Department of Health

NHS National Practitioner Programme

The Competence and Curriculum Framework for the Physician Assistant

The Competence and Curriculum Framework for the Physician Assistant*

September 2006

* Physician Assistant is the working title which replaces the previous working title of Medical Care Practitioner following the suggestions received through the public consultation process. It is recognised that the title will remain a working title until the role is regulated by the appropriate regulator.

Policy	Estates
HR/Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working

Document Purpose	Policy
ROCR Ref:	**Gateway Ref:** 7043
Title	The Competence and Curriculum Framework for the Physician Assistant
Author	DH/NHS
Publication Date	September 2006
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Medical Directors, Directors of Nursing, PCT PEC Chairs, NHS Trust Board Chairs, Directors of HR, Directors of Finance, allied health professionals, GPs, Communications Leads, Emergency Care Leads, potential employers of Physician Assistants, members of other health and social care professions. Educational bodies and advisory groups. Those considering training to become Physician Assistants
Circulation List	PCT CEs, NHS Trust CEs, SHA CEs, Medical Directors, Directors of Nursing, allied health professionals, GPs, Communications Leads, Emergency Care Leads, voluntary organisations/NDPBs
Description	This document is the main reference document for the Competence and Curriculum Framework for the establishment of professional standards and quality assurance of trainee Physician Assistants throughout England (the document may be used in Northern Ireland, Scotland and Wales in future)
Cross Ref	The Curriculum Framework for the Surgical Care Practitioner, The Curriculum Framework for the Anaesthesia Practitioner, The Competence and Curriculum Framework for the Emergency Care Practitioner – A consultation document, The National Education and Competence Framework for Advanced Critical Care Practitioners – A discussion document
Superseded Docs	The Competence and Curriculum Framework for the Medical Care Practitioner – A consultation document
Action Required	N/A
Timing	N/A
Contact Details	Robert Standfield National Practitioner Programme 170 Tottenham Court Road London W1T 7HA 07919 542366
For Recipient's Use	

© Crown copyright 2006

First published September 2006

Produced by the Department of Health

The text of this document may be reproduced without formal permission or charge for personal or in-house use.

www.dh.gov.uk

The development of this document

The purpose of this document is to share analysis of the Medical Care Practitioner (MCP) Competence and Curriculum Framework public consultation document and to integrate the responses to the questions asked within that document in the form of a revised narrative and explicit recommendations.

The MCP Competence and Curriculum Framework consultation document and this final document were developed between September 2004 and August 2006 in partnership with the Royal College of Physicians (RCP) and the Royal College of General Practitioners (RCGP). Further support has been provided by Skills for Health, those higher education institutions (HEIs) expressing an interest in providing an educational programme for the role and clinical colleagues drawn from a range of backgrounds, including the armed services.

The role of the Physician Assistant seeks to build capacity in the NHS workforce, by drawing in a new cadre of recruits from sources such as life-science graduates.

The role draws upon existing models, particularly that of the Physician Assistant role that has been well established in the United States for over 40 years, and has been positively evaluated in the NHS over the last two to three years.

The document seeks to provide a foundation for the movement towards professional regulation, and this will be pursued to ensure patient safety through agreed national standards for training and competence. This document stipulates the national standards of training and competence that those using the protected title, to be determined by the regulator, will need to meet before entering practice. When regulated, those in the role will be required to adhere to the standards set down by the regulatory body. These standards will include a professional code of conduct and a requirement to maintain and improve knowledge and skills through appropriate continuing professional development (CPD).

This document outlines the Competence and Curriculum Framework and sets the national standards of education, training and assessment to enable qualification from an HEI approved by the regulator of the profession.

Although this is the first definitive document there needs to be a realisation that any new profession will take time to form, and this document (or parts of it) may need to be superseded as the profession grows and standards change and as the role is adopted across Europe. Accordingly, this document identifies transitional arrangements to take account of the dynamic nature of progression, especially during the formative period.

The framework outlines the knowledge, skills and core competences expected at the point of qualification. Although it is recognised that, once qualified, those in the role may develop areas of special interest and expertise, they will be required to maintain this broad competence throughout their career.

Please note: Although this document is subject to Crown copyright, the conditions matrix described on pages 16 and 17 is the intellectual property of Nick Ross and the University of Birmingham.

Foreword

The Physician Assistant role provides an opportunity to improve and develop the skill mix in primary and secondary care, while recognising the unique skills and knowledge of other healthcare professionals. Both hospital practice and primary care have been under substantial pressure in recent years with demographic changes, technological and therapeutic advances and the need to improve access and choice for patients, leading to a rising workload. The current clinical and medical workforce strives to meet the demand for access to healthcare services in all areas, and innovative solutions have evolved.

Nursing staff and other allied health professionals have developed extended roles with benefits to patient care and job satisfaction, but the capacity issue in the workforce has led to the rapid establishment of a wide range of new posts of medical support workers across the country with variable training, roles and responsibilities and standards of clinical practice. This is unsatisfactory, both from the regulatory point of view, with the need to ensure that patient care is delivered by safe and competent practitioners, and from the need to define, certify and reward individuals who acquire knowledge and skills and allow transferability across the NHS.

The model of the Physician Assistant was developed in the United States in the mid-1960s, to meet a similar need to increase healthcare services, and is quality assured by educational courses that are based on national standards of training, competences and certification. The development of the model in the USA has resulted in increased capacity of high-quality healthcare, which is underpinned by independent accreditation of standards of practice, in contrast to the situation in the UK.

The development of new roles is often contentious, with perceived threats to the training, role and status of existing healthcare professionals, and the need to safeguard standards of patient care. We believe that there is a need for a broadly based, new healthcare professional who can contribute to holistic patient-centred care in both primary and secondary care settings, but we believe that it is essential to define the role and scope of practice and the standards for education and assessment in order to ensure that practice is to a uniformly high standard. The collaboration of the Royal College of Physicians and the Royal College of General Practitioners, in partnership with the National Practitioner Programme, the University of Birmingham Medical School and Skills for Health and with the support of many other clinical colleagues, has resulted in the development of this Competence and Curriculum Framework. We hope that this document is the first step to a new and welcome addition to healthcare teams in the NHS.

Mary Armitage
Clinical Vice-President
Royal College of Physicians

Nigel Sparrow
Vice-Chairman
Royal College of General Practitioners

Executive summary

This document has been produced by the Competence and Curriculum Framework Steering Group, which was commissioned originally by the former Changing Workforce Programme and is jointly chaired by Dr Mary Armitage, Clinical Vice-President of the Royal College of Physicians (RCP) and Professor Nigel Sparrow, Vice-Chairman of the Royal College of General Practitioners (RCGP).

The steering group was established for the time-limited task of developing a Competence and Curriculum Framework for the emerging role of the Physician Assistant. The RCP and the RCGP were asked to build on similar work being progressed by the Royal College of Anaesthetists and the Royal College of Surgeons of England to develop Competence and Curriculum Frameworks for Anaesthesia Practitioners and Surgical Care Practitioners, respectively. They were also asked to develop competences through Skills for Health, the sector skills council for the UK health sector.

The content of this document has also been informed by the results from the public consultation process, and we have indicated these contributions where appropriate. The document also takes into account the relevant aspects of the recently published consultation on non-medical regulation, *Healthcare Professional Regulation: public consultation on proposals for change* (Department of Health, July 2006) (www.dh.gov.uk/Consultations/LiveConsultations/fs/en).

Significant contributions have also been made by a wide range of participants, who have been acknowledged at the back of this document.

A detailed summary of the results of the public consultation exercise are set out in the Appendix. Although there were no major surprises in the response to the consultation exercise, a number of actions have been taken to accommodate the results of the consultation. As stated, these are highlighted throughout the document either in the narrative or within specific recommendations. The major recommendations are:

1. Qualified and registered Physician Assistants will have access to the same prescribing formulary as that of their supervising physician. This formulary will recognise their area of work and allows them to prescribe in accordance with treating the presenting patient without unnecessary delay. The local prescribing formulary will be adhered to at all times.

2. A period of internship of 12 months is required for the smooth transition between trainee and regulated professional. This would be a period to consolidate skills rather than a formal education programme and consequently the internship would be a salaried position that provides service and has a direct impact upon patient care. During this period the Physician Assistant will be responsible for their own caseload and have the right to refer patients to appropriate diagnostic facilities and to other practitioners with specialist skills.

3. A single national assessment for the profession will be in place before entry onto the statutory register. This is required to establish parameters of competence and for building public confidence.

4. Although it is not currently applied to any healthcare profession, the regular compulsory periodic assessment of knowledge through testing will be introduced to ensure the underpinning principles of demonstrating public safety and maintaining generalist function. The passing of the test every five years will be a condition of continuing use of the protected title. The first periodic compulsory test will be available within five years of the protected title being established so that it may be tested.*

5. Compulsory periodic assessment will be funded through test fees paid by the individual.

6. The validation and accreditation of Physician Assistant programmes of education will be carried out in accordance with the requirements and standards of the approved regulator. Interim arrangements will be transparent, will involve and be subject to independent academic, service and public scrutiny and will be able to transfer smoothly to the appointed regulator when appropriate.

7. Although there was no consensus in the consultation regarding the role of the regulator in the assessment and validation of education programmes, the regulator will have the primary role in accrediting courses that lead to entry onto the statutory register and the ability to practise in the UK using the protected title.

8. Although the regulator will determine the regulated title, the working title of Physician Assistant was overwhelmingly considered to be the most appropriate; therefore, in the interim, the working title of Physician Assistant will be adopted. However, it should be emphasised that the regulator will consider and approve the appropriate protected title.

Some responses questioned the need for the Physician Assistant role either because of the similarities in function to roles already embedded in the NHS or because of its potential impact upon junior doctor training. The role of the National Programme Board and the Competence and Curriculum Steering Group has never been to justify the need for the post. However, the NHS has a duty to ensure that national standards are in place for roles that employers have been, or will be, recruiting into, and the source of this recruitment may be current staff or staff trained outside the UK who may not have access to current regulatory bodies and as such are outside the remit of national standards, scope of practice and mechanisms to protect the public.

As indicated in this document many employers have developed similar roles over many years through a variety of routes by developing current staff to meet service requirements. More recently national competences and standards have been developed for the majority of these staff but not for new entrants into healthcare.

Although this is the final document to be published by the National Programme Board and Competence and Curriculum Framework Steering Group, it does not mark the end of the development. We believe that this document provides the foundation for the development of the Physician Assistant profession in the UK and as such some component parts will require revision over the forthcoming years as the profession grows and develops its own set of professional and practice values, scope of practice and role definition. Consequently, there are areas of the document that identify transitional arrangements, rather than rigid form and function, and as such will require further refinement through a small number of transitional groups that have, or will be, set up to oversee their progress.

* This reflects proposals for the revalidation of all healthcare professionals made by the Chief Medical Officer and the Department of Health, which have been published for public consultation in *Healthcare Professional Regulation: public consultation on proposals for change.*

This document will be accessible online at 'What's New' (www.dh.gov.uk/news) in addition to the following websites:

- Department of Health www.dh.gov.uk/publications
- The Royal College of Physicians www.rcplondon.ac.uk
- The Royal College of General Practitioners www.rcgp.org.uk
- Skills for Health www.skillsforhealth.org.uk

Contents

	The development of this document	iii
	Foreword	iv
	Executive summary	v
1	**Introduction**	3
1.1	Role of the Physician Assistant	3
1.2	Key points of the Competence Framework	4
1.3	Key points of the Curriculum Framework	5
2	**The Competence Framework**	6
2.1	Competence on qualification	6
2.2	Assessment of competence	7
2.3	Specification of core competences	8
2.4	Specification of core procedural skills	13
2.5	Specification of core clinical conditions	15
2.6	Model for categorising clinical conditions on the basis of required competence	16
2.7	Examples of core conditions matrices	18
2.7.1	Matrix showing indicative conditions across the full range of system categories	18
2.7.2	Example of a complete single system matrix: the cardiovascular system	19
2.7.3	Example of core conditions related to a particular disease process: infection	20
2.7.4	Example of a condition matrix for a clinical presentation: chest pain	21
3	**The Curriculum Framework**	22
3.1	Introduction to the Curriculum Framework	22
3.2	Principles of learning and teaching	22
3.3	Learning partnerships	23
3.4	Aims and outcomes of the Physician Assistant programme	24
3.5	Structure of the Physician Assistant programme	25
3.5.1	Overall length of the programme	25
3.5.2	Clinical experience in the programme	26
3.5.3	Progression	26
3.6	Criteria for entry to the programme	27
3.6.1	Major entry groups	27
3.6.2	Other entry routes	28
3.6.3	Transitional arrangements	28
3.6.4	APL/APEL for other groups	28
4	**Assessment**	29
4.1	Definition of competence	29
4.2	Roles of assessment	29
4.3	National assessment and accreditation	30
4.4	Criteria for assessment and standard setting	31
4.5	Maintaining professional competence	32
4.6	Periodic assessment and the maintenance of registration	33
4.7	Funding	33

5 The core syllabus 35
5.1 Core theoretical knowledge 35

6 Validation, accreditation and evaluation of the programme 37
6.1 Validation and accreditation of the programme 37
6.2 Evaluation of the programme 38

7 Regulation and accountability 39
7.1 Professional title 39
7.2 Regulation and registration 39
7.3 Accountability and supervision 40

8 The proposed timeframe 41

9 Glossary of terms 42

10 Bibliography 44

Acknowledgements 46

Appendix Medical Care Practitioner Competence and Curriculum Framework public consultation – summary of responses 49

1 Introduction

1.1 Role of the Physician Assistant

In order to meet the workforce requirements set out in the NHS Plan (2000) to maintain and increase capacity in healthcare, many practitioners have been developing and extending their role in the care of their patients. This is not a recent phenomenon as, over many years, non-medical staff interested in developing their skills have been encouraged and supported by their employers to do so. This has often been done in partnership with medical teams and has been very successful in ensuring improved access to care and the development of multi-professional team working.

