A different kind of ‘safety net’ for the new members of our workforce

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A different kind of 'safety net' for the new members of our primary care workforce

The COVID-19 pandemic has presented a plethora of challenges in primary care; a new way of working on a backdrop of increasing patient demand and Winter pressures, vaccination of the masses at the drop of a...delivery, variable morale amongst practice staff, whilst trying not to infect loved ones at home with potential COVID exposure from work. At the same time, Physician Associates (PAs), amongst other roles, have increasingly been introduced to primary care with the aid of recent financial incentives such as the Additional Roles Reimbursement Scheme (ARRS). Compounding the challenge of the addition of this new member to the team, is their probable lack of exposure to remote consultations that has now become our "norm". Early feedback from PAs in Sheffield reports a disconnect between their University learning and placement experience prior to the pandemic; with much of their student experience involving face-to-face consultations, yet surviving the current reality in general practice includes experience with remote consultation.

This is perhaps worth bearing in mind when considering employing a PA via ARRS, which is an alternative to existing schemes such as preceptorships but perhaps without its safeguards. For example, the Sheffield preceptorship scheme offers a formalised support package for both the PA and employer, and evaluated positively by the GPs and preceptees involved[1]. In this scheme, the PA starts on a part-funded Band 6 salary but with peer support, a dedicated scheme lead, protected weekly learning time for bespoke sessions, a mentorship session from an experienced primary care PA and an education budget. The concept of preceptorship allows time for the preceptee to grow into their role and enables support from both employer and the scheme. Prior to the pandemic, the mentorship session took the format of consultation observation by the senior PA, which grounded a two- way discussion on the PA's strengths and weaknesses. The purpose of consultation observation was to gain a flavour of each PAs clinical remit rather than the need for a formal competency assessment. However there was an instance where consultation observation did prove beneficial in aiding interventions for a PA who was failing to thrive at their employing practice.

In contrast, the Band 7 ARRS positions may come with an expectation from an employer of proficiency and expertise, yet the PA may well be newly qualified. There is also a lack of definitive guidance regarding supporting or utilising newly qualified PAs in these roles. If spread across several sites, could the PA end up being forgotten about in terms of pastoral care? **And how might the PA feel about being thrust into a different practice daily; losing some of that patient continuity that many of us thrive upon in our general practice careers?**

Whilst recommendations have been made by the Sheffield scheme regarding employer considerations for all newly qualified PAs in primary care regardless of location or funding[2], we feel that there is a continued need to support the PAs externally to their employer, especially with the added stressors of this pandemic. A busy GP supervisor who is 'wading through treacle' on a daily basis due to clinical demand, or an environment where the PA is utilised predominantly for face-to-face appointments regardless of their feelings about this, may lead to them feeling forgotten, unsupported, or even unsafe. To this end, the mentorship stream of Sheffield preceptorship scheme has been revamped to a more supportive and remote model; rather like the ethos behind the change in GP appraisals*. In this model, a remote meeting is now held with each preceptorship PA exploring issues that were previously discussed in the face to face session, but minus the consultation observation. These issues include supervision arrangement and regularity, timekeeping and appointment logistics, challenges faced at work, the preceptee's physical and mental health, clinical special interests, plans for annual appraisal and the future. Instead of consultation observation, a supportive discussion around two or three case vignettes that the preceptee selects in advance and demonstrates the breadth of their practice are instead explored. A summary of the discussion is then generated by the senior PA with specific recommendations bespoke to the preceptee's needs and interests.

The reality is that senior PAs in primary care may be hard to come by depending upon region, and schemes such as this one are not widespread; they are instead dependent upon regional pockets of funding. However, support for novice clinicians is paramount for patient and staff safety, especially in these times of reduced personal contact and opportunities for casual discussion. We must ensure that in some way, shape or form, the newest recruits of our workforce are supported to work in a way that is clinically safe and appropriate for their skillset, whilst their confidence in this climate of remote consultation grows. Some supervisors may well make time in their day to check in with their new recruits, but what happens for those that don't? The concept of a lead PA is often utilised in secondary care; a PA who is given protected time to mentor junior PAs within the trust. Is one solution to re-explore the value in PA preceptorships, or perhaps embed into ARRS a PA with several years of experience in primary care; an external agent that understands the role from a PA perspective and can provide unbiased support for the PA, and an action plan for the practice?

*These meetings are not, and do not, replace a formal appraisal with the employer; they are intended to support the PA only.

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References

1. Hoskin J, Agarwal R 'Preceptorship scheme for newly qualified physician associates working in general practice in Sheffield' (Clinical Medicine November 2020) https://www.rcpjournals.org/content/clinmedicine/20/6/e255
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