



PAEDIATRICS

A NATIONAL MODEL OF CARE FOR PAEDIATRIC HEALTHCARE SERVICES IN IRELAND

CHAPTER 22: PAEDIATRIC DERMATOLOGY



Féidhmeannacht na Seirbhíse Sláinte
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Clinical Strategy and Programmes Division



**ROYAL
COLLEGE OF
PHYSICIANS
OF IRELAND**

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22.0 INTRODUCTION

Paediatric dermatology specialises in the management of cutaneous, adnexal and vascular anomalies from birth to adolescence. One in five children is affected by atopic dermatitis, and a diverse range of more than 2,500 dermatological diseases are less frequently encountered. Secondary and tertiary level paediatric dermatology is characterised by severity or rarity of conditions including genodermatoses, complex vascular anomalies, and severe atopic, inflammatory or blistering diseases resulting in skin failure.

22.1 CURRENT SERVICE PROVISION

22.1.1 Primary Care

Skin disorders are amongst the most common diseases encountered by health professionals; more than 20% of General Practitioner (GP) consultations have a dermatological component (Centre of Evidence-based Dermatology, Nottingham, 2009). Fewer than ten conditions represent 80% of all primary care referrals. Despite this, education in Dermatology throughout the undergraduate and postgraduate curricula has historically been limited, with less than one in six GPs having any formal training in Dermatology. There has been a well-documented surge in atopic conditions presenting to primary care. There is good evidence to support the assertion that early intervention in atopic dermatitis can mitigate disease severity and persistence, and may prevent development of associated atopic conditions, including asthma, food allergy and anaphylaxis, with significant health and cost implications if not treated appropriately at the time of presentation at a primary care level.

Historically, referrals to the service originate predominantly from primary care, with a systematically poor knowledge base for common dermatological conditions. In order to prevent limited tertiary resources at the new children's hospital being overwhelmed, existing referral pathways need to be reconfigured, with access to care initially by local services as strategically and consistently as possible. We anticipate that in order to reverse current referral patterns, significant investment in education is required, focusing on general paediatricians and GPs, and we thus advocate new protected consultant dermatology educator sessions are created to focus on upskilling primary and secondary level health care professionals. This, in combination with the development of a practitioner-focused portal, devising and promoting guidelines and pathways for management of common skin diseases, development of Continuing Medical Education (CME) accredited e-learning and mandatory training in dermatology for GPs and general paediatricians have potential to impact referral patterns in the medium to long term.

22.1.2 Secondary Care

Dedicated paediatric dermatology clinics are currently held in ten regional centres: Ballinasloe, Castlebar, Cork, Donegal, Drogheda, Galway, Limerick, Mullingar, Sligo and Waterford. Secondary level paediatric dermatology services should ideally be delivered in well designed, appropriately equipped, child friendly and protected environments which will also require additional investment, manpower and planning (RCPCH, 2011; GMC Guidance, 2012). Historically, there have been few paediatric dermatology clinical leads, largely due to national pressure on dermatology resources. The development of a National Paediatric Dermatology Network, with local clinical leads in secondary centres, would allow better patient flow, national protocols and strengthen delivery of care.

We would anticipate that with increased paediatric dermatology consultant manpower at the new children's hospital, outreach clinics could be facilitated to augment existing services in peripheral paediatric centres in the midlands, with appropriate auxiliary staffing and support.

22.1.3 Tertiary Care

Our Lady's Children's Hospital, Crumlin (Crumlin)

