

Staffing and Facilities for Dermatological Units



These guidelines offer advice to providers and purchasers on the staffing and facilities necessary to run an effective dermatology service.

The requirements will vary with the location of the unit and the type of work it undertakes. However, every population needs locally delivered community care as well as hospital-based units providing specialist investigations and treatments, including admission. Many of the doctors and nurses will work in both settings and an integrated service must be maintained.

The services offered can be divided into 'core' services and 'special' services. 'Core' services in the main units will differ from those in community units. The appropriate services for each are listed below.

A Main Unit is defined as a hospital unit where the consultants and specialist nurses are based. It will provide outpatient, day case, and inpatient care. The overall dermatology service to the population will be coordinated from it.

A Community Unit is defined as a unit where a consultant and/or another suitably trained doctor (such as a fully accredited GPwSI in dermatology working with the support of the local secondary care service), with dermatology nursing support, provides a limited service to a small, local population. It may be located in a community hospital or a health centre.

Each type of unit should serve a community large enough to require a dermatology clinic at least once every 2 weeks. However individual consultants should not carry out more than 2 clinics a week outside their main unit. 'Special' services will usually be provided in the main departments, be these district general hospitals or teaching hospitals. Some specialist services may only need to be provided on a regional or per-population basis.

1. STAFFING

CONSULTANT DERMATOLOGISTS

The Royal College of Physicians and the NHS Workforce Review Team agree that 1 consultant dermatologist is needed per 55,500 of the population with traditional referral patterns. If the DoH initiative to move 40% of activity into the community has taken place, this would give a requirement of 1 per 90,000. However, at present, we advise working towards the figure of 1 consultant dermatologist per 100,000, recognising that this will mean an increase from 384 to 693 Whole Time Equivalent (WTE) posts in England and Wales. It can be seen from the figures outlined above, that even in areas where there has been a 40% shift of outpatient work into the community, the latter BAD recommendation is still appropriate. Ideally, no consultant dermatologist should work alone: units should be large enough to employ at least 2 consultants, who should meet regularly with colleagues in surrounding units for audit, CME and CPD.

A consultant dermatologist must be on the Specialist Register of the GMC having satisfactorily completed an accredited training programme in the U.K. or Eire and be in possession of a CCT (Certificate of Completion of Training). Applicants from outside the U.K. and Eire must have gained entry to the specialist register by virtue of eligibility under Article 14, Statutory Instrument 2003 No 1250, The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. Dermatologists will be expected to treat children as well as adults although specialisation in paediatric practice is becoming desirable as consultant numbers increase.

Academic consultant dermatologists (Senior Lecturers, Readers and Professors) will have completed the same accredited training, be on the Specialist Register and may have a further degree. They may be employed by a university or a hospital and will be expected to lead and carry out dermatological research as well as teaching activities, curriculum development and assessment of students. In order to preserve and develop a strong

academic base for clinical dermatology, it is essential that Academic Consultant Dermatologists are given adequate protected time to fulfil their research and teaching commitments.

SPECIALIST REGISTRARS

At present, the number of specialist registrars is decided nationally. There is competitive entry to the SpR grade in dermatology after gaining the MRCP, having spent a minimum of 2 years after registration in medical training posts. SpRs spend at least 4 years in a recognised Training Programme, conventionally within one Deanery, that delivers the approved curriculum (currently under review by PMETB). Training must include all specialist areas of dermatology as well as the care of inpatients and on-call commitments for dermatology. The 4-year training programmes involve working in dermatology units in more than one centre, usually both teaching hospitals and district general hospitals. An RCP logbook must be completed and satisfactory performance must be supported and demonstrated by regular appraisals and assessment using tools such as mini-CEX, DOPs, multi source feedback and a knowledge based assessment. Satisfactory training culminates in the awarding of a CCT and entry on the Specialist register of the GMC.

The Modernising Medical Careers (MMC) agenda means that after Foundation Training (see below) there will be competitive entry into Specialty Training in medicine for a period of two years after which allocation to Specialty Training in Dermatology (and other medical subspecialties) will occur. Acquisition of MRCP prior to entry to Dermatology training will be desirable but is unlikely to be mandatory.

NON-CONSULTANT CAREER GRADE DOCTORS (NCCGS): ASSOCIATE SPECIALISTS, STAFF GRADE DERMATOLOGISTS

These work mainly within dermatology but for various reasons are not in a position to complete a specialist registrar training post and so cannot currently acquire specialist accreditation. They may undertake general or specialist dermatology clinics and dermatological surgery.

