A SURVEY OF DERMATOLOGY SERVICES IN THE UK

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In 2017, the BDNG commissioned a survey to take a snapshot of dermatological services in the UK and Ireland. Here, we present the results and look at the implications for the British Dermatological Nursing Group.

In early 2017, the British Dermatological Nursing Group commissioned a survey to gain a snapshot view of dermatological services across the 5 countries that make up the Great Britain and Ireland. The survey was conducted against a backdrop of growing concern about access to dermatological services and the manpower available to deliver them.

With this in mind, the survey was designed to gain an understanding of:

a. What services looked like, and in particular, how these were meeting the demands of two week waits
b. The staff that provided the dermatology service, both medical and nursing
c. What roles the nursing staff undertook, at what grade and with what level of academic achievement
d. The availability of educational opportunities for nurses
e. The relationship of the nurses with the BDNG
f. How involved in research and audit the nursing staff were.

The survey was not specifically sent to BDNG members, but was instead sent by post and addressed to the lead for Dermatology services. Additionally, publicity was given to the survey through BDNG communication channels in order to increase the response rate. Respondents were given the option to respond on paper or via an online version of the survey on Survey Monkey.

Method

The survey was developed by the BDNG executive, reflecting the concerns highlighted above. A lot of work was put into identifying the dermatology departments in the 5 countries so that questionnaires could be sent to accurate addresses. In total, 346 questionnaires were sent to the lead for dermatology services. Stamped addressed envelopes were made available for returning the questionnaire or, as stated above, respondents could fill in the questionnaire online. Data was then put into a simple spreadsheet and frequencies of the various responses calculated. No statistical significance between the various data was sought.

Results

Fifty-three surveys were completed, representing 15% of those sent out. The map shows the distribution of the responses and whether they came from acute trusts, primary care or private providers. The results from the private providers has not been included in this write up.


In acute trusts, referrals were overwhelming triaged by medical staff at 79%. This figure fell to 40% in community services, where 60% of the services that had triage were carried out by nurses. Across the board, 14% of services reported that no triage was carried out by any member of the team. When it came to accessing services following on from the initial triage, 27 of the acute services offered a one stop service i.e. seen and treated on the same day – usually with a surgical procedure and 16

Two week wait work was only provided by acute trusts - 38 of which stated that it was part of their remit. Of these 34 trusts (89%) said they were meeting their 2 week waits – but 11% said that they were not meeting these targets. These were all English acute trusts. When considering the referral to treatment targets the figures showed that there is a struggle here to meet targets with only 56% of the acute trusts making their targets.
offered open access, i.e. open access for those with chronic conditions returning (usually within a specific time frame) without the need for a further referral.

Not all the respondents reported data on medical staffing, however it was clear that the provision of consultant services is not meeting the British Association of Dermatologists standard in the majority of acute trusts. For example, in England, of the 24 acute trusts that provided data, only 17% met the recommended standard of 1 consultant per 62,500 head of population. Scotland fared a little better, with 4 of the 6 trusts that reported data meeting the BAD standard. However, in Wales, Northern Ireland and Eire, none of the trusts that provided data met the BAD standard. Overall, only 29% of the trusts met the BAD standards for consultant numbers.

Further questions were then asked about other medical members of the team. It was found that most hospitals had other levels of doctors working with them. There didn’t appear to be any consistency on what type of doctor should be appointed and perhaps decisions were made more by who was available to fill roles. A total of 36% of acute trust employed specialty doctors and 29% associate specialists, while 58% of trusts employed GPWSSs.

The study set out to examine the type of caring roles that nurses undertake, but management responsibilities were not investigated in any depth. There are a huge number of different areas that dermatology nurses work in (see Box 1). Services were asked who undertook the initial patient consultation, and in 53% of cases nurses were reported to be undertaking the initial consultation. The questionnaire did not allow for us to identify in which type of clinics nurses were undertaking the initial consultation, but it is probably fair to assume that on many occasions this would be chronic disease management clinics. In community nurses were undertaking the initial consultation in 100% of the services.

