hpc health professions council

Council, 31 March 2011

Application for the regulation of Physicians' Assistants (Anaesthesia) by the Association of Physicians' Assistants (Anaesthesia)

Executive summary and recommendations

Introduction

At its meeting on 9 December 2010, the Council considered an application for the regulation of Physicians' Assistants (Anaesthesia) submitted by the Association of Physicians' Assistants (Anaesthesia) (APA(A)).

During its consideration of the application, the Council noted a number of areas where it felt more information was needed before a decision could be made on whether to recommend the profession for regulation. The Council asked to see further information about the role, areas of practice, and bodies of knowledge of Physician Assistants to ascertain whether the scope of practice of the two professions is sufficiently different. The Council also asked for further information about the role, scope of practice, and degree of autonomy shown by PA(A)s in their practice, and for information about the security of commissioning arrangements for training and employment of the profession. The APA(A) has supplied additional information in response to these requests, which is appended to this paper.

The HPC Executive has received additional comments from representatives of Physician Assistants expressing some concern about the effect the possible regulation of PA(A)s may have on their profession. The comments received have been summarised for the Council's consideration. These comments have also been passed on to the APA(A), which has responded to some of the issues raised in the additional information provided for Council.

We understand that the UK Association of Physician Assistants (UKAPA)—the professional body representing Physician Assistants—are preparing an application for the regulation of Physician Assistants which would be considered at a future meeting of Council.

The following are attached:

- Initial scoring by the HPC Executive of the application against the criteria
- Main body of the application submitted by APA(A), and the relevant appendices cited by APA(A) in the additional information submitted (previously considered by Council on 9 December 2010); and
- Additional information provided by APA(A) in response to the Council's requests for further information.

Decision

The Council is invited, after considering the additional information supplied by the Association of Physicians' Assistants (Anaesthesia):

- to consider the extent to which the new profession criteria have been met; and
- to consider whether the aspirant group should be invited to present at the next available Council meeting.

Background information

Article 3 (17) (a) provides that the Council may make recommendations to the Secretary of State and to Scottish Ministers concerning any professions which in the HPC's opinion should be regulated. Article 3 (17) (b) provides that the Council may give guidance on the criteria to be taken into account in making this decision.

However, the final decision about whether a group should be regulated, how they should be regulated, whom they should be regulated by and when they should be regulated is one for the Government and, ultimately, for parliament in Westminster and Holyrood.

Resource implications

None

Financial implications

None

Appendices

- Initial scoring by the HPC Executive of the application against the criteria;
- Application by the Association of Physicians' Assistants (Anaesthesia) and the relevant appendices cited by APA(A) in the additional information submitted (previously considered by Council on 9 December 2010); and
- Additional information provided by the Association of Physicians' Assistants (Anaesthesia) in response to the Council's requests for further information.

Date of paper

21 March 2011

Application for regulation of Physicians' Assistants (Anaesthesia) by the Association of Physicians' Assistants (Anaesthesia)

1. Introduction

1.1 At its meeting on 9 December 2010, the Council considered an application for the regulation of Physicians' Assistants (Anaesthesia) submitted by the Association of Physicians' Assistants (Anaesthesia) (APA(A)).

1.2 During its consideration of the application, the Council noted a number of areas where it felt more information was needed before a decision could be made on whether to recommend Physicians' Assistants (Anaesthesia) (PA(A)s) for regulation. Those issues were: that PA(A)s share their title with Physician Assistants who work in medicine; whether the work carried out by PA(A)s is sufficiently independent and autonomous for the profession to be regulated by the HPC; and that the profession is relatively new to the UK.

1.3 Following discussion, the Council asked to see further information about the role, areas of practice, and bodies of knowledge of Physician Assistants to ascertain whether the scope of practice of the two professions is sufficiently different. The Council also asked for further information about the role, scope of practice, and degree of autonomy shown by PA(A)s in their practice, and for information about the security of commissioning arrangements for training and employment of the profession.

2. Information supplied by APA(A)

2.1 The APA(A) has supplied additional information in response to the Council's requests, which is appended to this paper. The additional information highlighted by the APA(A) is contained within the appended information supplied by APA(A) in support of its initial application. The appendices indicated have been appended to this paper for the Council's information.

Particular issues the Council may wish to note are:

2.2 In paragraph 1, the APA(A) and the Anaesthesia Related Professions Committee of the Royal College of Anaesthetists have suggested that PA(A)s could be regulated under a different title such as 'Anaesthesia Practitioner', to prevent confusion between the two professions.

2.3 Information about the role and scope of practise of PA(A)s is summarised in paragraph 2 of the document. The Council may wish to note that the NHS Employers Organisation assessment of PA(A)s' relative 'freedom to act' compared to some of the other professions on the HPC register. PA(A)s are also assessed as a Band 7 position.

3. Physician Assistants

3.1 The UK Association of Physician Assistants (UKAPA)—the professional body representing Physician Assistants—are preparing an application for the regulation of Physician Assistants which would be considered at a future meeting of Council.

3.2 In the time since the Council considered the application from APA(A), the HPC Executive has also received correspondence from members of

UKAPA expressing some concern about the effect the possible regulation of PA(A)s may have on their profession. Particular concern has been expressed about the shared use of the title ‘Physician Assistant’, the possible confusion between the identity of the two professions as a result, and concern as to whether Physician Assistants would be able to continue to use their title if PA(A)s became regulated

3.3 The comments received have been summarised below for the Council’s consideration. These comments have also been passed on to the APA(A), which has responded to some of the issues raised in the additional information it has provided to the Council.

- The issue of title is a concern - the title of 'Physician Assistant' (PA) was decided through a public consultation conducted via the Changing Workforce Programme and the Department of Health in 2006. It was decided that this should be the working title until such time as the profession became regulated and the regulator decided on the title. The title PA is nationally and internationally recognised as described in the CCF (DH 2006) and the training and education provided for PAs in the UK is based upon the American PA model and does not describe or define what a PA(A) is or does.
- We have been told that the title 'Physicians' Assistant (Anaesthesia)' is a title that is not generally favoured by PA(A)s, and that PA(A)s may feel that this title does not accurately describe what they do. There is some feeling that the titles are already causing some confusion to both the general public and in the medical field as some people are assuming that someone using the title PA(A) has done PA training and then specialised in the anaesthetic field, rather than following a completely separate route to qualification. There is also a concern that it may set a precedence for those who for example work in surgery to decide to call themselves PA (surgical) without PA training. If the title were to be protected as PA(A) then PAs would not be able to use it and this would create a huge problem in terms recognition of the PA profession - causing something of an identity crisis.
- Concerns have been raised that the role of the PA in general practice is not accurately described in the APA(A) application. We have been told that PAs do not only work in general practice but across the full medical spectrum.

4. Protection of title

4.1 The issues regarding the use of the title ‘Physician Assistant’ would need to be resolved prior to any regulation taking place. The purpose of the new professions process is to determine whether the Council should recommend to the government that a certain group should be regulated, not to resolve every issue in relation to the regulation of a specific group. If recommendations were made in relation to the applications of both APA(A) and UKAPA, issues around what the future protected titles should be, including the title that might be protected for PA(A)s, would be for Government to make. If the Council decides to make any recommendation(s) about the future regulation of this profession, it may wish to specifically highlight these issues to Government.

Item 15 enc 11 a1 - HPC scoring: Overview

A		At least one of invasive procedures, clinical intervention with potential for harm, exercise of judgement by unsupervised professionals	Met	Evidence of invasive procedures and potential for harm, but practitioners are subject to indirect supervision by a physician
B	1	Discrete area of activity displaying some homogeneity	Partly met	Discrete area of activity - some overlap with other professions. This criteria has been part met because the title 'physician' assistant' is shared with another profession
B	2	Defined body of knowledge	Met	The profession has a defined body of knowledge
B	3	Evidence of efficacy	Met	Evidence of efficacy supplied
B	4	At least one established professional body accounting for significant proportion of occupation	Met	There is an established representative body
B	5	Voluntary register(s)	Met	A voluntary register has been established
B	6	Defined routes of entry to the profession	Met	Defined route of entry to the register - but there may be some unregistered practitioners who do not have the approved qualification
B	7	Independently assessed entry qualifications	Met	The profession has independently assessed entry qualifications
B	8	Conduct, performance and ethics standards	Met	The APA(A) has a set of defined standards for conduct, performance, and ethics
B	9	Disciplinary procedures to enforce those standards	Partly met	The disciplinary process is enforced through employers' actions - it has not currently been tested
B	10	Commitment to continuing professional development (CPD)	Met	APA(A) requires its members to carry out CPD
Overall		PA(A)s carry out invasive procedures with potential for harm. Practitioners exercise autonomy in decision-making as determined by a supervising physician. There is some overlap in area of activity with other professions. The application provides some basic information about the other profession that share the title 'physicians' assistant', however, the Council may wish to seek further information to satisfy itself that the scope of practice for physicians' assistants in general practice does not overlap with PA(A)s.		

Item 15 enc 11 a1 - HPC scoring: A

CRITERIA:	SCORE:
Either invasive procedures or clinical intervention with the potential for harm or exercise of judgment by unsupervised professionals which can substantially impact on patient health or welfare	Met

Summary comments (10 words max.)

Evidence of invasive procedures and potential for harm, but practitioners are subject to supervision by a physician

Detailed comments

Physicians Assistants (Anaesthesia) (PA(A)s) are required to perform invasive procedures including intravenous and arterial cannulation to administer drugs, and inserting devices in order to maintain a clear airway for patients undergoing surgery or resuscitation.

The emphasis of a PA(A)s role is on "working as part of a team, in partnership with colleagues and under the supervision of a physician".

A supervising physician must be present at the beginning and end of anaesthesia, and be on call to return to the anasthetised patient within two minutes of being called. However, PA(A)s exercise autonomy in decision-making as determined by the supervising physician. They make decisions about the immediate care of the patient which include adjusting levels of anaethetic administered, and giving intravenous drugs and fluids as required under patient specific directions.

Approximately 60 percent of PA(A)s were formerly healthcare professionals such as registered nurses or operating department practitioners. However, there is no requirement for these practitioners to maintain their professional registration once they are working as a PA(A).

The remaining 40 percent of the profession are direct-entry science graduates with no previous healthcare registration. It is likely that this proportion of the profession will increase in the future.

Item 15 enc 11 a1 - HPC scoring: 1

CRITERIA:	**SCORE:**
Discrete area of activity displaying some homogeneity	Partly met

Summary comments (10 words max.)

Discrete area of activity - some overlap with other professions. This criteria has been part met because the title 'physician' assistant' is shared with another profession.

Detailed comments

The scope of practice of PA(A)s is described in the application form and supporting information.

The scope of practice of this profession overlaps in some areas with operating department practitioners in the equipment and procedures used, specifically in the preparation of anaesthetic equipment, drugs, and infusions. PA(A)s are distinct in that they plan and administer anaesthesia within guidelines, rather than providing assistance to the medically trained anaesthetist in the manner of an ODP.

There is some overlap with the scope of practice of paramedics in the performance of invasive procedures such as intra-venous cannulation and the use of adjuncts to maintain a patient's airway, but PA(A)s only practice within elective anaesthesia, rather than emergency care.

The title 'physician assistant' is shared by another profession, physicians' assistants who practice in general medicine. Physicians' assistants in general practice work in primary care, usually in GP surgeries, and the scope of their role apparently does not overlap with physician assistants (anaesthesia).

PA(A)s were originally known as 'Anaesthesia Practitioners' but due to confusion with the role of operating department practitioners, the Department of Health decided that the profession would be renamed as Physicians' Assistants (Anaesthesia) in 2007.

Draft standards of proficiency for PA(A)s have been submitted as part of the application.

Item 15 enc 11 a1 - HPC scoring: 2

CRITERIA:	SCORE:
Defined body of knowledge	Met

Summary comments (10 words max.)

The profession has a defined body of knowledge.

Detailed comments

Some overlap in the body of knowledge with other professions, for example with operating department practitioners and anaesthetists. In addition, some PA(A)s were previously operating department practitioners or nurses, and may still be registered with either the HPC or NMC, although they are not legally obliged to do so. However, the scope of practice of PA(A)s is substantially different from the role of either an operating department practitioner or a nurse.

There is also some overlap with the role of medically-trained anaesthetists, but PA(A)s only operate within a much more limited scope of practice than medically trained anaesthetists. PA(A)s are the only non-medically qualified group recognised as applying this body of knowledge in the UK.

The Association of Physicians' Assistants (Anaesthesia) state that while the two occupations with the title physicians' assistant are studied at a postgraduate level, there are significant differences between them - holders of one qualification cannot be employed to practice the other type of role.

Item 15 enc 11 a1 - HPC scoring: 3

CRITERIA:	SCORE:
Evidence of efficacy	Met

Summary comments (10 words max.)

Evidence of efficacy supplied

Detailed comments

Evidence of research has been provided- an article from a medical journal - other articles and research are cited in the application. It is difficult to separate the specific practice of PA(A)s and therefore its efficacy from that of medically trained anaesthestists as PA(A)s are trained and required to practise within that model.

Much of the evidence cited is based on research carried out in the USA where these professionals are known as 'Anaesthesiologist's Assistants'. The Council may wish to note that the level of qualification for the equivalent for PA(A)s in the US is set at a Masters level, while the qualification for PA(A)s in the UK is at a post-graduate diploma level.

The research quoted in the application indicates that no difference in patient satisfaction was experienced when anaesthesia was administered by a consultant anaesthetist, a nurse practitioner, or a PA(A).

Item 15 enc 11 a1 - HPC scoring: 4

CRITERIA:	SCORE:
At least one established professional body a/c for significant proportion of occupation	Met

Summary comments (10 words max.)

There is an established representative body

Detailed comments

The Association of Physicians' Assistants (Anaesthesia) - (APA(A)) is the sole body representing the interests of the profession. It was established in 2008 with the aim of seeking the regulation of PA(A)s.

According to figures supplied by the Royal College of Anaesthestists, by November 2009 64 PA(A)s had successfully completed the recognised qualification, and a further 57 were in training, of whom 48 (40 percent) are members of APA(A). There is a lack of clarity in the figures supplied by the APA(A) around the difference between membership and registration within the organisation - there are currently 31 PA(A)s on the voluntary register.

Some PA(A)s may be registered with the relevant regulators for their former professions, although the application does not provide details for this.

The Association of Physicians' Assistants (Anaesthesia) considered making a joint application with the United Kingdom Association of Physician Assistants - (UKAPA) the representative body for physicians' assistants in general practice. UKAPA do not wish to pursue a joint application to the HPC, as they feel that PA(A)s and Physician Assistants in general medicine are two distinct professions.

Item 15 enc 11 a1 - HPC scoring: 5

CRITERIA:	SCORE:
Voluntary register(s)	Met

Summary comments (10 words max.)
A voluntary register has been established

Detailed comments
The Association of Physicians' Assistants (Anaesthesia) launched a voluntary register on 25 June 2010 after members present at the annual general meeting voted in support of the proposal.
The APA(A) and Royal College of Anaesthetists have written jointly to employers asking them to encourage all PA(A)s to join the register and also to participate in the reporting process.
Employers and members of the public can check whether PA(A)s are registered by contacting the APA(A) by email or phone.
Currently 31 PA(A)s have joined the voluntary register.

Item 15 enc 11 a1 - HPC scoring: 6

CRITERIA:	SCORE:
Defined routes of entry to the profession	Met

Summary comments (10 words max.)

Defined route of entry to the register - but there may be some unregistered practitioners who do not have the approved qualification

Detailed comments

The application states that there is only one recognised route of entry to the profession. PA(A)s must have successfully completed all modules and the final examination to gain a Post-Graduate Diploma (Physicians' Assistants (Anaesthesia)), formerly known as a Post-Graduate Diploma (Anaesthesia Practitioner). The qualification is awarded by the universities of Hull, Hertfordshire, Birmingham, and Edinburgh.

The post-graduate diploma is a minimum of 27 months' study. Students may opt to continue for a further year to complete a Masters qualification by dissertation. Successful completion of the two exit examinations at 24 months is followed by three months supervised practice before the final award of the PGDip.

The Royal College of Anaesthetists and the Association of Anaethetists of Great Britain and Ireland have stated that they only recognise PA(A)s who have successfully completed the approved training programme as being practitioners of the profession, and that they advise employers not to recognise any other route of entry.

The application also states that there may be practitioners employed in the role of a PA(A) in the UK who have not followed the defined routes of entry - in these cases employers would have satisfied themselves as to the fitness to practise of the candidates in question.

The Higher Education Institutions providing the academic component of the course have subjected their modules to internal quality assurance scrutiny. University of Birmingham modules are being submitted for formal QAA subject benchmarking.

Item 15 enc 11 a1 - HPC scoring: 7

CRITERIA:	SCORE:
Independently assessed entry qualifications	Met

Summary comments (10 words max.)

The profession has independently assessed entry qualifications

Detailed comments

The qualification - Post-Graduate Diploma (Physicians' Assistants (Anaesthesia)) - is administered jointly by a committee of Higher Education Institutions and the Royal College of Anaethetists. These independent bodies ensure that the fitness for purpose of the curriculum is revised on a regular basis.

The universities have submitted their components of the course and examinations for rigorous internal benchmarking procedures. The objective structured clinical examination which is run by the Royal College of Anaesthetists in conjuction with the HEIs is administered by examiners who are medically qualified anaethestists.

The curriculum framework for the qualification has been produced as evidence.

Item 15 enc 11 a1 - HPC scoring: 8

CRITERIA:	SCORE:
Conduct, performance and ethics standards	Met

Summary comments (10 words max.)
The APA(A) has a set of defined standards for conduct, performance, and ethics

Detailed comments
Since its formation, the APA(A) has required its members to abide by the Health Professions Council's standards of conduct, performance, and ethics.

Item 15 enc 11 a1 - HPC scoring: 9

CRITERIA:	**SCORE:**
Disciplinary procedures to enforce those standards	Partly met

Summary comments (10 words max.)

The disciplinary process is enforced through employers' actions - it has not currently been tested

Detailed comments

The APA(A) states that it has a disciplinary procedure but the procedure has not been implemented or tested.

Applicants to the voluntary register are asked to confirm that they have read and understood the standards of conduct, performance, and ethics, and to agree that their name could be removed from the register should their employer find them in breach of those standards.

Currently, cases of professional misconduct would be dealt with at a Trust level but reported to the APA(A) and the Royal College of Anaesthetists. Practitioners would be removed from the register subject to any appeals process with the employer being exhausted.

No case of misconduct of a qualified PA(A) has been reported to date.

Item 15 enc 11 a1 - HPC scoring: 10

CRITERIA:	SCORE:
Commitment to continuous professional development (CPD)	Met

Summary comments (10 words max.)

APA(A) requires its members to carry out CPD.

Detailed comments

The APA(A) expects its members to keep a portfolio detailing all CPD activity and to maintain a log book of all patient care episodes undertaken.

The APA(A) does not specify the number of hours of study to be undertaken, but practitioners must be able to demonstrate that sufficient activity has been performed to remain competent. While the APA(A) lacks the resources to investigate the CPD of members at the current time, all PA(A)s currently practising work within the NHS and are therefore subject to an annual performance review which includes an assessment of their CPD activity.

APPLICATION FOR THE REGULATION OF PHYSICIANS' ASSISTANTS (ANAESTHESIA) BY THE HEALTH PROFESSIONS COUNCIL.

The Association of Physicians' Assistants (Anaesthesia)

Background

The role of Physician or Physicians' Assistant is relatively new to the United Kingdom. It has however been practiced in the United States since the 1960s. It may be useful to look at the following definition of the US role;

"A physician assistant (PA) is a healthcare professional licensed to practice medicine with supervision of a licensed physician.[1] A physician assistant is concerned with preventing, maintaining, and treating human illness and injury by providing a broad range of health care services that are traditionally performed by a physician. Physician assistants conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and write prescriptions.[2]

Physician assistants exercise autonomy in medical decision making as determined by their supervising physician. Physician assistants are educated in the medical model designed to complement physician training. Physician assistants are not to be confused with medical assistants, who perform administrative and simple clinical tasks with limited college-level education in hospitals and clinics under the direct supervision of physicians, registered nurses, nurse practitioners, or physician assistants.

1. *About Physician Assistants.* American Academy of Physician Assistants (AAPA). Accessed 26 June 2009.

2. *The PA Profession*. Yale School of Medicine, 26 March 2009. Accessed 26 June 2009."

The US PA qualification is at Masters level and all practitioners must be registered.

The National Health Services of both England and Scotland have employed United States-trained PAs for a number of years and several UK universities are now offering the qualification.

The role of Physicians' Assistant (Anaesthesia), formerly known as Anaesthesia Practitioner, is a UK adaptation of the US Anesthesiologist Assistant, itself a variant of the PA role specialising in anaesthesia rather than primary care, but again at post-graduate level.

In 1997 the Audit Commission recommended that the NHS investigate the boundaries between different staff groups involved in providing anaesthesia, through the development of pilot projects. The Royal College of Anaesthetists (RCoA) and the Department of Health (DH) jointly agreed that there was a serious impending shortage of trained specialist anaesthetists and that they would undertake to develop Anaesthesia Practitioners as a means to facilitate the delivery of services.

A joint evaluation was undertaken by the Changing Workforce Programme, the DH and the RcoA, including visits to the USA, Sweden and Holland, which resulted in the report *The role of non-medical staff in the delivery of anaesthesia services*. The AP, now PA(A), programme was subsequently established in 2003 with training commencing in January 2004 and the first PA(A)s qualifying in January 2007.

The need for a protected title is demonstrated by the fact that the initial DH title of the occupation, Anaesthesia Practitioner, became confused with the many Operating Department Practitioners and Registered Nurses practising as anaesthetic assistants describing themselves as “anaesthetic practitioners”. When this job title started appearing in advertisments, the Royal College of Anaesthetists, in conjunction with the then Anaesthesia Practitioner occupation, the DH and the patient liaison group, decided to change title to PA(A), coming in to line with NHS Scotland who had decided on that title for the group as part of their Physician Assistant project.

Neither the titles Physician Assistant or Physicians’ Assistant (Anaesthesia) are protected in the UK and some employers have advertised untrained posts under similar names, leading to further confusion.

This application for the regulation of the occupation of Physicians’ Assistants (Anaesthesia) is made by the Association of Physicians’ Assistants (Anaesthesia), the sole representative body of PA(A)s in the UK.