Staff Grade Doctors must be supervised by accredited consultants. Associate Specialists may work independently, without such supervision, but should be part of a consultant-led dermatology team. NCCGs should have protected time and funding for administration, training, audit, CME and annual appraisal.

Recently, a framework that will enable Associate Specialists, after suitable training, to apply to the Postgraduate Medical Education Training Board (PMETB) to be on the Specialist Register has been put in place. In addition, a new pay structure for NCCG doctors is under negotiation.

F2 AND CORE MEDICAL TRAINING POSTS

Under MMC, the second year of postgraduate training (F2 year) will comprise 3 four month attachments in particular specialties which may include dermatology.

During this F2 year, doctors can apply for medical specialty training and will be selected to Programmes of 'Core' Medical Training (previously known as Basic Medical Training) which will precede allocation to specialty training in Dermatology (or any other medical specialty). It is possible that dermatology will develop specific 'themed' programmes which might also include 'surgical' or 'pathology' options for those considering dermatology as a career, though these will require local negotiations with Deaneries and Trusts and are under review through the MMC agenda.

Ideally the posts should be tailored to the needs of these different doctors, with protected time for training in dermatology and dermatological surgery, attending specialist and general outpatient clinics, and learning how to investigate and manage common dermatological disorders. These posts must be properly structured and supervised.

CLINICAL ASSISTANT AND HOSPITAL PRACTITIONERS IN DERMATOLOGY

Clinical assistants are not accredited dermatologists. Usually they are general practitioners with an interest in the management of skin disease. Most will have a sessional commitment within a dermatology unit. Experienced clinical assistants can apply to become Hospital Practitioners.

Some clinical assistants, who are not working in general practice, may apply for Staff Grade posts. They may participate in general or specialist clinics, or perform surgical operations. Clinical assistants should not work alone, but should be supervised by an accredited consultant dermatologist. They should have adequate protected and funded time for administration, audit and CME. Membership of the Primary Care Dermatology Society is to be encouraged.

GENERAL PRACTITIONERS PROVIDING DERMATOLOGY SERVICES (GPWSI)

Clear guidance has been issued by the Department of Health, the NHS Modernisation Agency Action on Dermatology Programme, the Royal College of GPs and the British Association of Dermatologists on the required training experience, and CPD for GPs wishing to develop a special interest in dermatology and to provide dermatology services within a local health community.

This is available at the following website www.doh.gov.uk/pricare/gp-specialinterests/dermatology.pdf and can easily be downloaded in PDF format (a more

detailed document regarding the requirements of this role is likely to be published in the near future). It recommends that general practitioners providing dermatology services in the community should do so as part of a locally agreed integrated dermatology service, developed with and working closely alongside the local secondary care dermatology service. Such doctors should continue to work with the consultant for at least one session a month to ensure continuing skills, to provide patients with proper investigation and treatment, and to have easy access for difficult cases. The general practitioner providing dermatological services must have protected time to undertake audit, training and CME, in dermatology as well as in general practice. A trained dermatology nurse should work closely with the general practitioner in both the community and the main unit. PCT Commissioners seeking to develop GPwSI services in dermatology should refer to the DoH guidance document at an early stage.

GP SENIOR REGISTRARS (EXTENSION OF TRAINING POSTS)

Some doctors who have completed their training in General Practice will apply for GP Senior Registrar posts. These are six-month attachments during which the doctor works 50% in general practice and 50% in a speciality of their choice. Dermatology is a popular choice and a GP Senior Registrar post can combine training with some service commitments (for example, minor surgery, audit projects, clerking new patients). The funding for these posts will be negotiated between the GP Senior Registrar and the Deanery. Such posts are individually arranged, but in many areas are now becoming regular appointments, of benefit both to the trainee and to the dermatology department.

DERMATOLOGY NURSES

Dedicated dermatology nurses are essential to any service. In main units they may take on specialist roles as well as using their core skills in outpatient clinics, day treatment units and inpatient units. It is essential that experienced dermatology nurses look after dermatology patients to ensure that they receive effective care. In addition, they should provide education to allow patients with chronic skin disease to become expert in the management of their condition, thereby empowering them to take responsibility for their own care.

