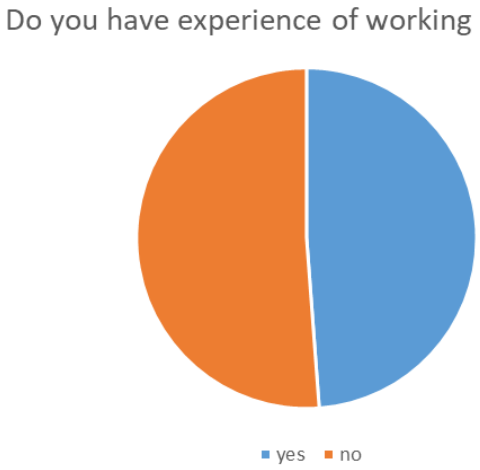
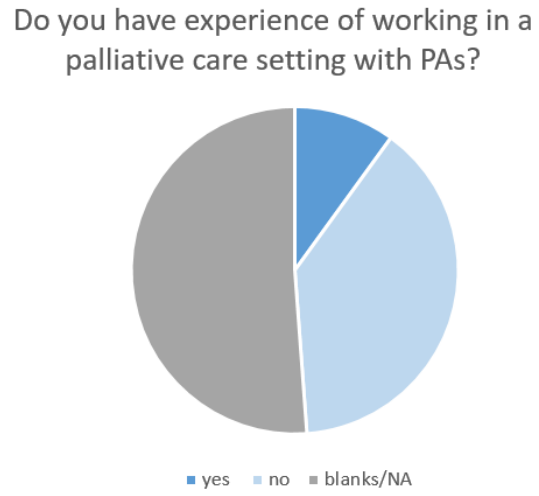
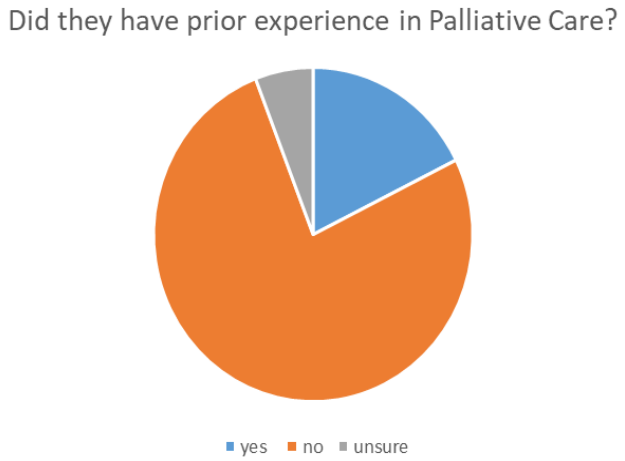
Quantitative data from ACP/PA survey

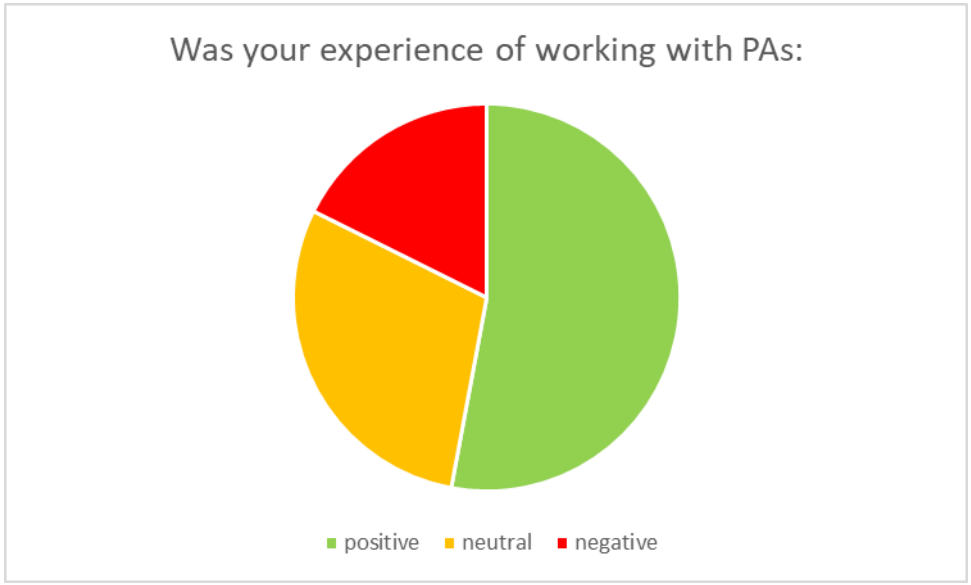
Experience of working with PAs

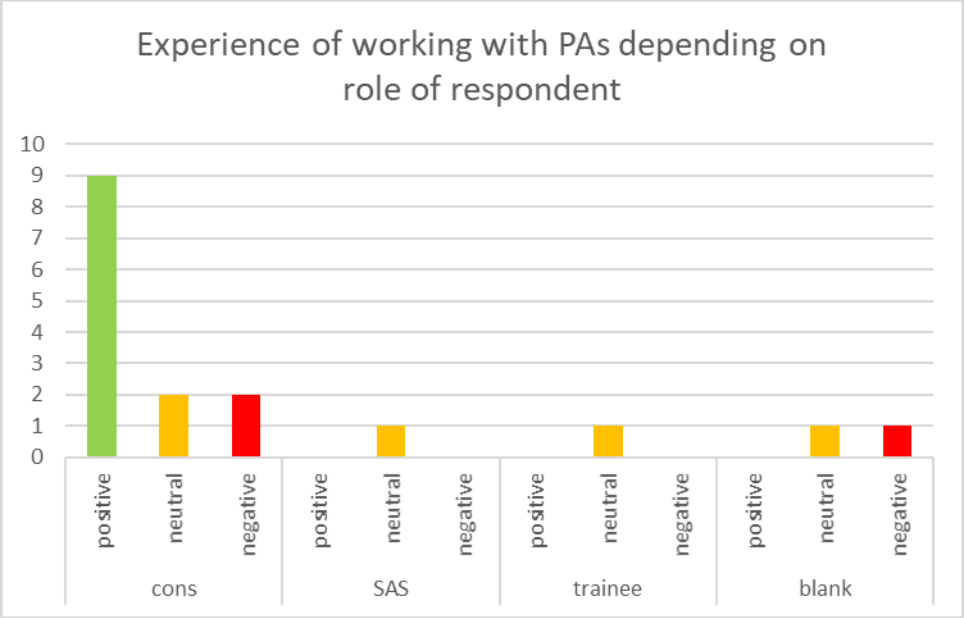


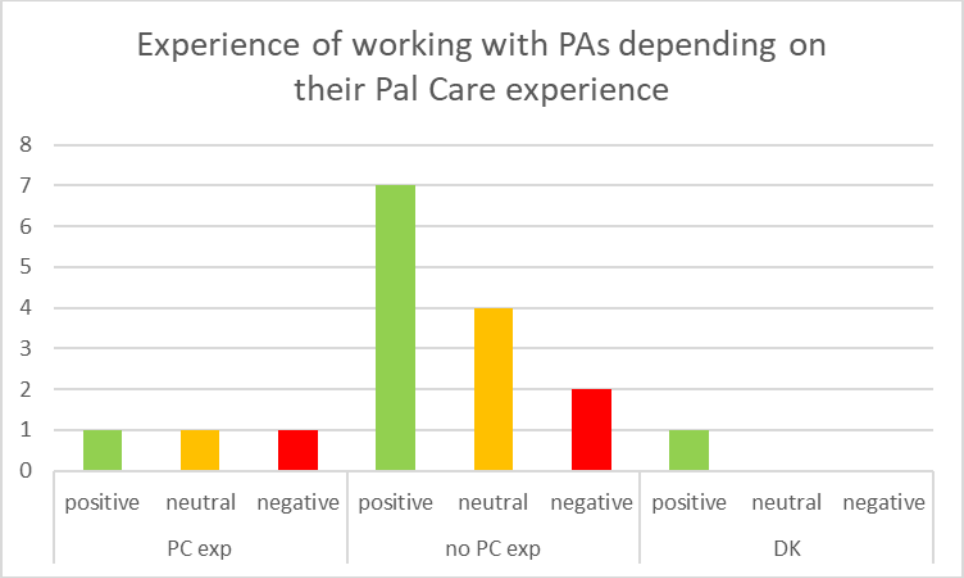
All respondents who answered no to first question left next one blank








