NHS
Midlands and Lancashire
Commissioning Support Unit

Equality Impact and Risk Assessment Stage 2 for Policies

Title of Policy / Strategy:

Policy for the commissioning of Sensory Integration Therapy

Pre engagement 27/03/2020 updated 10/05/2021 and 29/10/2021

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EQUALITY IMPACT AND RISK ASSESSMENT STAGE 2

ALL SECTIONS MUST BE COMPLETED

Guidance is provided in appendix 3

SECTION 1 – DETAILS OF POLICY

Organisation:

Lancashire and South Cumbria CCGs including:
NHS Blackburn with Darwen Clinical Commissioning Group
NHS Blackpool Clinical Commissioning Group
NHS Chorley & South Ribble Clinical Commissioning Group
NHS East Lancashire Clinical Commissioning Group
NHS Fylde & Wyre Clinical Commissioning Group
NHS Greater Preston Clinical Commissioning Group
NHS Morecambe Bay Clinical Commissioning Group
NHS West Lancashire Clinical Commissioning Group

Policy Assessment Lead: [redacted], Senior Project Manager MLCSU IFR Policy Development Team

Directorate/Team: Individual Funding Request / Individual Patient Activity Procedure for Policies of Lower Clinical Priority

Responsible Director / CCG Board Member for the assessment: All above CCGs

Who is involved in undertaking this assessment?

Policy review group members

[redacted] Equality, and Inclusion Business Partner MLCSU

Communication and Engagement (CSU and CCG’s) including public engagement

North Lancashire Directions Group (Autism Support group)

Date of commencing the assessment: 27/03/2020 updated 10/05/2021 and 29/10/2021

Date for completing the assessment: 01/11/2021

EQUALITY IMPACT ASSESSMENT

Section 1

Please tick which group(s) this policy will or may impact upon?	Yes	No	Indirectly

Patients, Service Users	x
Carers or Family	x
General Public	x
Staff	x
Partner Organisations such as disability groups	x

How was the need for the policy identified? (is it part of a workstream / strategy?)

This policy is a new policy for the commissioning of Sensory Integration Therapy (SIT).

The policy development work was the result of a request from the Lancashire and South Cumbria Children's Commissioners Network. The Commissioning Policy Development and Implementation Working Group (CPDIG) recently undertook an assessment to determine whether there was a need to develop a consistent L&SC wide commissioning policy on the provision of sensory diets and sensory integration therapy for children with Autism Spectrum Disorder (ASD) and other conditions.

What are the aims and objectives of the policy?

To provide criteria for the NHS commissioning of Sensory Integrated (SI) Therapy.

For the purpose of this policy, the CCGs define sensory integration therapy as stand-alone, one-to-one clinic-based therapy for children or adults who have been assessed to have a degree of sensory dysfunction.

The CCGs will not routinely commission sensory integration therapy (stand-alone, one-to-one clinic-based therapy), as it considers that the intervention does not accord with the Principles of Effectiveness and Cost-Effectiveness.

The scope of this policy includes requests for stand-alone, one-to-one clinic-based therapy and the provision of associated recommended equipment, such as weighted blankets, for sensory disorder/dysfunction.

The scope of this policy does not include:

- the incorporation of consideration of a patient's sensory needs during the multidisciplinary assessment and diagnosis process.
- the provision of advice and support for parents, teachers and carers on the management of sensory dysfunction, including how to structure daily activities and adapt environments, etc dependent on symptom severity, age and individual circumstances as part of a multidisciplinary commissioned service provided by local NHS provider

What evidence have you considered as part of the Equality Impact Assessment?

The Lancashire and South Cumbria Clinical Policy Development and Implementation group have carried out an evidence review for Sensory Integration Therapy following a request from the Children's Commissioners Network. CPDIG then developed a policy that was initially referred to as "Sensory diets", but later moved to the more generic description of Sensory Integration Therapy

Following the initial Evidence Review and drafting of the SIT Policy, policy development activities were put on hold for nearly a year due to the Covid-19 pandemic. Once resumed, the draft of this policy was approved to go to Clinical and then Public Engagement.

Evidence review information:

It was noted that sensory interventions are often separated into two groups that are frequently requested for, or delivered to, children who are assessed to have a degree of sensory dysfunction:

A) direct one-to-one clinic-based therapy usually delivered by an Occupational Therapist (OT). This is often defined as sensory integration therapy.

B) A tailored programme of sensory stimulation delivered by a parent, carer or teacher in the home or school setting. This "sensory programme" has been called a "sensory diet", but please note it is not about food.

In summary the evidence review work notes that there is limited evidence of the effectiveness of Sensory Integrated Therapy and a lack of consensus over its effectiveness. NICE guidance or Scottish Intercollegiate Guideline Network (SIGN) guidance. Neither source supports the adoption of sensory as outlined in (A) above.

NICE Clinical Guidance, CG170, Autism spectrum disorder (ASD) in under 19s: support and management does not specifically mention sensory integration or sensory diets. However, there is reference to interventions for behaviour that challenges, including the production of a care plan outlining treatment, support, and necessary adjustments.

