Royal College of Physicians

Physician associates

Guidance for safe and effective practice

Developed in consultation with the Faculty of Physician Associates

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Draft for consultation

Contents

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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 has been reviewed by RCP Council, our Trainees 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.

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1 Introduction

This document provides guidance for safe and effective practice for physician associates (PAs). The overarching principles in this document apply to all PAs, regardless of the clinical setting that they work in. This document seeks to ensure adherence to safe practices in the employment and deployment of the PA role at the point of qualification and includes recommendations and guidance on supervision and scope of practice.

PAs are not doctors. They should not be regarded as replacements for doctors, and they should never replace a doctor on a rota. They are healthcare professionals who participate in patient care as part of the wider multidisciplinary team. This should be made clear in relevant service provider communications.

Medical royal colleges and specialist societies should build on this guidance to support PAs working in their field of practice as they become more experienced.

2 Patient safety

Patient safety is of the utmost importance in healthcare and must be the foremost consideration during the development and deployment of PA roles. This document provides day-to-day workplace guidance and requirements to ensure that safe clinical practice is maintained.

PAs are responsible for their own practice, although they will always work under the supervision of a consultant, GP or specialist / associate specialist, who retains clinical and professional responsibility for patients treated under their care.

Patients need to understand who is providing their care. PAs must clearly explain their role to patients, colleagues and supervisors in line with the Faculty of Physician Associates (FPA) titles and introductions guidance, and provide details of their developmental and clinical supervision when required.

3 Summary of good practice recommendations

3.1 Supervision

1 PAs must have both a developmental and a clinical supervisor.

2 A supervising doctor must:
- 2.1 hold a full registration with a licence to practise with the General Medical Council (GMC)
- 2.2 be on the specialist register* and/or the GP register† and/or be employed on the specialist / associate specialist contract‡
- 2.3 be actively practising in the UK¶
- 2.4 not have restrictions against their practice from their employer or regulator that prevent them from fulfilling their role.

3 Developmental supervision
- 3.1 Every PA must have a developmental supervisor (DS).
- 3.2 Where a PA is employed across more than one organisation, a separate DS must be identified by each employer.
- 3.3 Where a PA is employed by a primary care network, a single DS who oversees their practice across the network is acceptable.
- 3.4 To be a DS, the supervising doctor must have experience of educational supervision, and ideally have undertaken formal supervision training.
- 3.5 The DS requires on average 1 hour per week (0.25 SPA) within their job plan to provide this supervision.

4 Clinical supervision
- 4.1 The clinical supervisor (CS) of the PA must be a consultant, GP or specialist / associate specialist, who retains clinical and professional responsibility for patients treated under their care.
- 4.2 The CS can change from day to day, but a CS must be available and contactable at all times.
- 4.3 Any out-of-hours supervision must be transferred to the on-call consultant (or equivalent) and is not the responsibility of doctors at any other grade.
- 4.4 PAs are responsible and accountable for their own practice and the CS will remain responsible for the overall management of the patient, any decisions around transfer of care, and the processes in place to ensure patient safety.
- 4.5 The CS requires adequate direct clinical care (DCC) time in their job plan to facilitate clinical supervision of PAs.

5 Levels of supervision
- 5.1 A newly qualified PA, or a PA moving into a new or unfamiliar role, will require direct supervision (see section 6.4 for definitions of supervision).
- 5.2 Supervision levels must be regularly reviewed to ensure that they are appropriate and proportionate.

6 Working in a team with a PA
- 6.1 PAs should seek advice and guidance from the most senior available doctor (ie ST3 level or above).
- 6.2 In situations where a delay in seeking advice from an ST3 doctor or above might lead to potential patient deterioration and/or clinical harm, PAs may seek advice and guidance from fully registered doctors (FY2 level or above), or another appropriate healthcare professional.
- 6.3 PAs need to refer any prescribing matters to a fully registered prescriber responsible for the patient's care. Whenever possible, this should be their supervising doctor.
- 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.

* List of doctors who are eligible to take up appointment in any fixed-term, honorary or substantive consultant post in the NHS.
† List of doctors who are eligible for appointment as a GP in the UK.
‡ Specialist contract reform. Specialist-terms-and-conditions-June-2022.pdf (nhsemployers.org)
¶ Practising based primarily on telecommunication devices or other telehealth technologies does not constitute actively practising in the UK.

6.5 Ionising radiation: PAs need to refer to the most appropriate healthcare professional present in their environment who can request such imaging. Whenever possible, this should be their supervising doctor.

3.2 PA practice

Standards and accountability

> PAs must uphold the standards set out in the GMC's Good Medical Practice. PAs remain accountable for their own practice.

Titles and introductions

> PAs must introduce themselves in line with the guidance from the FPA, and ensure that their role is clear to patients, members of the clinical team and in all clinical documentation.

7 Career development

7.1 PAs should progress within a scope of practice, following a defined pathway with training and competency assessments agreed beforehand. Development of these pathways must be undertaken nationally by medical royal colleges and specialist societies, following multi-stakeholder participation and in collaboration.

