IMPLEMENTATION OF SDM IN PRIMARY CARE

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“The Health Foundation is an independent charity working to improve the quality of healthcare in the UK. We are here to inspire and create the space for people to make lasting improvements to health services. Working at every level of the system, we aim to develop the technical skills, leadership, capacity and knowledge, and build the will for change, to secure lasting improvements to healthcare.”

Our six strategic priorities are:
- changing relationships between people and health services
- health professionals
- patient safety
- organising for quality
- use of knowledge
- value for money
My assumptions today

You know something about shared decision making already

Many of you are either doing it or working with others to make more SDM happen in the health system

We are concentrating on implementation in primary care settings – particularly general practice

Identified areas of interest:
Clinical engagement ‘buy in’ / communication skills/ risk communication/ challenges in this work

I am sure there is plenty you are doing that we can learn from! So i will leave plenty time for conversation
What I will cover (primary care only):

- Brief overview of the MAGIC programme
- Engagement
- Training programme incl. Risk communication
- Quality improvement methodologies
- Leadership
- Marketing and patient activation
- Decision support
MAGIC Making Good Decisions in Collaboration

The MAGIC Framework: Action learning with indicator feedback, located in a social marketing context and supported by organisational level leadership.
Focusing on implementation

• Evidence-based patient decision support

• Marketing

• Clinical skills development

• Organisation and clinical team engagement and leadership

• Measurement and rapid feedback, action learning, quality improvement cycles

• Patient & public engagement
MAGIC – Phase II

- Moving implementations from pilot departments and general practices to hospitals and health communities: embedding and sustainability
- Leadership and organisational engagement, including working with new commissioning structures
- Expanding and accelerating clinical engagement and impact, by testing learning from Phase 1
- Enhanced patient and public involvement, including an emphasis on patient activation and wider community.
- More efficient ways of delivering education and training
- Quality metrics: demonstrating value to commissioners and primary and secondary care organisations.
Models of clinical decision making in the consultation

SDM is an approach where clinicians and patients make decisions together using the best available evidence. (Elwyn et al. BMJ 2010)

Patient well informed (Knowledge)
Knows what’s important to them (Values elicited)
Decision consistent with values
Activated, engaged patients

Service improvement changes
Self management programme

Optimal functional and clinical outcomes

Tools

- Working in partnership
- Sharing decisions
- Planning care

Prepared, proactive teams

Beliefs, attitudes, skills training

Service improvement changes
Engagement

• Ask your friends!
• Ask whole health communities and make it competitive (but network too)
• Link it to referral management (and pay)
USPs for engagement

• Quality training (particularly if free)

• Decision support materials

• Risk communication training

• Evidence - cost/ compliance/reduction in high intensity interventions/litigation

• LEVERS: CPD/CQC/Trainees/local and national priorities/GMC
SDM Training workshops

Awareness raising 10 minutes
Introductory workshop/presentation (1 hour)

- Brief introduction to key aspects of SDM e.g. definitions, evidence
- Examples of decision support tools
- Clinical teams encouraged to deliver

Advanced SDM skills workshops (2-3 hours)
- Refresher of introduction to SDM e.g. definitions, evidence
- Introduction to the SDM consultation model
- Opportunity for role play with trained actor and use of decision support tools
- Brief reflection & recording of key learning points
SDM Training workshops

Key features of the design (we can discuss/debate these features later):

- Pre workshop reading/ preparation
- Workbook
- Actors
- Facilitators and occasional ‘demonstrations’/use of DVD
- Small group work
- Role play – in consultation tools
- Feedback with checklists
Training programme

• Skills based
• Attitudinal work is critical – particularly countering the: 1. “we do it already” and 2. “it takes too long”
• We have trained around 30 practices so far
• Our model – has gradually changed over 2 years
  – Highly focused
  – Skills based with microskills practice
  – Demonstrations, rehearsals, reflective spaces
Some specific work on risk communication but done as a separate workshop
Eye opening and valued – moving from “we do this already” to “I think we do this, but we could do it better”
  – “I thought I knew a lot about the best ways to communicate during informed consent…this has made me completely re-think…”
  – 95% of attendees in Newcastle agreed that “I will be able to use what I have learned in this workshop”
Training programme - challenges