The Scottish Intercollegiate Guideline Network (SIGN) guidance, 2016 states that children with ASD may benefit from occupational therapy, advice and support in adapting environments, activities, and routines in daily life. The SIGN guidance also contains a statement that studies of the use of strategies such as deep touch pressure, weighted vests or therapy balls were of low quality and showed limited consistent improvement.

Additional information gathered for this assessment:
SI is the neurological process that organises sensation from one's own body and the environment. It enables everyday life. For most people, sensory integration develops in the course of ordinary childhood activities. SI Therapy is a specialised treatment to improve functional skills, independence, social participation, and education attainment for children with ASD. It can improve adaptive responses to environmental challenges and reduction in challenging behaviour for some children.

https://files.cdn.thinkific.com/file_uploads/472793/attachments/ca2/dcd/42e/SI_Commissioning_Guidance_V2.pdf

Shine Therapy is an independent organisation providing consultancy services on occupational therapy and integration therapy for children and young people.
https://shinetherapyservices.co.uk/

SI helps the body organise, process, and respond to sensory input. For some people, the ability to organise sensory stimulus can be problematic and cause impact on daily life – this is called sensory processing disorder- SPD.

Developing a profile of the child or young person's strengths, skills, impairments and needs, including intellectual ability and learning style, academic skills, speech, language and communication, fine and gross motor skills, adaptive behaviour (including self-help skills), mental and emotional health (including self-esteem), physical health and nutrition, sensory sensitivities, and behaviour likely to affect day-to-day functioning and social participation. This profile can be used to create a personalised plan, considering family and educational context. The assessment findings should be communicated to the parent or carer and, if appropriate, the child or young person.
NICE: https://www.nice.org.uk/guidance/cg128/chapter/recommendations Autism spectrum disorder in under 19s: recognition, referral and diagnosis Clinical guideline [CG128] Published date: 28 September 2011 Last updated: 20 December 2017

Policy background:

There is no set definition of exactly what is meant by “sensory integration therapy” but it stems from Sensory Integration Theory as developed by Ayres in the 1970s which is based on a conceptualisation of how the brain organises and interprets sensory information:

Ayres Sensory Integration Therapy (ASIT) definitions.

- 1:1 therapy session using play.
- Likely duration would be between 30-60 mins.
- Likely frequency would be once/twice a week.
- Likely Length- this is very difficult to state, maybe 12-18 appointments (this is a rough average and would be dependent on progression with goals).

Sessions must follow ASI fidelity measure:

- safe environment
- provided by an accredited therapist
- therapeutic alliance present with the child
- therapist support modulation- i.e. the child has appropriate levels of arousal and alertness
- child led activity choices
- child is intrinsically motivated by the play activities
- activities challenge more than one sensory system (i.e. it requires sensory integration of 2 or more sensory systems),

- activities present the just right challenge
- activities challenge praxis and organisation of behaviour
- activities are successful

The purpose of therapy sessions is to:

- improve sensory integration i.e. the brain’s ability to
    - simultaneously receive information from more than one sensory system
    - integrate this information to make sense of “what”, “where” and “how important”
    - make a plan for an appropriate response to the sensory information (e.g. orientate body and coordinate limbs to: play, explore, protect self from harm)
    - execute the plan
- improve participation in daily activities.

Sensory Integration theory uses assessment of the child’s behaviour in response to sensory stimuli to develop a programme (or diet) of play-based sensory stimulation (e.g., swinging, bouncing on a ball, or wearing a weighted vest). Practicing the “diet” regularly and often is designed to have an effect on self-regulation, attention or behavioural organisation that facilitates optimal participation in developmentally appropriate tasks.

Sensory integration therapy can be used directly with children in an individual session and to help inform how carers and teachers can support children with sensory processing difficulties, largely children with autism. [Whilst “children” are referred to as it is aimed at helping the early development of the desired effects, it is used with young people and adults as well].

The scope of this policy includes requests for stand-alone, one-to-one clinic-based therapy and the provision of associated recommended equipment, such as weighted blankets, for sensory disorder/dysfunction. It does not include the incorporation of consideration of a patient’s sensory needs during the multidisciplinary assessment and diagnosis process.

The Royal College of Occupational Therapists recommends that Occupational therapists working with children and young people who present with sensory issues should use their professional skills and expertise to carry out a thorough assessment, in collaboration with colleagues from the multidisciplinary team as appropriate

Are there any identified health inequalities relating to this decision? If so, please summarise these:

Sensory Integration Therapy is one-to-one clinic-based therapy for children and adults who have been assessed to have a level of sensory interference or dysfunction. There is no common approach or agreement on how to define sensory integration, but it tends to be offered to children who have ADHD or Autistic Spectrum Disorder.

Patients with sensory conditions, including ADHD and ASD, may fall into the protected characteristic of disability under the Equality Act 2010. Some children and young people with Autism may also experience other conditions including ADHA, dyslexia, anxiety or depression and epilepsy. They may also have a learning disability (LD).

