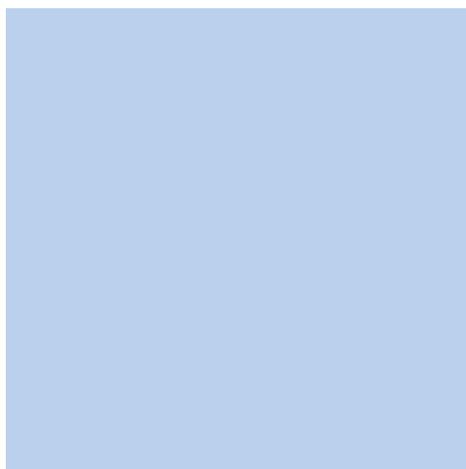


A toolkit to support the planning and introduction of training for Anaesthesia Practitioners



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March 2007

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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 report² 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

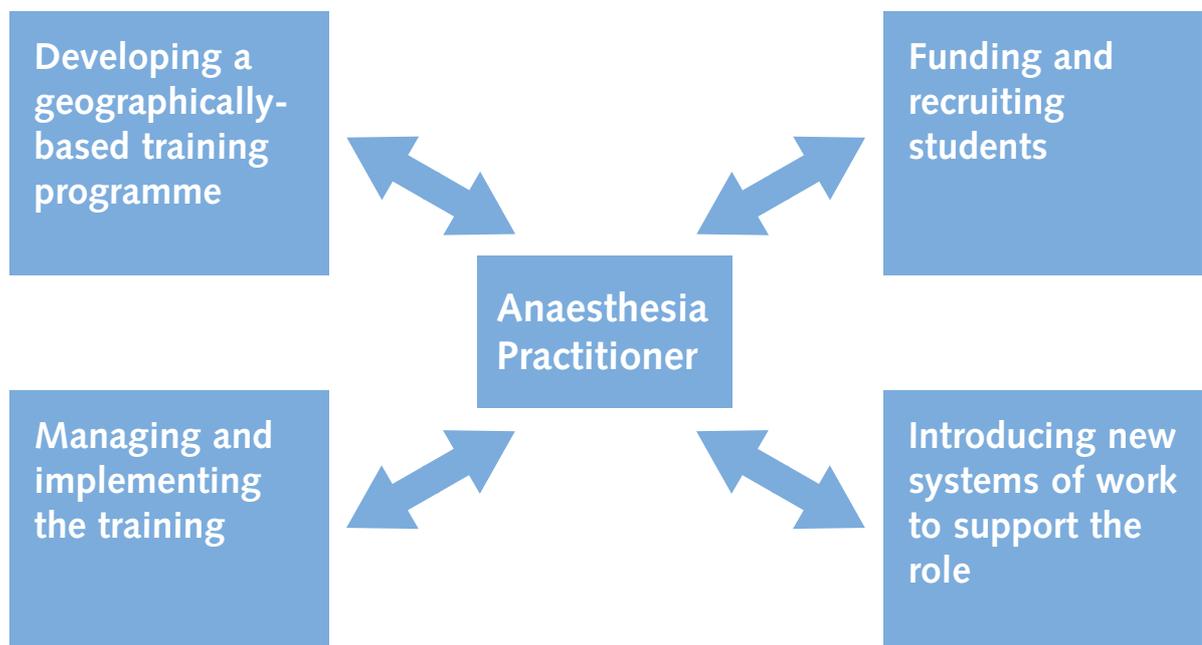
Preparation

- 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

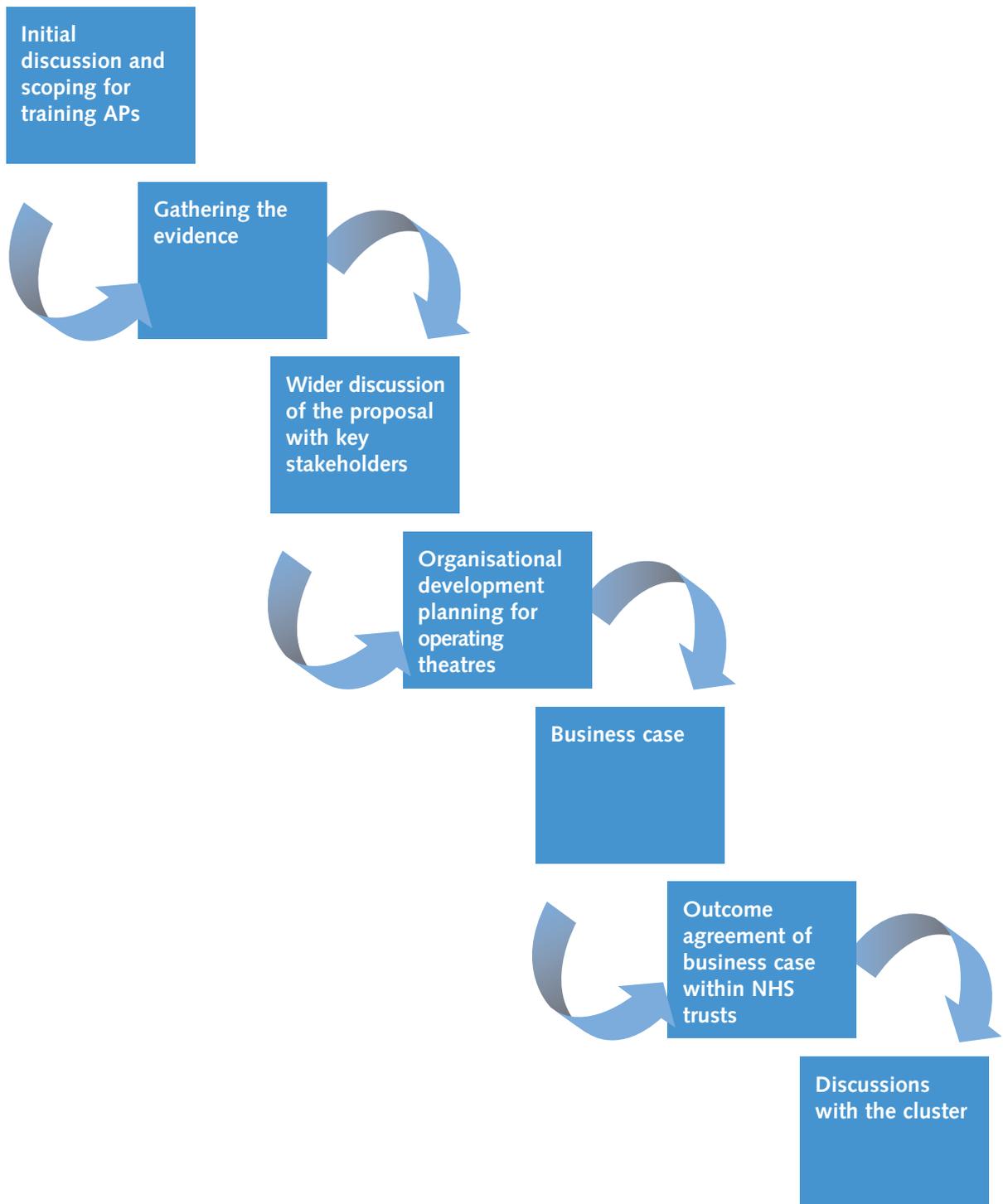
Publications relating to the AP role can be found on the RCoA website at: www.rcoa.ac.uk

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.

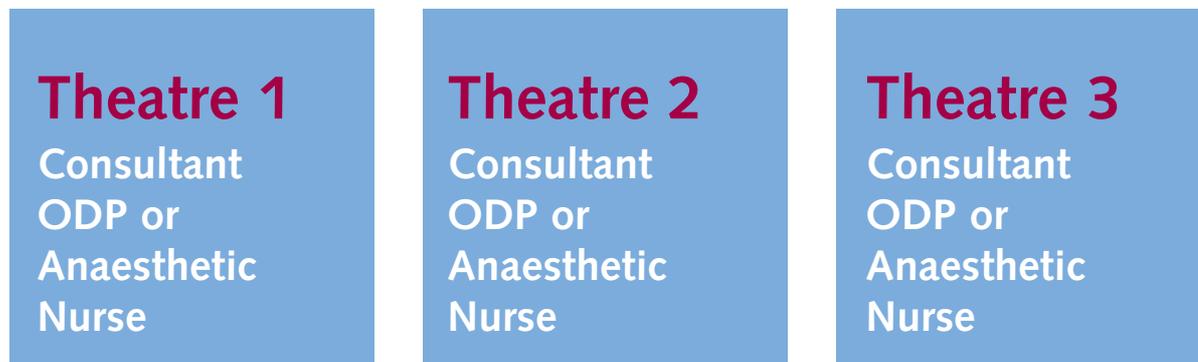
Scope interest in other local trusts in training APs.

