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

Physician associates: Guidance for safe and effective practice

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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This report presents a thematic analysis of responses received by the RCP on its draft guidance document: *Physician associates: Guidance for safe and effective practice.* The approach to the analysis is set out in section 1.2.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Areas of good agreement	• There was good agreement (60% agreed) that the draft guidance will support doctors and PAs to deliver safe and effective care (section 3.1) • The proposal that specialist and associate specialist doctors should be able to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 • Fewer than half of respondents (48%) agreed that the draft guidance would support safe and effective supervision of PAs by doctors (section 5.1).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.

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[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.

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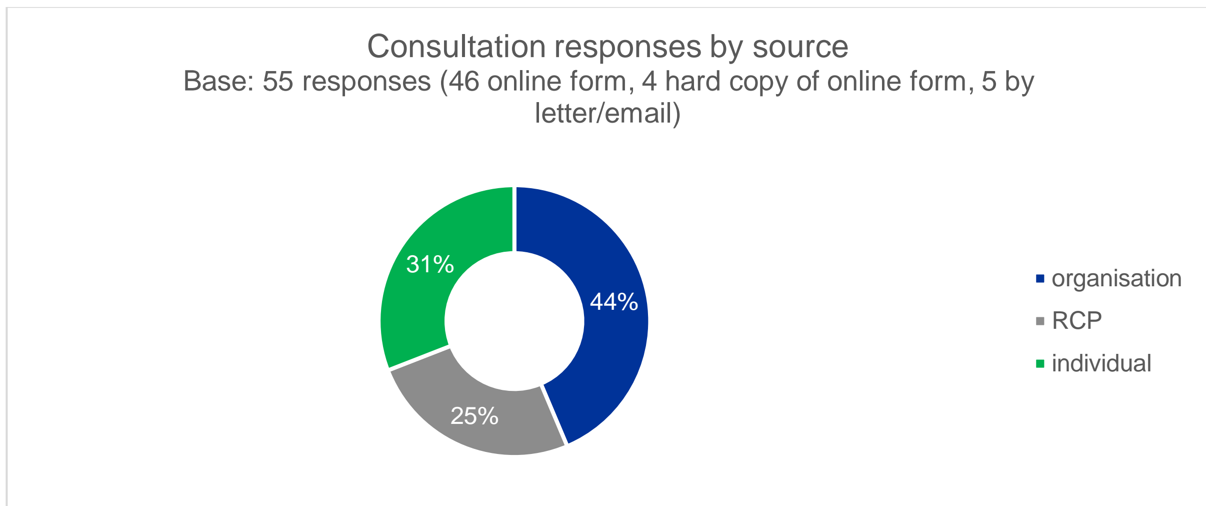
[2] The response was categorised as **organisational** if it was clearly organisational (e.g. referred to wider discussion within the organisation) or the job title of the person responding suggested that they were doing so on behalf of an organisation (e.g. chief executive, chair, vice president).

[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		

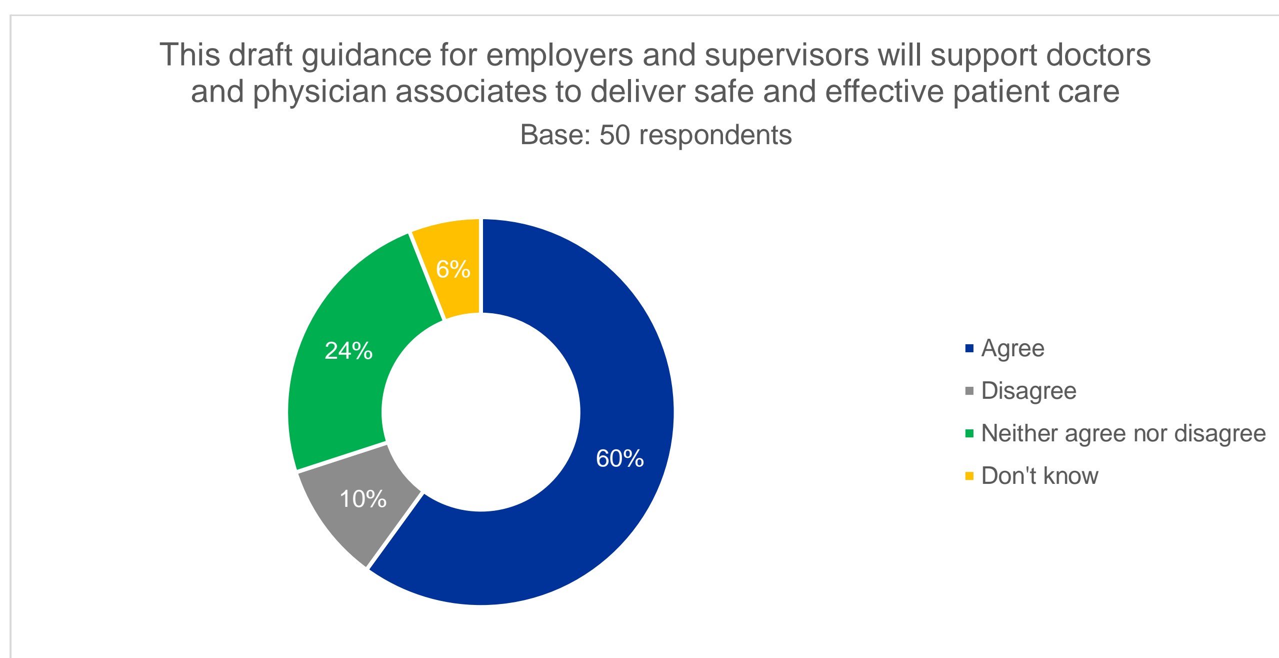
**Royal College of Ophthalmologists responded to say that it was running a pilot for PAs with an interest in ophthalmology and until the evaluation report was published, it would not be able to comment on whether PAs are an appropriate addition to the extended healthcare delivery team.*
~ Two online 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