When it came to linking a particular band to a specific role, it was difficult to be clear cut. Nurses of the same banding were expected to take on different roles depending on where they worked. As a general statement, those working in surgery and skin cancer were usually of a higher grade, as were those working in community services. Some generalisations that can be made are as follows:

- The single most common role undertaken by band 5s was phototherapy with 73% of acute trusts employing nurses of this grade to undertake this role. Otherwise it appeared that band 5s carried out most roles except for vulval clinics, domiciliary

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**Box 1. Areas dermatology nurses work in**

- Phototherapy
- Photo-dynamic therapy
- Patient education clinics
- Patch testing
- Skin surgery
- Iontophoresis
- Cryosurgery
- Laser
- Systemic monitoring for:
  - Methotrexate
  - Ciclosporin
  - Acitretin
  - Biologics
  - Isotretinoin
  - Other
- Leg ulcers
- Lymphoedema
- Cellulitis
- Tissue viability advice
- Skin cancer
- Paediatrics
- Eczema management clinics
- Vulval
- Skin camouflage
- Domiciliary visits
- Advice to other departments/services
- Telephone help-line
visits and cancer support. Their titles did not usually include the word specialist.

There was little consistency with the titles given to band 6s, however there was generally some reference to being a specialist nurse. Although their roles were extremely diverse, they were seen to be working more independently and with a greater focus on nurse-led services. Seventy per cent of the acute trusts employed band 6s in patch testing, and a small but significant number (20%) used band 6s in support services for patients with skin cancer.

Band 7s were employed in more independent roles. The majority of hospitals used band 7 nurses to carry out drug monitoring or chronic disease management clinics e.g. biologics or eczema management. They are clearly sources of information and support, reflected in the fact that 71% of acute trusts reported using this grade to provide information to other departments and 64% to carry out cancer support work.

Very few trusts employed band 8 nurses – 10 employing 8A and 1 employing an 8B. Their clinical roles were very similar to the Band 7 nurses – although other roles that they may have undertaken, for example management or education, were not reflected through the numbers in community were much smaller; they reflected a more independent workforce who were qualified to prescribe to a greater extent. Over time it will be interesting to see how this education profile changes.

The opportunities available for learning were measured by asking questions about protected learning time and funding. Around 40% of both acute and community trust staff were allowed protected learning time with study leave sometimes being granted 68% of the time in acute trusts and only 60% in community trusts. Asking about whether funding is provided for study activities provides us with a baseline for monitoring whether funding becomes more or less accessible. Currently, relatively few people are never provided with funding, and likewise, virtually no-one can guarantee that they will be funded. So the majority of nurses sometimes get funding and we can continue to monitor whether this position changes (see Graphs 2 and 3).

Audits have become a usual part of nursing services with 91% of acute trusts and 80% of community trusts saying that they carry out audits. Fifty-five percent of acute trusts said that nurses took part in medical research, while only 25% carry out their own nursing research. In community, 20% took part in medical research and there were no reports of nursing research.

Finally, the BDNG wanted to find out about numbers of nurses within departments that were members of the organisation. There was a huge range across acute trusts with membership of the BDNG ranging from 20%-100%, although 14 of the acute trusts had less than 50% membership. In the community, 100% of staff were members. When asked about the use of BDNG Quality Standards, 35% of those in acute trusts said they were using them and 40% in community trusts.

Discussion
As mentioned previously, this work has given a snapshot of dermatology nursing services across the country. For the first time, the BDNG has tried to capture what is happening in dermatology services in general, rather than just with
A general trend was noted that the more senior the band the more independently the nurse worked. However, it was clear that some band 5 staff were being expected to take on nurse-led clinics and how independently they were working was impossible to tell from the data collected. This may be an area that future work could focus on.

It would appear that nurses working in community settings tend to have greater autonomy, have a higher level of education and are most likely to be members of the BDNG.

