

# Equality Analysis

*Allied Health Professionals:  
Service Improvement Project*



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Prepared by the AHP Service Improvement Project 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 and 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.

# Equality analysis

**Title: AHP Service Improvement Project**

**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?

The Allied Health Professions (AHP) Service Improvement Project aims to reduce waits experienced by users of AHP services in community and acute settings by March 2011 and improve or maintain the quality of services by measuring clinical outcomes and user experience. The project is closely aligned to the Quality, Innovation, Productivity and Prevention work stream in the DH business plan and was re-approved by submission in October 2010.

The AHPs were not included in the 18 week target (DH 2009) unless their services were part of the consultant led episode of care. Some AHP services therefore began to identify increased waiting times due to a number of factors.

The AHP Service Improvement Project was implemented to support local services in the delivery of specific service improvements that quantified and addressed the long waits that prevented patient's accessing timely rehabilitation intervention. Local leaders were responsible for interventions and adopted service improvement tools engaging with teams in their locality to manage the process and share outcomes of improvement.

SHA's were co-producers of The Service Improvement Project. 97 AHP services were identified as having long waiting times or intractable issues associated with access. All the participating AHP services provide services and serve a total population delineated by geography and local demographic. Out of the group of 97 services, 30 were selected to receive a bespoke and programme funded support for their service re-design. 15 of the chosen services were for children with disabilities and 13 for adults predominantly with long term conditions. A further 2 services were based on system wide organisational improvement that aimed to improve waiting times for patients to a mixed population of adults and children.

The Service improvement project objectives, by the end of March 2011, were:

- To deliver sustainable reduction in waiting times in a diversity of AHP Services to meet the quality and productivity challenge
- To evidence the maintenance or improvement of quality in relation to effectiveness, safety and the service user experience
- To develop sustainable methods for managing data (Referral to Treatment)
- To disseminate learning from the project to support capability of AHP services to deliver service improvement

The project was delivered in two phases (September 2009- March 2010) and April 2010- March 2011). During the first phase, a process was constructed following the initial EQIA screening assessment for the project. An analysis of the local engagement with service users was undertaken and service improvement leaders were asked whether they had undertaken a local assessment of impact on equality. The survey was undertaken by a telephone interview conducted by the project managers. The outcome of the survey (Appendix A) informed the design of further development activity and interventions by the national project team.

### **Who will be affected?**

The local ambition for patient benefit focused on reduced waits and maintained or improved quality and productivity. These benefits were identified by local services in the initial project initiation document. The AHP Service Improvement Project has delivered the specific and measurable achievements of AHP services in 27 of the 30 organisations within the original cohort of 30. In addition, a further evaluation of those not selected for further support revealed that about half of the group who responded (54 non selected services) also reported service improvement and reduced waiting times for patients. The project has supported local leadership and team practices to apply methods that adopt good practice in improvement and ultimately to share outcomes of service re-design. The ambition was to spread knowledge and skills in service improvement widely in the AHP community and across professional practice.

The project reinforced a close alignment to QIPP ambitions, particularly in releasing savings where bureaucracy had been reduced. The initiative focussed on maintaining quality for patients *and* productivity; making cost savings by reducing waste and demonstrating that local AHP services were able to demonstrate efficiencies by reducing processes or offering direct access to assessment and treatment. Evidence relating to fair access to services and the retention of equality and fairness was therefore a continuing concern, especially in the light of the requirement to pilot the application of the referral to treatment data collection guide.

The approval for completion of the project ensured that the benefits to patients and service users were a foremost concern, through a service level agreement. All 30 services would engage service users and redesign their delivery to achieve better health outcomes, safer care and an improved patient experience.

#### *Patient engagement and participation in service redesign;*

Patients and staff reported that to tackle waiting times, the NHS would need to look at this from a patient's perspective. Waiting times are generally cited as a key requirement in the patient's experience of a service and access is among the top five considerations in the patient's requirement (see Picker Institute 2009). Equality of access to an AHP service relates to the methods by which the service manages waiting and also how the criteria for referral are applied. AHP services recruited to the project were all those with long waits where the service sought to manage a change and therefore also sought to provide better access to all populations currently served within the care group, within the locality of referral.

## **Evidence**

## What evidence have you considered?

The evidence supplied here relates to the Service Improvement Project as a particular programme funded activity within the Professional Leadership Team and is in line with the wider 'AHP Service Improvement Workstream', which works with the referral- to- treatment data, guide as part of Transforming Community Equipment (TCS). The evidence also recognises that the project objectives closely align with QIPP and the achievement of the efficiencies and reduction in waste, whilst also aiming for patient centred quality outcomes.

### *Access and waiting times;*

The available research suggests that the national 18-week target for consultant led services was being met and that there is scope for reductions below 18-weeks in some parts of the NHS (Harrison and Appleby, 2009). They suggest the degree of benefit from further reductions in the 18-week waiting times would depend on a range of circumstances, including patient preferences, their economic and social circumstances and their clinical condition. Harrison and Appleby (2009), further suggest that the scope of waiting times should be widened to include services provided by allied health professionals, as some patients' needs for therapy are as urgent as for some elective procedures and the benefits of health-related quality of life is just as great. For example, stroke patients where therapeutic support is required if the patient is to have a good chance of effective recovery. Currently there is very little information about the queues and waiting times for therapy services or their current capacity levels.

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

### *Access to children's services*

The ability to communicate effectively impacts on the quality of life outcomes for children and is a fundamental human right (DCSF, 2008). Additionally the cost to the nation of a society with poor communication skills is significant (ICAN, 2006).

