PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT

Sixth Delegated Legislation Committee

DRAFT ANAESTHESIA ASSOCIATES AND PHYSICIAN ASSOCIATES ORDER 2024

Wednesday 17 January 2024

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Sunday 21 January 2024

The Committee consisted of the following Members:

Chair: Dame Caroline Dinenage

† Baker, Duncan *(North Norfolk)* (Con)
† Cairns, Alun *(Vale of Glamorgan)* (Con)
† Cates, Miriam *(Penistone and Stocksbridge)* (Con)
† Day, Martyn *(Linlithgow and East Falkirk)* (SNP)
† Edwards, Ruth *(Rushcliffe)* (Con)
† Hamilton, Fabian *(Leeds North East)* (Lab)
† Keeley, Barbara *(Worsley and Eccles South)* (Lab)
† Long Bailey, Rebecca *(Salford and Eccles)* (Lab)
† Marson, Julie *(Hertford and Stortford)* (Con)
† Maskell, Rachael *(York Central)* (Lab/Co-op)
† Mohindra, Mr Gagan *(South West Hertfordshire)* (Con)
† Morris, David *(Morecambe and Lunesdale)* (Con)
† Seely, Bob *(Isle of Wight)* (Con)
† Smyth, Karin *(Bristol South)* (Lab)
† Stephenson, Andrew *(Minister for Health and Secondary Care)*
† Swayne, Sir Desmond *(New Forest West)* (Con)
† Wakeford, Christian *(Bury South)* (Lab)

Nicholas Taylor, *Committee Clerk*

† attended the Committee

The following also attended (Standing Order No. 118(2)):

Coffey, Dr Thérèse *(Suffolk Coastal)* (Con)
Greenwood, Margaret *(Wirral West)* (Lab)
Webbe, Claudia *(Leicester East)* (Ind)

Sixth Delegated Legislation Committee

Wednesday 17 January 2024

[Dame Caroline Dinenage *in the Chair*]

Draft Anaesthesia Associates and Physician Associates Order 2024

2.30 pm

The Minister for Health and Secondary Care (Andrew Stephenson): I beg to move,

That the Committee has considered the draft Anaesthesia Associates and Physician Associates Order 2024.

It is a pleasure to serve under your chairmanship, Dame Caroline. I will begin by setting out the policy context behind the draft order. Strengthening the future of the NHS workforce remains one of the Government's top priorities. Anaesthesia associates, AAs, and physician associates, PAs, are already a valued and integral part of the multidisciplinary healthcare team, but they have the potential to make an even greater contribution. Regulating those professions will increase the contribution that AAs and PAs can make to the UK healthcare sector, while improving patient safety and professional accountability.

As well as bringing AAs and PAs into regulation by the General Medical Council, the draft order paves the way for full-scale reform of the regulatory frameworks for all the healthcare professional regulators. This is a rare and significant opportunity to deliver a large-scale programme of reform that will implement improvements to patient and public safety, the system of professional regulation, and the health and care workforce. We are introducing the regulation of AAs and PAs under a new legislative framework without at this stage changing the GMC's regulatory framework for doctors. That means that the GMC's overall governance and its regulation of doctors will continue under the Medical Act 1983 after the order comes into effect.

The draft order will give the GMC powers to register AAs and PAs whom it assesses to be appropriately qualified and competent, and to set standards of practice, education and training, and requirements for continual professional development and the conduct of AAs and PAs. It gives the GMC the powers to approve AAs and PAs' education and training programmes, to operate fitness-to-practice procedures, to investigate concerns and, if necessary, to prevent or restrict an associate from practising.

The legislation provides a high-level framework for the GMC to regulate AAs and PAs, and importantly gives the GMC autonomy to set out the details of its regulatory procedures in rules. The GMC has committed to developing rules and processes for regulating AAs and PAs, which will be subject to public consultation, to enable regulation to begin by the end of this year.

We recognise some concerns about the deployment and planned expansion of the AA and PA roles within the NHS. Let me be clear: the role of associates is to work with doctors and not to replace them. AAs and PAs are distinct, complementary and valued professionals who can enrich the workforce skills mix, freeing up doctors and consultants to spend more time using their specialist skills and training to focus on complex clinical duties and decisions on patient care.

It is important to note that the NHS long-term workforce plan sets out an aim to double the number of medical places in England to 15,000 a year by 2031-32, and to work towards expansion by increasing places by a third to 10,000 a year by 2028-29. We have accelerated that expansion by allocating 205 additional medical school places for the 2024-25 academic year, with the process for allocating 350 additional places for the 2025-26 academic year under way. That demonstrates our commitment to the medical profession and that we do not see PAs or AAs as replacements for doctors.

Currently, more than 139,200 full-time equivalent doctors work in the NHS in England. That is more than 42,100—or 43%—more than in 2010. There are fewer than 3,500 PAs and AAs. Patient safety remains of the utmost importance, and regulation will help to bring further clarity to patients and healthcare professionals on the nature of the roles and their respective remits. Regulation will give the GMC responsibility and oversight of AAs and PAs, in addition to doctors, allowing the council to take a holistic approach to education, training and standards. That will enable a more coherent and co-ordinated approach to regulation, and make it easier for employers, patients and the public to understand the relationship between the roles of associates and doctors. Each nation is considering the operational deployment of those roles within their respective workforces.

