FINAL

Implementing safe and effective teledermatology triage pathways and processes

# A Teledermatology Roadmap for 2020-21 v1.0

This roadmap sets out what all systems can do **now** to optimise teledermatology triage and Advice & Guidance to help them safely manage new patient demand while restoring their dermatology services.

## Five steps to deliver teledermatology triage now:

1. **Include images with dermatology referrals and Advice and Guidance requests to enable consultant triage, ensuring face to face attendances only when necessary.**
2. **Triage both suspected cancer and routine referrals using teledermatology**
3. **Include clinical review of teledermatology A&G requests and referrals in consultant job plans as part of their direct clinical care**
4. **Record teledermatology activity accurately to reflect the type of clinical contact taking place, demonstrate the benefits and support sustainable funding models**
5. **Maintain teledermatology pathways through continuous training across professional groups and care settings.**

## Two key principles for delivery:

1. **Patients need to be kept informed directly about the care pathway they are on, their diagnosis and treatment plan in a clear, compassionate and timely way.**
2. **Teledermatology workflows should not add burden to primary or secondary care.**

**NHS England and NHS Improvement**

‘Teledermatology’ refers to the use of static digital images to triage, diagnose, monitor or assess skin conditions without the patient being physically present.

## Why teledermatology?

In 2019-20 there were 3 million dermatology outpatient appointments in England (HES), making it the sixth highest treatment function in terms of volume. Skin cancer is the most common cancer in the UK and dermatology services receive more urgent referrals for suspected cancer than any other specialty. Dermatology also use systemic and biologic therapies for many long term conditions, requiring ongoing regular outpatient reviews. Departments struggle to meet this growing demand due to the limited consultant dermatologist workforce (APPG Skin, 2019). The unmet demand from new suspected cancers can mean that review appointments for patients with painful and debilitating inflammatory conditions are delayed, or clinics are overbooked (Delivering care and training a sustainable multi-professional workforce; The BAD, 2019).

Existing models of teledermatology triage services suggest a significant opportunity for managing demand for dermatology diagnosis, and in doing so releasing capacity for better quality and more timely treatment for those who need it. A fourteen-year review of a UK teledermatology service found that 50% of cases were discharged to the GP with advice and 34% booked directly for surgery ('A 14 year review of a UK teledermatology service: experience of over 40,000 teleconsultations' Mehrtens, Shall, Halpern Clin Exp Dermatol 2019 44(8): 874-881). A range of skin cancer teledermatology models have also been developed nationally. Pilots in Leeds and York receiving referrals with high quality dermoscopic images from GPs suggest approximately 10-30% of cases can be managed without a face to face consultation (Outpatients Case Studies; The BAD, 2019).

The case for change in delivery of dermatology outpatient services was already clear. The Third Phase of NHS Response To Covid-19 states that clinicians should consider avoiding asking patients to attend physical outpatient appointments where a clinically-appropriate and accessible alternative exists. Teledermatology triage provides that alternative for dermatology outpatient services and by taking advantage of available technologies can also improve productivity while providing the same level of access to high quality care, diagnostics and treatments.

## Who is this roadmap for?

**This roadmap sets out what all systems can do now to implement, optimise and mobilise teledermatology models to help them safely manage new patient demand and the existing backlog while restoring their face to face services.** It is aimed at operational and transformation leads working at a regional or Integrated Care System (ICS) level to support planning and delivery of dermatology restoration and transformation.

Teledermatology triage is a multi-disciplinary and cross-sector solution. Where they do not already exist, local leads should establish a working group or network to deliver dermatology restoration and transformation that includes multi-disciplinary clinical leads (consultant, GP, specialist nurse, pharmacy), commissioners, managers and admin staff from primary, community and secondary care, provider eRS teams, IT teams and patients representing skin conditions and the local population.

This document sets out five actions that are achievable now in all systems to deliver teledermatology triage of new referrals and four principles to observe in implementation. The specific implementation will depend on the local context: IT systems already in use in primary and secondary care, locally available supporting platforms including smartphone secure image apps, and existing community and GPwER services. Available supporting guidance is signposted in the document.

The Going Further section highlights further opportunities for using teledermatology to improve dermatology care across the pathway.

We welcome feedback on this roadmap, on how it is being implemented and on different local approaches to manage demand for dermatology by transforming pathways and services. Please share your thoughts on the forum in the Elective Care Community of Practice Dermatology section. We will also be updating the resource hub with tools to support your local implementation. To access the workspace you first need to register as a member by visiting https://future.nhs.uk/ecdc/joingroup.

