BRITISH ASSOCIATION OF DERMATOLOGISTS
HEALTHY SKIN FOR ALL

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SERVICE GUIDANCE AND STANDARDS FOR THE USE OF TELEDERMATOLOGY

Next Review: November 2025

British Association of Dermatologists
Willan House
4 Fitzroy Square
London W1T 5HQ

Transformation and Quality Improvement Unit
Tel: +44 207 391 6085
Email: serviceimprovement@bad.org.uk

Produced by: Teledermatology Working Party Group
Approved by: The Officers of the British Association of Dermatologists

Acknowledgements

In 2023, the BAD invited a range of teledermatology service users and stakeholder representatives to form a Working Party Group to inform on our Teledermatology Service Standards and Guidance.

Our BAD Officers would like to express their gratitude to the Teledermatology Service Standards WPG (TD SGS WPG) for helping us to produce the Service Guidance and Standards for the use of teledermatology. These guidelines can be used at any stage of implementation to provide an invaluable resource for Integrated Care Boards (ICBs), Health Boards and dermatology service providers. Our BAD guidelines are produced independently of any funding body and through the time given freely by the TD SGS WPG members.

Multidisciplinary Working Party Group Members

The following people have provided continued advice and support in compiling and editing these standards:

Dr Walayat Hussain *Consultant Dermatologist*	Chair of WPG British Society for Dermatological Surgery
Tania von Hospenthal *Director of Transformation and Quality Improvement, British Association of Dermatologists*	Programme Manager
Emma Lennard *Teledermatology and Artificial Intelligence Administrator, British Association of Dermatologists*	WPG Administrator
Dr Carolyn Charman *Consultant Dermatologist*	Clinical Vice President of British Association of Dermatologists
Professor Brian Kirby *Consultant Dermatologist*	Northern Ireland/Ireland Representative
Professor Colin Fleming *Consultant Dermatologist*	Scotland Representative
Dr Ausama Atwan *Consultant Dermatologist*	Wales Representative
Dr Irshad Zaki *Consultant Dermatologist*	Dermatologist
Dr Hywel Cooper *Consultant Dermatologist*	Dermatologist
Dr Stephanie Gallard *GP or GPwER*	The Primary Care Dermatology Society (PCDS) Representative
ANP Amanda McQueen *Skin Cancer Nurse*	British Dermatological Nursing Group (BDNG) Representative

Becky Lee *Teledermatology Lead for the Institute of Medical Illustrators*	Institute of Medical Illustrators Representative
Nicole Dacosta *Transformation Manager*	Coventry and Warwickshire Integrated Care Board Representative
Kerry Porter *Cancer Alliance Teledermatology Project Manager*	Community Diagnostic Centre Representative
Suzette Fernandos *Senior Programme Manager*	NHS Greater Manchester Integrated Care Board Representative

Declarations of interest

All WPG members were asked to declare any pecuniary or non-pecuniary conflict of interest, in line with the BAD conflict of interest's policy. There were no declarations made from our WPG members.

Contents

Aims, purpose, and scope

Aims

Service guidance and standards (SGS) are developed primarily for commissioners of NHS services, service providers (NHS and private practice) and those regulatory bodies involved in the scrutiny of care.

The SGS aims:

- To produce evidence-based Service Standards for the provision of teledermatology services in the United Kingdom.
- To ensure commissioners of NHS services procure services from appropriately qualified and accredited providers.
- To improve direct access to care for patients requiring treatments, reducing unnecessary consultations, and improving cost effectiveness in the care pathway.
- To standardise the recording and labelling of images used in teledermatology interactions.
- To quality assure teledermatology education and training standards within services.
- To quality assure patient outcomes by improving the clinical recording of decisions and audit reporting for teledermatology services.
- To allow data to be interoperable and dual use in services, in preparation for being 'AI ready.'

Purpose

BAD Service Guidance and Standards for teledermatology are designed to provide a set of required Service Standards which underpin NICE clinical guidelines and inform NICE quality standards (outcome indicators). This document forms the basis of a quality assurance programme for all teledermatology services nationally. It sets out those essential criteria for the safe provision of care for all patients being virtually diagnosed and managed using teledermatology. Service Standards are aligned to existing frameworks for NHS clinical governance, CQC fundamental standards of care and their equivalent for the devolved nations, and the service and general conditions of the NHS standard contract for providers.

Scope

Advancements in information technology (IT), including wider availability of secure clinical image apps and enhancements to the NHS e-Referral Advice and Guidance Service (in England), high-definition video conferencing, mobile devices and networks, and ubiquitous broadband networks, have created an opportunity to leverage teledermatology as a way of improving access to dermatology care for patients. Dermatologists in the UK can use this technology to provide clinical services to patients, to diagnose and manage patients, to consult with other health care providers, and to provide patients access to educational resources.

It is important for the teledermatology service guidance and accompanying standards to reflect how these advancements in digital innovation and technology impact on the experience of patients and clinical teams using the service. For this reason, this guidance follows the patient teledermatology care pathway from referral to discharge. As far as possible, standards are written from the service user perspective and reflect the service infrastructure required to reduce risk and harm.

We recognise that services are under increased pressure to demonstrate that they comply with national policies and guidelines. For this reason, our guidance incorporates existing requirements and standards (recommendations) set out nationally for NHS services. Providers are able to identify the relevant

service standards applicable to their existing or intended services using our "Implementation Assessment Grid" contained in Appendix 1.

Introduction

There is an increasing amount of data regarding the effectiveness of asynchronous teledermatology for a variety of skin disorders that present in diverse practice settings including emergency departments, hospitals, patient homes, schools, chronic care facilities, the workplace, and the military. Published studies on advice and guidance and teledermatology review of referrals demonstrate a reduction in waiting times for secondary care dermatology consultations through the prevention of unnecessary appointments, and by increasing the number of patients with skin problems who can be safely managed in primary care.

There is however an absence of evidence on the potential for an increase in missed or delayed diagnosis that may result from fewer face-to-face consultations. Further data is required on the equality impact(s) of using teledermatology to review patients. Comparative studies are required examining the clinical and health economic effects of teledermatology usage in unselected primary care referrals for both adults and children.

In this document standards are expressed as measures which teledermatology services should meet as an overriding duty to provide quality care (NHS and private healthcare). They provide the basis for evaluating the quality of a service and areas for improvement through the use of audit.

