LESSONS FOR THE NHS

COMMISSIONING A DERMATOLOGY SERVICE

BASED ON CASE STUDIES FROM ENGLAND

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Foreword

Dermatology as a specialty in the NHS has faced many challenges since the introduction of the Care Closer to Home agenda in 2007. Often seen as a Cinderella specialty by Trust managers and Commissioners we should remember that nearly 4,000 patients a year die from their skin disease. Unlike some of the other care closer to home specialties we do not have a finite number of care pathways for our patients, with many often suffering from complex health problems. There are no quick win solutions for Commissioners in transferring Dermatology care into the community. Fragmentation of care pathways between the community and secondary care services is common and worsens with the use of multiple community providers. Cherry picking in community services by some private providers diverts much needed investments into secondary care services, while creating further capacity issues for Trusts. The impact on education, teaching, training and research requirements between community, secondary and tertiary services can be marginalised when unyoked from Hospital Trusts.

The BAD* has had to tackle a number of commissioning decisions that affect access to care for acutely unwell Dermatology patients requiring treatment from secondary and tertiary services. These decisions have been made in isolation by Commissioners and without appropriate engagement with local clinicians and patients. The longer term effects of destabilization and risk to acute and tertiary care services is often overlooked by commissioners.

Communicating our values to all we work with is important. We will endeavour, unremittingly, to ensure safe and equitable care happens for Dermatology patients. We have been diligent and vocal in highlighting to management and Commissioners inadequacies in Dermatology service provision. There have been successes where we have elicited mediation and a re-think from Commissioners and providers. We have encouraged a willingness to engage in a dialogue about how to provide safe, high quality, patient-centered care. We will continue to criticise but seek to resolve poor commissioning practice.

This document does not play down the challenges we face but rather highlights our experience and the areas that must be confronted if we are to change how things happen. We all have a role to play in the process and previous attitudes and behaviours to commissioning must not continue. The BAD look forward to working collaboratively with the new Clinical Commissioning Groups to assist them with the commissioning process. Clinically-led commissioning provides us with a new start to make the difference for our patients. We all need this to work.

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* The BAD is a charity funded by the subscriptions and activities of its Members. Its objectives are to enhance teaching, training, research and the practice of Dermatology to improve patient care.
Executive Summary

This *Lessons for the NHS* document is written for clinicians, service managers and Commissioners to illustrate the complexities in commissioning and procuring services for people with skin disease. It informs on areas where common mistakes with commissioning often occur such as understanding and being able to describe clearly the services required, allowing sufficient time to run the procurement exercise and establishing adequate contract management arrangements once the contract is agreed.

Under the new NHS commissioning model proposed by NHS England ‘services will be clinically led, underpinned by clinical insight and must have a real understanding of the local healthcare needs of patients and the public’.¹ Clinical Commissioning Groups (CCGs) will have statutory obligations for obtaining advice from other health care professionals and involving patients and the public in these discussions.

“Clinical Commissioning Groups will also take over responsibility for funding, planning and procuring health services for their local communities. As part of this role they will have to justify the way in which they commission care for people with long-term conditions. Clear goals, monitoring and review, with effective challenge of providers (backed up with data) are axiomatic. But so will be exploration of new forms of contracting and risk-sharing to ensure that the effort of commissioning is worth the cost – a question we are still asking after two decades.”²

The British Association of Dermatologists (BAD) has been actively involved in providing advice on commissioning Dermatology services to its members, patients, Primary Care Commissioners and Health Scrutiny Committees (Local Authority). Equally we have challenged poor commissioning practice with a number of Primary Care Commissioners when this has been necessary. In order to reflect the extent of problems experienced with the commissioning of Dermatology services in England, the BAD has undertaken a series of case reviews on service issues dealt with by our Clinical Services Unit since 2007. A selection of these are presented as ‘Regional Case Review Summaries’ in the accompanying appendices of this document. Due to confidentiality and ongoing engagement with some of these service issues, the BAD has not disclosed the names of those parties involved or their local areas. Each case review summary has been categorized by a maximum of two service issue examples. The definition for each ‘Service Issue Category’ is also included in the Appendices.

**Acknowledgements:**

The outline and approach to this case study is based on ‘Commissioning a Community COPD services: Lessons learned for the NHS – Somerset PCT’ written in 2008 and updated in 2009. Due to the commonality of the problems highlighted, we have used the COPD case study as a foundation for our Dermatology case reviews and Lesson for the NHS document.
BAD ‘Top Tips’ for Commissioning Dermatology Services

This short guide presents ‘top tips’ for Commissioners, clinicians and service providers to meet the most common challenges in the commissioning. We consider these ‘top tips’ key to delivering high value, effective, and timely services which will support all Dermatology services and clinical pathways. These should be read in conjunction with the latest guide to Principles and Rules for Cooperation and Competition (PRCC, July 2010).


Commissioners

✓ Local service users and the public must be engaged and consulted at the outset of the commissioning process through to the provision of any new service(s).

✓ Consultation with local Dermatology clinicians is required to establish a clinical network to guide the development of a needs assessment, service specification and care pathways.

✓ Commissioners and service providers should have a joint understanding of what defines quality and value in Dermatology service settings which allows for a good patient experience.

✓ Consider if a competitive procurement process is the most cost-effective and sustainable way of improving care, or if a continuous improvement programme could be developed.

✓ If it is, consider the readiness of the local NHS to enter a fair competition and discuss locally what support might be available if needed.

✓ Consider the impact on integration and on NHS sustainability over the longer term (outside of 3-5 years) if the contract is won by a non-NHS provider.

✓ Ensure that responsibility for keeping the service up-to-date with best practice is built into the specification.

✓ Consider whether you wish bidders to bid for the provision of audit, research, education and training of primary and community care professionals.

✓ Use relevant benchmark data for evaluation with manageable criteria such as continuity of care for patients, equity of access across practices and localities, activity data from all levels of care.

NHS Clinicians

✓ Get involved in any local clinical network and actively work together with colleagues across primary and secondary care to consider how care could be improved. Use BAD resources to assist in these conversations.
✔ Plan for how you and your colleagues will listen to patients and engage them in not just self-management but also in service design, information provision and service evaluation.

✔ Campaign for investment in Dermatology care, demonstrating how it can meet Commissioners’ aims such as reduction in avoidable hospital admissions, shorter lengths of stay and care closer to patients’ homes.

✔ Maintain relationships with colleagues and be aware of who the decision-makers are: who is a CCG Commissioner, who is in the CCG and who is a GP with an interest in providing services.

**Potential Providers**

✔ Familiarise yourselves with the bidding process, particularly the scoring system, timelines and adjudication process.

✔ Get help early from people who have the appropriate skills sets in budgeting, data analysis, scenario planning, marketing, presentations, and make connections with key stakeholders.

✔ Review the Service Specification and decide whether it is appropriate to bid – does it fit with your organisation’s strategy? Do you have the resources to bid? What are the risks of not bidding, or not winning? Do you have the resources to deliver the service?

✔ If you bid, respond to the Specification as it is written in the final documents; seek any clarification using the formal processes.

✔ Try to start by thinking “out of the box”, without being restricted by knowing how things are done now or the implications for the use of NHS assets.

✔ Think about not just the written submission but also any other adjudication processes such as an interview. Who should attend? For what reason? Imagine what your competitors might do.

✔ Consider any unintended consequences such as what happens to the residual costs of providing an acute medicine service and therefore the total costs of the system if investment is removed from a local trust.

✔ Consider the distinctions between evidence and knowledge. Bidders should stress their expertise is not just in knowing the evidence-base of what works, which all providers can access easily, but also in their wider knowledge base e.g. of know-about (problems), know-why (the root cause of behaviours), know-how (to interpret policy and guidelines into practice locally) and know-who (who are the local stakeholders to engage) (ref: Prof Huw Davies, NIHR SDO).
Recommendations

- The Department of Health should consider developing clear standards which define community care. This should include the use of consistent terms to describe accurately what is meant by care outside hospitals or closer to home and how these services relate to those offered in specialist hospital facilities.

- The concept of local care also needs to be more effectively marketed and communicated, both nationally and locally by NHS England.

- Clear frameworks for adherence and demonstration of commissioning activities are necessary to ensure a consistent and transparent approach to procurement. The problems often faced have been due to the interpretation of the commissioning process and an opt out approach.

- While commissioning may be viewed as laborious and time consuming these activities should be viewed as a continuous process which informs service planning, design and improvement, whether as part of the provider contract or the monitoring responsibilities of the Commissioner.

- The development of a long-term, joined-up approach to data recording should be a priority for the NHS to ensure data sets are fit for purpose and can be mapped to care pathways across all service settings. This is particularly problematic for outpatient services where in the majority of cases procedure codes are not recorded by Trusts.

- Community services are Consultant Led services. Commissioners need to be aware there is a serious shortage of trained Dermatology Consultants in the UK.
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1. Introduction

Skin disease is common and distressing. It is estimated that of the nearly 13 million people presenting to General Practitioners with a skin problem each year in England and Wales, around 6.1% (0.8 million) are referred for specialist advice.

While there are well over 1000 dermatological diseases, 10 of them (eczema, psoriasis, acne, urticaria, rosacea, infections/infestations, leg ulcers and stasis eczema, lichen planus and drug rashes) account for 80% of consultations for skin disease in General Practice. Specially collected data from four specialist Dermatology departments in England show that specialists most commonly see people with skin lesions (35-45%), eczema, psoriasis and acne. There were nearly 4,000 deaths due to skin disease in 2005, of which 1,817 were due to malignant melanoma.3

Although it is the case that the commonest disorders are not life threatening, if not treated appropriately patients can suffer harm and longer term health problems. Many of the rarer and some of the severe common skin conditions have an associated morbidity and mortality thus early and accurate diagnosis is critical to suitable management. For those disorders that are not life threatening, the psychological impact on everyday life, work, social interaction and healthy living are substantial.

