PHYSICIAN ASSOCIATE PRIMARY CARE HANDBOOK

Enfield Unity PCN

Adapted from the 'Employers guide to Physician Associates (PAs) in Primary Care in North West London.'

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Introduction

The aim of this handbook is to outline the clinical capabilities that a Physicians Associate (PA) should be expected to work around when working in a primary care setting, as it is vital that PAs are working competently and safely. It should also aim to cover queries and questions employers and PAs may have, whether this is about a current working Physician Associate in primary care or consideration of hiring a Physician Associate to complement their already growing multi-disciplinary team at their GP practice / Primary Care network (PCN).

Included in this document are competency frameworks which should be used as a template in order to ensure a PA is carrying out clinical skills at an appropriate and expected level. These are generated by the PCN whilst we are awaiting further guidance from the GMC. The level of responsibility and supervision of a PA will vary depending on their skills, experience and their scope of practice will develop over time.

Overview of PA role

'Physician associates are healthcare professionals with a generalist medical education, who work alongside doctors providing medical care as an integral part of the multidisciplinary team. Physician associates are dependent practitioners who can work autonomously, but always under the supervision of a fully trained and experienced doctor. They bring new talent add to the skill mix within teams, providing a stable, generalist section of the workforce which can help ease the workforce pressures that the NHS currently faces' (Faculty of Physician Associates).

Education and training

1. PAs would have completed a Science based undergraduate degree.
2. PAs would have completed a 2 year full time PGDip or Masters programme:
    a. 3200 hours over two intensive years – divided approximately into 1,600 hours of theory and 1,600 hours of clinical practice (based on the *Competence and curriculum framework for the PA*).
    b. End point assessments: MCQ style written examination and a 14-station objective, structured clinical examination (OSCE).
    c. Recertification exam every 6 years.
    d. PAs will be expected to sit a National Physician Associate exam following passing their degree.

Employment

Qualifications

1. PAs must hold a PGDip or Masters in Physician Associate studies certificate.

Professional registration and regulation

1. PAs would need to have successfully passed their final examinations of a recognised PA course at their university and also passed the National Examination.
2. In 2019, it was announced that there was plans to introduce statutory regulation of PAs, whereby the GMC were selected as the regulating body. This is still a work in progress whereby a provisional expected date would be in Autumn 2021. Unfortunately due to delays the GMC have now stated that the GMC will become the regulatory body hopefully by the end of 2024, as per their website at the time of writing. It is encouraging that the UK government has passed Legislation in 2024 that PAs are to be regulated by the GMC.
3. The Physician Associate should also be registered on the Physician Associate Managed Voluntary Register (PAMVR) which is run by the Faculty of Physicians Associates (FPA). This should be checked prior to the PA officially starting the role. Prior to starting their role, PAs must ensure that they are enrolled on the scheme.
    a. It is expected that physicians will ensure that the appropriate CPD (Continuing professional development) is carried out as well as other necessary commitments to ensure that they remain on the PAMVR during the course of their employment. This will include enrolment in the ePortfolio created by the FCA and GMC to log effectively their CPD so that this can be reviewed by the clinical and educational supervisors as well as the GMC/FPA as required.

Indemnity arrangements

1. Indemnity arrangements must be organised before starting the role.
2. All PAs will be covered under the Clinical Negligence Scheme for General Practice,
3. However it is encouraged that PAs do take out separate professional negligence insurance.
    a. This can be covered by the following medical defence organisations: Medical Protection Society (MPS), Medical Defence Union (MDU) or Medical and Dental Defence Union of Scotland (MDDUS).
    b. Group arrangements can be made with Medicus Health Partners scheme for all PAs employed within the Enfield Unity PCN. This is advised as CNSGP do not cover for professional negligence claims, medico-legal services such as representation at inquests or issues surrounding professional regulation matters.
    c. It is advised that this is arranged by the PA prior to commencing the role.

Salary

1. The starting salary will be between £42,500-£43,500 depending on experience
    a. After first year - £45320, after second year - £46350, after third year - £47380.
    b. Thereafter there will be an addition £1000 per year served until £51,500
2. Lead PA positions attract a higher salary to reflect the increased responsibility.
3. It should be noted that the PA can register with the NHS Pension scheme.
4. The PA will be asked whether they would like to join the scheme by the HR team at the point of starting.
5. The PA is advised to seek their own financial advice prior to enrolling to ensure the scheme is right for them at the start. They are also advised to seek ongoing independent financial advice as to whether they would like to remain part of the scheme or opt out at a later date should their circumstances change.

Sick leave

1. Sick leave will commence after the probationary period.
2. Will depend on years of service.
    a. Up to one year service = 1 week
    b. Between 1-2 years of service = 2 weeks
    c. Between 2-3 years of service = 3 weeks
    d. Between 3-4 years of service = 4 weeks
    e. Between 4-5 years of service = 5 weeks
    f. After 5 years of service = 6 weeks

Criminal disclosure

1. Employment should be subject to a satisfactory disclosure and barring service disclosure in accordance with the Rehabilitation of Offenders Act 1975.

Other considerations

a. Fitness to practice

I. PAs on the PAMVR are required to prove there have no fitness to practice issues. If there is a fitness to practice to concern, this must be reported to the PAMVR.

II. GMC fitness to practice guidelines must also be adhered to.

b. Place and hours of work

1. The place and hours of work should be clarified, particularly if PAs are expected to work across multiple sites (often as part of a PCN role).
2. 37.5 – 40 hours per week full time as required.

Primary Care Network

What can PAs do in primary care?

1. Manage patients ranging from young children (over 2 years of age) to elderly with acute and chronic conditions
2. Take a medical history
3. Physical examinations
4. Problem solving and clinical decision making to establish a working diagnosis/differential diagnosis and management plan
5. Work in partnership with patients / clinicians to create management plans
6. Utilise clinical guidelines and promote evidence based practice
7. Participate in duty rotas
8. Telephone and video consultations
9. Home visits
10. Referrals to other services via appropriate referral pathways
11. Instigate necessary invasive and non-invasive diagnostic tests
12. Manage laboratory results such as blood results, ultrasound and X-ray results
13. Discuss the results and implications of laboratory investigations with patients
14. Assisting with vaccinations (COVID-19, Flu jabs etc)
15. Assist with immunisations, minor surgery and specialist clinics
16. Procedures such as: bloods/venepuncture, perform and interpret ECGs and spirometry
17. Support integrated patient centered care through appropriate working with wider primary care / social care networks
18. Contribute to practice quality targets
19. Ensure consistent high standards of safe, evidence-based, cost-effective patient care and service delivery.

Current limitations

1) Requesting ionising radiation imaging such as x-rays and CT scans.
2) Prescribing.
3) Undertake Mental Health Act assessments.
4) Register/sign death certificates.
5) Issue sick notes.

Note: *it is expected that once regulation is in place, the above would also be followed in due course*.

Identifying as a PA towards patients

Given the recent press about “PAs who misinform patients that they are doctors” the following considerations have been made with regards to aiding public perceptions about what PAs are able to achieve:

1. Posters are to be available in the waiting rooms as well as clinical rooms.
2. Leaflets can also be kept within reception areas and should be easily accessible as well as clinical rooms with the PAs and then can be provided to patients at their request.
3. When an appointment is being booked, especially when this is a Face-to-Face appointment, it should be clearly stated that this will be a physicians associate.
4. A PA will identify themselves as a physicians associate at the beginning of a consultation.
5. The PA shall document at the beginning of the consultation in the history stating “seen by Physicians Associate” code on emis so that it is visible on online patient access.
6. Having badge/lanyards also identifying the PA as a PA, and not a doctor.

Sites

When initially starting, as part of the preceptorship year, the PA Preceptee must work in no more than 2 practices. Ideally this should be one site in the preceptorship year, however it is acknowledged that there may not be capacity within some surgeries to accommodate a PA fulltime, in other words only have the space/facilities/supervision for several days of the week. Therefore in these instances the hours which are to be worked by the PA can therefore be split between two sites. By minimising the number of sites in which a PA will be working, this will help create better working relationships with their on-site clinical supervisor and so aid in their development, given they are still very early on in their clinical careers.

