Department of Health & Social Care

From Lord Markham
Parliamentary Under-Secretary of State

39 Victoria Street
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Dear Lords

Anaesthesia Associates and Physician Associates Order 2024

Thank you for attending what I hope you will agree was a very interesting debate on the Anaesthesia Associates and Physician Associates Order (AAPAO). I committed to follow up in writing to further address the issues that were raised.

Delay to regulation

We recognise that there have been delays to the previously published timetable for the regulation of Anaesthesia Associates (AAs) and Physician Associates (PAs). Although this is in part due to the impact of the pandemic, it is important to reiterate that this work is being taken forward as part of a broader package of reforms to regulators' governing legislation, which is significant and complex. This has included extensive engagement with all healthcare regulators and other stakeholders and development of what is intended to be a template order for future statutory instruments. Whilst the legislation is a blueprint for future reforms to regulators' underpinning legislation, the Government is mindful of the need to tailor the drafting to ensure that each regulator is able to effectively regulate their specific professions.

Patient safety / Quality of training

Regulation of AAs and PAs will provide a standardised framework of governance and assurance for clinical practice and professional conduct, to enhance patient safety. Regulation ensures consistent entry standards and ongoing assurance.

Regulation will allow the General Medical Council (GMC) to take a holistic approach to the education, training and standards of both associate and doctor roles. This will enable a more coherent and co-ordinated approach to regulation. The GMC will also set the standards required for entry to its register. It will do this by approving the curricula and assessments for pre-qualification AA and PA courses and by setting and approving assessments which must be passed in order to be registered.

The GMC have been carrying out quality assurance checks on AA and PA courses since 2021. After regulation begins, the process will be similar, but the GMC will be able to approve courses, set conditions for course providers to meet and publish reports of the checks.

Whilst statutory regulation is an important part of ensuring patient safety it is coupled with local arrangements for oversight and supervision. AAs and PAs are supervised by a designated senior

doctor (consultant, registrar, or general practitioner) and the GMC has issued high-level guidance for employers on clinical governance.

Scope of Practice

Clearly scope of practice is an important issue, but it relies on much more than just regulation. The GMC will set out the principles, values and standards expected for AAs and PAs once regulation commences.

The GMC will also set the standards required for entry to its register, which will give assurance that AA and PA students have demonstrated the core knowledge, skills and professional and ethical behaviours necessary to work safely and competently.
As with any regulated profession, an individual's scope of practise will be determined by their experience, coupled with appropriate local governance arrangements. The Royal College of Physicians (RCP) has established a multi-professional working group to develop additional guidance on scope of practice and supervision for PAs. In addition, NHS England is currently analysing responses to its consultation on the MAPs Career Development Framework which aims to provide clarity on the career pathway for associates and their development over time.

Prescribing

The scope of practice of a PA does not include the ability to supply or prescribe medicines and there is no legal framework to support this. Prescribing responsibilities are only considered for roles that are statutorily regulated. Once PA's are regulated by the GMC, this becomes a possibility but will require an additional process which includes public consultation and changes to the Human Medicines Act. Any decision on whether a profession should be afforded prescribing responsibilities is based on independent advice from the Commission on Human Medicine. So this is an important step in allowing the potential for PA's to prescribe, but further steps would be required to enable this.

The Role of the GMC

The 2017 public consultation on the appropriate regulatory body evidenced widespread support for the GMC as the regulator for these roles, which will enable a holistic approach to the training and oversight of associate roles and doctors.

The GMC will be required to hold a single separate register for AAs and PAs and will have a prefix that makes their registration numbers distinct from those of doctors. The GMC is under a duty, set out in the legislation, to consult on any rules that it intends to implement to govern the day-to-day regulation of these roles.

The GMC register

Further to our discussion at the debate, the GMC will ensure the prominent labelling of profession type on their public-facing registers. This means that, in future when patients search the GMC registers, it will be very clear whether an individual is a doctor, an AA or a PA.

In the debate I referenced "PA123456" as an example prefix. To clarify, the GMC will not use 'AA' or 'PA' as a prefix. On 7 March, the GMC announced that the alphabetical prefix it will use for AA and PA reference numbers will be a capital letter A, for associate. The A-prefix will be the same for both AAs and PAs. There will be no change to doctors' GMC reference numbers which will remain a seven-digit number without a prefix.

Protection of Professional titles

National Institute of Clinical Excellence guidelines and GMC guidance require that all healthcare professionals should introduce themselves and explain their role to the patient regardless of their job title.

This legislation will protect the Anaesthesia Associate and Physician Associate titles. This means it will be a criminal offence to practise and use the titles AA or PA without being registered with the GMC. A change to the titles at this stage would in all likelihood create confusion for patients and employers rather than reduce it.

In the debate I stated that currently none of the titles are protected when in reality
there are many titles that are already protected. All healthcare professional regulators protect titles relating to the professions they regulate. Doctor and consultant are not protected titles as they are not always linked to the practice of medicine. Titles such as 'doctor of medicine', 'general practitioner' and 'surgeon', among other clinical titles, are protected.

The Government intends to reform legislation for doctors over the next couple of years and consider protected titles more broadly as part of that work.

Pay

Upon qualification, PAs enter the workforce at Agenda for Change (AfC) band 7 (currently £43,742). The framework for this role allows for career progression, with staff potentially reaching AfC Band 8a with advanced clinical skills and experience.

In contrast, junior doctors follow a distinct training pathway with different terms and conditions, including pay scales. The average basic pay for a full-time Doctor in Training is now around £47,600. With career progression through to a consultant role, average full-time earnings reach £134,000.

Junior doctors remain a vital cornerstone of our health system. We are ensuring that junior doctors have range of measures available that recognises the central role that they play in the delivery of health services. For example, we are supporting Less than Full Time training options, to allow trainees to continue to work in the service and progress with their training on a reduced working pattern, where this is beneficial for their personal circumstances.

Long Term Workforce Plan – Medical schools

We are fully committed and remain on track to deliver the pledges set out in the NHS Long Term Workforce Plan, including the doubling of medical school places in England to 15,000 by 2031. Work is underway to ensure that the necessary specialty training places are available to doctors as they progress through their career.

The plan for medical school places, which has always been the case, is to increase capacity incrementally up to 2031, rather than dividing the additional 7,500 evenly over the years – and the workforce plan sets out the planned trajectories for training intakes.

The Long-Term Workforce Plan commits to levelling up undergraduate training, focusing on new medical schools and additional places in geographical areas with the greatest staff shortfalls and unmet healthcare need. This will also promote applications from local populations, bringing employment opportunities to more socially deprived locations.

In the debate I said that the planned AA and PA expansion represents only 8% of the GP workforce. I should have said that, by 2036/37, the total number of AAs and PAs will be less than 7% of the total number of doctors.

The Explanatory Memorandum

I completely agree on the importance of explanatory memoranda (EMs) and will ensure comments are taken forward for future EMs. In the meantime, updates and points of clarification have been added to the EM for the AAPA Order in light of the SLSC's report and the discussion at the debate.

Thank you for your contributions to this debate and I hope that the above responses prove useful. I am copying this letter to all those who contributed. A copy of this letter will also be deposited in the House Library.

With my very best wishes,

LORD MARKHAM CBE