NHS SCOTLAND

APPENDIX: REALISTIC MEDICINE AROUND SCOTLAND

Chief Medical Officer's Annual Report 2015-16

REALISTIC MEDICINE

Healthier Scotland
Scottish Government

Appendix: Realistic Medicine around Scotland

Realistic Medicine can only be realised if it becomes part of how we deliver care on a daily basis. As part of the consultation process I asked for feedback from around the country about approaches to Realistic Medicine. This was collated in a Feedback Report published in December 2016. It was clear from the feedback that varied and interesting work was being undertaken across the country, inspired by or further informing the Realistic Medicine philosophy.

To this end I asked for further written feedback and my team undertook a series of short interviews with people involved in work related to Realistic Medicine in areas around Scotland. These interviews and written feedback are collated in this appendix providing practical examples of work being undertaken. Many fit closely with multiple aspects of Realistic Medicine – from new innovations to changing approaches to variation. While this appendix is not intended to provide a full compendium of all the work being undertaken, it aims to provide 'snapshots' that contributors have agreed to share more widely. I am aware that there are many other pieces of work going on around the country which are not detailed. However, I hope that this appendix can provide a flavour of the breadth and variety of innovations that Realistic Medicine has influenced – and perhaps provide some inspiration and connections for those looking to incorporate Realistic Medicine into their own practice in future.

NHS GREATER GLASGOW AND CLYDE

INITIAL THOUGHTS

There are many individual projects going on in GG&C which embody the principles of Realistic Medicine. Realistic medicine has been embraced across a range of specialties and settings – from the community to tertiary hospital environments. Further to the Inspire project discussed earlier, work is ongoing with people with dementia: diverse populations but with the same needs for person-centred and holistic care.

WHAT HAVE WE DONE SO FAR?

As well as the InSPIRE project, Realistic Medicine is also being taken forward in the area of dementia care. While the Getting to Know Me initiative is a nationwide initiative developed by Alzheimer's Scotland, NHS GG&C is currently the only Health Board with an Allied Health Professional consultant for dementia.

Additionally, education is delivered for a wide variety of professionals on how to use the Getting to Know Me document – highlighting that although it is intended for use in dementia this is not its only function and that it could be used in other environments such as those with sensory impairments. Getting to Know Me is used as a key part of post-diagnosis support for dementia.

Therapeutic Gardens are also in use, aiming to provide a more holistic and person-centred environment. Four gardens were set up across Glasgow with the aim of providing open access to a safe outdoor space which could be used in a therapeutic way. An example is the use of specific garden activities such as hanging laundry to assist physiotherapists and occupational therapists in assessing functioning.

Environments such as a mini-golf area allow people to re-engage with their families in a naturalistic way.

WHAT NEXT?

Research is now being undertaken locally in relation to InSPIRE in the form of a randomised control trial as well as a historical control group analysis using self-efficacy as an outcome measure ("How in control of their health do people feel?"). The aim is to provide evidence for future innovation. Work is also being undertaken with the University of Aberdeen on an external evaluation investigating the process involved in scaling up the innovation.

Educational sessions around Getting to Know Me are ongoing, with the aim of providing more of these within acute care as well as developing work on one-to-one care. There is a need to link this work with anticipatory care planning and it is recognised that education for carers is also important.

FINAL THOUGHTS

Realistic Medicine has been happening for some time now - in various pockets around the city and country. Recognition of this work as being closely allied with the Realistic Medicine philosophy will help engage professionals in future.

Therapeutic Garden in NHS GG&C - putting green, planting, gazebo and laundry area all used by various health professionals, patients and visitors.

UNIVERSITY OF GLASGOW

INITIAL THOUGHTS

Realistic medicine is important for Undergraduate education – embedding the philosophy in undergraduates at an early stage means they are likely to carry this though their career, and making links with other institutions who train health professionals, e.g. Caledonian University, is likely to help embed this philosophy.

WHAT HAVE WE DONE SO FAR?

A holistic, inter-professional education pilot has been started. Students from a variety of health professions undertake case-based discussions around a number of multidisciplinary themes; focusing on the patient-centred aspects of care.

The Vocational Studies programme includes training in communications, evidence-based medicine and professionalism. Students undertake four clinical placements in four team settings including General Practice, the Emergency Department, Medicine for the Elderly and a hospice setting, and then reflect on how the team functions; working with multidisciplinary students from a similar stage.

Resilience training is being developed, with a focus on mindfulness, and a peer support network has been established to promote professionalism and support networks at an early stage.

WHAT NEXT?

The inter-professional pilot is being expanded to include Social Work students and will start this academic year. The patient safety and resilience themes in the curriculum will be assessed using a broader exam. An enhanced ward-based simulation will be rolled out, where medical and nursing students will work together to make decisions in a simulated Hospital at Night scenario. A Director of Simulation has been appointed to share best practice.

FINAL THOUGHTS

Teaching students to appreciate and value their fellow professions at an early stage will enhance their ability to provide personalised care to future patients.

External views of the new Teaching and Learning Centre at the Queen Elizabeth University Hospital.

UNIVERSITY OF ABERDEEN

INITIAL THOUGHTS

Training at the university of Aberdeen is shaped by the principles and aligns with the values of Realistic Medicine. Meaningful educational experiences with an informed risk-based approach will underscore training for the future workforce. While students can't be wrapped in cotton wool, giving them a skill set and values to take into their later training will ensure Realistic Medicine is embraced by the future profession.

WHAT HAVE WE DONE SO FAR?

A curriculum review is being undertaken this year to align with Realistic Medicine, taking a person-centred approach. Students are being taught about the importance of recognising multi-morbidity and the variety of sources useful information can come from. Input from the third sector is now a part of teaching and later years undergo apprenticeship-style blocks with the aim of producing graduates who have a sense of the community they live and work in.

WHAT NEXT?

Work is ongoing to develop the curriculum. An educational programme looking at how to recognise risk is underway. Up to 20 students currently have a remote and rural experience and this will be expanded using technology such as GP live where students are able to observe a GP surgery via video-link and reflect on the interactions. This is available in Aberdeen but the aim is to expand to Shetland to enhance the students' understanding of person-centred care in different contexts.

FINAL THOUGHTS

When thinking about how to teach Realistic Medicine at Universities, we must consider how to achieve Realistic Education. Changing the infrastructure of curricula will help shape the values of future doctors.

NHS SHETLAND

INITIAL THOUGHTS

The themes of Realistic Medicine have been universally accepted and articulated in a positive way. Both Shared Decision Making and investigation of unwarranted Variation are important for the future of Medicine.

WHAT HAVE WE DONE SO FAR?

A seminar programme has been commenced involving the Integrate Joint Board. This included non-executive directors and council members. The seminar was example-focused, using scenarios based on real-life conversations clinicians have had about patients choosing to have or not to have treatments.

The seminar also covered the concept of Numbers Needed to Treat and highlighted the importance of explaining this accurately to lay people to enhance their ability to make decisions.