Unfortunately, Dermatology is often perceived as a quick win for Commissioners, with little understanding of the multidisciplinary nature of the care pathways, staffing and facilities required to treat acutely unwell patients with inflammatory skin conditions and skin cancer. This is in spite of recognized DH Care Closer to Home levels of care (see Figure 1) and community Dermatology service specifications which have been in use since 2007. In order to reduce unnecessary referrals to secondary care, we must remove intermediate levels of care from the acute setting to provide ‘one stop’, ‘see and treat’ services for patients. These services should see patients with mild to moderate skin conditions without complex co-morbidities and normally have a New: Follow up ratio of at least 1:1.5 to reflect this level of care. However this is often misunderstood by Commissioners with unrealistic reductions in referrals being demanded from secondary care. These discussions are usually not informed by accurate outpatient service data due to the large number of Trusts only recording new to follow up activity. Local Dermatology Consultants are also not consulted or asked to identify patients who could be treated or have their follow up care provided in the community. This process is essential in order to identify integrated care pathways across services and to agree local protocols for treatment.
1.1. Relevant documents

1. The Government’s White Paper *Our Health, Our Care, Our Say: a new direction for community services* (published 2006) proposed a planned shift of care closer to the patient and their community

2. *Implementing Care Closer to Home, Parts 1–3* (DH 2007) sets out the frameworks for delivering community based intermediate care services

3. *Revised guidance and competences for the provision services using GPwSI* (DH 2011) sets out the required accreditation requirements for practitioners and their services

4. The *Action on Dermatology: Good Practice Guide* describes the lessons learnt from 15 pilot sites of new models of care

5. The Dermatology Subgroup of the Long-Term Conditions Care Group Workforce team has recommended service models for Dermatology: ‘Models of Integrated Service Delivery in Dermatology’ Skin Care campaign (2007)

6. DH *Next Stage Review* 2008

7. DH *High Quality Care for All* 2009

8. BAD guidance for clinical management, commissioning and service standards

9. NICE guidance

10. *High Quality Care for Dermatology* 2012
2. Commissioning Dermatology Services

The new NHS commissioning model will be clinically led, underpinned by clinical insight and must have a real understanding of the local healthcare needs of patients and the public. Good commissioning support will help Clinical Commissioning Groups and NHS England to concentrate on the clinical and locally sensitive aspects of commissioning, making the best use of the resources available to the NHS for delivering improvements in healthcare.

Given the new focus on quality and outcomes for patients and the necessity to get best value from NHS resources, Commissioners will need to be able to describe clearly the services required, understand the skills and workforce capacity required to deliver proposed new services, identify and address past service design failures, allowing sufficient time to run the procurement exercise and establishing adequate contract management arrangements once the contract is agreed.

Previous mistakes in commissioning Dermatology services need to be addressed with clearer directions for adherence to commissioning and procurement activities (see Figure 2).

Figure 2: DH Commissioning Cycle
The BAD has carried out a series of case reviews where it has advised and/or challenged the commissioning of Dermatology services.

These reviews are not a formal evaluation, but illustrate some of the lessons that are important for clinicians, service managers and Commissioners in their roles and with their responsibilities in designing and managing local Dermatology services.

The common problems and mistakes arising from poor commissioning are discussed under their appropriate sections within the commissioning cycle (as demonstrated in Figure 2) to reflect the activities that should have been undertaken and demonstrated by Commissioners.

**2.1. Relevant documents**

1. DH Procurement Guide for Commissioners of NHS-funded Services (July 2010)
2. DH The Principles and Rules for Cooperation and Competition (July 2010)
3. NHS Commissioning Board: Better data, informed commissioning, driving improved outcomes: clinical data sets (December 2012)
4. NHS Commissioning Board NHS Standard Contract 2013-14
5. NHS Procurement Standards (May 2012)
3. Public and Patient Engagement

An inclusive design process must involve people with skin conditions across the spectrum of care levels, service user representatives, patient champions and all clinicians with both generalist and specialist expertise. The involvement of all stakeholders (including patients, public, service users, clinicians, health and social care professionals) is critical to not only inform the commissioning process but underpins the development and delivery of future service redesign and integrated care pathways; thereby ensuring that everything delivered is appropriate to local and individual need.

Commissioning considerations:

- The requirement for Commissioners to engage and consult with their local population has previously been carried out as token ‘one off’ exercises or not at all. This is in spite of the duty to consult under the NHS Constitution and Section 242 of the Health Act 2006.

- A patient survey or consulting with a minimal number of patients does not obtain the required level of engagement and service user feedback as part of reviewing service provision and service redesign.

- Local Involvement Networks (LINks), now Healthwatch, have often been previously overlooked by PCTs and not invited to participate in discussions or informed of proposed changes to local services.

- Asking public and patients if they would like their care provided closer to home as closed question does not provide enough information to make an informed response; we would all naturally say yes to this question. However, when proposals for how and where care would be provided are given, the answer to this question could change. Equally, not knowing who is going to provide a patient’s care also gives rise to concern.

- The NHS Commissioning Board published its planning guidance for 2013/14, which aims to help local clinicians deliver more responsive health services, focused on improving outcomes for patients, addressing local priorities and meeting the rights people have under the NHS Constitution. The proposed systematic capture of real-time patient and carer feedback and comments, as well as developing plans to gather public insight on local health services requires a generic framework for Commissioners and providers to use. Without this framework, the quality and consistency of obtaining public and patient feedback is open to interpretation, limited to a one off exercise and is inconsistent across regional areas. Patients and public should be assured of minimum demonstrable standards of engagement in their local services and what this will involve wherever they reside.

3.1. Relevant documents

1. The NHS Constitution (March 2013)

2. HealthWatch England (replaces LINks) http://www.healthwatch.co.uk/faq-page
3. The Mandate - A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015 (November 2012)

4. The Health Act 2009 includes provisions related to the NHS Constitution

5. The Health and Social Care Act 2012 also includes provisions related to the NHS Constitution

6. NHS Service Contract 2012-13 and 2013-14

7. Part 1 of Implementing Care Closer to Home: Convenient Quality Care for Patients (DH 2007b)

8. NICE clinical guideline 138 (2012). Quality standard for patient experience in adult NHS services

9. Department of Health: Essence of Care 2010

10. NHS Commissioning Board Everyone Counts: Planning for Patients 2013/14

11. NHS Confederation 2011: Patient and public engagement in the new commissioning system
4. Assessing Needs

A Needs Assessment exercise is a crucial step in service design and in the creation of a Dermatology Service Specification. This should not be ignored by Commissioners, irrespective of the procurement model. The reason for each CCG undertaking its own needs assessment is because as well as public health data, it should take into account local provision, geography, prevalence and incidence of skin disease. Local patients, clinicians, and managers must be involved in these discussions to ensure local representation and ownership of any resultant service redesign. Benchmarking against other NHS services must be comparative to the demographic needs and geographic access to services, for example London and the Northwest of England services would not be comparable.

Commissioning considerations:

- It is important to validate the activity data used in any baseline assessment so that an accurate local picture of skin disease trends is available. This must include all activity data (ICD 9) from local GP practices; existing community services providers and secondary care. An understanding of underlying local trends is essential for any evaluation of service impact, gap analysis, redesign and care pathway integration.

- As a majority of acute Dermatology care is provided in outpatient services where Consultants cannot record diagnostic codes (ICD 10), it is essential for Commissioners to review procedural activity (OPCS) with their local Dermatology Department(s). This identifies the types and severity of skin disease seen by the department, grading patients seen into recognized levels of care (primary, intermediate or acute care). Hospital activity for day cases and inpatient care must also be factored into these discussions.

- Patients with skin conditions often require management for existing co-morbidities and vice versa by their GP and a range of clinicians in the community and secondary care. These patients should be identified, as they impact on services as unmet need across the levels of care and other specialties.

- A majority of Hospital Trusts are on block contracts and only record new: follow up activity. This has implications for planning and redesigning services based on the actual need and costs for care across intermediate and secondary care pathways. Trusts often see increased patient activity outside of agreed contract volumes and will normally absorb the added costs. In not identifying these additional costs of care local health services budgets are flawed and have longer term effects on meeting local capacity and demand. Private providers will not give away free care.

- An important issue in Needs Assessment is health inequality. The baseline assessment should review access to care and outcome by locality, ethnic group, GP practice and age. The service should aim to reduce inequalities; this might require positive action in certain localities. This will also help to identify potential unmet need that consistently increases activity to both community and secondary care services.
4.1. Relevant documents

1. NICE Health Needs Assessment; practical guide 2005
2. Skin Conditions in the UK; a Health Care Needs Assessment 2009
3. Office of National Statistics; Population and Health and Social Care Data
5. NHS Commissioning Board 2012; Briefing 1: How does procurement fit with the different stage of Commissioning?
6. DH: A Simple Guide to Payment by Results (PbR) 2012
5. Review Current Service Provision

Current services (including primary care) require regular review to ensure they are adequate, appropriate and of sufficiently high standard to meet the needs identified in the Health Needs Assessment. Performance management of providers based on accurate data and information is an increasingly important element in the consideration of current service provision. Patient and population feedback and choice are also important elements to consider.

Commissioning considerations:

• Decommissioning is part of the ‘commissioning cycle’ and is the process by which certain commissioned (procured) services cease to be provided by the provider during the life of their contract. This may comprise all or some of the services provided by that provider. In this undertaking it is essential that Commissioners are able to demonstrate they have undertaken a needs assessment, provided extensive public, patient and clinician engagement, identified the risks by undertaking an impact and risk assessment which identifies potential destabilisation of other services, staffing resources required or transfers (TUPE), continuity of care patients and managing transitions along with associated costs. The activities associated with this undertaking are widely misunderstood by Commissioners and are too easily equated with making cuts rather than commissioning improved services.

• The decommissioning of whole acute outpatient services is not a viable option. Outpatient services treat acutely unwell patients with co-morbidities that generally require longer consultations and follow up care under a Consultant Dermatologist. Specialized treatments such as phototherapy, patch testing, 2 week waits for skin cancer, and immunosuppressant and biologic therapies require the clinical management and governance of a Consultant along with specialist nurses. There is general misunderstanding by a large number of Commissioners about Dermatology acute outpatient services and the infrastructure required to support the delivery of acute care and associated medico-legal implications.

• Contract renegotiation is often overlooked by Commissioners as a way of improving services. Commissioners fail to recognize that the removal of outpatient activity from the Trust without discussion warrants a service variation under the terms of the contract. Commissioners have often proposed removing between 45-92% of acute services into the community without any substantial review of activity or discussions with Dermatology clinicians about required care pathways.

• Commissioners should also remember that there is a balance between quality, costs and outcomes and if one is changed, this may impact on the others. So reducing costs may have impact on the outcomes⁴ that can realistically be delivered. When challenged by the BAD, Commissioners have been unable to justify how this change is going to save money or be of real benefit to local patients.

