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Introduction

1 What is your name?

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2 What is your email address?

Email:
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3 What is your organisation?

Organisation:
British Association of Dermatologists

4 Do you agree with our aims for the mandate to NHS England?

Q1:
We welcome the new mandate intentions for 2016-17. However, an update on the many objectives set for 2015 -16, where relevant, should be included to ensure continuity of strategy and appropriate triangulation of continued priorities.

We support the Government's continued commitment to consult widely on the mandate for NHS England.

We expect NHS England to ensure Clinical Commissioning Groups (CCGs) play their part in delivering the mandate. The mandate is not just a means of accountability between the Department and NHS England, but it should also mean wider accountability of those CCG commissioners who fail to commission in a transparent, honest, safe and cost effective way.

Transforming out-of-hospital care should ensure that dermatology services outside hospital settings are commissioned within NICE and recognised clinical guidance standards. Integration must ensure clinically appropriate, good quality and safe services and care pathways are in place for patients.

We believe that lessons have not yet been learned from the Mid-Staffordshire public inquiry as evidenced by increased numbers of Trusts in special measures. Our experience from service reviews undertaken in some of these Trusts, is that improvement in minimum standards to provide safe care will not happen through the mandate alone. Central Government must give the NHS room to allow cultural and behavioural change to develop ideas for best practice rather than encouraging staff to look to the centre for direction.

Setting the budget, and therefore CCG allocations, for three or more years is short sighted without a significant review of health services and care provided by NHS Trusts. Calculations of funding based on current projections of services is flawed, as Trusts are largely absorbing the costs of care on volume contracts. The needs of the public for services outstrip the cost of care paid for by CCGs, requiring a new dialogue with the public over what the NHS can provide. This becomes further evident when moving care closer to home when the costs of dermatology care and activity rise substantially.

Demand for NHS services is rising faster than the funding available. The forward view suggests that savings of at least £22bn will need to be made by 2020/21 if the quality of services is not to fall. It is not enough to ask NHS staff and organisations to identify and implement these savings without support.

Future transformation and, in particular, establishing new models of care should be reviewed and evaluated. For example, some commissioners will need to put in place different contracting models, while providers will develop new groupings and new service models. Funding will therefore need to support commissioners as well as providers, while investment in local areas attempting transformation will need to be provided in a joined-up way.

Funding to invest in the NHS workforce is the key component of our calculations for maintaining and improving access to access to care for patients. Proper investment in staff time and so demonstrating to staff that they are valued is consistently shown to be the most crucial aspect in ensuring success. This means both engaging staff in the process and releasing them from their day-to-day roles (1).

(1) Making change possible: a Transformation Fund for the NHS Making change possible: a Transformation Fund for the NHS The Health Foundation and The King’s Fund - Research Report July 2015

5 Is there anything else we should be considering in producing the mandate to NHE England?

Q2:
In the current financial climate we believe it is important for the Mandate to send a clear message that reducing or rationing access to high quality dermatology care – locally, regionally or nationally – is unacceptable. There are varied perceptions among Clinical Commissioning Groups (CCGs) of what treatments are regarded as clinically necessary and this must be addressed by NHS England.

There is evidence that good quality clinical research taking place in units produces substantial improvements in outcomes such as mortality. Research must therefore be central to the clinical agenda for the NHS. The NIHR should be engaged and integrated with clinical services. Research should not be seen as a "tag

on" if we wish to drive forwards and improve outcomes for patients. The UK is a world leader in this area and we should develop this for the benefit of patients, the NHS and the UK economy.

Evidence from various studies shows many opportunities to deliver better outcomes and lower costs in other areas of care through changes in clinical practice. This is because the NHS, like all other health systems across the world, sometimes fails to deliver high-quality care, leading to poor outcomes for patients and wasted resources for the NHS.
These opportunities can be illustrated in a number of different ways:
– There are wide variations in how care is delivered between different areas of England.
– There are examples of overuse (when unnecessary care is delivered), underuse (when effective care is not delivered) and misuse (when care is poorly delivered leading to preventable complications and harm) of care across the NHS, which, if tackled, could deliver better value and release resources.
– Improving care for people with long-term dermatology conditions, those who are frail and have complex needs, and those who are receiving care at the end of life, offers multiple opportunities to achieve better outcomes, patient experience, and care co-ordination – sometimes for a reduced cost.
– Clinical teams in some parts of the NHS are already improving care for patients and releasing resources, showing that these opportunities are not simply hypothetical.

Commissioning policies for dermatology specialised services are confused. Improvements have been made to the way that clinical reference groups operate and service specification guidance is welcome, however confusion remains over the commissioning and budget arrangements for these services.

