

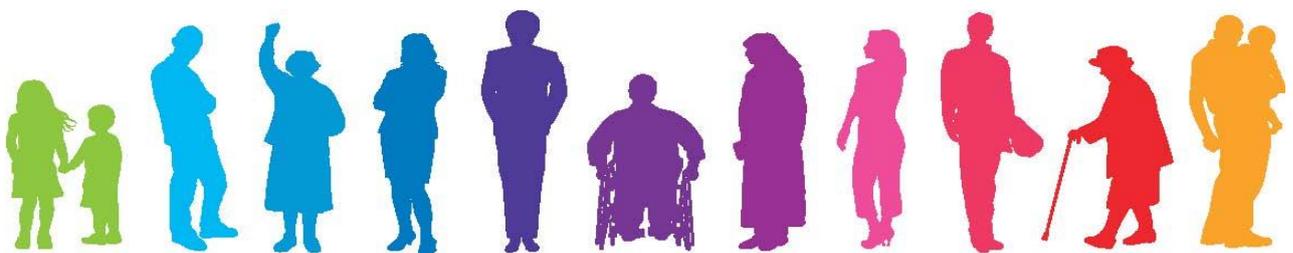


# STAFFING AND FACILITIES GUIDANCE

## FOR DERMATOLOGY SERVICES

SERVICE GUIDANCE

**Produced by: Clinical Services Unit  
British Association of Dermatologists  
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## Preface

These guidelines offer advice to providers, Commissioners and Local Health Authorities on the required staffing and facilities to run an effective Dermatology service. They should be read in conjunction with the British Association of Dermatologists' (BAD) more specific guidance:

- [Staffing and Facilities for Skin Surgery Dermatology Services \(2011\)](#)<sup>1</sup>
- [Phototherapy Working Party Report \(2011\)](#)<sup>2</sup>
- [Consultant Physicians working with patients: Dermatology, Royal College of Physicians \(2013\)](#)<sup>3</sup>
- [PsychoDermatology Working Party Report \(2012\)](#)<sup>4</sup>
- [Paediatric Working Party Report \(2012\)](#)<sup>5</sup>
- [Cutaneous Allergy Service Working Party Report \(2012\)](#)<sup>6</sup>
- [Quality Standards for Dermatology: providing the right care for people with skin conditions](#)<sup>7</sup>

Every population needs **locally delivered community care** as well as **hospital-based services** providing specialist investigations and treatments, including inpatient care. Many of the doctors and nurses will work in both settings and an integrated service must be maintained.

Requirements for staffing and facilities will vary with the location of the unit and the type of work it undertakes. These are set out in three service categories below.

**Community Care Services** are normally delivered from a health centre, larger General Practitioner (GP) practices or a community hospital. Community services normally provide intermediate care which is led by a Consultant Dermatologist and or another suitably trained doctor (such as a fully accredited GP with Special Interest (GPwSI) in Dermatology, working with the support of the local secondary care service) and Dermatology nursing support.

**Secondary Care Services** provide acute healthcare, in local District General Hospitals (DGH), and Teaching hospitals. Many Consultants work in more than one DGH, or provide outreach clinics in community hospitals in rural areas with dispersed populations and poor transport. Specialist services and inpatient facilities are provided in the central unit and Consultants have sessions in both central and peripheral hospitals. Secondary care services are delivered by a specialist team which includes Dermatology Consultants, Clinical Nurse Specialist (CNS), Specialist Registrars, Speciality Doctors and Associate Specialists (Non-Consultant Career Grade doctors) who provide outpatient, day care services and inpatient care.

**Specialised Care Services** (also known as tertiary care) provide a higher level of specialty care within University or larger Teaching Hospitals. Specialised adult Dermatology and Paediatric services include the investigation and treatment of rare diseases and the management of severe diseases not suitable for, or not responding to, conventional treatment available in local Dermatology departments. Services are delivered by Consultant

Dermatologists and a range of other healthcare professionals with specialist skills in the management of complex and/or rare skin disorders. The Department of Health (DH) [Specialised Services National Definitions \(SSND\)](#)<sup>8</sup> has been superseded by NHS England Dermatology Specialised Service Specifications.

## 1. Staffing

### Consultant Dermatologists

A Consultant Dermatologist must be on the Specialist Register of the General Medical Council (GMC), having satisfactorily completed an accredited training programme in the UK or Eire, and be in possession of a Certificate of Completion of Training (CCT). Alternatively, some Consultant Dermatologists in the UK or outside Eire may have gained entry to the Specialist Register through a different route, via Article 14 of The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. They will hold a Certificate of Eligibility for Specialist Registration (CESR).