7.2 PAs, their supervising doctors and their employers are responsible for ensuring that their scope of practice does not extend beyond nationally agreed guidance.

7.3 Employers must ensure that adequate governance processes are in place to support nationally agreed development pathways.

7.4 Development pathways should be regularly reviewed and kept updated to remain relevant; oversight should be provided by the regulator.

8 Evidence-based practice and CPD

8.1 PAs must document their experience and competencies through a portfolio of evidence demonstrating their knowledge, skills and progress within any nationally agreed development pathway. This evidence should reflect current working practices, uphold high standards of care and meet the needs for revalidation as defined by the GMC.

8.2 PAs must continually meet proficiency standards and undertake necessary training to meet the requirements of their development pathway and to evidence competency within their scope of practice. This training should not be to the detriment of doctors' training and must be documented as part of PAs' workplace-based assessments and appraisals.

3.3 Employing a PA

9 Principles

9.1 Organisations must require all PAs that they employ to be registered on the PA Managed Voluntary Register (PAMVR; 2024 only) and subsequently on the GMC register, once it is the regulator.

9.2 Employers should keep a record of when a PA is due to renew their registration, and check that it is maintained on an annual basis.

9.3 Employers must ensure that there is an appropriate level of senior medical supervision provided and that clinical and developmental supervisors have the resources and organisational support to deliver their role.

9.4 Employers should ensure that their HR team has the expertise to employ and manage PAs appropriately, in line with recommendations made in national guidance.

10 Role appropriateness

10.1 Employers must ensure that hiring a PA aligns with the needs of the team/organisation/service and that a PA skillset also best aligns with those needs.

10.2 Agreement with clinical leads and team members must precede decisions regarding the establishment of a PA post.

10.3 Time, managerial responsibility and accountability arrangements must be agreed and stated in the PA supervising doctors' job plan.

10.4 There should be consideration of the time needed to provide clinical support and supervision, and time required for developmental meetings for PAs and other members of the clinical team.

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

11 Work schedules

11.1 Work schedules must have senior-led clinical supervision and, wherever possible, PAs should work directly alongside their supervising doctor.

11.2 Work schedules must be established to outline expectations for the employer, PAs and their supervising doctors. This includes defining work hours, development opportunities and duties within the general competencies of the PA role.

11.3 PA work schedules must facilitate ongoing professional development, support the training needs of doctors, and ensure robust clinical supervision that allows for regular contact time and direct supervision from their supervising doctors.

11.4 Any specialty advice given by PAs remains the responsibility of their clinical supervisor.

12 Appraisal

12.1 PAs must undergo an annual appraisal with their DS to review their development.

12.2 Feedback from various CSs, other members of the multidisciplinary team (MDT) and patients/carers should be captured to understand the full scope of the PA's role.

13 Specific limitations, training and consent

13.1 Employers must be aware of limitations to the PA role, eg certifying death, prescribing and requesting ionising radiation are not within the remit of the PA role.

13.2 PAs must be fully trained in the specific procedure or treatment being consented for and have the knowledge and skills required to enable them to advise the patient and respond to specific questions in relation to the consent process.

14 Impact on service and training

14.1 Implementation of PA roles must not compromise doctors' training. The role should enhance service delivery and patient experience.

14.2 The PA role within a clinical team should ideally facilitate training opportunities for doctors.

14.3 PAs must not be used to replace roles or positions performed by doctors, but to enhance or augment current teams and patient care.

14.4 PAs must not replace doctors' positions in on-call rotas.

14.5 Prior to introducing a new PA role into a service, there should be a good understanding of the current training opportunities available to doctors. It is recommended that departmental leads work closely with educational leads to ensure no detrimental impact on the training of doctors and the wider clinical team.

15 Employment governance and organisational policies

15.1 Organisations must have clear governance processes that provide oversight of the PA role, with professional accountability and oversight by the medical director (MD) / chief medical officer (CMO).

15.2 Policies must cover practical aspects of the role, such as access restrictions on clinical systems and compliance with current legislation. These policies must demonstrate adherence to national guidance developed by medical royal colleges, specialist societies and statutory bodies.

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.

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

17 Revalidation for PAs will require annual appraisal, reflection and adherence to local clinical governance standards and will become a legal requirement after the transition period following GMC regulation. PAs must collate evidence in a portfolio to support their revalidation.

4 Who are physician associates?

Physician associates (PAs) are healthcare professionals who work as part of a multidisciplinary team under the supervision of a named senior doctor (a GMC-registered consultant, GP, specialist or associate specialist). PAs can assess, diagnose and treat patients in primary, secondary and community care environments. They are not medical doctors.

The Faculty of Physician Associates (FPA) is the professional membership body committed to supporting the PA profession through setting standards, educating, training and influencing. Until the GMC becomes the regulator, the FPA holds a managed voluntary register of PAs working in the UK (the PAMVR). The PAMVR will close once the GMC becomes the regulator (December 2024).

