|  |
| --- |
| **Equality Impact and Engagement Assessment Form** |
| **Complete this section****Please retain one copy, and pass one copy to both the Equalities and Engagement leads** |
| **Section one – Project or plan details** |
| 1.1 | **Project Title:**  |
| **CBT Waiting List on-line alternative provider** |
| 1.2 | **Project Lead:** | **Contact Details:** |
| Kate Tufnell  | Katherine.tufnell@nhs.net |
| 1.3 | **This activity /project is:** |
| **Policy – Project – Plan – Other - Review** |
| 1.4 | **Describe the activity/project**  |
| Since 2016/17 NHS England has set targets to increase the number of people accessing psychological therapies (IAPT). The table below shows the Rotherham IAPT access targets for 2019/20.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 2019/20 Rotherham IAPT Access Targets  | Q1 | Q2 | Q3 | Q4 |
| Number of people who receive psychological therapies | 1,615 | 1,615 | 1,615 | 1,615 |
| Number of people who have depression and/or anxiety disorders | 29,280 | 29,280 | 29,280 | 29,280 |
| %  | 5.52% | 5.52% | 5.52% | 5.52% |

The requirement to meet the national mandates and the contractual access target has led to a waiting list at RDaSH for cognitive behavioural therapy (CBT). As at 25 July 2019, 337 patients are waiting for their second treatment appointment (excluding those who have opted to wait for a specific time or day). The longest wait is 48 weeks, however this is a patient wanting a specific date, time and place. The majority of (207 of 337) patients have waited over 10 weeks and 64 have waited for 20 weeks or more.In order to address waiting times for CBT, RDaSH are progressing with the recruitment of three qualified CBT posts with 1.4 wte remaining vacant. In addition two well-being practitioners (trainees) will be recruited in the October 2019 cohort and further two well-being practitioners places have been secured for the March 2020 cohort. This EIA is in relation to the proposal to pilot an on-line CBT provider to support the reduction of waiting times **in addition** to the “more traditional” face to face delivery model provided by RDaSH. The on-line CBT provider, IESO, offers text based CBT delivered by a fully-qualified therapist through a secure on-line platform. Appointments are scheduled at times that best suit the patient, including evenings and weekends. Therapists deliver live, one-to-one, NICE-approved CBT following the Roth and Pilling competency framework.Sessions can be attended securely with **any device** that has access to the internet. In between appointments patients can revisit the transcripts of the therapy sessions and the patient can keep the therapist updated on progress using the secure messaging system. In this way the IESO model reinforces learning with therapy via reading and writing, versus speaking and listening as in a more traditional face to face model. IESO’s model has been validated in a randomly controlled trial to outperform recovery rates for traditional-face-to-face therapy and has demonstrated clinical effectiveness in more than 28,000 individuals worldwide. |
| 1.5 | **Timescales** |
| It is anticipated that an alternative additional provider might be in place between November 2019 – March 2020 (potential pilot period, subject to procurement and contract requirements) |
| 2 | **Equality Impact Assessment** |
| 2.1 | **Gathering of Information:** This is the core of the analysis; how might the project or work impact on protected groups, with consideration of the General Equality Duty.Please add any general information here. |
| It is anticipated that an additional provider will increase capacity within Rotherham to deliver CBT and thereby reduce waiting times. It is anticipated also that those who have waited longest will be offered a choice of using a new provider or continuing along the RDaSH IAPT pathway. As this is an on-line text based model, there may be patients who do not have the necessary technology to access it or the written English necessary to communicate effectively with the on-line therapist. There may be an impact therefore on people with English as a Second Language or with low levels of literacy. See section 3 for further analysis. On the other hand the traditional face to face therapy model relies on patients having the physical health and economic means to travel to appointments. IESO have shared that 66% of their current patients choose to access therapy out of office hours, especially during weekday evenings, to fit around work and other life commitments. The stigma of accessing appointments within community mental health services has not yet been eradicated and for some patients this stigma can prevent them from accessing help. A digital alternative may prove easier to access for those patients who may feel embarrassed or who have previously been stigmatised. The on-line model may be less daunting than face to face appointments.  |
| 2.2 | **Screening**  |
| **Please complete each area)** | **What key impact have you identified?** | **Information Source** |
|  | **Positive Impact** - will actively promote or improve equality of opportunity. | **Neutral Impact -** where there are no notable consequences for any group. | **Negative Impact** negative or adverse impact causes disadvantage or exclusion. **If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures.** | What action, if any, is needed to address these issues and what difference will this make? For example: *At this point no action is required. Further EIA screenings will be developed in future once there are recommendations to assess.* |
| Human Rights | **N** | **Y** | **N** |  |
| Age | **Y** | **N** | **N** |  |
| Carers | **N** | **Y** | **N** |  |
| Disability | **Y** | **N** | **N** | * Increase in IAPT CBT capacity, within Rotherham
* Offer individuals the choice of accessing Online CBT provision (waiting time 5-14 days)
* Text can be enlarged to improve access for people with visual impairment
* Contact in written format – text instead of telephone and written dialogue may make it easier for people who are deaf or hard of