Part A

The occupation of Physicians' Assistant (Anaesthesia) meets the criteria of part A of the assessment as follows:

- **Invasive procedures**

All PA(A)s are required to perform invasive procedures as part of their role. These include;

- performing intravenous and arterial cannulation in order to give drugs, administer fluids, collect blood samples or set up invasive monitoring of blood pressure.
- inserting devices such as laryngeal mask airways and endo-tracheal tubes in order to maintain a clear airway in patients undergoing surgery or resuscitation.

The NHS Employers Organisation job statement documenting the minimum range of procedures required of the role is attached in part B.

An inability to perform invasive procedures such as these correctly would lead to serious patient harm.

- **Clinical intervention with the potential for harm**
- **Exercise of judgement by unsupervised professionals which can substantially impact on patient health or welfare**

These two criteria can be considered together. PA(A)s are required to maintain anaesthesia in patients undergoing surgical procedures without the direct supervision of a medical professional.

Although the supervising physician must be present at the beginning of anaesthesia (induction) and at the end of the procedure (emergence) there is no necessity for their presence during the procedure. Although it is incumbent on the supervising physician to be available to return to the anaesthetised patient within two minutes of being called, PA(A)s must make numerous and frequent decisions about interventions relating to the immediate care of the patient, including at what point the condition of the patient has deteriorated to a level requiring the input of a physician.

These might include altering ventilator and gas-flow settings in order to maintain the oxygenation of the patient, adjusting levels of anaesthesia to prevent awareness, or giving intravenous drugs and fluids using Patient Specific Directions (PSDs).

There is no statutory framework to control PA(A)s' access to the drugs that they must administer to perform their role, which include muscle relaxants to facilitate surgery,

volatile anaesthetic agents to maintain anaesthesia, opiates and other analgesics to control pain, induction agents to induce anaesthesia, resuscitation drugs given in the event of cardio-vascular collapse and many others. These are currently given under PSDs agreed at local level.

Mistakes in these interventions or failure to exercise judgement correctly would lead to catastrophic harm or death for the patient.

The following two short case studies illustrate the level of autonomous practice undertaken by PA(A)s.

Case 1 Mr Smith is attending hospital for a total hip replacement. He will be anaesthetised by a PA(A), Jane Stevens, working in a 2:1 team with a PA(A) in an adjacent operating room and a consultant anaesthetist, Dr Paul Jones, who will oversee both rooms.

On the morning of surgery Jane meets Mr Smith in the ward and, after introducing herself, takes a medical history and performs an anaesthetic assessment so that she can plan his care. Mr Smith suffers from atrial fibrillation and high blood pressure, for which he takes medication and because of anatomical considerations presents a risk of difficult endo-tracheal intubation should his airway become compromised during the procedure.

Jane confirms that Mr Smith has stopped taking the anti-coagulant drug he normally needs for his atrial fibrillation and that temporary cover with a shorter-acting drug has been prescribed, as otherwise spinal anaesthesia, known to be of benefit in major orthopaedic surgery, would be precluded.

She discusses the relative risks and benefits of both general and regional anaesthesia with him, including the risks of serious harm, and explains to Mr Smith what will happen when he arrives in the anaesthetic room. She obtains consent for general and spinal anaesthesia and for the insertion of a urinary catheter.

Before leaving the ward Jane looks up Mr Smith's blood results and finds that his haemoglobin is low. She phones the blood bank and asks for two units of blood to be grouped and saved.

In the anaesthetic room Jane meets up with Dr Jones, gives him Mr Smith's history and tells him what anaesthetic plan she discussed. Dr Jones agrees with the plan, including which drugs from her formulary of Patient Specific Directions she can administer, and they both discuss it with the Operating Department Practitioner(ODP). Jane asks the ODP to get equipment ready for a difficult intubation in case it is required. Dr Jones

leaves to discuss a case with the PA(A) in the adjacent room. Jane confirms that the anaesthetic equipment is checked and functioning correctly.

When Mr Smith arrives Jane welcomes him and then sites an intravenous cannula to give drugs and fluids during the procedure. She takes a set of baseline observations of Mr Smith's heart rate, oxygen saturations and blood pressure and records them. Dr Jones returns and after he has met the patient he gives intravenous drugs to send the patient to sleep. Jane sites the laryngeal mask airway that the patient will breathe through during the operation without complication. Dr Jones performs a spinal anaesthetic injection and inserts a urinary catheter before returning to the other anaesthetic room.

Jane ensures that the patient's observations are stable before letting the rest of the team know they are ready to transfer to the operating room. Jane leads the team transferring the patient onto the operating table and then sets the anaesthetic machine to deliver the correct mixture of gases and volatile anaesthetic agent to keep the patient oxygenated and asleep. Jane checks that the positioning of the patient by the surgical team has not compromised patient safety by, for example, putting pressure on nerves or the eyes. Having satisfied herself that the patient is safe and stable, Jane performs the pre-operative surgical checklist with the surgeon and the rest of the team. She confirms that anti-coagulants are prescribed and gives intravenous antibiotics as per the local protocol, having checked for allergies.

As surgery progresses Jane continually assesses the patient by looking at his physical signs and the information from the monitoring systems. She has readouts of inspired and expired gases, anaesthetic agent, blood pressure, oxygen saturation and electrocardiography which enable her to make decisions on how she should manage the anaesthetic.

After fifteen minutes the patient's blood pressure and heart rate fall to a level that Jane feels requires treatment to ensure continued safety. She decides that the fall is caused by a combination of factors; spinal anaesthesia and the volatile anaesthetic agent have caused the patient to vaso-dilate and his blood pressure medication means that he has not raised his heart rate sufficiently to compensate. She gives the patient 6mg of ephedrine as she knows this will vaso-constrict the patient and increase the rate and contractility of the heart. She reduces the concentration of anaesthetic agent slightly whilst ensuring that the patient will still be adequately anaesthetised. The blood pressure returns to a satisfactory level.

Jane also monitors the intravenous fluid input she is giving and balances it with the blood loss from surgery and the urine output. Towards the end of surgery Jane decides to give the patient a unit of a starch-based plasma volume expander instead of further

cristalloid solution to compensate for a 500ml loss of blood which she feels is insufficient to warrant a blood transfusion.

She keeps a record of all treatments given and of the information from the monitoring which will remain in the patient's medical notes.

The surgery proceeds uneventfully and as the surgeon is closing the skin Jane telephones Dr Jones to let him know they will soon be finished. He arrives and Jane informs him of what treatment she has given. He completes the paperwork by signing for the drugs Jane has given and the patient is transferred back into bed. Dr Jones returns to the other anaesthetic room where a new patient has arrived and Jane takes Mr Smith to the Post-anaesthetic Care Unit.

Jane helps the nurse in the PACU to connect the monitoring to the patient and then gives her a full handover including the relevant parts of the medical history, what surgery has been performed, what anaesethetic technique was used and what post-operative care has been prescribed. Mr Smith recovers sufficiently from the anaesthetic that Jane and the PACU nurse remove his laryngeal mask airway. Jane tells the nurse that she is returning to the operating room and that she or Dr jones will be available if required.

Later in the day Jane will return to the PACU and then the ward to check on the patient's progress.

Case 2 Jane is scheduled to perform local anaesthesia for six cataract removal operations, having undertaken a further training course provided by her employer.

As with all PA(A)s providing regional anaesthesia Jane is a certified Advanced Life Support provider. On arriving in the ophthalmic theatres she checks that the equipment and drugs she would need to resuscitate a patient in the event of an adverse reaction to the local anaesthetic are available.

She checks that Dr Jones, the supervising consultant, is in the adjacent theatre and the first patient is sent for.

Jane introduces herself to Mrs Briggs and expains her role and the local anaesthetic technique that will be performed. She confirms with the patient which eye is being operated on and checks that this agrees with the notes. Whilst the ODP positions the patient, attaches monitoring and prepares the eye with antiseptic solution she checks the patient's medical history. Mrs Briggs does not have any medical condition that

prevents her from having her surgery, but she does take a low-dose aspirin. Jane warns her of the slightly increased risk of haemorrhage and confirms that Mrs Briggs is happy to proceed. She also checks the biometry measurements of Mrs Brigg's eye to make sure it falls within the limits of her protocol. As all the patient's parameters are within normal limits Jane does not need to discuss the case with her supervisor.

Jane washes her hands, dons sterile gloves and prepares her equipment. She explains to Mrs Briggs what is going to happen as she proceeds. She inserts a speculum to hold the patient's eye open whilst she performs the procedure. She uses forceps and scissors to make an incision in the conjunctiva and Tenon's capsule of the eye. She inserts a curved cannula and advances it to the back of the eye before injecting a mixture of local anaesthetic and an enzyme. She removes her intruments and applies gentle pressure to help the spread of the anaesthetic. After a few minutes the eye has become sufficiently anaesthetised and Jane and the ODP transfer the patient to the operating room and reattach the monitoring. Jane makes notes of the procedure she has performed.

This procedure is repeated for the remaining five patients. As they all fall within the parameters of Jane's protocol she has no need to contact Dr Jones during the list. At the end of the list Jane goes to the ward to check that there have been no problems before she leaves the department.

The National Practitioner Programme factsheet and the DH "toolkit" document which detail the level of independent decision making required of PA(A)s are attached in appendices 1.1 and 1.2

Appendix 1

Part B

The occupation of Physicians' Assistant (Anaesthesia) fulfils the criteria of part B of the assessment as follows;

SECTION 1 Contact details

Main contact David Wilkinson

Address Department of Anaesthesia, Royal Devon and Exeter Hospital, Barrack Road, Exeter, EX2 5DW.

Telephone 07952 873378

Email info@anaesthesiateam.com

Website www.anaesthesiateam.com

Name of applicant occupation Physicians' Assistant (Anaesthesia)

SECTION 2 Previous applications

No previous applications have been made by Physicians' Assistants (Anaesthesia) for regulation by the HPC or its predecesssor.

SECTION 3 Consideration of alternative routes to regulation

Has the occupation explored regulation as a distinct subsection within a profession already being regulated and if so have you rejected this route?

The Association of Physicians' Assistants (Anaesthesia) understands that occupations that already have a regulator are ineligible for registration by the HPC and has therefore explored the option of distributed regulation.

Whilst approximately 60% of PA(A)s were formerly healthcare professionals such as Registered Nurses or Registered Operating Department Practitioners, there is no requirement by employers for them to retain this registration in order to practice as a PA(A).

The remaining 40% of PA(A)s are direct-entry science graduates with no previous healthcare registration. In order to prevent the attrition of scarce specialist healthcare professionals and in view of the fact that direct entry students are paid a bursary which is substantially cheaper than the salary paid to existing staff, it is likely that employers will seek to increase the proportion of student PA(A)s drawn from this sector in future. Reliance on existing regulators would, therefore, leave a significant and increasing proportion of the occupation unregulated.

After consultation with the membership of the association, the APA(A) does not wish to pursue a model of regulation that would divide the occupation into two groups, one regulated and one not. This would lead to confusion both for patients and employers, with probable negative impact on the employment prospects of the unregulated group.

The NHS Employers organisation does not consider the PA(A) role an extension of existing healthcare professions, but as an independent occupation (by its former title of Anaesthesia Practitioner) under Agenda for Change. (Job profile attached in appendix 3.1)

Has the occupation considered joining other unregulated occupations in a similar field who are currently seeking HPC regulation or may do so?

The occupation has considered making a joint application with Physician Assistants practicing in general medicine.

Both the APA(A), representing PA(A)s, and the United Kingdom Association of Physician Assistants (UKAPA), representing Physician Assistants in general practice,

were invited in 2009 to join a group at the University of Hertfordshire (UoH) tasked with setting up an MVR for PAs of both disciplines.

The project was instigated at the behest of the DH, who wished to have a register of PA(A)s onto which overseas Nurse Anaesthetists could be placed as part of a scheme to employ them in treatment centres. The DH have now abandoned this scheme.

The UoH expended considerable time and effort on making the MVR work using their existing infrastructure, including modifying their student disciplinary procedure, and both APA(A) and UKAPA were in agreement that they would encourage their membership to join what would in effect be a two part register.

Due to the small number of potential registrants it was clear that the MVR would not be self-funding and it was initially thought that UoH would be able to use its existing staff to manage the register, but it has since transpired that this will not be possible due to legal constraints on how their budget is spent and the project is currently on hold.

Throughout the committee process of creating the MVR it was made clear by UKAPA and representatives of bodies training and employing PAs (General) that while they were in principle happy to be part of a voluntary register with PA(A)s, their preferred route to formal regulation would be through the General Medical Council in the first instance.

It is the view of UKAPA that they do not wish to pursue a joint application to the HPC at this time. The minutes of the last meeting of the UoH steering group indicating this and a letter stating their position are attached. (Appendix 3.2, 3.3)

Although the two occupations now share a common title stem, “Physicians’ (or Physician) Assistant” and are studied at postgraduate level there are significant differences between them.

As mentioned in Section A, PA(A)s were initially designated “Anaesthesia Practitioners”, but the proliferation of ODPs using this title was thought to be leading to confusion. The RcoA, AAGBI and the occupation itself therefore decided to use the title already in use in Scotland of Physicians’ Assistant (Anaesthesia) and this change was made in 2007 after consultation with the DH.

PA(A)s practice specifically in the secondary healthcare care setting as deliverers of anaesthesia and critical care and the curriculum is therefore biased heavily towards that. The Physician Assistants represented by UKAPA practice in primary care, usually in GP surgeries, and therefore their training is more closely modelled on under-graduate medical education. There would appear to be very little overlap between the two

occupations; holders of one qualification cannot not be employed to practice the other role.

The APA(A) is not aware of any core modules shared between the courses, even when provided by the same HEI.

The PA(A) qualification is a postgraduate diploma and a Masters can be gained by dissertation in an additional time period wheras the PA qualification is always a Masters.

For these reasons the APA(A) is understanding of the view of UKAPA that they do not wish to pursue a joint application.

Appendix 3

SECTION 4 The occupation must cover a discrete area of activity displaying some homogeneity.

All Physicians' Assistants (Anaesthesia) provide anaesthesia and critical care services, following the established model of medical practice.

All PA(A)s must hold a Postgraduate Diploma awarded by one of the four UK universities forming the Higher Education Institute (HEI) group, in conjunction with the Royal College of Anaesthetists. These are the Universities of Birmingham, Edinburgh, Hull and Hertfordshire. All PA(A)s follow the same curriculum and sit the same exit examination, regardless of education provider.

The curriculum defines the necessary training, skills and knowledge that PA(A)s require to plan and implement the pre-, peri- and post-operative anaesthesia care of the patient, in conjunction with a supervising physician where appropriate. The curriculum is agreed and accredited jointly by the HEI group and the PA(A) committee of the RCoA, on which the APA(A) is represented. The input of the students of the first cohorts of PA(A)s on subsequent curriculum development has been acknowledged.

The Post-Graduate Diploma is of a minimum of twenty-seven months' duration, seven university terms. Students may opt to continue for a further year to complete a Master's qualification by dissertation. Successful completion of the two exit examinations at twenty-four months is followed by three months of supervised practice before the final award of the PGDip.

Following succesful completion of the course the following learning outcomes must have been achieved:

- Be able to elicit the relevant history from the patient to identify potential problems before, during and after anaesthesia and to communicate this information to all members of the team.
- Demonstrate a thorough working knowledge of relevant anaesthetic pharmacology and be able to articulate in theory and practice the physiological action of these drugs and their interactions with the patient's existing medication.
- Demonstrate a clear knowledge of the normal physiological changes which occur in the body during and after anaesthesia and be able to use the information to assess the wellbeing of the patient before, during and after anaesthesia.
- Be able to use knowledge of physiology and pathology to identify and report the needs of patients who may be an anaesthetic risk due to pre-existing medical conditions.

- Demonstrate a clear working knowledge of the applied anatomy and physiology of the respiratory, cardio-vascular and nervous systems in order to induce anaesthesia and undertake emergency resuscitative procedures.
- Demonstrate a clear working knowledge of the physics relevant to anaesthesia and use that knowledge to monitor and measure patients' wellbeing during and after anaesthesia.
- Have the skills to reflect on their practice and to use the outcomes of that reflection for personal development and for innovation and change in practice.
- Have developed the ability to support the learning of colleagues entering practice.

Typically, on a day-to-day basis PA(A)s examine and take histories from patients pre-operatively in the ward or clinic environment, providing explanation and gaining consent for the appropriate anaesthetic technique. They liase with the operating theatre team to ensure equipment and drugs are available and checked. They induce anaesthesia in the presence of the supervising physician and maintain the patient's condition throughout surgery and then plan and implement post-operative care in conjunction with staff from the post anaesthetic care unit.

The KSF outline (Appendix 3.1) and job description and the draft standards of proficiency are attached. (Appendix 4.1, 4.2)

Are there professions regulated by the HPC with whom the scope of practice overlaps?

There is some overlap of scope of practice with the existing regulated profession of Operating Department Practitioner, specifically in the areas of preparation of anaesthetic equipment, drugs and infusions. Physicians' Assistants (Anaesthesia) are however distinct in that they plan and *administer* anaesthesia, within guidelines, rather than providing assistance to the medically trained anaesthetist in the manner of the Operating Department Practitioner.

There is some overlap with the existing regulated profession of Paramedic in the performance of invasive procedures such as intra-venous cannulation and the use of adjuncts to maintain the patient's airway, but PA(A)s are distinct in that they practice within elective anaesthesia, not emergency care.

There is clear overlap of scope with several professions regulated by the HPC in the areas of physical examination, history taking and the planning of patient care episodes. PA(A)s are distinct in that these patient care episodes relate to the planning and provision of anaesthesia.

Appendix 4

SECTION 5 The occupation must apply a defined body of knowledge.

Anaesthesia has a defined and scientific body of knowledge found in many thousands of textbooks and peer-reviewed journals internationally. The Royal College of Anaesthetists, which administers one of the two the exit examinations for the occupation and sets its educational standards, publishes one of the most prestigious, the British Journal of Anaesthesia. This body of knowledge has formed the basis of the Postgraduate Diploma which all PA(A)s must hold. PA(A)s will have undertaken a minimum of five years' study at undergraduate and postgraduate level to gain the requisite body of knowledge required to practice.

Traditionally in the United Kingdom anaesthesia has been administered solely by medically-trained anaesthetists. The introduction of PA(A)s has led to a second, as yet unregulated, occupation applying the same body of knowledge.

The HEI group and the PA(A) committee of the RCoA ensure that the taught body of knowledge is consistent across the institutional and occupational providers of education, through internal university quality assurance schemes and training site visits.

The curriculum document for the postgraduate diploma is attached in the appendix to section 10.

PA(A)s are the sole non-medically qualified group recognised as applying this body of knowledge in the UK.

Are there professions currently regulated by the HPC with whom the applicant occupation's body of knowledge overlaps?

There is some overlap with the bodies of knowledge required of many HPC regulated professions in that knowledge is required of subjects such as anatomy and physiology, basic sciences and pharmacology. However, Physicians' Assistants (Anaesthesia) are distinct in that they are they require knowledge of these subjects as they relate to anaesthesia at postgraduate diploma and master's level, demonstrated by both continuous assessment and final examination.

SECTION 6 The occupation must practice based on evidence of efficacy.

Research into the efficacy of the applicant occupation's practice.

Anaesthesia, as part of medicine, is a scientific, evidence- and research-based discipline. Tens of thousands of textbooks and learned journals world wide testify to its efficacy. As detailed in section 5, it is very difficult to separate the specific practice of PA(A)s, and therefore its efficacy, from that of medically-trained anaesthetists as PA(A)s are trained and required to practice within that traditional medical model.

As detailed in Section 4, the postgraduate curriculum requires that, as with the traditional medically-trained practitioners of anaesthesia, PA(A)s gain the necessary skills to reflect on the outcomes both of their own practice and that of the speciality as a whole. Numerous research papers are published monthly exploring the efficacy of both existing and potential new treatment options in anaesthesia. A copy of the paper *Perioperative Epidural Analgesia and Outcome After Major Abdominal Surgery in High-Risk Patients* by Peyton *et al,* which explored the efficacy of the two most commonly used methods of post-operative pain relief for laparotomy, is attached. (Appendix 6.1)

Evidence of practice outcomes.

Despite the relatively short time that PA(A)s have been in practice in the United Kingdom, reports and research data to which PA(A)s have contributed are available showing that the practice of PA(A)s is as efficacious as existing systems. For example, Modi *et al* [1] demonstrated no difference in patient satisfaction when anaesthesia for cataract surgery was administered by either a consultant anaesthetist, a nurse practitioner or a PA(A). Sanders *et al*[2] and the National Practitioner Programme[3] showed increases in efficiency when PA(A)s were included in the anaesthesia team.

Internationally there is a large volume of evidence that the practice of anaesthesia by similar non-physician grades such as Anaesthesiologist's Assistants and Certified Registered Nurse Anesthetists is efficacious. Both the American Association of Nurse Anesthetists (AANA)[4] and the International Federation of Nurse Anesthetists (IFNA)[5] promote research into practice outcomes. In a study published by the AANA Pine *et al*[6] found no significant difference in mortality rates when comparing the outcomes of 404,000 cases where anaesthesia was provided by non-physicians, physicans or teams including both specialities.

Evidence based practice.

PA(A)s are expected to have the ability to interpret such research data, perform audit and present complex case studies and to use the information gained to inform future practice, as evidenced by the course learning outcome “Have the skills to reflect on their practice and to use the outcomes of that reflection for personal development and for innovation and change in practice.”

Wilkinson[7], for example, compared the results of the paper of Peyton *et al* mentioned above (Appendix 6.1) with the conflicting conclusions of the meta-analysis of Rogers *et al*[8] in order to make recommendations on the pre-operative information offered to patients.

