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DOI:
10.1111/bjd.17427

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Article type : Research Letter

The views of consultant dermatologists on creating centralised skin lesion units

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Funding sources: Interview travel expenses for principal investigator, Lydia Scrivens, paid for by University of Birmingham.

Conflict of interest: None declared.

The proportion of United Kingdom (UK) specialist dermatology clinical activity related to skin lesions has been estimated at between 40–50%.[1] With skin cancer incidence rising,[2] this is likely to increase even further. In 2014, The King's Fund conducted research to investigate the sustainability of dermatology services, with participants identifying the need for service reconfiguration to improve efficiency. One suggestion was to create consultant-led centralised skin lesion units, receiving all referrals within a region.[1] To the best of our knowledge, there has been no published qualitative research on the organisation of dermatology services, and the views of key stakeholders on service reconfiguration remain unexplored. An independent review following the failed takeover of dermatology services in Nottingham by a private provider concluded that staff must be fully involved in service reconfiguration from the outset.[3] This study therefore aimed to explore consultants' views on perceived benefits of, and barriers to, implementing a centralised skin lesion unit, alongside potential settings, multi-disciplinary team working and private sector involvement. These are factors of importance identified in research regarding centralisation of other specialties.[4,5,6] A qualitative

research methodology was chosen in order to generate rich data and allow detailed explication of participants' views.

In March 2018, semi-structured, face-to-face interviews were held with individual consultant dermatologists from three National Health Service (NHS) trusts in one UK region. Interviews lasted between 25 and 46 minutes. A topic guide was used during interviews, drawing on the research aims and a programme theory utilised by researchers investigating stroke service centralisation.[5] To ensure a broad range of perspectives, the purposive sample encompassed several clinical settings and infrastructures. This included a gender mix of clinicians, with varying years as a consultant (2–19 years) and specialist interests, covering medical, surgical, genital and paediatric dermatology. Ethical approval was obtained from the University of Birmingham, NHS Health Research Authority and local Research and Development departments. Thematic data analysis began after the first interview following Braun and Clarke's six step process.[7] Data collection stopped after nine interviews as this was when data categories were well developed. Five final themes resulted, illustrated with example codes and quotations in Figure 1.

Theme 1 encompassed views on location. Participants expressed concerns that many departments were already at full capacity, therefore services would need to be centralised to a purpose-built facility. Several identified possible reluctance or inability of staff and/or patients, in particular the elderly, to travel further to a centralised unit. Reasons cited included increased commutes and patients having to travel from afar for diagnosis of a benign lesion. Concerns were raised regarding the impact of centralisation on the provision of in-patient dermatology care.

Theme 2, concerning breadth of services provided, revealed the majority thought it would be possible to centralise only a proportion of skin lesion work. Most deemed a one-stop service to be unfeasible in the current NHS, naming costs and inefficiencies as barriers. Provision of a walk-in service was widely rejected due to fears of unmanageable public demand. Many were cautious about the utility and safety of tele-dermatology in such a setting.

Theme 3 highlighted the importance of employing a broad range of specialists. Participants deemed this crucial to achieve a unified approach to care. Despite this, involvement of general practitioners was contested by many. The need for further dermatological education was identified as a priority to successfully integrate primary care into centralised services. The majority were positive about the role of nurse surgeons.

Theme 4 emphasised the need for clear governance, with a strong management and leadership team overseeing regular audit and evaluation, utilising hard and soft outcomes. Many highlighted effective teamwork and communication as important components of a high-quality care pathway.

However, a lack of local comparisons was identified by some as a limitation to setting up a centralised unit.

Theme 5 incorporated concerns regarding finances and the private sector. Only a minority of participants suggested areas for cost-saving through centralisation. Multiple participants were doubtful about the long-term financial gain, pointing out that a substantial initial investment would be necessary. Although benefits of involving the private sector were highlighted, such as equipment provision, most were sceptical, questioning the morals, regulation and frequent interchange of private sector employees.

Overall, participants expressed the view that presently, barriers to creating a centralised skin lesion unit substantially outweigh possible benefits. Whilst centralisation has the potential to concentrate expertise and save costs in some areas, there were overarching concerns regarding unit location and accessibility. The need for a multi-disciplinary approach and continuous service evaluation was strongly emphasised, yet the role of the private sector was questioned.

This study has produced novel findings and contributes to the limited evidence base surrounding service centralisation. In the context of health services research, qualitative methods are often drawn on to determine which services would be valuable in an area and to inform the future research agenda. Here, a qualitative methodology has successfully established the views of consultant dermatologists in detail. However, there remains a need for further research, exploring the views of other stakeholder groups, in particular nursing staff, patients and commissioners, across the UK. The NHS is constantly evolving, therefore it may be necessary to repeat investigations over time, since some of the current barriers to centralisation in dermatology may not exist in the future.

Acknowledgements

Many thanks to all participants for giving up their valuable time to be interviewed.

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Figure Legend

Figure 1. Final themes and illustrative quotations drawn from the qualitative research.