In England, the long-term workforce plan reaffirms the commitment to PAs and AAs, and commits to increase the PA workforce to 10,000, and the AA workforce to 2,000, by 2036-37. Over the same period of the long-term workforce plan, we will deliver an additional 60,000 doctors. That is a factor of 5:1 in favour of doctors, which I hope addresses the mistaken belief that PAs and AAs will replace doctors within our NHS. It is vital that this expansion is delivered safely. NHS England is working through partners, including the GMC, the Royal Colleges and other stakeholders, to ensure that associates can be effectively trained and integrated into teams across a range of specialities.

To summarise, the draft order will provide a standardised framework of governance and assurance for clinical practice and professional conduct to enhance patient safety and enable AAs and PAs to make a greater contribution to patient care. I commend the order to the Committee.

2.36 pm

Karin Smyth (Bristol South) (Lab): It is a pleasure to serve under your chairmanship, Dame Caroline. I thank the Minister and his officials for meeting me in advance of today's sitting, and for the courtesy they showed to the Opposition in doing so.

When we are in need of care from the NHS, we are usually at our most vulnerable. We expect to be seen and treated by a professional who is competent in their role and regulated. It is vital that patients know who is undertaking their care, and can be confident in their competence. It is paramount to patient safety that those treating patients in the NHS are regulated. There has clearly been a delay in getting to that point with physician associates and anaesthesia associates, and regulation is

long overdue. Those positions play an important role as part of a flexible and diverse workforce, but should never be seen as a replacement for doctors. I am pleased that the Minister has made that clear.

PAs and AAs were first introduced as assistants by the previous Labour Government because they are important in bringing people with different skills into the NHS and providing opportunities for those who do not take the traditional route into clinical roles. They exist in many systems around the world, and we thank them for their service. As part of a multidisciplinary team, they can provide much-needed capacity by supporting doctors and other frontline staff. So important are they that, as we have heard, their numbers are going to be increased as part of the Government's workforce plan.

However, we must be clear that associates are not a panacea to 14 years of Conservative mismanagement of the NHS. The current crisis on the frontline, the workforce crisis, and record high waiting lists will not be solved by increasing the number of associates. The Government have cut 2,000 GPs, and many people now find it impossible to get an appointment when they need one. The failure to recruit, and particularly to retain, enough fully qualified staff should not be papered over by using alternatives. The Government's inability to maintain relationships with frontline staff, including both junior doctors and GPs, is exacerbating worries about this legislation. The Government have already shattered morale among the health workforce. Many of us, as MPs, have heard from the people concerned most specifically in the run-up to this legislation. My first question for the Minister is: will he reassure me that the expansion of PAs and AAs will not impinge on medical specialty training expansion and, crucially, opportunities?

A number of concerns have been raised with me and other colleagues about the detail of this order and its implications for safety—concerns that really should have been addressed earlier if the Government had better relationships with key stakeholders. It is important for a Government to listen to and work with patients and professionals, and address their concerns. I ask the Minister to do that today, as this legislation goes through, and throughout the consultation process. That is my second question to the Minister: can he provide assurance that, going forward, all stakeholders will be fully consulted by the GMC on the details of the draft order? Patients need clarity about who is treating them and why. What measures will the Minister take to ensure that patients have that clarity, and improved awareness of who they could be speaking to in a GP surgery or other medical setting?

It is vital that people who are looking to become associates are properly supported and supervised to work within a defined scope in those roles. Addressing the workforce crisis in the NHS, so that staff have the time and, crucially, the capacity to support PAs and AAs, is crucial to ensure that those roles are successful. Can the Minister indicate what support would be available to PAs and AAs, what level of supervision will be suitable, and how the Government will ensure that that is in place, given that we all know how stretched the frontline already is? Has he had discussion with the GMC about defining the scope of PAs and AAs?

It will also be helpful to hear the Minister's thoughts on how the draft order may impact on career progression in the NHS and help with retention, which we all want. Are there plans to define the core capabilities expected of PAs and AAs? What assurances can the Minster give us that the GMC is the best regulator to undertake that work? That point has been raised with many Members. Will the Minister explain how the order fits in with wider regulation reform, which is to be undertaken over the next year or so? Patient safety is and must always be our No. 1 priority. Can the Minister provide any assurances about the measures in place to review this legislation over the two-year transition period, particularly given the expansion of the role of PAs and AAs in the NHS?

Finally, some have expressed concern about the safeguards around the fitness-to-practice decisions taken by regulators, including decisions to remove or reduce regulatory restrictions on a registrant who has been found to present a possibly serious risk to the public. What assurances can the Minister give on that point? If the legislation is deemed not suitable to improve patient safety, what measures will the Government take to remedy that and keep on top of the situation?

The draft order provides a framework for the regulation of associates. It is vital that all those treating patients in the NHS are regulated and safe, and for that reason we will not oppose the statutory instrument. We support regulation. However, I hope that my concerns and those of others—I know that other right hon. and hon. colleagues wish to speak—will be monitored closely. I look forward to hearing further assurances from the Minister as he works to ensure that the change is successful.

Several hon. Members *rose —*

The Chair: A number of colleagues have indicated that they would like to speak in the debate. I call Thérèse Coffey first.