Specialist roles include liaison between the hospital and community for conditions such as leg ulcers, paediatric skin disorders, atopic eczema, and the skin care of the elderly. These nurses help patients, carers, and community and practice nurses, and ensure continuity of care. Within main

units, dermatology nurses run day treatment units, supervise and monitor phototherapy, apply patch tests in contact allergy clinics, manage leg ulcer patients and support paediatric dermatology. They provide a variety of clinics (e.g. for monitoring long term cytotoxic therapy, supervising ongoing management in chronic diseases such as psoriasis, eczema or acne), support skin cancer patients, perform diagnostic skin biopsies and develop other services such as nurse-led clinics for pre-diagnosed skin conditions and nurse prescribing. Suggestions on the best way of involving dermatology nurses in service provision are included in the 'Models of Integrated Service Delivery in Dermatology' published by Skills for Health which will shortly be available on their website www.skillsforhealth.org.uk. BAD members will find a preview copy on the BAD website at http://www.bad.org.uk/members/Service_Models_Final_Nov_16_2006.pdf

At present the experience and training required for nurse specialists and nurse consultants in dermatology has not been standardised but useful information can be obtained from the British Dermatology Nursing Group (www.bdng.org.uk or email bdng@bad.org.uk). A competency based curriculum is under development by the Dermatology group at the Royal College of Nursing, and should be available late in the summer of 2004.

It is essential that dermatology nurses have protected time and resources for ongoing training, audit and research.

SECRETARIAL AND SUPPORT STAFF

Dermatology is a very high throughput speciality. There must be enough secretarial personnel and time to support it, so that letters are sent out to general practitioners within 7 days of a clinic visit (with copies to patients where appropriate). All clinical work generates the need for communication between professionals and secretarial staff provide a vital point of contact between primary and secondary care, as well as for patients. They are also critical in ensuring that results of investigations are received and acted upon. Their role is fundamental to the functioning of the clinical team, and because of the number of patients involved is unique amongst clinical specialties. A full time consultant dermatologist requires a full time secretary.

Support and clerical staff should know the function of individual clinics (for example two-week wait cancer clinics) and be involved with the organisation of MDTs and data collection where appropriate. Access to cancer services support staff is also important. Clinics carried out in the community need proper secretarial and clerical support too and all areas of practice require input from trained audit departments.

2. CORE SERVICES – MAIN UNITS

Dermatologists should not work in isolation. They must have appropriate support staff, including specialist dermatology nurses.

1. REFERRALS

There should be:

- Ideally, 24-hour cover and advice for in-patients and the admissions unit.
- A review of all referral letters by the dermatologist.
- Dedicated support staff.
- Explicit standards for the time from referral to first appointment for urgent and for non-urgent patients.

2. OUTPATIENT CLINICS

These should provide:

a. A dedicated outpatient area

The minimum should be a defined set of rooms where the dermatology clinic is always held. Facilities are required for routine and emergency outpatients, skin cancer clinics, day treatment, wound care including leg ulcer management, dermatological surgery, contact allergy testing, phototherapy, cryosurgery treatment and patient education. There should be an identified paediatric area, or access to a paediatric department for paediatric dermatology clinics.

b. A flexible appointment system

In any clinic, time should be available for the doctor to read referrals, to review and act on results, and to dictate letters, as well as to spend sufficient time with patients and their families as part of the consultation. The need for the flexibility, for example to spend more time with the family of a child with atopic eczema, should have greater priority than the need to keep strictly to outpatient waiting time guidelines.

c. An appropriate number of appointments for patients

– so that the clinic and its immediate administration can be completed within a single unit of programmed activity. Between 10 & 20 patients may be seen in a single consultant session at which there are no trainees, depending on the complexity of new and follow up patients seen (inflammatory dermatoses and lesions), the ratio of new to follow up patients and whether surgical procedures are to be carried out as ‘one-stop shop’ consultations. Clinics in which other doctors, trainees or medical students are supervised should be reduced by approximately 20%.

d. Experienced dermatology nurses to assist in the clinic.

e. A pharmacy service able to meet needs identified in the clinic.

f. Dermatology secretarial staff.

Secretarial staff should be trained in dermatological terms and policies, and provided with word-processing and data collection facilities to allow for proper clinical audit.

g. A medical photography service.

3. DAY TREATMENT UNIT

Access should be provided during the daytime, but also after hours and at weekends. The service should have:

a. A specified area where topical treatments can be applied, with an identified area for children.

b. Appropriately trained nursing staff.

All phototherapy units should be supervised by a named consultant to ensure accurate dosimetry and record keeping, and the training and monitoring of the staff who administer the treatment. A medical physicist should monitor the UV output of units. Computerized national managed clinical networks (as exist in Scotland) are likely to simplify and standardize these issues.

4. DERMATOLOGICAL SURGERY

A quality service should include:

a. A specified dermatology operating theatre equipped with appropriate instruments and facilities.

b. Trained nursing staff.

c. A defined caseload.

There should be an agreed definition of a day case and recognition of the time required to perform the various surgical procedures.

