Tackling Health Inequalities through Shared Decision Making (SDM): A Policy Position Paper

This policy paper has been developed by AbbVie following an AbbVie initiated and funded non-promotional roundtable discussion with clinicians, NHS representatives, patient group advocates, policy specialists and private sector stakeholders exploring the barriers that disadvantaged groups face when accessing shared decision making and the opportunities to overcome these barriers in order to help tackle health inequalities.

"Shared decision making is a collaborative process that involves a person and their healthcare professional working together to reach a joint decision about care. It could be care the person needs straightaway or care in the future, for example, through advance care planning. It involves choosing tests and treatments based both on evidence and on the person's individual preferences, beliefs and values. It means making sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing. This joint process empowers people to make decisions about the care that is right for them at that time (with the options of choosing to have no treatment or not changing what they are currently doing always included)[1]."

National Institute for Health and Care Excellence (NICE)

Introduction

Shared Decision Making (SDM) has been shown to help people to take control of their wellbeing and improve their health outcomes. At a time where the need to address disparities in health outcomes has become a key concern for healthcare planners, providers and policymakers across the country, tools such as SDM are becoming more useful than ever.

However, despite its proven utility, SDM's role in addressing health inequalities has been largely overlooked. By exploring how people from disadvantaged communities can be supported to use SDM and access its benefits, this paper addresses this oversight and sets out key recommendations on how SDM can be embedded into the evolving healthcare system to improve health outcomes across society.

The challenge

Health inequalities and SDM have both assumed a prominent role in the development of contemporary health policy. The NHS Long Term Plan (LTP) dedicates a full chapter to addressing the former[2], while a commitment to understanding and addressing inequities in health has become a staple feature of recent discourse from policy makers and senior healthcare leaders alike. SDM, meanwhile, has been embedded into Primary Care Network (PCN) plans for staff training in 2021/22 and 2022/23[3] and warranted its own dedicated guidelines from both NHS England and Improvement[4] and NICE[5].

The significance of health inequalities and SDM go beyond best practice guidance and policy documents. Both have significant repercussions for individual health outcomes and, by association, the demands placed on the health system. The societal implications of health inequalities have garnered widespread recognition since the launch of the Marmot Review in 2010[6] - recognition which has been underscored by the Institute of Health Equity's (IHE's) 2020 follow-up report, which found that a wide range of health inequalities continue to place

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significant burdens on disadvantaged communities and local health systems in the decade since the Marmot Review was published and have, in fact, worsened in many areas[7].

The COVID-19 pandemic has exacerbated these pre-existing inequalities, placing significant pressure on health services across the UK and having a disproportionately large impact on disadvantaged groups[8]. This impact includes the increased risk of death from COVID experienced by certain ethnic minority groups including black and Asian British individuals[9] , the clear gradation of COVID mortality risk by level of deprivation[10], the isolation, anxiety and deteriorating health reported by many older people at the height of the pandemic[11] and the Health and Social Care Select Committee's recent finding that the biggest increases in post-COVID waiting lists have occurred in areas of greater deprivation[12]. As the NHS looks to "re-build" in a post-pandemic world, address these inequality-induced pressures and drive better health outcomes across society, it is essential for every community to be involved in the decisions which shape their care.

The NHS should see SDM as an invaluable tool for this task - and the virtues of its implementation are already well-established. NHS England acknowledges that 'patients who are empowered to make decisions about their health that better reflect their personal preferences often experience more favourable health outcomes' such as 'being less anxious, a quicker recovery and increased compliance with new treatment regimes'[13]. Similarly, NICE guidance notes that involving people in decisions about their care may result in better communication between individuals and their healthcare professionals (HCPs), allowing them to feel they have "been heard" and report a better experience of care, including more satisfaction with the outcome and better concordance with an agreed treatment plan[14].

Despite being widely acknowledged and discussed individually, less focus has been placed on the overlap between health inequalities and SDM. NICE's SDM guidance encourages local commissioners and healthcare providers to enable the guideline 'in light of their duties to… advance equality of opportunity and to reduce health inequalities', but the document only mentions inequalities on one other occasion[15]. Similarly, the 2019 NHS SDM guidance makes a single reference to the role that SDM interventions can play in improving outcomes for disadvantaged groups[16]. Given the clear credence which is already given to SDM as a tool for driving patient engagement and improving patient outcomes, this broad oversight may lead to opportunities to tackle health inequalities being missed within the health system.

