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Raising the profile of the four Medical Associate Professions Regional Seminars October 2018

Building capacity

Objectives of the seminars

- Describe each MAP role, its scope of practice, and “fit” within medical teams
- Describe the education and training framework for each role
- Showcase best practice in MAP utilisation and evidence to demonstrate the value of these complementary roles to MDTs in primary and secondary care
- Promote employer friendly materials developed by HEE MAP Oversight Board members and NHS Employers
- Open discussion on how employers can train and deploy these roles in secondary and primary care

Regulation

- Matt Hancock, Secretary of State for Health and Social Care announced the introduction of statutory regulation for physician associates and physicians' assistants in anaesthesia, following direct engagement with the NHS workforce.

- HEE will work with the Department on progressing statutory regulation for the two roles **and** supporting the development of a legislative framework to bring in future roles into the MAP group.

- This move will provide these workforce groups with an important foundation, supporting them through a strong regulatory framework and reassuring patients that they are continuing to receive the highest quality of care from the NHS.

- We await the publication of the DHSC's written response to the consultation to understand the full details of the Department's proposals to regulate PAs and PA(A)s.

NHS Policy Context

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The Five Year Forward View (FYFV) set out <u>why</u> the NHS needs to change; the Next Steps on the FYFV sets out <u>what</u> will change in next 2 years and how the goals of the 5YFV will be achieved

October 2014

March 2017

Strengthening the Workforce

The major policy changes from the FYFV and Next Steps require short term, almost immediate changes to the workforce that can only be delivered by changing both the mix of teams; the roles and responsibilities of members of those teams; enhancing existing roles and introducing new roles

NHS Workforce Skills: Demand and Supply

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What drives the demand for skills?

What drives the supply for skills?

Extended roles
Enhanced roles
- Upskilling existing staff
- Advanced Clinical Practice roles
- Specialist training

New roles
- Nursing Associates
- Four Medical Associate Professions (MAPs)

Increasing skill mix: New Roles

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"**Having the right mix of competencies and skills across a team improves outcomes for patients, improves clinical productivity, and ensures individual clinicians are empowered to showcase the full range of their talents.**"
(HEE Draft Workforce Strategy, 13 December 2017)

Increasing skill mix: New Roles

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NEW ROLES

- ✓ A key part of supporting a richer skill mix in multi-disciplinary teams across health and care.
- ✓ Based on evidence of service need and demand pressures nationally
- ✓ Bridge a gap in care and address the barriers to creating modern agile teams and enable practitioners with a higher skill set to practice at the upper end of their proficiency.
- ✓ Enable direct entry routes into a new profession and ensure standardisation in the quality of the training, reducing unwarranted variation in quality of care to patients.

Identifying a need for new roles based on:

- Identification of a skills gap
- Evidence of national demand for skills
- Evidence of national shortage of skills
- Evidence of new technology or advances in clinical care or treatment which require new skills

New Roles: Medical Associates Professions

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Why does the English NHS need the four MAPs?

- Rising and ageing population increasing demand for NHS services and key medical specialties
- Changes to working practices of doctors
- Changes to education and training structure for junior doctors
- Waiting time targets – referral to treatment
- Changes in the popularity of certain medical specialities
- Changes in the personal choices of medical trainees
- Ageing medical workforce
- Medical recruitment and retention difficulties in different regions

Shape of Training Review 2013:

"*Patients and the public* ***need more doctors who are capable of providing general care*** ***in broad specialties*** *across a range of different settings. This is being driven by a growing number of people with multiple co-morbidities, an ageing population, health inequalities and increasing patient expectations*"

Medical workforce skill mix

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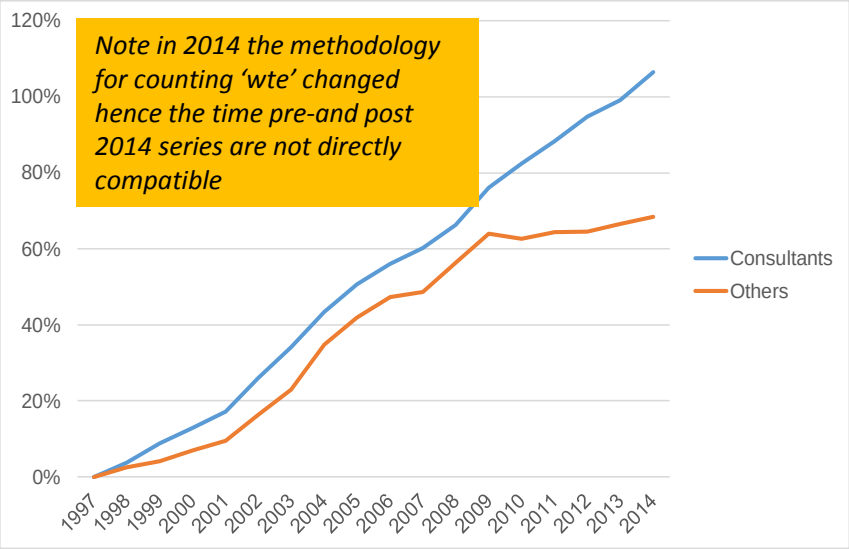
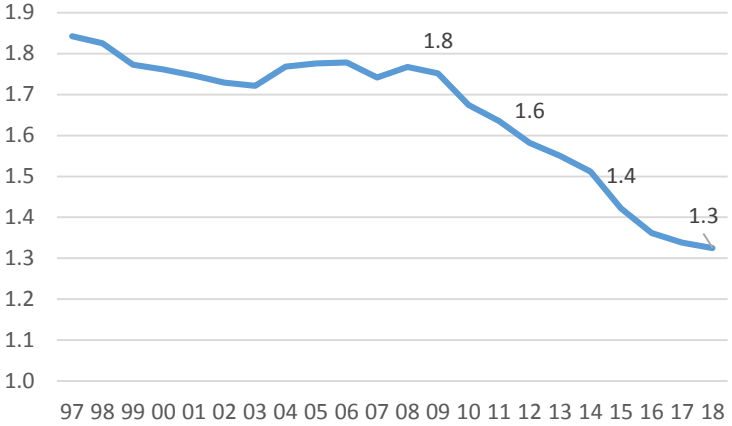
Growth in Consultants and 'other doctors' (WTE) England, indexed to 1997



While the medical workforce has grown the ratio of consultants to non-consultants has declined markedly.

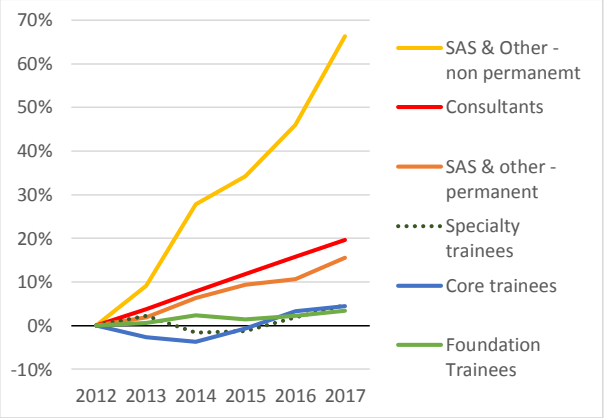
'Non consultants' per consultant



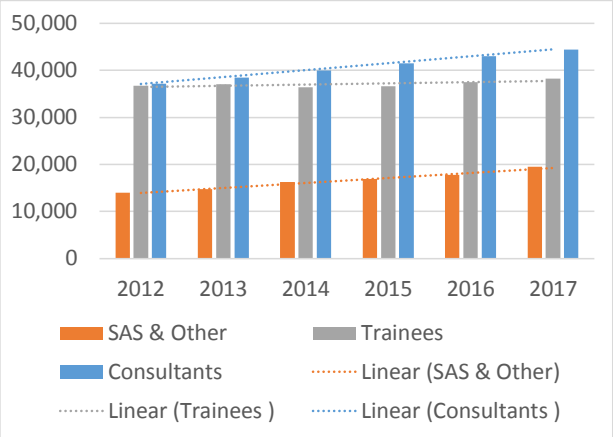
Medical workforce skill mix

Health Education England

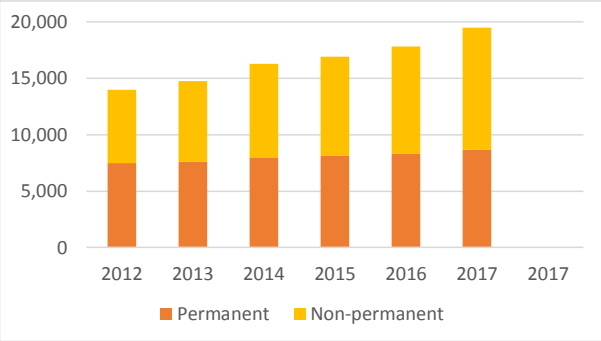
Change in components of the medical workforce 2012-2017 (wte) indexed to 2012



Components of the medical workforce 2012-2017 (wte)



Number (wte) of SAS and Other doctors 2012-2017



Retention

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In broad terms, *retention* of consultants is not a major concern:

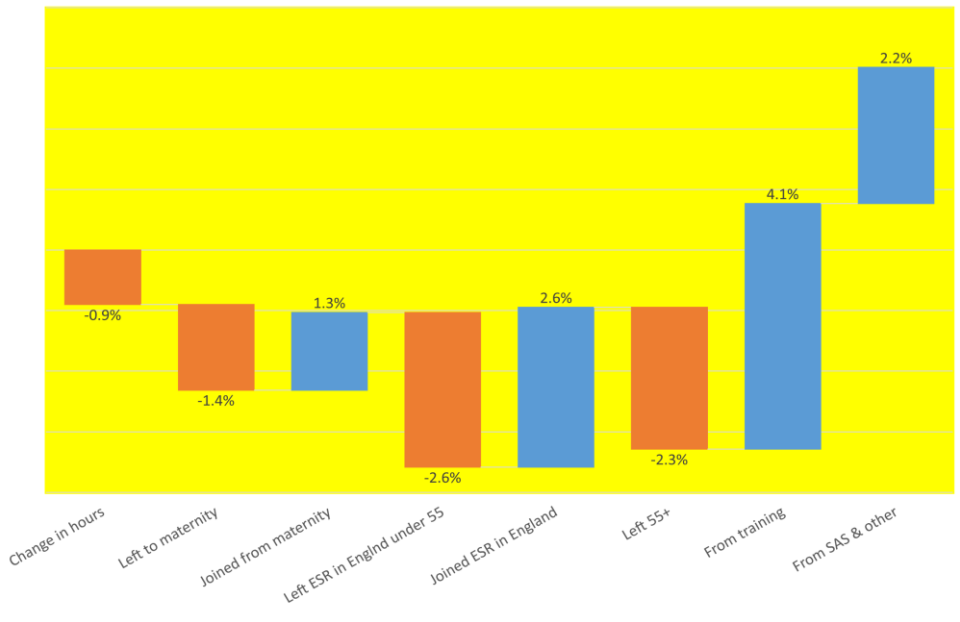
- an average of 2.6% of consultants under the age of 55 leave the NHS, but an average of 2.6% join the NHS from sources other than new supply (training).
- Rates of leaving age 55+ have, so far, been stable and predictable

If follow that retention initiatives need to be focussed in those specialties where there is most concern.

Notable exceptions to the above include:

- **Clinical Radiology**, where inflows under 55 have exceeded outflows. Recent growth in Consultant numbers has been fuelled in part by recruitment from overseas. To maintain recent growth this would need to continue
- **Emergency Medicine,** where rates of leaving under 55 and 55+ are higher than average. Sustaining growth relies on increasing trainee numbers. Numbers have been increased but we need to monitor attrition from training closely.
- **Psychiatry** where a combination of 'Mental Health Officer' status and very poor training fill are contributing to a projected decline in the consultant workforce.

Observed average annual rates of flow to and from the Consultant workforce 2012-17



SASO Staff

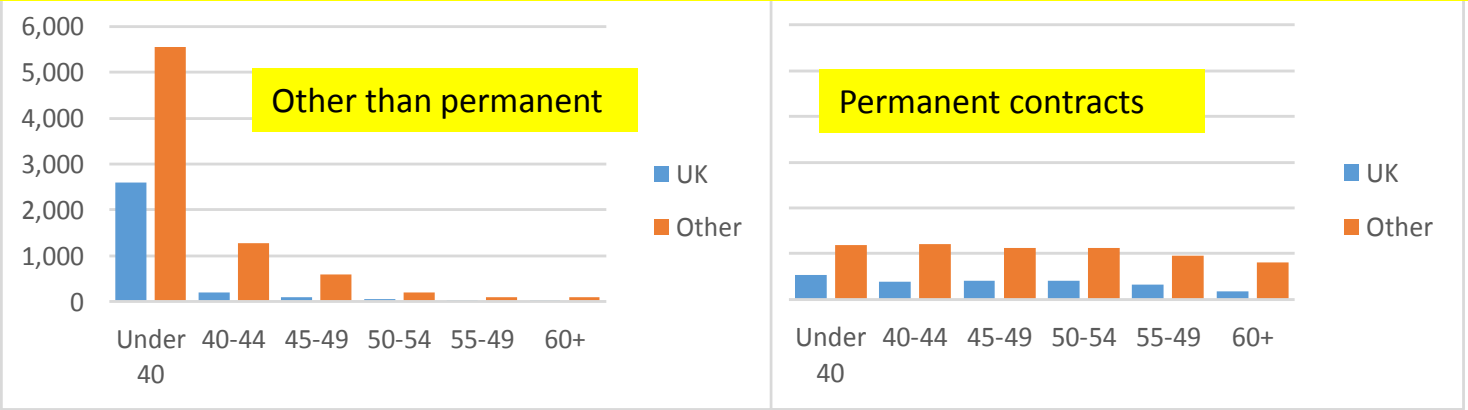
Health Education England

SASO staff are hugely volatile with annual flow rates in the high teens.

This reflects the fact that this group overwhelmingly:

- Are young
- Gained their primary medical qualification outside the UK

Age and gender of SAS and other staff (2017)



Geographical distribution of medical workforce resource

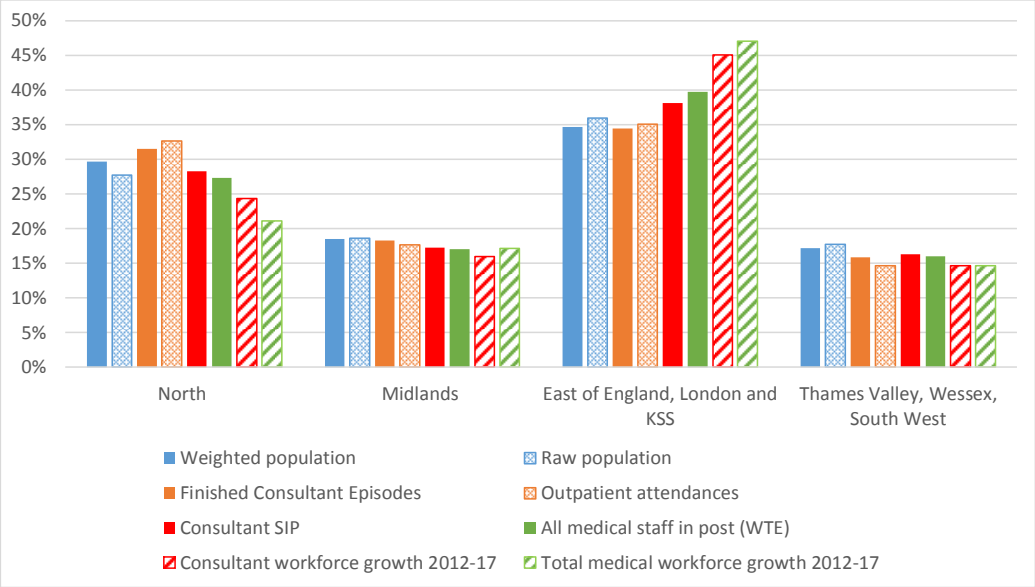
Health Education England

The medical workforce is not distributed evenly around the country.

This reflects the history of

- resource distribution
- medical training post distribution
- relative success of recruitment to medical staffing and PGME training

over many years.



Re-balancing of resource is a complex and lengthy process, not to mention politically charged.

It follows that, while all geographies will need to develop creative workforce solutions, the types of solution and the imperative to do so will entail different prioritisation.

*These data **illustrate** the issues. The values shift depending on the granularity of the analysis.*
***I**f resources were distributed evenly in relation to population or 'workload (as measured by Finished Consultant Episodes and Outpatient Attendances) then the bars within each geography would be the same height.*
The chart shows that London and the surrounding areas (in this case HEE local team 'catchments' have

- *a greater 'share' of medical staffing resource*
- *a greater share of recent growth in that resource*

than high level population and workload measures might imply.
Thus other areas have a lesser share.

Conclusions

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Demand for medical workforce is not going to decline

There are already;

- existing vacancies for Consultants
- significant reported (but not quantified) 'rota gaps'
- Extensive use of agency medical staff to fill gaps

Up until the mid 2020's, when the current expansion of medical school places delivers new graduate supply into medical training

- the available supply of CCT holders is projected to grow at *broadly* historic rates at national and regional levels. That is, the trainees are already in the pipeline
- the number of trainees is not projected to change as this is constrained by (i) output from medical schools and (ii) the number of *suitable* applicants from non-UK source
- Any redistribution of resource will be a lengthy process

Hence growth in the 'medical' workforce other than consultants will entail

- Further increases in SASO staff, which in turn entails greater levels of recruitment from overseas
- Increased development and deployment of medical associate professionals

The imperative, and the solutions, will vary by geography and specialty.

Medical Associate Professions

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…are four new healthcare roles, developed by the medical Royal Colleges with employers, who collectively form a Group of dependent clinicians working to a medical model in clinical practice. They have the attitude, skills and knowledge base to deliver medical care and treatment within a defined level of competence under defined levels of supervision by a consultant doctor or GP.

Medical Associate Professions

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Professional Role	Definition
Physician Associate	A dependent health care professional who has been trained in the medical model and works with supervision of a Doctor or Surgeon.”
Physician Assistant Anaesthesia	Supervised by a Consultant Anaesthetist - Provides 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.
Advanced Critical Care Practitioner	Clinical professionals who are experienced members of the critical care team and are able to diagnose and treat your health care needs or refer you to an appropriate specialist as required. They are empowered to make high-level clinical decisions as part of intensive care consultant-led teams and will often have their own caseload.
Surgical Care Practitioner	A registered practitioner, who has completed a Royal College of Surgeons accredited programme (or other previously recognised course)… working in clinical practice as a member of the extended surgical team, performing surgical intervention, pre-operative care and post-operative care under the direction and supervision of a Consultant Surgeon.

Trained as generalists, competent to work in multi-disciplinary teams, they remain flexible throughout their careers and readily adaptable to changing healthcare system needs

Generalist Skills across the Four MAPs

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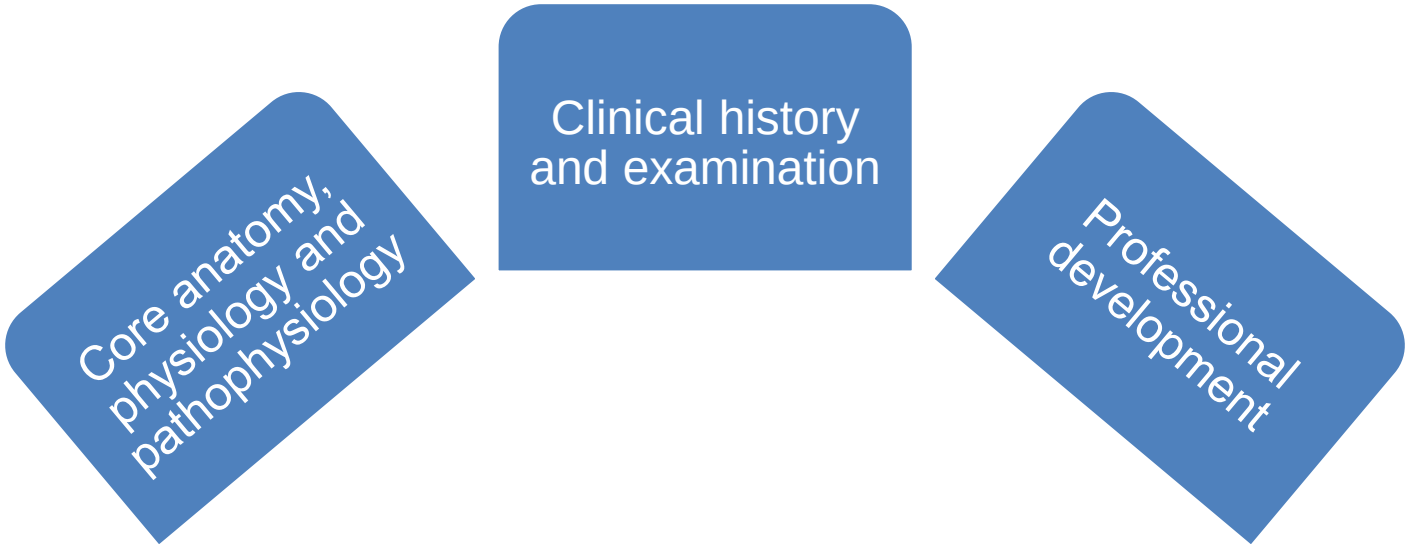

MAP Regulation: Limitations of roles without regulation

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- × Unable to independently prescribe
- × Absence of a clear career framework and structure for all four roles
- × Reliance on shortage occupations to train in these roles, creating further pressures in the workforce supply chain
- × Variation in the quality of training of MAPs as demand for these roles grow nationally and in the NHS and independent sector
- × No scheme for re-certification and revalidation to ensure quality in the continued practice

HEE Priorities for MAP Programme in 2018

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- ☑ Development of a career framework for all four MAPs
- ☑ Communications and marketing with key stakeholders on the MAP roles
- ☑ Curriculum and professional development
- ☑ Medicines mechanisms for each MAP role

Questions

NHS
Health Education England

For more information on Medical Associate Professions and the benefits of having them in the team, please visit:

www.nhsemployers.org/maps

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The Physician Associate: a brief overview

Faculty of Physician Associates

What is a Physician Associate?

'A new healthcare professional who, while not a doctor, works to the medical model with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision' (DHSC, 2006).

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PA Education

- Bioscience/Health and Life science Grads
- Healthcare or customer care experience
- 2yrs intensive programme - MSc/MPAS/PGDip
- 3200 hours
- University Exams
- National Examination
- Recertification Examination
- Funding of programmes

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Scope of Practice

Can:

- Take Histories
- Examine patients
- Request and interpret investigations/results
- Diagnose and treat
- Management plans
- Propose prescriptions/medications
- Manage uncertainty and complexity
- Carry out procedural skills

Cannot:

- Prescribe or request ionising radiation

*All with physician supervision

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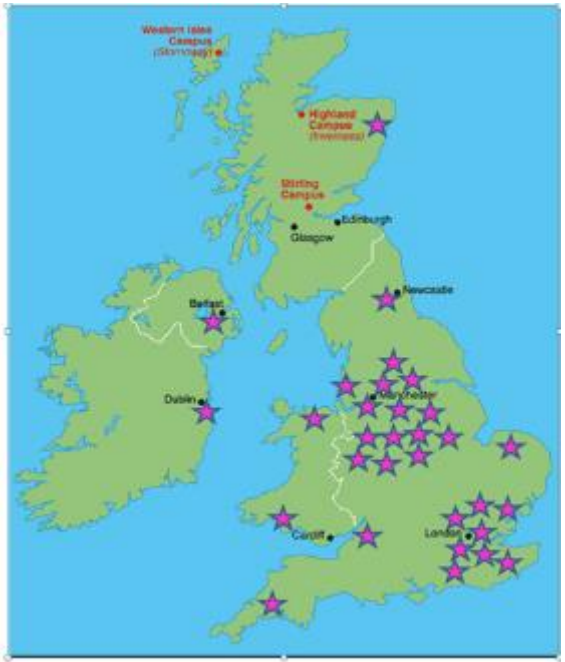
Physician Associate Numbers

- ✓ 31 programmes across the 4 countries
- ✓ No of students: 928(register)
- ✓ No of qualified PAs: 658 (register)
- ✓ Accreditation



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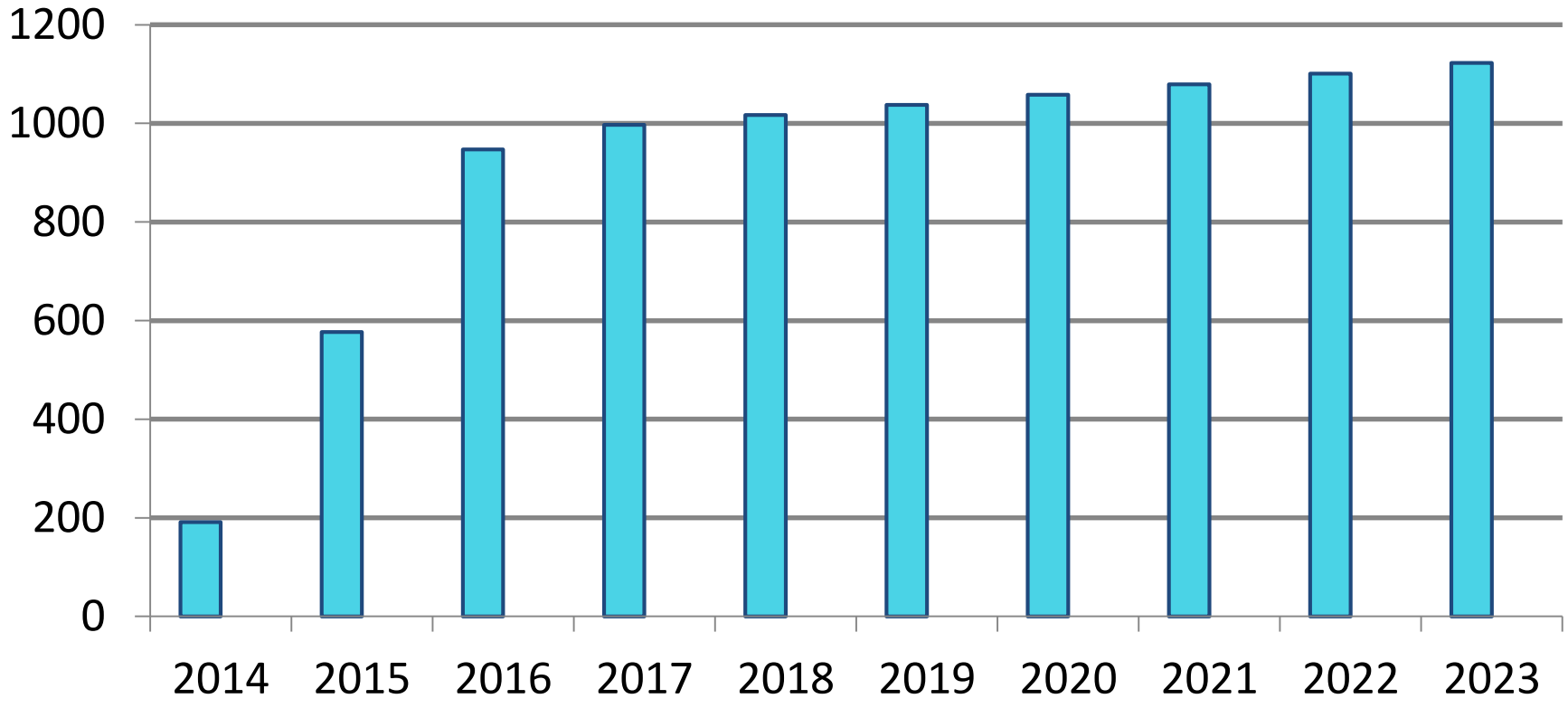
1st YEAR UK PA STUDENT NUMBERS



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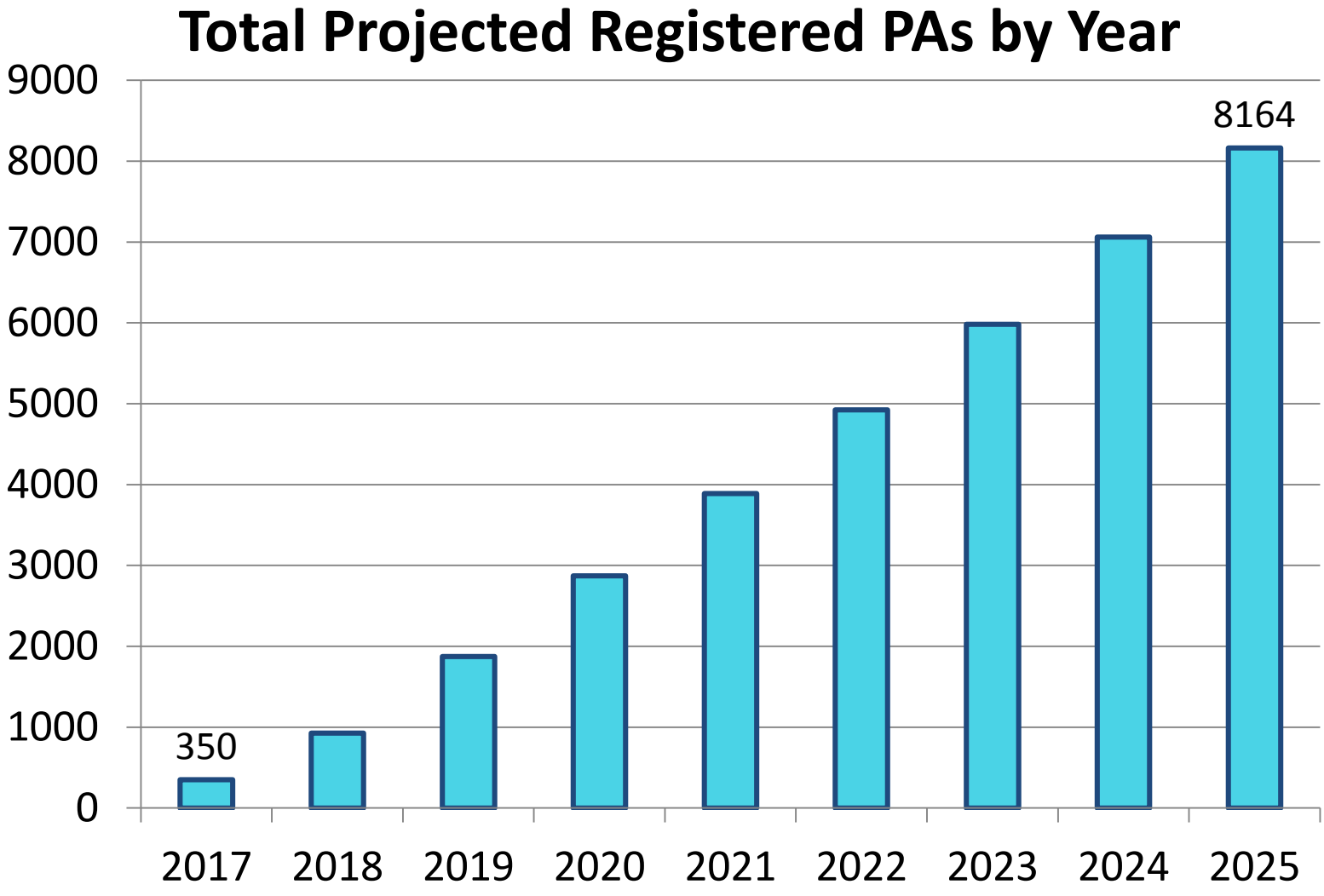

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Employment and Career Progression

Employment – FPA employer handbook

- Primary & Secondary Care
- Over 20 specialties
- Salaried member of the team
- Funding available - HEE
- New Graduate Year

Career Progression

- Flat
- Portfolio, Appraisal and CPD

Royal College of Physicians | Faculty of Physician Associates

Draft Guidance on Career Development and Support for the Physician Associate in Secondary Care

Skills & competency

0-12months

- Trust induction
- Job plan
- Knowledge and skills assessment
- Development plan to address knowledge & skills gap
- Less complex patients
- CPD
- Portfolio to demonstrate progression competencies and capabilities Including reflections, procedural skills

1year +

- Skills development
- Seeing more complex patients
- Developing areas of special interests
- Clinics
- On call (appropriate support)
- Audit
- Teaching/supporting others
- CPD
- Portfolio to demonstrate progression competencies and capabilities Including reflections, procedural skills

3 years +

- More complex skills/procedures
- More complex patients
- Developed areas of special interest
- Teaching students and staff
- Audit
- Clinics
- On call (appropriate support)
- Research and presentations
- CPD
- Portfolio to demonstrate progression competencies and capabilities

5 years +

- Complex patients
- Complex skills
- Teaching students/staff
- Managing students
- Managing new staff
- Audit
- Clinics
- Research and presentations
- CPD
- Developed areas of special interest
- On call (appropriate support)
- Portfolio to demonstrate progression competencies and capabilities
- Preparation for Recertification examination

Salary Range

Band 6/7 AFC → Band 7 AFC → Band 8a AFC

Level of Supervision/Support

- Allocated daily supervision (medical)
- Initial daily review of patients and notes
- Building trust/team working
- Weekly teaching session
- Regular review 3 monthly
- Annual appraisal

Level of Supervision/Support

- Daily medical supervision available
- Regular review of patients and notes
- Weekly teaching session
- Regular review 6 monthly
- Annual appraisal

Level of Supervision/Support

- Daily medical supervision available
- Review of patients and notes as required
- Monthly teaching sessions
- Annual appraisal

Level of Supervision/Support

- Daily medical supervision available
- Review of patients and notes as required
- Teaching sessions as required
- Annual appraisal

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Draft Career Development Primary Care

SKILLS & COMPETENCY

0 - 12 months

- Close supervision
- Trust building
- Confidence building
- Extended appointments (30 minutes)
- Same support required as a GP Registrar

1 + year

- 15 minute appointments
- Undertakes extended training such as Minor Surgery
- Own case load
- Long Term Conditions Case Management
- Care Planning

Undertakes responsibility for:

- QOF
- Training
- Medicine reviews
- Audit

3+ years

- Seniority and experience
- Multiple specialities
- Managerial Level
- Considered for Partnership
- Undertakes leadership role for clinical teams (non GP)
- Developing professional portfolio career

Salary Range

£32K → £40K+ → Dependent on competency

Level of GP Support *

- Needs analysis of what the PA knows and what they need to learn in the next year to develop in GP as PA.
- Dates for 3, 6, 9 month reviews of their learning needs and date for 1 year appraisal
- Initially daily supervision and review of surgeries after each surgery for a period of time
- Decrease this once gained trust in PAs abilities and as they grow as a PA
- Regular review of notes

Level of GP Support

- Some regular supervision - review of patients records/notes on an ad-hoc basis
- GP Available for consults as and when needed
- Weekly 1/2 hour supervision session for discussion of learning needs or complex patients
- 6 month appraisal
- GP support for 50 hours pro rata of CPD per year. 25 hours type 1 and 25 hours type 2 to be completed to maintain registration.

Level of GP Support

- Support as and when needed, on the day and for some patient reviews of complex cases
- Ad hoc review of patient notes.
- Yearly appraisals

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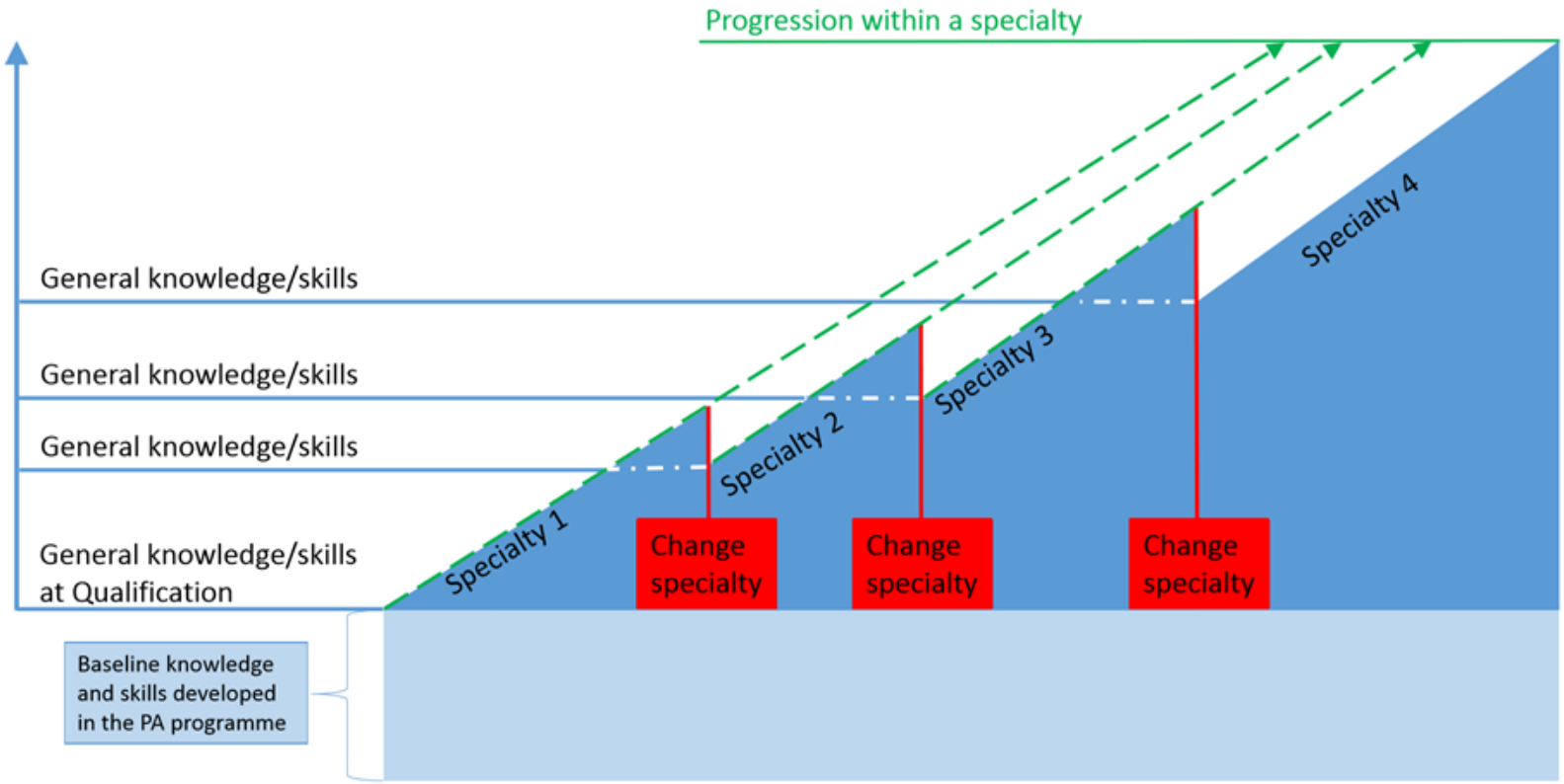
Draft Changing Specialty Career Support



Closing thoughts……

- PAs are here
- Complementary part of medical workforce not replacements for medical staffing
- Properly introduce into the workforce
- They will not be right for every post you have vacant
- Will not solve all of the problems in the NHS……but are definitely part of the solution
- Consider PA student placements!

Resources and Contact

- Faculty of Physician Associates www.fparcp.co.uk
- fpa@rcplondon.ac.uk

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For more information on Medical Associate Professions and the benefits of having them in the team, please visit:

www.nhsemployers.org/maps

Medical Associate Professions Health Education England Regional Events

Physicians' Assistants (Anaesthesia) [PA(A)]

October 2018

Development of the PA(A) role

What are PA(A)s?

Physicians' Assistants (Anaesthesia): are healthcare professionals who have completed a post-graduate diploma recognised by the Royal College of Anaesthetists.

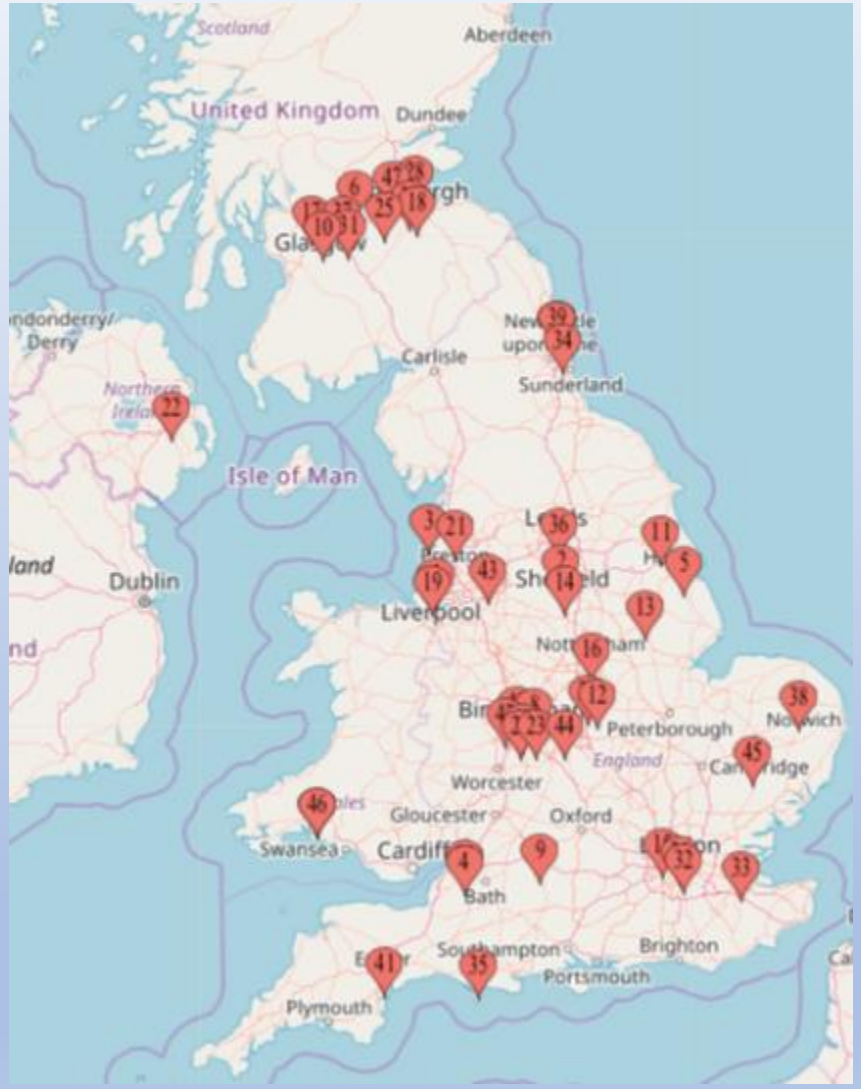
PA(A)s work within an anaesthetic team under the direction and supervision of a Consultant Anaesthetist.

Overall responsibility for the anaesthesia care of the patient remains with the named Consultant Anaesthetist at all times.

PA(A)s perform a number of anaesthesia-related roles including: pre-and-post operative assessment, administration and maintenance of general anaesthesia, procedural sedation and are qualified in resuscitation.

Where PA(A)s work around the UK

>40 Hospitals



APAA
Association of Physicians' Assistants Anaesthesia

RCoA & AAGBI Joint statement

- Initial cohort of PA(A)s has experience and are well integrated into anaesthetic departments where they work
- PA(A)s, supervised by medically qualified anaesthetists, can make a valuable contribution to patient care
- Agreed scope of practice for PA(A)s on qualification
- Voluntary register established as a prelude to formal regulation
- AAGBI and RCoA would only consider supporting role enhancement when statutory regulation is in place.

Funding

Trainees are employed by the Trust.

University fees paid by Trust - £6,000 for Post Graduate Diploma

Trainee salary:

£15,000 'graduate salary' up to band 5/6 during training.

If seconded by Trust – maintains current salary for duration of training

Banded on Agenda for Change at Band 7, but many trusts employ at Band 8a and a few PA(A) managers at 8b.

Training

12 modules over 24 months + 3 months consolidation and advanced practice

- Introduction to anaesthesia science & technology
- Anaesthesia science & technology
- Heart & Circulation
- The Airway & Lungs
- The Kidneys, Liver, Endocrine system & Blood
- The Brain & Nervous system
- Clinical History & Examination
- Managing life threatening emergencies
- Advance practice

Training

- University of Birmingham, distance learning, study days and OSCE's
- All clinical teaching delivered locally by the NHS trust

- Per module:
  - Directed self study 70 hours
  - Small group teaching 14 hours
  - Clinical skills teaching 21 hours
  - Workplace experience 140 hours

Entry Routes

- Registered healthcare practitioners - At least three years, full-time, post-qualification work experience in a relevant area and evidence of recent and successful academic activity

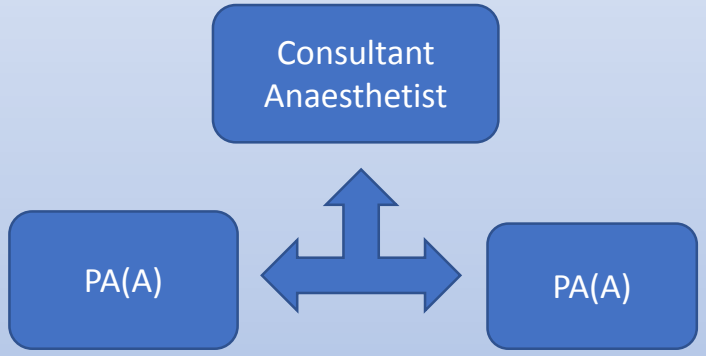
- New entrants to healthcare - a biomedical science degree, or biological science background with a demonstrable commitment to a career in healthcare.

What do PA(A)s do?

- ✓ General anaesthesia delivery – airway management, medicines administration
- ✓ Regional and local anaesthesia procedures (with local governance)
- ✓ Provision of sedation
- ✓ Preoperative assessment – on day and in preoperative clinics.
- ✓ Cardiac arrest teams
- ✓ NECPOD and Trauma lists
- ✓ Teaching and education
- ✓ A range of other perioperative and non-perioperative roles consistent with their scope of practice at qualification.
- ✓ 2:1 working – 2 PA(A)s, 1 consultant supervising 2 operating lists.
- ✓ 1:1 working
  - Reduce operating theatre downtime
  - Increase throughput on operating lists
  - Improve theatre utilisation

APAA
Association of Physicians' Assistants Anaesthesia

2:1 working



Information from RCoA survey

137 of 170 PA(A)s registered

n	Current Practice
137	Maintenance of General Anaesthesia
27	Eye Blocks
44	Upper Limb Block
60	Lower Limb Block
89	Spinals
3	Epidurals
65	Induction Without Direct Supervision
131	Induction With Direct Supervision
98	Emergence Without Direct Supervision
123	Emergence With Direct Supervision
55	Sedation
10	On Calls

Career Progression

- ‘Flat’ career progression at present, although 8b JD introduces managerial component. Career progression envisaged when formally regulated
- Most responses indicate role enhancement mainly through regional anaesthesia skills, sedation and vascular access – developed via local governance frameworks.
- Prescribing
- Move into education or management by minority

CPD

APA(A) recommends minimum of 25 CPD points per year.

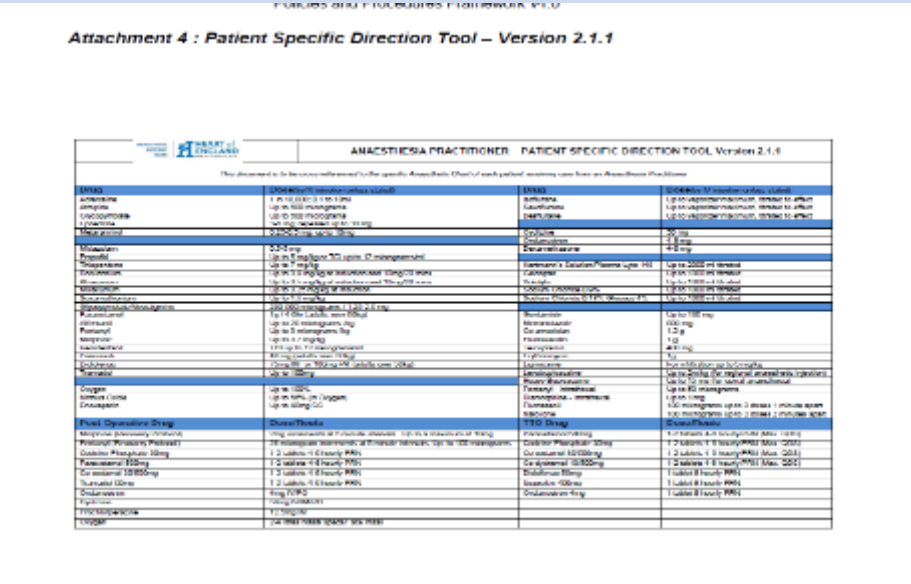
Average according to data is 25 points

Association of PA(A)s has an annual conference which the RCoA has accredited with CPD points.

APAA
Association of Physicians' Assistants Anaesthesia

Medication administration, advanced practice

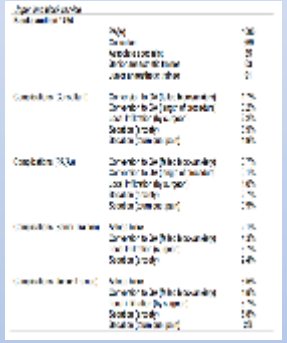
Patient Specific Directive

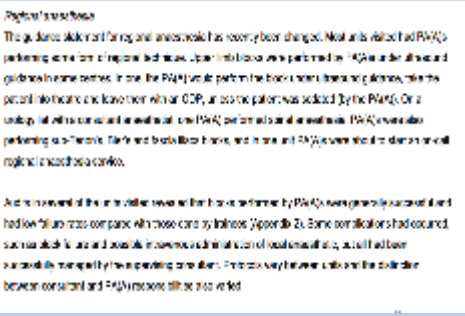


Attachment 4 : Patient Specific Direction Tool – Version 2.1.1

ANAESTHESIA PRACTITIONER PATIENT SPECIFIC DIRECTION TOOL Version 2.1.1

Regional anaesthesia





In Summary: What PA(A)s offer

- Alleviate workforce issues in daytime working
- Increase anaesthetic department staffing flexibility
- Reduce locum expenditure
- Deliver cost effective anaesthetic service
- Facilitate more dynamic deployment of consultant anaesthetic staff
- Deliver safe and effective general and regional anaesthesia
- Excellent training resource
- Support NCEPOD and Trauma anaesthetic service
- Effectively deliver pre-operative anaesthetic clinics

Practice Examples

Benefits of PA(A)s

Page 42 | Bulletin 86 | November 2014

The impact of Physicians' Assistants (Anaesthesia) at Heart of England NHS Foundation Trust

Mr P Cawkwell (Physicians' Assistant (Anaesthesia) Heart of England NHS Trust)

The concept of Physicians' Assistants (Anaesthesia) or PA(A)s has been established for 10 years. The initial proposal for the administration of anaesthesia by non-physicians in the United Kingdom arose due to a predicted future shortage of medically trained anaesthetists. The 'New Ways of Working in Anaesthesia Programme' was established in 2003. (www.rcoa.ac.uk/node/1457/). The product of this was Anaesthesia Practitioners (now called PA(A)s), and training commenced in January 2004. The plan for the PA(A) role was to enable one Consultant Anaesthetist to supervise two PA(A)s administering anaesthesia in geographically co-located theatres.

The original plan to initiate 'two-to-one' working proved initially challenging for various reasons including concerns regarding patient safety, whether the model would offer value for money and whether it would reduce training opportunities for junior anaesthetists. Some ten years later, perhaps due to the realisation of the workforce shortfall, PA(A)s are becoming a more obvious choice to many systems. Each PA(A) is involved in 700-900 cases per year, covering a range of specialties and anaesthetising patients for minor, intermediate and some major operations, all under the supervision of a Consultant Anaesthetist.

The supervising consultant's day

Fran Murray (Consultant Anaesthetist Heart of

References:

1 Phillips M, Dixon K, Murray F (2013) The 'Two-to-One Model' of Delivering Anaesthesia Using Physicians' Assistants (Anaesthesia) in Day Surgery has no Detrimental Impact on Clinical Outcomes, Heart of England NHS Foundation Trust, United Kingdom, *The Journal of One-Day Surgery*, Vol 23.

2 Phillips, Winwood, Murray (2012) Physicians' Assistants (Anaesthesia) Deployed in the 'Two-to-One Model'. Reduce the Cost of Providing an Anaesthetic Service to a Two-Theatre Day Surgery Unit by 22 Per Cent Heart of England NHS Foundation Trust, *The Clinical Service Journal* www.clinicalservicesjournal.com/Story.aspx?Story=10061.

Cost Benefits

- Reviewing the cost implication of the 2:1 model showed that there was a 22% reduction in costs in running two operating theatres over a standard five day working week.

- Cost of two Consultants staffing two operating theatres were £890.40, whilst the cost of two PA(A)s plus one consultant session was £695.34, making **a saving of £195.06 per session**.

- Yielded an **annual saving of £97,530** (Phillips et al 2012).

Case Study

- University Hospital Birmingham (UHB), PA(A)s predominately used for service delivery
- 2:1 work at Solihull, Queen Elizabeth & Good Hope Hospital
- Extensive involvement in regional anaesthesia especially in Orthopaedics and Ophthalmic surgery.
- Weekend working in Trauma theatres and Emergency theatres at Heartlands Hospital.
- Published audit and governance relating to PA(A)s
- Training and education of medical students and junior Doctors.

Case Study

- Salford Royal Hospitals - major trauma centre, high acuity hospital & remote site theatres
- 7 PA(A)s work 1:1 and 2:1 – 7 days trauma list cover.
- Work in Trauma and Emergency lists – regular lists, competent in caring for sickest patients in hospital under direct and indirect supervision.
- Clinical skills in patient assessment and optimisation for theatre, practical skills in airway management, line insertion, nerve blocks
- 2 remote theatres supported by 1 PA(A) for staggered admissions

Thank you. Any questions?

Further information

www.anaesthesiateam.com

info@anaesthesiateam.com

https://www.rcoa.ac.uk/node/261

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For more information on Medical Associate Professions and the benefits of having them in the team, please visit:

www.nhsemployers.org/maps

Advanced Critical Care Practitioners: An overview

Faculty of Intensive Care Medicine

The Faculty of
Intensive Care Medicine

What is an ACCP?

"Experienced clinical professionals who have developed their skills and theoretical knowledge to a very high standard. They are empowered to make high-level clinical decisions and will often have their own caseload."

– Skills for Health, 2007

- A healthcare professional who has acquired knowledge, skills and attitudes to deliver advanced level of holistic care and treatment within the critical care team, under defined levels of supervision and within the scope of practice of their role

What is an ACCP?

Usually from established roles in healthcare, such as nursing and Allied Health Professions

- The ACCP role crosses the professional boundaries of many functions within critical care including:
  - -medicine
  - -nursing
  - -technical
  - -physiotherapy
  - -clinical pharmacology

Career Structure

What does training look like?

Clinical	Academic HEI based
Content created and delivered by subject matter and clinical experts	PgD Modules: including advanced history-taking and clinical examination
Workplace-based clinical practice and assessment	Optional extension of MSc award
Supervised clinical practice	Non-medical prescribing module at MSc level

Scope of practice

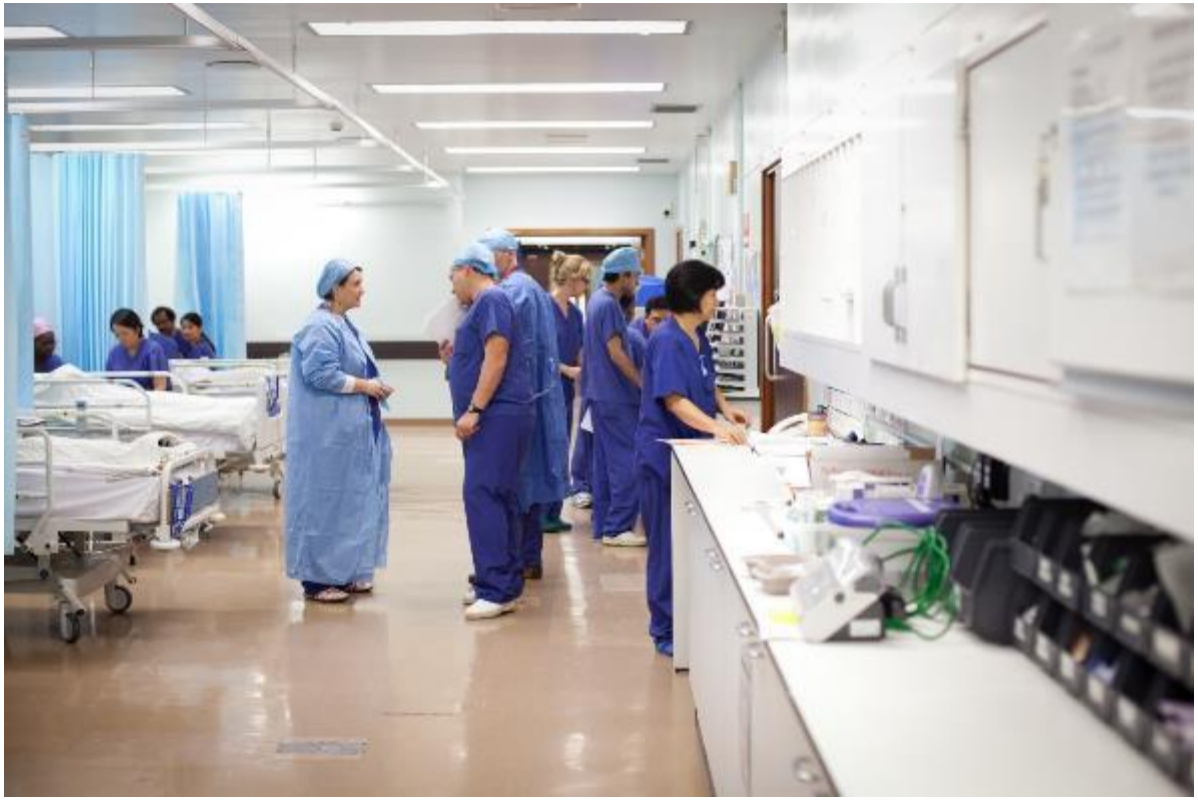
ICM specialists transcend the traditional borders of medical specialties developing a unique approach to critical illness.

Intensive Care Medicine specialists are therefore medical experts in a range of areas including:

- Advanced physiological monitoring
- Provision of advanced organ support (often multiple)
- Diagnosis and disease management
- Management and support of the family of the critically ill patient
- End of life care
- Collaboratively leading the intensive care team

Problems for the Workforce

- Overstretched - Cardiothoracic Intensive Care Unit @James Cook University Hospital
- 2005 -2009 absence of middle grade doctors to cover CITU
- Failure to meet minimum safe staffing levels

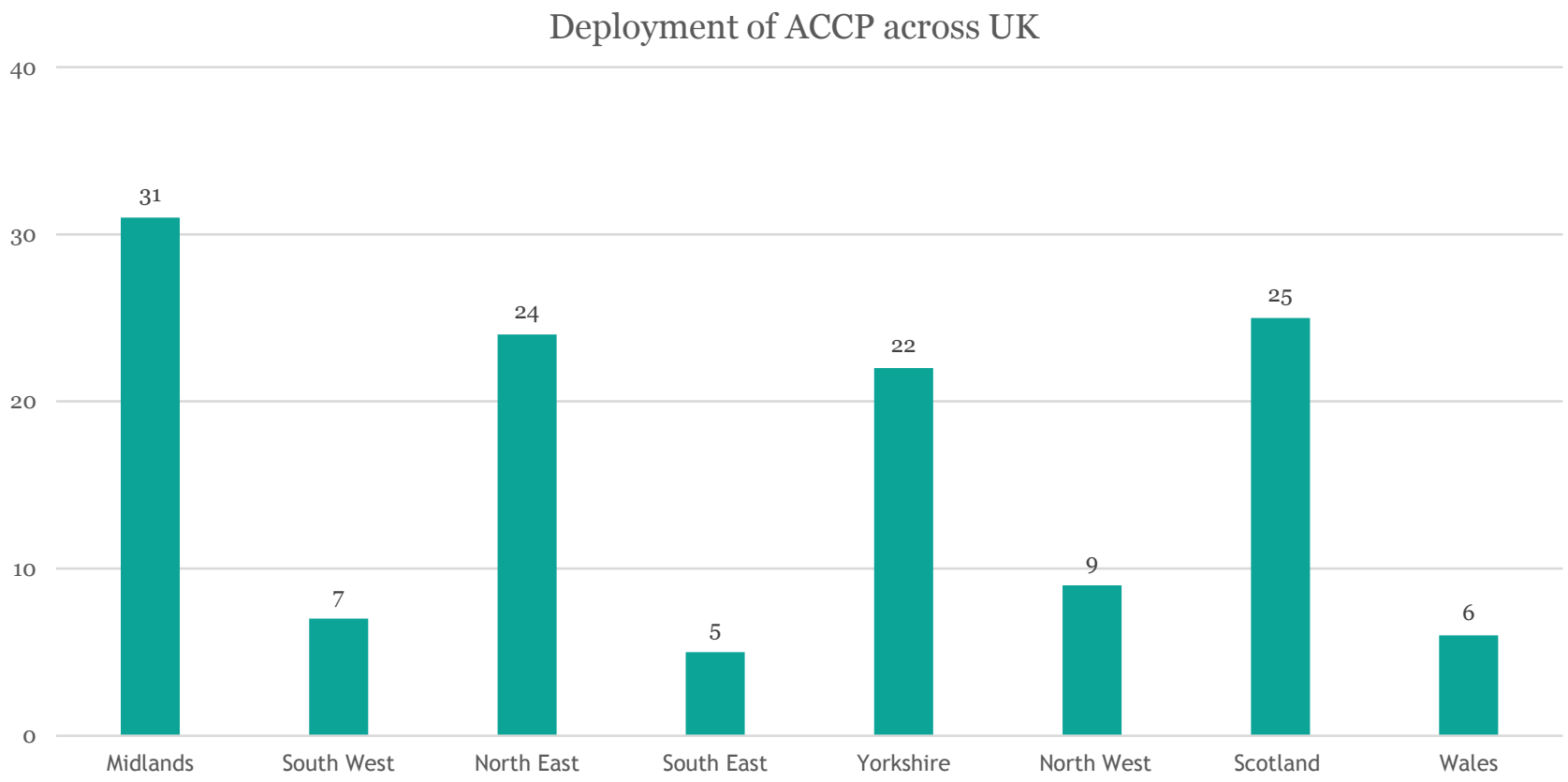


Finding a solution

- ACCP training program started 2009 with Teesside University
- Trained 14 ACCPs thus far (CITU +GITU) over an 8 year period
- Achieved seamless 24/7 cover for CITU in 2016

The solution

Deployment of ACCPs UK regions



What about funding?

There is no definitive established funding stream for ACCPs.

There is flexible and responsive funding through multiple models:

- Local funding
- Apprenticeship funding
- NHS funding (Scotland)

The Numbers

- Registered ACCP Trainees: 106
- ACCP Members of FICM: 129
- ACCP Membership applications under review:8

The status of ACCPs and MAPs

What does the DHSC's decision mean for ACCPs:

1. What would regulation have meant?
2. What is the message this sends?

- Growing and integral part of the ICM workforce fully supported by FICM and the NAACCP

How to contact FICM?

- Email: contact@ficm.ac.uk
- Tel: 0207 0921 653
- Website: www.ficm.ac.uk

ANY QUESTIONS?

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Intensive Care Medicine

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For more information on Medical Associate Professions and the benefits of having them in the team, please visit:

www.nhsemployers.org/maps

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Surgical Care Team

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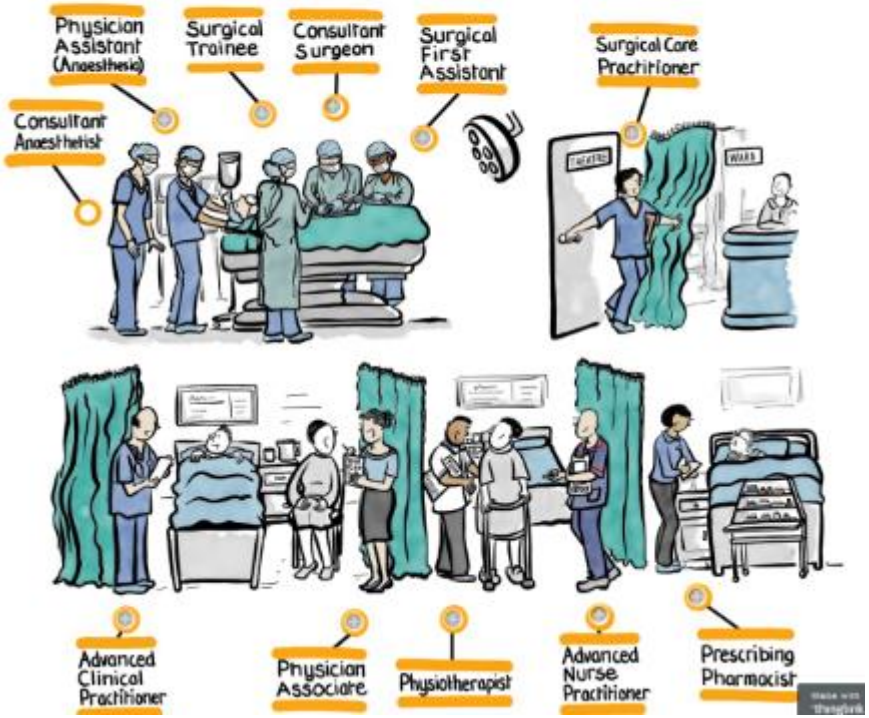
Surgical Care Team

Surgical Care Team

Well managed use of the wider team – with its mix of staff and skills – ultimately benefits patients, surgeons in training and the whole surgical team.



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Surgical Care Practitioner

"Registered non-medical practitioners who have completed an accredited training programme (ie MSc). A member of the surgical team able to perform surgical interventions, pre and post op care under direct supervision of the consultant surgeon".

Surgical Care Practitioner

- Curriculum framework leading to MSc Surgical Care Practice (RCSEng 2014)
- No voluntary register
- Scope of practice equivalent to ST3
- CPD a key issue
- Need to develop a career framework within surgical speciality

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Surgical Care Practitioner Programmes in the UK

MSc Surgical Care Practice	University of Plymouth	Janet Thatcher Programme Lead
MSc Surgical Care Practice	Anglia Ruskin University	Susan Hall Senior Lecturer
MSc Surgical Care Practice	Edgehill University	Bhuvana Bibleraaj Programme Lead

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Use of Formative Assessment in SCP Programmes

- Work based assessments (WBA) used to assess progress in ISCP domains of knowledge, judgement, technique and professional areas.
  - Observational tools eg DOPS ,miniCEX
  - Discussion tools eg CBD
  - Insight tools eg MSF

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Surgical Care Team

GUIDANCE FRAMEWORK

www.rcseng.ac.uk/surgicalcareteam

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Statutory Regulation

- Quality Assured Education & Training
- Dealing with concerns about competence and conduct (ie Fitness to Practice)
- Adhering to standards through CPD

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Medical Associates Oversight Board: Task & Finish Group

- Use of WBAs (CBD, DOPS, MSF) as an assessment of competence, teamwork and professionalism
- Portfolio of CPD activity, logbook, teaching, research, audit, critical events (ARCP).
- Named clinical/educational supervisor

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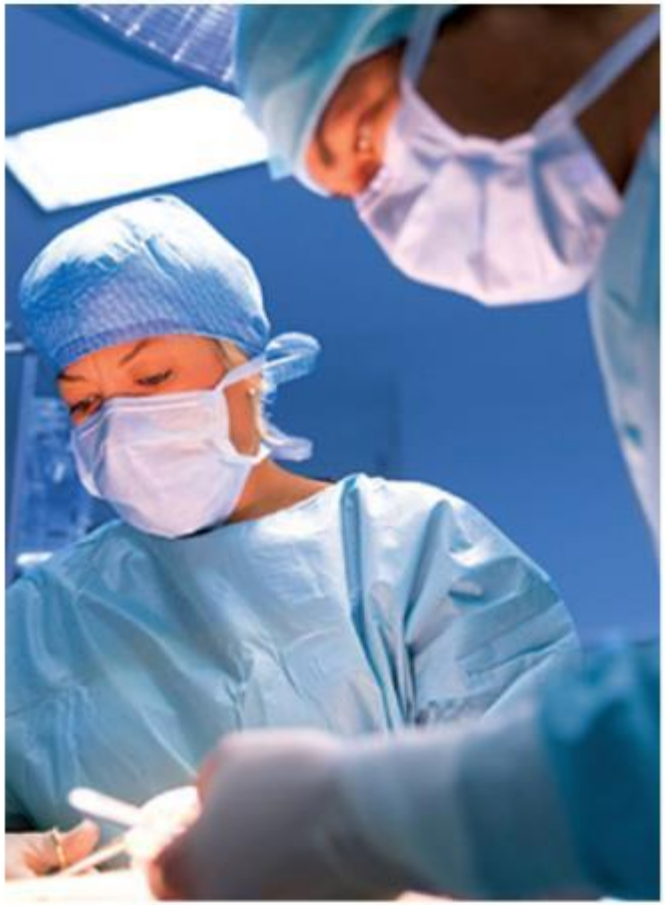
CPD for SCPs in Surgery

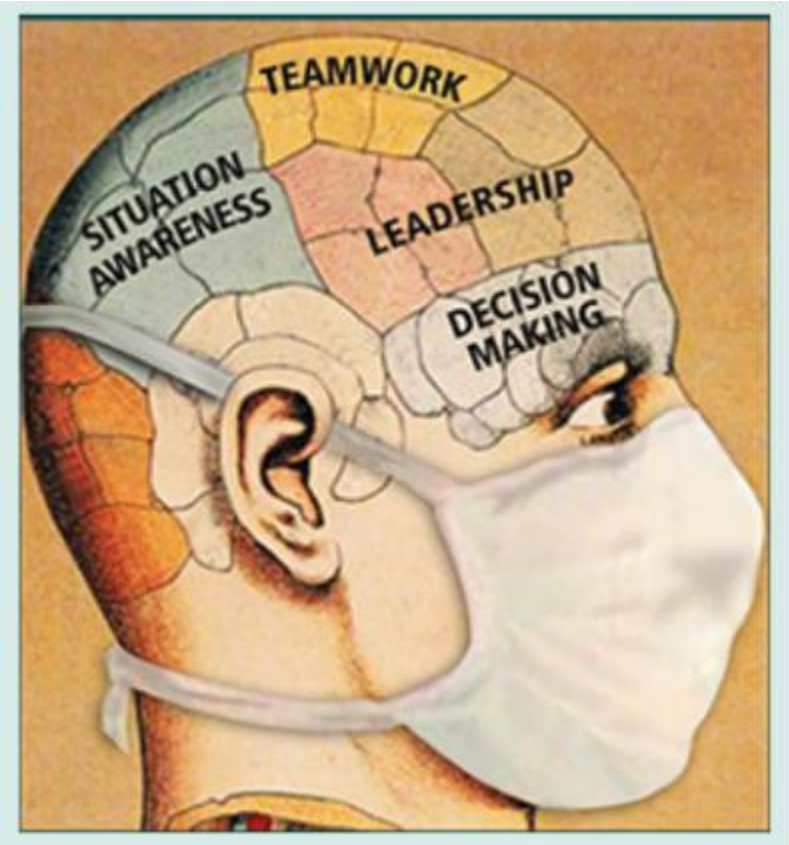
- CPD activity should be planned through a personal development plan at appraisal (50hrs p.a.)
- There should be a balance between internal and external activity
- The balance of activity should be across clinical, academic and professional categories with concise educational aims and objectives

Perioperative Keys Skills Course

Basic surgical skills are fundamental to the practice of safe surgery. The surgical assistant is an extremely important member of the operating team who needs to be familiar with the basic procedures in open and laparoscopic surgery as well as the dynamics of the theatre environment.

This one-day course aims to address the specific requirements of a surgical assistant who is assisting the operating surgeon. The areas covered are reproducible and applicable to all surgical specialities.

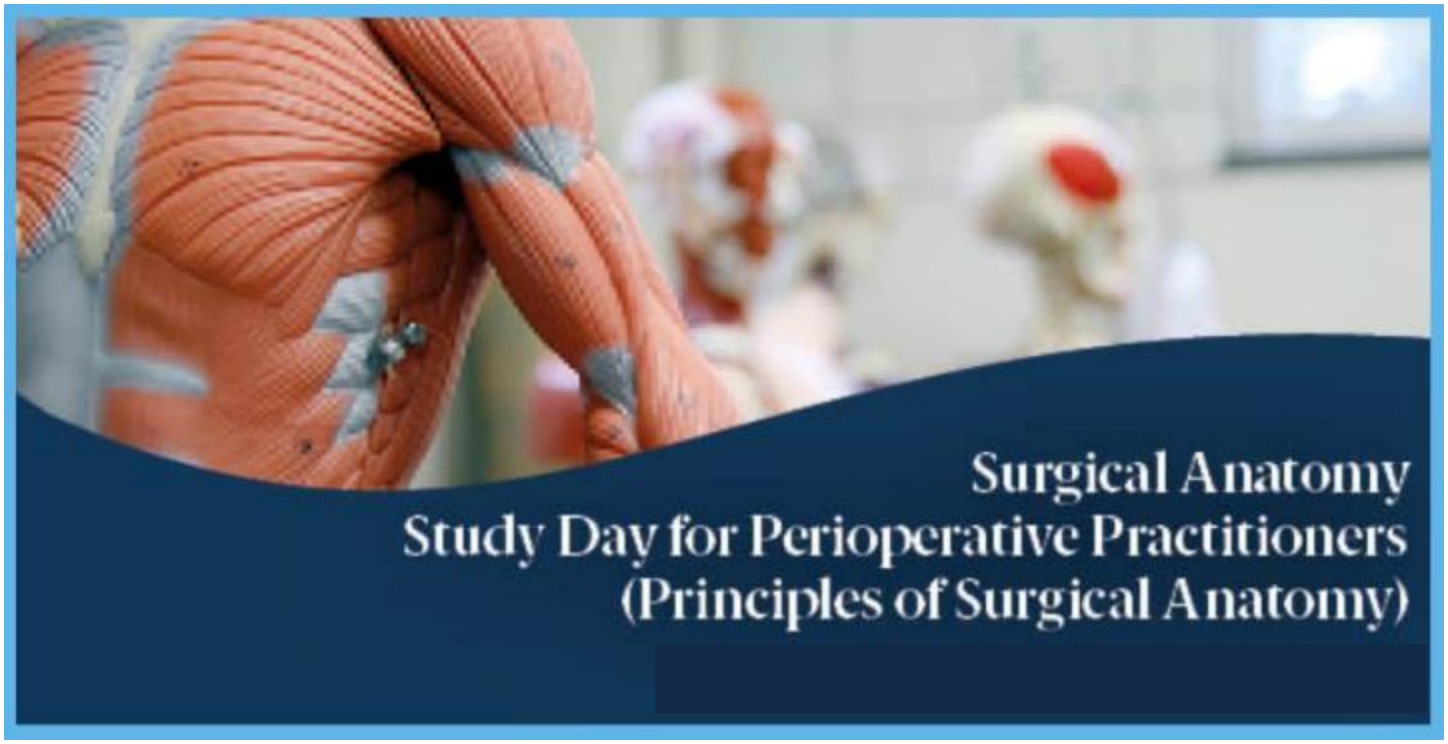




Perioperative Care Practitioners Intraoperative Non-Technical Skills (PINTS)

Birmingham, 1st June 2018

This one day course will enable perioperative care practitioners (PCPs) and surgical first assistants (SFAs) to improve their intra-operative performance and help them observe and rate intra-operative non-technical skills.


Surgical Anatomy
Study Day for Perioperative Practitioners
(Principles of Surgical Anatomy)

Leadership and Development

Birmingham, 2nd November 2018

This course will help participants to develop self awareness of their learning styles, individual strengths and development needs. It will also discuss service improvement including writing business cases and discuss areas such as time management and work life balance.

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Multisource Feedback (MSF) for SCPs

- Structured feedback process to the practitioner which can be used as part of the appraisal process
- Assessment of 16 competencies in areas of clinical care, maintaining good medical practice, teaching and relationships with colleagues and patients
- 12 raters from consultant, trainees, nursing and other healthcare professionals including clinical/educational supervisor.

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Appraisal

1. Current job plan
2. Assessment
   a. Assessment of clinical experience (eg CBD, miniCEX)
   b. Operative Competence (eg DOPS)
   c. Operative experience (eg logbook)
   d. Teamwork, professionalism, patient feedback (eg MSF)
3. CPD
4. Research/Audit
5. Teaching
6. Significant Events/Critical Incident Review
7. Personal Development Plan
8. Named Clinical/Educational Supervisor

Non Medical Workforce and Role in Surgical Training

- 52% had worked with non-medical practitioners (NMPs)
- 72% reported that NMW could improve surgical delivery
- 65% felt NMW could take training opportunities away from trainees
- 46% reported NMW could enhance surgical training

(ASIT 2015)

The Faculty of Perioperative Care

The Royal College of Surgeons of Edinburgh (RCSEd) established the Faculty of Perioperative Care in recognition of the evolving and increasingly important role that Surgical Care Practitioners and Surgical First Assistants play as part of the wider surgical team in delivering safe, surgical care to patients.

Membership

Membership to the Faculty of Perioperative Care (FPC) is open to all perioperative practitioners, including Surgical Care Practitioners (SCPs), Surgical First Assistants (SFAs), and those with similar job titles, e.g. Physician Assistants.

Join the Faculty today & shape its future

Membership to the Faculty is initially open with an introductory Affiliate membership rate.

This inaugural period is a key opportunity for practitioners to express the challenges and requirements of today's practitioners and to help shape and develop the future of the Faculty.

The affiliate subscription rate to join the Faculty is £50 (discounted rates are available for AAPP members and trainees).

fpc.rcsed.ac.uk

FACULTY OF PERIOPERATIVE CARE
THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

REGISTERED CHARITY NO. SC006317

The Faculty of Perioperative Care

Membership Benefits include:

- Certificate of RCSEd Faculty of Preoperative Care affiliation for your portfolio
- Discounted fees on relevent courses and events
- Access to networking events with surgeons and professionals in your field
- Professional support
- Access to Acland Anatomy - a versatile online educational, anatomy resource
- Quarterly copies of the College's award-winning publication Surgeons' News to which you can contribute
- Regular e-newsletters
- Personal library services using our well-resourced medical and surgical library, with the latest in texts, journals and electronic resources
- Discounted accommodation at the College's Ten Hill Place Hotel
- Discounted rates on meetings, events and celebrations at the College's venues, as well as discounted rates on food and beverage in all College restaurants and cafes

To find out more visit fpc.rcsed.ac.uk. or email fpc@rcsed.ac.uk

Full Membership

Requirements	Evidence
Knowledge	- MSc in Surgical Care Practice or relevant postgraduate diploma - Evidence of education or training role
Technical Skills	- Completion of a surgical skills course within the past five years - An up-to-date logbook of operative activity
Non-technical Skills	- Completion of a non-technical skills course
Leadership and Development	- Completion of a Leadership and Development course - Evidence of leadership role in the workplace
Audit / Research	- Demonstration of significant involvement in either: 1) An audit project which has been shown to change the working practice in the department / theatre complex of the hospital or 2) A research or audit project which has resulted in a peer reviewed paper published in an indexed journal and / or a presentation at a regional, national or international meeting.

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For more information on Medical Associate Professions and the benefits of having them in the team, please visit:

www.nhsemployers.org/maps

DEPLOYING MEDICAL ASSOCIATE PROFESSIONS

What do we know about deploying MAPs in NHS services to date?

Key benefits to service and patients from effective deployment of the roles?

Email : v.drennan@sgul.kingston.ac.uk

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Disclaimer : These projects received HEE, NHS and NIHR funding .
The views and opinions expressed are those of the researchers and not necessarily reflect those of the HEE , the NIHR, NHS or the Department of Health

This presentation uses evidence from:

- HEE Feasibility study of the implementation and impact of the 4 medical associates professions – ACCP, PA(A), PA and SCP (2016-2018)
  - Scoping review
  - Charting of employment and education of MAPs
  - Perspectives from patient organisations, from trust senior clinicians and managers
  - Perspectives from those providing training and in training for other professional groups.
- Two NIHR studies on the contribution of PAs (general practice & acute care)
- NHS study of the contribution of experienced US in acute care.

MAPs – the spread in England

https://www.healthcareers.nhs.uk/explore-roles/medical-associate-professions

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Advanced Critical Care Practitioner courses: HEI Providers

Source University websites. Courses meeting FICM requirements June 2017

NHS Trusts Employing Advanced Critical Care Practitioners or trainee ACCPs

Source https://www.ficm.ac.uk/unit-information (Accessed June
updated March 2018 from FICM)

- 23% critical care units were employing 93 ACCPs with 114 in training posts in Dec 2017.

Source Critical Care Network Lead Nurses National Critical Care Nursing and Outreach Workforce Survey April 2018 http://cc3n.org.uk/

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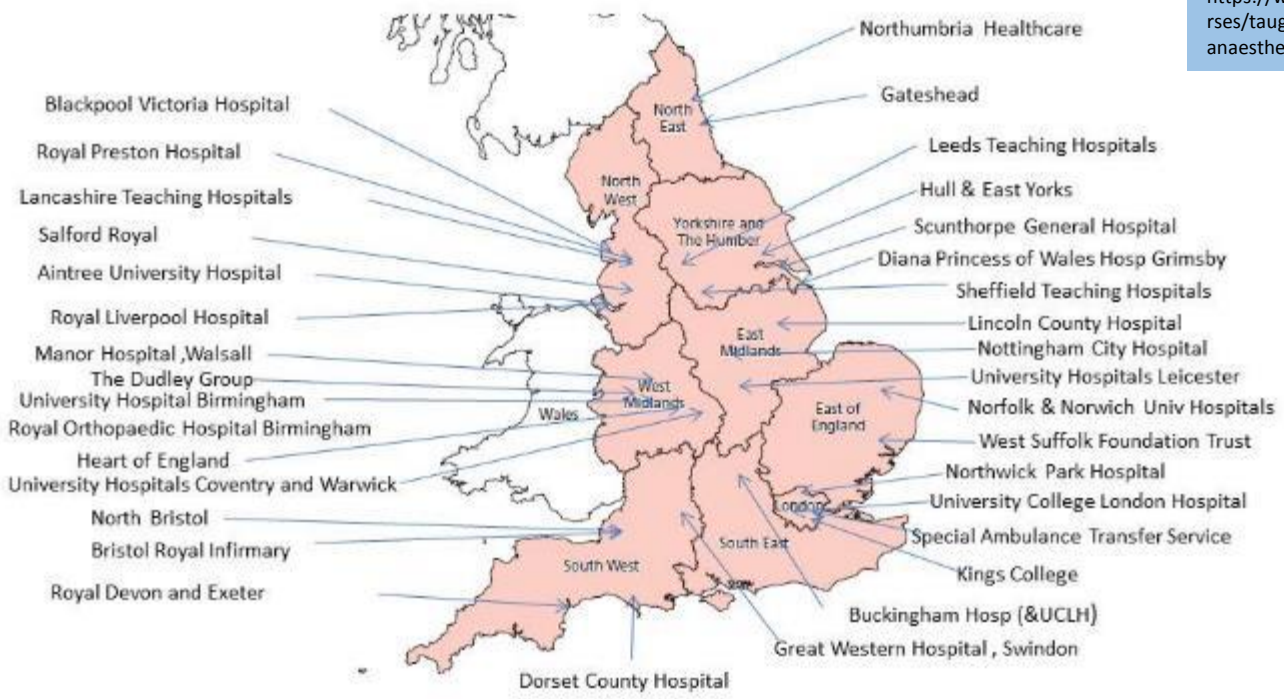
NHS Trusts in England Employing Physicians' Assistants (Anaesthesia)

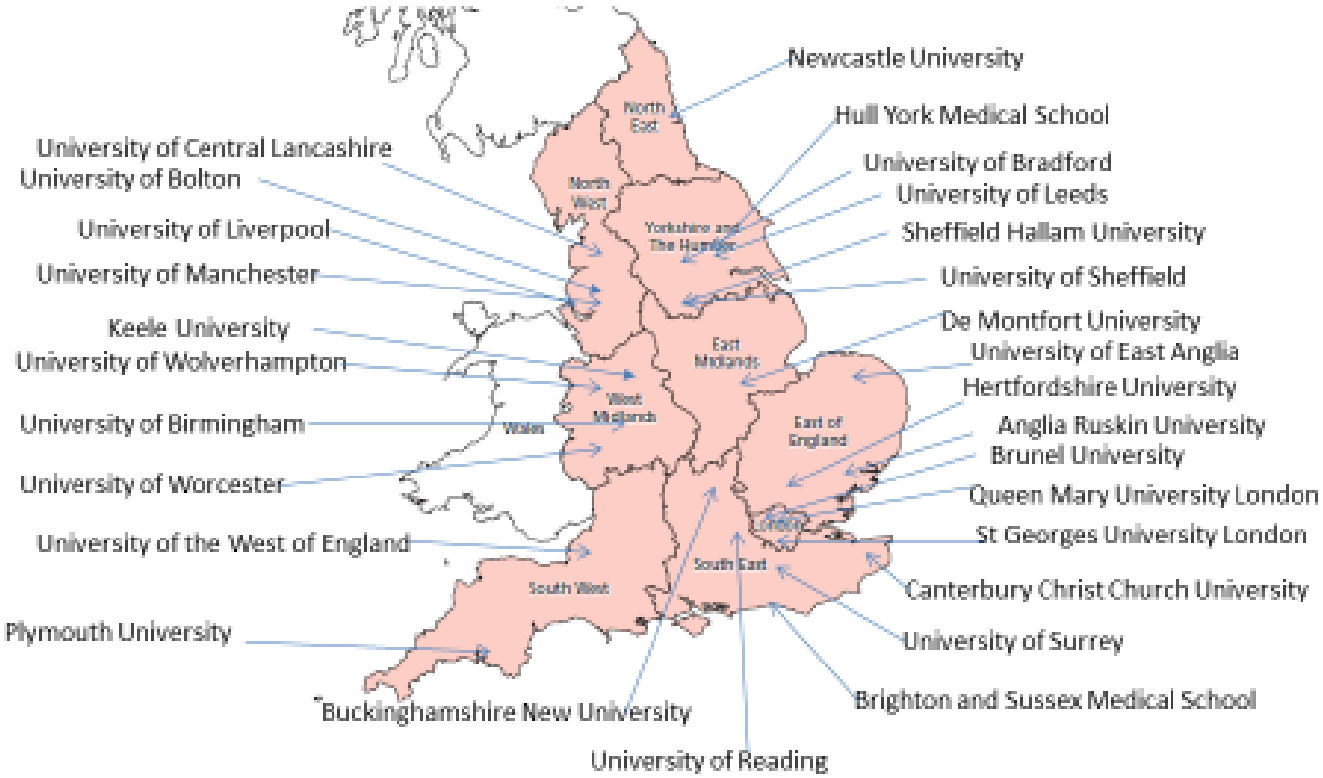


Sources: Association of Physician Assistants Anaesthesia at http://www.anaesthesiateam.com/organisation-info/employers/ and Royal College of Anaesthetists Physicians' Assistant (Anaesthesia) Register at https://www.rcoa.ac.uk/document-store/physicians-assistant-anaesthesia-register

1 distance learning course at the University of Birmingham
https://www.birmingham.ac.uk/postgraduate/courses/taught/med/physicians-assistant-anaesthesia.aspx#LearningAndTeachingTab

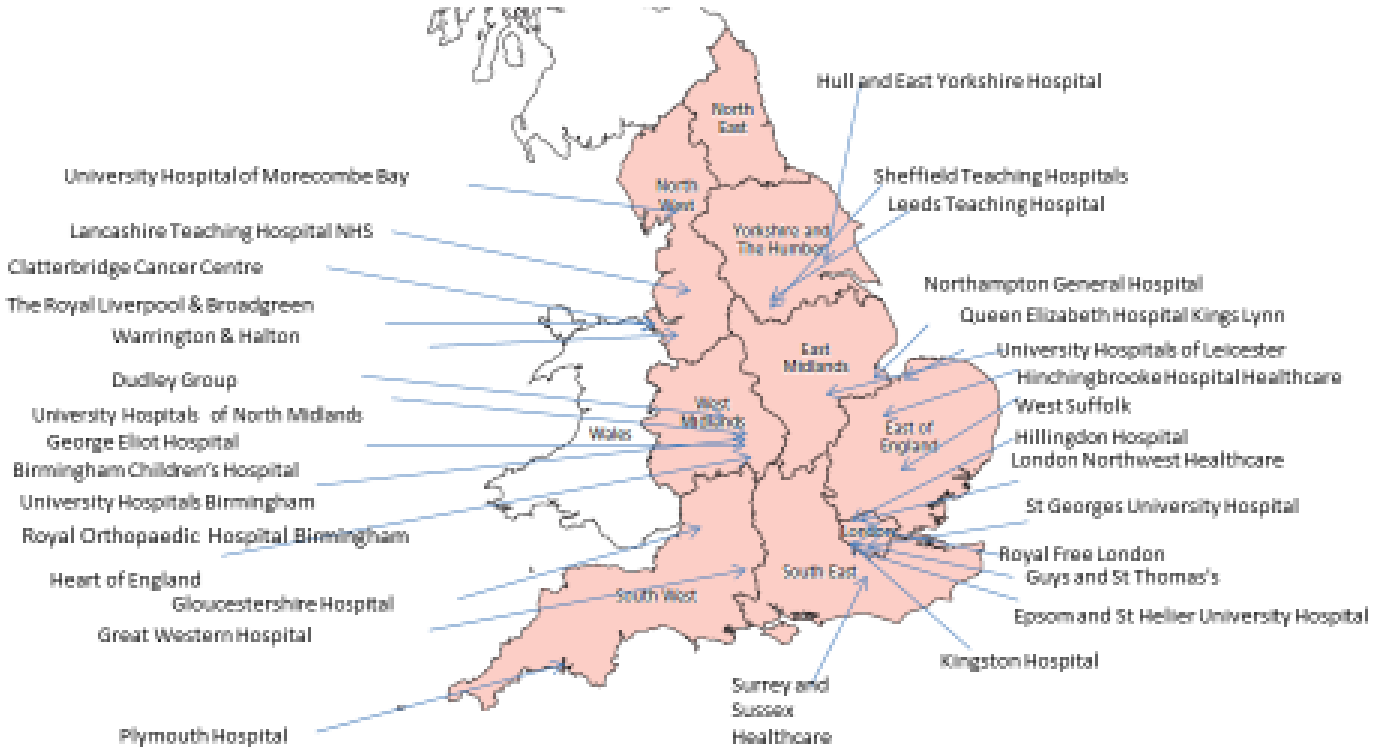
115 PA(As) on the voluntary managed register held by RCOA Training Department (September 2018) https://www.rcoa.ac.uk/document-store/physicians-assistant-anaesthesia-register

HEIs providing Physician Associate courses



Source Faculty of United Kingdom and Ireland Universities Board for Physician Associate Education (UKIUBPAE) & Faculty of Physician Associates

NHS Trusts employing Physician Associates in England 2017



Estimated 450 PAs and up to 1,200 PA students in UK in 2017

Source Faculty of Physician Associates 2017 Census http://www.fparcp.co.uk/about-fpa/fpa-census

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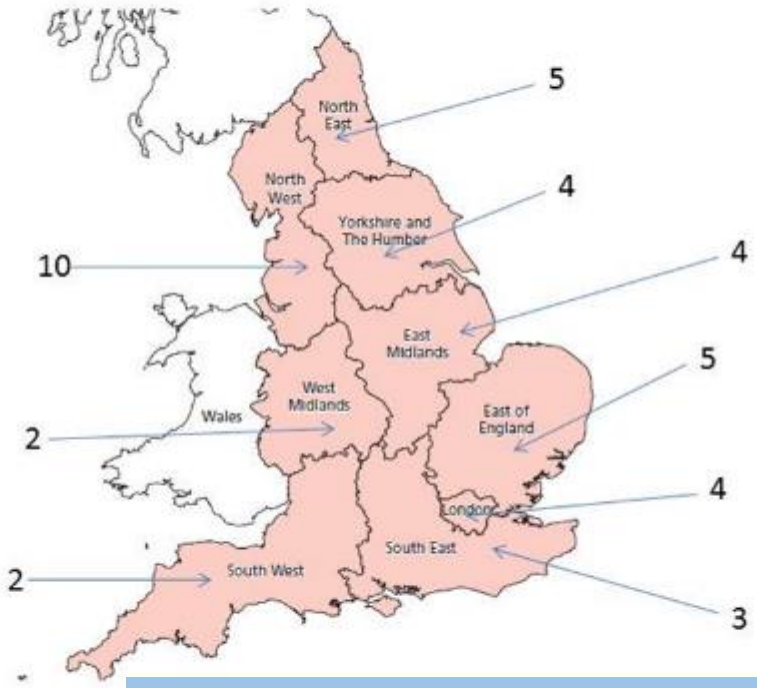
HEIs with Surgical Care Practitioner Course

Sources Royal College of Surgeons https://www.rcseng.ac.uk/education-and-exams/accreditation/surgical-care-practitioner/

NHS Trusts Employing qualified or trainee Surgical Care Practitioners



Source Websites and University Course D

Estimates of 200 SCPs in the UK .
SCPs are known to be working in the these specialities : orthopaedics , cardiothoracic, general surgery, minimal access robotics (urology) , plastic surgery and gynaecology .
(Source HEI course directors in England)

MAPs – the evidence in primary care in England

https://www.healthcareers.nhs.uk/explore-roles/medical-associate-professions

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NIHR research - PAs in primary care in England

- Deployed mainly to provide same day/urgent consultations
- Some PAs were developed to undertake specific procedures in response to the practice need e.g. insulin initiation, LARC insertion, warfarin bridging,
- Acceptable to patients – provided they know they have choice in who they consult

Drennan VM et al. Physician associates and GPs in primary care: a comparison. Br J Gen Pract. 2015 May;65(634):e344-50. doi: 10.3399/bjgp15X684877.