All Consultant Dermatologists are trained to treat children and adults but some will specialise in tertiary care for either of these groups.

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 Teaching 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.

**Hospital-based services** require at least one whole-time equivalent (WTE) Consultant Dermatologist per 62,500 population. This figure is based on government statistics for new patient referrals in 2009/10; a population of 250,000 generates 4000 new patients. A population of 250,000, therefore, requires 4 WTE Consultants.<sup>3</sup>

However, at present there is a shortfall of 250 WTE Consultants for the UK (61.8 million population).<sup>3</sup> This continues to cause recruitment problems for some services across the UK, with the majority in England. Moving care closer to home has not altered the need for more Consultant Dermatologists, particularly with increasing referral rates to both community and secondary care services.

In an average 42 week year, a Consultant will see 1008 new, 1344 follow up patients and perform 280 operations. This does not allow for specialist clinics, teaching students, supervising or training any grade of staff, ward referrals, inpatient care, on-call, travel, or attendance at Multidisciplinary Teams (MDT) meetings. Consultant Led activities to support community services also need to be factored into the Consultant's job plan.<sup>1</sup>

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, Continuing Medical Education (CME), Continuing Professional Development (CPD) and MDT.

### **Speciality Doctors & Associate Specialists**

New contracts for Specialty and Associate Specialist (SAS) doctors were introduced from 1 April 2008, as well as a new 'Specialty Doctor' grade. The 'Specialty Doctor' grade subsumes all Trust Grade, Staff Grade, Clinical Medical Officer, Hospital Practitioner and Clinical Assistant Grades. Previously appointed existing Associate Specialist (AS) grades are retained, but no new appointments are possible.

The use of this single contract for Non-Consultant Career Grade (NCCG) doctors ensures annual job planning and appraisal as core requirements for all Specialty Doctors and Associate Specialists. This aligns them with colleagues in the Consultant and AS grades, allowing for better team planning and continuing development for all doctors in the specialty.

Speciality Doctors must be supervised by accredited Consultants (although they may occasionally work alone in the event of sickness or annual leave). They will undertake procedures within their skill base in general Dermatology and/or skin surgery clinics.

Associate Specialists may work independently, without such supervision, but should be part of a Consultant Led Dermatology team. These doctors should have protected time and funding for administration, training, audit, CME and annual appraisal.

Some Specialty Doctors and Associate Specialists will gain the right skills, knowledge and experience to gain entry to the Specialist Register through Article 14, of The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. If successful they will be awarded a CESR allowing them to apply for and take up Consultant posts.

### **Specialist Registrars**

After the completion of Core Medical Training (CMT) and gaining an MRCP (UK) part 1 and part 2, doctors will begin their Dermatology Specialist Training (ST3). The length of the curriculum programme is 4 years and delivers the acquisition of all competencies required for a Consultant Dermatologist practicing in the UK's National Health Service (NHS). Trainees will work in both Teaching Hospitals and District General Hospitals (DGH) to cover all specialist areas of Dermatology. This includes the care of inpatients and on-call duties for Dermatology.

Registrars must pass the Dermatology Specialty Examination (SCE) which is usually undertaken during higher Specialty Training (ST) between ST4–5. Satisfactory training and assessment culminates in the awarding of a CCT and entry on the Specialist Register of the GMC.

## **Foundation and Core Medical Training Posts**

The Foundation Programme is a two-year training programme (F1, F2) that forms the bridge between medical school and specialty training. In the second year F2, trainees will have the opportunity to gain experience in a series of placements in a variety of specialties and healthcare settings, which may include Dermatology. During this year doctors can apply for entry to medical specialty training and will be selected, following successful completion of F2, for Core Medical Training (CMT) ST1, ST2.

CMT forms the first stage of Specialty Training for most doctors training in Physician specialties. The approved curriculum for CMT is a sub-set of both the curriculum for General Internal Medicine (GIM) and the curriculum for Acute Internal Medicine (AIM).

Training programmes consist of 4 to 6 over two years with direct involvement in the acute medical take. Trainees completing CMT will have a solid platform from which to continue into Specialty Training. Completion of CMT will be required before entry into Specialty Training in Dermatology at ST3. Acquisition of MRCP (UK) part 1 and part 2 is required before entry into ST3 (2011 onwards).

