Realistic Medicine

Feedback Report

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Realistic Medicine – Feedback Report

Foreword by CMO

I used the publication of my first annual report as Chief Medical Officer for Scotland (CMO) in January 2016, entitled *Realistic Medicine,* to encourage discussion with clinicians as collaborative leaders, to influence approaches to care and to be a driver for change.

The report laid out many of the challenges facing healthcare and the profession today and started a conversation with doctors about how these could be addressed. Since publication I have engaged with clinicians on how together we can successfully realise these aims contained in Realistic Medicine, by: changing our style to shared decision-making; building a personalised approach to care; reducing harm and waste; reducing unnecessary variation in practice and outcomes; managing risk better; and becoming improvers and innovators.

My purpose in writing to you today, is to update you on the discussion and share some of the further work already taking place in Scotland that assists making Realistic Medicine a reality.

Realistic Medicine was received well not only in Scotland but also internationally on social media – with #realisticmedicine reaching over 6.7m Twitter feeds and its infographic being shared globally. I welcome that Realistic Medicine has been accepted not only by clinicians but other professionals and practitioners in health and social care who want to embrace and adopt the philosophy and strengthen the movement. This is helping with the next steps, which will rely on collaboration from many across the health and care sector, with individuals themselves acting as role models and leaders.

I believe the engagement process has helped foster a collective and inclusive approach to realising Realistic Medicine. We have built a collaborative alliance by engaging clinicians in every Health Board in Scotland as well as stakeholders from health and care workforce education, professional membership organisations, registration and standards bodies, improvement and scrutiny bodies, shared services including data analysts, health promotion agencies, leaders and managers at regional levels, unions including those with responsibility for litigation and of course organisations that provide a patient and public voice.

Individual clinicians have told me they welcomed being able to connect with me, my team and with colleagues on these issues. I also think there has been a wider sense of Realistic Medicine as a “movement” that has enabled people, not only clinicians, in NHS Scotland to have authentic conversations about the way we improve quality of care. I am grateful that I now have invaluable evidence – set out in this report - from those who will be crucial to implementing Realistic Medicine, including what the barriers to change really are and how best to remove these. I will continue to lead with collaboration from my colleagues within Scottish Government and all my partners who have embraced Realistic Medicine and have all an important role to play in its delivery.

CATHERINE CALDERWOOD

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Executive Summary

The Chief Medical Officer for Scotland's Annual Report 2014/15 – Realistic Medicine was launched on 20th January 2016. One of the aims of the report was to discuss the challenges facing the profession and to begin a conversation with clinicians about how to change practice

Feedback was received by letters, emails, an online survey, through social media and from a series of engagement events across the country. A thematic analysis of this feedback has been carried out and the results are reported here. On social media the recognised healthcare hash tag #realisticmedicine reached 6.7 million twitter feeds and over 3491 tweets from 1235 participants from January to October 2016. This readed 11 countries (UK, Australia and New Zealand, Canada, Finland, Italy Japan, Norway (including Svalbard in Artic Circle) and Sweden, South Africa and the USA). A full feedback report across all the different channels is available at ANNEX A. Engagement and implementation activities are summarized in ANNEX B and C respectively.

Overall conclusions from feedback

The key conclusions from collated feedback are:

1. **Agreement with the principles of Realistic Medicine** and that if fully implemented it could enable improvements in care.

2. **Identification of the key barriers to implementation** including: not enough time to stop and plan; data access and availability; workload; relationships with colleagues; and concerns about litigation and complaints.

3. **Patient and public engagement is needed.**

4. **A focus on education and skills training is needed.**

5. **Shared decision making' and 'reducing harm and waste' are the main priorities.** These gained most support in written feedback while reducing ‘over-treatment’ especially at the end of life was emphasised.

6. **Shared learning and collaboration across structural boundaries is needed.**

7. **Integrated IT systems and clinically driven data** are needed.

8. **Policy and 'top down' support** including a move away from “target driven” medicine is needed.

9. **The whole multi-disciplinary team is needed for Realistic Medicine.**

10. **Realistic Medicine’s key aims are interrelated and interdependent**

Evaluation of written and email feedback

There were a total of 48 emails and letters which included a mixture of individual and collective responses. The feedback was positive and supportive of the themes and questions raised by Realistic Medicine. The overall view is that this is a suitable ambition. The "elements of this are not new, however further work is required to fully embed and change culture." There is wide spread acknowledgement of the good work already going on, as well as barriers in the current system to implement such an approach.

Shared decision making - Shared decision making was one of topics with the greatest number of responses.

There was consensus that every "clinician should be encouraged to enquire into every patient's preferences." The importance of the multi-disciplinary team communicating well and understanding the patient's wishes was highlighted: "As doctors we are involving patients in decisions much more than we used to. However, we have to remember that we can heavily influence patients in their choice by the way we word the options."

Shared -decision making at the end-of-life and importance of avoidance of overtreatment in order to improve people's "quality of death" was raised along with the need for anticipatory care plans as a tool to potentially help with this. A national conversation with people about death and dying was suggested.