Experience of working with PAs depending on role of respondent
10
9
8
7
6
5
4
3
2
1
0
positive
neutral
negative
cons
SAS
trainee
blank


Experience of working with PAs depending on their Pal Care experience
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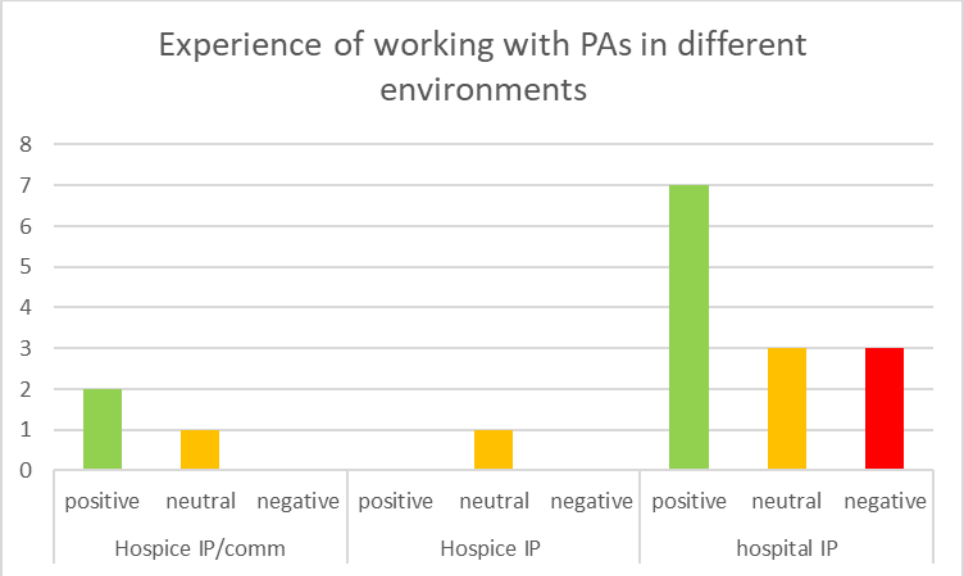
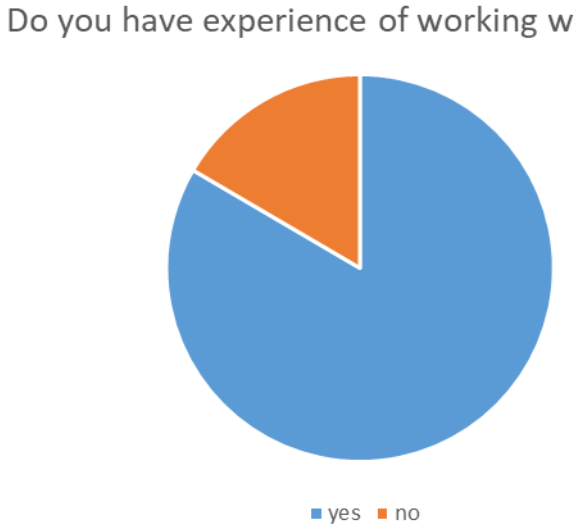
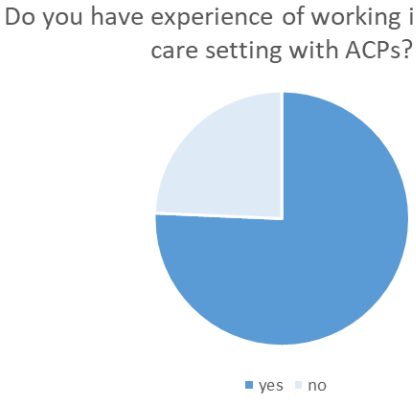
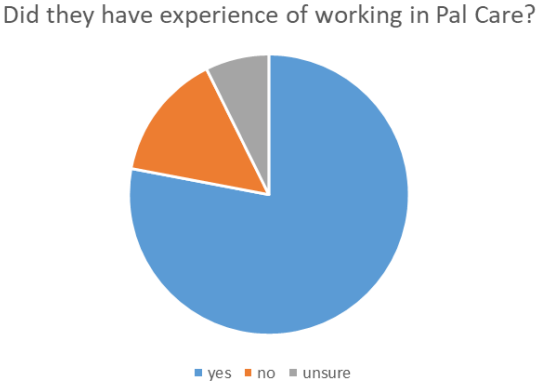
7
6
5
4
3
2
1
0
positive
neutral
negative
PC exp
no PC exp
DK

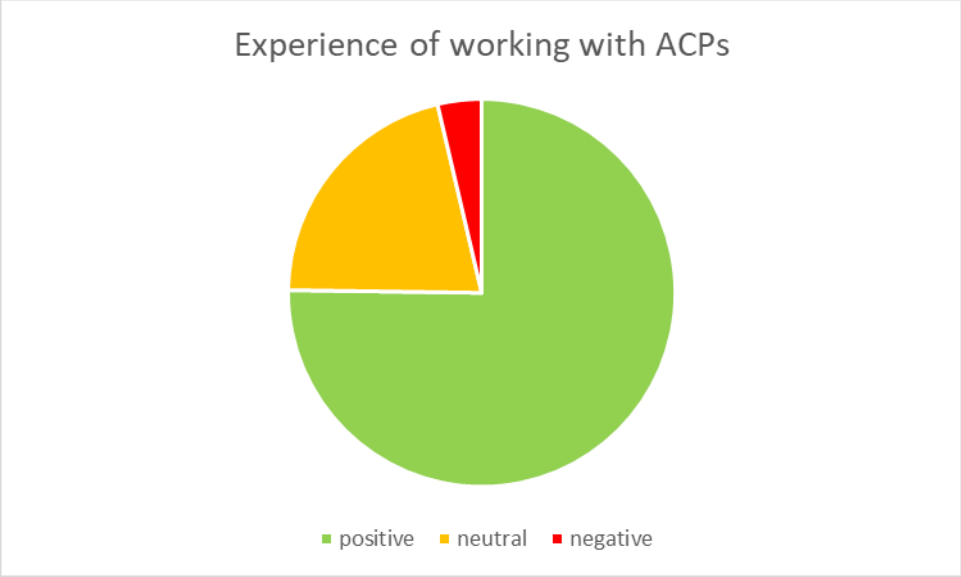

Experience of working with PAs in different environments
8
7
6
5
4
3
2
1
0
positive
neutral
negative
Hospice IP/comm
Hospice IP
hospital IP

