swansea University to conduct a programme of semi structured interviews with consultants and registrars who have left Wales over the last eight years in order to understand the factors which contributed to the failure to retain staff. It is hoped that this will help to inform the barriers to recruitment and retention across the country.

The Hywel Dda Dermatology service has long been recognised as a fragile service which has been the subject of various reviews led by senior officers within the Health Board dating back to 2010. The specialty is regarded as a 'hard to fill' service with long standing vacancies within the 2 WTE funded consultant establishment for Dermatology, with one vacancy dating from 2014, and a second from 2016. Since 2016, there has been no substantive consultant in post, despite ongoing recruitment campaigns. The service was, however, successful in recruiting three substantive Specialty Grade Doctors in 2016, with two of this number acting as Locum Consultants and supported to gain the appropriate Article 12 qualifications to allow them to be eligible for substantive employment at this grade.

The Nurse Specialist workforce in Dermatology has been developed to support patients in the long term management of:

- Skin lesions
- Cancer pathway
- Management of skin conditions, e.g. eczema, psoriasis, acne

The earlier than anticipated retirement of two senior Clinical Nurse Specialists in early 2018 created a gap in experience and skill mix within the team which is being addressed through speciality specific professional training and supervision. However, it is recognised that this has impacted on the number and complexity of patients that can be autonomously managed by the nursing team in the interim period, whilst development of the competence and experience of other team members progresses.

Historically, the service has been well-supported by an experienced cohort of GPs with a Special Interest (GPwSI) who have worked in partnership with the hospital based Dermatology medical team. Whilst further development and expansion of this model (together with specialist nursing expertise) has long been highlighted as the most appropriate strategic direction for the Hywel Dda service, progress has been compromised by the underlying deficit in senior hospital-based medical capacity to support transition to this model and issues regarding clinical consensus amongst senior clinicians within the service.

Progress towards a more integrated community and secondary care based model requires appropriate medical supervision and leadership at consultant level to support the development of primary care based expertise and the safe and effective delivery of clinical pathways. Without substantive appointments and a stable medical workforce, progress to date has been limited.

Asesiad / Assessment

It should be noted that 2018/19 has been a challenging period for the Dermatology team.

Medical Workforce

The substantive Specialty Doctors providing Locum Consultant cover has been depleted through 0.8 WTE maternity leave (originally until June 2019), and the resignation of 1.0 WTE from 4th November 2018 (the Locum Consultant on maternity leave will not be returning to the service)

At present, the service is medically supported by:
0.2 WTE Locum Consultant cover,
1.0 WTE Speciality Doctor and
0.47 WTE GPwSIs.

Despite a regular and repeated recruitment effort, as at 1st November 2018, there have been no applicants for the substantive consultant roles. Some partial success has been achieved in the recruitment of external locum / agency interest with the appointment of a fixed term locum (1 year) from Australia. Unfortunately the post holder is unable to commence employment until August 2019, with the risk of withdrawal of availability up until this point.

The Health Board has commissioned a recruitment agency to support efforts for locum and permanent appointments, however to date no suitably qualified candidates have been identified. All potential Curriculum Vitae's (CVs) are shared with established and experienced consultants employed in other Health Boards for assessment. Due to the fragility of the service and the need for close supervision of existing staff, the Health Board has been advised not to recruit doctors without UK experience.

The possibility of joint recruitment on a regional basis and with other Health Boards across Wales has been explored although specific proposals are still to be confirmed. Whilst this would not offer a solution for the short-term, it remains a potential opportunity for the medium-long term and discussions are continuing with neighbouring Health Boards.

Triage of Electronic Referrals

A Service Level Agreement (SLA) has been in operation since 1 October 2018 with Aneurin Bevan University Health Board (ABMUHB) to provide remote support for electronic referral triage via the Welsh Patient Administration System (WPAS), and allowing for the release of clinical capacity back into the Health Board.

This is designed to reduce the likelihood of process delays in booking of appointments, with the correct classification of urgency/clinical condition (to include cancer pathway referrals).

A similar arrangement was in place with Abertawe Bro Morgannwg UHB during 2017/18 however was subsequently withdrawn by the supporting consultant due to concerns about capacity within the ABMUHB service and the absence of a long-term solution for the service within Hywel Dda.

Management of Clinical Demand

The reduction in the consultant workforce has impacted on the clinic availability to see and treat patients. To mitigate the risk of increased waiting times the following have been introduced:

- Outsourcing contract for 1000 lesion patients to be treated before March 2019 in BMI Werndale Hospital in Carmarthenshire.

- Scoping of availability for further out/insourcing capacity from external providers.

- Additional weekend clinics have been established to facilitate both RTT and cancer pathway provision, provided by existing team members.

- Bridging support from Dr Sharon Blackford from ABMUHB (West) to support the delivery of systemic / biologic patient pathways from November 2018 - January 2019 (following the departure of the Locum Consultant on 4th November 2018, no current member of the Hywel Dda team has the clinical expertise to manage patients on systemic /biologic patient pathways without supervision).

- Patients on the cancer pathway continue to be prioritised for appointments.

Continuation of Quality Service Provision

The absence of a substantive consultant in conjunction with a depleted medical workforce and relatively inexperienced nursing team has impacted on the ability of the service to deliver specialist clinical skills within Dermatology. The current profile of sub speciality delivery within Dermatology is as below:

Subspecialty	Status
Biologic review of current patients	– Immediate clinical cover to be provided by Dr Sharon Blackford (ABMUHB, West) (November 2018 – January 2019) Discussions have also taken place with Dr Jenny Hughes (ABMUHB, East) in relation to virtual support; no confirmation of agreement/SLA to date.

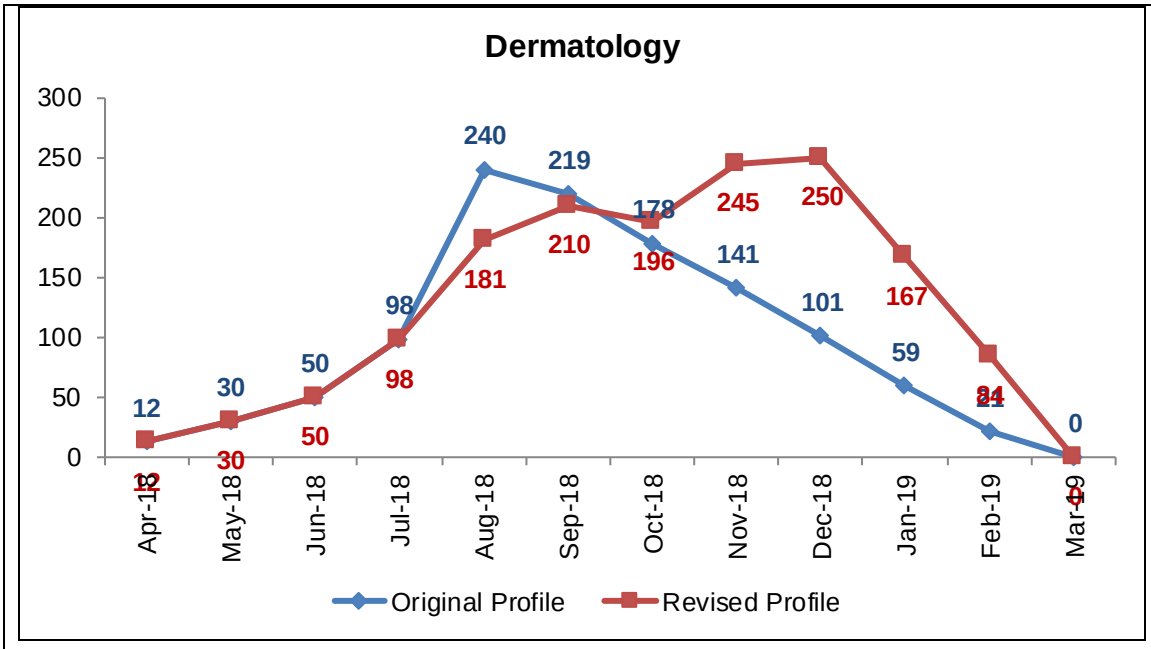
New biologic pathways	– Not appropriate for HDdUHB to initiate new treatments – Patients to be referred to neighbouring Health Boards for assessment – Opportunities for an SLA currently being explored with a neighbouring HB until Consultants are appointed to ensure patients are not disadvantaged from receiving treatment.
Patch testing to isolate contact allergies	– Not considered to be a clinically high risk service – Will temporarily cease if no alternative provision available – Opportunities for an SLA currently being explored with a neighbouring HB until Consultants are appointed to ensure patients are not disadvantaged from receiving treatment.
Acne	– Robust protocols in place for management – Professor Pope (remaining 0.2WTE consultant) is Named Consultant – Safe to continue as normal
Phototherapy	– Robust protocols in place for management – Safe to continue as normal
Cancer	– Continues to be managed by the existing team but with the need for additional sessions to be put in place – This is a high risk area as capacity is limited
Lesions	– Outsourcing of 1000 lesion treatments between October 2018 - March 2019

Discussions with neighbouring Health Boards for practical implementation of support/changes to patch testing and new biologic pathways are continuing, however will rely on the agreement of partner Health Boards and implementation of remuneration / SLA packages.

Impact on Delivery of Referral to Treatment Time (RTT) Performance

Despite the service capacity gaps highlighted above, the specialty maintained RTT performance within its projected monthly breach profile up to October 2018. The outline delivery plan for 2018/19 had been developed on the underlying assumption that greater recruitment /retention success would have been achieved during the first 6 months of the year. Given the limited progress achieved to date in securing replacement capacity, delivery of RTT performance during the remainder of 2018/19 will be dependent upon deployment of additional capacity via alternative external outsourcing/insourcing options and/or locum solutions.

As a consequence, the monthly breach delivery profile for the remainder of 2018/19 has therefore been revised to account for the current position within the specialty. This revised profile reflects current assumptions regarding the impact of additional outsourcing/insourcing solutions. In accordance with the All Wales Commissioning Framework, expressions of interest have been sought from commercial providers for both outsourcing (patients to be treated at alternative hospital locations) and insourcing (providers to deliver capacity locally within Hywel Dda).



Despite extensive discussions via the Welsh Dermatology Board, with other Health Boards directly and via Welsh Government officers, no other Health Board has been able to confirm the availability of clinical capacity to support RTT delivery at the present time.

Impact on Delivery of Urgent / Non-Urgent Suspected Cancer Performance

As reflected above, the service has prioritised its resources to address high clinical priority pathways, including urgent (USC) and non-urgent (NUSC) cancer pathways, whilst the capacity pressures outlined above continue. Notwithstanding these efforts, there has been an increase in Dermatology breaches of the USC cancer pathway 2018/19 year to date compared to the same period last year, as reflected in the table below:

Month	USC		NUSC	
	2018/19	2017/18	2018/19	2017/18
April	1	0	0	0
May	0	0	0	0
June	1	1	0	0
July	2	0	0	0
August	2	0	0	0
September	2	2	0	0
Sub Total	**8**	**3**	**0**	**0**

As reflected in monthly Integrated Performance Assurance Reports (IPAR), the 2018/19 breaches reflect delays for 1st outpatient and/or punch biopsy capacity within the local Hywel Dda service due to the medical staffing capacity challenges within the service.

There have no identified cases of clinical harm associated with these breaches of the USC target.

Impact on Delayed Follow-Up Performance

The table below summarises the change in delayed follow –up performance between the period April – October 2018:

	Total number of patients waiting for follow-up who are delayed past their target date - NOT BOOKED					Total number of patients waiting for follow-up who are delayed past their target date - BOOKED				
	0% up to 25% delay	Over 26 up to 50% delay	Over 50% up to 100% delay	Over 100% delay	Total NOT BOOKED	0% up to 25% delay	Over 26 up to 50% delay	Over 50% up to 100% delay	Over 100% delay	Total BOOKED
Apr-18	170	139	258	952	1,519	35	11	30	110	186
Oct-18	166	142	225	1,541	2,074	20	11	25	58	114
Change	-4	3	-33	589	555	-15	0	-5	-52	-72

This shows that the capacity pressures within the service are impacting upon the volume of patients recorded as over 100% delayed without a booked appointment date. All other categories are showing similar or improved performance over the period.

Service Development with GP Clusters / GPwSI

The Planned Care Directorate remains committed to the diversification of the clinical workforce and training of GPwSI in Dermatology to allow for long term treatment and management of routine dermatology within primary care. However, as reflected above, this programme is dependent upon access to sufficient consultant capacity to support the necessary levels of training, development and clinical supervision.

Opportunities for support of a development programme within Hywel Dda will be further discussed at the Welsh Dermatology Board.

Further Actions Under Discussion.

The Welsh Dermatology Board (via the Planned Care Programme) has been supportive of the HDdUHB situation however, due to universal demand pressures on all providers, the resources to deliver direct clinical activity are not currently available.

Appendix 1 provides a summary assessment of issues explored and current progress.

Argymhelliad / Recommendation

The Committee is asked to consider the above report and note the actions currently being pursued to secure short and longer-term improvements to capacity within the Dermatology service.

nion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	5.5 Provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that sources of internal assurance are reliable, there is the capacity and capability to deliver, and lessons are learned from patient safety incidents, complaints and claims.
Cyfeirnod Cofrestr Risg Risk Register Reference:	DATIX 174

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe Care 5.1 Timely Access 7.1 Workforce
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. To increase survival rates for cancer through prevention, screening, earlier diagnosis, faster access to treatment and improved survivorship programmes. 9. To improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. 10. To deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Develop a sustainable skilled workforce
Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 - Pum dull o weithio: The Well-being of Future Generations (Wales) Act 2015 - 5 Ways of Working:	Please explain how each of the '5 Ways of Working' will be demonstrated
	Long term - the importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs **Service is pursuing remedial measure to maintain service capacity in the short term as well longer-term opportunities to develop a sustainable model for the future.**
	Prevention – the importance of preventing problems occurring or getting worse **N/A**
	Integration - the need to identify how the Health Board's well-being objectives may impact upon each of the well-being goals, on its other objectives, or on the objectives of other public bodies **Future service model is likely to be based on further integration between secondary and primary care clinicians.**

	Collaboration – acting in collaboration with anyone else (or different parts of the organisation itself) which could help the Health Board to meet its well-being objectives **Future service model is likely to be based on further integration between secondary and primary care clinicians.**
	Involvement - the importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the Health Board serves N/A

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	NICE Guidance (Acne, Eczema, Psoriasis, Skin cancer, Skin conditions: general and other) British Association of Dermatologists – Clinical Guidelines
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Sicrhau Profiod: Parties / Committees consulted prior to Quality, Safety and Experience Assurance Committee:	Director of Operations Assistant Director Scheduled Care General Manager Scheduled Care Clinical Director Scheduled Care

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	e.g. financial impact or capital requirements: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906 Financial provision for additional short term solutions required is reflected in 2018/19 RTT Financial Plan.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	e.g. adverse quality and/or patient care outcomes/impacts: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906 As reflected in the above paper

Gweithlu: **Workforce:**	e.g. adverse existing or future staffing impacts: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906 As reflected in the above paper
Risg: **Risk:**	e.g. risks identified and plans to mitigate risks: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906 As reflected in the abaove paper
Cyfreithiol: **Legal:**	e.g. legal impacts or likelihood of legal challenge: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906 N/A
Enw Da: **Reputational:**	e.g. potential for political or media interest or public opposition: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906 To be further assessed if remedial solutions for short-term capacity cannot be secured
Gyfrinachedd: **Privacy:**	e.g. potential impact on individual's privacy rights or confidentiality and/or the potential for an information security risk due to the way in which information is being used/shared, etc: (if yes, please complete relevant section of the integrated impact assessment template available via the link below) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906 N/A
Cydraddoldeb: **Equality:**	e.g. potential negative/positive impacts identified in the Equality Impact Assessment (EqIA) documentation – follow link below • Has EqIA screening been undertaken? Yes/No (if yes, please supply copy, if no please state reason) • Has a full EqIA been undertaken? Yes/No (if yes please supply copy, if no please state reason) http://howis.wales.nhs.uk/sitesplus/862/opendoc/453906 N/A

Meeting Title	ARCH Regional Recovery Group
Title	South West Wales Regional Dermatology Services Update Report
Date	21 September 2021
Prepared by	Rose Turrell Service Planning Manager, ARCH
Presented by	Keith Jones Director of Secondary Care, Hywel Dda UHB Craige Wilson Deputy Chief Operating Officer, Swansea Bay UHB
Action Required	Noting and discussion

Situation

This paper is to provide an update to the ARCH Regional Recovery Group on activity taking place in relation to the South West Wales Regional Dermatology Service.

Background

In autumn 2020, activity resumed to look at the Dermatology Services in the ARCH region, and the Regional Dermatology Group were requested to draft a South West Wales Regional Dermatology 5 year vision (Appendix 1). This was presented to and approved by the ARCH Partnership Group in May 2021.

The vision sets out a strategic aim to;

- Collaborate and combine dermatology services
- Expand dermatology services to fully integrate with Primary Care
- Develop and embed a sustainable workforce model
- Ensure prudent health care through the use of technologies
- Strengthen links with education to ensure high quality patient care

It was requested by the ARCH Partnership Group that the ARCH Dermatology Steering Group develop a clear set of trajectories and timelines to be presented back to the ARCH Regional Recovery Group on 21 September 2021.

National Context

It is recognised that Dermatology Services in Wales are facing significant challenges, and the recent publication of the National Review of Dermatology Services in Wales, 2019 (Appendix 2), has highlighted the significant shortfalls in workforce and outpatient capacity that can be seen nationally. The report highlights the need for investment in a number of areas requiring focus, which will ultimately improve the access and quality of care for patients in Wales. The report was written in 2019, but has been published in 2021, therefore the report includes the full consequence of COVID related delays on the all Wales waiting lists.

A local version of the report was published for each Health Board (Appendix 3&4).
These reports were written in 2019, and do not include updated information on COVID impact. They are however completely reflective of the general picture of the long-term barriers to delivering a sustainable service in Dermatology. The action plans produced by each Health Board in response to the themed recommendations include;

- Addressing the issues surrounding visibility/ and access of data,
- The physical infrastructure or facility constraints
- The integration of primary and secondary care services
- The workforce stability challenges.

These action plans address the critical areas for attention, with short term timelines, but do not articulate the strategic opportunities within this service, and where the region hopes to be in 5 years' time.

Existing Programme of Work

The ARCH Dermatology Steering Group manages an existing programme of work alongside the developing national agenda and in the context of the recently agreed 5 year Dermatology Services vision. Updates on this programme of work are received periodically in the ARCH Clinical Projects Flash Report. This work programme includes the following three areas of focus.

1	The development of a Regional Teledermoscopy Model
2	Dermatology Speciality Training and Development Programme
3	Artificial Intelligence in Dermatology - Point, Click, Notify Project

A full list of deliverables and milestones can be seen in the South West Wales Dermatology Service Delivery Plan (Appendix 5).

1. Regional Teledermoscopy Model

Work is being done at a national level to accelerate the use of technology to provide services. The National Planned Care Board has recently published their all Wales Teledermoscopy pathway for Wales (Appendix 6), which outlines the evidenced based alternative pathway to the traditional face-to-face appointments. The pathway utilises a qualified clinical photographer to take a series of digital dermoscopy images of the skin lesion, the images are then accessed by a specialist remotely who will review/triage the clinical images and decide on next steps. A timeline for national roll-out is not yet published and the document specifies that finance costings will be undertaken locally. A Teledermoscopy Workshop is being hosted by the National Planned Care Programme on 12 October 2021, to which ARCH is invited.

Teledermoscopy services have been developed in both Health Boards. The pilot in Hywel Dda UHB has a full clinic scheduled, due to commence on 17 September 2021. This project is being funded internally with consultant resource being provided by Swansea Bay UHB. The project has been developed as a region, with representatives from both Dermatology services, medical illustration teams and IT teams working together to bring the pilot to fruition.

The Swansea Bay service has run its first clinic in August 2021, which went well. Staffing challenges have prevented further clinics from taking place at this time. The Swansea Bay service is being run with Swansea Bay clinicians and IT systems.

Next Steps include;

- A full evaluation, to identify recommendations for change, and improvements
- A financial breakdown of costs associated with running this service sustainably in each Health Board
- The implications to resource and finance of accelerating activity on a permanent basis

2a. Training and Development -GPwER's

GPs with Extended Roles (GPwERs) undertake roles that are beyond the scope of GP training. The term GPwER includes those previously referred to as GPs with Special Interests (GPwSIs).

The opportunity for GPs to develop and utilise additional knowledge and skills offers an element of career development that is valued in general practice. The ability to continue to grow and develop throughout a career has been regarded as one of the benefits of becoming a GP, and both young GPs coming into primary care and their senior colleagues identify the ability to develop extended roles as a factor that supports recruitment and retention.

To become a GPwER in dermatology, the appropriate Diploma in Dermatology would need to be completed. This is provided by a number of Academic Institutions, but only a few courses are endorsed by the British Association of Dermatology (BAD), one of which is Cardiff Universities' PGDip.

In June 2021, an EOI was sent to the GP's from the Director of Primary Care in Hywel Dda UHB, asking for Expressions of Interest for the GPwER in Dermatology. Over 20 responses were received.

Work has progressed since June to develop a rotational training plan to develop GP's with extended roles in Hywel Dda UHB. The Health Board have agreed to fund 5 Diplomas to kick start this scheme. An afternoon of interviews was held on 26th August, 3 suitable GP's were identified to enrol on Cardiff Universities PGDip course asap, and a further 5 GP's, who already have their diploma, were identified to start training with clinical supervision in secondary care clinics,

Next steps include;

- A timeline for replication of the same scheme in Swansea Bay UHB
- Development of a regional syllabus for the rotational training scheme
- A financial breakdown of costs associated with running this programme over 5 years
- A proposal for foundational activity/other training available to keep interested GP's motivated until they are enrolled on the course

2b. Training and Development - Certificate of Eligibility for Specialist Registration (CESR)

Developing GP's to enhance the knowledge base in primary care and increase sessional capacity in secondary care is only one area of development in medical training. The CESR qualification is a way for doctors who have been at staff, specialty, or associate specialist grade to gain a specialist qualification. It also acts as a route to applying for consultant jobs for doctors who have not followed a specialty training programme in the United Kingdom and achieved a certificate of completion of training. The process involves submitting evidence candidates have the equivalent experience, skills, and competences of doctors who have followed the specialty training route.

ARCH have held meetings with the British Association of Dermatologists (BAD) to gather information on best practice nationally, and this is an opportunity which seems to be endorsed and is working well in areas of the country.

Next steps include;

- Scope our opportunities and associated costs of this model of training
- Identify if there is appetite amongst associate specialists across the region to develop a specialist in Dermatology to this level via n EOI.
- Develop a financial plan for supporting this work

3. Point, Click, Notify

Funding was awarded to ARCH by the Cancer Innovation Network in September 2019, to fund the Phase 1 stage of an Artificial Intelligence classification system that can identify skin lesions and offer advice to patient whether to seek medical assessment.

The development of this application with Meridian began in 2019, and is almost at Phase 1 completion.

Next steps include;

- Finalising the clinical validation process
- Writing a full report evaluating the proof of concept Stage 1.
- Seeking funding to progress to Phase 2.

While project groups continue to gain momentum, the ongoing issues with consultant capacity in both Health Boards present a significant risk to the existing programme of work. Steps are being taken to address these shortfalls where possible with local recruitment and remedial solutions, but it is an important ongoing consideration for any plans which rely on consultant supervision.

It has been historically challenging to recruit consultants into the Dermatology service in South West Wales, and with numbers across Wales falling way below the Royal College of Physicians' recommended WTE per 100,000 population, it is clear that recruitment challenges are not restricted to South and West Wales. There is no allocated budget for regional Consultant posts in the budgeted establishment of either Health Board and both Health Boards are resourced financially lower than the recommended RCP numbers.

Dermatology Consultant Numbers in WTE	Hywel Dda UHB	Swansea Bay UHB
RCP Recommended numbers (1.6 WTE per 100,000 pop)	6.1	6.4
Substantive Establishment (budgeted)	2.0	4.1
Posts filled	1.2	2.1
Vacant Positions	0.8	2.0
Allocated budget for Regional Post	0	0

A Regional Workforce Model

Both Health Boards have agreed in the ARCH Regional Dermatology 5 year vision that developing and embedding a sustainable workforce model is a key enabler to this service.

The National Review of Dermatology Services publication highlights the opportunities in collaborative recruitment and development through partnerships such as ARCH, and as such, there is an opportunity for the ARCH region to design a regional workforce model which will make maximum utilisation of and expand the existing Dermatology Service workforce and look ambitiously at the way services can be delivered by those teams. Roles could include but not restricted to; Consultant Dermatologists, Associate Specialists, Junior Doctors, Advanced Pharmacists, Physicians Associates, and Clinical Nurse Specialists.

By addressing this more broadly and not limiting collaborative activity to joint recruitment campaigns, we aim to;

- Reduce the burden on consultant time in the long term
- Develop our pipeline of talent, at all levels and in all roles
- Profile the region as a desirable and innovative place to work
- Increase our viability as a centre for clinical excellence

There are now two workshops planned to set the foundations for a Regional Dermatology Business Case. These workshops are as follows;

Workshop 1 29th September and 4th October

Dermatology Pathways Vision Worksop

Scope: To discuss the Vision for the Dermatology Pathway as a region. This would then be used to overlay the current local Pathways and to identify the changes needed to implement a regional model.

Workshop 2 TBC – needed to be moved based on Clinicians' availability

Dermatology Workforce Vision Workshop

Scope: To use the drafted Regional Dermatology Pathway to design a workforce model that will deliver it. All roles will be on the table for discussion.

The relevant Workforce Planning colleagues are linked into ongoing discussions and planning workshop 2.

The workshops have been scheduled around the attendance and availability of key clinicians, service and project colleagues, which is critical for engagement and commitment to deliver the 5 year vision.

While this scheduled activity goes a long way to forming the basis of a Business Case, the true impact of what is required will not be able to be articulated until mid-late November 2021, once these workshops have taken place.

There is a risk that this timeline may not align with the upcoming opportunities to apply for further recovery funding. This will need to be kept under review.

Recommendation

The ARCH Regional Recovery Group are asked to;

- Review the update provided
- Note the trajectories and timelines in relation to the deliverables

2022-2023

THE ARCH REVIEW

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ARCH
A Regional Collaboration for Health
Cydweithrediad Rhanbarthol dros Iechyd

Foreword

Welcome to the annual review from ARCH (A Regional Collaboration for Health).

It's been another exciting year as we work with our partners to deliver change that will transform our health, care and wellbeing services and deliver benefits to people across the South West Wales area.

Our overall goal is to provide safe, effective and high quality care for patients wherever they live in the region that will improve their outcomes and experiences.

Where possible we want to work together to implement single regional services in key areas of need. We know we are stronger together and this approach will ensure we have a more skilled and sustainable workforce, as well as services that are fit for the future.

Our priorities for 2022/23 focused on three areas: NHS Service Transformation; Education, Workforce and Skills; and Research, Enterprise and Innovation.

As you will see as you read through our report, there has been lots of progress with some notable successes and the introduction of new programmes which are creating momentum for our work.

A particular highlight is how close we are to delivering a single regional neurosciences service to improve care and support for patients with life-long neuromuscular disorders.

There has been so much good work over the past year including a new approach to helping headache patients which reduced referrals to hospital by 80% and drastically reduced waiting times from 18 months to six weeks – a fantastic result.

Good progress has also been made in using telemedicine to improve care for patients with skin conditions, and on making the case for a comprehensive regional stroke centre.

THE ARCH REVIEW 2022-23

We have also supported the creation of a case to improve the care, outcomes and experiences for cancer patients across South West Wales. This was approved by Swansea Bay University Health Board (SBUHB) and Hywel Dda University Health Board (HDdUHB) in January 2023.

We're always keen to be involved in work that improves our population's wellbeing so are pleased to be working with Public Health Wales to carry out a Health Needs Assessment and Health Impact Assessment. This will inform the planning and development of the Life Sciences, Wellbeing and Sport Campuses City Deal.

Last but never least is the work we have been doing in the learning and innovation space which is really inspiring. To gain accreditation for our Swansea University-led Senior Leadership Development Programme, and to see the real benefits to patients and staff being delivered by the student's change projects, has been fantastic.

ARCH was delighted to lead the first ever Social Care Hack, where people working in the service come up with potential solutions to challenges and put them into action.

We have also begun work on the first ARCH Innovation and Research Strategy to set out our regional approach to supporting innovation and research.

We have an ambitious portfolio and it is a privilege to work with our partners to deliver a joined-up approach to help relieve pressure on our health and care services, to strengthen our workforces and drive a vibrant life science economy.

SIÔN CHARLES
Head of Strategy and Service Planning, ARCH

ARCH — a unique partnership to improve the health, wealth and wellbeing of South West Wales

ARCH is a unique partnership between HDdUHB, SBUHB and Swansea University. It aims to improve the health, wealth and wellbeing of the South West Wales region. Formed in 2015, the ARCH region spans the local authority areas of Ceredigion, Pembrokeshire, Carmarthenshire, Neath Port Talbot and Swansea.

We have a portfolio of regional programmes of work and individual projects that are led by the strategic ambitions of our partner organisations. This is underpinned by the Welsh Government's 'A Healthier Wales' policy.

We aim to deliver meaningful change to support the local population. A key strand of the ARCH Partnership is working in collaboration with local authorities and industry as part of the Swansea Bay City Deal. This is a £1.3bn investment awarded by the UK government to deliver nine programmes of work and create more than 9,000 jobs.

By working together, ARCH partners are:

- **Improving the health of our communities**, reducing inequalities and empowering and building confidence in the population to manage their own health and wellbeing
- **Recognising and overcoming the challenges** of both rural and urban healthcare
- **Delivering infrastructure and services** recognised for their excellence
- **Using technology to deliver innovative services** and knowledge that support prudent healthcare
- **Transforming services so they are integrated**, easy to access and navigate with health, social care providers, public, private and third sector working together for our communities
- **Encouraging NHS Wales' capacity to innovate** and translate ideas for the economic benefit of the region
- **Creating and supporting open innovation environments** where world-leading science, practice and enterprise are joined together
- **Harnessing, nurturing and adopting home-grown life science enterprises** while also attracting global innovators
- **Creating multi-professional learning and training environments** to support the workforce and increase opportunities for people in South West Wales.

To find out more about ARCH please visit our website www.arch.wales

ARCH Highlights of 2022/23

Our regional partnership focuses on three key priority areas: NHS Service Transformation; Education, Workforce and Skills; and Research, Enterprise and Innovation. These priorities align with Swansea University, SBUHB and HDdUHB's strategic vision and plans. It's an exciting agenda that will improve the health, wealth and wellbeing for people in South West Wales, and help to establish robust, sustainable and quality regional services. Here are some highlights of our progress and success during 2022/23.

NHS Service Transformation

Developing a single regional neurosciences service to improve care and support for patients

Plans to develop a single regional neurosciences service to improve care and support for patients are moving a step closer with plans being developed during 2023/24. This is exciting progress in our aim to deliver safe and equitable care across the South West Wales region. This will help patients with life-long neuromuscular disorders, such as muscular dystrophy, receive the best possible support in the community and avoid unnecessary admissions to hospital.

Our previous neurology work programme (2017-2022) has been closed and a new programme outlined to take forward the work needed to move towards a single service.

The work will build on the achievements so far, including:

- **A new way of working to improve care for headache patients** which reduced referrals to hospital by 80% and waiting times for new patients from 18 months to six weeks. The new care pathway was developed by HDdUHB and the same approach also implemented in SBUHB. It was agreed with General Practitioners (GPs) and offered more guidance and support in managing patients. It also generated efficiency for general neurology, freeing up clinic space and helping to reduce waiting lists for epilepsy patients from 12 months to four weeks
- **The first regional neurological service delivery plan** was drawn up in partnership with both SBUHB and HDdUHB
- **A new approach to move the service away from secondary care** towards a community-based support network that encouraged self-management was agreed
- **A regional multi-disciplinary team** for epilepsy was established.

The new Regional Neurosciences Plan for 2022-2024 includes developing enhanced specialist roles for Neurophysiologists to enable them to support consultants and allow the wider team to develop and strengthen.

Training will be key to this and physiotherapists will be supported to work towards a new qualification called Improving Quality in Physiological Services (IQIPs).

This is a national accreditation for standards of service for Neurophysiology.

We are also looking to expand the current service available in HDdUHB area and staff from the centre in Swansea will be providing support to help this happen, with the region then becoming a centre of excellence.

Creating the first ever regional service to help people with Functional Neurological Disorder

ARCH's vision of developing and delivering the first ever Functional Neurological Disorder (FND) regional service in Wales, to improve care for patients wherever they live in the South West region, remains on track.

FND is a common and disabling condition which causes an array of unexplained symptoms including blackouts and paralysis. Currently there are no care pathways in place to support patients. Many staff also lack knowledge in this specialist area which leads to delays in diagnosis, frequent attendances to hospital and GP practices, poor support and outcomes.

We have worked with our ARCH partners and professionals in primary, secondary and community care, to develop a business case that details the importance of establishing a new regional service.

The new service will provide safe and effective care tailored to individual needs and improve diagnosis, treatment and support.

Dr Tanya Edmonds, Head Consultant Clinical Neuropsychologist at Morriston Hospital said:

"This is an exciting opportunity to develop the first evidence-based, care pathway in Wales with person-centred, holistic, innovative and cost-effective interventions aimed at improving the outcomes that matter to people with functional neurological conditions and their families."

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Increase in CT scans for patients with heart conditions

Training for cardiologists in HDdUHB, to enable them to provide better and more efficient care locally for patients with suspected heart conditions, has been completed during the past 12 months.

The training, which began in September 2022, enables the cardiologists to complete and read cardiac Computerised Tomography (CT) scans. This means more patient scans can be done and read locally rather than being sent to the Cardiac Centre in Morriston Hospital, Swansea.

Following the completion of the training, the number of CT scan-qualified Cardiologists in HDdUHB increased from two to five. This in turn will increase the number of scans carried out locally by four-fold within a two-year period.

Dr Daniel Obaid, Clinical Associate Professor, Swansea University Medical School and Honorary Consultant Cardiologist at Morriston Regional Heart Centre has supervised the training. He said:

"This work under ARCH is a great example of collaborative working across organisations with peers supporting each other to help patients receive their treatments quicker, which is ultimately safer.

"We hope to repeat the training with another cohort later in the year and support HDdUHB to achieve their ambitions for the service."

Developing a sustainable Oral Maxillofacial Service across South West Wales

Our plans to develop a sustainable and stable service for patients who need oral maxillofacial care have taken a step forward following a productive workshop with colleagues from Hywel Dda and Swansea Bay UHBs in January 2023.

The workshop was an opportunity to review the current service, discuss regional solutions and learn from an exemplar intermediate oral surgery service in Powys. Delegates discussed ways of improving patient flow and waiting times, and actions that could help ensure a robust and sustainable workforce.

Craige Wilson, Deputy Chief Operating Officer, SBUHB said:

"The purpose of the review of oral maxillofacial pathways is to ensure that patients from across the South West Wales region receive equitable access to a safe, high quality service provided by the most appropriate clinician at the correct point of delivery."

Improving care for dermatology patients

Work to develop a regional dermatology service for South West Wales has continued to pick up speed.

A full teledermoscopy service is now running in SBUHB following a successful pilot. The service focuses on taking high quality clinical photographs of skin changes which can then be accessed remotely by a consultant dermatologist for a diagnostic assessment. The new way of working aims to avoid patients attending outpatient appointments in person unnecessarily and will provide care closer to home. This has helped to reduce waiting lists and improved the patient experience.

A second pilot was launched in HDdUHB in September 2022 and funding has been agreed to make this a substantive service. In this pilot, 251 patients with skin lesion referrals were assessed using teledermoscopy. This resulted in 58% of patients being directly discharged, as they had benign lesions or conditions that can be managed in the community.

Dr Ausama Atwan, Consultant Dermatologist in Aneurin Bevan University Health Board and National Clinical Lead for Teledermoscopy, said:

"There is a need for an effective and safe diagnostic service so those with benign conditions can be reassured without needing to attend a hospital appointment, and those who require urgent specialists' management are signposted to the appropriate pathway in a timely fashion.

"The teledermoscopy programme is a service model that aims to achieve these goals. This programme, funded by Planned Care Improvement and Recovery, is now operational in most of the Welsh Health Boards and the aim is to have the service implemented in all of Wales by March 2024."

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Designing a Comprehensive Regional Stroke Centre for South West Wales

The ARCH team has been busy drafting a business case outlining the resources needed to design and implement a Comprehensive Regional Stroke Centre (CRSC) for the South West Wales region.

A CRSC is a large centralised regional stroke centre offering specialist imaging, thrombolysis, assessment and referral, and Hyper Acute Stroke beds.

The business case highlights the investment required in all areas of the stroke workforce and describes how this could be implemented over three years.

Alongside this, a regional stroke programme has also been developed and will be delivered at the same time.

Work has begun to scope out the service and centre requirements. This will be shared with patients and staff to enable users of the service to input their views and shape the development to ensure it meets their needs.

Work on track to transform regional pathology services

Our aim to transform regional pathology services remains on track with an outline business case due to be submitted at the end of 2023.

The project will create a single regional service, including the development of a new Centre of Excellence for Pathology Services on the Morriston Hospital site, integrating the latest technological advancements, including artificial intelligence.

Over the past 12 months designs and costings have been developed. The project team has also visited other sites across the UK to inform the development of this exciting new facility.

The building will replace outdated facilities on existing sites and provide a focus for service delivery, innovation and research, and training. Programme Director, **Neil Miles** said:

"I am delighted to be working with such a wide range of enthusiastic and committed professionals to enhance and modernise pathology services in South West Wales. We have a fantastic opportunity to provide cutting-edge technology and levels of service delivery to our region through our proposed network of services including the Centre of Excellence on the Morriston site."

Developing the South West Wales Cancer Centre (SWWCC) and transforming regional cancer services

A detailed plan to improve the care, outcomes and experiences for cancer patients across South West Wales was approved by HDdUHB and SBUHB in January 2023.

The Strategic Programme Case (SPC) builds on the vision set out by ARCH in its Non-Surgical Oncology Strategy in 2018, to 'provide the best possible cancer care for the people of South West Wales' and local clinical plans.

It provides a framework for the development and delivery of non-surgical cancer services (radiotherapy and outpatients) to meet increased demand for treatment, improve access to high quality services and more efficient and effective care.

As new cancer diagnoses have increased by 25% since 2002, in the main due to an ageing population and earlier diagnosis, it is vital that there is capacity to deliver care to meet patient need and keep up with new technology and treatments.

The SPC aims to provide a fit for purpose South West Wales Cancer Centre and regional cancer services that will:

- **Improve health outcomes** for people diagnosed with cancer
- **Reduce waiting times** for treatment
- **Increase capacity** to meet the growing demand for services
- **Provide equitable access** to patients across the region
- **Provide a high quality cancer service** equipped with access to modern diagnostic and therapeutic equipment.

This will be enabled by the development of more sustainable workforce, improving digital infrastructure and ensuring the service is supported by the best research.

Dr Daniel Warm, Head of Planning for HDdUHB and co-chair of the Regional Strategic Programme Group, said:

"The approval of the SPC by both Health Boards is a significant step forward in delivering the vision of the South West Wales Cancer Centre. However, we know that there is still much to do, and the aim over the next year is to begin the development of the business cases that will deliver the changes we want to see in supporting our regional non-surgical oncology services for the population of South West Wales."

Developing Education, Workforce and Skills

ARCH Senior Leadership Development Programme delivers real benefits for patients and healthcare staff

It's been an exciting year for the ARCH Senior Leadership Development Programme as it moved from learning and training to delivering change projects that have made a real difference to patients and healthcare staff across the South West Wales region.

The programme brings together world class experts from health, care and academia to create a learning community aimed at developing senior leaders and clinicians in healthcare quality improvement skills. The programme covers a range of topics including leadership, strategy, innovation, and risk management. It is delivered through a combination of interactive workshops, expert-led sessions, communities of practice and individual coaching.

The 18 month programme welcomed its first cohort in May 2022 and sessions have focused on managing patient flows, dealing with backlogs and change management. A number of projects have already implemented and delivered significant benefits.

Of particular note are two Welsh Ambulance Services NHS Trust (WAST) projects which have improved handover times in emergency care and the management of patients who need palliative care.

Professor Nick Rich from Swansea University School of Management, who is helping to deliver the Programme, said:

"This partnership programme was established in a time of great need and the combined efforts of all the institutions involved is making real progress in meeting the current challenges in the NHS, including how we develop staff and innovate processes. It's been fantastic to see the team making significant progress in both training and supporting change projects that are delivering real benefits for patients and staff in the region. I can't wait to see what further improvements can be made."

The Arch Senior Leadership Development Programme was developed with the All Wales Intensive Learning Academy for Innovation in Health and Social Care, AgorIP, Swansea University STEM Skills Academy Wales and the Faculty of Medical, Health and Life Sciences at Swansea University.

Based on the success of this cohort, the programme will be recruiting the second cohort of senior leaders over the summer, so the benefits of the pilot programme can begin to be scaled to more teams and patient groups.

For more information please contact Sophie.marr@wales.nhs.uk

ARCH Senior Leadership Development Programme gains accreditation thanks to All Wales Intensive Learning Academy and ARCH

In other ARCH Senior Leadership Development Programme news, we are pleased to announce that the programme has gained Continued Professional Development (CPD) accreditation.

ARCH worked closely with the All Wales Intensive Learning Academy for Innovation in Health and Social Care to gain the accreditation for the programme – which has been awarded 30 CPD points.

The achievement demonstrates that the programme has met the rigorous standards set by the professional development community and that it is aligned with best practice in leadership development. The accreditation also provides assurance to participants that the programme will help them maintain and enhance their professional competencies and be recognised by their professional body.

Dr Roderick Thomas, MSc Programme Director from the All Wales Intensive Learning Academy (ILA), which is based in the Swansea University School of Management, said:

"This recognition is a testament to the dedication and commitment of the team behind the Senior Leadership Development Programme and the impact it has had on the professional development of senior leaders across the health and care sector. The ILA is proud to be playing a part in the professional development of so many senior leaders and we look forward to continuing to support them in their journey towards leadership excellence."

Value-Based Health and Care Academy

Partners in ARCH have worked closely with the Value-Based Health and Care (VBHC) Academy over the past 12 months in all three of its key areas: education; research; and consultancy.

Launched two years ago, the VBHC Academy is one of four Intensive Learning Academies in the Welsh Government Innovation, Technology and Partnership Programme. The Academy has a global outlook and reach and works across all of Wales too, delivering Executive Education, a purpose designed MSc in Advanced Health and Care Management (Value-Based) and a Doctorate of Business Administration (DBA).

In 2022/23 the Academy worked closely with HDdUHB and SBUHB on a number of initiatives including the following:

- **Welcoming staff from both health boards as students** on the Executive Education part-time MSc and part-time DBA programmes, which will build capacity within ARCH for adopting Value-Based principles in new and current clinical services
- **The co-creation and delivery of bespoke education programmes** for HDdUHB corporate senior managers and an advanced Practitioner Programme for operational managers and clinicians. This will run into 2023/24 and is supporting the VBHC projects they are managing
- **The design and build with Swansea Bay of an e-learning module** about Patient Reported Outcome Measures (PROMs) that builds to an Introduction to VBHC e-learning programme. Both of these courses went live in March 2023 and are freely available to anyone, anywhere in the world, growing understanding and putting South West Wales on the map
- **Partnering with TriTech, Dr Ffion John and the North Ceredigion Cluster**, to evaluate the value of digital adjuncts in the treatment of patients with persistent pain, helping to secure funding and resources from our partner Pfizer UK and also Patients Know Best™.

Professor Hamish Laing, Director of the Value Based Healthcare Academy said:

"I am delighted how our partners in ARCH are starting to lead the way in Wales on VBHC, because it is vital to making our health system sustainable."

Supporting Research, Enterprise and Innovation

Life Science, Wellbeing and Sport Campuses City Deal Project

ARCH is proud to be a key partner in the Swansea Bay City Deal Campuses project which is making good progress on its ground-breaking health and sport development for Swansea.

The project has taken a major step forward through the appointment of an architect and project managers. Architect and building consultancy AHR has been named as the successful bidder ahead of the launch of phase one of the project.

AHR will be expected to complete the development design and manage the planning process and application. The design is due to be completed by the end of summer 2023. It is expected that the construction will begin in the spring of 2024, with the build completion by the end of 2025.

The development will create an environment that fosters innovation between life science, health, wellbeing and sport, strengthening Wales's position as a leader in this sector.

To complement the plans to expand services at Morriston Hospital, routes for a new road from the M4 to the hospital are being explored by health senior leaders. This will create improved accessibility to and from Morriston Hospital which will better align health services, skills and education, and research and development in life sciences across the region.

Professor Steve Bain, Assistant Medical Director for Research & Development for SBUHB, said:

"The refurbishment at Morriston Hospital will establish it as a global example of best practice for healthcare by accommodating commercial and academic collaboration with clinical research and development, while facilitating access to modern technology and techniques."

You can read more about the Swansea Bay City Deal Campuses project here.

ARCH Innovation and Research Strategy

ARCH is currently developing an Innovation and Research Strategy to set out our approach to supporting innovation and research across the region. The strategy will define the common vision between the ARCH partners along with aligning local and national innovation and research strategies.

Work has taken place to review strategies from HDdUHB, Swansea University, University of Wales Trinity St David and Welsh Government, with a number of common themes analysed.

A series of eight workshops has also taken place with innovators and researchers to listen to their views and discuss how we can co-produce our approach to research and innovations to drive change and improve health outcomes for the population of South West Wales.

The next steps are to review and analyse the Welsh Government framework for NHS Research and Development and the SBUHB Research, Development and Innovation Strategy once published. This will help to inform our strategy which we are planning to publish in October 2023.

Siôn Charles, ARCH Head of Planning and Strategy, said:

"When it comes to innovation and research, scale matters. This ARCH strategy is an exciting opportunity to formalise our collective approach to coordinating our regional innovation and research assets and resources to more effectively compete at a global scale."

Health Needs and Health Impact Assessments

The ARCH team has begun work on a Health Needs and Health Impact Assessments (HNA and HIA) for the Swansea Bay City Deal Life Sciences, Wellbeing and Sport Campuses Project. The Health Impact Assessment will be informed by discussions and views from key stakeholders, including members of the public, to ensure any recommendations are steered by the evidence base and local need.

A regional group with representatives from SBUHB and HDdUHB Local Public Health Teams and Swansea University has been established and a plan agreed. Previous Health Needs and Health Impact Assessments have been identified, which will inform our work, and an ARCH Principal Public Health Practitioner has been appointed to lead the work from April 2023.

The findings and recommendations of the ARCH Health Needs and Health Impact Assessments will identify the health and wellbeing requirements of our regional population. It will also steer the health and wellbeing priorities for the ARCH Innovation and Research Strategy.

