BRITISH ASSOCIATION OF DERMATOLOGISTS
HEALTHY SKIN FOR ALL

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Dermatology Inpatient Consultation Report 2022

Produced by the BAD's Transformation and Quality Improvement Unit
A report detailing the results of the Dermatology Inpatient Consultation that took place in September 2022 that focused on standards of Inpatient care in Dermatology

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Summary

In late 2021, the BAD sent out a survey to all UK hospital trusts to ascertain the arrangements for their dermatology inpatients service. This identified a significant variation in patient access to a dermatology consultant after hours across the UK. A significant number of tertiary centres including specialised centres do not have 24/7 access to a dermatology consultant. Many tertiary centres are providing advice on an informal basis regionally without the necessary contracts between tertiary centres and district general hospitals being in place to ensure equity of access to specialised care for patients.

Given the variation in access to patient care identified, the BAD undertook an inpatient out of hours consultation during September 2022. The consultation included proposed inpatient standards and models of care to improve access and quality of care for patients presenting with acute and emergency skin conditions.

Our inpatient consultation resulted in responses from 62 dermatology departments contacted across the UK, (8 Midlands, 5 London, 2 North East, 2 North West, 4 South East, 6 South West, 8 Wales, 1 Northern Ireland, and 26 unknown). We will continue to pursue outstanding responses from the regional areas in the lead up to our planned regional specialised network discussions

Under Section 1, the Standards of Care, there was widespread support for the proposed standards. Those that disagreed largely cited core issues affecting their regional area such as a lack of staffing.

For Section 3, Models of Care, there was a wider range of support, with many responders not indicating a strong preference to a particular model. The most popular Model of Care was scenario 3, the Centres of Excellence proposal (strongly supported by 22 of the responders).

Many responders indicated the importance of patients being seen quickly when presenting with acute skin conditions, and that their treatment is managed correctly and efficiently by the right person the first time.

Unfortunately, a lack of dermatology trainees and sufficient numbers of full-time equivalent consultants has put a strain on dermatology services around the UK, not just around acute service provision. A full summary of the responses received to the consultation are set out below under the headings contained in the survey:

Section 1. Proposed Standards of Care for Patients with acute dermatological conditions.

Dermatology departments were asked was whether they believed that there should be standards of care for patients presenting with acute dermatological conditions.

Response:

Overall, 53 of the 61 responders (85%) agreed that there should be standards in place. Of the 7 who provided comments, most said that regional arrangements need to be taken into consideration. One department from North Wales said that 24-hour dermatology care is not necessary for their region.

Standard 1

"A clearly contracted pathway for access to care should be available to all patients of any age with an acute dermatological problem on a 24/7 basis. All providers of emergency and acute services for adults and children and local GPs will be made aware of the contracted dermatology pathways of care and how to access them."

Response:

Departments mostly agreed with this standard, although there were a few comments and suggestions. Of the 62 responders, 53 supported this standard, of which 12 suggested changes. The majority of the responders who disagreed with the first statement in particular came from Wales and the South of England, where there would be difficulties in arranging 24/7 dermatology care due to the lack of staffing and provisions. Some trusts do not see many acute patients for dermatology, or these patients are often seen in general medical wards/ emergency wards.

Standard 2

"This acute pathway of care needs to be staffed by appropriately trained dermatologists with access to in-patient beds and ITU/Burns services as required. This will require the provision of a formalised on-call rota with adequate time in the job plan to provide the necessary care."

Response:

Most responders agreed with this standard, with 54 of the 62 departments agreeing with this statement, and 7 suggesting additional changes. The departments who provided comments indicated that on-call rotas may not be popular with many consultants. Additionally, many said that most acute beds are on general medical wards, which is out of direct control or supervision of dermatologists, unless they are called for advice. One department from Wales was concerned that this standard would lead to more workforce problems around overworking staff

Standard 3

"The agreed contracted model of care will make appropriate use of teledermatology and multi-disciplinary teams and will direct to adequately commissioned face to face care as needed."

Response:

This standard was also strongly supported by the departments who answered the survey, with 56 of the 62 responders agreeing with it. Four responders agreed with the statement, but suggested changes, highlighting the need to address the staffing issues (with Standard 2) first. One responder from London noted that Teledermatology should not replace timely face-to-face appointments.

