PURPOSE
Equality Analysis is a best practice method to demonstrate due regard to the general duty under the Equality Act 2010 to eliminate discrimination, advance equality of opportunity and foster good relations between people from different groups.

The purpose of an Equality Analysis (EA) is to examine the extent to which existing or proposed services/policies/strategies may benefit different members of the community and, where appropriate, prompt the consideration of adjustments to ensure that all equality groups benefit equally from what is being analysed.

RESPONSIBILITY
Responsibility for compliance with the CCG’s public sector equality duty rests with the author’s lead Director. Specialist guidance and support is, however, available from the Policy & Engagement Manager and the Director of Governance & Compliance.

Equality analysis must be carried out for all policies, strategies and service change proposals. Existing services can also be the subject of an Equality analysis to ensure the activity is having intended benefits for all equality groups.

CONSULTATION & ENGAGEMENT
Please note that early engagement is recommended and in many cases is necessary to develop policies, procedures, strategies or service changes. Please ask the Communications & Engagement Team if you would like help with this.

INSTRUCTIONS
• Complete the Equality analysis
• Insert the Summary at the front of all Policies and append the Equality Analysis, not including this page, at the end.
• Insert the Summary and the Equality Analysis, not including this page, into Committee and Governing Body Papers between Front Cover and Main Report to inform decision making.

1 Note: Different impact does not necessarily mean adverse (or negative) impact.
### SUMMARY OF EQUALITY ANALYSIS for the INTEGRATED DERMATOLOGY SERVICE

<table>
<thead>
<tr>
<th>EQUALITY GROUP</th>
<th>Negative Impact YES / NO</th>
<th>Positive Impact YES / NO</th>
<th>Key areas to address YES/ NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Disability</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ethnicity / Race / Ethnic Group</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Religion &amp; Beliefs</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Marriage &amp; Civil Partnership</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Carers</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Areas of Deprivation/Geographical Location</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Vulnerable Groups</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
CONCLUSION:

The new Integrated Dermatology Service will overall have a positive impact on the majority of equality groups and our requirements are adequately covered within the clinical service specification. However this Equality Analysis has prompted the need for some lines of enquiry (bidder questions) that are now required, so that the CCG can be adequately assured that the needs of minority groups have been fully taken account of in the provision of the new service.

There are seven specific groups where, although overall they will benefit positively from the newly designed services, there are some adjustments that need to be made. These are listed as follows:

1. **Age**

As the CCG is home to the University of Surrey in Guildford which contributes a large number of young adults to the population at certain times of the year, there could be an increase in GP consultations for specific skin conditions like acne. As such some of these are likely to generate onward referral for specialist dermatology services. Potential providers will need to ensure that provision is made for referral variations and also consider how to best address access and the availability of services for this group.

2. **Disability**

Evidence suggests that individuals with both learning disabilities and mental health problems are less likely to access specialist dermatology services for their skin conditions. This could result in reduced quality of life if conditions go untreated and a poorer prognosis of malignancies due to possible late detection. The new provider will be expected to demonstrate how they will promote and improve access to these client groups. Our requirements are for the majority of patients to have their assessments and treatment (if required) on a single visit, referred to as a ‘one stop shop’. We are aware that some patients with disabilities may find this approach difficult and providers may need to offer longer appointment times. The new provider would be expected to take cognisance of these groups and to be flexible as to the way care and treatments are delivered.

3. **Ethnicity / Race / Ethnic Group**

As the Gypsy, Roma and Traveller Community Traveller community are all less likely to register with a GP, they will be less likely to access dermatology services. The majority of patients are referred via GPs and therefore consideration needs to be given to open access clinics which look to target these adults and children whom have a range of skin conditions. This could result in reduced quality of life if conditions go untreated and a poorer prognosis of malignancies due to possible late detection. The new provider will therefore be expected to demonstrate how they will promote and improve access to these client groups.

4. **Religion and Beliefs**

There will be a requirement for providers to consider the needs of different religions and beliefs. Specifically, as the service will be providing
assessment and performing surgical procedures it will be necessary to comply with privacy and dignity policies including the provision of chaperone and interpreter services. Options for same sex doctors to treat patients will be a requirement of the workforce.

5. Carers

It is likely that some carers will be caring for both adults and children with long term and enduring dermatology conditions and may be struggling with compliance. This is specific area that needs addressing by providers as there is a perception amongst clinicians that effective treatments such as the correct application of emollients are not fully complied with.

6. Areas of Deprivation / Geographical location

As a large part of Guildford and Waverley is rural and public transport is under pressure to deliver savings we must ensure that this is taken account of when selecting the location of the Integrated Dermatology Services. It is recognised that the longer it takes to get to the service, the fewer people will undertake the journey.

Providers therefore must therefore consider the transport arrangements when selecting and proposing the sites, specifically considering those areas that are the most deprived within Guildford and Waverley CCG. Particular social groups at risk of exclusion include households without a car.

The incidences of DNAs for people residing in these areas should be actively monitored by the provider and actioned as indicated.

7. Vulnerable Groups

People who are homeless are likely to have a higher incidence of untreated skin disease and not access services in conventional ways. As these groups are particularly vulnerable the provider will need to find creative ways of providing and offering advice and treatments to this group.

8. Additional issues

There are some additional issues that the dermatology provider will be required to monitor where current information is not available to assist in improving clinical outcomes. These relate to

- Capturing information on gender in the take up of services.
- The links between different ethnicity groups living in G&WCCG with specific skin conditions.
- Identifying any young carers that come into contact with the service whom may need support.

RECOMMENDATIONS: Summarise the amendments that need to be made to prevent any identified health inequalities from arising or continuing with this activity. We need to work with our new provider to:

Rec 1 Seek transformational ideas for improving access to services by the young adult community attending the university of Surrey. Ask for
assurances as to how demand will be managed at certain times of year.

Rec 2 Seek assurances that people with disabilities can access services and services are delivered flexibly. Ensure that these patient experiences are captured within patient surveys and post appointments to ensure we can monitor the situation.

Rec 3 As with young people, seek ideas for improving access to services by the Gypsy, Roma and Traveller community whom are all less likely to register with a GP.

Rec 4 Seek assurances that people with different religions and beliefs are treated in accordance with such beliefs. Specifically ensure that privacy and dignity, chaperone service and same sex doctors are available to patients.

Rec 5 Seek assurances that both adult and child carers are provided with bespoke support to improve compliance with certain treatments.

Rec 6 Ensure that the agreed locations for the new service has taken full account of all potential access issues to include: individuals without cars/ those living in the most deprived areas and where transport linkages are poorest. The incidences of DNAs for people residing in these areas should be actively monitored by the provider and actioned as indicated.

Rec 7 Ensure that vulnerable groups, particularly homeless people, are treated promptly and given appropriate advice with regard to their skin conditions.

Rec 8 Ensure that systems are in place to record equality data where it is not available currently.
**NAME OF THE SERVICE/STRATEGY / POLICY / GUIDANCE/ SERVICE CHANGE PROPOSAL / PLAN (‘ACTIVITY’)**

<table>
<thead>
<tr>
<th>Who is this ‘activity’ aimed at? Please delete and explain further if relevant.</th>
<th>Patients/Public</th>
<th>Staff/Workforce</th>
</tr>
</thead>
</table>

**INTEGRATED DERMATOLOGY SERVICE**

**What are the main aims and objectives of the ‘activity’?**

To redesign the current provision of dermatology care provided across the Guildford and Waverley area. The main aim is to commission an integrated dermatology service which brings together the existing acute and community provision into a single service. This will feature a single point of access, a consultant led multi-disciplinary team working together to provide service as a one stop model of care where. In return this aims to improve both clinical and cost efficiency.

**Describe the current situation:**

NHS Guildford and Waverley CCG commissions 82% of acute dermatology care from the Royal Surrey County Hospital (RSCH) and the remainder from other acute providers. Additionally, Surrey Dermatology Service (SDS) has been providing a community dermatology service via a pilot contract which started in February 2014 and is due to end in September 2016. The commencement of SDS was predicated on a requirement by the CCG to see more patients being seen in community settings and a changed model of care (one stop shop) which was deemed more cost effective. There was also an assumption that activity previously undertaken in the acute service would move to this new service. While the community service has proved popular with local patients and GPs, it has not resulted in the desired activity shift from secondary care into the community, and pathways have not been as well integrated across community and secondary care as had been desired. Although it is clear that overall demand for dermatology services has risen, it is now recognised that achieving the desired changes to the model of care will require a different commissioning arrangement and change in the way services are organised.

The CCG wishes to ensure that the majority of dermatological conditions are managed in community settings and that access into the service is via a single point. In return this should reduce the level of duplication and aid clarity for referrals and patients as there will be a single integrated service.

