

FOI REF: 26/270

12th May 2026

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Further to your recent request for information made under the Freedom of Information Act (FOIA) 2000, I now set out our answers to your specific questions, and any clarifications sought and provided, as follows:

- 1) Please disclose your current Scope of Practice document for Physician Associate/ Assistant Roles (or equivalent) and any related governance document on Physician Associate/ Assistant Roles (or equivalent).**

East Sussex Healthcare NHS Trust (ESHT) does not have a Trustwide PA Scope of Practice document. All job plans and job descriptions have been reviewed since the publication of the Leng Review by the lead PA and the Chief Medical Officer.

Please see the attached policy - '01262_03_P_Redacted'.

Please note that it is the Trust's FOI policy to only provide the names of staff that are grade 8a or above, therefore staff that are below that grade have been redacted from the attached policy.

Please also note that we have also redacted personal email addresses of staff, the names of individuals that do not work for the Trust and the names of the Trust's IT Systems and are applying Sections 31(1)(a), 40(2) and 44 respectively, please see below:

Section 31(1)(a)

Section 31(1)(a) has also been applied to the names of the Trust IT systems within this document; therefore, these have also been redacted.

Under Section 31(1)(a) of the Freedom of Information Act (FOIA), the Trust can confirm that it holds information relevant to your request, however, we are unable to disclose it for the reasons explained below.

Historically, we would disclose information relevant to the Trust's IT systems, infrastructure and software as part of our transparency agenda under the terms of the Freedom of Information Act (FOIA). However, in light of the recent cyber-attacks on NHS hospitals and the serious impact these have had on patient services and the loss of

patient data, we are having to reconsider this approach. Please see several links to news articles about these recent cyber incidents provided below for your information.

- [*NHS England — London » Synnovis Ransomware Cyber-Attack*](#)
- [*NHS England confirm patient data stolen in cyber attack - BBC News*](#)
- [*Merseyside: Three more hospitals hit by cyber attack - BBC News*](#)

As a result of these attacks, thousands of hospital and GP appointments were disrupted, operations were cancelled, and confidential patient data was stolen which included patient names, dates of birth, NHS numbers and descriptions of blood tests.

When we respond to a Freedom of Information request, we are unable to establish the intent behind the request. Disclosure under the FOIA involves the release of information to the world at large, free from any duty of confidence. Providing information about our systems or security measures to one person is the same as publishing it for everyone. While most people are honest and have no intention of misusing information to cause damage, there are criminals who look for opportunities to exploit system weaknesses for financial gain or to cause disruption.

In the context of the FOIA, the term “public interest” does not refer to the private or commercial interests of a requestor; its meaning is for the “public good”. The Trust receives a significant number of requests each year regarding our IT systems, infrastructure and cyber security measures. Most of these requests are commercially driven and serve no direct public interest. Information relevant to our IT portfolio is often requested by consultancy companies who then pass on this information to their client base. Many of these requests are submitted through the FOI portal whatdotheyknow.com who publish our responses, making this information available to an even wider audience.

As a large NHS Trust we hold extensive personal data relevant to our patients and staff, much of which is considered very sensitive. A lot of this information is held electronically on various administration and clinical systems. We have a duty under the Data Protection Act 2018 and the UK GDPR to protect this personal information and take all necessary steps to ensure this data is kept safe. This means not disclosing information that could allow criminals to gain unlawful access to our systems and infrastructure. The Trust can be heavily fined should it be found to have acted in a negligent way which results in a personal data breach. We need to demonstrate that we comply with our legal obligations under data protection and freedom of information legislation, but we must be careful that too much transparency does not result in harm to our patients or staff, or cause disruption to our services.

Moreover, under the Network and Information Systems (NIS) Regulations Act 2018, operators of essential services such as NHS organisations like ours have a legal obligation to protect the security of our networks and information systems in order to safeguard our essential services. By releasing information that could increase the likelihood or severity of a cyber-attack, the Trust would fail to meet its security duties as stated in Section 10 of the Network and Information Systems Regulations 2018. Should we not comply with these requirements regulatory action can be taken against the Trust. Further information about the Network and Information Systems (NIS) Regulations Act

2018 can be found here – [The Network and Information Systems Regulations 2018: guide for the health sector in England - GOV.UK](#)

Your request asks for policy documents which unfortunately mention specific details regarding our IT Systems which, for the reasons explained above, would be inappropriate to release into the public domain. If disclosed, it is possible that patient data as well as other confidential information would be put at risk. Such disclosure could also impact on the security of our systems and result in serious disruption to the health services we deliver to the local community. Section 31(1)(a) of FOIA provides that information is exempt if its disclosure would, or would be likely to, prejudice (a) the prevention or detection of crime. In this case, disclosure would be likely to prejudice the prevention of crime by enabling or encouraging malicious acts which could compromise the Trust's IT systems and infrastructure. The Trust's capacity to defend itself from such acts relates to the purposes of crime prevention and therefore Section 31(a) exemption is applicable in these circumstances. For these reasons, the Trust considers disclosure of the information you are seeking to be exempt under Section 31(1)(a) [law enforcement] of the FOIA and the names of the IT systems within the policy is being withheld. The full wording of Section 31 can be found here: [Freedom of Information Act 2000](#)

Section 31 is a qualified exemption and therefore we must consider the prejudice or harm that may be caused by disclosure of the information you have requested, as well as apply a public interest test that weighs up the factors in maintaining the exemption against those in favour of disclosure.

In considering the prejudice or harm that disclosure may cause, as explained should the Trust release information into the public domain which draws attention to any weaknesses relevant to the security of our systems or those of a supplier, this information could be exploited by individuals with criminal intent. Increasing the likelihood of criminal activity in this way would be irresponsible and could encourage malicious acts which could compromise our IT systems or infrastructure, result in the loss of personal data and/or impact on the delivery of our patient services. We consider these concerns particularly relevant and valid considering the increasing number of cyber incidents affecting NHS systems in recent years and the view by government, the ICO and NHS leaders that the threat of cyber incidents to the public sector is real and increasing.

- [*Organisations must do more to combat the growing threat of cyber attacks | ICO*](#)

In the Government's Cyber Security Strategy 2022-2030, the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office states on page 7:

"Government organisations - and the functions and services they deliver - are the cornerstone of our society. It is their significance, however, that makes them an attractive target for an ever-expanding army of adversaries, often with the kind of powerful cyber capabilities which, not so long ago, would have been the sole preserve of nation states. Whether in the pursuit of government data for strategic advantage or in seeking the disruption of public services for financial or political gain, the threat faced by government is very real and present.

Government organisations are routinely and relentlessly targeted: of the 777 incidents managed by the National Cyber Security Centre between September 2020 and August

2021, around 40% were aimed at the public sector. This upward trend shows no signs of abating.”

With this in mind, we then considered the public interest test for and against disclosure. It should be noted that the public interest in this context refers to the public good, not what is ‘of interest’ to the public or the private or commercial interests of the requester. In this case we consider the public interest factors in favour of disclosure are:

- Evidences the Trust’s transparency and accountability
- Provides information relevant to the IT systems and applications the Trust uses
- Reassures the public and partners that the Trust procures these systems in line with Procurement legislation
- Reassures the public and partners that the Trust’s IT infrastructure and systems are secure

Factors in favour of withholding this information are:

- Public interest in crime prevention
- Public interest in avoiding disruption to our health services
- Public interest in maintaining the integrity and security of the Trust’s systems
- Public interest in the Trust avoiding the costs associated with any malicious acts (e.g. recovery, revenue, regulatory fines)
- Public interest in complying with our legal obligations to safeguard the sensitive confidential information we hold

In considering all of these factors, we have concluded that the balance of public interest lies in upholding the exemption and not releasing the information requested. Although disclosure would provide transparency about our software systems and IT infrastructure, this is outweighed by the harm that could be caused by people who wish to use this information to assess any vulnerabilities in our security measures and consequently use this information for unlawful purposes. Cybercrime can not only lead to major service disruption but can also result in significant financial losses. As a publicly funded organisation, we have a duty for ensuring our public funding is protected and spent responsibly. Moreover, as a public body the Trust must demonstrate that it keeps its confidential data and IT infrastructure safe and complies with relevant legislation, but at the same time we must be vigilant that transparency does not provide an opportunity for individuals to act against the Trust. In considering the impact that recent cyber-attacks have had on NHS services, including the cancellation of thousands of patient appointments and procedures as well as the loss of confidential patient data, we consider the overriding public interest lies in withholding this information. The private or commercial interests of a requester should not outweigh the public interest in protecting the integrity of our systems and continuity of our essential patient services. Although we appreciate there may be legitimate intentions behind requesting this information, we must take a cautious approach to requests of this nature and appreciate your understanding in this matter.

Section 40(2)

I can confirm that we hold this information, but it is exempt under Section 40(2) of the Freedom of Information Act 2000 – Personal Information of third parties. This is because this information may allow the identification of individuals and disclosure would breach the principles of the Data Protection Act.

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

Section 44

We are unable to provide the contact details of staff as we consider this information to be exempt from release in accordance with section 44 of the Freedom of Information Act (Prohibition on disclosure) and would refer to the Privacy and Electronic Communications EC Directive Regulations 2003 which provide specific rules on electronic communication services, including marketing (by phone, fax, email or text) and keeping communications services secure. We will not provide any information that could result in the transmission of unsolicited communications which may place an unacceptable risk to our email network and could also have a detrimental impact on patient care and treatment.