This can then be adjusted beyond their preceptorship to take into consideration additional skills gained. For example, this may include carrying out specialty clinics (such as smear clinics or spirometry clinics) to fulfil PCN needs, and as such may mean working at more than 2 sites. This will be subject to discussion between the PAs, the PCN/Educational Supervisor as well as the individual sites also.

Preceptorship programme for newly qualified PAs

Health Education England has introduced a preceptorship programme for new PAs going into General Practice. This aims to support the PA's development from being new graduates, and improving confidence and skills in becoming an experienced clinician.

One of these changes will include a half day for self-directed study leave. The PA will be guided through discussions with their clinical supervisor as well as by carrying out reflections and via debriefing periods of their gaps in the knowledge, thus allowing PAs to research relevant conditions, go on relevant courses as well as read NICE/CKS/other guidelines to augment their knowledge.

Furthermore there will be increased number of appraisals in which the PA will be able to be supported as well as be able to raise issues to be discussed and more regular progress will be reviewed. This will include a 3 and 6 month review in addition to the typical annual review.

It will be the role of the on-site clinical supervisor to help the PA achieve core competencies as outlined in the handbook – appendix 6.

When enrolling as a new PA within the Preceptorship programme within the Enfield Unity PCN, the North Central London (NCL) Training Hub will assign PAs a mentor and will be entitled to 10 sessions of mentorship within the preceptorship year. This may be continued beyond this number of sessions as well as beyond the preceptorship year by the NCL Training hub. Whilst with the Enfield Unity PCN mentorship and advice can always be provided by the Lead PAs. For further information, please contact your local PA Ambassador or HEE.

Induction plan

Induction programme is vital for appropriate transition of PAs in a new role. Often this would be expected to be in the first 1-2 weeks of employment (See appendix one for example of an induction plan). Although the induction plan would be practice specific, the following considerations are important:

1. Introduction to practice and staff
2. System training
    a. SystemOne / EMIS
    b. Referrals training (If expected to do referrals)
3. Online module training
    a. Annual NHS modules
    b. Mandatory GP/PCN/locality training courses (Usually e-learning)

The induction plan is typically tailored by the Lead PAs who will formulate an induction plan for the new PA in conjunction with the Surgery which the PA would be joining. Further guidance and tailoring of the individualised inductions for new PAs can be obtained from the Lead PAs.

It is worth noting that certain elements of the induction programme, such as shadowing existing PAs, may not be able to be carried out at their intended sites and may need to be carried out other sites.

The PA should not be expected to commence clinics/clinical duties without having a formal induction plan for the first week. An example induction plan including an induction checklist have been included in Appendix 1. A template for work days is also shown as part of Appendix 1.

Support and development

An on-site Clinical supervisor will be allocated to the PA when starting at the Surgery who will aid in their develop and progression at the surgery. A clinical supervisor will be allocated to the PA at every site in which the PA will be working. If working at multiple sites, then they will have a clinical supervisor at each site.

The practice manager at the surgery will organise a site specific orientation on the first day of employment. On initiation, time will also be provided to complete the mandatory training. Time will also be provided to attend NCL and PCN PA study sessions and group meetings. These typically occur once a Month on a Thursday or Wednesday afternoon. It is important to use this time wisely to help the PA settle in, to meet key people as well as become familiar with the environment, local policy and guidelines. These will be provided by the clinical supervisor/Practice manager; they can also be found on the PCN intranet.

Whilst at the surgery the clinical supervisor will be the first port of call for the PA (also alongside the practice manager) for any on site related issues. If issues arise, that cannot be resolved onsite, then the PA or the clinical supervisor can liaise with the Educational Supervisor/PCN PA Lead or one of the Lead PAs to seek advice or escalation of the issue.

It is recommended that the clinical supervisor will need to have undertaken a HEE approved Clinical Supervision Training or be a GP trainer.

It will be the role of the clinical supervisor to carry out regular clinical reviews which are then to be fed back to the PCN PA Lead/Educational supervisor. This will include an introductory meeting when first starts at the practice as well as a 1 month initial settling in catch up. Within the preceptorship year there will also be clinical reviews at 3, 6 and 12 months during preceptorship year. Please refer to https://www.fparcp.co.uk/professional-development/fpa-materials on First Year Post Qualification Document. Thereafter annual reviews will be carried out.

During this year, it is expected that the PA will have attained competencies as stated in Appendix 6. These are to be assessed by their clinical supervisor and are to be signed off. Should they not be achieved within their preceptorship year then additional assessments and measures can be put in place in order for the PA to be meeting these standards.

Additional clinical reviews can be set up by the clinical supervisor/Educational supervisor if there are clear expected objectives or skills that have yet to be reached, to be agreed upon at the previous clinical meeting. This may include additional observed clinics for direct clinical feedback on specific clinical skills are yet to be attained as stated in Appendix 6. More details of the input of what is required for each review can found later in this document.

If a PA has multiple sites and therefore multiple Clinical supervisors then corresponding clinical review meetings will be carried out at both sites, with overview carried out by the PCN PA Lead/Educational Supervisor. The potential need for a subsequent educational supervisor meeting may then be set up for further discussion if indicated. A separate educational Supervisor meeting may also be carried out to assess overall performance but also to take into consideration a holistic approach including progression, CPD, professional and patient feedback as well as personal circumstances if indicated also.

Whilst working, a PA may identify certain learning needs/objectives. These are to be discussed with their clinical supervisor and can be used as the basis for their required CPD. It is important that the PA is proactive with their learning, especially in their preceptorship year in which they have a half day for self-directed learning. Guidance on how best to utilise this can be achieved through discussion with your clinical supervisor/the lead PAs as well as the PCN PA Lead/Education Supervisor.

There are NCL/PCN teaching sessions on a monthly basis, with links sent out to the PAs to allow them to join those sessions. If nothing is received, then the PA is to contact the Practice manager or the Lead PAs to assist with this. PAs are to be released for this by their practices. If this falls on a day in which they are not working, then time back in lieu is to be provided in order to catch up on the teaching which is typically recorded.

There is a local PA support group which runs a teaching and information update session each month. It will also be a great help if PAs wish to discuss any concerns or problems you have from both clinical and non-clinical life. Please get in touch with your Lead PAs/local PA Ambassador for more information.

Supervision

Each PA will have dedicated time at the end of their session in order to be able to debrief on the patients they have seen in that session. Each PA will have a names supervisor for their session. This may vary from their named clinical supervisor depending on availability. Their on-the-day supervisor will also have dedicated protected blocked off time in order to facilitate the debrief for PAs.

This period of time is to be used to discuss all the patients that the PA has seen but also as time allows to discuss the nuances in management which provides good opportunities for micro-learning as well as help direct PAs to areas of self-directed learning.

It is an opportunity to discuss about what further history, examination and investigations may be required and it can be expected that the PA may need to phone/bring the patient back again in order to achieve the above. This is also an opportunity for ensuring that appropriate red flags are identified (which the PA may not have known to ask about/examine at the time) and actioned as required by the PAs also therafter. Where further information/examination is required, the PA is to then discuss this further as required with their supervisor when this information has been gleaned which may be the following day in non-urgent cases and a further note can then be made if the plan changes.

This period will also be used to review and sign any prescriptions, review any investigations including blood tests as well as radiology/imaging. The supervisor should be prepared to discuss any referrals advised by them or initiated by the PA when necessary. If a PA feels that a patient is required to be referred urgently to hospital, then this is to be discussed in between the GPs patients with their supervisor. Their supervisor may then wish to review the patient and also liaise directly with the relevant hospital consultant.

