Lancashire & South Cumbria
PRIMARY CARE TRAINING HUB

Physician Associate and GP Supervisor Guide

A handbook for the first year in general practice

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Background

The landscape for Primary care has changed significantly over last few years, in terms of the complexity of care, delivery of care and accessibility. This is evident in the Primary Care Planning guidance. One of the areas highlighted as requiring focus is the expansion of the Primary Care Workforce. The methods to encourage this expansion are multifactorial.

The NHS has seen the emergence of new professional roles working within multi-professional teams as part of the continuing drive to provide safe, accessible high-quality care for patients in hospital and community services. Medical Associate Professions (MAP) roles have been identified as part of the solution to workforce issues outlined in the NHS People Plan.

The NHS England MAPs Oversight Board work in partnership with representatives of the devolved administrations, Medical Royal Colleges and their affiliated faculty representatives, to develop and shape the post-registration education, training and careers for each of the three MAPs roles:

- Anaesthesia associate (AA)
- Physician associate (PA)
- Surgical care practitioner (SCP)

Significant expansion and additional financial support for some of these roles was introduce in 2019 with the publication of the Network Contract DES Additional Roles Reimbursement Scheme. This provides funding to support the expansion of workforce within primary care by an additional 26,000 roles by 2023/24. Through Primary Care Networks (PCNs), general practice will be able to access funding via this scheme, allowing them to support the recruitment or engagement of services for a wide range of roles, including:

- Physician Associates
- First Contact Physiotherapist
- Occupational Therapists
- Podiatrists
- Dieticians
- Paramedics

Employment of PAs in primary care is varied with contracting between private providers, NHS trust and independent clinicians established. This variation has undoubtably lead to significant variation in the induction, orientation and supervision process of these new clinicians into practice.

Health Education England and NHS England have established a need to develop and standardise induction processes that will benefit all clinicians transitioning into primary care. It is important that employers in primary care understand the importance of supporting these new professions to help them establish, embed and flourish in these new roles.

This document will offer guidance to shape the experience of new PAs as they advance and develop their career in general practice.

Aim

The aim of this guide is to provide a consistent and comprehensive support for PAs and their employers, ensuring that all PAs who are new to primary care receive an effective period of induction.

You will find a range of information for employers – local contacts and frequently asked questions and downloadable templates on the Faculty of Physician Associates website www.fparcp.co.uk/pas-in-general-practice

Objectives

To provide the PA and employer with:

- Understanding of the requirements of this new role in a structured format
- Orientation and induction programme
- Pre-employment checks
- To enable the PA to work safely and effectively within a new environment
- Advise the PA on the educational and training requirements for this role
- Understanding of clinical supervision structure
- Clinical capability and duty of care
- Orientation guidance for new employees
- Role and Organisation Induction
- Mandatory training checklist
- Overview of professional indemnity insurance

The Physician Associate Role in General Practice

Physician associates are healthcare professionals who work as part of a multidisciplinary team under the supervision of a named senior doctor. While they are not medical doctors, PAs can assess, diagnose, and treat patients in primary, secondary and community care environments within their scope of practice. PAs add to the breadth of skills within multidisciplinary teams, to help meet the needs of patients and enable more care to be delivered in clinical settings.

The practice should have a clear understanding of the role that the PA will undertake. The practice will need to agree the supervision, support, and educational requirements for the role in determining the work plan for the individual.

PAs skills:

- Take medical histories.
- Clinical examinations
- Assess patients with undifferentiated diagnosis.
- Formulate differential diagnosis.
- Asses, manage and treat patients of all ages.
- Manage chronic conditions.
- Triage
- Telephone consultations
- Complete referrals
- Request, review and act on laboratory results
- Carry out diagnostic and therapeutic procedures.
- Home visits or nursing/residential homes.
- Teaching and supervision of PA, nursing, and medical students

Some PAs offer specialised clinics following appropriate training, including (but not exclusively):

- Family planning
- Baby checks
- COPD, asthma, diabetes, and anticoagulation.

PAs cannot currently:

- Prescribe
- Request ionising radiation
- Issue fit notes

PAs are trained to be aware of the level of their clinical competence and to work within their limits. Newly qualified PAs may initially need more supervision and support. The level of support and supervision required should lessen over time as the PA grows in confidence, knowledge and skills. As PAs become more experienced, they can take on a wide range of activities including service design and development, become clinical placement leads for students, undertake minor operations and becoming involved in practice-wide education and quality improvement projects.

Currently most PA careers develop laterally. After 5–7 years, some will be classed as senior PAs. Career progression is more closely aligned with the advancement of their knowledge and skills in practice and over time, a PA is likely to see increasingly complex patients and take on more responsibility. Many PAs are involved in activities related to PA education and this should be encouraged.

Governance

The practice will have its own governance framework in place in addition to supporting policies and procedures.