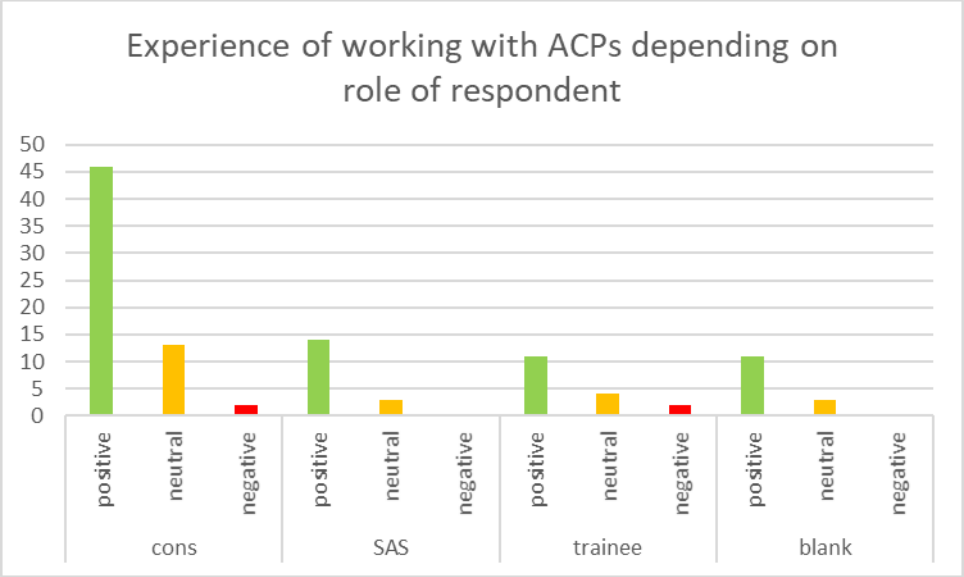
Experience of working with ACPs

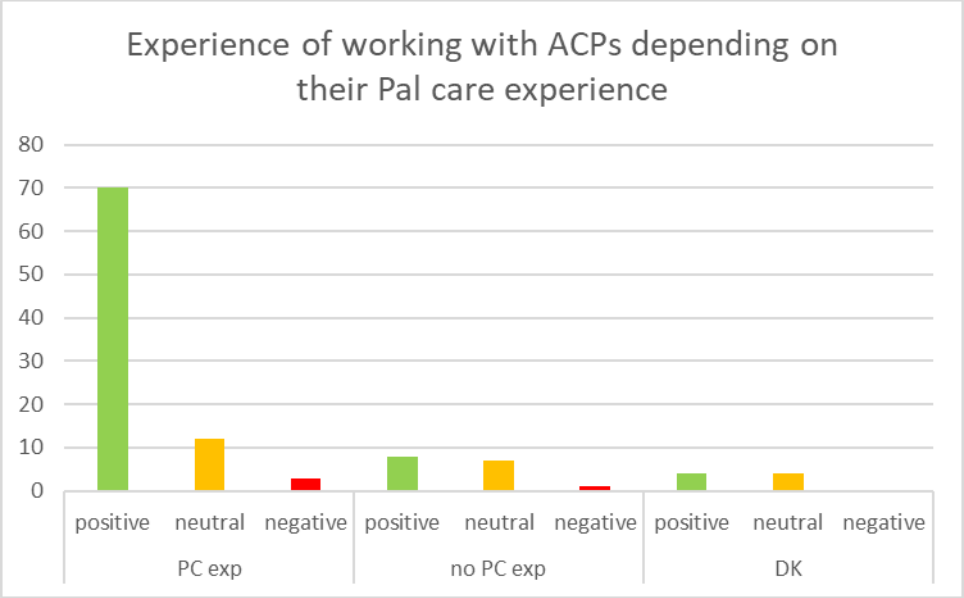


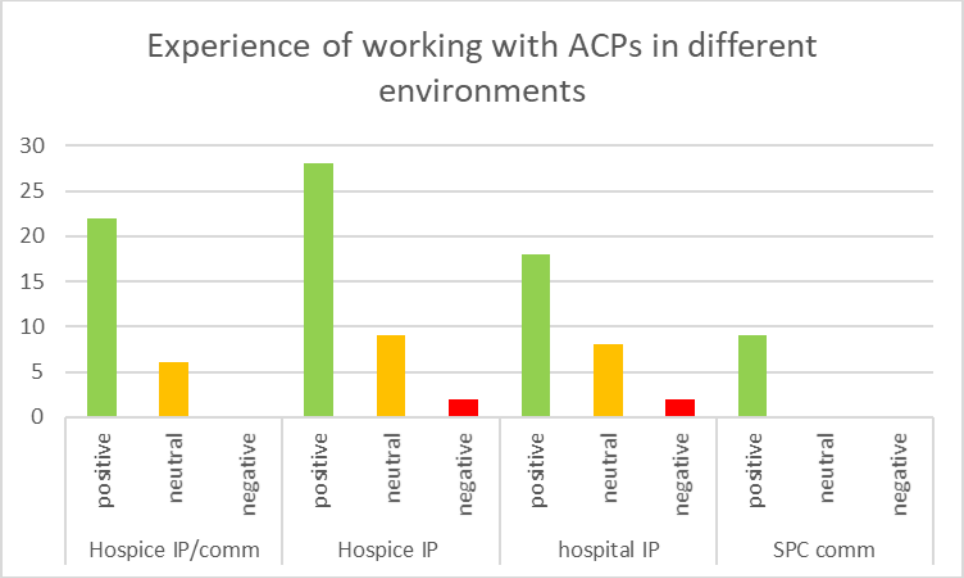






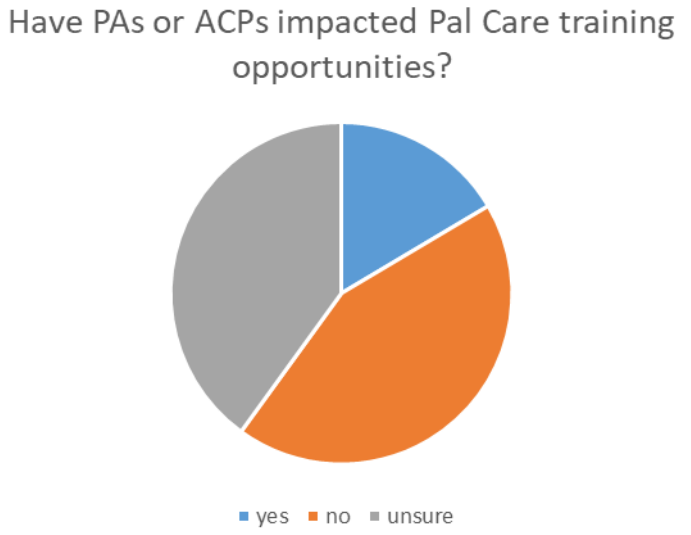


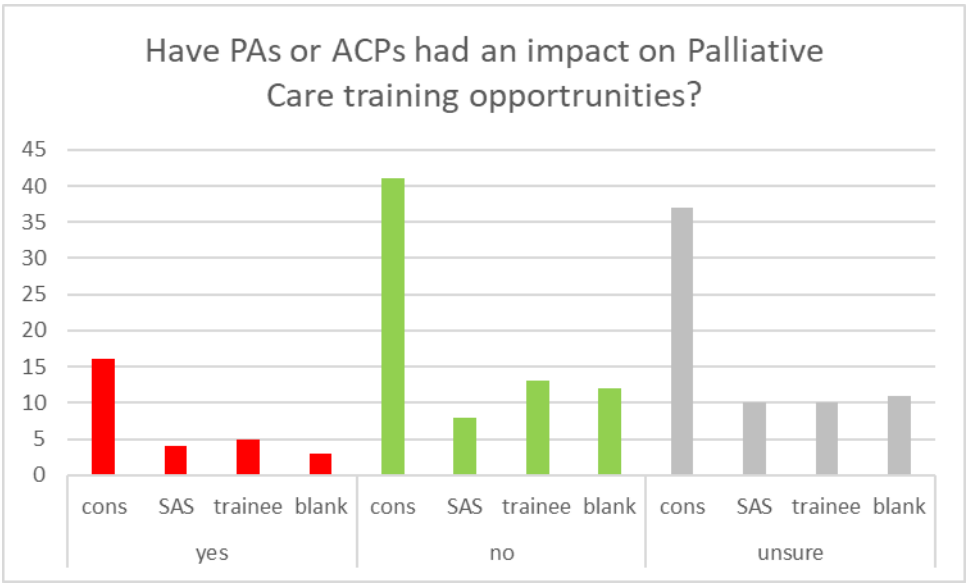


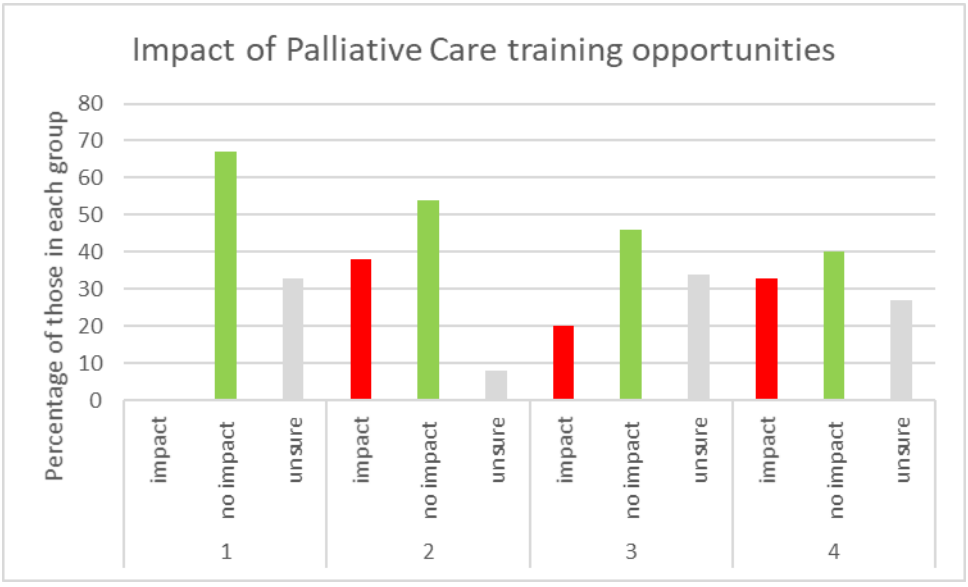