**Clarify what exactly is being analysed:**

The impact of providing a fully integrated dermatology service which includes all activities (adults and children) with potentially malignant and non-malignant skin conditions. The only exceptions are those services which are eligible for primary care and tertiary provision.
Please describe what ENGAGEMENT AND/OR CONSULTATION that has taken place to inform this equality analysis?

There has been a range of engagement and consultation activities undertaken which have informed the dermatology Outline Business Case. It was not deemed necessary to carry out formal consultation as the service changes are not regarded as major. However, we have taken cognisance of the different needs across our communities of interest and asked them a range of questions about their experiences and improvement areas that they would regard as important. Listed below are the activities:

- Planned care was discussed in the PPE Forum - October 2014
- A dermatology patient survey was developed and distributed to practice patient groups and several specialist LTC groups - February 2016
- A dermatology GP survey was developed and distributed to all 21 GP practices in Guildford and Waverley - February 2016
- Dermatology was discussed at the PPE group – March 2016

Does the ‘activity’ described above already impact negatively or positively on different equality groups or would the activity:'

- Have a POSITIVE impact (benefit) on any of the equality or vulnerable groups? **YES**
- Have a NEGATIVE impact / exclude / discriminate against any of these groups? **NO**

**AGE**

**Analysis:** Refer to national evidence and data and then think about the local population and how people belonging to different age groups may or may not benefit from the ‘activity’.

The local population analysis is provided here; in essence it is considered that all age groups will benefit from this activity.

**Local Data**

There are two main sources of information on the number of people living in Guildford and Waverley CCG area - resident and registered populations. The resident population is the number of people living within the CCG area mapped to administrative boundaries; these are estimated using the 2011 Census data as a baseline and taking into account subsequent births, deaths and movements into and out of the area. The registered population is a count of the number of people registered with GP practices which comprise the CCG on a given date. The two populations usually differ due to GP practices overlapping administrative boundaries and ghost patients on GP lists. Below we provide both populations, broken down by age and gender, and identify implications for the CCG.

The total Guildford and Waverley CCG population is 207,772 and consists of approximately 102,725 (49.4%) men and 105,047 (50.6%) women. Approximately one quarter (24%) are children and young people aged 0-19 years. Almost 60 per cent (58%) are adults of working
age (20-64 years). Approximately a fifth (18%) are older adults, aged 65 years and over, with 3% of the population the very old, aged 85 years and over.

Table 1: Mid 2013 Estimate of Guildford and Waverley Population by broad age group and gender

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19</td>
<td>25,915</td>
<td>24,188</td>
<td>50,103</td>
<td>24</td>
</tr>
<tr>
<td>20-64</td>
<td>59,792</td>
<td>59,962</td>
<td>119,754</td>
<td>58</td>
</tr>
<tr>
<td>65 and over</td>
<td>17,018</td>
<td>20,897</td>
<td>37,915</td>
<td>18</td>
</tr>
<tr>
<td>85 and over</td>
<td>2,071</td>
<td>3,958</td>
<td>6,029</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>102,725</td>
<td>105,047</td>
<td>207,772</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 1 shows the resident population by gender and 5-year age bands (bars), compared to the population of England (outline). Guildford and Waverley CCG has a similar proportion of men and women compared to the English population, but the CCG age profile differs from the English one. The proportions for both men and women aged 25-34 are significantly lower than England while those for men and women aged 35 and over are higher in every age band, especially in adults aged 40-54.
Figure 1: Mid 2013 Estimate of Guildford and Waverley Population by 5-year age group and gender

Source: ONS

Note: ONS estimated resident population represents the number of people who live in that area at that time
NHS Guildford and Waverley CCG had a GP registered population of 220,804 as of April 2015, of which approximately 49% were men and 51% women.
### Table 2: GP registered population (April 2015) and CCG resident population (Mid-2013 Estimate) by broad age group and gender

<table>
<thead>
<tr>
<th>Age Range</th>
<th>GP registered population (April 2015)</th>
<th>CCG resident population (mid-2013 estimate)</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
<td>%</td>
</tr>
<tr>
<td>0-19</td>
<td>26,326</td>
<td>25,493</td>
<td>51,819</td>
<td>23</td>
</tr>
<tr>
<td>20-64</td>
<td>64,894</td>
<td>63,742</td>
<td>128,636</td>
<td>58</td>
</tr>
<tr>
<td>65 and over</td>
<td>18,015</td>
<td>22,334</td>
<td>40,349</td>
<td>18</td>
</tr>
<tr>
<td>85 and over</td>
<td>2,215</td>
<td>4,186</td>
<td>6,401</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>109,235</td>
<td>111,569</td>
<td>220,804</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: HSCIC and ONS  
Note: Registered population is the number of patients signed on with GPs at that time.

### Table 3: Projected Guildford and Waverley population from 2015 to 2025

<table>
<thead>
<tr>
<th>Age</th>
<th>2015</th>
<th>2017</th>
<th>2019</th>
<th>2021</th>
<th>2023</th>
<th>2025</th>
<th>2015 to 2025</th>
<th>% Change Guildford and Waverley CCG</th>
<th>% Change Surrey</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>37,500</td>
<td>38,800</td>
<td>39,700</td>
<td>40,300</td>
<td>40,600</td>
<td>40,800</td>
<td>3,300</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>15-29</td>
<td>41,400</td>
<td>41,900</td>
<td>42,200</td>
<td>42,200</td>
<td>42,600</td>
<td>43,100</td>
<td>1,700</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>30-44</td>
<td>39,800</td>
<td>39,200</td>
<td>39,100</td>
<td>39,500</td>
<td>40,000</td>
<td>40,200</td>
<td>400</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>45-64</td>
<td>53,200</td>
<td>54,500</td>
<td>55,500</td>
<td>55,900</td>
<td>56,200</td>
<td>56,500</td>
<td>3,300</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>65 and over</td>
<td>39,700</td>
<td>40,800</td>
<td>42,200</td>
<td>43,700</td>
<td>45,400</td>
<td>47,200</td>
<td>7,500</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>85 and over</td>
<td>6,500</td>
<td>6,900</td>
<td>7,500</td>
<td>8,000</td>
<td>8,700</td>
<td>9,300</td>
<td>2,800</td>
<td>43</td>
<td>43</td>
</tr>
<tr>
<td><strong>All ages</strong></td>
<td>211,600</td>
<td>215,200</td>
<td>218,700</td>
<td>221,600</td>
<td>224,800</td>
<td>227,800</td>
<td>16,200</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>
Table 3 shows that Guildford and Waverley CCG population is expected to grow by 8% in the next 10 years which is consistent with the Surrey average (8%).

The 30-34 age cohort is projected to grow less than Surrey average whilst those aged 65 and over will increase (21%). Within this age cohort, the number aged 85 and over is projected to grow 43%. However, the absolute number of those aged 85 and over continues to be a small proportion of the overall population of the CCG. The proportion of the population in all age groups aged 55 and over is projected to increase and the proportion of people in age group 15 to 29 is set to decrease.

**Figure 2: Guildford and Waverley Population projection 2015 to 2025**

The CCG has substantially fewer young adults than the English population with higher numbers at older ages indicating that the CCG is likely to have a greater preponderance of patients with developing or developed long term conditions in the working adult population as well as greater proportion of frail elderly than the English norm. However, the CCG is home to the University of Surrey in Guildford which contributes a large number of young adults to the population at certain times of the year, all of whom are encouraged to register locally for...
healthcare. The registered population for Guildford and Waverley CCG is appreciably higher than the resident population, possibly indicating an issue with list inflation.

**Conclusion:**

| Positive |

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

In line with the data analysis on the increase in the young adult population at certain times of year, we will need to ask potential providers how they will address the specific needs of young adults. Particular consideration should be given to access and the availability of services for this group.

**Further Information**

- Resident population data by 5-year age band available from ONS
- Data for GP registered population available from Surrey-i
- JSNA chapter - Population estimates and projections
- JSNA data - Population estimates and projections (2015 update)
- CCG projected population data available from Surrey-i
- Housing constrained population projection data available from Surrey-i
- JSNA chapter - Population estimates and projections
- JSNA data - Population estimates and projections (2015 update)
- POPGROUP

**DISABILITY**

**Analysis:** Refer to national evidence and data and then think about the local population and how people with physical, mental and/or learning disabilities may or may not benefit from the ‘activity’.

**Physical disability**

People with physical disabilities are a very diverse group with a variety of causes and severity of disability. What they do have in common is that they are more likely than able-bodied people to suffer from falls, have poorer measured quality of life and health related quality of life, and be more likely to suffer from respiratory and urinary tract infections. Depending on the level and nature of their disability, they are more
likely to live in poverty or to be economically inactive, less likely to have educational qualifications and more likely to experience problems with hate crime, harassment or sexual violence and transport. The 2011 Census measured physical disability by asking if people had difficulty with activities of daily living due to a long-term illness or disability, i.e. one which lasted a year or longer. This information has been used to provide estimates at CCG level of the number of people with disabilities and to project what the future numbers are likely to be.

