Royal College of Physicians

11 St Andrews Place,
Regent's Park, London NW1 4LE

T +44 (0)20 3075 1649
www.rcp.ac.uk
policy@rcp.ac.uk

RCP

Leng.Review@dhsc.gov.uk

RCP response to the independent review of physician associate and anaesthesia associate professions

March 2025

The Royal College of Physicians (RCP) believes that the debate about physician associates (PAs) is a debate about patient safety. Patients must be treated by regulated healthcare professionals working to a clear scope of practice and national clinical and professional standards.

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[1] Following the extraordinary general meeting (EGM) held by the RCP on 13 March 2024 to discuss the role and regulation of PAs, the RCP published the data from its pre-EGM member survey on 18 March 2024. The pre-EGM member survey was run by an independent external provider, Civica Electoral Services. It was sent to all subscribing RCP members (n=12,053) who were practising NHS doctors in all four UK nations. Fellows were not included as they were able to vote in the EGM ballot. It was open for two weeks. We received 2,141 survey responses. This was a 17.8% response rate.

Key recommendations

The independent review of PA and anaesthesia associate (AA) professions (the Leng review) should recommend to the UK government and NHS England (NHSE) that they must:

1. develop and enforce a nationally agreed scope and ceiling of practice for PAs
2. ensure that PAs are supervised only by fully qualified consultant or autonomously practising specialist, associate specialist and specialty (SAS) doctors, and not by resident doctors
3. ensure PAs clearly introduce and explain their role in all clinical settings (and the named supervisor responsible for governance so patients know who is responsible for decision making)
4. ensure that the role and supervision of PAs does not have a negative impact on education and training opportunities for resident doctors. The educational supervision of resident doctors, especially those in training programmes, should be prioritised, particularly where capacity is limited.

We have also called on the UK government to work with NHSE to review the projections for growth in the PA role in the NHS Long Term Workforce Plan. The devolved nations should also clarify the position of PAs in their long term workforce planning. The lack of a national strategy for the introduction and implementation of the role of PAs has led to inconsistency of governance, scope, supervision and educational standards across NHS trusts and health boards and has contributed to a wider sense of dissatisfaction in the medical workforce, with many resident doctors left feeling undervalued.

PAs and resident doctors have been let down by a lack of coherent joined up oversight from national bodies over the past decade. The past year has had a serious impact on many people, many of whom are living with uncertainty about their future, and for some, a challenging, and at times, toxic social media environment has caused significant distress.

The RCP is supportive of the aims of the Leng review. Evaluating the safety and effectiveness of the PA role through gathering data and evidence is essential if the NHS intends to make the case for further development and investment in the medical associate professions.

Unlike other healthcare systems, the UK medical education system not only trains staff for individual hospitals but also for wider future workforce development. Anything that hinders resident doctor development could significantly impact the sustainable future of the NHS. New initiatives (such as the introduction of PAs to the workforce) should always consider effectiveness, patient safety and quality of care, as well as the impact on resident doctor training, development, and retention. The concept of stewardship, as highlighted by the World Health Organisation, involves building a future-ready health workforce through long-term investment in training programmes. Short-term solutions risk undermining this, with significant consequences for NHS care delivery and costs.

What is a PA?

A PA working in the medical specialties carries out basic clinical and administrative tasks at the direction, and under the supervision, of a senior doctor (a consultant or autonomously practising SAS doctor). In this way, they are health professionals who work as part of the multidisciplinary team (MDT) and can contribute to safe and effective care for patients. There is a role for PAs in secondary medical care, but only when supported by a national scope of practice and clear, enforceable standards of safety and supervision.

PAs are not doctors. They should not be regarded as replacements for doctors, and they should never replace a doctor on a rota. As part of their education and training, PAs gain a focused understanding of the diagnosis and initial management of common medical conditions. This permits their incorporation into the medical team and supervised provision of continuity of care.

PAs are not trained to undertake definitive, independent diagnosis and management of patients in secondary care settings or to provide a general or specialist medical opinion. Their training and competency is not interchangeable with that of resident doctors. PAs are trained to recognise – but not manage – complexity, risk and uncertainty. They will therefore always remain a dependent practitioner. Overall clinical responsibility for patient care will always remain with the supervising senior doctor.

Patient safety

Patient safety must be the central guiding priority when integrating PAs and AAs into healthcare teams. The RCP has published interim guidance on the scope, supervision and employment of PAs working in the medical specialties (also known as the physician specialties).

- PAs must support – not replace – doctors, have a nationally defined ceiling of practice, and have a clearly defined role in the MDT.
- PAs are not trained to make independent diagnostic or management decisions in secondary care. PAs must never function as a senior decision maker, nor should they decide whether a patient is admitted or discharged from hospital. PAs are not autonomous practitioners.
- Resident doctors are not, and must not be expected or asked to be, responsible for the supervision of PAs. PAs should only be supervised by consultant or autonomously practising SAS doctors.
- PAs cannot prescribe medications regardless of any prior healthcare background while working as a PA.
- PAs must clearly explain their role to patients, their families and carers, as well as colleagues and supervisors, and provide details of their educational and clinical supervision when required.

Scope of practice

The NHS needs to develop a clearly defined national scope and ceiling of practice for PAs. The PA role must complement rather than replace the role of a doctor.

- PAs should not undertake independent assessments of deteriorating patients, prescribe medication, request ionising radiation, or function as autonomous clinicians.
- PAs may assist in routine clinical tasks such as venepuncture, catheterisation, and history-taking, but must not lead ward rounds, formulate discharge plans, or act as senior medical decision-makers.
- In acute and outpatient settings, PAs should not assess new patients independently or determine admission/discharge plans.
- PAs should be trained to work in the areas of greatest need, including general internal medicine.
- PAs should be appraised following a standard national approach set out by the NHS. The same principle applies to performance management and support for PAs who are struggling or underperforming.

Impact on medical training

One of the most significant concerns raised by RCP fellows and members is the impact of the role of PAs on the training and development of resident doctors. The presence of PAs in a clinical team could potentially support the delivery of medical training, but only if the scope and ceiling of practice is clearly defined. The capacity of senior doctors to train and supervise the next generation of physicians is at an all-time low, especially in acute medicine. The education of resident doctors, especially those in training programmes, should be prioritised, particularly where capacity is limited.

- PAs working in medical teams must not compromise training opportunities for doctors in postgraduate medical education. This includes procedures, leadership, teaching and decision-making opportunities.
- Resident doctors must not be responsible for supervising PAs.
- PAs must not replace resident doctors in any circumstance, including on-call rotas.
- Educational supervisors (consultants and autonomously practising SAS doctors) must have protected time for training, mentoring and supervision written into their job plan. This is an area of real concern for our membership. Many doctors struggle to secure time in their job plans to support doctors in training, and the requirement to supervise PAs could further disadvantage the quality of supervision they can provide to resident doctors.

We strongly recommend that the Leng review specifically engages with resident doctors during the evidence gathering phase of the review.

Engagement with PAs and resident doctors during RCP trust visits in 2024

During 2024, RCP senior officers visited seven hospitals to meet with consultant, resident and specialist/associate specialist doctors as part of our regional membership engagement programme.

1. Derriford Hospital, Plymouth, England
2. University Hospital of North Durham, England
3. Queen Elizabeth Hospital Birmingham, England
4. Nottingham City Hospital, England
5. Blackpool Victoria Hospital, England
6. Craigavon Area Hospital, Northern Ireland
7. Royal Glamorgan Hospital, Llantrisant, Wales

Following every visit, we summarise our findings and share these (and any recommendations) with the trust executive team and the local postgraduate medical education centre, as well as RCP regional advisers and college tutors. Below we have summarised what we heard about the role of PAs when we spoke to consultant and resident doctors and PAs during these visits.

- Where PAs are integrated effectively into MDTs, they can help to enhance continuity of care, support patient flow and free up resident doctors to access training opportunities. However, the integration of the PA role was inconsistent: in some hospitals there was widespread uncertainty about what PAs were allowed to do, with varying degrees of responsibility causing confusion.

- A recurring concern across trust visits was the lack of a nationally defined scope and ceiling of practice for PAs. This often led to ambiguity and inconsistent expectations across different hospitals and trusts. Without clear governance and supervision structures, in some hospitals, we heard that many other members of the MDT (including doctors, nurses and allied health professionals) are unclear about what PAs can and cannot do, which creates a risk to patient safety. Some senior doctors told us that they were reluctant to delegate tasks to PAs, citing liability concerns and unclear scope of practice.

- The rapid expansion of PA numbers without regulatory oversight has caused serious tensions within the NHS workforce, with some doctors telling us that patient safety and high quality medical training had not been prioritised during the rollout of the PA role.

We recommend that the Leng review recommends that a national scope and ceiling of practice for PAs be developed and implemented across the NHS, supported by clear governance structures and national guidance on supervision, education and career progression.

The RCP has repeatedly shared this message in senior level stakeholder meetings, including with NHSE and the GMC, and in our written parliamentary briefings, including a House of Lords debate in December 2024.

The Physician Associate National Examination

To apply for registration with the GMC as a PA in the UK, an applicant must have completed the Physician Associate National Examination (PANE). The PANE is delivered by the RCP Assessment Unit (on behalf of the GMC) and is open to any candidate who has completed the requirements of the Competence and Curriculum Framework for the Physician Assistant within a UK university postgraduate programme in PA Studies (either as a postgraduate diploma or a master's course) and had completion signed off by their relevant university exam board. The PANE is made up of an online 200-question, single best answer, knowledge-based assessment (KBA) and a 14-station objective structured clinical examination (OSCE). The OSCE is held at the RCP's Liverpool base, The Spine. On successful completion of the PANE a candidate can then apply for registration with the GMC.

The GMC is solely responsible for educational standards and approval of the PANE.

The RCP and PAs

In March 2024, RCP fellows called an extraordinary general meeting (EGM) to debate the role of PAs. A short life working group (SLWG) was set up following the EGM to deliver the result of the fellows' ballot, which committed to RCP to limit the pace and scale of the rollout of the PA role. The SLWG met 4 times and reported to RCP Council on 21 May with a set of recommended actions. In July 2024, an oversight group for activity related to PAs (also known as the PA oversight group, or PAOG) was formed. The PAOG met 5 times and delivered three sets of interim guidance for PAs working in the medical specialties. Thanks to all those doctors and PAs who contributed to the work of the SLWG and the PAOG.

In November 2024, NHSE and the General Medical Council (GMC) were invited to meet with RCP Council to discuss the future role and scope of practice of PAs (once they became a regulated profession). With the permission of both organisations, the relevant extract from Council minutes is included in this pack.

This evidence pack was reviewed multiple times over the course of several weeks by members of PAOG (both over email and in a meeting) before being shared with RCP Council for debate on 19 March 2025.

The Faculty of Physician Associates

The RCP hosted the Faculty of Physician Associates (FPA), a professional body for PAs, between 2015 and 2024. When PAs became a regulated profession, the FPA was closed, and the independent College of Medical Associate Professionals was established.

RCP Resident Doctor Committee response to the independent review of physician associate and anaesthesia associate professions

The Resident Doctor Committee (RDC) of the Royal College of Physicians (RCP) welcomes the opportunity to contribute to the independent review of the safety and effectiveness of physician associates (PAs) working in the NHS. We appreciate the focus on research and real-world data to inform this work: having been intensely involved in policy-making on this subject for the last 18 months, we have also sought to base our analysis and recommendations on the best available evidence. However, our experience as part of this process is that the robust evidence sought, assessing the safety and efficacy of the PA role in the UK context, simply does not exist. As such, we share concerns expressed by many within the medical profession and the wider public about the potential risks to patient safety posed by the rapid expansion of the PA workforce in the absence of this evidence base.

Our submission is further informed by the recent survey of 2,141 RCP members and fellows, of which over a thousand were working as resident doctors. 83.9% of survey respondents had worked with PAs, demonstrating the relevance of our data. This data, alongside our experience participating in the RCP PA oversight group (PAOG), and feedback from our resident doctor networks, reveals the significant impact of PAs on patient safety and resident doctor training.

Concerns regarding PA expansion

Patient safety

The short training period for PAs raises concerns about their preparedness for providing clinical care without significant oversight. Despite this, we understand many PAs are employed in roles without this degree of oversight, potentially increasing the risk of misdiagnosis, delayed diagnosis, medication errors, and inadequate management of complex or critically ill patients. The RCP RDC is clear that, by definition, a PA working in the medical specialities ‘carries out basic clinical and administrative tasks at the direction, and under the supervision, of a consultant physician / associate specialist / specialist doctor’ (RCP, 2024). Nonetheless, it is very clear from our networks that many PAs are working as *de facto* doctor substitutes, including for senior decision making. Discussions in the RCP PAOG group indicated that many PAs feel their training is adequate not just to recognise, but to manage, high levels of risk and uncertainty. We would see the latter as being not just implausible, but a material risk to the ability of some PAs to escalate concerns appropriately without a clear ceiling of practice. The lack of a clearly defined national scope of practice and ceiling of practice for PAs, as acknowledged in *Interim Guidance on Scope of Practice (General Internal Medicine) for physician associates* (RCP, 2024), is a key driver for all of these concerns and can lead to confusion among patients and healthcare professionals, again compromising patient safety.

Clarity of roles

Our survey revealed that 55.3% of physicians feel that the term 'physician associate' is not well-understood within their MDT, compared to 24.2% who believe it to be clear. This raises significant concerns that the knowledge, skills, and experience of PAs risks being confused with resident doctors. This lack of clarity, coupled with patchy national regulation, can lead to role ambiguity, hindering effective teamwork and potentially jeopardising patient safety. This lack of clarity has been highlighted by coronial reviews following preventable deaths (HM Assistant Coroner for Surrey, 2025; Senior Coroner for Manchester North, 2024).

The paucity of evidence for the PA role

The limited evidence regarding the ability of PAs to practise within the NHS is based on small-scale quality improvement projects or local service evaluations. From our perspective, these do not provide the robust evidence needed to fully evaluate the safety and effectiveness of PA roles. It is also worth noting that it is unlikely that evaluations, led by departments who have invested in PAs, showing worsening metrics would be submitted for public appraisal in abstract or manuscript form: there is a particularly high risk of publication bias. More rigorous, unbiased research without conflicts of interest is needed to establish the effectiveness and safety of PA practice beyond the scope as set in the RCP interim scope guidance for PAs working in the medical specialities.

Failure of local governance processes

We are deeply sceptical regarding the ability of NHS local governance to identify and transparently investigate risks to patient safety. We are concerned that this will hinder the ability of the review to gather appropriate evidence on outcomes such as 'never events' or other safety-relevant endpoints related to PAs.

Training disruption

A concerning 74.2% of resident doctors who responded to our survey reported that the presence of PAs negatively impacted their training opportunities, compared to 5.2% who felt their training was enhanced, with the remainder neutral or unable to comment. We understand that this disruption includes reduced access to procedures, clinics, and decreased exposure to complex cases, undermining the development of essential skills and competencies for resident doctors. We are concerned that, should PA expansion continue without limits, this will ultimately impact the skillsets of the consultant physicians (and PA supervisors) of the future.

Recommendations

To mitigate these concerns, we recommend the following:

Prioritise patient safety

All decisions regarding the integration and utilisation of PAs must prioritise patient safety above all else. Local governance processes must be externally-assessed to ensure that staff and patients are supported to raise safety concerns and, where this occurs, these concerns are rigorously investigated and relevant actions implemented (eg as part of CQC inspections).

Clearly defined scope and ceiling of practice

Establish a requirement for clear national guidelines which define the scope of practice and ceiling of practice for PAs, including specific limits on the types of procedures and interventions they can perform. For general medicine, this should be in keeping with and build upon the RCP's interim guidance (RCP, 2024). It is our belief that the practice of medicine cannot be divided into discrete tasks for competency-based assessment and therefore a ceiling of practice becomes crucial for patient safety. Practising safely beyond such a ceiling would require deep and broad knowledge of the fundamentals of medicine, taught and assessed in medical school and postgraduate training, and therefore would not be achievable even by experienced PAs.

A limited role for PAs working in the medical specialties

Resident physicians handle a high volume of administrative and basic clinical tasks, and PAs could make a valuable contribution to service delivery in these areas, enhancing patient care and freeing doctors to focus on tasks that require medical training. This support could be particularly helpful in consultant-led and supervised inpatient care and medical take work. Our work within PAOG highlighted examples of best practice where PAs have been appropriately deployed in such roles, improving team efficiency and resident doctor training opportunities. PAs are not doctors and therefore should never form part of medical rotas. Where present they should be viewed as supplementary and providers should be held to account if PAs are being used in lieu of doctors, for example counting towards safe staffing requirements.

Name of role

We believe use of the internationally-recognised term 'Physician Assistant' provides a clearer role definition that would reduce role ambiguity and enhance patient safety. This should remain clearly distinct from the legal term 'medical practitioner'. The role of the PA within the multiprofessional team, as someone trained to undertake basic clinical and administrative tasks, will also need to be the subject of a significant education campaign for patients and staff, many of whom are unclear on what the role entails and its limitations.

Enhanced supervision and oversight

Implement safer supervision requirements for PAs, ensuring adequate high-level and practical oversight by consultant or specialist doctors, as per RCP guidance (RCP, 2024). In this way, patients can be confident they are receiving quality-assured and senior-led care and PAs can be supported rather than exploited.

Improved capacity for senior supervisors

Whilst the volume of clinical work is ever-expanding, consultant-delivered educational supervision is a finite resource. If the PA workforce is to expand, **senior doctor educational capacity must increase substantially**. The 2023 UK census of consultant physicians highlighted consultant concern over unmanageable workloads, workforce gaps, and inadequate job planning (RCP, 2024). Concerningly, 39% of consultant physicians reported excessive workloads most or all of the time, with training and supervision of doctors among the top three areas deprioritised when workloads became overwhelming. Additionally, 35% of respondents felt that the time allocated in their job plans for supervision was insufficient. Existing

pressures are already compromising the quality of training for resident doctors, even before any additional supervisory demands are placed on consultants. It is important that increased supervision requirements for PAs do not detract from the provision of this critical supervision for residents.

Increased investment in resident doctor training

It is not possible to uncouple PA role expansion and challenges faced by the resident physician workforce. This review should therefore acknowledge this link and call for investment in resident doctor training programs:

1. Current **bottlenecks in medical recruitment should be addressed** and doctors should be supported to progress within physician training pathways: as this occurs, the need for PAs to be employed in roles beyond their competency will lessen, driving an improvement in patient safety.
2. Where present, **PAs should enhance training**, rather than detract from it. This should include procedural training. It is important that this is stated, as the current system of rotational training disincentivises providers from investing resource in resident doctors. It is in the interest of all parties – patients, doctors, and PAs – to ensure that a highly skilled physician workforce is developed for the future.

Conclusion

The RCP RDC is committed to supporting a collaborative, multiprofessional healthcare workforce. However, the integration of PAs must not compromise patient safety or the training and well-being of resident doctors. We urge the review to consider critically the evidence presented and make recommendations that prioritise patient safety and the development of a highly skilled physician workforce.

We would welcome further engagement with the review team and would be available to provide additional evidence or insights as needed.

Royal College of Physicians

Physician associates

Interim guidance on scope of practice (general internal medicine)

December 2024

Introduction

This document sets out a safe and appropriate scope of practice for physician associates (PAs) working in general internal medicine (GIM) at the point of qualification. This guidance applies to PAs working in the medical specialties (also known as the physician specialties).

To ensure patient safety, PAs must be supported with supervision, professional regulation, and a nationally agreed scope of practice. PAs must support – not replace – doctors, have a nationally defined ceiling of practice, and have a clearly defined role in the multidisciplinary team (MDT). They should only be supervised by consultants, specialist or associate specialist doctors.

This guidance should be reviewed in collaboration with stakeholders following the publication of the report of the independent review of physician associate and anaesthesia associate professions (the Leng review) and when the General Medical Council becomes the regulator of the medical associate professions. The examples included are not intended to be exhaustive.

1 What is a PA?

A PA carries out basic clinical and administrative tasks at the direction, and under the supervision, of a consultant physician / associate specialist / specialist doctor. In this way, they work as part of the clinical team and contribute to safe and effective care for patients. PAs are not doctors. They should not be regarded as replacements for doctors, and they should never replace a doctor on a rota.

As part of their education and training, PAs gain a focused understanding of the diagnosis and initial management of common medical conditions. This permits their incorporation into the medical team and supervised provision of continuity of care. PAs are not trained to undertake definitive, independent diagnosis and management of patients in secondary care settings or to provide a general or specialist medical opinion.

PAs are trained to recognise – but not manage – complexity, risk and uncertainty. They will therefore always remain a dependent practitioner. Overall clinical responsibility for patient care will always remain with the supervising consultant physician / associate specialist / specialist doctor.

2 Scope of practice for PAs in a ward setting

In a general medical and ward setting, PAs can assist with basic clinical and administrative tasks. This includes:

- assisting the supervising clinician (SC) during ward rounds
- completing tasks defined in this guidance, and identified by the SC to be appropriate
- relaying information about the patient's care, including investigation results, to the SC
- working in collaboration with resident doctors and the wider MDT to ensure that patient lists are well maintained and that hospital discharges are expedited effectively.

Under the direction of the SC, a PA may provide routine updates to patients and relatives regarding ongoing treatment plans that have been defined by the SC. PAs may contribute to, but not lead, all aspects of multidisciplinary care.

PAs may perform core procedures, as defined in the PA curriculum (Box 1).

Some core procedures from the PA curriculum (eg administering intravenous medication) would require additional local competency assessment and national specialty guidance, and have therefore been excluded from the interim scope of practice.

All medical procedures inherently carry some degree of risk. In addition to technical competency, undertaking medical procedures requires a thorough understanding of the clinical situation. Complex decision making may be required in real time as the procedure is being undertaken. This is particularly true of invasive interventions with therapeutic intent, with a range of possible outcomes depending on the clinical circumstances, and these procedures (eg intercostal chest drain insertion) are beyond the ceiling of practice for a PA working in GIM.

A PA must never function as a senior decision maker. They should not make independent assessments of deteriorating patients or define discharge plans, nor should they do so by proxy via resident doctors and the MDT, nor be asked or expected to do so by others. A PA should follow local governance processes and speak to their SC if they have concerns about what is being asked of them.

Box 1: PA core procedures

- Baseline observations
- Perform cardiopulmonary resuscitation to the level expected in Immediate Life Support training
- Venepuncture
- Cannulation
- Take blood cultures
- Measure capillary glucose
- Peak flow measurements
- Urinalysis
- ECG
- Urinary catheterisation
- Inhaler technique

3 Scope of practice for PAs on the acute medical take

PAs who contribute to the acute medical take require specific further supervision and support, due to the high volume, rapid turnover and undifferentiated nature of patients presenting in this setting. All PAs should be able to contribute to the post-take ward round with the SC. Furthermore, they may assist with tasks that have been generated by the clerking medical team (provided they are included within this document) and identified by the SC to be appropriate.

A PA may be able to assess a patient presenting to the hospital, but only if this is followed by prompt in-person review by the SC to define the diagnosis and management plan. A PA should not be able to decide whether a patient is admitted or discharged from hospital. Under supervision, a PA may be able to action specific tasks defined by the SC. In this way, the PA contributes to patient care, but is not an independent diagnostic opinion provider or senior medical decision maker in secondary care GIM.

4 Scope of practice for PAs in outpatient care

In a medical outpatient care setting, there is a limited role for PAs (eg sitting in with the SC to assist with administration or carry out tasks at their discretion). A PA could assess a patient as part of a follow-up appointment, but only if this is followed by in-person review by the SC. A PA should never undertake outpatient clinics independently. They must not undertake outpatient clinics alongside resident doctors or other healthcare professionals without the SC in the clinic.