Standard 4

"For specialised dermatology diseases which may present acutely and require urgent care there should be clear regional protocols and pathways in place for both adults & children e.g. SJS/TEN, Pemphigus requiring Rituximab, neonates with severe skin disease such as EB and ichthyosis. "

Response:

This proposed standard was largely popular with 55 of the 62 responders supporting this. One responder noted that pathways for SJS/TEN are already in place. Another emphasised the importance of having regional protocols to ensure that patients are treated as close to home as is possible.

Section 2. Case examples of harm due to inadequate access to acute dermatology care

In order to evidence the need for clear pathways for access to care for patients with acute skin conditions we requested examples of harm that have occurred when there has been inadequate inpatient cover. We included 3 case examples as part of the consultation to assist dermatology departments, including a coroner's case.

Patient Case 1- Anonymised	Year of incident:	2018	Case Summary: 40 year old lady with TEN with poorly controlled diabetes transferred to (local) Burns unit within 48 hours at weekend. Initially diagnosed with SJS and complained that transfer was delayed by 24 hours and patient stated they were not told seriousness of the condition. This was in spite of Dermatology seeing her at weekend and explaining diagnosis in detail. She survived but complained afterwards about general ward care and delays.
	Patient skin diagnosis: /Primary diagnosis/ Secondary diagnosis	TEN with diabetes	
	Incident risk:	Low/ Moderate/ High	
	After hours service provided by:	Dermatology on-call 24/7	
	Age of patient	40	
	Main specialty responsible for patient care	Dermatology	
	Where patient was situated	Burns unit	
Case 2	Year:	2022	Case Summary: TEN in an elderly 90 year old lady previously diagnosed with subacute lupus. SCLE was clear at last outpatient review. She presented acutely with likely systemic infection. Was stable for 1 week and then blistering progressed rapidly after antibiotics. Dermatology on-call re-referral after 1 week was not received for 48 hours from ward and once reviewed by Dermatology trainee was transferred within 3 hours to (local) burns unit. Complaint from relative as patient died and was regarding general ward care and lack of communication from ward regarding seriousness of the condition.
	Patient diagnosis:	TEN with subacute Lupus	
	Incident risk:	Low/ Moderate/ High	
	After hours service provided by:	Dermatology on-call 24/7	
	Age of patient	90	
	Main specialty responsible for patient care	Dermatology	
	Where patient was situated	Burns Unit	
Local/ Regional overview of acute dermatology care on wards			Nursing care and general ward care usually falls short in most medical dermatology emergencies without specialist nursing care and advice.

Case 3 – Coroner's Report	Year:	2020	Case Summary: In 2020, a patient, who had been detained under the Mental Health Act the previous year,
	Patient diagnosis:	TEN with bipolar disorder	

	Incident risk:	Low/ Moderate/ High	died as a result of multi-organ failure, Emphysema, Pneumonia and DRESS syndrome. These conditions developed as a result of medication the patient was taking for bipolar disorder. Despite the best efforts of the healthcare professionals involved, the patient suffered malnutrition due to the lack of improvement in the conditions. The patient was left to self-administer emollients to treat DRESS syndrome, which was inadequate, and the patient was not attended to sufficiently for a dermatological review on the care received. The patient died of DRESS syndrome.
	Service provided by:	On-call 24/7	

To date we have received only one response from South West England.

This case concerned a patient with psoriasis (previously known by the Dermatology department) whose condition deteriorated quickly and was seen in general medicine. The patient unfortunately passed away, and the report found that while the outcome would not have changed, the patient should have been reviewed earlier so that they would have been more comfortable. Please see the table below:

Case 4	Year of incident:	2019	Case Summary: Patient was admitted under medicine and seen on Friday afternoon by Dermatology (known patient of Dermatology). Condition did not respond to expected treatment and worsened over weekend without IV access/ review by Medical team. Identified deterioration late on Sunday with hypotension and potential requirement for ITU support. Background co-morbidities made this inappropriate. Datix and Incident panel concluded did not change outcome for patient but that earlier review may have identified deterioration and escalation planned - ultimately meaning final weekend of life would have been more comfortable. Incident panel recommended on-call Dermatology which is being attempted to be put in place with merger of hospital Trusts
	Patient skin diagnosis: /Primary diagnosis/ Secondary diagnosis	Acute psoriasis/ erythroderma	
	Incident risk:		
	After hours service provided by:	N/A	
	Age of patient	70s	
	Main specialty responsible for patient care	Medicine	
	Where patient was situated	Medical ward	

Section 3. Proposed options for commissioning Out of Hours Inpatient Services:

The third part of the survey asked dermatology departments to indicate the level of support they would give to three scenarios. Departments used a scale to indicate how strongly they supported the scenarios below, from 0 (no support), to 100 (strongly support).

