November 2019 - Council Meeting

MEETING
6 November 2019 09:00

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## Agenda

### Wednesday 6 November 2019

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00 - 09:05</td>
<td><strong>M1</strong> Chair’s business and declarations of interest.</td>
</tr>
<tr>
<td>09:05 - 09:10</td>
<td><strong>M2</strong> Minutes of the meeting on 26 September 2019</td>
</tr>
<tr>
<td>09:10 - 09:30</td>
<td><strong>M3</strong> Chief Executive Report</td>
</tr>
<tr>
<td>09:30 – 9:50</td>
<td><strong>M4</strong> Review of guidance on decision making and consent</td>
</tr>
<tr>
<td>09:50 – 10:20</td>
<td><strong>M5</strong> People planning across the United Kingdom</td>
</tr>
<tr>
<td>10:20-10:30</td>
<td><strong>M6</strong> Any other business</td>
</tr>
</tbody>
</table>
# Contents

Meeting Part One

| M2 - Minutes of the meeting on 26 September  2019  | 4 |
| M3 - Chief Executive’s Report                        | 11 |
| M4 - Review of guidance on decision making and consent | 17 |
| Annex A - Draft guidance                            | 23 |
| M5 - People planning across the United Kingdom       | 54 |
Minutes of the meeting on 26 September 2019

Members present

Clare Marx, Chair
Steven Burnett
Christine Eames
Anthony Harnden
Philip Hunt
Deirdre Kelly
Paul Knight
Suzi Leather
Denise Platt
Amerdeep Somal

Others present

Charlie Massey, Chief Executive and Registrar
Paul Buckley, Director of Strategy and Policy
Una Lane, Director of Registration and Revalidation
Anthony Omo, Director of Fitness to Practise and General Counsel
Neil Roberts, Director of Resources
Colin Melville, Medical Director and Director of Education and Standards
Paul Reynolds, Director of Strategic Communications and Engagement
Melanie Wilson, Council Secretary

Chair’s business (agenda item M1)

1. The Chair welcomed members, the Senior Management Team and observers to the meeting.

2. Apologies were received from Shree Datta.
Minutes of the meeting on 12 June 2019 (agenda item M2)

3 Council approved the minutes of the meeting on 12 June 2019 as a true record.

Chief Executive’s report (agenda item M3)

4 Council considered the Chief Executive’s Report, noting that:

a We are continuing to work closely on the regulatory reform agenda with other regulators, particularly with the Nursing and Midwifery Council, on regulatory alignment.

b The health and wellbeing review, independently led by Michael West was due to be published shortly. This will be the third and final report forming part of our Supporting a Profession Under Pressure work programme.

c With continuing uncertainty about Brexit, engagement on ‘no deal’ planning with the Department of Health and Social Care was continuing and one of the outstanding issues would be the potential lack of reciprocity in most EU states for UK medical qualifications, although Ireland, France and Spain have put various forms of reciprocity in place.

5 During discussion, Council noted that:

a Details of planning for a possible general election, including messages we want to communicate to political parties, would be shared with Council.

b Confirmation would be sought that the organisation has taken into account current best practice in relation to its use of inclusive language, particularly personal pronouns.

c Consideration will be given to separating out investment income from operating income in the financial data.

6 Council approved the reappointment of Crowe UK LLP as external auditor of the GMC’s accounts, including GMC Services International Ltd.

Section 40A appeals update (agenda item M4)

7 Council received an update on the process by which the GMC considers whether to appeal decisions of MPTS hearings and on the recent decisions of the Section 40A Appeals Panel.
8 Council noted that:

a There is a three-stage process supporting the Section 40A Executive Panel in its decision-making, as set out in the paper.

b Of the 250 cases which have concluded at an MPTS hearing since January 2019, 120 had an outcome different to the sanction we had sought at the outset of the case. Following the three-stage process, the Panel had considered whether to exercise the GMC’s right of appeal in relation to a total of 19 Doctors, two more having been considered since publication of the paper.

c The Panel had decided to exercise the power to appeal in three cases to date and details of those cases were described in summary.

d The GMC must make any appeal within 28 days of the conclusion of a case and the Professional Standards Authority (PSA) has a considerably longer period within which to appeal. Therefore, the GMC notifies the PSA about decisions to appeal but the Panel makes its decisions independently from the PSA’s process. The PSA has joined us in being party to one of our three s.40A appeals.

e The decisions of the s.40A Executive Panel are published on the GMC website.

Update on regulation of Physician Associates and Anaesthesia Associates (agenda item M5)

9 Council received a paper providing an update following the Government’s decision in July 2019 to invite the GMC to take on the regulation of physician associates (PAs) and anaesthesia associates (AAs).

10 Council noted that:

a It will likely take between 18 and 24 months to develop and lay the necessary legislation, with the potential for the uncertain political climate to extend that period further.

b The Government has accepted that it needs to fund both the scoping phase and a costed implementation phase and we are working on agreeing the initial sum.

c Communications planning was needed to address the concerns expressed, including by the British Medical Association and medical trainees; to ensure that devolved administrations are kept updated; and to manage the expectations of PAs and AAs about how long the new arrangements will take to put in place.

d In particular we need to be clear that the GMC’s role is about developing an effective regulatory framework for PAs and AAs, whereas wider issues pertaining to PAs and AAs such as their roles, numbers and training pathways are matters for the wider health system.
Recruitment is already underway to manage five workstreams of activity to prepare for the changes.

Council noted the overarching principles that should govern the GMC’s approach to the regulation of PAs and AAs and the GMC’s initial plans for scoping the work ahead.

During discussion, Council noted that, following reference to the issue at the Labour Party Conference, any views on regulation of PAs/AAs of other political parties would be ascertained.

**Update on implementing the current Corporate Strategy (agenda item M6)**

Council received an update on progress in delivering the 2018-20 Corporate Strategy and a brief summary of next steps on developing the next strategy.

Council noted:

a. The progress the GMC has made towards achieving the Corporate Strategy and the next steps in the development of the next Corporate Strategy.

b. That significant progress has been made towards achieving the goals in the Corporate Strategy, but it would be three to five years before most of the impact would be clear, so we will continue to monitor progress.

During discussion, Council noted that there could be more of a balance in strategic aims relating to public/patient engagement, particularly in relation to patient responsibilities.

**Pension valuation (agenda item M7)**

Council received a paper providing the valuation, which is required every three years, of the Defined Benefit (DB) pension scheme to enable Council to agree with Trustees the future funding arrangements.

Council noted that Steve Burnett, Deirdre Kelly and Amerdeep Somal had declared interests as Trustees of the pension scheme.

Council noted that:

a. Following a further review of the Scheme’s liabilities, the 2018 valuation leaves a deficit of around £12 million.

b. Discussions have taken place between a sub-group of Trustees and the GMC’s Chief Executive, with both parties advised independently. Both sides and both sets of advisers were comfortable with the proposed recovery plan to move the scheme towards self-sufficiency.
c The members of Council on the Board of Pension Trustees were grateful to Jim McKillop, Chair of the Board, and Andrew Bratt, Assistant Director – HR, for their roles in the process.

d One outstanding uncertainty is the government’s proposal that the Retail Prices Index (RPI) inflation measure be discontinued, but the Trustees and GMC had agreed in principle to hedge that risk.

e GMC management were confident that the recovery plan was affordable against the GMC’s regulatory objectives.

f The Trustees were considering ways to make the lump sum option more attractive to scheme members considering their options as they approach retirement.

19 Council:

a Agreed the 2018 valuation.

b Agreed a seven-year recovery plan, involving six annual payments of £1.3m in 2020-2025, in addition to the £1.9m previously committed and paid in 2019.

c Noted the planned work on an Integrated Risk Management Plan and the potential implications for the scheme of the possible changes to how RPI is calculated.

The results of the staff survey (agenda item M8)

20 Council received a report on the GMC’s annual staff survey, which helps the GMC track performance as an employer and informs a range of work on issues such as staff welfare, career development and change management. Council noted the staff survey findings and the related ongoing work programmes.

21 Council noted that:

a The full report would be made available for any Council member who wished to read it in greater detail.

b Results were generally positive, with an engagement index score of 73% which is an increase of one percentage point over last year’s score. The GMC had performed well compared to the supplier’s benchmark.

c A more detailed breakdown of results showed almost identical scores between responses from male and female employees, higher scores from those with caring responsibilities and lower levels of engagement for black and minority ethnic staff, although those scores had seen some improvement.
d Three directors were leading on themes where we want to improve levels of employee engagement, which are: workloads and working hours; openness, inclusion and transparency; and change management.

e Activities to date to address the three themes include data gathering, focus groups and other conversations with teams across the organisation and reviewing relevant internal audit reports.

f Addressing the workload issue will require better prioritisation, including making decisions to stop doing some activities.

22 In discussion, Council noted that:

a Results relating to how complaints are dealt with and on experience of bullying and harassment were a cause for concern for Council members.

b Some reporting of bullying and harassment can be a result of interactions with individuals outside the organisation.

c The work of Lindsey Mallors as Freedom to Speak Up Guardian, in providing an additional way for staff to raise concerns, was acknowledged.

d There should be more scope to reinforce the values of the organisation by providing ways to recognise the daily contributions that colleagues make, such as with the use of values cards.

e Consideration would be given to how the results will be followed up with Council ahead of the 2020 staff survey.