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Comparative, adjusted, analysis of 2086 anonymised patient records consulting PAs and GPs in 12 practices:

- There were no significant differences in the rates of unplanned re-consultation (rate ratio 1.24, 95% confidence interval [CI] = 0.86 to 1.79, P = 0.25).
- There were no differences in rates of
  - diagnostic tests ordered (1.08, 95% CI = 0.89 to 1.30, P = 0.44),
  - referrals (0.95, 95% CI = 0.63 to 1.43, P = 0.80),
  - prescriptions issued (1.16, 95% CI = 0.87 to 1.53, P = 0.31),
  - or patient satisfaction (1.00, 95% CI = 0.42 to 2.36, P = 0.99).
- Records of consultations of 79.2% (n = 145) of PAs and 48.3% (n = 99) of GPs were judged appropriate by independent GP reviewers (P<0.001).
- The adjusted average PA consultation was 5.8 minutes longer than the GP consultation (95% CI = 2.46 to 7.1; P<0.001) and cost per consultation was GBP £6.22, lower (95% CI = -7.61 to -2.46, P<0.001).

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MAPs in secondary care

https://www.healthcareers.nhs.uk/explore-roles/medical-associate-professions

MAPs in secondary care : cross cutting themes in the evidence:

- Rationale for employing
- Patient safety and patient experience
- Advantages to the medical/surgical team and service
- Advantages and experiences of doctors and other professionals in training
- Cost benefit analysis
- Challenges and processes in innovation in the workforce.

Source https://unsplash.com/

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Rationale for employing MAPs

- Shortage of junior doctors – both as currently experienced but also predicted,
- Increasing patient /service demands and how best to meet , or enhance productivity , given medical and other workforce shortages,
- Deanery concerns about the quality of the training of junior doctors i.e. service demands impeding training
- Concerns about the quality of care and the patient experience

Source https://unsplash.com/

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Patient safety

"Our PA(A)s work predominantly in trauma and orthopaedics, day surgery and colorectal theatres, supervised by consultants in a 1 to 1 or 2 to 1 ratio. They do not work weekends or nights, and presently do not have prescribing privileges. The PA(A)s appear to have settled down well since their appointment more than a year ago. Reassuringly, there have been no patient safety issues, nor have their individual competencies been the subject of particular concern."

Dr Krish Ramachandran , Chair, RCoA Equivalence Committee, RCoA Council Member writing in RCoA Bulletin September 2018

Patient safety and experience

Source https://unsplash.com/

"I just think we have found - which is I think a difference in these groups than medics, these people (MAPs) follow protocols and it's very rarely that they will not do the whole job according to what they're supposed to do ." Interview 6 trust with SCPs, PAs, ACCPs

" So we've looked a things like critical incidents involving ACCPs and we haven't had any . We've done audits like for airway management and there are no differences between the ACCPs and the junior doctors " interview 4 , trust with ACCPs, PAs and PA(A)s

"PAs providing ward cover – this has increased the support to our junior doctors and nurses, increasing the safety of our wards. Patients are seen more regularly, and issues are proactively escalated to senior reg. or consultant level in a timely fashion." NIHR PA research interview with clinical manager

"No, no patient safety issues , no patient complaints – in fact we get compliments about the PAs – the patients love them " NIHR PA research interview with operational manager

Advantages to the medical/surgical team & service

Source https://unsplash.com/

- Continuity in the team:
  - Knowledge of the working practices and the hospital,
  - Knowledge of the consultant(s) preferences/ways of working ,
  - Knowledge of the patients, relatives, history and status ,
  - Knowledge of the management plan and status for individual patients.
- Assisting in patient flow (in, during and discharge from hospital)
- Releasing doctors' time
- Inducting doctors' new to the team

Releasing doctors' time and supporting productivity

Source https://unsplash.com/

Employing SCPs "allows us to be more efficient and productive in the operating theatres, and to release consultant time up from doing some of the less complex procedures and more minor procedures. " interview 6 trust with SCPs and ACCPs

"So physician assistants in anaesthesia, they do operating lists - around day surgery, in particular, which otherwise we would probably have staffed with consultants these days, so that's probably having an impact in anaesthesia in terms of, if you like, increased productivity we wouldn't have been able to achieve otherwise." Interview 3 trust with PA(A)s and ACCPs

"*PAs have a positive impact in staffing follow up clinics – this allows our consultants to see a higher number of new patients, generating a higher tariff and reducing patient wait times. Follow up capacity is also increased*." NIHR PA research interview of operational manager

Advantages and experiences of doctors in training ,


Source https://unsplash.com/

- Junior doctors:
  - Induction
  - Reducing the workload
  - Reducing the stress
  - Training
  - Caveats

"the SCPs I have worked with are excellent and valuable teammates. They have gone through basic surgical skills and helped me enhance these. Additionally, they always ensure I have priority in training and sometimes even convince my supervisors to give me additional training opportunities. I am very pleased to work with an excellent team of SCPs." Junior doctor quote from the feasibility study survey

"*Having the PAs frees me up because as trainees we like to go to clinics*." Foundation year doctor in NIHR PA research

Input to training of junior doctors

Source https://unsplash.com/

"she (SCP) does independent operating hernias, she does laparoscopic cholecystectomy , and she actually trains the junior doctors" interview 4 Trust with SCPs and PAs.

"they (ACCPs) play a really big part in training of junior doctors in the critical care unit now, ….. , they (junior doctors) get a lot more input into their training……. for the unit that I work in, deanery reports over the past few years have shown an increase in positive feedback in the [ACCP] role." interview 7 Trust with ACCPs, SCPs, PAs

" and the PA(A)s help teach the junior doctors peripheral and central line insertion" interview 3 Trust with PA(As) and ACCPs

" and so we've trained that PA in lumbar punctures and now she is very skilled and she helps teach the junior doctors " Interview from NPAEP programme evaluation

Case example of deployment to reduce junior doctor stress

"We have a weekly survey here, which we're really lucky about, that my director of medical education has set up. All the FY1s and all the FY2s are asked to complete a form every week to tell us if there is a problem. The metric we've got is that when we've had areas that we knew were high pressure, as soon as we've persuaded the divisions to put in physicians' associates and they're in place, those reports of less-than-good-quality experience have just disappeared.

We've got objective evidence of the improved experience of the trainees when we've put in the support; it sort of becomes obvious, really. If you've got more people to help you, it works better.

Also as I said, the positive thing that they've [FY1 & FY2 s] *said about having a PA with them goes beyond that. We've got objective evidence; there are hotspots where we know workload is high, the experience for the trainees is less than optimal. We've put physicians' associates in and the weekly reporting are dramatically improved. "* Interview 8 Trust with PAs and SCPs

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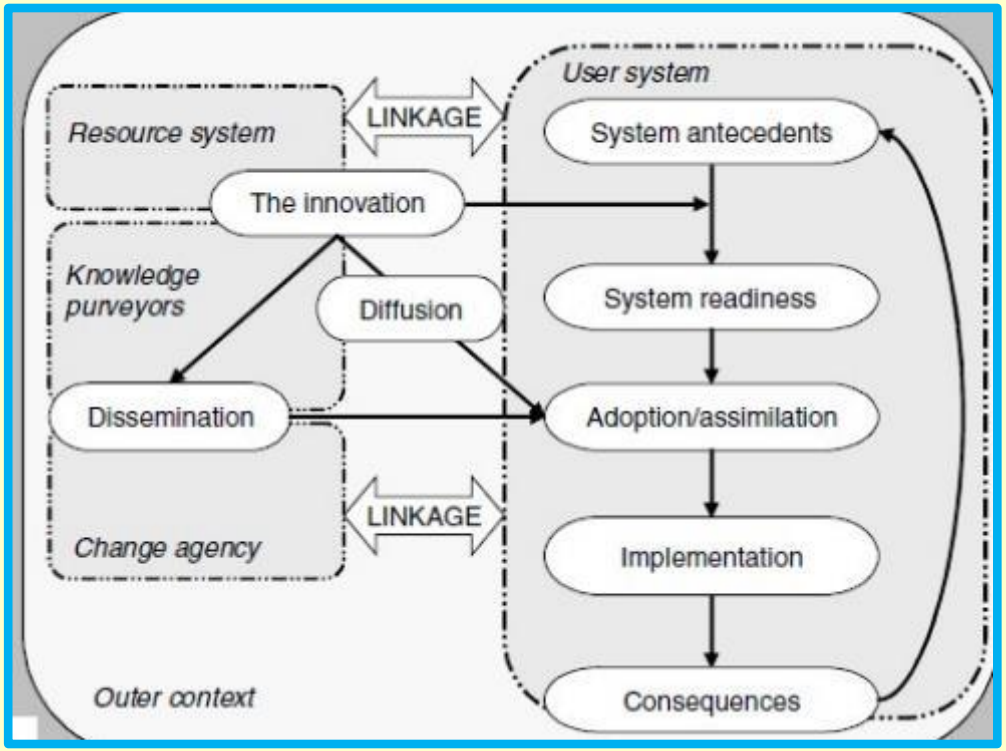
Experiences and other professionals in training

Source https://unsplash.com/

- We surveyed faculty staff for nursing and AHP course asking about any impact on professionals in training e.g. Operating department practitioners
- Overall view that MAPs support other types of students in their learning and induction

"All the MAPs I have worked with benefit the overall learning experience for students from all disciplines. For example they support medical students as well as ODP and nursing students. They also provide a good opportunity for nursing and ODP students to learn about other career pathways into advanced practice." survey AHP & Nursing Faculty respondent 20

Diffusion of innovation: innovation in workforce



Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: systematic review and recommendations. The Milbank Quarterly, 82 (4), 581-629. doi:10.1111/j.0887-378X.2004.00325.x.

Innovation, adoption and diffusion processes

"When our first PA started, clearly as doctors we weren't entirely sure, I think a lot of us, what PAs could or could not do. And I think we've realised how competent our PAs are and how trustworthy. It's been, you know, a revelation, we've been able to give them more and more jobs to do."

consultant interviewee NIHR PA research

Source https://unsplash.com/

Cost – benefit analysis

Source https://unsplash.com/

- MAPs are one part of complex system of delivering care – very hard to separate out the impact/cost of one element
- The only UK health economics evidence is from primary care research on PAs
- Many secondary care managers have told us their business cases were linked to the control on locum spending
- However , many managers and senior clinicians talked about benefits in terms of patient safety, patient experience, staff experience, wider productivity and patient flow gains rather than just financial considerations.

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Exemplar of cost –benefit –risk analysis

Source https://unsplash.com/

"I think, for example, I wouldn't be able to say anything about patient outcomes, and I'm not sure whether we'll ever be able to identify anything that linked [employment of MAPs] directly to patient outcomes.

I think we can talk about mitigation of risk. So for example, the critical care department, the fact that we've got two advanced critical care practitioners who now are on the rota for the junior doctors, so that's filling what might otherwise have been two gaps on that rota, which we might otherwise have had to fill either by expenditure on locums or agency staffing, or alternatively we might have just had gaps.

If you spend money on a locum then that's financial risk, obviously. If you've got a gap on the rota, then that's starting to become a real clinical risk. "

Interview with medical director in trust with ACCPs, PA(A)s

This presentation:

- Deployment MAPs in NHS services to date
- Key benefits to service and patients from effective deployment of the roles
- Evidence of PAs in primary care
- Cross cutting themes in MAPS secondary care evidence
  - Rationale for employing
  - Patient safety and patient experience
  - Advantages to the medical/surgical team and service
  - Advantages and experiences of doctors and other professionals in training
  - Cost benefit analysis
  - Challenges and processes in innovation in the workforce.

Source https://unsplash.com/

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Thank you - questions ?

Observations ?

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For more information on Medical Associate Professions and the benefits of having them in the team, please visit:

www.nhsemployers.org/maps

Health Education England

Developing MAPs to build multidisciplinary teams across medical specialties

Discussion

- How can you train and deploy these roles in secondary and primary care?
- How could you work in partnership to identify skill gaps which MAPs can fill?
- How do you see these roles developing in 10 years' time?

Health Education England

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