

General
Medical
Council

Education Advisory Forum - 5 December 2019

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Education Advisory Forum
Thursday 5 December 2019
10:00-13:00
Meeting Room 2.07/2.08
350 Euston Road
London NW1 3JN

Agenda

Meeting

- 1** Chair's business and minutes of the meeting on 7 May 2019
- 2** Working together: our plans for 2020
- 3** Decision making and consent: implementing the guidance
- 4** Regulation of Medical Associate Professions (Physician associates and Anaesthesia associates)
- 5** 2020 forward work programme planning
- 6** Any other business and date of the next meeting: Thursday 6 February 2020

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7 May 2019

Education Advisory Forum

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Draft at 20 May 2019

Minutes of the Meeting on 7 May 2019

Members present

Colin Melville, Chair

Keith Gardiner (by video conference)
Mark Gurnell
Sarah Hallett
Stewart Irvine
Catherine Knight
Sheona MacLeod
Pushpinder Mangat (by video conference)

Malcolm Reed
Lisa Smith (by video conference)
Russell Smith
Ann Trotter

Others present

Clare Barton, Assistant Director -
Registration and Applications: UK
Sue Carr, Deputy Medical Director
Judith Chrystie, Assistant Director -
Medical Licensing Assessment
Mark Dexter, Head of Strategic Policy
Development
Jenny Duncan (by telephone)
Jane Durkin, Assistant Director –
Registration and Contact Centre
Katherine Lang, Assessment Design,
Development and Policy Manager

Faye Orford, Corporate Governance
Manager, (Forum Secretary from next
meeting)
Paula Robblee, Policy Manager,
Education
Kirstyn Shaw, Assistant Director - Policy,
Information and Change
Melanie Wilson, Head of Corporate
Governance and interim Forum Secretary
Natalie Pattinson, Registration
Investigation Manager (observer)

Chair’s business

- 1 The Chair welcomed members to the second meeting of the Education Advisory Forum.
- 2 Apologies for absence were noted from Gareth Griffiths, Clare McKenzie, Julian Hancock and Stephanie Jordan.

Medical Licensing Assessment (MLA)

- 3 The Forum received an update on progress across the MLA programme, sharing feedback received and discussions to date.
- 4 The Forum was informed that a survey exercise has recently been launched to gather views on the first full draft of the MLA content map. They received a presentation on the project to develop materials to support
- 5 The Forum was asked, as an exercise separate to the survey responses, to provide feedback on the *relative* importance of each of the 23 clinical and professional capabilities listed, recognising that each was objectively important and that each will depend up the clinical governance arrangements in the local context. The Forum was reminded that this is only part of the assessment of medical students and does not represent the entirety of the medical degree.
- 6 During discussion the Forum noted:
 - a That it was important to consider not only how important a capability is, but also how feasible it would be to assess the capability.
 - b That whilst there were some differences in absolute scores, overall the group came to a consensus on the ranking of each of the 23 capabilities which will provide a helpful steer in the further development of the MLA.
 - c That students are naturally anxious about the content of new assessments, and the Forum asked that practice papers are made available as soon as possible to allay anxieties and to provide as much transparency and specificity about the tests as possible, in the context of a fair and rigorous process.
- 7 It was confirmed that following further consultation, a decision will be taken by Council at its June meeting. The Chair of the Forum recognised that everyone involved has a genuine desire to come up with workable solutions and to avoid ambiguity for students.

