



## Dermatology Procurement Engagement and Consultation Programme

April - June 2014

### 1.0 Executive Summary

1.1 Between April and December 2014 Dermatology Commissioners are seeking to procure a Community Dermatology Service to move a significant proportion of non-urgent Dermatology care from a hospital setting into the community.

1.2 Service improvement priorities include facilitating more rapid access to appropriate expertise closer to where people live; the promotion of self-management for patients with existing Dermatology conditions; reducing waiting times; maximising use of non-surgical interventions; improving patient experience and patient outcomes; and delivering improved value for money.

1.3 Commissioners have designed the procurement process to enable patient's, carers and members of the public to give their views and preferences to the procured service via a public consultation. The views captured from the consultation will be incorporated into the Invitation to Tender, and also into the Key Performance Indicators for the new service. Commissioners asked the Communications and Engagement Team to assist in gathering and interpreting the views of patients and the public on the past, present and future of Dermatology services in the London Borough of Hillingdon.

1.3.1 The Team worked principally with Hillingdon Libraries (to secure a pan-Hillingdon group of interviewees), the Community Cancer Centre in West Drayton (to investigate co-morbidities and the relationship between Dermatology and Mental Health, and to engage and involve Carers) and Brunel University (to target younger people through digital social media).

1.4 The Communications and Engagement Team adopted a community-based modular, hybrid approach to consultation and engagement in order to gather the broadest, deepest and most inclusive feedback.

1.5 The team discovered close links between dermatology and other conditions, including cancer and mental health. The team was able to incorporate public health messages into the engagement activity to promote self-management and the most appropriate use of NHS services.

1.6 Data from the Engagement exercise revealed wide support for the introduction of Consultant led community clinics.

1.7 A broad range of themes was identified that offer a useful starting point in assessing the degree of support for the proposed changes and the challenges that remain.

1.7.1 Issues identified include lack of confidence in current GP knowledge of skin conditions; inconsistency of diagnoses particularly in primary care; difficulties engaging with and gaining access to GP services; patients feeling dismissed and not listened to particularly in primary care but also in secondary/specialist care; and patient dissatisfaction with long waiting times for appointments, referrals and treatment.

1.8 Problems were also identified with patient and public perception of hospital services.

1.8.1 These include concerns with hospital hygiene (with Paget Ward singled out for criticism); perception that hospital staff are more highly qualified/professional/knowledgeable than staff based in the community

1.8.2 Respondent also spoke about the need for better communication between primary, secondary and community services, and the need for improved communication in hospitals (with Bevan Ward singled out as not comprehensive, careful or sensitive enough)

1.9 The concept of community clinics was strongly supported as a vehicle for more holistic integrated care.

1.9.1 Respondents felt that they would provide easier, more convenient access to services, helping to remove barriers to care.

1.9.2 Respondents perceived community-based services as more personalised, welcoming, friendly, relaxed and respectful of all patients and visitors

1.9.3 Respondents stressed the need to ensure patients are aware of what skin conditions will be suitable for treatment in community based clinics to help alleviate concerns around a lack of resources and expertise when shifting from hospital care, and to ensure patients are not rushed through appointments

1.9.4 There was support for additional/new appointment booking systems and assessment techniques.

1.9.5 There was broad support for wider patient choice and flexibility in the system around appointment times/days as well as choice of consultants/hospitals.

1.9.6 At end of May 2013 almost 400 formal surveys had been completed. At a conservative estimate a further 15,000 people were involved at some level in the engagement exercise, if only as recipients of information, though levels of absorption of this information would be challenging to measure.

## 2.0 Purpose of the Consultation

2.1 The purpose of the Consultation is to inform the Invitation to Tender (ITT documentation) and in turn to input into the Key Performance Indicators (KPIs) for the new service.

2.2 The new Provider will be obliged to carry out regular patient surveys. The design of these surveys will be informed by the KPIs, which in turn have been informed by the Consultation.

## 3.0 Methodologies Used

3.1 A range of methodologies was used to ensure optimal engagement and to fit with the needs and preferences of those taking part. The table below sets out the range of approaches used.

<p>Hillingdon Libraries:</p> <p>Botwell Green Library</p> <p>Uxbridge Library</p> <p>Ruislip Manor Library</p>	<ol style="list-style-type: none"> <li>1. Public computers booked by contacting Library Manager</li> <li>2. Refugee Council Advocate sourced on the basis of community knowledge and language expertise</li> <li>3. Advocate trained in online survey capture by CCG</li> <li>4. Area reserved in library for patient and public engagement</li> <li>5. Library staff briefed to direct people to the reserved PCs</li> <li>6. Outreach staff from the C&amp;E team</li> </ol>
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	<p>and the Refugee Council volunteer approached people in the library on arrival asking them to participate in the survey</p> <ol style="list-style-type: none"> <li>7. Staff support consultees in reading the survey introduction online and providing translation where needed into four major community languages via two Refugee Council volunteers, one bilingual and the other trilingual.</li> <li>8. Consultees complete survey online and are thanked for their time</li> </ol>
Brunel University Students	<ol style="list-style-type: none"> <li>1. Students stand on campus thoroughfares with paper surveys</li> <li>2. Students contact clubs and societies asking to line the survey on their websites</li> <li>3. Students attend University societies to introduce and promote the survey</li> <li>4. Visiting Brunel Volunteering Dept.</li> <li>5. Publicizing opportunity</li> <li>6. Training the volunteers to go out, briefing them on Health and Safety when undertaking engagement work</li> <li>7. monitoring the volunteers' levels of activity - in Brunel University campus/ library and Uxbridge town</li> <li>8. writing copy for student magazine with pictures of Brunel volunteers working on the NHS project and sending it to the Editor</li> <li>9. manually inputting survey data (40 surveys)</li> </ol>
Focus Groups	<ol style="list-style-type: none"> <li>1. liaise with Community Cancer Centre</li> <li>2. liaise with Commissioners</li> <li>3. design focus group introduction</li> </ol>

	<ol style="list-style-type: none"> <li>4. brief note taker</li> <li>5. brief community cancer centre on attendees required</li> <li>6. attend centre and conduct focus group with note taker capturing content</li> <li>7. thank the Centre for their contribution and ensure they are mentioned in subsequent publicity</li> </ol>
Carers' Impact Assessment	A formal CIA was attempted however it was deemed inappropriate to carryout the full analysis at the meeting due to the high emotions shared by members within the group.

## 4.0 Findings

4.1 A thematic technique was employed when examining both survey responses and data from focus group discussions, to identify recurrent themes and meaningful patterns. An inductive, exploratory approach was used to investigate, group and code data.

4.1.1 At the time of analysis, data from 392 surveys had been collected. 25% of respondents currently have a skin condition and 20% have recently received care for a skin condition.

4.2 The text of a statistical analytical report is quoted below:

### **Support for Consultant led community clinics.**

When asked if they would support a Consultant led community clinic the vast majority of respondents (84%) said they either strongly supported or supported the proposal. Only 3% objected or strongly objected to the idea.

- 35% Strongly support
- 49% Support

The main themes that emerged around support of the proposal included:

- Convenience and easier access to care
- Reduction of waiting and response times for an appointment

- Reduction of travel time
- Wider availability of specialist care
- Reduction of waiting time for hospital treatment
- Cost efficient

A number of respondents felt that the benefit of local services would allow for the availability of specialist information and treatment and that the reduction of travel would reduce stress levels. Others said that Consultant led clinics would provide more personal services that may help to build relationships, rapport and engender greater trust. Respondents also felt that local clinics can offer more efficient care and cater for specific conditions reducing the need for everyone to attend a central clinic that often results in stress on logistics and facilities. Some also suggested that local clinics would encourage the use of services and therefore support earlier diagnosis and treatment and that it would increase equality of access particularly for vulnerable patients, those with mobility problems and those who lack easy access to public transport. Several respondents mentioned the difficulties in accessing hospital services for those living in the northern part of the borough.

Respondents who did not support the proposal said that consultant care is better provided in hospitals where there are additional services available, like labs, which may be required in further diagnosis of the skin condition. Some respondents were concerned that there would be a lack of access to immediate hospital treatment if needed and that more people could be seen in hospitals. Others felt that existing services are adequate or that new services would be a waste of money.

While there is wide support for the proposal, a number of responses suggested that there may need to be more information given about the types of skin conditions suitable for treatment in community clinics. Reticence to move away from hospital care often focused around the inability of community clinics to treat serious conditions. One respondent commented:

‘Some conditions can be simple and treated with creams and lotions. However, conditions like skin sarcoidosis need a range of tests- X-ray, peak flow, lung capacity, eye examination, which are easier to organise in the hospital. If you are in the system then the appointments are quicker.’

