12 December 2017

Health and Care Professions Council response to Department of Health consultation on 'The regulation of Medical Associate Professions in the UK'

1. Introduction

1.1 We welcome the opportunity to respond to this consultation.

1.2 The Health and Care Professions Council (HCPC) is a statutory regulator of health, social work, and psychological professions governed by the Health and Social Work Professions Order 2001. We regulate the members of 16 professions. We maintain a register of professionals, set standards for entry to our register, approve education and training programmes for registration and deal with concerns where a professional may not be fit to practise. Our role is to protect the public.

2. Our response to the consultation questions

Physician associates (PAs) – assessment of risk

Q1. What level of professional assurance do you think is appropriate for PAs?

- Voluntary registration
- Accredited voluntary registration
- **Statutory regulation**
- Other

2.1 We consider that a persuasive case is made in the consultation document for the statutory regulation of PAs.

2.2 PAs are the only medical associate profession (MAP) to be rated as high risk against the Professional Standards Authority's (PSA's) criteria of intervention, context and accountability. Widespread direct entry into PA training means that few PAs have accountability to an existing statutory regulator. In addition, the growth in PA training numbers indicates a secure and expanding role for PAs in the future workforce.

Physician assistants (Anaesthesia) (PA(A)s) – assessment of risk

Q2. What level of professional assurance do you think is appropriate for PA(A)s?

- Voluntary registration
- Accredited voluntary registration
- **Statutory regulation**
- Other

2.3 We consider that statutory regulation may be appropriate for PA(A)s, but note that the consultation is seeking further evidence before a final decision is made.

2.4 The level of autonomy of this role is clearly articulated in the consultation document. Autonomy appears comparable to other statutory regulated professions who work in the operating theatre environment, including nurses and operating department practitioners. It seems to us that the primary reservation stated in the consultation to the statutory regulation of this group is its size and slow projected rate of growth.

2.5 An argument can be made for the statutory regulation of PA(A)s on the basis that, unlike the remaining MAP groups, direct entry into training means that some PA(A)s will not have accountability to an independent professional regulator.

2.6 There is also the practical question of protection of title. 'Physician assistant' is the professional title used in the United States for the profession now called 'physician associates' in the UK. Arguably, if physician associates were to be regulated in the UK, consideration would also need to be given to protecting 'physician assistant' to prevent an obvious evasion of regulation. This may therefore necessitate the regulation of PA(A)s in any event.

2.7 If PA(A)s were to be brought into statutory regulation, advance consideration might also be given (in partnership with the professional body) to introducing an alternative professional title. The title 'Physician Assistant (Anaesthesia)' may be confusing for members of the public, particularly given 'physician assistant' is used elsewhere in the world to describe what in the UK is a physician associate. In addition, 'Assistant' may not accurately convey the level of decision making autonomy involved in the role, one of the past drivers, we understand, for the renaming of the PA role in the UK.

Surgical Care Practitioners (SCPs) and Advanced Critical Care Practitioners (ACCPs) – assessment of risk

Q3. What level of professional assurance do you think is appropriate for SCPs?

- **Voluntary registration**
- **Accredited voluntary registration**
- Statutory regulation
- Other

2.8 We consider that voluntary registration or accredited voluntary registration, with employer controls, are likely to provide appropriate professional assurance for SCPs at this point in time. We note that accredited voluntary registration would rely on a voluntary register being willing to seek (and to pay for) accreditation.

2.9 The lack of direct entry into this role, meaning that practitioners are already accountable to a professional statutory regulator, indicates that direct statutory regulation of this group may not be necessary. We also note the small numbers of this group and the lack of national plans for expansion. However, there would be a case for statutory regulation should direct entry into training be introduced in the future.

2.10 In the absence of 'direct' statutory regulation of SCP's as a distinct group, consideration might be given to the means by which practitioners can be required to maintain their original professional registration, for example, through guidance to NHS employers. The risk that practitioners will allow their 'base' registration to lapse after having moved into a new role is cited frequently as a limitation of a lack of direct regulation.