Credentialing and Flexibility

- 8** The Forum received a presentation to highlight progress made in the current work stream to improve the flexibility of UK postgraduate medical training, subject to appropriate safeguards.
- 9** During discussion, the Forum noted that:
 - a** Formal feedback to key stakeholders will be provided once discussions, such as today’s, are concluded. It was noted that current trainees welcome the approach, which they see as increasing their autonomy over their working lives.
 - b** The GMC has received legal advice to clarify its scope to approve training, which by and large should be prospective approval. It appears possible to approve training retrospectively but this requires further exploration to ensure quality of training, patient safety and workforce issues are considered. This will be particularly important to specialty and associate specialist posts which in some areas (notably Wales) make up a significant portion of the permanent staff of a hospital
 - c** The NHS has responded to workforce challenges by creating new roles which directly attract trainees and are outside of the deanery programmes. The new posts are attractive but may destabilise the training landscape in harder to recruit areas.
- 10** The Forum then received a presentation to set out the GMC’s work to date on the introduction of GMC-regulated credentials, which had been discussed at the Council meeting in April and would be approved at the meeting in June. During the discussion, the Forum noted that:
 - a** Other bodies are already developing credentials, and the GMC is working to ensure that there is good communication to ensure that we are clear about what we are doing and what we are not doing in this area. It is not in the GMC’s interests to prevent others from developing good training, but the messaging is important.
 - b** It will be important to ensure patients are aware of the status and purpose of GMC-regulated credentials.
 - c** Other professional groups may be able to undertake the skills associated with a credential but GMC-regulated credentials will be restricted to doctors. There is no intention to prevent access to credentials for trainees but they will not be a requirement for obtaining specialist registration.

- d** The GMC is still seeking clarity from other organisations on the mechanisms for funding credentials.

CESR/CEGPR Update

- 11** Given its link to the previous item, the Forum received an item of ‘Any other Business’ at this point in the meeting, in relation to the work underway to streamline the process of overseas doctors receiving a certificate of eligibility for specialist registration or GP registration (CESR/CEGPR), following the recommendations of the Lord Patel Review in 2010.
- 12** The Forum noted the current challenges with the process, and the need for legislative change to make significant improvements to the process. Whilst these changes are awaited, the Forum was informed about the efforts to streamline the evidence process bearing in mind the need to respond to workforce pressures but to maintain standards for entrance to the specialist registers.
- 13** During the discussion, the Forum noted that:
 - a** There is considerable interest and support for improving the current system, which is felt to be burdensome.
 - b** There is a lack of understanding amongst medical students of the differing routes to accreditation and ensuring clear communication about how this landscape fits together would be beneficial to all stakeholders.

SAS doctors survey

- 14** The Forum received an update on the GMC’s intention to undertake a survey of specialty and associate specialist (SAS) and locally employed (LE) doctors. It was recognised that this is a diverse group about which the GMC holds little intelligence from a central perspective. The GMC has no statutory powers in relation to the training of this group but there is a sense that a better understanding of their experience will help inform policy and direction for the GMC.
- 15** The Forum noted that:
 - a** This is not a homogenous group of doctors.
 - b** The route for addressing any issues arising from the survey must be considered carefully in order to protect individuals. It may be that such issues could be corroborated via the National Training Survey, and it is likely that postgraduate deans would be interested in the findings but that ultimately the responsibility to

address issues would lie with individual trust/health boards. This will need to be reviewed on a case by case basis.

- c** Health Education and Improvement Wales have recently undertaken a listening exercise with SAS doctors who raised issues in relation to SPA time, job planning, IT and secretarial support.
- d** Matters relating to equality, diversity and inclusion must be identified through the survey and may have far-reaching implications for employers of this staff group.

2019 Work Programme

- 16** The Chair briefly set out the current business plan commitments of the Forum, against the GMC’s corporate strategy, to highlight areas where advice will be sought.
- 17** The Forum’s members were asked to consider sharing matters that they are developing that may have a wider impact or relevance to those in attendance and to consider including them on the Forum’s agenda.
- 18** The Forum noted the business plan.

Any other business and date of the next meeting

- 19** The Forum noted the date and time of its next meeting at 10:00 on Wednesday 11 September 2019

Confirmed:

Colin Melville, Chair

11 September 2019

Agenda item:	3
Report title:	Decision making and consent: implementing the guidance
Report by:	Cathy Finnegan Policy Manager, Education and Standards, cathy.finnegan@gmc-uk.org , 020 7189 5154 Faye Cranfield , Policy Manager, Education and Standards faye.cranfield@gmc-uk.org , 0161 250 6953
Action:	To consider

Executive summary

This paper sets out our plans to publish our updated guidance *Decision making and consent*. It explains the main changes to the guidance and how we are planning to help doctors put it into practice.

