Implementing Shared decision making:
A MAGIC view
Dave Tomson

With thanks to Richard Thomson (Co-PI), Natalie Joseph-Williams, Emma Cording, Carole Dodd, Glyn Elwyn (Co-PI) and whole MAGIC Team
Newcastle
Richard Thomson

Cardiff
Glyn Elwyn

Acknowledgements: The Health Foundation, Cardiff and Vale University Health Board, Newcastle upon Tyne Hospitals NHS Foundation Trust, and most importantly all staff and patients involved across both sites
Session Overview

1. Setting the context
   An overview of the MAGIC programme, what we did, and the current plans

2. What did we do in primary care?
   Training/ decision support/ measurement/working with patients

3. Emerging role of patient’s as change agents - aka ‘activation’
   3 Questions and DVD
Background

The Health Foundation
An independent charity working to improve the quality of healthcare in the UK

• Leadership and organisations
• Patient safety
• Changing relationships between people and health services
• Engaging healthcare professionals

2009 call for “SDM Design Team”
18 months project: started August 2010
So why aren’t we doing it?

- Multiple barriers
  - “We’re doing it already”
  - “It’s too difficult” (time constraints)
  - Accessible knowledge
  - Skills & Experience
  - Decision support for patients / professionals
  - Fit into clinical systems and pathways

Lack of implementation strategy
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

PLUS

- Social marketing
- Clinical skills development
- Organisation and clinical team engagement
- Measurement and rapid feedback, action learning, quality improvement cycles
- Patient & public engagement
Outputs from MAGIC 1

• Guidance for organisations wishing to embed SDM in practice — Virtual Resource centre coming soon

• Tools and techniques — Brief Decision Aids and Option Grids

• Training materials — 1 hour 2 hour and 3 hour training programmes and other materials available

• Champions
Working with Primary Care North east

- 4 practices
- Contracts with each practice
- A lead trio from each practice including manager, nurse/pharmacist and doctor
- Introductory talks to each practice, including admin teams
- 75% of all clinical teams attending 3 hour clinical skills training workshop
- Baseline measures and regular measurement of patient experience – Quality improvement programme
- Marketing - posters, leaflets
- Decision support tools
- Just ASK – exploring ways of changing behaviour and expectation of patients – Leaflets and Film
SDM Training workshops

• Created to provide MAGIC teams with SDM skills training

• Iterative development process
  • continually improving & changing workshop using QI methodology

• Introductory and Advanced SDM skills workshops
  • plus other training opportunities e.g. student lectures, specialist training, staff induction
SDM Training workshops

• Awareness raising 10 minutes

• Introductory workshop/presentation (1 hour)

• Advanced SDM skills workshops (2-3 hours)
Key Assumptions

1. An informed patient is desirable and important to you as a health care professional

2. Engaging patients in treatment decisions where there are real options is a desired goal and health care professionals need to support individuals to achieve this

3. A patient who is not informed of the possible consequences of the options is not able to determine what is important to them
Model of SDM consultation

Shared decision making: a model for clinical practice

DELIBERATION

Initial → Preference Construction → Informed preferences

Choice Talk
Option Talk
Decision Talk

Patient Decision Support
Brief as well as Extensive
SDM Training workshops

Key features of the design

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

Shared decision making: a model for clinical practice

**DELIBERATION**

Initial → Preference Construction → Informed preferences

- **Choice Talk**
- **Option Talk**
- **Patient Decision Support**
  - Brief as well as Extensive