- Crumlin provides specialised tertiary level services for the management of complex dermatological conditions not available elsewhere in Ireland, including epidermolysis bullosa, genodermatoses, vascular tumours and malformations, management of refractory atopic dermatitis, dedicated systemic immunosuppressive clinics, connective tissue disorders and laser surgery.
- The department provides one of the busiest outpatient services at Crumlin, reviewing in excess of 7,500 outpatient visits, 500 day cases and 500 inpatient admissions and consultations annually. A 1:3 on-call is also provided. While this is not funded as a national service it de facto performs this role.
- The British Association of Dermatologists workforce guidelines advocate a minimum of 8-12 consultants for this population base and level of complexity. Currently, the service is provided by three consultants: Dr. Rosemarie Watson (appointed in 1992), Professor Alan Irvine (appointed in 2002), and Dr. Grainne O'Regan (appointed in 2012), with a combined commitment of 2.2WTE. In addition, there are two specialist registrars (1x dermatology and 1x paediatric), one senior house officer, 4WTE clinical nurse specialists, 1 WTE research nurse, 0.5WTE senior dietitian, 0.4WTE senior occupational therapist, 0.25WTE senior physiotherapist, 0.5WTE paediatric psychologist and 2.6WTE administrative staff.
- Despite activity operating greatly in excess of Health Service Executive (HSE) benchmark levels, the service is in crisis. Due to cessation of services in Temple Street Children's University Hospital (Temple Street) in September 2014, all patients with severe disease or on systemic therapies have been transferred to the dermatology services at Crumlin. There is currently no capacity for routine paediatric dermatology referrals across any of the Dublin sites. Demand has also increased significantly due to closure of paediatric dermatology services at University Hospital Waterford.

Tallaght Hospital

- Paediatric referrals account for 28% of total dermatology referrals in Tallaght Hospital.
- 10 hours (0.25WTE) consultant cover allocated to the service (Dr. O'Regan) has recently been augmented (April 2015) by an additional 10 hours (Dr. Browne - locum position).
- Clinic waiting lists had reduced from 22 months to 6 months within six months; however waiting list is now breaching - routine waiting list 18 months and not currently being allocated appointments.

Temple Street Children's University Hospital

- Service provided by Dr. B. O'Donnell and Dr P. Lenane (combined 0.9WTE). The service is currently closed due to unplanned consultant leave and is not accepting referrals (since September 2014).

Outpatient activity for 2014 comprised:

Hospital	Number of new patients	Number of review patients
Temple Street	575	2,240
Crumlin	1,855	5,741
Tallaght	331	1,336

Total New and Return Patients reviewed: **12,078** by 3.4WTE consultants

To put this in context, the British Association of Dermatologists (2014), advocates that an adult consultant dermatologist should see 1,008 new and 1,344 follow up (2,352 total) patients annually. This does not allow for specialist clinics, teaching students, supervising or training any grade of staff, ward referrals, inpatient care, on-

call, travel, or attendance at multidisciplinary team (MDT) meetings. Paediatric dermatology is acknowledged as having twice the complexity of adult dermatology in terms of service provision and therapeutic challenges, and thus this number of patients should be reduced by 50% (i.e. 504 new and 672 return patients, and reduced further if the argument for quaternary level complexity is taken into account) (British Association of Dermatology, 2012). Currently, each WTE consultant is reviewing 2.5-3 times the recommended patient volume. Even at these levels of activity, there is no capacity for routine referrals across any of the sites.

22.2 PROPOSED MODEL OF CARE

The vision is for a national network of primary care interfacing with local paediatric services, regional dermatology services (each with a paediatric lead) and a tertiary dermatology service based in Dublin. Referrals should be online and a certain number of fields highlighting treatment to date need to be filled before accepting the referral. Rapid response clinic slots are required whereby urgent cases are seen within 14 days.

A business manager would be most helpful to streamline referrals and improve communication with primary care. Given that up to 25% of children under 2 years old have atopic dermatitis (eczema), improved management in primary care is very important and clear instructions are offered to GPs and practice nurses (as per NICE and SIGN 125 guidelines) on the management of mild to moderate eczema.

The future vision for paediatric dermatology entails:

- Establish Harmonising Outcome Measures for Eczema (HOME) as an outcome measure for atopic dermatitis
- Establish a business manager to streamline referrals from primary care
- Establish an interactive website for healthcare professionals and parents about common dermatological conditions in childhood
- Develop further paediatric leads in regional centres
- Implement national guidelines for common conditions in paediatric dermatology

22.2.1 Recommended Care Pathways

Care pathways and networks for children with skin disease must be implemented locally by a MDT to provide integrated services, with well established links.

