

Professor Elizabeth Hughes & Mr Ian Eardley
Co-chairs NHSE MAPs Oversight Board

1st February 2024

Dear Liz & Ian,

Re: MAPs career framework consultation

The BMA (British Medical Association) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. The Association welcomes the opportunity to respond to the consultation on the draft MAPs Career Development Framework.

We have always supported multi-disciplinary team working and we recognise the crucial role that different staff perform in the NHS. However, across the medical profession concerns have been raised that MAPs roles blur the distinction between doctors and non-medically qualified professionals. In our recent survey of nearly 19,000 doctors, 86% of respondents said that the public has no understanding of the difference between MAPs and doctors. Consequently, we are now calling for a range of measures to prevent this blurring and to prevent confusions for patients and clinicians.

The “Implementing MAPs in the Workplace” section of the draft framework highlights the importance of attaining clinician buy-in for new workforce configurations, and we therefore call upon NHS England to recognise the voice of the doctors who responded to our survey, 85% of whom either disapproved or strongly disapproved of the Long-Term Workforce Plan’s proposed expansion of the PA and AA workforce.

We have reiterated our view that the GMC should not be the regulator for PAs and AAs and we have called for PAs and AAs to revert to being ‘assistants’ rather than ‘associates’. We have also called for an immediate pause on PA and AA recruitment until such a point that their scope of practice is clarified, robust guidance on supervision of these roles has been provided, and they are subject to suitable regulation.

It is wholly inappropriate for MAPs to be making steps in career progression while these matters are unresolved, and we are therefore also calling for a pause in the implementation of the framework.

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However, we recognise that some form of career framework will be needed in future, and we have therefore provided detailed comments to guide the amendments needed to the draft framework which will need to be revisited once the question of scope of practice has been fully clarified and agreed with the profession.

In our response to the 2021 Core Capabilities Framework (CCF) consultation we stated the importance of not having 'Consultant MAP' as the title for the top tier. Not only was this our view, but it was a view strongly expressed by the majority of the HEE MAPs Oversight Board including the representatives of the MAPs professions. We were pleased to be able to contribute to the Board's subsequent work to choose an alternative and we remain satisfied with 'Principal' the title of the top tier.

Page 4 of the current consultation states that the framework 'is not designed to be prescriptive', but we feel strongly that it should be prescriptive about nomenclature. While 'consultant' is not a protected term and is used for some other senior roles in the NHS, using it to describe a practitioner who works to the medical model but is not a doctor and remains a dependent practitioner would be a bold and potentially harmful mistake. We have recent and tragic evidence of the potential impact on patients when there is confusion about who is providing treatment. The term 'consultant' is strongly associated with the highest level of medical practice, so it is essential that any MAP who reaches Tier 4 on the framework is referred to only as 'Principal' and never 'Consultant'. The career framework must make this clear.

We do not think that 'senior' and 'lead' for Tiers 3 and 4 are appropriate as titles as these appear insufficiently distinct from 'Principal' at Tier 4. The titles used for the Tiers should clearly indicate relative seniority, again with the imperative in mind that confusion is not caused for patients or other members of the multi-disciplinary team (MDT). 'Senior' clearly overstates the experience of a Tier 2 clinician by comparison with a doctor who must remain 'junior' for many years before being considered 'senior'. One suitable alternative would be for the tiers to be numbered rather than be named.

In the tier descriptions, the language used for understanding scope of practice and boundaries of knowledge must be strengthened. In our recent survey of doctors, 82% of respondents stated that PAs/AAs they worked with had undertaken work beyond their competence at least once, with 43% reporting it occurred frequently and we have received many individual reports of MAPs acting outside of their scope of practice, either due to a lack of understanding of their scope of practice, because they have disregarded it, or simply because it remains very poorly defined. Overall, as currently written, the tiers describe clinicians with a level of training far beyond the two-year postgraduate courses that MAPs complete.