References to section 6

1 Modi N, Shaw S, Allman K, Simcock P, *Local anaesthesia during cataract surgery: Factors influencing perception of pain and overall satisfaction.* Journal of Perioperative Practice 2008; **18**:1;28-33

2 Sanders D, Grayling M, Lillie H, *Defining efficiency requires more fidelity.* Anaesthesia 2008; **63**:2;204-5

3 DH/National Practitioner Programme/Royal College of Anaesthetists, *A toolkit to support the planning and introduction of training for Anaesthesia Practitioners.* 2007; 43-45

4 www.aana.com

5 www.ifna-int.org

6 Pine M, Holt K, You-Bei L, *Surgical mortality and type of anesthesia provider.* AANA Journal 2003; 71:109-116

7 Wilkinson D, *Epidural, friend or foe?* Anaesthesia Points West Spring 2006

8 Rodgers A, Walker N, Schug S, McKee A, Kehlet M, van Zundert A, Sage D, Futter M, Saville G, Clark T, MacMahon S, *Reduction of postoperative mortality and morbidity with epidural or spinal anaesthesia: results from overview of randomised trials*
BMJ. 2000 December 16; 321(7275): 1493

Appendix 6

SECTION 7 The occupation must have at least one established professional body which accounts for a significant proportion of that occupational group.

The Association of Physicians' Assistants (Anaesthesia) is the sole body representing the interests of the occupation. It was formed on the 15th of March 2008 with the aim of seeking the regulation of PA(A)s to ensure the highest standards of patient care.

It became registered company 6592581 on the 14th of May 2008. The Memorandum and Articles of Association and minutes of committee meetings are attached in appendices 7.1, 7.2 and 7.3

2010 Election results are attached in appendix 7.4. The ballot was conducted secretly and results collected by an uninterested party.

The association has represented the occupation on numerous committees and working groups nationally on issues such as regulation, educational standards, workforce planning and scope of practice.The association holds an educational conference, open to all PA(A)s, annually, in addition to the AGM for members featuring the annual report and accounts. The association website, www.anaesthesiateam.com, is used to disseminate information to PA(A)s, employers and patients.

Number of practitioners of the occupation.

According to figures provided by the RCoA, by the 6th of November 2009 64 PA(A)s had successfully completed the recognised qualification and a further 57 were in training, of whom 48 (40%) are members of the association.

Other professional bodies.

On the 24th of June 2010 there were no other professional bodies or representative organisations for the occupation.

Grandparenting arrangements.

The APA(A) has no members who have not followed the defined routes of entry to the profession and currently has no resources to assess the educational standards or fitness to practice of such practitioners. When the Managed Voluntary Register at the UoH was proposed, it was supposed by the DH that they would use their educational resources to assimilate other practitioners into the profession and the APA(A) was prepared to participate in that process. Following discussions with the RcoA the UoH decided that they would not undertake such an assimilation service as it conflicted with the view of both the Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland that only practitioners who have gained the postgraduate

diploma through the recognised training programme should be considered qualified to practice the occupation.

There may be practitioners employed in the role in the UK who have not followed the defined routes of entry, in which case their employers must have satisfied themselves as to the fitness to practice of the candidate.

Appendix 7

SECTION 8 The occupation must operate a voluntary register.

The Association of Physician's Assistants (Anaesthesia) launched a Managed Voluntary Register on the 25th of June 2010 after those members present at the 2010 annual general meeting voted unanimously to support the undertaking.

The launch of the register has been publicised on the APA(A) website and via email to members, who have been asked to inform any colleagues who are not members of its existence. There is no necessity to join the Association to be entered on the register which is open to all PA(A)s who have succesfully completed the recognised training programme.

The APA(A) and RCoA have written jointly to employers asking them to encourage all PA(A)s to join the register and also to partcipate in the reporting process. A copy of the letter is attached in appendix 8.1

The APA(A) expects PA(A)s to conform to the standards of conduct, performance and ethics laid down by the HPC and anyone found by their employer to have breached those standards will be removed from the register.

The application form, which also includes explanatory notes and data protection information is attached in appendix 8.2

Employers and members of the public can check whether PA(A)s are registered by contacting the APA(A) electronically or by telephone.

Currently 31 PA(A)s have joined the Voluntary Register.

Appendix 8

SECTION 9 The occupation must have defined routes of entry to the profession.

Currently there is only one recognised route of entry to the occupation. Physicians' Assistants (Anaesthesia) must have undertaken and successfully completed all modules and the final examination to gain the Post-Graduate Diploma (Physicians' Assistants (Anaesthesia)), formerly known as Post-Graduate Diploma (Anaesthesia Practitioner).

This qualification has been awarded by the universities of Hull, Hertfordshire, Birmingham and Edinburgh. Only Birmingham and Edinburgh currently have students enrolled on the programme. Information on their courses can be found at;

http://www.anaesthesiapractice.ed.ac.uk/

http://www.postgraduate.bham.ac.uk/programmes/taught/medicine/physician-assistant-anaesthesia.shtml

Evidence that demonstrates that only individuals choosing one of the entry routes are recognised as being practitioners of the profession.

The joint position statement of the RCoA and Association of Anaesthetists of Great Britain and Ireland of October 2007 stating that they only recognise PA(A)s who have succesfully completed the approved training programme as being practitioners of the profession and advising employers not to recognise any other route of entry is attached in appendix 9.1.

The HEIs will only award the diploma to those students who have succesfully completed the approved programme.

The Workforce Review Team analysis of the role which mentions no alternative route of entry is attached in appendix 9.2

A specimen person specification and job advertisment demonstrating the route of entry recognised by employers are attached in appendices 9.3 and 9.4

Information about the applicant occupation's QAA Subject Benchmark or equivalent.

The HEIs providing the academic component of the course have subjected their modules to internal quality assurance scrutiny. Doctor T. Clutton-Brock, who chairs the RCoA educational sub-committee for PA(A)s, is submitting the University of Birmingham modules for formal QAA Subject Benchmarking.

SECTION 10 The occupation must have independently assessed entry qualifications.

The qualification is administered jointly by a committee of Higher Education Institutes and the Royal College of Anaesthetists, on which the APA(A) is represented, who ensure that educational standards are met.

These independent bodies ensure that the fitness for purpose of the curriculum is reviewed on a regular basis as evidenced by the introduction to the curriculum document itself. (Appendix 10.1)

The universities have submitted their components of the course and examinations to rigorous internal benchmarking procedures. The Objective Structured Clinical Examination, run by the Royal College of Anaesthetists in conjunction with the HEIs, is administered by examiners who are medically qualified anaesthetists and therefore independent of the PA(A) occupation.

HEI Group

Dr Thomas Clutton-Brock, Senior Lecturer in Anaesthesia and Critical Care at the University of Birmingham supplied the following information on the work of the HEI group;

"In 2004 the University of Birmingham was awarded the contract to produce a national curriculum for the Anaesthesia Practitioner Post Graduate Diploma / MSc programme (this has subsequently been renamed the Physicians' Assistant (Anaesthesia)). This was completed in 2005 and the first intake of students went to the Universities of Birmingham, Newcastle, Hertfordshire and Edinburgh. All of the HEIs work to the same curriculum and assessments are conducted nationally

This unified curriculum with common learning outcomes and summative assessments has been a major factor in the success of the programme across the UK but has naturally required a considerable degree of collaboration between the HEIs delivering the programme. A national HEI subgroup was formed from the programme leads and their representatives at the individual institutions. This group initially met twice a year at the Royal College of Anaesthetists but now meets annually in Birmingham after the Mock OSCE examination in May

This group is currently chaired by the programme director in Birmingham and has representation from the Royal College of Anaesthetists as well as trainee and qualified Physicians' Assistants (Anaesthesia). It reports to the Anaesthesia Related Professionals committee at the Royal College of Anaesthetists and to the programme boards of the partner HEIs. cont....

Curriculum Development

The HEI group also has responsibility of curriculum development. The curriculum has undergone significant development since 2005 primarily as a result of student and tutor feedback. The latest version is due to be published by the end of 2010 and arrangements have been made to host this in the public domain.”

Appendix 10

SECTION 11 The occupation must have standards in relation to conduct, performance and ethics.

Since its formation, the Association of Physicians' Assistants (Anaesthesia) has, with the agreement of the HPC, instructed its members to abide by the standards of performance, conduct and ethics required by the HPC[1].

References to section 11

1.http://anaesthesiateam.com/code.php

SECTION 12 The occupation must have disciplinary procedures to enforce those standards.

The APA(A) does not have the resources to undertake formal disciplinary proceedings against PA(A)s. The APA(A) asks any applicant to the Managed Voluntary Register to confirm that they have read and understood the standards of conduct, performance and ethics expected of them, which are those of the HPC, and that they agree that their name will be removed from the register should their employer find them in breach of those standards. The application form which provides this information is attached in appendix 8.2. The joint letter from APA(A) and the RCoA asking employers to participate in this process is attached in appendix 8.1.

Currently, any cases of professional misconduct would be dealt with at Trust level but reported to the APA(A) and the RCoA Anaesthesia Related Professionals committee, on which the APA(A) is represented. No case involving a qualified PA(A) has been reported to date.

Any PA(A) found by their employer to be unfit to practice through a breach of standards of conduct, performance or ethics will have their name removed from the Managed Voluntary Register, subject to any appeals process they may have with the employer being exhausted.

SECTION 13 The occupation must require commitment to Continuous Professional Development.

The Association of Physicians'Assistants (Anaesthesia) expects its members to keep a portfolio detailing all CPD activity and to maintain a logbook of all patient care episodes undertaken. The Anaesthesia Related Professionals committee of the Royal College of Anaesthetists, on which the Association is represented, is in agreement with this policy.

In common with the HPC and other professional organisations the APA(A) does not specify the number of hours of study to be undertaken, but practitioners must be able to demonstrate that sufficient activity has been performed to remain competent. The APA(A) lacks the resources to investigate the CPD of members at the present time. However, all those PA(A)s currently in practice work within the NHS and are therefore subject to an annual performance review which includes assessment of their CPD activity.

The APA(A) runs an annual conference with content tailored to the educational needs of the occupation. The programme of the 2010 conference is attached. (Appendix 13)

SECTION 14 Views of others

The Royal College of Anaesthetists is in full support of the regulation of Physicians' Assistants (Anaesthesia) by the HPC and has communicated that view to the HPC via the attached letter. (Appendix14)

The Patient Liaison Group of the RCoA, the lay body that has represented the interests of patients throughout the development of the PA(A) role, has written to the HPC giving its opinion that regulation is essential for the protection of the public.

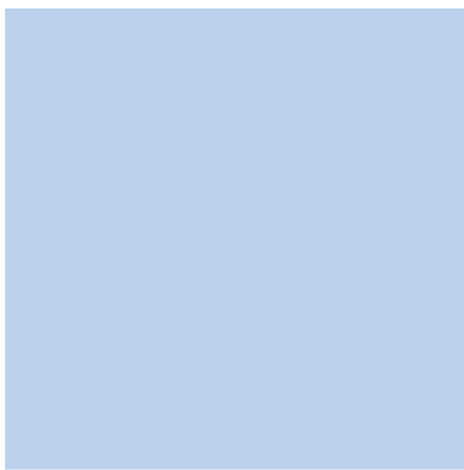
The four UK Chief Medical Officers and the DH have been contacted, but no formal replies have been received to date.

Appendix 14

Department of Health

NHS National Practitioner Programme

A toolkit to support the planning and introduction of training for Anaesthesia Practitioners



A toolkit to support the planning and introduction of training for Anaesthesia Practitioners

March 2007

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

Document Purpose	Best practice guidance
ROCR Ref:	**Gateway Ref:** 7312
Title	A toolkit to support the planning and introduction of training for Anaesthesia Practitioners
Author	DH/National Practitioner Programme/Royal College of Anaesthetists
Publication Date	March 2007
Target Audience	PCT CEs, NHS trust CEs, SHA CEs, foundation trust CEs, Medical Directors, Directors of Nursing, NHS trust Board Chairs, Directors of HR, Directors of Finance, Emergency Care Leads
Circulation List	
Description	This document will support the planning, preparation and implementation of training of Anaesthesia Practitioners within healthcare organisations. The toolkit should be used with the Anaesthesia Practitioner Curriculum Framework which supports the commissioning process for the educational delivery of the national learning programme
Cross Ref	Anaesthesia Practitioner Curriculum Framework, Gateway Ref 4942
Superseded Docs	N/A
Action Required	N/A
Timing	N/A
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Foreword

This toolkit is designed to support the introduction of non-medical Anaesthesia Practitioners. It is the result of four years' collaborative work between the Royal College of Anaesthetists and the National Practitioner Programme that has focused on exploring new ways of working, implementing the role and developing and refining the training programme.

The document will support NHS trusts and other employers in:

- developing a geographically based programme to meet their local needs
- funding and recruiting students
- managing training
- introducing new systems of work to support trainees and make the most effective use of the new practitioners.

The Anaesthesia Practitioner is seen as an effective and sustainable addition to the UK anaesthesia team. It is anticipated that with the support of NHS trusts, employers and the commissioners of education in health authorities these practitioners will increase the efficiency of operating theatres and make optimum use of the skills of medical anaesthetists.

The joint development team with the Royal College of Anaesthetists and other key stakeholders has produced a training system and curriculum and this toolkit is an effective guide to both the implementation of the role and the training of practitioners.

Although the introduction of a new practitioner may seem complex, this toolkit works systematically through each of the stages providing the core information and guidance required for successful introduction. The Appendices also provide examples of learning from the Anaesthesia Practitioner development sites and should help to prevent some of the major pitfalls.

This toolkit should be read in conjunction with the *Anaesthesia Practitioner Curriculum Framework* and I am confident that the two resources will provide essential support to employers in developing this new and important role through to its full potential to enhance our services to patients.

Neil McKellar
Chair of New Ways of Working in Anaesthesia Stakeholder Board
Transitional Director of Workforce
West Midlands Strategic Health Authority

1 Introduction

In 1997 the Audit Commission recommended that the NHS investigate the boundaries between different staff groups involved in providing anaesthesia, through the development of pilot projects.[1] The Royal College of Anaesthetists (RCoA) and the Department of Health jointly agreed that there was a serious impending shortage of trained specialist anaesthetists and that they would undertake the project to develop Anaesthesia Practitioners (APs) as a means to facilitate the delivery of services.

A joint evaluation was undertaken by the Changing Workforce Programme, the Department of Health and the RCoA, including visits to the USA, Sweden and Holland, which resulted in the report *The role of non-medical staff in the delivery of anaesthesia services.*

In summary, the report[2] concluded that:

- The ways in which anaesthetic services in the UK are currently delivered are not sufficient to maintain and increase future surgical throughput.
- In other countries, non-medical qualified staff work well within the anaesthetic team.
- The development of the role of non-medical qualified staff requires major input from the RCoA.

The Anaesthesia Practitioner (AP) programme was subsequently established in early 2003. Development of the AP role commenced in January 2004 and resulted in the *Anaesthesia Practitioner Curriculum Framework*. The Curriculum Framework has been implemented across a number of development sites and is now available to be used to commission the education and training programme for the role.

This toolkit aims to provide 'best practice' advice:

- To support the introduction of the AP role.
- To ensure appropriate local stakeholder involvement.
- To enable the commissioning of a training programme from higher education institutions (HEIs).
- To support the implementation of local training programmes in respect of the APs.

[1] *Anaesthesia Under Examination: The efficiency and effectiveness of anaesthesia and pain services in England and Wales*, London, the Audit Commission, 1997

[2] *The role of non-medical staff in the delivery of anaesthesia services*, Royal College of Anaesthetists, London, 2003

The toolkit is structured around three stages:

Planning

- Determining the need for the role
- Obtaining support
- Securing the funding

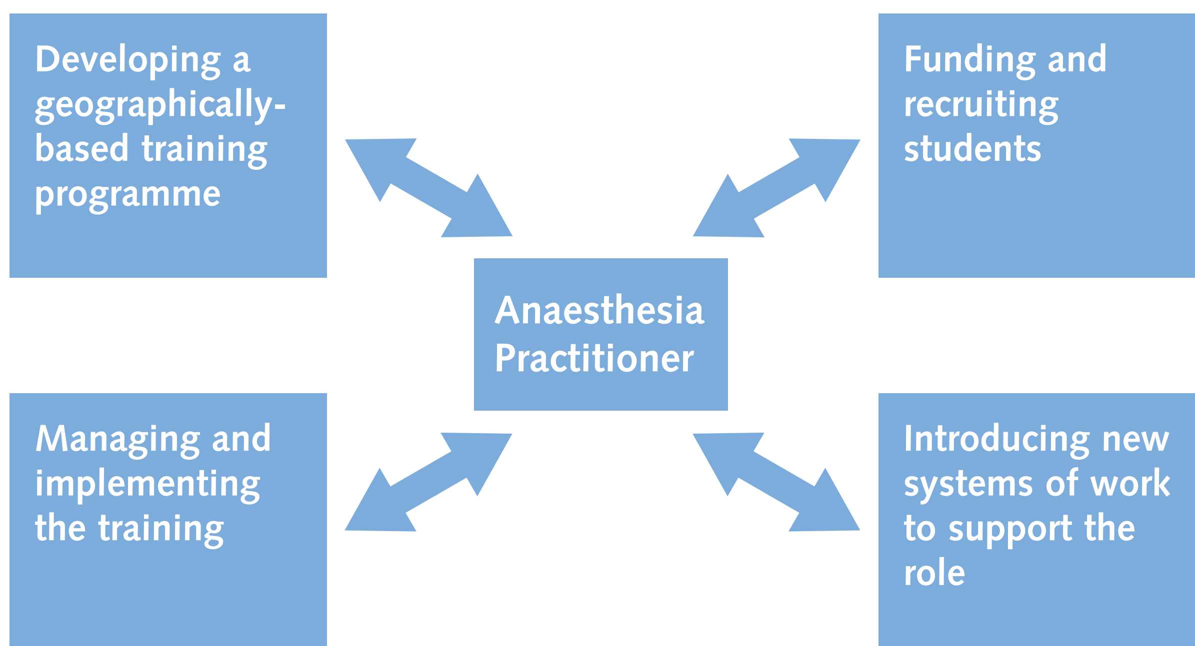
Preparation

- Identifying an education partner
- Recruiting the trainees
- Establishing clinical governance arrangements

Implementation

- Delivering the programme
- Supporting the trainees
- Ensuring safe practice

Although the toolkit is presented in a sequential timeline, other approaches can be used such as:



1.1 Key supporting information

Anaesthesia Practitioner Curriculum Framework

The Curriculum Framework is available and is being used by Workforce Development Directorates (WDDs) to commission local HEI partners to deliver the education and training programme. It is available at: www.dh.gov.uk/assetRoot/04/11/64/29/04116429.pdf

The RCoA works closely with clusters of NHS trusts and HEIs to ensure accurate and timely delivery of the national learning programme.

The first cohort of students admitted to the national learning programme were experienced nurses and Operating Department Practitioners (ODPs) that were seconded from their current roles. One cluster of NHS trusts is exploring the employment of graduates who will undergo an additional period of engagement. The cluster will be reviewing the plans to encourage those students and other graduates who wish to enter the NHS for the first time to access the programme.

Prior to accessing the course some students will be required to develop their knowledge and skills via university modules or the Accreditation of Prior Learning process (APEL/APL) to prepare them for entry to the course.

The competences within the Curriculum Framework for the AP role are being mapped into the Skills for Health national workforce competence framework for emergency, urgent and scheduled care.

Key websites

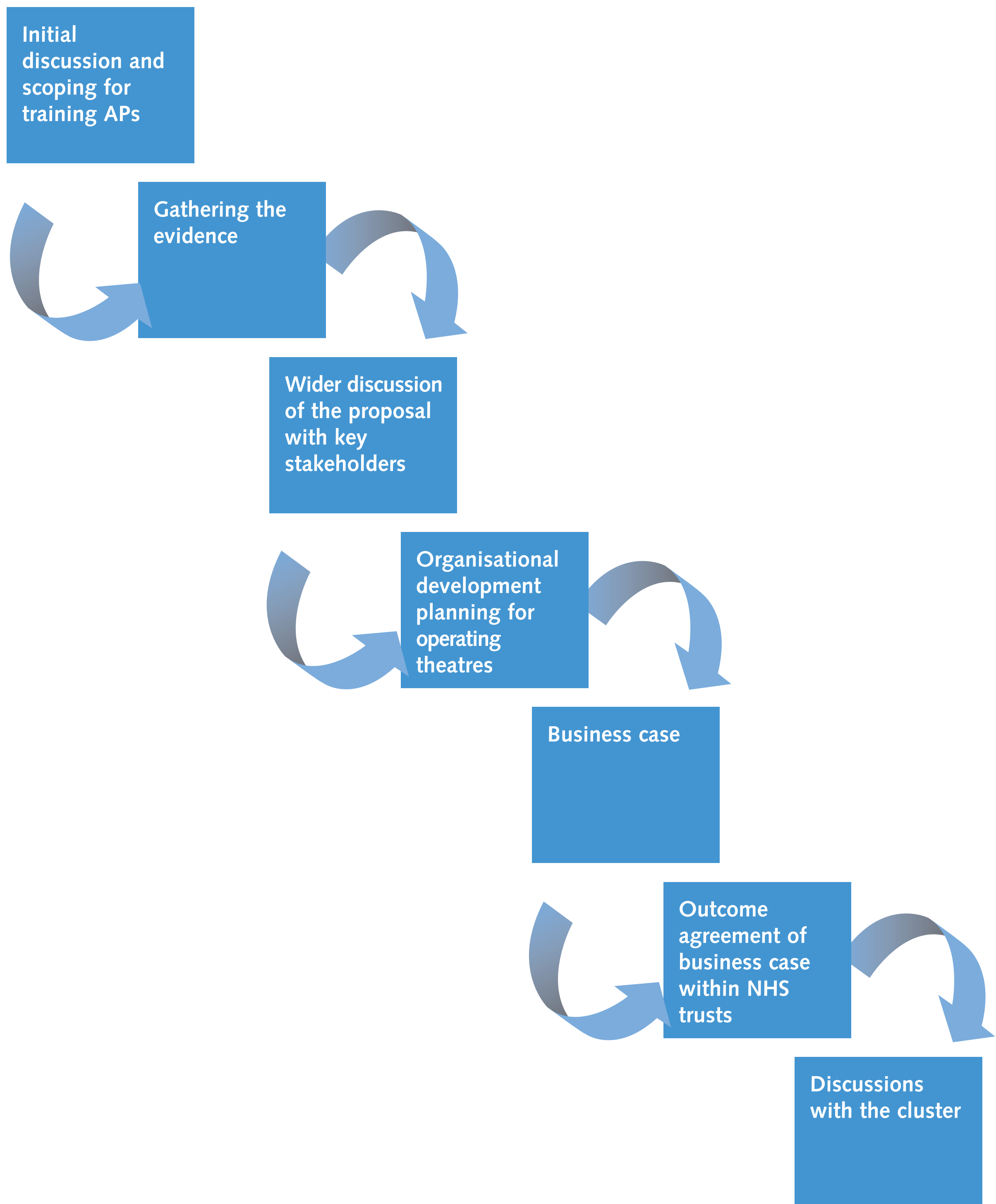
Publications relating to the AP role can be found on the RCoA website at: www.rcoa.ac.uk

Other useful websites are:

- Association for Perioperative Practice www.afpp.org.uk
- Association of Anaesthetists of Great Britain & Ireland www.aagbi.org
- British Anaesthetic & Recovery Nurses Association www.barna.co.uk
- College of Operating Department Practitioners www.aodp.org
- Department of Health www.dh.gov.uk
- Group of Anaesthetists in Training www.aagbi.org/gat.htm
- National Practitioner Programme www.wise.nhs.uk/sites/workforce/practitioners/anaesthetic
- Royal College of Anaesthetists Patient Liaison Group www.rcoa.ac.uk
- University of Birmingham www.bham.ac.uk
- University of Hertfordshire www.herts.ac.uk
- University of Hull www.hull.ac.uk

2 Planning

Determining the need for the role, obtaining support and securing the funding



2.1 Initial discussion and scoping for training Anaesthesia Practitioners

Initial discussions on the introduction of APs should focus on the needs of patients, patient safety and the capacity of these practitioners to help the organisation to deliver its service in the future. Possible topics for consideration during initial discussions are:

- What are the service and organisational workforce needs for anaesthesia over the next five years?
- How is the current service affected by recent or planned policy changes?
- Can the performance targets be met with the current workforce?
- Can the current level of service to patients be maintained and improved where appropriate?
- What options are available to deliver the service in the future?