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

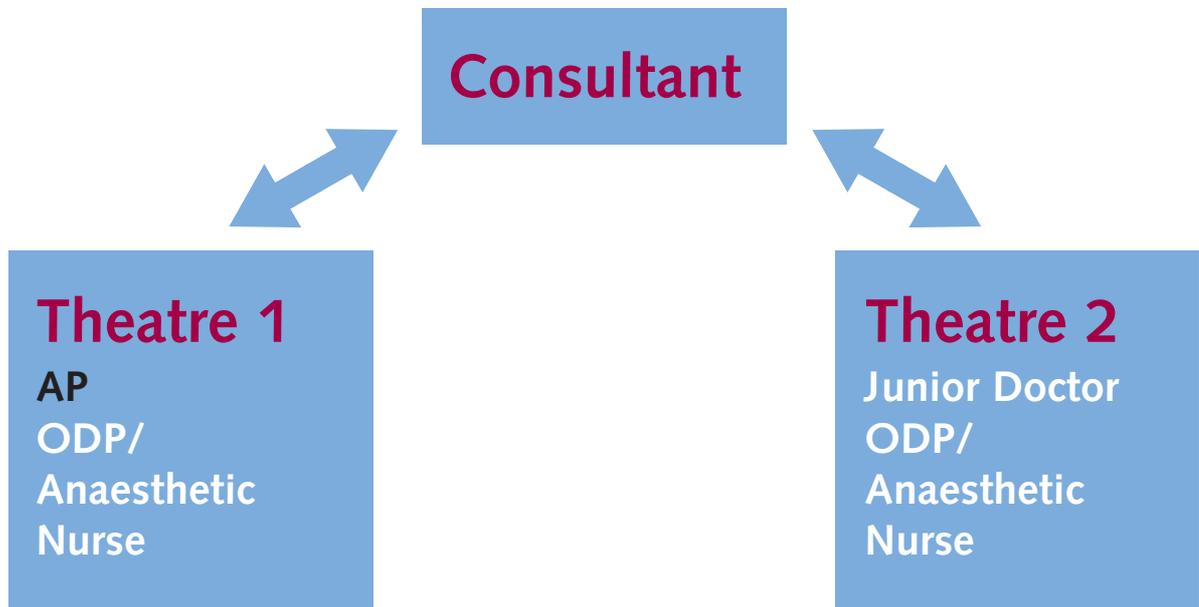
Theatre 1
Consultant
AP
ODP/Anaesthetic
Nurse

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

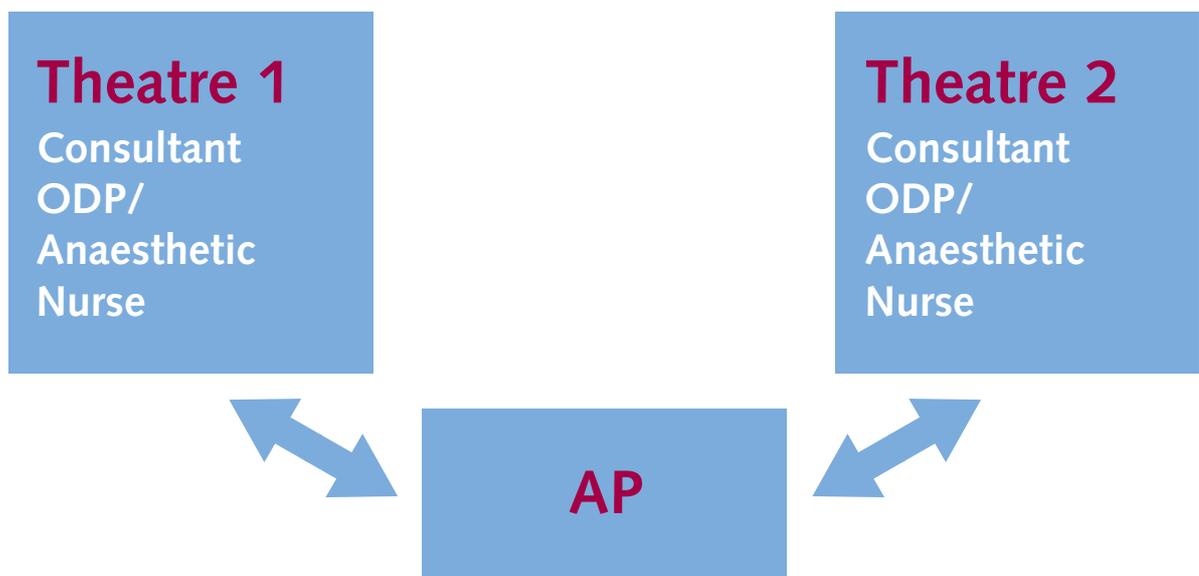
Where adjacent theatre suites are available, the following models of care delivery could be used to allow a two-theatre working model.

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 with 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.

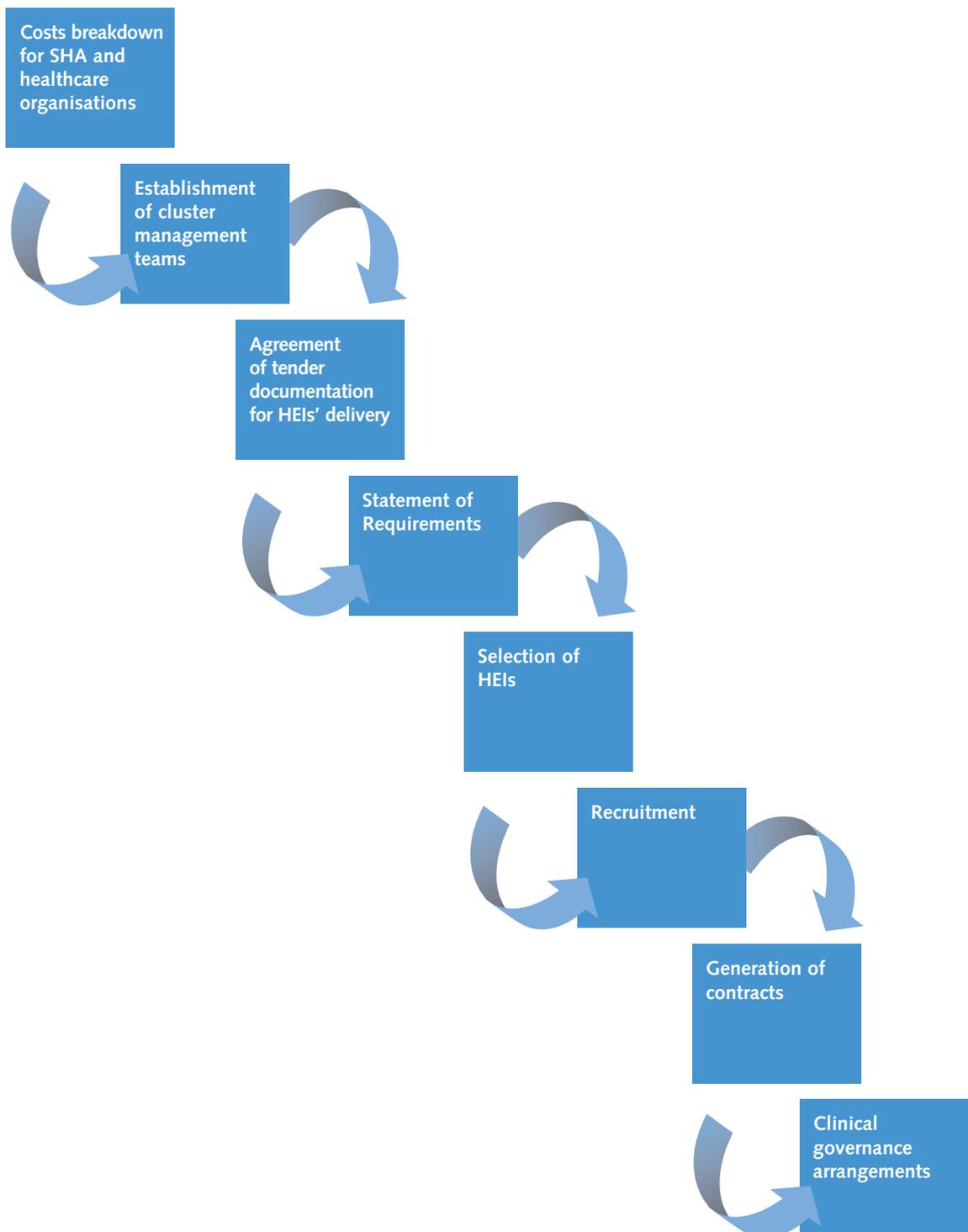
Workforce skill mix

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

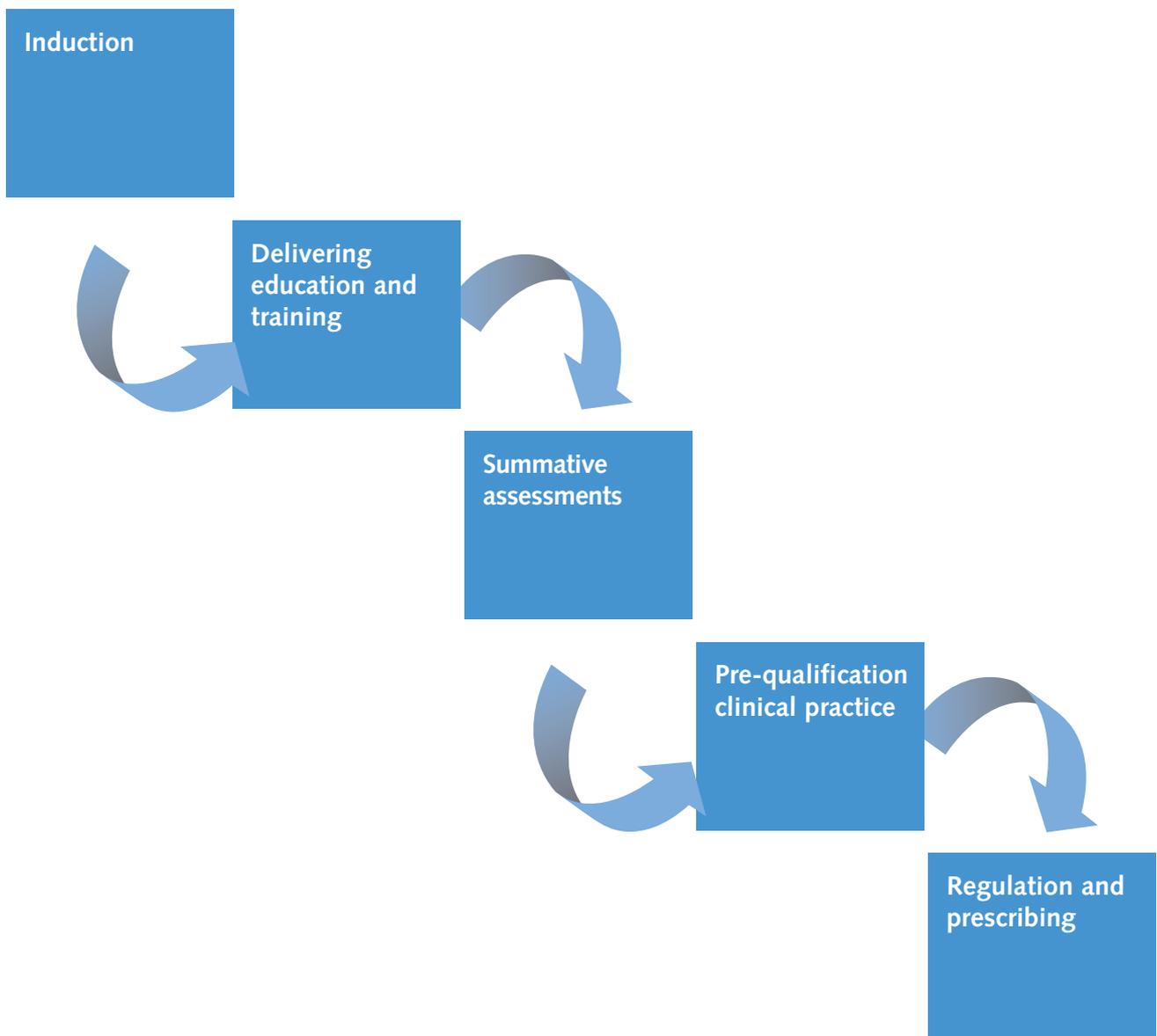
Key Recommendations

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