## Step 1. Include images with dermatology referrals and Advice and Guidance requests to enable consultant triage, ensuring face to face attendances only when necessary.

Consultants should be enabled to triage new referrals into their service and decide whether the patient can be seen virtually, can be booked directly for further diagnostics or surgery, can be managed in primary care with advice and guidance, or requires a face to face first appointment. This will streamline and prioritise patient care, ensuring face to face attendances only when necessary and minimise transmission of Covid-19. For dermatology, triage requires suitable images to be attached to the referral[1]. This presents a huge opportunity for dermatology with up to 30% of new referrals for lesions avoiding an otherwise face to face attendance. There will still be instances where it is not possible or appropriate to include an image (see Principle 1) but this capability will support the majority of cases.

Currently in England, all referrals must be made via the electronic Referral System (eRS). Images can be attached to referrals in eRS from GP integrated systems up to a maximum of 5MB. Web-based attachments can be 5MB each, with no limit to the number of files attached. Some commercially available GDPR compliant photo apps can automatically adjust the file size and resolution to support attachment to eRS. Application-programme interfaces (APIs) are in development that support the use of eRS referral pathways with images improve the user experience.

Some centres have introduced teledermatology using medical photography services. The benefit of this approach is that images are consistently high quality although, depending on their location, it can still require a hospital visit for the patient. Other secondary care driven teledermatology services can make use of patient communication platforms that send referred patients a link to instructions on how to take their own images and share directly. However, this is not suitable for skin cancer pathways where a dermoscopic image is required.

Secondary care departments can list their referral services on the eRS directory as either 'Directly Bookable' or a 'Referral Assessment Service' (RAS). RAS services allow the provider to assess the clinical information and triage the patient, prior to booking an appointment, and include the ability for referrals to be returned to the referrer with advice only or redirected to the most appropriate service. RAS have potential advantages in dermatology where images can allow effective triage. It may be appropriate for some services to remain directly bookable, maximising patient choice of appointment. A RAS can

[1] Images need to be in focus and good quality. For lesions, a dermoscopic image is necessary for conclusive diagnosis.

be configured so that once the referral is triaged patients can choose their own appointment in the correct clinic.

Advice and Guidance (A&G) is another route to specialist opinion for primary care, including with images. A&G can be requested via eRS and through other commercial platforms, often combined with GDPR compliant image sharing. A&G services should be used when the referring clinician needs advice on management in primary care or is unsure whether a referral is needed. Clinical responsibility remains with the referrer. The specialist reviewing the A&G request can advise that a referral be made, but it is the responsibility of the requesting clinician to make the referral.

**Key actions:**

*ICS leads*

- Ensure primary care practices have the necessary equipment and digital tools to take and transfer patient images. Information Governance compliant apps are available that allow photos to be taken on a personal device and transferred securely to the patient record without saving on the device itself.
- Facilitate regular update and communication of the Directory of Services between primary and secondary care.

*Secondary care and consultant-led community providers*

- Consider using eRS RAS pathways for dermatology referral triage.
- Provide a clear directory of services including consistent naming conventions with inclusion and exclusion criteria. Include clear instructions for the images required, e.g. one positioning and one or two close-up or dermoscopic images for lesions where possible.
- Provide a teledermatology Advice & Guidance service in addition to a referral triage pathway to provide rapid advice to primary care and avoid unnecessary referrals.

*Primary care providers*

- Attach suitable images to new referrals to dermatology services that will enable consultant triage.

**Tools and further guidance**

- The BAD Teledermatology web pages including Quality Standards
- Outpatients Case Studies; The BAD, 2019
- NHS e-Referral Service
- Advice and guidance toolkit for the NHS e-Referral Service (eRS)
- RCGP Dermatology toolkit
- NHSX: Dermatology Digital Playbook *expected publication October 2020*

- GIRFT Report: Dermatology *expected publication 2020*

## Step 2. Triage suspected cancer as well as routine referrals using teledermatology

The greatest demand on dermatology services comes from new suspected cancers. In many cases, dermatology consultants can quickly determine that a lesion is clearly benign (Outpatients Case Studies; the BAD, 2019). Recent guidance from the NHS Cancer Programme to Cancer Alliances on 'Urgent Cancer Diagnostic Services During Covid19' includes the use of images to support diagnosis of suspected skin cancers. These are indicative proposals and not mandatory changes with feedback being sought on local approaches as different models are piloted and implemented.