5 Scope of practice

Scope of practice is a description of what a healthcare professional is trained and competent to undertake. It sets out the limits of their knowledge, recognises the skills and experiences that they have gained and identifies the roles, tasks and activities that they carry out as part of their professional role. It is an essential part of ensuring that they provide safe and effective care to patients. Every clinical professional has entry proficiency standards to which they must adhere. In the UK, PAs cannot prescribe medications, refer patients for ionising radiation imaging studies, or sign death certificates.

5.1 Education and experience of PAs (entry scope of practice)

UK-trained PAs have completed PA studies as a 4-year undergraduate or a 2-year postgraduate programme, which is not an undergraduate medical degree. The PA course is quality assessed internally and externally, based on the FPA PA curriculum 2023, consisting of theoretical learning in medical sciences, pharmacology and clinical reasoning, as well as clinical placement experience in a wide variety of settings. Throughout their studies, PA students are required to demonstrate safe and effective practice, self-awareness and high levels of professional behaviour. For those PAs qualifying up until the end of 2024, their programme would have followed the competence and curriculum framework (2012).

All PA students must pass their university programme prior to sitting the PA National Examination (PANE). Passing the PANE is a mandatory requirement for entry onto the PAMVR and to work as a PA. The exam sets the standard for PAs across the UK and is designed, developed and administered by the Royal College of Physicians (RCP) Assessment Unit. It consists of comprehensive written and objective structured clinical examination (OSCE) components. PAs on the PAMVR must commit to maintaining good standards of clinical practice, public protection and safety.

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

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

The FPA, in partnership with the GMC, released the PA curriculum in September 2023. The GMC and the FPA are jointly responsible for setting standards, and this curriculum serves as a guiding framework for the development of PA courses offered by higher education institutions (HEIs).

HEIs are responsible for the development of learner curricula and assessment frameworks for their programmes. The PA curriculum document is used by the GMC to approve those PA study programmes.

The PA curriculum covers the:

- programme of learning, which sets out what a PA student should learn during their course
- educational approach, which contains requirements and guidance for course providers on how they should approach equality, diversity and inclusion, supervision and educator roles, feedback and reflection, record keeping, clinical placements and assessment.

As referenced in the physician associate curriculum, the newly qualified PA can be expected to:*

- formulate and document a differential diagnosis, having taken a history and completed a physical examination
- recognise life-threatening and emergency situations and escalate care appropriately
- request, perform and interpret diagnostic studies and therapeutic procedures, and recommend a management plan, including therapeutics
- deliver and maintain patient-centred clinical management in partnership with the patient and MDT, dealing with uncertainty when it arises
- work in partnership with patients from diverse backgrounds to agree comprehensive and individualised management plans
- undertake patient education, counselling and health promotion.

Based on the FPA's PA curriculum and the GMC's PARA content map, all newly qualified PAs should be competent to perform a specific set of procedures independently at the point of registration (laid out iin Appendix A).

After graduation, PAs must continue their learning in the clinical work environment and demonstrate this through continuing professional development (CPD). CPD is the educative means of updating, developing and enhancing the knowledge, skills and attitudes required to work safely and effectively.

All PAs must fulfil CPD requirements to remain on the PAMVR and, once the GMC becomes the regulator, for GMC revalidation. All PAs on the PAMVR should log their CPD onto the FPA ePortfolio. PAs are trained as general healthcare professionals and must keep up to date in all 18 areas of the core clinical practice curriculum (CCPC).† PAs are currently expected to complete 250 hours of CPD every 5 years, with 125 hours of this time divided across the 18 areas in the CCPC. Further information on PA CPD requirements can be found in the FPA's CPD guidance for PAs.

For information on the education and registration of USA-trained PAs, please see Appendix D. Although the FPA PA curriculum prepares PAs for working in a clinical environment, post-qualification their development must be determined by nationally agreed development pathways as described in Section 9.

6 Supervision

Supervision is key to safe and effective practice. The importance and role of supervision within healthcare is widely established. Regulators including the GMC, General Pharmaceutical Council (GPC), Nursing and Midwifery Council (NMC) and Health and Care Professions Council (HCPC) all provide standards for supervision. Common themes include the requirement for accountability, identification and management of concerns and the need to safeguard the wellbeing of patients, the public and the professionals themselves.

* Based upon the matrix of core clinical conditions. Matrix specification of core clinical conditions for the physician assistant. Department of Health, 2006. https://work-learn-live-blmk.co.uk/wp-content/uploads/2019/06/MSc-PA-Matrix-of-Core-Clinical-Conditions.pdf [Accessed 11 July 2024].

† The core clinical practice curriculum (CCPC) is within the FPA ePortfolio and taken from the GMA PA registration assessment (PARA) content map. The CCPC in the ePortfolio includes all the core areas of practice in which a PA is expected to maintain knowledge.