"Sufficient time" was highlighted by many as the key barrier to shared decision making. Also expressed was concern that allowing more time for improved communication would be difficult due to workload pressures. Several respondents commented that a "lack of continuity of care" makes shared-decision making more difficult. Other barriers to shared-decision making include examples where decisions are made without the patient being present, for example, in a multi-disciplinary team meeting where a treatment plan is created without the patient present. Concerns also raised included clinicians making "value judgments" about individuals' ability to engage in discussions about their own care and that patient expectations may go against simpler care options.

Personalised approach to care

Some respondents noted the need for the use of multi-morbidity guidelines rather than a focus on single conditions: "I think it will be difficult to reverse the tide of increasing investigation and treatment of patients because all the guidelines relate to single disease management."

The importance of people being at the centre of their health and care was seen as important with one suggestion being to encourage and “enable communities to take collective responsibility for health initiatives.” A lot of respondents emphasised the need for political and public buy-in for Realistic Medicine to be successfully implemented.

Reducing harm and waste

“The document is helpful in challenging how our actions as clinicians, directly impacts upon patients and other health services, often adversely.”
“We particularly endorse the proposals to avoid overtreatment and excessive prescribing, while increasing attempts to support individual and population lifestyle changes.”

Many observed that a change in culture is needed. “A culture needs to be available that permits doctors to not over treat – for example, treating an elderly patient in community and not hospital.” It is important to recognise that “our own actions put demands on NHS” and that “not following treatment plan” is often “well intentioned.” A clear theme from many respondents was the need to reduce investigations and treatment at the end of life. Personal stories were shared including the frustration of admitting “the frail elderly with multiple co-morbidities” to hospital as no other options are available. There are “two main factors in this. First, clinical confidence to watch and wait and second is public expectation.”

Some respondents suggested ideas that could reduce harm and waste: “There should be nationally agreed protocols for commonest illnesses.” This would also make it easier for “nurses to treat.” We need to “use the learning from morbidity and mortality meetings to improve services.”

Value based healthcare was suggested as an approach to reduce harm and waste. The Right Care programme led by Sir Muir Gray looks at “allocative, technical and personalised value determined by assets, resources and decisions.”

Variation

There was agreement of the need to reduce unwarranted variation: “Data critical to improve variation in practice” and that there needs to be a commitment to focus data gathering on clinically driven end points. "The data should be shared globally." The “challenge lies in conditions for which a gold standard is not available.”

Innovation and improvement

It was suggested to improve care we need to "encourage clinicians to question everything they do", share learning and learn from the good as well as areas that

have not worked well. One suggestion was that there should be secondments to different boards to facilitate learning from one another. Data is seen as vital to innovation and improvement.

Barriers to improvement and innovation were highlighted including that some “struggle due to lack of resource.” It was also noted that there is an onus on clinicians to innovate but in order to do this they need “support from their organisation in order to effect change.”

One respondent proposed the development of an “online resource to spread Realistic Medicine learning.”

IT and Data

For each of the subject areas within Realistic Medicine the importance of good IT and available data was reported to be critical to success. There is a need for better integration of health information, including the need to roll out of the electronic patient record: “Fully integrated IT systems with patient records visible across the spectrum would be beneficial.”

It was also proposed that data needs to be collected for outcomes and shared widely, in order to compare practice and learn from this. In order to discuss risk with patients it was stated that, “There needs to be clear data available about number needed to treat and number needed to harm”. It was suggested that this could link with electronic prescribing.

Respondents suggested that there also needs to be easier access to online resources for doctors.

Patient and public involvement

There was clear emphasis on the importance of patient and public involvement in Realistic Medicine.

“Realistic Medicine requires to be the combined responsibility of the healthcare team and all the clinical professionals within it, working in partnership with the patient and their carers/families to reap the added value this concept can provide.”
One reflection on the balance was: “The public are in a difficult position, they are given health advice on warning signs but then stand accused of seeking medical assistance for conditions that are self-limiting.”

“In order to achieve meaningful success in outcomes that success needs to be jointly defined by health professions and the public answering the question 'What does good look like?'"

Education

In order to bring in a 'Realistic Medicine' way of working, many highlighted the need for training and education. "Staff, clinician and public education will be key." "We strongly believe that staff development and training is essential to progress." There were many comments about the need for a focus in both undergraduate and postgraduate training that would enable implementation of the principles of Realistic Medicine. These included "advanced communication skills," "data acquisition," "how to handle uncertainty," and how to "improve bedside skills."

Enabling doctors to cope with uncertainty was the skill that was highlighted most. "Challenging… that our role is to heal, sustain life and fix the problem." Developing a tolerance of uncertainty, "holding and feeling more comfortable with risk, and having the difficult discussions about futility and reality will require a change in the undergraduate and postgraduate training of doctors."

This support and education also extends to between peers. We need to try and "keep a good balance between experienced consultants and younger consultants, as the former can help with 'realistic' approach to patients and support their more junior colleagues, but the younger consultants may bring knowledge of newer ways of doing things and perhaps more of an appetite for change."

Time for reflection

It was proposed that there is a need for reflection: "one challenge is somehow allowing staff time to reflect on what and how they do things."

"Doctors want and expect to be innovators and leaders in improving outcomes for patients. To do this well, they need time in their busy working lives to learn, teach and reflect. It is good to see the CMO's strong support for this crucial part of doctors' work, and her recognition of the benefits in productivity, as well as avoidance of burnout, that can flow from it."