Please note:

1. As PAs practice medicine, they are required to have a clinical supervisor who is trained and qualified to complete a required task for example, a practice nurse can support a student PA in learning peak flow and spirometry procedures or help a qualified PA to complete a smear taking course. It's usually a GP because PA assess and treat patients in the same way
2. PAs are responsible and accountable for their practice, but answerable to the general practitioner (GP) and subsequent medical governance structures within the practice
3. Currently PAs cannot prescribe medications or request ionising radiation. It is up to practices to have local policies in place to manage this and support the PA to carry out their duties safely and effectively
4. Ensure pre-employment checks are carried out. It is strongly advised for GP practices to check that candidates appear on the Physician Associate Managed Voluntary Register (PAMVR). Anyone on this register has successfully completed the university programme and passed the PA National exam. It is advisable to only employ PAs who appear on this list, until such time that PAs gain statutory regulation.

Professional Indemnity Insurance

In 2014 the UK Government introduced a new requirement for all healthcare professionals to hold an appropriate indemnity insurance arrangement in order to practice and provide care.
From the 1st April 2019, the Clinical Negligence Scheme for General Practice (CNSGP) established that all GPs and others working in general practice are automatically covered under CNSGP for liabilities arising from the provision of NHS primary medical services and ancillary health services as part of the NHS for England.

Private referrals and Medico-legal services (other than those directly relating to clinical negligence claims), such as representation at inquests or in relation to professional regulation matters are not covered under the CNSGP and therefore it is wise for PAs to maintain additional personal or registered professional body scheme.

Physician associates working in general practice benefit from the same state-backed clinical negligence indemnity as their general practice colleagues.

There are two general practice indemnity (GPI) schemes, which you can read more about on the GPI webpages on the NHS Resolution website:

- Clinical Negligence Scheme for General Practice (CNSGP); and
- Existing Liabilities Scheme for General Practice (ELSGP).

Whilst cover under both schemes is automatic, with no need to register and no need to pay, there are some things that the schemes do not cover and physician associates will need private indemnity cover for these. This is especially true of the ELSGP where, as PAs will be covered under the ELSGP only if at the time of the incident giving rise to a claim, they were employed by a general practice where the partners were beneficiaries under the ELSGP.

Fitness to Practice

As part of the Managed Voluntary Register the Faculty of Physician Associates (FPA) has a fitness to practice procedure and can advise on or investigate any fitness to practice issues that may arise regarding PAs on the Managed Voluntary Register (PAMVR). The FPA has also developed a Code of Conduct (including scope of practice) to ensure good standards of practice, public protection and safety.

The Code of Conduct along with the PAMVR aims to set out the guiding ethical, moral principles and values that physician associates are expected to apply in their daily practice until statutory regulation is achieved. The Code of Conduct for physician associates is supported and informed by the four domains of the GMCs Good Medical Practice which define the principles that underpin medical appraisal, outlined below.

Domain 1: Knowledge, skills and performance

- Develop and maintain your professional performance.
- Apply knowledge and experience to practice
  Record your work clearly, accurately and legibly.

Domain 2: Safety and quality

- Contribute to and comply with systems to protect patients.
- Respond to risks to safety
  Protect patients and colleagues from any risk posed by your health.

Domain 3: Communication, partnership, and teamwork

- Communicate effectively
- Work collaboratively with colleagues to maintain and improve patient care
- Teaching, training, supporting and assessing
- Continuity and Coordination of Care
- Establish and maintain partnerships with patients

Domain 4: Maintaining trust

- Show respect for patients
  Treat patients honestly and colleagues fairly ad without discrimination.
- Act with honesty and integrity

NHSE Physician Associate – New to Practice Preceptorship

Lancashire and South Cumbria Primary Care Training Hub (L&SC PCTH) are offering a New to Practice Preceptorship Programme for newly qualified PAs. The programme provides a supportive and developmental framework to guide the transition into practice and to further develop careers.

Supporting the development of a career in General Practice

As a new to practice fellow, PAs will have access to an excellent package of support, training, and development for 2 years, including allocated mentors/coaches, provided by the training hub. The PA is expected to have at least 1 dedicated session per week for education.

The Preceptorship includes:

- A comprehensive learning and development plan
- A high-quality induction into the ICS, Primary Care Networks (PCN) and General Practice
- Access to AQUA programme for Quality Improvement
- Access to the Edward Jenner Leadership programme
- Access to a 2 year plus an additional 1 Year PCN programme
- A professional coach/mentor for the duration of the fellowship experiences and shadowing opportunities to support the development of career portfolio.

Our induction package includes:

- An Induction to the Preceptorship
- Introduction to the Primary Care Networks (PCNs) and the Integrated Care System (ICS)
- Digital working
- Health and wellbeing
- Additional information and resource

If practices would like to engage with the L&SC PCTH 2-year Preceptorship offer there will be a cost, to the practice, of £1077.62 for this package.

To apply email - mbpcc.lscthub@nhs.net

Funding

As part of the nationally agreed funding model introduced in 2018, NHSE have invested a £5000 educational support payment for Practices/PCNs. This is paid to the primary care provider (GP Practice/PCN) with the expectation that the employer will provide support and supervision in return.

Practices/PCNs can apply when:

- New PAs are contracted to work in Primary Care within the first 12 months of practice after becoming registered OR a PA taking their first post in primary care since gaining registration
- Upon delivery of a Preceptorship Programme which meets HEE Preceptorship Criteria outlined in the below criteria.

