

A clinical protocol for physician assistants, their supervisors, team members and employers

Teamworking and undifferentiated patients

Draft document for targeted stakeholder consultation

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Section 1- Background

Context

The Leng Review

1. The [Leng Review](#) was published in July 2025, following a period of significant controversy about the roles of physician associates (PAs) ¹ (AAs)². The review set out 18 recommendations that provided support for the roles of PAs and AAs, with the proviso that the following measures were put in place to protect patient safety:
 - There should be a clear team structure where all members of the team are aware of the roles, responsibilities and accountability of other team members.
 - PAs should play a supportive, complementary role within the medical team.
 - There should be a formal certification and credentialing programme to support career development for PAs.
 - PAs should only see undifferentiated patients in the context of national clinical protocols because of safety concerns.
2. The recommendation that PAs should not see undifferentiated patients except within clearly defined national clinical protocols (recommendation four) was based on safety concerns raised about PAs making a diagnosis and deciding initial treatment, particularly in settings where patients first present with new signs and symptoms.
3. PAs currently make up a relatively small part of the NHS workforce and, because there has been limited national direction, their deployment varies considerably between organisations and settings.
4. This document describes the approach that has been taken to build on the Review recommendations and sets out guidance on effective teamworking, together with a national clinical protocol for the consistent, safe and effective deployment of PAs across settings.

Status of this document

5. This document has been developed for use in England, supported by substantial input and engagement from across the four nations which has been received as part of the design process. Feedback from relevant stakeholder organisations across the four nations is being captured and considered as part of the targeted consultation process.
6. This document is intended to provide a basis for a clear, consistent and evidence-informed framework to support implementation throughout the UK, while allowing relevant nation-specific requirements to be met separately. The four nations remain committed to working collaboratively to maximise consistency of approach, improve

1. ¹ In this document when discussed in the context of the Leng Review, references are made to 'physician associate' as per the title at the time. Otherwise, references are made to the proposed name of 'physician assistant'.

clarity for patients and professionals, and support the recommendations of the Leng Review.

7. The guidance is relevant to PAs themselves, those supervising them, plus employers and managers of teams deploying PAs.

This document is a draft shared as part of a targeted stakeholder consultation. Contents are not final and will be subject to revision.

Methodology

8. The Leng Review was underpinned by a comprehensive, mixed methods approach, combining quantitative data, literature review and extensive qualitative stakeholder engagement. It included feedback from multiple specialties and settings to capture local variation, and triangulated evidence across a range of sources including clinicians, employers, educators and professional bodies to ensure findings were balanced and grounded in real world practice.
9. The methodology for developing this protocol built on the findings of the Review, supported by consideration of:
 - a. Relevant documents produced by third party organisations such as Royal Colleges and the GMC
 - b. Local protocols relevant to the deployment of PAs provided by PAs, their supervisors and employers
 - c. Feedback from multidisciplinary teams received through a series of workshops.
 - d. The structure and curriculum of PA training through formal study as well as post-qualification
 - e. A survey of those working in teams including PAs to identify example roles and responsibilities.
10. An expert Clinical Advisory Panel ('the Panel') was established to provide independent advice from a range of relevant perspectives from across the four nations. It was made up of system, strategic and educational leaders, as well as those working with or as PAs. Relevant stakeholders were given the opportunity to put forward potential panellists, with final membership given in the appendix.

Workshops with multidisciplinary teams

11. Detailed workshops were held with multidisciplinary teams from across the four nations and working across a range of settings: secondary care; acute and emergency medicine; mental health; and primary care. The aims were to determine:
 - How PAs were integrated into the team, including supervision and oversight
 - Approaches to PAs seeing undifferentiated patients
 - Effective roles and responsibilities carried out or held by the PAs.
12. All workshops were run in conjunction with Policy Lab, a multidisciplinary team within the UK Civil Service that supports policymaking through a range of people-centred

approaches. Policy Lab co-designed and facilitated the workshops to capture insights on team working and supervision.

13. Workshops were held with over 40 teams and 140 individuals from across the United Kingdom, nominated by a range of relevant stakeholders as well as contacted directly. All team members had experience of working with or as PAs in a range of settings. The teams attending workshops were largely self-selecting, based on having relevant experience with integrating PAs into their workforce, and volunteering themselves to participate.
14. The majority of attendees were consultants, PAs and GPs, with a small number of others from the wider multidisciplinary team. Members of the panel and selected stakeholders were also invited to observe, but not to actively participate.
15. References in this document to a 'consultant' mean a medically qualified consultant doctor on the GMC specialist register. References to 'GP's mean fully qualified general practitioners.

