Ref. No:	2363
Date:	17/02/26
Subject:	Physician Associates in Emergency Departments

REQUEST

Under the Freedom of Information Act 2000, I am requesting the following information regarding the employment and deployment of Physician Associates (PAs) in your Trust's Emergency Department(s):

1. Pre-Leng Review Employment (before July 2025)
a) Did your Trust employ Physician Associates in Emergency Department(s) prior to July 2025?
b) If yes, how many PA posts (FTE) were there in ED as of June 2025?
c) What clinical activities and responsibilities did PAs undertake in ED during this period?

2. Current PA Deployment
a) How many PA posts (FTE) are currently deployed in Emergency Department(s)?
b) For any PAs previously working in ED who are no longer in those roles:

- How many have been redeployed to other departments? Please specify which departments/specialties
- How many posts have been made redundant or not renewed?
- What were the dates of any redeployments or redundancies?

3. Changes to PA Roles Post-Leng Review
a) How have the clinical activities and responsibilities of PAs working in ED changed since July 2025?
b) What restrictions or modifications have been placed on PA practice in ED?

4. Impact Assessment and Wait Times
a) Prior to making any changes, did your Trust conduct any impact assessment regarding PA deployment in ED? If yes, please provide a copy or summary of findings.
b) Prior to making these changes, did your Trust consult with or refer to documentation from the General Medical Council (GMC), Care Quality Commission (CQC), United Medical Associate Professionals (UMAPs), or the College of Medical Associate Professionals (CMAPs)?
c) What was the average wait time in ED for the periods:

- April-June 2025 (pre-Leng Review)
- October-December 2025 (post-Leng Review)

d) Has your Trust identified any correlation between changes to PA deployment and ED performance metrics?

5. Compliance with Professional Guidance
a) Were changes to PA deployment in ED made following guidance from the Royal College of Emergency Medicine?
b) Please provide copies of any internal policies, directives, or communications regarding PA deployment in ED issued since July 2025.

RESPONSE

1. Pre-Leng Review Employment (before July 2025)
1a) Yes we employed Physician associates in ED prior to July 2025.

1b) In June 2025 there were 9.8 FTE Physician associates

1c) Clinical activities were the review and assessment of patients attending the Emergency department at Southport under the supervision of the Consultant in Charge. Patients would be seen in Majors and SDEC under senior supervision. 2 Supernumerary sessions over 10 weeks were rostered in the Paediatric ED. In December 2024 the PA clinicians underwent a change in Rota to remove them from Night Shifts as there was not Consultant supervision in place overnight. From this point PAs were only working in the ED when a Consultant was present

2. Current PA Deployment
2a) Currently there are 9.8 FTE Physician associates employed currently

2b) No PAs have been redeployed from ED. No posts have been made redundant or not renewed

3. Changes to PA Roles Post-Leng Review

3a) At the initial release of the Leng Review the following guidance was implemented:

- PA's will be allocated to the following areas where they will work under the direct supervision of another senior clinician;
- RAT: The PA will work alongside the Senior Clinician in RAT
- ED-SDEC; The PA will see patient who have been through RAT, under direct supervision of the Senior Clinician who will retain clinical responsibility, and assist with tracking, investigations and liaison with speciality teams
- Part of the ED MET team: The PA will support the ED MET team
- Minor injuries: The PA will work alongside the ENP with support from senior medical staff
- Resus support/majors support: The PA will work alongside the EPIC Doctor in Majors and Resus
- Clinical admin within the ED

- Within these areas PA's will assess patients under the direct supervision of the senior clinician in that area
- The responsible clinician on Careflow will be the senior clinician
- The PA will also have their name allocated on Careflow but not ticked as the 'responsible' clinician to ensure we are able to maintain patient tracking accurately.
- The responsible clinician must physically review the patient and document in the notes that this has happened and what the suspected diagnosis and treatment plan is.
- If starting a shift at 8am and therefore RAT/SDEC hasn't yet started, the PA's will see patients under the supervision of the EPIC running the shift and the same rules above apply.

Following the UMAPS legal challenge, and the update from August 2025 from NHSE which states:
"NHS England's (NHSE) letter sought to provide guidance to employers on what implementing some of the key recommendations from the Leng Review would mean to ensure safe and effective management of PAs and Aas as part of multidisciplinary teams. We expect employers to review these in line with clinical guidance and protocols in their own organisational policies."

