

UK Advisory Forums – Wales

28 March 2018

13:30 - 16:00

GMC Wales office

4th Floor

Caspian 2

Caspian Way

CF10 4DQ

Agenda

Welcome and Chair's introduction

Review of actions from previous meeting

Medical workforce, quality and safety

1. Relationship between the profession and the regulator
2. Doctor mental health and wellbeing

Systems and collective assurance

3. Patient safety starts with us: working together to achieve our vision

Upstream regulation: preventing harm and supporting professionalism

4. Patients and doctors making decisions together

Review of actions and AOB

Close

Agenda item:	1
Title:	The relationship between the profession and the regulator
Action:	To discuss

Executive summary

- As a regulator the GMC needs to be proportionate in the actions we take to protect patients and safeguard medical education, while retaining the trust and confidence of the public and the profession. The challenge in balancing these aims has been brought into sharp focus by the recent response to the High Court decision in the case of Dr Bawa-Garba.
- The attached letter to Cabinet Secretary Vaughan Gething describes the programme of work we are planning to enable us to spend more time and resources on supporting doctors to prevent things from going wrong.
- This includes new work we are leading such as looking at the application of gross negligence manslaughter to medical practice across the UK, and also key areas of work which were already described in our new corporate strategy which will now be given enhanced priority such as co-producing our guidance on reflective practice and reviewing the effectiveness of processes for raising concerns.

Recommendations:

- a That Forum members have an opportunity to consider and discuss the content of the letter and any other issues relating to the relationship between the profession and the regulator.
- b That Forum member advise the GMC on how best to take forward this programme of work in Wales.
- c That this discussion informs the interactive session about the new corporate strategy.

Friday 23 February 2018

Regent's Place
350 Euston Road
London NW1 3JN

Vaughan Gething AM
Cabinet Secretary for Health and Social Services
5th Floor, Tŷ Hywel
Cardiff Bay
CF99 1NA

Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: 0161 923 6602

Chair
Professor Terence Stephenson

Chief Executive and Registrar
Charlie Massey

Dear Vaughan,

An ambition for change

I wanted to write to you ahead of the launch of the GMC's new corporate strategy. Against the backdrop of a healthcare system that is under intense pressure, we want to make sure that doctors are supported by regulation that eases rather than adds to the pressures of the systems they work within.

As a regulator we need to be proportionate in the actions we take to protect patients and safeguard medical education, while retaining the trust and confidence of the public and the profession. The challenge in balancing these aims has been brought into sharp focus by the recent response to the High Court decision in the case of Dr Bawa-Garba. I know and understand the anxiety from many in the medical community about the potential implications of this case. It has undoubtedly set the GMC back in our desire to promote medical professionalism and a learning culture as the best way to protect patient safety, and I recognise that we have more to do to get us back on track. While not all of the concerns have been grounded in fact, it is also clear that the case has acted as a lightning rod for wider concerns about the NHS. The anxiety doctors feel around being supported is very real and we need to play our part in addressing those concerns.

In addition to the review that Sir Norman Williams will lead on gross negligence manslaughter, we have convened a programme of work to look at the application of gross negligence manslaughter (and in Scotland, culpable homicide) to medical practice across the UK. I am delighted that Dame Clare Marx has agreed to lead this work for us, with the aim to report her conclusions by the end of the year.

This recent experience has reinforced for us the importance of the approach we are taking in our new strategy. That is why our plan for the next three years will see us spending more time and resources on supporting doctors to prevent things from going wrong, in addition to our important role in investigating where harm has come to patients or serious concerns have been raised. We also have ambitious plans to use our data more effectively to anticipate, understand and mitigate risks

for cohorts of clinicians or systems, taking action across the system to address them more quickly.

At the heart of our strategy is a commitment to promoting a culture of learning rather than blaming. We believe firmly that the best way to protect patients is to support doctors, and that is why we have called for legislative change to help us deliver this, and why promoting medical professionalism is the cornerstone of our plans. It is ambitious work and, while no one organisation can address all of the issues facing the medical profession, we are committed to playing our part to deliver change.

