



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

# **Report on the results of the public consultation on the health technology assessment of tele dermatology to support the management of primary care referrals**

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## About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory body established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

Reporting to the Minister for Health and engaging with relevant government Ministers and departments, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
  - **Regulating social care services** — The Chief Inspector of Social Services within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children’s special care units.
  - **Regulating health services** — Regulating medical exposure to ionising radiation.
  - **Monitoring services** — Monitoring the safety and quality of permanent international protection accommodation service centres, health services and children’s social services against the national standards. Where necessary, HIQA investigates serious concerns about the health and welfare of people who use health services and children’s social services.
- Health technology assessment** — Evaluating the clinical and cost effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland’s health and social care services.
  - **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health and social care services, with the Department of Health and the HSE.

Visit [www.hiqa.ie](http://www.hiqa.ie) for more information.

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## **1 Introduction**

A health technology assessment (HTA) is intended to support evidence-based decision-making in regard to the optimum use of resources in healthcare services. Measured investment and disinvestment decisions are essential to ensure that overall population health gain is maximised, particularly given finite healthcare budgets and increasing demands for services provided.

The aim of this HTA was to evaluate the use of teledermatology to support the management of patient referrals from primary care to secondary and or tertiary dermatology services in Ireland. This assessment provides advice to inform decision-making by the Minister for Health and the Health Service Executive (HSE).

The draft HTA report was published for public consultation in November 2025.<sup>(1)</sup> This Statement of Outcomes report summarises the feedback received during the public consultation period and outlines HIQA's responses to the issues raised, including any changes that were made to the report as a result.

## **2 Methods**

The aim of the public consultation was to seek feedback to identify any issues with the draft HTA report, to consider that feedback, and to amend the report as necessary.

### **2.1 The consultation process**

The draft HTA was published on the HIQA website on 6 November 2025 and was available for public consultation until 18 December 2025. The consultation webpage contained a link to the draft report, a link to the online survey (using the Qualtrics platform) for online submission of feedback, and a consultation feedback form that could be downloaded. To ensure wide accessibility, feedback could be submitted via an online survey, email, or by post.

A press release was issued to a wide range of media outlets at the beginning of the consultation period, and notifications of the public consultation were posted via social media sites (X, Facebook, Instagram and LinkedIn). To maximise awareness, social media notifications were posted on the day of publication, at regular intervals during the consultation period, and towards the end. The findings of the draft HTA were publicised in the media. Emails were sent to a targeted list including two stakeholder organisations with relevant expertise and individuals who are likely to be affected by the proposed introduction of a teledermatology-supported referral management pathway, alerting them to the consultation.

## **2.2 Feedback form**

The template for submission comprised a general request for feedback to enable respondents to flexibly provide their submission for any aspects of the report. A copy of the submission template is provided in Appendix A.

## **2.3 Synthesis**

Each submission was recorded (excluding personal information), read in its entirety and, where appropriate, broken down into individual components. In cases where a question was skipped by the respondent, it was assumed that there were no issues of concern specific to that question. The submissions were stratified according to whether they were from members of the general public or stakeholder organisations. Feedback considered broad in nature was described narratively. General feedback is presented in Table 1. Feedback relating to specific content in the draft report is presented in tabular format alongside responses to the feedback (Table 2). Feedback submitted by organisations and institutions is outlined in Table 3. Where amendments were made to the report based on feedback, this is highlighted in the HIQA response.

## **3 Results**

Overall, 37 submissions were received during the public consultation period. Submissions were received via the online survey and by email. Twenty-three incomplete responses with no feedback were excluded resulting in a total of 14 submissions considered within this Statement of Outcomes. Seven of these submissions were received from individual members of the general public, and seven were submitted on behalf of stakeholder organisations or institutions.

### **3.1 Summary of general feedback**

Most respondents agreed that the current dermatology service is overburdened, with two respondents highlighting their personal experiences of delays accessing dermatological care (Table 1). The majority of the respondents were in favour of introducing a teledermatology-supported referral management system; one respondent, however, did not believe it to be a good use of resources. Two respondents commented on the need for high-quality photos to inform consultant review, standardisation of processes, and training for GPs. Regardless of teledermatology implementation, the need for more dermatologists was expressed by two respondents.

**Table 1 Verbatim personal experience with dermatology services in Ireland\***

Number	Comment
<b>Personal experiences</b>	
1	"My mother was waiting almost ten years for a dermatology appointment following years of pain and discomfort. She was finally diagnosed with advanced psoriatic arthritis via other consultants. This should easily have been picked up earlier and treated before the disease was so advanced had a dermatologist been able to see her, in retrospect, very apparent symptoms."
2	"In my particular case it was 20 months before my condition was identified. In my case, my diagnosis was T-cell lymphoma, and I only got access to dermatology when I had developed a tumour which needed plastic surgery dressing."

\*Responses have been slightly amended to ensure anonymity and to correct for minor typos.

### **3.2 Comments on overall readability**

All but three responses either skipped the question on the overall clarity of the report, reported no feedback, or noted no issues. Two responses highlighted that the length of the document may limit readability, and one suggested the use of more visual summaries and definitions of key terminology. Responses to these suggestions are presented in Table 3.

### **3.3 Specific comments and or queries on report content**

The feedback received on the report content and the response to this feedback is outlined in Table 2.

