# Professional Standards Authority for Health and Social Care

# Evidence to the Health, Social Care and Sport Committee – Scrutiny of the Anaesthesia Associates and Physician Associates Order

## January 2024

### 1. Summary

1.1 The PSA supports the Four UK Country Governments' legislative reform programme for the regulators it oversees, of which the Anaesthesia Associates and Physician Associates Order (AAPAO) is a first step.

1.2 This piece of legislation which is intended as a blueprint for reform of all the regulators we oversee would replace the outdated and inflexible legislation that we believe is holding our sector back from adapting to changing times and pressures. We support:

- The greater flexibility and adaptability it would give regulators by removing detail from the legislation itself, and granting regulators powers to make the rules that would cover this detail
- The new, consensual fitness to practise process that would be quicker and less adversarial.

1.3 We are also grateful to the UK Governments for the changes that will be made to our own legislation, through the AAPAO and subsequent reforming legislation, to adapt our powers to the new model.

1.4 However, there are elements of the blueprint that we would like to see reconsidered before the legislation is rolled out to larger groups of professionals, such as doctors, nurses and allied health professionals:

- More checks and balances on powers allowing the regulators to override adjudication decisions about the conduct and competence of professionals
- An effective public protection mechanism for challenging decisions made under the new consensual fitness to practise process.

1.5 Ideally, we would have liked these changes to appear in the AAPAO, however, given the small number of registrants affected by this piece of legislation, we are focusing our efforts now on the potential impacts of this blueprint being applied to much larger groups of registrants.

1.6 With this in mind, we urge all involved, and especially officials working on the next phases of reform, to engage with, and listen to people who have experience of bringing complaints to a professional regulator. The current blueprint will deliver much for regulatory efficiency – which of course may benefit all – however, there is more to be learnt about what regulation should be doing better from talking to harmed patients and families, as well as professionals who have raised concerns about a colleague.

## 2. Introduction

2.1 This is the evidence submission of the Professional Standards Authority (PSA) to the Health, Social Care and Sport Committee's scrutiny of the Anaesthesia Associates and Physician Associates Order (AAPAO).

2.2 The PSA promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and registration of people working in health and care. We are an independent body, accountable to the UK Parliament. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

2.3 The PSA will be both directly and indirectly affected by the AAPAO. We oversee the General Medical Council (GMC), report on its performance to UK Parliaments, challenge in the Courts decisions about professionals' fitness to practise that do not protect the public, and scrutinise appointments to its Council. Our legislation is being amended by the AAPAO to adapt our powers to the new model of regulation that this Order will introduce.

2.4 This piece of legislation will not only bring anaesthesia associates (AAs) and physician associates (PAs) into statutory regulation under the GMC. It will also introduce a new model of professional regulation, and pave the way for this model to be rolled out to all the regulators and professions under our remit.

2.5 Our interest in this piece of secondary legislation – and this submission to the Committee – relates to the new way of regulating that is enshrined within it, both for AAs and PAs, and for other professions in due course. We offer below some thoughts on the merits of the model, and where we would like to see changes – not necessarily for this Order, which we know cannot be amended in Parliament, but for the roll-out to large numbers of other professionals including nurses, doctors, and allied health professions, over 1.5 million people in total.

2.6 We are aware that our feedback is likely to be an outlier, in not providing commentary on the question of whether and how to regulate Anaesthesia Associates and Physician Associates – beyond our acceptance of the decision to regulate this group, and for the GMC to take this forward. We felt that it was nonetheless important to raise awareness of the 'blueprint' status of this piece of legislation, that may otherwise pass unnoticed.

2.7 Our primary concern throughout is public protection, however we also consider the proposals from the point of view of the impacts on professionals, in the interests of good regulation.

## 3. Advances in regulatory policy

3.1 The AAPAO is an improvement on the outdated, inflexible model of legislation in place at the moment, in two key ways.

### Greater flexibility for regulators

3.2 The AAPAO represents a new way of legislating for professional regulation. Existing legislation (whether the GMC's, or that of other health professional regulators) tends to be prescriptive, setting out in detail the regulator's processes and procedures – and changing it requires further legislation. This is

both inefficient and inflexible, and prevents the regulator from making improvements to its processes, and adapting to changing circumstances.