Some of the key areas of work we are taking forward are:

- **Reflective practice:** Central to a culture of learning in healthcare is the development of reflective practitioners and we have clarified that the GMC never asks for doctors' reflective notes in our own processes. We have also committed to co-producing updated guidance for doctors and trainers on reflective practice, working in partnership with doctor in training leaders and others from across the UK.
- **Team-based reflection:** Recognising that doctors work in teams with other healthcare professionals, we have begun conversations with other professional regulators about how together we can better support team-based reflection, and the scope for possible joint guidance.
- **Raising concerns:** We have reaffirmed the need to make sure doctors are supported to raise concerns. Our annual National Training Survey will continue to provide valuable data on this issue, enabling us and partners to act to make sure training environments are safe for doctors and patients. We will engage with employers and appropriate bodies on how data on concerns raised is collected and shared nationally to identify themes and learnings. The starting point here is different in each of the UK countries, and there is significant scope for us and other NHS bodies to make improvements.
- **Returners and induction:** It is important that doctors are given appropriate support when they start new roles or return to work after a period of absence (such as maternity leave). We already run a successful Welcome to UK Practice programme for doctors new to UK practice, which we are committed to scaling up very significantly. Our standards are clear on the importance of this support for doctors in training, and we will bring renewed focus to this area in our conversations with employers. We will establish with them what is necessary to extend all of these types of training and support to those returning to practice after time away.
- **Mental health and wellbeing:** We have commenced an important programme of work looking at the mental health and wellbeing of the entire medical workforce. I am delighted that Dame Denise Coia, an eminent consultant psychiatrist and also Chair of Healthcare Improvement Scotland, will work with Professor Michael West, a senior King's Fund fellow and Professor of Work and Organisational Psychology at Lancaster University,

with specific expertise in compassionate and collaborative leadership, to lead our work in this area.

- **BME doctors:** As set out in our recent response to the British Association of Physicians of Indian Origin (BAPIO) and the Health and Social Care Committee, we take very seriously our responsibilities in relation to all doctors, including BME doctors. In support of our ongoing work, we have convened an extraordinary meeting of the BME doctors forum, which the GMC hosts, to consider what further work should be done in this area.

We have set ourselves an ambitious strategy and programme of work and are committed to delivering it in collaboration with others. By doing so will help us deliver on our objective of supporting doctors as the best way of protecting patients. We clearly have much more work to do and I look forward to working with you and your officials as we do that.

Yours sincerely

A handwritten signature in cursive script that reads "Charlie Massey". The signature is written in dark ink and is positioned centrally below the "Yours sincerely" text.

Charlie Massey

Chief Executive and Registrar

Cc.

Rt Hon Jeremy Hunt MP, Secretary of State for Health and Social Care
Richard Pengelly, Permanent Secretary of the Department of Health (NI)
Shona Robison MSP, Cabinet Secretary for Health and Sport

Report title:	GMC Update
Report by:	Shane Carmichael , Assistant Director, Strategic Communication and Engagement shane.carmichael@gmc-uk.org , 020 7189 5259
Action:	To consider

Executive summary

This paper provides an update on progress against a number of our priorities and key projects for 2018. Elements of the paper will form a basis for discussion at the Forum. Key points for Advisory Forum members to note in particular:

- Our *Corporate Strategy 2018-2020: An ambition for change* has recently been launched. The strategy maps out our future direction and ambition over the next three years.
- We have written to all four Governments to highlight the key elements of our strategy and its relevance in the context of the issues and concerns – which we acknowledge - raised recently by the case of Dr Bawa-Garba. It also outlines a number of specific initiatives we are taking forward in response to these issues and concerns.
- We have noted the findings of the Hyponatremia Inquiry in Northern Ireland and are reviewing its implications for the GMC and regulation for patient safety, medical education and training and doctor's fitness to practise.
- We continue to engage actively with all four Governments on the implications of Brexit for the continued safe movement of EEA qualified doctors.
- Our National Training Surveys will launch at the end of March which provides a proven opportunity for Doctors in Training and Trainers to share their experiences of frontline training and delivery of care.

Recommendation:

Members are asked to consider this update ahead of discussion at the Advisory Forum meeting. In particular, we are keen to hear suggestions as to how this programme of work can best be delivered as well as any queries, advice or concerns members may have.