**Table 2 Summary of general feedback**

Number	Comment*	Response
1	<p>I strongly object to the proposal. Multiple millions have been spent on primary care centres which are not functioning as planned or to the benefit of patients. I propose that the 66,000 people are reviewed in a rapid triage clinic in each primary care centre with the dermatologist from the relevant hospital and allocated 5-minute slots to view the skin problem. The paperwork should be prepared in advance by primary care staff and the follow-up decision recorded by the dermatology team and provided to the referring GP at the end of the session. This proposal would give immediate feedback to the patient, rapid information to the GP, prioritise urgent cases and validate waiting lists as an outcome.</p>	<p>In accordance with the agreed Terms of Reference, the scope of the HTA was to assess the clinical and cost-effectiveness of teledermatology-supported referral management within hospital dermatology departments. Other interventions were outside the scope of this review but could be considered as part of a wider solution.</p>
2	<p>It is not the clarity or presentation of the report which I challenge it is the ongoing complicating of processes, the failure to maximise existing resources and the constant view that spending more multi-millions on processes rather than actual patient care which I challenge.</p>	<p>See response to comment 1. The assessment highlights that there are currently insufficient specialists to meet demand (Chapter 3). As identified in Chapter 4 (effectiveness and safety) and Chapter 6 (budget impact analysis), teledermatology creates efficiencies that can reduce the demand-capacity gap and reduce waiting times.</p>
3	<p>I agree that teledermatology would greatly improve the diagnosis phase.</p>	<p>Thank you for your feedback.</p>
4	<p>Volumes of referrals will increase exponentially with teledermatology access to dermatologists. A huge number of additional dermatologists are needed far in excess of predicted numbers, and these numbers will need to keep increasing annually to meet need.</p>	<p>The HTA assumes that referrals will grow each year by 1.7% based on population changes (Chapter 6). It was not possible to predict the increase in referrals, if any, due to the introduction of teledermatology. International evidence identified in Chapter 4 showed mixed results regarding the change in rate of referrals, with rates in some services increasing with the introduction of teledermatology while remaining stable in other services. As outlined in Chapter 7, it will be important to ensure that current thresholds for referral are maintained even if a teledermatology pathway is introduced, given that the predicted increase in referrals</p>

		due to population changes will result in a need for more dermatologists to meet demand.
5	Quality and standardisation issues with forwarded photos will need huge initial investment and ongoing training of users.	The budget impact analysis (Chapter 6) considered costs related to digital cameras to ensure standardised equipment is used. Moreover, training costs for image acquisition were also accounted for. Chapter 7 further highlights the importance of developing appropriate guidance for both GPs and dermatologists using a teledermatology pathway, quality standards, and training support. In the context of an expected initial learning curve with the introduction of a new technology, the HTA assumes that within the first two years of implementation, a proportion of referrals would require re-imaging.
6	However good technology is nothing is like the person-to-person contact. Please we need more dermatologists in post.	Teledermatology-supported referral management is not intended to fully replace in person contact with patients who need to be see face-to-face. Chapter 3 and 6 highlight the current significant demand-capacity gap for dermatology services in Ireland. While teledermatology may help alleviate some of the pressures currently faced, the HTA clearly identifies that it will not negate the need for recruitment of additional dermatologists (Chapter 7).
7	<p>As both a user and designer of teledermatology services and having been involved in pilot studies, the GP taking the imaging has repeatedly proven to be very poor in quality and results due to the nature of their time limit per patient. It would be far more advisable to have the GP nurse fully trained to do this, or a core few centres per county where the nurses are doing it at scale and can be given feedback and updates from the consultants who they are taking the clinical data and images for.</p> <p>Two-way communication is key to success in this model.</p> <p>As seen in Scotland where they have since reversed their initial model of GP imaging to local designated centres.</p>	As highlighted in Chapter 4, the HTA did not identify published evidence examining image quality when captured by nurses compared with GPs. Moreover, limited evidence was obtained for the use of dedicated imaging clinics. However, various implementation models exist and as outlined in Chapter 7 should be explored if a teledermatology-supported referral management pathway were introduced. Additional wording specifically acknowledging the option of nurse-led imaging has been added to Chapter 7.

8	The concept of poor images in and expected outcomes to be good from a consultant who has to diagnose or advise on, is a poor model.	<p>As outlined in Chapters 1, 7, and 9, under the proposed model, teledermatology is primarily designed to support the management of referrals from primary care. Within the proposed care pathway, the dermatologist retains the option to see the patient face-to-face. It is envisaged that only where a dermatologist is confident that a patient does not require face-to-face assessment, would the referral be reverted back to primary care alongside advice, if necessary.</p> <p>International evidence (Chapter 2 and 4) also suggests that a store-and-forward teledermatology model is most frequently used. Data presented in Chapter 4 confirms that poor quality images may negatively impact on diagnostic concordance where this has been studied. Therefore, the evaluation highlights that image quality standards, guidance on obtaining images, and training should be considered if teledermatology-supported referral management were introduced (Chapter 7).</p>
9	Has AI been addressed correctly, as this is also essential in the future of dermatology.	Chapter 9 outlines that the review conducted by HIQA did not identify data that met pre-defined inclusion criteria on the use of AI to support decision-making in teledermatology. It is likely that AI will be used in this area as technologies develop and in recognition of this, and the need for further evidence in this area, NICE in the UK have recommended the use of AI technology within the context of a teledermatology service to identify and triage non-cancer skin lesions out of the urgent suspected skin cancer pathway (Chapter 9).
10	The assessment looks good. The medico-legal risk for individual consultants making an improper diagnosis based on photos alone will have a negative effect on this becoming a reality. Training will be key.	Chapter 8, section 8.4 outlines the medico-legal issues for consideration if teledermatology-supported referral

		management was to be implemented. Training considerations are discussed in Chapter 7, section 7.3.6.
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\*Responses have been slightly amended to ensure anonymity and to correct for minor typos.

### 3.4 Feedback submitted by organisations and institutions

We received feedback from four organisations or institutions as part of this public consultation. Feedback was received from the Primary Care Dermatology Society of Ireland, the Plastic Surgery Advisory Group, Johnson & Johnson, and AllView Healthcare.

The full responses to the feedback are provided in this document. Feedback pertinent to this HTA is outlined in Table 3.