## **General Practitioners with Special Interests in Dermatology (GPwSIs)**

A GPwSI framework for Dermatology was developed by a multidisciplinary working group for the DH in 2007 (revised in 2011). This document<sup>9</sup> provides a framework for the required training experience and accreditation criteria for GPs wishing to develop a Specialist Interest in Dermatology. This also sets out the compliance<sup>10</sup> requirements for the accreditation of the GPwSI and their Dermatology service which remain in place with the inception of Clinical Commissioning Groups.

Practical training should be appropriate to the skill and service to be provided by the GPwSI. This will include an attachment to a secondary care Dermatology unit under the supervision of a Consultant Dermatologist. Any theoretical training must be coupled with practical training for accreditation.

For skin surgeons this may also include an attachment to a Plastic Surgeon or Maxillo-Facial Surgeon and attendance at MDT meetings 4 times a year. Some sessions with an accredited GPwSI may be useful as part of the programme. The GPwSI will need to attend sufficient clinics to be able to obtain training and experience relevant to the specified area of clinical practice. They will need to demonstrate the competences required to meet the assessment requirements for accreditation and ongoing professional development.

GPwSI 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.

A trained Dermatology nurse should work closely with the General Practitioner in both the community and the main unit.

## **Dermatology Nurses**

Dedicated Dermatology nurses are essential to any service. Within the main unit, Dermatology nurses run day treatment units, supervise and monitor phototherapy, apply patch tests in Contact Allergy clinics, manage leg ulcers patients and provide support in Paediatric Dermatology.

They can provide a variety of 'Nurse Led' clinics for pre-diagnosed skin conditions (e.g. for monitoring long term cytotoxic therapy, supervising on-going management in chronic diseases such as psoriasis, eczema or acne) and nurse prescribing to ensure that patients receive effective care. In addition, they provide education to patients with chronic skin disease, empowering them to take responsibility for their own care.

Clinical Nurse Specialist (CNS) roles also include liaison between the hospital and community to ensure continuity of care. Competency based curriculums have been produced by the Royal College of Nursing (RCN).<sup>11,12</sup>

The CNS trained in skin cancer supports patients, performs diagnostic skin biopsies and liaises with the many different departments. They will be involved in the care of the patient with skin cancer from diagnosis throughout the pathway to discharge or death.

A skin cancer CNS can go on to be appointed as a Macmillan Skin Specialist Nurse after obtaining at least five years' experience, including 2 or more years in cancer or palliative care.<sup>13</sup>

## **Secretarial and Support Staff**

Dermatology is a high throughput specialty. There must be enough secretarial personnel and time to support it, so that investigation results are organised and other tasks are completed on time. It is important that discharge letters are sent out to the patients GP within 24 hours of the patient's discharge (a copy must also be sent to the patient if indicated).

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

Support and clerical staff should know the function of individual clinics (for example 2 week wait cancer clinics) and be involved with the organisation of MDT meetings, with the MDT coordinator, and data collection where appropriate. Clinics carried out in the community need proper secretarial and clerical support, and all areas of practice require input from trained audit departments.

## **Infection Control Officer**

An up to date infection control policy document should be available to all staff in all units, and a member of the team should be nominated as the infection control officer for the unit.

This person is responsible for the recording and reporting of any adverse events or near misses in adherence with the Trust's Infection Control Policy.

### **NHS Contractual Requirements for Staffing<sup>14</sup>**

The staffing expertise and experience covered in this section are applicable for any contracted acute, or community, NHS Dermatology service. Dermatology service providers will need to comply with their legal responsibilities in regards to the recruitment of appropriately trained and educated staff with the right skills to provide their contracted service.

## **2. Dermatology Service Provision**

### **Community Care Services**

Dermatology services can be provided across a range of settings in the community, such as healthcare centres, larger GP practices and community hospitals. Some NHS Trusts will also run community clinics within their departments in order to facilitate care closer to home.

The levels of community care, and how these are provided, must also take into consideration the available facilities and the required staffing expertise needed to run these services.

Intermediate services for Dermatology should provide local clinical assessment, treatment, minor surgery (NICE compliant) and advice for a variety of non-urgent skin conditions. These are best defined by the GPwSI curriculum and are reflected in the [British Association of Dermatologists \(BAD\) Dermatology community service specification<sup>15</sup>](#) in line with the DH care closer to home agenda.