Any Other Business (agenda item M9)

23 Council noted that the process to fill the registrant Council member position vacated by Michael Marsh earlier in the year had been started, with the intention of advertising the position shortly. The details of the application process would be circulated to Council members.

24 Council noted that some members had again experienced difficulty with the app for reading Council papers and that further efforts would be made to improve the functionality for accessing links.

25 Council noted that the next evening seminar and meeting would be on 5 and 6 November 2019 in London.
Annual report of GMC Group Personal Pension Plan governance (agenda item M10)

26 Council noted the 2019 report for the GMC Group Personal Pension Plan Management Board.

PSA Annual Review of our Performance 2017/18 (agenda item M11)

27 Council noted:

a The PSA’s report on our performance for the 2017/18 performance review period, which concluded that we met all 24 of the Standards of Good Regulation.

b The PSA’s proposals to introduce a revised set of Standards for the 2019/20 performance review cycle.

Council members’ register of interests (agenda item M12)

28 Council noted the Register of Members’ Interests.

Update to the Governance Handbook (agenda item M13)

29 Council approved the changes to the Governance handbook which had resulted from the restructure of the executive team.

Confirmed:

Clare Marx, Chair
6 November 2019
Executive summary
This report outlines developments in our external environment and progress on our strategy since Council last met. Key points to note:

- We are prepared for the different possible Brexit scenarios, and are in regular contact with the UK Government about them;
- We launched our Workforce report in October, and in the run-up to Christmas will be publishing the independent review into the mental health and wellbeing of doctors and our annual report into the State of Medical Education and Practice;
- We continue to monitor training at Weston General Hospital to make sure a safe, effective and positive learning environment can be maintained;
- In relation to the Medical Licensing Assessment, we reached an important milestone at the end of September 2019 with the publication of the content map.

Recommendations
Council is asked to consider the Chief Executive’s report.
Developments in our external environment

Preparations for Brexit

1. In the midst of the ongoing uncertainty around Brexit, we continue to prepare for the various potential scenarios that may occur in the coming weeks. We are in constructive dialogue with the Department for Health and Social Care (DHSC) about any further steps we can take to support the healthcare system whilst maintaining the high regulatory standards on which patient safety depends.

2. We published a blog earlier in October to provide reassurance to doctors that we have been preparing for whatever Brexit scenario we face and highlighting how we can help them with questions or concerns. We have further communications planned to maintain that message of reassurance. We are also regularly reviewing the FAQs for doctors on our website to make sure they are up to date.

3. In the event of a ‘no-deal’ Brexit, we have an amended version of the GMC website ready to launch. We have an agreed communication plan so that we can alert EEA qualified doctors to the changes to the registration process in the event of ‘no-deal’ and have drafted amended guidance for areas where we believe doctors may be impacted, such as the supply of medicines. We also have plans in place to contact individual doctors who may be directly impacted by a ‘no-deal’ Brexit, for example doctors with Temporary and Occasional registration, or those with live applications that may be affected.

4. We’ve also developed an internal briefing for staff. When we have a clearer idea on what outcome is expected, we’ll publish an article for all staff to advise on the impact that Brexit may have on teams and to repeat the important messages of reassurance to our colleagues with EEA nationality who may require additional support.

The Queen’s Speech

5. In the Queen’s Speech on 14 October 2019 the Government announced its intention to bring forward legislation to implement the NHS Long-Term Plan in England.

6. It has also announced that it will introduce a Bill to make the Healthcare Service Safety Investigation Branch (HSSIB) a new Executive Non-Departmental Public Body, with powers to conduct investigations into incidents that occur during the provision of NHS services and have, or may have, implications for the safety of patients. The Bill will also seek to amend the Coroners and Justice Act 2009, giving English NHS bodies the power to appoint medical examiners and placing a duty on the Secretary of State to ensure that enough medical examiners are appointed in England.
Workforce

7 We are working hard to influence thinking on workforce planning in all four countries of the UK. Our workforce report, published at the end of October 2019, emphasised the vital importance of attracting, supporting and retaining the excellent doctors and healthcare professionals we already have.

8 That means a step change in culture and leadership and a renewed focus on improving the wellbeing and working environments of the people who are the bedrock of our health services. The recommendations from Michael West and Denise Coia’s wellbeing review, and the Fair to Refer research we published in June, will be important in shaping how we work with others to build a more inclusive, healthier and supportive working environment for doctors and all healthcare professionals.

9 We will also shortly be publishing a stand-alone report providing trend data on the number of EEA doctors on the medical register.

The State of Medical Education and Practice 2019

10 We will publish our ninth annual report into the State of Medical Education and Practice (SoMEP) in December. The report will focus on how sustaining the current workforce, improving the workplace and the better alignment of regulation are all key to the long-term sustainability and the success of the medical profession in providing safe care for patients.

11 In November we will also be publishing a short headline report on our SAS and local employed doctors (LEDs) survey. The survey ran for six weeks in May and June 2019 and received over 6,000 responses. This headline report will be followed by a more detailed publication early in 2020 outlining recommendations for the GMC and others to support this important part of the medical workforce.

Changes to abortion law in Northern Ireland

12 Following the passage of the Northern Ireland Executive Formation (etc) Act 2019, abortion in Northern Ireland has been partly decriminalised with effect from 22 October 2019. The Northern Ireland Office has released guidance (in supplemental reading pack) for healthcare professionals on the planned changes. This guidance aims to provide clarity on the law framing termination of pregnancy in Northern Ireland during the interim period after 21 October, until a new legislative framework is in place.

13 We are working collaboratively with our regulatory partners in Northern Ireland, as well as the Nursing and Midwifery Council, to provide clarity for health professionals about their professional obligations following this legal change.
Remote prescribing

14 Along with other regulators and royal colleges we will shortly be publishing shared principles on remote consultations and prescribing for all UK healthcare professionals.

15 The principles outline a clear set of expectations for all UK healthcare professionals when prescribing remotely, whether online, over video-link or by phone.

16 Remote consultations and prescribing can benefit patients who want flexible access to healthcare. However, there are potential patient safety risks, particularly when the remote healthcare provider is not their regular prescriber. This work is part of our shared commitment to encourage good practice and ensure suitable safeguards are in place to protect patients.

17 We also intend to launch a call for evidence on remote consultations and prescribing by doctors. We are taking this step to help us understand whether our advice on this in *Good practice in prescribing and managing medicines and devices* needs to be developed further, given the fast past of change in remote healthcare services.

Weston General Hospital

18 We have been working with Weston Area Health NHS Trust to make sure that our postgraduate training standards are met.

19 We had particular concerns about the emergency medicine department and in September 2019 we asked the trust and local NHS leaders to provide us with a concrete proposal for addressing these issues.

20 We received their plan on 30 September 2019 and are satisfied with the actions they’re taking to protect trainees and patients. As a result, we’ve decided that GP and foundation trainees can continue their training in Weston’s emergency department, although the conditions we previously set on training in emergency medicine and urology in September 2018 remain in place.

21 Health Education England – as the organisation responsible for organising and delivering postgraduate training – will continue to work closely with trainees in the emergency department, to check they have the support they need.

22 We’ll continue to monitor training at Weston General Hospital to make sure a safe, effective and positive learning environment can be maintained.
Progress on our strategy

Medical Licensing Assessment (MLA)

23 The MLA will enable us to assess UK medical graduates and international medical graduates (IMGs) together. This will ensure that they meet a common threshold for safe practise before registering for a licence to practise.

24 In June 2019, we agreed that we will continue to appoint an exam board to set test papers for UK students and IMGs as well as mark and return the Applied Knowledge Test (AKT) results. However, we will allow medical schools to deliver the AKT at a time that suits their curricula and assessment cycle.

25 We will use a phased approach to implementation. Extensive piloting will take place into 2022, before full implementation from 2023 for UK medical schools and students, and international candidates. From 2024 onwards, UK graduates will have to pass the MLA to achieve a degree recognised by us as a primary medical qualification.

26 On 30 September 2019 we launched a UK-wide communications campaign about the MLA. This included the publication of the following material:

- The content map. This shows the professional skills, knowledge and behaviours that could be covered in the applied knowledge test or the clinical and professional skills assessment (CPSA). It is based on Good medical practice (GMP), Outcomes for graduates (2018) and the Generic professional capabilities framework (2017).

- A thematic report on medical schools’ CPSAs.

- Revised CPSA requirements for piloting.

- Transitional arrangements for IMGs.

- Refreshed webpages to provide updated information about the MLA – these include specific sections to help medical schools, medical students and international medical graduates access the information they need to prepare for the MLA’s introduction.

Executive Board

27 The Executive Board met on 30 September 2019 to consider items on:

- The regular high-level updates on operational performance on areas including finance and people, customer service and learning. There was a more detailed review of the Corporate Risk Register and risk reporting.
Guidance for Medical Practitioners’ Tribunals on Restoration Following Disciplinary Erasure, which the Board approved, alongside related changes to guidance for doctors in such circumstances. A recent Court of Appeal case noted the need for more guidance on how tribunals should exercise discretion with reference to the GMC’s overarching objective in restoration case following disciplinary erasure.