Tier 1 states an "awareness of the boundaries" of their knowledge, Tier 2 states that they "recognise boundaries of their practice" and at Tier 3 they "recognise the boundaries of and demonstrate expertise in their scope of practice". All of these are untrue, as one of the concerns raised by doctors is that MAPs do not have current scope boundaries. This document should be amended to note that all MAPs tiers should include the words "have full knowledge and understanding of the limits of their scope of practice and recognise their supervision by a qualified, CCT-holding, medical professional".

Even the most experienced MAPs must retain a focus on *assisting* doctors; allowing our most highly qualified clinicians to focus on providing the care that most needs their focus. Therefore, it is crucial that the top tiers of the framework clearly outline a level of practice that reflects that

they have not been trained to the level of a medical professional. Currently Tier 4 makes no mention of “boundaries” or “scope of practice” and includes reference to leadership responsibilities for MAPs that extend into areas that are the natural territory of doctors, such as “highly specialised knowledge” and “lead(ing) change strategically across whole systems”. This section must be amended to reflect the fact that MAPs remain dependent practitioners throughout their career, with a named, qualified, CCT-holding, medical professional.

Where Tier 3 states that they manage care at the “highest” level, this should be replaced with something that reflects the fact that MAPs are not medically qualified, do not hold a CCT, and therefore never manage care at the highest level. We suggest stating that tier 3 practitioners have years of experience in providing quality care under the direct supervision of doctors. The key is to emphasise the years of experience they may accrue in the role, not to identify MAPs with a skill-set and knowledge they do not possess. Language that inflates the role of MAPs will increase the likelihood that they will work beyond their competence and is undoubtedly a factor in the many cases we have seen of MAPs claiming to be doctors or failing to identify themselves as MAPs.

The appendix below includes more detailed analysis and suggestions for each section of the draft framework.

We urge NHS England to listen to the clear and overwhelming message from the medical profession that the direction of travel on MAPs must change urgently. Pressing on with implementation of this framework while so many concerns remain will be detrimental to patients and clinicians.

Yours sincerely,



Daniel McAlonan
Head of Professional Policy and Activities
British Medical Association

Appendix

Q1:

- There is no information in the first paragraph about the qualifications MAPs have, their level of training, or the fact that they are dependent practitioners that must have oversight by doctors. This omission does not provide patients with clarity of the role and risks confusing them. Patients need to know, and have the right to know, who they are being treated by and the level of training and qualifications they have. This section must be amended to add these details in.

- In the third paragraph, the sentence *'this framework identifies and describes the skills and knowledge which MAPs need to apply to deliver safe, high quality, compassionate, personalised care'* is misleading. There is no defined scope of practice for MAPs and this is of grave concern to many in the profession who have raised patient safety concerns about how this role is implemented currently in the NHS. Scope limits need to be decided before any career development can be safely set. We recommend pausing this career development work until scope limits can be set by the medical profession.

- The PA courses are currently unaccredited and there is no standardisation in the quality of the teaching provided. To imply that there is a reference standard for the skills and capabilities of MAPs is misleading. There is likely a varying standard of graduates exiting and entering the courses and without defined scopes of practice there is no way of ensuring that MAPs are meeting any nationally defined standards. References to MAPs delivering 'high quality healthcare' should be removed.

Q2:

- *Patients, carers, and the public:* The framework does not help patients to understand who is treating them, as it fails to define the training and qualifications of MAPs and how they are dependent practitioners that must always be supervised by doctors. This needs to be clarified and amended to avoid patients overestimating MAPs abilities and not raising concerns or seeking other help if problems persist after an interaction with a MAP.

- *Service commissioners:* it is inappropriate for the employer to be developing a role when a statutory regulator is not in place and there is no nationally defined scope of practice for MAPs. There are significant concerns from the medical profession that many MAPs are currently working beyond their competence, and this is a risk for patient safety. Scope definition must proceed before MAPs roles are developed further and the definition must be set by the medical profession as they provide the supervision and will know what is appropriate for MAPs to do and what is unsafe.