It is estimated that 10.8% of the adult population in Great Britain are disabled, which equates to 22,000 people in Guildford and Waverley CCG. The CCG was estimated to have 1078 people aged 18 – 64 with a serious personal care disability in 2015. This is projected to increase by 6% in the next ten years.

Table 1: Predicted numbers with a physical disability

<table>
<thead>
<tr>
<th>NHS Guildford and Waverley CCG</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>Change from 2015 to 2025</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 18-64 predicted to have a serious personal care disability</td>
<td>1078</td>
<td>1119</td>
<td>1144</td>
<td>66</td>
<td>6</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have a serious physical disability</td>
<td>2916</td>
<td>3056</td>
<td>3138</td>
<td>222</td>
<td>8</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have a moderate personal care disability</td>
<td>4815</td>
<td>5036</td>
<td>5154</td>
<td>339</td>
<td>7</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have a moderate physical disability</td>
<td>9855</td>
<td>10228</td>
<td>10431</td>
<td>576</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: PANSI  Note: Figures by Clinical Commissioning Group (CCG) are derived from PANSI figures. District based figures have been split by percentage of 18-64-year population living in the CCG area (population source: Office of National Statistics (ONS) Mid 2010 Population estimates for LSOA aggregated up to CCG.

Learning Disability
The Confidential Enquiry into Premature Deaths of People with Learning Disabilities (2013) found that men with learning disabilities died, on average, 13 years earlier than the general population, while women with learning disabilities died 20 years earlier. While some of the causes of learning disabilities are associated with health problems leading to lower life expectancy, 42% of deaths investigated in the
Confidential Enquiry were assessed as potentially avoidable, due to inferior healthcare or lack of reasonable adjustments to enable people with learning disabilities to access healthcare appropriately. Additionally, virtually all those investigated had at least one long term health condition including epilepsy, cardiovascular disease, hypertension, dementia and osteoporosis.

The Valuing People report (2001) defined a learning disability as a significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence) combined with a reduced ability to cope independently (impaired social functioning), which started before adulthood, with a lasting effect on development.

Surrey had large numbers of long stay hospitals and the placement of large numbers of people into these during the last century and their subsequent closure has artificially increased the proportion of people with a learning disability in the general population. Those who remained are ageing so that the population with learning disabilities in Surrey is believed to be older than those with learning disabilities in other areas. In the long term these numbers will gradually reduce returning the number of people in Surrey with a learning disability towards the national average for the indigenous population.

However, the only source of estimated numbers of people with learning disabilities locally uses national modelling, so the numbers presented here are believed to be an underestimation of local numbers, especially in the older age groups. Surrey County Council Public Health are undertaking a piece of work in 2015-16 to develop better local estimates of this particular population to support the commissioning of health and social care for this group of residents.

In Guildford and Waverley CCG, 3,091 adults (aged 16 -64) are estimated to have a learning disability, which is projected to increase to 3,196 by 2025. The number of adults aged 65 and over with learning disabilities is predicted to increase from 820 to 973 in the same period. In Surrey 21,239 adults are estimated to have a learning disability, which represents 2.37% of Surrey’s adult population.

Table 2: People predicted to have a learning disability

<table>
<thead>
<tr>
<th>Age Group</th>
<th>NHS Guildford and Waverley CCG</th>
<th>2014</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>Change 2014 to 2025</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predicted to Have a Learning Disability (Baseline Estimate)</td>
<td></td>
<td>3,075</td>
<td>3,091</td>
<td>3,152</td>
<td>3,196</td>
<td>121</td>
<td>3.9</td>
</tr>
<tr>
<td>Predicted to Have a Moderate or Severe Learning Disability</td>
<td></td>
<td>703</td>
<td>707</td>
<td>721</td>
<td>732</td>
<td>29</td>
<td>4.1</td>
</tr>
</tbody>
</table>
## Predicted to Have a Moderate or Severe Learning Disability

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Predicted to Have a Moderate or Severe Learning Disability</th>
<th>18 -64</th>
<th>266</th>
<th>268</th>
<th>269</th>
<th>273</th>
<th>7</th>
<th>2.6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Predicted to Have a Severe Learning Disability</td>
<td>188</td>
<td>189</td>
<td>191</td>
<td>195</td>
<td>7</td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Learning Disability Predicted to Display Challenging Behaviors</td>
<td>57</td>
<td>57</td>
<td>58</td>
<td>59</td>
<td>2</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Predicted to Have Down's Syndrome</td>
<td>79</td>
<td>79</td>
<td>81</td>
<td>81</td>
<td>2</td>
<td>2.5</td>
<td></td>
</tr>
</tbody>
</table>

### Source: Aged 65+ taken from Projecting Older People Population Information (POPPI) and 18 to 64 from Projecting Adult Needs and Service Information (PANSI)

**Note:** Figures by Clinical Commissioning Group (CCG) are derived from POPPI figures. District based figures have been split by per cent of 18 to 65+ population living in the CCG area - population source: Office of National Statistics (ONS) Mid 2010 Population estimates for LSOA aggregated up to CCG.

Disability is a protected characteristic under the Equality Act (2010), so the CCG must have regard to this population in the services they commission. Additionally, Indicator 1.7 of the NHS Outcomes Framework monitors the CCG’s progress in reducing the excess under-60 mortality in this particular group. It is worth noting that almost 40% of those with moderate or severe learning disabilities under 65 live with their parents. As they and their parents age there is a risk that parents may no longer be able to support their children, requiring substantial additional input by health and social care services.

### Mental Health

Data on the number of people living with mental health conditions is not routinely collected. The National Psychiatric Morbidity Study, which
is undertaken every 7 years, has the most robust estimates of this particular population. Data were most recently collected in 2014; the results of the study are expected during the summer of 2015, but have not yet been published. When they become available, Public Health will summarise the results for the CCGs.

An estimated 211,949 people in Surrey meet the criteria/screened positive for one or more psychiatric conditions. Approximately 5% of people living in Guildford and Waverley i.e. 10,800 people have a long term mental health problem. 10,800 people therefore require long term support. Of these 10,800 people, 1,580 are registered with their GP practice as having schizophrenia, bipolar disorder or other psychoses (National GP Profiles, Public Health England 2015).

People with a mental health diagnosis are registered mainly with seven GP practices, most of them located in the north of the Guildford and Waverley CCG area.

Figure 3: The map below illustrates where the greatest numbers of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers (18yrs and over) are registered (the bigger the green triangle, the more people there are in this area).

However, these figures are underestimates as the Adult Psychiatric Morbidity Survey also demonstrates there is considerably higher prevalence of mental health problems among the general population, than those receiving treatment as indicated by data from primary and secondary health services.

A survey carried out by the Office for National Statistics (2000) found that 85% of those with a probable psychotic disorder were having treatment at the time of interview; in comparison, only 24% of those assessed as having one or more neurotic disorders (depressive episodes and disorders (mild, moderate and severe), phobias, panic disorders, generalised anxiety disorder, mixed anxiety and depressive disorder and obsessive compulsive disorder) were receiving treatment at the time of interview. Often the stigma surrounding mental health can make it harder for people to seek help from health services, hence the importance of widely available self-help information and anti-stigma interventions.

Indicator 1.5 of the NHS Outcome Framework requires the CCGs to reduce premature mortality in people with mental illness, specifically the excess under 75 mortality rate in adults with serious
or common mental illness, as well as reducing suicide and mortality from injury of undetermined intent among people with recent contact from NHS services.

**Conclusion:** Positive

What amendments should be made to eliminate or reduce any adverse impact to this equality group identified by the analysis?

It is assumed that individuals with both learning disabilities and mental health problems are less likely to access specialist dermatology services for their skin conditions. This could result in reduced quality of life if conditions go untreated and a poorer prognosis of malignancies due to possible late detection. The new provider will be expected to demonstrate how they will promote and improve access to these client groups.

Patients with other physical disabilities may be disadvantaged if services are not accessible to them and possibly if appointments are for longer periods provided by one stop shops. The new provider would be expected to take cognisance of these groups and be flexible on the location and the way care and treatments are delivered.

All aspects of the patient journey must be accessible including communication methods (verbal and written including provision of hearing loops and SMS texting facilities for the hard of hearing), premises being DDA compliant and skilled workforce that can holistically treat patients with a range of disabilities. There must be robust access to interpretation services for those that communicate using British Sign Language.

Psychosocial support should be provided by the service as it is recognised that people present with skin conditions that often mask mental health problems (British Association of Dermatology, 2006, http://www.bad.org.uk/shared/get-file.ashx?id=1302&itemtype=document).