The contact number for the Trust is accessible on the Trust website <http://www.esht.nhs.uk>.

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

- 2) a) **Please disclose how Physician Associates/Assistants (or equivalent) are coded on the trust's electronic patient records?**

We do not have an electronic patient record at the Trust yet. This is currently planned to be rolled out from mid-September and PAs will be coded differently from doctors.

- b) **Are they coded generically as "clinician" or specifically as "Physician Associate/ Assistant" (or equivalent)? If neither, please specify how they are coded.**

Not applicable.

- c) **Please also disclose the full list of ALL staff codes used on the trust's electronic patient records.**

Not applicable.

- 3) a) **Please disclose how Physician Associates/Assistants (or equivalent) are coded on the trust's Datix system, or whether they are coded at all.**

ESHT do not currently have a code for PAs on the Trust's incident reporting system.

b) If they are NOT coded on Datix, please explain why this is so.

When the list was created on ESHT incident reporting system the role of PA was not used in the Trust and since then we have not been asked to add them to our list of Staff Groups.

c) Please also disclose the full list of ALL staff codes currently used within the Datix system.

Please see the list below of the current Staff Groups ESHT use on our incident reporting system:-

Administrative & Clerical
Allied Healthcare Practitioner
Ancillary & Support Worker
Manager - Line/Service/General/Supervisor/Team Leader
Medical Consultant
Medical Doctor in Training
Medical Specialty Registrar
Nursing - Healthcare Assistant
Nursing - Registered Nurse
Operational/Executive/Director
Scientific/Technician

4) Please disclose when the trust first introduced Physician Associate/ Assistant Roles (or equivalent) roles and the current number of FTE of such roles at the trust.

Physician Assistants, then Physician Associates, were first introduced to the Trust in 2019. There are six FTE PA role at the Trust.

5) Please disclose if and how the trust has evaluated the safety of Physician Associate/ Assistant Roles (or equivalent) roles since they were first introduced at the trust.

The Trust, through its monitoring of quality and safety, monitors the safety of all staff groups. We are able to analyse events where a PA was involved by use of the free text search in Datix and staff group search. All patient safety incidents involving any staff group that are moderate or above in severity are discussed at our weekly patient safety meeting and formally investigated.

6) Please disclose specifically if and how the trust has tracked and evaluated any patient safety incidents associated with or arising from these Physician Associate/ Assistant Roles (or equivalent) roles since they were first introduced.

- For example, does the trust hold central data on the number of serious incidents and Never Events associated with Physician Associate/ Assistant Roles (or equivalent) roles since their introduction?

The Trust has had one moderate harm incident, recorded on our incident reporting system in May 2024, which mentioned a Physician Assistant. This was reviewed and

monitored through the Weekly Patient Safety Summit and a Patient Safety Investigation Response Framework Debrief Template was completed.

- 7) **Has the trust produced any formal analyses or reports on the safety of Physician Associate/ Assistant Roles (or equivalent) roles at the trust? If so, please share these.**

All patient safety incidents are examined irrespective of role.

I trust this information is helpful in its detail or explanation however, if you are dissatisfied with the response, then you have the right to request an internal review. If you wish to seek an internal review, please write to the Freedom of Information Team at esh-tr.foi@nhs.net quoting the above FOI reference number, within 40 working days. Please note the Trust is not obliged to accept a request for an internal review after this time period.

Yours faithfully

Freedom of Information (FOI) Team
East Sussex Healthcare NHS Trust
0300 131 4716
Core Hours of Business: Monday to Friday 9.00am to 4.00pm

An Organisation-wide Policy for the Role of Physician Associates

| | |
|---|---|
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| Name of author and title: | Zoe Neale, Lead Physician Associate, East Sussex Healthcare NHS Trust Dr Osei Kankam, Consultant Respiratory Physician and Physician Associate Tutor, East Sussex Healthcare NHS Trust |
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| Compliance with CQC Fundamental Standard | Good Governance Staffing Fit and proper persons |
| Compliance with any other external requirements (e.g. Information Governance) | CQC GMC RCP FPA |
| Associated Documents: | N/A |

Did you print this yourself?

Please be advised the Trust discourages retention of hard copies of the procedural document and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

| Version number and issue number | Date | Author | Reason for Change | Description of Changes Made |
|--|----------------|-----------------------------|--|--|
| V1.0 | October 2021 | Zoe Neale Dr Osei Kankam | New Document | New Document |
| V2.0 | August 2023 | Zoe Neale Dr Osei Kankam | Amendment needed | Medicines optimisation group and medicine governance group recommendations |
| V2.1 | September 2024 | Zoe Neale Dr Osei Kankam | Major revision ahead of GMC regulation | |
| V3 | April 2025 | Zoe Neale | Updated study leave | Clarification on study leave |
| | | | | |
| | | | | |

Consultation Table

| Name of Individual or group | Title | Date |
|------------------------------------|---------------|--------------|
| Medicine Division Governance Group | | August 2022 |
| Medical HR | | January 2023 |
| Medicine Optimisation Group | | July 2023 |
| Chief Medical Officer | Simon Merritt | May 2023 |
| Medicine Governance Group | | May 2025 |
| | | |
| | | |

Information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

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1. Rationale

This policy aims to define how Physician Associates (PAs) will be employed within East Sussex Healthcare NHS Trust (ESHT). It provides a framework of standards to which the Trust and PAs working within the Trust should adhere and includes supervision arrangements and information regarding appraisal and professional development.

The policy applies to:

- All PAs working within the Trust regardless of specialty
- All supervisors of PAs
- PA line managers
- The PA Tutor
- Trust Lead PA
- Those supervising PA students on placement from Higher Education Institutions
- Those working alongside PAs within the multi-disciplinary team

This policy should be read by:

- All of the above
- HR functions
- Training and Development functions
- Clinical supervisors of both qualified PAs and students
- Employed PAs
- Student PAs

2. Introduction

The PA role is an innovative new health professional who works with the clinical team to provide quality health care across the NHS.

The Faculty of Physician Associates (FPA) at the Royal College of Physicians provides professional support to physician associates across the UK. Members of the faculty are part of a professional membership body campaigning for progress and change in the profession, advising government, and taking part in national debates on medical, clinical and public health issues.

The FPA defines a PA as:

“Healthcare professionals who work as part of a multidisciplinary team with supervision from a named senior doctor (a General Medical Council registered consultant or general practitioner), providing care to patients in primary, secondary and community care environments. PAs are part of the government’s medical associate professions (MAPs) grouping in the health and care workforce and have been working in the UK since 2003.”

The FPA reviews and sets standards for:

- The education and training of PAs.
- PA national certification which is administered by the Royal College of Physicians.

The FPA provides support to both qualified and student PAs in their education, training and professional development.

The FPA oversees and administers the running of the Physician Associate Managed Voluntary Register (PAMVR) and will hold this register until regulation comes into effect, from which time, the GMC will hold and maintain the register^[1].

Currently, the profession in the UK is unregulated although PAs employed by ESHT must be members of the FPA and registered on the PAMVR.

Regulation of PAs by the GMC will come into effect towards the end of 2024. All PAs working at ESHT will be required to transition to the new regulatory process and adhere to the revised published standards of Good Medical Practice

Physician Associates who are registered on the PAMVR may add to their name 'PA-R' to demonstrate that they are currently on the voluntary register and have signed up to maintaining high standards of practice. Once regulated, the title 'Physician Associate' will become protected^[2].

2.1. PA training

UK trained PAs have completed PA studies as a four-year undergraduate or a two-year postgraduate programme. The PA course is quality assessed internally and externally, currently based on the FPA PA curriculum, consisting of theoretical learning in medical sciences, pharmacology and clinical reasoning, as well as clinical placement experience in a wide variety of settings. Throughout their studies, students are required to demonstrate safe and effective practice, self-awareness and high levels of professional behaviour^[3].

The GMC sets the pre-qualification education framework for PAs, which helps course providers and student PAs understand the knowledge, behaviour and skills expected of newly qualified physician associates.

Two documents published by the GMC outlines the educational and assessment components for physician associates:

- Physician associate and anaesthesia associate generic and shared learning outcomes.
- Physician associate registration assessment (PARA) content map^[4].

All accredited UK PA programmes train PA students in the following fields:

- Community medicine
- General hospital medicine
- Urgent care, including Emergency and Acute Medicine
- Mental health
- General Surgery
- Obstetrics and Gynaecology
- Paediatrics

An apprenticeship standard for Physician Associates is available but currently ESHT does not employ any apprentice PAs.

All PA students must pass their university programme prior to sitting the PANE. The PANE is a mandatory requirement for entry into professional practice. The exam sets the standards for PAs across the UK and is designed, developed, and administered by the Royal College of Physicians assessment unit. It consists of comprehensive written and objective structured clinical examination (OSCE) components. Once a PA has passed both their university exams and the PANE, they are eligible to be registered on the PAMVR and work as a PA. PAs on the PAMVR are committed to maintaining good standards of clinical practice, public protection, and safety and to adhere to the FPA code of conduct^[1].