The following recommendations were made:

"I would propose that we return to usage of the RCEM Workforce Teir system in place since Feb 2025 in which PAs are classified as Tier 1 Clinicians and

must discuss or have the patient reviewed by a Tier 4/5 clinician (Consultant, Speciality Doctor, ST4-6).

I propose that the PA name will be allocated on Careflow and the reviewing Consultant or Tier 4 clinician will write in the notes and add their name to careflow after review. The current situation has made patient tracking and handover very difficult"

Futhermore, the release of the RCEM guidance on PAs was reviewed and the following recommendation was made in ED.

ED Senior Clinical Response to RCEM Guidance

- **Direct supervision is mandatory. PAs should be directly clinically supervised in line with the RCEM Workforce Tiers document (2025), at Tier 1.**
  This statement is in line with our revised interim guidance. The College tier guidance recommends that patients seen by Tier 1 PA clinicians must be discussed with or reviewed by tier 4 SAS doctors or tier 5 doctors. This is our current practice. There had previously been an understanding that departments with experienced PAs who worked at Tier 2 level (at the level of an FY2/GPST/Clinical Fellow) and that would be a locally agreed as to their level of supervision. The statement does not allow for any acknowledgement of previous experience, skills acquired and local entrustment of PA staff. The document also contains a section ***Existing arrangements*** *which states:*
  *"**RCEM recognises that many departments will have existing arrangements in place whereby individuals, or professional groups, are working within tiers in a way that is inconsistent with this document. We would recommend that such arrangements and the governance surrounding them are reviewed by the Clinical Lead for the service. However, this document is not intended to affect such arrangements retrospectively, and should not be used for this purpose."***

- **With Regards to PAs, undifferentiated patients must be seen by a Tier 3 clinician or above first. Patients triaged by paramedics, RATs, reception teams, triage nurses or patients referred into an ED from other clinical services remain undifferentiated until subsequently seen by a Tier 3 clinician or above who has seen, reviewed and formulated a differential diagnosis and management plan for the patient.**
  This guidance directly contradicts the statement above. The guidance from RCEM is that PAs should not see undifferentiated patients,

although there is no definition of "undifferentiated". The Tier guidance states the PA should be directly supervised and defines supervision as ***"a combination of providing shop-floor clinical advice and taking overall clinical responsibility / accountability for the advice offered****". This is an agreement we already have in place with patients being reviewed and discussed with the Tier 4 or 5 clinician. The guidance states that patients must be seen by Tier 3 or above first. It goes on to state that RAT (Rapid Assessment and Triage) does not circumvent that. We would argue that, in our department, RAT is performed by a Tier 4 or 5 clinician who clinically assesses the patients and initiates investigation and treatment. Our opinion is that this qualifies as senior assessment prior to PA review.*

- **Impact on patient safety.**
  The Leng review categorically states that there was no evidence of harm attributable to the PA workforce. As an ED, we are not aware of a large number of incidents related to patients reviewed by PAs. While it is difficult to interrogate InPhase specifically, there is ***no*** *underlying evidence from the Consultant body, who deal with all complaints and governance and discuss weekly at Patient Safety Meeting, that there has been an increase in incidents related to PAs given the current level of supervision.*
  There is no numerical method to quantify the safety aspect of experience accrued over time by our PAs and removing their ability to see patients most likely jeopardises safety by the need to back fill with unfamiliar bank staff in the short term

Revised Guidance was submitted to the Executive team for review:

As a group of ED clinicians, we are proposed that the following was implemented to enable our experienced PA workforce to continue to provide safe clinical care. We appreciate this is not if full agreement with RCEM guidance but feel this is a safe application of clinical supervision. We acknowledge that this may require review on a legal level by the trust but propose this as an interim measure

- *PAs are allocated a named clinical supervisor* ***(already in place)***
- *PAs will work alongside Tier 4 or 5 clinicians with direct supervision on the shop floor.* ***(Already in place as PAs were taken of nights rota to ensure that Consultant supervision is available on all PA shifts)***
- *We consider that RAT, undertaken by a Tier 4 or 5 Clinician constitutes senior review prior to assessment by PA, in line with guidance.*

