

Challenges in commissioning dermatology services

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The provision of dermatology services in the English constituency of the NHS is currently the subject of widespread debate. Regular contributors include specialist dermatologists, primary care commissioners, practice-based commissioners, general practitioners (GPs) with a special interest (GPwSI) in dermatology and various patient groups (eg Skin Care Campaign, National Eczema Society, Psoriasis Association). Occasional contributions are made by various government agencies, (eg Care Closer to Home committee) and some lobby groups (eg NHS Alliance). Much heat has been generated, but little light. Current policy initiatives from the Department of Health (DH) may unintentionally conspire to reduce the availability of care for patients who require specialist services and this is of concern not only to specialist dermatologists but, more importantly, to patients.

The debate began in 2003 with the publication of the *Action on dermatology good practice guide* which described new models of care for patients with skin disease and involved a number of pilot sites.¹ Subsequent publications included *Implementing care closer to home – convenient quality care for patients Parts 1–3*,² *Improving outcomes for people with skin tumours including melanoma*,³ *Models of integrated service delivery in dermatology*⁴ and *Staffing and facilities for dermatological units*.⁵ All of these have embedded unifying themes: dermatology services should be provided in the community and in secondary care; they should be of high quality and demonstrably ‘fit for purpose’; access should be convenient for patients; there should be a seamless and invisible interface between primary and secondary care; and, most importantly, (at least for the commissioners) services provided should be financially sustainable.

More recently, ‘patient choice’ has been added to the list of essential service attributes, but this can only be exercised when the services of secondary care are required. For patients who are referred to a local intermediate care service, ‘choice’ is not an option. Where referral management centres (clinical assessment and treatment services (CATS)) have been introduced by commissioners, patients are not usually offered the choice of a specialist consultation; they may instead be diverted to a community provider (eg GPwSI, nurse specialist or third-party provider). There is nothing intrinsically wrong in

allowing patients to access care more conveniently or with other providers, who must be appropriately accredited, provided that the patient is able to make an informed decision; lack of explicit information usually prevents this.

Referral management centres appear to be financially driven; intermediate care (pre-choice, pre-tariff) can in theory be more cheaply delivered in the community. In practice, services run by GPwSI have been shown to be more expensive than specialist services so any savings may be illusory.^{6,7} There is also a real risk of destabilising local hospital departments as a result of loss of tariff income. If intermediate, community-based services can ‘cherry pick’ the more straightforward cases, local secondary care departments are left with a cohort of more complex patients whose cost of care cannot be met by the national tariff. Some commissioners now aim to divert up to 50% of dermatology referrals away from specialist units – no department could survive this loss of income. A survey by the British Association of Dermatologists in July 2007 showed that 64% of English departments were affected by local referral management centres, and 46% of these were aiming to move up to 50% of patients away from secondary care.

There is no doubt that secondary care provision will always be required for those patients who have serious life-threatening dermatoses, complex disease, and widespread inflammatory conditions that require hospital admission. It is not clear how these patients would be managed (or by whom) if all services were located entirely in the community. In addition, approximately 30% of current dermatology workload is now surgically based and re-providing operating facilities outside hospital would be wasteful and expensive. Specialist training for junior doctors and teaching of medical students would be difficult if all services were dispersed, and future research, which needs a critical mass of experts, would be severely compromised.

However, it is equally certain that much basic dermatological care could and should be provided by primary care physicians. Historically, GPs were able to deal with many common skin problems, and most still do so. About 15% of the population consults their GP each year because of a skin complaint and only 5% of these are referred to secondary care. So 95% of patients with skin disease are already dealt with in the community.

Interest in dermatology in primary care has been stimulated by the availability of postgraduate courses leading to an examined diploma (Cardiff, London and Glasgow) and the development of special interest groups such as the Primary Care Dermatology Society (PCDS) which now has several hundred members. Many members of the PCDS are now working as GPwSI in the community either instead of hospital-based dermatology units, with predictable consequences for capacity within these services, or in addition to their hospital-based commitments. The service they provide depends on their individual training and competencies but should be overseen by a consultant dermatologist. GPwSI are expected to maintain their professional development by attending regular sessions in a local dermatology department in secondary care and by holding a joint clinic at least once a month for discussion of difficult cases. Mandatory guidelines for the accreditation of GPwSI in dermatology have been published by the DH.⁸

The service works best when the GPwSI is an integral part of a 'whole system' service – the challenge lies in ensuring that the funding available is sufficient to ensure the viability of the component parts. The British Association of Dermatologists (BAD) has published guidance for those responsible for commissioning dermatology services in order to ensure that decisions are firmly based on the body of evidence which already exists.⁹

The situation has been further complicated by the development of practice-based commissioning (PBC). These commissioners are incentivised to develop new models of care; any savings made may be used to develop further services. Some PBC groups are large enough to commission an entire specialty service and 'willing providers' are invited to tender. Early experience in dermatology has not been promising. The BAD is aware of contracts awarded to providers who have no consultant dermatologists, and primary care groups whose members are part of the PBC group. The DH urgently needs to address these conflicts of interest.

Dermatology services are at the crossroads. The overwhelming majority of consultants support the development of appropriate community services which are convenient for patients, but nevertheless recognise the importance of main-

taining a service, training and academic base within secondary care. Without this essential dual provision, community-based services have nowhere to turn to for training, continuing professional development, and the diagnosis and management of patients with anything more than mild disease. The unforeseen consequences of conflicting policy directives from the centre may yet sink us.

References

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