Physician associates: interim guidance on scope of practice (general internal medicine) was developed by resident doctors, with input from consultant physicians. It was reviewed by the RCP oversight group for activity related to PAs (PA oversight group, or PAOG) and signed off by RCP Council in December 2024.

Published as interim guidance that should be reviewed in collaboration with stakeholders, including RCP fellows and members, following the publication of the report of the Leng review.

For more information, please contact **PAOG@rcp.ac.uk**.

Royal College of Physicians

Royal College of Physicians

Physician associates

Interim guidance on supervision and employment in the medical specialties

December 2024

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Recommendations

Supervision

1 A supervising doctor must hold full GMC registration with a licence to practise, be on the specialist register and/or under the specialist/associate specialist contract, and actively practise medicine in the UK without restrictions that prevent fulfilling supervisory roles.

2 PAs must have an educational supervisor (ES) and a supervising clinician (SC), who may be the same person. An ES must be formally trained in educational supervision and have at least 0.25 SPA time allocated in their job plan for every PA that they supervise. An SC must be a consultant physician, associate specialist or specialist doctor. They must retain clinical and professional responsibility for patients and have adequate clinical time in their job plan for supervising PAs.

3 Newly qualified PAs or those in new roles will require direct supervision (as opposed to indirect supervision). Supervision levels must be reviewed regularly to ensure that the level of supervision remains appropriate.

Working in a team with a PA

4 Resident doctors are not, and must not be expected or asked to be, responsible for the clinical supervision of PAs.

5 SCs are responsible for prescribing, making informed decisions based on PA input and requesting ionising radiation for PA-seen patients.

6 In emergency situations, PAs should escalate to the most senior available doctor.

7 PAs are accountable for their practice and must follow GMC *Good medical practice* guidance.

8 PAs must explain their role clearly to patients, colleagues and supervisors.

Employing PAs

9 Employers must provide sufficient resource and support for SCs and ESs, align PA recruitment with team and service needs, and ensure that HR teams are equipped to oversee the employment of PAs.

10 Work schedules for PAs should clearly define duties, work hours and development opportunities, include regular supervisory contact time, and ensure annual appraisals with the ES for development review.

11 PA roles must not compromise the training experience of doctors. PAs must not replace doctors in any role, including the on-call rota.

12 Employers should monitor the impact of the PA role on patient outcomes and training for doctors.

13 Employers must establish governance processes for PA roles, ensuring oversight by the medical director / chief medical officer / responsible officer, implement policies on clinical system access, role limitations and adherence to national guidance, and be aware of GMC personal indemnity requirements.

Introduction

This document sets out interim guidance for the safe and effective supervision, employment and deployment of physician associates (PAs) at the point of qualification. This guidance applies to PAs working in the medical specialties (also known as the physician specialties).

To ensure patient safety, PAs must be supported with supervision, professional regulation, and a nationally agreed scope of practice. PAs must support – not replace – doctors, have a nationally defined ceiling of practice, and have a clearly defined role in the multidisciplinary team (MDT). They should only be supervised by consultants, specialist or associate specialist doctors.

At the time of publication, healthcare professionals working as PAs face an uncertain future. This interim guidance should be reviewed in collaboration with stakeholders as scope of practice is developed across the medical specialties, and following the publication of the report of the independent review of physician associate and anaesthesia associate professions (the Leng review) that has been commissioned by the secretary of state for health and social care (or similar reviews in the devolved nations). In the meantime, this guidance should be used to support physicians and their teams.

1 What is a PA?

A PA carries out basic clinical and administrative tasks at the direction, and under the supervision, of a consultant physician / associate specialist / specialist doctor. In this way, they work as part of the clinical team and contribute to safe and effective care for patients. PAs are not doctors. They should not be regarded as replacements for doctors, and they should never replace a doctor on a rota.

As part of their education and training, PAs gain a focused understanding of the diagnosis and initial management of common medical conditions. This permits their incorporation into the medical team and supervised provision of continuity of care. PAs are not trained to undertake definitive, independent diagnosis and management of patients in secondary care settings or to provide a general or specialist medical opinion.

PAs are trained to recognise – but not manage – complexity, risk and uncertainty. They will therefore always remain a dependent practitioner. Overall clinical responsibility for patient care will always remain with the supervising consultant physician / associate specialist / specialist doctor.

2 Patient safety

Patient safety is of the utmost importance in healthcare and must be the foremost consideration during the development, deployment and supervision of PA roles. PAs are not able to prescribe medications or request ionising radiation (see sections 5.1 and 5.2).

While PAs are responsible for their own practice, they must always work under the supervision of a consultant physician / associate specialist / specialist doctor. The senior supervising doctor retains clinical and professional responsibility for patients treated under their care.

It is important that patients understand who is providing their care. PAs must clearly explain their role to patients, their families and carers, as well as colleagues and supervisors (in line with RCP interim guidance on titles and introductions for PAs working in the medical specialties), and provide details of their educational and clinical supervision when required.

3 Scope of practice

PAs should have a nationally defined ceiling of practice and a clearly defined role in the MDT. These should be defined by the specialist societies.

All PA students must graduate from their university course before they sit the physician associate registration assessment (PARA). Passing the PARA is a mandatory requirement for entry onto the General Medical Council (GMC) PA register. The exam sets the standard for PAs across the UK, and is designed, developed and administered by the Royal College of Physicians (RCP) Assessment Unit.

Two key documents published by the GMC outline the educational and assessment requirements for PAs:

- Physician associate and anaesthesia associate generic and shared learning outcomes
- Physician associate registration assessment (PARA) content map

4 Supervision

To support doctors, the GMC has published advice for doctors who supervise PAs. These principles are mapped to *Good medical practice*.

Supervision must be time, situation and individual specific. Throughout this section we use the term 'supervising doctor', the requirements for which are set out below. There are two types of supervising doctor, the educational supervisor (ES) and the supervising clinician (SC). An ES requires on average 1 hour per week (0.25 SPA) in their job plan to supervise a PA.

4.1 Educational supervisor (ES)

Each individual PA must have an ES. The role of the ES is to oversee the long-term clinical, educational and professional development of the PA, providing guidance and managing any concerns that arise. An ES is a skilled and important role, and they must have undertaken and maintained formal training on educational supervision. Good communication between the ES and the supervising clinician(s) is essential for quality of supervision.

The **educational supervisor** is responsible for:

- establishing and agreeing an individual work schedule with the PA
- ensuring that an individual PA's work schedule and development are in line with national guidance from medical royal colleges and specialist societies
- meeting the PA at least twice a year to review their portfolio. For newly graduated PAs, those moving into a new medical specialty or those changing ES, there should be an initial meeting, followed by meetings at 3 months, 6 months and 1 year
- performing an annual appraisal
- providing pastoral support.

4.2 Supervising clinician (SC)

The SC of the PA must be the consultant physician/ associate specialist / specialist doctor who retains clinical and professional responsibility for patients treated under their care. The SC can change from day to day, but there must be an SC available and contactable for real-time, in-person advice.

With correct supervision, and with robust delegation arrangements in place, PAs are responsible and accountable for their own practice. The SC will remain responsible for the overall management of the patient, any decisions around transfer of care, and the processes in place to ensure patient safety.

The SC requires adequate direct clinical care (DCC) time in their job plan to facilitate clinical supervision of PAs. The time required will vary according to the experience and competency of the individual PA and the tasks being undertaken.

4.3 Levels of supervision

The level of clinical supervision required will change based on the experience of the PA. There are two levels of clinical supervision for a qualified PA:

Direct: The PA's supervising clinician is immediately available in the same clinical environment to provide advice to the PA and, if required, an immediate in-person review of a patient.

Indirect: The PA's supervising clinician is available to provide advice to the PA and, if required, an in-person review of a patient within a reasonable timeframe.

A newly qualified PA, or a PA moving into a new or unfamiliar role, will require **direct** supervision initially. Supervision levels must be regularly reviewed to ensure that they are appropriate and proportionate.

5 Working in a team with a PA

Supervising doctors have been defined above. The following guidance is for other members of the medical team who are working with PAs. **Resident doctors are not, and must not be expected or asked to be, responsible for the clinical supervision of PAs**.

5.1 Prescribing

PAs cannot prescribe medications regardless of any prior healthcare background (eg those with non-medical prescribing qualifications from previous roles) while working as a PA.

Responsibility for prescribing for patients who have been seen by a PA lies with the SC.

Prescribers must never prescribe unquestioningly at the request of any other clinician, but should weigh up the information that they have from a range of sources to make an appropriate prescribing decision. This is outlined in the GMC's *Good practice in prescribing and managing medicines*.

5.2 Ionising radiation

PAs cannot request ionising radiation (eg CT scans or X-rays). Responsibility for requesting ionising radiation for patients who have been seen by a PA lies with the SC.

5.3 Seeking advice and guidance

In situations where a delay in seeking guidance from the SC might lead to patient deterioration and/or clinical harm, PAs must seek guidance from the most senior doctor immediately available.

In this situation, the doctor is not supervising the PA, but they should respond as they would to anyone informing them about any acutely deteriorating patient.

6 Employing a PA

Employers must ensure that MDTs have the most appropriate skill mix to provide excellent healthcare to patients.

Careful consideration of the role and remit of a PA and how they might add value to a team/organisation is required before recruitment. Other roles may be more appropriate, depending on the needs of the service.

Clinical leads overseeing service delivery and development should engage in consultation with team members prior to making decisions regarding the establishment of a PA post, and should have researched, discussed and consulted on any proposal with the appropriate stakeholders.

When defining the role that a PA might undertake in a department, the clinical lead should assess the current skill composition of the department and determine how a PA might best integrate into the team.

Time, managerial responsibility and accountability arrangements must be agreed and stated in the job plans of those doctors supervising the PA (this applies to both SCs and ESs). Job plans should allow time for clinical support and supervision, as well as developmental meetings for PAs and other members of the MDT.

Employers should consider how they will measure the impact of PAs in terms of patient-reported experience and outcomes, and monitor for any impact on training for doctors.

6.1 Work schedules

A work schedule should be developed to allow both the employer and the PA to understand what is expected of them. The work schedule should indicate hours of work, opportunities for development and required duties. It must ensure that the requirements of the post are within the general competencies and scope of practice of the PA role.

PA work schedules should allow for ongoing professional development and encourage retention, while ensuring that the role supports patient care and the needs of resident doctors, the wider MDT and students within their clinical area. Work schedules should be reviewed regularly to ensure that there is continuity of supervision and a balance between patient care, meeting the needs of the service, supporting the training requirements of doctors, and development opportunities for the PA.

6.2 Appraisal

All PAs should have an annual appraisal with the ES who has oversight of their development (see section 4).

6.3 Impact on service and training

Where there is a plan to introduce a PA role into a service, there should be a good understanding of the current training opportunities available to doctors in this service – including foundation doctors, resident doctors in internal medicine training, higher specialty resident doctors, specialist, associate specialist and specialty (SAS) doctors and locally employed doctors – and the expected impact of employing a PA on the training opportunities of resident doctors. Implementation must be done in a way that enhances and improves training for doctors in the service and must not have a negative impact. It is recommended that departmental leads work closely with educational leads to ensure oversight in this regard.

6.4 Employment governance and organisational policies

Organisations must have clear governance processes that provide oversight of the PA role. Organisational policies must define the approved role and remit for PAs, ensuring alignment with regulatory requirements and clear reporting structures. These policies must be based on national guidance developed by medical royal colleges, specialist societies and statutory bodies, and be reviewed regularly. Policies must also set out the processes for monitoring of key patient safety indicators, experience and outcome measures in relation to the work of PAs.

Senior leaders in healthcare trusts, health boards and primary care networks must engage with requirements for revalidation for PAs.

The professional accountability of PAs should be overseen by the medical director / chief medical officer / responsible officer. More information in relation to effective clinical governance supporting revalidation that is inclusive of PAs has been published by the GMC:

GMC. Effective clinical governance to support revalidation, 2024

Clinical IT systems must restrict access for PAs from requesting ionising radiation and prescribing medications.

6.5 Indemnity

Employers and PAs should be aware of GMC requirements for personal indemnity.

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Glossary

AA	Anaesthesia associate
SC	Supervising clinician
DCC	Direct clinical care
ES	Educational supervisor
GMC	General Medical Council
HR	Human resources
MDT	Multidisciplinary team
PA	Physician associate
PARA	Physician associate registration assessment
RCP	Royal College of Physicians
SAS	Specialist, associate specialist and specialty doctors
SPA	Supporting professional activity

Physician associates: Interim guidance on supervision and employment in the medical specialties was developed by a short life writing group made up of resident doctors and consultant physicians. It was reviewed by the RCP oversight group for activity related to PAs (PA oversight group, or PAOG) and signed off by RCP Council in December 2024.

Published as interim guidance that should be reviewed in collaboration with stakeholders, including RCP fellows and members, following the publication of the report of the Leng review.

For more information, please contact **PAOG@rcp.ac.uk**.

Royal College of Physicians

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Physician associates

Interim guidance on titles and introductions in the medical specialties

December 2024

Introduction

This document sets out titles and introductions guidance for physician associates (PAs) aimed at supervising clinicians, employers and organisations. This guidance applies to PAs working in the medical specialties (also known as the physician specialties).

To ensure patient safety, PAs must be supported with supervision, professional regulation, and a nationally agreed scope of practice. PAs must support – not replace – doctors, have a nationally defined ceiling of practice, and have a clearly defined role in the multidisciplinary team (MDT). They should only be supervised by consultants, specialist or associate specialist doctors.

This guidance was originally published in October 2023; this update sits alongside interim guidance on scope of practice, supervision and employment of PAs, and explains how PAs should describe their role. It aims to increase understanding among patients, employers, other healthcare professionals and the public. This guidance applies to verbal interactions, clinical notes, clinic letters, clinical websites, social media platforms where people state their role as a PA, or any other setting relating to clinical practice and/or interactions with patients.

1 What is a PA?

A PA carries out basic clinical and administrative tasks at the direction, and under the supervision, of a consultant physician / associate specialist / specialist doctor. In this way, they work as part of the clinical team and contribute to safe and effective care for patients. PAs are not doctors. They should not be regarded as replacements for doctors, and they should never replace a doctor on a rota.

As part of their education and training, PAs gain a focused understanding of the diagnosis and initial management of common medical conditions. This permits their incorporation into the medical team and supervised provision of continuity of care. PAs are not trained to undertake definitive, independent diagnosis and management of patients in secondary care settings or to provide a general or specialist medical opinion.

PAs are trained to recognise – but not manage – complexity, risk and uncertainty. They will therefore always remain a dependent practitioner. Overall clinical responsibility for patient care will always remain with the supervising consultant physician / associate specialist / specialist doctor.

2 Titles and introductions

PAs must always take all reasonable steps to inform patients and staff of their role and to avoid confusion of roles. This includes considering the potential for verbal and written role titles to be misunderstood and taking the time to explain their role in any clinical interaction.

When a PA introduces themselves to a patient or staff member, they must make it clear at the start of the interaction that they are a physician associate, as well as explain the use of the term 'PA' as a recognised abbreviation of the title.

PAs should offer patients and staff the opportunity to ask for more information about their role. They should take sufficient time to explain the role of a PA, including their training and qualifications. They should be clear that they are not a doctor, that they work under the supervision of a named senior doctor (consultant / associate specialist / specialist doctor), and that they work to RCP interim guidance on scope of practice for PAs. The time required for this to be covered in sufficient detail must be factored into patient consultation scheduling.

PAs must proactively correct patients and staff if they directly or indirectly refer to them (ie through implication) as a registered doctor, nurse or other professionally protected role title. This includes communication via verbal, written and other forms of communication.

PAs, employers and organisations should not use the following terminology when referring to PAs and the PA profession:

- resident
- trainee
- foundation
- specialist/specialty
- consultant.

Below is an example of how PAs should introduce themselves to patients:

'Hello, my name is [forename surname] and I am a physician associate working in [specialty]. Physician associates are commonly referred to as PAs. I work in a team led by a doctor, and my supervisor is [named consultant / associate specialist / specialist doctor], but I am not a doctor.'

PAs should not use prefixes that imply medical training in clinical interactions, clinical notes or letters.

PAs must always use the full title 'physician associate' when they first interact with a patient or staff member, followed by the abbreviation PA, followed by the specialty in which they work. This is to ensure that patients hear and understand their role, followed by the specialty they are working in. PAs must not use protected titles or abbreviations which may imply that they are registered with the GMC as a medical doctor, including doctor of medicine, general practitioner (GP), surgeon, physician, licentiate in medicine and surgery, bachelor of medicine, apothecary or, indeed, any other name, title or description implying that they are registered as a medical doctor with the GMC (Medical Act 1983). It is illegal for anyone to claim or imply that they are registered with the GMC as a medical doctor when they are not.

PAs must not refer to, or describe themselves as, MRCP or a member of the Royal College of Physicians. PAs who hold affiliate membership of the RCP must always describe themselves as 'a physician associate holding affiliate membership of the RCP'.

PAs must not use the prefix 'Dr' or title 'doctor' in any clinical environment or interaction with patients, even if they hold a doctorate. This is likely to be confusing and/or misleading for a patient. 'Doctor of medicine' is a legally protected title, and most people would reasonably assume that anyone introducing themselves as 'doctor' in a healthcare setting is a 'doctor of medicine'. This is also the case in non-clinical settings when providing medical care, eg if a PA is providing first aid.

PAs who hold an accredited and recognised level 8 equivalent doctorate degree and work in academia are entitled to use the prefix 'Dr' or title 'Doctor' when working in an academic context/environment. PAs using the prefix 'Dr' in an academic setting, particularly a clinical academic environment, should also use their postnominal qualification to clearly identify their qualification.

PAs should not use prefixes such as Mr/Mrs/Ms/Mx in any verbal clinical interaction with patients, written clinical notes, clinic letters, clinical websites, social media platforms where they identify themselves as a PA, or any work relating to their clinical practice interacting with patients. This is a prefix that is traditionally associated with a surgeon in UK clinical settings and could be confusing or misleading for a patient.

Below is an example of how PAs should describe themselves in writing.

Sushmita Chatterjee MSc
Physician associate in acute medicine
GMC number: A1234567
Named clinical supervisor:
Named NHS trust/health board

James Smith PGDip
Physician associate in respiratory medicine
GMC number: A2345678
Named clinical supervisor:
Named NHS trust/health board

3 Working with other professions

PAs are not medical doctors. They are trained to provide care as a PA with supervision from a senior doctor (consultant / associate specialist / specialist). They must not be compared to doctors and should not be described as working at a 'foundation', 'senior house officer' or 'registrar' level.

PAs work across a variety of healthcare settings and specialties, providing patient care and supporting the wider MDT. PAs are not in a postgraduate medical training programme and are commonly employed to work in a set specialty area. The tasks of a PA working in one specialty area may differ from those of a PA working in another, making it difficult and confusing to make any comparison to traditional professional hierarchies. It is not helpful or effective to compare PAs to doctors or any other professional group and can lead to confusion for patients and their relatives.

Physician associates: interim guidance on titles and introductions in the medical specialties was originally developed by the Faculty of Physician Associates and published in October 2023. This version of the guidance was redrafted by resident doctors and consultant physicians, reviewed by the RCP oversight group for activity related to PAs (PA oversight group, or PAOG) and signed off by RCP Council in December 2024.

Published as interim guidance that should be reviewed in collaboration with stakeholders, including RCP fellows and members, following the publication of the report of the Leng review.

For more information, please contact **PAOG@rcp.ac.uk**.

Royal College of Physicians

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Minutes

RCP Council

This is an extract from the formal minutes circulated following a hybrid meeting of RCP Council that was held on 19 November 2024.

Items 4 and 5: Briefing on the future of the physician associate (PA) role with Professor Sir Steve Powis and Dr Navina Evans (NHS England) and Mr Charlie Massey and Professor Colin Melville (General Medical Council).

The chair welcomed Professor Sir Steve Powis, Dr Navina Evans, Mr Charlie Massey and Professor Colin Melville to the meeting.

Dr Evans thanked the chair for RCP's invitation to Council to discuss the role of PAs in the NHS.

[redacted] highlighted the need for improved regulation of PAs and a more accurate definition of their role in the service. PAs were not doctors and did not have the physician's depth of training and should never be involved in decisions around a patient's diagnosis or treatment. They should be limited to the role of an assistant who could perform specific tasks with appropriate oversight – this fitted well with the current task-based method of delivering care.

Professor Powis agreed that PAs should not be taking on the duties of doctors and that any such occurrence should be reported to NHSE who would contact the relevant employer to investigate. Scope of practice was defined at the point of qualification and required practitioners to understand the limitations of their skills. Similarly, employers should not place their employees in a position where they were expected to act beyond their level of competency. He noted RCP was performing useful work on behalf of other medical colleges to define the scope of practice for PAs beyond the point of qualification. He believed such work should be undertaken in the domain of the medical professions rather than a government body. He understood the concerns of doctors in training whose own development had been impacted by the introduction of the PA role. Dr Evans observed that the practical experience of medical colleges should inform NHSE about where doctor and PA roles were best placed within the service. Both Professor Powis and Dr Evans emphasised the need to revise the organisation and delivery of medical training in the UK. This was evidenced in the growth of graduates in medicine choosing to take on locally employed doctor (LED) roles rather than specialty training.

Council members raised the problematic nature of the title 'physician associate' for patients. Patients could misinterpret the title and assume they were being treated by a doctor. Professor Powis believed that defining roles and scope of practice for both doctors and physician associates should be determined by the medical profession itself and not government. Council members noted that the definition of multi-specialty and multi-specialist roles that comprised teams within the current service should be overseen by one body, be it NHSE or the GMC. In addition, Professor Powis also

highlighted the role of the AoMRC in overseeing such roles. Strategy and policy would always remain government's responsibility.

Members observed that any decision to define the scope of practice of PAs at a local level would be harmful to the service and to patients. NHS trusts that were struggling with recruitment could be incentivised to employ more PAs to fill gaps in the workforce, and potentially in expanded roles beyond their scope of practice. This could exaggerate existing health inequalities and negatively impact patient safety. Clarity was required over whether PAs would work as 'physician assistants' under the direct supervision of consultants to avoid risk to patients.

Professor Powis stated that PAs would practise with appropriate supervision from senior colleagues and with appropriate governance in place. He noted that regulation would mean PAs had to operate within a framework describing their skills and competences in line with all medical practitioners. Employers would have a responsibility not to place PAs in a position where they had to operate outside this framework. He explained that PAs could not be identified in patient safety incidents due to the lack of system data fields that described their role. However, frequently, such incidents were caused by system and process failures rather than human error. [redacted] observed that the level of supervision provided to PAs often did not equate to that provided to resident doctors and this was unfair. Professor Powis understood this point and stated that the structure and delivery of medical training in the UK should be re-examined. Medicine was now delivered through a more consultant-led approach which had disempowered doctors in training. Change was required to ensure junior colleagues' ability to manage complex situations and associated risk. Dr Evans stated that the merger of Health Education England into NHSE had provided the organisation with more leverage to ensure the appropriate provision of education and training to resident doctors.

Mr Massey provided details of steps being undertaken by the GMC in preparing for the regulation of PAs. He reported that over three thousand responses had been received to the GMC's consultation *Regulating anaesthesia associates and physician associates: consultation on our proposed rules, standards and guidance*. An analysis report would be published prior to regulation commencing on 13 December 2024. The GMC was grateful to the RCP for its cooperation in ensuring smooth transition from its own voluntary register to the GMC's register. A memorandum of understanding had been signed by both organisations to ensure continued delivery of the PA registration assessment for a further four-year period. The RCP was also developing the draft PA curriculum and would submit a final version to GMC in December 2024.