For specific common skin conditions such as atopic eczema, integrated models of care across primary and secondary care should be promoted (DOH, 2003). Primary care healthcare workers need to be able to access information quickly on the recognition and management of all common skin diseases. They also need rapid access to secondary care clinicians in the form of advice and clinics, when the interventions fail to achieve a satisfactory outcome. This form of advice is likely to be electronic and web-based, it will need to be locally customized and regularly updated by responsible named personnel. Whenever possible, secondary services should be undertaken close to home (DOH, 2001).

Rapid access pathways to local consultant dermatologist-led paediatric clinics for urgent cases should be readily accessible. The local specialist service (Level 3) should have established links with tertiary specialist services (Level 4) to facilitate referrals for children with rare and difficult to treat skin conditions.

The following are mandatory requirements in the management of any child or young person with skin disease. They should be established and maintained by the local specialist team.

1. Electronic advice on diagnoses, management and urgent referral.
2. Referral pathways from primary to secondary care.
3. In addition to dermatologists, the secondary care team should have available specialist nurses, paediatricians, dietitians, occupational therapists and Child and Adolescent Mental Health Services (CAMHS). Liaison access to other specialist paediatric services such as paediatric allergy/immunology, rheumatology, and infectious diseases should also be available in the tertiary centre.
4. Clear pathways known by all members of the department for rapid access to child protection teams for children and young people.
5. There must be defined methods of communication between primary and secondary care when patients do not attend scheduled appointments, with clear recommendations on further follow-up.
6. 24-hour dermatology on-call arrangements and a telephone advice service. This could not be implemented without adequate resourcing.
7. Transitional care arrangements for children moving into services for young people particularly in an outpatient setting. The management of young children is different from that of adolescents.
8. Tertiary services (level 4) should be accessible directly by specialist secondary care dermatologists either by letter, telephone, electronically, or face to face.

22.2.2 Patient Journey

Referrals

Referral pathways and guidelines for paediatric skin conditions should be drawn up for each service level setting. Each skin condition pathway will need to reflect recognized guidelines from the Royal College of Paediatrics and Child Health (RCPCH) and existing National Institute of Health and Clinical Excellence (NICE) recommendations, e.g. atopic eczema for children (DOH, 2007).

Triage

Triage of referrals, either by letter or electronically, must be performed by adequately trained experienced clinicians on a regular basis, to ensure that children are seen at an appropriate time and location by the most appropriate healthcare professional(s) to manage their condition.

Appointment System

Provision for rapid access clinics for the early assessment of children requiring urgent care is essential. Flexibility should be integral to the appointment system. Clinics should be age appropriate (British Association of Dermatology, 2012). Within the clinic template, priority should be given for some timing flexibility, e.g. to spend more time with the family of a patient with atopic eczema. Timing appointments to minimise loss of schooling and family disruption should be the norm.

Referrals to Other Services

In addition to clinical links within the specialty of dermatology, clear referral pathways between different services (general paediatrics, plastic and reconstructive surgery, maxillofacial surgery, paediatric rheumatology, paediatric allergy, paediatric ophthalmology and CAMHS) are needed, irrespective of the provider of care and consistent with national guidance.

Clinic Administration

In regional centres, children and young people should be seen on separate clinic lists from adults. If separate clinics are not possible then consideration should be given to grouping children at one end of a clinic.

DNA Management

The reason for non-attendance must be investigated to ensure that children who do not attend appointments are not being put at risk.

Inpatient Admissions

Inpatients should be admitted to the paediatric wards under a named consultant who will be responsible for the child's care. They should have access to a dermatology consultant opinion and clinical review to ensure that shared care provides the most effective treatment for the patient. Dermatology nurses should be available to attend the paediatric wards, assist with inpatient skin treatments and educate children's nursing staff and parents on dermatological management.

