GOP03
Group Physician Associate Governance Policy

Sections:

1.0 Policy Statement (Purpose / Objectives of the policy)

This document provides a framework and standards for the employment of physician associates (PAs) across the Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT). It includes guidance relating to supervision of PAs and the scope of practice.

1.1 This policy applies to:

- All PAs working within the Trusts
- All PAs' named clinical supervisors (CS) and development supervisors (DS)
- All supervising consultants and specialist doctors who provide clinical oversight of PAs work on a day-to-day basis
- Relevant managerial teams
- All members of the multi-disciplinary team working alongside PAs

In adhering to this policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict of Interest Policy is to be considered the primary and overriding policy.

2.0 Definitions

All terminologies are explained fully in the relevant sections of the policy.

AFC: Agenda for Change
ALS: Advanced Life Support
APCOG: Advanced Clinical Practice Oversight Group
BLS: Basic Life Support
CBD: Case-based discussion
CD: Clinical director
CNST: Clinical Negligence Scheme for Trusts
CPD: Continuing professional development
CMO: Chief Medical Officer
CS: Clinical supervisor
DBS: Disclosure and Barring Service
DOPS: Direct Observation of Procedural Skills
DS: Developmental supervisor
EPMA: Electronic prescribing and medications administration
FPA: Faculty of Physician Associates
GETC: Group Education and Training Council
GMC: General Medical Council
HR: Human Resources
ILS: Immediate Life Support
IM&T: Information Management and Technology
MEG: Medical Education Group
MiniCEX: Mini Clinical Evaluation Exercise
PA: Physician associates
PAMVR: Physician Associate Voluntary Register
PARA: Physician associate registration assessment
PILS: Paediatric Immediate Life Support
PGD: Patient Group Direction
PSD: Patient Specific Direction
QIP: Quality improvement project
ReSPECT: Recommended Summary Plan for Emergency Care and Treatment
RWT: Royal Wolverhampton NHS Trust
SLEs: Supervised learning events
WBPAs: Workplace-based assessments
WHT: Walsall Healthcare NHS Trust

3.0 Accountabilities

The Group Trust Lead Physician Associate is responsible for:

- Leading, coordinating and developing the PA programme with support and guidance from the Chief Medical Officer
- Ensuring PA governance policies are in place and updated on a regular basis
- Where significant changes to a policy occur, ensuring approval is gained at Group Education and Training Council (GETC)
- Ensuring that all employed PAs adhere to the policies and procedures listed in this document
- Ensuring that all intended readers have access to this information

The Chief Medical Officer (CMO) is responsible for:

- Providing guidance and support to the Group Trust Lead Physician Associate in the development and expansion of the PA programme
- Providing professional leadership to the PAs working within the Trusts
- Having oversight of the governance policies in place for PAs
- Sign off of a newly established PA role and the associated scope of practice (appendix 1)

For a comprehensive list of the roles and responsibilities of the Group Trust Lead Physician Associate, Chief Medical Officer and clinical and developmental supervisors, please see appendix 2.

4.0 Policy Detail

4.1 Background

All PAs are expected to work under the principles set out in the General Medical Council's (GMC) Good Medical Practice. This policy sets out the governance to support the safe and effective practice of PAs within the organisations.

4.2 Differentiation of PAs within the workplace

All PAs are expected to follow each Trust's uniform policy, and they must be visibly identifiable along with their level of experience as follows:

- At RWT, PAs must wear teal scrubs for clinical work. Clinical teaching physician associates must wear black scrubs for bedside teaching
- At WHT, PAs must wear teal scrubs for clinical work
- Full name, and title must be embroidered on scrubs tops at both organisations

For ease of the physician providing clinical oversight of a PA's work within a designated area, PAs can be differentiated by the number of years of experience as summarised below (further detail is set out in section 4.4.4).

- Physician associate intern (0-1 year)
- Physician associate (1-5 years)

- Senior physician associate (5 years +)

  A minimum of 5 years' experience in a clinical area is required to become a senior PA. The progression of a PA to a senior PA, or introduction of a new person to a senior PA post, will require a capability assessment as outlined in appendix 1.

4.3 Employment

4.3.1 Role creation and development

The development of a PA job should be undertaken by the department and supported by the PA leadership team using the template in appendix 1. Please see appendix 3 for the pre-employment summary checklist.

The role, responsibilities, scope of practice and supervision arrangements must be approved by the following people and in the following order:

- Departmental governance team
- Divisional director
- Chief Medical Officer - this final sign off will be through the Advanced Clinical Practice Oversight Group (APCOG)

PAs need to possess the following essential criteria for employment at the Trusts, which will be verified by Human Resources (HR) during the recruitment process:

- A completed qualification from a recognised and accredited university Physician Associate course, including 2-year postgraduate PgDip and MSc, or 4-year undergraduate integrated Master's course
- A pass certificate from the physician associate registration assessment (PARA)
- A relevant undergraduate degree prior to undertaking a postgraduate PA programme
- Registration on the GMC register or Physician Associate Managed Voluntary Register (PAMVR)
- Successful occupational health and Disclosure and Barring Service (DBS) clearance
- Appropriate references

The interview panel should consist of a senior PA within each Trust, a consultant or specialist from the relevant department, and an HR representative. Please refer to RWT's HR08 Recruitment and Selection Policy for more information regarding the recruitment processes at the Trust. Please see the Recruitment and Selection Policy for recruitment processes at WHT.

4.3.2 Renumeration (banding)

PAs are remunerated as per Agenda for Change (AFC) terms and conditions.
All PA interns are renumerated at AFC band 6 and will transition to a band 7 PA role subject to a satisfactory appraisal.

AFC contracts are based on 37.5 working hours per week and work schedules should be based on this. Additional payments for working out of hours or at weekends will be governed by existing AFC pay arrangements, terms, and conditions.

