Community Information Programme

Allied Health Professional Referral to Treatment
Revised Guide 2011

Equality Impact Screening Assessment

Analysing the Impact on Equalities

Title: Allied Health Professional Referral to Treatment
Relevant line in DH Business Plan 2011-2015: **Create a Patient-led NHS** > Extend patient choice of treatment and provider > Give people far more information and data on all aspects of healthcare correcting the imbalance in who knows what and enabling them to make informed choices about their care.

What are the intended outcomes of this work?

Framing the Contribution of Allied Health Professionals (DH, 2008) set out a commitment to mandate the collection and reporting of Allied Health Professional (AHP) referral to treatment data. Referral to treatment (RTT) waiting times, as highlighted in *The Operating Framework for the NHS in England 2011/12* (DH, 2010) remains a key indicator of service performance and patient experience to demonstrate how providers measure performance of services over time and against peers. This development demands that data are collected consistently according to national standards, as set in the *Allied Health Professions Referral to Treatment Guide* (DH, 2010) to support benchmarking and provide information to support patient choice.

The *Allied Health Professional Referral to Treatment Guide* (DH, 2010) was developed for NHS funded AHP Services (NHS AHP services) and sets out a framework of rules for when a clock starts and a clock stops to measure waiting times for patients when accessing NHS AHP services. The *Allied Health Professions Referral to Treatment Revised Guide* (DH, 2011) has superseded the 2010 guide.

Within this framework NHS AHP services have the autonomy to make sensible, clinically sound decisions about how to apply the rules in a way that is equal and consistent with how patients experience or perceive their wait.

Models of service provision vary across England and patient needs will be different when accessing AHP services. It is for the NHS locally to decide how the AHP RTT rules are applied equally to individual patients within their population, based on clinical judgement. This can be achieved through effective involvement, engagement and consultation with patients/carers, commissioners, providers and other key stakeholders.

The length of waiting times for NHS AHP services should be analysed, aggregated and monitored for the impact on different equality groups and communities, and used to develop and deliver services that promote equality and eliminate unlawful discrimination on the grounds of age, disability, ethnicity, sexual orientation, gender including transgender, religion or belief and human rights. The needs of carers, people in deprived communities and socially excluded, such as Asylum Seekers, Gypsies and Travellers, and homeless people should be considered in the context of AHP RTT data collection.

Who will be affected?

The AHP RTT Guide will help clinicians and frontline services to measure and monitor waiting times for patients accessing NHS funded AHP Services.

They will be of interest to clinicians, providers, commissioners and patients.

Evidence

What is the evidence for your answers to the above questions?

The available research suggests that the national consultant led RTT is being met and that there is scope for reductions in waiting times in some parts of the NHS (Harrison and Appleby, 2009)[1]. They suggest the degree of benefit from further reductions in waiting times would depend on a range of circumstances, including patient preferences, their economic and social circumstances and their clinical condition. Harrison and Appleby (2009), further suggest that the scope of waiting times should be widened to include services provided by allied health professionals, as some patients' needs for therapy are as urgent as for some elective procedures and the benefits of health-related quality of life is just as great. For example, stroke patients where therapeutic support is required if the patient is to have a good chance of effective recovery. Currently there is very little information about the queues and waiting times for therapy services or their current capacity levels.

It is suggested that a substantial amount of common health problems are either preventable or can be positively managed by the timely intervention of allied health professionals. Higgins (2009)[2] states that prompt access to appropriate services is known to improve the effectiveness of intervention and has a positive impact on sickness absence, staying in work or return to work. Services offered in a flexible, geographically accessible and timely manner result in reduced requirements for intervention, often prevent long-term problems developing and encourage personal responsibility for health.

Ghosh (2009) suggests that improving access to psychological therapies should cut waiting times for psychological treatment of depression and anxiety disorders from months to days.

Patients and staff said that to tackle waiting, the NHS would need to look at it from a patient's perspective. The consultant led waiting times rules capture the whole pathway journey from referral through to treatment and reports do not show any evidence that the consultant-led RTT policy has had any negative effect, therefore it is probable that AHP RTT would not either.