The recommendations for PA supervision are based on existing good practice, including clarifying the difference between developmental and clinical supervision. To support doctors, the GMC has outlined advice for doctors who supervise PAs. These principles are mapped to Good Medical Practice. Supervision must be time, situation and individual specific. Throughout this section we will refer to the term 'supervising doctor', the requirements for which are set out below. There are two types of supervising doctor, the developmental supervisor (DS) and the clinical supervisor (CS).

Recommendations

1 PAs must have both a developmental and a clinical supervisor.

2 A supervising doctor must:

- 2.1 hold a full registration with a licence to practise with the GMC
- 2.2 be on the specialist register* and/or the GP register‡ and/or be employed on the specialist / associate specialist contract†
- 2.3 be actively practising in the UK¶
- 2.4 not have restrictions against their practice from their employer or regulator that prevent them from fulfilling their role.

6.1 Developmental supervisor

Each individual PA must have a developmental supervisor (DS). Where a PA is employed across more than one organisation, a separate DS must be identified by each employer. Where a PA is employed by a primary care network, a single DS who oversees their practice across the network is acceptable. The role of the DS is to oversee the long-term clinical, educational and professional development of the PA, providing guidance to the PA on career progression and managing any concerns that arise. A DS is a skilled and important role, and they should have undertaken and maintained relevant training on supervision. Good communication between the DS and the clinical supervisor(s) is essential for quality of supervision.

The DS requires on average 1 hour per week (0.25 SPA) within their job plan to provide this supervision.

The evidence base, both qualitative and quantitative, for developmental supervision of healthcare professionals is well-established. Multiple good-practice, evidence-based guides exist, including those highlighted by the GMC in *Excellence by design: standards for postgraduate curricula*, based on standards from the Academy of Medical Educators.

The **developmental supervisor** has responsibility for:

- establishing and agreeing with the PA an individual work schedule
- ensuring that an individual PA's work schedule and development pathway are compliant with national guidance from medical royal colleges and specialist societies
- ensuring that any changes to a PA's work schedule, including progress on a development pathway, are assessed for their impact on other members of the team
- reviewing a PA's portfolio, meeting at least twice a year. For new graduate PAs, those moving into a new specialty or those changing developmental supervisor, there should be an initial meeting, followed by meetings at 3 months, 6 months and 1 year
- performing an annual appraisal
- providing education support to assist the PA to comply with the FPA core clinical practice curriculum and FPA CPD requirements, and to meet their national and local statutory mandatory training requirements
- providing pastoral support.

* List of doctors who are eligible to take up appointment in any fixed-term, honorary or substantive consultant post in the NHS.
† List of doctors who are eligible for appointment as a GP in the UK.
‡ Specialist contract reform. Specialist-terms-and-conditions-June-2022.pdf (nhsemployers.org)
¶ Practising based primarily on telecommunication devices or other telehealth technologies does not constitute actively practising in the UK.

Recommendations

3.1 Every PA must have a developmental supervisor (DS).

3.2 Where a PA is employed across more than one organisation, a separate DS must be identified by each employer.

3.3 Where a PA is employed by a primary care network, a single DS who oversees their practice across the network is acceptable.

3.4 To be a DS, the supervising doctor must have experience of educational supervision, and ideally have undertaken formal supervision training.

3.5 The DS requires on average 1 hour per week (0.25 SPA) within their job plan to provide this supervision.

6.2 Clinical supervisor

The clinical supervisor (CS) of the PA must be the consultant, GP or specialist / associate specialist who retains clinical and professional responsibility for patients treated under their care. Any out-of-hours supervision is transferred to the on-call consultant (or equivalent) and is not the responsibility of doctors at other grades. The CS can change from day to day, but there must be a CS available and contactable for real-time advice, in person or remotely.

With correct supervision, and when delegated to appropriately, PAs are responsible and accountable for their own practice. The CS will remain responsible for the overall management of the patient, any decisions around transfer of care, and the processes in place to ensure patient safety.

The CS requires adequate direct clinical care (DCC) time in their job plan to facilitate clinical supervision of PAs.

Recommendations

4.1 The clinical supervisor (CS) of the PA must be a consultant, GP or specialist / associate specialist who retains clinical and professional responsibility for patients treated under their care.

4.2 The CS can change from day to day, but a CS must be available and contactable at all times.

4.3 Any out-of-hours supervision must be transferred to the on-call consultant (or equivalent) and is not the responsibility of doctors at any other grade.

4.4 PAs are responsible and accountable for their own practice and the CS will remain responsible for the overall management of the patient, any decisions around transfer of care, and the processes in place to ensure patient safety.

4.5 The CS requires adequate direct clinical care (DCC) time in their job plan to facilitate clinical supervision of PAs.

6.3 Delegation

PAs can practise in the UK under the clause of delegation as outlined below, taken from the GMC Good Medical Practice.

'Delegation involves asking a colleague to take responsibility for providing care or treatment on your behalf. Accountability for safe delegation is shared between the colleague delegating and the colleague to whom care or treatment is delegated. You must work collaboratively with colleagues to make sure delegation is appropriate.