Dermatology services in the community are Consultant Led (18 week wait) and delivered by a range of Dermatology doctors and nurse specialists with appropriate administrative support. GPwSI's led services will require a joint monthly clinic with a Consultant Dermatologist to meet ongoing accreditation and reaccreditation requirements.<sup>16</sup> GPwSI should meet with their supervisory Consultant annually to complete an appraisal interview and appraisal summary related to the GPwSI activity for review as part of the GP's appraisal process.

Larger community hospitals may also provide outreach clinics<sup>17</sup> to give patients in geographically remote areas of the UK access to specialist expertise and acute care treatments. The types of treatments provided in this setting must be based on the staffing expertise and facilities available. These differ from the intermediate levels of treatment defined above.

For community hospital outpatient services providing acute treatments such as phototherapy please refer to **Secondary Care Services**.

## Community Facilities

The types of facilities required for an intermediate level service will vary according to the agreed service specification requirements.

Basic requirements for intermediate services include some of the following:

- Access to surgical equipment and appropriate resuscitation equipment that meets the requirements necessary for skin surgery.
- A well-lit consultation room with natural light.
- Adequate space and equipment for diagnostic and therapeutic procedures.
- Access to liquid nitrogen if cryotherapy is to be performed, with attention to Health and Safety Executive (HSE) guidance on storage and administration.

Dermatology service providers also need to comply with their legal responsibilities in regards to the environment and equipment required for contracted NHS Dermatology services.

## Secondary Care Services

All Dermatology departments providing acute hospital services will need to ensure Consultants have sufficient time and staffing arrangements to undertake the following:

### ***A. Referral management and flexible appointment system***

Clinical time should be available for the Dermatologist to read/triage referrals, to review and act on results, and to dictate letters, as well as to spend sufficient time with patients and carers.

Explicit standards for time from referral to first appointment, for urgent and non-urgent patients, are required to ensure the best use of clinic lists and staff time. The need for flexibility in clinics is essential, particularly when dealing with acutely unwell patients.

The outpatient service should also provide cover and advice for inpatients including referrals from other specialty disciplines, as well as the Admissions Unit or Accident and Emergency Department.

### ***B. Appropriate clinic template<sup>3</sup>***

This is important to ensure that the clinic and its immediate administration can be completed within a single unit of Programmed Activity (PA). The ratio of New to Follow-up appointments and time allocated varies depending on the type/complexity of the patients seen. Where community services are provided locally, secondary care services should expect to see more complex cases that require longer consultations with the Consultant. Reductions in clinic numbers are required for Consultants supervising and training other doctors, nurses and medical students or for clinics with complex patients.

### **C. Discharge letters and future management plans**

Since April 2010 the NHS Standard Contract requires acute hospitals to provide patients with a discharge letter at the time of their discharge from an inpatient or outpatient setting. A discharge summary should also be sent to the patients GP within 24 hours of discharge outlining the diagnosis, investigations, treatment plans, medication and patient advice. Some Trusts have been unable to meet this requirement due to having multiple discharge summaries across specialties, many of which are produced manually. In order to overcome this problem an [electronic discharge summary toolkit](#)<sup>18</sup> has been produced with the aim to help Trusts implement the nationally-agreed discharge summary.

### **Outpatient Services**

DGHs and smaller Teaching Hospitals provide inpatient care including ward referrals for other disciplines. They will also provide routine acute and emergency outpatient treatments such as:

- Phototherapy, iontophoresis, wound care (including leg ulcer and other day treatments).
- Patch and Prick Testing for cutaneous allergies.
- Paediatric dermatology clinics.
- Day case treatments.
- Rapid access clinics for skin emergencies.
- Cryosurgery treatment.
- Dermatological surgery.
- Skin cancer clinics and access to a local skin cancer MDT.

### **Outpatient Facilities**

The outpatient area should contain a dedicated set of consultation and treatment rooms where Dermatology clinics are always held. These rooms should be large enough to accommodate patients, their accompanying carer, and with space to be seen by the clinician.

Almost all Consultants undertake clinical teaching; adequate clinical space must be available to ensure patients' dignity and privacy.

Outpatient areas and rooms should have natural lighting with additional day-glow or spot lighting.