At an early stage ensure that anyone involved in the discussions is using the same definition of APs and their scope of practice, and this that is based on national criteria. The following questions need to be asked:

- Can APs be used in the workplace?
  - Is the case mix appropriate for the role?
  - Will the theatre layout allow for the appropriate levels of supervision?
- What are the benefits of introducing this role?
- What changes are required in order to realise these benefits?
- What workforce changes would be needed if APs are not trained?

Key Recommendation

Before proceeding, ensure there is a sufficient body of support from the anaesthesia department to explore APs as a potential workforce solution to service demand.

It is important that these questions are resolved to avoid potential conflict as the business case progresses. For more information please see the Frequently Asked Questions in Appendix A.

Each local health community will have in place a local delivery plan and integrated service improvement plan (ISIP), which provide a framework for future services and a systematic plan for improvement. The AP proposal should form an integral part of these processes and comply with any methodology for identifying benefits or implementing change. The ISIP framework is available at: www.isip.nhs.uk

The independent sector

The expectation is that where the independent sector is providing care and treatment for NHS patients, it will engage in the training of clinical staff; guidelines are available in the independent sector treatment centres training policy which can be found at:
www.dh.gov.uk/en/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/DH_4136988

An independent sector organisation that wishes to be engaged in the training of APs will be expected to meet the same criteria as NHS organisations. This may present challenges relating to:

- experience of medical training in anaesthesia
- volume and complexity of work
- training and education capacity
- the quality of training being provided to the expected standards.

Key Recommendation

Independent sector organisations should partner with NHS organisations in their initial proposals and implementation of training.

2.2 Gathering evidence

Evidence gathered highlights the potential benefits in reconfiguring anaesthesia services using APs, as shown below:

Flexibility – making medical anaesthetists more available

With a significant number of APs in a department, anaesthetists will be able to work using mixed teams of consultants, staff and associated specialists, doctors, trainee doctors and APs. Working in teams, it will be possible for medical staff to be released to do other activities such as attend the high dependency unit, outreach and pain services; this is developed further in Section 2.4. By reconfiguring the number of anaesthetists required to provide the same service, more senior anaesthetists will be able to participate routinely in out-of-theatre activities that are at present usually attended by junior doctors. This development has the potential to improve both the staff experience and patient 'journey'. Examples of improvements include:

- Less waiting for a medical anaesthetic opinion in pre-admission clinics.
- Faster resolution of problems in patients' post-operative pain.
- More immediate response by senior medical staff for attendance to 'outreach' patients.
- Less waiting for anaesthesia for out-of-theatre procedures such as cardioversion.
- More senior anaesthetic staff available for emergency calls in A&E.

APs can increase capacity in teams

Consultant anaesthetists can supervise two APs during the maintenance phases of anaesthesia. This allows one consultant to supervise two theatres. The efficiency of this team will depend on the length of the cases and the number of theatres being run by a team. As a consultant anaesthetist must be present at the start and finish of anaesthesia there is significant gain with longer cases, and with more theatres the benefits can be maximised. It is possible that more operations could be undertaken without an immediate increase in the numbers of anaesthetists.

Facilitating service reorganisation

Service reorganisation is a key aspect of the current health service agenda. Reconfiguration of junior doctor training and the shift of services have the potential for a significant effect on hospital services. Faced with reduced hours in light of the Working Time Directive 2009 and

possible loss of their junior doctors, anaesthetic departments may find a combination of career-grade anaesthetists and APs to be an attractive option, in order to maintain services. Please see Appendices B and C for more details.

Hospital services at night

With reductions in the night-time anaesthesia team, anaesthetists may find themselves with a high workload. Adding APs to the night-call team will provide additional availability of anaesthetic skills, building capacity both within the operating theatre and beyond.

Information supporting the work of the AP role within the development sites to date can be seen in Appendix D.

Key Recommendation

Prepare a draft paper outlining the potential local benefits of introducing the AP role and circulate it to all stakeholders for comment.

2.3 Wider discussion of the proposal with key stakeholders

A draft paper, outlining the AP role, should be circulated to all stakeholders for comment. It should ensure that:

- there is wide engagement of the theatre team
- the rationale for the proposal is sound
- all the options are highlighted
- there is engagement of stakeholders outside the immediate theatre environment.

All staff who will either be working directly with, or have potential to interact with, the AP should be consulted where appropriate. Discussions should also commence at this stage with patient representatives.

Detailed discussions should be held with key stakeholders within theatres and with the executive team of the NHS trust or healthcare organisation. Staff in the workforce/deanery should also be made aware of the proposal. Suggested key stakeholders include:

- the consultant anaesthetist clinical lead – the local expert in anaesthesia education
- the clinical/medical director – for clinical leadership
- the theatre manager – for understanding of theatre staffing and rostering
- the director of nursing – for nursing leadership as part of a multi-disciplinary team
- the director of finance – to consider financial backing and future investment planning
- the director of human resources – for understanding of current HR policies
- the education and learning manager – for training and education expertise
- patient representatives – for the patient perspective and public transparency
- staff representatives – to consider the impact on staff

- workforce/deanery representatives – for understanding of regional planning, co-ordination and investment
- the clinical governance/risk management lead – to ensure patient safety through the development of protocols for the role.

A small working party should be set up to consider the issues around establishing training for the AP role. This will require some administrative/project management support.

Key Recommendations

Establish monthly meetings and terms of reference for key stakeholders in order to move the training forward.

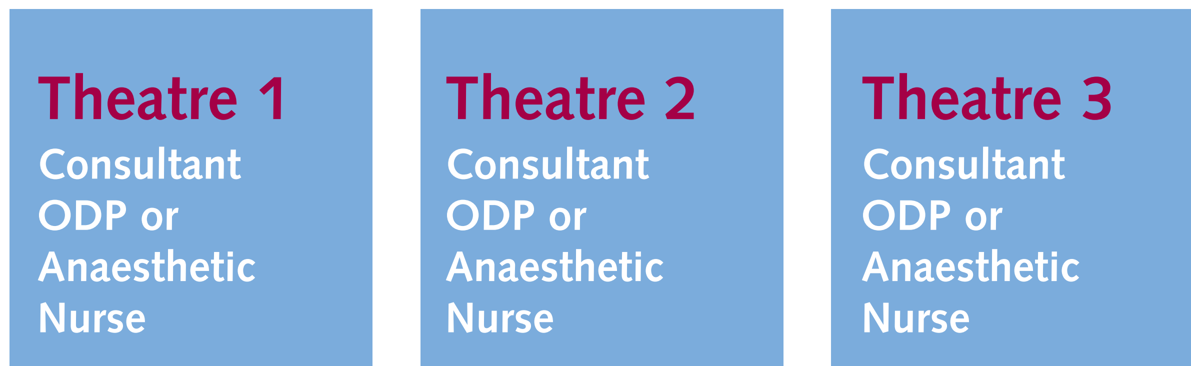
Scope interest in other local trusts in training APs.

Links should also be made with local healthcare organisations that may have experience in training APs (see Appendix E for a list of AP development sites).

2.4 Organisational development planning for operating theatres

Traditionally, anaesthesia staffing in theatres follows the model below, but it is acknowledged that there are added complexities such as the training of junior doctors and having two anaesthetists for complex cases.

Traditional staffing in theatres



When assessing the need for APs, consideration should be given to how they will be used once they are qualified. With the introduction of APs, greater flexibility can be introduced as to how staff can be used within theatres. The models opposite show some of the ways the role can be employed within theatres.

Introducing new models of working may require focusing attention on the organisational development principles of change management.

Key Recommendation

Consider consulting your local organisational development specialist, or equivalent, for help in supporting any change, and use the national resources and experience available for introducing new roles.

Model 1– Using the AP to improve theatre throughput

Theatre 1
Consultant
AP
ODP/Anaesthetic Nurse

The AP can be used to support the consultant in setting up complex anaesthesia or to support same day admissions.

They can also be used to enable the turn-and-turn-about method of anaesthesia or troubleshoot in recovery.

Model 2 – Using the AP to improve theatre teaching

Theatre 1
Consultant
Senior House Officer (SHO)
AP
ODP/Anaesthetic Nurse

Using the AP will allow the consultant time to undertake competency-based teaching of, for example, blocks and epidurals.

Model 3 – Using the AP to support long and complex surgical cases

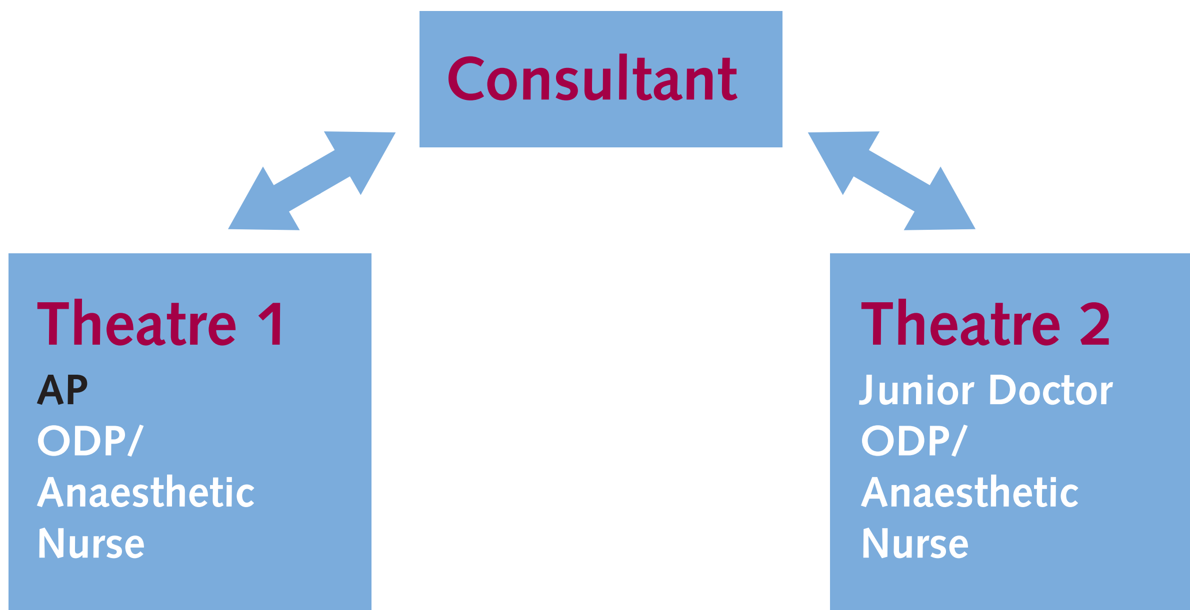
Theatre 1
Consultant
AP
ODP/Anaesthetic Nurse

APs can provide the support that would be typically given by a second anaesthetist and, where appropriate, allow for rest breaks for other staff members.[3] This is in line with Improving Working Lives and compulsory rest breaks within the Working Time Directive.

[3] Willoughby L, Morgan R. Neuroanaesthetists' workload issues. *Anaesthesia* 2005; 60:151–4

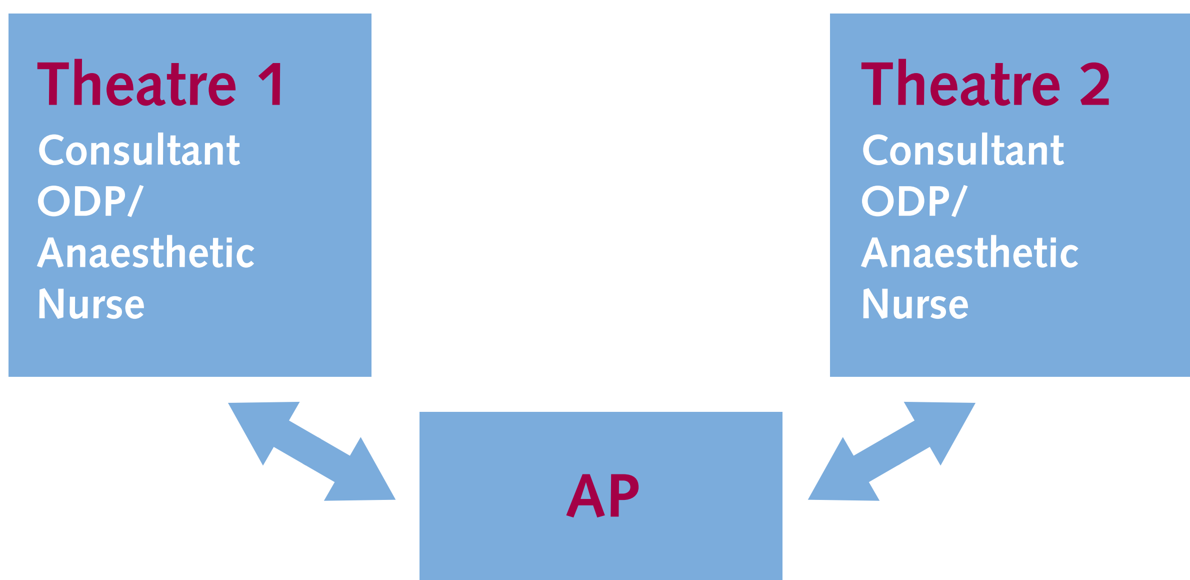
Where adjacent theatre suites are available, the following models of care delivery could be used to allow a two-theatre working model.

Model 4 – One consultant to two theatres, working with APs



Consultant supervision can be provided, as required, to both the AP and the junior doctor, to ensure that the junior doctor receives the most appropriate training. This model could also be run with two APs, particularly in non-teaching hospitals.

Model 5 – Flexible AP support for two-theatre working



The AP can be used to free up consultants to work outside theatres, so they can provide additional support, as required, throughout complex procedures or in emergency situations.

Model 6 – Potential reconfiguration of the anaesthesia team using APs

This model still requires comprehensive discussion with the appropriate professional bodies at a national level and needs to consider the following:

- *Anaesthesia Team*, The Association of Anaesthetists of Great Britain and Ireland – 2005 guidelines concerning the presence of dedicated trained assistants at: www.aagbi.org/publications/guidelines/docs/anaesthesiateam05.pdf
- *Scope of Practice for ODPs – Scope of Practice for Registered Operating Department Practitioners*, Appendix 1 Curriculum Standards document, May 04 at: www.aodp.org
- *Staffing for Patients in the Perioperative Setting*, Association for Perioperative Practice, 2003 at: www.afpp.org.uk/publications.cfm?start=36#601
- *NHSLA Risk Management Standards for Acute Trusts*, NHS Litigation Authority at: www.nhsla.com/RiskManagement/

For non-complex anaesthesia, it is possible to reconfigure how anaesthesia services are provided in theatres. This model is similar to that found when using Anaesthesiology Assistants in the United States.

APs are also able to work in non-theatre roles under the supervision of a consultant in a team activity, such as:

- perioperative procedures
- pre-operative assessment
- venous access
- sedation
- scanning
- transfer.

Changing the pattern of work in theatres will inevitably affect roles other than the AP's, and there are complex issues in operating two systems in a single organisation. Each employer will

need to work through the relative roles of each member of the anaesthesia team, to achieve the most effective and efficient system for their theatres. A general study of the potential impact of APs on the roles of Anaesthetic Nurses and ODPs has been undertaken by the Workforce Review Team (WRT) and is available by selecting 'Anaesthesia Practitioner Project Report' at: www.healthcareworkforce.nhs.uk/wrtprojects.html

For wider support on organisational development issues around new practitioner roles, *Optimising the contribution of non-medical healthcare practitioners within the multi-professional team: A good practice checklist* can be found by selecting 'Practitioner Good Practice Guide' at: www.wise.nhs.uk/sites/workforce/practitioners/npp/default.aspx

2.5 Business case

Achieving success will require a robust and well-presented business case, but it also depends on that case being seen and supported by key individuals at the right time. Therefore, prior to presenting the business case to any decision-making forum, you should consider who needs to approve the development of the business case during the following stages:

- Initial proposal
- Developing case
- Final case.

When developing the business case, consider the following key points:

- How the AP role serves a specified local need, ie whether it is patient and/or service driven
- Its impact on improving service to patients in line with local priorities
- Its relationship with national targets such as the 18 week patient pathway from GP referral to treatment, Working Time Directive 2009, Modernising Medical Careers, the productive time agenda, etc
- The strength of local clinical support
- Timeliness regarding availability of funds and any approval process
- The cost effectiveness of training APs
- The cost benefits for the role
- Quality standards and expectations to which the role will adhere:
  - Training standards
  - Selection criteria.

Outlined below are some additional topics that should be discussed within the business case.

Options appraisal

An options appraisal of other workforce solutions as an alternative to introducing the AP role should be undertaken, followed by identification of the preferred option. Each option needs to be scoped locally, in its own right, to assess its appropriateness, for example:

- Employing additional doctors

- Increasing international recruitment
- Extending the roles of current healthcare staff
- Service reconfiguration.

Workforce planning implications

The AP role may affect the specialty of anaesthesia in a number of ways, for example by:

- reducing the need for growth in the number of specialist anaesthetists
- increasing operating theatre throughput
- releasing trainee anaesthetists from service provision roles and hence improving training
- meeting Working Time Directive compliance
- addressing the potential implications following the introduction of Modernising Medical Careers.

Potential benefits of employing APs

Medical staffing:

- Achieving Working Time Directive compliance by 2009
- Undertaking specific elements of service currently provided by junior doctors, to release their time to improve training
- Maintaining patient safety and service provision in light of Modernising Medical Careers
- Improving the match between the patient's needs and the skills of the anaesthetist.

Theatre working:

- Maintaining standards and safety
- Helping to meet the 18 week patient pathway from GP referral to treatment
- Improving patient flow through theatres
- Reducing the number of cancelled operations
- Enabling two-to-one working in theatres
- Realising 'Gershon review of public sector efficiency' savings due to increased efficiency and productivity, see: www.hm-treasury.gov.uk/spending_review/spend_sr04/associated_documents/spending_sr04_efficiency.cfm
- Maintaining service provision in light of policy changes
- Increasing throughput

Anaesthesia team:

- Increasing job satisfaction
- Achieving enhanced teamworking

- More appropriate use of skills
- Maintaining or improving recruitment and retention
- Providing clinical career development opportunities.

See Appendix D for more detailed information collated from the development sites.

Sources of funding

The current funding strategies for training APs vary, depending on locally developed arrangements. The purpose of the funding may indicate who will provide it, for example:

- **Education costs**
  Educational costs, eg course fees and related supervision, are a legitimate claim on the discretionary Multi-Professional Education and Training (MPET) levy held by the strategic health authority (SHA). In addition, subject to local agreement, specialist programmed activities may be used to provide some of the teaching and administration time from medical staff.
- **Salary costs**
  Salary costs are more controversial and, although the MPET levy may meet some costs, any service contribution made by trainees is likely to be deducted, ie 20% of salary costs at least. If a department is holding vacancies due to recruitment difficulties, this may be a source of salary funding.

Other sources for funding could be:

- a reduction in monies associated with junior doctors' hours
- widening access funding
- development monies
- local healthcare community investment funds/service improvement.

Full costing for the proposed training programme must be established to allow organisations to identify any financial risks. However, shared costs across a cluster of NHS trusts may reduce risk.

Key Recommendation

The key driver when constructing a request for funding is that there must be a clear investment appraisal that identifies the cost/benefits of training APs, based on robust planning. Training APs is a relatively long-term investment, taking three years from planning to delivery.

Consideration should be given to the long-term cost/benefits of introducing the AP role.

Risk analysis

Within the business case it is important to identify the risks and challenges associated with introducing the role, and how each of the risks will be managed. Suggested areas to consider are shown in the table opposite:

Risk	Management of risk
Failure of APs to provide high-quality anaesthetic care	National training programme agreed by the RCoA should be adhered to. There should be effective supervision by the consultant anaesthetist and clinical governance systems should be implemented.
Failure of front-line teams to accept the integration of the AP role within the anaesthesia team	Involvement of all key stakeholders within the local team should mitigate this risk, but clear, consistent and open communication should be provided at all stages of the introduction of the role.
Variation in implementation of the national learning programme at departmental and regional level, resulting in variable output competences	Strategies for development of local and regional expertise, clear expectation and contracts between all parties involved, and adherence to national standards are necessary.
Failure to secure national professional registration and regulation, resulting in ambiguous career prospects and recruitment difficulties	This issue is being addressed nationally, but local clinical governance arrangements will need to be addressed.
Variability of standards, due to employment of overseas APs with differing backgrounds	Guidance should be taken from clinical governance colleagues until equivalence procedures are available.
Withdrawal of funding before a critical mass of APs are trained	The role should be included as part of long-term staffing requirements for the department and incorporated within strategic workforce plans.
Unclear expectations of the role, resulting in role confusion and risks in delineating scope of practice	The remit of the role should be discussed and defined with all parties involved in the employment and training of APs, including medical staff, non-medical staff, HR and finance.
Failure to realise the benefits, due to poor organisational development and failure to reconfigure theatre work and the role of medical and other staff	A clear organisational development strategy is in place for theatres which encompasses the role. Details will need to be locally agreed will all key stakeholders.