You must be confident that the colleague you delegate to has the necessary knowledge, skills, and training to carry out the task, or that they will be adequately supervised to ensure safe care.

Usually, you'll delegate to a colleague who is a medical, health or social care professional registered with a statutory regulatory body. If a colleague is not registered with a statutory regulatory body, registration on a managed voluntary register can give some assurance that they've met defined standards of competence, and that they adhere to agreed standards for their professional skills and behaviour.'

6.4 Levels of supervision

The degree of supervision required will change based on the experience of the PA. A newly qualified PA, or a PA moving into a new or unfamiliar role, will require direct supervision initially. Supervision levels must be regularly reviewed to ensure that they are appropriate and proportionate. Remote supervision is only appropriate where the DS and the CS(s) are satisfied that the individual PA has the appropriate competencies to practise with this level of supervision.

There are three levels of supervision for a qualified PA:

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

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

Remote The PA's supervising doctor is available for real-time advice, but not in-person review of a patient. There **must** be an appropriate system for escalation of deteriorating patients and emergency support.

Recommendations

5.1 A newly qualified PA, or a PA moving into a new or unfamiliar role, will require direct supervision.

5.2 Supervision levels must be regularly reviewed to ensure that they are appropriate and proportionate.

7 Working in a team with a PA

PAs are valued healthcare professionals who participate in patient care in addition to the rest of the wider MDT.

Supervising doctors have been defined above; the following guidance is for other members of the medical team who are working with PAs in their teams.

7.1 Seeking advice and guidance

It is recommended that PAs seek advice and guidance from the most senior available doctor (ie ST3 level or above).

In situations where a delay in seeking advice from an ST3 doctor or above might lead to potential patient deterioration and/or clinical harm, or when defined and agreed local pathways exist (such as referring to an on-call surgical team led by a consultant), PAs may seek advice and guidance from fully registered doctors (FY2 doctor or above), or another appropriate healthcare professional.

In all cases, the doctor is not supervising the PA but is providing advice and guidance based on information provided by the PA.

7.2 Referring for prescribing

PAs cannot prescribe medications regardless of any prior healthcare background (eg those with non-medical prescribing qualifications from previous roles) while working as a PA. PAs are trained in key aspects of therapeutics and management of commonly prescribed medicines. See Appendices B and C for detail.

As PAs cannot prescribe, PAs need to refer any prescribing matters to a fully registered prescriber responsible for the patient's care. Whenever possible, this should be their supervising doctor. In the most urgent circumstances, referral can be to someone who can prescribe in a timely manner.

Referral will involve the PA presenting the clinical case requiring a prescription to the prescriber.

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. Prescribers must never prescribe unquestioningly at the request of any other clinician, but should weigh up the information they have from a range of sources to make an appropriate prescribing decision. This is outlined in the GMC's Good practice in prescribing and managing medicines. PAs should only refer matters related to prescribing to fully registered doctors (FY2 level and above).*

Although the FPA PA curriculum includes PAs preparing safe and legal prescriptions in a simulated environment, this is not appropriate in clinical practice.

7.3 Referring for ionising radiation

Due to the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER), PAs cannot request ionising radiation (eg CT scans or X-rays). PAs will need refer to the most appropriate healthcare professional present in their environment who is able to request such imaging. Whenever possible, this should be their supervising doctor or, in the most urgent circumstances, someone who is able to request the imaging in a timely manner.

Recommendations

6.1 PAs should seek advice and guidance from the most senior available doctor (ie ST3 level or above).

6.2 In situations where a delay in seeking advice from an ST3 doctor or above might lead to potential patient deterioration and/or clinical harm, PAs may seek advice and guidance from fully registered doctors (FY2 or above), or another appropriate healthcare professional

6.3 PAs need to refer any prescribing matters to a fully registered prescriber responsible for the patient's care. Whenever possible, this should be their supervising doctor.

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.

6.5 Ionising radiation: PAs need to refer to the most appropriate healthcare professional present in their environment who can request such imaging. Whenever possible, this should be their supervising doctor.

8 Career development

As PAs progress in their career, they will become more experienced in their specific area of practice, which may include developing additional clinical, practical, managerial, leadership and academic skills. PAs should be supported in their career development and must follow a defined pathway. Development of these pathways must be undertaken nationally by medical royal colleges and specialist societies, following multi-stakeholder participation and in collaboration.

This will uphold a high standard of care, in line with Good Medical Practice to safeguard the patient, the PA and the employer.

* FY1s have extensive undergraduate training and the ability to prescribe independently but, as pre-registration doctors, they are not expected to take on the responsibility for referrals for prescribing from PAs.

PAs are responsible for their own practice, although they will always work under the supervision of a consultant, GP or specialist / associate specialist who retains clinical and professional responsibility for patients treated under their care.

Development pathways should be regularly reviewed and kept updated to remain relevant; and oversight should be provided by the regulator.