**Table 3 Feedback submitted by organisations and institutions**

Number	Feedback*	Response
<b>Primary Care Dermatology Society of Ireland (PCDSI)</b>		
1	The committee of the PCDSI support the proposal of the introduction of teledermatology for the speedy referral of patients in primary care to our secondary care colleagues in dermatology and plastic surgery provided there is funding for training and equipment within primary care to provide this service. The time taken by the GP to take the images, store and forward them and to get consent from the patient to carry this out would also have to be considered.	<p>The budget impact analysis presented in the HTA (Chapter 6) includes the following equipment and training costs:</p> <ul style="list-style-type: none"> <li>▪ Digital camera with appropriate lens supplied to all GPs</li> <li>▪ Development and provision of an e-training module for GPs</li> <li>▪ Windows laptop supplied to all consultant dermatologists</li> </ul> <p>The time requirement for GPs to take and upload images is discussed in Chapter 7. Additional text has been added to Chapter 7 to acknowledge the additional time required to support patients in providing informed consent.</p>
2	We fully endorse the concept of teledermatology as a means to facilitate efficient referrals of patients from general practice to dermatology and plastic surgery and are very appreciative that this is being considered. This innovation promises to accelerate referral pathways for patients requiring urgent care and enhance the appropriateness of referrals, potentially considering necessity for some patients to undergo face-to-face consultations.	Thank you for your feedback.

Number	Feedback*	Response
3	<p>We believe that the committee would have benefited from the inclusion of multiple GP representatives and that it would have been more appropriate. Over 50% of clinical activity and workload associated with this initiative will occur within General Practice. Therefore, input from a diverse group of General Practitioners comprising 20% plus of Committee is essential to help with assessment of the implications of this model on our practice and patient care.</p>	<p>For all HTAs conducted by HIQA, an expert advisory group (EAG) is convened. The EAG typically includes representatives from key stakeholders including public and or patient representatives, healthcare providers and managers, policy makers, as well as clinical, public health and methodological experts, as required. Nominations for representatives are sought from key organisations. For this HTA, GP representation was received through the ICGP. Additional primary care representation was obtained from the National Clinical Advisory and Group Lead who is also a practicing GP, and through a practice nurse. Both public and targeted feedback (from the PCDSI and ICGP) were also sought as part of this consultation process to help capture the diversity of experience and opinion from within the GP community. We do however take on board your feedback for the composition of future EAGs.</p>
4	<p>While the report acknowledges the significant potential role of teledermatology in primary care, it does not adequately assess the impact on general practice workload. It also appears inaccurate in its summary: The consultation time for addressing a dermatological assessment in the report is estimated at a 11.5-minute consultation including 5.2 minutes dedicated to image capture and upload (which doesn't occur currently). Suggesting erroneously that this will be a shorter than average GP consultation. This duration does not consider the multifaceted nature of general practice consultations.</p> <p>The PCDSI provided references to studies suggesting the average number of presenting problems per consultation ranging from <a href="#">2.5 in the UK</a> to <a href="#">3 in the US</a>, potentially having increased more recently to an <a href="#">average of 3 to 8</a>. The PCDSI highlighted that additional time</p>	<p>The primary focus of the HTA is referral management in the secondary and tertiary care setting. However, the implementation of teledermatology-supported referral management will have implications for GP workload, which are acknowledged in Chapter 7 (section 7.3.7.1). Based on the total annual number of dermatology referrals to the publicly funded system and the number of registered GPs working in primary care, it is estimated that dermatology-related GP referrals account for, on average, approximately 30 to 36 visits per GP per year, ultimately comprising a small proportion of overall activity.</p> <p>While the time required for these appointments may increase due to image taking and upload, it is anticipated that teledermatology-supported referral management would</p>

Number	Feedback*	Response
	<p>required for dermatological assessments through teledermatology will extend GP consultations further.</p>	<p>enable more timely access to specialist care. By reducing waiting times, teledermatology could reduce the number of patient visits to the GP to manage the issue while waiting for a dermatology consultation. Image acquisition by practice nurses may alleviate the time burden for GPs.</p> <p>As now highlighted in Chapter 7 and in the Advice, should teledermatology-supported referral management be introduced, the HSE would need to work closely with clinical and patient stakeholders to ensure a system that is fit for purpose.</p>
5	<p>High-quality cameras and dermatoscopes are vital for the successful implementation of teledermatology. Sufficient training and support must be provided to GPs to ensure effective use of these tools and to facilitate the interpretation of images captured during assessments.</p>	<p>While an implementation plan is outside the scope of a HIQA HTA, organisational considerations presented in Chapter 7 highlight the need to set minimum standards for cameras, and that all GPs will need to be provided with a camera meeting these standards. The cost of this has been included in the budget impact assessment (Chapter 6). If teledermatology is implemented using dermatoscopes, these would also need to be provided to GPs and costings are provided as part of the budget impact analysis.</p> <p>As discussed in Chapter 7, standardised training and guidance to GPs on image acquisition should be considered. The cost of such training has also been considered in the budget impact analysis (Chapter 6).</p>
6	<p>In conclusion, while we support the goal of integrating teledermatology into primary care, we urge the committee to consider our feedback regarding GP representation, the implications for General Practice workload, and the need for appropriate equipment and training. Adequate resources must be allocated to</p>	<p>Thank you for your feedback.</p>

Number	Feedback*	Response
	<p>ensure that this initiative enhances patient care without overwhelming general practice providers.</p> <p>Thank you for considering our feedback. We look forward to further engagement on this important initiative.</p>	
7	<p>Though maybe too lengthy for a non-health care professional, the draft assessment is presented well and in a clear format.</p>	<p>HIQA makes every effort to ensure reports can be read and understood by all. As such, the HTA includes an executive summary, plain language summary, and summary key points at the start of each chapter. The final document will also include Advice to the Minister for Health and the HSE.</p>
<b>Plastic Surgery Advisory Group (PSAG)</b>		
8	<p>PSAG members agree that Teledermatology has the potential to improve both the speed and volume of patient referrals to secondary and tertiary care, while also reducing the number of cases unnecessarily escalated beyond primary care.</p>	<p>Thank you for your feedback.</p>
9	<p>PSAG members expressed concern that established 'see and treat' pathways have not been fully considered, particularly their ability to reduce the need for additional appointments for patients and clinicians when managing non-complex skin cancers.</p>	<p>The role of see- and treat-clinics is acknowledged in Chapter 2, Section 2.2.3. However, it is expected that teledermatology-supported referral management will sit earlier in the clinical pathway than see-and-treat clinics. It is likely that a referral assessed via teledermatology could triage a patient for a see-and-treat clinic.</p>
10	<p>Pigmented Lesion Clinics (PLCs), a well-established pathway for assessing skin cancer, are not referenced specifically in the HTA. These clinics are well known to offer shorter waiting times, faster diagnoses and earlier treatment.</p>	<p>The pigmented lesion pathway is presented in Chapter 2 under the urgent referral route (Figure 2.3), Section 2.2.3, and highlighted in Chapter 7. Further clarification of pigmented lesion referrals has been added to Section 2.2.3.</p>
11	<p>There is concern from PSAG members that the impact of teledermatology on plastic surgery resources have not been sufficiently researched or addressed in the HTA. There will be an unquantified demand increase for plastic surgery services based on the teledermatology pathway.</p>	<p>In accordance with the agreed Terms of Reference, the scope of the HTA was limited to an assessment of dermatology services only. Therefore, the impact on plastic surgery resources has not been quantified. The uncertainty in estimating the number of dermatology-related referrals sent to plastic surgery departments is discussed in Chapter 3.</p>

