

Professional Regulation

At the last meeting of SCST Council the letter from Professor Hill, DH Chief Scientific Officer and Nick Clarke, Head of Health and Social Care Regulation was discussed. There was agreement that the present situation is unsatisfactory. After so many years without achievement of professional regulation of the cardiac physiology workforce it was felt that every effort must be made that may encourage the most urgent progress in the complex process towards regulation. SCST will work with other professional groups involved in present application process but input from members and other individuals was considered to be an appropriate means of maintaining momentum.

At the Annual General Meeting of the Society the following day, Professor Wilcox, SCST President, instilled an even greater sense of urgency in the matter through discussion and suggestions about the way forward. It was agreed that correspondence to Members of Parliament or other influential sources was one mechanism that may be of value. Rather than a single letter or petition signed by those in favour it was agreed that outline pointers that may be used in written correspondence would be published in the next (this) issue of SCST UPDATE. It was further agreed that SCST will explore recruitment of professional expertise to assist progress in the matter.

The following is not intended as a script. There are statements of fact that may be supplemented by local or national references. There also are a number of questions that may be included to encourage more complete and perhaps individual rather than standard response. These are not meant as a definitive set of questions. You may have additional queries to be answered. There has been suggestion that invitation to local MPs to visit Cardiac Physiology departments will provide additional first-hand discussion and direct view of the risks related to delivery of healthcare in cardiology.

Do not underestimate the difficulties now faced in achieving this long sought goal. There appears to be significant barrier to progress that will bring about regulation of this section of healthcare science workforce. Your involvement may be vital.

Suggestions for inclusion in correspondence

The potential for cardiac physiologist staff to harm patients is significant. Give (local) examples. May include need for accuracy of results, reports used directly to treat patients, direct actions that may cause harm to patients EG inappropriate implantable device program, failure to observe contra-indications to stress testing in physiologist led procedures.

There have been actual instances where patients have been adversely affected by the actions of cardiac physiologist. EG widely reported need for re-attendance of patients consequent to questionable echocardiograph reports.

Attempts to safeguard patients through professional registration have been ongoing for cardiac physiologist staff since the mid 1960's. Early attempts to secure professional registration met with resistance due to misinterpretation of the role: this was not a patient group that had 'hands-on' contact with patients. Initial meetings were held between senior members of the Council for Professions Supplementary to Medicine and SCST. More recently, the formation of RCCP has led a joint 'multi-disciplinary approach through the Department of Health to the Health Professions Council.

Cardiac Physiologist staff work single handed with vulnerable patient groups EG children, those with learning difficulties, older people.

Recent correspondence (enclose a copy of the published letter) from DH suggest there will be no solution before 2009. What guarantee is there that these risks will be controlled by statutory regulation at that time?

In England there is pressure on service delivery to achieve maximum 18 week wait and encouragement to utilise private sector providers to secure diagnostic and therapy services. Similar pressure exists in Wales although the target is currently 24 weeks.

There is significant evidence that demonstrates workforce shortfall for cardiology procedures. NHS Workforce Development Team report 2006. British Heart Foundation sponsored review of cardiac physiology workforce undertaken on behalf of DH by consultancy company Tangerine Bee. Acknowledgement by the Welsh Assembly Government which has funded more Welsh student CP training places and a new fast track undergraduate degree scheme.

Recruitment to trusts and private sector is increasingly dependent on sources where parity of training, assessment and qualification cannot be guaranteed equivalent to that in the UK. Income generation and achievement of targets may affect recruitment priorities at the detriment of patient safety.

Why must we wait at least another two years before enforceable regulation is in place? The timescale of individual elements of work outlined in the DH letter amounts to nine months.

Who will be responsible should a serious life-threatening or fatal incident to patients occur that involves cardiac physiologist?

Removing incompetent individuals from one healthcare organisation does not prevent reappearance in another. What can be established before at least 2009 to ensure appropriate control/regulation that secures as far as possible a 'safe-to-patients' workforce?

There has already been significant role development in the cardiac physiologist workforce. Achievement of waiting times is encouraging even more diverse development but this will be hindered without professional regulation. EG although professional regulation does not automatically gain inclusion with those listed in administration of medicines Patient Group Directions, it is not currently possible without. EG unable to appropriately provide GTN. Restricted ability for role development in procedures such as contrast echocardiography.