Recommendation

- a** We would like the Forum to consider where we can have the greatest impact in supporting trainers, postgraduate trainees and medical students, to help embed the principles in the revised guidance through education and training.

New guidance on decision making and consent

- 1** In early 2020 we are planning to publish *Decision making and consent*, an updated version of our current consent guidance, which was published in 2008. The guidance will come into effect three months after the publication date.
- 2** We consulted on a draft of the guidance between October 2018 and January 2019, and since then have been working to finalise it. Our Council approved it for publication at its meeting in November.
- 3** We were clear from the beginning of the review that we didn't expect the fundamental principles underpinning the guidance to change, and this proved to be the case. However, doctors' reactions to the Supreme Court judgment in the Montgomery case in 2015 indicated that there was a lower level of awareness and understanding of the guidance than we had realised.
- 4** Of course, consent is already central to medical education and training and there is a lot of good practice already happening. But we also know also that sometimes the core spirit of the guidance – doctors and patients working in partnership to make decisions together – can be diluted or misunderstood. And there can be practical challenges and pressures in the environments in which medical students and doctors in training are learning and working. So how we raise awareness of the guidance and support doctors to teach and practise in line with it will have major implications for how effective it is.

Main changes

- 5** There is a stronger focus on dialogue as being central to the consent process, with advice about how to find out what matters to patients so that the discussion can be tailored to their needs and priorities.
- 6** The guidance also acknowledges the pressures that doctors are under with new paragraphs about time and resource constraints and support from other members of the healthcare team.
- 7** We've also made clear that not every paragraph will be relevant to every decision, and that the guidance should be applied in proportion to the complexity and potential impact of the decision. We'll produce an infographic to help doctors navigate the guidance for decisions of varying complexity and urgency.
- 8** We've clarified guidance around delegation and responsibility. Parts of the process (e.g. exchanging information) may be delegated, but it's the responsibility of the doctor who'll be providing the treatment to make sure the patient has been given the information they need to make a decision. We've added paragraphs to make clear

what doctors should do if they are asked to have discussions with or seek consent from a patient where they feel they are not competent to do so. And just as importantly, what doctors should do if someone to whom they've delegated raises concerns about their own competence.

Putting the guidance into practice

- 9** We've used data from a range of sources to explore the practical challenges that doctors can face, and to identify groups that face particular challenges. We aim to use this information to tailor our messages and to prioritise our activities.
- 10** We've used this to develop a plan, taking into account the following:
 - The barriers to and enablers of good practice at different levels (individual, organisation and system).
 - Our position within the system, including how we can work with others to most effectively influence practice and ensure consistency of messages.
 - Evidence about particular challenges in practice.
 - How we might evaluate any interventions to learn from them and improve our future implementation work.
- 11** This is a new approach. In the past we've focused our attention mainly on individual doctors. While individual doctors remain a key audience for promotion, we've also thought more about the levers we can use to influence change. To this end, we have identified and begun conversations with external stakeholders across the UK to explore how they can help us land messages and influence behaviour change. For example, we're working with NHS England and The Scottish Government to make the connection between our guidance and the work in the wider system to support patient centred care and shared decision making. And we're working with colleagues in Belfast and Cardiff to engage with the Department of Health NI and the Academy of Medical Royal Colleges Wales.
- 12** We're also planning to engage senior medical leaders, who we recognise play an important role locally in enabling and promoting good practice. In October we ran interactive sessions with responsible officers through the RO reference group to understand how best to engage them in implementing the guidance. We're also planning to make contact with medical directors about the guidance and we're exploring the best ways of doing this in each of the four countries.