The development of new and extended roles has been driven by the local workforce needs of the NHS in response to national policy initiatives and European legislation such as the Working Time Directive. This localised response has resulted in the development of bespoke programmes of training for small groups of practitioners to enable them to fulfil roles that are often defined by their immediate supervisors. Because of local and often fragmented definition, such roles may lack the potential for sustainability and transferability across the NHS.

In view of the many emerging new roles within the NHS, it is acknowledged that there is potential for confusion and variable standards. Partnership working with the medical royal colleges to develop standardised nationally approved roles increases transferability and standardisation to the benefit of the NHS, the healthcare practitioner and the patient.

This document defines standards for the education and practice of a broadly based healthcare professional, who is able to contribute to holistic patient-centred care in both primary and generalist secondary care settings – the Physician Assistant.

A Physician Assistant is defined as someone who is:

> ***a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision.***

A Physician Assistant can:

- formulate and document a detailed differential diagnosis, having taken a history and completed a physical examination;
- develop a comprehensive patient management plan in light of the individual characteristics, background and circumstances of the patient;

- maintain and deliver the clinical management of the patient on behalf of the supervising physician while the patient travels through a complete episode of care;
- perform diagnostic and therapeutic procedures and prescribe medications (subject to the necessary legislation); and
- request and interpret diagnostic studies and undertake patient education, counselling and health promotion.

The Physician Assistant role provides a new way of working that will complement roles already developed in primary and secondary care and strengthen the multi-professional team. Like all other regulated healthcare professionals the Physician Assistant is responsible for their own practice, although they will always work under the supervision of a designated senior medical practitioner, and the medical consultant or general practitioner will retain ultimate responsibility for the clinical management of the patient. Their detailed scope of practice in a given setting is circumscribed by that of the supervising doctor. Although there may be circumstances when the supervising doctor is not physically present, they will always be readily available for consultation.

The Physician Assistant will be employed as a member of the medical team in either primary or secondary care and will have a clinical supervisory relationship with a named doctor who will provide clinical guidance when appropriate. It is expected that over time the supervisory relationship will mature and that although the doctor will remain in overall control of the clinical management of patients, supervision will diminish.

The Physician Assistant will always act within a predetermined level of supervision and within agreed national guidelines. Qualified Physician Assistants may develop specialist expertise that reflects the specialty of their supervising doctor. This will be gained through experiential learning and CPD. However, the response from the public consultation endorsed the view that Physician Assistants should be expected to maintain their broad clinical knowledge base through regular testing of generalist knowledge. It is likely therefore that similar structures and processes to those used in the United States to test the maintenance of generalist knowledge will be introduced.

1.2 Key points of the Competence Framework

In addition to competences and skills, this framework describes the level of responsibility that Physician Assistants will be expected to take for the diagnosis and management of a range of clinical conditions. An employing organisation can use the framework to set appropriate expectations of the Physician Assistant.

In the previous document a diagrammatic matrix was used to illustrate the responsibility in relation to different conditions. Although referring to individual clinical conditions, the classification of conditions within the matrix recognises that these may often be present as part of a more complex picture of co-morbidity. The response to the public consultation document indicated that this matrix provided clarity regarding the levels of disease and clinical management that Physician Assistants could adequately manage. The matrix, like this document itself, is a dynamic document that requires constant updating as the profession develops and as service needs change. It is intended, therefore, rather than setting out in this document what those diseases should be, that ways of providing the information electronically through a universal access system be sought. This will be established, maintained and governed

by the profession and recognise their increasing knowledge of service need. In the interim, the master matrix of core clinical conditions will be accessible online in a linked working electronic document entitled *Matrix specification of core clinical conditions for the Physician Assistant by category of level of competence* at www.dh.gov.uk/news and www.dh.gov.uk/publications (to be read in conjunction with this document).

1.3 Key points of the Curriculum Framework

This framework recognises that the development of common standards on qualification requires:

- flexible but rigorous entry criteria to programmes;
- a substantial academic programme that will allow the time required for individual professional development;
- agreed minimum levels of clinical experience;
- a common core knowledge base;
- common core learning outcomes; and
- national (or international) standardised assessment.

Physician Assistants will complete a degree-level academic programme of no less than 90 weeks. The public consultation document proposed that this should be followed by a period of internship in an approved clinical training setting, and this was universally agreed. Whilst those who responded suggested a range of periods of 'intern' time the most commonly accepted was a period of 12 months. This foundation will enable Physician Assistants to practise as part of the clinical team, within a range of primary and secondary healthcare settings. Those responding to the consultation also suggested that this internship should take place in a single setting but with access to other clinical areas to ensure clinical exposure to common systems of clinical management.

The interim arrangements will set out the process for ensuring that a partnership model is in place between the supervising doctor and the academic institution to ensure that robust governance is in place and the required professional standards are achieved.

2 The Competence Framework

2.1 Competence on qualification

This chapter defines the core achievements required of the Physician Assistant student at the point of qualification, in order to be placed on the register. There are three major components to this specification:

- The core competences which the Physician Assistant is expected to be able to demonstrate across all their clinical practice.
- The range of procedural skills in which the Physician Assistant must have demonstrated competence.
- The core clinical conditions and the level of responsibility which the Physician Assistant is expected to take for diagnosis and management – consequently the main body of the public consultation document included:
  - an explanation of the core clinical conditions matrix;
  - examples of indicative conditions across the full range of systems;
  - a complete example of the specification for one system;
  - an example of specification on the basis of a disease process; and
  - an example of specification of conditions on the basis of a clinical presentation.

The full list of core clinical conditions set out by category of level of competence in accordance with the matrix model is available electronically at www.dh.gov.uk/news and www.dh.gov.uk/publications as described in section 1.2.

This document sets out the competence expected at the point of qualification. A Physician Assistant is required to maintain this breadth of competence throughout their professional career. The additional expertise that they may acquire in particular fields, through experience or further training, is in addition to this general competence and not a substitute for it.

It is anticipated that Physician Assistant students will be drawn from a variety of backgrounds, but it is intended that a major pool of applicants will be life-science graduates, thus encouraging recruitment from this sector into the NHS. Other potential areas for recruitment include medical assistants/medical technicians from the armed services, nurses and allied health professions, and appropriate accreditation of prior learning/experiential learning (APL/APEL) processes will need to be in place (see sections 3.6.3 and 3.6.4). Consequently, there is likely to be considerable variation in knowledge levels and clinical and educational experience of different entrants, as well as variation in their life experience. Some prospective entrants with limited academic experience may need access programmes to enable them to follow the proposed intensive university-level education.

The competences detailed in this document reflect the requirement for a significant knowledge base and an understanding of the application of scientific principles, through professional judgement, in a range of clinical settings. This capability is to be acquired through an appropriate academic and clinical curriculum approved by the regulatory authority. In order to enable entrants from different backgrounds to achieve the required competences, curricula will have to target specific groups or demonstrate the flexibility to cope with the range of learning needs.

Responses from the public consultation exercise indicated a requirement to differentiate between the length, depth and breadth of this education programme and other programmes that have led to roles that provide similar outcomes for current NHS staff. This will be addressed through the NHS Knowledge and Skills Framework. A foundation and full post outline, together with examples of application for the Physician Assistant role, can be found at www.e-ksf.org

It was never the intention for the Physician Assistant role to substitute for established roles, as the justification for its development has solely been based upon service need. Experience from other countries has indicated that the role has flourished where workforce capacity within medical teams has been an issue of concern. Local workforce planning will be the single most significant aspect of whether this role becomes embedded into the NHS workforce.

The core competences outlined in this document must be achieved by those that are undergoing Physician Assistant education and training in order to take up the professional role. In keeping with the philosophy of lifelong learning in the NHS, further skills will be acquired and assessed, and accordingly Physician Assistants may then work in specialist areas.

Physician Assistants will be accountable for their own practice within the boundaries of delegation but they will work under the overall supervision of a general practitioner or medical consultant. Arrangements for supervision and the delegation of duties and responsibilities will vary according to the Physician Assistant's level of overall experience and expertise in the particular clinical field.

2.2 Assessment of competence

The day to day management of the assessment of students' knowledge, skills and attitudes as they develop through Physician Assistant education programmes will be the responsibility of individual higher education institutions (HEIs). However, in order to qualify as a Physician Assistant, students from all HEIs will be required to undertake a nationally determined assessment. HEIs may, if they wish, apply additional assessments for the award of their academic qualification based on:

- institutionally determined requirements;
- the academic level of their programme; and
- specific learning over and above that specified as core to the role but that does not detract from the national assessment requirement, which will include:
  - a national knowledge-based examination; and
  - an objective, structured clinical examination that uses nationally determined stations and assessment criteria (eg clinical skills laboratory, simulated patients or, where appropriate, actual patients).

In addition there will be a nationally agreed framework for:

- direct observation of the student's application of communication, interpersonal, clinical and procedural skills in practice;
- collection of evidence provided by other healthcare practitioners regarding the performance of the student;
- direct questioning by an assessor to check understanding of patient-centred care, health and safety procedures, technological interventions and interpretation of results, in addition to demonstrating core knowledge; and
- a portfolio of evidence maintained by the student – this will include a record of progress as well as reflective accounts of critical learning encounters and will inform the assessment process and its outcome.

In terms of providing evidence for the core clinical competences, skills and conditions, the evidence must reflect that the Physician Assistant has demonstrated the skills of working with patients in the clinical setting (with the exception of cardiopulmonary resuscitation (CPR), where competence can be demonstrated through simulation).

2.3 Specification of core competences

To specify competence, it is necessary within the following section to break down the clinical role into a series of component parts. In reality, the Physician Assistant moves freely between the application of these component competences as required by the clinical situation and service need. It is essential to the medical model, to which the Physician Assistant works, that their consultations and interventions are responsive to the individual patient and their situation, rather than mechanistic – that is, they should apply their knowledge and skills in a patient-centred way rather than sticking closely to predetermined protocols.

In addition, this document acknowledges the government expectation (please see *Common Core of Skills and Knowledge for the Children's Workforce*, Department for Education and Skills, 2005) that practitioners working with children and young people should have a basic common core set of skills, knowledge and values that promote equality, respect diversity, help provide more effective and integrated services and acknowledge the rights of children, young people and their families.

2.3.1 Professional behaviour and probity

- Consistently behave with integrity and sensitivity.
- Behave as an ambassador for the role of Physician Assistant, acting professionally and behaving considerately towards other professionals and patients.
- Recognise and work within the limitations of your professional competence and scope of professional practice.
- Maintain effective relationships with colleagues from other health and social care professions.
- Inform patients, carers and others of the nature of the clinical role.
- Contribute to the effectiveness of a clinical learning environment.
- Be a good role model.

2.3.2 The patient relationship

- Communicate effectively and appropriately with patients and carers even when communication is difficult.
- Demonstrate the ability to utilise the clinician–patient encounter therapeutically.
- Perform a flexible and holistic assessment in order to make an appropriate management plan.
- Facilitate patient involvement in management, planning and control of their own health and illness.
- Appropriately and sensitively identify and utilise opportunities for patient and carer education.

2.3.3 Common core skills and knowledge when working with children, young people and families

- Demonstrate effective communication and engagement with children, young people and families.
- Demonstrate effective observation and judgement in children's and young people's development.
- Recognise when to take appropriate action in safeguarding and promoting the welfare of the child.
- Intervene appropriately when supporting transitions between stages of development and/or services.
- Demonstrate effective multi-agency working through awareness of roles and responsibilities within other services.
- Identify when to share information in a timely and accurate manner while respecting legislation on the control and confidentiality of information.

The core competencies listed in 2.3.3 are adapted from the *Common Core of Skills and Knowledge for the Children's Workforce,* DfES, 2005.

2.3.4 History taking and consultation skills

- Structure interviews so that the patient's (or carer's) concerns, expectations and understanding can be identified and addressed.
- Elicit a patient history appropriate to the clinical situation, which may include presenting problem, history of the present illness, past medical history, social history, family history, medications, allergies, review of systems, risk factors and appropriate targeted history.
- Identify relevant psychological and social factors, integrating these perspectives with the biomedical evidence to elucidate current problems.