**Further information**

- Data available from Surrey-i
- JSNA chapter - Mobility
- JSNA Chapter - Long Term Neurological Condition
- JSNA Chapter - Visual Impairment
- JSNA Chapter - Hearing Impairment
- JSNA Chapter - Dual Sensory Loss
- NICE guidance People with physical disability
- Data available from Surrey-i
- JSNA Chapter - People with learning disability
- Confidential Enquiry into Premature Deaths of People with Learning Disabilities
- NICE guidance People with learning disability
- Estimates of people with mental health conditions available from Surrey-i
Long term mental health problem data available from GP practice survey
Adult Psychiatric Morbidity Study 2007
Adult Psychiatric Morbidity Study 2000
JSNA Chapter - Adult Mental Health PHE mental health profile
Risks of all-cause and suicide mortality in mental disorders: A meta-review Emotional Wellbeing and Mental
Health Integrated Commissioning Strategy
NICE guidance Mental health and behavioural conditions
Domestic Abuse Strategy
Physical Activity Strategy
Surrey Substance Misuse Strategy - Alcohol Consultation
The Government `s Alcohol Strategy

ETHNICITY / RACE / ETHNIC GROUP

Analysis: Refer to national evidence and data and then think about the local population and how people belonging to different ethnic groups may or may not benefit from the ‘activity’.

Nationally, the Afiya Trust suggests that “many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities” (Afiya Trust 2010).

The EHRC states that limited evidence and / or little research is available of the health needs of individuals with no fixed abode. However, there is an assumption that notably Gypsies and Travellers, asylum seekers and refugees, have particularly low levels of health and wellbeing. Those without fixed addresses, such as Roma, gypsies and travellers, asylum seekers and refugees, have difficulty in accessing services and their needs are often different and unknown” (EHRC 2010).

One specific ethnic group which is important locally but not necessarily well captured in routine information is the Gypsy Roma and Traveller population (GRT). Gypsies and Travellers collectively are believed to comprise one of Surrey’s largest minority ethnic groups. GRT ethnic groups include Gypsies, Travellers of Irish Heritage, and European Roma. The first two groups comprise the majority of Travellers in Surrey and include both mobile and housed families. Surrey has one of the highest numbers of resident Travellers in England. Non-ethnic Travellers include Fairground and Circus families, and New Travellers. Gypsy Travellers have significantly poorer health than any other disadvantaged UK residents. Local research with this community identified high levels of smoking (48%), high blood pressure...
(52%) and anxiety/depression (48%). This poorer health could lead to a greater prevalence of the long term conditions that require the kind of support provided by the localities. The general poorer health of this community could lead to persons presenting with the long term conditions and the associated frailty at an earlier age.

The Gypsy, Roma and Traveller Community encounter a range of different barriers to accessing health and social care services. Much of the community continues to travel from place to place and so is less likely to register with a GP. This movement also makes it difficult for other health and social care services to identify the needs of the GRT Community and to provide the necessary support. Increasingly, however, the Gypsy, Roma and Traveller Community are living in settled locations. This helps health and social care services to provide the needed health and social care to this community. In spite of this, the community still encounters barriers to accessing the right support from health and social care. For example, literacy skills are worse within the community and so literacy-based registration to services can be a barrier to access. Many of the community also report poor experiences when presenting to GP practices for treatment.

Table 3: Number of Traveller sites in the vicinity of GP practices

<table>
<thead>
<tr>
<th>Geographical area</th>
<th>Number of Traveller Sites in the Vicinity of GP practices²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guildford</td>
<td>6</td>
</tr>
<tr>
<td>Waverley</td>
<td>8</td>
</tr>
</tbody>
</table>

Another ethnic group which is more common in Surrey than other parts of the country is the Nepalese, who have settled locally because of links with the military and the Gurkhas. They usually describe themselves as Other Asian in the Census. They share the health profile of other South Asian communities such as Indian and Pakistani ethnic groups, with higher rates of diabetes and coronary heart disease than the general population.

The majority of the population in Guildford and Waverley CCG (86%) describe themselves as White British. A small but substantial number (7%) describe themselves as other white, likely to be either Eastern European or possibly Gypsy Roma Traveller. (See Figure 4).

There are around 403 Gypsy Roma Traveller. Almost 3% of the population describe themselves as other Asian and are likely to be Nepalese, while 1% of the local population describes themselves as Indian, and a further 1% as Black African Caribbean.

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² Surrey County Council 2010
Figure 4: Guildford and Waverley Population non-white ethnic group percentages

Source: Census 2011
Note: figure excludes White-British

Figure 5: Geographical distribution of non-white ethnic population by LSOA in Guildford and Waverley

Source: Census, 2011

Lower Super Output Areas (LSOAs) are areas with a population between 1,000 and 3,000
Conclusion: Positive

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

As the Gypsy, Roma and Traveller Community Traveller community are all less likely to register with a GP, they will be less likely to access dermatology services. The majority of patients are referred via GPs and therefore consideration needs to be given to open access clinics which look to target these adults and children whom have a range of skin conditions. This could result in reduced quality of life if conditions go untreated and a poorer prognosis of malignancies due to possible late detection. The new provider will be expected to demonstrate how they will promote and improve access to these client groups.

To our knowledge there is no obvious known link between different ethnicity groups living in G&WCCG with specific skin conditions. There will be a requirement to monitor this area and be responsive should there be any indication of change.

In addition, for those people who do not speak English, the provider must have arrangements in place with interpretation services such that these patients are not disadvantaged during consultations.

Further information
Ethnicity data available from Surrey-i
Gypsy and Traveller Caravan Count available from Surrey-i
JSNA chapter - Ethnicity
JSNA chapter: Gypsies, Roma and Travellers
NICE guidance Black ethnic minority

GENDER

Analysis: Refer to national evidence and data and then think about the local population and how men and women may or may not benefit from the ‘activity’.

National Information
National life expectancy statistics show women having a significantly higher life expectancy than men. These differences mean that it is likely that more women than men will receive support, as women will generally be living longer than men and require this kind of support. There is also anecdotal evidence that men and women access health and social care services differently. It is known that men are less likely to visit their GP than women, even when feeling unwell. In a study reported in the BMJ in 2013, the crude consultation rate was 32% lower in men than women. The greatest gender gap in primary care consultations was seen among those aged between 16 and 60 years; these differences are only partially accounted for by consultations for reproductive reasons. Differences in consultation rates between men and
women were largely eradicated when comparing men and women in receipt of medication for similar underlying morbidities.

Men are less likely to access services until their needs have escalated to the point where they need significant health and social care interventions. Women as a whole are generally more likely to approach health and social care at an earlier stage. For visual analysis charts and data tables, please see the ‘AGE’ section of this equality analysis.

For local information please see the ‘AGE’ section of this equality analysis.

| Conclusion | Positive |

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

The specific breakdown of men and women with dermatology conditions is unknown, however in line with the national data it is possible that men may leave accessing advice for possible malignancies later than women. This could be due to a number of factors, from education to accessing care at convenient times. The range of open and flexible appointments would aim to address this should the variation between men and women be found to be significant.

GENDER REASSIGNMENT

Analysis: Refer to national evidence and data and then think about the local population and how people who have undergone gender reassignment may or may not benefit from the ‘activity’.

The Department of Health’s 2007 briefing on trans people’s health notes that:
- female to male trans men are rarely included in breast screening programmes
- male to female trans women are rarely offered prostate screening
- Trans people have experienced the refusal of care such as smear tests, breaches of confidentiality and the practice of placing trans women on male wards, and trans men on female wards.

Equally Well, the Scottish Government’s report of the Ministerial Task Force on Health Inequalities, notes in its introduction that transgender people experience lower self-esteem and higher rates of mental health problems and these have an impact on health behaviours, including higher reported rates of smoking, alcohol and drug use. These behaviours have their associated health risks such as cardiovascular disease and various cancers. Hence it can be concluded that trans-gender people experience poorer health outcomes and barriers to accessing services that providers need to make adjustments for in their systems and processes.

There are no gender specific gender reassignment statistics for Guildford and Waverley. Those who have undergone gender reassignment have been found to have similar health outcomes to the Lesbian, Gay, Bisexual and Transgender (LGBT) community. For the impact on the
Conclusion: Positive

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

The activities provided by this service change should not have any adverse impact on this client group, however due to the potential for higher rates of mental health problems, smoking alcohol and drug abuse, then these patients should be addressed as for patients with these conditions.

RELIGION & BELIEFS

Analysis: Refer to national evidence and data and then think about the local population and how people of different religions or faiths or with different beliefs may or may not benefit from the ‘activity’.

The main source of information about what religion the local population practice is the 2011 Census. There was a significant increase in the number of people stating they had no religion in the 10 years between the last census and the 2011 Census.