Joint Clinical Research Facility and early collaboration with TriTech

The Joint Clinical Research Facility (JCRF) has begun some early collaborative work with the TriTech Institute in HDdUHB.

The first joint project, funded by AMGEN, will assess a new pathway in optimising the medical management of patients with heart disease and improving diagnosis and treatment.

It is being run across both HDdUHB and SBUHB and will involve recruiting 150 patients.

The project will analyse existing data at Swansea University's Secure Anonymised Information Linkage (SAIL) Databank to develop systems identifying patients at high risk of future disease. It will also examine the effectiveness of pharmacist-led clinics across both health boards in reducing the treatment gap, and ensuring high-risk cardiovascular patients are identified and seen by the right person, in the right setting, at the right time.

A second collaboration is on diabetes with Prof Sam Rice, Clinical Director of Research and Development for HDdUHB, working with the JCRF team to look at clinical studies of new medicines in diabetes and associated obesity.

Other areas for collaboration will be explored as we evaluate the experience with the current two projects.

Professor Chris Hopkins, Head of Innovation and TriTech Institute noted:

"We are very excited to be working with JCRF. The AMGEN project offers an opportunity for us to work collaboratively to support healthcare on a local and national level. This partnership demonstrates what can happen when you bring together research, clinical expertise and innovative technology for the benefit of patients across the region."

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Social Care Hack

We were delighted to support the first Social Care Hack in June 2022, which brought together innovators and social care teams to develop solutions to help Social Care develop technology solutions to operational challenges leading to better services for citizens. The event, which took place over two days, invited social care and health workers to share the challenges they face in their work.

The challengers were then matched up with private sector and university innovators to collaborate and develop a solution which they pitch to a panel to see if they can secure start-up funding from the £250,000 pot made available by Welsh Government. Six projects were chosen as winners for their innovative ideas to deliver benefits to citizens. They were:

- **Digitally Supporting Caring Communities:** Cwmpas and Scinap – making it easier for carers to register as a proxy user in order to use digital services on behalf of the person they are supporting
- **Nostalgify:** boosting wellbeing through a nostalgic lens. Hafod and Swansea University are using augmented reality (where computer-generated images are super-imposed on the real world) with nostalgic memories to improve the quality of life for people living with dementia
- **Wellbeing app:** Grwp Cynefin and Scinap – using new digital tools to connect the events management team directly with customers and their local support team to provide targeted signposting of wellbeing events
- **Tactile Pressure App:** SBUHB and Objectivity – developing a sensor tracking system to allow metrics and early warning of immobility (the largest risk factors for pressure ulcers) with care home residents
- **Digital Activities of Daily Living Intervention:** SBUHB and Agile Kinetic Limited – building upon research to develop a tool to demonstrate movement patterns used for frailty screening of patients
- **Harnessing Innovation in Social Care:** West Glamorgan Regional Innovation Coordination Hub and Objectivity – developing a digital platform to link innovations to people's needs reducing duplication of effort and increasing resources.

The Health Hack is delivered in partnership with Social Care Wales, M-SParc, Life Sciences Hub Wales, Welsh Government, Regional Innovation Coordination Hubs, Accelerate, Bevan Commission, AgorIP, Social Care Wales, Simply Do and MediWales, with support from across social care.

Working with TriTech to deliver healthcare innovations

Our work with the TriTech Institute at HDdUHB is one of our key strategic initiatives and we were pleased to support their progress over the past year.

The TriTech Institute was established to support the development and evaluation of innovative healthcare technologies which contribute to improved patient outcomes. Since its launch in May 2021, it has already established three key areas: research; evaluation; and advice.

During 2022/23, it has delivered the following achievements:

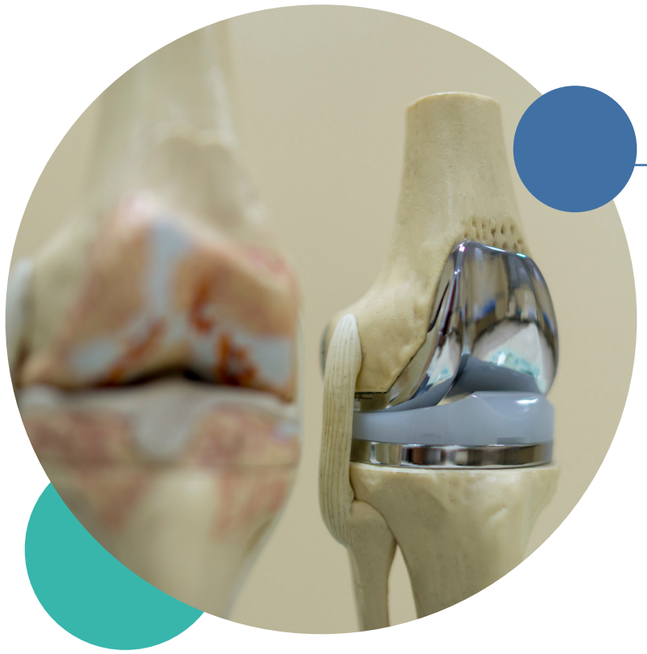
Partnership Commitment

HDdUHB and Swansea University signed a Memorandum of Understanding, which commits to a partnership in several new areas. This includes improving the number and diversity of clinical trials across the region; focusing on new diagnostic technologies and commercial drug trials; and supporting the growth of educational programmes.

Nasogastric Testing

TriTech worked with NGPOD Global Ltd, and SBUHB to understand the value gained from using an innovative NGPOD testing device for patients who need nasogastric feeding.

The service was evaluated over an eight-month period to assess the use of NGPOD in a real-world setting, including implementation of the device on the wards and its effectiveness.



Pain management for patients waiting for knee replacement surgery

An innovative, new clinical study to examine the effects of the use of bioelectrical technology for pain management in patients waiting for knee replacement surgery, concluded in December 2022. The six-month project was a collaboration between the University of Wales Trinity Saint David's (UWTSD) Assistive Technologies Innovation Centre (ATiC) and TriTech. It was supported by Life Sciences Hub Wales through Accelerate.

Professor Chris Hopkins, Head of Innovation and TriTech Institute noted:

"We are very excited to be involved in these innovative studies and working with partners across West Wales. All of these projects offer an opportunity to develop and improve systems to support healthcare on a local and national level. We hope that these studies will enable collaborative and innovative outcomes, leading to improved health for Wales."

Intellectual Property for Innovation in Healthcare

Innovating in healthcare often requires collaborating with universities or businesses to access skills, experience, funding and other resources. However, NHS Intellectual Property (IP) policies had been spotlighted as significant barriers to innovation and collaboration.

To provide a solution to this, ARCH and Welsh Government's Innovation in Health and Care Team, has been working in partnership with all the NHS organisations in Wales to develop a new Intellectual Property policy.

With the support of experts Medipex and Trustech, the policy helps to incentivise staff to innovate and work in Wales and simplifies the process for protecting and sharing IP. It also standardises and simplifies negotiations with universities and businesses, supports economic development, and enables opportunities for income generation.

The next steps are to work with Welsh Government to produce a Welsh Health Circular that will set their expectations for adopting and using the policy.

Welsh Government Innovation Strategy

We were pleased to work with and support Welsh Government to develop its Innovation Strategy for Wales which was published at the end of February 2023.

The new strategy has a number of missions at its heart, including creating better jobs, improving health and care services, a greener environment and a more prosperous economy. The aim is that through working together, entrepreneurship, innovation and new technologies can reach every part of society. It focuses on the following:

- **Education:** helping to ensure Wales has an education system that supports the development of innovation skills and knowledge throughout people's lives in Wales
- **Economy:** driving Wales forward to be a leading, innovation-based nation that collaborates across sectors for solutions to society's challenges, adopts new technologies for efficiency and productivity, uses resources proportionately, and allows citizens to share wealth through fair work
- **Health and wellbeing:** supporting health and social care to collaborate with industry, academia and the third sector to deliver new ways of working that deliver greater value and impact for citizens
- **Climate and nature:** optimising our natural resources for the protection and strengthening of climate and nature resilience.

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The strategy makes a firm commitment that Welsh Ministers will seek to drive up investment from the UK Government and beyond in Welsh research, development and innovation (RD&I).

Siôn Charles, ARCH Head of Planning and Strategy, said:

"Our collaboration with Welsh Government and other health boards in Wales to shape national strategy is key to our future success. It demonstrates how effectively we can work together in Wales to achieve our collective ambitions."

Supporting the development of Pentre Awel Zone One

ARCH has continued to support the Pentre Awel development across 83 acres of land in south Llanelli. Led by Carmarthenshire County Council, it will create a new landmark infrastructure providing facilities for business, research, education, community healthcare, leisure and assisted living – establishing an 'ecosystem' for life sciences.

The project is partly funded through the Swansea Bay City Deal. Benefits include:

- The creation of over 1800 jobs
- Health focused education and training opportunities
- Improved population health and wellbeing across all life stages.

Pentre Awel Zone One has made great strides during 2022/23, reaching a number of milestones that will provide an excellent launch pad for current and future phases. A number of stakeholder and public engagement events have taken place to ensure working opportunities and community benefits are maximised. This included the roll out of a Social Value Programme which delivers targeted initiatives across community benefits such as recruitment, training and education.

In March 2023, a formal ground-breaking and start of construction was commemorated by a site visit by Secretary of State for Wales David TC Davies MP. This was followed by a successful community 'Meet the Contractor' event to engage local residents and stakeholders.

Cllr. Gareth John, Carmarthenshire County Council's Cabinet Member for Regeneration, Leisure, Culture and Tourism said:

"Pentre Awel brings together a unique combination of elements covering Business, Academia, Health and Care and critically our community; all of which will build a network to create a whole system where partners can identify opportunities for working across traditional boundaries. Zone 1 is just the start. Watch this space."

Looking forward to 2023/24

We are looking forward to working closely with our partners in 2023/24 and continuing to build on and progress a number of exciting projects which will make a big difference to health and care for people across South West Wales.

Our passion for NHS Service Transformation will be driven during the coming year by:

- Submitting to Welsh Government an outline business case to create a Centre of Excellence for Pathology Services
- Creating a regional Functional Neurological Disorder (FND) service in 2023/24 to support patients and provide safe, effective and equitable care across South West Wales
- Starting the Improving Quality in Physiological Services (IQIPS) national accreditation process for standards of practice in neurophysiology
- Continue to increase capacity for cardiac CT scanning in HDdUHB
- Supporting the delivery of a single regional service for neurosciences.

We will be continuing to develop and support programmes around Education, Workforce and Skills by:

- Delivering another ARCH Senior Leadership Development Programme
- Supporting a number of global life sciences companies (MedTech, diagnostics and Pharma) with Value-Based propositions and encouraging them to consider ARCH an ideal place to offer those to the health sector. This will help get important technologies into the region with the sharing of risks and rewards based on outcomes that matter to patients.

Our drive to deliver Research, Enterprise and Innovation will be focusing on:

- Swansea University, lead for the Campuses project, will be launching its first key strategic partnership with the Welsh Rugby Union (WRU) and Ospreys. This partnership will be based at the Swansea Bay Sports Park development and see Swansea University host the West Wales Women's Player Development Centre (PDC)
- Publishing the ARCH Innovation and Research Strategy
- Completing the Health Needs and Health Impact Assessments
- Delivering the first ARCH Innovation and Research Strategy Conference.

Why ARCH is making a difference

"2022/23 has been a year which the focus for all of us has shifted from the immediate pandemic response to beginning the process of recovery. ARCH has provided us with the ability to address some of these huge recovery challenges across our whole region, helping us to recover more quickly for the benefit of our local communities and patients."

STEVE MOORE
Chief Executive, Hywel Dda University Health Board

"It has been fantastic to be involved with the partnership working with HDdUHB and Swansea University to drive change across our region. Building on SBUHB's new Research, Development and Innovation Strategy, 2023/24 will be even better!"

MARK HACKETT
Chief Executive, Swansea Bay University Health Board

"Swansea University greatly values its partnership with the NHS. We are extremely proud of the tangible difference that we can make to peoples' lives through our strong and impactful collaborations across education, workforce development, and research and innovation."

PROFESSOR PAUL BOYLE
Vice Chancellor, Swansea University

ARCH Dermatology programme

Meeting Title	ARCH Regional Recovery Group
Title	ARCH Dermatology Programme Closure Report
Agenda Item	2.6
Meeting Date	05 October 2023
Prepared by	Rose Turrell, Service Planning Manager ARCH
Presented by	Keith Jones, Director of Secondary Care, Hywel Dda UHB Craige Wilson, Deputy Chief Operating Officer, Swansea Bay UHB
Action Required	The ARCH Regional Recovery Group is asked to: • Note the summary update provide in this report; • Approve the formal closure of the ARCH Dermatology Programme

Purpose

The purpose of this document is to provide the ARCH Regional Recovery Group with the relevant information to support the decision to close the ARCH Dermatology Programme.

Background

There had been a need for several years to address the challenges of rising demand, finite capacity, workforce challenges, geographical variances and financial constraints faced by the Dermatology services in South West Wales. The traditional hospital based outpatient care models cannot keep pace with the increasing demand on services and unfortunately, the overwhelming majority of patients are experiencing unacceptable delays in their care.

The ARCH Dermatology Regional Programme was established in May 2019 with clinical, managerial, operational and planning representation from the two University Health Boards through the ARCH Strategic Developments Group.

There continues to be increasing pressure on the provision of Dermatology services across South West Wales, exacerbated by the Covid-19 pandemic.

Work for the ARCH Dermatology Regional Programme drew to a natural close in spring 2022, after the Teledermoscopy model had been fully implemented in both Health Boards. The last regional Dermatology Steering Group meeting took place in March 2022.

The programme has been dormant since this time and a formal closure will enable the release of project resource to support other programmes of work which are awaiting ARCH prioritisation.

Programme Objectives

The ARCH Dermatology Programme had an agreed set of objectives as follows;

1. To review all Dermatology service pathways and to standardise these across the South West Wales Region;
2. To implement technological solutions into dermatology services in order to address capacity issues and promote patient self-management; including implementing the all-Wales Teledermoscopy model and to maximise the use of Artificial Intelligence (A.I) to support and enhance the service.
3. To support the development of a sustainable medical and non-medical workforce model that is able to support capacity and demand across Primary and Secondary care.

Initial work in 2019 began at pace with wide stakeholder engagement, productive workshops, and well attended meetings. As workforce pressures intensified, exacerbated by Covid-19 in March 2020, progress faltered.

Dermatology Service Pathways Progress

At a workshop hosted by ARCH in June 2021 – the Health Board Pathways were reviewed, and the opportunities for further collaboration and alignment were discussed. Highlighted areas for focus were;

Referral process into plastics – In 2019 improvements were made in the referral process across both health boards, facilitating a timelier treatment and surgery outcome for relevant patients.

Referral process into secondary care – In 2019 improvements were made by the SBUHB Consultants, to the referral pathway from primary care. These changes included the introduction in CION these changes were subsequently rolled out across both health boards resulting in a standardised process.

Standardised pathways for general Dermatology and USC - In order to create a joint consultant workforce, standardised pathways for general Dermatology and USC across the

region were required. Attempts were made in 2019 to standardise pathways but were never progressed beyond the workshops due to Covid-19 timing. Subsequently this pathway discussion could not be resumed due to availability of appropriate medical representatives to progress.

A dedicated Dermatology Centre – In 2019 HDdUHB looked into the opportunity to create a dedicated Dermatology Centre, similar to SBUHB. This did not progress after initial investigations due to Covid-19 timing. It is anticipated that opportunities for the development of dedicated Dermatology Centre will be considered as part of the Clinical Services Plan review currently underway in HDdUHB.

Technological Solutions Progress

The Implementation of the all-Wales Teledermoscopy model

In 2021 HDdUHB received funding from the national programme for the pilot and the Teledermoscopy model initiated in autumn 2022. The data collected following commencement of the service is outlined below:

Outcomes	Amount	Percentage
Discharge	161	53%
Repeat Photos	7	2%
F2F – follow ups	42	14%
Minor Operation requests	87	29%
PIFU	3	1%
SOS	3	1%
Total	303	100%

*data *excluding DNAs*

SBUHB funded its own pilot (IT infrastructure was already in place) and began by running two sessions per week from Sept 2021 to March 2022. The pilot saw the following results;

- 56% of patients were directly discharged from the clinic and referred back to primary care
- 33% of patients were referred for a minor operative procedure
- 10% of patients required a follow up with Dermatology consultants
- 1% of patients received a referral to plastic surgery.

As a direct result of these positive results, SBUHB expanded and implemented a substantive Teledermoscopy Service. Due to limitations of available workforce with suitable qualifications

to lead the service in HDdUHB, an SLA has been agreed between both organisations to extend the service to both health board populations.

Artificial Intelligence (AI)

At the beginning of the ARCH Dermatology Programme's work, there was a work stream which looked specifically at developments in the world of Artificial Intelligence and its use in clinical areas such as with Dermatology. A project was completed, known as 'Point, Click, and Notify'.

The aims of the project reflected the ambitions of the Swansea Bay UHB Clinical Services Plan 2019-2024 which outlined key ambitions to improve the use of digital technology and self-care to empower the patient in decision-making when further care may be needed.

An End Stage report was produced for the project after the initial funding had been exhausted. Further funding for next stage was prohibitive and ARCH was unable to continue working with the technology company to progress the work.

ARCH has been approached by other larger organisations, who are developing similar applications. It is hoped in the future that the region can take advantage of these.

A development which is similar to the above for a risk assessment app has been developed by Nexus DT. The technology is more advanced and is called 'SkinScreener'. A representative from Nexus has asked for any interest from Health Boards to run a trial. The details are in Appendix 1. This may be an opportunity for exploration by individual Health Boards. Operational Teams who wish to explore the opportunity further can contact Mona Hyat on mhayat@nexus-dt.com.

Sustainable Workforce Model Progress

Primary Care

Utilise Primary Care Staff to the top of their license to deliver a wider range of treatments in the community and hospital

- In 2019 SBUHB consultant delivered Dermatology Minor Operation Procedure (MOP) training to one GP from HDdUHB. This GP is now delivering two Dermatology MOP sessions a week in Prince Philip Hospital.
- During 2021 and 2022 the training material for a GP Dermatology Diploma has been developed and signed off by SBUHB Dermatology and HDdUHB Burns and Plastics Consultants. Three GPs within HDdUHB have signed up to complete this diploma.
- In 2022 the Expansion of the Primary Care Non-USC Dermatology Scheme was developed and implemented within SBUHB. With GP completing Dermatology MOP for BBC and AK Legions in the GP practice.

Regional Consultant resource – Development of a regional Dermatology Consultant workforce to deliver treatment across the two Health Boards.

- Between 2019 and 2020 a SBUHB Consultant delivered one Paediatrics Dermatology Session per week in HDdUHB. These stopped as the SBUHB Consultant retired.

- In 2019 it was decided to create a regional Dermatology Consultant Workforce. There was funding for six and a half consultants. The posts went out to advert three times between 2019 and 2020, with no applicants. In 2021 SBUHB decided to try and just recruit SBUHB, HDdUHB also did so off the back of this. The consultant workforce is now four new substantive consultants SBUHB. HDUHB currently have x2 part time Plastic Surgeon Consultants, 1.5 WTE Locum Consultants and 2 WTE Dermatology Specialty Doctors (the Dermatology posts were filled between December 2022 and July 2023). A further 1 WTE Dermatology Specialty Doctors will join the team in October 2023.
- There is half a WTE Plastics substantive consultant & one locum consultant HDdUHB, with one current vacancy within HDdUHB. Due to capacity pressures faced by the consultant team in SBUHB, consultant support to develop the workforce in HDdUHB has been limited.

Training - Development of training for Secondary Care Clinical Staff to deliver a wider range of treatments in the community and hospital from diagnosis through to the See and Treat approach.

- CESA is a qualification to create Dermatology Consultants from Physician Associates in 2021 one Specialist Doctor is now taking part in the scheme in SBUHB with the support of the SBUHB Consultant. There was no capacity at SBUHB to support any HDUHB Locum Consultants to undertake their CESA.
- Over this period, it was hoped that other training would take place for Specialist Doctors, Pharmacists and Specialist Nurses so they could work to the top of their license in Dermatology. This failed due to a lack of consultant resources for supervision and additional pressures on the service due to the Covid Pandemic.
- In June 2023 HDUHB have recruited an Advanced Pharmacist to support the service by taking responsibility for prescriptions and management if specific pathways in conjunction with the Locum Consultants and Clinical Nurse Specialists.

The programme team met monthly until autumn 2022, which included a ‘reset’ in late 2022, which included a review of the old work programme being undertaken and a list of further opportunities to explore once the consultant availability improves, these included;

- Regional Consultant workforce, with standardised pathways and a joint list. Where there is appetite, engage the existing workforce to move to this model so that the service is managing one body of consultants across the region.
- Expand the Primary Care Non-USC Dermatology Scheme. Create a MOP service within primary care across the region. The service would be able to deal with a larger range of AK and BBC operations. Including referrals from Teledermoscopy
- Joint Consultant Support – Joint Audit days, joint clinical governance and joint difficult case meetings

- Training and Development – Development of training for Secondary Care doctors to deliver a wider range of treatments in the hospital from diagnosis through to the See & Treat approach. SBUHB consultants to support HDdUHB. Support and development GPwER in Dermatology at HDUHB in order to expand the knowledge and skills within Primary Care to deliver focussed patient care in Primary Care without the need to refer to secondary care, e.g. removal of non-malignant lesions, topical treatment regimen dermatological diseases.

Current Position

An agreed work programme in 2019 specified what the ARCH Dermatology Programme aimed to achieve as a whole. Against an ever changing backdrop of service pressures, financial constraint, the evolving of strategic health board priorities and the unprecedented impact of the Covid-19 pandemic, the ARCH resource, and operational teams across the region worked consistently to maintain momentum where possible.

Progress was achieved but pace and productivity continued to be a challenge. In particular, the recruitment and retention of Consultant Dermatologists in South West Wales continues to cause difficulty, and there is a significant lack of capacity nationally as well as in South West Wales. Although many opportunities to explore alternative ways of resourcing the service, with nurse prescribers, developing junior doctors, utilising primary care medical resource, they were all challenging to bring to fruition without sufficient consultant resource to train, mentor and oversee activity. Progress in this regard has therefore stalled and ARCH cannot add further value until this is resolved.

Project Closure

Project or programme closure is the final stage of its lifecycle.

Whilst the administration of this programme has been minimal since Spring 22, there has been some activity in monitoring, sharing and reporting Teledermoscopy progress, including interaction with Service Planning Managers and Project Officers in the ARCH PMO.

Given the projects' delivery in Teledermoscopy and its inability to progress broader workforce development due to limitations of capacity across the available consultant

workforce, it is proposed that the programme be closed as a formal ARCH supported programme. The inclusion of Dermatology within the scope of the HDdUHB Clinical Service Plan review will inform future priorities for development of the service across HDdUHB.

The closure will release resource to support other programmes of work which are awaiting ARCH prioritisation.

Action required

The ARCH Regional Recovery Group is asked to:

- Note the summary in this report;
- Approve the closure of the ARCH Dermatology Programme

Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

National Review of Dermatology Services in Wales 2019

Published by the
Welsh Dermatology Board
March 2021

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List of abbreviations

Advice & Guidance	A&G
Aneurin Bevan University Health Board	ABUHB
Basal Cell Carcinomas	BCC
Betsi Cadwaladr University Health Board	BCUHB
British Association of Dermatologists	BAD
Cardiff & Vale University Health Board	CVUHB
Certificate of Completion of Specialist Training	CCST
Certificate of Eligibility for Specialist Registration	CESR
Clinical Nurse Specialists	CNS
Clinical Work Station	CWS
Coronavirus - 2019	COVID-19
Cwm Taf Morgannwg University Health Board	CTMUHB
Did Not Attend	DNA
European Age Standardised Rate	EASR
Face to Face	F2F
General Medical Service Contract	GMSC
General Practitioner	GP
General Practitioner Committee	GPC
General Practitioner with Special Interest	GPwSI
Hywel Dda University Health Board	HDUHB
Information Technology	IT
Integrated Medium Term Plan	IMTP
Interventions Not Normally Funded	INNF
Local Enhanced Service	LES
Mohs micrographic surgery	MMS
National Cancer Standards	NCS
National Planned Care Programme	NPCP
Nonmelanoma Skin Cancers	NMSC
OPCS Classification of Interventions and Procedures version 4	OPCS-4
Patient Administration System for Wales	WPAS or Welsh-PAS
Patient Initiated Follow Up	PIFU
Prince Charles Hospital	PCH
Princess Of Wales Bridgend	POWB
Royal Glamorgan Hospital	RGH
See on Symptom	SOS
Skin Cancer Nurse Specialists	SCNS
Squamous Cell Carcinomas	SCC
Swansea Bay University Health Board	SBUHB
Urgent Suspected Cancer	USC
Welsh Clinical Portal	WCP
Welsh Dermatology Board	WDB
Whole Time Equivalent	WTE
Ysbyty Glan Clwyd	YGC

Foreword - Simon Dean: Deputy Chief Executive – NHS Wales

I am pleased to introduce this report from the National Planned Care Programme led by Dr. Caroline Mills, the Planned Care clinical lead for dermatology. This is the first ever review of dermatology services in Wales.

The National Planned Care Programme covers five specialities, working directly with health boards' clinical and managerial staff to develop sustainable pathways which reduce unwarranted variation and improve patient experience. Dermatology was the fifth speciality to be included as part of the programmes' remit in 2016.

In compiling this report, Dr. Mills and the team visited 16 hospital sites, covering six health boards in Wales[1]. This report builds on these visits and the wide ranging discussions held by the Welsh Dermatology Board. The willingness and commitment of clinicians and managers to look at their services in an open and transparent way as they engaged in the review process is very encouraging.

Dermatology faces recurrent and significant challenges across a number of areas. These include a very real shortfall in the dermatology workforce, rising number of skin cancers, insufficient outpatient capacity and the lack of robust activity reporting.

This report highlights the need for investment in a number of areas to enable a sustainable dermatology model of care including facilities, infrastructure, digital technologies, data capture, reporting, workforce planning, governance and audit. An example of the developments recommended is investment in teledermoscopy. Implementation would bring positive benefits by improving access and quality of care for patients in Wales.

The recommendations in this report are both ambitious and achievable, yet, it provides a model that health boards should strive towards and include in any future planning of dermatology services. All health boards should ensure that the recommendations in this national report and from their local visits are implemented. The clinical advisory group will work with all stakeholders, including Health Education and Improvement Wales (HEIW), primary care and Digital Health and Care Wales (DHCW) to ensure that the model of care described in this report is achieved.

Simon Dean

Deputy Chief Executive – NHS Wales

[1] These included health boards offering dermatology services (as a provider), Powys Teaching Health Board was excluded from the review as it predominately a commissioner for dermatology services (rather than a provider).

1. Introduction

Dermatologists provide a clinical service to patients of all ages with disease of the skin, hair and nails. Skin problems are common accounting for one in four General Practitioner (GP) consultations and around 6,000 referrals a month to secondary care services in Wales.

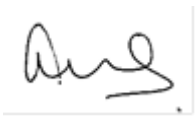
As with the rest of the United Kingdom (UK), skin cancer accounts for around half of all cancers treated and rates in Wales have been increasing steadily; the prevalence well documented and doubling every 10 years. Whereas data exist for melanoma, a lack of accurate prevalence data for the more common forms of skin cancer has contributed to a lack of understanding as to the scale of the problem and, as a consequence, insufficient resource allocated to maintain services.

In addition to dealing with increasing rates of skin cancer, dermatologists also offer help with management of over 4,000 skin conditions including common skin diseases such as eczema, psoriasis and acne. These conditions have a significant impact on patients physical and mental wellbeing; interfering with function, sleep and the ability to study and work. Both acute and chronic skin disease may impact on a patient's ability to work. The investigation and management of such conditions have economic implications for both patient and employer.

We have presented a national overview of dermatology having collated local reports from the six health boards providing dermatology services. We have highlighted variation in workforce and facilities which has resulted on unacceptable inequality of care to patients with skin disease around Wales. Increased complexity and subspecialisation have resulted in smaller units being unable to match the range of services available to patients in larger units. Only one health board in Wales currently offers a comprehensive service.

The recent pandemic injects a new sense of urgency into dealing with the increasing demand/capacity gap and growing backlog of referrals. Digital technology can help not only with rapid diagnosis but also facilitate effective care and reduce the need for hospital appointments. Whereas dermatology is a speciality well placed to benefit from advances in digital technology, the roll out is hampered by variable Information Technology (IT) infrastructure as observed within individual health boards.

Patients in Wales should expect an early diagnosis and the best treatment available. This report and the recommendations within provides a framework for modernising and transforming dermatology services across the country.



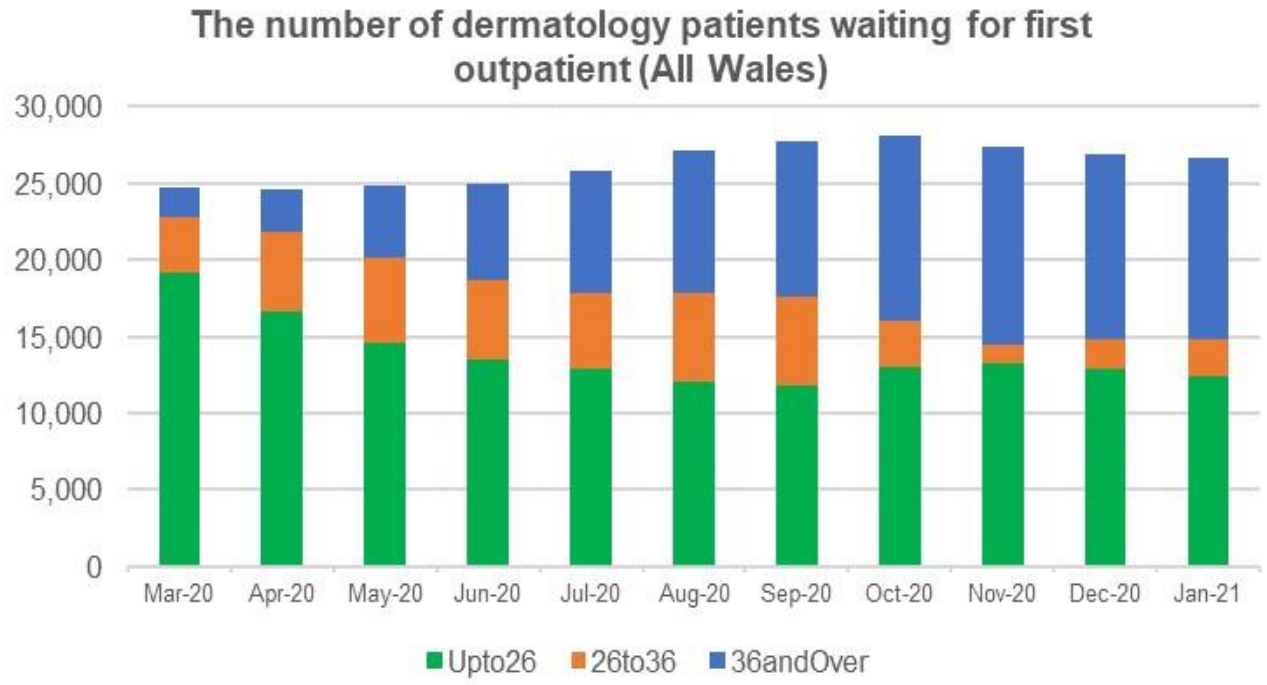
Caroline M Mills MD, FRCP

Consultant Dermatologist, Aneurin Bevan University Health Board
Chair Dermatology Board, Planned Care Programme

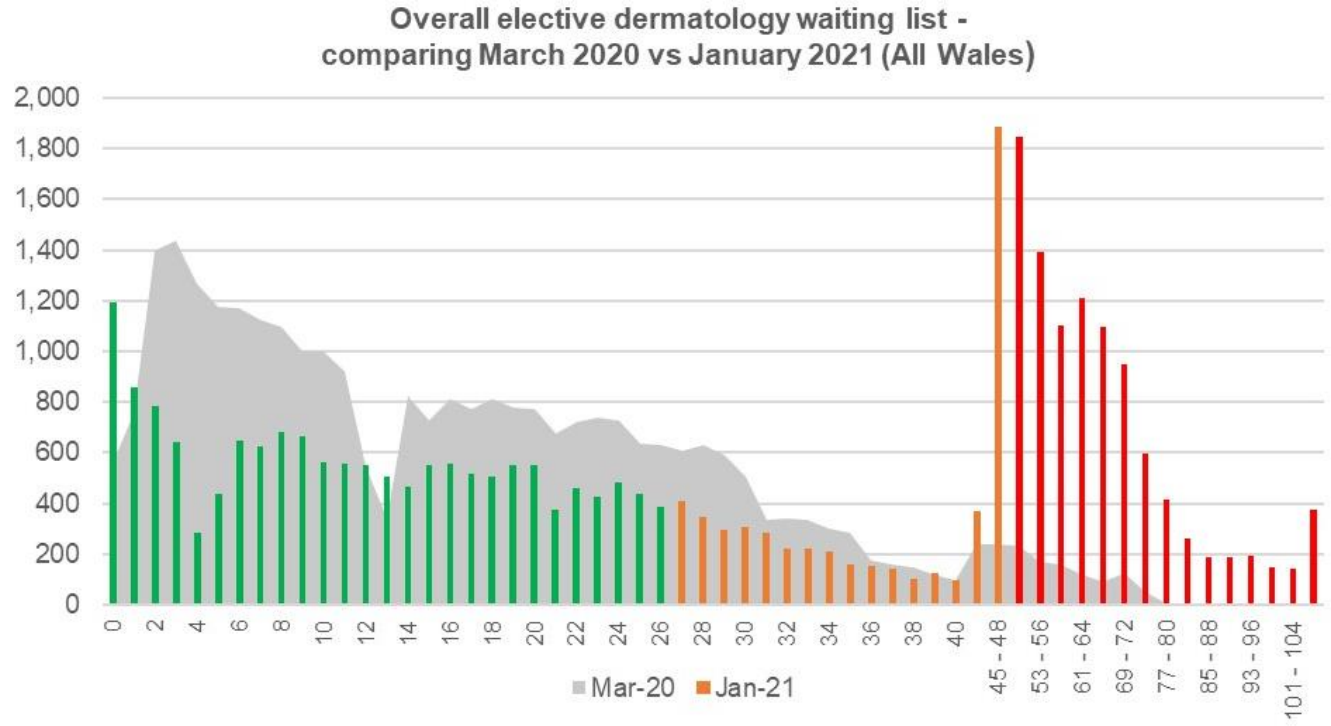
2. Impact of COVID-19

The review of dermatology services in Wales was undertaken during 2019 with the intention to publish the findings in spring 2020. However, the COVID-19 pandemic has forced a delay in the presentation of the report. Welsh Government proactively suspended all elective activity within hospitals in March 2020 to allow the system to implement pandemic response plans. The consequences for dermatology services was an immediate shut down of all non-cancer work, re-deployment of non-consultant medical staff and non-medical workforce, and repurposing of outpatient facilities for other clinical uses.

On the 31 March 2020 there were 24,682 people waiting for a first outpatient appointment in dermatology, with 5,515 patients waiting more than 26 weeks. By 31 January 2021 the number increased to 26,687 people waiting, with 14,336 waiting more than 26 weeks. While the total number of patients waiting has increased by 8.1% in an 11 month period, the number waiting over 26 weeks increased from 22% of the waiting list to 54%.



The graph below demonstrates the impact of COVID-19 on the total waiting list, the lower number of patients on the pathway (green and amber) compared to March 2020 is reflective of the reduction of people visiting their GP and being referred in, whereas those waiting longer (red) is an indication of those entering the pathway as services stopped as a result of the pandemic who are now waiting 52 weeks or more. As of January 2021, 27% of patients waited over 52 weeks for their appointment or treatment, compared to only 3% of patients in March 2020.



Despite the significant challenges facing the provision of dermatology care, teams around the country have been able to maintain services for Urgent Suspected Cancer (USC) referrals while exploring new ways of working via telephone and video consultations. Despite the best efforts of all health boards, it has not been possible to provide care to all patients and all conditions. There is growing clinical concern over the number of patients waiting to be seen who may have a serious or deteriorating condition. The question of easier access for routine advice and treatment, alternative care pathways and the use of pre-clinic diagnostics were identified within the review of dermatology services in 2019. The importance of national implementation and transformational change within dermatology in Wales has been brought into sharper focus over the intervening period.

3. Executive Summary

Workforce

There is a little evidence of co-ordinated or cohesive multi-disciplinary workforce plans within dermatology locally or nationally. Dermatology in the UK is a service that has moved towards integrated multi-professional service delivery teams which includes primary care. However, there is minimal evidence that this approach has been adopted within workforce planning in Wales.

The difficulty in recruiting and retaining medical staff into posts has been a recurring theme of the review. Many units have or are beginning to encounter skills gaps caused by the retirement of long-standing team members with several posts being held as long-standing vacancies. Technology, specifically teledermatology and virtual consultations present opportunities to support services where there are consultant shortages supporting local teams to continue services safely with appropriate supervision and guidance.

Improving training opportunities within Wales has been identified as a major factor in recruitment and retention. While there has been provisional funding for Clinical Fellow posts in dermatology incorporated in health boards workforce plans as part of their Integrated Medium Term Plan (IMTP), the funding (initially for 3 years) needs to be made permanent. This scheme enables trainees to gain the experience required to get a national training number and Certificate of Completion of Specialist Training (CCST) in dermatology improving retention as Welsh consultants. These posts also present the option to apply for consultant posts via the Certificate of Eligibility for Specialist Registration (CESR) route. Currently no training budget is allocated to these posts.

The nursing workforce, at both specialist and general level was variable. Whilst some units have stable and experienced workforce, some do not which hinders service delivery. There is not a standard model for the use of Clinical Nurse Specialists (CNS). Some health boards do not have adequate, or any, Skin Cancer Nurse Specialists (SCNS) to support patients receiving a diagnosis of malignancy.

A mix of staffing models are in place across Wales, but in all cases there was the potential to diversify service provision with investment in an allied health profession workforce, such as general practitioners, pharmacists and medical photographers. Inability to obtain funding for posts was frequently encountered.

Workforce recommendations:

1. A clear, multi-professional and integrated workforce plan for the next decade is required to ensure that dermatology can continue to be delivered across Wales to include clinical nurse specialists, pharmacists, general practitioners, and medical photographers.

2. Retain the Clinical Fellow posts to allow local trainee doctors an opportunity to gain experience within dermatology and consider training budget allocation for clinical fellows and trainees undergoing CESR.

3. Each health board to review the current workforce establishment to understand where current gaps exist and to understand the impact this has for service delivery in the short term (3 years). Longer term workforce plans will be required to be developed once demand and capacity has been established.

Environment / Infrastructure

With only a few exceptions, the clinical environment from which dermatology is delivered is challenged. It is not uncommon for services to be delivered from locations which are inefficient and do not support patient flow. Some sites do not have dedicated facilities that allow treatment or multidisciplinary care to be delivered at the same time as an outpatient appointment, resulting in multiple visits to hospital sites.

It was observed that units with dedicated facilities have less trouble recruiting and retaining staff.

Environment / Infrastructure recommendation:

4. An audit of each area from which dermatology is delivered should be carried out against the British Association of Dermatologist (BAD) standards for dermatology services and surgical services.

Service models

The transition from a consultant delivered to a consultant led service model by some health boards has supported diversification of the workforce and improved access for patients by increasing capacity. This unfortunately is not consistent leading to unacceptable variation in services available to patients with skin conditions across Wales.

Separation of dermatology services into smaller units within health boards were associated with higher levels of variation and less sub-speciality investigations and services available to patients. Smaller units are unable to provide the same range of sub-specialist expertise as larger units. Only one health board offered a full range of specialist diagnostic service and treatments to all patients in their area.

Throughout the review process health boards showed different approaches to streaming patients into appropriate clinic templates which varied even within the same organisation in some cases. “General” dermatology clinics are commonly utilised which can be created into a simple booking template. This does not support the use of one-stop or treatment clinic models or allow for specialist resources or staff being routinely available. Sub-speciality clinics allow for higher complexity patient pathways to be managed more efficiently and support multidisciplinary delivery of care. While there is a case for the use of “general” clinics this should not be the default through which all activity is delivered.

Variation was also found in respect to sub-speciality services offered, as well as the clinical experience and competencies of those delivering the service.

Mohs Micrographic Surgery (MMS), the gold standard for treatment of Basal Cell Carcinoma (BCC) is a specialised form of surgery for difficult tumours, and is only provided by one health board in Wales. Lack of access can result in suboptimal treatment with incomplete excision and repeat treatment episodes for patients.

Teledermatology is a term used to describe different functions within health boards. In the majority of health boards the term is used to describe tele-triage which aid prioritisation of referrals added to the waiting list. This contrasts with teledermoscopy which leads to a diagnosis, discharge, or treatment.

Patch testing services for cutaneous allergy is only provided to the standards set by the British Association of Dermatologists cutaneous allergy group across three health boards in Wales. The service was not always consultant led and delivered by nursing staff at a very basic level. In many units no evidence of ongoing training, updates and audit was demonstrated.

Provision and governance of phototherapy varies considerably in terms of consultant supervision, delivery by a mixed workforce including nurses and physiotherapy technicians who were often isolated from colleagues.

Collaboration with primary care is also patchy. Where it is working, it works very well. There are different models that have been shown to be effective, these are vital to promote going forward. Having General Practitioners (GPs) working in and alongside secondary care, whilst undoubtedly of great value in terms of taking their skills back into their practices to the benefit of patients, is often logistically complex in terms of contracts and attractive levels of remuneration.

It is widely acknowledged that there is inadequate training in dermatology at both undergraduate and postgraduate GP training.

All units in Wales were aware of the list of Interventions Not Normally Funded (INNF) via the NHS and confirmed they did not accept referral for treatment of benign skin lesions. Some units, however, reported they were under pressure to provide basic procedures normally undertaken in primary care. Patients from GP practices opting out of this level of service provision were referred to secondary care rather than alternative arrangements being made within the community setting.

Service models recommendations:

5. Sub specialist services within Wales should be audited against BAD standards to ensure high standards care for all patients.

6. Ensure that all health boards support consultants to develop sub-speciality services to offer a full range of diagnostic and treatment options to all patients within their area. A hub and spoke model may be required to avoid disadvantaging patients.

7. Enable teledermoscopy across Wales to provide a national service.

8. Review contractual arrangements and levels of remuneration to facilitate closer working with primary care.

9. Review the list of Interventions Not Normally Funded (INNF).

Sustainability (Demand and Capacity)

The lack of outpatient coding in Wales is particularly damaging to specialities like dermatology as this is where most of the service is delivered. The baseline quantitative questionnaire consistently yielded inaccurate activity reporting. Inadequate coding also obscures the level of intervention undertaken within dermatology. Apart from Aneurin Bevan University Health Board (ABUHB) who use outpatient coding within their Clinical Work Station (CWS) system, teams are unable to quantify the proportion of patients receiving specific procedures or interventions within the service which hampers the tracking and evaluation of service changes or understanding service costs. During the review it was clear that a lack of data and understanding of treatments carried out in an outpatient setting has resulted in some health boards providing inadequate surgical facilities and treatment

rooms for dermatologists. This has resulted in a costly model of dependency on local maxillofacial, ENT and plastics surgeons to deliver treatment.

The ability to code patients by sub-speciality on the waiting list would support planning of services. The Welsh Dermatology Board has approved coding for outpatient procedures but only ABUHB have a robust system in place to record outcomes. Attention has also been drawn to reporting of activity by members of the wider clinical team. Currently only the proportion of activity undertaken in consultant led sessions are recorded consistently.

Sustainability (Demand and Capacity) recommendations:

10. The introduction of more detailed outpatient coding should be prioritised within dermatology.

11. A regular schedule reporting and reviewing activity should be introduced which is comparable across health boards.

12. Agreement will be sought through the Welsh Dermatology Board for subspecialty coding categories. Health boards will introduce the recording and reporting of categories.

13. Health boards will work with the Welsh Government on the revision of the national outpatient data set to support accurate recording all activity undertaken within dermatology at point of delivery.

14. Offer primary care enhanced service provision across Wales to facilitate local treatment for patients with low risk tumours.

Outpatient Transformation

Teledermatology

Dermatology has much to gain by embracing new technologies such as tele-triage, virtual consultations including teledermoscopy, and e-advice systems. Unfortunately inconsistent provisions of Information Technology (IT) infrastructure across Wales is hampering progress even in basic processes such as management of e-referral.

Teledermatology and teledermoscopy have been successfully piloted and introduced in some health boards. This has the potential to massively reduce the footfall in outpatients and provide a national service to support areas with vacancies and recruitment vacancies. These sessions arising from collaborative working need to be appropriately funded and included in job plans.

Advice and Guidance (A&G)

Since the COVID-19 pandemic health boards have come under increasing pressure through staff re-deployment and reduced capacity, which has emphasised the need for clinicians to work differently. Dermatology departments acknowledge the need to rapidly adapt to running significantly reduced services, both in the short and long term. Pathways are required for common skin conditions to ensure a consistent approach across Wales. This will help ensure that patients with the greatest need for secondary care services can access without long waits.

Outpatient Transformation recommendations:

15. The adoption of successful innovation projects in other health boards should be encouraged through the provision of support for transformation within health boards.

16. The Welsh Dermatology Board should provide a higher profile for sharing innovative practice, with formal requests that health boards respond to spread good practice.

17. Standardised Advice and Guidance should be developed for common conditions to ensure appropriate treatment for patients in the correct setting.

4. Background

The Welsh Dermatology Board (WDB) was established in 2016 as the fifth speciality to be included in the National Planned Care Programme portfolio. The aim was to be a clinically led forum to support the sharing of best practice and identification of national variation in service provision. It has matured to be an advocate for the delivery of high quality care in line with the principle of value based health care and looks to provide a co-ordinating body for investment of national resources to support dermatology.

The board identified that there were several regional challenges being faced by health boards in relation to the delivery of dermatology services which meant that not all patients had access to the same level of care. In order to understand reasons behind regional variation, the National Planned Care Programme commissioned the Welsh Dermatology Board, in conjunction with the NHS Wales Delivery Unit, to undertake a review of all dermatology units / health boards in order to establish an overarching picture of services within Wales. The outcomes of the local reviews would be presented to health boards, while the national report would be published to share findings, recommend good practice and prioritise the WDB work programme moving forward.

The nature of dermatology services

The 2011 British Association of Dermatologists (BAD) report "Quality Standards for Dermatology[2]" showed that 24% of the population reported a skin condition to their GP every year. The management of skin conditions can be divided into four levels of severity.

Level 1: Self management by the patient with access to high quality information / advice

Level 2: Requiring generalist care, often from GP practices and community nurses.

Level 3: Specialist care, delivered by specialist dermatology multidisciplinary teams.

Level 4: Supra-specialist care, delivered by tertiary or regional multidisciplinary teams.