Prescriptions

With topical prescriptions particular care has to be taken to avoid local and systemic side effects.¹⁹

General requirements include:

- Prescriptions should be made by appropriately trained health care professionals with up-to-date competences
- Good communication with child and parent is essential to facilitate informed decisions when discussing any treatment options. This will enhance concordance and should be supported by appropriate patient information leaflets.
- Informed consent for treatments should be explicit and age appropriate.
- The prescriber must be able to justify and feel competent when using unlicensed medicines or licensed medicines for unlicensed applications ('off-label' use) as is more common in the case of prescribing for children.
- Nurse prescribing in the setting of dressing clinics is to be actively encouraged, to ensure timely administration of appropriate topical medication.

Topical Preparations

- Adequate training and up-to-date competencies in dermatological prescribing is mandatory to take into account amounts of treatments used on various sites, bases available, potencies of topical preparations and age of patient.
- Adequate amounts of emollients and barrier preparations should be available on repeat prescription with clear prescribing instructions including amounts required between secondary and primary care.
- Anti-inflammatory preparations are frequently used in dermatology particularly topical steroids and topical calcineurin inhibitors. A clear understanding is needed of appropriate prescribing in various body sites, with extra care in infants, neonate and premature babies.
- Prescribers should recognise the local and systemic side effects of topical preparations.

Systemic Therapies

- When prescribing syrups, where possible, the sugar-free preparations should be prescribed. Prescriber should be able to recognise predictable and unpredictable adverse reactions of systemic therapy.
- Access to paediatric day investigation units under the care of a named paediatric dermatologist or paediatrician is essential for delivery of some systemic medication.
- Identifying developmental needs of staff and disseminating information about clinical governance activities within the organisation.

22.2.3 Roles of Healthcare Professionals Involved in Service Provision

<p>Nursing</p>	<p>Nursing staff have a pivotal role in the care of children and young people with skin disease at all levels of clinical settings. Close liaison is needed with the local dermatology department (see pathways) for continuity of care and continuing advice. Within the specialist service, experienced clinical nurse specialists in paediatric dermatology ensure effective care both in outpatient and inpatient settings. Outpatient dermatology nurses are involved in individual, family or group education sessions and application and demonstration of dressings, often in the environment of day treatment centres. Extended roles include liaison roles, nurse led clinics, specialised care and management of the genodermatoses (including epidermolysis). Paediatric trained nurses should be available in specialist outpatient services caring for children with skin disease (Royal College of Nursing, 2005). Staff need to understand and respect the role of parents and carers and should have training in the necessary communication skills to enable them to work effectively with children, young people and their parents and carers¹¹. In nurse-led clinics there is a need for both dermatology and paediatric competencies.</p>
<p>General Practitioners</p>	<p>Most skin disease is managed in primary care by GPs or practice nurses, and some GPs develop a special interest in dermatology. GPs should work with the local secondary care specialists to develop an integrated dermatology service model with care pathways. They should also develop links with other professional groups, including pharmacists, public health nurses and school nurses to ensure effective shared care for patients with chronic skin conditions.</p>
<p>Adult Dermatologists with a Special Interest in Paediatric Dermatology</p>	<p>Children and young people with skin disease should be managed in secondary care by dermatologists who have undergone dermatology training in the diagnosis, investigation and treatment of skin disease in this age group. In regional centres, the paediatric dermatology service should include a named lead clinician trained in the care of children with skin disease. Other specialists such as general paediatricians, respiratory paediatricians, and allergy specialists seeing children with skin disease, should have competencies in dermatology or liaise closely with the dermatology service. For inpatient care, children should be admitted to a paediatric ward under a named paediatrician, with access to a dermatology consultant opinion and shared care between the specialties. Level 4 care should be undertaken by a paediatric dermatologist with special skills in the management of complex and/or rare skin disorders in children, in close liaison with a range of healthcare professionals.</p>
<p>School Nurses and Teachers</p>	<p>School nurses provide an invaluable link to the school environment where children spend much of their time. They are able to liaise with teachers and first aiders within the school environment, and input management advice to the school tailored to the child's individual needs.</p>
<p>Dietitians</p>	<p>Assessment of nutrition and ensuring adequate growth is an essential part of any paediatric condition, particularly chronic conditions such as eczema and psoriasis. Involvement of dietitians in the management of these patients is often necessary. Good links with paediatric dietetic services should be established.</p>
<p>Occupational Therapy</p>	<p>Occupational therapists have a key role in the treatment of children with vascular anomalies and fragile skin conditions. Specialist interventions are provided in the areas of pressure therapy, splinting, adaptive equipment, functional assessment and engagement in age-appropriate activities of daily living, school attendance and leisure activities. Collaborative working between the tertiary hospital and community occupational therapists is essential to provide seamless care for these children.</p>