2.42 pm

Dr Thérèse Coffey (Suffolk Coastal) (Con): It is a pleasure to serve under your chairmanship, Dame Caroline. This may surprise Members, but I am not a member of the Committee. However, I care about this issue. I believe that the expansion in the number of associates is fully in the interests of patients. By virtue of this Order in Council—which has also been put forward by Scottish Government Ministers—there will be a necessary and rightful route by which physician associates and anaesthesia associates can be regulated by the General Medical Council, with all its professional elements. There will be a curriculum, continuous professional development, and a variety of other things that we expect of other professionals in the NHS and the wider health services.

This may all sound a bit odd. Why do we not just get more people to become doctors? The Government, however, have already addressed that, through the expansion in medical school places that is to happen. I will tell the Committee a personal story, through which I saw the issues at first hand. I will not pretend otherwise: when I was, for a brief time, Secretary of State for Health and Social Care, this event reinforced the reasons why I was keen to see this move make the progress that it is making.

About 18 months ago, Parliament was busy with a potential change in leadership, although Prime Minister Boris Johnson was still in post. I suffered an infection and

[Dr Thérèse Coffey]

went to a hospital in London, where I waited more than nine hours to see a doctor. I went home without any treatment, and then re-presented myself at a different London hospital, where I got the treatment that I needed within a much shorter time. This meant that I attended my last Cabinet meeting by phone from an NHS hospital bed.

The second hospital was quicker to deal with my situation, because it had a wider range of medical professionals, including a physician associate, who was able to do a lot of the work on the appropriate treatment, although of course that still needed sign-off by the doctor. Instead of patients waiting for hours for that one doctor, the hospital was using a full range of NHS professionals to the extent of their abilities. That is a sensible, practical way to ensure that patient care and safety is absolutely paramount.

Not all hospital trusts have associates, nor are they necessarily planning to have them, but I would strongly recommend that they do. When I think about the number of operations that could be happening, I really welcome the expansion of anaesthesia associates. The anaesthetist will be a key part of that, but imagine one anaesthetist helping with three operations at one time, along with appropriately trained and regulated anaesthesia associates. That is an approach that modernises the NHS's capacity and capability to treat as many patients as possible.

In the past, there has been resistance to Pharmacy Direct, which is about to be launched, expanding the number of things that pharmacists can do. There has also been resistance to expanding what nurses can do without a doctor's sign-off. There will be plenty of situations where people in community hospitals say, "Ah, yes, you've come in. We will try to treat that in the minor injuries unit, but we don't have a prescribing nurse here, so you've got to either wait, or go to the doctor to get a prescription." The modern NHS has to think about those situations, and be careful in how it deploys staff. This Order in Council is a key element of that. It brings associates into the same professional regulatory body and inspection regime as doctors—of course, people will know that there are other regulators for different professions.

I felt strongly about coming along to the Committee to support this order and see it progress. For me, patient safety will always be paramount, but I see this as a professional step forward, and I look forward to the change happening right across the United Kingdom.

2.46 pm

Barbara Keeley (Worsley and Eccles South) (Lab): It is a pleasure to serve on this Committee with you in the Chair, Dame Caroline. I am pleased to be able to speak in our discussion of this very important area of legislation, as the right hon. Member for Suffolk Coastal just called it. In my view, this issue is so important that we should be debating it in the Chamber; perhaps we could have found a way to do that.

Schedule 1(3)(a) to the order states that the regulator

"has the objective of promoting and maintaining—

(i) public confidence in, and

(ii) proper professional standards and conduct for members of, the anaesthesia associate and physician associate professions".

I hope that the regulator takes those duties very seriously, because public trust in physician associates has already been damaged by the very sad death of Emily Chesterton, who died after being seen twice and diagnosed by a physician associate at a local GP practice. Emily was the daughter of my constituents, Marion and Brendan Chesterton, and I raised her case at an Adjournment debate on 6 July 2023. I would like to give details of Emily's case, because it illustrates the need for the greatest clarity in the distinction between doctors and staff in the medical associate professions.

Emily Chesterton died in November 2022 after suffering a pulmonary embolism, after being seen twice by a physician associate, rather than a GP. She was just 30 years old when she died. Emily was a budding actor in musical theatre. She and her partner had moved to London from Boothstown, in my constituency, to pursue their careers in the arts. They registered with their local GP surgery, the Vale Practice in Crouch End, north London. Emily had been diagnosed with polycystic ovary syndrome and had also contracted covid-19 in late summer 2022. Marion Chesterton, her mother and my constituent, said that Emily had been feeling unwell for a few weeks before she made an appointment at the Vale Practice on 31 October 2022, as she had calf pain and was breathless. Emily believed that this appointment was to see a GP, but the person she was booked to see at the practice was a physician associate.

Physician associates and doctors have a very different depth of expertise. Physician associates have to complete just two years of clinical training, following a biosciences undergraduate degree. Doctors, on the other hand, must complete a five-year medical degree, as well as several years of foundation training and specialism training, interspersed with national exams. As both the Minister and my hon. Friend the Member for Bristol South on the Opposition Front Bench have said, physician associates are intended to support and assist more medically qualified staff, not replace them.

