Professionalism and Excellence in Scottish Medicine
- a national initiative

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Generic Challenges to Professionalism

- highly politicised nature of healthcare
- heavy central control
- highly managed target-driven culture
- societal culture/attitudes
- contractual issues: micromanagement; working time
- manager -physician disconnect
- lack of ownership: learned helplessness
- production-line attitudes to delivery of medical training –mediocrity vs excellence
- Self-defeating anti-professional effect; disengagement
Francis Report & Berwick Review

• Professional behaviours vs scrutiny - Berwick

• ‘In the end, culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime.’

• ‘In such a culture, measurement is not a threat, it is a resource; ambition is not stressful, it is exciting; defects are seen as opportunities to learn; and curiosity abounds.’
‘Perhaps the culture of accountability that we are relentlessly building for ourselves actually damages trust rather than supporting it. Plants don't flourish when we pull them up too often to check how their roots are growing: political institutional and professional life too may not go well if we constantly uproot them to demonstrate that everything is transparent and trustworthy.’

Dame Onora O’Neill,
BBC Reith Lecture, 2002
Value of Clinical Engagement

• Culture: contribution & striving for excellence
• Medical engagement correlates with:
  – Hospital mortality rates
  – Patient safety
  – Financial performance
  – CQC overall quality score

  Spurgeon, Mazelan and Barwell, 2011

• Professional responsibility & satisfaction
• Professionalism in medical education
• GMC Generic Professional Capabilities
Professionalism and Excellence in Scottish Medicine Reports

• 2009 CMO’s Advisory Group Report
  – Celebrated successes
  – Highlighted themes for action

• 2014 Professionalism Alliance Progress Report
  – Highlights significant progress
  – Articulates a series of specific ‘next steps’

• 2017 Refresh & realign with Realistic Medicine
  – Prioritising work program
  – Aligning with Realistic Medicine
Professionalism and Excellence in Scottish Medicine Report, 2009

• Much is positive
• Promoting better medical leadership at all levels of the service
• More effective team working
• Increasingly evidence based services underpinned by a strong research base
• Doctors as role models for doctors in training and other health professionals
• Doctors as advocates for health services and the health needs of the population.
Professionalism and Excellence in Scottish Medicine 2009-2014

• Call to action
• Scottish Academy of Medical Royal Colleges
• Cross System Implementation Alliance
• Endorsed as Scottish Government Health Policy
Professionalism and Excellence in Scottish Medicine - 2014 Report

• Illustrates further progress
• Articulates a series of specific ‘next steps’
• Specific commitments and accountabilities
• Timelines

Professionalism and Excellence in Scottish Medicine - 2014 Report

• Professionalism & Clinical Engagement
  – Management, leadership and academic development
  – Quality Improvement; promoting collaborative working across professions between management and doctors
  – Rotations, rota design and working patterns
  – Policy development, strategic implementation and medical training
Professionalism and Excellence in Scottish Medicine - 2017 Refresh

• Professionalism & Clinical Engagement
  – Evaluating progress of workplan
  – Restyling and prioritising workplan
  – Refocus commitment and accountability of member organisations
  – Aligning with Realistic Medicine and RRM
Aligning with Realistic Medicine and RRM:

‘The Professionalism and Excellence in Medicine Action Plan will be refreshed aligning and prioritising high impact actions that will support clinicians with Realistic Medicine.’
P&E and Realistic Medicine

• Valuing clinical leadership and engagement
• Formal leadership development
• Working patterns
• Changing the culture
• Added value to professionalism:
  – Clinical engagement and participation
  – Improved professional esteem
  – Building Quality Improvement capacity
  – Rallying call: if you don’t like it, fix it
  – Don’t give up
  – Striving for the best
Professionalism and Excellence in Scottish Medicine
By 2025, Scotland will have a medical workforce, working within multi-professional teams, which is motivated, skilled and able to contribute to our ambition to practice realistic medicine and provide the people of Scotland with one of the highest quality health and social care systems in the world.