2.3.5 Examination (general)

- Perform a physical examination (including screening examinations) appropriate to the clinical situation. This will include neurological examination, musculoskeletal examination, blood pressure (BP) measurement and control, male and female genitourinary examination, breast examination, ophthalmic examination, oropharyngeal examination, cardiovascular examination, respiratory examination, abdominal examination and dermatological examination (including pressure area risk management).

- Perform a comprehensive mental state examination. This will include assessment of appearance and behaviour, levels of consciousness, posture and motor behaviour, thoughts and perceptions, affect, speech and language, orientation, memory and higher cognitive function.

2.3.6 Interpreting evidence and determining the requirement for additional evidence

- Interpret the findings from the consultation (history, physical examination and mental state examination) in order to determine the need for further investigation and/or the appropriate direction of patient management.
- Understand the indication for initial and follow-up investigations.
- Select, interpret and act upon appropriate investigations.
- Determine the relevance of screening tests for a given condition.

2.3.7 Clinical judgement in diagnosis and management

- Formulate a differential diagnosis that is based on objective and subjective data.
- Use clinical judgement to select the most likely diagnosis in relation to all information obtained.
- Recognise when information/data is incomplete and work safely within these limitations.
- Recognise when a clinical situation is beyond your competence and seek appropriate support.

2.3.8 Therapeutics and prescribing

- Determine appropriate therapeutic interventions from the full range of available prescription medications.
- Write accurate and legible prescriptions in out-patient, in-patient and primary care settings.
- Prescribe appropriate fluid regimes on commencing intravenous infusion.
- Use the *British National Formulary* (BNF) and local formularies appropriately and be familiar with the yellow card system for reporting side effects and drug interactions.
- Recognise your responsibility for gaining the patient's compliance for the drug regime you are prescribing.

The public consultation document requested views regarding full prescribing rights, and the majority of respondents agreed that the Physician Assistant should have access to the same prescribing formulary as that of their supervising physician. Many respondents highlighted the need to adhere to local policies and guidelines.

Recommendation 1

Qualified and registered Physician Assistants will have access to a prescribing formulary that recognises their area of work and allows them to prescribe in accordance with treating the presenting patient without unnecessary delay. The local prescribing formulary will be adhered to at all times.

Note: Although it is recognised that the granting of independent prescribing rights is subject to separate approval/legislation (via a process of consultation with the Commission on Human Medicines and the Medicines and Healthcare Products Regulatory Agency under the auspices of the Department of Health) this recommendation is included here because independent prescribing is central to the role and practice of the Physician Assistant, unlike professions for whom it is a part of the extended role.

2.3.9 Clinical planning and procedures

- Formulate and implement a management plan in collaboration with the patient, the carers and healthcare professionals.
- Perform clinical procedures using knowledge of the indications, contraindications, complications and techniques.
- Monitor and follow up changes in the patient's condition and response to treatment, recognising indicators of the patient's response.

2.3.10 Documentation and information management

- Initiate and maintain accurate, timely and relevant medical records.
- Contribute to multi-professional records where appropriate.

2.3.11 Risk management

- Recognise potential clinical risk situations and take appropriate action.
- Recognise risks to yourself, the team, patients and others and take appropriate action to eliminate or minimise danger.
- Value the importance of clinical governance and participate as directed.

2.3.12 Teamwork

- Value the roles fulfilled by other members of the health and social care team and communicate with them effectively.
- Effectively manage patients at the interface of different specialties and agencies, including primary/secondary care, imaging and laboratory specialties.
- Effectively and efficiently hand over responsibility to other health and social care professionals.

2.3.13 Time/resource management

- Prioritise workload by using time and resources effectively.
- Recognise the economic constraints on the NHS and seek to minimise waste.

2.3.14 Maintaining good practice

- Critically evaluate your own practice to identify learning/developmental needs and identify and utilise learning opportunities.
- Use evidence, guidelines and audit (including significant event analysis) to benefit patient care and improve professional practice.

2.3.15 Ethical and legal issues

Identify and address ethical and legal issues that may impact on patient care, carers and society. Such issues will include:

- ensuring that patients' rights are protected (eg that Gillick competence applies in the case of children);
- maintaining confidentiality;
- obtaining informed consent;
- providing appropriate care for vulnerable patients (including vulnerable adults, children and families in need); and
- responding to complaints.

2.3.16 Equality and diversity

- Recognise the importance of people's rights in accordance with legislation, policies and procedures.
- Act in a way that:
  - acknowledges and recognises people's expressed beliefs, preferences and choices;
  - respects diversity;
  - values people as individuals; and
  - incorporates an understanding of your own behaviour and its effect on others.
- Identify and take action when your own or others' behaviour undermines equality and diversity.

2.3.17 Current developments and guiding principles in the NHS

Be aware of:

- patient-centred care;
- systems of quality assurance, such as clinical governance, national clinical guidelines and clinical audit;
- the significance of health and safety issues in the healthcare setting;
- risk assessment and management strategies for healthcare professionals;
- the importance of working as part of a team within a multi-professional environment; and
- broader government policy impacting on health.

2.3.18 Public health

- Address issues and demonstrate techniques involved in studying the effect of diseases on communities and individuals, including:
  - assessment of community needs in relation to how services are provided;
  - recognition of genetic, environmental and social causes of, and influences on, the prevention of illness and disease; and
  - application of the principles of promoting health and preventing disease.

It is not intended that Physician Assistants will be the primary care provider in the care of children and young people. Inevitably, in practice children and young adults will present in clinical situations, and a Physician Assistant must be able to determine the correct course of action in such circumstances that ensures the child gets access to appropriate and immediate care.

Physician Assistants are more likely to have contact with children and young people when working in primary care and emergency department settings. In order to ensure that Physician Assistants are able to demonstrate core skills and knowledge when working with children and young people, as reflected by national policy and guidance,* the *Common Core of Skills and Knowledge for the Children's Workforce* will form part of future qualification requirements for everyone working with children, young people and families.

2.4 Specification of core procedural skills

The following is a list of procedural skills which the Physician Assistant will be able to perform on completion of the educational programme. This section is designed to be read in conjunction with the competences (section 2.3), and for the sake of brevity we do not repeat the vitally important skills of routine examination, communication with the patient, seeking informed consent, ensuring safety, avoiding infection etc.

2.4.1 Cardiovascular system

- Undertake an ECG.
- Participate in cardiopulmonary resuscitation to the level expected in Immediate Life Support Training: which medication to use and when, depending upon ECG reading, oxygen with mask and bag intubation.

2.4.2 Respiratory system

- Undertake pulmonary function tests, including the administration of peak flow measurement.
- Commence and manage nebulised therapy.
- Commence and manage oxygen therapy.

**Common Core of Skills and Knowledge for the Children's Workforce* (Department for Education and Skills, 2005); *Core Standards Document, National Service Framework for Children, Young People and Maternity Services* (Department of Health, 2004); Children's Workforce Strategy (Department for Education and Skills, 2005); 'Keep Me Safe': The Royal College of General Practitioners strategy for child protection (RCGP, 2005)

2.4.3 Gastro-intestinal system

- Insert a nasogastric tube.

2.4.4 Musculoskeletal system

- Undertake appropriate initial management for common musculoskeletal injuries.

2.4.5 Eyes

- Perform fluorescein dye examination of the cornea.

2.4.6 Ear, nose and throat

- Perform anterior nasal packing.

2.4.7 Female reproductive system

- Obtain a cervical smear, cultures for high vaginal swabs etc.

2.4.8 Renal and genitourinary system

- Undertake male and female urinary catheterisation.
- Perform a urine dipstick test.
- Perform a urine pregnancy test.

2.4.9 Skin

- Undertake simple skin suturing.
- Undertake incision and drainage of abscesses.
- Initial wound debridement.

2.4.10 Diagnostics and therapeutics

- Draw up and give intramuscular, subcutaneous, intradermal and intravenous injections and infusions.
- Take a venous blood sample, using appropriate tubes for required tests.
- Obtain an arterial blood gas (ABG) sample.
- Undertake venous cannulation.

2.5 Specification of core clinical conditions

The model on the following page describes a two-dimensional categorisation – the X axis referring to competence in undertaking the diagnostic process and the Y axis referring to competence in managing the condition. This model of conditions is then used in the systems-based lists on subsequent pages.

Depending on local arrangements and agreement with the supervising practitioner, experience post-qualification may draw diseases from a lower into a higher category (eg 2B to 1A). However, it is key to the Physician Assistant role that, whatever their current field of practice, they maintain competence in the breadth of clinical conditions outlined in this section.

Following the explanation of the core condition matrix, this chapter gives four examples of matrices as follows:

- examples of indicative conditions across the full range of systems;
- a complete example of the specification for one system;
- an example of specification on the basis of a disease process; and
- an example of specification of conditions on the basis of a clinical presentation.

An electronic working document containing a full list of clinical conditions set out by category of level of competence in accordance with the matrix model can be found at www.dh.gov.uk/news and www.dh.gov.uk/publications as described in section 1.2.

2.6 Model for categorising clinical conditions on the basis of required competence

X axis: Is the Physician Assistant competent to take a significant role in the diagnostic process?

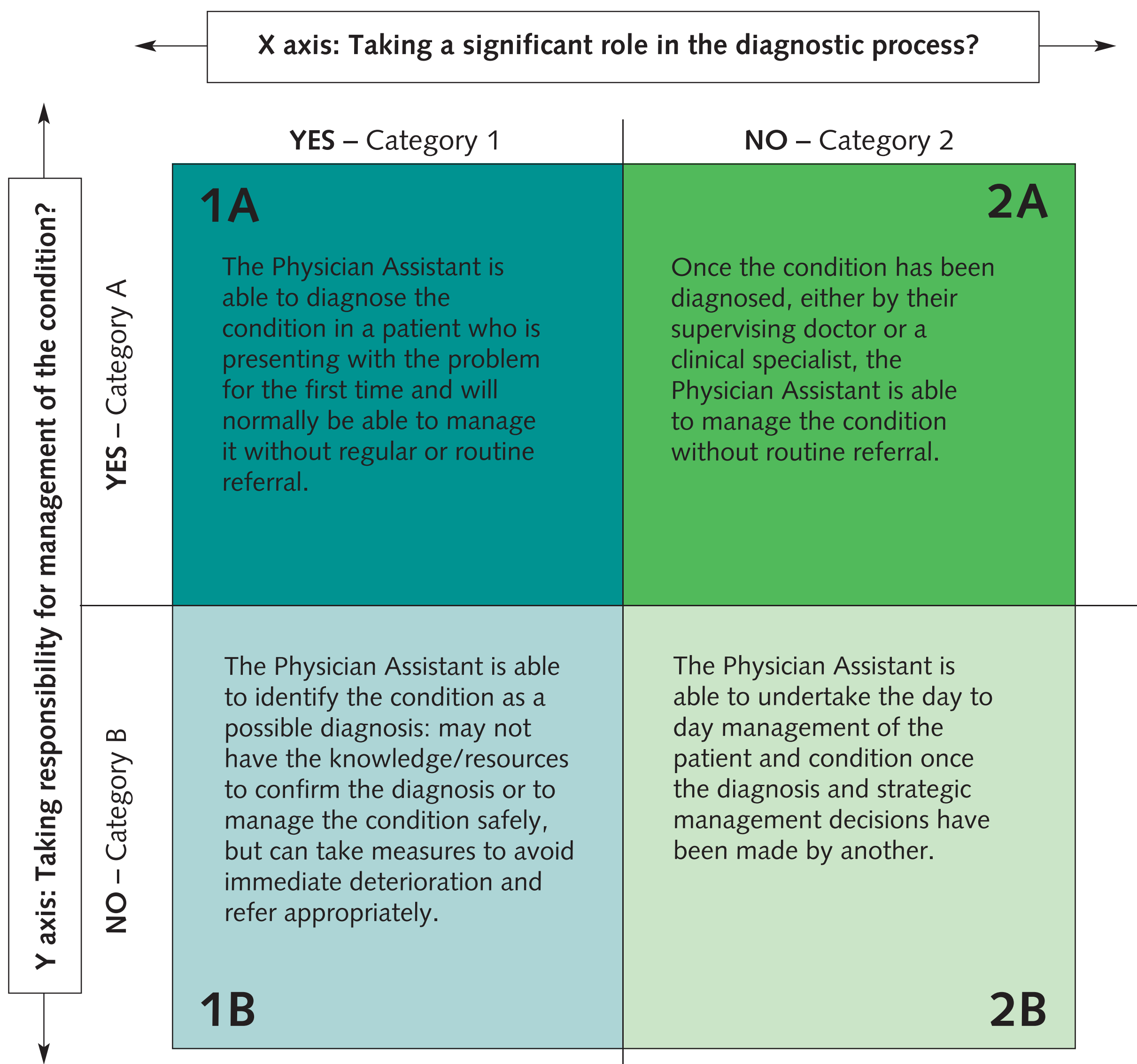
YES: Category 1 — The Physician Assistant is able to identify a condition as a possibility within differential diagnoses and to take measures to confirm or refute the diagnosis.

