All Party Parliamentary Group on Skin

COMMISSIONING OF SERVICES FOR PEOPLE WITH SKIN CONDITIONS

This report was prepared by a panel of independent experts in skin disease on behalf of the officers of the All Party Parliamentary Group on Skin (APPGS). Both the officers and expert group are listed at the back of the report. APPGS is supported by grants from the British Association of Dermatologists and the Skin Care Campaign and by individual subscriptions from external members of the Group. None of these latter subscriptions, several of which were from pharmaceutical companies, exceeded £1,000. These funding sources support the APPGS' Secretariat, which provided administrative assistance in the preparation and publication of this report.

A REPORT OF THE
ALL PARTY PARLIAMENTARY GROUP ON SKIN

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June 2008

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Foreword

The All Party Parliamentary Group on Skin (APPGS) was established in 1994 and has a large and active membership including Members of Parliament from all political parties, Members of the House of Lords, health professionals, patient groups and pharmaceutical companies. The Group was set up as a result of a campaign to raise awareness of skin issues in Parliament by the Skin Care Campaign, an umbrella charity incorporating most of the main skin patient groups.

The APPGS seeks progress on a number of key areas:

- Increasing understanding of the nature, extent, causes and problems associated with skin diseases
- Improvement of delivery of treatment to those with skin diseases
- Education of Government as to the ways in which treatment management can be improved
- Examination of socio-economic and environmental factors associated with skin diseases

The APPGS holds a small number of well-attended meetings each year, which look at topical issues impacting on the delivery of dermatology services.

This report focuses on issues raised by the group. We understand that these issues can evoke emotion but we have tried to look at the underlying elements to draw our conclusions, which have been verified by a strong panel of stakeholders in the skin care field.

The APPGS welcomes any further feedback or comments from stakeholders.

Rt Hon Bruce George MP
Chair, All Party Parliamentary Group on Skin
June 2008

COMMISSIONING OF SERVICES FOR PEOPLE WITH SKIN CONDITIONS

1.0 EXECUTIVE SUMMARY

1.1 Following the implementation of major reforms to the procurement of NHS services over the last 4 years, the All Party Parliamentary Group on Skin (APPGS) has conducted an enquiry into the way in which services for people with skin conditions has been affected and also impacted on our other stakeholders.

1.2 Written and oral evidence was taken from a wide range of sources including our associate membership, professional bodies and Primary Care Trusts that currently commission dermatology services. Consistent messages that emerged from the evidence we received are included in this report.

1.3 The Department of Health has outlined 11 competencies that are needed by commissioners to enable the development of 'World Class Commissioning'. This report puts forward a number of suggestions as to how the development of these competencies might be facilitated. Our stakeholders highlighted 8 areas that warrant particular attention:

1. Patient Consultation
2. Demand Management
3. The Economics of Practice-Based Commissioning
4. Patient Outcomes and Patient Choice
5. Training of all healthcare staff, especially GPs and nurses
6. Long-term Partnerships with Primary Care Trusts
7. Conflicts of Interest
8. Equity of Service Provision

1.4 The issues raised in this report are relevant not only for those concerned with skin care but also for other conditions which have been affected in a similar way by commissioning reforms. These recommendations should play a role in ensuring continuing improvements to the efficiency and equity of the NHS.

2.0 SUMMARY OF POLICY RECOMMENDATIONS

Models of Commissioning

• National guidance for the commissioning of services for patients with skin disease must be developed as a priority, with the support of expert commissioners and a wide stakeholder group

• Commissioning of new dermatology services/review of existing ones should only take place if there is evidence of a need for this

• If a new service is necessary, development should take place in an integrated fashion, that includes patient and public input, in accordance with recent Department of Health Guidelines

• The commissioning cycle should be used widely to recognise demand and shape the supply of new services

Patient and Public Consultation

• The importance of involving patients in the commissioning of dermatology services within the commissioning cycle must be emphasised

• All health communities should be required to have an active dermatology stakeholder group to facilitate the commissioning process. Commissioners should co-ordinate service planning so there is consistency in the service models that Trusts provide

• Commissioners and providers should ensure that advertisement of services is unbiased and fair, to enable patients to be as fully informed as possible

• Commissioners and providers should be reminded of their responsibility to declare conflicts of interest and to provide accurate, unbiased information to patients

• There must be a formal means whereby patients can be advised that there is a financial conflict of interest arising in their GP practice

• Patients and the public must be consulted during any service re-organisation to ensure that local needs are met

• The importance of involving patients in the commissioning of dermatology services should be recognised within the commissioning cycle and enforced

• Local authorities should be given adequate support to initiate LINks to ensure the continuity of public consultation

• An independent enquiry should be carried out into the process leading up to the awarding of the commissioning contract in Liverpool in 2007

Demand Management

• Relationships between and across primary and secondary care should be improved to ensure that there is transparency about the tensions and conflicts of interest that clinicians and commissioners face

• Collaboration between the workforces of primary and secondary care stakeholders such as the British Association of Dermatologists (BAD) and the Primary Care Dermatology Society (PCDS) is needed

• Clinical Assessment Services have to be developed with local consultants, care pathways should be developed with commissioners and an element of choice should be incorporated into the referral

• Teams working in a new/expanded service should originate from primary or secondary care or preferably a combination of both, depending on local resources; one size does not fit all

• There must be adequate transparency in service redesign to ensure that conflicts of interest are kept to a minimum

• The Department must ensure there is an adequate mechanism whereby the implementation of National Guidance is ensured, particularly with regard to accreditation and monitoring/assessment of compliance

The Economics of PBC

• There must be emphasis on undertaking a comprehensive economic evaluation when reconfiguring services. There should be consideration of the cost implications of 'double running' services when undertaking service reconfiguration

• There must be removal of financial barriers which prevent the development of truly seamless care pathways and currently create competition between primary and secondary care providers

• The aim should be to have "one pot spent well", which addresses local needs whilst adhering to patient guidelines

Patient Outcomes and Patient Choice

• More needs to be done to ensure that patients are fully informed, so that choice is a realistic option

• Current policy is directed towards dealing with the relocation of services and is not explicitly formed to address capacity deficiencies in service provision. More needs to be done to address this issue

• The systems in place should enable assessment of such capacity deficiencies

• Commissioning of skin cancer services should be strengthened to meet the NICE Improving Outcomes Guidance for skin cancer, with particular attention given to ensuring the accreditation of community cancer clinicians