All decisions in the development of this guidance have been made by the WPG through a process of informal-consensus and agreement. The finalised teledermatology service guidance and standards have been scrutinised and approved by the BAD Officers prior to consultation with our stakeholders.

A formal consultation period (normally one month) also took place to allow for stakeholder registration and feedback on the teledermatology service guidance and standards. Comments received have been collected using a standard proforma recognised by NICE. Stakeholder feedback has been responded to by the WPG and any necessary changes to guidance actioned prior to its publication.

Service Standards Framework

As far as possible, standards are written from the service user perspective and reflect the service infrastructure required to reduce risk and harm. For this reason, the guidance follows the patient care pathway to capture how teledermatology should be used in the virtual management of patients.

Our standards are covered by the following topic headings:

STANDARD 1: Patient Criteria for Teledermatology
STANDARD 2: Patient Information and Consent
STANDARD 3: Teledermatology Virtual Review of Patients
STANDARD 4: Staff, Training, and Education
STANDARD 5: Equipment and Facilities
STANDARD 6: Governance, Audit, and Quality Improvement

Evidence/Minimum requirements

Each service standard has its own 'rationale' and 'essential criteria' section, which must be demonstrated with a range of supporting evidence. Some of the evidence requirements relate to existing national

policy and guidelines, which underpin all services. All standards require a set number of anonymised patient cases to be used in the self–assessment audit which accompany each standard.

Please note that providers are not required to meet all essential criteria in each service standard. This should be specific to the use of teledermatology and application in the service. This allows providers to tailor teledermatology usage to their service needs and assess its effectiveness once implemented. Please see the accompanying teledermatology service options grid for selecting your service criteria. ***

Self-Assessment Audit

Each service standard has a series of audit questions used to demonstrate how essential criteria are being met by a department. The following flag status system is used to identify areas of risk within the essential criteria and their self-audit outcomes.

For Example:

	Essential Criteria	Comments	Status
100%	90% of all referrals will start treatment within six weeks of referral	79% of patients started treatment within six weeks of referral	100% Green Flag 70-99% Yellow Flag <70% Red Flag

- Red Flag [Action Required]: failure to meet these standards places undue clinical risk on patients, breaches their rights or dignity and/or may result in remedial action.
- Yellow Flag [Monitoring Required]: service standards that a service would be expected to meet.
- Green Flag [No Action Required]: meets service standard essential criteria.

Please note where the 'Essential Criteria' outcome dictates clear boundaries for % 100 Green without any moderation, then the Status should be changed to indicate only Yes = Green and No = Red. The yellow flag is deleted.

It is recommended that secondary care providers should allow an implementation period of 12 months to identify gaps and barriers in their teledermatology service provision. This enables the multi-disciplinary team to review their local procedures and practices against the standards and, if necessary, implement the changes required. A summary of the results from the self-assessment audit should form the basis of a Gap analysis and business case for any identified areas of service improvement.

Participation in the self-assessment audit provides valuable assurance about dermatology services and provides important evidence about the safety, effectiveness, and responsiveness of services.

It is particularly recommended that trainee cohorts are involved in the self-assessment audit process. Many of the standards require audit evidence to demonstrate compliance and these can form the basis of quality improvement projects.

Registration

The registration form is available on the BAD website. It requires each department to provide contact details for the person responsible for co-ordinating the department's participation in the Service Guidance and Standards (SGS) audit. This should be the teledermatology lead(s) for the department.

For departments in England, the CQC regards the BAD SGS as an approved source of information on the quality and uses these in its inspections of dermatology services.

Medicolegal implications of SGS

SGS are intended to provide measurable service frameworks for the safe delivery of clinical care to patients. These are underpinned by evidence, laws and professional standards that support each standard. Health-care professionals should be able act in accordance with service guidelines accepted as proper by a responsible body of professionals.

All self-assessment audit reports for the SGS should be used for quality outcome reporting to Trust Boards, Integrated Care Boards, Health Boards and for CQC inspections (and their equivalent in the devolved nations).

SERVICE GUIDANCE AND STANDARDS

Standard 1: Patient Criteria for Teledermatology

Standard Statement 1A – Inclusion and Exclusion Criteria for Teledermatology

Rationale

Providers of teledermatology services should provide nationally recognised clearly defined criteria to local clinical teams to identify suitable patients who would benefit from virtual diagnosis and/or management. All teledermatology services should specify inclusion and exclusion criteria in the four core areas of practice for dermatology:

- Urgent suspected skin cancer (virtual urgent suspected skin cancer referral)
- Basal cell carcinomas and precancerous skin lesions (Advice and Guidance +/- referral) or (virtual referral)
- Adult general dermatology (Advice and Guidance +/- referral) or (virtual referral)
- Paediatric general dermatology (Advice and Guidance +/- referral) or (virtual referral)

The provision of teledermatology services across these four core patient groups will vary according to the specialist care provided by the provider organisation. BAD national referral guidance can help support appropriate use of teledermatology services and provide GPs with an additional patient management resource.

Providers of teledermatology services should publish agreed response times for turn-around of teledermatology requests and referrals to support appropriate selection of patients.

Essential Criteria

1A.1	Define local exclusion criteria with the skin cancer consultant team for urgent suspected skin cancer teledermatology pathways. Examples of exclusion criteria **may** include: • More than two lesions for review • Lesions of a certain size, i.e. lesions that may necessitate the capture of several clinical and dermatoscopic images, may not be feasible (see standard 3; Essential Criteria 3A.2) • Subcutaneous lumps • Lesions on mucosal surfaces due to infection control procedures • Lesions on genital skin (difficult to photograph areas) • Lesions in scars, tattoos, and hair-bearing sites (difficult to visualise) • People with a previous history of multiple skin cancers and extensive sun damage (face-to-face review for total skin examination recommended) • Patients who are unable to have dermoscopic images taken
1A.2	Define local exclusion criteria for Advice and Guidance (A&G) teledermatology services. Examples of exclusion criteria include: • Benign lesions (according to local benign skin lesion policy e.g. warts, molluscum, cysts, etc) unless there is diagnostic uncertainty • Requests for generic dermatology advice which is already available in local and BAD national referral management guidelines A&G should not be used for administration requests, e.g. requesting for change in appointment, or for drug information available from the BNF or pharmacy departments.