Staff wellbeing

Respondents suggested that the "key to this is ensuring that doctors at all levels in the profession are valued and recognised for the work that they do in delivering excellent patient care." The risk of workload pressures impacting on doctors who would otherwise be enthusiastic about embracing new ways of working was also expressed.

Permission

People expressed “fear of litigation,” and “complaints” if the level of investigation or treatment reduced. “If the prevailing view is to treat or investigate then it takes a brave physician to take a more holistic view and recommend the opposite to our patients.”

Offers of involvement and support

The emails also expressed many offers of support for the Chief Medical Officer and the Realistic Medicine message, and a willingness to be involved in Realistic Medicine projects going forward.   These were welcomed.

Other comments and suggestions included:

“Realistic Medicine is assisted greatly by ‘realistic policy’”.
There is a need to "reduce [the] gap between primary and secondary care" to successfully implement Realistic Medicine.

"Caring for those with greatest need first" should be one of Realistic Medicine principles, it is included in Prudent Healthcare.

There should be "more focus on prevention."

In order "to get value for money [we]should have a much narrower publically funded formulary and annual review of medications should be compulsory."

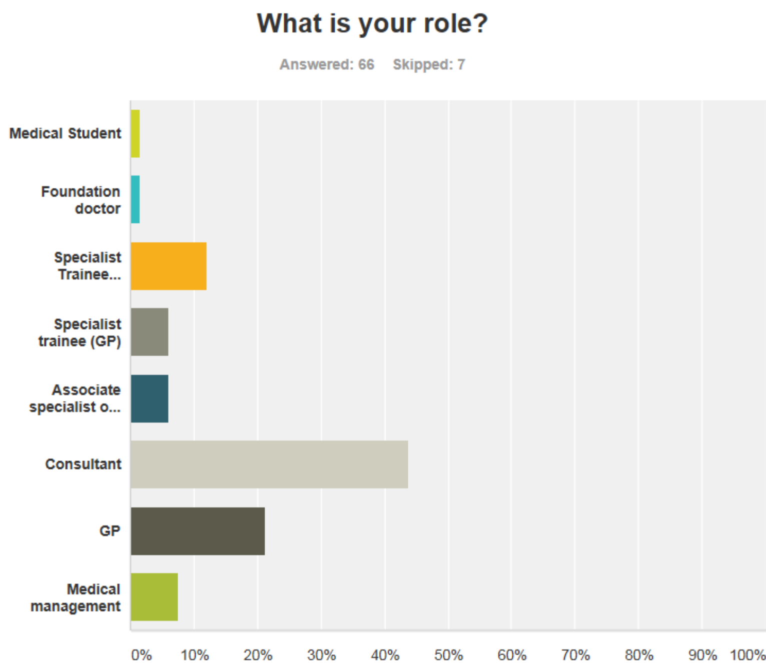
"National planning is preferable" rather than Regional planning
One person gave a summary of what needs to be in place for Realistic Medicine to work: “In summary well trained doctors, who know the data in their field, able to handle uncertainty are essential to provide patients with realistic and personalised healthcare, within a health service using the skills of a multidisciplinary workforce, all of whom can contribute ideas around improving the way we provide care, or even better prevent illness in the first place.”

Summary of conclusions of written and email feedback

- Realistic medicine has been well received.
- Across Scotland there is an acceptance that there is a need to evolve from current practice and embrace Realistic medicine.
- Key barriers to its implementation include time, data access and availability, concerns about litigation and complaints.
- There needs to be a focus on education and skills training.
- 'Shared decision making' and 'reducing harm and waste' were the main priorities that gained most support. Reducing ‘over-treatment’ especially at the end of life was emphasised.
- Integrated IT systems and clinically driven data are needed.
- Shared learning is important.
- Policy and 'top down' support is needed to enable Realistic Medicine.
- Public consultation and engagement will be required.

Evaluation of survey feedback

73 survey responses were received as of the end of June 2016. Feedback was from a broad range of roles and from across the Health Boards.



The survey asked 4 questions that required a written answer:

1. Which of the main themes do you view as the top priority?
2. What would enable you to make changes and improvements to your practice and the service you deliver?
3. In your own practice what could you do to bring about improvements?
4. What actions by others in wider health and social care system, locally or nationally, will help to bring about improvements?

The thematic analysis of these qualitative answers is reported here.
Note: quotes received in the survey are provided throughout this section.

1. Which of the main themes do you view as the top priority?

People were asked to choose their top priority. **1 top priority – 6 lowest**

	1	2	3	4	5	6	Total	Score
To build a personalised approach to care	25.71% 18	8.57% 6	20.00% 14	11.43% 8	22.86% 16	11.43% 8	70	3.69
To change our style to shared decision-making	2.86% 2	21.43% 15	14.29% 10	24.29% 17	20.00% 14	17.14% 12	70	3.11
To reduce inappropriate variation in practice and outcomes	23.94% 17	12.68% 9	11.27% 8	16.90% 12	8.45% 6	26.76% 19	71	3.46
To reduce harm	22.86% 16	32.86% 23	18.57% 13	15.71% 11	7.14% 5	2.86% 2	70	4.40
To manage risk better	11.27% 8	19.72% 14	23.94% 17	18.31% 13	15.49% 11	11.27% 8	71	3.59
To become improvers and innovators	15.28% 11	5.56% 4	12.50% 9	12.50% 9	25.00% 18	29.17% 21	72	[illegible]

For those that gave their top priorities the reasons were as follows:

Personal approach to care:

Caring for patients is the purpose of and basis for the practice of medicine. Patient centredness improves engagement, decision making and quality of care.

