Audit Risk Level: Low

Rapid Impact Assessment summary report

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.**
SCAN Oncology Telehealth Pilot- Out Patient Breast Cancer Clinic, Dumfries and Galloway

2. **What will change as a result of this proposal?**
A specific group of patients who meet the agreed clinical criteria* will be offered a follow-up consultation via video-link, rather than the conventional face to face follow-up consultation. The use of video-link will allow the Consultant to undertake a follow-up clinic without having to travel from Edinburgh to Dumfries. Any savings made will be reinvested into the Breast Cancer service.

Over a 30 week period between 25th April 2012 and 28th November 2012 (incorporating 2 weeks annual leave), three clinics will take place using video-link. The first clinic using video-link took place on 25th April 2012.

Once patients have been identified who meet the selection criteria for the service, they are contacted in writing and sent an information leaflet, explaining the video-link option. In addition, the Breast Care Nurse telephones the patient to explain what will happen and answer any questions. Patients can refuse the option at any stage. The Nurse accompanies the patient in the video-link consultation.

*Agreed Clinical Criteria
- People with breast cancer
- Not newly diagnosed patients
- Patients who do not need a physical examination by a doctor
- Patients who will not be receiving difficult news
- Patients who have met the Consultant already
- Patients who live in Dumfries and Galloway
- Patients who do not have complex medical or psychological needs

3. **Briefly describe public involvement in this proposal**
As part of a broader piece of work to review Non-Surgical Oncology Services, over 100 patients were involved in the review process. As part of this exercise, patient views were sought on the concept of using telehealth.

Patient feedback will be sought before and after the video-link consultation. This data will be analysed by the Scottish Centre for Telehealth and Telecare who are independent of the service.

SCAN's Patient Involvement Manager is part of the Oncology Telehealth Working Group and has offered support, e.g. seeking consent, developing patient information and gathering patient experiences.

4. **Date of RIA**
14th May 2012

5. Who was present at the RIA? Identify facilitator and any partnership representative present

Name	Job Title	Date of RIA training	Email
Sandra Bagnall (Facilitator)	SCAN Patient Involvement Manager	7th June 2011	Sandra.bagnall@nhslothian.scot.nhs.uk
Cathy Brown	Breast Cancer Nurse, NHS Dumfries and Galloway	n/a	Cbrown6@nhs.net
Tamasin Evans	Consultant Clinical Oncologist, NHS Lothian	n/a	Tamasin.evans@luht.scot.nhs.uk
Alex Little	Strategic Planning and Commissioning Manager, Cancer, Palliative Care and Children's Services, NHS Dumfries and Galloway	n/a	Alexlittle1@nhs.net

6. Evidence available at the time of the RIA

Evidence	Available ?	Comments
Data on populations in need	**Yes	
Data on service uptake/access	**Yes	
Data on quality/outcomes		Treatment outcomes and wider service impacts will be monitored
Research/literature evidence		A literature review has been undertaken by Kate Macdonald, SCAN Network Manager and Christine McClusky from the Scottish Centre for Telehealth
Patient experience information	Yes	Patient evaluation firms will continue to be completed with the Scottish Centre for Telehealth and Telecare undertaking the data analysis
Consultation **and involvement** findings		Pre-pilot consultation and ongoing patient/staff feedback via questionnaires and focus groups

Good practice guidelines		While there are no guidelines available, the Scottish Centre for Telehealth and Telecare was established in 2006, which will drive the development of telehealth nationally. It supports NHS Boards to pilot the use of telehealth to help redesign and improve patients' access to healthcare, no matter where they live. Better Cancer Care[1] states that "where deployed effectively, telehealth can improve the patient's experience of care by reducing the need for travel to major cities and hospitals to receive their care and treatment". Audit Scotland's Review of Telehealth in Scotland[2] stated "Targeted appropriately, telehealth offers the potential to help NHS boards deliver a range of clinical services more efficiently and effectively. NHS boards should consider the use of telehealth when introducing or redesigning clinical services."
Other (please specify)		