Findings

Definition of an undifferentiated patient

16. No standard national or international definition of an undifferentiated patient was identified. The definition given below was based on advice from the panel and is similar to others developed by specialist colleges and societies. It was used as a working definition throughout meetings with stakeholders and multidisciplinary teams.
17. An undifferentiated patient is defined as "a patient with new signs and symptoms who has not yet had an initial clinical assessment". An assessment is defined as "the point where a differential diagnosis and/or significant interventions are made". Where these signs and symptoms are either a continuation of, or an expected exacerbation of known symptoms for a previously diagnosed condition, the patient is understood to be differentiated.

Consultation question: Do you agree with the definition of an undifferentiated patient as "a patient with new signs and symptoms who has not yet had an initial clinical assessment"? [Mandatory, Yes/No]

Consultation question: Please explain your answer and/or provide an alternative proposal, including identification of the relevant paragraph(s) or section(s). [Optional, Free text]

Consultation question: Do you agree with the definition of an initial clinical assessment as "the point where a differential diagnosis and/or significant interventions are made?" [Mandatory, Yes/No]

Consultation question: Please explain your answer and/or provide an alternative proposal, including identification of the relevant paragraph(s) or section(s). [Optional, Free text]

General workshop findings

18. Across all workshops feedback was generally consistent in reporting that:

- a. PAs played an important role in providing consistency and continuity for the healthcare system, supporting consultants and GPs in managing their patients.
- b. Readily available, in-person clinical supervision, as well as holistic oversight from a named supervisor, was essential to ensure safe deployment of PAs in a range of roles, especially when assessing undifferentiated patients. In this context, the presence of a multidisciplinary team was essential in providing support to the PA, which was much more readily available in secondary care than in primary care. PAs played a flexible, generic role within the multidisciplinary team, generally seen as adding important capacity rather than a distinct set of skills and experience.
- c. PAs were more effective in organisations with mature supervision and governance arrangements, including protected time for supervision, routine opportunities for case discussion, and clear role boundaries and escalation routes within the multidisciplinary team.
- d. PAs were usually, but not always, supervised by a senior doctor such as a consultant or GP.
- e. The role that an individual PA could fulfil varied depending on their individual experience and training, and this needed to be carefully assessed.
- f. PAs did not complete custom training because it was not available, but often made use of training designed for other professions. There was a perceived need for custom training to be made available.
- g. PAs often filled discrete service gaps, for example in providing certain procedures and services, and training other types of clinician in performing these roles. The kinds of procedures and training provided varied depending on service need.
- h. PAs expressed concerns about disparity between their role and that of other non-doctor roles, and that they are still unclear about future career progression. There were a range of different approaches to certifying the skills and expertise of PAs, which tended to draw on frameworks developed for other professions.

19. Detailed outputs from the workshops were considered by the panel and used to inform protocol design. The focus of the panel's consideration was on effective supervision and governance, the general roles carried out by PAs and specifically on how and when PAs were deployed to see undifferentiated patients.

20. The sections below provide a summary of existing ways of working by setting.

Findings in secondary care

21. In secondary care, PAs formed part of a clear multidisciplinary team, with regular consultant-led discussions. Senior clinical colleagues were readily available should advice and support be required.
22. Most patients seen by a PA were expected to be already differentiated, as they will have undergone an initial clinical assessment and triage on admission. The PA would sometimes be the first to see these patients, but a preliminary diagnosis and management plan would then be agreed by a clinical supervisor. The supervisor would also review and refine both diagnosis and management as new information emerged, and this would inform the work of the PA.

Findings in the emergency department

23. In the emergency department, patient care was delivered through close multidisciplinary team working. PAs had regular real-time access to consultant or other senior medical oversight embedded in assessment and treatment pathways.
24. By definition, the majority of patients in the emergency department were undifferentiated. Although routine triage systems were available, the importance of the lead consultant was emphasised in determining which patients could be seen by a PA in their department. In this context, with appropriate direction and supervision, PAs were able to see new patients. Advice on diagnosis and initial management was given by agreed clinical colleagues in the department, and PAs would sometimes take responsibility for discharge processes.

Findings in mental health

25. In mental health settings, PAs were playing two types of roles. One was to support the management of mental health conditions, and the other was to provide a resource for assessing any concurrent physical health conditions.
26. In assessing new patients with a possible mental health condition, PAs worked closely with a multidisciplinary team. Regular and routine consultant-led discussions were described, and these were used to review and refine both diagnosis and management as new information emerged. It was recognised that patients may not receive a definitive diagnosis for a significant period, and agreeing this diagnosis was the responsibility of the consultant-led multidisciplinary team, not of the PA. PAs would provide follow up against a management plan already agreed by a clinical supervisor.
27. In assessing physical health conditions, PAs provided both medication reviews and routine health checks for patients with chronic conditions. It was reported that this helped reduce the need for resident doctors to provide this function, so they could focus on psychiatry training. There was lack of clarity however, in where the PAs should go for additional support in relation to clinical advice and support for physical health.