Physiotherapy	Physiotherapists provide care in inpatient and outpatient settings. They complete detailed assessments and provide advice, education and exercise programmes for achieving optimum function in activities of daily living, school attendance and social engagement for children attending dermatology services. They liaise with community therapists to ensure seamless transition of care.
Clinical Psychology	Psychologists provide an integrated assessment and intervention service as children may experience significant and complex adjustment issues when coping with chronic and severe skin conditions. They also contribute to psychoeducational programmes, and research into the psychological factors associated with illness onset and progression as well as evaluation of the effectiveness of psychological interventions.
Child and Adolescent Mental Health Services	A number of skin conditions are associated with significant psychological co-morbidity in the child or the family or can occur as a result of psychological issues affecting the skin. Access to CAMHS should be part of a national paediatric dermatology services.
Play Therapists	Play specialists should be available for children undergoing procedures such as phlebotomy, skin biopsy and also during inpatient care.
Interpreter Services	Lists of named interpreters trained to work with children and their parents/carers should be available in outpatient clinics. This can be supported by patient information leaflets translated into appropriate languages which should be available from all health care settings.
Social Services	In the hospital setting, clear information for accessing social services should be available for families.

22.3 REQUIREMENTS FOR SUCCESSFUL IMPLEMENTATION OF MODEL OF CARE

22.3.1 Staffing Requirements and Training

Human Resources	Staffing requirements: medical, nursing, health and social care professionals, administrative, support	
	Current	Recommended
Consultant	3.4	8-12
Nursing	6	12
NCHD	5	8
Dietetics	0.8	1.2
Occupational Therapy	0.4	1
Physiotherapy	0.25	1
Psychology	0.5	1
Administration	4	7

Care must be delivered in an integrated fashion and coordinated around the child or young person's particular needs and the needs of their family. Dermatology clinical staff must have the appropriate level of education, training, knowledge and skills to provide high quality care to children and young people (DOH, 2007). In addition, secondary care teams must include professionals trained and competent to manage children who are unwell.

Staff training and development programmes should ensure safe practice and comply with clinical governance and good practice guidelines. For all medical staff, maintaining and appraising competencies on an annual basis by continuing education and training is essential. It is also essential that all providers of care for children and young people with skin conditions are appropriately trained and competent to deliver care. All providers of services for children with skin conditions should have a clear framework for education, training and continuous professional development that includes mentorship, clinical supervision, case note review (where appropriate) and assessment of development and ongoing competence.

Discussion of Difficult or Instructive cases:

As with any clinical service, there are some cases that respond in an atypical or unusual way. Discussion of these cases is often instructive for the team members. Furthermore, such discussion is usually helpful in order to optimize treatment for individual cases and to improve patient outcomes generally.

22.3.2 Infrastructure

Paediatric dermatology services should be delivered in well designed, appropriately equipped, child friendly environments. Ideally, dedicated paediatric facilities should be used but when this is not possible, a suitably adapted and separate area within an adult or general healthcare setting may be used. The British Association of Dermatology (2012) minimum standards for psychodermatology services recommend ‘counselling and consultation rooms are ideally situated within the dermatology unit and in a quiet, undisturbed area suitable for psychological interventions’.