NO: Category 2 — The Physician Assistant is aware of the condition, but does not necessarily have the knowledge or resources to make the diagnosis.

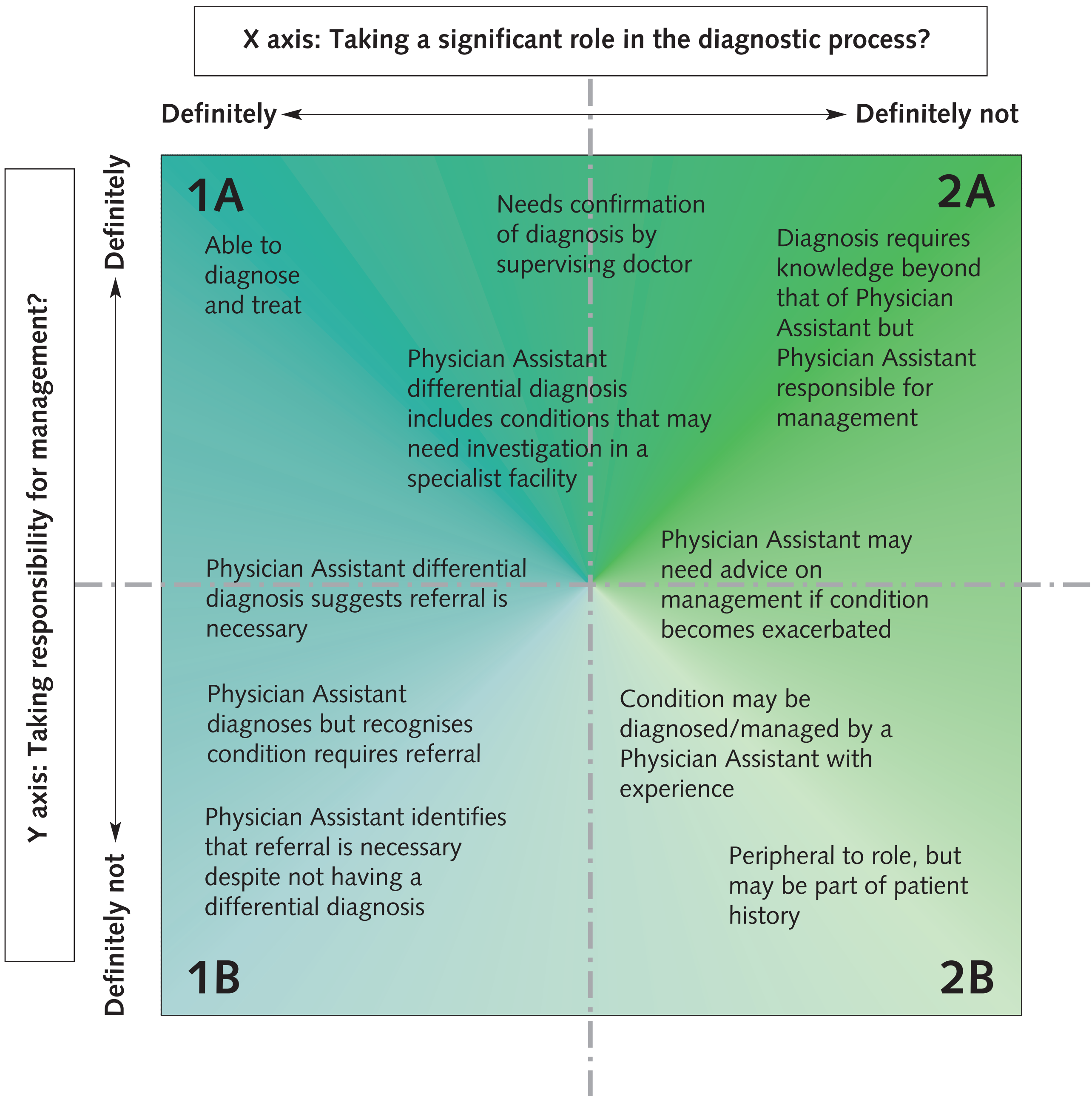
Y axis: Is the Physician Assistant competent to take responsibility for management of the condition?

YES: Category A — The Physician Assistant is able to manage the uncomplicated condition without routine referral to others.

NO: Category B — The Physician Assistant participates in the management of the condition, but does not take a lead role in determining the management strategy.



As with most models, this is something of an oversimplification of reality. Relatively simple conditions may be complicated by the personal circumstances of the patient, their reaction to the disease process or some other underlying health problem. Equally, a Physician Assistant may already be familiar with a non-core condition because of prior experience. However, whilst the following diagram may be closer to the truth, we believe that the simplified model is a more appropriate basis for the development of curricula.



2.7 Examples of core conditions matrices

2.7.1 Matrix showing indicative conditions across the full range of system categories

Taking a significant role in the diagnostic process? (columns: Yes / No)

Taking responsibility for management? (rows: Yes / No)

Taking responsibility for management: Yes

1A (Diagnostic: Yes)	2A (Diagnostic: No)
Mental health: depression	Mental health: dysthymic disorder
Cardiovascular: essential hypertension	Cardiovascular: giant cell arteritis
Respiratory: acute bronchitis	
Gastro-intestinal: gastroenteritis	
Musculoskeletal: gout	Musculoskeletal: rheumatoid arthritis
Eye: corneal abrasions	
Ear, nose and throat: acute otitis media	
Female reproductive: dysmenorrhoea	
Neurological: migraine	Neurological: partial/partial complex seizures
Metabolic and endocrine: hyperkalaemia	Metabolic and endocrine: hypertriglyceridaemia
Renal and GU: cystitis	
Dermatological: atopic eczema	
Haematological: folate deficiency	
Sexual health: contraceptive advice	
Systemic infection: measles	

Taking responsibility for management: No

1B (Diagnostic: Yes)	2B (Diagnostic: No)
Mental health: phobias	Mental health: autistic disorder
Cardiovascular: acute myocardial infarction	Cardiovascular: dilated cardiomyopathy
Respiratory: acute epiglotitis	Respiratory: tuberculosis
Gastro-intestinal: acute pancreatitis	Gastro-intestinal: pancreatic neoplasms
Musculoskeletal: fracture of the hip	Musculoskeletal: juvenile rheumatoid arthritis
Eye: cataract	Eye: hyphaema
Ear, nose and throat: mastoiditis	Ear, nose and throat: acoustic neuromas
Female reproductive: placenta previa	Female reproductive: carcinoma cervix
Neurological: nerve entrapment, eg carpal tunnel	Neurological: Guillain-Barré syndrome
Metabolic and endocrine: thyroiditis	Metabolic and endocrine: acromegaly
Renal and GU: testicular carcinoma	Renal and GU: renal vasculitis
Dermatological: basal cell carcinoma	Dermatological: lichen simplex chronicus
Haematological: aplastic anaemia	Haematological: G6PD deficiency
Sexual health: gonococcal infections	
Systemic infection: malaria	Systemic infection: toxoplasmosis

2.7.2 Example of a complete single system matrix: the cardiovascular system

Taking a significant role in the diagnostic process? (columns: Yes / No)

Taking responsibility for management? (rows: Yes / No)

1A (Diagnostic process: Yes; Management: Yes)

Hypertension
Essential
Isolated systolic
Iatrogenic
Hypotension
Orthostatis/postural
Hypovolaemic shock
Vascular diseases
Phlebitis/thrombophlebitis

2A (Diagnostic process: No; Management: Yes)

Vascular diseases
Giant cell arteritis
Ischaemic heart disease
Angina pectoris
• *Stable*

1B (Diagnostic process: Yes; Management: No)

Hypertension
Secondary
Malignant/accelerated
Hypotension
Cardiogenic shock
Conduction disorders
Bundle branch block
Premature beats
Atrioventricular block
Paroxysmal supraventricular tachycardia
Ventricular tachycardia
Ventricular fibrillation/flutter
Atrial fibrillation/flutter
Vascular diseases
Chronic/acute arterial occlusion
Varicose veins
Venous thrombosis
Peripheral vascular disease
Acute rheumatic fever
Aortic aneurysm/dissection
Arterial embolism/thrombosis
Valvular disease
Aortic stenosis/regurgitation
Mitral stenosis/regurgitation
Tricuspid stenosis/insufficiency
Pulmonary stenosis/insufficiency
Cardiac failure
Ischaemic
Valvular
Hypertensive
Ischaemic heart disease
Acute myocardial infarction
Angina pectoris
• *Unstable*
• *Prinzmetal's/variant*
Other forms of heart disease
Acute and subacute bacterial endocarditis
Acute pericarditis
Cardiac tamponade
Pericardial effusion

2B (Diagnostic process: No; Management: No)

Cardiomyopathy
Dilated
Hypertrophic
Restrictive
Congenital heart disease
Atrial septal defect
Ventricular septal defect
Coarctation of aorta
Patent ductus arteriosus
Tetralogy of Fallot
Valvular disease
Mitral valve prolapse

2.7.3 Example of core conditions related to a particular disease process: infection

Taking a significant role in the diagnostic process? (columns: Yes / No)

Taking responsibility for management? (rows: Yes / No)

	Yes (diagnostic)	No (diagnostic)
Yes (management)	**1A**	**2A**
	Respiratory system	
	Bacterial pneumonia	
	Neurological system	
	Herpes zoster/shingles	
	Eyes	
	Acute bacterial conjunctivitis	
	Renal and GU systems	
	Orchitis	
	Skin	**Skin**
	Cellulitis	Lyme disease
No (management)	**Cardiovascular system**	
	Acute bacterial endocarditis	
	Respiratory system	**Respiratory system**
	Acute epiglotitis	HIV-related pneumonia
		Bronchiectasis
	Digestive system	**Digestive system**
	Appendicitis	Intra-abdominal abscess
		Neurological system
		Prion disease
	Musculoskeletal system	
	Septic arthritis	
	Ear, nose and throat	
	Mastoiditis	
	Peritonsillar abscess	
		Systemic infection disease
		Botulism
	1B	**2B**

2.7.4 Example of a condition matrix for a clinical presentation: chest pain

Taking a significant role in the diagnostic process? (columns: Yes / No)

Taking responsibility for management? (rows: Yes / No)

	Diagnostic process: Yes	Diagnostic process: No
Management: Yes	**1A**	**2A**
		Cardiovascular
		Angina pectoris: stable
	Respiratory	
	Bacterial pneumonia	
	Viral pneumonia	
	Gastro-intestinal	
	Oesophagitis	
	Gastro-oesophageal reflux disease	
	Dyspepsia	
	Neurological	
	Herpes zoster (of chest wall)	
Management: No	**Mental health**	
	Panic disorder	
	Cardiovascular	
	Acute myocardial infarction	
	Angina pectoris: unstable	
	Angina pectoris: Prinzmetal's variant	
	Respiratory	**Respiratory**
	Pulmonary embolism	Fungal pneumonia
	Pleurisy	HIV-related pneumonia
	Gastro-intestinal	
	Acute cholecystitis	
	1B	**2B**

3 The Curriculum Framework

3.1 Introduction to the Curriculum Framework

For a new profession (in some ways even more so than for one that is already well established and understood in the public mind) it is vital that all entrants to the voluntary and or statutory register meet a transparent and agreed professional standard.

The purpose of this Curriculum Framework is to make that professional standard explicit and to set out the criteria which any initial training programme for Physician Assistants must meet, in order to ensure that such a professional standard can be achieved.

To fulfil this purpose, it is clearly important that the document should identify the outcome of any such programme – the competences to be demonstrated by graduates and the clinical problems that they should be able to address. In the case of a programme leading to professional regulation, it is also appropriate that a Curriculum Framework includes certain specifications of structure and content and the nature of the educational process and experience.

However, it is not the purpose of this framework to create homogeneity by placing unnecessary constraints on individual HEIs running Physician Assistant programmes. It is recognised that different institutions have their own constraints and opportunities and may well be tailoring programmes to specific catchment groups. Variation in programmes is, in any case, to be welcomed, as an enrichment of the professional educational resource and the opportunity to develop and share areas of good practice.

The competences set out within this document are therefore a minimum, to which an individual institution may choose to add in determining the outcomes for their own graduates. The length of the programme and the hours of clinical experience (both general and in terms of particular fields) are equally set as minima. Educational process is discussed in terms of the philosophical underpinning and the effect of process on the equipping of the professional for fulfilling their role, rather than in terms of a specification of particular learning and teaching strategies.

This document also proposes a role for a national assessment of competence as a determinant of registration, without wishing to contest the right of individual HEIs to determine the academic award for their own students.