### **Important factors when visiting a health clinic**

Respondents were asked to rank in order of importance, what factors matter most when visiting a health clinic from pre-selected choices. The majority (68%) indicated that

closeness to home was the most important factor. Access to public transport followed with (16%). The results in ranking order are as follows:

1. Closeness to home
2. Public transport
3. Car parking
4. Closeness to other services

Other important factors given included:

- Welcoming, trustworthy, compassionate, respectful and friendly staff
- Flexible appointment times that are kept
- Short waiting times
- Quality of care
- Being listened too & taken seriously
- Personalised care
- Reputation of clinic
- Appropriateness of medical setting
- Good service
- Expertise & experience of clinicians
- Effective reliable communications
- Proper patient and time management
- Privacy & confidentiality
- Relaxed, polite atmosphere
- Provision of health promotion information
- Longer appt times
- Good directions and signage
- No overcrowded clinics
- Clean hygienic environment with comfortable waiting rooms

Many respondents felt that the other factors listed were more important than the four choices offered on the survey. For instance, one respondent stated:

‘Yes, more important than any of the above, is that the clinician has read my notes in advance of my attendance and I don't have to repeat my story more than once.’

Another wrote:

‘Everything in one place, skin biopsy, medication, advice, treatment etc.’

### **Most important factors when making an appointment**

Respondents ranked late evening/week day (26%) and Saturday (25%) appointments as almost equally important. Being able to change appointments online (21%) ranked 3rd.

Factors ranked in order of importance:

1. Late evening/week day appointments
2. Saturday appointments
3. Being able to change appointments on line
4. Text reminder of appointment time
5. Telephone reminder of appointment time.

Other important factors included:

- Availability & ease of use
- Online appointments
- Quick & efficient booking system
- Reduce waiting time on phone
- Ability to choose consultant & hospital online
- Variety & flexibility of appointment times
- Availability of short notice-emergency appointments
- Ease of cancelling appointments
- Ability to make appointments in advance

Other responses indicated a desire for a more personal service, citing a dislike of ‘impersonal’ automated or online booking systems. Many respondents commented on the need to get through to clinics promptly. There was also some support for open walk-in clinics and language support services. One respondent felt very strongly that, ‘customer service - being treated as a human rather than a "patient" or "client" ‘ was of particular importance.

### **Additional services available for patients with a skin condition**

Responses ranked in order of importance:

1. Telephone access to support and advice from a healthcare professional (44%)
2. Patient education and information (42%)
3. Skin support group (12%)

### **Preference of location when being seen by a Dermatology Consultant**

#### **Community clinic near to your home**

When respondents were asked where they would prefer to be seen the majority (52%) indicated in a community clinic near their home. Reasons cited broadly reflect those given in response to support of a move to community based clinics: reduction of travel time, easier access, convenience, need for consistency and more personalized care, motivation for greater uptake of services, promote equal access and reduced waiting times. Other reasons included:

- Closeness of dermatologist very important
- Feel more comfortable using local services
- Offer specialised services
- Reduction of parking difficulties & fees
- Dislike of hospital environment and Perception that hospitals are unclean
- More approachable service
- Direct access to consultant

Overall, most respondents were happy with the idea of community clinics providing that full dermatology services were available. Furthermore, many respondents felt that GPs lacked specialist knowledge and that this had led to misdiagnoses and ineffective treatment of their skin condition.

#### **GP discussion first**

Feedback from respondents who indicated that they were not sure and preferred to discuss this with their GP first, (24%), felt that more reliable and better information on options would

be offered at surgeries. Many wanted help with decision making and felt their GP was best placed due to the personal relationship, knowledge of patient history and trust that exists. Other respondents said they felt more comfortable discussing their condition with their GP. Overall, responses indicate that confidence in a GP's judgement and ability to make treatment choices was the deciding factor.

### **Hospital based clinics**

23% of respondents indicated a preference to attend a clinic based in a hospital. Many comments focused on the perception that hospitals have more professional staff and that better care and advice would be available. More generally respondents indicated that they felt safer and had more confidence in hospital based services because they perceived that the doctors there were better qualified, professional and knowledgeable which, engendered greater trust in the quality of care. And that more effective treatment could be provided in a hospital setting.

Other reasons given for this choice included: 1) More equipment for diagnosing & treating conditions; 2) Access to other services/further treatments available; 3) Better transport links; 4) Condition taken more seriously in hospital and; 5) Less familiarity with community based clinics.

It is also important to note that some respondents felt that they did not have enough information to form an opinion and others felt that their choice would depend on the severity of their skin condition. Again, this suggest that higher visibility and clarity of the proposal may be necessary and that better and more detailed information provided to the public is required to affect misperceptions of community care which can influence behavioural intentions.

### **Initial assessment of skin condition by GP**

Respondents were asked how happy they were with the initial assessment of their skin care condition by the GP. Out of 124 responses 31% said that they were happy while 13% indicated that they were Very happy. Of those who felt negatively about the GP assessment, 18% indicated that they were Very unhappy and 12% were unhappy and 26% of respondents where neither happy nor unhappy.

Positive responses broadly suggested satisfaction with the quality of examination, diagnosis and treatment given as well as the quality of information and advice offered and that a referral was made. Other comments included: helpfulness of GP; ease of communication; GP knowledge and; additional.

Negative comments roughly focused on a lack of confidence in GP knowledge about skin conditions, which many felt led to a misdiagnosis or a vague diagnosis being given, resulting in worsening of the condition. Some responses suggest that there is dissatisfaction due to a perceived dismissive attitude exhibited by some GPs and did not feel they were taken seriously. Others commented that too little information and advice was given, that the quality of advice was low and treatment options were either not given or not explained fully enough. Many respondents were also unhappy that no referral was made to specialist services and felt that there was a general unwillingness to refer.

Other comments included: 1) Short consultation times, 2) Inconsistency of diagnosis (when consulting more than 1 GP), 3) Long wait for referral (some reported waiting up to 2 years), 4) Intermittent care given/ lack of consistency of care and, 4) Failure to recognise the psychological impact that skin conditions can have on sufferers.

One respondent summed it up in this way:

'Incorrect diagnosis leading to steroid induced rosacea. Unsympathetic GP's with little knowledge of common skin conditions (eczema, seborrhic dermatitis): A general feeling that if you look healthy (for example, no life threatening illness or the patient is not overweight and therefore not a problem or future problem for the health service) then the skin condition is only minor. Very little is done to assess the psychological impact on the patient's quality of life and no mention has ever been made of support groups. Quite frankly, the impression is that GPs know very little about skin conditions (even common ones) and do not consider them on a par with other health issues.'

### **Treatment of skin condition by GP**

Respondents were asked how happy they were with GP treatment of their skin condition. Out of 122 responses, 25% indicated that they were happy and 13% were Very happy. Overall comments focused on the quick treatment and improvement of the skin condition.

Responses from those who felt negatively about their treatment experience, (18%) unhappy and (11%) Very unhappy, indicated that many respondents felt that the problem was not solved and as a result the condition worsened or that ineffective treatment was offered which

only relieved symptoms temporarily. Others again commented on their lack of confidence in the GP due to the belief that they do not have the degree of specialist knowledge necessary for either diagnosis or treatment. Additionally, some respondents said that no advice was given.

A selection of responses highlight a number of the issues identified:

'had to go private in the end and had minor operation and check for skin cancer.'

'I was given antibiotics for a basal cell carcinoma. I don't think I was taken seriously due to my age.'

'The treatment given was incorrect (steroids prescribed), very little effort was made to determine the cause of the skin condition and only repeated asking lead to an appointment with the consultant which eventually led to a diagnosis and proper treatment.'

### **Amount of information received for skin condition**

Respondents were asked if they were happy with the amount of information received regarding their skin condition. Out of 119 responses (30%) indicated that they were happy and (10%) Very happy. Many respondents commented that the information given was informative and others felt that there was good information on prevention.

Negative feedback from the (19%) of respondents who were unhappy, and (14%) Very unhappy, centred around dissatisfaction that either not enough or only basic information had been given that did not adequately help them to understand the skin condition. Some respondents said that they had to research the condition themselves online.

There was a significant neutral response, (26%), that indicated they were neither happy nor unhappy about the amount of information received.

### **Information sent to hospital**

Respondents were asked how happy they were that information about the skin condition was sent to the hospital in a timely way if a referral was made. 43% said they were either happy or Very happy. However, 17% indicated they were either unhappy or very unhappy, with some respondents citing reasons such as having to wait far too long for appointments and being left with no support during this period as a major concern.

It is important to note that the low number of responses and the relatively high percentage of those who were neither happy nor unhappy in this category (39%), may suggest that this

question is not fully understood by respondents or that they do not have sufficient information and knowledge about the process to answer this question fully. Furthermore, both positive and negative comments focused broadly around quality of treatment and difficulty of access, which may go some way to support this observation. It also appears that at least some respondents based their choice on how long they had to wait for an appointment although there may be other factors involved in waiting times for appointments that do not reflect how quickly information was sent to the hospital, which is not made explicit.