DCSF (2008) The Bercow Report: A review of services for children and young people (0-19) with speech, language and communication needs London: HMSO. Speech, language and communication difficulties represent a substantial problem in the community. Nationally, one in six children have difficulty in learning to talk and understand others, according to a 2009 You Gov poll of parents of children aged 1-7; amongst boys this figure rises to 22 percent. 7 percent of five year olds nationally – on average two or three in every classroom – have specific difficulties in speech, language and communication, which are not associated with environmental or demographic factors. In addition, there are children with speech, language and communication needs that are secondary to other impairments or disabilities.

In areas of high social deprivation the percentage of children with difficulties is considerably higher than this. More than half of children starting nursery school in socially deprived areas of England have delayed language – while their general cognitive abilities are in the average range for their age, their language skills are well behind. Those who struggle to communicate are at high risk of poor outcomes. They include educational achievement, behaviour and vulnerability, mental health, employability and criminality. A recent study of unemployed men

found that over 88 percent were described as language impaired, having some degree of difficulty with spoken language.

#### *Access and productivity*

There is currently no robust data to suggest how best to triage and prioritise assessment to AHP services (Harding et al 2009) but this is one of the mechanisms intended to include or exclude groups of patients from treatment. Many AHP services across different sectors set criteria in order to manage demand against capacity. Productivity outcomes are therefore achieved by focussing assessment on particular groups of patients (referrals) that meet criteria (eg, 'High risk patients with diabetes). Alternative or additional methods to drive efficiencies in care delivery are associated with the implementation of consistent documentation and the use of specific assessment and treatment processes (Scurrah et al 2009). There is some evidence to suggest that different methods of patient participation may achieve more efficient delivery of desired treatments (Demming 2000) due to the involvement and opportunity to engage with practitioners in the planning of care and resulting in better attendance and compliance with care (Petersson et al 2009)

Further evidence relates to the different populations of patients who may be affected by local service re-design.

#### **Disability**

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

Pitt (2009) reports that most of England's adult social services have seen a rise in adult safeguarding referrals, and the Healthcare Commission (2009) reported that groups representing patients and staff emphasised difficulties in accessing care for older people with mental health problems. However, there is increasing evidence of inequality in English mental health service provision between 'younger adults' and people over 65 years old, with lower use of services by older people (Beecham, J et al., 2008). Ghosh (2009) cites The 2006 Depression Report and, argues that NHS evidence-based psychological therapies should be available for all who need them to maximise the benefit of reduction in distress and suffering. This highlights the need for the local access policy to address and safeguard children and people in vulnerable circumstances. The project team are confident that the requirement on providers to comply with the associated legislation will mitigate any risk of discrimination on the grounds of disability.

#### **Sex**

There is limited evidence regarding gender considerations relating to access to AHP services. Clinical factors may, occasionally create a gender disparity in some services for example, more boys need to access to scoliosis services. There is a gap in the evidence associated with how

services equalise the access to AHP services to men and women as particular groups and no evidence relating to how gender may create a diverse demand on the AHP service.

### **Race**

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

Older people from minority ethnic groups tend to be less aware of what services are available and how to access them (Butt and O'Neil, 2004), but they were over-represented among those consulting their GP. Many referrals to AHP services are from the primary care setting and therefore the likelihood of minority ethnic groups being under-represented due to access problems should be reduced.

Service leads taking part in the project could identify a number of BME populations in their locality, South West Kent recognised a new older population of retired Gurka men and Leicester had completed an Equality Impact Assessment recognising the diversity of BME populations who may access physiotherapy. We are therefore confident that the requirement on providers to comply with the associated legislation will mitigate any risk of discrimination on the grounds of race or ethnicity.

### **Age**

The Service Improvement Project aimed to achieve improved quality to AHP services but prioritised the recruitment of at least 10 children's services (one per region) to ensure that the critical challenges of accessing children's services was evidenced within the project. A number of children's services (within the initial 97) reported under funding and a need to deliver productivity gains so that they could see more patients at the age when the intervention could be most beneficial, for example Speech and Language therapy at pre school age. The AHP SIP specifically aimed to recruit children's services used? the evidence in the Bercow report (2009) which identified that access to AHP services was limited.

AHP clinicians led improvement to specific services where the referral criteria identified an older population (eg stoke services), a disease based population (eg diabetic) or a specific intervention (eg wheelchairs) but none of those adult services recruited specifically identified a target age group. There is no evidence that services distinguish between older and younger patients of different genders.

### **Gender reassignment (including transgender)**

There is no research evidence that specifically links gender reassignment with issues of access to AHP services or of gender related discrimination in waiting times for AHP services. We are confident that the requirement on providers to comply with the associated legislation

will mitigate any risk of discrimination on the grounds of gender.

### **Sexual orientation**

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

Indirect discrimination occurs when services, criteria or practices that are applied generally, lead to people of a certain sexual orientation being put at a disadvantage. It is important to note that the negative impact on the person discriminated against does not have to be intentional. The project team is confident that the requirement on local providers to comply with the associated legislation mitigates any risk of discrimination on the grounds of sexual orientation.

### **Religion or belief**

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

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

### **Pregnancy and maternity**

The impact of pregnancy and maternity was evident in the cohort of service improvement leaders selected to undertake improvement, there was no evidence of any being disadvantaged. Four of the 30 selected service leads transferred project responsibilities to colleagues and we are confident that the requirement on employers to support AHP service managers was in place for the duration of the project. This mitigated any possible discrimination on the grounds of pregnancy or maternity.

### **Carers**

Carers and parents were identified as key stakeholders, particularly by children's services within the project. There is limited evidence about the impact of carer engagement or carer need in AHP services, although clearly there is transferred information from other evidence. Local initiatives have engaged parents as partners in children's services and the project team have confidence that local responsibility mitigates any risk of discrimination on the grounds of carer /parental role and has, in a number of cases enhanced the participation of carers.

