British Orthopaedic Association (BOA) statement on the incorporation of Physician Assistants (PAs) into Trauma and Orthopaedic surgery

July 2025

The BOA welcomes the recommendations contained in 'The Leng Review: an independent review into the physician associate and anaesthesia associate professions' and the clarity that this brings to the proposed incorporation of PAs into the Trauma and Orthopaedic workforce. This BOA statement summarises the pertinent recommendations, the Government response and sets out the core competencies and other recommendations on supervision and training of PAs working in the wider Trauma and Orthopaedic team.

The recommendations that are directly relevant to Trauma and Orthopaedic practice are:

1: Positioning of the role
The role of physician associate should be renamed as 'physician assistant', positioning the role as a supportive, complementary member of the medical team.

2: Credentialling
Physician assistants should have the opportunity for ongoing training and development in the context of a formal certification and credentialling programme. This should include the ability to take on added responsibilities that are commensurate with that training, including the potential to prescribe and order non-ionising radiation.

3: Career development
Physician assistants should have the opportunity to become an 'advanced' physician assistant, which should be one Agenda for Change band higher and developed in line with national job profiles.

4: Undifferentiated patients
Physician assistants should not see undifferentiated patients except within clearly defined national clinical protocols.

5: Initial deployment in secondary care
Newly qualified physician assistants should gain at least 2 years' experience in secondary care prior to taking a role in primary care or a mental health trust.

6: Teamworking and oversight
The physician assistant role should form part of a clear team structure, led by a senior clinician, where all are aware of their roles, responsibilities and accountability. A named doctor should take overall responsibility for each physician assistant as their formal line manager ('named supervisor').

7: Identifying the role
Standardised measures, including national clothing, lanyards, badges and staff information, should be employed to distinguish physician assistants from doctors.

8: Professional standards
A permanent faculty should be established to provide professional leadership for physician assistants, with standards for training and credentialling set by relevant Medical Royal Colleges or the Academy of Medical Royal Colleges.

9-14: *These consider the introduction of Anaesthesia assistants and are not directly relevant to Trauma and Orthopaedic practice.*

15: Regulation and accountability
The General Medical Council requirements for regulation and reaccreditation of physician assistants and physician assistants in anaesthesia within Good Medical Practice should be presented separately to reinforce and clarify the differences in roles from those of doctors.

16: Supporting doctors as leaders and line managers.
Doctors should receive training in line management and leadership and should be allocated additional time to ensure that they can fulfil their supervisory roles, and to ensure effective running of the health service.

17: Redesigning medical and multidisciplinary teams.
The Department of Health and Social Care (DHSC) should establish a time limited working group to set out multidisciplinary models of working in different settings. The group should include input from a small group of experienced leaders covering medicine, other relevant healthcare professionals, management, and human resources.

18: Safety reporting
Safety systems should routinely collect information on staff group to facilitate monitoring and interrogation at a national level, against agreed patient safety standards, to determine any system-level issues in multi-disciplinary team working.

NB. Details of the rationale for the recommendations can be found within the Review report (pages 86-97).

Government response

The Government has accepted the recommendations of the Review in full. In a Written Statement to the Westminster Parliament (16th July 2025), the Secretary of State for Health and Social Care stated, inter alia,

'Some actions will be implemented immediately, whilst others will require wider input, with benefits being fully realised over time. I have asked NHS England to move with immediate effect to implement those recommendations which most directly affect patient safety, including moving to the use of physician assistants and physician assistants in anaesthesia titles and ensuring that physician assistants do not see undifferentiated patients, except within clearly defined national clinical protocols.'

and that,

'We will consider Professor Leng's findings and recommendation in detail in conjunction with the 10-year health plan. The lessons learned in the Review will be embedded into the upcoming workforce plan to improve how we effect change in the NHS, and ensure the mistakes of the past are not repeated in the future. We will work with key partners, including NHS England in advance of publishing a fuller response, setting out a clear implementation plan to make the required changes in due course.'

BOA comment

The Leng Review does not define scope of practice, but the standardisation of training set out by the General Medical Council (GMC) is a clear building block for defining the roles undertaken by PAs. The Review recommendations enable a systematic way forward including the following key elements:

- A defined national initial job description for PAs in primary and secondary care (Review report, Appendix 5), based on their core training and informed by the work on initial scopes of practice produced across the Medical Royal Colleges and by the BOA.

- Opportunities for further training through a national credentialling programme (Review report, Recommendation 2), approved by new faculties for PAs and AAs and supported by the host Royal Colleges. It is envisaged that with engagement from the Colleges, the roles will develop in a way that is appropriate and provide local services with the ability to train PAs and AAs in a flexible way that meets their needs.

A BOA Working Group identified core competencies and made recommendations on supervision and training of PAs working in the wider Trauma and Orthopaedic team.

This was discussed with, and agreed by, the British Orthopaedic Trainees Association and BOA Council, and contributed to work by the Academy of Surgical

Royal Colleges led by Royal College of Surgeons of England that considered the role of PAs within surgical teams.

This has also been considered as part of a widely attended session on the PA role in Trauma and Orthopaedics at BOA Congress 2024.