To apply for funding email HEE - physicianassociates.nw@hee.nhs.uk

Clinical Induction

The purpose of an initial orientation is to integrate employees into the organization. Orientation 'sets the scene' for what the employee can expect from an employer, colleagues, service users and the whole organisation. The GP practice/PCN may already have a structured induction programme that may need to be tailored to the needs of a PA.

At the end of a successful induction, the PA should:

- Have met their key colleagues
- be able to find their way around the practice and have information that allows them to understand the context of their working environment
- have a clear understanding of the requirements and expectations of the role
- identify any training and development needs to carry out their role effectively
- know what is expected of them and the way in which their work will be monitored.

See Appendix 1 for Clinical Induction checklist and induction example

Mandatory Training

Mandatory training refers to training that the employer deems essential for the safe and efficient delivery of services and care. It is designed to reduce risk and to comply with regional or national policies and governmental guideline.

The UK Core Skills Training Framework (CSTF) and set out 11 statutory and mandatory training topics for all staff working in health and social care settings. The CSTF includes nationally agreed learning outcomes and training delivery standards.

On-line platforms are available to complete and record progress via E-Learning for Health and Bluestream Academy. These platforms allow records of mandatory training to transfer accurately and safely between NHS employer organisations which is particularly applicable for AHPs transferring from NHS Trusts to Primary Care.

Employers will provide a checklist for Mandatory/Statutory training to meet their requirements.

See Appendix 2 for Mandatory / Statutory training checklist

Supervision

As the medical supervisor is responsible for reviewing the PAs current knowledge and skills to develop the job plan, it is strongly recommended that this person has undertaken formal training in education and supervision to make sure the PAs learning needs are met. Supervision of a qualified PA is similar to that of a doctor in training or trust grade doctor, in that the PA is responsible for their actions and decisions. However, the supervisor is the clinician ultimately responsible for the patient.

The level of supervision and support will vary depending on the individual PA and their experience. A newly qualified PA will require to discuss each patient case, this may be after every patient or at the end of a session dependant on the PA/Supervisor agreement. This should be discussed during the induction.

The time and level of supervision will ultimately reduce, working towards discussing more complex cases and prescription queries as the PA develops. Adjustments to their support and supervision will be made on an individual basis through discussion and the use of the PA portfolio to evidence their development and acquisition of knowledge and skills at regular reviews and annual appraisal.

See Appendix 3 for Supervision Schedule

See Appendix 4 for Job Plan

See Appendix 5 for Supervisor Meeting Record

Development plan

During the PAs first week, the induction process will enable you to undertake an assessment of their skills, knowledge and confidence in practice. This will help to identify strengths, weaknesses and gaps in knowledge. This can be used to inform a structured programme of specific educational goals to be reviewed throughout the first 12 months on a 3–6-monthly basis and appraised at the annual review.

It is very important that your PA has a clearly defined and agreed job plan that offers a variety of activities and the opportunity to practice across the breadth of their competencies. This will allow the supervisor and PA to highlight the day-to-day supervisory arrangements to enable the correct level of senior support and the competency level expected within the limitations of their practice.

It is useful to identify areas of interest to the PA, help develop longer term goals and identify and use any skills not currently being employed. PAs should be actively encouraged to contribute to the development of their profession. This may involve time release for activities to develop in areas such as leadership, management and research or teaching/examining on a PA university course either as a secondment or ad-hoc.

See Appendix 6 for Development Plan

Prescription management

Current legislation does not permit physician associates to sign prescriptions. This will change once Parliament enacts legislation granting them independent or supplementary prescribing rights. The process began in 2018. Working under the GMCs delegation clause, your practice will need to have clear arrangements in place to allow the safe and timely issue of any prescriptions that arise from a PAs clinical work. It is important to take time to design a written protocol that is understood in advance by the PA and prescribers. This protocol can be varied as changes within the practice and PA develop.

PAs can, based on their clinical assessment, aided by patient records or other relevant information, raise a prescription and present this together with the required information to the authorised prescriber. The authorised prescriber must be provided with sufficient information for them to be able to sign the prescription and therefore assume ultimate responsibility to include:

- age
- gender
- history of presenting complaint
- past medical history
- PAs consideration of the bigger picture for the patient
- if patient is on any other medication
- any allergies and contra-indications

The sign off process itself can either be through a brief face to face presentation with the prescriber or by using an inhouse communication system in order to keep the clinic flowing. Please consider the additional admin time needed when structuring PA clinics to facilitate prescription management.

See Appendix 7 for Proposed Prescribing Process

Continuing Professional Development (CPD)

The Faculty of Physician Associates requires documented evidence of members CPD as an essential component of the information needed to remain on the PAMVR. This evidence is required, under membership of the FPA, to be documented in the members' Royal College of Physicians (RCP) CPD diary. PAs must complete **50 hours of continuing professional development each year.** This should include activities within and outside the employing practice. Requiring a **minimum of 25 external CPD credits** per year.