1A.3	Define provider exclusions criteria for patients that may not be suitable for teledermatology and should be directly referred for a face-to-face appointment, for example where: · the skin condition may not photograph well, particularly with skin of colour · there is widespread inflammation of the skin involving multiple body sites, including scalp and nails · the skin condition is chronic causing significant physical, social, and psychological impairment and may require complex treatment plans for safe and effective long-term management · Where the patients skin care management and support may exceed the clinical experience of the referrer. · Skin conditions where current BAD guidelines cannot be followed Patients being referred with severe skin conditions requiring an urgent appointment can be reviewed using teledermatology to help prioritise their care. Referrers should be encouraged to include macroscopic images and complete clinical history with the referral.

Examples of Suitable Evidence	
1A.1 to 1A.3	Locally agreed patient inclusion and exclusion criteria covering the range of teledermatology services of the provider published on the provider's service directory.
1A.1 to 1A.3	Published agreed response times for responding to the select range of teledermatology services provided by the provider.

Audit Outcomes - of 50 Patient Cases		**Status**
1A.1	90% of urgent skin cancer teledermatology referrals exclude patients with agreed exclusion criteria.	90% **Green** 70-89% **Yellow** <70% **Red**
1A.2	90% Teledermatology Advice and Guidance requests exclude patients with agreed exclusion criteria.	90% **Green** 70-89% **Yellow** <70% **Red**

Audit Questionnaire			
1A.1 + 1A.3	**Q.1.** Does the teledermatology service have published inclusion and exclusion criteria for patients with skin disease?	**YES**	**NO**

Standard 2: Patient Information and Consent

Standard Statement 2A: Obtaining Explicit Consent	

Rationale

Patient consent should be documented for all teledermatology services. It is important that consent is given for taking patient images before the photographic session occurs. This should be properly discussed, understood, and agreed by the patient, and a record of any key elements of verbal discussion recorded in their healthcare record.

Where patient images are being taken for intended use beyond direct patient care (e.g. training and research) written consent is recommended. A clear indication of the governance arrangements for this data must be indicated, for example in a specifically ethically approved clinical study, consent to participate requires a very clear and specific statement of consent to be recorded and retained for as long as the images are held. Patients must be provided with clear information to opt in and to withdraw their images (opt out) from health records at any time.

Teledermatology images can provide a valuable source of education and quality assurance for health care professionals. Images made as part of the patient's care can be disclosed for teaching or training without additional consent where they can be anonymised, (i.e. not identifiable through scars, markings, or tattoos, etc).

Essential Criteria	
2A.1	Informed patient consent should be recorded in the patients' health record to use teledermatology images in secondary care to provide the patient with a diagnosis and management of their skin condition.
2A.2	Patient consent is sought for use of their images beyond direct patient care, and they are provided with information on how to withdraw their images at any time (opt out).
2A.3	There must be defined systems in place for patients to directly raise any queries or concerns relating to the teledermatology service in a timely manner.
2A.4	Staff must be aware of their providers chaperone policy for examination, investigation, or clinical recording. Any child or young person must be offered a chaperone prior to images being taken, usually a parent or carer chosen by the child for non-intimate areas. A formal chaperone must be present for photographing intimate areas for child protection purposes.

Examples of Suitable Evidence	
2A.1 to 2A.4	Teledermatology patient information, leaflet or teledermatology patient-facing website information.
2A.1 to 2A.4	Informed consent policy for teledermatology including vulnerable adults and children.
2A.1 to 2A.4	Copy of patient consent form used for the teledermatology service.
2A.4	Hospital chaperone policy for examination, investigation, or clinical recording.
Audit Outcomes - Review of 50 Patient Cases	**Status**

2A.1	100% Patient consent for the use of clinical images obtained in secondary care is visible in the patients record (including any optional consent for use in teaching).	>95% **Green** 70-95% **Yellow** <70% **Red**
2A.1 to 2A.4	100% Patients verbal discussion is recorded in their health records for taking images and using teledermatology.	>95% **Green** 70-95% **Yellow** <70% **Red**
2A.1 to 2A.4	100% Teledermatology patient information leaflet given to patients undergoing photography by the teledermatology provider.	>95% **Green** 70-95% **Yellow** <70% **Red**
Audit Questionnaire		
2A.3	**Q.1**. Are there defined systems in place for patients to directly raise any queries or concerns relating to the teledermatology service?	**YES** **NO**
2A.4	**Q.2.** Do all teledermatology staff follow their providers chaperone policy for examination, investigation, or clinical recording when photographing patients?	**YES** **NO**

Standard 3: Teledermatology Virtual Review of Patients

Standard Statement 3A: Teledermatology Images and Clinical Information	
Rationale Core clinical information is required to standardise the review of patients by teledermatology services. Teledermatology referrals and advice requests should be accompanied by a locally agreed clinical information proforma or a digital referral letter. Existing urgent suspected skin cancer (formerly 2-week wait suspected skin cancer) referral proformas can be modified so that their use can be extended to the virtual pathway. Patients on waiting lists can also be reviewed virtually using patients provided images and clinical history. Departments should provide information to patients on capturing of high-quality images to support accurate identification of skin site affected and skin disease severity. Core clinical data should be recorded with skin images in line with DICOM (Digital Imaging and Communications in Medicine), the international standard for medical images and related information. See 3A1 for the DICOM standards for skin cancer for use in AI. https://www.bad.org.uk/clinical-services/artificial-intelligence/.	
Essential Criteria	
3A.1	Core clinical data should accompany teledermatology images sent or captured by clinical teams, in line with DICOM standards: • Date and time of image capture. • Site location of image capture e.g. primary or secondary care setting. • Details of the health professional referring the patient for image capture. • Details of the clinician with overall responsibility of the patient. • A 10-digit identity number unique to each patient, or an equivalent identity number designated by another hospital/health service if the above does not apply. • Patient surname and forename(s). • Age or date of birth of patient at time of image capture. • Sex of the patient. • Ethnicity of patient – this relates to a shared history and culture, language, religion and traditions, as well as skin colour. • Fitzpatrick Skin Type (Type 1, 2, 3, 4, 5, 6) • Anatomical Site: (Head/Neck -Palms/Soles -Oral/Genital -Torso -Upper extremity -Lower extremity) • Anatomical Laterality: (Right or Left) • Patient Reported Lesion Characteristics & Lesion Visual Findings: -Itching -Erythema -Bleeding - Change. • Patient Reported Lesion Characteristics & Lesion Visual Findings: (- Changes in Size, Shape, Colour, Pattern, Pain from Lesion, time factors if known). • Previous history of skin cancer/melanoma
3A.2	Teledermatology Services should advertise minimum image criteria requirements for referrals and advice requests as follows (the number of lesions per referral will vary according to how well-established a service is and should be agreed amongst all local stakeholders): Core Images:

	• One macroscopic locating image to show the anatomical location of the lesion or skin condition on the body • At least one close-up image of the whole lesion • A lateral close-up image for lesions that are raised from the skin, to show the lesion in profile, if feasible • Patients own images can only be used if of adequate quality in line with the above. Dermoscopic image: • Essential for the virtual diagnosis of patients referred for urgent suspected skin cancer • Can be used for skin lesions sent through teledermatology Advice and Guidance (Specialist Advice services) by primary care • Lesion size may necessitate the capture of several clinical and dermatoscopic images to encompass the entirety of the lesion. Local teams may consider exclusion criteria based on lesion size if it is felt that accurate lesion representation is not feasible Macroscopic and dermatoscopic images should be checked for clarity before sending. Anyone undertaking medical photography should be trained appropriately (see 4A.5). Health Care Assistants should have links with the medical photography hubs in their locality.
Examples of Suitable Evidence	
3A.1+ 3A.2	Referrals received with complete patient demographic data, adequate clinical history, good-quality images and completed urgent skin cancer referral form.
3A.2	The department has documented minimum image criteria requirements for referrals and patients.

Audit Outcomes - Review of 50 Patient Cases		**Status**
3A.1	70% Teledermatology requests and referrals should include core clinical information to record with clinical images (DICOM).	>70% **Green Flag** 50%-70% **Yellow** <50% **Red**
3A.2	On average what percentage of urgent skin cancer referrals received from primary care contain a useable dermoscopic and macroscopic images?	%
3A.2	On average what percentage of urgent skin cancer referrals from primary care without images are booked in for medical photography (first seen)?	%

Audit Questionnaire			
3A.1	**Q.1.** Does the teledermatology service specify core clinical image and history criteria to clinical users of the service?	**YES**	**NO**

Standard Statement 3B: Teledermatology Specialist Review

Rationale

Providers of teledermatology services should respond within agreed local turn-around times. It is recommended that the response time for teledermatology Specialist Advice (including Advice and Guidance and referral review) should not exceed 10 working days for routine requests to minimise any risk to delaying patient care. Early response times will only be attainable when clinicians have appropriate time allocated in job plans that covers every working day.

The teledermatology review should provide a proposed diagnosis, or differential diagnosis, and a management plan, if appropriate to the referring clinician in a timely manner, to ensure a smooth pathway of care.

Urgent suspected skin cancer virtual reviews should continue to meet all waiting time standards (Cancer Waiting Times Guidance) for England or Health Boards in devolved nations. This includes any patients that are reviewed and booked straight to surgery (28 days, 31 days and 62 days). Urgent skin cancer diagnosis must be provided by consultant dermatologists and/or dermatology specialists who are core members of the hospitals local skin cancer Multi-Disciplinary Team (LSMDT) in the patient's locality.

When teledermatology is used for validation and clinical prioritisation of patients on outpatient waiting lists, systems must have clearly identified and agreed pathways to ensure all clinical information and images are available in the relevant patient record, including the original referral letter and images, as well as recent images. There should be agreed turnaround times for communication to the patient on their waiting list priority.

Providers of inpatient and on-call services should respond within locally agreed turn-around times for emergency teledermatology referrals.

Where teledermatology services are outsourced to independent providers, systems must have clearly identified and agreed pathways to link activity to local dermatology services.

Essential Criteria

3B.1	Urgent skin cancer referrals should be reviewed by consultant dermatologists and/or dermatology clinicians who are core or extended members of the hospitals local skin cancer Multi-Disciplinary Team (LSMDT) in the patient's locality. Membership on an MDT is specific to a patient locality. Patient cases needing discussions at MDT should be appropriately represented. See BAD Skin Cancer Service Standards.
3B.2	If a patient diagnosis or management plan cannot be provided through teledermatology because of low-quality images / clinical information, then the response should include feedback to the referrer to support quality improvement of future teledermatology requests.
3B. 3	Teledermatology requests returned to the referrer with advice should include links to patient information where appropriate.
3B.4	Patients on waiting lists should be written/emailed to ascertain their continued need for an appointment (waiting list validation). Patients may confirm the status of their skin condition using photographic images sent through to a secure NHS. Net, secure app, or patient engagement portal for review by the consultant team.
3B.5	All teledermatology patients booked directly for skin surgery have been provided with preoperative information and the contact details (email or phone) of the dermatology surgical team to discuss any queries prior to their surgical appointment.

Examples of Suitable Evidence

3B.1	Data on teledermatology service turn-around times and urgent skin cancer waiting times.
3B.3	Inclusion of GP and patient educational weblinks and resources in teledermatology responses.
3B.1 to 3B.5	GP / referring health care professional satisfaction survey assessing quality of teledermatology diagnosis and management plans and speed of response.

Audit Outcomes - Review of 50 Patient Cases		**Status**
3B.1	100% Urgent suspected skin cancer teledermatology referrals are reviewed and responded to by consultant dermatologists and/or dermatology specialists who are core members of hospitals local skin cancer Multi-Disciplinary Team (LSMDT) in the patient's locality.	>90% **Green** 70%-90% **Yellow** <70% **Red**
3B.2	100% Constructive feedback is provided to the referrer or image provider on low image quality or insufficient clinical information.	>90% **Green** 70%-90% **Yellow** <70% **Red**
3B.4	100% Teledermatology waiting list validation and prioritisation encounters (including images) are recorded in the patient's NHS hospital medical record.	>90% **Green** 70%-90% **Yellow** <70% **Red**

Audit Questionnaire			
3B.1 to 3B.5	**Q.1** Does the dermatology department regularly review/report on its teledermatology activity to look at rates of conversion to a face-to-face appointment?	**YES**	**NO**

