

Chair's Report – September 2024

1. Purpose of Report

To flag developments at the HCPC from the Chair's perspective and to update on activities of note.

2. Highlights

Completion of 'consent' principles

I am delighted to report that after over a year's work, the group of five healthcare Chairs (the HCPC and the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the General Pharmaceutical Council (GPhC) and the General Optical Council (GOC)) I convened has co-produced, with the Patient Safety Commissioner, the Patients Association and the Council of Deans for Health, and input from a NHS working group, a set of principles on the complex question of 'consent' in a healthcare setting. These are appended.

The aim of the principles is to shift the nature of consent to a partnership with each patient, becoming relational rather than transactional. The commitment from the Chairs is that the principles are integrated into our respective standards and used to inform education programmes approved by each regulator.

We will now be socialising these with other sector regulators and planning to raise awareness among patients of what they can expect when giving permission in a health or care context.

I would especially like to acknowledge the generous contribution of Dr. Henrietta Hughes, Patient Safety Commissioner for England and Wales, and of the GMC.

This collaboration is a sector first and we will be building on it. Other discussion topics are underway.

Zoë Allan (Business Manager of Chair and CEO Office) has provided invaluable support and shape to the work of the project and has presented at its meetings.

Sexual safety hub

Following a seminal conversation with victims of serious abuse by a registrant, I was moved to moot a 'sexual safety hub' as a resource for patients. Led by our Chief Executive, Andrew Smith (Executive Director of Education, Registration and Regulatory Standards and Deputy Chief Executive), Kellie Green (Head of Professionalism and Upstream Regulation), Claire Baker (Head of Adjudication Performance), Tony Glazier (Communications and Digital Lead) and Rosemary

Flowers-Wanjie (Policy Lead) this has been made real in double-quick time and a beta version is now up and running. It is a great privilege to have had guidance from the victims I mentioned, with whom I have kept in contact on several matters.

The hub is being further developed before launch and I encourage you to take a look and feel free to signpost materials or give your views on content.

<https://www.hcpc-uk.org/sexual-safety/>

Social media posts

Two of my recent posts, 'Sexual safety: why we all need to improve our response to help keep people safe'

<https://www.linkedin.com/feed/update/urn:li:activity:7228773540433440769/>

and 'Why paramedics' locker room 'banter' must stop'

<https://www.linkedin.com/feed/update/urn:li:activity:7236700554104623106/>

have generated much response and made useful connections for us.

My thanks to Dr Gareth Davies, Head of Insight and Analytics, for the data that informed and illuminated these pieces.

The Association for Perioperative Practice (AfPP) 60th anniversary conference

I was privileged to attend and give a keynote address to what turned out to be a packed lecture theatre. Warm thanks to the AfPP, which put on an exceptionally interesting conference and gave me an opportunity to hear direct from many operating department practitioners, as well as making new connections.

Breakfast round table with BBC Health Correspondent

Our communications advisers, Luther Pendragon, arranged a fascinating discussion with a key correspondent, which both Matt Peck and I attended. We were able to air several of our communication themes on a Chatham House rule basis.

3. Nursing and Midwifery Council

As both Chair and Chief Executive, we have offered any assistance that the NMC might find helpful.

4. Professor Lord Darzi Review

I have provided guidance and support to the Executive Leadership Team in formulating the HCPC's response to Lord Darzi's report on the state of the National Health Service in England.

5. Council recruitment

With a number of Council members due to leave us shortly, some long serving, preparations for recruitment of both registrant and lay members are in hand and the Council's views will of course be sought. A skills mapping exercise has given us data about areas for strengthening expertise. However, this does not all need to come from within the Council itself.

6. Council workshop – Integrity in Professional Regulation

Council member Professor Steven Vaughan has kindly agreed to present an HCPC lecture and conversation, which we will host at our offices and open up to other regulators and a wider audience. A date before the year end is being sought. The occasion will be rather poignant as Steven will be leaving the UK for a wonderful new role in Australia at the beginning of 2025 and hence will be stepping down from the Council.

7. Stakeholders and colleagues

During the period, I met colleagues and stakeholders including:

Suzanne Rastrick – Chief Allied Health Professions (AHP) Officer for England
Professor Dame Carrie McEwan, Chair, GMC (twice)
Sir David Warren, Chair, NMC (twice)
Gisela Abbam, Chair, GPhC
Anne Wright, Chair, GOC
Senior stakeholders, Scottish Government

8. Fee increases for registrants

The parliamentary processes for the HCPC's proposed smaller incremental fee rise have resumed as MPs and MSPs begin parliamentary duties. I have provided guidance and support to the Executive Leadership Team.