Figure 6: Religion and belief in the population

About two-thirds of Guildford and Waverley CCG's population said that their religion was Christian in the 2011 Census, while a substantial proportion said they had no religion or did not state their religion.

Source: Census 2011
Note: Figures excludes Christians

People who follow different religions may have beliefs which need to be taken into consideration in the commissioning of health services. For example, modesty in dress while receiving clinical care and being treated by a doctor of the same sex are important in some religions, while care plans and short breaks services for carers may need to take into account aspects of religion such as festivals and holidays. Different religions tend to have different rituals particularly around births and deaths.
Religion is increasingly being recognised as an important signifier of customs and traditions which may have a bearing on health and prevalence of ill-health (for example dietary habits). It can also help, but not always, in consideration alongside data on race (ethnicity), to identify physical, cultural, or behavioral barriers to accessing health and social care services.

**Conclusion:** Positive

**What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis**

There will be a requirement for providers to consider the needs of different religions and beliefs. Specifically, as the service will be providing assessment and performing surgical procedures it will be necessary to comply with privacy and dignity policies including the provision of chaperone and interpreter services.

Options for same sex doctors to treat patients will be a requirement of the workforce.

**Further information**

Data available from Surrey

JSNA chapter - Religion and belief

**MARRIAGE & CIVIL PARTNERSHIP**

**Analysis:** Refer to national evidence and data and then think about the local population and how people who are married or in civil partnerships may or may not benefit from the ‘activity’.

**Table 4: Breakdown of Marital Status - Health Profile 2015**

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Married</th>
<th>Same-sex civil partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Guildford %</strong></td>
<td>35.2</td>
<td>49.4</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Guildford Number</strong></td>
<td>39,639</td>
<td>55,650</td>
<td>174</td>
</tr>
<tr>
<td><strong>Waverley %</strong></td>
<td>26.9</td>
<td>55.3</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Waverley Number</strong></td>
<td>26,219</td>
<td>53,874</td>
<td>161</td>
</tr>
</tbody>
</table>

The 2000 General Household Survey (GHS) showed that married or cohabiting adults are more likely to be carers than those who are
single, or were previously married. However, there are gender differences with married women twice as likely to provide care as married men, as women are more likely to juggle a range of caring roles (grandchildren and elderly parents). It is worth considering social isolation under this equality characteristic. Not being married or in a same-sex civil partnership is one factor that impacts on the ‘social isolation index’ ([https://www.surreyi.gov.uk/Resource.aspx?ResourceID=1604](https://www.surreyi.gov.uk/Resource.aspx?ResourceID=1604)).

### Table 5: % of all households with one person aged 65 and over

<table>
<thead>
<tr>
<th></th>
<th>% all households: one-person household aged 65 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>England Average</td>
<td>12.4</td>
</tr>
<tr>
<td>South East Average</td>
<td>12.7</td>
</tr>
<tr>
<td>Surrey Average</td>
<td>12.6</td>
</tr>
<tr>
<td>Guildford Average</td>
<td>11.4</td>
</tr>
<tr>
<td>Waverley Average</td>
<td>14.2</td>
</tr>
<tr>
<td>Guildford &amp; Waverley CCG Average</td>
<td>12.8</td>
</tr>
</tbody>
</table>

There is a higher proportion of people in Waverley compared to Guildford living in a one-person household. This has implications in terms of unpaid carer resource and mental health that providers need to account for when designing the services.

Spouses and civil partners have a higher likelihood of being carers.

Issues have been identified nationally with same sex partners not having easy access to loved ones in emergency/urgent circumstances, or being included in consultations in the same way that heterosexual couples/married partners would.

**Conclusion:** Positive

**What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?**

It is not felt that there would be a significant impact for the changes proposed as current providers should be aware of this requirement. However, the new provider would need to demonstrate equal access by same sex partners in consultations and where treatment and care planning is being discussed.
**PREGNANCY & MATERNITY**

**Analysis:** Refer to national evidence and data and then think about the local population and how women who are pregnant or who have recently had a baby may or may not benefit from the 'activity'.

The birth rate in Surrey (62.9 per 1,000 women aged 15-49) is similar to the England birth rate (62.4), but varies considerably within Surrey. Births in Surrey are characterised by relatively low rates of teenage pregnancy but high rates of live births in older mothers (aged 35+) compared to the rest of the country. Risks and complications within pregnancy and birth increase with maternal age – as a consequence services need to cater for a more complex maternity population.

There were 2,200 births in Guildford and Waverley in 2013. The Guildford and Waverley CCG birth rate for women aged 15-44 years (56/1,000) is significantly lower than the England average (62/1,000).

**Table 6: Live births per 1,000 women aged 15-44 years (2013)**

<table>
<thead>
<tr>
<th>Area</th>
<th>Female population 15-44 years</th>
<th>Births</th>
<th>Rate per 1,000 Female population</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>10,653,480</td>
<td>664,517</td>
<td>62.4</td>
</tr>
<tr>
<td>Surrey</td>
<td>215,556</td>
<td>13,569</td>
<td>62.9</td>
</tr>
<tr>
<td>NHS Guildford and Waverley CCG</td>
<td>39,511</td>
<td>2,200</td>
<td>55.7</td>
</tr>
</tbody>
</table>

**Source:** ONS 2013

Health outcomes for mother and child are disproportionately worse for women who can be described as vulnerable, for example if they have learning disabilities.

**Conclusion:** Positive

**What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?**

It is not felt that there would be a significant impact on pregnancy and / or maternity care for the activities proposed. However, the new provider will need to be responsive to any referral for a mother or baby with a significant and urgent dermatology condition and this will be addressed via the advice and liaison service we are proposing to our local inpatient services.
SEXUAL ORIENTATION

Analysis: Refer to national evidence and data and then think about the local population and how people who are gay, lesbian, bisexual or transsexual may or may not benefit from the ‘activity’.

The health needs of people may vary depending on their sexual orientation.

Members of the lesbian, gay, bisexual and transgender communities (LGBT) have been found to have higher levels of certain health behaviors such as excess alcohol consumption, drug use and smoking, as well as lower uptake of screening programmes.

They have also been found to have higher levels of anxiety and depression, attributed to experiences of homophobia, domestic abuse and bullying. There is also variation within the LGBT community with those from ethnic minority groups suffering greater health inequalities than those with White British ethnicity. There is little information on life expectancy by sexual orientation but recent evidence on self-reported health status suggests that lesbians and gay men may have better self-rated health than the general population while bisexual and trans people have worse health.

It is estimated that the LGBT population is 5-7% of the population (assumed to mean the adult population). For Guildford and Waverley CCG, this equates to between 8,430 and 11,800 people identifying as LGBT, in the absence of specific population data for this equality group in the CCG area.

Table 7: Estimated numbers of people who identify themselves as LGBT in Guildford & Waverley - Health Profile 2015

<table>
<thead>
<tr>
<th>Age</th>
<th>%</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-18yrs</td>
<td>16.6</td>
<td>1,679</td>
</tr>
<tr>
<td>19-49yrs</td>
<td>41.1</td>
<td>4,157</td>
</tr>
<tr>
<td>50-64yrs</td>
<td>18.7</td>
<td>1,892</td>
</tr>
</tbody>
</table>
Although awareness is improving, research shows that older people are still the least likely age demographic to be open about their sexuality due to continuing stigma. This is likely to contribute to riskier health behaviours and higher rates of mental health issues within this group.

### Conclusion:

**Positive**

### What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

The evidence on sexual orientation is not regarded as having an impact on the changes proposed.

### Further information

**JSNA chapter - Lesbian, gay, bisexual and transgender young people LGBT Public Health Outcomes Framework Companion Document**

### Other categories relevant to CCG’s statutory duty to reduce health inequalities:

**CARERS**

**Analysis:** Refer to national evidence and data regarding this group and then think about the local population and how carers (including young carers) may or may not benefit from the ‘activity’.

Carers provide unpaid care for family partners or friends in need of help because they are ill, frail or have a disability. They can be adults looking after other adults, parents looking after disabled children or young people under 18 looking after siblings, parents or other relatives. The physical and mental health of carers can suffer as a result of their caring. 40% of carers have been found to suffer from mental distress or depression, with levels of distress increasing with the amount of time spent in caring activities. There is evidence that carers have an increased risk of back injuries and may have higher blood pressure and increased risk of stroke. In addition to risk associated with the number of hours spent caring, carers reporting ‘strain’ appear to have worse health outcomes. Young carers may suffer particularly from the health effects of their caring responsibilities.

The 2011 Census shows that there are around 20,000 people in Guildford and Waverley CCG who provide unpaid care. Almost one in ten (9.4%) in Guildford and Waverley are providing unpaid care.