WHAT NEXT?

The chief Nurse for NHS Shetland and the Medical Director are presenting to the whole Clinical Care and Professional Governance Committee on Realistic Medicine, aiming to consider how Clinical Governance can support the aims of Realistic Medicine.

FINAL THOUGHTS

Doctors apply science to human people. We need to consider this as part of our long-term national training process.

UNIVERSITY OF DUNDEE

INITIAL THOUGHTS

Realistic Medicine links closely with changes to the curriculum that have been developed in recent years. A wide variety of University initiatives link closely with Realistic Medicine, however it is essential to recognise the link between the Universities and local NHS services in providing a Realistic approach to care.

WHAT HAVE WE DONE SO FAR?

A wide variety of initiatives are underway. Habits of Improvers is already embedded in teaching and most recently a session was held connecting staff and students from the NHS, University and third sector. Students were from the medical and art schools. They worked together to focus on example themes with most choosing 'Patients and the community'. The King's Fund has been used to inspire work around shadowing patient journeys and collecting patient stories while recording 'touchpoints' where patients connect with the service. This has been tested in a summer scholarship and spread to one tutor group, who reflected positively.

Patient experience interviews have been started – with two students interviewing patients two weeks after discharge, focusing in the holistic experience of care.

The lecture theatre at the Medical School has been redesigned to support team-based learning and move away from solely didactic teaching.

Interprofessional teaching has also been recognised as being key to providing patient-centred care in the future. Students now undertake interprofessional education alongside dentistry, nursing, social work and Allied Health Professions students – linking with the universities of Abertay and St Andrews. Early in the course students are linked and must undertake 'team tasks' which do not presume a specific professional role – for instance using team skills to triage simulated patients in an earthquake scenario.

WHAT NEXT?

The summer scholarship received good feedback and investigation on how to make this a core part of the curriculum is underway.

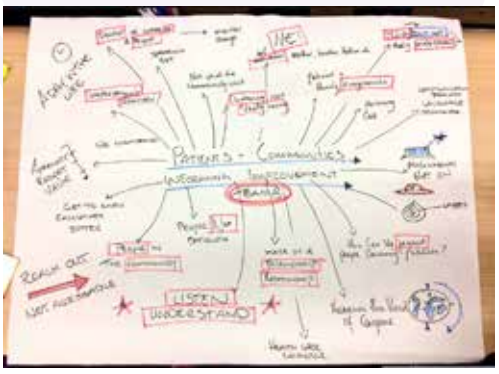
This year students in second year will start attending the pre-assessment clinic and interview patients after the appointment, focusing on their experience.

The aim is to make patient interviewing and shadowing in this context core within the next three years. Over five years all MBChB students will be required to be involved in improvement work using a variety of methodologies.

Team tasks will be built upon as part of the 'doctors as professionals' theme. The link with Abertay University is new and in March 2017 work will start on a module around communicating with people with disabilities, involving real carers and people using services. This will be a move away from classroom-based learning into the community.

FINAL THOUGHTS

Interprofessional education allows students to better understand their colleagues' roles at an early stage and prepares them for working at teams where the patient is at the heart and where all team members should share in decisions. This prepares them for practicing in a Realistic Medicine world where patient-centred care will come naturally to them.



Storyboard and Photographs from Interprofessional Learning event in Gannochy Trust Lecture Theatre, Ninewells Hospital.

NHS FORTH VALLEY

INITIAL THOUGHTS

Realistic Medicine is a core part of the NHS Forth Valley philosophy. Leadership from Medical Directors and others will be key in supporting Realistic Medicine to continue in practice.

WHAT HAVE WE DONE SO FAR?

A number of pieces of work have been undertaken, including being supported by MacMillan to employ a secondary care consultant to look at educational and professional elements about improving decision making about end of life care. There is a real focus on primary care, with innovative practice around GP practices in particular with two large practices having a multidisciplinary work force, so patients see relevant practitioner (for instance pharmacist, Mental Health nurse, physiotherapist). A diabetic foot pathway to reduce variation has been implemented.

An area of particular focus is Pharmacy. Pharmacy and General Practice have worked together to support a mindful approach to prescribing which has resulted in excellent engagement. Successful results in reducing unnecessary polypharmacy are being prepared for publication and the next step was agreed as investigating step 2 opioid use. It was noted that prescriptions in NHS Forth Valley were higher than the Scottish average, specifically related to Tramadol. Opioids had been identified as a key factor in hospital admissions and this led to a QI approach, starting with teaching and learning on comparative doses of morphine for prescribers. An initiative was launched to focus specifically on step 2 opioids and 54 of 55 GP practices signed up to this. Patients now need to be reviewed a minimum of annually and if no improvement is noted in wellbeing with or without pain scores this leads to a review of whether opioids are appropriate. The chronic pain service has become involved and developed a tool that GPs can use. This includes a pain management patient agreement and help with looking at pain issues holistically.

WHAT NEXT?

The pharmacy work has now moved on to include the addictions services, looking at Gabapentinoids. A treatment pathway has been created that includes these drugs and aims to enhance a holistic view of their use and put patients at the centre of discussions about their ongoing use – including open discussion of specific symptoms and side effects. This approach to change can now be considered in the context of other frail patients. Other work will include looking at developing enhanced skills for staff to have conversations around ITU referrals and ceilings of care and developing leadership from Medical Directors and others to support the GMC in their work with doctors at all stages of their career and future doctors about professionalism and the place for the elements of realistic medicine in this.

FINAL THOUGHTS

A 'building blocks' approach to change helps clinicians in the real world take a realistic approach to providing care. Realistic medicine in the context of medicines is not about stopping medication but about investigating its efficacy and ensuring that results are measured holistically, beyond simple pain scores etc.

NHS TAYSIDE

INITIAL THOUGHTS

Realistic Medicine has come at a time where it fits closely with the vision of improvers and innovators within NHS Tayside.

WHAT HAVE WE DONE SO FAR?

Links between the NHS and local universities are close. At the early stage of postgraduate medical life, foundation doctors undergo inductions where the focus is on teams and the working environment. Foundation doctors are placed into a ward team and are asked to comment on support systems, skill sets and team working. During the first week of work doctors spend time with a staff member from the deanery and they meet again at the end of the first rotation. This aims to help junior doctors fit in with their teams. They also have a three-month window in which they must use the Datix system and reflect on a clinical incident using the Mayo Clinic tool, focusing on the impact on the patient and teams that the incident has had. This aims to embed person-centredness in their practice from an early stage. Data is analysed and fed back clinically. Improvement work then commences during the third rotation, with foundation doctors encouraged to come up with improvement innovations. One of the improvement areas doctors focus on is Realistic Medicine, for instance focusing on variation between teams.