### **Other identified groups**

Health and life expectancy are linked to social circumstances and childhood poverty and despite improvements, the gap in health outcomes between those at the top and bottom ends of the social scale remains large and in some areas continues to widen. These inequalities mean poorer health, reduced quality of life and early death for many people. Generally, more affluent people have better health outcomes; conversely, poorer people have the worse outcomes in relation to their health (DH, 2003). 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), informs of real improvements in health and social standards in recent years which have improved the lives of almost all individuals and families. The report states that well-intended policies can improve average health but they may have no effect on inequalities and may even widen them by having greater impact on 'better-off' groups. The evidence suggests that health improvements among 'better-off' groups may have occurred at a faster rate than in other groups in the population. The result has been that the gap has not narrowed for life expectancy in disadvantaged areas but has widened, particularly for women.

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

## Data

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## Engagement and involvement

Was this work subject to the requirements of the cross-government [Code of Practice on Consultation](#)? NO

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

30 services were selected from a wider group of 97 based on their project initiation documentation. They were selected for their local engagement in service improvement to benefit their patient group.

The services were selected to participate on the basis of their ability to deliver the planned improvement and the local organisational sponsorship. The selection process was designed to ensure that fairness and transparency were put in place and that participating and non selected services would be informed throughout the process.

This was also an important process to reflect the range of professional and care group areas, so that a diversity of patient groups were reflected in the distribution of selected services. The following table provides an overview of the number of projects submitted from each SHA, as well as the mix of children's and adult services to go forward to the selection process.

Submitted projects were invited to attend a day long development that helped them to prepare a project initiation document. Following the 10 regional events there were a total of 88 submissions of which 18 were submitted incomplete following the initial events.

#### **NHS North West:**

10 submitted (1 mixed; 3 children; 5 adults)

#### **York and Humber:**

9 submitted (2 mixed; 3 children; 4 adults)

#### **South Central:**

9 submitted (2 children; 7 adults)

#### **East of England:**

10 submitted (4 children; 6 adults)

#### **East Midlands:**

9 submitted (1 mixed; 3 children; 5 adults)

#### **South East Coast:**

9 submitted (2 children; 7 adults)

#### **South West:**

5 submitted (1 mixed; 1 children; 4 adults)

#### **London:**

10 submitted (1 mixed; 3 children; 6 adults)

30 services were selected using the following five criteria. Project documents were scrutinised for the following ;

1. Measurable improvement in waiting times
2. Selection of key performance indicators for the project including clinical outcomes, productivity, effectiveness and patient experience
3. Potential for generic, transferable learning
- 4 Clear project action plan

## 5 Demonstration of clear data collection methodology

A panel was created to select 30 services, this included user and professional representation alongside DH project team membership. The projects that were selected were those that demonstrated a confident level of capability and understanding of the improvement task and showed evidence of capability to manage local improvement. The selection group were concerned with retaining the diversity of services in the selected group including; scope of project, range of AHPs, and care groups. The number of children's services (ideally one third of all AHP services) that attended the 10 regional events was also specified in the selection criteria and the original project brief.

The breakdown of the 30 AHP services selected for intensive project support were as follows;

Childhood obesity 2  
 Orthotics 1  
 Childhood scoliosis 1  
 Parent led therapy 1  
 Children's therapy 5  
 Personal equipment 1  
 Chronic fatigue 1  
 Physiotherapy MSK – acute service 4  
 Integrated point of access 1  
 Physiotherapy MSK – chronic 2  
 Integrated therapies 1  
 Podiatry 2  
 Neurology services 2  
 Speech and Language Therapy Services for Children 3  
 Wheelchairs 3

### **Break down by Children, adult and mixed projects**

The overall outcome of selected projects were 15 children's services, (5 more than had been specified in the original project specification) 13 adult services and 2 services for adults and children. These selected projects included 5 different AHP groups working in uni-professional services or within a multi-professional therapy team. Physio therapy were the largest group of practitioners followed by Occupational Therapy, Speech and Language Therapy, Dietetics and Orthotists

### **Project Planning and Implementation**

Each selected service was offered bespoke and intensive support for their service improvement. In addition, a range of guidance and requests for information were made directly to services by the project team alongside the consultant support offered. An initial survey relating to EQIA and user engagement was undertaken in October 2009.

The following actions were undertaken by the project team;

- Suggestion and requirement to address key local issues related to EQIA responsibility
- Development and distribution of particular values and principles to support user engagement and patient participation
- Professional social networking to share knowledge and take up evidenced based knowledge and practice

The consultant support was focussed on;

- The management and reporting of local data, particularly related to patient waiting times
- Learning and development activity to initiate stakeholder engagement at an organisational level and as a cross sector commitment
- Methods and support for strategic communications and collaborative working with stakeholders including the use of technology
- Adoption of tools and methods to improve sustainability and ensure that helpful changes to local delivery are maintained

The SIP project also procured a university (YSJU) to undertake a wider analysis of the outcomes across the 30 services and to identify the achievements and improvements in the remaining 67 services. The report on the achievements at the end of phase 1 (to March 2010) identified that 4 of 30 services had undertaken a systematic approach to user engagement in their redesign and that only 1 had reported formally undertaken a local EQIA.

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

The 30 services were supported to improve quality and productivity through local redesign. The DH vision (*Equity and excellence: Liberating the NHS* Department of Health, July 2010) for an NHS will:

- put patients at the heart of everything the NHS does
- focus on continuously improving those things that really matter to patients - the outcome of their healthcare, and
- empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services

Specifically, the SIP engages with the Government's strategic vision by achieving the following:

- rehabilitation and re-ablement to realise patient goals
- evidence-based treatments to achieve independent living and return to work
- services that work across organisational boundaries and proactively engage with commissioners to benefit patients and reduce cost

The non-selected services were not offered further project support following the initial meeting. We have collected information that suggests that about 30% of these services have undertaken service improvement through re-design but we do not have data on local EQIA undertaken to support this work.