Number	Feedback*	Response
		<p>The HTA considers the implementation of a teledermatology-referral pathway in the context of referrals from GPs to dermatology services (and not plastic surgery which is outside of the scope of the HTA). Additional wording has been added to the HTA in Chapter 7 outlining that the potential impact of teledermatology-supported referral management on the number of referrals to plastic surgery departments is unknown. Chapter 9 also highlights that a change in plastic surgery resourcing will have a proportional impact on managing dermatology-related cases.</p>
12	<p>Plastic surgery services are already under significant pressure from high volumes of skin cancer referrals. It would be beneficial for the HTA to evaluate and recommend approaches that prevent the referral of straightforward, easily managed skin cancers from primary care to plastic surgery.</p>	<p>The scope of the HTA, as requested by the Department of Health, was limited to an assessment of dermatology services only. Therefore, the impact on resources and organisational implications for plastic surgery departments have not been presented in full. However, teledermatology-supported referral management offers a learning opportunity for GPs which may over time contribute toward a reduction in referrals which could also apply to dermatology referrals to plastic surgery. Additional wording on the potential to implement teledermatology beyond the dermatology service has been added to Chapter 7.</p>
13	<p>Although skin cancer is referenced 364 times in the document, plastic surgery is mentioned only 16 times and general surgery is not mentioned at all. Skin cancer referrals commonly involve Plastic Surgery, ENT, OMFS, and General Surgery, yet these pathways and the potential impact of Teledermatology on them are not explored in the HTA.</p>	<p>As noted, in accordance with the agreed Terms of Reference, the scope of the HTA was limited to an assessment of referrals to dermatology services only. Acknowledging though that skin cancer referrals in particular may involve multidisciplinary care, if implementation is expanded to other specialities, there may be implications and organisational considerations that need to be explored. Chapter 7 now</p>

Number	Feedback*	Response
		acknowledges the potential to expand implementation to specialities beyond dermatology.
<b>Johnson &amp; Johnson Innovative Medicine</b>		
14	<p>Johnson &amp; Johnson Innovative Medicine Ireland welcomes HIQA's assessment and strongly supports the introduction of teledermatology as part of a wider clinical pathway. This initiative aligns with the goal of improving patient access and reducing waiting times for dermatology services, which currently exceed capacity with over 66,000 patients on waiting lists and delays of up to three years for routine appointments.</p> <p>While teledermatology can help triage and manage referrals, it is critical to ensure that patients requiring advanced systemic treatments for chronic conditions such as psoriasis are suitably prioritised for secondary care without having to wait up to three years. Appropriate and timely intervention with systemic treatments significantly improve quality of life and co-morbidities for people living with dermatological conditions but are only available in specialist settings. The draft assessment should emphasise the need for clear referral pathways to secondary care for patients who meet criteria for systemic therapy.</p> <p>The draft correctly notes that teledermatology alone will not resolve capacity issues. Recruitment of consultant dermatologists and investment in infrastructure remain essential.</p>	<p>Chapter 2 describes the current referral pathways in Ireland. If teledermatology-supported referral management is introduced, patients requiring systemic therapy will fall under this pathway where appropriate triaging can take place.</p>
15	<p>We recommend that the final report highlight teledermatology as a complementary measure, not a substitute for workforce expansion.</p>	<p>The Executive Summary, Chapter 7, and Chapter 9 highlight that teledermatology alone will not address the current demand-capacity gap and increasing the consultant workforce should be considered alongside other interventions.</p>

Number	Feedback*	Response
16	<p>Teledermatology can improve access for patients in rural or underserved areas. However, the draft should address potential disparities in GP practices' ability to adopt technology (e.g., camera equipment, broadband connectivity). A national implementation plan should include funding and training for GPs to ensure equitable rollout.</p>	<p>Organisational issues relating potential disparities in GP practices to adopt the technology and implementation considerations are discussed in Chapter 7 and Chapter 9.</p>
17	<p>The draft assessment is well-structured and provides a clear rationale for introducing teledermatology. The inclusion of cost analysis and patient access benefits is particularly strong and demonstrates a balanced approach.</p> <p>Opportunities for Enhancement:</p> <p>Visual Representation of Patient Pathways - Adding a simple flowchart to illustrate how teledermatology integrates into existing referral processes would make the document even more accessible for stakeholders. This would help clarify decision points and patient journey steps without changing the substance of the assessment.</p> <p>Terminology Clarification - Brief definitions of technical terms such as "store-and-forward" and "live-interactive" would enhance readability for non-specialist readers and ensure consistent understanding across audiences.</p>	<p>A visual depiction of the current referral pathway is provided in Chapter 2, figure 2.1 and the teledermatology-supported referral management pathway in figure 2.2. A visual representation of the potential teledermatology process is also provided in Chapter 7, figure 7.1.</p> <p>Technical terms have been defined in the Executive Summary, Plain Language Summary, and Description of Technology (Chapter 2).</p>
<b>AllView Healthcare</b>		
18	<p>Teledermatology is already delivering practical, Ireland-relevant benefits when it is implemented as a governed, consultant-led referral management service rather than a standalone technology (Section 1: Introduction; Section 4: Description of the technology). Teledermatology is not just about technology; while a very high bar should be set for minimum requirements, technology certifications,</p>	<p>Thank you for your feedback. As discussed within the report, there are a multitude of factors and elements to consider should teledermatology-supported referral management be implemented which require operation in accordance with suitable standards. The implementation of teledermatology within the context of a quality-assured integrated care</p>