Business case guidelines entitled *Making the Case for Anaesthesia Practitioners* are available on the RCoA website at: www.rcoa.ac.uk

2.6 Outcome agreement of business case within NHS trusts

Local guidance will be available which will outline the due process of agreement and submission of business cases. The submission of business cases should be in line with the business planning cycle of the organisation and should normally be submitted no later than one financial year prior to requiring the funding, to allow it to be included in financial plans and forecasts.

It is anticipated that a number of NHS trusts across a region will have submitted business cases to train APs in line with individual trust requirements. Once agreement of support and funding has been identified within individual organisations, consolidation of training proposals should be undertaken and a cluster of trusts formed.

Key Recommendation

Generate an action plan for introducing the training for APs within the cluster of trusts, with clearly agreed timescales and responsibilities.

2.7 Discussions with the cluster

When forming a cluster of local NHS trusts, a number of key considerations must be taken into account to make maximum use of all available resources and experience.

Training capacity

- Identification of training capacity to train APs must ensure that training of other staff is not compromised.
- The implications of other policy changes such as Modernising Medical Careers and Working Time Directive 2009 will need to be carefully managed.
- Consideration should be given to the impact of the independent sector on training capacity.

Key Recommendation

Discussions regarding training capacity should take place with the RCoA regional representative and local workforce deanery.

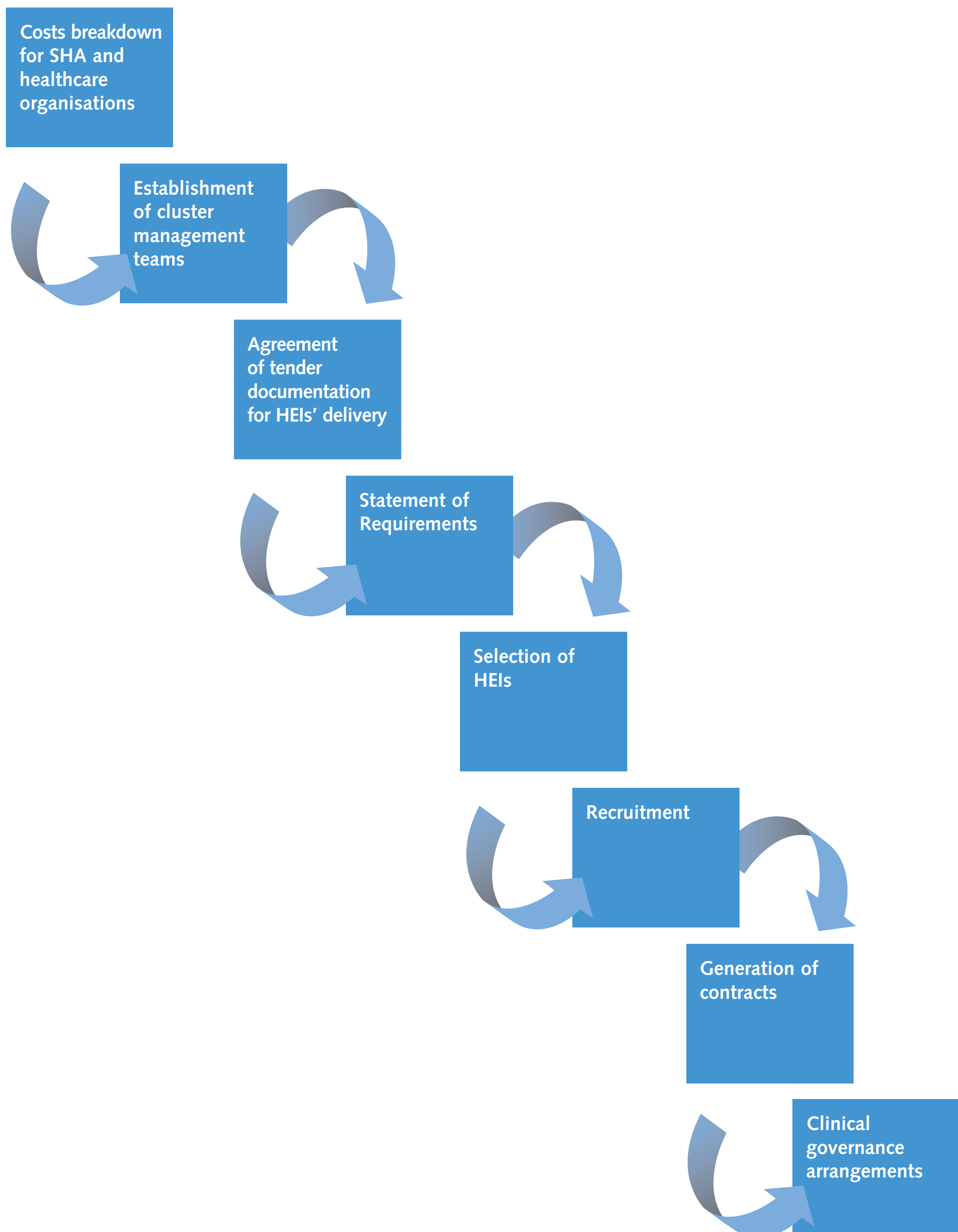
Workforce skill mix

While some areas still have staff shortages, others may be looking at reducing total staff numbers.

- The AP role may provide career development for the existing workforce to meet future service need and form an additional clinical career pathway.
- Where there are workforce shortages, the AP role may provide science graduates from outside the NHS with an opportunity to have a clinical career.

3 Preparation

Identifying an education partner, recruiting the trainees and establishing clinical governance arrangements



3.1 Costs breakdown for the strategic health authority and healthcare organisations

Anticipated costs for training APs include the following:

Pay:

- 0.25 Whole Time Equivalent administration staff
- Salaries for trainee APs
- 2.5 programmed activities per week/per cluster of trusts to backfill consultant anaesthetists' time spent in teaching and administration. Subject to local agreement, some of this time may come from existing specialist programmed activities.

Non pay:

- Recruitment costs
- Training and education costs
  - Course fees
  - E-learning access
  - RCoA final examination
- Travel costs and consumables.

The MPET levy may be used to meet the course fees and education-related expenses. The MPET levy is only likely to meet the costs of the educational component of the course, ie it is expected that during clinical work the trainee will at times make a net contribution to the service. At a minimum this will be around 20% but could be as high as 40%. Further detail can be found in Section 2.5.

3.2 Establishment of cluster management teams

The cluster of local NHS trusts should begin to consider a forum for discussion across the region and it is advisable that, as part of this, the following should be put in place:

- **The clinical lead** for the cluster should be identified. This person will have key responsibility for clinical leadership and training of APs. It is advisable that the key responsibilities of the clinical lead are identified and clearly laid out at the outset.

Key Recommendation

Clinical leads should have 2.5 programmed activities per week to provide teaching and administration support across the cluster of trusts.

- **The cluster manager/co-ordinator** should also be identified. This person will ensure that the tendering process and initial establishment of contracts, clinical governance arrangements and recruitment needs are identified. They will also offer a point of administrative and management contact during the training of the APs. It is expected that these responsibilities will fall within the remit of an existing member of staff.

3.3 Agreement of tender documentation for higher education institutions' delivery

Tendering will be governed by specific standing financial instructions (SFIs) within the organisation and will usually be undertaken by the workforce directorate/deanery as part of the SHA. SFIs can seriously affect timescales and usually include the:

- amount above which a contract should go for open tender
- detailed instructions of how the tendering process is to be handled (ie sealed envelopes and opening instructions)
- tender assessment criteria which are generic to the organisation
- post-tender negotiation processes.

It is always important to ensure a competitive approach to secure value for money.

HEIs can have substantial lead-in times for development of new courses but these are negotiable and it is usually easier to negotiate these when there are alternative providers.

When requesting a written tender response it should include:

- a detailed delivery plan (two sides of A4)
- how the AP programme would be validated
- student support provided
- how the relevant clinical leads would be engaged
- addressing the multi-disciplinary context
- ability to respond to local service need.

Key Recommendation

The tender specification must be based on the Curriculum Framework and Statement of Requirements for the national programme. Any serious variation puts at risk the national transferability of the qualification.

3.4 Statement of Requirements

The RCoA, along with other key stakeholders, has produced a Statement of Requirements to support the commissioning of the education and training programme for APs. The Statement of Requirements outlines the partnerships between the RCoA, HEIs and healthcare providers wishing to offer the AP training programme.

A partnership agreement between HEIs and healthcare providers is an essential first step in the Statement of Requirements for organisations wishing to offer the AP programme, and covers the following areas:

- management support of the programme
- support from the commissioners of the programme
- student support
- programme delivery*
- student selection
- quality assurance
- support from the directorates that include operating theatre services and anaesthetics.

*The AP Curriculum Framework is the core document to inform the educational requirements for the programme delivery element.

A copy of the Statement of Requirements can be found in Appendix F.

Evidence will need to be provided to demonstrate that the criteria have been met by the partnership of organisations to be able to deliver the AP programme in line with the requirements outlined in the Statement of Requirements.

3.5 Selection of higher education institutions

The selection of an HEI partner should be led by the SHA workforce directorate/deanery. Suggested criteria for the selection of HEI partners as part of the tendering process are outlined below:

- track record of partnership working with the NHS
- experience of successfully delivering similar related clinical training
- evidence of successfully delivering basic medical science training
- evidence of ability to deliver to timescales
- value for money
- access to appropriate clinical skills laboratory
- ability to work with the RCoA and integrate the RCoA national exam with the post-graduate qualification as detailed in the Curriculum Framework
- flexibility of approach to delivery of education and training.

3.6 Recruitment

Trainee AP posts can be advertised as secondment opportunities for existing staff, external recruitment or a combination of both. The organisation will need to work within its current local recruitment policies.

All applicants should be able to show that they have carefully considered the commitment involved. They must demonstrate to the selection panel that they have good communication skills and the ability to work well within a team. To facilitate equitable access it is anticipated that an admissions adviser will advise applicants appropriately.

There are two main routes of entry to the AP training programme, as follows:

- **Registered healthcare professionals**

  For example nurses or ODPs with one or both of the following:

  - at least three years', full-time, post-qualification work experience in a relevant area and evidence of recent (within three years) and successful academic activity
  - a first degree in a health-related subject

- **New entrants to healthcare (graduates or graduate equivalent)**
  - with a biomedical science or biological science background
  - preferably with a second-class honours degree or better, or other evidence of recent and successful academic activity
  - with a demonstrable commitment to a career in healthcare.

All applications will be individually assessed. The NHS trust and HEI should be involved in the selection and interview process, and the selection panel should include both clinical and managerial staff.

The recruitment strategy selected should be based on the local workforce strategy and Career Framework. It is anticipated, where there are current staff surpluses, that existing healthcare professionals should be given the priority to enhance their skills and train to be APs in line with the needs of the service.

The AP role offers current healthcare professionals opportunities within the Career Framework to progress their competences in line with the 'Skills Escalator' concept at: www.skillsforhealth.org.uk/workforce-1.php It may be particularly attractive to those staff who wish to advance their career within clinical practice in line with the Career Framework, which builds on the concept of skills escalation but also recognises the opportunity for career movement within a level on the framework to support motivation and retention. More information is available at: www.skillsforhealth.org.uk/careerframework

Where there are workforce shortages within certain geographical locations, a combined recruitment strategy covering both current healthcare professionals and new entrants to healthcare may need to be actively pursued.

A job description for the newly qualified AP and the *Knowledge and Skills Framework* outline is available in Appendix G. In addition, the national profile for APs in line with Agenda for Change is available in Appendix H.

Additional information on the guidance relating to the treatment of trainees is contained within Annex U of the *NHS Terms and Conditions Handbook* covering the application of Agenda for Change to trainees, which is available at:
www.nhsemployers.org/pay-conditions/pay-conditions-396.cfm

Key Recommendation

Identification of local HR policy in relation to recruitment will help highlight the most appropriate sources of recruitment.

3.7 Generation of contracts

Training of clinicians is always a partnership and all sides usually benefit from being clear about their responsibilities. There are a number of parties involved in the agreements/or contracts required and each of these parties will need clear lines of responsibility and accountability in the following areas:

Trainee

- Employment during the training programme
- Implications of failure on the training programme
- Expectation at the end of the training programme

NHS/service supervision and education

- Time/remuneration
- Standards
- Honorary agreements with HEI

HEI

- Educational delivery requirements
- Reporting data
- Quality assurance/standards
- Cost

NHS trust

- Clinical governance requirements
- Supervision
- Resources/clinical experience
- Reporting data to SHA

These agreements are interdependent for success and should be seen as a whole.

3.8 Clinical governance arrangements

It is important that, when new roles such as the AP are proposed, the organisation and the public have confidence that their introduction has been accompanied by a full consideration of the clinical governance issues. Each organisation will have robust systems in place to ensure sound clinical governance arrangements, which can be found at: www.cgsupport.nhs.uk These should cover both the trained practitioner and the practitioner in training and should clearly identify the limitations of the role.

The proposal for the training and the role should be taken through the clinical governance procedures. The process will help focus on some key issues, and the challenges will not only support patient safety and excellence in practice, which are paramount, but they will also be preparation for the issues that will be raised as the business case and the role are developed.

Discussion should include:

- the scope of the role and its boundaries
- interaction with other roles
- compliance with the organisation's policies and procedures
- patient and public understanding and expectations of the role
- monitoring and evaluation of the role while it is being introduced
- the training programme, its standards and its external validation
- the preparation and induction of trainees before they have contact with patients
- supervision of trainees during training
- prescribing, supply and administration of medicines.

The RCoA Patient Liaison Group has developed an information leaflet for patients, which is available at: www.rcoa.ac.uk/docs/AP%20leaflet.pdf

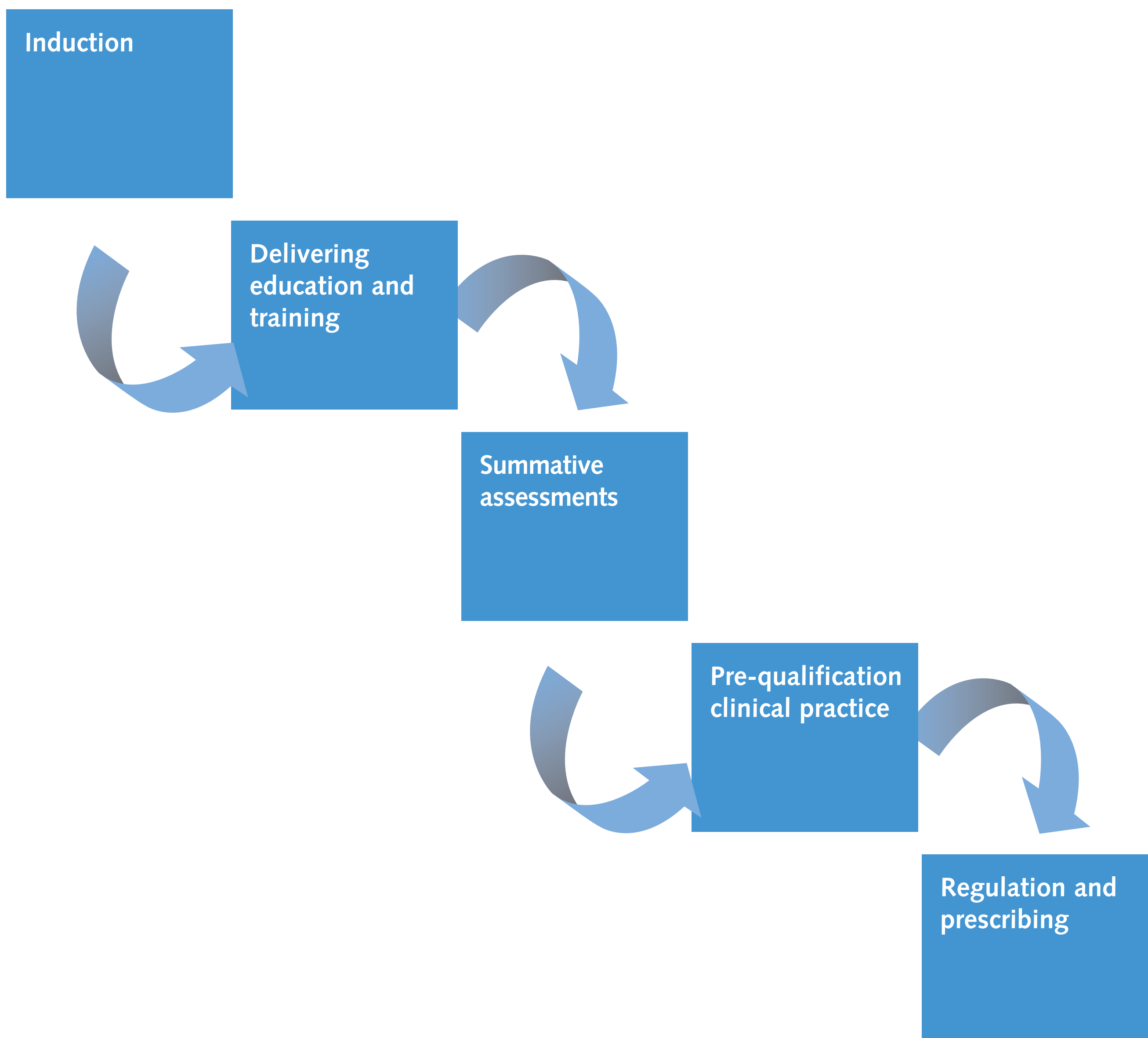
Key Recommendations

Early discussions should be held with the organisation's chair of the clinical governance committee or their equivalent to seek advice on the expectations for your particular organisation.

Ensure availability of patient information leaflets.

4. Implementation

Delivering the programme, supporting the trainees and ensuring safe practice



4.1 Induction

Trainees need to be orientated to their changing role and to the training programme generally. Broadly, the orientation is in three areas:

- **The organisation**

All trainees need to be fully conversant with the organisation's policies and procedures and have the relevant statutory or other mandatory training, for example:

  – Health and safety
  – Manual handling
  – Cardiac Pulmonary Resuscitation (CPR)
  – Corporate induction
  – Full HR procedures, including verification of all documentation.

They should be fully inducted into the expectations of the organisation regarding their behaviour, the reporting of incidents, their personal health and safety, and what they can expect the organisation to provide for them, for example occupational health and support.

- **The training programme and the university**

All trainees should have the opportunity to fully understand and discuss their training programme including their placements/clinical experience, the supervision they can expect, the academic component, the competences, and the standards expected for successful completion.

Trainees will be registered students of a university, with all the privileges and rights that go with that, and they should have a formal university induction which will outline all aspects of university work and expectations regarding their course, eg rules on plagiarism, etc. and the requirements of academic submissions.

- **The work they will undertake**

As well as the organisational induction, the trainee should be inducted specifically into the anaesthesia department and, if necessary, the operating department. This should include all the operating procedures for each, and any specific expectations in terms of reporting.

The boundaries and limitations of the role should be clearly covered and reference should be made to the *Anaesthesia Practitioner Curriculum Framework*.

Particular attention should be paid to expectations regarding working as part of a team and under supervision, and in what circumstances they should request additional support.

Where possible, the induction package should be tailored to the needs of the individual and should reflect their prior experience.

Week one of the education and learning programme should involve introduction to HEI staff and the clinical team, and identification of a clinical mentor as well as a one-to-one meeting with them. Information about, and access to, all educational and academic facilities should also be provided.

4.2 Delivering education and training

Following the preparation of the course in line with the Curriculum Framework, the delivery of the education programme for the first cohort provides a vital learning experience for the programme tutors, supervisors, mentors and trainees. The staff delivering the programme should take every opportunity to record the effectiveness of the programme and refine it as early as possible. Although the programme is predetermined, this should not be seen as a block to improvements where these can be shown to increase its effectiveness. During the initial stages of the programme, close attention should be paid to the core standards, for example supervision and attendance, because inappropriate standards or behaviour in either trainees or others become increasingly difficult to correct as the programme progresses.

Trainee and staff support

During the initial stages of the programme, an open-door policy should operate for students, with access to both an identified consultant anaesthetist mentor and university staff. These students will be undertaking a new type of training within your organisation and also will be introducing significant change to working practice within theatres. Therefore managing the clinical and academic environment and offering high levels of support will often help offset some of the initial difficulties that may be faced.

In addition, it is important to recognise the support needs of the staff supervising the trainee APs. It is anticipated that many of the staff delivering the education and training will be highly experienced in their speciality, but they may need guidance in dealing with the level of training for APs and the style of the course. It would be useful to consider regular meetings of supervisors and mentors to discuss problems within the programme and, if necessary, with individual trainees.

Formative assessment

Formative assessment of trainees' progress provides an opportunity to enhance the quality of the learning environment to better meet identified learning needs. It is advised that the following feedback points be built into the end of each module, and cover:

- feedback on practical competence acquisition
- review of progress within the Record of In-service Training Experience (RITE) Diary, ensuring hours and experience are commensurate with providing the appropriate number of hours and adequate number and variety of cases
- promotion of student self-assessment and reflective practice

Monitoring progress

The introduction of the AP role will require clear systems of monitoring to take into account the impact of the new member of staff both during training and after qualification. Clear baseline information should be available using the standard systems of data collection within operating theatres, and during the introduction of the role to the organisation regular reviews should be undertaken. Key areas for monitoring should be around:

- patient safety
- patient and staff feedback
- operational issues such as delays and cancelled operations

Where there is variation in data when compared against the baseline information, clear mechanisms for analysis, review and management of the situation should be available.

Evaluation and review of training

Delivery of the education and training strategies provides an opportunity to validate the implementation of the plans and to illustrate strengths and identify weaknesses and correct them. In order to learn from the first cohort of trainees, organisations should have a robust system of feedback from trainees and a continuing evaluation of progress from supervising staff, theatre staff, university and other stakeholders. The review should include the delivery of the education within both the healthcare organisation and university.

Key Recommendation

Setting up robust arrangements for obtaining feedback during the first year of the training programme will ensure any major problems are avoided in the future.