PAs and their supervisors should draw up agreements and review regularly an allocation of CPD-dedicated work hours, including an agreement on the frequency of tutorials. Offering education and training is a good way of retaining PAs and can benefit the development of the relationship between supervising GP and PA.

Employers should consider whether they are able to offer financial support and accommodate time release by offering study days and study budget to their PAs to help support their CPD requirements.

An annual 5% validation audit is carried out requiring evidence that participants have fulfilled their annual requirement. The document **'CPD Guidance for Physician Associates'** on the FPA website provides more detailed descriptions of the types of CPD.

Core Capabilities Framework

In February 2021, HEE commissioned Skills for Health to lead the development of a MAPs core capabilities framework. This was published in June 2022. The framework can be used alongside other professional frameworks, standards and guidelines and for those delivering, planning, and developing services including MAPs at all stages of their career. It can be used as the basis for formal or informal appraisal, alongside a training needs analysis, comparing current skills and knowledge with those that are required.

It sets out clear expectations for each of the MAPs roles, providing clarity about characteristics and requirements as well as setting out a structure of core capabilities. There are high level descriptors so that more detailed skills and knowledge can be agreed and developed within the care settings these roles work in.

Case based discussion

Case based discussion is a structured interview to assess a PAs professional judgement in clinical cases and can be used as a useful tool to collect evidence for their portfolio. The PA will be responsible for selecting cases and completing the relevant paperwork.

Cases should reflect different contacts to include home visits and surgery clinics. Ideally, the PA should present cases to the supervisor a week before the discussion. The supervisor will select one for discussion and will cover as many relevant competencies as possible in the available time.

See Appendix 8 for Case Based Discussion form

Reflective Practice

An important aspect of a PAs learning is to reflect on clinical practice, developing the ability to process their thoughts and actions to engage in a process of continuous development and learning. It allows the PA to take meaning from experience and transform this into strategy for personal growth and development, including the development of the PA and supervisor's professional relationship. Reflecting on how a PA would change or improve their work as a result, directly impacts patient care.

There are several models that can help the PA structure their thoughts and reflections to ensure the greatest level of analysis and evaluation to inform learning about practice. Some of these include:

- Johns' model of reflection
- Gibb's Reflective cycle
- The Driscoll Model

Assessment	Recommendation of minimum numbers per year
Reflections	3
Reflection feedback (to be obtained from an individual trained in supervision/reflective feedback)	3

Feedback

It is important for PAs to look outwards when assessing performance. Sourcing feedback can offer an opportunity for both colleagues and patients to provide their opinion about a PA, this encourages a culture of openness and transparency. It is recommended to incorporate the following feedback methods into the PA portfolio.

Multi-source Feedback (MSF)	1 every three years
Patient Feedback	5 per year

Annual summative self-assessment

Self-assessment is a vital component of maintaining and improving the quality of care given by the PA. Self-assessment has the potential to reinforce standards and increase accountability. PAs are expected to undertake an annual self-assessment – this is uploaded to the RCP diary.

Quality improvement activity

Quality improvement allows the PA to demonstrate regular participation or lead in activities that review and evaluate the quality of their work, as an individual or part of the wider clinical team. Quality improvement activities should be relevant to the work setting, including an element of evaluation and action and where possible, demonstrate outcome or change.

The PA must record:

- the nature of the activity - brief description of its form and function including dates and times if applicable.
- how they participated - lead auditor, data collection etc.
- that appropriate action has been taken in response to the outputs of the quality improvement activity.

Annual Appraisal

All PAs should have an annual appraisal with their supervisor. Ask for feedback from the primary care team prior to appraisal to give a more rounded picture of the PA. This method aims to evaluate and document job performance. The personal portfolio should inform the appraisal process and demonstrate ongoing development.

Practices are likely to have their own appraisal documentation. However, you will find the FPA appraisal and portfolio documents within the FPA Materials

PA Knowledge Skills and Attributes

There are central principles that are applicable to all PAs in primary care.

Leadership skills

A PA working in General Practice will need to be a strong leader and advocate for high quality patient care for those most vulnerable in our communities. This makes them well suited to leadership roles in the future. There are a variety of online and face to face educational programmes that may be suitable. It may be useful to contact Lancashire and South Cumbria Training Hub for more information. www.lscthub.co.uk

Record Keeping / Serious Untoward Incidents

Record keeping is a way of collaborating with all those people involved in the care of your patient. Accurate record keeping and documentation is very important in professional practice. Once something is written down, it is a permanent account of what has happened. Without a written record of events, there is no evidence to support a decision made or an audit trail from which to follow a sequence of events. Ensure you are familiar with all additional patient records, e.g. district nurse, dietician notes and social care notes. In General Practice you will be using specific computer systems, you should receive appropriate training to enable you to use these systems effectively.

A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. All NHS organisations and local authorities that provide social services, and GP Practices must have a Caldicott Guardian.

The other element of accurate record keeping relates to investigations and serious untoward incidents (SUI). Significant Event Analysis is an increasingly routine part of General Practice. It is a technique to reflect on and learn from individual cases to improve quality of care. Significant event audits can form part of your individual and practice-based learning and quality improvement and the process mirrors that of your own reflections on practice as a PA working in General Practice.

