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

Developed in partnership with the Medicines and Healthcare products Regulatory Agency
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Prepared by the Allied Health Professions team, Department of Health

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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? include outline of objectives and function aims

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. In addition, it increases the confidence of the patient and medical colleagues in the clinician.

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 doctors’ directions and 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.

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 by the need to accommodate incongruence between existing mechanisms and patient need.

The purpose of this draft 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 is being sought as part of the consultation process to fill the gaps in information relating to the impact on equality groups by the proposal to introduce independent prescribing by physiotherapists.

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
- increase patient confidence in the care they receive from physiotherapists
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 coincided with the increased use and supply of medicines.

Who will be affected? *e.g. staff, patients, service users etc*

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

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

If any other individuals or groups will be affected, please state these on the reply form.

There are 35,200 physiotherapists registered with the HPC in England¹. Many are already participating in the non-medical prescribing agenda through PGD/PSD or exemption mechanisms or as trained supplementary prescribers.

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The Department of Health funds Strategic Health Authorities (SHAs) to commission non-medical training locally, and employers are responsible for selecting suitably eligible and prospective services/practitioners. The selection of services/prescribers 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, and are at the forefront of maintaining quality (for patients) and productivity by reducing processes or offering direct access to their service for assessment and/or treatment.

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” 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 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 recent evaluation of nurse and pharmacist independent prescribing by the University of Southampton and Keele University 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 within the Professional Leadership Team. 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 AHPs (specifically physiotherapists) and their interactions with service users 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
- inform further work within the Department of Health to identify impact of the AHP Non Medical Prescribing/Medicines Project on physiotherapists and their interactions with service users, the public and clinical colleagues.

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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, 2009\(^3\) 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. At present, there is very little information about access/waiting times for therapy services or their capacity levels.

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\(^10\)).

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\(^{7}\) Direct Survey of the AHP SIP service leads (2009)(unpublished)

\(^{8}\) 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


Disability

A MORI poll (2003)\(^{11}\) 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).

Pitt (2009)\(^{12}\) identifies that the majority of adult social services in England have seen an increase in adult safeguarding referrals. The Healthcare Commission (2009)\(^{13}\) 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)\(^{14}\). This highlights the need for local health policies to address and safeguard vulnerable people when they require access to services. We are confident that requirements on providers to demonstrate compliance with the associated legislation will mitigate any risk to patients and the public on the grounds of disability.

There is no evidence regarding the prevalence of people with a disability in the physiotherapy workforce.

However, 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* \(^{15}\) 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.” However, in 2007 the *Breaking Barriers project*\(^{16}\) identified that 87% of respondents with a disability believed that disabled people experience barriers to career progression.

The AHP Medicines Project public consultation will highlight the gap in information to ensure that healthcare sector organisations who choose to implement independent prescribing by physiotherapists, support people with disabilities to undertake roles, for which they are, with reasonable support from their employers, competent and eligible to undertake.


\(^{16}\) Breaking Barriers Project (http://www.liverpool.ac.uk/breakingbarriers/)
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\textsuperscript{17}. 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. For example; there are currently 35425 female physiotherapists and 9399 male physiotherapists registered with the HPC\textsuperscript{18} 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.

Race

In 2008, a report by Moriarty\textsuperscript{19} 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.,\textsuperscript{20}). Older people from minority ethnic groups are inclined to be less aware of services and how to access them (Butt and O’Neil, 2004).\textsuperscript{21} However, this group are over-represented among the proportion of patients accessing/consulting their GP. 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\textsuperscript{22} identified a number of BME groups within their local populations where services had considered the needs of these groups by completing equality assessments. For example recognising the diversity of groups who may access physiotherapy services.

\textsuperscript{18} http://www.hpc-uk.org/publications/index.asp?id=453

Direct Survey of the AHP SIP service leads (2009)(unpublished)
Data shows that 8.2% of AHPs are from minority ethnic groups and more specifically, 6.8% of physiotherapists\(^{23}\) as compared to 14% for all non-medical staff groups.\(^{24}\) There is no similar data for AHP support staff but 11.1% of all scientific, therapeutic and technical staff (which includes AHP support staff) are from minority ethnic groups.\(^{25}\) The proportion of minority ethnic groups in the population in England is 9%.\(^{26}\)

The University of Liverpool’s Breaking Barriers project\(^{5}\) 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 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)\(^{27}\) identifies that the majority of adult social services in England have seen an increase in adult safeguarding referrals. The Healthcare Commission (2009)\(^{28}\) 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 et al)\(^{29}\). 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 under funding and a requirement for productivity gains which combined to influence intervention and service ability to offer patient care at a time when it could be most beneficial. Many services who 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.