A dermoscopic and macroscopic image are required for conclusive diagnosis of pigmented lesions and suspected melanoma. Without dermoscopic images, triage can still support direct booking for skin surgery for some squamous cell carcinoma (SCC). Dermoscopic images can be taken by trained staff in primary care or medical photography services, ideally based in the community. Dermatoscope attachments for cameras and smartphones can be purchased so that digital images can be shared using the same workflows as normal image sharing. High quality, in-focus images are required for accurate diagnosis.

Triage of suspected cancer referrals should be carried out by a dermatologist core member of the local skin cancer multidisciplinary team (LSMDT) or specialist skin cancer multidisciplinary team (SSMDT). Local triage pathways should also allow for the upgrade of routine referrals to the cancer pathway where identified.

Guidance on managing two-week wait referrals during Covid-19 allows for a video or telephone consultation to be recorded as a 'first seen date' for those on a 2 week wait pathway, but not a review of images. Currently, to include referrals in the cancer waiting times dataset for patients where cancer has been conclusively excluded using teledermatology, the patient must be 'seen' by phone/video. A review of digital images can be entered as a conclusive diagnostic for the Faster Diagnosis Standard where appropriate.

**Key actions:**

*ICS leads*

- Provide primary care practices with dermatoscope, smartphone attachment and GDPR compliant app plus training to support total dermatology triage.

- Collaborate with the cancer alliance to ensure compliance with monitoring cancer waiting times and to fully understand the impact of teledermatology triage on the data. Further guidance will be developed on applying cancer wait times guidance to support services introducing skin cancer teledermatology.

*Secondary care and consultant-led community providers*

- Ensure triage of suspected cancers is carried out by consultant dermatologists, ideally members of the LSMDT or SSMDT.
- Record the correct cancer wait times data for the two-week wait and faster diagnosis standard. Further guidance will be developed on applying cancer wait times guidance to support services introducing skin cancer teledermatology.

*Primary care providers*

- Support staff to complete training in dermoscopy.
- Where the equipment and training has been made available, attach dermoscopic images to skin lesion referrals, urgent or routine.
- Nominate teledermatology champions who can train others in the practice or network and engage with system partners to design and implement teledermatology pathways.

**Tools and further guidance**

- Letter: Cancer alliance information on managing cancer referrals
- RCGP Dermatology toolkit: Learning resources for dermoscopy
- RCGP Dermatology toolkit: Clinical resources for practitioners
- The BAD Dermatoscope Comparison
- NHS Cancer Programme 'Urgent Cancer Diagnostic Services During Covid19' via the Cancer Alliances workspace on FutureNHS.

## Step 3. Include clinical review of teledermatology A&G requests and referrals in consultant job plans as part of their direct clinical care

Including time for teledermatology – referral triage, virtual attendance and Advice & Guidance - in clinician job plans is crucial for properly understanding service capacity, maintaining quality, and developing sustainable funding models.

Time spent on teledermatology, including the associated administration, should be included within the direct clinical care (DCC) component of the consultant's programmed activities (PAs). This means that teledermatology review should take up some of the time currently spent doing face to face appointments or other DCC activities, rather than being additional unscheduled work.

**Key actions:**

*Secondary care and consultant-led community providers*

- Review job plans with dermatology specialists and include direct clinical time for delivery of different types of teledermatology care - triage, virtual attendance and Advice & Guidance.
- Establish consistent coding and classification practices so that teledermatology care is counted as activity and encourage clinical teams to perform regular audit and service evaluation of case numbers and outcomes.

**Tools and further guidance**

- A guide to job planning for dermatologists (The BAD)
- An overview of job planning (The BMA)

## Step 4. Record teledermatology activity accurately to reflect the type of clinical contact taking place and support sustainable funding models

Specialists can provide care teledermatology in many ways, including

1. Advice & Guidance to the primary care clinician
2. Triage of new referrals
3. Virtual review of images taking the place of an otherwise face to face appointment

Planned reforms to the NHS payment system will mean a move away from activity-based payments and ensure a majority of funding is population-based. A blended payment approach places more emphasis on system planning and working and less emphasis on individual units of activity delivered by consultants in a face-to-face setting, which can create barriers to shifting care to non-acute settings. Blended payments are made up of a fixed element based on an agreed level of activity, a quality or outcomes-based element and an optional risk share element. Activity forecasts for agreeing blended payments should include all types of teledermatology activity.