Findings in primary care

28. In primary care, the focus described by teams who attended the workshops was one of supportive supervision, training PAs to see the majority of patients with increasing levels of independence. Unlike in secondary care, access to a multidisciplinary team was less immediate, with care being delivered by individual clinicians, working independently with their own lists of patients.
29. A substantial proportion of activity in this setting related to patients with established diagnoses, including follow-up and delivery of agreed management plans. However, a significant volume of patients also presented with new symptoms, either during new appointments or unexpectedly during follow-ups.
30. There was some variation in how closely PAs were supervised, and in whether every patient was discussed with a supervisor. Time was usually set aside for clinical supervisors to review actions taken at PA appointments after morning or afternoon surgery, once the patient had left. PAs were also able to call clinical supervisors for immediate support via an in-person review of the patient before they left, or to delay confirmation of aspects of diagnosis or management plans until they received agreement by a clinical supervisor.

Considerations and rationale

31. Feedback from the workshops was considered in the light of the review's original recommendations, taking into account the GMC's professional standards. The panel took particular note of the following principles in developing this protocol:
- Recommendations from the review must not be compromised, in particular noting that PAs should play a supportive, complementary role within a clear team structure where everyone is aware of their roles and responsibilities.
 - Clarity of roles for PAs is essential, as this is an important element of ensuring patient safety. This reflects those industries that have a clear safety focus, such as aviation and nuclear technology, where clear roles and responsibilities are seen as a crucial element of safe infrastructure.
 - PAs should not be carrying out roles as substitutes for doctors, and should be working within their level of training and scope of practice. This is in line with the published Review, and the regulation of PAs as distinct professions by the GMC.
32. The panel was in general agreement about the oversight and supervision requirements for PAs working in general secondary care, the emergency department and in mental health settings. There was confidence in the structure and function of the multidisciplinary team and the immediate availability of clinical supervisors to provide support as required.
33. There were some mixed views in relation to the roles that PAs should perform in primary care. On balance, advice received from the panel supported more restrictive recommendations in relation to PAs seeing undifferentiated patients in primary care, but

recognised that there are many useful roles that PAs can play in this setting. The restrictions on assessing undifferentiated patients relate to the relative lack of immediate supervisory support in primary care, the lower level of training received by a PA compared to a GP, and the risks to patient safety of a misdiagnosis.

Section 2- Overarching protocol

Overarching principles to support deployment of PAs

Patient awareness and agreement

34. To avoid confusion, clinical staff should always introduce themselves to make the patient aware of their role. For PAs, this should include that they are not a doctor.
35. Where specific appointments with a PA are being made, the patient should be informed of the training and expertise of the PA in the same way they would if an appointment was made with another non-medical professional. The patient should be given the option to see a doctor, subject to availability within the service.

General oversight and supervision

36. Supervision of PAs should build on the principles set out within [GMC guidance on supervision](#) and the advice set out on their ethical hub, specifically ensuring each PA has a:
 - a. Named supervisor who provides ongoing support and oversight of their roles, responsibilities, training and development, but is not required to be physically present every day.
 - b. Clinical supervisor who is available for prompt review of a patient on any given day and provides day to day oversight and supervision.

The named supervisor

37. The named supervisor should be a doctor with appropriate experience of supervision, familiarity with PA training and curriculum requirements, and sufficient understanding of the service context to oversee induction, development planning and review of progress. This means that in primary care this must be a fully qualified GP and in other settings it must be a consultant.
38. The named supervisor should oversee the PA's induction and, where relevant, preceptorship. They should agree and regularly review the PA's development plan and support access to appropriate continuous professional development and training opportunities. Formal educational supervision should take place at regular intervals, normally at least quarterly, with an annual appraisal. More frequent review may be needed during induction or where additional support needs are identified. The named supervisor should collect insights from the PA's clinical supervisor or supervisors as part of this process.

39. The named supervisor should assess the PA's ability to appropriately escalate concerns about a patient, taking any additional local or profession-specific advice on induction into account.

The clinical supervisor

40. The clinical supervisor is responsible for on the day clinical oversight and supervision. This includes discussing and signing, where appropriate, prescription requests suggested by a PA.