• Disinvestment and reduction in clinical and support staff by Commissioners and Trusts since the Care Closer to Home agenda continues to be short sighted. This is particularly a problem
in planning a workforce strategy that delivers the most effective pathways as they are likely to involve both community and hospital based providers. This is because some Dermatology treatment modalities will range across all levels of care. The exceptions are of 2 week wait services, patch testing, phototherapy, immunosuppressant and biologic therapies etc, as these require equipment and technology that is not easily (or efficiently) decentralised and best left in secondary care.

- The DH vision of reducing Consultant and Trainee numbers with the Care Closer to Home agenda was fundamentally short sighted and has in essence both diminished and deskillled the Dermatology workforce. The aftermath of this decision has resulted in a shortfall of Dermatology nurses and Consultants across England with not enough trainees coming up through the ranks to replace retiring staff.

- Community services and reductions in referral activity to secondary care service should not lead to a reduction of staff or skills. Community services remain under 18 week service rules and are Consultant led services (with the exception of GPwSIs) which require the same skilled intermediate grade staff. The clinic structures in the acute service also change with Consultants and nurses dealing with patients who have complex health needs. Commissioners need to recognize this and make adjustments to acute contracts to reflect longer clinical sessions for a smaller amount of patients being treated. Less means more in this instance.

- Moving care into the community does not equate to moving the skill set into primary care. Few GPs have developed a special interest in the full range of skin conditions commonly presented in their surgeries. Improved access to training for GPs is required in their generalist capacity at undergraduate and postgraduate levels to reduce unnecessary referrals to the community and secondary care services. The current GP training programme needs to be extended to accommodate training posts in Dermatology alongside the most common co-morbidities that affect the skin in adults and children, i.e. diabetes, rheumatology, alcohol, transplant patients, HIV, immunosuppressed patients, mental health, etc.

- The Care Closer to Home agenda has largely failed to grow the community level practitioner outside of the GPwSI and Dermatologist. Dermatology specialist services in community settings may also be delivered by NHS-employed staff such as nurses, non-Consultant career grade medical staff under the governance of a Dermatology Consultant and with support from Allied Health Professionals (AHPs), Pharmacists and Community Nurses who have developed specialised roles within these multidisciplinary teams. Further growth is needed to support better integration and facilitate self care management for patients.

- Cutting across all of these issues is the idea that shifting care closer to home and promoting choice and competition in the NHS is likely to lead to a more diverse and dynamic provider landscape. This has come with challenges for effectively managing and growing the workforce required to deliver this agenda - particularly as private providers will have to employ local clinicians or will be the clinicians themselves. In effect all that has been
achieved is moving care from one place to another with the current workforce. Additional providers from outside of the local area can create issues of quality and increase fragmentation of care pathways.

5.1. Relevant documents

1. Department of Health PCT Procurement Guide for Health Services June 2010
2. Department of Health Principles and Rules for Cooperation and Competition June 2010
4. NHS Standard Contracts
5. NICE Health Impact, Equality and Needs Assessments
6. Department of Health benchmarking toolkit
7. Association of Public Health Observatories The Spend and Outcomes Tool
8. NAPC/KPMG Commissioning Foundation Series: Good Governance for Clinical Commissioning Groups: An introductory guide
9. NHS Service Contract 2012-13
10. RCP Consultants working with Patients 2011
11. Part 1 of Implementing Care Closer to Home: Convenient Quality Care for Patients (DH 2007b)
12. Part 2 of Implementing Care Closer to Home: Step by Step guide to commissioning services using practitioners with a specialist interest (DH 2007b)
13. Centre for Workforce Intelligence: Medical Specialty Workforce Factsheet – Dermatology 2010
14. NHS Institute for Innovation and Improvement: NHS and Social Care Long Term Conditions Model 2005
6. Deciding and Agreeing Priorities

Services need to be examined to identify gaps in overall provision, quality, cost effectiveness and geographical distribution. National and local priorities need to be taken into account, when deciding on which services to commission or possibly decommission. Local Trusts may also have insufficient capacity to deliver both acute and community based services. It is vital that planned services have sufficient capacity to cope with fluctuations in demand, avoid duplication and ensure delivery of quality. Ongoing planning and monitoring are required. A dynamic understanding of future service demands is also required, using knowledge taken from a range of sources, and built around local outcomes.

Commissioning considerations:

• The scale of workforce development, organisational development and education and training needed to underpin new ways of working is often underestimated. Changing demographics makes new demands on staff. This in turn affects the staffing ratios that are needed to deliver effective, safe care. It also affects the skills, knowledge and experience that staff need. An analytical based workforce review is required as part of any service redesign. When conducting the initial gap analysis of services, Commissioners should also be consulting with service leads/managers at trust level to consider possible training implications across clinical pathways. The provision of high quality education and training must be a key consideration, for providers and Commissioners.

• It should be noted the HES figures do not accurately capture the activity of Dermatology Departments in England. This is particularly problematic where a Trust’s divisional budget and activity are recorded to one department, for example, surgery activity to plastics to receive a higher tariff. This undermines the work of the Dermatology Department and does not allow for the recognition of multidisciplinary care pathways or accurate planning of services both for the trust and Commissioners.

• Despite the reduction of inpatient bed numbers for Dermatology and moves to general wards (2 beds per 100,000 populations), there is still an increasing drive to reduce these numbers further. The reduction or removal of Dermatology beds from inpatient services is often decided without consultation with the Trust’s Dermatology Consultants and patients under their care. This is further complicated with some Dermatology Consultants also losing admitting rights to beds on general wards. Both the Trusts and Commissioners must ensure Dermatology patients have access to general ward beds and Consultants are able to admit patients under their care to wards. The BAD has challenged these decisions on the basis of service variation, breaches to the NHS constitution and duty of care.

• There is an increasing drive by Commissioners to pay outpatients procedures tariffs for day case activity. Commissioners are reminded that they must pay providers in accordance with PbR rules. Dermatology has a mandatory day case tariff and any variation will be subject to PbR rules under the NHS Service contract. A review of all day case activity is required by the
Commissioner and the Dermatology Department to identify anomalies and justify the reduction of any tariff. Equally, we would also surmise that a Hospital should be able to justify the costs of care it charges back to the Commissioner. A continuous review of activity is required from both parties, something which is not undertaken with great scrutiny.

- This is symptomatic of a wider problem, in that the current NHS national data sets do not properly reflect what is happening to patients. Government policy aims to provide more patients with better care without the need for a hospital admission. But valuable data that describes a patient’s diagnoses and treatment is significantly reduced when a service moves from an inpatient to an outpatient setting, and is lost entirely when it moves into the community. A majority of Trusts are on block contracts and only record new: follow up data for their outpatient services. Commissioners have used this incomplete data to redesign services and patient care pathways into the community.

6.1. Relevant documents

1. Royal College of Physicians (RCP): Consultants working with Patients 2011
2. Royal College of Physicians (RCP) Report 2012: Hospitals on the edge? The time for action
4. BAD/RCP Audit of the provision of Dermatology services in secondary care UK: with a focus on the care of people 2008
5. Audit Commission Report 2011: By definition Improving data definitions and their use in the NHS: A briefing from the Payment by Results Assurance Programme
7. Designing Services

Many of the biggest opportunities to improve service outcomes and patient experience lie in the way individual services fit together. Service design or redesign requires both clinician and service user involvement in mapping, measuring and improving systems and pathways of care. Services can be clarified or changed, or a new service may be required to meet the identified needs or to drive best evidence based practice and to deliver cost-effective services. Changes will result in a service specification being created with quality measures which form part of the NHS service contract.

Commissioning considerations:

- There are some key questions to consider, such as: can changing the location of care act as a catalyst for developing completely new models of delivery, and will redesigning services lead to more convenient and cost-effective settings? Although moving care closer to home has been a policy ambition for some time, referral rates to both community and secondary care services have continued to rise since its inception, and there are worrying signs that primary care is buckling under the current pressures of demand.\(^5\)

- Integrated care pathways—also known as coordinated care pathways, care maps, or anticipated recovery pathways—are task orientated care plans which detail essential steps in the care of patients with a specific clinical problem and describe the patient's expected clinical course.\(^6\) This is a significant area of service design that Commissioners repeatedly fail to understand leading to the fragmentation of services and access to the right care setting for patients over the longer term.

- It is common-place for Commissioners not to engage local Dermatology Consultants in service redesign discussions and in drawing up the new service specification. Consultants must be involved at the outset of the commissioning process to identify required integrated care pathways and those patients with complex health needs. Not all care can be delivered in the community or by intermediate grade clinicians.

- Recognised Dermatology care pathways across the levels of care become fragmented under Any Qualified Provider (AQP), even if these services are provided by local clinicians as private or independent providers. In the majority of cases the cost of care remains the same per head of patients as the acute hospital service. This does not factor in the additional costs of the patient who is often lost on the referral highway in-between their GP and community service providers before accessing secondary care.

- Most new providers focus on well-defined and predictable clinical interventions, such as discrete episodes of surgery or inflammatory skin disease in otherwise well people. But for the more complex patient with a number of health issues, separating out treatment for different conditions in a piecemeal way, or referring on to secondary care is counter-productive to overall efficiency and results in unnecessary referrals to secondary care (allows ‘cherry picking’ by providers).
• There will always be a cohort of patients with acute skin conditions and co-morbidities requiring treatment and admission to hospital. It is important to remember that Hospitals, and those who work in them, have a duty of care and responsibility to ensure that the needs of these patients are represented and met. This is often overlooked by senior Trust managers when faced with meeting unrealistic demands from Commissioners to redesign services or attempting to decommission an existing service. Any proposed transition of care needs to be discussed with patients before any changes to contracts and decommissioning of an existing service takes place.

• Specialised Adult and Paediatric Dermatology services are for patients that require complex investigation, diagnosis, management of rare and severe diseases that are not suitable for, or not responding to, conventional treatments. These cases usually require multi-disciplinary input with access to specialised Dermatology facilities. Commissioners need to understand the critical clinical interdependencies between service frameworks and recognized Dermatology care pathways at an acute and tertiary level. The destabilization of local tertiary care services will have lasting consequences for service provision in surrounding areas.

• Outpatient services within University Hospitals will treat both acute and tertiary level patients across multidisciplinary specialties. The tendering of outpatient services which support Acute and tertiary level services to a private provider will lead to the destabilisation of the Specialist Skin Cancer MDT and failure of skin cancer Peer Review, loss of the Mohs surgery service and National Specialised Commissioning Service Capacity for vulval disease, psoriasis and eczema. This has further implications for trainees and medical student teaching for Dermatology.

