Academy Council
08.09.17
GMC Office, Cardiff Bay
MEETING NOTES

ATTENDEES	Paul Myres (Chair, AMRCW), Ollie John (AMRCW) Notes, Jane Fenton May (RCGP), Simon Emery (RCOG), Abrie Theron (RCoA), Isra Hassan (RCoA), Karl Bishop (FDS), Chris Sanderson (RCSed), Huw Anslow (GMC), Charlotte Jones (BMA), Frank Atherton (CMO), Chris Jones (HEIW)

CHAIRS REPORT **PAUL MYRES**

DISCUSSION	**Brexit** ❏ AoMRC has developed an initial position statement on Brexit ❏ AoMRC is a member of the Cavendish Coalition group, a broad group looking at the impact of Brexit
CONCLUSIONS	❏ Council is keen to develop a Welsh view on Brexit ❏ The future of the Alert Mechanism was one highlighted concern

PRIMARY & SECONDARY CARE INTERFACE **PAUL MYRES / JANE FENTON MAY**

DISCUSSION	Council considered the completed and published AMRCW project work 'Professional Behaviours and Communications across the Primary & Secondary Care Interface' and how this may be taken forward by the Academy. ❏ Any further work would have to address and focus upon 'systems' , which is a need identified from feedback of initial report ❏ There is a need to embed the developed principles from the initial report to aid a cultural change Questions Raised : ❏ There are existing forums out there; Primary Care Board, Scheduled Care board - Does this work sit across them? Could we utilise an existing, broader group that is in place? ❏ Could we produce a subsidiary doc at minimal cost 'where we think this should go' and lead the agenda? ❏ Could we further explore patient stories? It was noted that patient representatives were involved within focus groups of initial report ❏ Developing the project further and creating further meaningful publications would require funding beyond council. Could we encourage circulation and seek endorsement? ❏ Could we engage the Wales clinical leadership fellows program and contribute a project for a fellow to take forward for next year?
CONCLUSIONS	**New Project** ❏ Council keen to take this work forward if financially viable ❏ Taking forward the work would rely on funding in partnership ❏ Next step would be to create a project proposal (Identifying costings considered and suggestions received based upon 'System Issues') for consideration of potential project partners

	Existing Report ❏ Consider informing trainees of this work through engaging education supervisors via foundation program directors. ❏ Act upon contact suggestions to further disseminate document

ACTIONS	**RESPONSIBILITY**
Approach Foundation Directors	Ollie John
Document dissemination suggestions ❏ Defense Bodies ❏ HIW ❏ Ombudsman ❏ Bevan Commission ❏ Welsh Risk Pool	Ollie John
Distribute document to UK level colleges	Ollie John
Approach BMA about partnership opportunities	Paul Myres / Ollie John

END OF LIFE CARE **PAUL MYRES / JANE FENTON MAY**

DISCUSSION	Council considered the AMRCW project proposal into End of Life Care and how this work may be taken forward by the Academy. ❏ The aim for the pilot is to improve communications between primary and secondary care. Cluster of GPs and ambassador (maybe Macmillan doctor or nurse in area) to spread word of this work. ❏ Support for doctors managing patients on EOLC who additionally require support themselves to be included in document. Questions Raised : ❏ Can we provide added value to this area of work? ❏ It's a complex issue - Does group have resources to do this justice? ❏ How as a group do we account for associated cultural challenges? ❏ We need to make this work patient centred? e.g. Accounting for the contrast of what a peaceful death in hospice compared to ICU can look like?
CONCLUSIONS	❏ Council keen to take this work forward if financially viable ❏ Project must 'fit the financial envelope' ❏ Next step is to approach the EOLC implementation group and see what they are prepared to fund ❏ There is an obvious tie in with Choosing Wisely, and with a focus on communication, this work is complementary to AMRCW work ❏ Patients do want doctors to be candid with them ❏ In taking on this work, 'We need to do something different', as its often talked about : ❏ We can establish a focus of 'where this work has come from', as doctors are having difficulty in conversation and a feeling from group is that it was no longer acceptable. This needs to be a core skill - do not need to have the solutions, it's about honesty and letting patients feel comfortable making decision.