hearing to accessible * Those will cognitive impairment may not be able to access this service (depending upon level of cognitive impairment
 |
| Sex | **N** | **Y** | **N** |  |
| Race | **N** | **Y** | **N** |  |
| Religion or belief | **N** | **Y** | **N** |  |
| Sexual Orientation | **N** | **Y** | **N** |  |
| Gender reassignment | **N** | **Y** | **N** |  |
| Pregnancy and maternity | **N** | **Y** | **N** |  |
| Marriage/civil partnership (only eliminating discrimination) | **N** | **Y** | **N** |  |
| Other relevant groups | **N** | **N** | **Y** | Those who are unable to read and write basic English may be unable to access this service |
|  |  |  |  |  |  |
| **3**  | **Engagement Assessment** |
| 3.1 | **What is the level of service change**? – see diagram 3 above**If your project is classed as a ‘significant variation’ (level 3) or ‘major change’ (level 4)** please contact england.yhclinicalstrategy@nhs.net for a preliminary discussion to support planning and agree whether the service change needs to follow the NHS England Service Change Assurance process. The assurance process generally looks at the ‘case for change’ The key players in the process include overview and scrutiny teams, and the clinical senates. You can also refer to the DH guidance: (please note that level 4 changes will require considerable long term planning and this DH guidance is mandatory for all level 4 changes) <http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/nhs_public_involvement_-hempsons_stp.pdf> DH 2013 |
| **Circle or highlight the appropriate level of service change**Level 2  |
| **Add additional information and rationale for this scoring below** |
| Within the NHSE criteria as set out above, the level of engagement required is level 2 **Minor Change**This is because engaging an additional provider of CBT will require engagement with patients to offer choice and also engagement with the current service provider (RDaSH) to integrate the offer within the existing pathway.  |
| 3.2 | **Who are your stakeholders?**Consider using a mapping tool to identify stakeholders - who is the change going to affect and how? Complete below or attach or link to a mapping document |
| Individual waiting for CBT:* Choice of accessing Online CBT
* Faster access to therapy
* Access to CBT out of hours or weekends

RDaSH:* Support the IAPT staff team and the organisation to reduce current IAPT CBT waiting time

CCG:* Provide a flexible approach to enable the CCG to commission both additional capacity and offer choice (service type and availability)

Primary Care:* Reduction in GP contacts resulting from long waits
* Improved choice available to patients (online, appointment can be booked out of hours or weekends)
* Faster patient access / reduce overall waiting times

HealthwatchOnline CBT providers |
| 3.3 | **What do we already know?**What do you already know about peoples’ access, experience, health inequalities and health outcomes? Use intelligence from existing local, regional or national research, data, deliberative events or engagements. |
| **Access** – currently, people waiting to access IAPT CBT services are experiencing long waits, asillustrated below:

|  |  |
| --- | --- |
| **Length of time waiting (in weeks)** | **Number of people waiting** |
| 25 | 1 |
| 24 | 14 |
| 23 | 14 |
| 22 | 11 |
| 21 | 14 |
| 20 | 10 |
| 15-19 | 74 |
| 10-14 | 69 |
| 0-9 | 130 |

* \*it should also be noted that those entering the CBT element (step 3)of the pathway will have already experienced a wait of up to six weeks to access the Step 2 element of the pathway. Currently, people have to access Step 2 prior to entering Step 3.
* Evidence from the implementation of this type of Online CBT model elsewhere indicates that between 20-30% of people opt to access this type of service, with a 2-3% drop out expected (based on learning from other areas).
* Online CBT waiting times range from 5-14 days.

