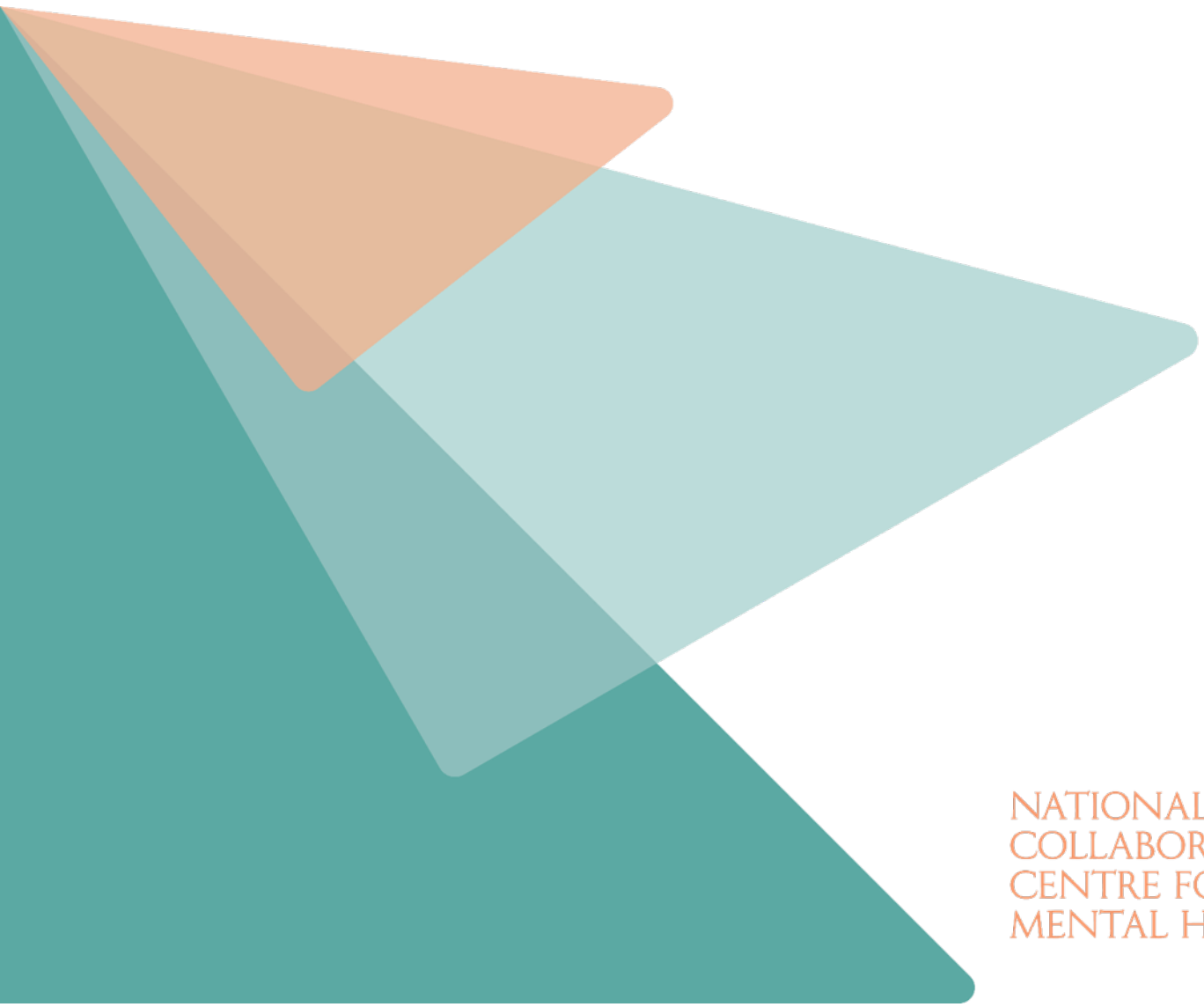
The Competence Framework for Physician Associates in Mental Health

Supporting Document

Developed in partnership with XXXXX

Draft



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

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1. Introduction

This document sets out the context for the competence framework for physician associates in mental health (MH PAs) (referred to as 'the Framework'). It includes information about the background of physician associates in the NHS, how they can be integrated into mental health multidisciplinary teams and what they can offer.

