Scope of Practice for a physician associate (PA) working in ophthalmology

A guidance document from the Royal College of Ophthalmologists

A scope of practice document is to help support a clinician with what activities they should feel comfortable undertaking in their role.

It is useful to consider the Scope of Practice under four areas:

1. Do I have the skills and knowledge to carry out the activity safely and effectively?
2. Can I complete training or receive other support (such as supervision) that will give me the skills and knowledge needed to carry out the activity safely and effectively?
3. Is the activity restricted by law (eg prescribing) and, if so, can I legally do it?
4. Does my professional indemnity insurance cover the activity?

This document is to support the PAs with an interest in ophthalmology that are recruited to the pilot run by NHS England and The Royal College of Ophthalmologists.

Example timetable

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Eye Casualty	Intravitreal injections	Scribe clinic	Scribe clinic	Eye casualty
PM	Pre-assessment	Ward/ admission/ discharge	Study/research	Telephone clinic	Teaching

Activities that will NOT be carried out by PA during this preceptorship-

1 - No intraocular surgery
2 - No minor operative surgery
3 - No independent treatment plan
4 - No independent management plan
5 - No initiation of investigations or treatments/medications
6 - No unsupervised responsibility for patient care or management plans.

Proposed activities

Areas of work (not exclusive)

- Outpatient activity
- Telephone-based activity
- Preoperative and post-operative activity
- Admission and discharge activity
- Site specific role (such as telemedicine, imaging, emergency care)

Examples include but are not limited to:

- Scribe within clinic with senior clinician
- Providing protocol-delivered care. History taking and initial examination in emergency eye setting Supporting doctors to make referrals between hospital departments

- Providing support to patients in hospital ward-based settings
- Admission and discharge from theatre
- Checking consent and marking patients
- Intravitreal injections

Example proposed case scenarios:

1) Dr Z is an ST3 doctor working in a regional teaching hospital as the first on-call. When on call, they are responsible for seeing patients in the walk-in eye casualty in the afternoon and for queries raised by the nursing team on the ophthalmology ward throughout the day. They have raised concerns that the large number of medical queries raised from the ward are interfering with their access to surgical training opportunities when they are on-call. PAs are trained as generalists under a medical model and could potentially address concerns from the ward as an additional point of contact. They would then be able to liaise with the on-call doctor as necessary. This could reduce the level of interruption to Dr Z's theatre time and provide the ward team with a dedicated and accessible point of contact for their clinical queries.

2) Dr X is an ST4 doctor working in a district general hospital. They usually undertake a list of intravitreal injections on a Wednesday morning. They have been struggling to access surgical training opportunities. They have performed more than 1,500 intravitreal injections. The department has had an unfilled advertisement for a nurse-injector for 18 months. A PA in this setting would be able to be trained to deliver intravitreal injections which could free this session for the doctor in training to access additional surgical training opportunities either within the hospital eye service or within the independent sector.

3) Dr W is an ST5 doctor working in a tertiary hospital eye department with a walk-in eye casualty. The casualty closes its doors at 4.30pm with any patients remaining in the department being the responsibility for the doctor on call to review. The number of patients left for the on-call doctor to review usually varies between five and ten, resulting in the on-call doctor having to stay in the hospital for several hours after the close of the department. The introduction of a PA to the emergency eye department could facilitate a reduction in consultation time for doctors as they could complete a clear history from the patient, arrange appropriate investigations and perform an initial examination of the patient before they are reviewed by a doctor. If a doctor were to review a patient during the day that required onward referral to another specialty -for example, a patient with malignant hypertension and papilloedema requiring medical input for the management of their blood pressure or a patient with suspected stroke requiring onward referral to the acute stroke team - the management of such patients could be delegated under appropriate supervision to the PA to permit doctors in the eye casualty to continue to review patients.

4) Dr Y is an ST6 doctor with an aspiration to become a glaucoma specialist. They are keen to develop their knowledge and experience in managing patients with complex glaucoma. They have raised concerns that they regularly undertake clinics that predominantly consist of low/medium risk glaucoma patients whose review does not provide them with significant additional training opportunities compared to their experience. A PA could be trained to scribe in a glaucoma clinic to allow more efficient through put of patients allowing Dr Y to join a consultant managing complex glaucoma patients in the outpatient setting in a supernumerary role.

5) The. Department is short of a paediatric ophthalmologist. The PA scribes for the paediatric ophthalmologist in their clinic to ensure efficient flow of patients increasing the number of appointments booked.
6) The oculoplastic waiting list is long for surgery. The PA works with the oculoplastic consultant to carry out telephone preoperative reviews to ensure that patients are medically ready for theatre and still appropriately listed.
7) Slow turnaround. time is limiting the number of cataracts completed on a list. The. PA works to ensure. the turnaround time is reduced.

The example timetables will have local variations depending on the need of the department.

Supervision

All PAs will have a named consultant ophthalmologist, named clinical supervisor and named educational supervisor. The educational supervisor is from the College.

References

1. NHS England. NHS Long Term Workforce Plan. 2023.
2. TRCo Ophthalmologists. Facing workforce shortages and backlogs in the aftermath of COVID-19: The 2022 census of the ophthalmology consultant, trainee and SAS workforce. 2022.
3. TRCo Ophthalmologists. Launch of physician associate pilot 2023 [Available from: https://www.rcophth.ac.uk/news-views/launch-of-physician-associate-pilot/.
4. TRCo Physicians. Physician associate title and introduction guidance for PAs, supervisors, employers and organisations. The Faculty of Physician Associates; 2023.