Care delivered at each level of the pyramid is important in the management of skin complaints and can involve the complex health histories that require coordinated medical and psycho-social support for patients. This review focuses on the specialist (level 3) and supra-specialist (level 4) service delivery by teams based on acute hospital sites across Wales. In 2019 the national budget for "skin care" in Wales is £147,813,000 of this only small percentage 21%; £31,747,399 is allocated to the dermatology teams in secondary care[3].

Dermatology is an ambulatory service predominately delivered from an outpatient setting in acute hospitals. This often conceals the highly specialist care that is being delivered. In 2013 BAD highlighted that the traditional definition of new or follow-up appointment recorded within hospital administration systems does not accurately capture the activity undertaken. In its publication "Lessons for the NHS – Commissioning a dermatology service"[4] it is suggested that unless you are able to distinguish, or code, activity undertaken within outpatients it would not be possible to understand demand for services or plan for appropriate investment. Within an outpatient clinic a range of clinical interventions, diagnostic procedures, medication review or specialist treatments can be undertaken. Some of these can be managed in a one-stop setting or may require long term

[2] 2011 British Association of Dermatologists: Quality Standards for Dermatology
[3] Stats Wales: NHS Expenditure by budget category and year
[4] Lessons for the NHS: Commissioning a dermatology service

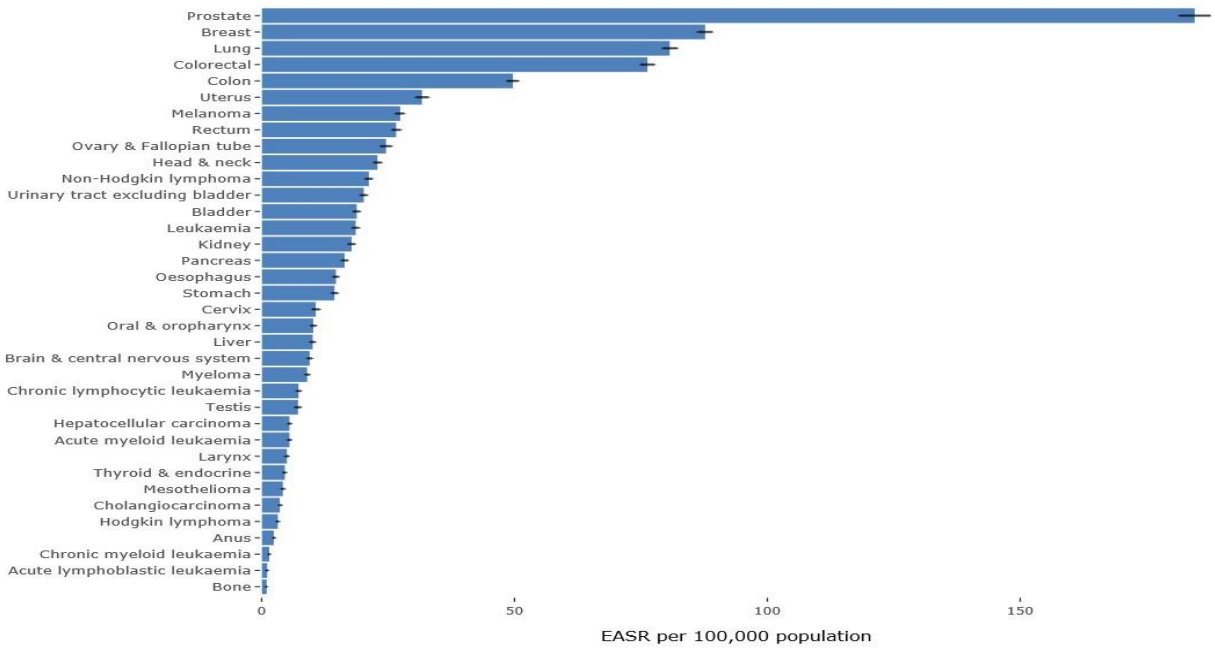
management. Not all outpatient appointments are equal. In 2020 dermatology in Wales was not able to deploy more sophisticated demand modelling due to the lack of systematic data collection.

Skin cancer is the commonest cancer by body site. Basal cell cancer (BCC) is a low-grade follicular tumour and has a very low mortality rate, however it can have high associated morbidity particularly when it occurs around the eye and rarely extenuation (removal of the eyeball) is required. Squamous cell cancer (SCC) has the potential to metastasise and has been increasing in incidence over recent decades. Mortality rates have also increased (see further info below). BCC and SCCs are collectively known as keratinocyte cancer or non-melanoma skin cancer.

UK incidence data for keratinocyte skin cancers only became available since 2015. The reported number of keratinocyte skin cancers in 2017 in Wales was 10,194[5]. To put this in context the next most common cancer in Wales is prostate cancer with 2,705 cases in 2017. Malignant Skin cancer melanoma, which also has the potential to is metastasise, is the third commonest skin cancer and the 7th most common cancer in the Wales (excluding keratinocyte cancers), accounting for 4% of all new cancer cases (n=863 in 2017).

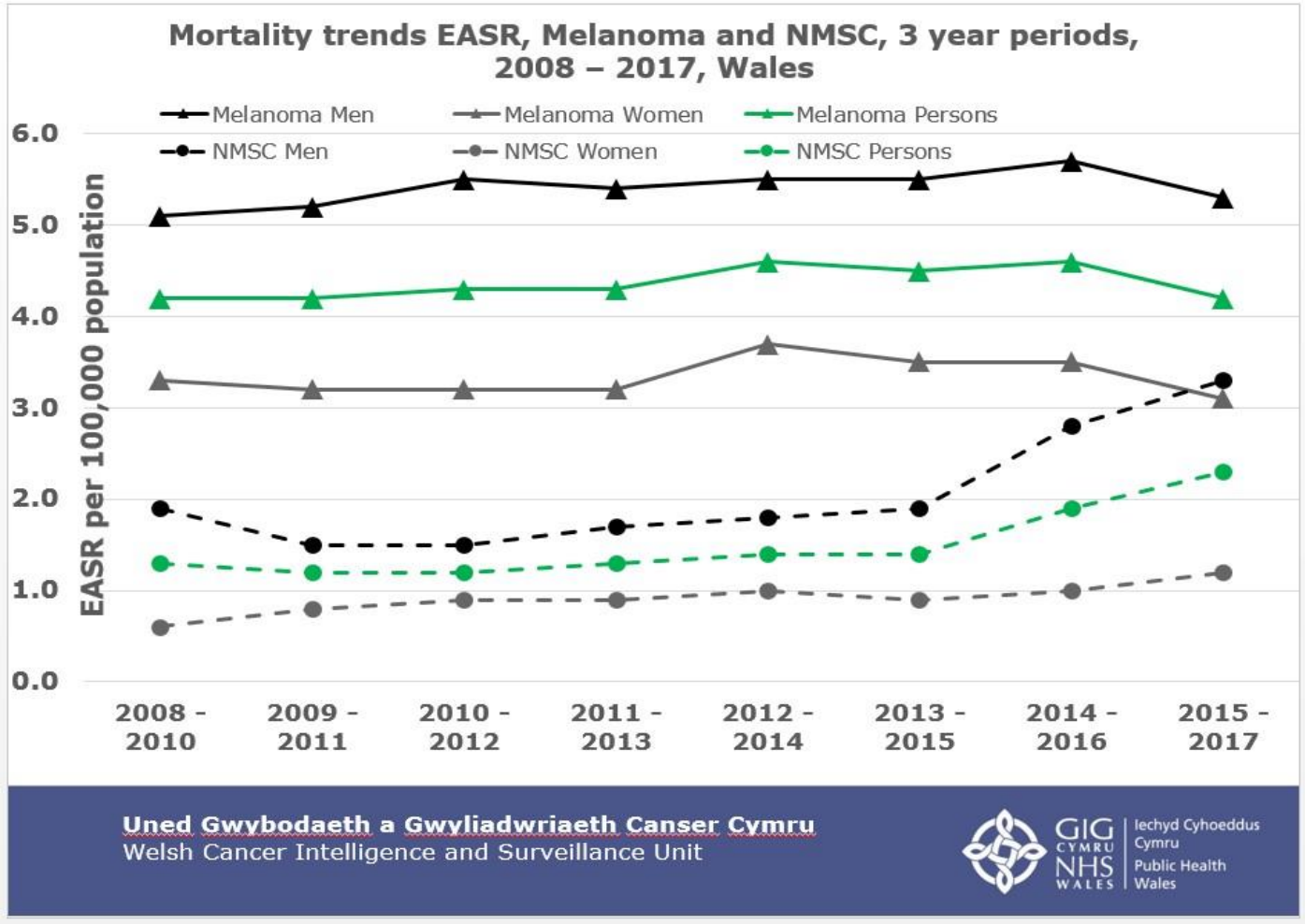
However, looking beyond these statistics, many more patients are seen, investigated through skin biopsy or lesion removal to rule out cancer. Care is also provided for patients with inflammatory skin disease such as acne, eczema, and psoriasis. Although rarely life-threatening, these conditions are often life changing for patients interfering with work, impacting on family life and general well-being. Dermatologists also have a significant role to play within the hospital setting offering advice and diagnostic skills. Serious medical conditions may present with a manifestation of skin disease or develop as a consequence of both disease and treatment.

The graph below shows European Age Standardised Rate (EASR) per 100,000 population for the incidence of Melanoma cancers (2001-2017).



[5] Cancer Research UK: Non melanoma skin cancer incidence rates

The graph below shows the mortality rate for Nonmelanoma Skin Cancers (NMSC) and Melanoma between the periods of 2008-2017 in both men and women per 100,000 population[6]. Whilst earlier diagnosis and new immunotherapy treatments have reduced mortality in patients with melanoma there is a worrying trend in both the prevalence and mortality associated with the more common squamous cell carcinoma. Deaths from squamous cell carcinoma in men have now surpassed that from melanoma in women.



Throughout the UK, the dermatology workforce has been under pressure for some time with high vacancy rates and an aging medical and non-medical workforce. Wales has not escaped this phenomenon. Prior to the review being undertaken it was recognised that 28% of funded medical posts within dermatology in Wales were classed as vacant. There are six retirements planned within the next five years, and 50% of Welsh consultants are due to retire before 2030. Dermatology training programmes have been long established within Wales, however there is a low retention rate for trainees to remain in the country. The UK shortage has created a competitive jobs market with only three of the last thirteen trainees opting to stay in Wales post-training. This loss of experienced practitioners mirrors the non-medical workforce experience, with a significant proportion of experienced speciality nurses approaching retirement.

It is against this context that the review into dermatology was undertaken. Its purpose was to understand the local challenges being faced in different parts of Wales, what solutions are there and

[6] Welsh Cancer Intelligence and Surveillance unit (WCISU)

could be introduced, and what priorities need to be addressed collectively to ensure high quality care is delivered to patients anywhere in Wales.

Peer Review Methodology

The Welsh Dermatology Board, in collaboration with the NHS Wales Delivery Unit, undertook a national peer review of dermatology. The aim was to provide a detailed overview of how services are provided in the seven health boards across Wales.

The review was designed to:

- Support the development of sustainable dermatology models for Wales.
- Identify variation in delivery models across Wales.
- Identify variation in service demand.
- Recognise and support the spread of innovation and good practice.
- Identify service constraints and offer support to departments to release capacity.
- Identify key themes as priority areas of work for the Welsh Dermatology Board.

The review was formed of three parts, and was based upon similar reviews undertaken within the cancer and palliative care national reviews:

Baseline questionnaire

Health boards were asked to complete a baseline quantitative questionnaire which outlined staffing levels, activity, and evaluation of the clinical environment.

Departmental visit

The review team visited each health board, to undertake a review of services based upon the information submitted in the baseline questionnaire. This process facilitated wider discussions on service models in place, constraints and plans for improvement. The exercise was supported by members of the Welsh Dermatology Board, the NHS Wales Delivery Unit and the National Planned Care Programme.

Health board visits took place between July – December 2019 and included a review of the department's clinical environment, often on multiple physical locations used by the teams.

Patient experience survey

Health boards were asked to conduct a bespoke patient experience survey, developed by the national listening and leaning group consisting of representative from health boards Patient Advice & Liaison teams.

Following each of the review visits, health boards received a factual summary report of findings, which highlighted good practice and areas which required internal review. These reviews were validated for accuracy by the local clinical teams prior to publication.

This report brings together overall themes, evidenced good practice, and areas for improvement and is structured to provide:

- An overview of findings from across Wales that summarises challenges to the delivery of a sustainable and equitable dermatology service within Wales.
- Key recommendations which need to be considered by all health boards.
- Further information to support the recommendations. This section expands upon the challenges being faced by dermatology, whilst highlighting local good practice and innovation within local teams.

5. Key findings for Wales and recommendations

The peer review process has highlighted the dedication and commitment of dermatology teams across Wales to deliver a high-quality service for patients. However, it was felt that the complexity and challenges involved in delivering this service were not always recognised. It was highlighted on a number of occasions that there was a perception that skin issues are not often life threatening, that skin cancer does not have as high a mortality rate as other tumours and that outpatient services cannot be as complex as other specialities, resulting in the services feeling under-valued, under-represented and under-invested in.

Health boards have fed back positively to the process of the peer review and the recommendations that have been made. They welcomed the opportunity to showcase how they have addressed local issues and raise those challenges which remain. There has been a significant amount of good work undertaken nationally and locally to transform the way in which dermatology services are delivered, but a system wide understanding and leadership is required to ensure that Wales is not left behind by services in the other home countries, Europe and the wider world.

Workforce

At the time of the review there were 30.7 Whole Time Equivalent (WTE) dermatologists working in Wales and seven vacant posts. In almost all health boards expensive short term plans to either employ locums or outsource dermatology services were regularly being used. In addition, seven further consultants are planning to retire within the next five years. All but one health board had advertised posts, often on several occasions, and received no suitably qualified applicants.

The Royal College of Physicians (RCP) recommends one full-time equivalent consultant dermatologist per 62,500 population, which scales up to 1.6 consultants for 100 000 population[7]. Based on this recommendation, with the exception of one health board, the remaining health boards do not have sufficient dermatologist consultants for their population size.

Health board	Per 62,500 population
Betsi Cadwaladr	0.62
Aneurin Bevan	0.76
Cardiff & Vale	0.95
Cwm Taf Morgannwg	1.07
Swansea Bay	0.32
Hywel Dda	0
Powys	0
All Wales	0.63
RCP recommendation	**1**

[7] The British Medical Journal

Many units have or are beginning to encounter skills gaps caused by the retirement of long standing team members, the recruitment of less experienced staff, or long standing vacancy gaps.

It was reported from several sources that challenging (unrealistic) job plans, limited investment in appropriate clinical facilities, remote working, and the perceived lack of concern for long term staff welfare had been cited as contributory factors to the recruitment challenge.

Medical recruitment

There is a UK shortage of consultant dermatologists and a significant factor in the recruitment challenges for the medical workforce within dermatology in Wales. Health boards across Wales are holding unfilled vacancies for consultant posts, while one health board has no substantive consultant staff. The current staffing profile predicts that within 10 years 50% of the current workforce will have retired.

Wales has 16 training posts on both north and south Wales rotations which produce high quality candidates who often take permanent appointments outside Wales. There are many reasons for this; the most frequent being that registrars are appointed by a UK wide selection process and will travel/commute to take up training opportunities only to return closer to home once a local post is advertised[8].

The Welsh Dermatology Board obtained support for five clinical fellow posts in Wales, however only four posts were appointed due to consultant and resource capacity. This was deemed essential as previously only 27% of trainees who completed training in Wales stayed to take up a consultant post. The posts were advertised in three health boards. Dermatology experience is required to be able to compete for a national training number (a highly competitive process) and CSST. Prior to these appointments there were limited opportunities for a junior doctor interested in a career in dermatology to gain adequate experience to enable them to gain a place on a training rotation. Since funding was secured, four have successfully applied for a training place and have expressed their intentions on planning to stay in Wales.

It is noticeable that the larger units in Wales have been more successful in recruiting than smaller units. Support for junior consultants is important particularly working in a small unit. Developing a national network for advice and support with hub and spoke models would go a long way to providing an improved working environment. It would also allow for development of sub-specialisation and improved access to specialist investigation and treatment for patients across Wales.

There is the potential for collaborative recruitment, as part of the A Regional Collaboration for Health (ARCH) programme a regional solution is being developed between Swansea Bay University Health Board (SBUHB) and Hywel Dda University Health Board (HDUHB).

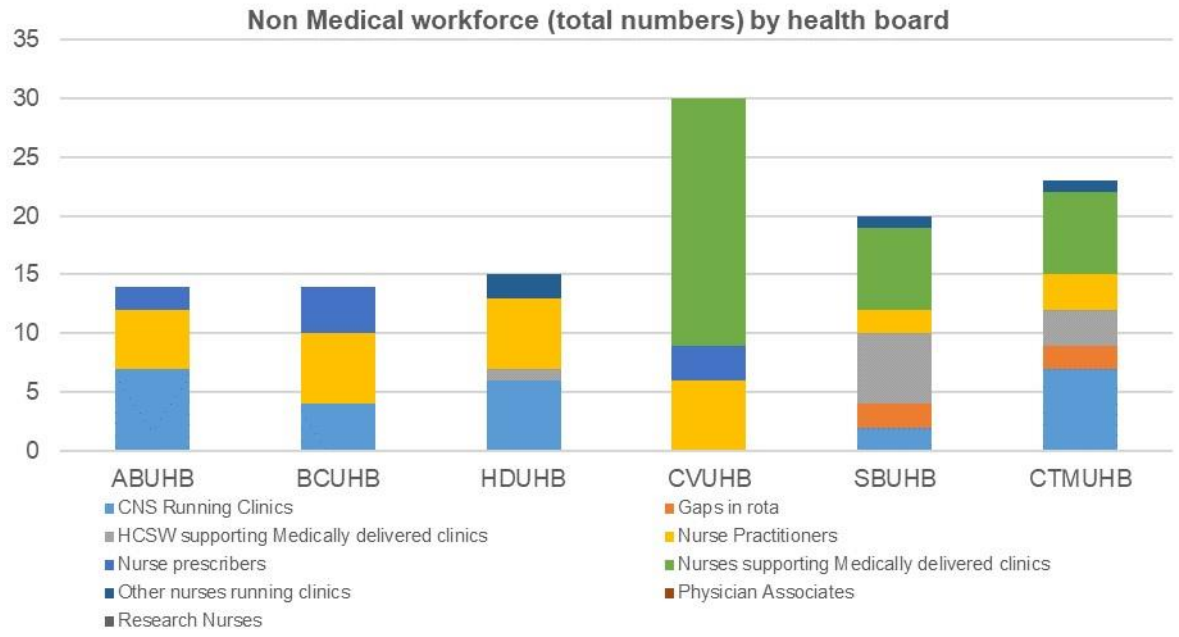
Several health boards run clinics which are multidisciplinary with consultants leading a team including clinical nurse specialists, trainees, general practitioners, and speciality doctors. These clinics present the opportunity for more comprehensive services for patients, training opportunities, facilitates staff development and enables more patients to be seen and assessed by the consultant. This model is not possible within smaller units with less staff or access to adequate facilities and space.

[8] Good N, Levell NJ. UK Dermatology specialist trainee career intentions. Clin Exp Dermatol 2018 Mar;43(2):200-201

Skin Cancer Nurse specialists/Clinical Nurse Specialists

National Cancer Standards (NCS) stipulate that Skin Cancer Nurse Specialists (SCNS) are key roles in the delivery of care. Not all health boards had an adequate SCNS workforce. Recommendations from the Skin Cancer Peer Review (2015) for Dermatology should be implemented. Where no suitable candidates are available, a professional development plan should be created to support a staged training program to meet a standardised job description.

Clinical nurse specialists (CNS), where present, also play an important role in providing support for non-cancer patients whilst enabling more efficient running of services by taking on roles previously undertaken by medical staff. Some health boards have nurse specialists who run their own clinics, for example: children's eczema and acne clinics working closely with consultant colleagues. Independent prescribing training and status for CNS facilitates this model and leads to increased efficiency within units. At the time of review there were only 9 nurses who were trained out of 33. In other health boards they are isolated without regular consultant support working with locums and non-consultant grade doctors. High levels of anxiety were expressed on some visits with this lack of consistent support. Some clinical nurse specialists were found to work in isolation without any regular contact with colleagues resulting in a high turnover of staff in these posts.



There appeared to be no consistency in roles, responsibility, and support for clinical nurse specialists across Wales. Where a CNS workforce is in place, the age profile of the workforce demands immediate succession plans to be established to minimise disruption to service provision to patients when staff retire.

Study leave budgets were universally inadequate and as a result training and access to courses was extremely variable.

Training programmes

The level of exposure of dermatology within general nursing training, and access to higher specialist nurse training was highlighted throughout review sessions. The lack of dermatology knowledge, training and clinical updates within both primary and secondary nursing raised concern as it has an impact on the referral levels to dermatology teams. The potential to treat simple skin conditions during routine contact with other health care providers (primary care, inpatients, community care) allows the opportunity to prevent escalation to more serious conditions but is reliant on regular clinical updates. Further work will be needed to systematise and set standards across Wales.

Support for CNS training is inconsistent. Several individuals reported they were left working in isolation, responsible for both diagnostic services and treatments without supervision. Apart from the SCNS there is no consistency in training days/updates for nursing providing non cancer care. Funding and study leave budgets were highlighted as a problem within this group.

As well as basic training, recent experience would suggest that more can be done to deploy technology to support and mentor members of the wider team to encourage inclusivity.

Integrated workforce plans

The provision of dermatology in the twenty-first century requires a multi-professional workforce. Unfortunately, the separation of medical, nursing and allied health professional workforce planning has impacted the ability for dermatology to progress. There is the opportunity to reapportion the patient demand within a team led by consultants but delivered by other professionals. This requires teams to rethink how referrals, treatments and monitoring can be delivered differently. COVID-19 has accelerated the need to work differently to deliver care to patients. Where there are opportunities, IT systems within health boards are often a limiting factor and not all departments have the same level of support.

Workforce recommendations

1. A clear, multi-professional and integrated workforce plan for the next decade is required to ensure that dermatology can continue to be delivered across Wales to include clinical nurse specialists, pharmacists, general practitioners, and medical photographers.

2. Retain the Clinical Fellow posts to allow local trainee doctors an opportunity to gain experience within dermatology and consider training budget allocation for clinical fellows and trainees undergoing CESR.

3. Each health board to review the current workforce establishment to understand where current gaps exist and to understand the impact this has for service delivery in the short term (3 years). Longer term workforce plans will be required to be developed once demand and capacity has been established.

Environment / Infrastructure

The clinical environments from which dermatology services were delivered vary enormously across Wales. Investment in dermatology units by health boards has been variable with clear distinctions evident and reflected in the level of clinical services offered. Several were not compliant with published BAD standards "Staffing and Facilities Guidance for Dermatology Services[9]". In some sites it was apparent that the areas in use have not been allocated based upon the best practice requirements of clinical care but availability of clinical space. The requirements for dermatology need to be considered by health boards to support the application of efficient service models.

Lack of suitable clinical facilities should not be underestimated as a factor in the recruitment challenge faced by dermatology. The standard of accommodation, access to co-located services and ability to provide a physical designated dermatology unit do not compare favourably with some other units in the UK and disadvantages Wales within a competitive recruitment environment.

With only a few exceptions, the clinical environment from which dermatology is delivered is challenged. It was not uncommon for services to be delivered from locations which are inefficient and do not support patient flow. Some sites do not have dedicated facilities that allow treatment or multidisciplinary care to be delivered at the same time as an outpatient appointment, resulting in multiple visits to hospital sites.

Co-location

The overall trend for dermatology facilities is to locate them within outpatient departments within multi-use facilities alongside other specialties. To efficiently utilise patient contact it is recommended that parallel treatment facilities are co-located. These include treatment – procedure spaces, as well as spaces appropriate for surgery and phototherapy. In many sites these facilities were not co-located or managed as a single service resulting in the need of either prolonged or return appointments to administer care.

Treatment / Surgical facilities

The 2014 BAD standards "Staffing and facilities for skin surgery units[10]" outlines the higher environmental standards required of a treatment room and / or minor surgery space for dermatology. Examination of unit's facilities highlighted a wide variety of deficits with very few meeting all standards as a result of services being "shoe-horned" into outpatient facilities which do not meet infection control or patient dignity standards. At a basic level, while general dermatology procedures do not require theatre quality facilitates, there is a requirement for suitable systems for enhanced air-change levels, clean and dirty utility areas and secure storage for medical instruments, as well as accessibility for patients with limited mobility. The best example of facilities can be seen in Cardiff & Vale University Health Board and Swansea Bay University Health Board.

In some areas there were concerns over the compliance with infection control standards for procedure rooms.

[9] Staffing and Facilities Guidance for Dermatology Services
[10] 2014 British Association of Dermatologists standards: Staffing and facilities for skin surgery units

Good practice - Consultant led super clinics

Singleton Hospital, Swansea Bay University Health Board

Dedicated outpatient facilities and nursing staff has allowed consultants in Swansea to hold super clinics for patients with suspected cancer. Up to 90 patients are seen in a clinic. Three treatment rooms are co-located enabling patients to take advantage of one stop delivery of care. The clinic is consultant led, supported by a combination of specialist and outpatient nurses, junior and speciality doctors. The clinic is often attended by medical students. High satisfaction was recorded by patients and staff attending these clinics.

The advantage of a consultant led rather than consultant delivered service is that the consultant can see and supervise the care of many more patients. This model, dependent on sufficient space and workforce, improves flow increasing efficiency of the cancer pathway. It provides training and supervision of junior staff resulting in less biopsies, unnecessary tests and follow up appointments.

Unfortunately, this model has only been replicated in a minority of units in Wales due to a mixture of physical and clinical constraints.

Multi-disciplinary clinics

The delivery of dermatology is supported by a multidisciplinary team which can offer support to patients during a single appointment. This model requires a service to have multiple rooms available simultaneously in the same location. Cardiff & Vale University Health Board has good examples of this with the provision of psychological support (PsoWell model) alongside dermatology, rheumatology and specialist nursing in the same location. Not all teams have access to such facilities.

Good practice – Psycho-Dermatology (PsoWell model)

Cardiff & Vale University Health Board

An Integrated psychology services that provides psychological support to dermatology patients. This service aims to identify the needs and provision for patients with skin conditions as a means to providing holistic care and improve the training for specialists in dermatology to better manage psychological and psychiatric aspects of skin conditions including psoriasis.

The advantage of having such service, ensure the psychological needs of patients are addressed through an integrated service rather than as a separate service.

IT infrastructure

Variation in access to IT systems provided by NHS Wales was in evidence in several visits. This includes lacking access to functionality within Welsh Clinical Portal (WCP), availability of PC's / office space for the extended team, and variation in access to equipment for delivery of treatments.

Environment / Infrastructure recommendation:

4. An audit of each area from which dermatology is delivered should be carried out against the British Association of Dermatologist (BAD) standards for dermatology services and surgical services.

Service models

One-stop clinics

One-stop see and treat clinics are a recommended model for dermatology where there is a likelihood that patients will require a procedure or treatment. The clinic is held in conjunction with a treatment list that may be frontloaded with several pre-booked patients to ensure list utilisation. Barriers to implementation include lack of co-located facilities, availability of suitable team members, and underutilisation of facilities. It is important to note that this model works most effectively when used in conjunction with appropriate sub-speciality clinics where there is a higher likelihood of need for procedures to be undertaken. This process limits the number of visits / potential for delay or procedure for the patient. Currently only SBUHB and ABUHB consistently offer this service to patients. Other health boards should look to enable staff to deliver this model of care which will required a combination of upgraded facilities and recruiting consultants with appropriate skills.

Expert patients / self-management

Dermatology encompasses a number conditions that require long term / lifelong management. Learning from best practice developed other long term condition specialities, some health boards have been exploring the use of self-management tools, use of See on Symptoms (SoS) and Patient Initiated Follow Up models (PIFU) which allow patients to receive reviews based upon need rather than time-based contacts. Each of these initiative has the potential to reduce pressure on capacity within outpatients departments but are only successful with changes to the patient management model.

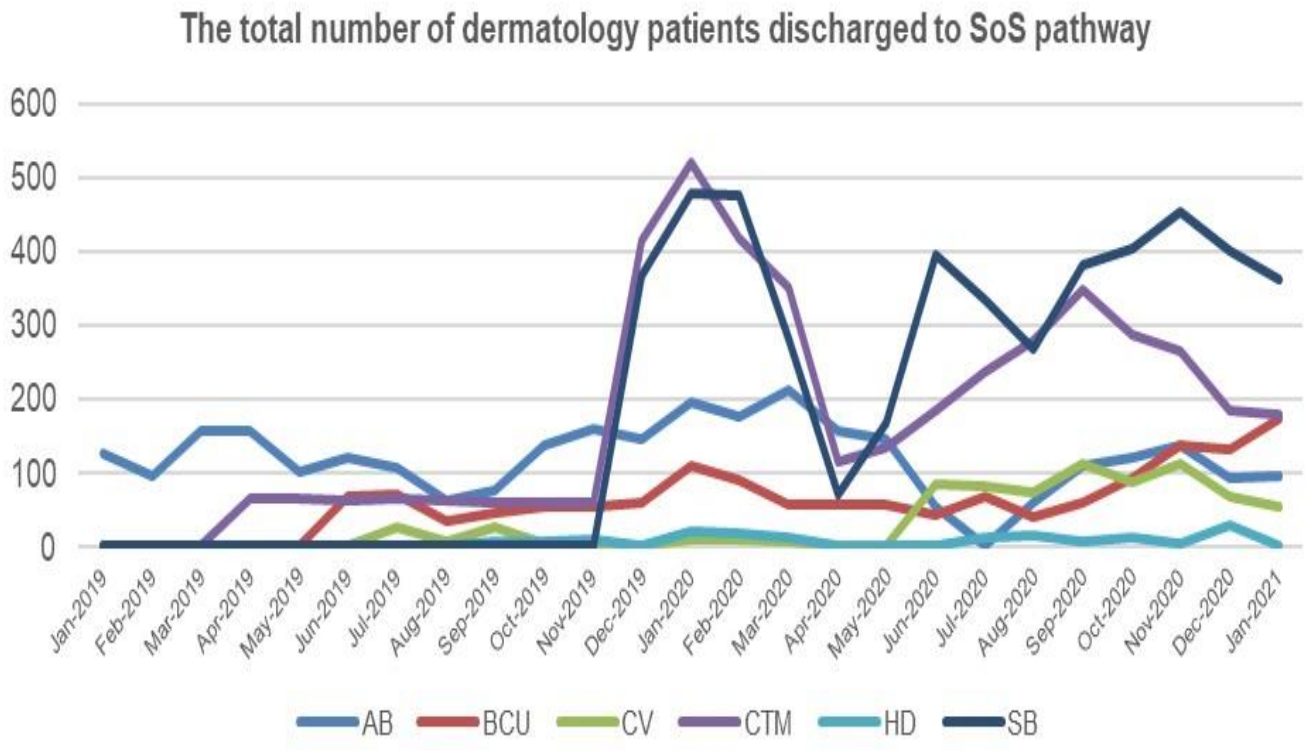
Good practice - Patient self-management platform

Singleton Hospital, Swansea Bay University Health Board

Empowering patients with chronic skin disease to take the initiative in managing their condition is a key enabler in the delivery of outpatient transformation. As part of the initial pilot, clinicians used a self management platform to initiate virtual communication, follow – ups and to carry out medication review, avoiding the need to call patients into hospital for an appointment every 12 weeks. At the time of review it had reduced face to face outpatient appointments by 75%, and of the 88 patients recruited onto the platform it had saved 264 appointments.

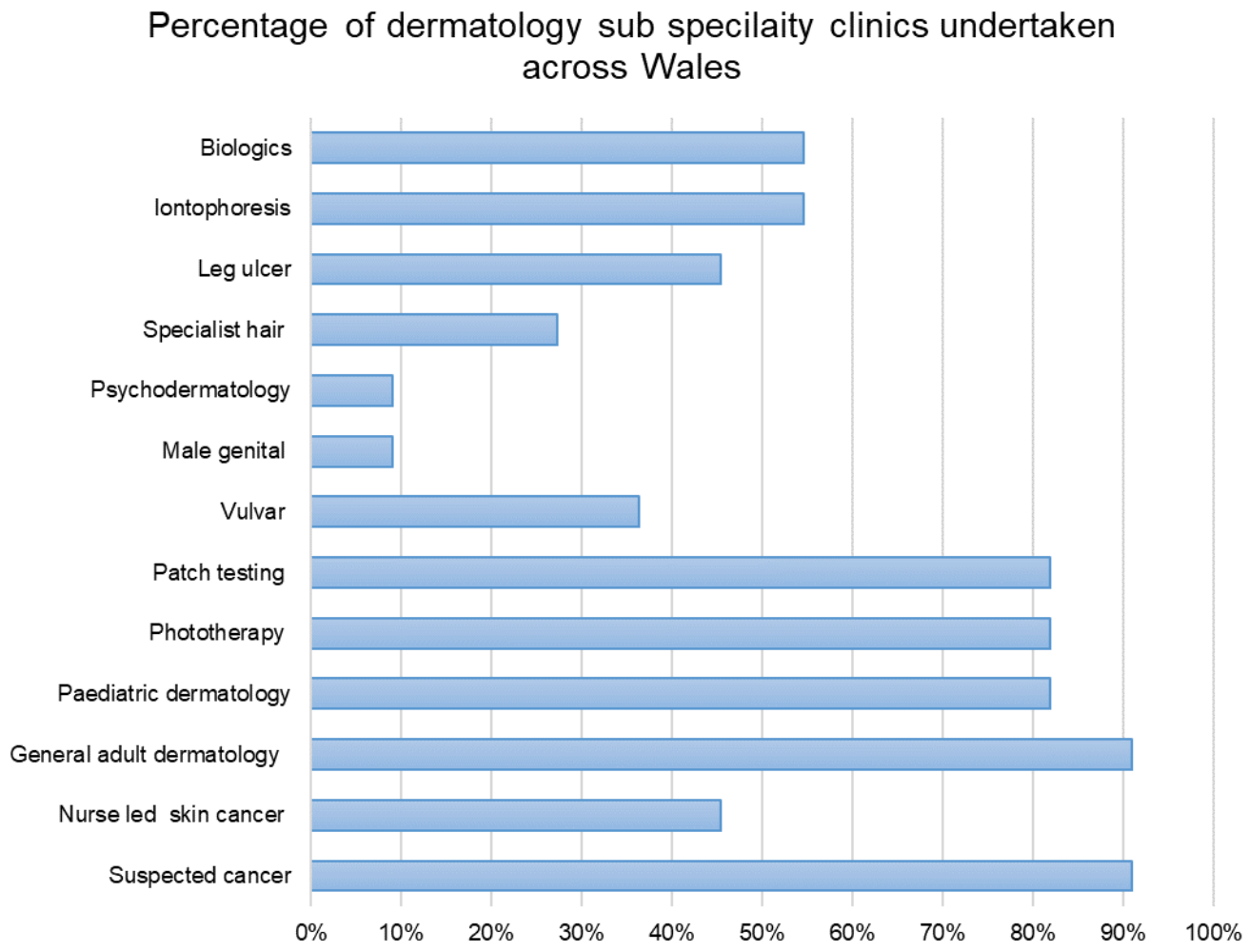
The use of self-management technology depends upon the development of appropriate education and support of patients to understand trigger points for contact, and an appropriate non-medical workforce to support asynchronous queries and requests for support. In a similar vein, SoS and PIFU pathways are based upon patient education and the ability to obtain access to clinical support at short notice.

Since the time of the initial review, SoS and PIFU pathways have been in development within all health boards, while self-management programmes are in the process of development within HDUHB, and SBUHB. The graph below shows the number of dermatology patients discharged onto a SoS pathway.



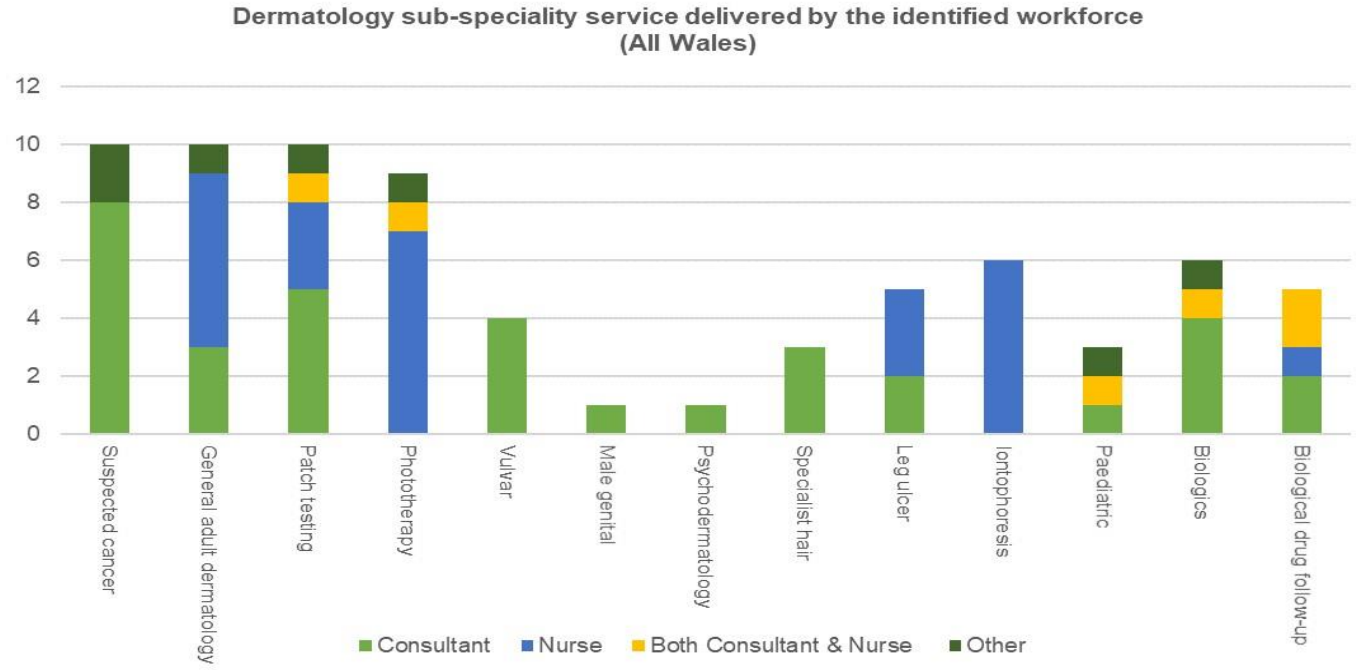
Sub-speciality clinics

Some treatments within dermatology are not able to be offered at all centres. This can be due to several factors, including the recruitment of staff with expertise / interest in a treatment; the availability of facilities to perform specialist procedures; the collaboration with other specialist teams; and the number of cases to support the safe introduction of a service. When reviewed, CVUHB were providing access to Mohs surgery for the appropriate BCC, which is a service that developed providing care to patients within the South East of Wales, or the introduction of psychological support to specific patient groups.



The challenge for Welsh dermatology provision is to ensure that innovations can be accessed by patients across the nation equally. The population demographics make it difficult to introduce comparable service models in all locations or regions, however the ambition to developed sustainable regional collaborations will require strategic partnerships to be established.

There is variation in service models used by dermatology teams to provide care. The transition from a consultant delivered to a consultant led service model by some health boards has supported diversification of the workforce and improved access for patients by increasing capacity. This unfortunately is not consistent leading to unacceptable variation in services available to patients with skin conditions across Wales.



Range of services available to patients

Mohs Micrographic Surgery (MMS)

Mohs Micrographic Surgery (MMS), is a specialised form of surgery in which analysis of the tissue is undertaken at the time of tumour removal to optimise clearance. Ninety nine percent of cure rates are achieved as opposed to 95% with standard treatment, thus saving patients from complicated secondary surgery. This is particularly important for tumours on the face as cancerous cells can be accurately removed sparing healthy tissue and so reducing disfiguring scarring and need for follow up. Whilst the gold standard for treatment of BCC[11], MMS is increasingly being used in the management of squamous cell cancers (cSCC). MMS is provided by one health board in Wales. There is currently no formal Service Level Agreement (SLA) in place for patients outside of the Cardiff & Vale area, despite other health boards referring suitable patients to CVUHB Mohs surgery (24%). As of January 2021, there are 127 patients waiting for an outpatient appointment requiring Mohs surgery, with an additional 149 patients who have been seen at an outpatient appointment and are awaiting Mohs surgery. Lack of access and delay can result in suboptimal treatment and repeat treatment episodes for patients. However, delivering such service that meets the essential standards requires a long-term programme of change and investment for expansion.

[11] BSDS - Mohs Standards 2020

Patch testing

Patch testing (to diagnose allergy triggered skin disorder) are variable and a comprehensive service is only offered within two health boards in Wales to all patients in their area. It is often offered at a basic level, but even this is may have no consultant oversight or governance structure.

The table below shows the variation across the patch testing service including who it is led by and its frequency.

	ABUHB	BCUHB-YGC	BCUHB Wrexham	BCU Gwynedd	HDUHB	CVUHB	SBUHB – Neath Port Talbot	SBUHB-Singleton	CTMUHB - PCH	CTMUHB - POWB	CTMUHB - RGH
Led by	Consultant	Consultant	Consultant	Nurse	Other	Consultant	Nurse led	Consultant	Both Consultant & Nurse	Nurse led	
Frequency	4 per week	Monthly	1 every week	1 every week	monthly	3 per week	monthly	monthly	3 per week	1 per month	-

Paediatric services

The number of paediatric referrals into dermatology is not easily accessible, and is usually included in the overall number into dermatology services. It was recognised that paediatric services varied across organisations, whilst some health boards have clear linkages with paediatric workforce, others had dedicated resources within the dermatology teams. Health boards should consider how children services are better coordinated across a wide variety of services.

The table below shows the variation across paediatric services including who it is led by and its frequency.

	ABUHB	BCUHB-YGC	BCUHB Wrexham	BCU Gwynedd	HDUHB	CVUHB	SBUHB – Neath Port Talbot	SBUHB-Singleton	CTMUHB - PCH	CTMUHB - POWB	CTMUHB - RGH
Led by	Both Consultant & Nurse	0	Mixed Consultant & Nurse	Mixed Consultant & Nurse	Other	Consultant	0	Both Consultant & Nurse	Consultant	Both Consultant & Nurse	Consultant
Frequency	1.5/week	0	1 every week	every other week	every other week	3 Per week	0	weekly	2 clinics a month	5 every month	2 clinics a month

Teledermatology

'Teledermatology' is a term used to describe different activity within health boards. In some areas this does not refer to a step in a pathway to a diagnosis and treatment but more often as a mechanism for triaging referrals. There is not only inconsistency between health boards in the approach to developing teledermatology but also in the behaviours of consultants within individual units. GPs providing images with referral has been shown to be useful for triage purposes and more recently during the pandemic a useful tool in being able to give advice to patients with a range of skin conditions. In terms of managing skin lesions and screening for skin cancers, teledermoscopy has proved very effective at producing high diagnostic rates and concordance between clinicians and facilitating quick treatment for patients often locally through a local enhanced scheme. This has the obvious benefit of consultants being able to diagnose and support services remotely.

Dermatology teams across Wales have examples of service innovation which needs to be commended. However there is less evidence of innovative service model adoption / learning across

health board boundaries, and in some cases across localities within a health board. It has been cited on several occasions that delivering change is a convoluted process requiring multiple levels of organisational approval leading to innovation fatigue.

Good practice - Teledermoscopy as a community based diagnostic service[12]

Aneurin Bevan University Health Board

Teledermatology including dermatoscopic images has been shown to improve the reliability of telediagnoses. Since 2013, Aneurin Bevan have developed and refined a teledermoscopy service which now accounts for approximately a third of skin lesion referrals. Situated in 5 locations within Gwent, medical photographers can provide high quality diagnostic images locally for patients who have been referred by their GP. These are uploaded and consultants receive electronic notification. Images are reviewed along with e-referral and patient record. Data shows that over 85% of patients avoid a face to face outpatient appointment in a dermatology clinic. Over 50% are discharged, 28% are referred straight to treatment either in secondary care or by a GP via the local enhanced service. The service also facilitates rapid transfer to a more appropriate speciality and remote photographic monitoring of their condition. This is another example of a consultant led service resulting in discharge or directing patients to appropriate investigation and treatment. High levels of concordance are consistently recorded through departmental governance meetings reflecting the teams' confidence in the model. Embracing technology in this way yields a productivity dividend, consultants can review twice as many patients as compared with a standard face to face clinic. High levels of satisfaction were recorded from patients and general practitioners.

General Practitioners

Some health boards have shown that the engagement and employment of GPs within secondary care teams enhance service development by:

- Creating a stable sub-Consultant medical workforce to undertake minor procedures and consultations alongside dermatologists.
- Supporting peer-to-peer education within GP clusters.
- Professional support for the provision of community based services within the NHS Wales Enhanced Service Contract.
- Support community multi-disciplinary teams with wider "skin" services.

Current medical student training programmes do not offer adequate training in dermatology. To supplement this there is an established training programme for "GPs with Special Interest" (GPwSI), which requires professional mentorship and supervision from consultants – something which has been introduced within HDUHB with the support of the team within SBUHB.

The ambition for dermatology would be to have a GPwSI in 50% of GP clusters within 5 years and within all clusters within 10 years in order to provide a localised interim level of care for common skin conditions which are currently referred to secondary care. In addition minor skin surgery could be managed in a more timely way locally under the NHS Wales Enhances Service Contract. The Dermatology board has successfully negotiated a local enhanced service which facilitates the

[12] Lowe A, Atwan A, Mills C. Teledermoscopy as a community based diagnostic test in the era of Covid-19? Clin Exp Dermatol. 2020;(46):173-174

removal of low risk skin cancers to be removed by GPs with appropriate surgical skills. Within ABUHB this has facilitated hundreds of patients to have their basal cell carcinomas treated closer to home.

Strong advice frameworks, training clinics and professional update sessions have been shown to reduce the number of referrals to secondary care through early primary care delivery of care which is an improvement in delivery of care to patients. Further work is needed to support the adoption across all health boards. The Welsh Dermatology Board will continue to champion this role within the national frameworks for Wales and would expect health boards to include within their planning process.

Allied health professionals

The review process yielded several examples of allied health professionals within dermatology teams. BCUHB and POWB have introduced clinical prescribing pharmacist sessions into their establishment to support patients with undergoing immunosuppressant medication treatments, reducing the frequency in which appointments with the consultant team was required, and improving the patient experience through a holistic medication review. Several other teams were interested in introducing similar posts but reported that systems of approval were complicated and made innovation slow and challenging.