Patients with ASD and learning disabilities may be more likely to experience health inequalities, have poorer health outcomes and may have a reduced life expectancy.

The NHS Long Term plan sets out plans to tackle the causes of morbidity and preventable deaths in people with a learning disability and autism and aims to improve NHS employee's understanding of the needs of people with learning disabilities and autism, to help improve their health and wellbeing. The Government have also set out plans to reduce the gap in life expectancy for autistic people within the 'Think Autism' Strategy.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/696667/think-autism-strategy-governance-refresh.pdf

https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/learning-disability-and-autism/

Children and young people with Autism may also experience delays and long waiting times for a diagnosis, followed by inadequate or ineffective support, which can be significant barriers to their development. https://www.hee.nhs.uk/our-work/autism

Children and young people who have access to Sensory Integration Therapy, along with their families and carers, may find that it is beneficial to their overall health and contributes positively to their development and wellbeing. This may have a potential positive impact in terms of health inequalities. See information on public engagement for more information.

Not commissioning Sensory Integration Therapy may have a perceived potential negative impact on health inequalities for children and young people with ASD or ADHD.

SECTION 2

In this section you will need to consider:

What activities you currently do that help you to comply with the Public-Sector Equality Duty (three aims).

Will your policy affect your ability to meet the Public-Sector Equality Duty?

How you will mitigate any adverse impact?

- Eliminate, unlawful discrimination, harassment, victimisation and any 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.

Please answer ‘Yes’ or ‘No’ and explain your answer	Yes	No
Does the policy provide an opportunity to eliminate discrimination, harassment, and victimisation? What do we mean? Unlawful discrimination takes place when people are treated ‘less favourably’ as a result of having a protected characteristic. Harassment is unwanted conduct (including a wide range of behaviours) because of or connected to a protected characteristic. Victimisation is where one-person subjects another to a detriment because they have acted to protect someone under the act. (e.g. bullied for reporting discrimination / harassment for a work colleague with a protected characteristic)	x	
Explanation: This policy has been developed through the Clinical Policy Development Group on behalf of the Lancashire and South Cumbria CCGs. The governance surrounding policy development ensures compliance to the NHS constitution, NHS standards, NICE guidance, the Equality Act 2010, the Public Sector Equality Duty, Social Care Act, Human Rights Act and the FREDA principles. Due regard has been given to the aims of the Public Sector Equality Duty of the Equality Act 2010. This development of the policy has considered how the criteria has been reached and any potential negative impacts on those with protected characteristics. The current criteria have been reached by reviewing the clinical evidence for the effectiveness of commissioning Sensory Integration Therapy.		

Please answer ‘Yes’ or ‘No’ and explain your answer	Yes	No
Does the policy provide an opportunity to advance equality of opportunity between people who share a protected group and those who don’t share it? What do we mean? Equality of opportunity is about making sure that people are treated fairly and given equal access to opportunities and resources. Promoting is about: • Encouraging people/services to make specific arrangements • Take action to widen participation • Marketing services effectively	x	

• Remove or minimise disadvantages • Take steps to meet different needs Securing special resources for those who may need them		
Explanation: Due regard has been given to the aims of the Public Sector Equality Duty of the Equality Act 2010. This development of the policy has considered how the criteria has been reached and any potential negative impacts on those with protected characteristics. The current criteria have been reached by reviewing the clinical evidence for the effectiveness of commissioning Sensory Integration Therapy. Engagement work with clinicians and the wider public has taken place as part of the policy development process. The outcomes of the engagement are detailed under the engagement, involvement and consultation section of this assessment, and within each of the protected characteristic sections.		
Please answer ‘Yes’ or ‘No’ and explain your answer	**Yes**	**No**
Does the policy provide an opportunity to Foster Good Relations between people who share a protected characteristic and those who don’t share it? What do we mean? Foster Good Relations between people: This is about bringing people from different backgrounds together by trying to create a cohesive and inclusive environment for all. This often includes tackling prejudice and promoting understanding of difference. • Tackle prejudice • Promote understanding • Could the policy create any issues for Community cohesion (will it impact certain communities compared to others and how this be managed?)	x	
Explanation: Due regard has been given to the aims of the Public Sector Equality Duty of the Equality Act 2010. The policy development work has involved clinicians and the public in the development of the criteria. The clinical evidence review work undertaken has highlighted that Sensory Integration Therapy is usually delivered by an Occupational Therapist (OT) with the intention of reducing the child’s sensory symptoms. Engagement work with clinicians and the wider public has taken place as part of the policy development process. The outcomes of the engagement are detailed under the		

engagement, involvement and consultation section of this assessment, and within each of the protected characteristic sections.