41. Clinical supervision should be provided in person, unless a PA is conducting a home visit or an e-consult, where it should be provided in line with the supervision processes specified in that setting.

42. Clinical supervision should only be provided by the following list of doctors. Only resident doctors on this list should supervise PAs.

- a. Doctors working at ST4 level or above
- b. Clinical fellows with experience equivalent to ST4 or above
- c. Specialty doctors with experience equivalent to ST4 or above
- d. Consultants
- e. Fully qualified GPs

43. The clinical supervisor should not supervise more than three PAs at any one time.

Consultation question: Do you agree that doctors at ST4 level or above, and clinical fellows and specialty doctors with equivalent experience, should be able to act as clinical supervisors for PAs? [Mandatory, Yes/No]

Consultation question: Please explain your answer and/or provide an alternative proposal, including identification of the relevant paragraph(s) or section(s) and reference to the grade and experience of the clinical supervisor. [Optional, Free text]

Consultation question: Do you agree that a PA's clinical supervisor should not supervise more than three PAs at any one time? [Mandatory, Yes/No]

Consultation question: Please explain your answer and/or provide an alternative proposal, including identification of the relevant paragraph(s) or section(s) and reference to the grade and experience of the clinical supervisor. [Optional, Free Text]

Other considerations

44. There are no restrictions to PAs doing out of hours work, provided that appropriate supervision is available.
45. PAs should not act as clinical or educational supervisors for doctors.

Time required for supervision

46. The appropriate duration and frequency of the time required for supervision varies by setting as well as with the experience of the PA. More supervision will be required for newly qualified PAs, those new to a setting, and those undertaking an induction or preceptorship period.
47. In all settings, initial supervision should include a period during which the clinical supervisor conducts an in-person review of every patient seen by the PA, until the named supervisor is satisfied that this is no longer required.
48. PAs, named supervisors and clinical supervisors should be informed and content with the expected time set aside for supervision.

Allocation of supervisors

49. The allocation of a named and clinical supervisor to a PA should be undertaken with the informed agreement of those involved. The process should take account of the time required for effective supervision, which should be reflected in the supervisor's job plan or equivalent workforce planning and FTE allocation, so that sufficient time remains for other clinical, educational and managerial duties.
50. Employers are responsible for ensuring that supervisors have the training, capacity and organisational support required to supervise PAs safely and effectively, including protected time for supervision and access to relevant supervisor training. Members of staff who do not consider they have the training or capacity required should not supervise PAs.

Training for supervisors

51. All named and clinical supervisors should receive training that covers:
 - a. The role of the supervisor
 - b. Their responsibilities for oversight and approving any delegation
 - c. Training and qualifications of a PA.
52. Refresher training should be provided every 5 years, or more frequently if required.
53. In the exceptional circumstance that a member of staff who has not undertaken this training is required to temporarily supervise a PA, the employer remains accountable for the management of the service. The employer should consider mechanisms to enable the supervisor to receive this training as soon as possible.

Assessing undifferentiated patients

54. An undifferentiated patient is anyone with new symptoms and signs who has not yet had an initial clinical assessment. The assessment is the point where a differential diagnosis and/or significant interventions are made.
55. A PA can assess undifferentiated patients only if all of the following are in place:
- a. They are working within a multidisciplinary team where clinical supervisors are routinely available and readily accessible to discuss potential diagnoses and treatment options to inform next steps of management, as well as review the patient if needed.
 - b. Their named supervisor is confident they have the appropriate skills, experience and training to undertake the relevant tasks.
 - c. The undifferentiated patients assigned to the PA are among those specified in the [setting-specific advice](#) section of this document.

Consultation question: Do you agree with the criteria laid out in paragraphs 54 to 55 for assessing undifferentiated patients? [Mandatory, Yes/No]

Consultation question: Please explain your answer and/or provide an alternative proposal, including identification of the relevant paragraph(s) or section(s). [Optional, Free text]

Emergency situations

56. In emergency situations where a patient acutely deteriorates or experiences a life-threatening event, PAs must act promptly within the limits of their training and competence to stabilise the patient. This is consistent with the expectations set out in GMC's Good Medical Practice guidance. Urgent support from an appropriately qualified clinician must be sought as soon as possible, with the patient's ongoing care transferred or overseen according to standard practice.

Using guidelines to inform practice

57. When using clinical guidelines and protocols to inform practice, PAs and their supervisors should be aware that they are a guide only. They do not override the clinical judgement of healthcare professionals and any decisions must be appropriate to each patient's specific circumstances and taken in consultation with the patient or their carer.