"A personalised approach is key to a holistic approach to medicine; it is accepted now, certainly by medical educators and students, that the day of patriarchal medicine is over and it is time to move from treating the problem and move to treating the patient as a whole."

Change our style to shared decision making:

"Because we need to find a way of ensuring that patients get the treatments that benefit them and that their priorities which may be different from ours are recognised."

Reduction of inappropriate variation in practice and outcomes:

The main issues shared were the need to increase effectiveness and equity. As well as seeing a reduction in variation an achievable target.

"Concern about the obvious variation that is evident across even a small country like Scotland. While we must allow for patient choice, we must also try harder to standardise care to enhance the value delivered to patients. There are obviously many causes of variation - some "good" some "bad" - and some of the bad reasons for variation include clinician choice and an over-

production that may be driven by hubris, or pharmaceutical company influence (not always direct)."

To reduce harm:

Respondents see 'do no harm' as a fundamental part of medical practice. Many reflected on the harm they had seen and the need to reduce this.

"I believe that reducing and preventing harm should be the top priority for all clinical staff. This applies not only to ensuring our interventions are safe but also that we do not intervene unnecessarily. An unnecessary intervention and the potential for resultant overdiagnosis can be more harmful than many of the patient safety indicators to which we work at present."

To manage risk better:

Risk is a core part of work and failure to manage risk properly can contribute to a range of problems.

"Educating society regarding the uncertainty of medicine and the facts of risk are essential to deliver a realistic healthcare system."

Improvers and innovators:

Improving quality of care and practice is essential but not always encouraged. Improvers and innovators require the focus as the other challenges have already the necessary level of priority or should be done anyway.

"We all have areas of practice which need improving so should learn from the best, to help reduce health inequalities."

Respondents commented that the options are interrelated and interdependent. "Through a personalised approach, shared decision making and support for improvers and innovators we will collectively reduce variation, manage risk better and as a result reduce harm."

2. What would enable you to make changes and improvements to your practice and the service you deliver?

The answers covered three broad themes: structure and management; resources and information sharing and communication.

Structure and Management

This is a need for a flexible approach with facilitation of multidisciplinary working. There needs to be "better management support" and "better working with managers."

There needs to be support for change and improvement. "Different hospitals, units and consultants communicating with each other about their different practices, and being more responsive to feedback from junior colleagues." Services need to be better coordinated.

There should be reassessment of targets and indicators. "A high level political decision to move away from a waiting time/target driven service, to one that is "user" centred in every way."

Resources

There needs to adequate levels of staffing in all disciplines including administration staff. There needs to be a reduction in the amount of paperwork and "bureaucracy." "Time" is key for all aspects. Time for "planning and reflection" and "to focus on improvement" were particularly highlighted.
In addition there needs to be "realistic expectations from society and an honest discussion regarding what we can achieve with the resources available."

Information sharing and communication

There needs to be better access and use of data. "I need better access to IT and better data collection to look more easily at what I do now and how I could improve it. There is lots of really useful information gathered - but it's very tricky to access it as a practicing clinician."

Learning and data should be shared "across Health Boards or across Hospitals." There needs to be "improved inter-specialty communication."

3. In your own practice what could you do to bring about improvements?

The answers included six main themes: patient focus, ongoing learning, collaboration, system improvements, staffing and working practices and barriers.

Patient focus

Many expressed the importance to regain the patient focus in their own practice. "Finding time to make that difference to the individual patient, by taking an extra 5

minutes in a busy morning to ask whether someone's pain is well controlled, or discuss if they still want to take a statin at the age of 92."

Others suggested that there could be broader support for patient networks and groups. "Continue and develop strong partnership with patients and an understanding of what are the individual values."

“Engage patients in their own management - we only see them for an hour a year at most have time to give them structure and solutions to help them in their daily life. Look at systems and processes to keep them safe and away from harm.”

Ongoing Continuous Professional Development, learning and reflection

The importance of taking time to reflect in order to improve was noted. "I seek outcomes of my performance to reflect and act on."
"I, like most doctors constantly self-improve through education. I also take part in audit and quality improvement. Much of which is in my free time. Admin time and improved rotas will improve this."

Collaboration

It was felt to be important to collaborate, share ideas and engage staff in order to bring about change. There should be "better cross team reporting and communication."This collaboration needs to use evidence and have an awareness of risks and outcomes.

Some respondents gave examples that this kind of collaborative work is already ongoing. "We meet on a Tuesday afternoon to work on quality improvement."

System improvements

There were examples of system changes that would enable individuals to make improvements. We need to "streamline processes." Examples included reporting, audit and improved handovers.