Accommodation strategy, in particular an update on the proposed layout for the reconfiguration of the London office space. There is increasing demand for desk space, so there are plans to manage this through scheduled home working and the implementation of more flexible workspace.

The Board also noted the annual health and safety report, which provided an overview of health and safety activities and accident/incident data for 2018. This report forms part of our review of our health and safety processes, to ensure we align to the British Standard for health and safety management systems.
Executive summary
This is an update on the review of our guidance on consent, summarising the process of guidance development, including engagement with all of our main key stakeholders and a formal consultation on a revised draft guidance. The new guidance Decision making and consent is presented to Council for approval. The key changes are highlighted at paragraphs 7-12.

The rest of the paper sets out our plans for implementing the guidance once it’s published. Following on from the conversation at the Council seminar in April, we’ll use our evidence base to target doctors in particular specialties, as well as having sustained themed promotion of the guidance addressing issues we know all doctors find challenging. We’re working with partner organisations to try and influence behaviour change, and exploring ways to support doctors and patients to improved decision making.

Recommendations

a To agree that the process by which the guidance on consent was reviewed provided sufficient and appropriate opportunities for key interest groups to inform the decisions about content and format.

b To approve for publication the revised draft guidance Decision making and consent at Annex A.

c To consider our developing plans to support doctors put the guidance into practice, over a 12-18 month period.
The review of our guidance on consent

1 In 2016 we began work to revise our 2008 guidance on consent to make sure it remained compatible with the law and relevant to medical practice.

2 After an initial scoping and evidence gathering phase, during which we commissioned research about doctors’ and patients’ attitudes to consent, we established a Task and finish group (TFG), chaired by Professor Deborah Bowman MBE. Under the TFG’s direction a new draft of the guidance was developed.

3 The draft revised guidance was considered by Council on 18 February 2018 when concerns were raised about how it might be received by a profession under pressure. Following a review of the tone and language, as suggested by Council, the draft for consultation was agreed by the Executive Board.

4 Between October 2018 and January 2019 we carried out a consultation on this revised draft, *Decision making and consent*, during which we held engagement events with individuals and organisations including groups of doctors, patients and carers, Royal Colleges, Government officials around the UK, and 582 written responses were received from individuals and organisations around the UK.

5 At its meeting on 27 February 2019 Council considered the emerging findings from the consultation, which indicated high levels of support for the new draft, based on quantitative analysis of the data. Council noted the wide-ranging engagement with a variety of stakeholders around the UK, and the positive response this generated.

6 Detailed qualitative analysis of the consultation data took place over the following months and high level policy recommendations were agreed by the TFG in May, with a first redraft being considered at its final meeting on 15 July 2019. Over the summer subsequent redrafts of the guidance were considered by TFG members, colleagues in Fitness to Practise policy, and the Chair of Council.

7 Given Council’s previous concern about how the draft guidance would be received by the profession, we added a new step to our guidance development process: late-stage testing of the draft guidance. We informally tested recent versions of the guidance, in confidence, with frontline doctors in various specialties, and bodies representing them. All those asked responded positively to the question “Is it reasonable that the GMC should expect these standards of all doctors?”. As a result, we are confident that the draft at Annex A describes good practice as frontline doctors expect to see it and sets achievable standards which we can reasonably expect of all doctors.

8 After a *Tone of Voice* edit the guidance will be ready to publish at the end of this year, although colleagues in Communications indicate that early 2020 may be
preferable for launch. The guidance will come into effect three months after the publication date.

9 We’ve developed a draft document which gives more detail about each stage of the guidance development process, and carried out an equality analysis, setting out the steps we’ve taken to comply with the public sector duty under the Equality Act 2010. Both these documents are available as additional reading and will be published alongside the guidance.

**What is different about the new guidance?**

10 The revised draft, at Annex A, is 20% shorter than the consultation draft, with less repetition, and we’ve restructured it to make it easier to navigate. The key changes are set out below.

- **a** There is a strong 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.

- **b** The guidance acknowledges the intense pressure that doctors are under with new paragraphs about time and resource constraints and support from other members of the healthcare team.

- **c** We make 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 will produce an infographic to help doctors navigate the guidance for decisions of varying complexity and urgency.

- **d** The description of the relationship between the guidance and action under our FtP procedures has been softened, to make clear that (with the new words in bold text):

  *Only* serious or persistent failure to follow our guidance *that poses a risk to patient safety or public trust in doctors* will put your registration at risk.

11 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* – which essentially ratified our 2008 guidance – indicated that the

* Montgomery (Appellant) v Lanarkshire Health Board [2015] UKSC 11
guidance was not well known by doctors and was not routinely being followed. The ongoing Independent Medicines and Medical Devices Safety Review, chaired by Baroness Julia Cumberledge CBE DL, has similarly highlighted a disparity between the standards set in GMC guidance and its application by doctors in day to day practice. How we implement the guidance – i.e. how we support doctors to practise in line with it – will therefore have major implications for how effective it is.

Implementing the guidance

12 Since discussing our new OneGMC approach to implementation with Council in April, we’ve worked closely with colleagues across the business to develop a roadmap of activity to support good practice, taking into account:

- 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.

13 This is a new approach: in the past we have focused our attention mainly on individual doctors. While individual doctors remain a key audience for promotion we have also thought more about the levers we can use to influence change. To this end, we have identified and begun conversations with partner organisations to explore how they can help us land messages and influence behaviour change. We are also working with colleagues in the education teams to understand how best to influence how the guidance is taught in undergraduate and postgraduate education.

14 We know from our pre-consultation research, the consultation itself, data on fitness to practise allegations and intelligence from the outreach teams that doctors in particular specialties can face specific challenges. We have identified surgeons, obstetricians and gynaecologists and GPs as particular cohorts to prioritise. And we have begun discussions with the three relevant medical royal colleges to explore how we can collaborate to help their members work in line with the guidance. We’re discussing how they might be able to help us communicate messages to their members and what resources they have that we might promote. We’re also working with the Academy of Medical Royal Colleges to explore developing some specialty-specific examples to illustrate how the guidance works in practice.
15 We also want to make the connection between our guidance and the work in the wider system to support patient centred care and shared decision making. For example, we are engaging with NHS England to understand how we can influence the development of new training materials and modules they are developing to support personalised care. Throughout the review we have also engaged with the Realistic Medicine Team in the Scottish Government and we’re in close contact with the offices in all the devolved nations to ensure that we identify similar opportunities across the whole of the UK.

16 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. Providing support for appraisal discussions is one idea, and NHS England has offered to develop a template on shared decision making to support appraisal discussions. NHS England has also offered to write out to clinical/medical directors in support of the guidance and we’re exploring with the devolved offices the best ways of engaging senior leaders in Northern Ireland, Wales and Scotland.

17 Patients are another key group. We are engaging with our strategic patient group to understand how best to support patients to understand what they can expect from their doctors. We’re aware that there are many patient resources already available from other sources, such as procedure-specific decision tools and examples of questions to ask doctors. While we don’t want to replicate content, we plan to use patient voices to shape our messaging, and we’ll use our strategic relationships with patient stakeholder groups to explore possibilities for other patient-focused materials.

18 In terms of GMC-led activity to support the guidance, there are three main elements.

a **Communications around the launch (publication) of the new guidance.** This will include contact with all doctors, writing to medical/clinical directors via NHS England, media work and contact with partner organisations including medical defence organisations and some high priority Medical Royal Colleges.

b **A sustained, themed campaign** addressing issues that we know from our evidence are particularly challenging for doctors. There will be four themes that will run consecutively, beginning when the guidance comes into effect. These themes are:

   i  key messages about decision making and proportionality

   ii  the importance of communication and listening

   iii  roles and responsibilities
iv assessing capacity

This approach means that the issue of decision making and consent will be visible to doctors over an extended period while remaining engaging and digestible. It also gives us the opportunity to evaluate the work as we go and learn from this as we develop the later themes.

c Some **targeted interventions** aimed at particular cohorts that we’ve identified through our evidence. These include some speciality groups, IMGs and F1/F2 trainees. Interventions planned already include a multi-media app that we will promote to doctors who book to take the PLAB 2 assessment and face to face sessions with foundation trainees. These interventions allow us to link in to existing activity, contacting doctors at times and in ways that maximise our reach.