The Academic Health Science Partnership (AHSP) is also key in building on work related to Realistic Medicine. It has supported the development of a Quality Improvement (QI) curriculum for medical staff with outputs including real-world improvement projects focusing on reduction of waste and variation in systems. Work is particularly advanced in Anaesthesia with QI teaching for trainees in Tayside currently testing a model based on a combination of elements described by Bill Lucas in Habits of an Improver combined with curriculum requirements from the Royal College of Anaesthetists. The overarching aim is to produce clinicians with the required mindset to be habitual Improvers and drivers of change- key components of Realistic Medicine. The powerful combination of QI expertise, strength in skills training and design is embedded in the AHSP architecture and has already delivered a number of successful projects with plans for further spread over the next and subsequent years.

Links between the NHS and Community in NHS Tayside are also strong, in particular with the creative arts. A number of events have been held looking at design thinking in the interpretation of Realistic Medicine, 'flipping the pyramid' and using design to improve person-centred care. This has led to NHS Tayside representation during a QI Connect Session focusing on innovation and design in Healthcare.

WHAT NEXT?

The academic foundation programme is also being developed to include improvement methodology as a specific area of academic focus, moving from the themes of research and teaching which have previously been in place.

A further phase of the QI and Safety work will develop inter-professional and cross sector 'paired learning' to promote clinical engagement and improve health and social care integration. This will combine QI and educational expertise with access to research support. Innovative work on implementation of Realistic Medicine in NHS Tayside will be supported through this process.

FINAL THOUGHTS

Innovation - including involving partners from agencies outside the NHS - is crucial to achieving the aims of Realistic Medicine. Innovation for improvement is a key part of Realistic Medicine and using design principles in Quality Improvement is a way forward to achieving this. Links between the community and universities must be fostered and maintained.

NHS TAYSIDE CONTINUED

NHS Tayside Foundation Doctors QI Programme Diagram.

Realistic medicine event in NHS Tayside alongside Open Change.

NHS ORKNEY

INITIAL THOUGHTS

Geographically isolated communities such as Orkney can risk becoming isolated and losing touch with advances in medicine. Many older patients in Orkney are reluctant to travel to other health board areas for treatment or investigation which can often restrict the options available, however NHS Orkney sees this as an opportunity to open discussions regarding patient expectations of care. We need national and local leadership and strategies must reflect and be much honest about this. Cost effective use of resources must apply to all of us no matter where we are in the organisation. Locally, we need to find ways to involve the community much better in the difficult decisions we make – both about individual care and about strategic decision making.

WHAT HAVE WE DONE SO FAR?

Realistic Medicine principles are being spread within NHS Orkney. Barriers to personalised realistic care have been identified, with time constraints and IT infrastructure identified as needing special consideration. Care is being undertaken 'Realistically' in some areas such as goal-setting being a focus in the cardiac rehabilitation clinic, where people attending think about what they personally would like to achieve rather than every attendee having the same rehab package. A team development session on Realistic Medicine was also well received.

WHAT NEXT?

Good communication between specialties and across professions is very important. For example, it would be useful for the dental team to be notified early of a patient planning to start anti-reasorptive or anti-angiogenic drugs. There might be some instances where a person's oral health is so poor that the risks would outweigh the health benefits. The combination of people retaining teeth for longer and people living for longer with complex medical issues is creating a considerable challenge for the dental team. The risks associated with providing dental treatment increase and often co-operation (with daily oral hygiene and with dental treatment) diminishes. Therefore, a solid preventative programme needs to be in place for these patients in addition to choosing more conservative treatments.

Primary Care currently have a regular newsletter and this is an approach that could be considered elsewhere in the organisation in order to share information and generate discussion. Managed clinical networks (MCN) share a suitable way to come together for mutual support and to work through guidelines and action plans together.

FINAL THOUGHTS

We must find a way to describe that providing treatment is not always the way to go and that patient dignity must be foremost. We must have the courage to be honest, open and balanced. Accept that we all have the right to make the decisions that are right for us. Have the courage to involve the community in difficult decisions and explain these in a manner which is open and honest.

NHS WESTERN ISLES

INITIAL THOUGHTS

NHS Western Isles has embraced Realistic Medicine in a variety of different healthcare areas and believes that the patient experience and journey should be at the heart of any new programmes.

WHAT HAVE WE DONE SO FAR?

A Patient Centred Care Pathways Programme has been established with the remit to explore individual pathways to improve efficiency and effectiveness of care. These include the Do It Referral Pathways, Patient Travel and Video Conferencing, Anticipatory Care Pathways, Self-Management and Pro-active Specialist Care.

A biologics reduction programme is already underway whereby patients on biologics are evaluated as to their suitability for dose reduction. Biosimilars have been adopted in full for new patients, once remaining stock is used up.

Anticipatory Care Planning (ACP) has been identified as an important area. A sharper focus on ACPs is looking to maintain the patient at home where safe and appropriate, and ensure that healthcare is in line with a previously agreed, patient centred, plan.

In another priority area, Ophthalmology, NHS Western Isles has trained a specialist nurse for intra–vitreal injections, thereby releasing consultant time to perform cataracts. This is the latest in a series of moves to enhance the nursing role and reduce the pressure on medical consultants to enable them to address the more complex needs of patients.

WHAT NEXT?

Incremental changes to the Patient Centred Care Pathways Programme will be delivered on a pathway by pathway basis. The programme aims to change the way people receive care so that the benefits are long term and transferable to other pathways.

In the area of Varicose Vein treatment, we are currently working with NHS Highland in reviewing the number of patients referred for varicose vein treatment. All patients currently travel to Raigmore for treatment, often twice. Indications are that at least 50% of those patients could be more for cosmetic treatment than for the relief of symptoms. NHS Highland is reviewing the referral guidelines and it is expected to reduce the number treated by 50-70%. NHS Western Isles is likely to adopt the guidelines set out by NHS Highland.

The ACP work will in future focus on early supported discharge to minimise the time people need to spend out of familiar home circumstances. Length of stay has been identified as an area where NHS Western Isles is an outlier, particularly in relation to pre-operative stays. We are working to develop alternatives to pre-operative stay where there is no medical indication for early admission.

FINAL THOUGHTS

NHS Western Isles has adopted the principles of Realistic Medicine and is actively working towards translating them into everyday clinical practice.

NHS EDUCATION SCOTLAND (NES)

INITIAL THOUGHTS

Education and training has a significant role to play in ensuring that our trained medical workforce has the skills and attributes required by NHS Scotland – including those set out in Realistic Medicine – while recognising that we work in a context where training curricula are determined and approved across the UK, by medical Royal Colleges, and the General Medical Council. NES currently supports a broad range of areas of education and training beyond the delivery of these core curricula which are of direct relevance to the delivery of Realistic Medicine.

WHAT HAVE WE DONE SO FAR?

Ongoing work within the Patient Safety Group has resulted in a new e-learning resource on Human Factors available summer 2016. Accredited by the Chartered Institute of Ergonomics and Human Factors, this resource will offer NHS and Social Care staff in Scotland an overview of this discipline and its contribution to enhanced wellbeing and performance.