Training of primary healthcare professionals

• Training of dermatology healthcare professionals was addressed in a previous APPGS report, on Dermatological Training for Health Professionals (August 2004)

• The continued lack of undergraduate training is concerning and it is essential that this area of education and training is addressed for the future of primary care dermatology service provision

• An increase of nurse-led clinicians would allow for greater support and advice for both people with skin conditions and those that are affected. This will improve the dissemination of accurate information about treatments and encourage greater adherence to therapies

• Education of GPs and other primary care professionals must form an integral part of any hospital/community-based dermatology service and this must be recognised by commissioners

• All primary healthcare professionals require up-skilling. Examples include nurse practitioners in the development of nurse-led services, pharmacists via medicines use reviews and health visitors in improving eczema management. Encouraging co-ordination with local academic institutions should play an important role in ongoing professional development. Appropriate up-skilling of GPs and all health care professionals is important but should take place with adequate support from secondary care professionals

• Further development of 'expert patient groups' will provide essential insight and experience that guides healthcare professionals' advice and support

• Specialist hospital-based dermatology departments require appropriate levels of funding in order to support education of its junior staff and research projects. There is still a need for larger numbers of consultant dermatologists. Funding needs to be multi-disciplinary and co-ordinated, currently this is non-existent for nursing

• The opportunities that PBC presents to increase collaboration between professionals and greater focus on management of chronic disease should be harnessed to improved patient education and awareness of their disease. Chronic disease management in primary care may be best managed by developing nurse-led services

Long-Term Partnerships with PCTs

• There should be an urgent review of the 'willing provider framework'

• There must be stipulation of a mandatory timeline along which the commissioning process takes place

• There must be a consideration of pre-agreed levels of activity for commissioning of chronic diseases

• New Care Closer to Home Commissioning Guidance will be available later this year to provide a framework that supports national and local commissioning

Conflicts of Interest

• There must be transparency to ensure that issues of conflict of interest are made apparent in situations where commissioners are providers or have a financial interest in prospective services. PCTs should play a strong role in monitoring and enforcing this

• PCTs and commissioners must be faced with greater deterrents to prevent them acting against the public's interest in cases where there is a conflict of interest

• Regulation of PBC should be strengthened

• PCTs must ensure patient and public involvement in Professional Executive Committees

Equity of Service Provision

• A national minimum standard, written from the patient's/consumer's perspective, should be drawn up to inform them of the standard of care expected

• There must be greater information collection to enable inequalities to be actively targeted, with a nationally supported Minimum Data Set for all dermatology services.

3.0 BACKGROUND TO COMMISSIONING

3.1 In 2000, the Government set out a 10-year programme of reform for the NHS. The NHS Plan[1] outlined the development of 'an NHS characterised by free choice across a range of providers, competing on quality and outcomes as money follows the patient.'

3.2 Introduced gradually since 2004, practice-based commissioning (PBC) stems from policy which aims to give more influence and control to General Practitioner (GP) practices over how money is spent on health care services. The bulk of NHS money is currently allocated to Primary Care Trusts (PCTs) who then commission and reimburse providers for the services used by their local populations, and pay GP practices for the services they deliver to patients.

3.3 Under PBC, GP practices are given their own 'notional' budgets with which to buy health services for their patients. The practices are accountable to their PCTs, who draft the contracts with hospitals and other providers, whilst remaining legally responsible for the funds. The policy is designed to raise GP awareness of how the money is spent once a patient leaves their surgery - active commissioning encouraging practices to design services that are more cost-effective and convenient for patients.

3.4 Dermatology has been cited[2] as one practice area that is particularly suited to PBC, as a primarily outpatient-based service. It is a specialty in which there is a drive to move much more into primary and community care settings. For example, 75% of secondary care departments in England deliver 30% of their care in a community care setting[3].

3.5 Future referral rates are likely to increase significantly as a result of the ageing population and increasing rates of skin cancer. PBC has to be appropriately designed to address both of these challenges. The proposals in the White Paper Our health, our care, our say[4] set the strategic direction for delivering healthcare with a greater focus on prevention and promoting well-being.

3.6 Incentive payments are an integral part of PBC. Surpluses gained through better financial management can – within reason – be reinvested into patient care. This is not a new concept; parallels have been drawn with the internal market policies of the Conservative government in the 1990s, which also emphasised a distinction between purchaser and provider, although there are differences.

3.7 In 2004, the NHS Improvement Plan[5] committed PCTs to providing commissioning budgets to any GP practice that requested them by April 2005. The Department of Health (DH) continually updates guidance to PCTs and GP practices wishing to implement PBC.

3.8 One of the most recent pieces of guidance from the Department of Health, published in December 2007, outlines 11 core organisational competencies that commissioners should develop to ensure 'World Class Commissioning'[6]. These are listed below and will form a framework for our report.

World Class Commissioning Competencies

1 Locally lead the NHS
2 Work with community partners; engage with public and patients
3 Collaborate with clinicians
4 Manage knowledge and assess needs
5 Prioritise investment
6 Stimulate the market
7 Promote improvement and innovation
8 Secure procurement skills
9 Manage the local health system
10 Make sound financial investments

3.9 The Health and Social Care Bill 2007[7], which will lead to the formation of the Care Quality Commission in 2008/09, is designed to strengthen the legislative framework that regulates the process of PBC.

4.0 MODELS OF COMMISSIONING

Competency 1: Locally lead the NHS
Competency 2: Work with Community Partners

4.1 All commissioning should be based on the 'World Class Commissioning' cycle as outlined by the Department of Health (Appendix I).

4.2 In January 2007, the Department of Health's Long Term Conditions Dermatology Workforce Group, which included representation from healthcare professional, patient and industry groups, published their report entitled 'Models of Integrated Service Delivery in Dermatology'.[8]

4.3 It set out a clear role for the primary, secondary and tertiary sectors in the commissioning process, placing emphasis on the three distinct elements of diagnosis, treatment and management. The report offers a reference for commissioners/providers around the country, to show how good work practice across these sectors can be effectively integrated to provide an efficient service.

Organisational Development

4.4 Some PCTs are taking the opportunity to develop various methods of PBC but many practices still retain key aspects of the traditional methods of service commissioning. The Department of Health has produced a commissioning framework for Health and Wellbeing, with commissioning cycle guidance to direct the process from start to finish. PBC take-up has been highly variable to date and depends, predictably perhaps, on the initiative taken by local practitioners.