3. Definitions

| Acronym/Abbreviation | Meaning |
|----------------------|--|
| ALERT | Acute Life-threatening Events—Recognition and Treatment |
| ALS | Advanced Life Support |
| CBD | Case-based Discussion |
| CPD | Continuous Professional Development |
| CNST | Clinical Negligence Scheme for Trusts |
| DEXA | Dual energy X-ray absorptiometry |
| DofH | Department of Health |
| DNAR | Do Not Attempt Resuscitation |
| DOPS | Directly Observed Procedural Assessments |
| ECG | Electrocardiogram |
| ESHT | East Sussex Healthcare Trust |
| FAST | Focused Assessment with Sonography in Trauma |
| FPARCP | Faculty of Physician Associates at the Royal College of Physicians |
| HR | Human Resources |
| ILS | Immediate Life Support |
| IRMER | Ionising Radiation (Medical Exposure) Regulations |
| IUD | Intrauterine Device of coil |
| MDDUS | Medical and Dental Defence Union of Scotland |
| MDU | Medical Defence Union |
| miniCEX | Mini Clinical Evaluation Exercise |
| MPS | Medical Protection Society |
| MRI | Magnetic Resonance Imaging |
| MSF/360° | Multi-Source Feedback/360° appraisals |
| NCCPA | National Commissions on Certification of Physician Associates |
| NG | Nasogastric |
| NOF | Neck of Femur |
| OGD | Oesophago-gastro-duodenoscopy (endoscopy/gastroscopy) |
| PA | Physician Associate |
| PAMVR | Physician Associate Managed Voluntary Register |
| PDP | Professional Development Plan |
| RCGP | Royal College of General Practitioners |
| RCP | Royal College of Physicians |
| PG Diploma | Post Graduate Diploma |
| SAM | Society for Acute Medicine |
| SASH | Surrey and Sussex Healthcare NHS Trust |
| SGUL | St George's University of London |

4. Accountabilities and Responsibilities

4.1 Physician Associate Tutor

- The Trust PA Tutor will oversee and support the role of Physician Associate at the Trust. The PA Tutor will endeavour to ensure that the PA role at the Trust is always in support of doctors in training and other members of the MDT.
- The PA Tutor will understand the principles of the GMC's Effective clinical governance to support revalidation^[5].
- The PA Tutor will identify, access, and appropriately interpret and scrutinise the clinical governance data and information it requires PAs to effectively undertake their role. This might include data on; complaints, incident reporting, appraisals, management of concerns and clinical indicators
- The PA Tutor and the Lead PA are responsible for providing information to the Chief Medical Officer in relation to clinical governance data surrounding PA practice.
- The PA Tutor will work within remit of the Health Education Kent Surrey and Sussex PA Programme.
- The PA tutor will chair the PA Governance Group to ensure rigorous governance arrangements regarding practice of PAs within the Trust.
- The PA tutor will work with the university placement coordinator to arrange placement and escalate any practice concerns of PA students.
- The PA Tutor will take part in interview and in recruitment process of PAs.
- The PA tutor will ensure access to continued professional development opportunities are available to PAs.
- The PA Tutor will conduct PA professional appraisals.
- The PA Tutor will ensure where areas of development or need are identified that the PA and the clinical supervisors are supported.
- The PA tutor will raise fitness to practice issues.

4.2 Lead Physician Associate

- The Trust Lead PA is responsible for the support and development of the PA role and provides leadership to qualified PAs and PAs in training. The Lead PA also provides support to PA supervisors in relation to PA practice and associated governance processes. They will support the PA Tutor with professional appraisals. The Trust Lead PA will represent PAs at the local faculty group meetings and medicine governance group.
- The Trust Lead PA will support the PA tutor in the recruitment of new PAs and in mentoring new appointed Physician Associates and students.
- The Trust Lead PA will work with other professionals in health and social care to develop the roles and responsibilities of the physician associate. They will develop effective communication with the Medical Director, Associate Medical Directors, Divisional Directors, General Managers, Clinical Directors and Supervising Consultants to ensure that both the standard of training provided for Student Physician Associates, newly qualified and established Physician Associates meet organisational and national standards and requirements. They will champion, represent and develop the Physician Associate role within the Trust.
- The Trust Lead PA will work with the medical Education team and local universities to support quality student placements. Coordinate the student placements, allocation of supervision and placement opportunities and liaise with HEI leads to ensure structured and well-governed placements.
- The Trust Lead PA will oversee the governance of the role of the Physician Associate within the Trust including quality and safety, local management of Physician Associate development and workforce development. This would include the preparation for medical governance meetings and updates to the current Physician Associate governance policy.

4.3 Physician Associate Governance Group

The PA Governance Group is made up of:

- PA Tutor (chair).
- Lead PA for ESHT.
- Listed PA clinical supervisors.
- PAs at ESHT.
- Director of Medical Education.

With representatives from:

- Local HEIs.
- South East School of PAs.

This group meets three times a year. The responsibilities of this group are:

- Responsible for the strategic direction for the design, delivery and evaluation of robust educational and professional governance systems and processes for PAs within ESHT in accordance with GMC and specialty College standards.
- Receives reports from PAs and Supervisors and ensures that best practice is shared, and poor practice is reviewed against national/local benchmarks and revised guidance and change of practice is implemented.
- Receives reports and directives from SEPSS for implementation and on-going review with feedback where appropriate.
- Support for specialties taking PA Students for placements.
- Reporting back to the Local Academic Board and Local Faculty Groups.

4.4 Summary of Clinical Supervisor Responsibilities

- The PA named clinical supervisor will work with the PA to determine the level of current practice of the PA, to help to set development targets and to ensure that the PA works within their scope of practice and competence. Support completion of workplace-based assessments and review of the PA's portfolio.
- The named clinical supervisor should have undertaken formal training in educational and/or clinical supervision. The SE School of PAs run an education workshop dedicated to PA supervision and supervisors are strongly advised to attend this.
- Job plans for PAs should be designed to ensure reasonable opportunities for direct observation of the PA's practice and to review progress and provide feedback by the named clinical supervisor.
- The supervisor should promote awareness of the PA role within the MDT and with patients

4.5 Summary of PA Responsibilities

- PAs will work to and uphold the standards set out in the GMC Good Medical Practice. They will work within the scope of practice as set out in this policy and within their level of competence. PAs are expected to highlight to their supervisor any areas of practice that they may require support or development in.
- PAs should introduce themselves by name, title and role to patients and members of the MDT.
- PAs should offer patients and staff the opportunity to enquire more about their role, taking sufficient time to explain the role, including their training, qualifications, that they are not a doctor and that they work under the supervision of a named senior doctor, and within a consultant/GP and employer approved scope of practice. The time required for this to take place in sufficient detail should be factored into any patient consultation times. PAs must correct patients and staff if they refer to them as a registered doctor, nurse or other professionally protected role title. This includes verbal, written and other forms of communication.
- PAs are expected to maintain a personal development portfolio such as the FPA ePortfolio or their own collected portfolio that demonstrates continued professional development since the last appraisal. They must ensure they have completed the required number of workplace-based assessments e.g. DOPS and Achievement Review paperwork prior to appraisal or review^[6].

- PAs should work collaboratively within the MDT to ensure a valuable learning environment for all team members and ensure that the training requirements of doctors in training are prioritised and enabled at all times.

5. Employment of Physician Associates at ESHT

PAs are employed at ESHT to support clinical teams. PAs are not a replacement for doctors; they are highly valued members of the MDT who support patient care.

Specialties that seek to employ PAs within their departments should liaise with the Trust Lead Physician Associate and/or PA Tutor to understand the rationale and ensure that the PA role is the most appropriate to meet the needs of the service.

All PAs must have a named clinical supervisor who must be on the GMC Specialty Register.

Line management of PAs varies on the department they are employed in.

5.1 Pre employment

Qualifications and Professional Registration

To be appointed by the Trust, PAs must have successfully passed both the final examinations of a recognised UK or US PA course and the PANE in the UK or the Physician assistant national certifying examination (PANCE) in the US. Following formal regulation, the PANE is expected to transition to become the Physician Associate Registration Assessment (PARA) from Summer 2025 onwards. Evidence of this must be provided and confirmed at interview^[1].

PAs must also be registered on the PAMVR or, once formal GMC regulation for PAs is in place, the GMC Register, which will be checked prior to appointment and reviewed each year at appraisal by the Trust Lead PA or PAs line manager.

Indemnity Arrangements

The current practice of PAs is covered by the Department of Health Clinical Negligence Scheme for Trusts (CNST) which is administered by the NHS Resolution^[7]. However, qualified PAs are strongly encouraged to have their own personal professional negligence insurance from one of the medical defence organisations as there are aspects that the CNST scheme does not cover including access to personal regulatory and medico-legal support and advice. Personal professional negligence insurance for PAs is currently provided by the: Medical Protection Society (MPS), Medical Defence Union (MDU) and Medical and Dental Defence Union of Scotland (MDDUS).

Job Plans

Specialties that seek to employ PAs within their departments should liaise with the PA Tutor and Lead PA to ensure that job plans match the requirements of the post and are within the general competencies of the PA role. PA job plans should allow for ongoing professional development and encourage retention of PAs, whilst ensuring the role supports the needs of doctors in training, multi-disciplinary staff and students within their clinical area. Job plans must ensure robust and senior led clinical supervision. PAs should be working directly alongside a consultant or senior clinician (SAS) and have regular direct observation of practice by the named supervising consultant/senior clinician.

