Royal College of Physicians

Joanne Kearsley
Senior coroner
HM Coroner for the district of Manchester North
Newgate House
Rochdale OL16 1AT

Ref: [redacted]

25 September 2024

Dear Ms Kearsley

Royal College of Physicians response to Regulation 28 report to prevent future deaths

The Royal College of Physicians (RCP) notes with concern the content of the Regulation 28 report for the prevention of future deaths related to the death of Susan Pollitt.

We send our sincere condolences to the family of Susan Pollitt.

The Regulation 28 report is addressed to the president of the Faculty of Physician Associates (FPA). The FPA is a managed faculty of the RCP. Considerable work is required to enhance the safety of the deployment of physician associates (PAs) as part of multidisciplinary teams. We therefore believe it is helpful that the RCP also submit a response to this report.

Many of our fellows and members have significant concerns about the safe deployment of PAs, especially concerning regulation, scope of practice and supervision. The RCP held an extraordinary general meeting (EGM) to debate issues relating to PAs in March 2024.

Following a vote of the RCP fellowship, the RCP is now calling for a limit in the pace and scale of the roll-out of PAs. We have called on NHS England to review its projections for growth for the PA role as set out in the 2023 NHSE Long Term Workforce Plan.

The RCP also established a short life working group (SLWG) to make recommendations to RCP Council for how the EGM motions would be implemented. This group reported in May 2024. All recommendations are on track to be delivered by the end of the year. The RCP has now set up an oversight group for activity related to PAs (PA oversight group, or PAOG).

To ensure that the PA workforce is able to contribute to patient care actively and safely, the RCP believes that considerable changes need to be made. This will require time, commitment, coordination, transparency, and above all, collaboration between the NHS, patient groups, royal colleges, the GMC, and medical associate professionals, including PAs.

Matters of concern and the RCP response

1. **There is no regulatory body with oversight of physician associates. It is understood that this is currently the subject of a consultation by the General Medical Council.**

In the interests of patient safety, the RCP has campaigned for over 5 years for the regulation of PAs. It has been a long and unpredictable journey that will finally see the majority of regulatory provisions come into force in December 2024.

[redacted], who is acting as RCP president, and [redacted], chair of the PAOG, continue to meet regularly with the GMC. We have written to NHS England to ask whether they intend to review the projections for growth in the PA workforce. Both the GMC and NHS England will attend an RCP Council meeting in November 2024 to discuss the post-regulation landscape for PAs.

We responded to the GMC consultation on the regulation of PAs earlier this year, raising concerns around the content of the curricula for PA and anaesthesia associate (AA) postgraduate studies, issues around prescribing and medicines safety, the capacity of supervisors, and the impact of the PA role on training opportunities for resident doctors.

We understand that the GMC believes that further development of scope of practice should be determined locally. **The RCP disagrees.** Scope of practice for PAs (and the obligations of supervisors to maintain within scope of practice working) should be determined nationally to reduce variation and enhance patient safety.

This is key, and a widespread concern within the medical profession. It must be addressed to enable the PA workforce to work safely and successfully.

2. **The Physicians Associate Managed Voluntary Register (PAMVR) held by the Faculty of Physician Associates (FPA) is voluntary. While employers are encouraged to check the register, there is no duty to do so, nor is it clear how the FPA would be made aware of any concerns relating to an individual physician associate.**

The response of the FPA is noted.

The RCP has confirmed that the FPA will close in December, along with the PAMVR. The initial transfer of PAMVR data from the RCP to the GMC will begin on 31 October 2024. The GMC register will open on 13 December 2024, when regulation begins, but will continue to be voluntary for the first two years. The PAMVR will remain static, but searchable, until 31 March 2025 when it will be closed.

The post-EGM SLWG noted that the RCP is not, and has never been, a regulatory body. Holding the PAMVR has contributed to patient safety while the campaign for regulation was ongoing. The GMC starts regulation in December 2024 and there will be a transition period of two years while PAs join the register. From December 2026, it will become an offence to practise as a PA in the UK without being registered with the GMC.

The FPA has written to all its members to update them with this information and to clarify that all PAs should move onto the GMC register as soon as possible.

3. **There is no national framework as to how physician associates should be trained, supervised and deemed competent. This is placing patients, physician associates and their employers at risk. The court heard that since the death of Mrs Pollitt, the Northern Care Alliance has put in place a local trust framework. Unlike all other clinical roles, there is no national guidance save for very recent guidance issued by the British Medical Association (March 2024).**

The RCP agrees with this concern.