4.3.3 Work schedule

All PAs employed at the Trusts must have a work schedule that is agreed with the PA leadership team, their clinical supervisor (CS), and the employing department. Work schedules must be established before the commencement of the post, be in accordance with the post requirements and correlate with the general capabilities of a PA. Work schedules must be agreed by the relevant clinical director (CD) and the Group Trust Lead Physician Associate. Work schedules should allow sufficient time for continuing professional development (CPD) and should be reviewed at each appraisal. Clinical supervisors should review the work schedule for internship PAs at the initial 3-month meeting. Work schedules should be agreed and recorded in the PA's personnel file.

Working hours must be discussed in conjunction with the PA's CS, department management team and PA leadership team and agreed formally in their work schedule, adhering to the AFC contract, (standard working hours Monday-Friday 06:00 – 20:00).

PA interns must not work outside of standard hours.

4.3.4 Indemnity

PAs working in secondary care are indemnified against clinical negligence through their employer's membership of the Clinical Negligence Scheme for Trusts (CNST) administered by NHS Resolution. There are some situations where the CNST scheme does not apply, including access to personal, regulatory and medico-legal support and advice. Individual PAs are strongly encouraged to have their own personal professional indemnity, which can be provided by several medical defence organisations. The Trusts are not liable for the cost of such personal indemnity.

4.3.5 Capability and disciplinary processes

Capability concerns must be managed through the HR 19 Performance Capability Policy at RWT and Capability policy HR34 at WHT. Disciplinary concerns must be managed through the Disciplinary Policy HR03 at RWT and Disciplinary Policy at WHT.

4.3.6 Study leave

PAs may access five days of study leave pro rata (7.5 hours a day) per annum and a study budget of £500 per annum to meet the professional CPD requirement. Study leave requests must be made at least 6 weeks prior and approval will be at the discretion of the department or line manager. Senior PAs who have developmental supervisory responsibilities may access 1 extra day of study leave per annum to achieve CPD credits for this additional role. Please see HR 50 Study Leave Policy for RWT's study leave procedure and the Study Leave Policy for WHT's.

4.3.7 Absence reporting

PAs are required to report any leave of absence as soon as possible. Policies may vary slightly from department to department, and this should be established on the commencement of employment. To report a leave of absence, the PA must:

- Contact the consultant in charge of the area that day
- Inform a member of the managerial team responsible for that department, for example the directorate manager

All absences must be logged by the managerial team in the relevant area and absence policies followed accordingly as per HR guidance.

4.3.8 Incident reporting

A form must be submitted via RLDatix at RWT and WHT by a PA if they are involved in or witness a clinical incident. Clinical incidents or 'near misses' are reviewed by the relevant department and line managers. At RWT, on a quarterly basis, the PA leadership team will be sent information regarding incidents involving any physician associates working within the Trust from the Information Management and Technology (IM&T) team. At WHT, incidents are automatically sent to the relevant line managers.

4.3.9 Anti-fraud and anti-bribery

Fraud and bribery are criminal offences and could result in prosecution. All PAs at RWT must adhere to the GP02 Anti-fraud and Anti-Bribery Policy and raise any concerns if necessary. At WHT the Anti-fraud, Bribery and Corruption policy must be followed.

4.4 PA supervision and appraisal

4.4.1 Levels of supervision

There are three levels of clinical supervision which are linked to the clinical experience of the PA:

- **Direct (suitable for a PA intern)** - The doctor providing clinical oversight is immediately available in the same clinical area to provide advice and to review the patient in-person as required

- **Indirect – local (suitable for a PA)** The doctor providing clinical oversight is working within the department and available to provide advice to the PA and, if required, is able to attend promptly for an in-person review of a patient

- **Indirect - distant (suitable for a senior PA)** The doctor providing clinical oversight is working within the hospital and is available to provide advice when required. If they are unable to provide an in-person review immediately (for example they are in theatre), they will delegate the review of the patient to another doctor

Where cross site working is necessary, adequate supervision must be factored in and arranged.

4.4.2 Overview of supervision

To support doctors who supervise PAs, the GMC has provided advice for doctors who supervise PAs. These sets of principles are also mapped to good medical practice:

- PAs are dependent practitioners
- PAs must work under the supervision of a senior doctor in secondary care. This will be a consultant or specialist doctor
- This does not mean that a doctor must be physically present during the PA's contact with patients, but a doctor *must* always be available for consultation
- An intern or newly appointed PA will require closer supervision until their clinical supervisor (CS) has determined that the PA has sufficient knowledge and skills to carry out delegated tasks as set out within the role's scope of practice (section 4.5). Please see section 4.4.4 for further information regarding PA intern supervision.

Supervision of PAs in the clinical area is broken into in 3 distinct roles:

- Named clinical supervisor (CS)
- Named developmental supervisor (DS)
- Day-to-to clinical supervisor (clinical oversight)

4.4.3 Named clinical supervisor

On appointment, each PA must have a named CS assigned to them; this will be a consultant or specialist doctor in the specialty they are working in. The named CS may also be the PA's DS.

The named CS must be a consultant or specialist doctor in the hospital setting, or a general practitioner in community/primary care (relevant to PAs employed in vertically integrated GP practices at RWT). The named CS should be allocated 0.125 programmed activity in their work schedule to undertake the role.

The named CS will be responsible for the following:

- Reviewing and agreeing an individual job plan with each PA
- Ensuring the PA is working within the scope of practice defined in the approved role
- Reviewing the level of clinical oversight the PA requires (see 4.4.1) and communicating that to colleagues who may provide clinical oversight
- Ensuring that PA activity has no negative impact on doctors in training. This may be done in conjunction with the clinical director or local education lead with support from the Director of Medical Education and the Chief Medical Officer
- General oversight of the PA's clinical work with a view to providing constructive feedback for professional and personal development

- Supporting the completion of workplace-based assessments (WPBAs)
- Collating regular developmental feedback from colleagues. It may be appropriate to undertake this as part of a local faculty group
- Contributing to an annual appraisal
- Following Trust protocols when addressing/investigating clinical incidents

Where concerns around clinical capabilities are raised, the named CS will be responsible for undertaking a gap analysis against the role and relevant scope of practice document. They will work with the DS to address the gaps and detail any changes required to ensure patient safety within the boundaries of the relevant capability policy. Any unresolved concerns must be escalated to clinical leads and the PA leadership team.