Currently, all NHS trusts and foundation trusts have moved to block contract payments with suspension of the usual PBR national tariff payment architecture (Next steps on NHS response to Covid-19). The intention is to move towards a revised financial framework for the latter part of 2020/21, which will retain simplified arrangements for payment and contracting but with a greater focus on system partnership and the restoration of elective services. Monitoring and recording teledermatology activity and costs during this period will support the development of sustainable funding models for the future.

**Key actions:**

*Secondary care and consultant-led community providers*

- Record teledermatology attendances as non face-to-face activity in the activity dataset
- Record teledermatology Advice & Guidance requests and triage outcomes to monitor avoided face to face appointments.
- Perform regular service evaluation of your teledermatology service, including clinician time, digital resources, equipment and outcomes.

**Tools and further guidance:**

- Guidance on blended payments

## Step 5. Maintain teledermatology pathways through continuous training across professional groups and care settings.

Continuous training and shared-learning is necessary to maintain teledermatology pathways as part of a sustainable, integrated multi-disciplinary dermatology service. It is important to refresh and update training on teledermatology processes regularly for both primary and secondary care and to consider the training needs for the entire clinical and administrative workforce, not just consultants and GPs.

Software developments may provide opportunities for greater productivity that are missed if staff are not made aware of them or do not know how to use them. New staff joining a practice or department will need to be trained in the local teledermatology pathway as part of their induction. Developing local teledermatology champions across primary and secondary care can help to make sure this focus is sustained.

Systems implementing teledermatology pathways for lesions with primary care dermoscopy need to provide access to training. Training GPs in using a dermatoscope will also increase diagnostic accuracy of skin lesions in primary care and reduce the number of referrals for benign lesions that are made.

There are several accredited courses for dermoscopy training, as well as an array of online learning opportunities, dermoscopy blogs, apps, and books. Once started the fastest way to improve is by looking at ALL skin lesions using a dermatoscope daily in your practice and refer to pictures online or in books. *RCGP Dermatology Toolkit*

**Key actions:**

*ICS leads*

- Consider ongoing training needs when facilitating the design of an end-to-end teledermatology pathway including process training for primary and secondary care, clinicians and administrative staff.
- For pigmented lesion pathways, provide training for primary care staff taking dermoscopic images.
- Collect feedback of how the pathway is performing across the system and use this as a basis for further training and development.

*Secondary care and consultant-led community providers*

- Provide regular and updated training on use of teledermatology processes for the different care pathways.
- Ensure that software updates or new system integrations are implemented alongside training for all staff.

*Primary care providers*

- Support staff to complete training in dermoscopy.
- Provide regular and updated training on the use of teledermatology processes for the different care pathways.
- Ensure that software updates or new system integrations are implemented alongside training for all staff.

**Tools and further guidance**

- RCGP Dermatology Toolkit
- BAD Annual Teledermatology Course
- eRS trainer resources

## Principle 1. Patients need to be kept informed directly about the care pathway they are on, their diagnosis and treatment plan in a clear, compassionate and timely way.

As with all non-face to face attendances, it is very important that people are given clear information about their care, what is happening next and how they will find out.

In primary care, people should be given information about why an image is needed, how it will be stored, transferred and used so they can give their informed consent. People need to understand whether the image is being shared with another service for A&G or for a referral

triage and how they will hear about the response. Both clinical and administrative staff should be able to answer questions about use of personal information, including images.

While referrals with images should be the default, pathways need to be flexible to manage patient choice with respect to image sharing. Clinicians must be sensitive to peoples' concerns and anxieties about being photographed, and not put pressure onto them (directly or indirectly) to be photographed and share images of themselves. This is particularly relevant to skin conditions of intimate body areas.

Communicating effectively with patients is central to being a good doctor. Writing an outpatient clinic letter directly to the patient, rather than sending them a copy of a letter sent to their GP, can greatly improve communication with a patient. Patients who receive such letters much prefer them, are very appreciative, and would like more doctors to write them in this way. *Please, write to me: Writing outpatient clinic letters to patients Guidance, AOMRC 2018*

The triage or A&G outcome should be communicated back to patients in a timely manner. Where direct communication is not available, the body of the response should still be addressed to the patient and written in a way that makes it easy to understand the suggested management plan. Links to self-management resources or patient information should also be included.