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

The engagement with 30 AHP SIP services, was as follows;

#### **1. Telephone survey- All SIP leaders were interviewed to establish the extent of user engagement and EQIA activity within the local project**

- The extent to which the 30 AHP services were using local EQIA protocols
- Evaluate the local user and carer engagement in the AHP SIP
- Suggest that local EQIA was a priority to underpin the local understanding of inclusion and good practice in service redesign

### **Findings**

All 30 service improvement leaders were approached to respond to a telephone interview and responded to 10 questions (see appendix A). The results of the survey demonstrated that the AHP leads were not fully aware of their responsibilities in terms of equality impact assessments associated with the service re-design and required further project-based support to help them to achieve the re-design of service that improved waiting times and access to all their local populations.

Furthermore, very few services had access to local EQIA services via their organisations and considered themselves to be 'at a distance' from the local support for the procedure. In some cases, SIP leads knew that the EQIA was a requirement but had not recognised that the project may have implications for service user populations who were harder to engage and who may be disadvantaged by the planned changes. Some examples of services who did recognise the requirement for equality impact assessment included;

- Self Referral Physiotherapy Project- Barnet- the system required patients to 'ring-and-rebook' that necessitated access to a telephone and an understanding of written communication
- Children's wheelchair Service- Haywood, Richmondshire and Hambleton, - the project sought to increase and measure the social inclusion of children by improving access to wheelchair service
- A&E discharge planning –North Tees and Hartlepool, recognised the diversity needs in the older people being referred to intermediate care and sought to manage the more vulnerable older people within their re-design of documentation and waiting times

The AHP SIP leads surveyed through the telephone interviews were knowledgeable about the more marginal populations that they served, particularly in relation to ethnic background and social-economic disadvantage. Several service leads were able to identify the demographic make up of their locality and name at least two groups who were disadvantaged in relation to the uptake of their service. In other cases, services were less informed and could not recognise any special attention to their planning as a result of equalizing opportunity for harder to reach groups and stated that no measures had been used or were planned to ensure equality of access. This high level of variation in knowledge and awareness was identified as a concern for the national project.

Finally, the survey also identified the priority that SIP leads were giving to user participation and engagement in their service delivery and the re-design. There were a limited number of services using direct mechanisms to speak to or garner opinion about user and patient experience, particularly in relation to access and waiting times. The opportunity existed for services to significantly address this as a priority during the AHP Local SIP and several services identified this as a key action to support their improvement.

## **2. Report and advice from User Sub Group of the SIP Project Board**

User groups are consistently identifying access to services as a primary preference (Picker

Institute 2010). The reduction in waits to AHP services directly relates to improving access for all populations. AHP services offer services that focus on;

- rehabilitation and re-ablement to assist self-management of a long-term condition,
- optimising function within a disabling condition or
- managing a deteriorating condition or end of life care.

User representatives brought the issue of user, patient engagement in service redesign to the project board for further consideration and a sub group of the project board was formed to generate the advice and guidance for the project. This set of values and principles were formulated by a sub-group and introduced to SIP leaders at a project learning event in April 2010.

### **Outcomes**

The principles and values associated with user participation in service improvement (see Appendix B) were intended to support learning and development for the project teams and to reinforce the notion of user participation in service re-design. A further catalyst to the adoption of the principles and values was a small grant of £2k in March 2010, which was offered to participating services. The project did not seek formal reporting of how the grant was used but services have reported that they have used the grant to plan and carry out events focussing on user and stakeholder engagement at local level;

- Coventry Children's OT service delivered several open events where face to face briefings were held with parents and carers and children to inform their priorities for accessing the service
- Buckinghamshire NHS Trust held a number of PALS co-ordinated events in June 2010 to engage service users. They invited feedback on the rehabilitation they had received and sought to evaluate the access issues for the back care service, including an appraisal of guidelines for earlier intervention and re-design plans.

The outcomes of user and carer /patient participation in the 30 local SIPs was reported in September 2010 at a further SIP meeting with service leads and reports from services about their collaboration with user and carers as stakeholders evidenced a significant change to the level and type of consultation and feedback. The improvements in operational aspects of equality and diversity management were evident and are more fully reported as an impact of the interventions:

- Services saw service user evaluation of treatment intervention as a minimum engagement.
- Services developed systems to engage users and carers to inform the improvement and prioritization of organisational change.
- Services used several organisational methods to ensure that services met patient expectation including, complaints monitoring and association with PALS teams and governance teams
- Services engaged with the local EQIA teams and undertook EQIA in line with their local governance arrangements

### **3. Raising awareness and shared learning related to EQIA**

The emphasis on local leadership of the SIP necessitated a clear devolution of responsibility for the EQIA ,user engagement and patient participation, the project team have not sought further information from local services. The interim national meeting included a presentations

from national and regional leaders relating to inclusive service improvement from NHS West Midlands SHA- regional programme Lead for Pacesetters change programme. The final meeting to close the AHP SIP is planned for 29<sup>th</sup> March and each service will present a displayed summary relating to the achievement of their improvement activities, especially focussed on efficiencies and quality improvements in relation to safety, experience, including access and clinical outcomes. This meeting will raise the criticality of the improvement champions who will share and learn the outcomes in relation to sustainability and review the outputs in relation to project goals. Several services who demonstrated a high achievement in relation to equalising impact will present at this meeting.

**Summary of Analysis** *Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.*

There is a gap in the evidence associated with gender specific access to AHP services and 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.

AHP services have local accountability for equality impact within their service re-design and whilst to the organisational support available, there initially appeared to be low level of knowledge relating to the local responsibility for Equality Impact Assessments.

The participating AHP services in the project have actively taken up the development offered, particularly in relation to engaging patients and carers and many have understood the requirement to achieve an equality of access to all patient populations. The knowledge about the diversity of groups within locality was good and there was particular knowledge related to the specific needs within the area of disabled children and vulnerable older people.

*Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.*

**Eliminate discrimination, harassment and victimisation** *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

The project sought to recruit services equally across the country by engaging regions with a focus on AHP services. Improvements have been carried out in children's services and in services for adults with long term disabilities, including older people.

**Advance equality of opportunity** *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

There is no clear evidence that any particular group has been advanced by the project

**Promote good relations between groups** *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

There is a particular emphasis in the project on engaging patients as partners in the redesign of services and this is evidence in the services where they have generated systematic ways of discussing service delivery with users and carers. There are examples of where people with

disabilities, users of wheelchairs and parents of children with disabilities have informed the planned change. The development of better partnership working between professional groups and patients has been evident and this has modelled the ways of systematically engaging service users and carers in the service re design

**What is the overall impact?** *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?*

The overall object of the project was to increase quality of access and achieve local improvement in relation to safety, patient experience and clinical outcomes. 24 of the 30 selected services have evidenced reduced waiting times to their local population of patients and many services have provided direct access to AHP services.

The 27 AHP teams taking part in the SIP from January 2010 to January 2011 have all made a great deal of progress. The changes were all designed to be sustainable in the longer term, but current and imminent challenges to sustainability including financial and re-organisation need to be taken into account. In the course of undertaking this change, the AHP teams have developed their ability to bring about change, use data to analyse, demonstrate and validate improvements, and take a more patient centred and productive view of their service.

All services sought engagement with service users and carers, with the principal methods being user surveys, meetings with existing groups, and establishing focus groups specifically for the improvement.

The services are using a wide range of quality and outcome metrics to identify and measure improvements, reflecting the variety of different services taking part in the SIP. Outcome measures include registered Patient Reported Outcome Measures (PROMs) and progress against individually agreed patient goals.

The main strategies for achieving the improvements were;

- giving patients easier and quicker access to a service
- altering the skill mix of practitioners involved in a care pathway
- redesigning clinical pathways or developing new ones

Most services used multiple changes in order to achieve their results and in some cases, it is clear that the strategy for change emerged as the improvement progressed. Service improvement leads reported that membership of the national SIP had been helpful, specifically in relation to the practical elements it provided (advice, support and service improvement tools), the heightened profile the SIP gave the local work, and the positive effect on motivation and morale of the team.

Many of the services have shown gains in productivity and 10 have quantified projected financial savings from the improvement, ranging from projected annual savings ranging from £1900 to £275,000. Others indicated that they made better use of clinician time and were able to treat a larger number of patients with no increase to resources.

## Addressing the impact on equalities

All services reported engagement with service users during the delivery of service re-design. Raised awareness of user engagement in service redesign and the provision of resources supported the implementation of more effective methods of user engagement. A specific requirement within the service level agreement was a commitment to “enhanced user engagement and feedback from patients demonstrating clinical outcomes, safe care and reporting patient experience”.

An evaluation of the progress of the project was carried out by York St John University in January 2011 (Ref). The report showed, all services provided evidence of active engagement of users in their service improvement, with a range of activities illustrated in the following table:

Method of engaging with service users	Responses
User survey	19
Set up specific focus groups	11
Worked with existing user group(s)	14
Worked with expert patients on an individual basis	3
Worked with carers	6
Worked with education staff	2
Set up a user group	2
Other*	5

\*‘Other’ responses included inclusion on a project board, publishing a newsletter, stakeholder consultation events, and carrying out a scoping exercise with the general public.

For some services, user engagement has included partner agencies. This is particularly the case with service to children and young people where services will aim to achieve effective access for parents, carers and early years and education staff as a means of embedding intervention into home and school environments.

10 teams said they sought information from users on their baseline experiences of their services, 7 teams said they sought user advice on aspects of the proposed new services, and 10 teams had sought feedback on aspects of the new service: 3 of these had already set up ‘before’ and ‘after’ the change feedback mechanisms.

***“Service users have been consulted prior, during and after their treatment to canvass their thoughts and feelings about the service redesign. This has been achieved through Patient Focus Groups, pre and post questionnaires, calling patients who DNA (did not re-attend) post classes/groups/treatment and completing Patient Stories”. (MSK Therapy Service, Barnet Community Services)***

*From our initial patient focus group the patients identified the following issues for change:*

- *Reduction of waiting times*
- *Easier to contact the service*
- *Keen to self refer*

This resulted in the development of a “ring and rebook” function which empowered service users to call to book their follow-up appointment with the exception of vulnerable adults and children who were offered a follow-up appointment after the initial intervention.

Two services reported user involvement in the development of their local access policy as an aspect of adopting Referral to Treatment Definitions and Guidance (insert RtT ref)

*[Users were involved in] Reporting on their experience of the patient pathway both before and after service improvement. (Stroke Rehabilitation, East Kent Hospitals University NHS Foundation Trust)*

Two teams said they had involved users in process mapping to redesign the service, bringing users into the detail of what the new services should provide:

*Through the focus group a revised service process map was developed and changes to service contact points were introduced to streamline the referral and engagement process for the programmes. (Childhood Obesity Services, SW Essex Community Services)*

*[A significant involvement was] Process mapping with referrers and users to map services, blockages and barriers to determine areas required for change. (Posture and Mobility Centre, Heywood, Middleton & Rochdale Community Healthcare)*

In addition to seeking information from service users, it was common to provide patients and carers with information about the changes to services, and more opportunity to discuss the treatment, as in these two examples from children's services.