• Generally very well liked
• Hard to assess effectiveness above Kirkpatrick level 1 and 2
  – reaction of student - what they thought and felt about the training
  – learning - the resulting increase in knowledge or capability
  – behaviour - extent of behaviour and capability improvement and implementation/application
  – results - the effects on the business or environment resulting from the trainee's performance
• Time that learners prepared to take learning SDM
• Content of exercises - familiar or new to the learners?
• Ratio of learners to facilitators/ trainers
• Train the trainers - open it up or tightly control?
Quality improvement methodologies:

Particularly:
- rapid measurement and feedback
  - Team Feedback tool
  - Patient experience questionnaires
- Most significant change, and reflective diaries

Small change in practice systems or clinician behaviour plus review
Measurement & rapid feedback

• Action learning model
  • Regular meetings to share good practice and experiences

• Measurement for monitoring, research or QI?
  • QI skills limited
  • Skills – rapid QI/PDSA, early
  • Role of rapid testing locally and ownership
  • Patient experience data a challenge
About this questionnaire
This brief confidential questionnaire will help us find out how well we are doing at involving patients in choices and decisions about their own care. It focuses on how things went in your consultation today. We will repeat the questionnaire regularly to see whether you think we are improving!

Completing the questionnaire
Please complete this voluntary questionnaire after your appointment. Whether you answer the questions or not, this will not affect your care in any way. Once completed, please place in the box marked ‘MAGIC – Strictly Confidential’ at the reception desk or in the waiting area.

Part A. How was your consultation today? (Please only consider today’s appointment)

Please answer the following questions by placing a tick clearly inside one box.

1. In my consultation today, I was told that there was more than one choice for my care and treatment.
   - [ ] Strongly agree
   - [ ] Agree
   - [ ] Neither agree nor disagree
   - [ ] Disagree
   - [ ] Strongly disagree
   - [ ] Does not apply

2. In my consultation today, we talked about the pros and cons of each choice for my care and treatment.
   - [ ] Strongly agree
   - [ ] Agree
   - [ ] Neither agree nor disagree
   - [ ] Disagree
   - [ ] Strongly disagree
   - [ ] Does not apply

3. In my consultation today, I was asked what was important to me in making a decision on my care and treatment.
   - [ ] Strongly agree
   - [ ] Agree
   - [ ] Neither agree nor disagree
   - [ ] Disagree
   - [ ] Strongly disagree
   - [ ] Does not apply

4. In my consultation today, I was involved in decisions about my care and treatment.
   - [ ] Strongly agree
   - [ ] Agree
   - [ ] Neither agree nor disagree
   - [ ] Disagree
   - [ ] Strongly disagree
   - [ ] Does not apply
The clinician asked what was important to me

- Practice A: 45 (Strongly agree), 27 (Agree), 119 (Neutral), 38 (Disagree), 4 (Strongly disagree), 3 (Does not apply), 1 (No response)
- Practice B: 138 (Strongly agree), 119 (Agree), 38 (Neutral), 21 (Disagree), 3 (Strongly disagree), 2 (Does not apply), 1 (No response)
- Practice C: 64 (Strongly agree), 31 (Agree), 73 (Neutral), 6 (Disagree), 5 (Strongly disagree), 2 (Does not apply), 2 (No response)
- Practice D: 7 (Strongly agree), 8 (Agree), 2 (Neutral), 1 (Disagree), 2 (Strongly disagree), 1 (Does not apply), 1 (No response)
Challenges

Ceiling effects – social acceptability bias

Comfort with continuing measurement

value of the feedback

Culture of general practice
Leadership

Trios in each practice
Learning sets
Facilitating activities in each practice
Bringing leaders to supportive meetings
Marketing and Patient Activation

Posters, leaflets, calling cards
Questionnaires
DVD –

3 Questions approach
Based on original Australian research, adapted after an iterative approach with patients (Shepherd et al, University of Sydney):

What are my Options
What are the possible benefits and risks?
How can we make a decision together that is right for me?
Ask 3 Questions

A6 flyer for use in appointment letters, waiting areas, consulting rooms.