How the Education Advisory Forum can help

- 13** We would like to explore with you what we can do to help trainers, medical students and trainees to teach, understand and practice in line with our new guidance. We would greatly value your thoughts and suggestions about ways in which we can help to further embed an understanding of the guidance in medical education and training.
- 14** While our specific focus is now on the *Decision making and consent* guidance, we would also like to use what we learn from implementing this piece of guidance to inform our future work in other areas.

General Medical Council

Regulation of Medical Associate Professions

(Physician associates and Anaesthesia
associates)

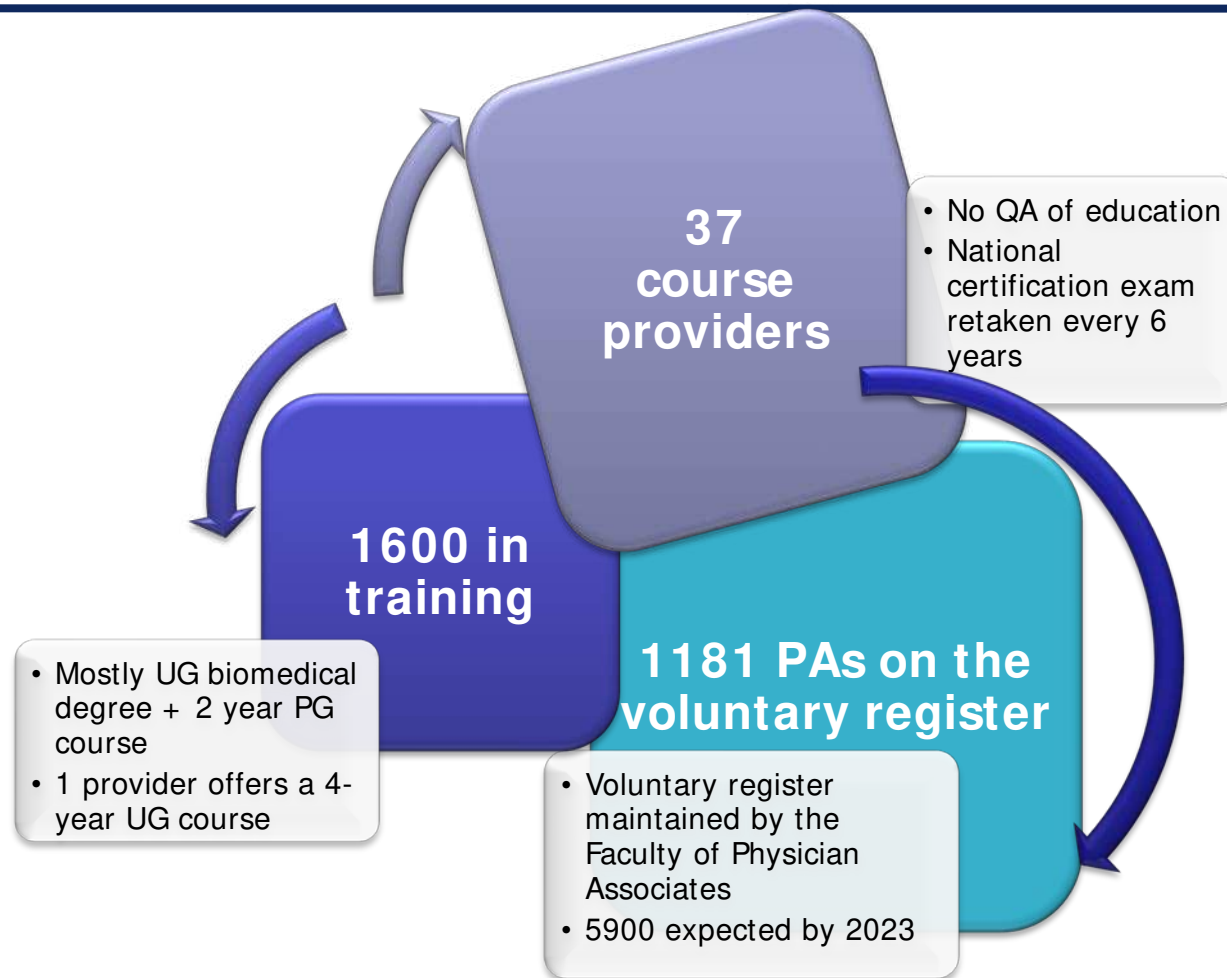
Helen Arrowsmith – Programme Manager

Working with doctors Working for patients

What do Physician associates do

- Medically trained, generalist healthcare professionals, who work alongside doctors and provide medical care as part of the multidisciplinary team
- Work within a defined scope of practice and limits of competence
- Currently unable to prescribe or request ionising radiation

PAs



What do Anaesthesia associates* do

- Work within an anaesthetic team under the direction and supervision of a consultant anaesthetist

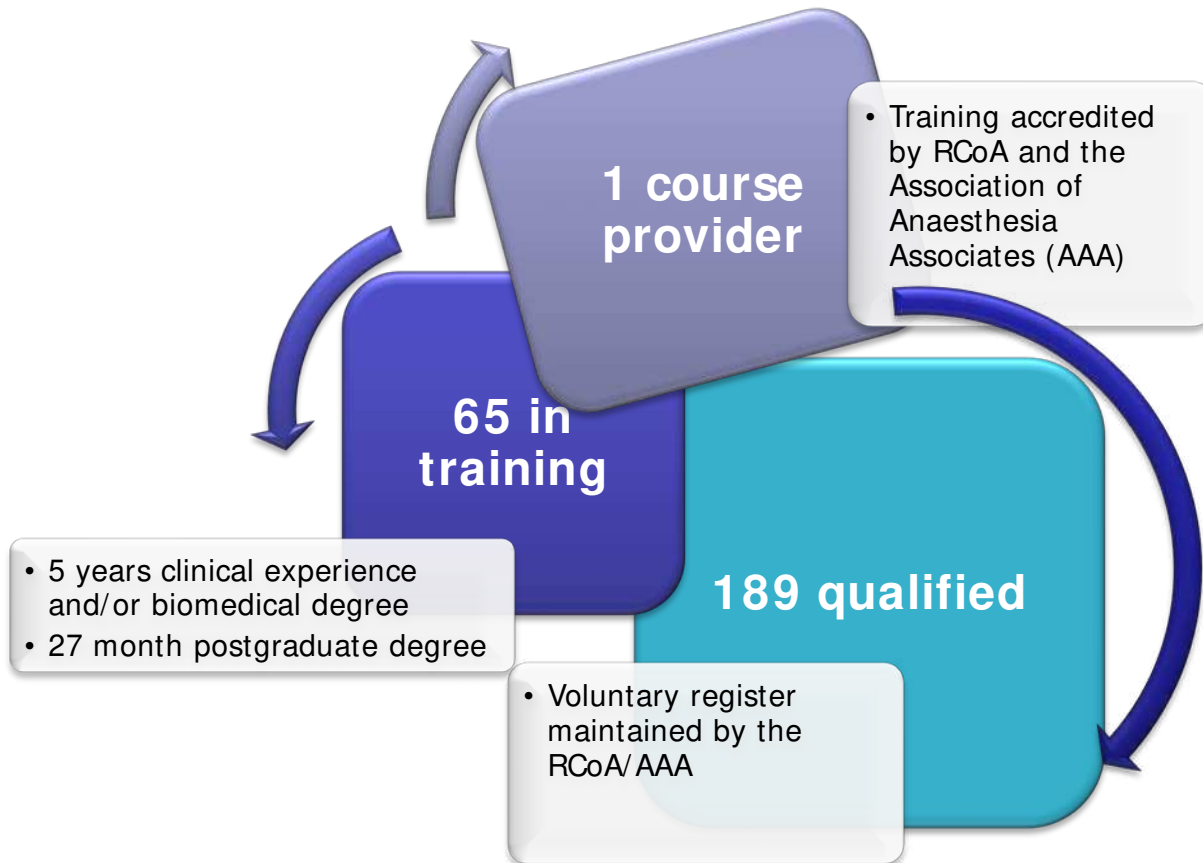
- Various duties including:
 - Pre and post-operative assessment and care