**Standard data collection systems will be utilised to collect patient data.

7. Population groups considered

	Potential differential impacts
Older people, children and young people	The majority of people are aged between 35-75 years, but there is no upper age limit to the service. The change will have no impact on any particular age group.
Women, men and transgender people (include issues relating to pregnancy and maternity)	The majority of people using the service are female. However, men and transgender people would be given equal opportunity to use the video-link option.
Disabled people (includes physical disability, learning disability, sensory impairment, long term medical conditions, mental health problems)	Experience from other NHS services in Dumfries (e.g. pulmonary rehabilitation service) which already use video-link technology, informs us that these groups have not experienced any difficulties, e.g. in terms of hearing problems, communication difficulties, so we anticipate there will be no impact

[1] 'Better Cancer Care, An Action Plan', Scottish Government,
[2] 'A Review of Telehealth in Scotland', Audit Scotland, October 2011

Minority ethnic people (includes Gypsy Travellers, non-English speakers)	A translator will be provided if there are language issues as per usual practice, so no impact
Refugees & asylum seekers	n/a as not first point of contact, but similar issues as above
People with different religions or beliefs	Patients can be accompanied by a partner, family member, friend, as they would in a conventional face to face consultation, so no impact
Lesbian, gay, bisexual and heterosexual people	n/a clinically, so no impact
People who are unmarried, married or in a civil partnership	n/a clinically, so no impact
People living in poverty / people of low income	We know that cancer can have a real impact on income, e.g. the need for time off work, sickness absence. Travel expense reimbursement processes will not differ for patients using video-link, so no impact
People in different social classes	No difference, all social classes treated as equals
Homeless people	n/a no impact
People involved in the criminal justice system	No previous contact with individuals involved in criminal justice system, but no anticipated negative impact
People with low literacy/numeracy	No difference, staff spend time to explain with those with low literacy / numeracy
People in remote, rural and/or island locations	The use of video-link may have a positive impact on those living in remote / rural areas. If we amend the pilot so that patients living in remote areas can remain in a more local clinical setting, e.g. Stranraer, this will reduce the need to travel to Dumfries
Carers	Patients can be accompanied by a partner, family member, friend, as they would in a conventional face to face consultation, so no impact
Staff (including people with different work patterns e.g. part/full time, short term, job share, seasonal)	There will be some negative impacts during the pilot The administrative burden has increased which has resulted in staff working longer hours to see the same number of patients A computer was not available in the consultant's room, meaning that she could not access LUHT or the internet and make best use of free time

Staff (cont.)	The Clinical Nurse Specialist could not carry out usual activities during the clinic, as she was required to remain with patients throughout
OTHERS (PLEASE ADD): Video-link consultation patients Conventional consultation patients	 Consultations lasted longer and patients were supported by a nurse during the consultation. This is a positive impact for the individual patient but not for the service as a whole As fewer patients were seen as part of the video-link clinic than would have been seen in the conventional face to face clinic, this made the latter busier. Three patients were not eligible for the pilot and so their appointments had to be postponed to the following week. This is a negative impact on individual patients and the service. In addition, it should be noted that patients who are not eligible for the pilot may have more complex needs.

We feel it is important to state that as a service, staff work hard to build relationships with patients, which helps to identify any special requirements and take appropriate actions, e.g. booking translators for patients whose first language is not English, identify those on low incomes who may need help with travel expenses, ensure support is in place for those with low numeracy and literacy.

8. What positive impacts were identified and which groups will they affect?
The affected populations would include all groups listed in section 6.

Impacts	Affected populations
Efficiency of medical processes, in that the savings made will be re-invested into patient care. Patient feedback from first video-clinic was very positive and people felt that the service was of equal quality to a face to face consultation The Consultant Oncologist spent more time explaining things than would happen in a face to face clinic. Patients praised her good communication skills	All breast cancer patients Patients attending first video-link consultation Patients attending first video-link consultation

9. What negative impacts were identified and which groups will they affect?

The affected populations would include all groups listed in section 6.