*Outpatient facilities should include:*

- Dedicated surgical operating room(s).
- Dedicated treatment rooms for phototherapy, cutaneous allergy testing, including appropriate refrigerated storage for allergens, wound care including leg ulcer management, day treatments such as Infusion Therapies and Cryotherapy.
- Waiting room areas for adults and children.
- Examination couches.

- Patient changing rooms with lockable storage cabinets for patients receiving day care.
- Showering and bathing facilities.
- Equipment and appropriate storage for cryotherapy.
- Rooms for patient education with educational material, breaking bad news and counselling.
- Access to Medical Photography.
- A dedicated paediatric area and separate clinic lists when provided in the Dermatology department. Alternatively clinics may be provided in the Paediatric department to comply with National Service Framework (NSF) requirements.
- Staff changing rooms and a library area with books and subscription journals.

### **Day Care Services**

Day care services complement and reduce the need for inpatient care. Access should be provided during the daytime and ideally during extended hours.

The service should have appropriately trained nursing staff to provide:

- Phototherapy, iontophoresis, wound care and other day treatments.
- Infusions of disease-modifying drugs.
- Cellulitis day case services (which may produce substantial NHS savings).<sup>19</sup>

CNS must be appropriately trained in order to run day care services. These services should always be provided under the supervision of a named Consultant to ensure appropriate governance and monitoring.

### **Day Care Facilities**

Patients being treated in the day treatment or phototherapy units require private areas/rooms where topical treatments can be applied or they can receive infusion therapies.

For day care services there must be:

- Waiting areas that are separate from treatment areas.
- A phototherapy area which is TLO1 and PUVA compliant with the [BAD working party report](#).<sup>2</sup>
- Secure storage of all drugs and other chemicals used in the unit, which must have had a Control of Substances Hazardous to Health (COSHH) risk assessment.
- Separate facilities for men, women and children.
- A treatment room with separate facilities for bathing or showering.
- Facilities for other treatments including iontophoresis and photodynamic therapy (PDT).

### **Dermatological Surgery Services**

Please refer to the BAD's separate guidance on [Staffing and Facilities for Skin Surgery Units](#).<sup>1</sup>

## **Inpatient Services**

In many Acute Trusts, Dermatology inpatient care is changing from dedicated Dermatology beds to Dermatology patients being admitted to general medical wards.

Patients requiring such facilities will include those with generalised skin failure (e.g. erythrodermic eczema, erythrodermic psoriasis or acute pustular psoriasis), severe drug eruptions, severe blistering disorders (e.g. immunobullous diseases), Stevens-Johnson syndrome and pyoderma gangrenosum, amongst others. Consultants, together with F2/CMT doctors or Specialist Registrars, provide medical cover where dedicated Dermatology beds are available. Where Dermatology patients are admitted to general wards, the Dermatology team will provide strategic advice, regular review of care and discharge of the patient. This must be reflected in job plans so that patients on wards continue to receive dedicated dermatological care. In addition there should be:

- A daily review by trained Dermatology CNS to oversee all topical therapies.
- 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.

## **Inpatient Facilities**

In a dermatological inpatient unit there should be:

- Dedicated Dermatology beds for adults and children, adhering to the delivering same sex accommodation agenda (DSSA).<sup>20</sup>
- Geographical proximity of inpatient and outpatient units for maximum efficiency.
- 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.
- Sufficient office accommodation and computer access for doctors, nurses, secretaries and support staff.

## **Specialised Care Services (Tertiary Care)**

The Specialised Services National Definitions (SSND)<sup>21</sup> set identified the type of activity that should be regarded as 'Specialised Services' and the settings where these are carried out (larger Teaching Hospital and University Hospitals). NHS England has since developed Specialised Service Specifications for Dermatology tertiary services.

## **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 (PDT).
- 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 (MCN).
- Iontophoresis.
- Electrolysis.
- Laser or pulsed light treatment clinics.

### **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. Appropriately trained nurses may also undertake skin cancer follow ups, biologic patient monitoring and isotretinoin monitoring.

### **Day Case Lists**

The nature of these clinics and specialist procedures provided will include Mohs surgery, laser lists and cytotoxic treatments. A laser-safe area and general anaesthesia facilities for adults and children will be required.

### **Combined Clinics (MDT)**

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 children with difficult dermatoses).
- Plastic Surgery, Radiotherapy, Dermatology (for skin cancers).
- Multidisciplinary Team meetings are required to discuss all patients needing multidisciplinary input into their care or an action plan for their discharge. MDT meetings for skin cancer services are also a mandatory requirement of the Cancer Network and Peer Review.
- 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 such as monochromated light testing, photopatch testing (PPT) or photoprovocation testing in Tertiary Centres.