Job plans should be reviewed yearly to ensure that there is continuity of supervision and a balance between development opportunity for the PA, meeting the needs of the service and in support of the training requirements of doctors in training.

Salary

All newly qualified PAs appointed to the Trust are appointed at Agenda for Change Band 7.

Interviewing

It is recommended that the PA tutor, the Lead PA within the Trust, a consultant from the specialty the PA will be appointed to, and an HR representative should be present on the interview panel.

5.2 Considerations during first year of employment

Immediately following qualification, the FPA suggest that PAs require at least one year to consolidate their core knowledge and skills and demonstrate their competence in practice. This is often referred to as the “New Graduate Year”. During this period, it is recommended that PAs have regular meetings with the designated supervisor, formal reviews at 3 and 6 months with evidence of case-based discussions and mini clinical examination assessments at each review (see appraisal section) as well as annual appraisal. They should also have experiential learning in the clinical area in which they are working and should maintain a portfolio of cases and case discussions with clinicians which are reviewed with their clinical supervisor.

The New Graduate Year recommendations may also be appropriately applied to a PA being employed in a new specialty even if they have qualified more than one year ago. They should complete the following assessments in their first graduate year or first year in a new specialty.

| Timing | Number of CBD/MiniCEX |
|--|--|
| Year one ‘Internship’ or upon entering new specialty | |
| Commencement meeting | N/A |
| 3 months | 3 x CBD, 3 x MiniCEX |
| 6 months | A further 3 x CBD, 3 x MiniCEX |
| 1 year | An overall total of 8 x CBD, 8 x MiniCEX |

All Agenda for Change staff undergo a period of six months’ probation. Refer to HR protocols and guidance where necessary^[8].

5.3 Core skills

All PAs have a core skill set that they will perform on a regular basis and as part of their role within the Trust regardless of the specialty in which they work.

Core skills include being able to:

- Take medical histories
- Conduct comprehensive physical exams
- Request and interpret certain investigations
- Diagnose and treat illnesses and injuries
- Counsel on preventive health care

The supervising clinician (Consultant or Registrar) must ensure that the PA is assigned to see a patient that does not exceed their competence. PAs should not be restricted to one category of acuity however and should be encouraged to see a variety of acute and chronic disease including resuscitation patients and those acutely deteriorating, providing both supervisor and PA are confident, and the PA is competent, to do so.

PAs working at ESHT are not part of on-call rotas and must not be asked to cover sickness or rota gaps. PAs can take on additional shifts outside of the main rota for example to support surge activity or bank holiday weekends and at the request of departments, providing the role is supported e.g. supporting a post take ward round with a consultant and undertaking tasks that they would usually perform as part of normal duties.

Core Procedural Skills

PAs have trained and been assessed as competent to perform a number of core procedural skills at qualification. Some of these include:

Taking baseline physiological observations (measure temperature, respiratory rate, pulse rate, blood pressure, oxygen saturation and urine output) and record and interpret appropriately

- Participate in cardiopulmonary resuscitation to the level expected in Immediate Life Support training
- Venepuncture and blood culture sampling
- Cannulation
- Perform arterial blood gas and acid base sampling from the radial artery in adults and be able to interpret results
- Catheterisation (male and female)
- Peak flow examination
- Urine dip stick
- Perform a 12-lead electrocardiogram and be able to interpret results
- Instruct patients in the use of devices for inhaled medication

PAs are expected to use pre-filled and sealed saline flushes when inserting cannulas^[4].

5.4 Ward rounds

Ward rounds will be a key activity for most of the PAs working within the Trust. Experienced PAs can lead the clinical review without direct supervision providing a qualified and registered doctor is also working within the same clinical area and the supervising doctor is happy for them to do so. Newly qualified PAs should not be leading clinical reviews without direct supervision.

All PAs working at the Trust can assess new patients. This is a core activity for those working in the Emergency Department or Acute Medicine. The supervising senior clinician should determine and oversee the patients being assessed. It is recommended that PAs working outside of these areas should spend one session a week supporting acute assessment to maintain their assessment skills providing it does not impact on ward level staffing or doctors in training.

It should be ensured that when designing departmental work allocations including PAs, careful attention should be paid to the balance of skill mix in the clinical team. Wherever possible, PAs should be working supported by senior clinicians (above the level of Foundation year 1 doctors).

In situations where PAs require the support of a doctor for prescribing or ordering ionising radiation, it should be done so on the understanding that the PA, in return, will relieve the doctor of other tasks within their competency to free up their capacity to support the PA.

Where and whenever possible, these activities should be supported by the Consultants as a part of the ward round duties or other clinical activities. PA job plans should be regularly reviewed to ensure continuity of senior supervision.

5.5 Consent

The Trust Policy on Consent:

The healthcare professional carrying out the procedure is ultimately responsible for ensuring the patient is genuinely consented. Where written consent is sought it may be appropriate for other members of the team to participate in the process of seeking consent, subject to the following restriction that the healthcare professional is competent to obtain consent for the procedure/treatment proposed to the patient. Competency is established when either 1. the healthcare professional themselves carries out the procedure or is capable of carrying out the procedure unsupervised or 2. because they have received specialist training in advising patients about the procedure and have been assessed as competent to do so. This includes demonstrating that they are aware of the limits of their knowledge and that their practice is subject to audit.

With appropriate training by a competent practitioner and competency assessment which has been recorded in the PA's portfolio, PAs are able to obtain verbal/written consent for additional

skills providing that the consent is documented in the medical record or using Trust approved procedure specific documentation that should be scanned.

PAs are unable to consent patients for operative procedures that require general anaesthesia or procedures in which they are not competent to perform themselves^[9].

5.6 Ordering investigations

PAs are able to use electronic ordering to request most common and standard blood tests but also specialist blood tests under instruction by a senior doctor.

PAs are able to request specific ultrasound examinations providing that the request is justified and directly sanctioned by a supervising clinician who takes overall responsibility for reviewing and acting upon the results of that investigation.

PAs lack statutory regulation so are unable to make requests for ionising radiation (ie. x-rays) at present, this may change with statutory regulation. The use of ionising radiation has been subject to specific legislation since 1988 which clearly specifies that only registered healthcare professionals are able to order ionising radiation. Even though many PAs have undertaken Ionising Radiation (Medical Exposure) Regulations (IRMER) training they are still unable to make these requests. However, PAs are encouraged to take IRMER training as part of their professional development in anticipation of regulation^[10].

PAs are able to request Magnetic Resonance Imaging (MRI) where asked to by their supervising consultant.

5.7 Referrals

PAs are able to make both written and verbal referrals to other specialties and healthcare facilities. This would be under the direction of the supervising clinician.

5.8 Prescribing

The upcoming regulator for PAs, GMC states: Physician associates (PAs) cannot currently prescribe. Prescribing responsibilities aren't included in the legislation that will bring in regulation. Additional legislation will be required.

This means that PAs are **currently unable to prescribe medications** in the UK. Following regulation, **prescribing ability will not automatically be granted** as further public consultation will be necessary before any responsibility for the supply of medicines or prescribing is added to the role.

This policy will be updated accordingly once further guidance is released^[10].

PAs must undertake the appropriate ePMA training before requesting read-only access to the software. The PA's ePMA access restricts PAs from prescribing medication via the electronic prescribing system at ESHT.

All UK trained PAs have had training in the drug management of common conditions using applied pharmacology. PAs are expected to have a good understanding of the appropriate medications and doses to be given for a range of conditions across a range of specialties. They should, therefore, be able to adequately discuss a patient with a colleague and come to an agreement on the medication requirements of that patient based on their training, review of the patient and guidance from the supervising clinician. In handing over to other members of the clinical team, PAs should ensure that any instruction to commence a drug treatment including IV fluids is an instruction from a named prescriber and be able to explain the rationale^[10].

Oxygen can however be applied by a PA in Emergency situations.

Transcribing Medication

PAs must be assessed to be competent to safely transcribe before they are able to transcribe from an earlier inpatient drug chart to a new drug chart. All transcribing must be countersigned by a qualified and registered doctor before the medicine can be administered. The responsibility of prescribing for the patient stays with the Consultants team, but the PA is accountable for their own actions. PAs are unable to transcribe cytotoxic medications or controlled drugs. Verbal requests for medication must not be made by the PA to other healthcare professionals.

When a PA is seeing an acute admission, the PA will be responsible for ensuring that time-critical medications/treatments are not delayed and must discuss any potential prescriptions with their supervising senior Clinician. Initiation of new medication or changes to prescriptions must be made and written by a qualified and registered doctor, they cannot be countersigned by a non-medical prescriber.

5.9 Discharge letters

PAs can complete the clinical summary of an electronic discharge letter. PAs are not permitted to transcribe medicines from the drug chart onto electronic discharge summaries. Discharge medications must be added to the electronic discharge summary and signed for by a registered doctor only. The final letter must be reviewed and finalised for printing by a doctor.

5.10 Certification of death

PAs are unable to verify death or complete the Medical Certificate of Cause of Death or make referrals to HM Coroner.