When creating schedules, it is important to keep in mind that PAs may need additional time to briefly discuss an urgent patient case and also for urgent prescriptions. This can be achieved through blocking off 1-2 slots (15-30 minutes) in their clinics. The PAs will need to debrief every patient contact with their allocated supervisor. This does not need to be after every appointment and can be during a break or at the end of clinic. Normally, debrief time per session should initially be 30 minutes. Supervision will naturally evolve depending on the experience and competencies of the PA. PAs must be clearly informed of their allocated supervisor/mentor for every clinic/session. If PAs are required to do admin duties, they should be given allocated time as well as supervision for this. How to set out the supervision time in clinics can be seen within Appendix 2. The allocated supervision time for the GP may be all at the end of the session or can be split if the PA is junior and is needing assistance during the clinic. This is to allow time for PAs especially towards the beginning of their preceptorship position to be able to more freely come in to discuss patients after seeing them OR if requiring assessment from their supervisor to also go to examine the patient also. This is to be at the discretion of the individual supervising GP.

It is advised that when reviewing the notes the EMIS code for ARRS supervision is used. If the supervisor has seen the patient, then additional documentation within the patients notes is advised. Further actions that are expected from the PA can also be documented also. The documentation is expected to reference if need be the documentation of the PA. This is because the documentation of the PA can then be viewed prior to the GP reviewing the case/patient (PA should have written up their notes by then) and as such there should be a visible audit trail.

Ideally the clinical supervisor will be supervising the PA (in particular during the preceptorship year) on a day to day basis when possible/available when at the surgery. This is to build a better understanding of the strength and weaknesses of the PAs and help build a constructive relationship that enables the provision of both support, challenge and develop reflective practice. As a consequence, this will better aid in their development as well as their confidence. This will aid in a better working relationship and understanding which will allow the clinical supervisor to be better placed to advise in suggested Personal development plans, areas to focus in their CPD as well as allowing the clinical supervisors to be better placed to sign off required competencies (as stated in appendix 6) and carry out appraisals alongside the educational supervisor. Through supervision, if any concerns or gaps in knowledge are identified then the supervisors should inform the PA Lead/Educational Supervisor. These can then be added to their competencies for update and training in future and discussed at any future appraisals. Similarly, PAs should keep a record of their own PUNs (patients unmet needs) & CENs (clinicians educational needs). They should regularly share these with the educational supervisor at appraisals / meeting for review to map against the competencies to continue their professional development.

It is appreciated that there will be days in which their clinical supervisor will not be available to supervise and as such other GPs will be supervising the PA along the same stated guidance. When other GPs supervise the PAs the details/outcomes of the supervision can then be fed into the clinical supervisor and used in discussion for their appraisals as well as part of Profession feedback also. Beyond the preceptorship year this can be relaxed further so that other GPs will have a greater role in their supervision

If there is any clinical uncertainty or concern from a PA about their patient, then the PA may seek out help/review from their supervising doctor on the day. This can be done if there is an immediate clinical concern about the patient or if they would like the supervising doctor to examine the patient. Unless it is a clinical emergency then ideally then ideally this should take place in between the patients of the clinical supervisor. If there is a long wait/unavailable, then help can be sought from the duty/another doctor within the practice. Ideally this should be kept to a minimum and that clinical cases are discussed mainly within the specified debrief time. For non-urgent issues then advice can be sought form the supervising doctor and then the PA can call back the patient after the debrief period to inform and council the patient of the appropriate plan.

This allocated debrief time is not to be used as additional time by the PA, and that the PA is expected to debrief and not just leave after their session. If there are time constraints, then theses are to be discussed with their supervisor on the day to be able to achieve adequate supervision.

Supervision in out of hours clinics and for home visits will be addressed later in this document.

It can be expected that all circumstances cannot be accounted for in these new provisions and that all sites work slightly differently. It is expected in the first instance that any issues are to be attempted to be resolved between the PA and the Clinical supervisor to discuss elements of supervision and support and how this can be best tweaked at that practice. If further guidance/external opinion is sought especially if there is a disagreement, then the guidance from the Lead PAs as well as the Educational supervisor/PA Lead can be provided. The ultimate aim is that all PAs will feel that they are having adequate supervision and development within their role as well as GP surgeries ensuring that PAs are practising safely and within their competency.

Appointments / Consultations

This is dependent on the PAs experience. For newly qualified PAs this will follow the suggested templates in appendix 2. With regards to PAs with previous experience there may be an adjustment period required when starting to adjust to the new environment prior to following the typical post-preceptorship template.

The ideal minimum time for a PA appointment is dependent on the appointment type and complexity. As a guidance, the expected appointment times for the following appointment types are:

- Acute illness appointments – 15 minutes
- Continuity of care appointments – 15 minutes
- Routine appointments – 15 minutes
- Chronic illness review appointments – 20-30 minutes
- Mental Health appointments – 15-20 minutes

Attached in Appendix 2 are example timetables for PAs at different stages within their preceptorship year and beyond. This is an approximate timetable with a suggested number of patients as well as allowing time for catch-up, debrief time and lunch, and it is appreciated that with discussion with the PA lead and the Clinical supervisors that the time timetables can be adjusted to accommodate both the practice as well as the PAs needs. For example starting at 8am rather than at 9pm or having a longer lunch period but then finishing later. If there are any concerns then this can be discussed further with the PCN PA lead for appropriate accommodations.

Please note that PAs can have either a 30 or 60 minute unpaid lunch break. The example templates include a 30 minute
Another example includes the transitioning between longer appointments in the preceptorship year to shorter length appointments. To aid in the adjustment for the PA, additional catch-up slots can be added into the suggested schedule by converting a consult into a catch-up slot. Then as the PA becomes more accustomed to the shorter appointments then they can be removed to resemble the suggested timetable/ultimate goal. This will be through regular discussion and review between the PA and the clinical supervisor.

Within the preceptorship year, given the PAs relative inexperience it is advisable that hours are not compressed into fewer days.

Triaging / Complexity

It is appreciated that all sites will triage appointments to clinicians in their own unique system that works best for them, BUT it is important to consider what the PAs are able to cover will vary greatly from PA to PA as well as depending on years of experience and linked to their training to date/CPD. It is important that between the PA and their clinical supervisor a list is created of appropriate conditions and presenting complaints, that can be triaged into their clinics ideally by clinicians. This can be based on the clinical cases grid https://www.fparcp.co.uk/webapp/data/media/58eb57fd01018_Matrix_of_core_clinical_conditions.pdf. This list is to be re-evaluated regularly and updated as the PA undergoes learning, training and their skill set increases. It is appreciated that there will be cases which stretch PAs knowledge and understanding, and there may be cases that may initially appears simple become a lot more complex and may require further discussion with their On-the-day supervisor.

HOWEVER, cases should not be allocated in such a way that it is out of the depth of the PAs knowledge base. They should be able to conduct a full assessment and conduct a management plan without needing in depth discussion before/during/afterwards with their on the day supervisor. If the person carrying out the triage is unsure of the patient concerns from the information provided by e-consult system or from receptionist logging the call request, then this patient should not be booked with a PA until further information is known about the patient and that this patient is appropriate for the PA. If the PA finds themselves with a complex patient that wasn't expected from initial appointment booking, they should discuss with the Triage doctor, duty doctor or their on-the-day supervisor promptly. That way the patient can be booked with a GP as soon as possible or later in the day. Non-triaging Doctors adding to PA's appointment lists must adhere to the above. They should also ensure they have given sufficient information for the PA to consult appropriately or discuss with the PA prior to adding to the appointments.

Cases can be allocated with some slight increased complexity, but this is to be agreed with the clinical supervisors and extra time allowed for this. This is to be done in a measured way to allow PAs to further develop in a controlled manner without feeling overburdened. This is to be done in conjunction with the PAs carrying out their own independent learning/CPD on these presentations/conditions. For example to carry out exacerbation of COPD assessments/heart failure assessments. For example a this "complex" list should be very short <5 things. This can also be adjusted in time as the PA develops in both knowledge and experience in these specific areas through regular discussions with their clinical supervisor. This list should be agreed in advance so that all parties (PA/Clinical Supervisor/other triaging GPs/Reception team) are aware of this at the time of triaging.

The PA's must not work outside their own competencies. If they are unsure, they must ask before initiating any management plan with their allocated supervisor, practice partner or duty doctor.

