Skin Disorders and the NHS White Paper

A Position statement for Medical Peers from the British Association of Dermatologists (BAD)

The BAD has submitted responses to all the government consultations and has formally responded to the Listening Exercise

Our concerns are:-

Choice and Competition:

- ***Choice is only useful if it is informed choice.*** People should know the details of the experience, qualifications and outcomes of those who are treating them.
- There must be ***no conflicts of interest*** in competition: many GPs are shareholders in private organisations who will benefit from allocation of public funds controlled by the same GPs.
- Providers must not ***cherry pick simple cases*** leaving unprofitable complex cases (in the elderly, those with chronic illness, the disabled) to fight for remaining funds.

Accountability and Patient Involvement:

- The ***patient voice must be heard*** in decisions about commissioning. The large number of people with the thousands of rare diseases must not be ignored.

Education and Training:

- It is essential **that *providers that do not include comprehensive education and training*** should not be able to compete equally against those providers that deliver these services in order to maintain NHS sustainability.
- Providers should never dictate workforce numbers. The national requirement should be determined through collaboration between the Centre for Workforce Intelligence (CfWI), Deaneries and SACs.
- Financial ***support must be offered to those who provide training.***
- The same principles apply to those providers that support ***research and the professional activities of clinicians which underpin the management function of the NHS*** through specialist societies and colleges. All these activities are necessary for the long term function of UK healthcare.
- Quality assurance and management of the training programme should be monitored by deaneries and SACs with input from the Royal Colleges.

Advice and Leadership:

- The white papers tend to ***exclude local consultants and effectively disenfranchise them*** from the proposed changes.
- Excluding experts from commissioning decisions will result in ***patients with less common conditions being disadvantaged.*** The changes will not produce good outcomes for patients and are unlikely to work if the potential help and involvement of hospital consultants is rejected.
- All recognised ***medical specialties should be represented on the NHS Commissioning Board.*** This should include Dermatology as 50% of the population experience a skin problem each year, 25% of GP consultations relate to skin disease and 1-2% of the population are referred to secondary care dermatology each year. Central guidance with specialist knowledge will be required to ensure that secondary care services for all patients, (not only those with the common diseases, but also those with the 2,000 rarer diseases), are delivered without major local inequalities around the country.

The BAD supports some changes

In contrast to the above concerns, the BAD endorses the change in emphasis from '***process'*** *towards* ***'outcome'***. We have organised a multi-stakeholder group producing skin disease outcome measures that can be used to underpin the 150 outcome measures/quality standards proposed for NICE. The BAD has produced a multi-stakeholder clinical standards document with the support of the DH and forwarded by Baroness Masham of Ilton – 'Quality Standards for Dermatology, providing the right care for people with skin conditions' now published on the Primary Care Commissioning website (1), to mandate minimum standards for dermatology services.

Peers may wish to make specific recommendations in the following areas:-

.

1) Education and Training

Deaneries (which supervise training for junior doctors) should not be abolished. Whilst Deaneries can be inflexible, leaving teaching and training to the vagaries of market forces will lower standards for training doctors.

We strongly support the submissions in this regard from the Academy of Medical Royal Colleges and the RCP and we are pleased to see that this issue seems to have been recognised by the 'Future Forum'. We urge Peers to ensure that revised recommendations are indeed included in the revised Bill.

There is little mention of Research in the proposed changes.

2) Specialists and Commissioning

Commissioning Bill Amendment

Evidence to date from the Care Closer to Home Agenda and World Class Commissioning (2.3) suggests that quality services are ***integrated*** and indeed, DH guidance for GPwSIs already states that they and community services need to integrate with secondary care. To obtain best use of resources all stakeholder groups (commissioners, *local* Dermatologists, GPs and patient groups) should be involved in service design to minimise 'blind alleys' and maximise efficient agreed pathways.

Consultants are the greatest expert resource in the NHS and processes excluding them will inevitably be flawed, particularly as undergraduate and GP registrar training contain minimal Dermatology. They are pivotal in delivering and coordinating all aspects of Dermatology care (Appendix 1) and provide high quality care (Attachment 1). In areas with inadequate provision of expert care, including inpatient care for those with severe inflammatory skin disease, Dermatology patients are easily ignored as few die. It is, therefore, imperative that outcome measures for Dermatology are included by NICE so that these can be measured and reliably compared.

Evidence from the Care Closer to Home (CC2H) initiative suggests that whilst patients might find community clinics etc 'convenient' there is no evidence that they increase quality or save costs and many patients choose expertise and consistency of provider over convenience (Attachment 2).

The BAD recommends

Commissioning Boards should be informed as to the diseases represented by the '29 specialties' outlined in the White Paper. Monitor should be aware of these specialties (whether large or small) and be aware of what comprises high quality care in each to ensure robust commissioning of appropriate services in all areas.

The BAD has at every opportunity

- Offered to help the National Commissioning Board produce guidance for commissioners regarding skin disease provision.

- Recommended that Consortia engage with secondary care experts when commissioning services to ensure that they are integrated and of high quality.

Refs

1) NHS Primary Care Commissioning (2011) Quality Standards for Dermatology, providing the right care for people with skin conditions
2) NHS Primary Care Contracting (2008). Providing care for patients with skin conditions: guidance and resources for commissioners. Leeds:NHS Primary Care Contracting
3) Schofield JK, Grindlay D, Williams HC. (2009). Skin conditions in the UK: a health care needs assessment. Centre for Evidence Based Dermatology, University of Nottingham UK.

Appendix 1

WHAT MAKES CONSULTANT DERMATOLOGISTS THE AUTHORITY ON SKIN DISEASE?

A Consultant Dermatologist is the best person to treat, and represent the needs of patients with skin diseases, through their commitment to, and leadership of the specialty.

Patients' benefits from a Consultant Dermatologist:

1. Knowledge, which is, focused 100% on skin disease. (A dermatologist's working life is spent dealing exclusively with skin disease, which combined with their unrivalled training, gives them the most extensive experience of dealing with dermatological disorders of all medical professionals.)

2. Ability to diagnose skin disorders early and accurately.

3. Commitment to creating and maintaining guidelines and minimum 'standards of care' for patients with skin disease, to make sure any medical professional treating a skin disorder patient is working to an acceptable standard and possesses adequate knowledge.

4. Ability to treat patients whose needs are complex and challenging; this includes the rare, hard to diagnose or complex disorders, and willing to champion the cause for costly unlicensed treatments.

5. Leadership of teams and networks of healthcare workers responsible for the care of patients with diseases of the skin

6. Ability to educate patients about their disease and teach them how best to manage their condition. Leadership of local and national health education campaigns aimed at the community.

7. Availability for 'on-call', urgent consultation and in-hospital care of patients with severe and life threatening skin diseases.

8. Leadership of the dermatological teaching and training of medical students and doctors, and contribution to the training of GPs, nurses, pharmacists and other healthcare professionals. Consultant dermatologists ensure that systems are in place to train the next generation of dermatologists, to secure the survival of dermatology as a specialty and to maintain the continued improvement of treatment for skin disease patients.

9. Commitment to research and innovation, vital to the development of preventions, treatments and cures for all skin diseases.

10. Contribution to the development of local and national health policy for patients with skin disease.