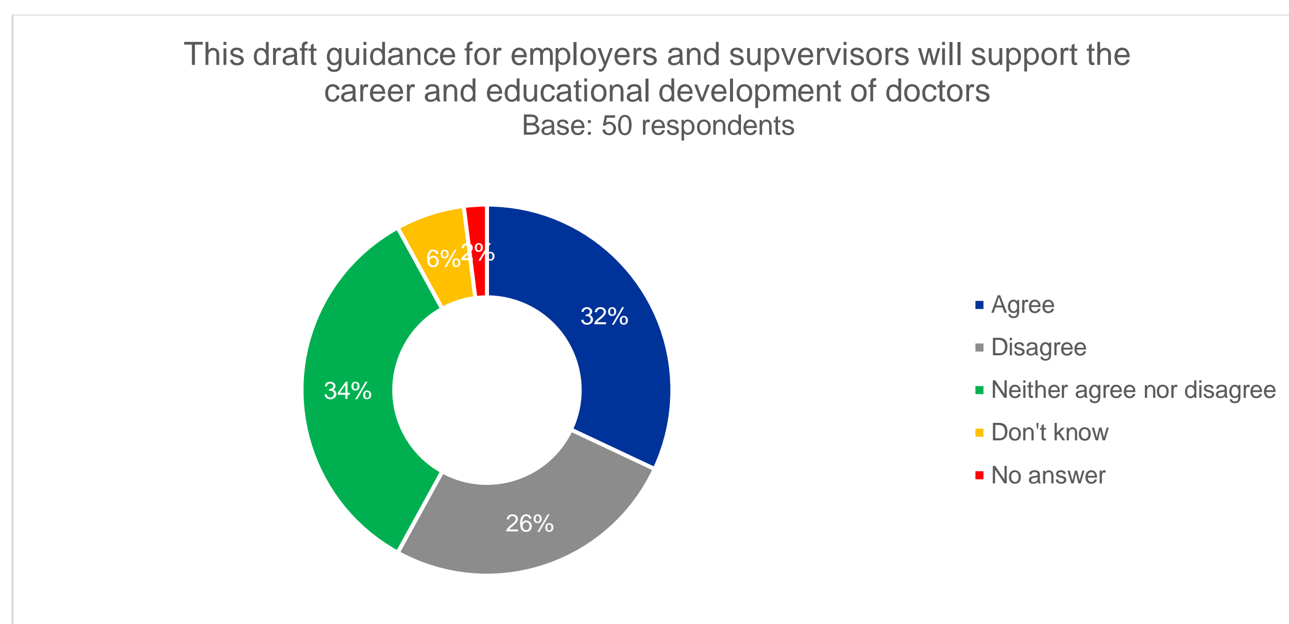
A question was raised over whether the draft guidance had been co-produced with patient and carer involvement. This is something RCP may wish to address in finalising the guidance. The consultation responses indicated good engagement from the RCP's patient and carer network (section 2), who may be able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