Please answer 'Yes' or 'No' and explain your answer	Yes	No
Has engagement/involvement or consultation been carried out with people who will be affected by the policy?	x	

Clinical engagement:

Clinical engagement on the was undertaken between 18 March and May 2021. The draft policy (version 0.2) was circulated to the Children's Commissioners Network who forwarded on the CCGs, local authorities and NHS Trusts in Lancashire and South Cumbria, NHS England & NHS Improvement. In addition, clinical comments were received from two healthcare professionals (Occupational Therapists) during public engagement, so they have been considered along with the other input.

- Six responses were received in total, all from healthcare professionals who care for children with neurodevelopmental disorders as part of multi-disciplinary teams
- 5 out of 6 respondents agreed that there was some kind of "sensory service", with one respondent saying "many occupational therapists are strong advocates for using sensory assessments and interventions as part of their OT practice"
- Many respondents acknowledged that there was a lack of an evidence base for SI therapy and 3 referred to the literature specifically. One respondent noted that they agreed "with the conclusions drawn within the draft policy which are also backed up by recent publication on the informed view of SI along with an evidence spotlight from the Royal College of Occupational Therapists (RCOT) which was published after the evidence summary was completed". The "RCOT Informed View" referred to states that:
    - Occupational therapists should maintain their occupational focus. Sensory issues must be considered in the context of the person's occupational engagement and performance within relevant environments.
    - Ayres Sensory Integration® and sensory-based interventions (SBIs) are concepts/intervention modalities that occupational therapists may consider incorporating into their practice but should be used as part of a wider approach to address a person's occupational needs."
- Many of the responses provided through the clinical engagement process gave the impression that many people do not understand exactly what this policy is with others noting that there is inconsistency with professional language used in the literature leading to misunderstandings and misinterpretations of research results

Public engagement:

An online survey was created to capture the views of patients, members of the public and other stakeholders. The survey ran from Friday 28th May until Friday 9th July 2021 and was disseminated via CCG networks and social media. In addition, a presentation to the Children and Maternity Commissioning Network was undertaken during the engagement exercise, and through them SENDIASS and parent/carer groups for children with special educational needs were contacted to inform them of the survey and seek their feedback.

Respondents were given the opportunity to read the new draft policy and complete the survey accordingly. Respondents, as individuals or groups, were able to request a virtual meeting or discussion if they wished to be involved in a more personal or direct involvement in the engagement process. There was very little uptake of this opportunity.

Two Occupational Therapists provided a significant level of feedback during the patient engagement exercise – these responses have been included within the clinical engagement feedback.

- Overall, 32 responses were received to this survey and an additional 4 comments sent by email or by 'phone (including the responses from the Occupational Therapists)
- The majority of responses (59%) came from residents of one CCG, Morecambe Bay
- 44% of respondents had looked after someone who had received the therapy and a further 16% knew someone who had had it - many were parents responding on behalf of their children
- 78% of the respondents did not agree with the policy. They found it "appalling" that Sensory Integration Therapy would not be funded by the NHS (or other channels).
- Many respondents felt failed by services because there was so little available to support children and young people with ASD in particular. Responses included comments that services were "severely lacking", that people "do not get any useful support" and "the only real help and support I have ever received in the 4 years has been that which I have paid for myself"
- Most respondents were supportive of Sensory Integration Therapy, and generally more supportive of a greater use of sensory assessment in care planning and adaptations
- Several respondents made the point that sensory assessment has been underused in healthcare and it is only now that its importance is being recognised.
  We didn't fund SIT anyway but now that we are explicitly saying that we don't there is a lot of resistance. A lot of respondents have paid for SIT privately and feel there are many benefits to their child/children – the OT's agreed

Overall, there is significant support for the greater use of sensory assessments as part of the overall package of assessment of needs, from both clinical and public feedback. Feedback has also highlighted the need to use assessment findings in planning and involving parents and carers in discussions on how best to support their child to help them develop and achieve personal goals.

There is support for sensory integration therapy from a cohort of people who have experience of the service and some committed healthcare professionals. Including OTs. However, those who may not have found it beneficial may not have felt inclined to respond.

Some clinicals and members of the public supported the policy and referred to how the money could be spent on other things.

Public engagement highlighted that there is some confusion around the current funding of SI therapy with some respondents feeling that this policy was a decision not to invest in autism services more widely across Lancashire and South Cumbria.

Please answer 'Yes' or 'No' and explain your answer	Yes	No
Has the engagement/involvement or consultation highlighted any inequalities?	X perceived inequalities for the public	

Explanation:

Clinical engagement:

Respondents highlighted the lack of evidence in terms of data that backs up the clinical effectiveness of Sensory Integration therapy. One respondent noted that "the scientific rigour is improving and in recent times (the last 2-3 years) there has been a big push in the academic community to produce high quality research studies relating to sensory integration, ASD will likely be a major focus for this research."

They also noted that "evidence base aside, many occupational therapists are strong advocates for using sensory assessments and interventions as part of their OT practice which must signify that there is some merit in using this approach to improve the clinicians understanding of the occupational performance challenges for children and young people and to improve clinical outcomes. There is also anecdotal evidence from family feedback to signify that this approach is valued and helpful."