In Emily's case, after a short appointment, the physician associate diagnosed Emily with a sprain and possibly long covid. Emily was told to rest and take paracetamol. At no point during the appointment at the GP surgery was Emily made aware that the person who had diagnosed her was not a doctor.

A week later, on 7 November, Emily began to feel very unwell. Her leg was swollen and hot, and she struggled to walk a few steps without becoming out of breath. She made another appointment at the Vale Practice and saw the same physician associate. It appears that this was a short appointment, and that Emily's legs were not examined. The physician associate suggested that Emily's breathlessness was due to anxiety and long covid. She prescribed propranolol. In messages that Emily sent to her family on that day, it appears that she described seeing "the doctor", and that she was never told that the person she was consulting for medical assistance was not a fully qualified GP.

In its serious incident report after Emily's death, the Vale Practice stated that patients should not see a physician associate twice for the same condition. The guidelines make it clear that physician associates cannot prescribe; any prescriptions need to be signed off by a supervising GP. It appears that the oversight of prescribing medication was missing, and the system failed in Emily's case.

Later in the evening of that same day, 7 November, Emily's health deteriorated, so she took a propranolol tablet, as advised by the physician associate. She then became drowsy, and then very ill. Her partner Keoni recalled to the inquest that she lost her pulse, and he had to perform CPR on her, which recovered the pulse. He then called an ambulance.

Emily suffered a cardiac arrest on the way to the hospital. Her family had to say their goodbyes to her while she was still on the machine that was pumping her heart for her. Keoni recalled that staff at the A&E department at Whittington Hospital, where Emily died, told him that the propranolol tablet "definitely would not have helped" Emily's condition, and staff had to give her an antidote to the drug.

The circumstances that led to Emily Chesterton's death were investigated by a coroner, and there was a hearing at St Pancras coroner's court on 20 March 2023. Messages from Emily to her partner and family at the time of her appointments were shared at the inquest. These messages provide evidence that Emily believed that she was seeing a doctor. They also provide evidence that the appointments with the physician associate were short, and that Emily was not examined fully.

The coroner's conclusion was as follows:

"Emily Chesterton died from a pulmonary embolism, a natural cause of death. She attended her general practitioner surgery on the mornings of 31 October and 7 November 2022 with calf pain and shortness of breath, and was seen by the same physician associate on both occasions. She should have been immediately referred to a hospital emergency unit. If she had been on either occasion, the likelihood is that she would have been treated for pulmonary embolism and would have survived."

That heartbreaking statement lays out clearly the failings in the health system, which should have supported Emily with appropriate care.

Sadly, further failings were evidenced in the incident report that the Vale Practice provided to the coroner. In particular, it was noted that the physician associate who saw Emily did not introduce herself and her role to Emily during the appointment. The practice said that the physician associate had failed to explore the causes of Emily's symptoms, failed to refer Emily for clinical investigations, and failed to consult a doctor after seeing a patient who had presented twice in one week with significant risk factors for pulmonary embolism. The practice also raised concerns about the physician associate's overconfidence and lack of insight into the limitations of her clinical knowledge and practice. Although the physician associate's contract at that practice was later terminated, Mrs Chesterton was upset to learn that she was still practising in the NHS in London, but I understand that that changed after I raised concerns in the Adjournment debate.

I must add that Emily's is not the only case like this. Sadly, Ben Peters, a previously healthy 25-year-old, died from a heart haemorrhage after being diagnosed with a panic attack by a physician associate. A freedom of information request sent to Scottish health boards found that there have been at least 12 "never events" linked to physician associates in Scottish health authority areas.

These cases demonstrate the urgent need for this profession to be regulated in a way that avoids further confusion among patients, their families and medical staff. To patients, associates and doctors may look the same—they appear to be doing a similar job—but the fact is that the associates do not have the same qualifications or expertise as doctors. I understand that it was originally envisaged that physician assistants would be vital members of multidisciplinary teams, assisting with the workload and contributing to a high quality of care, but the regulator must ensure that there are now clear guidelines for associates to make their role clear to patients when they introduce themselves. As I have described, that did not happen in the case of Emily Chesterton.

There is a bigger question around the titles of associate. At the time of my Adjournment debate, Marion Chesterton raised with me the point that the title sounds

"extremely grand, even grander than a General Practitioner".

Some have suggested changing the title back to the original title of physician assistants and anaesthesia assistants to avoid that confusion. There may be other solutions that the Minister could consider.

Getting the approach to associates right will become even more urgent as the profession grows in line with the proposals set out in the NHS long-term workforce plan. There is certainly a need to tackle workforce shortages in the NHS, as my hon. Friend the Member for Bristol South said. A lack of qualified professionals is the root cause of many of the challenges that our health service faces. We must be careful that any adaptations to the workforce to fix those issues do not push existing professionals out.

I had many GPs write to me after my Adjournment debate about Emily's case. One told me,

"There is much talk amongst GP locums of work drying up, possibly due to the increasing use of Additional Roles Reimbursement Scheme staff (including the associate roles) to fill vacancies (and these are much cheaper than employing locum GPs), and last week there was considerable disquiet about the Surrey practice that made its salaried GPs redundant due to 'new ways of working'."

He wrote on,

"For GPs—salarieds, locums, and trainees—who have been working in an over-stretched, high-stress system, and [who have] been told that there is a national shortage of GPs—this leaves many wondering about the security of their career and exploring other options. I am seriously concerned that the many intelligent, enthusiastic and valuable people in training and working as GPs are looking at options outside the NHS, outside medicine, and outside the country."

