Final Stage
Equality Analysis – proposals to introduce independent prescribing by physiotherapists

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Equality Analysis – Proposals to introduce independent prescribing by physiotherapists

Prepared by the Allied Health Professions team, Department of Health

Introduction

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty. It is up to each organisation to choose the most effective approach for them. This standard template is designed to help Department of Health staff members to comply with the general duty.

Equality analysis

Title: Proposals to introduce independent prescribing by physiotherapists

Relevant line in DH Business Plan 2011-2015: Engaging with citizens to co-produce better health and well-being outcomes and improving value for money

What are the intended outcomes of this work?

Under the current regulatory framework physiotherapy services use existing prescribing and supply mechanisms safely and effectively to improve patient care in clinical pathways where the application of the mechanisms are suited to the needs of patients. Extending independent prescribing to physiotherapists has the potential to improve the overall patient experience by allowing patients greater access, convenience and choice.

Physiotherapists assess and treat people with physical problems caused by accident, ageing, disease or disability using physical approaches in the alleviation of all aspects of the person's condition. Physiotherapists have been using medicines for injection therapy since the early 1990s via Patient Specific Directions (PSDs). Since 2000, local anaesthetics and corticosteroids have been used extensively via Patient Group Directions (PGDs) by injection therapists. PSDs, PGDs and, increasingly, Supplementary Prescribing are used by physiotherapists in a broad range of community and acute settings. Physiotherapists use these mechanisms with a range of relevant medicines in clinical areas spanning musculoskeletal, pain management, neurological, respiratory, emergency, women's health, paediatric and older peoples care.

Appropriately trained and annotated physiotherapists will be able to prescribe any licensed medicine within national and local guidelines for any condition within their area of expertise and competence within the overarching framework of human movement, performance and function.

In many clinical pathways, physiotherapists are the lead/first contact clinician. From a non-medical prescribing perspective, some services are unable to optimise the effectiveness of patient care because access to appropriate prescribing mechanisms is limited. Introducing independent prescribing by physiotherapists will future-proof healthcare services, with a frontline workforce that is flexible and capable of initiating the development of innovative new pathways for the benefits of patients. A more flexible workforce offers potential to improve value for money. It offers bespoke care to the patient, tailored to their personal needs. There is a negative cost implication to maintaining the status quo as service efficiency and innovation is potentially hampered.

The purpose of this final equality analysis (along with the regulatory impact assessment) is to outline potential impacts on both patients/service users and professionals from the introduction of independent prescribing by physiotherapists. Additional information was sought as part of the consultation process to inform this final equality analysis.

The objective of the project is to enhance patient care by improving access to medicines through the introduction of independent prescribing by physiotherapists to:

- improve the quality of service to patients without compromising patient safety
- make it easier for patients to get the medicines they need
- improve/increase patient choice in accessing medication
- streamline patient care by reducing the need for additional appointments e.g. with GPs
- contribute to increased collaborative and flexible team working
- maximise the benefits of fully utilising physiotherapists skills and decision making

Non-medical prescribing policy aims to improve patients' access to the medicines they need in a variety of locations; i.e. primary and secondary care, in the community, care settings and in people's homes. Non-medical prescribing helps to increase access to medicines and services for patients. It may specifically benefit and reduce barriers in access to medicines for different equality groups included in but not restricted to those included in the Equality Act 2010:

- age
- disability
- gender reassignment
- pregnancy and maternity
- race – this includes ethnic or national origins, colour or nationality
- religion or belief – this includes lack of belief
- sex
- sexual orientation.

Additionally other specific groups should be considered when developing policy, including; children and young people, travellers, asylum seekers, students, homeless and offenders.

Physiotherapists are a diverse group of healthcare practitioners, offering high quality specialised services and skills within their clinical field to patients and clients across a wide range of care pathways, in a variety of different settings. The Health Professions Council (HPC) is the statutory regulator for physiotherapists within the UK. Physiotherapists are graduates. From the point of registration, they are autonomous practitioners. Physiotherapists have four common attributes:

> They are, in the main, first-contact practitioners.

> They perform essential diagnostic and therapeutic roles.

> They work across a wide range of locations and sectors within acute, primary and community care.

> They perform functions of assessment, diagnosis, treatment and discharge throughout the care pathway – from primary prevention through to specialist disease management and rehabilitation.

An expansion in physiotherapist roles and responsibilities in recent years has included responsibilities for supply and administration of medicines using Patient Group Directions (PGDs) and responsibilities for prescribing as supplementary prescribers.

Currently, in England, Strategic Health Authorities (SHAs) commission non-medical training. Local Education and Training Boards (LETBs) will take over workforce planning and education and training commissioning from the Strategic Health Authorities (SHAs) in April 2013. Employers are responsible for selecting suitably eligible and prospective services/practitioners. The selection of services/practitioners is based on local need and competence, e.g. where there is a service gap or development that will enhance treatment offered to service users by improving access, streamlining service efficiency, improving patient outcomes and providing value for money.

