ANNEX 3: THE CONSULTATIONS ON THE NEED TO REGULATE AAs & PAs

1. The DoH conducted 4 consultation processes between 2017 and the 2024 Order:

   (1) The 2017 Consultation *The Regulation of Medical Associate Professions in the UK* **[SB2/J/57/887-927]**: see Marks 1, §§64-77 **[CB/C/15/216-221];** Marks 2, §175 **[CB/C/18/316-317]**. This sought views on proposals to regulate MAPs to "*protect the public*" by setting "*the standards required to practise safely and effectively*" (p.6) and to limit what was permissible locally where there would inevitably be variations in practice (p.6). It identified that the work of associates posed risks to patient safety, including due to AAs working outside the 2016 RCoA SoP and both PAs and AAs conducting high-risk work with inadequate supervision (pp.22-24). The DoH's Consultation Response **[SB2/J/61/993-1040]** (see Marks 1, §§82-89 **[CB/C/15/222-223]**) affirmed that there was a "*compelling case*" for statutory regulation for these very reasons (§§1.6-7, 5.9).

   (2) The 2018 Consultation *Promoting professionalism, reforming regulation* **[SB2/J/58/928-978]** (see Marks 1, §§78-81 **[CB/C/15/221-222]**; Marks 2, §176 **[CB/C/18/317-318]**). This set out options for achieving coherent national regulation of healthcare professionals generally as recommended by the Law Commission, emphasising that regulation should respond to and protect the public from the risk of harm (pp.7, 14) and provide assurance that practitioners are competent in their roles (pp.7-8). The Consultation Response **[SB2/J/1041-1099]** (see Marks 2, §176 **[CB/C/18/317-318]**) reflected the same**.**

   (3) The 2021 Consultation *Regulating healthcare professionals, protecting the public* **[SB2/J/63/1100 - 1209]** (see Marks 1, §§90-94 **[CB/C/15/223-224];** Marks 2, §177 **[CB/C/18/318]**). This set out specific proposals for the statutory regulation of healthcare professionals generally (and the regulation of associates by the GMC in section 5), reassuring consultees that the context in which associates' roles are practised and the "*risks posed*" by them meant there would be some differences between the way they were regulated compared to doctors (§§376, 399) and underscoring that associates are supervised (§§366-7). The Consultation Response **[SB/J/65/1226-1426]** (see Marks 1, §§101-104 **[CB/C/15/226-227]**; Marks 2, §177 **[CB/C/18/318]**) echoed the same ideas, emphasising that regulation of associates "*must be proportionate to the roles and associated risks*" (p.172).

   (4) The 2023 Consultation *Regulating anaesthesia associates and physician associates* **[SB2/J/66/1427 - 1481]** (see Marks 1, §§105, 117-120 **[CB/C/15/227; 231-233];** Marks 2, §178 **[CB/C/18/319]**). This consulted on the legislation that would empower the GMC to regulate associates (i.e. the 2024 Order). It emphasised that the GMC must be able to take action to prevent associates from putting the safety of patients or public confidence in the

profession at risk (**[SB2/J/66/1436]**). The Consultation Response **[SB2/J/68/1485 - 1565]** (see Marks 1, §§117-120 **[CB/C/15/231-233]**) noted the significant concern expressed by consultees about patient safety in the context of associates and that the powers conferred would be broad enough to provide reassurance on that front.

2. As the case for regulation developed, NHSE published documents prior to the enactment of the 2024 Order indicating its views on the regulation of AAs and PAs:

   (1) In June 2022, HEE (since merged into NHSE) published a *Core Capabilities Framework for Medical Associate Professions* **[SB4/M/135/3461 - 3491].** This provided a high-level overview of what would be expected of MAPs post-registration and assumed that they would practice in accordance with supervisory requirements and a "*defined scope of practice*" as set by their regulator: Marks 1, §§97-100 **[CB/C/15/225]**; Marks 2, §162 **[CB/C/18/314]**.

   (2) In June 2023, the NHS LongTerm Workforce Plan was published **[SB4/M/148/3654-3804].** As well as foreshadowing massive expansion in the numbers of associates (to 10,000 PAs and 2,000 AAs by 2036/37: a c.3 fold and 30 fold increase respectively), this envisaged an SoP for AAs and PAs: Marks 1, §§110-111 **[CB/C/15/228-229]**.

   (3) In October 2023, NHSE published an open letter **[SB5/M/160/3875-3877]**. This also envisaged a "*defined scope of practice*" and appropriate supervision: Marks 1, §114 **[CB/C/15/230-231];** Marks 2, §163 **[CB/C/18/314]**.

3. The 2024 Order was then the subject of briefing to the House of Lords:

   (1) A DoH briefing for the House of Lords **[SB5/M/187/ 4047-4071]** assumed AAs and PAs would be limited to delivering "*specific aspects of patient care*", "*always under the supervision of a fully trained and experienced doctor*" and referred to work with the GMC and other partners on "*developing national standards, defined scope of practice*" in relation to AAs and PAs: Marks 1, §20 and 121 **[CB/C/15/205; 233-234]**; Marks 2, §182 **[CB/C/18/319]**.

   (2) A GMC briefing **[SB5/M/184/4030 - 4039]** referred to PAs and AAs always working under supervision (§1) and stated that NHSE, employer bodies and the Royal Colleges were looking at how SoP may develop over time (§13): Marks 2, §181 **[CB/C/18/319].**

   (3) The Explanatory Memorandum to the 2024 Order also assumed AAs and PAs would be limited to delivering "*specific aspects of patient care*": Marks 1, §21 **[CB/C/15/205]**.

4. This evidence demonstrates that the push for regulation was a response to the perceived risks to patient safety and confidence in the medical profession resulting from the work of PAs and

AAs, whose numbers and role were forecast to expand. The safeguards considered to be important included a defined SoP and direct supervision by a senior doctor. The central purpose of the 2024 Order was to confer powers of sufficient width to enable the GMC to address/prevent any identified risks to patient safety or public confidence.