

British Association of Dermatologists response to Liberating the NHS: Commissioning for Patients (White paper 2010)

3.4 Questions

- *In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?*

There are many rare diseases in dermatology. The specialty has over 2000 diagnoses. There must be a co-ordinated approach between the NHS commissioning board and the GP consortia to ensure that patients with rare diseases continue to have joined up and fully funded care.

Intermediate care services in dermatology are provided by local GPs who are usually financial stakeholders in these groups. Attempts to commission intermediate care services would almost certainly result in conflicts of financial interest.

Due to this complexity of dermatology and the potential conflicts of interest for GP consortia in commissioning care, there is a strong argument for central commissioning of a national network of dermatology services.

- *How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?*

Back-up systems need to be foolproof to avoid patients with rare diseases falling between two services.

Consortia should be required to commission services for dermatology patients who will require more specialised services at secondary or tertiary care level.

This need for secondary care is still present even when quality intermediate services exist as has been found during the CC2H agenda.

Patients with low risk chronic disease and rare diseases risk not being heard. Secondary care clinicians should be listened to as advocates for these groups when commissioning services.

- *Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?*

Not to our knowledge

- *How can other primary care contractors most effectively be involved in commissioning services to which they refer patients, e.g. the role of primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?*

Primary care dental and ophthalmic services refer to dermatology for various indications and services including patch allergy testing. This would be most efficiently done directly rather than through primary medical care.

3.22 Questions

- *How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?*

Peer audit of referral letters to secondary care would be a powerful tool.

- *What arrangements will support the most effective relationship between the NHS Commissioning Board and GP consortia in relation to monitoring and managing primary care performance?*

Performance will be most effectively measured by patient experience. Patients should be asked how easy it was to access the practitioner/provider who ultimately provided an effective outcome.

Considerable inefficiency in the NHS is caused by inappropriate patients being triaged in intermediate care, who consequently undergo multiple expensive and inefficient patient/doctor interactions before ultimately meeting a consultant who can manage their condition. Diagnosis is essential before correct treatment can be commenced and early diagnosis by a specialist may avoid many unnecessary investigations and misdirected treatments.

- *What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?*

Ensure that GPs have no financial interest in services which gain financially from their commissioning activity.

There is much cynicism around the words “patient choice” which have in the past had the opposite meaning.

We suggest that **patients** should be asked whether they consider that they have had a choice – this outcome measure would determine effectiveness of local and national processes aiming to achieve “choice”.

3.33 Questions

- *How can the NHS Commissioning Board develop effective relationships with GP consortia, so that the national framework of quality standards, model contracts, tariffs, and commissioning networks best supports local commissioning?*

Local commissioning must balance local needs with standardized national outcomes. Areas with ethnic groups susceptible to skin cancer will have differing dermatology priorities to those areas with ethnic groups susceptible to severe childhood eczema. In each situation there is danger of ethnic minority suffering if commissioning is not sensitive to local needs. This danger will be far worse if the quality standards are biased towards the needs of particular ethnic groups. There is a considerable danger of this in skin disease reflecting a need for a broad range of quality standards. Such a series of standards is being developed by the British Association of Dermatologists.

- *Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?*

Dermatology care has suffered in the past due to variable local provision resulting from lack of understanding of the specialty by those commissioning services. To avoid repeating these expensive and harmful mistakes, there should be a minimum safety net of secondary care dermatology provision across the UK.

4.2 Questions

- *What features should be considered essential for the governance of GP consortia?*

There should be a complete financial declaration by all GPs of any financial involvement in any healthcare provider service.

4.7 Questions

- *How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?*

Distant practices could involve movement of large numbers of patients to providers far from their homes. One way to overcome this would be to insist that patients are always offered as one choice of provider, the local DGH or teaching hospital.

- *Should there be a minimum and/or maximum population size for GP consortia?*

Minimum size: If much below 500 000 it is likely that economic risk could be too great. The previous PCGs in the early 2000s showed smaller units to have excessive management costs.

Maximum size: This will depend on the population density so that in rural Norfolk a size much greater than 500 000 will cover an area too large to effectively administer, whereas a larger group might be more efficient in central London.

5.5 Questions

- *How can GP consortia best be supported in developing their own capacity and capability in commissioning?*

They should be encouraged to share the expertise available from secondary care clinicians, who have an equal and complimentary experience of patient care. Experience has shown that integrated services provide quality outcomes with patients seeing the *right person in the right setting first time*. Secondary care should always be involved at the service planning stage to ensure local services appropriate for the locality 'no one service model is applicable to all'.

- *What support will GP consortia need to access and evaluate external providers of commissioning support?*

As for previous answer

5.10 Questions

- *Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?*

No comments on this.

5.13 Questions

- *What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?*

As before, patients should be asked whether they consider that they have had a choice in attending the provider whom they wished. Patients will only be able to answer this if fully

informed of the competencies and training of different providers. Providers must be transparent about their expertise and should not use misleading titles.

Some primary care doctors providing secondary and intermediate care services in dermatology may claim to be “dermatologists” to their patients– a self designated title. The public might expect a dermatologist to be somebody who is recognized by the GMC as being trained in dermatology.

‘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 all important part of any clinical ‘choice they make.

5.17 Questions

- *What are the key elements that you would expect to see reflected in a commissioning outcomes framework?*

The British Association of Dermatologists is developing an outcome framework with which:

- Involves all relevant stakeholders (including patients)
- Is evidence based
- Covers common and rarer disorders
- Has generic features applicable to all units and specialist features applicable to units offering more complex services.

- *Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?*

This seems reasonable as long as the practices do not have financial interests in the providers that they use

- *What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?*

There should be a minimum level of secondary care service provision below which they cannot drop to avoid closing essential services.

Secondary care doctors should be involved to protect patients with very rare diseases, many of which will not be suitable for national commissioning.

6.5 Questions

- *How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?*

Local scrutiny boards will be helpful for this but this will inevitably exclude some patients with rare diseases with considerable health needs who will be in danger of being overlooked.

- *How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?*

This is where partnership with secondary care consultants will allow identification of seldom heard groups.

- *How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices' Patient Participation Groups?*

These groups need strengthening with financial support for travel and meeting costs.

- *What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients and, where appropriate, staff?*

It is important to engage with hospital consultant staff with whom some of the neediest and most vulnerable patients will have close contact.

6.10 Questions

- *How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?*

No comment on this except that the LA funds will need to be very well ring-fenced to avoid haemorrhage into other projects.

- *Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts, 32Children's Trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to the new arrangements?*

No comment

6.13 Questions

- *How can multi-professional involvement in commissioning most effectively be promoted and sustained?*

By effective and full engagement with hospital consultants and specialist doctors who, by stark contrast with GPs, are hardly mentioned at all in any of the white paper documentation. This major omission needs urgent rectification to engage these groups of staff whose involvement will be essential in delivering change.