Number	Feedback*	Response
	<p>and governance before any solution is approved for use, teledermatology is best understood as a shared-care pathway designed to improve patients' access to timely and urgent diagnostics (Section 4; Section 9: Organisational considerations; Section 10: Ethical and legal considerations).</p> <p>In a system where dermatology demand outstrips face-to-face capacity, teledermatology can shorten time to specialist input, reduce unnecessary outpatient attendances, and help ensure that patients who genuinely need in-person review or procedural care are prioritised appropriately (Section 6: Clinical efficacy, effectiveness, service utilisation, and safety). From AllView Healthcare's service delivery experience in Ireland, rapid access to consultant diagnosis is provided within 10 days or less, and 99.3% of patients are diagnosed through teledermatology, based on internal reporting (Section 6). In AllView Healthcare's June 2025 submission to HIQA, AllView reported 17,072 HSE appointments, with 47% of patients directly discharged at the teledermatology stage, 31% requiring face-to-face consultation and/or intervention, and 22% going directly to surgery; we also reported that 99.3% of patients were given a diagnosis via teledermatology (Section 6)."</p> <p>Importantly, those patients routed directly to surgery also receive a face-to-face full skin examination, which remains the gold standard of care, ensuring that teledermatology supports rapid pathway allocation while maintaining in-person clinical standards where most critical (Section 4; Section 6; Section 9). This demonstrates how a well-run teledermatology model can convert a high volume of referrals into timely consultant decisions without defaulting to face-to-face appointments for every case (Section 6).</p>	<p>pathway is discussed in Chapter 2; the national and international experience of the impact of TD on service utilisation is discussed in Chapter 4, and the potential impact of a national service is discussed in Chapters 6 and 7.</p>

Number	Feedback*	Response
	<p>These outcomes depend on the people and processes around teledermatology (Section 4; Section 9: Organisational considerations). Consultant involvement is central. Teledermatology works best when referrals are reviewed by experienced dermatology consultants who can make triage and management decisions, provide clear advice back to primary care, and identify those who require escalation (Section 4; Section 6). High-quality nurse-led clinical imagery is equally critical. Image capture is a clinical task requiring consistent technique, appropriate lesion framing, and, where relevant, dermoscopic imagery, because image quality directly determines whether a consultant can safely discharge with advice, recommend treatment in primary care, or escalate to face-to-face review or surgery (Section 4; Section 6). GPs and practice nurses remain essential partners. Teledermatology is most effective when it closes the loop with actionable guidance, clear follow-up treatment plan, and explicit safety-netting so that care continues seamlessly outside the hospital setting (Section 6; Section 9).</p> <p>For the HTA, teledermatology should be evaluated not only on diagnostic concordance, but on its ability to deliver measurable system outcomes in Ireland, including faster time to consultant decision, a higher proportion of patients appropriately managed without hospital visits, and safe, auditable escalation for the minority who need face-to-face assessment or procedural intervention (Section 6; Section 9). The strongest determinants of success are governance and quality controls, including consultant-led triage, trained clinical imagery capture, structured clinical information, and routine quality assurance; ideally as part of a structured MDT;</p>	

Number	Feedback*	Response
	making teledermatology reliable, scalable, and safe across healthcare settings (Section 4; Section 9).	
<b>Primary Care Surgical Association (PCSA)</b>		
19	<p>The committee, on behalf of our approx. 150 members, fully endorse the concept of teledermatology to assist with the referral of patients from GPs to dermatology and plastic surgery.</p> <p>Teledermatology should speed up the referral pathway for those that need urgent care and may avoid the need for some patients to be seen face to face by the consultant team. However, sufficient funding will need to be sourced to train and equip GPs to purchase equipment (digital cameras, dermatoscopes).</p>	<p>The budget impact analysis presented in the HTA (Chapter 6) includes the following equipment and training costs:</p> <ul style="list-style-type: none"> <li>▪ Digital camera with appropriate lens supplied to all GPs</li> <li>▪ Development of an e-training module for GPs</li> <li>▪ Windows laptop supplied to all consultant dermatologists</li> </ul>
20	<p>The extra time required by GPs to take the images, store them, get consent from the patient and forward them to the consultant also needs to be taken into consideration. Worthwhile and welcome transformation at the primary-secondary care interface has significant implications for both hospital and community services. This has been demonstrated recently, for <a href="#">example</a>, in relation to enhanced access in primary care to diagnostic imaging.</p>	<p>The time requirement for GPs to take and upload images is discussed in Chapter 7. Additional wording has been added to Chapter 7 to acknowledge the additional time required to get consent from the patient. Chapter 7 also highlights the organisational considerations across primary and secondary care if teledermatology-supported referral management were introduced.</p>
21	<p>The PCSA suggested that enhanced training, equipment and funding in GP to properly assess and treat low to moderate severity dermatology problems in GP rather than employing more dermatologists should be considered.</p> <p>Examples of recent initiatives in practice were provided. The first was the development of a skin surgical accreditation process in GP by the Primary care Division of the HSE in 2016.<sup>(2)</sup> The second, unreported project was the DermView teledermatology business, which required collaboration between a number of general practices</p>	<p>The scope of the HTA was limited to teledermatology-supported referral management. However, additional strategies to enhance the dermatology care pathway can be considered in the future.</p>