Regarding PA scope of practice, Mr Massey stated that once regulation began for PAs the GMC would set the required standards to join the register. PAs would be required to pass a two-part assessment of their clinical knowledge and skills to join the register. The GMC would not advise on how PAs should develop their skills and competencies over time, post-registration. Employers had overall responsibility to ensure PAs had the required competencies to undertake the tasks they were to perform. The medical royal colleges alongside the AoMRC would also have a role in defining the level of clinical expertise required for PAs to develop their skills over time. The work of PAs would need to be overseen by a named senior doctor with whom they should agree appropriate limitations to their practice.

With regard to fitness to practice, any concern raised about a PA would be examined on its own merit and within its own context, and reference:

- to what extent the PA had departed from the expectations set out in the GMC's *Good medical practice.*
- working environment and local employer policies and procedures.
- whether the activity in question was in the PA's job description, and whether they had been judged by a supervisor as competent to undertake the clinical activity in question
- guidance of royal colleges and other expert bodies.

Mr Massey reiterated that PAs were not doctors and should not replace them nor should they be used to fill rota gaps. He shared concerns over the negative impact of PAs activities on resident doctors' access to training and had made representations to government on this matter.

Mr Massey believed that regulation of the PA workforce would be beneficial to patient safety. Any potential review of the PA role by the Secretary of State for Health would also help to reassure the public and address their concerns.

Discussion

[redacted] welcomed the introduction of formalised training for LEDs and recommended NHSE's endorsement of the recent RCP guidance *Educational and career support for locally employed doctors and international medical graduates*, as the GMC had done. They asked whether NHSE and the GMC would adopt the scope of practice for PAs produced by the royal medical colleges. Professor Powis confirmed that implementing a scope of practice* for PAs with the agreement of all three organisations was intended. Mr Massey stated that he had not yet seen any finalised scope of practice documents but noted GMC's intention to utilise such documents once finalised by the medical royal colleges provided that their contents did not conflict with each other. Any such conflicts would need to be addressed prior to their adoption.

[redacted] noted that motion five at the RCP extraordinary general meeting (13 March 2024) stated: *Caution in pace and scale of roll-out: The RCP should limit the pace and scale of the roll-out of PAs until medicolegal issues are addressed.* They asked whether both organisations would support a need to pause in consideration of any potential review by government. Dr Evans noted the government's intention to review the proposed actions listed in the NHS Long Term Workforce Plan and consequent to this it was difficult to assess the scale of change, and which areas of the service would be affected.

[redacted] questioned whether the GMC would consider publishing details of supervisors of PAs on the register. Mr Massey stated that whilst this was a sensible suggestion and would rest on technical considerations to implement this feature**.**

Professor Powis explained that there was no collective intention on the part of NHSE and the royal medical colleges to define scope as a set of tasks or procedures beyond the skills required for registration. [redacted] highlighted the need for greater clarity and a precise definition of scope of practice for PAs. A decision was required at a higher level than the AoMRC and GMC on what the requisite skills for a practising PA should be. They suggested setting the scope of practice should be

the responsibility of the Department of Health and Social Care. Professor Powis noted that coordination between all stakeholder organisations would be desirable. [redacted] highlighted the confusion over the term 'scope of practice' within the profession. He observed that doctors worked under an unlimited scope of practice – provided they had the required training they could transfer their skills to different areas of clinical practice. However, for PAs, a ceiling of practice should exist that was consistent across services. Defining this ceiling of practice would be helpful. They noted work by the General Dental Council on providing definitions for members of multidisciplinary teams that could usefully be translated to medicine.

Professor Powis welcomed [redacted] comments and that a conversation regarding the nature of scope of practice was useful in itself and with particular regard to the growth of multi-professionalism in the service. Mr Massey urged some caution around introducing ceilings for practice across medicine. Doctors were trusted to work within their competence and to create necessary governance arrangements. It was key that doctors should be working to the top of their licence without limitation.

[redacted] highlighted concerns that a two-tier approach to fitness to practice could develop with the introduction of the PA role, with PAs and doctors potentially being subject to assessment by different criteria. He also noted public anxiety regarding the role of PAs in light of recent patient safety incidents. He believed that clear communication regarding the differences between PA and doctor roles was necessary to restore public confidence in the medical profession. Mr Massey stated that the GMC would ensure that PAs and doctors' fitness to practice would be assessed under the same criteria for clinical competence. PAs would be subject to revalidation. Prof Melville noted that the expansion of locally employed doctors (LED) was employer led.

[redacted] urged more care to be taken when publicly discussing PAs in the NHS. There had been many negative comments in the media and on social media and these had caused personal upset and distress to PA members of the RCP.

[redacted] highlighted the lack of expansion in national training numbers (NTNs) in recent years. Failure to recruit specialist doctors had increased workload and led to burn out amongst colleagues. The increase in locally employed doctors and PAs in the service was one consequence of this issue. They questioned whether there was an intention to increase the availability of NTNs to help address the specialist workforce shortages that negatively impacted the service. Professor Powis recognised the issue and was working with medical royal colleges to increase the number of NTNs available. He noted that consideration should be given to recognising training undertaken outside NTN posts, for example, the Certificate of Eligibility for Specialist Registration (CESR) route. Increasing the number of doctors in specialty roles would need to be achieved through increasingly flexible means. Dr Evans highlighted the need for RCP to engage in consultations on the NHS Long Term Workforce Plan which aimed to transform services and the composition of healthcare teams.

Professor Powis thanked [redacted] for providing an open discussion about the role of the PA.

Royal College of Physicians

Minutes

Post-meeting note

Leng review: independent review of physician associate and anaesthesia associate professions terms of reference

On 20 November 2024 the Secretary of State for Health and Social Care established an independent review of the physician associate and anaesthesia associate professions, to agree recommendations for the future. It would consider the safety of the roles and their contribution to multidisciplinary healthcare teams. The conclusions of the review would inform the workforce plan to deliver the 10 Year Health Plan. The Secretary of State had appointed Professor Gillian Leng CBE to lead the review.

***Footnote:**

Correction: In reviewing the transcript and minutes side-by-side, an error was found in the unconfirmed version of these minutes. This error relates to the inclusion of the word 'national' in one sentence related to the PA scope of practice. When we revisited the recorded transcript, we found that neither the person asking the question, nor the person answering the question used the word 'national' during that section of the discussion. To correct this, a post-hoc amendment to the unconfirmed version of the minutes has been made to ensure a true record of discussions was captured.

Original sentence: *Professor Powis confirmed that implementing a national scope of practice for PAs with the agreement of all three organisations was intended.*

Amended sentence: *Professor Powis confirmed that implementing a scope of practice for PAs with the agreement of all three organisations was intended.*

inQuisit inquire involve inspire

Thematic analysis of responses to the Royal College of Physicians' (RCP) stakeholder consultation

Physician associates: Guidance for safe and effective practice

16 October 2024

inQuisit Ltd
5 Rowley Gardens
Bottisham Cambridge
CB25 9TA

M: 0776 525 0626
sallywilliams@inquisit.co.uk
www.inquisit.co.uk

VAT no.151 9588 82
Company registered in
England no.09613022

CONTENTS

Key messages

This report presents a thematic analysis of responses received by the RCP on its draft guidance document: *Physician associates: Guidance for safe and effective practice.* The approach to the analysis is set out in section 1.2. Details of the respondents to the consultation can be found at section 2.

This is an important consultation for the RCP, and it will want to consider carefully the breadth of comments made by its stakeholders. The themes identified are best illustrated by quotes from stakeholders, and this report uses many quotes to illustrate common themes, as well as opposing viewpoints. Themes are captured under each of the consultation questions, to enable the RCP to consider each element of the guidance in turn. Inevitably there is repetition across the different sections. The table below draws out the key messages.

Areas of good agreement	• There was good agreement (60% agreed) that the draft guidance will support doctors and PAs to deliver safe and effective care (section 3.1) • The proposal that specialist and associate specialist doctors should be able to act as supervising doctors attracted the highest level of agreement across all the consultation questions – 70% agreed (section 5.7).
Areas where agreement was weakest	• Less than a third (32%) agreed with the statement that the guidance will support the career and educational development of doctors. This was the lowest level of agreement across the questions (section 4.1). • Fewer than half of respondents (48%) agreed that the draft guidance would support safe and effective supervision of PAs by doctors (section 5.1).
Supervision	A cross-cutting theme was arrangements for supervision of PAs, with unanswered questions over how supervision will work in practice and calls for greater clarity. Key issues include: • The supervisory burden: the time entailed in providing safe and effective supervision of PAs, the burden expected to fall on senior doctors, the role of resident doctors, and the secondary impact on medical training. • The need for supervisors to understand the breadth of an individual PA's practice and competency, and questions about the handover of clinical supervision, particularly out of hours. • Training for supervisors. • Accountability and oversight, particularly where PAs provide specialty advice (section 5.5) and with respect to prescribing and referrals for ionising radiation (section 6). • A need for greater clarity about the distinction between supervision and advice and guidance, and the level of experience a doctor needs to provide these distinct inputs. • The type of supervision outlined in the guidance was said to be difficult to achieve in general practice and did not align with levels of supervision defined by the Royal College of General Practitioners (RCGP). The specific requirements with respect to PAs working with children and young people were also highlighted.

	In terms of developmental and clinical supervisor roles, one revision that came through quite clearly was that the developmental supervisor should be retitled educational supervisor to align with existing structures and established concepts (section 5.3). Over half (54%) agreed that any specialty advice given by a PA should remain the responsibility of their clinical supervisor (section 5.5). However, several comments revealed discomfort over whether PAs should provide specialist advice at all, and many highlighted a need for greater clarity over clinical supervisor responsibility in this situation. A lack of alignment with Good Medical Practice and General Medical Council (GMC) guidance on delegation and referral was highlighted. The proposal that specialist and associate specialist doctors should be able to act as supervising doctors attracted the highest level of agreement across all the consultation questions (section 5.7). Many respondents highlighted caveats to their support (e.g. focused on specialists and associate specialists who are practising autonomously or have undergone training to become a supervisor) and some specific issues were raised with respect to children and young people. However, overall, the RCP may consider that this is one of the more straightforward aspects of the guidance to finalise.
Uncertainty over the PA role	Uncertainty regarding PA scope of practice underpinned ongoing patient safety concerns, together with worry about a potential blurring of PA and doctor roles (section 3.2 and section 9.1.1). This linked to questions over the interface between the guidance document and scope of practice by other medical royal colleges or specialist societies and concern about a lack of coherence, with multiple scopes of practice. There were calls for the benefit of PAs in terms of enhancing patient care as part of the wider multidisciplinary team (MDT) to be more clearly drawn out, and for the guidance to be more inclusive in tone. The collision of different viewpoints was most evident with respect to the impact the guidance could have in supporting the career and educational development of doctors. There was a tension in the responses between those who wanted the guidance to go further in prioritising medical training, and those who felt the guidance should give greater weight to integrating PAs into the MDT and focus on training opportunities across the MDT (section 4). The RCP will need to consider how to strike a balance between these different positions. It is worth noting that most respondents agreed that PAs should not compromise medical training but were uncomfortable with statements that appeared to prioritise doctors over the wider MDT. The need to put the guidance in the context of the MDT also surfaced with respect to prescribing referrals by PAs (section 6.2). Some respondents pointed to a lack of congruence between the guidance and contemporary practice in terms of MDT working, and believed PAs should be able to seek advice and guidance from non-medical prescribers, as well as from doctors.
Implementation and enforcement	A recurring theme was around implementation of the guidance, including: • Questions about how PAs would be “mandated” to meet certain standards and measures to ensure employers meet their “obligations” (section 3.2). These point to a need to clarify the primary audience and status of the guidance (section 1.2), and the regulatory changes coming at the end of the year.

	• Implementation with respect to prescribing, the role of the supervising doctor and the likelihood that PAs will have to rely on resident doctors (section 6.2). • Governance structures was another area where concerns were raised about implementation at a local level, with some aspects of the guidance considered challenging for employers to meet (section 8.3). • Many of the additional comments also spoke to issues around implementation and enforcement of the guidance, including ongoing monitoring (section 9.1). • There were recurring calls for examples to illustrate best practice, including situations where PAs have been safely embedded into clinical teams and examples of potential development pathways.
The role of employers	Concerns about implementation gave focus to the role of employers, particularly with respect to training pathways and competency assessments (section 7.2.2) and governance (section 8.3.1). It was notable that no employers or employer representatives responded to the consultation. Similarly, no medical directors were involved in the consultation. The RCP may consider that consultation with those responsible for implementing the guidance is an important next step to explore concerns raised that some aspects of the guidance could be restrictive or overly burdensome on employers and, therefore, hard to implement.
Alignment with existing standards	Some specific inaccuracies were highlighted with respect to ionising radiation (section 6.2.5), revalidation (section 7.2), and responsibility for delegated advice (section 5.5). Some comments spoke to a need to better align the draft guidance with existing guidance, as well as guidance being developed by other medical royal colleges (section 9.1.5). This included aligning the approach to PAs with the approaches taken to other healthcare professionals (section 8.3.3). It may mean limiting the scope of the RCP guidance to physician specialties to avoid conflicts created by a lack of specificity for certain patient populations (e.g. children and young people) or settings (e.g. general practice and primary care).
Patient and carer engagement	A question was raised over whether the draft guidance had been co-produced with patient and carer involvement (section 3.2.6). Patient involvement was questioned with respect to PA competency assessments and developing training programmes (section7.2.2). This is something the RCP may wish to address in finalising the guidance.
Terminology	Specific comments on terminology are made throughout the report (see 3.2.5, 7.2.4, 8.3.5, 9.1.6). A recurring message was that terms like ‘ideally’ and ‘where possible’ should be avoided.

1. Introduction

The *Physician associates: Guidance for safe and effective practice* consultation document was developed by a writing group of consultant physicians with input from physician associates. The document was reviewed by RCP Council, the RCP Resident Doctors Committee, the RCP Patient and Carer Network, and the Faculty of Physician Associates and was also shared for internal consultation with RCP committees and working groups between May-July 2024.

The next step was consultation on the draft guidance. The consultation involved asking stakeholders to provide their views on the draft guidance by answering 9 specific questions, with the option of providing additional 'free text' feedback. A link to the document and an online form containing the questions was shared with the stakeholders listed at Appendix A. The primary aim of the consultation was to hear from external stakeholders. However, the draft document was also shared with RCP committees and networks that had commented on previous drafts and some of these also responded to the consultation, which opened on 1 August 2024 and closed on 12 September 2024.

1.1 Thematic analysis

The RCP sought independent analysis of the consultation responses. This thematic analysis was undertaken by Sally Williams, Director of inQuisit Ltd[1], and an experienced health policy analyst and health services researcher.

The analysis began by capturing the level of agreement and disagreement with each of the 9 consultation questions, based on the 46 responses to the online form. These provided a framework for thematic analysis of the free text comments made by respondents next to each question and in the space provided for additional comments. Further comments made by letter or email were incorporated into the analysis of other free text comments. The next step was to become familiar with the comments and to annotate these with descriptors. This led to a search for themes and quotes that best illustrated these themes, including showing opposing viewpoints.

All responses were given equal weight, whether they were made by an individual or by an organisation. The RCP may attach its own weighting to responses or wish to consider comments in the round.

Sections 3 to 9 describe the themes identified in response to each question (section 6, on supervision, comprised 4 questions). The final step was to identify overarching themes from across responses to each question, and key points for the RCP to consider in further developing the draft guidance.

1.2 Audience, terminology and status of the guidance

The introduction to the draft guidance set out its aims to provide 'guidance for safe and effective practice for physician associates (PAs)'. The document contains 'overarching principles' that 'apply to all PAs' and the document seeks to ensure 'adherence to safe practices in the employment and deployment of the PA role'. It includes 'recommendations and guidance on supervision and scope of practice'. Medical royal colleges and specialist societies are expected to build on this guidance to support PAs working in their field of practice as they become more experienced (page 3).

The primary audience for the guidance is somewhat unclear and the recommendations rely on several different groups taking action (see figure 1). The consultation questions describe the document as 'draft guidance for employers and supervisors'. RCP may consider that this should be reflected in the document itself, or even in the title to clarify who the guidance is for.

[1] https://inquisit.co.uk/

The summary of good practice recommendations on page 3 uses the term 'must' 35 times relating to supervision, PA practice, and employing a PA (see figure 1). It is often unclear where responsibility rests for delivering the recommendations (e.g. who should be responsible for the regular review of supervision levels as per recommendation 5.2, or responsible for ensuring that PA work schedules facilitate ongoing professional development as per recommendation 11.3). Some appear to be principles rather than recommendations (e.g. 14.3 PAs must not be used to replace roles or positions performed by doctors; 14.4 PAs must not replace doctors' positions in on-call rotas).

The RCP does not specify what is meant by use of the term 'must'. The GMC uses 'must' to refer to a legal or ethical duty the individual doctor is expected to meet, and 'should' for duties or principles that either may not apply to the individual doctor or the situation they are currently in, or they may not be able to comply with because of factors outside their control.[i] The term 'should' is used 12 times in the summary of good practice recommendations, including 6 times in relation to actions that either PAs or employers (or both) should undertake.

Figure 1: 'Must' recommendations

Who 'must'?	*Frequency*	*Paragraph*
Undefined	10	1, 3.1, 5.2, 11.1, 11.2, 11.3, 12.1, 14.1, 14.3, 14.4
PAs	6	PA practice (x2), 8.1, 8.2, 13.2, 17
Employers	6	7.3, 9.3, 10.1, 10.2, 10.3, 13.1
Organisations	5	9.1, 15.1, 15.2 (x2), 15.3
Clinical supervisors	3	4.1, 4.2, 4.3
Developmental supervisors	2	3.2, 3.4
Supervising doctors	1	2
Prescribers	1	6.4
Medical royal colleges and specialist societies	1	7.1
Total	35	

The draft guidance is not statutory or regulatory body guidance, and yet a recurring message across the consultation responses is that certain aspects of the guidance should be mandated. The RCP may wish to consider some of the language used in recommendations, who should carry responsibility for delivering each recommendation, and whether it would be helpful to explain the status of the guidance upfront. The focus on employers, including recommendations specifically aimed at employers, highlights the importance of consultation with this stakeholder. One respondent questioned whether the guidance "may go beyond the College's remit in seeking to place requirements on employers in relation to matters of employment".

2. Overview of respondents

99 respondents clicked on the online link to respond to the consultation:

- Blank responses were removed, leaving 46 online responses (of which 40 respondents completed all the consultation questions)
- 18 appeared to have been made on behalf of **organisations**[2] (including 2 responses made by different people from the same organisation)
- 17 responses were made by **individuals**[3]
- 12 responses were categorised as **RCP responses**[4]

A further 9 responses were received by letter or email :

- 6 were organisational responses (of which 3 comprised a cover letter and a hard copy response using the same format as the online form – these 3 responses were incorporated alongside the 46 online responses as they indicated clear agreement or disagreement with the consultation questions)
- 2 were from RCP committees (of which 1 used a similar format to the online form and was incorporated alongside the 46 online responses)
- 1 was an individual response

Additional feedback:

- Additional feedback was received from 1 organisation and 1 RCP respondent adding further detail to responses already made online
- These were not counted as new responses

Total: 55 responses, of which 50 used the online form or submitted a hard copy version of it.

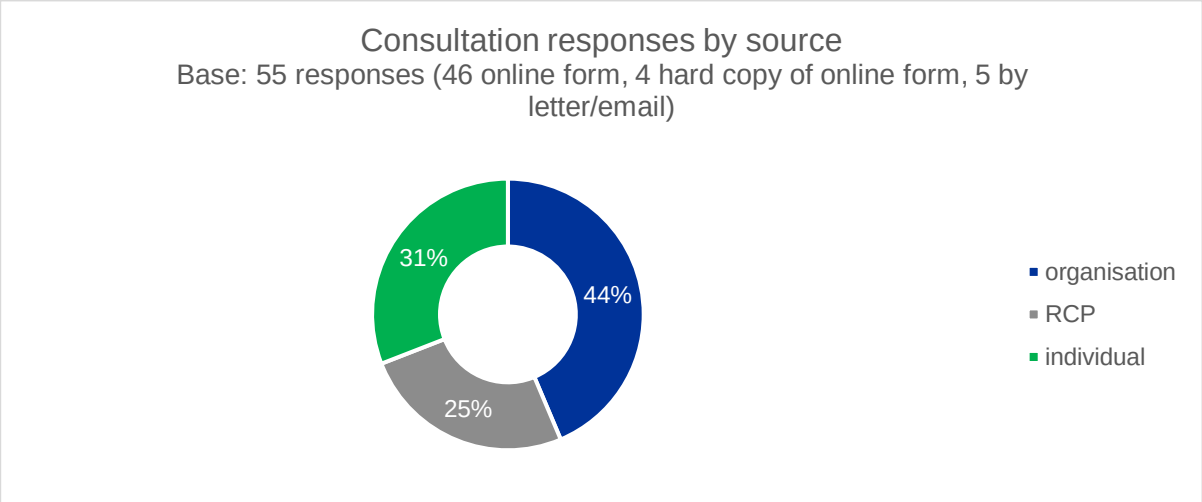
[2] The response was categorised as **organisational** if it was clearly organisational (e.g. referred to wider discussion within the organisation) or the job title of the person responding suggested that they were doing so on behalf of an organisation (e.g. chief executive, chair, vice president).

[3] The response was categorised as **individual** if it came from someone whose job title indicated they were responding in a personal capacity. These were mainly from consultant physicians (and two specialty registrars), from the following specialties: acute medicine, endocrinology and diabetes, neurology, palliative medicine, gastroenterology, geriatric medicine, respiratory medicine. Other individual responses were from people in clinical neurophysiology, academia, a retired NHS worker, a retired member of a patient group, and a patient representative of a foundation trust.

[4] Responses categorised as **RCP** were from people associated with the RCP (recognising that they could be providing a personal viewpoint). These comprised 9 responses from the RCP Patient and Carer Network, a College Censor, two RCP council members, and responses on behalf of two RCP committees: RCP Joint Neuroscience Committee and RCP Resident Doctors Committee. Faculties and specialty associations were considered organisations.

Figure 2 shows that most responses (44%, 24 responses) were made on behalf of organisations, 31% (17 responses) made by individuals in a personal capacity, and 25% (14 responses) were made on behalf of RCP committees or individuals associated with the RCP.

Figure 2: Consultation responses source (organisation/individual/RCP)



The organisations listed in figure 3 were represented amongst the responses. Except for NHS Education for Scotland and the UK Health Security Agency, all the organisations were concerned with medicine, the medical profession, or PAs. There were no responses from employer or provider representatives, even though the list at Appendix A shows several were invited to participate in the consultation.

Across the individual responses, none of the respondents identified as a medical director, although there was one associate medical director for education and training. Individual employers did not appear to be represented across any of the individual responses. There were no responses from specialist or associate specialist doctors.

There was good representation of the RCP Patients and Carers Network (9 responses), but only 2 responses came from other individuals said to be representing patients and carers.