5.11 End of life care and Do Not Attempt Resuscitation decisions

Experienced PAs, if asked to do so by the Registrar or Consultant they are working with, and provided they are confident to do so, may be involved in discussions with patients and relatives around end of life care and resuscitation but are not authorised to make decisions regarding resuscitation. They can complete the Respect providing it is to be immediately countersigned by the responsible senior clinician (Consultant or Registrar). The overall responsibility for the content of the form and ensuring communication of that order remains with the countersigning senior clinician. The PA is responsible for clearly documenting the discussion in the clinical notes.

5.12 Gaining extended skills

The Trust expects PAs to acquire any additional skills in a manner that upholds the highest standard of care, and to safeguard the patient, practitioner and the Trust. The extended skill-set that a PA might develop must always consider the needs of the service whilst ensuring that the training requirements of the rotating and resident doctors are prioritised and will depend on the clinical speciality in which the PA is employed.

Training Pathway for Extended Skills

The Trust expects PAs to acquire these extended skills in a manner that upholds a high standard of care, and to safeguard the patient, practitioner and the Trust.

Firstly, the PA should receive training from a qualified and competent practitioner in that skill, then subsequently a period of supervised practice should be undertaken. Appropriate training would mean attending an accredited course in procedural skills. Given the need to ensure that the trainer is qualified and competent, all PAs wishing to learn extended skills must seek permission from the PA tutor. They must be taught and supervised by a Registrar or Consultant who is proficient in the procedure.

Both the initial training and supervised practice should be documented and form part of the PA's work-based yearly appraisal. Competency to continue practicing the extended skills should be reviewed at this yearly appraisal. Extended skills specific to the speciality (for example nerve blocks for Fractured neck of Femur) must be taught and competency assessed as noted above by a Registrar or Consultant who is proficient in these procedures.

The format of the initial training may vary per procedure; however it is expected that the same Directly Observed Procedural Assessment (DOPS) record be used for the supervised practice element. The number of DOPS required will depend on the procedure and the competency demonstrated by the PA.

DOPS should be assessed in terms of level of competency 1-4 as follows:

1. Unable to perform procedure
2. Competent to perform procedure under direct supervision
3. Competent to perform procedure with minimal supervision
4. Competent to perform unsupervised and able to deal with possible complications

Levels of Competency and Supervision Required

The following table lists the current extended skills agreed by the PA Tutor for PA practice. Once the number of required DOPS at levels 1-3 is achieved then the PA should be observed by a consultant prior to being deemed level 4 competent.

With current restrictions imposed by lack of regulation, PAs must have a competent practitioner in attendance *even if* the PA is level 4 competent in that particular procedure.

Some procedures will require administration of local anaesthetic; training for which should form part of the DOPS for each procedure required. The PAs can administer a medication under a Patient Specific Direction. A Patient Specific Direction (PSD) is the traditional written instruction, signed by a doctor, dentist, or non-medical prescriber (hereafter referred to as “the prescriber” unless stated otherwise) for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. The PSD is a prescription by a qualified and fully registered doctor on an appropriate ESHT Trust approved prescription chart or ePMA.

If formal training to recognise and manage complications of the procedure has been undertaken, for example diagnostic ultrasound, and also the supervising Consultant deems the PA competent to perform extended skills with remote supervision (i.e. the Consultant is not in the room but is aware of the time and location that the procedure is taking place and is available via bleep or telephone) then the PA may be allowed to perform extended scope procedures under remote supervision.

Table of agreed Extended Skills – based on current procedures carried out by UK PAs^[11].

| Procedure | Currently Practiced | Minimum Number of DOPS required through each levels 1-3 to achieve level 4 |
|--|---------------------|--|
| Ascitic drain insertion | Yes | 5 |
| Ascitic tap | Yes | 5 |
| Backslab application | Yes | 5 |
| Casting/Splinting | Yes | 5 |
| Chest drain | Yes | 5 |
| Fascia-iliaca blocks with ongoing infusions (#NOF) | Intended | 5 |
| Incision and drainage of abscesses | Intended | 5 |
| Joint aspiration | Intended | 5 |
| Lumbar puncture (diagnostic/therapeutic) | Yes | 5 |
| Nerve Blocks | Yes | 5 |
| NG placement | Yes | 3 |
| Pleural tap (diagnostic/therapeutic) | Yes | 5 |
| Pulmonary Lung Function Tests | Yes | 3 |
| Relocation of joints | Yes | 5 |
| Ring blocks | Intended | 5 |
| Suturing | Yes | 5 |

Once the number of required DOPS at levels 1-3 is achieved then the PA should be observed by a Consultant prior to being deemed level 4 competent.

Intended skills are ones that the Trust intends to support the development and training of PAs within specific specialties. Extended skills and the competencies of the Physician Associates performing them will be reviewed at yearly appraisals and should be documented in their portfolio. The Trust requires that any additional extended skills not included in the table above be raised with the PA Tutor for consideration. They will be discussed at the internal PA governance group meetings.

All PAs undertaking any of these extended practical skills must take out personal professional negligence insurance with one of the medical defence organisations.

PAs should keep a log book of all additional procedures as well as Directly Observed Procedural Assessment (DOPS) records to demonstrate knowledge and competence acquisition. Log books should be reviewed as part of appraisal processes. It is expected that procedural logs will be stored in the PA e-portfolio for those who are members with the FPA or paper-based portfolios.

5.13 Excluded skills

The Trust requires that any additional skills not included in the table above be raised with the PA Tutor, Lead PA and the Lead Clinician for the department for consideration to determine the need and whether appropriate for the PA role.

Although the following appear as frequently practiced in the Physician Associate Census^[6], the Trust does not anticipate that its PAs will perform these procedures or skills at this time:

- Arterial line insertion
- Bier Blocks
- Central line insertion
- Cervical Smear
- Contraceptive implant placement and removal
- Fitting of diaphragm
- Intubation
- IUD insertion and removal
- Port placement
- Skin lesion removal
- Antenatal ultrasound
- DEXA scanning
- General new-born examination
- OGD
- Psychiatric Assessment

Current regulations from the faculty of Physicians Associates dictate that IM, IV and O2 therapy procedures must not be performed even if performed as students under direct supervision of a qualified competent medical or healthcare professional.

Logging of procedures

PAs should keep a logbook of all additional procedures as well as Directly Observed Procedural Assessment (DOPS) records to demonstrate knowledge and competence acquisition. Logbooks should be reviewed as part of appraisal processes. It is expected that procedural logs will be stored in the PA e-portfolio for those who are members with the FPA or paper-based portfolios

5.14 PAs in outpatient clinic settings

PAs can support clinic activity where the service requirements support it and providing doctors in training are not disadvantaged by doing so. PAs will work under the supervision of a named Consultant who will allocate suitable patients. Time must be allocated in the supervising

consultant's job plan to allow for discussion time and review of patients as needed. Clinic specific Standard Operating Procedures are in place for PAs whose job involves outpatient clinics.

At all times the training requirements of doctors will be prioritised.

5.15 Clinical supervision

On appointment each PA will be given a named Consultant Supervisor from the specialty they are working in. PAs must have daily supervision in their practice. The format of supervision will vary from individual to individual and is dependent on a number of factors including, but not limited to, any past health care experience, years of clinical experience as a PA and evidence of progression assessed at review points and appraisal. Those in the New Graduate Year, or those moving from primary to secondary care, will require more intensive and direct supervision compared to an experienced PA as previously described.

Accountability of Supervising Consultant

PAs are able to practice in the UK under the clause of delegation within the General Medical Council's Good Medical Practice 2024:

Delegation involves asking a colleague to take responsibility for providing care or treatment on your behalf. Accountability for safe delegation is shared between the colleague delegating and the colleague to whom care or treatment is delegated. You must work collaboratively with colleagues to make sure delegation is appropriate.

You must be confident that the colleague you delegate to has the necessary knowledge, skills, and training to carry out the task, or that they will be adequately supervised to ensure safe care.

“Usually, you will delegate to a colleague who is a medical, health or social care professional registered with a statutory regulatory body. If a colleague is not registered with a statutory regulatory body, registration on a managed voluntary register can give some assurance that they've met defined standards of competence, and that they adhere to agreed standards for their professional skills and behaviour. Information about accredited registers can be found on the website of the Professional Standards Authority. Until statutory regulation is in place, physician associates can join the Physicians Associate Managed Voluntary Register...”

When you delegate or refer care you are accountable for:

1. your decision to delegate or refer care
2. the steps you take to make sure patient safety isn't compromised
3. the instructions you give
4. *the overall management of a patient if you're the responsible consultant or clinician”*

Although individual PAs are accountable for their practice within the boundaries of supervision and defined scope, their supervising consultants are accountable for their overall work and must accept responsibility for any duties undertaken by a PA in training or a qualified PA. On this basis, any intended extension to the scope of practice outside of core duties set out in Section 3.3 must have been agreed by the PA tutor and determined as reasonable and justifiable to meet service requirement^[11].

Clinical supervisor meetings

The Clinical Supervisor and PA must ensure that a Commencement of Employment meeting takes place during the induction period and that regular reviews are scheduled.

During meetings an educational plan should be drawn up/maintained with the supervisor and agreement made over allocation of dedicated CPD hours.

Frequency of review meetings will depend on the experience of the PA and whether any areas are identified where the PA requires additional support but generally should be meeting twice per year.

Supervising consultants will also be invited to a bi-annual PA Governance Group to feedback and discuss individual PA practice and development in the Trust.