Number	Feedback*	Response
	<p>and the consultant principals of that business, and which demonstrated the working of a two-way specialist dermatology service in private practice.</p> <p>Examples of studies in Ireland were provided which demonstrated that with suitable training, equipment, funding and resources, most low and moderate risk NMSCs can be managed safely in primary care.<sup>(3-6)</sup> Data were also provided in relation to melanoma, specifically, in Australia where approximately 50% of melanomas are diagnosed in primary care.<sup>(7)</sup> Additionally, one small Irish study also showed that melanoma can be safely diagnosed in Primary Care when properly resourced and with suitable training.<sup>(8)</sup></p> <p>Renewed initiatives in support of the accreditation of interested GPs and Advanced Nurse Practitioners in the diagnosis and management of low and moderate risk skin cancers has the potential to contribute to meeting the requirement for dermatology services. The Australasian response to service pressure for skin cancer seems to have much to recommend it.<sup>(9)</sup></p>	
22	Your document mentioned that 7.6 to 8.6% of GP consultations are for skin complaints. We feel this is an underestimation. Many studies have shown that between 15 and 20% of GPs consultations involve dermatology complaint. <sup>(10)</sup>	The range of 7.6% to 8.6% relate specifically to studies that have been conducted in an Irish healthcare setting. Additionally, data from international studies have been provided in Chapter 3, section 3.3.1.1.
23	Section 2.2.4 mentioned "cryotherapy" as a treatment option. A better term is "cryosurgery".	This has been updated where appropriate throughout the HTA.
24	It is perhaps regrettable that only one GP was included in the committee that drafted this proposal. We would have felt that such an important proposal involving GPs should have had greater representation from primary care. I am sure the Primary Care Dermatology Society of Ireland, the Primary Care Surgical	For all HTAs conducted by HIQA, an expert advisory group (EAG) is convened. The EAG typically includes representatives from key stakeholders including public and or patient representatives, healthcare providers and managers, policy makers, as well as clinical, public health and methodological experts, as required. Nominations for representatives are

Number	Feedback*	Response
	Association and the ICGP could contribute to any further work in operationalising these proposals, if required.	sought from key organisations. For this HTA, GP representation was received through the ICGP. Additional primary care representation was obtained from the National Clinical Advisory and Group Lead who is also a practicing GP and through a GP nurse. Both public and targeted feedback (from the PCDSI and ICGP) were also sought as part of this consultation process to help capture the diversity of experience and opinion from within the GP community. We do, however, take on board your feedback for the composition of future EAGs.
25	This is a very comprehensive document. For most readers the document is far too long. However, there are some good summaries. Perhaps it might be better to have the main document much shorter (10-20 pages) and the remainder as appendices which can be looked at if a reader wants more detailed information.	HIQA makes every effort to ensure reports can be read and understood by all. As such, the HTA includes an executive summary, plain language summary, and summary key points at the start of each chapter.
<b>Children's Health Ireland CHI</b>		
26	Most of the evidence review attached pertains to an adult population where teledermatology can be excellent for triaging lesions and skin cancers. For our paediatric population, the primary utility is in triaging - what is severe vs what can wait longer. Also, would be useful for haemangiomas as an enhanced triage.	The HTA examined teledermatology-supported referral management, which primarily acts a support for triaging referrals. While the scope of the HTA considered all dermatology referrals from primary care, it is acknowledged that the majority of the evidence base related to adults. Of the 120 studies identified through the systematic literature review (Chapter 4), only five were limited to a paediatric population. This limitation is acknowledged in Chapter 4 Section 4.11.1.
27	CHI advised that from UK experience, provision of advice and guidance to the GP can frequently take more than the estimated 5 minutes, in terms of resourcing appropriately.	The type of teledermatology modelled in Chapter 6 for the purposes of budget impact and resource implications is not intended to be the same as the UK full 'advice and guidance' service. HIQA acknowledges however that there may be

Number	Feedback*	Response
		<p>variations in the time required to provide general advice back to GPs where patients are not required to be seen face-to-face, however, five minutes has been considered a reasonable average by members of the expert advisory group. Chapter 7 highlights that based on the total annual number of dermatology referrals to the publicly funded system and the number of registered GPs working in primary care, dermatology-related GP referrals account for, on average, approximately 30 to 36 visits per GP per year, ultimately comprising a small proportion of overall activity.</p>
28	<p>CHI advised that where investigations are recommended, it can result in 'return replies', with the GP updating the initial triaging physician on the results, which can further add to the workload and muddy the water as to who is primarily responsible for the patient.</p>	<p>Chapter 1 describes the definition of teledermatology in the context of this HTA. Under this model, teledermatology is used for the management of referrals from primary care, rather than the ongoing management of patients. Patients requiring ongoing specialist management would be triaged for face-to-face appointments while those who do not require an in-person appointment are discharged back to primary care as no further specialist input is required.</p>
29	<p>Consideration should also be given to GP time. GPs will need to have sufficient time to review the advice provided and arrange for a further in-person or virtual consultation with the patient to go through it.</p>	<p>The time requirement for GPs to follow-up on patient care following teledermatology advice is acknowledged in Chapter 7.</p>
30	<p>On the whole we would welcome high quality photos accompanying our referral letters (video is not appropriate for our population).</p> <p>We would like to note that one of the organisational contributors was on the expert advisory panel group for this HTA report and involved in its development.</p>	<p>Thank you for your feedback.</p>

\*Responses have been slightly amended for brevity and to correct for minor typos.

### **3.5 Changes to the report from the consultation process**

The following changes were made to the draft report in response to comments and feedback received through the consultation process:

- 'Cryotherapy' has been amended to 'cryosurgery' in Chapter 2 and Chapter 8.
- Additional clarification of pigmented lesion referrals has been added to Chapter 2 section 2.2.3.
- Chapter 7 key points and section 7.3.7.1 have been updated to acknowledge the additional time required by GPs to support patients in providing informed consent for a referral through teledermatology.
- Chapter 7 has been updated to acknowledge that in a teledermatology-supported referral management system, images could be acquired by various appropriately trained staff in the primary care setting, including both GPs and practice nurses.
- Chapter 7 has been updated to outline the potential to implement teledermatology beyond the dermatology service to other specialities involved in dermatological care.
- Additional clarification has been added to Chapter 7 in relation to the challenges in quantifying the number of dermatology referrals managed within plastic surgery services and the potential impact of teledermatology-supported referral management on these services.
- Chapter 7 has been updated to highlight that should teledermatology-supported referral management be introduced, the HSE would need to work closely with clinical and patient stakeholders to ensure a system that is fit for purpose.