The responses received from the Occupational Therapists, supported by comments from parents, challenges the lack of evidence around the clinical effectiveness of Sensory Integration Therapy and champions the vital role that understanding and supporting sensory difficulties in the learning and development of children and adults with ASD and other conditions.

The Occupational Therapist responses also highlight the confusion around the use of language or terminology in relation to sensory integration therapy, sensory diets and other terms, in both professional and lay circles, and suggest that this should be addressed.

Public engagement:

The overall response from public engagement was "strongly disagree" with the decision to not routinely commission the SIT policy.

It may be possible that the respondents had misinterpreted the position and assumed that this was a service in existence that was now being decommissioned – this is not currently a service that is commissioned.

Many of the responses came from parents or carers of children and young people who have ASD and who are already struggling with the scarcity of services commissioned for their children. There was a great deal of responses that were emotive, with many respondents feeling frustrated at the lack of provision of services for children and young people with ASD. A high proportion of respondents found it ‘appalling’ that sensory integration therapy would not be funded and/or that it was not available through the NHS or via other education or social service channels. Respondents also expressed the view that the use of sensory integration therapy would reduce the need for other treatments, including mental health and medication, in the long term. In addition, where parents had purchased this service privately, they found it to have been of great benefit. The benefits witnessed by parents were also supported by the two OTs.

Following the presentation of the public engagement feedback on September 16th, 2021, policy group members agreed that it was difficult to ignore the overall response from the public, but that as the published evidence for this service did not support change to the commissioning position the decision to not routinely commission could not be reversed.

Policy group members empathised with the experience of parents trying to secure services for this cohort of patients and agreed to feed this back to their respective CCGs to information.

Following the engagement exercise, the Comms and Engagement team ([redacted]) recommended that further research is done on the SIT evidence base and that any potential inequalities are exacerbated. Due to the high number of negative responses, it was also suggested to the group that the policy should change direction or be withdrawn.

Overall, there is a potential equality risk with not routinely commissioning the SIT policy – with a possible legal challenge a result due to the strong disagreement following public engagement. CCGs will need to consider how to mitigate any potential negative impact on protected characteristic groups if this policy is not commissioned.

Please answer ‘Yes’ or ‘No’ and explain your answer	Yes	No
Have you added an Equality Statement to the Policy? Example statement: Promoting equality and addressing health inequalities are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document, we have given regard to the need to • eliminate discrimination, harassment, and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic	x	

(as cited under the Equality Act 2010) and those who do not share it; and • reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities • make reasonable adjustments when necessary		

Explanation:

The policy has an overarching set of principles which include an equality statement.

SECTION 3

Does the 'policy' have the potential to:

- Have a positive impact (benefit) on any of the equality groups?
- Have a negative impact / exclude / discriminate against any person or equality groups?
- Have a neutral / potential indirect effect on any equality groups?
- Explain how this was identified? Evidence/Consultation?
- Who is most likely to be affected by the proposal and how (think about barriers, access, effects, outcomes etc.)

Guidance document available on Equality Groups and their issues. This document may help and support your thinking around barriers for the equality groups.

Equality Group / Protected Group	**Positive effect**	**Negative effect**	**Neutral or indirect effect**
Age		X by perception	X

Explanation:

For the purpose of this policy the CCG defines sensory integration therapy as stand-alone, one-to-one clinic-based therapy for children or adults who have been assessed to have a degree of sensory dysfunction.

The scope of this policy includes requests for stand-alone, one-to-one clinic-based therapy and the provision of associated recommended equipment, such as weighted blankets, for sensory disorder/dysfunction.

Sensory Integration Therapy is usually delivered to children with sensory processing difficulties and disorders.

Public engagement work has helped to gain further insight in relation to age:

- Most respondents were adults responding on behalf of their children
- 62.5% were aged between 35 and 54 - this is reflective of the pre-dominance of parents responding
- 12.5% of respondents were between the age of 25 and 34
- All respondents were of working age, with no-one above the age of 64 responding and no-one below the age of 17
- 44% of respondents had either received sensory integration therapy or cared for someone who had received it
- 78% of the survey respondents did not agree with the sensory integration therapy not being routinely funded, with 65.63%) strongly disagreeing. 15.61% agreeing that the procedure should not be routinely funded
- 72% of the survey respondents provided feedback on why they disagreed, with a large number of these respondents having had direct experience of sensory integration therapy or sensory integration diet as they have funded the therapy for their children privately. Those who provided feedback were very positive about the benefits of sensory integration therapy

There may be perceived negative impacts for children and young people with sensory disabilities that are currently receiving this therapy. Parents and carers of children who are currently receiving this treatment or who wish to access this treatment in the future may feel that not routinely commissioning sensory integration therapy will negatively impact on their child’s development and overall wellbeing.

Under the Equality Act 2010, Children and young people (under 18’s) do not have full legal protection from unlawful age discrimination. However, they can bring a challenge based on other protected characteristics such as disability.