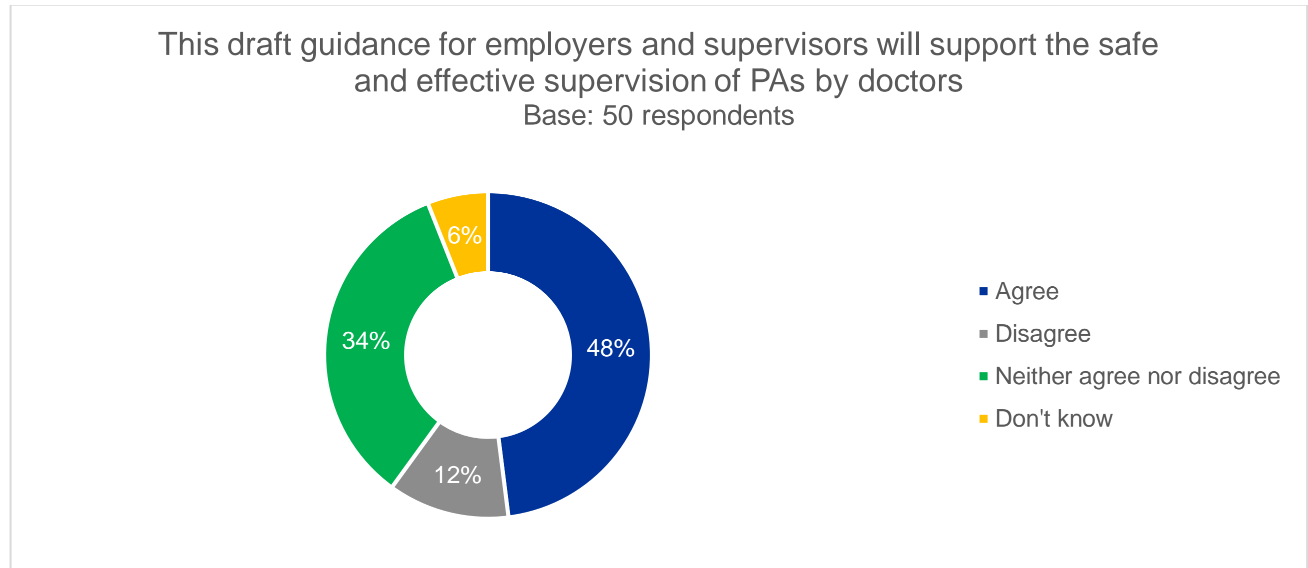
One comment highlighted uncertainty over the professional landscape, questioning how the College of Medical Associate Professionals would contribute to oversight arrangements.

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

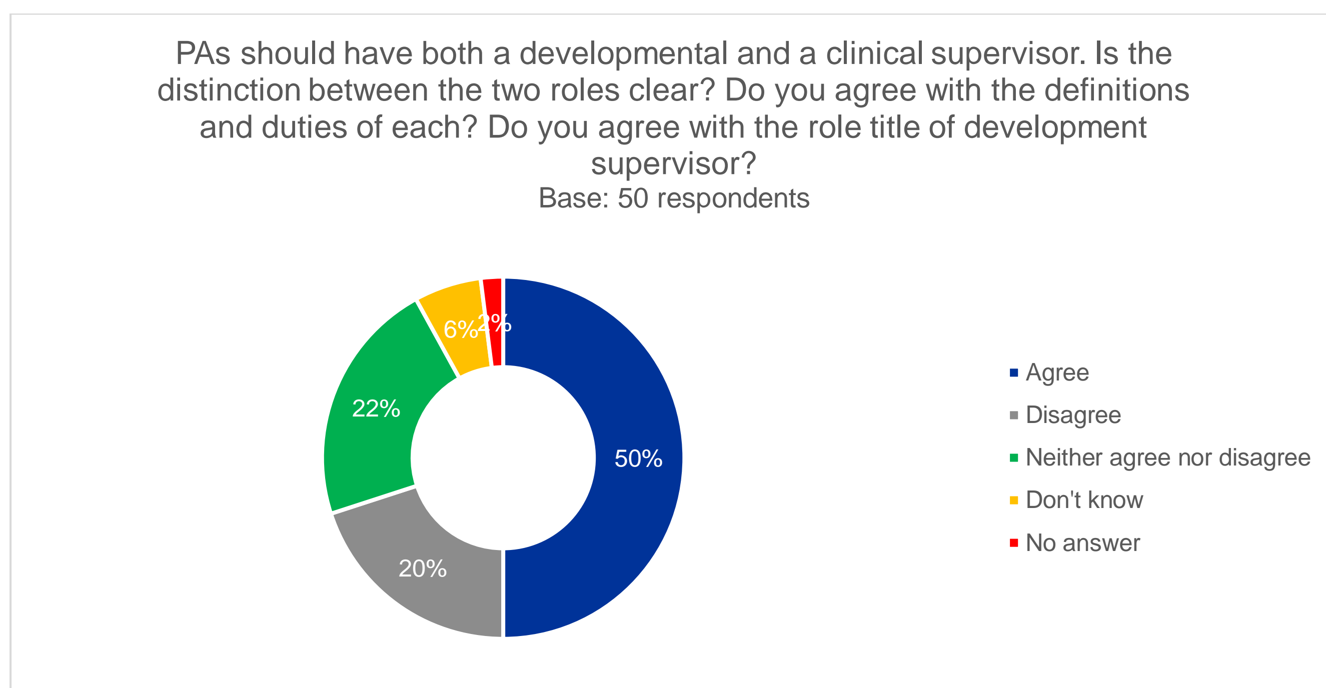
The type of supervision outlined in the guidance would be difficult to achieve in general practice and primary care settings, according to some respondents. Stipulations already made by the RCGP with respect to supervision of PAs working in general practice, and different levels of supervision (namely 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".