These changes were also reflected in the Plain Language Summary and the Executive Summary, where appropriate. Every attempt has been made in the Plain Language Summary, the Executive Summary and the Advice to the Minister, which was newly added following consideration of the findings of the public consultation, to emphasise issues of importance that were highlighted during the consultation process.

## References

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## Appendix A – copy of submission feedback form

### Health Technology Assessment of teledermatology to support the management of primary care referrals.

#### Public consultation feedback form

The Health Information and Quality Authority (HIQA) is holding a six-week public consultation to give people an opportunity to provide feedback on the health technology assessment (HTA) of teledermatology to support the management of primary care referrals.

Your views are important to us. HIQA will carefully assess all feedback received and incorporate feedback into the report, where appropriate.

The final HTA and a statement of outcomes report (a summary of the consultation responses) will be published on HIQA's website once the HTA has been completed.

**The closing date for the public consultation is 5pm on 18 December 2025.**

## How to provide feedback:

- If you are commenting on behalf of an organisation, please combine all feedback from your organisation into one submission form if possible. We will request a name and contact number for a designated representative from your organisation in case we need to clarify your feedback.
- If your feedback contains any commercially sensitive or confidential information, please highlight this at the time of submission, so it can be excluded from the summary of feedback that will be published by HIQA.
- Please spell out any abbreviations that you use.

You can **email** the completed form to [consultation@hiqa.ie](mailto:consultation@hiqa.ie)

### **OR**

Print the consultation feedback form and **post** the completed form to:

Health Information and Quality Authority  
Public consultation for teledermatology to support the management of primary care referrals  
Health Technology Assessment  
Dublin Regional Office  
George's Court, George's Lane  
Smithfield, Dublin 7  
D07 E98Y

## Data protection and Freedom of Information

HIQA will only collect personal information in case we need to contact you for clarification on your feedback. No personal information will be included in the stakeholder consultation document that will be published by HIQA.

Any response you provide will be held securely and anonymised. Information provided in your response, for example, an anecdote or statement about an experience, may be included in the statement of outcomes that will be published by HIQA at the end of the HTA process. However, the information will be reported in a manner that protects your privacy. Any personal information you give as part of your submission will be deleted once the HTA is published.

For further information on how HIQA uses personal information, please see our Privacy Notice available [here](#). If you have any concerns regarding your personal information, please contact HIQA's Data Protection Officer on [dpo@hiqa.ie](mailto:dpo@hiqa.ie).

Please note that HIQA is subject to the Freedom of Information (FOI) Act and the statutory Code of Practice in relation to FOI. We cannot give you an assurance that confidentiality can be maintained in all circumstances due to the requirements of the FOI Act.

**I agree to take part in the public consultation**

## 1. About you

### 1.1 Your name:

### 1.2 Are you providing feedback as:

- an individual
- on behalf of an organisation

### 1.3 If answer is 'on behalf of an organisation', please give the name of the organisation:

**If applicable, for clarification purposes, please provide your name, your role in the above organisation and your contact details:**

**You can request that your organisation's name be kept confidential and excluded from the published summary of responses:**

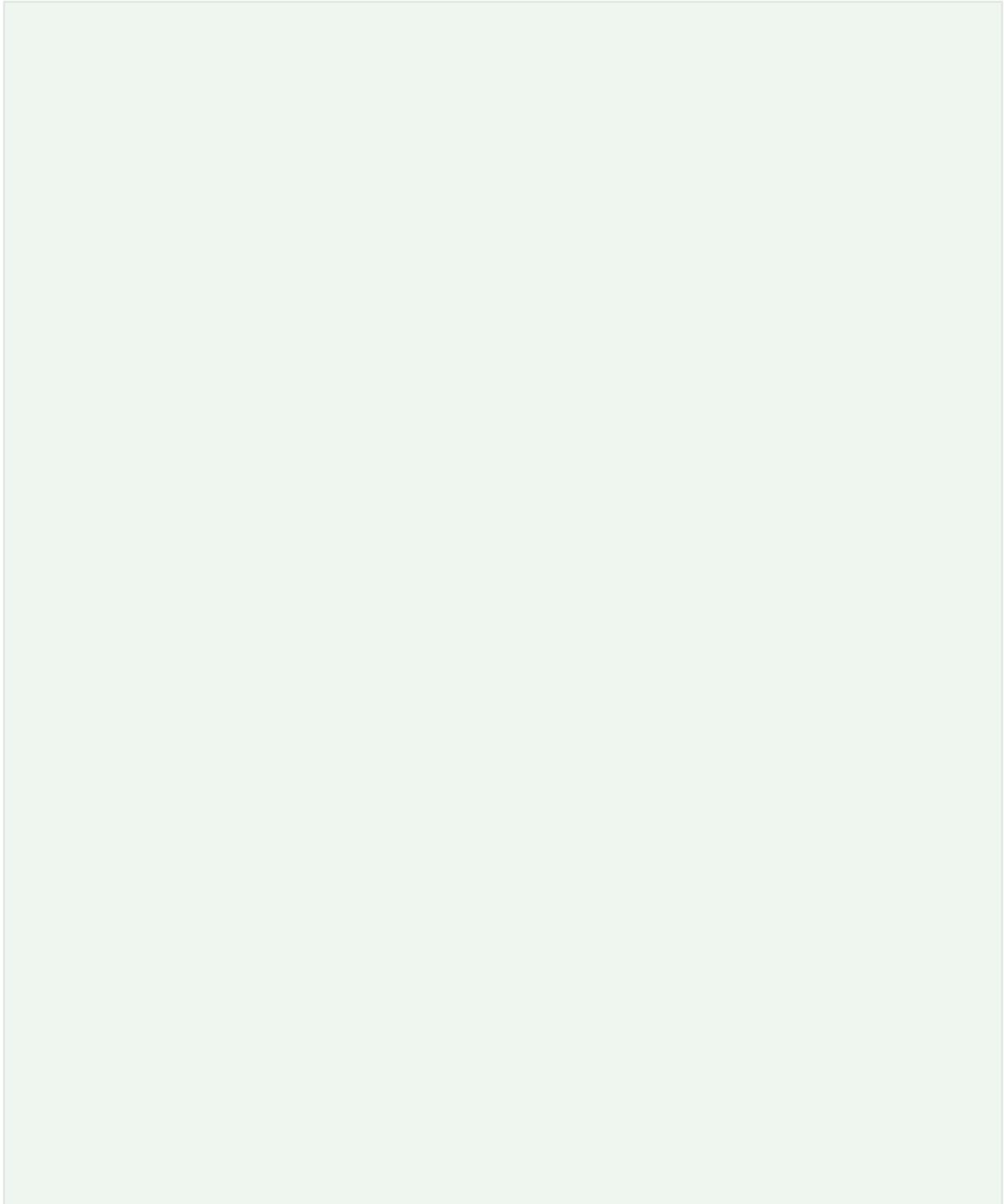
- Do not publish organisation name
- Publish organisation name