I am sure the Minister would agree that this is deeply concerning when the UK already faces intense competition from other countries to retain our doctors. While multidisciplinary teams with a diversity of roles are vital, doctors must still be valued. Most importantly, patients and clinicians must have a clear understanding of the skills, qualifications and limitations of those providing care.

I want to acknowledge that there have been many tragic cases leading to avoidable deaths of patients that have involved other roles. We could look at the case of Connor Sparrowhawk, an epileptic teenager who had a seizure and drowned in a bath at a hospital unit run by Southern Health. Connor was just 18. Dame Caroline, you will know well the case of Oliver McGowan, who died in Southmead Hospital at the age of 18. Oliver was prescribed the anti-psychotic medication olanzapine by a consultant in the hospital, despite his notes saying that he had reacted badly to it previously. Oliver died as a result of the brain injury caused by the medication.

[Barbara Keeley]

Those are tragic cases, but in neither of them was it the role and the limitations of an NHS professional that caused the problem. The issues I have raised are about the safety of patients and the accepted standards of knowledge, training and experience that we should expect from our medical professionals in order for them to provide a high quality of care. I hope that the Minister notes the points raised in this debate, and takes steps to ensure that the NHS workforce delivers for patient safety.

2.58 pm

Rachael Maskell (York Central) (Lab/Co-op): It is a pleasure to serve on the Committee, Dame Caroline. Before I begin, I declare that I was a registered professional with the Health and Care Professions Council, and worked in the NHS for 20 years before coming to this place. I was also the head of health at Unite, so I have a strong background in understanding the regulatory frameworks in the NHS.

I understand the issues that the Government are trying to resolve, given the changing nature of the NHS, the emergence of new professions, and the need to protect patients. I agree that all NHS professionals must be registered, and regulatory reform is long overdue, including for anaesthesia associates and physician associates. When Agenda for Change was piloted in 2003 and fully instituted in 2004, a job evaluation scheme was designed for this very purpose, and was overseen by the formidable Sue Hastings. However, emergent professions cannot just be add-ons to existing regulation. They required their own registers, governance and accountability, not least to ensure professional competence. The order is the first expression of that, 20 years on.

Also, the knowledge and skills framework enabled people to grow in their professional competencies and provide a higher level of care. That could lead to hybrid roles forming. I remember Alan Milburn saying at the time that the NHS career framework should enable someone to move from the role of porter to neurosurgeon—I do not know if that has ever been achieved. It is important that at every stage there is protection for the professional and, most importantly, the patient.

The reality behind the order is that the professional silos of the last 150 years or more are rapidly evolving and morphing in new ways, and the regulatory framework has to capture that and catch up. I agree that we urgently need a system of statutory regulation for anaesthesia associates and physician associates. They are working at a significant level of decision making, and they have a duty to uphold professional standards, their training must be of the highest standard, and there must be a fitness-to-practise process through which they can be called to account. I agree with my hon. Friend the Member for Bristol South that we need to ensure that that is rigorous and upholds standards, but I also welcome the fact that they may be expedited within the new system.

I have been asked whether the GMC is the right regulatory body. I understand the arguments for and against. This is where a lot of the concern comes from, which is why regulation is important. The challenge to this order is the lack of clarity about titles, roles and the competencies associated with each role. It could be argued that, for greater distinction, the HCPC, for example, is a more relevant registrant. I believe that that should have been examined further, not least as AAs and PAs are professionals allied to health and sit within the "Agenda for Change" family.

The public are nearly universally unaware of different roles in the NHS, let alone what they can or cannot do. In a clinical setting, if someone with a stethoscope around their neck calls themselves part of the medical team and they assess, diagnose and treat a patient, it will generally be assumed that they must be a doctor. I remember that when I started practising, if you were a woman, you were a nurse, and if you were a man, you were a doctor, so I certainly know that the distinctions are not always there. However, some use the title "Dr" because they hold a doctorate in another field, and that needs to be looked at. Further, there is a new lexicon of technicians, assistants, associates, advanced practitioners, and no doubt many more. I urge the Minister to find a common language so that there is simplicity and accuracy, and so the public understand the distinctions between these roles and those of the established professions.

In talking to the British Medical Association, I heard how people are now working above their competencies as AAs and PAs—carrying the consultant's bleep, for example. That is deeply disturbing and just reinforces the public confusion over the distinct identity and purpose of each clinical role. Boundaries must be clear and distinct and, for the sake of safety, defined nationally rather than determined locally.

While the Government are very much focused on vertical integration, which can exacerbate things such as skill mix, I urge the Minister to further consider the power of horizontal integration. We have seen some, for example with advanced practitioners reaching across professional silos, and in developing a focus on primary care it could bring strong benefits. We need to ensure that new regulatory frameworks address that. The blueprint for a future professional regulation framework must account for this opportunity.

