SAMsterDAM2
LIFE IN THE DAM
Connecting Protecting Liberating
Hotel Novotel, Amsterdam City
3-4 May 2018

Realistic Acute Medicine
@djbeckett
#RealisticMedicine
REALISTIC MEDICINE

CAN WE:

BUILD A PERSONALISED APPROACH TO CARE?

CHANGE OUR STYLE TO SHARED DECISION-MAKING?

REDUCE HARM AND WASTE?

MANAGE RISK BETTER?

REDUCE UNNECESSARY VARIATION IN PRACTICE AND OUTCOMES?

BECOME IMPROVERS AND INNOVATORS?

Scottish Government
Riaghaltas no h-Alba
gov.scot
Multimorbidity is common in Scotland

The majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions.

More people have 2 or more conditions than only have 1
Most people in Scotland with any long term condition have multiple conditions

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<th>Condition</th>
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Percentage of patients with each condition who have other conditions

- This condition only
- This condition + 1 other
- + 2 others
- + 3 or more others

20% 40% 60% 80% 100%
Each stop on the Argyll line travelling East represents a drop of 1.7 years in male life expectancy.

Males - 75.8y
Females - 83.1y

Males - 61.9y
Females - 74.6y

Life expectancy data refers to 2001-5 and was extracted from the GCPH community health and well-being profiles. Adapted from the SPT travel map by Gerry McCartney.
Public Finances - Fall in Government Expenditure

REALISING REALISTIC MEDICINE

1. HAVING OR SHOWING A SIBLÉ AND PRACTICAL IDEA OF WHAT CAN BE ACHIEVED OR EXPECTED.

2. REPRESENTING THINGS IN A WAY THAT IS ACCURATE AND TRUE TO LIFE.

By 2025, everyone who provides healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of Realistic Medicine.
Realism in Healthcare

• Doctors generally choose less treatment for themselves than for patients
• Striving to provide relief from disability, illness and death, modern medicine may have overreached itself – is it now causing hidden harm?
• Focus on unwarranted variation in clinical practice and outcomes
• Multiple conditions – management leading to over-complex medical regimes?
• Clinicians have duty to acknowledge powerlessness at times
J Gallo et al. Life-sustaining treatments: what do physicians want and do they express their wishes to others?
Value Based Healthcare

Point of optimality

Benefits - harm

Benefits

Investment of resources
Atlas of Variation for Scotland

- Initial Atlas Maps
  - Cataract rates
  - Hip replacement rates
  - Knee replacement rates
  - Endoscopies
  - Shoulder operations
  - Polypharmacy
OP ADVISOR  Health chiefs reveal plans to create TripAdvisor-style hospital ratings website for patients

It will provide surgery stats, infection rates and re-admission figures due to failed operations at NHS sites

By Chris Masson
Updated: 11th April 2018, 10:58

COMMENTS

HEALTH chiefs are creating a TripAdvisor-style hospital ratings website for patients.
Reducing harm and waste

• Harm in healthcare not just missed diagnoses or under-intervention but ‘hidden harm’ exists in over treatment, excessive interventions and medicalising normality.
  • This is far harder to measure.
• Focus on better value care – including ‘the gentle art of doing nothing’
  • This isn’t always in the nature of Acute Physicians...
Figure 1: From Early Palliative Care for Patients with Metastatic Non-Small Cell Lung Cancer. New England Journal of Medicine.

Over-investigation and over-diagnosis...
Snowball in a Blizzard
The tricky problem of uncertainty in medicine

‘Wonderfully user-friendly. Like a conversation with a doctor that you’d trust with your life.’
Roy Tolia - author and former Professor of Medicine at the University of Manchester
CHANGE OUR STYLE TO SHARED E 50 KING?

BUILD A PERSONAL SE APPROACH TO CARE?
How comfortable would you feel asking your doctor...?

While 92% would feel comfortable asking their doctor about their treatment/care options, only 67% said they have actually asked their doctor this.

Over 9 in 10 respondents (91%) feel comfortable asking about the possible benefits and risks of those options, with only 64% stating they have asked their doctor this.

Similarly, 87% feel comfortable asking about how likely the benefits and risks of each option would be to happen to them compared to 54% who have asked their doctor this.