Equality Group / Protected Group	**Positive effect**	**Negative effect**	**Neutral or indirect effect**
Disability		X by perception	x

Explanation:

Current version 0.3 of the policy states that the CCGs will not routinely commission sensory integration therapy (stand-alone, one-to-one clinic-based therapy), as it considers that the intervention does not accord with the Principles of Effectiveness and Cost-Effectiveness.

The scope of this policy includes requests for stand-alone, one-to-one clinic-based therapy and the provision of associated recommended equipment, such as weighted blankets, for sensory disorder/dysfunction.

There is no common approach or agreement on how to define sensory integration, but it is mostly offered to children who have sensory processing difficulties and disorders which may fall under the protected characteristic of disability.

[redacted] – an independent consultant in Children's Physiotherapy notes that sensory processing difficulties are often seen in the following conditions:

- Autism / Autistic Spectrum Disorder (ASD) including Asperger's Syndrome
- Sensory Processing Disorder / Sensory Integration Dysfunction
- Dyspraxia/Developmental Co-ordination Disorder (DCD)
- Attention Deficit Hyperactivity Disorder (ADHD). https://www.juliadyer.com/

People may also experience Sensory Integration Disorder if they have a learning disability or mental health issues to including Depression, Anxiety and OCD, all of which are considered to be a disability under the Equality Act 2010. Some children and young people with Autism may also experience other conditions including ADHD, dyslexia, anxiety or depression and epilepsy. They may also have a learning disability (LD).

Patients with ASD and learning disabilities are at higher risk of experiencing health inequalities and have may have a reduced life expectancy, compared to people without a learning disability – please see earlier section on health inequalities for more information.

People with sensory conditions, including ADHD and ASD, who may wish to access this treatment may fall into the protected characteristic of disability under the Equality Act 2010. The policy position may be perceived by some people as negative for those that receive this therapy or hope to in the future. However, as there is a lack of clinical evidence to the effectiveness of this therapy, the impact of the policy should be neutral and may in fact have an indirect positive impact regarding best use of NHS resources and Occupational Therapy time.

During the research of this assessment, limited information was found on the effectiveness of SI from NICE. This lack of evidence may be due to low numbers of clinical trials and lack of research in this area rather than reflecting that the therapy does not have individual benefits.

Public engagement work has helped to gain further insight regarding disability:

- Most respondents were adults responding on behalf of their children
- 25% indicated they have a disability, with the majority of these having multiple impairments - a significant proportion and higher than the national average
- 44% of respondents had either received sensory integration therapy or cared for someone who had received it.
- 78% of the survey respondents did not agree with the sensory integration therapy not being routinely funded, with 65.63%) strongly disagreeing. 15.61% agreeing that the procedure should not be routinely funded
- 72% of the survey respondents provided feedback on why they disagreed, with a large number of these respondents having had direct experience of sensory integration therapy or sensory integration diet as they have funded the therapy for their children privately. Those who provided feedback were very positive about the benefits of sensory integration therapy
- A high proportion of respondents found it ‘appalling’ that sensory integration therapy would not be funded
- Respondents also expressed the view that the use of sensory integration therapy would reduce the need for other treatments, including mental health and medication, in the long term.
- Respondents generally felt let down by a lack of appropriate services for people/children with autism and ADHD across the area

Due to the negative responses received from the public in relation to sensory integration therapy not being routinely funded, there is the potential of a legal challenge due to the perceived potential negative impact on people with sensory conditions that may wish to access this treatment.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral or indirect effect
Sexual Orientation			X

Explanation:

There are currently no negative impacts identified in relation to this group.

There was good representation from people who are Gay, Lesbian or Bisexual (LGB) for public engagement exercise - national data states that 2.7% of the population are LGB (2019).

https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2019

Public engagement responses indicated that:

- 87.5% of respondents were heterosexual
- 3.13% gay/lesbian
- 9.38% who preferred not to say.

No issues in relation to sexual orientation were raised as part of the clinical or public engagement work.

People who identify as LGBTIQ+ are more likely to develop mental health problems including depression, anxiety, and eating disorders. People experiencing mental health problems may also experience sensory processing difficulties and may wish to access this treatment. Mental health conditions are considered to meet the definition of a disability under the Equality Act 2010.

https://www.mind.org.uk/information-support/tips-for-everyday-living/lgbtiqplus-mental-health/about-lgbtiqplus-mental-health/

Equality Group / Protected Group	Positive effect	Negative effect	Neutral or indirect effect
Gender Reassignment			x

Explanation:

There are currently no negative impacts identified in relation to this group.

There is some evidence to show a link between Gender Dysphoria and autism, and that autistic people may be more likely than other people to have gender dysphoria. However, there is little evidence about the reason(s) why, and some recent research suggests the link between autism and gender dysphoria is not so clear.

https://www.autism.org.uk/advice-and-guidance/what-is-autism/autism-and-gender-identity

There is some evidence that suggests the co-occurrence of ASD and Gender Non-Conformity/Gender Dysphoria in adolescents presents significant diagnostic and treatment challenges https://www.tandfonline.com/doi/full/10.1080/15374416.2016.1228462

Data in relation to gender reassignment and public engagement respondents showed that all respondents indicated that their current gender was the same gender that they were assigned at birth.