The proposed introduction of independent prescribing by physiotherapists in phase 1 of the AHP medicines project is closely aligned to QIPP (Quality, Innovation, Productivity, Prevention) objectives, particularly by improving patient access, choice and convenience and with potential to release savings where bureaucracy is reduced and service re-design improves efficiency. Physiotherapy services have the potential to improve quality (for patients) and productivity by reducing processes or offering direct access to their service for assessment and/or treatment.

Who will be affected?
Patients, the public, health professionals in the NHS and independent/private sector practitioners will be directly affected.

Commissioners, the professional body (the Chartered Society of Physiotherapy), the Health Professions Council (HPC), Commission on Human Medicines(CHM), the Medicines and Healthcare products Regulatory Agency (MHRA) and academic/education providers will be indirectly affected.

There are 44785 physiotherapists registered with the HPC in UK[1]. Some are already using medicines supply and administration, and prescribing mechanisms through PSD/PGD or as supplementary prescribers.

Evidence

Non-medical prescribing policy was developed following consultation and recommendations in a review led by Dr June Crown *"Review of prescribing, Supply and Administration of Medicines"* [2]published in 1999. It recommended expanding prescribing by nurses and introducing non-medical prescribing by other professions, including AHPs to improve access to medicines for service users.

The Department of Health (DH) has extended independent prescribing responsibilities to nurses, pharmacists and optometrists in the last decade. The AHP medicines project comes under the umbrella of the Non-Medical Prescribing Programme at the DH. The objective of the non-medical prescribing programme is to: *"give patients quicker access to medicines, improve access to services and make better use of nurses', pharmacists' and other health professionals' skills".*

The report of the evaluation of nurse and pharmacist independent prescribing by the University of Southampton and Keele University[3] concluded that 'nurse and pharmacist independent prescribing in England is becoming a well-integrated and established means of managing a patient's condition and giving him/her access to medicines'.

What evidence have you considered?

The evidence presented below relates to the AHP Medicines Project. The evidence acknowledges the close alignment of the project objectives and QIPP to reduce inefficiencies and bureaucracy, focusing on improving outcomes for patients.

This analysis considers the implications of designing and developing the AHP Medicines Project and the proposal to introduce independent prescribing by physiotherapists on the equality agenda. There are two dimensions to this analysis: assessment of the impact on physiotherapists and interactions with patients, carers and the public according to their equality characteristic.

The equality analysis therefore aims to:

- identify any potential issues to progressing the introduction of independent prescribing by physiotherapists on any of the equality characteristics
- ensure mechanisms by which healthcare sector providers who decide to implement independent prescribing by physiotherapists take account of the potential equality issues informing continuing practice and service delivery to reduce inequality

[1] http://www.hpc-uk.org/publications/index.asp?id=453
[2] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4077151
[3] Department of Health (2011), *Evaluation of nurse and pharmacist independent prescribing*, London, DH

- inform further work within the Department of Health to identify impact of the AHP Non Medical Prescribing/Medicines Project on physiotherapists and patients, carers,,the public and clinical colleagues.

In relation to patient access and waiting times:

Research (Harrison and Appleby, 2009)[4] suggests that the national 18-week target for consultant led services is being met and that there is further scope for reductions below this in some parts of the NHS. The research suggests that further reductions in waiting times would depend on differing circumstances including patient preference, their specific circumstances and clinical condition. In addition, the report suggests the scope of access (waiting times) has the potential to expand to include services delivered by physiotherapists to support timely access and optimise patient outcomes. Harrison and Appleby further suggest that the scope of waiting times should be widened to include AHP services including physiotherapy. Patients' needs for therapy treatment may be as urgent as for some elective procedures and the benefits of health–related quality of life are just as great, for example, management of long term conditions, such as diabetes outside of a secondary care.

Higgins 2009[5] suggests that many health problems are preventable or can be managed positively by the timely intervention of AHP services including physiotherapy. The report states that prompt access to appropriate services may improve the effectiveness of intervention with a positive impact on sickness absence, staying in, and returning to work. Flexible services that are accessible from a variety of locations and offered in a timely manner result in reduced need for intervention often preventing long-term problems developing and encourage personal responsibility for health.