### Table 8: People providing unpaid care

<table>
<thead>
<tr>
<th>Age Group</th>
<th>% of Population</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>65+</td>
<td>18.4</td>
<td>1,861</td>
</tr>
</tbody>
</table>

---

28
## Table 9: Carers receiving support from Surrey County Council

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number of Carers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-18yrs</td>
<td>2400</td>
<td>12%</td>
</tr>
<tr>
<td>19yrs and over</td>
<td>16820</td>
<td>88%</td>
</tr>
<tr>
<td>Total</td>
<td>19220</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Source: Census 2011*

### Table 10: Percentage of population receiving carer support from Surrey County Council

<table>
<thead>
<tr>
<th>CCG of Residence</th>
<th>&lt;18</th>
<th>18 to 54</th>
<th>55 to 64</th>
<th>65 to 74</th>
<th>75 to 84</th>
<th>85 plus</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS East Surrey CCG</td>
<td>84</td>
<td>265</td>
<td>204</td>
<td>176</td>
<td>116</td>
<td>67</td>
<td>912</td>
</tr>
<tr>
<td>NHS Guildford and Waverley CCG</td>
<td>98</td>
<td>312</td>
<td>291</td>
<td>232</td>
<td>206</td>
<td>123</td>
<td>1,262</td>
</tr>
<tr>
<td>NHS North East Hampshire and</td>
<td>32</td>
<td>81</td>
<td>66</td>
<td>54</td>
<td>73</td>
<td>34</td>
<td>340</td>
</tr>
<tr>
<td>NHS North West Surrey CCG</td>
<td>110</td>
<td>691</td>
<td>561</td>
<td>447</td>
<td>387</td>
<td>194</td>
<td>2,390</td>
</tr>
<tr>
<td>NHS Surrey Downs CCG</td>
<td>119</td>
<td>344</td>
<td>357</td>
<td>253</td>
<td>235</td>
<td>157</td>
<td>1,465</td>
</tr>
<tr>
<td>NHS Surrey Heath CCG</td>
<td>50</td>
<td>154</td>
<td>131</td>
<td>135</td>
<td>105</td>
<td>61</td>
<td>636</td>
</tr>
<tr>
<td>NHS Windsor, Ascot and Maidenhead</td>
<td>4</td>
<td>14</td>
<td>13</td>
<td>11</td>
<td>10</td>
<td>7</td>
<td>59</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>497</td>
<td>1,861</td>
<td>1,623</td>
<td>1,308</td>
<td>1,132</td>
<td>643</td>
<td>7,064</td>
</tr>
</tbody>
</table>

*Source: People List Report - AIS (1st May 2015). Notes: Some clients may be open to social care as both a carer and as an individual in receipt of social care.*

Numbers for the CCGs have been identified by client postcode. The number of people open to the different area teams is likely to be different to those identified here. Some of the difference will be due to lack of current postcode; people open to area team but placed outside Surrey or elsewhere in Surrey; difference in CCG and LA boundary.
<table>
<thead>
<tr>
<th>CCG of residence</th>
<th>% of Population Age 65-74 that are Carers who are open to ASC</th>
<th>% of Population Aged 75-84 that are Carers who are open to ASC</th>
<th>% of Population 85+ that are Carers who are open to ASC</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS East Surrey CCG</td>
<td>1.10%</td>
<td>1.24%</td>
<td>1.43%</td>
</tr>
<tr>
<td>NHS Guildford and Waverley CCG</td>
<td>1.24%</td>
<td>1.69%</td>
<td>2.01%</td>
</tr>
<tr>
<td>NHS North West Surrey CCG</td>
<td>1.52%</td>
<td>1.94%</td>
<td>2.32%</td>
</tr>
<tr>
<td>Englefield Green (part of NHS Windsor, Ascot and Maidenhead CCG)</td>
<td>1.67%</td>
<td>2.32%</td>
<td>3.85%</td>
</tr>
<tr>
<td>NHS Surrey Downs CCG</td>
<td>0.91%</td>
<td>1.27%</td>
<td>1.78%</td>
</tr>
<tr>
<td>NHS Surrey Heath CCG</td>
<td>1.46%</td>
<td>1.86%</td>
<td>2.97%</td>
</tr>
<tr>
<td>Farnham (part of NHS North East Hampshire and Farnham CCG)</td>
<td>1.54%</td>
<td>2.60%</td>
<td>3.15%</td>
</tr>
</tbody>
</table>

**Source:** People List Report - AIS (1st June 2015). **Notes:** Some clients may be open to social care as both a carer and as an individual in receipt of social care. Numbers for the CCGs have been identified by client postcode. The number of people open to the different area teams is likely to be different to those identified here. Some of the difference will be due to lack of current postcode; people open to area team but placed outside Surrey or elsewhere in Surrey; difference in CCG and LA boundary.

**Young carers**

Being a young carer can have a severe, significant and long-lasting impact on a young person’s health and wellbeing. Conflicts between the young carer and the person being cared for may arise, which may lead to feelings of guilt, anger, isolation or being trapped. Young carers are also more likely to suffer traumatic life events such as the death of a parent or sibling.

A 2012 Surrey Young Carers Survey received 265 responses and found that 56% wanted to know about opportunities for the future and nearly 30% wanting to know more about ‘coping methods’, with approximately 18% concerned about bullying.

GPs and other health professionals can refer the young carer to Surrey Children’s services for an assessment under the Common Assessment Framework. A young carer's assessment should automatically trigger a community care assessment or review of the person
being cared for. Some young carers and their families are reluctant to admit the child's role as a carer and are fearful of seeking help from social care. There is a range of services available to Carers in Surrey. The support can be provided to the Carer directly, or to the person being cared for, to help the Carer have a better balance between their caring role and their life away from caring. See www.surreynhscarersprescription.org.uk for more details.

**Carer Prescription Service**

The Carers Prescription provides GPs with an easy solution to support Carers they come into contact with. Across Surrey there are a number of organisations that GPs can refer Carers to. The Carers Prescription is a secure mechanism for GPs to make a referral. The team will then make arrangements for the referral to be processed quickly and efficiently.

**Conclusion:**

Positive

**What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?**

It is likely that some carers will be caring for both adults and children with long term and enduring dermatology conditions and maybe struggling with compliance. This is an area that we will be asking providers to demonstrate within their bids to provide the service. Young carers that come into contact with the service need to be identified and linked with support which in turn may help to improve their health outcomes.

**Further information**

Data available from Surrey-i
JSNA Chapter - Carers
JSNA Chapter - Young Carers and Young Adult Carers
RCGP Carers Action Guide
Open cases data available from Surrey-i
Adult Social Care Profiles
JSNA Chapter - Carers
JSNA Chapter - Young Carers and Young Adult Carers
RCGP Carers Action Guide

**AREAS OF DEPRIVATION and GEOGRAPHICAL LOCATION (urban, rural, isolated)**
Analysis: Refer to national evidence and data and then think about the local population and how people that live in different parts of the CCG, in more or less deprived wards, may or may not benefit from the ‘activity’.

National
The Marmot report, *Fair Society, Health Lives: Strategic Review of Health Inequalities post 2010*, laid out in great detail the variety of health impacts deprivation has across the life course of individuals. People living in deprived communities have riskier health behaviors and experience more long term conditions at earlier ages, with consequent impact on the individuals and the health service. The CCG will want to ensure that local service provision takes into account areas of deprivation where need for health services is likely to be greater.

In overall terms, Marmot estimated the potential years of life lost nationally due to health inequalities from 1.3 to 2.5 million years. More detail on the effect of deprivation on inequalities in life expectancy is given in the *Life expectancy* section of this report.

Deprivation is usually measured using the Index of Multiple Deprivation, which incorporates deprivation across 7 domains, including income, employment, health and disability, education training and skills, barriers to housing and services, crime, and living environment. A new deprivation index will be issued during the summer of 2015 but was not available in time for this year’s profile.

Local
Surrey as a whole is the fifth least deprived county in England ranking 144th out of 149, with 60.9% of the population falling into the least deprived quintile. However, there are pockets of significant deprivation and variation across the county. Figure 7 shows the variation in deprivation in the CCG area, with small areas (lower super output areas (LSOAs)) ranked by index of multiple deprivation and divided into tenths. In the map, 1 is the least deprived and 10 is the most.

The most deprived area within Guildford and Waverley CCG is in the ward of Westborough but there are other small pockets including Shalford which sits within an area which is one of the least deprived. The five most deprived LSOAs within Guildford and Waverley CCG are in the wards of Westborough, Godalming Central, Ockford and Stoke.
Figure 7: Overall deprivation by LSOA (decile 10 is most deprived)

Source: DCLG Index of Multiple Deprivation 2010

Notes: Lower Super Output Areas (LSOAs) are areas with a population between 1,000 and 3,000. Decile is each of ten equal groups into which the LSOAs are divided after ordering by the rank of deprivation, 10 being the most deprived.