We need to "seek out data and challenge local clinicians to justify significant variation." We need “authentic conversations about the stuff that really matters. Increased focus on what does not add value.”

Staffing and working practice

The desire to improve team continuity and stability was noted. “Better multidisciplinary working. We need to understand the roles and straits for other health care professionals before we can ask them to consider change.” We must ensure a “good skills mix” and have “devolved leadership at the heart of it”
“Better use of IT to improve information management to inform decisions on appropriate investigation.”

“Continue to promote a culture of responsibility for our own actions - their effect on patients, ourselves, our colleagues and the service in general.” “Gain confidence in discussing with patients what interventions and treatments are realistic, proportionate and least likely to cause harm.”

Barriers

A few expressed feelings that they had done all they could and that “the clinical environment” did not allow them to do any more. Some expressed the need to reduce bureaucracy and increase resources.

4. What actions by others in wider health and social care system, locally or nationally, will help to bring about improvements?

The answers included six broad themes: recognition and support for staff, remove system barriers, practice changes, broader policy changes, patient involvement, and health and social care integration.

Recognition and support for staff

There needs to be recognition and support for staff. “Compassion as a compulsory asset. In our healthcare system we must cultivate an attitude of unconditional compassion towards all our patients and towards each other.” Better understanding from all staff of frontline roles. “Empowering clinicians” to make changes is vital.

Remove system barriers

There needs to be “clear messages from leaders followed by action to remove system barriers.”

Suggestions for the removal of systems barriers included “Break[ing] down barriers between boards to allow better networks.”; allowing easy “sharing of data across boundaries.”; “Developing communication tools (ideally patient held) that ensure that important conversations are clearly documented and shared among different teams including health and social carers in primary and secondary care.”; and “Investment and education in e-health across Scotland.”

Practice changes

Change was supported around the way we practice in order to “shift from interventions to supporting lifestyle change.” “Agreement around avoiding interventions in the morbid population, emphasis on individual valuing their own health and adapting lifestyle appropriately.” There was an emphasis on continuity of care.

There were calls to “promote primary care and smooth interface with other sectors.” We need to widely share what went well.

Broader policy changes

“Politicians stressing patient responsibilities as well as rights and honesty in our achievable aims within our current constraints.”

Specific policy suggestions include “minimum unit alcohol pricing” and “tackling income inequalities.”

Central support was emphasised. “If supported centrally, I think that [the Health Board] could take a lead role in "healthcare by design" creating a model of engagement between public, private, third sector and most importantly our patients and carers.”

Patient involvement

“Public Involvement is key to success.” Good patient engagement and involvement is needed. One suggestion was a “national conversation on how to approach frailty and dementia.”

Health and social care integration

“Changes in social and community care to speed and facilitate discharge from secondary care.”

“Nationally I would like to see careers paid more so that the jobs are attractive and those who do that really important work feel valued for what they do.”

Summary of conclusions from survey

- Agreement with the principles of Realistic Medicine and that if fully implemented it could enable improvement in care.
- Overall appetite to improve the quality of care.
- Key barriers: time, workload, relationship with colleagues, access to data.
- People currently feel they don't have sufficient time to stop, reflect and plan.
- There is a desire to move away from "target driven" medicine.
- All the key aims of Realistic Medicine are interrelated and interdependent.
- Great enthusiasm for collaboration and shared learning across departments, hospital and Health Boards and across usual boundaries.
- Multidisciplinary working, including working well with managers, emphasised.
- Patient involvement seen as fundamental.

Evaluation of social media feedback

The “Twittersphere” was generally supportive with the recognised healthcare hash tag #realisticmedicine reaching 6.7 million twitter feeds and over 3491 tweets from 1235 participants from January to October 2016. Twitter analytics showed 11 countries were reached including UK, Australia and New Zealand, Canada, Finland, Italy Japan, Norway (including Svalbard in Artic Circle) and Sweden, South Africa and the USA.

The Chief Medical Officer’s Annual Report and infographic were also welcomed with one person hailing it as “the best CMO report ever” and indeed the first one to have been read by some clinicians. “This was “the only government publication that I have ever felt an emotional connection with” was one such example of how the clinical community embraced the concept of Realistic Medicine. Sir Muir Gray, pioneer in medical screening and Ben Goldacre, academic, physician and the Guardian’s Bad Science columnist were some of the more high-profile Twitter followers to praise the Report. Ben Goldacre thought the report was “incredibly smart” and Sir Muir Gray thought it “one of the best documents I have read in 44 years”.

There was one Tweet that was more sceptical, which questioned how realistic medicine could be implemented without also having realistic politicians, media and patients.