Age:

There is an ageing population, and older people are heavier users of health and social care services, there is little research evidence that specifically links age with issues of being able to access AHP services or of age-related discrimination in waiting times for NHS AHP services. And Davys (2008)[3], reports that it is considered to be good practice to involve older people in the planning of services.

[1] Harrison, A, J. and Appleby, J. (2009) English NHS waiting times: What next? Journal of the Royal Society of Medicine. 102. pp.260-264

[2] Higgins, J. (2009) Health, wellbeing and productivity. Chartered Society of Physiotherapists. November

[3] Davys, D. (2008) Ageism within Occupational Therapy? British Journal of Occupational Therapy, 71 (2)

Disability:

A MORI poll (2003)[4] found that more than nine out of ten disabled people had used a health service in the past three months, which is significantly higher than the general population. Dissatisfaction was highest among disabled people with the location of services (12 per cent) and choice over appointment times (18 per cent), whom they saw (12 per cent) and treatment or therapy provided (ten per cent). Control over appointments was an issue particularly identified by working and 35–54-year-old disabled people (21 per cent and 23 per cent respectively), and the amount of choice over appointment times was criticised most heavily by working disabled people (21 per cent, compared with 16 per cent of those who were not working).

Pitt (2009)[5] reports that most of England's adult social services have seen a rise in adult safeguarding referrals, and the Healthcare Commission (2009)[6] reported that groups representing patients and staff emphasised difficulties in accessing care for older people with mental health problems.

However, there is increasing evidence of inequality in English mental health service provision between 'younger adults' and people over 65 years old, with lower use of services by older people (Beecham, J et al., 2008)[7]. Ghosh (2009)[8] who cites *The 2006 Depression Report*[9] argues that NHS evidence-based psychological therapies should be available for all who need them to maximise the benefit of reduction in distress and suffering. This highlights the need for the local access policy to address and safeguard children and people in vulnerable circumstances. We are confident that the requirement on providers to comply with the associated

[4] MORI. (2003) Public perceptions of the NHS – winter 2003 Tracking Survey.

[5] Pitt, V. (2009) Safeguarding referrals up and jobs for disabled down. Community Care. 22 October. p.5

[6] Healthcare Commission. (2009) Equality in later life. A national study of older people's mental health services. London

[7] Beecham, J. et al,.(2008) Age Discrimination in mental health services. Personal Social Services Research Unit.

[8] Ghosh, P. (2009) Improving access to psychological therapies for all adults. Psychiatric Bulletin 33 (5) May. pp. 186-188

[9] The London School of Economics and Political Science. (2006) The Depression Report.

legislation will mitigate any risk of discrimination on the grounds of disability.

Ethnicity:

A report by Moriarty (2008)[10], noted that many research studies do not distinguish between older and younger people from minority ethnic groups, making it difficult to establish the effects of other influences on health, such as age or income. However, older people from black and minority ethnic groups tend to report poorer health than their white counterparts (Bajekal et al., 2004)[11].

Older people from minority ethnic groups tend to be less aware of what services are available and how to access them (Butt and O'Neil, 2004)[12], but they were over-represented among those consulting their GP. Many referrals to AHP services are from the primary care setting and therefore the likelihood of minority ethnic groups being under-represented due to access problems should be reduced. We are confident that the requirement on providers to comply with the associated legislation will mitigate any risk of discrimination on the grounds of race or ethnicity.

Gender:

There is little research evidence that specifically links gender with issues of access to AHP services or of gender related discrimination in waiting times for AHP services. We are confident that the requirement on providers to comply with the associated legislation will mitigate any risk of discrimination on the grounds of gender.

Religion or belief:

The Department of Health guide (2009)[13], reports on the wide range of religions and beliefs in the UK today, and how these impact on and influence attitudes to planning, giving and receiving healthcare. This requires NHS staff and clinicians to be culturally sensitive to the many perspectives that patients bring to ethical decision making.