The AHP Service Improvement Project[6] recognised that waiting/access times to NHS services is best addressed from a patient's perspective. The time taken to access services is a key criterion in the overall patient's experience of a service and is one of the top five considerations in their requirements. Equality of access to a physiotherapy service relates to the methodology by which the service prioritises referrals and manages waiting times. Currently there is no robust data to suggest the best way to triage and prioritise access and assessment to physiotherapy services (Harding et al 2009)[7], although many of these in different sectors apply criteria in order to manage demand and capacity. Outcomes can be achieved by focussing on particular high-risk patient referrals e.g. high-risk patients with diabetes. Additional efficiency methods in care delivery are associated with the implementation of consistent documentation and the use of specific assessment and treatment processes (Scurrah et.al 2009)[8]. There is some evidence to suggest that different methods of patient participation may improve efficiency in the delivery of treatment due to the opportunity to engage and be involved with practitioners in the planning of their individual care. In turn this has potential to affect patient attendance and compliance with care programmes (Petersson et al[9] , NICE,2009[10])

Referral to treatment waiting times are a key indicator of service performance and patient experience.The Allied Health Professions (AHP) Referral to Treatment (RTT)[11] data collection enables services to gather consistent and robust data on access/waiting times.

[4] Harrison, A, J. and Appleby, J. (2009) *English NHS waiting times: What next?* Journal of the Royal Society of Medicine. 102. pp.260-264
[5] Higgins, J. (2009*) Health, wellbeing and productivity*. Chartered Society of Physiotherapists. November
[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126840
[7] Harding K, Taylor N, Shaw Stuart (2008) *Triaging patients for allied health services: a systematic review of the literature* British Journal of Occupational Therapy April 72 (4) 153-161
[8] Scurrah, A, (2009). *Effects of introducing an AHP proforma on the management of acute stroke patients.* Disability & Rehabilitation, Vol31, no15, July 2009
[9] Petersson, P et al. (2009). *Telling stories from everyday practice.* Health & Social care in the Community, vol17, no6. 2009
[10] National Institute for Health and Clinical Excellence, 2009. *Medicines Adherence Guidance*. January 2009. London
[11] http://www.dh.gov.uk/health/2012/01/ahp-rtt-data-collection

Disability

A MORI poll (2003)[12] identified that 90% of disabled people had accessed health services over a three month period. This is a significantly higher proportion compared to the general population. Disabled people ranked choice of appointment time (18%), location of service (12 %), clinician seen (12 %) and treatment provided (10%) according to their level of dissatisfaction. Control over appointments was an issue particularly identified by working and 35–54 year old disabled people (21% and 23% respectively). The amount of choice over appointment times was criticised most heavily by working disabled people (21%), compared with 16% of those who were not working). Respondents to the public consultation highlighted the potential for independent prescribing by podiatrists to support maintaining people in work and return to work.

Pitt (2009)[13] identifies that the majority of adult social services in England have seen an increase in adult safeguarding referrals. The Healthcare Commission (2009)[14] reported that both patient and staff groups emphasised difficulties in accessing care for older people with mental health problems. In addition, there is increasing evidence of inequality in English mental health service provision between 'younger' adults and adults over 65 years of age, with lower access of services by older people (Beecham J et al)[15]. This highlights the need for local health policies to address and safeguard vulnerable people when they require access to services.

There are examples of physiotherapists with disabilities training and working in the NHS, for example individuals with severe visual impairment practising as physiotherapists.
In 2002, *Improving Working Lives for the Allied Health Professions and Healthcare Scientists* [16]identified scope for people with disabilities to work as valuable members of the healthcare team.
"They will bring different insights and experience which can be important in relating to the needs and expectations of patients and others."

The *Breaking Barriers project*[17] identified that 87% of respondents with a disability believed that disabled people experience barriers to career progression.

Sex

There is limited evidence regarding gender considerations in relation to accessing physiotherapy services. Clinical factors may occasionally create a gender disparity in some services, for example, more boys may need to access musculoskeletal physiotherapy services. There is a gap in the evidence relating to how allied health professionals in general and physiotherapists in particular associate equal access to their services by men/women as particular groups and no evidence relating to how gender may create a diverse demand on the physiotherapy service.

Women make up four-fifths of the health workforce, a larger proportion than the wider public sector and significantly higher than in private industry[18]. Data indicates that women make up slightly higher proportions of the AHP workforce - 86.6% of the registered AHP workforce and 87.9% of support staff.

[12] MORI. (2003) Public perceptions of the NHS – winter 2003 Tracking Survey.
[13] Pitt, V. (2009) Safeguarding referrals up and jobs for disabled down. Community Care, p.5. 22 October.
[14] Healthcare Commission (2009). Equality in Later Life: A National study of older people's mental health services. Commission for Healthcare Audit and Inspection. March 2009
[15] Beecham J, Knapp M, Fernandez JL, Huxley P, Mangalore R, McCrone P, Snell T, Winter B, Wittenberg R (2008) Age Discrimination in Mental Health Services (PDF), Report to the Department of Health, PSSRU Discussion Paper 2536, Personal Social Services Research Unit, London.
[16] Department of Health (2002) *Improving Working Lives for the Allied Health Professions and healthcare Scientists*. Department of Health. London
[17] Breaking Barriers Project http://www.liverpool.ac.uk/breakingbarriers/

For example; there are currently 35156 female physiotherapists and 9629 male physiotherapists registered with the HPC[19] in the UK.