### Primary Drivers

- **Leadership Development**
  - Provide leadership opportunities to all doctors including those in training
  - Open opportunities to develop strategic clinical leadership
  - Consolidate clinical leadership programmes
- **Lifelong Education, Training and Development**
  - Continued inclusion of professionalism teaching in undergraduate and postgraduate curriculum
  - Supporting Academic opportunities
  - Specialty training equips trainees with the skills and knowledge for excellence within their specialty
- **Supportive Environment for Medical Workforce**
  - Promoting positive work patterns (all trainees rotas assessed using PCAT; consultant job plans)
  - Positive culture of engagement amongst doctors and with other healthcare professionals
- **Promoting Best Practice**
  - Building capacity and capability in approaches to quality improvement
  - Collaboration of medical and non-medical managers (paired learning)
  - Professional standards and appropriate application of guidance
Realistic medicine in the management of advanced kidney disease

Caroline Whitworth
Percentage Population change by 2037 - Lothian

- Children (0-15) Lothian: 22%
- Working age (Lothian): 20%
- Pensionable age (Lothian): 35%
- 75+ (Lothian): 94%

Source: ONS Scotland

https://www.nrscotland.gov.uk/files/
Increasing burden of chronic disease as we age

New patients starting RRT 1960-2015

Scottish Renal Registry Report 2015
Prevalent patients by modality & age group on 31 December 1991-2015

Scottish Renal Registry Report 2015
Themes from clinician free text comments where haemodialysis withdrawal was primary cause of death 2008-2014
Development of a conservative care programme (CCP) in Lothian 2008
Background

- Challenging our assumptions
- Acknowledging the burden of treatment as well as impact of clinical conditions
- Listening to the patient
- Giving patients permission
- Shared decision-making

- Move from efforts to prolong life in those with ESRD to a focus on quality of life & symptom control
Design

- Conservative care nurses core to the programme
  - Many years of dialysis experience & necessary skills
  - Work as part of renal multi-disciplinary team
  - Liaise directly with primary care and other services

- Informed patients, shared decision-making for patients & their families - choose RRT or conservative care

- CCP targets treatment of symptoms to promote quality of life

- Patients receive quality care without having to attend hospital

- Bereavement counselling for families & carers
Survival of elderly patients with stage 5 CKD: comparison of conservative management and renal replacement therapy

Shahid M. Chandna, Maria Da Silva-Gane, Catherine Marshall, Paul Warwicker, Roger N. Greenwood and Ken Farrington

Renal Unit, Lister Hospital, Stevenage, Hertfordshire SG1 4AB, UK

**Fig. 2.** Comparison of Kaplan–Meier survival curves by modality (RRT vs conservative kidney management) in patients > 75 years. The panel on the left depicts the relationships in those with low comorbidity and that on the right in those with high comorbidity.
Typical CCP workload

- 104 patients currently under active conservative care
- 70 years & over
  - 36% eGFR <20mls/min
  - 23% eGFR <10mls/min
- 6 patients currently on RRT considering withdrawal
- 5 new referrals / month

[July 2016]
Outcomes

Qualitative results

Positive feedback from patients, families & carers

‘Professional, dedicated, source of friendship, moral support’

‘Good death’

Quantitative results

BMJ Qual Improv Report 2013
Age specific incident RRT population 1996-2015 per 100 000 population

Scottish Renal Registry Report 2015
Incidence of new patients starting RRT 2011-2015 by NHS Board area of residence standardised for age, sex and SIMD
Lessons & limitations

• **Engagement**
  – Clinical team engagement
  – Patient engagement

• **Skills and attitudes**
  – Reassurance and support for staff. ‘Top cover’
  – Patient, family, carers – positive/ discrepant / negative attitudes

• **Tools**
  – Evidence-based practice and guidelines?

• **End of life aspect:**
  – Work towards anticipatory care planning for selected dialysis patients
  – Dept meetings - Could we have done better?

• **Dissemination**
  – Presentation and discussion at local and national meetings
‘Conversation’ is critical

- Providing staff with skills, support
  - Address impact of medical models, EBM and guidelines – expectations of professionals?
  - Managing expectations of patient, family, society
  - Managing uncertainty
    - Where there is lack of evidence
    - Challenge of understanding and managing risk
- Time and space
- Compassionate care – managing suffering