Phototherapy is a core treatment for psoriasis and provided in all health boards. When introduced the delivery of phototherapy was a competence undertaken by physiotherapy teams. Over the years, this is no longer a core skill of physiotherapists and ability to provide the treatment has diminished. In some areas nursing staff have been trained, and in others, services have been challenged to take the phototherapy into the service. The administration of phototherapy can be undertaken by competency trained technicians to deliver within a dermatology department in appropriate amounts to support annual leave, sickness and service provision across multiple sites. BCUHB (Ysbyty Glan Clwyd) have been working to develop a community based / at home service to support rural communities.

Good practice – Integrated Dermatology Service

Betsi Cadwaladr University Health Board

The team in Bangor have developed an innovative approach to demand management working across primary and secondary care through establishing community dermatology hubs. Each year all GP teams are visited by the specialist team to review patients and provide education and support. Building relationships between generalists and specialists empowers GP's to manage more patients closer to home without the need for a hospital appointment.

Medical photographers provide valuable support to dermatology services in several ways. At the simplest level they can provide a record of the skin condition which tracks progression, or used as a diagnostic tool in the management of skin cancer. Access to medical photography across Wales was variable. Some health boards had dedicated teams, while others had no formal access. It was reported that the difficulty of securing funding for posts, rather than the shortfall in personnel, was the barrier in many areas. ABUHB has shown the advantages of investing in medical photography to support diagnosis of skin cancer using teledermoscopy. The service proves to be efficient and

received high levels of patient satisfaction and should be considered as part of an outpatient transformation programme[13].

Service models recommendations:

5. Sub specialist services within Wales should be audited against BAD standards to ensure high standards care for all patients.

6. Ensure that all health boards support consultants to develop sub-speciality services to offer a full range of diagnostic and treatment options to all patients within their area. A hub and spoke model may be required to avoid disadvantaging patients.

7. Enable teledermoscopy across Wales to provide a national service.

8. Review contractual arrangements and levels of remuneration to facilitate closer working with primary care.

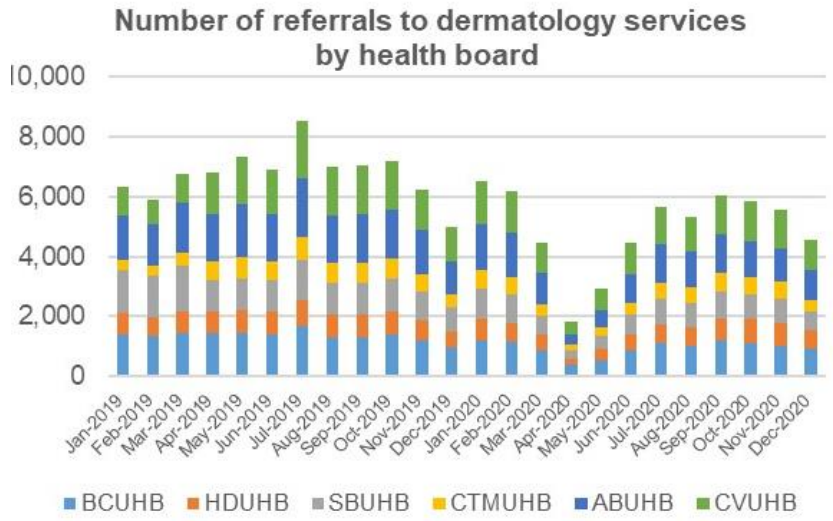
9. Review the list of Interventions Not Normally Funded (INNF).

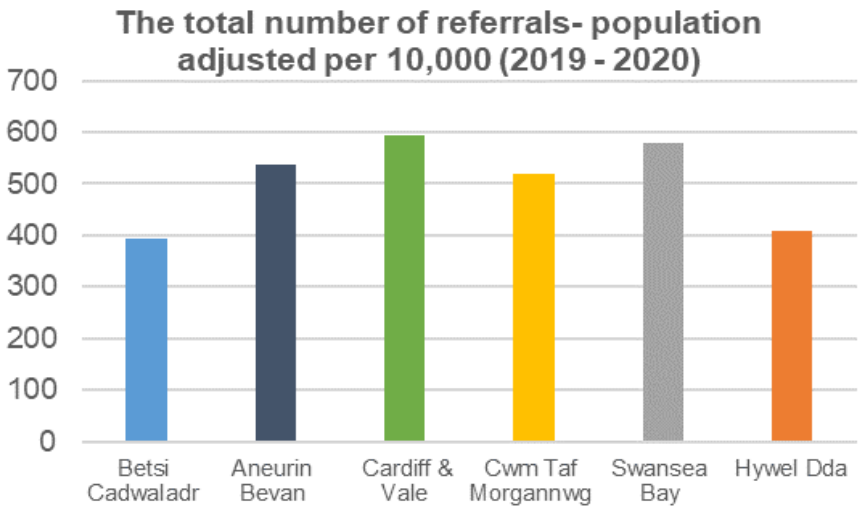
[13] Benedict S, Qwen ED, MillsC. Teledermatology: an audit of patient and referring primary care physician satisfaction. Br J Dermatol 2015; 173:181. Abstract BTS01

Sustainability (Demand and capacity)

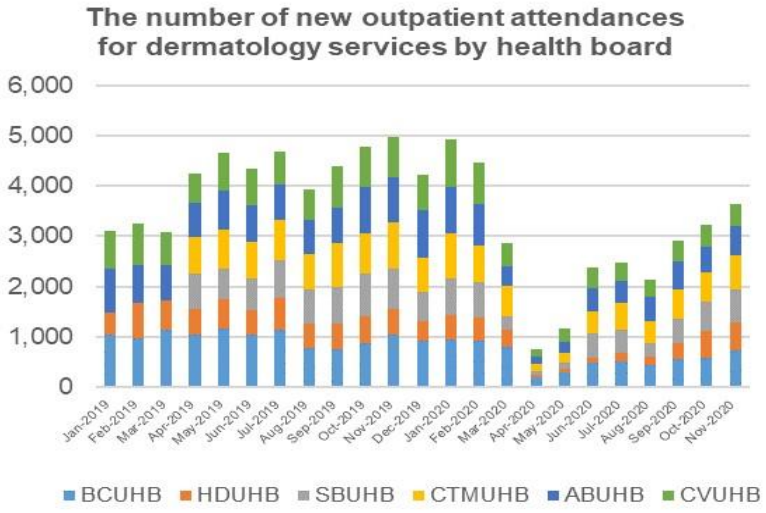
The scale of dermatology sustainability

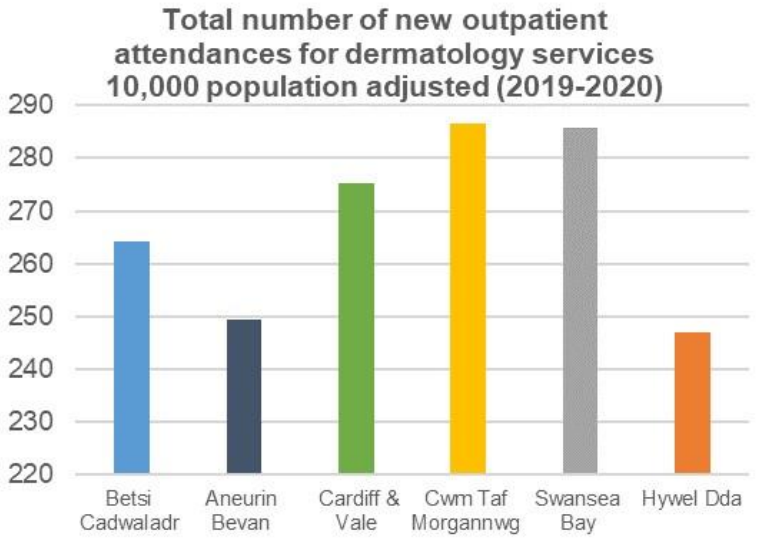
In Wales, in a typical year there are more than 80,000 referrals received into dermatology services and 55,225 new outpatient attendances per year. An analysis of health boards baseline quantitative questionnaire highlighted the wide-ranging variation in activity reporting and in some cases outright mistrust of data pulled from information management systems.





Understanding demand and capacity within dermatology remains challenging. Outpatient appointments are generally led by a consultant. However, patients may be seen by a more junior member of the team and, in some cases, by another clinical professional for example, a specialist nurse, which is not routinely recorded on management systems or recognised within the review of the whole patient pathway.



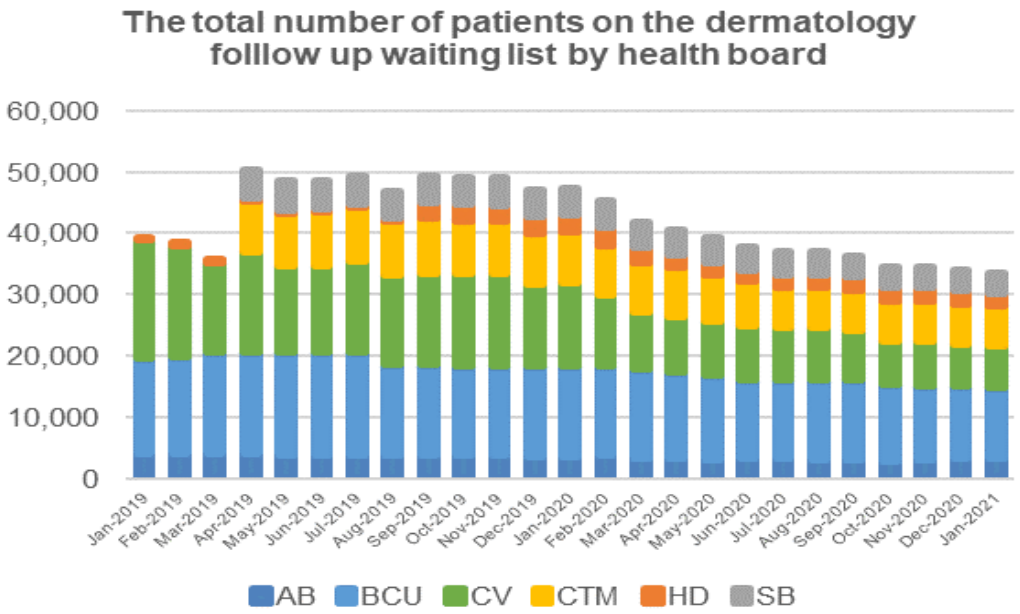


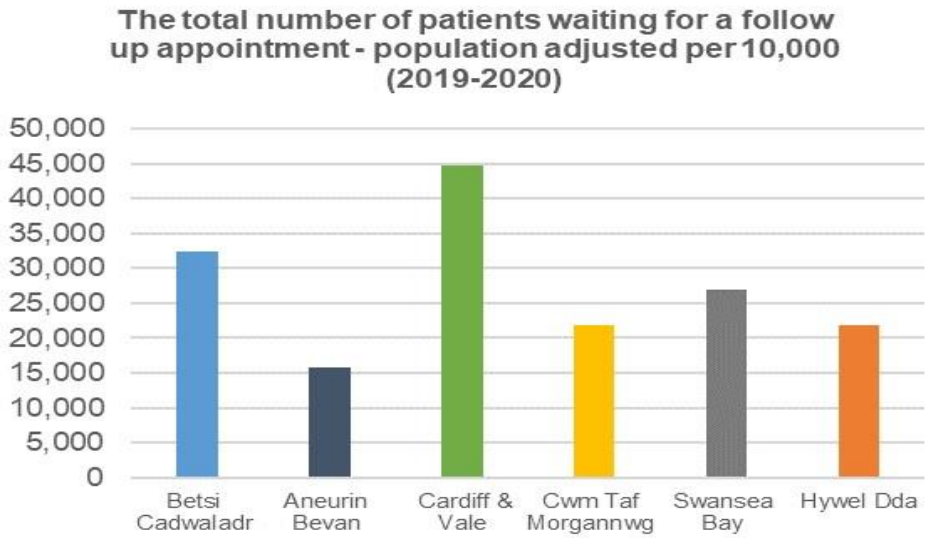
The lack of activity coding obscures the level of intervention undertaken within dermatology. Apart from ABUHB who use outpatient coding within their Clinical Work Station (CWS) system, teams are unable to quantify the proportion of patients receiving specific procedures or interventions within the service which hampers the track and evaluate service changes or understand service costs.

In other specialities the distinction between consultation and treatment is demarked more clearly, while the prevalence of long-term condition management lends itself to contacts with different members of a multi-disciplinary teams. To understand capacity within the system the availability of consistently recorded information is key. With this service modelling can be undertaken and mitigating action and or planning cycles can be entered.

Follow up rates

The overall number of patients waiting on a dermatology follow up waiting list has continuously decreased since January 2018. As of January 2021 there were 30,691 patients on the follow up waiting list, compared to 35,932 patients in January 2018. Whilst the number of patients on the total follow up waiting list is reducing, there is considerable variation when comparing health boards based on their provider population (per 10,000).





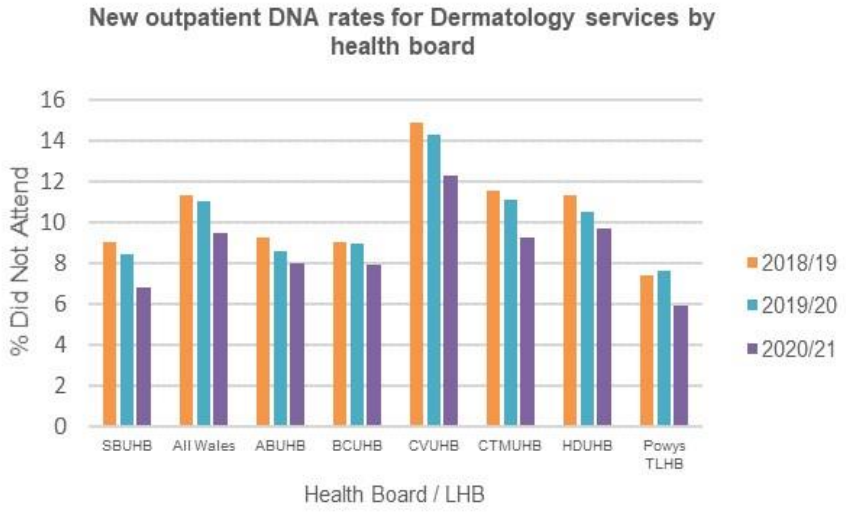
New to follow up ratio

The Royal College of Physicians recommend that a 1 new to 1.6 follow-up ratio is achievable for general dermatology clinics (this does not include patients attending for patch testing, phototherapy, surgery and other specialist treatments). Whilst the data below does include those who require frequent follow up appointments, the data should be considered with caution as it will not include those patients who are not yet booked or are currently waiting on within the backlog of a waiting list.

Health Board	Ratio of follow up to new attendances[14]
Wales	**2.2**
BCUHB	1.9
HDUHB	1.6
SBUHB	2.8
CTMUHB	1.8
ABUHB	2.1
CVUHB	2.4

Did Not Attend (DNA)

The average Did Not Attend (DNA) rate for dermatology services across Wales is 6.81% (new outpatients) and 10.76% (follow ups) as of January 2021[14]. Whilst improvements have been made in some health board's appointment management systems through the use of technology led changes such as text messaging reminder systems and patient led bookings, further is needed to improve efficiency and patient experience. The Outpatient Strategy Action Plan 'Delivering a quality service' has challenged health boards to reduce their DNA rate (for new and follow up appointments) to be no more than 5% by March 2023



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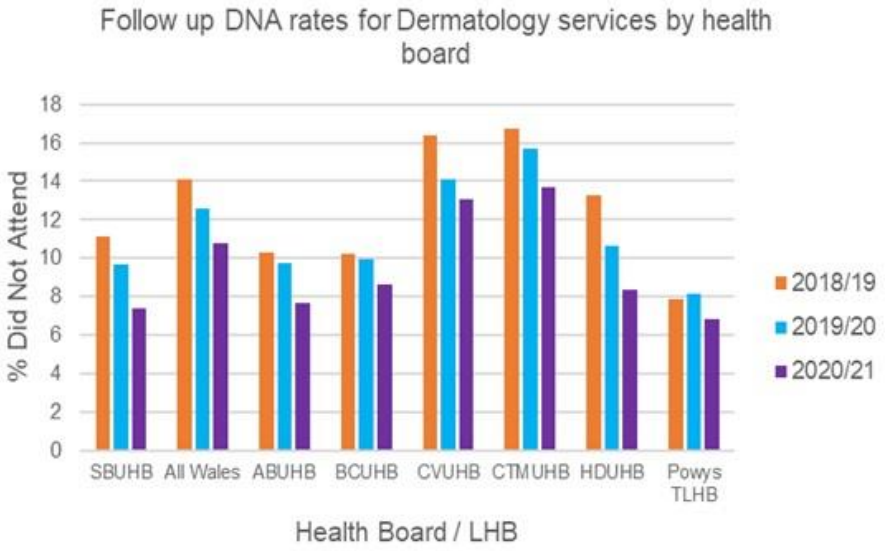
[14] Digital Health and Care Wales



Sub speciality waiting list coding

Patient administration systems within Wales have the capability to allocate sub-speciality coding to patient pathways to support service planning. This has been undertaken in other specialities, for example ophthalmology, to stream patient into appropriate clinical sessions. In some cases, other than a case note review, the only way of identifying patient sub-specialities is through the consultant or clinic title they have been seen under. Unfortunately there are examples where these labels have not been updated or accurately represent the patient's diagnosis. The only way to ensure this is through patient level recording at time of referral, which can be refined throughout the pathway. Currently, ABUHB have a separate clinical workstation application which has supported categorisation of patient condition for a number or years. While this is not currently in place in other health boards, there is potential for development of the Welsh Clinical Portal to support this function nationally.

Standardisation of activity coding

It has previously been discussed that the label of "outpatient" hides the complexity and range of patient interactions within dermatology. In 2019 the Welsh Dermatology Board recommended the recording of activity in line with an agreed subset of OPCS-4 codes using W-PAS capability at the time of procedure. At the time of the review this had not been instigated within health boards, apart from ABUHB which utilises its clinical workstation application to record and retrieve information. Further work is needed to support this process, including understanding whether it is infrastructure or behavioural barriers preventing adoption for both data collection and recording.

Recording of non-Consultant clinical activity

The review process highlighted the challenges faced by teams when articulating service demands and designing job plans / service expansion. The activity undertaken by non-consultant staff was particularly challenging as it was often recorded under consultant activity or in separate online / offline diaries, so it is not a simple process to collate, monitor or represent accurately. This challenge is not unique to dermatology but does impact on wider service and team planning processes.

Systematic and standardised recording of non-consultant activity will allow more concise and refined capacity planning.

Improving demand and capacity analysis

Due to the complexity of mapping service capacity discussed within this report, it is clear that there is a need to adopt a consistent approach to demand and capacity modelling, which is sensitive enough to encapsulate the variation in patient contact type. The Welsh Dermatology Board will be looking to lead on setting standards of activity reporting to support this process.

Universal primary care enhanced service provision

The employment of the enhanced service contract within ABUHB should be an exemplar for integrated working between primary and secondary care teams. Its success is linked to the ring-fencing of funding to release GP sessions for community-based sessions supporting minor surgery. This offers local services for patients with all the advantages of not having to travel to hospital for treatment. It also has beneficial effect of reducing waiting times for treatment and allows secondary care services to focus on the more complex cases.

Despite the sharing of the funding and operational model through the Welsh Dermatology Board, no other health board has been able to replicate the implementation, which raises the question of local barriers to change.

Good Practice: GPs working with secondary care to reduce skin cancer treatment waits

Aneurin Bevan University Health Board

During the last renegotiation of the General Medical Service Contract (GMSC), members of the Dermatology board entered into discussion with General Practitioner Committee (GPC) to agree a new category of local enhanced service. This would allow diagnosis of a low risk cancer, by a consultant dermatologist, and onward referral for treatment, local to the patient, by an approved GP. The target date set for this treatment was 6 weeks from receipt of referral. ABUHB are the only health board to have funded this service in primary care. In 2019, 456 patients were treated in 9 practices via the scheme. Treatments were delivered closer to home avoiding unnecessary inconvenience to patients, in a timely fashion. Moving this low risk cancer treatment to primary care resulted in increased capacity and shorter waiting times within secondary care for urgent cancer treatment.

Working with other clinical specialties

There are new models of care emerging in pockets throughout Wales where the delivery of care is managed in conjunction with other specialities, which are proving attractive to some clinician's and can greatly assist the service in managing peaks in surgery demand. The use of maxillofacial consultants has been seen to provide a vital resource in effectively managing a significant volume of urgent patients requiring procedures. In CTMUHB and ABUHB this is as part of one stop clinics which decreases the number of visits patients need to make, while areas of BCUHB have rapid access to maxillofacial lists to support treatment.

Other areas where cooperative service delivery has been seen is with Ophthalmology, Rheumatology and Psychological services. Dermatology also offers support to acutely admitted patients. Such interdependencies require local awareness that changes to service delivery within other teams may have an unintended impact on dermatology patients and / or the service.

Regional / national service planning

The national review has highlighted how fragile the delivery of dermatology is in Wales. Identification of areas of work for regional and national working will be particularly beneficial for those organisations with current or foreseeable work force challenges. Potential areas for exploration are the development of a national teledermoscopy service to support rapid diagnostic evaluation of lesions to support diagnosis or discharge. There is the opportunity to community based services, with a national hub of clinicians reviewing images remotely for all health boards to reduce demand upon local teams and releasing capacity. All developments need to be designed and approached from a national perspective to ensure that information systems and pathways are aligned from the outset.

Sustainability (Demand and Capacity) recommendations:

10. The introduction of more detailed outpatient coding should be prioritised within dermatology.

11. A regular schedule reporting and reviewing activity should be introduced which is comparable across health boards.

12. Agreement will be sought through the Welsh Dermatology Board for subspecialty coding categories. Health boards will introduce the recording and reporting of categories.

13. Health boards will work with the Welsh Government on the revision of the national outpatient data set to support accurate recording all activity undertaken within dermatology at point of delivery.

14. Offer primary care enhanced service provision across Wales to facilitate local treatment for patients with low risk tumours

Outpatient Transformation

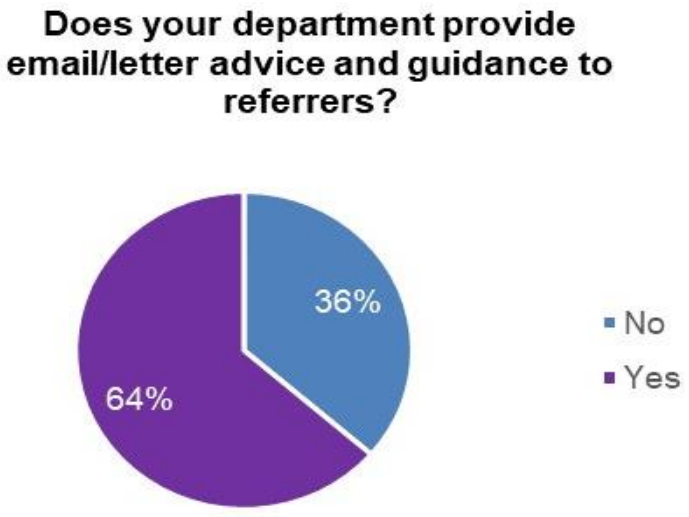
Application of new technologies within Dermatology were highly variable across Wales at the time of the review. This has changed significantly because of the pandemic which has also highlighted the comparative success of the unit with pre-existing systems to adapt more quickly to the obvious benefit of their patients. Tele-triage, virtual consultations including teledermoscopy, and e-advice systems have all been used to varying extents. However, innovation and adoption across the Wales has been hampered by inadequate and inconsistent roll-out of information technology infrastructures.

The availability of advice and guidance provision is not a universal feature of dermatology services. Some health boards have mature systems using email, such as SBUHB while others have been developing systems of returning referrals to primary care with advice for initial treatment, such as in BCUHB West and ABUHB. The development of such systems provides an intermediary point in the system to ensure that first line treatments and changes in conditions can be delivered promptly without having to enter the referral process. Alongside this, these services support other secondary care professionals provide appropriate care to skin conditions while a patient is in or visiting hospital with advice being sought or provided from different members of the wider team. However, the time required to support such systems, and the recording of activity levels is not at the level to which demand can be measured with any confidence or consistency.

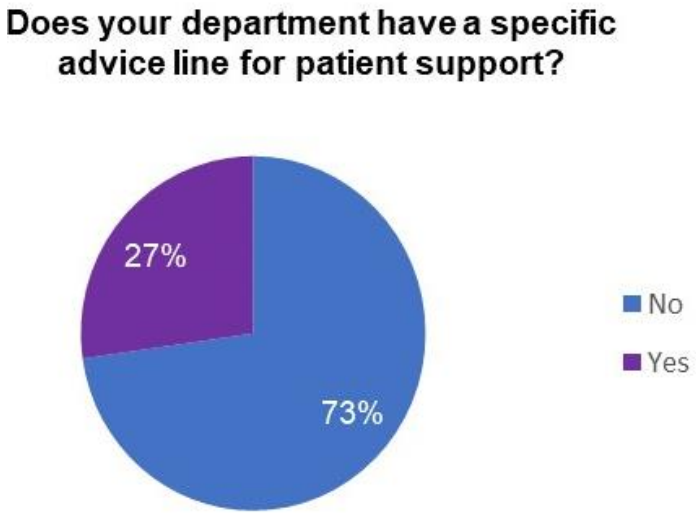
Teledermoscopy has been successfully introduced within ABUHB, which has allowed patients to have a diagnostic image be taken in the community prior to seeing a consultant within secondary care. The image is reviewed remotely and the patient can be discharged or booked directly for a minor-procedure, a system which aerates a lean pathway. While nationally recognised for this innovation, it has been unable to be implemented in other areas.

Advice and Guidance (A&G)

Sixty four percent of dermatology sites have agreed Advice and Guidance (A&G) services in place. The need to standardise and redirect patients through advice and guidance services where possible rather than referral in this unprecedented situation is more necessary than before.

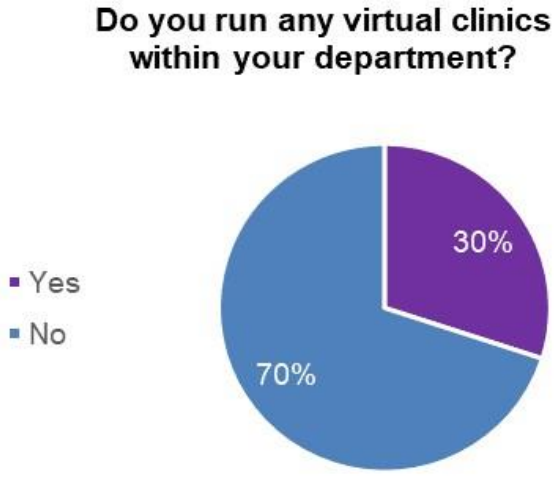


Health boards should work in collaboration with GPs to consider A&G or other established pathways such as teledermatology A&G rather than routine referral where possible. Evidence from health boards demonstrate that between 10-50% of referrals could avoid an outpatient face to face appointment through A&G.



Virtual consultations

Only 30% of dermatology units undertook virtual consultations at the time of the review, it is expected that as a result of the COVID-19 pandemic more units are now offering patients the opportunity for a virtual consultation such as telephone or video –consultations rather than previous face to face appointments. The roll out of Attend Anywhere and Microsoft Teams are widely used platforms.



Pathways are required for common skin conditions to ensure a consistent approach across Wales. Solar keratosis, a common form of sun damage, is managed differently within the units visited varying from advice and guidance in some to regular three months follow up appointments in secondary care for cryotherapy treatment in others. Consistency in application of pathways and more proactive delivery of advice and guidance will allow patients more rapid access to help with their conditions.

Patient experience

Patient experience needs to be central to the planning and delivery of dermatology services. To build trust and confidence in services health boards must listen and learn from the experiences of service users. Whilst all health boards collated local feedback, the themes across all organisations were similar. Overall, the service provided by dermatology units are well valued with recurrent themes of improvements included:

- Long patient waits or not being informed of delays in clinic
- Access to car parking (at ease)
- Facilities and infrastructure of units (need to modernise)

Outpatient Transformation recommendations:

15. The adoption of successful innovation projects in other health boards should be encouraged through the provision of support for transformation within health boards.

16. The Welsh Dermatology Board should provide a higher profile for sharing innovative practice, with formal requests that health boards respond to spread good practice.

17. Standardised Advice and Guidance should be developed for common conditions to ensure appropriate treatment for patients in the correct setting.

List of recommendations

Area	Recommendation	Timeline
Workforce	**1.** A clear, multi-professional and integrated workforce plan for the next decade is required to ensure that dermatology can continue to be delivered across Wales to include clinical nurse specialists, pharmacists, general practitioners, and medical photographers.	December 2021
	2. Retain the Clinical Fellow posts to allow local trainee doctors an opportunity to gain experience within dermatology and consider training budget allocation for clinical fellows and trainees undergoing CESR.	For continual development, until business as usual.
	3. Each health board to review the current workforce establishment to understand where current gaps exist and to understand the impact this has for service delivery in the short term (3 years). Longer term workforce plans will be required to be developed once demand and capacity has been established.	Concurrent to recommendation 1
Environment / Infrastructure	**4.** An audit of each area from which dermatology is delivered should be carried out against the British Association of Dermatologist (BAD) standards for dermatology services and surgical services	For immediate consideration
Service Model	**5.** Sub specialist services within Wales should be audited against BAD standards to ensure high standards care for all patients.	For immediate consideration
	6. Ensure that all health boards support consultants to develop sub-speciality services to offer a full range of diagnostic and treatment options to all patients within their area. A hub and spoke model may be required to avoid disadvantaging patients.	Concurrent with recommendation 7
	7. Enable teledermoscopy across Wales to provide a national service.	December 2022
	8. Review contractual arrangements and levels of remuneration to facilitate closer working with primary care.	For agreement with primary care
	9. Review the list of Interventions Not Normally Funded (INNF)	December 2021

Area	Recommendation	Timeline
Sustainability (Demand and Capacity)	**10.** The introduction of more detailed outpatient coding should be prioritised within dermatology	For agreement with Outpatient Minimum Data Standards work programme
	11. A regular schedule reporting and reviewing activity should be introduced which is comparable across health boards	For agreement with Outpatient Minimum Data Standards work programme
	12. Agreement will be sought through the Welsh Dermatology Board for subspecialty coding categories. Health boards will introduce the recording and reporting of categories.	For immediate consideration
	13. Health boards will work with the Welsh Government on the revision of the national outpatient data set to support accurate recording all activity undertaken within dermatology at point of delivery.	For agreement with Outpatient Minimum Data Standards work programme
	14. Offer primary care enhanced service provision across Wales to facilitate local treatment for patients with low risk tumours	For continual Development with primary care and health boards, until business as usual
Outpatient transformation	**15**. The adoption of successful innovation projects in other health boards should be encouraged through the provision of support for transformation within health boards.	For continual development, until business as usual.
	16. The Welsh Dermatology Board should provide a higher profile for sharing innovative practice, with formal requests that health boards respond to spread good practice.	For continual development, until business as usual.
	17. Standardised Advice and Guidance should be developed for common conditions to ensure appropriate treatment for patients in the correct setting	For immediate consideration – concurrent with recommendation 9

6. Priorities for the Welsh Dermatology Board

The dermatology review identified that, following the health board visits, the challenges and potential solutions are similar across all health boards in Wales. Each health board has received their own local review document that sets out recommendations specifically for their dermatology units, receiving approval from their clinical and executive leads. This report provides an overview of the way dermatology services is delivered in Wales, including examples of good practice and recommendations for potential improvements at a national level.

The Welsh Dermatology Board is set up to lead on national solutions to improve dermatology services across Wales. The board will be able to advise on how to reflect these national recommendations into local practice and support efforts to deliver. The remit of the Welsh Dermatology Board for the next two years will be underpinned by the recommendations in this report. Summary of this work programme is outlined below:

Workforce:

Develop a national workforce plan for dermatology service, including retention plans for Clinical Fellow, upskilling and expansion posts in Wales

Environment / Infrastructure:

Undertake an audit of dermatology services against the BAD standards and support those organisations who are currently not meeting the standards.

Service Model:

Undertake an audit of dermatology services against the BAD standards and support organisations who are not currently meeting the standards.

Enable teledermoscopy across Wales to provide a national service

Establish a networking hub and spoke model for dermatology services

Review the list of Interventions Not Normally Funded (INNF)

Sustainability:

Agree and standardise outpatient coding for dermatology

Agree sub-specialty coding categories for dermatology conditions

Board should work with the Outpatient Minimum Data Standards group to support the accurate recording of activity

Support health boards to offer primary care enhanced service provision for low risk tumours

Outpatient transformation:

Standardised Advice and Guidance should be developed for dermatology pathways.

Board should continue to share innovate projects and practices to spread good practice

7. Acknowledgements

This review of dermatology services is the first to have been done within Wales, the commitment and dedication across health boards and the welcoming and engaged approach adopted by all of the clinicians and managers during this review was heartening.

Many thanks to all of the dermatology units who participated in the review, and those who have assisted in the coordination of the visits and submissions, as well as health boards patient experience leads for organising and collating the patient satisfaction surveys.

The review team, led by Dr Caroline Mills (Dermatology Consultant, Aneurin Bevan University Health Board and Welsh Dermatology Board Chair), William Oliver (Performance Improvement manager, NHS Wales Delivery Unit), Michelle Banks (Senior Project Support officer, Planned Care Programme) and Rebecca Andrews (Project Manager, National Planned Care Programme).

Olivia Shorrocks (Head of Major Conditions, Welsh Government) and Lesley Law (Head of Planned Care, Welsh Government) for their support and involvement throughout the review.

Finally, the dermatology clinical advisors / independent leads: Dr Sharon Blackford (Consultant Dermatologist, Swansea Bay University Health Board), Dr Jenny Hughes (Consultant Dermatologist, Cwm Taf Morgannwg University Health Board), Dr Manju Kalavala (Consultant Dermatologist, Cardiff & Vale University Health Board), Dr Natalie Stone (Consultant Dermatologist, Aneurin Bevan University Health Board) and Dr Rachel Abbott (Consultant Dermatologist, Cardiff & Vale University Health Board) for their clinical expertise and support during the site visits.

Appendix A: Baseline questionnaire

Introduction

1. What is the name of your organisation (hospital/Health Board etc.)?
2. Does your department also provide and manage dermatology services to hospitals under other management (other Health Boards)?
3. If yes to question 2, please name the other organisations (Health Boards) for which your department provide dermatology services.
4. What is the approximate catchment population for general dermatology of your department?
5. If your department only provides a specialised service and provides no general dermatology service, what is the catchment area of your specialised service?
6. Does your department do any clinics in primary care/community clinics?
7. If yes to question 5, approximately what proportion is this primary care or community work of your department's total clinical workload?
8. Does your department teach medical students?
9. How much sessional time is allocated per week for medical student teaching?
10. How many (if any) hospitals beds do you have designated to dermatology in your hospital(s)?

Staffing: Consultants and Clinics

11. What is the number of substantive medical consultants (not WTE) in your department (do not count staff who are on a period of leave lasting more than 3 months)?
12. How many WTE substantive consultants are there in your department (to the nearest 0.5)?
13. What is the number of locum consultants (not WTE) in your department?
14. How many WTE locum consultants are there in your department (to the nearest 0.5)?
15. How many consultants in your department are aged over 55?
16. How many consultants in your department (not WTE) see urgent suspected cancer patients in clinic?
17. How many consultants in your department (not WTE) see general adult dermatology patients in clinic?
18. How many consultants in your department (not WTE) see paediatric dermatology patients in clinic?
19. How many consultants in your department (not WTE) do paediatric dermatology clinics containing just children?

20. How many consultants (not WTE) in your department do surgical lists?
21. How many consultants in your department (not WTE) do Mohs surgery?
22. How many consultants in your department (not WTE) do separate phototherapy clinics?
23. How many consultants in your department (not WTE) do separate patch testing clinics?
24. How many consultants in your department (not WTE) do separate vulvar clinics?
25. How many consultants in your department (not WTE) do separate male genital clinics?
26. How many consultants in your department (not WTE) do separate psychodermatology clinics?
27. How many consultants in your department (not WTE) do combined clinics with rheumatology?
28. How many consultants in your department (not WTE) do specialist hair clinics?
29. How many consultants in your department (not WTE) do teledermatology clinics (assessing images)?
30. How many consultants in your department (not WTE) do biologics clinics?
31. Please list any other specialist clinics taking place in your department:
32. How many substantive consultants (not WTE) has your department recruited in the last 24 months?
33. How many vacant WTE consultant posts are there in your department (to the nearest 0.5 WTE)?
34. Staffing: Trainees
35. How many specialist trainees (StRs) in dermatology (not WTE) work in your department?
36. How many WTE specialist trainees in dermatology are there in your department (to the nearest 0.5 WTE)?
37. How many GP trainees (not WTE) work in your department?
38. How many WTE GP trainees are there in your department (to the nearest 0.5 WTE)?
39. How many core medical trainees (not WTE) work in your department?
40. How many WTE core medical trainees are there in your department (to the nearest 0.5 WTE)?
41. How many post CCT trainees (not WTE) work in your department? These are doctors who have finished StR training and are doing a separately funded period of extra training.
42. If you have any post CCT trainees in your department, please tell us in which specialist areas they are training (i.e Mohs fellows / patch test fellows)

Staffing: Other Medical grades

43. How many CESR trainees as defined above (not WTE) work in your department?
44. How many WTE CESR trainees - as defined above - are there in your department (to the nearest 0.5 WTE)?
45. How many other SAS doctors - as defined above - (not WTE) work in your department?
46. How many other SAS doctors - as defined above - are there in your department (to the nearest 0.5 WTE)?
47. How many GPs - (not WTE) work in your department?
48. In total, how many sessions/weeks do GPs work in your department?
49. How many dermatology sessions are held in Primary Care (surgical lists)?
50. How many other doctors - not so far counted in this survey- (not WTE) work (doing dermatology) in your department? Please state what area

Job planning and hours worked

51. Please indicate if any of the following take place in your department (tick any that apply)
    a. waiting list clinics or lists on Saturday
    b. out of 9-5 working hours on call on a formal rota
    c. out of hours on call by consultants
52. How are adult dermatology in-patients managed? (admitted to dermatology bed/ general medicine / shared care)
53. Do dermatology inpatients get daily review. (Yes/No)
54. If applicable, what hours are covered by the on call service?
55. How does dermatology support the general adult acute on take? (tick any which apply)
    d. acute patients who are under other specialties seen as ward referrals or given telephone advice
    e. acute dermatology cases are seen with an on call rota for part/all of week
    f. GP calls answered and advice given
    g. Other
56. How many in patient referrals do you receive per year?
57. By how many patients are clinics reduced on average for every junior doctor supervised?
58. How many new patients (including overbooks) are seen in a USC clinic?
59. How many follow up patients (including overbooks) are seen in a USC clinic?
60. Do you have facilities to run see and treat clinics? Please describe:
61. How many patients (including overbooks) are booked on surgical list for excisions (no flaps or grafts)?

62. Is time spent on teledermatology and/or advice and guidance to GPs included in doctors' job plans in your department?

Nurse clinics and procedures:

1. How many clinical nurse specialists are there (not WTE) - excluding research nurses - in your department?
2. Do you have nurses undertaking the following roles in your department? Please tick all that *apply:*
3. Skin cancer Nurses
4. Skin cancer nurse led clinics
5. Nurse prescribers
6. Research nurses
7. Biological drug follow up nurse clinics
8. Systemic drug follow up nurse clinics
9. Leg ulcer nurse clinics
10. Iontophoresis nurse clinics
11. Nurses reading patch tests
12. Nurses seeing new patch test patients
13. Nurses doing surgical lists
14. Nurses helping with the management of skin problems for inpatients in your hospital under other specialties
15. Paediatric supervised
16. Paediatric unsupervised
17. Do you have up to date written training, supervision and governance protocols for all areas ticked above including patch testing, phototherapy and all surgery?
18. Do you have Physician Associates working in your department?

Surgery

19. Where is skin cancer excision surgery done in your department? (please tick all that apply)
20. Outpatient clinic room
21. Outpatient procedure room
22. Day case unit / dermatology theatre
23. What policy (BSDS/local) do you follow for anticoagulants and surgery?
24. What policy (BSDS/local) do you follow for pacemakers/ICDs and surgery?
25. To your knowledge are benign/cosmetic procedures done locally on the NHS e.g. in local GP

26. surgeries?
27. Do you use any disposable surgical packs?
28. What is the approximate longest waiting time in weeks today for conventional BCC surgery in your department?
29. Do you know your department's completeness of excision rate for BCCs?
30. Does your department normally follow up patients after complete excision of a first BCC?
31. If your department does Mohs, will you aim to do the national Mohs service standards audit?

Skin Cancer

32. Is psychology support available for skin cancer patients at your hospital?

Pathology

33. Is the routine skin histopathology services provided in house?
34. How many weeks do you currently wait for routine histopathology from your department?

Medical Dermatology

35. Are consenting psoriasis patients on biologicals entered on BADBIR?
36. Are effective shared care protocols (with primary care) in place for appropriate long-term systemic drugs?
37. How many IFRs do you estimate your department has submitted in the last year?
38. Have you had difficulty in treating patients in the way you considered would be appropriate due to difficulty in accessing high cost drugs in the last year?

Facilities

39. Do you have your own dedicated dermatology rooms or unit and if so how many?
40. If you do dermatology clinics in the main out patients department, how many rooms are available for you to use?
41. Do you have access to procedure rooms when doing dermatology out patient clinics?
42. Do you have your own dermatology operating theatres?
43. How many operating theatres are available on average for dermatology?
44. Do you have adequate capacity to hold more clinics?

Teledermatology and Advice and Guidance

45. Are any local dermatology services in addition to your department? If yes, are they safely integrated within your department?
46. Do you offer teledermatology services? If yes, approximately how many referrals do you handle a year?
47. Does your department provide email/letter advice and guidance (responding to letters from GPs with an email/letter reply)?
48. Does your department provide telephone outpatient consultations? If yes, who provides this?
49. Do you run any virtual clinics within the department? If so, describe.
50. Do you have a specific advice line for patient support?

Appendix B: Patient experience survey

Please tell us about your outpatient experience in dermatology

To help us understand how well we care for you and help us improve, we would be grateful if you could complete this short questionnaire. When answering each question, please tick only one box or write on the lines provided.

When answering the following questions, please base your answers on your experiences of your most recent dermatology appointment.

Your comments will be shared to collate information across Wales regarding experiences of using dermatology services

This document is also available in Welsh. Mae'r ddogfen yma hefyd ar gael yn Gymraeg.

1. If you are completing this questionnaire on behalf of the patient, please tick this box ❒

2. In which Health Board was your appointment?

Cardiff and Vale University Health Board ❒
Betsi Cadwalader University Health Board ❒
Swansea Bay University Health Board ❒
Cwm Taff Morgannwg University Health Board ❒
Powys ❒

Aneurin Bevan University Health Board ❒

Hywel Dda University Health Board ❒
Other, please say …….

Section A - Before arriving for your appointment.

3. Was the date and time of your appointment convenient?

Yes ❒
No ❒

Not applicable ❒

4. If you've had to rearrange this appointment, was this easy to do?

Yes ❒
No ❒
Not applicable ❒

5. How far did you have to travel to get to your appointment?

less than 1 mile ❒
1 to 5 miles ❒
5 to 10 miles ❒
More than 10 miles ❒

Section B - Arriving at the Outpatient department.

6. On arrival at the department, did the receptionist greet you in a friendly manner?

Yes ❒
No ❒

7. Did your appointment start at the stated appointment time?

I was seen early, the appointment started before the planned appointment time ❒
Yes, it started more or less on time ❒
No, it started 5 - 30 minutes late ❒
No, it started 31 - 60 minutes late ❒
No, it started more than 1 hour late ❒
Unsure ❒

8. If the appointments were running late, did a member of staff inform you of this when you arrived?

Yes ❒
No ❒
Not applicable, as the appointments were not running late ❒

Section C - Your overall view of your outpatient appointment

9. Was there anything particularly good about your experience that you would like to tell us about?

10. Was there anything that we could change to improve your experience?

11. Using a scale of 0 - 10 where 0 is very bad and 10 is excellent, how would you rate your experience so far?

12. How likely are you to recommend our service to family and friends, if they needed similar care or treatment?

Extremely likely ❒
Likely ❒
Neither likely nor unlikely ❒
Unlikely ❒
Extremely unlikely ❒
Don't know ❒

Section D - About you.
We are committed to ensuring that everyone receives fair and equal respect. Whatever your age, disability or sexual identity, you can expect to be treated with dignity. We can only achieve this with your help by providing the information below. Data will be used for monitoring purposes only and held in strictest confidence. Your identity will not be disclosed to anyone.

Which of the following best describes your gender?
(Please give the patient's gender, if completing the questionnaire on their behalf)

Male ❒
Female ❒
Prefer not to say ❒

If you prefer to use your own term, please provide it here:……

Do you consider yourself to be disabled?
(Please indicate whether the patient considers themselves to be disabled, if completing the questionnaire on their behalf)

Yes ❒
No ❒
Prefer not to say ❒

What is your preferred language?
(Please give the patient's preferred language, if completing this questionnaire on their behalf)

Welsh BSL ❒
English Other (please say) …….. ❒
Prefer not to say ❒

What is your age?
(Please give the patient's age, if completing the questionnaire on their behalf)

Under 16 ❒ 55 – 64 ❒
16 – 24 ❒ 65 – 74 ❒
25 – 34 ❒ 75 – 84 ❒
35 – 44 ❒ 85 and over ❒
45 – 54 ❒ Prefer not to say ❒

Review of Dermatology Services in Wales

Hywel Dda University Health Board

Constitute hospitals:

Glangwili Hospital
Withybush Hospital
Prince Phillip Hospital
Bronglais Hospital

Date of review: 24 October 2019

1. Background and Introduction

The Welsh Dermatology Board, was set up in 2016 and is the fifth speciality to be included as part of the National Planned Care Programme portfolio. The role of the Welsh Dermatology board is to transform dermatology services to become sustainable; whilst implementing and adopting a range of interventions to improve service delivery and patient experience.

Dermatology is predominantly an outpatient led service and requires some urgent attention. There are over 100,000 new cases of skin cancer diagnosed each year in the UK[1], making skin cancer the UK's most common cancer. In some parts of Wales - health boards have already developed leading models of care to address the challenges of a rising demand, limited workforce, geography and financial constraints. It is evidence that despite the number of challenges the speciality area is poorly understood and has received comparatively little attention compared to other specialities.

The Welsh Dermatology Board in collaboration with the NHS Wales Delivery Unit have agreed to undertake a national review to understand and gather detailed information of the dermatology services offered across the seven health boards in Wales. This review purposes is to:

- Identify variation in practice and service models with a key objective to recognise and support the spread of specific initiatives and good practice at a regional and national level.
- Identify key themes to be incorporated as part the Welsh Dermatology Board agenda.
- Identify constraints within health boards and to support dermatology departments.
- Assist in the development of sustainable dermatology models for Wales.