Multilingual PAs

Even if you are able to speak in another foreign language, a PA would not be expected to carry out consultations in any language other than English. Via the Surgery there should be appropriate telephone translation services (typically Language Line) which should be made available to be used when needed – details of which can be obtained form the Practice Manager/Clinical Supervisor. Appropriate time (typically longer/double appointments) should also be provided to ensure that you have enough time to conduct these consultations as using an interpreter can potentially be very time consuming.

Out of Hours Clinics / Home visits

When considering out of hours clinics it is important to state that similar principles as with in hours will remain true. PAs should not be the only clinician on site. There must be an onsite doctor in case of clinical emergency. If a supervisor is allocated to a specific PA, then a supervisor should be chosen who will be present on site for the duration of the PA's out of hours session. If the PA is carrying out telephone consultations, this can be done without another clinician onsite. HOWEVER, there must be a clinician available during this period to discuss patients as well as to be able to debrief the extended hours patients via telephone. The supervising GP as well as the PA should have adequate time blocked off in order to carry out the debrief within the Extended hours time. Given the above, it is advisable that if an extended hours session is to be carried out after 18:30 then they are only telephone. In order to help facilitate Out of hours sessions, these can be split across multiple days if this makes it more achievable both for the PA as well as the for the practice after discussion between both parties. Out of hours clinics are not to be carried out within the first 3 months of the preceptorship year.

When home visits are carried out, this should not be for acute patients. Furthermore, there needs to be adequate debrief period after the home visit. In addition, their on-the-day supervisor should be contactable throughout the period of the home visit. This may include a video call with the PA and the patient.

Referral system

All referrals should be done on Emis system, including 2 weeks wait and non-urgent referral to different speciality. Please keep in mind each practice has its way of sending referrals and as such the PA is expected to become familiar with their surgeries system within their induction week for this – to be discussed with their Clinical Supervisor/Practice Manager/Admin team. It is also important to consider that there are also specific forms which include but are not limited to 2ww, community referral forms and mental health referral forms. All speciality referrals including urgent and non urgent need to be done through the choose and book referral system. If you are not sure which form to use then please discuss with your clinical supervisor/on the day supervisor. It is important to note that it will take some time to get used to these new systems at the beginning and so please do not worry about this.

All referrals are to be discussed with the supervising GP prior to be being made.

Prescription process

1. Safe prescribing and handling of medications are of great importance, and therefore clear arrangements should be put in place to ensure safe and timely prescriptions are issued to patients.

2. As PAs are not yet regulated, they currently carry out their scope of work under the 'delegation clause'. This means that they are under the responsibility of the supervising doctor. In 2018, the government did announce their intention to also introduce prescribing rights for PAs which would be part of the regulation process of the role.

3. Manual patient prescriptions can be signed following every patient; however, this is timely and could cause delays in clinics. Fortunately, now with the use of EPS, PAs can recommend medications which can be signed off by their supervisor if appropriate. It is recommended this is done during debrief time at the end of the session where the appropriateness can be discussed with the supervising GP and the patient can collect their prescription from their nominated pharmacy later (during the same working day). Alternatively, if printed scripts are used, there should be time in the schedule to allow this. It is important that there is a clear, written and agreed protocol to ensure this process best suits the team. This can be regularly reviewed and updated as per practice development and changes and also during the PA regulation period.

4. The PA should provide sufficient information during the prescription discussion with the authorised prescriber to enable them to sign the prescription and ultimately accept responsibility. The below should be documented in the notes and should include:
    I. Age and Gender
    II. History of presenting complaint
    III. Past Medical History
    IV. Drug history/Interactions
    V. Allergies & Contraindications
    VI. Any other factors the PA feels is necessary to discuss

5. If a prescription is required whilst a PA is on a home visit/nursing home visit, it should be discussed with the supervision following the visit. This can then be printed for collection or sent electronically to the nominated pharmacy for collection/delivery.

X-ray and scan requests

1. As PAs are not permitted to request ionising radiation such as X-rays, a smooth and safe process for the management of signing requests should be created. Often, each individual X-ray request should be discussed with the supervising clinician, highlighting the reason for the request and the usefulness. Consequently, if a mutual decision is made that the X-ray is required, it can be signed off by the supervisor.

2. PAs are permitted to request US scans and blood requests if appropriate.

What PAs can get involved with:

1. Flu Vaccinations & COVID-19 Vaccinations – This can be administered under a PSD (Patient specific direction).
    a. *Patient specific direction (PSD)*: This is the traditional written instruction, signed by a doctor (the prescriber) for medicines to be issued and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. In General Practice, this means the prescriber has a duty of care and is professionally and legally accountable for the care he/she provides, including tasks delegated to others. The prescriber must be satisfied that the PA to whom practice is delegated has the qualifications, experience, knowledge and skills to provide the care or treatment involved.
    b. *Patient Group Directions (PGDs):* This allows particular healthcare professionals to be trained to assess a patient within stated parameters. These are a specific set of instructions which directs the healthcare professional in their assessment of a patient, which allows the professional to determine whether or not the patient should receive a specific medication. [An appropriate practitioner is described as: a. an independent prescriber: someone able to prescribe medicines under their own initiative. They include, amongst others, doctors, dentists and nurse independent prescribers who can issue Patient Specific Directions; b. a supplementary prescriber: someone able to prescribe medicines in accordance with a pre-agreed care plan that has been drawn up between a doctor and their patient. Supplementary prescribers include, amongst others, nurses, midwives and pharmacists. Registrants from these professions need to complete an approved post-registration training programme to become independent or supplementary prescribers.]
    It is noteworthy that PAs cannot use PGDs.

2. Chronic illness clinics and reviews (Asthma clinics, COPD clinics, HTN management, Diabetes etc)
3. Contraception/Family planning clinics
4. QoF clinics, Check and test
5. Specialist clinics (diabetic clinics, spirometry etc)
6. Training and development

Administrative tasks

Docman

1. Appropriate site based training on how to use Docman to action/ complete tasks
2. Appropriate amount of time must be allocated to the PAs each day - e.g if 10 documents per day assigned, ~30-45 minutes allocated. Marked 'Admin' on appointment diary. This should be instead of similarly timed appointments AND not in addition to the suggested appointment diary as stated in Appendix 2. Guidance on how this can be introduced can be achieved through discussion with the Lead PAs of the PCN PA Lead/Educational Supervisor.
3. Maximum amount of admin sent to PA each day should be established and Admin team scanning documents should be aware (e.g. no more than 15 documents) this will ensure tasks can be cleared preventing build up on the next day. On initiation this should be reviewed regularly in order to ensure that time allowed for the tasks is sufficient for the quantity of the workload.
4. Suggested max 1 hour of admin per day.
5. Adequate supervision time should be allowed specifically for any administrative work in order for the PA to also be able to discuss admin tasks that have tasked to the PA. This is also ensure that any clinical questions that may pertain to the admin task can be answered and actioned appropriately.
6. Admin that is suitable with appropriate supervision and training include: USS, Xray, MRI reports, onward referrals to specialities and outpatient clinical letters or rejected referrals that require additional information.
7. Not suitable: hospital discharge summaries or new meds/ adjustments to medications
8. No red flagged docman letters are to be given to the PA. Also no docman that required on the day assessment or action is to be given to PAs.
9. If a docman letter requires an appointment (e.g. a discussion of a scan result which may warrant a referral, or the initiation of certain medications) they should be able to book into pre-bookable slots to call patient to discuss further or arrange for admin to contact patient to book an appointment.

Blood test results

1. It is not appropriate for PAs to file and go through blood tests. This is because they typically come grouped and even if normal there are nuances that will require experience in order to interpret.
2. If blood test results are to be incorporated into PA's workload, the following may help:
    a. PA should only be given results to inform patients, that have already been reviewed by a GP with clear instructions. This can be documented by GP in patient noted prior to PA consultation. (e.g. inform pt raised LFTs – refer to USS, abnormal TFT, make following adjustments to meds etc)
    b. PAs should be provided with appropriate training/guidance about how to discuss the results with patient.
    c. Blood test results already interpreted by a doctor, but needs informing/explaining to patients – e.g. raised cholesterol/QRISK, new Pre-diabetes,
    d. Have allocated routine appointment slots/pre-bookables – this can then be booked by the doctor interpreting the results in advance if non-urgent results.
    e. The same can also be done for other results e.g. x-ray, USS, DEXA scan – that are non-urgent can be booked on to pre-bookables.