Other issues raised in Twitter were:

- **How Realistic Medicine had spread across Scotland and the globe**: “America starts to catch up #realisticmedicine”; “TED residency idea worth sharing”; “#ChoosingWiselyCanada on how we, as patients, can help deliver #Realisticmedicine”; “Refining this poster [the Realistic Medicine infographic] for imminent launch in @NHSBorders”. We’re up for this”;

- **Agreement with the concept and the engagement programme led by CMO and her team**: “Inspired hearing @CathCalderwood1 talk about #realisticmedicine. How do [sic] doctors add value and help navigate health in complex system?”; “Ace day yesterday talking about #minimallydisruptivemedicine and Scotland’s planned realistic medicine healthcare”; “More medicines, but less healthiness “long on quantity, short on quality” “Read this -then read it again...then use it to plan the future”; Chance of harm reduced by stopping unwanted (by patient) admissions and treatments #realisticmedicine”;

- **The importance of communications and a person-centred approach**: “Communication skills should be taught and developed. Shared decision making involves listening not just info giving”’; “The probability of death stubbornly stuck at 100%. We need to have balanced conversations about when to treat”; “High intervention doesn’t necessarily mean high satisfaction!”; Doing what patient wants challenging everywhere. #realisticmedicine in Scotland aiming to change that”.; “Key role for relationship continuity and trust if de-prescribing is to be achieved.”

“Increasing monetary spend does not improve patient or family experience in end of life care, it may make it worse #realisticmedicine #tEAMed”

- **The importance of training for the care and support workforce**:
“#realisticmedicine does anyone know if we teach risk assessment principally in medical and nursing schools? And in general education?” “We need to train junior doctors that sometimes non action is preferable to action”.

- **The importance of shared learning and data to bring improvement:**
“Understanding of data is key to implementing meaningful change for our patients”; “we should have 'Never Do's' alongside 'Never Events' to eliminate unwarranted variation #realisticmedicine”; “Reducing variation requires Healthcare professionals to swim against the tide. Need strong swimmers”; ”we must be connected 2 Discovery 2 reduce variation & increase outcome based care #realisticmedicine each dot is a patient”; “@profchrisham tells #nhsscot16 about the risks and costs of unwarranted variation and over prescribing #realisticmedicine”; “I’m going to start wearing a badge: ‘Want to understand your variation in care? Ask me how!’ “Great idea to reduce OPD appointments – we should make this happen”

- **Spreading Realistic Medicine beyond doctors to multi-disciplinary teams:**
“Fed up seeing nurses taken away from time to care by wads of paperwork. Maybe we need #realisticnursing?”; “extra time for nursing means less medications and more shared decisions”

Realistic medicine engagement activities undertaken

A number of engagement events on Realistic Medicine were attended by CMO, DCMO and her team as listed below, the feedback from which has helped support writing this report:

Date	Event	Venue	Audience
Jan 20	Launch	Western General Hospital, Edinburgh	NHS Lothian doctors
Jan 27	Healthcare Improvement Scotland Board Seminar	Gyle Square, Edinburgh	Healthcare Improvement Scotland Board
Feb 9	Tayside CARS Drug Discovery Unit	Dundee University	Clinicians, academics and researchers Scottish Universities
Feb 26	Tayside – Ninewells visit	Ninewells Hospital, Dundee	Clinicians
Feb 27	Royal College of General Practitioners: Over diagnosing from health to Sickness	Stirling	General practitioners
Mar 14	GMC Advisory Committee	The Tun,Edinburgh	UK Advisory Forum Scotland
Mar 15	Health and Sport Committee, Scottish Parliament	Scottish Parliament	Members of the Scottish Parliament
Mar 17	Visit to Glasgow Royal Infirmary	Glasgow Royal Infirmary	Clinicians and members of multidisciplinary teams
Mar 18	Health Literacy in the Deep End	Beardmore Conference Centre, Glasgow	Clinicians, local authority and third sector
Mar 24	Hairmyres	Haimyres Hospital, Lanarkshire	Chief Executive and clinical and multi-disciplinary teams
April 5	GMC Medical Professionals Matters event		
April 13	State Hospital	The State Hospital, Carstairs	Clinical and multidisciplinary teams
April 18	Speciality Advisers to the Chief Medical Officer	Royal College of Surgeons Edinburgh	Medical directors, directors of public health, directors of medical education and other advisors on health specialities

April 19	Borders Clinical Club	Buccleuch	Clinicians
April 22	Institute of Healthcare Management AGM	Edinburgh Training and Conference Centre	Healthcare managers
April 25	Visit to Edinburgh Medical School	University of Edinburgh	University of Edinburgh medical students and teaching staff
April 27	Visit to NHS Grampian	Aberdeen	Clinicians and multi-disciplinary teams
April 27	Aberdeen Post-Graduate Seminar	Univesity of Aberdeen	Dean of Medicine, medical students and teaching staff
May 3	Glasgow University Medical School	Glasgow University	Medical students and teaching staff
May 5	Medical Education Conference	EICC	NHS NES, clinicians, educators and management
May 10	Ninewells Hospital	Dundee	Dean of Medicine, Medical School students and teaching staff
May 19	Scottish Association of Medical Directors AGM	Dunkeld	Medical Directors
May 24	NHS Highland	Inverness	Clinicians and multi-disciplinary teams
May 25	Combined meeting with Glasgow Obstetric and Gynaecological Society	Edinburgh	Obstetricians and Gynaecologists
June 9	St Andrews University		Meeting with Dean and teaching staff
June14/ 15	NHS EVENT	Glasgow Exhibition Centre	1500 healthcare leaders, key decision-makers and frontline staff from across NHS Scotland and the wider health and social care sector
June 16	Video conference between Chief Medical Officer and NHS Ayrshire, Forth Valley, Grampian, Highlands, Orkney, Shetland and Western Isles	Edinburgh	Clinicians and multi-disciplinary teams