No issues in relation to gender reassignment were raised as part of the clinical or public engagement work.

Equality Group /	Positive effect	Negative effect	Neutral or indirect

Protected Group			effect
Sex (Gender)			x

Explanation:

There are currently no negative impacts identified in relation to this group.

Data suggests that males are more likely to be diagnosed with ASD compared to females - it is estimated that the ratio of autistic males to females is 3:1.

Women and girls may face barriers in terms of getting a diagnosis for ASD. There are a number of theories as to why this may be – these include the 'female autism phenotype' – whereby females have characteristics which don’t fit with the profile, the 'extreme male brain' theory of autism, which focuses on the effects of foetal testosterone on brain development, biological and environmental factors which mean a higher prevalence of autism in males, females may be better at masking or camouflaging their difficulties and that autism traits in girls are under-reported by teachers.

https://www.autism.org.uk/advice-and-guidance/what-is-autism/autistic-women-and-girls

Therefore, there may be more males than females who may wish to access Sensory Integration therapy.

Public engagement responses highlighted that:

- 97% of respondents described their gender as female with 3% describing their gender as male
- This imbalance may be because most of the respondents were parents, commenting on behalf of their child/children
- Due to the small sample size, there is a wider margin of error and it is difficult to know if the gender of respondents reflects the gender of those wishing to access the treatment themselves.

No issues in relation to sex were raised as part of the clinical or public engagement work.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral or indirect effect
Race			x

Explanation:

There are currently no negative impacts identified in relation to this group.

There is a lack of research about the experience of people from Black, Asian and minority ethnic groups who have ASD. This may mean it is more difficult for people with ASD from

Black, Asian and minority ethnic groups to access the support they need.

https://www.autism.org.uk/advice-and-guidance/what-is-autism/autism-and-bame-people

https://s3.chorus-mk.thirdlight.com/file/1573224908/63849355948/width=-1/height=-1/format=-1/fit=scale/t=445333/e=never/k=7c17beeb/Diverse-perspectives-report.pdf

Public engagement responses highlighted that:

- 90.6% of respondents were White British
- 6% of respondents were from other ethnic backgrounds
- 3.13% of respondents preferred not to say
- Other ethnic groups were generally underrepresented in these responses

No issues in relation to race were raised as part of the clinical or public engagement work.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral or indirect effect
Religion or Belief			x

Explanation:

There are currently no negative impacts identified in relation to this group.

Public engagement responses highlighted that:

- 50.1% of respondents were Christian
- 37.5% of respondents had no religion or belief
- 6.25% of respondents preferred not to say
- 3.13% of respondents were Muslim

No issues in relation to religion and belief were raised as part of the clinical or public engagement work.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral or indirect effect
Pregnancy and Maternity			x

Explanation:

There are currently no negative impacts identified in relation to this group.

Data in relation to pregnancy and maternity was not collected as part of the public engagement work.

For carers of children accessing SI therapy or hoping for their child to receive as part of their care plan they may perceive the policy position not to routinely commission this therapy as negative. There may be a perception that SI helps meet the care and health needs of their child.

No issues in relation to pregnancy and maternity were raised as part of the clinical or public engagement work

Equality Group / Protected Group	Positive effect	Negative effect	Neutral or indirect effect
Marriage and Civil Partnership			x

Explanation:

There are currently no negative impacts identified in relation to this group.

Public engagement responses highlighted that:

- 69% of survey respondents indicated they were married
- 22% confirmed that they were single
- A few respondents indicated they were in a civil partnership and only one respondent preferred not to say

No issues in relation to marriage and civil partnership were raised as part of the clinical or public engagement work.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral or indirect effect
Carers		X by perception	x

Explanation:

For carers of children accessing SI therapy or hoping for their child to receive as part of their care plan they may perceive the policy position not to routinely commission this therapy as negative. There may be a perception that SI helps meet the care and health needs of their child.

During the research of this assessment, limited information was found on the effectiveness of SI however engagement work will help to gain further insight regarding the views of carers and parents/guardians. This lack of evidence may be due to low numbers of clinical trials and lack of research in this area rather than reflecting that the therapy does not have individual benefits.