2. Peer Review Process

The initial part of the review was for health boards to complete a baseline questionnaire, followed by a clinically led process to review their dermatology services based on the responses received. On completion of this, a clinically led process to provide positive peer support - for improvement and not as a performance approach - was undertaken. This exercise was supported by members of the Welsh Dermatology Board and endorsed by National Planned Care Programme Board and follows similar schemes for cancer and palliative care reviews.

The final part of the review consisted of onsite departmental visit which entailed a peer-to-peer review as well as meeting with associated staff (both medical and non-medical) to understand the setup of the service (by site).

In addition to the review meeting, all health boards via the listening and learning group agreed to undertake a bespoke patient experience survey as part of the review to ensure it is aligned to outcomes and are considered as part of the evaluation, to understand what matters to patients. Fifty three patients responded to the patient experience survey who attended clinic in the last six months.

The service review for Hywel Dda University Health Board took place on Thursday 24 October at Glangwili hospital and Thursday 31 October at Withybush general hospital.

[1] CRUK

Membership of the review:

Peer review panel

- Caroline Mills - Welsh Dermatology Board Chair
- Rebecca Andrews - Welsh Dermatology Board Project manager
- Jenny Hughes - Independent Dermatology consultant
- William Oliver - NHS Wales Delivery Unit lead
- Michelle Banks – Welsh Dermatology Board project support

Hywel Dda representative

- Keith Jones (Hywel Dda UHB - Assistant Director – acute services)
- Stephanie Hire (Hywel Dda UHB - General Manager Scheduled Care)
- Donna Morris (Hywel Dda UHB - Service Manager)
- Debora Harry (Hywel Dda UHB - Interim Lead Nurse Rheumatology and Dermatology)

3. Key messages

1. The integration between secondary and primary care dermatology services is subject to support from a number of general practitioners with special interest (GPwSi) across the health board. The appointment of primary care clinicians is being used to substitute the medical vacancies, which is an ongoing issue for the health board. The age profile of the GPs supporting the service is a concern.
2. Attempts to recruit to the wider Dermatology team at both locum and substantive consultant level have, to date, been unsuccessful; there is currently 2.4 whole time equivalent medical vacant posts in the health board. Compared to other organisations in Wales this figure is particularly low for its population and should be reviewed.
3. The prevalence of skin cancers across Wales is increasing, and is not unique to Hywel Dda UHB. Discussions are underway with Swansea Bay UHB regarding the use of other medical professionals such as plastic surgeons to increase the surgical capacity. Whilst this model is being used in other health boards, there are concerns should these posts be used to replace dermatology consultants.
4. Use of an external provider (Your medical services) are contracted as part of the health board's core activity on weekends supporting general dermatology. The feedback from patients has been positive and has maintained the health board's waiting list position.
5. The health board has been successful in receiving funds to expand their teledermatology and medical illustration departments, allowing further opportunities for remote working. Whilst Teletriage is restricted - there are existing services in North Ceredigion which lies within Primary Care, supported by a GPwSi, CVUHB consultants and other networks to deliver dermatological care.
6. Hywel Dda UHB intend on exploring joint regional opportunities with Swansea Bay UHB to bring together a range of services (both clinical /operational and MDT support). Other health boards along the M4 corridor have also indicated that they could provide support in the short to medium term.
7. Managerial staff feel supported by the *A Regional Collaboration for Health* (ARCH programme) which is a collaboration between; Swansea Bay University Health Board, Hywel Dda University

Health Board and Swansea University. The work programme aims to explore a regional dermatology model in order to stabilise its core service, and expedites dermatology as one of its key areas of work.

8. The establishment and commitment of the nursing workforce is commended, however, there are governance and support concerns for nurses working in isolation as well as its current job plans.
9. Whilst the Health Board remains in a fragile position, there is clear evidence of future planning to develop a more robust service with support from colleagues in Swansea Bay UHB. Further work needs to be carried out to ensure services are brought in house, with additional investment.
10. Although currently the service is spread thinly with no dedicated dermatology unit, space has been identified which, if plans are enabled locally, could result in consolidation of services which in turn will help with less individuals working in isolation and improve staff retention.
11. The assessment of patient experience survey shows high rates of patient satisfaction with 75% of respondents recommending the service. The recommendations for improvements include indicating reduced travel time, patient waits, and parking.

4. Site findings

Key findings
Data ❖ The use of electronic referrals has been rolled out for dermatology, across the health board. Following a recent analysis of their demand data the organisation has seen an increase in referral activity which is thought be a result of a change in triage process. However the pattern of increased referrals is not unique to Hywel Dda UHB and is comparable across other organisations in Wales. ❖ The health board have a number of patients with a delayed follow up appointment (approximately 3,000 are waiting). There is a wider strategy to reduce their overall follow up numbers, and are undertaking a validation exercises to reduce this figure on a short term basis. Weekly reports to monitor their follow up cohort is performance managed by the team, to identify individuals not adhering to their follow up protocol. ❖ Additional activity is not included in the health board's data response and are reliant on support from a dermatology consultant in Swansea Bay UHB one day a week to see patients. Insourced activity through the use of an external provider is however included and are scheduled as part of their core planning. ❖ Whilst the level of diagnostic coding is not well captured, the organisation has made considerable improvements to their data as well as having a more robust grading process in place that has allowed a better understanding of the data compared to previous years. ❖ Nurse activity is under reported and historically has been captured under consultant clinics. However, the nurses are now undertaking a number of nurse led and virtual clinics which is being recorded on WPAS and are monitored in the same approach as general clinics. ❖ Contracts with an external provider: Your Medical Services forms part of the health board's core activity, and has scheduled clinics on the weekend seeing 120 general dermatology patients as well as undertaking see and treat clinics (cryotherapy). This insource activity has supported the health board to maintain its general waiting list seeing both new and follow up patients. Feedback from patients has been positive and adhere to the organisations policy.

Workforce

- Whilst there is no formal workforce plan in place for the organisation, the health board are consistently advertising substantive consultant posts to backfill the 2.4 whole time equivalent (WTE) vacancies. However, compared to other organisations in Wales (per head of population) the WTE medical workforce establishment is considerably lower in Hywel Dda UHB. A comprehensive plan to review the medical team composition is needed, considering increasing its WTE by a minimum of one, which may increase the attractiveness of the posts.

- According to the British Association of Dermatologists (BAD) recommendations: hospital-based services require at least one whole-time equivalent (WTE) Consultant Dermatologist per 62,500 population. With a population of 387,000 the health board should aim for at least 6 dermatology consultants, the current medical workforce of 2.4 WTE does not meet this recommendation.

- The organisation does not currently employ a substantive dermatology consultant, however with support from Swansea Bay UHB, there is clinical oversight in place which forms part of the organisations regional plan. In addition to this support, the health board have a part time locum consultant who provides clinics over two days a week, and sees general dermatology patients only. Succession plans need to be in place to manage the retirement profiles of both these consultants.

- Due to the lack of consultant oversight, the organisation has been unable to recruit to a clinical fellow post. However there are plans in place for a speciality doctor who has expressed an interest to proceed down the Certificate of Eligibility for Specialist Registration (CESR) route, with support from Swansea Bay UHB consultants.

- As part of the regional workforce plan, the health board are reviewing its model of care and are in discussions with Swansea Bay UHB to appoint a plastic surgeon to undertake surgery. Whilst the organisation has an SLA in place with Morriston - this approach has been rolled out across other organisations and was only recommended if individuals are formed part of the team and does not replace a dermatology consultant posts. This would make the service more appealing to other medical workforce and has been evidenced to maintain retention rates.

- Due to the lack of medical workforce, the non-medical workforce has had to transform and upskill to manage the cohort of patients in Hywel Dda. Whilst the nursing workforce supports consultant clinics, a number of dedicated clinics for acne and virtual have recently been established. There is support to upskill the nursing team with a number of nurses being put forward for a prescribing courses, however due to the limited clinical support, the team feel that independent prescribing courses wouldn't be appropriate in all cases.

- The health board has been successful in securing a number of GPwSi to support their dermatology services across the region. There are plans in place to fund a GP to undertake additional training to support the service, with governance structures and clinical oversight in place from a Swansea Bay consultant. In additional to these posts and training opportunities, a proposal for GP Hybrid posts is being presented to the medical directorate which will allow the expertise to flow between primary and secondary care, as well as additional support for the non-medical workforce.

Service profile

- A one stop (see and treat) clinic operates once a week (two sessions) in Glangwili hospital and is undertaken by a GP with support from Clinical Nurse Specialist (CNS). The health board have plans in

place to expand their one stop clinics, and are undertaking a specification review of other unit in Wales to help inform planning.

- Biologic services for psoriasis and other conditions are managed in house, with a locum consultant oversight. There are currently 130 patients on biologics which has reduced as a result of limited number of new patients being added. All biologic patients are followed up by a band 7 nurse, the department has also recently established virtual follow ups for these patients. Biosimilars are also in use.

- As part of the health board's sustainability plan, in collaboration with Swansea Bay UHB a business case to establish a telederm photography/ dermoscopy service has been submitted. Approximately 55% of the total referrals received for Hywel Dda are skin lesions, the use of digital image technology will provide a real opportunity to ensure that patients are seen promptly by the correct clinician in an appropriate location, in a timely manner. This would allow for an early diagnostic phase for dermatology and is crucial to the 28 day Single Cancer Pathway.

- Phototherapy services is managed by nurses across two sites (PPH and Withybush). There are governance meetings in place with oversight from a locum consultant and speciality doctor. However nurses are felt to be under pressure to move across sites as well as covering lost hours due to annual and study leave. A review of this service is required to support the nursing workforce rather than the current model of isolated working.

- Patch testing services is undertaken by the specialty doctor, however due to limited consultant oversite the service has not been priorities but is something they would like to re-establish. Nurses have established links with Swansea consultants for support and advice.

Facilities

- The service operates over four different sites with no dedicated dermatology units and is reliant on rooms in outpatients being available. Discussions are underway to secure additional rooms in outpatients which is awaiting approval and consultation with staff.

A review and re location of the phototherapy unit in Withybush should be considered, the current layout of the facilities does pose some health and safety concerns.

- Access to treatment rooms is limited and is reliant on rooms that are not being utilised to undertake see and treat clinics.

5. Conclusion and next steps

The review identified the ongoing workforce recruitment and retention issue that has been known to the health board for some time, however there have been some significant improvements in structures to support the service with opportunities with key individuals to upskill. There are some governance and support concerns for nurses which the health board is reliant on to deliver a service.

In addition to the key messages above, the panel team have highlighted the key next steps to be considered:

Action

1. Health board to invest and support in an additional consultant whole time equivalent, considering increasing the number by a minimum 1 WTE with opportunities of other medical specialities such as plastic surgery to support locally and other dermatology units to support remotely.
2. Support the expansion of teledermatology and medical illustration departments bids
3. Consolidate and expand the core services in the periphery to support nurse workforce.
4. Re- establish the organisations patch testing service.
5. Allow access to the identified clinic space in outpatients to expand.

Areas of good practice
1. Availability of Medical photography department 2. Established primary care workforce. 3. Highly skilled and organised nurse workforce 4. Regional plans with Swansea Bay UHB.

Annex 1: Summary of health board position (Referrals / New OPD/ Follow ups/ DC treatments)

The number of GP referrals accepted into the Dermatology Service (2018/2019)

University Health Board	Hospital site	Referrals	Per 10,000 population	Consultant WTE
Betsi Cadwaladar UHB	Glan Clwyd Hospital	4665	67	2.9
	Ysbyty Gwynedd	5112	73	1
	Wrexham Maelor Hospital	6627	95	3
Hywel Dda UHB	All sites (HDUHB)	8545	222	0
Swansea Bay UHB	Neath Port Talbot	3894	100	0
	Singleton Hospital	7428	191	2
Cardiff & Vale UHB	UHW / UHL	17,798	362	7.6
Cwm Taf Morgannwg UHB	Royal Glamorgan	4252	96	1.9
	Princess of Wales	4275	96	4.6
	Prince Charles Hospital	2621	59	1.3
Aneurin Bevan UHB	All sites (ABUHB)	17,941	303	7.2

The number of New Outpatients into the Dermatology Service (2018/2019)

University Health Board	Hospital site	New Outpatients	Per 10,000 population
Betsi Cadwaladar UHB	Glan Clwyd Hospital	3639	52
	Ysbyty Gwynedd	4040	58
	Wrexham Maelor Hospital	4602	66
Hywel Dda UHB	All sites (HDUHB)	5250	136
Swansea Bay UHB	Neath Port Talbot	2748	71
	Singleton Hospital	5979	154
Cardiff & Vale UHB	UHW / UHL	8871	179
Cwm Taf Morgannwg UHB	Royal Glamorgan	3597	81
	Princess of Wales	2531	56
	Prince Charles Hospital	2231	50
Aneurin Bevan UHB	All sites (ABUHB)	9311	157

The number of Follow up Outpatients in the Dermatology Service (2018/2019)

University Health Board	Hospital site	Follow up	Per 10,000 population
Betsi Cadwaladar UHB	Glan Clwyd Hospital	6159	88
	Ysbyty Gwynedd	5920	85
	Wrexham Maelor Hospital	10752	154
Hywel Dda UHB	All sites (HDUHB)	5688	148
Swansea Bay UHB	Neath Port Talbot	6894	177
	Singleton Hospital	11,630	299
Cardiff & Vale UHB	UHW / UHL	21,692	437
Cwm Taf Morgannwg UHB	Royal Glamorgan	3404	76
	Princess of Wales	4574	103
	Prince Charles Hospital	2070	46
Aneurin Bevan UHB	All sites (ABUHB)	19,923	337

The number of Outpatients & DC treatments in the Dermatology Service (2018/2019)

University Health Board	Hospital site	Day Case & OPD treatments	Per 10,000 population
Betsi Cadwaladar UHB	Glan Clwyd Hospital	1597	23
	Ysbyty Gwynedd	1600	23
	Wrexham Maelor Hospital	2711	39
Hywel Dda UHB	All sites (HDUHB)	2810	73
Swansea Bay UHB	Neath Port Talbot	1151	30
	Singleton Hospital	2656	68
Cardiff & Vale UHB	UHW / UHL	3400	68
Cwm Taf Morgannwg UHB	Royal Glamorgan	1009	23
	Princess of Wales	7124	160
	Prince Charles Hospital	590	13
Aneurin Bevan UHB	All sites (ABUHB)	15,608	264

Annex 2: Dermatology survey

Site Name	All Sites Combined							
Referrals	***Site Level***		***Total***					
Number of GP referrals accepted into Dermatology Service in 2019/19	All sites combined		17941					
Outpatient Activity	***Consultant/Medical Led***	***Nurse Led***	***Total***					
New Outpatient Activity in 2018/19	8861	450	9311					
Follow-up Outpatient Activity in 2018/19	13978	5945	19923					
Outpatient/Daycase Treatments in 2018/19	1062	331	15608					

Phototherapy			13475					
USC referrals			4355					
DNA Rates (news)			4.80%					
DNA Rates (Fups)			5.22%					
Medical Workforce	***Number***	***WTE***	***Age over 55 year***					
Consultant Vacancies	0	0	0					
Consultants	8	7.2	1					
Core Trainees	0	0	0					
Gaps in rota	0	0	0					
General Practioner sessions per week	9	0.9	3					
General Practioner Trainees	1	1	0					
Locum Consultants	1	0.1	0					
Locum Specialist Trainees	1	1	0					
SAS / Other Medical staff	3	1.9	0					
Specialist Trainees	1	1	0					
Vacancies for Specialist Trainees	0	0	0					
Vacancies for Core Trainees	0	0	0					
Vacancies for General Practioner Trainees	0	0	0					
Vacancies for SAS / Other Medical staff	0	0	0					
Non-Medical Workforce	***Number***	***WTE***	***Age over 55 year***					
CNS Running Clinics	7	0	1					
Gaps in rota	0	0	0					
HCSW supporting Medically delivered clinics	0	0	0					
Nurse Practitioners	7	0	1					
Nurse prescribers	2	2	0					
Nurses supporting Medically delivered clinics	0	0	0					
Other nurses running clinics	0	0	0					
Physician Associates	0	0	0					
Research Nurses	0	0	0					
Service Profile	***Led_by***	***Frequency***	***Nos_ Clinics_per_year***	***Nos_Clinics_per_year_Hospital***	***Community***	***Primary***	***Virtual***	***Led_by_other***
Suspected cancer	Consultant	10/week	400	400	0	0	0	0
Nurse led skin cancer	follow up clinics only	0	0	0	0	0	0	0
General adult dermatology	Consultant	7/week	280	280	0	0	0	0
Paediatric dermatology	Both Consultant & Nurse	1.5/week	60	60	0	0	0	0
Phototherapy	Other	2/week	80	80	0	0	0	Medical Scientist
Patch testing	Consultant	4/week	160	160	0	0	0	0
Vulvar	Consultant	1 per month	12	12	0	0	0	0

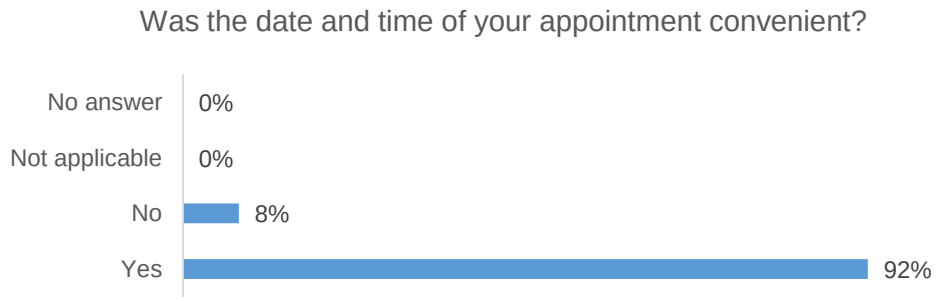
Male genital	No	0	0	0	0	0	0	0
Psychodermatology	No	0	0	0	0	0	0	0
Specialist hair	No	0	0	0	0	0	0	0
Leg ulcer	No	0	0	0	0	0	0	0
Lontophoresis	No	0	0	0	0	0	0	0
Paediatric	Other	0	0	0	0	0	0	Paeds CNS has 6 clinics/week; Consultant clinics are 1.5 per week
Biologics	Consultant	1/week	40	40	0	0	0	0
Biological drug follow-up	Nurse led	1/week	40	40	0	0	0	0
Service Profile	***Response***							
Do you provide one stop clinics?	Yes							
How many teledermatology referrals do you handle each year?	5890							
How many Teledermatology sessions on average are undertaken each week?	9							
Is teledermatology activity job planned?	Yes							
Do you undertake waiting list initiative clinics?	Yes							
How many consultants (not WTE) in your department do surgical lists?	5							
Facilities	***Response***							
How many dedicated dermatology rooms do you have?	5							
Do you have access to procedure rooms when doing dermatology out patient clinics?	Yes							
Do you use operating theatre facilities for dermatology?	Yes							
If ***'yes'***, how many sessions per week?	15							
Primary Care Advice & Guidance	***Response***							
Does your department provide email/letter advice and guidance to referrers?	Yes							
Do you run any virtual clinics within the department?	Yes							
If ***'yes'***, how many sessions per week?	1/month - CNS led for follow ups							
Do you have a specific advice line for patient support?	Yes							
Dermatology IP Services	***Response***							

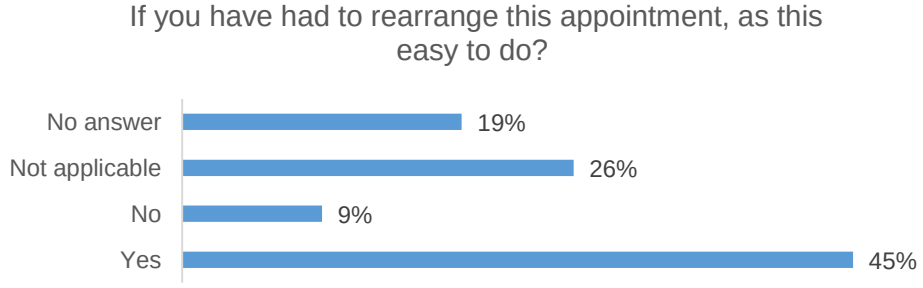
Do you have a dermatology on call rota?	No							
If ***'yes'*** what hours are covered by the on call service?								
How are adult dermatology in-patients managed? (e.g. admitted to dermatology bed/ general medicine / shared care)	admit to derm bed							
Surgical Treatments & Outcomes	***Response***							
What is the approximate longest waiting time in weeks today for conventional BCC surgery in your department?	36 weeks							
What is your department's completeness of excision rate for BCCs?	0.92							
Does your department normally follow up patients after complete excision of a first BCC?	No							
How many weeks do you currently wait for routine histopathology from your department?	4 weeks							

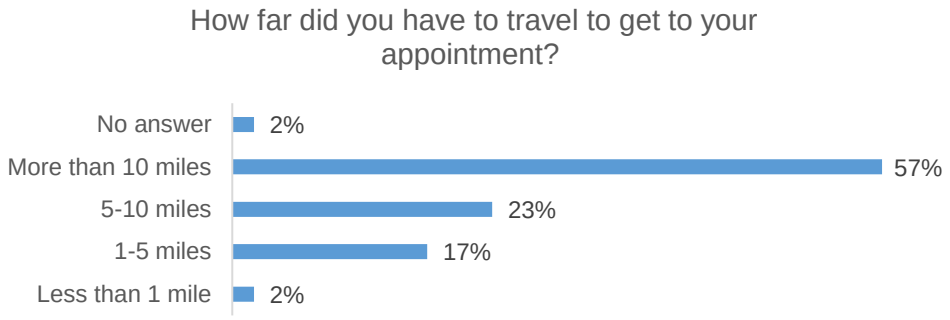
Annex 3: Patient experience survey

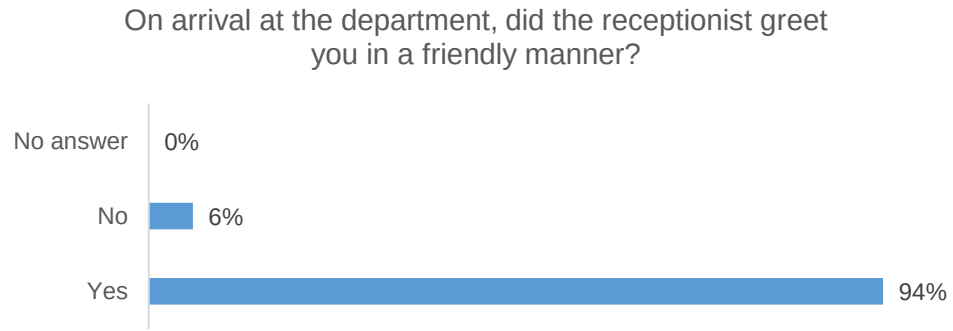
Dermatology survey – 2019

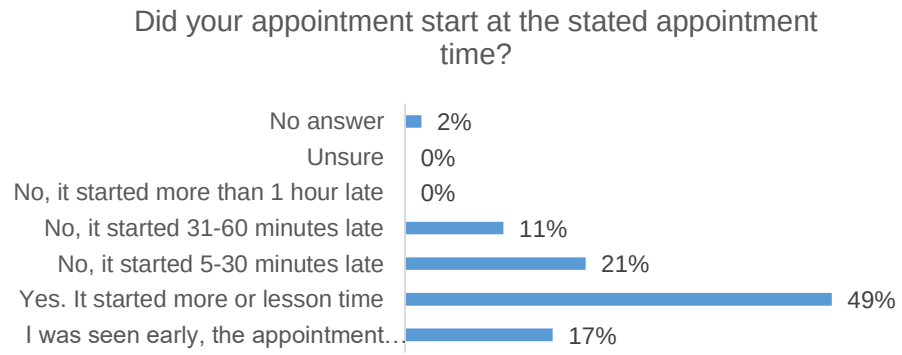
Number of responses: 53

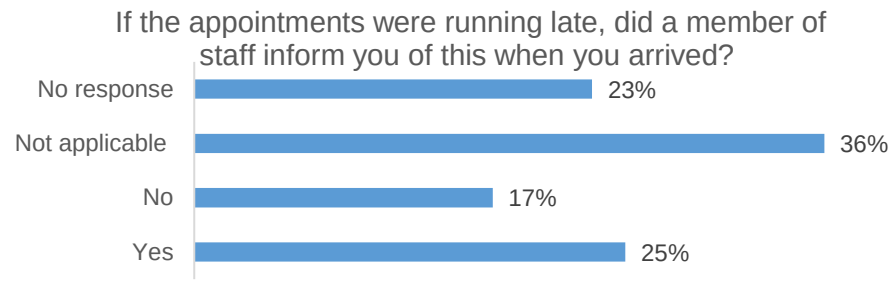


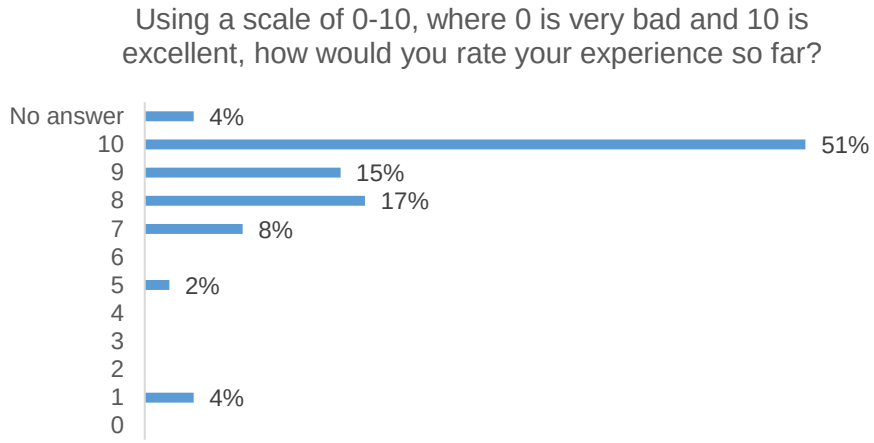


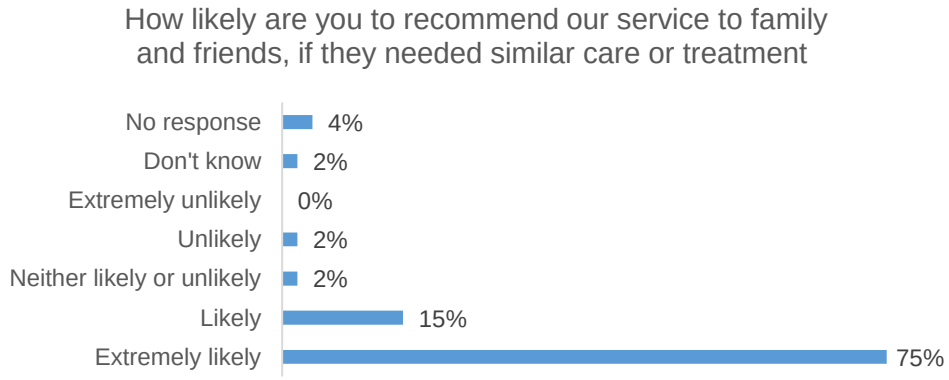

How far did you have to travel to get to your appointment?
No answer
2%
More than 10 miles
57%
5-10 miles
23%
1-5 miles
17%
Less than 1 mile
2%


On arrival at the department, did the receptionist greet you in a friendly manner?
No answer
0%
No
6%
Yes
94%


Did your appointment start at the stated appointment time?
No answer
2%
Unsure
0%
No, it started more than 1 hour late
0%
No, it started 31-60 minutes late
11%
No, it started 5-30 minutes late
21%
Yes. It started more or lesson time
49%
I was seen early, the appointment…
17%







Was there anything particularly good about your experience that you would like to tell us about?	Comments
	• Everything 4 star. • Nurses and staff were very informative and made me feel at ease. • Staff were excellent (fantastic team). Made me feel at ease from the moment I arrived. Thank you, Diolch. • Excellent treatment all around. It's the end of 5 years with this department. Very friendly and informal. Thank you all. • The Nurse doing the biopsy was very kind and done a good job, and made me feel at ease. His name was XXXXXX and was very helpful and has done a fe biopsy's for me, he is a very professional Nurse. • My experience was good and I have no complaints. • Outstanding service from XXXXX. He explained my issues fully and dealt with them promptly. The follow up appointment arrived as promised within the timeframe discussed. He has an excellent and caring approach. First class! • Friendly, helpful staff. • The appointment was good and they were all friendly and helpful, and explained everything to me. • I found all the staff very helpful, even the clinicians. All explained thoroughly. • Friendly and answered all my questions. • Very pleasant and took the time to explain our questions and concerns.

	• The doctor was a very xxx man. • Doctor was very pleasant and took care of my problems very well. • Mr. XXXXXX and his nurse treated me very well with understanding and care. He explained what he planned to do and in a light-hearted way reassured me of his actions. He put me completely at ease and I'm very happy with my treatment. • Staff friendly and supportive. • Yes - all staff were pleasant, courteous and helpful. Everywhere there was efficiency in my requirements. Punctuality was also greatly appreciated. The need for a local hospital was essential for my needs. Congratulations Withybush for being so wonderful. • Friendly staff, very helpful. • Nurses are lovely and helpful. • They were very good at explaining what they were going to do. • Delightful young man who explained things clearly. • "The nurses, giving out the medication, were all very polite and very helpful. • We were given phone numbers to contact the nurses with. • All the information was clearly explained. • We were not rushed at all and the nurses were very patient." • Staff were friendly and I was kept informed about appointments running late. • Everyone who we spoke to that day was pleasant. The specialist XXXXXX explained everything slowly and was very patient. • Everything was explained to me in full, I was treated very well. Nurses and doctor were extremely warm and friendly. • Right from the start, at the initial examination, the service has been exemplary. All the follow-ups and subsequent examinations have been prompt and carried out in a friendly and professional manner. Every procedure has been fully explained and any questions answered • The dermatology department was very clean and the staff were very friendly. The person I saw explained everything clearly and listened to my questions and put me at ease. • Extremely polite and paid attending to detail. Ensured I knew what would happen in the procedure. Very caring and respectful. Kind. Competent and assured. Positive atmosphere. • Seen promptly. Pleasant staff attitude. Situation explained clearly and in detail. • All staff were very polite and thorough. • The waiting room was pleasant. The nurses never fail to be nice • Everyone is really friendly and when I come to the hospital I feel really confident to speak about my problems. The understanding for patients are very good. • Dermatology team always took time to discuss my medication and the side effects that I might expect. They were always happy to re-assure me if I had any worries and I felt well supported throughout. • Friendly nurse. Text reminder for appointment was helpful • Very efficient and great staff • Staff very friendly and welcoming • Dr XXXX and the dermatology nurses are very understanding and sympathetic • Lovely staff
Was there anything that we could change to improve your experience?	Comments
	• Make sure you're not waiting nearly an hour for your appointment, and to be updated of delay by a member of staff. • No, everything was first class. • I don't think so! • No nothing, I was very happy with how they treated me. • My original appointment took over 15 months to arrange. I had to re-arrange initially as I was an in-patient at Withybush. My case was transferred to Carmarthen and again I was unwell. My case was transferred back to Withybush where I was put at the bottom of the list. Finally the department secretary managed to bring my appointment forward for me. • I need a lump removed and they keeps putting off the appointment back and back and the lump is getting larger. • No comment • Car Parking • No - all is already efficient. • Better parking as it took me 30 minutes to find a space. • Nope. • No it was all ok. • No.

	• Waiting time in the Pharmacy afterwards was extremely long, (unto 25-40 minutes) with people who came after us being served first. • Not having to wait so long to be seen. Parking is difficult majority of the time. • No - all excellent. • No • Not really • My GP sent photos and asked for an appointment in June 2018. I received a text message in September 2018 asking me did I wish to stay on the waiting list. I replied "yes" and was told the earliest it would be was June 2019. My actual appointment was July 2019, it was a very long and stressful wait. • Waiting room posters looked very dated. Seating was crammed in in waiting room. A view out of the windows, not dated "prison" (waiting room. • Possibly less of a ride down to the hospital • Have a Dermatology clinic nearer to where I live. I have to travel 45-50 miles to get to an appointment. • Appointment in Carmarthen • More appointments in glangwili

Dermatology Activity Data Review

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Background

As per the agreed and approved Clinical Services Plan methodology, high level activity between 1 August 2018 and 31 July 2023 has been included for Dermatology services at sites in scope of the project, as follows:

- Prince Philip Hospital, Llanelli
- Glangwili Hospital, Carmarthen
- Withybush Hospital, Haverfordwest
- South Pembrokeshire Hospital, Pembroke Dock
- Cardigan Integrated Care Centre, Cardigan

There is also some data present for other locations across the health board and, where relevant, Outsourced locations.

This data is accurate as of Quarter 3 2023/24.

In response to the COVID-19 pandemic, some temporary service changes were put in place, from Public Board (16 April 2020). This is reflected in each chart by a vertical blue line.

These service changes were ratified at the following Public Board meeting on 28 May 2020, and this is reflected in each chart by a vertical red line.

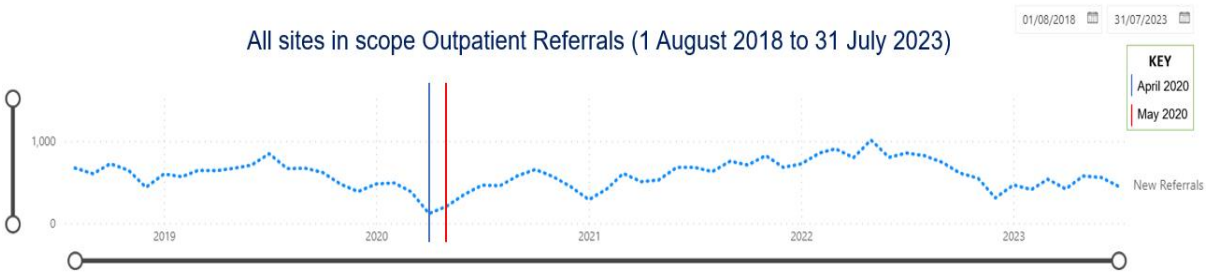
The summary of the service changes is as follows:

- Urgent Suspected Cancer (USC) clinics condensed with Minor Operation (MOP) sessions to create ‘See and Treat’ sessions, therefore reducing the number of times a patient has to visit the Outpatient Department
- Telephone validation took place for all clinic appointments that had been cancelled
- Virtual telephone follow-ups put in place for acne and biologic clinics.

With reference to the ‘Other sites Outpatient Activity’ chart – patients attending Werndale did so via outsourcing, and so were seen by Werndale clinicians and not Hywel Dda University Health Board clinicians. Other sites not included in scope of the project stopped being used during the COVID-19 pandemic and have not recommenced.

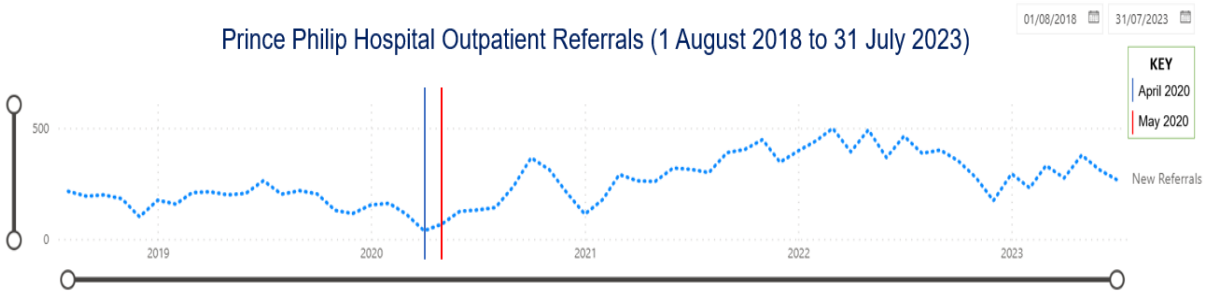
Outpatient Referral Charts

All sites



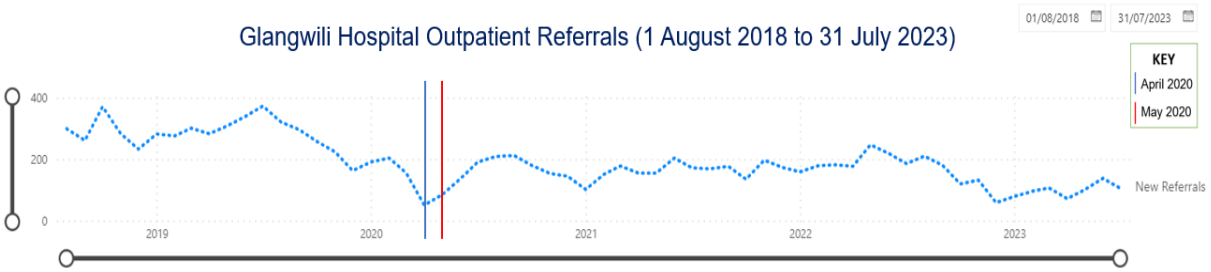
Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Cardigan Integrated Care Centre	0	0	0	0	0	0	**0**
Glangwili General Hospital	2,306	3,116	1,793	2,058	1,812	416	**11,501**
Prince Philip Hospital	1,429	2,176	2,210	4,379	4,162	1,230	**15,586**
South Pembrokeshire Hospital	0	6	0	122	147	3	**278**
Withybush General Hospital	1,147	1,720	1,136	1,904	1,777	345	**8,029**
Total	**4,882**	**7,018**	**5,139**	**8,463**	**7,898**	**1,994**	**35,394**

Prince Philip



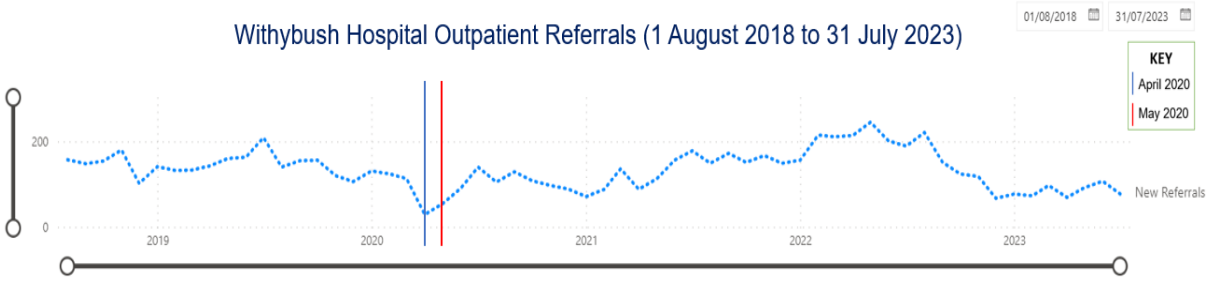
Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Prince Philip Hospital	1,429	2,176	2,210	4,379	4,162	1,230	**15,586**
Total	**1,429**	**2,176**	**2,210**	**4,379**	**4,162**	**1,230**	**15,586**

Glangwili



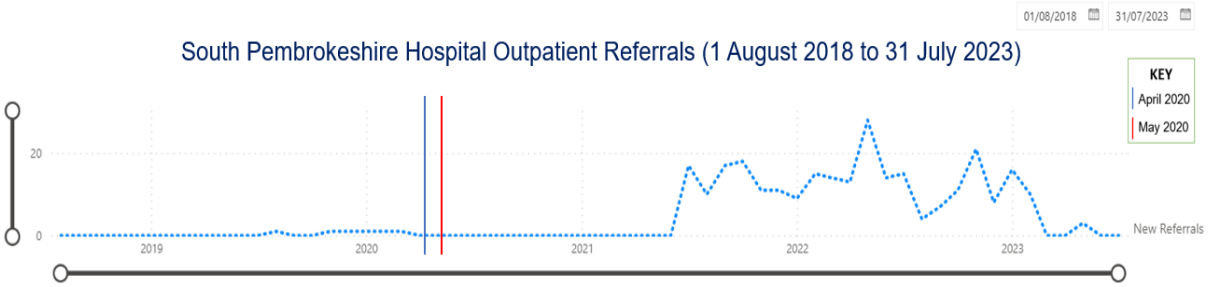
Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Glangwili General Hospital	2,306	3,116	1,793	2,058	1,812	416	11,501
Total	**2,306**	**3,116**	**1,793**	**2,058**	**1,812**	**416**	**11,501**

Withybush



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Withybush General Hospital	1,147	1,720	1,136	1,904	1,777	345	8,029
Total	**1,147**	**1,720**	**1,136**	**1,904**	**1,777**	**345**	**8,029**

South Pembrokeshire Hospital



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
South Pembrokeshire Hospital	0	6	0	122	147	3	278
Total	**0**	**6**	**0**	**122**	**147**	**3**	**278**

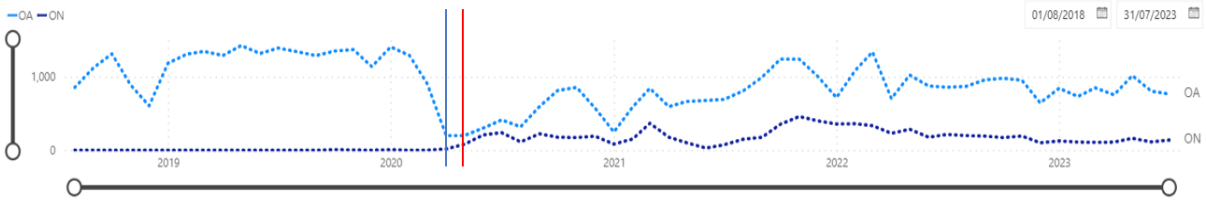
Cardigan Integrated Care Centre

No patient referrals recorded at Cardigan Integrated Care Centre.

Outpatient Activity Charts

All sites

All sites in scope Outpatient Activity (1 August 2018 to 31 July 2023)

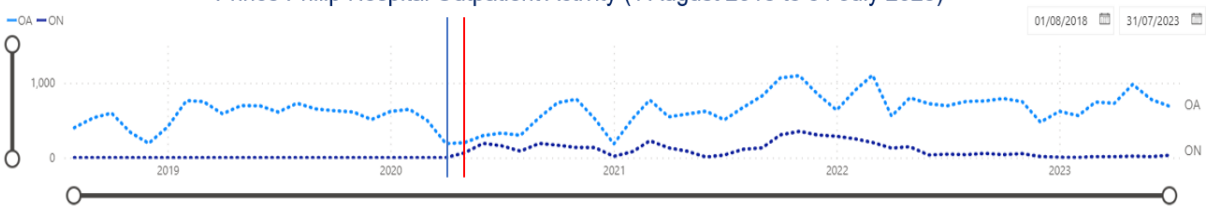


Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Cardigan Integrated Care Centre	0	0	0	0	95	59	**154**
Glangwili General Hospital	3,753	6,830	595	916	1,747	506	**14,347**
Prince Philip Hospital	3,983	7,484	6,817	11,626	8,809	3,249	**41,968**
South Pembrokeshire Hospital	219	221	3	353	664	21	**1,481**
Withybush General Hospital	675	1,007	569	1,149	1,087	31	**4,518**
Total	**8,630**	**15,542**	**7,984**	**14,044**	**12,402**	**3,866**	**62,468**

KEY
April 2020
May 2020
OA = F2F
ON = Virtual

Prince Philip

Prince Philip Hospital Outpatient Activity (1 August 2018 to 31 July 2023)

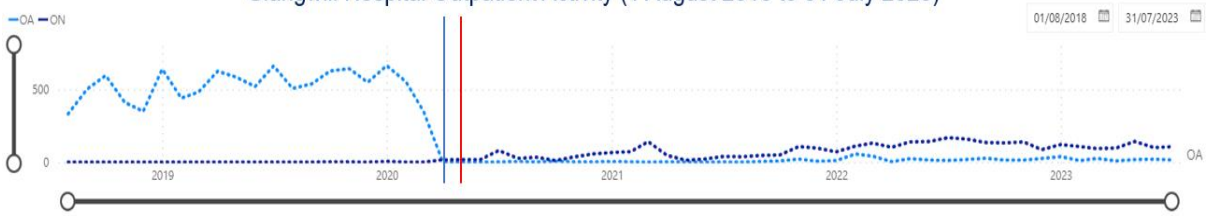


Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Prince Philip Hospital	3,983	7,484	6,817	11,626	8,809	3,249	**41,968**
Total	**3,983**	**7,484**	**6,817**	**11,626**	**8,809**	**3,249**	**41,968**

KEY
April 2020
May 2020
OA = F2F
ON = Virtual

Glangwili

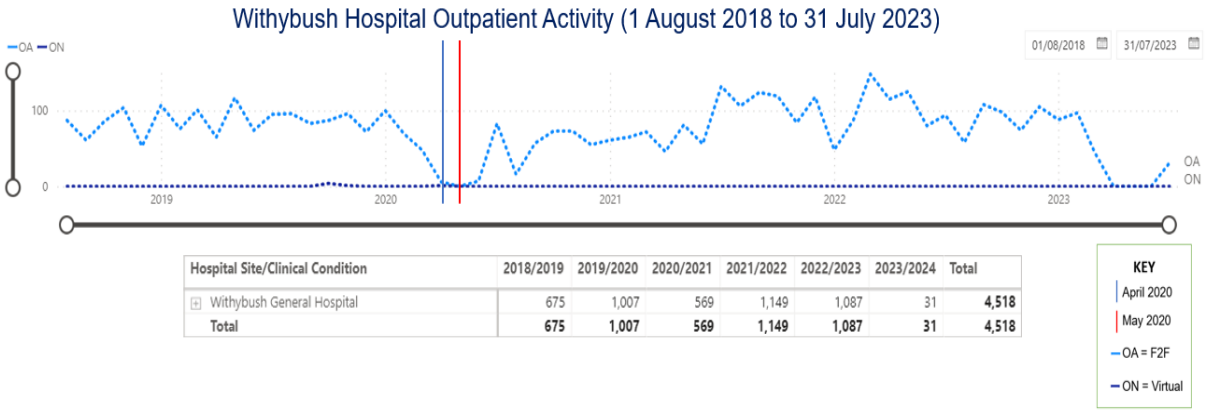
Glangwili Hospital Outpatient Activity (1 August 2018 to 31 July 2023)



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Glangwili General Hospital	3,753	6,830	595	916	1,747	506	**14,347**
Total	**3,753**	**6,830**	**595**	**916**	**1,747**	**506**	**14,347**

KEY
April 2020
May 2020
OA = F2F
ON = Virtual

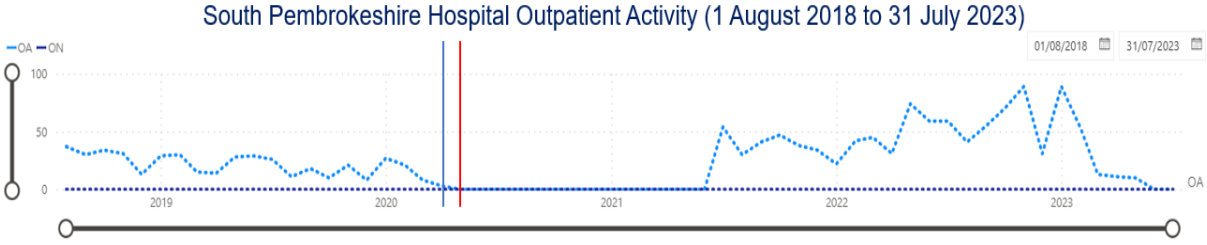
Withybush



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Withybush General Hospital	675	1,007	569	1,149	1,087	31	4,518
Total	**675**	**1,007**	**569**	**1,149**	**1,087**	**31**	**4,518**

KEY
April 2020
May 2020
OA = F2F
ON = Virtual

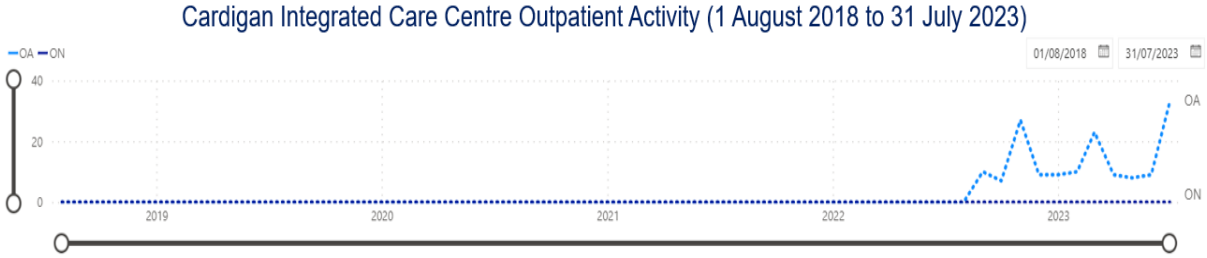
South Pembrokeshire Hospital



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
South Pembrokeshire Hospital	219	221	3	353	664	21	1,481
Total	**219**	**221**	**3**	**353**	**664**	**21**	**1,481**

KEY
April 2020
May 2020
OA = F2F
ON = Virtual

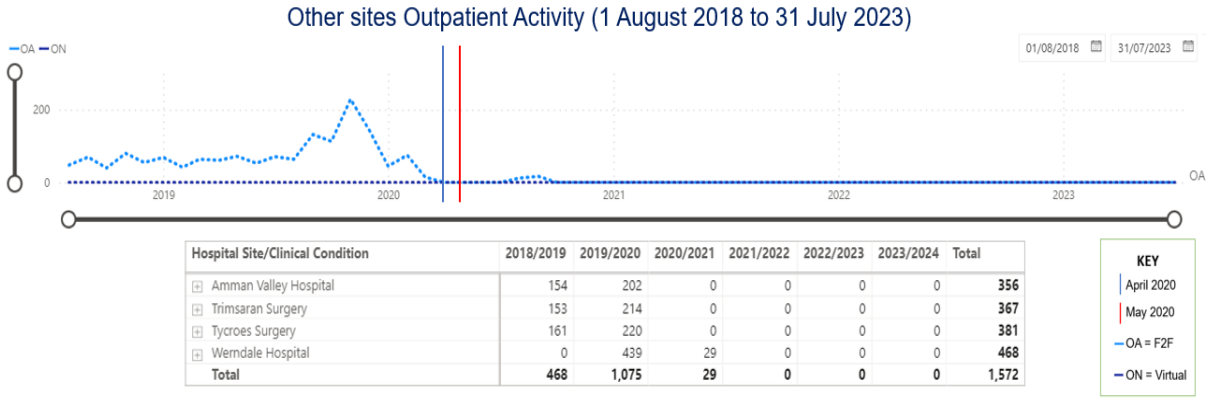
Cardigan Integrated Care Centre



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Cardigan Integrated Care Centre	0	0	0	0	95	59	154
Total	**0**	**0**	**0**	**0**	**95**	**59**	**154**

KEY
OA = F2F

Other sites



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Amman Valley Hospital	154	202	0	0	0	0	**356**
Trimsaran Surgery	153	214	0	0	0	0	**367**
Tycroes Surgery	161	220	0	0	0	0	**381**
Werndale Hospital	0	439	29	0	0	0	**468**
Total	**468**	**1,075**	**29**	**0**	**0**	**0**	**1,572**

KEY
April 2020
May 2020
OA = F2F
ON = Virtual

Outsourced activity data

The outsourced activity table below highlights the number of activities which have been outsourced by the health board (a patient may have more than one activity). Due to the nature of how this data is captured we have represented this in financial year form between 1 April 2018 to 31 March 2023, which varies from the remainder of the activity data as highlighted throughout this document.