Document requirements

In developing cross regulator principles of consent, the document should:

1. Be understood by everyone: aimed at patients (and their family and friends), multi-disciplinary professional teams, employers, public/in lay language and with infographics and animations (for each principle) to help people understand what consent is and the need to look at how consent is framed.
2. Be consistent across multi-disciplinary teams and environments
3. Reference the importance of shared decision making - consent reaches across the patient journey (it is not about putting a signature on a piece of paper). Importance of patients being informed and able to change their mind at any time in the process (and needs to take account of patient aptitudes/capacity/levels of understanding and interest in the decision).
4. Reference the importance of consent being an end-to-end process, a dialogue and with the conversation around consent starting as soon as patient starts their care, not just at formal consent points but crucially the importance of informed consent and 'talking it through', more of a focus on talking through procedures rather than necessarily providing any additional information.
5. Acknowledge that the detail of the consent process is still likely to vary contextually.

‘Shared decision making & consent’

Introduction: The purpose of these Principles is to help patients, services users and practitioners have better conversations about patients’ healthcare.

When a patient gives ‘consent’ to a practitioner, that gives the practitioner permission to carry out a medical procedure. Equally important can be a patient’s decision not to proceed with a course of action.

Consent should mean much more than one decision. Consent is given by patients, not taken by practitioners. It is not a technicality or a signature on a form, it is the basis of an ongoing partnership between patient and practitioner, who make a series of decisions together, trying to get the best health and quality of life result for the patient.

During this journey, a patient should be actively listened to, with respect, and given the information, time and support they need to make decisions to suit that patient’s condition and life. Practitioners should be valued for their healthcare knowledge and experience. Both practitioner and patient should have the same aims, specific to each individual patient. Each time a patient chooses a decision about treatment or a variation to it, consent either is, or is not given.

These Principles have been produced by leading patient advocacy organisations and healthcare regulators. They have been co-ordinated with work on consent principles by the NHS. The principles set out best practice and meet standards of good regulation. Each healthcare regulator will ensure that the principles are adopted within regulatory Standards and that patients know how to raise a concern if practitioners are not behaving in line with those standards.

If you spot anything that could be improved, please contact us with your suggestions.

Best Practice Principles

1. Start with shared decision making

The process starts with unbiased conversations about all reasonable options available to patients and their potential risks and benefits, including the option to take no action. This discussion should include expected outcomes for varying options to support a shared understanding between patient and practitioner about the expectations and limitations of the available options.

2. Individualised:

Risks and benefits should be individualised to the (clinical and personal) circumstances of the individual patient and communicated in a way that supports understanding, including what risk (s) they would be prepared to take in order to achieve a desired outcome. Patients should be supported to consider the options in the context of their own lives and their preferences and values. When a patient is not able to consent or understand the risks and benefits, conversations about options should involve the family, friends of the patient or advocate.

3. Continuous process:

Decision Making and Consent should be seen as a continuous process which may be distributed between multiple professionals across time and location through which a patient can fully understand the options available to them, is supported to deliberate on these options and then freely give their consent to proceed with their chosen course of action, unless the decision is to take no action. Some patients may be supported by their friends or family or have someone making decisions on their behalf.

4. Conclude with consent to treatment (or no treatment):

Once a decision has been reached through shared decision making, there should follow a conversation that confirms this decision, answers any outstanding questions, and provides any additional information required (including any risks that the patient is likely to attach significance to not previously discussed).

5. Equal partners:

Patients are equal partners and active participants in the decision making and consent process. Practitioners should encourage and support patients to ask questions and share their thoughts and opinions. Patients should not be pressured into making any decision and they should be free to change their mind at any stage. Consent is given by patients, not taken by practitioners.

Enablers

1. Role of education providers and employers in enabling professionals to be skilled in decision making and consent, fostering an environment to encourage shared decision making
2. Awareness of challenges patients can face in understanding health information
3. Resources to support patients in making decisions should be provided to patients throughout the process and as early as possible. This should include decisions support tools where available.
4. All stages of the decision making and consent process should be documented in such a way that allows other professionals to build on and complement what has already been discussed.
5. Awareness of law around consent
6. Written communications (e.g. clinic letters) should where possible include individualised risks and benefits and factors involved in the decisions to support deliberation in the 'cooling off' period.