Recommendations

7.1 PAs should progress within a scope of practice, following a defined pathway with training and competency assessments agreed beforehand. Development of these pathways must be undertaken nationally by medical royal colleges and specialist societies, following multi-stakeholder participation and in collaboration.

7.2 PAs, their supervising doctors and their employers are responsible for ensuring that their scope of practice does not extend beyond nationally agreed guidance.

7.3 Employers must ensure that adequate governance processes are in place to support nationally agreed development pathways.

7.4 Development pathways should be regularly reviewed and kept updated to remain relevant; oversight should be provided by the regulator.

8.1 Evidence-based practice and CPD

During a PA's career, they must continue to meet and evidence the standards of proficiency required of their practice. PAs must gather and build a portfolio of evidence that demonstrates expanding knowledge, skills and experience along nationally defined development pathways. This information should be collated in the FPA ePortfolio so that PAs can provide evidence for GMC revalidation.

Recommendations

8.1 PAs must document their experience and competencies through a portfolio of evidence demonstrating their knowledge, skills and progress within any nationally agreed development pathway. This evidence should reflect current working practices, uphold high standards of care and meet the needs for revalidation as defined by the GMC.

8.2 PAs must continually meet proficiency standards and undertake necessary training to meet the requirements of their development pathway and to evidence competency within their scope of practice. This training should not be to the detriment of doctors' training and must be documented as part of PAs' workplace-based assessments and appraisals.

9 Governance structures for PAs

The PAMVR includes a code of conduct to ensure good standards of practice, public protection and patient safety. Following regulation, the GMC will be responsible for fitness to practise concerns. The FPA code of conduct document sets out the guiding principles and values that PAs are expected to apply in their daily practice.

PAs who are on the PAMVR may add the letters 'PA-R' as a postnominal to demonstrate that they are currently on the register and commit to maintaining high standards of practice.

The FPA recommends that employers require all PAs that they employ to be registered on the PAMVR (2024 only) and subsequently on the GMC register. This must happen prior to a PA being eligible for employment, a position supported by NHS Employers. It also recommends that employers keep a record of when a PA is due to renew their registration, and check that membership is maintained on an annual basis. Further information regarding the PAMVR, and to check whether a PA is registered, can be found on the FPA website.

Once regulation begins, the GMC has said that all PAs will be required to adhere to the standards set out in Good Medical Practice.

Recommendations

9.1 Organisations must require all PAs that they employ to be registered on the PAMVR (2024 only) and subsequently on the GMC register, once it is the regulator.

9.2 Employers should keep a record of when a PA is due to renew their registration, and check that it is maintained on an annual basis.

9.3 Employers must ensure that there is an appropriate level of senior medical supervision provided and that clinical and developmental supervisors have the resources and organisational support to deliver their role.

9.4 Employers should ensure that their HR team has the expertise to employ and manage PAs appropriately, in line with recommendations made in national guidance.

10 Employing a PA

It is imperative that employers ensure that multidisciplinary teams have the most appropriate skill mix to provide excellent healthcare to patients. Careful consideration of the role and remit of a PA and how they might add value to a team/organisation is required before recruitment. Other roles may be more appropriate, depending on the needs of the service.

Clinical leads overseeing service delivery and development should engage in consultation with all team members prior to making decisions regarding the establishment of a PA post, and should have researched, discussed and consulted with the appropriate stakeholders. The role that the PA will undertake for the department/practice must be agreed to maximise the use of the post. The clinical lead should assess the current skill composition of the department and determine how a PA might best integrate into the team.

Time, managerial responsibility and accountability arrangements must be agreed and stated in the PA supervising doctors' job plan (for both clinical and developmental supervisors). There should be consideration of the time needed to provide clinical support and supervision, and time required for developmental meetings for PAs and other members of the clinical team.

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

Recommendations

10.1 Employers must ensure that hiring a PA aligns with the needs of the team/organisation/service and that a PA skillset also best aligns with those needs.

10.2 Agreement with clinical leads and team members must precede decisions regarding the establishment of a PA post.

10.3 Time, managerial responsibility and accountability arrangements must be agreed and stated in the PA supervising doctors' job plan.

10.4 There should be consideration of the time needed to provide clinical support and supervision, and time required for developmental meetings for PAs and other members of the clinical team.

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

10.1 Work schedules

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

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

Any specialty advice given by PAs remains the responsibility of their clinical supervisor.

Recommendations

11.1 Work schedules must have senior-led clinical supervision and, wherever possible, PAs should work directly alongside their supervising doctor.

11.2 Work schedules must be established to outline expectations for the employer, PAs and their supervising doctors. This includes defining work hours, development opportunities and duties within the general competencies of the PA role.

11.3 PA work schedules must facilitate ongoing professional development, support the training needs of doctors, and ensure robust clinical supervision that allows for regular contact time and direct supervision from their supervising doctors.