19 We are in the early stages of planning the detail of these activities. We expect the whole implementation programme to run for 12-18 months beyond the date on which the guidance comes into effect.
M4 – Review of guidance on decision making and consent

M4 – Annex A

Decision making and consent v8.8
## Contents

**About this guidance** ................................................................................................................................. 4

How to use this guidance .............................................................................................................................. 4

Terminology .................................................................................................................................................. 5

The seven principles of decision making and consent ....................................................................................... 6

The scope of this guidance ............................................................................................................................. 7

Taking a proportionate approach ................................................................................................................... 7

The dialogue leading to a decision .................................................................................................................. 9

  The information you give patients................................................................................................................... 9

  Exceptional circumstances in which you may decide not to share all relevant information ........................................................................................................................................ 11

Finding out what matters to your patient ....................................................................................................... 11

Discussing benefits and harms ....................................................................................................................... 12

Answering questions and dealing with uncertainty ......................................................................................... 13

Supporting patients’ decision making ........................................................................................................... 13

The scope of decisions ..................................................................................................................................... 15

  Looking ahead to future decisions.................................................................................................................. 15

Support from other members of the healthcare team ......................................................................................... 17

  Responsibility and delegation ......................................................................................................................... 18

If you disagree with your patient’s choice of option ....................................................................................... 19

Recording decisions ........................................................................................................................................ 20

  Consent forms................................................................................................................................................ 21

Reviewing decisions ........................................................................................................................................ 21

Circumstances that affect the decision-making process ..................................................................................... 22

  Time and resource constraints......................................................................................................................... 22

  Treatment in emergencies ................................................................................................................................. 23

If your patient doesn’t want to be involved in making the decision .................................................................. 23

If you’re concerned a patient can’t make a decision freely ............................................................................... 24

If your patient may lack capacity to make the decision ..................................................................................... 26

  Mental capacity .............................................................................................................................................. 26

  The legal framework ....................................................................................................................................... 26

  Presuming capacity ....................................................................................................................................... 26

  Assessing capacity ........................................................................................................................................ 27
Making a decision when your patient lacks capacity: ‘overall benefit’ .........................28
Making decisions about treatment and care when a patient’s right to consent is affected by law.................................................................30
Taking a patient-centred approach ..............................................................30
About this guidance

Consent is a fundamental legal and ethical principle. All patients have the right to be involved in decisions about their treatment and care and to make informed decisions if possible.

Doctors must be satisfied that they have a patient’s consent or other valid authority before providing treatment or care. The purpose of this guidance is to help doctors to meet this standard. It reflects the ethical principles underpinning good practice.

While the law relating to decision making varies across the UK, this guidance is consistent with the law in all four countries and supports doctors to act within it. Key legislation and case law relating to decision making is summarised in the Legal Annex¹. Doctors are expected to keep up to date with the law and follow our guidance and other regulations relevant to their work.

The guidance is addressed to doctors but may also be of interest to others.

How to use this guidance

This is guidance on good practice. It sets out a framework for decision making that will help you practise ethically and in line with the law. If you’re not sure how the law applies in a particular situation, seek advice through local procedures, consult your defence body or professional association, or seek independent legal advice.

You must use your professional judgement to apply this and other GMC guidance² to your practice. If you do this, act in good faith and in the interests of patients, you will be able to explain and justify your decisions and actions. Only serious or persistent failure to follow our guidance that poses a risk to patient safety or public trust in doctors will put your registration at risk.

¹ Available online at www.gmc-uk.org/***
² Good medical practice and all its explanatory guidance. For a full list go to www.gmc-uk.org/guidance
**Terminology**

We use the terms ‘must’ and ‘should’ in the following ways.

- ‘You must’ is used for an overriding duty or principle.

- ‘You should’ is used in two ways:
  - when we are explaining how to meet an overriding duty
  - where the duty or principle doesn’t apply in all situations or circumstances, or there are factors outside your control that affect whether or how you can follow the guidance.
The seven principles of decision making and consent

- All patients have the right to be involved in decisions about their treatment and care, and be supported to make informed decisions if possible.

- Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient.

- All patients have a right to be listened to, to be given the information they need to make a decision, and the time and support they need to understand it.

- Doctors must seek to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.

- Doctors must start from the presumption that all adult patients have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements.

- The choice of treatment or care for patients who lack capacity must be of overall benefit to them, and decisions should be made in consultation with others close to them or advocating for them.

- Patients whose right to consent is affected by law should be supported to be involved in the decision making process, and to exercise choice if possible.
The scope of this guidance

1. This guidance is relevant to all the health and care decisions that you and your patient make together. This includes decisions about treatments, procedures, interventions, investigations, screening, examinations and referrals.

2. Decisions about providing innovative treatments or approaches are covered by this guidance, and we have additional guidance about research. Decisions about consent to disclosure of information are covered in our guidance on Confidentiality.

3. This guidance applies equally to decisions about mental and physical health, and in whatever setting your interaction with a patient takes place, including remote consultations.

Taking a proportionate approach

4. Not every paragraph of this guidance will be relevant to every decision that you make with or about a patient. Your judgement about how to apply the guidance will depend on the specific circumstances of each decision, including:

   a. the nature and severity of the patient’s condition and how quickly the decision must be made

   b. the complexity of the decision, the number of available options and the level of risk or degree of uncertainty associated with any of them

   c. the impact of the potential outcome on the patient’s individual circumstances

   d. what you already know about the patient, and what they already know about their condition and the potential options for treating or managing it

   e. the nature of the consultation.

3 See paragraphs 58-59 on Treatment in emergencies
5 Obtaining a patient’s consent needn’t always be a formal, time-consuming process. While some interventions require a patient’s signature on a form, for most healthcare decisions you can rely on a patient’s verbal consent to provide treatment or care, as long as you are satisfied they’ve had opportunity to consider any relevant information (see paragraph 9) and decided to go ahead.

6 For some quick, minimally or non-invasive interventions – particularly examinations – it would be reasonable to rely on a patient’s non-verbal consent. Examinations are a necessary part of diagnosis, and it’s reasonable to believe that a patient presenting for a consultation wants to be diagnosed. However, even for such routine procedures you should:

- a explain what you’re going to do and why,
- b make clear the patient can say no, and stop immediately if they do
- c be alert for any sign that they may be confused or unhappy about what you are doing.

The dialogue leading to a decision

7 The exchange of information between doctor and patient is central to good decision making. It’s during this process that you can find out what’s important to the patient so you can identify the information they will need to make the decision.

8 The purpose of the dialogue is:

- to help the patient understand their role in the process, and their right to choose whether or not to have treatment or care

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4 Example: treatment covered under HFEA Act
5 NB although the patient can give consent verbally (or non-verbally) you should make sure this is recorded in their notes – see paragraphs 48-49 for more information.

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to make sure the patient has the opportunity to consider relevant information that might influence their choice between the available options.

- to try and reach a shared understanding of the expectations and limitations of the available options.

The information you give patients

9 You must give patients the information they want or need to make the decision. This will usually include:

a diagnosis and prognosis

b uncertainties about the diagnosis or prognosis, including options for further investigation

c options for treating or managing the condition, including the option to take no action

d the nature of each option, what would be involved, and the desired outcome

e the potential benefits, risks of harm, uncertainties about and likelihood of success for each option, including the option to take no action.

10 You must try to make sure the information you share with patients about the options is objective. You should be aware of how your own preferences might influence the advice you give and the language you use. When recommending an option for treatment or care to a patient you must explain your reasons for doing so, and also share information about reasonable alternatives including the option to take no action. You must not put pressure on a patient to accept your advice.

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6 See also paragraphs 24-25 on discussing uncertainties

7 We use ‘harm’ here to mean any potential negative outcome, including side effects and complications. See section on Discussing benefits and harms (paragraphs 20-23)

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11. You should not rely on assumptions about:

   a. the information a patient might want or need
   b. the factors a patient might consider significant
   c. the importance a patient might attach to different outcomes.

12. Other examples of information that might be relevant and, if so, should be shared with patients include:

   a. whether an option is an innovative treatment designed specifically for their benefit
   b. whether there is a time limit on making their decision and what might the implications be of delaying
   c. the names and roles of key people who will be involved in their care, and who they can contact (and how) if they have questions or concerns
   d. their right to refuse to take part in teaching or research
   e. their right to seek a second opinion
   f. any bills they will have to pay
   g. any conflicts of interest that you or your organisation may have
   h. any treatments that you believe have greater potential benefit for the patient than those you or your organisation can offer.
Exceptional circumstances in which you may decide not to share all relevant information

13 You should not withhold information the patient needs to make a decision for any reason, including if a patient’s relative, partner, friend or carer asks you to.8

14 There may be circumstances in which you decide not to share all relevant information with the patient straight away. If you delay sharing information necessary for making a decision, you should let the patient know there’s more to discuss and make sure arrangements are made to share the information as soon as it’s appropriate to do so. You must make a record of the information you still need to share, your reasons for not sharing it now, and when it can be shared.

Finding out what matters to the patient

15 You must listen to patients and encourage them to ask questions.

16 You should try to find out what matters to patients about their health – their wishes and fears, what activities are important to their quality of life, both personally and professionally – so you can support them to assess the likely impact of the potential outcomes for each option.

17 You must seek to explore your patient’s needs, the values and priorities that influence their decision making, their concerns and preferences about the options and their expectations about what treatment or care could achieve.

18 You should ask questions to encourage patients to express what matters to them, so you can identify what information about the options might influence their choice between them.

8 In very exceptional circumstances you may feel that sharing information with a patient would cause them serious harm and, in such circumstances, it may be appropriate to withhold this information. In this context ‘serious harm’ means more than that the patient might become upset or decide to refuse treatment. Seek legal advice if you are considering withholding information. Please see the legal annex for relevant case law. [Montgomery vs Lanarkshire 2015].
19 You should explore with patients what risks they would, and wouldn’t, be prepared to take to achieve a desired outcome, and how the likelihood of a particular outcome might influence their choice of option.