3.2 Principles of learning and teaching

The primary responsibility for the achievement of the required learning rests with the student. It is the responsibility of curriculum developers, programme organisers and teachers to provide educational structures and experiences through which the student can fulfil their

responsibilities. This includes teaching, but also the facilitation of individual and group work and the encouragement of autonomous learning.

Clinical environments provide many of the most important learning experiences for healthcare professionals. Unlike in other learning environments, the education of the student is not the primary purpose of such environments and the student must learn how to make best use of the opportunities available without imposing upon patients or disrupting the provision of service.

The inter-relation of theory and practice is fundamental to the development of professional competence. Students must learn to:

- seek out and recognise clinical applicability while they are undertaking theoretical learning;
- apply the theory they have learnt in the 'classroom' when they are in the practice setting;
- reflect on practice to identify learning needs;
- theorise during practice (ie how to, during a particular practical incident, formulate new ways of thinking and doing, which go beyond what the text book can offer); and
- theorise practice itself (ie how to recognise, in a particular piece of practice, the principles, assumptions, beliefs and theories that actually shaped that practice).

Learning in professional practice is a collaborative activity in which members of one profession or of a number of professions may enhance their ability to achieve common learning needs by working together or may share their knowledge and skills to enable others to satisfy their learning needs. This behaviour should be encouraged and rewarded through the educational process.

Professional practice involves living with uncertainty and making decisions in situations where there is no single right answer and where professional judgement must be used to determine the appropriate response. Learning and teaching in the Physician Assistant programme needs to prepare students for this reality and to equip them to make and live with such decisions.

Learning is moulded and driven by assessment and it is vital that both formative and summative assessment are designed in such a way that this direction coincides with the outcomes stated in the curriculum.

3.3 Learning partnerships

The establishment of effective learning partnerships between the student Physician Assistant and their clinical supervisors is vital to the professional learning process. To be effective, such individual partnerships must be framed by a partnership between the HEI and the service provider which mutually values the role that each plays in shaping and enabling learning.

The learning partnership between the student Physician Assistant and their clinical supervisor moves beyond the traditional approach of apprenticeship. Learning is to be co-directed and questioning encouraged, so that both parties engage more thoughtfully in the processes of teaching and learning. This in turn will provide the basis for more motivated and better-directed education.

For the partnership to work effectively, the clinical supervisor must have an understanding of the educational principles and values underpinning the programme, a detailed understanding of the student's learning needs in the educational experience they facilitate and an understanding of how that experience fits into the totality of the course.

Training in clinical decision making is more complex than training in technical or factual matters. Where circumstances permit, the clinical supervisor will help students to make a professional judgement rather than simply offering their own. Where the supervisor does offer their own professional judgement, they must be prepared for the student to question how that judgement was made. Students in turn must recognise that there is much professional knowledge that is tacit and may be difficult for the supervisor to elucidate.

Both supervisor and student will make efforts to be adaptable to the normal learning or teaching style of the other.

The partnership will be guided by educational principle and must not be a collusion of ease. It is important for the student to be thrown back on their own resources and to learn independently (whether from patients or library/internet resources) even where this may be more time consuming and where it involves a loss of control of the learning agenda by the clinical supervisor.

Where the clinical supervisor is involved in processes of formative and summative assessment, they must recognise both the different and the common intentions of the two processes.

Consequently, this Curriculum Framework supports the belief that the following principles are essential in shaping the education of the Physician Assistant.

- Observation in clinical settings is directed so that student Physician Assistants learn to see, analyse and interpret all that occurs.
- Action (rather than just observation) in the practical setting is essential to foster learning.
- Ongoing dialogue in the clinical setting between educator, clinical supervisor and trainee Physician Assistant is a vital part of the learning process.
- Clinical supervisors help student Physician Assistants to investigate examples of professional judgement in both medical and educational practice.
- Student Physician Assistants solve problems in a range of different practical activities, using critical thinking, creativity and improvisation.
- Clinical supervisors enable student Physician Assistants to develop their use of the processes of deliberation and reflection, encouraging self-knowledge and self-appraisal.

3.4 Aims and outcomes of the Physician Assistant programme

As mentioned previously, this Curriculum Framework aims to identify the core criteria which any Physician Assistant programme will enable students to meet. The statements included in this section may therefore not constitute the complete criteria against which students on any particular programme are judged.

In this section, the broad aims of the Physician Assistant programme are specified. The more detailed learning requirement from the programme, in terms of competences and skills and core conditions, is included on pages 6 to 21 of this document, and further information on clinical conditions set out by level of competence can be found in the accompanying electronic working document: *Matrix specification of core clinical conditions for the Physician Assistant by category of level of competence* at www.dh.gov.uk/news and www.dh.gov.uk/publications (as described in section 1.2).

The programmes aim to produce professionals who have the knowledge, skills and professional behaviours to function as Physician Assistants (and to have their qualification nationally and, potentially, internationally recognised) and the personal and intellectual attributes necessary for lifelong professional development. Such graduates will be:

- safe practitioners working in a wide variety of clinical settings within their scope of practice and agreed supervision;
- expert communicators who are empathic in a manner appropriate to a healthcare profession;
- aware of health inequalities and the challenges of working in a multicultural environment, with patients from diverse social and ethnic backgrounds;
- aware of the limits of their competence and determined to act within those limits;
- trained in the context of multi-professional working in a team environment;
- adept in the use of communication and information technology (C&IT) skills for healthcare;
- capable and motivated lifelong learners who are continually engaged in active professional development;
- understanding of the need to maintain and promote health, as well as to cure or palliate disease, and aware of their obligations to the wider community as well as to individuals; and
- trained to integrate theoretical and clinical learning.

3.5 Structure of the Physician Assistant programme

The structure of the Physician Assistant programme will be highly dependent on the institution running it and the nature of the catchment group for which the course is primarily intended. For this framework it is therefore only possible to state the structural specification which all courses must meet.

3.5.1 Overall length of the programme

The programme will be equivalent in length to a three-year degree programme: ie the minimum length of the programme will be 90 weeks. This is believed to be the minimum length of time required in order to enable the development of the knowledge base and the competences/skills identified above, but also the minimum time in which effective professional socialisation can be achieved. Ninety weeks is equivalent to the six semesters of the standard honours degree programme. Some programmes may choose to follow the standard pattern for a three-year programme. Other programmes are likely to compress the six semesters into two calendar years.

3.5.2 Clinical experience in the programme

Ninety weeks will constitute a minimum of 3,150 hours of nominal study time. Of this time, a minimum of 1,600 will be designated as clinical learning. Up to 200 hours of the designated clinical learning time may consist of learning in skills centres, but a minimum of 1,400 hours will be spent in practice in the clinical area, in substantive attachments to a unit or to a doctor. This includes time spent with the doctor in hospital or general practice, on ward rounds, in clinics, etc, as well as time spent in tutorials. It also includes independent learning in the clinical area that is facilitated by the doctor, or time spent with other healthcare professionals.

It is intended that on qualification the Physician Assistant will be able to undertake first-contact medical care in general practice, emergency departments and general medical hospital wards. There is also the potential to provide 'out of hours cover' in hospital and primary care/community settings with appropriate and adequate medical supervision. For this to be achieved, it is important that students have a breadth of clinical placement. Whilst recognising that many of the competences can be demonstrated and many of the core conditions encountered in any, or at least many, clinical areas, it is felt appropriate to set certain minima for experience in different fields. The minimum core placements are as follows:

Community medicine	280 hours
General hospital medicine	350 hours
A&E	160 hours
Mental health	70 hours
Obstetrics and gynaecology	70 hours
Paediatrics (acute setting)	70 hours

Within this framework of clinical attachment, students must have the opportunity to have experience relevant to a broad range of core areas identified in National Service Frameworks.

This adds up to 1000 hours, leaving a minimum of 400 hours to be designated by individual institutions. Although not a requirement, institutions will be encouraged to use these 400 hours to extend the time spent in core placements, reflecting local educational opportunity, rather than simply to broaden the training circuit. In addition, institutions will be encouraged to maintain flexibility in their programmes which would allow individual students to spend further periods of time in a clinical area in which they were experiencing some difficulty in achieving the learning or, alternatively, in which they had a particular interest.

3.5.3 Progression

Progression through the programme is largely a matter for regulation by individual HEIs, but all institutions must ensure that they have in place a rigorous and formally constituted process to ensure that student progress is dependent on the demonstration of appropriate clinical skills and the development and maintenance of appropriate professional performance (fitness to practise) as well as on what might be considered the standard basis of academic performance.

As with other professions, acceptance for registration is dependent on a combination of both academic achievement and a statement from the institution of the candidate's fitness to practise, in terms of professional behaviour and clinical competence.

Following registration it is recommended that there will be a period of internship during which levels of supervision are such that supervisors, in partnership with the relevant HEI, are able to sign off practitioners as able to apply their knowledge and skills appropriately in clinical practice. This is aimed at ensuring that clinical practice is provided in a manner that is safe and productive. Assessment of practice in the 'real world' adds value in that the exposure to these pressures and circumstances of clinical practice can be assessed more fully.

Recommendation 2

A period of internship of 12 months is required for the smooth transition between trainee and regulated professional. This would be a period to consolidate skills rather than a formal education programme and consequently the internship would be a salaried position that provides service and has a direct impact upon patient care. During this period the Physician Assistant will be responsible for their own caseload and have the right to refer patients to appropriate diagnostic facilities and to other practitioners with specialist skills.

3.6 Criteria for entry to the programme

3.6.1 Major entry groups

It is envisaged that, during the early implementation of Physician Assistant programmes produced on the basis of this framework, there will be two main catchment groups from which students will be drawn – life-science graduates and existing health professionals. Universities may tailor the programmes they offer to one group of candidates or the other and select accordingly. In their selection processes for their programmes, we would encourage universities to recognise and value life experience as well as proven academic ability.

Whichever catchment a university is drawing on, the institution has a duty to ensure that the students it recruits to its programme are 'of good character' as well as academically capable of completing the course and undertaking the clinical role. As specified by the General Medical Council (GMC), with regard to undergraduate medical training:

"Universities have a duty to make sure that no member of the public is harmed as a result of taking part in the training of their medical students. Medical students cannot complete the undergraduate curriculum without coming into close, and sometimes intimate, contact with members of the public who may be vulnerable or distressed. The vocational part of their training, which prepares them for clinical practice when they become registered doctors, is such that they may not be directly observed or supervised during all contact with the public, whether in hospitals, in general practice or in the community."

The means by which the character and capability of candidates are assessed is a matter for individual institutions or groups of institutions. However, in determining admission processes, institutions must be cognisant of developing practice in other healthcare professions* and the

* This might include, for example, developments aimed at assessing the intellectual capacity of candidates as opposed to their achievement (eg the Medical School Admission Test) and/or admission processes which allow institutions to broaden the basis of selection beyond the traditional mix of paper qualification and interview, to include team working, debating current issues, problem-solving, interpersonal skills etc.

need to take opportunities to widen participation in both higher education and the NHS. However, account needs to be taken of the eventual acceptability of candidates to the regulatory body (eg candidates previously removed from a professional register, those with a criminal record etc).

3.6.2 Other entry routes

Some of those interested in training as a Physician Assistant may not have the professional experience or appropriate education to allow direct entry to Physician Assistant programmes. As the Physician Assistant role becomes better known, the catchment may include mature students looking for a change in career and school leavers selecting a Physician Assistant career. It may also include medical technicians/assistants in the armed services looking for professional development within the forces or a means of ensuring a career path when they return to civilian life. In this context, HEIs offering Physician Assistant programmes may wish to look at graduates from degrees or other preparatory programmes, or to consider providing access routes into Physician Assistant programmes.

3.6.3 Transitional arrangements

A number of trainees on recognised Physician Assistant pilot programmes would like to be among the first to register as home-grown Physician Assistants. From a patient safety point of view there is nothing to be gained by requiring this group to undertake formal training, once it exists, if it replicates training they have already received while developing the role. However, there is a need for individual practitioners to demonstrate their fitness to practise against the standards of proficiency based on the competences developed once the role itself has been established and the decision taken to regulate it in its own right. So all those who wish to practise in the role will need to demonstrate that they are fit to practise as such to achieve registration in the new role. Such trainees are an important resource, and institutions offering approved Physician Assistant programmes set up under this Competence and Curriculum Framework will seek to provide tailored 'fast track' courses to meet the needs of these individuals, through the accreditation of prior learning/experiential learning (APL/APEL).

3.6.4 APL/APEL for other groups

Although current Physician Assistant trainees seeking to top up their existing learning are the most pressing group to consider in terms of APL/APEL, there may well be a flow of highly experienced personnel from other health professions who would wish to receive a shortened training. In this context, it is important to identify that the Physician Assistant role differs in important respects from roles that such candidates have previously undertaken. There are issues of socialisation into the Physician Assistant profession that can only be achieved through an accepted quantum of experience as a Physician Assistant trainee. In addition, it should be noted that experience in a given clinical area (eg as a nurse working in A&E) may not necessarily mean that there is no need to undertake experience in that field as part of Physician Assistant training. Having said this, there are clearly circumstances where APL/APEL would be appropriate, but any other health professional, whatever their experience, will undertake a minimum of 1000 hours of clinical experience as part of Physician Assistant training. The clinical fields in which the 1000 hours is spent will depend on prior learning and experience.