Please see appendix 1 for further information regarding CS roles and responsibilities and appendix 3 for a supervisor summary checklist.

To be a PA named clinical supervisor the doctor must:

- Hold a full registration with a licence to practise with the GMC
- Be listed on the specialist register and/or the GP register and/or employed on the specialist grade contract
- Be actively practising in the United Kingdom
- Be without restrictions on their practice from their employer or regulator that prevent them from fulfilling their role
- Be a GMC accredited clinical supervisor or educational supervisor

4.4.4 Supervision guidance according to a PA's number of years of experience

Please note that the following information is to be used as a guide for departments and named CSs and is not an exhaustive list of criteria that differentiates between the levels of PAs.

Intern (<1 years)

A newly qualified PA should be provided with a supportive learning environment in which they can consolidate and expand their skills and competencies in their chosen field. While a newly qualified PA must be able to provide care to patients, they will still require increased levels of training and supervision, as would any new member of staff in a first job. There must be a concerted effort from both the newly qualified PA and their CS to ensure that clinical development is optimised. WPBAs must be completed to ascertain competence and the ability of the PA to work within the scope of practice defined by the role. Below offers guidance on the expectations of an intern PA:

- The PA is consolidating their postgraduate degree training
- The PA can apply clinical knowledge to solve diagnostic problems and make clinical management judgements through analysis and interpretation
- It is advised that a newly qualified PA must be directly supervised by a consultant until the PA's competence has been assessed and confirmed. As explained in section 4.4.1, with regards to direct supervision, the doctor providing clinical oversight is immediately available in the same clinical area to provide advice and to review the patient in-person. Prior to the PA reviewing patients under indirect supervision, there needs to be a discussion and agreement between the PA and their CS

PA (1-5 years)

- The PA will have consolidated their postgraduate training and have an awareness of the boundaries of that knowledge
- The PA can apply clinical knowledge to solve diagnostic problems and make clinical management judgements through analysis and interpretation
- During years 1-5, the PA will develop a deeper awareness of increasingly complex clinical problems
- The PA will predominantly assess patients under indirect supervision, as defined in section 4.4.1.This should be regularly reviewed with the named clinical supervisor

Senior PA (>5 years)

- The PA will be developing decision-making skills enabling them to manage a caseload of patients with increasing autonomy
- The PA will require a reducing amount of input from those providing clinical oversight as their experience and skills progress
- The physician providing clinical oversight must be readily available if needed but may not need to physically review the patient
- The PA is likely to possess competence in locally appropriate extended clinical procedures and will be able to perform certain procedures to a higher level of competency.

4.4.4 Clinical Supervisor meetings

Intern (<1 years)

PAs in their first year, or first year in a new speciality should have regular meetings with the named CS at 1, 3, 6, and 12 months.

PA and senior PA

Beyond the first year, PAs must meet with their CS every 3 months.

4.4.5 Developmental Supervisor (DS)

- Each PA will be assigned a DS
- The role of the DS is to oversee long term clinical and professional development of the PA and to undertake an annual appraisal.
- If the DS is a doctor, they will be allocated 0.125 programmed activity to undertake the role.
- If based in primary care/vertically integrated practices, this individual would oversee the PA across the primary care network or multiple sites if relevant.

To be a PA's named DS as a doctor you must:

- Hold a full registration with a licence to practise with the General Medical Council
- Be listed on the specialist register and/or the GP register and/or employed on the specialist grade contract
- Be actively practising in the United Kingdom
- Be without restrictions on their practice from their employer or regulator that prevent them from fulfilling their role
- Be a GMC accredited clinical supervisor or educational supervisor

To be a PA named DS who is not a doctor you must:

- Be approved as a DS by the Group Trust Lead Physician Associate
- Have evidence of training with a minimum of 6 hours CPD on educational supervision

The DS will be responsible for:

- Undertaking the annual appraisal
- Agreeing development plans in response to feedback collected as part of appraisal or during intervening performance reviews
- Providing education support, guidance and supervision to support the PA and facilitate their professional development within the service.

4.4.6 Appraisal and revalidation

PAs must have an annual appraisal completed. It is expected that PAs will also be subject to a revalidation process which has not yet been confirmed by the regulator.

Both Trusts require that all PAs undertake a formal appraisal each year with their DS in collaboration with the PA's CS. At RWT, 'non-medical appraisals' must be completed on My Academy. WHT have equivalent non-medical appraisal documents that are used, and appraisals are recorded on ESR. Part 1 and part 2 of the appraisal documents are linked.

Both Trusts expect each PA to develop a portfolio of clinical evidence on an ongoing basis. The PA must record all clinical assessments and CPD activities as per the PA professional requirements set nationally by the appropriate professional body. It is the responsibility of the PA to arrange their appraisal in a timely manner and submit their appraisal evidence to their appraiser at least 7 days prior to the appraisal. Evidence to be collected prior to appraisal may include:

- Personal details and professional registration number
- Scope of work
- Mandatory training
- Health and probity
- Significant events
- Complaints
- Quality improvement projects
- CPD activities
- Review of WPBAs, including Mini Clinical Evaluation Exercises (MiniCEXs) and Case-based discussions (CBDS)
- Direct observation of procedural skills (DOPs)
- Personal development plan for the next year
- Multisource feedback (MSF)
- Patient feedback
- Activities outside of the Trust e.g. teaching, examining at nationals
- Evidence of reflective practice and recognitions of limits of expertise

Please see section 4.6 or more information regarding annual requirements

4.4.7 Clinical oversight on a day-to-day basis

A consultant or specialist grade doctor must always clinically supervise PAs and retain professional and clinical responsibility for the overall management of the patient. However, when performing delegated tasks, the PA is accountable for their own practice and actions and must not act outside the limits of their competence. The level of supervision as explained in section 4.4.1 required for each PA must be discussed prior to employment (see appendix 1) and reviewed at regular intervals by the relevant CS. This information should then be cascaded to all day-to-day supervisors providing clinical oversight.