**Discussing benefits and harms**

20 You must give patients clear, accurate and up to date information, based on the best available evidence, about the potential benefits and risks of harm of each option, including the option to take no action.

21 It wouldn’t be reasonable to share every possible risk of harm, potential complication or side effect. Instead you should tailor the discussion to each individual patient, guided by what matters to them, and share information in a way they can understand.

22 You should usually include the following information when discussing benefits and harms:

   a Recognised risks of harm that you believe anyone in the patient’s position would want to know. You’ll know these already from your professional knowledge and experience.

   b The effect of the patient’s individual clinical circumstances on the probability of a benefit or harm occurring. If you know the patient’s medical history, you’ll know some of what you need to share already, but the dialogue could reveal more.

   c Risks of harm and potential benefits that the patient would consider significant for any reason. These will be revealed during your dialogue with the patient about what matters to them.

   d Any risk of serious harm, however unlikely it is to occur.

   e Expected harms including common side effects, and what to do if they occur.

9 “Risk” used here as a shorthand for risk of harm i.e. the likelihood of any negative outcome occurring including side effects and complications.

10 See *Finding out what matters to the patient*, paragraphs 15-19.
23 You should consider using visual or other explanatory aids to support patients to understand their personalised risk, taking account of their individual clinical and personal circumstances, compared with population level risk.

**Answering questions and dealing with uncertainty**

24 You must answer patients’ questions honestly and accurately, and as fully as is practical in the circumstances. You must be clear about the limits of your knowledge and, if you can’t answer a question, explain whether it is something you are uncertain of or something that is inherently uncertain.

25 If you are uncertain about the diagnosis, or the clinical effect a particular treatment might have, or if the available evidence of benefits and harms of an option is unclear, you should explain this to the patient. Some things will become clearer after treatment starts, and so you should discuss in advance what the arrangements will be for monitoring the effect of the treatment and reviewing the decision to provide it. You should also explore in advance what choices the patient might make, and the factors influencing them.

**Supporting patients’ decision making**

26 Patients need relevant information\(^{12}\) to be shared in a way they can understand and retain it, so they can use it to make a decision. To help patients understand and retain relevant information you should:

- a share it in a place and at a time when they are most likely to understand and retain it
- b anticipate whether they are likely to find any of it distressing and, if so, be considerate when sharing it
- c use an interpreter or translation service if they have difficulty understanding spoken English

\(^{11}\) see paras 15-19, *Finding out what matters to the patient* and 20-23 on *Discussing benefits and harms*

\(^{12}\) *Relevant information* = listed in paragraph 9a-e
d share it in a format they prefer - written, audio, translated, pictures\textsuperscript{13} or other media or methods

e give them time and opportunity to consider it, before and after making a decision

f consider sharing it in advance if appropriate\textsuperscript{14} and/or enabling them to take it away

g consider using patient decision aids, or other explanatory aids in a format they prefer.

27 You should be alert to signs that patients may need support to understand and retain the relevant information, use it to make a decision, and communicate that decision to you.

28 You should make sure that reasonable adjustments\textsuperscript{15} are made so that patients with additional needs have enough time and support to understand relevant information and make a decision. In all cases, you must treat patients fairly and not discriminate against them.

29 You must check whether patients have understood the information they have been given, and if they would like more information before making a decision.

The scope of decisions

30 You must be clear about the scope of decisions so that patients understand exactly what they are consenting to. You must not exceed the scope of a patient’s consent, except in an emergency (see paragraphs 58-59). Agreeing the scope of a patient’s consent with them in advance is particularly important if:

\textsuperscript{13} For example https://booksbeyondwords.co.uk/

\textsuperscript{14} For example www.explainmyprocedure.com

\textsuperscript{15} GMP paragraph 60 states “You must consider and respond to the needs of disabled patients and should make reasonable adjustments to your practice so they can receive care to meet their needs.” ‘Reasonable adjustments’ does not only mean changes to the physical environment. It can include, for example, being flexible about appointment time or length, and making arrangements for those with communication difficulties such as impaired hearing. For more information see the EHRC website.
a treatment or care will be provided in stages with opportunity to review and make adjustments in between

b different healthcare professionals will provide different parts of the treatment or care

c there may be opportunity, once an intervention is underway and the patient’s decision making ability is compromised, to carry out another intervention

d there is significant risk of a specific harm occurring during an intervention, which would present more than one way to proceed.\(^{16}\)

**Looking ahead to future decisions**

31 For some patients, there are foreseeable circumstances when they will have a choice of options at a time when they might find it more difficult to make decisions – for example:

a because they may be in pain, confused or afraid

b because their capacity or insight may be impaired by their condition or the effects of an intervention

c because a decision may need to be made quickly so there will be less time for dialogue.

32 You should anticipate such circumstances and discuss them with patients in advance if practical, so that when a decision needs to be made patients have already had time and opportunity to consider the relevant information.\(^{17}\) Discussing a risk of serious harm will be easier to do in advance than in a time-pressured situation when the patient might be in pain, confused or afraid, and the mention of potential serious harm for the first time could be distressing.

\(^{16}\) See paragraphs 20-23 on *Discussing benefits and harms.*

\(^{17}\) See paragraph 9a-e
33 Discussing options in advance doesn’t remove the need to have a further dialogue immediately before providing treatment, and at regular intervals as treatment or care progresses. Even if there’s a care plan in place, or the patient’s made an advance decision, you will still need to talk to them about the options available in case the options have changed, or the patient has changed their mind.

34 If a patient has a condition that is likely to impair their capacity as it progresses, you should sensitively encourage them to think about what they might want to happen if they become unable to make healthcare decisions. You should bear in mind that some patients may not be ready to talk about these issues. Such discussions might include:

- the patient’s wishes and fears, their concerns and preferences about their future care, and the values and priorities that influence their decision making
- any treatment or care the patient might want to refuse, and in what circumstances
- any interventions that might become necessary in an emergency such as cardiopulmonary resuscitation (CPR)
- whether the patient would like anyone else – relatives, friends, carers or representatives – to be involved in decisions about their care.

35 A patient may want to nominate someone to make decisions on their behalf if they lose capacity or may want to make an advance statement about refusing or requesting a particular treatment. In these circumstances, you should let patients know that there are ways to formalise their wishes and suggest how they can seek support and independent advice about this.

36 You must record a summary of your discussion with the patient and any decisions they make, including as much detail as practical about the patient’s wishes and fears, their concerns and preferences about their future care, and the values and priorities that influence their decision making. If possible, you should make this record while the

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18 See paragraphs in *Treatment and care towards the end of life*.
19 See legal annex.
patient has capacity to review and understand it. You should make sure this record is made available to the patient and others involved in their care, so everyone is clear about what has been agreed: this is particularly important if the patient has made an advance decision to refuse treatment. You should bear in mind that care plans need to be reviewed regularly and may need to be updated.

37 If you are giving treatment or care to a patient who is nearing the end of their life, you must follow the guidance in *Treatment and care towards the end of life: decision making.*

**Support from other members of the healthcare team**

38 Because decision making is a dynamic, ongoing process, a team-based approach can be helpful in fulfilling patients’ information needs, which may change as their treatment or care progresses.

39 There may be members of your healthcare team who are expert in particular conditions and their treatment, who are skilled communicators, or with whom the patient has already developed a trusting relationship. You should consider the role these team members could play in contributing to the dialogue leading to a decision while following the guidance on responsibility and delegation.

**Responsibility and delegation**

40 You may decide to delegate part of the decision making process, such as sharing detailed information with a patient about a specific intervention. This type of delegation is routinely used in some multidisciplinary teams for specific interventions.

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20 Please see the legal annex for more information about advance refusals. [Please see Mental Capacity Act 2005 ss 24-26 for information about advance decisions in England and Wales. In Scotland, advance decisions have not been tested by the courts, but it is likely that they would be treated as legally binding if they were directly applicable to the circumstances. In Northern Ireland, they are governed by common law although when it comes into force, the Mental Capacity Act (Northern Ireland (2016) will place them on a statutory footing.]

21 See paragraphs 9-29.

22 See paragraphs 40-45.

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41 When deciding whether it is appropriate to delegate, you should consider:

a the nature of the intervention, and the complexity of the information about it

b the level of uncertainty surrounding the outcome

c whether the patient has already developed a trusting relationship with you or the person you would delegate to

d anything unusual about the patient’s conditions and any concerns that you anticipate the patient may have.

42 You must make sure the person you delegate to:

a is suitably trained and competent

b has sufficient knowledge of the intervention and associated benefits and harms, as well as alternative options for treatment and care

c has the skills to have a dialogue with the patient, following this guidance

d feels competent to carry out the delegated task, and understands and agrees that they will revert to you (or another appropriate colleague) for further information, advice or support if necessary.

43 If part of the decision making process has been delegated, you are still responsible for making sure that the patient has been given the information they need to make a decision, has had time and support to consider it, and has given their consent before you provide treatment or care. You should also check that the patient has a realistic expectation of the outcome.