Example roles for PAs across settings

58. There are many roles that a PA can play, with appropriate training and supervision, that do not involve assessing undifferentiated patients. PAs in these roles can make significant and highly valued contributions to the teams in which they work. While specific examples are given in each setting, common themes include:
- a. Playing a lead role in quality improvement and audit, including mortality reviews and work on local governance

- b. Providing advice on disease prevention and health promotion
- c. Undertaking patient follow-up
- d. Associated correspondence and admin tasks
- e. Implementation of agreed management plans
- f. Undertaking, supporting and coordinating local and national research projects
- g. Teaching other staff procedures in which the PA is qualified and skilled
- h. Providing local continuity, including introducing other staff to service processes
- i. Running routine clinics for management of long-term conditions

Accountability for clinical decision-making

- 59. Named supervisors are accountable for ensuring that delegation processes are safe and appropriate and that the PA is assigned duties in line with their training, skills and experience.
- 60. Clinical supervisors are accountable for ensuring the PA is not working outside their agreed individual scope of practice during the day-to-day performance of their duties, and is carrying out these duties as agreed with their named supervisor.
- 61. PAs are accountable for their own independent actions and clinical decisions made within the individual scope of practice agreed with the named supervisor.
- 62. Employers are accountable for ensuring that the governance, time and infrastructure required for safe supervision, induction, oversight and development are in place, including adequate local workforce capacity and providing protected time for training and supervision.
- 63. Processes of delegation and referral should be conducted in line with [GMC guidance](#).

Induction for team members about the roles of the PA

- 64. The roles and responsibilities of PAs as well as all other staff in the team should be explained as part of induction processes for all members of staff. This means clearly identifying the PA's named supervisors, specifying which clinical supervisors they typically work with, and explaining how to find and contact the appropriate supervisor on any given day.

Role advertisements and banding

- 65. The advertising of a role at any specific banding should be undertaken in line with usual NHS Employers' guidance on job evaluation and national NHS Agenda for Change terms and conditions or any successor framework. Banding should reflect the requirements of the role as designed, including the level of autonomy, supervision and scope of practice expected.
- 66. Where roles are evolving or where individuals are expected to develop into more advanced practitioners over time, employers may wish to advertise at a lower or developmental band, with defined expectations and review points for progression as competencies are achieved.

Training and development of PAs

Continuous professional development and appraisal

67. PAs must engage in induction and orientation, continuous professional development and maintain evidence of competence and engage in annual appraisal, in addition to periodic assessment as required by the GMC.
68. Employers must ensure that PAs have access to appropriate induction and orientation, continuous professional development, study time and relevant upskilling opportunities.
69. Formal discussion should take place with the named supervisor at regular intervals, normally at least quarterly, to review general progress and outcomes. The named supervisor should oversee the PA's development and support the identification of appropriate courses or capability development relevant to the PA's current role.
70. All PAs should undergo an annual appraisal. More frequent review may be needed during induction or where additional support needs are identified. The clinical supervisor should provide documentary evidence to inform the appraisal and support the PA in undertaking relevant courses and accreditation, where required.
71. PAs must learn from feedback and respond constructively to the outcomes of appraisals, performance reviews and assessments.

Standard frameworks to support PA development

72. PAs should have the opportunity to undertake ongoing training and development in the context of a formal programme, as recommended in the Leng review.
73. In advance of this programme being developed, induction, training and development of PAs might draw on relevant elements of established frameworks such as:
 - a. The standards of proficiency for registered nurses
 - b. The multi-professional framework for advanced practice in England
 - c. The generic professional capabilities framework, together with the relevant specialty curriculum

Section 3- Setting-specific protocol

General expectations

74. In each setting, the expectations set out regarding initial deployment into a new role, induction and supervision should be followed.

Secondary care

75. When a PA is working in secondary care as their first role after qualification, particular care needs to be taken by their named supervisor to ensure their practice is safe with appropriate supervision.

Assessing undifferentiated patients

76. PAs can assess undifferentiated patients in secondary care assuming they are working within a consultant-led multidisciplinary team environment where patients are discussed

with a clinical supervisor to review outcomes of assessment, formulate a diagnosis and management plan and review the patient if needed. A PA should not hold sole responsibility for making a final diagnosis.

77. The named supervisor must be confident they have the appropriate skills, experience and training to undertake the initial assessment.
78. Most patients in secondary care will already be at least partially differentiated, but the clinical supervisor should ensure the PA only assesses patients that are appropriate for their experience.

