

British Association of Dermatologists response to Local Democratic Legitimacy in Health

Q1 Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?

Yes it is important that Healthwatch should be pro-active in indentifying problems.

Q2 Should local HealthWatch take on the wider role outlined in paragraph 17, with responsibility for complaints advocacy and supporting individuals to exercise choice and control?

It seems sensible to devolve these functions to a local group who will be able to take local issues into consideration regarding complaints and problems with choice. This will better identify specific issues re 'problem services' or specific services which have not been commissioned locally.

Q3 What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

Standards for all aspects of healthwatch performance should be set against which they should be obliged to present audits to local authority.

Guidance should be produced to inform Local Authorities/Healthwatch as to what services should be offered by commissioners to ensure high quality/inclusive/integrated services for each specialty.

Q4 What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?

The private sector health providers collect and guard for commercial reasons information on their most profitable patients. There is a danger that encouraging competition between providers will limit communication about patients and will prevent integrated work. This will be dangerous to patients (eg if information about drug allergies is withheld or not volunteered).

Communication of confidential information is an expensive process and a competitive service might minimise administrative overheads and reduce all unnecessary communication. An integrated service is not compatible with true competition.

Legislation mandating communication between providers is essential to maintain integration but it should be recognised that to be effective it will inevitably stifle uncontrolled competition and result in some overheads and barriers to small units setting up.

Q5 What further freedoms and flexibilities would support and incentivise integrated working?

Current experience from private sector/NHS interactions suggests that repealing data protection restrictions would encourage the flow of information between providers. The recent tightening up of the data protection act has in the last few months prevented easy email transfer of patient data between NHS and private providers. An unintended consequence of the data protection act is that it is an effective barrier to integrated work between health care providers.

To allow integrated working some relaxation of data protection rules will be necessary. This will result in “headline cases” of lost data and some litigation.

Q6 Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?

It will not get done in all areas unless there is a statutory framework. This would help even out health outcomes.

Q7 Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

Yes, a statutory health and wellbeing board is more likely to result in equality of healthcare provision.

Q8 Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30?

Yes

Q9 Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?

There is a recent health needs assessment produced for skin disease in 2009. This would help inform health board function.

Q10 If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

Children's services will be complex for skin disease where children's services are provided by dermatologists and not by paediatricians. Children represent approx 15% of secondary care dermatology. Although there are a few paediatric dermatologists, the vast majority of paediatric skin care is carried out by general dermatologists. As some children's care will be commissioned centrally and adult care locally this will produce a complex mix of commissioning for most dermatology units. Integration between local and central commissioning will help health and wellbeing board assist with this complexity.

Q11 How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

No comment

Q12 Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?

The membership should also include local Foundation trust clinician representatives to provide knowledge of complex healthcare problems and diseases.

Q13 What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

The commissioners and local authorities will need expert knowledge of health needs and legal frameworks. In house lawyers may be able to provide the latter. Knowledge of health needs in disputed areas is likely to require expert review by medical specialists who may be appointed as now by the CQC. Foundation trusts should (as now) be required to free their consultant staff for CQC and dispute resolution work and should not be penalised for the expense of clinicians undertaking this work in the commissioning process.

Guidance should be produced to inform Local Authorities/Healthwatch as to what services should be offered by commissioners to ensure high quality/inclusive/integrated services for each specialty.

Q14 Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

Yes

Q15 How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

By specifying that local groups should liaise with national specialist societies and if necessary the CQC at an early stage to advise before problems become entrenched. Patient groups should have a strong voice and be listened to. Failure to address safety concerns in a timely manner should result in sanctions for local commissioners.

Q16 What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

The HAWB should produce a six monthly report to the LA showing the times to resolution and outcomes of reports. Any issues of problems unresolved should be recorded. A standard should be set that 90% of all issues should be dealt with within twelve months.

Q17 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, the public and, where appropriate, staff?

The greatest danger of these reforms is that skin disease outcomes will not be met and so provision will be very variable disadvantaging many vulnerable individuals with severe skin disease. Patient groups indicate that they would like national commissioning of basic level of dermatology care with a maximum travel time for 95% of residents of less than 30 minutes.

Q18 Do you have any other comments on this document?

1. A minimum national framework of dermatology nationally commissioned would help to avoid disadvantaging people with skin disease. Otherwise care will be fragmented.
2. Health and Wellbeing Boards should include expert advice from local dermatologists when dealing with skin disease.
3. HAWB should liaise with specialist societies (eg the British Association of Dermatologists) early to get expert advice to resolve disputes locally.
4. The patient voice should be heard when dealing with commissioning issues, monitoring of services and dealing with complaints.
5. There is a danger that poor communication between competing providers will harm patient care. Providers may hide behind data protection laws to protect their competitive advantage and avoid requirements for integrated healthcare.