They advise that it should never be assumed, however, that an individual belonging to a specific religious group will necessarily be compliant with or completely observant of all the views and practices of that group. Individual patients' reactions to a particular clinical situation can be influenced by a number of factors, including what branch of a particular religion or belief they belong to, and how strong their religious beliefs. For this reason, each person should be treated as an individual, and those treating them should try to ascertain their views and preferences before treatment begins.

[10] Moriarty, J. (2008) Better Health Briefing – The health and social care experiences of black and minority ethnic older people. Race Relation Foundation.. London

[11] Bajekal, M. et al,. (2004) Ethnic differences in influences on quality of life at older ages: a quantitative analysis. Ageing and Society.

[12] Butt, J. and O'Neill, A. (2004) Let's Move On – Black and Minority Ethnic Older people's views on research findings. Joseph Rowntree Foundation: York

We are confident that the requirement on providers to comply with the associated legislation will mitigate any risk of discrimination on the grounds of religion or belief.

Sexual Orientation:

Guidance from the *Care Quality Commission for inspectors* (2008)[14] highlights that good practice within services is to ensure that the words 'lesbian'/ 'gay'/ 'bisexual' and/or 'transgender' are visible in information, policies and guides on display in the service. It also advises that assessment and care plans should demonstrate that people have been given the opportunity to express any needs around their sexual orientation and gender identity.

Indirect discrimination is when services, criteria or practices that are applied generally, lead to people of a certain sexual orientation are put at a disadvantage, compared with other people when there is no justifiable reason for it. It is important to note that the negative impact on the person discriminated against does not have to be intentional. We are confident that the requirement on providers to comply with the associated legislation will mitigate any risk of discrimination on the grounds of sexual orientation.

[13] Department of Health. (2009) Religion or belief – A practical guide for the NHS. London

[14] CareQuality Commission. (2009) Sexual Orientation Guidance – Guidance for inspectors. London

Socio-economic groups:

Health and life expectancy are linked to social circumstances and childhood poverty and despite improvements, the gap in health outcomes between those at the top and bottom ends of the social scale remains large and in some areas continues to widen. These inequalities mean poorer health, reduced quality of life and early death for many people. Generally, the more affluent people are, the better will be their health; conversely, the poorer people are the worse will be their health (DH, 2003)[15]. There are wide differences among social groups, due to differences in opportunity, in access to services, and material resources, as well as differences in the lifestyle choices of individuals, but health inequalities exist across the population as a whole.

The *2007 Status Report* (DH, 2008)[16], informs of real improvements in health and social standards in recent years, which have improved the lives of almost all individuals and families. The report states that well-intended policies can improve average health but they may have no effect on inequalities and may even widen them by having greater impact on better-off groups. The evidence suggests that health improvements among better-off groups may have occurred at a faster rate than in other groups in the population. The result has been that the gap has not narrowed for life expectancy in disadvantaged areas; indeed, the gap has widened, particularly for women.

To address the needs of disadvantaged groups and areas *Commissioning Framework for Health and Well-being* (DH, 2007)[17], has put people at the centre of commissioning by promoting the use of information across boundaries to enable a better understanding of the needs of individuals and communities. A Joint Strategic Needs Assessment (JSNA) will underpin local needs assessments between the NHS and local government, providing a vehicle for tackling health inequalities at local level.

Age

The guide does not specifically address age, but it does focus on improving outcomes and experience for all equality groups, and includes scenarios that relate to children, adults and older people, therefore, no-one group is likely to be excluded as a result of implementing AHP RTT data collection.

Gender reassignment (including transgender)

Gender reassignment (including transgender) is not explicitly addressed in the AHP RTT guide. Community services are expected to promote health and well-being of gender reassignment (including transgender) people and should not discriminate or disadvantage people because of their gender.

[15] Department of Health. (2003) Tackling Health Inequalities. A Programme for Action. London

[16] Department of Health. (2007) Tackling Health Inequalities. Status Report on the Programme. 2007. London

[17] Department of Health. (2007) Commissioning Framework for Health and Wellbeing. London

Sexual orientation

The guide does not specifically address sexual orientation, but it does focus on improving outcomes and experience for all equality groups. The guide focuses on defining the NHS AHP RTT rules that can be applied equally and consistently for each patient referred to an NHS AHP service, so enabling the measurement of the time patients wait for treatment to take place.