ACTIONS	RESPONSIBILITY
Funding may be available from EOL Implementation group. JFM to chase up on result of meeting.	Jane Fenton May
Project document to be updated upon outcome of funding enquiry.	Jane Fenton May

GENDER IDENTITY SERVICES **PAUL MYRES**

DISCUSSION	Background to the statement 'Responding to Individuals with Gender Identity issues' was given : ❏ Issues arising from doctors and teams who were not giving people with gender identity issues due attention, respect and acknowledging differences and the diversity agenda. ❏ Concerns those with significant gender identity issues were not accessing pathway or were not getting treatment they deserved and that was causing distress. Considerations : ❏ Previously decided that AMRCW would produce guidance. ❏ Guidance has been superseded by some extent by what the service will be following Cab Sec announcement. ❏ Tabled document also seen by RCP, RCPsych and RCPCH in addition to Council, asking for comment.
CONCLUSIONS	❏ BMA had no concerns with AMRCW document, as doesn't say doctors 'should' prescribe but 'can' prescribe with support ❏ Agreement was given to publish as it contributes to the work and pushes it forward. Clearly identifies 'Can' prescribe and identifies need to be sensitive to patient's need. ❏ Document to highlight how 'Pediatric service will still be provided in London, with an outreach team that comes into Llandough, no suggestion that GPs should be treating children or stopping puberty, that should still be delivered through specialised care.'

ACTIONS	RESPONSIBILITY
Publish positional statement 'Responding to individuals with gender identity issues'	Ollie John

CHOOSING WISELY UPDATE **PAUL MYRES**

DISCUSSION	Choosing Wisely update was given : ❏ 2 years of funding from WG secured ❏ Lots of project time taken to date on what shared decision making means and how you teach that. ❏ Cabinet Secretary remains supportive of CW but wishes to see results in order to justify funding of work. ❏ It was agreed with Cabinet Secretary that CW would focus on advanced stage cancer, and decisions on someone who has had 3 stages of unsuccessful chemotherapy and what to do next. CW will still keep a relationship with primary care, but also focussing on stage 4 to prove value. ❏ Currently CW is determining outcome measures that are important to patient ❏ Currently CW is looking to procure for training into shared decision making ❏ Training will begin in October, CW will aim to show results in November ❏ CW is progressing well with patient groups but needs to work with clinicians to develop champions. ❏ CW hopes to appoint a clinical lead for a day a week in Velindre with an interest in oncology, likewise for Betsi Cadwaladr ❏ CW will be going through a name change for the general public. CW did challenge this decision, but

	the decision stands. The working group are exploring options, including Exploring 'Making Choices Together'. ❏ Continuing to call CW collaborative so clinicians are aware. ❏ Happy to receive name suggestions, alongside CW group considering. ❏ Suggestion 'Good Choices, Better Outcomes' Questions / Comments Raised : ❏ Suggestion to write back to Cabinet Secretary stating how CW believe they can demonstrate, and would expect outcomes for patients to follow, rather than make a promise on a clinical outcome that is difficult to deliver. ❏ Suggested alignment with the unscheduled care program, whereby points exist along work streams where a patient makes a decision - These could be written as CW principles. There is opportunity to inform CW principles to the scheduled care board as a recommendation of good practice. So it's not up to CW team to convince people, it's now part of a team that is very focussed. CW principles would be present at nodal points in pathway, making patients aware of this and building processed around that. Suggestion to make Peter Lewis aware and make sure principles already established are used. ❏ Suggested that there may be possible interest from clinical psychologists in CW. ❏ Interventions could be identified from clinician suggestions, aside from colleges. ❏ Planned care board have produced lists of low value interventions - do they marry up with CW? ❏ May be value in revisiting exercise in colleges.
CONCLUSIONS	❏ CW can't neglect wider influencing work ❏ More Clinical Champions need to be identified

ACTIONS	**RESPONSIBILITY**
Colleges to pursue 'Clinical Champions' to help support CW	ALL
Proposed and forthcoming name suggestions to be forwarded to the working group for consideration	ALL
Suggestions from council to be considered and written to work plan	Paul Myres

NEW AMRCW PROJECT WORK **PAUL MYRES**

DISCUSSION	3 project pieces of work currently to be undertaken by Academy ❏ Primary & Secondary Care Interface ❏ End of Life Care ❏ Choosing Wisely
CONCLUSIONS	Suggestions of future work can be received by Academy, ready for consideration at Council in December

ACTIONS	**RESPONSIBILITY**
Suggestions to be sent in advance of December council	ALL

CMO PRESENTATION **FRANK ATHERTON**

DISCUSSION	**Prudent Healthcare** ❏ Lots of small scale examples of PHC exist, Value based healthcare, CWW etc. We've done a good job in introducing concept of PHC but others are possibly stealing the march. Where do we go next with PHC? 1) How do embed PHC in minds of clinicians and workforce more generally? How do we make sure its a guiding principle for the health system we have for the next 20 years? We are perhaps lacking an oversight or central drive to this 2) Need to improve documenting what has been done e.g. PHC compendium 3) Speaking with Scotland around faculty of realistic medicine and BMJ are hosting a conference in Liverpool. Discussing various approaches to this with Scotland and Ireland, currently summarising where we are in Wales. ❏ Looking at possibility of establishing a PHC group, yet to determine its make up. Possibly a representative from the AMRCW, rather than a representative from every college. Colleges may be a route that could be used to identify examples of PHC, possibly putting someone in touch through the academy. **Clinical Engagement** ❏ Formal structure exists by statute with the medical advisory committee. MAC has a new chair and a workshop (22nd Sep) running to try and reinvigorate itself. ❏ How do we engage clinicians in service changes that we know need to happen, if we are going to have a more effective and sustainable health service? ❏ Sometimes clinicians can be resistant to change, it can be difficult. Can we deal with that collaboratively? How do colleges work with that?
FEEDBACKS	**Prudent Health Care** ❏ Perioperative movement is gaining more momentum in Wales. ❏ PHC message is trickling down. Seeing lots of examples of PHC across interfaces so job planning, or through a procurement setting, with people questioning 'how is this prudent?', Understanding is being seen, and beginning to see that at different levels and interfaces. ❏ BMA view that PHC is widely held as the way forward. Feel message has trickled through clusters. ❏ AMRCW would be keen to be part of any group into PHC. ❏ Query about Obesity. AMRCW discussed this as a council a long time ago, with a focus for someone in Wales to draw together all the different initiatives with a clinical lead to bring all these strands together. All colleges had issues about it and no one had a coordinated strategy. **Clinical Engagement** ❏ Can we use the regional advisor to bigger extent? (some colleges have a regional advisory structure, used through NSAGs). Most groups have an NSAG that works and those 2 agendas are very common. ❏ You can have too many advisory groups sometimes, some are narrow to the speciality and need a wider perspective of where that speciality sits. ❏ Colleges can develop champions locally in order to aid change. Maybe colleges or regional advisor could be that champion. **Summary** On engagement, this has been point of frustration about when engaged, that we are listened to. We recognise structures are in place, AMRCW made a decision to leave these structures as we thought we might be more effective being independant. Weren't quite sure whether we were duplicating the WMC, we discussed this many times and feel that our input is probably useful and we are happy to be part of that informal advisory

	structure. There are some of us that feel, that if we are coming back to advise, then we really do need that resource again to provide that. Where clinicians are difficult to engage with as individuals, whilst colleges are not responsible for behaviour of members (medical directors and GMC), we do have ability to influence through structures.

ACTIONS	**RESPONSIBILITY**
AMRCW to find early documentation into Obesity	Simon Emery / Ollie
AMRCW to follow up on expressed interest into PHC group	Ollie John
Tim Havard (RCS) to represent AMRCW at WMC workshop on 22/09	Tim Havard

HEIW PRESENTATION **CHRIS JONES**

DISCUSSION

- Commence post of Interim Chair of HEIW from 1st October.
- Currently gathering initial thoughts on present, future of 2 - 3 yrs and long term.
    - Listening a lot to people who are not yet part of NHS,
    - people in their formative years of NHS and,
    - have started listening to people deciding NHS isn't for them.
- There is a real issue of culture, in that people assume you 'get by' getting a job in NHS; but reality is life for anyone working in NHS is entirely different from 2010 to prior to that.
- Whilst colleges are setting standards and doing a great job within their specialisms, real message is that longevity of career when you qualified in 1990 was 30 - 35 year, reality is that you will be working for about 40 years, this has had a huge impact. Old models of service delivery are 'creaking' and at the same time technological advances are breathtakingly fast.
- Currently, We are not planning for people who are multi capable, who could at any point need or choose to go to any other area. How do we look at all ends? where we can improve? and how we help people continue to want to serve the NHS.
- We are in danger of driving generalism out very early on, which means the transfer of skills later on are a long way from where the culture is.
- Opportunities are to work together in some parts to optimise very quickly some of the things that are already delivered and start selling the NHS to people who may want to be part of it.
- We are losing some of the most powerfully skilled people in NHS, we need to have a conversation about how an organisation like HEIW doesn't lose what they are doing well but takes it into a different sphere. Asking people to look at :
    - What would good look like?,
    - What could HEIW do in the next 2 - 3 years?,
    - Have you any idea what the potential is for your particular brand for the future of the NHS?
- Can we actually help people in that time of F1/F2 in realising their ambition. Is it too soon to get into specialist training?
- Are there some recognised things that people could do that could be recognised as part of their development into specialist training?

Things would like from Royal Colleges

- Would ask for views and advice from each Royal College - but end of the day it's about a whole system.

	❏ Not about individual events, but cycles of consultation going forward, so that we can actually start to collect a meaningful discussion about the sum of the parts. ❏ Really interested, in the how Royal Colleges understand their critical role in recruitment and career advice. ❏ Not up to HEIW alone to solve issues, as Royal Colleges you have the people who can raise people's aspirations at any point.
FEEDBACK	❏ Different approaches are needed to reflect different generations. Current training program was developed for the 'baby boomers' by the 'baby boomers', we need to change that. Need flexibility in training to reflect the Y generation, who often hold a different perspective on work - Good if HEIW is starting to think like that. ❏ Where do we interface with HEE? We have not been brave enough in Wales, we have often followed England. We are different, with different population, needs, geography etc. National recruitment perhaps doesn't suit us in some of these specialities, lets pull out if that's the case. How brave are wales going to be? ❏ Really important to think about recruitment, but within general practice there is a loss at top end of spectrum. Lot of GPs are leaving in their 40s and 50s, don't know where they are going but that is the evidence from the shared care services. We need to ensure they have an ongoing professional life that suits their needs. One of the issues is the feminisation of the workforce, women are working in a diff way, so they are having babies, working part time, later in finishing training (mat leave), want to work part time and this may be difficult. ❏ Need to look at CPD for Doctors in place, not only concentrate on undergraduate. ❏ Emotional Intelligence Resilience for under / post grads is hugely important. We need to address why people are leaving. People don't feel like they are listened to or appreciated and this needs addressing. Medical students don't feel prepared, they are very task focussed (exams etc), when it comes to real world - F1 is a completely different battlefield. ❏ Little things also make a huge difference; knowing names, having a hot meal etc. **Summary** Clear statement that workforce has to be trained and relevant to what the population needs and not just carrying on providing what we have always done. People will only carry on working if they feel rewarded and your identifying that money is probably not the biggest issue. It's about being valued and people feeling fulfilled. Flexibility is a challenge, not everybody wants to train in the same way, not everyone wants to work in the same way. We have to offer flexibility. We need to identify the lost tribe of F1/F2 and understand, what is our responsibility to these people. We may have to redesign curriculum, to suit newer generation We need people to retain a sense of generalism so they can choose to change subspeciality at some point.

ACTIONS	**RESPONSIBILITY**
AMRCW to follow up with HEIW about appropriate way to continue engagement	Ollie John

A.O.B. **PAUL MYRES**

DISCUSSION	**Council Officer Positions** Council were updated on AMRCW elected officers terms Considerations :

	❏ In November, Paul Myres (Chair) will be asking council if they would like him to carry on to do another year, equating to a 3rd year in post. ❏ Martin Rolles (Vice Chair) has done 2 years and has an option of another year in post. ❏ Sue Hill (Vice Chair) has done 3 years and therefore the post of Vice Chair is up for election. This will be done formally at next meeting. Sue is entitled to stand for a further term. **FLM Request for AMRCW support to become recognised as medical speciality** The Faculty of Forensic & Legal Medicine have written to AMRCW garnering support to become a recognised medical speciality. FLM is a faculty of RCP and a member faculty of AoMRC. Considerations : ❏ Not a GMC recognised speciality. ❏ There is precedent for it to be recognised as a specialty i.e. forensic pathology ❏ Initial concern that there are a few GPs that do some legal forensic type of work, particularly. There is uncertainty that they would always want to be part of this faculty as they may wish to be accredited through a GP system and the RCGP is looking at how they can accredit GPs do things outside of normal general practice. ❏ Concern of having to be a member of this faculty in order to do forensic and legal work. ❏ There is long term value in driving standards up. However there may be a danger in only people in this speciality can do this piece of work and then may very quickly find themselves in a shortfall speciality. Questions Raised : ❏ Whether you can achieve the same purpose through other methods, accreditation, licensing, credentialing etc?
CONCLUSIONS	**Council Officer Positions** Papers to be circulated to council in November **FLM Specialty Request** ❏ Uncertainty of the complexity of interaction with other specialties. ❏ AMRCW support the idea that we do need good standards of care in that area as well. ❏ AMRCW will consider the AoMRC discussion of proposal.

ACTIONS	**RESPONSIBILITY**
Request for nominations for Vice Chair to go out to council asap for an election prior to the next council.	Ollie John
Remind Council that current Chair has another year to run but council will be asked to confirm that position.	Ollie John
Circulate AoMRC response once received for consideration.	Ollie John

Next Council Meeting Dates arranged for

FRI 8th December 2017, GMC Office, Cardiff Bay	10:30am - 1:30pm
FRI 9th March 2018, GMC Office, Cardiff Bay	10:30am - 1:30pm