Access

The Department for Transport estimate the travel time by several modes of travel (car, public transport, cycling and walking) to key local services, including health services, shops, offices and other services. This dataset provides a wealth of information showing how easily local people can access essential services. Here we have produced maps showing variation in access to health services using public transport, since those without access to a car (at risk users) may find accessing healthcare more difficult. Other data is available using the links given in further information.
Figure 8 above shows that a significant proportion of LSOAs in rural areas may have as low as 17.2% of at risk users with access to a GP (practice or surgery) within a reasonable time by public transport and walking.

**Source:** Department for Transport

**Notes:** ‘At risk’ users are particular social groups at risk of exclusion. In this instance considering access to GPs or hospitals, at risk users are defined as households without a car. The measure of access to services within a reasonable time takes into account the sensitivity of users to the travel time for each service. Deterrence factors are applied which reflect the user’s willingness to travel and are derived from the National Travel Survey identifying the sensitivity of trip making to travel time. The longer it takes to get to the service, the fewer people will undertake the journey. Lower Super Output Areas (LSOAs) are areas with a population between 1,000 and 3,000.

Quintile is each of five equal groups into which the wards are divided after ordering by the percentage. The range of the percentage for each quintile is shown.
A lower percentage suggests key services are less accessible from a particular LSOA by public transport / walking. That population may find it more difficult to access GPs or hospitals if they do not have access to alternative forms of transport.

Rural Area
Action with Communities in Rural England (ACRE) commissioned Rural Health Profiles for CCGs, published in 2013, which bring together quantitative data for the rural areas in CCGs with comparisons to the CCG urban areas. The profiles include information on:

- Health and wellbeing
- Population
- Social place and wellbeing
- Lifestyles and health improvement
- Service use

With 34% of Guildford and Waverley CCG living in rural areas, this is a useful resource to consider the needs of people living in these areas.

A third of the local population live in rural areas, with associated health issues including lower healthy life expectancy compared to those living in urban areas, greater proportion of the population over 65 and greater difficulty accessing services, especially for those without access to a car.

There is also reportedly poorer access to the 4G signal and high-speed internet in some rural parts of the CCG. This can increase isolation from online methods of information and support as well as being challenging in terms of the ability to provide an equally safe, high quality service using mobile working technology compared to areas that do not have these technological challenges.

Food banks
Surrey County Council recently completed a Food Access Needs Assessment 2014 which maps the location of food banks in Surrey against deciles of deprivation. Five are located within Guildford and Waverley CCG. There are five food banks identified within the CCG area.

Cold homes and fuel poverty
In Guildford and Waverley CCG, there are 5,474 dwellings (6% of all dwellings) presenting an excess cold hazard due to poor insulation and energy efficiency. Figure 12 shows LSOAs where the proportion of dwellings with an excess cold hazard is highest, mainly rural areas of Guildford and Waverley CCG, as would be expected.
**Figure 9: Percentage of households presenting an excess cold hazard by LSOA**

**Source:** BRE Housing Stock Appraisal 2014.

**Notes:** The Housing Health and Safety Rating System (HHSRS) scores excess cold as a category 1 hazard which is one of the highest and most prevalent hazards. Properties identified as presenting an excess cold hazard have a Standard Assessment Procedure (SAP) rating of less than 35. This is equivalent to the Energy Performance Certificate (EPC) rating G-F. Lower Super Output Areas (LSOAs) are areas with a population between 1,000 and 3,000.

Quintile is each of five equal groups into which the wards are divided after ordering by the percentage. The range of the percentage for each quintile is shown.

The areas of Guildford and Waverley with the highest proportion of households in fuel poverty are the rural areas of the CCG, although there are a few pockets in North Guildford. 8,174 households are in fuel poverty which is 9.3% of all dwellings.

**Social Isolation and Loneliness**

There is good evidence that loneliness and social isolation are related to increased risk of ill-health and death, comparable in size to other more established physical risk factors such as smoking. In particular, loneliness appears to be linked with increased risk of overall mortality, cognitive decline, depression and high blood pressure, as well as increased use of health services.

A variety of factors contributes to social isolation, such as bereavement, unemployment or retirement, physical disabilities or sensory loss and can affect people of any age. However, these factors tend to converge in older age. Prevalence in the general population is about 6%, and greater in those under 25 (9%) and over 55 (9%). Amongst those in the older population, those most at risk are members of ethnic minorities, those with sensory loss and those over 80 years of age.
The areas with the highest concentration of people who are socially isolated include Stoke and Westborough, Clandon and Horsley, Friary and St. Nicholas, Cranleigh East, Onslow, Milford and parts of Haslemere and Godalming.

**Figure 10: Social isolation index by LSOA**

Source: Census; Mosaic; ONS. Data for West Sussex is incomplete

**Notes:** Lower Super Output Areas (LSOAs) are areas with a population between 1,000 and 3,000. Each LSOA is graded according to whether its index is in the top 25% (red), middle 50% (yellow) or bottom 25%. The index is a summary measure of a number of different indicators that may indicate social isolation.

**Conclusion:** Positive

**What amendments are required to eliminate or reduce any adverse to this equality group impact identified by the analysis?**

As a large part of Guildford and Waverley is rural and public transport is under pressure to deliver savings we must ensure that this is taken account of when selecting the location of the integrated Dermatology services. It is recognised that the longer it takes to get to the service, the fewer people will undertake the journey.

Providers therefore must therefore consider the transport arrangements when selecting and proposing the sites, specifically considering those areas that are the most deprived within Guildford and Waverley CCG. Particular social groups at risk of exclusion include households...
without a car.

The incidences of DNAs for people residing in these areas should be actively monitored by the provider and actioned as indicated.

**Further information**

- Data available from Department for Communities and Local Government
- Fair Society Health Lives: The Marmot Review
- JSNA chapter - Index of Multiple Deprivation
- JSNA Chapter - Health Inequalities
- Data available from Surrey-i
- More information available from the Department for Transport
- Guildford and Waverley Rural Health Profile
- Data available from Surrey-i
- JSNA chapter - Environment
- NICE Guidance - Excess winter deaths and morbidity and the health risks associated with cold homes

**VULNERABLE GROUPS e.g. ex-military, homeless, looked-after children, those seeking asylum**

**Analysis:** Refer to national evidence and data and then think about the local population and how these various health inclusion groups may or may not benefit from the ‘activity’.

There are various markers of vulnerability in a community such as those listed below:

**Homeless**

The word ‘homeless’ is often used to refer to those sleeping rough. There are groups that are defined as statutorily homeless who are threatened with losing their home. Guildford and Waverley CCG has very low rates of statutory homelessness compared to London and the rest of England.

The provider must ensure that homeless people can access their services. Homeless people attend A&E up to six times as often as the general population; are admitted four times as often and once admitted; tend to stay three times as long in hospital as they are invariably sicker. As a result, acute services are four times, and unscheduled hospital costs are eight times those of general patients. Nearly 90% of all ‘NFA – No Fixed Abode’ admissions are emergency admissions compared to around 40% for the general population. (Deloitte Centre; p5).
Asylum Seekers

The Faculty of Public Health briefing (2008) states that: “Asylum seekers are one of the most vulnerable groups within our society, with often complex health and social care needs. Within this group are individuals more vulnerable still, including pregnant women, unaccompanied children and people with significant mental ill-health”.

The number of people seeking asylum in the UK is increasing with the most recent arrivals coming from Eritrea, Pakistan and Syria (www.gov.uk/government/publications/immigration-statistics-april-to-june-2015/asylum). There were 25,771 asylum applications from main applicants in the year ending June 2015, an increase of 10% compared with the previous year (23,515). Where those granted asylum settle is unknown but Providers need to have systems in place to manage people granted asylum requiring community services.

Armed Forces

The Armed Forces Community is made up of serving members of the Armed Forces (regulars who are full time and reservists who are part time), veterans (or ex-service personnel) and their respective families. The responsibilities for commissioning health services for the armed forces community is complex, with NHS England retaining responsibility for serving members, but the CCG being responsible for healthcare for veterans, reservists not currently mobilised and armed forces families registered with NHS GPs.

Surrey has three major Armed Forces training bases: The Royal Military Academy Sandhurst, The Army Training Centre Pirbright and Princess Royal Barracks Deepcut. The Defence Medical Services (DMS) medical centres (at the RMAS Sandhurst and the ATC Pirbright) are training centres and service families have the option of registering with a military GP.

The Defence Medical Rehabilitation Centre (Headley Court) which offers intensive rehabilitation for injured service personnel is located in Leatherhead. A new regiment has recently located to Pirbright. There will also be a movement of a new brigade regiment to Aldershot, which although located in Hampshire, will have implications for local families living off-base within Surrey. There are also three Army Reserve Centres in Surrey (Farnham, Reigate and Redhill).