There were also 5 positive responses from respondents who had not completed environment question

Impact of ACPs and PAs on Palliative Care training opportunities





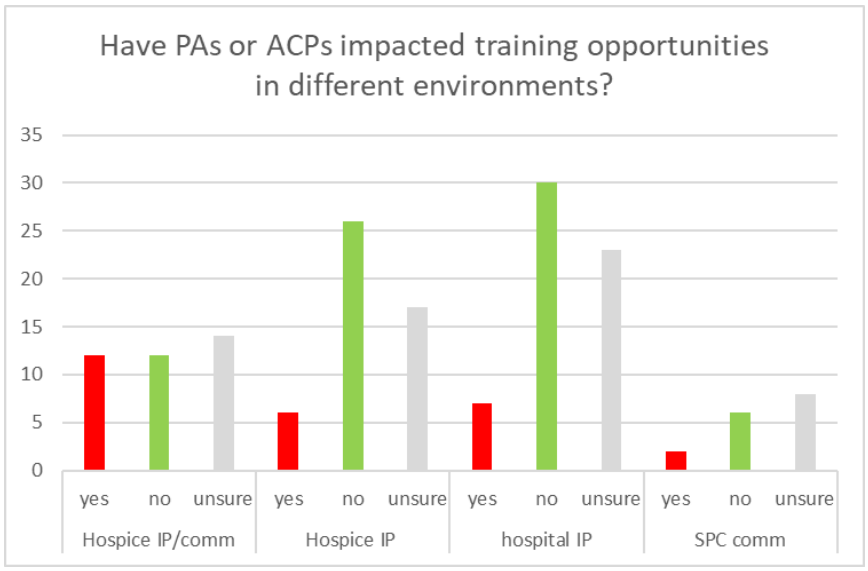


1=working with PAs with PC experience in PC environment

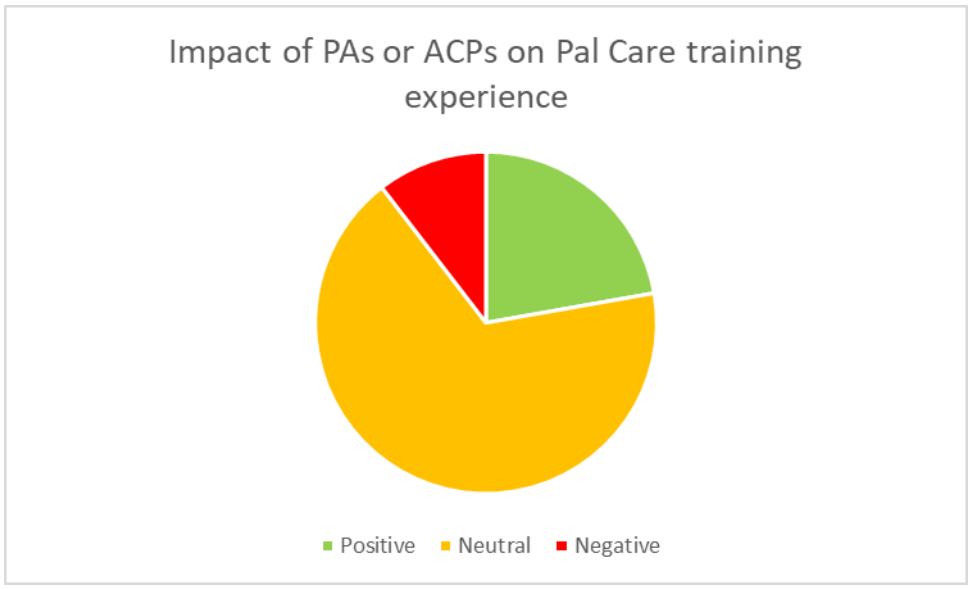
2= working with PAs without PC experience in PC environment