To assist with local definition of scope of practice of PAs working in Trauma and Orthopaedics, the BOA has identified **Core Competencies**, which are appropriate for newly qualified PAs (**Green**), **Extended competencies**, appropriate for advanced PAs, following further training suggested in Leng Report (Review report, Recommendation 3) (**Orange**) and areas of practice considered to be outside the competency of PAs, irrespective of their level of training, (**Red**).

	Core Competencies	Extended Competencies	Outside Competency
Ward	• Supporting the medical team including initial or subsequent review as directed by the senior medical team, organisation, investigations and scribing, and discharges as required. • Assisting in review of ward patients on senior clinician led ward rounds. • Preparing discharge summaries for patients after decision to discharge made by a Consultant, equivalent level SAS, or Resident doctor. • Management of pre/post-op patients according to local pathways e.g. NOF pathway, elective arthroplasty and AHP-led discharge.	• Undertaking minor procedures as per individual competencies e.g. VAC changes, dressings, suture removal, catheterisation, ABGs, phlebotomy when competencies allow. • Assessing clinically unwell patients, after completion of 'Recognising and Responding to the Deteriorating Patient' or 'Care of the Deteriorating Adult Patient' or equivalent, and discussing with a Consultant, equivalent level SAS, or Resident doctor.	• Unsupervised decision making, although delegated responsibility as per agreed local pathway is permissible as per all AHPs. • Assessing clinically unwell patients independently without appropriate training, escalation, and discussion of management plan with senior clinician. • Prescription of medications or requesting investigations with ionising radiation (as current, to be reviewed if legislation changes).

Outpatients	• None.	• Undertaking minor procedures and review subject to achieving relevant competencies e.g. plaster application, splint fitting, removal of K-wires.	• Unsupervised working e.g. own clinic codes, reviewing patients referred in without specialist review (including extended scope physiotherapy).

	Core Competencies	**Extended Competencies**	**Outside Competency**
Theatres	• None.	• Doctors in training must be given first priority in roles as both lead surgeon, assistant surgeon and as first assistant. Each surgical case should be set up to maximise training whilst maintaining patient safety and optimising outcomes. • Surgical assisting and interventions respectively, only after SFA or SCP training to the level currently expected of other health care professionals and with appropriate locally agreed competencies e.g. wound closure, drain placement etc.	• Undertaking unsupervised procedures, operating, or whole procedures under supervision.

On call	• Supporting acute admissions including initial or and subsequent review directed by, and under the supervision of, the designated Consultant or equivalent level SAS.	• Act within agreed local pathways after a diagnosis is established. • Application of plasters after completion of plastering course recognised for AHP and plaster technicians' competencies.	• Independent review of undifferentiated patients. • Single point of decision without discharging to agreed protocolised pathway. • Prescription of medications or requesting investigations with ionising radiation (as current, to be reviewed if legislation changes).

The BOA recommends that competencies are assessed to national standards following principles similar to allied health professionals (AHPs).

The Review recommends that supervision is delegated by the supervising senior surgeon according to local governance arrangements (Review report, Recommendation 6). The BOA recognises the importance appropriate supervision but considers that this

should be the responsibility of a named Consultant or equivalent level SAS and must not be delegated to surgeons in training. PAs must therefore, work within a defined scope of competence under the supervision of an appropriately qualified, experienced, and named Consultant or equivalent level SAS and provide medical care as an integral and valued part of the multidisciplinary T&O team.

The Review recognised that there are wider challenges relating to management capacity across the NHS and postgraduate training of doctors that are important dependent factors but were beyond the scope of the Review.

It should also be noted that:

- PAs will be required to use their own judgement to apply the principles of Good Medical Practice. (NHS England 7th February 2024, GMC 2024) Patient care may be delegated according to the principles described in 'Supervision of physician associates and anaesthesia associates - Good practice advice for doctors who supervise and work with physician associates and anaesthesia associates'.

- The supervising Consultant or equivalent level SAS is not accountable to the GMC for the actions (or omissions) of the PA but remains responsible for the overall management of the patient, decisions around transfer of care, and processes in place to ensure patient safety.

The Supervising Consultant or equivalent level SAS must be supported to carry out their role as a supervisor and that the resources, scope and responsibilities for this activity are agreed as part of formal job planning. (Supervision of physician associates and anaesthesia associates - Good practice advice for doctors who supervise and work with physician associates and anaesthesia associates) Funding streams for this activity should be identified prior to the recruitment of PAs and neither the time commitment or funding should be detrimental to the experience and supervision of surgeons in training.

Professional standards for patient safety, standards of practice and training in Trauma and Orthopaedics (T&O) lie within the scope of the BOA and a competency framework specific to T&O should inform and be considered within any overarching Joint Royal Colleges of Surgeons' position and submission to the DHSC and NHS England.

Supervising Consultants or equivalent level SASs should support PAs to establish their role in the team by being clear with them and with others about the skills and expertise that they are contributing and how this interacts with the wider work of the team. Delegating tasks to PAs must not compromise the education of surgeons in training and should enable them to attend learning opportunities (Supervision of physician associates and anaesthesia associates - Good practice advice for doctors who supervise and work with physician associates and anaesthesia associates).