Figure 3: List of organisations that responded

Organisation^	Online form	Hard copy of form + cover letter	Letter/email
Academy of Medical Royal Colleges and Faculties in Scotland			X
Association of British Clinical Diabetologists	X		
British Cardiovascular Society	X		
British Geriatrics Society	X		
British Junior Cardiologists' Association (BJCA)	X		
British Medical Association		X	
British Society of Gastroenterology	X		
Faculty of Physician Associates (FPA)	X		
Faculty of Sport and Exercise Medicine UK	X		
General Medical Council		X	
NHS Education for Scotland (NES)	X		
Physician Associate Schools Council	X		
Royal College of General Practitioners (RCGP)	X		X
Royal College of Ophthalmologists*			X
Royal College of Paediatrics and Child Health			X
Royal College of Psychiatrists		X	
The Royal College of Anaesthetists ~	X		
The Royal College of Paediatrics and Child Health	X		
The Royal College of Physicians and Surgeons of Glasgow	X		
The Royal College of Physicians of Edinburgh	X		
The Royal College of Radiologists	X		
UK Health Security Agency - Medical Exposures Group	X		
UMAPS LTD (United Medical Associate professionals)	X		

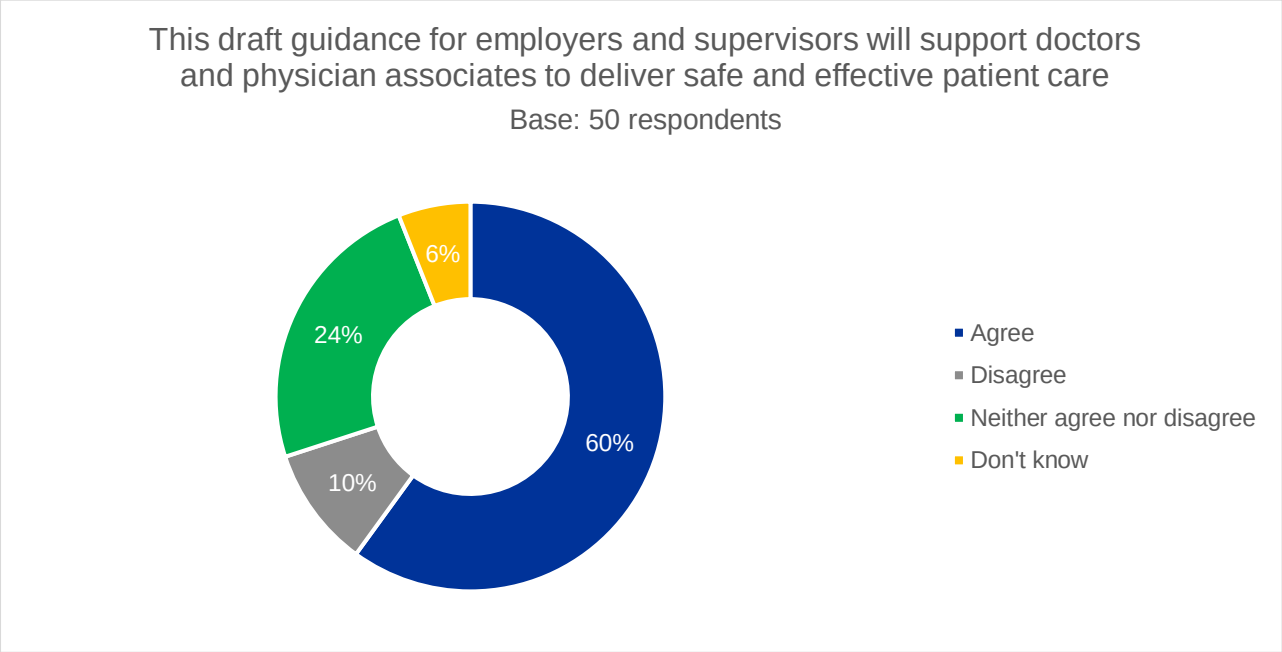
**Royal College of Ophthalmologists responded to say that it was running a pilot for PAs with an interest in ophthalmology and until the evaluation report was published, it would not be able to comment on whether PAs are an appropriate addition to the extended healthcare delivery team.*
~ Two online responses were made by individuals associated with the Royal College of Anaesthetists – one from a council member and one from a clinical quality and research business coordinator.
^ Responses from the RCP Joint Neuroscience Committee and RCP Resident Doctors Committee were categorised as RCP responses, not organisational.

3. Patient safety

3.1 Levels of agreement with the question

There was agreement among 60% (30 respondents) that the draft guidance would support doctors and PAs to deliver safe and effective care, as shown in figure 4. This was the joint second highest level of agreement to a consultation question – see section 10 for an overview of agreement and disagreement across the consultation questions. A further 10% (5 respondents) disagreed. Nearly a quarter, 24% (12 respondents) selected neither agree nor disagree, and a further 6% (3 respondents) answered 'don't know', leaving a sizeable proportion uncertain in their response.

Figure 4: Responses to question on patient safety



3.2 Analysis of free text comments

Several themes were observed from the free text responses made with respect to this question.

3.2.1 The potential of the guidance to support patient safety

Several respondents believed the draft guidance would support or "enhance" patient safety. Importance was placed on clarity of expectations regarding PA roles and their position within the wider multidisciplinary team. The emphasis placed on clear governance frameworks was also regarded as key to improving patient safety. For example:

- "The document informs us what should be done surrounding patient safety".
- "There has been a clear need for a standardised governance process and [we] hope that this will provide a framework to safely employ and supervise Physician Associates".

Several caveats were made regarding safety. Specific concerns were raised with respect to prescribing and ionising radiation (returned to under section 6) and a worry that any doctor, but particularly resident doctors[ii], would be placed in an unfair position by an expectation that they should prescribe on referral from a PA. A recurring theme was that doctors should never feel "admonished" for refusing to prescribe or order ionising radiation "for a PA" or to agree to supervise a PA, and for the guidance to be clear on this point.

3.2.2 Supervision

Several comments about patient safety pointed to a need for greater clarity regarding supervision (which is the focus of section 5). This included confusion over situations in which a PA should approach a clinical supervisor for advice and when to approach the most senior doctor available. Issues were raised over the availability of developmental and clinical supervisors, the burden of supervision and assumptions that consultants would be willing to provide PA supervision. "Stretched clinical supervisors will have to marry the competing demands of PAs and doctors in training," remarked one. Others worried that expectations around supervision of PAs would undermine training opportunities for resident doctors "and thereby risking patient safety".

Questions included: the seniority of supervisors if the supervising doctor was not available; the supervision expected for PAs in requesting an ultrasound scan, magnetic resonance imaging and blood tests; clinical and professional responsibility of doctors supervising PAs and with respect to medical error; out of hours supervision (highlighted as a particular area of vulnerability with many consultants off-site) and the type of activities PAs could undertake out of hours.

3.2.3 Scope of practice

Patient safety concerns arose for some respondents from a perceived limited scope of PA education. One respondent highlighted that PAs have only 1600 hours of formal training and argued this was insufficient to allow them to "independently manage patients safely". This respondent expressed concern that the draft guidance would allow employers and supervisors "to set the scope limits for PAs" and wanted the RCP to work with stakeholders to set nationally agreed "scope limits".

The free text comments highlighted uncertainty regarding scope of practice, with calls for clearer and more specific detail here. There was some recognition that specialty scope of practice had not yet been addressed, but other comments pointed to confusion over where responsibility lay for defining scope of practice. One respondent drew attention to a lack of detail regarding safety measures needed for different clinical populations, such as older patients. The interface between the guidance document and scope of practice documents by other medical royal colleges or specialist societies, some of which were already underway, was unclear. Concern was expressed that "multiple scopes of practice" could be created, resulting in uncertainty for employers.

A sub-theme was concern about a potential blurring of PA and doctor roles, with a lack of clear differentiation. As one said: "The guideline states that PAs can assess, diagnose and treat patients – this is misleading as it makes it sound like they can do everything a doctor does." There were calls for greater clarity about the difference between PAs and medically qualified staff and a recurring call that a PA should not replace the role of a doctor.

A few respondents took a different view. One respondent supported PAs filling absences on medical rotas: "Provided this is done with appropriate supervision and as part of a wider medical team, I do not see why we should say that PAs should never replace a doctor on a rota. They already do." Another expressed concern that the guidance appeared in places to be "somewhat burdensome and restrictive, to the extent that, if adopted as drafted, it could have the effect of dissuading employers from employing PAs". This respondent questioned whether the RCP had reflected on the extent to which the draft guidance deviates from current practice and whether it has considered areas of good practice in hospitals and GP practices where PAs have been safely incorporated into teams.

3.2.4 Implementation and enforcement

The degree to which the draft guidance can support safe and effective patient care was dependent on the approach to implementation and this ran as a theme through many of the free text comments. Concern was expressed that the guidance was unlikely to be transferred into practice within the context of existing

burdens on senior clinicians. Re-review of patients in areas like management plans, prescribing and ionising radiation were cited as likely to increase the burden on doctors. There was a worry that the guidance could even serve as a disincentive to using PAs. For example:

- "The document informs us what should be done surrounding patient safety but [provides] no assurances on how it will be implemented and monitored at a local level".
- "While individual doctors and PAs using the guidance will be facilitated to practice safely, the guidance may be a deterrent for those wishing to recruit a PA because it outlines tight governance structures and supervision requirements."

Some comments suggested confusion over the primary audience for the guidance.

- "Individual doctors and PAs using the draft guidance document will be facilitated to deliver safe and effective practice".
- "This guidance provides clear information for employers and supervisors to ensure that staff working in physicians associate roles can perform their duties safely".

A suggestion was made to separate guidance for supervisors from guidance for employers. These comments reinforced earlier observations about the purpose of the guidance and its primary audience (section 1.2).

Issues were raised regarding enforcement, including what should happen relating to PAs undertaking procedures not mentioned within the guidance, or where PAs are used on medical rotas to fill for absences. Questions were raised over how PAs would be "mandated" to uphold the standards in *Good Medical Practice* and over measures to ensure that employers meet their "obligations" detailed in the guidance. These questions pointed to a need for greater clarity over the status of the guidance and the regulatory changes planned for PAs at the end of 2024.

Questions were also raised over impact assessment, including for patients and carers to be part of employer impact assessment, how patient outcomes would be measured, and for there to be a review of the guidance document 6-9 months after publication.

3.2.5 Terminology

Views were mixed on the clarity of the draft guidance. Some described it as clearly written. Some objected to specific terms (e.g. use of "ideally" and around patient consent), wanted the language to be "firmer and stronger", or perceived contradictions that required further clarification (e.g. between paragraphs 6.3 and 6.5 and 13.1). A recurring message was a need for greater specificity, including scenarios (e.g. to demonstrate the demarcation of roles between PAs and doctors and around supervision), and with respect to patient populations (e.g. older people, and children and young people). Clarification was sought of terms such as "appropriate health professional", "relevant service provider communications", and "national" in terms of the UK versus country-wide reach of the guidance. One respondent summed up: "This document will help support the framework for PAs to deliver safe care but isn't detailed enough, leaving considerable uncertainty."

3.2.6 Patient and carer engagement

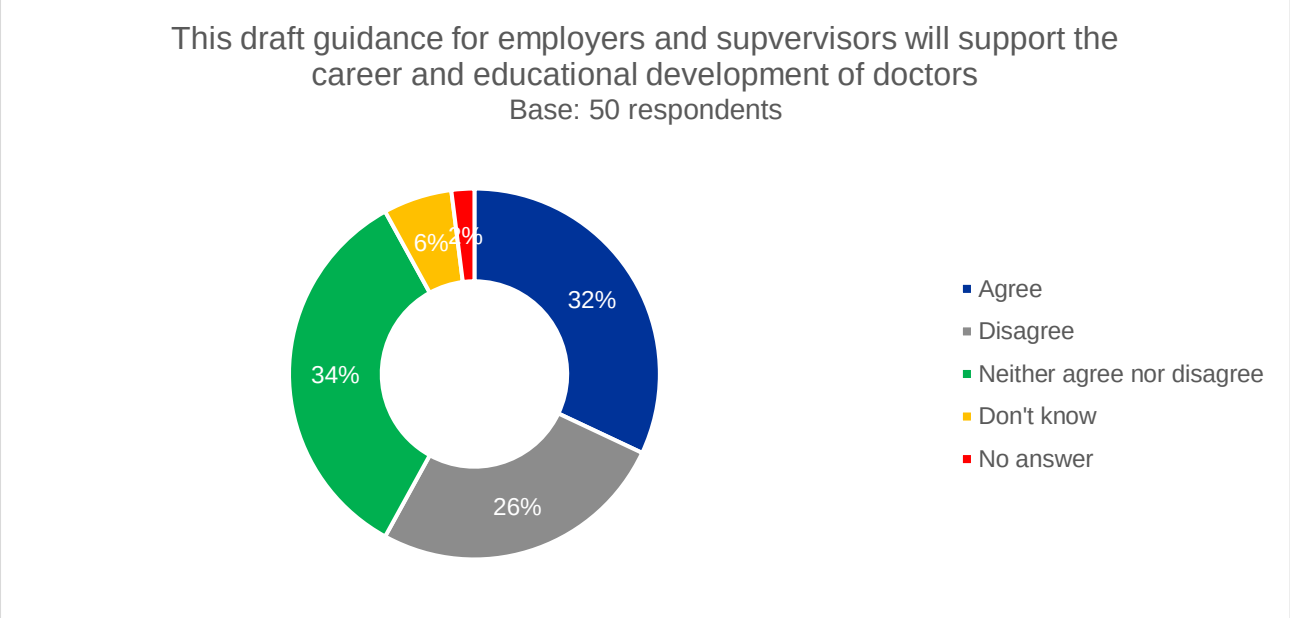
A question was raised over whether the draft guidance had been co-produced with patient and carer involvement. This is something RCP may wish to address in finalising the guidance. The consultation responses indicated good engagement from the RCP's patient and carer network (section 2), who may be able to provide further advice.

4. Impact on medical training

4.1 Levels of agreement with the question

This question had the lowest level of agreement of all the consultation questions and the joint highest level of respondents choosing neither agreed nor disagreed. In total, 32% (16 respondents) agreed; 26% (13 respondents) disagreed; and 34% (17 respondents) neither agreed nor disagreed. One respondent did not answer the question, and 3 respondents (6%) answered don't know.

Figure 5: Responses to question on impact on medical training



4.2 Analysis of free text comments

Five major themes emerged from the free text responses to this question.

4.2.1 Statement on doctor training

The consultation form drew attention to the following statement: 'The PA role within a clinical team should ideally facilitate training opportunities for doctors' (page 16). There was support for this messaging among several respondents. For example:

- "The clear statement on this issue [is] welcome in this new guidance".
- "We are grateful for the explicit statements that PA[s] should not replace doctors, must not compromise doctors' training and should facilitate doctors' training, if possible".

However, some respondents questioned the appropriateness of including the statement within a guidance focused on PAs. For example, one questioned: "whether guidance on the integration of PAs into the MDT should focus on the impact on doctors' training rather than on how to ensure safe and high-quality care for patients". This respondent doubted the likely impact of PAs on the career and educational development of doctors, and referred to ambitions in NHS England's Long Term Workforce Plan to increase the number of doctors in the workforce far more swiftly than the number of PA.

4.2.2 Prioritising doctor training

Several respondents wanted the guidance to go further, as illustrated by these comments:

- "The only way in which PAs will facilitate training opportunities for doctors is if this is mandated and prioritised over their career progression".
- "Training for doctors must be prioritised at all times".
- "To support doctors' training (and therefore ensure that the consultants and GPs of the future remain highly skilled), there needs to be consistent and firm messaging, and their medical training must be prioritised".
- "It is imperative that the training opportunities for doctors in training is not jeopardised by the presence of PAs. This document does not make provision for this, in my opinion".

One respondent argued for doctors to have priority to take up any training opportunity over non-medical staff. Another argued for instances where PAs had access to training at the expense of resident doctors to be "looked into/stopped immediately." Reference was made to protecting training opportunities for doctors across all relevant healthcare settings.

Such statements reflected concerns that the employment of PAs creates an additional pressure for consultants in terms of training, causing PAs and doctors to "compete for limited opportunities." One respondent stated: "Sadly there are too many places where PAs are getting training and service opportunities while resident doctors are on the wards completing admin tasks." Some respondents relayed anecdotal accounts of resident doctors, while others quoted survey results to demonstrate the extent of the challenges. One respondent called for the guidance to apply to existing PA roles and to address situations where these roles were currently impacting doctor training.

4.2.3 Equality across the MDT

In contrast to those who advocated for stronger language to prioritise and protect training opportunities for doctors, a group of respondents felt that the guidance should give greater weight to integrating PAs into the MDT. There was some discomfort that the wording of recommendation 14.5 appeared to prioritise doctors and all other clinical roles over PAs. For example:

- "When planning to integrate a PA into an MDT that includes doctors the post should enhance the quality of patient care and allow all members of the MDT opportunities to reach their developmental goals".
- "The guidance gives a clear message that the implementation of PAs should not compromise doctors' training, that PAs should not replace doctors. While we agree this is the case, the guidance would benefit from additional material and content further emphasising the positive enhancement to patient care from PAs, doctors and other members of the clinical team working effectively together within the MDT to demonstrate how this may be achieved".
- "Seeking to ensure that PA training and roles are implemented to try and enhance medical training is welcome. The aim should be for no group to be disadvantaged in their training by the adoption or change to other training pathways, groups or staffing levels".
- "Development should be bi-directional for all members of the MDT (PAs included)".
- "The current focus is restrictive and denies PAs being part of a bigger picture of training opportunities that are available to the wider multidisciplinary team. Training opportunities for PAs need to be available, as the more training they get, the safer they will practice."

One suggestion was for the guidance to focus on "not detracting from training opportunities rather than facilitating training opportunities for doctors."

A minority of comments revealed continued uncertainty over the PA role. As one said: “It is still unclear what a PA brings to the MDT that cannot be fulfilled by other roles.” This respondent took issue with the description in the document of PAs as healthcare professionals and would prefer to see them described as “healthcare practitioners” and thought this would help to ensure that training opportunities did not overlap. Another argued for a change in title from associate role to assistant: “This will ensure that doctors in training are enabled to act towards the ceiling of their own practice more than is currently the case.”

4.2.4 PAs as trainers

A small number of respondents spoke about the role PAs could play in the training of doctors and called for a section setting out the ways in which a PA could provide training to resident doctors. Another respondent commented that “doctors can learn from PAs as well as PAs learning from doctors.” Ascitic (assumed to mean ascitic tap) and lumber punctures, as well as ultrasound guided cannulation in PAs who have undertaken additional training in this, were suggested as examples that PAs could teach to doctors in training. One respondent said: “experienced PAs may be able to play a role in the supervision and training of their junior colleagues.” It was assumed that junior colleagues in this context referred to newly qualified PAs.

4.2.5 Implementation and enforcement

Enforcement of the guidance and monitoring of its impact was again a theme. Some comments highlighted uncertainty as to how PAs could facilitate training opportunities given the need for their supervision. There was a call for examples of best practice to illustrate the potential here.

Reference was made to a “lack of regulation” and to having “mandatory requirements” for employers to review training opportunities, and for the document to outline the consequences of not following the guidance. A recurring message was that the term “ideally” should be removed from this section (and elsewhere in the document), reflecting a belief that employers will not follow the guidance if it is phrased as an ideal. The challenges of implementation surfaced in a few comments, and one respondent called for monitoring of the impact of PA roles on the training for doctors.

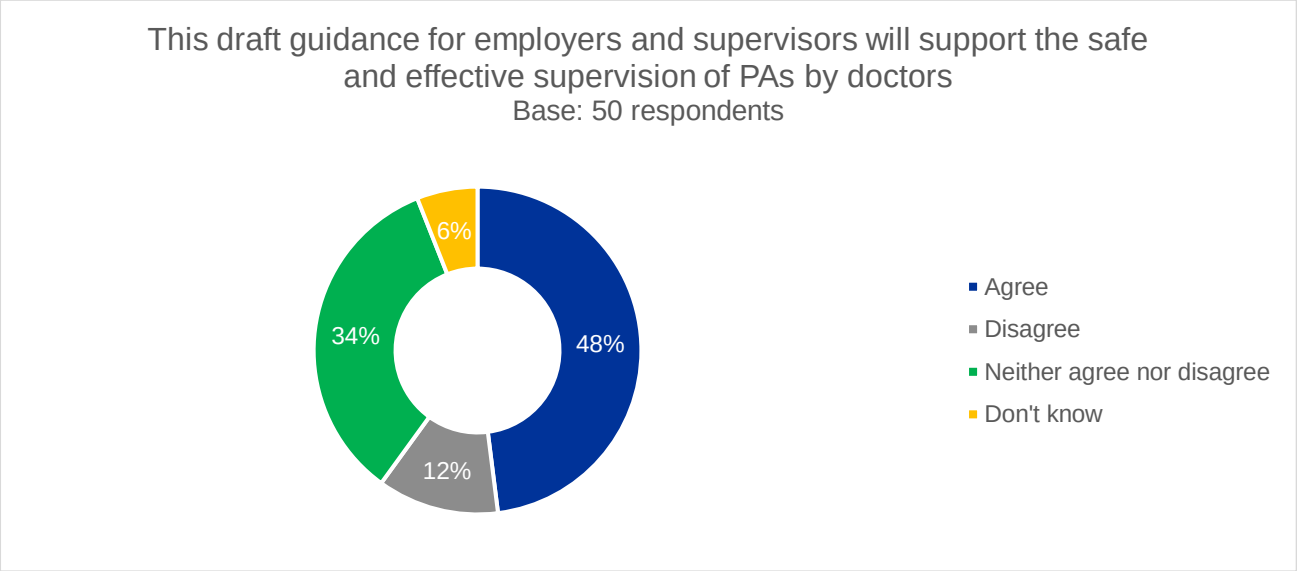
One comment highlighted uncertainty over the professional landscape, questioning how the College of Medical Associate Professionals would contribute to oversight arrangements.

5. Supervision

5.1 Levels of agreement regarding safe and effective supervision

Less than half of respondents, 48% (24 respondents), agreed that the draft guidance would support the safe and effective supervision of PAs by doctors. A further 12% (6 respondents) disagreed; more than a third, 34% (17 respondents), selected neither agree nor disagree; and 6% (3 respondents) answered don't know.

Figure 6: Responses to question on safe and effective supervision of PAs by doctors



5.2 Analysis of free text comments

Comments supportive of the guidance with respect to supervision, described it as "helpful", "sensible" and "clear", as the following quotes illustrate:

- "The setting of these requirements as a minimum standard has been missing for some time and the RCP has done well to attempt to tackle this".
- "The role of supervisor is an important asset to the safe continued implementation of the PA into the clinical team".
- "Good supervision is essential if this group of healthcare professionals is to improve patient care. This document clearly outlines how this should happen".

Some positive comments were made specifically relating to definitions of the levels of supervision. However, many comments were caveated by concerns regarding implementation, and perceived challenges for employers in applying the guidance in practice, particularly for those who have already successfully integrated PAs into their teams. The themes arising from these concerns are captured below.

5.2.1 Alignment with existing frameworks

The draft guidance describes three levels of supervision. One respondent drew attention to guidance on the Core Capabilities Framework for Medical Associate Professions (2022)[iii], which describes four "defined tiers", and observed that employers may find it difficult to reconcile conflicting guidance in this area. The RCP was

also advised to ensure the draft guidance aligns with current arrangements for other ARRS[5] roles, foundation doctors and trainees, and to explain the reasons for any significant divergence.