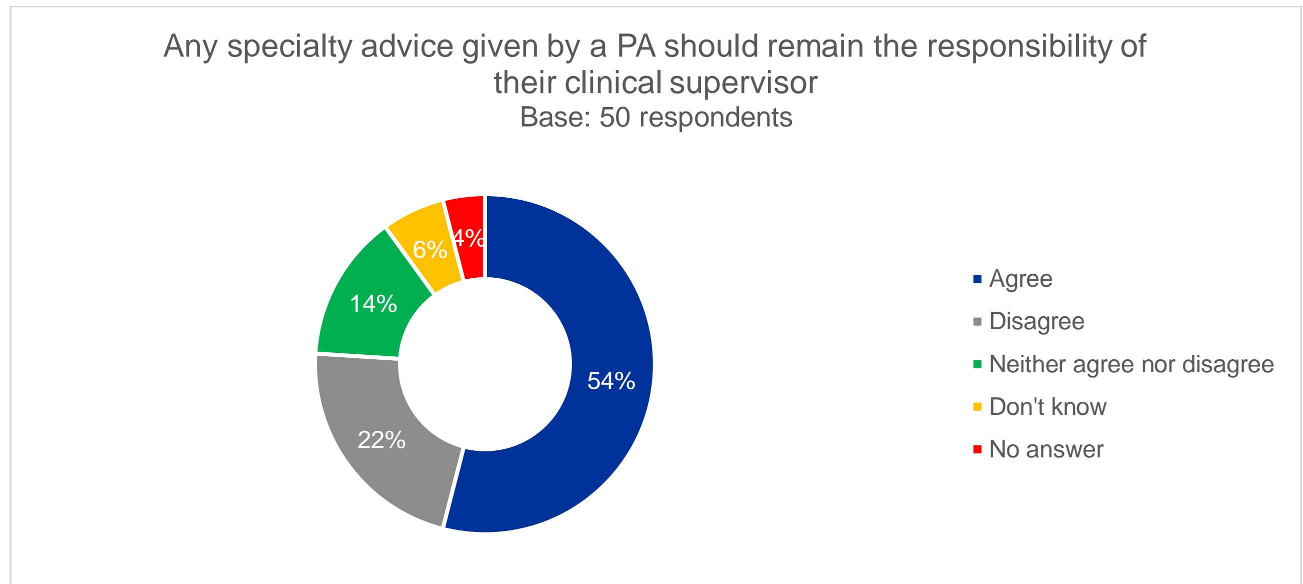
The burden on employers was also highlighted. "The time demand is prohibitive, and this would make the business case for PAs in practice null and void", said one respondent. The RCP was asked to reconsider the requirements and the effects they would have if implemented on doctor training. The draft guidance 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".

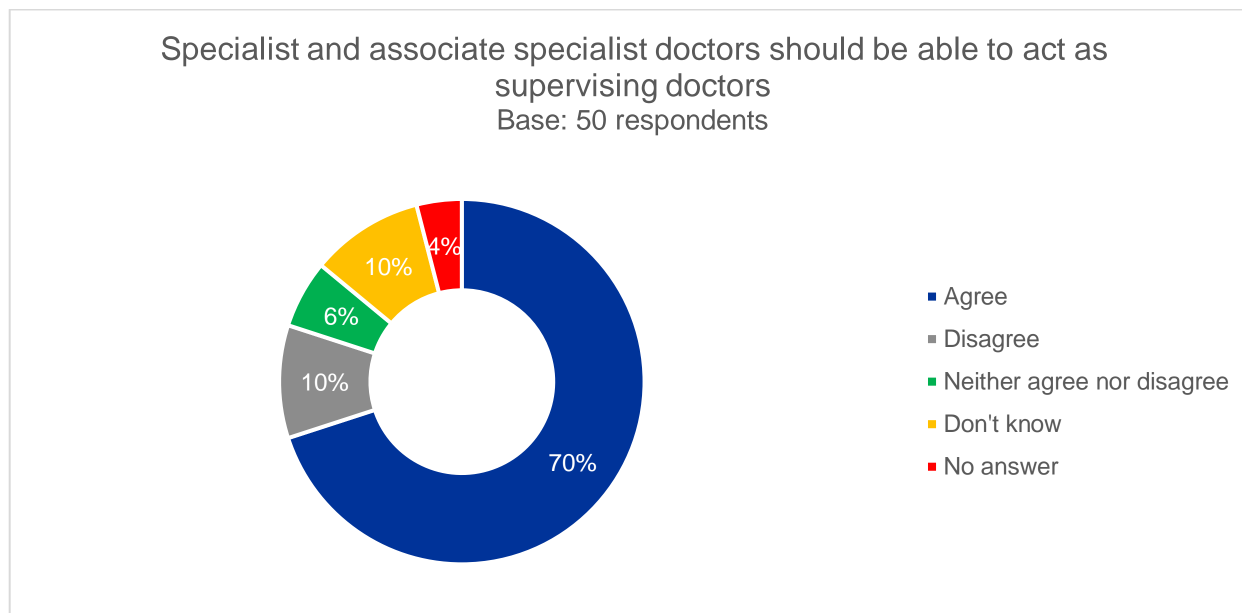
Another respondent emphasised that the guidance "should be consistent with current guidance on delegated responsibility which applies to doctors in training roles and advanced practitioners". This respondent was keen to see an emphasis in recommendation 4.4 (page 10) on the importance of effective communication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