 - Maintenance anaesthesia

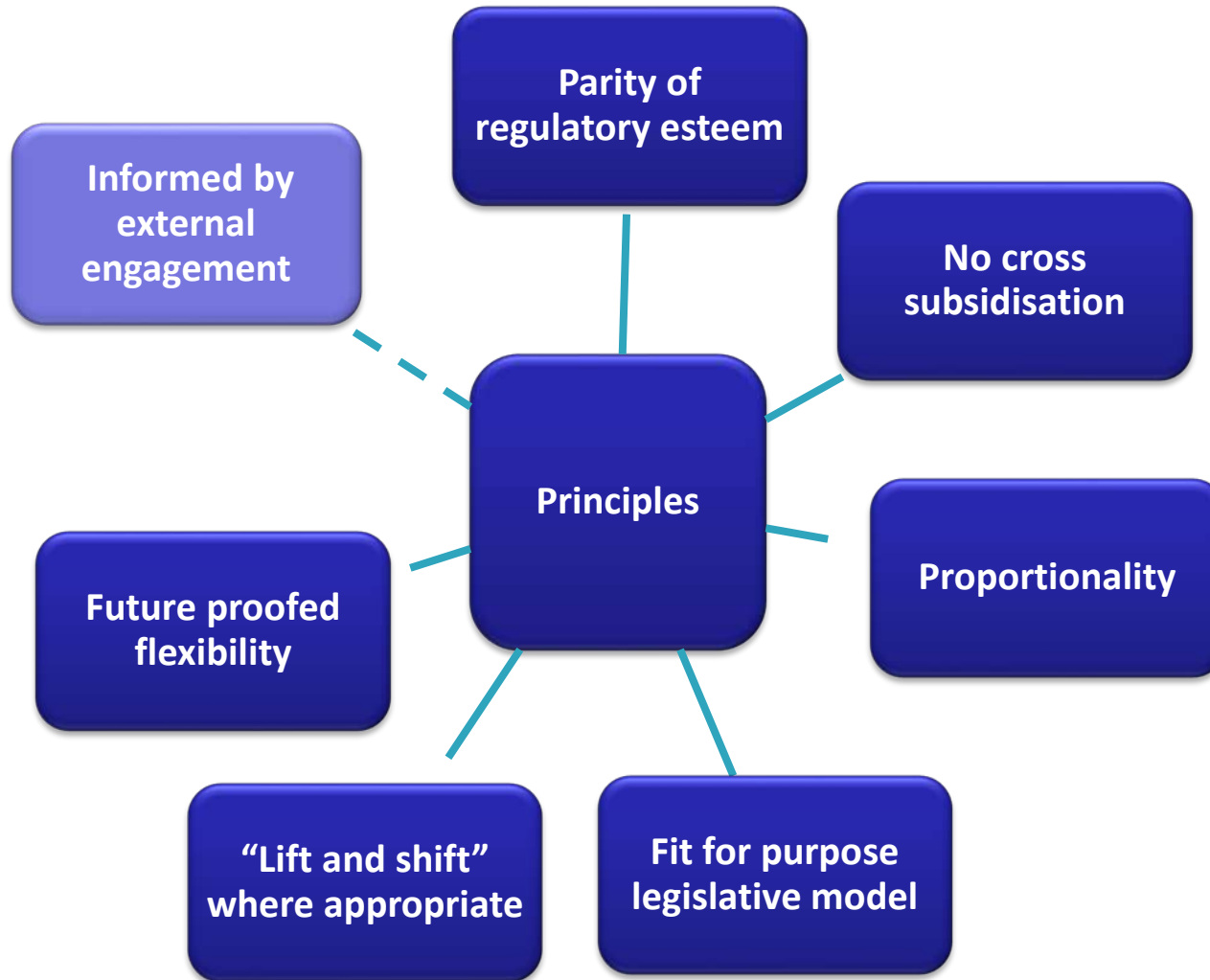
 - Induction and emergence from anaesthesia (under direct supervision)