Source: Our Voice/Scottish Health Council
Very poor skills. May not be able to determine the amount of medicine to take

Weak skills. Can only deal with well laid out material and tasks that are not complex

Skills at or above level required for coping with demands of everyday life

4 O skills to understand basic elements
Making it Easier
A Health Literacy Action Plan
for Scotland
2017-2025
REALISTIC MEDICINE
What was good  What could be improved
Doctors and risk

• Managing risk is an inherent part of our role
• There is risk associated with every clinical decision, whether it is to do something or to do nothing

• **The importance of positive risk taking** – avoidance raises anxiety rather than reduces it
• It is psychologically healthy to stimulate and empower ourselves by taking risks
JUDGMENT

Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland)

before

Lord Neuberger, President
Lady Hale, Deputy President
  Lord Kerr
  Lord Clarke
  Lord Wilson
  Lord Reed
  Lord Rodge

JUDGMENT GIVEN ON

11 March 2015

Heard on 22 and 23 July 2014
“Montgomery complements the Realistic Medicine focus of the CMO’s previous annual reports and the international “Choosing Wisely” campaign of the Academy of Medical Royal Colleges in a number of ways. It has renewed the focus on the process of consent, and requires that the emphasis of this is patient focused.”

Emma Cave/Margot Brazier
So...‘Realistic Acute Medicine’?

• How are we doing?...
Variation between AMUs

• We all know it exists
• It’s very hard to measure
• Poor coding
• Activity data variably recorded
  • Admission vs Attendance vs Ambulatory Care
  • In-patient vs Out-patient
In order to meet the demands for consultant cover in the emergency department, patient care on the acute medical surgical unit to cover extended day working, seven days a week. All patients on acute medical and surgical units to be seen and reviewed by a consultant during twice daily ward rounds, including all acutely ill patients directly transferred, or others who deteriorate.

- All hospitals admitting medical and surgical emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision-making:
  - Critical - imaging and reporting within 1 hour
  - Urgent - imaging and reporting within 12 hours
- All non-urgent - within 24 hours
- All hospitals admitting medical and surgical emergencies 24 hours a day, seven days a week:
  - Critical patients - 1 hour
  - Non-critical patients - 12 hours

Rotas to be constructed to maximise continuity of care for any patients in an acute medical and surgical environment. A single consultant is to retain responsibility for a single patient on the acute medical surgical unit. Subsequent transfer or discharge must be based on clinical need.

A unitary document to be in place, issued at the point of entry, which is used by all health professionals and all specialists throughout the emergency pathway.

Patients admitted for unscheduled care to be nursed and managed in an acute medical surgical unit, or critical care environment.

All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. A policy is to be in place to access social services 7 days per week. Patients to be discharged to their named GP.

All hospitals admitting emergency general surgery patients to have access to a fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night.

All patients admitted as emergencies are discussed with the responsible consultant if immediate surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or specialist surgeons. This decision is recorded in the notes and auditable.

All patients considered as ‘high risk’ to have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is

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SAMBA17 Report
Against the Clock - Time for Patients

A National Audit of Acute Medical Care in the UK

Main Edition
Variation within an AMU

Direct discharge rate from FVRH AMU, per consultant physician 2014-2016
Practising Realistic Acute Medicine is hard...
Recommendation 4: Patients with abnormal liver blood tests should be considered for investigation with a liver aetiology screen irrespective of level and duration of abnormality. Abnormal refers to an analyte which is outside the laboratory reference range (level 2h, grade B).

Recommendation 5: In adults a standard liver aetiology screen should include abdominal ultrasound scan (USS), hepatitis B surface antigen, hepatitis C antibody (with follow-on polymerase chain reaction (PCR) if positive), anti-mitochondrial antibody, anti-smooth muscle antibody, antinuclear antibody, serum immunoglobulins, simultaneous serum ferritin and transferrin saturation. (level 2b, grade C)
However, ocorors need supper in choos·ng, with heir pat·ents, not to apply evidence based gu·de ·nes: he strength of gu· e ·nes can make doctors fee unable to dev·ate from them, dr·ven by ee ·ngs of peer pressure, assu ed patient demand, concern about 
·t·gat·on and an understan ·be, emat·onal need to "do someth·ng" in the face of long term con·tions.
Cancer Treatment Helpline

Remember to call the Cancer Treatment Helpline on 0800 9177711

if you are worried about any symptoms whilst having your chemotherapy or radiotherapy

There is someone who will be available to assess your symptoms and either offer advice or arrange for you to see or speak with a cancer nurse or doctor

NHS Highland
Where do we start?