5.16 Revalidation

Although PAs will acquire specialist knowledge relevant to their field of practice, they are expected to maintain the same level of general competence across PA curriculum and PARA content map.

Previously to remain in good standing, PAs were required to pass the PA recertification assessment every 6 years of clinical practice. This was replaced in May 2023 as the GMC announced its revalidation approach which is based on annual employer appraisal, reflection, and local clinical governance.

Revalidation for PAs will be implemented after the two-year regulation transition period which will begin when regulation starts at the end of 2024. At the end of the transition period it will be a legal requirement for all PAs on the GMC register.

Revalidation will be based on the collection of six pieces of supporting information. The information will be discussed and reflected upon at annual appraisals.

The six categories of supporting information will mirror those currently required for doctors:

1. continuing professional development (CPD)
2. complaints and compliments
3. feedback from colleagues
4. feedback from patients
5. quality improvement activity
6. significant events

This is set out in the GMC guidance around Revalidation for Physician Associates on the GMC Website:

“Once every five years we’ll ask employers for a recommendation about each PA to confirm they are:

Collecting the required supporting information and discussing this during annual appraisal Fit to practise, complying with any conditions on their registration and working within the bounds of their competence.

Keeping their knowledge and skills up to date by participating in CPD/lifelong learning, training and other activity.

Working within a locally agreed framework of clinical governance that includes a requirement for supervision appropriate to their role and experience.”

To support this ongoing requirement of Revalidation, the FPA launched an ePortfolio for qualified FPA members in 2023. Prior to this, PAs will have been expected to maintain a paper-based portfolio. Following revalidation PAs will be continue to be responsible for holding a portfolio even if they choose not to remain members of the FPA^[13].

The ePortfolio also allows PAs to:

- Log evidence of clinical competencies. For example, completing direct observation of procedural skills (DOPS), mini clinical evaluation exercise (mini-CEX), and case-based discussion (CBD) forms
- Gather multi-source feedback (MSF) and patient feedback forms
- Complete the FPA appraisal toolkit
- Record CPD^[6].

5.17 Continuous professional development requirements

Continuing professional development (CPD) is the educative means of updating, developing and enhancing the knowledge, skills and attitudes required to work safely and effectively as a PA. All PAs must fulfil CPD requirements to remain on the PAMVR and for GMC revalidation.

From 1 April 2024 all PAs on the PAMVR will be required to start logging their CPD through the FPA ePortfolio and this will be the start of the first year of recording CPD in this way. Any PAs registered on the RCP CPD Diary should transfer over to the new FPA ePortfolio.

PAs are generalists and must keep up to date in all 18 areas of the Core Clinical Practice Curriculum (CCPC) which was launched in September 2023. Each of these 18 areas has specific topics within them; the detail on this can be found within the PA content map document.

PAs are currently expected to complete 250 hours of CPD every five years with 125 hours of this time spent divided across the 18 areas in the CCPC^[14].

| This table displays the CPD breakdown of current annual and 5-year cycle requirements Annual CPD requirement | | 5 year CPD cycle requirement |
|---|--------------------------|-------------------------------------|
| Core CPD - CCPC | 25 hours (25 CPD) | 125 hours (125 CPD) |
| Additional/Supplementary/My speciality CPD | 25 hours (25 CPD) | 125 hours (125 CPD) |
| *Verifiable | 10 hours (10 CPD) | 50 hours (50 CPD) |
| *Non-verifiable | 40 hours (40 CPD) | 200 hours (200 CPD) |
| Total CPD to achieve | 50 hours (50 CPD) | 250 hours (250 CPD) |

The South East School of PAs provides a rolling PA educational programme delivered by different members of the multi-disciplinary team and mapped to the PARA curriculum. The teaching is on-line streamed. PAs can also attend Trust training events and grand round but do not attend dedicated teaching intended for doctors in training.

Study Budget for CPD

The trust offers each employed PA a study budget of £500 per year.

The financial support to provide this study budget is not able to be guaranteed over time as the number of PAs working within the Trust increases. On-going financial support will need to be discussed in PA Governance Group meetings and this policy will be amended accordingly. PAs are encouraged to make use of the available funds and ensure they book and claim for their CPD.

Claims for reimbursement of study leave must be made within 90 days (3 months) of the course being attended. Failure to do so may mean the claim cannot be made and must be discussed with the PA Tutor.

All claims for the period immediately before the end of the financial year in March must be made as soon as possible after the event and advance notification of the intention to attend a course must be submitted to the PA Tutor.

The ability to provide qualified PAs with an annual study budget will be reviewed on an annual basis as it may not always be possible.

Study Leave

At present PAs are entitled to five days of study leave per year, at their line manager's discretion, to attend external courses in addition of the requirement to attend yearly mandatory training. Study leave to attend internal courses will be in addition to these seven days but will be at the discretion of their line manager.

PAs wishing to take part in additional activities to aid their profession such as OSCE examinations and question writing may be granted professional leave at the discretion of their line manager.

Study leave is subject to approval by the rota coordinator for the clinical area that the PA works in.

5.18 Appraisal

Trust appraisal

The Trust Appraisal, which is the pay progression appraisal, should be performed annually by the PA's line manager using the Trust Appraisal template for Agenda to Change staff.

The appraisal provides an opportunity to review development and objectives over the year and set new achievable goals and identify areas for further development.

Appraisal documentation will be submitted to HR and workforce development so that the Electronic Staff Record can be updated.

PA professional appraisal

In addition, annually professional appraisal will be conducted by the PA Tutor and may also involve the Lead PA. Each PA will be expected to have prepared for the appraisal by drafting an appraisal form on the ePortfolio, which reviews the years training and development, clinical and non-clinical activities. It reviews miniCEXs and CBDs (from their first year in post), DOPs and MSF/360 documentation.

For the PA professional appraisal, the Trust expects each PA to develop a portfolio of evidence throughout the year. Evidence to be collected prior to appraisal includes:

- Current job plan
- Review meeting documentation copies (filed in the PA's portfolio)
- Certificates of completion of Mandatory and Statutory training
- Personal development plan (review of previous and for the next year)
- MSF/360 – recommended every five years
- Work Place Based Assessments and DOPS

Suggested additional documentation for portfolio:

- Evidence of experience in audit, research and teaching
- Patient and/or staff feedback results

The purpose of the appraisal is to:

- Support the PA in their personal development
- Review the PDP objectives
- Identify any areas for performance development
- Ensure all contractual elements of practice are up to date including; mandatory and statutory training and status of registration on the PAMVR

Please note that if FPA or GMC alter recommendations for appraisal or appraisal documentation then this section of the policy will be updated in line with the changes^[14].

5.19 Fitness to practice

Fitness to practice issues should be raised with the Trust Lead PA and PA Tutor who will, in turn, report concerns to the FPA. The PAMVR ensures that no PA is placed on the register or remains on the register without demonstrating fitness to practice. Following regulation, fitness to practice concerns will be managed by the GMC.

PAs are also expected to work to a code of conduct as outlined in the FPA Code of Conduct and the uphold the GMC standards set out in the Good Medical Practice.

Please note following regulation, fitness to practice concerns will be managed by the GMC and the policy will be updated in line with any changes.

5.20 Physician Associate students

The Trust currently supervises PA student placements from Brighton and Sussex Medical School MSc course. Students will have a dedicated induction to the Trust led by the PA tutor and Trust Lead PA.

Whilst on placement, PA students will be supervised by a named Consultant within each specialty and where possible paired with a working PA to provide mentorship and support, even if that PA does not work within the specialty of the placement. Students from the different universities will have specific and differing learning objectives. The supervising consultants will be provided with student placement handbooks by the universities prior to the student arriving which should provide all the necessary details. Concerns about the progress of students should be raised with the PA tutor and Lead PA in the first instance and this will be forwarded on to the student's corresponding HEI.

Whilst on placement, PA students should work under the scope of practice set out within this policy and within the scope of practice set out by the training universities. Student PAs are not permitted to perform any of the extended skills listed above.

Specialties seeking to take PA students where they do not currently employ PAs are asked to request this via the PA Tutor to ensure that the placements meet the requirements of the students and university standards for placement and to ensure that the supervising consultants receive support in providing the placement.

Student Indemnity

Indemnity for the work of the PA student is provided by standard NHS Indemnity. We would expect them to be in contact with patients either as an observer only or in a directly supervised role with the supervising doctor retaining responsibility for any patient contact and treatment. PA students are able to see patients without a doctor being present at the time, however. We would not expect students to make independent decisions about the diagnosis or management of patients or to provide specific clinical advice to patients (unless in the presence of the supervising doctor).

Supervising doctors or nurses working alongside student PAs have ethical and legal duties of care to their patients and retain professional responsibility for their patients when they are supervising the involvement of a student. If a patient were to be harmed as a result of a PA student's involvement in their care, it is most likely that any claim brought would name the supervising doctor.

5.21 1:1 reviews

PAs should have a minimum of two 1:1s with their line manager annually to review performance and identify development opportunities that benefit the service. The 1:1 ideally would take place with the Lead PA for the service but otherwise can occur with their line manager. A wellbeing conversation should occur within this 1:1, guidance for which can be found via the Trust Intranet.

