

## Section 4 Integrated Impact Assessment

### Summary Report Template

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| Audit Risk level |
|------------------|

(Risk level will be added by Equalities Officer)

Each of the numbered sections below must be completed

|                |  |              |   |                       |
|----------------|--|--------------|---|-----------------------|
| Interim report |  | Final report | x | (Tick as appropriate) |
|----------------|--|--------------|---|-----------------------|

#### 1. Title of plan, policy or strategy being assessed

NHS Board paper: Support and development of Realistic Medicine in Lothian.

#### 2. What will change as a result of this proposal?

There will be better shared decision making between clinicians and patients to enable mutual understanding of risks, benefits and expected outcomes of all treatment options specific to an individual patient's context. This may include stopping or not starting treatments.

It is important to note that this approach reflects good quality care and is already taking place currently in Lothian and in Scotland. The paper asks for support to encourage the further development of this approach following the high profile publication of the CMO report calling this concept 'Realistic Medicine' and publication of NICE Guideline NG56.

#### 3. Briefly describe public involvement in this proposal to date and planned

Some public engagement in 'Realistic Medicine' at national level. No specific public involvement in the development of this paper. It should be recognised that the essence of Realistic Medicine is improved involvement of individual patients in decision making; 'What matters to me'.

#### 4. Date of IIA

26<sup>th</sup> September 2016

5. Who was present at the IIA? Identify facilitator, Lead Officer, report writer and any partnership representative present and main stakeholder (e.g. NHS, Council)

| Name               | Job Title                              | Date of IIA training | Email  |
|--------------------|--|----------------------|--|
| Elizabeth Bream    | Consultant in Public Health            |                      | <a href="mailto:Elizabeth.bream@nhslothian.scot.nhs.uk">Elizabeth.bream@nhslothian.scot.nhs.uk</a>       |
| Martin Higgins     | Senior Health Policy Officer           |                      | <a href="mailto:Martin.higgins@nhslothian.scot.nhs.uk">Martin.higgins@nhslothian.scot.nhs.uk</a>         |
| Simon Watson       | Chief Quality Officer                  |                      | <a href="mailto:Simon.watson@nhslothian.scot.nhs.uk">Simon.watson@nhslothian.scot.nhs.uk</a>             |
| Caroline Whitworth | Associate Medical Director for Surgery |                      | <a href="mailto:Caroline.whitworth@nhslothian.scot.nhs.uk">Caroline.whitworth@nhslothian.scot.nhs.uk</a> |

6. Evidence available at the time of the IIA

| Evidence                    | Available?  | Comments: what does the evidence tell you? |
|-----------------------------|---|--|
| Data on populations in need | This spans the whole system. The populations most in need will be those for whom the risk/benefit of treatment is less clear and these tend to be patients with greater burdens of multi-morbidity. Patients who are older and from more deprived social groups tend to have greater prevalence of multimorbidity. However understanding the individual patient context is crucial. The CMO report includes | See opposite.                              |

| <b>Evidence</b>               | <b>Available?</b>  | <b>Comments: what does the evidence tell you?</b>  |
|-------------------------------|--|--|
|                               | <p>references from the literature to illustrate that this approach is needed – for example those patients who experience decision regret about their choice to have treatment.</p> <p><a href="http://www.gov.scot/Resource/0049/00492520.pdf">http://www.gov.scot/Resource/0049/00492520.pdf</a></p>  |  |
| Data on service uptake/access | <p>Again, at this stage this report spans the whole system and specific data are not available. There is an awareness that this approach has been used/is being used already in many areas, but this is not captured.</p> <p>Data on some aspects of Realistic Medicine are collected: e.g. numbers of patients who actively decide not to pursue dialysis, minuted outcomes from Multi-disciplinary team (MDT) discussions e.g. Cancer MDT, Vascular MDT which show which treatments patients take up/do not.</p> | N/A  |
| Data on equality outcomes     | Again, at stage this report spans the whole system.  | N/A  |
| Research/literature evidence  | <p>This report follows the CMO report where the concept of 'Realistic Medicine' was launched. The CMO report included data/research evidence.</p> <p><a href="http://www.gov.scot/Resource/0049/00492520.pdf">http://www.gov.scot/Resource/0049/00492520.pdf</a></p>   | <p>In general terms, there is evidence showing that care for patients could be improved with a more considered approach to communication so that patients were able to opt for the right treatment for them – which may mean less or no treatment.</p> |

| Evidence | Available? | Comments: what does the evidence tell you?  |
|----------|------------|---|
|          |            | <p>The King's Fund 2012 report, "Patient's Preferences Matter" showed the following:</p> <ol style="list-style-type: none"> <li>1. Doctors often fail to take into consideration patient preferences in suggesting and providing treatment. Treatment that does not coincide with the patient's preferences may ultimately be wasteful (in that it doesn't provide value for them). This can be seen in the use of heroic, complex and uncomfortable treatments as a patient approaches the end of life. It also appears to be demonstrable in many more settings.</li> <li>2. Patients tend to choose less treatment when they are provided with greater detail of the impact, potential benefits and harms of a proposed intervention.</li> <li>3. Doctors generally choose less treatment for themselves than they provide for their patients.</li> <li>4. Despite our beliefs that treatment is based on evidence, the complexity of presentations possible means that 30-45% of care is not based on available evidence – partially a reflection of gaps in available evidence, and</li> </ol> |