CPD

1. CPD diary runs from 1st November until the October 31st every year subject to change by the GMC and the Royal College of physicians.
2. PAs must register to the CPD diary by the first April following their graduation.
3. PAs are expected to complete 50 hours of CPD each year.
4. Amongst the mandatory CPD, PAs are expected to carry out an annual BLS training to include management of anaphylaxis. This is typically arranged by the practice as this is a requirement for all staff.
5. PAs are expected to carry out Safeguarding level 3 for both adults and children, which is usually carried out every 3 years.
6. PAs within their preceptorship year will have their weekly half day in which to carry out the required CPD.
7. PAs (who have completed their preceptorship year) will have 5 days pro-rata study leave in order to aid them complete the mandatory annual CPD of 50 hours. Some PAs have additional study leave in their recertification year. It is expected that the rest of the required CPD will be achieved in their own time.
8. As a member of the PAMVR, access will be given to the ePortfolio where PAs must document their CPD hours as proof. To remain on the PAMVR, the FPA will audit the CPD diary and ensure all requirements are met.
9. Certain restrictions apply to the Type of CPD points (Taken from FPA guidance- see website for full details):
    a. **External** – the annual minimum requirement for External credits is 25.
    b. **Internal** – There are no restrictions or requirements on the number of Internal credits claimed.
    c. **Personal** – Only 10 Personal credits may count towards the total annual minimum credit requirement. However, you may record as many Personal credits as you have completed.
    d. **Distance learning** - only the first 10 RCP approved Distance Learning credits will be counted as External, the remainder can be claimed as Personal.
    e. **MSc -** only 12 External credits may be claimed for an MSc or equivalent activity each year. The remainder can be claimed as Personal.
    f. **Examining** - only 12 External credits may be claimed for Faculty of Physician Associates examining activities each year. All other examining activities can be claimed as Personal.
    g. Further details on education activities that qualify for CPD can be found in Appendix 4.

10. It is advisable that CPD is carried out in order to undertake a range of CPD activities. When documenting the CPD, it is important to link this to different areas of the FPA curriculum and to ensure that all areas do the portfolio are addressed through the year as part of the portfolio. A summary of this can be viewed on the CPD summary from the ePortfolio
11. Each item of CPD is to be clearly logged and entered along with any certificates where appropriate especially with regards to External CPD.
12. With every entry into the CPD diary entry it is important to not only document a brief summary of the learning event and the key learning points, but it is also important to document any reflections on this learning along with how this new knowledge may impact on clinical practice as well as whether this has further identified additional learning needs to the PA.
13. CPD can be used to show progress towards a personal development plan and how the personal development plan may change as a result of this.
14. The CPD log is to be reviewed and discussed at appraisals. This will aid in discussions about how CPD can be utilised to aid in the development of the PA. CPD can then be shown to evidence for working towards agreed educational objectives.
15. All registered Physician Associates should remain up to date with the CPD requirements. Physician Associates working less than full time have an equal obligation to provide high quality patient care as do those working full time, and thus should maintain the same commitment to their CPD. In some circumstances participation in CPD may be difficult or impossible for periods of time. The following are some of the circumstances to be considered – sick leave, maternity or other career breaks. The outstanding CPD should then be made up after the period of absence. This is to be achieved that the rolling 5 year CPD activity equates to 250 hours of CPD.

16. In order to quality assure their CPD system and to verify that claimed activities have been undertaken and are appropriate, the Faculty of Physician Associates will audit participants' activities on a random basis. There will be an annual random audit of the records of 5% of all Faculty of Physician Associate CPD Diary users. This is to ensure that credits claimed are supported by evidence, that the minimum annual requirement has been achieved and that Diary users use their diaries correctly.
17. eLearning which has been carried out can then be linked to the ePortfolio as well as to the curriculum once it has been completed.

The following is a useful link for further information about CPDs made by the Royal college of Physicians- Faculty of Physicians Associates:

- Continuing Professional Development Guidance for Physician Associates

]https://www.fparcp.co.uk/file/image/media/63c19037b1a1d_CPD_guidance_for_Physician_Associates_Jan_23_FINAL.pdf

Enfield Unity Primary Care Network

Portfolio and Appraisals

1. It is the responsibility of the PA to ensure that they carry out an annual appraisal as well as the required preparation that has been outlined below.
    a. They will need to ensure that they have achieved the appropriate number of work-based assessments as well as other criteria prior to having a review with their Clinical Supervisor.
    b. This needs to be done prior to arranging the mandatory annual appraisal with their Educational Supervisor/Enfield Unity PA Lead.
    c. Within the preceptorship year a review is carried out at 3, 6 and 12 months of the preceptorship year and then annually thereafter.

2. There will be a number of forms which will be required prior to the Clinical Supervisor meeting and Educational supervisor annual appraisal. These will be reviewed and commented on at the time of the clinical review and annual appraisal.
    a. These include:
        i. CPD log book (as stated previously)
        ii. Work based assessments
            1. Case-based Discussions (CbD) – 12 per annum
            2. Mini-Clinical evaluation exercise (mini-Cex) – 12 per annum
        iii. Personal Development Plans – 3 per annum
        iv. Multisource feedback – minimum 6 (ideally 10) every 2 years
        v. Reflections – 12 per annum
        vi. Significant events – form must be completed for every significant event that has been raised
        vii. CPD reflections – as stated previously
    b. The quantities are subject to changes to be implemented by the GMC

3. Prior to the Clinical Supervisor meeting the PA will need to carry out a self-reflection and rating of the different competencies as part of the FPA curriculum. Then as part of the Clinical Supervisors report, the Clinical Supervisor will also rate the competencies of the PA.
4. It will be the role of the clinical supervisors to review the clinical ability which will help support the annual appraisal carried out by the educational supervisor. This may come in the form of completing work-based assessments as well assessing their competencies as stated by the FPA curriculum.
    a. As a PA transitions from qualification through their 12 months post-qualification their competencies can be signed off by their clinical supervisor as per Appendix 6.

5. All clinical stuff must be reflective in their practice, and this will help them progress through their carers by reflecting on their consultations. PAs are to complete 12 reflection per annum on consultations by using the Reflection form on clinical events on the ePortfolio.

6. Personal Development plans are geared to aid you with your development in the coming year and be geared towards future career plans and aspirations as well as where clinically you would like to progress also.
    a. They must be written in a SMART goal format → Specific, measurable, achievable, relevant and time-based
    b. They can be discussed at the annual appraisal meeting with a view to what the

7. Feedback
    a. It is important for any healthcare professional to look outwards rather than inwards when assessing performance. Providing an opportunity for both colleagues and patients to provide their opinion about a PA can help to encourage a culture of openness and transparency. Putting the patient first in everything a PA does is paramount. Contributing to and working with systems to protect patients is vital. It is recommended to incorporate the following feedback methods into the PA portfolio.
    b. These forms can be generated via the ePortfolio.
    c. Multi Source Feedback
        i. Can be completed by any member of the team both clinical as well as non-clinical, with at least for each of these groups.

ii. Each domain as listed below will be ranked by the assessor ("Not observed by me"/"Development required"/"Satisfactory"/"Outstanding"
iii. There is also the ability to provide specific feedback and comments as part of each of the domains in order to justify the ranking provided.
iv. Domains
    1. History taking and examination skills
    2. Relevant knowledge and diagnostic skills
    3. Ability to formulate appropriate management plans
    4. Procedural (technical) skills
    5. Record keeping (timely, accurate, legible)
    6. Ability to manage time and work under pressure
    7. Decision making and implementation skills
    8. Awareness of own limitations (willingness to ask for help)
    9. Initiative and leadership skills
    10. Focuses on patient safety (clinical governance)
    11. Willingness to ask for feedback and learn from it
    12. Teaching (enthusiasm and effectiveness)
    13. Communicates effectively with patients and their families
    14. Communicates effectively with healthcare professionals
    15. Active involvement with your team
    16. Respects and values contributions of other members of the team
    17. Supportive and accepts appropriate responsibility, approachable
    18. Reliable and punctual
    19. Takes responsibility for own actions and actions of the team
    20. OVERALL PROFESSIONAL COMPETENCE
v. There is also the opportunity to highlight if there are any concerns about the honesty and integrity of the Physicians Associate.