**This form contains two questions focused on the draft assessment. These relate to (i) general or specific feedback on the draft assessment, and (ii) the clarity or presentation of the draft report.**

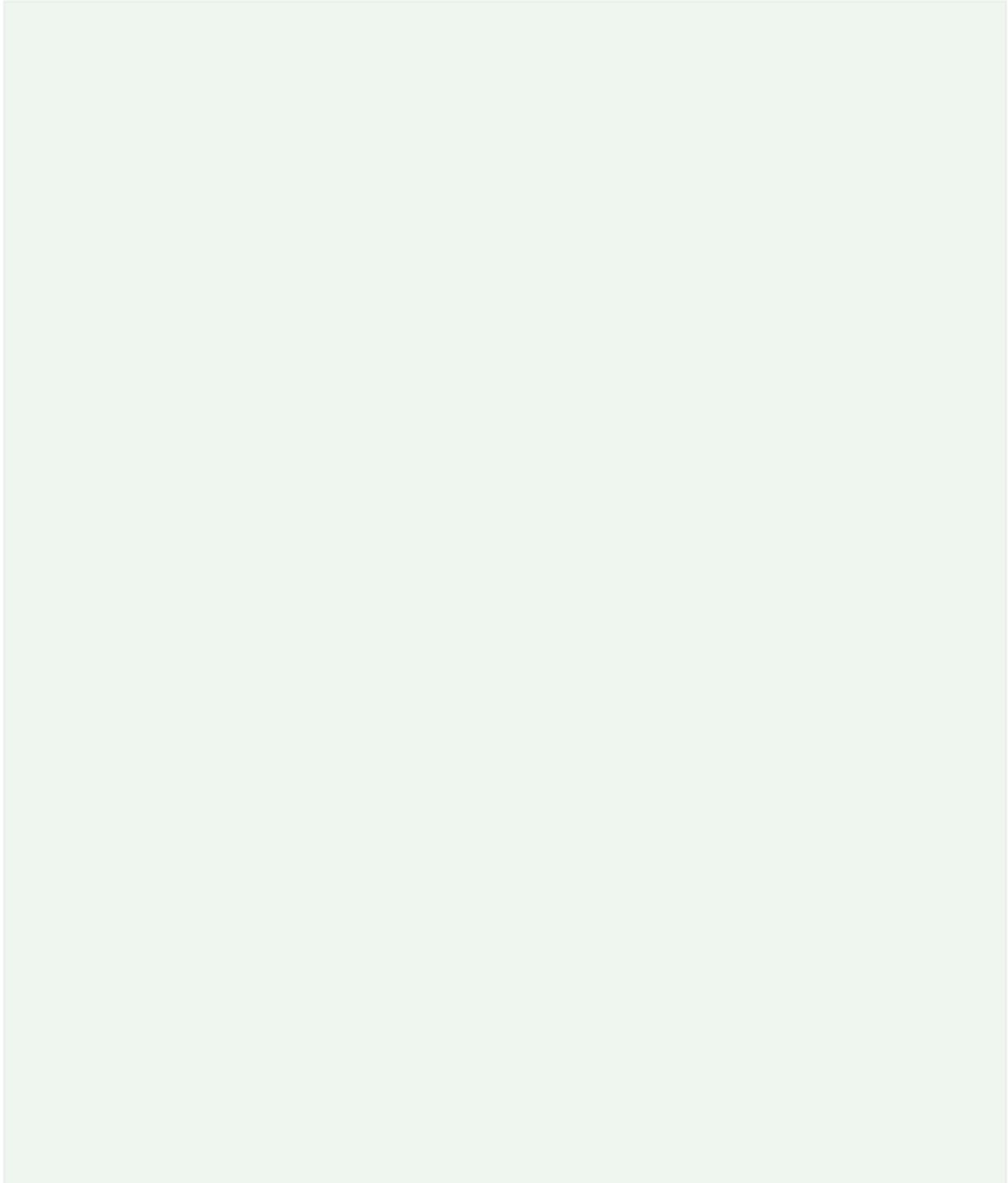
**These questions are presented on the following two pages.**

## **2. Your feedback on the draft health technology assessment**

**2.1 Please provide any general or specific feedback you have on the draft assessment. Where applicable, please specify the section of the draft assessment to which you are referring.**



**2.2 Please outline any issues with the clarity or presentation of the draft assessment. In your response, where applicable, please specify the section to which you are referring.**



**Thank you for taking the time to share your views with us**

After the closing date, we will carefully assess all feedback and incorporate it into the report, where appropriate. The final report and the Statement of Outcomes (a summary of responses) will be published on [www.hiqa.ie](http://www.hiqa.ie).

If you have any questions, please contact the evaluation team at [consultation@hiqa.ie](mailto:consultation@hiqa.ie).

**Please ensure that you return your form to us either by email or post, to reach us by 18 December 2025.**

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