| Evidence   | Available?  | Comments: what does the evidence tell you?  |
|--|---|---|
|  |   | <p>partially a reflection of the impossibility for clinicians in keeping up with the increasing volumes of guidance.</p> <p><a href="http://www.kingsfund.org.uk/sites/files/kf/field/publication_file/patients-preferences-matter-may-2012.pdf">http://www.kingsfund.org.uk/sites/files/kf/field/publication_file/patients-preferences-matter-may-2012.pdf</a></p> |
| Public/patient/client experience information                               | See above findings of the King's Fund report.   | See above findings of the King's Fund report.   |
| Evidence of inclusive engagement of service users and involvement findings | <p>Realistic Medicine is fundamentally about involving patients. There has been no specific user involvement in writing this paper. However, patient advocates have been involved in broader discussions e.g. CMO/RCPE.</p> <p>The evidence cited in CMO report suggests that patients are supportive of this approach.</p> | See opposite.   |
| Evidence of unmet need   | Some.   | <p>There is evidence of unmet need – for example local work showing that one of the main reasons for not attending/cancelling a surgical procedure is that patients did not want the procedure.</p> <p>There is also evidence to show that some patients regret treatments that they embark on in cancer settings.</p>  |

| Evidence                     | Available?   | Comments: what does the evidence tell you?  |
|------------------------------|--|---|
|                              |  | Hacking B. <i>et al.</i> Testing the feasibility, acceptability and effectiveness of a “decision navigation” intervention for early stage prostate cancer patients in Scotland – a randomised controlled trial <i>Psycho-Oncology</i> : Vol 22; 5 p1017-24 2013 |
| Good practice guidelines     | <p>Yes – in GMC guidance and specific guidance following the Montgomery ruling.</p> <p>Consent: Patients and doctors making decisions together General Medical Council <a href="http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp">http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp</a> Supreme Court judgement Montgomery vs NHS Lanarkshire <a href="https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0136_Judgment.pdf">https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0136_Judgment.pdf</a></p> <p>NICE Guideline NG 56 <a href="https://www.nice.org.uk/guidance/ng56">https://www.nice.org.uk/guidance/ng56</a></p> | These require doctors to explain and explore all treatment options with patients.   |
| Environmental data           | N/A  |   |
| Risk from cumulative impacts | N/A  |   |
| Other (please specify)       | N/A  |   |
| Additional evidence required | N/A  |   |

**7. In summary, what impacts were identified and which groups will they affect?**

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| <p><b>Equality, Health and Wellbeing and Human Rights</b></p> <p><b><u>Positive</u></b></p> <p>This approach should:</p> <ul style="list-style-type: none"> <li>• improve access to and quality of services;</li> <li>• enable people to have more control of their social/work environment;</li> <li>• promote participation, inclusion, dignity and control over decisions;</li> <li>• build family support networks, resilience and community capacity;</li> <li>• promote healthier lifestyles (by improving patient activation)</li> </ul> <p><b><u>Negative</u></b></p> <p>No potential negative impacts were identified. It will be important to ensure that populations with lower levels of health literacy and/or reduced levels of engagement are supported to be able to engage fully with 'Realistic Medicine'.</p> | <p><b>Affected populations</b></p> <p>Should be all populations, but the following may be more likely to benefit because of their greater burden of disease:</p> <p>Older people and people in their middle years</p> <p>Disabled people (includes physical disability, learning disability, sensory impairment, long-term medical conditions, mental health problems)</p> <p>People misusing substances</p> <p>People with literacy problems</p> <p>People for whom English is not first language</p> |
|--|--|

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| <p><b>Environment and Sustainability</b></p> <p><b><u>Positive</u></b></p> <p>Potential positive impact on reduced need to travel for treatments that are not wanted or do not offer benefit and avoidance of drugs or treatments that offer no benefits will reduce waste.</p> <p><b><u>Negative</u></b></p> <p>One potential negative impact is evidence that patients</p> | <p><b>Affected populations</b></p> <p>As above as these are the groups most likely to be receiving treatment.</p> |
|--|---|

|  |  |
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| who live further from treatment centres may choose less treatment/intervention because of the increased burden of the treatment. |  |
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| <p><b>Economic</b><br/><b><u>Positive</u></b></p> | <p><b>Affected populations</b></p> |
|---|------------------------------------|

|  |                  |
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| <p>This approach should improve patient experience and quality of service. It will reduce treatments offered that have reduced or minimal benefit and/or increased harm for example due to polypharmacy or multimorbidity.</p> | <p>As above.</p> |
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| <p><b><u>Negative</u></b></p> |  |
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|   |  |
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| <p>No potential negative impacts were identified. It is important that there is explicit discussion with patients about risks, benefits and harms so that shared decision making occurs and that there is no perception of rationing.</p> |  |
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**8. Is any part of this policy/ service to be carried out wholly or partly by contractors and how will equality, human rights including children’s rights , environmental and sustainability issues be addressed?**