The University of Liverpool's *Breaking Barriers* project found that almost twice as many men (15%) as women (7%) hold senior AHP positions, despite the fact that women are heavily represented in junior roles. The survey found defined stereotypical views of men and women in the professions encapsulated as the view that "men progress and women care". Respondents saw part-time working as one reason for women's lack of progression, with many believing that part-time workers are treated less favourably. Another obstacle to progression was the nature of senior roles. Most AHPs interviewed wanted to remain clinically focused, but opportunities for progression were often limited to managerial roles.

No responses to the consultation commented on gender issues in regard to the proposals.

Race

In 2008, a report by Moriarty[20] 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 BME groups tend to report poorer health than their white counterparts (Bajekal et al,2004)[21].

Older people from minority ethnic groups are inclined to be less aware of services and how to access them (Butt and O'Neil, 2004)[22]. Many referrals to physiotherapy services are from the primary care setting and therefore there is potential to reduce access problems to physiotherapy services by minority ethnic groups, by direct referral or improved communication and awareness of physiotherapy services by GPs. Co-locating services within primary care/community settings could also improve access. Clinical staff participating in the AHP service improvement programme[23] identified a number of BME groups within their local populations, recognising the diversity of groups who may access physiotherapy services. A number of responses to the consultation highlighted the potential to improve access to services by vulnerable groups such as asylum seekers.

Data shows that 8.4% of AHPs are from minority ethnic groups and more specifically, 6.9% of physiotherapists[24] as compared to 14.2% for all non-medical staff groups.[25] There is no similar data for AHP support staff but 11.6% of all scientific, therapeutic and technical staff (which includes AHP support staff) are from minority ethnic groups[26]. The proportion of minority ethnic groups in the population in England is 9%[27].

The University of Liverpool's Breaking Barriers project[28] researched ways to remove obstacles to career progression for AHPs and to improve equality and diversity in the AHPs. In the first phase of the project, 1600 AHPs were surveyed and obstacles were identified to progression for women and minority groups. It found that while respondents agreed that the workforce should reflect the local community in terms of ethnicity, only 58% agreed that their own workforce did so. In addition, 64% of respondents felt

[18] Yar, M., Dix, D. and Bajekal, M. (2006) *Socio-Demographic Characteristics of the Healthcare Workforce in England and Wales – Results from the 2001 Census,* Health Statistics Quarterly 32, Winter 2006, pp44-56, National Statistics, London.
[19] http://www.hpc-uk.org/publications/index.asp
[20] Moriarty, J. (2008). *The Health & Social Care Experiences of black and minority older people.* Race Equality Foundation. London
[21] Bajekal, M. et al,. (2004) *Ethnic differences in influences on quality of life at older ages: a quantitative analysis.* Ageing and Society.
[22] 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
[23] ibid page 7
[24] *Non-medical staff 2011, detailed results table*, http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2001--2011-non-medical
[25] ibid
[26] ibid
[27] http://www.statistics.gov.uk/census2001/profiles/commentaries/ethnicity.asp
[28] ibid page 9

that people from ethnic minorities were not well represented at senior levels. Phase two of the project looked at senior career progression and barriers to achievement within the bio/health sciences sector and phase three explored experiences of progression to seniority in the Bio/Health/Care sectors. The research reviewed labour market issues in regards to the participation and progression of women. Findings of phases two and three will be used to further develop the competences to support career progression. The project is now complete and published.

Age

Pitt (2009)[29] identifies that the majority of adult social services in England have seen an increase in adult safeguarding referrals. The Healthcare Commission (2009)[30] reported that both patient and staff groups emphasised difficulties in accessing care for older people with mental health problems. In addition, there is increasing evidence of inequality between 'younger' adults and adults over 65 years of age in English mental health service provision with lower access of services by older people (Beecham J et al)[31]. This highlights the need for local health policies to address and safeguard vulnerable people when they require access to services across ages.

The AHP service improvement project aimed to improve the equality of care provided by services. A minimum of one children's service from each health region participated to ensure that the critical challenge of accessing/providing children's services was evidenced within the project. Many of these services reported a requirement for productivity gains which influenced innovation and service redesign to improve service delivery. Many services that participated in the project demonstrated leading improvement to service delivery where referral criteria identified an older population (stroke services), or a disease based population (diabetic services). However, none of the participating adult services specifically identified a target age group and there is no evidence that physiotherapy services distinguish between older and younger patients of different genders.

The responses to the consultation highlighted the potential for independent prescribing physiotherapists to improve access to medicines for particular groups such as older people – for example through provision of care closer to home.

