Implementing Active Clinical Referral Triage in Dermatology Services in NHS Scotland: A Guide

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Foreword

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The principles of Active Clinical Referral Triage (ACRT) are familiar to all clinicians in Dermatology - managing incoming referrals and waiting lists to optimise efficiency and improve patient care. Nationally, dermatology continues to be affected by a shortage of senior clinicians and demand capacity mismatch, resulting lengthy waiting times, often with significant associated clinical risk. ACRT should therefore continue to be at the forefront of our efficiency toolkit aiming to create a sustainable way forward for Scottish Dermatology.

With safe and efficient image capture now enabled throughout Primary Care, and increasing rates of photos accompanying Dermatology referrals, our ability to perform ACRT has never been greater. This guidance is aimed at ensuring that workforce, job plans and logistics are in place to maximise ACRT potential within Dermatology in Scotland.

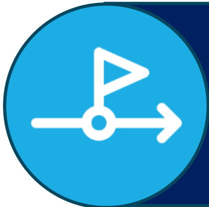
Dr Fiona Craig, Consultant Dermatologist, Secondary Care Lead, Digital Dermatology Pathway (CfSD)

What is ACRT?

Active Clinical Referral Triage (ACRT) refers to the enhanced process of vetting referrals. A senior clinical decision-maker (e.g. a Consultant or Advanced Practitioner) reviews each patient's electronic records, including any photographs, and triages to the most appropriate, evidence-based pathway.

Good for patients: In 2024/25 - 32,000 patients were returned to Primary Care with advice rather than having lengthy waits for outpatient appointments.

Good for resources and the environment: To see these patients face-to-face in outpatient clinics it would have cost £5.7 million, and resulted in 520,000 miles of patient travel.



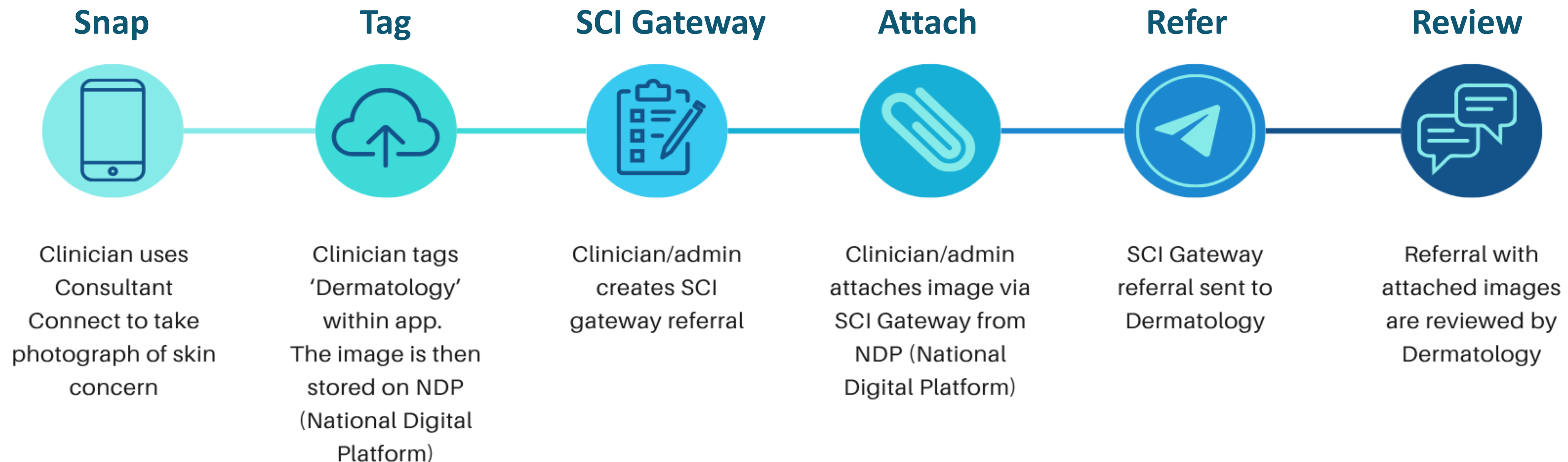
Good for flow: Avoiding these appointments frees up clinic space for patients who will benefit from timely Secondary Care intervention.

Ensuring the right pathway: ACRT also enables upgrade of routine patients to urgent where appropriate, enables alternative pathways such as 'opt-in', nurse or pharmacist-led clinics, straight-to-surgery, and spots errors at the beginning of a patient's wait.

Digital Dermatology

A picture is worth 1,000 words. This is particularly true for Dermatology ACRT, where access to a clear image can help considerably with diagnosis and prioritisation, assigning patients to the most appropriate pathway.

This has led to the Digital Dermatology pathway being rolled out across Scotland. The Consultant Connect app is available to all GP practices as a secure way of taking patient images and linking them to referrals to Secondary Care to support ACRT.



Who should do ACRT?

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Work to Clinicians' strengths, but don't have a single point of failure: It is unlikely that all Consultants will be confident with ACRT, but conversely too few will cause issues with cover.