### **Dignity and respect**

When respondents were asked if they were treated with dignity and respect, the majority indicated positively (40% happy with this and 27% Very happy) out of a total of 105 responses. Feedback included:

- Treatment offered in a polite manner
- Respectful and sympathetic service
- Understanding staff

A much smaller number of respondents (under 6%) were either unhappy or Very unhappy. Negative responses included: feeling rushed, not listened to and of being dismissed. Some also felt that the short appointment slots allowed minimal interaction between patient and Consultant.

24 % indicated that they were neither happy nor unhappy.

### **Overall experience**

Respondents were asked how their experience was overall. The majority (56%) said they were either happy or very happy, while a little over 10% indicated they were either unhappy or Very unhappy with their overall experience.

Positive comments broadly reflect responses already made throughout the survey such as satisfaction with the quick treatment received and the good management and treatment of the skin condition. Other responses pointed to the helpful staff, same day treatment and convenient appointment times.

Negative feedback primarily centred around feeling that the problem was left unresolved and that ineffective treatment was offered. Complaints about the long wait for specialist treatment were common and the perception that GPs lack specialist knowledge resulting in a reduction

of confidence was echoed. Similarly, some respondents felt that they did not receive follow up care or that not enough information, advice or practical help was given.

### **Focus Group Discussions – Living with Cancer**

Three focus groups were conducted in the community with both women and men living with cancer. A number of broad themes emerged:

#### **GP services**

##### **Negative themes:**

1. Difficulties engaging with GP services
2. Fear of approaching doctors/ to busy (women's group)
3. Inconsistency of diagnoses (different doctors for the same condition/same practice)
4. Short appointments/not enough time given
5. Overpopulated GP surgeries

A more positive response referred to the quick treatment received.

#### **Hospital based services**

All participants in the men's group agreed that communication was not very good at Hillingdon's Bevan Ward. It was felt that the service was not comprehensive, careful or sensitive enough and that improvement was needed. It was noted that parking was also an issue at Hillingdon.

It was pointed out in the women's group that bad hospital experiences reduce the chances of patients returning to hospital for support and future treatment.

A more positive view put forward by one participant was that the dermatologist attended to her very quickly and she found the consultation interesting and felt that a good amount of information was given.

#### **Community based services**

It was felt that a number of benefits would be gained from community based clinics. Key themes included: 1) Reduce long wait for a referral; 2) Reduce waiting time for appointments

and the long wait for a diagnosis; 3) Need for speedier test results to alleviate anxiety and; 4) Consultant led clinic opened up potential for more personalised service.

Other comments centred around the need to implement the changes effectively. Participants felt that it would be good for senior hospital clinicians to get out more into the community but that changes should be introduced gradually with resources in place to ensure that implementation is handled properly. There was strong support for continual patient participation and it was felt that this, along with ongoing communication with the public is vital. Also that there may be a need to increase the number of dermatologists to cover consultant led services.

Participants hoped that community based consultant led clinics would allow more time that would encourage patients to reveal stressful aspects of life that may exacerbate ill-health and alleviate feeling patronised and excluded from decision making, experienced by some patients.

Move toward co-productive & collaborative care / New Appointment systems & diagnostic techniques

Participants felt that the new model of care would foster more confidence in dermatology services but reiterated that changes should be incremental and phased rather than aggressive, which could prove de-stabilizing for both patients and the NHS. Even though they agreed strongly with the general principle, they felt that 80% of Dermatology services moving into the community would move far too quickly.

Other points included:

- 1) Online appointments worked well and a good innovation;
- 2) Telephone appointments were a great idea; 3) Strong support for pictures of a skin problem emailed to doctor for quicker prioritisation, if not diagnosis; 4) Approval of Skype appointments and; 5) Communication about changes needs to be clear and accessible.

### **Patient and public engagement**

It was widely felt that support from community organisations, such as the Community Cancer Centre was crucial to ensure broad patient engagement. It was felt that public awareness of service changes was important and it was suggested that the best way to do this would be through local newspapers. 'Also that information should be prominently displayed in GP

Practices. It was felt that the CCG is getting better at this, but there is still some way to go as it is vital that information is cascaded to patients.

Other issues and suggestions that arose included: 1) Community cancer centre not big enough and should be expanded; 2) Services delivered from the community cancer centre would increase confidence and improve service uptake; 3) Telephone helpline a good idea, but there needs to be a person on the other end, not a machine and; 4) Attention should be paid to transport links.

### **Patient choice**

It was felt that people are were unaware that different hospitals specialised in different things. This needs to be corrected through improved communication.

### **Treatment of skin cancer**

Participants shared a number of insights into the experience of skin cancer treatment. It was felt that information given out at the hospital was much better than that provided by GPs both for skin cancer and for a range of other cancers and that this needed to be addressed in any move of services out of hospital into the community. This was said to be the main downside of GP services, although other aspects were deemed to be positive. Others commented that some GPs' attitudes seemed less than committed to the welfare of each individual, as though they were referring and washing their hands of the patient although it was thought that this was only true in a minority of cases and that younger GPs were felt to be in more of a rush.

In illustration of this point, one participant in the men's group relayed a negative experience when undergoing surgery to his ear for skin cancer. He commented that the doctor arrived, hung his coat up, performed the procedure (badly) and left without speaking to him at all.

### **Carers Impact Assessment Focus Group**

A number of broad themes were identified that help to highlight the experience and concerns of carers. Issues identified included:

#### **Hospital Care**

- Long waits at hospital
- Hospital Acquired Infections, poor hygiene and cleanliness standards an issue
- Paget Ward at Hillingdon Hospital singled out for criticism – (Ex. given of a participant's father left in blood stained clothes on the ward. Felt he was stripped of

dignity, daughter left to help him due to no support of staff. Catheter blocked, bedsores developed as patient left in own faeces and urine. Subsequently developed MRSA on ward. Patient felt that he was left feeling despondent and uncared for and desperate to leave hospital)

- Vital need for more staff and those dedicated to caring for patients

### **GP Care:**

GP surgeries perceived as cleaner than hospitals however, it was noted that some GPs also fail to wash their hands so, it was felt that hygiene is an overall issue of concern. It was suggested that a list of patients needing a house call would be beneficial so visits are made routinely. Participants missed the closer relationships with GPs that existed in the past thought it would be beneficial if home visits were seen in a more positive light complimented by district nurses who would provide follow up care. It was also felt that some GPs were dismissive possibly due to the brevity of appointments and that short time slots would have to be expanded to accommodate any addition of specialist services.

Communication with some GPs remained problematic and long waits for primary care (2 weeks reported) caused symptoms and overall health to worsen. Participants also expressed concern that GPs were not responsive enough to the needs of housebound patients (example of having to call in relatives to change dressings).

### **Dermatology services**

#### **Key points:**

- Unhappiness with being discharged from service with no discussion
- Concerns with ineffective treatment
- Confusion about how to access services if needed after discharge
- Ongoing difficulties with dermatology treatment and diagnosis for cancer patients. Felt that contact with dermatologist and other specialist can be frustrating when dealing with so many health issues and problematic when needing to fit with other specialties
- Some experience of dermatologist not listening to concerns of patients causing great frustration (example of mother advocating for child and feeling dismissed)
- Problem with patients being sent back and forth between GP, hospital and specialist services

## Communication/medical records

### Main points:

- Lack of communication between Hospital/GP/Dermatology service causes confusion particularly for more vulnerable that can result in prolonged/ misjudged care (Ex. given of being sent 3 different hospitals address)
- Patient delivery of medical records problematic, particularly during an emergency admission to hospital (Ex. given of specialist hospital telling patient to go to GP to request/ update file and manually deliver)
- Patient records being lost still a problem

## Community Care

### Key points:

- Complaints of lack of care shown by district nurses
- Argument witnessed between community nursing team and practice nurse - unprofessional and off putting
- Community nursing and schools need to be better linked up (Ex. of school not being allowed to administer a cream to a child)

### Other issues identified:

- Ongoing communication problems in both primary and secondary care a big concern
- Need/desire for mobile GP facility to assist access for very ill/disabled/vulnerable patients
- Extra help and support needed in the community for vulnerable patients and those with mobility problems
- More voluntary support services needed
- Support for satellite hubs
- Support for adoption of a more holistic approach, consultants placed out into the community closer to patients
- Concern about wide access to computer records

## Conclusion

The results reveal that there is wide support for the introduction of Consultant led community clinics. A broad range of themes was identified that offer a useful starting point in assessing the degree of support for the proposed changes and the challenges that remain. The

analysis revealed insight into patients' perceptions and experiences with regards to primary, secondary and community care that will need to be carefully considered to ensure that patients and the wider public are made aware of and understand the benefits of change and to help mitigate against some of the more persistent negative perceptions of community care.

