Physician Associates – Context for introductory pilot

The appetite for introducing PA roles is growing steadily across all health care sectors, in response primarily to the shortage of doctors in a number of specialities e.g. emergency medicine, elderly care/rehabilitation and general practice.

However, there is still a lack of whole system awareness and consensus of opinion regarding the PA role – the numbers of PAs in the UK still being relatively low, compared to the US where PAs have been part of the healthcare workforce since the 1960's – and there is work to be done to facilitate this as part of workforce transformation plans.

Despite this, the number of HEIs now delivering or planning delivery in 2015/16 in the absence of any confirmed LETB[1] commissioning arrangements is growing significantly, including in the North geography and there is pressure mounting from some NW Providers and through the Local Workforce and Education Groups[2], for a coordinated approach.

Nationally there are a number of Education Providers now delivering Physician Associate programmes and the learning from this and other LETB approaches to supporting/commissioning, has informed the approach proposed by Health Education North West.

The key learning points include;

1) There is no national framework in place for the commissioning of PAs and no national training tariff, although there is a national curriculum and examination through UKIUBPAE[3], enabling HEIs to develop locally tailored provision quite readily to meet core learning outcomes. A number of Higher Education Institutes across the NW are currently planning delivery or have expressed an interest in doing so.

2) The two year PGDip/Masters PA programme is open to candidates with an existing first degree in a science related subject (i.e. not exclusively to existing clinical professionals), making it an attractive option to attract additional supply of healthcare workforce to the NHS.

3) There is evidence nationally of some programmes struggling to recruit to planned numbers, primarily due to existing student debt and the absence of any nationally agreed financial support e.g. bursary.

4) There is also evidence of some failing to retain students on programme, noticeably where exposure to clinical placement is limited or late in the programme, or where the quality of student experience is lacking.

5) There have been reports of insufficient clinical placement exposure during training, leading to inadequate confidence and clinical competence on completion of training.

[1] Local Education Training Board – regional representatives of Health Education England
[2] The North West's 3 sub-regional boards which sit underneath the LETB. These cover the geographies Greater Manchester, Cheshire and Merseyside, and Cumbria and Lancashire
[3] The United Kingdom and Ireland Universities Board for Physician Associate (formerly Assistant) Education

These and the further considerations presented below signal that the need to agree an approach which meets the needs of all parties and is sustainable moving forward, will be key to success.

Further considerations

1) The role and contribution of PAs is outlined in Appendix 2, including how they differ from Advanced Practitioners. Fundamentally though, PAs are not a regulated profession and therefore they are not able to prescribe or request X-rays. They do however have a Voluntary Register and are recognised by the Royal College of Physicians, which has added strength to the national case being made to regulate the profession.

2) There is an opportunity to recruit from the surplus of Pharmacy graduates exiting programmes across the North West, which alongside the already enabling curriculum, could facilitate regulation and lead to prescribing capability quite readily.

3) As an unregulated healthcare worker currently, the responsibility for indemnity whilst on clinical placement rests with the employing Provider, which whilst not expected to be problematic for hospital trusts, could pose an obstacle for general practice. Possible solutions to this include the establishment of Lead Employer arrangements across care sectors, or CCG, federation or neighbourhood models of collaborative management.

4) There is a risk that in the absence of definitive demand, supply exceeds requirement and the financial and human investment made is lost. To avoid this (whilst also contributing to the need to attract and retain applicants), it is proposed to adopt an employer sponsorship model for the inaugural cohort. This is explained further in the Funding Model.

These considerations alongside the need to act quickly given escalating demand; to attract, support and retain candidates to the programme; to maximise fitness for purpose/practice on completion of training and to be able to flex funding arrangements to ensure future sustainability if demand grows consistently, are all influencing factors in the design of the funding model and evolving implementation plan.

The intent is to determine a funding model which is attractive to students and quells the training and supervision pressure upon Providers, whilst formalising the commitment being made by both parties

Kirstie Baxter
Head of workforce Transformation

15th May 2015