The opportunities

In November 2021, AbbVie funded and organised a policy roundtable meeting to discuss '*Tackling Health Inequalities through Shared Decision Making* (SDM)'. The meeting was chaired by health campaigner and broadcaster Dr Carrie Grant MBE (hc). It brought together clinicians, NHS representatives, policy specialists, patient group advocates and private sector stakeholders with an interest and expertise in health inequalities and the lived experience of disadvantaged groups. The expertise and specialties of participants ensured a wide range of disadvantaged groups were represented, including people living with rare and long-term conditions, older people, black, Asian and other ethnic minority groups, neurodiverse individuals, people from areas of high deprivation, people living with brain tumours and members of the LGBTQ+ community.

During an open discussion, attendees shared their personal and professional insights of SDM and how it can be used to reduce health inequalities. Through a detailed conversation, participants highlighted the barriers to SDM which risk exacerbating health inequalities and suggested ways that these barriers can be addressed. Discussion

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of both factors placed a particular emphasis on **the health system, the role of the patient within the system, and the mediating influence of community organisations and public policy** more broadly**.**

While participants discussed barriers in great detail, there was a sense of optimism that these barriers could be addressed through:

- Enhanced collaboration between and across healthcare systems and services.
- Greater transparency in discussions between patients and their HCPs and an inclusive operational architecture to facilitate this.
- An improved sense of parity between traditional health services and the community organisations that play an increasingly essential role in supporting them.

Underlying all discussions was a conviction that the evolving healthcare system - with its emphasis on integrated care and an holistic approach to personalised healthcare provision - should be placing SDM at the heart of its operational planning. In doing so, health services across the country could take great strides in delivering LTP ambitions and boosting workforce efficiency by extracting greater value from each patient interaction. The 2021 ICS Design Framework provides a promising foundation for these cohesive, person-centred and community-focused approaches to take shape[17]. It is in the interest of health systems more broadly to consider how these lenses can improve outcomes across the board. As Integrated Care Services (ICSs) begin their operational functions in 2022, it is important that these benefits are not overlooked. Indeed, as NHS England has noted:

'SDM is not new… but in 2022 the case for change is more compelling than ever'[18].

The way forward

Based on the roundtable discussion, and given the aforementioned significance of SDM within the evolving health system, we believe that the following recommendations will ensure more patients from disadvantaged groups are able to access the benefits of SDM going forward.

Key Policy Recommendations

Recommendation 1: Integrated Care Systems (ICSs) should embed SDM, patient involvement, diversity and inclusion into their operational guidelines.

Recommendation 2: Health services must ensure that patients can access support through a variety of channels, both virtual and face-to-face, and not adopt a 'one-size-fits-all' approach. Greater focus also needs to be placed on delivering inclusive and accessible communications and patient resources.

Recommendation 3: Disadvantaged communities can be supported to access SDM by investing in formal collaborations between health systems and community organisations.

Recommendation 4: New and existing healthcare professionals (HCPs) should receive ongoing communications training, including 'coaching conversations', to facilitate increasingly collaborative relationships between patients and clinicians.

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List of attendees

AbbVie would like to thank the following individuals and organisations that attended the roundtable: Dr Carrie Grant MBE (hc), Chair; Dr Michael Alexander, Senior Research Associate, UCL Institute of Health Equity; Lis Boulton, Health and Care Policy Manager, Age UK (attended virtually); Dr Helen Bulbeck, Director of Services and Policy, *brainstrust*; Dr Jugdeep Dhesi, Consultant Geriatrician, Guy's and St Thomas' NHS Foundation Trust; Danielle Frewin, Corporate Policy Lead, AbbVie UK; Gail Grant, Head of Government Affairs, AbbVie UK; Annette Jack, Chief Executive/Founder, Egality**;** Dr Tony Lloyd, CEO, ADHD Foundation Neurodiversity Charity; Dr Vivienne Lyfar-Cissé, Chair, NHS BME Network; Hashum Mahmood, Senior Policy Adviser for Population Health, NHS Confederation (attended virtually); Nick Meade, Interim Chief Executive of Policy, Genetic Alliance (attended virtually); Salma Mehar, Consultant Dietitian, North West London Clinical Commissioning Group; Kirit Mistry, Chair, South Asian Health Action (attended virtually); Rachel Power, Chief Executive, Patients Association; Sophie Randall, Director, Patient Information Forum; Neil Tester, Director, The Richmond Group of Charities; Chris Thomas, Senior Research Fellow, Institute for Public Policy Research; Christine Williams MSc, specialist in NHS Commissioning (attended virtually).

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