4.5 Restructuring of services should only occur if there is evidence of a need. Anecdotal evidence suggests that in some areas, ring-fencing of funds for PBC is occurring in spite of the need for secondary care investment. There is some suggestion that this happens because of the financial incentives in place and clearly such a situation would be undesirable.

4.6 Recent reforms have resulted in a variety of different models of care emerging around the country. These models tend to be randomly, rather than uniformly adopted and can be grouped into 5 categories, as identified by the Royal College of Physicians (RCP) and British Association of Dermatologists (BAD).

1. PCT commissioned services using the traditional Service Level Agreement arrangement/Payment by Results funded services
2. Consultant-led models of care in a secondary care setting
3. Models of care in a primary care setting using General Practitioners with a Special Interest (GPwSI)
4. Models where GPwSIs triage referrals from other GPs
5. Telemedicine.

4.7 Hub and spoke models, such as those found in South Birmingham PCT and North East Lincolnshire PCT, enable greater co-ordination of services across the community.

Evaluation of Commissioning Models

4.8 A full audit and review to evaluate these models still remains to be undertaken. It is therefore difficult to recommend one over the other. However, the Royal College of Physicians (RCP) notes three factors that are key to the success of any given model:

1. Good relationships with all stakeholders, including PCT/PBC commissioners and hospital consultants
2. Patient and public involvement in service redesign
3. Transparency by both the Trusts and PCTs when declaring competing interests.

Collaboration between Clinicians

4.9 Clinician involvement and engagement is vital to ensuring the smooth running of a service. In 2007, The Care Closer to Home (CCTH) Dermatology Group, in association with

the Department of Health, undertook an audit that found that in the previous 4 years, there had been a significant increase in proportion of GPwSIs working in an integrated fashion with local secondary care clinicians. This was a marked improvement on 2003, when 48% had not even been aware of whether or not they were operating within approved frameworks.

4.10 Evidence received by the APPGS[9] suggests that use is being made of nurse-led clinics. The relatively recent development as well as small scale of these clinics means it is not yet appropriate to carry out formal research and evaluation of them. However, anecdotal evidence suggests that patients have benefited from the additional specialist dermatology nursing expertise in primary care and a more focused approach to chronic disease management.

4.11 Dermatology specific guidance, "Guidance and Competencies for the provision of services using GPs with Special Interests (GPwSI) – Dermatology and Skin Surgery"[10], has been produced by the Department of Health. However, the Audit Commission recently conducted a review of PBC that discussed how policies in these areas have resulted in some challenges and tensions for GPs. For example, practices may be faced with an incentive to reduce demand for external services, e.g. those provided by an acute trust in secondary care, to save money. Such potential conflicts of interest must be openly discussed by clinicians and this issue is discussed more fully in Chapter 11.

Recommendations

- National guidance for the commissioning of services for patients with skin disease should be developed as a priority, with the support of expert commissioners and a wide stakeholder group
- Commissioning of new dermatology services/review of existing ones should only take place if there is evidence of a need
- If a new service is necessary, development should take place in an integrated fashion in accordance with recent Department of Health Guidelines
- The commissioning cycle should be used widely to recognise demand and shape the supply of new services

5.0 PATIENT AND PUBLIC CONSULTATION

Competency 3: Engage with Public and Patients

5.1 Patient and public consultation is an essential part of service redesign and review. Until April 2008, this was facilitated by Patient and Public Involvement (PPI) Fora which will be replaced by Local Involvement Networks (LINks).

5.2 The introduction of Referral Management Systems (see Chapter 6) means that the opportunity for GPs to refer directly into secondary care may be removed. Many PBC/PCT groups are commissioning services with a mandatory requirement for primary care clinicians to refer only to the RMS and with there being no referral route direct to a specialist service. These changes are often implemented without consultation from the patients, public or local health community. Greater awareness needed to be raised of these cases to ensure that patients are aware of these developments and are not misled.

5.3 The Royal College of Physicians (RCP) noted in its evidence that several sources had suggested that adequate consultation, in accordance with DH guidelines, was not being carried out. Such cases have received media coverage, including one case concerning Liverpool PCT, that was highlighted on Channel 4 in September 2007[11].

5.4 Evidence received from consultants practising in Liverpool, as well as from the chair of the local PPI forum, states that there was a lack of public consultation before a new service there was rolled out by the PCT. The consortium concerned justified this on the grounds that the new service was a pilot scheme and did not, therefore, warrant any consultation.

5.5 The Channel 4 report claimed that more than 70 GPs in Liverpool had a financial stake in companies awarded contracts under PBC. Were this to be the case, it would surely comprise a conflict of interest. We understand that this issue was raised with Liverpool City Council by the PPI but that further consultation was refused. We are glad to see that the Department of Health recognises potential conflicts of interest in its guidance '*Practice based commissioning – budget setting refinements and clarification of health funding flexibilities, incentive schemes and governance*' (December 2007), with recommendations for 'transparent management'.

5.6 However, to our knowledge, there is no formal means whereby patients can, in general, be made aware of conflicts of interest that involve their medical practitioners. According to GMC guidelines, if referring GPs have a financial interest in a service to which they refer, then this must be specifically disclosed to the patient at the time of the referral, but how often, in practice, does this happen?

5.7 Reports from the Liverpool PPI forum also claimed that leaflets advertising the new dermatology Integrated Care Assessment and Treatment Service (ICATS) failed to include the service provided by the regional dermatology unit. The Chairman of the South Central PBC Consortium has a responsibility to ensure that patients are informed of all new services and there is a strong view, amongst stakeholders, that this has not happened in this case.

5.8 The APPGS has received differing versions of events in the case outlined above. However, the balance of evidence we received suggests that there may be some cause for concern, warranting further investigation.

5.9 Current commissioning policy relies heavily on self-governance to ensure that conflicts of interest are managed appropriately without compromising the interests of patients. However, as accountability officially lies with PCTs, in cases where patients, clinicians or members of the public do wish to raise concerns, it is difficult to find a body to which they are accountable. This problem has been exacerbated by the current restructuring of regulatory agencies overseeing the healthcare sector that will eventually result in the formation of the Care Quality Commission.

5.10 The APPGS hopes that the regulatory bodies emerging from this new legislation will be granted the adequate powers to enforce the current commissioning guidance and also reprimand or otherwise act against commissioners who contravene national guidelines.

5.11 In the meantime, we would like to see an independent review undertaken on the process leading up to the awarding of the contract in Liverpool in 2007 to establish whether,

indeed, the rules were followed in this instance. This could perhaps be carried out by the Healthcare Commission.

5.12 The APPGS notes examples of good practice in this area. South Birmingham PCT carried out a 3 month statutory patient and public consultation process, with consultation questionnaires circulated to 10% of the current service users. Other mechanisms used for consultation included public meetings, skin support groups, parliamentary constituency offices, the Cancer Network Skin Cancer Group and local acute providers. This provides a good model for others to follow.

5.13 There is also concern that, in some areas, there will be a delay in the creation of new LINks partnerships after PPI fora have been dissolved. This will leave some patients without an official channel through which to become involved in local decisions for several months, which is of great concern.

Recommendations

- The importance of involving patients in the commissioning of dermatology services within the commissioning cycle should be emphasised.
- All health communities should be required to have an active dermatology stakeholder group that facilitates the commissioning process. Commissioners should co-ordinate their service planning so there is a consistency in the service models that Trusts provide
- Commissioners and providers should ensure that advertisement of services is unbiased and fair to enable patients to be as fully informed as possible
- Commissioners and providers should be reminded of their responsibility to declare conflicts of interest and to provide accurate, unbiased information to patients
- Patients and the public must be consulted during any service re-organisation to ensure that local needs are met
- There must be a formal means whereby patients can be advised that there is a financial conflict of interest arising in their GP practice
- The importance of involving patients in the commissioning of dermatology services should be actively recognised within the commissioning cycle and enforced
- Local authorities should be given adequate support to initiate LINks to ensure the continuity of public consultation
- An independent enquiry should be carried out in the process leading up to the awarding of the commissioning contract in Liverpool in 2007

6.0 DEMAND MANAGEMENT

Competency 4: Collaborate with Clinicians
Competency 5: Manage Knowledge and Assess Needs

Type of Diagnosis and Required Treatment

6.1 Different dermatology problems require different responses, ranging from chronic disease management approaches for conditions such as eczema and psoriasis to cases of suspected skin cancer, which may require immediate acute treatment. Rarer skin conditions

(Gorlin Syndrome, Pseudoxanthoma Elasticum, Pemphigus, etc.) require specialist centres of excellence. PBC has to accommodate the needs of patients with a wide-ranging variety of conditions. In line with 'care closer to home', commissioners should allow for and support travel over long distances to reach specialist services when necessary.

Referral Management Systems

6.2 Demand management refers to actions taken by primary care trusts and/or GP practices to moderate the demand for health care services. Given the financial restructuring that has taken place alongside PBC reforms, there are considerable incentives to implement Referral Management Systems (RMS). These enable the clinical appropriateness of GP referrals to be assessed before treatment is allowed to proceed (NHS National Library for Health). The NHS Operating Framework 2006/7 includes an expectation for PCTs to have plans in place for the management of demand in practice-based commissioning.

Whilst designed to ensure that treatment is provided in the most appropriate setting, there is a danger with such systems that patients are forced back into a part of the NHS where the clinician does not feel adequately equipped to help. The enquiry was told that this situation has resulted from the growth of RMSs in some areas and this is of great concern. The scale of this problem, however, is very difficult to assess.

6.3 The BAD carried out a survey in 2006 and 2007 to evaluate scale on which modernisation of service delivery had occurred. Their results suggest that 64% of services were affected by Clinical Assessment and Treatment Centres (CATS) or RMS. The data showed a 10% increase in the number of PCTs exploring the implementation of CATS or RMS in England over one year. This means that the vast majority of services are affected.

6.4 These can be broadly grouped into two categories:

• Those that have been developed with the support of secondary care in an integrated fashion with adequate clinical audit, and are showing promising results. The CCTH 2007 reports showed that some services had reduced referrals and waiting lists by up to 70% for dermatology and plastic surgery. (In this case, much of the triage was carried out by GPwSIs. Wherever and by whomsoever triage is conducted, it is obviously important that the person responsible is appropriately trained and accredited)

• Those that have been developed without the support of secondary care and provide a risk to the provision of high quality dermatology care and to the stability of secondary care services.

Problems with Demand Management

6.5 Rapid restructuring of services may create problems for patients:

• Services may become fragmented (Chapter 4)

• The patient may not see the most appropriate health professional at the first point of contact, which may increase tertiary referrals and costs (see below)

• Patients are faced with treatment by demoralised clinicians who have a poor working relationship with the PCT (Chapter 7, 10)

• The quality of service may suffer (Chapter 8)

• Patient Choice may not be implemented (Chapter 8)

• There is concern that as dermatology is already a core part of general practice, the introduction of PBC and intermediate services in this particular area could lead to the de-skilling of GPs, if it results in the production of another service to which patients are referred (Chapter 9)

6.6 There is concern that RMSs will delay the time it takes a patient to see a specialist, which may be crucial in cases of skin cancer. However, triage in a community care setting with the support of secondary care can be invaluable in ensuring that low-priority framework (i.e. principally cosmetic) conditions are not managed in the NHS and therefore direct patients to the most appropriate individual at the first point of contact. However, triage in the absence of such support is not advocated and is against national guidelines. More must be done to encourage local collaboration and communication between primary and secondary care, in order to meet national guidelines, whilst maintaining the appropriateness of referrals in the interests of efficiency.

6.7 Surprisingly, RMSs may also increase referral levels. Work by Action on Dermatology shows that there are reduced waiting times for GPwSI clinics, but there is little overall impact on wait times unless there are several GPwSIs in post.

To ensure that CAS operate optimally:

1. They must be developed with local consultants, with triage according to DH guidelines
2. Care pathways should be developed closely with commissioners to highlight practices needing more input
3. They should incorporate an element of choice so that, if patients express a preference to be seen by a consultant, this should be marked on the referral.

Recommendations

• Relationships between and across primary and secondary care should be improved to ensure there is transparency about the tensions and conflicts of interest that clinicians and commissioners face

• Collaboration between the workforces of primary and secondary care stakeholders such as the British Association of Dermatologists and the Primary Care Dermatology Society is needed

• Clinical Assessment Services should be developed with local consultants, care pathways should be developed with commissioners and an element of choice should be incorporated into the referral

• Teams working in a new/expanded service should originate from primary or secondary care or preferably a combination of both, depending on local resources; one size does not fit all

• There should be adequate transparency in service redesign to ensure conflicts of interest are kept to a minimum

• The Department should ensure there is an adequate mechanism whereby the implementation of National Guidance is ensured, particularly with regard to accreditation and monitoring/assessment of compliance

7.0 THE ECONOMICS OF PBC

Competency 6: Prioritise Investment

Hidden Costs

7.1 Whilst driven presumably by the motivation to cut costs, those involved with PBC also face the cost of reconfiguring services. There are several costs that contribute to the total of the reconfiguration of a service but may not always be overtly considered. The RCP and BAD have highlighted the following:

• The costs of setting up and then maintaining a specialised but non-secondary care service. This includes the cost of training GPwSIs, which involves consultant time. The opportunity cost of this training is seeing the patient and gaining hospital income via the treatment tariffs. There may be no incentive for acute hospitals to support this training if subsequent income is then removed from them by a competitive service that they helped to establish. The current financial structure of the NHS creates artificial competition between primary and secondary care, which is detrimental to co-operation and patient care.

• The opportunity cost of accrediting intermediate care practitioners is consultant time. The opportunity cost of on-going supervision of GPwSIs (in accordance with GPwSI accreditation guidelines) is again, clinician time.

• Intermediate care facilities may need to be built or updated to allow people with skin conditions to be seen and treated.

• Community-based services such as operating facilities are expensive to set up, may require additional staff and must abide by Health and Safety regulations, amongst others.

• The cost of certain investigative procedures and treatments are often not included in the GPwSI tariff, whilst these are included in the secondary care hospital tariff, which distorts financial incentives further.

• There may be diseconomies of scale associated with the fragmentation of services.

Cost-Effectiveness of GPwSIs

7.2 There have also been a limited number of studies investigating the cost-effectiveness of such specialised but non-secondary care services, which incorporate GPwSIs. *Sanderson et al.* (2002) found that GPwSIs did not generate demand *per se* but found that one GPwSI generated 33% more referrals than neighbouring trusts without GPwSIs. Other studies also suggest that a lowering of the referral threshold is responsible for the increase in referrals seen. However, the appropriateness of the referrals made also has to be considered before a negative conclusion can always be drawn from such results.

7.3 Initial studies also suggested that costs per consultation were significantly lower for GPwSIs compared with outpatient hospital costs (£30-40 compared to £60-80 respectively). However, there were three concerns with these conclusions:

1. Hospital costs included overheads not included in the GPwSI costs
2. GPwSI costs omitted the costs of hospital supervision, management and training
3. Costs were not adjusted to reflect the simpler case-mix seen by the GPs.

Quality and Outcomes Framework & Tariff Structure

7.4 The current costing of skin disease in primary care does not include Quality and Outcomes Framework (QOF) points for dermatology in primary care. Because of this lack of

financial incentive, service provision in some areas has deteriorated (e.g. treatment of patients with leg ulcers) and some patients have needed to be shifted from community to secondary care for their treatment.

7.5 The current tariff structure and payment by results (PBR) does not provide an incentive for secondary care to redirect patients back into the community. This system creates a barrier between primary care and secondary care. A number of those providing evidence to our enquiry echoed the opinion that these artificial financial barriers are preventing the development of smooth care pathways, which are needed for cost-effective care.

'Cream-Skimming' of cases

7.6 Community-based services were intended to improve patient access to medical services. However, 'cream skimming' of the simpler cases that would usually be referred to secondary care is clearly a risk and results in the average cost per case rising in secondary care. This is encouraged by the tariff system. It may also have an effect on other specialities. Such 'cherry-picking' is also an attractive option for private providers if they are able to select their cases in this way and provide a bid to offer services below tariff.

Destabilisation of Secondary Care

7.7 There is concern that large-scale withdrawal of patient referrals (greater than 20%) will lead to the disappearance of secondary care dermatology from district hospitals, that will lead to a shortage of provision for patients who are more seriously ill and a loss of infrastructure.

Recommendations

- There must be emphasis on undertaking a comprehensive economic evaluation when reconfiguring services. There should be consideration of the cost implications of 'double running' services when undertaking service reconfiguration
- There must be removal of financial barriers which prevent the development of truly seamless care pathways and currently create competition between primary and secondary care providers
- The aim should be to have "one pot spent well", which addresses local needs whilst adhering to patient guidelines

8.0 PATEINT OUTCOMES AND PATIENT CHOICE

Competency 7: Stimulate the market

Patient Choice

8.1 The World Class Commissioning document states that 'commissioners will need a choice of responsive providers in place to meet the health and care needs of the population… commissioners will use their investment choices to influence service design, increase choice and drive continuous improvement and innovation'.

8.2 The RCP, alongside other stakeholders, raised concerns about patients with non-urgent cases in situations where a CATS or GPwSI is in place. Whereas they would previously have

been given a choice of acute sector specialist provider for their treatment, they are now managed by a CATS service or by a GPwSI, without the patient themselves exercising a 'choice' of provider. The 'choice' of where the patient is treated is made by the GP or triage system instead. Therefore, it is often difficult to ensure that the DH's policy focusing on increased patient choice can be achieved.

Choose and book system

8.3 There is concern that there is insufficient flexibility in this system to allow patients to have a real choice. Popular hospitals often have no available appointments, due to lack of capacity.

8.4 The current systems in place do not allow any measure of capacity deficits that exist, making forward business planning difficult. The RCP also cites the perception that the system supports hospitals with relatively poor facilities, as they are often the only providers with slot availability.

8.5 There is also currently a mixture of Choose & Book in addition to paper referrals. Since Trusts are obliged to accept both types of referrals, many acute trusts have to take referrals over and above their recognised capacity.

Care Closer to Home

8.6 Recent Department of Health policy has been to establish more Care Closer to Home (CCTH). Some stakeholders suggested that there should be clarification of the meaning of the word 'closer'. For many patients, the word 'closer' implies a geographical closeness, whereas the Department of Health interprets 'closer' in terms of whether care is provided in primary, intermediate or secondary care. The APPGS is aware that primary care services are not always those that are geographically closest for the patients, and that supposedly enhanced services in primary care may actually lead to patients travelling longer distances for treatment.

8.7 Nonetheless, CCTH is based on several key principles, including a basis on public preference, an increasingly ageing population, the developments in technology which make it possible and the conclusions drawn up by the Wanless Review[12]. In addition, the UK lags behind other western countries in terms of the amount of care that is delivered outside the traditional hospital setting[13].

Quality of Services

8.8 The Department of Health has produced guidance, outlining quality standards frameworks to try to ensure that standards of care across the country meet the same minimum standards regardless of whom the service is provided by. There is clear guidance for skin cancer services and GPwSI-led services.

8.9 Although it is still too early to report back on the compliance with these implementation documents, there is anecdotal evidence that the NICE guidance for skin cancer is proving difficult to implement. Excision of skin cancer is rumoured sometimes to be performed by clinicians that are not suitable trained or accredited in accordance with this new guidance.

8.10 Several audits have been carried out as part of the NICE cancer service guidance for Improving Outcomes for People with Skin Tumours (including melanoma)14. This reviewed the

excision margins of skin cancer, comparing consultant dermatologists against primary care practitioners. These audits appear to show a consistently lower tumour clearance rate by primary care practitioners (40-50%) compared to secondary care practitioners (a minimum of 90% and usually higher).

8.11 The APPGS is conducting a separate enquiry into skin cancer that will examine these issues in greater depth and make recommendations.

8.12 One study found that 12/33 malignant (skin cancer) cases were not suspected as malignant by the GP in their initial diagnosis. GPs are also more likely to diagnose false negatives in the case of skin cancer, which gives patients a false sense of security. These additional studies also found that GPs were less likely to completely and adequately remove malignant melanomas, which then required further follow-up.

8.13 The Care Closer to Home Report, however, states that there has been no decrease in quality of care since the implementation of PBC policy.

Recommendations

- More needs to be done to ensure that patients are fully informed, so that choice is a realistic option
- Current policy is directed towards dealing with the relocation of services and not explicitly formed to address capacity deficiencies in service provision. More needs to be done to address this issue.
- The systems in place should enable assessment of such capacity deficiencies
- Commissioning of skin cancer services should be strengthened to meet the NICE Improving Outcomes Guidance for skin cancer, with particular attention given to the accreditation of community cancer clinicians

9.0 TRAINING OF PRIMARY HEALTHCARE PROFESSIONALS

Competency 8: Promote Improvement and Innovation

Education

9.1 All deaneries and units that train healthcare professionals should review and improve the dermatology component of training to reflect the need for improved knowledge, by all healthcare professionals, of holistic dermatology.

9.2 There is also potential for an educational element to be built into PBC, which could be facilitated by sharing of expertise within a commissioned service to prevent the deskilling of GPs. Suggestions have been put forward to develop mentorship with regards to a primary care focus, with emphasis on management of particularly severe cases in secondary care.

9.3 Integrated clinical-academic development has the potential to play an important role in professional development. There may be opportunities to develop research programmes, linking in Trust staff and postgraduate students.

Up-skilling

9.4 There is a need for up-skilling of all primary healthcare professionals. Areas which might benefit from this include training of nurse practitioners developing nurse-led services, medicines usage reviews for pharmacists and enabling health visitors to improve their skills in atopic eczema management.

9.5 The Royal College of General Practitioners (RCGP) argues that there is scope for GPs to manage more conditions than they generally do at present. If GPs are excluded from certain practice areas, this will lead to deskilling and an increased number of referrals. Up-skilling, it is argued, of GPs in certain areas, could, on the other hand, lead to fewer referrals and avoid deskilling, which has been the philosophy underpinning the role of the GPwSI. Up-skilling may play an important role and should take place if it will serve an unmet need. However, this needs to be in collaboration with adequate support from secondary care practitioners.

Patient Education

9.6 PBC allows scope for more focused chronic disease management, part of which might involve improved self-management and health promotion, with GPs dispensing advice on appropriate treatment. Practices are in the process of discussing or implementing a variety of initiatives in this area, including Expert Patient Groups, promotion of healthy living, group teaching of disease management and increasing awareness of other factors, such as alcohol intake, which may affect their condition.

9.7 PBC for chronic disease management in dermatology should have a multi-disciplinary focus. Self-management, health promotion and treatment advice can be effectively provided by developing nurse-led services in primary care. Resources need to be secured to enable patient review of services and to ensure continuity of care so that patients are provided with on-going support.

Recommendations

- Training of dermatology healthcare professionals was addressed in a previous APPGS report, on Dermatological Training for Health Professionals (August 2004)
- The continued lack of undergraduate training is concerning and it is essential that this area of education and training is addressed for the future of primary care dermatology service provision
- An increase of nurse-led clinicians would allow for greater support and advice for both people with skin conditions and those that are affected. This will improve the dissemination of accurate information about treatments and encourage greater adherence to therapies
- Education of GPs and other primary care professionals should form an integral part of any hospital/community based dermatology service
- All primary healthcare professionals require up-skilling. Examples include nurse practitioners in the development of nurse-led services, pharmacists via medicines use reviews and health visitors in improving eczema management. Encouraging co-ordination with local academic institutions should play an important role in ongoing professional development. Appropriate up-skilling of GPs and all health care professionals is important but should take place with adequate support from secondary care professionals

• Further development of 'expert patient groups' will provide essential insight and experience that guides healthcare professionals' advice and support

• Specialist hospital-based dermatology departments require appropriate levels of funding in order to support education of its junior staff and research projects. There is still a need for larger numbers of consultant dermatologists. Funding needs to be multi-disciplinary and co-ordinated, currently this is non-existent for nursing

• The opportunities that PBC presents to increase collaboration between professionals and greater focus on management of chronic disease should be harnessed to improved patient education and awareness of their disease. Chronic disease management in primary care may be best managed by developing nurse-led services

• The opportunities that PBC presents to increase collaboration between professionals and greater focus on management of chronic disease should be harnessed to improved patient education and awareness of their disease. Patient groups and charities should be financially support by the Department of Health to continue providing expert advice and information for people with a skin condition and for those who may be affected, such as carers and parents

10.0 LONG-TERM PARTNERSHIPS WITH PCTS

Competency 9: Secure Procurement Skills
Competency 10: Manage the Local Health System
Competency 11: Make Sound Financial Investments

10.1 The 'willing provider' arrangement that is currently being encouraged enables commissioners to enter into an agreement with any number of providers to provide a service. The commissioners give no undertaking of the commissioned activity, i.e. the level and price of services provided is not pre-determined.

10.2 Because dermatology is a high volume speciality, which requires a critical mass of clinical and administrative input, it becomes difficult to invest in this area without a prior guarantee of return in terms of activity levels.