As with all professions, medicine must not be exempt from looking at how it can be reshaped. However, when someone who has had two years' training is paid more —ironically, 35% more; Members might recall that number—and assumes more authority than a doctor of seven years' training with a higher level of competency, there is clearly a problem in the design of the role and cause for concern. We need to look at how we can move beyond traditional silos and create skills pathways that honour professions and the level of their skills, so that competencies can be gathered, tested and examined along the way. I believe that there needs to be a full job evaluation to understand the challenges between the professions—yes, across the two core NHS pay structures—and then a clear delineation of roles. For example, senior doctors in training in anaesthetics are now in a logjam, unable to progress to a consultant post due to the rise in the redeployment of anaesthetist competencies to AAs.

The same could be said of the Government's prioritisation of PAs over, for instance, traditional senior house officers. There is serious concern about the diagnostic skills of PAs; there have been examples of failure, as we

heard so powerfully about Emily Chesterton, the daughter of the constituent of my hon. Friend the Member for Worsley and Eccles South.

These functions need serious reconsideration and tight regulation. The GMC must ensure that their scope is clearly defined and that, before further role reforms occur, there are assurances that there will be no further scope creep. Clarity of role is really important in prescribing too. Some AAs and PAs may have transitioned from professions where they were already prescribers. We need to hear from the Minister how that situation will be managed, with clear delineation.

I want to touch on the issue of liability—where responsibility lies. With registration, AAs and PAs will be autonomous practitioners, liable for their own conduct and practice. How will the regulator ensure that liability is apportioned in the right way between them and those who provide supervision? Will they receive one-to-one supervision, and how far will liability carry on to, say, the consultant or senior registrar? That is a really important issue to consider in the immediate future, not only for AAs and PAs, but for doctors and doctors in training, who must receive supervision too. We need to ensure that a new generation of doctors in training are able to receive the support that they need, and that it is not all dedicated to AAs and PAs.

Furthermore, with the envisaged rapid expansion in the number of AAs and PAs, the GMC needs to determine that supervision is safe and appropriate, and at the level required to enable people to mature into highly skilled professionals. It must also ensure that there is not a spike in fitness-to-practise cases due to lack of investment. The call from the medical profession is for us to slow down and properly evaluate and understand the consequences, seen and unforeseen.

On part 3 of the order, which concerns the register, can the Minister clarify that the associates will be on a separate register to doctors at the GMC, and that they will have their own register, as identified in article 5(2)(a)? I note that AAs and PAs will be on one register, but in separate parts. Will he explain to the Committee exactly how that will operate? Holding information separately would enable greater access for the public to the information they seek with respect to the new associate roles. The register must be robust and easy to navigate and, like the register for doctors, provide the public with all the information that they require. I know that the GMC has agreed to put a simple prefix ahead of registration numbers, but the professions are calling for more distinction so that there can be no confusion.

I am mindful of the higher proportion of cases generated from AAs and PAs. Will the Minister ensure that the registration fees reflect that? It is vital that the Government and the GMC, in formally setting up the statutory register over the coming three years, work closely with the professionals to ensure that they are engaged in the process and that their concerns are picked up and addressed along the way. I am asking the Minister to commit to that today, as I know my hon. Friend the Member for Bristol South will when she has the opportunity later in the year.

Patients, the wider public and fellow clinicians need to understand these fine lines and distinctions for their safety and safe practice across the NHS. The culture of "get it right first time" must be central to this debate and all that flows from it. If regulation lands in the wrong place, the Minister and the GMC need to be candid and ensure that it is changed so that it is fit for purpose. I trust that Parliament will have further opportunity to scrutinise these developments.

3.10 pm

Claudia Webbe (Leicester East) (Ind): It is a pleasure to serve under your chairship, Dame Caroline. I am concerned, however, that this matter is not being debated in the main Chamber.

The renaming of NHS medical assistant roles to physician associate and anaesthesia associate is confusing the public by blurring the clear distinction between doctors and other professionals who do not have medical physician qualifications and training. In response to a British Medical Association survey last month, 30% of patients said that they had no idea that they were not seeing a doctor, and 90% of doctors believe that the shift has been dangerous for patients.

According to at least two coroners, including the Chief Coroner, and the British Medical Association, the use of associates instead of fully qualified physicians has contributed to the avoidable deaths of patients who were misdiagnosed. Emily Chesterton from Salford, who was 30 years old, and 25-year-old Ben Peters both died after being sent home by physician associates who diagnosed emergency health issues as a calf strain and a panic attack, respectively—in Mr Peters's case, despite a history of heart problems. Ms Chesterton's family said that she was never aware that she had not been seen by a doctor.

The use of associates has been the subject of dangerous scope creep. One physician associate told a podcast that he was performing basic brain surgery and "learning on the job". Another hospital—in Leicester, as it happens—congratulated a nurse practitioner on being the first to perform a heart operation unsupervised. According to NHS campaigners, such non-medical roles are being used and expanded to cut staff costs and to fill vacant places as part of overall cost-cutting in the so-called integrated care service programme, which is the US accountable care system under a different name. A deliberate system of incentives ensures that the NHS and its regional providers will keep cutting the corners of what used to be a comprehensive, state-funded service, turning it into something that business can profitably provide.

The plan to regulate these non-medical roles through the General Medical Council adds to the dangerous confusion. It has been opposed by both the Royal College of General Practitioners and the British Medical Association. For the safety of patients and the proper functioning of the NHS, I urge the Committee to oppose the draft order. Instead, the titles of these roles should revert immediately to the previous titles, physician assistant and anaesthesia assistant. The NHS workforce plan must put doctors into doctor roles and unambiguously distinguish between medically qualified roles and other roles. As the British Medical Association has recommended, the Government must regulate those assistant roles through the Health and Care Professions Council, so that patients and their families are fully aware of who is treating them and how qualified they are.