Working with other patients

79. PAs can support the clinical care of other patients by delivering against existing, agreed management plans. This includes discharging a specified patient once specified criteria are met, but where no explicit criteria are in place, they should seek approval from the clinical supervisor for admission and discharge decisions.
80. In the case of new signs or symptoms, deterioration, unexpected findings or diagnostic uncertainty, the PA should follow the approach for undifferentiated patients above. PAs should not hold sole responsibility for revising diagnoses, or managing patients whose condition has materially changed without senior review by a clinical supervisor.

Example roles

81. There are many roles that a PA can play in a secondary care environment, with appropriate training and supervision. This includes:
- Supporting discharge procedures
 - Providing continuity and consistency of care
 - Seeing patients for follow-up in outpatient clinics in the context of agreed management plans
 - Carrying out specific procedures such as peritoneal drainage, lumbar puncture, ascitic taps/drains, biopsies, ultrasound-guided cannulation and vascular access, PICC lines and port access, joint aspiration and DVT clinic work
 - Training others to perform specific procedures.

The emergency department

82. When a PA is working in the emergency department as their first role after qualification, particular care needs to be taken by their named supervisor to ensure their practice is safe with appropriate supervision. This is particularly important as undifferentiated patients make up the majority of presentations in the emergency department.

Assessing undifferentiated patients

83. PAs can assess undifferentiated patients in the emergency department assuming they are working within a consultant-led multidisciplinary team environment where patients are discussed with a clinical supervisor to review outcomes of assessment, formulate a

diagnosis and management plan and review the patient if needed. A PA should not hold sole responsibility for making a final diagnosis.

- 84. The named supervisor must be confident that the PA has the appropriate skills, experience and training to undertake the initial assessment.
- 85. The consultant in charge of patient allocation in the emergency department should ensure the PA only assesses patients who are appropriate for their experience.

Example roles

- 86. There are many roles that a PA can play in the emergency department, with appropriate training and supervision. This includes:
 - a. Implementing a pre-agreed management plan, such as discharging a specified patient once agreed criteria are met. Where no explicit criteria are in place, they should seek supervisor approval for admission and discharge decisions.
 - b. Performing ultrasound-supported work, including difficult vascular access
 - c. Carrying out nerve blocks
 - d. Participating in emergency response and acute stabilisation where appropriately trained
 - e. Supporting and training others in Immediate Life Support (ILS), Advanced Life Support (ALS), Advanced Trauma Life Support (ATLS) and Advanced Paediatric Life Support (APLS).

Mental health units

- 87. When a PA is working in a mental health unit, particular care needs to be taken by their named supervisor to ensure their practice is safe with appropriate supervision. This may involve specific induction and training relevant to that setting.

Assessing undifferentiated patients with mental health conditions

- 88. PAs can assess undifferentiated patients with new psychiatric symptoms assuming they are working within a consultant-led multidisciplinary team environment where patients are discussed with a clinical supervisor to review outcomes of assessment and formulate a diagnosis and management plan. Depending on the patient, their condition and the PA's experience, this may involve in-person review by the clinical supervisor. PAs should not hold sole responsibility for making a final diagnosis.
- 89. The named supervisor must be confident that the PA has the appropriate skills, experience and training to undertake the initial assessment.
- 90. The clinical supervisor or the consultant in charge of patient allocation should ensure the PA only assesses patients who are appropriate for their experience.

Other patients with mental health conditions

- 91. PAs can see differentiated patients with mental health conditions, including delivering against existing, agreed management plans where the clinical supervisor judges this to be within their capability. They can carry out medication reviews, document care, follow

up investigations, liaise with other services, support discharge planning and work in depot, clozapine and lithium clinics.

92. In the case of incidental new signs or symptoms, deterioration, unexpected findings or diagnostic uncertainty, the PA should follow the approach for undifferentiated patients above. PAs should not hold sole responsibility for revising diagnoses, or managing patients whose condition has materially changed without senior review.
93. PAs may implement a pre-agreed management plan, such as discharging a specified patient once specified criteria are met, but where no explicit criteria are in place, they should seek supervisor approval for admission and discharge decisions.

Performing physical health checks and medication reviews

94. PAs can perform routine physical health checks and carry out routine medication reviews on patients with chronic mental health problems provided there is a clear escalation plan in place to a defined service, such as a physical health liaison or acute medicine team, to obtain further, timely advice if required. This plan should be agreed with the clinical supervisor, with oversight from the named supervisor, and be in line with standard governance frameworks.
95. The employer is accountable for ensuring that appropriate governance frameworks, and supervision arrangements are in place to facilitate the above. This includes enabling access to timely clinical advice, relevant contact pathways and appropriate training in physical health skills.
96. The relevant consultant should continue to provide overall clinical leadership within the service, including when advice is sought from other specialties.