d. Patient Feedback
    i. should be completed by 15 patients per annum prior to carrying out clinical review.
    ii. These should be randomly selected and the feedback can be requested by reception staff
    iii. This allows patients to answer a variety of questions by answering yes/sometimes/no Does not apply, as well as providing reasons for their response.
    iv. Questions include:
        1. Was the physician associate polite and considerate?
        2. Did the physician associate listen to what you had to say?
        3. Did the physician associate give enough opportunity to ask questions?
        4. Did the physician associate answer all your questions?
        5. Did the physician associcate explain things in a way you could understand?
        6. Are you involved in the decisions about your care and treatment?
        7. Did you have confidence in the physician associate?
        8. Di the physician associate respect your views?
        9. If the physician associate examined you, did he or she
            a. Ask permission?
            b. Respect your privacy and dignity?
        10. By the end of the consultation did you feel better able to understand and/or manage your condition and your care?
        11. Did you feel you were involved as much as you wanted to be in the decision about your care and treatment?
        12. Overall, how satisfied were you with the physician associate that you saw

8. Where a significant event has taken place a reflection must be undertaken by the PA a subsequent form competed within the ePortfolio. This is then subsequently to be discussed at the Clinical review with their Clinical Supervisor as well as at their annual appraisal with their Educational Supervisor.

9. Audits
    a. The practice/clinical supervisor can identify potential areas for service improvement which can be undertaken by the PA, particularly in their first year. This can be agreed during the appraisal or review meetings. The nature of the audit and what is to be expected of the PA is then to be agreed between the PA and their clinical supervisor, along with a plan or action, timeframe and expectations. It is expected that at least one completed audit cycle will be carried out over a 3 year period.
    b. The PA is to complete the reflection form on the ePortfolio prior to their clinical reviews and appraisals.

10. All mandatory training must be complete prior to the annual appraisal. This will include adult and child safeguarding level 3 as well as the Basic Life Support (BLS) course also.
11. An example of a timetable for reviews and appraisals is shown in Appendix 3.
12. Appendix 6 shows multiple competences which the PA should be expected to work through and complete 12 months post qualification. This should be reviewed as part of their regular appraisals.
13. All logs are to be carried out on the newly created ePortfolio which has been created by the Royal College of physicians
14. Elements of the curricula which forms should be linked to as part of the ePortfolio are listed in Appendix 8

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Career Development

1. Appendix 6 shows multiple competences which the PA should be expected to work through and complete 12 months post qualification. This should be reviewed as part of their regular appraisals.

2. Develop laterally rather than vertically
    a. It is expected that all PAs will be familiar with conditions in 1A of the matrix initially when starting. The link below is to the Matrix specification of Core Clinical Conditions for the Physician Assistant by category of level of competence
        i. https://www.fparcp.co.uk/file/media/58eb57fd01018_Matrix_of_core_clinical_conditions.pdf
    b. It is expected through self-directed as well as guided CPD from their clinical supervisor that the PA will in time to be able to expand their understanding of other conditions/differential diagnosis and thus expand their breadth of knowledge, and thus to other areas of the matrix.
3. It is important that PAs work within their competency. This means understanding the boundaries of your ability, and knowing when to refer or escalate to a colleague - Johari's Window
    a. New PAs should have self-awareness about their deficiencies. 'It's important to appreciate PAs are not going to see every type of condition regardless of whether or not it is within their matrix.
    b. It is important to not be afraid to escalate any concerns or doubts with your clinical supervisor.
4. Over time, will develop confidence and will be expected to see more complex patients with multiple co-morbidities

5. Some PAs are able to run specialist clinics with appropriate training such as:
    a. Diabetic specialist clinics
    b. Contraception / family planning
    c. Anticoagulation
    d. COPD / Asthma
6. Most PAs are able to take on more responsibility with experience, such as become Lead PA in their practice and may become a GP partner.
7. PAs should be given the opportunity to undertake a variety of research and analysis tasks associated with the improvement of clinical care, medical diagnosis and treatment where appropriate using the following means:
        a. Audits of clinical practice
        b. Significant event review/root cause analysis
        c. Review of relevant literature
        d. Research unusual treatment options and symptoms through consultation with other doctors/specialists/clinical staff.

8. PAs should contribute to regular MDT and practice meetings.
9. PAs can work closely with other clinical and administrative managers to set up and/or improve practice systems for monitoring and measuring performance against Clinical Governance and Quality Indicator Targets.

Study Leave

Beyond the preceptorship year, PAs will have 5 days of study leave pro rata compared to full time equivalency. All study leave needs to be notified at least 4 weeks in advance to the surgery/Practice Manager.

In addition to this PAs will need to be given time 3 hours per month to attend NCL PA teaching which usually falls on the last Wednesday of the month as well as one hour per month for the Enfield Unity PCN PA teaching which usually falls on the second Thursday of the week. Should the PA not be timetabled to work on that specific day (as potential teaching days may vary) then time will be given in lieu to be able to watch the recorded teaching – this is to be agreed in advance with the surgery to accommodate both parties.

Enfield Unity Primary Care Network

Useful information/Contacts

This part of template is for local region only, please change accordingly as numbers will change frequently.

Useful Mobile app

Cconnect (consultant connect)- instant advise from national consultant network from different specialities

Useful numbers to keep on your phone

Advice &Guidance (9am-8pm)- mostly will be North Middlesex speciality, can be directed to national consultant network.
Ambulance Health Care Profession Admission line: 02031627525
Rapid response team (direct referral) – 02087025681,07436027882 (email: beh-tr.rrt@nhs.net)
Enfield District nurses – 02087025910 Mon-Fri 9am-4.30pm (Out of Hours 02087023298, 08451114000)
North London Hospice Palliative Care Team – 08003687848
Inhealth radiology reporting line – 03332023185 (URGENT), 03332020297 (non-urgent)
Enfield council General Enquiries – 02083791000
Enfield Council (Occupational therapy, social worker assessment) – 02083791001
Enfield Council 24-hour Adult safeguarding line – 02083795212
Enfield Council Child safeguarding line – 02083795555 (Mon-Thurs 9am-5pm, Friday 9am-4.45pm – if outside of these hours then emergency Duty team via 02083791000)
London Ambulance Service - 02031627525

Barnet Hospital

Barnet Hospital Switchboard 02082164600
AAU 02082165150
Microbiology lab reception to chase up results- 02082165037; email: rf-tr.barnetlab.helpdesk@nhs.net
Microbiology on-call- 02082164055, 07730667622
Referral email for Early pregnancy assessment unit → rf-tr.bh-epagufax@nhs.net
Referral email for rapid access Paediatric clinic → rf-tr.paedsreferralsbcf@nhs.net
Referral email for OPAU → rf-tr.opau-cfh@nhs.net
Radiologist on call – 02082164092
Radiology Reporting Radiographer – 02082166072

North Middlesex hospital

North Middlesex Hospital Switchboard Bypass Number 02088873500
(Direct referral numbers – when out of hours stated then please contact switchboard to be put through to the oncall registrar)
A@E triaging line - 07718981712 (Mon-Sun, 24hours)
A&E Secretaries → 02088872303 northmid.edsecretaries@nhs.net (can be used to request missing discharges
Anicoagulation – 07776991840, 07484042477
Fracture clinic - 02088872866
Geriatrician on-call – 07890039025 (Mon-Fri, 9am-5pm)
Gynaecology - 07423524940 (Mon-Fri, 9am-5pm)
Haematology hotphone - 07483357060
Maternity direct - 02088874238 (Mon-Fri, 10am-6pm)
Under 75 medic – 07436036515 (Mon-Fri, 9am-5pm)
Oncology (advice) - 07423459076 (Mon-Sun, 24hours)
Paediatrician – 07436283463 (Mon-Fri, 9am-9pm)
Stroke TIA – 07776991889