Year	Point of Delivery	Specialty	Provider	Sum of No. of Activities
19/20	**Outpatient New**	Dermatology	BMI Werndale	555
	Outpatient New Total			**555**
19/20 Total				**555**
21/22	**Day case**	Dermatology	BMI Werndale	22
	Day case Total			**22**
	Outpatient New	Dermatology	BMI Werndale	1,206
	Outpatient New Total			**1,206**
	Outpatient Procedure	Dermatology	BMI Werndale	36
	Outpatient Procedure Total			**36**
21/22 Total				**1,264**
22/23	**Outpatient Procedure**	Dermatology	BMI Werndale	85
	Outpatient Procedure Total			**85**
22/23 Total				**85**
18/19	**Outpatient New**	Dermatology	BMI Werndale	577
	Outpatient New Total			**577**
18/19 Total				**577**
Grand Total				**2,481**

Dermatology Incident Data Review

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By Severity/Level (1st August 2018 – 31st March 2021) 6
By Severity/Level (1st April 2021 – 31st July 2023) 6
By Type (1st August 2018 – 31st March 2021) 7
By Type (1st April 2021 – 31st July 2023) 7
Bronglais Hospital (1st August 2018 – 31st March 2021) 8
By Severity/Level 8
Bronglais Hospital (1st April 2021 – 31st July 2023) 8
By Severity/Level 8
Bronglais Hospital (1st August 2018 – 31st March 2021) 9
By Type 9
Bronglais Hospital (1st April 2021 – 31st July 2023) 9
By Type 9
Withybush Hospital (1st August 2018 – 31st March 2021) 10
By Severity/Level 10
Withybush Hospital (1st April 2021 – 31st July 2023) 10
By Severity/Level 10
Withybush Hospital (1st August 2018 – 31st March 2021) 11
By Type 11
Withybush Hospital (1st April 2021 – 31st July 2023) 11
By Type 11
Glangwili Hospital (1st August 2018 – 31st March 2021) 12
By Severity/Level 12
Glangwili Hospital (1st April 2021 – 31st July 2023) 12
By Severity/Level 12
Glangwili Hospital (1st August 2018 – 31st March 2021) 13
By Type 13

Glangwili Hospital (1st April 2021 – 31st July 2023) 13
By Type 13
Prince Philip Hospital (1st August 2018 – 31st March 2021) 14
By Severity/Level 14
Prince Philip Hospital (1st April 2021 – 31st July 2023) 14
By Severity/Level 14
Prince Philip Hospital (1st August 2018 – 31st March 2021) 15
By Type 15
Prince Philip Hospital (1st April 2021 – 31st July 2023) 15
By Type 15
Patient's Home (1st August 2018 – 31st March 2021) 16
By Severity/Level 16
By Type 16
Patient's Home (1st April 2021 – 31st July 2023) 16
By Severity/Level 16
By Type 16

Background

As per the approved Clinical Services Plan methodology, Incidents reported between 1 August 2018 and 31 July 2023 have been included for Dermatology services at Withybush Hospital, Glangwili Hospital, Prince Philip Hospital, and Bronglais Hospital. Due to data formatting across the current Datix system and historical records, data has been visualised within two dashboards representing the implementation of the current system. Data tables and graphics reflect the dates of this change.

In April 2021, Datix Cymru, a Once for Wales Concerns Management System, was introduced. Hywel Dda UHB were the first Health Board in Wales to adopt the new system.

Prior to the implementation of Datix Cymru work had been undertaken to develop a system which made reporting of incidents simpler and therefore this may account for a rise in incident reports seen in April 2021.

It is possible that the data shows a variation in the number of reported incidents attributable to the service when comparing the old system to the current. This relates to the system being able to distinguish between different specialties within the service that may be related to other services within the previous system.

Due to gaps at the reporting stage of records, categorised totals may not equal the overall totals for the service.

Service Changes

In response to the COVID-19 pandemic, some temporary service changes were put in place, from Public Board (16 April 2020). This is reflected in each chart by a vertical blue line.

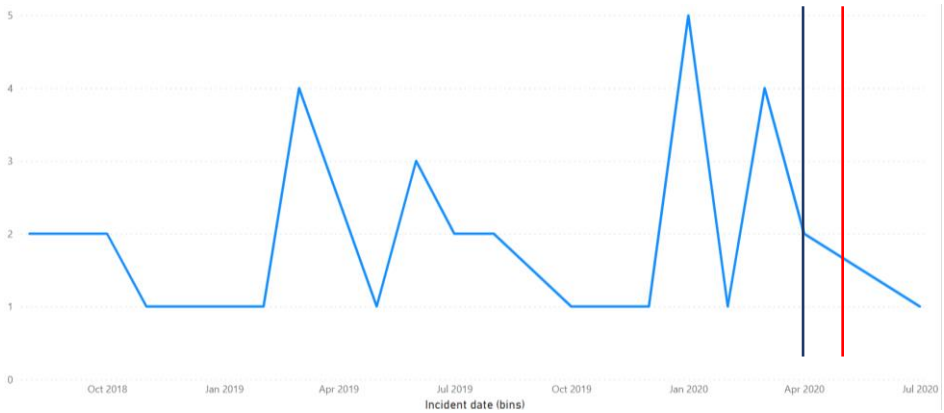
These service changes were ratified at the following Public Board meeting (28 May 2020), and this is reflected in each chart by a vertical red line.

The summary of the service changes is as follows:

- Urgent Suspected Cancer (USC) clinics condensed with Minor Operation (MOP) sessions to create ‘See and Treat’ sessions, therefore reducing the number of times a patient has to visit the Outpatient Department
- Telephone validation took place for all clinic appointments that had been cancelled
- Virtual telephone follow-ups put in place for acne and biologic clinics.

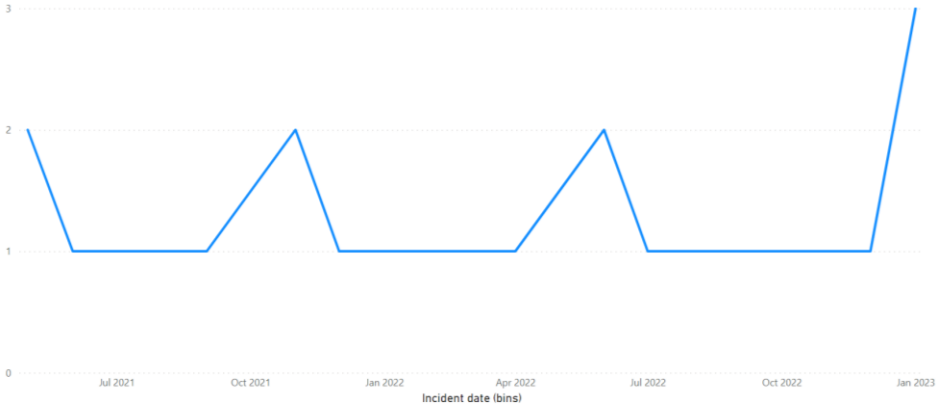
Incidents

All sites (1st August 2018 – 31st March 2021)



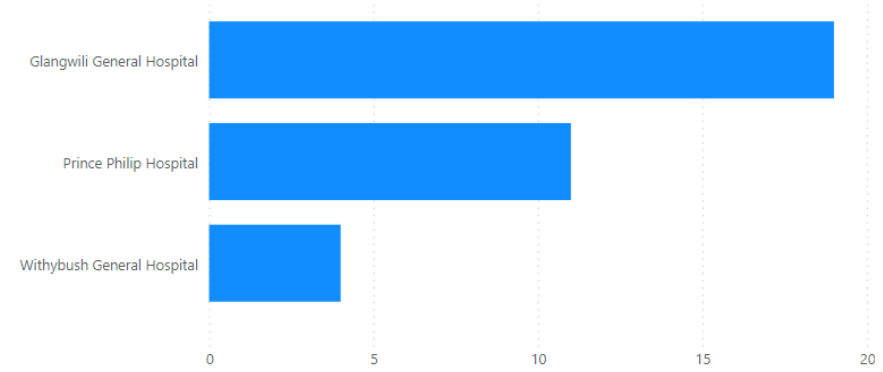
							Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	**2018**
							2	0	2	1	0	5
Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	**2019**
0	1	4	0	1	3	2	2	0	1	1	1	16
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	**2020**
5	1	4	2	0	0	1	0	0	0	0	0	13
Jan 21	Feb 21	Mar 21										**2021**
0	0	0										0
												34

All sites (1st April 2021 – 31st July 2023)



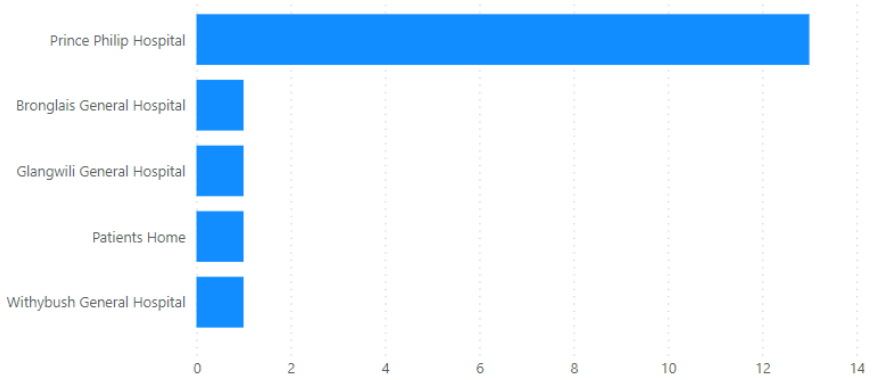
			Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	**2021**
			0	2	1	1	0	1	0	2	1	8
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	**2022**
0	0	0	1	0	2	1	0	0	0	1	1	6
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						**2023**
3	0	0	0	0	0	0						3
												17

By Location (1st August 2018 – 31st March 2021)



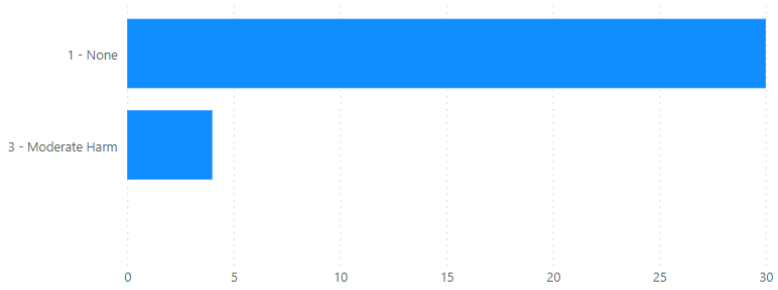
Primary Location	Count
Glangwili Hospital	19
Prince Philip Hospital	11
Withybush Hospital	4

By Location (1st April 2021 – 31st July 2023)



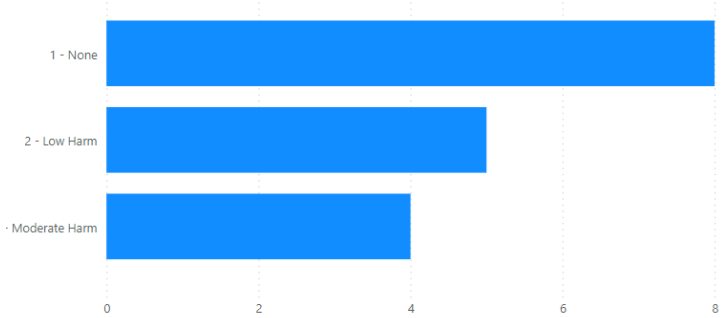
Primary Location	Count
Prince Philip Hospital	13
Bronglais Hospital	1
Glangwili Hospital	1
Patients Home	1
Withybush Hospital	1

By Severity/Level (1st August 2018 – 31st March 2021)



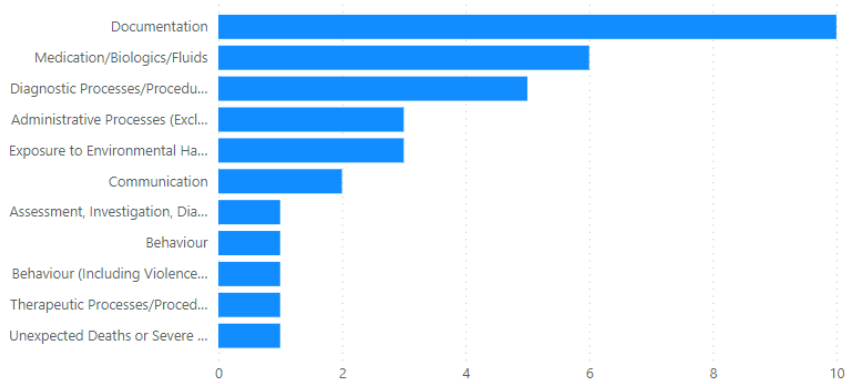
Severity	Count
1 - None	30
2 – Low Harm	0
3 – Moderate Harm	4
4 – Severe Harm	0
5 – Catastrophic Death	0

By Severity/Level (1st April 2021 – 31st July 2023)



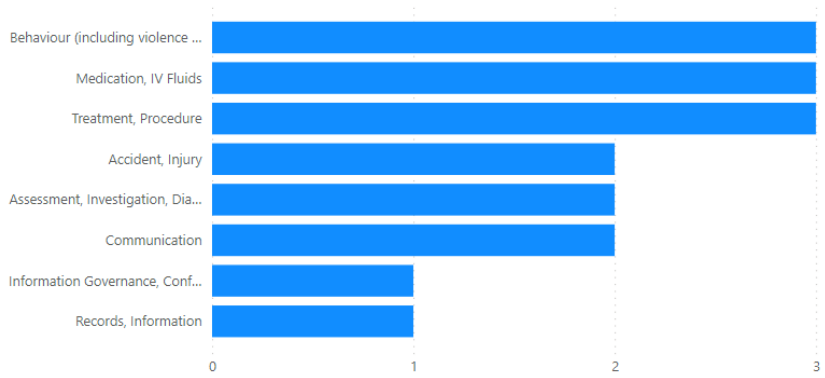
Severity	Count
1 - None	8
2 – Low Harm	5
3 – Moderate Harm	4
4 – Severe Harm	0
5 – Catastrophic Death	0

By Type (1st August 2018 – 31st March 2021)



Incident type tier one	Count
Documentation	10
Medication/Biologics/Fluids	6
Diagnostic Processes/Procedures	5
Administrative Processes (Excluding Documentation)	3
Exposure to Environmental Hazards	3
Communication	2
Assessment, Investigation, Diagnosis	1
Behaviour	1
Behaviour (Including Violence and Aggression)	1
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	1
Unexpected Deaths or Severe Harm	1

By Type (1st April 2021 – 31st July 2023)

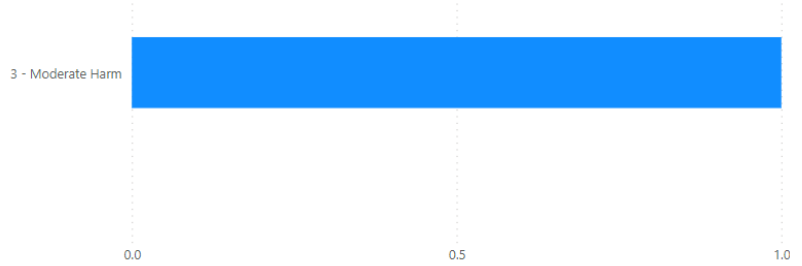


Incident type tier one	Count
Behaviour (including violence and aggression)	3
Medication, IV Fluids	3
Treatment, Procedure	3
Accident, Injury	2
Assessment, Investigation, Diagnosis	2
Communication	2
Information Governance, Confidentiality	1
Records, Information	1

Bronglais Hospital (1st August 2018 – 31st March 2021) By Severity/Level

No Incidents reported during this time period

Bronglais Hospital (1st April 2021 – 31st July 2023) By Severity/Level

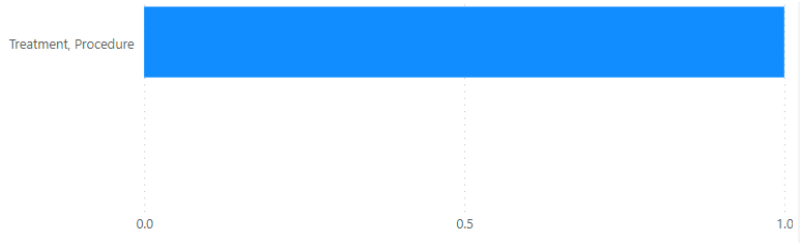


Severity	Count
1 – None	0
2 – Low Harm	0
3 – Moderate Harm	1
4 – Severe Harm	0
5 – Catastrophic Death	0

Bronglais Hospital (1st August 2018 – 31st March 2021) By Type

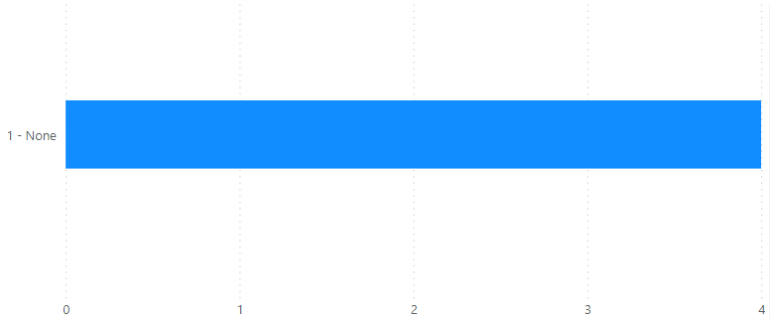
No Incidents reported during this time period

Bronglais Hospital (1st April 2021 – 31st July 2023) By Type



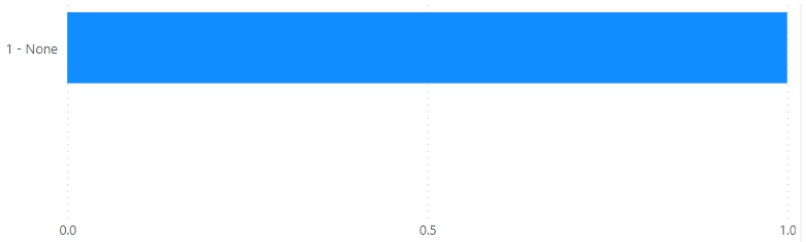
Incident type tier one	Count
Treatment, Procedure	1

Withybush Hospital (1st August 2018 – 31st March 2021) By Severity/Level



Severity	Count
1 - None	4
2 – Low Harm	0
3 – Moderate Harm	0
4 – Severe Harm	0
5 – Catastrophic Death	0

Withybush Hospital (1st April 2021 – 31st July 2023) By Severity/Level

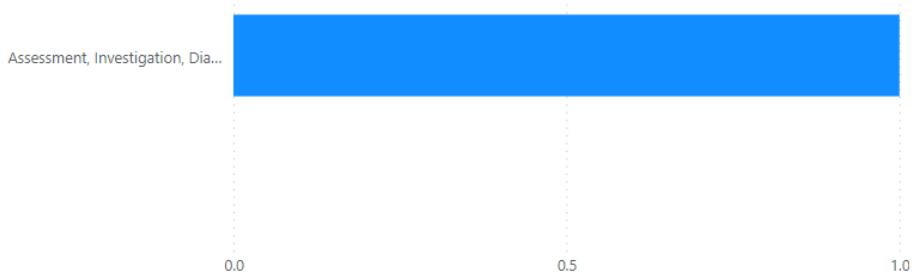


Severity	Count
1 - None	1
2 – Low Harm	0
3 – Moderate Harm	0
4 – Severe Harm	0
5 – Catastrophic Death	0

Withybush Hospital (1st August 2018 – 31st March 2021)
By Type

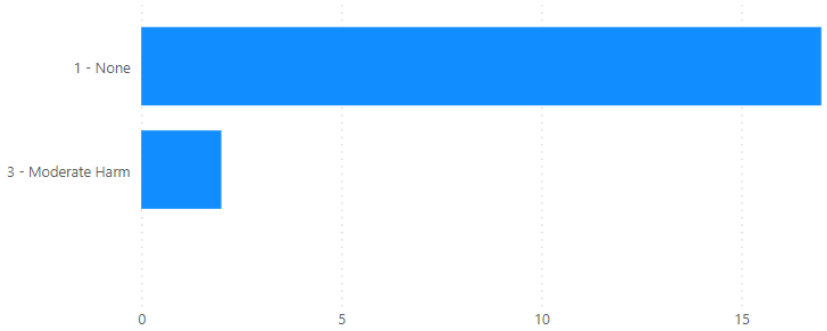
Incident type tier one	Count
Behaviour	1
Diagnostic Processes/Procedures	1
Documentation	1
Exposure to Environmental Hazards	1

Withybush Hospital (1st April 2021 – 31st July 2023)
By Type



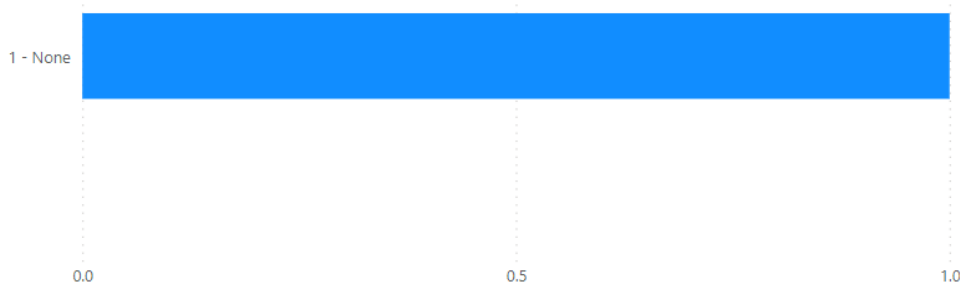
Incident type tier one	Count
Assessment, Investigation, Diagnosis	1

Glangwili Hospital (1st August 2018 – 31st March 2021) By Severity/Level



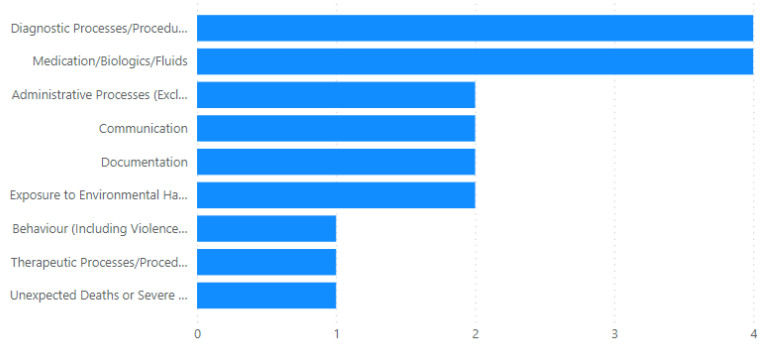
Severity	Count
1 - None	17
2 – Low Harm	0
3 – Moderate Harm	2
4 – Severe Harm	0
5 – Catastrophic Death	0

Glangwili Hospital (1st April 2021 – 31st July 2023) By Severity/Level



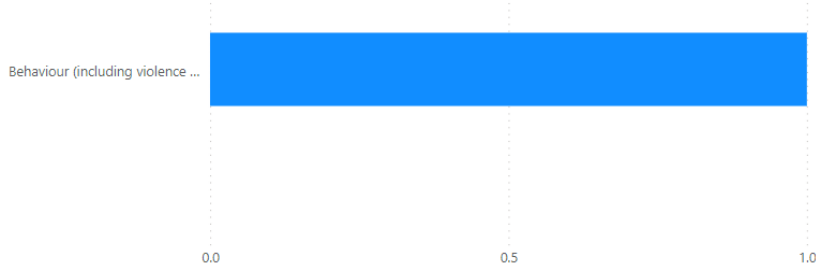
Severity	Count
1 - None	1
2 – Low Harm	0
3 – Moderate Harm	0
4 – Severe Harm	0
5 – Catastrophic Death	0

Glangwili Hospital (1st August 2018 – 31st March 2021)
By Type



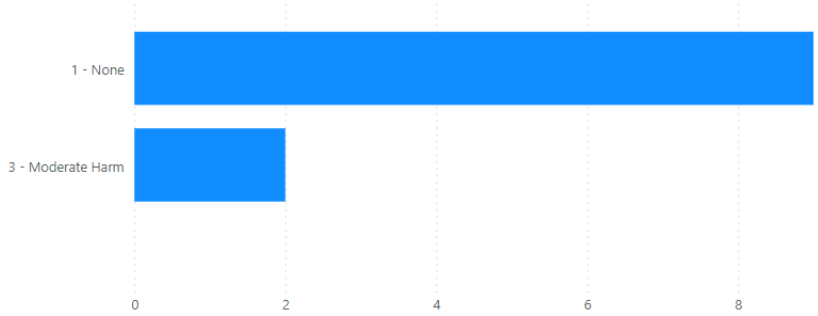
Incident type tier one	Count
Diagnostic Processes/Procedures	4
Medication/Biologics/Fluids	4
Administrative Processes (Excluding Documentation)	2
Communication	2
Documentation	2
Exposure to Environmental Hazards	2
Behaviour (Including Violence and Aggression)	1
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	1
Unexpected Deaths or Severe Harm	1

Glangwili Hospital (1st April 2021 – 31st July 2023)
By Type



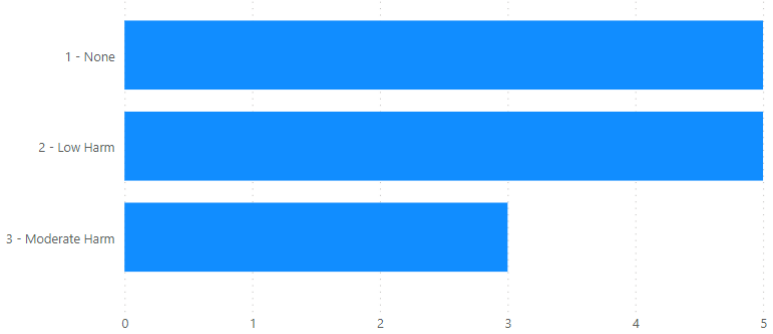
Incident type tier one	Count
Behaviour (including violence and aggression)	1

Prince Philip Hospital (1st August 2018 – 31st March 2021) By Severity/Level



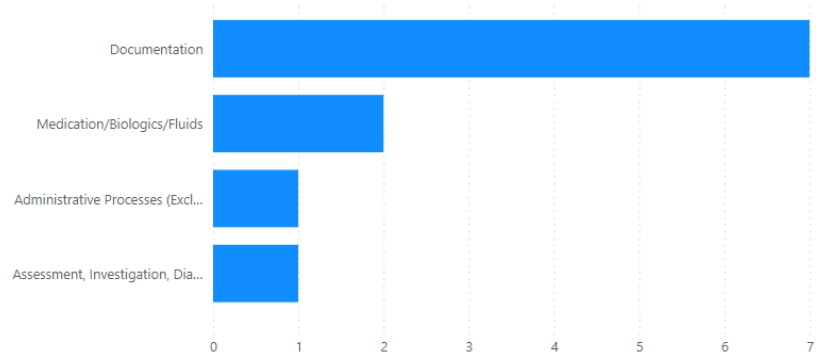
Severity	Count
1 - None	9
2 – Low Harm	0
3 – Moderate Harm	2
4 – Severe Harm	0
5 – Catastrophic Death	0

Prince Philip Hospital (1st April 2021 – 31st July 2023) By Severity/Level



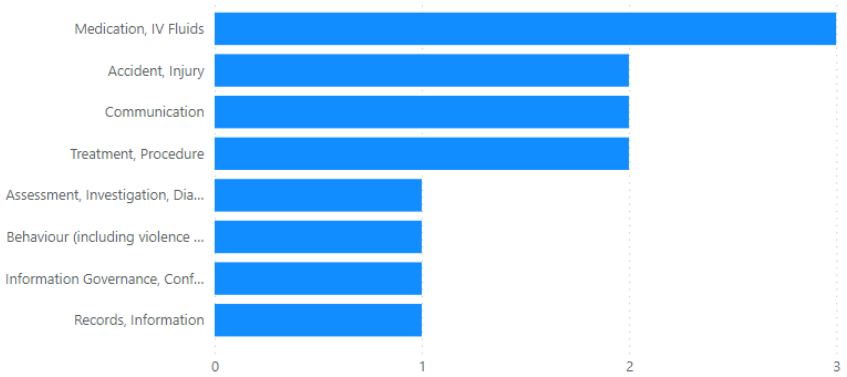
Severity	Count
1 - None	5
2 – Low Harm	5
3 – Moderate Harm	3
4 – Severe Harm	0
5 – Catastrophic Death	0

Prince Philip Hospital (1st August 2018 – 31st March 2021)
By Type



Incident type tier one	Count
Documentation	7
Medication/Biologics/Fluids	2
Administrative Processes (Excluding Documentation)	1
Assessment, Investigation, Diagnosis	1

Prince Philip Hospital (1st April 2021 – 31st July 2023)
By Type

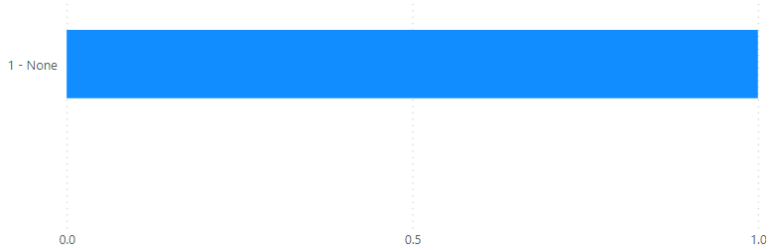


Incident type tier one	Count
Medication, IV Fluids	3
Accident, Injury	2
Communication	2
Treatment, Procedure	2
Assessment, Investigation, Diagnosis	1
Behaviour (including violence and aggression)	1
Information Governance, Confidentiality	1
Records, Information	1

Patient's Home (1st August 2018 – 31st March 2021) By Severity/Level

No Incidents reported during this time period

Patient's Home (1st April 2021 – 31st July 2023) By Severity/Level

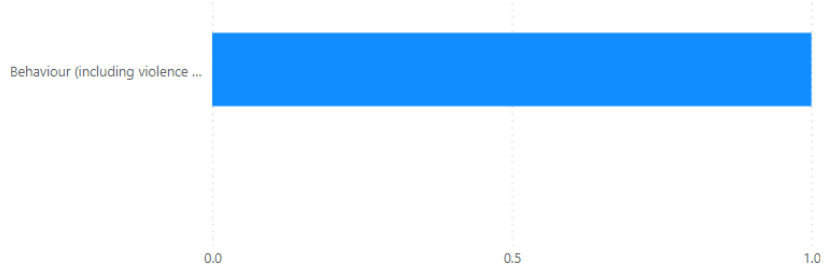


Severity	Count
1 - None	1

By Type

No Incidents reported during this time period

By Type



Incident type tier one	Count
Behaviour (including violence and aggression)	1

Dermatology Complaints Data Review

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Background

As per the approved Clinical Services Plan methodology, Complaints reported between 1 August 2018 and 31 July 2023 have been included for Dermatology services at Withybush Hospital, Glangwili Hospital and Prince Philip Hospital.

Due to data formatting across the current Datix system and historical records, data has been visualised within two dashboards representing the implementation of the current system. Data tables and graphics reflect the dates of this change.

Service Changes

In response to the COVID-19 pandemic, some temporary service changes were put in place, from Public Board (16 April 2020). This is reflected in each chart by a vertical blue line.

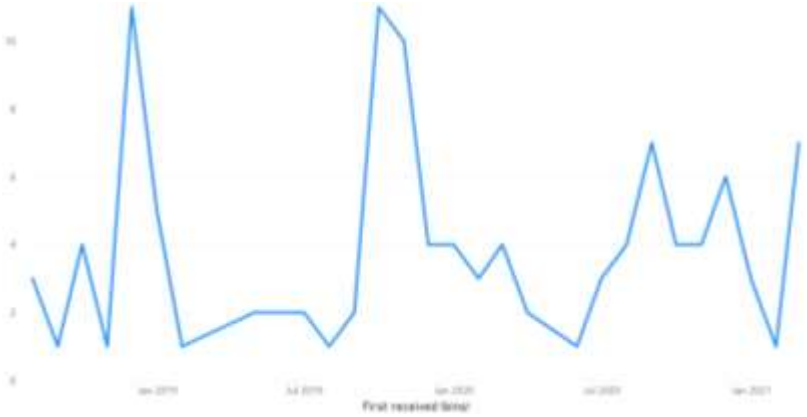
These service changes were ratified at the next Public Board meeting (28 May 2020) and this is reflected in each chart by a vertical red line.

The summary of the service changes is as follows:

- Urgent Suspected Cancer (USC) clinics condensed with Minor Operation (MOP) sessions to create ‘See and Treat’ sessions, therefore reducing the number of times a patient has to visit the Outpatient Department
- Telephone validation took place for all clinic appointments that had been cancelled
- Virtual telephone follow-ups put in place for acne and biologic clinics.

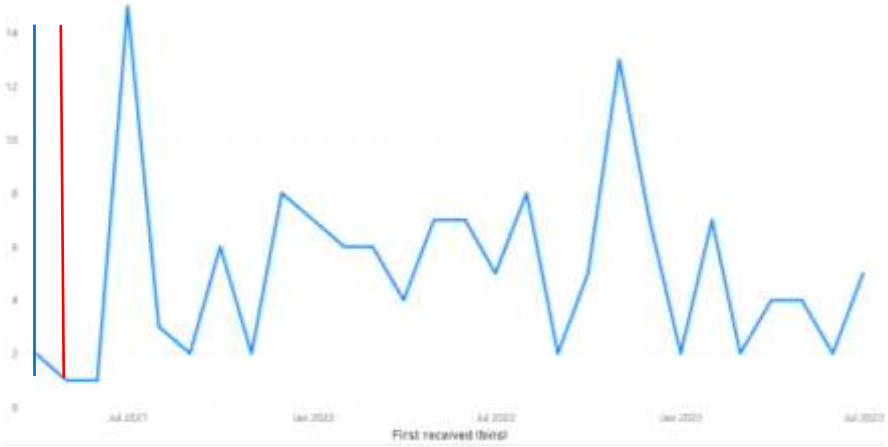
Complaints

All sites (1st August 2018 – 31st March 2021)



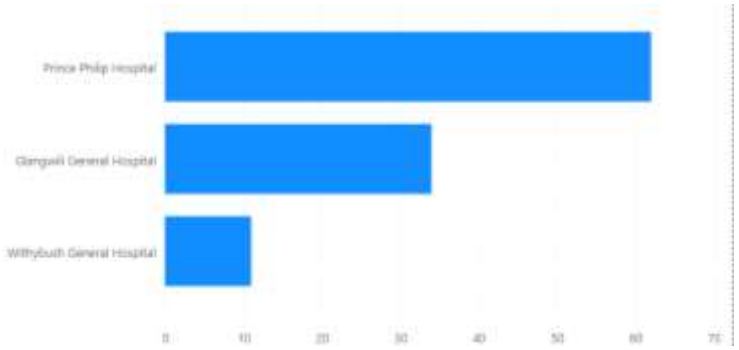
							Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	**2018**
							3	1	4	1	11	20
Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	**2019**
5	1	0	0	2	2	2	1	2	11	10	4	40
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	**2020**
4	3	4	2	0	1	3	4	7	4	4	6	42
Jan 21	Feb 21	Mar 21										**2021**
3	1	7										11
												113

All sites (1st April 2021 – 31st July 2023



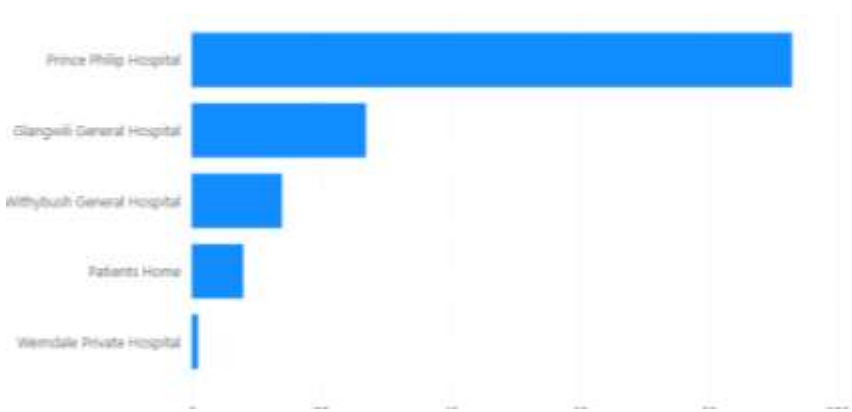
						Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	**2021**
						2	1	1	15	3	2	6	2	8	40
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	**2022**			
7	6	6	4	7	7	5	8	2	5	13	7	77			
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						**2023**			
2	7	2	4	4	2	5						26			
												143			

By Location (1st August 2018 – 31st March 2021)



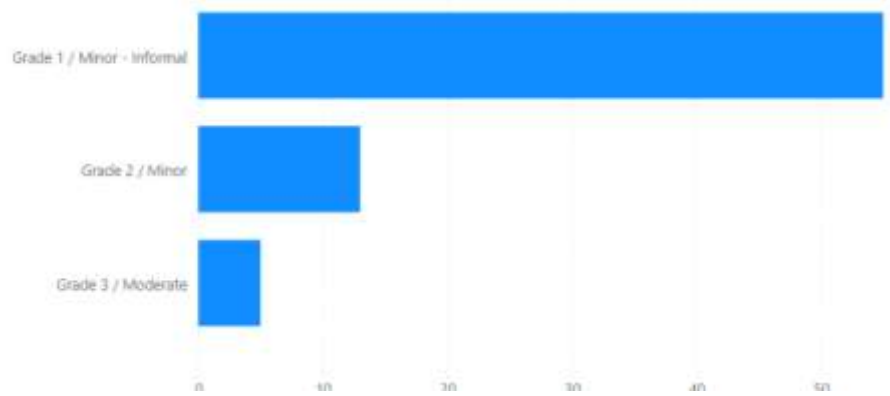
Primary Location	Count
Prince Philip Hospital	62
Glangwili General Hospital	34
Withybush General Hospital	11

By Location (1st April 2021 – 31st July 2023)



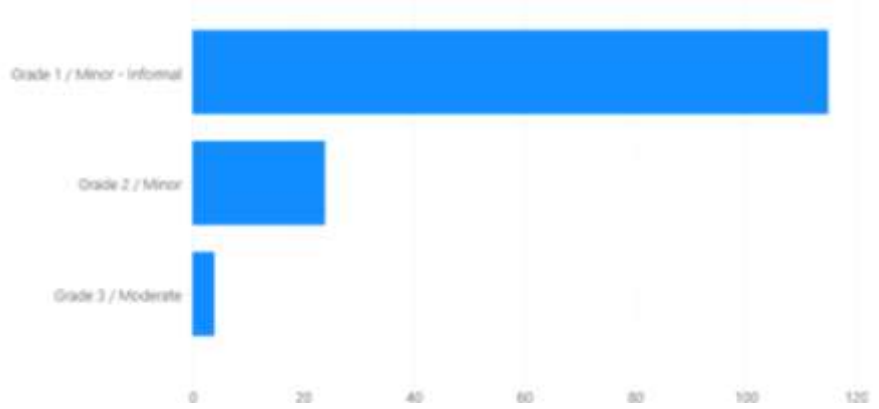
Primary Location	Count
Prince Philip Hospital	93
Glangwili General Hospital	27
Withybush General Hospital	14
Patients Home	8

By Grading (1st August 2018 – 31st March 2021)



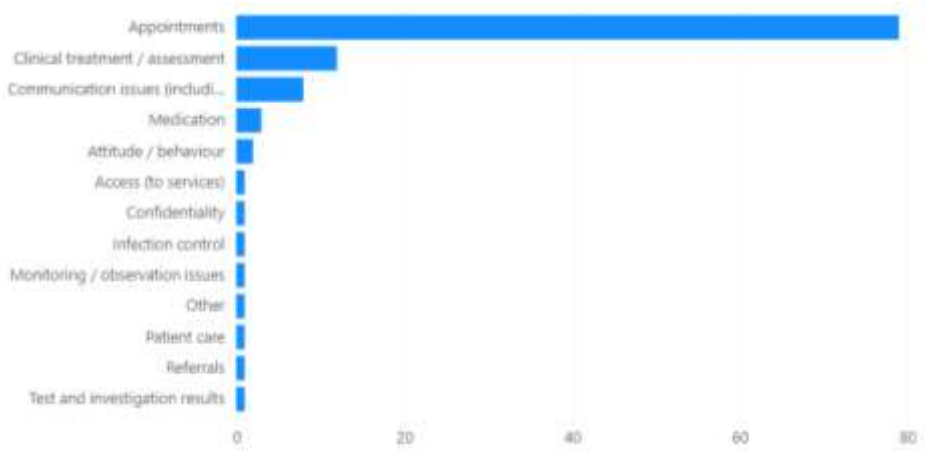
Grade	Count
Grade 1 – Minor - Informal	55
Grade 2 - Minor	13
Grade 3 - Moderate	5
Grade 4 - Major	0
Grade 5 – Catastrophic	0

By Grading (1st April 2021 – 31st July 2023)



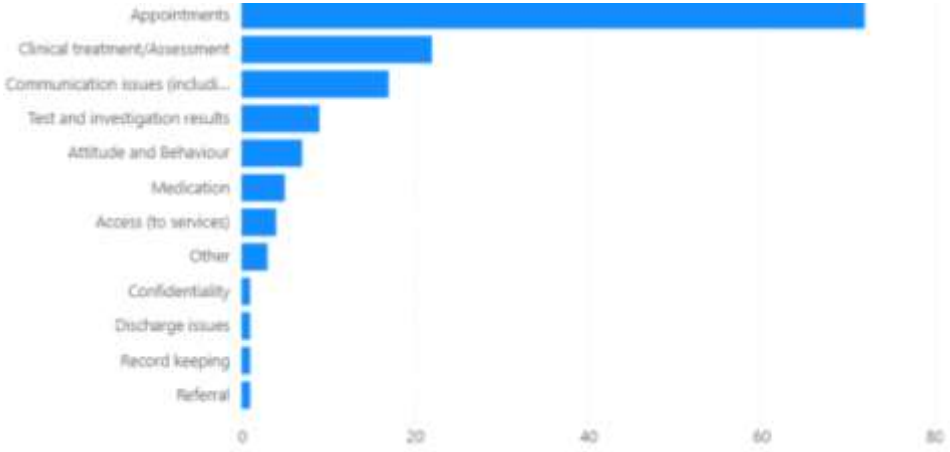
Grade	Count
Grade 1 – Minor - Informal	115
Grade 2 - Minor	24
Grade 3 - Moderate	4
Grade 4 - Major	0
Grade 5 – Catastrophic	0