Face to Face workshops covering areas such as 'Human Factors Awareness', 'Why things go wrong (and right) in complex systems' and 'How to respond when things go wrong in complex systems' are available to consolidate and develop knowledge around Patient Safety further. Additional learning options will become available during 2016/2017. Train the Trainer/Master class sessions will also be available to help those directly involved in the education of patient safety discuss the subject in more depth and share educational strategies with colleagues.

Within a complex health and care system, healthcare professionals will need to draw on more than their clinical and technical skills alone. The LaMP programme has been designed by NES to help and support individuals as they develop a range of personal and professional skills and behaviours which will contribute to their effectiveness as a clinician.

The LaMP programme **www.scotlanddeanery.nhs.scot/your-development/leadership-and-management-programme/** has been designed to offer a blended learning approach which consists of two face-to-face development workshops, an online module and a workplace-based project.

NES in partnership with Scottish Government and a range of partner organisations are now working with the 6th cohort of the Scottish Clinical Leadership Fellow SCLF programme. These one-year Clinical Leadership Fellow posts are an integral aspect of NHS Scotland's approach to developing Professionalism & Excellence in the medical and dental professions. Fellows will have a bespoke opportunity to develop leadership capabilities and contribute to aspects of contemporary health- and care-related activity. The programme aims to provide NHS Scotland with a cadre of doctors and dentists who are committed to living and working in Scotland and have enhanced capability to offer leadership in their work place and potentially at national and international levels.

WHAT NEXT?

A prototype 'train-the-trainers' pack (based on NES enhanced Significant Event Analysis work) has been developed build capacity and capability across NHS Scotland. This work is also contributing to related national programmes on the Reporting and Management of Adverse Events and the Duty of Candour.

NES is developing a spiral educational framework that focuses on preparing doctors to deliver an episode of enhanced communication, specifically tailored to each instance of death and bereavement loss. It considers this from the perspective of the undergraduate, the early postgraduate, the specialist trainee and the trained practitioner. At each level domains reflect the journey of communication episodes: preparing what needs to be known ahead; delivering and recording the information given; reflecting on the professional and personal aspects of the episode; and quality assuring this aspect of care.

NHS EDUCATION SCOTLAND (NES) CONTINUED

FINAL THOUGHTS

The changing needs of the population and the continued development of new health technologies will mean that the service provided by the NHS in Scotland will change and evolve - meaning staff doing different things, in different ways, and developing new skills. Healthcare professionals will need to ensure that they continue to Realistically meet the needs of patients and their carers, whether in hospitals, at home or in the community.

NHS Education Scotland: A Problem Based Small Group Learning session in progress.

GOLDEN JUBILEE FOUNDATION

INITIAL THOUGHTS

In keeping with the principles of realistic medicine, the Golden Jubilee Foundation strives to deliver a patient-centred service which is strongly focused on the experience of care as well as good clinical outcomes. Episodes of hospital care should be kept as short and efficient as possible with minimal disruption to patients' everyday life and maximal clinical benefit. Underpinning this is an explicit effort towards reducing unnecessary variation in practice and outcomes.

WHAT HAVE WE DONE SO FAR?

We have already been very successful in reducing length of stay for lower limb arthroplasty in association with low re-admission and complication rates. We have significantly reduced length of stay and critical care bed use for our lung cancer resection patients over the past two years whilst retaining excellent outcomes.

Re-design work in cataract surgery is going at a rapid pace. We already benchmark well for efficiency with good clinical outcomes by UK standards as a result of changing working practices, logistics and enhanced optometrist roles.

We have a strong eHealth department and as well as physical outreach clinics we have for some time been offering routine follow up tele-consultations to patients from Shetland and Highland following joint replacement.

We are currently well into a systematic review of our treatment consent processes. As a result of this we have refreshed much of our patient information and added new material including patient-journey videos (accessible to patients on YouTube). The drivers for this have been supporting patients' understanding of what to expect from their care, optimising their engagement and participation towards getting the best out of their treatment, and promoting understanding of risks and side effects. In the context of shared decision making within realistic medicine, it has the potential to be developed much further to provide a resource for supporting dialogue around treatment choices and meaningful treatment outcomes.

WHAT NEXT?

The work on re-design in cataract surgery is expected to bear further fruit in the near future. We have just started piloting pre-operative tele-consultations in orthopaedics, and a further pilot is just about to commence with NHS Fife of tele-clinic assessment for 'see and treat' patients referred for assessment of suitability for cataract surgery. This last will be hugely beneficial if successful, by obviating the need for travel for those patients not progressing to operation.

We have started work on developing a clinical outcomes framework which will allow us to understand and monitor meaningful sets of clinical outcome indicators for our main specialties that are meaningful to both patients and clinicians. This is at early stage, but we are aiming to have an initial report in place for Spring 2017. This will be useful for quality-improvement, benchmarking and re-assurance, but as it develops it will become an important resource to inform shared decision making around treatment choices.

GOLDEN JUBILEE FOUNDATION CONTINUED

FINAL THOUGHTS

Our work focuses on different but interlinked areas of Realistic Medicine. The Golden Jubilee Foundation is improving and innovating in a variety of areas to provide an enhanced service for our patients.

Still from the Golden Jubilee social media videos – one of a number of videos addressing what to expect when attending the hospital. Available at **www.youtube.com/user/NHSGoldenJubilee**

NHS FIFE

INITIAL THOUGHTS

NHS Fife has welcomed Realistic Medicine. It is timely and has been well received by doctors in Fife across primary and secondary care. The six key themes resonate with our experience in the service of areas we need to improve.

WHAT HAVE WE DONE SO FAR?

In addition to the case study describing the gypsy traveller initiative, NHS Fife is focusing on using data to understand variation in treatment and investigation rates as well as in prescribing in line with the national Effective Prescribing Programme.

We have introduced a frailty team in the Emergency Department to identify people who do not require urgent hospital admission but do need rapid multidisciplinary assessment and appropriate package of care to look after them in the community. The team has already demonstrated benefit by reducing admissions since it was introduced.

WHAT NEXT?

NHS Fife has seen a significant increase in the feedback from patients and relatives through Patient Opinion and we are now preparing to engage with our communities using Patient Voice. We are promoting the Good Conversations work for all staff in order to prepare staff to discuss difficult issues in a way that enables patients to make their own decisions about care.

We acknowledge the need to improve the information provided to patients to enable genuinely informed consent to be realised in partnership with their clinicians. Ideally this should be early in a care pathway and we will consider how we support primary care clinicians to start this conversation. It will also require consideration of how we improve health literacy in our communities.

We are working to update our consent forms to ensure patients receive adequate information in a format they can understand.

FINAL THOUGHTS

We need to think about the circle of engagement when trying to undertake Realistic Medicine in practice: Listen - Engage - Do - Feedback - Listen.

Photographs of Social Prescribing community meetings at Heathery Wood Gypsy Traveller site in Fife.

NHS DUMFRIES AND GALLOWAY

INITIAL THOUGHTS

NHS Dumfries and Galloway has taken a number of different actions in order to support the progression of Realistic Medicine at a local level.