Standard 4: Staff, Training, and Education

Standard Statement 4A – Qualified Professional Staff	
Rationale Teaching and learning should be incorporated into all aspects of teledermatology services, including collaborative review of cases and reflective learning for both referring and providing clinical teams. Skin cancer recognition requires a high degree of diagnostic accuracy; regular calibration of teledermatology diagnostic decisions against other clinicians can help maintain safe practice. Except for specific situations, teledermatology is expected to be only one part of the clinical activity most clinicians undertake, and usually, clinicians undertaking teledermatology activity would be expected to maintain their clinical skills by also doing face-to-face consultations. Appropriate time must be set aside for teledermatology, and this task must be explicitly included as part of the reporting specialist's job plan as direct clinical care. Job-Planning-for-Dermatologists-2022-.pdf (bad.org.uk) For models of care where a teledermatology encounter may replace a face-to-face consultation with a dermatologist, the reporting specialist must be in active clinical practice as an NHS consultant or a suitably trained member of the provider specialist dermatology team with experience in teledermatology. Healthcare professionals submitting teledermatology requests/referrals should be trained to use agreed-upon local national referral guidelines for teledermatology.	
Essential Criteria	
4A.1	Clinical leadership is vital in supporting education, training, and ongoing clinical governance arrangements for teledermatology. Dermatology services should have a named teledermatology clinical lead, to support the development of the service and work with all relevant partners across the local healthcare system (including primary, intermediate and secondary care and patients).
4A.2	There is a recognised teaching and training role for skin MDTs through feedback on teledermatology cases, both within the team itself and to clinicians in training on the virtual review/management of patient cases.
4A.3	Service providers using teledermatology to review / assess patients should be able to produce evidence of case-based discussions, audit, and peer reviews to show their healthcare professionals are competent.
4A.4	All clinicians diagnosing skin cancer lesions virtually need to be trained in the use of a dermatoscopes and complete diagnostic audits and peer reviews, where possible.
4A.5	Medical photographers and any staff (including GPs) undertaking photography should be trained appropriately in photographing the skin (including dermoscopy where required) and taking the clinical history of the patient using a standard clinical history form agreed locally. Guidance on training of clinical teams for teledermatology image taking is available from the Institute of Medical Illustrators. Staff undertaking photography should also undertake the following online photography module on eLearning for Health: Clinical photography on mobile devices - practical, legal and ethical requirements - eLearning for healthcare (e-lfh.org.uk).
Examples of Suitable Evidence	
4A.4	Evidence of teledermatology dermoscopy training courses for clinicians and CPD completed relevant to the individuals use of dermatoscopes.
Audit Outcomes - Review of 50 Patient Cases	**Status**

4A.1	100% Education for the referring clinician (when necessary) is incorporated as part of the feedback from the reporting specialist clinician.	>90% **Green** 70-90% **Yellow** <70% **Red**	
4A.5	100% of teledermatology referrals on the urgent suspected skin cancer pathway contain clear dermoscopic and macroscopic images and complete patients' clinical history.	>90% **Green** 70-90% **Yellow** <70% **Red**	
Audit Questionnaire			
4A.1	**Q.1** Is there a named teledermatology clinical lead on the GMC Dermatology Specialist Register to support the development of this service?	**YES**	**NO**
4A.2	**Q.2** Are Skin MDT individual members who virtually diagnose skin cancer cases able to take up relevant CPD opportunities?	**YES**	**NO**
4A.3	**Q.3** Do all teledermatology staff have an up-to-date development portfolio including teledermatology training courses and ongoing local teledermatology education?	**YES**	**NO**
4A.5	**Q.4** Are all healthcare professionals who take dermoscopy and macroscopic images competent in the technique and able to take a relevant patient's clinical history?	**YES**	**NO**

Standard 5: Equipment and Facilities

Standard Statement 5A – Facilities

Rationale

A well-structured medical photography service in the hospital or community setting requires suitable facilities which include a cubicle or a room to provide privacy for patients. The following conditions should also be observed:

- Both patient and provider environment should ensure visual and auditory privacy.
- When taking images, all persons in the room / photographic studio should be identified to the patient.
- Seating and lighting should be designed for both comfort and professional interaction.
- Examination should be supported by a chaperone where requested.

Health care professionals should determine other environmental conditions that may affect the taking of high-quality images.

Essential Criteria

5A.1	The room should allow an area for the patient to remove clothing, this could be an adjacent cubicle, or a curtained-off area.
5A.2	The space should meet space and lighting standards to optimise the image quality.
5A.3	The review of images (prior to sending or on receipt) should be undertaken on an appropriate monitor as size and resolution will dictate how sharp or clear images will be. PACS standards prescribe a minimum of two megapixels which is equivalent to a 1920 x 1080 display or higher depending on screen size.
5A.4	All images should be reviewed on a computer monitor by the medical photographer / primary care team prior to referral to ensure quality images and accurate patients' clinical history.

Examples of Suitable Evidence

5A.2 to 5A.4	The photography space should provide patient privacy and be equipped with appropriate lighting, cameras / dermatoscopes and the ability to securely upload teledermatology images to the patient's healthcare record.

Audit Questionnaire

5A.1	**Q.1** Do you have a suitable room or dedicated space available to provide privacy for patients?	**YES**	**NO**
5A.2 + 5A.3	**Q.2** Do all healthcare professionals using teledermatology to review images have access to a monitor meeting the minimum specifications to review the images?	**YES**	**NO**

Standard Statement 5B – Secure Transfer of Patient Images

Rationale

The provider organisation for the teledermatology service is responsible for documenting evidence that the teledermatology IT platform is compliant with national digital clinical safety standards and regulations. The Digital Technology Assessment Criteria (DTAC) provides a national baseline criteria for NHS providers that includes compliance with the clinical safety standards, alongside data protection, technical security, interoperability and usability and accessibility standards. All providers must ensure their information technology systems comply with DCB0160 in relation to clinical risk management (and DCB0129 where they are also the manufacturer of the health technology).

Use of systems incorporating GDPR compliant secure clinical image apps are recommended for teledermatology services using healthcare professionals' personal mobile devices.

Teledermatology services which request images direct from patients rather than from another health care professional (including clinical validation of waiting lists and patient-initiated follow up) should comply to the same standards.