Recommendations:

- A newly qualified PA, or a PA moving into a new and unfamiliar role, will require direct supervision for a period time
- Supervision levels must be regularly reviewed to ensure that they are appropriate and proportionate to the clinical setting and experience of the PA, depending on the complexity or acuity of the clinical case
- Decisions to progress to more advanced levels of clinical practice, which may require changes in clinical oversight, must be clearly documented and evidenced by the clinical and developmental supervisor. It should be supported by the departmental local faculty group to ensure a shared level of understanding of the clinical oversight required by the group

4.4.8 Seeking advice and guidance

PAs must seek advice and guidance from the most senior available doctor (i.e. ST3 level or above). In situations where a delay in seeking advice from an ST3 doctor or above might lead to potential patient deterioration or clinical harm, or when defined and agreed local pathways exist (such as referring to an on-call surgical team led by a consultant), PAs may seek advice and guidance from fully registered doctors (FY2 doctor or above). For instance, where there are changes to the patient's situation or condition, the PA may seek advice and discuss the patient with a resident doctor in order to provide appropriate care. If the clinical concern falls outside both the PA's and the resident doctor's scope, prompt escalation to a senior decision maker is then required. In all cases the resident doctor is not supervising the PA but is providing advice and guidance based on information provided by the PA and both parties are subject to consultant or specialist doctor supervision.

Both the PA and the advising doctor must ensure clear, accurate and contemporaneous records of their conversation and outcomes in the patient's clinical record whether this is electronically or in the physical notes.

4.4.9 Accountability and delegation

PAs can practise in the UK under the clause of delegation as outlined below, taken from the GMC's Good Medical Practice.

"Delegation involves asking a colleague to take responsibility for providing care or treatment on your behalf. Accountability for safe delegation is shared between the colleague delegating and the colleague to whom care or treatment is delegated. You must work collaboratively with colleagues to make sure delegation is appropriate."

PAs should be supported to develop their roles through appropriate delegation of tasks and responsibilities. When delegating tasks, the GMC has written principles for consultants and specialist doctor providing clinical oversight. Please read the GMC's guidance on delegation and referral for the exhaustive guidance. Some important points have been outlined below:

- When you delegate care in line with the principles set out in this guidance, you are not accountable to the GMC for the actions (or omissions) of those to whom you delegate care. You will remain responsible for: the overall management of the patient, decisions around transfer of care, and the processes in place to ensure patient safety
- You must be confident that the colleague you delegate to has the necessary knowledge, skills, and training to carry out the task, or that they will be adequately supervised to ensure safe care

- Usually, you'll delegate to a colleague who is a medical, health or social care professional registered with a statutory regulatory body. If a colleague is not registered with a statutory regulatory body, registration on a managed voluntary register can give some assurance that they've met defined standards of competence, and that they adhere to agreed standards for their professional skills and behaviour
- The colleague's role, grade and training can also provide some reassurance of their level of competence
- You should help to create a compassionate and supportive working and training environment where less experienced colleagues can feel safe to ask questions and supported when they express uncertainty or a lack of confidence.
- You must give clear instructions when delegating, including about what needs to be done, by whom and by when
- You should check that colleagues understand what they are being asked to take responsibility for and when to seek input from a more experienced colleague
- You must respond constructively to any concerns colleagues have and make sure they know where they can find support or access to supervision

You must encourage colleagues to:

- Ask questions so they understand what they are being asked to do
- Familiarise themselves with organisational protocols or guidelines concerning treatment escalation or senior review
- Seek support or supervision if they need it at any point after a task has been delegated

4.4.10 Reporting structure

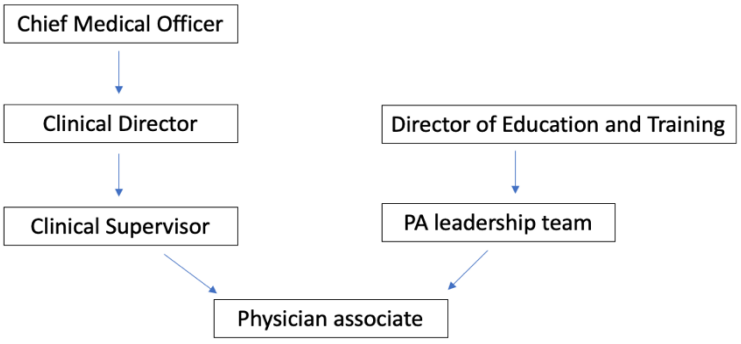

Figure 1: The organisational and reporting structure for PAs at RWT and WHT

4.5 Scope of practice

Prior to the employment of PAs into a new speciality, the scope of practice of a PA should be developed by the department and the Group Trust Lead Physician Associate (see appendix 1). This should be approved by the clinical director at the departmental governance meeting, then be approved at divisional level before being signed off by the CMO.

Detailed below is the scope of practice for all trained PAs at RWT and WHT.

4.5.1 Clinical capabilities in practice for all PAs

As per the GMC's Physician associate registration assessment (PARA) content map and the GMC's Physician associate and anaesthesia associate generic and shared learning outcomes, a newly qualified PA must be able to:

- Formulate and document a differential diagnosis having taken a history and completed a physical examination
- Recognise life-threatening and emergency situations and escalate care appropriately
- Request, perform and interpret diagnostic studies and therapeutic procedures, and recommend a management plan, including therapeutics
- Deliver and maintain patient-centred clinical management in partnership with the patient and multidisciplinary team, dealing with uncertainty when it arises
- Work in partnership with patients from diverse backgrounds to agree comprehensive and individualised management plan
- Undertake patient education, counselling and health promotion

4.5.2 Procedural skills

As per the GMC's physician associate registration assessment (PARA) content map all trained PAs should be proficient at certain procedural skills at the point of qualification. These can be found in appendix 4.