Religion or belief

The guide does not specifically address religion or belief, but it does focus on improving outcomes and experience for all equality groups. The Q&A section acknowledges that some patients may choose to delay their appointment and this could be for religious reasons. The guide focuses on defining the AHP RTT rules that can be applied equally and consistently for each patient referred to an NHS AHP service, so enabling the measurement of the time patients wait for treatment.

Pregnancy and maternity

The guide does not specifically address pregnancy and maternity, but it does focus on improving outcomes and experience for all equality groups. The guide focuses on defining the NHS AHP RTT rules that can be applied equally and consistently for each patient referred to an NHS AHP service, so enabling the measurement of the time patients wait for treatment to take place.

Carers

The guide does not specifically address carers, but it does focus on improving outcomes and experience for all equality groups. However the guide includes scenarios that relate to carers, therefore, no-one group is likely to be excluded as a result of implementing AHP RTT data collection.

Other identified groups

The guide does not specifically address socio-economic status, but it does focus on improving outcomes and experience for all equality groups. The guide focuses on defining the AHP RTT rules that can be applied equally and consistently for each patient referred to an NHS funded AHP service, so enabling the measurement of the time patients wait for treatment to take place.

Engagement and involvement

Was this work subject to the requirements of the cross-government Code of Practice on Consultation? No

How have you engaged stakeholders in gathering evidence or testing the evidence available?

Invitations were sent out to the NHS requesting expressions of interest in becoming a pilot site. Their role in the project involved defining and testing the rules for AHP RTT and testing the ability of their local IT systems to collect AHP RTT and to extract the data for reporting purposes. AHP and IT representatives from the chosen 12 pilot sites attended regular meetings where their experiences could be shared and documented as lessons learned.

The DH 'AHP RTT Guide' was first published in March 2010, and over the past year a variety of NHS staff across England have made contact regarding AHP RTT data collection and reporting. Within the revised guide (2011), this feedback has been included as scenarios or Q&A's to provide greater clarity for applying AHP RTT rules, especially for multi-disciplinary and mental health services where AHP roles are blurred.

How have you engaged stakeholders in testing the policy or programme proposals?

All 12 pilot sites involved have received site visits and the data collected on their IT systems has been reviewed with them to ensure that clock starts and stops, including the reason for a clock stop, can be collected or derived.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

The pilot sites attend a pilot site meeting approximately every 8 weeks, initially to develop the rules for measuring RTT, to relate back what can actually be collected and reported at a local level, and to discuss what the national reporting should look like. Throughout lessons learned by the pilot sites have been shared and all this information has been included in a report to the Information Standards Board to support the approval of the Community Information Data Set which contains the RTT data items.

Summary of Analysis

Local voluntary monitoring of AHP RTT data, prior to mandatory collection nationally from April 2011 will provide services with information on the lengths of waiting times. The future implementation of community datasets, which includes the collection of data on all the above groups, will enable the collection of AHP RTT data, there will be the ability to analyse equality and diversity to understand if there are any links between waiting times and any of the above discussed evidence groups to ensure no particular group is adversely affected and reduce inequality at a local level.

Eliminate discrimination, harassment and victimisation

The guide recognises the need to ensure that every patient when accessing NHS AHP Services is treated equally and that the length of waiting times should be analysed, aggregated and monitored for the impact on different equality groups and communities. This information is to be used to develop and deliver services that promote equality and eliminate unlawful discrimination on the grounds of age, disability, ethnicity, sexual orientation, gender including transgender, religion or belief and human rights. The needs of carers, people in deprived communities and socially excluded, such as Asylum Seekers, Gypsies and Travellers, and homeless should be considered.