5. INPATIENT CARE

a. Dedicated inpatient beds for adults and children.

b. Experienced dermatology nurses.

c. A named nurse should be allocated to each patient on admission.

6. LABORATORY SUPPORT SERVICES

Dermatology requires the same support services as other medical specialties - for example, chemical pathology, haematology, microbiology including mycology and radiology. It has an extra requirement for services in immunology, immunopathology and histopathology. Arrangements should be in place to provide these for regular clinics.

7. SUPPORT BY OTHER HOSPITAL SPECIALITIES

Dermatology patients need access to other hospital specialists, including histopathologists with a specific expertise in dermatopathology, plastic surgeons, radiotherapists, immunologists, and psychiatrists.

8. DISCHARGE LETTERS AND FUTURE MANAGEMENT PLANS

General practitioners should be informed within 24 hours when a patient is discharged from inpatient care. For outpatients a letter should be sent to the GP within 7 days with a copy to the patient if appropriate. Details should be provided of the patient's status, with advice on further management, including follow-up.

3. ADDITIONAL SPECIAL SERVICES – MAIN UNITS

These will depend on the specialist expertise available.

Outpatient Clinics

Specialist clinics may include:

Occupational skin disease

Photodermatology clinics

Specialised skin cancer/pigmented lesion clinics

Clinics for the investigation of cutaneous allergy

Vulval clinics

Paediatric clinics, atopic eczema clinics

Photodynamic therapy

Specialist clinics in psoriasis, eczema, leg ulcers, connective tissue disease, lymphoedema, psychosomatic disorders and others - depending upon available expertise and population.

Teledermatology support for a managed clinical network

Iontophoresis

Electrolysis

Botulinum toxin for axillary hyperhidrosis

Nurse led clinics

These are appropriate in a number of fields including the management of chronic diseases such as psoriasis, eczema and leg ulcers, minor surgery, phototherapy, and drug monitoring.

Day Cases

Mohs' micrographic surgery.

Laser treatment - including general anaesthetic lists for children with haemangiomas.

Cytotoxic treatment facilities.

Combined clinics

A range of combined clinics can offer patients the benefits of extra expertise and 'one-stop' facilities. Dermatologists may take part in a variety of combined clinics, including the following:

- Rheumatology, immunology, dermatology (for connective tissue diseases, psoriasis).
- Gynaecology, genitourinary medicine, dermatology (for vulval diseases).
- Paediatrics, dermatology (for atopic eczema).
- Plastic surgery, radiotherapy, dermatology (for skin cancers). In addition, Multidisciplinary team meetings are a mandatory part of cancer centre and unit function. Facilities to administer, hold and record these meetings are essential. The meetings themselves may usefully be held at the same time as collaborative clinical meetings but this may not be possible.
- Oral medicine, dermatology.
- Vascular surgery, dermatology (for leg ulcers).
- Psychology, psychiatry, dermatology.
- Infectious diseases, dermatology (HIV).
- Medical genetics, dermatology (inherited diseases)

Inpatient or Accommodation required

Patients may require overnight stay facilities when undergoing investigation eg by monochromator testing, photopatch testing or photoprovocation.

4. CORE SERVICES – COMMUNITY UNITS

The range of facilities will depend on local needs within a managed clinical network. Most units will be staffed by appropriately trained GPs with a Special Interest, but will require regular (probably monthly) support from a consultant.

General dermatology clinics.

Leg ulcer clinics (nurse led).

Psoriasis clinics (nurse led).

Atopic eczema clinics (nurse led).

Skin surgery - diagnostic biopsies and skin cancer excisions. Any doctor managing patients with skin cancer must be part of the local MDT and attend at least 4 meetings per year.

5. CORE FACILITIES – MAIN UNITS

OUTPATIENT UNITS

Outpatient units should provide:

- A dedicated outpatient area with consultation and examination rooms large enough for patients and their accompanying persons, and for the consultant plus medical students or other trainees. Almost all consultants undertake clinical teaching and it is inappropriate and demeaning to patients to attempt this in space that is too small. Two adjacent communicating rooms per doctor are required for efficiency and patient privacy.
- Natural lighting and additional lighting.
- Examination couches.
- Private areas for undressing.
- Equipment for cryotherapy.
- A wound dressing area.
- Treatment rooms with facilities for adults and children.
- A specific area with facilities for contact allergy testing, including appropriate storage for allergens.
- Rooms for patient education and educational material.
- Medical photography services.
- Access to a pharmacy for the preparation of topical medicaments and allergens for contact allergy testing.
- Accommodation within a paediatric department for paediatric dermatology clinics and the outpatient treatment of children.