Infrastructure	<p>Facility requirements / physical infrastructure:</p> <ul style="list-style-type: none"> - Office Space to accommodate staff: 8 Consultants / 10 Nurses / 8 NCHDs / 1 Occupational Therapist / 1 Dietitian / 1 Physiotherapist / 1 Psychologist / Administration 6 / Research 2 - Outpatients Clinic Spaces: 12 clinic rooms per clinic (allergy clinics run in parallel) - Bed requirements: Inpatient 4/week (5 days on average) - Outpatient requirements: Dressing rooms / Dedicated isolation rooms (4 per clinic - high rate of skin colonisation in Dermatology patients) / Conversation room / infusion rooms x 4 / Laser room for local anaesthetic laser - Laser upgrade anticipated 2018 Laser Surgery: Access to 20 patient GS slots/week Interventional Radiology: Access to two anaesthetic slots/week MRI: Access to 4x General Anaesthetic MRI/week anticipated
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When planning facilities for delivering paediatric dermatology services, the following should be taken into consideration:

Safety	All furnishings and equipment designed with child safety in mind (no low level shelving or sharp edges, tamper proof couch mechanisms, cool water taps and protected power sockets). It is sensible to have a ‘no hot drink’ policy for both parents and staff, or if they are being consumed they should be in lidded cups.
Environment	Child friendly decor and furnishings appropriate for children, young people and adults (parents). There should be adequate space within waiting areas, clinic rooms and inpatient facilities to accommodate buggies and other family members. A separate waiting areas for young people with age appropriate information and activities.

Toileting	Child friendly toileting facilities should be available in all areas where children are being seen. Baby changing facilities are essential and may usefully be combined with measuring facilities (see below).
Measuring Growth	Measurement of weight and linear growth is an essential part of paediatric healthcare, and a designated and private area should be part of any facility where children are being assessed. Equipment should include baby scales, standard scales (sitting and standing), infant length and child height stadiometers. All equipment should be calibrated regularly.
Play	Children have a basic need for play and recreation and therefore all children and young people should have access to play and hobby materials within any healthcare setting. The availability of age appropriate, wipe-clean and preferably quiet toys, books, games and art materials will ensure a more relaxed patient and parent experience. Television and DVDs within waiting areas and procedure rooms provide a good distraction.
Education	Children, young people and parents should have access to age appropriate educational materials in the form of healthcare advice leaflets, access to helpful websites and information about patient support groups. Within an inpatient setting, children and young people should be able to continue with their school activities and education if they are able to. Provision of a school room to allow this to occur away from the bedside is important.
Investigations and Procedures	Venepuncture, skin prick and patch testing, dressing changes, therapeutic baths, phototherapy and biopsies may all be required in the management of children with dermatological conditions and where these should take place must be planned. Informed consent for procedures should be explicit and age appropriate ¹¹ . Where these procedures cannot be undertaken in a dedicated paediatric setting, e.g. phototherapy or patch testing, children should be seen at a separate time to adult patients and consideration made about how best to facilitate a child focused experience. DVDs and music can be useful distractions during painful procedures and the involvement of play therapists and children's nurses will also improve the experience for children and their parents. Children should not be sedated for painful procedures without appropriately skilled staff (able to manage paediatric airways) immediately available.
Medical Photography	This is an essential part of dermatology assessment in many clinical situations. Provision needs to be made for this to occur within the healthcare setting, in situations where it is inappropriate to send the child to the medical illustration department.

22.3.3 Interdependencies with Other Programmes

- Allergy: 45% patients with atopic dermatitis attending the service also have food allergies
- Vascular Anomalies / Interventional Radiology / MRI
- Diagnostic imaging
- Ophthalmology: infantile haemangiomas, neurofibromatosis
- Pathology
- Rheumatology
- Dental services
- General paediatrics for coordinated management of children with multiple co-morbidities

22.4 PROGRAMME METRICS AND EVALUATION

The paediatric dermatology team should have regular team meetings, ideally every month but at a minimum 4 times a year. The agenda for these regular paediatric clinical governance meetings should include the following elements:

1. *Clinical effectiveness*

All services should review their clinical effectiveness including paediatric waiting list data and paediatric activity since the previous meeting.

2. *Risk management*

All providers of services for children and young people with skin conditions should have procedures in place to minimise risk to both service users and staff. Clear mechanisms should be in place to report, review and respond formally to all clinical incidents and complaints using, for example:

- Incident and near miss recording, with investigation and root cause analysis.
- Audit of current practices, standards and medical records.