We would welcome NHS England's willingness to challenge on poor commissioning decisions and providers who are failing to engage with specialist associations for advice. This is an area where some commissioners or trusts have been historically weak or refuse to heed clinical and service advice when concerns are raised by the BAD. In these situations it is common for organisations to come back to ask for help, only when services have collapsed or patient care has been compromised. It would be much better to prevent problems rather than manage crises.

6 What views do you have on our overarching objective of improving outcomes and reducing health inequalities, including by using new measures of comparative quality for local CCG populations to complement the national outcomes fin the NHS Outcomes Framework?

Q3:
Examples of under-use include the under-diagnosis of people’s skin conditions (e.g. early skin cancers) leading to missed opportunities to prevent them from getting worse, failures to deliver effective treatments and the under-use of effective drugs. In many cases, tackling problems of under-use could save the NHS money (particularly over the longer term) while in other cases it might increase costs (particularly in the short term). In both cases, tackling these problems will improve quality of care and outcomes for patients.

The scale of these quality problems in the NHS is illustrated by data reviews undertaken by the BAD and the development of its auditable service standards. These data and clinical variations are widespread across different parts of the country – so wide that they explain the differences in people’s health needs and access to quality care. For people with long-term conditions and skin cancer, the NHS could diagnose their conditions earlier and prevent them from getting worse, support people to manage their own health and involve them in treatment decisions, and co-ordinate services more effectively between different parts of the health and care system. However dermatology patients now experience such variations to accessing care particularly with community services that they are often placed on a care pathway which is fractured, causes undue clinical risk and is not cost effective.

7 What views do you have on our priorities for the health and care system?

Q4:
There are a number of pressures currently facing dermatology services (e.g. workforce shortages), many of which are unlikely to disappear within the next 12 months. It is therefore right that the Mandate asks NHS England to prioritise this area for action and for the Government to assess performance accordingly. NHS England must do everything it can to support progress in stabilising and improving dermatology services in primary and secondary care. A significant aspect of this – that is within the organisation's control – will be driving improvements in, and the availability of, primary care services, particularly GP education in skin disease and management of skin cancer in all sectors according to NICE guidelines.

It is also important for the Government to consider how improvements can be made in other related services such as social care (e.g. by enabling better discharge of patients with co-morbidities to be supported by key workers and carers for mental and public health issues.

The BAD is particularly concerned by the number of unfilled consultant posts, despite dermatology being one of the most attractive specialties as judged by applications to training places, which are oversubscribed. Over half of all cancer in the UK is skin cancer and the failure to invest in adequate training posts, cancer prevention services and early treatment and diagnosis is partially responsible for an expensive and damaging increase in skin cancer service requirement in the UK. The shortage of dermatologists is resulting in huge private agency and locum costs for managing skin cancers that are projected to increase by around 8%/year for the next 30 years.

8 What views do you have on how we set objectives for NHS England to reflect their contribution to achieving our priorities?

Q5:
The challenge facing the NHS over the coming years is fundamentally about improving value rather than reducing costs.

It is clear that there is a body of evidence that illustrates where the NHS should focus its attention to improve quality and outcomes – and by doing so increase value from its limited resources.

In focusing on clinical practice we do not mean to ignore other opportunities such as smarter procurement, the more effective use of staff or the high costs of agency staff. All areas of expenditure need to be scrutinised and work is in hand through the Carter review and other means to do just that. We are also keenly aware that innovations in care, for example through the use of innovations in digital technologies, have the potential to positively disrupt and improve how NHS resources are used.

Action is needed at a number of different levels in the system to make change happen.
A number of common factors driving improvement which require further investments can be identified across all of these examples:
• health technology developments (tele-medicine and tele-health, new surgical techniques, improved access to biologic therapies)
• clinical/managerial culture (engagement of clinicians with financial and management issues, greater co-operation between managers and clinicians)
- deal with workforce shortage dermatology with increased training posts to avoid increased use of locums and a distorted and exponentially expensive market to arise
• patient pathway design (redesigning the patient journey from start to end of treatment to minimise resource use and maximise patient health and experience outcomes)
• data and information (more accurate performance metrics, better comparisons and understanding of performance and variation)
• frontline support to enable change (central collation/dissemination of best practice, clinical retraining) • financial incentives (performance/activity-related payment systems)
• financial pressures/financial support (tough financial times focus productivity efforts… but ‘invest to save’/‘transformation’ funding to facilitate productivity gains)

9 Do you have any other comments?

Q6:

Extra comments:
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