In developing the Framework and supporting document, the project team have aimed to reflect the wide diversity of perspectives on the MH PA role, and to produce a framework that does justice to the generalist training and background of physician associates while also reflecting the work of MH PAs and the organisations in which they work. Its primary application will be to physician associates working in mental health services, but may be relevant to other settings in which physician associates work.

1.1. What is a physician associate?

According the Faculty of Physician Associates (FPA),

> Physician associates are medically trained, generalist healthcare professionals who work alongside doctors and provide medical care as an integral part of the multidisciplinary team. Physician associates are dependent practitioners working with a dedicated medical supervisor, but are able to work autonomously with appropriate support.[4]

Though relatively new in mental health, physician associates have been part of the NHS workforce since 2003.[4]

1.2. What qualifications do physician associates have?

All physician associates hold at least a bachelor's degree, usually in a life science field (biomedical science or a health-related science degree). Most physician associate programmes require at least a 2:1 honours degree for entry into the postgraduate masters course, along with some prior health or social care experience.

UK postgraduate physician associate medical training is spread over a period of at least 90 weeks (approximately 3,200 hours, divided into 1,600 hours of theory and 1,600 hours of clinical practice). The current curriculum stipulates a minimum of 90 hours in mental health.

1.3. What can physician associates do?

Physician associates work across the NHS. Their generic roles include:[4]

- taking medical histories from patients
- carrying out physical examinations
- seeing patients with undifferentiated diagnoses
- seeing patients with long-term chronic conditions
- formulating differential diagnoses and management plans
- performing diagnostic and therapeutic procedures

- developing and delivering appropriate treatment and management plans
- requesting and interpreting diagnostic studies
- providing health promotion and disease prevention advice for patients.

Physician associates are not yet licensed or regulated and as such are unable to prescribe or request x-rays and other investigations involving ionising radiation. There are plans for statutory regulation to be introduced for physician associates, at which point decisions are likely to be made regarding prescribing rights.

1.4. Other professionals called physician associates

In the UK, organisations can employ people to do technical tasks such as phlebotomy, electrocardiograms (ECGs) and administrative duties. While they may also be called 'physician associates/assistants', they have not undertaken the training required for physician associates in the UK at a recognised university, and have not passed the UK PA National Certification Examination or had the training of National Commission on Certification of Physician Assistants (for physician associates from the US). Therefore, the FPA and universities are working towards regulation of the profession, to protect the title.

There is also a separate profession called ‘physicians’ assistant (anaesthesia)’. It has a different set of competences, which enable them to work under the supervision of anaesthetists within the operating theatre environment.[5]

1.5. Physician associates in mental health

Over recent years there has been a gradual rise in physician associates working specifically in mental health, as organisations seek to address long-term workforce difficulties. Physician associates are one of a wide range of new roles that support and enhance pre-existing multidisciplinary teams.

The Royal College of Psychiatrists estimate that there are currently 80 physician associates working in psychiatric settings. As such, it is not surprising that an expansion in MH PA roles is part of the NHS ambition to improve mental health services and provide good-quality and timely mental health care for everyone who needs it.

In 2019, the NHS Long Term Plan[1] detailed a commitment to transforming mental health care in England, with improvement in mental health care services being one of its four priority target areas for investment. The Long Term Plan recognised that mental health services were not meeting current need and were ill-placed to meet an anticipated increase in demand.