3.14 pm

Margaret Greenwood (Wirral West) (Lab): It is a pleasure to serve under your chairmanship, Dame Caroline. Regulation of the roles of physician associates and

[Margaret Greenwood]

anaesthesia associates is long overdue. Let me say first that physician associates and anaesthesia associates have a valuable contribution to make to the NHS workforce.

I want to highlight some concerns that doctors in my constituency have raised with me about the fact that the responsibility for regulation will rest with the General Medical Council, the same body that regulates doctors. Their concern is that patients often do not understand that physician associates are not actually doctors and do not have the same medical training as them. The British Medical Association is among those that have highlighted that the deployment of those roles can be problematic, and that when patients have been seen by a physician associate, they are

"often unaware they have not been seen or assessed by a doctor".

That is extremely important because, in the treatment of illness, diagnosis is key. We have heard some harrowing examples this afternoon showing why this is so important.

A recent survey by the BMA found that 86% of the doctors who took part felt that patients were not aware of the difference between these roles and the roles of fully qualified doctors. They are concerned that the General Medical Council regulating responsibilities with a single register for doctors, physician associates and anaesthesia associates will only exacerbate the confusion. Further cause for concern is that 87% of doctors who took part in the same survey revealed that the way that physician associates and anaesthesia associates currently work in the NHS is always or sometimes a risk to patient safety. That is a matter of extreme concern.

A number of my constituents, many of whom are medical professionals, have contacted me about this legislation. A consultant wrote to me to say that

"the professional titles used for these roles—'physician associate' and 'anaesthesia associate'—are highly misleading and only add to patient confusion, because it is clear that patients often think they are being treated by a doctor, when they are not."

My constituent suggested that the titles revert to what they were—namely, "physician assistant" and "physician assistant (anaesthesia)" or "anaesthesia assistant". I would go further and suggest that the name "doctor's assistant" be used. That is much clearer and everybody would be able to understand it.

Another Wirral West resident, a retired consultant, said that doctors are

"increasingly concerned about the expansion of medical associate roles in the NHS while significant confusion remains about the scope of the roles, supervision and expertise."

They also suggest clearly defining the roles of physician associates and anaesthesia associates because there is currently such little definition of what the roles entail and what their limits are.

It is vital that the scope and limits of the roles of physician associates and anaesthesia associates are clearly set out, not just for people taking up those roles, but for their patients. That needs to be clearly communicated. Many constituents have also suggested, as has the BMA, that these roles would be better regulated by the Health and Care Professions Council. Will the Minister share with us what consideration has been given to whether that body might be better as a regulator?

This SI concerns regulation. It comes about following the Health and Care Act 2022, which made provision for taking health professions out of regulation. This SI shows the need for the exact opposite. It is important that the high standards that we enjoy in the NHS are protected, so it is vital that the roles are clearly defined, as well as regulated.

I hope the Minister will take on board and respond to the concerns that have been raised in this debate. Concerns are likely to persist that the Government see the training and deployment of medical associate professionals as simply a cheaper alternative to training doctors. To take GPs, for instance, as of November 2023, there were 2.3% fewer fully qualified full-time equivalent GPs in England than in 2019 and 6.8% less than in 2015. In 2023, there were 7% fewer GP practices than in 2019.

Meanwhile, the number of patients per GP has increased considerably. There are now 2,290 patients per GP, an increase of 6.9% since 2019. We can see that our GPs are doing more work than they had been required to do and they are clearly working under increased pressure. Added to that, those who have physician associates in their practice also have to oversee them. The expansion of the number of physician associates and anaesthesia associates should not be used as a solution to the shortage of hospital doctors and GPs.

3.19 pm

Andrew Stephenson: I thank my right hon. Friend the Member for Suffolk Coastal and the hon. Members for Bristol South, for Leicester East, for Worsley and Eccles South, for York Central, and for Wirral West for their contributions to today's debate.

I would like to turn first to the contribution by the hon. Member for Worsley and Eccles South, who spoke movingly on behalf of her constituents Marion and Brendan Chesterton about the death of their daughter, Emily. I know that the hon. Lady also did so in a very moving fashion during an Adjournment debate, which was responded to by my predecessor, my hon. Friend the Member for Colchester (Will Quince). Ahead of today's debate, I was very keen to listen to that debate, so I watched it back and I am keen to see what more we can do to learn lessons.

No family should ever have to endure the loss of a child, and no words from me will assuage the family's grief. However, I hope that by passing this order we are helping to ensure that some lessons have been learned and that we can deliver improved patient safety through better regulation of these roles. I recognise that there have been delays to the previously published timescale for the regulation of AAs and PAs. Although that is in part due to the pandemic, it is important to reiterate that this work is being taken forward as part of a broader package of reforms of regulators, governing a whole range of medical professions. That work is significant and complex. On that basis, a huge amount of work and input from all the regulators and a range of stakeholders has contributed to the draft legislation for AAs and PAs, which will be used as a template for reforms to other regulatory bodies.