Physiotherapists are degree entry professionals and are therefore unlikely to become a registered practitioner before 21/ 22 years of age. Data from the NHS Information Centre shows that 46% of physiotherapists are aged between 35 and retirement and 54% are concentrated between the ages of 25 to 40.[32]

There is an anecdotal rise in the number of mature students and physiotherapists returning to practice after a career break. AHPs have been at the forefront of improving access to training programmes, for example by introducing part-time and distance learning routes to education and training.

Gender reassignment (including transgender)

There is no research evidence linking gender reassignment with issues of access to physiotherapy services or of gender related discrimination in waiting times for services.
Similarly, no data is available regarding the number of transgender and transsexual individuals in the physiotherapy workforce.

[29] ibid page 9
[30] Healthcare Commission (2009). *Equality in Later Life: A National study of older people's mental health services.* Commission for Healthcare Audit and Inspection. March 2009
[31] Beecham J, Knapp M, Fernandez JL, Huxley P, Mangalore R, McCrone P, Snell T, Winter B, Wittenberg R (2008) *Age Discrimination in Mental Health Services* (PDF), Report to the Department of Health, PSSRU Discussion Paper 2536, Personal Social Services Research Unit, London.
[32] ibid page 10

Sexual orientation

The Care Quality Commission (CQC) has published regulatory guidance[33] which states that providers should ensure that care and treatment is provided to service users with due regard to all the protected characteristics defined in the Equality Act, including sexual orientation.

In 2006, Stonewall produced a report '*Harrassment and sexual orientation in the health Sector*[34]. This report provides a detailed analysis of what constitutes discrimination and homophobia and provides recommendations about how to respond to and prevent it. The Department of Health commissioned Stonewall to undertake a project identifying the key barriers to reporting of homophobia against health and social care employees. Stonewall's report '*Being the gay one: Experiences of lesbian, gay and bisexual people working in the health and social care sector*'[11] was published on 15 June 2007. The purpose of the report was to consider the nature rather than the extent of homophobia and as a result, the number of workers interviewed was 21. The participants represent a small number of staff who have faced discrimination at work, yet the participants were drawn from a wide range of locations and work in a variety of sectors.

Findings from the Breaking Barriers project[35] included that more than a third of all respondents thought sexual orientation would be a barrier to career progression, and nine per cent of male respondents felt their own sexuality had proved a barrier.

Indirect discrimination occurs when services, criteria or practices that applied 'generally', lead to people of a certain sexual orientation being put at a disadvantage. It is important to acknowledge that any negative impact on the discriminated person does not have to be intentional. No data is available regarding the number of lesbian, gay and bisexual people in the physiotherapy workforce:

The Employment Equality (Sexual Orientation) Regulations 2003[36] protect employees from harassment, victimisation, direct and indirect harassment. The Modernising AHP Career framework aligns competences with the *Health Functional Map*[37] that has underpinning principles including diversity and equality.

The responses to the consultation did not make specific reference to gender reassignment or sexual orientation. However, they did highlight the potential to improve access to medicines via delivery of services in a wider range of settings which may benefit these groups amongst others.

Religion or belief

The 2001 Census indicates 72% of the population of England state their religion or belief as Christian, 5% follow other religions or beliefs and 23% no religion or belief not stated[38]. No studies of this equality strand in respect of physiotherapists have been identified[39]. Religion or belief is not recorded in the *national survey of NHS staff*[40].

The Department of Health Guide (2009)[41] reports on the broad range of religion and beliefs in the UK today, and how these impact on and influence attitudes to planning, delivering and receiving healthcare. This requires staff and clinicians to be culturally sensitive to the many perspectives that patients bring to

[33] Care Quality Commission (2010) Essential Standards of Quality & Safety. Outcome 1 Regulation 17. March 2010. London
[34] Hunt, R., Cowan, K. (2006) '*Harrassment and sexual orientation in the health Sector*' Stonewall, London
[35] ibid page 9
[36] UKSI (2003)*The Employment Equality (Sexual Orientation) Regulations*
[37] https://tools.skillsforhealth.org.uk
[38] http://www.statistics.gov.uk/
[39] ibid page 10
[40] *Picker Institute Europe, NHS Staff Survey (2011), Oxford www.nhsstaffsurveys.com*
[41] Department of Health. (2009) *Religion or belief – A practical guide for the NHS*. London

ethical decision making.

Furthermore, the guide recommends that there should not be any assumptions that an individual belongs to a specific religious group, nor that they will necessarily be compliant with all the views and practices of that group. Individual patients' reactions to a particular clinical situation may be influenced by a number of factors, including what particular religion or belief they belong to and how strong their beliefs are. Therefore, every patient should be treated as an individual and their views and preferences should be ascertained and accommodated as part of their care/treatment programme by staff before treatment commences.