By Type (1st August 2018 – 31st March 2021)



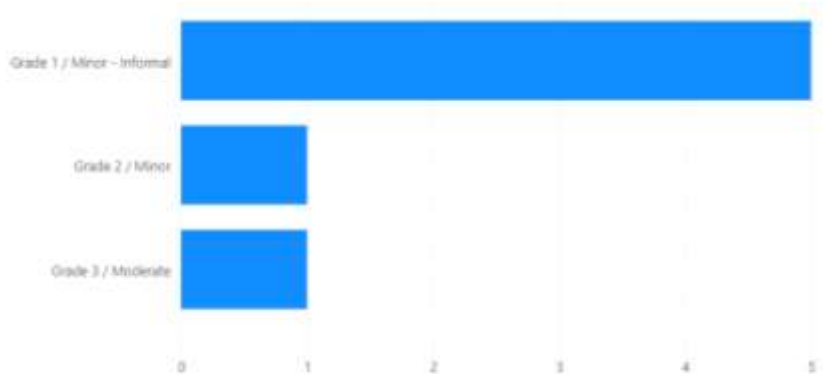
Subject (primary)	Count
Appointments	79
Clinical treatment / assessment	12
Communication issues (including language)	8
Medication	3
Attitude / behaviour	2
Access (to services)	1
Confidentiality	1
Infection control	1
Monitoring / observation issues	1
Other	1
Patient care	1
Referrals	1
Test and investigation results	1

By Type (1st April 2021 – 31st July 2023)



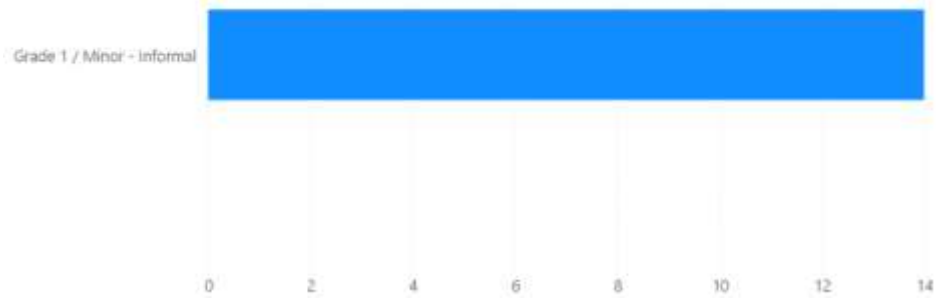
Subject (primary)	Count
Appointments	72
Clinical treatment/Assessment	22
Communication issues (including language)	17
Test and investigation results	9
Attitude and Behaviour	7
Medication	5
Access (to services)	4
Other	3
Confidentiality	1
Discharge issues	1
Record keeping	1
Referral	1

Withybush Hospital (1st August 2018 – 31st March 2021) By Grading



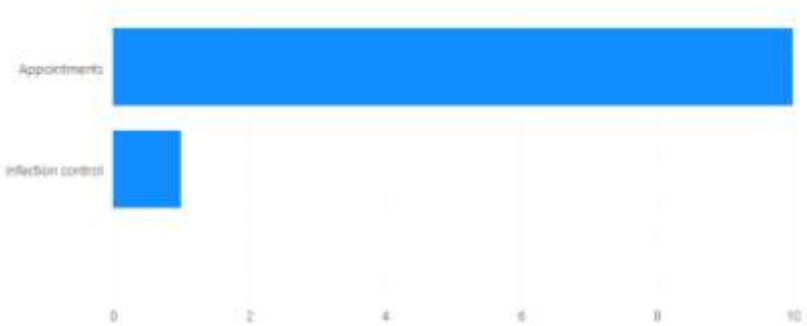
Grade	Count
Grade 1 – Minor - Informal	5
Grade 2 - Minor	1
Grade 3 - Moderate	1
Grade 4 – Major	0
Grade 5 – Catastrophic	0

Withybush Hospital (1st April 2021 – 31st July 2023) By Grading



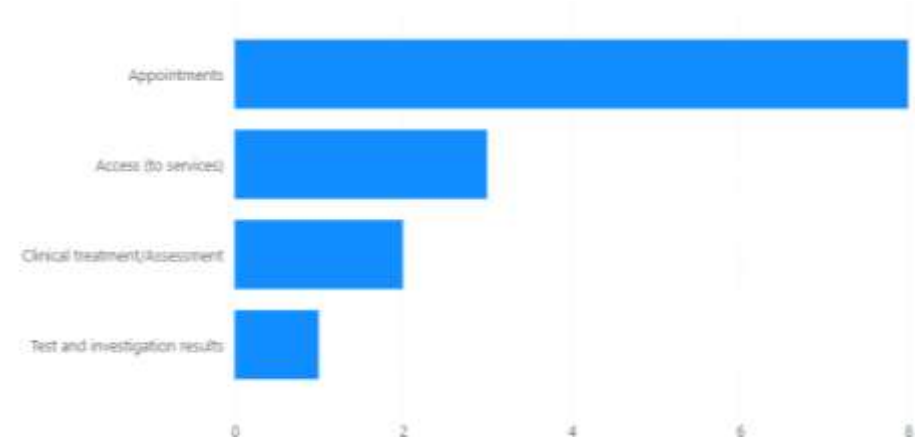
Grade	Count
Grade 1 – Minor - Informal	14
Grade 2 - Minor	0
Grade 3 - Moderate	0
Grade 4 – Major	0
Grade 5 – Catastrophic	0

Withybush Hospital (1st August 2018 – 31st March 2021) By Type



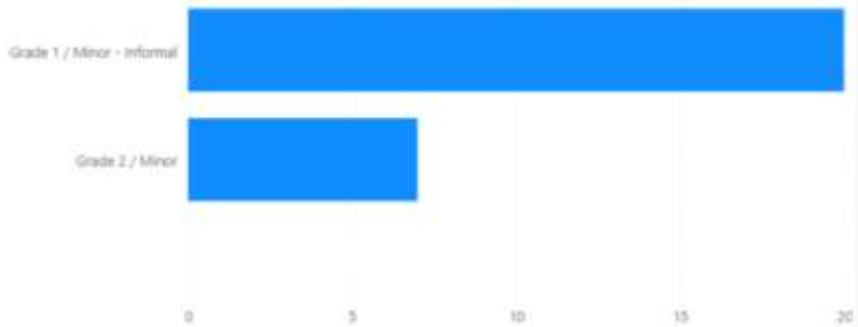
Subject (primary)	Count
Appointments	10
Infection Control	1

Withybush Hospital (1st April 2021 – 31st July 2023) By Type



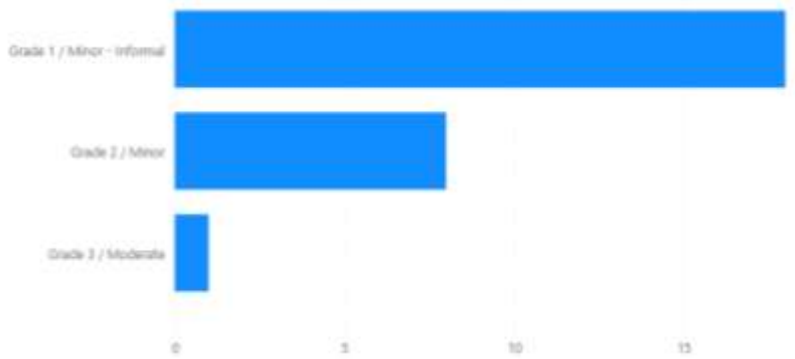
Subject (primary)	Count
Appointments	8
Access (to services)	3
Clinical treatment/Assessment	2
Test and investigation results	1

Glangwili Hospital (1st August 2018 – 31st March 2021) By Grading



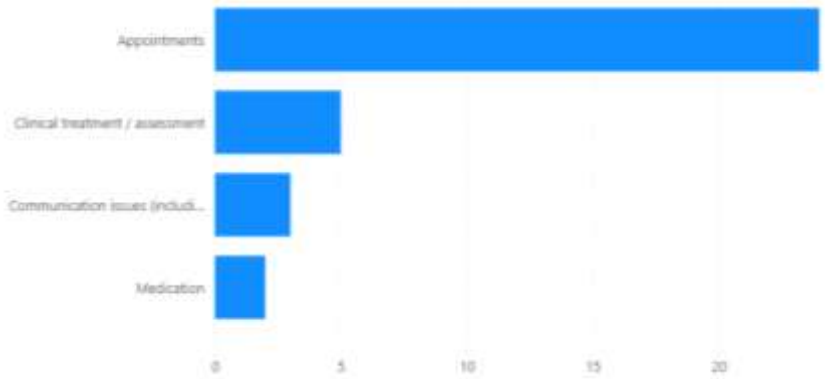
Grade	Count
Grade 1 – Minor - Informal	20
Grade 2 - Minor	7
Grade 3 - Moderate	0
Grade 4 – Major	0
Grade 5 – Catastrophic	0

Glangwili Hospital (1st April 2021 – 31st July 2023) By Grading



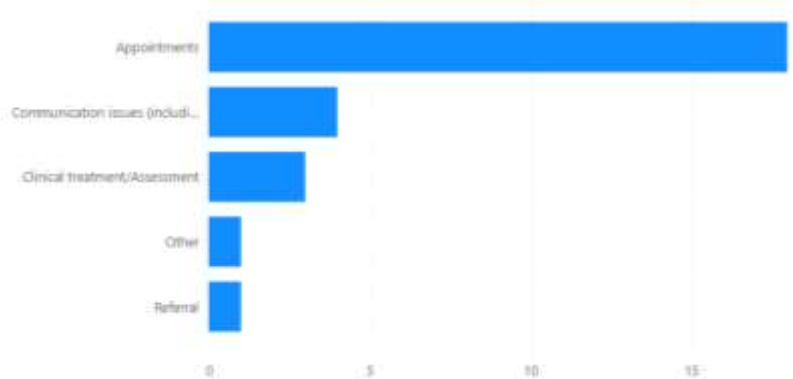
Grade	Count
Grade 1 – Minor - Informal	18
Grade 2 - Minor	8
Grade 3 - Moderate	1
Grade 4 - Major	0
Grade 5 – Catastrophic	0

Glangwili Hospital (1st August 2018 – 31st March 2021)
By Type



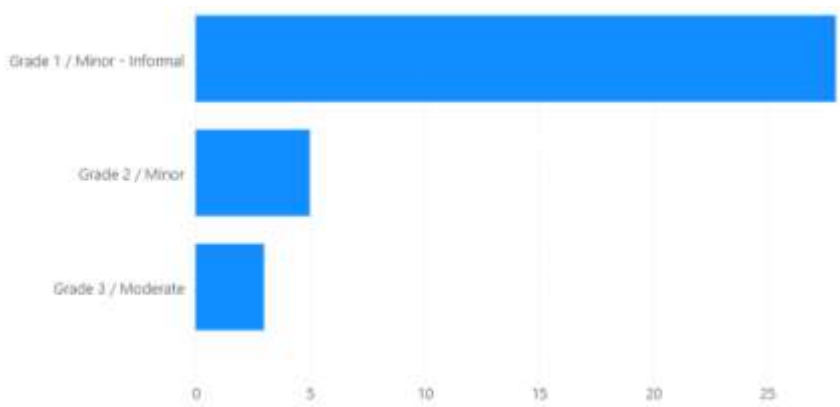
Subject (primary)	Count
Appointments	24
Clinical treatment/Assessment	5
Communication issues (including language)	3
Medication	2

Glangwili Hospital (1st April 2021 – 31st July 2023)
By Type



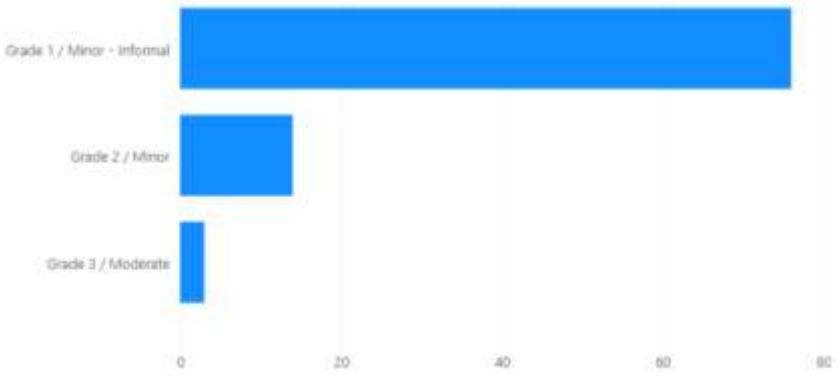
Subject (primary)	Count
Appointments	18
Communication issues (including language)	4
Clinical treatment/Assessment	3
Other	1
Referral	1

Prince Philip Hospital (1st August 2018 – 31st March 2021) By Grading



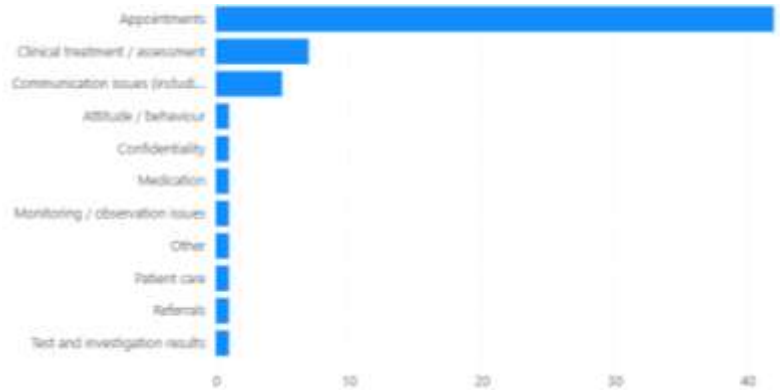
Grade	Count
Grade 1 – Minor - Informal	28
Grade 2 - Minor	5
Grade 3 - Moderate	3
Grade 4 – Major	0
Grade 5 – Catastrophic	0

Prince Philip Hospital (1st April 2021 – 31st July 2023) By Grading



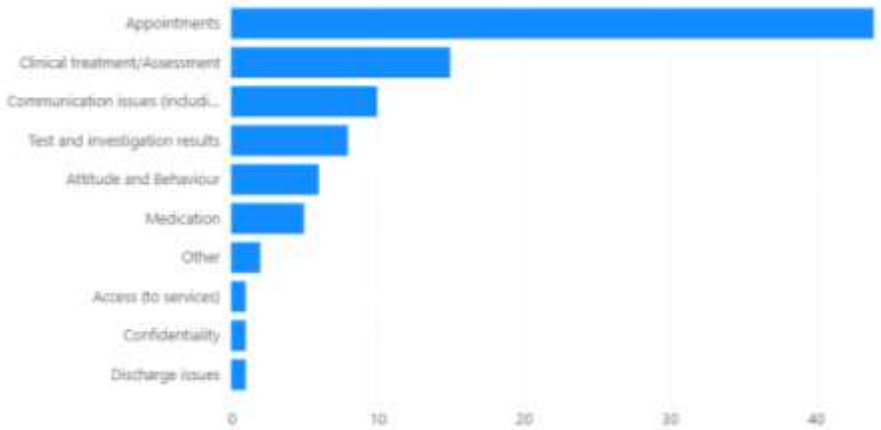
Grade	Count
Grade 1 – Minor - Informal	76
Grade 2 - Minor	14
Grade 3 - Moderate	3
Grade 4 – Major	0
Grade 5 – Catastrophic	0

Prince Philip Hospital (1st August 2018 – 31st March 2021) By Type



Subject (primary)	Count
Appointments	42
Clinical treatment / assessment	7
Communication issues (including language)	5
Attitude / behaviour	1
Confidentiality	1
Medication	1
Monitoring / observation issues	1
Other	1
Patient care	1
Referrals	1
Test and investigation results	1

Prince Philip Hospital (1st April 2021 – 31st July 2023) By Type



Subject (primary)	Count
Appointments	44
Clinical treatment/Assessment	15
Communication issues (including language)	10
Test and investigation results	8
Attitude and Behaviour	6
Medication	5
Other	2
Access (to services)	1
Confidentiality	1
Discharge issues	1

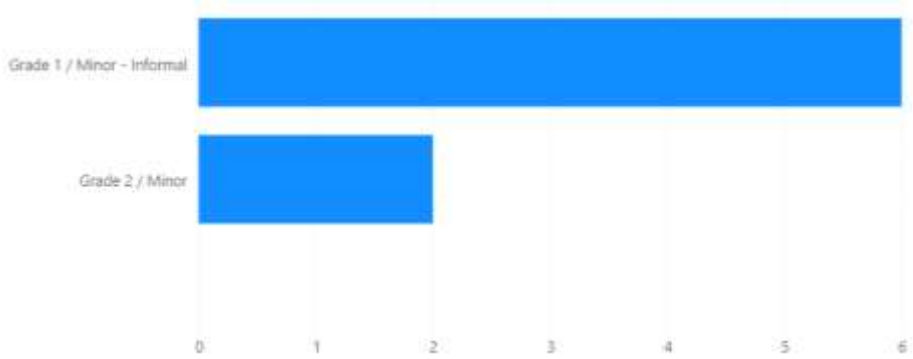
Blank Location Records (1st August 2018 – 31st March 2021) By Grading

Grade	Count
Grade 1 – Minor - Informal	2
Grade 3 – Moderate	1

Blank Location Records (1st August 2018 – 31st March 2021) By Type

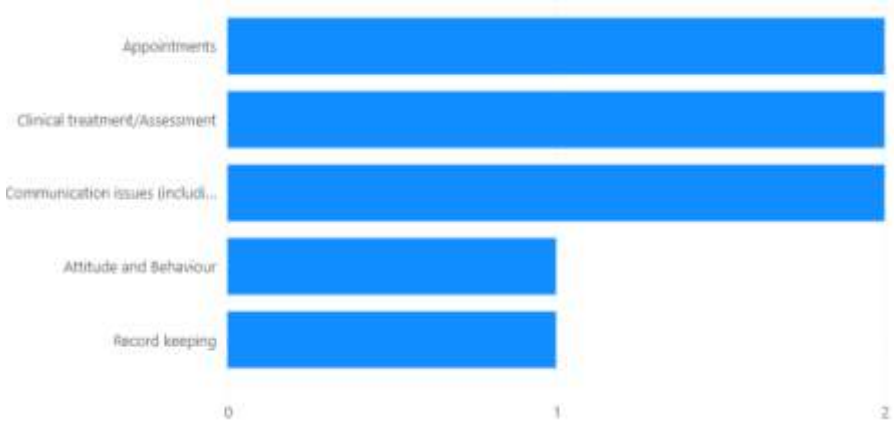
Subject (primary)	Count
Appointments	3
Access (to services)	1
Attitude / behaviour	1

Patient's Home (1st April 2021 – 31st July 2023)
By Grading



Grade	Count
Grade 1 – Minor - Informal	6
Grade 2 – Minor	2

Patient's Home (1st April 2021 – 31st July 2023)
By Type



Subject (primary)	Count
Appointments	2
Clinical treatment/Assessment	2
Communication issues (including language)	2
Attitude and Behaviour	1
Record Keeping	1

Dermatology Patient Experience Data Review

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Background

As per the approved Clinical Services Plan methodology, Patient Experience data captured has been included for Dermatology services at Prince Philip Hospital, Glangwili Hospital, Withybush Hospital, Cardigan Integrated Care Centre, and South Pembrokeshire Hospital.

Due to data formatting across the current Civica system and historical records, data has only been analysed from 1st April 2021 to 31st July 2023. Historical records, pre-April 2021, cannot be assigned to particular services in their entirety and so the methodology was updated to only analyse the current Civica system data.

Due to the implementation of the new Civica system, there was an initial decline in patient feedback as the system was being established and rolled out across the health board. The new system was implemented on a phased basis and therefore some services had a higher percentage of the feedback in the early stages. There will be an ongoing increase since the introduction of Civica as the health board's priority is to increase the volume of feedback.

Traditionally, emergency departments have always had a larger number of claims, complaints, and patient feedback due to activity numbers. Patients that have a number of appointments in a relatively short period of time within a service will generate more feedback.

It is possible that the data shows a variation in the number of reported complaints attributable to a service. This relates to the system not always being able to distinguish between different specialties within the service that may be related to other services within the system.

Due to the way records have been captured within the system and potential gaps in the data, the categorised totals may not equal overall totals per service.

Data that has been analysed includes All Wales Patient Experience data, Friends and Family Test data, and Compliments data. ‘The Big Thank You’ has been discarded in its entirety as the formatting of the data follows the same structure as pre-2021 data and therefore cannot be assigned to a particular service.

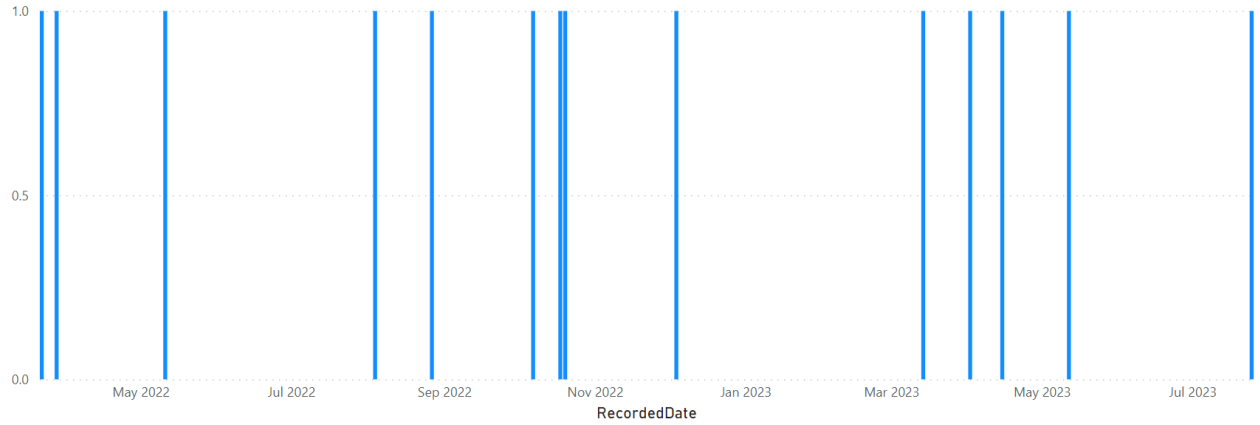
The thematic analysis was undertaken using Microsoft Copilot and has been used to provide a summary of themes per service per year based on the patient feedback received.

Service Changes

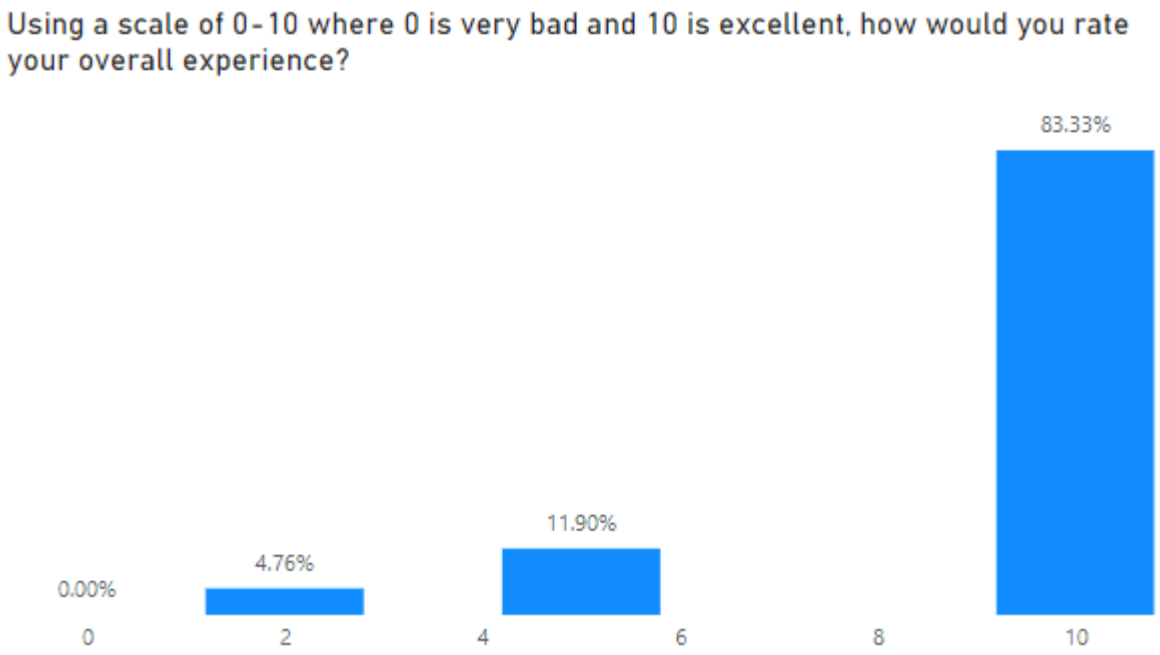
The temporary service changes in response to COVID-19 commenced 16 April 2020, and are therefore out of the date range that has been analysed for this data.

Patient Experience

All Wales Experience – Health Board Survey (1st April 2021 to 31st July 2023)



			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2021
			0	0	0	0	0	0	0	0	0	0
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2022
0	0	2	0	1	0	0	2	0	3	0	1	9
Jan	Feb	Mar	Apr	May	Jun	Jul						2023
0	0	1	2	1	0	1						5



Themes – 2022

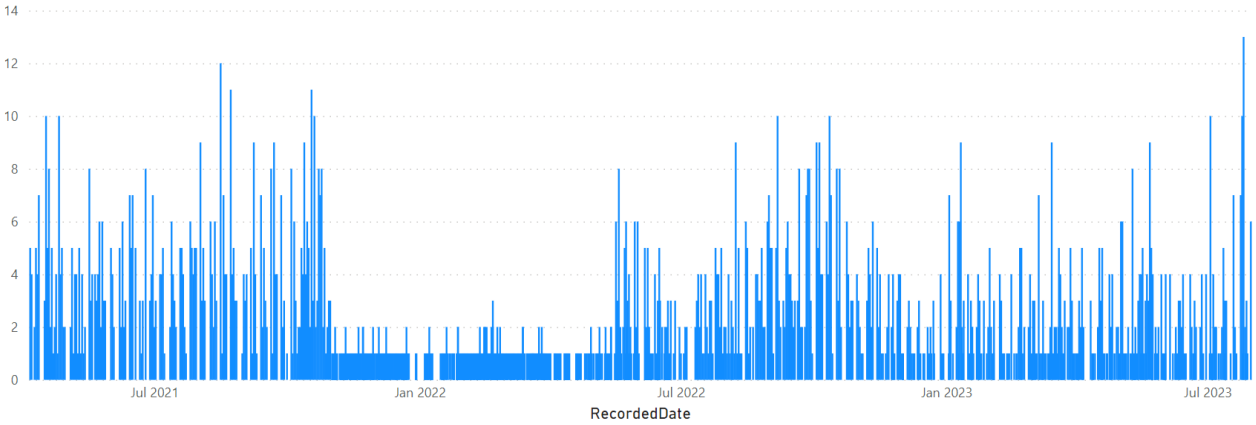
Most feedback is around appointments and staff interactions. Positive experiences include professionalism, friendliness and helpfulness of staff. Negative experiences include long wait times, multiple cancellations and poor communications.

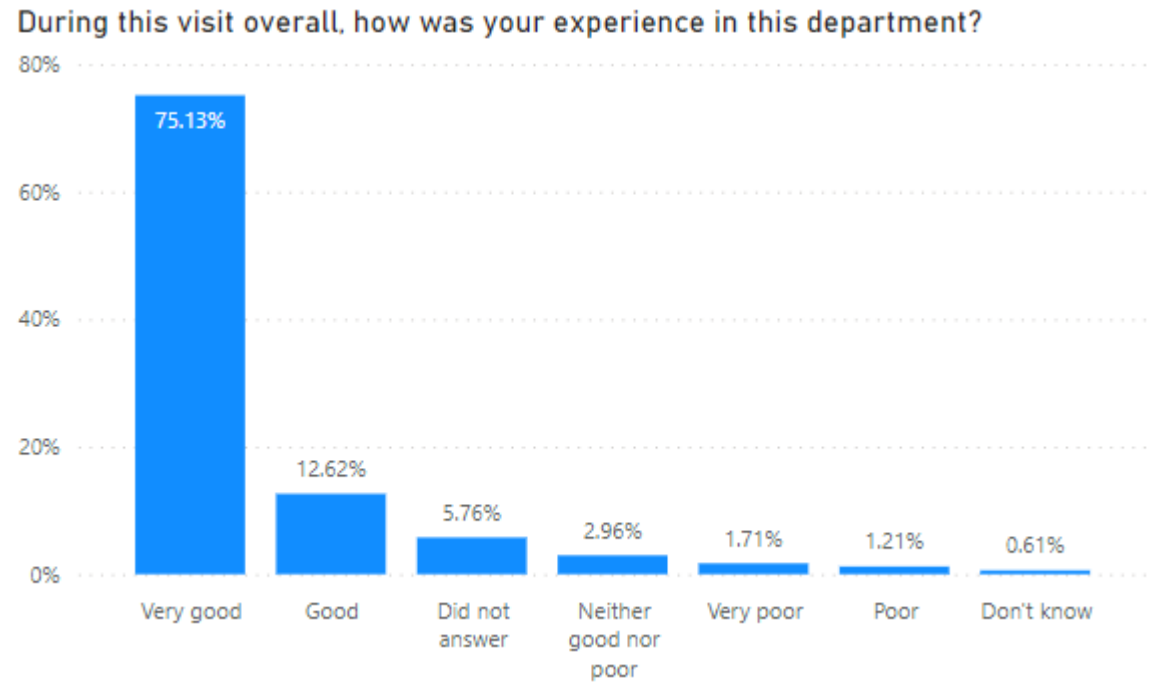
Themes – 2023

Most feedback is around appointments and staff interactions. Positive experiences include professionalism, friendliness and helpfulness of staff. Negative experiences include long wait times, multiple cancellations and poor communications.

Patient Experience

Friends and Family Test (1st April 2021 to 31st July 2023)





Themes – 2021

The themes arising are the efficiency and professionalism of the staff, the safety measures in place, and the friendliness of the clinicians. Many people felt safe and well taken care of during their visit, and appreciated the Covid precautions that were in place. The staff attitude was also frequently mentioned, with many people commenting on the good and efficient service they received.

Themes – 2022

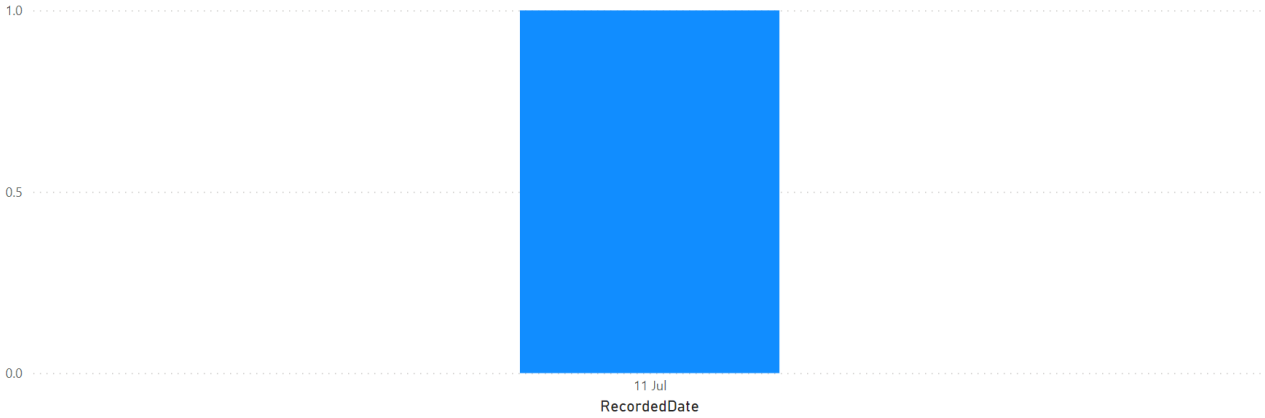
The themes arising include the friendliness, helpfulness, and professionalism of the staff, the efficiency of the service, and the informative nature of the treatment. There were a few negative comments mentioned, such as difficulty finding the room, long waiting times, and difficulty finding parking. Overall, the feedback was mostly positive, with patients expressing gratitude and satisfaction with the service they received.

Themes – 2023

The themes arising include the friendliness, helpfulness, and professionalism of the staff, the efficiency of the service, and the informative nature of the treatment. Positive comments mention short waiting times and appointments being on time, with staff giving clear and informative explanations around their treatment. There were a few negative comments mentioned, such as difficulty finding the room, long waiting times for appointments and difficulty finding parking.

Patient Experience

Compliments (1st April 2021 to 31st July 2023)



Recorded Date	Count
Jul 23	1

3 Sentiments that relate to Compliment

Sentiment	Count
Listening, Understanding, Calm	1

3 Health Board Values that relate to Compliment

Value	Count
Dignity, Respect, Caring	1

Themes – 2023

Theme arising is that staff were kind and caring in their support of patients.

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Workforce Data

Clinical Services Plan: Activity Modelling Workstream

DERMATOLOGY

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Glossary of terms

Term/Acronym	Definition
ESR	Electronic Staff Record – This is the National recording system within the NHS that houses all staff information. The majority of the workforce information contained within this report will have been extracted from the reporting functionality within the system.
WTE	Whole Time Equivalent – For the medical workforce 1WTE equates to a 40 hour working week or 10 sessions. For all other staff working in the NHS under AfC terms and conditions 1WTE equates to a full time position of 37.5 hour working week.
AfC	Agenda for Change is the current NHS grading and pay system for NHS staff across Wales, with the exception of doctors, dentists, apprentices and some very senior managers.
Cost code	The Health Board Budget is structured to take into account all areas that incur a cost and is therefore broken down into different directorate areas. Each of these areas is made up of a number of cost codes covering a particular service or location. Every member of staff employed within the Health Board will be allocated a position based on their role within a cost code. This allows finance and services to track and manage their costs relating to the service area in which they work.
Staff group	There are 9 staff groups to which workforce will belong dependent on their role. These are: Additional Professional Technical & Scientific; Additional Clinical Services; Administrative & Clerical; Allied Health Professionals; Estates & Ancillary; Healthcare Scientists; Medical & Dental; Nursing & Midwifery Registered and Students
TRAC	NHS Recruitment system

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Workforce Data Methodology overview

As part of the Activity Modelling workstream of the Clinical Services Plan the Strategic Workforce Planning team has provided the following report to assist the Workforce picture for the issues paper.

For the 9 Service areas noted, it is agreed that the Workforce data supplied will be based on the staffing consisted within the defined cost codes provided for each area. Where needed, additional information will be discussed with Service Managers as part of the current Task & Finish groups for each service.

As the scope of the project is to look at potential configuration changes for specific services, the workforce supporting the wider pathway will not be included within the data.

The data will focus on the clinical roles within the services i.e. Medical and Nursing workforce, but where available all professional group data from the cost codes will be presented.

To ensure any interdependencies are highlighted, any known workforce risks for the service will be included.

On the following pages the supplied cost codes for the service area are noted along with the intended outputs from each data set.

Due to the complexity of the workforce breakdown of some cost codes which can cover a number of service areas, where we may have not been able to disaggregate the specific workforce aligned to the service. Where these issues are raised within the data, this has been noted within the information provided.

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Workforce Data Sources and outputs

Workforce Area	Data Source	Output
Current Workforce	ESR Staff In Post for: 31st July 2023	Table/Graph denoting current Budget, Actual and Vacancies for each of the service areas based on cost codes supplied. This will be by Professional group and where possible by role and location (this will be determined by data availability for each area). Where possible this will also include details of any Temporary Workforce utilised.
Workforce Risks	Risk Register / Datix: 31st August 2023	Information on Current Service specific Workforce risks and any known interdependent service risks associated.
Historic Workforce Trend	ESR Staff in Post for 1st April 2018, 1st April 2019, 1st April 2020, 1st April 2021, 1st April 2022, 1st April 2023	Table/Graph denoting current Budget, Actual and Vacancies for each of the 9 service areas based on cost codes supplied for the period April 2018 to 2023. This will be by Professional group and where possible by role and location (this will be determined by data availability for each area).
Starters & Leavers	ESR Staff Movements Yearly data for 1st April to 31st March for each year	Table/Graph denoting number of Starters and Leavers across each of the service areas. As above, where possible additional information will be provided for role and location however we are aware for leavers some of this data is not available within ESR.
Recruitment Issues	TRAC / Recruitment Team	Information in table or narrative format detailing any known targeted campaign activity for each of the service areas across the time period 2018 – 2023. Additional data were available on volume of vacancies advertised in the last 12 months for each service.

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Dermatology Workforce Overview

31st July 2023

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Dermatology Workforce : Cost code 100CAR GGH Dermatology 0072 (as of 31st July 2023)

Staff Group	Role	Location/Site				Grand Total
		Borth Surgery	Glangwili General Hospital	Prince Philip Hospital	Withybush General Hospital	
Add Prof Scientific and Technic	Pharmacist			0.8		0.8
Add Prof Scientific and Technic Total				0.8		0.8
Additional Clinical Services	Assistant Practitioner Nursing			1.0		1.0
	Healthcare Assistant				1.0	1.0
Additional Clinical Services Total				1.0	1.0	2.0
Administrative and Clerical	Medical Secretary		4.0		1.0	5.0
	Officer	0.4				0.4
Administrative and Clerical Total		0.4	4.0		1.0	5.4
Healthcare Scientists	Healthcare Science Practitioner		1.0			1.0
Healthcare Scientists Total			1.0			1.0
Medical and Dental	Consultant			1.7		1.7
	Hospital Practitioner (Closed to new entrants)		0.3			0.3
	Specialty Doctor		0.2	2.0		2.2
Medical and Dental Total			0.5	3.7		4.2
Nursing and Midwifery Registered	Specialist Nurse Practitioner		4.3	1.0		5.3
Nursing and Midwifery Registered Total			4.3	1.0		5.3
	Additional Workforce*					4.2
	TOTAL	0.4	9.8	6.5	2.0	22.8

***Additional Workforce outside of the above cost code:**

Managerial Roles within cost codes 1455 equating to an additional 3WTE for Admin & Clerical Staff Group

SLA agreement with SBUHB Plastic Surgeons, 12 sessions per week equating to an additional 1.2WTE within the Medical Staff Group

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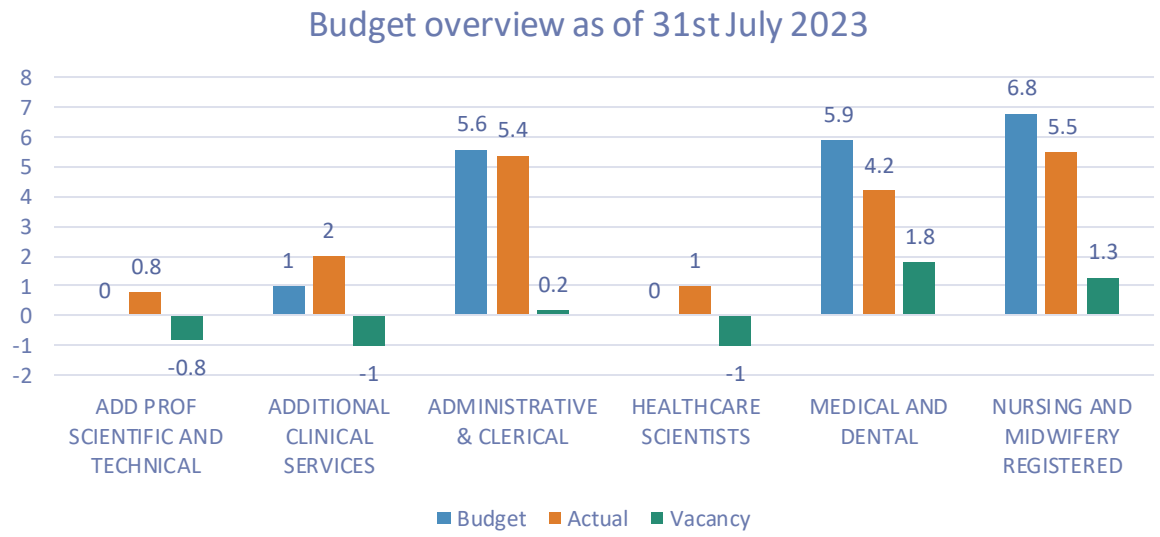
Dermatology Workforce continued (as of 31st July 2023)

Staff Group	Budget	Actual	Vacancy
ADD PROF SCIENTIFIC AND TECHNICAL	0.0	0.8	(0.8)
ADDITIONAL CLINICAL SERVICES	1.0	2.0	(1.0)
ADMINISTRATIVE & CLERICAL	5.6	5.4	0.2
HEALTHCARE SCIENTISTS	0.0	1.0	(1.0)
MEDICAL AND DENTAL	5.9	4.2	1.8
NURSING AND MIDWIFERY REGISTERED	6.8	5.5	1.3
Grand Total	19.3	18.9	0.5



The table and graph show the current Budget, Actual workforce in post and the vacancies within the Dermatology service.

As of 31st July 2023 there was a total of 0.5WTE vacancies within the service however as can be seen a number of these roles are not within the current budget, 0.8 WTE within Add Prof, Scientific and Technical roles; 1WTE within Additional Clinical Services and 1WTE Healthcare Scientist.

The highest vacancies are within the Medical & Dental and Nursing & Midwifery workforce (1.8WTE and 1.3WTE).

During this period no additional temporary staffing was utilised.

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Workforce Risks

The below Workforce themed risk appeared on Datix (as of 31st August 2023).

Service Risk No. (Linked to Corporate Risk 1649)	Directorate	Risk Statement	Workforce Themes	Workforce Control Mesaures in place	Current Risk Score	RAG Rating	Staff Group/ Groups affected
747	**Scheduled Care: Dermatology**	There is a risk that the Dermatology service within the Health Board will not be able to sustainably provide timely or appropriate care to patients, leading to avoidable harm. This includes timely triaging referrals.This is caused by the long-term Consultant vacancies within Dermatology as a result of a national shortage of suitably trained clinicians. This is coupled with an increase in demand for condition management and increased complexity of treatment pathways. There is only one non-medical prescriber to manage patients that require hospital-only medications. The service relies on in-sourcing to bridge the gap in capacity. This will lead to an impact/effect on the ability for services to be delivered in 3 Counties within appropriate clinical timeframes. Patients not receiving triage referrals in a timely manner, along with timely prescriptions for medicines. This relates to routine new appointment and treatment pathways, including phototherapy services, Cancer referrals and follow-up care. Risk location, Health Board wide.	**Long-term medical vacancies, locum usage.**	Hywel Dda have established a local MDT and continue to link with Swansea for a regional model. Support with triage of new referrals. Review of service provision on each site and booking of patients in order of waiting times using next available appointments. Commissioning of in-sourcing team to support outpatient demand. ARCH have established a forum to explore regional working models in Dermatology. Continuing to actively recruit and advertise Nursing and medical positions as vacancies arise. Advanced pharmacist recruited, and Medical Team prescribing hospital-only medications for patients. Successfully recruited 3 Speciality Doctors, 1 locum consultant, 1 part time locum consultant and 2 part-time plastic surgeons. Rapid access slots at the end of each inflammatory clinic to support the emergency general Derm conditions. Business governance meetings have been re-established.	**8**		**Medical**

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Dermatology Workforce Overview

Historic picture

April 2018 – April 2023

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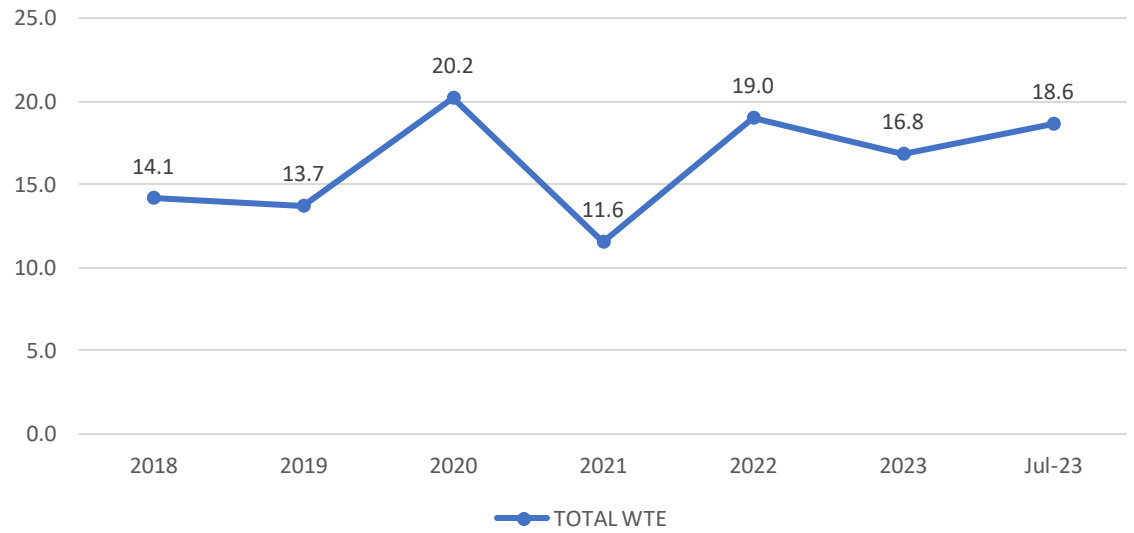
University Health Board

Historic Workforce

The data below shows a historic picture of the ESR Staff in post for cost code 0072 as at 1st April each year.

Dermatology Cost code 0072	2018	2019	2020	2021	2022	2023	Jul-23
Add Prof Scientific and Technic			0.8	0.8	0.8	0.8	0.8
Additional Clinical Services	1.0	1.0	2.0	1.0	2.0	2.0	2.0
Administrative and Clerical	3.4	2.4	5.4	3.4	5.4	6.4	5.4
Healthcare Scientists			1.0				1.0
Medical and Dental	3.7	2.7	4.2	0.7	4.7	2.2	4.2
Nursing and Midwifery Registered	6.0	7.6	6.9	5.7	6.1	5.5	5.3
TOTAL WTE	14.1	13.7	20.3	11.6	19.0	16.9	18.7



An increase in workforce can be seen in 2020 of 6.5WTE however this followed with a significant decrease to the service in 2021 of 8.6WTE. In the preceding years the workforce has increased to 18.6WTE as at 31st July 2023.