### **Key points to consider:**

#### **GP Services**

- Dissatisfaction of quality of diagnosis and lack of confidence in GP knowledge of skin conditions
- Inconsistency of diagnoses particularly in primary care
- Difficulties engaging with and gaining access to GP services
- Patients feeling dismissed and not listened to particularly in primary care but also in secondary/specialist care
- Patient dissatisfaction with long waiting times for appointments, referrals and treatment

#### **Hospital Services**

- Hygiene concern in hospitals (Paget ward singled out for criticism)
- Perception that hospital staff are more highly qualified/professional/knowledgeable than staff based in the community
- Need for better communication between primary, secondary and community services
- Need for improved communication in hospitals (Bevan ward singled out as not comprehensive, careful or sensitive enough)

#### **Community based clinics**

- Strong support for more holistic integrated care
- Provide easier more convenient access to services resulting in helping to remove barriers to care
- Support for what is perceived as the provision of more personalised services
- Primacy of the need for clinics to overall be welcoming, friendly, relaxed and respectful of all patients and visitors
- Need for continual patient and public engagement throughout the process of change

- Need to ensure patients are aware of what skin conditions will be suitable for treatment in community based clinics to help alleviate concerns around a lack of resources and expertise when shifting from hospital care
- Need to ensure that clear advice and information is given and that patients have enough time to talk through their concerns and not rushed through appointments
- Support for additional/new appointment booking systems and assessment techniques
- Support for wider patient choice and flexibility in the system around appointment times/days as well as choice of consultants/hospitals

## **5.0 Communications**

5.1 A media release was prepared in collaboration with the Commissioning Support Unit. A detailed briefing and FAQs was prepared and was cascaded by Hillingdon Association of Voluntary Services and a range of other groups including Community Voice and Strickland Scanner.

5.2 The Consultation was also cascaded in the North of the Borough by Community Voice, whose social network and mailing list is thought to number more than 10,000.

5.3 The London Borough of Hillingdon cascaded the Consultation to a further sample of 1,634.

## **6.0 Coverage by comparison with other recent engagement exercises**

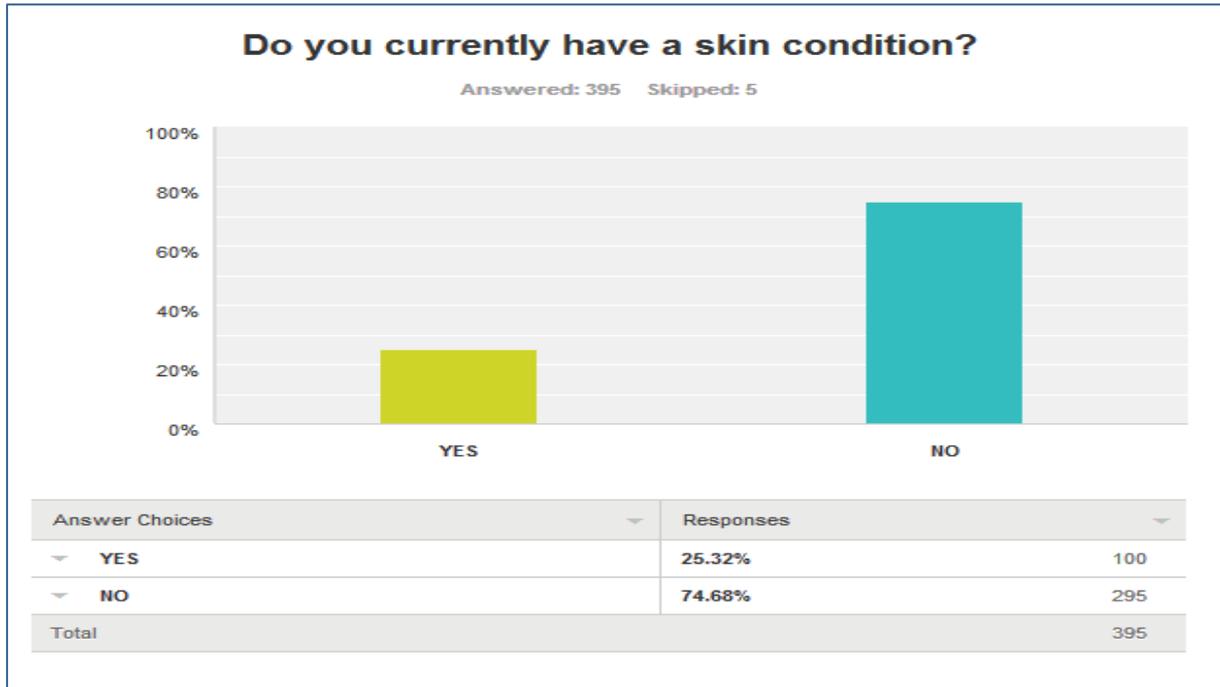
6.1 An audience in excess of 12,000 was targeted throughout the consultation.

6.2 This trawl led to 400 formal survey responses, some of them yielding in excess of 500 words of free text qualitative data.

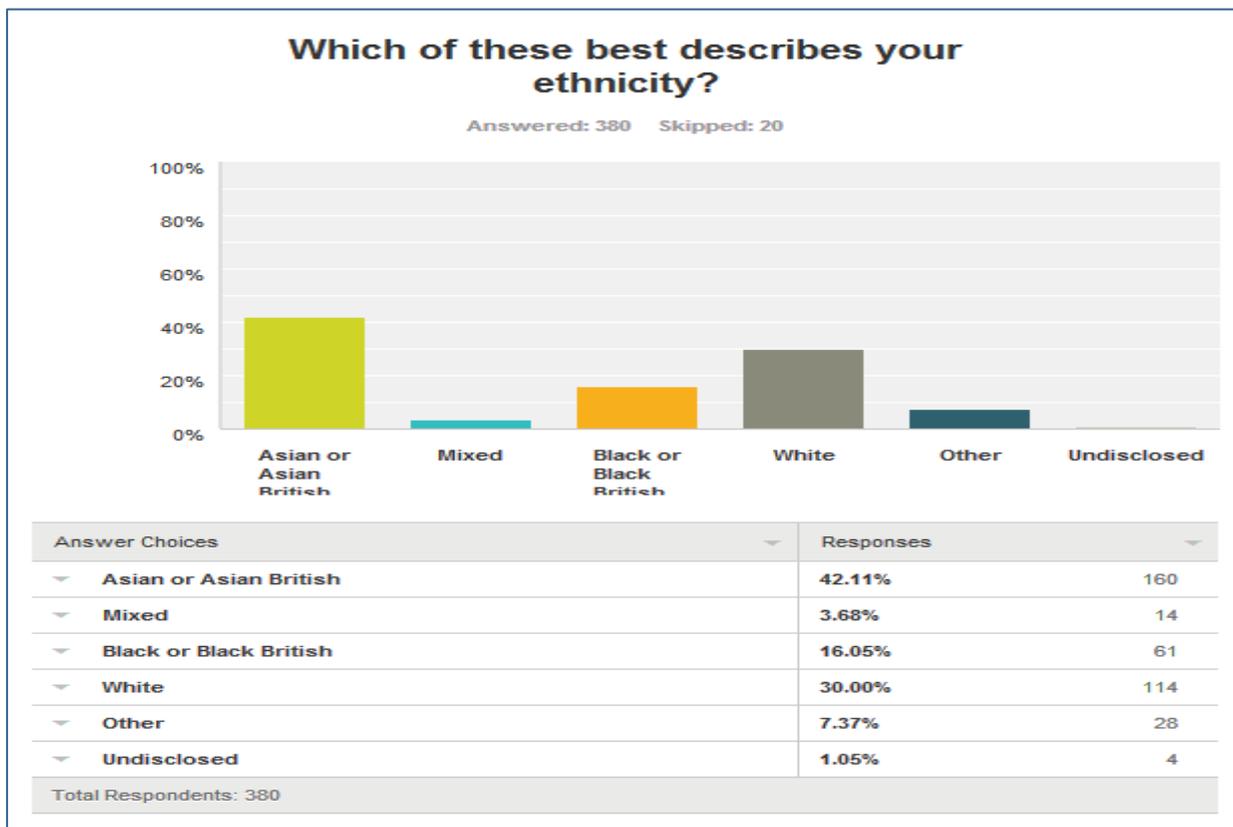
6.3 In addition to the 400 formal survey responses, 25 individuals took part in two focus groups, providing more in-depth, integrated feedback.

6.4 From an Equality and Diversity perspective, the team achieved balanced coverage in terms of health status (people with and without current dermatology issues), age (including older and younger people) and ethnicity (a BME group within the sample which is credibly reflective of Hillingdon's diverse communities).

6.5 100 out of 395 respondents for this question were currently experiencing and being treated for a skin condition.