WHAT HAVE WE DONE SO FAR?

We have appointed an Associate Medical Director with a specific responsibility to progress work on Realistic Medicine locally. We have established a Clinical Effectiveness Group that will oversee the work – prioritising initiatives, monitoring progress and refining activity.

We also aim to promote Realistic Medicine through the work done by GP clusters – aiming to address variation more effectively.

The Clinical effectiveness Group and Associate Medical Director will report to our Healthcare Governance Group and we hope that there will be opportunities to share ideas and work with other health board areas.

We have already had marked success in the separate Demand Optimisation Group – noting, and then reducing Sex hormone assays, TSH testing, Vitamin B12 testing, pre-op screening and Vitamin D tests – to encourage clinicians to think more carefully about the clinical picture: blood tests done on patients where there is a reasonably clear clinical picture of a problem can make the testing more specific and more sensitive.

WHAT NEXT?

The Clinical Effectiveness group is currently developing a work plan for the first year: This will include addressing unwarranted variation in both outcomes and intervention rates, and the consent process. The group will be multidisciplinary in approach and have a number of enthusiastic opinion leaders – including physicians, surgeons, anaesthetists, pharmacists, laboratory staff, public health consultants and some senior managers.

FINAL THOUGHTS

These are a snapshot of the work currently being planned and undertaken in NHS Dumfries and Galloway.
We hope to continue with support of and progression towards the aims of Realistic Medicine.

NHS HIGHLAND

INITIAL THOUGHTS

Realistic Medicine needs exposure within the clinical environment to ensure the concepts are endorsed by the multidisciplinary team.

WHAT HAVE WE DONE SO FAR?

Awareness-raising has been key. The Realistic Medicine infographic and report was discussed in local district clinical meetings, the area clinical forum and in board committee meetings such as GP subcommittees, Area Medical committee and others. An article in NHS Highland 'Highlights' staff newspaper was published and Realistic Medicine was presented as a 'news' item on the NHS Highland intranet.

The Area Clinical Forum is an area of specific interest and it has taken responsibility for each of its subcommittees to present a work plan related to the themes of 'Realistic Medicine', for example the Area Ophthalmic committee proposes to develop and embed guidance and protocols for local optometrists regarding referral to ophthalmology. This relates to the 'reducing variation' and 'reducing waste and harm' themes. Members of the Area Clinical Forum have been asked to discuss the individual implications of work undertaken.

WHAT NEXT?

It is essential to involve the public and for 'what is realistic for me?' to become part of the philosophy taken when considering care. Implementation of the Realistic Medicine oversight group will include clinicians from a variety of specialties. Plans to embed the Realistic Medicine culture include using reminders or checklists in consultations to ask the clinician – are you working realistically? Raising awareness still needs to occur before work undertaken can be truly effective.

FINAL THOUGHTS

We need to practice 'Realistic not Nihilistic Medicine'. Realistic Medicine in NHS Highland is not about cost-saving, it is about improving the way that we all practice in order to better involve patients in care that is safe and individualised.

UNIVERSITY OF ST ANDREWS

INITIAL THOUGHTS

Implementation of Realistic Medicine will require a very clear demonstration of risk-defined practice. This will be the only way of bringing about safer, more efficient care in more centralised facilities. Patients will have to be shown clear evidence that they have a better outcome from a new way of doing things. Concern about travel time will have to be offset by improved outcomes. This will require data and its communication. It should, however, help with dealing with unwarranted variation.

WHAT HAVE WE DONE SO FAR?

As a medical School at St Andrews we have a responsibility to drive home these issues at the early stages. We have majored on introducing communication skills training early in the course and have expanded the number of staff who teach in this area.

WHAT NEXT?

We have, in partnership with the University of Dundee launched a Graduate Entry Medical Degree course to take in students in 2018. The training will be overtly in the community for this course and will instil the principles of conducting medicine in this environment with these complex patients

FINAL THOUGHTS

We should consider going beyond Realistic Medicine to 'Safe and Realistic Medicine'. Patient safety is a major issue and we need to make all healthcare encounters safer.

HEALTHCARE IMPROVEMENT SCOTLAND (HIS)

INITIAL THOUGHTS

Healthcare Improvement Scotland has welcomed Realistic Medicine and will play a key role in the Realisation of this philosophy nationwide in the coming years.

WHAT HAVE WE DONE SO FAR?

HIS engaged with Realistic Medicine early and this influenced the development of strategic planning – identifying multiple commitments towards Realistic Medicine from HIS.

HIS will emphasise the value of the wider concept and key messages for health and care professionals in our work. We will continue to support the building of QI skills' capacity and capability through our work with NES including the Scottish Quality and Safety Fellowships, the Scottish Clinical Leadership Fellowships and other developments.

Our expertise in quality control, external assessment, accreditation, audit and inspection as 'tools for improvement' cannot be understated and can be related to Realistic Medicine. We consider that the focus on 'habits of an improver' offers opportunity to ensure that all three elements of Juran's trilogy.

With the advent of Quality of Care Reviews we are actively involving doctors at all levels in the design and operation of the quality framework and the future delivery of reviews.

A number of the challenges set out in Realistic Medicine relate to clinical guidelines. These challenges are recognised and are being explored and considered by organisations including the Scottish Intercollegiate Guidelines Network (SIGN). All of our evidence programmes actively involve patients and public partners and we ensure that shared decision making is at the centre of our designing of these programmes. We produce products specifically to support the shared decision making discussions to take place and these have been amended in the light of the findings of the EU funded DECIDE project (http://www.decide-collaboration.eu).

Our work programmes around palliative care, safe use of systemic anticancer drugs, the Area Drugs and Therapeutic Committees (ADTCs) Network and other related areas aim to reduce variation, reduce harm and support decision making around risk. Our contribution via the Scottish Medicines Consortium around the clinical and cost effectiveness of new medicines in Scotland and new procedures or non-drug interventions via the Scottish Health Technologies Group (SHTG) continue to actively involve patients and the public.

Nearly all of the HIS Improvement Hub (ihub) programmes contribute to the realisation of the vision set out in Realistic Medicine specifically via the Scottish Patient Safety Programmes and support for the Scottish Quality and Safety Fellowship.

HEALTHCARE IMPROVEMENT SCOTLAND (HIS) CONTINUED

WHAT NEXT?

The potential effects of Realistic Medicine will be difficult to measure and HIS would be interested in working with Scottish Government to develop a measurement framework around Realistic Medicine. We will work to further explore the development and use of guidelines and related products in the era of Realistic Medicine in support of better informed and shared decision making.