Not applicable

**9. Consider how you will communicate information about this policy/ service change to children and young people and those affected by hearing loss, speech impairment, low level literacy or numeracy, learning difficulties or English as a second language? Please provide a summary of the communications plan.**

This approach should enable clinicians to communicate more effectively with individuals in these groups (if appropriate to do so i.e. if there is a need for treatment). It is anticipated that the training for clinicians will include this and that this will be informed by local experts and best practice. It is envisaged that there will be a need to ensure that there are appropriate aids to communications e.g. literature suitable for patient groups, communication aids regarding discussion of risk. It is envisaged that all staff groups will require additional training in communication to support effective shared decision making. There is no specific plan to communicate about the approach/training required with the groups noted above.



**10. Is the policy a qualifying Policy, Programme or Strategy as defined by The Environmental Impact Assessment (Scotland) Act 2005? (see Section 4)**

Not applicable

**11. Additional Information and Evidence Required**

**If further evidence is required, please note how it will be gathered. If appropriate, mark this report as interim and submit updated final report once further evidence has been gathered.**

No further evidence required.

**12. Recommendations (these should be drawn from 6 – 11 above)**

1. Training for staff should be planned to take into account the fact that most patients who will benefit from this approach will be those who suffer from multi-morbidity such as: older people and people in their middle years, disabled people and people misusing substances and patients with frailty and confusion.

2. Training for staff should be planned to take into account the particular challenges of communicating with those patients and families/carers who may find these conversations and decision making more challenging, specifically:

- those with the following protected characteristics: parents and guardians of young people/children, learning disabilities, sensory impairment, mental health problems, non-English speakers, people with different religions/beliefs;
- vulnerable families/those with low self worth who may require additional advocacy;
- those with low literacy/numeracy (recognising that the way information is provided by clinicians commonly includes numbers and other information which may need to be presented in another form).

3. Training for staff should be planned so that staff at all levels should feel empowered to 'ask the questions' so that improved shared decision making can take place for all patients.

4. Support should be provided for staff, recognising that this approach may have additional psychological demands on them. Particular support may be required for staff who have chronic disease/ill health themselves.

5. As health and social care integration progresses, it will be important that Realistic Medicine and shared decision making is shared (and developed) with Lothian Health and Social Care Partnerships and other partners, notably in the third sector. There needs to be consideration about how to develop this partnership approach to providing Realistic Medicine.

**13. Specific to this IIA only, what actions have been, or will be, undertaken and by when? Please complete:**

| <b>Specific actions (as a result of the IIA which may include financial implications, mitigating actions and risks of cumulative impacts)</b> | <b>Who will take them forward (name and contact details)</b> | <b>Deadline for progressing</b> | <b>Review date</b> |
|---|--|---------------------------------|--------------------|
| The development of training as detailed above.  | TBC – further discussion planned in CMT                      |                                 |                    |
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|   |  |                                 |                    |

**14. How will you monitor how this policy, plan or strategy affects different groups, including people with protected characteristics?**

As Realistic medicine reflects high quality care, measuring it will be done using the measures/methods in place currently, with a particular emphasis on methods for measuring patient experience. Some early work is taking place to measure some specific aspects of this (e.g. treatment regret).

**15. Sign off by Head of Service**

**Name**

**Date**

## **16. Publication**

Send completed IIA for publication on the relevant website for your organisation. [See Section 5](#) for contacts.

## **Section 5 Contacts**

- **East Lothian Council**

Please send a completed copy of the IIA to [equalities@eastlothian.gov.uk](mailto:equalities@eastlothian.gov.uk) and it will be published on the Council website shortly afterwards. Copies of previous assessments are available via [http://www.eastlothian.gov.uk/info/751/equality\\_diversity\\_and\\_citizenship/835/equality\\_and\\_diversity](http://www.eastlothian.gov.uk/info/751/equality_diversity_and_citizenship/835/equality_and_diversity)

- **Midlothian Council**

Please send a completed copy of the IIA to [zoe.graham@midlothian.gov.uk](mailto:zoe.graham@midlothian.gov.uk) and it will be published on the Council website shortly afterwards. Copies of previous assessments are available via [http://www.midlothian.gov.uk/downloads/751/equality\\_and\\_diversity](http://www.midlothian.gov.uk/downloads/751/equality_and_diversity)

- **NHS Lothian**

Completed IIAs should be forwarded to [impactassessments@nhslothian.scot.nhs.uk](mailto:impactassessments@nhslothian.scot.nhs.uk) to be published on the NHS Lothian website and available for auditing purposes. Copies of previous impact assessments are available on the NHS Lothian website under Equality and Diversity.

- **City of Edinburgh**

Complete impact assessments should be forwarded to the Equalities Officer.

- **West Lothian Council**

Complete impact assessments should be forwarded to the Equalities Officer.