



Dear Colleagues

Our principle concerns around this process relate to:

- (1) There should be a minimum framework of secondary dermatology care provided throughout England and the UK. This should cover skin cancer surgery (the commonest cancer in the UK), childrens' dermatology services (representing up to 15% of skin problems), skin allergy services (a major cause of disability in the workplace), photodermatology, genital dermatology services and other specialist services. Patients with psoriasis often require phototherapy which requires 3x weekly hospital visits for 8 weeks. Patient groups therefore advise us that this framework should provide a secondary care specialist dermatology unit within 30 minutes of all members of the public. Monitor should be aware of this need.
- (2) GP education in dermatology is currently limited to approximately 2 weeks at medical school with no obligation or opportunity to study dermatology further during GP registrar training and so GP knowledge of the indications and reasons for complex secondary care investigations and treatments is limited. Therefore, limited involvement of secondary care clinicians in the commissioning process would inevitably affect patient care through errors and omissions.
- (3) Diagnosis is essential before correct treatment can be commenced and early diagnosis by a specialist may avoid many unnecessary investigations and misdirected treatments.
- (4) Which services should be commissioned should not be left to the "expert manager GP" who may have a limited clinical commitment and therefore be distant from the needs of ordinary patients. The views of "ordinary" GPs – who may have little interest in health service management should be represented to ensure that commissioning follows a clinical rather than a 'political/financial' agenda.
- (5) Patient opinion should influence commissioning. How this will occur for patients with rare diseases affecting only a handful of individuals in any locality is of particular concern in dermatology. Dermatology consultants, who know about these patients, should be consulted in commissioning their care.
- (6) Dermatology intermediate care services are often provided by GPs who may also own the profit-making organizations delivering these services. There will be a substantial conflict of interests when GPs commission these services. These earnings will be private and therefore almost impossible to detect and regulate.
- (7) The conflicts of interest for GPs providing dermatology services and the need for a national framework of secondary care dermatology strongly support the argument for national commissioning of secondary care dermatology.
- (8) 'Any willing provider' bids should be required to state who will be providing a proposed service at the commissioning stage so that the quality of likely outcomes can be assessed. This has not happened during the CC2H agenda where in many instances, bidders have been given a contract for which they then struggle to find provider clinicians. Patients, therefore, may have little continuity and no true 'choice' of clinician, the most important part of any 'choice' they might make.