Health Education England’s report, Stepping Forward to 2020/21: The Mental Health Workforce Plan for England[2] describes a longer-term strategy to expand the mental health workforce, including recruiting 5,000 people into ‘new roles’ including physician associates. The NHS Mental Health Implementation Plan 2019/20 – 2023/24[3] stated an aim of recruiting 140 MH PAs to the workforce over five years in addition to the requirements specified in Stepping Forward to 2020/21: The Mental Health Workforce Plan for England.[2]

The Framework has been developed to support this expansion. It aims to provide a clear understanding of how MH PAs add value to the competences of teams and services. It also aims to protect people working in MH PA roles from being asked to work in inappropriate ways, either beyond their competence or in a way that does not make best use of their skills.

1.6. The role of the physician associate in mental health

MH PAs work in inpatient and community settings, across all ages, and in specialist services such as eating disorders and intellectual disabilities (with appropriate training and support). They take on a variety of roles and responsibilities: these include (but are not limited to):

- Undertaking full psychiatric assessments including mental state examination and risk assessments.
- Carrying out physical health assessments and procedures, including phlebotomy and ECGs.
- Liaising with other services including primary care or specialist services.
- Carrying caseloads under supervision.
- Preparing reports and discharge summaries.
- Performing quality improvement and audit activities.
- Delivering education to service users, other staff and students.
- Assist the managing consultant by writing letters, chasing referrals/treatments, and preparing medical notes.

1.7. Physical health and mental health

People with severe mental illness (SMI) are at a higher risk of developing physical health conditions. Compared to the general population people with SMI have a lower life expectancy (by 15–20 years) and a death rate that is three to four times higher.[6] These deaths are largely due to cardiovascular disease, endocrine disorders and respiratory disease. Physical health issues are also prevalent in people with eating disorders, personality disorders, and depression or anxiety. Contributing factors include side effects of psychotropic medication, lifestyle, socioeconomic factors and difficulty in accessing mainstream health services.

These disparities justify placing a focus on physical health outcomes for service users accessing mental health services. Reflecting their generalist training, physician associates are well placed to address this concern: they are able to:

- Assess for risk factors associated with poor physical health outcomes including increased body mass index, smoking status and comorbidities.
- Carry out investigations at baseline and for monitoring including weight, ECG, blood tests.
- Interpret the results of investigations and provide appropriate advice to service users.
- Support service user access to primary care and specialist services.
- Liaise with primary care and specialist services to promote integrated care.
- Provide health promotion advice to service users.
- Provide physical health and wellbeing education to other members of staff.

All staff working in mental health have a responsibility to consider the physical health and wellbeing of service users. Physician associates are well placed to advocate for a service user's physical health within the mental health multidisciplinary team.

1.8. Stigma and discrimination in mental health

Despite mental health issues being commonplace, there remains significant stigma around mental health in society. Nine out of ten people with mental health problems say that stigma and discrimination have a negative impact on their lives.[9] It is important that the stance MH PAs take to their work acknowledges the effect this can have on a person's mental health and wellbeing.

1.9. The competence framework for physician associates in mental health

The Framework is designed to reflect the work of MH PAs, whose generalist medical education enables them to provide holistic care and treatment as part of a multidisciplinary team. To do this well in a specialised setting is an important skill, but it shares with other roles the need for the right knowledge, abilities, values and other attributes. The Framework tries to set these out in a way that stays true to the defined scope of practice of the MH PA. At the same time, it tries to make clear the core expectations of the role and the responsibilities of employers for the training, support and personal development of MH PAs working in their organisations. The Framework also includes additional skills, which some MH PAs may wish to develop to improve the support they can offer to individuals and to groups.

Competence frameworks make the link between evidence and practice, and can be a valuable basis for training and an agenda for supervision. They can also serve as a guide for self-monitoring and personal development for people working in the role. We anticipate that the core curriculum (Part 3 <not included> of this set of documents), which is based on the Framework, will also be helpful in the development of training programmes.