*Physician Associates (Anaesthesia) in Scotland

AAs



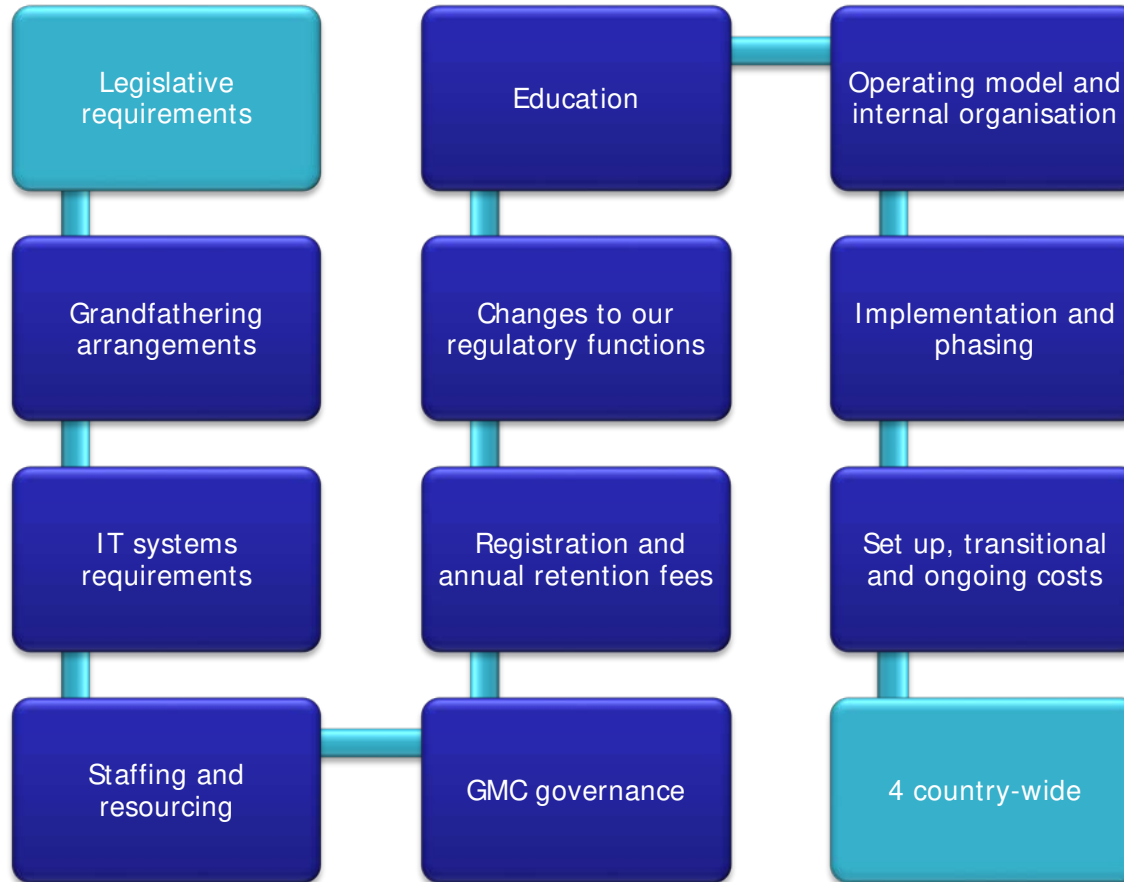
Principles governing our regulatory approach