*[Work with parents included] Improving parents' understanding through introduction of parent groups alongside OT treatment groups, parent workshops SLT, screening assessments (SLT and Physio) parent advice at drop in clinics. (Children's AHP Therapies, Hampshire Community Health Care)*

*[One action has been] the introduction of a range of parent / carer workshops. The assessment to treatment waiting time has also been significantly reduced by the introduction of these workshops. They are offered to parents/carers as soon after the initial assessment appointment as possible. (Children's Speech and Language Therapy Service, West Kent Community Health)*

Seven service improvement initiatives lead to changes in the location of the delivery of service to increase accessibility and to offer choice to service users.

For example:

**West Kent Community Health Speech and Language Therapy Service**

Created a parent forum and developed a service improvement objective:

*Reduction in the inequity of provision because of the centralization of the booking process for initial appointments and the introduction of a prioritization tool across the service*

All Early Years therapists in this service now provide a set number of initial assessment appointment slots per week to the team's administrator so that families have a choice of venues and appointments to choose from. Previously, a child referred in March 2009 would have waited on average 666 days or 95 weeks from referral to treatment. As a result of the redesign from September 2010 a child waited on average 119 days or 17 weeks. The team have also reduced the number of Early Years children waiting for their first appointment from 463 at the beginning of the project to 68 in mid January 2011.

Two teams said they had involved users in process mapping to redesign the service:

For example,

### **Heywood, Middleton & Rochdale Community Healthcare Wheelchair Service**

*[A significant involvement was] Process mapping with referrers and users to map services, blockages and barriers to determine areas required for change*

Involving users in process mapping enabled the service to explore barriers to clients attending appointments. Non-attendance was broken down to 11 areas and solutions were generated to break down barriers to attendance.

This led to development of an advocacy system on receipt of referral to support child and family through process. Waiting time was reduced from 40 weeks to 25 and the non-attendance rates were reduced from 15 % to 5 %.

## **Action planning for improvement**

The Service Improvement Project completes in March 2011 with a final national meeting and final project board meeting. There are no plans to continue to monitor or centrally manage the 27 projects that have achieved the local improvements. Sustaining local improvement has been an ongoing objective of the AHP service improvement project reflected in the project objectives. Services selected to receive bespoke support also reflected on the risk of failing to manage waiting times and ensured that their project initiation documents identified these risks. They also sought to plan service improvement that demonstrated commitment to sustainable benefit to patients.

Given the present policy context and the emphasis on localism and clinical leadership, the service improvement project will end in March 2011. Responsibility for monitoring local service re-design will be with the host organisation and accountable to the commissioning arrangements. The local assessment of impact on equalities will be the responsibility of the clinical manager; to ensure that the optimum outcome is achieved for all populations of patients for service innovation and quality improvements.

A number of conclusions can be drawn in relation to the EQIA from the work and these are supported by the independent evaluation of the project. There is a need to raise awareness and share local knowledge about the organizational support available for assessing and

equalising the impact of service re designs. The additional support and prompt within the project ensured that local responsibility was taken up by the AHP clinical leaders.

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

The survey undertaken in March 2010 identified only 5 services had undertaken local EQIA in line with their responsibilities and when prompted (by the survey intervention) several committed to take this forward. It would appear for the survey of local AHP services, that many services did not understand their responsibility for managing the equality of impact and that they were insufficiently connected with their local officer to support the activity.

The AHP SIP has made only minimal intervention in relation to further prompting EQIA. Taking the survey results as indicative of low levels of patient and user engagement in the 30 AHP services, the project prioritised the introduction of patient participation in local re-design, and the systematic and patient centric planning of quality improvement. The spread of good practice and facilitation of the adoption of local EQIA is necessary and will promote further engagement within the AHP community.

This priority was successful insofar as the services shared and spread methods to both seek and use patient feedback- but also made significant and systematic engagement possible. The consultation and involvement now needs to be progressed to include, all service user populations and particularly those who have not accessed services due to social, economic or factors associated with ethnicity, race or gender.

The ambition to publish widely is a project objective and a number of channels have been put in place to achieve the desired learning from the work undertaken in local services. The channels reflect local, national and international audiences and internal liaison within DH, for example, the quality and health improvement community, the AHP professional bodies and AHP Federation.

Planned channels for communication are as follows;

- CHPO website
- The AHP Bulletin
- Professional journals and publications including professional conferences
- International conferences
- Local and regional clinical and professional fora

**For the record**

**Name of person who carried out this assessment: Sally Fowler Davis**

**Date assessment completed:**

17<sup>th</sup> March 2011

**Name of responsible Director/Director General:**

Karen Middleton

**Date assessment was signed: Ref 1605**

# 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
<b>Involvement and consultation</b>	<p>The local leadership of the SIP necessitated a clear devolution of responsibility for the local improvement including EQIA.</p> <p>The project team has used a number of approaches to ensure EQIA is an integral element of service improvement:</p> <ul style="list-style-type: none"> <li>• Initiated the use of EQIA, user engagement and patient participation</li> <li>• Presentation at the interim national meeting from the programme lead for Pacesetters, NHS West Midlands SHA in April 2010</li> <li>• Presentations and poster displays at the final national meeting including several services who have demonstrated a high achievement in relation to equalising impact</li> </ul> <p>No further action is planned but we are confident that the wider knowledge of impact assessment will be spread</p> <p>E.G Leicester Musculoskeletal Physiotherapy have fully assessed their service redesign and have spread the work via CHAIN</p>	NA	NA
<b>Data collection and evidencing</b>	<p>Services reported that their services were “accessible by all populations equally” but did not have data to</p>	NA	NA