Our new improvement programme, Effective Care Programme (ECaP), which has been heavily informed by Realistic Medicine. ECaP has been commissioned by the NHS Board Chief Executives and is designed with a primary focus on supporting the reliable implementation of agreed standards of care in segments of pathways where there is evidence of high levels of unwarranted variation that, if addressed, would improve outcomes and reduce costs. It delivers these aims through an approach that is inclusive of a focus on outcomes, a shift to shared decision making and an understanding that unwarranted variation includes delivery of interventions that individual patients would not have chosen had they been fully informed on the balance of risks versus benefit, supporting a step change in the use of data and evidence to drive improvement. ECaP offers a vehicle for studying and reducing variation, improving care and reducing cost and we are working closely with SAMD and territorial health boards to put ECaP into practice.

FINAL THOUGHTS

We see Realistic Medicine more as a thread that runs through all work to improve and change care and is constantly referenced, rather than a stand-alone concept. As a paradigm shift it should enable a focus on programmes that are already going on that fulfil its objectives and lead to re-prioritisation.

NHS LOTHIAN

INITIAL THOUGHTS

A strength of the CMO's articulation of Realistic Medicine is familiarity. At its best, Realistic Medicine describes high quality, person-centred clinical care with genuine shared, informed decision making. Hence many of our colleagues have recognised Realistic Medicine as something they are already doing and would like to do more.

WHAT HAVE WE DONE SO FAR?

A number of initiatives in NHS Lothian are directly reflective of the Realistic Medicine principles. In addition to the conservative clinic for renal disease discussed earlier, patients with Urological disease potentially requiring surgery now have an enhanced multidisciplinary admission review by medical Consultants in MOE, Anaesthetics and Urology to identify frailer patients in whom the benefits of surgery may outweigh risks. This leads to an enhanced pre-operative counselling and preparation process to facilitate shared decision making and informed consent for elective urological procedures.

Oncology MDTs are well-established forums for clinical decision making. However they are prototyping enhanced services to bring patients further into the options appraisal process before a final 'best treatment' recommendation is made by the MDT. This specifically includes discussing the benefits as well as risks of 'no' or 'minimal' treatment.

WHAT NEXT?

Care guidelines for Renal referrals are being developed including strong links with GPs including advice on asymptomatic low eGFR. The Clinical Change Forum pre-dates Realistic Medicine however the renal unit experience was recently presented there and this will continue to be developed. The oncology MDT service continues to be developed and will now expand beyond the pilot service.

FINAL THOUGHTS

In reality, patients are often more realistic than we are. It is essential to consider the care we provide in a pragmatic and holistic way - to the benefit of the people we look after.

Alistair's Story': A patient shares his story of shared decision making in his treatment at the renal conservative care clinic.

NHS LANARKSHIRE

INITIAL THOUGHTS

Realistic Medicine has been used to stimulate discussion at forums across NHS Lanarkshire. Work streams inspired by this have resulted in work starting in acute, community and primary care services. These work streams are important in achieving some tangible outcomes aligned with Realistic Medicine, but it is equally important to bring about culture change so that supporting actions become embedded in normal practice.

WHAT HAVE WE DONE SO FAR?

A 'Virtual Intelligence Group' has been established to support the commissioning of the evidence related to Realistic. The group has been tasked with scoping current key areas of work dovetailing this with other work that is being developed across Lanarkshire such as the trialling of an Ethical Peer Group, roll out of Hospital Anticipatory Care Planning and development of a Prescribing Quality & Efficiency Programme. A template has been developed for 'Realistic Medicine' projects to capture the vision and outcomes.

Key assessment criteria are:

1. Realistic Medicine Domains
2. Croydon Guiding List
3. NHS Lanarkshire Guiding Parameters

Support from Public Health, NSS and project management has been essential.

While proposed projects to improve pathways are accepted via the template, a proposal to reduce or stop an intervention must by investigated by the Board. Some work undertaken has confirmed that current pathways are working well, which is helpful to be aware of. In other areas pathways have been improved, such as improving shared decision making at the pre-assessment stage in a nurse-led group setting for people considering tonsillar surgery.

The recently published Healthcare Strategy 'Achieving Excellence' references 'Realistic Medicine' a number of times. Within the primary care section the need for a new clinical paradigm that adopts the least invasive or disruptive processes as a first step is highlighted.

HACP is also essential. HACP has been introduced for patients with long term conditions who are on an end-of-life trajectory. It is designed to make interventions appropriate given the patient's wishes, to ensure that futile and harmful treatments are avoided, and to prompt early use of palliative treatments. The approach is structured and person-centred and the overall aim is to avoid bad deaths and facilitate good ones.

This work has now progressed to implementation across the clinical areas of the Acute Division.

WHAT NEXT?

The next steps for the VIG include further development of the commissioning template, collecting additional evidence and developing a benefits matrix and performance metrics. Reports will be fed back from each hospital site.

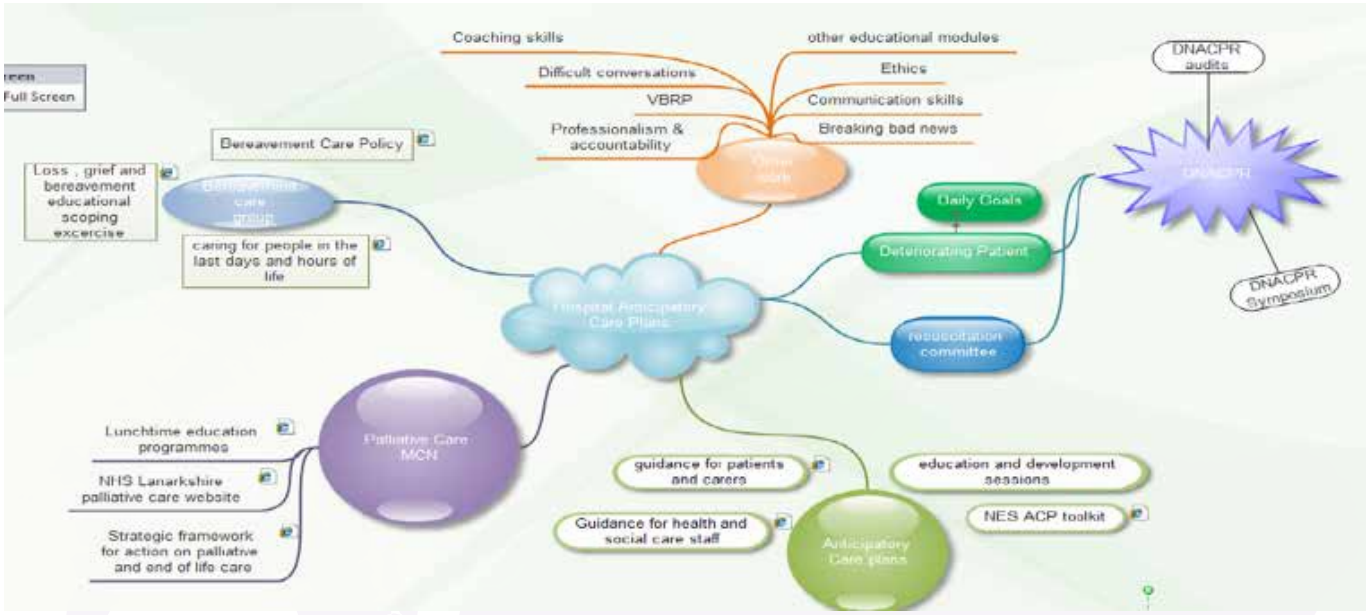
In the area of HACP, the team is now visiting sites across NHS Lanarkshire speaking with clinicians to discuss barriers and challenges to HACP. An educational video has been developed and a Learn-Pro module will be up and running in early 2017 focusing on this area. Reference material will also be available on the intranet with agreed documentation being held alongside other complementary advance directives.