Scoping: the next 3-4 months

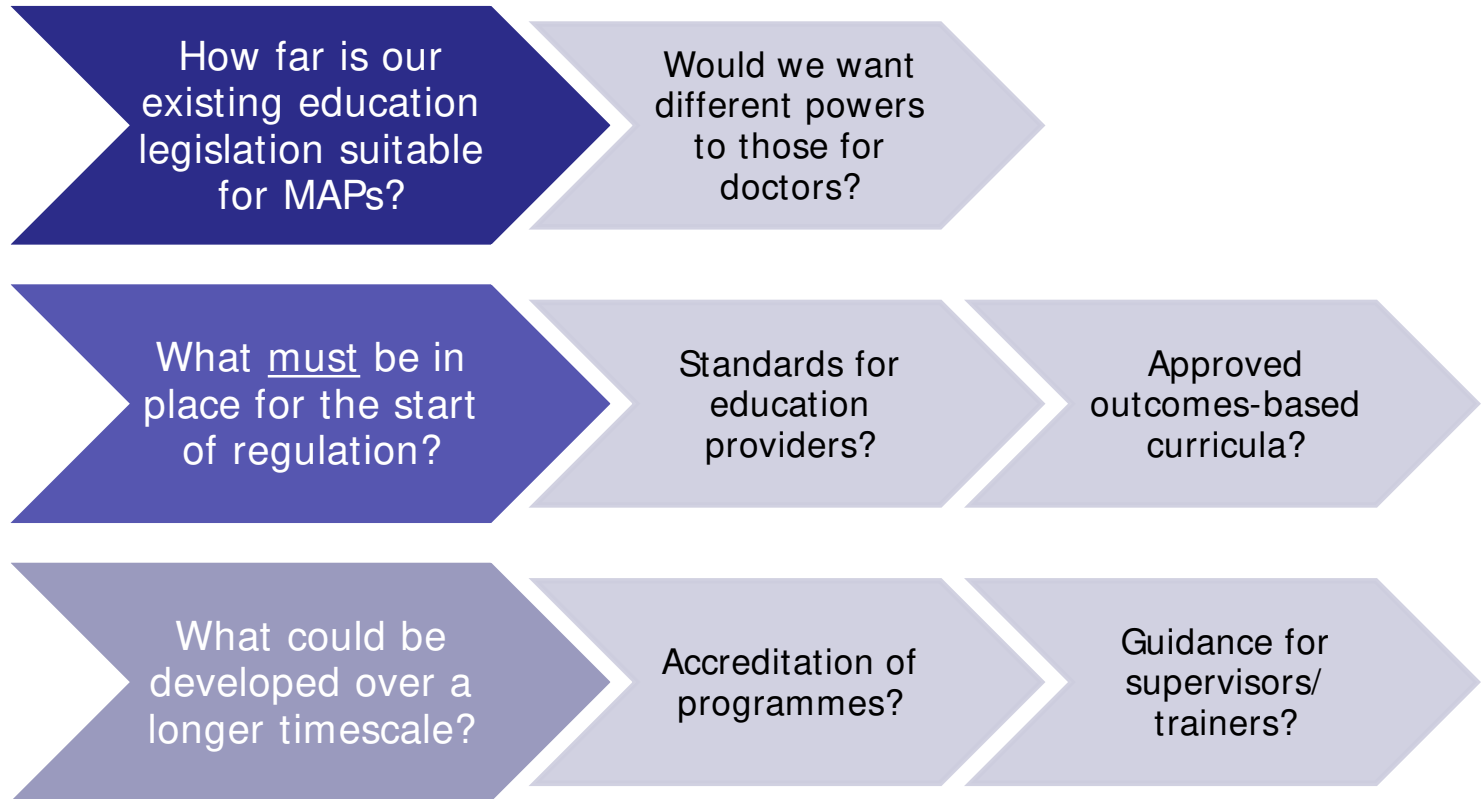


Development and Implementation: by 2021?



18 – 24 months
[Subject to legislation]

Key issues and questions for discussion



What else should we be considering?