6. References and associated documents

Associated documents

| Organisation | Author | Date of Publication | Title of Document |
|-------------------------|---|--|--|
| Department of Health | DofH | 2012 | Competence and Curriculum Framework for the Physician Associate |
| Department of Health | DofH | 2012 | Guidance for use of the Clinical Negligence Scheme for Trusts (CNST) |
| Department of Health | DofH | 2006 | Matrix specification of Core Clinical Conditions for the Physician Assistant |
| ESHT | Simon Walton | 2019 | Consent to Treatment, Examination and Care Policy and Procedure |
| Department of Health | DofH | 2012 | Ionising Radiation (Medical Exposure) Regulations 2000 and amendments made in 2006 |
| FPARCP | [REDACTED] | 2015 | Fifth Annual UK Physician Associate Census. |
| General Medical Council | GMC | 2013 | Good Medical Practice |
| Department of Health | DofH | 2014 | Knowledge and Skills Framework |
| AAPA | AAPA | 2013 | Guidelines for Ethical Conduct for the Physician Assistant profession |
| General Medical Council | [REDACTED], Assistant Director, Regulation Policy, Strategy and Communication | Council meeting, 30 September 2015 | The scope of medical regulation: physician associates |

Associated documents

| Organisation | Author | Date of Publication | Title of Document |
|--------------|--------|---------------------|---|
| ESHT | ESHT | 2013 | Procedural Documents Policy and Procedure |

7. References

1. Faculty of Physician Associates - quality health care across the NHS (fparcp.co.uk)
2. Get ready for regulation - GMC (gmc-uk.org)
3. 653a42380d285_FPA_PA_curriculum_Sep_23_FINAL_WEB_VERSION.pdf (fparcp.co.uk)
4. PA registration assessment content map - GMC (gmc-uk.org)
5. Effective clinical governance to support revalidation - GMC (gmc-uk.org)
6. ePortfolio | Faculty of Physician Associates - quality health care across the NHS (fparcp.co.uk)
7. Clinical Negligence Scheme for Trusts - NHS Resolution
8. Faculty of Physician Associates - quality health care across the NHS (fparcp.co.uk)
9. 01269_P.pdf (esht.nhs.uk)
10. Guidance case studies for physician associates and anaesthesia associates - GMC (gmc-uk.org)
11. Focus on physician associates: census 2022 (FPA census | Faculty of Physician Associates - quality health care across the NHS (fparcp.co.uk)
12. <https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/delegation-and-referral/delegation-and-referral>
13. Revalidation for physician associates and anaesthesia associates - GMC (gmc-uk.org)
14. 63c19037b1a1d_CPD_guidance_for_Physician_Associates_Jan_23_FINAL.pdf
15. Good medical practice 2024 - GMC (gmc-uk.org)

8. Monitoring policy implementation

This policy and the employment of PAs across all specialties will be monitored by the PA Tutor in order to ensure consistency and compliance. Any issues identified will be addressed via the appropriate specialty manager with support from Human Resources.

This policy will be reviewed annually. The PA tutor is responsible for updating the document as change occurs or as directed by any change in practice by the FPARCP.

8.1 Monitoring approval, amendments and document control

The Trust process for amendment of policies will be conducted as specified in Organisation-Wide Policy for Procedural Documents Template, available on the Extranet.

This includes:

- Approval, ratification and review checklist
- Minor changes audit proforma
- Review cycle

It also includes:

- Posting on the dedicated policies webpage on the Trust Intranet.
- Inclusion of key information regarding scope of practice in induction packs for new PAs and doctors in training.
- Notification to all staff of the policy on the next email bulletin.
- Specific training for specialty managers when requesting PA resource.

8.2 Document Monitoring Table

| Element to be Monitored | Lead | Tool for Monitoring | Frequency | Responsible Individual/Group/ Committee for review of results/report | Responsible individual/ group/ committee for acting on recommendations/action plan | Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented |
|-------------------------|-------------|---------------------|-----------|--|--|---|
| Compliance with Policy | Dr O Kankam | Audit tool | Annually | Specialty Governance Group | Division Governance Group | Division Governance Group |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

9. Equality and Health Inequalities Assessment

An Equality and Health Inequalities Assessment was completed and did not identify any impact on protected characteristics or health inequality groups. Please see Section 9.

Appendix A: Equality and Health Inequalities Impact Assessment (EHIA) template

Undertaking EHIA helps us to make sure that our services and policies do not inadvertently benefit some groups more than others, ensuring that we meet everyone's needs, and our legal and professional duties.

This is important because:

- Assessing the potential for services and policies to impact differently on some groups compared with others is a legal requirement.
- People who find it harder to access healthcare services are more likely to present later when their disease may be more progressed, have poorer outcomes from treatment, and need more services than other groups who have better access.

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It is against the law to discriminate against anyone because of:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation.

These are called 'protected characteristics'. The Act requires that public sector organisations meet specific equality duties in respect of these protected characteristics. This is known as the public sector equality duty.

Public Sector Equality Duty

Public bodies have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees.

Public bodies must have due regard to the need to:

- eliminate discrimination
- advance equality of opportunity
- foster good relations.

Armed Forces Covenant Duty

The new Covenant Duty raises awareness of how Service life can impact on the Armed Forces community, and how disadvantages can arise due to Service when members of that community seek to access key local services. The Duty requires organisations to pay due regard to the Covenant principles when exercising functions in healthcare. "Due regard" means that we need to consciously consider the unique obligations and sacrifices made by the Armed Forces; that it is desirable to remove disadvantages faced by the Armed Forces community; and that special provision may be justified in some circumstances.

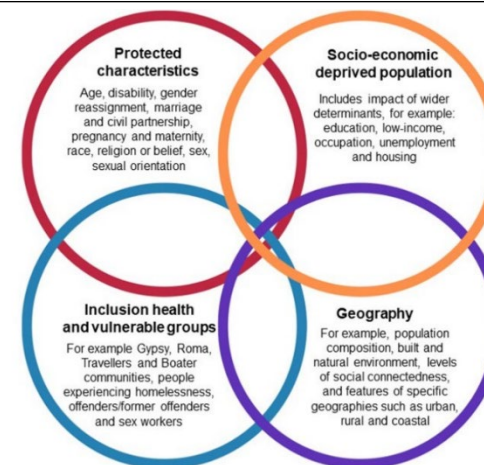
Health Inequalities Duties- Equity for all

In addition to our legal duties in relation to Protected Characteristics, the Health and Social Care Act and other legislation, NHS Planning Guidance and sector specific recommendations require the NHS to have regard to the need to address health inequalities (or differences in access to or outcomes from healthcare) and take specific action to address them.

Figure 1 shows the different population groups, factors associated with where we live, or our individual circumstances, which separately, or when combined, influence access to and outcomes from health care.

Getting equal outcomes may require different inputs (or services). In completing an EHIA its important to think about whether a one size fits all approach will generate the same good outcomes for everyone, or whether we might need to make some tweaks or adjustments to enable everyone to benefit equally. The health tree diagram shows that unless we think about the needs of different people, equal services might generate unequal outcomes.

Factors associated with poorer health outcomes (PHE 2021)¹



The Health Tree¹

The following principles, drawn from case law, explain what we must do to fulfil our duties under the Equality Act:

- **Knowledge:** everyone working for the Trust must be aware of our equality duties and apply them appropriately in their work.
- **Timeliness:** the duty applies at the time of considering policy options and/or before a final decision is taken – not afterwards.
- **Real Consideration:** the duty must be an integral and rigorous part of your decision-making and influence the process.
- **Sufficient Information:** you must assess what information you have and what is needed to give proper consideration.
- **No delegation:** the Trust is responsible for ensuring that any contracted services which provide services on our behalf can comply with the duty, are required in contracts to comply with it, and do comply in practice. It is a duty that cannot be delegated.
- **Review:** the equality duty is a continuing duty. It applies when a policy/process is developed/agreed, and when it is implemented/reviewed.
- **Proper Record Keeping:** to show that we have fulfilled our duties we must keep records of the process, and the impacts identified.

NB: Filling out this EHIA in itself does not meet the requirements of the equality and health inequalities duties. All the requirements above must be fulfilled or the EHIA (and any decision based on it) may be open to challenge. Properly used, an EHIA can be a tool to help us comply with our equality and health



¹ https://www.researchgate.net/figure/Equality-and-equity-of-medical-resources-distribution_fig2_323266914

inequalities duty and as a record that to demonstrate that we have done so. It is advised that you complete the short EHIA training session on [REDACTED] before completing this EHIA.