The guidance states that 'PAs can practice in the UK under the clause of delegation' (6.3, page 10). However, one respondent stated that no such clause exists, emphasising that delegation and supervision are different concepts and the GMC publishes separate guidance for both. It was thought that reference in the draft guidance to a GMC document called 'Standards for medical supervisors' had been made in error as this document is not about general supervision and instead sets out the framework used to monitor a doctor's health and progress during a period of restricted practice. It was suggested that the draft guidance should instead link to:

- Good medical practice[iv]
- Leadership and management for all doctors[v]
- Delegation and referral[vi]

5.2.2 Supervisory burden

The most prevalent theme related to the time entailed in providing safe and effective supervision of PAs and the additional burden this was expected to place on senior doctors. For example:

- "I do not believe some of the supervision will be practically achievable on the wards as often there are no ST3+ doctors on the wards. Also, the numbers of doctors and ACPs [advanced care practitioners] we already have to supervise as consultants is above and beyond what is manageable most of the time, so where will all this extra supervision time be found if the PAs are extra staff on top of the doctors?"

- "Supervision is not an on-paper, theoretical exercise. It involves practical, "in-shift" actions and work for and by doctors designated as supervisors. This requires time. Time must be afforded within clinical supervisors' job plans or patient safety will be jeopardised further. Supervision is particularly important in the assessment of suddenly unwell or otherwise undifferentiated patients in hospital or community settings".

- "We remain concerned about the extra burden the need to supervise PAs places on senior clinicians, who must also supervise resident doctors, carry out their own clinical care work, and possibly work in leadership/management capacities, e.g. service improvement projects". Another respondent asked for a statement outlining the steps to be taken in clinicians decline to supervise".

Several respondents expressed concern about a secondary impact on medical training. For example:

- "There needs to be guidance on how this would be achieved without compromising training and learning needs for all doctors. The time commitment as described appears large and unachievable".

- "The document makes it clear that educational opportunities of doctors should be prioritised over that of PAs. Given the finite number of supervisors, please can we see a similar consideration given to supervision?"

- "In my experience doctors in training/ resident doctors struggle to get meaningful clinical supervision/feedback/appraisal as consultants are overstretched as it is. How will PAs having both developmental and clinical supervisors be job planned for consultants?"

[5] This acronym was used by the respondent and not explained. It is assumed to refer to the Additional Roles Reimbursement Scheme, which covers several roles including clinical pharmacist, dietician, podiatrist, paramedic, nursing associate, and physician association.

Some comments focused on the weekly average 0.25 supporting professional activity (SPA) time required by the guidance for developmental supervisors (recommendation 3.5) and questioned why clinical supervisors were expected to have only "adequate direct clinical care (DCC) time in job plans for clinical supervision of PAs" (recommendation 4.5). The phrasing "adequate time" was questioned. One respondent said the 0.25 SPA time should be "an absolute minimum in optimal circumstances", adding: "there should be no upper limit as some PAs may require continuous supervision". One respondent wanted to see "a defined allocation of time" included for clinical supervision. Another said:

- "I am concerned that "adequate DCC" is too loose and there is no suggestion about a mechanism to determine how this adequate time will be determined. This especially when we see consultants are directly responsible out of hours (4.3) and that in 5.1 it is clear the need for supervision will change with PA experience. I would argue the time allocation should fulfil the highest level of need, not the lowest – and a median or average will be impossible to predict and hard to measure".

Given time limitations, an argument was made for the role of the PA to be "clearly demarcated and static". There were calls for clarification over how long a PA starting in a new department should be directly supervised for and for the guidance to refer to a graduation of supervision requirements from the early months of a PA's practice. For example:

- "It is unrealistic to expect supervisors to spend time managing the evolving portfolio of PAs in the way that they do doctors."

- "PAs do not complete any further formal qualifications and will always remain dependent practitioners. As such, they will always need a very close level of supervision to ensure they work safely".

5.2.3 Supervisor continuity

Some concern was expressed about a lack of continuity of supervision, and several argued for a PA supervisor to be someone with understanding of the breadth of an individual PA's practice and competency. Large variation in the scope of practice amongst PAs currently working in the NHS was raised, which was thought to present a real challenge to supervisors.

Questions were raised about the handover of clinical supervision and how this would be managed, particularly out-of-hours and how the on-call consultant would be made aware of an individual PA's ability. One argued for PAs to routinely work in settings where they can seek advice from their clinical supervisor (i.e., the clinical supervisor would be expected to be on hand).

5.2.4 Supervisor training

A recurring message was that developmental supervisors would require training in providing supervision to PAs and for such training to be mandatory and not "ideal" (as set out in recommendation 3.4). Some advocated training for PA clinical supervisors too. The theme is best illustrated by the quote below:

- "The document misses that doctors supervising PAs will have training needs above those needed to supervise JDs [doctors in training], particularly as there are currently no national standards for PA training. We will need a national training programme for PA supervisors. Without this and dedicated time for it in job plans, PA supervisors may adapt what they do for JDs, creating variation across the UK which is undesirable and risks PAs being treated like doctors by their supervisors. Clinicians supervising doctors, nurses or pharmacists rely on a nationally agreed training and assessment scheme for therapeutics and prescribing, which doesn't exist for PAs. Teaching and mentoring novice prescribers is a very specialised skill – this document doesn't address those needs in PAs or the likely risks to patients."

5.2.5 Accountability and oversight

Ambiguity was highlighted across the guidance in terms of accountability. Section 6.2 (page 10) stated that, with correct supervision and appropriate delegation, the PA is responsible and accountability for their own practice. There was some uncertainty over how this married with the statement in section 2 (page 3) that the consultant, GP etc. retains clinical professional responsibility for patients treated under their care. Or, with the statement in 6.2 that the clinical supervisor will remain responsible for the overall management of the patient.

One highlighted a need for employers to ensure there were clear pathways to escalate concerns about PAs being asked to work out of scope.

Patient representatives suggested a debriefing for each patient before a PA ended a shift. One raised concern about the option of remote supervision within the current PA scope of practice.

5.2.6 Advice and guidance from resident doctors

There were calls for the guidance to be clearer about the distinction between 'supervision' and 'advice and guidance'. Questions were raised over references made to seeking advice from doctors at ST3 or above, and whether this included doctors in third year internal medicine training (IMT3). Clarity was also requested in terms of whether every acute admission seen by a PA would need to be reviewed by an ST3 or above. One respondent highlighted that, in some hospitals, a second year IMT doctor may be the most senior on-site and suggested the guidance should be amended to seek advice from post-registration doctors (FY2 and above). Another wanted to see clarification that a PA should only seek advice and guidance from FY2 doctors in urgent situations and that relying on an FY2 "should be viewed as an emergency measure".

5.2.7 Applicability to primary care and other settings

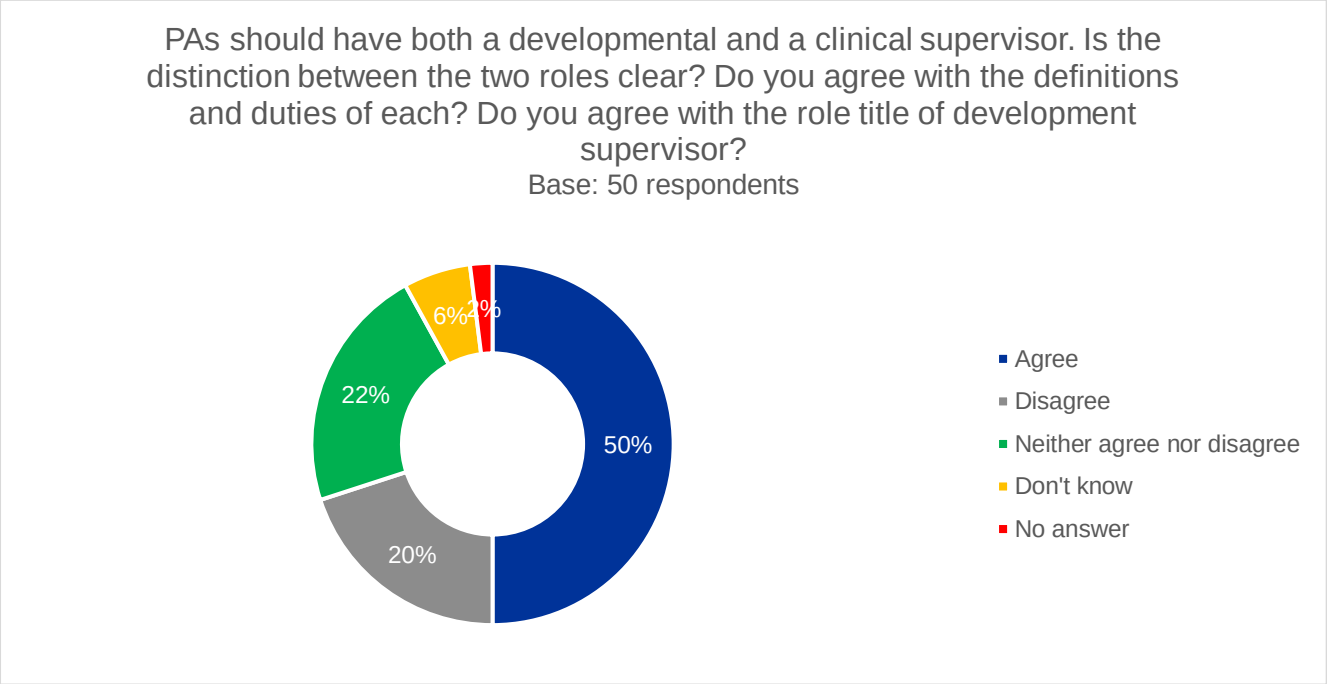
The type of supervision outlined in the guidance would be difficult to achieve in general practice and primary care settings, according to some respondents. Stipulations already made by the RCGP with respect to supervision of PAs working in general practice, and different levels of supervision (namely clinic/practice supervision; clinical/professional supervision; educational supervision) were highlighted.

The specific requirements of PAs working with children and young people were mentioned, including for any named supervisors of PAs in pediatrics to be a paediatric doctor on the GMC specialist register. One respondent observed that the guidance did not address the supervision of locum PAs.

5.3 Levels of agreement regarding developmental and clinical supervisors

In addition to asking whether respondents agreed or disagreed that PAs should have both a developmental and a clinical supervisor, the consultation asked three supplementary questions (figure 7). There cannot be confidence that the agreement (50%, 25 respondents) or disagreement (20%, 10 respondents) or those that neither agreed nor disagreed (22%, 11 respondents) relates to the first statement (in addition, 3 answered don't know and one respondent left no answer). Equally, RCP cannot have confidence that respondents have given their views with respect to the distinction between the developmental and clinical supervisor roles – a binary question is asked, which did not fit with the choice of answers available (to agree, disagree etc).

Figure 7: Responses to question on having both developmental and clinical supervisors



5.4 Analysis of free text comments

The following themes emerged from the free text comments relating to this question; many of these built on themes arising from answers to the previous question on supervision.

5.4.1 Distinction between the two roles

Those in favour tended to see value in having the two roles and found them to be clearly distinguished from one another. For example:

- "Similar to the medical model of supervision – this is practical and supports both development and patient safety. The distinction is clear, and the duties/roles well described".
- "Both are essential. Roles and duties are clear. It is vital for PAs to have supervision whilst working but also someone to help with their career development".

While describing the definitions between the two roles as clear, one respondent queried whether the developmental supervisor could also be the clinical supervisor. Another expressed concern that too many duties may be assigned to the developmental supervisor and encouraged RCP to consider that, in addition to a clinical and developmental supervisor, the PA will also have a line manager who, for example, could agree a PA's work schedule and provide pastoral support.

Those against tended to believe that there should not be too distinct roles; one suggested there should be a line manager instead of a developmental supervisor, based on Agenda for Change arrangements, another highlighted the risk of duplication. For example:

- "I don't understand the need for two different roles unless the clinical supervisor is simply the consultant in charge of that specific patient receiving care from the PA".

- "There is far too little reference to scope of practice within this document [and] how that relates to both the developmental and clinical supervisors. This leaves 'competency responsibility holes' in which both supervisors may deny responsibility and unsafe practice or unsafe assumptions about competencies have direct impact on patient care. Dividing the responsibility for clinical and developmental supervision in the case of PAs I would suggest, in view of the disagreement regarding scope of practice is a clear patient risk. A single consultant acting as both clinical and developmental supervisor at any one time is in my opinion a clear line of liability and responsibility".

Some respondents expressed uncertainty, either because the developmental supervisor role was unclear, or over day-to-day clinical supervision. One remarked that the guidance did not compare the two roles equally, which made it confusing – for example, detailing the qualification clinical supervisors would need but not for developmental supervisors.

5.4.2 Developmental versus educational supervisor

Many respondents advocated for the developmental supervisor to be retitled educational supervisor, to reflect known structures for other members of multidisciplinary teams (including doctors in training and advanced care practitioners (ACPs)), as these quotes illustrate:

- "Everyone else has a clinical and educational supervisor. I'm not sure of the benefit of using different terminology in this instance for PAs".

- "This is no different to any member of the team including doctors in training who have an ES [educational supervisor], CS [clinical supervisor] and clinical day to day supervisor they work with. The concept is not new".

- "We think that the distinction is not clear between roles and could lead to confusion. It is simpler to use Educational Supervisor and Clinical Supervisor. This would be clearer to understand".

- "ACPs and PAs should have a clinical supervisor for each shift and an overall educational supervisor".

- "This seems sensible and is consistent with other healthcare trainees. It will support PAs in their professional development and requirements for appraisal. However, equitable approaches and terminology, for example 'educational supervisor' could enhance consistency of approach".

- "The title 'educational supervisor' is often used to describe what the guidance calls a 'developmental supervisor'. The definitions around educational supervisors are already established".

- "We also question the 'developmental supervisor' title and suggest their responsibilities describe an educational supervisor, which is a well understood role".

- "The role of development supervisor is essentially that of an educational supervisor and it would be reasonable to stick with terms that are widely used and understood".

One respondent thought developmental supervisor was a reasonable title and that educational supervisor could be seen as too close to the medical model. Another respondent highlighted confusion that could arise from using the title clinical supervisor for PAs as well as for doctors in training.

Draft guidance being developed by another royal college has used the terms clinical and educational supervisor but anticipates that it will be unlikely to recommend the need for an educational supervisor role beyond the PA's preceptorship year in that specialty.

5.4.3 Clinical supervision

There were opposing views over the level of seniority needed to provide clinical supervision, with some expressing concern that it would not be consultants supervising PAs, but resident doctors. Others were comfortable with clinical supervision happening across the MDT. These two quotes illustrate the different viewpoints:

- "This draft guidance fails to ensure that the clinical supervision on the job is sufficient to prevent the risk to patients from PAs working beyond their competences. There should always be direct supervision available from the supervising consultant or senior doctor with delegated responsibilities. Placing resident doctors in a situation to provide *de facto* supervision in the absence of the supervising consultant is unsafe and inappropriately adds to their workload".

- "While there should be a named consultant with overall responsibility, we believe clinical supervision may be delivered by other members of the team including trainee doctors, provided they are competent to provide their supervision and there is appropriate clarity around delegation".

Draft guidance being developed by another royal college was not expected to support any scenario where PAs are supervised remotely or to have PAs working in out of hours settings. Another respondent said: "Remote supervision should never be appropriate for dependent practitioners with only 1600 hours of formal training".

5.4.4 Supervisor training

A need for training for supervisors of PAs echoed comments made in response to the previous question. For example:

- "We noted that few clinicians will have knowledge of the career development needs and what might constitute appropriate progress of PAs and there should be specific training in this subject. In the absence of a formal process with central oversight analogous to the postgraduate medical training schemes, it is not clear how this progress might be measured or monitored".

- "Recommendation 3.4 should be reworked. A supervising doctor should have undertaken formal training in supervision/development in order to take up the DS [developmental supervisor] role. The recommendation's current wording is not strict enough in this regard".

5.4.5 Implementation

A further theme related to implementation of the guidance with respect to these supervisory roles. This included flexibility to reflect local settings, the time involved in providing supervision, and the wider impact on the training of doctors. For example:

- "There needs to be a level of flexibility regarding whether both an educational and clinical supervisor is needed. In some teams, it is not realistic to have two separate roles, especially when the team is small. The guidance suggests that a consultant needs to be readily available to assist PAs all the time, which is prohibitive when other healthcare professionals, such as SAS Doctors can assist."

- "We would stress the importance that sufficient time is allocated to individuals undertaking these activities. It may be that the amount of supervision required (both clinical and developmental) is less for more senior PAs."

- "Whilst recommendation 4.5 is welcome, it could quickly require a significant portion of the CS's job plan – limiting the supervision they can provide for doctors in training, their own direct clinical care responsibilities, and other activities".

One respondent questioned whether the recommended time allocation for developmental supervisors (0.25 SPA or 1 hour per week) could be cumulative (e.g. 4-5 hours or one session a month).

Issues were raised around job planning of PA supervision and where funding would come from to enable this. One respondent observed that the long-term workforce plan does not address recognition of educator/supervisor time. For example:

- "We cannot currently fluently provide "developmental supervisors" for all medical trainees. The expectation that doctors take on the role of developmental supervisor without substantial change in job plans is deeply concerning. This applies to specialist and associate specialist doctors as much as consultants".

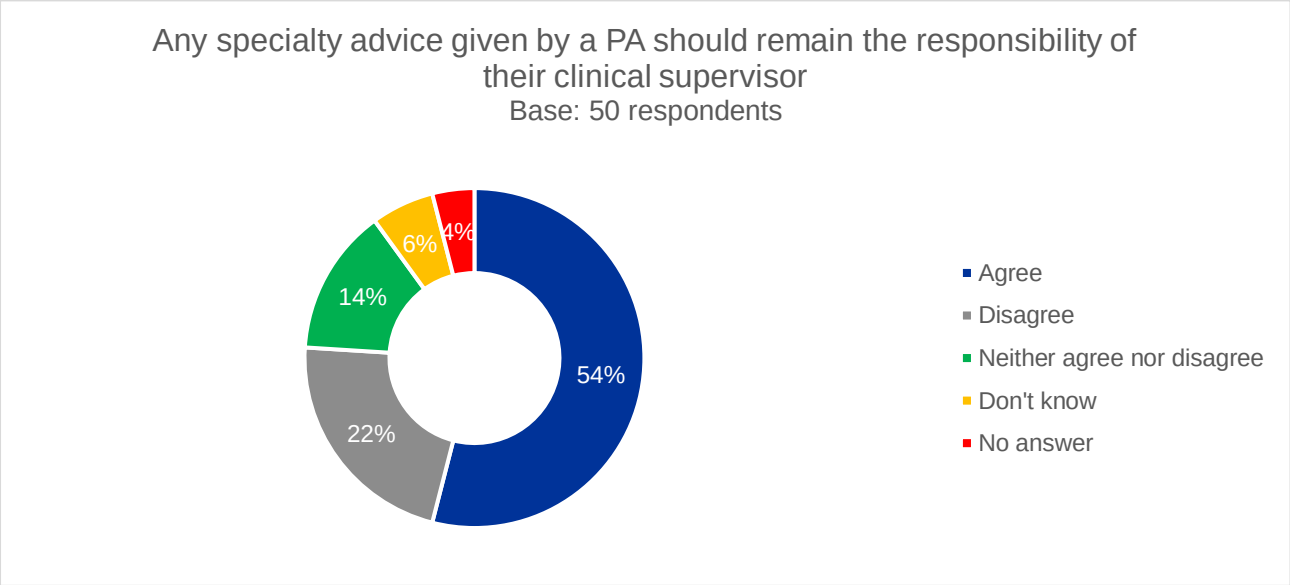
The burden on employers was also highlighted. "The time demand is prohibitive, and this would make the business case for PAs in practice null and void", said one respondent. The RCP was asked to reconsider the requirements and the effects they would have if implemented on doctor training. The draft guidance was thought to go further than existing NHS England guidance on supervision of primary care network multidisciplinary teams.[vii]

One respondent questioned whether the RCP's remit extended to defining titles and job descriptions on behalf of employers.

5.5 Levels of agreement regarding specialty advice

Over half (54%, 27 respondents) agreed that any specialty advice given by a PA should remain the responsibility of their clinical supervisor. Almost a quarter (22%, 11 respondents) disagreed and 14% (7 respondents) selected neither agree nor disagree; a further 6% (3 respondents) selected don't know and 2 left this question blank.

Figure 8: Responses to question on responsible for specialty advice given by a PA



5.6 Analysis of free text comments

The following themes were observed from the free text responses made with respect to this question.

5.6.1 Appropriateness of PAs giving specialty advice

While over half agreed to the statement, the free text comments revealed discomfort amongst many respondents over whether PAs should provide specialty advice at all, as highlighted by these comments:

- "I don't believe that PAs should be offering specialist advice, I think this is a competence that should remain outside their scope of practice. They could see referrals and perform histories/examinations, in order to speed up the review process for medical staff, following adequate training/experience, but I don't think they should be giving advice to medical staff".
- "This is difficult – if the PA does not have insight into their lack of knowledge, they may not appreciate their limitations and make not ask for advice. This is why they should not be working in roles where they see undifferentiated patients unless this is under very close supervision with review of every case by the consultant".
- "There are concerns from doctors as well about the advice that they receive from PAs given the lack of breadth and training they receive and the potential risks of following that advice".
- "In what circumstance should/would a PA at the point of qualification (which is what this guidance is aimed at) be giving specialty advice? Offering specialty advice is something that normally happens when doctors enter registrar training (4/5 years minimum post qualification) and so this seems inappropriate".
- "A PA may only repeat the advice of a consultant/autonomously practising SAS doctor and make it clear where this advice came from. In such cases, the advice remains the responsibility of the supervising doctor who provided it".

5.6.2 Clinical supervisor responsibility

The free text comments highlighted a need for greater clarity over clinical supervisor responsibility for advice given by a PA. Some respondents felt that the clinical supervisor should be responsible. For example:

- "It is vital any specialty advice given to PAs should remain the responsibility of their clinical supervisor because the role of a PA is a dependent role. Responsibility in this way reflects the level of training undertaken, and ensures PAs are supported in their role".
- "Important that responsibility for the overall care remains the consultant's responsibility".
- "We believe that all advice and actions undertaken by PAs must remain the responsibility of the clinical supervisor at the time, in the same way that the supervisor is responsible for all clinicians not on the specialist or GP register. Any PA making a clinical decision should follow the same escalation pathway as any other medical professional working that shift".
- "If a PA is allowed to provide specialty advice as a delegated duty from their supervisor, the responsibility for patient care stays with the doctor who delegated that task to the PA. The draft guidance should be amended to ensure that supervisors are aware of the additional risk they take when agreeing to supervise PAs".

More often however, respondents highlighted complexities and perceived unfairness in a clinical supervisor being expected to carry this responsibility. For example:

- "I think this can only be the case where the PA has sought advice and guidance appropriately from their clinical supervisor and worked strictly within an agreed scope of practice".
- "Only the consultant responsible for signing off the relevant competency for the PA should be responsible if they are found to not be competent. A supervising consultant who has not had time to assess or sign off a competency has but is forced to act as a supervisor cannot be held responsible".
- "When a PA has consulted with their clinical supervisor then the specialty advice will be the delegated responsibility of the clinical supervisor. If the specialty advice has been given directly without consultation with the supervisor, then it should remain the responsibility of the PA".
- "PA's clinical decisions need to be discussed with and remain the responsibility of the most senior doctor managing that clinical scenario. The CS [clinical supervisor] does not have the time (and is often unaware of the clinical context) to manage all specialty advice".
- "PAs, despite how good their training may be, aren't doctors, and their knowledge and experience will be limited. Therefore, there's a higher risk of making mistakes that could harm the reputation of those who are good and fully trained doctors (CSs)".
- "It is unclear exactly how this would work in a court of law – especially when the PA's named CS [clinical supervisor] is away/ not available".
- "It is different in degree to the supervision of a trainee doctor and puts undue responsibility on the supervisor".
- "The indemnity for this should be considered before agreement, in worst case scenario planning".
- "How can the supervisor control what a PA says if they are not immediately present?"