Updates

Systems and collective assurance

Corporate Strategy

- 1 We have just launched our new *Corporate Strategy 2018-2020: An ambition for change*. The strategy maps out our future direction and ambition over the next three years. Against the backdrop of a healthcare system that is under intense pressure, we want to make sure that doctors are supported by regulation that eases rather than adds to the pressures of the systems they work within.
- 2 We have laid out four key areas of strategic focus, also known as our 2020 goals:
 - Supporting doctors in maintaining good practice.
 - Strengthening collaboration with our regulatory partners across the health services.
 - Strengthening our relationship with the public and the profession.
 - Meeting the changing needs of the health services across the UK.

Sharing GMC Data

- 3 We are currently in the process of developing phase two of our [Data Explorer](#) and have undertaken work to enhance the data we publish on a four country basis. We will continue to review how we build on current data to enable us provide a more comprehensive four country analysis of the medical workforce, education and training, revalidation and fitness to practise.

Collective Assurance

- 4 We continue to build on our relationships with other regulators and patient safety bodies across the UK. In England, through our membership of the Health and Social Care Regulatory Forum (HSCRF), we have established, with partner organisations, a protocol for escalating issues of concern in real time for the purposes of collective assurance. In Scotland we continue to engage with the work of the National Information Sharing Group, in Wales the HIW Risk Summit process and in England the Joint Strategic Oversight Group made up of HEE, NHSI, NHS England and the CQC.

Fitness to Practise reforms

- 5 Our strategy for 2018-2020 is also focused on an 'upstream' approach to regulation, where we seek to address problems or risks at the earliest opportunity. Through our *'Local First'* initiative we will work with Responsible Officers and Employer to support the appropriate local resolution of concerns about doctors where that is the most effective and efficient way of securing protection of the public.
- 6 Over the next three years we will:
 - a Further strengthen the role of the Responsible Officer (RO) in fitness to practise cases, particularly in relation to managing restrictions on a doctor's practice.
 - b Providing support and use our influence to strengthen local investigation systems.
 - c Conducting a pilot of more effective working with local processes based on the 'local first' principle.
- 7 This year, following a successful pilot, we are implementing the use of provisional enquiries in single clinical incident cases and will commence a pilot on using provisional enquiries in single clinical concern cases (more than one incident but a single patient and course of treatment).

Hyponatremia

- 8 On 31 January 2018 the [report](#) of the Northern Ireland independent inquiry into hyponatremia related deaths of five children was published. The report of the 14 year inquiry makes profound criticisms of the care the children received and the conduct of both individual doctors and the institutions involved. While the report contains little criticism of the GMC, the content and recommendations are relevant to our work in standards, education and fitness to practise.
- 9 We are considering the report's findings and their potential implications for medical regulation across the United Kingdom. We have also indicated our willingness to work collaboratively with the Department of Health in Northern Ireland which is developing a detailed action plan to address the 96 recommendations in the report.

Health Education and Improvement Wales

- 10 Health Education and Improvement Wales (HEIW) has [announced](#) the appointment of a new independent board to support the Chief Executive. HEIW will be responsible for workforce, education and training for all health professionals in Wales, incorporating the functions of the current Wales Deanery and Workforce Education and Development Service. The Chair also announced that the organisation will have a shadow period from April until October 2018 when it will become fully operational.

- 11 We continue to work closely with the Chair and his new team during this transition period, focusing on the quality assurance of training, and to identify opportunities for closer working in the future, particularly in relation to the new workforce function.

New GP Contract in Scotland

- 12 After a long period of co-production between the Scottish Government and the BMA Scotland, on 18 January 2018 BMA Scotland announced that members have voted to accept phase one of the Scottish Government's new GP contract. The contract aims to re-focus the role of GPs as Expert Medical Generalists, involving a focus on undifferentiated presentation, complex care, and whole system quality improvement and leadership.
- 13 Our Scotland team is working to support the GP workforce in Scotland as general practice moves to a cluster model: groups of practices in close geographical locations which encourage quality improvement activity between their peers. They have supported the implementation of this framework, advising Scottish Government on new Information Sharing Arrangements between Clusters and Health Boards and more practically supporting the workforce through workshops in *Leadership and Management* and *Consent*.