The competence-based career framework has a positive impact in terms of religion or belief as the competences are aligned to the Health Functional Map. Skills for Health's *Health Functional Map tool* helps indivuals to find competences that have been mapped to eight functional areas which are underpinned by four principles: communication; equality and diversity; health, safety and security; and safguarding and protecting individuals. This raises awareness of respecting the religion or belief of individuals and considers these interactions with service users and work colleagues, identifying those competences necessary to achieve this.

The responses to the consultation did not include any comments with regard to religion or belief.

Pregnancy and maternity

There is no research evidence linking pregnancy and maternity with issues of patient access to /waiting times for AHP services.

The impact of pregnancy and maternity was apparent in the cohort of service leaders participating in the AHP service improvement project. Just over 10% of the service leads transferred their responsibilities to colleagues and no disadvantages were evident – demonstrating employer support for AHP service managers.

Carers

There is limited evidence about the impact of carer engagement or carer needs in physiotherapy services. Local initiatives have engaged parents as partners in children's services. Carers and parents were identified as key stakeholders in the AHP service improvement project.

The responses to the consultation did not specifically reference impact on carers directly. However, a number of responses did refer to the potential for care closer to home, travel (time and costs), taking time off work and reducing need for additional appointments which might impact on both patients and carers.

Other identified groups

Health and life expectancy are linked to social circumstances and childhood poverty. 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, more affluent people have better health outcomes; conversely, poorer people have the worse outcomes in relation to their health (DH, 2003)[42]. 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.

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

The 2007 Status report (DH,2008)[43] highlights real improvements in health and social standards which have changed 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 equalities and may even widen them by having a greater impact on 'better-off' groups. The evidence suggests that health improvements amongst affluent groups may have occurred at a faster rate than in other population groups. The result has been that the gap for life expectancy in disadvantaged areas has increased, particularly for women.

The review of progress[44] since the Acheson Report in 1998 noted significant improvements in the health of the population , mainly by disadvantaged groups – for example average life expectancy for all groups in England had increased and infant mortality had fallen. However inequalities between different groups and areas and the whole population persisted.

To address the needs of disadvantaged groups/areas, the Commissioning Framework for Health and Wellbeing (DH,2007)[45] promoted the use of sharing information across traditional boundaries to put people at the centre of commissioning and to enable a better understanding of the needs of individuals and communities. A Joint Strategic Needs Assessment (JSNA) and strategy undertaken by Health and Wellbeing Boards will underpin local needs assessments between the NHS and local government, providing a vehicle for tackling health inequalities at local level.

Engagement and involvement

Was this work subject to the requirements of the cross-government Code of Practice on Consultation?
Yes

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

A clinical stakeholder engagement workshop took place on the 4th April 2011 to gather intelligence and evidence of current equality evaluation within clinical practice. A further workshop was held on 4 November 2011. The workshops highlighted the potential for independent prescribing by podiatrists to improve access to medicines, delivery of care closer to home and redesign of service delivery to streamline care for all groups. Communication between healthcare professionals was also highlighted as key to realising the potential for independent prescribing by podiatrists to improve services for all groups.

Representatives from the Devolved Administrations sit on the AHP Medicines Project Board.

The Impact Assessment and Equality Analyses carried out by DH with input from the devolved countries meets the necessary requirements of the categories outlined in the Section 75 Order with regards legislative changes to the, UK wide Medicines Act 1968 and the Misuse of Drugs Regulations (Northern Ireland) 2002 and Pharmaceutical Services Regulations (Northern Ireland) 1997 to implement the changes in Northern Ireland, to enable the development of Independent Prescribing for Podiatrists and Physiotherapists.

Each of the Devolved Administrations has highlighted a number of policies/strategies that support the evidence presented in this EA.[46] [47] [48] [49] [50] [51] [52] [53] [54]

[43] Department of Health. (2007) *Tackling Health Inequalities.* Status Report on the Programme. 2007. London
[44] Department of health (2009) *Tackling Health Inequalities 10 years on, A review of developments in tackling health inequalities in England over the last 10 years*, DH, London.
[45] Department of Health. (2007) Commissioning Framework for Health and Wellbeing. London
[46] *A Healthier Future, a Twenty Year Vision for Health and Well-being in Northern Ireland, 2005 – 2025, DHSSPS 2004* http://www.dhsspsni.gov.uk/healthyfuture-main.pdf
[47] *A Workforce Learning Strategy for the Northern Ireland Health and Social Care Services 2009-2014, DHSSPS April 2009* http://www.dhsspsni.gov.uk/workforce-learning-strategy-apr-2009.pdf

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

Following recommendation of the MHRA, an engagement exercise was held over twelve weeks between the 3rd September - 26th November 2010, in respect of physiotherapy independent prescribing. The engagement exercise had been approved by ministers and was available to everyone to respond. We sought to gather the views of patients/patient representative groups, the public, healthcare providers, commissioners, doctors, pharmacists, regulators, non-medical prescribers, the Royal Colleges and other representative bodies.