- "Where PAs are in a position to give any clinical advice, this should be under the auspices of the direct supervising consultant nominated for that patient (or associate specialist) not necessarily their Clinical Supervisor".

One respondent observed that the guidance states that the clinical supervisor retains clinical and professional responsibility for patients treated under their care, including where a PA is involved in delivering that care (page 10), and yet also states that PAs are responsible for their own practice (page 10), and caveats suggesting the PA can seek and accept advice from resident doctors from FY2 and above (page 11). This respondent said: "It is therefore not clear where responsibility for 'specialty advice' given by PAs lies. The guidance must be clarified in this regard". Similarly, another said: "This statement seems at odds with the information in section 6.2 where the guidance states that, with correct supervision and delegated to appropriately, that the PA is responsible and accountable for their own practice".

Specific and distinct requirements relating to PAs working with children and young people were highlighted.

5.6.3 GMC standards on delegation

Several respondents believed the draft guidance did not align with Good Medical Practice or with GMC guidance on delegation and referral. For example:

- "We suggest that this is consulted on with the GMC. This seems to breach GMP [Good Medical Practice] and try to insinuate a new standard where consultants are vicariously liable for the actions of those they supervise which is misinformation and has already been rebuked by the GMC. Please reconsider".

- "This also appears to contradict the GMC guidance on delegation, which suggests the responsibility of delegation is shared between the delegator and those delegated to. A clinical supervisor simply cannot control what a PA says, and so shared responsibility, as opposed to sole responsibility, is needed".

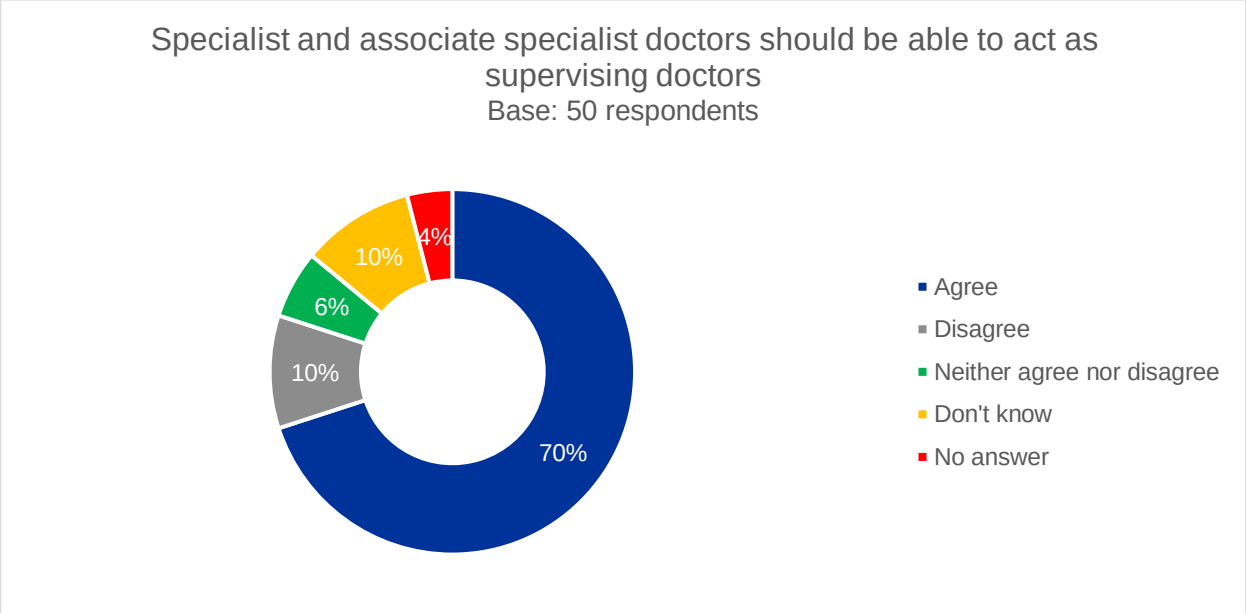
Another respondent emphasised that the guidance "should be consistent with current guidance on delegated responsibility which applies to doctors in training roles and advanced practitioners". This respondent was keen to see an emphasis in recommendation 4.4 (page 10) on the importance of effective communication at all levels to ensure safe delegated responsibility.

One respondent encouraged the RCP to seek a consensus position jointly with the BMA on this issue.

5.7 Levels of agreement regarding supervision by specialist and associate specialists

This statement attracted the highest level of agreement across all the consultation questions – 70% (35 respondents) agreed; 10% (5 respondents) disagreed; 6% (3 respondents) answered neither agree nor disagree (the lowest across all the questions); and 10% (5 respondents) answered don't know.

Figure 9: Responses to question on supervision by specialist and associate specialist doctors



5.8 Analysis of free text comments

There were fewer comments next to this question and most of those expanded on agreement with the statement.

5.8.1 Agreement with caveats

Most comments spoke to agreement with the statement that specialist and associate specialist doctors should be able to act as supervising doctors for PAs. For example:

- "These clinical roles are more than capable of carrying out this task, again with suitable allocation of time in job plans".
- "The current bar to become a supervisor of a PA is set too high, and registrar level supervision is the most appropriate level to start supervising a PA, including SAS doctors".
- "Specialist and associate specialist clinicians work autonomously, and we see no reason they should not act in supervisory roles as they do for doctors and other healthcare professionals".
- "Specialist and associate specialist doctors supervise clinical fellows etc. so why not PAs – it will help".
- "We support any senior clinician who has been trained appropriately and wishes to undertake this role to act as supervisor to PAs including specialist and associate specialist doctors".

Several caveats were highlighted, including: only where these doctors hold an independent caseload/ are practising autonomously; have time available to undertake the role; are willing to undertake the role (it should be a personal choice); and have confidence to supervise PAs. For example:

- "This is a positive change. Many specialist and associate specialist doctors have enormous experience and a great interest in education and training, so it makes sense to have them as supervisors of PAs. They are permanent members of staff so are key to a good, functioning clinical team. They have much to contribute to supervision. They should of course be autonomously practising doctors in their own right if they do take on this role".

- "If they are on the GMC register of recognised trainers, it is entirely appropriate for specialist and associate specialist doctors to be allowed to supervise PAs if they consent to taking on that responsibility".

Some respondents believed that PA supervision was straightforward for specialist and associate specialist doctors on the specialist register but would depend on other factors for those who were not. Others focused on the doctors' level of seniority. For example:

- "We are of the opinion that those SAS doctors on the specialist register are equivalent in responsibilities to consultants and should be able to supervise PAs. For those not on the specialist register, it would depend on their specific individual circumstances. This would also need to be recognised in job planning".

- "Specialist doctors (providing they have a defined level of seniority eg in keeping with the 'Trust Grade' system) should be able to act as supervising doctors".

- "Senior hospital grades (associate specialists) act as ESs [educational supervisors] in many Trusts. They are senior doctors and should undertake these wider responsibilities.

Some caveats focused on the doctor having experience and training in clinical supervision. For example:

- "This element of the guidance is welcome. The SAS doctors in question must have the requisite levels of experience and expertise to take up the clinical supervisor role".

- "SAS doctors also need time and training to act as supervisors – and often, they do not get much, if any, SPA time in their job plans. This must be accounted for if SAS doctors are to supervise PAs".

One focused on the need for the supervisor to be in a substantive post:

- "It would depend on whether they are permanent in the team or if they rotate on as this would cause instability for the PA and lack of assurance that the PA is getting annual appraisals".

Draft guidance being developed by another royal college was expected to take a different approach regarding the level of doctor who could supervise a PA.

5.8.2 Other issues

The specific and distinct requirements of PAs working with children and young people were highlighted, including that any named supervisor of PAs in paediatrics must be a paediatric doctor on the GMC specialist register.

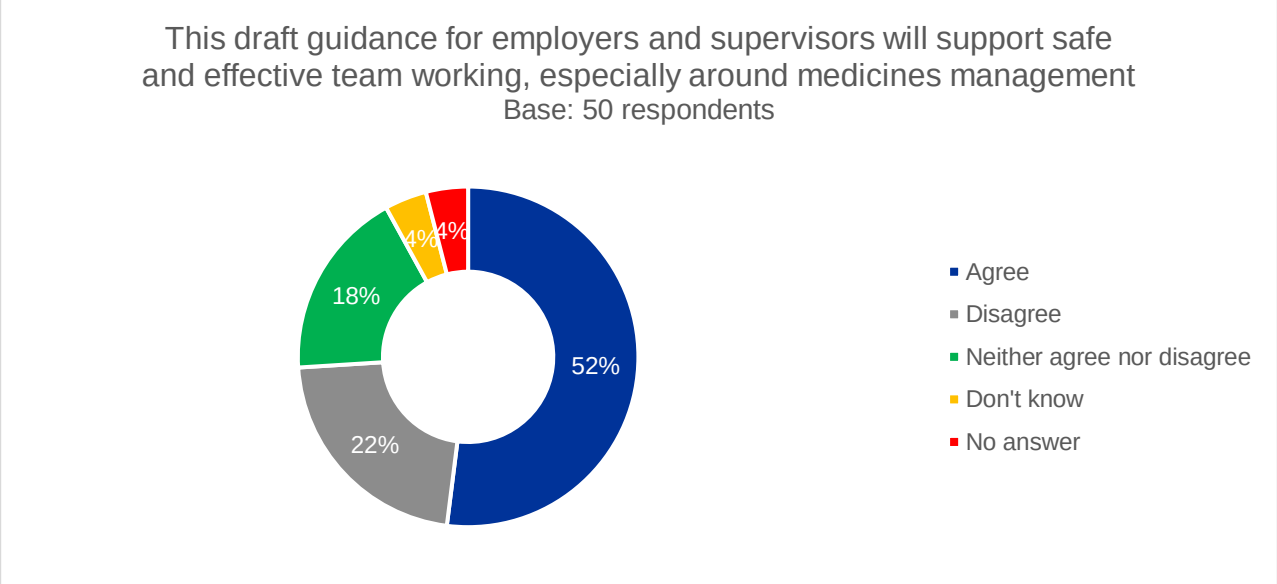
One respondent argued that clinical supervision should not be restricted only to specialist or associate specialist doctors, consultants and GPs, and said it may be delivered by other members of the team including "trainee doctors", provided they are competent to provide this supervision and there is appropriate clarity around delegation. Another respondent said: "This document may well damage the ability for the take to operate and force a situation where we end up with a consultant-led PA take and a junior doctor and reg [registrar] led take. This would not be acceptable to have dual pathways".

6. Working in a team

6.1 Levels of agreement with the question

More than half (52%, 26 respondents) agreed that the draft guidance would support safe and effective team working, especially around medicines management. Just over a fifth (22%, 11 respondents) disagreed and 18% (9 respondents) selected neither agree nor disagree. Two respondents answered don't know and two did not answer this question.

Figure 10: Responses to question on working in a team



6.2 Analysis of free text comments

The following themes surfaced from the free text responses made in response to this question.

6.2.1 Support for the principle

Several respondents voiced support for the thrust of the draft guidance regarding team working and medicines management, as illustrated by the following quotes:

- "This helps clarify the current position while PAs cannot prescribe".
- "This is a patient safety issue and makes complete sense".
- "This is clear and prioritises patient safety".
- "The way that PAs can work as an integral part of the medical team is clear in the document".
- "The description of expectations around the referral process is useful".
- "PAs should be facilitated to make recommendations and suggestions about medication, as this is what they are trained to do and are examined on".

A minority of respondents were opposed to the idea of PAs providing prescribing advice. For example:

- "Physician associates are not prescribers and should not be providing prescribing advice".

- "PAs do not have formal training in pharmacology nor physiology in enough detail to be able to recommend any medications for patients. They must not alter medications nor prescribe them. It is our opinion that PAs should not be directing any doctor to prescribe or alter medications given their lack of qualifications".

A couple of respondents wanted to see this section tightened to ensure that PAs do not act outside their remit and alter medications or offer advice on medication management. For example:

- "It should be stated clearly and simply at the very beginning of this section that PAs cannot and should not prescribe".

- "Guidance must be designed to account for human behaviour, known pressures, and incentives. Doctors working in a busy department who are approached by a PA recommending a drug be prescribed are under significant pressure to accept the PA's recommendation – both practical (they often don't have time to see every patient themselves again to verify the PA's findings) and sociological (it is often difficult to refuse a colleague's well-intentioned and seemingly-reasonable request). This guidance does not protect patients, doctors, or PAs from those pressures by setting the clear boundaries necessary: PAs should not be making prescribing recommendations".

6.2.2 Implementation with respect to prescribing

Whilst some supportive comments were made about the underlying principles, many respondents raised issues regarding implementation. This reflected concern that the draft guidance was unrealistic, particularly with respect to supervision. As one said: "Great in theory but completely unworkable in practice".

Concerns centred on the supervising doctor not being immediately available to respond to PA prescribing referrals and about the need for patient review before prescribing. Some of the comments pointed to a need for further consideration of the practicalities of doctors treating their own patients, whilst also supervising PAs and undertaking prescribing on referral from a PA. A recurring message was that it would fall to less experienced doctors to respond to PA prescribing referrals, not least to avoid patients waiting for a PA supervising doctor to prescribe urgent medications. For example:

- "There should be practical guidance around the level of review required by the supervising doctor. It's not practical for the doctor to re-review a patient before prescribing every time."

- "Prescribing on behalf of PAs by anyone other than their named supervisor should be discouraged".

- "It is impractical to think that consultants will be doing the majority of the prescribing for PAs. Stating it should be their 'supervising doctor whenever possible' does little to ensure that this happens. Stating it should be a fully registered prescriber allows F2s to do this role. And in the real world it will be F2s and not consultants who will be approached to do this day to day".

- "The supervising consultant will often not be around on the ward. It will lead to them referring to F2 and above which is unfair on these doctors. The doctors will resent it, or they will follow what the PA says without appropriately checking as that will be seen as a duplication of work".

- The doctor being consulted is unlikely to have the time or capacity to fully review the patient and decide if the prescription is correct but will be hassled into prescribing".

- "The prescribing doctor will have to take additional time to assess the patient and the case appropriately to see if the prescription is appropriate".

The wording in recommendation 6.3 ('wherever possible, this should be the supervising doctor') was regarded as ambiguous and open to misinterpretation. A question was raised over recommendation 6.4

('When prescribing based on the referral of a PA, a prescriber must be satisfied that the prescription is necessary, appropriate for the patient and within the limits of both the PA's and their own competence') and how a resident doctor should be expected to assess the limits of the PA's competence.

A question was raised over protections in place for doctors who prescribed based on a PA recommendation. There were also calls for the document to state explicitly that doctors have the right to refuse to prescribe for PAs.

6.2.3 The most senior doctor available

A minority disagreed with the emphasis in section 7.1 (page 11) that PAs should seek advice and guidance from the most senior available doctor. For example:

- "It is perfectly acceptable for PAs to seek advice and guidance from the wider medical team in order to facilitate good patient care. Please do not put statements in here that will lead to delays in patient care."
- "It is vital that resident doctors gain experience training and supervising other team members. Therefore, resident doctors' job plans, where possible, should reflect the time required for supervising or training PAs, under which this activity would fall".

One respondent observed that PAs are trained in preparing prescriptions and are involved in prescribing decisions and that this is reflected in the GMC's professional standards guidance (Good Medical Practice, paragraph 7). The statement in the guidance that 'PAs need to refer any prescribing matters to a fully registered prescriber….' was said not to align with how the GMC understands the role of PAs in proposing and providing prescriptions. "We are concerned there may be a negative impact on patient care if PAs are barred from doing tasks which would help reduce doctors' workloads (e.g. preparing discharge summaries),"said one.

6.2.4 MDT and non-medical prescribers

Some respondents pointed at a lack of congruence between the draft guidance and contemporary practice in terms of MDT working. Some took issue with the guidance that 'PAs should only refer matters related to prescribing to fully registered doctors' (page 12, paragraph 1) and argued this should be extended to "any registered prescriber whether medical or non-medical prescriber" or "any qualified prescriber". The absence of reference to non-medical prescribers was a source of confusion for some. For example:

- "This creates the idea that PAs and doctors should wait for CS [clinical supervision] availability rather than seek advice from a colleague. The fact that the RCP is accidentally stating here that PAs and doctors should wait until the patient is unstable to speak to a colleague, rather than utilising the MDT, will create a delay in patient care. We propose "doctors or to a relevant qualified health professional with prescribing rights, working within their scope of practice as per their regulator".
- "What is the intended relationship with advanced nurse practitioners, and AHPs, for example, with qualifications in advanced or specialist practice, many of whom are rightly used to prescribing drugs and advising doctors. I understand this is coming from RCP but I suggest the other professions should at least be referenced and cannot not be ignored in the real workplace setting or we are setting hostages to fortune".

Some respondents questioned whether PAs will be able to undertake non-medical prescribing in the future. For example:

- "I don't see why not, especially if trained in medicine management as part of the curriculum," said one. "Any PA prescribing medication should at least complete and pass the same course as advanced practitioners".

- "PAs may be granted prescribing rights in future should the UK government decide to legislate for this following the introduction of regulation, which would require the guidance to be revised".

6.2.5 Ionising radiation

Similar issues to prescribing were also raised with respect to ionising radiation, with questions about the practicalities of expecting the PA's supervising doctor to be the one consulted about imaging requests "wherever possible." However, a key inaccuracy was raised regarding the outlook for PAs and requests for ionising radiation, which the guidance will need to consider. The guidance was thought to imply that PAs will be unable to order ionising radiation once regulated, which was highlighted as incorrect by two respondents:

- "Registered healthcare professionals can request ionising radiation for patients as 'non-medical referrers' (NMRs) providing their employer has entitled them and they have undergone the appropriate training. The position statement from the British Institute of Radiology provides further detail on the training and governance requirements for NMRs and the different types of entitlement.[viii] PAs may be able to become NMRs once they are registered with the GMC".

- "In December 2024, PAs will become regulated by the General Medical Council; this will potentially remove the obstacle to their being able to request ionising radiation created by IR(ME)R. It would be sensible if the focus were to shift towards training PAs and setting appropriate levels of responsibility under IR(ME)R, as is the case with other staff groups".

In the meantime, another respondent recommended specific changes to section 7.3 (page 12) regarding referral to ionising radiation (that it should be updated to clarify that PAs will need "to" refer to "their clinical supervisor" or the most appropriate "registered" healthcare professional who is entitled to refer for such imaging) and further detail regarding the role and responsibilities of the IR(ME)R referrer, who is submitting a request following a request from the PA. This respondent asked:

- "The person who submits the request for imaging (IR(ME)R referrer) will be responsible for making the request rather than the PA. The IR(ME)R referrer will also need to act on the clinical evaluation findings and potentially be responsible for dealing with any accidental or unintended exposures. What happens if [a] PA asks for an x-ray referral to be generated on the wrong patient?"

It was suggested that a recommendation should be inserted into section 6 to the effect that the referrer must be satisfied that ionising radiation is necessary and appropriate for the patient.

6.2.6 Specific patient populations and settings

Emphasis was placed on specialty-specific training for PAs caring for certain patient populations (such as children and young people). One respondent called for a "clear national capability framework from the NHS across the four UK nations" to provide an assured level of competence to define scope of practice that all employers would need to adopt, adding: "This is the only way to robustly regulate healthcare professionals and ensure lines of responsibility and accountability between professions are made clear to ultimately keep all patients safe". They added such work would need to be centrally mandated and externally funded.

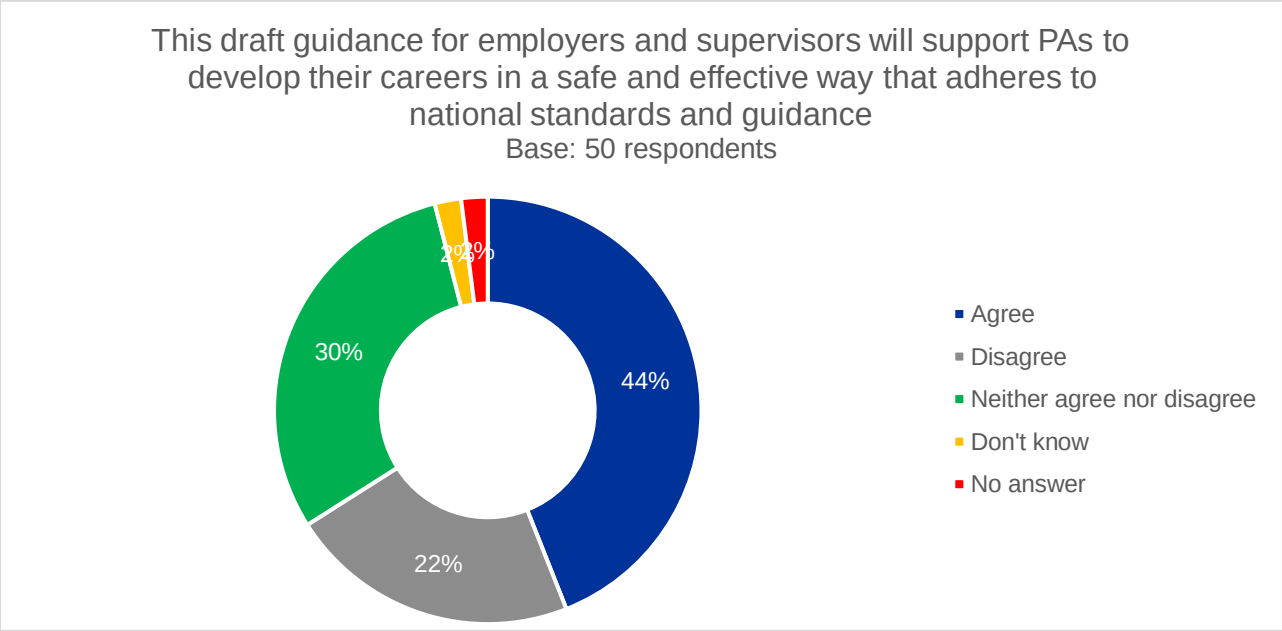
Cardiology was another area where specialty-specific focus was highlighted. "Prescribing and therapeutics decisions in cardiology are recognised to be complex due to the potential for interactions and also the coexistence of multimorbidity and frailty. Drug prescriptions and administration can therefore be potential significant sources of harm and error in clinical practice. Training of doctors and other prescribers includes robust, nationally agreed and assessed education in prescribing and therapeutics. Physician associate courses do not have this and will not have this even when regulation begins," said one respondent.

7. Career development

7.1 Levels of agreement with the question

Less than half, 44% (22 respondents), agreed that the guidance would support PAs to develop their careers safely and effectively. Nearly a third, 30% (15 respondents), selected neither agree nor disagree, and just over a fifth, 22% (11 respondents), disagreed. Two respondents did not know or did not answer this question.

Figure 11: Responses to question on career development



7.2 Analysis of free text comments

Underpinning many of the free text comments was uncertainty over whether PAs should be regarded in the same way as other health professionals within a MDT, or closely aligned to medicine and therefore drawing on the same tools for assessment and career progression that are used for postgraduate medical training.

7.2.1 Support for the principle

There was support from some for the principle of PA career development. Providing PAs with opportunities to progress was seen as an acknowledgement that their skills will evolve with experience and training. It was also considered to be essential for the recruitment and retention of PAs and aligned with wider allied health professional frameworks. For example:

- "I'm very much in favour of this. Up to now, PAs were the only staff group where once they took up posts there didn't seem to be any clear route for progression so I'm glad to see this is being addressed".
- "In planning a future workforce, taking a skills and capabilities approach enhances planning of what and who is required where. Additionally, career opportunities and equitable access are both important [to] enhance recruitment and retention of skilled staff in varied forms."