- *Employers:* this framework fails to show how MAPs will be demonstrating that they possess these key capabilities at the time of employment nor that standards will be maintained over time. Unless this can be demonstrated, there is a risk that patient safety standards will not be maintained.

- *"This Framework does not replace regulatory requirements or existing standards, including those for education and training (for example those set by Regulators and/or Medical Royal Colleges)."* The lack of such existing standards and regulatory requirements shows that it is premature to be creating a career progression framework when the MAP role and its limits have yet to be decided. Failure to set regulatory standards and scope definition will set up supervising doctors and employers to fail in their obligation to adequately protect patients.

- *Supervisors*: this framework is insufficient to give supervisors the ability to judge the standards of care that a MAP is providing and therefore this section is misleading. The tier definitions need to be drastically amended to meet the capability of someone with a two-year course and should reflect that of a dependent practitioner who requires supervision and oversight.

- *Current and future MAPs*: this framework does not set out clear expectations to keep patients safe. This statement should reflect the unregulated status of MAPs and the fact that they have no defined scope limits.

Q3:

- *“It is also for employers with their employees to agree a scope of practice and a job plan”*. It is entirely inappropriate for an employer to define a scope of practice. This will lead to MAPs being asked to perform tasks way beyond their competence/capabilities, as is currently already happening. This is linked with harm to patients and this phrase must be removed from this document entirely.

- For dependent practitioners, this scope of practice must be set by the medical profession who will supervise and oversee MAPs. This phrase must be added to the document.

- *“MAPs must practice in accordance with the requirements, including supervisory requirements and defined scope of practice, as set by their respective regulator”* directly contradicts the statement that the employer can set the scope and is also in contradiction with what the GMC has said will occur (they will not set the scope but expect the medical profession via the Royal Colleges to do so).

- Stating that the *“safety and wellbeing of patients must be paramount”* is not enough when there are grave concerns from the medical profession and the public alike about the MAPs roles. If patient safety is to be prioritised, then strict scope limits in line with the level of education that MAPs have must be imposed and this document changed to reflect that.

Q4:

- *Tier 1*, requires “a comprehensive, factual, and theoretical knowledge”, something that cannot be adequately covered in the 2-year training time MAPs receive. For comparison, doctors receive 4-6 years of medical school training, with additional postgraduate training upon graduation. This phrase should either be removed from the career framework document or, if this is not possible as it is key to that tier, then consideration of revising all of the tiers downwards to reflect the limitations of a two-year course is strongly recommended.

- *Tier 2* MAPs are suggested to be able to ‘devise and evaluate complex care plans in partnership with the team’. MAPs should not be seeing complex patients, as they do not have the relevant breadth and depth of knowledge needed to do so.

- *Tier 3* MAPs under the framework will be able to manage patient care from admission through to discharge. This would open the door to patients going through a whole admission process with no input from a doctor and is completely inappropriate. There have already been cases of patient harm in the media where this has occurred. This will likely be detrimental to patient outcomes and reference to this removed from the document.

- *Tier 3* MAPs will also be “regularly undertaking activities to support the capability

development of others". Dependent practitioners who rely on doctor supervision to practice should not be facilitating the development of others. In particular, they should not provide teaching to any doctor or medical student.

- *Tier 4* is particularly concerning as it explicitly states that people in this tier may work without a supervising doctor on site. MAPs should always be able to access a CCT-holding supervisor, and the wording of this tier needs to make it clear that MAPs do not work independently.

- *Tier 4* - the description of tier 4 is very like a medical consultant job description. However, a medical consultant will have a minimum of 10 years formal training and qualifications, compared to a two-year postgraduate course for MAPs. MAPs training and knowledge is insufficient to be working at a senior level with offsite supervision and there is potential for patient harm.

