

The White Paper: Our Health, Our Care, Our Say What does it mean for Dermatology and how should we respond?

In the Government White Paper published on 30th January 2006, Dermatology was mentioned in several places, as were more “generic” aspects of future NHS provision that are likely to affect Dermatology and Dermatologists. What will it mean for our specialty?

Summary of key points

The White Paper contains a number of important comments for patients with skin disorders and for those practising in the field of Dermatology:

People are to be more in control of their own health and health care:

- Life checks will be introduced at certain ages.
- People will be more aware of how to keep healthy and how to seek help if necessary.
- Better access to sources of information about a person’s condition will enable them to self-manage their care.

There will be increased support for people with longer-term needs:

- The Expert Patients Programme will be expanded to enable more patients with knowledge and personal experience of certain diseases to educate and support others.
- A ‘Community interest company’ will be established to market and deliver self-management courses.
- By 2008, everyone with a long-term condition should be able to receive information and receive peer and other self-care support.
- By 2010, all patients with a long-term condition will have an integrated care plan.

Access to health care should be easier and fit in with individual needs:

- Access to GPs should be easier – different surgery opening hours, telephone contact, etc.
- Access to specialist care should be quicker and easier.
- There will be more choice as to where the specialist care can be accessed
- Intermediate layer support such as specialist GPs, community hospitals etc. will be available.
- However, the public made clear during the recent consultation process that although they would like care close to home, this must not be provided at the expense of a high quality service.

The expansion of these ‘new’ layers of service should not be at the expense of the care and services necessary for individuals with a high level need:

- Hospitals (the “acute sector”) will excel at the services that only they can provide.
- The tariff will be unbundled, so that more expensive care of a complex condition will be “priced” at a higher level than less complex care for the same condition.

- Sites where alteration in practice has led to improvements in service delivery will disseminate the good practice to others.
- Delivery of care outside the acute hospital will be under the same rules of clinical governance.

What has the BAD done so far?

Consultation on "Your Health, Your Care, Your Say"

Through both direct information and interactions with the Royal College of Physicians, the All Party Parliamentary Group for Skin (APPGS) and the Skin Care Campaign (SCC), the BAD and its members were alerted to this public consultation. We encouraged all members and their patients to participate in the consultation; we sent out an email of the details and date and there was a note in the Autumn Newsletter.

The President and President elect took part in a discussion session co-ordinated by the APPGS, and in September, the Officers of the BAD also met with the Deputy Director of the Department of Health Strategy Unit. Initial documents contained suggestions from the Strategy Unit indicating huge shifts of care (up to 45%) from current (largely acute) settings for Dermatology and several other specialties. The BAD responded on a number of fronts, including the following:

- We pointed out that the majority of diagnosis and management of "simple" skin disease is already undertaken by GPs and others in the community, and that patients are predominantly referred to secondary care specialists where the diagnosis was in doubt or for more sophisticated treatment.
- We noted that many Dermatologists and Dermatology Departments already delivered a great deal of dermatological management "close to home" in community hospitals and other settings.
- We accepted that in some health communities there might still be room for more care to be delivered closer to patients' homes.

BUT.....

- That thought needed to be given to how the additional facilities and manpower required to accommodate additional shifts of work would be provided.
- That there was a limit to the extent to which care closer to home could be developed without adversely affecting the ability of the central service to deliver that which only secondary care can deliver because of the inevitable reduction in the "cover" available in acute units.
- That additional threats came from the funding arrangements under Payment by Results and the flat rate Out Patient Tariffs, which might further undermine the viability of essential secondary services by the "cherry-picking" of less complicated work by peripheral service units.

The BAD Officers then engaged in a series of communications with the Department of Health team preparing the White Paper. We were also fortunate that Dr Julia Schofield, as a member of the Clinical and Social Care Strategy Group (CSSG) was invited to contribute at a later stage in the process. We were able to modify and eventually broadly accept the wording that now appears in the document (See Appendix 1). We proposed additional changes that recognised good practice in

many dermatology departments across the country but these were not included. In particular we were able to ensure that a number of potentially unachievable numerical targets were not included, arguing that they would be unwise and counter-productive,.

What the BAD will be doing from here on

The White paper provides the speciality with the following opportunities:

- The Department of Health is keen to work with the speciality associations to *'define clinically safe pathways that provide the right care in the right setting, with the right equipment, performed by the appropriate skilled person'* (page 131-132). This to ensure a stronger evidence base and better clinical engagement.
- Dermatology is recognised as one of the specialities that can provide care close to home and over the next 12 months the DH will work with our speciality in *'demonstration sites'* to define appropriate models of care.
- There is a commitment to *'unbundling the tariffs'* to take account of varying complexity of casemix.

We propose to engage as fully as possible in these areas and will continue to make ourselves available for consultation and discussion. We have already been in contact with the Director of the NHS Institute for Innovation and Improvement who will be responsible for developing some "demonstration sites". I am pleased to say that he (Professor Bernard Crump) is keen to engage with us, and we will be in close contact.

We are currently clarifying with the Royal College of Physicians (who are faced with similar issues in other specialties too) how they would wish us to take this forward with them.

We have already given evidence to the latest APPGS Report, which will be published in the next few weeks and will provide a barometer of current opinion regarding the standards of dermatological care to be expected in the UK in the 21st Century. The BAD has also had significant input into the drafting of a Model for Dermatological Services, produced under the auspices of the Department of Health. This, too, should appear soon. Usefully it emphasises again and again the need for strong, secure secondary Dermatology services, while encouraging a focus on community provision *where appropriate*.

We have also, with the RCP and the NHS Alliance, recently bid to the DH for funding to develop better models for working together across the primary/secondary care interface. On the linked, and very important, topic of GPwSIs, the BAD has been working with the Royal Colleges of Physicians and GPs, the Department of Health, the Primary Care Dermatology Society and the Skin Care Campaign with the aim of firming up accreditation and standards for this key intermediate group of practitioners.

Finally, we aim to improve the BAD membership's ability to share good practice area on Members' area of BAD Website, and to air the experience of difficulties encountered too. With members' help, we will continue to gather data about effective

and less useful models of community care: Dermatology in community hospitals, GPwSIs and PwSIs, GPs, Dermatology nurse specialists; who already does what, what could be done by someone else, and what is best done by one type of service? We need to collect as many robust examples as possible of good and bad service models in order to inform the evidence base whilst we are engaged with the DH over the next 12 months.

Any member who wishes to make his or her views known to the officers should feel free to do so. E mails are, of course, a quick and effective way of communicating, but if you wish to talk directly, please ring BAD House and we will arrange to get someone to contact you.

WATCH THIS SPACE!!

Robin Graham-Brown BSc MBBS FRCP FRCPCH

President
British Association of Dermatologists

February 2006

Appendix 1: White Paper, dermatology specific comments (P 134)

Specialty	Model of Care
Dermatology	<ul style="list-style-type: none"><li data-bbox="400 409 1310 584">• Wherever possible, patients with long term skin conditions such as psoriasis and eczema should be managed by appropriately trained specialists in convenient community settings and should be able to re-access specialist services as and when needed.<li data-bbox="400 607 1310 748">• Many specialist dermatology units already provide up to 30% of their services in community settings, usually in well-equipped community hospitals. This type of service should be encouraged wherever possible.<li data-bbox="400 770 1310 943">• PwSIs and specialist dermatology nurses can have an important role in providing care close to home for patients with skin disease. Health communities should develop these services where they are not already in place.