Consider the wider workforce: Some Boards have successfully used non-medical roles (e.g. Clinical Nurse Specialists) to undertake ACRT. However, if using non-Consultant workforce to triage, what arrangements are in place for supervision and training?

Ensure ACRT is reflected in job plans: ACRT is not 'free activity' – clinicians need dedicated time to undertake the work. ACRT should be recorded in job plans as direct clinical care (offering an additional EPA session is not the same as a job-planned triage session).

Dedicated time means just that: Trying to fit ACRT around other clinical or non-clinical activities is likely to introduce a risk of missing important details, or result in unnecessary appointments.

Team service planning

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Balancing demand and capacity: Just as you would any other activity. Clinicians / managers should agree the time to triage each referral depending on local systems (e.g. this may be affected by local systems for patient letters).

Keeping on top of the list: Ensuring at least one member of the ACRT team reviews the ACRT list each day means that Urgent Suspicion of Cancer (USOC) referrals and other urgent cases will be picked up in a timely way.

Multiple shorter sessions May be more effective vetting, for example, 4x1 hour sessions may be more productive (and enjoyable) than a continuous 4-hour session.

Training and Standard Operating Procedures (SOPS): All vetting clinicians should be working the same way. SOPs should be in place to ensure that triaging clinicians are clear on how to use the various systems and processes, and all vetting clinicians should be up to date with national and local referral guidelines and pathways.

Undertaking ACRT: practical points

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Ensure that vetting clinicians have access to appropriate IT: Dual screens can be very helpful and a dictaphone (where appropriate) so that letters can be dictated in real time.

Clinicians should have access to all relevant software and systems: Including Trak, Clinical Portal and SCI store.

Don't overcomplicate vetting outcome codes: Your vetting outcome codes will decide which queue patients can go into and, ultimately, what appointment slots they can be booked into. Fewer queues make it easier to adjust capacity as demand changes.

Minimise interruptions: This is easier said than done, but distractions reduce effectiveness and increase risk.

Timely information for patients: Consider writing to the patient with GP copied in (or, as a minimum, to the GP with the patient copied in) rather than relying on Primary Care to communicate with the patient.

Standard letter templates: For common conditions, which can support good quality information and make vetting easier.

Double vetting: Consider whether a double vetting or buddy system will support vetting clinicians making more confident decisions. This could be a double review of all referrals returned, or by exception, where a second opinion might help triage. It can also be used to build confidence in Clinicians with limited previous ACRT experience.

Focus on adding value

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ACRT should be a value adding step and should be timely:

- Reassurance for benign conditions rather than lengthy waits.
- Treatment options offered in days rather than months (or years).
- Avoided journeys to hospital.
- Reduced waits by directing patients to the most appropriate pathway at initial vetting.

If you are triaging all patients to clinic, ACRT is not adding value: Review your processes again. Do you have enough time to vet? Do you have the equipment, space and systems you need and are the processes set up to help you succeed? Are there agreed pathways to vet to, including agreed thresholds for returning to Primary Care, as well as alternatives to Consultant outpatient clinics (opt-in pathways, Nurse or Pharmacy-led clinics, straight to surgery etc)?

Avoid ACRT delays: It is imperative that any vetting backlog is addressed as a matter of urgency. ACRT relies on referrals being reviewed at the beginning of a patient’s wait. Patients who have waited many week are unlikely to view advice as an acceptable outcome. Similarly, GPs may be discouraged from attaching images if there is no confidence that they will be viewed in a timely manner.