The RCP is developing draft guidance on safe and effective practice for employing PAs. The college recently carried out an external stakeholder consultation on the first draft of this guidance. Work is now taking place to review the consultation feedback, refresh the draft guidance, consider how fellows and members should be consulted, and take the final guidance to RCP Council for sign-off and publication by the end of 2024.

The draft guidance is clear that only consultants, GPs, specialist or associate specialist doctors should be the named clinical supervisors of PAs. PAs should always clearly explain their role to patients, colleagues and supervisors; and they should progress within a scope of practice, following a nationally defined pathway with training and competency assessments agreed beforehand.

Failings in scope of practice and supervision were important factors in the death of Susan Pollitt. The RCP is very concerned that capacity among senior doctor supervisors is extremely stretched and the effective implementation of guidance on supervision will be very difficult. The supervision of PAs must not be at the expense of the supervision of doctors.

The PAOG is also hosting an online roundtable with other royal colleges, faculties and specialist societies to discuss next steps on developing a clinical scope of practice for PAs. This will have a specific focus on medical teams and the physicianly specialties.

A comprehensive, national, safe and clear scope of clinical practice for PAs is essential. However, we note the following:

> There is insufficient central coordination or agreement within the NHS and among employers on how a national scope of practice should be developed and by whom.
> There is limited awareness of what a PA can safely do in a clinical setting upon completion of PA studies and no agreed mechanism for extended clinical practice.
> PAs are employed in a very wide range of clinical settings and specialties, and within both the NHS and private healthcare settings.

System leaders, including the GMC, should take a leading role in developing and overseeing a national scope of practice for PAs. The RCP is strongly supportive of multidisciplinary working, but this must be supported by full regulation and competency assessment. We therefore strongly believe that a national framework for the employment and deployment of PAs is now required, with the understanding that national policy and guidance must be understood and delivered locally supported by good governance structures, including raising concerns.

4. **There remains limited understanding and awareness of the role of a physician associate among medical colleagues, patients and their families. The lack of a distinct uniform and the title 'physician' gives rise to confusion as to whether the practitioner is a doctor.**

The RCP recognises this concern. We acknowledge that there remains limited understanding of the role of PAs. This is supported by research from patient organisations, including HealthWatch England, which has found that only around half of patients (52%) in one survey agreed or strongly agreed that they 'understood the difference between a physician associate and a doctor'.

In October 2023, the FPA published titles and introduction guidance which makes it clear that PAs are not doctors, and that PAs should introduce themselves clearly and with a full explanation about their role in the healthcare team. The RCP was supportive of this guidance, which was disseminated widely to stakeholders.

Working with our fellows and members, the RCP will continue to actively campaign to limit the pace and scale of roll-out of PAs in the NHS until we are reassured that there are safe systems in place for PA deployment. We have repeatedly made clear that PAs are not doctors, and they cannot and must not replace doctors. We have also called on the UK government and the NHS to develop and publish an evidence base and evaluation framework around the introduction of PAs. This should be a priority, and we are working with the RCP Patient Safety Committee to consider what more we can do to support this agenda.

5. **In June 2022 the Physician Associate had been signed off as competent for the insertion of ascitic drains. This sign off was completed by a liver nurse specialist using a competency form which was provided by the FPA. Whilst the competency form assessed the technical aspect of placing the drain, it did not include competency around the wider aspects of care such as taking consent risk factors and after care.**

The RCP agrees with this concern.

To be able to perform a procedure safely, the healthcare professional should be able to demonstrate the required knowledge and skills around the procedure ('technical skills') and non-technical skills. Non-technical skills are a combination of *cognitive and social skills, demonstrated by individuals and teams to reduce risk, error, harm and improve human performance in complex systems*. Those skills involve decision making, situational awareness, teamworking, leadership, perception of risk, escalation and communication including consent. The perception, comprehension and projection of technical and non-technical skills is key to patient safety at individual and team level of the healthcare team.

The competency of any healthcare professional to undertake a procedure should be signed off by a competent supervisor who is able to make assessments of these skills.

The competency form did not adequately take into account wider aspects of care, and there is currently no national framework for post-qualification competencies for PAs (including procedures).

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This is why the RCP will continue to campaign for a limit to the pace and scale of roll-out of PAs in the NHS until we are reassured that there are safe systems in place for PA deployment.

With best wishes,

[redacted]
Clinical vice president
Royal College of Physicians