

06 August 2024

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Chair
Professor Dame Carrie MacEwen

Chief Executive and Registrar
Charlie Massey

Dear Kamila

Thank you for sharing the RCGP's draft guidance on the deployment of physician associates (PAs) in general practice. I am grateful to have been given an opportunity to comment prior to publication.

We have now reviewed the documents and I have provided some high-level views below as well as an [annex](#) with some more detailed comments from colleagues in our Education and Standards team. I know that Colin has been in touch with you separately and would be happy to have a further conversation if that would be helpful.

We welcome this draft guidance and appreciate the pressures that the College is facing as a result of the wide range of strongly held views around how PAs can be safely deployed in general practice. We also welcome the commitment by the College to review this guidance in 12 months' time or sooner should circumstances change.

Overall, we think the draft guidance will be helpful to PAs, GPs and GP practices and will also provide a level of reassurance to patients and the public. However, we are concerned that the draft guidance on PA supervision and scope of practice appear in places to be somewhat burdensome and restrictive, to the extent that, if adopted as drafted, it could have the effect of dissuading GP practices from employing PAs. The College also might want to reflect on the extent to which the draft guidance deviates from current practice, and whether the College has taken account of areas of good practice that we know exists across the country in those GP practices that have safely incorporated PAs into their teams.

We also wondered whether this new RCGP guidance conflicts in any way with the guidance produced by NHSE in March of this year on the effective integration of PAs into general practice ([NHS England » Ensuring safe and effective integration of physician associates into general practice teams through good practice](#)). It would be difficult for GPs who employ PAs in England to reconcile any such conflicts in guidance at local level and this may be further exacerbated by the range of further guidance around PAs that has been or is currently being produced by a range of other organisations. The RCP has just published draft guidance on safe and effective practice for PAs which they are consulting on at present. Separately, the CQC published its guidance on the supervision and oversight of PAs in general practice in late July ([GP mythbuster 82: Physician associates in general practice - Care Quality Commission \(cqc.org.uk\)](#)) and you will have seen the BMA's guidance on PAs in primary care which was published last week (for which, as far as we are aware, there was no engagement with other relevant parties). I think GP practices will find it difficult to negotiate their way around such a range of guidance – particularly if there are significant conflicts in terms of the oversight arrangements that GP practices should have in place.

Finally, we think there could be opportunities to tighten up some of the language around the roles of the educational supervisor (ES), clinical supervisor (CS) and preceptee's mentor to make their respective responsibilities clearer in the guidance. It might be helpful to set out some of the overarching detail in a cover note to prevent repetition of certain aspects across all three documents.

Draft guidance on induction and preceptorship

We think this guidance is useful overall and agree that comprehensive and supportive induction is important for all colleagues starting work in a new healthcare setting. It might be helpful, however, to make sure that the approach outlined in the draft guidance for PAs aligns with current arrangements for other ARRS roles, Foundation doctors and GP trainees, and to explain the reasons for any significant divergence if it exists.

The importance of patients being clear about who is treating them is also mentioned in this guidance and the guidance on scope of practice. We think this is crucial for patients and you may want to link to the FPA's guidance on this ([Faculty of Physician Associates - quality health care across the NHS](#)).

Draft guidance on supervision

The approach set out in this guidance appears to be sensible, although it may be perceived by GPs as quite challenging in practice, particularly if it places additional burdens on GP partners over and above the guidance already published by NHSE. So, for example, the requirement for the ES to have training

that ‘cover[s] the role of the PA and include[s] information on the knowledge and skills the PA should have acquired during their UK university postgraduate programme’, as well as the requirement for the CS to sign off the notes of every PA/patient encounter, and check or be consulted on the majority of tasks undertaken by their PA supervisee might be considered very restrictive and directive for those GP partners who have already successfully integrated PAs into their practice.

Separately, this guidance describes three levels of supervision whereas HEE guidance core capabilities framework for Medical Associate Professions, published in 2022 ([June 2022 MAP Core Capabilities Framework FINAL.pdf \(hee.nhs.uk\)](#)) describes four ‘defined tiers’. Again, it might be difficult for GP practices to reconcile conflicting guidance in this area.