Essential Criteria			
5B.1	Images must be archived in a secure searchable storage system which records image data and the consent level for the designated use. Data should be backed up regularly on a central server and the server must be within England, Scotland, or Wales, as appropriate.		
5B.2	Any data stored on a PC or other removable device in a non-secure area or on a portable device such as a laptop, PDA or mobile phone should be encrypted.		
5B.3	Any device that is being used to capture clinical images that will not be either anonymised or pseudonymised should, as a minimum, have a strong passcode (6+ characters), data encryption enabled, and any cloud-based backup systems disabled before use.		
5B.4	Any application (apps) that captures the patient skin images, and medical information will need to be NHS N3 compliant, device level encryption such as the Advanced Encryption Standard (AES 256), is applied on all mobile devices used such as laptops, tablets, and mobile phones. Emails sent to and from the health provider must meet the secure email standard DCB1596 for sensitive and confidential information.		
5B.5	DTAC, DCB0129 and DCB0160 certification should be obtained to ensure compliance with standards governing the development, assessment, and deployment of health IT systems, including clinical safety criteria and risk management requirements.		
Examples of Suitable Evidence			
5B.4	Secure clinical image app specifications.		
5B.5	Teledermatology IT platform Information Governance specifications, frameworks and accreditations, including GDPR compliancy.		
Audit Questionnaire			
5B.1	**Q.1** Is patient image data and consent for designated use are archived in a secure storage system?	**YES**	**NO**

5B.2	**Q.2** Does the teledermatology service provider allow clinicians to use their personal mobile devices and laptops to store patient images including images with an encryption device?	**YES**	**NO**
5B.3	**Q.3** Do all healthcare professionals using teledermatology to take images have access to a digital camera / smart phone with a GDPR secure clinical image app?	**YES**	**NO**
5B.4	**Q.4** Is the teledermatology service compliant with GDPR, Clinical Safety standards and meets all NHS Information Governance (IG) standards?	**YES**	**NO**
5B.4 + 5B.5	**Q.5** Are all teledermatology requests and referrals received through a secure digital transfer platform approved by the provider organisation's IT information governance, and compliant with national digital clinical safety standards and regulations?	**YES**	**NO**

Standard 6: Governance, Audit, and Quality Improvement

Standard Statement 6A – Governance		
Rationale Providers must be able to demonstrate they have the required infrastructure to provide a teledermatology service, including protocols for reporting outcomes, audit, risk, clinical accountability and incident reporting for decisions made on individual patient care. Providers of teledermatology services should employ a continuous quality improvement program incorporating audit, including oversight of: • technical or administrative failures • patient and/or provider satisfaction • patient outcomes • pathology or imaging results • recommendations for follow-up		
Essential Criteria		
6A.1	It is expected that all teledermatology services will complete at least one audit and one patient survey every 12 months and report the results to all members of the service. Implementation plans for improvement areas should be actioned accordingly.	
6A.2	All teledermatology records should remain accessible for audit or clinical review and should be retained for the duration of the patient record and for time periods required by national guidance (hospital records 20 years) for purposes of comparative audit. The aim should be to ensure that all images are accessible in both primary and secondary care.	
6A.3	Teledermatology images should be recorded using DICOM standards to be searchable by demography, diagnostic outcomes, skin disease categories, pathway of care, subsequent care pathways, outcomes of care, etc.	
6A.4	Dermoscopy devices and apps for photographing and reviewing skin cancer lesions should meet locally agreed minimum specification requirements at system level, with agreement from the skin cancer Multi-Disciplinary Team (MDT).	
Examples of Suitable Evidence		
6A.1	All providers using teledermatology should have policies and procedures in place to ensure the safety, security, and effectiveness of equipment through ongoing support and maintenance and electronic security of data.	
6A.1	Annual record of teledermatology service quality improvement program incorporating audit.	
6A.1 to 6A.4	Conversion rates for NHS e-Referral teledermatology services published through local e-RS data reports and through the NHS e-Referral Service providers' dashboard (private version) - NHS Digital (not applicable for devolved nations).	
Audit Outcomes		**Status**
6A.1	100% The teledermatology service is audited against the **SERVICE GUIDANCE AND STANDARDS FOR THE USE OF TELEDERMATOLOGY** at least annually. This	Yes **Green** No **Red**

	includes patient outcomes and lesson learned from complaints and poor teledermatology encounters.		
6A.2	100% The teledermatology service record-keeping and storage practices allow for each episode to be audited including the audit of individual patient outcomes.	Yes **Green** No **Red**	
6A.2	100% Providers have an information governance policy in place to ensure that legal and national guidelines and the provisions of the Data Protection Act 1998 are followed regarding the use of teledermatology.	Yes **Green** No **Red**	
Self-Assessment and Audit Questionnaire - Review of 50 Patient Cases			
6A.1	**Q.1** Does the teledermatology service have policies and procedures in place to ensure, the safety, security, and effectiveness of equipment through ongoing support and maintenance and electronic security of data?	**YES**	**NO**
6A.2	**Q.2** Does the teledermatology service have a named lead dermatologist in the provider organisation who is responsible for overseeing audit and governance?	**YES**	**NO**
6A.1 to 6A.2	**Q.3** Is the teledermatology service accountable to a named Clinical Safety Officer in the specialist provider healthcare organisation?	**YES**	**NO**

References and Evidence

Evidence searches were made using the following electronic databases from September 2023 until March 2024: Cochrane Library; PubMed; British Medical Journal (BMJ); British Journal of Dermatology (BJD); Royal Society of Medicine (RSM) Library.

Our selection criteria included the headings from our Service Guidance and Standard's core principles, on a generalist and clinical intervention level (e.g. general facilities versus clinical intervention-specific facilities). This provided us with a wider scope, due to the limited availability of service-based evidence.