Q4. What level of professional assurance do you think is appropriate for ACCPs?

- **Voluntary registration**
- **Accredited voluntary registration**
- Statutory regulation
- Other

2.11 We consider that voluntary registration or accredited voluntary registration, with employer controls, are likely to provide sufficient professional assurance for ACCPs at this point in time. However, we do note the assessment that this role performs high-risk interventions with high levels of decision-making autonomy.

2.12 The lack of direct entry into this role, meaning that practitioners are already accountable to a professional statutory regulator, would indicate that direct statutory regulation of this group may not be necessary. We also note the lack of national plans for expansion. However, there would be case for statutory regulation should direct entry into training be introduced in the future.

2.13 In the absence of 'direct' statutory regulation of ACCPs as a distinct group, consideration might be given to the means by which practitioners can be required to maintain their original professional registration, for example, through guidance to NHS employers. The risk that practitioners will allow their 'base' registration to lapse after having moved into a new role is cited frequently as a limitation of a lack of direct regulation.

Prescribing responsibilities

Q5. In the future, do you think that the expansion of medicines supply, administration mechanisms and/or prescribing responsibilities to any or all of the four MAP roles should be considered?

- Yes
- No
- **Don't know**

2.14 We consider that the MAP groups and service providers are better placed to answer this question.

2.15 Patient Group Directions (PGDs), exemptions to sell, supply and/or administer medicines and prescribing entitlements are currently limited only to those professions that are statutory regulated. Subsequent consideration of extension of such mechanisms to any or all of the MAP groups if they were regulated might be one way of realising the full potential of these roles to healthcare delivery.

Consideration of the appropriate professional regulator

Q6. Which healthcare regulator should have responsibilities for the regulation of any or all of the four MAP roles?

- General Medical Council
- **Health and Care Professions Council**
- Other
- Don't mind

2.16 It is right that the decision about the most appropriate regulator is made independently of either potential regulator.

2.17 However, we consider that there is a strong case for the HCPC to be the regulator of any or all of the MAP groups. The consultation document highlights a number of considerations that might inform the choice of regulator. We have highlighted our suitability against these areas below.

- **Existing scope of the regulator**. We are a multi-professional regulator, with experience of regulating a diverse range of professions. Our model of regulation, underpinned by generic and profession-specific standards, is well able to take account of both the similarities and the individuality of the different professions we regulate. We already have 'umbrella' parts of our Register under which related groups with distinct scopes of practice are regulated together (e.g. practitioner psychologists).

- **Speed of delivery**. We have a successful track record of bringing further professions into statutory regulation: operating department practitioners (2004), practitioner psychologists (2009), hearing aid dispensers (2010) and social workers in England (2012). As an existing multi-professional regulator, our rules, standards and systems are already designed in a way that would allow us (with relatively minimal changes required) to accommodate easily further professions. For example, our governance arrangements are able to accommodate further professions. Whilst the needs and challenges of every new profession are unique, we estimate that we would be able to open the Register within approximately 12 months of the publication of legislation.

- **Cost**. Our model of regulation outlined above means that the set-up costs to the taxpayer of extending professional regulation would be minimised. We benefit from economies of scale and currently have the lowest renewal fee of all the nine UK regulators overseen by the PSA - £90. This would keep the ongoing cost to practitioners who pay for the day-to-day costs of regulation as low as possible.

Costs and benefits analysis

Q7. Do you agree or disagree with the costs and benefits on the different types of regulation identified above? If not, please set out why you disagree. Please include any alternative cost and benefits you consider to be relevant and any evidence to support your views.

- **Yes**
- No
- Don't know.

2.18 The consultation document includes an accurate summary of the main costs and benefits of each form of assurance.

Equality considerations

Q8. Do you think any changes to the level of professional assurance for the four medical associate professions could impact (positively or negatively) on any of the protected characteristics covered by the Public Sector Equality Duty, or by Section 75 of the Northern Ireland Act 1998?

- Yes
- **No**
- Don't know

2.19 We have not identified any positive or negative impacts on the public sector equality duty.