As with the guidance on induction and preceptorship, it might also be helpful to ensure that the draft guidance for PAs aligns with current arrangements for other ARRS roles, Foundation doctors and GP trainees, and to explain the reasons for any significant divergence if it exists.

Draft guidance on scope of practice

Again, we think this is a useful document overall and we particularly welcome the acknowledgement that an individual’s scope of practice can be safely extended over time. However, the detailed nature of the guidance and some of the task based approach to defining scope of practice might diminish the attractiveness of employing PAs in GP practices should the guidance be perceived as overly restrictive, particularly for those practices who have been working with PAs for many years already.

We think the College should also be aware of the potential conflict between this draft guidance and the NHS Network Direct Enhanced Services Contract in that the College advises that ‘a PA can see a patient triaged to them by their GP CS, or GP with delegated responsibility for supervision’ whereas the contract provides that ‘where their named GP supervisor is satisfied that adequate supervision, supporting governance and systems are in place, [PAs can] provide first point of contact care for patients presenting with undifferentiated, undiagnosed problems by utilising history-taking, physical examinations and clinical decision-making skills to establish a working diagnosis and management plan in partnership with the patient.’

The College might also want to ensure that this scope of practice guidance is not more restrictive than the qualification outcomes set out in the PA curriculum which was consulted on and agreed a number of years ago. You will have seen Colin’s email to the Academy of Medical Royal Colleges in June ([Annex B](#)) which reminded Colleges that any scope of practice guidance that seeks to be more restrictive than the qualification outcomes will require a curriculum change, and be aware of the process for seeking any such change to established curricula.

Thank you again for the opportunity to comment on this guidance. I hope you find this feedback helpful and we look forward to seeing the final versions. As I have said, Colin will be happy to discuss further with you at any stage.

Yours sincerely

A handwritten signature in black ink that reads "Charlie Massey". The signature is written in a cursive style with a long, sweeping underline.

CHARLIE MASSEY

Annex A

Detailed comments on draft guidance

Draft guidance on induction and preceptorship

- Induction proposals look very helpful and good to see emphasis on pre-employment checks.
- Preceptorship is a sound proposal re patient safety
- Footnote on page 1 – incorrect information regarding the PA national recertification exam. PAs are no longer required to pass this exam every 6 years. Once regulated by the GMC, they will be required to participate in revalidation to demonstrate they remain up to date and fit to practise.
- Lots around induction that looks good but should be consistent in approach to others – ARRS professionals and Foundation and GP trainees – or, if not, there’s a clear rationale for the difference.
- The inclusion of a preceptee mentor adds a third person in the oversight of PAs (alongside ES/CS). This feels overly confusing and complicated.
- With a CS, ES and mentor there are many people involved. There is no official mentoring scheme for doctors and, whilst a good idea, this could cause some challenge from doctors. Is the mentor for the purposes of supporting career development?

Draft guidance on supervision

- Overall a good approach but we find it quite confusing to have distinct responsibilities for the ES and CS. In medical trainee supervision, the ES take pre-eminence, whereas here it appears to be the CS. We think this can be better explained, but not sure it’s helpful as written. The NHSE guidance uses the phrase ‘named senior doctor’ (typically a doctor on the specialist/GP register or – in secondary care – a specialist doctor) as the person with overall responsibility for supervision.
- The three levels are not easy to follow. It is also implicitly linked to ‘entrustment’. Perhaps some rewording could help.
- The delegated responsibility paragraph (top of third page) seems wordy and convoluted. We struggle to understand why the sentence beginning ‘If appropriately trained, a locum...’ is

needed. By definition they are all ‘fully qualified GPs’. Alternatively, if this is about being trained as a supervisor, it would be helpful to make that more explicit.

- On the page 4 bullets, it would be helpful to explain how this is likely to change over time, especially beyond the first 12 months (linked to preceptorship document).
- We would have thought the principle of appraisal should follow as for doctors and so wouldn’t necessarily be the ES/CS and should change every three years.
- Could be more useful to have a paragraph about annual job planning with the CS to agree changes to scope of practice as demonstrated by relevant training/CPD.
- We are pleased to see that resources for supervision are highlighted.
- While a change in level of supervision will occur with increasing experience this seems to be facilitated at an earlier stage in the document than in the HEE MAPs core capabilities framework document - [June 2022 MAP Core Capabilities Framework FINAL.pdf \(hee.nhs.uk\)](#).