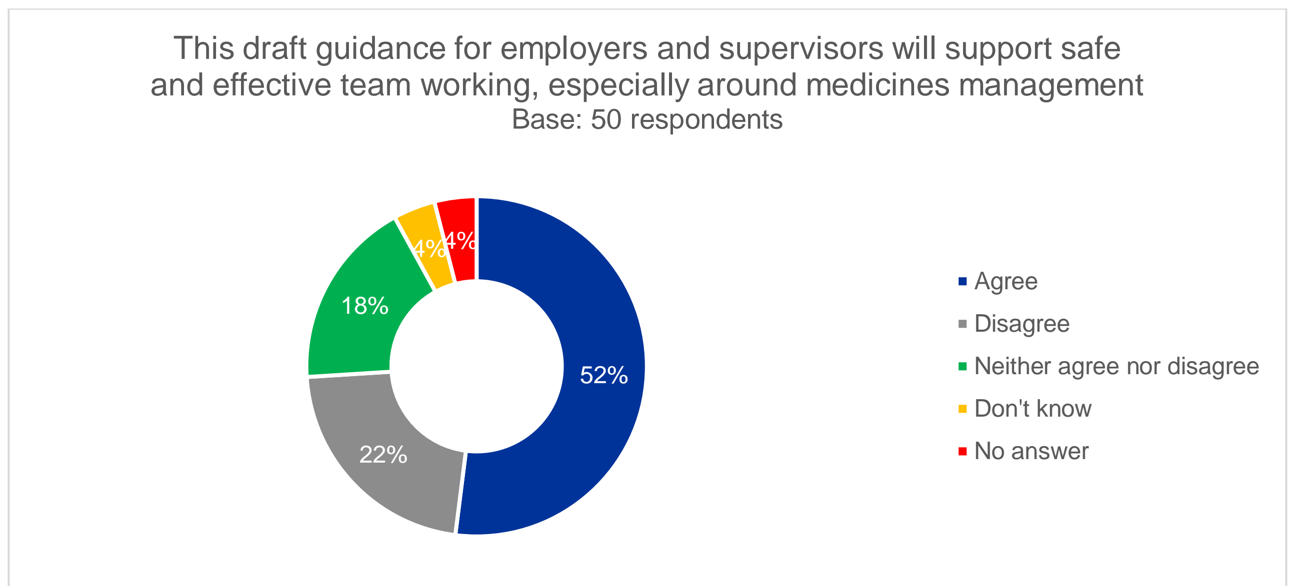
One respondent argued that clinical supervision should not be restricted only to specialist or associate specialist doctors, consultants and GPs, and said it may be delivered by other members of the team including "trainee doctors", provided they are competent to provide this supervision and there is 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.