SURGICAL FACILITIES

- Well-lit operating rooms with couches.
- Equipment for electrocautery, diathermy and hyfrecation.
- Equipment for cryosurgery and the storage of liquid nitrogen.
- Facilities for freezing biopsies and storing frozen samples.
- Laser-safe areas, where required.
- Facilities for Mohs' surgery e.g. cryostat and histopathology equipment in some specialist units.
- Access to latex free facilities.

DAY-CARE CENTRES AND PHOTOTHERAPY

Day-care complements in-patient care. Day-care centres should be able to provide an out-of-hours service, including phototherapy. There should be separate facilities for men and women, and identified space for children. Specialist

dermatology nurses, who can provide skin care, should run phototherapy units rather than physiotherapists.

- Phototherapy area with TLO1 and PUVA.
- Treatment room: e.g. facilities for bathing or showering.

INPATIENT UNIT

All dermatologists should have admitting rights to a dedicated inpatient dermatology unit staffed by trained specialist nurses. If possible, the inpatient unit should be located close to the outpatient unit, and staff should work flexibly between the two. Consultants, F2/CMT doctors or specialist registrars provide medical cover. Patients requiring such facilities will include those with generalised skin failure (eg erythrodermic eczema, erythrodermic psoriasis or acute pustular psoriasis), severe drug eruptions, severe blistering disorders (eg immunobullous diseases), Stevens-Johnson syndrome and pyoderma gangrenosum amongst others. Dedicated inpatient beds, some with facilities for reverse barrier nursing, are also required for patients with severe and life-threatening skin conditions such as toxic epidermal necrolysis. Teaching hospitals need dedicated inpatient dermatology units to manage the tertiary referral of patients with complex diseases, and also to train undergraduates and specialist registrars. Patients with multisystem disorders, who require both specialist dermatological care as well as management of their medical and surgical problems, should be looked after in the area defined by their most serious problem. Outreach care by dermatology-trained nursing staff is essential for such patients with significant skin disease who are being cared for on general wards.

The preferred requirement is two dedicated dermatological beds per 100,000 population; but a minimum of eight beds make an ideal self-contained unit. Bed provision has fallen to around 1/100,000 population (BAD survey 2005). This has occurred as NHS Trusts have been forced to make savings, rather than as a result of any needs analysis.

In large urban areas, a hub and spoke arrangement is often the best way of ensuring that patients have access to a suitable dedicated dermatology inpatient facility, however, in rural areas, such a model may not be appropriate as the beds would be an unacceptable distance from the patient's home. In some instances, therefore, dermatologists will have admitting rights to a ward which is not a dedicated dermatology ward. In such situations, high quality care is likely to occur only if this setting provides the core facilities outlined below with, in addition:

- Availability on a daily basis of trained dermatology Clinical Nurse Specialists to oversee all topical therapies
- Availability of a Dermatologist to oversee patient management,

- Regular training/teaching of the non-dermatology ward staff to ensure they have insight into what constitutes good nursing care of patients with severe skin disease
- The provision of sufficient time in the work schedule of non-dermatology ward nurses to carry out dermatological treatments.

The financial pressures which have led to the loss of dermatology beds mentioned above, along with the current push to shift dermatology care into the community present dermatologists with a strong case for developing high quality day units in local general hospitals. The increase in the numbers of highly effective dermatology Clinical Nurse Specialists associated with these units provides a resource which could and should be made available to inpatients with multi-system disease to administer or supervise the dermatological aspects of their care.

INPATIENT FACILITIES

In a dermatological inpatient unit there should be:

- Dedicated dermatology beds for adults and children.
- At least one bed in a side room, with provision for isolation and photoprotection.
- Provision of access to beds for barrier/reverse barrier nursing
- Adjacent bathing and showering facilities.
- A treatment area.

ADMINISTRATIVE OFFICES

These should include:

- Sufficient office accommodation for doctors, nurses, secretaries and support staff.
- Computer access for these groups.
- Hardware and software for diagnostic coding.
- A teaching area with suitable facilities.
- A library area with books and subscription journals.

6. CORE FACILITIES – COMMUNITY UNITS

OUTPATIENT AREA

- Dedicated outpatient area with natural lighting, additional lighting, and examination couches.
- Equipment for cryotherapy. Fully equipped skin surgery unit.
- Area for the assessment and dressing of leg ulcers.
- A phototherapy area with TLO1 and PUVA may be required in larger units.

ADMINISTRATIVE OFFICES

- Sufficient office accommodation for the doctors, nurses, secretaries and support staff.
- Computer access for these groups.
- Hardware and software for diagnostic coding.