The exercise provided background information to the existing prescribing and supply mechanisms used by physiotherapists and invited views on possible changes to medicines legislation, which would enable appropriately trained physiotherapists to prescribe independently where there was an identified population need. The same questions were asked in each of the physiotherapist and podiatrist engagement exercises. 388 responses were received with 91% of respondents supporting taking forward independent prescribing by physiotherapists and podiatrists (83% from individuals, 17% from organisations).

The engagement exercise gathered information on the key issues in respect of independent prescribing by physiotherapists and this was used to inform the public consultation in the autumn of 2011.

A public consultation on proposals for independent prescribing by podiatrists took place between 15 September and 20 December 2011. The UK wide consultation was issued jointly by DH and the Medicines and Healthcare products Regulatory Agency (MHRA) on the DH website and consultation hub with a link on the MHRA website.

Invitations to respond to the public consultation were sent to chief executives of all Royal Colleges, regulators, national professional organisations and NHS Trusts. Wider engagement with organisations and groups with an interest were also contacted including third sector organisations, patient groups, Arms Length Bodies and NHS Networks. In addition to notification of the consultations on DH and MHRA websites there were links on Devolved Administrations websites, on HPC and NPC websites and in DH Bulletins. Leaflets and posters were disseminated through networks to frontline clinicians, patients, carers and the public.

There were 689 responses in total, 77 on behalf of organisations and 612 responses from individuals including doctors, pharmacists, nurses, podiatrists, patients, carers and members of the public. Two questions invited respondents to provide additional information on specific equality characteristics particularly concerning; disability, ethnicity, gender, sexual orientation, age, religion or belief, and human rights (Question 7) and specific groups e.g. students, travellers, immigrants, children, offenders

[48] *Quality 2020 – A 10 Year Quality Strategy for Health and Social Care in Northern Ireland, DHSSPS 2011* http://www.dhsspsni.gov.uk/quality2020.pdf

[49] *Improving Health and Well-being Through Positive Partnerships, A Strategy for the Allied Health Professions in Northern Ireland 2012-2017,* 2012, DHSSPS Belfast www.dhsspsni.gov.uk/ahp-strategy-feb-2012.pdf

[50] *Transforming your care – A Review of Health and Social Care in Northern Ireland*, 2011, DHSSPS Belfast http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf

[51] *AHPs as agents of change in health and social care – The National Delivery Plan for the Allied Health Professions in Scotland, 2012 – 2015*, The Scottish Government, Edinburgh (2012) http://www.scotland.gov.uk/Publications/2012/06/9095/0

[52] Welsh Government(2011). Together for Health A Fiver Year Vision for the NHS in Wales. Welsh Government http://wales.gov.uk/topics/health/publications/health/reports/together/?lang=en

[53] Welsh Government (2012) Achieving Excellence. The Quality Delivery Plan for the NHS in Wales 2012-2016. Welsh Government http://wales.gov.uk/topics/health/publications/health/strategies/excellence/?lang=en

[54] Welsh Government (2012) Working Differently - Working Together. A Workforce and Organisational development framework. Welsh Government http://wales.gov.uk/topics/health/publications/health/strategies/working/?lang=en

(Question 8). Not all responses to the public consultations included responses to these questions (20 responded to question 7 and 33 responded to question 8).The responses received were used to inform completion of this final stage Equality Analysis.

A wide range of clinical, professional, policy, service user, educational stakeholders and representatives from the Devolved Administrations have been included in the project board, consultation drafting group, equality workshop and impact assessment development following evaluation of the responses to the engagement exercise to ensure information and data is accurate and appropriate where available.

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

Equality workshop – 4th April 2011 – presentation by the Equality & Inclusion Team at the Department of Health, to the workshop attendees on the purpose of the new Equality Act 2010 and the requirement of the equality evaluation for the policy development.

Attendees included: professional bodies, council of Deans, AHPF, Royal Army Medical Corps, England Hockey, AHP clinicians from, podiatry, physiotherapy, radiography, dietitians, service managers, SHA, PCT, commissioners and service users.

Information captured at the workshop was used to inform the consultation stage Equality Analysis.

Equality workshop – 4 November 2011 - Following up on feedback from the consultation, the original workshop members were invited to a follow-up workshop to reflect upon responses and comments on the Equality analyses and to undertake further work examining the proposals' potential impact on equalities.

Attendees included: professional bodies, patient representatives, AHPF, Royal Army Medical Corps, podiatrists, physiotherapists and radiographers.

The key outputs include summaries of responses to three questions:

- What issues barriers may groups face in fully benefiting from podiatry services currently?
- How could independent prescribing by podiatrists affect the issues/barriers that groups face?
- What suggestions can you offer to mitigate any negative impact identified?

Information gathered at the workshop informed this final stage Equality Analysis.