Response:

The answers varied greatly, with the overall average being as follows:

Model of Care	Support	Indifferent	Do not support	Did not answer
Scenario 1- Do Nothing	19	13	20	10
Scenario 2- Advice and Guidance	17	19	16	10
Scenario 3- Centres of Excellence	22	17	13	10

The most popular scenario was the Centres of Excellence approach, which achieved a higher average score as well as a higher number of green scores (22 of the 62 responders gave a supporting response).

However, 19 of the 62 responders indicated that they were strongly in support of no changes to the current model of OOH care for dermatology patients. This was largely down to the lack of staffing and contractual arrangements to provide on-call advice out of hours.

Regional barriers to providing inpatient cover

Many responders to the OOH survey outlined the local/ regional barriers to implementing their desired scenarios. One responder from Northern Ireland noted that due to the lack of specialists in the country, patients would have to travel to mainland UK in order to receive treatment.

In the East Midlands, issues included a lack of in-person dermatology care and a lack of substantive consultants able to undertake inpatient care. In the West Midlands there are similar issues, in addition to a lack of trainees,

In London, a lack of trainees, funding and personnel to cover an inpatient service were noted as barriers. Some of the responders indicated that they worked at a hospital where a substantial inpatient dermatology service is run. However, the lack of proper SLAs in place with smaller trusts for out of hours advice has led to workforce demand and capacity problems.

The issue of pay and time off in lieu was noted by one dermatology department from the North East. Another issue described by a responder from the North West was the issue of travel to centres of excellence for patients who are acutely unwell.

In the South East of England, issues around the centres of excellence model included a lack of support available for consultants, a lack of suitably trained nurses and high pressure on regional centres. In the South West of England, barriers to implementing the A&G and/ or Centres of Excellence model included a lack of funding, in addition to the different systems that regional centres use. Consultants may also approach some conditions differently to another consultant, which may be an issue.

There are similar barriers in Scotland around workforce issues (particularly with regards to trainees). One responder noted: " I would like to see a formalised standard operating procedure for dealing with advice calls from neighbouring health boards. I work in a large regional centre where we have 24/7 consultant on

call but neighbouring health boards have no on call cover so patients with severe skin disease do not have timely access to specialist opinion. I think a centralised advice and guidance approach would work here but would need to be properly renumerated and job planned."

In Wales, there is a wide spectrum of inpatient care for dermatology patients available, with Cardiff having a dedicated service, but health boards further north having little or no service in place. One department from Wales said the following:

"It is imperative that you consider consequences for remote non-teaching hospitals such as consultant retention, trainee retention and the implication of no dermatologists in rural areas before introducing any changes

The Welsh NHS is also very different from England. We do not make money as a department and would not want money diverted away from our department when it is to the detriment of the majority of the local population."

Next Steps

It is essential for any patient presenting with an acute or emergency skin conditions (see Appendix 2) to have access to a dermatologist 24/7 and they receive immediate care.. This ensures patients are treated quickly and have a clear follow-up plan put in place. Those who require more specialised inpatient care should be treated at the most appropriate place, possibly transferring to a larger neighbouring tertiary hospital, if needed.

Highly Specialised and specialised services contracted by NHSE in regional areas should all be providing 24/7 inpatient dermatology services. This agreement needs to be contractually put in place in a number of regional areas which are not providing any after- hours inpatient cover. Additional SLAs agreements for seeking advice after hours from a regional tertiary centre must also be agreed between local hospitals.

A separate piece of work has also been undertaken by the BAD to identify the specialised skillset of all consultants within each regional area of the UK. This will help to inform much needed discussions with NHSE on the formation of dermatology clinical networks and Multidisciplinary Teams (MDTs) to allow care to be better organised across regional areas with hospital hubs working to their strengths.

This should be a priority for the newly formed Dermatology WPG (previously CRG) to take this forward with immediate effect.