The Framework will help those involved in mental health care services who wish to deepen their understanding of the MH PA role, and will be useful to team members working with MH PAs, to their managers and to commissioners. It will support the work of MH PA supervisors and peer coordinators, and those delivering education and training to them.

More work will be needed to adapt the Framework for specialist contexts, such as in dementia care or children and young people's services.

This framework is not a mandate. It aims to be flexible and adaptable. It outlines core skills for people starting out as MH PAs and includes additional skills that some may want to acquire, to help them be more effective in providing support to individuals and to groups, or be better able to contribute in specific care environments.

2. The development of the Framework

1.10. Oversight and peer review

The work described in this project was overseen by an expert reference group (ERG), comprising experts in training MH PAs, physician associates, researchers and experts by experience, all selected for their expertise in research, training and service delivery.

1.11. Adopting an evidence-based approach to framework development

A guiding principle for the development of previous frameworks[10] has been a commitment to staying as close as possible to the evidence base for the efficacy of interventions, focusing on the competences for which there is either good research evidence or strong expert professional consensus about their probable efficacy.

1.12. Extracting competence descriptions

The procedure for extracting competences starts with the identification of training materials, relevant competence frameworks and published descriptions of professional practice. The process for extracting and collated competences is described in Roth and Pilling (2008).[10] Draft competence lists were discussed by members of the ERG and subject to iterative peer review by members of the ERG, external experts and external parties and organisations.

1.13. Integrating knowledge, skills and attitudes

A competent MH PA brings together knowledge, skills and attitudes. It is this combination that defines competence; without the ability to integrate these areas, practice is likely to be poor.

MH PAs need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in clinical situations that marks out competence. Knowledge helps them understand the rationale for applying their skills, to think not just about how to implement them skills but also why they are implementing them. Beyond knowledge and skills, their attitude to and stance on an intervention is also critical – not just their attitude to the relationship with the patient but also to the teams with whom they work, and the many cultural contexts in which this work is located (including a professional and ethical, as well as societal, context). All of these need to be held in mind because all have a bearing on the capacity to deliver interventions that are ethical, conform to professional standards, and that are appropriately adapted to the patient's needs and cultural contexts.

1.14. How the competence lists are organised

Competence lists need to be of practical use. To achieve this, they need to be structured in a way that reflects the practice they describe, be set out in a structure that is both understandable and valid (recognisable to MH PAs as something that accurately represents the approach taken when executing their role).

The Framework has been arranged into a map (**Figure 1**), to create an accessible visual representation of its domains and sub-domains.

The first two domains identify areas that underpin the physician associate role – knowledge relating to mental health, and knowledge of (and ability to put into practice) professional and legal issues. The next domain contains a suite of competences relating to engagement and communication; this includes shared decision-making and co-production, and so emphasises the importance of actively working with service users.

The fourth domain focuses on skills, relating to diagnosis, assessment and treatment planning, and the fifth on intervention skills relating to the management of both mental and physical health, especially important given the overlap between each of these areas.

The sixth domain covers team-working – particularly relevant given that MH PAs will almost always be working with and alongside other professionals.

The final domain sets out 'metacompetences' for MH PAs. Here the focus is on making informed adjustments to an individual intervention, and the decisions that underpin this – in other words, the ability for a MH PA to work thoughtfully and in a person-centred manner rather than by rote.

1.15.Layout of the competence lists

Specific competences are set out in boxes.

Most competence statements start with the phrase, 'An ability to…', indicating that the focus is on the clinician being able to carry out an action.

Some competences are concerned with the knowledge that a practitioner needs so that they can carry out an action. In these cases, the wording is usually, 'An ability to draw on knowledge…'. The sense is that clinicians should be able to draw on knowledge, rather than having knowledge for its own sake (hence, the competence lies in the application and use of knowledge in the furtherance of an intervention).