Whether clinical, administrative or organisational, the significant event analysis process should enable the practice to answer the following questions:

- What happened and why?
- How could things have been different?
- What can we learn from what happened?
- What needs to change
- The impact on practice – clinician and organisation.

Safeguarding

All staff have a responsibility to safeguard children and adults at risk of abuse or neglect in the NHS and should receive appropriate statutory and mandatory training. Working in General Practice, you may be exposed to potential 'risks of harm' to patients. How you understand and work with risk will evolve as you become more experienced.

Duty of Care

The law imposes a duty of care on practitioners, whether they are support workers, students, Allied Health Professionals, registered nurses, doctors or others, when it is 'reasonably foreseeable' that they might cause harm to patients through their actions or their failure to act (Cox, 2010)

Health Promotion – Making Every Contact Count (MECC)

Health promotion is the process of empowering people to increase control over their health and its determinants to increase healthy behaviours. Health Promotion in General Practice is a growing field and an area of practice that you will be involved with daily.

MECC is an evidence based approach to help people improve their mental and physical health by identifying, supporting and promoting behavioural change. The MECC approach enable health and care workers to engage people in conversations about improving their health by addressing risk factors such as alcohol, diet, physical activity, smoking and mental wellbeing. This approach is a requirement of the NHS standard contract and supports prevention of disease that is a key element of the NHS Long Term Plan.

Primary Care Clinical Roles

Primary care provides integrated care to the community through a large network of multi-professional clinicians. As a Physician Associate you will be part of this multi-professional team and it is useful to understand different health professional roles that you may encounter. In the first weeks of induction it would be useful to gain an understanding of the additional roles in your practice or PCN and the services available locally.

Health Professional	Role and responsibilities
District Nurse	Registered nurses who undertake further training and education to become specialist community practitioners. They visit patients in their own homes or in residential care. As well providing direct patient care, district nurses also work with patients to enable them to care for themselves or with family members.
Community Matron	A registered nurse with post registration education and training. Provides a single point of care for patients and prevent hospital admissions. Undertakes variety of tasks and responsibilities including: treating, prescribing, or referring patients to a specialist. Provides skilled care that meets patients' health and social care needs. Plays a key role in organising and coordinating care and may run MDT (multidisciplinary team) meetings.
Community Mental Health Nurse / Community Psychiatric Nurse	A Registered mental health nurse may be attached to a GP practice, community mental health team, or psychiatric units or within a care home in an elderly mental illness unit. Has wide range of expertise and gives advice and support to people with long-term mental health conditions, and administers medication. May specialise in treating children, older people, or people with a drug or alcohol addiction.
General Practice Nurse	Registered Nurse with post registration education and training within GP practices as part of primary care team to assess, screen and treat patients of all ages. Runs clinics for patients with long-term conditions. Also offers health promotion advice in contraception, weight loss, smoking cessation, travel immunisations and others.

General Practitioner	Doctors who have completed GP Speciality training providing a complete spectrum of care within the local community: dealing with problems that often combine physical, psychological and social components. At partner level, may be an independent contractor to the NHS and have responsibility for providing adequate premises and for employing staff.
Health Visitor / Specialist Community Public Health Nurse	A registered nurse or midwife with further training. Works mainly with families with children under the age of 5, however some have an older person focus. Supports families and children in growth and development, post-natal depression, breastfeeding and weaning, domestic violence and bereavement. Plays a key role in safeguarding and protecting children from harm.
Learning Disability Nurse	Registered Nurse that specialises in healthcare for people with learning disabilities. Offers support to their families. In settings such as adult education, residential and community centre, patients' homes, workplaces and schools.
Rapid Response or integrated Care team	Multidisciplinary health and social care teams made up of physiotherapists, occupational therapists, support workers and nurses. The service aims to prevent unnecessary patient admission to hospital and provide short-term support and rehabilitation in the home.
Social Worker	Social workers are concerned with the welfare of communities, families, and individuals. Social workers are trained to find solutions to individual problems, this may be to protect vulnerable people from hard or abuse or supporting people to live independently. It is their priority to improve the quality of lives of their patients, and to help protect people from those who might try to take advantage of their vulnerabilities.
Specialist Nurse	Plays a key role in the management of patient care. Works closely with doctors and other members of the multidisciplinary team, to educate and support patients, relatives and carers from a variety of specialties, for example, Drug and Alcohol misuse, Tissue Viability, Palliative Care, TB,

	Diabetes, Epilepsy, Cancer and many others.
Speech and Language Therapist	Assess and treat speech, language and communication problems in people of all ages to help them better communicate. Will also work with people who have eating and swallowing problems.
Clinical Pharmacist	Clinical pharmacy is the branch of pharmacy in which clinical pharmacists provide direct patient care that optimizes the use of medication and promotes health, wellness, and disease prevention.
Social Prescriber Link Worker	Social prescribing is a way for local agencies to refer people to a link worker. Link workers give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support.
Health and Wellbeing coaches	Health and Wellbeing Coaches (HWBCs) will predominately use health coaching skills to support people with lower levels of patient activation to develop the knowledge, skills and confidence to become active participants in their care so that they can reach their self-identified health and wellbeing goals.
Advanced Nurse Practitioner	Advanced Nurse Practitioners are Registered Nurses who have undergone extra training and academic qualifications to be able to examine, assess, diagnose, treat, prescribe and make referrals for patients who present with undiagnosed/ undifferentiated problems.
First Contact Physiotherapy	A diagnostic clinician in primary care assessing undiagnosed and undifferentiated musculoskeletal problems, managing complexity and uncertainty at the first point of contact - has a minimum of 5 years post graduate experience. *Key Skills* – musculoskeletal, rehabilitation, frailty and public health.