Example roles

97. There are many roles that a PA can play in a mental health setting, with appropriate training and supervision. This includes:
- Supporting discharge procedures
 - Providing continuity and consistency of care
 - Seeing patients in outpatient clinics in the context of agreed management plans
 - Reviewing patients with chronic mental health conditions
 - Performing annual health checks
 - Supporting medicines management
 - Supporting and training teams in maintaining physical health competencies around common comorbidities
 - Carrying out specific procedures where required
 - Training others to perform specific procedures
 - Quality improvement and audit

Primary care

98. When a PA is working in a primary care setting, particular care needs to be taken by their named supervisor to ensure their practice is safe with appropriate supervision. This will involve oversight as set out below.

Assessing undifferentiated patients

99. PAs working in a primary care setting should assess only limited groups of undifferentiated patients because primary care does not represent an environment where immediate in-person review can easily take place. Within these limitations and the PA's experience, assessing undifferentiated patients may also involve in-person review by the clinical supervisor. PAs should not hold sole responsibility for making a final diagnosis.
100. The named supervisor must be confident they have the appropriate skills, experience and training to undertake any initial assessments.
101. The practice must run an effective triage system that ensures PAs are only allocated patients presenting with minor ailments. The clinical supervisor should review and approve the list of undifferentiated patients with minor ailments assigned to the PA, ensuring the allocation matches the PA's capability and experience.

Consultation question: Do you agree with the proposal for how PAs should work in primary care, including in relation to undifferentiated patients? [Mandatory, Yes/No]

Consultation question: Please explain your answer and/or provide a proposal for how PAs should work in primary care, including identification of the relevant paragraph(s) or section(s) where applicable. [Optional, Free text]

Consultation question: If existing, experienced PAs might be able to see a broader group of undifferentiated patients in primary care, please select one of the following circumstances that you think could enable this: [Mandatory, Select one]

- There are no circumstances that should enable this
- Approval of the PA's named supervisor
- Completion of approved training that demonstrates competence to undertake the relevant additional work and approval of the PA's named supervisor
- I would like to specify a different circumstance

Consultation question: [If you would like to specify a different circumstance], which are the circumstances under which existing, experienced PAs should be able to see a broader group of undifferentiated patients in primary care? [Optional, Free text]

Consultation question: Should PAs, or some PAs, only see a narrower group of undifferentiated patients in primary care than those indicated? [Mandatory, Yes/No]

Consultation question: Please explain your answer and/or provide a proposal, including identification of the relevant paragraph(s) or section(s) where applicable. [Optional, Free text]

Consultation question: Should there be any restrictions on PAs seeing specific patients, such as those below a certain age, those who are pregnant, or any other specific groups in primary care? [Mandatory, Yes/No]

Consultation question: Please explain your answer and/or provide a proposal for any suggested restrictions, including identification of the relevant paragraph(s) or section(s) where applicable. [Free text]

102. PAs may see or observe the assessment of other patients with new signs and symptoms when directly accompanied by a GP throughout the appointment to support learning and provide effective follow-up, but should not see these patients alone.
103. In line with Jess's Rule, if a patient re-presents to the service with the same unexpectedly unresolved or worsening symptoms:
- On a second presentation the PA should discuss the patient with their supervisor either:
 - before the patient leaves the surgery for in person consultations or
 - by the end of surgery for remote consultations, with consideration to arranging a face-to-face assessment by a GP.
 - On the third presentation the patient should be given an appointment with a fully qualified GP.

Effective triage

104. To be effective as a triage system, all appointments booked with PAs must be either triaged:
- directly by a GP who has knowledge of the PA's individual scope of practice.
 - by a trained member of staff or an electronic system which has been approved for use by the practice. In this case, there should be an initial review of the patient list assigned to the PA by the clinical supervisor available on the day, in advance of the patients being seen by the PA.

105. If triaging patients to a PA, a GP should indicate the presence of a differential diagnosis by documenting key clinical impressions or concerns within the patient's notes or appointment booking entry. This will help to signpost steps the PA may take in the consultation, and may include flagged symptoms or specific diagnostic considerations.
106. If there is not enough information in the triage process to identify the clinician a patient should see, either the required information should be requested from the patient within a reasonable time period, or the patient should be booked in with a GP.
107. If a patient is booked with a PA for a condition outside their competencies, the PA should flag this to their clinical supervisor and arrange for a suitable rebooking, at the time or on another day as appropriate. Practices are encouraged to regularly audit appointments to ensure proper governance.