44 If a colleague who is sharing information with a patient on your behalf raises concerns about their competence to do this you should offer support, supervision or training and/or make alternative arrangements.

23 See paragraph 9.
If a colleague asks you to share information with a patient or seek a patient’s consent on their behalf, you must be satisfied you have the necessary knowledge and skills to do so in line with this guidance. If you’re not, you should explain this and seek support. If you believe you’re being asked to practise outside your competence, or you are insufficiently supported you must consider raising a concern.

If you disagree with your patient’s choice of option

You must respect your patient’s right to decide. If their choice of option (or decision to take no action) seems out of character, or inconsistent with their beliefs and values, it may be reasonable to check their understanding of the relevant information and their expectations about the likely outcome of this option and the alternatives. If it’s not clear whether a patient understands the consequences of their decision, you should offer more support to help them understand the relevant information. But you must not assume a patient lacks capacity simply because they make a decision that you consider unwise.

If a patient asks for treatment or care that you don’t think would be in their clinical interests, you should explore their reasons for requesting it, their understanding of what it would involve and their expectations about the likely outcome. This discussion will help you take account of factors that are significant to the patient and assess whether providing the treatment or care could serve the patient’s needs. If after discussion you still consider that the treatment or care would not serve the patient’s needs, then you should not provide it. But you should explain your reasons to the patient and explore other options that might be available, including their right to seek a second opinion.

24 Cross-ref GMP you must work within the limits of your competence.
25 See our guidance on Raising and acting on concerns about patient safety and/or call the GMC’s confidential helpline for advice on 0161 923 6399.
26 See Finding out what matters to your patient, paragraphs 15-19
Recording decisions

48 Keeping accurate records of decisions and the reasoning behind them is necessary for continuity of care for patients. It will also help you explain and justify your decisions and actions, which you must always be prepared to do\textsuperscript{27}.

49 You should take a proportionate approach to the level of detail you record. You must record any decisions made about patients’ treatment and care, including decisions to take no action. You should usually include a summary of the discussion:

a relevant information\textsuperscript{28} shared with the patient about diagnosis, treatment options, and what was discussed about the potential benefits and risks of harm of each option

b information the patient gives you about what matters to them\textsuperscript{29} – specific needs, concerns and preferences they express, and anything they specifically request

c what you and the patient discuss about the likely outcome of treatment, and whether you reach a shared expectation

d information about the circumstances in which the decision was made, if this might be helpful to subsequent decisions about the patient’s care.

Consent forms

50 Consent forms can be a helpful prompt to share key information, as well as a standard way to record a decision that can make regular review easier. They can also be used to review decisions made at an earlier stage, and the relevant information they were based on.

\textsuperscript{27} GMP paragraph 4.
\textsuperscript{28} See paragraph 9.
\textsuperscript{29} See Finding out what matters to your patient, paragraphs 15-19.
51 But filling in a consent form isn’t a substitute for a meaningful dialogue tailored to the individual patient’s needs.\(^{30}\)

**Reviewing decisions**

52 Unless treatment or care begins immediately after the patient has given consent, there will be opportunity for a decision to be reviewed.

53 You should review a patient’s decision immediately before providing treatment or care and, if treatment is ongoing, make sure there are clear arrangements in place to review decisions regularly, allowing patients opportunity to ask questions and discuss any concerns. You should also consider regularly reviewing a decision to take no action.

54 Reviewing a decision is particularly important:

- **a** if you haven’t personally had a discussion with the patient because the patient was initially seen by a colleague
- **b** if significant time has passed since the decision was made
- **c** if the patient’s condition has changed
- **d** if you have reason to believe the patient might have changed their mind
- **e** if any aspect of the chosen treatment or care has changed
- **f** if new information has become available about the potential benefits or risks of harm of any of the options which might make the patient choose differently.

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\(^{30}\) Legal annex [See The lead judgment in *Montgomery*, at [90], made clear that a doctor’s duty would not be fulfilled by “routinely demanding [the patient’s] signature on a consent form; and *Thefaut* at [77]: “It is accepted that the simple fact that Mrs Thefaut signed the hospital consent form is not to be taken as an indication of acceptance of risk. In my view the document is of no real significance on the present facts. (It would have greater significance in emergency cases involving no prior contact between patient and clinician).”]
55 You must make sure that patients are kept informed about the progress of their treatment, and you should let patients know that they can change their mind at any time.

**Circumstances that affect the decision-making process**

**Time and resource constraints**

56 Being able to meet patients’ individual needs for information and support depends, in part, on the time and resources available to doctors and their colleagues in the organisations where they work. Where there are pressures on your time, or resources are limited, you should:

- **a** consider the role other members of the health and care team might play

- **b** consider what other sources of information and support are available to the patient: for example, patient information leaflets, advocacy services, expert patient programmes, or support groups for people with specific conditions.

57 If factors outside your control mean that patients aren’t being given the time or support they need to understand the relevant information, and this seriously compromises their ability to make informed decisions, you must consider raising a concern. You should also consider if it is appropriate to proceed, bearing in mind that you must be satisfied that you have the patient’s consent or other valid authority before providing treatment or care.

**Treatment in emergencies**

58 In an emergency, decisions may have to be made quickly so there’ll be less time to apply this guidance in detail, but the principles remain the same. You must presume a

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31 See paragraphs on support from other members of the healthcare team.
32 See GMC guidance on *Raising and acting on concerns about patient safety* and/or call the GMC’s confidential helpline for advice on 0161 923 6399.

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conscious patient has capacity to make decisions and seek consent before providing treatment or care.

59 If a patient in an emergency situation is unconscious or you otherwise conclude that they lack capacity, you can provide treatment that you believe will be of overall benefit to them, in line with paragraphs 83-90. If there are options, the treatment you provide should be the least restrictive of the patient’s rights and freedoms, including their future choices. For as long as the patient lacks capacity, you should provide ongoing care following the guidance in paragraphs 83-90. If the patient regains capacity while in your care, you must tell them what has been done, and why, as soon as they are sufficiently recovered to understand. And you must discuss with them the options for any ongoing treatment.

If your patient doesn’t want to be involved in making the decision

60 No one else can make a decision on behalf of an adult who has capacity. If a patient who has capacity asks you or someone else to make a decision on their behalf, you should explain this to them. You should explain that it’s important they understand some basic information so that you can proceed with treatment or care. This would usually include what the options are, and what they aim to achieve.

61 If a patient has chosen an option but doesn’t want to discuss the details, you should explain they will need to have some information about what it would involve before you can proceed, such as:

- whether the procedure is invasive
- what level of pain or discomfort they might experience and what can be done to minimise it
- anything they should do to prepare for the intervention

33 See also paragraphs 76 and 79.
if it involves any risk of serious harm.

62 You should try to find out why they don’t want to be involved in decision making and explore whether you can do anything to reassure and support them. They might be anxious about the decision or overwhelmed by the information and need time or support to process it.

63 If, after trying to discuss options with them along the lines set out above, your patient insists that they don’t want even this basic information, you will need to judge whether their consent is valid so that you can proceed. This is more likely to be the case if the proposed option is a well-established intervention commonly used for treating the condition they have, and there’s reason to believe the patient wants to be treated or cared for rather than take no action. You should consider seeking advice from your medical defence body or professional association in these circumstances.

If you’re concerned a patient can’t make a decision freely

64 Many factors influence patients’ decision making, but it’s important that nothing influences a patient to such an extent that they can’t exercise free will. If a patient can’t make a decision freely, they won’t be able to consent.

65 Patients may feel pressure to have particular treatment or care. Pressure can come from others – partners, relatives or carers, employers or insurers – or from patients’ beliefs about themselves and society’s expectations.

66 You should be aware of this possibility and of other situations in which patients may be particularly vulnerable or susceptible to pressure, for example, if they are:

a experiencing domestic or other forms of abuse

b resident in a care home

c cared for or supported by others because of a disability

d detained by the police or immigration services, or in prison
subject to compulsory treatment or assessment orders, or at risk of becoming so\textsuperscript{34}.

\textbf{67} If you suspect a patient’s rights have been abused or denied, you must follow local safeguarding procedures and consider raising a concern.

\textbf{68} You should do your best to make sure patients reach their own decision, having considered relevant information\textsuperscript{35} about the available options including the option to take no action likely outcomes. You should support them to make a decision, following the steps in paras 26-29 as well as:

- giving them more time and a safe, quiet space to consider the options
- making sure you have an opportunity to talk to them on their own
- signposting them to specialist support services.

\textbf{69} You must make sure your patient is aware that they have the right to choose whether or not to have treatment. You should not proceed with treatment or care if you don’t think it will serve the patient’s needs\textsuperscript{36}.

\textbf{70} If, after following the guidance in paragraphs 68-69, you still believe a patient is under such extreme pressure to agree to or refuse a particular intervention that they can’t exercise free will, or that their capacity to make a decision may be impaired\textsuperscript{37,38}, you should seek advice through local procedures, consult your medical defence body or professional association or seek independent legal advice.