\(^{27}\) Pitt, V. (2009) Safeguarding referrals up and jobs for disabled down. Community Care, p.5. 22 October.


Physiotherapists are degree entry professionals (with the exception of operating department practitioners) 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. \(^{30}\)

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. The competences obtained during training through use of the learning design principles are then the same competences that all AHP practitioners need to deliver services.

### 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.

### Sexual orientation

The Care Quality Commission (CQC) has published regulatory guidance \(^{31}\) 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’ \(^{32}\). 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’ \(^{33}\) 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 \(^{33}\) 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.

The Employment Equality (Sexual Orientation) Regulations 2003 \(^{34}\) protect employees from harassment, victimisation, direct and indirect harassment. The Modernising AHP Career framework aligns competences with the *Health Functional Map* that has underpinning principles including diversity and equality.

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\(^{33}\) Breaking Barriers Project ([http://www.liverpool.ac.uk/breakingbarriers/](http://www.liverpool.ac.uk/breakingbarriers/))

\(^{34}\) OPSI (2003)*The Employment Equality (Sexual Orientation) Regulations*
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: However the AHP professional leadership team is confident that, going forward, the requirement on local providers to comply with the associated legislation mitigates the risk of discrimination on the grounds of sexual orientation.

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. No studies of this equality strand in respect of physiotherapists have been identified. Religion or belief is not recorded in the national survey of NHS staff.

The Department of Health Guide (2009) 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 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 individuals 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 safeguarding 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.

Pregnancy and maternity
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 leaders transferred their responsibilities to colleagues and no disadvantages were evident – demonstrating employer support for AHP service managers for the duration of the project.

There is no research evidence linking pregnancy and maternity with issues of access/waiting times to AHP services. However, the AHP professional leadership team is confident that the requirement on local providers to comply with the associated legislation mitigates the risk of discrimination on the grounds of pregnancy and maternity.

35 http://www.statistics.gov.uk/cci/nugget.asp?id=954
36 http://www.statistics.gov.uk/cci/nugget.asp?id=954
37 The Information Centre for health and Social Care (2007) Non-medical workforce census
Carers
Carers and parents were identified as key stakeholders in the AHP service improvement project. 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.

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)\(^39\). 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)\(^40\) 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.

To address the needs of disadvantaged groups/areas, the Commissioning Framework for Health and Wellbeing (DH,2007)\(^41\) promotes 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) 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 4\(^{th}\) April 2011 to gather intelligence and evidence of current equality evaluation within clinical practice. This general understanding of the scope of awareness and current activity will be followed up with a more targeted workshop during the consultation period to fill any gaps in existing knowledge, to identify and plan any further activity required, to ensure that we have consulted with all equality groups, and to establish where information may be lacking.

To be updated following the public consultation to include actions that will be required of others

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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 will be used to inform the public consultation in the autumn of 2011. In addition, the responses provide a basis for further discussion with the MHRA to seek their advice regarding the options for inclusion in the public consultation.

A wide range of clinical, professional, policy, service user and educational stakeholders 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.
The key outputs include a draft report that captures the information and data currently in place within clinical practice and identified the gaps in information. The draft report identified a number of gaps and further engagement workshops are planned to be held with equality group representatives to look at ways in which information can be captured and to ensure engagement and communications with equalities groups during the consultation period.

Further information to be added following the public consultation, including actions that will be required of others.
Summary of Analysis

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

Physiotherapy services have local accountability for equality impact within their service/service redesign. However, whilst organisational support may be available, there appears to be a general low level of awareness relating to the local responsibility for assessment of the impact on equality. 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.

This Equalities Assessment will be reviewed after the public consultation on the proposals to introduce independent prescribing for physiotherapists. It is hoped that the responses received from the consultation will help inform this document, which will be updated and amended with relevant evidence that comes to light.