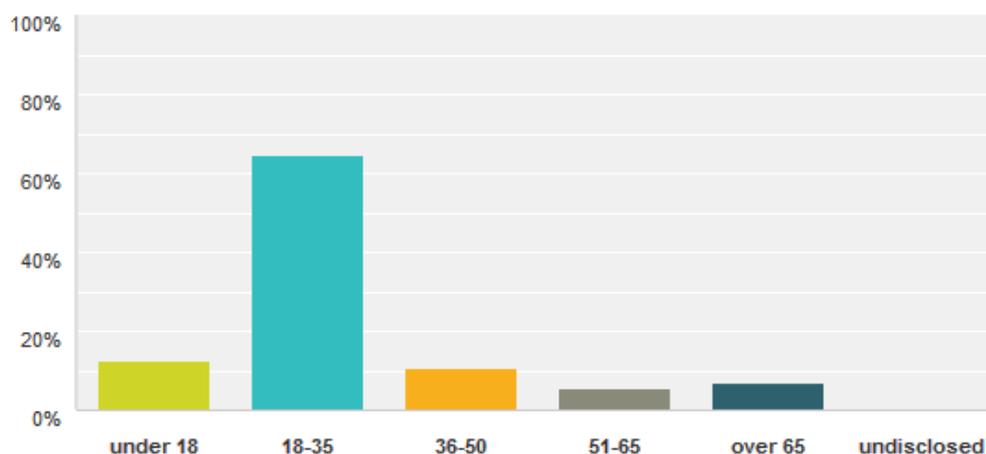
6.6 from an ethnicity perspective 61.84% of those completing the survey declared themselves to be either “Black or Black British”, “Asian or Asian British”, or “Mixed”.



6.7 48 respondents, or 12.53% of the sample, were under 18 at the time they answered the survey.

## How old are you?

Answered: 383 Skipped: 17



Answer Choices	Responses
under 18	12.53% 48
18-35	64.49% 247
36-50	10.70% 41
51-65	5.48% 21
over 65	6.79% 26
undisclosed	0.26% 1
Total Respondents: 383	

6.8 For context it is useful to compare this coverage with that achieved by other NHS organisations carrying out similar pieces of work during the past five years. NHS Leicester City carried out a Dermatology Consultation in June 2009 which achieved a total of 16 formal survey responses.

6.9 Between February and May 2013, NHS Gloucestershire and its partners carried out a Consultation on the future of emergency and urgent medical care, Gastroenterology & Hepatology, Cardiology and Respiratory (or thoracic medicine), plus the treatment of Paediatric day cases, a much broader and deeper range of subject areas than for the present Consultation. This Gloucestershire Consultation garnered a total of 239 survey responses.

## 7.0 Activity Matrix

Activity	Numbers of people involved	Method	Stakeholder groups	Organizations
Surveys	400	Face to face introduction, social networking, Facebook, Twitter feed	Students, members of religious groups, library users, two volunteers with experience of refugee status, people living with cancer, Carers, dermatology patients, volunteers, retired NHS professionals	<ol style="list-style-type: none"> <li>1. London Borough of Hillingdon</li> <li>2. Brunel University</li> <li>3. Community Cancer Centre, West Drayton</li> <li>4. Botwell Green Library</li> <li>5. Ruislip manor Library</li> <li>6. Uxbridge Library</li> <li>7. Refugee Council</li> <li>8. Brunel University Volunteering Department</li> <li>9. Brunel University Catholic Society</li> <li>10. Brunel University Islamic Society</li> <li>11. Hayes and Harlington Pentecostal Churches</li> <li>12. The Roman Catholic Diocese of Westminster</li> </ol>
Focus Groups	Three groups involving 25 people	Face to face in small groups	People living with cancer, dermatology patients, carers, retired NHS professionals, volunteers, Carers	
Press	It is difficult		Hillingdon	

Releases	to be certain about the reach of local media, but The Uxbridge Gazette for example has a readership of over 65,000; the Hillingdon and Uxbridge Times has a circulation of over 50,000		communities via Third Sector and local media	
FAQs	est. 10,000  (a conservative estimate based on Hillingdon Association of Voluntary Services having 450 member organisations with an average of 20 members in each organization)		All Hillingdon communities via Third Sector	<ol style="list-style-type: none"> <li>1. HAVs</li> <li>2. Community Voice</li> </ol>

## 8.0 Legal Underpinning

### When in reconfiguring services must NHS bodies consult the public?

The law requires NHS bodies to engage with members of the public before making decisions on changes to health services. Currently, separate sections of the NHS Act apply to CCGs and to other organisations.

CCGs are governed by section 14Z2 of the NHS Act 2006, which states:

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions (“commissioning arrangements”).

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

(a) in the planning of the commissioning arrangements by the group,

(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

There are two other relevant aspects to section 14Z2. Subsection 3 requires all CCGs to include in their constitution a description of their public engagement arrangements and a statement of the principles that they will follow in when implementing them. Subsection 4 empowers NHS England to publish guidance on compliance with this section, which CCGs must have regard to. This was published in September 2013. See <http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf>

Section 13Q of the Act applies to NHS England and contains effectively identical provisions to section 14Z2.

Section 242 of the Act contains the same obligations for NHS Trusts and Foundation Trusts. Any NHS body considering changing the services it commissions or provides must be aware of the obligations discussed in this note.

In summary, any significant commissioning decision or reconfiguration will be caught by these statutory requirements. You will note that the statute does not insist on “consultation”, but seeks to make sure that service users are “involved”. In practice, for any significant proposed change to services, some form of consultation exercise will be required to comply with this duty.

There have been numerous reported cases in the last three years, where commissioners and other public bodies have faced a judicial review brought by individuals or groups angered by service changes.

The following cases came to court in 2013:

- Regina (on the application of Save our Surgery Ltd) v Joint Committee of Primary Care Trusts – relating to specialist centres for paediatric cardiac surgery
- Regina (on the application of Copson) v Dorset Healthcare University NHS Foundation Trust – relating to Mental Health Urgent Care Services reconfiguration
- Regina (on the application of Lewisham LBC and Save Lewisham Hospital Campaign Limited) v Secretary of State for Health (and others) – relating to the Trust Special Administrator appointed to South London Hospital

### **How do they go about doing it?**

See Solicitors Mills and Reeve’s “Ten rules for an effective, lawful consultation process.”

1. Consult when your proposals are at a formative stage. Making a decision on a change to services, and then consulting on that decision, is unlawful. If you are strongly of the view that only one of a number of alternatives is realistic, then you should say so and explain why, but you must give people the opportunity to disagree.
2. Mind your language! Decisions by public bodies have been struck down by the courts simply for the use of language that gives an appearance to the public that a decision had already been taken and the consultation was a sham.
3. Set out what you are proposing; what the options are; and why these changes are needed. The public body must give out information that contains sufficient reasons for particular proposals, to allow those consulted to give those reasons intelligent consideration and an intelligent response. If the public do not know what they are being consulted about or why a change needs to be made, they cannot properly take part in the consultation process.
4. Be up front about the reasons for a proposed change. In the current climate, the driver for change will often be largely financial. If that is the case, say so. Set out the financial position that you are faced with and if this is the reason for the proposed changes. Hiding behind other, more palatable, reasons to change a service risks your consultation being struck down as unlawful.
5. Think about how long the consultation will last. The public must have adequate time to respond. The Cabinet Office Principles state “timeframes should be proportionate and realistic to allow stakeholders sufficient time to provide a considered response ... and might typically vary between two and 12 weeks”.

6. Take the responses into account before making a final decision. NHS bodies are not bound by the views of the public. Consultation is not a vote. It is, however, essential that you put the public's views in front of the decision makers and that they take those views into account when reaching their decision. You must ensure that you have a paper-trail demonstrating that this was done. If a public body takes a decision that goes against the general views of the public, it needs to have good reasons for it and to make sure those reasons are recorded.

7. There is no set form for a consultation. How to conduct one is a decision for the public body. The courts have approved consultations that involve responses on paper or electronically, public meetings and even citizens juries. What matters is whether the consultation is fairly conducted.

8. You can consult on a single option. If a public body identifies only one serious option to put to the public, it is entirely lawful to consult on implementing that single option. However, you may need to justify why only one option was realistic. Also, you must allow members of the public to suggest alternative options and, if they do so, you must give those options genuine consideration.

9. You can reach a final decision that was not one of the options put forward for consultation. But remember two points. First, there must be good reason for such a change of approach – usually it will be based on information discovered as part of the consultation. Secondly, if the final decision departs very substantially from the initial options, it may be necessary to undertake a second consultation. You do not have to give consultees the opportunity to see and to comment on the responses of other consultees. However, if a response has opened up a new issue that you are taking into account, you should consider giving other consultees the opportunity to comment on that issue.

10. Be careful of making promises! If clear, unequivocal promises have been made to individual service users or groups as part of the consultation process, the public body will have created a “legitimate expectation” that those promises will be kept. If you want to go back on them, you will need to redo the consultation exercise. Failure to do this risks the whole process being struck down by the courts. It is far safer never to make a promise or, if you do so, to qualify the circumstances in which you will be bound by it.