Impacts	Affected populations
The video-link clinic took longer than the 20 minutes per patient that was anticipated	Patients who meet the selection criteria
There may be an impact on the remaining two conventional face to face clinics. Fewer patients will be seen via video link than would have been seen in the conventional face to face clinic. Therefore, more patients will need to be seen in the remaining two clinics, which could result in longer waiting times for patients.	Patients who do not meet the selection criteria and so must attend conventional face to face out patient Breast Clinics at Dumfries and Galloway Royal Infirmary
Three patients who were not suitable for the video-link service on 25th April were not able to be seen until the following week when the next conventional face to face clinic was scheduled.	As above
The clinical criteria cannot foresee unexpected events, e.g. the need for a physical examination by a doctor, which was not anticipated. As the consultant is not present to be able to do this, it can take time to organise with colleagues who are on-site	Patients who meet selection criteria
Patients receiving chemotherapy or radiotherapy may need two visits, rather than one, if they do not wish to use video-link option	Patients who meet selection criteria but who do not want to access video-link option and who are undergoing chemotherapy or radiotherapy
For patients who do not meet the selection criteria, there may be occasions when they need to be 'slotted in' to the out-patient clinic. This is possible with the conventional face to face clinic, but cannot be done with the video-link option and alternative solutions need to be sought via colleagues on-site to ensure they are seen by a doctor.	Patients who do not meet the selection criteria
The use of video-link makes it more difficult for colleagues to have access to the Consultant to discuss clinical matters regarding other patients	Patients who do not meet the selection criteria

10. Additional Information and Evidence Required

Nothing further required for this Impact Assessment. It was agreed that there is a need to monitor the issues identified in Section 9, such as the impact on the conventional face to face clinics

11. What communications needs were identified? How will they be addressed?

In terms of the lengthier consultation time and the impact on the conventional face to face clinics, this needs to be explored further and monitored as part of the pilot. It should be noted that this is not due to an identified patient need for more communication, nor due to a nurse also being present in the room. Rather, it is as a consequence of the Consultant working in a new way and being conscious that this is also a new experience for the patient. As such, she was keen to explain things as much as possible in response to these factors.

The patient information leaflet will be circulated to a wider patient group for comment by the SCAN Patient Involvement Manager and amendments made as necessary.

12. Recommendations

The Oncology Telehealth Working Group will continue to meet to oversee the implementation of the pilot service. One immediate revision following the first video-link clinic held on 25th April is to ensure that invitation letters will be sent out to patients at least one week before the appointment date. This will give patients more time to consider whether they wish to participate as well as contact the Breast Care Nurse if need be.

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

Specific actions (as a result of the RIA)	Who will take them forward (name and contact details)	Deadline for progressing	Review date
Please see Oncology Telehealth Working Group Issue Log and Workplan attached Working Group meetings: 29/05/2012 10/07/2012 21/08/2012 02/10/2012 13/11/2012 18/12/2012			

14. How will you monitor how this policy, plan or strategy affects different groups?

Standard data collection systems will be utilised to collect patient data

How will we capture progress on addressing the time issue? How will; we monitor staff feedback and other actions noted?

15. Who will be consulted about the findings of this impact assessment?

The Oncology Telehealth Working Group

16. Has a full EQIA process been recommended? If not, why not?
We have been advised by Public Health that an EQIA is not necessary.

Manager's Name: Kate Macdonald, SCAN Network Manager
Kate.macdonald@nhslothian.scot.nhs.uk or
Sandra Bagnall, SCAN Patient Involvement Manager
Sandra.bagnall@nhslothian.scot.nhs.uk

Date: 17th July 2012

Please send a completed copy of the summary report to:

James Glover, Head of Equality and Diversity
James.Glover@nhslothian.scot.nhs.uk

Note that you **will** be contacted by a member of NHS Lothian's impact assessment group for quality control and/or monitoring purposes.

5. Criteria for quality assurance of Rapid Impact Assessments.

Periodically, the EQIA Steering Group meets to assess the standard to which Rapid Impact Assessments have been completed. A sample of RIAs is reviewed against quality criteria. Each RIA report is reviewed by a group of 3 or 4 members of the Steering Group. If a report is found not to meet the criteria, the author is contacted and support offered to repeat the RIA.

These are the criteria the Group uses.

Criteria
There are at least 4 participants who bring appropriate perspectives. At least one participant should have been on the RIA training and Equality and Diversity training or have experienced a previous RIA. The facilitator is identified
There is evidence of staff partnership participation in the RIA where appropriate
There is evidence that all relevant populations were considered.
There is evidence that all headings on the checklist were considered.
There are no obvious impacts that were *not* identified.
The recommendations are appropriate to the impacts. Recommendations should be able to be justified by the RIA findings
There is an action plan to implement the recommendations, which has specific measurable and achievable actions within it.
The report specifies how actions will be monitored
The Manager responsible for the service/strategy/policy being assessed has signed the RIA.

Further QA Action to be taken: