

Shared Decision Making in Primary Care for Healthcare Professionals

10 top tips

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- 1** The RCGP describes Shared Decision Making (SDM) as 'a process by which clinicians and patients work together to make decisions and select tests, treatments and care **plans**'. It is a fundamental element of personalised care and should be integral to all our interactions in primary care.
- 2** There are multiple intended benefits of SDM for both the patient and the clinician, including increased patient engagement and empowerment, supporting improved clinician/patient relationship, improved adherence to treatment and increased satisfaction with outcomes.
- 3** It may be possible for some patients to start the SDM process ahead of appointments by encouraging people to think about and ask questions such as "What are my options?" and "What are the potential benefits and risks?". This can be done simply by sharing information. Good examples of this relating to cancer are by sharing a needs checklist or using a text questionnaire in advance of a CCR or by sharing patient-facing tools like the PCUK PSA risk calculator.
- 4** Offer patients the opportunity to include others in the SDM process (family members, friends, or other advocates). This may be easier now with the increased use of virtual consultations, and patients may feel more comfortable doing this in their own environment.
- 5** Avoid jargon and explain technical terms. Remember other important communication skills, particularly in delivering complex information, e.g. 'chunk and check' and 'teach back', to check a patient's understanding. Be aware of, and practise the use of, SDM models (e.g. the three-talk model: introducing choice, describing options, helping people explore their **preferences**). Consider revisiting communications skills training as part of your Personal Development Plan to support your SDM skills.
- 6** Where available, use Patient Decision Aids. PDAs are available from a number of sources, including NICE (e.g. on the benefits of using **Tamoxifen for primary prevention** of breast cancer) and the NHS (e.g. the **PREDICT** tools for treatments in early prostate cancer and adjuvant treatment in breast cancer). Ensure that PDAs are quality assured and relevant to that discussion.
- 7** When communicating risks and benefits, consider using pictograms. Use numerical data where possible (people will interpret 'rare' and 'common' differently) and use natural frequencies (1 in 100) rather than percentages. Use the same frequencies (7 in 100 and 20 in 100, not 1 in 14 and 1 in 5). It is better to define risks over a specified period.
- 8** Information sharing is fundamental to SDM. Offer people resources in their preferred format, which may include printed information, but also share links to high-quality online resources, including **videos**. Ensure information is provided in a format that people can understand and enables them to make decisions.
- 9** It is vital to be mindful of health inequalities, such as language barriers, digital exclusion and literacy, when it comes to SDM discussions. Use translators, and make sure to seek out culturally relevant information in the appropriate language. Urgent Suspected Cancer Patient Information leaflets are often available in **multiple languages**. Cancer screening support videos should also be available in **different languages and with BSL** and should be **culturally relevant**.
- 10** Training is available in SDM. The DES requires PCN staff to have completed the Personalised Care Institute **eLearning module**. NICE also has an online learning package. However, training should ideally have a practical element (e.g. with role play). Macmillan has various communications skills training available, including **'Courageous Conversations'**, which is available to support Primary Care Professionals to have difficult conversations regarding cancer and end-of-life. Scottish GPs may find this resource from **Effective Communication 4 Healthcare** useful.

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