- *Tier 4* also indicates that MAPs in the tier will be leaders with considerable management responsibilities. MAPs must not be able to supervise doctors or other healthcare professionals, this must always be the role of a senior doctor.

Q5:

- *Impact on doctors in training* - "An implementation plan should also demonstrate...the impact of implementing such a role would have on the wider team". The impact of the training on doctors has not been sufficiently explored. MAPs are already being prioritised for training opportunities over doctors. Doctors have provided us with numerous examples of their training being deprioritised in favour of MAPs. MAPs, as dependent practitioners, rely on doctors in training progressing to supervisory roles in the future and, as such, clinical and training opportunities must be safe-guarded and prioritised for doctors.

- *Employer input in deciding framework level for roles* - Any decisions on scope for each role should be decided by the medical profession, including supervising doctor(s), alone, and not by the employer. This framework does not set out how supervising doctors would do this and as noted several times in this consultation response, there are concerns that MAPs have insufficient knowledge and qualifications to safely operate on any of the proposed tiers but particularly tiers 2-4.

Q6: Are the appendices a useful set of workforce development tools?

Appendix 1 - Implementation Checklist

Needs analysis - the needs analysis does not include guidance for employers to consider the employment of doctors (either doctors in training or locally employed doctors) instead of MAPs in order to meet the demands of the department, nor does it mention the impact of recruitment of MAPs on doctors and medical students whose training and supervision may be impacted on by the presence of MAPs in their department taking up time and opportunities from consultants. If a doctor's training is disrupted this risks ultimately producing less competent consultants and therefore reducing the overall quality of the medical profession, affecting patient care. It must be compulsory for employers to first justify why they are not hiring doctors in this role.

Communication - Formal consultation with staff representatives should not just be "considered", it should be mandatory. Again, this section does not mention getting input from doctors, which is essential as they will be supervising any MAPs and should have a say about their suitability to join the team.

Safety and effectiveness - the complexity and increasing demand of patients in the NHS today must be forefront at the mind of any employer considering hiring to a team. An individual with only a

two-year qualification is not equipped to deal with complex presentations. They will ultimately require oversight from doctors, which is inefficient and expensive. Hiring a doctor would make more economical sense in most respects and be safer for patients and employers must justify to staff in the department or practice concerned why they are not hiring doctors.

Clinical supervision - The framework gives no clear guidance on supervision and would allow for broad variation in scope between employers. The guidance does not even specify which grade of doctors should be supervising MAPs, in fact it doesn't even specify that it must be a doctor at all. MAPs must always be supervised by a consultant or GP who explicitly consent in writing to being a supervisor, and they must always be on site when supervising in order to maintain appropriate levels of patient safety.

It is essential that the section about 'how much supervision should MAPs have' is amended to reflect the fact that MAPs are dependent practitioners with only a two-year course. They should always work under close and direct supervision. It is entirely inappropriate to scale this down for years of experience and they should never work with off-site supervision. They must always be supervised by senior doctors (Consultants or GPs) who consent in writing to doing so and are appropriately indemnified. Supervision by any other health professional group or by MAPs themselves is not acceptable.

Education, training, & development - Group supervision is completely inappropriate for a dependent practitioner with only a two year qualification and this option must be removed from the checklist.

Multisource feedback: The question examples provided only talk about the MAPs demeanour and lack details about who should complete it. It is also essential that clinical supervisors review every MSF completed and act on any concerns raised. Minimum numbers be specified (we suggest one per year at a minimum)

Given significant safety concerns about MAPs working outside of their competence as assistants, it is essential that MSF comment on how the MAP performs any clinical duties that they might have, are they performing to the level expected (depending on how many years' experience they may have), are there areas they are particularly good at? Are there areas of concern? What are their communication skills like? Do they work well as a team? This needs to be expanded. There also must be a criterion that MSF be sought from doctors that they work with who are in a key position to comment on any clinical acumen and team-working aspects.