It was very gratifying to see that so many staff were involved with audit, which is now an integral part of providing dermatological services. However, relatively few staff are involved in research, either supporting medical research or undertaking their own nursing research. We cannot tell from the data why this is and future work may need to focus specifically on this area.

The outcomes of this survey work fall into two broad areas; those issues that the BDNG as an organisation can have little control over, e.g. staffing, and those that the BDNG can have a direct influence on. While the BDNG will continue to influence policy in dermatology whenever it can, the issues that can be most successfully affected are those directly relating to how the organisation relates to its membership. Specifically:

Although numbers were small, it would appear that nurses working in community settings tend to have greater autonomy, have a higher level of education and are most likely to be members of the BDNG. They are more than three times as likely to have a prescribing qualification as a nurse in the acute trusts. These factors are unsurprising in that the services provided in hospitals are much more varied and on many occasions may be carried out by staff who not only work in dermatology but also carry out duties in general out patients. It was notable that the level of consultant dermatologist provision is not adequate in many parts of the country, and that one response has been to employ other types of medical staff. It remains a recurring theme that there is a shortage of dermatology staff to provide the necessary care. Although nurses are taking on more and more independent roles these will not always expand the capacity of a service to see more patients, but rather improve the quality of the care that patients receive.

BDNG members. The response rate was low, and although this is not unusual for this type of survey, it was disappointing that more responses were not received. The survey was sent to the lead for dermatology services who may, in some cases, have not been intimately familiar with the data required for this survey. This was reflected in the fact that, for some of the sections, data was frequently missing. For example, when whole time equivalent figures were required, these were not always provided. Thus, the interpretation of the results should take these factors into account.
a. **BDNG membership.** There were some workplaces where a very low percentage of staff were members. We need to continue to push the benefits of being a member (see box) and ask current members to encourage others in their departments to join. It is easy to assume that our colleagues are members, but if they are not receiving the Journal their membership has lapsed. Please can we ask current members to check membership status with work colleagues and remind them of the benefits of belonging to the BDNG [Box 2].

b. **BDNG Quality Standards.** A lot of work went into developing the BDNG standards, and yet relatively few people are using them. It would be useful for the BDNG to look at ways of making these more accessible and encouraging their use. With this in mind, can we ask that if you have used the standards in your department that you write and tell us about how you used them and the consequent benefits. It would be wonderful to have some short articles for the Journal outlining how they have been used, the benefits and any thoughts for future development.

c. **Research activity.** The BDNG has always supported and encouraged research activity through, for example, opportunities to present at conference. This will be continued, and we will look for ways to develop the capacity for dermatology nurses to undertake their own research.

**Conclusions**
The survey has provided a point in time picture of dermatology services in the five countries that make up Great Britain and Ireland. The response rate was low meaning that this is in no way a complete picture. However, the results do highlight issues around manpower and indicate to us the variety of roles that nurses are now undertaking. It has also provided a baseline of information against which services can be monitored in the future, along with some specific issues that the BDNG can tackle as an organisation in order to improve what it offers to its members.

Future surveys may be used to look more closely at the roles that people are undertaking and in particular examine more closely the roles that health care assistants are being asked to undertake. **DN**

**References**
1. British Association of Dermatologists Clinical Services Unit 2014 Staffing and facilities guidance for dermatology services

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**NEWS FROM THE SUB-GROUPS**

**Psychodermatology**  
**By Karen Stephen**

We held a successful sub-group educational meeting on April 25th in Birmingham. Topics included An Introduction to Psychosocial Assessment, Motivational Interviewing, Habit Reversal and an interactive overview of psychosocial interventions for nurses at level 2.

There was also a very interesting presentation on skin camouflage delivered by Liz Allen, our patient representative on the sub-group. We were delighted to see attendees from around England who enthusiastically participated in the day with an excellent exchange of ideas and experiences.

The sub-group has been involved in making short videos of patients living with chronic skin disease which will be presented at conference and we look forward to seeing everyone there. **DN**