• Hunt out the dogma and the pseudoaxioms
• Look for ‘Must’, ‘All’ and ‘Should’...
All admissions to an Acute Medical Unit need a baseline ECG

All patients with atrial fibrillation and a fast VR need to be admitted to hospital...AND on a cardiac monitor...

All admissions to an Acute Medical Unit need a set of baseline bloods

All patients with pneumonic consolidation must have follow up CXR

All patients with ‘CT-negative’ thunderclap headache need a lumbar puncture...

All patients admitted to an AMU with an overdose must be reviewed by psychiatry before discharge
All patients with atrial fibrillation and a fast VR need to be admitted to hospital...AND on a cardiac monitor...

All admissions to an Acute Medical Unit need a baseline ECG

All admissions to an Acute Medical Unit need a set of baseline bloods

All patients with pneumonic consolidation must be reviewed by radiology before discharge

Challenge the ‘can’t exclude’ referral culture,

All patients with ‘CT-negative’ thunderclap headache need a lumbar puncture...

All patients admitted to an AMU with an overdose must be reviewed by psychiatry before discharge
ECaP Chest Pain
The Effective Care Programme

Key features of programme
- Examine pathways of care
- Pilot looking at high volume or high cost pathways
- Address unwarranted variation
- Reduce waste by examining processes
- Reduce harm by reducing unnecessary interventions
- Engage clinicians involved in frontline care
- Address some of the aspirations in Realistic Medicine

Ischaemic Chest Pain Group
- Emergency Medicine
- Acute Medicine
- Biochemistry
- Primary Care
- Cardiology
- Business Unit
- Improvement Advisor

Start date 1/3/17

Actions so far
- Process mapping sessions
- Identified areas of variation in acute pathway
- Discussed in relevant specialty groups
- New guidance for AMU decision making
- Tests of no clinical value removed from ACS blood panel
- Study of potential benefit of switching to hs-Troponin

Headline results from latest data
- Median weekly inpatient admissions reduced from 54 to 40.5
- Avg LoS 7.68 days now 7.2 days for inpatient cases
- Gradual upward trend in numbers with 0 day Length of Stay
- Fewer ETT requests since new AMU guidance
- Overall use of ambulatory care up

Number of discharges per week with an Ischaemic Chest Pain diagnosis - NW

New Medical Model
New guidance AMU
Start of ECaP

Reaping Realistic Medicine - Create the Conditions
Communicate, Connect, Collaborate, Culture
Thunderclap Headache Protocol

**C O B E** — of sudden, painless, crescendo RSB

The following should be considered red flags: **undertaking a lumbar puncture** in RSB — to exclude subarachnoid haemorrhage in patients with a thunderclap headache.

Recent large trials have suggested that modern CT scans undertaken within 4 hours of headache onset might be helpful in excluding subarachnoid haemorrhage. Sensitivity is 95% in patients with aphasia, photophobia and CT brain scan findings (haemorrhage) at the time of the headache.

**P R I T I** or described as a specificity, specificity, positives predict value (PPV) and negative predict value (NPV) of 100% for CT brain undertaken within 6 hours of headache onset, and read by experienced neuroradiologists, for detection of subarachnoid haemorrhage. Sensitivity is 80% in patients with aphasia, photophobia and CT brain scan findings (haemorrhage) at the time of the headache.

**P 2** or described as sensitivity, specificity, PPV and NPV (20%) for CT brain undertaken within 6 hours of headache onset, and read by experienced neuroradiologists, for detection of subarachnoid haemorrhage. Results are described as a normal cerebrospinal fluid (CSF) in 75% of patients with a thunderclap headache.

**T I** or described as a sensitivity, specificity, PPV and NPV (20%) for CT brain undertaken within 6 hours of headache onset, and read by experienced neuroradiologists, for detection of subarachnoid haemorrhage. Results are described as a normal cerebrospinal fluid (CSF) in 75% of patients with a thunderclap headache.