Posters for use in waiting areas and consulting rooms.

Short film to encourage patient Involvement: ‘So Just Ask’

Acknowledgement to Shepherd et al, School of Public Health, University of Sydney
Challenges – in 3 q work

Dosage – multiple angles

Visibility – keep changing the view

Clinicians need to model the behaviour

“Three important questions for us to look at are....
Patient and public involvement

• Role of patient narratives/stories

• Role to challenge!

• Social marketing to patients: PPI role
  • Patient materials design and content – MAGIC or SDM
  • Ask 3 questions
  • Timing of switch from clinicians to patients

• Wider PPI needed at all levels
Evidence-based decision support

• Timely and appropriate access for clinicians and patients
  • Booklets/DVDs
  • Internet and intranet
  • Desk folders in primary care
  • Patient access to internet

• In consultation or outside?
  • Complex PDAs and/or brief in-consultation tools
Heavy Menstrual Bleeding (Heavy Periods)  
Management Options[1]  
A Brief Decision Aid

There are four options for the management of heavy menstrual bleeding:

- **Watchful waiting** - seeing how things go with no active treatment.
- **Intrauterine system (IUS)** – a hormonal device placed in the womb that lasts five years.
- **Medication** - tablets taken before and during periods, the combined oral contraceptive pill, or progestogens either as tablets or a 3 monthly injection.
- **Surgery** - endometrial ablation or hysterectomy. These are hospital procedures that are usually considered only if other options have not worked well or have been unacceptable.

[1] Only for use once other causes of HMB such as fibroids or polyps have been excluded
### Benefits and Risks of Intrauterine System (IUS)

<table>
<thead>
<tr>
<th>Treatment option</th>
<th>Benefits</th>
<th>Risks or Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intrauterine system (IUS)</strong></td>
<td>Blood loss is normally reduced by about 90%</td>
<td>Bleeding can become more unpredictable especially in the first 3-6 months. This usually, but not always, settles down</td>
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<tr>
<td></td>
<td>About 25 in every 100 women will have no periods at 1 year</td>
<td>At the time of fitting, an IUS may rarely be placed through the wall of the uterus (about 1 in 1000 fittings).</td>
</tr>
<tr>
<td></td>
<td>It lasts five years but can be removed at any stage.</td>
<td>IUS falls out 5 times in every 100 times it is put in. (this is usually obvious at the time)</td>
</tr>
<tr>
<td></td>
<td>It is more often considered if the treatment is wanted for longer than a year.</td>
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<tr>
<td></td>
<td>It usually reduces period pain.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>It is an effective contraceptive. (see separate leaflet)</td>
<td></td>
</tr>
<tr>
<td><strong>Watchful waiting - no active treatment</strong></td>
<td>No side effects or hospital treatment – can choose another option at any time. Your periods will eventually disappear – average age of menopause is 51.</td>
<td>It is already having an impact on your life and wellbeing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It is possible that periods will get worse running up to the menopause</td>
</tr>
</tbody>
</table>
## Downloads of BDAs

- Cramps 3,679
- IBS 3,606
- Plantar fasciitis 2,641
- Warts and verrucae 2,096
- Carpal tunnel syndrome 2,009
- Tennis elbow 1,986
- Heavy periods 1,764
- Prostate enlargement 1,704
- Stopping smoking 1,675
- Contraception 1,609
- What is shared decision making 197
- How to use a BDA 176
Thinking particularly about primary care

- Generally SDM makes sense
- They do it and after training often do ‘buy’ that they can do it better
- They love the decision support - but you need to be careful that it does not become a script with no change in underlying behaviour
- Attitudes are key

There are some tensions:
- QoF
- Pathways and guidelines
- It probably does NOT always save money
- It really takes time to ‘get it’
Time for some discussion

Questions Please!!!
Further information


Resources for SDM - www.health.org.uk/sdm

Brief decision aids - http://www.patient.co.uk/pils.asp

Option Grids - http://www.optiongrid.co.uk/

THANK YOU

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