3.3 With the AAPAO, the Government has taken a new approach. This Order is what is known as 'enabling legislation' – essentially a set of powers and duties, for the GMC to implement as it sees fit, through rules that it will sign off itself. This is another departure from the current model, which requires rules to be approved by the Privy Council. The GMC must implement its legislation in line with an overarching public protection duty, along with several new factors to which it must have regard, namely transparency, accountability, proportionality and consistency.

3.4 These changes will grant the GMC significantly greater autonomy than it currently has over the regulation of doctors in two ways: firstly, the prescription in the legislation is being removed, allowing those details to sit in rules; secondly, making and amending rules will be easier and quicker.

3.5 With this newfound flexibility and autonomy, the GMC, and other regulators in due course, will be shouldering greater responsibility for how they operate. It is worth noting that the Government also intends to make changes to the GMC's governance arrangements when it introduces legislative reform for doctors. These are intended to help bolster accountability, as a counterweight to increased autonomy. The PSA is also considering what needs to change to make its oversight of reformed regulators as effective as possible, to help balance out autonomy with accountability.

### A less adversarial fitness to practise process

3.6 The AAPAO will introduce for AAs and PAs a process for dealing with concerns about performance or conduct (known as 'fitness to practise') that differs significantly from what is in place for doctors and other regulated professions.

3.7 Currently, almost all cases where it looks like some action will be required to protect the public, maintain public confidence, or uphold professional standards, are heard by a panel at a public hearing. The new legislation allows specific members of regulator staff ('case examiners') to decide whether to refer the case to a hearing, or to dispose of it consensually with the registrant.

3.8 These consensual disposals, or 'accepted outcomes' would save time and money, and reduce the stress on both registrants, and witnesses, who are often the complainers.

## 4. Further improvements needed before rolling out to larger professional groups

4.1 While the new model offers much in terms of flexibility for regulators and a likely more efficient model of fitness to practise, there are in our view still some areas that would benefit from further work, to ensure that public protection is maintained.

4.2 Ideally, we would have liked these changes to appear in the AAPAO, however, given the small number of registrants affected by this piece of legislation, we

are focusing our efforts now on the potential impacts of this blueprint being applied to much larger groups of registrants.

### Getting the balance right between flexibility and safeguards

4.3 The AAPAO gives regulators the ability to review fitness to practise decisions made by adjudicators, whether case examiners or panels. We would recommend that the Government looks again at these proposals to ensure that they are adequate for public protection.

#### *Review of conditions and suspensions*

4.4 The regulator will be able to review (which in this context can mean replacing or revoking):

- a decision by a panel to impose an interim measure (a suspension or condition imposed where there is a serious risk to the public, usually pending a final decision at a hearing or as an accepted outcome) (Article 12)
- a decision by a panel or case examiners to impose a suspension or condition as a final measure (as opposed to an interim one) (Article 14)

4.5 There are no stipulations as to decision-makers or any other aspect of process for either of the above, save that in order for a measure to be revoked and not replaced, the regulator must judge the registrant to be safe to practise. These would be high-risk decisions to remove or reduce regulatory restrictions on the practice of an individual registrant who has previously been found – by a panel or case examiners – to present a possibly serious risk to the public. It seems potentially risky for there to be fewer safeguards around these decisions than around the original decision. This seems to run counter to the usual hierarchical structure of decision-makers in judicial and quasi-judicial settings.

4.6 We welcome the proposal to grant the PSA a public protection right of appeal over decisions to review or revise final measures under Articles 14[1] – the absence of safeguards around these processes makes our ability to challenge unsafe decisions all the more important. [2] However, it would be preferable, and more in line with the principles of *Right-touch regulation*[3] for the legislation to set out some basic, non-onerous requirements for the process, to increase the chances of getting the decision 'right first time'. This would reduce the likely need for the PSA's appeal powers, which involve referral of the decision to the Courts. The Order could, for example, require case examiners or panels to approve these decisions, which could be done on the papers.