As far as possible, the competence descriptions are behaviourally specific – in other words, they are there to identify what the clinician needs to do to execute the competence.

Some of the boxes are indented, when a high-level skill is introduced and needs to be 'unpacked'. In the example below, the high-level skill is the notion of being 'collaborative and empowering'; the indented boxes that follow are concrete examples of what the clinician needs to do to achieve this.

An ability to work in a manner that is consistently collaborative and empowering, by:
translating technical concepts into plain language that clients can understand and follow
taking shared responsibility for developing agendas and session content

The competences in indented boxes will make most sense if the clinician holds in mind the higher-level skill that precedes them. So, with the above example, although it is always sensible to use plain language, there is a conceptual reason for doing so, because it will impact on (and, therefore, contribute to) clients' sense of collaboration in (and engagement with) the therapy process. Bearing in mind that the conceptual idea behind an action should give the clinician a 'road map', and reduce the likelihood that they apply techniques by rote.

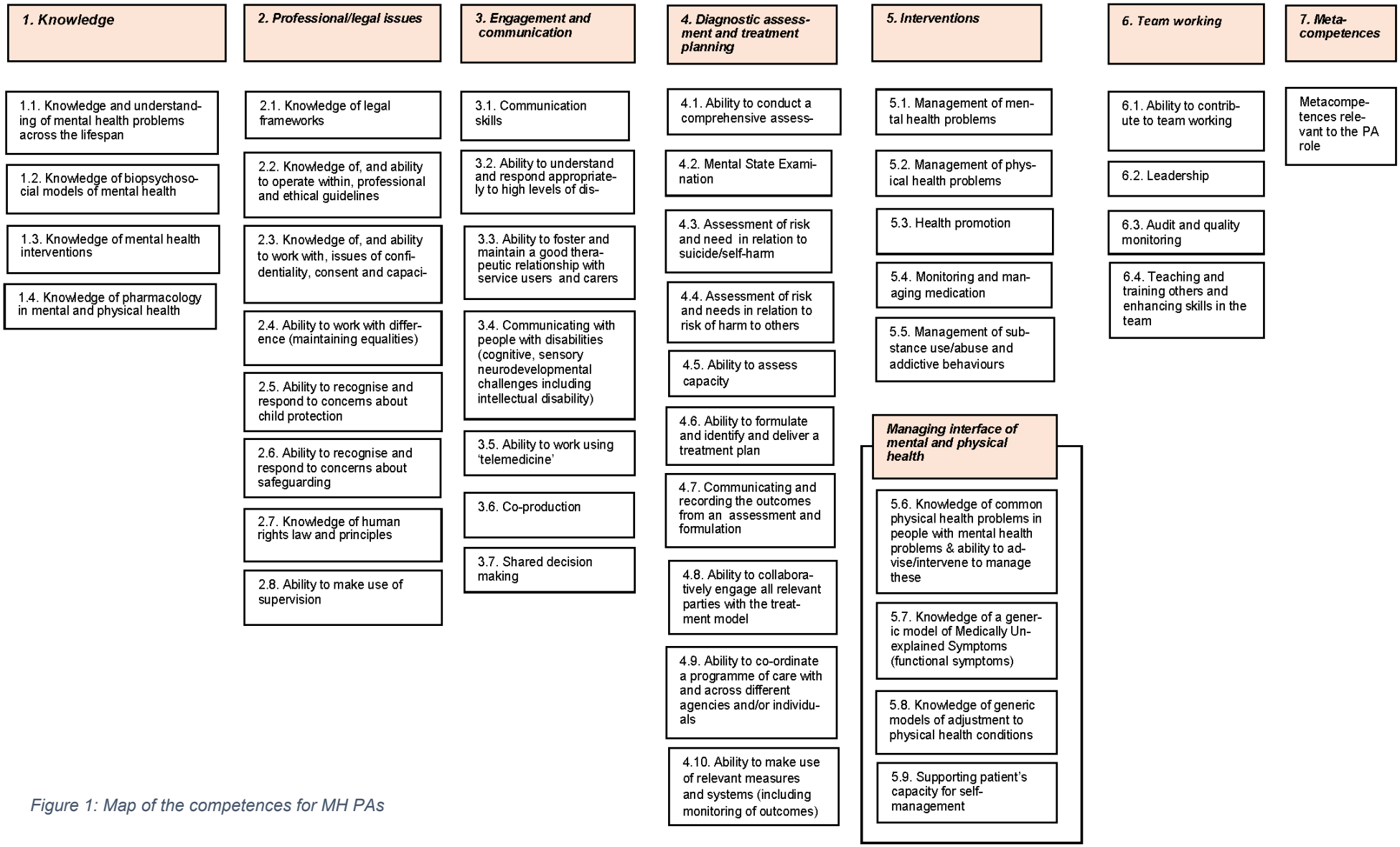

Figure 1: Map of the competences for MH PAs

3. Support for physician associates in mental health

1.16. Supervision

The FPA state that: ‘physician associates' ability to practice medicine is enabled by collaboration and supportive working relationships with their clinical supervisor, meaning that there is always someone who can discuss cases, give advice, and attend to patients if necessary.’[8]

A clinical supervisor has responsibility for working in collaboration with a MH PA to support their ongoing development. Generally speaking, a clinical supervisor would be a consultant psychiatrist, though experienced associate specialists have also fulfilled this role.

Levels of supervision will vary from individual to individual and is dependent on several factors, including their past healthcare experience and years of experience. A new graduate will require much more intensive supervision compared to an experienced physician associate. Physician associates working in highly specialised areas will also require greater supervision.

1.17. Preceptorship/inceptorship

The faculty recommend employing organisations consider offering an ‘internship’ for newly qualified physician associates. They also recommend this for those who have just moved to a new specialty, during which PAs receive ‘experiential learning’ and maintain a portfolio of cases and case discussions.