4.5.3 Extended procedural skills

Extended procedures are defined as procedures that a PA can acquire competence in once qualified and therefore are not listed in the PA curriculum. The extended procedures that a PA may acquire is likely to differ according to the speciality in which they work.

Prior to a PA being trained in an extended skill, agreement is required from the clinical director in conjunction with the named CS. The format of the initial training may vary according to the procedure. The PA should then be observed carrying out the procedure until they are deemed competent to complete it without direct supervision.

Direct Observations of Procedural Skills (DOPS) should be completed by the PA and the supervisor to determine competence 0-4. Levels of competence must not only consider the ability of the PA to perform the procedure but also the PA's training and ability in consent, procedural risks, mitigation of risks, post procedure management and care.

Table 1 – Levels of competency with descriptors

Level	Competency
0	Unable to perform procedure
1	Trained and competent in skills lab/simulated environment (this does not equate to clinical competence
2	Competent to perform procedure under direct supervision/assistance
3	Competent to perform procedure with limited supervision/assistance
4a	Competent to perform unsupervised to a high standard with minimal intervention
4b	Competent to perform unsupervised – able to recognise and manage complications

For those extended skills that require medication, the competency level that the PA can achieve will be limited to level 3. For those extended skills that require medication to manage a complication, the ceiling competency level will be limited to 4a. Regardless of a PA's level of competency in any given procedure, a competent practitioner must be immediately available to provide assistance if required.

PAs are expected to keep a logbook of their extended procedures as well as recording on their e-portfolio.

The following table lists the current extended skills performed by PAs in the Trusts and the minimum number of DOPS to be obtained prior to gaining level 4a competence. Department specific scope of practice documents must be referred to for further guidance.

The below skills requirements are suggested as a general guide. There will be variation in the rate of progress and acquisition of competence between individuals, therefore absolute numbers of individual assessments required may be higher.

Table 2 – The minimum number of DOPS required for each extended skill

Procedure	Number of level 3 DOPS required
Ascitic drain insertion and management	5*
Ascitic tap	5
Backslab application	5
Bridle insertion following NG/NJ	5*
Casting/splinting	5
Chest drain management	3*
Endometrial pipelle biopsy	5
Fascia-iliac blocks with ongoing infusions (#NOF)	5
Incision and drainage of abscesses	5
Lumbar puncture (diagnostic and therapeutic)	5
Pleural aspiration (if appropriately Ultrasound trained)	5*
Point of care ultrasound	N/A – see AMU Scope of Practice (FAMUS)
Surgical first assist	N/A – must be locally signed off as competent by supervising surgeons

*Local protocols exist for training, consent, competency assessment and audit of practice

If the extended skill requires administration of a drug prior to the skill being completed, this should be administered under a Patient Specific Direction (PSD) (see 'administration of medication' section 4.5.7).

4.5.4 Consent

- PAs can consent patients for procedures for which they are deemed to be competent at performing
- Local departmental guidance must be followed and where relevant and appropriate, the PA must complete consent training for the procedure
- The PA providing the treatment or investigation is responsible for ensuring that the patient has given valid consent before the procedure takes place
- PAs are unable to obtain written consent for procedures requiring general anaesthesia

Delegated consent

At RWT, if there has been a prior agreement with the relevant clinical director, and the PA has completed procedure-specific consent training, the PA may be able to take consent for treatments, interventions, procedures and operations for which they have not been fully trained to perform. This is known as delegated consent and can be referred to at CP06 Consent to Treatment and Investigation Policy.
At WHT, PAs may only consent for procedures they are competent to perform.

4.5.5 Prescribing medications

PAs are prohibited from prescribing medications. They must refer prescribing matters to a fully registered doctor, ideally the doctor providing clinical oversight. However, if this is not possible or in urgent situations, the PA can refer to another fully registered doctor who can complete the prescription or who subsequently assumes responsibility for assessing and providing care for the patient.

4.5.6 Proposing and transcribing medications

Proposals of medications is a part of the patient care that PAs provide. See GMC's PA/AA learning outcomes 2023 for more detail.

As outlined by the GMC, if a doctor prescribes a medication on the recommendation of a healthcare professional:

- The doctor needs to be satisfied that the prescription is necessary, appropriate for the patient and within the limits of their competence
- If the prescriber delegates assessment of a patient's suitability for a medication, they must be satisfied that the person has the qualifications, experience, knowledge and skills to make the assessment
- The prescriber takes overall accountability for the prescription
- The PA is responsible for ensuring that the correct information regarding the patient is relayed to the prescribing doctor

Transcription of medications can be proposed by a PA on a handwritten chart and signed for by a clinician at RWT and WHT. PAs are unable to propose or transcribe medications onto the electronic prescribing and medicines administration (EPMA) system.

4.5.7 Administration of medications

PAs are able to prepare and administer medications (intramuscular, intravenous and subcutaneous injections) using a PSD. Situations in which a PA may administer medications are when completing an extended procedural skill, such as the administration of local anaesthetic. PAs are unable to administer medications using Patient Group Directions (PGDs).

4.5.8 Ordering imaging

Ionising radiation

At RWT and WHT, PAs cannot currently request ionising radiation.

Non-ionising radiation

PAs are permitted to request non-ionising radiation.

PAs at RWT are able to request ultrasound scans, the scope of practice for which is specified in the non-medical referrer agreement. Before gaining access to ultrasound requesting at RWT, PAs must ensure:

- They have completed the 'Non-Medical Referrer Training' on My Academy
- They have been added to the non-medical referrers list by the radiology department and the relevant clinical director of the PA's employing department has also signed the agreement
- When requesting ultrasounds, the request is reasonable and agreed by the doctor responsible for clinical oversight.