Evidence Search: March 2024

	Standard					
	1	2	3	4	5	6
Care Quality Commission. The Fundamental Standards.	X	X	X	X	X	X
Care Quality Commission: Clarification of regulatory methodology: PMS digital healthcare providers March 2017	X	X				X
Memorandum of understanding - Systems regulators for the four nations; https://www.cqc.org.uk/about-us/our-partnerships/joint-working-agreements/memorandum-understanding-4-nations	X	X	X	X	X	X
Confidentiality: good practice in handling patient information. General Medical Council. 2018	X	X	X	X	X	X
Confidentiality. NHS Code of Practice. 2003.	X	X	X	X	X	X
Data Protection Act 2018.	X	X	X	X	X	X
Department of Health. Health Building Note 00-02: Sanitary Spaces.					X	
Department of Health. Health Building Note 00-03: Clinical and Clinical Support Spaces.					X	
Department of Health. Health Building Note 12: Out-patients Department.					X	
Department of Health. The NHS Constitution for England (last updated 2015).	X	X	X	X	X	X
Equality Act 2010	X	X	X	X	X	X
Essential Standards of Quality and Safety. Care Quality Commission. 2010.	X	X	X	X	X	X
Fitness to Practice Rules: Nursing and Midwifery Council. 2004.			X	X		
Good Medical Practice. Standards and Ethics Guidance for Doctors. 2019.	X	X	X	X	X	X
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9: Person-Centred Care.	X	X	X	X	X	X
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10: Dignity and Respect.				X	X	X

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11: Need for Consent.		X				
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15: Premises and Equipment.					X	
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good Governance.	X	X	X	X	X	X
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18: Staffing.			X	X		
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19: Fit and Proper Persons Employed.			X	X		
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Duty of Candour.	X	X	X	X	X	X
How to Write in Plain English. The Plain English Campaign.	X	X	X	X	X	X
National Health Service England. 2023/24 National Tariff Payment System.				X		
National Health Service Standard Contract 2020/21	X	X	X	X	X	X
National Institute for Health and Care Excellence. Health and Social Care Directorate Quality Standards Process Guide. 2016	X	X	X	X	X	X
Nursing and Midwifery Council Registration.			X			
Principles for best practice in clinical audit. NICE. 2008.					X	X
NHSX, NHS Transformation Directorate Records Management Code of Practice for Health and Social Care 2023.		X		X		X
Joint Royal Colleges of Physicians Training Board. Specialty Training Curriculum for Dermatology. 2010.			X			
Royal Pharmaceutical Society and Royal College of Nursing. Professional Guidance on the administration of Medicines in Healthcare Settings. 2019.					X	
MRHA: Guidance: Medical device stand-alone software including apps (including IVDMDs)					X	
Specialist Evidence						
A review of guidelines and standards for telemedicine M Loane and R Wootton Centre for Online Health, University of Queensland, Australia			X		X	X
'A Teledermatology Pilot Study in Hertfordshire: Triage of 2-Week-Wait Referrals' British Journal of Dermatology 165 (Suppl. 1): 137. Bataille V, Hargest E, Brown V and Blackwell B (2011)	X					
UK Guidance on the use of Mobile Photographic Devices in Dermatology https://cdn.bad.org.uk/uploads/2022/02/29200021/UK-GUIDANCE-ON-THE-USE-OF-MOBILE-PHOTOGRAPHIC-DEVICES-IN-DERMATOLOGY.pdf		X	X		X	
AAD Practice Guidelines for Dermatology (2016)	X	X	X	X	X	X

Advice and guidance: guide for secondary care. 7 September 2020 Version 1			X			
GIRFT: Dermatology: Specialty 'Advice and Guidance' (A&G) Toolkit https://future.nhs.uk/connect.ti/GIRFTNational/view?objectID=57759312			X			
Advice and Guidance in Dermatology using the NHS e-Referral Service (e-RS) FAQs https://cdn.bad.org.uk/uploads/2024/04/29092306/Dermatology-e-RS-AG-FAQs-June-2024.pdf			X			
AGENCY FOR CLINICAL INNOVATION: Guidelines for the use of Telehealth for Clinical and Non-Clinical Settings in NSW Australia. Produced by: Rural Health Network Telehealth Working Party 2015		X			X	
American Telemedicine Association: Core Operational Guidelines for Telehealth Services Involving Provider-Patient Interactions (An Update of the February 2008 "Core Standards for Telemedicine Operations")		X	X	X	X	
American Telemedicine Association: LET THERE BE LIGHT: A quick guide to telemedicine lighting November 2017					X	
BAD Skin Cancer DICOM Standards. Key minimum dataset of clinical metadata			X			X
Community Photo-triage for Skin Cancer Referrals: An Aid to Service Delivery: Clin Exp Dermatol 36: 248—254: Morton CA et al (2sauk011).	X		X			
Department of Health. The operating framework for the NHS in England 2011/12. London: DH, 2010.	X					
Digital Technology Assessment Criteria for Health and Social Care (DTAC) - Version 1.0 22 February 2021.					X	
'Does Teledermoscopy Validate Teledermatology for Triage of Skin Lesions?' British Journal of Dermatology 162: 709-710. Halpern SM. (2010)	X					
E-RS dashboard https://digital.nhs.uk/dashboards/e-referral-service-private-providers-dashboard#getting-access	X		X			
Efficient triaging of advice and guidance referrals using teledermatology via the UK National Health Service e-Referral service platform: reporting positive outcomes from the COVID era https://academic-oup-com.libproxy.ucl.ac.uk/ced/article/49/3/235/7331761			X			
Faster diagnostic pathways Implementing a timed skin cancer diagnostic pathway Guidance for local health and care systems			X			
Future NHS: Specialist Advice: Clinical Responsibility and Medicolegal liability FAQs (2023)						X
BAD Dermatology Referral Management Guidelines	X					
A Guide to Job Planning for Dermatologists			X	X		
General Medical Council (GMC) Regulatory approaches to telemedicine Published 1 March 2018	X	X			X	