At the other end of the spectrum, several respondents questioned the desirability of career development opportunities for PAs. For example:

- "Doctors are up in arms at their treatment anyway. Do you want to finish the job?"
- "It will support the PAs to develop, which is great for them, but it will lead to them definitely taking roles from doctors".

One respondent expressed a preference for developing additional clinical, practical, managerial, leadership and academic skills in resident doctors and doctors in training. Another worried that the inability of PAs to prescribe (medicines or x-rays) would risk them being drawn towards leadership, managerial or academic areas and lost to the clinical setting, raising another potential area of friction with doctors. A call for a full consultation process if any future national development of the PA role proposed that supervision by a doctor was no longer required in specialty settings, underlined the worry of doctors being sidelined.

Those uncertain at the impact of PA career progressions were most likely to call for examples of potential career trajectories and development pathways within different specialties.

7.2.2 Responsibility for training pathways and competency assessments

A second theme related to who will be responsible for developing the training pathway and how such work will be resourced. This appeared to be a particular issue for specialist societies in having the necessary resources to develop competency pathways. One respondent argued that specialist societies could "contribute members to assist a medical royal college committee to develop these pathways rather than taking the lead role in development". One respondent opposed the onus placed on medical royal colleges by recommendation 7.1 (that medical royal colleges and specialist societies should develop defined pathways for training and competency assessments, following multi-stakeholder participation and in collaboration), arguing that responsibility should be shared between the medical royal colleges and the Faculty of Physician Associates. Emphasis was placed on the final guidance clarifying this joint responsibility and "the scale of this piece of work and the resources that would be required to deliver it well".

There was some uncertainty over the interface between professional bodies, like specialty societies, and local employer-led arrangements, with some cautioning against local skills or competency assessment. For example:

- "Early on, there should be a defined specialty pathway led by the medical royal colleges and supported by specialist societies. However, once the PA reaches a more advanced level, then the local team should have the flexibility to decide what duties a PA can undertake within the close governance structure in place locally".
- "A PA has only a two-year postgraduate qualification with 1600 hours of clinical skills and education. They sit no further nationally set postgraduate exams to demonstrate any additional competencies gained; the *"defined training pathway"* mentioned in the guidance does not exist. It is unsafe and inappropriate for their scope to be expanded based on local assessment of their skills".

One respondent expressed concern for patient harm by allowing "subjective local judgement for whether a PA is competent or not" and pointed out that competency in an isolated skill (e.g. to remove a chest drain) does not mean a PA is able to recognise and manage complications that may arise. This respondent argued for nationally set limits to a PA's scope of practice. Another respondent reinforced the case for a national scope/ceiling of practice and to discourage locally developed scope of practice.

One respondent called for clearer guidance for employers about the requirements for PAs to meet their career development and continuing professional development (CPD). Another emphasised the need for employers and NHS England to develop mechanisms for PAs to continue their postgraduate education that mirror arrangements for other healthcare professionals. One questioned whether employers would be

mandated to work within scope of practice, defined pathways of training and competency assessments set by specialist societies and medical royal colleges.

Instead of the phrase 'progressing within a scope of practice', one suggestion was instead: "PAs may develop their individual scope of practice by following a defined pathway". The document was though to rely heavily on the existence of 'nationally agreed development pathways' and it was unclear what will happen where these do not exist in a particular specialty or area of work, or are contested. This respondent added: "If this guidance is extended on a UK-wide, the term 'nationally', which is used throughout the document, may need replacing. It may be more appropriate to refer to 'specialty-specific development pathways'".

The guidance mentioned multi-stakeholder engagement, however one comment focused specifically on including patient and carer perspectives in developing training programmes and the use of lay examiners.

7.2.3 Assessment tools

There appeared to be an assumption amongst some respondents that the same tools used for medical career progression would need to be applied within the PA context. For example:

- "They must follow the same pathways and curriculum in the style of medical specialties if the FPA would like to develop specialties and their associated curricula."
- "Ultimately career development will only be able to be appropriately quality assured if a system of certification, based either on the prospective method seen in medical training, the CESR/portfolio route or some other mechanism such as "credentialling" is developed." This respondent also argued for regular multi-source feedback (MSF) and patient surveys to be considered alongside CPD.

One respondent cautioned against developmental pathways becoming too specialist ("niche").

7.2.4 Terminology

Some comments were made about specific aspects of the guidance, as follows:

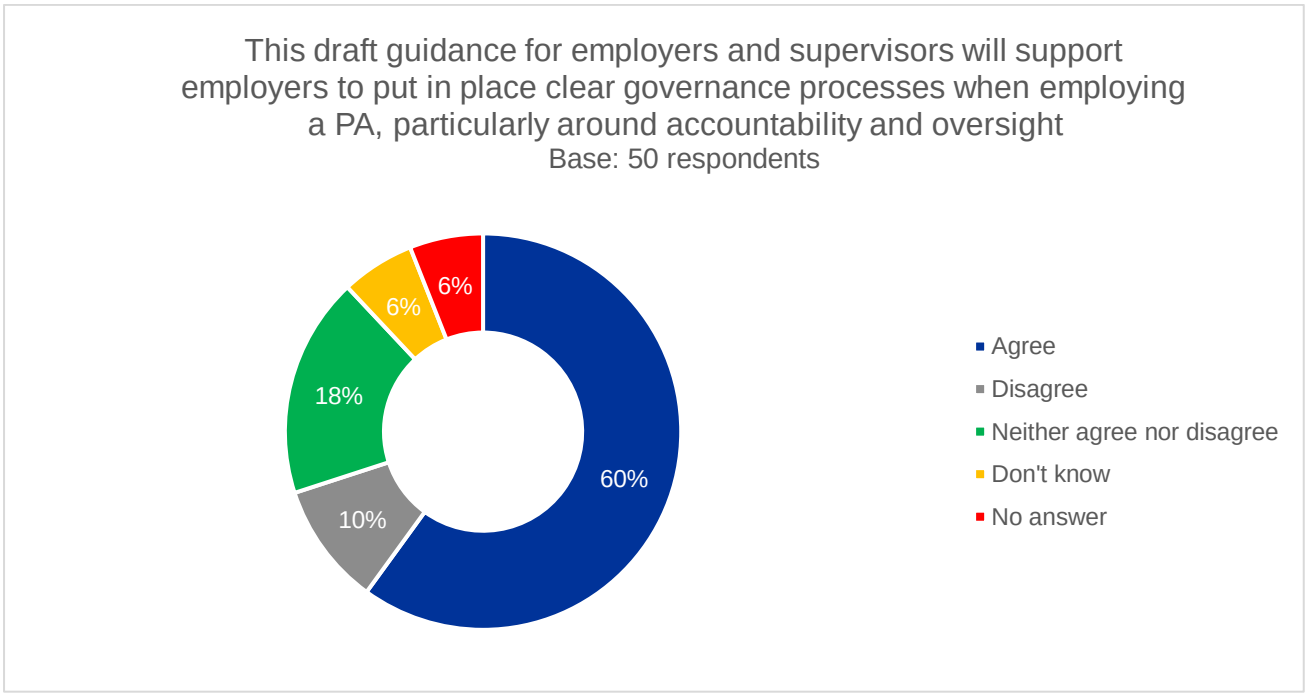
- One respondent disagreed with the statement that PAs 'must follow a defined training pathway' (page 12), adding: "I do not think that PAs "must" follow a training pathway; unless they are looking for further specialist development."
- Section 5.1, a distinction between entry-level knowledge and skills, and entry-level scope of practice was highlighted.
- Section 5.1, paragraph 1, states that the PA course is quality assessed internally and externally. One respondent observed that the GMC will need to approve all PA courses and quality assure them against its standards and the PA curriculum after the start of regulation.
- Section 5.1, paragraph 4, one respondent observed that it would be useful to reflect the role of the GMC in setting standards for PAs when regulation begins at the end of 2024.
- One respondent commented that "individual" should be added before scope in recommendation 7.1.
- A need for clarity was highlighted with respect to recommendation 7.4, which referred to regular review of development pathways and oversight by the regulator. This respondent questioned who was the regulator and what should oversight entail?
- Reference is made to the FPA e-portfolio (page 13) – one respondent questioned whether this should be replaced by reference to a generic portfolio (rather than the FPA one).

8. Governance structures

8.1 Levels of agreement with the question

There was agreement among 60% (30 respondents) that the draft guidance would support employers to put in place clear governance processes when employing a PA, as shown in figure 12. This was the joint second highest level of agreement to a consultation question. In all, 10% (5 respondents) disagreed and 18% (9 respondents) selected neither agree nor disagree. Three respondents answered don't know and the same number did not answer this question.

Figure 12: Responses to question on governance structures



8.2 Analysis of free text comments

8.2.1 Employer oversight

Some comments elaborated on the agreement given in response to the question. For example:

- "The guidance provides clear recommendations for employers on the governance processes that should be in place".
- "This document helps by adding clarity to where the responsibility for governance belongs, which is with the employer".
- "Employers have a statutory responsibility to do this for all clinical staff, PAs are no exception".

Others perceived the guidance to represent a shift in accountability to employers, or felt the guidance was unclear on where PAs sit within organisational structures. For example:

- "While we strongly agree with the statement 'organisations must have clear governance processes' and welcome the recommendation that the MD/CMO should provide oversight, we think the guidance is unclear on where the College believes PAs should sit within the organisational structure".

One argued for organisational oversight of PAs to be the responsibility of the Responsible Office of the Trust/Board. There was a call for patients and carers to be embedded in governance processes, and mechanisms for accountability and oversight. One asked whether medical directors outside of the RCP had been consulted widely in preparing the guidance.

8.2.2 Implementation and enforcement

Several raised issues over implementation of the guidance at local level and observed that its effectiveness will depend on the way employers respond to the recommendations. For example:

- "Governance structures are only as good as the people who make the decisions…If PAs are included in the governance structures of an already weak organisation, then it spells disaster. Just having a document changes nothing, it has to be implemented and adhered to".
- "Completely unclear how this will work in practice on the wards."
- "If a Trust does not follow the guidance, who will hold them to account and what resolution would be achieved?"

Several questioned how employers would be supported to deliver the recommendations. Recommendation 9.3 (employers must ensure that there is an appropriate level of senior medical supervision and that clinical and developmental supervisors have the resources and organisational support to deliver their role), was described by one respondent as "an extremely challenging requirement to meet" and they considered it "unrealistic to assume it will be met without an increase in training capacity". The risk of local variation was highlighted, together with "the possibility of employers prioritising PAs over rotating resident/specialist training doctors due to the fact that PAs can provide continuity and permanence".

Several respondents envisaged that the GMC will be able to mandate standards. One was keen for the document to outline how colleagues can escalate concerns about the actions of a PA if local processes fail.

One respondent offered to help the RCP by working directly with employers. Another reinforced the importance of a collaborative approach amongst professional bodies, Royal Colleges and specialist societies.

8.2.3 Alignment with other health professionals

Some comments built on a theme identified earlier that the approach to PAs did not align with the approach taken to other healthcare professionals. For example:

- "There must be clear governance structures in place for patient safety. However, the guidance appears to be restrictive to employers wishing to employ PAs and more so than any other healthcare role. For example, it is unlikely to be realistic for all employers to gain permission from every team member before the employment process can start".
- "We question the proportionality of measures such as seeking the agreement if all team members before employing PAs given this is not the approach taken for any other roles".

Similarly, others questioned whether recommendation 15.3 (policies must set out the processes for monitoring of key patient safety indicators, experience and outcome measures in relation to the work of PAs) aligned with policies "for any other cohort of staff or profession". The RCP would be expected, argued one respondent, to provide evidence of a similar policy existing for other staff cohorts or professions to justify the recommendation.

One argued that employer governance structures "must be identical to those in place for doctors, if PAs continue to be regulated by the GMC." Another questioned the suggestion that PAs on the PAMVR (PA managed voluntary register) may add the letters 'PA-R' as a postnominal, pointing out that "a postnominal

denotes a qualification, not a registration." One responded tried to clarify the governance position for PAs, as follows:

- "PAs are dependent healthcare workers but are also on the Agenda for Change contract. While they should have clear supervision rules and oversight from consultants/ autonomously practising SAS for the clinical work done in the doctor's name, the rest of the governance could sit appropriately within other Agenda for Change frameworks".

8.2.4 Specific patient populations and settings

One respondent drew attention to specific requirements needed for PAs who see children and young people (CYP) within their clinical practice, in terms of further relevant child health training both during their PA course and additional training on graduation. "Guidance, regulatory processes and revalidation requirements should therefore meet necessary standards for the safe delivery of care for CYP and their families irrespective of specialty," they said. Where PAs have points of contact with CYP, whether that feeds into paediatrics services or not, there needs to be assurances that these roles have appropriate senior medical supervision. This respondent added: "Consideration will be needed on how annual appraisals should take place for PAs working in specialised areas such as paediatrics, and who is the named responsible officer within a healthcare organisation. Any concerns raised about PAs working in paediatrics should be assessed by those who are experienced with these patient populations, families and carers."

Concern was expressed over the extent to which GP practices would adopt the guidance. One observation was that terminology used around medical directors and chief medical officers (recommendation 15.1) did not align with primary care settings, which do not have such roles.

8.2.5 Terminology

Some comments were made about specific aspects of the guidance, as follows:

- Revalidation – PAs' registration will not be 'renewed'. There is a requirement to pay an annual fee and engage with revalidation. Failure to do those two things could result in removal from the register". A preference was expressed for reference to the GMC's revalidation requirements to be separated out from the guidance around CPD requirements for voluntary registrants on page 8. This responded added that it was not quite right to say that revalidation 'will become a legal requirement after the transition period', as it will be subject to consultation.
- Use of the word "possible" in recommendation 11.1 and with respect to prescribing and radiology requests, was thought to be open to interpretation and therefore risk.
- Reference to 'access restrictions on clinical systems' in recommendation 15.2 was unclear to one respondent, who requested an example of such access restrictions.
- One respondent said the statement at the end of section 10.5 on restricting access to clinical IT systems (page 17) should be changed from "due to current legislation" to "in accordance with current legislation". This same suggestion was made with respect to section 7.3.
- One respondent sought clarity on what was meant by "HR expertise in PA management".

9. Additional feedback

9.1 Analysis of free text comments

The free text comments at the end of the consultation provided room for respondents to raise a range of questions. These built on existing themes with respect to the PA role, supervision, scope of practice and implementation. There were some positive comments about the draft guidance, including that it was "well-written and covers key aspects". One respondent expressed thanks for the "hard work" and thought that had gone into the document. Another described it as "well-constructed and very specific around supervision levels and responsibilities."

9.1.1 PA role

Many of the additional comments highlighted uncertainty over the role of the PA, including how patients would comprehend it. For example:

- "We are still not certain of the precise role of PAs within [named specialty], but there are definite advantages to some specific parts of the role (as originally envisaged) such as scribing during ward rounds, doing discharge letters and other tasks, thereby freeing up doctors to enable training but also help improve patient flow… but we are unsure of any benefit over and above a specialist nurse, clinical scientist (with physiology background), ACP or a junior doctor".

- "A PA is not a nurse, not a pharmacist, not a doctor, not a paramedic, then what is it?"

A recurring request was for case examples to understand where PAs have been used successfully.

A specific tension was highlighted with respect to guidance statements that PAs should not be regarded as replacements for doctors and should never replace a doctor on a rota (page 3). For example:

- "There are a few instances where the text is pandering to current tastes. An early example is, 'They should not be regarded as replacements for doctors, and they should never replace a doctor on a rota.' Given the current climate, I fully understand the use of language such as this. However, the GMC should be above this and support the RCP in moderating its language. Junior doctors have been replaced effectively on the morning phlebotomy rounds as well as the terrible morning ECG round. There is really no reason why a PA could not replace a doctor for a specific role (with the caveats noted in the document). While an on take rota might be different, there are other rotas where a PA could replace a doctor such as the staying-behind-while-everyone-else-goes-for-teaching rota".

- "This document encounters difficulty where it proposes that PAs cannot replace medical roles. Greater clarity is required regarding how the skills and capabilities of PAs add to an increasingly diverse workforce model responding to changing service needs…Where experience, training and suitable governance is in place, PAs could contribute to out of hours duties as part of rotas which may also include doctors in training and advanced practitioners. It is accepted that this may be limited at present by the inability to independently prescribe or request radiological investigations but when that becomes possible, PAs are likely to have a role in supporting rotas".

- "While we fully understand the current difficult climate surrounding PAs, the tenor of the document is not aligned with the more holistic and inclusive approach to medicine adopted by the GMC. For example, the document states early on that PAs should never replace a doctor on a rota. This would be sensible for on take rotas. However, doctors have gratefully been replaced on the morning phlebotomy rotas. Generally, it would be preferable if the document could rise above the recent negativity and take a more inclusion and uplifting approach within the boundaries of patient safety, governance, capability development and scope of practice".

9.1.2 Supervision

Additional comments made with respect to supervision, included support for the time allocated for clinical supervision and developmental meetings with PAs, but concern that no extra time is provided for trainees, GPs with a specialist interest or extended scope practitioners. A couple of comments raised the issue of doctors who do not want to supervise PAs, given GMC guidance on delegation. The minimum seniority for a registered prescriber if the supervising doctor were to be unavailable was also queried.

9.1.3 Scope of practice

Some respondents took the opportunity to raise specific issues regarding PA scope of practice, as follows:

- Page 7, section 5, scope of practice, "In the UK, PAs cannot prescribe medications, refer patients for ionising radiation imaging studies, or sign death certificates." One respondent observed a lack of clarity between that statement and the table on page 8, which stated that "the newly qualified PA can be expected to: request, perform and interpret diagnostic studies and therapeutic procedures, and recommend a management plan, including therapeutics." They suggested that it should be made clear that this excludes diagnostic studies and therapeutic procedures that involve exposure to ionising radiation.

- One questioned whether ECG interpretation and blood gas analysis would apply to stable patients only, and what the pathway would be where a PA was unable to interpret a result.

- One respondent argued for PAs not to be allowed to refer patients for any imaging (e.g. MRIs) or be able to perform ultrasound-guided procedures, on the grounds that they are not trained in postgraduate ultrasound and cannot prescribe or administer the related medication.

- In relation to annual appraisal there was some confusion as to how this would help "understand the full scope of the PA's role" and more clarity was requested. Some concerns were raised about the apparent lack of externality in terms of PA annual appraisals and again, more clarity was sought.

- It was suggested that the guidance include information "on the task of clinical evaluation as well as referral, and the corresponding IR(ME)R operator role and responsibilities, in regards to PA's training and entitlement requirements, scope of practice, governance etc".

- In terms of consent, one questioned: "Is it appropriate that PAs are held to a higher standard than doctors with regards to gaining consent? i.e. PAs must be fully trained in the specific procedure/Rx [medical prescription]. Whereas (junior) doctors need to be competent to gain consent and understand what is being proposed but are not necessarily fully trained."

9.1.4 Implementation and enforcement

Echoing concerns raised in response to specific consultation questions, many of the additional comments spoke to issues around implementation and enforcement of the guidance, and ongoing monitoring, as illustrated by the following comments:

- "The key to safe delivery of this sits with individual Trusts and Practice[s], supported by NHSE and the regulator in ensuring that resources are made available to support the implementation and development of this important role within the healthcare family".

- "The greatest concern for patients, carers and HCPs [health and care partnerships] is whether the supervision necessary for PAs will actually take place. There may be scenarios where supervision is limited, ineffective or unavailable. Perhaps the governance advice should extend to outlining what a PA should do in those circumstances, and what protections they will be guaranteed?"

- "Please clarify what measures the RCP intends to take to ensure adherence with this guidance and to monitor their effectiveness".

- "We are of the opinion that one of the main challenges is ensuring that PAs' work and learning should not be at the detriment of doctors, particularly doctors in training. How the guidance is applied in real life will need to be closely monitored. As described earlier, some of the guidance may not be practically implemented. The burden of supervision is not insubstantial and needs to part of the consideration when employers are looking at PA roles".

9.1.5 Co-production with other professional bodies

Several comments emphasised the need for co-production with other professional bodies. One respondent questioned whether the RCP's counterparts in Edinburgh and Glasgow would be issuing separate guidance or adding to the draft guidance. Another placed emphasis on "a collaborative and prospective form of co-production" between the three physicianly colleges. Questions were raised regarding the applicability of this guidance across the four nations, or whether it was nationally focused on England. Reference made to "HM Coroner" relating to death certification was an example of an English term that would need to be amended to reflect a four-nation approach.

One respondent questioned whether the guidance should be written with the RCGP "as the majority of doctors and PAs are likely to be in general practice rather than secondary care". A recurring message was that the guidance lacked specificity and applicability to children and young people's care.

9.1.6 Terminology

Several comments related to specific terminology used in the document. One expressed concern that some language "may confuse or be seen as diminishing to PAs" and said that employers should not be encouraged to distribute communications focused on what PAs are not (this referred to the suggestion on page 3 for service provider communications on the PA role). This respondent questioned why the RCP was not supporting use of the PA prefix to help identity PAs and found a statement on page 14 regarding employing a PA ('Careful consideration of the role and remit of a PA and how they might add value to a team/organisation is required before recruitment') to be undermining of PAs.

Specific comments on terminology:

- Section 4 'Who are physician associates?', one respondent considered the following statement to be misleading: 'PAs can assess, diagnose and treat patients in primary, secondary and community care environments' and stated that PAs will not yet have the skills needed to diagnose more complex, unselected patients in either primary or secondary care.

- Use of "ideally" and "wherever possible" was criticised.

- Two respondents commented that the PA title should change, one on the grounds that the current title was "a cause for safety issues" and the other for fear it would suggest that these staff were physicians. One suggested "healthcare associate" as an alternative.

- Page 12, section 7.2, one respondent questioned why there were elements of the curriculum that "would not be appropriate in clinical practice?".

- Page 14, recommendation 9.4, one respondent believed this recommendation should be for employers and HR teams to liaise with medical professional associations and unions.

- Page 14, recommendation 10.5, one respondent said that instead of "employers should consider how they will measure the impact of PAs…" this should read "Employers should audit…".

- Page 15, recommendation 12.2, instead of recommending 'to understand the full scope of the PA's role', one respondent suggested "to understand the PA's capability/performance."
- One respondent asked for the language used in patient communication regarding PAs to be regulated.
- One respondent suggested replacing FPA with "professional body", to future proof the document. Another respondent suggested referencing that the curriculum for PAs will be approved by the GMC following the introduction of statutory regulation.
- Appendix D, one respondent observed that it was not correct to say that only US qualified PAs are 'allowed' to work in the UK. It would be more accurate to say that only US-qualified PAs have been permitted to join the PAMVR.

9.1.7 Approach to consultation

Some respondents gave feedback regarding the consultation, including frustration with the character limit (of 1250 characters) per response. One said this had prevented them from submitting "a much more nuanced and detailed response". Repetition within the guidance, and the numbering system used for paragraphs and recommendations was the source of some confusion.

More substantial feedback included an expectation that the guidance would limit its focus to PAs working in physician specialties and uncertainty of the scope of the guidance. A need for consistency with other published guidance or guidance currently under development was a recurring theme.

The GMC asked for hyperlinks to professional standards guidance to take the reader to the landing page on its website and not directly to the PDF, to ensure important contextual information is accessed.