At WHT, PAs are able to request ultrasound but currently cannot request MRI and ionising radiation.

4.5.9 Referrals

PAs are able to make both written and verbal referrals to other specialities when required. PAs may be able to receive referrals following predetermined criteria which have been agreed at APCOG (see 4.7.17).

4.5.10 Discharge summaries

- PAs are able to populate and sign off discharge letters
- PAs are able to sign off the EPMA component of a patient's discharge letter providing there are no new changes to the patient's medication
- Upon discharge, if changes are made to a patient's medication, a prescribing colleague will need to complete the EPMA component of the discharge letter and will take responsibility for this element. The PA must provide the prescriber with appropriate and accurate information to do so
- At both Trusts, the PA can gain the authorisation to do the above by contacting the IT helpdesk via switchboard and asking for non-medical sign off on Clinical Web Portal/Fusion as appropriate

4.5.11 Documentation

- PAs are expected to document in patients' notes
- PAs must use their full title or abbreviate to PA-R with the use of a stamp with their full name, role and GMC or PAMVR number as appropriate

4.5.12 Death verification and death certification

- PAs can verify death
- PAs are not permitted to complete a medical certificate of cause of death (MCCD) or make referrals to HM Coroner

4.5.13 Recommended Summary Plan for Emergency Care and Treatment forms (ReSPECT)

Recommended Summary Plan for Emergency Care and Treatment forms (ReSPECT)
The senior healthcare professional with overall responsibility for a person's care like a Consultant or a GP is responsible for the completion of the ReSPECT form; however completion may be delegated to other health care professionals including PAs. , under their supervision a PA may complete the form, provided they have sufficient knowledge and skills to do so and completion forms part of the job role, they must also have completed the ReSPECT authorship training on My Academy.
Any PA who does complete the form must be supervised by the Senior healthcare professional responsible for the care of the patient and form must be countersigned.

4.5.14 Delegated ward rounds

PA interns must not complete delegated ward rounds. PAs with appropriate experience and capability can complete delegated ward rounds on behalf of the day-to-day clinical supervisor who takes ultimate responsibility for the patient. The following guidance must be taken into account:

- All clinical reviews should be discussed with the supervising consultant and documented appropriately. Such patients must have already been seen following admission by a responsible consultant
- To facilitate delegated ward round activity, the PA and their named CS must both agree that this is within their capability and scope of practice

4.5.15 Blood transfusion

For PAs to complete blood forms or request blood components from blood bank, they must complete the My Academy 'Blood Transfusion Training E-learning – 2 yr' followed by a face-to-face 'Blood Transfusion Assessment (Once Only)' with the transfusion lead at both Trusts.

Following the successful completion of training, the PA can request blood and other products from blood bank provided that:

- It has been prescribed AND
- The plan has been agreed by a senior decision maker, for example a registrar or consultant

4.5.16 Resuscitation

Trust mandatory training requirements stipulate that all clinical staff are Basic Life Support (BLS) trained as a minimum. Both Trusts advise that:

- It is desirable that all PAs or senior PAs are Immediate Life Support (ILS), or if working with children, they are Paediatric Immediate Life Support (PILS) trained
- If working with high acuity patients, it is desirable that the PA or senior PA is Advanced Life Support (ALS) trained or Advanced Paediatric Life Support (APLS) trained if working with children

4.5.17 Advanced Practice Clinical Oversight Group (APCOG)

When there is a proposal for a significant change in the scope of practice of a PA, it will be reviewed by the APCOG prior to this change being implemented. Before discussion at the group, the proposal must follow relevant departmental governance processes and have been discussed with the clinical director and divisional director.

Minor changes to a PA's role do not need to be discussed in this forum and can be agreed with the named CS.

4.6 Expected requirements and continuing professional development

4.6.1 Continuing professional development (CPD)

- All PAs must complete 50 hours of CPD annually and document this accordingly using their e-portfolio. This includes 25 hours of external CPD (standardised external courses e.g. ALS, external conferences) AND 25 hours of internal CPD (personal learning, grand rounds, Schwartz rounds, departmental teaching).
- All PAs must accrue CPD in all 18 areas of the Core Clinical Practice Curriculum which are listed in the PARA content map
- More information regarding CPD requirements can be found here

4.6.2 Clinical assessments

Workplace based assessments (WPBAs)

Evidence must be provided in the form of WPBAs which must be undertaken with a consultant, SAS doctor, high speciality doctor or senior clinical fellow and documented on their e-portfolio. WBPAs can be in the form of CBDs, MiniCEXs and DOPs. PAs are also encouraged to reflect regularly, particularly following significant events that have occurred.

Feedback

All PAs need to collect feedback from colleagues and patients on a regular basis in the form of patient surveys and MSFs.

4.6.3 Minimum requirements to be reviewed at annual appraisal

Level of PA	CBDs	MiniCEX	DOPS	Patient survey	MSF
Intern	6	6	if applicable	5	10
PA	6	4	if applicable	5, (3-yearly)	10
Senior PA	6	4	if applicable	5, (3-yearly)	10

If there is significant change to a PA's scope of practice, requirements for clinical assessments will be discussed in the APCOG (see 4.5.17)

4.6.4 Service development

- PA Interns are not expected to participate in service development
- Senior PAs are encouraged to partake in service development including audits and quality improvement projects (QIPs)
    - 10% whole time equivalent may be allocated to complete this
    - This arrangement should be overseen by their named CS

4.6.5 Teaching

- At RWT, weekly 1 hour lunchtime PA teaching sessions are mandatory
- At WHT, PA teaching sessions are monthly and are mandatory
- PAs at WHT may be able to attend RWT teaching sessions, and vice versa
- Teaching sessions are face to face, but PAs should be able to attend remotely where possible
- PAs are encouraged to attend departmental teaching sessions, Schwartz rounds and grand rounds provided there is sufficient cover in their relevant department.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

6.0 Equality Impact Assessment

An equality analysis has been carried out and it indicates that:

Tick	Options
X	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.
	B. There is some likely impact as identified in the equality analysis. Examples of issues identified, and the proposed actions include

7.0 Maintenance

The Group Trust Lead Physician Associate will be responsible for updating the policy which will need to be reviewed and discussed at the GETC to ensure that it reflects current practice and the changing needs of the Trusts.