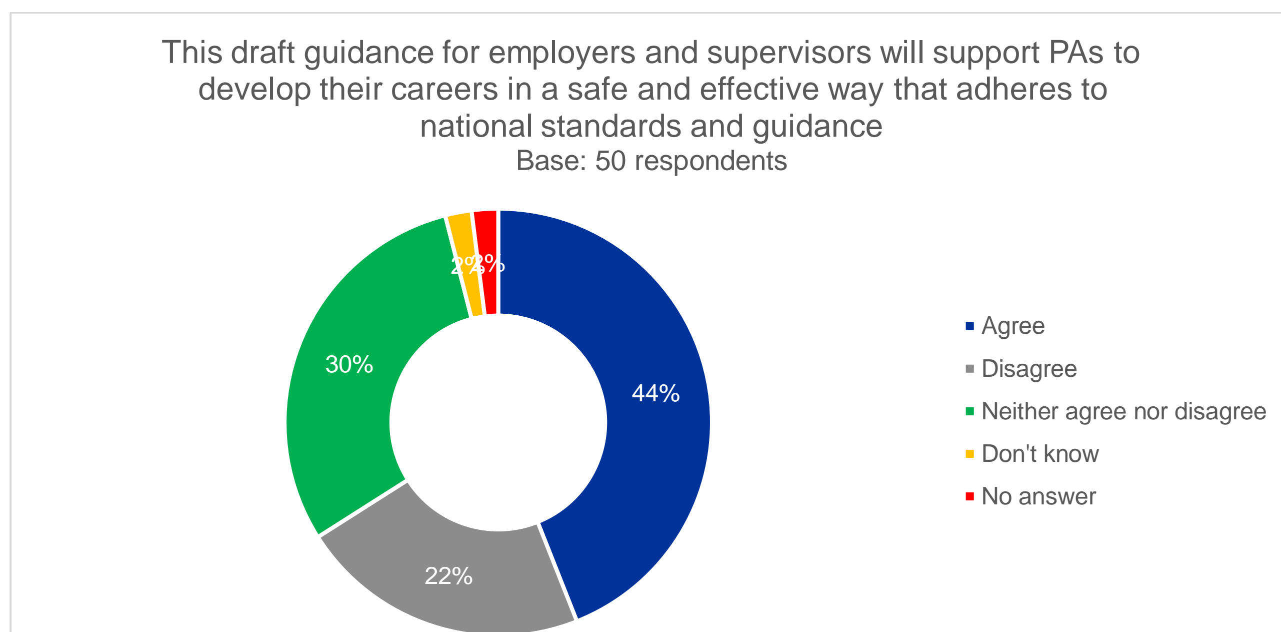
Cardiology was another area where specialty-specific focus was highlighted. "Prescribing and therapeutics decisions in cardiology are recognised to be complex due to the potential for interactions and also the coexistence of multimorbidity and frailty. Drug prescriptions and administration can therefore 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:

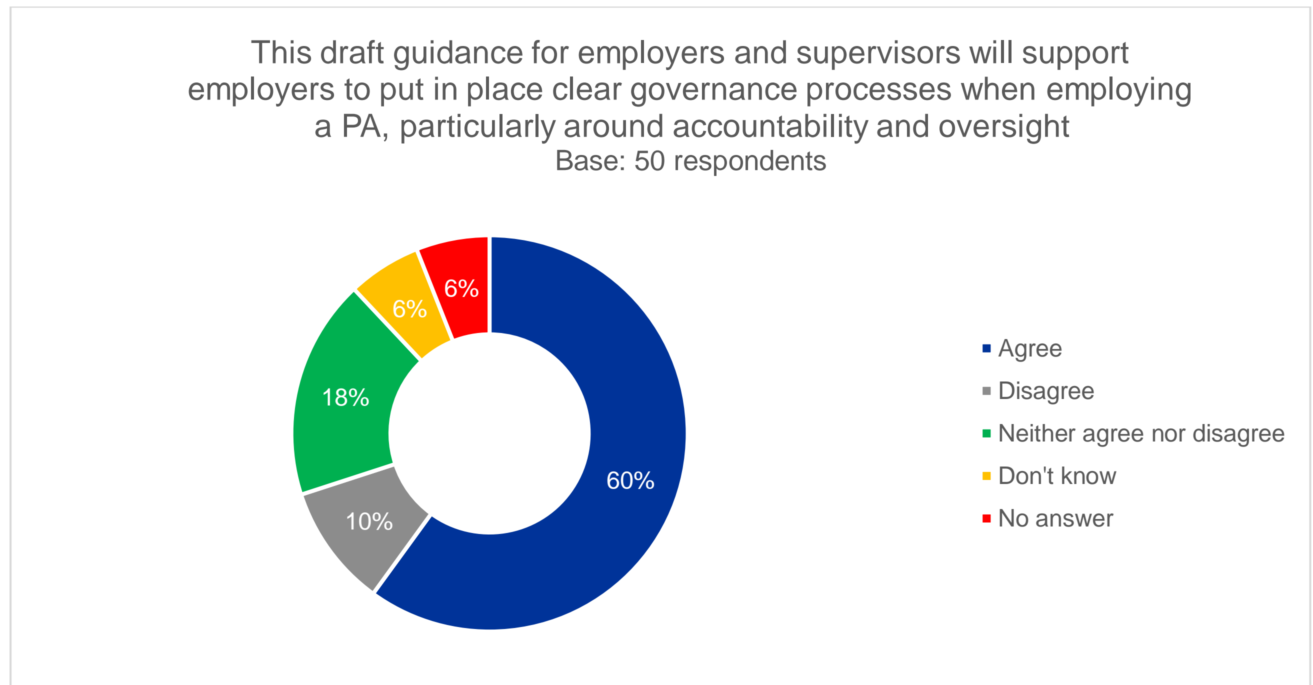
- One respondent disagreed with the statement that PAs ‘must follow a defined training pathway’ (page 12), adding: “I do not think that PAs “must” follow a training pathway; unless they are looking for further specialist development.”
- Section 5.1, a distinction between entry-level knowledge and skills, 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.