Summary of Analysis

There is a gap in the evidence associated with gender specific access to physiotherapy services. Whilst there is sometimes a clinical rationale for greater numbers of patients of one gender: there is no evidence of the equality or inequality of access to service.

Physiotherapy services who participated in the service improvement project have developed their understanding of local requirements to address the equality agenda by engaging with patients to achieve equality of access to services across all patient populations. Knowledge relating to the specific needs of children and older people is particularly good by physiotherapy services at a local level.

The public consultations highlighted the potential for independent prescribing by physiotherapists to improve access to services for vulnerable groups such as the homeless and travellers, and to streamline care for other groups – particularly for older people and those with disabilities.

Eliminate discrimination, harassment and victimisation

Evaluation of prescribing by physiotherapists should include work to better understand how prescribing activity can support equality in health service provision.

Advance equality of opportunity

As this is a new policy there is no evidence already available, however it is anticipated that the introduction of independent prescribing will improve access to medicines for groups within the community or home setting. This will reduce some of the barriers faced by groups in accessing services including older people, disability, carers and groups such as travellers. As autonomous practitioners, physiotherapist independent prescribers would be able to work in a much more flexible way. Within a local context service providers and commissioners can use service redesign to address specific characteristics of equality and the needs of specific groups.

Promote good relations between groups

The workshops held in April and November 2011 specifically focused on equalities and brought together participants to contribute diverse perspectives

What is the overall impact?

At present physiotherapist supplementary prescribers are restricted by the requirement for a medical prescriber to agree the medical treatment required. This involves additional appointments and delays in patients receiving the required medications. This is particularly problematic in rural and remote communities where access to a GP or acute doctor may not be practical. The introduction of independent prescribing by physiotherapists will enable innovative care pathway redesign. An independent prescriber physiotherapist would be able to treat patients directly and prescribe the required medications at the time, reducing cost, time and travel for patients. This will be particularly beneficial for groups in rural and remote locations, travellers, small community hospitals or specialist clinics or services.

Specific groups such as older people and people with disabilities can benefit through avoiding the need for additional appointments to obtain a prescription. Vulnerable groups such as homeless people may not be registered with a GP. Physiotherapists working as independent prescribers can play a role in delivering services for such groups.

Addressing the impact on equalities

The workshop held on the 4th April 2011 demonstrated that there is not sufficient existing evidence to evaluate whether Equality Act characteristic groups are either positively or negatively impacted by the current service provision. As the proposed changes to regulations enabling physiotherapists to independently prescribe will increase flexibility of access to services and the way in which services can be delivered it is assumed that there will be a benefit to any existing inequalities. However raising awareness of clinicians in considering equality characteristic groups in the development of service re-design would ensure that groups are not inadvertently disadvantaged. A further workshop held in November 2011 confirmed the potential for independent prescribing by physiotherapists to address specific characteristics of inequalities and the needs of specific groups. Further work will be undertaken to highlight the potential impact on equalities within the outline curricula, practice guidance and

DH Implementation guidance.

Action planning for improvement

Equality Area	Key legislation/policy	Level of impact	Assessment
Disability	Equality Act 2010		Need to consider people with learning, physical and sensory disabilities and their ability to understand and take their medicines.
Sex	Equality Act 2010		
Race	Race Relations Act 1976/Race Relations (Amendment) Act 2000 Equality Act 2010		Need to consider verbal and written communication and the needs of ethnic minorities.
Age	Equality Act 2010		
Gender/sexual Orientation	Equality Act 2010		
Religion/Belief	Equality Act 2010		Local services will need to be aware of products which may be inappropriate for patients due to their religion/belief.
Pregnancy/Maternity	Equality Act 2010		
Carers	Equality Act 2010		

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

  -Preparation of a specification for evaluation of prescribing by podiatrists to include how prescribing activity can support equality in health service provision
  - Review of practice guidance documents in respect of equality and diversity
  - Review of outline curricula frameworks in respect of equality and diversity
  - Review of DH Implementation Guide in respect of equality and diversity

For the record

Name of person who carried out this assessment:
Andrea Holder/Laura Weatherill/Jo Wilkinson/Shelagh Morris

Date assessment completed:
7 August 2012

Name of responsible Director/Director General:
Karen Middleton
Chief Health Professions Officer

Date assessment was signed:
8 August 2012

Action plan template

This part of the 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 your policy.

Category	Actions	Target date	Person responsible and their Directorate
Monitoring, evaluating and reviewing	- Preparation of specification for evaluation and identification of funding	March 2013	Shelagh Morris, PHD/ Jo Wilkinson, PHD
	- Review of practice guidance	August 2012	Shelagh Morris PHD/ Jo Wilkinson PHD
	- Review of Outline Curricula Frameworks	August 2012	Shelagh Morris PHD/ Jo Wilkinson PHD
	- Review of DH Guidance for Implementation of independent prescribing	March 2013	John Wright MPI

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