Many mental health organisations that employ physician associates have developed a ‘preceptorship/Inceptorship’ programme to help address the gap in knowledge and experience of physician associates that have not previously worked in mental health.

1.18. Developing skills

MH PAs should be encouraged to develop their skills, including:

- having access to training or development opportunities (such as attending relevant workshops or conferences)
- having protected time for training or development
- shadowing – spending time with a team member to learn about their role
- supervision
- having access to a peer network, or support to establish a local network, to ensure they are not working in isolation and can share their learning
- having access to educational opportunities at other organisations such as acute physical health trusts

1.19. Keeping well

Teams should encourage self-care and wellness in their staff, and provide accessible health and wellbeing support, because this creates a better working environment. MH PAs can benefit from workplace environments and teams where the mental health and wellbeing of staff is a priority. Examples of support for mental wellbeing of staff include:

- proactive use of wellness action plans
- access to an employee assistance programme
- a ‘reasonable adjustment’ policy, for example flexible working or a flexible workload schedule
- access to reflective practice

MH PAs are no different from other staff in needing this health and wellbeing support. Everyone working in mental health care services needs to have access to a range of support options to help them stay well.

1.20. Career pathways

Supervisors or service managers should be alert to potential career opportunities open to MH PAs and share these with them. Examples of such opportunities are:

- senior MH PA roles
- service development roles
- educational roles
- managerial roles.

Supervisors and managers of MH PAs also have a responsibility for developing the skills of MH PAs. These include skills in leadership, management and supervision, as well as skills in working well with service users, families and groups.

4. Introducing a physician associate role into an organisation

This section is relevant to service managers and leaders, provider organisations and commissioners, to support them to effectively establish and implement the MH PA role in statutory organisations and teams.

It will also help MH PAs know what to expect, in terms of challenges they may face and the level of support they should receive from their managers and organisations.