• Service Specifications are one of the most important parts of the NHS contract, as they describe the service being commissioned and can, therefore, be used to hold the provider to account for the delivery of the services. Unclear service specifications in contracts are the cause of many legal disputes. For this reason, it is essential that the service specification is clear, correct and complete. Ultimately, it is not going to be possible to show that the provider has failed to deliver the service within the terms of the contract if the obligations placed on the provider are unclear.

• There is a general lack of understanding about community service (intermediate care) and the more complex acute care provision provided by a Dermatology outpatient service. Some Commissioners are replicating expensive acute based treatments and facilities as additions to community intermediate services, without identifying actual need and actual cost. These acute treatments still need to be retained by local acute Trusts to provide care for patients with complex health needs.

• Community based services still provide specialist care at an intermediate level and are provided as Consultant led services complying with the 18 week rules, or by a GPwSI with ongoing accreditation and appraisal from a local Consultant. Commissioners often mistake
these services as primary care services, and as such do not require these to be Consultant Led or have the appropriate governance and supervision.

- We advocate the use of clinical networks, involving Commissioners, providers and service users from health and social care, working together to create multidisciplinary services that best meet the needs of the people who use them. This would ensure that consistently good services are available to all who need them and also supports expert commissioning as a driver for service improvement.

- Terms in Specifications such as “specialist” and “integrated” need better definition if bids are to be compared fairly, and the service evaluated appropriately, as they have been open to wide interpretation by Commissioners. “Specialist” relates to certain competences required to manage the care of a patient supported by a relevant qualification and or accreditation or experience. This is an issue of quality control and patient safety. ‘Integration’ is often used in service specifications without care pathways being appropriately identified or agreed with local clinicians. Integration is a word that is used often in commissioning Dermatology services, without any substance. How would you monitor or know a service was “integrated” if you are unable to identify relevant clinical and care management pathways?

- One of the hardest challenges in commissioning is recognising and planning for interdependencies; not only between different disease areas for patients with comorbidities, but also between different services within an acute Trust. However, it is important to bear in mind when agreeing the scope of a specification, that many people with skin disease have comorbidities, and depending on what services are included in the specification, there will be “knock-on” effects on other diagnostic and specialist services.

- There is a need for improved education of GPs and Commissioners about the impact of skin conditions on individuals and the time and treatment implications for primary care. For those with more complex or rare skin conditions it appears to be largely a matter of chance as to which pathway they follow, with the fortunate ones progressing fairly directly to see a specialized service either in the community or in secondary care. Patients often receive unnecessary treatments and delayed access to care by not being referred by their GP or being referred into a community service.

- GP to GP referral schemes (unless this is to an accredited GPwSI service) are not in the best interest of patient care and cause longer term harm by delaying accurate diagnosis and treatment the first time. Delaying access to acute care increases the cost of care to the NHS. The quality outcomes for patients under these schemes have been largely unchecked by Commissioners and are not quality assured or audited by specialist clinicians.

- The recognition of NICE guidance in designing a community service is often seen as an option rather than a requirement for community service specifications. The monitoring and assessment of providers against relevant NICE clinical guidelines, particularly where Any Qualified Provider (AQP) exists, is often overlooked. This is in spite of the NHS Litigation
Authority *Risk Management Standards and Assessment*, which have been developed to reflect issues arising in negligence claims reported to the NHSLA. Within the general Standards, one criterion relates specifically to how organizations utilize NICE guidance (Standard 5, Criterion 8: *Best Practice – NICE*). Non-compliance with NICE guidance opens up both Commissioners and Providers to litigation, if clinical guidelines have been breached and a patient should come to harm.

- The underlying principles of all good governance (Financial Reporting Council 2010) are accountability, transparency, probity and focusing on the sustainable success of an entity over the longer term. If the NHS is to succeed in managing its budget, there must be a greater financial accountability at all levels. Service risk arises from not understanding the cost of care and having budgets which do not meet the demand for local care. Financial risk management must be a central facet to the ongoing reforms and providing quality care for all.

7.1. **Relevant documents**

1. NHS Commissioning Board: The new Operating Model for commissioning specialized services
2. NHS Commissioning Board: The Commissioning Intentions 2013/14
3. NHS Commissioning Board; A3B Dermatology specialized service specification
4. NHS Commissioning Board: B3A Skin Cancer specialized service specification
5. NHS Commissioning Board: Strategic Clinical Networks – Cancer
6. NICE clinical Guidance and Quality Standards (Skin Cancer, Psoriasis, PUVA, PDT)
7. Skin Cancer Peer Review Measures 2012
8. NHSLA Risk Management Standards and Assessment
10. Monitor’s Quality Governance Framework
11. The Kings Fund: Can competition and integration co-exist in a reformed NHS? July 2011
12. The Kings Fund: Lessons from experience – Making Integrated Care Happen at Scale and Pace March 2013
14. Cancer Peer Review
8. Shaping the Supply and Contract

It is important that CCGs identify suitable and responsive providers that they can commission healthcare services from. They also need to ensure that where adequate provider choice does not exist, a strategy is in place to help address this, taking account of areas of the population where there is poor health experience, access or outcome and workforce capacity. The contracting process should ensure that formal agreements with all providers (community and acute services) are in place, and that these contracts clearly set out what is expected from both the Commissioner and the provider.

Commissioning considerations:

- Commissioners often do not have a good enough understanding of the relevant markets they need to engage in before tendering for new services. Some Commissioners start the formal process too early in the procurement process without conducting sufficient research to clarify their requirements beforehand. For example, in some cases the Commissioner has cancelled tenders due to a lack of provider interest, or providers have pulled out due to the proposed service being unviable. This creates significant uncertainty in the market, discouraging some providers from participating and increases costs for the tax payer.

- Evidence from the care homes market suggests that in the absence of effective market engagement, commissioning behaviour can be informed by mistaken perceptions of suppliers’ capacity, views, and motivations. Market engagement involves engaging directly with potential providers, and gathering accurate information to inform discussions.⁷

- In some cases Commissioners and procurers may be focused on short-term price to the detriment of quality, longer-term value and economic growth. In other cases they appear to be very price-insensitive and instead more focused on particular aspects of ‘quality’, for example, being comfortable with the people they are dealing with.

- Commissioners do not always design the best procurement process for the task. EU procurement rules seem often to be interpreted in a highly prescriptive way or not at all. This can lead to perceived restrictions driving procurement activity, rather than the process being driven by the procurement objectives.

- If there is a good, effective and integrated, patient-centered service, then there is no particular reason why a Commissioner would choose to use a competitive process to improve care. Certainly, the overwhelming paperwork created by such activity, and significant number of person-hours spent by the Commissioners and bidders is often not financially effective. This is particularly wasteful when appointed providers decide they cannot provide the service after a delayed service commencement date (six months) allowed to start the new contracted service. Therefore it is important both Commissioners and potential NHS providers check that they can provide a good, effective, integrated and patient-centered service.
• The standard time for tenders under EU law is six weeks, and NHS providers will need to have bid processes in place to cope with this. It would also be helpful if Commissioners could either avoid periods when many will be away on pre-planned holidays or perhaps build in an extra week or two. Some Commissioners may wish to issue the specification early, as part of the Memorandum of Information (MOI) stage in recognition of the tight timescale and time of year.

• NHS providers do not have the levels of support in bid preparation that the commercial sector does. Bid preparation requires financial modeling and marketing, but also in thinking “outside the box”. A commercial provider works up a bid from a zero-base: it may not have local fixed assets like buildings or equipment that it has to use; it has no staff in post (although there will sometimes be TUPE rules to consider if the same job is offered). Unfortunately a number of providers are being appointed on this basis; in spite of being unable to fulfill the service terms of the contract and provide a safe service to patients.

• Three to five years is a short period in the life of either a practicing clinician or a patient with a long term condition. Therefore service contracts for this period can seem insufficient. However, if a contract is won by a new provider, then three to five years is sufficient time for the NHS provider to have lost the capability to bid again when the contract is renewed. This may be less true for the private sector that may have a central resource to draw on for bid development and recruitment.

• When a service specification is developed, the overall aim may well be couched in a management target-driven language that is off-putting for some clinicians. This commissioning language, of outcome-based commissioning, quality targets and incentives will be an increasingly frequent element of service requirements and contracts, which is the core business for Commissioners. Therefore it will be important for Providers – both clinicians and managers – to become familiar with the language and engage with each other on a regular basis.

• We have also noted a trend by Commissioners for appointing private providers (usually local GPs who have formed a Limited Liability Partnership) over a bidding local Trust. This is regardless of the Provider being able to fulfill the contractual obligations for the service. We would suggest in these instances there is a direct conflict of interest for the Commissioner and other procurement models should be used to avoid this practice.

• The PbR tariff structure currently over-compensates for simpler conditions and consistently under-compensates for more complex and unpredictable areas of care. In order to encourage integrated working, consideration should be given to moving towards a system in which payments are received, not for single episodes of care, but over the longer term (e.g. annually or by pathway). Tariffs should be mapped to care pathways and procedures agreed across the levels of care.
8.1. Relevant documents


2. Procurement guidance for Commissioners of NHS Funded Services July 2010

3. NHS Confederation Procurement Procedure - "a toolkit"

4. Cooperation and Competition Panel: The Implications of Competition Rules for the Unilateral Conduct of Providers of NHS-funded Services, 22 March 2013

5. DH Code of Conduct for Payment by Results in 2013-14

6. DH Payment by Results Guidance for 2013-14

7. Care Quality Commission (CQC), Outcome 4 states that: “Healthcare organisations should reduce the risk of people receiving unsafe or inappropriate care, treatment and support by taking account of published research and guidance”

8. The seven principles of public life, called the ‘Nolan principles’ were published in 1995 by the Committee on Standards in Public Life

9. NAPC/KPMG Commissioning Foundation Series: Good Governance for Clinical Commissioning Groups: An introductory guide
9. Managing Performance

There is a danger in contract monitoring, of simply collecting what is easy to count rather than what is required. All too often providers are required to collect lots of data because monitoring the outputs is usually easy to count and collect. Too much of an emphasis on measuring outputs can mean that all we report on is how busy the service is, rather than how effective it is. Commissioners and providers should identify those areas that require review, taking into account the reporting requirements set out in the Quality and Information schedules of the NHS contract. Commissioners also need to agree immediate consequences for failure against service quality outcomes and performance. Agreed outcomes should show that the provider is making a difference.