## Appendix 1

## Community Voice Newsheet April 2014



## NEWS-SHEET – APRIL 2014

## STOP PRESS!

- a. Hillingdon Clinical Commissioning Group’s Dermatology Services Survey:** Our Hillingdon members are asked to assist Hillingdon CCG by completing its Dermatology Survey. The survey and an accompanying introduction will be circulated by email with our April mailing. Paper copies will also be available at our May meeting. Please feel free to ask other Hillingdon residents, and cross-border residents who use Hillingdon services, to take part in this survey, which can be photocopied.
- b. Hillingdon CCG’s Musculoskeletal and Mental Health surveys:** This CCG has been awarded funding to pilot a Friends and Family patient and carers experience survey across Musculoskeletal (conditions that affect the muscles, bones and joints) and Mental Health services. Surveys are anonymous and will help to improve services. The survey is available at clinics across Hillingdon and on-line at [www.hillingdonccg.nhs.uk](http://www.hillingdonccg.nhs.uk) For any queries contact Aaron Mutiti Tel: 01895 488160
- c. Sources of information in this news-sheet:** Diary dates are copied from information sent to us, news items are from our representatives’ reports or as noted if extracted from other sources.

## 1. NEW DIARY DATES:

- a. Drop-in for Harrow Mental Health Carers:** 25<sup>th</sup> April and every 2<sup>nd</sup> and 4<sup>th</sup> Friday each month, 1.30pm – 3pm at Harrow Carers, 376/37 Pinner Road North Harrow. Tel: 0208 868 5224

- b. An Evening Drop-in for Harrow Mental Health Carers:** 1<sup>st</sup> May and every 1st and 3rd Thursday 6.30pm – 8.30pm at Harrow Carers, 376/37 Pinner Road North Harrow. Tel: 0208 868 5224
- c. Friends of Michael Sobell Hospice Plant Sale:** Saturday 10<sup>th</sup> May 10am – 12.30pm at Michael Sobell Hospice. Entry free. Refreshments available. Plant donations welcome from 6<sup>th</sup> May.
- d. Friends of Michael Sobell Hospice “On Your Bike” sponsored ride:** Sunday 11<sup>th</sup> May. Registration 7.30am for start 8am. 35 mile route, via Amersham, Bovingdon and Hemel Hempstead. Pre-registration £15 or £20 on the day.
- e. Friends of Michael Sobell Hospice Comedy Bunker Night:** Friday 16<sup>th</sup> May, 8pm, Ruislip Golf Centre, Ickenham Road, West Ruislip. Barry Cryer and Ronnie Golden performing. Tickets £12 – over 16s only.
- f. Friends of Michael Sobell Hospice, “Ladies in the Night Walk”:** Friday 6<sup>th</sup> June. Registration 8.30pm. Walk starts 10pm. For further details Tel: 01923 844829

## Appendix 2:

### Example of a Brunel University Student’s weekly workplan

Date	Activity
Sunday (18th May 2014)	Manual data entry of 20 paper surveys. Retrieval of paper surveys shared in the church from the last sunday.
Tuesday (20th May 2014)	Shared link to The Catholic Society to be shared on their Facebook page and sent as email to Members
Wednesday (21st May 2014)	1. Exchange of mails with the Brunel Graduate school for link to be shared at the dissertation week. 2. Sharing link and putting posters at the Residence's reception. 3. Sent link as emails to Masters students in the department.

Thursday(22 May 2014)	Shared the remaining paper surveys gotten from church at the dissertation week
Friday (23rd May 2014)	Manual data entry of 20 paper surveys.

Activity
<p>Ask people to fill out survey through Brunel groups and societies - these include:</p> <ul style="list-style-type: none"> <li>- Pakistani</li> <li>- Saudi</li> <li>- Arabian</li> <li>- Mathematical</li> <li>- Entrepreneurial Society</li> <li>- Baking Society</li> <li>- Islamic Society</li> <li>- Investment and Trading</li> <li>- Fashion</li> <li>- Teach first</li> <li>- Photography</li> <li>- East meets West</li> <li>- History</li> <li>- Digital Media</li> </ul> <ol style="list-style-type: none"> <li>1. contacting leaders</li> <li>2. sending the link via email to members</li> <li>3. attending a meeting to brief people on the consultation and answer any questions they have</li> </ol>

<b>Activity</b>
<p>Brunel Volunteers</p> <ol style="list-style-type: none"> <li>1. Visiting Dept.</li> <li>2. Publicizing opportunity</li> <li>3. Training the volunteers to go out, briefing them on Health and Safety when undertaking engagement work</li> <li>4. monitoring their levels of activity - in Brunel University campus/ library and Uxbridge town</li> </ol>
<p>Student Magazine</p> <ol style="list-style-type: none"> <li>1. writing copy for student magazine with pictures of Brunel volunteers working on the NHS project and sending it to the Editor</li> </ol>
<p>Jummah Prayer announcement</p> <ol style="list-style-type: none"> <li>1. speak to Islamic Society President</li> <li>2. hand briefing to relevant people, possibly Imam</li> </ol>
<p>Brunel Medical Centre visit</p> <ol style="list-style-type: none"> <li>1. Visit Centre</li> <li>2. Put up posters</li> <li>3. Hand them printed PDF of FAQs</li> </ol>
<p>Data Inputting</p>
<p>Trugym - Uxbridge + Brunel Gym - putting poster and paper surveys + brochures with link</p>
<p>Ruislip Manor library data Collection</p>
<p>Uxbridge Library Data Collection</p>
<p>Oak Farm Library Data Collection + printing &amp; putting poster, leaving and collecting paper surveys</p>

## **Appendix 3 – key themes from Focus Group held at Community Cancer Centre**

### **Hospital cleanliness/ Staff Hygiene**

Patient expressed dissatisfaction with Hillingdon Hospital, and pinpointed waiting times as a particular issue.

Issues regarding Hospital Acquired Infections at Hillingdon Hospital were raised. Patient stated that he saw a cockroach under his bed. Compared the cleanliness at Hillingdon Hospital to GP Surgery and questioned whether it would be better to visit surgery.

Another patient claimed that their GP did not wash hands so hygiene is an issue which is prevalent across all sectors of healthcare.

Patient gave a number of examples about general dermatology. Patient explained her son suffers from eczema. Reference was made to the community nurse who supplied creams.

### **Discharge Process**

Carer explained that she received feedback letter saying she was discharged with no discussion. She went to state that the creams prescribed were no longer working. She went on to express her discontent at possible readmission or being “caught in the loop”

Patient described how Hillingdon Hospital holds three different addresses for her and information was not reaching the correct address.

She stated that if communication came from a homogenous body there would be less room for confusion. She then stated that this would allow her more time to advocate for people. Patient went on to question what would happen to vulnerable adults who face barriers and do not have the confidence to express their concerns, prolonging the provision of care creating increased room for error.

### **Primary Care**

Patient described scenario where Hillingdon Hospital had lost patient record following an emergency admission to Hillingdon Hospital. Patient had to request updated file from GP and manually deliver.

A carer questioned whether a mobile facility could be provided for her neighbour, as the symptoms of her cancer sometime render her immobile.

There is a two week wait in Primary Care for GP. By the time they wait a couple of days the issues might have worsened or may have become weaker.

### **Community care/volunteer services**

Patient questioned whether provisions could be made for house calls for patients who are immobile.

Patients were also unsatisfied with the number of volunteer services in Hillingdon.

### **Alternative approaches**

Patients agreed that the idea of satellite hubs were a positive step, because of the density of the population and is especially a good idea when regarding topical applications. However patients called for an even more holistic approach to develop such hubs in a much more cost effective way.

The idea of consultants going into the community received a positive reception, however concerns were expressed regarding the level and number of clinicians that would be in the fulfilling such a role.

### **Lack of care/communication/negligence**

Patient described that following her breast operation, tissue fluid began to drip from her wounds and that her dressings needed changing three times a day. Following this there was a disagreement between the community nursing team and practice nurse and lamented at the loss of care from doctors.

Carer explained story about her father in Paget ward at Hillingdon Hospital and the impact the lack of resources had on his admission. She described how Doctors tried to avoid breaking bad news to her father, problems with application of catheter, Nurses failed to provide a general lack of cleanliness, lack of continence care. Carer explained that the patient was treated with a general lack of dignity.

Patients stated that before implementation of any new services resources needed to be made available.

Patient described that when in appointments GPs are dismissive and would prefer to let their ailment 'pass'. This was said to impact on family carers as their emotional resources are stretched.

Communication is the big issue difficulty but also communication with GP is substandard.

Patient described that her dilemma in being prescribed an effective cream for her sons eczema as she was prescribed the same medication she was prescribed by her GP. She went on to describe that her sons medication needs to be applied at school however there are no community nurse to apply cream.

A representative from Hillingdon carers notes that there is co-productivity between respiratory services and schools, however there is not the same for dermatology services.

Patients also mentioned that referral system needed to be reviewed.

## Appendix 4 FAQs prepared for Voluntary Sector cascade



### **In Our Skin**

#### **Safe and Equal Dermatology Services for All - A Consultation**

We want Patients, Carers and members of the public to take part in our Dermatology Consultation by clicking on the following link:

<http://www.surveymonkey.com/s/InOurSkinSurvey>

This will take minutes, and will help us to plan the future of local Dermatology services.