June 21	Dumfries and Galloway	Dumfries	Medical Director, clinicians and multidisciplinary teams
June 21	John Lawson lecture (Royal College of General Practicioners)	Dundee	General Practitioners

Realistic Medicine Activity Currently Underway

This is a snapshot of activity that is currently underway on Realistic Medicine across the country which was obtained from sharing the draft feedback report with key stakeholders. It is clear there is a huge amount of activity underway – this is not intended to be a summary of all Realistic Medicine activity in Scotland but merely a snapshot. Should you wish to find out more about any particular contribution please contact the CMO (email:cmo@gov.scot; telephone 0131 244 2379) and we would be happy to share contacts for you to collaborate and learn further from those championing Realistic Medicine in their areas.

Who?	What are they doing already?	What offered to do?
Public Health Service Improvement Interest Group	• House of Care Collaboration in Lothian • Fife Shine Project (improving conversations between care providers and people) • Redesign of brain injury rehabilitation in NHS Lanarkshire • NHS Highland Healthy Weight Pathway • New QFIT test for Bowel Screening	
NHS Highland	• Awareness raising • Directed work – Area Clinical Forum taken responsibility for themes of RM • Clinical meetings looking at variation	• Promotion of the themes of RM • Senior clinician on Board to lead communications • Board objectives aligned with the themes • International learning applied – Choosing Wisely Canada
Directors of Public Health (DPH), Ayrshire and Arran	• House of care collaboration in Lothian • Fife Shine Project (changing conversation between staff and patients) • Redesign of brain injury rehabilitation service in NHS Lanarkshire • NHS Healthy Weight Pathway • New QFIT test for Bowel Screening	
CEO NHS Lanarkshire	• Acute: Virtual Intelligence Group (VIG) linked to RM to	• Hospital Anticipatory Care Planning led by

Who?	What are they doing already?	What offered to do?
	find evidence with improvement leadership • HSCPs: Recenty published "Achieving Excellence" referencing RM, Project with GPs around risk and public health and planning care for oncology patients • Primary/ secondary: considered RM at 3 hopsital /GP interace groups with Prescribing and Efficiency programme established	Robin Taylor (for roll out across Scotland)
CEO NHS Lothian	• Considering application of RM in primary and secondary environments including management of risk and shared decision making in oncology	For Scotland and wider community: • Insights into concerns among clinical community that might impede spread of RM • Proactive measures to support spread of RM
CEO NHS Tayside	• RM one of seven transformation workstreams in Five Year Transformation • Engaging clinical colleagues locally through development work • Working with NHS Lothian – aimed at building coalition of willing and RM champions around their RM/ Choosing Wisely Programme • Discovering tool utilised for benchmarking • Transformation programme focused on medicine management, optimising demand for disagnostic interventions, managing demand for clinical interventions, optimising patient stays and recalls and care pathways	• RM Clinical Reference Group/ Champions • Development programme to embed RM • Work with HENS on evidence • Considering wider campaign with clinicians and patients • RM approach in palliative care
GMC	• Professionalism through Promoting Professionalism for Medical Students and Doctors Programme and considering how with SAMD support can	• Consent – embarking on a review of our consent guidance with RM team

Who?	What are they doing already?	What offered to do?
	include RM • Communication – Developed with Academy of Medical Royal Colleges a framework for generic professional capabilities	
Healthcare Improvement Scotland	• Supporting person centred care, empowering and enabling citizens to have meaningful say • Providing strong and comprehensive assessments of quality of health and social care in Scotland • Supporting redesign of health and social care service • Improving analysis and assessment of inappropriate variation • Providing independent external assessment of the sustainability of service provision • Play part in raising quality of health and social care • Supporting leadership in NHS	• Actively developing Effective Care Programme (ECaP)
Scottish Ambulance Service	Following RM approach with: • Care of Frail Elderly Patients • Care of patients following stroke • Out of Hospital Cardiac Arrest • Care of patients with mental health crisis • Paramedics in support of primary care services	• Towards 2020 – Taking Care to the Patient maps onto Realistic Medicine and will consider detail in development of evidence based pathways, working with HSCPs to develop alternatives to transport to hospital and decision support in field, workforce development and data to drive innovation.
NHS GGC	RM being addressed in: • Advanced nurse practitioners • Chronic disease management • Primary Care • Holistic needs and care planning – test of change • Improving the cancer journey	• Adopting Getting to Know me and What Matters to Me • Better monitoring of variation including CDM programme uptake this year

Who?	What are they doing already?	What offered to do?
	and application of tools to life changing conditions • Local health literacy action plan	• Workforce development • Better user of technology enabled care to involve patients in decision making • Multi-disciplinary approach to RM • Tests of change in maternity and diabetes to other areas
DPH NHS Lanarkshire	• Contributing to work programme on RM with a specialty registrar in PH supported by CPHM and working with Assoc MD and Director Acute Services at evidence for RM	• Skills and expertise in critical appraisal. Population perspectives as well as individual
DPH Western Isles	• Patient Centred Pathways Programme • Varicose Vein Treatment-reviewing referral guidelines • Biologics and biosimilars-evaluation of dose reductions in existing patients and biosimilars for new patients • Anticipatory Care Planning • Ophthalmology – releasing consultant to perform cataracts with specialist nursing role enhanced	
CEO NHS Borders	• Transformed existing Quality and Efficiency Programme – with RM subheading – leadership and clinical group meet every few months. The group looking at variation, patient participation • Poster in waiting rooms to ask the patient to think ahead for the questions they should ask doctors	• Creating and effective organisational vehicle for delivery of RM • Support with empowering patient • Ongoing commitment to RM and focused and accessible CMO Annual Report