Medical workforce, quality and safety

State of Medical Education and Practice (SoMEP)

- 14 [The state of medical education and practice 2017](#) was published on 19 December 2017, highlighting that the UK's medical profession is at 'a crunch point' and will suffer increasing pressure over the next 20 years unless action is taken. It also highlighted:
 - a That supply has not been keeping up with demand.
 - b That we are heavily reliant on overseas doctors, but UK may be becoming a less attractive destination.

Mental health and wellbeing of Doctors

- 15 We have just begun a major piece of work looking at the Mental Health and Wellbeing of the medical workforce and medical students, working collaboratively across the UK with partner organisations, and building on the work we have been doing on supporting vulnerable doctors in our fitness to practise processes.
- 16 Dame Denise Coia, an eminent consultant psychiatrist and Chair of Healthcare Improvement Scotland, and Professor Michael West, a senior King's Fund fellow with

specific expertise in compassionate and collaborative leadership, will co-chair this programme of work. On Friday 9th February we held a symposium involving around 30 people across the UK to explore four key themes: stigma; leadership, systems and culture; early intervention; and crisis support and suicide prevention. The Chair and Chief Executive are meeting with Denise and Michael in early March to agree next steps (include wider engagement) and key lines of enquiry on what we expect to be a three year programme of work as part of our focus on upstream regulation and supporting doctors to give good care.

High Court judgment on the case of Dr Bawa-Garba

- 17** The High Court judgment on our appeal in the case of Dr. Bawa-Garba was handed down on 25 January 2018. The court agreed that the tribunal's original sanction of suspension was insufficient to maintain public confidence in the medical profession and has replaced suspension with a direction of erasure from the medical register.
- 18** On 15 February 2018 we received notification of Dr Bawa-Garba's application for permission to appeal the decision of the Divisional Court. The application will first be considered on the papers and, if granted, a further hearing will take place in due course.
- 19** We know and understand the anxiety from many in the medical community arising from the potential implications from this case. It has undoubtedly set the GMC back in our desire to promote medical professionalism and a learning culture as the best way to protect patient safety, and we recognise that we have more to do to get us back on track. While not all of the concerns have been grounded in fact, it is also clear that the case has acted as a lightning rod for wider concerns about the NHS. The anxiety doctors feel around being supported is very real and we need to play our part in addressing those concerns while ensuring that we fulfill our core objectives – to protect patients and uphold the good name of the profession in the interest of public confidence.
- 20** We have written to all four Governments to explain how our Corporate Strategy provides a framework for our response to the issues raised by the Bawa-Garba case and outlines a number of specific initiatives we are taking forward in that context which cover:
 - a.** The application of Gross Negligence Manslaughter and Culpable Homicide (in Scotland) to the medical profession.
 - b.** Encouraging Reflective practise.
 - c.** Support for induction and returners.
 - d.** Raising and acting on concerns.

- 21** A fuller update on this work will be provided at the Forum.

Brexit

- 22** EU leaders agreed the provisional terms of the UK's withdrawal from the EU in December. Under the agreement, consensus was found on legacy rights for the recognition of professional qualifications (RPQ). It was agreed that recognition of decisions made before EU exit will be respected - this means that the registration status of doctors with an EEA qualification who are currently on the medical register will not be impacted. It was also agreed that any applications for registration, or compensation measures, that are underway as of Brexit day (29 March 2019) will benefit from legacy RPQ rights for the remainder of that application process. The future status of the RPQ regime post EU exit was not covered in this agreement and this will be subject to discussions on the future trade relationship between the UK and EU which will begin in the spring. Details of the transition period also need to be finalised, but are likely to include a continuation of the RPQ framework for the full period (i.e. up to the end of December 2020).
- 23** Our legal team have been working with the Department of Health (England) officials to submit comments on draft amendments to the Medical Act to encompass the various EU exit scenarios. We have worked with the Department both to identify which pieces of primary and secondary legislation impact on our work and will need re-drafting as per the assumption above. Officials hope to introduce these legislative changes via the special powers in the EU (Withdrawal) Bill. It is also possible that a formal RPQ regime could be included in the future trade agreement between the UK and EU. Should the RPQ framework not apply in the future (post transition), we will need to ensure that the 1,300 EEA qualified doctors who join our specialist and GP registers annually through automatic recognition of their qualifications via the RPQ Directive can access the specialist register in a timely way and without undue delay.