4 Assessment

4.1 Definition of competence

In common usage, the word 'competent' often implies 'only just good enough', ie 'not incompetent, but not very good either'. When the term competence is used in this document, it refers to a specified level of capability or proficiency in relation to an activity (see definition in the next paragraph). Although the achievement of such competences may define the borderline between the student passing and failing, they do not define the borderline between competent and incompetent and are generally set at a high level of performance.

In this framework competence is defined within a professional context as the broad ability with which a professional person is able to practise to the required standards in a predetermined range of clinical fields and across a range of situations. This broad definition includes attributes that can be applied, clinical performance (Stuart, 2003) and the use of professional judgement (Carr, 1993).

Competences therefore are the elements performed to the predetermined standard, which combine to create professional competence in a defined role (Stuart, 2003).

4.2 Roles of assessment

Assessment fulfils a number of roles in an educational programme leading to a professional qualification. These can be primarily divided into summative and formative roles.

Summative assessment relates to the setting of standards and of assessments to judge whether standards have been met, and it thus protects the public and, in this case, the health service by ensuring that all those qualifying from a course have achieved the required competences and knowledge, and the skills and professional behaviours that underpin them. Equally, it protects the educational institution by ensuring that there is no devaluation of the degrees or other qualifications that they offer.

Formative assessment is a 'no stakes' process, in as much as failure does not bar progress or affect grades or classification, but it is no less important for that. Its main purpose is to provide feedback and enable students to identify their learning needs, so that they can focus their future efforts effectively.

Formative assessment is a largely continuous rather than event-based process, with a portfolio playing a key role. The portfolio will include a log of experience and a reflective diary. This would form the basis for discussion with personal tutors and mentors so that students can receive appropriate guidance and feedback. It must be structured in such a way that it encourages students to recognise weaknesses as well as demonstrate strengths and to determine their learning needs accordingly.

The two types of assessment (formative and summative) both have a role in shaping learning. Although formative assessment may enable a student to prioritise learning in response to their current performance profile, it is summative assessment that sets the learning agenda in the first place. All candidates look at what they are going to be tested on and what form the test will take, as a major determinant of what they are going to learn. Assessment drives learning, and, if the problems associated with a hidden curriculum at variance to the published curriculum are to be avoided, there is a need to ensure that the syllabus is in concordance with the programme – in other words that the pattern of assessment is what would be expected from the pattern and purpose of the curriculum.

In the case of Physician Assistant programmes, it is vital that assessment will drive students towards education, intellectual development and the application of knowledge and professional judgement, rather than just training, the simple accumulation of knowledge and the unquestioning use of protocols.

In setting standards to be tested, it is vital that knowledge, skill and professional behaviour, although they may be used together in the clinical environment, are seen as constituting separate domains for the purposes of assessment; that there can be no compensation between them; and that a satisfactory standard must be demonstrated in each. It is as inappropriate for a student who has 'a good way with patients' to be allowed to graduate, despite a lack of knowledge, as it is for academic brilliance to be allowed to compensate for a lack of probity in a student.

The nature of the assessment process appropriate to one domain may be entirely different from that for another. Students need to demonstrate that they can perform a particular skill. Skill development takes longer for some students than for others, and it may be perfectly appropriate for them to go several times around the learning and testing cycle until they have achieved the standard required. It may be perfectly appropriate for students to demonstrate in an examination that they can apply knowledge and professional judgement in a given scenario, but in terms of professional behaviour they need to demonstrate that they habitually act in an appropriate way towards patients rather than that they can behave appropriately in an examination situation.

4.3 National assessment and accreditation

There will be a national assessment (theoretical and clinical) taken by all Physician Assistant students, to assess their core knowledge, skills and attitudes. Individual institutions may incorporate this into their overall assessment package as a component of a graduating examination, or may choose to use it as a separate and additional hurdle, relating to registration rather than academic qualification. In either case, the individual institution is left free to set further assessments on the basis of any additional elements and the academic level of the programme. Such a national assessment is the only way to ensure that a common standard is met by all entrants to the Physician Assistant profession, since, because the profession is new, the published professional standard may be open to different interpretations by different institutions.

Qualification from the Physician Assistant programme will be followed by a 12-month period of internship in an approved training environment, during which time Physician Assistants will be supervised more closely and their 'competence in action' will be formally assessed on an ongoing basis. Registration will be dependent on this assessment, and Physician Assistants who do not demonstrate the required competence in action will be offered an additional period of provisional registration and training. Ultimately entry onto the full register must depend on satisfactory performance.

In addition to any requirement by the regulator for intermittent re-application for registration on the basis of CPD, it is proposed that all Physician Assistants be required to take a national examination on a five-yearly basis. This reflects the recommendation for revalidation of all healthcare professionals in *Healthcare Professional Regulation: public consultation on proposals for change*. The re-accreditation examination will be closely related to that for initial accreditation, requiring candidates to demonstrate that they have maintained competence across the whole range of potential clinical settings, rather than simply having developed expertise in the single setting in which they have been working. It is this maintenance of general competence that maintains career flexibility and transferability for the Physician Assistant and offers a major advantage to doctors and others working with Physician Assistants. In the context of secondary care, the breadth of competence is a useful counterbalance to the increasing specialism of the doctor and ensures that concurrent problems that are relevant but outside the specialism (eg mental health problems in the surgical patient, cancer in the client at the alcohol dependency unit) are not missed by the team.

4.4 Criteria for assessment and standard setting

Although the professional standards which qualifying Physician Assistants are expected to achieve are set out in some detail in the competences, skills and core conditions, such specifications are still open to interpretation, and a common standard for all registrants can only really be achieved through a common assessment process. As a minimum, it is proposed that a national paper- or computer-based examination be used for the assessment of knowledge and that there will be a national assessment of clinical competence. In addition, comprehensive national criteria will be set for the content of and expectation in locally held assessment of competence, decision making, professional behaviour etc.

Although a common standard is, in itself, very important, it is equally important that the standard set is correct, that the assessment is reliable (ie that it is maintained from one type of assessment to another), that it is rigorous (ie that candidates cannot pass by chance), that it is valid (ie it tests what it purports to test) and that it is congruent with the stated aims of all the curricula developed under this framework.

This requires a rigorous and formalised process of standard setting (eg modified Angoff or borderline method) for individual examination papers, so that any variation in the pass/fail standard between sittings is smoothed out. It is equally important that reliability is ensured in assessments of practical competence, problem-solving etc. The most common method for undertaking standard setting in this context is the borderline group method.

Recognising that this is a new profession and that maintenance of patient safety is paramount, the establishment of a National Examination Board is recommended. It is envisaged that this National Examination Board ensures consistent national professional standards at the introduction of the profession and is responsible to the regulator.

Such a board would need to be constituted as the sole provider of assessment for the register. It would need to have the support of all HEIs running courses leading to registration, both in terms of valuing its role in standard setting and the standards set and in terms of practical support – the provision of questions and assessment 'stations', involvement in the professional standard-setting process, and involvement in assessing, moderating and external examining.

Recommendation 3

A single national assessment for the profession will be in place before entry onto the statutory register. This is required to establish parameters of competence and for building public confidence.

4.5 Maintaining professional competence

As with any profession, the Physician Assistant will need to undertake CPD to maintain and update their professional competence and to fit it to the professional role they are required to undertake. However, it is one of the strengths of the role that the practitioner will be expected to maintain a generalist capability, whatever field they happen to be working in at a given time. For the Physician Assistant working in a specialist field, or taking special interest in particular aspects of a generalist role, the purpose of CPD is twofold and must involve both a generalist and specialist component.

CPD taken as a whole is likely to be assessed by a rigorous approach to regular appraisal with consistency of application, as recommended by the Department of Health (2006) in the recently published review of regulatory arrangements for non-medical healthcare professions, *Healthcare Professional Regulation: public consultation on proposals for change*. Such an approach will enable the Physician Assistant to demonstrate that they have undertaken sufficient learning to support their practice (eg by the compilation of a portfolio of evidence). There will be a requirement for a certain quantity of learning to have been undertaken during any period of professional practice, but the focus of that learning will normally be determined by the Physician Assistant, with or without input from their supervising doctor.

This revalidation system is closely linked to the principles of assessment outlined in section 4.2 and will be both formative (an aid to development) and summative (a check that a required standard is met) and will demonstrate that a person remains safe to practise for the purpose of protecting the interest and safety of the patient, meeting the employer's (or commissioner's) needs and the regulator's requirements.

Within the NHS, the Knowledge and Skills Framework (KSF) will form the basis of ensuring that professional competence is maintained (Department of Health, 2004). The main purpose of the KSF is to provide an NHS-wide framework that can be used consistently across the service to support personal development while in post, career development and service development. KSF post outlines (full and foundation) for the Physician Assistant role can be accessed at www.e-ksf.org

Whatever the profession, CPD must be highly individualised, and the determination of content and therefore outcome is largely a matter for each professional. Although the Physician Assistant remains free to choose the content of their CPD, they have to be aware that there will be formal periodic assessment of their generalist capability, and the outcome of the generalist component of the CPD must support them in achieving the required standard.

4.6 Periodic assessment and the maintenance of registration

As the Physician Assistant role is a new profession within the UK health services, in order to further assure public safety it is suggested that, on a five-yearly cycle, each Physician Assistant will have to demonstrate that they have maintained the generalist capability central to the role. For this purpose a national examination will be set, which will focus on knowledge but may also involve assessment of core skills. The assessment is about knowledge applied in practice and the level of competence that will be required of the qualifying Physician Assistant after the period of internship referred to in section 3.5.3.

Since the assessment is intimately involved with the maintenance of the professional register, it is anticipated that the registering body, or an expert panel designated by the registering body, will:

- remind Physician Assistants of the date by which they must have passed the periodic assessment in order to maintain unbroken practice;
- construct the assessment and set professional standards;
- administer the assessment and manage the processes of marking and moderation; and
- inform Physician Assistants of the outcome of the assessment and arrangements for any reassessment required.

Periodic assessment and the maintenance of registration for the Physician Assistant role will be subject to further consideration in light of the public consultation on the regulation of healthcare professions, *Healthcare Professional Regulation: public consultation on proposals for change*.

Recommendation 4

Although it is not currently applied to any healthcare profession, the regular compulsory periodic assessment of knowledge through testing will be introduced to ensure the underpinning principles of demonstrating public safety and maintaining generalist function. The passing of the test every five years will be a condition of continuing use of the protected title. The first periodic compulsory test will be available within five years of the protected title being established so that it may be tested.

4.7 Funding

The NHS has traditionally commissioned a range of non-medical educational programmes that deliver the NHS workforce through the Multi Professional Education and Training (MPET) budget. It is envisaged that education programmes that lead to the Physician Assistant qualification will be commissioned through the flexible use of this budget. Alternative funding streams should not be discounted, and significant sums are available through negotiation with bodies that fund higher education such as the Higher Education Funding Councils. It is also envisaged that students will also fund themselves through such courses as they recognise the potential for future earnings and the global transferability of the role.

Uncertainty remains with regard to the likely costs of provision of periodic assessment of CPD. Should the profession grow then the professional body representing Physician Assistants will lead the development and maintenance of their professional standards. However, the public needs to be reassured that the standards cannot be compromised through a conflict of interest and therefore sufficient safeguards will need to be in place (similar to those in other healthcare professions) to protect the public.

Recommendation 5

Compulsory periodic assessment will be funded through test fees paid by the individual.

5 The core syllabus

Any division of curriculum content into separate subjects may suggest barriers which are not really there. Whether focusing on the domain level of knowledge, skills and professional behaviours or the discipline level of anatomy, ethics and immunology etc, the whole purpose of the curriculum is to provide graduates with an integrated platform from which to undertake the professional role.

Although the following sections of this framework necessarily separate out the various strands of professional learning, for the purpose of specifying the core elements which must be included in the whole, any curriculum must explicitly help students to integrate these areas of study into a meaningful whole.

5.1 Core theoretical knowledge

As with the specification of clinical experience, it is not intended that there will be a national specification to identify the whole theoretical input that might be included in any given programme, but only those aspects which all Physician Assistant students will cover.

Equally, the detailed structure and provision of such a programme of theoretical knowledge to students is not specified. The information is presented on the basis of standard academic subject areas (itself an unlikely structure for a Physician Assistant programme), so that individual institutions have free rein to offer courses structured on a systems-based approach, problem-based learning etc. For each academic discipline, the information is structured as shown in the list below.

The list of theoretical (ie non-clinical) knowledge subject areas to be covered in the core syllabus is as follows. The list is alphabetical and does not suggest chronological order or the subject's priority or the amount of time it will have within the programme. In addition, there are a number of threads which will run throughout the programme, including diversity in society and the appropriate professional response, competence as a user of and participant in research, and the basis of inter-professional working.