10.3 The 'willing provider' model can potentially benefit local health communities by enabling local stakeholder groups to use the commissioning cycle to become engaged in the commissioning process and also reduce the need for lengthy tendering contracts. With the former system it could often take up to 12 months to become a preferred provider and to sign contracts.

10.4 However, several concerns have been raised. There are cases, such as that concerning South Central Liverpool Consortium, which advertised for bids for a Clinical Assessment Service in March 2007, where the timescale has been deemed unreasonably short (2 weeks). This may leave inadequate time for scrutiny of providers to ensure they are adequately qualified and accredited and to enable all concerned to make adequate declarations of interest. These two concerns were raised in the case above.

10.5 We would therefore urge a review of the willing provider commissioning framework. Changes are needed to ensure that procurement of services occurs in such a way as to

optimise the available services to the patient. It is necessary for commissioners and clinicians to be given adequate time to prepare for restructuring of services to enable them to make the optimal financial investments in the interests of the patients.

10.6 The ethos of 'one pot well spent' has to be encouraged to ensure that limited financial resources are allocated as sensibly as possible.

Recommendations

- There should be an urgent review of the 'willing provider framework'
- There must be stipulation of a mandatory timeline along which commissioning process takes place
- There must be a consideration of pre-agreed levels of activity for commissioning of skin conditions

11.0 CONFLICTS OF INTEREST

11.1 Governance mechanisms are in place to try to ensure that conflicts of interest are dealt with as they arise. Responsibility at a local level lies with the PCT concerned. Individual healthcare professional groups may also be bound by professional standards regarding the way in which they must behave in cases where conflicts of interest arise. These must also be adhered to.

11.2 Concerns have been raised about conflicts of interest arising between those commissioning services and those providing services. Although guidance reinforces the idea that commissioning and provider arms are separate organisations, it is often the case that individuals may play the role of both commissioner and provider. For example, a local commissioning group may commission a service from a local provider that employs GPs from the same practice.

11.3 Conflicts of interest may reduce the operating efficiency of a service. Commissioning groups may commission skin surgery services to be provided by local GPs, whereas a skin surgery nurse specialist working as part of the local dermatology services may be able to perform this role more cost-effectively in some cases. This model has been seen in North West Hertfordshire PCT.

11.4 Conflicts of interest occur not only during the tendering process but, if the contract is won by an individual with a conflict of interest, will continue to persist each time a referral is made to that service. There should be a clear route whereby action can be taken to remedy such situations should they occur.

11.5 Concerns have also been raised about the size and membership of the Professional Executive Committee (PEC). Although the Department of Health has set out clear guidance as how to manage financial conflicts of interest that may arise, some of those providing evidence to the enquiry were concerned that PECs were too small (in some cases made up of only three individuals) and that it was often difficult truly to ensure good governance. In addition, the clear conflicts of interest that will occur with clinicians and commissioners sitting on scrutiny

committees means avoidance of conflict of interest in the commissioning process is nearly impossible to achieve. Some stakeholders might suggest that there is over-reliance on self-regulation.

11.6 The RCGP advocates the use of specific service-level agreements to state the services needed and the competencies required, with thorough audit.

Recommendations

- There must be transparency to ensure that issues of conflict of interest in situations where commissioners commission services do not arise. PCTs must play a strong role in this supported by their board
- PCTs and commissioners should be faced with greater deterrents to prevent them acting against the public's interest in cases where there is a conflict of interest
- Regulation of PBC should be strengthened
- PCTs must ensure patient and public involvement in Professional Executive Committees

12.0 EQUITY OF SERVICE PROVISION

12.1 Dermatology services are inequitable across the country and evidence from the Skin Care Campaign suggests that standards range from adequate to very poor, with few centres of excellence. A minimum deliverable core standard per PCT, stating by population what the minimum dermatology service requirements should be, must be developed so that patients know what level of care they can expect. In Hertfordshire, there is a well co-ordinated multi-disciplinary team in the West, whereas there is at least anecdotal evidence of understaffing in the North East.

12.2 Availability of different therapies is also highly inequitable. PCT pharmaceutical advisors are known to be issuing advice, which prevents GPs from prescribing specific essential emollients, biologics and other dermatological treatments. This leaves many patients with no other option than to buy their own emollients.

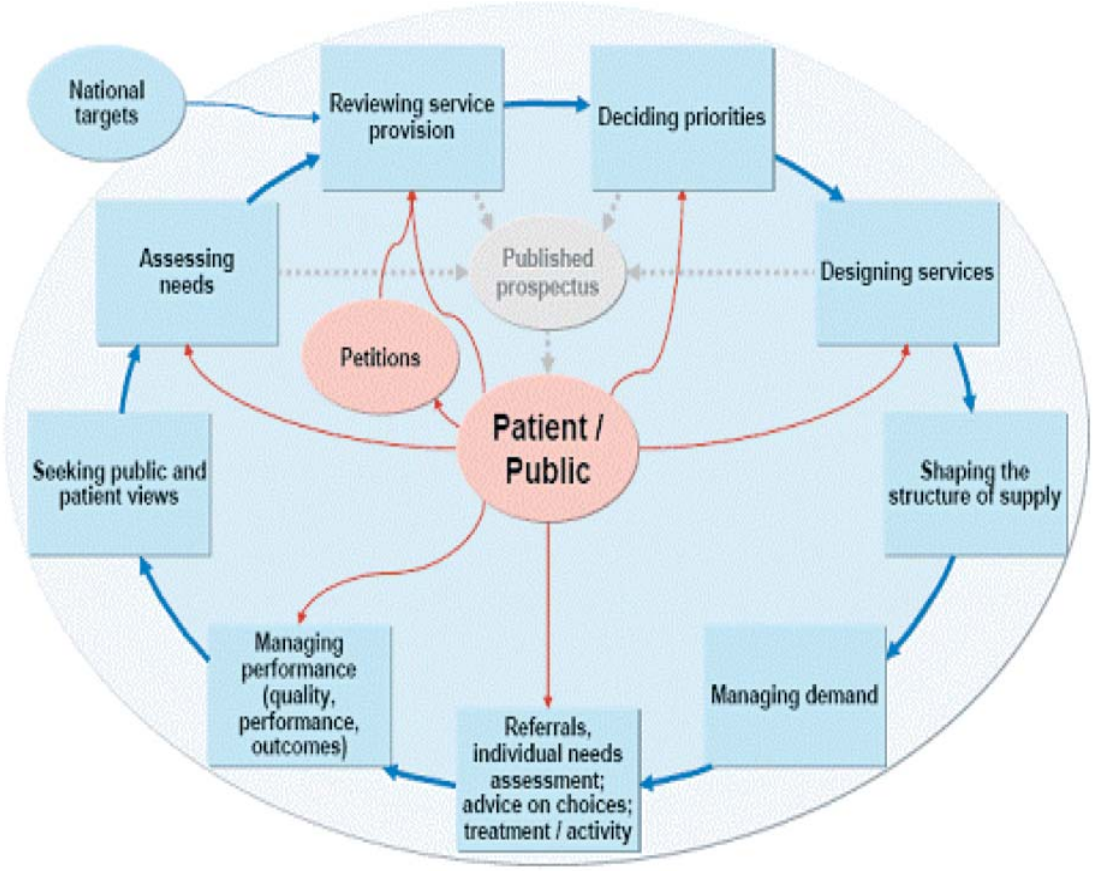
12.3 In light of recent evidence showing that regional health inequalities in England have increased over the last 10 years, our concern about inequity of service provision is timely. Collation of information about service availability and provision in different regions across the country would enable those most in need to be targeted accordingly.