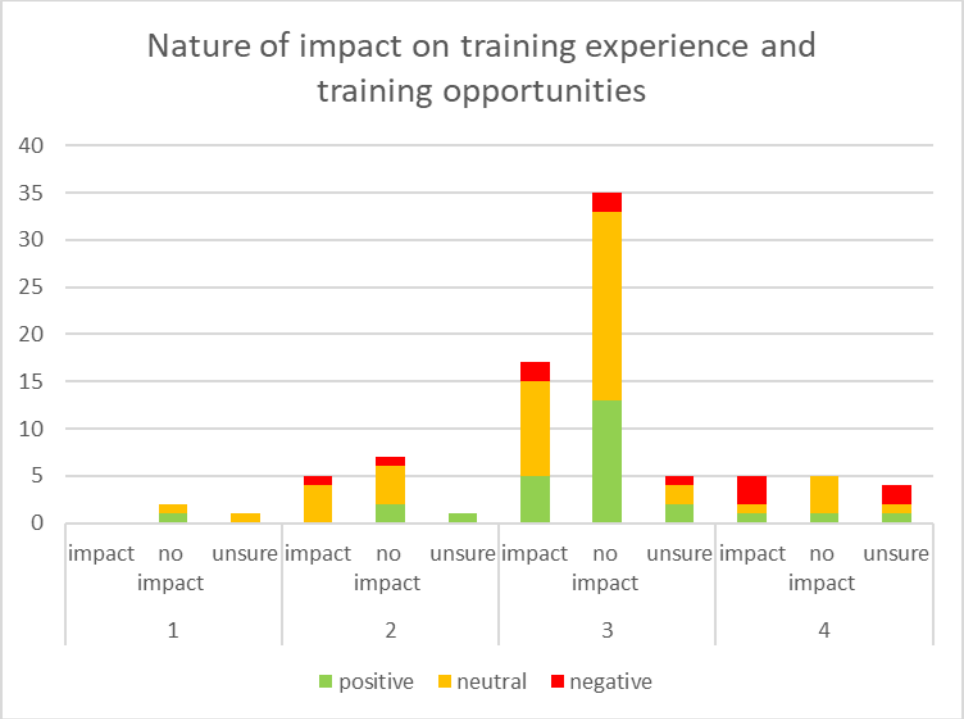
3=working with ACPs with PC experience in PC environment

4= working with ACPs without PC experience in PC environment



Impact of PAs or ACPs on Palliative Care training experience (eg trainee supervising)



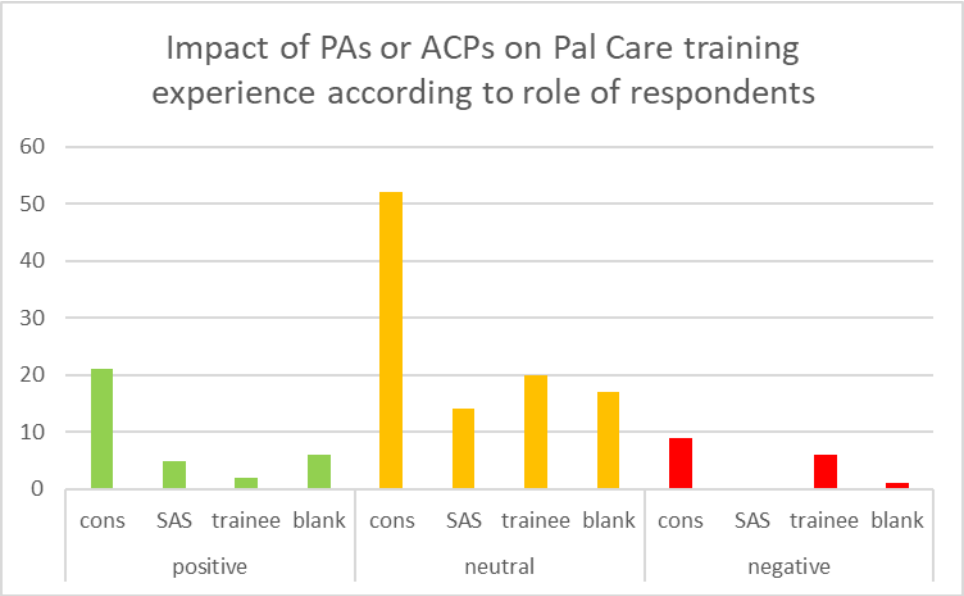


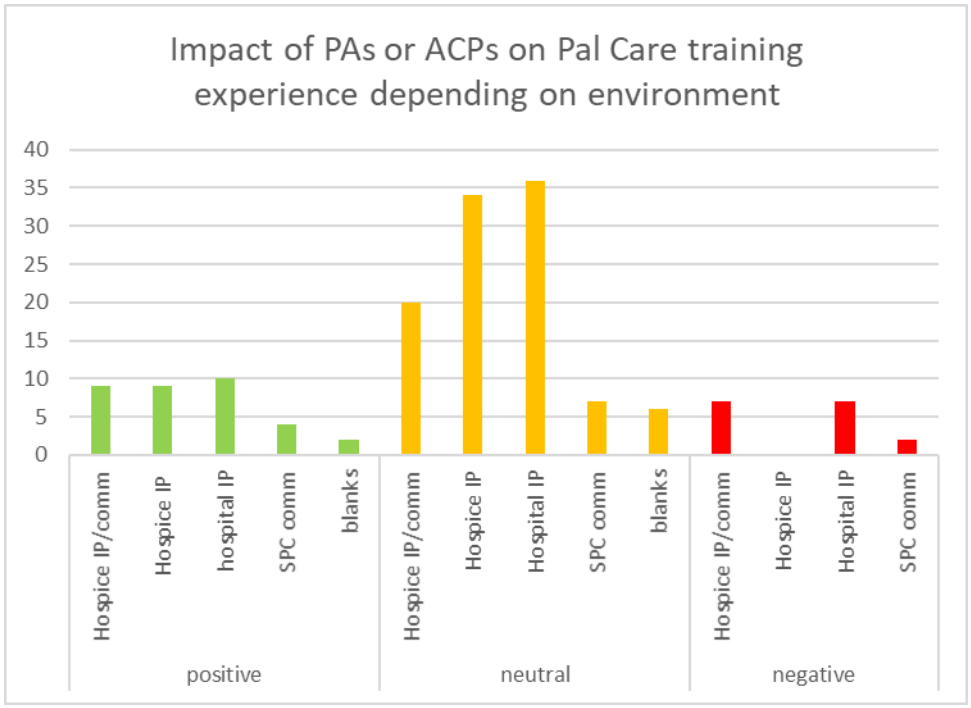
1=working with PAs with PC experience in PC environment

2= working with PAs without PC experience in PC environment

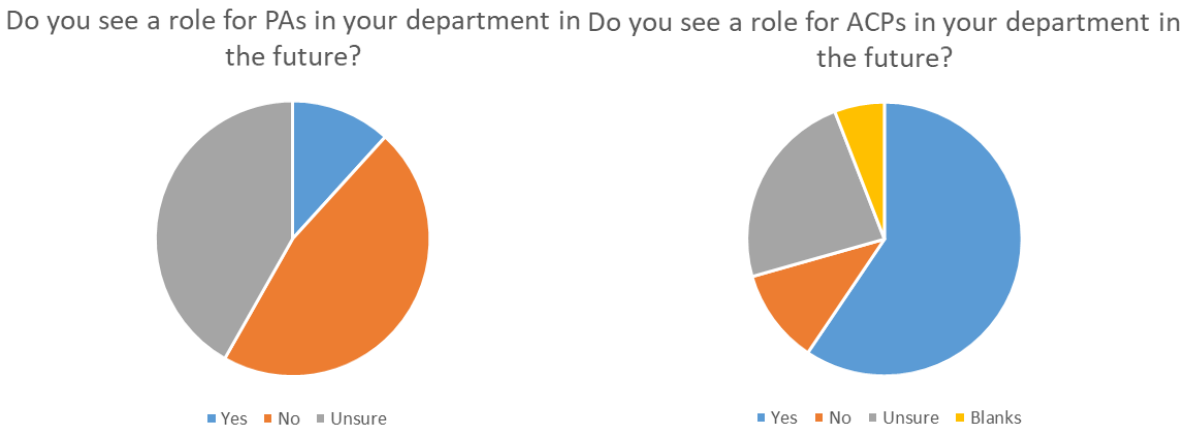
3=working with ACPs with PC experience in PC environment

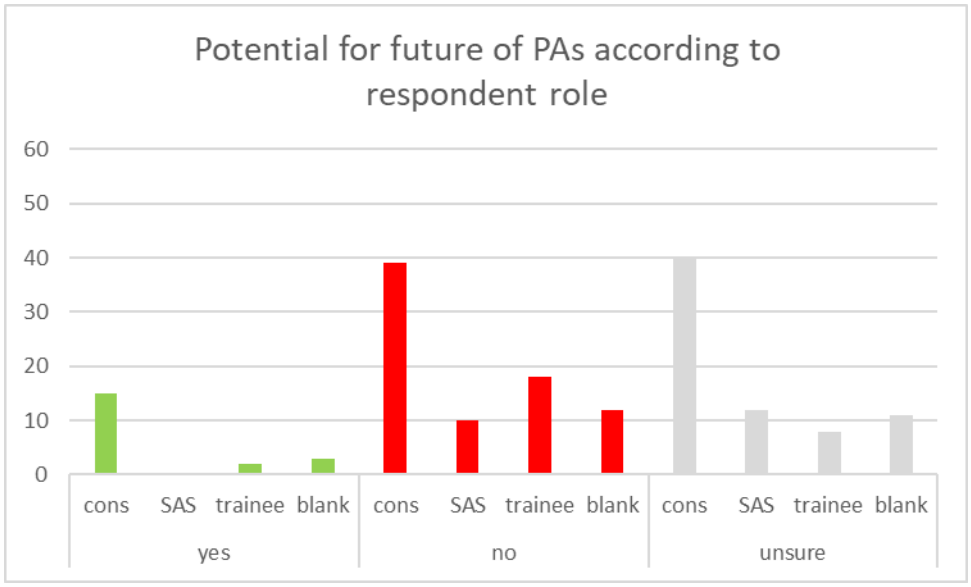
4= working with ACPs without PC experience in PC environment





Role of PAs or ACPs in respondent's departments in the future




Potential for future of PAs according to respondent role
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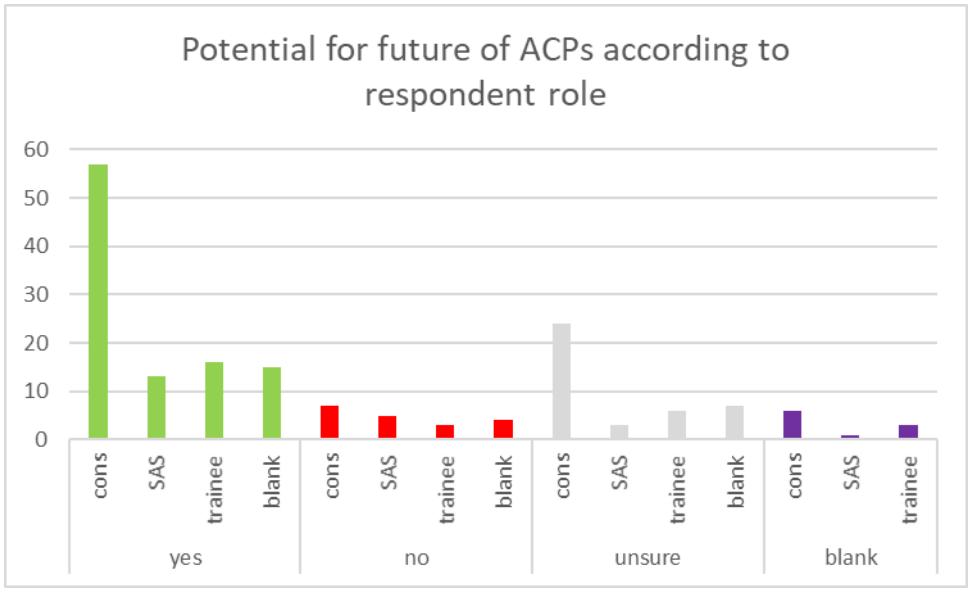
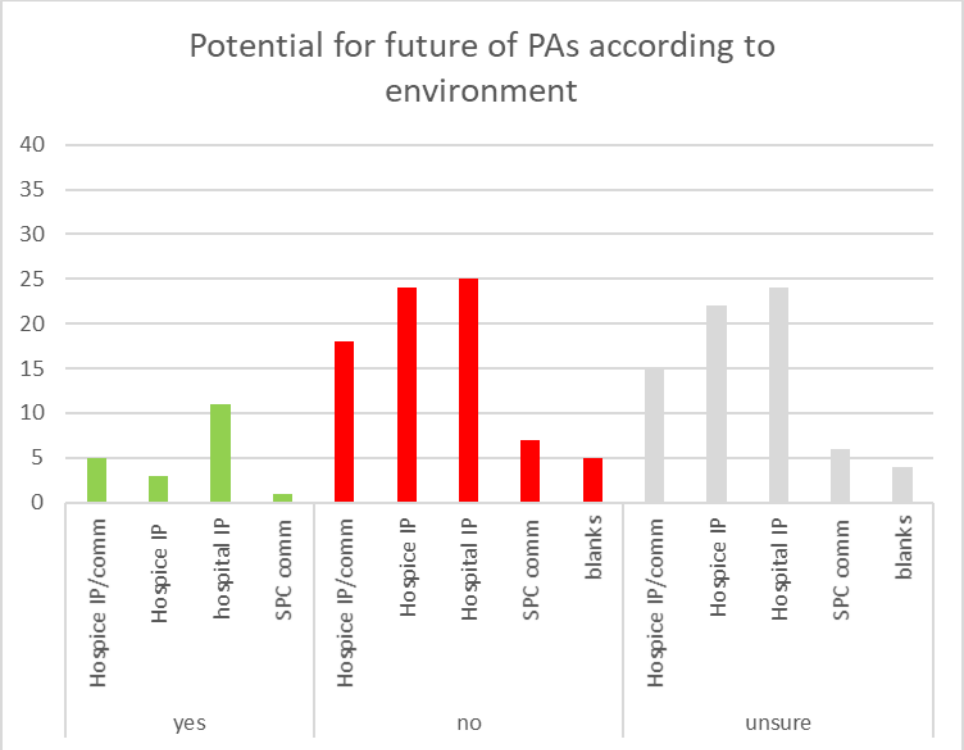
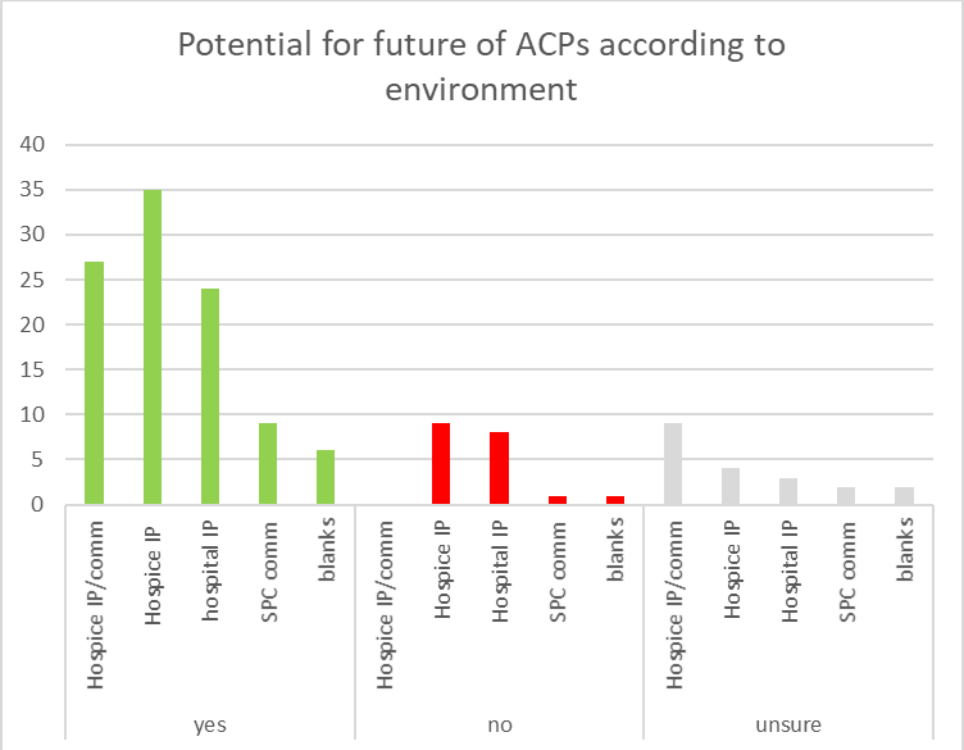
50
40
30
20
10
0
cons
SAS
trainee
blank
cons
SAS
trainee
blank
cons
SAS
trainee
blank
yes
no
unsure


