

## **GMC's Response to the Department of Health's Consultation on Liberating the NHS: Greater Choice and Control**

This letter responds to a number of the questions raised in the consultation document. The GMC is the statutory regulator, and does not therefore represent the views of either patients or doctors, nor do we have first-hand operational knowledge or experience.

Nonetheless, in developing guidance and dealing with patients' concerns we engage with doctors, other health professionals, managers, educators, patients and the public, which gives us a broad understanding of the issues and concerns of those providing and using NHS services. The comments that follow reflect our published guidance in *Good Medical Practice*; *Consent: patients and doctors making decisions together*; and *Treatment and Care Towards the End of Life: Good Practice in Decision Making*

### **Q1. How should people have greater choice and control over their care? How can we make this as personalised as possible?**

The strong focus on patient choice and involvement in decisions about their care is strongly aligned with the obligations we place on doctors, through our guidance on good practice. We support and promote a partnership approach to decision making while encouraging doctors to support those patients who wish to play a greater part in maintaining and improving their own health.

This needs to be supported by:

- Better quality and more accessible information about: NHS services; effective treatments; local health & social care services; legal rights (the MCA, NHS constitution etc); and in individual cases - clarity about the factors that go to deciding what treatment & care is appropriate & what is available on the NHS or through sources.
- Adequate resources & training: to meet the information & service needs of individual patients & carers, and the needs of commissioners & quality/safety organisations.

**Q2. Which services should be priorities for introducing choice of 'any willing provider'?**

This should be based on existing evidence of greatest need or important gaps in services. For example, we know there are health inequalities affecting certain communities or patient groups; that problems around end of life care generate the highest percentage of NHS complaints; that mental health services struggle to meet even urgent/acute needs.

**Q4. What would help more people have more choice over where they are referred?**

Some patients need more accessible information and better advocacy e.g. patients/carers with learning disability. Services need to be better adapted to meet their needs and healthcare professionals need access to resources & training that help them to be better able to recognise and respond to need.

**Q13. What choices are most important to people as they approach the end of their lives? What would best help to meet these?**

**Q14. We need to strengthen EOLC services. How can we best enable this?**

The work that underpinned the EOLC national strategy provided good evidence. Our own public consultation in 2009 reinforced those findings: increased availability of palliative care (especially in community settings, in particular more effective pain & symptom management); up to date evidence/research on treatments/therapies; more/better public information about the issues around death & dying.

The challenge is to achieve effective implementation of the strategy. Providing needs coordination and continuity of services may be difficult in the 'any willing provider' local health & social care economy. It is also unclear how the new commissioning process will support training for doctors and other healthcare professionals to support the EOLC strategy.

**Q22 and Q24. What should we do first, to ensure shared decision making becomes the norm? What advice would help healthcare professionals to ensure everyone can make choices?**

Doctors and other health care professionals already have a professional duty to work in this way with patients & carers, for example our guidance in *Good Medical Practice* and *Consent, Treatment and care towards the end of life* are based on the idea of partnerships between doctors and patients, where both have an integral, but separate roles, in the decision-making process. Where clinical governance and other local systems identify examples of poor practice, there should be local means to help deliver improvements.

More training and examples of good practice in overcoming communication difficulties with patients with learning disabilities, or with conditions such as dementia, would help health professionals work confidently to maximise patients' capacity and empower them to make decisions about their lives and care.

**Q23. Should healthcare professionals support the choices their patients make, even if they disagree with them?**

Generally, doctors should support patients' choices. We advise doctors that, having discussed the patient's condition and listened and understood the patient's feelings and needs, doctors should offer patients the options which are clinically appropriate. Doctors must in this situation respect the patient's choice. However, we do not require doctors to provide treatments which a patient requests, if the doctor judges the treatment to be of no benefit or harmful to the patient. In addition, situations may arise where a patient seeks a treatment to which the doctor has 'conscientious objection'. The doctor should explain his or her position and that the patient has a right to see another doctor. Further advice about conscientious objection is included in our guidance '*Personal beliefs in medical practice*'.

**Q25. How can we encourage more people to engage in advance care planning about their preferences for support and care?**

Patients needing to consider advance care planning generally need a series of interactions with health professionals before they are able to accept the situation and consider the own preferences and needs. Health care professionals need to be skilled in listening, questioning, explaining, and providing good information for patients and their carers.

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