Abstract

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Skin disease is the most common reason for people to present to their general practitioner (GP) with a new episode of disease. In April 2010 there were estimated 23,000 patients on dermatology outpatient waiting lists in Ireland, including almost 11,000 patients waiting over 6 months. We analysed the data of 200 dermatology outpatient visits scheduled under an initiative to target patients waiting more than 120 days for a new dermatology outpatient appointment. There were 171 (85.5%) patients seen, 29 (14.5%) patients did not attend the appointment. The data from 161 patients seen under the initiative was included in the analysis. Skin lesions accounted for 81 (50%) referrals, of these 71 (44%) patients had benign skin lesions and 10 (6%) patients were considered to have suspicious skin lesions. There was no case of malignant melanoma. After the initial consultation, 66% (106) of the patients were discharged to their primary care physician.

Introduction

Skin disease is the most common reason for people to present to their general practitioner (GP) with a new episode of disease. In England and Wales, in 2006, 24% of the population (around 13 million people) visited their general practitioners with skin problems. In Ireland, dermatology waiting lists are notoriously long, coming 4th on the national outpatient waiting lists that account for patients waiting longer than one year for an outpatient appointment, after orthopaedics, ENT and general surgery. In April 2010 there were estimated 23,000 patients on dermatology outpatient waiting lists, including almost 11,000 patients waiting over 6 months. St. James Hospital, similar to other Irish hospitals had long waiting lists. Our aim was to reduce the unacceptable waiting time for a new patient dermatology appointment, and as such a waiting list initiative was undertaken as one short term measure to tackle the problem.

In August 2011 there were 830 patients waiting a new patient dermatology appointment in St. James Hospital, of whom 201 were waiting over 120 days. Referral letters are date stamped on receipt. In order that each patient is seen according to the right person, right place, first time principle the referrals are triaged by the same consultant and distributed to the appropriate clinic or consultant dermatologist. Individual consultants then assign a priority to the referral routine, urgent or urgent. Priority is decided on the basis of the information provided in the referral letter. Dedicated clinics are scheduled for urgent suspected skin cancers, inflammatory skin conditions, complex multisystem disease and urgent new patients. In July 2011 the Surgical and Medical Subspecialties (SaMS) Directorate, the administrative section responsible for dermatology in St. James Hospital, decided to tackle the waiting list by scheduling ten extra clinics over a defined period of 5 weeks. Prioritisation was done more than 120 days and for urgent patients appointments were offered within the hospital. Dedicated clinics were validated by administrative staff and they were offered a sooner appointment. The clinics were run out of hours and were staffed from within the dermatology department (nursing and clerical) working overtime. All patients were seen by the same consultant dermatologist (LB, author).

Methods

We analysed the data of the 200 dermatology outpatient visits scheduled under the initiative to target patients waiting more than 120 days for an appointment. Information was gathered from the referral letter, the clinical notes from the initial consultation, the proforma response sent after the first visit to the referring doctor and from subsequent treatments or investigations carried out within the hospital. Data collected included demographics (age, gender), date of receipt of referral letter, wait time prior to rescheduling, difference in wait time by rescheduling for the waiting list initiative, if the presenting complaint was the primary reason for their visit to the GP, 63 (70%) answered yes and 27 (30%) patients answered no. Data was not available on 53 patients and 18 were referred from other specialities so, for these patients, the question was not relevant.

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Results

In total, 200 appointments were scheduled for 10 clinics over a five week period in August and September 2011. There were 171 (85.5%) patients seen, however 29 (14.5%) patients did not attend the appointment. Of the 171 patients seen, 143 (83%) were male and 18 (10%) were female. All the patients were referred by their GP in 88.8% cases (143 patients) while referrals from other specialities within the hospital accounted for 11.2% (18 patients). 73.9% (119) patients were initially prioritised as routine with an average waiting time 248.94 days (range 130-463) and an average change in waiting time as a result of the extra clinics 76.83 days (range 18-195). 26.1% (42) patients were initially prioritised as urgent with an average waiting time of 165.17 days (range 125-195) and an average change in waiting time of 38.29 days (range 8-67). No patients prioritised as urgent were included as they were not waiting longer than 120 days for an appointment. Of 90 patients asked whether the presenting complaint was the primary reason for their visit to the GP, 63 (70%) answered yes and 27 (30%) patients answered no. Data was not available on 53 patients and 18 were referred from other specialities so, for these patients, the question was not relevant.

Patients were referred with benign skin lesions in 44% (seborrhoeic keratoses, actinic keratoses, warts) and 6% were considered to have suspicious skin lesions (including basal cell carcinoma, squamous cell carcinoma and Bowen's disease) (Figure 1). There was no case of malignant melanoma. After the initial consultation, 66% (106) of the patients were discharged to their primary care physician. Follow up was arranged for 55 (34%) patients. Of these 27 (48.31 years and 79 (49%) patients were male, 82 (51%) were female.

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Figure 1
Discussion

This outpatient waiting list initiative was undertaken by the department of dermatology in St. James’s Hospital as part of a strategy to reduce what at the time was the longest outpatient waiting list in the hospital. The majority of patients were referred by their GP. It is helpful to know that 11.2% of patients seen were referred from other specialities within the hospital. This is a rather high intra-hospital referral rate and possibly reflects the complexity of casemix within the hospital. Despite the fact that all patients were contacted and participated in the re-scheduling of their appointment there was a DNA rate of 14.5%. This is disappointing and indicates that many patients do not value their clinic appointment. Clinical validation may have a role to play in reducing this figure. The processes involved from the point at which a referral is requested to the actual clinic visit involves many steps and is therefore costly. Of 90 patients questioned, 30% said the presenting complaint was not the primary reason for attending the GP on the day of referral. This suggests that the presenting complaint was not bothersome for the patient, and is reflected in the DNA rate. Some patients did not know why they had been referred to dermatology but attended the appointment none the less and had no skin problem at the time. A high proportion of patients (66%) were reassured and discharged after one visit. A further 8% had no skin abnormalities to find on examination. This reflects the non-serious nature of the presenting complaint in a majority of referrals. The impact on dermatology daycare services in this cohort was 14.9%, spread between nurse led clinics, phototherapy and minor surgery.

Our results indicate that the prioritisation method used in our department for this small sample did not miss any cases of suspected melanoma. We are reassured that, within our department, referral letters are being appropriately prioritised. There is increasing pressure to improve access to outpatient services. Our study was undertaken as part of a strategy to reduce what, at the time, was the longest outpatient waiting list in the hospital. We must take into consideration the resources required to run these clinics: space, equipment and consultant, nursing and clerical time. Currently, 10 months after the initiative, there are no patients waiting longer than 120 days for a dermatology outpatient appointment in St. James Hospital. This initiative contributed significantly to reducing our waiting list. The challenge now is to maintain the waiting time less than 120 days for a new patient dermatology appointment.

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