Review, audit and feedback

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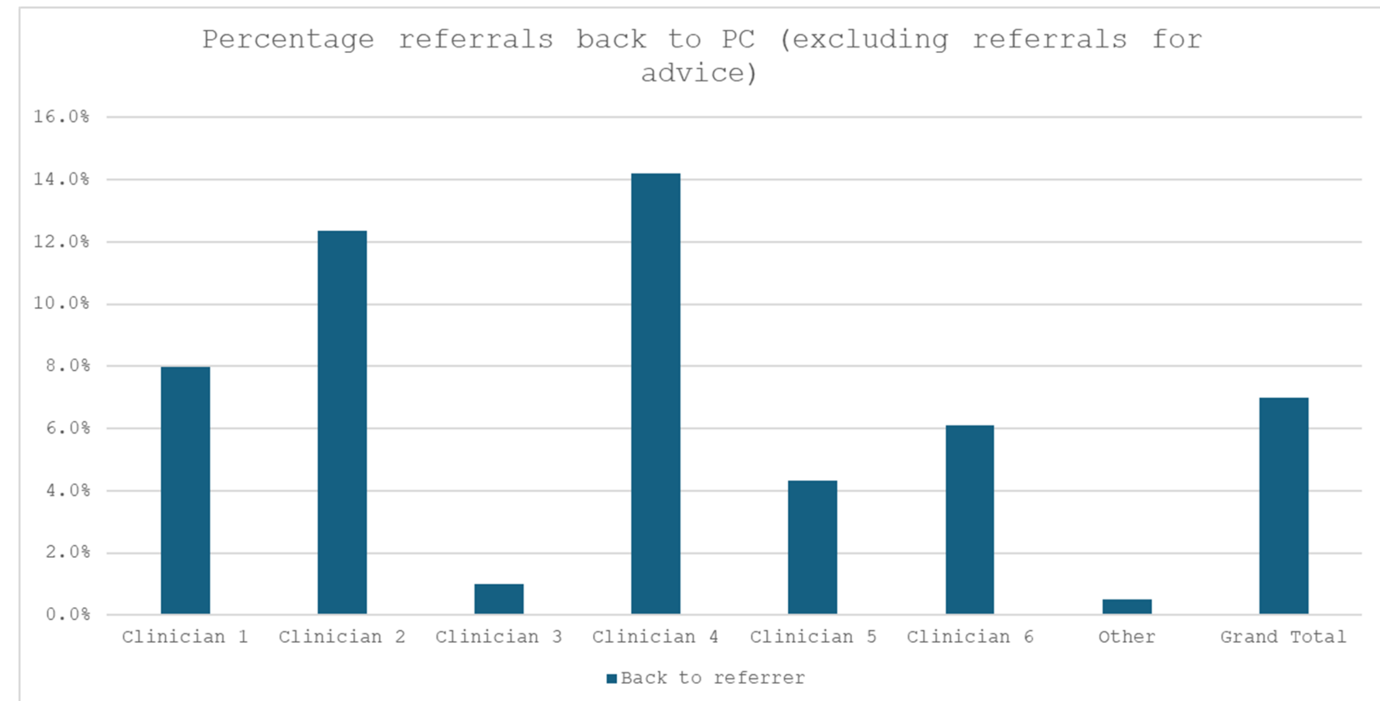
Vetting outcomes percentages should be reviewed: Regularly and transparently within the team to address unwarranted variation. In the example below, clinicians 3 and 5 have significantly lower back-to-referrer rates. This is not necessarily wrong, but it should be explored and understood.

Maintain good relations with Primary Care: Attending local meetings to promote image capture can help. Highlight positive patient stories, including examples of referrals upgraded, as well as those moved to alternative pathways and returned to Primary Care with advice.

Approach image quality audits sensitively: Consider how embedded the use of images is within the system as you do not want to dishearten Primary Care colleagues, who may interpret your result as an opportunity to stop taking images altogether.



ACRT as part of the wider dermatology service

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ACRT is just one aspect of potential service redesign in Dermatology. Services should also consider some of the following:

Use of Primary Care pathway information: The Right Decision Service now contains 20 national resources aimed at Primary Care (where Health Boards have local systems such as Ref Help, these can be updated to reflect any new national guidance).

Patient Focused Booking (PFB): Provides a more person-centred service and has the potential to reduce DNA rates by up to 5%. While some justified exceptions remain, PFB should be the default approach for new routine outpatient clinics. It has been shown to be effective in certain urgent and USOC services and, where systems support it, for return patients.

Patient Initiated Review (PIR - sometimes called Patient Initiated Follow-Up): As with PFB, PIR provides a more person-centred approach and frees capacity for patients who need it.

Maximising use of the wider workforce: Nurse Specialist, Pharmacist and Trainee roles provide opportunity to see many particular groups under appropriate supervision.

Further resources

CfSD ACRT Toolkit: https://www.nhscfsd.co.uk/media/i4zmi4eh/active-clinical-referral-triage-and-discharge-patient-intitiated-review-toolkit.pdf

Digital Dermatology:

CfSD website page: https://www.nhscfsd.co.uk/our-work/innovation/accelerated-national-innovation-adoption-ania-pathway/what-we-are-doing/innovations-approved-for-adoption/digital-dermatology/

Education and Training Resources for clinicians (NES page): https://learn.nes.nhs.scot/78219/nes-innovation-and-workforce-diversification/accelerated-national-innovation-adoption-ania/digital-dermatology-ducation-and-training-resources

British Association of Dermatology guidance on teledermatology and job planning:

https://www.bad.org.uk/clinical-services/teledermatology

https://cdn.bad.org.uk/uploads/2022/11/17161530/Job-Planning-for-Dermatologists-2022-.pdf

National Dermatology pathway information on the Right Decision Service:

https://www.rightdecisions.scot.nhs.uk/dermatology-pathways/

Appendix I: implementation checklist

Clinical Checklist

- ☐ Clinicians identified
- ☐ Session agreed in job plan
- ☐ Sufficient capacity to maintain short ACRT turnaround (including USOC)
- ☐ Pathways agreed, including vetting outcomes plus any direct to test or opt-in
- ☐ Standardised leaflets and letters
- ☐ All clinical staff aware of the new processes

Admin Checklist

- ☐ Admin process established (Standard operating procedure)
- ☐ Vetting outcomes on Patient Administration System
- ☐ Process for letters / leaflets established
- ☐ Recording for any opt-in pathways established
- ☐ Patient Focused Booking established

Wider engagement and review

- ☐ Communications with Primary Care
- ☐ Process for ongoing review of vetting outcome data (comparing individual clinicians)
- ☐ Sufficient capacity to maintain short ACRT turnaround (including USOC)
- ☐ Review of ACRT delays
- ☐ Review of comparative waits for specific services

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