NHS LANARKSHIRE CONTINUED

FINAL THOUGHTS

NHS Lanarkshire are committed to the direction of travel set out in Realistic Medicine and have used its publication as a catalyst for change in how we deliver healthcare to our population.

NHS LANARKSHIRE CONTINUED



NHS Lanarkshire Hospital Anticipatory Care Plan flow chart (Board Paper, March 2016).

NHS GRAMPIAN

INITIAL THOUGHTS

Realistic Medicine impacts on a wide variety of work being undertaken in NHS Grampian. While much of this pre-dates Realistic Medicine it is helpful to have a context to put this work within and for the recognition and support provided by Realistic Medicine.

WHAT HAVE WE DONE SO FAR?

Major work has been undertaken in the area of ENT surgery. It was highlighted that there were concerns about the levels of ENT surgery for snoring. Other departments in Scotland were reviewed along with the literature which showed there was very little evidence for snoring surgery. Based on this alternate pathways were put in place, working closely with local GPs. Patients were still seen in clinic but offered alternatives including advice. There was a significant drop in procedure numbers with no change in patient outcomes. Guidance around tonsil surgery is now being reviewed as it was noted that NHS Grampian was an outlier in this area. A new template was put in place for referrals, based on SIGN guidelines for surgery – from then on referral letters were clearer and the route to surgery for those who needed it became streamlined. The department is now taking part in a multi-centre RCT looking at tonsillectomy.

The Grampian clinical strategy can be described as the realisation of a response to a new healthcare environment. The strategy took a collaborative approach with significant patient input.

Another important project is Early Comprehensive Geriatric Assessment: When the Geriatric Assessment Unit in the ECC opened, the model of care for frail elderly people was changed to provide same-day comprehensive geriatric assessment. The key component is early identification of frailty at the front door using a simple tool developed nationally alongside colleagues from HIS, and specialist senior medical, nursing, physiotherapy and OT input at the very earliest opportunity, even in acutely unwell patients. This provides holistic and person-centred care. Evidence has shown that this novel intervention resulted in dramatic reductions in length of stay in hospital, doubled the capacity of the department to care for frail older people (despite bed reductions), reduced the number of people needing to move to care homes and provided a better patient experience than the previous, more traditional model of care.

In the area of Diabetes, 'outreach' programme has been developed by senior clinicians from the diabetes team in Grampian and Moray. Each primary care practice has been aligned to a consultant/associate specialist in diabetes who can provide advice and support as appropriate. Regular visits are now made to primary care diabetes teams who are willing to invest time into developing joint primary and secondary care outreach. About 50% of primary care diabetes teams in Grampian and Moray now receive regular visits from the multidisciplinary diabetes team. Individual cases are also discussed and management plans reviewed in a 'virtual clinic'.

This development has enabled more complex patients to be managed in primary care minimising the number of visits to secondary care and ensuring that primary care teams are supported and adequately skilled for the delivery of care.

NHS GRAMPIAN CONTINUED

WHAT NEXT?

In the area of ENT, it has been noted that there is also conflicting evidence around the benefit for nasal septal surgery and a literature is planned to investigate this further to establish if a more patient-centred pathway could be put in place.

The projects described above continue to undergo evaluation and improvement. A further proposed project in Acute Psychology addresses Realistic Medicine with the implementation of Shared Decision Making alongside psychological assessment with some specialties. Acute Psychology will be working with ENT, cardio-thoracic and with HPB cancer surgeons to develop processes which help ensure that patients are more fully involved in decisions and unwanted elective surgery is not undertaken. In addition, psychological assessment will be provided in cases where surgeons are unsure whether psychological factors underpin patient requests for surgery and surgery may not be the best solution.

In Rheumatology, a psychologist (and assistant psychologist) have been working within the department to help reshape the patient pathway to ensure that medical consultant reviews can be most effectively employed and time is not wasted in seeing patients who require self-management or psychological support. Patients are offered psychological assessment/treatment and a self-management group will be rolled out. In addition, other resources are being developed including appropriate signposting for community interventions.

FINAL THOUGHTS

Patient reported outcome measures mean having Realistic Conversations about healthcare - we need to listen to our patients in order to practice realistically.

NHS BORDERS

INITIAL THOUGHTS

Realistic Medicine is at the forefront of clinical leaders' minds in NHS Borders. Patient and public engagement will be key in achieving the aims of Realistic Medicine

WHAT HAVE WE DONE SO FAR?

Sessions have been undertaken with ISD and Discovery looking at helping the Health Board deal with variation.

Realistic Medicine was featured in the NHS Borders Annual Review and discussed in a forum which was well-received. It was also taken to the Borders Carers Voice, which is an overarching body for the third sector. Information was shared and this will continue.

The Clinical Leads group set up three collaborative sessions involving clinical leaders to discuss quality and efficiency in the context of Realistic Medicine. Leads all discussed what they were going to look at around variation in individual departments.

There are now monthly meetings chaired by the Medical Director where a template report to the Director explicitly includes Realistic Medicine and so it has become part of the usual order of business.

The Quality Improvement programme has also become more closely linked with Realistic Medicine, linking Human Resources and Finance staff with QI opportunities in order to use different skills and ideas. Realistic Medicine is a 'hook' which can help build relationships in the system and provide a structure with which to look at variation.

WHAT NEXT?

An 'empowering poster' has been developed and will be displayed. It includes questions for patients to be encouraged to ask their doctor. It will be displayed in waiting areas and used to encourage dialogue from the patient perspective. This will be aligned with themes from Realistic Medicine and Choosing Wisely and further literature will also be aimed at junior doctors and students, empowering them to approach seniors and ask about tests, management, etc.

FINAL THOUGHTS

A trusting and supportive Health Board is essential to allow clinicians to not only practice Realistic Medicine, but produce innovations related to it and undertake novel improvement projects.

Head of Service Report

Name Date

Name of Service

What are you most proud of since last report?

Realistic Medicine

What, by when?

Next project headlines (teams should look at two areas of variation per year)

Shared care and decision making with patients – how are you progressing this? Eg, using Patient Opinion

Job Planning in year Progress 2016/17

No of Cons/SDs	JPs completed	No. in progress	Not started

Is (he/she/trainee identified in JPs for trainee supervision?

Values and Team Culture

What have you been doing since your last report to support your team?

What is your trainees' experience of your service? How do you know?

Anything you want the group's help with?