Potential for future of ACPs according to respondent role
60
50
40
30
20
10
0
cons
SAS
trainee
blank
cons
SAS
trainee
blank
cons
SAS
trainee
blank
cons
SAS
trainee
yes
no
unsure
blank


Potential for future of PAs according to environment
40
35
30
25
20
15
10
5
0
Hospice IP/comm
Hospice IP
hospital IP
SPC comm
Hospice IP/comm
Hospice IP
Hospital IP
SPC comm
blanks
Hospice IP/comm
Hospice IP
Hospital IP
SPC comm
blanks
yes
no
unsure


Potential for future of ACPs according to environment
40
35
30
25
20
15
10
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0
Hospice IP/comm
Hospice IP
hospital IP
SPC comm
blanks
Hospice IP/comm
Hospice IP
Hospital IP
SPC comm
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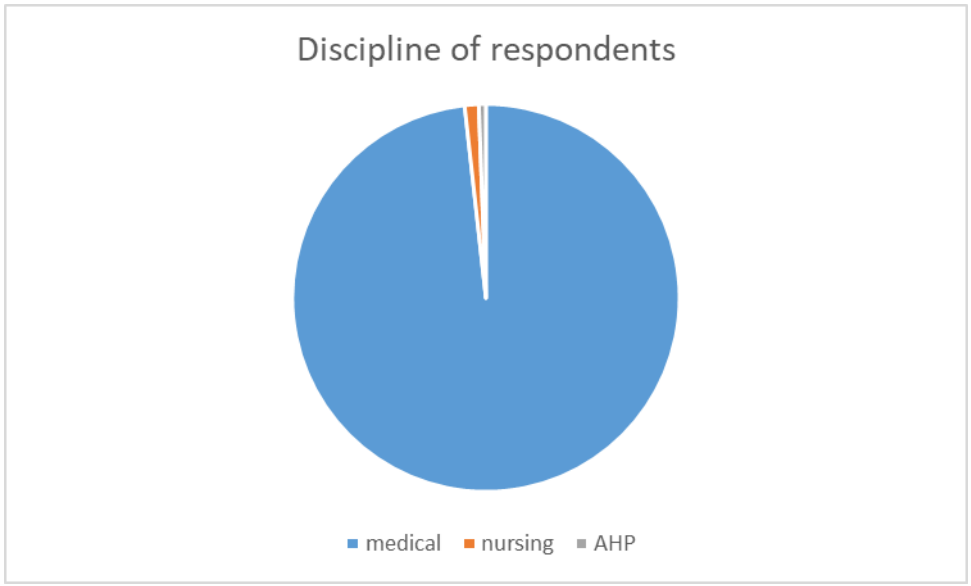
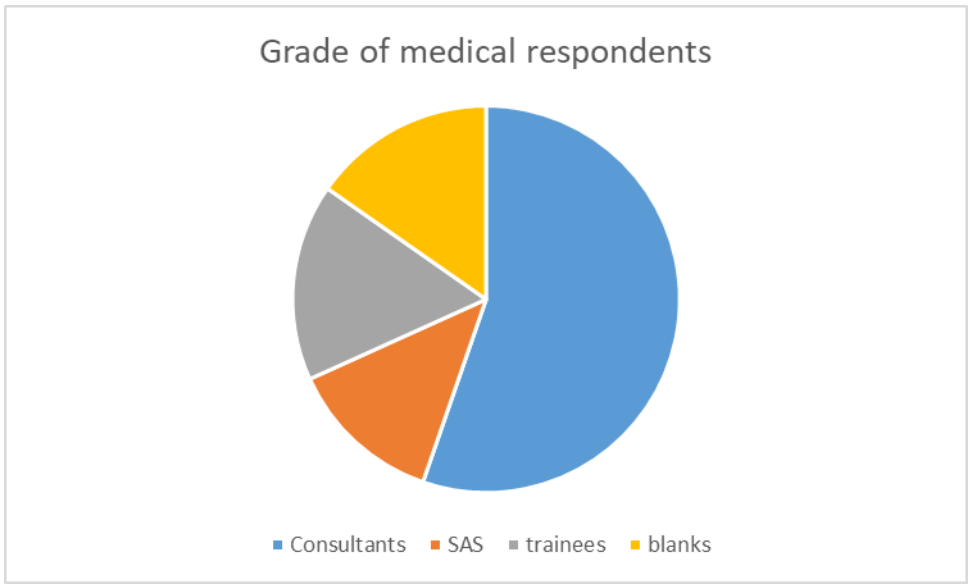
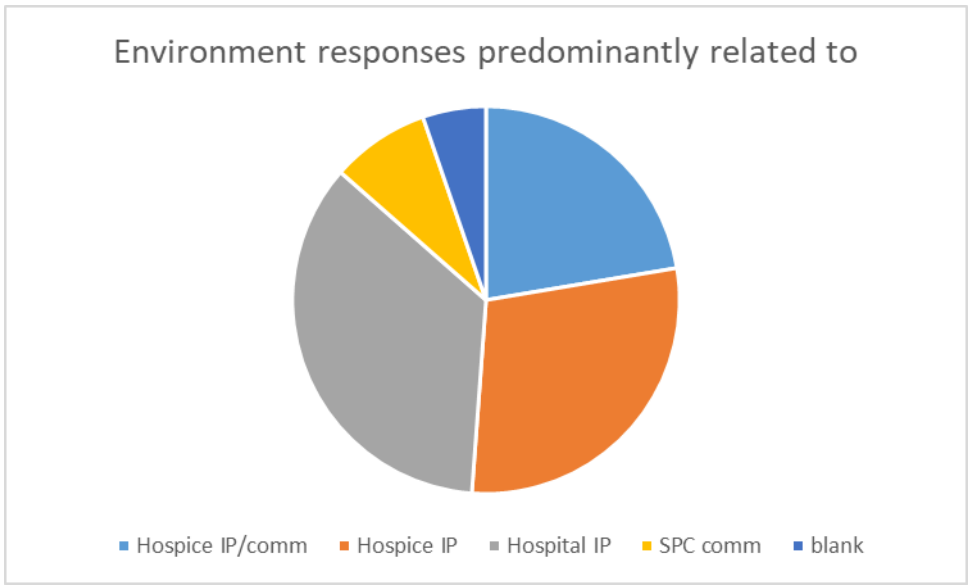
Hospice IP/comm
Hospice IP
Hospital IP
SPC comm
blanks
yes
no
unsure

Demographics of respondents







Qualitative data from ACP/PA survey

Themes

Roles

ACPs different role, scope of practice and experience from PAs: Neither equivalent to role of doctor due to breadth of medical training. Need roles to be clear (to all). PAs need to not identify as a doctor or allow confusion to exist about their role to patients. Important not to include in doctor numbers eg on rotas etc

"..organisations can appear to use them as 'cheaper' members of a team but asked to perform the same role as a GP or palliative care physician but not acknowledging that we are not the same"

More positive experiences with ACPs than PAs .