\textsuperscript{34} See paragraphs 89-91 on when a patient’s ability to consent is affected by law.
\textsuperscript{35} See paragraph 9
\textsuperscript{36} See also paragraphs 46-47, If you disagree with your patient’s choice of option
\textsuperscript{37} See paragraphs 82-88 on making a decision when your patient lacks capacity
\textsuperscript{38} Link to legal annex: Where adults lack capacity due to fear, coercion or undue influence, in England and Wales, the High Court can authorise protective measures aimed at facilitating autonomous decision making. Please see the case law section of the legal annex. [Text for Legal Annex: (see \textit{LBL v RYJ} [2010] EWHC 2665 (Fam), [2011] 1 F.L.R. 1279 (“\textit{RYJ}”) at [62]).Please see Re DL [2012] EWCA Civ 253]
If your patient may lack capacity to make the decision

Mental capacity

71 Capacity is the ability to make a decision. This ability can vary depending on a patient’s condition and how it changes over time, and on the nature of the decision to be made. For this reason, capacity is described as ‘decision-specific’ and ‘time-specific’; so, a person can only ‘have capacity’ or ‘lack capacity’ to make a specific decision at a specific time, and not as a permanent state.

The legal framework

72 Each jurisdiction of the UK has its own mental capacity legislation which, together with accompanying codes of practice, provides a framework for making decisions when patients lack the capacity to decide for themselves.

73 You must be aware of your duties under the relevant legislation, and have regard to the relevant code of practice, wherever you practise in the UK.

74 The legal annex provides a summary of capacity legislation and relevant case law across the UK, and the impact these have on decision-making for people who lack (or may lack) capacity to make healthcare decisions, and those treating them.

75 The guidance that follows doesn’t explain the detail or use the specific language of the legislation, but it is consistent with the law across the UK. If you follow this guidance you will be acting lawfully.

Presuming capacity

76 You must start from the presumption that every adult patient has capacity to make decisions about their treatment care. You must not assume a patient lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including mental illness), their beliefs, their apparent inability to communicate, or because they choose an option that you consider unwise.
Assessing capacity

77 Assessing capacity is a core clinical skill and doesn’t necessarily require specialist input (eg by a psychiatrist). You should be able to draw reasonable conclusions about your patient’s capacity during your dialogue with them. You should be alert to signs that patients may lack capacity and must give them all reasonable help and support to make a decision (see paragraphs 26-29).

78 A person has capacity if they can do all the following:

a understand information relevant to the decision in question

b retain that information

c appreciate the relevance of the information, use and weigh it to make their decision

d communicate a decision.

79 If you believe that a patient may lack capacity to make a decision, you must assess their capacity using the test set out in the relevant legislation, taking account of the advice in the relevant guidance. If you find it difficult to judge whether a patient has capacity to make a decision, you should seek support from someone who knows the patient well: another member of the healthcare team or someone close to the patient.

80 In complex cases where you believe you’re unable to make a judgement, you should seek specialist input: from psychiatrists, neurologists, speech and language therapists or liaison nurses. You should also seek specialist input if the patient or someone close to them disagrees with your judgement.

81 If the patient may regain capacity and the decision can be delayed then you must consider this.

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39 See legal annex (legislation)
40 Link to legal annex relevant paras [s.4(c) of the new Act in Northern Ireland will codify the existing common law test of capacity case of PT]
Making a decision when the patient lacks capacity: ‘overall benefit’

82 We use the term ‘overall benefit’ to describe the ethical basis on which decisions are made about treatment and care for adult patients who lack capacity to decide for themselves. This involves weighing up the risks of harm and potential benefits for the individual patient of each of the options available, including the option of taking no action. ‘Overall benefit’ is consistent with the legal requirements to consider whether treatment ‘benefits’ a patient (Scotland), or is in the patient’s ‘best interests’ (England, Wales and Northern Ireland).

83 If you are the treating doctor then, before concluding that it is your responsibility to decide which option or options would be of overall benefit to a patient who lacks capacity, you should take reasonable steps to find out:

   a whether there’s evidence of the patient’s previously expressed values and preferences that may be legally binding, such as an advance statement or decision

   b whether someone else has the legal authority to make a decision on the patient’s behalf or has been appointed to represent them.

84 If there is no evidence of a legally binding advance refusal of treatment, and no one has legal authority to make this decision for them, then you are responsible for deciding what would be of overall benefit to your patient. In doing this you must:

   a consult with those close to the patient and other members of the healthcare team, take account of their views about what the patient would want, and aim to reach agreement with them

   b consider which option aligns most closely with the patient’s needs, preferences, values and priorities

41 See legal annex.
42 A person may be appointed or nominated to make decisions in the best interests of a patient who lacks capacity. See legal annex.
43 If the decision is about life sustaining treatment there are additional requirements as to whether a or b is valid at this point – see legal annex.

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c consider which option would be the least restrictive of the patient’s future options.

85 If a proposed option for treatment or care will restrict a patient’s right to personal freedom, you must consider whether you need legal authorisation\(^{44}\) to proceed with it in the circumstances.

86 You should allow enough time, if possible, for discussions with those who have an interest in the patient’s welfare, and you should aim to reach agreement about how to proceed.

**Resolving disagreements**

87 Sometimes members of the healthcare team disagree about what would be of overall benefit to the patient, or those close to the patient disagree with you and the healthcare team. It is preferable, and usually possible, to resolve disagreements about a patient’s treatment and care through local processes. For example, by:

- **a** involving an independent advocate or local mediation service
- **b** consulting a more experienced colleague and/or an independent expert
- **c** holding a case conference or seeking advice from a clinical ethics committee.

88 If, having taken these steps, there is still disagreement about a significant decision, you must follow any formal steps to resolve the disagreement that are required by law\(^{45}\) or set out in the relevant code of practice. You must make sure you are aware of the different people you must consult, their different decision-making roles and the weight you must attach to their views\(^{46}\). You should consider seeking legal advice and may need to apply to an appropriate court or statutory body for review or for an independent ruling. Your patient, those close to them and anyone appointed to act for them should be informed as early as possible of any decision to start legal proceedings, so they have the opportunity to participate or be represented.

\(^{44}\) Link to legal annex DoLS/liberty protection safeguards

\(^{45}\) Link to legal annex capacity legislation extracts

\(^{46}\) See the legal annex

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A29
Making decisions about treatment and care when a patient’s right to consent is affected by law

89 A patient’s right to make a healthcare decision for themselves can be affected by mental health legislation, or other legislation, as well as common law powers of the courts. Patients may be required by law to comply with assessment or treatment because they present a risk to themselves, to their health or to others. There are strict safeguards around using these legal powers to restrict or restrain which determine what is permitted without consent. You should be aware of what treatment is, and is not, legally permissible.

90 If you consider it necessary to use these legal powers to treat or assess a patient without consent, you must follow the procedures set out in the relevant legislation and statutory guidance and the guidance in paragraph 91, below. If you need advice or support, contact your defence body or professional association or seek independent legal advice.

Taking a patient-centred approach

91 You must take a patient-centred approach even if the law allows you to assess or treat a patient without their consent. For example, you must:

   a be polite and considerate and respect your patient’s dignity and privacy

   b protect your patient’s rights and freedoms and, if restriction or restraint is necessary, use it for the minimum time and in the least restrictive way possible

   c support your patient to be involved in decisions about their care, let them know if they can exercise choice about any aspect of their treatment, and respect their choices if possible

47 Please see the legal annex for further information. Please see the Mental Health Act 1983, as amended by the Mental Health Act 2007; Nottinghamshire Healthcare NHS Trust v RC [2014] EWCOP 1317; the Public Health (Control of Disease) Act 1984; the Public Health etc. (Scotland) Act 2008; the Public Health Act (Northern Ireland) 1967

48 Link to legal annex
d keep your patient informed about the progress of their treatment and regularly review decisions.
Agenda item: M5
Report title: People Planning across the United Kingdom
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Considered by: Council
Action: To consider

Executive summary
The challenges of attracting, training, sustaining and retaining the workforce the health and care systems of the UK need are high on the policy agenda right now. This reflects a widespread recognition that without action the challenges are likely to get worse with significant implications for service delivery, patient safety and staff satisfaction and wellbeing. In England, the NHS People Plan is in development, in Scotland the government is finalising an integrated workforce plan, in Wales, a health and social care workforce strategy has been developed, and in Northern Ireland they are progressing actions to achieve their Health and Social Care Workforce Strategy 2026.

The GMC is involved in all four countries’ initiatives on workforce, developing our ideas how we can best support the workforce and encourage others to play their part. We are using these fora to implement the recommendations from our Supporting a Profession Under Pressure reviews and to align priorities and objectives across regulators.

Recommendation:
   a  To consider the GMC’s role in the workforce initiatives across the UK.
**GMC position on workforce**

1. Among increasing pressures on doctors and other healthcare professions, workforce has become a top priority for governments and system regulators across the UK, with each of them developing workforce strategies.

2. As a professional regulator, the GMC is aware of the ever-growing pressures on all members of the healthcare team. We have a responsibility to do what we can to reduce that pressure because of its substantial impact on the ability of our registrants to meet our professional standards. We can also play a powerful role shaping how that healthcare team works in the future, through the levers we have for professionals’ education and training. This is in line with our current strategic aims of supporting the profession and meeting the changing needs of the health services across the four countries of the UK.