Legislative Reform

- 24** DHSC (England) recently completed a consultation on the reform of professional healthcare regulation. This included a proposal for regulators to be afforded greater flexibility and autonomy over how they carry out their core functions, including the ability to amend key procedures and have rule making powers, without seeking direct parliamentary approval for doing so. We and indeed all four Governments across the UK are fully supportive of this proposal.
- 25** Our response also highlighted the need for devolved assemblies and parliaments, to develop enhanced processes for holding us to account for how we might exercise such powers. We continue to call on UK Government to urgently legislate in this area so we can regulate more effectively, constrained by outdated legislation which is not

fit for 21st Century healthcare or the 1,000,000 healthcare professionals regulated across the UK.

- 26** The GMC [responded](#) to the Governments' consultation on Medical associate professions (MAPs). As medical associates work closely with doctors, we believe there is a strong argument that we should accept responsibility for them. We are in a good place to do this, providing the Government gives us funding for set up costs and the underlying legislation is fit enough for modern healthcare.

National Training Survey

- 27** The national training surveys - open from 20 March to 2 May, 2018 - are powerful tools that help assure the quality of postgraduate medical training in the four countries.
- 28** We recognise that this is a challenging time. Many doctors are concerned about the systems they're working in; and we know that this winter has been particularly hard. We are grateful that postgraduate deans, employers and those representing trainees and trainers continue to give their support for the survey. We hope that once again they'll help encourage a high response rate, so we are able to provide a comprehensive picture of training environments across the UK.
- 29** In 2018, for the first time, we will also be asking trainees and trainers about the impact of wellbeing on training. We have developed these questions with support from doctors, the BMA and key education partners, to help us pinpoint where issues may exist.

Supporting medical students and trainees with disabilities

- 30** We have developed a draft of the new guidance with our external expert steering group, chaired by Professor Bill Reid. This is tentatively scheduled for a public consultation launching in April, with new guidance likely to be launched towards the end of 2018.
- 31** The guidance has been informed by external research that we commissioned with medical school staff, medical students and postgraduate providers. Towards the end of last year we hosted nine roundtables with the same audiences (plus doctors) within the four countries, and have engaged with disability-related organisations and key stakeholder groups to understand what they would like from the revised guidance. We will continue to provide updates via our blogs.

Outcome for Graduates review

- 32** The consultation on the outcomes for graduates closed on 10 January and we are analysing the results. The outcomes will be a key building block for the assessment blueprint for the Medical Licensing Assessment (MLA). We expect to publish a new version of the outcomes in summer 2018.

Medical Licensing Assessment

- 33** In December 2017 GMC Council considered a proposal for the MLA that reflected the feedback we received from the 2017 public consultation. The [paper](#) published on our website and all the recommendations were agreed. In summary:
- We reflected deeply on the comments we received in the consultation.
 - We are proceeding with the online Applied Knowledge Test (AKT) as set out in the public consultation.
 - For the clinical and professional skills assessment (CPSA) for UK graduates we now envisage these will be delivered by medical schools subject to key performance indicators and quality assurance by the GMC.
 - There will still be a GMC CPSA for International Medical Graduates (IMGs) to replace the Professional Linguistics Assessment Board (PLAB) Part 2.

Credentialing

- 34** The Shape of Training Steering Group, chaired by Professor Ian Finlay, published the [Shape of Training implementation report](#) in August 2017. Its principles are embedded in our education framework, *Excellence by design*. Working with colleges and faculties we have a two-year plan to evaluate all 103 current curricula against our standards, which will embed the Shape principles, by 2020.
- 35** As part of this our credentialing framework, which we plan to introduce from 2019, will seek to assure patients and employers that doctors are trained safely and competently in areas of practice that are not covered by postgraduate training, and we are proposing that GMC regulated credentials will apply to areas of practice with significant patient safety concerns.
- 36** In February 2018 we wrote to the four UK governments setting out a timetable by which we proposed to have developed a consensus-based model for the credentialing framework. Our letter to the four governments sought their support in identifying priority areas for credentials, as well as highlighting that under our current legislation approving and assuring credentials can only operate through a voluntary scheme, as we cannot set credentials as a regulatory requirement without legislative change.