3. *Audit*

All providers of services for children with skin conditions should, as a minimum, audit annually elements of clinical practice against current local and national guidelines, evidence-based pathways and procedures. Audit outcomes should be used to evaluate care pathways, monitor the quality of clinical activity and make changes as necessary to optimise care.

4. *Patient experience*

Services should, as a minimum, gather patient recorded experience measures annually. The results should be shared and any actions agreed.

5. *Service developments*

Policies and procedures: New evidence-based practice, research, national standards, guidance and audit results all need to be disseminated to staff to ensure the implementation of procedures which achieve quality outcomes.

6. *Update on new clinical guidelines including;*

- Treatment specific guidelines
- Disease specific guidelines

22.5 CLINICAL GOVERNANCE

Children's dermatology services should operate in an environment that is committed to the principles of clinical governance, with the primary aim of providing the safest and most effective care. Each department should have a named clinical governance lead (usually a consultant dermatologist) who is a member of the hospital clinical governance sub-committee. The clinical governance lead for the department is responsible for:

- Identifying capability and capacity of the department.
- Identifying deficits in current services.
- Producing a developmental plan for the department.
- Organising and chairing clinical governance meetings.
- Identifying developmental needs of staff and disseminating information about clinical governance activities within the organisation.

The seven key components of clinical governance can be broadly categorised into 3 areas:

1. Processes for quality improvement: Patient and public involvement, risk management, clinical audit, clinical effectiveness programmes, staffing and staff management.
2. Staff Focus: Education, training and continuing personal and professional development.
3. Information: Support clinical governance and health care delivery, diagnostic database and clinical information systems, keeping of medical records and documentation, appropriate use and processing of high-quality patient data, maintaining confidentiality.

22.6 KEY RECOMMENDATIONS

Paediatric dermatology is an exceptionally high volume specialty, with >15,000 patient attendances across the three Dublin sites per annum. In order to plan for sustainability of a paediatric dermatology service at the new children's hospital, integrated with national services, we foresee the following as strategic priorities:

- Significantly increase the medical, nursing and health and social care professional staffing of the multidisciplinary team providing secondary and tertiary dermatology care at the national centre.
- Prioritise increase in consultant manpower to 8WTE. The service is currently provided across three sites by 3.4 WTE and is in crisis. Waiting times for referrals are currently greater than 18 months; routine referrals are currently not being allocated appointments in two of the sites.
- Provide adequate space, streamlined patient flows and environment to deliver high volume ambulatory and inpatient tertiary dermatology services at the national centre.
- Develop and embed the roles of clinical nurse specialists (CNSs), nurse prescribing for all CNS posts and advanced nurse practitioners for chronic conditions / laser surgery.
- Prioritise timely access to laser therapy under anaesthesia at the national centre; this will necessitate additional theatre access (20 GA slots/ week).
- Ensure dedicated access to MRI imaging and Interventional Radiology (IR) for vascular anomalies / neurogenodermatoses (current activity generates 5 MRI / 1 IR procedure per week).
- Provide business manager, data management and IT resources to track clinical activities and facilitate electronic interface capability
- Develop adequately resourced national and regional clinical, research and education networks of multidisciplinary healthcare professionals to enable local and shared care. This will be necessary to fully enable the model of care.
- Embed protected time within consultant job descriptions for service management, direction of research and development and maintenance of education.

22.7 ABBREVIATIONS AND ACRONYMS

CAMHS	Child and Adolescent Mental Health Service
CME	Continuing Medical Education
CNS	Clinical Nurse Specialist
DOH	Department of Health
GP	General Practitioner
HOME	Harmonising Outcome Measures for Eczema
HSE	Health Service Executive
ICGP	Irish College of General Practitioners
IR	Interventional Radiology
MDT	Multidisciplinary Team
MRI	Magnetic Resonance Imaging
NCHD	Non-consultant Hospital Doctor
NICE	National Institute of Health and Clinical Excellence
RCPCH	Royal College of Paediatrics and Child Health
RCPI	Royal College of Physicians of Ireland
SIGN	Scottish Intercollegiate Guideline Network
WTE	Whole Time Equivalent

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