3. We have raised these issues for several years in our State of Medical Education and Practice reports. In October 2019 we published our first ever Workforce Report. This found that:

   - The workforce is increasingly international and diverse. For the first time, more non-UK medical graduates took up a licence to practise than UK medical graduates. And, UK medical graduates were more ethnically diverse than ever before.

   - There are significant threats to retaining existing doctors. We are struggling to retain substantial numbers of doctors who, in the face of pressures, are reducing their hours or intending to leave UK practice. This is especially serious for certain groups of doctors, such as GPs and international medical graduates (IMGs) in specialty and associate specialist (SAS) and locally employed (LE) roles.

   - Wellbeing is key to improving retention of doctors and quality of patient care. Better planned and resourced medical leadership can spread the positive, inclusive and supportive cultures that are evident in many places across the UK.

   - A different mix of specialties is required for the future workforce. Meeting future patient demand requires more expert generalists, as well as more specialists identified in national workforce plans as being in increasing demand, such as psychiatrists and radiologists. Greater flexibility in training and job design is also needed. Our data shows the system is starting to respond to these needs. For example, this year there’s been a sharp increase (6%) of doctors on GP training programmes.

4. Last year, we developed a workforce manifesto setting out what more we and others could do to support the workforce (which was discussed at Council in November 2018). We have updated our workforce manifesto this year. The full paper can be found on [www.gmc-uk.org](http://www.gmc-uk.org).
found in the additional reading pack and groups our ideas for what we and others could do under three themes:

- Supply – ensuring a flow of doctors into the medical workforce, for example through streamlining our registration processes or supporting induction for international doctors through *Welcome to UK Practice*. We are continuing to ask for legislative reform, particularly to the CESR/CEGPR route to registration. We are also asking for the UK government to consider visas and costs for doctors to enter the UK, which would also allow expansion of the Medical Training Initiative and sponsorship pathway.

- Support – ensuring the workplace culture is supportive and fair, with compassionate, collective leadership and a focus on staff wellbeing. For example, through our *Professional behaviours and patient safety* programme that we’re currently piloting in 14 healthcare organisations across the UK.

- Strategic change – ensuring the workforce is equipped to treat patients of the future, through appropriate education and use of new professions. We are also using our data to understand the workforce - for example the SOMEP workforce report.

5 We are aiming to use our engagement on workforce across the UK to support implementation of the recommendations from the Supporting a Profession Under Pressure (SAPUP) reviews and embed them within the healthcare system. Council has previously discussed these reviews which are:

- *Independent review of gross negligence manslaughter and culpable homicide* – the review was led by Leslie Hamilton and highlighted the need for a just culture in healthcare and improving consistency across local, coronial, criminal and regulatory processes.

- *Fair to Refer?* report: this independent research by Dr Doyin Atewologun and Roger Kline explored why some groups of doctors are referred to us more than others. The recommendations focused on improving support for doctors new to the UK, addressing systemic issues that may affect doctors’ professional performance and ensuring engaged, positive and inclusive leadership.

- *Mental Health and Wellbeing Review*. In the autumn, Professor Michael West will be publishing his independent report into our UK-wide review, into doctors and medical students’ wellbeing in the workplace.

6 We are also using the workforce discussions as a unique opportunity for creating better regulatory alignment, sharing our priorities with other regulators to better
support the workforce. We believe this is important to give us a greater impact, 
increase consistency and lead to ‘light touch regulation’ through reducing duplication.

This could mean aligning shared objectives with other regulatory partners such as the 
NMC, potentially sharing approaches to local clinical governance (particularly in the 
context of Local First), or aligning frameworks (such as ensuring NHS Improvement 
and CQC’s Well-Led Framework in England is aligned with our revised Effective 
Clinical Governance for the Medical Profession handbook). We believe it is best to 
focus on a few key areas for regulatory alignment and cooperation; we would 
propose the following given their prominence in the SAPUP reviews, workforce 
engagement and the potential impact: induction and new qualified doctors, CPD, 
unprofessional behaviours and clinical leadership.

Workforce initiatives across the UK

We are engaged with initiatives across the UK to support the workforce and we 
discussed workforce at our UK Advisory Fora in March 2019. A key risk for us is that 
priorities, views and approaches naturally differ amongst governments and regulators 
across the four countries. We therefore need to ensure our proposals are applicable 
to all countries while tailoring our engagement and approach to each country’s 
context.

England

NHS England and NHS Improvement have been developing an ‘NHS People Plan’ to 
ensure sufficient and supported workforce. An interim people plan was published on 3 
June 2019 and had a focus on leadership, wellbeing, importance of education and 
training, and multi-professional working. We welcomed the interim plan and were 
involved in many of the workstreams that contributed to developing it.
10 We have continued our involvement through sitting on advisory boards and workstreams as they develop the full people plan, which we believe will be published before Christmas. The full structure of the programme is below. We have representation on several workstreams including: the advisory group, medical workforce, making the NHS the best place to work, improving the leadership culture, workforce redesign, and securing current and future supply.

11 Relatedly, Health Education England’s Future Doctor work seeks to identify the skills, knowledge and behaviours (the capabilities) doctors are likely to need in the future to deliver high quality patient care. This work will approach the role of the doctor in the future within a multidisciplinary team context. As part of this they have launched a call for evidence and will be formally consulting next year. We are working with them on this and have responded to their call for evidence. We are commissioning research on the preparedness of recent medical graduates for practice to inform the consultation and our wider work. Our response to the call for evidence is in the additional reading pack.

Scotland

12 Key issues in Scotland include a commitment to recruit 800 GPs over the next decade, remote and rural workforce shortages, above UK-wide reliance on EEA doctors in remote and rural health boards, specific specialty recruitment challenges (e.g. radiology) and political interest in radical options (e.g. ‘golden handcuffs’).
Scotland’s *Overarching 2020 Vision* was updated with a three-part *National Health and Social Care Workforce Plan* in 2017-18. A final ‘integrated workforce plan’ was due to be published at the end of 2018 but has been significantly delayed, partly due to Brexit. We have responded to the Scottish Parliament Consultation on the future of Primary Care.

We have engaged with the Scottish Government’s Project Lift Programme (a new approach to recruit and manage talent within Health and Social Care in Scotland) to consider how we work together to embed recommendations from the SAPUP workstreams. We are part of an emerging Clinical Leadership Forum (of which the GMC is a founding member) to establish an NHS Scotland clinical leadership programme which would start at undergraduate level and continue throughout people’s careers.

We have embarked on a programme of quality assurance for ScotGEM, a graduate entry programme in Scotland focusing on rural and remote education. We are also engaged with Edinburgh University, as they develop a programme aimed at health care professionals, which would see students undertake a split programme of three years part-time/online study followed by a final two years full-time. The development of the remote and rural medicine credential is of interest to the whole of the UK, but particularly in Scotland.

**Wales**

The most pressing workforce challenges in Wales include recruitment issues in rural and remote areas, demonstrated by a high reliance on locums and SAS doctors in North Wales and of IMG doctors in North and West Wales. The integrated health and social care plan, *a Healthier Wales*, promotes seamless systems of care, through MDT working both in hospitals and in the community. This calls for a joined-up workforce through shared training.

Health Education and Improvement Wales (HEIW) and Social Care Wales (SCW) have developed a joint health and social care workforce strategy due for launch at the end of 2019. The Wales office engaged on this and formally responded to their consultation in September (detailed in additional reading pack). Once the strategy is launched HEIW and SCW will be developing short, medium and long-term implementation plans.

The Welsh Government is about to publish its National Clinical Plan that will work alongside the Workforce Strategy. This plan will detail future service provision and service models.

Prof Michael West, who has led our independent Mental Health and Wellbeing Review, has been working with NHS Wales around collective leadership and cultures
and the Wales Office will be linking with HEIW to see how we can work together over this.

Northern Ireland

20 In Northern Ireland, a Health and Social Care Workforce Strategy 2026 was published in May 2018 to support the delivery of *Health and Wellbeing 2026 – Delivering together*. Despite the lack of an Assembly, the Department has progressed the strategy, for example: announcing transformation funding for additional training places; beginning to work up a longer-term draft training and development strategy; publishing a review of medical school places; and commencing the phased introduction of a single lead employer for doctors and dentists in training in August 2019. NIMDTA has also carried out a review on the F1 placement experience, with 12 recommendations to HSC Trusts.

21 There is a HSC-wide collective leadership strategy, which aims to develop collective leadership capabilities at all levels and create the desired collective leadership culture. The HSC Leadership Centre delivers three multi-professional leadership courses.

Next steps

22 Workforce and leadership is a business planning priority for 2020 and will be considered as we develop our new 2021-25 corporate strategy.

23 We’re coordinating our work on workforce across the UK but seeking to respond and engage locally. Immediate engagement is seeking to land the SAPUP recommendations within national strategies and implementation plans. Further work will be in deepening the relationships that enable us to better align our regulatory approaches, particularly in the high impact areas of induction, leadership, behaviours and CPD.