Eliminate discrimination, harassment and victimisation

To be completed following the public consultation, including actions that will be required of others.

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. This assumption can be assessed by respondents during the consultation period, but as autonomous practitioners, physiotherapist independent prescribers would be able to work in a much more flexible way.

To be updated following the public consultation, including actions that will be required of others.

Promote good relations between groups

To be completed following the public consultation, including actions that will be required of others.
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.

To be updated following the public consultation, including additional information.

Addressing the impact on equalities

Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.

The workshop held on the 4th April 2011 demonstrated that there isn’t 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 workshop will be held during the consultation period to engage with clinicians and equality groups to address this.

To be updated following the public consultation, including additional actions that will be required of others.
**Action planning for improvement**

To be updated following a further engagement workshop and the public consultation.

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<th>Equality Area</th>
<th>Key legislation/policy</th>
<th>Level of Impact</th>
<th>Assessment</th>
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<tbody>
<tr>
<td>Disability</td>
<td>Disability Discrimination Act 1995 and 2005</td>
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<td>Need to consider people with learning, physical and sensory disabilities and their ability to understand and take their medicines: this will be a question to be included in the forthcoming public consultation to introduce independent prescribing by physiotherapists (autumn 2011)</td>
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<td>Disability Equality Duty 2006</td>
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<td>Single Equality Act 2010</td>
<td></td>
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</tr>
<tr>
<td>Sex</td>
<td>Sex Discrimination Act 1975 / Equal Pay Act 1970 / Equalities Act 2006 / Gender Recognition Act 2004 / Gender Equality Duty 2007</td>
<td></td>
<td>Need to consider verbal and written communication and the needs of ethnic minorities: this will be a question to be included in the forthcoming public consultation to introduce independent prescribing by physiotherapists (autumn 2011)</td>
</tr>
<tr>
<td></td>
<td>Single Equality Act 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>Race Relations Act 1976/Race Relations (Amendment) Act 2000</td>
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<tr>
<td></td>
<td>Single Equality Act 2010</td>
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<tr>
<td>Age</td>
<td>Age Regulations 2006</td>
<td></td>
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<tr>
<td></td>
<td>Single Equality Act 2010</td>
<td></td>
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<tr>
<td>Gender/sexual</td>
<td>Equalities Act 2006</td>
<td></td>
<td></td>
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<tr>
<td>Orientation</td>
<td>Relevant employment legislation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Single Equality Act 2010</td>
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<td></td>
</tr>
<tr>
<td>Religion/Belief</td>
<td>Equalities Act 2006</td>
<td></td>
<td>Local services will need to be aware of products which may be inappropriate for patients due to their religion/belief: this will be explored with representatives from minority ethnic groups and in addition will be a question to be included in the forthcoming public consultation to</td>
</tr>
<tr>
<td></td>
<td>Relevant employment legislation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Single Equality Act 2010</td>
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</table>
introduce independent prescribing by physiotherapists (autumn 2011)

<table>
<thead>
<tr>
<th>Category</th>
<th>Relevant Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers</td>
<td>Single Equality Act 2010</td>
</tr>
</tbody>
</table>

- Please give an outline of your next steps based on the challenges and opportunities you have identified.
  - Engagement workshop with key stakeholders and equality group representatives
  - Public consultation questions to improve knowledge of existing inequalities

For the record
Name of person who carried out this assessment:
Andrea Holder/Laura Weatherill/Jo Wilkinson

Date assessment completed:
14th July 2011

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

Date assessment was signed:
# 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.

<table>
<thead>
<tr>
<th>Category</th>
<th>Actions</th>
<th>Target date</th>
<th>Person responsible and their Directorate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement and consultation</td>
<td></td>
<td>September 2011</td>
<td>Jo Wilkinson, CNO-D</td>
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<td>Laura Weatherill, CNO-D</td>
</tr>
<tr>
<td>Data collection and evidencing</td>
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<td>Ongoing</td>
<td>Laura Weatherill, CNO-D</td>
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<tr>
<td>Analysis of evidence and assessment</td>
<td></td>
<td>Ongoing</td>
<td>Laura Weatherill, CNO-D</td>
</tr>
<tr>
<td>Monitoring, evaluating and reviewing</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Transparency (including publication)</td>
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<td></td>
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</tbody>
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