NHS D and G MD	• Appointment of Associate Medical Director • Clincial Effectiveness Group • RM promoted through GP clusters – to address variation more effectively • Identifcation of Data Analyst • Project manager to support the work of Assoc Medical Director into RM and reporting to Healthcare Governance Group	• Sharing ideas with other Boards including demand optimisation Group
NHS Fife MD	• Six key themes resonate with RM – person centred (working with Patient Opinion/ Voice and Good Conversations and initiatives to improve communications with gypsy/travellers), leadership (mandatory training review), variation in practice (consultants agree to reduce number of minor surgical procedures that add no value and updating clinical strategy), informed consent (including updating consent forms, good examples in Learning Disability), managing risk (around older patients), supporting improvement (including through Hospital Huddles)	
NHS Forth Valley	• Polypharmacy reviews • Reduction in step 2 opiods by GP practices • Macmillan to employ consultant for improving end of life decision making • Data about acute admissions – leading to practice change • Variation in ward based practice through IHO work • Mental health in Falkirk –	• Developing enhance skills for staff to have conversations around ITU referrals and ceiling of care • Leadership from MDs to support GM in their work with doctors at all stages of career

	involved stopping activity not supported by evidence base • Clear pathways in day case and 23 days surgery to reduce variation • Innovative practice around GP practices • Diabetic foot care to reduce variation • ALFY and patient based plans • Prevention and self-management prioritised in new healthcare strategy • Supporting consultants to lead innovation projects in dermatology and diabetes	
NES	Safety and improvement : • Quality improvement work • Patient Safety • Patient Safety Training • Patient Safety Tools • Enhanced SEA • Structured handover, Adverse Event, Trigger Review Method, Patient Stories • Healthcare Associated Infections • Primary Care Safety and Improvement resources • Human Factors Training • Sharing Intelligence for Health and Care Leadership and Management • Scottish Clinical Leadership Fellow Programme • Advance Communication skills in both undergraduate and postgraduate training • Promoting need for reflection and staff wellbeing • Enabling doctors to cope with uncertainty • Communicating • Supporting self-	

	management • Practice based small learning groups	
NSS Medical Director		• Practical implementation and delivery
NHS D and G Director of Med Education	• Human factor courses • Trainees to take part on Qi projects to reduce variation • RM summary documents to all trainees at generic induction and emphasised importance of shared decision making • FY doctors have session on what matters to me and RM early in year • Consultation skills courses advertising- people may choose CPD to improve shared decision making	• Enthusiastic support
NHS Grampian DME	• Presented RM to ENT Scotland at 2016 summer meeting • Investigate evidence base of routine nasal surgery, review local neck ultrasound protocols to address rising numbers of incidental thyroid findings picked up	• Enthusiasm to promote this concept with ENT Surgery and strive for a critical analysis of procedures of limited benefit to patients (eg snoring surgery) • Continue to engage with Primary Care colleagues to ensure appropriate referrals
Dean of Medicine University of Dundee	• Introduction of RM into the curriculum around reducing harm, managing risk, building a personalised approach to care modules	
Principal and Head of School of Medicine, Univ of Glasgow	• Acknowledging RM importance and tie in with Professionalism teaching	

University of St Andrews	• Commitment to patient safety	• Introduction of communication skills in curriculum • Graduate Entry Medical degree to take students in 2018 with training in community for complex patients.
RCPSG	• Teaching and training around good communication • Mentoring doctors • Addressing unwarranted variation embedded in work with SIGN etc • Body of clinical expertise to support RM •	• Welcome SG policy to support RM • Recognise challenge professional workload represents • Innovation, leadership and improvement should be recognised by employers • Invite to speak at College
State hospital	• Supporting patients in work around shared decision making, reducing haram and waste, variation, innovation, education.	• Lessons from Forensic Network to apply to RM
RCGP	• Founding member of Link worker programme • Strategy and support for GP clusters to reduce variation • Supporting efforts to reduce waste including *Spend to Save* in RCGP Scotland's *A Blueprint for General Practice* • Combining expertise for collaborative work. • *Core Values* publication on patient/ doctor relationships • Quality work based on GP clusters to better manage clinical risk • *Leadership for Innovation* programme	
NHS Grampian	• Grampian's Clinical Strategy with links to Realistic Medicine is out for consultation	

Golden Jubilee	• Leading in enhanced recovery after surgery • Systematic review of treatment consent procedures	• Developing clinical outcomes frameworks • Examples of service redesign via Strategic Projects Group and Quality Bid Process • Exploring pilots with SAMD and DOFs on clinical treatment sets • Leadership framework implementation - universal Human Factors and QI awareness training

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