Working with other patients

108. PAs can see patients with known conditions or those requiring specific tests or interventions, with approval of the named supervisor. This includes delivering against existing, agreed management plans where the clinical supervisor judges this to be within the PA's capability.
109. In the case of unexpected or alarming new signs or symptoms, deterioration or diagnostic uncertainty, the PA should follow the standard approach for escalating any concerns. PAs should not hold sole responsibility for revising diagnoses, or managing patients whose condition has materially changed without senior review.

Example roles

110. There are many roles that the PAs can play in primary care that do not involve being the first clinician seeing an undifferentiated patient. These may require additional training, and include:
- Seeing patients with exacerbations of known conditions using appropriate clinical guidelines
 - Seeing patients for management of long term conditions in the context of agreed management plans
 - Providing follow up of patients in line with a management plan agreed with a multidisciplinary team for a range of conditions, including home visits with appropriate supervision
 - Working in clinics running specific tasks such as joint injections, FeNO testing for asthma, fitting intrauterine devices
 - Supporting integration as part of a Neighbourhood Health Team
 - Quality improvement and audit.
 - Providing prevention advice on areas such as smoking cessation

Appointment duration

111. Sufficient time should be set aside for PAs to take appointments, within the requirements for assessing undifferentiated patients, starting with 30 minutes per patient for PAs new to primary care, and moving towards 20 or 15 minute appointments if the clinical supervisor is content in the PA's ability to effectively assess patients within this period.
112. Appointments should not be shorter than this, as time needs to be available throughout the day for the PA to seek immediate advice, patient review or discussion of prescription requests with their clinical supervisor.

Additional time with a clinical supervisor in primary care

113. At the start of their time in primary care, a clinical supervisor should review every patient seen by a PA in person. When the clinical supervisor is confident in the PA's ability and no longer feels this is required, the clinical supervisor should still discuss all patients with the PA at the end of each morning and afternoon surgery.
114. The clinical supervisor should allow at least the following amount of time available to review the patients seen by a PA:
- a. A minimum of 30 minutes after each surgery during the PA's first year in primary care
 - b. A minimum of 15 minutes after each surgery following the PA's first year in primary care
 - c. Additional time throughout the day to discuss any patients which present in the PA's practice and may require immediate consideration or review, as well as manage any prescribing requests which cannot wait until the scheduled slot after the surgery.

Working in different settings within primary care

115. When a PA sees a patient in the practice, the clinical supervisor should always be physically on site and prepared to directly assess the patient if the PA raises concerns before the patient leaves the practice.
116. When a PA sees a patient in a care home or other high-complexity residential environment, they should always do this as part of a multidisciplinary team including the clinical supervisor that will discuss the management of all patients.
117. When a PA sees a follow-up patient for a home visit, the clinical supervisor must be available to respond remotely to any concerns and be prepared to attend in person within an hour if clinically necessary. PAs in their first year should not see patients for home visits unaccompanied.
118. When a PA sees a patient via e-consult, the clinical supervisor should be prepared to directly contact the patient to arrange an appropriate assessment within an hour if the PA raises concerns.

Section 4 – Implementation

119. Implementation guidance will accompany publication of this protocol. Recognising that current deployment models, supervision arrangements and workforce structures vary across organisations, employers should undertake implementation in a planned and pragmatic manner. This should include reviewing governance arrangements, supervision capacity, workforce planning and local clinical pathways, with changes introduced over an appropriate timeframe that maintains service continuity and patient safety.
120. This document should be reviewed in future subject to service need.

Consultation question: Would further advice be helpful for your organisation or service in relative to service delivery and implementation of this protocol? If so, what would you like this advice to cover? [Optional, Free text]

Consultation question: Are there any other comments you would like to provide? This may include implications for service delivery, equalities, comments on other parts of the protocol not previously specified or other matters directly relevant to the protocol. Include identification of the relevant paragraph(s) and/or section(s). [Optional, Free text]

Annex A: Membership of the Clinical Advisory Panel

- Gillian Leng, independent author of the Leng Review and Panel chair
- Consultant Psychiatrist and Associate Medical Director
- Senior nurse
- Paediatric oncologist and Executive Medical Director
- Associate Medical Director and educator in PA studies and medicine
- Acute medical consultant and PA forum lead
- Patient with lived experience
- Senior PA and educator in primary care
- Former GP and workforce researcher
- Former GP and former NICE chair
- Resident doctor²
- Resident doctor³
- GP and educator in PA studies and medicine
- Senior PA and educator in secondary care⁴

This work was supported by a DHSC Secretariat.

² Attended panel on a rotational basis with another resident doctor

³ Attended panel on a rotational basis with another resident doctor

⁴ Not a member of the panel at conclusion.