/PublicationPolicyAndGuidance/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 patient⁴ 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.

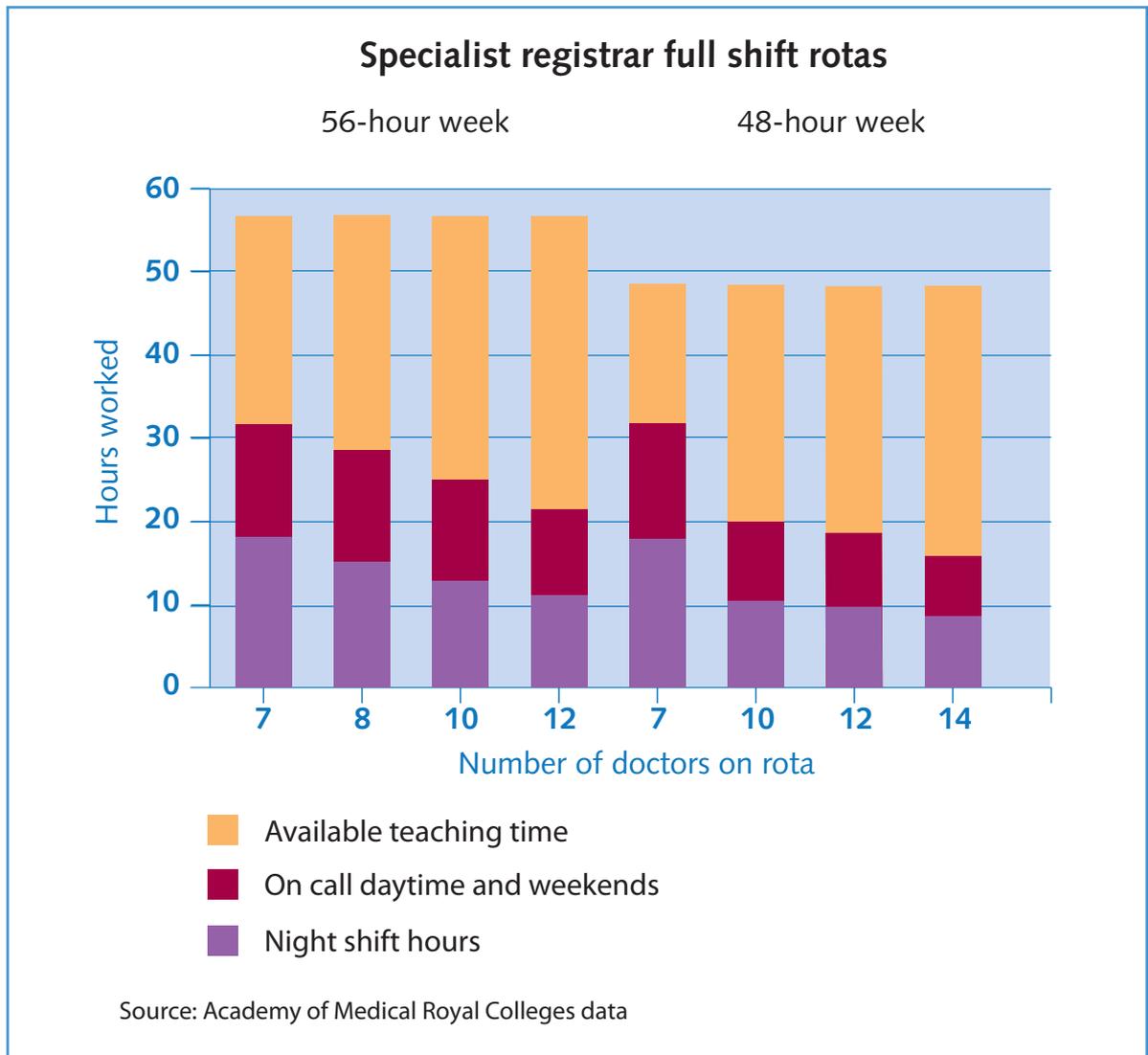
Sourced from the RCoA.