Commissioning considerations:

• The Department of Health’s current procurement guide for Commissioners makes it clear that all Commissioners must use the standard NHS contracts provided by NHS England for all NHS funded services they commission. An important area for Commissioners to get to know and understand is performance monitoring and performance management. The standard NHS contracts contain detailed processes that must be followed when raising performance issues. These provisions set out what notices must be served, along with any requirements for meetings, remedial plans, exception reports etc. There are also provisions allowing the Commissioner to withhold or retain payment, which is a useful contractual lever.

• There is little point in negotiating robust contract terms if these will not be enforced by Commissioners. Many parties assume that to use contract management tools is overly aggressive. However, they often come to regret that approach when problems become very serious or persistent and there is no track record of contract management to justify more severe contractual action. Of greater concern are responses received from Commissioners about not holding information in relation to the monitoring of the contract when clarification has been sought under FOI by the BAD. Using these contract management tools properly will help to ensure transparency and that service outcomes are achieved.

• Previous resistance by PCTs to look into service issues with private providers, particularly those who are GPs who have formed an LLP company, when raised by the Trust and the BAD has been commonplace. Issues with private providers having adequate and skilled staff in place to provide a Consultant Led service are not unusual. Private provider service information and the clinicians providing these services are often not advertised on NHS Choices or the Commissioners own website. Agreed monitoring protocols and enforcement clauses are not used by Commissioners when problems are highlighted.

• The major impact of procurement from the private sector on local services and resources will require qualitative, not just quantitative, evaluation. Our hypothesis is that national guidelines and consensus are not available for every situation or may not be easily sourced by Commissioners, and therefore local clinician engagement is necessary to support local
needs assessment, service design and service pathway development. There is the potential for a loss of intellectual property, expertise and goodwill from the NHS if this is not acknowledged and respected.

- Whilst the BAD advocates integration, the challenge is to define measures that could be used to evaluate the impact of a new service. That is, will the new service lead to more or fewer steps in the care pathway?

- One of the invisible attributes of a NHS service, particularly a specialist one, may be intellectual advancement. That is, keeping up with new evidence and contributing to it through audit and research. If that is not in the specification, then it is unfair to ask the provider to demonstrate this. However, evaluation of the impact of awarding the contract to a locally untested provider ought to capture whether there is active engagement in research and development, since the NHS requires there to be an active R&D programme.

- If the conclusion of a market testing exercise is to remove investment from a local acute Trust, or not to make an additional investment, then what happens to the residual costs of providing an acute Dermatology service and therefore the total costs of the system? Evaluation needs to capture this.

- There needs to be continued investment in Consultant posts (1 per 64,000 of the population) to ensure clinical governance across all care settings. Commissioners are equally responsible for encouraging Trusts to invest in the right skilled workforce for local service provision. Clinical networks should be developed so that all Consultants work within teams and have the support of colleagues.

- Specialist Dermatology Nurses enhance patient care, but provision of specialist nurses is variable with a median of 1.5 WTE per Dermatology Unit. Disappointingly, one in five departments has no specialist nurses due to lack of investment in this staffing resource by Trusts. Better integration with community services cannot be achieved without investment in Dermatology nursing expertise.

9.1. Relevant documents

1. NHS Commissioning Board: 2013-14 NHS Standard Contract


3. NHS Commissioning Board Commissioning for Quality and Innovation (CQUIN): 2013-14 guidance

4. NHS Procurement Guidance for NHS funded services: contract management
10. Unintended Consequences of System Change

In a whole system, any change will create consequences; some may not be foreseen or intended. If a Commissioner initiates such a change it will need to model consequences in advance; and identify the “what ifs”. The NHS has gained experience in different procurement models, yet it continually fails to anticipate a full range of consequences from repeated mistakes with commissioning. Failure to capture, record and disseminate findings of poor commissioning decisions is common-place.

- The guardian of NHS funds is the Commissioner. Plurality of providers means that some NHS money will be spent on non-NHS Providers for the public good. However, there are some cost factors that should be considered. For example, if there is a financial incentive to reach targets e.g. reducing referrals or follow-up outpatient care, which the provider achieves, then the financial reward will use NHS money that will not necessarily be channelled back into providing services.

- A plurality of providers under AQP has not provided integrated care locally despite being a requirement of the Service Specification and contract. Fragmentation of care pathways is common with increasing issues of quality and clinical governance breaches. Providers need active management by Commissioners as part of their contract monitoring responsibilities. Commissioners have largely taken a ‘hands off’ approach and will not address quality issues when raised by the BAD, local clinicians and patients.

- The provision of informal training, mentoring and research are often not documented or costed. There is a risk that the NHS will stop providing these if provider management does not draw attention to them and to their value. The Commissioner needs to factor in the values for these activities by including them in the Service Specification.

- For people with long term conditions, self care and self management have become increasingly important in improving well-being, maintaining independence and quality of life. However, for Dermatology this has not largely been achieved. There is too much expectation on patients managing their own care.

- In reality, the role of GPs is increasingly complex as they can play a role both as provider and Commissioner, and there are, therefore, potential conflicts of interest. It will be important for national policy on how this will be managed to ensure transparency in dealing with the problems already highlighted in this report.

- Commissioners have a responsibility to commission sustainable services that will support people over their lifetime of chronic illness. It is hard to see how a 3-5 year contract can achieve this and suggests that such a procurement process is problematic for long term care.
References

1. NHS Commissioning Board - Developing commissioning support: Towards service excellence 2 February 2012

2. Nuffield Trust Commissioning High Quality Care for People with Long Term Conditions Research Summary March 2013


4. NICE (2013) Clinical Commissioning Group Outcomes Indicator Set
   www.nice.org.uk/aboutnice/cof/cof.jsp


Appendix 1: Definitions for Service Case Review Categories

Commissioning

Commissioning is the process of ensuring that care services are provided effectively and that they meet the needs of the population. Where this category is indicated this will usually mean the following commissioning activities have not been undertaken by Commissioners (see Figure 2):

- Assessing the needs of a population;
- setting priorities and developing commissioning strategies to meet those needs in line with local and national targets;
- securing services from providers to meet those needs and targets;
- monitoring and evaluating outcomes; and
- the above combined with an explicit requirement to consult and involve a range of stakeholders, patients/service users and carers in the process.

When dealing with local service issues, the BAD requests documentary evidence from Commissioners to support all of the above areas.

Contract Management

Contracting is the means by which the procurement process is made legally binding along with monitoring the success of that service. This category will be allocated to service issues where there are problems with the contract being fulfilled by the appointed providers. This can include problems with Commissioners failing to appropriately monitor the provider’s performance and address breaches to the NHS Service contract.

Decommissioning

Decommissioning is the process by which certain commissioned (procured) services cease to be provided by the provider during the life of the contract, which may comprise all or some of the services provided. Changes in the service specification and how services are delivered requires the Commissioner to decommission services and exercise their right to withdraw from the contract to commission alternative services.

For example, reconfigurations/redesign of services may mean the service cannot be delivered in accordance with the contract terms or demand significantly increases/decreases beyond the contract/provider’s capabilities and/or capacity to service.

Commissioners must assess the risk for potential destabilisation of other services, managing staff reductions or transfers, failure to fully realise commissioning benefits, continuity of care
and managing transitions. Alternative commissioning approaches can deliver the same goals as decommissioning.

**GPwSI Accreditation**

This category indicates problems with the required training, accreditation and facilities for GPSI clinics and the service they provide. Commissioner’s press ahead with GPwSI services despite a lack of local Consultant resources to provide the training and ongoing accreditation, leading to breaches in patient care, clinical governance and access routine clinical audit. The costs associated with GPwSI service are often not identified by Commissioners before drawing up the service contract.

**Procurement**

It is helpful to contrast the terms ‘procurement’ (purchasing) and ‘contracting’ with commissioning, as a common confusion is to assume that commissioning relates only to procuring services from external suppliers. Procurement has been defined by the Audit Commission as ‘the process of securing or buying services’.
Appendix 2: Regional Case Review Summaries

The following case review summaries have been allocated a maximum of two ‘Service Issue’ categories where relevant. The definition for each category is provided in Appendix 1.

East Midlands

CASE 1  
**Start date:** 28/09/2012  
**End date:** ongoing  
**Action Taken:** Advice

**Service Issue: GPwSI Accreditation**
A local Clinical Commissioning Group (CCG) has pressed ahead with setting up a Dermatology clinic with one newly qualified GPwSI who has no previous practical experience. They have requested supervision assistance from all three Consultants in the area with one of the local Consultants offering to let the GP sit in on a couple of his clinical sessions. The Consultants have sent a response to the CCG to confirm they are willing to help but the GPwSI and service must meet all the accreditation requirements. The CCG have since issued a service contract to the GP for the community service which the Consultants have raised concerns about and are addressing to ensure this meets required accreditation frameworks.

East of England

CASE 2  
**Start date:** 26/08/2011  
**End date:** ongoing  
**Action Taken:** Advice & Challenge

**Service Issue: GPwSI Accreditation and Decommissioning**
The local PCT would like integration between its community service which is staffed by a GPwSI and another Practitioner with a Special Interest. There were some concerns raised over the governance for the Practitioner with a Special Interest. One of the local Dermatology Consultants has agreed to assess the Practitioner with a Special Interest and provide additional training.

The Trust also met with their PCT Commissioner to discuss current service agreements and proposals for further reductions to its Dermatology service tariffs. The PCT indicated it would tender the whole outpatient service if reductions to tariffs were not met to reduce its Dermatology budget by £150,000. Referrals from this PCT represented approximately 40% of the Trusts Dermatology income. The BAD worked with the Trust to identify potential cost savings which were submitted to the PCT. The Trust thought they had reached an agreement with the PCT for their savings plan (not the full 150K) but were subsequently told by the PCT it would be seeking the full savings in Dermatology over the next year or would put the service out to tender. The BAD assisted the Trust with challenging this decision. The PCT was asked to clarify whether it was seeking a contract renegotiation or intending to decommission the Trusts outpatient service. Either scenario required due process to be followed and demonstrated by the PCT. The cost of the GPwSI service was also equal to Trusts Dermatology service (per head
of patient) and cost reductions were not being sought from this service. The PCT consequently withdrew its plans and asked Trust to develop appropriate clinical pathways and identify actual costs where savings could be safely made.