Major involvement from clinical staff is required initially, and front loading of resources will provide a smoother path for the second part of the course. Consideration should be given to providing a written brief of progress for local trust stakeholders at key points in the programme and will allow the continued highlighting of the role within the hospital. These briefings should then be fed into the cluster management team meetings.

4.3 Summative assessments

Summative assessments will figure prominently in the concerns of both trainees and supervisors. This is common and can usually be resolved by further discussion of the links between experience, competence and assessment. In addition, guidance will be available from the university partner concerning expectations of the trainees and the responsibilities of the tutor. The programme will have systematic plans to deal with trainees who are in difficulty, and the resources of the validating university will be available. However, it is important that assessment schedules remain intact.

Month 8

This is the first of the summative assessment points within the programme. All trainees will be required to undertake the eight-month assessment, which will comprise the following:

- Tutor assessments:
  - Module sign-off (across all modules to date)
  - Professional behaviour and attitudes
  - Review of the RITE Diary
- Multiple choice question paper.

These elements form the total assessment. All elements must be passed individually in order to progress.

The examination is co-ordinated across all HEIs and has a pass/fail assessment scheme. All trainees are expected to successfully complete the examination prior to progressing within the training programme. If students are unsuccessful on the first attempt they will only be required to resit the element they have failed.

Therefore there is a one-month 'resit' period, after which a final decision regarding progression should be taken, as the eight-month assessment provides a point at which students can leave the programme if they are unsuccessful. This will be via individual HEI progression regulations.

Month 24

This is the final assessment point within the programme, where examinations that have been agreed between the RCoA and HEIs will be undertaken. The process for assessment is the same at the 24-month exam as for the eight-month exam and all elements of assessment are of equal importance.

The trainees will undertake examinations in the following formats:

- Multiple-choice question paper
- Practical assessment of competence within the workplace
- Review of the RITE Diary
- Objective Structured Clinical Examination (OSCE) undertaken by RCoA with university staff.

The OSCE is a summative assessment of the competences of the AP curriculum.

All trainees will be expected to successfully complete all aspects of the examinations prior to being awarded the post-graduate diploma in anaesthesia practice.

4.4 Pre-qualification clinical practice

Prior to successful sign-off of clinical competence, all trainees are expected to undertake three months of work-based experience working under two-to-one supervision as identified within the Curriculum Framework. During this period of time the trainees' work will be observed with decreased levels of supervision, and any areas of development addressed.

This three-month period will also provide trainees who were not successful initially at the 24-month examinations with an opportunity to retake their qualification examinations and to consolidate any knowledge and skills required.

Upon successful completion of the three-month period of clinical practice, the trainee AP will be classed as qualified and competent to work within the scope of practice of an AP.

Following successful completion of clinical practice, APs will be expected to maintain their skills by undertaking appropriate continuing professional development in their areas of practice.

Key Recommendation

Continuing professional development requirements will need to be promoted from initial qualification as the responsibility of the practitioner.

4.5 Regulation and prescribing

Regulation

Currently the majority of healthcare professionals working at practitioner level and above are already registered with one of the statutory regulators. Although it is not a requirement that everyone working in healthcare is part of a regulated profession, it is normal practice that, where a body of specific knowledge and skill defines a new professional group, then that group works towards regulation. As the AP role has developed, links have been established with the Regulation Branch at the Department of Health to ensure the most effective mechanism for regulating this new group of practitioners in order to safeguard patients.

In order to obtain regulation for any group of practitioners, a number of areas have to be addressed. Currently work is continuing as part of the review of the regulation of non-medical healthcare professions to ensure that the appropriate regulatory framework is identified and initiated for new and extended roles. However, once the regulatory mechanism is agreed, the legal requirements to implement such changes will take two to three years.

In the absence of statutory regulation, a voluntary register is to be developed and the RCoA is currently discussing options for establishing the register. A voluntary register is necessary prior to any form of statutory regulation.

Prior to formal regulation of APs, local clinical governance mechanisms should be appraised, as well as the role's scope of practice and status, and appropriate steps should be taken within the organisation to establish the validity of the qualifications and competences of these practitioners. For more information see Section 3.8.

When the role is established within an organisation, it is likely that overseas practitioners in anaesthesia may wish to work as APs. This will require a system for establishing equivalence. This is currently under development. Pending the implementation of formal equivalence arrangements, organisations should refer to the RCoA for advice on overseas practitioners.

Prescribing

Anaesthesia departments will have in place systems for ensuring the safe administration of anaesthesia using APs, prior to the commencement of the programme. This will include procedures and protocols for the administration of medicines. These should comply with relevant legislation and build on the experience of APs in the development sites. It has been possible to have effective and safe working practice of APs without the need for prescribing rights. However, major initiatives are taking place in other professional groups on 'non-medical prescribing' and this will be explored for APs.

APs will be required to be regulated before they can be considered for prescribing rights or for the use of patient group directions (PGDs).* Additional information can be found within *Medicines Matters* July 2006 at:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationPolicyAnd Guidance/DH_064325

The review of the regulation of the non-medical healthcare professions considers the regulatory requirements of a number of new care practitioner roles. Depending on the outcome of the consultation, one or more of these new care practitioner roles may need to be involved in the prescribing, supply and administration of medicines.

Prescribing rights (prescribing, supply and administration mechanisms) are only likely to be agreed where a case has been made that they will directly improve patient care and the efficiency of the service.

*A PGD is a written instruction for the sale, supply and/or administration of named medicines in an identified clinical situation. It applies to groups of patients who may not be individually identified before presenting for treatment. Only registered members of professions that are listed in the Prescription Only Medicines Order are able to use PGDs.

Appendices

A
Frequently asked questions

1. What is an Anaesthesia Practitioner?

An Anaesthesia Practitioner (AP) is a new member of the anaesthetic team. They are trained both in the underlying scientific and medical knowledge pertinent to anaesthesia, and in the skills of administering anaesthesia. They will work in a team with anaesthetists. The AP role has been evaluated through Agenda for Change and has been placed at Band 7 for newly qualified APs.

2. Why are we developing this new role?

Rapidly changing demographics, changes in technology and patient expectation outlined in *HR in the NHS Plan: More staff working differently* emphasise the need for a modernised NHS workforce with access to a more flexible career pathway. This will be achieved by basing job design on the skills and competences required, leading to the development of roles that lie outside traditional boundaries; it may extend to the creation of completely new roles within the Career Framework for the NHS.

This will require the widening of entry points into the Career Framework for the NHS, enabling existing roles, skills, competences and educational qualifications to become transferable across the NHS. There will also be the potential to increase access to and diversity in new and developing roles aimed at building workforce capacity within the NHS, whilst improving access for patients, as set out in *The NHS Improvement Plan.*

All workers within health and social care organisations are being encouraged to consider new ways of working to improve the patient's experience. It is not about staff working harder or cost cutting, or simply to address staff shortages; it is ensuring that the service user receives the most appropriate care, at the most appropriate time from the most appropriate person.

In 1997 the Audit Commission reported that the number of consultant anaesthetists employed by Trusts had risen by 40% in the preceding decade and wondered whether it was possible to sustain such expansion, as all indications were that the forces driving expansion were set to continue operating. Subsequent experience has shown that the previous estimates of 5% expansion per annum were conservative. The Audit Commission recommended that the NHS should investigate the boundaries between different staff groups involved in providing anaesthesia, through the development of pilot projects. This has been followed up both by the Department of Health (DH) and our professional organisations, resulting in the National Practitioner Programme (NPP) Anaesthesia Practitioner Programme. A joint Royal College of Anaesthetists (RCoA), the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and DH group visited anaesthetic services in Europe and the USA and produced a report that called for the careful development of a non-medical anaesthetic worker. A comprehensive account of those visits and the subsequent position adopted by the RCoA and AAGBI is available at: www.rcoa.ac.uk/index.asp?PageID=763

3. What will APs do?

The emphasis will be on working as part of a team in partnership with colleagues under the supervision of a physician.

They will perform duties delegated to them by their consultant anaesthetist supervisor. These will include pre- and postoperative patient assessment and care, maintenance of anaesthesia and (under direct supervision) conducting the induction of and emergence from anaesthesia. APs will also deputise for anaesthetists in a variety of situations where their airway and venous cannulation skills will assist in patient care and where medically qualified anaesthetists cannot be available.

An AP is a new role within the anaesthesia team; as part of that team they fulfil a role that is currently provided, in the UK, only by medical staff. The AP may undertake the induction of and emergence from general anaesthesia under the direct supervision of a consultant or senior anaesthetist, and will make clinical decisions themselves under indirect supervision while established anaesthesia is maintained. This partial autonomy is based on their position as a member of a clinical anaesthetic team that is at all times led by a medically qualified consultant anaesthetist, with supervision that must not exceed 2:1 in accordance with national guidelines. This role, with its continual 'consultative' relationship, is new to UK anaesthesia.

The AP role has a defined scope and does not require the knowledge and skills specific to other groups of healthcare professionals (eg the wider theatre skills of Operating Department Practitioners and perioperative nurses); however, it is acknowledged that there is an inevitable overlap of skills and competences with both medical and non-medical roles.

The clinical responsibilities of the role include administering anaesthesia and caring for the patient during surgical procedures. The range of practice extends from preoperative assessment to postoperative anaesthetic care; however, the role is primarily defined by the scope of work undertaken in the operating theatre where the AP will, in a supervised capacity, participate in induction, maintenance and reversal of anaesthesia using skills and knowledge that are based on an in-depth understanding and application of physiology and pharmacology.

Given the variability inherent in the clinical management of different types of patient[4] and types of surgery, APs cannot work only from protocols. Their work requires them to make considered, independent clinical decisions and actions with a limited degree of discretion. An example is monitoring, interpreting and acting on physiological changes (eg breathing and blood pressure) and taking the necessary anaesthetic care to manage these during a surgical intervention.

4. How does this new role fit in with the current anaesthesia team?

The role will complement existing roles already developed in acute care.

5. Will the practitioner remain as a part of the consultant team or be able to work independently?

The practitioner will remain as part of the anaesthesia team and the patient will remain the responsibility of the consultant anaesthetist.

[4] At this time it is not anticipated that APs will be involved with obstetric anaesthesia; they will assist only in paediatric anaesthesia

6. Is this new role just a cheap substitute for anaesthetists?

As healthcare changes, and new drugs and technology offer new ways to treat patients, the roles of all NHS staff are changing and we are now seeing the development of new roles that cut across various clinical professions. The aim is to increase capacity and ensure that patients are given the appropriate treatment by the most appropriate practitioner within the healthcare team. It will expand the availability of skills that currently only anaesthetists have. It will also allow staff to have rewarding jobs that allow them to develop an alternative career within the clinical environment.

7. What criteria are being used to evaluate formally the benefit to both patients and staff?

Work on developing the role is still at an early stage so we have not yet identified a full set of criteria. Consideration of formal evaluation will be subject to New Ways of Working in Anaesthesia Stakeholder Board approval, and this is being sought at the moment.

8. What is the background/training/experience of an AP?

We anticipate that there will be two streams of potential applicants and the education and training will be planned so that a flexible entry route is achieved:

Registered healthcare practitioners

- at least three years, full-time, post-qualification work experience in a relevant area and evidence of recent (within three years) and successful academic activity
- a first degree in a health-related subject.

New entrants (graduates or equivalent)

- with a biomedical science, or biological science background
- preferably with a second-class honours degree or better, or other evidence of recent and successful academic activity
- with a demonstrable commitment to a career in healthcare.

Patient/public safety, together with rigorous adherence to clinical governance requirements, will be central in developing this new role, with treatment and care being delivered by competent practitioners who have been trained and educated to the agreed national standards for this practice.

9. What is the training of an AP?

Depending on their level of skill, previous education and experience, current trainee APs will take part in an enabling programme of clinically focused education that will last for 27 months. Regulators will be guided by experts within the relevant Royal Colleges and other key stakeholders, including higher education institutions, to set out the exact requirements for fitness for practice, fitness for purpose and fitness for awards.

Generally, trainee APs will undertake a 27-month service-based course. Workplace teaching and competency assessment will be combined with distance learning and small-group teaching in the theory elements of anaesthetic practice. There will be academic assessment and work-based assessment throughout the course that will lead to the simultaneous award of a

Postgraduate Diploma in Anaesthetic Practice and Affiliate of the Royal College of Anaesthetists.

Trainees who wish to do so will be able to continue part-time academic work whilst working as a trained AP, in order to achieve a Master's degree.

10. How will the training be organised?

Hospitals that offer training will link with a number of local hospitals to form a group. Each hospital will recruit two trainees. The group of 6 to 12 trainees so formed will constitute a training cluster. Academic support will be provided by a local university that will have been recruited to support the cluster in offering the course developed by the RCoA, NHS University and the University of Birmingham. There will be a programme of workplace instruction and regular tutorials and small-group sessions. Successful trainees will be awarded the Postgraduate Diploma in Anaesthetic Practice by the local university that has supported their cluster.

11. Who will set the standard for the level of training/knowledge/experience required to practise as an AP?

The NPP has worked with RCoA, AAGBI, the Association for Perioperative Practice, the British Anaesthetic and Recovery Nurses Association, the Association (now College) of Operating Department Practitioners, patient representatives and higher education institutions to develop the competences and Curriculum Framework for this role.

12. Which universities or education bodies are providing the education and training for practitioner roles?

A Curriculum Framework has been developed and is currently being used in the University of Birmingham, University of Hertfordshire and the University of Hull to ensure that educational programmes produce practitioners who are 'fit for purpose'.

The NPP recognises that educational commissioning needs to follow best practice commissioning processes and the potential curriculum is subject to the production of standards and competences agreed by the RCoA and the future regulator.

13. Why did you not consult on the Curriculum Framework in line with other NPP programmes?

We did not consult formally on the Curriculum Framework for APs. However, the Curriculum Framework has been under development since September 2003. Produced by the RCoA and NHSU in partnership with the University of Birmingham, it builds on previous work from the Royal College, work within the Changing Workforce Programme, overseas nurse anaesthetist curricula, and from members of the Stakeholder Board. All key stakeholders, including patient groups, have been involved in the development of the Curriculum Framework. The AP Curriculum Framework builds on curricula in the USA and Europe. Supervision will be greater than supervision in the USA and Europe and junior doctors have been involved in regular discussions with the RCoA on the role.

Strategic health authority workforce leads are now using the final version of the *Anaesthesia Practitioner Curriculum Framework* to commission education centres to deliver this training. Informal discussions with medical leaders suggest that the RCoA and the Association of Anaesthetists are now supportive of this role and we are keen to maintain this support.

14. Don't we already have nurses and other non-medical professionals in advanced roles undertaking this work?

These members of the anaesthetic team are educated and trained to work alongside the anaesthetists providing support in the preparation and management of the environment and patient care; this does not include the devolved responsibilities for any of the clinical care of the anaesthetised patient. The ODPs' and anaesthetic nurses' clinical skills are employed in the preoperative and postoperative periods and some may be trained to undertake procedures on behalf of anaesthetists as part of an extended role. These extended roles should be defined by, and conducted with the use of, protocols. Extended roles should not include undertaking induction, maintenance or emergence from anaesthesia, except where there are established practices in emergence, such as the transition from anaesthesia to consciousness under the discretion of an anaesthetist as seen in recovery rooms – in relation to which AAGBI/RCoA guidance is already available.

15. Why are we not simply training more anaesthetists?

We are training more anaesthetists but health and safety regulations protect the number of hours staff are allowed to work and junior doctor training is changing so that a higher percentage of their time is now allocated to training. We need to ensure that junior doctors have protected teaching time, meet the Working Time Directive (WTD) and, when they are performing clinical tasks, that their experience is maximised. To do this we need to extend the anaesthesia team to support consultant anaesthetists and maximise the use of all staff skills.

16. Can a patient refuse to be treated by an AP?

Yes, and without detriment to their care.

17. Are patients involved in the development of the AP role?

Patient representatives are invited to sit on the national Stakeholder Board and also locally on the cluster management teams.

18. What is being done to reassure patients that the new or redesigned roles are not providing an inferior service?

Patient safety is paramount. APs work under the supervision of a consultant and only accept delegated duties that they are confident and competent to perform.

All staff performing new duties are undergoing or have undergone training and will collect a portfolio of evidence to demonstrate competence that will be assessed by the local supervising consultant and training centre staff.

All project sites have been advised to work closely with clinical governance committees and procedures to ensure patient safety. We advise all sites to keep outcome measures relating to patient safety. All trainees involved in our pilots are keeping detailed records of their clinical activities.

19. Will clinical standards deteriorate?

The RCoA would not be involved in this project if it was felt that standards of UK anaesthesia would decline with the introduction of APs. The most compelling evidence is the absence of reports of differences in outcomes from those countries that currently use mixed doctor/non-doctor teams. This literature has recently been comprehensively reviewed. We presently operate a service with a much larger contribution from trainee anaesthetists than in most countries, and in particular our more junior trainees are permitted greater autonomy. The safety of this

arrangement rests with the supervising consultants and this will also be the case with the introduction of APs. Overseas, non-medical anaesthetists work in operating theatres that have been designed for team work, using theatre management practices that give special consideration to anaesthetic difficulty during the allocation of surgery to theatres and teams.

We do not have this experience in the UK and the AP project is collecting information about changes in practice that are needed as the current APs are added to the team. The introduction of APs to a department requires that the clinical director is of high calibre and that the consultants have the flexibility to consider major changes in their working practices. A team approach to anaesthesia has evolved in most systems that use nurse-anaesthetists and other paramedicals to administer anaesthesia; it is likely that the same will happen here.

20. Will APs be forced on trusts?

No. It is up to trusts to determine their need for AP trainees.

B
Workforce planning in anaesthesia

Planning the specialist anaesthesia workforce is a complex undertaking. Demand is driven by increasing requirements for the services of specialists to meet policy initiatives for faster treatment, such as the 18 week patient pathway from GP referral to treatment. Supply is constrained by the complexity of medical training (Modernising Medical Careers), and availability by restrictions on working hours (the WTD). The service currently copes by using a number of strategies that are unsatisfactory.

- Much of the shortfall of specialists is made up by allowing trainee anaesthetists to work independently (supervised by a named consultant who is not immediately present in theatre and is undertaking other work elsewhere). The reports of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) on who operates and administers anaesthetics, indicate that up to 25% of operations are undertaken by junior doctors who are the only anaesthetist present in theatre. This in turn has further effects.
    - Morbidity and mortality are greater.
    - Junior doctors often undertake work that is inappropriate to their stage of training and do not get the opportunity to see cases that would be beneficial to them.
    - It is contrary to the Government's (and public's) wish that treatment should be undertaken by registered specialists.
- Other anaesthetic services such as critical care and pain management are sacrificed in order to provide theatre anaesthesia. In intensive care units (ITUs), consultants may not be available to supervise junior doctors, and consultants who are not specially trained in critical care medicine are required to provide occasional ITU cover. This results in critical care services being less well delivered than they would be if the correct workforce were available. Pain services are similarly understaffed and often there are insufficient sessions by anaesthetist pain specialists to deal efficiently with the workload.

There are a number of imminent threats to the existing pattern of working.

- The demography of the anaesthetic workforce is such that there will be a high rate of retirement within the next five years. This applies equally to consultant and SAS (staff and associate specialists) anaesthetists.
- Many more trainee anaesthetists than senior consultants are women. It is certain that replacing male consultants who are in their fifties or sixties with female consultants in their thirties will increase the number of consultant absences due to maternity leave and increase the demand for flexible part-time contracts.
- The Working Time Directive 2009.

Sourced from the RCoA, 2006.

C
The Working Time Directive 2009

In August 2004 the Working Time Directive (WTD) came into force to protect the health and safety of doctors in training by restricting the number of hours worked (to a maximum of 58) and imposing minimum rest requirements (with a maximum of 13 hours of work in any 24 with at least 11 hours of rest between shifts).[5] The next challenge will be WTD 2009, which takes the maximum working hours down to 48. Full-shift working places specialist trainee doctors in nighttime work at the expense of daytime work experiences that are usually more appropriate for their training. The Academy of Medical Royal Colleges provided advice on the number of training hours that should be available to specialist trainee doctors working full shifts and concluded that 10 to 12 doctors need to share a full-shift rota under WTD rules in order for the training to be satisfactory.[6]

In fact, most training rotations in anaesthesia have only seven or eight doctors per rota. The consequence of this upon training can be seen by consideration of the following Figure. With seven doctors in a shift system there are only 23 working hours left when night shifts and weekend work have been considered. For specialist registrars, the majority of clinical cases suitable for training occur during the daytime and the emergency workload undertaken during the daytime is only of limited training value once the related competences have been achieved. It is now the frequently expressed opinion of the Medical Royal Colleges that the training experience available to postgraduate specialist trainee doctors is at a critical level that interferes with their progression towards competence. Mr Bernard Ribeiro, President of the Royal College of Surgeons of England, has recently issued a press release describing the effect of the WTD on surgical training, and the same applies to anaesthesia.[7]

When the working hours are reduced to 48, the whole reduction will be from the time available for specialised training, unless the number of doctors per rota is increased. With seven doctors per rota there will be only 15 hours per week for formal training. Training will not be possible with these hours, competences will not be achieved, and junior doctors may be asked to repeat sections of training. The net result will be an extension of training time.