Radiologist hot phone – 07501228664 (Mon-Fri, 9am-5pm)
General surgery – 07436038685 (Mon-Fri, 9am-5pm)

UCLH

GP switchboard – 02034479000
HASU Queens Square - 07753739286

Mental health

Crisis referral- 08001510023
Psychiatry advice line – 02087023997, 02087023620 (if called before 12 noon then will get response the same day, afterwards will get response the next day)
Sanctuary service if IAPT long waiting- 02089067509
IAPT for CBT-Enfield: http://www.lets-talk-iapt.nhs.uk/contact-us/enfield-iapt/
Barnet: http://www.lets-talk-iapt.nhs.uk/self-referral/
CAHMs crisis line – 02087025100, 02087024500, 02087024070
CAHMs advice line – 02087023997
CAHMs <13 years old non-urgent line – 02087025100
CAHMS >13 years old/Safe Team Non-urgent - 02087024070

Enfield Unity Primary Care Network

Appendix 1 – Example Induction checklist and example Induction Plan:

Induction checklist

Introduction to workplace Please complete within the first week of working	Date completed
Introduction to the team.	
Tour of the practice site.	
Cover fire procedure, including exits, assembly points, location of alarms and extinguishers and evacuation procedure.	
Show where the refreshment and dining facilities are located.	
Show where the toilet and ant possible cloakroom facilities are.	
Ascertain if any special requirements are required for new employee to carry out daily task, e.g. mobility aid, sever allergies, etc.	
Work related equipment discussed and shown where to find them, e.g. BP machine, dermatoscope, otoscope, thermometer, PPE, etc.	
Discuss health& safety procedures, e.g. infection control, mobbing &handling and point of contact, etc.	
Discuss security of personal property and personal security, including alarm systems, door codes, etc	
Explain any dress code requirements and make arrangements for providing any necessary uniform if required.	
Clarify methods of using office equipment, e.g. photocopier, fax machine, etc.	
Clinical orientation	
Provide name of clinical supervisor.	
Clarify where applicable hours of work, e.g. shift rotas, breaks, etc.	
Clarify annual leave entitlement, confidentiality and data protection laws.	
Clarify study leave and professional leave entitlement.	
Clarify the process of requesting leave, e.g. point of contact.	
Explain sickness and absence procedure, including paper work required to be completed in the event of sickness absence.	
Explanation of the role and work of the department, e.g. services running on different date of the week.	
Policies	
Ensure access to mandatory e learning training material, e.g Bluestream assess, e learning for Health access and local intranet resources.	
Ensure access to local policy and procedure.	
Ensure understanding to report significant events and injury.	
Fit to work	
Ensure completion of occupational check	
Ensure completion of DBS check	
Provide evidence of being registered with Physician Associate Managed Voluntary Register (PAMVR).	
Ensure appropriate indemnity arrangements are in place for clinical practice.	

Physician Associate 2 week Induction Timetable

As stated above there will be a period of induction into the new practice. There will also be a period of shadowing for those starting the preceptorship year

1st week

	Morning Session	Afternoon session
Day 1	Welcome to the Practice Introduction to Staff and their roles GP/PCN Policies & Procedures (Study leave, Annual leave / Sickness) Fire Procedure	Observe GP/PA clinic
Day 2	Observe GP/PA clinic	Observe PA/ANP/Paramedic/GP clinic
Day 3	Observe PA/ANP/Paramedic/GP clinic	Blue stream Training/Practice EMIS
Day 4	Sit in with Admin staff	Observe GP/PA clinic
Day 5	Blue stream Training/Practice EMIS	Observe PA/ANP/Paramedic/GP clinic

2nd week

	Morning Session	Afternoon session
Day 1	Observe PA/ANP/Paramedic/GP clinic	Observe PA/ANP/Paramedic/GP clinic
Day 2	Dependent consultations with supervision	Sit in with PA/ANP/Paramedic or Dependent consultations with supervision
Day 3	Blue stream Training/Practice	Dependent consultations with supervision
Day 4	Dependent consultations with supervision	Sit in with GP/PA or Dependent consultations with supervision
Day 5	Blue stream Training/Practice EMIS	Sit in with PA/ANP/Paramedic or Dependent consultations with supervision

Appendix 2 – Draft Mock Timetable:

First year (Preceptorship Year)

All appointment will initially start at 30 minutes for the first 3 months. This will then transition to 20min appointments from month 3 to month 12. Please see below for standardised templates for PAs in their preceptorship year across the PCN.

Note: all PAs in their preceptorship year should have 3.5 hours self-directed learning per week (one session per week)

Post preceptorship year:

All PA's within the PCN after the preceptorship year should be doing 15 minute appointments, 4 appointments per hour, with a 15 minute catch up slot after every 4 patients (Table 3).

At a local practice or site level there may be agreement to block off a number of slots for Clinical Admin to include Docman. The number of slots to be blocked will be agreed between PA and practice and will take into account the volume of admin the PA is being asked to process.

Template guidance for PAs working 37.5 hours over 5 days can be seen below. For PAs working compressed hours, the template will still remain the same e.g. for post-preceptorship year, 15 minute catch-up slot after every 4 patients.

There will be a 30 minute debrief time after both the morning as well as the afternoon sessions.

Extended Hours:

Extended hours would follow the same principals as above which would mean after every 4 15-minute appointment there should be one block of 15mins to catch up.

LTC

A full-time PA will have the option to deliver 2 half days as LTC clinics – these appointments can be flexibly diarised based upon the requirements of the practice and the skill set and learning needs of the PA.

Table 1
Template for Preceptorship Year
0-3 Months

30-minute appointments 09:00-1700 = 12 Patients

09:00	Appointment
09:30	Appointment
10:00	Appointment
10:30	Catch Up
10:45	Appointment
11:15	Appointment
11:45	Appointment
12:15	Debrief
12:45	Lunch
13:15	Appointment
13:45	Appointment
14:15	Appointment
14:45	Catch UP
15:00	Appointment
15:30	Appointment
16:00	Appointment
16:30	Debrief

Table 2
Template for Preceptorship Year
3-12 Months

09:00	Appointment
09:20	Appointment
09:40	Appointment
10:00	Catch Up
10:15	Appointment
10:35	Appointment
10:55	Appointment
11:15	Catch Up
11:30	Appointment
11:50	Appointment
12:10	Appointment
12:30	Debrief
13:00	Lunch
13:30	Appointment
13:50	Appointment
14:10	Appointment
14:30	Catch UP
14:40	Appointment
15:00	Appointment
15:20	Appointment
15:40	Catch UP
15:50	Appointment
16:10	Appointment
16:30	Debrief

Table 3
Template for post-preceptorship year

09:00	Appointment
09:15	Appointment
09:30	Appointment
09:45	Appointment
10:00	Catch Up
10:15	Appointment
10:30	Appointment
10:45	Appointment
11:00	Appointment
11:15	Catch Up
11:30	Appointment
11:45	Appointment
12:00	Appointment
12:15	Debrief
12:45	Lunch
13:15	Appointment
13:30	Appointment
13:45	Appointment
14:00	Appointment
14:15	Catch UP
14:30	Appointment
14:45	Appointment
15:00	Appointment
15:15	Appointment
15:30	Catch UP
15:45	Appointment
16:00	Appointment
16:15	Appointment
16:30	Debrief

Appendix 3 - Suggested timetable for reviews and appraisals as per FPA.

Timing	Number of CBDs and COTs	Date	Signed
Commencement meeting	Set plans		
1 month	Review integration into practices		
3 months	3x CBD, 3x COT		
6 months	3x CBD, 3x COT		
12 months/End of preceptorship review	6x CBD 6x COT		
Post-preceptorship Annual Appraisal	12x CBD 12x COT		

Consultation Observation Tool in Primary care

Either record a number of consultations on video and select one for assessment and discussion or arrange for your trainer to observe a consultation. Consultations should be drawn from your entire period of practice, reflecting a range of patient contexts. Complex consultations are likely to generate more evidence, as well as provide for a better discussion and learning tool. When you are selecting a recorded consultation, it's natural to choose one where you feel you've performed well. This is not a problem: the ability to discriminate between good and poor consultations indicates professional development. But do not spend a lot of time recording different consultations. COT is not a pass/fail exercise: it's part of a wider picture your practice.