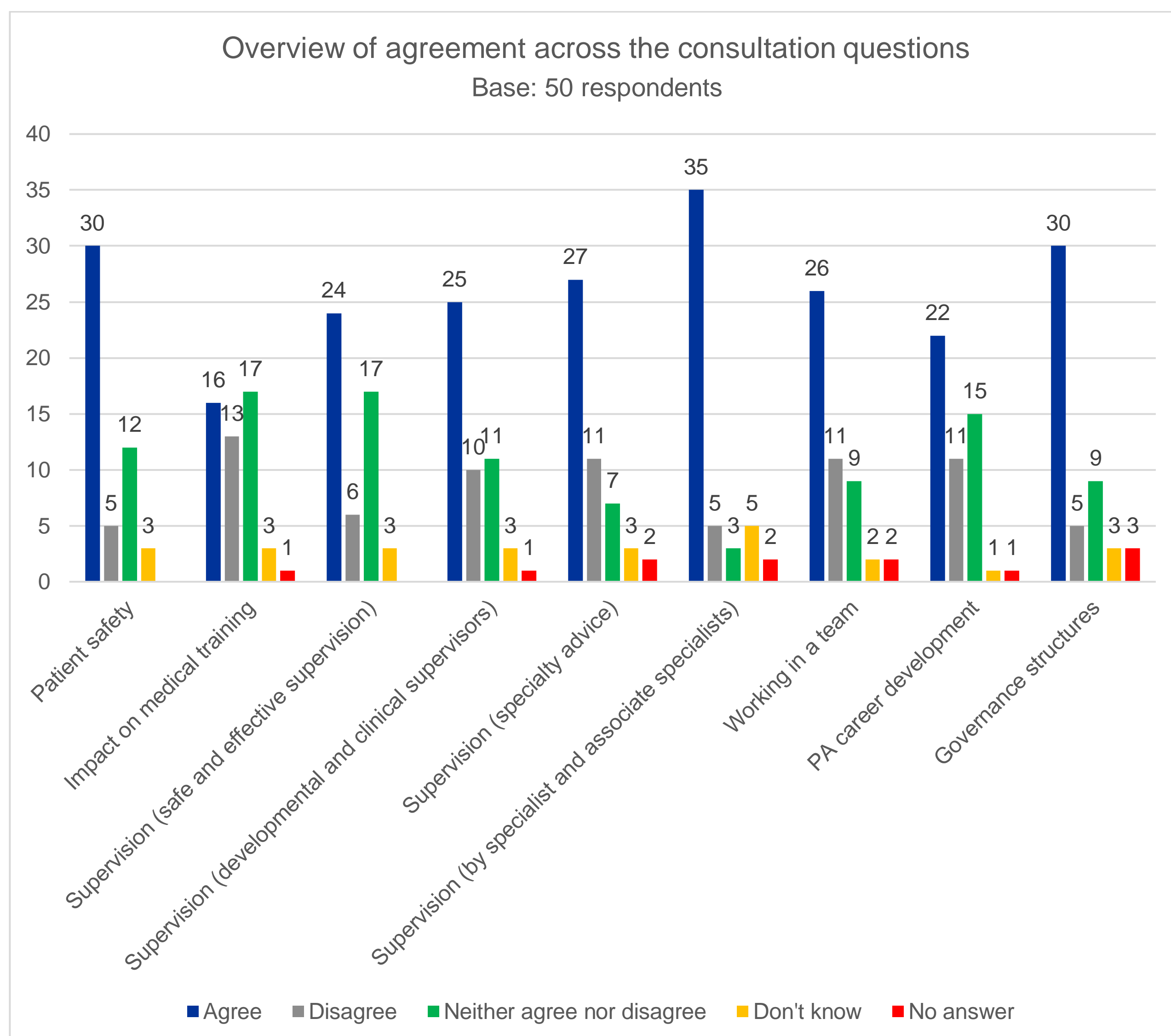
10. Overview of agreement and disagreement

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.