Advance equality of opportunity

The guide recognises the need to ensure that every patient when accessing NHS AHP Services is treated equally, thus promoting equal opportunity; And that within the framework NHS AHP services have the autonomy to make sensible, clinically sound decisions about how to apply the rules in a way that is equal and consistent with how patients experience or perceive their wait.

Promote good relations between groups

The guide recognises the need to ensure that every patient for any community group when accessing NHS AHP Services is treated equally, thus promoting equality and good relations between groups. And that within the framework NHS AHP services have the autonomy to make sensible, clinically sound decisions about how to apply the rules in a way that is equal and consistent with how patients experience or perceive their wait. Better integration would allow services to be organised around the needs of individuals, for example through individual care pathways to support people at home regardless of their disability, including those with long-term conditions. This approach is about promoting positive attitudes and challenging societal stereotypes about what disabled people can do or how they feel, focusing on their health and well-being not their disability.

What is the overall impact?

The guide recognises the need to ensure that every patient when accessing AHP Services is treated with fairness, equality, dignity, respect and autonomy. It emphasises the importance of:

- all equality groups of people and communities have equal and timely access to NHS AHP services in accordance with local access policy
- access to appropriate NHS AHP services, care and support when they need them with the dignity and respect
- ensuring that people have access to timely NHS AHP services to enable them to live at home giving them the autonomy
- ensuring that children's needs are looked through a holistic approach when they access NHS AHP services including at home and at school promoting equality
- ensuring people with mental health conditions and learning disabilities have access to NHS AHP services taking account of their needs fairly and equally people having information to be able to take an active role in their care giving them autonomy

Addressing the impact on equalities

We do not expect the guide to have a negative impact on any of the equality groups in terms of creating any problems or barriers, excluding people or having a negative impact on community relations.

The guide recognises the need to ensure that every patient when accessing NHS AHP Services is treated equally, and that within the framework NHS AHP services have the autonomy to make sensible, clinically sound decisions about how to apply the AHP RTT rules in a way that is equal and consistent with how patients experience or perceive their wait.

The length of waiting times for NHS AHP services should be analysed, aggregated and monitored for the impact on different equality groups and communities, and used to develop and deliver services that promote equality and eliminate unlawful discrimination on the grounds of age, disability, ethnicity, sexual orientation, gender including transgender, religion or belief and human rights. The needs of carers, people in deprived communities and socially excluded, such as Asylum Seekers, Gypsies and Travellers, and homeless should be considered in the context of AHP RTT data collection.

Action planning for improvement

The importance of AHP waiting times will increase as quality is embedded into the business agenda of the NHS. Commissioners will incorporate waiting times for patients accessing AHP services in service specifications and will monitor improvement in contract discussions with their providers.

From April 2011, providers of community services will be required to publish a Quality Account. By publishing a Quality Account, Provider Boards will be presenting their perception of the quality of their services, reflecting the dialogue with local stakeholders such as Commissioners and Local Involvement Networks (LINks), as well as what patients tell them is important to high quality care. A good Quality Account will draw on effective and systematic quality improvement programmes led by frontline services and informed by the feedback from patients on their experience of the care received. AHP RTT data will provide some of the evidence required to substantiate the information presented in the Quality Account.

Please give an outline of your **next steps** based on the challenges and opportunities you have identified.

It will take time to develop sufficiently robust AHP RTT data to enable benchmarking and comparison across all NHS funded AHP services. The first priority is to start collecting AHP RTT on local IT systems.

The data should also support analysis, aggregation and monitoring of the impact of services on different groups and communities, promoting equality and eliminating unlawful discrimination on the grounds of age, disability, ethnicity, sexual orientation, gender including transgender, religion or belief and human rights.

For the record

Name of person who carried out this assessment:

Debbie Wolfe

Date assessment completed:

2 Spetember 2011

Name of responsible Director/Director General:

Bob Ricketts

Date assessment was signed:

Action plan template

This template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for each policy.

Category	Actions	Target date	Person responsible and their Directorate
Involvement and consultation			
Data collection and evidencing			
Analysis of evidence and assessment			
Monitoring, evaluating and reviewing			
Transparency (including publication)			