The health needs of this group are broadly similar to the general population but with some specific differences:

- Armed forces families move every two to three years so may experience difficulty with continuity of care or variations in treatments which are funded between areas;
- Serving and ex-service personnel have a greater prevalence of excess alcohol consumption compared to the general population;
- Mental health is a significant health and wellbeing issue affecting military personnel, particularly combat personnel involved in...
challenging operations (predominantly depression and anxiety, but for a minority, more severe and enduring mental health issues such as Post Traumatic Stress Disorder).

- Engaging this population group with psychological support can be challenging; and
- A limited number of ex-service personnel return from conflicts with life changing injuries.

According to the 2011 Census there were around 2,500 members of the armed forces living in Surrey. Approximately 600 of these were living in communal establishments (Pirbright Barracks, very close to the Guildford border – 441 members). Guildford and Waverley has a further 659 members of the armed forces living in the community, possibly with families. There is no source of routine information of the number of ex-services men and women living locally but given the history of military presence there are likely to be greater numbers living locally than in other parts of the country.

Table 11: Armed Forces in Surrey

<table>
<thead>
<tr>
<th>Region</th>
<th>All Armed Forces</th>
<th>Armed Forces: Living in households</th>
<th>Armed Forces: Living in Communal Establishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>146,348</td>
<td>112,447</td>
<td>33,901</td>
</tr>
<tr>
<td>South East</td>
<td>33,483</td>
<td>24,506</td>
<td>8,977</td>
</tr>
<tr>
<td>Surrey</td>
<td>2,519</td>
<td>1,908</td>
<td>611</td>
</tr>
<tr>
<td>Guildford</td>
<td>920</td>
<td>479</td>
<td>441</td>
</tr>
<tr>
<td>Waverley</td>
<td>180</td>
<td>180</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Census 2011

Adult Social Care

Surrey County Council’s Adult Social Care team (ASC) provides a variety of support packages to residents who have long term and more complex needs which prevent them from undertaking routine activities of daily living as well as providing support to carers of all ages. ASC also provides short term support to help people back to fitness after a hospital stay or period of poor mental health.

The number of ASC open cases provides a snapshot of the number of people ASC is supporting at any given time in a locality but does not reflect the totality of ASC activity over a year.

Over 3,000 adults were receiving personal support from Adult Social Care in May 2015. A third of these are 85 years or older, but a quarter were young adults aged 18 to 54.
This is a snapshot at a particular date in time so does not capture the number of people supported over a year.

Table 12: Adults receiving social care from Surrey County Council

<table>
<thead>
<tr>
<th>CCG of Residence</th>
<th>18 to 54</th>
<th>55 to 64</th>
<th>65 to 74</th>
<th>75 to 84</th>
<th>85 plus</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS East Surrey CCG</td>
<td>921</td>
<td>303</td>
<td>376</td>
<td>636</td>
<td>930</td>
<td>3,166</td>
</tr>
<tr>
<td>NHS Guildford and Waverley CCG</td>
<td>772</td>
<td>258</td>
<td>324</td>
<td>633</td>
<td>1,120</td>
<td>3,107</td>
</tr>
<tr>
<td>NHS North East Hampshire and Farnham CCG</td>
<td>174</td>
<td>73</td>
<td>81</td>
<td>213</td>
<td>280</td>
<td>821</td>
</tr>
<tr>
<td>NHS North West Surrey CCG</td>
<td>1,271</td>
<td>498</td>
<td>675</td>
<td>1,273</td>
<td>1,740</td>
<td>5,457</td>
</tr>
<tr>
<td>NHS Surrey Downs CCG</td>
<td>1,091</td>
<td>388</td>
<td>598</td>
<td>1,070</td>
<td>1,624</td>
<td>4,771</td>
</tr>
<tr>
<td>NHS Surrey Heath CCG</td>
<td>414</td>
<td>120</td>
<td>154</td>
<td>338</td>
<td>467</td>
<td>1,493</td>
</tr>
<tr>
<td>NHS Windsor, Ascot and Maidenhead CCG</td>
<td>30</td>
<td>11</td>
<td>32</td>
<td>44</td>
<td>67</td>
<td>184</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>4,673</strong></td>
<td><strong>1,651</strong></td>
<td><strong>2,240</strong></td>
<td><strong>4,207</strong></td>
<td><strong>6,228</strong></td>
<td><strong>18,999</strong></td>
</tr>
</tbody>
</table>

Source: People List Report - AIS (1st May 2015). Notes: Some clients may be open to social care as both a carer and as an individual in receipt of social care. Numbers for the CCGs have been identified by client postcode. The number of people open to the different area teams is likely to be different to those identified here. Some of the difference will be due to lack of current postcode; people open to area team but placed outside Surrey or elsewhere in Surrey; difference in CCG and LA boundary.
### Table 13: Percentage of adults receiving social care from Surrey County Council

<table>
<thead>
<tr>
<th>CCG of residence</th>
<th>% of Population Aged 65-74 open to ASC</th>
<th>% of Population Aged 75-84 open to ASC</th>
<th>% of Population Aged 85+ open to ASC</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS East Surrey CCG</td>
<td>2.45%</td>
<td>7.11%</td>
<td>21.65%</td>
</tr>
<tr>
<td>NHS Guildford and Waverley CCG</td>
<td>2.04%</td>
<td>6.34%</td>
<td>21.86%</td>
</tr>
<tr>
<td>NHS North West Surrey CCG</td>
<td>2.53%</td>
<td>7.11%</td>
<td>22.15%</td>
</tr>
<tr>
<td>Englefield Green (part of NHS Windsor, Ascot and Maidenhead CCG)</td>
<td>5.17%</td>
<td>9.07%</td>
<td>32.21%</td>
</tr>
<tr>
<td>NHS Surrey Downs CCG</td>
<td>2.27%</td>
<td>6.51%</td>
<td>20.89%</td>
</tr>
<tr>
<td>NHS Surrey Heath CCG</td>
<td>2.07%</td>
<td>7.34%</td>
<td>25.94%</td>
</tr>
<tr>
<td>Farnham (part of NHS North East Hampshire and Farnham CCG)</td>
<td>2.57%</td>
<td>8.79%</td>
<td>29.77%</td>
</tr>
</tbody>
</table>

**Source:** People List Report - AIS (1st June 2015).  
**Notes:** Some clients may be open to social care as both a carer and as an individual in receipt of social care. Numbers for the CCGs have been identified by client postcode. The number of people open to the different area teams is likely to be different to those identified here. Some of the difference will be due to lack of current postcode; people open to area team but placed outside Surrey or elsewhere in Surrey; difference in CCG and LA boundary.

As at 1st May 2015, ASC were supporting 1262 carers. A small proportion of carers comprised young people under the age of 18. Just under half were adults of working age, while the other half were 65 and over. About 10% of carers are themselves 85 years or older.

**Conclusion:** Positive

**What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?**

People who are homeless are likely to have higher incidences of untreated skin disease and not access services in conventional ways. As
these groups are particularly vulnerable the provider will need to find creative ways of providing and offering advice and treatment to these patients who are unlikely to register with a GP.

<table>
<thead>
<tr>
<th>Name of person completing EA</th>
<th>Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pam Coen</td>
<td>Planned Care Project manager (Interim)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of lead Manager / Director</th>
<th>Signature</th>
<th>Date completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katie Thomas</td>
<td></td>
<td>4th April 2016</td>
</tr>
</tbody>
</table>

There are many resources available regarding the local population of NHS Guildford & Waverley CCG. Some examples are given below. You are recommended to consult and use the following to inform your Equality Analysis:

- Local Practice Profiles: [http://fingertips.phe.org.uk/profile/general-practice](http://fingertips.phe.org.uk/profile/general-practice)
- Public Health England: Longer Lives; Outcomes Framework; Segment Tool; Local Health Tool; Data & Knowledge Gateway
- Reports of relevant Patient & Public Engagement forums and formal consultations
- Research (the evidence base e.g. National Institute for Health and Clinical Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN). Charities and the voluntary sector often produce guidance regarding inequalities e.g. SignHealth)
- Complaints, public enquiries, audits & reviews

The CCG’s Integrated Strategic Plan 2013-18 sets out a strategic commitment to deliver more care in the community and in locations closer to patients. Supporting National Documentation – Lessons for the NHS ‘Commissioning a Dermatology Service’, Quality Standards for Dermatology and Nice Guidance.

Dermatology is a specialty specifically identified by the Department of Health as being suitable for the relocation of a large proportion of work from secondary care to primary care under the Moving Care Closer to Home policy. Our Health, Our Care, Our Say; A New Direction for Community Services (DH, 2006).

Referrals to Dermatology services have risen as a consequence of increasing population numbers and frequency of diseases such as skin cancer, leg ulcers and atopic eczema. (Guidance for Commissioning Dermatology Services – BAD)