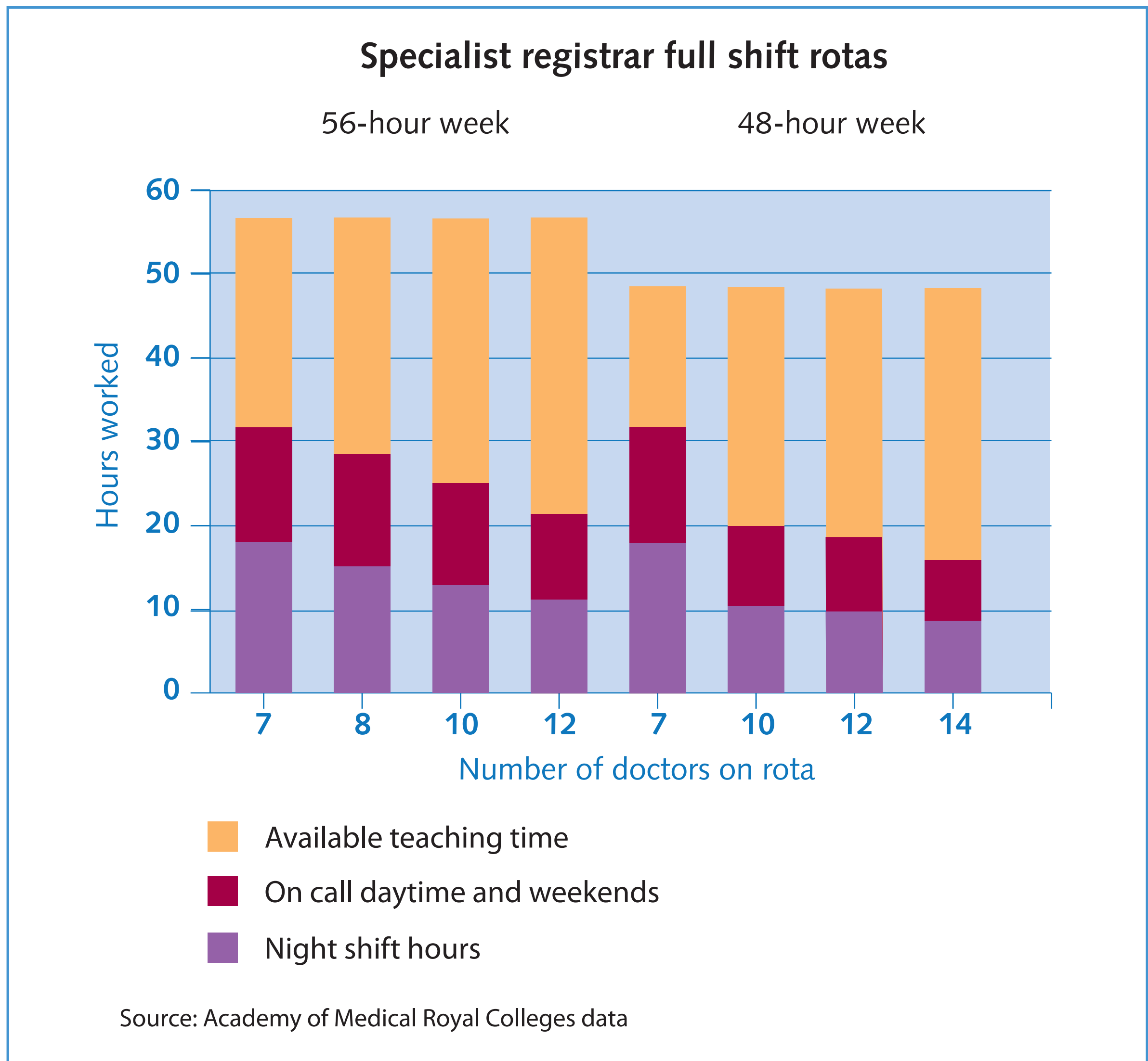
Sourced from the RCoA.

[5] *A Compendium of Solutions to implementing the Working Time Directive for Doctors in Training from August 2004*, Department of Health, May 2004

[6] *Implementing the European Working Time Directive: A Position Paper from the Academy of Medical Royal Colleges*, 2005, available at: www.aomrc.org.uk/pdfs/ewtd-acad-6.pdf

[7] Royal College of Surgeons, press release, 15 November 2005, available at: http://rcs.niss.ac.uk/public/pns/DisplayPN.cgi?pn_id=2005_0015

The time available for training when night shifts and daytime on call have been accounted for



Source: Academy of Medical Royal Colleges data

Without special provisions being made, the introduction of the 48-hour week in 2009 will result in substantial reductions to service and damage to the ability of junior doctors to gain essential experiences.

To maintain both service and training with current service deployment will require extra doctors. These will not be available from UK training. This includes overseas doctors who come to the UK and subsequently train in anaesthesia – they are included in national figures.

As discussed in the main body of the document, no one solution will be found for implementing the WTD in UK hospitals and it is likely that most hospitals will use a combination of the strategies described.

D
Information collated from development sites

As the AP role has been introduced within the development sites, monitoring of progress has been undertaken to assess the impact of the role both for APs in training and APs working in the AP role as overseas practitioners in anaesthesia.

Within the development sites, there were a number of reasons behind the introduction of the AP role and this has led to diverse collation of information. It is well documented that the non-medical AP works well overseas; however, there is a paucity of information identifying the benefits of this system of anaesthesia delivery.

A full evaluation of the AP role and the benefits of this system of anaesthesia provision for patients and the NHS will need to be undertaken once there are a sufficient number of trained and experienced APs in post. Meanwhile, monitoring and capturing information related to the introduction of the AP role in training and for newly qualified APs remain of paramount importance.

Below are a number of benefits that have been identified at specific development sites.

Financial savings

Consultant surgical sessional capacity (per week)				
	Development site	**Trust A**	**Trust B**	**Total**
Funded surgical sessions	64.75	21.75	48.5	135
Consultant elective PAs	40	9	37	86
Vacant posts	2	2	0	4
Vacant programme activities	10	10	0	20
Non-consultant career grade doctors/Clinical Fellows	3	0	32	35
APs	16	0	0	16

Cost of anaesthetic locum staff (all grades)				
Costs in £k	**Development site**	**Trust A**	**Trust B**	**Total**
2003/04	324.5	118.4	128.5	571.4
2004/05	284.4	153.9	150.9	589.2
Difference	-40.1	+35.5	+22.4	17.8

With the introduction of two overseas practitioners in anaesthesia, the delivery of financial savings across the trust can be demonstrated. The above tables show information on the surgical sessions across the development site trust as well as the cost of anaesthetic locum staff, in comparison with Trusts A and B which did not have APs.

The tables highlight that, at the development site hospital, the cost of locum cover for anaesthetic staff saw a reduction from 2003/04 of 12%, whilst at the two remaining trusts without overseas practitioners in anaesthesia, there was an increase in locum costs, with Trust A showing an increase in locum costs of over 30%.

Turn-and-turn-about

Example from development site – turn-and-turn-about	APs	Traditional lists	Trust waiting list initiative (staff paid at double time)
Start time	08:00	08:00	17:00
Finish time	17:15	17:05	19:00
No. joints replaced	4	2	1
Cost per joint	£3,507.75	£4,623.00	£4,287.00
Total operating time	449	305	110
Total anaesthesia time (excluding surgery)	88	50	25
Total theatre fallow/down-time	12 min. max	33 min.	N/A
Total staff cost	£5,031.00	£4,747.00	£1,787.00
Staff cost per min. (operating time)	£11.20	£15.56	£16.25

The table above shows the effect of having two overseas practitioners in anaesthesia working using the turn-and-turn-about process when compared with traditional lists and waiting list initiatives for hip replacements. As a result, the theatre ran to time, more joint replacements were undertaken (from two to four joints), and there was also less theatre down-time, increasing the efficiency of NHS resources.

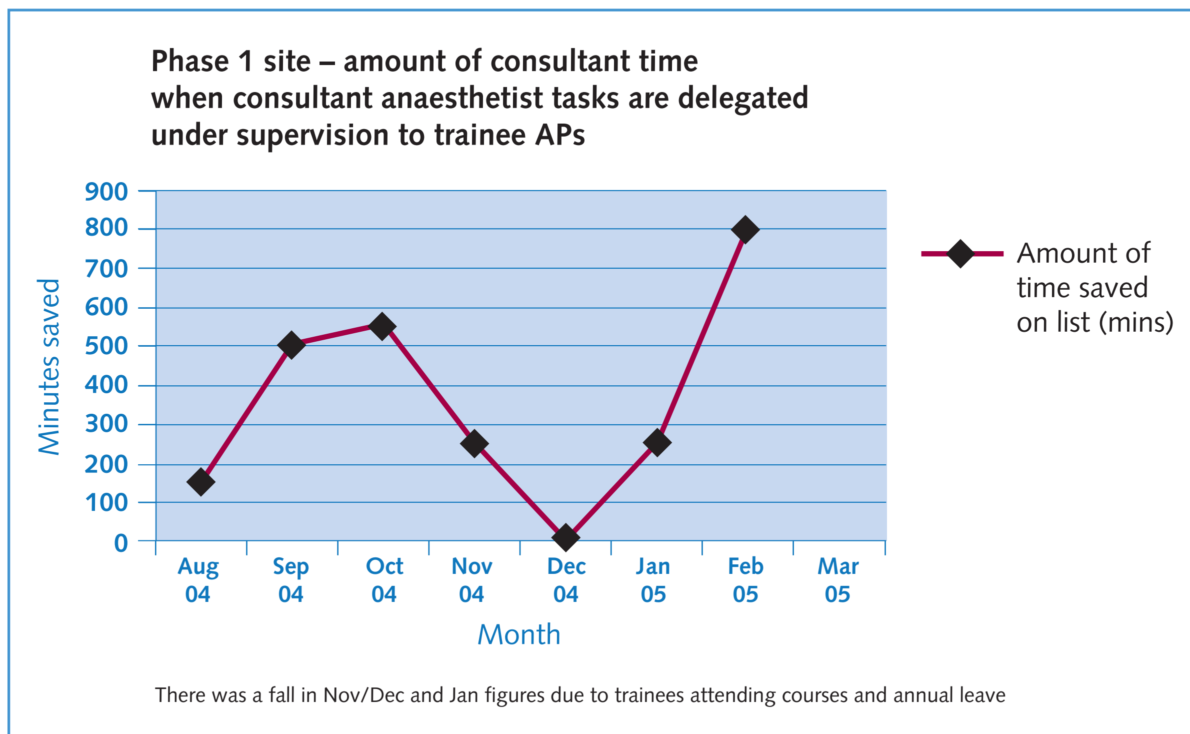
In addition, the resultant cost per operation was reduced, although there were accompanying increases in staff costs.

Increased throughput

A development site using experienced overseas practitioners in anaesthesia demonstrated an increased throughput when they were working in the capacity of APs.

- Two overseas practitioners in anaesthesia working 1.6 whole-time equivalent over a six-month period (January to June 2006) contributed to achieving **48 extra lists**.
- Both practitioners working resulted in a 10% increase in capacity per week.
- This reduced the number of times consultants were asked to do additional sessions to avoid cancellations.

Consultant time saved during training



The graph above shows consultant anaesthetist time saved when tasks are delegated under supervision to trainee APs.

Currently, the consultant is still in theatre as the practitioners are under direct supervision during training. The consultant can teach in theatre, check emails and take breaks. More significant time will be saved once the APs are fully qualified. Tasks delegated include maintenance of anaesthesia, inserting lines, preoperative anaesthesia assessment and pain management.

Areas of impact that have been noted at sites using overseas practitioners in anaesthesia when monitoring the introduction of the role suggest:

- increased number of lists and cases covered, particularly over the summer workload
- decreased number of cancelled lists
- decreased use of waiting list initiatives
- consultant time freed to deliver teaching and undertake administrative tasks.

Models of costs of employing APs

Providing additional support on standard lists	**Per list £**
Current cost salaried consultant anaesthetists	250.00
Basic format two consultant anaesthetists + two APs covering three lists	232.14
Difference per list affected	**17.86**

Providing cover where otherwise a locum would be needed	**Per list £**
Current cost per list of locum consultant anaesthetists	780.00
Basic format two consultant anaesthetists + two APs covering three lists	232.14
Difference per list affected	**547.86**

Calculations should then be undertaken to ascertain the number of lists that bank or locum staff are required to cover during an average week.

E
Sites currently training and/or employing Anaesthesia Practitioners

- Buckinghamshire Hospitals NHS Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- Heart of England NHS Foundation Trust
- Hinchingbrooke Health Care NHS Trust
- Hull and East Yorkshire Hospitals NHS Trust
- King's College Hospital NHS Foundation Trust
- North Bristol NHS Trust
- Northern Lincolnshire and Goole Hospitals NHS Trust
- Ravenscourt Park Hospital – Hammersmith Hospitals NHS Trust
- Royal Brompton and Harefield NHS Trust
- Royal Devon and Exeter NHS Foundation Trust
- Royal Hospitals NHS Trust, Belfast
- Royal Orthopaedic Hospital NHS Foundation Trust
- Royal United Hospital Bath NHS Trust
- Royal Wolverhampton Hospitals NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- St Mary's NHS Trust
- Swindon and Marlborough NHS Trust
- United Bristol Healthcare NHS Trust
- United Lincolnshire Hospitals NHS Trust
- University Hospital Birmingham NHS Foundation Trust
- Walsall Hospitals NHS Trust

Numerous organisations across Scotland are currently training APs. For more information please visit www.nes.scot.nhs.uk

F
Statement of Requirements for higher education institutions and NHS partner organisations

This Statement of Requirements has been designed to enable higher education institutions and NHS organisations to agree how students on the AP programme will be supported. The signing of this agreement by all parties indicates that there is a tacit contract to support and enable the programme.

The following form should be completed by providing supporting information and evidence as to how each of the statements below will be met within your organisation and cluster of trusts.

Completed forms should be submitted to the Royal College of Anaesthetists within one month of the start of the academic programme.

1. Management support of the programme

1.1. Who will be the individual within your organisations who has the overall responsibility to coordinate the activities of the higher education institution, the NHS partner organisations and the Royal College of Anaesthetists?

1.2. What staff preparation has there been within the partner organisations to support the developing practitioners?

1.3. What evidence is there that the programme has secured executive support from all key stakeholders?

1.4. What evidence is there that the governance arrangements for the organisations will extend to this programme?

2. Support from the commissioners of the programme

2.1. Please provide evidence that there is student support in terms of a salary or a bursary for the duration of their training.

2.2. What evidence is there of the support for the students with their course fees?

3. Student support

3.1. What evidence is there that the student placements will offer the range of experience to enable the achievement of the learning outcomes for the programme?

3.2. Please provide evidence that there are identified ‘tutors’ and mentors in the clinical environment to support work based learning.

3.3. What evidence is there that the identified ‘tutors’ will be given the time and support to undertake their role to the extent required by the programme?

3.4. How will arrangement for the ‘tutors’ to have honorary/associate lecture status within the partner higher education institution be managed?

4. Programme delivery

4.1. What evidence is there that the practical elements of the programme e.g. simulated exercises can be delivered to the standards as specified by the curriculum framework and the RCoA?

5. Student selection

5.1. Can you provide evidence that the recruitment process used to assess applicants for entry into the programme demonstrates that:

a) each applicant is individually assessed; and

b) the process has correctly applied the guidelines laid down in the published version of the national curriculum framework?

6. Quality assurance

In addition to the normal quality assurance arrangements that are the hallmark of higher education institutions it is essential that standards for the Partnership Quality Assurance Framework for Healthcare Education in England are in place

6.1. Please provide evidence of how the students on this programme will be supported academically in the clinical environment and that pastoral support will be available.

6.2. Can you provide evidence that arrangements for monitoring the students' progress have been identified?

6.3. Please provide evidence that there will be mechanisms in place to support the teaching, learning and assessment in the clinical environment.

6.4. Can you provide evidence that the students will be awarded a post graduate diploma after the successful completion of the programme?

7. Support from the directorates that include operating theatre services and Anaesthetics

7.1. Please provide evidence that the Clinical Director or Directors have agreed to cooperate with the training initiative

7.2. Please provide evidence that the Royal College of Anaesthetists College Tutor has planned the incorporation of AP training into the department's educational programmes without detriment to existing anaesthesia training.

Signed by University Head of School	Date:
Signed by Cluster Clinical Lead	Date:
Signed by Commissioners (Workforce Directorates and Trust Board Executive)	Date:

G
Anaesthesia Practitioner job description including the NHS *Knowledge and Skills Framework* outline

NAME OF NHS TRUST

JOB DESCRIPTION

Job role **Anaesthesia Practitioner**

Responsible to **Consultant Anaesthetist**

Accountable to

1.0 Core purpose

To provide anaesthetic services to patients requiring anaesthesia, respiratory care, cardiopulmonary resuscitation and/or other emergency, life sustaining services within the anaesthesia and wider theatre and critical care environments.

2.0 Responsibilities

1. To work competently, under appropriate supervision, in the role of Anaesthesia Practitioner, within their code of professional practice, being aware of boundaries of the role and referring patients appropriately to other healthcare professionals as appropriate.

Dimension 5, level 2

2. To work as a member of the anaesthetic team.

Dimension 5, level 3

3. To perform/participate in the preoperative interviewing and physiological and psychological assessment under supervision of the consultant anaesthetist.

Dimension Health and Wellbeing (HWB) 6, level 3

4. To evaluate and/or collect patient information from the patients history, physical examination, laboratory, radiographic and other diagnostic data and identify relevant problems.

HWB 6, level 3

5. To implement the anaesthesia care plan under supervision of the consultant anaesthetist.

HWB 6, level 3

6. To administer and/or participate in the planned administration of general anaesthetic for a variety of surgical and medically related procedures.

HWB 7, level 3

7. To use a broad variety of techniques, anaesthesia agents, drugs and equipment in providing anaesthesia care.

HWB 7, level 3

8. To administer drugs as prescribed and use prescribing mechanisms as permitted by medicines legislation for your primary registered qualification. (This is subject to change once the AP role is regulated.)

HWB 7, level 3

9. To interpret and utilise data obtained from the effective use of current invasive and non invasive monitoring equipment.

HWB 7, level 3

HWB 7, level 3

10. To initiate and manage fluid and blood therapy within the plan of care.

HWB 7, level 3

11. To recognise and take appropriate actions with reference to complications occurring during anaesthesia management.

HWB 7, level 3

12. To position or supervise positioning of patients to assure optimal physiologic function and patient safety.

HWB 7, level 3

13. To identify and take appropriate actions related to anaesthesia equipment problems that might lead to patient problems.

HWB 7, level 3

14. To identify and take appropriate action in the immediate postoperative period in relation to common postoperative problems.

HWB 7, level 3

15. To assess patient responses for readiness to move to the next level of care in relation to common postoperative problems.

HWB 7, level 3

16. To serve as a resource person in cardiopulmonary resuscitation, respiratory care and for other acute needs.

Dimension 3, level 2

17. To participate in the education of patients and their carers.

Dimension 2, level 3

18. To participate in the critical review of audit, complaints, compliments and clinical/non-clinical incidents with a view to improving patient care as part of the wider anaesthetic team.

Dimension 4, level 2

19. To assist with the implementation of risk management and health and safety recommendations as part of the wider anaesthetic team.

Dimension 3, level 2

20. To monitor and maintain a safe, clean, and therapeutic environment for patients, staff and visitors, initiating appropriate action to achieve this.

Dimension 3, level 2

21. To adhere to quality objectives, hospital policies and codes of practice.

Dimension 5, level 2

22. To be responsible for timely, accurate and complete records both manually and electronically ensuring safety and confidentiality of information and any hospital and statutory requirements are met.

HWB 7, level 3

HWB 6, level 3

23. To use resources appropriately in order to ensure a high quality and cost effective service.

Dimension 5, level 2

24. To actively participate in all relevant meetings.

25. To promote and contribute to the development of the new ways of working in anaesthesia, within the trust and other organisations, by taking part in presentations and conferences.

Dimension 1, level 3

26. To assist the Local Management Team in the research and evaluation of the project, including the collection and analysis of data required.

Dimension 4, level 2

27. To establish working relationships with rest of hospital and act as an ambassador for the role.

Dimension 1, level 3

28. To assist in the development and review of protocols and patient group directives within the anaesthetic team.

Dimension 4, level 2

29. To take part in the teaching, supervision and assessment of other team members.

Dimension 2, level 3

30. To take part in personal development planning. To maintain a professional portfolio and logbook.

Dimension 2, level 3

31. To ensure own actions support equality, diversity and rights.

Dimension 6, level 2

Staff working within the anaesthetic department are required to exercise and maintain confidentiality at all times. Any breach of confidentiality will become a disciplinary matter.

This job description is intended only as a guide and it can be subject to change as the Anaesthesia Practitioner role develops. All changes will be undertaken in consultation with the postholder.

H
Anaesthesia Practitioner Agenda for Change national profile

Available by selecting 'Theatre Practitioners' at:
www.nhsemployers.org/pay-conditions/pay-conditions-1990.cfm

Profile Label: Anaesthesia Practitioner

Job Statement:

1. Administers prescribed anaesthesia, monitors and maintains condition of patients.
2. Prepares, equips and maintains environment for anaesthesia.
3. May prescribe intraoperative fluids, postoperative analgesia and anti-emetics.
4. May undertake postoperative assessment of patients, provide anaesthetic skills in care of patients in ward situations.

Factor	Relevant job information	JE level
1. Communication & Relationship Skills	**Communicates complex, sensitive information, barriers to understanding** Communicates condition related information to patients, relatives, requires empathy, reassurance	4(a)
2. Knowledge, Training & Experience	**Highly developed specialist knowledge, underpinned by theory and experience** Professional knowledge acquired through postgraduate diploma plus further theoretical knowledge acquired through specialist training to master's level equivalent	7
3. Analytical & Judgemental Skills	**Complex facts or situations, requiring analysis, interpretation, comparison of range of options** Skills for assessing & interpreting specialist acute patient conditions, taking appropriate action, recognising and managing emergency situations	4
4. Planning & Organisational Skills	**Plan, organise complex activities, programmes, requiring formulation, adjustment** Plans anaesthetic provision within prescribed framework	2

Factor	Relevant job information	JE level
5. Physical Skills	**High degree of precision** High levels of dexterity and accuracy required for e.g. insertion of spinal/ epidural, suturing of arterial/ neck lines, airway management	4
6. Responsibility for Patient/Client Care	**Develop specialised programmes of care; provide specialised advice in relation to care** Assesses, develops & implements anaesthetic programmes within prescribed framework; provides advice to surgeon on anaesthetic care of patient	6(a) (c)
7. Responsibility for Policy/Service Development	**Implement policies, propose policy, service changes for own area** Comments on policies and protocols, contributes to changes	2
8. Responsibility for Financial & Physical Resources	**Safe use of expensive/highly complex equipment** Responsible for safe use, setting up of anaesthetic equipment	2(e)
9. Responsibility for Human Resources	**Clinical supervision** Clinically supervises anaesthetic assistant	2(b)
10. Responsibility for Information Resources	**Record personally generated clinical observations** Updates patient records	1
11. Responsibility for Research & Development	**Occasionally/regularly undertake R&D, lead clinical audits** Participates in research, lead clinical audit in own area	1–2(a)
12. Freedom to Act	**Broad occupational policies** Accountable for own professional actions: works in accordance within professional anaesthetic standards and competences, specialist in monitoring and maintaining anaesthesia in normal situations	4

Factor	Relevant job information	JE level
13. Physical Effort	**Frequent sitting or standing in a restricted position/frequent moderate effort for several short periods** Works in restricted position in operating theatre/manoeuvres patients from table to bed, bed to table	2(a)–3(c)
14. Mental Effort	**Occasional/frequent prolonged concentration** Concentration on patient anaesthesia for lengthy periods	3(b)/4(a)
15. Emotional Effort	**Occasional highly distressing circumstances** Unexpected deterioration of patient	3(b)
16. Working Conditions	**Frequent highly unpleasant conditions** Body fluids, open wounds	4 (b)
JE Score/Band	**JE Score 498–516**	**Band 7**

I
Summary of key recommendations

Planning

- Before proceeding, ensure there is a sufficient body of support from the anaesthesia department to explore APs as a potential workforce solution to service demand.
- Independent sector organisations should partner with NHS organisations in their initial proposals and implementation of training.
- Prepare a draft paper outlining the potential local benefits of introducing the AP role and circulate it to all stakeholders for comment.
- Establish monthly meetings and terms of reference for key stakeholders in order to move the training forward.
- Scope interest in other local trusts in training APs.
- Consider consulting your local organisational development specialist, or equivalent, for help in supporting any change, and use the national resources and experience available for introducing new roles.
- The key driver when constructing a request for funding is that there must be a clear investment appraisal that identifies the cost/benefits of training APs, based on robust planning. Training APs is a relatively long-term investment, taking three years from planning to delivery.
- Generate an action plan for introducing the training for APs within the cluster of trusts, with clearly agreed timescales and responsibilities.
- Discussions regarding training capacity should take place with the RCoA regional representative and local workforce deanery.