Health Education England strategy

- 37** A consultation on '[Facing the facts, Shaping the future](#)' a draft health and care workforce strategy for England to 2027 consultation runs until 23 March, 2018. The GMC is currently considering its response. There are eight actions identified for the GMC or 'regulators' working with other organisations and we will make the case for demonstrable alignment of workforce planning across the four nations of the UK.

Upstream regulation: preventing harm and supporting professionalism

Consent

- 38** We are continuing with the process of finalising plans to consult on our [2008 Consent guidance](#) which outlines what doctors should consider when discussing treatment and care with patients. This links in particular to both the Realistic Medicine and Prudent Healthcare in Scotland and Wales respectively.

We have worked with a task and finish (TFG) group to redraft the guidance to make sure it's clear, helpful, and relevant to both doctors' and patients' needs, and compatible with laws throughout the UK.

Taking Revalidation Forward

- 39** We continue our programme of work to implement the recommendations from Sir Keith Pearson's independent review of revalidation. In January we published a [progress report](#) on our website. We will launch a number of programme outputs in the next two months, including updated guidance on Supporting Information required for appraisal, improved revalidation information on our website for both doctors and patients, and a set of principles to govern the sharing of concerns where doctors work in multiple locations. And over the summer we will launch a consultation on patient feedback. The programme is scheduled to conclude in September.
- 40** We have now completed the long term evaluation of revalidation and expect to publish the final report shortly.

Promoting Professionalism

- 41** Our programme to support doctors, educators and patients in understanding and adopting our professional guidance in delivering good medical practice continues across the four countries of the UK. We work with over 40,000 doctors and medical students on the frontline each year on the application of our guidance to their work.
- 42** Our project to expand our [Welcome to UK Practice](#) (WtUKP) programme is currently underway. We recognise that the transition into UK practice is especially hard for doctors who qualified outside the UK and may be unfamiliar with our culture of

healthcare. The WtUKP programme was developed to help these doctors. The course consists of a half-day workshop which guides doctors through the ethical issues they could face in their practice. Last year saw a growth of 10% more doctors attending WtUKP workshops. Our ambition is to increase take up to 80% of doctors new to the UK by 2020. An evaluation of the programme is underway.

Agenda item:	3
Title:	Patient safety starts with us: working together to achieve our vision
Action:	To discuss

Executive summary

We have just launched our new *Corporate Strategy 2018-2020: An ambition for change*. The strategy maps out our future direction and ambition over the next three years. It gives us a clear vision of the kind of organisation we aspire to be, and helps us to make the right choices for the benefit of patients.

In our new strategy we have taken a fresh look at our aims for the next three years, but our goal remains the same - to keep patients safe. We have laid out four key areas of strategic focus, also known as our 2020 goals:

- Supporting doctors in maintaining good practice
- Strengthening collaboration with our regulatory partners across the health services
- Strengthening our relationship with the public and the profession
- Meeting the changing needs of the health services across the four countries of the UK

We recognise that in an increasingly complex healthcare environment, with the range of challenges facing those working within it, we cannot achieve these goals alone. For this reason we and our partners in healthcare must look beyond the limiting frame of our individual statutory responsibilities to achieve a level of collective assurance about the quality of healthcare in the UK. It is already starting to happen. This strategy sets out our ambition to do more.

Recommendation

To discuss how we can work together to deliver the ambitions described in the strategy across the four countries of the UK.

Introduction

Whilst we must continue in our excellent work to investigate doctors where that is appropriate, our new corporate strategy emphasises a new focus on how we can support all doctors to be the very best they can be. By helping them to deliver the very highest standards of care, we are keeping both patients and doctors safe.

Our vision

We use our insights to re-focus medical regulation on supporting a high quality workforce in delivering good medical practice.

A simple vision with profound meaning. This is the very real and very relatable impact we have on the world. Great healthcare is something that every one of us wants and expects for ourselves, our friends and our family.

Our mission

To prevent harm and drive improvement in patient care by setting, upholding and raising standards for medical education and practice across the UK.

This is why the GMC exists. It is what we are fully committed to achieving.

Equally, we recognise how big an ambition this is. In the context of a changing environment we have to take a strategic approach. Our new strategy is our response to the world we live in.