It is acknowledged that this digital offer will not be appropriate for everyone. This pilot will offer a choice where previously there was none. For some people the more traditional face to face therapy model might better suit their needs, however it is anticipated that as the digital offer is taken up by some it will reduce waiting times overall and therefore have a positive impact.RDaSH collect ethnicity data on those accessing IAPT but cannot easily extract the ethnicity data for those waiting for CBT. Ethnicity data would not help us understand the level of written English for those waiting for CBT. The use of translators in RDaSH is not monitored at the service level and therefore cannot help to build a picture of how many patients might have English as a Second Language. As this is intended as a pilot, the take up of the offer will be closely monitored to identify what the local barriers might be to accessing the offer and to evaluate the levels of satisfaction of those who choose this alternative.The Office of National Statistics (ONS) official estimate is that 93% of UK homes now have internet access – the ONS data also suggests that most people who choose not to have internet access at home, make this decision because they are not interested or feel it is irrelevant to their lives rather than a lack of skills to be able to use it. |
| **Describe any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight?**How will the insight available to you help to inform your decision? |
| Those patients currently waiting for CBT will be offered a choice as to whether they would like to use an on-line model. As this is intended as a pilot, the take up of the offer will be closely monitored to identify what the local barriers might be to accessing the offer and to evaluate the levels of satisfaction of those who choose this alternative. |
| **Briefly describe how the existing or proposed engagement will be ‘fair and proportionate’**, in relation to the activity? |
| The offer of an alternative provider of CBT will be communicated to those on the waiting list.  |
| 3.4 | **Reaching out to overlooked communities**Are additional arrangements for patient and public involvement required for this activity and in particular how will you ensure that ‘seldom-heard’ groups, those with ‘protected characteristics’ under the Equality Act, and those experiencing health inequalities are involved* Seldom-heard groups Yes/No
* Nine Protected Characteristics Yes/No
* Health inequalities Yes/No

If yes, please provide a brief outline of your approach and objectives for any additional patient participation targeted at these groups |
| No additional arrangements are required at this stage. The take up of the pilot will be monitored to identify whether there are specific impacts for overlooked communities.  |
| Do you need to make any of your resources accessible (i.e. for people with learning disabilities, sight impairments, or alternative languages?) |
| Yes – communication for patients will need to be accessible.  |
| 3.5 | **What resources do you need for this?**Consider the sections above* The timescales
* The need to reach overlooked communities
* Accessible materials
* Gaps in knowledge
 |
| No additional resources have been identified as being needed at this stage.  |
| 4 | **Feedback and Evaluation** |
| 4.1 | How will you use the feedback – who does it need to be shared with? |
| Feedback on the take up of the digital offer will be shared through the Mental Health and Learning Disability Transformation Group to ensure that future commissioning is informed by patient feedback.  |
| 4.2 | Provide a brief outline of how the information collected through patient and public participation will be used to influence the plan/activity. |
| Report to go through RCCG governance route; and those of partners, where appropriate. |
| 4.3 | How will the outcomes of participation be reported back to those involved?  |
| Individual level – this is an outcome based therapy / recovery outcome recordedService level – the contract requirements will include a performance monitoring dashboard  |
| 4.4 | How will you assess the ongoing impact of the change on patients and the public after it has been completed? |
| As with RDaSH IAPT commissioned services a recovery outcome will be collected. |
|  |
| 5 | 1. **Engagement and Equality Impact Plan**
 |
|  | **Action** | **Approx.** **Timescale** | **Lead** | **Deadline** | **Comments/****progress** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| 6 | Form details |
|  | Completed by:  | Beki McAlister / Kate Tufnell |
|  | Job title: | Senior Contract Manager Mental Health / Head of Adult Mental Health Commissioning  |
|  | Date | 21.08.19 / 27.08.19 |
|  | Reported to | Kate Tufnell / Ian Atkinson |