**U N C O N T R O L L E D** — of sudden, painless crescendo RSB

**H A M A** — of sudden, painless crescendo RSB

### Thunderclap Patient Information

**You** are admitted to hospital with a thunderclap headache (a headache that lasts minutes — in almost all cases due to subarachnoid haemorrhage). There are no number of factors that can cause a thunderclap headache. Probably the most likely to cause a thunderclap headache is subarachnoid haemorrhage (40%), or blood in the brain. This is a rare cause of headache affecting 5-8 people per 100,000 of the population each year.

**If** you have any of these serious causes, you are admitted to a hospital care. A person with a thunderclap headache is highly unlikely to suffer from any causes of subarachnoid haemorrhage that might have been missed on the CT scan.

**However** recent studies have suggested that a normal CT undertaken within 6 hours of headache onset, will exclude any vascular subarachnoid haemorrhage in 99% of cases. Data from the PiP showed that 99.5% of subarachnoid haemorrhage, followed up by a CT scan (but without a scan at headache onset).

**Some** people have a history that a lumbar puncture may not be needed. To help you decide whether you would like a lumbar puncture, this information is helpful to understand the risks of the procedure.

The best information suggests that a normal CT scan undertaken within 6 hours of headache onset is about 15,000 lumbar punctures/10,000 people in hospital or outpatient setting or any causes of subarachnoid haemorrhage.

The risks of performing an uncontrolled lumbar puncture are more difficult to quantify but include a further bleed in 3% of patients within the first week, and up to 5% of patients within a year. The risk of further bilateral (8% in 60%) and bilateral (50%). If you decide you would like a lumbar puncture, the complications are: a severe headache, subarachnoid haemorrhage, and bleeding, brain swelling, and infection including meningitis are all very rare complications.

Please consult information to think about whether you would like a lumbar puncture in further headache/your thunderclap headache, or further you are assumed that a normal CT brain is reassurance enough. Your doctor deciding will be happy to answer any questions.
Restrictive versus liberal transfusion strategy for red blood cell transfusion: systematic review of randomised trials with meta-analysis and trial sequential analysis

Lars B Holst, 1 Marie W Petersen, 1 Nicolai Haase, 1 Anders Perner, 1 Jørn Wetterslev 1

SINGLE Unit Blood Transfusions reduce the risk of an adverse reaction

Don't give two without review

THINK!
- Is your patient symptomatic?
- Is the transfusion appropriate?
- What is the haemoglobin trigger level?
- What is the patient's target haemoglobin level?

Each unit transfused is an independent clinical decision

DO!
- Only one unit should be ordered for non-bleeding patients.
- Document the reason for Transfusion.

Guidelines for the management of iron deficiency anaemia

Andrew F Goddard, 1 Martin W James, 2 Alistair S McIntyre, 3 Brian B Scott, 4 on behalf of the British Society of Gastroenterology

When these stories were told
About: Interactive tag bubbles about all stories on this site about NHS Borders submitted between 01/10/2016 and 31/10/2017.
Are we really focusing on the right things?

- Embracing risk?
- Are we delivering value based Acute Medical Care?
- 2.9 million admissions per year
Work in the pipeline

• Realistic Medicine Clinical leads
• Value-Based Healthcare training program (including SAM)
• Single national formulary
• Citizen’s Jury
• Realistic Medicine Website
• Embedding RM into lifelong education
Asking the Right Questions Matters

To help ensure you have all the information you need to make the right decisions about your care, please ask your doctor or nurse:

• Is this test, treatment or procedure really needed?
• What are the potential benefits and risks?
• What are the possible side effects?
• Are there simpler, safer or alternative treatment options?
• What would happen if I did nothing?

Find us at www.nhsforthvalley.com
Improvement

GETTING IT RIGHT FIRST

The four principles of prudent healthcare

Public and professionals are EQUAL PARTNERS through CO-PRODUCTION

CARE FOR those with the greatest health need FIRST

Do only WHAT IS NEEDED and do NO HARM

Reduce INAPPROPRIATE VARIATION through EVIDENCE-BASED approaches

For further information visit www.prudenthealthcare.wales

Choosing Wisely®

The Atlas of Variation

An initiative of the ABIM Foundation
With thanks to

- @drgregorsmith, Deputy CMO
- @CathCalderwood1, CMO
- @damson29, National Clinical Lead for Realistic Medicine
- @ChristineGregs5, ST7 in GIM and ID
- @weeSAMScotland