	<p>evidence this assertion. Other services recognised the risk of not offering equal access to those without technology or the ability to use self referral guidelines, but also found it difficult to identify with certainty which groups and what barriers were known and verified. Many services knew how to access population and demographic data for their service and could report with confidence the local socio-economic, age and ethnic differences within their locality.</p> <p>Local data collection and reporting has been a demand within the AHP SIP, however, services have not reported the uptake of service by different populations. The AHP SIP has not specifically sought this information. However several services, through their better consultation, have begun to identify and use their initial improvement to specify and plan improvement impact for harder to reach populations. Local actions identified in continuation of the improvement activity in NHS organisations.</p>		
<b>Analysis of evidence and assessment</b>	<p>As suggested, local services are just beginning to recognise the need to equalise impact of improvement and appreciate how the different populations may use services, for example, Roma communities accessing podiatry services and older children accessing childhood obesity clinics. The AHP SIP interventions have built local capability in core competencies associated with improvement and championing of all populations of patients wishing to access the services.</p> <p>No further work is planned</p>		
<b>Monitoring, evaluating and reviewing</b>	<p>The DH will not be monitoring the progress of further improvement in local services. Planning for the</p>	NA	

	sustainability of improvement outcome and the ongoing monitoring of service outcomes transfers to local organisations.		
<b>Transparency (including publication)</b>	A range of communication channels will be used to publish the outcomes of the SIP.	October 2011	Shelagh Morris

## Appendix A

### Local organisations and teams “**User engagement and Equality and Diversity: Content analysis of telephone survey conducted with the 30 Service Improvement Projects**”

Sally Fowler Davis, Service Improvement Project Manager, DoH

Dawn Smith, Service Improvement Associate Project Manager (Children), DoH

### Introduction

The AHP SIP Project Manager and Associate Project Manager approached the 30 services via email to invite them to take part in a half hour telephone survey. Questions were sent in advance of the telephone survey to the SIP Leads to prepare for their telephone call with the appropriate SIP Manager. These surveys were undertaken over a three-week period from late May to mid June 2010, and we completed 28 responses.

### Method

During the telephone call, the responses were recorded the information was then categorised (see sample form, Appendix I).

### Results

#### Question One “**What action, if any, have you taken to date to incorporate service user opinion in your plans for service improvement?**”

<b>Responses to Question One</b>	<b>Frequency</b>
PALS Service Involvement	<b>2</b>
Communication/other team involvement	<b>2</b>
Satisfaction questionnaire/comment on discharge/post treatment	<b>9</b>
User/carer/patient/event/focus group	<b>11</b>
Trust wide/patient survey results used	<b>3</b>

Consultation with other services/GP/Nursing/Education	3
No action	5
Monitoring complaints	4
Planning further actions	5
Service users survey sent to i.e., – GPs, Staff	2
Links with other voluntary organisations/patient groups	3

**Question two “What evidence do you have of this action?”**

<b>Responses to Question 2</b>	<b>Frequency</b>
Specific documentation i.e., questionnaire, appointment letters, referral information/objectives	8
Posters or other literature for patients/carers	2
Specific events/outcomes /objectives	8
Data and information in reports	3
No evidence	7
Complaints processes/feedback	1
Other	4

**Question 3 “Have you carried out a local Equality Impact Assessment for your project?”**

<b>Responses to Question 3</b>	<b>Frequency</b>

Yes	5
No	19
Ongoing actions planned	4

**Question 4 – “If yes, have you documented it in line with local guidance?”**

Responses to question 4	Frequency
Yes	5
No	17
Ongoing	3

**Question 5**

**Have you had contact with or support from the Equality & Human Rights Officer within your organisation in relation to your service improvement?”**

Responses to question 5	Frequency
Yes	6
No	10
Will find out who it is!	8

**Question 6 – “Will your service improvement have a positive or negative impact on any of the following groups in the population? “**

The responses below include planned positive impacts of service re-design, recognised negative impacts and potential impacts that were identified as a result of the EIA telephone discussion.

This illustrates how the process of EIA itself can stimulate new thinking about the needs of service users, which have not yet been planned for or may need further investigation as a part of service improvement.

Responses to question 6 related to user population	Comments		
	Yes	No	
Ethnic Groups	6	4	<ul style="list-style-type: none"> <li>- Nepalese communities and use of interpreters</li> <li>- Aiming to recruit a bilingual worker for Asians and Eastern European groups</li> <li>- Bigger number of eastern european and also Gurkha soldiers</li> <li>- Homogenous population</li> <li>- Disorder does not affect the ethnic population</li> <li>- Interpreter services offered</li> </ul>
Particular Ages	11	2	<ul style="list-style-type: none"> <li>- Children's services</li> <li>- Older people with mental health disorders</li> <li>- Self-referral tends to favour younger clients</li> <li>- Focus on pain management for older group</li> <li>- More children in the city</li> <li>- Improvement will impact on how children access service in a timely way</li> <li>- Younger disabled (under 65)</li> </ul>
Religion & Belief	3	2	
People with disability	6	1	<ul style="list-style-type: none"> <li>- hoping to offer support networks</li> <li>- Block booking 80% of appointments on system one and seeing children in clinics we can provide flexible service for the 20% who have more complex needs</li> <li>-</li> </ul>
Sexual orientation	1	2	<ul style="list-style-type: none"> <li>- wanting to engage fathers in children's services</li> <li>- patient population predominantly female with consultants male</li> </ul>
Men/women/transgender	5	2	<ul style="list-style-type: none"> <li>- Conscious of particular problem/sensitivities for male clients</li> </ul>

Socially/economically disadvantaged	8		<ul style="list-style-type: none"> <li>- Pockets of disadvantage but if child needs service then they get it</li> <li>- Transient population and plan to use phone</li> <li>- GP identified negative impact of travel cost</li> <li>- Marginalised, disadvantaged group not using email, concern about self-referral and e-referral</li> <li>- Most clients more economically disadvantaged</li> </ul>
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Comments below were made in response to Question 7 and are a selection of specific activity to increase the opportunity for all service users to benefit equally from the planned changes to service delivery