#### **Some Frequently Asked Questions...**

##### **Why are we involving patients and the public?**

Commissioners of NHS services must base their decisions on knowledge of what is best for patients and local people. This will vary according to a number of factors, such as

- where people live,
- the range of health challenges people face
- local transport
- access to information
- clinical factors such as the types of skin conditions that are most frequently encountered in the local population

**How will we engage people?**

We will learn about these factors by engaging clinicians, the general public, and people currently using Dermatology services. People can engage by:

- responding to our questionnaire
- attending one of our focus groups
- looking up information about the consultation online

**What are our priorities for developing community Dermatology services closer to where patients live?**

- Rapid access to appropriate expertise, within a community setting close to people's homes where possible/appropriate
- The development of a clear, streamlined and managed patient pathway
- Promotion of self-management for patients with existing Dermatology conditions
- Reduced waiting times
- Conveniently located services
- Maximum use of non-surgical interventions
- Safe and clinically-effective services
- Excellent and improved patient experience and patient outcomes
- Value for Money

We look forward to hearing from you. We will be producing a full report of your views, showing how these have influenced our decisions about the new service.

Further information can be obtained by emailing Ian McDowell, Senior Communications and Engagement Manager at Hillingdon Clinical Commissioning Group [ian.mcdowell@nhs.net](mailto:ian.mcdowell@nhs.net)

## APPENDIX 5 - EIA

Dermatology Equality  
Impact Analysis 2002

ONLINE READERS CLICK HERE

<p align="center"><b>Equality Impact Analysis: Dermatology Service</b></p> <p>Equality Impact Analysis is the method used by the Hillingdon Clinical Commissioning Group (HCCG) to demonstrate that it is giving due regard to equality when developing and implementing changes to services, strategy, policy and/or practice.</p> <p>The purpose of this equality analysis is to:</p> <ol style="list-style-type: none"> <li>Identify unintended consequences and mitigate them as far as is possible.</li> <li>To actively consider how the CCG can support the advancement of equality and fostering of good relations</li> <li>Reduce health inequalities across the Borough of Hillingdon</li> </ol>	
<p><b>Section 1: General information</b></p> <p>Please note: The term 'policy' in this document is shorthand for what needs to be analysed e.g. strategy, service redesign.</p> <p>Hillingdon Clinical Commissioning Group (HILLINGDON CCG) wishes to commission a Community based Consultant-led Dermatology Clinical Assessment and Treatment Service (CATS) for the patients of Hillingdon.</p> <p>Hillingdon is the second largest of London's 32 boroughs covering an area of 42 square miles (11,571 hectares), over half of which is a mosaic of countryside including canals, rivers, parks and woodland. As the home of Heathrow Airport, Hillingdon is London's foremost gateway to the world and is also home to the largest RAF airport at RAF Northolt. Hillingdon shares its borders with Hertfordshire, Buckinghamshire, Hounslow, Ealing and Harrow.</p> <p>Geographically, Hillingdon CCG is divided into 3 localities: North Hillingdon, Uxbridge &amp; West Drayton and Hayes &amp; Harlington.</p> <p>Accountability and decisions are overseen by the Governing Body made up of member GPs, lay members and an executive team. The Clinical Responsible Officer for Planned Care is a member of the CCG Governing Body.</p> <p>The Governing Body is supported by a team of clinicians and managers.</p> <p>The CCG commissions a range of health services for the local population including needs assessment, planning, procuring and monitoring.</p> <p>The CCG involves patients, carers and the public in healthcare planning and commissioning of services.</p> <p>On 21<sup>st</sup> June 2013, the Dermatology Recovery Plan Business Case was approved by the Hillingdon CCG Governing Body. The Business Case aims to improve the way current services are delivered whilst reducing the overall expenditure by agreeing a range of revised care pathways which more fully reflect current clinical best practice.</p>	
<p><b>Section 2: Data gathering</b></p> <p><b>What are the aims of the policy?</b></p> <ol style="list-style-type: none"> <li>To ensure patients are mainly managed in primary care and only referred to community and secondary care where clinically appropriate</li> <li>To reduce variation in referral rates between practices</li> <li>To transform the outpatient and elective day case Care Pathways so that care is provided at a reduced cost, through two mechanisms: <ul style="list-style-type: none"> <li>Reducing levels of secondary care activity through simplifying pathways, reducing duplication and the number of follow-ups and ensuring the provision of right care in the right place at the right time</li> <li>Providing care at lower cost through using different skill mix and delivering care in lower intensity settings to ensure that general practice is appropriately supported to deliver these objectives</li> </ul> </li> </ol> <p><b>What health outcomes do the HCCG hope to achieve?</b></p> <ol style="list-style-type: none"> <li>Improved access to the most appropriate care at the right time</li> <li>Improved management of patients from compliance with agreed clinical care pathways</li> <li>Reduced incidence of cases progressing to more complex stage</li> <li>Empower patients to look after themselves and keep them in community health care with appropriate management of health problems.</li> </ol> <p><b>Are there any factors that might prevent these outcomes being achieved?</b></p> <p>Non-compliance with agreed care pathways</p>	
1	2

<p><b>What is the equalities profile of service users?</b></p> <p>Younger people (0-19) and elderly population (&gt;65) are primary users of Dermatology services. The annual demand growth for services among the younger group is about 0.5% whilst in the older group it is about 2%. Within these groups female users are greater users of this service than males.</p> <p>The incidence of both melanoma and non-melanoma skin cancer is growing. It is estimated that rates will double every 10-20 years. The incidences of melanoma are more common in older people, with the highest proportion in people over 80s.</p> <p>Numerous dermatological diseases such as psoriasis, atopic dermatitis and eczema tend to present differently in dark skin and light skin. These disorders may prove more of a diagnostic challenge in patients in the former category. Other dermatological disorders are more common in darker skin and may be more debilitating.</p> <p>46% of all Dermatology appointments were women referred by their GP, 38% were men referred by their GP. The majority of the other appointments were consultant referrals.</p> <p>2011/12 attendances by ethnic category are as follows:</p> <table border="1"> <thead> <tr> <th>Ethnic Category</th> <th>Attended</th> <th>DNA</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>White</td> <td>52%</td> <td>8%</td> <td>58%</td> </tr> <tr> <td>Mixed</td> <td>1%</td> <td>0%</td> <td>1%</td> </tr> <tr> <td>Asian or Asian British</td> <td>13%</td> <td>2%</td> <td>15%</td> </tr> <tr> <td>Black or Black British</td> <td>8%</td> <td>1%</td> <td>9%</td> </tr> <tr> <td>Other ethnic groups</td> <td>8%</td> <td>1%</td> <td>9%</td> </tr> <tr> <td>Not stated or Not known</td> <td>1%</td> <td>3%</td> <td>4%</td> </tr> </tbody> </table> <p>2011/12 attendances by gender and age category are as follows:</p> <table border="1"> <thead> <tr> <th>Age</th> <th>Female</th> <th>Male</th> </tr> </thead> <tbody> <tr> <td>0 - 19</td> <td>199</td> <td>359</td> </tr> <tr> <td>20-29</td> <td>399</td> <td>626</td> </tr> <tr> <td>30-39</td> <td>4364</td> <td>3399</td> </tr> <tr> <td>40+</td> <td>2351</td> <td>4777</td> </tr> </tbody> </table> <p><b>Are there any barriers that will prevent service users from accessing these services?</b></p> <p>Yes there are potential barriers around patient awareness of skin conditions, including melanoma and non-melanoma skin cancer which are both on the rise. The Commissioner will seek to identify what Public Health promotional activities are in place to raise awareness of common/high risk skin conditions in the public.</p> <p><b>Did you carry out any consultation or engagement as part of this assessment?</b></p> <p>YES/NO (If yes please complete next series of questions. If no go to section 3)</p> <p>A Public Consultation is expected to commence in March 2014 for a period of 12 weeks.</p> <p><b>Who was consulted or engaged?</b></p> <p>To be confirmed</p>	Ethnic Category	Attended	DNA	Total	White	52%	8%	58%	Mixed	1%	0%	1%	Asian or Asian British	13%	2%	15%	Black or Black British	8%	1%	9%	Other ethnic groups	8%	1%	9%	Not stated or Not known	1%	3%	4%	Age	Female	Male	0 - 19	199	359	20-29	399	626	30-39	4364	3399	40+	2351	4777	3
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<p><b>From the consultation what feedback did you receive?</b></p> <p>To be confirmed</p> <p><b>What changes have been made as a result of the feedback you have received?</b></p> <p>To be confirmed</p> <p><b>Section 3: Impact</b></p> <p>Consider the information gathered in section 2 of this assessment form and assess:</p> <ol style="list-style-type: none"> <li>Where you think that the strategy could have a <b>NEGATIVE</b> impact on any of the equality groups, i.e. it could disadvantage them</li> <li>Where you think that the strategy could have a <b>POSITIVE</b> impact on any of the equality groups like promoting equality and equal opportunities or improving relations within equality groups</li> <li>Where you think that this strategy has a <b>NEUTRAL</b> effect on any of the equality groups listed below i.e. it has no effect currently on equality groups.</li> </ol> <p>Do you think that the policy impacts on people on the grounds of their race/ethnicity?</p> <table border="1"> <thead> <tr> <th>Race</th> <th>Positive</th> <th>Negative</th> <th>Neutral</th> <th>Reasons for your decision</th> </tr> </thead> <tbody> <tr> <td>Promoting equality of opportunity</td> <td>X</td> <td></td> <td></td> <td>The service specification will be clear that there must be a provision of translation material and interpretation services (on request) / Collection of patient and staff ethnicity data/ evaluation criteria used to score bids will include a section on equality of access, to allow organisations that can bring effective solutions to equalities issues to benefit in the selection process.</td> </tr> <tr> <td>Promoting good race relations</td> <td>X</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Eliminating unlawful discrimination</td> <td>X</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>Do you think that the policy impacts on people because of their religion or faith?</p> <table border="1"> <thead> <tr> <th>Religion or Faith</th> <th>Positive</th> <th>Negative</th> <th>Neutral</th> <th>Reasons for your decision</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td>X</td> <td>There is no specific data in relation to this indicator in the project specification. The services are able to be accessed equally by patients registered with a GP in Hillingdon</td> </tr> </tbody> </table> <p>Do you think that the policy impacts on people with a disability?</p> <table border="1"> <thead> <tr> <th>Disability</th> <th>Positive</th> <th>Negative</th> <th>Neutral</th> <th>Reasons for your decision</th> </tr> </thead> <tbody> <tr> <td>Visually impaired</td> <td>X</td> <td></td> <td></td> <td rowspan="3">The service specification will be clear that people with other co-occurring diagnoses will not be excluded from accessing the service provided that the presenting problem is pertinent to the service offered. This includes serious and enduring mental health problems, physical health impairments, physical and sensory impairments and long-standing health conditions.</td> </tr> <tr> <td>Hearing impaired</td> <td>X</td> <td></td> <td></td> </tr> <tr> <td>Physically disabled</td> <td>X</td> <td></td> <td></td> </tr> </tbody> </table>	Race	Positive	Negative	Neutral	Reasons for your decision	Promoting equality of opportunity	X			The service specification will be clear that there must be a provision of translation material and interpretation services (on request) / Collection of patient and staff ethnicity data/ evaluation criteria used to score bids will include a section on equality of access, to allow organisations that can bring effective solutions to equalities issues to benefit in the selection process.	Promoting good race relations	X				Eliminating unlawful discrimination	X				Religion or Faith	Positive	Negative	Neutral	Reasons for your decision				X	There is no specific data in relation to this indicator in the project specification. The services are able to be accessed equally by patients registered with a GP in Hillingdon	Disability	Positive	Negative	Neutral	Reasons for your decision	Visually impaired	X			The service specification will be clear that people with other co-occurring diagnoses will not be excluded from accessing the service provided that the presenting problem is pertinent to the service offered. This includes serious and enduring mental health problems, physical health impairments, physical and sensory impairments and long-standing health conditions.	Hearing impaired	X			Physically disabled	X			4
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Learning disability	X			<ul style="list-style-type: none"> <li>The service specification will specify that all printed materials produced by the service must be available in easy-read format to maximise the access to the service for people with learning disabilities or sensory impairments.</li> <li>Providers will be required to offer alternatives to one to one traditional appointments in the agreed locations, where appropriate and practicable. These measures are yet to be decided but may include telephone working to improve access to the service for those with limited mobility.</li> <li>The evaluation criteria that will be used to score the bids during the contested process to decide a provider will include a section on equality of access, to allow organisations that can bring effective solutions to equalities issues to benefit in the selection process.</li> </ul>
Mental health	X			
Other (HIV positive, multiple sclerosis, cancer, diabetes, epilepsy)	X			

