



British Association of Dermatologists: White Paper Key Responses March 2011

1. Dermatologists and patients must influence commissioning

- The commissioning process must include secondary care specialists. Consultants are the greatest expert resource in the NHS and processes excluding them will inevitably be flawed.
- Choice is meaningless unless it is 'informed' and based on full information about providers.
- The patient voice should be heard when dealing with commissioning, service monitoring and complaints. Patients with rare diseases (often affecting only a few people in any locality) should be clearly heard.
- A BAD led multi-stakeholder project has produced evidenced based outcome measures suitable for use by NICE (for inclusion in the 150 quality standards/outcome measures) and by those commissioning dermatology services.

2. A minimum standard of dermatology service should be set across the UK

- Monitor should mandate a quality framework for skin disease care covering skin cancer surgery (the commonest cancer in the UK), paediatric dermatology, allergy and occupational dermatology (a major cause of disability in the workplace), photodermatology, genital dermatology and other specialist services.
- The BAD led department of health, multi-stakeholder group will provide evidence-based, quality standards for skin disease healthcare providers both inside and outside the NHS.

3. Education, training, research and NHS management by specialists leads to sustainability

- Education, training, research and NHS management work by clinicians is essential. Providers failing to support all these necessary activities could make financially attractive bids to commissioners at the cost of the long-term quality, safety and sustainability of services.
- There must be central controls to prevent cash-strapped providers cutting medical and nursing education.

4. There must be no conflict of interest in commissioning. There should be national commissioning for rare skin diseases

- GPs and other commissioners must not have any financial interest in the process. Clear rules on conflicts of interest with the sanctions for any transgressions must be codified.
- Dermatology intermediate care is often provided by GPs who own profit-making organizations delivering these services. There will be substantial conflict of interests when GPs commission these services. Earnings will be private and almost impossible to detect and regulate.
- People with rare skin diseases may suffer as GPs may not be familiar with these conditions. To ensure that excellent care is provided, these services should be commissioned nationally.

5. Avoid cherry-picking the cheap and easy and failing to consider rare, chronic & expensive diseases.

- Cherry picking of aspects of service which are easy and cheap to provide will be the focus of potential providers from outside the NHS. This must not disadvantage patients who require services for conditions which are less common, more difficult or more costly to provide.

- Chronic skin diseases which naturally fluctuate or deteriorate despite optimum care may be less amenable to systems which align outcomes with costs. Care must be taken to avoid a system which leads to “gaming”, with providers or commissioners deviously avoiding treating chronic, elderly and disadvantaged patients.