**CASE 3**

**Start date:** 27/01/2010  
**End date:** 20/12/2010  
**Action Taken:** Advice & Challenge

**Service Issue: Decommissioning**

Trust Management at a local hospital made the decision to cease providing a Dermatology service as of September 2010 without appropriate consultation. This seemed to be as a result of unsuccessful recruitment exercises after the previous Consultants had moved to other posts. A neighbouring Trust entered into negotiation with this local hospital to arrange clinical sessions to ensure Dermatology patients in the area continued to receive local care. Another Trust in the northernmost catchment area of the local hospital, was also made aware that they may need to provide additional clinical sessions. Unfortunately, this service issue was further complicated due to the tender for management of the local hospital and one of the PCTs in the area trying to redesign community services on already limited resources. Trusts in the nearby areas providing clinical sessions were also concerned about the cost and future security for the additional Consultant post required to permanently support the local hospital. The local PCT agreed to ‘underwrite’ half of the post in this regard and a Consultant was appointed into post. The management of the local hospital was also successfully awarded to a new provider; with reassurances from them they would not be decommissioning its Dermatology services.

**CASE 4**

**Start date:** 25/03/2011  
**End date:** ongoing  
**Action Taken:** Advice & Challenge

**Service Issue: Procurement and Contract Management**

Concerns over the quality and integration of an appointed private provider service were raised by Consultants at a local Trust. The BAD wrote to the Commissioner under the FOI Act requesting information on the governance arrangements for the service as it was unclear whether this was a GPwSI or Consultant Led service. This was clarified by the shadow CCG commissioner as a GPwSI services with mentorship by a specialist. The service operates on average for 3-4 days per month and the outcomes for the service focus on waiting times and referral numbers to secondary care rather than the number of clinics provided. The BAD continues to question the value of procuring such a service which has limited scope to run clinics and is not reducing referrals to secondary care. There are also issues of integration with acute services and the use of a GPwSI and specialist clinicians to provide accreditation from outside the local area. Further discussions with the Trust and Commissioners will be undertaken to look at governance, patient’s complaints, better integration and service design.
CASE 5  
**Start date:** 09/09/2009  
**End date:** ongoing  
**Action Taken:** Advice & Challenge

**Service Issue: Commissioning and Procurement**
A local SHA requested their PCT tenders as many community services as possible due to previous lack of investment in this area. A Vision meeting was held with stakeholders where issues were raised with the proposed care pathways for Dermatology. Commissioners were not aware of the NSF for children and the relevant NICE guidance for children’s Dermatology e.g. eczema. This local area has one of the highest rates of genetic skin disorders which can mimic eczema. GPs referral rates are in the lowest deciles (12 per 1000 of the population compared with national rates or 10–21 per 1000). 50% of the areas patients or parents and their families are in the most deprived categories. The resulting Needs Assessment did not factor in this information despite this being pointed out to Commissioners. They decided to apply estimates of prevalence using statistics from the Skin Disease Needs Assessment (Schofield 2009).

The proposal for the procurement model then took some years to come into fruition with a Prime Contractor model being agreed in 2012. The BAD attended a market engagement for bidders in July 2012 and was made aware through the PCT presentation that none of the previous issues above had been addressed. The BAD challenged the PCTs on undertaking the required commissioning activities to inform the service design. A letter requesting documentary evidence of commissioning activities under the Freedom of Information Act (FOIA) proved failings by the PCT since starting the commissioning process in 2008. During the course of these discussions the PCT tendered for a Prime Contractor with two of the three bidders pulling out of the process. The tender has been withdrawn until July 2013. The BAD has written a further letter requesting previous failings and lack of public consultation are addressed before any further tender proceeds.

CASE 6  
**Start date:** 14/03/2008  
**End date:** ongoing  
**Action Taken:** Advice

**Service Issue: GPwSI Accreditation and Commissioning**
A local PCT commissioned a Clinical Assessment Service (CAS) without any consultation or input from the Trusts Dermatology Consultants. The CAS service used three GPwSIs and occasionally a Nurse Practitioner. All GP referrals for Dermatology except two week wait referrals passed through this service. Referrals were made by the CAS to a variety of providers: the Dermatology department, GPwSI clinics and GPwSI’s doing minor surgery sessions and GPs who do minor surgery. The three GPwSI’s were appointed with the help of the Dermatology department and do a monthly clinic in the hospital to deal with diagnostic or therapeutic problems. The PCT also appointed GPwSI minor surgeons independently of the Dermatology department, who had no specialist training in skin surgery and skin cancer management. The most troubling problems arose from this latter group, although there were also a number of cases from the GPwSIs trained by the Dermatologists where serious skin cancers have been misdiagnosed, mismanaged or both. These concerns were raised at the skin cancer network meeting by
Consultants where a list of nine patients who have been seriously mismanaged by the surgical care pathways arrangements implemented by the PCT were discussed.

CASE 7  
**Start date:** 01/01/2008  
**End date:** 11/04/2008  
**Action Taken:** Advice & Challenge

**Service Issue: Commissioning and Procurement**
A PCT tendered for new Dermatology service that aimed to either replace existing hospital based NHS services or push the hospital service into providing their service at a significantly reduced income. These decisions and actions took place without patient or public consultation. This was challenged and a patient meeting was organized to discuss potential changes in service delivery for Dermatology services. It was attended by the BAD, Skin Care Campaign and local Dermatology Consultants.

A meeting was also held with the PCT and Trust where the Consultants put forward their proposal to provide community Dermatology which was accepted under 'Any Willing Provider'. The Trust was the only applicant and was awarded the contract. However the PCT wrongly advised the Trust they may tender for additional providers at any time. Market engagement had it been undertaken, would have indicated there was only one provider and as such to advertise under a single tender action. The PBC groups were also keen for the Trust to be the sole provider and would not allow the service to advertise in a health service journal; however the PCT wanted to ensure 'competition and diversity'.

**London**

CASE 8  
**Start date:** 04/11/2011  
**End date:** 27/07/2012  
**Action Taken:** Advice & Challenge

**Service Issue 1: Commissioning**
Two PCT Commissioners in the London area made the decision to commission 50% fewer new patient attendances and 50% fewer follow up visits in the next financial year from its local Trust. The Trusts managers agreed to this reduction in activity without discussing this with their Dermatology Consultants or identifying the patients this would affect. The Consultants had already been working closely with the PCTs to try and help move acute care into the community but the staffing capacity to deliver this was much greater than anticipated. There was also to be no 'policing' of the reduction in referrals by PCT Commissioners, who expected the GPs to do this themselves with no formal barriers to the GPs referring as before. If the Trust continued to see patients outside of these agreed New to Follow up rates they would not be paid. The Trust proposed the Consultants review all GP referral letters and refer patients not requiring urgent acute treatment back to their GPs. A meeting was arranged with the PCT, Consultants, Trust management and the BAD to discuss the problems with what was being proposed. The PCT agreed to allow the Trust to review its current activity to identify patients suitable for treatment in the community as due commissioning process had previously not been undertaken. Community clinics were to remain at one per fortnight until care pathways and
workforce capacity could be identified. There continued to be no drop off in GP referrals despite all the PCT promises to address poor referral practice by some GPs.

**CASE 9**

**Start date:** 01/06/2010  
**End date:** 06/01/2011  
**Action Taken:** Advice & Challenge

**Service Issue: Commissioning and Procurement**

In August 2010 a London PCT contacted the BAD to enquire if a Consultant representative would be available to sit on their Clinical Advisory Group for developing skin cancer pathways and their community Dermatology service. This was in spite of the PCT's community Dermatology service already being out for tender for a preferred provider. There were significant concerns raised at this point by the BAD over the PCT commissioning process, activity levels proposed for the community service and care pathways along with a lack of consultation with local Dermatology Consultants and patients. Further discussions over the removal of 2 week wait services were challenged on the basis of breaches to NICE skin cancer guidance, failure to be able to meet peer review requirement and destabilisation of the acute service and skin cancer SSMDT. During these discussions the local Trust bid for the community service and won, however discussions around the service specification lead to further proposals for the whole outpatient service to go out into the community along with skin cancer two week waits. The service site which was stipulated by the PCT as part of the contract was wholly inadequate to provide an outpatient service. Trust Managers also supported this move into the community without appropriate discussions with Consultants to identify issues of NICE, governance issues and appropriate service settings for patients. The BAD wrote to challenge the PCT on this decision and breaches to commissioning given the lack of Trust management support and safety issues for patients. This led to acute outpatient treatments and 2ww remaining with the Trust with intermediate Dermatology service being provided in the community.

Contractual complications arose between the PCT and Trust over the community service care pathways. An audit of referrals was undertaken as the PCT felt too many patients were being referred to secondary care according to it estimated figures in the service specification. An audit provided by a BAD appointed independent Consultant revealed there were some cases which should have been seen in the community but not at the numbers estimated by the PCT. The BAD offered to work with the Trust to identify care pathways and look at realistic numbers for the community service based on a review of acute activity data as part of their contract renegotiations; however this was ignored by the Trust. The contract was terminated shortly afterwards and the service was retendered without the previous commissioning issues still not being addressed by the PCT.
CASE 10

**Start date:** 20/08/2012  
**End date:** ongoing

**Action Taken:** Advice & Challenge

**Service Issue: Decommissioning**

NHS London service reconfiguration of A&E departments has had repercussions on a Local Trusts Dermatology service. A local PCT has used this opportunity to tender for single providers of outpatient services in each of the care closer to home specialties, including Dermatology. This includes whole acute outpatient’s services which will be provided in the community with providers being encouraged to bid for more than one specialty where possible. The site for the service has not been specified by the commissioner and could lead to outpatient services in these specialties being provided in a number of locations across the borough with fragmentation of care pathways for patients with co-morbidities. The BAD advised the Trust to challenge this decision based on breaches to the process for decommissioning of their services and risk to patient care. The PCT also failed to discuss the TUPE arrangements for staff prior to tendering, and there has been no patient consultation or risk assessment for the proposal. The PCT cannot use the service reconfiguration and consultation for A&E closures to commission new services without appropriate engagement. The PCT has since withdrawn the tender to consider its options and this is now on hold.

CASE 11

**Start date:** 16/06/2009  
**End date:** closed

**Action Taken:** Advice & Challenge

**Service Issue: Commissioning and Procurement**

A PCT advertised for Expressions of Interest for the provision of a new community Dermatology service in June 2009 under Any Willing Providers. The submission date for AWP documentation was extended and re-extended until April 2011. There was no consultation or engagement by the PCT commissioner with local providers prior to the tender being advertised. This is the third time the PCT had tendered for a community Dermatology service and changed the specification of the service from a single preferred provider model to AWP. After speaking to three members of the CCG Pathfinder Group it became clear there had been no significant engagement with them over commissioning this service or the tender.