**Question 7 “Are you planning any particular re-design elements to suit the diversity of users of your service”**

<b>Planning for diversity</b>
- Whole service improvement is planned to provide care closer to home and accommodate to special needs
- Service plans to open service to people with severe or increased risk of ulceration i.e., (clinical need)
- Service improvement should reduce number of appointments and therefore travel costs
- Planning web services with info that will be culturally sensitive in terms of language and dietary advice
- Focus on faith group leaders to raise awareness and sign-post services
- Reliant on relationship with schools so aim to empower schools with knowledge to support children with disability
- Need to offer different location to reduce cost of travel for low-income families
- Rural population, transient population of army and looked after children,

need quicker responses from service
- Need to offer service to people with complex needs – a more integrated provision
- Electronic/telephone booking system may improve access for diverse populations
- Opening up new ways of communicating within the service – text/internet booking to suit different age groups
- Need to consider literacy difficulties in the service users in terms of accessible information
- Mental health lead doing a project on access to services
- Running clinics in special schools, care closer to home. Children with MD – provide tools sooner
- Provision of a PPI forum in organisation that comments on leaflets and information. (Possible need to use this more for parents with learning disabilities)
- Have existing pathway that accommodates children with learning disability very well. Aim to target children with mental health issues for psychological support as part of service improvement. This would be done by effective referral-on”

**Question 8 – “Do you know the demographic of your population?”**

<b>Response to Question 8</b>	<b>Frequency</b>
Yes, but don't have data	13
Yes, data held within the	8

service	
No, not yet identified within the data collected	3
No, has not been asked for	4

**Question 9 – “If so, from where did you get this information?”**

<b>Response to Question 9</b>	<b>Frequency</b>
Communications team	1
Public health Observatories	15
Other	5

**Question 10 “Are you proposing in your service improvement to increase access to services e.g., more proactively engage with people with mental health problems/learning disabilities? If so, share this with us.”**

<b>Response to Question 10</b>	<b>Frequency</b>
Specific Organisational response is available	7
Referral used into other services	5
Requires a proactive response	8

No accommodation made	5
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Comments shared with us from Question 10
“Mental health lead doing a project on access to services”
“Running clinics in special schools, care closer to home. Children with MD – provide tools sooner”
“Do have a PPI forum in organisation that comments on leaflets and information. Possibly need to use this more for parents with learning disabilities”
“Have existing pathway that accommodates children with learning disability very well. Aim to target children with mental health issues for psychological support as part of service improvement. This would be done by effective referral-on”
“Will need to consider literacy difficulties in the service users in terms of accessible information”

### Suggested Response

As a result of this information you may wish to consider asking further questions to support EiA activity. We have suggested a number below by you may have others:-

- What new methods would increase your effectiveness at engaging the opinions of service users?
- What does your service need to know more about in terms of its impact upon diverse groups of service users?
- Who in your organisation/wider network will you approach to help you?

- What will you do next to increase your evidence of user-engagement?
- Which groups of service users do you know least about?
- What assumptions are you making on behalf of your service users that you have not tested-out?
- What next step will you take to move towards equality of access and experience for all your service users?
- What developments do you want to tell us about?

## Appendix B

### Values and Principles for Engaging Patients and Service Users in Service Improvement and Redesign

With thanks to Marilyn Ekers for the first draft on which we based this version. Also to the SIP user and carer involvement subgroup of the Project Board whose discussion and comment informed the suggested principles and values.

#### **Principles and Values**

1. Service user and carer involvement must be focused on improving their experience and outcomes.
2. Service improvements are based on what the service users and carers have said is important to them.
3. Feedback is given to service users and carers about how their input has influenced the project and/or service redesign.
4. Service users and carers are active partners in the redesign process through, for example:-
  - Membership of a steering group
  - Planning, monitoring and/or evaluation of the redesign
  - Participation in the distribution of the outcomes and learning from a redesign process.
5. User/carer /patient feedback is important data and equally valued in relation to other information and data informing the redesign.
6. User and carer engagement is enabled by a range of existing functions across the organisation including but not limited to Patient Advice and Liaison Services (PALS), Patient and Public Involvement Teams (PPI), Equality and Human Rights Offices or Public Relations departments. This is to ensure that:
  - Service users and carers are refunded out of pocket expenses
  - Service users and carers are compensated for their involvement
  - Recruitment and continuity is supported.
7. The service should strive for inclusivity in service user and carer involvement by encouraging participation from the range of people who use the service e.g. children, frail elderly people, people with learning difficulties, people with English as their second language and meeting any particular needs that some service users and carers will have, that enables them to participate.

8. Information about the service improvements is communicated in accessible formats appropriate to the needs of the users and carers using the service.

9. Involvement is purposeful and fully explained and users and carers are invited to participate in tasks proportionate to their interests and abilities. (e.g. most users will not consider themselves to be 'service user representatives').

10. Users and carers can make informed choices about their involvement and are free to withdraw their involvement.

11. The means of obtaining the views of service users and carers (e.g. questionnaires, focus groups, discovery interviews) are undertaken in ways that ensure confidentiality in order to ensure honest feedback. Also, that the chosen method for gathering information seeks to learn from their experience.

12 As users and carers will often experience a whole service and not be aware of the departmental boundaries, this may mean that people comment on whole service re-design (see point 4) and identify improvements across the organisation.

13. As involvement in redesign is significantly different from being asked to comment on the outcomes of a care experience, so services need to ensure that every story is listened to and treated as information about the quality of the service. Every experience is valid.

14. Users and carers offer suggestions uninfluenced by clinical, financial or professional interests may provide the potential for redesign based on greater creativity.

15. Involvement of users and carers embedded within normal practice is more likely to sustain than single events, but better to start somewhere than not to seek engagement at all.

The AHP Service Improvement Project  
June 2010