- **Decision Talk**
## Check List of Skills: Option Talk

<table>
<thead>
<tr>
<th>Option talk core Skills</th>
<th>Demonstrated? Handy phrases used?</th>
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<tbody>
<tr>
<td>Check existing knowledge</td>
<td></td>
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<tr>
<td>List options</td>
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<tr>
<td>Introduce decision support</td>
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<tr>
<td>Describe options</td>
<td></td>
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<tr>
<td>Describe benefits and harms</td>
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<tr>
<td>Checking understanding</td>
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<tr>
<td>Continue preference talk where appropriate and summarise</td>
<td></td>
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<tr>
<td>Example phrases you might like to use</td>
<td>OPTION TALK</td>
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<tr>
<td>--------------------------------------</td>
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<tr>
<td>“Are you already aware of how this problem could be managed or treated?”</td>
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<tr>
<td>“Have you been searching for information on this yourself?”</td>
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<tr>
<td>“It is possible to do three things in this situation, let me list them quickly before I describe them in more detail”</td>
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<tr>
<td><strong>What to say if options are:</strong></td>
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<tr>
<td>Similar: “Both options are very similar and involve taking medication on a regular basis”</td>
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<tr>
<td>Different: “These two options are different and will have different impact on you and your family, let me explain what they involve”</td>
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<tr>
<td>“I am going to describe the most relevant risks and benefits of each option to you… let me know if I go too quickly or if you do not understand…”</td>
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<tr>
<td>“I will try and give you an idea of the likelihoods of each of these risks and benefits”</td>
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<tr>
<td>“Let me just check that I have explained this well enough- can you tell me what you have picked up from what I’ve told you?”</td>
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<td>“Here is a diagram; Decision Grid etc that will help me describe the options to you. I am going to describe the possible risks as well as the possible benefits of each – so lets start with…”</td>
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<td>“There is a large amount of information to grasp here. Would you like me to provide you with materials which you could read and discuss with your family? And then we could meet again when you have had a chance to digest it?”</td>
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Decision support

- Cardiff have developed Option Grids
- Newcastle have developed Brief Decision Aids
### Lumpectomy with Radiotherapy vs. Mastectomy

| **Which surgery is best for long term survival?** | There is no difference between surgery options. | There is no difference between surgery options. |
| **What are the chances of cancer coming back?** | Breast cancer will come back in the breast in about 10 in 100 women in the 10 years after a lumpectomy. | Breast cancer will come back in the area of the scar in about 5 in 100 women in the 10 years after a mastectomy. |
| **What is removed?** | The cancer lump is removed with a margin of tissue. | The whole breast is removed. |
| **Will I need more than one operation?** | Possibly, if cancer cells remain in the breast after the lumpectomy. This can occur in up to 5 in 100 women. | No, unless you choose breast reconstruction. |
| **How long will it take to recover?** | Most women are home 24 hours after surgery. | Most women spend a few nights in hospital. |
| **Will I need radiotherapy?** | Yes, for up to 6 weeks after surgery. | Unlikely, radiotherapy is not routine after mastectomy. |
| **Will I need to have my lymph glands removed?** | Some or all of the lymph glands in the armpit are usually removed. | Some or all of the lymph glands in the armpit are usually removed. |
| **Will I need chemotherapy?** | Yes, you may be offered chemotherapy as well, usually given after surgery and before radiotherapy. | Yes, you may be offered chemotherapy as well, usually given after surgery and before radiotherapy. |
| **Will I lose my hair?** | Hair loss is common after chemotherapy. | Hair loss is common after chemotherapy. |
## Lumpectomy with Radiotherapy

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BDAs - Launched last week

• You can find all the latest BDA on www.patient.co.uk
Heavy Menstrual Bleeding (Heavy Periods)
Management Options
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.