Do you think that the policy affects men and women in different ways?

Gender	Positive	Negative	Neutral	Reasons for your decision
Male	X			Improved access/ reduced waiting times/ more responsive service
Female	X			Improved access/ reduced waiting times/ more responsive service

Do you think that the policy impacts on people because of their sexual orientation?

Sexual Orientation	Positive	Negative	Neutral	Reasons for your decision
Lesbian			X	There is no specific data in relation to this indicator in the project specification. The services are able to be accessed equally by patients registered with a GP in Hillingdon
Gay			X	There is no specific data in relation to this indicator in the project specification. The services are able to be accessed equally by patients registered with a GP in Hillingdon
Heterosexual			X	There is no specific data in relation to this indicator in the project specification. The services are able to be accessed equally by patients registered with a GP in Hillingdon
Bisexual			X	There is no specific data in relation to this indicator in the project specification. The services are able to be accessed equally by patients registered with a GP in Hillingdon
Transsexual			X	There is no specific data in relation to this indicator in the project specification. The services are able to be accessed equally by patients registered with a GP in Hillingdon

Do you think that the policy impacts on people because of their age?

Age	Positive	Negative	Neutral	Reasons for your decision

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Young (Children and young people, working age)	X			Improved access- There is no paediatric dermatology service provided in the north of the Borough. This will be addressed as part of the implementation of a community dermatology service.
Older (Working age, 60+ and retirement age)	X			Improved access/ reduced waiting times/ more responsive service

**Section 4: Evaluation / On-going monitoring**

Please describe the evidence used in reaching the impact analysis in section 3 (e.g. staff or manager perceptions, Trust data, results of consultation, community views, external data, and external reports).

- Evidence from other organisations which have developed services in the manner proposed for HCCG.
- Discussion with Provider staff

If the service this policy refers to already exists please fill out sections 4A and then proceed to section 5. If the service in this policy is a new service please complete section 4B and then proceed to section 5.

**Section 4A: [Existing service]**

What systems are currently in place to monitor/record the profile of service users? [e.g. patient survey collects ethnic background]

None

How often is this information collected?

N/A

As a result of this policy will you monitor any additional equality profile information? If yes what additional information will you gather?

N/A

As a result of this policy will the CCG increase the frequency of which it collects the above data? If yes, what will the increase be? [e.g. monthly to weekly]

N/A

Who in the CCG reviews the data collected? Will they continue to review the data? If not who will monitor the information?

N/A

**Section 4B [New service]**

What equality information will be collected that will assist in evidencing that the service is being accessed and meeting the needs of protected groups identified in section 3?

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- Key performance indicators
- Compilation of Patient user evaluation forms including demographic data and user comments.
- Data on race, faith, disability, gender, sexual orientation and age

How often will this data be collected?  
Quarterly

Who in the CCG will monitor this information?  
Lead Commissioner

**Section 5: Assessment**

From your responses gathered in section 3 has a 'No differential impact' been identified and does this likely to amount to an adverse impact?  
No

If yes please state below:  
If a differential impact has been identified which can amount to an adverse impact you will need to complete and attach to this EIA an Equalities Implications Action Plan.  
Contact Diana Garanto [diana.garanto@nhs.net](mailto:diana.garanto@nhs.net) for the form.

Is the policy directly or indirectly discriminatory under the equalities legislation?  
No

If the policy is indirectly discriminatory can it be justified under the relevant legislation?  
Not Applicable

**Section 5: Publish Assessment Results**

In order demonstrate openness about the way Hillingdon Clinical Commissioning Groups policies, services and partnerships are developed and our commitment to promoting equality and diversity, results of the impact assessment will be published onto the public facing website: [www.hillingdonccg.nhs.uk](http://www.hillingdonccg.nhs.uk)

Is there any reason why this Equality Impact Assessment should not be published, please use this space to state your reasons:  
No

**Section 6: Sign off**

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**Section 7: Glossary**

Listed below are definitions of key words that will provide additional guidance in relation to meeting requirements of an Equality

**Direct Discrimination**  
That is treating people less favourably than others as it would apply to age, disability, gender, race, religion and belief, sexual orientation. There is no justification for direct discrimination

**Indirect discrimination**  
Applying a provision, criterion or practice that disadvantages people as applies to age, disability, gender, race, religion and belief, sexual orientation and can't be justified as a proportionate means of achieving a legitimate aim. The concept of 'provision, criterion or practice' covers the way in which an intention or policy is actually carried out, and includes attitudes and behaviour that could amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping. To find discrimination it will be sufficient to show that a practice is likely to affect the group in question adversely.

**Definition of Disability**  
The Disability Discrimination Act 1995 defines Disability as being:  
"an impairment which has a substantial, long term adverse effect on person's ability to carry out normal day-to-day activities".

**Differential Impact**  
Suggests that a particular group has been affected differently by a policy, in either a positive, neutral or negative way.

**Adverse Impact**  
This is a significant difference in patterns of representation or outcomes between equalities groups, with the difference amounting to a detriment for one or more equalities groups.

**Ethnic monitoring**  
A process for collecting, storing and analysing data about individuals' ethnic (or racial) background and linking this data and analysis with planning and implementing policies.

**Functions**  
The full range of activities carried out by a public authority to meet its duties.

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