8.0 Communication and Training

This policy will be sited on the policies page on the Intranet. There are no training requirements for this policy.

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
Monitor the standards to which physician associates working in the Trust must adhere to. This supports the Trust's values of safe and effective	Group Trust Lead Physician Associate	Feedback from employing departments and physician associates working within the Trust, random audits, DATIX	Annually	Group Education and Training Council (GETC)

10.0 References

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- NHS Employers (2024) NHS Terms and Conditions of Service Handbook. Available at: NHS Terms and Conditions of Service Handbook | NHS Employers
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11.0 Appendices

Appendix 1

Template for the development of new a PA role and to propose a change to an existing PA's role

1. Indicate whether this form is regarding:
   - ☐ A new PA role
   - ☐ A change to an existing PA role

2. Specialty:

3. If this is a new PA role, indicate whether this will be:
   - ☐ Intern PA
   - ☐ PA
   - ☐ Senior PA

   If this is a change to an existing role, indicate whether this is…
   - ☐ Intern PA to PA
   - ☐ PA to senior PA
   - ☐ Senior PA only

4. Include proposed names for:

   Clinical supervisor:
   Development supervisor:
   Clinical oversight physician(s):

5. Responsibilities

   a) Briefly describe the PA's responsibilities using the points below. Please indicate which responsibilities are to be expected on appointment and which are to be performed in the first 12 months with the CS will undertaking a capability assessment against these:

   Clinical
   - General clinical:
   - Procedures:
   - Proposing medication:

- Discharges:
- Imaging:
- Referrals:

Non-clinical:

b) Please confirm that:

- ☐ The PA will not be prescribing medication
- ☐ The PA will not be ordering ionising radiation investigations
- ☐ The PA will not be working under remote supervision (with the exception of cross site working under an agreed process under the relevant speciality)

6. Extended skills and extensions to scope of practice

Please list all responsibilities that are extensions to scope of practice beyond original qualifications and skills of a PA. In addition, indicate any local policies or governance processes that cover acquisition of this capability and monitoring of the safe delivery of it, or where one does not exist an intention to create one or justification as to why this is not necessary. e.g. ascitic drain- SOP XYZ which covers consent, procedure performance and aftercare and auditing of safe practice.

7. Level of supervision

a) Please indicate the level of supervision required:

- ☐ Direct
- ☐ Indirect- local
- ☐ Indirect -distant

Below is a reminder of the different levels of supervision:

- **Direct (suitable for a PA intern)** - The doctor providing clinical oversight is immediately available in the same clinical area to provide advice and to review the patient in-person as required
- **Indirect – local (suitable for a PA)** The doctor providing clinical oversight is working within the department and available to provide advice to the PA, and if required attend promptly for an in-person review of a patient

- **Indirect-distant (suitable for a senior PA)** The doctor providing clinical oversight is working within the hospital and are available to provide advice when required. If they are unable to provide an in-person review immediately (for example they are in theatre), they will delegate the review of the patient to another doctor

b) Describe how and by whom supervision will be provided in the workplace settings the PA will be working in:

c) Is this expected to change for some or all responsibilities within the first 12 months:
- ☐ Yes
- ☐ No

d) If yes, to what level:
- ☐ Direct
- ☐ Indirect - local
- ☐ Indirect - distant

e) If yes to question 7c, describe how and by whom supervision will be provided in the workplace settings the PA will be working in:

8. Impact on other training professionals
Describe any anticipated impact on other professionals training and development (positive and negative) and any necessary mitigations.

I confirm this has been developed with the support of the team and approved at our local governance meeting

Clinical Director signature:
Divisional Director signature:

Following review at APCOG
Chief Medical Officer:

Appendix 2- Roles and responsibilities

The Group Trust Lead Physician Associate is responsible for:

- Leading, coordinating and developing the PA programme with support and guidance from the Chief Medical Officer
- Ensuring PA governance policies are in place and updated on a regular basis
- Liaising with clinical directors to support the recruitment of PAs in departments and develop work schedules
- Chairing quarterly PA forums with all employed PAs
- Providing support and guidance to the Deputy Lead PA in the teaching and education of the qualified PAs at the Trust
- Overseeing the student PA programme with support from the Deputy Lead PA
- Representing PAs at committee meetings and ensuring reports are completed in a timely manner
- Providing pastoral support to PAs at the trusts as required

The Chief Medical Officer is responsible for:

- Providing guidance and support to the Group Trust Lead Physician Associate in the development and expansion of the PA programme
- Providing professional leadership to the PAs working within the Trust
- Having oversight of the governance policies in place for PAs
- Escalating fitness to practice concerns to the regulator
- Ensuring that the employment of PAs within the trusts do not have a negative impact on the training of doctors

Clinical directors are responsible for:

- Ensuring all day-to-day supervising clinicians are aware of the PA role and scope of practice
- Collaborating with the Group Trust Lead Physician Associate to develop PA work schedules
- Ensuring that relevant clinical supervision of the PA is always in place with escalations pathways outlined
- Ensuring a robust local induction
- Assigning the PA a CS and ensuring the CS has sufficient time in their job plan to perform this role

- Ensuring that the employment of PAs within the department does not have a negative impact on the training of doctors
- Submitting a request to the APCOG for significant changes to the PA's scope of practice

The named clinical supervisors are responsible for:

- Establishing the experience and capabilities of the PA and ensuring that the PA works within their scope of practice
- Supporting the PA with any deficits in experience that may limit practice
- Raising fitness to practice concerns if required
- Offering guidance and support for ongoing clinical development
- Ensuring and supporting completion of work-place based assessments
- Completing regular CS meetings with the PA
- Participating in an annual appraisal and create a Personal Development Plan (PDP)

The named developmental supervisors are responsible for:

- Supporting the PA with any deficits in experience that may limit practice
- Raising fitness to practice concerns if required
- Offering guidance and support for ongoing clinical and career development
- Completing regular DS meetings with the PA
- Leading the annual appraisal

Appendix 3- PA employment overview

This checklist should be completed by the relevant service manager and supervisor as detailed below:

Prior to employment - service manager	Yes/No
Banding agreed	
Work schedule completed including CPD time	
CS/DS assigned (incorporated into their job plan)	
Study leave agreed	
Mandatory training requirements (are appropriate and updated)	

Prior to employment – clinical supervisor	Yes/No
Clinical oversight supervisors informed RE scope of practice and supervision requirements including specifically: • Skills, including procedural skills • Prohibition of prescribing/ ordering ionising radiation • Prohibition of writing death certificates	
Meetings booked in with PA	

Upon/during employment – clinical supervisor	Yes/No
Initial meeting taken place to discuss: • Work schedule • Scope of practice • Supervision arrangements • Expectations of Supervised Learning Events (SLEs)	
Gap analysis completed with information from other clinical supervisors. Information shared RE results	
Regular meetings in place to discuss progress and review	
Scope of practice discussion points: • Delegated ward rounds • Extended clinical procedures • Resuscitation	

• Theatre (if applicable) • ReSPECT forms	
Annual appraisal scheduled	

Appendix 4- Procedural skills at which physician associates are expected to be competent upon qualification Physician associate registration assessment (PARA) content map

Category	Procedure
Core clinical practice	Take baseline physiological observations and record appropriately
	Perform surgical scrubbing up
	Perform in cardiopulmonary resuscitation to the level of intermediate life support
Core clinical practical procedures	Carry out venepuncture
	Carry out intravenous canulation
	Carry out arterial blood gas sampling from the radial artery and interpret results
	Take blood for culture from peripheral venepuncture
	Measure capillary blood glucose
	Explain how to perform a peak expiratory flow (assess that it is performed adequately and interpret results
	Carry out a urine dipstick and interpret results
	Carry out a 12-lead electrocardiogram and interpret results
	Take/or instruct patients how to take a swab
	Carry out male and female urinary catheterisation
Core therapeutic procedures	Carry out nasogastric tube placement
	Recommend and administer oxygen appropriately
	Instruct patients on the use of devices for inhaled medication
	Set up an infusion
	Undertake basic drug dose calculations
	Prepare and administer medications (subcutaneous, intramuscular, intravenous)
	Use local anaesthetics in different forms (topical, subcutaneous and urethral)
	Carry out wound care and closure including suturing and dressing

Part A - Document Control

Policy number and Policy version: GOP03 Version 1.1	**Policy Title:** **Group Physician Associate Governance Policy**	**Status:** Final		**Author(s):** **Deputy Lead Physician Associate (RWT and WHT)** **Group Trust Lead Physician Associate** **Chief Officer Sponsor:** **Chief Medical Officer**
Version / Amendment History	Version	Date	Author	Reason
	1.0	Feb. 2025	Deputy Lead Physician Associate Group Trust Lead Physician Associate	Implementation of policy
	1.1	May 2025	Deputy Lead Physician Associate Group Trust Lead Physician Associate	Update to section 4.5.13 - Recommended Summary Plan for Emergency Care and Treatment forms (ReSPECT)
Intended Recipients: All PAs working within the Trusts, all PAs' named clinical supervisors (CS) and development supervisors (DS), clinical directors, all supervising consultants and specialist doctors who provide clinical oversight of PAs work on a day-to-day basis, relevant managerial teams, directorate managers, all members of the multi-disciplinary team working alongside PAs				
Consultation Group / Role Titles and Date: RWT – Medical Education Group (MEG) – 18/09/24 Group Education and Training Steering Group (GETC) – 15/10/24 WHT – Medical Education Group (MEG) – 16/10/24				
Name and date of Trust level group where reviewed	RWT Trust Policy Group – April 2025 WHT Policy Management Core Group – April 2025 Virtual approval via TPG, PMCG & Sponsor– version 1.1 – May 2025			
Name and date of final approval committee	RWT Trust Policy Group – April 2025 WHT Policy Management Core Group – April 2025			
Date of Policy issue	May 2025			

Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	April 2026 - 1 Year
Training and Dissemination: Trust intranet, Trust communications, ETSG, MEG	
To be read in conjunction with: The Royal Wolverhampton Trust HR 08 Recruitment and Selection policy HR19 Performance Capability Policy HR03 Disciplinary Policy HR01 Work life Balance / Family Friendly Policy OP41 Induction and Mandatory Training Policy GP02 Anti-fraud and Anti-Bribery Policy HR 50 Study Leave Policy CP06 Consent to Treatment and Investigation Policy Walsall Healthcare NHS Trust Recruitment and Selection Policy Employment Checks Policy HR31 Capability Policy Disciplinary Policy HR911 Annual Leave Policy Attendance Policy Statutory and Mandatory Training Policy Induction Policy GP02 Anti Fraud, Bribery and Corruption Policy Study Leave Policy	
Initial Equality Impact Assessment (all policies): Completed Yes - Full Equality Impact assessment (as required): Completed Yes	
Monitoring arrangements and Committee	The Group Trust Lead Physician Associate Programme Lead has overall responsibility for the update and maintenance of this policy.
Document summary/key issues covered. This document provides a framework and standards for the employment of physician associates (PAs) across the Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust. It includes guidance relating to supervision of PAs and the Scope of Practice.	
Key words for intranet searching purposes	Physician associates, supervision of physician associates, governance of physician associates, physician associate governance