The model proposed by the PCT did nothing to improve the accessibility for patients, and proposed the triaging of referrals be undertaken by a GP with a Specialist Interest in Dermatology. The PCT stipulated that the service must be provided in one of two designated PCT sites and was unwilling to allow providers to explore other options (such as GP surgeries) that may be more convenient for patients. All surgery was also to be undertaken at one site which will be much less convenient for patients.

Many of the CQIN and quality outcomes were poorly thought out and unachievable. The volumes expected to be seen in the community were unrealistic and out of line with national experience. These were 60% in the first year (40-50% is more realistic) rising to 80% by year 3 when 'Education provided by the Service will lead to a decrease in overall referrals to CCAS and into the community service for non-complex patients'. Experience actually suggests that
education increases the visibility of the service and the tendency of GPs to refer more Dermatology patients.

Providers were incentivised to restrict the availability of urgent appointments. The PCT stipulated onward referral rates to secondary care of 1% or less, where nationally presented data suggest that 6% is achievable with Consultant triage of referrals.

On challenging the PCT commissioner it would appear that the people charged with sorting out the tender had already left the organisation but the tender still went ahead with the two of the local Trusts putting in a bid. The AWP contract was awarded to one of the local Trusts and a private provider with no links to any local secondary care service. An FOI was issued by the appointed Trust in relation to the private provider not having an appropriately qualified Consultant Dermatologist on the Specialist Register as specified by the service contract. Two other doctors listed as clinicians by the private provider were described as GPwSIs, but were unable to provide evidence that they had completed training and accreditation as GPwSI. This private provider had a history of not having appropriate staffing in place and this contract was also terminated shortly after they were appointed. It should be noted the PCT appointed this private provider over a highly regarded teaching hospital because it failed to meet ‘Access criteria’ in its bid by wanting to start its morning clinics at 8.30am instead of 8.00am.

**CASE 12**

**Start date:** 18/02/2009  
**End date:** 23/09/2009  
**Action Taken:** Advice & Challenge

**Service Issue: Contract**

In 2008 a PCT commissioned community Dermatology services from two clinical assessment and treatment service (CATS) private providers. The services began operation in July 2008 with all referrals to the services made via the PCT’s referral management centre (RMC).

As a part of the work of the Cancer Network Tumour Working Group it was recommended that an audit of the skin cancer related pathology received from primary care should be undertaken to ensure that IOG guidelines were being followed. This audit identified concerns in the management of patients both in primary care and within the local CATS. A report of these findings together with recommendations, were sent to the Chief Executive of the PCT. In response to this the CE of the PCT commissioned the Cancer Network to undertake an Independent Review of the patients that had been identified as having skin cancer and managed via the CATS service.

The review evidence revealed that cancer patients’ journeys had been delayed because 2WW referrals were not being used appropriately and waiting lists for the CATS. There was a possibility that SCCs and MMs were being knowingly operated on by CATS, contrary to the service specification requirements. There was evidence of poor excision margins in surgery undertaken by CATS. An inadequate excision was done of a malignant melanoma which is a serious clinical failing if malignant melanoma had been suspected clinically, and required further investigation. There was greater concern expressed about one CATS provider. The
service was suspended by the PCT. Due to the extent and seriousness of the issues identified by the reviewers it was recommended that further action were needed to address the issues identified.

A multidisciplinary steering group was set up by the PEC chair and had its first meeting on 18th June 2009. This included Consultant representatives from the BAD. An audit of all Dermatology patients treated by the CATS providers since service commenced in July 2008 until the services were suspended was carried out and reviewed. There were no missed cancers identified in the review. The CATS services were suspended by the PCT in April 2009. Since then all Dermatology referrals from GPS have been assessed by the Consultant Dermatologist at the Trust. The PEC felt that one of the providers had effectively withdrawn from CATS provision due to their lack of response to the PCT’s request for evidence of their potential to improve their services. The PEC recommended that the current patient pathway involving the Consultant Dermatologist at the local Trust should continue and the contract with the remaining private provider being terminated.

CASE 13

Start date: 21/11/2012    End date: 30/03/2013

Action Taken: Advice & Challenge

Service Issue: Contract

A Clinical Commissioning Group (CCG) and a local Trust agreed care pathways for an integrated community service provided by GPwSIs and supported by its Dermatology Consultants. The CCG then decided to start providing phototherapy and patch testing services without consultation with the Trust or its patient and outside of the agreed community service specification. The Commissioners proposed that the GPwSIs could be trained to provide phototherapy and patch testing services so they could cut costs in this area. The BAD helped draft a letter for the Trusts Medical Director to challenge this decision, highlighting governance and safety issues for patients. The letter also challenged the CCG on their proposal pointing out the training requirements for phototherapy and patch testing (more than a two day course) and requested documentary evidence under the FOIA to determine that due commissioning process has been followed by the CCG commissioner. A further letter re-emphasising the breaches to clinical governance, service standards and use of inappropriately trained staff was sent from the BAD Clinical Vice President. The South East Phototherapy Network was also informed as it was proposed that they would provide the governance for the service without prior discussion, along with the CQC’s Registration Manager for the area. Consequently the CCG commissioner withdrew its plans for patch testing and phototherapy treatments and returned the equipment purchased its supplier.
North West

CASE 14  
Start date: 30/06/2009  End date: 30/10/2011  
Action Taken: Advice & Challenge

Service Issue: Commissioning and Procurement
A local PCT decided to tender for an ICATS service and appointed a private provider made up of local GPs over the local bidding Trust. The Trust bid failed on the basis they did not provide enough education, despite providing training for GPwSIs. There was no public and clinical consultation over the decision to set up the ICATS or due commissioning process undertaken by the PCT. The appointment of the private provider raised questions over conflicts of interest particularly with the only medical representative on the selection panel having shares in the private provider company.

The appointed private provider had never run a community Dermatology service before and had no Dermatology Consultant in post prior to being awarded the contract. Recruitment exercises for local Dermatology Consultants were unsuccessful and the private provider went on to appoint a Locum Consultant who was not on the GMCs Specialist Register. As community Dermatology services are Consultant Led services under the 18 week wait pathway, there was no appropriate governance provided for the service or staff. Consultants at the local Trust became concerned with the quality of community skin cancer referrals and undertook a pathology audit of the Locum Consultant’s surgical excisions. Out of 100 excisions only 50% met NICE skin cancer guideline criteria and four excised lesions were for melanoma. Concerns were flagged up with the PCT and the ICATS provider who gave reassurance that this practice would be rectified but still continued to use the same Locum Consultant. The PCT then decided to extend the Dermatology ICATS and commissioned a second service without consultation despite an enquiry about its previous failings in this area. The local Dermatology department bid for this service and was appointed as a provider.

The private provider continued with its service over the three year contract period despite a number of clinical governance issues being raised. They were not reappointed for this service but went on to provide another service in the local area, where the same problems previously highlighted continued without being addressed.

CASE 15  
Start date: 11/03/2010  End date: ongoing  
Action Taken: Advice & Challenge

Service Issue: Commissioning and procurement
In April 2010, the BAD were approached by a local PCT to provide clinical advice for the final version of their community Dermatology service specification. The service was tendered sometime in May 2010 under a competitive tender and a private provider made up of local GPs was appointed over the local bidding Trust. In December 2010 the BAD wrote to PCT commissioner to seek reassurance that the staffing and governance issues with this private
provider’s previous service had been addressed. The BAD was informed that the private provider and PCT commissioner were in the contract negotiation phase of the procurement process and could not respond due to confidentiality.

The BAD wrote to the PCT commissioner again in May 2011 raising concerns under the FOIA, and in June 2011 requesting an internal review. We received a response to our questions in July 2011 and whilst this did not provide specific details, it went someway to reassure the BAD that contractual processes were in place to monitor the service. In February 2012, the BAD was contacted by concerned Consultants and patients in nearby Trusts, who advised that the service offered by the private provider did not appear to be consistently Consultant Led. The problems previously raised by the BAD appeared not to have been corrected and would therefore indicate breaches to the NHS Service contract along with contract management issues.

In May 2012, the BAD wrote to the Chief Executive of the interim NHS local area Cluster which had been formed in preparation to the abolition of PCTs in 2013. We received an unsatisfactory response from the Cluster and sought an internal review under the FOI which again failed to provide the information requested in any detail. The BAD referred the matter onto the Information Commissioners Office as a complaint under the FOIA but received limited information from this exercise, with the Cluster stating they did not hold any information on the private provider’s service. This is in spite of mandated requirements for managing the NHS service contract by Commissioners with providers having to demonstrate progress against agreed performance milestones. The Cluster and its Board should have assured themselves that the services commissioned met appropriate levels of safety and quality. This has not been demonstrated throughout the FOI process and highlights the Clusters failure to be able to transparently meet its contract management responsibilities.

**Case 16**

- **Start date:** 04/09/2008  
- **End date:** 16/06/2010

**Action Taken:** Advice & Challenge

**Service Issue: Decommissioning**

Dermatology services at this Trust were provided via a hub and spoke model with the local Foundation Trust acting as the Hub, and providing the majority of the Consultant workforce to the Trust. Problems with the level of Dermatology provision at the Trust occurred early in 2009 due to staffing arrangements and increased referrals. The Trust then decided to decommission its Dermatology service for its 900,000 population and the service was closed to all new referrals. This happened without formal consultation with local PCTs, clinicians, patients and neighboring Trusts. There was no interim arrangements made for patients already receiving care and requiring follow up appointments. A crisis meeting between the BAD, the acute Trust and the PCT was held with the Trust agreeing to continue to see 2 week wait referrals. However, this was also stopped with the Trust decommissioning the skin cancer MDT later on in 2009.

The capacity issues already being experienced within the surrounding area were further exacerbated by the decommissioning of Dermatology services by this Trust. A regional Pan
Workshop was hosted by the local PCTs’ Association, the Commissioning Business Service, British Association of Dermatologists and the Skin Care Campaign. The purpose of the workshop was to develop a model for the future delivery of Dermatology services, to address local issues and to make the most efficient use of the available workforce.

Further work was undertaken by local area PCTs and Trusts in the surrounding areas to try to improve the level of Dermatology service provision across the sector. Referrals were directed to one of the Trusts with dedicated capacity which had been established to deal with overflow. On exhaustion of this capacity, referrals were then directed to other providers across the sector, dependent on the patient’s postcode. However, these Trusts soon refused to accept referrals due to capacity issues, leaving patients unable to access services locally. While access to services has been improved across this sector, patients from the decommissioned service area still have problems accessing Dermatology care. Patient transport services or hospital taxi services are used to ferry patients to 2 week wait available appointments in neighbouring Trusts.