As with all patient communications, accessibility standards must be met.

For people with long term skin conditions, referral to secondary care may only happen after several years of trying different treatments in primary care. Increased use of Advice and Guidance should mean that patients are referred at the right time and do not experience a delay to referral. However, because of this common experience it is important for both the referring and receiving clinician to be sensitive to patients' expectations of their referral when communicating their opinion or management advice. Clinicians also need to acknowledge the potential burden of treatment, especially self-management, as well as the burden of the presenting condition.

Dermatology patients sometimes report feeling dismissed by either their GP or the consultant. This can be because of a perceived lack of knowledge or a lack of interest in the social and psychological impacts of skin disease (Ineffective consultations for acne: what is important to patients? Cowdell et al. Br J Dermatol. 2016 Oct;175(4):826-8). Long term skin conditions can lead to serious disability, carry a significant psychosocial burden and should

not be trivialised (The psychological and social impact of skin diseases on people's lives; APPG Skin, 2013). Management advice should consider the psychosocial impacts on the patient as well as the physical skin complaint. When it is clinically appropriate to continue management in primary care, this should be carefully communicated to people with long term conditions with an opportunity for them to ask questions. Ideally, this information should be given verbally and in writing, and the opportunity to ask questions should also be available via multiple routes: phone, email, in person etc.

**Key actions:**

*ICS leads*

- Ensure members of the public and dermatology patients are involved in the co-production of end-to-end teledermatology pathways.
- Collect feedback from patients specifically about the quality of communication they experience as part of a teledermatology pathway to support continuous improvement.

*Secondary care and consultant-led community providers*

- Follow the 'Please, write to me' guidance from the Academy of Medical Royal Colleges in communication with patients, even via the GP.
- Include links to good quality patient information and self-management support in standard letters.
- Address psychosocial impacts as well as the physical skin condition in teledermatology Advice & Guidance.

*Primary care providers*

- Practice shared decision making with patients about making a teledermatology A&G or triage request and provide written information about how they will hear back from the consultant.
- Allow time for patients to discuss with a primary care clinician any self-management advice suggested by the dermatologist.

**Tools and further guidance**

- Please, write to me: Writing outpatient clinic letters to patients Guidance
- eRS: Information for referrers
- BAD teledermatology web page (including Quality Standards)
- Skin conditions patient information from the BAD
- The BAD Patient Information Remote Consultations Guidance

## Principle 2. Teledermatology workflows should not add burden to primary or secondary care.

It is essential that teledermatology pathways do not place additional administrative burdens on staff. Sustainable teledermatology pathways make use of additional digital tools that make the process quick and simple.

> The primary care consultation should be focussed on interacting with the patient, understanding their concerns and coming to a shared decision of next steps – not searching the practice for a camera and cable, saving images, moving image files, deleting image files, and finally completing the referral.

Primary care services have moved to more virtual methods during the response to Covid-19. Patients can now usually share photos of their skin problem virtually with the GP using apps available to primary care through the Future GP IT systems and services. These images can then be simply added to the referral without a face to face appointment in primary care if of sufficiently high quality. However, not everyone will be able to take their own images. People may not have access to a smart device, need someone else to take the photograph for them or need dermoscopy. Therefore, the option to have images taken by a healthcare professional in primary care should be available. There is a risk that relevant skin lesions may be missed if a total skin examination is not carried out; so, suspected skin cancer images will usually be taken in primary care and a full skin check performed by the GP. It does not have to be the GP who takes all images, but staff asked to take images should be trained in the relevant safeguarding, consent and information governance policies.

The main long-term benefit of teledermatology triage is to ensure patients receive timely care in the most appropriate setting and at greater convenience. This in turn increases capacity in secondary care for patients who need face-to-face referrals. However, moving to teledermatology triage does not necessarily mean productivity gains will be realised. Poorly designed workflows and a lack of supporting infrastructure, equipment and administration can mean that teledermatology reviews are more burdensome for secondary care clinicians to deliver than a face to face appointment.

In response to Covid-19 some services have rapidly moved to teledermatology to reduce hospital attendances but have not realised the productivity gains through a sustainable implementation. Patient images that are sent via email, even to a secure mailbox, need to be managed and stored properly. Without a suitable archive system, the images may not be immediately accessible or require the clinician or administrator to perform many separate computer processes.