GMC (2011) Making and using visual and audio recordings of patients (http://bit.ly/1kYn7r1		X	X			
ICO (2012) Anonymisation: Managing Data Protection Risk Code of Practice		X				
ICO UK GDPR guidance and resources re. Lawful basis for consent		X			X	X
IMI Confidentiality and Consent (2020)		X			X	
IMI Guidelines for a Teledermatology Studio: A Guidance to Good Practice					X	
NHS & IMI e-learning: Clinical photography on mobile devices - practical, legal and ethical requirements programme https://www.e-lfh.org.uk/programmes/clinical-photography-on-mobile-devices-practical-legal-and-ethical-requirements/				X		
Improving Outcomes for People with Skin Tumours including Melanoma (Update): The Management of Low-Risk Basal Cell Carcinomas in the Community (Partial Guidance Update). London; National Institute for Health and Clinical Excellence. National Institute for Health and Clinical Excellence (2010)				X		
'Impaired Quality of Life of Adults with Skin Disease in Primary Care', British Journal of Dermatology 143: 979--982. Harlow D, Poyner T, Finlay AY and Dykes PJ. (2000)			X			
Implementing patient-initiated follow-up: guidance for local health and care systems			X			
Implementing telehealth to support medical practice in rural/remote regions: what are the conditions for success? Implementation Science20061:18 Published: 24 August 2006 Marie-Pierre Gagnon, Julie Duplantie, Jean-Paul Fortin and Réjean Landry.	X		X			
Interobserver reliability of Teledermatology across all Fitzpatrick skin types Lisa Altieri*, Jenny Hu, , Myles Cockburn, Melvin Chiu, Jonathan Cotliar, Jenny Kim, David Peng, Ashley Crew, First Published January 4, 2016	X					
Model Hospital Activity Data https://model.nhs.uk/						X
NHS Bristol. Teledermatology: diagnosis, triage and effective care of dermatology (ID11/0038). London: NHS Evidence, 2012	X		X			X
NHS Bristol. 9-month review of the Teledermatology service in south Bristol provided by Vantage Diagnostics. Bristol: NHS Bristol, 2011						
NHSE A Teledermatology roadmap: implementing safe and effective Teledermatology triage pathways and processes (2023)	X	X	X	X	X	X
NHSE Referral optimisation for people with skin conditions	X		X			
NHSE The two-week wait skin cancer pathway: innovative approaches to support early diagnosis of skin cancer as part of the NHS COVID-19 recovery plan			X			
'Outcomes of Referral to Dermatology for Suspicious Lesions: Implications for Teledermatology' Archives of Dermatology 147 (5): 556-560. Viola KV, Tolpinrud WL, Gross CP, Kirsner RS, Imaeda S and Federman DG (2011)	X					

PCC Quality Standards for Teledermatology (2013)	X	X	X	X	X	X
Quality Standards for Dermatology: Providing the Right Care for People with Skin Conditions (Primary Care Commissioning, 2011).	X					
'Simple Excision of Basal Cell Carcinomas; Patients Prefer to be Booked in for Surgery via Teledermatology Referral Rather than via the Out-patient Clinic', British Journal of Dermatology 159 (S1): 59. Charman CR et al (2008)	X					
Skin conditions in the UK: a health care needs assessment. Nottingham: Centre of Evidence Based Dermatology, University of Nottingham, 2009. Schofield J, Grindlay D, Williams H.	X					
Store-and-forward teledermatology for triage of primary care referrals https://shtg.scot/media/2306/20230126-shtg-assessment-of-store-and-forward-teledermatology-for-triage-of-primary-care-referrals-v10.pdf			X			X
'Successful Triage of Patients Referred to a Skin Lesion Clinic using Teledermoscopy (IMAGE IT trial)', British Journal of Dermatology 162: 803-811. Tan E, Yung A, Jameson M et al. (2010)			X			
Teledermatology as a means to improve access to inpatient dermatology care. Priyank Sharma, Carrie L Kovarik, Jules B Lipoff First Published September 16, 2015,	X		X			
Teledermatology and Digital Dermatology Symposium Orals	X		X		X	
Teledermatology for chronic disease management: coherence and normalization: Tracy Finch First Published June 1, 2008,		X	X			
Teledermatology for Diagnosis and Management of Skin Conditions: A Systematic Review', Journal of the American Academy of Dermatology 64 (4): 759-772. Warshaw EM, Hillman YJ, Greer NL, Hagel EM et al. (2011).	X		X			
The two-week wait skin cancer pathway: innovative approaches to support early diagnosis of skin cancer as part of the NHS COVID-19 recovery plan			X			
Two Decades of Teledermatology: Current Status and Integration in National Healthcare Systems, E. Tensen, J. P. van der Heijden, M. W. M. Jaspers, L. Witkamp Teledermatology (D Oh, Section Editor) **First Online:** 28 March 2016	X	X				
Use of Teledermatology in the Management of Psoriasis Neal Kumar, B.A.First Published April 30, 2018		X	X		X	
Waikato Teledermatology: a pilot project for improving access in New Zealand. Suzanne T McGoey, Amanda Oakley, Marius Rademaker First Published June 1, 2015	X	X	X	X	X	X

Appendix 1. Teledermatology Implementation Grid

Essential Criteria	A&G	General Inflammatory and other referrals	Urgent Skin Cancer	Waiting List Validation	Follow up	Inpatient and After-hours
Standard 1A: Patient Criteria for Teledermatology: Inclusion and Exclusion Criteria for Teledermatology						
1A.1			✓			
1A.2	✓					
1A.3	✓	✓	✓	✓	✓	✓
Standard 2A: Patient Information and Consent: Obtaining Explicit Consent						
2A.1	✓	✓	✓	✓	✓	✓
2A.2	✓	✓	✓	✓	✓	✓
2A.3	✓	✓	✓	✓	✓	✓
2A.4	✓	✓	✓	✓	✓	✓
Standard 3A: Teledermatology Virtual Review of Patients: Teledermatology Images and Clinical Information						
3A.1	✓	✓	✓	✓	✓	✓
3A.2	✓	✓	✓	✓	✓	✓
Standard 3B: Teledermatology Virtual Review of Patients: Teledermatology Specialist Review						
3B.1			✓			
3B.2	✓	✓	✓	✓	✓	✓
3B.3	✓					
3B.4				✓		
3B.5			✓			
Standard 4A: Staff, Training, and Education: Qualified Professional Staff						
4A.1	✓	✓	✓	✓	✓	✓
4A.2			✓			
4A.3	✓	✓	✓	✓	✓	✓
4A.4			✓			
4A.5	✓	✓	✓	✓	✓	✓
Standard 5A: Equipment and Facilities: Facilities						
5A.1	✓	✓	✓	✓	✓	✓
5A.2	✓	✓	✓	✓	✓	✓
5A.3	✓	✓	✓	✓	✓	✓
5A.4	✓	✓	✓	✓	✓	✓
Standard 5B: Equipment and Facilities: Secure Transfer of Patient Images						
5B.1	✓	✓	✓	✓	✓	✓
5B.2	✓	✓	✓	✓	✓	✓
5B.3	✓	✓	✓	✓	✓	✓
5B.4	✓	✓	✓	✓	✓	✓
5B.5	✓	✓	✓	✓	✓	✓
Standard 6A: Governance, Audit, and Quality Improvement: Governance						
6A.1		✓	✓	✓	✓	✓
6A.2	✓	✓	✓	✓	✓	✓
6A.3	✓	✓	✓	✓	✓	✓
6A.4			✓			