SECTION A ADMINISTRATIVE INFORMATION

This form is a central part of how the Trust makes sure and can demonstrate to others that we are meeting our legal duties; and how we can assure ourselves that all patients will get the best outcome for them from our services.

| | | | |
|--|--|--|--|
| <p>A completed copy of this form must be provided to the decision-makers in relation to your proposal. The decision-makers must consider the results of this assessment when they make their decision about your proposal. Function/policy/service name and number:</p> | <p>An organisation-wide policy for the role of Physician Associates.</p> | | |
| <p>Main aims and intended outcomes of the function/policy/service and summary of the changes you are making (if existing policy/service):</p> | <p>To provide clear and easy to understand governance for Physician Associates employed by East Sussex Healthcare Trust.</p> | | |
| <p>How will the function/policy/service change be put into practice?</p> | <p>To provide guidance for Physician Associate practice at East Sussex Healthcare Trust.</p> | | |
| <p>Who will be affected/benefit from the policy?</p> | <p>Staff, patients, service users, partner organisations, physician associates, physician associate students.</p> | | |
| <p>State type of policy/service</p> | <p>Policy (YES)</p> | | |
| <p>Is an EHIA required? NB: Most policies/functions will require an EA with few exceptions such as routine procedures</p> | <p>Yes</p> | | |
| <p>Accountable Director: (Job Title)</p> | <p>Lead Physician Associate</p> | | |
| <p>Assessment Carried out by:</p> | <p>Name: Zoe Neale</p> | | |
| <p>Contact Details:</p> | <p>[REDACTED]</p> | | |
| <p>Date Completed:</p> | <p>28/04/2025</p> | | |

SECTION B ANALYSIS AND EVIDENCE

Analysis of the potential impact – Equality and Health Inequalities Duties

For this section you will need to think about all the different groups of people who are more likely to experience poorer access or have poorer outcomes from health and care services. For each group please describe in the first column the potential impact you have identified, in the second column explain how you have arrived at this conclusion and what information you used to identify the potential impact, and in the third column say what you are going to do to prevent it from happening, or which elements of a service or policy specifically address the potential impact. Key things to remember.

- Everyone has protected characteristics but some groups who share one or more protected characteristics may be more likely to have poorer outcomes or access compared with others – and it is this potential that the EHIA process seeks to identify and address.
- The information included here should be proportionate to the type and size of the policy/service/change.
- An update to a policy should demonstrate that you have considered the potential for the policy to impact differently on different groups and taken steps to address that.
- A minor policy update is likely to need to be much less comprehensive than an EHIA for a major service change.
- You will need to know information about who uses or could use your service/policy will apply to (the population). You can use information about current patients or staff, and about the general population the Trust serves.

3. PROTECTED CHARACTERISTICS - Main potential positive or negative impact of the proposal for protected characteristic groups summarised

Please write in the box below a brief summary of the main potential impact (positive or negative) Please state **N/A** if your proposal will not impact adversely or positively on the protected characteristic groups listed below, but make sure you include information on how you know there will be no impact.

| |
|------|
| N/A. |
|------|

| Protected characteristic groups | Summary explanation of the <i>potential</i> positive or adverse impact of your proposal | How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback | Action that will be taken to address the potential for negative impact. |
|--|---|--|---|
| Age: older people; middle years; early years; children and young people. | This policy protects staff from all age groups no matter what age they are as outlined in the Equality Act 2010 | There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS | |

| Protected characteristic groups | Summary explanation of the <i>potential</i> positive or adverse impact of your proposal | How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback | Action that will be taken to address the potential for negative impact. |
|--|--|--|---|
| Disability: physical, sensory and learning impairment; mental health condition; long-term conditions. | This policy has a positive impact on all staff that have a disability or long term health condition. It links into the (Dis)Ability & Health Passport to enable adequate adjustment to take place and the Carers Passport to achieve a work life balance | The Workforce Disability Equality Standard, set out by NHS England details the positive association between increased disability equality and workplace experience for disabled individuals. | |
| Gender Reassignment and/or people who identify as Transgender | This policy has a positive impact on those that are transitioning from their gender assigned at birth to another gender. This policy links into the Gender Recognition Act 2004 | There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS. | |
| Marriage & Civil Partnership: people married or in a civil partnership. | This policy does not have a negative impact on a member of staffs marital or civil partnership status | There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS. | |
| Pregnancy and Maternity: before and after childbirth and who are breastfeeding. | This policy has a positive impact on pregnancy, maternity and also including paternity rights with, The Employment Rights Act 1996 which sets out rights to health and safety, time off for antenatal care, maternity leave and unfair dismissal | There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS. | |
| Race: | This policy has a positive impact for all staff regardless of their race or ethnicity | The Workforce Race Equality Standard, set out by NHS England details how the positive association between increased race equality and workplace experience for disabled individuals | |
| Religion and belief: people with different religions/faiths or beliefs, or none. | This policy has a positive impact on all staff the wish to observe religious practices and those that don't | There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS. | |

| Protected characteristic groups | Summary explanation of the <i>potential</i> positive or adverse impact of your proposal | How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback) | Action that will be taken to address the potential for negative impact. |
|--|--|---|---|
| Sex: | This policy has a positive impact on gender and looks at statutory duties under the Gender pay Gap | The Gender Pay Gap Report details the positive association with gender equality and workplace experience | |
| Sexual orientation | This policy has a positive impact on staff no matter what their sexual orientation is | There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS | |
| Veterans/Armed Forces Communities | This policy ensures ‘due regard’ is considered for veterans and the armed forces community | There is strong evidence that where an NHS workforce is representative of all protected characteristics it fosters a sense of belonging – detailed in the NHS People Plan NHS England » Belonging in the NHS | |

4. HEALTH INEQUALITIES -Potential positive or adverse impact for people who experience health inequalities summarised

Please briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below). **If the policy/procedure is unrelated to patients, this section does not require completion.**

Please state none if you have assessed that there is not an impact, but please make sure you complete the ‘how do you know this’ column to demonstrate that you have considered the potential for impact. **If you identify the potential for impact for one or more of these groups, please complete the full assessment in Appendix A**

| Groups who face health inequalities ² | Summary explanation of the potential positive or adverse impact of your proposal | How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback) | Action that will be taken to address the potential for negative impact. |
|--|--|---|---|
| <p>This includes all groups of people who may have poorer access to or outcomes from healthcare services. It includes: People who have experienced the care system; carers; homeless people; people involved in the criminal justice system; people who experience substance misuse or addiction; people who experience income or other deprivation; people with poor health literacy; people living in rural areas with limited access to services; refugees or asylum seekers; people in or who have been in the armed force; other groups who you identify as potentially having poorer access and outcomes.</p> | <p>There is strong evidence that where an NHS workforce is representative of the community that it serves, patient care and the overall patient experience is more personalised and improves</p> | <p>NHS England » Belonging in the NHS</p> | |

SECTION C ENGAGEMENT

5. Engagement and consultation

a. Talking to patients, families and local communities can be a rich source of information to inform health care services. If you are making substantial changes, it's likely that you'll have to undertake specific engagement with patients. For smaller changes and policies you may have undertaken some engagement with patient groups, gained insight from routine sources e.g. patient surveys, PALS or Complaints information or information from Healthwatch, you may also have looked at relevant engagement that others have undertaken in the Trust, or locally

Have any engagement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? Please place an x in the appropriate box below.

| | |
|-----|--|
| Yes | |
|-----|--|

b. If yes, please ensure all stakeholders are listed in the consultation table at the beginning of the policy.

SECTION D SUMMARY OF FINDINGS

Reflecting on all of the information included in your review-

6. EQUALITY DUTIES: Is your assessment that your proposal will support compliance with the Public Sector Equality Duty? Please add an x to the relevant box below.

| | Tackling discrimination | Advancing equality of opportunity | Fostering good relations |
|--|-------------------------|-----------------------------------|--------------------------|
| The proposal will support? | X | X | X |
| The proposal may support? | | | |
| Uncertain whether the proposal will support? | | | |

7. HEALTH INEQUALITIES: Is your assessment that your proposal will support reducing health inequalities faced by patients? Please add an x to the relevant box below.

| | Reducing inequalities in access to health care | Reducing inequalities in health outcomes |
|---|--|--|
| The proposal will support? | | |
| The proposal may support? | | |
| Uncertain if the proposal will support? | | |

8. Outstanding key issues/questions that may require further consultation, research or additional evidence. Please list your top 3 in order of priority or state N/A

| Key issue or question to be answered | Type of consultation, research or other evidence that would address the issue and/or answer the question |
|--------------------------------------|--|
| 1 N/A | |
| 2 N/A | |
| 3 N/A | |

9. EHIA sign-off: (this section must be signed)

| | | |
|---|---------------|-----------------------|
| Person completing the EHIA: | Zoe Neale | Date: 28/04/25 |
| Line Manager of person completing: | Dawn Urquhart | Date: 28/04/25 |

Appendix A

Breakdown of Groups who are more likely to experience health inequalities:

| Groups who face health inequalities³ | Summary explanation of the potential positive or adverse impact of your proposal | How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback) | Action that will be taken to address the potential for negative impact. |
|---|---|--|--|
| Looked after children and young people | | | |
| Carers of patients | | | |
| Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs. | | | |
| People involved in the criminal justice system: offenders in prison/on probation, ex-offenders. | | | |
| People with addictions and/or substance misuse issues | | | |
| People or families on a low income | | | |

| Groups who face health inequalities ³ | Summary explanation of the potential positive or adverse impact of your proposal | How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback) | Action that will be taken to address the potential for negative impact. |
|---|--|---|---|
| People with poor literacy or health Literacy: (e.g. poor understanding of health services poor language skills). | | | |
| People living in deprived areas | | | |
| People living in remote, rural and island locations | | | |
| Refugees, asylum seekers or those experiencing modern slavery | | | |
| People who have served in the Armed Forces | | | |
| Other groups experiencing health inequalities (please describe) | | | |

Appendix B – EHIA Resources

Sources of Information on the East Sussex population and sources of community or patient insight.

Population Data

[State of the County 2021 Focus on East Sussex](#)

[East Sussex JSNA](#)

[Community Insight](#)

[Further Reading on Equality and Health Inequalities](#)

[Training](#)