First Contact Paramedic	Work with urgent and unscheduled care and acute presentations that have had an acute or chronic onset. They examine, assess, diagnose, treat, and make referrals for patients who present with undiagnosed/ undifferentiated problems. *Key Skills* - urgent and unscheduled care, acute conditions, and prevention of unplanned admissions.
First Contact Dietician	Provide evidence-based nutritional management - including diabetes, weight management, frailty, functional bowel disorders (including IBS) and coeliac disease. Some dieticians are supplementary prescribers and can effectively prescribe and de-prescribe medicines to improve care. *Key Skills* – Diabetes, Weight Management, Frailty, Functional Bowel disorders and Coeliac Disease
First Contact Podiatrist	Experts in all aspects of foot and lower limb function and health. They diagnose, treat, rehabilitate and prevent abnormalities of the foot and lower limb. They can manage pain, skin conditions, infections, neurological disorders and circulatory disorders of the legs and feet. *Key Skills* - Lower Limb Musculoskeletal, Dermatology, Cardiovascular and Neurology
First Contact Occupational Therapist (OT)	Occupational therapists focus on resolving health and social issues at an early stage, to minimise crisis situations that result in inappropriate presentation or admission to residential or hospital care. This includes people who are frail with complex needs, people living with chronic physical or mental health conditions, and people who require advice to return or remain in work *Key Skills* - Mental Health, Frailty and Vocational Support

Community health and primary care

Integrated Care Systems

ICSs bring together NHS, local authority and third sector bodies to take on responsibility for the resources and health of an are or 'system'. Their aim is to deliver better, more integrated care for patients. They are seen by NHS leaders as central to both the NHS Long Term Plan and Health and Care Act. As of July 2022, all 42 ICSs across England are operational as statuary bodies as per the Health and Care Act, but they will continue to develop over time.

Two bodies with collectively make up the ICS:

- ICB (Integrated Care Board) – responsible for NHS services, funding, commissioning and workforce planning across the ICS area. The establishment of ICBs resulted in clinical commissioning groups (CCGs) being closed down.

- ICP (Integrated Care Partnership) - responsible for ICS-wide strategy and broader issues such as public health, social care, and the wider determinants of health.

Local authorities

Local authorities in the ICS area, which are responsible for social care and public health functions as well as other vital services for local people and businesses.

Place-based partnerships

Within each ICS, place-based partnerships will lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships will involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in supporting the health and wellbeing of the population.

Provider collaboratives

Provider collaboratives will bring providers together to achieve the benefits of working at scale across multiple places and one or more ICSs, to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers.

Quality and Outcomes Framework (QOF)

The Quality and Outcomes Framework is a system for the performance management and payment of general practitioners in the National Health Service in England, Wales, Scotland and Northern Ireland. The object of the QOF is it improve the quality of care given in primary care by rewarding practices across several indicators, covering a range of key clinical care and public health issues. Practices are required to hold registers of their patients with these specified conditions and to meet specific targets relating to their management, in order to achieve the additional funding. The framework is made up of clinical domains that relate to long term conditions. Each domain is worth a fixed number of points.

Practices are rewarded financially based on the number of points received over each domain which are rewarded based on the level of achievement for each domain.

Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It plays a vital role in ensuring that people have the right to expect safe, effective, compassionate, high-quality care. In General Practice you may from time to time be involved when the CQC comes to inspect your place of work. You may also be aware of their monitoring role in your day-to-day practices as the organisation adheres to their recommendations, action points and reporting measures to improve quality care.

Inspections are based upon five key questions:

Are they safe? – Patients are protected from physical, psychological or emotional harm or abuse.

Are they effective? – Patients' needs are met, and care is in line with national guidelines and NICE quality standards.

Are they caring? – Patients are treated with compassion, respect and dignity and that care is tailored to their needs.

Are they responsive to people's needs? – Patients get the treatment or care at the right time, without excessive delay, are involved and listened to.

Are they well led? – There is effective leadership, governance and clinical involvement at all levels, and a fair, open culture exists which learns and improves listening and experience.