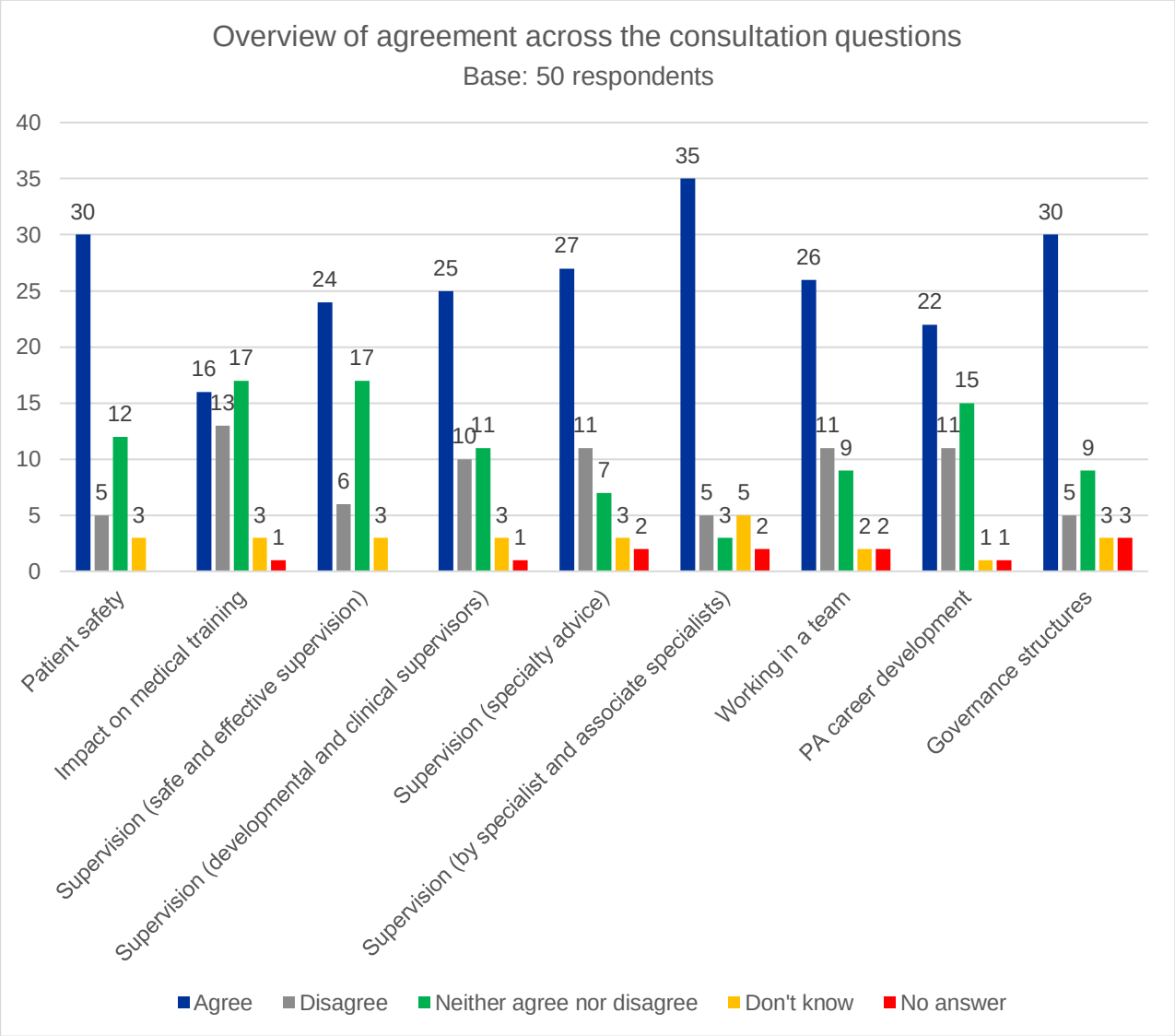
10. Overview of agreement and disagreement

Strongest agreement was evident to the question asking about supervision of PAs by specialist and associate specialist doctors, followed by the extent to which the draft guidance will support patient safety (safe and effective patient care), and the degree to which the guidance will support employers to put in place clear governance processes when employing a PA. Three respondents (2 organisations and 1 RCP) selected agree in response to every question.

Most disagreement centred on the impact of PAs on medical training, followed by specialty advice given by a PA to remain the responsibility of their clinical supervisor, and the extent to which the draft guidance will support safe and effective team working, and around PA career development. One respondent (an individual) selected disagree in response to every question.

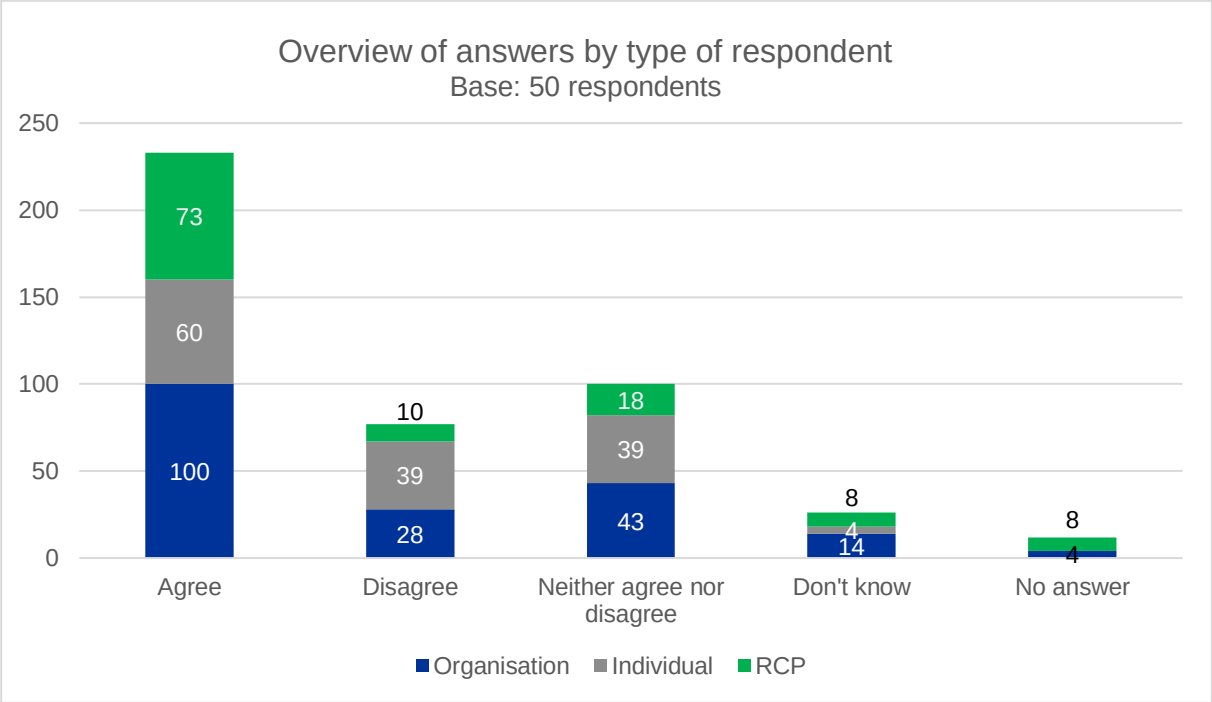
Respondents were most likely to select neither agree nor disagree regarding: the impact on medical training; the extent to which the draft guidance will support supervision; and with respect to PA career development. One respondent (an organisation) selected neither agree nor disagree in response to every question.

Figure 13: Agreement across the consultation questions



One RCP respondent answered don't know in response to 3 questions and left the others blank. This response was included in the sample as it was assumed that the don't know responses were active responses. RCP respondents were more likely to answer 'agree' or 'neither agree nor disagree'.

Figure 14: Answers by type of respondent (organisational/individual/RCP)



Appendix A: Stakeholders invited to respond to the consultation

Medical royal colleges and academies	• Academy of Medical Royal Colleges • Federation of the Royal Colleges of Physicians of the UK • Royal College of Anaesthetists • Royal College of Emergency Medicine • Royal College of General Practitioners • Royal College of Obstetricians and Gynaecologists • Royal College of Ophthalmologists • Royal College of Paediatrics and Child Health • Royal College of Physicians of Edinburgh • Royal College of Physicians and Surgeons of Glasgow • Royal College of Psychiatrists • Royal College of Radiologists • Royal College of Surgeons of England • Scottish Academy of Medical Royal Colleges • Welsh Academy of Medical Royal Colleges
Department of health workforce teams	• Northern Ireland Department of Health • Welsh Government Department of Health and Social Services • UK Government Department of Health and Social Care (DHSC)
NHS workforce, training and education bodies	• General Medical Council • Health Education and Improvement Wales • NHS Education for Scotland • NHS England Workforce, Training and Education directorate • Northern Ireland Medical and Dental Training Agency
Doctors' and PAs' representatives	• British Medical Association • PA Schools Council SC • United Medical Associate Professional (UMAPs)
Employer / provider representatives	• NHS Confederation • NHS Employers • NHS Providers
RCP committees and groups	• Joint specialty committees • Medical Specialties Board • New Consultants Committee • Patient and Carer Network • RCP Board of Trustees • RCP Council • RCP Resident Doctors Committees (formerly Trainees Committee) • SAS Regional Representatives Network • Student Foundation Doctors Network
In addition, the following faculties and specialist societies received a specific invitation to a roundtable to discuss next steps on PA guidance on 15 August. A link to the consultation was included in the invitation.	
Faculties	• Faculty of Forensic and Legal Medicine • Faculty of Intensive Care Medicine • Faculty of Occupational Medicine • Faculty of Pharmaceutical Medicine • Faculty of Public Health Medicine • Faculty of Sexual and Reproductive Healthcare • Faculty of Sport and Exercise Medicine
Specialist societies	• Association of British Clinical Diabetologists

	• Association of British Neurologists • Association for Palliative Medicine • British Association of Audiovestibular Physicians • British Association of Dermatologists • British Cardiovascular Society • British Geriatrics Society • British Society of Allergy and Clinical Immunology • British Society for Clinical Neurophysiology • British Society of Gastroenterology • British Society for Haematology • British Society for Rheumatology • British Thoracic Society • Clinical Genetics Society • Society for Acute Medicine • Society for Endocrinology • The UK Kidney Association

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[vii] NHS England. Supervision guidance for primary care network multidisciplinary teams. https://www.england.nhs.uk/long-read/supervision-guidance-for-primary-care-network-multidisciplinary-teams/ [accessed 9 October 2024]
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Royal College of Physicians

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

Ref: 2024-0416

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.

Dr Mumtaz Patel, who is acting as RCP president, and Dr Hilary Williams, 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).

Royal College of Physicians

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,

Dr John Dean
Clinical vice president
Royal College of Physicians

RCP EGM 13/03/2024

Survey sent to 12053 subscribing members of RCP working in the four UK nations prior to EGM

Survey responses = 2141 (response rate 17.8%)

Grade	Number	%
Consultant	884	41.29%
Specialty trainee (registrar)	634	29.61%
Internal medicine trainee	294	13.73%
SAS	92	4.30%
Locally employed doctor (eg clinical fellow)	99	4.62%
Foundation	23	1.07%
Currently in research	18	0.84%
Currently not in clinical practice	14	0.65%
GP	40	1.87%
Retired	25	1.17%
Other please specify	18	0.84%
Total	**2141**	**100.00%**

Nation	Number	%
England	1957	91.41%
Northern Ireland	40	1.87%
Scotland	19	0.89%
Wales	125	5.84%
Total	**2141**	**100.00%**

Location	Frequency	%
Acute Hospital	1970	92.01%
Community or Rehabilitation Hospital	70	3.27%
Primary Care Setting	59	2.76%
Not in clinical practice	42	1.96%
Total	**2141**	**100.00%**

Working with a physician associate/s	Frequency	%
I am currently working with a physician associate/s	781	36.48%
I have previously worked with a physician associate/s	994	46.43%
I have not worked with a physician associate	366	17.09%
Total	**2141**	**100.00%**

Specialty (where >10 responses)	Frequency	%
Acute Internal Medicine	274	12.80%
Geriatric Medicine	257	12.00%
Respiratory Medicine	206	9.62%
General Internal Medicine	198	9.25%
Cardiology	177	8.27%
Gastroenterology	140	6.54%
Endocrinology And/or Diabetes Mellitus	92	4.30%
Palliative Medicine	79	3.69%
Renal Medicine	75	3.50%
Neurology	65	3.04%
Rheumatology	63	2.94%
Infectious Diseases	56	2.62%
General Practice	53	2.48%
Intensive Care Medicine	53	2.48%
Dermatology	48	2.24%
Haematology	46	2.15%
Other (please Specify)	40	1.87%
Medical Oncology	35	1.63%
Genito-urinary Medicine	25	1.17%
Stroke Medicine	25	1.17%
Rehabilitation Medicine	24	1.12%
Not Relevant	21	0.98%
Clinical Oncology	15	0.70%
Clinical Genetics	12	0.56%
Hepatology	11	0.51%
TOTAL	**2090**	

RCP EGM 13/03/2024

Survey sent to 12053 subscribing members of RCP working in the four UK nations prior to EGM

Survey responses = 2141 (response rate 17.8%)

Does having a physician associate on your team impact on training opportunities for you?

ALL GRADES		Frequency	%	
5	PAs enable	184	8.59%	13.22%
4		99	4.62%	
3	neutral	327	15.27%	15.27%
2	PAs limit	261	12.19%	44.04%
1		682	31.85%	
Unable to comment		588	27.46%	27.46%
	Totals	**2141**	**100.00%**	**100.00%**

CONSULTANT		Frequency	%	
5	PAs enable	122	13.80%	17.87%
4		36	4.07%	
3	neutral	117	13.24%	13.24%
2		76	8.60%	23.08%
1	PAs limit	128	14.48%	
Unable to comment		405	45.81%	45.81%
	Totals	**884**	**100.00%**	**100.00%**

SPECIALTY TRAINEE (REGISTRAR)		Frequency	%	
5	PAs enable	33	5.21%	11.51%
4		40	6.31%	
3	neutral	134	21.14%	21.14%
2	PAs limit	97	15.30%	55.52%
1		255	40.22%	
Unable to comment		75	11.83%	11.83%
	Totals	**634**	**100.00%**	**100.00%**

INTERNAL MEDICINE TRAINEE		Frequency	%	
5	PAs enable	5	1.70%	5.44%
4		11	3.74%	
3	neutral	39	13.27%	13.27%
2	PAs limit	53	18.03%	77.21%
1		174	59.18%	
Unable to comment		12	4.08%	4.08%
	Totals	**294**	**100.00%**	**100.00%**

SAS, LOCALLY EMPLOYED DOCTOR, FOUNDATION, GP		Frequency	%	
5	PAs enable	20	7.87%	11.42%
4		9	3.54%	
3	neutral	30	11.81%	11.81%
2	PAs limit	26	10.24%	51.57%
1		105	41.34%	
Unable to comment		64	25.20%	25.20%
	Totals	**254**	**100.00%**	**100.00%**

Does having a physician associate on your team impact on training opportunities for doctor colleagues in your team?

ALL GRADES		Frequency	%	
5	PAs enable	192	8.97%	13.78%
4		103	4.81%	
3	neutral	272	12.70%	12.70%
2	PAs limit	337	15.74%	58.24%
1		910	42.50%	
Unable to comment		327	15.27%	15.27%
	Totals	**2141**	**100.00%**	**100.00%**

CONSULTANT		Frequency	%	
5	PAs enable	135	15.27%	23.08%
4		69	7.81%	
3	neutral	125	14.14%	14.14%
2		126	14.25%	42.31%
1	PAs limit	248	28.05%	
Unable to comment		181	20.48%	20.48%
	Totals	**884**	**100.00%**	**100.00%**

SPECIALTY TRAINEE (REGISTRAR)		Frequency	%	
5	PAs enable	24	3.79%	7.10%
4		21	3.31%	
3	neutral	78	12.30%	12.30%
2		123	19.40%	71.77%
1	PAs limit	332	52.37%	
Unable to comment		56	8.83%	8.83%
	Totals	**634**	**100.00%**	**100.00%**

INTERNAL MEDICINE TRAINEE		Frequency	%	
5	PAs enable	4	1.36%	3.06%
4		5	1.70%	
3	neutral	37	12.59%	12.59%
2		54	18.37%	79.59%
1	PAs limit	180	61.22%	
Unable to comment		14	4.76%	4.76%
	Totals	**294**	**100.00%**	**100.00%**

SAS, LOCALLY EMPLOYED DOCTOR, FOUNDATION, GP		Frequency	%	
5	PAs enable	25	9.84%	12.20%
4		6	2.36%	
3	neutral	25	9.84%	9.84%
2	PAs limit	23	9.06%	57.09%
1		122	48.03%	
Unable to comment		53	20.87%	20.87%
	Totals	**254**	**100.00%**	**100.00%**

RCP EGM 13/03/2024

Survey sent to 12053 subscribing members of RCP working in the four UK nations prior to EGM

Survey responses = 2141 (response rate 17.8%)

How do you feel about physician associates being part of the multi-disciplinary team (MDT)?

		Frequency	%	
5	Very supportive	336	15.69%	29.05%
4		286	13.36%	
3	Neutral	574	26.81%	26.81%
2	Not supportive	434	20.27%	40.78%
1		439	20.50%	
Unable to comment		72	3.36%	3.36%
	Totals	**2141**	**100.00%**	**100.00%**

Within your multi-disciplinary team (MDT), how well understood is the term 'Physician Associate'?

		Frequency	%	
5	Clear	294	13.73%	24.19%
4		224	10.46%	
3	Neutral	306	14.29%	14.29%
2	Unclear	401	18.73%	55.30%
1		783	36.57%	
Unable to comment		133	6.21%	6.21%
	Totals	**2141**	**100.00%**	**100.00%**

In secondary care, do you feel that you, or doctors you work with, are appropriately supervised and supported?

		Frequency	%	
5	Most of the time	589	27.51%	56.75%
4		626	29.24%	
3	Neutral	499	23.31%	23.31%
2	Rarely	246	11.49%	16.44%
1		106	4.95%	
Unable to comment		75	3.50%	3.50%
	Totals	**2141**	**100.00%**	**100.00%**

In secondary care, in your opinion, do you think physician associates are appropriately supervised and supported?

		Frequency	%	
5	Most of the time	283	13.22%	23.26%
4		215	10.04%	
3	Neutral	338	15.79%	15.79%
2	Rarely	476	22.23%	42.83%
1		441	20.60%	
Unable to comment		388	18.12%	18.12%
	Totals	**2141**	**100.00%**	**100.00%**

RCP EGM 13/03/2024

Survey sent to 12053 subscribing members of RCP working in the four UK nations prior to EGM

Survey responses = 2141 (response rate 17.8%)

How do you feel about physician associates being part of the multi-disciplinary team (MDT)?

	Very supportive				Neutral		Not supportive				Unable to comment		Total	
	5		4		3		2		1					
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
I am currently working with a physician associate/s	217	27.78%	117	14.98%	182	23.30%	132	16.90%	129	16.52%	4	0.51%	781	100.00%
I have previously worked with a physician associate/s	86	8.65%	128	12.88%	307	30.89%	239	24.04%	219	22.03%	15	1.51%	994	100.00%
I have not worked with a physician associate	33	9.02%	41	11.20%	85	23.22%	63	17.21%	91	24.86%	53	14.48%	366	100.00%
Total	**336**	**15.69%**	**286**	**13.36%**	**574**	**26.81%**	**434**	**20.27%**	**439**	**20.50%**	**72**	**3.36%**	**2141**	**100.00%**

In secondary care, do you feel that you, or doctors you work with, are appropriately supervised and supported?

	Most of the time				Neutral		Rarely				Unable to comment		Total	
	5		4		3		2		1					
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
I am currently working with a physician associate/s	262	33.55%	229	29.32%	154	19.72%	72	9.22%	47	6.02%	17	2.18%	781	100.00%
I have previously worked with a physician associate/s	227	22.84%	307	30.89%	270	27.16%	131	13.18%	47	4.73%	12	1.21%	994	100.00%
I have not worked with a physician associate	100	27.32%	90	24.59%	75	20.49%	43	11.75%	12	3.28%	46	12.57%	366	100.00%
Total	**589**	**27.51%**	**626**	**29.24%**	**499**	**23.31%**	**246**	**11.49%**	**106**	**4.95%**	**75**	**3.50%**	**2141**	**100.00%**

In secondary care, in your opinion, do you think physician associates are appropriately supervised and supported?

	Most of the time				Neutral		Rarely				Unable to comment		Total	
	5		4		3		2		1					
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
I am currently working with a physician associate/s	191	24.46%	104	13.32%	141	18.05%	154	19.72%	152	19.46%	39	4.99%	781	100.00%
I have previously worked with a physician associate/s	85	8.55%	104	10.46%	173	17.40%	267	26.86%	244	24.55%	121	12.17%	994	100.00%
I have not worked with a physician associate	7	1.91%	7	1.91%	24	6.56%	55	15.03%	45	12.30%	228	62.30%	366	100.00%
Total	**283**	**13.22%**	**215**	**10.04%**	**338**	**15.79%**	**476**	**22.23%**	**441**	**20.60%**	**388**	**18.12%**	**2141**	**100.00%**

Does having a physician associate on your team impact on training opportunities for you?

	PAs enable				Neutral		PAs limit				Unable to comment		Total	
	5		4		3		2		1					
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
I am currently working with a physician associate/s	137	17.54%	56	7.17%	138	17.67%	86	11.01%	226	28.94%	138	17.67%	781	100.00%
I have previously worked with a physician associate/s	39	3.92%	39	3.92%	172	17.30%	153	15.39%	394	39.64%	197	19.82%	994	100.00%
I have not worked with a physician associate	8	2.19%	4	1.09%	17	4.64%	22	6.01%	62	16.94%	253	69.13%	366	100.00%
Total	**184**	**8.59%**	**99**	**4.62%**	**327**	**15.27%**	**261**	**12.19%**	**682**	**31.85%**	**588**	**27.46%**	**2141**	**100.00%**

Does working with a physician associate impact on training opportunities for doctor colleagues in your team?

	PAs enable				Neutral		PAs limit				Unable to comment		Total	
	5		4		3		2		1					
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
I am currently working with a physician associate/s	148	18.95%	58	7.43%	131	16.77%	114	14.60%	302	38.67%	28	3.59%	781	100.00%
I have previously worked with a physician associate/s	36	3.62%	40	4.02%	121	12.17%	188	18.91%	512	51.51%	97	9.76%	994	100.00%
I have not worked with a physician associate	8	2.19%	5	1.37%	20	5.46%	35	9.56%	96	26.23%	202	55.19%	366	100.00%
Total	**192**	**8.97%**	**103**	**4.81%**	**272**	**12.70%**	**337**	**15.74%**	**910**	**42.50%**	**327**	**15.27%**	**2141**	**100.00%**

Within your MDT, how well understood is the term "Physician Associate?"

	Clear				Neutral		Unclear				Unable to comment		Total	
	5		4		3		2		1					
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
I am currently working with a physician associate/s	169	21.64%	121	15.49%	123	15.75%	125	16.01%	235	30.09%	8	1.02%	781	100.00%
I have previously worked with a physician associate/s	95	9.56%	84	8.45%	150	15.09%	222	22.33%	397	39.94%	46	4.63%	994	100.00%
I have not worked with a physician associate	30	8.20%	19	5.19%	33	9.02%	54	14.75%	151	41.26%	79	21.58%	366	100.00%
Total	**294**	**13.73%**	**224**	**10.46%**	**306**	**14.29%**	**401**	**18.73%**	**783**	**36.57%**	**133**	**6.21%**	**2141**	**100.00%**