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 and Academic Units will also need dedicated inpatient Dermatology units to manage the tertiary referral of patients with complex diseases, and 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 comorbidity. 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 number of beds should be based on demographic need.

## **3. Support Services**

### **Estates and Facilities Support Services**

Service providers are expected to ensure that the standards of all facilities meet health and safety requirements and COSHH<sup>22</sup> regulations, by undertaking regular risk assessments. Estates and Facilities staff can also provide advice on clinical support spaces.

### **Medical Support Services**

Dermatology requires the same support services as other medical specialties, for example, Chemical Pathology, Haematology, Microbiology including Mycology and Radiology with extra requirement for services in Immunology, Immunopathology and Histopathology. Arrangements should be in place to provide these services in regular clinics.

Dermatology patients need access to other hospital specialists, including Histopathologists with a specific expertise in Dermatopathology, Plastic Surgeons, Clinical Oncologists, Rheumatologists, Immunologists, Paediatricians and Psychiatrists.

### **Medical Photography Services**

Access to a Medical Photography and Illustration Service is essential in the practice of secondary care Dermatology as potential child abuse, pressure ulcers, pigmented lesions and other cases need to be photographed as a part of the medical record.

Each Trust should have a 'Visual and Audio Recordings of its Patients' Policy document which incorporates the GMC's ethical guidance for making and using visual and audio recordings of patients.<sup>23</sup>

### **Pharmacy Services**

Pharmacy departments offer a range of Pharmacy services including:

- Checking drugs prescribed to ensure correct dosage, that they are suitable for the patient's condition or illness and that prescribed medicines do not adversely affect each other.
- Purchasing all medicines for use within the Trust.
- Medicines supply for all wards, departments and clinics.
- Inpatient dispensing, including discharge medication.
- Outpatient dispensing.
- Aseptic pharmaceutical dispensing.
- Dispensing medicines as part of clinical trials.

Some Trusts will also have specialist Pharmacists for admissions and discharge, and specific disease areas such as Dermatology.

Access to a Pharmacy for the preparation of topical medicaments and allergens for contact allergy testing is now limited to a number of centres. In 2008, the BAD reviewed the national use of dermatological 'Specials' and subsequently produced a rationalised formulary to improve access to and appropriate prescribing of Specials.<sup>24</sup>

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## DH Health Building Notes

Health building notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities.

They provide information to support the briefing and design processes for individual projects in the NHS building programme.

### Publications of interest to Dermatology departments

1. Guidance for infection control in the built environment  
<https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment>
2. Guidance for facilities for providing primary and community care services  
<https://www.gov.uk/government/publications/guidance-for-facilities-for-providing-primary-and-community-care-services>
3. Guidance on flooring, walls and ceilings and sanitary assemblies in healthcare facilities  
<https://www.gov.uk/government/publications/guidance-on-flooring-walls-and-ceilings-and-sanitary-assemblies-in-healthcare-facilities>
4. Design and layout of generic clinical and clinical support spaces  
<https://www.gov.uk/government/publications/design-and-layout-of-generic-clinical-and-clinical-support-spaces>
5. Guidance on the design and layout of sanitary spaces  
<https://www.gov.uk/government/publications/guidance-on-the-design-and-layout-of-sanitary-spaces>
6. General design principles for health and community care buildings  
<https://www.gov.uk/government/publications/general-design-principles-for-health-and-community-care-buildings>
7. Planning and designing of in-patient facilities for adults  
<https://www.gov.uk/government/publications/adult-in-patient-facilities>
8. Design of circulation and communication spaces in healthcare buildings  
<https://www.gov.uk/government/publications/guidance-on-the-design-of-circulation-and-communication-spaces-in-healthcare-buildings>
9. Day surgery facilities buildings guidance <https://www.gov.uk/government/publications/day-surgery-facilities-buildings-guidance>
10. Resilience planning for NHS facilities  
<https://www.gov.uk/government/publications/resilience-planning-for-nhs-facilities>

11. Hospital accommodation for Children and young people

<https://www.gov.uk/government/publications/hospital-accommodation-for-children-and-young-people>

12. Guidance on the design of an out-patients department

<https://www.gov.uk/government/publications/guidance-on-the-design-of-an-out-patients-department>