After assessment, a scoring system is used to produce a rating for the service:

- Outstanding
- Good
- Requires improvement
- Inadequate

Appendix 1 – Orientation and clinical induction

INTRODUCTION TO THE PRACTICE	DATE COMPLETED
Induction into the practice and organisation structure	
Tour of practice premises/site and facilities	
Practice profile/local hospitals	
Fire procedures	
Location of emergency equipment	
Identify any special requirements in order that reasonable adjustments can be made	
Emergency contact details	
Introduction to key members of the team/immediate colleagues and additional roles	
Allocation and introduction to named medical mentor	
Allocated daily supervisor from the medical team/ supervision schedule	
Access and training for relevant IT systems	
Discuss appointment system	
ID badges / access codes / smart cards / car parking	
Introduction to mandatory training – completed and up to date	
Primary Care & Community Care Structures – link and introduction to PCN	
Health & Safety Procedures	
Accident Reporting & COSHH Folders	
Dress code requirements/access to uniform	
Access to practice/trust policies	

TERMS & CONDITIONS OF EMPLOYMENT	
Contract of employment	
Indemnity Insurance details	
Job plan schedules – discussed and provided	
Working hours, shifts, rotas and breaks	
Proposed prescription management process – discussed and agreed with PA and all GPs in the practice	
Knowledge/skills assessment to identify where development needs are – discussed and completed	
Development plan for the next year – discussed and agreed	
Access to regular, appropriate teaching sessions or educational opportunities – discussed and schedule provided	
Regular formal review (suggested minimum of 3 monthly or more often if required in first 12 months of employment) – discussed and schedule provided	
CPD Provision – discussed and agreed	
Annual appraisal and portfolio review – dates agreed	

NB This list is not exhaustive, topics may be added or removed according to area of practice

Induction example

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Introduction to practice and team Complete any outstanding paperwork for HR purposes Familiarise with policies and paperwork Get IT access/smart card Meet with clinical supervisor – knowledge and skills baseline assessment	Shadow clinicians Sit in with other members of the team to integrate - nurse/midwife/HCA/pharmacist etc.	Shadow clinicians Sit in with duty doc or clinical supervisor	Shadow clinicians Sit in with other members of the team to integrate - nurse/midwife/HCA/pharmacist etc.	Shadow clinicians Sit in with other members of the team to integrate - nurse/midwife/HCA/pharmacist etc.
PM	Sit in with reception/back-office staff/understand booking system	IT systems training Shadow home visits	Arrange time to shadow community teams/PCN/ Preceptorship mentor	Shadow clinicians Sit in with other members of the team to integrate - nurse/midwife/HCA/pharmacist etc.	End of first week review and discuss skills/knowledge requirement. Build in time for education/support/weekly CPD throughout the first year Arrange 3/6/12 month meetings with clinical supervisor

Week 2-12 example

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Start seeing patients – 30-minute appointments on the day acute patients Build in administration time for paperwork, results and referrals	Start seeing patients – 30-minute appointments on the day acute patients Build in administration time for paperwork, results and referrals	Start seeing patients – 30-minute appointments on the day acute patients Build in administration time for paperwork, results and referrals	Start seeing patients – 30-minute appointments on the day acute patients Build in administration time for paperwork, results and referrals	Start seeing patients – 30-minute appointments on the day acute patients Build in administration time for paperwork, results and referrals
	Review of patients as required and review/debrief of clinic after morning surgery	Review of patients as required and review/debrief of clinic after morning surgery	Review of patients as required and review/debrief of clinic after morning surgery	Review of patients as required and review/debrief of clinic after morning surgery	Review of patients as required and review/debrief of clinic after morning surgery
PM	Shadow on home visits PM surgery as per morning surgery	Shadow on home visits PM surgery as per morning surgery	Shadow on home visits PM surgery as per morning surgery	CPD Time	Shadow on home visits PM surgery as per morning surgery

Appendix 2 - Mandatory / Statutory Checklist

Training	Date completed
Conflict resolution	
Equality, diversity and human rights	
Fire Safety	
Health, safety and welfare	
Infection prevention and control	
Information governance and data security	
Moving and handling	
Preventing Radicalisation	
Basic Life Support	
Safeguarding adults	
Safeguarding children	

NB This list is not exhaustive, aspects may be added or removed according to area of practice.

Appendix 3 – Example Supervision Schedule

Dates	Time	Discussion Topic
Week 1: Daily	Monday – 12:00 and 17:30 Tuesday – 12:00 and 17:30 Wednesday – 17:30 Thursday – 17:30 Friday – 12:00 and 17:30	Discuss after each patient case, debrief at end of session. Issues/concerns following observation Tutorial Thursday afternoon
Week 2: Daily	Monday – 12:00 and 17:30 Tuesday – 12:00 and 17:30 Wednesday – 17:30 Thursday – 17:30 Friday – 12:00 and 17:30	Discuss after each patient case, debrief at end of session. Issues/concerns following observation Tutorial Thursday afternoon
Week 3: Daily	Monday – 12:00 and 17:30 Tuesday – 12:00 and 17:30 Wednesday – 17:30 Thursday – 17:30 Friday – 12:00 and 17:30	Discuss after each patient case, debrief at end of session. Issues/concerns following observation Tutorial Thursday afternoon
Week 4: Daily	Monday – 12:00 and 17:30 Tuesday – 12:00 and 17:30 Wednesday – 17:30 Thursday – 17:30 Friday – 12:00 and 17:30	Discuss after each patient case, debrief at end of session. Issues/concerns following observation Tutorial Thursday afternoon
Review After 1 Month		

To be agreed flexibly depending on working days and hours including tutorial and CPD time.