Recommendations

- A national minimum standard, written from the patient's/consumer's perspective, should be drawn up to inform them of the standard of care expected
- There must be greater information collection to enable inequalities to be actively targeted, with a nationally supported Minimum Data Set for all dermatology services

13.0 Appendices

Appendix I: The Commissioning Cycle



From: Health Reform in England: Update and Commissioning Framework. Department of Health (2006)

Appendix II: References and Written Evidence

The APPGS gratefully acknowledges the receipt of written evidence from stakeholders included in the list of references below.

1. The NHS Plan: a plan for investment, a plan for reform. Department of Health, July 2000.
2. North Staffordshire Primary Care Trust
3. British Association of Dermatologists
4. Our health, our care, our say. Department of Health, January 2006.
5. The NHS Improvement Plan: Putting people at the heart of public services. Department of Health, June 2004.
6. World Class Commissioning. Department of Health. December 2007.
7. Health and Social Care Bill. 15 November 2007. http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill/index.htm
8. http://www.skincarecampaign.org/pages/documents/Service%20Models%20Final%20(February%202007).pdf

9. Professor Stephen Ersser, Southampton City PCT
10. Guidance and competencies for the provision of services using GPs with Special Interests (GPwSIs): dermatology and skin surgery.15 May 2007. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074665
11. http://www.channel4.com/news/articles/society/health/are+gps+exploiting+nhs+markets/758447
12. Securing Our Future Health: Taking A Long-Term View. Derek Wanless. April 2002. http://www.hm-treasury.gov.uk/Consultations_and_legislation/wanless/consult_wanless_final.cfm
13. Primary Care Dermatology Society
14. Improving Outcomes for People with Skin Tumours including Melanoma. Cancer service guidance. National Institute for Health and Clinical Excellence. February 2006. http://www.nice.org.uk/csgstim
15. Dr Maggie Andrews
16. Dr Richard Azurdia
17. Birmingham East and North Primary Care Trust
18. Blackpool Primary Care Trust
19. Central Lancashire Primary Care Trust
20. Dudley Primary Care Trust
21. Ealing Primary Care Trust
22. East Lancashire Primary Care Trust
23. Dr Andrea Franks
24. Havering Primary Care Trust
25. Heart of Birmingham Primary Trust
26. Liverpool Primary Care Trust
27. Dr Richard Motley MA MD FRCP, Welsh Institute of Dermatology
28. NHS South of Tyne and Wear
29. North East Lincolnshire Primary Care Trust
30. North Tees Primary Care Trust
31. Primary Care Dermatology Society
32. Redbridge PCT
33. Royal College of General Practitioners
34. Royal College of Physicians
35. Dr Julia Schofield
36. Dr Graham Sharpe
37. Skin Care Campaign
38. Solihull PCT
39. South Birmingham PCT
40. Sunderland Teaching PCT
41. Telford and Wrekin PCT

Appendix III: Expert Witnesses

1. Dr Maggie Andrews, Chair, PPI Forum for The Royal Liverpool and Broadgreen University Hospitals, Liverpool
2. Dr Richard Azurdia, Consultant Dermatologist, The Royal Liverpool and Broadgreen University Hospitals, Liverpool
3. Dr Pauline Brimblecombe, Royal College of General Practitioners and Senior Partner, Newnham Walk Surgery, Cambridgeshire
4. Mr Nick Evans, Director for Partnerships, West Herts NHS Trust
5. Dr Andrea Franks, Consultant Dermatologist, Countess of Chester Hospital, Chester
6. Mr Andrew Langford, Chief Executive, Skin Care Campaign
7. Dr Graham Sharpe,Consultant Dermatologist and Clinical Director of Dermatology, The Royal Liverpool and Broadgreen University Hospitals, Liverpool
8. Dr David Shuttleworth. Vice-President, British Association of Dermatologists and Consultant Dermatologist, Essex Rivers NHS Trust
9. Rhona Woosey, Primary Care Development Manager, Directorate of Service Modernisation and Primary Care, Selly Oak Local Health Group

Appendix IV: Index of previous APPGS Reports

1. An Investigation into the Adequacy of Service Provision and Treatments for Patients with Skin Diseases in the UK (March 1997)
2. Enquiry into the Training of Healthcare Professionals who come into contact with Skin Diseases (July 1998)
3. Enquiry into Fraudulent Practice in the Treatment of Skin Disease (December 1999)
4. Enquiry into Skin Diseases in Elderly People (November 2000)
5. Enquiry into Primary Care Dermatology Services (April 2002)
6. Enquiry into the Treatment, Management and Prevention of Skin Cancer (January 2003)
7. Enquiry into the Impact of Skin Diseases on People's Lives (July 2003)
8. Dermatological Training for Health Professionals (August 2004)
9. Enquiry into the Adequacy and Equity of Dermatology Services in the United Kingdom (March 2006)

Appendix V: Officers of the APPGS

1. Bruce George MP, Chair, APPGS
2. Frank Cook MP, Vice-Chair, APPGS
3. Cheryl Gillan MP, Vice-Chair, APPGS
4. Baroness Masham of Ilton, Vice-Chair, APPGS
5. Lord Henley, Treasurer, APPGS
6. Paul Burstow MP, Secretary, APPGS