[1] Under section 29 of our legislation, the National Health Service Reform and Healthcare Professions Act 2002.
[2] We do not wish for, and nor have we been granted, powers to appeal interim measures – from a purely practical standpoint, the timescales would not allow for this, and we have not seen sufficient evidence of risk with these decisions under the current processes at least, to justify the significant increase in resources a power of appeal here would require.
[3] https://www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation

### *Revision of fitness to practise decisions*

4.7 In addition, Article 15 gives the regulator a power to 'revise' any formal decision made under the Order, provided it has prescribed this in rules. Fitness to practise decisions could be 'revised' on grounds of an error of fact or law, but if the decision in question included the imposition of conditions or suspension, the revision can result neither in the duration of the measure being extended, nor in the conditions being varied.

4.8 As with the power to review, the power to revise in 15(1) has little prescription around it – the Order does not explain what a revision constitutes, what outcomes are possible, or who should make these decisions.

4.9 It is also unclear what purpose these revision articles are intended to serve. This power was originally put forward by the Government as a safeguard for the new powers for case examiners to dispose of cases without a hearing, allowing challenge from both a registrant and a public protection perspective.[4]

4.10 The latter was seen as particularly important, because the PSA has – and will continue to have – section 29 powers to challenge fitness to practise panel decisions that are insufficient to protect the public. The disposal decisions case examiners will make are decisions that we can challenge under s.29 at the moment. The proposal that has become the revision power in Article 15 was seen as an alternative to our s.29 powers for the cases that will, as it were, fall out of our s.29 jurisdiction.[5]

4.11 However, since then, this proposal has evolved. In particular, it has lost those features that made it a public protection mechanism, as opposed to just an efficient means of rectifying 'errors' that disadvantage the registrant.

4.12 We would like to see the following in the legislation for wider reform of professional regulation:

- Change the test to enable a decision to be challenged because it is deemed insufficient to protect the public. An 'error of fact or law' is significantly narrower than the test that was originally proposed of a 'material flaw' combined wit reference to public protection
- Remove the restriction on possible outcomes of the revision when it comes to conditions and suspensions so that an outcome that is insufficient to protect the public can be rectified
- Make it mandatory for the power to revise to be available for case examiner decisions
- Amend the PSA's legislation to enable it to challenge an article 15 decision through Judicial Review for the purposes of public protection.

[4] See questions 61 and 62 of the policy consultation that preceded the drafting of the AAPAO: https://assets.publishing.service.gov.uk/media/607daac6d3bf7f0132941916/Regulating_healthcare_professionals__protecting_the_public.pdf

[5] Albeit one that provided a lesser form of protection, a case we argued strongly at the time: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/psa-first-look-at-government-consultation-on-reforming-regulation.pdf?sfvrsn=f9a44920_5

4.13 We have asked officials to confirm whether the policy intent for Article 15 still includes for it to be used as a means of identifying and addressing case examiner decisions that do not effectively protect the public, on request from the PSA, or a member of the public. As currently drafted, it would not fulfil that purpose.

### Bringing patient and complainant groups into the conversation for the next phases of reform

4.14 We are grateful to have been involved, alongside the regulators we oversee, in the development of the blueprint legislation that is now before the Committee in the form of the AAPAO. However, we have also called throughout this process for officials to engage more frequently with people who have experience of bringing a complaint to a regulator. These will be mostly harmed patients, or their families, but may also be professionals seeking to raise legitimate concerns about colleagues – such as those represented by the group Surviving in Scrubs.[6]

4.15 The reforms offer much by way of regulatory efficiencies, some of which are likely to be of benefit to these groups, especially where they lead to quicker resolution of cases. However, it is unclear whether the concerns people have about the current processes would necessarily be addressed by the new model, particularly when it comes to transparency, public confidence and voice in the process.

4.16 For the next phases of reform, we urge officials to work closely with these groups to see what more could be done to improve the process for those bringing complaints, on whom professional regulators rely to keep others safe.

## 5. Our other work on regulatory reform

5.1 The PSA's position on reform is simple and has not changed: we welcome reform; we will work with others to design legislation that enhances public protection; and we will do everything within our remit, powers and capacity to ensure that reformed regulation is as effective as possible in protecting the public.

5.2 On this point, we will soon be consulting on our initial guidance documents that will support the implementation of reform. These focus on making the best use of case examiners and panels for public protection, and good practice in rule-making. We would be happy to provide the Committee with more information on this work. In addition, we will be looking at how our performance reviews and standards might need to adapt so that we can scrutinise reformed regulators effectively.

[6] https://www.survivinginscrubs.co.uk/