Appendix 4 – Job Plan

Work setting

Regular clinical roles

Ad-hoc clinical roles (undertaken less than once per month)

Out-of-hours commitment

Educational roles

Any other roles

Please describe any changes you have made to your scope of work since your last appraisal

Please describe and changes to your scope of work that you envisage taking place in the next year

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	3-hour clinic session (15-minute appts)	3-hour clinic session (15-minute appts)	2-hour clinic session 1-hour Docman/ correspondence action session	3-hour clinic session (15-minute appts)	3-hour clinic session (15-minute appts)
	Debrief/admin time 30 minutes	Debrief/admin time 30 minutes	Debrief/admin time 30 minutes	Debrief/admin time 30 minutes	Debrief/admin time 30 minutes
PM	3-hour clinic session (15-minute appts)	2-hour clinic session 1-hour tutorial with GP supervisor	3-hour clinic session (15-minute appts)	CPD time	3-hour clinic session (15-minute appts)
	Debrief/admin time 30 minutes	Debrief/admin time 30 minutes	Debrief/admin time 30 minutes		Debrief/admin time 30 minutes

Appendix 5 – Supervisor Meetings Record

Name of clinical supervisor	
Job Title	
Date of meeting(s)	
Outcome of discussion	

Date of meeting(s)	
Outcome of discussion	

Appendix 6 – Development Plan

Physician Associate Name		**Date**	
Supervisor Name		**Date**	

Development What needs to be developed?	**Solution** How will the need be addressed?	**Measured By** How will you know that the need has been met?	**Priority** Low, medium or high	**Responsibility** Who is required to progress this activity?

Physician Associate Signature		**Date**	
Supervisor Signature		**Date**	

Appendix 7 – Proposed Prescribing Process

This guidance is designed to help you determine what will work best in your practice

Purpose

To ensure a safe and efficient means of providing prescriptions to patients seen by the physician associate (PA)

The process

- The PA will electronically send a prescription request asking the duty GP/supervisor to sign on the day.
- The patient can wait to pick up the signed prescription or have it sent electronically to their preferred pharmacy
- If the duty GP/supervisor is very busy, the PA will send an urgent message via the clinical system so that the GP can issue between patients
- If a patient has a more complex condition, the duty GP/supervisor can be messaged urgently via the clinical system asking the GP for a face-to-face discussion to allow the PA to provide the following information:

  - age
  - gender
  - history of presenting complaint
  - past medical history
  - PA to display consideration of the bigger picture for the patient - any other medication, allergies or contra-indications

  When the prescribing clinician is satisfied, the prescription can be issued.

- If a prescription is not urgent for example pill checks, the PA will use the ‘request issue’. Patients can either wait, come back later or collect the following day

PAs on home visits

- If a prescription is required it can be generated after the visit and signed by the duty GP/supervisor. The PA may wish to discuss a patient history and diagnosis before the prescription is issued. It can either be printed for collection or sent electronically to a nominated pharmacy for collection/delivery
- PAs visiting a nursing home are likely to use a hand-held tablet with the mobile clinical system. The prescription can be raised and forwarded to the duty GP/ supervisor for signature

Appendix 8 – Case-based Discussion Form

Physician Associate	
PAMVR Number	
Assessor's Name	
Assessor's Job Role	
Date of assessment	

Case setting/location	
Case complexity	**Low Moderate High**
Summary of case	

	Unsatisfactory	**Satisfactory**	**Above expectation**
Documentation			
History taking			
Clinical assessment			
Management plan			
Follow-up			
Overall clinical judgement			

Please comment on what was done well and the areas for improvement. Please note, constructive feedback is required for this assessment/learning event to be valid. It aims to identify areas for learning and reflection.

Strengths	**Areas for development**

Assessor's Signature	**Date of assessment**

Useful links

Lancashire and South Cumbria Primary Care Training Hub
https://www.lscthub.co.uk

PA Professional Resources Webpage (LSCTH)
https://www.lscthub.co.uk/physician-associates/

Preceptorships:
https://www.lscthub.co.uk/preceptorships

References

Lancashire and South Cumbria Physician Associate page https://www.lscthub.co.uk/physician-associates

Lancashire and South Cumbria Physician Associate - New To Practice Preceptorship Book https://www.lscthub.co.uk/wp-content/uploads/2023/09/PA-NTP-Handbook-Oct-2022-v2.1-2-2.pdf

NHS England » Clinical Commissioning Groups (CCGs)
Primary care networks explained | The King's Fund (kingsfund.org.uk)

Medical Associate Professions (MAPs) https://advanced-practice.hee.nhs.uk/welcome/regional-faculty-for-advancing-practice-north-east-and-yorkshire/medical-associate-professions-maps/

NHS (2014) Five Year Forward View NHS England » NHS Five Year Forward View

NHS (2019) Long Term Plan https://www.england.nhs.uk/long-term-plan

Making Every Contact Count (nice.org.uk)

What are integrated care systems https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

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