Preparation

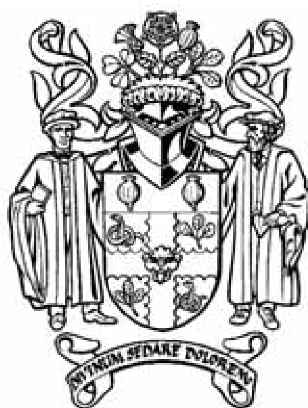
- Clinical leads should have 2.5 programmed activities per week to provide teaching and administration support across the cluster of trusts.
- The tender specification must be based on the Curriculum Framework and Statement of Requirements for the national programme. Any serious variation puts at risk the national transferability of the qualification.
- Identification of local HR policy in relation to recruitment will help highlight the most appropriate sources of recruitment.
- Early discussions should be held with the organisation's chair of the clinical governance committee or their equivalent to seek advice on the expectations for your particular organisation.
- Ensure availability of patient information leaflets.

Implementation

- Setting up robust arrangements for obtaining feedback during the first year of the training programme will ensure any major problems are avoided in the future.
- Continuing professional development requirements will need to be promoted from initial qualification as the responsibility of the practitioner.

This toolkit was developed with representatives from the following organisations:

National Practitioner Programme



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University of Hertfordshire

School of Postgraduate Medicine, Health and Human Sciences

PHYSICIAN ASSISTANT MANAGED VOLUNTARY REGISTER STREERING GROUP

Minutes of the meeting held at UH on 10 February 2010

Members attending:
Duncan Empey, Professor Emeritus, University of Hertfordshire
Cheri Hunter, Associate Dean & Head of Postgraduate Medical School, University of Hertfordshire
David Wilkinson, Chairman APA(A)
Kirsten Gipson, President, UKAPA
Rachel O'Connell, Principal Lecturer Health Law and Ethics, University of Hertfordshire
David Kuhns, Assistant programme lead PA Studies, University of Birmingham
Charlie McLaughlan, Royal College of Anaesthetists
Paul Forsythe, Physician Assistant (anaesthesia)
Anne McShea, Executive Assistant to Cheri Hunter

Members apologies:
Phil Begg, Associate Dean for Primary Health Care, University of Wolverhampton
Andrea Kelleher, Consultant Cardiothoracic Anaesthetist, Royal Brompton Hospital
Dr Patricia O'Connor, Consultant in A&E, Hairmyres, Lanarkshire, Scotland
Jerome Barton, Physician Assistant

APOLOGIES

1. Apologies were received from Phil Begg, Andrea Kelleher, Patricia O'Connor and Jerome Barton.

PREVIOUS MINUTES

2. The minutes from the previous meeting on 4 November 2009 were accepted.

MEMBERSHIP

3. Barry Hunt will no longer attend these meetings he is now the Pro-Vice Chancellor International at UH.

APPLICATION TO REGULATORY BODIES

4. David W has submitted a draft application to the HPC. Their comments were: that a joint application of both PA groups would be considered more favourably - this would allow further PA groups to be added in the futureIf a joint application was not to be made they requested evidence that a discussion had taken place between APAA and UKAPA. The Royal College of Anaesthetists support the application to HPC. It was noted that HPC is the registering body for all health care professionals who are not doctors (GMC) or nurses/midwives (NMC).

5. Kirsten reported that UKAPA have written to the GMC for Niall Dickson's comments. He responded indicating that others had approached him, including the Scottish Government, and he said he would be back in touch within two months or so. If they have not had a further response by April 2010 Duncan, who had an informal discussion with him in December, will approach him again.

CURRENT POSITION

6. Technically setting up the MVT register is relatively straightforward. Duncan has approached the DoH for additional funding but has so far there has been no support. He will seek other avenues of funding from the DH approaching a different section as the original funds came from a now disbanded department.

7. UH are unable currently to commit to managing the Register as the policing of a Fitness to Practise policy raises important issues of suitability of the University to undertake (and fund) such a role, and of liability. The register will continue to be created as a voluntary list but cannot be managed in a regulatory way unless these issues are resolved. In the absence of substantial funding and clarity on the legal issues no progress can be made at present.

8. Rachel showed the group her draft F2P policy which she has adapted from the UH Health & Human Science faculty document. The final version should be available in March and Rachel will be willing to supply this to the APAA for submission to the HPC as evidence of the way forward for regulating this group, which should assist the HPC in reaching a positive decision.

PROJECT SCHEDULE

9. The planned schedule of events will need amending in light of the issues arising. No further meetings have been arranged pending the outcome of the HPC submission and feedback from the GMC.

SUMMARY

10. The Group remains committed to assisting registration for PAA's and PA's General with the HPC/GMC as appropriate. APAA are encouraged to pursue their HPC application with the appropriate letter from UKAPA and the modified UH Fitness to Practise Policy. UKAPA will remain in touch with the GMC and DE will help to facilitate a meeting in April with Niall Dickson.

PREVIOUSLY ISSUED DOCUMENTS

11. The recently issued documents (letter inviting PAs to join MVR, Application form and Guidance notes to accompany the application form) will need amending and reissuing.

WEBSITE

12. The website will require little work to set up to receive information, but no details will be available to the Public.

INTERNATIONALLY QUALIFIED PHYSICIAN ASSISTANTS

13. This will not be considered at present.

14. The next meeting will be scheduled when more information is available.

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8. Rachel showed the group her draft F2P policy which she has adapted from the UH Health & Human Science faculty document. The final version should be available in March and Rachel will be willing to supply this to the APAA for submission to the HPC as evidence of the way forward for regulating this group, which should assist the HPC in reaching a positive decision.

PROJECT SCHEDULE

9. The planned schedule of events will need amending in light of the issues arising. No further meetings have been arranged pending the outcome of the HPC submission and feedback from the GMC.

SUMMARY

10. The Group remains committed to assisting registration for PAA's and PA's General with the HPC/GMC as appropriate. APAA are encouraged to pursue their HPC application with the appropriate letter from UKAPA and the modified UH Fitness to Practise Policy. UKAPA will remain in touch with the GMC and DE will help to facilitate a meeting in April with Niall Dickson.

PREVIOUSLY ISSUED DOCUMENTS

11. The recently issued documents (letter inviting PAs to join MVR, Application form and Guidance notes to accompany the application form) will need amending and reissuing.

WEBSITE

12. The website will require little work to set up to receive information, but no details will be available to the Public.

INTERNATIONALLY QUALIFIED PHYSICIAN ASSISTANTS

13. This will not be considered at present.

14. The next meeting will be scheduled when more information is available.

25/10/2010

Health Professions Council

Dear Sirs and Madams:

This is to verify that the organization titled the United Kingdom of Physician Assistants (herein referred to as UKAPA), are happy to put in writing a statement to the fact that our two organizations (Association of Physician Assistant-Anaesthesia and UKAPA) have had discussions about approaching the HPC and whether we would jointly apply or separately apply. I can confirm that we feel that we are two very distinct types of health care practitioners; with different educational and vocational skills and that we do not wish to apply jointly to the HPC with the Association of Pas in Anaesthesia. We wish them the best of will, but we will also pursue our own separate registration with the HPC.

Regards,

Kirsten Gipson, PA-C

Past President of UKAPA

NHS Workforce Review Team

Workforce Summary – Physicians' Assistants (Anaesthesia)

2008 – England only

Summary of findings

- Commissioning levels are not set to increase. There is no nationally agreed commissioning route or level of commissioning for this group.
- Until those in training begin to practice and an assessment can be made of their true impact on services, it is not possible to estimate true demand from the service. However, the Royal College of Anaesthetists (RCoA) estimated 1,000 by 2010 as of 2006.
- Physicians' Assistant (Anaesthesia) (PA(A)) is a new and developing role and research indicates that advanced practitioner roles such as PA(A) have a positive impact on service delivery and there is increased evidence that where they are used they are very successful and very highly regarded by employers once in place.
- From 2009 onwards this profession will be included in WRT's nationally planned work. WRT, in conjunction with the Deans Workforce Group and the Conference of Postgraduate Medical Deans (COPMeD), has compiled a list of specialties and professions (including PA(A)s) which it believes should be considered for either a national planning and funding mechanism, or for special attention by inter-SHA planning processes.

Analysis

1. Brief discipline description

A change in title from Anaesthesia Practitioners to Physicians' Assistants (Anaesthesia) (PA(A)s) has been agreed.

A PA(A) is a member of the anaesthetic team who, after specific training, has the scientific and medical knowledge to administer anaesthesia. The role has been developed to help increase capacity in anaesthetic departments throughout the NHS.

The clinical responsibilities of PA(A)s include administering anaesthesia and caring for the patient during surgical procedures. The range of practice extends from pre-operative assessment to post-operative anaesthetic care. However, the role is primarily defined by the scope of work undertaken in the operating theatre where the PA(A) will, in a supervised capacity, participate in induction, maintenance and reversal of anaesthesia. PA(A)s will also deputise for anaesthetists in a variety of situations where their airway and venous cannulation skills will assist in patient care and where medically qualified anaesthetists cannot be available. PA(A)s are required to have support of Operating Department Practitioners (ODPs) in theatre.

Based on a voluntary list held by West Midlands SHA, there are 60 qualified PA(A)s in England and 10 trainees entering this year (see 'Workforce Profile' in 'Current Workforce' section below).

PA(A) is a new and developing role and research below indicates that advanced practitioner roles such as PA(A) have a positive impact on service delivery and there is increased

evidence that where they are used they are very successful and very highly regarded by employers once in place.

Service benefits as stated in the *Evaluation of Advanced Practitioner roles* (Draft report, 2008) include: The impact on work practices was widely believed to have brought improved service delivery. The benefits cited included reduced length of stay, improved patient care, reduced costs, a more efficient service and improved patient and staff satisfaction. However, because of the relative newness of the roles trusts had few data to support these claims.

Pattern of training
Depending on their level of skill, previous education and experience, current trainee PA(A)s will take part in a programme of clinically focused education that will last for 27 months. Experts within the RCoA and other key stakeholders including higher education institutions will set out the exact requirements for fitness for practice, fitness for purpose and fitness for awards.

Workplace teaching and competency assessment is combined with distance learning and small group teaching in the theory elements of anaesthetic practice. There is academic assessment and work based assessment throughout the course that will lead to the simultaneous award of a postgraduate diploma in anaesthetic practice and affiliate of the RCoA. It is a complex, professional and very intensive national programme with national exams, which leads to highly skilled professionals.

The course is now fully developed and is being run by three universities in England: Birmingham, Hertfordshire and Hull. Entry to the programme is open to applicants through one of two different routes:

Registered healthcare practitioners
Nurses, ODPs and others with one or both of the following:

- at least three years' full-time, post-qualification work experience in a relevant area and evidence of recent (within previous three years) and successful academic activity; and
- a first degree in a health-related subject.

New entrants to healthcare (graduates or graduate equivalent)
- with a biomedical science, or biological science background (1/3 of intake);
- preferably with a second class honours degree or better, or other evidence of recent and successful academic activity; and
- with a demonstrable commitment to a career in healthcare.

There is an eight month assessment and a final assessment at 24 months that includes a national objective structured clinical examination (OSCE), a multiple choice questionnaire (MCQ) exam and sign off of clinical competences.

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2. Current workforce

Based on a voluntary list held by West Midlands SHA, there are 60 qualified PA(A)s in England and 10 trainees entering this year.

Data issues
As this is a new role, there is no occupation code and no data available from the Information Centre for Health and Social Care (IC) Census. With the introduction of the electronic staff record, data about PA(A)s should become available. PA(A)s are not HPC registered unless they are an ODP or nurse.

3. Demand drivers and estimates

Key issues:

- Maintaining 18 week wait and reducing access times may increase demand for PA(A)s.
- Evidence being gathered on effectiveness of new role with the aim of raising the profile of the role is likely to increase demand for PA(A)s, in particular helping to make junior doctors' hours Working Time Directive (WTD) compliant .
- DH and the National Practitioner Programme (NPP) published a toolkit[1] in March 2007, about the benefits of the new role.
- There may be resistance from clinicians in supporting the new role, but where PA(A)s are used, they are very successful and highly regarded. Anecdotal evidence suggests that some are even employed at Agenda for Change Band 9.
- Until those in training begin to practice and an assessment can be made of their true impact on services, it is not possible to estimate true demand from the service. However, the RCoA estimated 1,000 by 2010 as of 2006.
- A national commissioning framework could be a solution for a time limited period of three or four years by establishing a nationally agreed route and level of commissioning.
- Establishment of a lead SHA for this group could be useful to them in terms of commissioning consistency.

Views from:

Profession:
Currently, there is no statutory regulatory body for the PA(A) workforce and as mentioned earlier, they are not HPC registered unless they are an ODP or nurse. However the Association of Physicians' Assistants (Anaesthesia) is the representative body of PA(A) in the UK now. PA(A)s are being offered affiliate status of the RCoA upon graduation from the current programme. The following two paragraphs are based on an unpublished document by RCoA – 'The Workforce Consequences of Anaesthesia Practitioners[4].

The RCoA believes the addition of PA(A)s to a departmental anaesthetic team will allow a new flexibility that could be useful in meeting service and training needs. It estimates that there will be a need for 1,000 PA(A)s by 2010.

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Department of Health:
Changes in the way that elective and emergency surgery is delivered are going to lead to a wider range of locations where surgical care is delivered. These changes, alongside recognised pressures caused by WTD and changes in working hours of medical staff means that the way that services are currently staffed is neither sustainable nor affordable. This points to the need for a greater range of professional, specialist staff providing anaesthetic services. The PA(A) role will help to meet this need.

In addition, increasing demands for critical care services - arising from demographic, technical and operational change - will require more specialist intensive or critical care medical staff. Many of these have also traditionally been drawn from anaesthesia. These needs can also be met through the wider deployment of PA(A)s supporting anaesthetic staff working in theatre areas. PA(A)s are seen as supporting existing medical and nursing staff working under the overall guidance of the medical consultant, as part of a cohesive and effective surgical team.

The NHS Institute is doing work on Productive Theatres, which will help to quantify the productivity of the role.

Skill mix issues
CODP is currently gathering data to establish profiles of where ODPs have extended their roles, or have taken on new roles. As noted above, the introduction of PA(A)s is intended to aid skill mix with other health professionals in anaesthetic teams. PA(A)s have been developed by the changing workforce programme of the Modernisation Agency in collaboration with DH, the RCoA and the Association of Anaesthetists of Great Britain and Ireland.

The University of Birmingham who commission the PA(A) course report that there is high job satisfaction and it is a very popular programme, with high recruitment and retention as well as very low attrition.

Agenda for Change (AfC)
PA(A)s are employed mainly at AfC Band 6-8. There are a few employed at Band 9, although this is unusual.

4. Workforce supply

There is no nationally agreed commissioning route or level of commissioning for this group.

The reduction in service contribution by medical trainees and WTD may increase demand for PA(A)s.

There is insufficient workforce data to model supply; however the indication is that supply will increase in the future.

Recruitment and Retention
No real issues with recruitment or retention (e.g. North West SHA had 150 applications for 8 posts).

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Attrition from training
Low attrition - one trainee has left for personal reasons (significantly less than anticipated).

5. Summary of key issues

Commissioning levels are not set to increase. There is no nationally agreed commissioning route or level of commissioning for this group**.**

18 week wait and WTD are possible demand drivers for PA(A)s. It is not possible to estimate true demand from the service. However the RCoA estimated 1,000 by 2010 as of 2006.

There is a need to increase evidence of best practice of the role where it has been successfully adopted and share this with other areas where it has not adopted.

A national commissioning framework could be a solution for a time limited period of three or four years by establishing a nationally agreed route and level of commissioning.

Establishment of a lead SHA for this group could be useful to them in terms of commissioning consistency.

From 2009 onwards this specialty will be included in WRT's nationally planned work.

6. Bibliography

1. *A toolkit to support the planning and introduction of training for Physicians' Assistants* (*Anaesthesia*), Department of Health, March 2006. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074709 [last accessed 1 June 2007].

2. Association of Physicians' Assistants (Anaesthesia) http://www.anaesthesiateam.com/ [last accessed 20 November 2008]

3. RCoA Physicians' Assistant (Anaesthesia) [PA(A)] http://www.rcoa.ac.uk/index.asp?PageID=761 [last accessed 20 November 2008]

4. *The Workforce Consequences of Anaesthetic Practitioners*, the Royal College of Anaesthetists, 2006 (unpublished).

5. *Evaluation of Advanced Practitioner roles (Draft report)*, Skills for Health, 2008 (unpublished).

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ASSOCIATION of PHYSICIANS' ASSISTANTS (ANAESTHESIA)

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14th February 2011

To **Health Professions Council**

Re **Further information regarding the application of Physicians' Assistants (Anaesthesia) for regulation by the HPC.**

Dear Council Members,

Following the Council meeting of 9th December 2010 you requested further information on the occupation of Physicians' Assistant (Anaesthesia) in the following areas;

1. Differences between PAs (Anaesthesia) and PAs (General)
2. Role, scope of practice and degree of autonomy.
3. Commissioning and employment opportunities.

1. At the time of writing of our initial application it was the position of UKAPA, the representative body of Physician Assistants practising in general medicine, that they did not wish to pursue an application to the HPC jointly with APA(A) or otherwise, as documented in appendices 3.2 and 3.3 of the application.

Whilst seeking documentation on the role of PAs (General) on the UKAPA website, http://www.ukapa.co.uk/, which has links to sources of the information you are seeking, it became apparent that UKAPA is now making application to the HPC independently and therefore the HPC may already be in possession of sufficient documentation on the training, competencies and scope of practice of the role to make a decision on the differences and similarities between the two occupations.

The APA(A) is not opposed to the concept of being part of a joint register but is aware that the HPC has received correspondence from PAs in opposition to this.

In order to avoid potential confusion between the roles, the members of the APA(A) and the Anaesthesia Related Professionals committee of the RCoA are in agreement that the occupation could be regulated under a different title such as the

original “Anaesthesia Practitioner”,or a similar alternative, as the object of the application is the protection of the public rather than the protection of the title.
The occupation is still described under the title of “Anaesthesia Practitioner” by the NHS Employers Organisation for the purposes of Agenda for Change job profiling.

2. The document *A toolkit to support the planning and introduction of training for Anaesthesia Practitioners,* included as appendix 2 of part A of the application, contains on pages 49 to 55 a highly detailed description of the scope of practice and degree of autonomy of the occupation, supported by the two case studies on pages 6-9 of the body of the application. The Curriculum Document attached in Appendix 10 of the application also contains information on the level of knowledge and skill required to underpin the role.
Whilst PA(A)s are supervised indirectly by an anaesthetist during the conduct of surgery, they themselves must make the decision as to whether the condition of a patient is deteriorating to a level they cannot treat alone, in effect determining their own level of supervision. A failure to act or an incorrect action whilst working under remote supervision could result in serious harm or the death of the patient within minutes.
Because of this, the NHS Employers Organisation, which provides independent assessments of healthcare occupations for the purposes of Agenda for Change pay banding, has graded the role at band 7 (under its original title) for newly qualified practitioners[1].
Those parts of the profiles that relate specifically to the areas of scope of practice and degree of autonomy are “analytical and judgement skills”, “physical skills” “responsibility for patient care” and “freedom to act”. PA(A)s are scored at 4, 4, 6(a)(c) and 4, which compares favourably with other professions regulated by the HPC when assessed on the same criteria.
Many professions already regulated by the HPC such as Operating Department Practitioners and Physiotherapists are, for example, assessed at Band 5 on initial qualification and are not assessed as having the same “Freedom to Act” as PA(A)s.

Reference

1.http://www.nhsemployers.org/PayAndContracts/AgendaForChange/NationalJobProfiles/Documents/Theatre_Practitioners.pdf

3. As detailed in appendix 9.2 of the application, the occupation has since 2009 been included in the Workforce Review Team's nationally planned work and is included on the list of specialities and professions which it believes should be considered for either a national planning and funding mechanism or for special attention by inter-SHA planning processes.

There is no nationally agreed commissioning level.

Despite the economic climate, demand for trained PA(A)s has remained steady with a very high percentage of newly qualified practitioners being offered posts. The APA(A) has received numerous requests for information on how to recruit PA(A)s and it may be the case that the reductions in costs such as those demonstrated by the pilot sites of the training scheme and included on pages 42 and 43 of appendix 2 of part A of the application may make the role increasingly attractive to employers.

I hope this further information is sufficient but please do not hesitate to contact me for anything further you require.

Yours sincerely,

David Wilkinson PgDip(AP)
Association of Physicians' Assistants (Anaesthesia)