**South Central**

**CASE 17**  
**Start date:** 17/01/2011  
**End date:** ongoing  
**Action Taken:** Advice & Challenge

**Service Issue: Commissioning**  
The BAD has provided advice and reviewed a local PCTs proposed service specification for their Dermatology service. However undertaking the necessary commissioning process to identify need and care pathways was largely not taken on board.

A private provider was appointed by the PCT over the local Trust and community provider who bid jointly to provide the service. The PCT insisted on a competitive tender despite the BAD advice for a single tender action given the remote locality and limited provider market. After a six month delay to the start date for the new service, the private provider (from another regional area in the UK) forfeited the contract as they were unable to find staff to provide the secondary and community services. It was also unclear how their only Consultant who was in another county was going to provide governance for the service given the travel distance and their other work commitments in another service. The PCT Commissioner then had to retender under a single tender action to appoint the Trust and community provider. There are still issues with the care pathways and governance of the service but arrangements are being discussed with other local area Trusts to provide Consultant sessions. Skin cancer services remain a problem given the previous fragmentation of service pathways which are being discussed with the local Cancer Network.
CASE 18  

Start date: 17/01/2011  
End date: 08/02/12  

Action Taken: Advice & Challenge  

Service Issue: Commissioning  

A local PCT contacted the BAD for advice on the commissioning of GPwSI services as part of its community service plans for Dermatology. This lead to further enquiries by the BAD over the PCTs proposed service specification for both community and acute services which had not been signed off by the current provider due to a number of problems with the proposal. Confusion arose with the proposed service specification for the community and acute service which had been written up jointly under one contract. The performance measures and requirements for each service differ and require separate service specifications and contracts. Essential information which is required for the service specification such as population demographics, activity data and agreed care pathways for each service had not been included, indicating the commissioning process had not been undertaken by the PCT.

The removal of acute activity for the community service had also not been identified as part of current contract negotiations with the Trust. This was important for the acute service redesign discussions which were also being undertaken for the Trusts three sites. Proposals for acute services were not aimed at meeting demographic need but more about distributing patient’s numbers evenly across these three sites. The PCT signed off the Dermatology service specification for its community service and acute service respectively with its current provider. However, it also decided to pursue its proposal for training and accrediting seven GPwSIs for each locality area, despite the BAD and Consultants raising resource concerns. This proposal proved unfeasible given the resource capacity required of local Consultants to train this number of GPwSIs and provide ongoing accreditation.

During these discussions the BAD also had to write to the Trust seeking clarification over the proposed closure of the Dermatology department inpatient beds. The Trust did not undertake appropriate consultation with its Dermatology patients or inform their local Health and Overview Scrutiny Board. The PCT Commissioners also had not assessed the impact and appropriateness of the Trusts service change, in respect of an individual and the overall local population with skin disease. As almost 50% of the Trusts patients came from outside the local PCT area we sought clarification on what consultation and impact assessments had taken place with neighboring PCTs. This resulted in process being halted and an inpatient bed meeting held with Consultants and service users, where proposed changes to the services were presented and discussed. The new service arrangements included a day case unit being set up at the Trust to provide better access to emergency resources with 24 hour coverage agreed. The service was to be staffed by Consultants and Dermatology nurses.
South East Coast

CASE 19  
Start date: 19/10/2010  
End date: ongoing  
Action Taken: Advice & Challenge

Service Issue: Commissioning and procurement
The BAD has been involved in the ‘task and finish group’ with a local CCGs proposed Integrated Care Organisation (ICO) for Dermatology services. Through this interaction we became concerned over the manner in which existing Community Dermatology Services had been previously procured by the outgoing PCT. The BAD entered into significant correspondence with the PCT and new CCG commissioner; but felt it had not been provided with sufficient evidence show that the appropriate procurement processes had been followed. As the Commissioning Lead for the CCG considered the matter to be closed, we felt that we have no alternative but to raise this issue with the PCT/CCG Board.

Our concern related to whether flaws in the procurement process could have exposed the PCT to challenge, and our desire to ensure that future procurements conducted by the CCG avoided these risks. One of the key features when considering suitability of AQP is whether patients will be in a position to exercise choice of provider following completion of the process. Whilst the PCTs 2009 AWP process successfully appointed 3 providers; we were not satisfied that appropriate market engagement was undertaken prior to running subsequent AQP processes to appoint further providers. We are concerned that the 2010 and 2012 AQP schemes were conducted on different grounds to the 2009, placing new entrants at a disadvantage compared to the incumbent, whose contract was not renewed at that time.

Whilst not all procurements will need to be formally advertised, and some contract variations can be managed without a full procurement, the CCG has a duty to comply with the principles of fairness, transparency and non-discrimination. We were concerned that the unintentional consequence of decisions taken in relation to Dermatology services had resulted in services being delivered by a single supplier under the AQP model, without adequate reassessment of the local market, restricting patient choice. The CCG confirmed that in its prior re-advertising of Dermatology services there was no provider interest. This should have indicated to the CCG that an alternative procurement approach was more suitable to the specific service offering (for example a single tender action, or restricted procurement for a different service).

It was important for the CCG and its Board to understand the implications for procuring and contracting services outside of procurement rules. The CCG and Board must be able to demonstrate due process at all times so as not to open itself up to challenges by potential providers or investigation by Monitor.
**South West**

**CASE 20**

**Start date:** 18/09/2009  
**End date:** ongoing

**Action Taken:** Advice

**Service Issue: Commissioning**

A local PCT contacted the BAD for advise on its community service specification after its local Dermatology Consultants raised some issues with the quality of service and patient safety. The BAD reviewed the service specification and advised this needed to be supported by review of local hospital activity with Dermatology Consultants to identify the numbers of patients and care pathway for this level of service. The review was also required for both service planning in the community and as part of managing existing contracts with secondary care. Clarification was also provided on the difference between a GPwSI services and a Consultant Led community Dermatology service.

The local Trusts decided to planning to bid as one group as they already undertook a number of community clinics and decided to building on these in their AQP bid.

However there continued to be a number of concerns raised with the PCTs approach to commissioning, patient engagement in the process and the use of AQP. The timescales allocated for the procurement exercise were felt to be too short resulting in a letter from each of the hospital Chief Executives to the PCT disputing the plan to tender these services under AQP.

The local Trusts went on to withdraw their bid for the community service under AQP. They were unwilling to provide clinical support to multiple providers which included accreditation to appointed GPwSI services. The local Health Overview Scrutiny Committee referred the Trusts concerns about lack of consultation in the commissioning process and the risk of introducing a poorly integrated service to the Secretary of State.

The complaint has not been upheld by the Secretary of State as this was a procurement dispute but recommendations were made for the Commissioner to undertake the necessary consultation and provide an integrated service specification for the AQP tender.

**West Midlands**

**CASE 21**

**Start date:** 01/12/2011  
**End date:** ongoing

**Action Taken:** Advice & Challenge

**Service Issue: Decommissioning**

The BAD were contacted by Consultants and patients regarding the proposed service design for their community Dermatology service and closure of the outpatient department. In the interest of patient safety and ensuring the quality of care was maintained, the BAD sought clarification on the care pathways being proposed, and the continuation of acute care services. Further
reassurances were sought over the accreditation of the PCTs Dermatology GPwSI practitioners and services they provided, particularly those doing skin cancer surgery work. Prior to commissioning a service, the Trust and commissioners should work collaboratively to undertake a needs assessment, which includes a review of both hospital and GP activity, to identify appropriate Dermatology care pathways. Extensive public, patients and clinician engagement prior to designing any community service is a compulsory requirement of the commissioning process. It is important that both the PCT and Trust recognise their duty of care and continue to provide acute services to local patients who require specialist treatments, day and inpatient care. Any decision to decommission the Trusts Dermatology service in the longer term needed to be handled within a framework of clear accountabilities. Statutory consultation is necessary for any major change to existing service provision; i.e. relocation from a hospital setting of a significant proportion of non-acute general Dermatology outpatient activity into a community based service. A meeting was held with the BAD, Consultants, commissioners, a LINks representative and a patient to discuss the above areas which had not been undertaken. The Trust agreed to review its hospital activity to identify numbers of patients for the community Dermatology service, the PCT is also revisiting its service specification and engaging with Dermatologists and patients.

Yorkshire & Humber

CASE 22

Start date: 16/10/2011  End date: ongoing

Action Taken: Advice & Challenge

Service Issue: Decommissioning

The BAD were informed by local Consultants that their acute outpatient service had been decommissioned and the Trust discouraged from bidding for the new service. A community based acute outpatient service was put out for tender by the local commissioner. The service was awarded to a private GP provider with the new service provided in close proximity to the hospital. Subsequently, there proved to be a number of errors in planning, and conflicts of interest in the decision to commission and appoint the new service provider. A request, by the BAD, for clarification of the decommissioning process, and the planning undertaken by commissioners over the two year period, demonstrated a lack of insight into the requirements for providing an acute outpatient service and care pathways. The service specification produced was inadequate for a full acute outpatient’s service, and the different performance measures required for the service compared to an intermediate community based service. The hospital activity used in the service specification was inaccurate and clarification was never sort by commissioners, despite recommendations from the BAD. Consequently commissioners were unable to identify appropriate multidisciplinary care pathways for service users with more complex health conditions. The Trust also receives patient referrals for both acute and tertiary care from neighboring areas which represent up to 60% of its workload. There was no impact or risk assessment undertaken to look at the impact on the Trust services, it was presumed the Trust would simply shut the Dermatology department.
Outpatient service framework requirements and care pathways proved problematic for the private provide given the limited number of Consultants in post. This included provision for 2 week waits for skin cancer patients, as the private provider’s Consultant was not part of the LSMDT and could not provide the service without an honorary contract being provided by the Trust. Recommendations were also made by commissioners to refer patients to another regional area LSMDT rather than use the Local Trust. This included inappropriate referrals for reconstructive surgery for skin cancer patients outside of the local area, as the private provider did not have the required surgical expertise. The local Trusts Consultant did have the necessary multidisciplinary surgical skills to undertake this work. The PCT failed to take into account the relevant NICE guidance, governance and multidisciplinary requirements for providing outpatients services. The actions by the PCT Commissioner removed patient choice.

Issues persist with the care pathways and 2 week waits remain problematic and have not been progressed.