Draft guidance on scope of practice

- Generally a useful document and seems very sensible overall. It hints that scope is individualised but would be better if made clearer. Could link this point to regular (annual) job planning to agree scope of practice.
- It is not clear how this operates over time, and we think it reasonable to expect scope to develop over time and level of entrustment and competence to develop. We are not opposed to the safeguards in the guideline section, but more needs to be said to explain how this might change over time (and some PAs have been in GP settings for a long time and have demonstrable competence so scope would exceed what is in this list).
- Need to check whether these limitations fall below those in the curriculum as knowledge and understanding don’t imply capability in practice.
- We would replace ‘can’ with ‘may’ in the listed items. As it is not a question of whether they can, but rather whether they are allowed – hence ‘may’ is better.
- End of life care - competences are very limited in the new PA curriculum. Recognises how treatment and care can place an additional burden on patients, carers and others, and makes decisions to reduce this burden where appropriate, particularly where patients have multiple conditions or are approaching the end of life.
- Does the guidance mention health promotion and prevention role?

- Ionising radiation – we say ‘Registered healthcare professionals can request ionising radiation for patients as ‘non-medical referrers’ (NMRs) providing their employer has entitled them as an NMR and they have undergone the appropriate training. The position statement from the British Institute of Radiology provides further detail on the training and governance requirements for NMRs and the different types of NMR entitlement. PAs and AAs may be able to become NMR’s once they are registered with us.’ The College may wish to consider being more forward looking on this element to allow for the position post the start of regulation.

Annex B

Email to AoMRC on process for seeking changes to curricula and developing guidance on scope of practice

From: Colin Melville

Sent: Friday, June 28, 2024 4:07 PM

To: Dr Jeanette Dickson <jeanette.dickson@aomrc.org.uk>

Subject: scope and PA/AA curricula

Dear Jeanette,

I thought I might follow up on the letter that Charlie sent in late May and specifically about our role in approving the PA and AA curricula once we begin regulating these two new groups of professionals at the end of this year. As you know, these curricula are owned by the RCP and the RCoA and were subject to consultation with a wide group of stakeholders in 2021. The report on the consultation was published in 2022 and is [available on this webpage](#). The GMC have accepted these draft curricula in principle in advance of our powers to formally approve them and these curricula are now embedded in PA and AA courses and will form the basis of the PA registration assessment (PARA) and the AA registration assessment (AARA) that PAs and AAs will need to successfully complete prior to gaining registration with the GMC.

I understand that there are discussions about making some amendments to these curricula. I thought it might be useful to remind Colleges about the process they would need to follow before we would be able to approve any such changes. Colleges will already be very familiar with our Excellence by Design framework that sets the standard for the development and design of postgraduate curricula for doctors - [Excellence by design](#) – and the guidance we provide on the process that needs to be followed when making changes to those curricula - [Making changes to postgraduate curricula and programmes of assessment \(gmc-uk.org\)](#). Our standards for the design and development of PA and AA curricula (attached) reflect very similar requirements. Paragraph CR2.5 indicates the less of input, feedback and evidence we would need before we can approve any change:

CR2.5 Describe how input and involvement was sought from relevant groups including patients, employers and learners. Engagement and consultation should be proportionate to the change being made and tailored to the relevant group. It must include input from all the following groups:

- a. employers and service providers
- b. patients, relevant patient groups, carers and lay people
- c. course providers and assessment developers
- d. statutory education bodies
- e. learners, including specific input from learners who share protected characteristics
- f. professionals and professional bodies, including those involved in relevant research and policy areas, where appropriate
- g. curricular design experts

Similarly it will be relevant to those considering aspects of scope of practice beyond qualification standards to bear in mind that any scope that seeks to be more restrictive than the qualification Outcomes will require a curriculum change and therefore will need to follow the process as set out above.

Kind regards

Colin

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