Public engagement work has helped to gain further insight regarding carers:

- Most respondents were adults responding on behalf of their children
- 44% of respondents had either received sensory integration therapy or cared for someone who had received it.
- 78% of the survey respondents did not agree with the sensory integration therapy not being routinely funded, with 65.63%) strongly disagreeing. 15.61% agreeing that the procedure should not be routinely funded
- 72% of the survey respondents provided feedback on why they disagreed, with a large number of these respondents having had direct experience of sensory integration therapy or sensory integration diet as they have funded the therapy for their children privately. Those who provided feedback were very positive about the benefits of sensory integration therapy
- A high proportion of respondents found it ‘appalling’ that sensory integration therapy would not be funded
- Respondents also expressed the view that the use of sensory integration therapy would reduce the need for other treatments, including mental health and medication, in the long term.
- Respondents generally felt let down by a lack of appropriate services for people/children with autism and ADHD across the area

Due to the negative responses received from the public in relation to sensory integration therapy not being routinely funded, there is the potential of a legal challenge due to the perceived potential negative impact on people with sensory conditions that may wish to access this treatment. It may be argued by parents or carers of children with sensory conditions who may wish to access this treatment, that not routinely commissioning SI therapy will negatively impact on the current inequalities identified by the respondents during public engagement in relation to the wider provision of services for children with ASD across Lancashire and South Cumbria.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral or indirect effect
Deprived Communities		X potentially by perception	x

Explanation:

Data in relation to deprivation was not collected as part of the public engagement work.

Comments raised during the public engagement work noted the potential inequality the current environment creates, as those who can afford to pay privately can get SI support for their children while those who cannot afford this have no alternative.

Some respondents noted that they were unable to pay for SI therapy privately because they had to leave their jobs to care for their child or children.

There may be a perceived potential negative impact on people from deprived communities who may wish to access this treatment, or for those with a child or children who wish to access this treatment, as they may not be able to pay for SI therapy privately.

It may be perceived that not routinely commissioning SI therapy will negatively impact on the current inequalities identified by the respondents during public engagement in relation to the cost of privately funded treatment.

Equality Group / Protected Group	Positive effect	Negative effect	Neutral or indirect effect
Vulnerable Groups e.g., Asylum Seekers, Homeless, Sex Workers, Military Veterans, Rural communities			x

Explanation:

There are currently no identified impacts relating to this group.

Data in relation to underserved groups was not collected as part of the public engagement work.

No issues in relation to underserved groups were raised as part of the clinical or public engagement work.

SECTION 4: EQUALITY IMPACT AND RISK ASSESSMENT CHECKLIST

Please use the checklist in Appendix 2 to ensure and reflect that you have included all the relevant information

SECTION 5: HUMAN RIGHTS ASSESSMENT

How does this policy affect the rights of patients set out in the NHS Constitution or

their Human Rights?
If the Stage 1 Equality Impact and Risk Assessment highlighted that you are required to complete a full Human Rights Assessment, please request, and complete a Stage 2 Human Right Assessment from the Equality and Inclusion Team.

SECTION 6: RISK ASSESSMENT **See guidance and table of risks in appendix 3 section 6 for step-by-step guidance for this section**					
RISK MATRIX					
	Risk level				
Consequence level	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**VERY LIKELY 5**
1.Negligible	**1**	**2**	**3**	**4**	**5**
2.Minor	**2**	**4**	**6**	**8**	**10**
3.Moderate	**3**	**6**	**9**	**12**	**15**
4.Major	**4**	**8**	**12**	**16**	**20**
5.Catastrophic	**5**	**10**	**15**	**20**	**25**
Consequence Score: **Likelihood Score:** **Risk score = consequence x likelihood**					**8**
Any comments / records of different risk scores over time (e.g., reason for any change in scores over time):					
Important: If you have a risk score of 9 and above you should escalate to the organisations risk management procedures.					

EQUALITY IMPACT AND RISK ASSESSMENT AND ACTION PLAN				
Risk identified	**Actions required to reduce / eliminate the negative impact**	**Resources required *(see guidance below)**	**Who will lead on the action?**	**Target date**
Engagement	Carry out engagement work with the public		[redacted]	TBA
Clarification points in EIA	JM to discuss clarification points with group		[redacted]	TBA

'Resources required' is asking for a summary of the costs that are needed to implement the changes to mitigate the negative impacts identified

SECTION 7 – EQUALITY DELIVERY SYSTEM 2 (EDS2)

Please go to Appendix 1 of the EIRA and tick the box appropriate EDS2 outcome(s) which this policy relates to. This will support your organisation with evidence for the Equality and Inclusion annual equality progress plan and provide supporting evidence for the annual Equality Delivery System 2 Grading

SECTION 8 – ONGOING MONITORING AND REVIEW OF EQUALITY IMPACT RISK ASSESSMENT AND ACTION PLAN

Please describe briefly, how the equality action plans will be monitored through internal governance processes?

Discussion at Policy development meetings.

Date of the next review of the Equality Impact Risk Assessment section and action plan? TBA

SECTION 9

FINAL SECTION

Date completed: pre engagement 27/03/2020, updated 10/05/2021 and 29/10/2021 post engagement

Date received for quality check: 01/11/2021

Signature of person completing the assessment: [redacted], [redacted]

Date reviewed by Equality and Inclusion Team: 01/11/2021

Signature and Date quality check completed by Equality and Inclusion Team:

[redacted], *Equality and Inclusion Business Partner*

01/11/2021

Date signed off by CCG / CSU Committee: 02/11/2021