"Definite role for ACPs…. Less certain of role of PAs…"

.."genuinely worried about the increasing PA culture"

…"but need both dr and ACP roles in the team for it to function well.", "ACP were useful but didn't feel different to working with senior experience nursing colleagues known by any other name", "bridge between medical and nursing team clinically", "very important to focus on their skills as an experienced nurse rather than try to make them fit into a medical team model", "Most ACP prefer support of being part of medical team to maintain advanced practice skills."

Experience/self awareness

Range of experience – if experienced and aware of limitations then very helpful member of the team

If lack experience or awareness of their limitations this can be challenging and adds risk to patient care

" you don't know what you don't know"

"not knowing you need to know something is dangerous"

"Perhaps the PA role needs to be more administrative than clinical?"

"…mostly excellent, working within their competence, useful source of continuity….limited amount of consultant support…..discourse around PAs in particular has become very toxic….impact on the PAs on the ward…not recognising or valuing their contribution in a stretched system."

"…new palliative medicine curriculum highlighting the importance of having clinicians who are generalists, and have a broad knowledge of medicine to meet the growing complexity of our patient cohort. I don't believe the current non rotational ACP/PA model fits with these values…."

Limitations/ Benefits

Sometimes PAs add to workload due to their limitations as can't prescribe/order scans or do MCCD. Lack of broad based training/experience can be limiting/make care unsafe – *"not always able to manage unfiltered patients", "..a lot of medical decision making ability, but potentially lack the overall medical recognition and responsibility that comes with being a doctor", "all is well until something unusual occurs and then we expect them to be able to recognise and manage this problem which is totally unfair"*

Also concern re medicolegal issues related to who is responsible for prescribing etc for patients assessed by Pas.

.."expectation that I will take responsibility for their clinical work and decision making (as I would normally do with a junior Dr) but not really having an understanding as to what is within their zone of clinical competence or what their experience/training to date has covered."

"PAs overall will have limited role until able to prescribe"

"…without background knowledge of prescribing they would have limited capacity to make prescribing recommendations safely"

Able to provide continuity/consistency of patient care eg in hospice IPUs which is not afforded by rotational posts of trainees. May be seen by trusts/hospices as a better investment of their money. Often training posts are vacant - more stable workforce?

"..with recruitment crisis has been great to grow and develop ACPs",

Bring extra set of skills eg paramedic ACP. Visible career progression to ambitious nurses. Add to strategic development/governance etc. of service

Possibly more suited to OP/A&E assessments or where work is process/guideline driven (to compensate for lack of experience)

"..ACPs are very valuable – they have experience developed from a clinical career leading up to their ACP role. PAs do not have this experience and so I think their ability to contribute to clinical care is and should remain very limited."

Impact on training

Mixed in views re impact on training of doctors – some feel dilutional effect of training/supervising too many people negatively impact training of junior doctors, some feel experienced ACP can help either train and support junior doctor/trainees or free them up from ward work/admin to be able to attend training opportunities.

"…their presence helps us to fulfil our training obligations, allowing us more time to spend with trainees. They are also knowledgeable and help with the training of junior doctors (not registrars)" versus

"Due to the restrictions of the role of PAs……, the workload for the doctors increased and so the time for training opportunities was decreased."

Opportunity for trainees to learn from/or supervise depending on experience

"Useful as a specialty trainee to have experience of working with colleagues with different backgrounds to help me understand what levels of supervision different groups need. The ANP I have worked with is so good that it really helps with workload management and facilitates trainees getting to other training opportunities eg clinic"

"…negligible benefit to trainees in supervising PAs and risk of significant medicolegal harms"

" …concept of a trainee 'supervising' a senior nurse is inappropriate and borderline offensive"

If ACP trained to do a procedure (Palliative medicine not a particularly procedure-driven specialty) and trusted to do this then this may reduce opportunity of trainee to learn how to do this eg paracentesis.

PAs "*preferentially selected for training tasks as they will remain on the ward to use them, unlike the medics who will be moved to a different ward shortly"*

No space for trainee if ACP/PA in post?

Some have chosen to say 'no' to PAs as "*think it would impact on training of nurses and doctors*"

"We need junior doctors for rotas so we have a future consultant workforce"

.."use of ACPs in hospices have reduced the pool of posts available to Specialty Doctors and Doctors gaining experience before gaining a training number"

Need time allocated for supervising (which could be used to supervise junior doctors) which can be significant even when ACP experienced.

"..even very experienced ACPs will want and need senior medical support from palliative care consultants or senior doctors for complex decision making"

"I spent a lot of time trying to upskill our ACP to increase her confidence at clinical reasoning. This meant I had less time for trainees"

Difficult to supervise as not clear what their skill set is and what they should be expected to know/be able to do. Must not be pressured into taking responsibility that is too much for their expertise.

"Both PA elective students we had were motivated and easy to supervise"

Not possible to meet the increasing requests for PC clinical placements

"I want to support doctors to receive high quality training. I do not want more PAs. I do not wish to have PAs join our team, which would take away training opportunities"

Responsibility

"*difficulty knowing where responsibility lies at times… at times leads to duplication of work which exacerbates pressures on doctors."*

…"*with such small consultant numbers …remote support of an increasingly group of staff with different skill sets working in different settings makes it feel less safe."*

"..not being line managed by doctors means there are issues with accountability"

Costs

Need to weigh up extra consultant/senior doctor support required - ?SAS doctor more cost effective?

"*I do not see a role for PAs as they are expensive, not regulated and require time consuming supervision beyond that of a doctor."*

"I don't think our hospice can survive without them"

"…pay grades are so ridiculous why would you employ a PA if you could get an ACP…"

“”..PAs have a potential helpful place in the roles in which I was originally informed they would have (I worked with some of the first cohorts of PAs in an acute medical admissions unit) eg advanced clinical admin, discharge letters etc. However, I feel the expansion of the role is dangerous and compromises patient care. There need sto be a clear pathway of supervision and acknowledgement of the increased medicolegal risk burden on the supervising clinician, who should not be a trainee. Supervision of PAs must be accompanied by corresponding remunerationand time to review patients thoroughly, most likely making this arrangement not cost-effective without compromising patient care”

Individual and organisation specific

“..impact has varied depending on – the experience of the PA/ACP, their establishment within the team, their relationship with supervising consultants, the culture of the department and/or organisation towards the responsibilities of PAs and ACPs”

“no in community and hospital liaison roles but possibly in an inpatient environment it may be beneficial to have the continuity of medical staffing to support changeover periods etc and a middle tier of personnel”

“*Hard to imagine how PAs could be useful in a specialty such as ours which is not at all protocol/evidence driven. Decisions are taken based on instinct and clinical experience*”

“I respect some of the PAs a lot more than other health care pro