Anatomy
Biochemistry
Communication
Development, growth and reproduction
Ethics and law
Health education
Healthcare policy
Histology
Immunology and microbiology

Pathology
Pharmacology and therapeutics
Physiology
Psychology
Public health and epidemiology
Sociology
Teaching and assessing
Health informatics

6 Validation, accreditation and evaluation of the programme

Validation, accreditation and evaluation are central elements of the quality assurance process in professional education. Although the processes are interlinked in their aims, each is carried out separately by the body or group with the legitimate authority to do so.

6.1 Validation and accreditation of the programme

Validation refers to the approval process applied by each university to the programmes they run. It will normally require the submission of detailed plans for the programme and for individual modules. Each university will complete a self-assessment to assure itself that there is a market for the programme, that it is supported by effective management structures and resources, that it is fit for purpose in terms of the level and content of the education it purports to offer and that the processes of assessment are sufficiently rigorous to differentiate appropriately between those who have and those who have not achieved the required standard.

Accreditation refers to the equivalent approval process as carried out by the competent professional or regulating body (eg the GMC for medicine). The purpose of accreditation is for the body to assure itself that all programmes conferring professional registration on those qualifying will enable the appropriately selected and duly diligent student to achieve nationally agreed minimum standards in relation to knowledge, skills and attitudes. In the case of Physician Assistants it is expected that the professional body will carry out this function under the umbrella of the appropriate regulating or registering body. Until the Physician Assistant title is registered and a formal professional body is established, it is proposed that this function will be performed by a panel drawn from the Curriculum Framework and Competence Steering Group, the Physician Assistant National Programme Board and the participating HEIs.

Where appropriate, validation and accreditation can be carried out through a single joint process, enabling negotiation on any issues dividing the validating and accrediting bodies.

It is recognised that interim arrangements will be required to ensure that HEIs who develop a Physician Assistant education programme meet the requirements of the regulator. To ensure this is realised, robust transitional arrangements that are transparent and open to independent scrutiny are essential. Although the consultation document suggested that this could be done internally, the responses pointed out that there could be conflicts of interest with those who developed the Competence and Curriculum Framework. This needs to be avoided at all costs, although we need to recognise that the in-depth knowledge of those who developed the framework have a role in validation.

Recommendation 6

The validation and accreditation of Physician Assistant programmes of education will be carried out in accordance with the requirements and standards of the approved regulator. Interim arrangements will be transparent, will involve and be subject to independent academic, service and public scrutiny and will be able to transfer smoothly to the appointed regulator when appropriate.

Recommendation 7

Although there was no consensus in the consultation regarding the role of the regulator in assessment and validation of education programmes, the regulator will have the primary role in accrediting courses that lead to entry onto the statutory register and the ability to practise in the UK using the protected title.

6.2 Evaluation of the programme

Universities will have their own regulations regarding the evaluation of programmes which they validate. These regulations usually relate to the formal, cyclical processes of review, although review, in its turn, will require the submission of evidence from evaluation of the programme by individual students and their teachers or supervisors.

Evaluation will take account of as wide a range of audiences as possible. It will cover all aspects of the programme, and reports will be sought both orally and in writing. The evaluation will be focused on the intentions of the programme, as expressed by aims and learning outcomes, and the utility of teaching and available learning opportunities for enabling outcomes to be achieved.

The university-led processes of cyclical review will not usually be replicated by the professional body, which will have access to all relevant university reports. However, such processes may, on occasion, be supplemented by the professional body, to explore different perspectives or areas.

7 Regulation and accountability

7.1 Professional title

It is acknowledged that the title for this profession needs both to reflect the proposed role and to avoid confusion between this and other healthcare professions. Legal advice will be sought on the viability of the final preferred protected title.

Recommendation 8

Although the regulator will determine the regulated title, the working title of Physician Assistant was overwhelmingly considered to be the most appropriate. Until such time as appropriate (ie when the profession is firmly established) the working title Physician Assistant will be adopted. The regulator will consider and approve the appropriate protected title.

7.2 Regulation and registration*

It is expected that new legislation will enable Physician Assistants to be registered as a separate profession. A separate regulatory framework is necessary because the proposed role is inherently and sufficiently different from that of existing professions and their primary regulated roles (as opposed to extended practice).

Statutory regulation has four functions:

- To set standards of proficiency (competence), ethics and conduct for practitioners of a profession.
- To set standards for education and training which will produce competent, safe and effective practitioners in that profession.
- To keep a register of those who meet the standards and are fit to practise.
- To have a mechanism for dealing with those registrants who stop meeting the standards and need to be removed or restricted from practice, by investigating complaints and taking any necessary action to restrict their practice.

As registered professionals, Physician Assistants will be accountable for their own practice and subject to the requirements of the regulator.

* This section is subject to further consideration from a legislative and regulatory perspective and expresses one of a number of views. All the concurrent positions will be considered as part of the public consultation process on the review of regulation of non-medical healthcare professions (Department of Health, July 2006).

The regulation of the non-medical healthcare professions consultation document (Department of Health, July 2006), recommends that one or more existing regulators will become the 'lead regulator' for new groups such as the Physician Assistant role. The lead regulator will set the standards applying to everyone registering as a Physician Assistant, whether a direct entrant or from an existing profession. Work remains to be done about the exact form regulation of new non-medical professional roles should take, subject to the outcome of the consultation.

7.3 Accountability and supervision

It is envisaged that supervising doctors will be accountable overall for the work of the Physician Assistant, in a similar manner to their responsibilities for trainee doctors, non-consultant career grade doctors and staff grade and associate specialist grade doctors. Individual Physician Assistants will still be accountable for their own practice, within the boundaries of supervision and defined scope of practice. Supervising clinicians must accept overall responsibility for any duties that are undertaken by a Physician Assistant in training or a qualified Physician Assistant. On this basis, doctors will determine the scope of duties and responsibilities of the Physician Assistant on the basis of known competence within the relevant area of practice.

Physician Assistants work under the supervision of doctors throughout their professional lives. Although this may appear to contrast with autonomous practice in nursing and other health professions, it should be remembered that all health professions, including doctors, remain professionally and managerially accountable to others throughout their working lives despite being independent, clinically autonomous practitioners. The particular position of the Physician Assistant relates to the fact that they are working in association with and under the supervision of the doctor as an integral part of the medical team. Those who come from other professions, but wish to undertake the Physician Assistant role, must recognise and respect this relationship.

8 The proposed timeframe

It is evident that a number of employers view the Physician Assistant role as necessary in delivering care in primary and secondary care settings. This is demonstrated by the employment of an increasing number of US-trained Physician Assistants within England, Wales and Scotland. As mentioned earlier, these ad hoc arrangements, while successfully addressing local need, have resulted in the growth of non-regulated professional groups with no assimilation, equivalency or incorporation into the UK regulatory framework.

The results of the public consultation will shape the development of the processes required to ensure public safety of the role, and its equivalencies. A number of HEIs have developed, or are developing, Physician Assistant-type courses as local employers are seeking to replicate the US-type Physician Assistant to serve their local health economy.

Consequently, there will be a requirement for employers to have established a framework for employment of this type of post in a regulated manner by 2007.

9 Glossary of terms

APL/APEL	Accreditation or assessment of prior learning/experiential learning.
Appraisal	The process by which others (whether peers, superiors or others) help a person to review their performance and draw lessons from it.
Carer	Someone who, without payment, provides help and support to a partner, child, relative, friend or neighbour who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability.
Child or young person	Someone up to the age of 19 (up to the day before their 19th birthday) or care leavers up to the age of 21 (up to the day before their 21st birthday or beyond if they are continuing to be helped with education or training by their local authority) or up to 25 (up to the day before their 25th birthday) if they have learning difficulties or disabilities.
Clinical supervisor	A senior registered medical practitioner with responsibility for an identified trainee Physician Assistant within their medical team.
Co-morbidity	Co-existence of more than one disease in an individual patient.
Competence	A practitioner's current ability to practise an entire role, combining individual competences and the use of wider judgement through the consistent integration of skills, knowledge, attitudes, values and abilities that underpin safe and effective performance.
Continuing Professional Development (CPD)	A process of lifelong learning for all individuals and teams which enables professionals to expand and fulfil their potential and which also meets the needs of patients and delivery of the health and healthcare priorities of the NHS. CPD should be purposeful, patient-centred and educationally effective.
Core knowledge	The content of medical practice that is common to all medical specialties.
Curriculum Framework	The main educational policy document providing the background, development entry routes, definitions, structure of education and training, and assessment strategy for trainees on the programme.
Differential diagnosis	Distinguishing between two or more diseases and conditions with similar symptoms by systematically comparing and contrasting their clinical findings, including physical signs and symptoms, as well as the results of laboratory tests and other appropriate diagnostic procedures.

Medical model	The medical model is a perspective which is predominantly concerned with the diagnosis and treatment of disease that is based on pathology and disease processes, but which places this within the context of the individual patient and their social context.
Patient-centred care	Care which explores (a) the patient's main reason for the visit, concerns and need for information, (b)seeks an integrated understanding of the patient's world – that is, their whole person, emotional needs and life issues, (c) finds common ground on what the problem is and mutually agrees on management, (d) enhances prevention and health promotion, and (e) enhances the continued relationship between the patient and health professional.
Performance	The manner in which a practitioner has carried out a particular task or function. This is the observable part of competence.
Professional judgement	The application of relevant knowledge and experience within the context provided by clinical standards (that reflect the collective judgement of the profession) and rules of professional conduct in reaching decisions where a choice must be made between alternative possible courses of action.
Regulation	The set of systems and activities intended to ensure that healthcare practitioners have the necessary knowledge, skills, attitudes and behaviours to provide healthcare safely.
Revalidation	The process by which a regulated professional periodically has to demonstrate that they remain fit to practise.

10 Bibliography

Anaesthesia Practitioner Curriculum Framework (Department of Health, June 2005)

Carr, D (1993) Questions of competence, *British journal of educational studies*, **41**: 253–71

Children's Workforce Strategy: A strategy to build a world-class workforce for children and young people (HM Government, 2005)

Common Core of Skills and Knowledge for the Children's Workforce (Department for Education and Skills, 2005)

Core Standards Document, National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004)

Curriculum for the Foundation Years in Postgraduate Education and Training (Academy of Medical Royal Colleges and Department of Health, 2005)

Curriculum Framework for the Surgical Care Practitioner (Department of Health, March 2005)

The European Working Time Directive for junior doctors – a review of the available information and guidance (Clinicians in Management, London vol 12, no 3, British Association of Medical Managers, 2004)

Evaluation of US trained Physician Assistants working in the NHS in England (Health Services Management Centre, Birmingham University, 2005)

General Medical Council, *Good Medical Practice* (GMC, May 2001)

Good doctors, safer patients: proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients (Department of Health, July 2006)

Healthcare Professional Regulation: public consultation on proposals for change – Good doctors, safer patients and *The regulation of the non-medical healthcare professions* (Department of Health, July 2006) (www.dh.gov.uk/Consultation/LiveConsultation/fs/en)

Hospital at Night (www.wise.nhs.uk/hospitalatnight)

HR in the NHS Plan (Department of Health, 2002)

'Keep Me Safe': The Royal College of General Practitioners strategy for child protection (RCGP, September 2005)

Medicines Matters: A guide to current mechanisms for the prescribing, supply and administration of medicines (Department of Health, National Practitioner Programme, July 2006) www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/fs/en

Modernising Medical Careers (www.mmc.nhs.uk)

NHS Knowledge and Skills Framework (Department of Health, October 2004) (www.dh.gov.uk/PolicyAndGuidance) (www.e-ksfnow.org)

NHS Plan (Department of Health, 2000)

The NHS Career Framework (www.skillsforhealth.org.uk/careerframework)

The NHS Improvement Plan: Putting People at the Heart of Public Services (Department of Health, 2004)

Primary Care Version, National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004)

Stuart, CC (2003) *Assessment, Supervision and Support in Clinical Practice*, Churchill Livingstone, Edinburgh

Acknowledgements

The contributions and ongoing support of the following individuals and organisations throughout the development of this document are warmly acknowledged.