Throughout this process, officials from my Department have met the BMA and other stakeholders to develop the policy behind this legislation. On the basis of feedback received through public consultation and additional targeted engagement, officials have made a number of amendments to the draft order to ensure that the legislation is fit for purpose and delivers the flexibility and autonomy required to empower regulators to be able to introduce new regulatory processes that would better serve patients

and their registrants. That engagement has been crucial in shaping both our policy intention and the resultant legislation to ensure that it remains a practical piece of legislation that can be used by regulators.

The forthcoming GMC rules consultation, which will follow the passage of this order, represents a further opportunity for the BMA and others to have input into the regulation of these roles. When I met the GMC, I was assured that they were confident that they could bring forward this consultation quickly so that there are no further delays to the timetable of implementing these regulations.

Turning to the AA and PA titles, which quite a few Members have raised today, the physician associate title has been well established in the UK since 2014, and the Government have no plans to change the titles of PAs or AAs. As set out in the National Institute for Health and Care Excellence guidelines, all healthcare professionals directly involved in patient care should introduce themselves and explain their role to the patient. AAs and PAs are not and should never be referred to as medical practitioners, doctors or consultants.

The GMC has published interim standards for AAs and PAs in advance of regulation that make it clear that professionals should always introduce their role to patients and set out their responsibilities in the team. Ahead of regulation by the GMC, the Faculty of Physician Associates has issued guidance for PAs, supervisors, employers and organisations that helps to provide a structured and standardised way of using the title. In addition, NHS England has produced patient-facing materials that have been shared widely with GP practices to support patient awareness and understanding of the PA role.

Barbara Keeley: I thank the Minister for his words of sympathy; I will pass them on to Mr and Mrs Chesterton. On patient-facing advertising, I think a couple of months ago, I raised with the previous Secretary of State for Health, the right hon. Member for North East Cambridgeshire (Steve Barclay), a post from Norfolk and Waveney integrated care system that read, "Got abdominal pain that isn't going away? A Physician Associate based in your GP practice can help…They are highly skilled at diagnosing conditions". That was marketing material related to the role, which does not help. We have had tragic cases like Emily's, and it does not help to have over-egged advertising like that. Can the Minister can say anything about that?

Andrew Stephenson: I completely agree. Things like that do not help, and that is why bringing forward these regulations will help. The GMC is obviously very keen to start its consultation and have the regulations introduced. As soon as this is set out in statute, it will be very helpful, not just for PAs but everybody, particularly employers and others, in ensuring that they never oversell the abilities of a PA and are clear about the role of a PA or AA in an integrated health team.

Turning to the shadow Minister, the hon. Member for Bristol South, I thank her for her contribution and join her in paying tribute to the PAs and AAs already working in our NHS. She asked about the impact on training opportunities for junior doctors, which leads me on to addressing quite a few of the points about why we have decided to go with the GMC as the regulator. The assessment of the most appropriate regulatory body for AAs and PAs was completed in 2019 following a public consultation. The majority of respondents were in favour of the GMC taking on regulation, including the professional bodies representing the two roles and the medical royal colleges. For the record, from a total of over 3,000 responses, 59% of respondents felt that the GMC was the most appropriate, while 20% thought it should be the HCPC.

Regulation of the associate roles by the GMC will allow it to take a holistic approach to the education, training and standards of associate and doctor roles. That will enable a more coherent and co-ordinated approach to regulation, hopefully ensuring that concerns around training places for junior doctors, for example, are addressed appropriately. I am happy to reassure the shadow Minister that I will continue to work with all stakeholders to ensure that we get the regulations right.

I thank the hon. Member for York Central, who spoke knowledgeably about these roles. We would all agree that it has been long recognised that we need to reform the legislative framework for the regulation of healthcare professionals to make things faster and more flexible. The current UK model needs to change to better protect patients, support our health service and help the workforce to meet future challenges.

Successive Governments have considered such reforms, but they have never come to fruition until now. While it is our intention to work as swiftly as possible to deliver reform for each regulator and profession, we will prioritise delivery based on criteria including the size of the registrant base, the need for reform, and our assessment of regulators' readiness to implement the changes. Based on those criteria, we intend to start working with the regulators to develop reform legislation for their professions over the next couple of years.

The hon. Lady asked about fee levels. I believe the GMC's current plan is to charge AAs and PAs a fee of £221 per annum, adjusted for inflation. That is what PAs are currently paying the FPA—of course, AAs do not currently pay a fee. The GMC, like the NMC and other regulators, works on the basis of their activities being funded by the fees from registrants, which is an important way of keeping them independent from Government.

This draft order represents a vital step forward to improve patient safety by ensuring that PAs and AAs meet the standards that we expect of all regulated professionals and that they can be held to account if serious concerns are raised. I hope that I have addressed as many of the points raised by the Committee as I can, but I am more than happy to continue dialogue with the Opposition Front-Bench team and others to ensure we get the changes right. I commend the draft order to the Committee.

The Chair: Order. Before I put the question, I have a reminder. We have heard from Members from both sides of the House who are not formal members of this Committee, but only members of the Committee are allowed to vote.

Question put and agreed to.

Resolved,

That the Committee has considered the draft Anaesthesia Associates and Physician Associates Order 2024.

3.28 pm

Committee rose.