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://rcof.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



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.

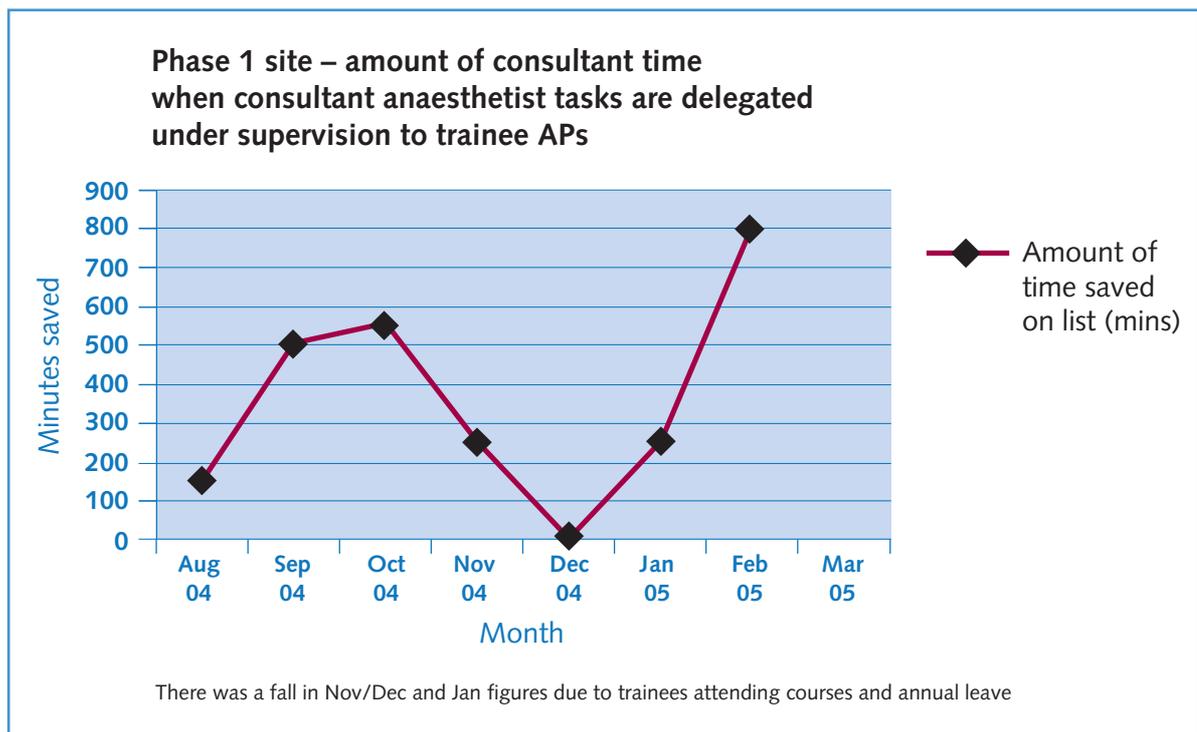
In addition, the resultant cost per operation was reduced, although there were accompanying increases in staff costs.

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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