Realities of frontline healthcare

Nobody can be in any doubt about the challenges currently facing those who work in the UK health services. Regulation is sometimes seen as reactive, reactionary and removed from the realities of frontline care. But our ambitious new strategy will see us using our data and insights to greater effect in anticipating and highlighting emerging risks, particularly where these threaten doctors' education and training, and their health and well-being. If these are undermined, then patient safety is also put at risk.

We cannot address these issues alone. The UK healthcare system is too layered and complex for any one organisation to do that. For this reason we and our partners in healthcare must look beyond the limiting frame our individual statutory responsibilities to achieve a level of collective assurance about the quality of healthcare in the UK. It is already starting to happen. This strategy sets out our ambition to do more.

Agenda item:	4
Title:	Patients and doctors making decision together
Action:	To discuss

Executive summary

- Patients and doctors making decisions together is central to our core guidance, and embedded in our existing guidance on Consent.
- We are currently reviewing our guidance on Consent and will be proposing a number of revisions, including changes to our decision making frameworks aiming to move the focus away from 'consenting a patient' to thinking more about the quality of the dialogue and the decision making process.
- In Wales, shared decision making underpins the principles of co-production contained within *Prudent Healthcare*, and the ambition to change clinical conversations being driven through the *Making Choices Together* movement.
- This item is intended to stimulate further discussion on the principle of making decisions together, and encourage engagement with *Making Choices Together* and the forthcoming review of our Consent guidance.

Recommendation: that the Forum discuss the principles of shared decision making and how this might be further embedded in practice, and that members consider responding to the consultation on our Consent guidance when it is launched.

Our guidance on making decisions together

- 1 Our core guidance for doctors [Good Medical Practice](#) states that 'Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual.'
- 2 It states that doctors must 'establish and maintain partnerships with patients' and in particular that they must 'work in partnership with patients, sharing with them the information they will need to make decisions about their care'.
- 3 Our [Generic Professional Capabilities](#) framework highlights that an important professional value and behaviour is 'listening to patients, carers and guardians, and accepting that they have insight into, preferences for and expertise about the patient's own condition and context.'
- 4 Making decisions together is embedded in our existing [guidance on Consent](#) which includes the following principles:
 - 4.1 Whatever the context in which medical decisions are made, you must work in partnership with your patients to ensure good care. In so doing, you must:
 - a Listen to patients and respect their views about their health.
 - b Discuss with patients what their diagnosis, prognosis, treatment and care involve.
 - c Share with patients the information they want or need in order to make decisions.
 - d Maximise patients' opportunities, and their ability, to make decisions for themselves.
 - e Respect patients' decisions.
- 5 We are reviewing our consent guidance to make sure it remains clear, relevant, accurate, and helpful to doctors in practice and will shortly be publishing a formal consultation to seek views on our proposed revisions. Although we are not proposing significant changes to our core principles, we are changing the emphasis and some of the language we use.
- 6 In particular we are proposing changes to our decision making frameworks aiming to move the focus away from 'consenting a patient' to thinking more about the quality of the dialogue and the decision making process. These changes include:
 - a Increased focus on supporting patient decision making and on encouraging doctors to involve patients in decisions as far as they can.

- b Increased emphasis on communication, and on the importance of doctors finding out about what is meaningful for their patients, in order to most effectively explore the different options and tailor the information they give to patients.

Prudent Healthcare and co-production

- 7 The importance of shared power and decision making underpin Prudent Healthcare (<http://www.prudenthealthcare.org.uk/>), which includes as one of its principles:

- 7.1 Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production

- 8 Co-production is an approach where people and professionals share power and work together in equal partnership. It values all participants as equals and is built around people, and not around systems. Instead of fitting people into existing services, professionals work with people to find the best way to achieve the outcomes that matter to them.
- 9 Co-production offers the possibility of transforming the NHS from an organisation which treats ill people into an organisation which works in equal partnership with citizens to improve the health and wellbeing of all of us.

Making Choices Together: changing clinical conversations

- 10 [Making Choices Together](#) is a movement to encourage open conversations between patients and their clinicians, to make decisions together about the right care for the individual.
- 11 The movement aims to make sure that healthcare conversations and decisions will be informed by good evidence, and responsive to what is important to the patient.
- 12 Making Choices Together reflects the principles of *Prudent Healthcare*: it supports patients to make decisions about their care, to help avoid tests and treatments that are unlikely to benefit them, or might even be harmful.