Patient consent

The patient must give consent, in accordance with the guidelines for consenting patients. If any recordings are carried out then they should not be stored on a mobile or personal devices but should be kept and then subsequently reviewed on site.

Appraisal Forms

CBD/COT template Assessment Form

Case Complexity	Low	Moderate	High
Case Number: summary of case:			

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	Unsatisfactory	Satisfactory	Above Expectation
Documentation			
History Taking			
Clinical Assessment			
Management Plan			
Follow-up and Future plan			
Overall Clinical Judgement			

Strengths:	Areas for development

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Appendix 4- Reflection template

Description	• Explain what you are reflecting on, the situation and what happened? • If required, provide background information to explain • Who was involved?
Feelings	• Discuss your feelings and thoughts about the experience • Discuss how it made you feel, during the incident and as you reflected afterwards • Discuss your emotions honestly
Evaluation	• Focus on how you think things went • How did you react to the situation? • What was good or bad about the situation? • Include the theory and work of other authors – it's important to include references in reflective writing
Analysis	• Compare your experience with the literature you have read

Appendix 5 –Educational activities which qualify for CPD:

Internal CPD / Type 2	External CPD / Type 1	Personal CPD
Internal CPD meetings	Work related MSc or equivalent activity	Carrying out information searches
Internal trust or employer mandatory training	Unlisted External meetings	Making new presentations at conferences
Participating in audit meetings or Morbidity and Mortality meetings	BLS / ILS / ALS CPR	Participating in Committees/Working parties
Participating in Grand Rounds or Specialty Clinical Meetings	Conferences and CPD events accredited by RCP and other organisations	Reading Journals and texts
Participating in Seminars/Workshops Internal trust or employer mandatory training		Refereeing articles and texts
		Undertaking a research project
		Undertaking QA/enhancement/peer reviews
		Writing examination questions or examining
		Writing review articles and texts

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Appendix 6 - Transitioning from Qualification through 12 months post qualification

History Taking and Consultation

Competency	Date of Completion	Evidence
Able to carry out a focused history and produce an appropriate list of differentials		
Able to identify appropriate comorbidities and predisposing/risk factors		
Able to understand most likely differential based on the clinical case and justify reasoning		
Able to carry out an appropriate structure of history taking to ensure the patient is encouraged to express their ideas, concerns, expectations and understanding, so that these can be appropriately addressed		
Develop consultation skills to enable shared patients and practitioner decision making		
Able to accurately record patient history, examination findings and plan		

Supervisor sign off ……

Date ……

General examination

Competency	Date of Completion	Evidence
Complete a thorough examination		
Confident in the ability to distinguish normal from abnormal during clinical examination		
Able to combine examinations of different systems to elicit the full clinical picture		
Able to abbreviate their examination to become more focused		
Supervising doctor has confidence in PA clinical findings		

Supervisor sign off ……

Date ……

Mandatory examinations:

Examination	Date	Sign off	Examination	Date	Sign Off
Cardiovascular			Male urogenital		
Respiratory			Female urogenital		
Abdominal			Breast		
Neurological			Ophthalmic		
MSK			Dermatological		
ENT			Mental State		

Supervisor sign off ……

Date ……

Interpreting evidence and investigation

Competency	Date of completion	Evidence
Identify the appropriate investigations required to aid in the diagnosis of a condition		
Aware of the limitations of investigations		
Confidently interpret results of requested investigations		
Produce appropriate management plans based on diagnostic results		
Determine the relevance of screening tests for a given condition		

Supervisor sign off ……..

Date ……..

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Clinical judgement and risk management

Competency	Date of completion	Evidence
Consistently able to identify high risk conditions requiring immediate attention		
Recognise when a clinical situation is beyond their competence and seek appropriate support.		
Able to identify patients who need referral to secondary care, both urgently and routinely		
Recognise key diagnostic errors and the issues relating to diagnosis in the face of incomplete data.		
Undertakes risk assessments and manages risk effectively		
Value the importance of clinical governance and participate as directed		

Supervisor sign off ……

Date ……

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Therapeutics and prescribing

Competency	Date of completion	Evidence
Broad understanding of medication choice for presentations of common and important conditions		
Aware of contraindications and monitoring needs		
Able to suggest appropriate prescribing		
Confident in explaining to patients their clinical management plan		
Understand the impact of comorbidities and polypharmacy on medications and prognosis		
Able to modify the management plan according to age and comorbidity		
Use the British National Formulary (BNF) and local formularies appropriately and be familiar with the yellow card system for reporting side effects/ drug interactions.		
Provides information and advice to patients and carers concerning drug regimes, side-effects and interactions in an appropriate form		
Integrates appropriate non-drug-based treatment methods into a plan of management		

Supervisor sign off ……..

Date ……..

Clinical planning and procedures

Competency	Date of completion	Evidence
Aware of risk and benefits of common procedures		
Formulates management plans based on scientific rational, evidence-based standards of care and practice guidelines		
Provides guidance, counselling, advice and support regarding management of the health condition		
Monitor and follow up changes in patients condition and response to treatment, recognising indicators of patients response		
Negotiates a jointly determined plan of care, based on continual assessment of the patient's readiness and motivation, resetting goals and optimal outcomes as necessary.		
Consults with other healthcare providers and agencies obtaining specialist and referral care for patients where appropriate while remaining the primary care provider		
Considers access, cost efficacy and quality when making care decisions.		

Supervisor sign off ……..

Date ……..

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Mandatory Procedural skills

Skill	Date	Sign off	Skill	Date	Sign off
Perform peak flow monitoring			Commence and manage oxygen therapy		
Obtain cultures for HVS			Perform urine dipstick		
Perform both a manual and electric blood pressure			Instruct patients in the use of devices i.e. glucometer, inhalers		
Measure and monitor oxygen saturations			Measure body temperature		
Measure pulse rate			Take appropriate swabs i.e. ENT, skin		
BLS					

Supervisors sign off ……

Date ……

Professionalism

Competency	Date of completion	Evidence
Recognise and work within the limits of your professional competence and scope of practice		
Maintain effective relationships with colleagues from other health and social care professions		
Inform patients, carers and others of the nature of the clinical role		

Supervisor sign off ……..

Date ……

Appendix 7 - Audit and quality Improvement form

You must demonstrate that you regularly participate in activities that contribute to quality improvement. Please complete a separate form for each quality improvement activity.

Brief description of the quality improvement activity; please include it's function, dates and times if applicable
What was your involvement in this activity?
What action have you taken in response to the results/outputs of the activity? (e.g. action plans, changes to practice)
Demonstrate evaluation and reflection on the results of the activity (e.g. reflective notes, discussion of the results with peer-supervision, contributions to your personal development)
Is any further action to be taken, such as re-audits? If so, please provide details

Appendix 8 – FPA Curriculum domains

- Clinical capabilities
    - Acute and emergency care
    - Cardiovascular
    - Child and adolescent health
    - Clinical haematology
    - Dermatology
    - ENT
    - Ophthalmology
    - Obstertrics and gynaecology
    - Endocrine and metabolic
    - Gastrointestinal
    - Infection (inc sexually transmitted infections)
    - Mental Health
    - Musculoskeletal
    - Neurosciences
    - Palliative and end of life care
    - Renal and urology
    - Respiratory
    - Surgery

- Professional knowledge and skills
    - Teaching and learning
    - Healthcare service and structure
    - Research and evidence based medicine
    - Health promotion

- Professional values and behaviours
    - Personal and professional conduct
    - Patient safety and quality improvement
    - Leadership and teamworking
    - Person centred care and shared decision making
    - Lifelong learning
    - Legal framework of practice and healthcare ethics

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