Table 1 shows potential challenges that may be encountered when establishing the MH PA role in the organisation for which they work and examples of solutions for each challenge.

Table 1: Establishing the MH PA role

Potential challenges	Examples of solutions
Integrating the work of MH PAs into multidisciplinary teams	• Clearly established recruitment and staffing processes that are co-produced with MH PAs, to ensure newly recruited MH PAs are supported throughout the process • Strong leadership within the team, to ensure clarity and agreement about the PA role, and to help a MH PA to establish themselves as part of a team • A clear plan and identified support, including from senior MH PAs, to help them to integrate in the team • For MH PSWs to have access to a physical space in which to work
Unclear role	• Have a clearly defined role and job description that is regularly evaluated, reviewed and updated • Support from supervisors • Education to other staff members regarding the roles and responsibilities of a MH PA • Have a detailed role specification in the job description, to protect MH PSWs from working outside their job role or competence and to allow them to challenge unsafe practice or care that is not person-centred • Opportunities for career progression, with protected time for learning or professional development
Acceptance by other professionals	• Regular communication with other staff members throughout the recruitment process to establish MH PAs within the team • Make sure that the MH PA role, function and purpose is understood by all members of a team, and is supported by leadership and management • Answer any concerns or queries staff have about the role openly and honestly

Potential challenges	Examples of solutions
	• Share successful experiences of MH PAs with the team • Staff training and professional development activities on the importance of physical health and where MH PAs can fit in to that
Not enough contact with other MH PSWs, leading to isolated working	• Ensure MH PAs have access to peer or group supervision • Encourage the MH PAs to connect with an existing peer support network outside the mental health organisation they are based in • If there is no existing peer support network, help MH PSWs develop a local network
Lack of effective supervision	• Clearly set out the line management and supervision arrangements • Ensure supervisors have an excellent understanding of the MH PA role and their role in supporting a MH PA • Make sure that additional support or supervision is easily available when needed outside of scheduled meetings
Lack of knowledge/experience of mental health and mental health services	• Provide a robust and detailed organisation induction, giving MH PAs the local guidance and information they require • Provide MH PAs with access to the electronic systems they will require as part of their role • Provide MH PAs with role specific training they may require early for example de-escalation training, capacity training • Set up a regular continuing professional development educational programme for MH PAs to bridge the gap between university and working in mental health • Integrate MH PAs into pre-existing educational programmes for other staff (for example junior doctors, medical students)
Remaining up-to-date with physical health competencies	• Work in collaboration with PAs working in physical health organisations and primary care to all MH PAs to access educational opportunities not otherwise available at a mental health organisation • Provide study leave and study budget to allow MH PAs to attend courses and conference to maintain their physical health competences

Abbreviations

ECG	Electrogardiogram
ERG	Expert reference group
FPA	Faculty of Physician Associates
HEE	Health Education England
MH PA	Physician associate in mental health
PA	Physician associate
SMI	Severe mental illness

References

1. www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
2. www.hee.nhs.uk/sites/default/files/documents/Stepping%20forward%20to%20202021%20-%20The%20mental%20health%20workforce%20plan%20for%20england.pdf
3. www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf
4. www.fparcp.co.uk/about-fpa/who-are-physician-associates
5. www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/physician-associates-working-in-mental-health.pdf
6. Public Health England. Severe mental illness (SMI) and physical health inequalities. London: Public Health England; 2018. Accessed 18 August 2021 via: www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing#fn:4
7. www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/05/serious-mental-hlth-toolkit-may16.pdf
8. www.fparcp.co.uk/employers/guidance
9. www.mentalhealth.org.uk/a-to-z/s/stigma-and-discrimination
10. Roth AD, Pilling S. Using an evidence-based methodology to identify the competencies required to deliver effective cognitive and behavioural therapy for depression and anxiety disorders. Behavioural and Cognitive Psychotherapy. 2008:36;129–47. doi:10.1017/S1352465808004141.