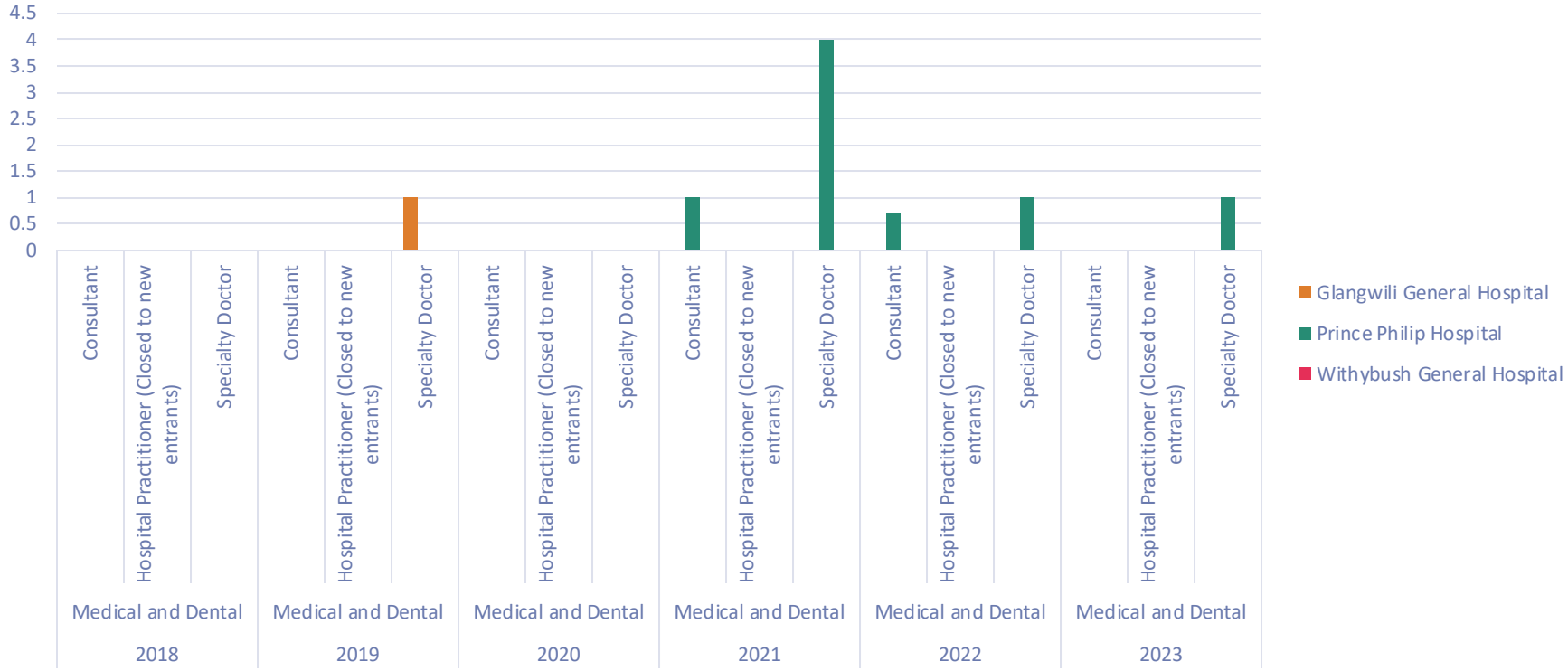
Additional service insights

Significant drop in Medical & Dental roles 2021 - key theme for loss of doctors is the ongoing lack of a substantive consultant dermatologist (i.e. lack of a clinical lead). Staff feel unsupported and leave to join roles in other Health Boards with better clinical structure and clinical leadership

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Starters



	2018	2019	2020	2021	2022	2023.0
Starters	0	1	0	5.0	1.7	1.0

An increase of 5 new starters were seen in 2021 in middle grade speciality doctors within Dermatology. The highest increase of staff across the five year period.

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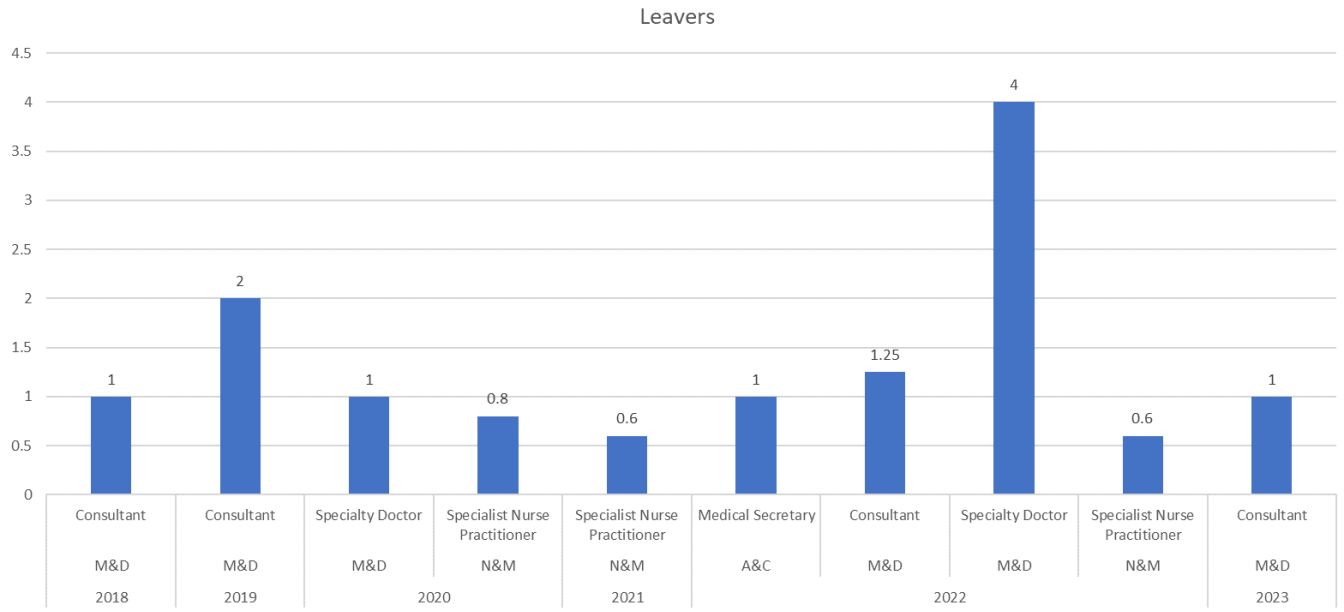
Leavers



Leavers	2018	2019	2020	2021	2022	2023
Medical & Dental	1	2	1		5.25	1.0
Nursing & Midwifery			0.8	0.6	0.6	
Admin & Clerical					1	
Total	**1**	**2**	**1.8**	**0.6**	**6.85**	**1**

The loss of 4 speciality middle grade doctors in 2022 was due to the lack of a substantive consultant dermatologist (i.e. lack of a clinical lead). A number of the staff had started in 2021 however felt unsupported due to the lack of a clinical lead and therefore left to join roles in other Health Boards with better clinical structure and clinical leadership.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
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Hywel Dda
University Health Board

Recruitment

Targeted Campaigns across the period 2018 – 2023:

No targeted recruitment campaigns were noted during the period for Dermatology

Vacancy /Recruitment overview:

Vacancy Information (last 12 months)	Outcomes
100-MED-PPH-073	5 offered - 3 withdrawn - 2 started in post
100-MED-PPH-073-A	1 onboarding
100-MED-PPH-062-L	Locum Consultant in Dermatology - 1 WTE, 1 started in post
100-MED-PPH-074-L	Locum Consultant in Dermatology - 1 WTE, 0 applications
100-MED-PPH-074-L1	Locum Consultant in Dermatology - 1 WTE, 1 started in post

Headhunting:

44 Doctors were headhunted via LinkedIn across the last 12 months (2022-2023).
2 responses were received however neither wanted to relocate to Wales.

Hywel Dda University Health Board
Equality Impact Assessment (EqIA)

Please note:

Equality Impact Assessments (EqIA) are used to support the scrutiny process of procedures / proposals / projects by identifying the impacts of key areas of action before any final decisions or recommendations are made.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions please consult the Health Board's Equality and Health Impact Assessment Guidance Document and associated forms.

The completed Equality Impact Assessment (EqIA) must be:

- Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval.
- Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.

For in-house advice and assistance with Assessing for Impact, please contact:

Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Form 1: Overview

1.	**What are you Equality Impact assessing?**	Dermatology Service
2.	**Brief Aims and Description**	This is an EQIA of the Dermatology Service in status quo.
3.	**Who is involved in undertaking this EqIA?**	The Dermatology Department
4.	**Is the Policy related to other policies/areas of work?**	- All Wales Safeguarding Procedure (policy no. 868) 868 - All Wales Safeguarding Procedures (sharepoint.com) - Clinical Record Keeping Policy (policy no. 195) 195 - Clinical Record Keeping Policy (sharepoint.com) - Equality and Diversity Policy (policy no. 133) hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/equality-diversity-and-inclusion-policy/ - All NICE and other National Guidance Implementation Policy (policy no. 013) 013 - Management of NICE and other National Guidance Policy (sharepoint.com)
5.	**Who will be affected by the strategy / policy / plan / procedure / service?** (Consider staff as well as the population that the project / change may affect to different degrees)	- All patients under and referred to the secondary care Dermatology service - All staff working within and in partnership with the Dermatology service

6.	**What might help/hinder the success of the Policy?**	Engagement from key stakeholders along the process will support the Clinical Services Plan to successfully draw up all the required information to allow for a successful service review. Elements that might hinder the process relate to lack of resources such as staffing time and availability to engage with the process, lack of or reduced information available to inform the review as required.

Form 2: Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below.

Depending on the Policy you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the Policy relevant to:	**Yes**	**No**
Article 2: The right to life **Example**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control	✓	
Article 3: The right not to be tortured or treated in an inhuman or degrading way **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control	✓	
Article 5: The right to liberty **Example**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control	✓	
Article 6: The right to a fair trial **Example**: issues of patient choice, control, empowerment and independence	✓	

Article 8: The right to respect for private and family life, home and correspondence; Issues of patient restraint and control **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life	✓	
Article 11: The right to freedom of thought, conscience and religion **Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers	✓	

Form 3 Gathering of Evidence and Assessment of Potential Impact

<table>
<tr><th>How will the strategy, policy, plan, procedure and/or service impact on:</th><th>Positive</th><th>Negative</th><th>No impact</th><th>Potential positive and / or negative impacts

Please include unintended consequences, opportunities or gaps. This section should also include evidence to support your view e.g. staff or population data.</th><th>Opportunities for improvement / mitigation
If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan.</th></tr>
<tr><td>Age
Is it likely to affect older and younger people in different ways or affect one age group and not another?</td><td>✓</td><td>✓</td><td></td><td><u>Population Data</u>
<table>
<tr><td>County</td><td colspan="2">Carms</td><td colspan="2">Cere</td><td colspan="2">Pembs</td><td colspan="2">Total</td></tr>
<tr><td>Age</td><td>value</td><td>%</td><td>value</td><td>%</td><td>value</td><td>%</td><td>value</td><td>%</td></tr>
<tr><td>Total: All usual residents</td><td>187,895</td><td>100</td><td>71,468</td><td>100</td><td>123,366</td><td>100</td><td>382,729</td><td>100.0</td></tr>
<tr><td>Aged 4 years and under</td><td>9,057</td><td>4.8</td><td>2,706</td><td>3.8</td><td>5,586</td><td>4.5</td><td>17,349</td><td>4.4</td></tr>
<tr><td>Aged 5 to 9 years</td><td>10,274</td><td>5.5</td><td>3,288</td><td>4.6</td><td>6,731</td><td>5.5</td><td>20,293</td><td>5.2</td></tr>
<tr><td>Aged 10 to 15 years</td><td>13,080</td><td>7</td><td>4,087</td><td>5.7</td><td>8,494</td><td>6.9</td><td>25,661</td><td>6.5</td></tr>
<tr><td>Aged 16 to 19 years</td><td>7,799</td><td>4.2</td><td>4,129</td><td>5.8</td><td>4,890</td><td>4</td><td>16,818</td><td>4.7</td></tr>
<tr><td>Aged 20 to 24 years</td><td>8,821</td><td>4.7</td><td>6,366</td><td>8.9</td><td>5,621</td><td>4.6</td><td>20,808</td><td>6.1</td></tr>
<tr><td>Aged 25 to 34 years</td><td>20,692</td><td>11</td><td>7,106</td><td>9.9</td><td>12,907</td><td>10.5</td><td>40,705</td><td>10.5</td></tr>
<tr><td>Aged 35 to 49 years</td><td>31,801</td><td>16.9</td><td>10,145</td><td>14.2</td><td>19,459</td><td>15.8</td><td>61,405</td><td>15.6</td></tr>
<tr><td>Aged 50 to 64 years</td><td>40,905</td><td>21.8</td><td>15,256</td><td>21.3</td><td>27,335</td><td>22.2</td><td>83,496</td><td>21.8</td></tr>
<tr><td>Aged 65 to 74 years</td><td>24,605</td><td>13.1</td><td>9,942</td><td>13.9</td><td>17,444</td><td>14.1</td><td>51,991</td><td>13.7</td></tr>
<tr><td>Aged 75 to 84 years</td><td>15,246</td><td>8.1</td><td>6,095</td><td>8.5</td><td>10,855</td><td>8.8</td><td>32,196</td><td>8.5</td></tr>
</table></td><td></td></tr>
</table>

Aged 85 years and over	5,615	3	2,348	3.3	4,044	3.3	12,007	3.2

Staff Data

Age Range	
26- 40	14
41 to 55	7
56 and over	6

*Some of the Age Bands result in headcounts totalling under 5 to which we are not allowed to publish due to the possibility of identification.

Patient Data

*Data source for the patient data provided is from the Clinical Services Plan Early Engagement respondent profile, which represents a small fraction of the patient cohort.

	Questionnaire responses	
Characteristics	Number of respondents	%
34 or under	9	2%
35 - 44	14	4%
45 - 54	30	8%
55 - 64	95	26%
65 - 74	163	45%
75 or over	53	15%
Total Number of Valid respondents	364	100%

- Actinic Keratosis usually present in Middle aged and elderly individuals. As above in the population table there are 47.2%

				of the population above 50 that this would impact. British Association of Dermatologists' guidelines for the care of patients with actinic keratosis 2017 | British Journal of Dermatology | Oxford Academic (oup.com) • Registry data collection in England has confirmed that the incidences of Basal Cell Carcinomas increase with age. British Association of Dermatologists guidelines for the management of adults with basal cell carcinoma 2021* | British Journal of Dermatology | Oxford Academic (oup.com) • Eczema affects approximately 1 in 5 babies and children in the UK. According to the population data above 9.6% of the population is under 10 years old. Overview | Atopic eczema in under 12s: diagnosis and management | Guidance | NICE • Acne is a skin condition that affects many people, most commonly teenagers and young adults. As per the population data above, 17.3% of the population is in the age range of 10 years old to 24 years old. Overview | Acne vulgaris: management | Guidance | NICE • Melanomas are more common in older people; people who spend a lot of time in the sunlight. Overview | Melanoma: assessment and management | Guidance | NICE • Cutaneous Squamous Cell Carcinoma is the sixth most common cancer in the UK and continuing to rise. Increasing longevity (longer life expectancy) may also be responsible for the increasing incidence of these tumours. British Association of Dermatologists guidelines for the management of people with cutaneous squamous cell carcinoma 2020* | British Journal of Dermatology | Oxford Academic (oup.com) • Psoriasis can start at any age, but it is less common in children.	

				Overview | Psoriasis: assessment and management | Guidance | NICE • Hidradenitis Suppurativa - The typical age of onset is in the second to fourth decades of life. According to the population data above there is 16.6% of the population in the Hywel Dda area that are in the age range of 20 – 34 years old. British Association of Dermatologists guidelines for the management of hidradenitis suppurativa (acne inversa) 2018 | British Journal of Dermatology | Oxford Academic (oup.com) **Positive impact** All Health board staff undertake equalities (including Safeguarding Adults, Safeguarding Children and Dementia Awareness) training relating specifically to age as part of mandatory competency training. **Negative Impact** • Minor Operations - we do not perform minor operations on patients under 16, due to no surgical treatment pathway in Prince Philip or Withybush Hospital. • Teledermoscopy service – We are not able take dermoscopic pictures of lesions on children. Skin cancers are rare in children. The skin lesions on children should be assessed in a face-to-face clinic by clinicians with experience in paediatric dermatology to establish clear clinical history.	• Ensure mandatory training (including Safeguarding Adults, Safeguarding Children and Dementia Awareness) training relating specifically to age is kept up to date for all staff. • Minor Operations – Patients under 16 will be referred to a Paediatric Plastics Surgeon based in Swansea Bay University Health Board who will undertake the minor operations. • Teledermoscopy - However this could be perceived as a positive impact as patients under 16 will be seen in dedicated face to face clinics so that the clinicians can have a discussion with the parents

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Patients under 17 years old are unable to drive so will therefore be dependent on family members / guardians to bring them to hospital appointments.
Older patients are more likely to have mobility issues. Therefore, rely upon transport either from hospital transport or relatives.
Patients who are seen in Cardigan Integrated Care Centre are not able to use hospital transport, as hospital transport does not provide a service for this facility.
Older patients may have the additional challenge of having a relative, friend or carer to attend secondary care with them.
Older patients may have issues walking around the hospital and will therefore be required to be dropped off at the hospital entrances, due to some parking bays being further away from the entrances.
Working age patients are more likely to require flexible clinics or virtual clinics to work around their jobs.

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with regards to the management plan going forwards.

There is hospital transport available for patients that are eligible.
Patients that are invited to Cardigan Integrated Care Centre but use hospital transport will be offered an appointment at one of the acute / community hospital sites.
All sites will have accessible toilets.
Wheelchairs are widely available at hospital entrances.
When required, clinical staff will support the patients acting as a chaperone for their appointments or treatment.
We have various virtual clinics (Attend Anywhere / Telephone clinics) for inflammatory patients if they meet the criteria for a virtual follow up.

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<tr>
<td>Disability
Those with a physical disability,</td>
<td>✓</td>
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<td>
<u>Population Data</u>
<table>
<tr><th></th><th>Carms</th><th>Cere</th><th>Pembs</th><th>Total</th></tr>
<tr><td>Disabled under the Equality Act: Day-to-day activities limited a lot</td><td>21225</td><td>6686</td><td>12522</td><td>40463</td></tr>
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learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes

Disabled under the Equality Act: Day-to-day activities limited a little	21897	8951	14651	45499
	43152	15637	27173	85,963
Total population	187,895	71,468	123,366	382,729
Percentage of population with a disability	23%	22%	22%	22%

Staff Data

Disability	
No	23
Other	4

*Other has been made up of 'yes' and 'unspecified' due to the potential identification where the headcount figures were under 5.

Patient Data

*Data source for the patient data provided is from the Clinical Services Plan Early Engagement respondent profile, which represents a small fraction of patient cohort.

Characteristics	Questionnaire responses	
	Number of respondents	%
Has a disability	57	16%
No Disability	293	84%
Total Number of Valid respondents	350	100%
Not known	*158*	-

Positive impact

- All Health Board staff undertake equalities (including Paul Ridd Learning Disability Awareness, Equality, Diversity and Human Rights, Autism awareness and Mental Capacity Act)

- The Health Board has a series of resources available, as part of the Wellbeing Service, who support staff with physical disorders and management of

				training relating specifically to disabilities as part of mandatory competency training. • All main sites have hearing loops fitted into the Outpatient's reception areas. • Telephone calls to patients who are unable to read appointment letters can be requested (providing that this information is made available when booking appointments). • Patient leaflets and information are available through the Health Board in easy read documents should patients have difficulties in reading the documents. • Patients who are deaf can request specific interpreters through the information and translation services offered by the Health Board. • Patients with physical / sensory / cognitive impairments will be able to access the dermatology service. **Negative Impact** • Some patients find it hard in sitting in crowded waiting areas. Patients with disabilities can have issues with: • Locating the building / service within the building • Accessing areas physically – ramps, steps, etc.	mental health and psychological concerns. • The service can offer virtual follow ups for certain clinical conditions (inflammatory) within a certain criteria. The service holds several lesion clinics in the evening in Prince Philip Hospital where the waiting rooms are less crowded and quieter. • Porters in the acute hospital sites are available to support patients who are unable to walk long distances. • Wheelchairs are available at the entrance of acute hospitals for those who are unable to

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Accessing accessible transport
Difficulty walking long distances

</td>
<td>walk long distances.

All hospital sites adhere to minimum accessibility standards.
There are drop off points at the entrance of the hospitals and community centres, for patients to be dropped off closer to the entrance, avoiding parking in the car parks and walking long distances.
Hospital transport is available for patients that meet the criteria for the acute and community hospitals.
Wide trolleys and chairs are available to use for bariatric patients.
There are facilities in the Outpatient's department for the patients to come in on hospital beds and trolleys.

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<tr>
<td>Gender Reassignment
Consider the potential impact on individuals who either:

•Have undergone, intend to undergo or are currently</td>
<td></td>
<td></td>
<td>✓</td>
<td><u>Population Data</u>
<table>
<tr><th>County</th><th colspan="2">Carms</th><th colspan="2">Cere</th><th colspan="2">Pembs</th><th colspan="2">Total</th></tr>
<tr><th>Gender</th><th>value</th><th>%</th><th>value</th><th>%</th><th>value</th><th>%</th><th>value</th><th>%</th></tr>
<tr><td>All persons</td><td>187,897</td><td>100</td><td>71,475</td><td>100</td><td>123,360</td><td>100</td><td>382,732</td><td>100.0</td></tr>
<tr><td>Male</td><td>91,685</td><td>48.8</td><td>34,963</td><td>48.9</td><td>60,071</td><td>48.7</td><td>186,719</td><td>48.8</td></tr>
<tr><td>Female</td><td>96,212</td><td>51.2</td><td>36,512</td><td>51.1</td><td>63,289</td><td>51.3</td><td>196,013</td><td>51.2</td></tr>
<tr><td>Gender identity the same as sex registered at birth</td><td>144,924</td><td>93.2</td><td>55,874</td><td>91</td><td>95,794</td><td>93.4</td><td>296,592</td><td>92.5</td></tr>
<tr><td>Gender identity different from sex registered at</td><td>210</td><td>0.1</td><td>84</td><td>0.1</td><td>121</td><td>0.1</td><td>415</td><td>0.1</td></tr>
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undergoing gender reassignment. •Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.										

birth but no specific identity given								
Trans woman	93	0.1	73	0.1	58	0.1	224	0.1
Trans man	90	0.1	62	0.1	66	0.1	218	0.1
Non-binary	60	0	143	0.2	40	0	243	0.1
All other gender identities	38	0	66	0.1	32	0	136	0.0

Staff Data

Data is currently not available.

Patient Data

Data is currently not available.

- Correct title of patients will be used for those undergoing/having undergone gender reassignment.
- Welsh Government guidance advocates a patient centred approach to meet individual needs.

Positive impact

All Health Board staff undertake equalities (including Equality, Diversity and Human Rights) training relating specifically to gender identity as part of mandatory competency training.

Patient confidentiality is maintained using the Health Board guidelines regarding confidentiality.

Negative Impact

Regarding specific medication, those assigned female at birth who now identify as male/non-binary may need to still be considered for the Pregnancy Prevention Program. Those assigned male at birth who now identify as female / non-binary will not. This may impact

- For Isotretinoin there is a section on the new form for the lead prescriber to record if

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<td>discussion around pregnancy / contraception for initiating systemic or biologic medication.</td>
<td>the patient does or does not require contraception, as per their clinical judgement which is kept confidential if the patient wishes. The form is stored in the patient notes which is confidential. Details may be in clinic letters on Welsh Clinical Portal which also helps staff to know without asking. For the other oral retinoid there is no form, but details can be stored in letters on Welsh Clinical Portal.</td>
</tr>
<tr>
<td>Marriage and Civil Partnership
This also covers those who are not married or in a civil partnership.</td>
<td></td>
<td></td>
<td>✓</td>
<td><u>Population Data</u>

There is currently no data available for the population regarding Marriage and Civil Partnership. However, population data will be included at the earliest possible opportunity.

<u>Staff Data</u>

<table>
<tr><th>Marital Status</th><th></th></tr>
<tr><td>Civil Partnership / Married</td><td>21</td></tr>
<tr><td>Other</td><td>6</td></tr>
</table>

*Other was made up of ‘single’ and ‘unknown’ as a potential identification of headcount numbers being under 5.

<u>Patient Data</u>

*Data source for the patient data provided is from the Clinical Services Plan Early Engagement respondent profile, which represents a small fraction of patient cohort.</td>
<td></td>
</tr>
</table>

Married Status	Number of respondents (Unweighted Count)	% of respondents (Unweighted Count)
Married / in a civil partnership	274	78%
Not Married / Not in a Civil Partnership	77	22%
Total Number of Valid respondents	351	100%
Not known	*157*	-

Positive impact

Negative Impact

No impact currently identified based on marital status on a person's ability to access the service, though this will be reviewed when undertaking service change.

Pregnancy and Maternity Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.	✓	✓		**Population Data** In 2021, there were 29,007 births registered across Wales. Maternity and birth statistics: 2021 | GOV.WALES **Staff Data** There is currently no data available for the staff regarding pregnancy and maternity. However, staff data will be included at the earliest possible opportunity. **Patient Data** There is currently no data available for the patients regarding pregnancy and maternity. However, patient data will be included at the earliest possible opportunity. **Positive impact** The Health Board has clear policies to address pregnancy and maternity. Risk assessments for staff are carried out and actioned when needed. Workforce and Occupational Health Teams can support with specific concerns. hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/leave-and-pay-for-new-and-existing-parents-policy/ hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/new-and-expectant-mothers-	

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Negative Impact

• Many of the biologic and systemic medications are unsuitable in pregnancy and have not been studied in breastfeeding.</td>
<td>• Should medication be required during pregnancy, alternative treatment would be offered, until the patient is able to receive such treatment.</td>
</tr>
<tr>
<td>Race/Ethnicity or Nationality
People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, gypsies/travellers, asylum seekers and migrant workers.</td>
<td></td>
<td></td>
<td>✓</td>
<td><u>Population Data</u>
<table>
<tr><td>County</td><td colspan="2">Carms</td><td colspan="2">Cere</td><td colspan="2">Pembs</td><td colspan="2">Total</td></tr>
<tr><td>Ethnicity</td><td>Value</td><td>%</td><td>Value</td><td>%</td><td>Value</td><td>%</td><td>Value</td><td>%</td></tr>
<tr><td>Total: All usual residents</td><td>187,898</td><td>100</td><td>71,473</td><td>100</td><td>123,359</td><td>100</td><td>382,730</td><td>100</td></tr>
<tr><td>Asian, Asian British or Asian Welsh</td><td>2,321</td><td>1.2</td><td>1,096</td><td>1.5</td><td>1,159</td><td>0.9</td><td>4,576</td><td>1.2</td></tr>
<tr><td>Black, Black British, Black Welsh, Caribbean or African</td><td>455</td><td>0.2</td><td>366</td><td>0.5</td><td>244</td><td>0.2</td><td>1,065</td><td>0.3</td></tr>
<tr><td>Mixed or Multiple ethnic groups</td><td>1,756</td><td>0.9</td><td>867</td><td>1.2</td><td>1,162</td><td>0.9</td><td>3,785</td><td>1</td></tr>
<tr><td>White</td><td>182,652</td><td>97.2</td><td>68,776</td><td>96.2</td><td>120,375</td><td>97.6</td><td>371,803</td><td>97</td></tr>
<tr><td>Gypsy or Traveller</td><td>450</td><td>0.2</td><td>55</td><td>0.08</td><td>585</td><td>0.5</td><td>1,090</td><td>0.3</td></tr>
<tr><td>Another ethnic group</td><td>714</td><td>0.4</td><td>368</td><td>0.5</td><td>419</td><td>0.3</td><td>1,501</td><td>0.4</td></tr>
</table></td>
<td></td>
</tr>
</table>

Staff Data

Ethnicity	
White	21
Other	6

*Other was made up of ‘BME’ and ‘Not stated’ as these were potential identification numbers less than 5.

Patient Data

*Data source for the patient data provided is from the Clinical Services Plan Early Engagement respondent profile, which represents a small fraction of patient cohort.

Ethnic Group	Number of respondents (Unweighted Count)	% of respondents (Unweighted Count)
White British	309	88%
White other	34	10%
Any other Ethnic Group	8	2%
Total Number of Valid respondents	351	100%
Not known	*157*	-

- Melanoma is most common in people with pale skin, however it is often diagnosed at a more advanced stage in people with darker skin. This highlights a need for equal opportunity of diagnoses for people with darker skin. The risk factors are skin that tends to burn in the sun, having many moles, intermittent sun exposure and sunburn. Context | Melanoma: assessment and management | Guidance | NICE

- Squamous Cell Carcinoma: Its occurrence is usually related to chronic ultraviolet (UV) exposure and is therefore

				especially common in people with sun-damaged skin, fair skin, albinism and xeroderma pigmentosum. British Association of Dermatologists guidelines for the management of people with cutaneous squamous cell carcinoma 2020* | British Journal of Dermatology | Oxford Academic (oup.com) • Within the Health Board there is a Black, Asian, and Minority Ethnic staff network, which offers advice and support to staff from Black, Asian, and Minority Ethnic backgrounds. The network offers staff the opportunity to come together to discuss any common issues that can affect this cohort of staff. **Positive impact** All Health Board staff undertake equalities (including Equality, Diversity and Human Rights) training relating specifically to race and ethnicity as part of mandatory competency training. **Negative Impact** • A non-English or Welsh speaker may be unable to communicate (verbal or written) to staff.	• Health Board approved translation services will be used for obtaining patient consent and if translation of forms is required. Interpretation support can be arranged for appointments if required.
Religion or Belief (or non-belief) The term 'religion' includes a religious or philosophical belief.			✓	**Population Data** See table below	

County	Carms		Cere		Pembs		Total	
Religion	Value	%	Value	%	Value	%	Value	%
Total: All usual residents	187,899	100	71,476	100	123,3630	100	382,738	100
No religion	83,409	44.4	30,749	43	52,998	43	167,1560	43.5
Christian	89,378	47.6	33,409	46.7	60,174	48.8	182,961	47.7
Buddhist	557	0.3	378	0.5	462	0.4	1,397	0.4
Hindu	419	0.2	158	0.2	161	0.1	738	0.2

Jewish	103	0.1	75	0.1	58	0	236	0.1
Muslim	1,026	0.5	515	0.7	587	0.5	2,128	0.6
Sikh	177	0.1	35	0	32	0	244	0.0
Other religion	1,127	0.6	677	0.9	746	0.6	2,550	0.7
Not answered	11,703	6.2	5,480	7.7	8,145	6.6	25,328	6.8

Staff Data

Religion	
Christianity	10
I do not wish to disclose my religion / belief	6
Other	11

*Other was made up of ‘Atheism’, ‘Buddhism’, ‘Islam’, ‘other’ and ‘unspecified’ as potential identification on headcount numbers less than 5.

Patient Data

*Data source for the patient data provided is from the Clinical Services Plan Early Engagement respondent profile, which represents a small fraction of patient cohort.

Ethnic Group	Number of respondents (Unweighted Count)	% of respondents (Unweighted Count)
Buddhist	1	*%
Christian	214	62%
Any other Religion	6	2%
No Religion	122	36%
Total Number of Valid respondents	343	100%
Not known	*165*	-

				Different cultural beliefs will be observed and respected accordingly. • The Health Board is committed to putting people at the centre of everything that we do. This includes celebrating the diversity of the workforce and the communities that we serve. **Positive impact** All Health Board staff undertake equalities (including Equality, Diversity and Human Rights) training relating specifically to religion and belief as part of mandatory competency training **Negative Impact** • There are certain capsules that use pork gelatine which is an issue for those patients who practise Islam and Judaism. With some capsules containing beef gelatine which would be a problem for Hindus. Excipients (substance formulated alongside the active ingredient of a medication) can vary between brands, so it is hard to produce a definitive list of Dermatology specific drugs.	• The Pharmacy department have experience with accommodating patients' religious and spiritual beliefs and are more than happy to recommend alternative formulations, brands, or medications.
Sex Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?	✓		✓	**<u>Population Data</u>** County / Gender: Carms Value / Carms % / Cere Value / Cere % / Pembs Value / Pembs % / Total Value / Total % All persons: 187,897 / 100 / 71,475 / 100 / 123,360 / 100 / 382,732 / 100.0 Male: 91,685 / 48.8 / 34,963 / 48.9 / 60,071 / 48.7 / 186,719 / 48.8 Female: 96,212 / 51.2 / 36,512 / 51.1 / 63,289 / 51.3 / 196,013 / 51.2 Gender identity the same as sex registered at birth: 144,924 / 93.2 / 55,874 / 91 / 95,794 / 93.4 / 296,592 / 92.5	

Gender identity different from sex registered at birth but no specific identity given	210	0.1	84	0.1	121	0.1	415	0.1
Trans woman	93	0.1	73	0.1	58	0.1	224	0.1
Trans man	90	0.1	62	0.1	66	0.1	218	0.1
Non-binary	60	0	143	0.2	40	0	243	0.1
All other gender identities	38	0	66	0.1	32	0	136	0.0

Staff Data

Gender	
Female	21
Male	6

Patient Data

*Data source for the patient data provided is from the Clinical Services Plan Early Engagement respondent profile, which represents a small fraction of patient cohort.

Gender	Number of respondents (Unweighted Count)	% of respondents (Unweighted Count)
Female	212	58%
Male	152	42%
Total Number of Valid respondents	364	100%
Not known	*144*	-

Positive impact

				All Health Board staff undertake equalities (including Equality, Diversity and Human Rights) training relating specifically to gender as part of mandatory competency training. There are male and females working in the service; if a patient requests a specific gender of staff for their review prior to their appointment, this can be provided. A chaperone can be present during the examination request. **Negative Impact** • Female patients with acne as a clinical condition are treated differently to males due to the Pregnancy Prevention Programme and contraception the patients would need to be on. • Photographs are requested with all referrals for skin conditions to be clinically triaged.	• For Isotretinoin there is a section on the new form for the lead prescriber to record if the patient does or does not require contraception as per their clinical judgement. This can be kept confidential if the patient wishes. The form is stored in the patient notes which is confidential. Details may be in clinic letters on Welsh Clinical Portal which also helps staff to know without asking. For the other oral retinoid there is no form, but details can be stored in letters on Welsh Clinical Portal. • Photographs are requested on referral, so

					the patients are put on the right pathway, however, should the referral involve a sensitive area, providing the clinician has sufficient information and the details meet a criteria for a clinical condition, the referral will be approved and no request for photograph will be asked. • Referrals with lesions on genitals will not be referred to the Teledermoscopy service. These patients will be seen at face to face appointments that take place in Prince Philip Hospital, Llanelli.
Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	✓			**Population Data**	

County	Carms		Cere		Pembs		Totals	
Sexual Orientation	Value	%	Value	%	Value	%	Value	%
Total: All usual residents aged 16 years and over	155,486	100	61,391	100	102,551	100	319,428	100.0
Straight or Heterosexual	139,511	89.7	51,998	84.7	92,094	89.8	283,603	88.1
Gay or Lesbian	1,845	1.2	941	1.5	1,093	1.1	3,879	1.3
Bisexual	1,500	1	1,617	2.6	1,050	1	4,167	1.5
Pansexual	202	0.1	225	0.4	149	0.1	576	0.2
Asexual	79	0.1	140	0.2	52	0.1	271	0.1
Queer	23	0	49	0.1	12	0	84	0.0

All other sexual orientations	19	0	16	0	7	0	42	0.0

Staff Data

Sexual Orientation	
Heterosexual or Straight	22
Other	5

*Other was made up of 'Not Stated' (person asked but declined to provide a response) and 'unspecified'.

Patient Data

*Data source for the patient data provided is from the Clinical Services Plan Early Engagement respondent profile, which represents a small fraction of patient cohort.

Sexual Orientation	Number of respondents (Unweighted Count)	% of respondents (Unweighted Count)
Heterosexual or Straight	308	89%
Other Sexual Orientation	39	11%
Total Number of Valid respondents	347	100%
Not known	*161*	-

Positive impact

- All Health Board staff undertake equalities (including Equality, Diversity and Human Rights) training relating specifically to sexual orientation as part of mandatory competency training

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<td>Negative Impact

• Oral Retinoid (Acitretin and Alitretinoin) – Patients are asked if they are exclusively in a same sex partnership, as if they are in a female and female couple, they do not need to go on contraception but are still required to do a pregnancy test.</td>
<td>• Females in same sex partnerships for the Pregnancy Prevention Programme. For those under 16 we may need to ask the parent to leave the room whilst discussing sexual activity and contraception to allow a more open dialogue. We would be covered by Fraser guidelines to do this.</td>
</tr>
<tr>
<td>Armed Forces
Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through ‘unfamiliarity with civilian life, or frequent moves around the country and the subsequent</td>
<td>✓</td>
<td></td>
<td></td>
<td>
<table>
<tr><th></th><th>Carms</th><th>Cere</th><th>Pembs</th><th>Total</th></tr>
<tr><td>Previously served in the UK regular armed forces</td><td>5610</td><td>1851</td><td>4654</td><td>12115</td></tr>
<tr><td>Previously served in UK reserve armed forces</td><td>1334</td><td>537</td><td>930</td><td>2801</td></tr>
<tr><td>Previously served in both regular and reserve UK armed forces</td><td>336</td><td>137</td><td>248</td><td>721</td></tr>
<tr><td></td><td>7280</td><td>2525</td><td>5832</td><td>15637</td></tr>
</table>
Positive impact

Some Armed Forces individuals are eligible for priority treatment, provided they adhere to the specific criteria as noted within the Welsh Government Armed Forces Covenant: Armed Forces Covenant: annual report 2021 [HTML] | GOV.WALES

If their injury or illness is attributable to their military service, then they are eligible for priority treatment.

If they were on a waiting list in another Health Board or even in England and they get posted (moved) to our Health Board area, then they are entitled to join the Health Board waiting list at the</td>
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difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.' For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: [Armed-Forces-Covenant-duty-statutory-guidance]				same point as when they left the previous location, e.g. they had been waiting for an operation for two years and they join the waiting list here at the same point as someone who has been waiting two years, and do not join at the end of the queue. We treat Armed Forces in line as per Health Board policies. **Negative Impact** Currently no negative impact is foreseen based on Armed Services. This will be reviewed when undertaking service change.	
Socio-economic Deprivation Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty	✓	✓		**Population Data** County / Economic Factor: Carms Value / Carms %; Cere Value / Cere %; Pembs Value / Pembs %; Totals Value / Totals % Total: All usual residents aged 16 years and over: 155,487 / 100 / 61,392 / 100 / 102,551 / 100 / 319,430 / 100.0 Economically active (excluding full-time students): 83,262 / 53.5 / 29,845 / 48.6 / 54,182 / 52.8 / 167,289 / 51.6 In employment: 79,927 / 51.4 / 28,718 / 46.8 / 51,697 / 50.4 / 160,342 / 49.5 Unemployed: 3,335 / 2.1 / 1,127 / 1.8 / 2,485 / 2.4 / 6,947 / 2.1 Economically active and a full-time student: 2,612 / 1.7 / 2,119 / 3.5 / 1,352 / 1.3 / 6,083 / 2.2	

and personal or household debt should also be considered.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see: **https://gov.wales/more-equal-wales-socio-economic-duty**

In employment	2,025	1.3	1,401	2.3	1,068	1	4,494	1.5
Unemployed	587	0.4	718	1.2	284	0.3	1,589	0.6
Economically inactive	69,613	44.8	29,428	47.9	47,017	45.8	146,058	46.2
Retired	43,170	27.8	16,997	27.7	30,306	29.6	90,473	28.4
Student	6,422	4.1	6,150	10	3,544	3.5	16,116	5.9
Looking after home or family	6,296	4	2,119	3.5	4,755	4.6	13,170	4.0
Long-term sick or disabled	9,710	6.2	2,730	4.4	5,632	5.5	18,072	5.4
Other	4,015	2.6	1,432	2.3	2,780	2.7	8,227	2.5

Staff Data

There is currently no data available on socio-economic status for staff.

Staff socio-economic status should not impact or be impacted by changes in the service, as any expenses incurred as part of travelling and education are reimbursed by the Health Board.

Patient Data

It can be difficult to ascertain the socio-economic status of our population. One metric is employment status, which is detailed in the table above for the populations, but there is no patient specific data.

Socio-economic status – malignant melanoma is associated with affluence. There is a 60% to 70% lower incidence among people from deprived areas compared with their more affluent peers (Cancer Research UK 2010b). However, people from more affluent areas are more likely to survive the condition (Coleman et al. 2001). In addition, it should be noted that sunbed outlets are particularly prevalent in areas of socio-economic deprivation (Walsh et al. 2009) – and that this could affect the rate among lower socio-economic groups in the future.

				[2 Public health need and practice | Skin cancer prevention | Guidance | NICE] **Positive impact** • There will be community hubs within the 3 counties for patients to access the Teledermoscopy clinics if the lesions are considered suitable for photography. Teledermoscopy clinics will be closer to where the patients live so that they will not have to travel as far for initial appointments. • There are several mitigation actions in place across the Health Board to minimise the impact of patients' or staff socio-economic status in the way they access the Health Board for treatment or work. **Negative Impact** • Hywel Dda University Health Board covers a very large geographical area, which may impact service users and staff when trying to access certain parts of the service that might only be delivered from sites which are not local. • Patients currently travel to Prince Philip Hospital for the majority of the face-to-face appointments.	• Telephone follow up clinics have recently been introduced for systemic and inflammatory patients, allowing patients to access the follow up service via telephone. Therefore, allowing the patients to access the appointments in the comfort of their own home. • We have a minority of Skin Cancer follow up clinics in the Cardigan and South Pembrokeshire area, therefore allowing access closer to home for some patients

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- Hospital transport is provided to a certain criterion of patients.
- Patients can make a claim for travel from the general office in the hospital.
- Staff can claim travel expenses when working away from their assigned working base.

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<tr>
<td>Welsh Language
Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.</td>
<td>✓</td>
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<td></td>
<td>
<u>Population Data</u>

According to Welsh Census 2022 data, it is estimated that 29.5% of people aged three or older were able to speak Welsh. This figure equates to around 900,600 people.

<u>Staff Data</u>

<table>
<tr><th>Welsh Language Level</th><th></th></tr>
<tr><td>No Skills</td><td>11</td></tr>
<tr><td>Entry</td><td>4</td></tr>
<tr><td>Foundation</td><td>2</td></tr>
<tr><td>Intermediate</td><td>1</td></tr>
<tr><td>Higher</td><td>3</td></tr>
<tr><td>Proficiency</td><td>3</td></tr>
<tr><td>Not recorded</td><td>3</td></tr>
</table>

<u>Patient Data</u>

*Data source for the patient data provided is from the Clinical Services Plan Early Engagement respondent profile, which represents a small fraction of patient cohort.

Positive impact
</td>
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</table>

				The Health Board adopted the Welsh Language Standards in 2019 across all directorates including Mental Health & Learning Disabilities Services. Following this a Welsh Language Services report is produced annually. In March 2021 the Bilingual Skills Policy was introduced across the Health Board. The main aims of the policy are as follows: • To increase the use of Welsh within the workplace. • To enable everyone who receives or uses our services to do so through the medium of Welsh or English, according to personal choice, and to encourage other users and providers to use and promote the Welsh Language within the health sector. • To ensure staff are able to enact their right to receive services through the medium of Welsh within our internal administrative systems. All service users and patients are offered a proactive service of Welsh language, which is recorded. The Health Board is supportive of any staff who would like to learn or improve their Welsh speaking ability. **Negative Impact** For patients who would like to converse in Welsh, there may not always be a Welsh speaking staff member available.	• Health Board approved translation services will be utilised if no Welsh speaking staff are available on the day.

Form 4: Examine the Information Gathered So Far

1.	**Do you have adequate information to make a fully informed decision on any potential impact?**	N/A
2.	**Should you proceed with the Policy whilst the EqIA is ongoing?**	N/A
3.	**Does the information collected relate to all protected characteristics?**	N/A
4.	**What additional information (if any) is required?**	N/A
5.	**How are you going to collect the additional information needed? State which representative bodies you will be liaising with in order to achieve this (if applicable).**	N/A

Form 5: Assessment of Scale of Impact

This section requires you to assign a score to the evidence gathered and potential impact identified above. Once this score has been assigned the Decision column will assist in identifying the areas of highest risk, which will allow appropriate prioritisation of any mitigating action required.

Protected Characteristic	Evidence: Existing Information to suggest some groups affected. (See Scoring Chart A below)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B below)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C below)
Age	**3**	**-1**	**-3**
Disability	**3**	**0**	**0**
Gender Reassignment	**1**	**0**	**0**
Marriage and Civil Partnership	**1**	**0**	**0**
Pregnancy and Maternity	**3**	**0**	**0**
Race/Ethnicity or Nationality	**3**	**-1**	**-3**
Religion or Belief	**3**	**0**	**0**

Sex	**3**	**-1**	**-3**
Sexual Orientation	**3**	**-1**	**-3**
Armed Forces	**3**	**0**	**0**
Socio-Economic Deprivation	**2**	**-1**	**-2**
Welsh Language	**3**	**-1**	**-3**

Scoring Chart A: Evidence Available	
3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact	
-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Scoring Chart C: Impact	
-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

Form 6 Outcome

You are advised to use the template below to detail the outcome and any actions that are planned following the completion of EqIA. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.

Will the Policy be adopted?	This is a status quo EqIA based on an existing service
If No please give reasons and any alternative action(s) agreed.	N/A
Have any changes been made to the policy/ plan / proposal / project as a result of conducting this EqIA?	N/A
What monitoring data will be collected around the impact of the plan / policy / procedure once adopted?	N/A

How will this be collected?	
When will the monitoring data be analysed? Who will be responsible for the analysis and subsequent update of the impact assessment as appropriate?	N/A
Where positive impact has been identified for one or more groups please explain how this will be maximised?	N/A
Where the potential for negative impact on one of more group has been identified please explain what mitigating action has been planned to address this. **If negative impact cannot be**	N/A

mitigated and it is proposed that HDUHB move forward with the plan / project / proposal regardless, please provide suitable justification.	

Form 7 Action Plan

Actions (required to address any potential negative impact identified or any gaps in data)	**Assigned to**	**Target Review Date**	**Completion Date**	**Comments / Update**
Ensure that Dermatology department mandatory training is kept up to date	Colette Poole	Ongoing		
Review where it is assumed there is no negative impact currently foreseen for protected characteristics: These will be reviewed during future service change options	Colette Poole	Ongoing		
More accurate data will be included at the earliest possible opportunity regarding the patient data provided	Colette Poole	Ongoing		

EqIA Completed by:	**Name**	Colette Poole
	Title	Service Manager Dermatology
	Team / Division	Scheduled Care
	Contact details	Colette.poole@wales.nhs.uk
	Date	26.01.2024
EqIA Authorised by:	**Name**	Ceri Wisdom
	Title	Service Delivery Manager
	Team / Division	Scheduled Care
	Contact details	Ceri.wisdom@wales.nhs.uk
	Date	01.02.2024
Seen by Diversity & Inclusion Team:	**Name**	Eiddan Harries
	Title	Diversity and Inclusion Manger
	Team	Strategic Partnership Diversity & Inclusion
	Contact details	Eiddan.harries@wales.nhs.uk
	Date	26.01.2024