11.4 Any specialty advice given by PAs remains the responsibility of their clinical supervisor.

10.2 Appraisal

All PAs should have an annual appraisal with their developmental supervisor (DS), who has full oversight of their development (for more information, see supervision section). PAs may work with many clinical supervisors (CSs) and other members of the MDT in either primary or secondary care, so it is important that all feedback is captured. Patient and carer feedback is essential. This can be done via 360-degree assessment (multisource feedback) and collated as part of the FPA ePortfolio.

Recommendations

12.1 PAs must undergo an annual appraisal with their DS to review their development.

12.2 Feedback from various CSs, other members of the MDT and patients/carers should be captured to understand the full scope of the PA's role.

10.3 Specific limitations, training and consent

As per the collaborative GMC/FPA curriculum, PAs can verify expected deaths if they have had relevant training and demonstrated the required competencies, but are not permitted to certify death, complete the Medical Certificate of Cause of Death, or make referrals to HM coroner.

GMC guidance states that the task of seeking consent may be delegated to another person, provided that they are suitably trained and qualified. The health professional carrying out a procedure or treatment is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done.

Recommendations

13.1 Employers must be aware of limitations to the PA role, eg certifying death, prescribing and requesting ionising radiation are not within the remit of the PA role.

13.2 PAs must be fully trained in the specific procedure or treatment being consented for and have the knowledge and skills required to enable them to advise the patient and respond to specific questions in relation to the consent process.

10.4 Impact on service and training

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

Recommendations

14.1 Implementation of PA roles must not compromise doctors' training. The role should enhance service delivery and patient experience.

14.2 The PA role within a clinical team should ideally facilitate training opportunities for doctors.

14.3 PAs must not be used to replace roles or positions performed by doctors, but to enhance or augment current teams and patient care.

14.4 PAs must not replace doctors' positions in on-call rotas.

14.5 Prior to introducing a new PA role into a service, there should be a good understanding of the current training opportunities available to doctors. It is recommended that departmental leads work closely with educational leads to ensure no detrimental impact on the training of doctors and the wider clinical team.

10.5 Employment governance and organisational policies

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

It is important that senior leaders in healthcare trusts, health boards and primary care networks engage with requirements for revalidation for PAs.

Given the close working relationship between PAs and doctors, and with forthcoming regulation by the GMC, it is recommended that PAs are placed within the medical governance framework to ensure that their professional accountability is overseen by the medical director. More information in relation to effective clinical governance supporting revalidation that is inclusive of PAs can be found here.

Due to current legislation, it is imperative that clinical IT systems restrict access for PAs from ordering ionising scans and prescribing medications.

Recommendations

15.1 Organisations must have clear governance processes that provide oversight of the PA role, with professional accountability and oversight by the medical director (MD) / chief medical officer (CMO).

15.2 Policies must cover practical aspects of the role, such as access restrictions on clinical systems and compliance with current legislation. These policies must demonstrate adherence to national guidance developed by medical royal colleges, specialist societies and statutory bodies.

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.

10.6 Indemnity

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

Recommendation

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

11 Revalidation

Revalidation for PAs will be implemented after the 2-year regulation transition period, which will begin when regulation starts at the end of 2024. At the end of the transition period, it will be a legal requirement for all PAs to be on the GMC register. Revalidation will be based on the collection of six pieces of supporting information, which should be discussed and reflected upon at appraisal. Further information regarding revalidation for PAs can be found on the GMC website.

Recommendation

17 Revalidation for PAs will require annual appraisal, reflection and adherence to local clinical governance standards and will become a legal requirement after the transition period following GMC regulation. PAs must collate evidence in a portfolio to support their revalidation.

12 References

Physician associate curriculum 2023 (Faculty of Physician Associates)
Physician Associate National Examination
GMC PA and AA generic and shared learning outcomes 2022
GMC Physician associate registration assessment (PARA) content map 2022
Faculty of Physician Associates CPD guidance 2024
Faculty of Physician Associates code of conduct 2022
Faculty of Physician Associates ePortfolio
GMC Good Medical Practice 2024
Competence and curriculum framework for the physician assistant 2012
GMC Delegation and referral summary 2024
GMC Good practice in managing medicines and devices 2021
GMC guidance on supervision for PAs and AAs
GMC Excellence by design 2017
GMC Decision making and consent 2020
GMC Guidance on supporting information for revalidation 2024
Physician associate title and introduction guidance for PAs, supervisors, employers and organisations
FPA letter to employers 'Employing physician associates' December 2022
Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER)