Members of the Competence and Curriculum Framework Steering Group:

*Mary Armitage – Clinical Vice-President, Royal College of Physicians (co-chair of steering group)

*Nigel Sparrow – Vice-Chairman, Royal College of General Practitioners (co-chair of steering group)

Jim Parle – Professor of Primary Care, University of Birmingham

Nick Ross – Director of Learning and Teaching (Medicine), University of Birmingham

Philip Begg – Associate Dean in Primary Health, University of Wolverhampton

Andrew Butcher – Project Consultant, Skills for Health

Jenny Manning – Technical Consultant, Skills for Health

Alison Baker – Director of Professional Development and Quality, Royal College of General Practitioners

Mike Wallen – Royal College of General Practitioners Patient Partnership

Declan Chard – Chair, Royal College of Physicians Trainees Committee

Sunny Kaul – Public Relations and Communications Officer, Royal College of Physicians Trainees Committee

Peter Lapsley – Royal College of Physicians Patient and Carer Network

*Christine Homer – Workforce Modernisation Manager, Birmingham and the Black Country Strategic Health Authority (SHA)

*Kirsten Gipson – US-trained Physician Assistant working in the West Midlands

*Robert Standfield – Lead Workforce Designer, National Practitioner Programme

*Cheryl Wright – Workforce Designer, National Practitioner Programme

*Jo-Anne Welsh – Associate Workforce Designer, National Practitioner Programme

*Alison Belk – Business Manager, National Practitioner Programme

(*Also members of the Physician Assistant National Programme Board)

With additional advice from:

The Physician Assistant National Programme Board (chaired by Dr David Colin-Thome)

Alan Pearce – Defence Medical Education & Training Agency

Alexandra Mortimer – Deputy Project Manager, New Regulation Projects, Department of Health

Alison Donaldson – Patient Representative

Benny Hartson – Royal College of Nursing (Nurse Practitioner Association)

Caroline Hopper – Service Improvement Lead, South West London SHA

David Colin-Thome – National Director for Primary Care, Department of Health

Eve Jagusiewicz – Policy Adviser, Universities UK

Jane Tobin – Health Strategy Consultant, South West London SHA

Kay East – Chief Health Professions Officer, Department of Health

Lynn Young – Primary Care Adviser, Royal College of Nursing

Maureen Morgan – Professional Officer, Policy & Practice, Department of Health

Olwyn Westwood – Reader in Medical Education, University of Surrey at Guildford

Rikki Chamberlain – Training Analyst, Royal Navy (Warrant Officer 1), Institute of Naval Medicine

Rosalind Mead – New Regulation Projects Manager, Department of Health

Roy Manwaring – Head of Training, Institute of Naval Medicine

Simon Green – Assistant Director Workforce Transformation, North East London SHA

In addition to those mentioned above, the core reference group for the development of the Competence and Curriculum Framework for the Physician Assistant role comprised the following contributors:

Julia Henderson, Barry Hunt and Guy Dean, University of Hertfordshire

Tim Heymann and Di Jackson, St George's University of London

Janice Forbes-Burford, London South Bank University

Carol Bailey and Lilian Richardson, University of Surrey

Hilary Paniagua and Ingrid Callwood, Wolverhampton University

Managers and clinicians from pilot sites in:

North East London – Dr Shahid Dadaboy, Karen Stubbs, Heather McKoy, Julie Dalphinis

South West London – Dr Chris Streather, Sue McDonagh

Birmingham and the Black Country – Chris Homer, Rachel Catanzaro, Lynn Tyrer

The Armed Services

Neale Piper, Iain Dell (Lt Cdr)

National Practitioner Programme

Jacqueline Younger – National Practitioner Programme Lead

Effie Stevenson – National Practitioner Programme Communications Manager

Royal College of Physicians Education Department

David Parry

APPENDIX

National Practitioner Programme

Medical Care Practitioner Competence and Curriculum Framework public consultation (November 2005 to February 2006) – summary of responses

Introduction

The following pages provide a summary evaluation of the numerical data and noteworthy comments from the Medical Care Practitioner (MCP) Competence and Curriculum Framework public consultation document. The consultation document was developed over 12 months and the process was led, on behalf of the MCP National Programme Board, co-jointly by the Royal College of Physicians and the Royal College of General Practitioners. The public consultation period ran from Friday 4 November 2005 to Friday 10 February 2006.

The consultation document was constructed to give the reader an introduction to the role, its potential scope of practice and an outline of the competences required to fulfil the role and broad scope of the intended curriculum. The intention of the document was to solicit opinion about these facets of the role and not necessarily scope the need for the role as this will be determined by local service and workforce planning across health and social care.

The document was developed with reference to the US Physician Assistant model, a role that has been established there for over 40 years. Similar roles are currently being developed to address service and workforce needs across the world.

During the consultation period 1650 copies of the document were distributed via a combination of email and telephone requests, distribution at workforce and service redesign events and through national/local networks. At the end of the consultation period we received 258 responses. These responses ranged from one-line opinions and brief perceptions of the role to full reflections of the whole document and consideration of all the questions asked. The responses included responses from individuals and organisations, including organisations mandated to respond on behalf of their members and organisations who sought consensus from a variety of stakeholders. A full list of organisations who responded to the consultation can be found at the end of this document.

The following pages provide a summary of the responses to each of the questions asked within the document.

Summary of responses

Question 1
Do you believe that the practitioner should have access to a prescribing formulary identical to that of their supervising physician to be used within local agreed guidelines?

The majority of respondents agreed that the MCP should have access to the prescribing formulary identical to that of their supervising physician. Many respondents highlighted the need to adhere to local policies and guidelines.

Question 2
What are your views on the proposed standard of proficiency as set out in the preceding sections, which focus on competence, procedural skills and core clinical conditions, in terms of the level at which the practitioner will practise upon registration?

The majority agreed with the proposed standards of proficiency for a newly qualified MCP as set out in the document.

Question 3
Would you agree that there should be a period of 'probationary practice' post academic qualification and prior to formal registration as an MCP?

Most were in agreement with a period of probationary practice.

Question 4
If you agree that there should be this period, how long should it be and what should be the outcomes?

Although responses ranged from a period of 3 months to 2 years, the general opinion was for a period of 6 to 12 months.

Question 5
During this period would you agree that the practitioner should have their own caseload?

The majority supported the idea of practitioners having their own caseload and believed this would be necessary to demonstrate the achievement of desired competences.

Question 6
During this period would you agree that the MCP should be able to refer on to other practitioners including hospital consultants, therapists and other specialist medical services?

The majority of respondents were in agreement.

Question 7
Would you agree that arrangements need to be put in place to assimilate practitioners who meet the competences of the MCP into the regulatory process?

There was general agreement here, and the key role of the regulatory body was recognised by many.

Question 8
Who should be responsible for this?

There was a range of responses that included the current regulatory bodies and the medical royal colleges.

Question 9
Do you think that the above proposals regarding the accreditation of prior experiential learning (APEL) process provide sufficient protection for public safety whilst not being too restrictive?

The majority agreed that an APEL process would be required to ensure clinical and corporate governance.

Question 10
What are your views on the proposal for a single national assessment for the profession?

Almost all respondents agreed that a single national assessment for the profession should be in place. Some respondents noted that this might be a useful transitional arrangement while establishing parameters and building public confidence.

Question 11
The assessment of professional examinations through either an examination board or a professional body is the usual route prior to regulation. However, on becoming part of a statutory register there is a requirement for qualifications to be independently assessed and quality assured and therefore requires professional body examinations to be embedded within the HEI sector. Should the regulator be the sole assessor of educational programmes?

There was no consensus among the responses regarding the role of the regulator in assessing educational programmes.

Question 12
The steering group members who have written this document have the combined expertise to validate educational programmes for the role in the interim period. What are your views?

There was no consensus among the responses regarding the role of the steering group in assessing educational programmes.

Question 13
Periodic re-registration through the passing of a re-accreditation examination is a relatively new process for healthcare professions. Do you foresee any issues with the introduction of this process?

Some respondents were confused with regard to the terms re-registration and re-accreditation. Many respondents commented that this rigorous approach was not currently applied to existing healthcare professionals.

Question 14
What are your views on compulsory periodic re-assessment?

Covered in response to question 13 above.

Question 15
Do you have any suggestions regarding how this periodic re-assessment will be funded while remaining independent?

A range of responses were offered, including central funding, professional fees and funding from employers and individuals.

Question 16
This list is not exhaustive, but do you think that there is a core theoretical knowledge area that is missing?

A wide range of suggestions were made. Consideration of these will be made by the MCP Development Steering Group and recommendations will be reflected in the final MCP Competence and Curriculum Framework document.

Question 17
What is your opinion of the weighting that should be given to each core theoretical knowledge area, ie what are the priority theoretical knowledge areas?

A wide range of suggestions were made. Consideration of these will be made by the MCP Development Steering Group and recommendations will be reflected in the final MCP Competence and Curriculum Framework document.

Question 18
Do you think it is appropriate that until the regulatory body is established the accreditation function be carried out by a panel drawn from the Curriculum Framework and Competence Steering Group, the MCP National Programme Board and participating HEIs? If not, what alternatives would you suggest?

There was no consensus but a polarity of viewpoints. Many respondents noted the difficulty in establishing interim arrangements for this process.

Question 19
The issue of the eventual title of the role has been contentious. Ultimately the title should be one that the public are able to recognise as a descriptor of the role. The title is not a beauty contest and neither should it be a descriptor of 'rank' in a team. Do you have a suggestion that meets the needs of the patient and one that the profession will be happy to adopt?

The majority favoured the working title 'Physician Assistant'.

Question 20
Do you anticipate that the proposed timeframe is adequate?

The majority believed that the proposed timeframe to develop the infrastructure required to fulfil mainstreaming of the role was adequate.

Question 21
Have you any further comments regarding the process, the document and the role?

There were a range of comments, which will be considered by the MCP Development Steering Group, and the recommendations will be reflected in the final MCP Competence and Curriculum Framework document.

Organisations that responded as part of the consultation process

American Academy of Physician Assistants
Association of Advanced Nursing Practice Educators
Avon Gloucestershire and Wiltshire WDC and SHA
Barking and Dagenham PCT
Berkshire Workforce Forum
British Association of Otolaryngologists – Head & Neck Surgeons
British Cardiac Society
British Dental Association
British Medical Association
British Orthopaedic Trainees Association
British Psychological Society
Carlisle (informal group of doctors and medical students)
Cheshire and Merseyside SHA
College of Emergency Medicine
Collaborative Universities Project
Council of the Heads of Medical Schools
County Durham and Darlington Unscheduled Care Network
Cumbria and Lancashire SHA (Workforce and HR Directorate)
East Cambridgeshire and Fenland PCT
Eastern and North Birmingham PCT
Education for Health
ENT UK
Faculty of Health and Social Care Sciences Kingston University/St George's University of London
Forum for the Future (collaborative forum of the NE London Local Health Community)
Gloucestershire Local Medical Committee
Greater Manchester PCT
Guild of Healthcare Pharmacists
Guys and St Thomas' NHS Foundation Trust
Health Informatics Unit of the Royal College of Physicians
Health Professions Wales
Healthcare Commission
Heart of Birmingham Teaching PCT
Hospital Consultants and Specialists Association
Keele University, School of Medicine
KSF Group of the NHS Staff Council (NHS Employers)
Leeds West PCT
London, Eastern and South East Clinical Pharmacy Specialist Service
Medical Defence Union
Medical Protection Society
National Patient Safety Agency
NHS Health Informatics Faculty (CFH)

North West Deanery
Northern Ireland Health Professions Forum Advisory Committee for the Allied Health Professions
Northumbria Healthcare NHS Trust
Nursing and Midwifery Council
Officers of the Council of Emergency Medicine
Patient and Carer Network of the RCP
Professional Modernisation Team at the Trent Multi Professional Deanery
Royal College of General Practitioners Midland Faculty
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Physicians and Surgeons of Glasgow
Royal College of Physicians of Edinburgh
Royal College of Radiologists
Royal College of Surgeons of England
Royal Surrey County Hospital
Salisbury Healthcare NHS Trust – Senior nurses and midwives
Sandwell & West Birmingham Hospitals NHS Trust
Scottish Executive Health Department
Slough PCT Nurse Forum
Society and College of Radiographers
South Gloucestershire PCT
South Yorkshire SHA (Workforce Development and Non-Medical Prescribing)
St George's Healthcare NHS Trust
Staffordshire University
Thames Valley SHA
UK Association of Physician Assistants (UKAPA)
Universities Board for MCP Programmes
University of Birmingham
University of Huddersfield
University of Liverpool
Vascular Workforce and CHD Choice (Department of Health)
Wales Cyngor Cymru for Nursing, Midwifery and Allied Health Professional Education
Waltham Forest PCT
Welsh Assembly (Community, Primary Care and Health Services Policy Directorate)
West Midlands Deanery
Workforce Development Confederation for North and East Yorkshire and North Lincolnshire and the Hull York Medical School (HYMS)

Full responses from individuals and organisations can be requested at the following email address: practitioner.queries@nwlondon.nhs.uk

The Competence and Curriculum Framework for the Physician Assistant was developed by a working party with representatives from the following organisations:

National Practitioner Programme

Royal College of Physicians
Setting higher medical standards

UNIVERSITY OF BIRMINGHAM

© Crown copyright 2006

276976 IP IK Sep06 (HSW) COI

Published by the Department of Health
www.dh.gov.uk

If you require further copies of this booklet
email: **practitioner.queries@nwlondon.nhs.uk**
or write to:
Competence and Curriculum Framework for the Physician Assistant
National Practitioner Programme
NHS London
Victory House
170 Tottenham Court Road
London W1T 7AH