Patient images supporting either a referral or A&G request should be accessible from provider hospital IT platforms, either in eRS, or transferred via a suitable GDPR compliant

platform. Receiving clinicians should be able to review images and patient information in a digital format, i.e. not printed out, and action them directly in the system.

Images received via eRS referrals will remain archived in eRS and accessible from both primary and secondary care. Patient images should be added to the electronic patient record, or to a digital picture archiving system. National eRS workstreams are in place to improve the interoperability between eRS and provider organisations to facilitate transfer of A&G images to Trust systems.

There is significant scope for digital tools to improve teledermatology processes in secondary care, making workflows simple and automatic for staff. This requires additional investment and site-specific development. However, proper set up of eRS with a RAS pathway, A&G and suitable training for clinical and administrative staff should alone deliver a benefit over default face to face appointments.

**Key actions:**

*ICS leads*

- Ensure that teledermatology pathways are designed end-to-end by a multi-disciplinary, cross-system group to minimise unintended additional burden on single parts of the system.
- Make sure primary care staff are supported by suitable digital platforms and workflows that are GDPR compliant and have the right equipment available.
- Collect feedback of how the pathway is performing across the system and share with all providers involved so that continuous improvements can be made: experience of patients, usability/quality of images shared, time taken to respond etc.

*Secondary care and consultant-led community providers*

- Implement RAS pathways to optimise referral triage *only* after co-producing an end-to-end pathway with colleagues from across the system.
- Provide IT support to dermatology services to identify their user needs and potential solutions. Support services to optimise their use of existing systems such as eRS, the provider electronic patient record, PACS or other systems.
- Provide training and support to clinical and administrative staff in using digital teledermatology processes.
- Perform regular service evaluation of existing and new teledermatology processes to quantify the productivity of the service. Use a continuous improvement approach to ensure that this way of working delivers the benefits that it should.

*Primary care providers*

- Nominate teledermatology champions who can train others in the practice and engage with system partners to design and implement teledermatology pathways.
- Provide information on the use and storage of images and obtain informed consent from patients.
- Train staff to be able to answer queries about use of images and support patients to make informed decisions.
- Support effective triage pathways by referring with images of sufficient quality and patient history.

**Tools and further guidance**

- Example of eRS teledermatology consent form (The BAD)
- RCGP Dermatology toolkit
- Future GP IT systems and services
- How to take the best photographs of your skin lesion or rash (Gloucestershire Hospitals NHS FT)
- Skin conditions patient information from the BAD
- Advice and guidance toolkit for the NHS e-Referral Service (eRS)
- Referral Assessment Services - NHS e-Referral Service
- NHSX: Dermatology Digital Playbook *expected publication October 2020*

## Going further: increasing the role of teledermatology to deliver personalised care across dermatology services

This roadmap is focussed on what all systems can do now to optimise dermatology triage services to manage demand, reduce unnecessary patient attendances and restore their outpatient services. Already there are further opportunities identified for teledermatology to be used in new and innovative ways to deliver more personalised and better integrated care:

- Teledermatology can be used to support shared care protocols between primary, community and secondary care for patients with long term conditions. Use of digital tools could also facilitate greater access to a wider range of specialist support that can be valuable to people with skin conditions, such as dietary advice, psychodermatology and pharmacy.

- Shared patient records give patients greater control over their condition. Images of the patient's skin condition, results from blood tests and other information can be shared with the specialist team to be reviewed in their appointment or to support a personalised schedule for follow up appointments.

- It will not always be possible for patients to take images of themselves. They may not have the necessary devices or may need to photograph a hard to reach area. Community access making use of shared patient records can mitigate digital and social exclusion.

- Teledermatology can support integrated care between different secondary care providers and support access for patients in areas with particularly low numbers of consultants.

- There are apps available and in development that can help patients take pictures of their own skin and monitor changes over time. This technology could be used as part of long term condition management to help patients monitor their own condition, and also support dermatology pathways that need a whole skin check.

## A Teledermatology Roadmap for 2020-21 produced in partnership with:

British Association of Dermatologists
healthy skin for all

GIRFT
GETTING IT RIGHT FIRST TIME

NATIONAL ECZEMA SOCIETY

RCGP Royal College of General Practitioners

psoriasis association

PCDS
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