Benefits and Risks of Watchful Waiting

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[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>
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| **Intrauterine system (IUS)**  
Involves a minor procedure done in the GP practice/sexual health clinic. Majority of women say that the fitting is similar to moderate period discomfort | Blood loss is normally reduced by about 90%  
About 25 in every 100 women will have no periods at 1 year  
It lasts five years but can be removed at any stage.  
It is more often considered if the treatment is wanted for longer than a year.  
It usually reduces period pain.  
It is an effective contraceptive.(see separate leaflet) | Bleeding can become more unpredictable especially in the first 3-6 months. This usually, but not always, settles down  
At the time of fitting, an IUS may rarely be placed through the wall of the uterus (about 1 in 1000 fittings).  
IUS falls out 5 times in every 100 times it is put in. (this is usually obvious at the time) |
| **Watchful waiting** - no active treatment | No side effects or hospital treatment – can choose another option at any time.  
Your periods will eventually disappear – average age of menopause is 51. | It is already having an impact on your life and wellbeing.  
It is possible that periods will get worse running up to the menopause |
<table>
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<tr>
<th>Treatment option</th>
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<tbody>
<tr>
<td><strong>Tranexamic acid</strong></td>
<td>Blood loss is normally reduced by about 40%</td>
<td>Does not reduce length or pain of periods.</td>
</tr>
<tr>
<td>Involves taking a tablet three</td>
<td></td>
<td>Common side effects include upset stomach and diarrhoea.</td>
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<tr>
<td>times a day for up to four days</td>
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<tr>
<td>from the moment your period</td>
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<tr>
<td>starts</td>
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<tr>
<td><strong>Non-steroidal anti-inflammatory drug (NSAID)</strong> e.g. ibuprofen and mefenamic acid</td>
<td>Blood loss is normally reduced by about 20-30% It usually eases period pain.</td>
<td>Common side effects include upset stomach. Should not be taken if you have asthma.</td>
</tr>
<tr>
<td>Involves taking tablets for up to five days from the moment the period starts, usually three times a day</td>
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<tr>
<td><strong>Tranexamic acid plus NSAID</strong></td>
<td>Likely to work better than either alone – but there are no studies to say by how much.</td>
<td>Side effects: as for the individual medications.</td>
</tr>
<tr>
<td><strong>Combined oral contraceptive pill</strong></td>
<td>Blood loss is normally reduced by about 40% for most varieties of 'the pill' It often helps with period pain. It is an effective contraceptive (see separate leaflet on Patient.co.uk).</td>
<td>Forgetting to take regularly, this will reduce its effectiveness. Risks (such as blood clots) increase slightly as you get to your mid 40s. Side effects sometimes occur. (see separate leaflet on Patient.co.uk).</td>
</tr>
<tr>
<td>Involves taking a tablet usually every day for three weeks, stopping for a week, and then repeating.</td>
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<tr>
<td><strong>Norethisterone</strong></td>
<td>Probably reduces blood loss by around 40% but studies are small and side effects tend to be less well tolerated</td>
<td>Common side effects include weight gain, bloating, breast tenderness, headache and acne –most tend to be mild and short lived</td>
</tr>
<tr>
<td>Taken from day 5 – 26 of the menstrual cycle</td>
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Process for developing BDAs

• Local primary care first author
• Expert second author
• Drawn from the EMIS PILS leaflets as primary source
• Started with cross match of top 100 most popular clinician/public
• Academic review of literature where necessary
• Voice North providing patient voice
• Single editor (DT) liaising with editor of Condition Leaflets on patient UK (Dr Tim Kenny)
• PILOT with feedback from users (both patients and clinicians)
Working with patients

• How could we engage patients more fully?
• Marketing – posters and leaflets
• Just Ask campaign
  – Based on Australian work
  – Adapted in Newcastle using repeat testing and measuring
  – Used to encourage a different conversation
  – Used to measure patient experience
Ask 3 Questions

Sometimes there will be choices to make about your healthcare. If you are asked to make a choice, make sure you get the answers to these 3 questions:

- What are my options?
- What are the possible benefits and risks?
- How can we make a decision together that is right for me?

www.making-good-decisions.org
Making a GOOD shared healthcare decision means you:

- Know the options available to you.
- Know the benefits, risks and consequences of the options and the chances of these happening.
- Are asked about what is important to you in making a decision.
- Are as involved in the discussion as much as you want to be.

If there was no decision to make today please tick here □ and do not fill in the rest of the survey – thanks!

If there was a decision to make today:

Please circle a number below to tell us what you think about the quality of the shared decision making in your consultation today.

| Very poor shared decision making | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very good shared decision making |

Thank you for completing this survey

Please post back in the ‘MAGIC’ box at reception
MAGIC DVD
Magic 2 – starts today!

• Newcastle and Cardiff
• Moving implementations from Pilot departments and general practices to hospitals and health communities
• Further development of decision support and training packages
• Further development of work with patients
Thank you

d.p.c.tomson@ncl.ac.uk

Doctor, I want to choose how I’m treated

Hmm. You’re not just ill – you’re deluded
Dr Dave Tomson FRCGP
Freelance consultant in Patient Centred care
Primary care lead, North East of England MAGIC programme

The MAGIC Programme is supported by the Health Foundation, an independent charity working to continuously improve the quality of healthcare in the UK.