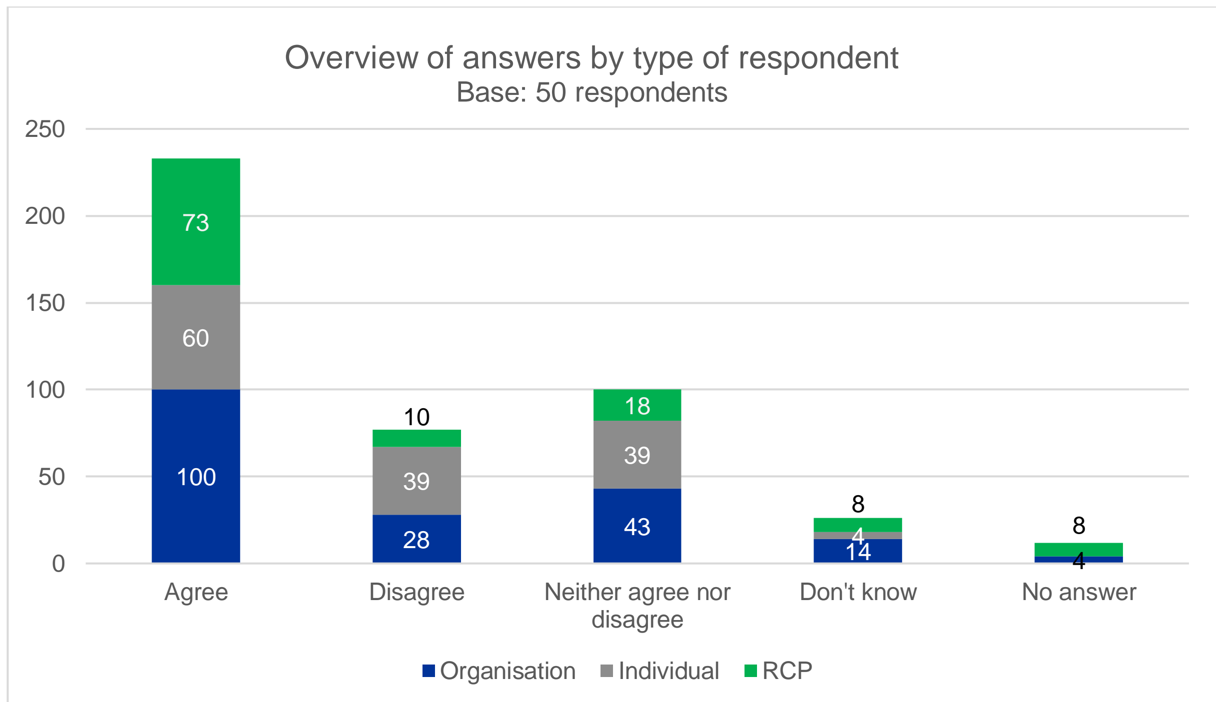
Respondents were most likely to select neither agree nor disagree regarding: the impact on medical training; the extent to which the draft guidance will support supervision; and with respect to PA career development. One respondent (an organisation) selected neither agree nor disagree in response to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

<table>
<tr><td>Medical royal colleges and academies</td><td>• 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</td></tr>
<tr><td>Department of health workforce teams</td><td>• Northern Ireland Department of Health
• Welsh Government Department of Health and Social Services
• UK Government Department of Health and Social Care (DHSC)</td></tr>
<tr><td>NHS workforce, training and education bodies</td><td>• 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</td></tr>
<tr><td>Doctors' and PAs' representatives</td><td>• British Medical Association
• PA Schools Council SC
• United Medical Associate Professional (UMAPs)</td></tr>
<tr><td>Employer / provider representatives</td><td>• NHS Confederation
• NHS Employers
• NHS Providers</td></tr>
<tr><td>RCP committees and groups</td><td>• 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</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>Faculties</td><td>• 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</td></tr>
<tr><td>Specialist societies</td><td>• Association of British Clinical Diabetologists</td></tr>
</table>

	• 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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References

[i] How to use Good Medical Practice https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-medical-practice/about-good-medical-practice [accessed 1 October 2024]

[ii] BMA. “Junior” doctors change name to “resident” doctors. https://www.bma.org.uk/bma-media-centre/junior-doctors-change-name-to-resident-doctors#:~:text=Resident%20doctors%20are%20fully%20qualified,GPs%20or%20specialists%20of%20tomorrow. [accessed 1 October 2024]

[iii] NHS Health Education England, and Skills for Health. Core Capabilities Framework for Medical Associate Professions. https://www.hee.nhs.uk/sites/default/files/documents/June%202022%20MAP%20Core%20Capabilities%20Framework%20FINAL.pdf [accessed 9 October 2024]

[iv] GMC. Good medical practice. https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/leadership-and-management-for-all-doctors [accessed 9 October 2024]

[v] GMC. Leadership and management for all doctors. https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/leadership-and-management-for-all-doctors [accessed 9 October 2024]

[vi] GMC. Delegation and referral. https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/delegation-and-referral [accessed 9 October 2024

[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]

[viii] British Institute of radiology. Guidance for non-medical referrers to radiology. https://www.bir.org.uk/media-centre/position-statements-and-responses/guidance-for-non-medical-referrers-to-radiology/ [accessed 9 October 2014]