NHS Borders Template report for monthly meetings with Medical Director.

Realistic Medicine poster for display in waiting areas in NHS Borders.

STATE HOSPITALS BOARD FOR SCOTLAND

INITIAL THOUGHTS

The State Hospital's function working with mentally disordered offenders is specific, but many of the physical as well as mental health issues related to geographical health boards are relevant to the State Hospital and Realistic Medicine is an important document in considering the future for care of patients in the State Hospital.

WHAT HAVE WE DONE SO FAR?

The Forensic Network has been crucial in improving the care of patients within Forensic services. The network was built on research that pre-dated Realistic Medicine but echoes its themes.

At present, all patients in the State Hospital are invited to attend their Care Programme Approach review alongside an advocate – with the aim of sharing the decision making process with patients and their carers as far as possible.

Monitoring variation in practice is also a core part of ongoing work. An annual census was established in 2013 to gather information about all forensic inpatients across Scotland. This was developed into a Network database, thereby allowing units to access their own data and compare reports with different areas. Every new patient coming into the system will now be logged into the database. Units will be able to see their own patient data and the national host will be able to see all data. This will go live in early 2017 with catch-up work to collect data on all patients.

The most recent Forensic Network annual report describes improvement work in depth. An integration group with joint guidance has been developed and a matrix to allow spread implemented. Guidance from Healthcare Improvement Scotland has been sought in the area of Quality Improvement, and this has resulted in self-generated improvement plans. A conference was then held looking at new improvement ideas and a further Quality Improvement cycle is underway.

Education is also important given the nature of the work in the State Hospital: staff must be able to work on a multidisciplinary basis and a Scotland-Wide training scheme in Forensic Psychiatry has been created to foster these links, hosted by the State Hospital. This enhances clinicans' ability to provide truly individual care.

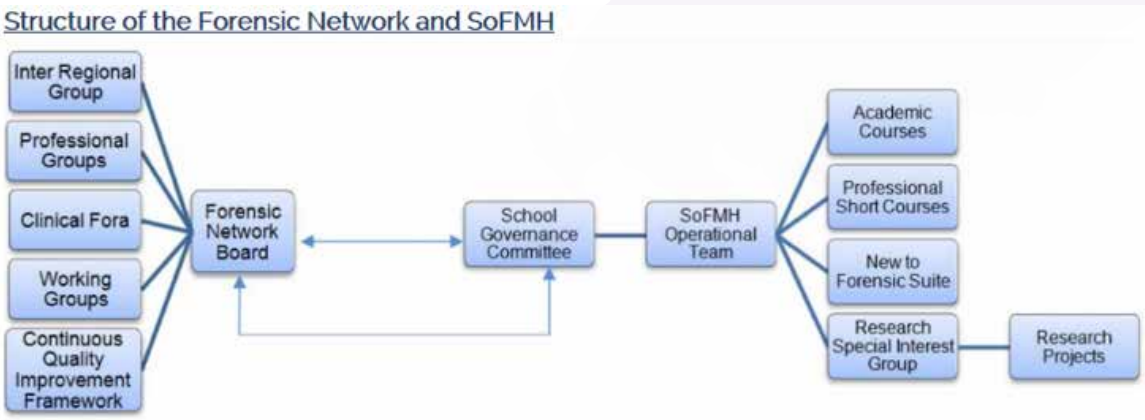
WHAT NEXT?

The annual census is important to continue developing. This means that shared learning about issues such as length of stay and risk management can go ahead. As mentioned, the patient database will be key in allowing this work.

A joint referral and admission criteria is being developed: this will provide a structure that allows variation at the point of admission to be researched and addressed.

FINAL THOUGHTS

The State Hospitals Board for Scotland is closely interlinked with the Forensic Network, and this provides a mechanism though which to tackle issues and to communicate. It also helps remove territorial barriers with an emphasis on improving care through networking and education with a person-centred focus.



The State Hospital: Structure of the Forensic Network in Scotland.

SCOTTISH AMBULANCE SERVICE

INITIAL THOUGHTS

The Scottish Ambulance Service (SAS) is supportive of Realistic Medicine. It has a number of programmes underway that support its principles and will continue to look at ways to deliver its services to the people who need it with shared decision making and risk management.

WHAT HAVE WE DONE SO FAR?

Specialist paramedics have an enhanced set of skills in line with the Scottish Government's 2020 vision to keep people away from hospital settings. They have different referral rights – which means they can send patients to urology, surgery, neurology etc. as appropriate and not just general admission at A and E. Treatment at home or anticipatory care planning with the patient is an option that is becoming more available. SAS is developing from a transport service to a service that can provide different responses to reflect the situation. Specialist paramedics are being trained to postgrad level to ensure they have the enhanced clinical skills necessary to safely manage risk. SAS is working with locality hubs including around falls pathways to provide an effective service for frail elderly people in the community. The Active Independent Living Improvement Programme is national strategy that ties in with Realistic Medicine. SAS provides data to create reports for areas of practice. This allows a mapped landscape of Scotland which can be analysed to see where there is variation in addressing falls in area.

The SAS is also undertaking a deep dive – looking at falls on a case by case basis to map variations. Management of risk has also been strengthened by staff not on active duties engaging and improving the response of hospitals and falls co-ordinators.

The COPD falls pathway which was set up in 2012 is also managing risk appropriately – a team of community respiratory physiotherapists are now in place with seven-day referrals from GPs/district nurses/SAS with an EH postcode or General Practitioner. This initiative has ensured 400 regular hospital attendees – patients with two or more hospital admissions in a year – are now being more often treated at home.

The personalised approach is being extended to direct mental health with an initiative in Edinburgh, East and Mid Lothian where a Community Physciatric Nurse can provide assisting with assessment via telephone and arrange for patients to then be followed up in the community or at Royal Edinburgh hospital if required.

The SAS is also responding to cardiac arrests with the fire service which is proving a real success in first responder rates. The FLOW model is also trying to streamline scheduled care patients and low acuity unscheduled transport so that SAS can send the most appropriate kinds of vehicles – cars not ambulances where this is appropriate.

WHAT NEXT?

The SAS is continuing to look at how it can improve its shared decision making with the patients its sees and how it can manage the risk appropriately to avoid harm and waste and keep people out of hospital settings where they can. Falls co-ordinators are being recruited and the data will be used to train the workstream, and educate staff around falls referrals. It is also looking at variation and data to see where it can improve services and looking at working collaboratively in a number of initiatives to improve and innovate.

SCOTTISH AMBULANCE SERVICE CONTINUED

FINAL THOUGHTS

Many of the SAS initiatives predate the launch of the Realistic Medicine framework, however this strengthens the resolve of SAS to continue to act within its principles. SAS looks forward to realising Realistic Medicine with the support of CMO and other health and care professionals and is delighted to share its knowledge to help others from other fields.

Paramedics in NHS Lothian.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78652-677-9 (web only)

Published by The Scottish Government, February 2017

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS63778 (02/17)