- *We consider the statement that RAT does not constitute this level of assessment to be too generic and flawed and is in direct conflict with the previous statement about senior review before PA assessment*
- *PAs will work along side a clinician in RAT*
- *PA's will work in ED-SDEC and review patients who have undergone RAT.*
- *In the situation where RAT has not been functioning, the PA will see patients as directed by the Consultant in Charge of the clinical area they are working in*
- *All patients seen by a PA will be reviewed or discussed with a Tier 4 or 5 Clinician before discharge or referral to speciality. The senior clinician will document in the case notes and be clinically responsible for that patient*
- *PAs will undertake clinical admin roles to assist in Review of results in the department on a rotating basis*
- *I am in regular contact with RCEM and will formally request clarity around RAT and senior review and also "Existing Arrangements"*

4. Impact Assessment and Wait Times

- 4a) **<u>Impact of Patient flow and waiting times</u>**

  PAs are a consistent workforce in the ED and provide continuity of care and process when resident doctors rotate through ED. They are highly productive and hard-working group of clinicians. PAs constitute approximately 30% of our junior workforce and removing them from clinical care in full response to the guidance would decimate the rota, directly impact patient care and safety and attract a significant financial cost.

  On review of "productivity" a sample of 5 PAs vs 5 resident doctors was undertaken.

  Between 6th August and 7th October the number of patients seen was compared.

PA	Resident Dr
149	*96*
128	*141*
140	*99*
101	*81*
201	*80*
143.8	*99.4*

It is a stark contrast that the PA cohort, over that time period saw approximately 44% more patients that the comparable number seen by resident doctors. Given that suggested historical guidance is that a resident Doctor will see 0.7 patients per hour, that would equate to 7.9 patients per shift for PA vs 5.6 for resident doctors.

To fully adhere to College Guidance in its current form would remove the PAs from engaging in any meaningful clinical assessment and would require back fill of all their shifts to maintain the status quo. To fully replace the 10 WTE PA group would require 15 WTE clinical fellows to assess and treat the same number of patients, along with the incurred financial burden, simply to maintain current standards.

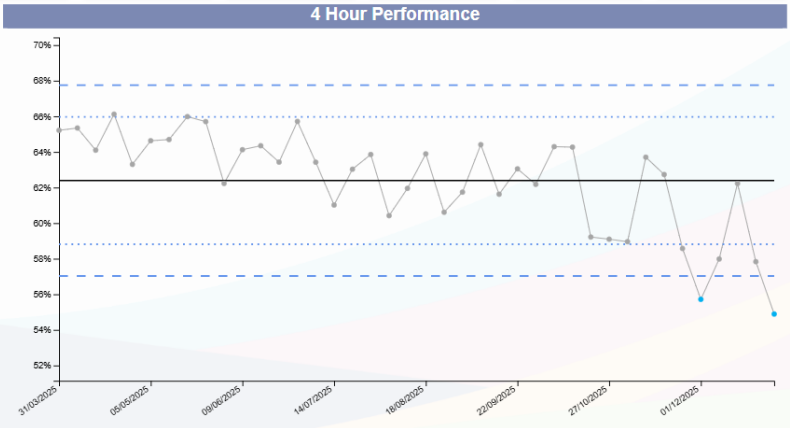
4b) We reviewed the documentation from the Leng Review, the GMC response statement from 16th July 2025 and the UMAPS guidance to employers and members.

4c)

MWL A&E Average Wait Times:

	Arrival to Triage	Arrival To Seen	Arrival To Departure
April – June 2025	15 Mins	132 Mins	431 Mins
October – December 2025	11 Mins	149 Mins	483 Mins

Financial Year	Admitted	Not Admitted	Total
2025/26	56.3%	66.9%	62.5%
Apr	59.0%	70.1%	65.3%
May	57.9%	69.7%	64.7%
Jun	57.8%	68.0%	63.7%
Jul	57.9%	67.4%	63.4%
Aug	57.3%	65.1%	61.8%
Sep	58.7%	66.6%	63.2%
Oct	54.2%	66.6%	61.4%
Nov	54.3%	65.4%	60.9%
Dec	49.4%	63.5%	58.0%
Total	56.3%	66.9%	62.5%



4d) No specific changes in relation to metrics other than the above

5. Compliance with Professional Guidance

5a) PA deployment remains the same in line with information provided above in section 3

5b) Attached is the interim guidance sent to PA staff post Leng review

Implementation of revised guidance was done in person