13 Appendices

13.1 Appendix A: Procedural framework (excerpt taken from FPA curriculum)

Category	Procedure
Core clinical practice	Take baseline physiological observations (measure temperature, respiratory rate, pulse rate, blood pressure, oxygen saturations and urine output) and record and interpret appropriately
	Perform surgical scrubbing up
	Participate in cardiopulmonary resuscitation to the level expected in Immediate Life Support training
Core clinical practical procedures	Perform venepuncture
	Perform intravenous cannulation
	Perform arterial blood gas and acid base sampling from the radial artery in adults and be able to interpret results
	Take blood for culture of infectious organisms via peripheral venepuncture
	Measure capillary blood glucose
	Explain to a patient how to perform a peak expiratory flow, assess that it is performed adequately and interpret results
	Perform a urine multi-dipstick test and be able to interpret results
	Perform a 12-lead electrocardiogram and be able to interpret results
	Take and/or instruct patients how to take a swab
	Perform male and female urinary catheterisation
Core therapeutic procedures	Carry out nasogastric tube placement (in simulation only)
	Recommend and administer oxygen appropriately
	Instruct patients in the use of devices for inhaled medication
	Undertake basic drug dose calculations
	Set up an infusion
	Prepare and administer medications, including parenteral medications (subcutaneous, intramuscular and intravenous).
	Use local anaesthetics in different forms (topical, subcutaneous infiltration, urethral)
	Perform wound care and closure, including suturing and dressing

13.2 Appendix B: Previous educational requirements: Competency and curriculum framework 2012 (physician assistant)

2.3.8 Therapeutics and prescribing

- Working under medical delegation clauses, determine and propose appropriate therapeutic interventions from the full range of available prescription medications used in the clinical setting.
- Write accurate and legible prescriptions in outpatient, inpatient and primary care setting for review and signature by a supervising clinician.
- On commencing intravenous infusion, write accurate and legible prescriptions for appropriate fluid regimes for review and signature by a supervising clinician.
- Use the British National Formulary (BNF) and local formularies appropriately and be familiar with the yellow card system for reporting side effects / drug interactions.
- Recognise their responsibility for facilitating patient concordance for the drug regimen being proposed by them and prescribed by their supervising clinician.

13.3 Appendix C: Current educational requirement: Physician associate / anaesthesia associate (PA/AA) learning outcomes 2023

Physician associates commencing training from September 2023 will have been trained in line with the FPA Physician Associate Curriculum (2023), which lists the following competencies for physician associate training.

- Establishes an accurate medication history, covering both prescribed and non-prescribed medications, herbal medicines, supplements and drugs of abuse.
- Establishes and clarifies medication allergies and the types of medication interactions that patients experience.
- Describes medications and medication actions: therapeutics and pharmacokinetics, medication side effects and interactions, including for multiple treatments, long-term conditions and non-prescribed drugs.
- Describes the role of antimicrobial stewardship in safe prescribing.
- Recognises the challenges of safe prescribing for patients in high-risk groups such as those with long-term conditions, multiple morbidities and medications, in pregnancy, at extremes of age and at the end of life.
- Recognises patient choice to use complementary therapies and how this might affect the safety and efficacy of other types of treatment that patients receive.
- Recognises the challenges of delivering care when prescribing and providing treatment and advice remotely, for example via online services.

13.4 Appendix D: Education and registration of USA-trained PAs

Currently, of PAs trained outside the UK, only USA-qualified PAs are allowed to work in the UK.

USA-trained PAs will be a graduate of a nationally recognised US physician assistant programme, including those accredited by:

- Accreditation Review Commission on Education for the Physician Assistant (ARC-PA)
- ARC-PA's successor agency
- one of ARC-PA's predecessor agencies:
  - Committee on Allied Health Education and Accreditation (CAHEA)
  - Commission on Accreditation of Allied Health Education Programs (CAAHEP).

They will have passed the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA).

USA-qualified PAs will have maintained certification by passing either the Physician Assistant National recertification exam (PANRE) or the Physician Assistant National Recertifying Exam – Longitudinal Assessment (PANRE-LA). They will have met the necessary CME hours as stipulated by the NCCPA.

14 Glossary

AA	Anaesthesia associate
ARC-PA	Accreditation Review Commission on Education for the Physician Assistant (USA)
CAAHEP	Commission on Accreditation of Allied Health Education Programs (USA)
CAHEA	Committee on Allied Health Education and Accreditation (USA)
CCPC	Core clinical practice curriculum
CMO	Chief medical officer
CS	Clinical supervisor
CPD	Continuing professional development
DCC	Direct clinical care
DS	Developmental supervisor
FPA	Faculty of Physician Associates
FY1 and FY2	Foundation year 1 and 2 doctors
GMC	General Medical Council
GPC	General Pharmaceutical Council
HCPC	Health and Care Professions Council
HEI	Higher education institution
HR	Human resources
IRMER	Ionising Radiation (Medical Exposure) Regulations 2017
MDT	Multidisciplinary team
NCCPA	National Commission on Certification of Physician Assistants
NMC	Nursing and Midwifery Council
OSCE	Objective structured clinical examination
PA	Physician associate
PAMVR	Physician Associate Managed Voluntary Register
PANE	Physician Associate National Examination
PA-R	Physician associate registered on the PAMVR
PARA	Physician associate registration assessment
RCP	Royal College of Physicians
SAS	Specialist, associate specialist and specialty doctors
SPA	Supporting professional activity
ST3	Specialty trainee year 3

Royal College
of Physicians